SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

BEHAVIORAL HEALTH SERVICES ACT (BHSA) THREE-YEAR INTEGRATED PLAN

October 30, 2025 – Template

****Plan amended April 27, 2026 following 30-Day Public Comment Period and DHCS feedback***

Table of Contents

Introduction

The Behavioral Health Services Act (BHSA) (Senate Bill (SB) 326, Chapter 90, Statutes of 2023) requires all county Behavioral Health Departments to submit a three-year Integrated Plan for Behavioral Health Services and Outcomes outlining intended use of funds and a budget for behavioral health programs administered, beginning with Fiscal Years (FY) 2026-2029 (July 1, 2026 – June 30, 2029). The Department of Health Care Services (DHCS) is developing a portal where counties will enter their Integrated Plans and updates (herein referred to as the "county portal").

This document is the template for the Three-Year Integrated Plan. The final release of the Integrated Plan will be available on the county portal and questions will be formatted to collect information in a streamlined manner. The county portal will include web form elements such as dropdown menus and text fields. **Throughout this template, bracketed text represents planned user interface elements for the county portal.** Additional information on standards for completing and submitting the Integrated Plan is provided in the Behavioral Health Services Act County Policy Manual (herein referred to as the "Policy Manual") Chapter 3.

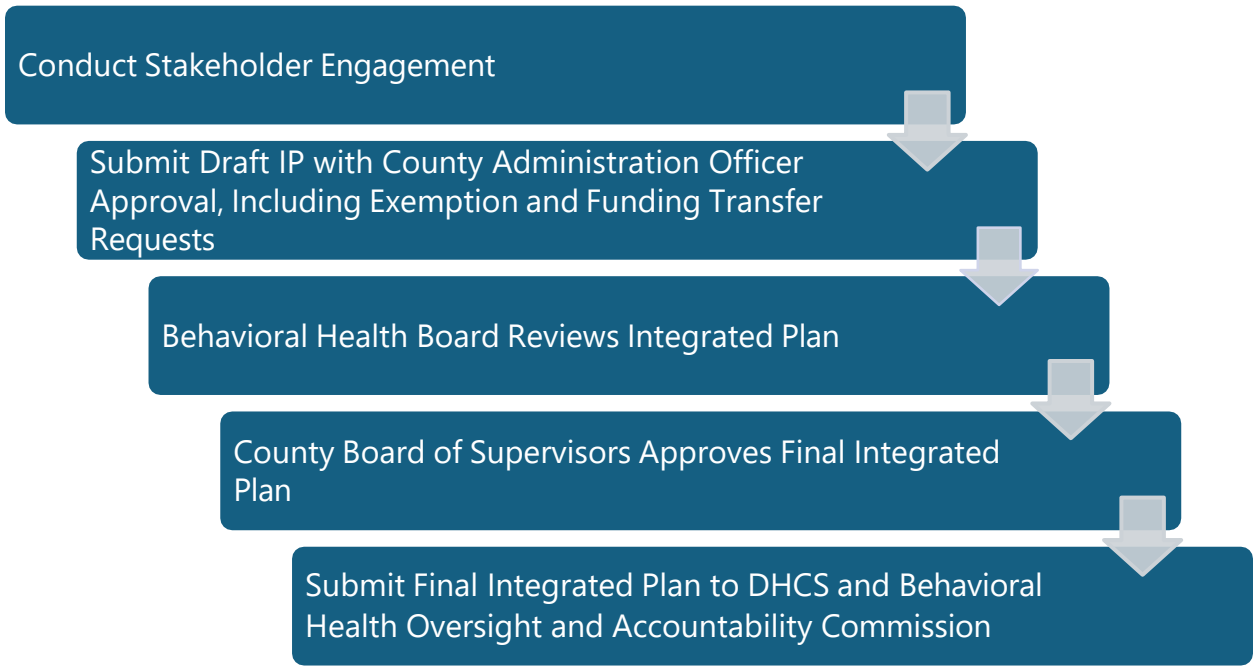


Figure 1. Integrated Plan Submission Workflow

*Recommended sequence. See details on the exemption submission process in the Integrated Plan Submission section (Policy Manual Chapter 3, Section E.4).

General Information

1. County, City, Joint Powers, or Joint Submission: County
2. Entity Name (county, city, joint powers, or other): San Mateo County
3. Behavioral Health Agency Name: San Mateo County Health, Behavioral Health and Recovery Services
4. Behavioral Health Agency Mailing Address: 2000 Alameda de las Pulgas, Suite 235, San Mateo, CA 94403
5. Primary Mental Health Contact
    a. Name: Jei Africa, Director
    b. Email: jafrica@smcgov.org
    c. Phone: (650) 573-2748
6. Secondary Mental Health Contact
    a. Name: Doris Estremera, BHSA Coordinator
    b. Email: destremera@smcgov.org
    c. Phone: (650) 573-2889
7. Primary Substance Use Disorder Contact
    a. Name: Clara Boyden, Deputy Director
    b. Email: cboyden@smcgov.org
    c. Phone: (650) 995-3880
8. Secondary Substance Use Disorder Contact
    a. Name: Sheryl Uyan, Health Services Manager
    b. Email: suyan@smcgov.org
    c. Phone: 650-802-5016
9. Primary Housing Interventions Contact
    a. Name: Talisha Racy, Deputy Director
    b. Email: tracy@smcgov.org
    c. Phone: (650) 573-2038
10. Compliance Officer for Specialty Mental Health Services (SMHS)
    a. Name: Sheryl Uyan, Health Services Manager
    b. Email: suyan@smcgov.org
11. Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
    a. Name: Sheryl Uyan, Health Services Manager
    b. Email: suyan@smcgov.org

12. **Behavioral Health Services Act (BHSA) Coordinator (Minimum one contact required)**

Name	Email Address
Doris Estremera	Destremera@smcgov.org

13. Substance Abuse and Mental Health Services Administration (SAMHSA) liaison (Minimum one contact required)

Name	Email Address
Clara Boyden	cboyden@smcgov.org

14. Quality Assurance or Quality Improvement (QA/QI) lead (Minimum one contact required)

Name	Email Address
Claudia Tinoco	Ctinoco1@smcgov.org

15. Medical Director (Minimum one contact required)

Name	Email Address
Tasha Souter	Tsouter@smcgov.org

Exemption Requests

Please complete the following section if the county is requesting a Housing Interventions exemption for the Integrated Plan (IP) covering Fiscal Years (FY) 2026-2029. Only counties with a population of less than 200,000 may request a Housing Interventions exemption for the FY 2026-2029 IP. Counties must submit their exemption request by March 31 of the fiscal year prior to the fiscal year covered in the IP (i.e., exemption requests for the FY 2026-2029 IP must be submitted to DHCS by March 31, 2026) to facilitate timely review and approval.

For the FY 2026-2029 IP, all counties, regardless of population size, are exempt from the evidence-based practice (EBP) fidelity requirements for Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Individual Placement and Support (IPS) model of supported employment, and High Fidelity Wraparound (HFW); counties must deliver Full Service Partnership (FSP) services and adhere to the FSP requirements outlined in the Policy Manual, including EBP implementation requirements in Policy Manual Chapter 7, Section B.3.4. Counties do not need to submit exemptions to FSP requirements for this IP. For related policy information, refer to 7.C.6 Transfers and Exemptions.]

No Exemptions Requested

Funding Transfer Requests

If the county aims to submit a funding transfer request for the Fiscal Years (FY) 2026-2029 Integrated Plan (IP) period, please complete the questions below. Counties must submit their request by March 31 of the FY prior to the FY covered in the IP (i.e., exemption requests for the FY 2026-2029 IP must be submitted to DHCS by March 31, 2026) to facilitate timely review and approval.

[Logic: display the following statement if county population is less than 200,000]

Counties with populations under 200,000 can assume that their request to reduce Housing Intervention Component funds from the required 30 percent is approved when completing the table below.

1. Please enter the proposed allocation adjustments to the tables below.

   Counties may transfer no more than 7 percent of total funds from each component to another component, with a maximum of 14 percent of total funds transferred.

No Transfers Requested

Table 1. Proposed Allocation Adjustments for Each Funding Component

BHSA Component	Plan Year One	Plan Year Two	Plan Year Three
Behavioral Health Services and Supports [Base 35%]	35%	35%	35%
Full Service Partnership [Base 35%]	35%	35%	35%
Housing Interventions [Base 30%]	30%	30%	30%
Housing Interventions for Outreach and Engagement	0%	0%	0%

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).

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

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

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)	2788 (San Mateo County BHRS Data, FY2425)
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	48 (San Mateo County BHRS Data, FY2425) Please note that age data was not provided by all respondents in these programs
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	62 (San Mateo County BHRS Data, FY2425)
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	28 (San Mateo County BHRS Data, FY2425)
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	47 (San Mateo County BHRS Data, FY2425)
Were chronically homeless or experiencing homelessness or at risk of homelessness	99 (San Mateo County BHRS Data, FY2425)
Were in the juvenile justice system	319 (San Mateo County BHRS and Probation Department Data, FY2425) *Please note that this data is based on referral source, program involvement, and juvenile release data and may not accurately capture the entire population of justice involved folks served by BHRS.
Have reentered the community from a youth correctional facility	66 (San Mateo County BHRS and Probation Department Data, FY2425)
Were served by the Mental Health Plan and had an open child welfare case	131 (San Mateo County BHRS Data, FY2425) *Please note that this data is based on referral source and program involvement and may not accurately capture the entire population of children served by MHP who had an open child welfare case.

Criteria	Number of Children and Youth Under Age 21
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	5 (San Mateo County BHRS Data, FY2425) *Please note that this data is based on referral source and program involvement and may not accurately capture the entire population of children served DMC-ODS who had an open child welfare case.
Have received acute psychiatric care	218 (San Mateo County BHRS Data, FY2425)

Adults and Older Adults

1. 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	2454 (San Mateo County BHRS Data, FY2425)
Received Medi-Cal SMHS	8133 (San Mateo County BHRS Data, FY2425)
Received DMC or DMC-ODS services	1351 (San Mateo County BHRS Data, FY2425)
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	536 (San Mateo County BHRS Data, FY2425)
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	2401 (San Mateo County BHRS Data, FY2425)
Experienced unsheltered homelessness	We are unable to estimate this for individuals served by BHP using internal data. In 2024, there were 1086 adults identified as unsheltered and unhoused in the point in time count. (CoC Homeless Populations Reports, 2024)
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	We are unable to estimate this for individuals served by BHP using internal data.
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	We are unable to estimate this for individuals served by BHP using internal data.

Criteria	Number of Adults and Older Adults
Were in the justice system (on parole or probation and not currently incarcerated)	2649 (San Mateo County BHRS Data, FY2425) Please note that this data includes all adults served by BHRS in FY2425 who were identified as justice-involved, regardless of their parole or probation status.
Were incarcerated (including state prison and jail)	The average daily population in county jail was 936 as of 2024. 936 ADP BSCC Jail Population Survey Dashboard, 2024
Reentered the community from state prison or county jail	272 CDCR Recidivism Dashboard, FY2019
Received acute psychiatric services	774 (San Mateo County BHRS, FY2425)

2. Input the number of persons in designated and approved facilities who were
   a. Admitted or detained for 72-hour evaluation and treatment rate
      - 3167 (LPS Facility Reported Data, FY2425)
   b. Admitted for 14-day periods of intensive treatment
      - 568 (LPS Facility Reported Data, FY2425)
   c. Admitted for 30-day periods of intensive treatment
      - 0 (LPS Facility Reported Data, FY2425)
   d. Admitted for 180-day post certification intensive treatment
      - 0 (LPS Facility Reported Data, FY2425)

3. Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
   - 78 (DSH IST Determinations Annual Report Final Adjusted IST Determination, FY2023)

4. Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
   - 186 (San Mateo County BHRS Data,FY2425)

5. Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding? **Yes**
   - 2a-d (LPS Act): Data is based on quarterly reporting dashboards from LPS facilities in FY2425 for individuals age 18+. People may be double counted

if they had multiple admissions in the fiscal year or transferred between facilities. One facility was missing reporting data for one quarter. Data for missing quarter was calculated based on average individuals served in other quarters.

- 4 (DSH Community solution programs) captures clients involved in the mental health diversion Pathways program in FY2425.

San Mateo County BHRS was unable to differentiate between incarceration status, community transition status, and probation status for adult members served. The population of adults served by BHRS who were justice involved was included under "were in the justice system." Publicly available data was used as a proxy for adults who were incarcerated and those who reentered the community. Publicly available data is not specific to clients served by BHRS.

6. Please describe the local data used during the planning process:

   BHRS hosted 14 Community Input Sessions that provided an opportunity for clients, family members, and community partners to learn about the Priority Statewide Behavioral Health Goals, review the data, disparities analysis, and provide insights related to strengths, needs, and potential strategies. Each input session included disparities data for Access to Care and focused one of the six required Priority Goal or the additional goal selected by BHRS -- "Social Connection". Over 200 clients, family members, community members, contracted agencies and community partners participated in the input sessions.

7. If desired, provide documentation on the local data used during the planning process [optional file upload - **See Appendix 1**].

8. Identify the specific service components within your 3-year Integrated Plan that will support CARE participants. Explain how the county will ensure these individuals receive priority access and specialized coordination within the broader behavioral health continuum, including housing if appropriate.

   BHRS CARE services are designed to disrupt the revolving door of homelessness, short-term hospitalization, and incarceration often experienced by those with untreated serious mental illness (SMI) by connecting the individuals to a CARE plan, which will include comprehensive treatment, housing, and supportive services. The FSP, Outreach and Housing service components all support CARE services. Eligible CARE clients are referred to FSP level services, currently BHRS has dedicated FSP slots for CARE referrals and will continue to prioritize CARE clients as FSPs transition to an ACT/FACT and Intensive Case Management model. Housing supports are provided to unhoused FSP clients and outreach and engagement activities are a minimum service requirement for all FSP contracted providers. Outreach is expected within 1-3 business days of receiving a referral (prioritizing imminent discharges from hospitals, jails, etc.) and can last up to 60 days. Other engagement activities include weekly attempts to locate individuals in the field, repeated contacts with friends, family members and referring providers and 24/7 availability, use of motivational interviewing, contingency management, culturally/gender-matched teams, and warm handoffs.

9. Describe how CARE referral pathways will be integrated into existing referral and service pathways within the county behavioral health system.

   CARE clients are connected to services depending on their individual need. Because there are dedicated CARE FSP slots, the CARE BHRS team refers directly to the FSP for services. For BHRS regional clinics, CARE clients are connected via the BHRS Access Call Center. For substance use treatment, CARE clients are administered the ASAM to determine eligibility for placement level. All CARE clients receive case management services, including support with benefits, obtaining documentation, and housing support.

10. Describe the process for identifying and redirecting individuals who are potentially eligible for CARE to alternative pathways when a formal petition is not required or appropriate. For individuals redirected from CARE, describe how the county will confirm and document successful connection to services.

    The CARE BHRS team operates a phone line and email for both community members and other providers. The team helps explain eligibility criteria, provides support with petitions, and will assess clients when information is unclear. CARE BHRS meets with family members, providers, and the referred clients to engage in services and evaluate the appropriate level of care. This may include reconnecting clients to treatment that had recently been terminated, connecting to regional clinics through Access, as well as accessing higher levels of care like Assisted Outpatient Treatment. Clients are provided a warm hand-off to the appropriate services. All referrals to the CARE BHRS team are documented in both our electronic health records as well as the state required data entry reports on CARE petitions and referrals.

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

1. Does the county behavioral health system use an Electronic Health Record (EHR)? **Yes**
   a. Please select which of the following EHRs the county uses
      - ☐ Altera Digital Health
      - ☐ Athena Health
      - ☐ Clinician's Gateway
      - ☐ CPSI
      - ☐ eClinicalWorks
      - ☑ Epic Systems
      - ☐ GE Centricity
      - ☐ Greenway Health
      - ☐ MEDHOST
      - ☐ MediTech
      - ☑ Netsmart

- ☐ NextGen Healthcare
- ☐ Oracle Cerner
- ☐ Practice Fusion
- ☐ Qualifacts Credible
- ☐ SmartCare
- ☐ TherapyNotes
- ☐ Other [narrative box]

2. Does the county behavioral health system participate in a Qualified Health Information Organization (QHIO)? **No**

    a. Please select which QHIO the county participates in
    - ☐ Cozeva
    - ☐ Health Gorilla, Inc.
    - ☐ Long Health, Inc.
    - ☐ Los Angeles Network for Enhanced Services (LANES)
    - ☐ Manifest MedEx
    - ☐ Orange County Partners in Health HIE
    - ☐ Serving Communities Health Information Organization
    - ☐ San Diego Health Connect
    - ☐ SacValley MedShare

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

1. Please provide the link to the county's API endpoint on the county behavioral health plan's website: **https://fhir.netsmartcloud.com**

2. Does the county wish to disclose any implementation challenges or concerns with these requirements? **No**

    a. Please describe these challenges and concerns:

3. 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**

    a. Please describe these challenges and concerns:

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

1. Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period? **Yes**
    a. Please select all services the county behavioral health system plans to provide under the PATH grant [multi-select list]
        - ☐ Alcohol or Drug Treatment Services
        - ☐ Case Management Services
        - ☑ Community Mental Health Services
        - ☐ Habilitation and Rehabilitation Services
        - ☐ Outreach Services
        - ☐ Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services
        - ☐ Screening and Diagnostic Treatment Services
        - ☐ Staff Training, including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services
        - ☐ Supportive and Supervisory Services in Residential Settings

2. [logic: Populate question if vi is selected in list above] Please select the county's referrals for Primary Health Care, Job Training, Educational Services, and Housing Services **N/A**
    - ☐ Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations
    - ☐ Improving the Coordination of Housing Services
    - ☐ Minor Renovation, Expansion, and Repair of Housing
    - ☐ One-time Rental Payments to Prevent Eviction
    - ☐ Planning of Housing
    - ☐ Security Deposits
    - ☐ Technical Assistance in Applying for Housing

3. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **No**
    a. Please describe these challenges or concerns: **N/A**

Community Mental Health Services Block Grant (MHBG)

1. Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period? **Yes**
    a. Please select all set asides that the county behavioral health system plans to participate in under the MHBG
    - ☐ Children's System of Care Set-Aside
    - ☐ Discretionary/Base Allocation
    - ☑ Dual Diagnosis Set-Aside
    - ☑ First Episode Psychosis Set-Aside
    - ☐ Integrated Services Agency Set-Aside

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **No**
    a. Please describe these challenges or concerns: **N/A**

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

1. Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period? **Yes**
    a. Please select all set-asides that the county behavioral health system participates in under SUBG [multi-select list]
    - ☑ Adolescent/Youth Set-Aside
    - ☑ Discretionary
    - ☑ Perinatal Set-Aside
    - ☑ Primary Prevention Set-Aside
    - ☐ Syringe Services Program Allowance

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **No**
    a. Please describe these challenges or concerns: **N/A**

Opioid Settlement Funds (OSF)

1. Will the county behavioral health system have planned expenditures for OSF during

the Integrated Plan period? **Yes**

a. Please check all set asides the county behavioral health system participates in under OSF Exhibit E

- ☑ Address The Needs of Criminal Justice-Involved Persons
- ☑ Address The Needs of Pregnant or Parenting Women and Their Families,
- ☑ Including Babies with Neonatal Abstinence Syndrome
- ☑ Connect People Who Need Help to The Help They Need (Connections to Care)
- ☑ First Responders
- ☑ Leadership, Planning, and Coordination
- ☑ Prevent Misuse of Opioids
- ☑ Prevent Overdose Deaths and Other Harms (Harm Reduction)
- ☑ Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
- ☑ Research
- ☑ Support People in Treatment and Recovery
- ☑ Treat Opioid Use Disorder (OUD)
- ☑ Training

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **No**
   a. Please describe these challenges or concerns: **N/A**

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) ***(no action required).***

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

1. 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:
   - ☑ Assertive Community Treatment (ACT)
   - ☑ Clubhouse Services
   - ☐ Community Health Worker Services (CHW)
   - ☐ Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
   - ☑ Forensic Assertive Community Treatment (FACT)
   - ☐ Individual Placement and Support (IPS) Model of Supported Employment
   - ☐ Other Programs and Services: **N/A**

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **No**
   a. Please describe these challenges or concerns: **N/A**

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

1. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **No**
   a. Please describe these challenges or concerns: **N/A**

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

1. Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?
   - ☑ ACT
   - ☑ Clubhouse Services
   - ☑ CSC for FEP
   - ☐ Enhanced CHW Services
   - ☑ FACT
   - ☑ IPS Supported Employment
   - ☑ Peer Support Services

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **No**
   a. Please describe these challenges or concerns: **N/A**

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

1. Select which of the following services the county behavioral health system participates in [single-select list]

☐ DMC Program [if selected, populate DMC questions]

☑ DMC-ODS Program [if selected, populate DMC-ODS questions]

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 Narcotic 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

l. Early Intervention for individuals under age 21

1. 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

☐ Inpatient Services (ASAM Levels 3.7 & 4.0)

☐ IPS Supported Employment

☐ Partial Hospitalization Services (ASAM Level 2.5)

☑ Peer Support Services

☑ Recovery Incentives Program (Contingency Management)

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

a. Please describe these challenges or concerns:

Referrals from external partners for the Recovery Incentive Program (Contingency Management) continue to present a challenge. Most participants receiving these contingency management services are clients of the contracted provider. The contracted provider is focusing on conducting outreach to other SUD providers to increase awareness of the Recovery Incentive Program.

Other Programs and Services

1. Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs. [narrative box, with option to create unlimited number of entries]

Care Transitions

1. Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth)? **No**

2. Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition? **Yes**

Statewide Behavioral Health Goals

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 to strengthen their evaluation and better understand community needs.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures.

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

Access to Care: Primary Measures

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

1. How does your county status compare to the statewide rate? [above/below/same/N/A]
    a. For adults/older adults: **above**
    b. For children/youth: **below**

2. What disparities did you identify across demographic groups or special populations?
    - ☑ Age
    - ☐ Gender
    - ☐ Race or Ethnicity
    - ☐ Sex
    - ☐ Spoken Language
    - ☐ None Identified
    - ☐ No Disparities Data Available
    - ☐ Other

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

1. How does your county status compare to the statewide rate? [above/below/same/N/A]
    a. For adults/older adults: **below**
    b. For children/youth: **above**

2. What disparities did you identify across demographic groups or special populations?
    - ☑ Age
    - ☐ Gender
    - ☑ Race or Ethnicity
    - ☐ Sex
    - ☐ Spoken Language
    - ☐ None Identified
    - ☐ No Disparities Data Available
    - ☐ Other

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

1. How does your county status compare to the statewide rate? [above/below/same/N/A]
    a. For adults/older adults: **below**
    b. For children/youth: **below**

2. What disparities did you identify across demographic groups or special populations?
    - ☐ Age
    - ☐ Gender
    - ☐ Race or Ethnicity
    - ☐ Sex
    - ☐ Spoken Language
    - ☐ None Identified
    - ☑ No Disparities Data Available
    - ☐ Other

Access to Care: Supplemental Measures

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023

1. How does your county status compare to the statewide rate? [above/below/same/N/A]

    same

2. What disparities did you identify across demographic groups or special populations?
    - ☐ Age
    - ☐ Gender
    - ☐ Race or Ethnicity

- ☐ Sex
- ☐ Spoken Language
- ☐ None Identified
- ☑ No Disparities Data Available
- ☐ Other

Access to Care: Disparities Analysis

1. 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 [narrative box]

The Access to Care disparity analysis highlighted the following:

- Low DMC-ODS penetration rates for adults and youth.
- Low SMHS penetration rates for youth (3.7% San Mateo compared to 4.2% Statewide)
    - There is a need to understand youth access to SMHS as it relates to their higher penetration rates for NSMHS (16.5% San Mateo compared to 15.5% Statewide
- Adults ages 21-56 and the Latino community could benefit from additional supports to access NSMHS.
    - Adults 33-44 in San Mateo have the lowest NSMHS penetration rate (8.3%) relative to California (10.1%).
    - Adults 21-56 have comparably lower NSMHS penetration rates than adults 57+.
    - Latino community in San Mateo has slightly lower penetration rates than statewide rates.
- Black and Latino communities are overrepresented in NSMHS, SMHS and in Total ED Visits with Self-Harm Intent relative to their proportion of the San Mateo County population demographics.

Interpreting differences across penetration rates is particularly challenging without also relating them to community health data. Existing literature highlights that penetration rates can and do vary by key demographic categories. The most appropriate comparisons relate each demographic category's specific penetration rate at the County-level relative to the comparable statewide rate.

The dynamic between higher penetration rate for youth NSMHS and lower penetration rate for SMSH highlights the potential for the two key measures to be interrelated. It is probable that a focus on NSMHS penetration rates has an impact on the *need* for SMHS penetration rates. Therefore, these aggregate statistics are presented as part of a broader picture and not as conclusive evidence of an existing demographic disparity.

Intra-measure dynamics could be more informative for understanding disparities. Relative to comparable California penetration rates, adults ages 21-56 have lower NSMHS penetration rates than other age groups. Relatedly, comparing levels for penetration rates as well as comparable statewide rates suggests that the Latino population receives fewer services than other race/ethnicity groups.

To account for need and better contextualize representation in the context of mental health services, analysts calculated representation indices as indicated by the appendix included in the first publication of the County Population Behavioral Health Measure Workbook.

- If the index is around 1, the group is represented about as expected (e.g., 1.0–1.1).
- If it is above 1, the group is over-represented (they are using services more than expected based on their proportion of the population).
- If it is below 1, the group is under represented (they are using services less than expected based on their proportion of the population).

When comparing the representation indices for SMHS, NSMHS, and Total ED Visits with Self-Harm Intent, as a proxy for potential urgent need for mental health services in a particular community, key demographic trends stand out:

- The Black San Mateo County community is overrepresented in NSMHS (2.25) and SMHS (4.14). Total ED Visits with Self-Harm Intent data was not available.
- While individuals identifying as white were approximately equally represented relative to the population, they were slightly overrepresented in Total ED visits with Self-Harm intent (1.2).
- Latino persons were also slightly overrepresented, relative to their proportion of the San Mateo County population demographics, in NSMHS (1.38), and Total ED Visits with Self-Harm Intent (1.26).

Access to Care: Cross-Measure Questions

1. 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 key disparities for SMHS are related to DMC-ODS access (as indicated by adult and youth penetration rates) and the need to explore further and understand youth access to SMHS as it relates to their higher access to NSMHS. There are also additional disparities across NSMHS and overrepresentation of Black and Latino communities in mental health services.

   For BHRS, these gaps can be addressed through institutional equity work, which will be prioritized both through behavioral health organizational initiatives (e.g., Multi-Cultural Organizational Development (MCOD), Government Alliance on Race and Equity (GARE), Trauma- and Resiliency-Informed Systems Initiative (TRISI)), strengthening prevention strategies funded through Substance Use Prevention, Treatment, and Recovery Services Block Grant, Opioid Settlement Funding and through our partnership with the public health department in the development and implementation of our local Community Health Improvement Plan (CHIP).

   Additionally, strengthening how youth are identified, assessed, and supported after a behavioral health crisis will be a key strategy as well as culturally grounded engagement, and stronger linkages to ongoing outpatient and community supports for Black and Latino youth. An Early Intervention Services Request for Proposal (RFP) will be released in fiscal year 2026-27 focused on the following:

   1) Addressing observed disparities across all statewide priority goals – disparities often stem from systemic inequities and strategies like targeted outreach for high-risk groups, appropriate level treatment, and supportive services can have a positive impact across all statewide goals.
   2) Access to integrated substance use and mental health services.
   3) Youth populations ages 0-25; with the exception of any observed disparities across the statewide priority goals for adults and/or older adults.
   4) Alignment with CHIP priorities within the scope of BHRS DMC-

ODS/SMHS and high-risk population responsibilities.

5) Community-defined and evidence-based practices.

The following are "Access to Care" priority goal strategies were identified and prioritized by clients, staff and community, during our BHSA Community Program Planning process and will be addressed by the new Early Interventions RFP and strengthening of existing efforts as further described below.

- **Targeted Outreach**: Leverage and enhance culturally appropriate and targeted outreach to specific cultural communities. For example, navigators, peer and family supports, community health workers or "promotora" model approach to outreach.
- **Community Approaches:** Implement local and community-defined approaches to connecting individuals to services. For example, closed loop referrals – tracking community referrals across systems of care with follow-up to confirm connection to services or conducting Adverse Childhood Experiences (ACE) screenings in community settings.
- **Culturally and Linguistically Appropriate Services:** Increase the number of behavioral health providers that represent the community they're serving and increase access to language supports in residential treatment.

To systemically address inequities and quality care, BHRS recently engaged in a strategic visioning process aimed at reshaping the way we provide care across our behavioral health system. The BHRS Transformation Journey 5-Year Roadmap was developed outlining our strategic priorities, milestones, activities to achieve them, and the outcome metrics for measuring success and a refined mission, vision and values affirming our commitment to honoring lived experience; advancing equity, trauma-informed care, and staff wellbeing; strengthening responsiveness to emerging needs through compliance and quality management, evidence-based practices, performance and data-driven planning, and strategy and fiscal stewardship.

Specifically, BHRS will continue to strengthen the existing following services within BHRS' prevention and early intervention (PEI) continuum of care and across many of our DMC-ODS and SMHS outpatient treatment programs, which also conduct outreach and awareness activities in the community and are engaged in our Transformation Journey goals and addressing organizational inequities.

- The Overdose Prevention Coalition works towards reducing drug overdoses by providing education and outreach, access to services, and youth and policy advocacy, that is data-informed and people-driven.
- The BHRS Community Health Promotion Unit (CHPU) AOD prevention programs empowers communities to minimize risk factors associated with substance misuse and focus on social determinants of health (SDOH).
- The Recovery Connection drop-in center services are for individuals with

substance use challenges or co-occurring substance use and mental health challenges at all stages of their recovery, from pre-contemplative to maintenance and enhancement. It centers around Wellness Recovery Action Plan (WRAP) programming, uses a peer support model, provides linkages as needed and serves as a training center to expand capacity countywide.

- Seeing Through Stigma is a campaign, facilitated by Heart and Soul, Inc., focused on removing the stigma associated with behavioral health challenges that consist of presentations from two or more panelists who share their journey and their path toward recovery with various audiences.
- Early Childhood Community Team (ECCT) services support healthy social emotional development of children through outreach, case management, parent education, behavioral health consultation, and child-parent psychotherapy services.
- (re)MIND, BEAM, BEAM UP and (re)MIND alumni early psychosis programs provide outreach, awareness and science-based early diagnosis, treatment, and rehabilitation services for psychotic disorders such as Schizophrenia.
- Trauma-Informed PEI Services for Youth target youth who are at the greatest risk for adverse childhood experiences (ACEs) including youth in poverty, justice involved, immigrant, unhoused, in foster care, and identifying as LGBTQIA+. Group-based interventions address trauma and substance use issues and a community engagement component addresses community-level supports that are necessary for positive youth outcomes. The group-based interventions utilize culturally relevant evidence-based or promising practice curriculums.
- Trauma-Informed Systems (Ages 0-5) is a countywide effort to integrate a comprehensive commitment to address trauma and promote resiliency into local programs, structures, and culture with a long-term goal of embedding trauma- and resiliency-informed policies and practices at every level of the system.
- INSPIRE (Innovative Strategies for Prevention and Intervention through Restorative Education) is a brief intervention/alternative to suspension program effective in lowering youth suspension and expulsion rates.
- Music therapy and support groups as a culturally responsive approach for Asian/Asian Americans to reducing stigma, increasing behavioral health literacy, promoting linkages to behavioral health services, and building protective factors to prevent behavioral health challenges and crises.
- The Cariño Project provides culturally responsive outreach to the Coastside community opening pathways for increased services including crisis counseling, family counseling, and counseling at schools, local churches, and community spaces.
- The Farmworker Equity Express program provides mobile behavioral health services to farmworkers and their families in the south coast. It extends direct behavioral health and wraparound resources in Spanish integrating

cultural arts practices as a pathway for engaging individuals with formal clinical care, prevention, early intervention and recovery supports.

- The San Mateo County Pride Center creates a welcoming, safe, inclusive, and affirming space for individuals of all ages, sexual orientations, and gender identities through outreach, education, counseling, advocacy, and support.
- The Barbara A. Mouton Center in East Palo Alto is a place where clients of behavioral health services and their family members can go to receive support, information, and be in community with each other.
- BHRS participates in a countywide Social and Racial Equity Plan (SREAP). One of the strategies is focused on increasing penetration rates leveraging the BHRS Office of Diversity and Equity (ODE) programs including Health Equity Initiatives' (HEI), the Health Ambassador Program (HAP) and communications to spread awareness of how communities connect to BHRS services.
- ODE's Health Ambassador Programs addresses barriers to accessing services and quality of care issues impacting marginalized ethnic, racial, and cultural communities. This program will be leveraged to strengthen substance use outreach and access to care specifically.
- Suicide Prevention Month (SPM), Mental Health Month (MHM) and Recovery Month activities focus on reducing stigma, raising awareness, sharing services and promoting wellness, local advocacy efforts, communications campaign and free events.
- In partnership with BHRS, the San Mateo County Office of Education launched the United for Youth Vision 2030 and collaborates with school and community partners to implement a wide variety of prevention and education efforts that promote social-emotional well-being and improve early identification of youth behavioral health needs.
- allcove youth centers are integrated drop-in spaces for young people ages 12–25 that offer mental health, physical health, substance use, peer and family support, and education/employment services in a welcoming, youth-designed environment. Currently, a center exists in the City of San Mateo and a new allcove center is being planned for the coastal region in the City of Half Moon Bay.

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

   ☑ BHSA Behavioral Health Services and Supports (BHSS)

   ☐ BHSA Full Services Partnership (FSP)

   ☐ BHSA Housing Interventions

   ☑ 1991 Realignment

   ☑ 2011 Realignment

- ☐ State General Fund
- ☑ Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
- ☑ Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH)
- ☑ Community Mental Health Block Grant (MHBG)
- ☑ Substance Use Block Grant (SUBG)
- ☑ Other: Opioid Settlement Funds (OSF), Medi-Cal Administrative Activities (MAA), local Measure K Funds

Homelessness

Homelessness: Primary Measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

1. How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region? [above/below/same/N/A]

   below

2. What disparities did you identify across demographic groups or special populations? [Multi-select]
   - ☐ Age
   - ☑ Gender
   - ☑ Race or Ethnicity
   - ☐ Sex
   - ☐ Spoken Language
   - ☐ None Identified
   - ☐ No Disparities Data Available
   - ☐ Other

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

1. How does your county status compare to the statewide rate? [above/below/same/N/A]

   below

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

- ☐ Age
- ☐ Gender
- ☑ Race or Ethnicity
- ☐ Sex
- ☐ Spoken Language
- ☐ None Identified
- ☐ No Disparities Data Available
- ☐ Other

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

1. How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region? [above/below/same/N/A]

   below

2. What disparities did you identify across demographic groups or special populations?
   - ☐ Age
   - ☐ Gender
   - ☐ Race or Ethnicity
   - ☐ Sex
   - ☐ Spoken Language
   - ☐ None Identified
   - ☑ No Disparities Data Available
   - ☐ Other

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

1. How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region? [above/below/same/N/A]

   below

2. What disparities did you identify across demographic groups or special populations?
   - ☐ Age
   - ☐ Gender

- ☐ Race or Ethnicity:
- ☐ Sex
- ☐ Spoken Language
- ☐ None Identified
- ☑ No Disparities Data Available
- ☐ Other [narrative]

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.)

1. How does your local CoC's rate compare to the average rate across all CoCs? [above/below/same/N/A]

   below

2. What disparities did you identify across demographic groups or special populations?
   - Age
   - Gender
   - Race or Ethnicity
   - Sex
   - Spoken Language
   - None Identified
   - ☑ No Disparities Data Available
   - Other

Homelessness: Disparities Analysis

1. 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

   Overall, homelessness rates data for San Mateo County is below statewide rates across all selected indicators. Representation in Homelessness counts by key demographics is tied to many components in the housing pipeline beyond BHRS programmatic control. Our local Human Services Agency, Continuum of Care (CoC), is responsible for planning, coordinating, and carrying out PIT counts. BHRS collaborates with the CoC and homeless services system on PIT planning, outreach logistics, survey tool design, and volunteer recruitment, especially leveraging field-based outreach teams. BHRS also provides services for people experiencing homelessness with

behavioral health conditions and embeds supports at access points (shelters, coordinated entry, interim housing), including outreach, engagement, assessment, treatment for mental illness and SUD, case management, benefits enrollment, and peer support.

Disparities in the unhoused community were evaluated further by highlighting how many individuals were experiencing *unsheltered* homelessness. In homelessness counts, unsheltered means a person's primary nighttime residence is a place *not* meant for human habitation. Disparities analysis highlighted the following for unhoused persons in San Mateo County:

Homeless PIT Counts

- Gender: transgender persons are a minority gender in the scope of all unhoused persons in San Mateo County yet, 95% of unhoused persons who identified as transgender were also unsheltered. Persons who identified as a Man were the next less likely to be sheltered, 67%.
- Race/Ethnicity: 89% of unhoused persons who identified as only Latino in the PIT counts were unsheltered. For comparison, 54% of all unhoused persons in San Mateo County were unsheltered.

Homeless Student Enrollment by Dwelling Type

- African American, Latino, American Indian or Alaska Native, and Pacific Islander groups all have a higher rate of student homelessness than comparable statewide rates and the overall student homelessness rate in San Mateo County.
- The two groups with the highest overrepresentation in homelessness rates, relative to their proportion of the San Mateo County population, are American Indian or Alaska Native and Pacific Islander students. These groups have a San Mateo County homelessness rate of 10.3% and 11.7% respectively.
- The vast majority of students who are homeless are Latino or Latino (73.5%), even if the San Mateo County Latino student homelessness rate is similar to that of California's Latino student homelessness rate.

Homelessness: Cross-Measure Questions

1. 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)

While overall homelessness rates data for San Mateo County is below statewide rates, disparities in shelter status exist for unhoused persons who identify as transgender and/or Latino. Additionally, American Indian or Alaska Native students and Pacific Islander students are overrepresented in homelessness rates.

As mentioned under the Access to Care, Priority Statewide Behavioral Health Goal, disparities often stem from upstream social and organizational inequities that create barriers to accessing services, quality of treatment, retention in care and behavioral health outcomes. To systemically address inequities and quality care, BHRS:

1) recently engaged in a strategic visioning process, the BHRS Transformation Journey aimed at reshaping the way we provide care across our behavioral health system;
2) will continue to implement organizational equity and trauma-informed initiatives (e.g., Multi-Cultural Organizational Development, Government Alliance on Race and Equity, Trauma- and Resiliency-Informed Systems Initiative);
3) will continue to strengthen our partnership with the public health department in the development and implementation of our local Community Health Improvement Plan (CHIP) for upstream prevention approaches including stigma reduction; and
4) will enhance early intervention strategies through a new RFP to solicit new community-defined and evidence-based practices focused on overall disparities identified for the statewide priority goals.

Homeless outreach, improved data and documentation, appropriate level of treatment, and supportive services for SMI/SUD individuals housed can facilitate a transition towards a more stable housing experience.

Homeless outreach, improved data and documentation, appropriate level of treatment, and supportive services for SMI/SUD individuals housed can facilitate a transition towards a more stable housing experience. Specifically, BHRS is committed to strengthening documentation of homelessness, risk of homelessness and chronic homelessness. There is a need to improve

documentation as it relates to housing instabilities such as inadequate housing, past homelessness, economic difficulties or family/caregiving stressors. As of November 2025, BHRS Documentation Manual has been updated to include a list of z-codes and training has begun to support appropriate documentation.

The following are "Homelessness" priority goal strategies that were identified and prioritized by clients, staff and community, during our BHSA Community Program Planning process. All strategies are within the scope of BHRS and will be addressed as aligned with our BHRS Transformation Journey 5-Year Roadmap.

- **Supportive Housing**: Enhance supportive services provided to clients housed in behavioral health permanent supportive housing. For example, onsite supportive services, daily check-ins, case management, mental health and substance use treatment, mediation and life skills coaching.
- **Early Identification**: Conduct proactive and early outreach, navigation and case management. For example, partnerships with schools, navigation centers, during point-in-time homelessness counts provide early connections to supports, hospitals/detox centers, housing navigation, transportation services and other basic life needs.
- **At-Risk of Homelessness**: expand documentation of "at-risk" for homelessness to support care planning for housing instability. For example, implementing validated screenings for at-risk of homelessness or utilizing z-codes to document housing instabilities such as inadequate housing, past homelessness, economic difficulties or family/caregiving stressors.

The following existing and new services will continue to be strengthened to specifically address identified disparities.

- Permanent Supportive Housing
    - BHRS has 88 permanent supported housing units across ten housing developments funded by the Mental Health Services Act (MHSA) and No Place Like Home Program (NPLH) for individuals experiencing homelessness and chronic homelessness. Four new housing developments will provide an additional 48 permanent housing units that will be available by 2028-30. On-site housing support services include tenant engagement, daily living skills coaching, housing retention and eviction prevention interventions, harm reduction, motivational interviewing, crisis intervention/de-escalation, service coordination, and property management liaison services.
    - FSP Housing Program for Adults and Older Adults provides housing subsidies, helps locate and obtain timely housing placements for FSP clients and manages housing property owner relationships to

provide a variety of clean, safe, affordable, and stable supervised housing options for adult and older adult FSP clients. The range of housing options provided include emergency shelter, room and board, board and care, shared housing, and independent living. FSP housing and peer specialists provide direct client housing supports (e.g., housing navigation, application assistance, moving support, etc.).
    - FSP Housing Support Program for Transition Age Youth (TAY) aimed at achieving residential stability. The program helps youth locate and obtain scattered-site housing, ensure clean, safe and habitable housing, coordination with the FSP treatment teams, property owner engagement, ensures timely rent payment and monitoring lease provisions, manage evictions or transfers when necessary.
    - CoC Supportive Housing Project (SHP) works collaboratively with the Housing Authority to provide behavioral health homeless clients with supportive services to maintain their housing in the community including intensive case management, mental health and substance use services, access to health care, educational and vocational programs.
    - The New Ventures program serves as a step down and helps participants locate and maintain housing through daily living skills development and achievement of vocational and educational goals. The program offers housing units through New Ventures Colma Ridge Apartments, a partnership with MidPen Housing (22 units); New Ventures Tahanan, a partnership with Mental Health Association (14 units); and independent apartments in Redwood City, San Carlos, and Burlingame (49 units).
    - On-site Coordination supports property managers with orientation and engagement on behavioral health units, maintain regular posted hours on site for behavioral health clients, coordination with treatment team, intermediary between resident services, property management and the treatment team and support with housing retention skills and eviction prevention.
- Rental Assistance (Vouchers) for transitional and permanent housing is provided to eligible clients. BHRS provides case management, referrals, and assistance to clients in completing housing voucher applications, housing unit applications, housing searches and support when meeting with prospective landlords. Clients may be eligible for Project-Based Vouchers, Tenant-Based Voucher, Permanent Supportive Vouchers, or Moving to Work Vouchers. Permanent Supportive Housing (PSH), formerly Shelter Plus Care, provides rental assistance and supportive services to assist individuals living with serious mental illness. These can be accessed through the County's Coordinated Entry System (CES) by going to one of

the San Mateo County Human Services Agency, Core Service Agencies.
    - San Mateo County Affordable Housing Fund provides financial assistance for the development of multifamily affordable rental housing in the County. BHRS contributes BHSA capital development funds to secure units for behavioral health clients and BHSA Housing Interventions funds will be used to ensure project-based vouchers are available for clients in future developments.
    - Scattered Site Housing (Tenant-Based Vouchers) are provided by contracted providers and located in multiple, non-contiguous buildings across a community rather than concentrated in a single large facility, allowing tenants to live in regular neighborhood settings alongside market-rate households.
- Enhanced Board and Care (B&C) provide a supported living environment for clients living with a SMI/SUD that have completed a social rehabilitation program or are stepping down from a locked setting who are psychiatrically stable, compliant with medications and in need of a supported living environment. The BHRS B&C liaison approves referrals, completes assessments, and oversees admissions and discharges.
- Transitional Housing beds for behavioral health clients provide onsite support including case management, clinical therapy and groups, psychiatry, supported education/ supported employment, housing retention skills, & peer support.
    - Canyon Vista Center (29 units) offers supportive services to residents and access to shared spaces like an art center, spiritual room, gym and kitchen.
    - Spring Street (7 units) transitional housing provides eighteen-month single room occupancy (SRO) housing with case management.
    - Young Adult Independent Living (YAIL) provides 6 units of transitional housing rooms for 18 to 23 year old individuals. YAIL works with youth to manage symptoms, develop healthy lifestyle choices, support school or employment goals, and provides a hub for social activities.
- Short-term Shelter Beds (32 total beds) provides on-site wraparound case management and support to behavioral health clients.
    - Spring St. Shelter provides 15 emergency shelter beds with support services for behavioral health clients.
    - Safe Harbor Shelter offers emergency and short-term housing options in a 105-bed shelter (5 beds for behavioral health clients).
    - Navigation Center provides 240 safe temporary living spaces (7 beds for behavioral health clients), including onsite access to psychiatric services, substance use treatment, and other BHRS linked supports for residents.

    - Pathways, Housing Assistance- Pathways provides field-based outpatient services to clients from specialty courts and mental health diversion programs. There are two contracted beds the Navigation Center. The intake process for Pathways clients has been streamlined, allowing clients to be sheltered immediately if a bed is available.

- Recovery Residence Housing (56 recovery residence beds for men) are short-term residential dwellings that provide primary housing for individuals who seek a cooperative living arrangement that supports personal recovery from a substance use disorder and that does not require licensure by DHCS and may not provide SUD treatment on site. Individuals are required to participate in outpatient treatment to live in recovery residences and the maximum length of stay is 24 months.

- Housing and Homeless Outreach
    - Adult Resource Management (ARM) outreach and support services team provides field-based intensive case management, early identification, and engagement to adults living with SMI/SUD who are unhoused or at risk of homelessness.
    - Health Care for the Homeless (HCH) provides field-based outreach, short-term case management and linkages to medical, dental, and behavioral health services to unhoused individuals of all ages regardless of insurance or severity of behavioral health needs.
    - Homeless Engagement Assessment and Linkage (HEAL) provides field-based outreach, assessment, and treatment to unhoused individuals with behavioral health conditions. HEAL partners with community Homeless Outreach Teams (HOT) to engage sheltered and unsheltered individuals who may have behavioral health needs.
    - Integrated Medication Assisted Treatment Team (IMAT) provides on-site outreach, engagement, and onsite education and field-based case management to individuals at the Navigation Center, the County's largest shelter. Co-located, on-site substance use treatment services are also provided at the Navigation Center five days a week for shelter residents.
    - Two community DMC ODS providers have recently been identified through an RFP process to expand outreach, engagement, and education of unhoused individuals within the field and at the four other shelters to increase engagement in SUD treatment. On-site SUD treatment at these shelters will be available by 7/1/2026.

2. 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
- ☑ 1991 Realignment
- ☑ 2011 Realignment
- ☑ State General Fund
- ☑ Federal Financial Participation (SMHS, DMC/DMC-ODS)
- ☑ SAMHSA PATH
- ☑ MHBG
- ☑ SUBG
- ☑ Other (Opioid Settlement Funds)

Institutionalization

[Context text: 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

1. How does your county status compare to the statewide rate/average? [above/below/same/N/A]
    a. For adults/older adults: **above**
    b. For children/youth: **N/A**

2. What disparities did you identify across demographic groups or special populations?
    - ☐ Age
    - ☐ Gender
    - ☐ Race or Ethnicity

- ☐ Sex
- ☐ Spoken Language
- ☐ None Identified
- ☑ No Disparities Data Available
- ☐ Other

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

1. How does your county status compare to the statewide rate/average? [above/below/same/N/A]
    a. 14-day involuntary detention rates per 10,000: **below**
    b. 30-day involuntary detention rates per 10,000: **N/A**
    c. 180-day post-certification involuntary detention rates per 10,000: **N/A**

2. What disparities did you identify across demographic groups or special populations?
    - ☐ Age
    - ☐ Gender
    - ☐ Race or Ethnicity
    - ☐ Sex
    - ☐ Spoken Language
    - ☐ None Identified
    - ☑ No Disparities Data Available
    - ☐ Other

Conservatorships, FY 2021 - 2022

1. How does your county status compare to the statewide rate/average? [above/below/same/N/A]
    a. Temporary Conservatorships: **above**
    b. Permanent Conservatorships: **above**

2. What disparities did you identify across demographic groups or special populations?
    - ☐ Age
    - ☐ Gender
    - ☐ Race or Ethnicity
    - ☐ Sex

- ☐ Spoken Language
- ☐ None Identified
- ☑ No Disparities Data Available
- ☐ Other

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

[Context text: Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities.]

1. How does your county status compare to the statewide rate/average? [above/below/same/N/A]
    a. Crisis Intervention
        i. For adults/older adults: **below**
        ii. For children/youth: **below**
    b. Crisis Residential Treatment Services
        i. For adults/older adults: **above**
        ii. For children/youth: **N/A**
    c. Crisis Stabilization
        i. For adults/older adults: **above**
        ii. For children/youth: **same**
2. What disparities did you identify across demographic groups or special populations?
    - ☑ Age
    - ☐ Gender
    - ☑ Race or Ethnicity
    - ☐ Sex
    - ☑ Spoken Language
    - ☐ None Identified
    - ☐ No Disparities Data Available
    - ☐ Other

Institutionalization: Disparities Analysis

1. 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

    There was insufficient data to determine disparities for Inpatient Administrative Days, Involuntary Detention Rates, or Conservatorships. Yet, there is data that suggests the Latino population have fewer minutes per

beneficiary than other beneficiaries benefitting from Crisis Intervention or Stabilization services.

Institutionalization: Cross-Measure Questions

1. What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)
   N/A

2. 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 county is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

   While there was not sufficient data to determine disparities, our County performance status on the following indicators indicate opportunities for improvement:

   Inpatient administrative days rate

   Administrative days represent inpatient hospital stays for Medi-Cal beneficiaries who no longer need acute psychiatric care but remain due to a lack of residential placement options, such as non-acute facilities. Higher inpatient administrative days rate/average may indicate inefficiency in transitioning patients to lower levels of care. For San Mateo County the rate is 34.9, which is exactly the statewide median (34.9) but above the statewide rate (25.6), indicating an average performance rather than poor. Any above benchmark rate could suggest discharge barriers or coordination gaps and may disproportionately affect overrepresented groups (Black/Latino) if systemic delays exacerbate disparities.

   Temporary and Permanent Conservatorship

   San Mateo's temporary conservatorship rate of 1.7 and permanent rate of 7.5 both exceed statewide averages of 0.7 and 2.8, respectively, typically signaling a negative outcome in Medi-Cal behavioral health performance. While sometimes necessary, an increased rate of conservatorships can point to insufficient community-based support and a lack of less-restrictive alternatives, preventive or step-down services. Consistently high rates may also lead to reduced bed availability for others needing acute psychiatric care.

For San Mateo, this contrasts positively with lower involuntary detention rates. San Mateo's 14-day involuntary detention rate of 6.7 per 10,000 falls below the statewide rate of 10.2, indicating a positive outcome in Medi-Cal behavioral health performance. Shorter acute holds minimize trauma and costs, while conservatorships provide sustained support for gravely disabled individuals, potentially lowering future involuntary episodes, homelessness, or emergency utilization. EQRO metrics often view this as system maturity, especially when coupled with our County's strong crisis response times. In San Mateo County, average crisis intervention service times of 107.5 minutes for adults/older adults and 113.7 minutes for children/youth both fall substantially below statewide averages of 240.1 and 266.8 minutes, respectively, indicating a strong positive outcome.

Crisis Residentials and Stabilization

The average days of crisis residential treatment services for adults/older adults was 29.1 days vs. 22.8 statewide, indicating longer average stays, which can reflect both higher acuity/complexity and downstream placement barriers. In many EQRO and CalMHSA frameworks, longer crisis residential stays is interpreted as a system flow issue when not clearly tied to intentional longer-term stabilization models. Children and youth data is not available. These current gaps in the youth crisis continuum create barriers to timely placement from Psychiatric Emergency Services (PES), and limited step-down services after acute hospitalization. BHRS continues to explore options through the Behavioral Health Community Infrastructure Program (BHCIP) and other means to expand the youth crisis continuum of care. BHRS submitted Round 2 application for a Youth Crisis Healing Campus, which will be a rehabilitation of an existing County facility, with a proposed match from BHSA.

Average hours of crisis stabilization utilized is slightly negative for adults and older adults (27.2 hours vs. 24 hours statewide) and for children and youth it is equivalent to the statewide figure. The slightly above status for adults and older adults may suggests individuals remain in crisis stabilization longer than the typical, often pointing to emergency department boarding dynamics, wait for inpatient/crisis residential beds, or conservatorship/placement delays.

The following are the top three "Institutionalization" priority goal strategies that were identified and prioritized by clients, staff and community, during our BHSA Community Program Planning (CPP) process. All strategies are within the scope of BHRS and will be addressed as aligned with our BHRS Transformation Journey 5-Year Roadmap.

- **Recovery Oriented Approaches:** Enhance client well-being and recovery through the implementation of strength-based approaches. For example, motivational interviewing, wellness recovery action planning (WRAP), and cognitive behavioral therapies (CBT/DBT).

- **Crisis Continuum:** Increase crisis intervention and post-institutional supports. For example, warm lines, stabilization centers, and follow-up post discharge, navigation and linkages.
- **Caregiver Supports:** Provide resources, education, and respite to caregivers mitigating the need for institutional care.

The following existing services will continue to be strengthened to address specific identified disparities.

Crisis Intervention Services

- The San Mateo County Crisis Line provides a 24-hour crisis and warm line resource in San Mateo County and educational behavioral health crisis prevention presentations to the community and schools.
- Youth Case Management (YCM) provides continuity of care to minors living with SED in the least restrictive, most appropriate environment to prevent out-of-home placement. Services provided include consultation and assistance to San Mateo County Medical Center (SMMC) Psychiatric Emergency Services (PES) for youth in crisis, including evaluation, follow-up services and ongoing treatment, linkages and substance use assessment, case management, crisis intervention, referrals to appropriate community resources and placement.
- Mobile Crisis Response Team (MCRT) provides specialized 24/7 mobile crisis response team. MCRT responds to individuals that are experiencing an escalation of behavioral health symptoms and provides support for current/former foster youth and caregivers in need of trauma support, allowing for the team to directly support stabilizing the situation and keep individuals safe under the Family Urgent Response System (FURS).
- Community Wellness Crisis Response Team (CWCRT) launched in 2021 in Daly City, San Mateo, Redwood City, and South San Francisco where a Mental Health Clinician is deployed by 9-1-1 along with police officers to calls involving individuals suspected of experiencing behavioral health crises to help manage high-risk situations and improve outcomes and public safety.
- San Mateo County Mental Health Assessment and Referral Team (SMART) mental health-trained paramedics provide assessment assistance to law enforcement when dealing with a mental health crisis. SMART can transport individuals to a local hospital that provides psychiatric emergency services or to other appropriate services as necessary.
- Psychiatric Emergency Response Team (PERT) is a co-response approach with two BHRS mental health clinicians and two Sheriff's Office's detectives following up on all 5150s and as needed to behavioral health crises within Sherrif Office jurisdictions, which include the Cities of San Carlos, Millbrae,

and unincorporated parts of San Mateo County.

- Family Assertive Support Team (FAST) and Mobile Support Services provides field-based supports and in-home outreach services including assessment, consultation, and support services to individuals experiencing a severe behavioral health challenge and their family members. Mobile Support Services provides 24/7 outreach support services by bilingual staff to address the immediate needs of clients including transportation and supports.
- Integrated Medication Assisted Treatment (IMAT) team provides outreach, engagement, information, screening, and referrals to medication assisted treatment for individuals using alcohol and/or opioids, and harm reduction tools such as fentanyl test strips, Naloxone, and medications to alleviate withdrawal symptoms and support recovery. IMAT case managers are located at San Mateo Medical Center (SMMC) Emergency Department and Psychiatric Emergency Services (PES) to engage patients.
- Serenity House is a 13-bed facility that provides short term respite/crisis support services in San Mateo County for up to10 days. Services consist of crisis stabilization, life skills support, and linkage to needed support services as individuals' transition back to the community.

Residential and Acute Services

- Canyon Oaks Youth Center (COYC) is a Short Term Residential Therapeutic Program (STRTP) that provides comprehensive services to youth with serious emotional and behavioral challenges. Each youth resident receives individual services to meet their needs and circumstances and help them reduce symptoms, gain stability and transition into the least restrictive setting.
- Temporary Conservatorship (T-Con) is a 30-day conservatorship for individuals who are gravely disabled16 initiated at the end of 72-hour hold and then a 14-day hold; 5250 holds following a 5150 hold17. If the referral is appropriate, a petition is filed with the Court, and the person is placed on a T-Con, which is needed for placement of a client.
- BHRS contracts with the 7 community-based agencies to provide DMC-ODS certified residential services. These agencies are licensed to deliver American Society of Addition Medicine (ASAM) Level 3.1, ASAM Level 3.3 and ASAM Level 3.5 residential services, for both men and women. In addition, ASAM 3.WM Residential Detoxification is provided at two sites and includes Incidental Medical Services.

Utilization Management

- Access Outpatient Utilization Management (UM) Team oversees referrals and provides utilization management for specialty mental health services

for adolescents ages 12 -17, Transition Age Youth (TAY) ages 18-25, and adults 18 and up. Services include Intensive Outpatient and Partial Hospitalization Eating Disorder Programs, Therapeutic Behavioral Services, Psychological Testing, and brain stimulation therapies.

- Facilities Utilization Management (FUM) Team oversees referrals and provides utilization management for contracted in-county licensed facilities. The team supports psychiatric inpatient discharge planning and referral to appropriate Level of Care (LOC) placements for adults living with SMI and/or SUD at BHRS contracted licensed facilities including Cordilleras Mental Health Rehabilitation Center (MHRC) and Residential and Inpatient Eating Disorder Programs.
- Collaborative Care Team (CCT) is a collaboration between BHRS, the San Mateo Medical Center (SMMC) and Aging and Adult Services (AAS), CCT prevents clients from being "stuck" in an inappropriate level of care. CCT strives to provide the right level of care at the right time and place, promote clients' wellness and recovery, and facilitate warm hand-offs to community-based programs. Staff work closely with Lanterman-Petris-Short Act (LPS)15 conservators.
- AOD Residential Treatment Team (RTX) oversees residential treatment referrals for all youth and adults seeking admission to DMC ODS residential treatment services, excluding residential detoxification services. Evaluation, treatment authorization, treatment referral, and time limited case management are provided to all clients seeking residential treatment.

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

☐ BHSA BHSS

☐ BHSA FSP

☐ BHSA Housing Interventions

☑ 1991 Realignment

☑ 2011 Realignment

☐ State General Fund

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

☐ SAMHSA PATH

☑ MHBG

☐ SUBG

☑ Other - Opioid Settlement Funds

Justice-Involvement

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023

1. How does your county status compare to the statewide rate/average? [above/below/same/N/A]
    a. For adults/older adults: **above**
    b. For juveniles: **below**

2. What disparities did you identify across demographic groups or special populations?
    - ☐ Age
    - ☐ Gender
    - ☑ Race or Ethnicity
    - ☐ Sex
    - ☐ Spoken Language
    - ☐ None Identified
    - ☐ No Disparities Data Available
    - ☐ Other [narrative box]

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

1. How does your county status compare to the statewide rate/average? [above/below/same/N/A]

    below

2. What disparities did you identify across demographic groups or special populations?
    - ☑ Age
    - ☐ Gender
    - ☑ Race or Ethnicity
    - ☐ Sex
    - ☐ Spoken Language
    - ☐ None Identified
    - ☐ No Disparities Data Available
    - ☐ Other

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.

1. How does your county status compare to the statewide rate/average? [above/below/same/N/A]

   below

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

   - ☐ Age
   - ☐ Gender
   - ☐ Race or Ethnicity
   - ☐ Sex
   - ☐ Spoken Language
   - ☐ None Identified
   - ☑ No Disparities Data Available
   - ☐ Other

Justice-Involvement: Disparities Analysis

1. 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

   San Mateo has arrest rate (2,490 per 100,000) that is slightly above the statewide average (2,440) but below the statewide median (2646), indicating a neutral-to-positive outcome in a distribution that is often skewed by a few high-arrest jurisdictions rather than elevated enforcement or criminalization.

   Disparities regarding experiences with justice-involvement based on race and/or ethnicity and age are as follows:

   Arrests: Adult and Juvenile Rates

   Most of San Mateo's population experiencing arrests are Latino (43.9%). Persons identifying as white are 27.2% of all arrests and persons identifying as Black are 15.5%.

Like the California recidivism rates, San Mateo County 's recidivism rates show younger justice-involved persons having higher rates of recidivism. Black/African American persons (44.3%) had a higher rate of recidivism than other ethnicities. Persons who identified as white had a recidivism rate of 32.9% and persons who identified as Latino/Latino had a recidivism rate of 31.4%.

Justice-Involvement: Cross-Measure Questions

1. 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)

   As mentioned previously, disparities often stem from upstream social and organizational inequities. BHRS will systemically address inequities and quality care as 1) aligned with our strategic visioning process, the BHRS Transformation Journey, 2)continued implementation of organizational equity and trauma-informed initiatives, 3) strengthening of our partnership with the public health department CHIP for upstream equity work; and 4) enhancing early intervention strategies through a new RFP to solicit new community-defined and evidence-based practices focused on overall disparities identified for all statewide priority goals.

   Additionally, cross-sector coordination will be critical to leverage existing strategic initiatives and funding opportunities across systems of care. For example, having a joint study session with the Juvenile Justice & Delinquency Prevention Commission to improve cross-coordination, improve the care experience and service delivery.

   The following are "Justice-Involved" priority goal strategies that were identified and prioritized by clients, staff and community, during our BHSA Community Program Planning process. All strategies are within the scope of BHRS and will be addressed as aligned with our BHRS Transformation Journey 5-Year Roadmap.

   - **Substance Use Services:** Increase access to detox services and substance use recovery programs targeting justice system involved clients.
   - **Early Justice Intervention:** Expand alternatives to arrests and diversion programs. For example, warm hand-offs through the police department for youth, increase adolescent engagement, restorative justice practices,

and brief intervention models.

- **Re-entry Supports:** Enhance reentry planning and coordinated follow up with individualized case plans to support successful reintegration into the community.

The following existing and new services focused on justice-involved populations will continue to be strengthened to address specific identified disparities. Substance use treatment and residential services are integrated in services for justice-involved individuals.

- Youth Services Center (YSC) BHRS team offers services to justice involved youth including individual, group, and family therapy, court-ordered mental health evaluations, psychotropic medication management, and resources and support to families.
- Trauma-Informed PEI Services for Youth target youth who are at the greatest risk for adverse childhood experiences (ACEs) including youth in poverty, justice involved, immigrant, unhoused, in foster care, and identifying as LGBTQIA+ . The group-based interventions utilize culturally relevant evidence-based or promising practice curriculums including Mindfulness-Based Substance Abuse Treatment (MBSAT) and El Joven Noble, developed by the National Compadres Network, a comprehensive healing-centered, indigenous-based youth development, support, and leadership-enhancement program.
- INSPIRE – Brief Intervention Program is a brief intervention/alternative to suspension program effective in lowering youth suspension and expulsion rates. INSPIRE is offered to high-school age youth by the Daly City Youth Health Center in collaboration with Jefferson Union High School District.
- Adult forensic and specialty court services provide outpatient treatment and support services to individuals living with SMI/SUD and non-violent offenders to divert from incarceration into community-based services.
    - David Lewis Community Reentry Center - Service Connect assists residents returning home from prison or jail with their reintegration back into the community. An assessment is completed to determine the needs and skills of the person and to make referrals to other services. Services include therapy, personal development, cognitive restructuring and healthy lifestyles, resume development, job search assistance, support groups, and social activities.
    - Pathways Programs is an alternate path through the criminal justice system for those living with SMI and/or SUD. Pathways is the umbrella structure for a field-based outpatient team that provides services to clients from specialty courts and mental health diversion programs including Intensive Mental Health Diversion (IMHD) Pathways 1370 Court, Veteran's Treatment Court, and Military

Diversion Court.
    - Assisted Outpatient Treatment (AOT) – "Laura's Law" provides court ordered intensive community-based mental health treatment who do not meet the LPS criteria for involuntary hospitalization but whose condition is currently deteriorating and who are unwilling to accept treatment.
    - Community Assistance, Recovery, and Empowerment Court (CARE) Courts differs from both LPS Conservatorship and Laura's Law approaches in that it may be initiated on a petition to the Court by family members, service providers, and other authorized parties, in addition to County Behavioral Health. The CARE Court service is designed to disrupt the revolving door of homelessness, short-term hospitalization, and incarceration.
- Deferred Entry to Judgment (DEJ) programs are for individuals, who enter a plea of guilty or no contendere ("no contest") to legally specified drug-related charges ordered to participate in a program of drug education, counseling, and self-help meetings. BHRS contracts with the community-based agencies to provide these services.
- Drug Courts offer individuals facing criminal charges for drug use and/or possession an opportunity to enter substance use treatment and obtain recovery resources in lieu of a traditional jail sentence. Defendants are frequently drug tested, attend substance abuse recovery meetings, make court appearances regularly and abide by all other rules. Upon successful completion, defendants may have a lesser penalty imposed or have their original charge dismissed or reduced.
- Driving Under the Influence (DUI) Programs are mandated programs and designed to provide alcohol and drug education and counseling and improve traffic safety for individuals charged with driving under the influence. BHRS administers the following DUI programs, each based on the type of charges the defendant was convicted of. These include:
    - Wet & Reckless, a 12-hour DUI education program
    - First Offender Program (FOP) with a 3-month program with 32-hours of education and counseling, a 6-month program with 45-hours of education and counseling; and 9-month program with 62-hours of education and counseling.
    - Multiple Offender Program (MOP) consists of 12-month program with 71-hour program of education and counseling and an 18-month program with 77-hour program of education and counseling.
- Multiple DUI Court provides intensive supervision of multiple DUI offenders while connecting them with the community and recovery resources they

need to address their driving habits and their alcohol use. The Multiple DUI Court utilizes a multidisciplinary team approach combined with intensive supervision to identify and treat the root causes of criminal behavior and aims to improve traffic safety.

2. Please identify the category or categories of funding that the county is using to address the justice-involvement goal [multi-select dropdown]
   - ☑ BHSA BHSS
   - ☑ BHSA FSP
   - ☑ BHSA Housing Interventions
   - ☑ 1991 Realignment
   - ☑ 2011 Realignment
   - ☐ State General Fund
   - ☑ Federal Financial Participation (SMHS, DMC/DMC-ODS)
   - ☑ SAMHSA PATH
   - ☑ MHBG
   - ☑ SUBG
   - ☐ Other

Removal Of Children from Home

Removal of Children from Home: Primary Measures

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025

1. How does your county status compare to the statewide rate? [above/below/same/N/A]

   below

2. What disparities did you identify across demographic groups or special populations?
   - ☐ Age
   - ☐ Gender
   - ☑ Race or Ethnicity
   - ☐ Sex
   - ☐ Spoken Language
   - ☐ None Identified
   - ☐ No Disparities Data Available

- ☐ Other [narrative box]

Removal of Children from Home: Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

1. How does your county status compare to the statewide rate? [above/below/same/N/A]

   above

2. What disparities did you identify across demographic groups or special populations?
   - ☑ Age
   - ☐ Gender
   - ☐ Race or Ethnicity
   - ☐ Sex
   - ☐ Spoken Language
   - ☐ None Identified
   - ☐ No Disparities Data Available
   - ☐ Other [narrative box]

Child Maltreatment Substantiations (CWIP), 2022

1. How does your county status compare to the statewide rate? [above/below/same/N/A]

   below

2. What disparities did you identify across demographic groups or special populations?
   - ☐ Age
   - ☐ Gender
   - ☑ Race or Ethnicity
   - ☐ Sex
   - ☐ Spoken Language
   - ☐ None Identified
   - ☐ No Disparities Data Available
   - ☐ Other [narrative box]

Removal of Children from Home: Disparities Analysis

1. 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.

While overall removal of children from home data indicators for San Mateo County are positive compared to statewide rates, disparities exist across race/ethnicity. Children who were identified as Black, American Indian or Alaska Native, or Latino were overrepresented in San Mateo's Child Maltreatment Allegation rates, based on expected population proportion.

The magnitude of overrepresentation for children identified as Black and American Indian or Alaska Native, is similar to the California statewide rate. This is not the case for the Latino child population, where San Mateo has a higher rate of overrepresentation in child maltreatment allegations than the statewide rate.

Allegations have been decreasing for all races/ethnicities throughout the past five years. Allegations are used for disparity comparisons as a substitute for substantiations in an environment where an increasingly high number of allegations are being evaluated out, as is the case with San Mateo. Of note, even though there were a similar percentage of families below the poverty level in the Black and Latino community, 7.5% and 7.2% respectively, child maltreatment substantiation rates were highest for Black children (10.9).

Removal of Children from Home: Cross-Measure Questions

1. 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 the removal of children from home. 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)

As mentioned previously, disparities often stem from upstream social and organizational inequities. BHRS will systemically address inequities and quality care as 1) aligned with our strategic visioning process, the BHRS Transformation Journey, 2) continued implementation of organizational equity and trauma-informed initiatives, 3) strengthening of our partnership with the public health department CHIP for upstream equity work; and 4) enhancing early intervention strategies through a new RFP to solicit new community-defined and evidence-based practices focused on overall disparities identified for all statewide priority goals.

BHRS will increase youth leadership, engagement and voice by partnering with Foster Advisory Group, BHC Youth Action Board and related youth-centered bodies to ensure decisions and services are centered in the needs, interests and current and future generations. Additionally, BHRS will encourage youth participation and involvement in BHRS committees.

The following are "Removal of Children from Home" priority goal strategies that were identified and prioritized by clients, staff and community, during our BHSA Community Program Planning process. All strategies are within the scope of BHRS and will be addressed as aligned with our BHRS Transformation Journey 5-Year Roadmap.

- **Family Engagement:** Outreach to parents and caregivers, ensuring they are aware of services and reduce stigma and cultural barriers to accessing services.
- **School-Based Services:** Prioritize on-site direct services to reduce barriers, provide early identification, facilitate engagement, and allow for coordinated supports.
- **Cross-Sector Coordination:** Leverage existing strategic initiatives and funding opportunities across systems of care to increase cross-sector coordination. For example, the San Mateo County Office of Education United for Youth Vision 2023 and the Family First Prevention Services Act (FFPSA).

The following existing and new services will continue to be strengthened to address specific identified disparities.

- Full Service Partnership (FSP) High-Fidelity Wraparound and Housing Supports offers: 1) comprehensive FSP Turning Point program provided to children, youth and their families; 2) comprehensive FSP Turning Point program and Drop-In Centers provided to transition-age youth (TAY) and their families; and 3) integrated FSP Short-Term Adjunctive Youth and Family Engagement (SAYFE) wraparound services provided to children, youth and transition-age youth within the BHRS outpatient, Therapeutic Day School and the regional behavioral health clinics and 4) housing navigation and supports for TAY.
- The Children and Youth System of Care (CYSOC) committee composed of BHRS, Juvenile Probation, Human Services Agency-Children and Family Services, Golden Gate Regional Center, Department of Rehabilitation, and County Office of Education focusing on children and youth at risk of adverse psychological, health and social outcomes and their families.
- In partnership with BHRS, San Mateo County Office of Education (SMCOE) launched the United for Youth Vision 2030 and collaborates with school and community partners to implement a wide variety of prevention and education efforts that promote social-emotional well-being and improve early identification of youth behavioral health needs.

- Ongoing partnership with the SMCOE and local school districts. BHRS has built a coordinated approach to supporting students with complex behavioral health needs, particularly those requiring mental health services through their IEPs, which includes consistent presence in school-based multidisciplinary team (MDT) meetings, district forums, and other educational and community venues to strengthen collaboration, enhanced early identification, and ensured that students and families receive timely, culturally responsive support.
    - Level II Student Threat Assessment (COE lead): a Level 2 Student Threat Assessment meeting is part of San Mateo County's countywide protocol for evaluating and responding to students who may pose a threat of harm to others. It helps schools identify concerning behaviors early and coordinate appropriate safety measures, interventions, and supports while avoiding unnecessary discipline.
    - SARB Panel (COE lead): a countywide School Attendance Review Board that brings together educators and community partners to address chronic absenteeism and support students in returning to consistent school engagement.
    - CSEC Steering Committee Meeting (CFS lead): a multidisciplinary committee led by Children and Family Services that coordinates prevention, identification, and response efforts for youth who are at risk of or experiencing commercial sexual exploitation. COE participates.
    - Interagency Placement Review Committee (IPRC): a cross-agency team that reviews complex youth cases to ensure appropriate placement decisions, service coordination, and stability for children and adolescents with high-level needs.
    - Coalition for Safe Schools: a collaborative network of school, county, and community partners focused on promoting campus safety, emergency preparedness, and supportive school environments.
    - Child and Youth System of Care Committee: A countywide advisory group that brings together Executive Youths System of Care leadership from COE, Child and Family Services, Juvenile Probation, GGRC, Department of Rehab guide planning, coordination, and improvement of behavioral health services for children, teens, and young adults.
    - School–Mental Health Collaboratives: four regional partnership meetings between school districts and mental health providers to coordinate mental health services, share updates, and strengthen supports for students with behavioral health needs on school sites.
- Child Welfare Mental Health team provides therapeutic services to youth involved in the child welfare system (court ordered and voluntary services). The team provides youth with individual and family therapy. Whenever appropriate, linkages

to other services such as behavioral support and psychotropic medications are offered.

- Partners for Safe and Healthy Children is a collaborative program for families with children aged 0-5 who are referred to BHRS by Child Protective Services. This is a systematic, coordinated, and integrated approach to providing high risk children and their families with evidence-based behavioral health assessment, case management and treatment services.
- Prenatal to Three (Pre-to-Three) program supports early child development and parent-child relationships when there are emotional, physical, developmental, or social risk factors. The program serves prenatal and postpartum individuals and provides child mental health services including maternal and child mental health assessments, evidence-based therapy and treatment services, case management, and specialized psychiatric services.
- The School Based Mental Health (SBMH) program provides collaborative education and Individual Education Plan (IEP)-related behavioral health services to special education children living with SED. Services are provided on school campuses and in the community as needed.
- Therapeutic Day Schools (TDS) provides integrated special education and behavioral health services for adolescents who are eligible for special education, have an IEP and are at risk of school failure due to social, emotional, behavioral, and learning difficulties. Services provided include individual, group and family therapy, case management, crisis intervention, art therapy, and occupational therapy.
- Therapeutic Behavioral Services (TBS) are a one-to-one mental health services for children/youth to help children/youth, parents/caregivers, foster parents, group home and school staff learn new ways of reducing and managing challenging behaviors as well as strategies and skills to increase the kinds of behavior that will allow children/youth to be successful in their current environment.
- Plans of Safe Care (POSC) Initiative: BHRS is partnering with our Human Services Agency's Children and Family Services to support best practice implementation for babies identified at birth as being affected by prenatal substance exposure and their families. It addresses the health and substance use treatment needs of both the infant and affected caregivers, ideally initiated before birth or at discharge. The federal Comprehensive Addiction Recovery Act (CARA) and the Child Abuse Prevention and Treatment Act (CAPTA) require infants affected by substance exposure to have a POSC in place.
- BHRS partners with the San Mateo County Director of Maternal and Child Health and our Deputy Health Officer to provide education and training for OB/GYN and other physicians within the San Mateo County Medical Center (SMMC) to know what SUD screening tools to use, how to talk to their patients about substance use, and the referral pathways to access SUD care for the women who are pregnant and parenting and their family

members. We also educate about the specific perinatal substance use treatment services that exist in San Mateo County for the MediCal population.

2. Please identify the category or categories of funding that the county is using to address the removal of children from home goal
   - ☑ BHSA BHSS
   - ☑ BHSA FSP
   - ☑ BHSA Housing Interventions
   - ☑ 1991 Realignment
   - ☑ 2011 Realignment
   - ☐ State General Fund
   - ☑ Federal Financial Participation (SMHS, DMC/DMC-ODS)
   - ☐ SAMHSA PATH
   - ☐ MHBG
   - ☐ SUBG
   - ☑ Other – Measure K

Untreated Behavioral Health Conditions

Untreated Behavioral Health Conditions: Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022

1. How does your county status compare to the statewide rate/average? [above/below/same/N/A]
   a. For the full population measured: **above**

2. What disparities did you identify across demographic groups or special populations?
   - ☐ Age
   - ☐ Gender
   - ☐ Race or Ethnicity
   - ☐ Sex
   - ☐ Spoken Language
   - ☐ None Identified
   - ☑ No Disparities Data Available
   - ☐ Other

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022

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

[above/below/same/N/A]

a. For the full population measured: **above**

2. What disparities did you identify across demographic groups or special populations?
   - ☐ Age
   - ☐ Gender
   - ☐ Race or Ethnicity
   - ☐ Sex
   - ☐ Spoken Language
   - ☐ None Identified
   - ☑ No Disparities Data Available
   - ☐ Other

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

1. How does your county status compare to the statewide rate/average? [above/below/same/N/A]

   a. For the full population measured: **below**

2. What disparities did you identify across demographic groups or special populations?
   - ☐ Age
   - ☐ Gender
   - ☐ Race or Ethnicity
   - ☐ Sex
   - ☐ Spoken Language
   - ☐ None Identified
   - ☑ No Disparities Data Available
   - ☐ Other

Untreated Behavioral Health Conditions: Disparities Analysis

1. 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 [narrative box]

There were no consistent disparities data available for the 2022 provided primary or supplementary measures. A recent 2024 Descriptive Analysis Report provided by CalMHSA summarizes county performance for the following measures:

- Follow-Up After Emergency Department Visits for Substance Use (FUA-30): potential disparities for ethnicity, gender and language were assessed. Rates for each subgroup were compared to the overall rate for the total population. In San Mateo County, Black/African American is a subgroup that was identified as experiencing some disparities when compared to the overall rate; 38.6% of ED visits for which the client received follow-up visit within 30 days of the ED visit compared to 54.1% overall rates for all clients.
- Follow-Up After Emergency Department Visits for Mental Illness (FUM-30) was determined to have no identified disparities across ethnicity, gender and language subgroups.

San Mateo County has a higher proportion of persons visiting professional services for mental health, alcohol/drug use at least four times, showing a higher rate of buy-in. Persons in San Mateo who struggle with mental health, emotional concerns, and alcohol/drug use are accessing using available services more often than statewide.

Untreated Behavioral Health Conditions: Cross-Measure Questions

1. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026, that may decrease 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 county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

   As mentioned previously, disparities often stem from upstream social and organizational inequities. BHRS will systemically address inequities and quality care as 1) aligned with our strategic visioning process, the BHRS Transformation Journey, 2) continued implementation of organizational equity and trauma-informed initiatives, 3) strengthening of our partnership with the public health department CHIP for upstream equity work; and 4) enhancing early intervention strategies through a new RFP to solicit new community-defined and evidence-

based practices focused on overall disparities identified for all statewide priority goals.

Specifically, the following are the top three "Untreated Behavioral Health Conditions" priority goal strategies that were identified and prioritized by clients, staff and community, during our BHSA Community Program Planning process. All strategies are within the scope of BHRS and will be addressed as aligned with our BHRS Transformation Journey 5-Year Roadmap.

- **Integrated Care:** Enhance integrated services and increase coordination across sectors. For example, coordination between primary care providers and peers, hospitals and follow-up care for clients with behavioral health challenges, and coordinating substance use treatment with shelters, correctional health and psychiatric emergency services.
- **Peer Supports:** Expand peer support opportunities including increased compensation for peer workers, and capacity building. For example, peer certification and ongoing continuing education.
- **Early Screening:** Increase early screening in community settings by peer navigators/outreach workers to help reduce stigma of accessing care.

Strategies for addressing untreated behavioral health conditions align with the Access to Care statewide priority goal. Specifically, the new Early Interventions RFP to solicit new community-defined and evidence-based practices focused on overall disparities identified for the statewide priority goals.

2. 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
   - ☐ BHSA Housing Interventions
   - ☐ 1991 Realignment
   - ☑ 2011 Realignment
   - ☐ State General Fund
   - ☑ Federal Financial Participation (SMHS DMC/DMC-ODS)
   - ☑ SAMHSA PATH
   - ☐ MHBG
   - ☑ SUBG
   - ☑ Other – Opioid Settlement Funds

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

Care Experience: Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024

1. How does your county status compare to the statewide rate/average?
    a. For adults/older adults: **below**
    b. For children/youth: **below**

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

1. How does your county compare to the statewide rate/average?
    a. For adults/older adults: **above**
    b. For children/youth: **above**

Engagement In School

Engagement in School: Primary Measures

Twelfth Graders who Graduated High School on Time (Kids Count), 2022

1. How does your county status compare to the statewide rate/average? **above**

Engagement in School: Supplemental Measures

Meaningful Participation at School (California Health Kids Survey (CHKS)), 2023

1. How does your county status compare to the statewide rate/average? **same**

Student Chronic Absenteeism Rate (Data Quest), 2022

1. How does your county status compare to the statewide rate/average? **below**

Engagement In Work

Engagement in Work: Primary Measures

Unemployment Rate (California Employment Development Department (CA EDD)), 2023

1. 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

1. How does your county status compare to the statewide rate/average? **below**

Overdoses

Overdoses: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured: **below**
    b. For adults/older adults: **below**
    c. For children/youth: **below**

Overdoses: Supplemental Measures

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured: **below**
    b. For adults/older adults: **below**
    c. For children/youth: **below**

Prevention And Treatment of Co-Occurring Physical Health Conditions

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

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

a. For adults (specific to Adults' Access to Preventive/Ambulatory Health Service): **above**
b. 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

1. How does your county status compare to the statewide rate/average?
    a. For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications): **same**
    b. For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing): **below**

Quality Of Life

Quality of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured: **below**
    b. For adults/older adults: **below**
    c. For children/youth: **below**

Quality of Life: Supplemental Measures

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS)), 2024

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured: **below**

Social Connection

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured: **below**
    b. For adults/older adults: **same**
    c. For children/youth: **below**

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

1. How does your county status compare to the statewide rate/average? **above**

Suicides

Suicides: Primary Measures

Suicide Deaths, 2022

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured: **below**

Suicides: Supplemental Measures

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured: **below**
    b. For adults/older adults: **below**
    c. For children/youth: **below**

County-Selected Statewide Population Behavioral Health Goals

For related policy information, refer to 3.E.6 Statewide Behavioral Health Goals.

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

1. **Goal #1: Social Connection**
    a. Please describe why this goal was selected.

    San Mateo evaluated all additional statewide population goals' population behavioral health measures, including potential disparities among demographic groups. Social Connection was selected as the most appropriate goal to focus on given our County's under performance compared to the statewide rate and averages. This aligns with local priorities, San Mateo County was the first County in the U.S. to declare loneliness a public health emergency including approval of

$1 million in local funding to support anti-loneliness programs, including peer counseling and transportation services to support residents of all ages who are feeling isolated or disconnected.

Research on mental health and prevention highlight two primary dynamics in community mental health. Firstly, mental health has been declining, particularly amongst youth, since 2010. Anxiety and depression in adolescence affect educational outcomes, which in turn affect professional outcomes, and so on. Birrell et al (2025) highlight that social connection can be a key target to improve youth mental health and show specific interventions that have produced positive effects. There is some evidence that indicates a smaller proportion of students across California report a caring adult relationship relative to 2015-2017. This statewide gap is largest for 7th graders, with a seven percentage point decrease from 2015-2017 to 2023-2025.

Secondly, even though San Mateo's overall rate of students reporting a caring adult relationship is 63%, relative to California's 60%, reporting students in Grade 7 for San Mateo in 2021-2023 reported a rate of 59%, 10 percentage points lower than 2015-2017. Although, the percentage of 7th Grade students reporting a caring adult relationship has rebounded back to 65%, the post-Covid decrease suggests youth in San Mateo may be vulnerable with respect to social connection. Additionally, students in Grade 9 have reported a consecutively decreasing proportion of students reporting a caring adult relationship from 2015-2017 to 2023-2025. The data suggest younger students in San Mateo are experiencing increasing vulnerability as social connection decreases, potentially influenced by environmental factors. Provided with the broader context and importance of youth mental health, it is imperative to continue to direct efforts at improving social connection in youth.

BHRS can play a role in providing social connection supports for behavioral health clients as they maneuver an increasingly challenging environment for social connection. The California Consumer Perception Survey (CPS)' Perception of Social Connectedness Scores in San Mateo were below the statewide average for families of youth, youth, and older adults, all of them key vulnerable populations for behavioral health concerns. The difference in Perception of Social Connectedness scores was largest for youth, with a difference of 0.15 points out of five possible points. The score of 3.91 was the sixth lowest score for youth in the domain of Social Connectedness amongst all counties.

b. 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.

Disaggregated data is available to better understand how demographics may highlight higher need for social connection in some San Mateo communities than others. Specifically, looking deeper into the San Mateo student population highlights the following disparities:

- In San Mateo County, Latino and Black children have considerably lower rates of caring relationships in Grade 7 relative to their peers. An estimated 43% of Black students in Grade 7 report having a caring adult relationship, compared to a statewide 59% of Black students in Grade 7 report a caring adult relationship.
- Statewide, the Latino student population report comparatively low proportion of students with a caring adult relationship. Although San Mateo, outperforms the statewide benchmark for that population, in 2023-2025, 53% of San Mateo 9th Graders reported a caring adult relationship.

c. 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 [selected goal] 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)

As mentioned previously, disparities often stem from upstream social and organizational inequities. BHRS will systemically address inequities and quality care as 1) aligned with our strategic visioning process, the BHRS Transformation Journey, 2)continued implementation of organizational equity and trauma-informed initiatives, 3) strengthening of our partnership with the public health department CHIP for upstream equity work; and 4) enhancing early intervention strategies through a new RFP to solicit new community-defined and evidence-based practices focused on overall disparities identified for all statewide priority goals.

Specifically, the following are the top three "Social Connection" priority goal strategies that were identified and prioritized by clients, staff and community, during our BHSA Community Program Planning process. All strategies are within the scope of BHRS and will be addressed as aligned with our BHRS Transformation Journey 5-Year Roadmap.

- **Community Belonging:** Expand accessible and inviting physical spaces for social connection for behavioral health clients of all ages.

For example, community gardens, drop-in centers, recovery-oriented wellness centers, vocational opportunities for older adults, and youth advisory boards.

- **Outreach and Engagement:** Offer and enhance community and school-based outreach. For example, over-the-phone connection for homebound older adults, community-based services for LGBTQIA youth, on-site services for school-aged youth, train school staff to identify needs, conduct regular check-ins and provide linkages.
- **Relationship Building:** Create intergenerational opportunities, expand peer-to-peer support for older adults and youth.

The following existing and new services focused on social connection will continue to be strengthened to address the identified disparities:

- Community multi-cultural drop-in centers are welcoming neighborhood hubs that celebrate cultural diversity while intentionally linking participants to appropriate behavioral health services. These centers offer low-barrier spaces for cultural events, wellness and support groups, behavioral health education, and intergenerational activities where people can meet, reduce isolation, and build trusted relationships. By affirming cultural and LGBTQ+ identities, normalizing help-seeking, and embedding access to prevention and early intervention services, they help address stigma and strengthen protective factors for mental health.
    - San Mateo County Pride Center takes a holistic approach to improving the health and well-being of the LGBTQIA+ community by providing direct behavioral health services and individuals seeking support groups, resources, community-building activities, and social and educational programming.
    - Recovery Connection Drop-in Center services are for individuals with substance use challenges or co-occurring substance use and mental health challenges at all stages of their recovery, from pre-contemplative to maintenance and enhancement. Services center around the Wellness Recovery Action Plan (WRAP) evidence-based approach, uses a peer support model, provides linkages as needed and serves as a training center to expand capacity countywide.
    - The Barbara A. Mouton Multicultural Wellness Center (The Mouton Center) is a place where clients of behavioral health services and their family members can go to receive support, information, and be in community with each other.
    - The Cariño Project creates new models of mental health and wellness wraparound services for marginalized farmworker

communities on the Coastside. The Project provides a culturally affirming space and outreach to the community opening pathways for increased services on the Coastside including crisis counseling, family counseling, and counseling at schools, local churches, and community spaces.

  - allcove youth centers are integrated drop-in spaces for young people ages 12–25 that offer mental health, physical health, substance use, peer and family support, and education/employment services in a welcoming, youth-designed environment. A new allcove center is being planned for the Coastside (Half Moon Bay area).

- Older Adult Peer Counseling provides specially trained volunteer counselors in various languages including Cantonese, English, Mandarin, Spanish, and Tagalog for older adult clients. Counselors make weekly visits to the participant's home or location of their choice in person, via zoom or by phone. Support topics include coping with grief, loss, physical limitations, financial challenges, housing, mild depression, family relationships, loneliness, isolation, anxiety, and caregiving for a partner.
- Full Service Partnership (FSP) recognize social connection as a core outcome and design element in the FSP model. Counties participating in the 2022 Multi-County FSP Innovation Project, including San Mateo County, identified social connectedness as a central outcome for participants and adopted it as a standardized performance metric assessed at intake and via quarterly self-reporting, alongside housing, justice involvement, and service use.

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

i. BHSA BHSS
ii. BHSA FSP
iii. BHSA Housing Interventions
iv. 1991 Realignment
v. 2011 Realignment
vi. State General Fund
vii. Federal Financial Participation (SMHS, DMC/DMC-ODS)
viii. SAMHSA PATH
ix. MHBG
x. SUBG
xi. Other

Community Planning Process

Stakeholder Engagement

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

1. Please indicate the type of engagement used to obtain input on the planning process
    - ☐ County outreach through social media
    - ☐ County outreach through townhall meetings
    - ☐ County outreach through traditional media (e.g., television, radio, newspaper)
    - ☑ Focus group discussions
    - ☐ Key informant interviews with subject matter experts
    - ☑ Meeting(s) with county
    - ☑ Provided data to county
    - ☐ Public e-mail inbox submission
    - ☑ Survey participation
    - ☑ Training, education, and outreach related to community planning
    - ☑ Workgroups and committee meetings
    - ☑ Other
        a. Please specify the other strategies that demonstrate the meaningful partnerships with stakeholders

        Other strategies included 1) holding deep dive informational sessions to review the impacts of Proposition 1/BHSA on specific programs/services (e.g., housing, early intervention, peer services, MH/SU integration) and 2) hosting input sessions at existing community or county meetings that were open to the public to share data around one of the seven priority areas and have a discussion about strategies to address identified gaps or needs.

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

    Workgroup and committee meetings

    - BHSA Taskforce 4/3/25
    - BHSA Taskforce 6/5/25
    - BHSA Taskforce 8/7/25 (also a Community Input Session)
    - BHSA Taskforce 10/2/25
    - Survey participation: 11/11/25 (survey closed on 11/26/25)

    Training, education and outreach related to community planning

    - Northern California Permanent Supportive Housing Working Group Presentation 5/23/25

- Information Session on Early Interventions 6/18/25
- Information Session on Peer Based Services 7/1/25
- Information Session on Substance Use/Mental Health Integration 7/9/25
  Information Session on Housing Interventions 7/10/25
- Information Session on Outcomes 8/6/25

Focus Group Discussions

- CoastPride and Youth Leadership Institute & Behavioral Health Commission (BHC) Youth Committee Focus Group 9/15/25

Other (CPP Community Input Sessions)

- Diversity and Equity Council 8/1/25
- Children and Youth System of Care 8/4/25
- Lived Experience Education Workgroup 8/5/25
- North County Collaborative 8/8/25
- Peer Providers 8/12/25
- Housing Operations and Policy Committee 8/14/25
- Coastside Collaborative 8/18/25
- Contractors Association 8/21/25
- Alcohol and Other Drug (AOD) Providers 9/4/25
- BHC AOD Committee 9/10/25
- BHC Adult Recovery Committee 9/17/25
- BHC Older Adult Committee 9/17/25
- East Palo Alto Community Service Area 9/24/25

Other (Presentation and Discussion)

- Continuum of Care 7/11/25
- Healthcare for the Homeless/Farmworker Health Program 8/14/25
- Health Ambassadors Program 8/28/25
- San Mateo County Veterans Commission 9/8/25
- Aging & Disability Services Older Adult Providers 10/2/25

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

   Abode Services, Ayudando Latinos a Soñar (ALAS), Alta Housing, Alta Housing, Anamatangi, Bridge Housing, CA Clubhouse, Cabrillo Unified School District, Caminar, Camp Recovery, Cañada College, City of East Palo Alto Police Department, City of Half Moon Bay, City of Redwood City, City

of San Mateo, City of San Mateo Police Department, City of South San Francisco, CoastPride, College of San Mateo, Contractors Association, CORA, County Office of Education, Daly City Partnership, Edgewood, El Centro de Libertad, El Concilio, Family Connections, Felton Institute, First 5 of San Mateo County, Fred Finch, Free at Last, Friendship Line (Institute of Aging), Golden Gate Regional Center, Half Moon Bay Library, Health Plan of San Mateo, Health Right 360, Heart & Soul, HIP Housing, In Home Supportive Services, Jefferson Union High School District/Daly City Youth Health Center, Juvenile Justice & Delinquency Prevention Commission (JJDPC), Kaiser Permanente, Kingdom Love, Legal Aid Society of San Mateo County, LifeMoves, Mental Health Association, MidPen Housing, NAMI, Northeast Medical Services, One EPA, One New Heartbeat, Our Common Ground, Project 90, Peninsula Family Services, Peninsula Health Care District, Puente de la Costa Sur, Ravenswood Family Health Center, San Mateo Medical Center (SMMC), San Mateo Pride Center, Service League, SMC Aging Disability Services, SMC Behavioral Health Commission, SMC BHRS Office of Community and Family Affairs, SMC Continuum of Care, SMC Dept of Housing, SMC Health Ambassador Program, SMC BHRS Health Equity Initiatives, SMC Healthcare for the Homeless/Farmworker Health Program, SMC Housing Authority, SMC Human Services Agency Center on Homelessness, SMC BHRS Lived Experience Workgroup, SMC Public Health Policy & Planning, SMC Sherrif's Office (CARON program), SMC Veterans Commission, Solutions for Supportive Housing, StarVista, Taulama for Tongans, The Latino Commission, U.S. Department of Veterans Affairs - Palo Alto Health Care System, Voices of Recovery, YMCA, Youth Leadership Institute

a. For counties with a population greater than 200,000, what are the five most populous cities in the county (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State) (optional) [Context text: For counties with a population over 200,000, this field is required.]
    i. City name: Daly City
    ii. City name: South San Francisco
    iii. City name: San Mateo
    iv. City name: Redwood City
    v. City name: San Bruno

4. Were you able to engage all required stakeholders/groups in the planning process? **No**
    a. If not, which required stakeholder/groups were you unable to engage in the planning process?
        ☐ Area agencies on aging

- ☐ BHSA eligible adults and older adults (individuals with lived experience)
- ☐ Community-based organizations serving culturally and linguistically diverse constituents
- ☐ Continuums of care, including representatives from the homeless service provider community
- ☐ County social services and child welfare agencies
- ☐ Disability insurers
- ☐ Early childhood organizations
- ☑ Emergency medical services – attempted but did not receive response
- ☐ Families of BHSA eligible children and youth, eligible adults, and eligible older adults (with lived experience)
- ☐ Higher education partners
- ☐ Health care organizations, including hospitals
- ☐ Health care service plans, including Medi-Cal managed care plans
- ☑ Independent living centers – attempted but did not receive response
- ☐ Individuals with behavioral health experience, including peers and families
- ☑ Labor representative organizations – attempted but did not receive response
- ☐ Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+) communities
- ☐ Local education agencies
- ☐ Local public health jurisdictions
- ☐ Organizations specializing in working with underserved racially and ethnically diverse communities
- ☐ People with lived experience of homelessness
- ☐ Providers of mental health services
- ☐ Providers of substance use disorder treatment services
- ☐ Public safety partners, including county juvenile justice agencies
- ☐ Regional centers
- ☑ The five most populous cities in counties with a population greater than 200,000 – Contacted all 5 cities. Three of the five cities participated in our local BHSA community program planning process.
- ☑ Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes – this group is not applicable to San Mateo County
- ☐ Veterans and representatives from veterans' organizations
- ☐ Victims of domestic violence and sexual abuse
- ☐ Youth from historically marginalized communities
- ☐ Youths (individuals with lived experience), youth mental health organizations, or youth substance use disorder organizations

b. What was the reason stakeholder was not engaged?

- ☐ Stakeholder declined to participate
- ☑ Attempted but did not receive a response – Emergency Medical Services, Independent Living Centers, Labor Representative Organizations
- ☑ Stakeholder group is not applicable to county
- ☑ Other - The five most populous cities in counties with a population greater than 200,000 – Contacted all 5 cities. Three of the five cities participated in our local BHSA community program planning process.

5. 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. [optional file upload - **See Appendix 2**].

Central to the CPP process was the BHSA Transition Taskforce ("The Taskforce"), the primary community partner engagement mechanism. The Taskforce met four times over a 6-month period to guide the CPP process. An estimated 117 unique individuals participated across the four taskforce meetings and represented diverse demographic and partner groups. Participants received in-depth BHSA training and played a key role in identifying additional groups to engage throughout the CPP Process, such as youth and older adults. Furthermore, the Taskforce reviewed statewide priority goals data and provided input and received briefings on the overall findings from the various CPP activities, allowing them to contribute additional context and insights based on their real-world experiences.

Outside of the BHSA Taskforce, there were a variety of activities aimed at engaging the community through education and soliciting feedback. Early in the CPP process, BHRS hosted Deep Dive Information Sessions based on the BHSA system impacts across housing, early intervention, peer-based services, outcome reporting, and integration of substance use disorder (SUD) treatment and mental health. Deep Dive Information Sessions were conducted across these topics and over 120 participants learned more about the specific changes required as a result of the transition to BHSA and how those changes would look within BHRS.

Next, BHRS hosted 14 Community Input Sessions ("Input Sessions") that provided an opportunity for groups to learn about the DHCS Behavioral Health Goals, review data and provide insights related to strengths, needs, and potential strategies. Each Input Session included access to care disparities data and focused one of the six required Priority Goal or the additional goal selected by BHRS -- "Social Connection". Over 200 clients, family members, community

members, contracted agencies and community partners participated in the input sessions.

In addition to the Community Input Sessions, BHRS also hosted five targeted discussions with specific community partner groups (youth from historically marginalized communities, veterans, older adult providers, people experiencing homelessness, and culturally and linguistically diverse residents) reaching over 80 participants. These focus groups served a similar purpose as the Community Input Sessions and facilitated a similar conversation around system needs, strengths, and strategies. The focus groups, as well as the other CPP activities (BHSA Taskforce, Deep Dive Information Sessions, and Community Input Sessions) were all hybrid, with options for community partners to participate over Zoom/Teams and in-person.

Although San Mateo County does not have a Tribal and Indian Health Program designee established for Medi-Cal Tribal consultation purposes, the Native & Indigenous People's Initiative (NIPI) was engaged aspart of the CPP process. NIPI is represented by two co-chairs, one BHRS staff member, and a community member who provides culturally grounded therapeutic support. The initiative brings together Native and Indigenous community members, elders, cultural leaders, behavioral health providers, and community partners. NIPI represents Native and Indigenous peoples broadly, including Indigenous community members from the United States as well as Indigenous peoples from Mexico, Central America, and other regions whose cultural identities and traditions remain central to their wellbeing and healing practices. Although only about 1% of San Mateo County residents identify as Native American or Indigenous, NIPI continues working to increase visibility, reduce barriers to care, and support culturally grounded healing practices within the community.

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.

1. 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.*
    a. **Yes.** [Populate question 2 and 3, if selected]
    b. No. The LHJ is not currently working on and/or did not develop a recent

CHA and/or CHIP.

c. Other. Please explain why or describe an alternate approach taken.

2. 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.

Collaboration: BHRS has historically, over 20+ years, collaborated on the CHA development, specifically in the development of the Health and Quality of Life (HQoL) survey, a local effort to assess the health needs and quality of life of San Mateo County residents. The HQoL covers various topics like housing, mental health, and community life to help local organizations identify needs, strengthen services, and secure funding for improvements.

Additionally, he development of the San Mateo County 2024-2026 CHIP kicked off September 2023 and included representatives from over 90 community-based organizations, community advocates and leaders and local hospitals, health care districts, managed care plans and members of San Mateo County Health divisions, including Behavioral Health & Recovery Services (BHRS).

Participants reviewed key findings from the 2023 Community Health Needs Assessment (CHNA) and feedback from community forums held in September and October 2023. Attendees participated in a prioritization process and identified three (3) priority areas were identified for the 2024-2026 CHIP for San Mateo County: 1) Access to Health Care Services; 2) Mental Health; and 3) Social Determinants of Health (SDOH).

Workgroups were gathered soon after for each priority area to develop an implementation plan, review data and select outcome measures. BHRS has participated in the Mental Health workgroup since inception and **a BHRS staff member has served as the co-lead** along with a community representative starting August 2024 to the present.

Data-Sharing:

While the existing CHIP plan, published in 2023, did not include specific data-sharing from BHRS, there was collaboration in the CHA and the CHIP development process. Additionally, the CHIP Mental Health work group intended to guide the implementation of the CHIP, began with a process for data sharing and alignment. A comprehensive review of data and outcomes utilized by all partners including public health, behavioral Health plans, managed care plans and community partners led to the selection of outcome measures to track progress towards the overarching goal and a data crosswalk to ensure buy-in and representation from all partners at the table.

A new CHA planning process began this Fall 2025, led by our local public

health department. The goal is to develop a comprehensive assessment that all partners can use for their respective planning processes. BHRS is participating in the planning and shared the statewide priority goal data and the specific requirements for our community program planning process. Additionally, BHRS is contributing to our local Health and Quality of Life Survey Conducted, which has been conducted in San Mateo County every 3-5 years since 1998. The goal is to include questions for the San Mateo County public at large that could delve a little deeper into key priority goals within our scope as a behavioral health plan. Questions will support our planning around access to care, untreated behavioral health conditions, and general mental health and substance use prevalence in the community.

Stakeholder Activities:

The plan was a result of a seven-month planning process led the San Mateo County Health Public Health, Policy & Planning (PHPP). Seven CHA community forums throughout San Mateo County were conducted. Five of the forums were conducted in English and two were conducted in Spanish. Small group discussions were then conducted to learn more about community lived experiences using the following prompts: What are the top health-related issues people are facing in your community that you would change or improve? What types of things would make it easier for people in your community to be healthy? What are the barriers that make it harder to improve health issues at a community level?

Stakeholder engagement continues as part of the workgroups. Workgroup members include BHRS as a co-lead, both our local Managed Care Plans (Health Plan of San Mateo and Kaiser Permanente), local health care districts, and various community-based organizations and leaders.

3. Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance? **No**

Collaboration

1. Please select how the county collaborated with the LHJ

   ☑ Attended key CHA and CHIP meetings as requested.

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

   ☐ Other [logic: if selected, populate question i below]

   ☐ Please describe the other way the county collaborated with LHJs and MCPs in developing the CHA/CHIP

Data-Sharing

Data-Sharing to Support the CHA/CHIP

1. 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
   - ☐ Care Experience
   - ☐ Engagement in School
   - ☐ Engagement in Work
   - ☑ Homelessness
   - ☑ Institutionalization
   - ☑ Justice-Involvement
   - ☐ Overdoses
   - ☐ Prevention of Co-Occurring Physical Health Conditions
   - ☐ Quality of Life
   - ☑ Removal of Children from Home
   - ☑ Social Connection
   - ☐ Suicides
   - ☑ Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)
   - ☐ Other

2. Was data shared? **Yes**

Data-Sharing from MCPS and LHJs to Support IP development

1. Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development

   - ☑ Access to Care
   - ☐ Care Experience
   - ☐ Engagement in School
   - ☐ Engagement in Work
   - ☐ Homelessness
   - ☐ Institutionalization
   - ☐ Justice-Involvement
   - ☑ Overdoses
   - ☐ Prevention of Co-Occurring Physical Health Conditions

- ☐ Quality of Life
- ☐ Removal of Children from Home
- ☑ Social Connection
- ☑ Suicides
- ☑ Untreated BH Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)
- ☑ Other: General mental health and substance use prevelance

2. Was data shared? **Yes**

Stakeholder Activities

1. 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.
   - ☑ Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.
   - ☐ Other. Please describe how the county has coordinated stakeholder activities for IP development and the CHA/CHIP

Most Recent Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) or Strategic Plan

1. 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/No radio buttons]

   - ☑ **Yes**

i. Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP

When preparing for the IP, the key goal as it relates to the CHA/CHIP was to seek alignment. Sharing of the statewide priority goals and ensuring behavioral health metrics are utilized for planning and tracking progress. Utilizing priorities identified through CHIP to inform early intervention strategies. Additionally, the CHIP workgroup identified strategies that would benefit all stakeholders at the table.

☐ No

ii. Please explain why the county did not consider the LHJ's CHA/CHIP or strategic plan when preparing its IP [narrative box]

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

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

   Health Plan of San Mateo, Kaiser Permanente

2. 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?

   Community Reinvestment plans are still under development and due to DHCS at the end of Q1 2026. Reinvestment is focused on priorities identified through their local Population Needs Assessment, which incorporates encounter data from BHRS and learning from participation the CHA/CHIP process, which BHRS also participates in and was part of our community planning process.

Comment Period and Public Hearing

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

1. Date the draft Integrated Plan (IP) was released for stakeholder comment
   February 4, 2026

2. Date the stakeholder comment period closed
   March 5, 2026

3. Date of behavioral health board public hearing on draft IP
   March 4, 2024
   a. Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
      ☑ Link - https://www.smchealth.org/behavioral-health-services-act
      ☐ PDF, image, or other document

4. [Optional] 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: **https://www.smchealth.org/behavioral-health-services-act**

5. Please select the process by which the draft plan was circulated to stakeholders
   ☑ Public posting
   ☑ Email outreach
   ☑ Other

6. Please specify the other process the draft plan was circulated to stakeholders Various means are used to circulate information about the availability of the plan and 30-day public comment period:
   - Announcements at internal and external community meetings engaging diverse families and communities (Health Equity Initiatives, Health Ambassador Program, Lived Experience Academy, etc.)
   - Emails disseminating information to an MHSA distribution list of more than 2,400 subscribers, an Office of Diversity and Equity distribution list of more than 2,100 subscribers, and a BHRS subscriber list of over 2,500 subscribers.
   - Word of mouth on the part of committed staff and community partners, peers/family partners and health ambassadors
   - Posting on the MHSA webpage (smchealth.org/MHSA) and the BHRS Blog (smcbhrsblog.org)

7. Please describe stakeholder input in the table below. Please add each

stakeholder group into their own row in the table. **See Appendix 3. All Public Comments Received**

Table 7. Stakeholder Input

Stakeholder group that provided feedback	Summarize the substantive revisions recommended this stakeholder during the comment period
Community member	**Comment** – SUD Treatment Facility: (summarized below; see Appendix 3 for all public comments received): Formally object to the Behavioral Health Services Act Integrated Plan for Fiscal Years 2026-29 based on the inclusion of the proposed 69-bed facility at 101 N. El Camino Real, referenced on pages 108 and 125 of the plan as the proposed SUD Campus by BHRS contractor Horizon Services. - A 60-day extension of the public comment period, which would require voting against closing the comment period - Establishment of an Ad Hoc Subcommittee to engage stakeholders and analyze the site setting - Decoupling of 101 N. El Camino Real from the BHSA Integrated Plan for FY 2026-29 - Identification of an alternative site that is not directly adjacent to schools, childcare centers, senior facilities, or dense residential neighborhoods **Response:** BHRS acknowledges and appreciates the community's engagement and input regarding the proposed substance use disorder (SUD) treatment facility. The recent closure of the First Chance Sobering Station created a significant gap in local services, impacting approximately 2,400 community members who historically benefited from safe,

	effective, and timely access to care each year. Addressing this gap remains a priority for the County of San Mateo and BHRS. 1. A required element of the BHSA Integrated Plan is to report to the state of any funding commitments specific to a BHCIP project. The County has committed funding to a proposed BHCIP project, the Horizon Project, so to remove mention of the project would result in the Integrated Plan submittal being inaccurate and incomplete. Page 118 generally states the following with no mention of site-specific plans: "SUD Treatment Facility – a proposal was submitted by a BHRS contracted provider, Horizons, with BHRS commitment of $2 million for land acquisition, funded through opioid settlement funds." 2. Another aspect of the plan is to inform the state of all potential funding possibilities under the Plan. The county is committed to funding SUD treatment services. If we do not include language about committing funding to this type of project in the BHSA Plan, BHRS loses the opportunity to fund SUD treatment projects. Page 134 of the Integrated Plan will be amended to remove mention of the specific Horizon project and include only the general plan for new SUD services including; bringing SUD services to the Navigation Center, Mobile Methadone services and a Sobering Center. 3. Our reporting of the horizon project in this BHSA Integrated Plan has no impact on whether Horizon receives approval by the state, or on the local level. Horizon Services remains subject to all required local jurisdictional reviews and community engagement processes, and state-level approvals prior to any implementation.

Health Ambassadors	**Comment** – Health Ambassador Program (summarized below; see enclosure 2 for full comment): Proposal: Formal Integration of Alcohol and Other Drug (AOD) Services into the Health Ambassador Program (HAP). We propose that the Health Ambassador Program be formally integrated into the BHSA Three-Year Plan strategies to expand outreach and connection to BHRS Alcohol and Other Drug (AOD) services. **Response:** BHRS appreciates the proposal to formally integrate the Health Ambassador Program (HAP) into the BHSA Three-Year Integrated Plan strategies to strengthen outreach and connection to Alcohol and Other Drug (AOD) services. Strengthening outreach and connection to AOD services aligns with BHRS overall priorities to become a more integrated organization. HAP is administered through the Office of Diversity and Equity (ODE), which is encompassed within the existing Integrated Plan under ODE programs. ODE strategies are prioritized to address the statewide goals of (1) Access to Care and (2) Workforce Development. HAP will be explicitly added as a strategy contributing to the Access to Care priority area to further highlight its role in outreach and engagement—particularly for communities disproportionately affected by behavioral health disparities. Response to specific recommendations for HAP: • Provide expanded AOD education and training to Health Ambassadors. o This recommendation can be implemented at the program level, contingent upon available funding and staffing capacity.

	• Formally integrate HAP within DMC-ODS access and culturally grounded outreach strategies. o Currently ODE, which is inclusive of HAP, is represented under the Access to Care strategies, encompassing both mental health and substance use services (i.e., DMC-ODS). Page 29 of the Integrated Plan will be amended to explicitly add HAP as a strategy to strengthen culturally grounded substance use outreach efforts. • Include HAP within the new Early Intervention RFP framework as a proven community model. o Community-based organizations are encouraged to apply to the Request for Proposal (RFP) when it releases and can propose any community-defined practices like HAP, if they are able to meet the requirements for early intervention services, which include 1) culturally responsive and targeted outreach, 2) screening for Medi-Cal eligibility and linkages, and 3) Medi-Cal billable interventions. • Fund stipends and certification pathways for Ambassadors pursuing AOD credentials. o BHRS has a process in place for funding stipends and certification pathways. The Peer Support Specialist Certification is under the purview of the Office of Consumer & Family Affairs (OCFA), information regarding the requirements and roll out of these stipend and certification opportunities will be managed by the OCFA team. • Incorporate HAP impact metrics into BHSA access and equity indicators. o BHSA access and equity indicators are determined by the State and cannot be modified. However, specific programs can identify additional metrics to track progress

	and demonstrate impact within programmatic evaluations and reporting processes.
Family Member	**Comment** – Aging Caregivers: I'd like to add a specific request to my comment letter dated February 24th regarding the proposed 3 year integrated plan. As it relates to my comments noted as item 1 on page two of my letter, where I state that there is a significant number of BHSA eligible disabled adult children who are forced to live with aging parents due to the shortage of available PSH and Augmented Board & Care beds in our county, I'd like to request that the proposed Plan be amended to include a 'specific and codified pathway for DIRECT REFERRAL FOR URGENT PRIORITY RE-HOUSING of BHSA eligible adults currently residing with an aging parent(s)' in the following cases: • one of the caregiving parents is diagnosed with a life threatening or severely impairing illness (ie. cancer, stroke, experiences a heart attack, dementia, or other serious illness) which undermines the parent's ability to continue to house and care for their adult child with an SMI. This should apply even in the case of two aging parents in the home as the caregiving focus of the second parent needs to shift by necessity to the ailing parent. • the caregiving parent(s) is 70 years old or older. • the caregiving parent is experiencing significant economic hardship and can no longer afford to provide housing, meals, medical and other services coordination for their adult child with SMI. • the caregiving parent is moving and will no longer be able to provide housing and caregiving for his/her adult child with SMI.

	▯ the caregiving parent no longer feels safe living with his/her adult child with SMI. ▯ All of the above scenarios warrant urgency and a 'priority need' for the re-housing of a disabled adult child with SMI for the health, safety, and welfare of all involved. Having a clear designated pathway for this in your PSH allocation and housing supports workflow is needed. Thank you for taking this additional comment into consideration. **Response:** Thank you for the thoughtful and detailed comment and for elevating the needs of aging parents who are supporting adult children with serious mental illness (SMI). We agree that these caregiving situations can quickly become unsafe, unsustainable, and deeply distressing for everyone involved. Eligibility for BHSA-funded housing and related supports is governed by state definitions of homelessness, chronic homelessness, and at risk of homelessness in the DHCS Behavioral Health Services Act (BHSA) County Policy Manual Appendix A, and our local policies must align with those criteria. Because BHSA eligibility criteria and allowable uses are set at the state level, creating a new, codified "direct referral for urgent priority re housing" category specifically for adults residing with aging parents would likely require state level policy changes. Within the existing framework, BHRS can work to clarify and communicate that adults with SMI who are in unsustainable family housing situations may qualify as at risk of homelessness and therefore be eligible for BHSA-funded housing supports when other criteria are met. Page 35 of the Integrated Plan will be updated to include the overarching strategy to improve documentation and training for

	clinical staff as it relates to housing instability
Provider	**Comment** – Children Ages 0-5: Early Intervention (EI) is the only BRHS funding stream that currently includes ECMH services for the youngest children 0-5. The existing allocation is $8.0M annually across all BHRS funding sources for EI — covering the full 0–25 age range, not just young children. This makes dedicated funding for the 0–5 population extremely limited. A minimum of $2M annually should be dedicated through the RFP specifically to ECMH Early Intervention activities and services, enabling CBOs and nonprofits to continue serving children ages 0–5 and their caregivers. Explicit language protecting this population in the RFP is essential to ensure they are not absorbed into the broader 0–25 funding pool. This Matters because: • Over 60 clinicians have been trained currently in Child-Parent Psychotherapy (CPP) to serve this population in the county in partnership with F5, SMC BHRS and CYBHI funding. • F5SMC's 2024 Early Childhood Mental Health Landscape Scan identified significant barriers to access: eligibility restrictions, logistical challenges, language access gaps, and high staff turnover disrupting continuity of care. • Early intervention is an inherently upstream strategy — addressing mental health needs in the 0–5 window mitigates longer-term health challenges and reduces inequitable outcomes. • Families in the county are already struggling to navigate the ECMH system, and current funding is insufficient to meet the need. Without explicit RFP language and a dedicated budget floor for children 0–5, this vulnerable population risks being deprioritized within a broader age range. Doubling the allocation to $2M annually is a

	targeted, evidence-informed investment in the county's youngest and most developmentally critical residents. We appreciate your partnership and consideration! **Response:** Thank you for your advocacy on behalf of our county's youngest children and their caregivers. We agree that early childhood mental health (ECMH) services and early intervention are critical, upstream investments that can reduce long term inequities and improve outcomes across the lifespan. Under the Behavioral Health Services Act, our Early Intervention (EI) allocation for all ages is set at 51% of the BHSS allocation, and our county is currently meeting that required level. Within that constraint, EI funding must support the full 0–25 age range, which means we do not have unlimited flexibility to carve out large, fixed sub allocations for specific age groups without impacting other EI priorities and services. We also recognize, as you highlight, that the 0–5 population has unique developmental needs, that families face significant barriers to accessing ECMH services, and that a trained workforce is already in place and should be sustained. While we may not be able to change the overall EI percentage requirement or commit to a specific dollar floor at this time, we can take concrete steps to protect and elevate ECMH within the RFP and implementation, such as including explicit language in the RFP that identifies children 0–5 and their caregivers as a focus population within EI and exploring opportunities to braid and align EI funds with other local and state funding streams to maximize support for ECMH services without duplicating or supplanting existing investments.

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

Comment – Youth Strategies:

- Add to the comment above re: HAP Integrations — AOD >> Please explicitly include mention of the Health Ambassadors Program Youth (HAP-Y) program under ODE programming, too.
    - Response: The HAP-Y program was determined to end July 1, 2026 given Prop. 1 shifts of population-based prevention programs and funding to the State. In Spring 2025, BHRS notified all contracted providers of prevention programs that will sunset under Prop 1. Due to StarVista closure, the program ended August 1, 2025.
- I agree with the commenter regarding the need for an overarching mission and North Star. This also applies to the BHSA Transformation Journey. I request that -- the formation of a North Star is included as a strategy to effectively implement the BHSA Integration Plan, of which all strategies should align to and support. Additionally, as a holistic strategy, BHRS engage in a horizon scanning & foresight process to identify emerging trends, structural shifts to build resilience and mitigate against future shocks.
    - Response: BHRS has an updated Mission and Vision statements that will be added to Transformation Journey Roadmap referenced in the Integrated Plan (page 27)
- I asked a question at the February meeting and offered a directive comment for joint study sessions with the Juvenile Justice & Delinquency Prevention Commission. Please add that as an explicit strategy to improve cross-coordination, improve the care experience and service delivery.
    - Response: This will be added as an overarching strategy to improve cross-sector coordination, in the Integrated Plan
- Removal of Children from Home — Add Strategy. In addition to Family Engagement, School-Based Services, Cross-Sector Coordination — add Youth Leadership, Engagement & Voice as a strategy and focus area to partner with Foster Advisory Group, BHC Youth Action Board and related youth-centered bodies to ensure decisions and services are centered in the needs, interests and current and future generations.
    - Response: This will be added as an overarching strategy to improve youth engagement, in the Integrated Plan
- Add 1-2 youth seats (ages 12-24) to all steering committees and decision-making bodies to provide youth lived experience, voice and perspectives — same with

Engagement at Schools + Social Connection

- Response: This will be added to the overarching strategy to improve youth engagement, in the Integrated Plan. The specific recommendation can be implemented at the program level for each committee, contingent upon youth capacity to serve in various committees – BHRS committees include the Behavioral Health Commission committees, Lived Experience Education Workgroup, Housing Operations and Policy Committee, Tobacco Education Coalition, Overdose Prevention Coalition, the Diversity and Equity Council and 8 Health Equity Initiatives.

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.

County Provider Monitoring and Oversight

Cities submitting their Integrated Plan independently from their counties do not have to complete the Medi-Cal Quality Improvement Plan questions or Question 1 under All BHSA Provider Locations. Otherwise, all fields must be completed unless marked as optional. For related policy information, refer to 6.C.2 Securing Medi-Cal Payment.

Medi-Cal Quality Improvement Plans

1. 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 [**See Appendix 4**].

2. 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**
    a. For standalone DMC-ODS, please upload a copy of the county's current QIP for SFY 2026-2027 [**See Appendix 4**]

Contracted BHSA Provider Locations

1. 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	25
Substance Use Disorder (SUD) services only	1
Both MH and SUD services	19

2. 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	12
DMC/DMC-ODS only	9
Both SMHS and DMC/DMC-ODS systems	1

All BHSA Provider Locations

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

1. 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? *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.*

   DHCS provided a rate of 30.2% for San Mateo County SMHS provider sites that also contract with Medi-Cal MCPs for NSMHS.

   [if estimate is <60 percent, populate question a below]

a. Please describe the county's plans to enhance rates of MCP contracting starting July 1, 2027, and over the subsequent two years among the BHSA provider locations that are providing services that can/should be reimbursed by Medi-Cal MCPs

Most of the dually contracted network providers will not be funded under BHSA. Of the 20 SMHS providers that will be funded by BHSA, only 4 are able to provide NSMHS-level of care and 100% of the 4 are contracted with an MCP.

Additionally, BHSA will fund an estimated 7-10 providers under Early Intervention strategies that do not provide SMHS but, could dually contract with MCPs for NSMS.

BHRS opted in to the PIVOT multi-county Innovation project component focused on innovative solutions for increasing MCP reimbursement for eligible NSMS. This innovation project will expand dually contracted providers and is our local effort to address the BHSA requirement to make a good faith effort to seek reimbursement from Medi-Cal MCPs and commercial health plans for covered services, by July 1, 2027.

2. 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.
        i. Does the county wish to describe implementation challenges or concerns with these requirements? **No concerns at this time**
            1. Please describe any implementation challenges or concerns with the requirements for BHSA providers

3. 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:

a. 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**
    i. If not, please describe how the county will monitor these providers for compliance with BHSA requirements
b. Do not participate in the county's Medi-Cal Behavioral Health Delivery System? **Yes**
    i. If not, please describe how the county will monitor these providers for compliance with BHSA requirements

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS)

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

General

1. Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan
   - ☑ Children's System of Care (non-Full Service Partnership (FSP))
   - ☑ 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)

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

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

Program #1

1. Please select the service types provided
   - ☑ Mental health services
   - ☐ Supportive services
   - ☐ Substance Use Disorder treatment services

2. Please describe the specific services provided

   Neurosquential Model of Therapeutics (NMT)

   The NMT program provides training and technical assistance to county clinicians who deliver intensive mental health services to individuals who are living with serious mental illness (SMI) and have experienced severe trauma. NMT program operations are functionally organized by client age: youth (ages 0–18), transitional age youth (ages 16–25), and adults (age 26 and older), including clients who are involved with the criminal justice system and are reentering the community following incarceration.

   Individuals may be referred to the NMT program from regional mental health clinics or specialty mental health providers. Children system of care providers that refer to the NMT program include the Prenatal to Three Initiative, Edgewood Center for Children and Families, and Fred Finch Youth and Family Services.

Based on NMT assessments, clinicians recommend specific therapeutic interventions that promote the development of functional capacities within domain(s) in which the client demonstrates the largest potential for improvement. Program staff commonly refer clients to one or more BHSA-funded contracted service providers that offer guided therapeutic activities such as trauma-informed yoga, equine therapy, swimming, martial arts, art, music, intensive speech therapy, and Eye Movement Desensitization and Reprocessing (EMDR) psychotherapy. In addition to providing financial support for these activities, BHSA funds cover clients' self-care tools, including weighted blankets, sound machines, and gliding chairs. Clients' use of these therapeutic services and self-care tools complements traditional mental health care services, such as talk-based therapy and psychiatric medications.

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

Table 10. Number of Individuals in the **Children's System of Care (Non-FSP)** Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	60
FY 2027 – 2028	60
FY 2028 – 2029	60

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

Projections based on # of clients served in FY 2024-25

Program #2

5. **Please select the service types provided**

- ☐ Mental health services
- ☑ Supportive services
- ☐ Substance Use Disorder treatment services

6. Please describe the specific services provided

Family Partners

Family Partners (FPs) and Family Peer Support Specialists (FPSSs) are employed throughout the Youth and Adult Systems. These workers provide direct services to the

families drawn from their personal experience with recovery, either in their own lives or as relatives of someone affected. They understand firsthand the challenges of living with and recovering from a behavioral health diagnosis and work collaboratively with our clients and families based on that shared experience.

The FPs/FPSSs are individuals who have personal experience caring for a child, youth or TAY with behavioral health needs, uses their knowledge of behavioral health, child welfare, juvenile justice, and educational resources to engage parents and caregivers in case planning and service delivery. They provide the families they serve culturally and linguistics services with resources, guidance support, and advocacy to parents, help address racial disparities and connect families with others who have similar experiences to offer mentorship and hope. Additionally, they share evidence-based practices to educate families to feel more empowered and help them make informed treatment decisions.

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

Table 10. Number of Individuals in the Children's System of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	140
FY 2027 – 2028	140
FY 2028 – 2029	140

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

Projections based on # of clients served in FY 2024-25

Program #3

9. Please select the service types provided

- ☐ Mental health services
- ☐ Supportive services
- ☑ Substance Use Disorder treatment services

10. Please describe the specific services provided

Substance Use Residentials for Youth

Muir Wood Teen Treatment Center provides dual-diagnosis treatment for boys and girls including residential detox and treatment services for teens ages 12-17; these residential

treatment services meet both the substance use and mental health needs of the teens. Muir Wood programs combine evidence-based modalities such as individual, group, and family therapy sessions, experiential therapies, and art therapy with holistic support that promotes overall wellness. Residential homes and campus-style spaces foster comfort, connection, and belonging. Muir Wood provides academics, medication management, nutritious meals, and engaging activities, teens gain the tools to rebuild confidence, healthy relationships, and move forward with hope. Family members are active participants throughout care and continuing support after discharge, helping teens sustain long-term recovery and well-being.

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

Table 10. Number of Individuals in the **Children's System of Care (Non-FSP)** Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	5
FY 2027 – 2028	5
FY 2028 – 2029	5

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

Projections based on # of clients served in FY 2024-25

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

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.

Program #1

1. Please select the service type provided
   - ☑ Mental health services
   - ☐ Supportive services
   - ☐ Substance Use Disorder (SUD) treatment services

2. Please describe the specific services provided

Justice Involved

Forensic and Specialty Court Services provide outpatient treatment and support services to individuals living with SMI/SUD and non-violent offenders to divert from incarceration into community-based services.

BHSA will fund staff employed to support and oversee forensic and specialty court services and specifically funds the Pathways program – a partnership among BHRS, San Mateo County (SMC) Superior Court, Probation Department, District Attorney, Private Defender Program, Sheriff's Office, Correctional Health Services, and National Alliance on Mental Illness (NAMI). Pathways is an alternative to incarceration for eligible adults. Eligibility criteria include individuals with a functionally impairing serious mental illness (SMI) who have been arrested for a crime, have entered a plea of guilty or no contest, are statutorily eligible for probation, and agree to undergo Pathways-supported treatment and community rehabilitation in lieu of incarceration.

Once enrolled in Pathways, clients receive intensive case management and individualized treatment services for their SMI and any co-occurring mental health or substance use disorders (SUDs). Primary program activities include referrals to other health care providers and social needs supports, individual and group therapy, psychoeducational services, probation supervision, placement and crisis management, and facilitation of peer support and mentoring services. Case managers provide clients with logistical support, including assistance with enrolling in Medi-Cal and other benefit program applications, as well as warm handoffs to regional mental health clinicians, primary care providers, SUD treatment providers, and housing agency staff, as needed.

3. 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

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

Projections based on # of clients served in FY 2024-25

Program #2

1. Please select the service type provided
   - ☐ Mental health services
   - ☑ Supportive services
   - ☐ Substance Use Disorder (SUD) treatment services (SU Contracted Providers, Adult Residentials)

2. Please describe the specific services provided

Peer Supports

Office of Consumer and Family Affairs (OCFA) helps clients and their family members navigate the BHRS system and increase awareness of services and resources available to support them. OCFA increases client and family participation in BHRS policy, planning and implementation. Clients can contact OCFA for assistance filing a grievance if they are dissatisfied with the quality of care or services received, feel staff did not respect their rights, or did not authorize and/or provide the services requested.

Peer Support Specialists (PSS) and Certified Medi-Cal Peer Support Specialists (CMPSS) are employed throughout the Adult System. These workers provide direct peer support services to adult clients drawn from their personal experience of recovery from mental health, substance use disorder and/or trauma in their own lives, coupled with peer support training and certification by the California Mental Health Services Administration (CalMHSA). PSS/CMPSS engage adult clients at BHRS in assessment and in collaboration with the treatment/program team, provide voluntary peer support according to individual's goals and hopes for recovery including, collaborative development of a care plan, 1:1 peer support encounters in clinics or in the community, and provision of support, educational and skill building groups.

Peer supports are offered through contracts with community-based peer-run agencies. Aspire House is a California Clubhouse evidence-based model providing social and vocational rehabilitation services to individuals living with a mental illness. Helping Our Peers Emerge (HOPE) is a collaboration with BHRS and Aspire House designed to provide peer and family support services using peer mentors to assist individuals who are exiting psychiatric hospital settings to successfully transition into the community, with the intention of reducing recidivism. Seeing Through Stigma removes the stigma associated with behavioral health challenges and supports presentations from individuals with lived experience who share their journey and their path toward recovery with various audiences. Wellness Recovery Action Planning (WRAP) – an evidence-based practice – is offered by peers to support individuals in recovery, prevent relapse, sustain long-term recovery, and support family members. Additional peer supports help individuals with substance use and/or mental health challenges acquire the tools and confidence needed to begin, maintain, and enhance their recovery.

3. 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	380
FY 2027 – 2028	380
FY 2028 – 2029	380

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

   Projections based on # of clients served in FY 2024-25

Program #3

1. Please select the service type provided
   - ☐ Mental health services
   - ☐ Supportive services
   - ☑ Substance Use Disorder (SUD) treatment services

2. Please describe the specific services provided

   SUD Contracted Providers and Adult Residentials

   BHSA funding funds substance use providers and BHRS Alcohol and Other Drug (AOD) unit staff to ensure integration of mental health and substance use disorder treatment. A clinical consultant provides co-occurring mental health and substance use disorder capacity development training to BHRS staff and multiple agencies, consultation for complex co-occurring mental health and substance use disorder clients, and system transformation support.

   Adult residentials treatment centers for addiction and mental health issues offer detox, therapy, and more for adults and adolescents. BHRS currently contracts with community-based agencies to provide certified residential services and deliver American Society of Addition Medicine (ASAM) Level 3.1, ASAM Level 3.3 and ASAM Level 3.5 residential services and to offer Residential Detoxification ASAM 3.2 WM with Incidental Medical Services (IMS). These services are available for both men and women. In addition to SUD residential treatment services, Free At Last and Service League offer Perinatal Services residential services and Sitike Counseling provides Intensive Outpatient Perinatal service.

3. 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	1,070
FY 2027 – 2028	1,070
FY 2028 – 2029	1,070

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

   Projections based on # of clients served in FY 2024-25

Program #4

5. Please select the service type provided

   ☐ Mental health services

   ☑ Supportive services

   ☐ Substance Use Disorder (SUD) treatment services

6. Please describe the specific services provided

   Innovation Encumbered

   Three MHSA-encumbered INN projects are continuing under BHSA. The Recovery Connection Center offers peer support services for individuals with substance use challenges or co-occurring substance use and mental health challenges at all stages of their recovery.

   Additionally, BHRS is contracting with One New Heartbeat to pilot a peer support for peer workers program for peers that are either contracted or employed by BHRS. This project aims to provide on-demand non-clinical support for peer workers who are experiencing work-related stress to reduce burnout and increase job satisfaction, retention and work-life balance. Finally, the Animal Fostering program provides animal foster care and animal support services to behavioral health clients so that they access timely treatment and maintain housing stability. The program will utilize BHRS trained peers to provide volunteer foster care and animal support services.

7. 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

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

   Projections for Recovery Connection Center are based on # of clients served in FY 2024-25 (200). For Animal Fostering projections based on estimated # of behavioral clients living in MHSA-funded housing in FY24-25 that reported owning a pet (60). Peer support for peer workers projections were based on a reasonable caseload for three part-time peer support providers (35).

Early Intervention Programs

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

Program #1

1. Program or service name

   Crisis Response & Supports

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

   - ☑ Outreach
   - ☑ Access and Linkage: Screenings
   - ☑ Access and Linkage: Assessments
   - ☑ Access and Linkage: Referrals
   - ☐ Access and Linkage: Other

- ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
- ☑ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
- ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
- ☐ Treatment Services and Supports: Other
- ☐ Please specify "other" type of Access and Linkage
- ☐ Please specify "other" type of Treatment Services and Supports

3. 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 **N/A – biennial list of EBPs, CDEPs not available**
   - ☐ Please select the EBPs and CDEPs that apply [PLACEHOLDER: biennial EBP list]

4. Please describe intended outcomes of the program or service

   A BHRS reporting framework for early intervention programs was originally developed in June 2022 in collaboration with community partners, providers and clients and family members. Early intervention programs report individual client demographics, referrals provided, and individual outcomes across the following nine outcome domains: increased access to services, community advocacy, connection and support, cultural identity/cultural humility, general mental health, improved knowledge, skills, and/or abilities, self-empowerment, stigma reduction, and utilization of emergency services.

   Crisis Response and Support services anticipated outcomes include:

   1. *Access to services*: reduce barriers to accessing services due to financial, administrative, social, and cultural challenges:
      - Increased understanding of existing services and systems
      - Connecting individuals to services
   2. *General Behavioral Health*: contribute to improved overall mental health outcomes:
      - Reduced symptoms of anxiety, depression, and stress
      - Improved coping tools to deal with stressors
      - Improved general behavioral health and functioning
   3. *Utilization of emergency services*: help individuals identify and manage health challenges before a crisis arises:
      - Reduced need for emergency services
      - Reduced length of stay in emergency facilities

5. 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

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

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	1096
FY 2027 – 2028	1096
FY 2028 – 2029	1096

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

This is a duplicated number of calls, deployments and client episodes that required crisis intervention, the projections are based on # of clients served in FY 2024-25.

Program #2

1. Program or service name

Primary Care Integration

2. Please select which of the three EI components are included as part of the program or service
   - ☑ Outreach
   - ☑ Access and Linkage: Screenings
   - ☑ Access and Linkage: Assessments
   - ☑ Access and Linkage: Referrals
   - ☐ Access and Linkage: Other
   - ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   - ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   - ☑ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   - ☐ Treatment Services and Supports: Other
   - ☐ Please specify "other" type of Access and Linkage

☐ Please specify "other" type of Treatment Services and Supports

3. 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 **N/A – biennial list of EBPs, CDEPs not available**

   ☐ Please select the EBPs and CDEPs that apply [PLACEHOLDER: biennial EBP list]

4. Please describe intended outcomes of the program or service

   A BHRS reporting framework for early intervention programs was originally developed in June 2022 in collaboration with community partners, providers and clients and family members. Early intervention programs report individual client demographics, referrals provided, and individual outcomes across the following nine outcome domains: increased access to services, community advocacy, connection and support, cultural identity/cultural humility, general mental health, improved knowledge, skills, and/or abilities, self-empowerment, stigma reduction, and utilization of emergency services.

   Primary Care Integration services anticipated outcomes include:

   1. *Access to services*: reduce barriers to accessing services due to financial, administrative, social, and cultural challenges:
      - Increased understanding of existing services and systems
      - Connecting individuals to services

   2. *General Behavioral Health*: contribute to improved overall mental health outcomes:
      - Reduced symptoms of anxiety, depression, and stress
      - Improved coping tools to deal with stressors
      - Improved general behavioral health and functioning

   PCI clinicians are trained in the treatment of clients with substance use disorders by motivational interviewing techniques and coordinating with the Integrated Medication Assisted Treatment (IMAT) team for ongoing SUD care services for clients encountered in the medical emergency department or in the field.

5. 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

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

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	995
FY 2027 – 2028	995
FY 2028 – 2029	995

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

   Projections based on # of clients served in FY 2024-25

Program #3

1. Program or service name

   Children & Youth Strategies

2. Please select which of the three EI components are included as part of the program or service
   - ☑ Outreach
   - ☑ Access and Linkage: Screenings
   - ☑ Access and Linkage: Assessments
   - ☑ Access and Linkage: Referrals
   - ☐ Access and Linkage: Other
   - ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   - ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   - ☑ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   - ☐ Treatment Services and Supports: Other
   - ☐ Please specify "other" type of Access and Linkage
   - ☐ Please specify "other" type of Treatment Services and Supports

3. 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 **N/A – biennial list of EBPs, CDEPs not available**
   - ☐ Please select the EBPs and CDEPs that apply [PLACEHOLDER: biennial EBP list]

4. Please describe intended outcomes of the program or service

   A BHRS reporting framework for early intervention programs was originally developed in June 2022 in collaboration with community partners, providers and clients and family members. Early intervention programs report individual client demographics, referrals provided, and individual outcomes across the following nine outcome domains: increased access to services, community advocacy, connection and support, cultural identity/cultural humility, general mental health, improved knowledge, skills, and/or abilities, self-empowerment, stigma reduction, and utilization of emergency services.

   Children & Youth Strategies anticipated outcomes include:

   1. *Access to services*: reduce barriers to accessing services due to financial, administrative, social, and cultural challenges:
      - Increased understanding of existing services and systems
      - Connecting individuals to services
   2. *General Behavioral Health*: contribute to improved overall mental health outcomes:
      - Reduced symptoms of anxiety, depression, and stress
      - Improved coping tools to deal with stressors
      - Improved general behavioral health and functioning
   3. *Connection and Support*: help participants strengthen these relationships and community ties, leading to a greater sense of belonging:
      - Strengthened relationships with family members, friends and others in their lives
      - Developed sense of belonging through a welcoming and inclusive environment
   4. *Improved knowledge, skills, and/or abilities*: develop capacity to improve overall mental well-being:
      - Improved skills, abilities and confidence to respond to and/or support mental health and substance use needs
      - Increased awareness about mental health and substance use

5. 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

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

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	415

FY 2027 – 2028	415
FY 2028 – 2029	415

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

   While programs report unduplicated client counts, number of individuals served are duplicated since individuals can participate across more than one program. Projections are based on # of clients served in FY 2024-25.

Program #4

1. Program or service name: **Community Defined Practices**

2. Please select which of the three EI components are included as part of the program or service
   - ☑ Outreach
   - ☑ Access and Linkage: Screenings
   - ☑ Access and Linkage: Assessments
   - ☑ Access and Linkage: Referrals
   - ☐ Access and Linkage: Other
   - ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   - ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   - ☑ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   - ☐ Treatment Services and Supports: Other
   - ☐ Please specify "other" type of Access and Linkage
   - ☐ Please specify "other" type of Treatment Services and Supports

3. 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 **N/A – biennial list of EBPs, CDEPs not available**
   - ☐ Please select the EBPs and CDEPs that apply [PLACEHOLDER: biennial EBP list]

4. Please describe intended outcomes of the program or service

   A BHRS reporting framework for early intervention programs was originally developed in June 2022 in collaboration with community partners, providers and clients and family members. Early intervention programs report individual client demographics, referrals provided, and individual outcomes across the following nine outcome domains:

increased access to services, community advocacy, connection and support, cultural identity/cultural humility, general mental health, improved knowledge, skills, and/or abilities, self-empowerment, stigma reduction, and utilization of emergency services.

Community Defined Practices anticipated outcomes include:

1. *Access to services*: reduce barriers to accessing services due to financial, administrative, social, and cultural challenges:
   - Increased understanding of existing services and systems
   - Connecting individuals to services
2. *General Behavioral Health*: contribute to improved overall mental health outcomes:
   - Reduced symptoms of anxiety, depression, and stress
   - Improved coping tools to deal with stressors
   - Improved general behavioral health and functioning
3. *Connection and Support*: help participants strengthen these relationships and community ties, leading to a greater sense of belonging:
   - Strengthened relationships with family members, friends and others in their lives
   - Developed sense of belonging through a welcoming and inclusive environment
4. *Improved knowledge, skills, and/or abilities*: develop capacity to improve overall mental well-being:
   - Improved skills, abilities and confidence to respond to and/or support mental health and substance use needs
   - Increased awareness about mental health and substance use

5. 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

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

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	995
FY 2027 – 2028	995
FY 2028 – 2029	995

7. Please describe any data or assumptions the county used to project the number

of individuals served through EI programs

Projections based on # of clients served in FY 2024-25

Program #5

1. Program or service name

   Homeless Outreach Programs

2. Please select which of the three EI components are included as part of the program or service
   - ☑ Outreach
   - ☑ Access and Linkage: Screenings
   - ☑ Access and Linkage: Assessments
   - ☑ Access and Linkage: Referrals
   - ☐ Access and Linkage: Other
   - ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   - ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   - ☑ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   - ☐ Treatment Services and Supports: Other
   - ☐ Please specify "other" type of Access and Linkage
   - ☐ Please specify "other" type of Treatment Services and Supports

3. 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 **N/A – biennial list of EBPs, CDEPs not available**
   - ☐ Please select the EBPs and CDEPs that apply [PLACEHOLDER: biennial EBP list]

4. Please describe intended outcomes of the program or service

   A BHRS reporting framework for early intervention programs was originally developed in June 2022 in collaboration with community partners, providers and clients and family members. Early intervention programs report individual client demographics, referrals provided, and individual outcomes across the following nine outcome domains: increased access to services, community advocacy, connection and support, cultural identity/cultural humility, general mental health, improved knowledge, skills, and/or abilities, self-empowerment, stigma reduction, and utilization of emergency services.

   Homeless Outreach services anticipated outcomes include:

1. *Access to services*: reduce barriers to accessing services due to financial, administrative, social, and cultural challenges:
   - Increased understanding of existing services and systems
   - Connecting individuals to services
2. *General Behavioral Health*: contribute to improved overall mental health outcomes:
   - Reduced symptoms of anxiety, depression, and stress
   - Improved coping tools to deal with stressors
   - Improved general behavioral health and functioning
3. *Utilization of emergency services*: help individuals identify and manage health challenges before a crisis arises:
   - Reduced need for emergency services
   - Reduced length of stay in emergency facilities

5. 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

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

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	285
FY 2027 – 2028	285
FY 2028 – 2029	285

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

   Projections based on # of clients served in FY 2024-25

Program #6

8. Program or service name

   Innovation Encumbered

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

- ☑ Outreach
- ☑ Access and Linkage: Screenings
- ☑ Access and Linkage: Assessments
- ☑ Access and Linkage: Referrals
- ☑ Access and Linkage: Other
- ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
- ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
- ☑ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
- ☐ Treatment Services and Supports: Other
- ☑ Please specify "other" type of Access and Linkage – **Medi-Cal Billing**
- ☐ Please specify "other" type of Treatment Services and Supports

10. 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 **N/A – biennial list of EBPs, CDEPs not available**
    - ☐ Please select the EBPs and CDEPs that apply [PLACEHOLDER: biennial EBP list]

11. Please describe intended outcomes of the program or service

    Two MHSA-encumbered INN projects are continuing under BHSA. Allcove Half Moon Bay provides Coastside youth ages 12-15 with access to early intervention mental health, physical health, substance use, peer and family support, and education/employment services in a welcoming, youth-designed environment.

    PIVOT is supporting agencies in making a good faith effort to bill Medi-Cal for eligible services. PIVOT helps community-based organizations align on strategy and fiscal stewardship through Medi-Cal billing. PIVOT also works to support services that reflect the voices, needs, and aspirations of those being served by considering the impact of Medi-Cal billing on community-defined service delivery models and vulnerable client populations served. An intended outcome of PIVOT is to increase access to early intervention and peer support services and increase fiscal stewardship.

12. 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

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

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	1,320
FY 2027 – 2028	1,345
FY 2028 – 2029	1,345

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

    Allcove projections are based a percetange (5%, 100-125) of youth ages 12-25 in the Coastside region. PIVOT projections are based on the number of individuals who were served by MHSA-funded early intervention programs in FY24-25 (1,220)

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.

1. Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program
    a. CSC program name: **(re)MIND® and BEAM**
    b. CSC program description:

    The (re)MIND® and BEAM ((Bipolar Disorder Early Assessment and Management) programs are implemented using the coordinated specialty care model for prevention and early intervention of psychotic disorders. (re)MIND® specializes in early intervention for schizophrenia spectrum disorders (non-affective psychosis), while BEAM focuses on bipolar and affective psychosis. (re)MIND® and BEAM deliver comprehensive assessment and treatment grounded in wellness, recovery and resilience to youth and young adults experiencing early symptoms of psychosis with evidence-based and culturally responsive interventions. The (re)MIND/BEAM aftercare program – (re)MIND® Alumni – was developed to provide program graduates and caregivers with an internal step-down level of care to sustain gains achieved through engagement in psychosis early intervention.

2. [Context text: 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	65
Number of Uninsured Individuals	7
Number of Practitioners Needed to Serve Total Eligible Population	9
Number of Teams Needed to Serve Total Eligible Population	2

3. 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-operated and 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

4. Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)? **Yes**
    a. Please list the other funding source(s):

Outreach and Engagement (O&E)

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 #1

1. Program or activity name: **Family Assertive Support Team (FAST)**

2. Please describe the program or activity:

   FAST provides in-home, outreach and support services to assess, educate, assist, support and link families and adult SMHS/DMC-ODS clients that are living with their family (two or more people with close and enduring emotional ties) to appropriate mental health and substance use. Interventions include, crisis intervention, facilitating 5150, collaborating closely with law enforcement in service of clients and family, forensic mental health linkage, diagnosis, psychiatric and medication consult, role of medication in treatment; benefits and side effects, mental health education about diagnosis and behavioral health resources, motivational interviewing, destigmatizing mental health, obtaining benefits, "warm handoffs" to behavioral health and substance use disorder services, primary care, peer support, shelter, social rehabilitation, permanent housing. These services do not include paying directly for shelter and permanent housing.

3. 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	85
FY 2027 – 2028	85
FY 2028 – 2029	85

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

   Projections based on # of clients served in FY 2024-25

County Workforce, Education, and Training (WET)

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 #1

1. Program or activity name: **Trainings for System Transformation**

2. Please select which of the following categories the activity falls under
   - ☐ Continuing Education
   - ☐ Internship and Mentorship Programs
   - ☐ Loan Repayment
   - ☐ Professional Licensing and/or Certification Testing and Fees
   - ☐ Retention Incentives and Stipends
   - ☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program
   - ☑ Workforce Recruitment, Development, Training, and Retention
   - ☐ Other

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

   The Workforce Education and Training (WET) team is housed under the BHRS Office of Diversity & Equity and is critical to supporting BHRS' strategic initiatives and priorities through training and workforce development strategies. The goal is to create a behavioral health system of care that is responsive to client behavioral health needs and core principles of equity,

trauma-informed services, cultural humility, consumer and family-driven services, a focus on wellness, recovery, and resilience, and an integrated service experience. All trainings provided by BHRS are available to staff and our network of contracted providers. Trainings employ equity and trauma-informed lens and are assessed for cultural humility concepts including whether trainings affirm diverse cultures and backgrounds and/or encourage self-reflection and awareness of biases and assumptions about culture. Some of the highest rated outcomes as reported by staff were those related to integrating culturally informed practices at work (73%) and increased understanding around diversity, equity and inclusion (72%).

Trainings topics have included, Cultural Considerations: Responding Multi-culturally with CLAS via Cultural Complexities in Assessment Diagnosis and Engagement, Eating Disorders Training Series, Hoarding Disorder Series, Welcoming Integrated Systems for People with Co-occurring Mental Health and Substance Use Disorders, Culturally Responsive Clinical Supervision for Supervisees, Embracing Difference Through the Lens of Cultural Humility: Focus on Implicit Bias, Engaging African American and Black Clients and Families: Building Trust and Deepening Practice in Behavioral Health, Law and Ethics Training, Mindfulness Based Substance Use Treatment (MBSAT), Motivational Interviewing (MI) – The Basics for Behavioral Health Professionals / MI for Trauma Informed Care, Neurosequential Model Treatment (NMT), Prevention and Management of Assaultive Behavior, Pronouns and Transgender 101, and Sexual Orientation, Gender Identity, and Gender Expression (SOGIE) 201.

Program #2

1. Program or activity name: **Trainings for/by Peers and Family Members**

2. Please select which of the following categories the activity falls under
   - ☐ Continuing Education
   - ☐ Internship and Mentorship Programs
   - ☐ Loan Repayment
   - ☐ Professional Licensing and/or Certification Testing and Fees
   - ☐ Retention Incentives and Stipends
   - ☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program
   - ☑ Workforce Recruitment, Development, Training, and Retention
   - ☐ Other

3. 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

   BHRS is committed to addressing disparities amongst peers in the workforce by developing client and family member leadership skills, supporting meaningful engagement of clients and family members in shaping BHRS programs, services, and policies. Efforts in trainings for/by peers and family members encompass various initiatives, including the Peer Support Specialist Certification, Lived Experience Academy (LEA), Advocacy Academy and Advocacy Council, the Lived Experience and Education Workgroup (LEEW), and a Speakers Bureau. These initiatives are under the Office of Consumer & Family Affairs (OCFA), which comprises six dedicated team members, all of whom have personal or family experiences with mental health or substance use disorder challenges.

Program #3

1. Program or activity name: **Career Pathways and Financial Incentives**

2. Please select which of the following categories the activity falls under
   - ☐ Continuing Education
   - ☑ Internship and Mentorship Programs
   - ☐ Loan Repayment
   - ☐ Professional Licensing and/or Certification Testing and Fees
   - ☐ Retention Incentives and Stipends
   - ☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program
   - ☐ Workforce Recruitment, Development, Training, and Retention
   - ☐ Other

3. 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

   Disparities in the behavioral health workforce can be addressed across the pipeline of recruitment, retention and advancement strategies. BHRS will leverage the BH-CONNECT workforce initiative including the student loan repayment, scholarships, recruitment and retention, and provider training to develop and sustain a diverse and skilled workforce.

   Local efforts include mentorship, internship and residency training programs. Mentoring serves to help individuals build professional competencies,

develop leadership skills, support career advancement and prevent job burn-out. The BHRS Intern Program provides training opportunities for psychology interns, master-level trainees, alcohol and drug certificate program students, and psychiatric residents each year. The Psychiatry Residency Training Program provides comprehensive medical education with a rigorous focus in the public health sector including clinical care, scholarly activities and advocacy informed by the values of equity.

The Office of Diversity and Equity specifically oversees the management and implementation of a Cultural Stipend Internship Program (CSIP) to award stipends to trainees and interns that support equity efforts and provide culturally responsive services to clients including bilingual/bicultural lived experience and willingness to complete a project that informs our organizational equity and trauma-informed practices.

Capital Facilities and Technological Needs (CFTN)

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

Program #1

1. Project name: **Behavioral Health Continuum Infrastructure Program (BHCIP) Match**
2. Please select the type of project
   - ☑ Capital facilities project
   - ☐ Technological needs project

If capital facilities project, please indicate which of the following categories the project falls under:

- ☐ Acquiring, renovating, or constructing buildings that are or will be county-owned. *The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.*
- ☐ Acquiring facilities not secured to a foundation that is permanently affixed to the ground
- ☐ Establishing a capitalized repair or replacement reserve
- ☑ Meeting match requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award
- ☐ Renovating or constructing buildings that are privately owned

If acquiring, renovating, or constructing buildings, please indicate if the project involves leasing or renting to own a building: **N/A**

a. Please explain why purchase of the building was not possible

If Technological Needs Project, please select the focus area(s) of the project: **N/A**

- ☐ Data exchange and interoperability
- ☐ Data security and privacy
- ☐ Data warehouse
- ☐ Electronic health record system
- ☐ Individual/family access to computing resources
- ☐ Imaging/paper conversion
- ☐ Monitoring
- ☐ Online information resources for individuals/families
- ☐ Personal health record system
- ☐ Resources to support web content and mobile app accessibility
- ☐ System maintenance costs
- ☐ Telemedicine
- ☐ Other

3. Please describe the project

   BHRS submitted the two proposals for BHCIP that are currently under consideration:

   - SUD Treatment Facility – a proposal was submitted by a BHRS contracted provider, Horizons, with BHRS commitment of $2 million for land acquisition, funded through opioid settlement funds.
   - Youth Crisis Healing Campus – BHRS submitted Round 2 application with a 10% match commitment from MHSA/BHSA. Currently projected at $1,834,915.

Program #2

1. Project name: **County-Owned Building Renovations**
2. Please select the type of project
   - ☑ Capital facilities project
   - ☐ Technological needs project

If capital facilities project, please indicate which of the following categories the project falls under:

- ☑ Acquiring, renovating, or constructing buildings that are or will be county-owned. *The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.*
- ☐ Acquiring facilities not secured to a foundation that is permanently affixed to the ground

- ☐ Establishing a capitalized repair or replacement reserve
- ☐ Meeting match requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award
- ☐ Renovating or constructing buildings that are privately owned

If acquiring, renovating, or constructing buildings, please indicate if the project involves leasing or renting to own a building: **No**

b. Please explain why purchase of the building was not possible: **N/A**

If Technological Needs Project, please select the focus area(s) of the project: **N/A**

- ☐ Data exchange and interoperability
- ☐ Data security and privacy
- ☐ Data warehouse
- ☐ Electronic health record system
- ☐ Individual/family access to computing resources
- ☐ Imaging/paper conversion
- ☐ Monitoring
- ☐ Online information resources for individuals/families
- ☐ Personal health record system
- ☐ Resources to support web content and mobile app accessibility
- ☐ System maintenance costs
- ☐ Telemedicine
- ☐ Other

3. Please describe the project

   BHRS is pursuing renovations at multiple County-owned behavioral health clinic sites to enhance safety, violence prevention, and accessibility, enclosing reception areas and creating spaces that are welcoming for clients.

Program #3

1. Project name: **Epic Systems - Electronic Health Record (EHR)**
2. Please select the type of project
   - ☐ Capital facilities project
   - ☑ Technological needs project

If capital facilities project, please indicate which of the following categories the project falls under: **N/A**

- ☐ Acquiring, renovating, or constructing buildings that are or will be county-

owned. *The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.*

- ☐ Acquiring facilities not secured to a foundation that is permanently affixed to the ground
- ☐ Establishing a capitalized repair or replacement reserve
- ☐ Meeting match requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award
- ☐ Renovating or constructing buildings that are privately owned

If acquiring, renovating, or constructing buildings, please indicate if the project involves leasing or renting to own a building: **N/A**

c. Please explain why purchase of the building was not possible

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

- ☑ Data exchange and interoperability
- ☑ Data security and privacy
- ☑ Data warehouse
- ☑ Electronic health record system
- ☐ Individual/family access to computing resources
- ☑ Imaging/paper conversion
- ☑ Monitoring
- ☐ Online information resources for individuals/families
- ☑ Personal health record system
- ☐ Resources to support web content and mobile app accessibility
- ☐ System maintenance costs
- ☐ Telemedicine
- ☐ Other

3. Please describe the project

BHRS is transitioning its EHR system to Epic Systems as part of a broader county-wide Health implementation to manage patient data, clinical workflows, billing, and patient engagement, provide a centralized hub for care coordination, analytics, and improved efficiency across the entire healthcare continuum. The EHR will replace fragmented legacy systems across County Health divisions, including BHRS, Correctional Health, and outpatient clinics. Epic Systems are also utilized by many Bay Area counties, partners and leading health care systems with the goal to implement a uniform EHR for specialty mental health and substance use services, improving data sharing with primary care and enabling CalAIM initiatives like Enhanced Care Management.

Full Service Partnership Program

[Context text: 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]

1. 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	5,769
Number of Uninsured Individuals	698
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	366

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

1. Please input the estimates provided to the county in the table below:

Table 17. Estimated Number of Individuals Eligible for ACT and FACT and Estimated Number of Teams Needed to Serve Total Eligible Population

ACT and FACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	197
Number of Uninsured Individuals	24
Number of Total ACT Eligible Individuals with Some Justice-System Involvement	74

ACT and 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

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county-operated and 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 18. Total Number of ACT and FACT Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	10	10	10
Total Number of Teams	1	1	1

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

1. Please input the estimates provided to the county in the table below:

Table 19. 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	827
Number of Uninsured Individuals	100
FSP ICM Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	40

Number of Teams Needed to Serve Total Eligible Population	8

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county-operated and 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 20. Total Number of FSP ICM Practitioners and Teams

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

High Fidelity Wraparound (HFW) Eligible Population

1. 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 21. 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	*[Forthcoming]*
Number of Uninsured Individuals	*[Forthcoming]*
HFW Practitioners and Teams Needed	***Estimates***
Number of Practitioners Needed to Serve Total Eligible Population	*[Forthcoming]*
Number of Teams Needed to Serve Total Eligible Population	*[Forthcoming]*

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county-operated and 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 22. Total Number of HFW Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	59	59	59
Total Number of Teams	3	3	3

Individual Placement and Support (IPS) Eligible Population

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

Table 23. 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	1,565
Number of Uninsured Individuals	202

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	113
Number of Teams Needed to Serve Total Eligible Population	45

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county-operated and 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 24. Total Number of IPS 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	3	3	3

Full Service Partnership (FSP) Program Overview

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

1. Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP? **Yes**
    a. Please describe how the estimated practitioners will provide more than one EBP

        It is anticipated that some FSP practitioners will be trained in both ACT and FACT in order to ensure sufficient capacity and flexibility to meet any changes in needs and demands.

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

    FSPs deliver intensive, individualized wraparound services that integrate behavioral health, physical health, housing, employment, and social supports tailored to high-need clients (e.g., adults with SMI or youth with complex needs). Each FSP client receives a shared care plan co-developed with family/peers, reviewed monthly, incorporating wellness/recovery goals like WRAP, MAT, or tenancy supports alongside therapy. These services do not include paying directly for shelter and permanent housing.

    - Whole-person care: FSPs address all life domains via multidisciplinary teams (clinicians, peers, family partners, primary care coordinators) that coordinate Medi-Cal specialty MH/SUD services, medical care (e.g., via SMMC referrals), housing navigation, benefits advocacy, and vocational rehab, reducing silos and frequent ED/jail use.
    - Trauma-informed principles: Staff use trauma screening (e.g., ACEs), de-escalation training, and recovery-oriented language; services emphasize safety, trust-building, empowerment, and cultural humility, avoiding re-traumatization in engagement or crisis response.

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

    FSPs actively prioritize enrollment for high-need populations with goals to reduce gaps in access and outcomes. Multidisciplinary teams include bilingual/bicultural clinicians, peers with lived experience from priority groups, and family partners. BHRS requires all contracted providers delivering client services to submit an annual Cultural Competence Plan (CCP), aligning with state mandates and National CLAS Standards to reduce disparities and ensure culturally/linguistically responsive career. Providers report on their CCP efforts via a streamlined survey covering workforce diversity, language capacity, disparity reduction strategies, training, and client/family engagement. Plans must address BHRS priorities like cultural humility training, multicultural staffing growth, interpreter services, and adaptation of services for diverse populations (e.g., BIPOC, SOGIE, immigrants). BHRS offers many diversity-focused training courses to all contracted providers including cultural humility, working effectively with interpreters and SOGIE competency.

4. Select which goals the county is hoping to support based on the county's allocation of FSP funding [statewide priority goals and county goals selected from the Plans, Goals, and Objective section]
    - Homelessness
    - Institutionalization
    - Justice Involvement
    - Removal of Children From Home
    - Untreated Behavioral Health Conditions

5. Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM
    a. (Optional) Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW. Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP

    Ongoing engagement services are provided to FSP participants through intensive, 24/7 wraparound supports designed to build long-term trust and prevent disengagement. Engagement activities include high-frequency contact by multidisciplinary teams (clinicians, peers, family partners) who conduct regular field based in-person, phone, and/or virtual check-ins, using motivational interviewing and shared care plans to address immediate needs. Peers and family partners foster rapport with FSP clients via recovery-oriented practices and their shared lived experience. Crisis and step-down protocols support ongoing engagement including 24/7 crisis response, skills training and graduation from intensive FSP to wellness check-ins, which ensure continuity, reducing no-shows.

6. 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.)

    BHRS is developing a tiered model for stepping up or stepping down to different levels of care for FSP clients from community outpatient (e.g., therapy, case management, IPS supported employment) to intensive services (e.g., ICM, ACT/FACT, MAT), and beyond based on client acuity, needs, stability, and Individualized Treatment Plan (ITP) goals. The following will be implemented to comply with required FSP levels of care:

    - Existing FSP contracted providers will be trained to operate as ACT/FACT teams. BHRS has submitted an Engagement Initiation Form for ACT/FACT to the Center of Excellence (COE) to begin consultation.

- FSP ICM level of care providers will be identified either as part of existing FSP teams or integrated with regional clinics.
- FSP staff will assess clients regularly to ensure they are served at the most appropriate level of care and trained on the criteria for the different levels of care.

7. Please indicate whether the county FSP program will include any of the following optional and allowable services:
    a. Primary substance use disorder (SUD) FSPs: **No**
        i. If Y, please describe
    b. Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section): **Yes**
        i. Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program

        Outreach, engagement and enrollment activities are included as a minimum service requirement for all FSP contracted providers. FSP providers are required to deliver trauma-informed outreach and engagement to enroll eligible clients. Outreach is expected within 1-3 business days of receiving a referral (prioritizing imminent discharges from hospitals, jails, etc.) and can last up to 60 days. Other requirements include: weekly attempts to locate individuals in the field, repeated contacts with friends, family members and referring providers and 24/7 availability, use of motivational interviewing, contingency management, culturally/gender-matched teams, and warm handoffs.

    c. Other recovery-oriented services: **Yes**
        i. Please describe the other recovery-oriented services the county's FSP program will include:

        Recovery oriented services are also a minimum service requirement for all FSP contracted providers. FSPs embody a client-driven philosophy emphasizing hope, personal responsibility, self-advocacy, choice, and respect, and positioning providers as allies rather than directors of care – services are guided by an individualized plan developed between client and staff and providers are required to employ a variety of supportive and recovery techniques to encourage clients to assume responsibility for their own wellness and recovery. Key supports include having basic needs met including supports with benefit enrollment, transportation, life skills development, vocational and educational goals and social integration.

8. 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. **N/A**

9. 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:@

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

    San Mateo County has a long history of strong inter-agency planning and coordination through the Children and Youth System of Care (CYSOC) committee composed of BHRS, Probation, Human Services Agency-Children and Family Services and schools and districts focusing on children and youth at risk of adverse psychological, health and social outcomes and their families.

    CYSOC was engaged during the BHSA Community Program Planning process to discuss early identification, intervention and treatment of children and families with the highest risks and needs and to review statewide priority goal data as it relates to lower SMHS penetration rates for children and youth and removal of children from home. CYSOC emphasized the importance of family engagement to ensure they are aware of services and reduce stigma to accessing services and prioritizing on school campus early identification and engagement. There were also a number of input sessions focused on justice-involvement and the review of statewide priority goal data as it relates to justice-involved youth. Youth specific strategies emphasized the importance of warm hand-offs and restorative justice practices, and brief intervention models in schools. Youth FSP programs would benefit from additional outreach activities to reach families, this will be addressed via our Early Intervention expansion effort, ensuring that high risk youth are connected to the right level of care.

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

    Additionally, special outreach was conducted with youth representing Coast Pride, Youth Leadership Institute, and the Behavioral Health Commission (BHC) Youth Committee to discuss specific priorities from youth perspective. Feedback from youth specifically centered around the importance of geographical access (given transportation barriers for youth) to intensive higher level of care services regardless of insurance, family education and involvement, gathering spaces and school-based supports, and youth-friendly SUD care. These will also be incorporated into our Early Intervention planned expansion, which will be focused on addressing barriers to accessing care for young people.

    c. In the child welfare system

    Child Welfare system representation was also part of the CYSOC community input session summarized above and ongoing inter-agency planning and coordination.

10. 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:

    a. Older adults

    Our local Behavioral Health Commission Older Adult Committee was engaged during the BHSA Community Program Planning process. Additionally, targeted efforts with our local Older Adults and Disabilities Services providers were conducted to ensure we reached a broader representation of older adult's needs and priorities. Input centered around the themes of acute bed shortages leading to early discharge and post discharge barriers related to accessing medications, need for case managers to support this and for caregiver support. For FSP eligible clients, outreach and engagement is a minimum requirement for FSP providers and prioritizes individuals referred by institutions.

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

    Health Equity Initiatives representing seven marginalized cultural groups, including the Pride Initiative, were engaged in the BHSA Community Program Planning process. Over 30 individuals participated in discussions related to untreated behavioral health conditions. Input centered around strengthening partnerships with culturally rooted organizations, increasing access to early screening, strengthening linkages and providers that represent diverse experiences, making LGBTQ resources available including SOGIE education, peer supports, and increasing access to SUD services. There are a number of efforts that BHRS is involved in, will strengthen, and/or implement to address these challenges including the required cultural competence planning and peer supports for all FSP contracted providers, expansion of early intervention strategies focused on early screening and linkages, continuation of the Pride Center education and training component.

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

    Three input sessions from the BHSA Community Program Planning process focused on the topic of justice-involvement and included a review of statewide priority goal data and disparities analysis. Specific input for adults involved in the justice system included increasing access to detox services and substance use recovery programs and enhancing reentry planning and coordinated follow up with individualized case plans to support successful integration into the community. Key efforts to address this feedback include the implementation of ACT/FACT, and integration of assertive field-based SUD and MAT with FSP programming.

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.

1. 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.

Table 25. Existing Programs for Assertive Field-Based SUD Treatment Services

Requirement	Existing Program	Program Description	Current Funding Source	BHSA Changes to Existing Program(s) to Meet BHSA Requirements	Expected Timeline of Operation
Targeted Outreach	**Integrated Medication Assisted Treatment (IMAT) Team**	The IMAT team provides information, screening, and referrals to medication assisted treatment and harm reduction tools such as fentanyl test strips, Naloxone, and medications. Case managers are located at San Mateo Medical Center Emergency Department and Psychiatric Emergency Services, the Navigation Center (240+ beds), and Correctional Health.	Opioid Settlement Funds (OSF) and local Measure K funds	N/A	Currently in place
Targeted Outreach	**RTX/SUD Case Management Team**	The RTX Case Management Team of SUD Case Managers partners with Correctional Health Services (CHS) to assure that individuals who have been arrested and determined by CHS to have a SUD treatment needs, and who agree to receiving SUD treatment at release will receive at least three outreach attempts at release for engagement and connection to community based SUD services.	OSF	N/A	Currently in place

Mobile Field-Based Program(s)	**IMAT Program**	The IMAT program has a mobile component to support field based outreach in community settings	OSF and Measure K	N/A	Currently in place
Mobile Field-Based Program(s)	**Mobile crisis**	San Mateo County has an integrated behavioral health mobile crisis team that provide field based on DHCS standards and requirements.	BHSA, Medi-Cal PCR, NCC, Realignment	N/A	Currently in place
Mobile Field-Based Program(s)	**Mobile Health Van**	San Mateo County has a mobile health van which goes to many locations to provide health services in the field.	Public Health Policy & Planning	N/A	Currently in place
Open-Access Clinic(s)	**BAART San Mateo NTP Program**	BAART San Mateo NTP Program is open 6 days a week and provides outpatient, low barrier MAT and Methadone treatment to clients. Individuals may drop-in Monday - Saturday without an appointment, can see a doctor virtually for intake to streamline rapid MAT access.	DMC-ODS	N/A	Currently in place
Open-Access Clinic(s)	**Palm Ave Detox.**	A 3.2 Residential Withdrawal management with Incidental Medical Services where MAT is prescribed. This facility is open 24/7. Clients can safely detox, get connected to MAT, and be transferred to an ongoing SUD treatment program post detox.	OSF, DMC-ODS, BHSA	N/A	Currently in place
Open-Access Clinic(s)	**HR 360 drop in MAT clinic**	A Federally Qualified Health Center (FQHC) where low barrier MAT is prescribed and there is a drop in clinic at 1pm to assure low barrier access to MAT.	FQHC, AOD, BHSA	N/A	Currently in place

Table 26. New Programs for Assertive Field-Based SUD Treatment Services

Requirement	New Program(s)	Program Description(s)	Planned Funding	Planned Operations	Expected Timeline of implementation
Targeted Outreach	**SUD Services at Shelters**	This new program is an expansion of a pilot that began in 2023 at the Navigation Center Shelter. Two community based, certified, outpatient substance use providers are co-located at the county's five largest shelters. SUD counselors, peers and case managers meet with shelter staff weekly for a list of shelter residents for SUD provider outreach, engagement, and education regarding overdose prevention, and SUD services.	Opioid Settlement Funds and Health Care for the Homeless (HCH) Funding	On-site at shelters	7/1/2026
Mobile Field-Based Program(s)	**BAART Mobile Methadone**	For the past six months, BHRS has partnered with our Narcotic Treatment Provider to understand the unmet NTP needs of residents and to research how a mobile methadone/NTP program can flexibly meet client need and BHSA requirements. This will enhance rapid MAT access and field based access.	OSF, DMC-ODS, other private pay. Applying for DHCS grant for mobile methadone start-up.	Field-based	7/1/2028
Open-Access Clinic(s)	**Sobering Center**	San Mateo County plans to re-open sobering services for low barrier, low threshold drop in services to people in the community under the influence. Local law enforcement, FSP, hospitals and place	OSF, County General Funds, Law Enforcement funding, BHSA, local Managed Care Plans	Treatment Facility	1/1/2027

		individuals here to get screened for services and referrals for rapid access to MAT and other SUD treatment. This services will be operated 24/7.			

Medications for Addiction Treatment (MAT) Details

[Helper Text: 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.]

1. 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

   BHRS will inventory existing MAT services, utilization of MAT services including demographic and geographic trends to identify disparities in access to MAT and use prevalence data (from DMC-ODS enrollment, CalOMS, and local epidemiological estimates) to estimate the number of individuals with Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD) likely to benefit from MAT. These estimates will be compared against current service utilization rates to quantify the treatment gap. Through this structured approach, BHRS will ensure that resource allocation and program planning align with the county's identified MAT needs, barriers to accessing MAT and disparities across population groups.

2. Select the following practices the county will implement to ensure same day access to MAT
   - ☑ Contract directly with MAT providers in the county
   - ☐ Operate MAT clinics directly
   - ☑ Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
   - ☑ Leverage telehealth model(s)
   - ☑ Partner with neighboring counties: **Yes**
     i. Please provide the names of the neighboring counties: San Francisco County and Santa Cruz County
   - ☑ Contract with MAT providers in other counties **Yes**
     ii. Please provide the names of neighboring counties: San Francisco and Santa Cruz County
   - ☑ Other strategy – Exploring mobile NTP and/or added NTP medication units; Jail access and coordinated behavioral health links to ensure continuity of care at jail release.

3. What forms of MAT will the county provide utilizing the strategies selected

above?

- ☑ Buprenorphine
- ☑ Methadone
- ☑ Naltrexone
- ☑ Other
    i. Please specify other forms of MAT: long acting injectables such as Brixadi and Subocade, and Vivitrol.

Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations.

System Gaps

1. 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.

   a. Supportive housing – Small gap
   b. Apartments, including master-lease apartments – Medium gap
   c. Single and multi-family homes – Medium gap
   d. Housing in mobile home communities – Not applicable
   e. (Permanent) Single room occupancy units – Medium gap
   f. (Interim) Single room occupancy units – Medium gap
   g. Accessory dwelling units, including junior accessory dwelling units – Medium gap
   h. (Permanent) Tiny homes – Medium gap
   i. Shared housing – Small gap
   j. (Permanent) Recovery/sober living housing, including recovery-

oriented housing – Medium gap

k. (Interim) Recovery/sober living housing, including recovery-oriented housing – Medium gap
l. Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care) – Large gap
m. License-exempt room and board – Medium gap
n. Hotel and Motel stays – Small gap
o. Non-congregate interim housing models – Small gap
p. Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings) – Small gap
q. Recuperative Care – Medium gap
r. Short-Term Post-Hospitalization housing – Medium gap
s. (Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units – Medium gap
t. Peer Respite – Large gap
u. Permanent rental subsidies – Small gap
v. Housing supportive services – Small gap

2. 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?

BHRS has formal, operational partnerships with Human Services Agency (HSA), Continuum of Care (CoC), Housing Authority, the Department of Housing (DOH) and Managed Care Plans (MCPs).

Operational and service coordination efforts include:

- The countywide CoC Coordinated Entry System (CES) is run through eight Core Service Agencies and is used by BHRS to connect clients experiencing homelessness to shelter and permanent supportive housing opportunities.
- BHRS is a key partner in mobile outreach efforts, including Street Medicine and Homeless Outreach Teams, focusing on unsheltered people and supporting their access to behavioral health care while they transition to shelter and housing.
- The San Mateo County Navigation Center and other shelters operate under the CoC and incorporate onsite access to psychiatric services, substance use treatment, and other BHRS-linked supports for residents.
- BHRS is a referral and services partner for multiple Housing Authority

voucher types, including Mainstream, Shelter Plus Care, project-based, tenant-based, and other permanent supportive vouchers and provides the ongoing case management and supportive services for behavioral health clients.

- BHRS provides on-site and/or closely linked supportive services for all permanent supportive housing units.

3. 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 cover costs related to ongoing capital development, on-site coordination for tenants, property management for some sites and both tenant-based and project-based vouchers. Additionally, BHSA Housing Interventions will work closely with transitional rent providers to ensure smoot integration of the MCPs benefit for eligible populations.

   BHSA Housing Interventions will be intentionally braided with existing County and regional housing and homelessness resources to expand and strengthen the continuum of housing supports available to BHSA-eligible individuals. Specifically, BHSA Housing Interventions will fund ongoing capital development, on-site coordination and services for tenants, operating/property management supports for some sites, and both tenant-based and project-based rental subsidies that build on the County's existing permanent supportive housing portfolio and for behavioral health clients who may lose, or be unable to access, HUD-funded- assistance as a result of recent federal restrictions and funding reductions.

   BHSA Housing Interventions will work closely with MCP Community Supports—especially the Transitional Rent benefit—to ensure that members who are experiencing or at risk of homelessness can move from interim housing into permanent units without a break in rental assistance, using BHSA subsidies as the longer-term "bridge" following MCP-covered Transitional Rent when appropriate. In addition, BHSA resources will support BHRS-eligible individuals to receive housing navigation and tenancy-support services, and retain housing stability over time.

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

   BHRS' overall strategy is to use BHSA Housing Interventions as part of a Housing First, PSH-centered approach that moves BHSA-eligible individuals into permanent housing and then surrounds them with coordination and supportive services. BHRS will coordinate closely with MCPs, DOH, the Housing Authority, and the Continuum of Care to ensure that clients in interim settings,

encampments, or institutional settings have clear, individualized pathways into permanent units supported by BHSA-funded rental assistance, vouchers, or other long-term subsidies.

To promote long-term retention, BHRS will pair BHSA-funded housing with ongoing clinical care (including regional clinic-based services, FSP-level services and other treatment services), intensive case management, and field-based tenancy-sustaining services such as housing navigation, landlord mediation, crisis response, and eviction-prevention supports. The system will also use data from CES, MCP housing support plans, and BHSA reporting to identify and prioritize those with the highest behavioral health needs and longest histories of homelessness, and to make course corrections when clients are at risk of losing housing.

5. 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)?

   BHRS will continue and expand contracts with community-based organizations to provide on-site coordination, housing navigation, and supportive services across all existing and new PSH developments serving BHSA-eligible individuals. These providers deliver services such as tenant engagement, daily living skills, harm reduction, crisis intervention, and coordination with property management to promote housing stability and prevent evictions.

   On the capital development and subsidy side, BHSA Housing Interventions will supplement DOH administered Affordable Housing Funds to support new PSH development, while also contributing operating and rental subsidies where needed. In parallel, BHRS will collaborate with MCPs and the Housing Authority to layer BHSA-funded tenant- and project-based rental assistance with Medi-Cal Community Supports and federal/local vouchers, ensuring that BHSA-eligible individuals in PSH and other permanent housing settings have access to both stable rent subsidies and ongoing supportive services.

6. 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

   All housing settings available to behavioral health clients will be embedded within the county behavioral health system so that every BHSA-eligible tenant has access to a treatment team and housing services tailored to their level of need. Clients in permanent supportive housing and other BHSA-supported units will be connected either to BHRS regional outpatient clinics, Full Service

Partnership (FSP) teams, or other contracted treatment providers.

Supportive housing services will follow Housing First principles and include engagement, assessment, individualized service planning, field-based case management, linkage to substance use and mental health treatment, benefits and employment supports, and ongoing tenancy-sustaining services such as landlord mediation and early intervention when rent arrears or behavioral issues arise. BHRS will also coordinate with MCPs to align clinical care and housing-related Community Supports (e.g., Transitional Rent, Housing Transition Navigation, Housing Tenancy and Sustaining Services), ensuring BHSA-funded housing settings function as part of a coherent, integrated continuum of behavioral health and housing support.

Eligible Populations

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

   BHRS is collaborating closely with our local Managed Care Plans to develop a workflow process for identifying, screening and referring individuals eligible for BHSA Housing Interventions to ensure that the MCP Transitional Rent benefits are exhausted first. Community Supports Housing Support benefits have been active and referral processes are in place. BHRS Case Managers identify clients that need housing interventions as part of their standard assessment processes and refer eligible clients to MCPs, Housing Authority and/or our CoC for vouchers. Currently, BHRS permanent supportive housing settings, which all have project-based vouchers, go through a dedicated Supervising Mental Health Clinician that is responsible for communicating available BHSA units to all BHRS clinical staff and case managers, as they become vacated or new behavioral health units become available, developed in partnership with our Department of Housing. The Supervising Mental Health Clinician reviews and determines eligibility and supports the process for connecting the client to the appropriate housing unit. FSP programs have BHSA Housing Interventions funding embedded in their services and provide rental assistance, operating subsidies and housing supports to all clients. We are also working with our local Managed Care Plans to develop a workflow process for FSP programs to ensure MCP benefits are exhausted first.

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

   Yes

   a. Please indicate why the county behavioral health system will not provide BHSA funded Housing Interventions to individuals living with a SUD only and include data to support. **N/A**

      i. Insufficient need (i.e., individuals living with an SUD only have

sufficient access to housing, there is a limited number of individuals with an SUD only who are unhoused)

ii. Insufficient resources

iii. Other

iv. Please upload supporting data

b. Please explain why there is insufficient need to provide BHSA-funded Housing Interventions living with a SUD only. **N/A**

c. Please explain why there are insufficient resources to provide BHSA-funded Housing Interventions to individuals living with an SUD only. **N/A**

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

3. 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:

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

      The Children and Youth System of Care (CYSOC) committee composed of BHRS, Probation, Human Services Agency-Children and Family Services and schools and districts were engaged during the BHSA Community Program Planning process There were also a number of input sessions focused on homelessness and justice-involvement and the review of statewide priority goal data as it relates to youth. Youth specific strategies emphasized the importance of early engagement and identification through schools.

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

      Special outreach was conducted with youth representing Coast Pride, Youth Leadership Institute, and the Behavioral Health Commission (BHC) Youth Committee to discuss specific priorities from youth perspective. Feedback from youth specifically centered around the importance of geographical access (given transportation barriers for youth) regardless of insurance.

   c. In the child welfare system

      Child Welfare system representation was also part of the CYSOC community input session summarized above and ongoing inter-agency planning and coordination.

4. 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:

   a. Older adults

      Our local Behavioral Health Commission Older Adult Committee was engaged during the BHSA Community Program Planning process. Additionally, targeted

efforts with our local Older Adults and Disabilities Services providers were conducted to ensure we reached a broader representation of older adult's needs and priorities.

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

Three input sessions from the BHSA Community Program Planning process focused on the topic of justice-involvement and included a review of statewide priority goal data and disparities analysis.

c. In underserved communities

Health Equity Initiatives representing seven marginalized cultural groups, including African American, Chinese, Filipinx, Native and Indigenous, Latinx, LGBTQ+, and Pacific Islander, were engaged in the BHSA Community Program Planning process. Over 30 individuals participated in discussions.

Local Housing System Engagement

3. How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?

   BHRS will coordinate with the CoC primarily through shared governance structures and the County's Coordinated Entry System (CES). When CES identifies individuals with significant behavioral health needs, referrals are made to BHRS for assessment and coordination across housing needs.

4. 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

   a. Local CoC

      BHRS is a voting member of the CoC structure and participates in CoC policy and housing planning, including monthly "Housing Our Clients" meetings with HSA, Health Plan of San Mateo (HPSM), Housing, Sheriff, Probation, and others.

   b. Public Housing Agency

      BHRS meets regularly with our local Housing Authority to navigate and coordinate behavioral health client needs for housing vouchers and other housing-related client needs.

   c. MCPs

      BHRS participates in ongoing planning meetings with MCPs as it relates to transitional rent benefit planning and the required launch of January 1, 2026 for the behavioral health population of focus.

   d. ECM and Community Supports Providers

Ongoing planning meetings with MCPs cover these topics. BHRS has an monthly Care Coordination meeting to coordinate and link members to these services.

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

BHRS was a key partner on planning for state initiatives such as No Place Like Home, Homeless Housing, Assistance and Prevention (HHAP), Housing for a Healthy California (HHC) and HomeKey+ projects, and local Affordable Housing Funding (AHF) development opportunities to allow for dedicated units for behavioral health clients.

BHRS leads and facilitates the Housing Operations and Policy (HOP) Committee, a standing collaboration with DOH and community providers that focuses on housing needs of people with behavioral health challenges and includes landlord engagement and voucher-acceptance strategies.

5. 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?

BHRS will partner closely with our local DOH who is the lead entity for Homekey+ and permanent supportive housing (PSH) developments. Available capital development resources will be contributed to dedicate a portion of units specifically for BHSA-eligible individuals and ensure that rent subsidies, clinical care, and supportive services are maintained over time. BHRS participates in project planning and tenant selection processes to ensure that BHSA-eligible individuals are identified, referred, and supported to successfully obtain and retain housing.

6. Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding? **No**
    a. How will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community?

BHSA Housing Interventions Implementation

[Context text: 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)

[Context text: 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*)]

1. Is the county providing this intervention? **Yes**
    a. Please explain why the county is not providing this intervention [narrative box]

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

3. How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis? **412**
    a. How many of these individuals will receive rental subsidies for permanent housing on an annual basis? **383**
    b. How many of these individuals will receive rental subsidies for interim housing on an annual basis? **29**

4. What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?

    The methodology takes into account

    1) historical program data – FSPs provide tenant-based rental assistance to about 50% of their client census or 200 individuals, Board & Cares patches serve about 84 individuals a year
    2) allocations amounts – BHSA housing amount available for a planned intervention ÷ avg annual cost/household = units + reserve 10–15% for admin/tenancy supports (34 units = estimated individuals served)
    3) project project-based units planned that will require rental assistance (37 units = estimated individuals served)
    4) existing permanent units through our Canyon Vista supportive housing project (57 units = estimated individuals served)

    For transitional rent, eligibility will require a guaranteed permanent placement, therefore BHSA will primarily fund permanent settings for clients receiving transitional rent via the MCPs. Some clients may not qualify for the MCP benefit and will require BHSA for interim supports.

5. For which setting types will the county provide rental subsidies? BHSA Policy Manual Housing Interventions Chapter (Chapter 7, Section C.9.3 Allowable Settings)]

Non-Time-Limited Permanent Settings:

- ☑ Supportive housing
- ☑ Apartments, including master-lease apartments
- ☑ Single and multi-family homes
- ☐ Housing in mobile home communities
- ☑ Single room occupancy units
- ☐ Accessory dwelling units, including Junior Accessory Dwelling Units
- ☐ Tiny Homes
- ☑ Shared housing
- ☑ Recovery/Sober Living housing, including recovery-oriented housing
- ☑ Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
- ☑ License-exempt room and board
- ☑ Other settings identified under the Transitional Rent benefit

Time Limited Interim Settings:

- ☑ Hotel and motel stays
- ☑ Non-congregate interim housing models
- ☑ Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) (does not include behavioral health residential treatment settings)
- ☑ Recuperative Care
- ☑ Short-Term Post-Hospitalization housing
- ☐ Tiny homes, emergency sleeping cabins, emergency stabilization units
- ☐ Peer respite
- ☑ Other settings identified under the Transitional Rent benefit

6. Will this Housing Intervention accommodate family housing? **Yes**

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

   Rental subsidies will be funded by BHSA for the following planned programs and

services:

- FSP tenant-based rental assistance: FSP providers will coordinate with the County's designated transitional rent provider and other partners to facilitate access to temporary, transitional, and permanent housing resources for eligible individuals. FSP providers will cover rental assistance after the 6-month transitional rent assistance, continue supporting housing maintenance and on-site coordination with property service coordinators, property management, and the clients' clinical teams.
- Board and care (B&C) patches cover the gap between a client's SSI/SSP benefit and the full monthly rate of a licensed board and care facilities. Nine contracted facilities (typically 4–6 beds) provide room, board, meals, and non-medical supervision for adults with behavioral health needs, SMI, or elderly clients.
- Department of Housing, Affordable Housing Funds: Over the past three years MHSA contributed capital development funding to secure units within larger affordable housing complexes for behavioral health clients. Currently, there are four developments in construction (48 behavioral health units) with expected completions between 2028 and 2030. Of these developments 37 behavioral health units will require ongoing project-based vouchers.
- Canyon Vista Center is a BHRS supportive housing project providing 28 permanent supportive units and 29 transitional housing units. BHSA will fund ongoing rental assistance for all 57 units.
- The transitional rent provider for our local MCPs will manage the transition from MCP to BHSA funding for rental assistance. BHSA funding will be allocated to the selected transitional rent provider for clients that do not meet qualifications for MCP benefit and for ongoing scattered-site rental assistance.

8. 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? [multi-select check box]

   ☑ Project-based

   ☑ Tenant-based

9. 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.

   There are a number of BHRS partnerships that will contribute to the portfolio of available units for behavioral health clients including:

- Full-Service Partnership (FSP) Housing, Tenant-Based – providers have built relationships with landlords, property managers, developers, facility managers, and other partners to develop their inventory for housing units.
- Board and Care (B&C) patches – B&C operators play a key role in the sustainability of B&C facility beds. BHSA funding provides B&C incentives to prevent additional facility closures. Operators have used this funding to support onsite mental health groups, training to fulfill Continuing Education Unit (CEU) requirements, facility improvements to resolve licensing issues or address safety concerns, staff bonuses and to fund special events or outings for clients.
- Project-Based Permanent Supportive Housing (PSH) – the Department of Housing (DOH) takes the lead on all capital development projects in San Mateo County. BHRS staff meet regularly with DOH staff to discuss and plan for upcoming PSH opportunities. Currently there are 48 behavioral health units with an expected construction completion between 2028-2030. BHSA capital development funding will support additional developments during the three-year integrated plan period, with an estimated 80 future units across affordable housing developments.
- Tenant-Based Scattered Site Housing – key partnership to develop our portfolio of available scattered site units Human Services Agency (HSA), Continuum of Care (CoC), Housing Authority, County Health Public Health Policy & Planning, Managed Care Plans (MCPs) and contracted providers.

10. Total number of units funded with BHSA Housing Interventions per year
    337

11. [Optional question] 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. **N/A**

Operating Subsidies (Chapter 7, Section C.9.2)

1. Is the county providing this intervention? **Yes**
    a. Please explain why the county is not providing this intervention

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

3. Anticipated number of individuals served per year: **64**

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

   BHSA will fund property management services for Canyon Vista, a BHRS supportive housing project providing 28 permanent supportive units and 29 transitional housing units. The property management service oversees operations for the 57-unit project and works closely with the onsite behavioral health services. The provider manages leasing, maintenance, tenant relations, shared spaces and co-housing logistics.

5. For which setting types will the county provide operating subsidies? [multi-select dropdown of allowable settings included in the BHSA Policy Manual Housing Interventions Chapter (Chapter 7, SectionC.9.3 Allowable Settings)]:

   Non-Time Limited Permanent Settings, Time Limited Interim Settings

6. Will this be a scattered site initiative? **No**

7. Will this Housing Intervention accommodate family housing? **No**

8. Total number of units funded with BHSA Housing Interventions per year: **57**

9. [Optional question] Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units. **N/A**

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

1. Is the county providing this intervention? **Yes**
   a. Please explain why the county is not providing this intervention [narrative box]

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

3. Anticipated number of individuals served per year: **314**

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

   FSP Housing programs funded by BHSA include working with landlords to provide any needed advocacy and support to help clients retain housing, responding immediately to lease violations or concerns of the landlord, property

manager, facility manager, developer and/or other tenants to avoid eviction.

These are also services provided by our local Community Supports provider, who will be dually funded by BHSA to ensure access for all BH clients regardless of MCP eligibility. Additionally, BHSA funds contracted providers for scattered sites housing for transitional age youth and adults, which requires landlord outreach and mitigation.

5. Total number of units funded with BHSA Housing Interventions per year: **243**

6. [Optional question] Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units. **N/A**

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

1. Is the county providing this intervention? **Yes**
    a. Please explain why the county is not providing this intervention [narrative box]

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

3. Anticipated number of individuals served per year: **65**

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

    FSP Housing programs funded by BHSA provide participant assistance including assisting clients with their applications and documentation for housing, funding for security deposits and other one-time deposits and move-in costs, securing furniture and other household goods, and transportation.

    These are also services provided by our local Community Supports provider, who will be dually funded by BHSA to ensure access for all BH clients regardless of MCP eligibility. Additionally, BHSA funds contracted providers for scattered sites housing for transitional age youth and adults, also provides participant assistance services.

Housing Transition Navigation Services and Tenancy Sustaining Services

[Context text: 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)].

1. Is the county providing this intervention? **Yes**
    a. Please explain why the county is not providing this intervention

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

3. Anticipated number of individuals served per year: **65**

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

   FSP Housing programs, the MCP transitional rent provider and contracted providers for scattered site housing will provide BHSA-funded navigation services and tenancy sustaining services to individuals that are not eligible for the Medi-Cal MCP benefit.

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

1. Is the county providing this intervention? **No**
    a. Please explain why the county is not providing this intervention

       Homeless Outreach will be funded under BHSA BHSS Early Intervention category to allow for the coupling of outreach and immediate treatment services. On-site treatment boosts treatment adherence (e.g., MAT retention), minimizes drop-off during linkages and supports recruitment efforts for staff that need clinical hours.

2. Is the county providing this intervention to chronically homeless individuals? **N/A**

3. Anticipated number of individuals served per year **N/A**

4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding **N/A**

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

1. Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects? **Yes**
    a. Please explain why the county is not providing this intervention [narrative box]

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

3. How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions? **9**

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions [logic: allow for multiple entries]

1. Name of Project: **Permanent Supportive Housing – Affordable Housing Fund**
2. What setting types will the capital development project include? [multi-select dropdown of allowable settings included in the BHSA Policy Manual Housing Interventions Chapter (Chapter 7, Section C.9.3 Allowable Settings)]

   ☑ Supportive housing

   ☑ Apartments, including master-lease apartments

3. Capacity (Anticipated number of individuals housed at a given time): **65**
4. Will this project braid funding with non-BHSA funding source(s)? **Yes**
5. Total number of units in project, inclusive of BHSA and non-BHSA funding sources: **65**
6. Total number of units funded with Housing Interventions funds only: **65**
7. [Optional question] Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units. **N/A**
8. Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe): **07/01/2033**
9. Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000): **$450,000**
10. Have you utilized the "by right" provisions of state law in your project? **Yes**
    a. If you have not incorporated use of the "by right" provisions into your project, please explain why. **N/A**

Other Housing Interventions (Optional)

1. If the county is providing another type of Housing Interventions not listed above, please describe the intervention. **N/A**
   a. Is the county providing this intervention to chronically homeless individuals?
   b. Anticipated number of individuals served per year.

Continuation of Existing Housing Programs

1. 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)

   Yes, BHSA Housing Interventions funding will be used to support the continuation of components of Behavioral Health Bridge Housing program including property management, support service, and rental assistance. The outreach and engagement services will be funded under BHSA BHSS component.

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

1. Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of? **N/A**
   - ☐ Housing Transition Navigation Services
   - ☐ Housing Deposits
   - ☐ Housing Tenancy and Sustaining Services
   - ☐ Short-Term Post-Hospitalization Housing
   - ☐ Recuperative Care
   - ☐ Day Habilitation
   - ☐ Transitional Rent

2. For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of? **N/A**
   - ☐ Housing Transition Navigation Services
   - ☐ Housing Deposits
   - ☐ Housing Tenancy and Sustaining Services
   - ☐ Short-Term Post-Hospitalization Housing
   - ☐ Recuperative Care
   - ☐ Day Habilitation
   - ☐ Transitional Rent
     i. [logic: if Y for a-g populate for each service] When does the county behavioral health system plan to become an MCP-contracted provider?

3. 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)?

A Transitional Rent Workflow is being developed in collaboration with our local MCPs (Health Plan of San Mateo and Kaiser Permanente). SMHSH/DMC-ODS members experiencing or at risk of homelessness are first referred to BHRS for housing interventions. Referrals may come from community partners including shelters, hospitals, ECM/CS, FSPs and other contracted providers. BHRS will 1) assess eligibility; 2) enroll if not already; and 3) identify availability of permanent setting through BHSA. BHRS will then submit the authorization request for HTNS to the MCPs.

4. 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

   BHRS has ongoing regular meetings with our local MCPs to plan and collaborate around both Transitional Rent and Housing Interventions. This group has expanded meetings with County leadership to stay up-to-date on the progress of transitional rent efforts. County partners for the expanded meetings include HSA CoC, Housing Authority, Department of Housing and our County Executive Office.

5. Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)? **Yes**

   a. Please describe the county behavioral health system's coordination efforts to align network development

      As part of the ongoing planning with our local MCPs, decisions were made collaboratively about contracted providers for transitional rent. BHRS will contract with the same provider to ensure individuals not eligible for the MCP benefit, receive services funded by BHSA. The provider will also support the transition to ongoing BHSA permanent rental assistance.

6. 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?

   All Medi-Cal SMHS/DMC-ODS members referred to MCP housing supports will be authorized by BHRS. Before referring, BHRS requires that a BHSA permanent housing plan or placement pathway be identified. This ensures that members have an ongoing housing option at or before the conclusion of the six-month MCP transitional period. If additional supports are needed beyond

MCP housing benefits, members are transitioned directly into BHSA Housing Intervention services or other locally funded assistance programs without interruption.

Through these procedures, BHRS ensures that every Medi-Cal member receiving MCP housing services has a defined pathway to permanent housing and continuous behavioral health support, minimizing any risk of service interruption once MCP-funded assistance concludes.

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.

1. Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)? **No**
    a. Is the county behavioral health system participating in or planning to participate in the Flex Pool? **N/A**
        i. Please explain why the county is not participating in the Flex Pool
    b. What role does the county behavioral health system have or plan to have in the Flex Pool? **N/A**
        - ☐ Lead Entity
        - ☐ Operator
        - ☐ Funder
        - ☐ Housing Supportive Services Provider

    c. What organization is serving as the Operator? **N/A**

    d. Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool? **N/A**
        i. Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?

2. Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?

   Yes

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

      ☐ Lead Entity

      ☐ Operator

      ☑ Funder

      ☑ Housing Supportive Services Provider

   b. Have you identified an Operator of the Flex Pool? **No**

   c. What organization will serve as the Operator? **N/A**

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

      i. Which Housing Interventions does the county plan to administer through or in coordination with a Flex Pool? [multi-select list of BHSA Housing Interventions (Chapter 7, Section C.9)]

         ☑ Rental Subsidies

         ☑ Landlord Outreach and Mitigation Funds

         ☑ Participant Assistance Funds

         ☑ Housing Transition Navigation Services and Tenancy and Sustaining Services

3. 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.

   San Mateo County was selected to participate in the Flex Pools Technical Assistance Academy and BHRS was awarded a Planning Grant. BHRS will support capacity analysis and design to determine what entity is best fit for other flex pool roles.

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.

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

   a. What Behavioral Health Services Act (BHSA) component will fund the innovative program? **N/A**

- ☐ Housing Interventions
- ☐ Full Service Partnership
- ☐ Behavioral Health Services and Supports

b. Please describe how the innovative program or pilot will help build the evidence base for the effectiveness of new statewide strategies **N/A**

c. Please describe intended outcomes of the project **N/A**

Workforce Strategy

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:

1. 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
2. Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.
3. 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.
    a. 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**
        i. If not, please describe how the county will ensure that BHSA-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner.
    b. 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**
        i. If not, please describe how the county will ensure that BHSA-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner

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

1. What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)? **11.3%**
2. Upload any data source(s) used to determine vacancy rate
3. For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
   - ☐ Advanced Emergency Medical Technicians
   - ☐ Certified Nurse Specialist
   - ☐ Community Health Workers (CHW) defined in the Enhanced Community Health Workers Services benefit
   - ☐ Community Paramedics
   - ☐ Emergency Medical Technicians
   - ☐ Licensed Clinical Social Worker
   - ☑ Licensed Marriage and Family Therapist
   - ☐ Licensed Professional Clinical Counselor
   - ☐ Licensed Psychologist
   - ☐ Licensed Vocational Nurse
   - ☐ Medical assistant
   - ☑ Medi-Cal Certified Peer Support Specialist
   - ☐ Mental Health Rehabilitation Specialist
   - ☐ Nurse practitioner
   - ☐ Occupational Therapist
   - ☐ Pharmacist
   - ☐ Physician
   - ☐ Physician assistant
   - ☐ Psychiatric Technician (PT)
   - ☑ Psychiatrist
   - ☑ Registered nurse
   - ☑ Substance Use Disorder Counselor
   - ☐ Other

4. Please describe any other key workforce gaps in the county.

   Similar to many Bay Area Counties, San Mateo County BHRS faces shortages in bilingual/bicultural clinicians, peer specialists with lived experience, SUD counselors, and providers serving rural youth and older adults.

   Additionally, a 2024 Organizational Capacity Assessment reviewed current staff capacity and skill proficiencies across functions that will be critical given regulatory changes. The assessment identified areas for increased capacity and competence including, data

management and analysis, strategic planning, fiscal and contract management, communications, and regulatory compliance. Over the past year BHRS has worked to identify opportunities for strengthening capacity including hiring of new positions to implement BHSA requirements, role reassignments, and training.

5. 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)?

   The emphasis on Evidence-Based Practices (EBPs) and BH-CONNECT will drive demand for clinicians and providers that are trained and supervised to implement EBPs to fidelity and for peer workers to support navigation and supports. Additionally, hiring, training, and supervising/supporting a behavioral health workforce that is more co-occurring capable is another significant need.

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.

1. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program? **Yes**
   a. Please explain any actions or activities the county is engaging in to leverage the program:

      Opportunities to apply for the Behavioral Health Scholarship Program will be promoted via email, meeting announcements, and other communication channels to BHRS staff and our network of providers.

2. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program? **Yes**
   a. Please explain any actions or activities the county is engaging in to leverage the program:

      Opportunities to apply for the Behavioral Health Student Loan Payment Program will be promoted via email, meeting announcements, and other communication channels to BHRS staff and our network of providers.

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

a. Please explain any actions or activities the county is engaging in to leverage the program:

Opportunities to apply for the Behavioral Health Student Recruitment and Retention Program will be promoted via email, meeting announcements, and other communication channels to BHRS staff and our network of providers.

4. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program? **Yes**

   a. Please explain any actions or activities the county is engaging in to leverage the program:

   Opportunities to apply for the Behavioral Health Community-Based Provider Training Program will be promoted via email, meeting announcements, and other communication channels to BHRS staff and our network of providers.

5. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program? **Yes**

   a. Please explain any actions or activities the county is engaging in to leverage the program:

   Future opportunities to apply for the Medi-Cal Behavioral Health Fellowship Training Program will be promoted via our current Psychiatry Residency Training Program, managed by our BHRS medical team. 4 residents per year participate in a 4 year post graduate training program. 280 psychiatrists have been trained to-date and 50% of our psychiatrists have trained in our program.

6. 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:

   A BHRS Workforce Development Plan will guide implementation of workforce strategies for fiscal years 2026-2029. The plan addresses objectives related to:

   - Workforce Recruitment and Retention – identifying and prioritizing recruitment, retention, and career advancement strategies for the next three years to build a behavioral health workforce that reflects and responds to San Mateo County's diverse client population.
   - Workforce Training – identifying and prioritizing workforce training priorities strategies that align with our BHRS Transformation Journey (strategic planning goals and refined BHRS mission/vision and values), including honoring lived experience; advancing equity, trauma-

informed care, and staff wellbeing; strengthening responsiveness to emerging needs through compliance and quality management, evidence-based practices, performance and data-driven planning, and strategy and fiscal stewardship.

Budget And Prudent Reserve

Download and complete the budget template

1. Please upload the completed budget template [**See Appendix 5**].

2. 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 wo uld allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template.
   N/A - no excess prudent reserve funds

3. Enter date of last prudent reserve assessment: **9/25/2024**

4. 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

   N/A - no excess prudent reserve funds

County Administrator or Designee Certification

DHCS | County Portal

County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Certification

1. I hereby certify that:
   - ☑ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
   - ☑ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
   - ☑ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   - ○ Yes
   - ◉ No

a. If answered yes above, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

San Mateo County

Signature

3. Print name
   Roberto Manchia
4. Date
   1/23/2026
5. Signature
   Roberto Manchia Digitally signed by Roberto Manchia Date: 2026.01.23 10:45:42 -08'00'

Contact information

6. County Name
   San Mateo County
7. Certification for
   - (•) Three-Year Integrated Plan
   - ( ) Annual Update
   - ( ) Intermittent Update

7a. Submission type
   - (•) Draft

8. County Chief Administration Officer Name
   Roberto Manchia
9. County Chief Administration Officer Phone number
   650-363-4597
10. County Chief Administration Officer Email
   RManchia@smcgov.org

Plan Approval and Compliance

DHCS | County Portal

Behavioral Health Director Certification

Certification

1. I hereby certify that San Mateo County has complied with all statuses, regulations, and guidelines in preparing and submitting this Three-Year Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that:

   - ✔ The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
   - ✔ I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
   - ✔ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
   - ✔ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
   - ✔ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
   - ✔ The IP was submitted to the local behavioral health board

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

   - ○ Yes
   - ◉ No

a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

N/A

County Behavioral Health Agency Director contact information

3. County Name

San Mateo

4. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) ..... Update

4a. Submission type

- (•) Draft
- ( ) Final

5. County Behavioral Health Agency Director name

Dr. Jei Africa

6. County Behavioral Health Agency Director phone number

650-573-2748

7. County Behavioral Health Agency Director email

jafrica@smcgov.org

Additional contact information for counties with separate MH and SUD directors (optional)

8. Name

9. Title

10. Phone

11. Email

County Behavioral Health Agency Director signature

12. Print name

Dr. Jei Africa

13. Title

BHRS Director

14. Date

01/22/26

15. Signature

Jei Africa

Digitally signed by Jei Africa
Date: 2026.01.22 09:09:36 -08'00'

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

17. Title

18. Date

19. Signature

Board of Supervisors Certification

[to be completed after Board Approval]

Appendix 1. Documentation of Data Used During Planning

Prop. 1 - Behavioral Health Services Act (BHSA)
Community Input Sessions

Join behavioral health staff, providers, clients and families to provide input.

Share your input at a Community Input Session this summer where we will review San Mateo County's status on each of the required Prop. 1 Priority Goals and discuss strategies to address identified needs.

Group	Priority Goal (all sessions will discuss Access to Care + add'l topic)	Date	Time	Meeting Information
Diversity and Equity Council	Untreated Behavioral Health Conditions	8/1/2025	11:00am - 12:00pm	Zoom link Meeting ID: 840 4489 5737 Passcode: DEC BHRS
Children and Youth System of Care (CYSOC)	Removal of Children from Home	8/4/2025	3:30pm - 4:30pm	*Closed Session*
Lived Experience Education Workgroup (LEEW)	Institutionalization	8/5/2025	3:30pm - 4:30pm	*Closed Session*
BHSA Transition Taskforce	Homelessness, Justice Involvement, Social Connection	8/7/2025	3:00pm - 4:30pm	Zoom link
North County Outreach Collaborative	Access to Care – Early Interventions	8/8/2025	9:30am - 10:30am	Zoom link
East Palo Alto Community Service Area	Access to Care – Early Interventions	9/24/2025	1:00pm - 2:00pm	Zoom link Meeting ID: 829 5721 9606 Passcode: 544140
Coastside Collaborative	Institutionalization	8/18/2025	4:00pm - 5:00pm	Zoom link Meeting ID: 952 6730 6599 Passcode: Coastside
Housing Operations and Policy (HOP) Committee	Homelessness	8/14/2025	9:00am - 10:00am	Zoom link
Peer Providers	Untreated Behavioral Health Conditions	8/12/2025	4:30pm - 5:30pm	Zoom link
Contractors Association	Untreated Behavioral Health Conditions	8/21/2025	9:00am - 10:00am	*Closed Session*
Alcohol and Other Drug (AOD) Providers	*TBD*	9/4/2025	10:30am - 11:30am	*Closed Session*
Behavioral Health Commission (BHC) AOD Committee	Homelessness	9/10/2025	4:00pm - 5:00pm	Teams link Mtg ID: 291 374 826 400 5 Passcode: Ao9vE9Dy
BHC Adult Recovery Committee	Justice Involvement	9/17/2025	10:30am - 11:30am	Zoom link
BHC Older Adult Committee	Institutionalization	9/17/2025	1:00pm - 2:00pm	Zoom link
BHC Youth Committee	*TBD*	TBD		

Please check back regularly for most up-to-date information– last updated 9/11/25

Questions?

Contact: Doris Estremera, MHSA Manager
(650) 573-2889 ♦ mhsa@smcgov.org
www.smchealth.org/MHSA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Prop.1 Community Input Sessions

Agenda

- Welcome
- Prop. 1- Behavioral Health Transformation
- Statewide Priority Goals
- Input: Access to Care – Early Intervention Strategies

Glossary of Key Terms

- **Serious mental illness (SMI) and/or Substance use disorder (SUD)** are mental health challenges and/or recurrent use of alcohol and/or drugs resulting in serious functional impairment, which substantially interferes with major life activities.
- **Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS)** primarily provided by County Behavioral Health Plans are intensive mental health and SUD services provided to clients that meet medical necessity criteria.
- **Non-Specialty Mental Health Services (NSMHS)** primarily provided by Managed Care Plans focus on individuals with mild to moderate needs, County Behavioral Health Plans also provide NSMHS through early intervention strategies.
- **Penetration Rates** are the percentage of Medi-Cal eligible individuals who receive specific behavioral health services and can indicate how effectively a program or system reaches and serves its intended population.
- **Co-occurring capacity** focuses on the ability of providers to address mental health and substance use disorders; integrated services provides care concurrently, rather than being referred to separate programs or services.
- **Continuum of care** is a comprehensive range of health and support services to individuals ensuring seamless transitions between different levels of need.
- **Evidence-based practices (EBPs)** have documented (e.g., peer-reviewed studies, and publications) effectiveness on improving behavioral health. **Community-defined evidence practices (CDEPs)** are an alternative or complement to EBPs, that offers culturally anchored interventions.
- **Medi-Cal billing** is the process of submitting claims to California's Medicaid program, Medi-Cal, for reimbursement of services provided.

Prop. 1 - Behavioral Health Transformation

Prop. 1 – Behavioral Health Transformation (BHT) passed in March 2024 and is the Governor's effort to re-envision public mental health and substance use services.

Prop. 1 was a catalyst for transformation across the State and included legislation that requires system-level changes and Mental Health Services Act (MHSA) millionaires' tax re-allocation.

Prop.1 builds upon many other state initiatives.

Alignment and implementation of this statewide vision is expected by July 1, 2026.

*BHSA Overview Sheet

Statewide Priority Goals

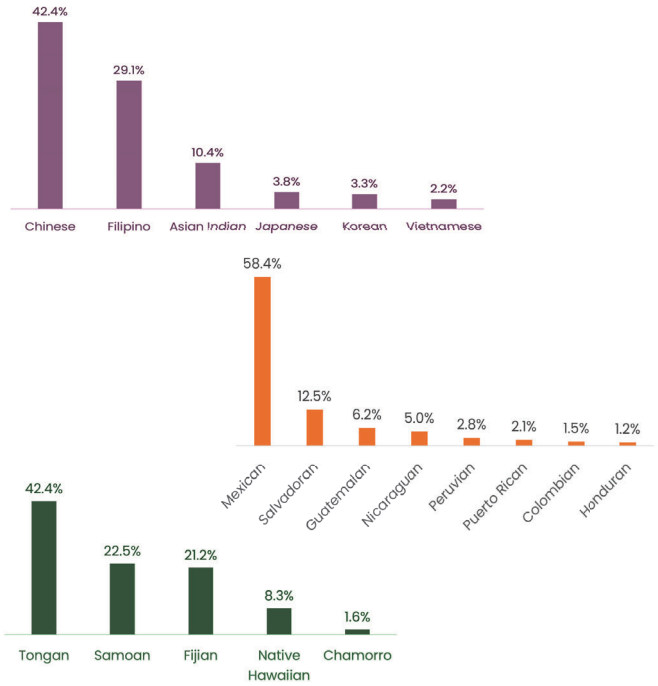
6 Statewide Goals
- ⬆ Access to Care
- ⬇ Homelessness
- ⬇ Institutionalization
- ⬇ Justice Involvement
- ⬇ Removal of Children from Home
- ⬇ Untreated Behavioral Health Conditions

1 Additional County Goal
- ⬆ Social Connection

Demographics and Service Penetration Rates

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Race/Ethnicity Overview: San Mateo County



- San Mateo County is a ***diverse community*** mostly split in thirds between Asian, White, and Latino/a/x communities and largely adults (56% ages18-59) with older adults following closely at 25% and youth at 19%.
- When we talk about Asian communities, we are talking largely about **Chinese**, **Filipino/a/x**, and **Asian Indian** ethnicities.
- Our Latino/a/x community largely corresponds to **Mexican** and followed by **Central American** ethnicities.
- Pacific Islander communities are largely **Tongan**, **Samoan**, and **Fijian** ethnicities.

Data Source: American Community Survey (ACS)2019-2023

Why does this matter?

Behavioral health strategies should employ an *equity-oriented approach* considering disparities in outcomes by specific demographics (age, race/ethnicity*).

**While the race categories have been determined by the state, when we talk about San Mateo County, we will consider the specific makeup of ethnic communities.*

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Access To Care

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Definition & Rationale

Access to care is defined as the timely and appropriate use of behavioral health services to achieve the best possible health outcomes.

Compliance with provider availability, strategies for navigating the complex care delivery system, and improving wait times for appointments will enable Californians to better access the right care at the right time.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Adult Access to Services – Penetration Rates

1. San Mateo County has **higher penetration rates** for Specialty Mental Health Services
2. San Mateo County has **lower penetration rates** for Non-Specialty Mental Health Services

- *Notably, data shows that younger adults, women, and Latino/a/x community members have **lower** rates of access.*

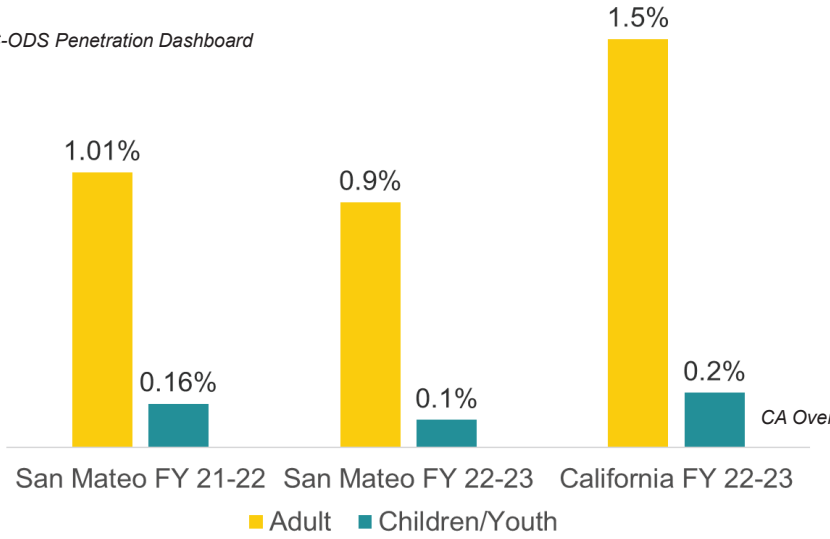
Youth Access to Services – Penetration Rates

1. San Mateo County has **lower penetration rates** for Specialty Mental Health Services***
2. San Mateo County has **higher penetration rates*** for Non-Specialty Mental Health Services**

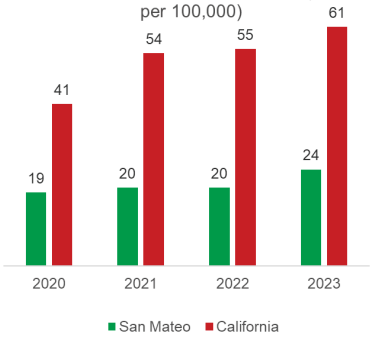
These two data points could be related! *It may be that the high access to Non-Specialty Mental Health Services is substituting or preventing access of higher intensity Specialty Mental Health Services.*

Adult DMC-ODS* Penetration Rates

CA DHCS DMC-ODS Penetration Dashboard



Context: Opioid-Related ED Visits (Rate per 100,000)



CA Overdose Surveillance Dashboard

*DMC-ODS **penetration rates have decreased** from FY 21-22 to FY 22-23, despite an **increase in Opioid-Related Emergency Department visits***

** See glossary of terms*

Early Intervention

The goal of early intervention under Prop. 1 – Behavioral Health Services Act (BHSA) is to identify and address behavioral health concerns in their early stages for high-risk individuals, before they escalate into more severe, disabling or chronic conditions.

- *High-risk* individuals have experienced trauma, Adverse Childhood Experiences, or involvement in child welfare or corrections system.

Early Intervention Required Components

- Culturally Informed Outreach
- Access and linkage to care
- Treatment Service (Medi-Cal billable)

Homelessness

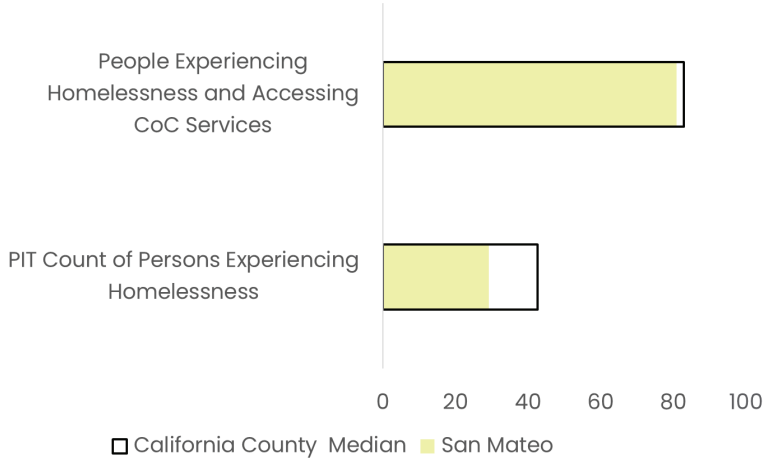
SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Definition & Rationale

Homelessness is defined below in Section 7.C.4.1.1 of the Housing Interventions chapter.

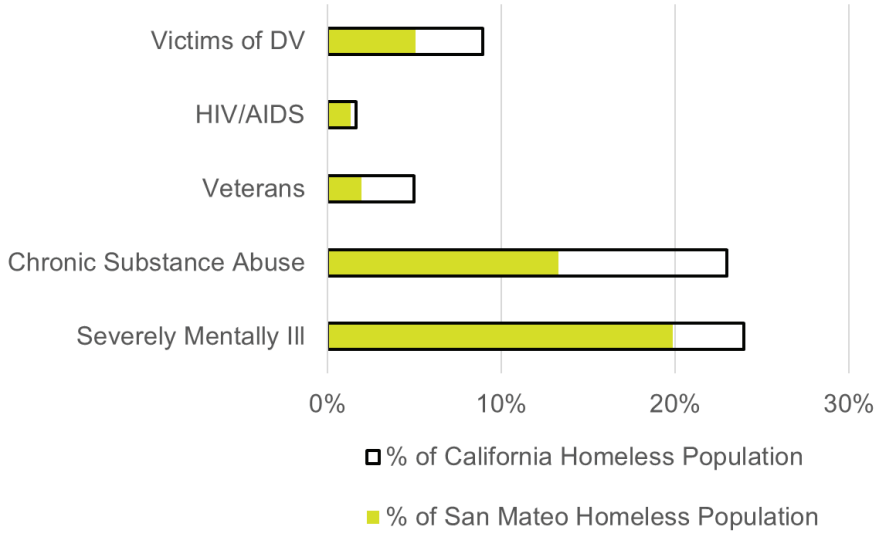
Addressing the increase in statewide homelessness is crucial to ensuring unhoused individuals living with significant behavioral health needs receive regular access to behavioral health treatment and safe and stable housing where they can recover.

San Mateo County has fewer persons identified as Homeless in the Point In Time (PIT) data but comparable to other Counties of persons accessing Continuum of Care (CoC) Services



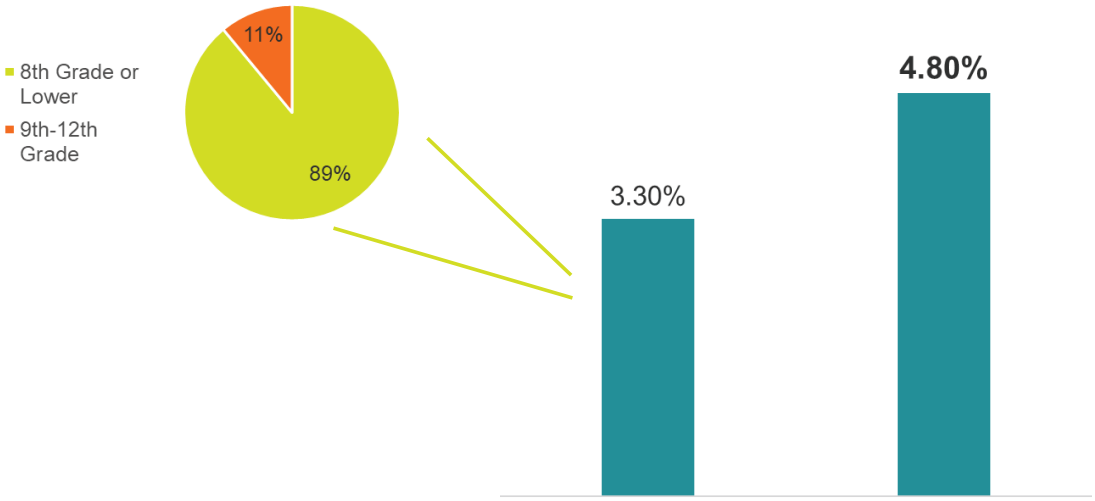
Data Sources:
HUD Point-In-Time Count & CA's Homeless Data Integration System

The PIT Count also estimates that San Mateo's Unhoused Population has lower rates of Substance Abuse and SMI than California



Data Sources:
HUD Point-In-Time Count

There are still youth in San Mateo experiencing homelessness, most of them are in 8th grade or lower



Data Sources:
CA Dept of Education

Institutionalization

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Definition & Rationale

Minimize time in institutional settings by ensuring timely access to community-based services across the care continuum and in a clinically appropriate setting that is least restrictive.

Reducing institutionalization entails maximizing community integration and making supportive housing options with intensive, flexible, voluntary supports and services available to all individuals who would benefit. Stays in institutional settings are sometimes clinically appropriate and therefore the goal is not to reduce institutionalization to zero.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

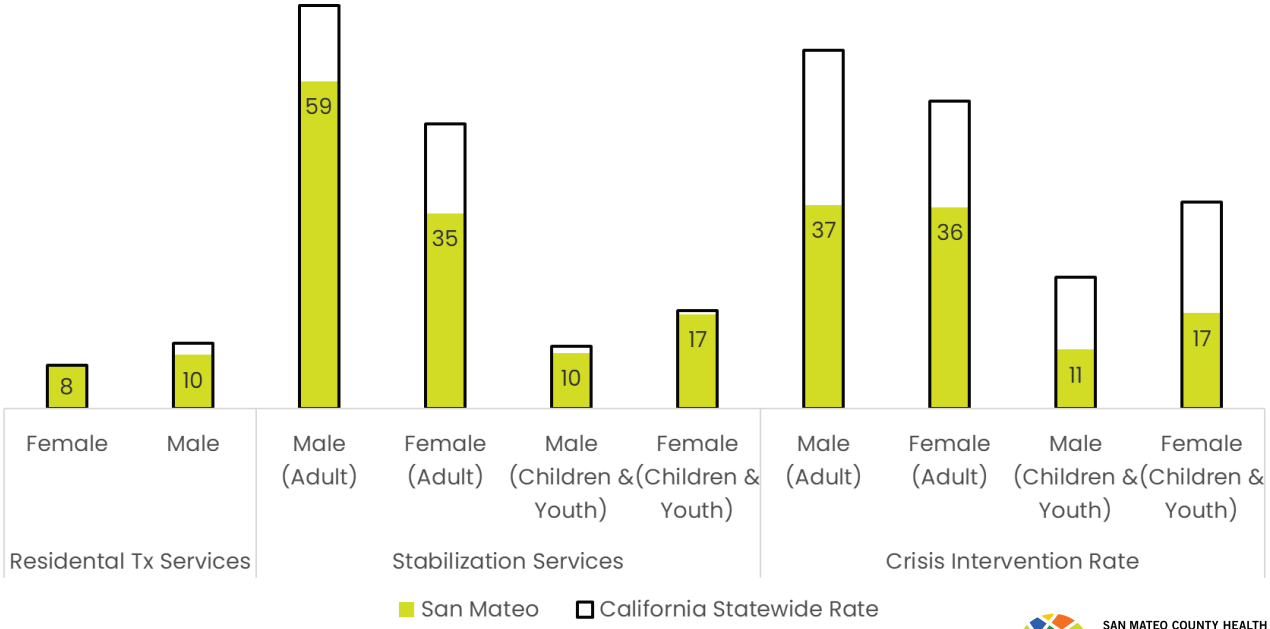
Understanding Institutionalization

Compared to California, San Mateo County reports:

1. **Higher** rate of both **permanent and temporary conservatorships**
2. **Lower or comparable** rates for beneficiaries accessing Crisis Treatment Services, Crisis Intervention Services, and Crisis Stabilization Services

- *Stays in institutional settings are sometimes clinically appropriate; the goal is not to reduce the measures to zero.*
- *Access to hospital and crisis utilization services reduce need for institutionalization.*

Crisis Services (Rate per 100,000)



Adult MHS Demographic Dashboard, Behavioral Health Reporting

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Justice Involvement

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

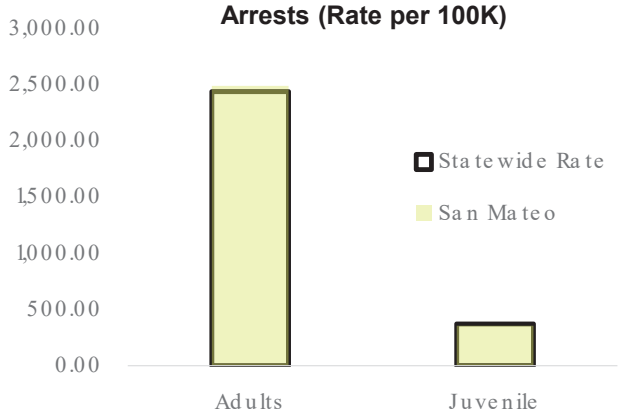
Definition & Rationale

Reducing justice involvement refers to:

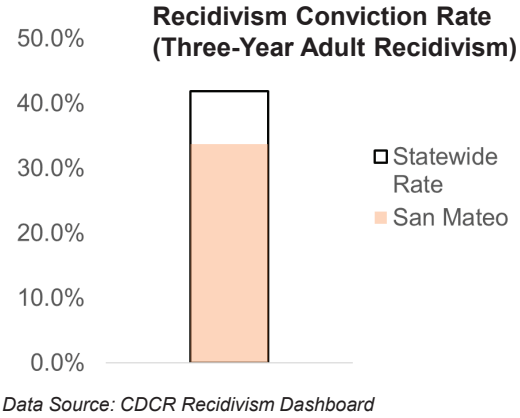
- Reducing adults and youth living with behavioral health needs who are involved in the justice system.
- Including those who have been arrested, are living in, who are under community supervision, or who have transitioned from a state prison, county jail, youth correctional facility, or other state, local, or federal carcel settings where they have been in custody of law enforcement authorities.
- More than 50 percent of incarcerated individuals are living with a behavioral health condition.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo rate of arrests is comparable to California, but other key measures *outperform the state average*



Data Source: Open Justice, CA Dept of Justice



Data Source: CDCR Recidivism Dashboard

Latino/a/x rate of arrests has been steadily increasing in the past years.

Removal of Children from Home: Data Overview

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

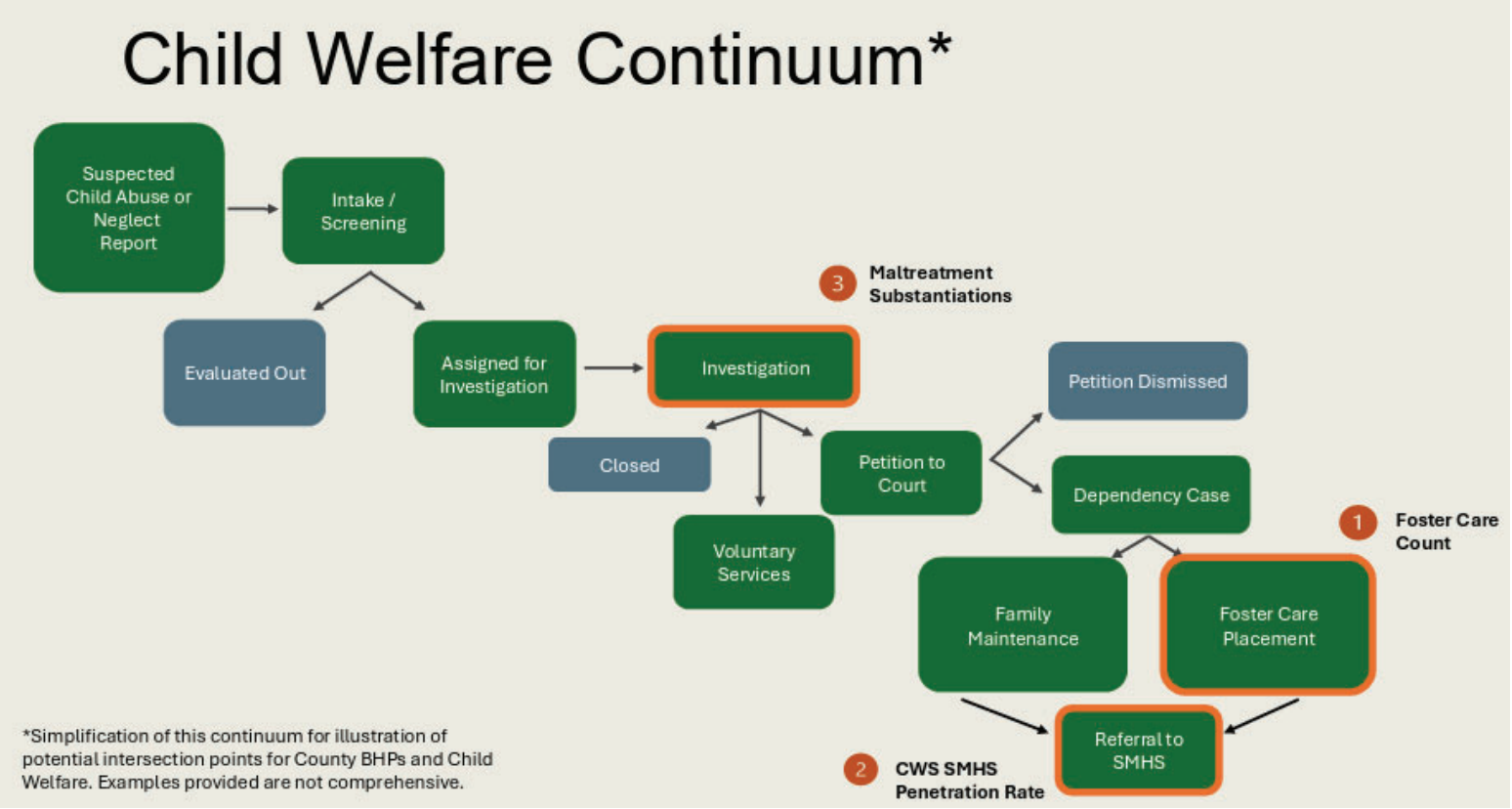
Definition & Rationale

- Removal of children from home, specifically those with an open child welfare status, refers to when children may be removed from their home due to abuse and/or neglect.
- Providing **early intervention and intensive behavioral health services** to parents and additional members of the family unit living with a behavioral health condition can prevent family disruption and improve child welfare outcomes, as children are less likely to be placed in foster care and exposed to early childhood trauma.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Performance Measures

Key Performance Measure	Measure Descriptions
Children in Foster Care Rate Source: Child Welfare Indicators Project	Point in Time/In Foster Care Counts (per 100K) of children in foster care including all children who have an open child welfare or probation supervised placement episode in the Child Welfare Services/Case Management System (CWS/CMS).
Open Child Welfare Cases Specialty Mental Health Services (SMHS) Penetration Rates Source: Department of Health Care Services (DHCS)	Children and Youth under age 21 years with an Open Child Welfare Case SMHS Penetration Rates.
Child Maltreatment Substantiations Source: Child Welfare Indicators Project	Incidence of child maltreatment substantiations in children (0 - 17 years) per 1,000.



Removal of Children from Home & Access to Care

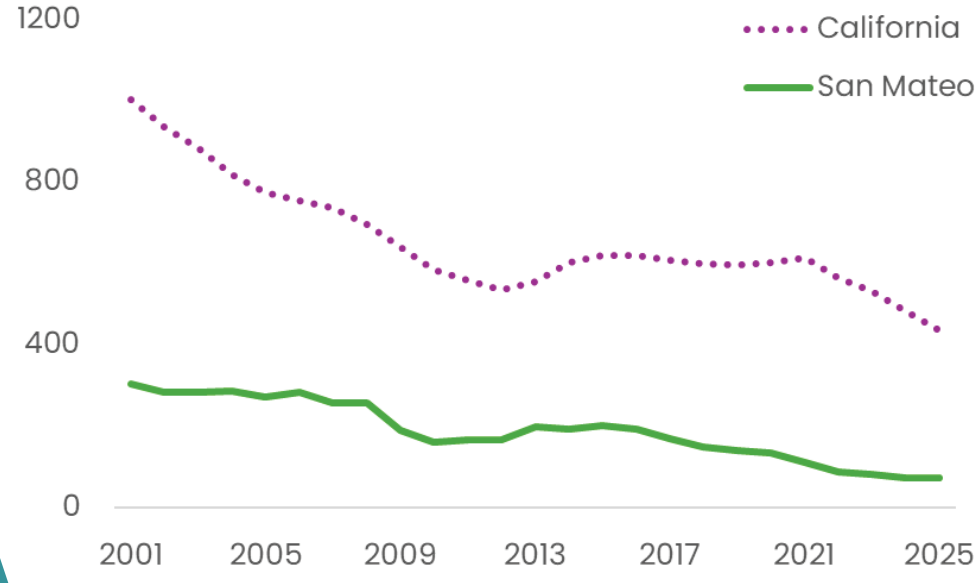
Key Data Takeaways

- ✓ San Mateo County is **removing children from homes** at the **lowest** rate in CA
- ✓ San Mateo County has one of the **highest penetration rate** in CA for specialty mental health services *for children with an open child welfare case.*
- ✓ San Mateo County has the **lowest** child maltreatment **substantiation rate** in CA

- ➢ San Mateo **can improve** proactively addressing **overrepresentation of Black and Latino youth** in maltreatment allegations and substantiations

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

The Rate of Children in Foster Care has been consistently decreasing



San Mateo County PIT county Rate (per 100K) Jan 1, 2025:

79

**Statewide Median: 525*

San Mateo County Youth Access to Care

1. Children and Youth:
   - **Lower** penetration rates for Specialty Mental Health Services (SMHS)*
   - **Higher** for Non-Specialty Mental Health Services (NSMHS)*

   It may be that the high access to NSMHS is substituting or preventing access of higher intensity SMHS.

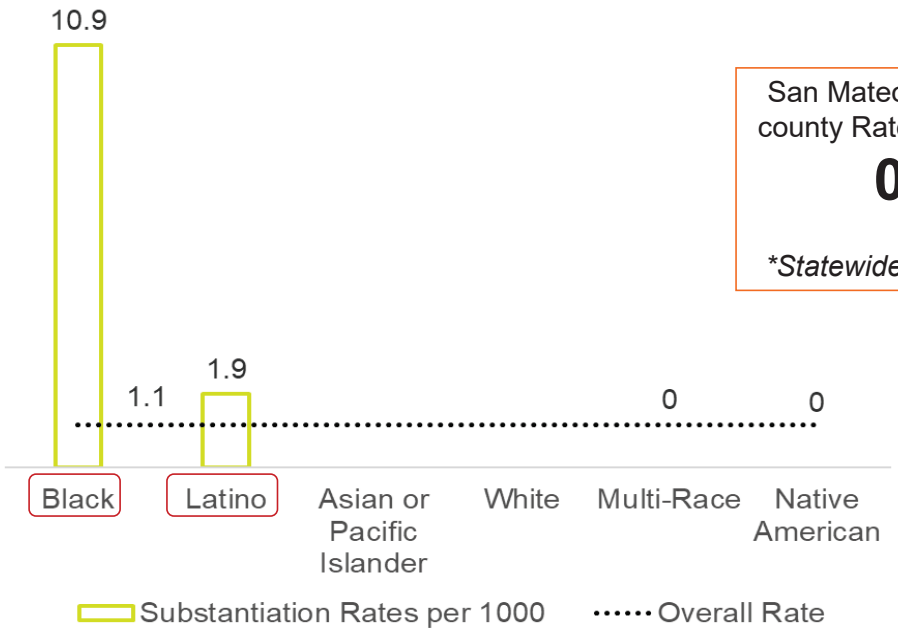
2. Children and Youth With An Open Child Welfare Case
   - **High** penetration rate in CA for child welfare youth SMHS

San Mateo County Open Child Welfare Case Penetration Rate

52.9%

**Statewide Median: 39.5%*

Child Maltreatment Substantiations (2024) Rates

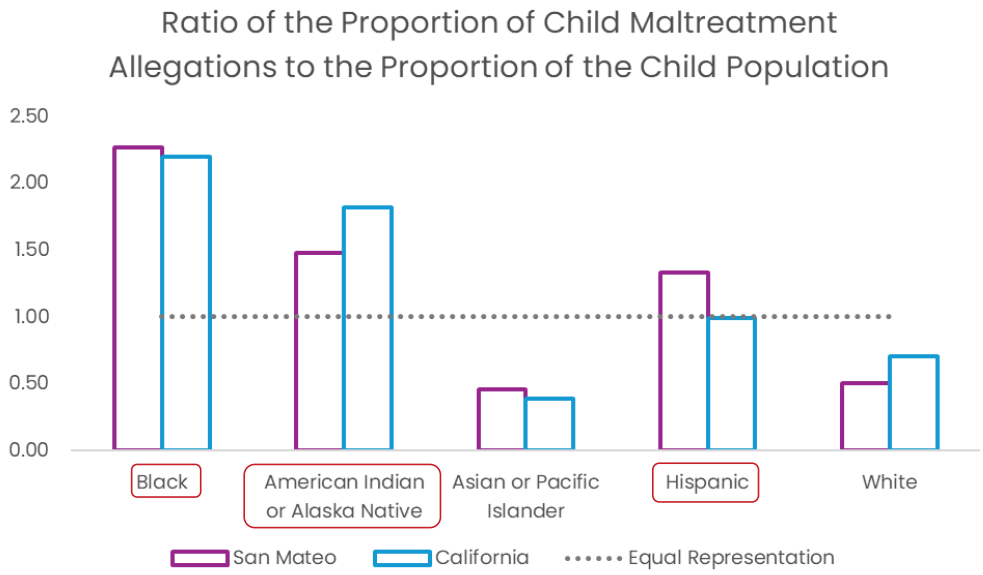


San Mateo County PIT county Rate (per 1,000):

0.9

**Statewide Median: 6.5*

Key groups receive more Maltreatment Allegations than their population proportion would suggest



Behavioral Health Strategies

Safety at Home
- Early, trauma-informed behavioral health supports may prevent removals and keep families safely together
- Crisis intervention and stabilization services are accessible pre-removal
- Behavioral health teams collaborate with child welfare to proactively address caregiver and child needs

High Quality Care
- Timely, developmentally appropriate, and culturally responsive SMHS initiated upon foster care entry
- Strong family involvement throughout case planning and treatment
- Continuity of care maintained during placement changes, including out-of-county moves

System Collaboration
- Seamless communication and referrals across BH, child welfare, probation departments, and MCPs
- Data-driven efforts to reduce racial/ethnic disparities in removal, access, and outcomes
- Families with lived experience inform service design and quality improvement

Untreated Behavioral Health Conditions

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Definition & Rationale

Untreated behavioral health conditions refer to an individual's behavioral health condition that has not been diagnosed or attended to with **appropriate** and **timely care**.

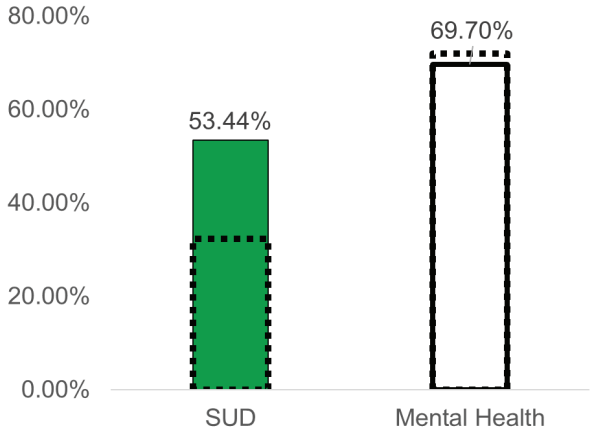
Living with untreated behavioral health conditions can lead to worsening symptoms, diminished quality of life, unemployment, reduced educational attainment, homelessness, and higher risk of severe outcomes such as suicide or self-harm.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Emergency department visit follow-ups

San Mateo County performs better than the established high-performance level for SUD emergency department (ED) visit follow-ups but, can improve for mental health ED visit follow-ups.

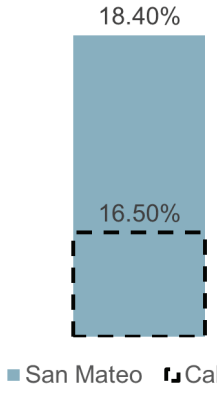
% of ED visits with a follow-up within 30 days of the visit



Medi-Cal Managed Care External Quality Review Technical Report (July 2022-June 2023)

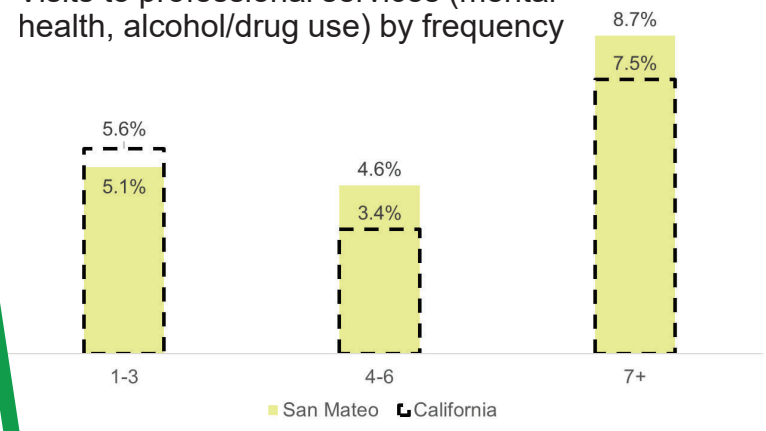
San Mateo County performs better than the state for visits to professional services

% who have visited a professional for mental health, alcohol/drug use



AskCHIS Dashboard by UCLA Health Policy

Visits to professional services (mental health, alcohol/drug use) by frequency



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Social Connection

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Domain Scores are an average of the following survey responses:

1: Strong Disagree

2: Disagree

3. Neutral

4. Agree

5. Strongly Agree

Social Connectedness

Mean Perception of Social Connectedness Score (2024)

	CA	San Mateo
Family	4.27	4.15*
Youth	4.10	3.82*
Adult	3.98	3.92*
Older Adults	3.97	3.76*

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Social Connectedness: Detailed

% of People who Agree with Social Connectedness Questions (2024)

	Youth	Family
Get along better with family members	53%	69%
Gets along better with friends and other people	69%	77%
Doing better in school and/or work	63%	71%

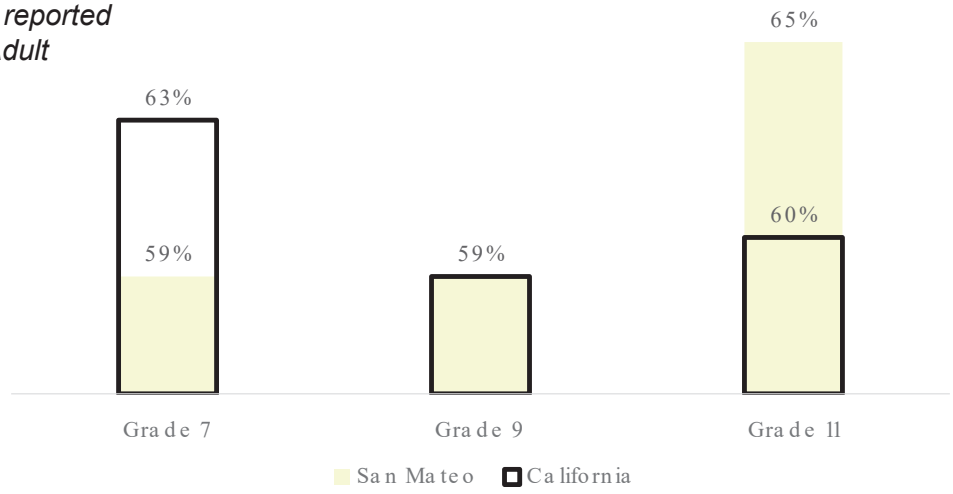
% of People who Agree with Social Connectedness Questions (2024)

	Adults	Older Adults
I have people with whom I can do enjoyable things	75%	66%
I feel I belong in my community	67%	70%
I would have the support I need from family and friends	79%	68%

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

% of Youth with Caring Adult Relationship

52% of Latinx and Black Grade 7 students reported having a Caring Adult Relationship.



Input Session Questions

1. Based on the data shared, your knowledge, observations and experiences in the community...
   a) What is needed (strategies) to improve community outcomes?
      - Is there work to sustain/expand or new work needed?
   b) What partnerships are needed to support the strategies?

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Thank You!

- **Subscribe** to stay up-to-date and receive opportunities to get involved in Prop.1 planning: www.smchealth.org/MHSA
- **Contact:** mhsa@smcgov.org
- **Let us know how we can improve:**

  https://www.surveymonkey.com/r/BHSA_Transition

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Appendix 2. Documentation of CPP Process

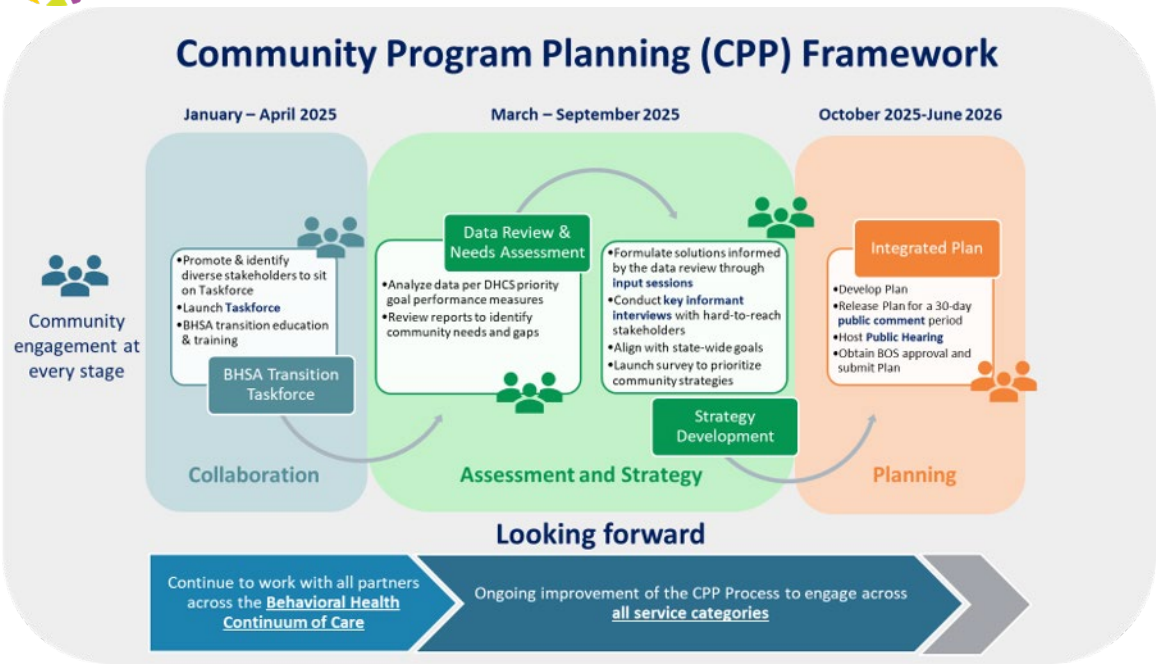
SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

BHSA Three-Year Integrated Plan Community Program Planning (CPP) Process

San Mateo County (SMC) Behavioral Health and Recovery Services (BHRS) developed and led the Community Program Planning (CPP) Process in partnership with RDA Consulting, SPC. The objective of the CPP Process was two-fold: to educate the community regarding the BHSA transition and to solicit community partner input. This feedback focused on identifying the county behavioral health system's strengths and needs, as well as developing strategies to address service gaps. These strategies align with the Department of Health Care Services (DHCS) Behavioral Health Goals and support SMC in improving community outcomes, especially among the individuals and groups facing the most challenges receiving behavioral health care.

Central to the CPP process was the **BHSA Transition Taskforce ("The Taskforce")**, the primary community partner engagement mechanism. The Taskforce met four times over a 6-month period to guide the CPP process. An estimated 117 unique individuals participated across the four taskforce meetings and represented diverse demographic and partner groups. Participants received in-depth BHSA training and played a key role in identifying additional groups to engage throughout the CPP Process, such as youth and older adults. Furthermore, the Taskforce reviewed statewide priority goals data and provided input and received briefings on the overall findings from the various CPP activities, allowing them to contribute additional context and insights based on their real-world experiences.

- Taskforce Meeting #1 (4/3/2025) – Introduction to Prop. 1, Behavioral Health Transformation and the Community Program Planning (CPP) Framework
- Taskforce Meeting #2 (6/5/2025) – BHSA Overview, Planning and Program Requirements
- Taskforce Meeting #3 (8/7/2025) – Community Input Sessions (Access to Care, Homelessness, Justice Involvement and Social Connection)
- Taskforce Meeting #4 (10/2/2025) – Review of Overall Themes from Community Input Sessions and Next Steps for Public Comment



Outside of the BHSA Taskforce, there were a variety of activities aimed at engaging the community through education and soliciting feedback. Early in the CPP process, BHRS hosted **Deep Dive Information Sessions** based on the BHSA system impacts across housing, early intervention, peer-based services, outcome reporting, and integration of substance use disorder (SUD) treatment and mental health. Deep Dive Information Sessions were conducted across these topics and over 120 participants learned more about the specific changes required as a result of the transition to BHSA and how those changes would look within BHRS.

- **Early Intervention** (6/18/25) – Behavioral Health Commission (BHC) Youth Committee
- **Peer-Based Services** (7/1/25)– Lived Experience Education Workgroup (LEEW)
- **Substance Use and Mental Health Integration** (7/9/25)– BHC Alcohol and Other Drug (AOD) Committee & AOD Treatment Providers
- **Housing Interventions** (7/10/25) – Housing Operation and Policy (HOP) Committee
- **Outcomes** (8/6/25) – Behavioral Health Commission

Next, BHRS hosted 14 **Community Input Sessions ("Input Sessions")** that provided an opportunity for groups to learn about the DHCS Behavioral Health Goals, review data and provide insights related to strengths, needs, and potential strategies. Each Input Session included access to care disparities data and focused one of the six required Priority Goal or the additional goal selected by BHRS -- "Social Connection". Over 200

clients, family members, community members, contracted agencies and community partners participated in the input sessions.

Access to Care

- North County Outreach Collaborative (8/1/25)
- BHSA Transition Taskforce breakout group (8/7/25)
- East Palo Alto Behavioral Health Outreach (9/24/25)

Homelessness

- BHSA Transition Taskforce breakout group (8/7/25)
- Housing Operation and Policy (HOP) Committee (8/14/25)
- BHC Alcohol and Other Drug (AOD) Committee (9/4/25)

Institutionalization

- Lived Experience Education Workgroup (LEEW) (8/5/25)
- Coastside Collaborative (8/18/25)
- BHC Older Adult Committee (9/17/25)

Justice Involvement

- AOD Treatment Providers (9/4/25)
- BHC Adult Recovery Committee (9/17/25)
- BHSA Transition Taskforce breakout group (8/7/25)

Removal of Children From Home

- Children Youth System of Care (CYSOC) Providers – Human Services Agency, San Mateo County Office of Education, Probation, BHRS (8/4/25)

Untreated Behavioral Health Conditions:

- Diversity and Equity Council (DEC) (8/1/25)
- Peer Providers (8/12/25)
- Contractors Association (8/21/25)

Social Connection

- BHSA Transition Taskforce breakout group (8/7/25)
- Older Adult and Youth targeted sessions (see below)

In addition to the Community Input Sessions, BHRS also hosted five **targeted discussions with specific community partner groups** reaching over 80 participants. These focus groups served a similar purpose as the Community Input Sessions and facilitated a similar conversation around system needs, strengths, and strategies. The focus groups, as well as the other CPP activities (BHSA Taskforce, Deep Dive Information Sessions, and Community Input Sessions) were all hybrid, with options for community partners to participate over Zoom/Teams and in-person.

- Youth: Coast Pride, Youth Leadership Institute, and Behavioral Health Commission (BHC) Youth Committee (9/15/25)
- Older Adults Adult & Disabilities Services (ADS) Providers (10/2/25)

- Veterans Commission (9/8/25)
- Healthcare for Homeless/Farmworker Health Program (8/14/25)
- Health Ambassadors – Spanish session (8/28/25)

The notes captured from each of the Input Sessions and focus groups were reviewed and strategies were identified to address each Behavioral Health Goal. The strategies were based on system strengths and needs and were aggregated into themes that represented a summary of the most common strategies that were voiced by community partners.

The strategy themes were then prioritized through a community survey developed by BHRS. The survey sections were organized by Behavioral Health Goal, and each section included a ranking-type question that asked respondents to rank the strategy themes by importance based on community partner experiences and perspectives. The survey was open/available for 18 business days (two and a half weeks). The survey was widely circulated and promoted through BHRS' email listserv, as well as direct outreach to specific groups. Consumers of behavioral health services and family members of consumers who completed the survey were given a $10 gift card to thank them for their participation.

The prioritized strategies make up the final result of BHRS' CPP efforts. BHRS leadership will use the strategies to prioritize resources, shape programming/service offerings, and inform their Three-Year BHSA Integrated Plan.

I. Breakdown of participant numbers per data collection type

Data Source	**Timeline**	**# of groups**	**#of participants**
BHSA Transition Taskforce	April-October 2025	4	225 total, 117 unique
Deep Dive Information Sessions	June-August 2025	5	~120

Community Input Sessions	August-September 2025	14	~212
Targeted Discussions/ Focus Groups	August-October 2025	6	~88

II. CPP Participant Demographics

BHRS engaged a diverse group of community partners throughout the CPP process, including community members, family members, providers, and representatives from various sectors, such as healthcare, social services, education, law enforcement, and veterans. Demographics were collected for the BHSA Transition Taskforce Meetings and Community Survey and serve as a proxy for the participants in the CPP process, as these community partners, or similar groups, were also involved in other CPP activities where data collection was not possible due to time and/or virtual meeting platform limitations. However, these demographic findings are not representative of all CPP participants. Targeted sessions conducted intentionally sought out specific populations that were underrepresented in standard community outreach. These target groups included youth, veterans, older adults, people experiencing homelessness, and farm workers, among others.

The BHSA Taskforce and Community Survey respondents had a very similar breakdown of demographics. Participants of both represented a variety of community partner groups and backgrounds and also spanned the behavioral health continuum of services. A quarter to one-third of the BHSA Taskforce and Survey respondents identified as a provider of Mental Health and/or SUD services (25% of Taskforce and 29% of Survey), a consumer/client of behavioral health services (34% of Taskforce and 18% of Survey), and/or a family member of a consumer (36% of Taskforce and 23% of Survey).

Figure 1: BHSA Taskforce Group Representation

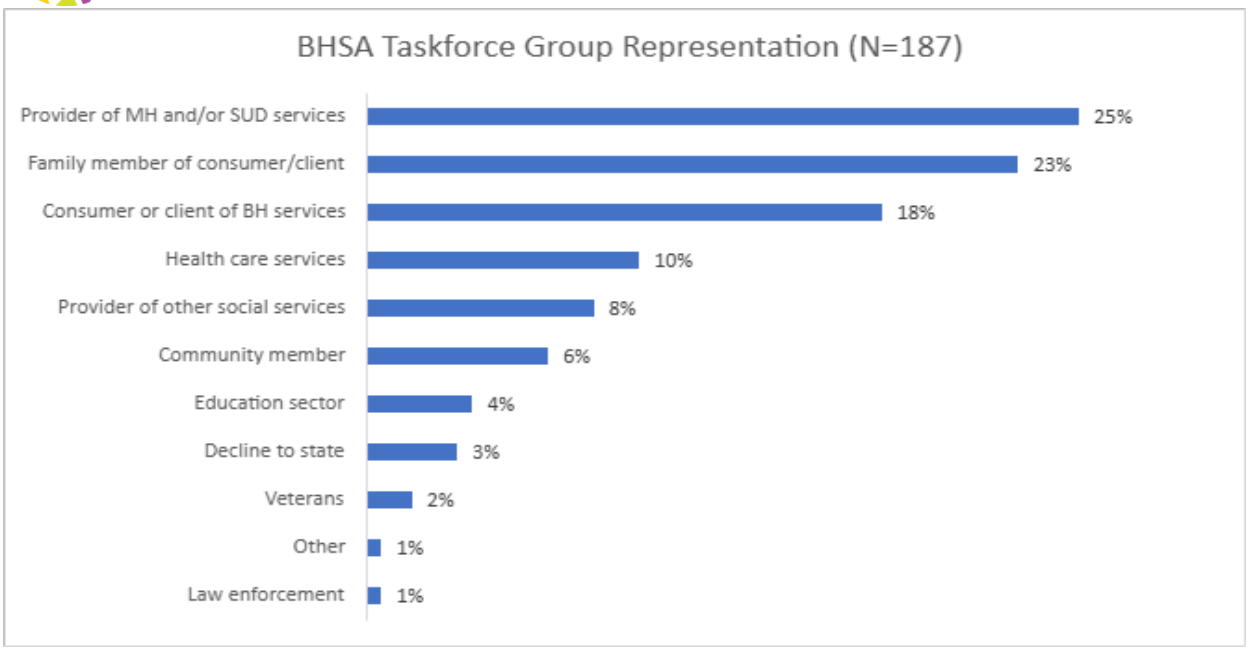
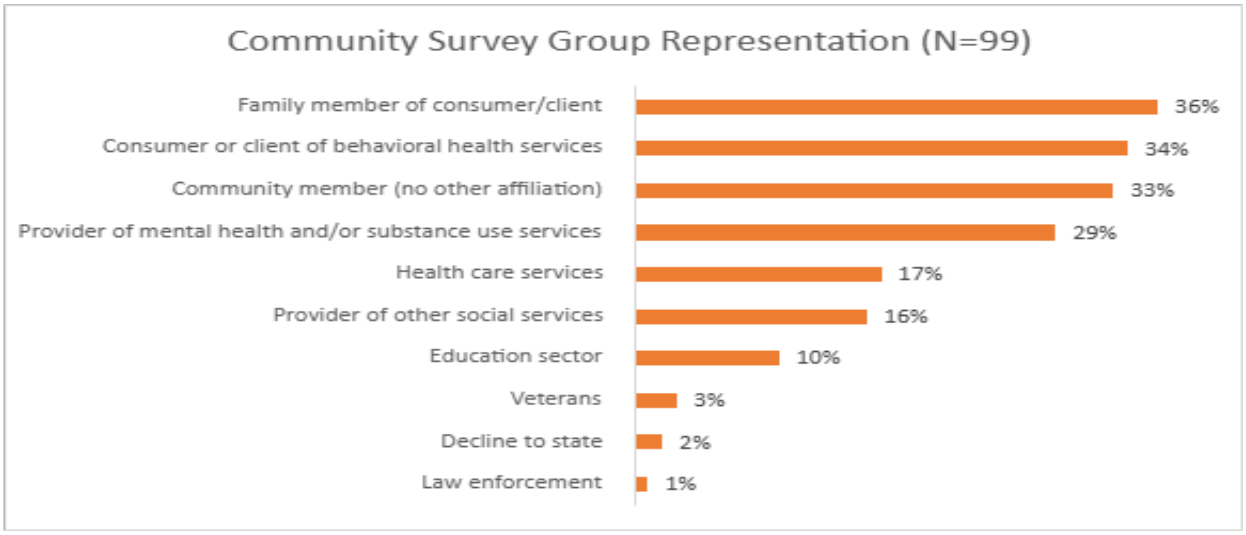


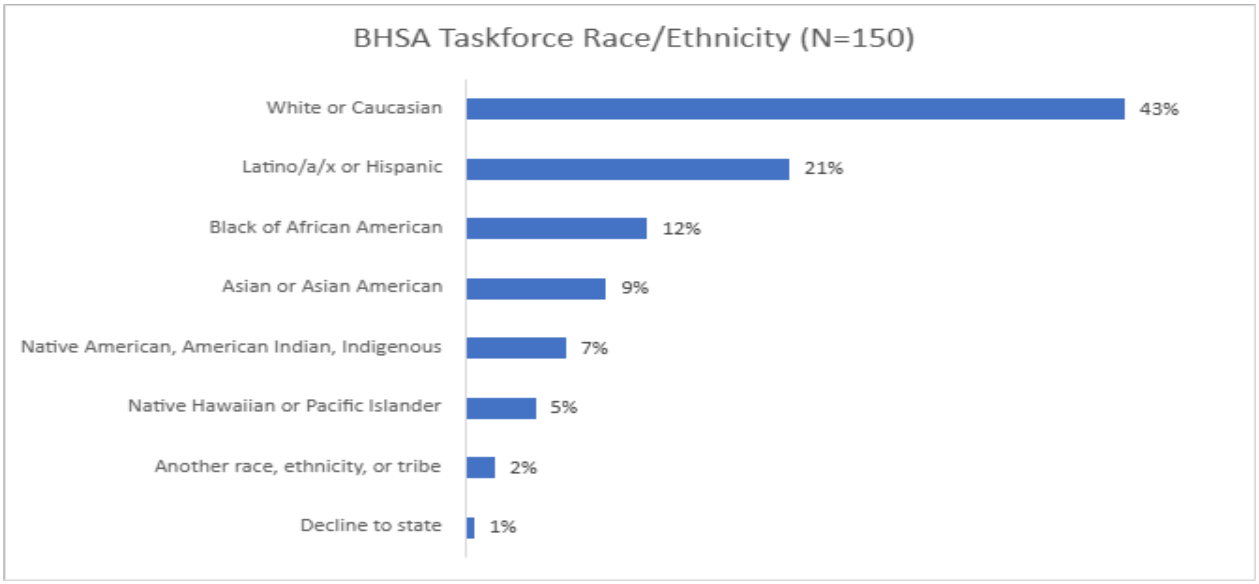
Figure 2: Community Survey Group Representation



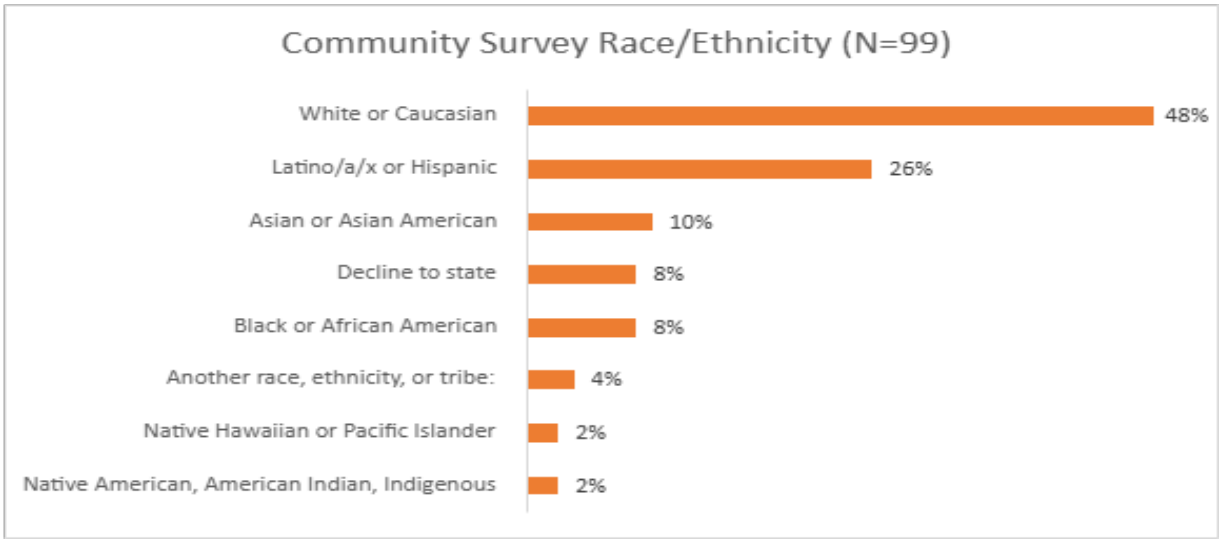
In addition, almost two-thirds of BHSA Taskforce members and Survey respondents were between 26-59 years old (65% of both), and a majority identify as heterosexual/straight (84% of Taskforce and 80% of Survey) and as a female/woman/ cisgender woman (76% of Taskforce and 74% of Survey). Furthermore, half of BHSA Taskforce members and Survey respondents identified as White or Caucasian (43% of Taskforce and 48% of Survey), with a smaller proportion identifying as Latino/a/x or Hispanic (21% of Taskforce and 26% of Survey) (Figures 3 and 4). Lastly, there was a mix of representation from across the county in the BHSA Taskforce and Community Survey, with one-third representing Central San Mateo (37% of Taskforce and 39% of Survey), followed by

South (16% and 12%) County-wide (16% and 15%), and Coast (7% and 10%) representation.

Figures 3: BHSA Taskforce Race/Ethnicity Representation



Figures 4: Community Survey Race/Ethnicity Representation



III. Key Findings from the CPP

The Community Survey prioritized strategy themes identified during the Community Input Sessions and focus groups. It's important to note that prioritization does not diminish the importance of other strategies. In fact, achieving a goal often requires a combination of strategies that build upon and amplify each other's impact. While all

strategies possess equal value and impact, they differ in terms of implementation feasibility and optimal timing for effectiveness.

The survey asked respondents to rank strategies for each Behavioral Health Goal and included open-ended questions to allow respondents to explain or elaborate on their choices. A review of these open-ended responses provided valuable context regarding the reasons for strategy prioritization. The strategy themes, as well as the results of the Community Survey, are outlined in the following sections.

Access to Care

Strategy Themes

- **Targeted Outreach**: Leverage and enhance culturally appropriate and targeted outreach to specific cultural communities. For example, navigators, peer and family supports, community health workers or "promotora" model approach to outreach.
- **Community Approaches:** Implement local and community-defined approaches to connecting individuals to services. For example, closed loop referrals – tracking community referrals across systems of care with follow-up to confirm connection to services or conducting Adverse Childhood Experiences screenings in community settings.
- **Culturally and Linguistically Appropriate Services:** Increase the number of behavioral health providers that represent the community they're serving and increase access to language supports in residential treatment.

Prioritization

Through the survey, **Targeted Outreach** was the top-ranked strategy prioritized by community partners, followed by **Community Approaches** and **Culturally and Linguistically Appropriate Services**.

Item	Overall Rank	Rank Distribution	Score	No. of Rankings
Targeted Outreach	1		187	87
Community Approaches	2		185	91
Culturally & Linguistically Appropriate Services	3		163	85

Lowest Rank — Highest Rank

The strategies were prioritized in this way because a majority of community partners felt that targeted outreach is a first line of action when it comes to increasing participation and engagement in services. Community partners expressed there is a lack of awareness of available services and how to access them, which can be addressed by targeted outreach. They emphasized that targeted outreach, especially when peer-led, could build trust and connection with historically marginalized groups who are often overlooked by traditional outreach efforts. Furthermore, the strategies were prioritized based on feasibility and timeline, with community partners noting that targeted outreach and community approaches could be implemented within three years. Improving culturally and linguistically appropriate services is a more long-term strategy.

"For impacts within 3 years, I think targeted outreach and community approaches are most likely to be implemented and see results. We need to continue investing in education and training to be able to hire a more diverse workforce. This is an essential long-term strategy." - Survey Respondent

"With San Mateo County having more individuals working as peer support specialist I would hope they are utilized to their fullest potential. Not only encouraging the recovery community but helping build better connection and trust with government and programs" - Survey Respondent

Homelessness

Strategy Themes

- **Supportive Housing**: Enhance supportive services provided to clients housed in behavioral health permanent supportive housing. For example, onsite supportive services, daily check-ins, case management, mental health and substance use treatment, mediation and life skills coaching.
- **Early Identification**: Conduct proactive and early outreach, navigation and case management. For example, partnerships with schools, navigation centers, during point-in-time homelessness counts provide early connections to supports, hospitals/detox centers, housing navigation, transportation services and other basic life needs.
- **At-Risk of Homelessness**: expand documentation of "at-risk" for homelessness to support care planning for housing instability. For example, implementing validated screenings for at-risk of homelessness or utilizing z-codes to document housing instabilities such as inadequate housing, past homelessness, economic difficulties or family/caregiving stressors.

Prioritization

Through the survey, **Supportive Housing** was the top-ranked strategy prioritized by community partners, followed by **Early Identification** and **At-Risk of Homelessness**.

Item	Overall Rank	Rank Distribution	Score	No. of Rankings
Supportive Housing	1		191	89
Early Identification	2		178	86
At-Risk of Homelessness	3		161	86

Supportive housing provides immediate stability and promotes long-term tenancy by offering essential services like case management and life skills support. This secure foundation then enables individuals to address other significant concerns, such as behavioral health needs. Furthermore, community partners emphasized that supportive housing is needed to accommodate those needing housing through early identification and other proactive outreach. While recognizing the primary importance of supportive housing, community partners also acknowledged the vital role of the other strategies in addressing "upstream" factors and preventing conditions from worsening.

"People suffering with SMI are routinely left out especially when it comes to housing. They require in site support at varying levels depending on need. The motto housing first is real. People need to be safely housed as a foundation to moving forward in life." - Survey Respondent

Institutionalization

Strategy Themes

- **Recovery Oriented Approaches**: Enhance client well-being and recovery through the implementation of strength-based approaches. For example, motivational interviewing, wellness recovery action planning (WRAP), and cognitive behavioral therapies (CBT/DBT).
- **Crisis Continuum**: Increase crisis intervention and post-institutional supports. For example, warm lines, stabilization centers, and follow-up post discharge, navigation and linkages.

- **Caregiver Supports**: Provide resources, education, and respite to caregivers mitigating the need for institutional care.
- **Acute Psychiatric Beds:** Increase acute bed availability for short-term stabilization, intervention and appropriate facilitation of step-down care; avoiding premature discharge.

Prioritization

Through the survey, **Recovery Oriented Approaches** was the top-ranked strategy prioritized by community partners, followed by **Crisis Continuum, Caregiver Supports,** and **Acute Psychiatric Beds**.

Item	Overall Rank	Rank Distribution	Score	No. of Rankings
Recovery Oriented Approaches	1		240	84
Crisis Continuum	2		227	80
Caregiver Supports	3		181	79
Acute Psychiatric Beds	4		174	78

Lowest Rank — Highest Rank

Community partners generally viewed all four strategies as vital for addressing Institutionalization. However, they emphasized that recovery-oriented approaches, such as cognitive behavioral therapies, are fundamental to successful recovery and transitioning individuals out of institutional settings into community living. The most effective recovery-oriented approaches highlighted by community partners include peer support, the development of actionable goals, and engaging with clients in non-judgmental way. Although recovery-oriented approaches were prioritized, the other strategies were seen as equally important, with many advocating for enhanced caregiver support and expanded crisis services as means to reduce hospitalizations.

> *"Interviews with clients without judgement...and complete knowledge of treatment plans that have small achievable timed goals with case managers that consistently follow-up and guide the client to be active in the recovery plan and goals" - Survey Respondent*

Strategy Themes

- **Family Engagement:** Outreach to parents and caregivers, ensuring they are aware of services and reduce stigma and cultural barriers to accessing services.
- **School-Based Services**: Prioritize on-site direct services to reduce barriers, provide early identification, facilitate engagement, and allow for coordinated supports.
- **Cross-Sector Coordination**: Leverage existing strategic initiatives and funding opportunities across systems of care to increase cross-sector coordination. For example, the San Mateo County Office of Education United for Youth Vision 2023 and the Family First Prevention Services Act (FFPSA).

Prioritization

Through the survey, **Family Engagement** was the top-ranked strategy prioritized by community partners, followed by **School-Based Services** and **Cross-Sector Coordination**.

Item	Overall Rank	Rank Distribution	Score	No. of Rankings
Family Engagement	1		198	86
School-Based Services	2		171	83
Cross-Sector Coordination	3		143	83

Lowest Rank — Highest Rank

Community partners largely agreed that family engagement and buy-in are essential to maximize the impact of behavioral health services, including those provided in schools, with many highlighting their proven effectiveness in improving child outcomes. In addition, community partners stressed that the method of engaging families is critical, recommending an approach focused on providing information and resources without judgment. Notably, there was consensus among community partners that cross-sector coordination requires improvement, though this is acknowledged as a long-term strategy demanding a shift in organizational culture.

"Services at school or in the community need the buy-in of the family. without it, the services are not effective long term" - Survey Respondent

"Communicating with parents and keeping them informed is fundamental. After that, schools will support the parents once they are informed, and then they will utilize strategies and opportunities to offer support resources" [translated from Spanish] - Survey Respondent

Untreated Behavioral Health Conditions

Strategy Themes

- **Integrated Care**: Enhance integrated services and increase coordination across sectors. For example, coordination between primary care providers and peers, hospitals and follow-up care for clients with behavioral health challenges, and coordinating substance use treatment with shelters, correctional health and psychiatric emergency services.
- **Peer Supports:** Expand peer support opportunities including increased compensation for peer workers, and capacity building. For example, peer certification and ongoing continuing education.
- **Early Screening**: Increase early screening in community settings by peer navigators/outreach workers to help reduce stigma of accessing care.
- **Culturally Informed Services**: Strengthen partnerships with community-based organizations and build capacity to support trust building. For example, implement community navigators, ongoing community listening sessions, expanding provider base that reflects the communities served.
- **Client Re-engagement**: Develop tools to reconnect with disengaged clients and conduct tailored approaches and assessments for those who opt out of medication support.

Prioritization

Through the survey, **Integrated Care** was the top-ranked strategy prioritized by community partners, followed by **Peer Supports, Early Screening, Culturally Informed Services,** and **Client Re-engagement**.

Item	Overall Rank	Rank Distribution	Score	No. of Rankings
Integrated Care	1		295	82
Peer Supports	2		266	83
Early Screening	3		252	81
Culturally Informed Services	4		222	81
Client Re-engagement	5		219	82

Improving collaboration and service integration across sectors was identified by community partners as a critical area for impact in San Mateo County. The current siloed approach creates barriers, making it difficult for clients to access the comprehensive care they often require, such as integrated mental health and substance use support for those with co-occurring needs. The second highest priority strategy identified was the need for peer supports. Community partners agreed that peer support is a cost-effective solution that provides a safe and motivating environment for clients, proving particularly beneficial for individuals with untreated behavioral health conditions.

"Collaboration with peers, care providers, and partner agencies remains weak and has been overlooked for years. We continue to work in silos..." - Survey Respondent

Justice-Involvement

Strategy Themes

- **Substance Use Services:** Increase access to detox services and substance use recovery programs targeting justice system involved clients.
- **Early Justice Intervention:** Expand alternatives to arrests and diversion programs. For example, warm hand-offs through the police department for youth, increase adolescent engagement, restorative justice practices, and brief intervention models.
- **Re-entry Supports:** Enhance reentry planning and coordinated follow up with individualized case plans to support successful reintegration into the community.

Prioritization

Through the survey, **Substance Use Services** was the top-ranked strategy prioritized by community partners, followed by **Early Justice Intervention** and **Re-entry Supports**.

Item	Overall Rank	Rank Distribution	Score	No. of Rankings
Substance Use Services	1		179	81
Early Justice Intervention	2		175	80
Re-entry Supports	3		133	79

Community partners emphasized the critical need for substance use services, recognizing that many individuals are incarcerated as a result of substance use or related offenses. The availability of these services, especially detoxification and substance use treatment coupled with case management, would be highly effective in reducing justice system involvement. Community partners also noted that the timeliness of services is imperative, given the narrow window during which an individual seeks assistance. Furthermore, community partners advocated for investments in early justice interventions, such as restorative justice and diversion programs, citing their proven effectiveness.

"When clients seek help for substance use, there is often a brief window - sometimes as little as 15 minutes in which they are willing to engage in services. If we cannot connect them quickly, many disengage and later enter justice-involved systems." - Survey Respondent

Social Connection

Strategy Themes

- **Community Belonging:** Expand accessible and inviting physical spaces for social connection for behavioral health clients of all ages. For example, community gardens, drop-in centers, recovery-oriented wellness centers, vocational opportunities for older adults, and youth advisory boards.
- **Outreach and Engagement:** Offer and enhance community and school-based outreach. For example, over-the-phone connection for homebound older adults, community-based services for LGBTQIA youth, on-site services for school-aged

youth, train school staff to identify needs, conduct regular check-ins and provide linkages.

- **Relationship Building:** Create intergenerational opportunities, expand peer-to-peer support for older adults and youth.

Prioritization

Through the survey, **Community Belonging** was the top-ranked strategy prioritized by community partners, followed by **Outreach and Engagement** and **Relationship Building**.

Item	Overall Rank	Rank Distribution	Score	No. of Rankings
Community Belonging	1		179	81
Outreach and Engagement	2		161	80
Relationship Building	3		153	82

Community partners emphasized that fostering a sense of community belonging is crucial for addressing behavioral health needs, as it promotes connection and reduces stigma. There is a recognized need to create more welcoming, voluntary spaces for community connection that prioritize safety and comfort. These spaces are particularly needed for populations currently underserved or often excluded, such as people experiencing homelessness, older adults, and BIPOC communities.

"This is exactly what we need to do more of and better. Safe spaces. Doing fun and safe things with peers." - Survey Respondent

"County programs often focus on familiar populations rather than those most in need. While social connection events are plentiful, there is a lack of safe spaces for homeless individuals, youth, and older adults" - Survey Respondent

Prop. 1 –Behavioral Health Services Act (BHSA) Transition Taskforce

Open to the public! Join advocates, providers, clients and families to provide input on the transition to Prop. 1 – BHSA.

Key priorities for BHSA include:

- Inclusive of substance use without a primary mental health diagnosis
- Focus on the most vulnerable individuals living with serious mental illness (SMI) and/or substance use disorder (SUD), who are at-risk or chronically homeless and at risk for justice involvement.
- Build supportive housing and mental health and substance use treatment settings.
- Redirect the Mental Health Services Act (MHSA) funds.
- Create transparency in fiscal planning and reporting across all behavioral health revenues (local and state).
- Standardize outcome reporting across all behavioral health services.

✓ Stipends are available for clients/families
✓ Language interpretation is provided as requested**

** *To reserve language services, please contact us at mhsa@smcgov.org at least 2 weeks prior to the meeting.*

DATES & TIMES

April 3, 2025, 3 – 4:30 PM

June 5, 2025, 3 – 4:30 PM

August 7, 2025, 3 – 4:30 PM

October 2, 2025, 3 – 4:30 PM

- *All meetings will be hybrid*
- *Please plan to attend all four (4) meetings*

Location: Redwood Shores Library, Meeting Rooms A/B, 399 Marine Pkwy, Redwood City
Zoom: https://us02web.zoom.us/j/83635203327
Dial in: +1 669 900 6833 / Mtg ID: 836 3520 3327

Questions?

Contact: Doris Estremera, MHSA Manager
(650) 573-2889 ♦ mhsa@smcgov.org

www.smchealth.org/MHSA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

The Mental Health Services Act (MHSA) provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income over $1 million.

Prop. 1 Impacts on Housing, Early Interventions, Peer Services and Substance Use/Mental Health Integration

Open to the public! Join behavioral health staff, providers, clients and families to provide input and learn about Prop. 1 impacts.

Meeting objectives:

- Learn more about Prop.1 requirements for early interventions, peer-based services, housing interventions, and substance use and mental health (SU/MH) integration.
- Provide input on BHRS' proposed plans and strategies to address the Prop. 1 requirements.

✓ Stipends are available for clients/families
✓ Language interpretation is provided as requested**

*** To reserve language services, please contact us at mhsa@smcgov.org at least 2 weeks prior to the meeting.*

Questions?

Contact: Doris Estremera, MHSA Manager
(650) 573-2889 ♦ mhsa@smcgov.org

www.smchealth.org/MHSA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Topic, Date and Time

Early Interventions: June 18th, 4:00PM
BHC Children and Youth Committee
Virtual: Zoom or dial (669) 444-9171
Meeting ID: 990 0971 9684 Passcode 932097

Peer-Based Services: July 1st, 3:30PM
Lived Experience Education Workgroup (LEEW)
Virtual: Zoom or dial (669) 900-6833
Meeting ID: 926 2123 1608 Passcode: 605963

SU/MH Integration: July 9th, 4:00PM
BHC Alcohol and Other Drug (AOD) Committee
Virtual: Teams
Meeting ID: 299 707 975 332 Passcode: cw79zA3m

Housing Interventions: July 10th, 9:00AM
Housing Operations and Policy (HOP)
Virtual: Zoom or dial (669) 900-6833
Meeting ID: 913 3619 9982

Outcomes: August 6th, 3:30PM
Behavioral Health Commission (BHC)
Virtual: Zoom or dial (669) 900-6833
Webinar ID: 942 7552 1280 Passcode: 457259

The Mental Health Services Act (MHSA) provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income over $1 million.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Behavioral Health Services Act (BHSA) Transition Taskforce Meeting #1

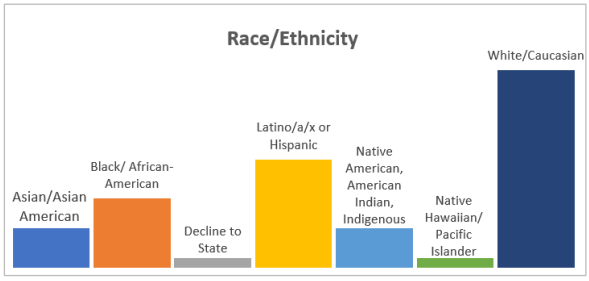
Thursday, April 3, 2025 / 3:00 – 4:30 PM

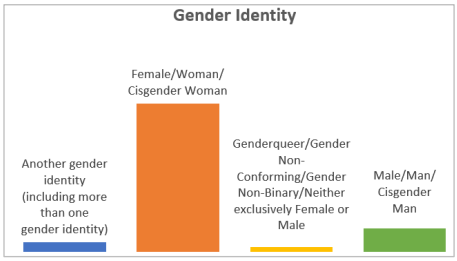
Hybrid Meeting
Location: Redwood Shores Library, 399 Marine Pkwy, Redwood City
Zoom: https://us02web.zoom.us/j/83635203327
Dial in: +1 669 900 6833 / Meeting ID: 836 3520 3327

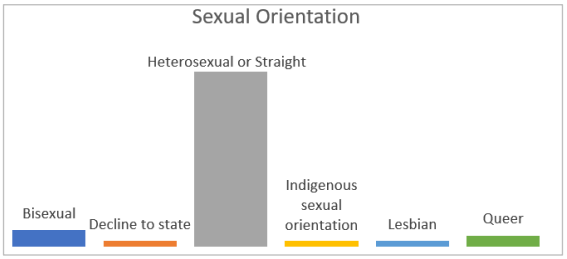
MINUTES

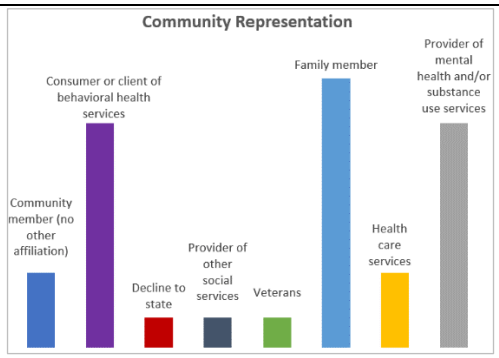
1. Welcome & Introductions *Doris Estremera, MHSA Manager* • Doris welcomes attendees to the meeting • Attendees are asked to share their name, pronouns, and affiliation in the chat • Doris introduces Sofia Recalde, Management Analyst, and RDA Consulting facilitators, Courtney Chapple, Aditi Das, and Paulina Hatfield • RDA Consulting will help facilitate the BHSA transition process • Dr. Jei Africa opens the meeting by thanking everyone for attending, highlighting that this is an opportunity to share with stakeholders and partners what is happening at the state-level through BHSA. Stakeholders and partners are an important part of the process. Jei encourages everyone to attend the upcoming taskforce meetings. • Agenda and objectives reviewed. • Logistics for participation reviewed. • Attendees completed Demographic Survey (via Zoom poll for those online and on paper for those in-person)	10 min

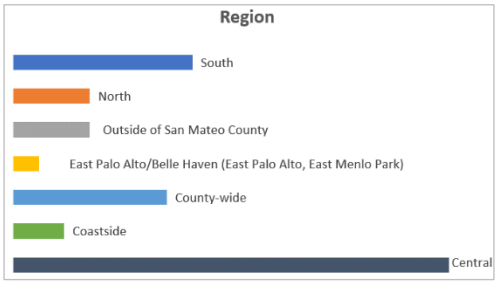
Age Range	Count	%
16-25	1	3%
26-59	25	64%
60-73	11	28%
74+	2	5%











- Participation Guidelines reviewed.
- Michael Lim asked if the recording will be open to the public to view after the meeting, and Doris confirmed that the materials will be on the MHSA website.

2. General Public Comment – *Doris Estremera* • No public comment. • Doris reviewed alternative ways to provide public comment.	10 min
3. BHSA Transition Taskforce – *Doris Estremera* • The taskforce is open to the public and is not limited in number. The hope is to keep everyone informed on this process, decisions, and considerations. The taskforce will have an advisory role on the process. There will be more intentional opportunities for input in the summer. • There are four taskforce meetings at the same time (3:00-4:30pm), same location, and same Zoom link. First Thursday of the month in June, August, and October. • Today, we will spend time on understanding Prop 1 and the Community Planning Process (CPP). Meeting #2 will focus on changes to the millionaire's task (e.g., MHSA/BHSA funding). RDA is working in the background reviewing reports, data, and assessments to look for needs and gaps. They will share their findings, and you will review those findings. After the needs assessment, there will be a survey to ensure what we're seeing in the data resonates. Meeting #3 will be an input session with specific questions on topics we are considering for the transition. Meeting #4 will focus on the Three-Year Integrated Plan. There will be changes to the structure of the plan.	10 min
4. Introduction to Prop 1 – *Jei Africa and Doris Estremera* • Prop 1 passed in March 2024, creating an opportunity to transform the behavioral health system of care. Governor Newsom is grappling with what it would look like to transform behavioral health services in a way that is effective and accessible. We began to understand that it doesn't focus on the millionaire's tax – it is a transformation of the entire behavioral health system. We have benefitted from MHSA, and Newsom's vision is transforming the entire behavioral health system. There is an opportunity to look at the different levels of the behavioral health system and how to transform it to benefit beneficiaries. • There are many other initiatives in addition to Prop 1, such as CalAIM, Prop 36, SB 43, and Child Youth Behavioral Health Initiative (YBHI) that are changing the behavioral health landscape. • It is time for our county and partners to work through these changes. There is an expectation that full implementation will be July 1 of 2026. • We are thinking about the local needs – how can we align with what the community is needing and what the state needs. Our work is local, the impact is always local. The County has prioritized emergency preparedness, housing, serving the justice-involved	10 min

population, etc. County Health has prioritized increasing people's life expectancy. Within County Health, there are departmental priorities. • We operate like a managed care plan, overseeing the care of people with specific behavioral health conditions. There are certain expectations that since we are a mental health plan and Drug Medi-Cal Organized Delivery System, we are mandated to comply with regulations. There is a managed care portion that we haven't talked about yet (e.g., operations). We are now engaging in a system-wide reflection/ prioritization as an organization to provide the services the community needs. Organizational priorities – metrics, contracts, financial responsibility, making sure partners meet the requirements of the state, and workforce. • How do we strengthen our priorities? We are contracted by the State to provide core services, and I want us to be stellar at that. Providing quality care. Aligning funding and priorities across our system of care. Engaging staff and community. Anchoring our work in data and feel like our data has full integrity. And making sure the data aligns with the experiences of our clients and their families. Lastly, improving communication and transparency so stakeholders know why we are making decisions. • There is an opportunity to do things differently – there is no better time to be in behavioral health than now. We need to be more mindful, intentional on the things we are going to do to serve the most vulnerable. We can't do it all. We want to ensure that what we do – we are stellar. And we can't do that without your partnership. • Doris provides an overview of how Prop 1 is aligned. Prop 1 will have an impact on prevention, which calls for a strengthen connection with Public Health. There is a lot of expertise in Public Health around root causes. • The Community Program Planning (CPP) Process happens every three years to inform a three-year plan. This will continue but will include our whole system. The CPP process will inform our entire system. We will create a structure where leadership will hear the community voice. • There are some specific changes we will need to make internally. We have brought on consultants and partnered with Public Health on the Community Health Improvement Plan. Now, we are in transition planning. • Pat Willard agrees and is passionate about data-driven decision making. Pat is excited to see more integration between behavioral health and substance use and initiatives to do cross-county collaboration (e.g., with Santa Clara County). Pat raises a concern -- If you do everything that the state requires, that means innovation is not on your mind. Pat feels that mandates are narrowly defined (e.g., the mobile crisis response mandate). Pat asks if there is anything that BHRS has done that has not been mandated but put in place by advocacy and activists. • Doris acknowledges Pat's comment has been noted and that it is important to lift-up the community-specific needs. • Jei affirms that there are things that BHRS has done that are innovative. If we can't do the mandates, we can't exist. I want to continue existing so we can continue to innovate.	
5. Community Program Planning (CPP) Process -- *Courtney Chapple, RDA* • Presented the CPP Framework (visual). • January-April 2025 has built the foundation for this group and to understand what work needs to be done and how to build diverse partnerships. Today, we are launching the BHSA taskforce. • There will be multiple ways to inform the work and provide feedback. There will be other opportunities outside of the taskforce. • The Needs Assessment will require reviewing existing data and affirm gaps and needs	40 min

with the community through a survey.

- Then, we will move to strategy development to ensure solutions are informed by what we have seen through the survey. There will be Strategy Development Sessions. There are four principles for strategy development.
- We want to ensure there is a diversity of stakeholders engaged.
- October 2025-June 2026 is the culmination of our work and will include engagement with partners through public comment.
- There are groups that must be engaged through this process.
- Breakout sessions. Four breakout groups held, each moved through the three identified questions below.
- Summary from breakouts, by discussion question:

What groups/communities are missing that may need targeted engagement?

- Coastal & rural residents, Department of Housing, Elected Officials (+individuals on County Boards & Commissions), Individuals with Disabilities (physical & mental integrated), IHSS Members, LGBTQ+ Communities, Non-English speaking residents (Including those who are English Language Learners), Peer Workers and Organizations, Persons with Lived Experience (across MH, SUD, Unhoused groups, substandard housing groups) + Sub-groups here [Aging adults, Unhoused Youth, Justice-involved individuals, Veteran's], PSH residents, Racial/Ethnic Groups (Black/African American Residents, Indigenous/Native American Residents, Latinx and Hispanic Residents, Pacific Islander Residents)
  - Can create a spreadsheet based off the IP

What community partners and/or leaders can support outreach?

- Center for Independence of Persons with Disabilities; Contractor's Association; *Engaging Youth/Families:* NAMI, SSF Community Children, Freshlines for Youth (justice-involved youth), County Office of Ed/School districts, high school clubs, Sana Youth Center; *Engaging Peers & Lived Experience*: Health Ambassadors Program (through the Office of Diversity & Equity), Mateo Lodge (Individuals with SMI and housing insecurity), Shelters/Navigation Centers, Street Medicine, Safe Harbor, LifeMoves, Nation's Finest, Samaritan house; Farmworkers Commission; FSP Groups (Caminar, Telecare); Indigenous Initiative (through county, monthly meetings); *Not-for-profits/CBOs:* ALAS, Coast Pride, El Concilio, Kingdom Love Partners, La Casa Nuestro, One East Palo Alto, Redwood City POW, RTS & Cora, San Mateo Pride Center, Star Vista, Voice for Recovery; *Prevention Partners* (Caron Program); Public Health (Engaging/Reengaging those from CHIP process); *Public Housing Providers:* Mercy Housing, Bridge Housing; *Public Libraries* (SSF CCCS Group - meets monthly - S. SF Library); *Other/General:* Care Centers, Core Services Agencies, Providers, City Council Members (to support planning and especially housing development needs)

  *Note to use paper/ground outreach in addition to virtual/online

What would be helpful to ask about during the community input sessions?

- *General:* What are their needs? What are the system gaps and/or biggest repeat issues seen? What kind of support has been helpful on their journey? In what ways has the system failed you? What would you like to see improved? What support/services do you want? What gets in your way? What helps you maintain

	recovery? What advocacy is needed? *MHSA Programs focused:* What programs have been most helpful to you? What programs have you interacted with the most? What changes/outcomes have you experienced? If this program were to "go away" what would that mean to you? *Transition (MHSA to BHSA) focused:* What is positive or exciting about the MHSA to BHSA transition? What is negative or worrisome about it? *Needs Response/Prioritizing:* What order would you give (most needed to least) from the pressing issues identified by community members? [list provided] *In all questions and interactions: be mindful of language, avoid language that reinforces stigma/shame, provide the why behind the line of questions, set clear expectations for what funding can and cannot support. Don't assume needs, ask and learn.	
6. General Question & Answer -- *Doris Estremera* • No questions.		10 min
7. Adjournment		

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

ATTENDANCE

There were 60 attendees; 11 participants in-person, 49 logged in through Zoom. Below is a list of attendee names; call-in numbers are unidentifiable and not included.

BHSA Transition Taskforce Members

1. John McMahon
2. Jean Perry, BHC Commissioner
3. Michael Raustler, Consumer
4. Desiree Perez
5. Alexandra Amaya
6. Sydney Hoff, Felton Institute
7. Kristin Moser, UCSF
8. Pat Willard, Peninsula Anti-Racism Coalition
9. Patricia Urbina
10. Brenda Nunez, StarVista
11. Lisa Mena
12. Melissa Platte, Mental Health Association of SMC
13. Christina Kim, Department of Housing
14. Alex Rogala
15. Karina Marwan, NAMI
16. Rachel Day
17. Tina Dirienzo, Department of Housing
18. Linder Allen
19. Francisco Sapp, San Mateo County Pride Center
20. Dee Wu, North East Medical Services
21. Anne DiTiberio
22. Carolyn Shepard
23. Andrea Holmes
24. Mary Bier
25. (phone number)
26. (phone number)
27. Lanajean Vecchione
28. Laura Parmer-Lohan
29. Adriana Furuzawa, Felton Institute
30. Sharon Heath
31. Jackie Almes, Peninsula Health Care District
32. Jared Thomas
33. Lucianne Latu, Taulama for Tongans
34. Maryann Sargent
35. Mluv
36. Nicole Bertucci, VORSMC
37. Waynette Brock
38. Willian Elting
39. Michael Lim, BHC Commissioner
40. Leticia Bido, BHC Commissioner
41. Leslie Wambach

BHRS Staff

42. Doris Estremera
43. Sofia Recalde
44. Maria Lorente Foresti
45. Edith Cabuslay
46. Daisy Ramirez
47. Jana Spalding, OCFA
48. Yolanda Ramirez, OCFA
49. Frances Lobos
50. Stacy Williams
51. Diana Campos-Gomez
52. Dr. Jei Africa
53. Christina Vasquez
54. Lee Harrison

RDA Consultants

55. Aditi Das
56. Courtney Chapple
57. Paulina Hatfield

Ernst & Young Consultants

58. Jeff Blood
59. Kaitlyn Bushell
60. Matthew Cutwright

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

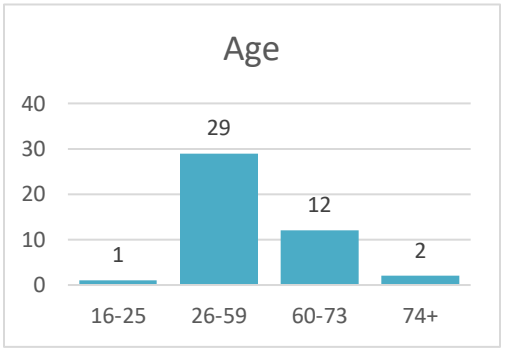
Behavioral Health Services Act (BHSA) Transition Taskforce Meeting #2

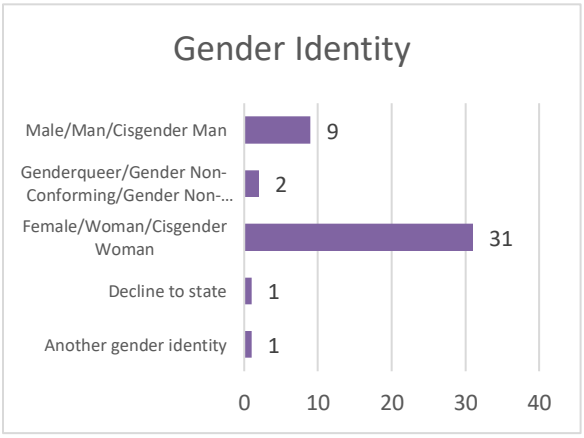
Thursday, June 5, 2025 / 3:00 – 4:30 PM

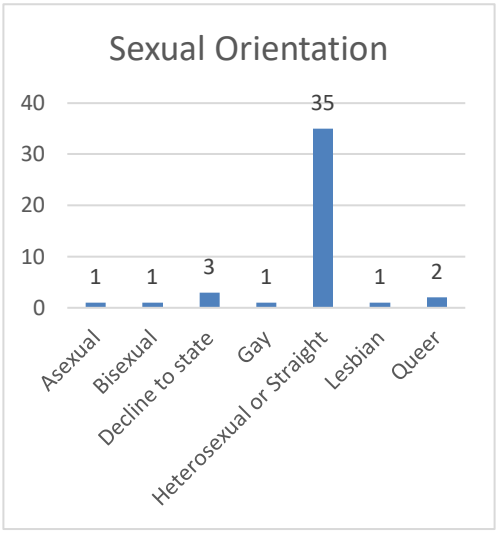
Hybrid Meeting
Location: Redwood Shores Library, 399 Marine Pkwy, Redwood City
Zoom: https://us02web.zoom.us/j/83635203327
Dial in: +1 669 900 6833 / Meeting ID: 836 3520 3327

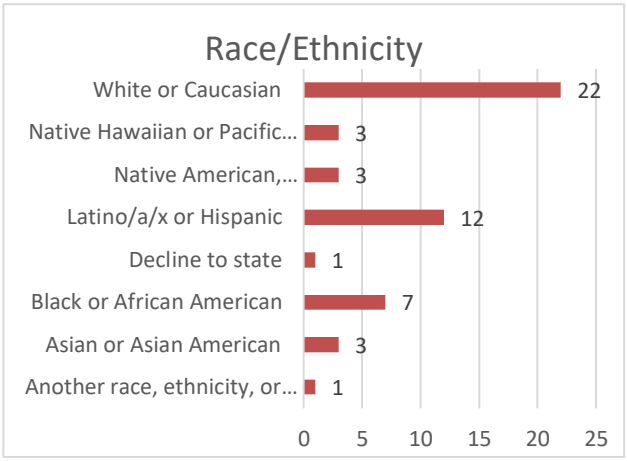
MINUTES

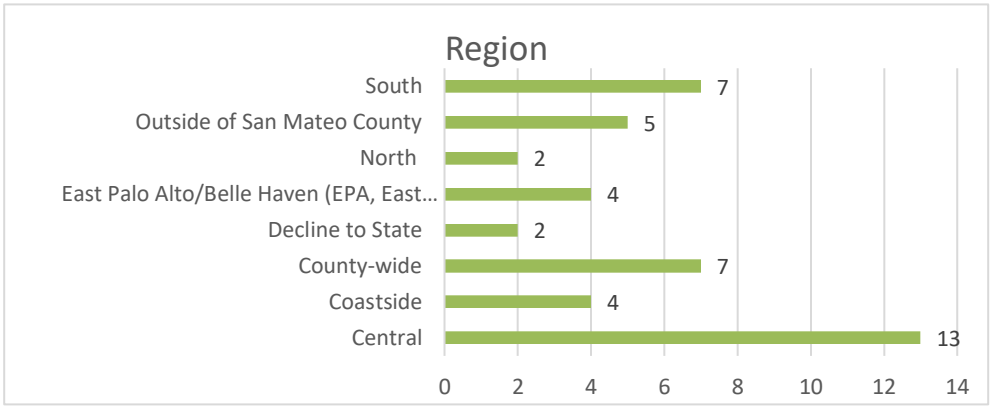
1. Welcome & Introductions *Courtney Chapple, RDA Consulting* • Attendees were asked to share their name, pronouns, and affiliation in the chat • Facilitator welcomed attendees to the meeting • Facilitator introduced RDA Consulting facilitators, Courtney Chapple, Aditi Das, and Paulina Hatfield • RDA Consulting will help facilitate the BHSA transition process • Facilitator reviewed the taskforce meeting topics for each of the four taskforce meetings. At our first meeting, we mentioned that guidance is coming out about BHSA, and we learned more since the last taskforce meeting. As a result, the taskforce meeting topics slightly changed. Today's meeting is very heavy with information. When we come back together in August, we will host you all and others for an input session. Will share more focused data and have that time available for you all to give feedback and input. • Agenda and objectives reviewed. • Logistics for participation reviewed. • Participants completed Demographic Survey (via Zoom poll for those online and on paper for those in-person). • Participation Guidelines reviewed.	10 min

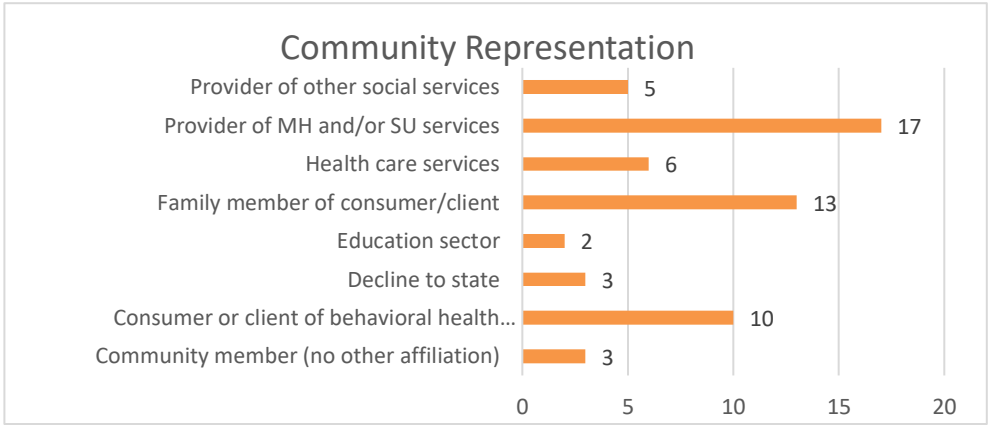












2. General Public Comment – *Doris Estremera* • Prior to meeting beginning, a participant noted in the chat that peer lead services are in demand. Social enterprises are on the rise due to the gap in government services. Jonathan Anderson also mentioned that social and private enterprises have a warm market to provide services due to need because humans exist. Even without money the services are a necessity. • Facilitator reviewed all ways to provide public comment. • Participant comment: At the BHRS commission meeting, Dr. Africa said that there would be a restructure of the organization. I take that to mean that these are all things that have to do with the BHSA transition. The point that I've made a number of times – for advocates such as myself, there's no place other than BHRS commission to	10 min

advocate for a good idea. The structure of the commission...[you]can advocate for whatever you want but due to the structure of that body, we never hear "I love your idea" or "get a hold of me later." My vision of a structure would be one where there are subcommittees and have input on programs and find opportunities where someone has a great idea. [When working] with an advocate, [say] "great idea, let's go with it, let's set up meetings together." There's no way to do that sort of way. ○ The facilitator noted they could not respond in the moment but said we would touch on it a bit later. • Participant comment: A few weeks ago, I attended Building Community in Supportive Housing – 70 unit building in Menlo Park. Impressed on the collaboration. Paying attention to every individual there and building a group. [That's what] makes an affordable housing situation like this feel like home for people. A huge impact on keeping people housed. Housing is not enough – homes not housing. We need to make sure that any kind of advocacy we do for housing, services are as essential as the building to keep people housed. • Participant comment: I wanted to provide an update if I could. I'm Lisa Mena, the Executive Director of Kingdom Love, and I partner with BHRS ODE to provide Mental Health First Aid (MHFA) trainings county wide. [I have] exciting updates and an invitation – through a grant from Humana National Council of Mental Wellbeing has developed a national roadmap for implementing MHFA community-wide. They partnered with pilot sites and Kingdom Love was one of them that got awarded. I'm working with San Mateo County to implement this roadmap and see how we can support MHFA on a systemically wider lens. To implement this successfully, there are 6 core principles to achieve. Our vision for San Mateo County is to have a community-wide MHFA approach -- Reaching different populations across communities and collaboratively identify needs and solutions. We also want to develop a community-informed plan. We use the CHIP measures, and one of those three priorities is mental health. I will drop the link in the chat to join a MHFA training and learn more about it. • Participant comment: Representing the Pacific Islander community in San Mateo County. [I want to bring up] the importance of data disaggregation. The data being collected doesn't truly see me and my community – not seen, not heard, being ignored. Many people are aware of Pacific Islander members in this county but entities that don't collect data that speak to our community, we will continue to be unseen and ignored. We will suffer. Language the government, county, and other entities speak...we will suffer in the dark.	
3. BHSA Overview – Planning and Program Requirements – Courtney Chapple and *Doris Estremera* • We have received new information for BHSA, specifically requirements for the Community Program Planning (CPP) process and what we need to include in the Three-Year Integrated Plan. Therefore, we are shifting our CPP from how the transition work is being done to focus on how we will address Statewide priority goals (recent guidance that came out from the state). State-wide level metrics and state-wide "why" - what are we working towards? With MHSA, we didn't have state-wide metrics/goals. This is for tracking impact across the state, improvements needed, and identifying gaps and needs. • Reviewed the six (6) Pop. 1 Required Priority Goals with brief descriptions/definitions: Access to care, Homelessness, Institutionalization, justice-involvement, removing children from the home, and uncontrolled behavioral health conditions. • A participant added in the chat that due to a shift in funding, SMART goals are the main focus. Wordsmith some KPI's so that funds are not taken away from necessary funding. The language has changed in other spaces, which means the language has to match to move forward.	50 min

- A participant asked in the chat, what is defined as specialized and non-specialized behavioral health services?
    - Facilitator clarified that specialty is what BHRS provides (for those with severe mental illness), and non-specialty is what managed care plans provide (mild-moderate mental health conditions).
- A participant added the following in the chat: Adults with jobs will not go to treatment due to the outcomes of job and income loss. Adults without jobs may be more likely to try treatment. Adults = 18 years old. Loss of job increases of homelessness. What is the middle point to reach a state goal?
    - Facilitator answered that as we go into input sessions this summer, we can show you where we stand as a county in comparison to the state. We will see how San Mateo County compares top other counties and identify interventions to address any gaps.
- A participant asked about defining priority areas and wanted to make sure we're not talking about specialized populations for care. Not just mild to moderate – but those that work with specialized populations like the pride center.
    - Facilitator answered that that is not clarified by the State. Specialized populations will come later on when we talk about solutions. Facilitator added that the definitions BHRS is providing are broad/high-level but there are more nuanced layers that will be addressed as data is shared.
- Facilitator explained that counties can select an additional goal from preexisting list. Data and needs assessment work will inform what is selected. We will come back to this during the next Taskforce meeting in August, which will include an input session focused on the additional goal.
- Facilitator further clarified that counties are not receiving additional funding, it's a shift/reallocation of funds.
- Facilitator shared the Prop 1 components and what is being impacted. Prop 1 is bigger than the millionaire's tax. Governor Newsom's vision is behavioral health transformation. Prop 1 is made up of two different bills:
    - AB 531 - an obligation bond that authorizes $6.4 billion is being administered by the state for residential facilities and permanent supportive housing. Residential treatment facilities are being funded through the statewide Behavioral Health Community Infrastructure Program (BHCIP) and San Mateo County has applied for funding. Supportive Housing are being funded through the HomeKey+ program as competitive grants. The local application for these funds are being led by the San Mateo County Department of Housing in partnership with BHRS to ensure there are supportive services provided to clients accessing these units. Every unit we build, there are supportive services attached.
    - SB 326 – Behavioral Health Services Act (BHSA) is reforming MHSA to include new funding allocations, creating new accountability and transparency and shifting our CPP process. It requires that community input inform our entire BHRS system of care (not just the millionaire's tax allocation) and that the required Three-Year Integrated Plan represent all BHRS services and funding streams to allow for transparency on how we use all behavioral health funding whether local, state or federal.
- Facilitator explained MHSA to BHSA reform and new allocations of funding. San Mateo County uses MHSA funds for housing interventions but now it's a new category. There is 35% for FSP (same as now) and the last 35% is a catch all and 30% for Housing Interventions. A Figure was displayed on the shift in funding from MHSA to BHSA and the fiscal impact.
    - Facilitator explained that one of the biggest shifts is losing prevention dollars.

After July 1, 2026, Behavioral Health will not receive BHSA millionaire's tax funding to do prevention work, and it will shift to public health. All prevention programs have received letters informing them of the shift and staff have met with many providers. Plenty of lead time to support the transition.
    - Figure displays estimated amounts in each category needed to meet BHSA requirements. There is a $7.5M deficit in the "Other BHSS" category, which funds outpatient treatment programs. Facilitator affirmed nothing is getting shut down as of now and they can cover the costs of these. They had to move funds out of MHSA to accommodate the new housing requirements.
- Participant Questions
    - What is the difference between prevention and early intervention?
        - Facilitator: I am going to hold that question for a later slide.
    - Did I catch this correctly? AB531 is $6.38 billion dollars?
        - Facilitator: Yes, that's the obligation bond administered by the state for the entire state.
    - Is the state allocation for administration of BHSA?
        - Facilitator: Yes, the state takes an allocation before it goes to county to fund the monitoring, oversight, administration - develop policy and implementation guidance. The State allocation will also include prevention out and workforce initiative.
- Facilitator shared that impacts to BHRS services are across eight (8) topic areas – fiscal strategies, housing, full-service partnerships, prevention and early intervention, substance use and mental health integration, peer-based services workforce development and evidence-based practices, and outcomes. We will not be doing input sessions on these topics because input sessions will be focused on the six (6) statewide Priority Goals presented earlier. We will conduct information sessions (deep dives) on many of the impact to services though to talk through the changes and get your thoughts. See the flyer on the website to learn more and sign up.
- Facilitator talked through what BHRS is doing to address the required changes. There are managers/leaders to facilitate this. Currently creating milestones and plan to share progress. There is a new site on the MHSA webpage with updates.
    - Fiscal strategies: Goal is transparency and to maximize Medi-Cal billing to increase revenues and BHSA can cover the gaps. Leveraging CalAIM for new opportunities for billing, and BH-CONNECT allows for more billing too. There are more billable services, and the Integrated Plan (IP) will give a picture of all of our revenues (local, state, etc.). Also, there is a reduction in the prudent reserve (reducing $28 million to $12 million).
    - Housing: Goal is to increase access to permanent supportive housing – Capital development and services to support folks with serious mental illness and substance use disorders. BHSA prioritizes those chronically homeless and expands allowable expenditures for housing. Adhering to Housing First Model.
    - FSPs: FSP is a "whatever it takes" model based on an evidence-based practice (EBP) known as Assertive Community Treatment (ACT) and Forensic ACT. Previously BHRS hosted a workgroup of clients, family members, providers and staff that focused on improving FSP services. We will build on the feedback provided by the workgroup. Under MHSA, we could not use funds for clients that did not have a primary MH diagnosis – this is a big deal. BHSA now includes funding for substance use disorder treatment, so we need to ensure FSP clients have access to Medication Assistance Treatment (MAT) and that there is co-occurring capacity across providers. Also, EBPs need to be implemented to fidelity by 2029 (ACT and FACT) and a tiered model

approach to FSP services where clients with highest acuity are receiving ACT and FACT and step down to lower levels of care.

- **PEI:** Early Intervention includes strategies that identify and address BH concerns in early stages (e.g., early psychosis and crisis response work). Prioritizing childhood trauma and substance use integration. We are working with consultants, and we've assessed every program funded by MHSA (60+). Early Intervention emphasizes we have culturally informed outreach – bringing folks into our system of care – with the goal to intervene and connect folks to the right level of care. Also incorporating Medi-Cal billable services– Most Early Intervention programs will have to work on this. Outreach with the intent to connect folks continues but now need to include a billable of intervention. Prevention shifting to Public Health Department, which is an important partnership. The Public Health Department puts together the Community Health Improvement Plan (CHIP). There are workgroups – Access, Social Determinant of Health, and Mental Health workgroups.
  - A participant asked, will current SUD funding co-mingle now with MHSA?
    - Facilitator: Yes, creating a plan that integrates all funding sources.
- **Substance Use Disorder and Mental Health Integration:** Expanding funding for individuals with substance use disorders regardless of primary mental health diagnosis. There is new work in the Continuum of Care to support this. Also, workforce training.
- **Peer services**: Adding peer support specialists as a provider type and peer support services as a service type (senate bill). Prop 1 want to build off of this -- billing and integration.
- **Workforce Development and Evidence Based Practices (EBPs):** Recruiting and training the workforce. Prioritizes diversity of the workforce, creating pathways for folks with lived experience, and increase capacity of staff to utilize evidence-based practices and culturally informed care.
- **Outcome tracking reporting:** Will be the focus of the Behavioral Health Commission deep dive. This expands outcome reporting to include priority goals, client outcomes, and performance measures. Outcome reporting for the entire system.

- Participant Questions
  - 1) I am wondering if the county is making progress on housing individuals that are living with parents and are not able to provide for their own housing? Using Z-codes. 2) The 25% for capital development – Is there a specific team involved? 3) What is or will be the process to being referred to permanent supportive housing unit?
    - Facilitator: Great questions. (re: z-codes) We will do a deep dive at Behavioral Health Commission on data – we will bring this up to prepare. Solutions for Supportive Housing have been strong advocates on this. (re: capital development) We're able to allocate money towards building units but it will be managed by the Department of Housing. I will follow up with a contact. (re: referral) Hold question for the deep dive.
  - Are there any plans to train more peer support specialists? You're hiring people who are too institutionalized. We need to find peer support specialists that are meeting people where they are.
    - Facilitator: We have a few Subject Matter Experts (SMEs) in the

room. ▪ SME: I work at BHRS. Just this year, we were able to bring two certified peer support specialist trainings to San Mateo County. We need more and we need positions. Hidden gems – peer run agencies in the community. We have agencies – Voices of Recovery, California Clubhouse – where peers are where the people are. We do need to get more people trained. One of my big concerns – how BHSA will impact funding for peer support. The CPP process – maybe there might be something there. ▪ Facilitator: We are not anticipating any cuts to what we're already doing; 15-19 peer positions in our system of care (confirmed: 23). They are not going away. As for more funding, probably not. There is no additional funding for peer support services but it's a priority.	
4. Community Program Planning (CPP) Process -- *Courtney Chapple, RDA* • Facilitator reviewed the CPP framework and displayed the visual timeline. • Community wide survey is shifted into the fall to be more aligned with the input sessions. • Facilitator gave overview of the community input sessions. They will start in August and dates will be shared out. There will be high-level data overviews, as well as time to identify needs from needs assessment efforts. There will also be space to talk through solutions and strategies that would address needs and gaps, as well as programs and partnerships that will further support the solutions/interventions. • There will be additional input opportunities, including interviews	10 min
5. General Question & Answer -- *Doris Estremera* • There was no time for General Q&A.	10 min
6. Adjournment	

Follow up on Unanswered Participant Questions

Question	Answer
When you had that chart up, does that include homeless veteran housing money?	The obligation bond funding to develop permanent supportive housing for veterans is administered by the state. We don't receive the funding unless we apply for it. Department of Housing is taking the lead and currently has applied for a housing development but, not specifically for veterans at this point. We will track this.
With BHSA housing prioritizing chronically homeless individuals – Are services available for those who are undocumented?	I don't have an answer to that. Would like to bring that to the deep dive info session on Housing. We will follow up.
Where can we see the Medi-Cal billable early intervention list?	We will be working with our local Managed Care Plans (Health Plan of San Mateo and Kaiser) to identify a list of non-specialty mental health billable services. For specialty mental health, the BH-CONNECT site (https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx) has new opportunities for billing.

	Additionally, DHCS will create a clearinghouse of evidence-based practices, especially for Early Intervention – we are still waiting on this. It will build off of the Children and Youth Behavioral Health Initiative (CYBHI) efforts, https://www.dhcs.ca.gov/CYBHI/Pages/EBP-CDEP-Grants.aspx. We are expecting to receive information on how counties can include their local community-designed practices.
The 25% for capital development – Is there a specific team involved?	We're able to allocate up to 25% of the Housing Intervention funding towards development costs for permanent supportive housing units. Funding will be administered by our San Mateo County Department of Housing either through their Affordable Housing Fund (AHF) Notice of Funding Availability process, https://www.smcgov.org/housing/san-mateo-county-affordable-housing-fund-ahf and/or statewide competitive processes like HomeKey+, https://www.hcd.ca.gov/grants-and-funding/homekey-plus.
Will [there] be interpretation services in Spanish for the Community Input session?	Yes, language interpretation services can be provided with advance notice. Please reach out to MHSA@smcgov.org if interpretation is need for any of the information sessions and/or input sessions listed on the MHSA site.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

ATTENDANCE

There were 66 attendees; 19 participants in-person, 47 logged in through Zoom. Below is a list of attendee names; call-in numbers are unidentifiable and not included.

BHSA Transition Taskforce Members

1. Adriana Furuzawa
2. Alex Rogala
3. Anne DiTiberio
4. Arlae Alston
5. Brenda Nunez
6. Carolyn Shepard
7. Christina Kim
8. Dee Wu
9. Francisco Sapp
10. Gloria Bernal
11. Jackie Almes
12. Jean Perry
13. Jennifer Wong
14. John Butler
15. Jim Stewart
16. John McMahon
17. Jonathan Anderson
18. Judy Davila
19. Juliana Fuerbringer
20. Karina Marwan
21. Kira Liess
22. Kristin Moser
23. Lanajean Vecchione
24. Laura Rodriguez
25. Leslie Wambach
26. Leticia Bido
27. Lisa Mena
28. Luci Latu
29. Mary Bier
30. Mary Cravalho
31. Melinda Henning
32. Melissa Platte
33. Michael Lim
34. Michael Raustler
35. Michelle Sudyka
36. mluv
37. Pat Willard
38. Paul Nichols
39. Rachel Day
40. Ramesh Azariah
41. Richard Stowell
42. ShaRon Heath
43. Veena Raghavan
44. Waynette Brock

BHRS Staff

45. Charo Martinez
46. Christina Vasquez
47. Clara Boyden
48. Diana Campos-Gomez
49. Doris Estremera
50. Frances Lobos
51. Jana Spalding, OCFA
52. Kai Thornton
53. Lee Harrison
54. Maria Lorente Foresti
55. Nicoletta Kelleher
56. Sofia Recalde
57. Stacy Williams
58. Tia Bell
59. Yolanda Ramirez, OCFA

RDA Consultants

60. Aditi Das
61. Courtney Chapple
62. Paulina Hatfield

Ernst & Young Consultants

63. Jeff Blood
64. Kaitlyn Bushell
65. Matthew Cutwright
66. Millka Baetcke

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Behavioral Health Services Act (BHSA) Transition Taskforce Meeting #3

Thursday, August 7, 2025 / 3:00 – 4:30 PM

Hybrid Meeting
Location: Redwood Shores Library, 399 Marine Pkwy, Redwood City
Zoom: https://us02web.zoom.us/j/83635203327
Dial in: +1 669 900 6833 / Meeting ID: 836 3520 3327

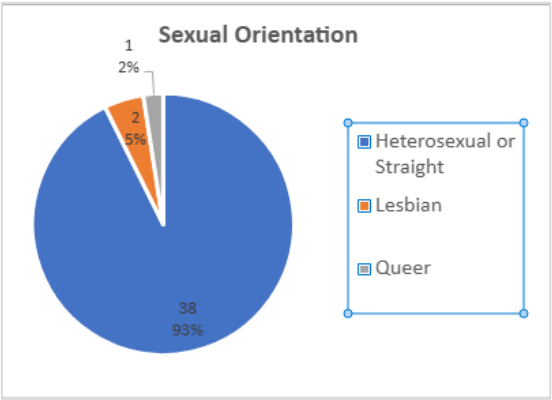
MINUTES

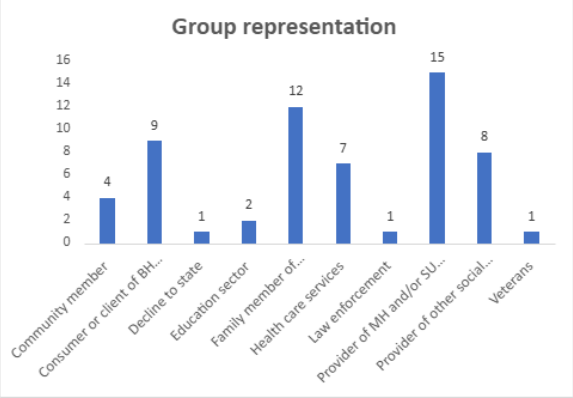
1. Welcome & Introductions — 10 min

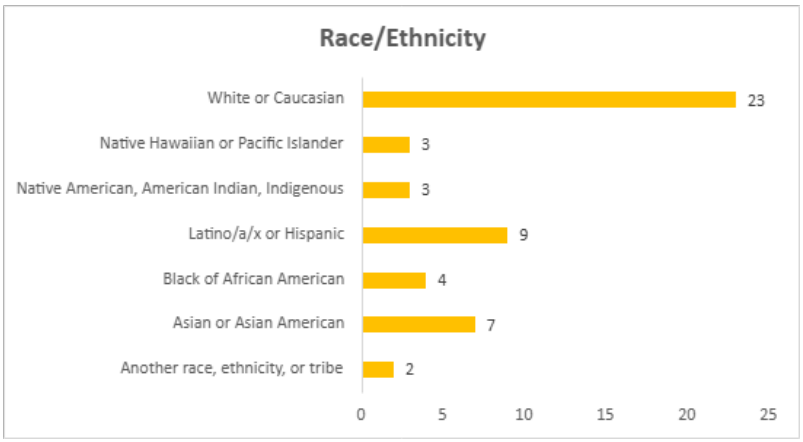
Courtney Chapple, RDA Consulting

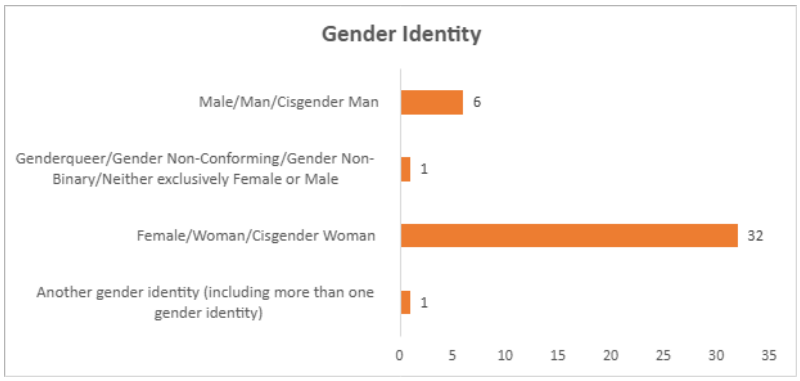
- Attendees were asked to share their name, pronouns, and affiliation in the chat
- Facilitator welcomed attendees to the meeting
- Facilitator reminded everyone of where we are in our taskforce meetings – in CPP process to identify strategies impactful to community members and inform integrated plan
- Agenda and objectives reviewed.
- Logistics for participation reviewed.
- Participants completed Demographic Survey (via Zoom poll for those online and on paper for those in-person).
- Participation Guidelines reviewed.

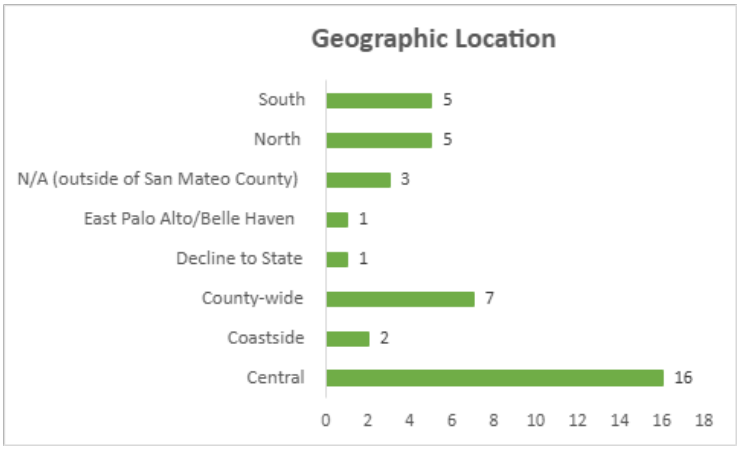
Age Range	Count
26-59 years	27
60-73 years	12
74+ years	2











2. General Public Comment – *Courtney Chapple* • The facilitator reviewed all ways to provide public comment. • Participant: Something I've been thinking about – With the BHSA transition, Public Health is taking on the preventative part of resources and services for the community. Is there anything that's happening with Public Health to bring them up to par? Don't want them to have to do catch up and everything that's been done on the BHRS side has been lost – the progress that's been made. I hope the leadership is looking at that. Public health is different but it's all one health system. I hope pride and egos are set aside and the priorities of the community come first. The goal is to serve the community. • No further comment.	10 min

3. BHSA Community Input Sessions Overview – *Courtney Chapple and Doris Estremera* • The facilitator reviewed the list of priority goals and pointed out that today's focuses will be: Access To Care, Justice Involvement, Homelessness, And Social Connection. • The goals have arrows to indicate which goals the state wants to increase and which goals they want to decrease. • Social Connection is an additional goal. The other six are state-wide and are required to be reported on. Counties were asked and required to select a goal where they aren't doing as well or performing below the state average. Because Social Connection is the local priority goal, we're going to have two breakout groups to talk about it today. • Today, we are focusing on strategy development. These are big priority goals, and they not going to be fully accomplished by one partner. Partnership across organizations is needed. • There are 15 input sessions – 11 are open to the public. There's been a lot of outreach to encourage participation. There is a flyer with all the input sessions, the dates, and topics: https://www.smchealth.org/sites/main/files/bhsa_transition_-_cpp_input_sessions_flyer_v6.pdf • Participant: The seven priority goals are required? o Six are required plus one additional goal based on county-specific needs. Social connection is an San Mateo County -specific goal. • Participant: Regarding the up and down arrows, is that for feedback from San Mateo County on whether we want to see more of that specific thing or receive less of it? There's not state-level feedback? o This is based on the metrics that the state has associated with each of the goals. For example, we want to decrease the impact of homelessness. These arrows are about improving access to care and decreasing homelessness. o We're going to select the strategies we want to prioritize to address these goals. • Participant: When the state makes a statement, they want to increase or decrease something based on what? o Based on data indicators that have been selected for each priority. These indicators are all from publicly available and statewide data sources.	20 min
4. Input Session Breakouts-- *Courtney Chapple, RDA* • San Mateo County demographics: o Two graphs on race/ethnicity and age – San Mateo County does trend older; there is a lower percentage of folks identifying as Hispanic than the state; and San Mateo County has a higher percentage of Asian and Pacific Islander persons than California as a whole ▪ Participant: I STILL don't understand why Asian and Pacific Islanders are lumped together...It's not an honest reflection of the demographic makeup of the county. I understand that it might make the PI look bigger but when you make a deeper dive by disaggregating the data it can be seen that the disparities and inequities that the PI community faces is disproportionately larger and remains unaddressed ▪ Participant: 18-59 is a big age range ▪ Participant: % of Black folks in SMC is quite low ▪ Participant: What is the percentage of Black persons in SMC and how does it compare to the state? 2% o Race/ethnicity overview • Participants were put into breakout rooms according to the following goals: o Access to Care o Homelessness	40 min

○ Justice Involvement ○ Social Connection	
5. Next Steps -- *Courtney* • Input will be synthesized into recommended strategies and will be incorporated into a future survey for community prioritization. • Facilitator walked through the CPP Framework to identify where we are in the process • Upcoming: ○ Conducting key information interviews with community that is more difficult to engage ○ A community survey is forthcoming this fall. The survey will broaden community voice – getting feedback on which strategies should be prioritized. • There is a fourth taskforce meeting this fall. Will share input summary and initial survey findings. • Questions/comments ○ Participant: Also there any demographic data on who has been present at the table at these info sessions so we know who's missing? ▪ We have information on the taskforce. For the input sessions, we can't collect demographic information for all of them. We will share out demographics at the 4th taskforce meeting. ▪ We will also collect demographics through the survey. ○ Participant: I think that Public Health, Policy, and Planning should have an active role in these discussions since this BHSA transition directly impacts and effects Public Health. This is where they could hear where the community is and learn from it and hopefully not reinvent the wheel. ○ Participant: The engagement of San Mateo County Health, Public Health Policy and Planning (PHPP) in these sessions should not be an option but a requirement.	10 min
6. Adjournment	

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

ATTENDANCE

There were 65 attendees; 7 participants in-person, 59 logged in through Zoom. Below is a list of attendee names; call-in numbers are unidentifiable and not included.

BHSA Transition Taskforce Members

1. Alex Rogala
2. Alin Lancaster
3. Billie Benson
4. Briana Fair
5. Carolyn Shepard
6. Chris Morales
7. Christina Kim
8. David Johnson
9. Dee Wu
10. Francesca Reyes
11. Francisco Sapp
12. Frieda Edgette
13. Guadalupe Mejia
14. Heather Cleary
15. Ivy C
16. Jackie Almes
17. Jean Perry
18. Joanne Qiao
19. John Butler
20. Judy Davila
21. Kelly Delaney
22. Lala Doost
23. LaShelle Burch
24. Laura Parmer-Lohan
25. Leslie Wambach
26. Leticia Bido
27. Luci Latu
28. Mary Bier
29. May Lee
30. Megan Wooley-Ousdahl
31. Melinda Henning
32. Melissa Platte
33. Michael Lim
34. Mike Noce
35. Pat Willard
36. Rachel Day
37. ShaRon Heath
38. Sydney Hoff
39. Ted Stinson
40. Tina Dirienzo
41. Victoria Asfour
42. Waynette Brock
43. Whitney Cottle
44. William Elting
45. Zenia Cardoza

BHRS Staff

46. Chandrika Zager
47. Charo Martinez
48. Christina Vasquez
49. Clara Boyden
50. Desiree Perez
51. Doris Estremera
52. Edith Cabuslay
53. Frances Lobos
54. Jana Spalding
55. Jei Africa
56. Maria Lorente Foresti
57. Mayra Amador
58. Sofia Recalde
59. Stacy Williams
60. Yolanda Ramirez

RDA Consultants

61. Aditi Das
62. Courtney Chapple
63. Paulina Hatfield

Ernst & Young Consultants

64. Jeff Blood
65. Millka Baetcke

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Behavioral Health Services Act (BHSA) Transition Taskforce Meeting #4

Thursday, October 2, 2025 / 3:00 – 4:30 PM

Hybrid Meeting
Location: Redwood Shores Library, 399 Marine Pkwy, Redwood City
Zoom: https://us02web.zoom.us/j/83635203327
Dial in: +1 669 900 6833 / Meeting ID: 836 3520 3327

MINUTES

1. Welcome & Introductions — 10 min

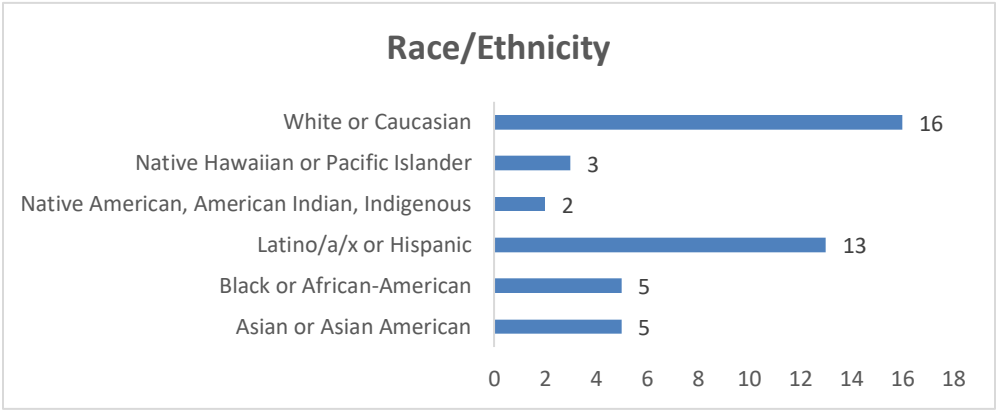
Courtney Chapple, RDA Consulting

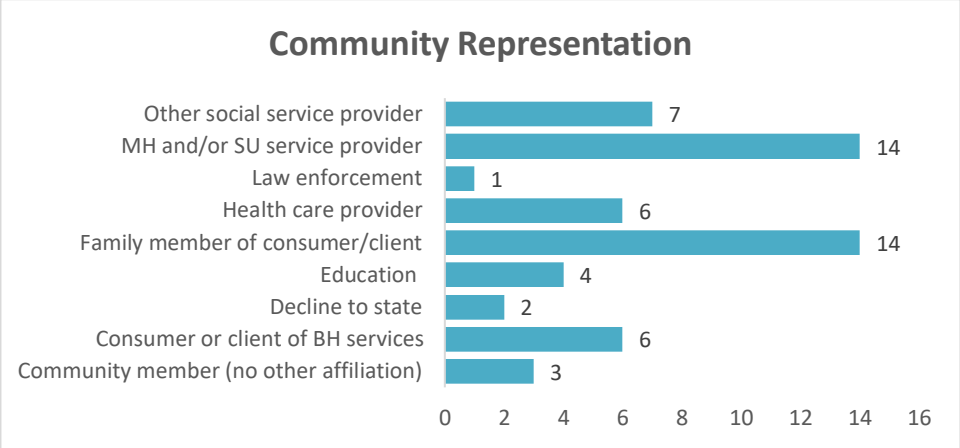
- Attendees were asked to share their name, pronouns, and affiliation in the chat
- Facilitator welcomed attendees to the meeting
- Agenda and objectives reviewed.
- The "Glossary of Key Terms" was briefly reviewed and sent in the Zoom chat
- Logistics for participation reviewed.
- Participants completed Demographic Survey (via Zoom poll for those online and on paper for those in-person).
- Participation Guidelines reviewed.

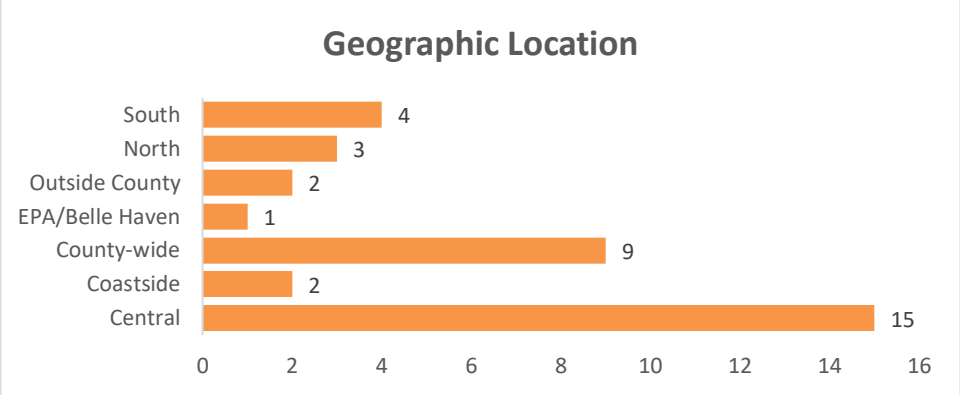
Age	Count
26-59	20
60-73	14
74+	2

Sexual Orientation	Count
Decline to State	1
Heterosexual/Straight	31
Lesbian	3
Queer	1

Gender Identity	Count
Another gender identity	1
Female/Woman/Cisgender Woman	30
Genderqueer/Gender Non-Conforming/ Gender Non-Binary	2
Male/Man/Cisgender Man	3







2. General Public Comment – *Courtney Chapple* — 10 min

- The facilitator reviewed all ways to provide public comment.
- Participant: At the Behavioral Health commission meeting, Dr. Jei said that prevention under BHSA is going to the state. I was trying to think of the prevention we do. We have the Alcohol and Other Drug (AOD) prevention committee and a Suicide Prevention Committee. When Dr. Africa says it goes to the state, does that mean we won't have these committees?
    - Doris: That has been a common question. Under Prop 1, specifically the allocation of the millionaire's tax for "population-based" prevention strategies, has shifted to the CA Department of Public Health. Population-based prevention includes efforts targeted to the community at large BHRS will no longer receive millionaire's tax allocation for these types of activities. . We are working closely with our local Public Health department to support the Community Health Improvement Plan (CHIP) development and implementation, which includes behavioral health prevention efforts.
    - Decisions reltated to the role of BHRS and the Suicide Prevention Committee are still to be determined. BHRS does receive other prevention funding (e.g., Opioid Settlement Funds, Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SAPT), etc.). So, some prevention activities under AOD will continue and we can ensure that there is integration with mental health needs as relevant.
- Participant: Thank you everyone for being here. For preventative services, peer support is critical to recovery and a sustained recovery. The work in particular that

NAMI does around education and support is peer-based and the data shows that folks have a longer recovery. I believe that peer support keeps people out of the hospital. At time of crisis, it is extraordinarily expensive. More at risk of brain damage each incident. I hope that the county will continue to find ways to fund early preventative measures that cost less than crisis ○ A participant in the chat agreed with this comment. • No further comment.	
3. Community Program Planning (CPP) Review – *Courtney Chapple, RDA* • Reminder that the Taskforce has met three times – meeting #1 was focused on planning and which groups should be engaged in the CPP. Meetings #2 provided information on what BHSA is, what the goals are, and impacts to BHRS services. Meeting #3 was an input session. Today is a culmination of all input to give you a sense of what we heard and where we are headed. • Review of the CPP Framework • Overview of the BHRS Taskforce demographics ○ Lower representation from some groups, including representation from the Coast. BHRS made intentional efforts to engage these groups through the Deep Dives and Input Sessions. • Review of the CPP engagement efforts thus far, over 300 community partners engaged through Deep Dive information sessions (5) on the changes BHRS is undergoing; Community Input Sessions (14 with 11 open to the community) tied to the Behavioral Health Goals; Targeted Discussions with groups that haven't yet had much of a presence/voice in the CPP process (6); and additional outreach efforts, such as announcements/presentations, targeted invitations, and individual outreach by BHRS Director. • Participant: Peer support is also very important for family members with a loved one struggling with mental health challenges. By supporting them we indirectly also support their loved ones. • Participant: On the six targeted discussions, are there opportunities for additional discussions [with older adults]? ○ Doris answered: We did a lot of outreach to get folks into meetings but couldn't get everyone. At this point, we are done with community input. We did notice early on in the process that we did not have older adult representation so, we reached out to aging and disability providers and where able to meet with 30+ providers to give us great input. Still hope to get older adult clients engaged as well. • Participant: Will you be communicating when the older adult sessions are scheduled? ○ Doris: The older adult session already happened. We visited the BHC Older Adult Committee and did a targeted session and another session with 30+ Older Adult and Disability providers. The only sessions pending are a few interviews with clients in our system of care. • Participant: Just to clarify, are the demographics of the taskforce data only from those who participated in the 3 sessions? Is there an overall number of how many were in the meetings (A total from all 3 sessions)? ○ Sofia: Yes, demographics were only collected for the Taskforce meetings. Int total, over 300 participated with about 100 participants in the first 3 taskforce meetings.	10 min
4. Community Input Session Outcomes -- *Courtney Chapple, RDA* • Facilitator reviewed the BH Goals ○ Participant: Sorry, but I've forgotten what the up arrow and down arrow means. It would be nice to have them labeled indicating this at the bottom of the slide.	50 min

    - Sofia: Up means we want to increase that goal (increase access to care). Down means we want to reduce on that goal (reduce homelessness, untreated BH conditions, etc.)
- Facilitator provided context/framing on the Strategy Themes. These are not fully fleshed out strategies and services, these are overarching themes.
- Access to care: Targeted Outreach, Local Focus, and Community-Defined Practices
- Homelessness: Supportive Housing and Enhanced Outreach (proactive and early outreach)
    - Participant: supportive housing would include families of children with SED?
        - Doris: YES! We are definitely looking at expanding housing units for families. ALL housing units that we develop with BHRS funding are linked to supportive services and treatment.
        - Participant: Great! Thanks Doris for your response. Could you please specify that in the report?
- Institutionalization: Crisis Continuum, Recovery Oriented Approaches, Caregiver Supports, Acute Psychiatric Beds, Community-Based Resources
    - Participant: I agree that family-centered (regardless of the ages of children) services should be included in the planning. We should try to keep families healthy and together when possible.
- Justice Involvement: Early Justice Intervention, SUD Services, and Re-entry Supports
- Removal of Children from Home: Funding Alignments (aligning various funding sources), Strategic Alignments (aligning with existing initiatives), Family Engagement, and School-Based Services
- Untreated Behavioral Health Conditions: Culturally Informed Care, Community Engagement, Peer Supports, Integrated Care, and Early Identification
    - Participant: There are many educated family peer supporters in the county who are not active. Take well care of them who are passionate about education and support.
- Social Connection: Community Belonging, Relationship Building, Safe Environments, Address Barriers, and Outreach & Engagement
    - Participant: "IEP" is not defined on the glossary of key terms slide
        - An Individualized Education Program (IEP) is a written plan that outlines the special education services and supports a student with a disability needs to succeed in school
- Intersecting themes that arose across multiple goals/conversations: Culturally and Trauma-Informed, Comprehensive Supports, and Holistic Approaches
- Facilitator invited participants to ask questions and/or share reflections
    - Participant: I wanted to add – I really feel that very intentional vocational and rehabilitative services are key. My family's own experience proves that it's fundamental to wellbeing. Assistance in access and engagement. People with SMI coming out of the criminal justice system would benefit from transitional step-down. There's a plan for this, but I would go one step further – I would strongly consider it a standard that there's a 1-3 month locked, rehabilitative treatment program that is community-based. They need step-down training. It needs to go beyond what can be done in a jail setting -- more of a medical, rehabilitative setting
    - Participant: There is so much mention of Peer Support there. What is the commitment to develop and implement Peer Support effectively across these implementations? Who will do it? When?
    - Participant: What does 'Recovery' mean in this context? What does it mean to the community and people with lived experience as opposed to what it means to BHRS? What efforts will be made to develop common

understanding and practice strategies to assure that the needs of people most effectively get their needs met?

- Participant: Gratified to see that there is a broader definition of 'at risk of homelessness' and naming adult children living with older parents. I'm glad that's being named. We've learned that this population isn't being accounted for in the county data system. A PhD student from UCSF did research on this – the invisible population. I don't know if we can include the use of z-codes – It's an easy way in the Electronic Health Record (EHR) to track this data at intake (and other times). Through this, we can have accurate data to plan for housing needs (like other disability groups do).
  - Participant: I'm also with Solutions for Supportive Homes. That data is critical.
  - Participant: Kristen Moser (PhD student) presented this to the Behavioral Health Commission and Dr. Africa was there.
- Participant: What funding commitments will be made to ensure that evidence based best practices are made available to communities and implemented in treatment and recovery programs?
- Participant: (re: Justice involvement) Alternatives to arrest -- I would like to see diversion to start working with the schools in terms of monitoring or decreasing their rates of suspensions. Suspensions are a gateway path toward incarceration.
- Participant: I have a question about the board and care (B&C) situation in the county. In my experience, having an adult child in your system who has had to be place in other counties because there were no facilities available in county. I am acutely concerned about the amount of licensed, quality B&Cs. Older adults in B&Cs don't have much of a choice in the county and are sent out of county. They need to be close to family support. How can we increase the number of B&C facilities with a quality support system attached to them?
- Participant: Amazing work, team, over the past few weeks. I'm curious about two things, after you mentioned the state priorities, you mentioned that services will require a request for proposal (RFP)? Also, I believe I noticed a turn – early identification?
  - Doris: When we mention the RFP process, that's talking about how we allocate funding and put it back out into the community. Anytime we have new money being allocated to community-based providers, it has to go through an RFP bidding process – fair competative process.
  - Courtney: Early identification – that's on the intersecting themes. We're trying to encompass a theme – help and assessment and identification needs to happen early before someone is in crisis.
  - Doris: Early intervention is the category -- Identifying individuals who need supports. There's still room in BHSA for early intervention and it's still a priority. The loss of prevention dollars – we're talking specifically about broad population strategies for increasing awareness, which is more under public health.
- Participant: I've read recently that autism needs to be found out by the age of three years old.
- Participant: I'm also happy to see that the county chose social connection as a goal -- there's so much to do in that area. Do we know what proportion of funding would go towards social connection (i.e. social enterprise)?
  - Doris: I don't have a target dollar amount. Where we have targeted dollars are the BHSA categories (Housing, BHSS, FSP). Within those is where we can get into strategies.

○ Is there a central housing list by level of care so we know what is already available? ▪ Doris: No, but it's a goal. That is one of the housing interventions. Housing is going to be a huge priority for us and we're hoping to hire a housing coordinator. ○ Participant: Why was social connection chosen but HEI initiatives are ending their yearly events? Example The Latino collaborative "Sana sana" and spirit initiative "national day of prayer"? ▪ The HEI events are considered "population-based" prevention strategies and are no longer eligible for BHSA millionaire's tax funding. We will have to think about targeted social connection strategies - targeted to BHRS responsibility for individuals living with serious mental illness and substance use disorders. Drop-in centers are a great example of spaces for individuals to connect.	
5. Next Steps -- *Courtney* • Survey will launch soon ○ Participant: Please make the survey available in Spanish as well. The BHRS-Health Ambassador will be happy to distribute it within the program and in our networks, if you consider it necessary. • BHRS will now begin drafting the Three-Year Integrated Plan and present it at the February 4, 2026 Behavioral Health Commission (BHC) meeting. It will be a big document – will be covering the entire BHRS department services and funding. • There will no longer be an MHSA Steering Committee. The BHC is the advisory board to BHRS and the BHRS Director. The BHC has committees and adhoc groups that can target specific topics as prioritized. This is where annual updates and three-year planning for BHRS will be housed. • The Integrated Plan will be open to public comment. At the same time, it will go to the State Department of Health Care Services (DHCS) for review. • BHRS will submit the final Three-Year Integrated Plan in May/June for Board of Supervisor approval. • Prop 1 not only has Behavioral Health goals, but it also has big impacts on our system of care (e.g., peer-based services, evidence-based practices). ○ Managers chose individuals who will lead efforts across 11 areas of focus ○ To-date, implementation plans have been developed with milestones, activities, and timelines for all areas of focus. ○ Will publish a dashboard with milestones, in the near future, to share our progress • BHRS assessed programs that received MHSA dollars to ensure there is alignment with BHSA • BHRS Transformation Journey ○ Presented this publicly at the Behavioral Health Commission and Dr. Africa also released a newsletter • Doris explained how everyone can submit public comment • Participant: Under BHSA, community input is not required for annual updates. Is there any opportunity for the community to provide input? ○ Doris: We are still going to have 30-day public comment for every annual update. We are just not required to conduct a public hearing at the BHC for the annual updates.	10 min
6. Adjournment	

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

ATTENDANCE

There were 54 attendees; 7 participants in-person, 47 logged in through Zoom. Below is a list of attendee names; call-in numbers are unidentifiable and not included.

BHSA Transition Taskforce Members

1. Adriana Furuzawa
2. Alheli
3. Ammin Rostin
4. Billie Benson
5. Briana Fair
6. Carolyn Shepard
7. Cassandra Wilson
8. Christina Kim
9. Erendira Blake
10. Francisco Sapp
11. Gladys Balmas
12. Guadalupe Mejia
13. Heather Cleary
14. Jackie Almes
15. Jayashree Nathaniel
16. Jean Perry
17. Jennie Liebermann
18. Jo
19. Kate Phillips
20. Kris Anderson
21. Laura Parmer-Lohan
22. Leslie Wambach
23. Leticia Bido
24. Linder Allen
25. Lisa Mena
26. Lourdes Briseño
27. Mary Bier
28. Melinda Henning
29. Melissa Platte
30. Michael Lim
31. Pat Willard
32. Rachel Day
33. Sydney Hoff
34. Tina DiRienzo
35. Twila Dependahl

BHRS Staff

36. Charo Martinez
37. Christina Vasquez
38. Clara Boyden
39. Daisy Ramirez
40. Doris Estremera
41. Edith Cabuslay
42. Estefanie Hernanez
43. Maria Lorente Foresti
44. Mayra Amador
45. Mayra Diaz
46. Sofia Recalde
47. Sonia Vasquez
48. Stacy Williams
49. Tia Bell
50. Yolanda Ramirez

RDA Consultants

51. Aditi Das
52. Courtney Chapple
53. Paulina Hatfield

Ernst & Young Consultants

54. Jeff Blood

Appendix 3. All Public Comments Received

BHSA Three Year Integrated Plan 2026-2029

30-Day Public Comment Process - Public Comments Received

Substantive Comments[1]

Comments requesting a change to the plan received (as of 3/05/26)

1. **Comment – SUD Treatment Facility:** *(summarized below; see enclosure 1 for public comments received):*

   Formally object to the Behavioral Health Services Act Integrated Plan for Fiscal Years 2026-29 based on the inclusion of the proposed 69-bed facility at 101 N. El Camino Real, referenced on pages 108 and 125 of the plan as the proposed SUD Campus by BHRS contractor Horizon Services.

   - A 60-day extension of the public comment period, which would require voting against closing the comment period

   - Establishment of an Ad Hoc Subcommittee to engage stakeholders and analyze the site setting

   - Decoupling of 101 N. El Camino Real from the BHSA Integrated Plan for FY 2026-29

   - Identification of an alternative site that is not directly adjacent to schools, childcare centers, senior facilities, or dense residential neighborhoods

   - **Response:** BHRS acknowledges and appreciates the community's engagement and input regarding the proposed substance use disorder (SUD) treatment facility. The recent closure of the First Chance Sobering Station created a significant gap in local services, impacting approximately 2,400 community members who historically benefited from safe, effective, and timely access to care each year. Addressing this gap remains a priority for the County of San Mateo and BHRS.

     1. A required element of the BHSA Integrated Plan is to report to the state of any funding commitments specific to a BHCIP project. The County has committed funding to a proposed BHCIP project, the Horizon Project, so to remove mention of the project would result in the Integrated Plan submittal being inaccurate and incomplete.

        Page 118 generally states the following with no mention of site-specific plans: "SUD Treatment Facility – a proposal was submitted by a BHRS contracted provider, Horizons, with BHRS commitment of $2 million for land acquisition, funded through opioid settlement funds."

     2. Another aspect of the plan is to inform the state of all potential funding possibilities under the Plan. The county is committed to funding SUD treatment services. If we do not include language about committing funding to this type of project in the BHSA Plan, BHRS loses the opportunity to fund SUD treatment projects.

        Page 134 of the Integrated Plan will be amended to remove mention of the specific Horizon project and include only the general plan for new SUD services including; bringing SUD services to the Navigation Center, Mobile Methadone services and a Sobering Center.

     3. Our reporting of the horizon project in this BHSA Integrated Plan has no impact on whether Horizon receives approval by the state, or on the local level. Horizon Services remains subject to all required local jurisdictional reviews and community engagement processes, and state-level approvals prior to any implementation.

[1] MHSA legislation requires that the MHSA Three-Year Program and Expenditure Plan include a summary of any substantive public comments received (that may require a change to the plan) and if applicable, include recommended revisions to the plan.

2. **Comment – Health Ambassador Program** *(summarized below; see enclosure 2 for full comment):*

   Proposal: Formal Integration of Alcohol and Other Drug (AOD) Services into the Health Ambassador Program (HAP). We propose that the Health Ambassador Program be formally integrated into the BHSA Three-Year Plan strategies to expand outreach and connection to BHRS Alcohol and Other Drug (AOD) services.

   - **Response:** BHRS appreciates the proposal to formally integrate the Health Ambassador Program (HAP) into the BHSA Three-Year Integrated Plan strategies to strengthen outreach and connection to Alcohol and Other Drug (AOD) services. Strengthening outreach and connection to AOD services aligns with BHRS overall priorities to become a more integrated organization.

     HAP is administered through the Office of Diversity and Equity (ODE), which is encompassed within the existing Integrated Plan under ODE programs. ODE strategies are prioritized to address the statewide goals of (1) Access to Care and (2) Workforce Development. HAP will be explicitly added as a strategy contributing to the Access to Care priority area to further highlight its role in outreach and engagement—particularly for communities disproportionately affected by behavioral health disparities.

     Response to specific recommendations for HAP:

     - Provide expanded AOD education and training to Health Ambassadors.
       - This recommendation can be implemented at the program level, contingent upon available funding and staffing capacity.
     - Formally integrate HAP within DMC-ODS access and culturally grounded outreach strategies.
       - Currently ODE, which is inclusive of HAP, is represented under the Access to Care strategies, encompassing both mental health and substance use services (i.e., DMC-ODS).
         Page 29 of the Integrated Plan will be amended to explicitly add HAP as a strategy to strengthen culturally grounded substance use outreach efforts.
     - Include HAP within the new Early Intervention RFP framework as a proven community model.
       - Community-based organizations are encouraged to apply to the Request for Proposal (RFP) when it releases and can propose any community-defined practices like HAP, if they are able to meet the requirements for early intervention services, which include 1) culturally responsive and targeted outreach, 2) screening for Medi-Cal eligibility and linkages, and 3) Medi-Cal billable interventions.
     - Fund stipends and certification pathways for Ambassadors pursuing AOD credentials.
       - BHRS has a process in place for funding stipends and certification pathways. The Peer Support Specialist Certification is under the purview of the Office of Consumer & Family Affairs (OCFA), information regarding the requirements and roll out of these stipend and certification opportunities will be managed by the OCFA team.
     - Incorporate HAP impact metrics into BHSA access and equity indicators.
       - BHSA access and equity indicators are determined by the State and cannot be modified. However, specific programs can identify additional metrics to track progress and demonstrate impact within programmatic evaluations and reporting processes.

3. **Comment – Aging Caregivers:** I'd like to add a specific request to my comment letter dated February 24th regarding the proposed 3 year integrated plan. As it relates to my comments noted as item 1 on page two of my letter, where I state that there is a significant number of BHSA eligible disabled adult children

who are forced to live with aging parents due to the shortage of available PSH and Augmented Board & Care beds in our county, I'd like to request that the proposed Plan be amended to include a 'specific and codified pathway for DIRECT REFERRAL FOR URGENT PRIORITY RE-HOUSING of BHSA eligible adults currently residing with an aging parent(s)' in the following cases:

- one of the caregiving parents is diagnosed with a life threatening or severely impairing illness (ie. cancer, stroke, experiences a heart attack, dementia, or other serious illness) which undermines the parent's ability to continue to house and care for their adult child with an SMI. This should apply even in the case of two aging parents in the home as the caregiving focus of the second parent needs to shift by necessity to the ailing parent.
- the caregiving parent(s) is 70 years old or older.
- the caregiving parent is experiencing significant economic hardship and can no longer afford to provide housing, meals, medical and other services coordination for their adult child with SMI.
- the caregiving parent is moving and will no longer be able to provide housing and caregiving for his/her adult child with SMI.
- the caregiving parent no longer feels safe living with his/her adult child with SMI.
- All of the above scenarios warrant urgency and a 'priority need' for the re-housing of a disabled adult child with SMI for the health, safety, and welfare of all involved. Having a clear designated pathway for this in your PSH allocation and housing supports workflow is needed. Thank you for taking this additional comment into consideration.
    - **Response:** Thank you for the thoughtful and detailed comment and for elevating the needs of aging parents who are supporting adult children with serious mental illness (SMI). We agree that these caregiving situations can quickly become unsafe, unsustainable, and deeply distressing for everyone involved. Eligibility for BHSA-funded housing and related supports is governed by state definitions of homelessness, chronic homelessness, and at-risk of homelessness in the DHCS Behavioral Health Services Act (BHSA) County Policy Manual Appendix A, and our local policies must align with those criteria. Because BHSA eligibility criteria and allowable uses are set at the state level, creating a new, codified "direct referral for urgent priority re housing" category specifically for adults residing with aging parents would likely require state level policy changes. Within the existing framework, BHRS can work to clarify and communicate that adults with SMI who are in unsustainable family housing situations may qualify as at risk of homelessness and therefore be eligible for BHSA-funded housing supports when other criteria are met.

      Pages 35 of the Integrated Plan will be updated to include the overarching strategy to improve documentation and training for clinical staff as it relates to housing instability

4. **Comment – Children Ages 0-5**: Early Intervention (EI) is the only BRHS funding stream that currently includes ECMH services for the youngest children 0-5. The existing allocation is $8.0M annually across all BHRS funding sources for EI — covering the full 0–25 age range, not just young children. This makes dedicated funding for the 0–5 population extremely limited. A minimum of $2M annually should be dedicated through the RFP specifically to ECMH Early Intervention activities and services, enabling CBOs and nonprofits to continue serving children ages 0–5 and their caregivers. Explicit language protecting this population in the RFP is essential to ensure they are not absorbed into the broader 0–25 funding pool. This Matters because: • Over 60 clinicians have been trained currently in Child-Parent Psychotherapy (CPP) to serve this population in the county in partnership with F5, SMC BHRS and CYBHI funding. • F5SMC's 2024 Early Childhood Mental Health Landscape Scan identified significant barriers to access: eligibility

restrictions, logistical challenges, language access gaps, and high staff turnover disrupting continuity of care. • Early intervention is an inherently upstream strategy — addressing mental health needs in the 0–5 window mitigates longer-term health challenges and reduces inequitable outcomes. • Families in the county are already struggling to navigate the ECMH system, and current funding is insufficient to meet the need. Without explicit RFP language and a dedicated budget floor for children 0–5, this vulnerable population risks being deprioritized within a broader age range. Doubling the allocation to $2M annually is a targeted, evidence-informed investment in the county's youngest and most developmentally critical residents. We appreciate your partnership and consideration!

- **Response:** Thank you for your advocacy on behalf of our county's youngest children and their caregivers. We agree that early childhood mental health (ECMH) services and early intervention are critical, upstream investments that can reduce long-term inequities and improve outcomes across the lifespan. Under the Behavioral Health Services Act, our Early Intervention (EI) allocation for all ages is set at 51% of the BHSS allocation, and our county is currently meeting that required level. Within that constraint, EI funding must support the full 0–25 age range, which means we do not have unlimited flexibility to carve out large, fixed sub-allocations for specific age groups without impacting other EI priorities and services.

  We also recognize, as you highlight, that the 0–5 population has unique developmental needs, that families face significant barriers to accessing ECMH services, and that a trained workforce is already in place and should be sustained. While we may not be able to change the overall EI percentage requirement or commit to a specific dollar floor at this time, we can take concrete steps to protect and elevate ECMH within the RFP and implementation, such as including explicit language in the RFP that identifies children 0–5 and their caregivers as a focus population within EI and exploring opportunities to braid and align EI funds with other local and state funding streams to maximize support for ECMH services without duplicating or supplanting existing investments.

5. **Comment – Youth Strategies:**
   - Add to the comment above re: HAP Integrations — AOD >> Please explicitly include mention of the Health Ambassadors Program Youth (HAP-Y) program under ODE programming, too.
     - **Response:** The HAP-Y program was determined to end July 1, 2026 given Prop. 1 shifts of population-based prevention programs and funding to the State. In Spring 2025, BHRS notified all contracted providers of prevention programs that will sunset under Prop 1. Due to StarVista closure, the program ended August 1, 2025.
   - Page 7: I agree with the commenter regarding the need for an overarching mission and North Star. This also applies to the BHSA Transformation Journey. I request that -- the formation of a North Star is included as a strategy to effectively implement the BHSA Integration Plan, of which all strategies should align to and support. Additionally, as a holistic strategy, BHRS engage in a horizon scanning & foresight process to identify emerging trends, structural shifts to build resilience and mitigate against future shocks.
     - **Response:** BHRS has an updated Mission and Vision statements that will be added to Transformation Journey Roadmap referenced in the Integrated Plan (page 27)
   - Page 15/49: I asked a question at the February meeting and offered a directive comment for joint study sessions with the Juvenile Justice & Delinquency Prevention Commission. Please add that as an explicit strategy to improve cross-coordination, improve the care experience and service delivery.

- **Response:** This will be added as an overarching strategy to improve cross-sector coordination, in the Integrated Plan (page 50)

- Removal of Children from Home — Add Strategy. Page 55: In addition to Family Engagement, School-Based Services, Cross-Sector Coordination — add Youth Leadership, Engagement & Voice as a strategy and focus area to partner with Foster Advisory Group, BHC Youth Action Board and related youth-centered bodies to ensure decisions and services are centered in the needs, interests and current and future generations.
  - **Response:** This will be added as an overarching strategy to improve youth engagement, in the Integrated Plan (page 56)
- Add 1-2 youth seats (ages 12-24) to all steering committees and decision-making bodies to provide youth lived experience, voice and perspectives — same with Engagement at Schools + Social Connection
  - **Response:** This will be added to the overarching strategy to improve youth engagement, in the Integrated Plan (page 56). The specific recommendation can be implemented at the program level for each committee, contingent upon youth capacity to serve in various committees – BHRS committees include the Behavioral Health Commission committees, Lived Experience Education Workgroup, Housing Operations and Policy Committee, Tobacco Education Coalition, Overdose Prevention Coalition, the Diversity and Equity Council and 8 Health Equity Initiatives.

Public Comments and Questions

Question received via email/online form (as of 03/05/26)

- **Question**: I may have missed it, but I didn't hear any reference in the presentation to infant, early, or child mental health- only youth- which led me to wonder if there is a meaningful opportunity for the plan to address and prioritize the needs of this critical population. If I understand correctly, the only area that would support young children and ECMH is Early Intervention, although admittedly I remain a little confused about whether prevention needs show up at a county level and opportunities in that space. If in fact EI is the only area where ECMH could be addressed, I also noted that it looks like its also the smallest funding allocation by percentage with only 2.2% of the $380M over 3 years, which equals a little over $8M, or less than $2M a year to address all needs in the EI space, not just those of young children. Can you confirm if I have that correct?
    - **Response:** That is correct, Early Intervention (EI) is the BHSA category where early child mental health is being addressed. $8.4M is the **annual** allocation for EI across all BHRS funding sources. The EI Ages 0-25 RFP that was mentioned will include an opportunity for proposals to specifically serve the 0-5 population. Also, the current MHSA programs Early Childhood Community Team (ECCT) and Early Childhood Mental Health Consultation (ECMHC) will continue through BHSA.

      As for population-based prevention, BHRS continues to some population-based prevention work through other local and state funding like Opioid Settlement Funds and SAMHSA Substance Use Prevention grants. BHSA shifted local county prevention funding to the State. Prop. 1 allocates 4% of BHSA funding to the California Department of Public Health, you can learn more about that effort here: https://www.cdph.ca.gov/Programs/OPP/Pages/BHSA-Population-Based-Prevention-Program-Guide.aspx

      Locally, public health departments are required to develop Community Health Improvement Plans (CHIP) to address population-based strategies including behavioral health. BHRS continues to be involved in this effort led by our County Health, Public Health Policy and Planning. There is a CHIP Mental Health Work Group that is co-facilitated by Edith Cabuslay (BHRS) and Luci Latu (Taulama for Tongans). You can learn more about the work here: https://www.smcalltogetherbetter.org/tiles/index/display?alias=chip

- **Comment:** I am a 12 year old from San Mateo County and a Youth Mental Health Advocate Fellow with YLI. I appreciate that this plan focuses on youth mental health and social connection. Many kids my age struggle with stress, anxiety, and loneliness. I think one of the most important things adults can do is make sure young people have caring adults we can talk to and places where we feel safe asking for help. Places like schools and youth health centers create easy access points for kids to receive support. I hope the county will continue expanding school and community based mental health programs and youth spaces where students can connect and get support early. When kids get help early, it can prevent bigger problems later. Thank you for listening to youth voices.

- **Comment:** I am a youth advocate and young person in San Mateo County. I appreciate the programs described in the Children's System of Care section of the Behavioral Health Services and Supports (BHSS) plan. I encourage the County to include youth with lived experience in the design and implementation of these programs. Youth perspectives can help ensure services are accessible, welcoming, and effective for the young people they are meant to support.

- **Comment:** I am the mother of a seriously mentally ill son. Has been sick since a teenager and is now 41. He is now homeless in one of the wealthiest counties in the country! Living by the railroad tracks and in parks. We have run out of ways to help him. Thank you.

- **Comment:** Please continue to include early childhood mental health, specifically for children ages 0-5 and their families, in your focus areas. Investments in this age group have very high positive impacts on future needs of children as they grow, both in terms of mental health needs and other systems.

- **Comment:** On behalf of the Board of Directors and leadership of the National Alliance on Mental Illness San Mateo County (NAMI SMC), thank you for the opportunity to comment on the BHSA Three-Year Integrated Plan.
  We commend the County for its community engagement process and its stated commitment to access, equity, and cross-system coordination. To fully meet the intent of BHSA and the documented needs in this plan, we urge strengthened action in three areas: permanent supportive housing, diversion from jail to clinical care, and prevention through public education.

  1. Permanent Supportive Housing: Set Measurable Production Targets
     The data in the plan confirm significant housing instability among adults served by Behavioral Health and Recovery Services. We urge the County to establish a clear, time-bound Permanent Supportive Housing (PSH) production target aligned with the documented need among individuals with serious mental illness (SMI). Addressing behavioral health-related homelessness requires explicit production goals, coordinated financing, and cross-system accountability. We also commend leveraging ICD-10 Z-codes, particularly those related to housing instability, caregiver strain, and social vulnerability, to quantify the number of dependent adult children whose aging parents are supporting them. This "hidden precarity" should inform long-term housing and service planning.
     Every unhoused resident should have a clear pathway to housing paired with timely access to medical, substance use, and psychiatric care.

  2. Behavioral Health Care in Clinical Settings - Not County Jails
  Nearly half of individuals booked into County jail have a mental illness. Jail is not a treatment facility. Individuals experiencing psychosis, suicidal crisis, or acute substance use disorder require clinical stabilization, not incarceration. Recent in-custody deaths, including suicides and overdoses, underscore the urgency of reform. We urge the County to implement structural changes centered on diversion and clinical care:

  Immediate Diversion Infrastructure
  - Rapid transfer to hospitals for individuals in acute behavioral health crisis
  - Establishment of a 24-hour crisis triage and drop-in center
  - Clear booking protocols that prioritize clinical placement for stabilization

  Substance Use & Detox Reform
  - Detoxification in medically supervised hospital or specialty units, not correctional housing
  - Strengthened overdose prevention measures

  In-Custody Standards (When Custody Is Unavoidable)
  - Expanded psychiatric services and therapeutic programming
  - Peer support programming

- Daily access to outdoor space and meaningful exercise
- Standard of care suicide prevention staffing and infrastructure
- Medication management aligned with physician orders
- Comprehensive discharge planning with housing and community-based provider linkage

Public safety includes protecting individuals with SMI from preventable harm while in custody. Humane, clinically appropriate care is both a moral obligation and sound public policy.

3. Early Intervention: Partner with NAMI SMC
Untreated mental illness continues to drive avoidable crisis presentations, homelessness, and justice involvement. Prevention must be a core investment strategy.
NAMI SMC is uniquely positioned to partner with the County to deliver culturally responsive mental health education to high school students, families, and community members.

We recommend the County:
1. Invest in expanded public education delivered in partnership with NAMI SMC.
2. Formalize school- and community-based early identification efforts through NAMI SMC programming.
3. Leverage NAMI SMC's trusted community presence to reach historically underserved Latinx and Asian communities identified in the County's disparities analysis.

Prevention reduces downstream crisis costs and aligns directly with BHSA's equity and public health goals.

Closing
We respectfully urge the County to:
- Establish measurable, time-bound Permanent Supportive Housing production targets
- Build robust diversion infrastructure so individuals in crisis receive clinical care, not jail
- Invest in prevention and formal partnership with NAMI SMC to expand public education and early identification

These actions will materially strengthen the BHSA Three-Year Plan and ensure residents with serious mental illness have a clear pathway to housing, treatment, and recovery.
NAMI San Mateo County stands ready to partner in implementation and looks forward to participating on March 4.

Thank you for the opportunity to provide comments for the record.

- **Comment:** My son has Schizophrenia. He once held a loaded shotgun to deter the Mexican mafia in front of our house. This was our first notice of his psychosis. He is on meds but goes off them often due to weight gain. We have a good support group and stay on top of this. Please keep MHSA supported!

Permanent Housing for Adults with SMI and Aging Caregivers

- **Comment:** Loneliness is at the root of suffering for most adults with serious mental illness. This is what I know as a mother and as a facilitator of NAMI parent support groups.
  My name is Joan Dower. I'm a resident of Pacifica. I am also the loving mother of 54 year old son who has been struggling with a serious mental illness for decades. I have been his sole support and caretaker as a single parent. Going forward, I see that he will always need assistance and likely always will have an

extremely low income (from Social Security). I am 75 and I worry about where he can live and who will help him when I am gone or if I become incapacitated, because there is no one else to take over.

Over the years, my son has been placed in various living situations, but none with adequate onsite support to help him learn the life skills or to have the encouragement or socialization he would need to be able to manage more independently. The most significant unmet need for my son has been for companionship. It's when he gets lonely that he has difficulty. Helping him to know he is not alone and that he matters continues to be my role. He adheres to a prescribed medication schedule, and his condition is stabilized, but no doctor or medicine can meet his fundamental need for human connection.

Currently my son is living in an apartment in Pacifica managed by MidPen. There he's been told that it's best to have all the residents of the building "keep to themselves", so he doesn't communicate with anyone else who lives there. So that he doesn't get lonely, and so that he can get the help he needs, I pick him up at 11:30 most days and bring him to my home for lunch and watching TV. Sometimes he enjoys helping me with simple tasks around the house. I take him shopping for groceries, things he can heat in a microwave. He would not be able to do this by himself, or to use his phone to order food, and of course, he doesn't have a car. I take him back to his apartment in the afternoon.

He says he would like to live in an apartment where there is someone to talk with and to rely on in case there is some kind of problem. This is my hope for any new supportive living we build or operate in San Mateo County: always include the essential onsite, 24/7, personal support – not just property management, but relationship and experiences of community for the residents. Please don't let our beloved disabled adult kids be all alone.

- **Comment:** A Burlingame resident of 31 years, and the parent of a 47-year-old adult child with schizophrenia, I am writing to advocate for affordable supportive housing. Since my son's discharge from Cordilleras Mental Health Rehabilitation Center last year, he has resided in a San Mateo board and care home. Though he likes and is grateful for his present living situation, he dreams of having his own apartment. An active member of Aspire Clubhouse, a supportive community structured on a work-ordered day, he is working hard to prove that he can handle the responsibility of a home, and knows he will need help once there. He has clear ideas about the services he will require, including medication support and on-site group meetings. As the mother of a challenged and resilient individual who continues to hope and plan for his future, I am concerned that his disabilities place him at high risk for an uncertain housing future, including homelessness, or having to live in substandard settings or isolated in an apartment without easy-to-access help for his daily needs. It concerns me that he may be in unsupported housing when i am no longer to help; many others are in this position. It is good to think that he will have access to independent living spaces in communities where he can continue to thrive. I also hope that the new impetus for supportive housing includes assistance for board and care homes, which are often crucial transitional residences for the mentally ill moving back into the community and which may need to become permanent homes for those who need more intensive support, In closing I would reiterate my request for building supportive, affordable housing for the mentally ill and similarly challenged individuals. Thank you for your time and attention in this critical matter.

- **Comment:** We are aging parents 81 and 70 supporting a 50 year old son. We have been caring for him for over 23 years. I am a member of SMC/NAMI and a supporter of Solution for Supportive Homes(S4SH). My son is part of the invisible population who will be best supported by single style apartment with onsite support services. My child has many talents and skills worthy of living a dignified life which include

excellent writing and problem solving skills. There are hundreds of other adult children living at home with aging parents who need to transition these adult children to a safe living environment. Please include this invisible population in this plan so that they don't become homeless

- **Comment:** Supported housing for Mental health adult children with On Site support.

- **Comment:** “What will happen to my adult children with serious mental illness when I’m gone?” I am a 65 year old parent supporting a son and daughter who live with a diagnosed and disabling mental health disorders. I have been caring for them for 25 years. I am a volunteer for NAMI-SMC and supporter of Solutions for Supportive Homes. I am on the board of Mateo Lodge. I lead support groups. I am a psychiatric nurse. My children are part of the “Invisible Population” who need to be counted and will need a place to live and be cared for. The support that I provide includes financial support, a home, health care costs for one, social and emotional support, etc). The most appropriate housing for my son would be Board and Care or other full-service Residential Support Facility. And for my daughter Single style apartment with on-site supportive services and community engagement
  As I age, I cannot be relied upon to continue to house and provide supportive housing any longer. My children have many skills and talents like artistic and other creative abilities, interest in computers, music, engagement with nature and pets, empathy for others. One of my children can work only very part time and occasionally due to other invisible illnesses. The other cannot due to the severity of symptoms. They are isolated and worthy of living a meaningful, safe and dignified life. They require assistance navigating this complex world. There are hundreds of other adult children living with parents or family members who are at great risk of homelessness through no fault of their own. Please include funding and a clear pathway of housing supports in this historic and transformative Plan. Housing alone is not enough for my adult children. It must provide supports and keep them safe. Count them in.

- **Comment:** My son was diagnosed with schizophrenia at 19 and is now 35. He never finished high school and has never really held a job. Thankfully his psychosis is well controlled on Clozapine but I take care of him financially and he lives in his childhood bedroom. There are lots of us parents who are doing this but as we age our adult children will need to transition to other accommodations and care. It would be wonderful if the State could provide humane housing for people with severe mental illness so that they do not become homeless. Please also survey how many parents like me are out there.

- **Comment:** For many living with disabling serious mental illness, permanent supportive housing needs to be considered a fundamental component of treatment. No one can successfully engage in treatment without this fundamental need being met. But I also appreciate all of the improvements being proposed - they are all desperately needed and long overdue. Thank you for your attention.

- **Comment:** Public Health has always identified the role of prevention as one of the most economical and effective interventions available as healthcare providers. To our credit, we identified groups at high risk for homelessness and created programs to assist them with housing: veterans, those leaving incarceration, families in abusive relationships, young people leaving foster care. However, we have failed to identify an uncounted and invisible population: those with mental health conditions unable to care for themselves who live with aging family members. It is one of the greatest fears of aging parents who ask, "What will happen to my son or daughter when I can no longer care for them?" The death of a caregiver is one reason

why those with mental illness spiral into homelessness. We have the ability to identify these families and intervene, and we could save money and lives if we choose to do so. The providers already have access to a tool to record housing status: ICD Z Codes. Consider a pilot of those at risk, and assist in a housing transition before housing destabilization occurs with a caregiver's deteriorating health. ACTIONS; 1. Start data collection. 2. Initiate a pilot. Some families are on the edge of a traumatic catastrophe. We can avert these traumas with preventive measures now. Please intervene.

- **Comment:** My name is Carolyn Shepard. I am the President of Solutions for Supportive Homes, a non-profit organization representing parents and family members who are supporting their adult children with mental health challenges.
  The overriding questions that our parents ask are “Where will our adult children live and who will take care of them when we are gone?”

  Our list of supporters has grown over the years. Today we have about 65 parents and families who live in San Mateo County and the list continues to grow. In addition, we have families who live in Santa Clara County and Alameda County who have joined our group.

  These families represent a variety of situations. Most are supporting their adult children at home. Some families have children in transitional situations which are not permanent and may or may not require some level of parental support. And sadly, we now have a handful of parents whose children are homeless with parents providing some food and money.

  From 9/2022 - 5/2025, we collaborated with the University of San Francisco’s Doctor of Nursing Practice Program. According to the research done by Dr. Kristin Moser, our adult children are a population at high-risk of homelessness. In November of 2024, she presented a tool to the Behavioral Health Commission called the z-code found in the EPIC computer system where the housing situation of clients can be documented, including those who live at home, supported by parents. It is the aging parents who are most at risk of passing away before their adult child has a permanent place to live with supportive care.
  *(Following this comment, I have included the location of Kristin Moser’s “Invisible Population” Project. Her Policy Brief is in the smchealth files.)

  Currently, our adult children living at home are not counted as a population in need of permanent supportive housing. In contrast, as reported by the GGRC for the fiscal year 2023-2024, San Mateo County had approximately 9,066 adults with I/DD who lived at home with families or relatives. This number represents 4 out of 5 adults with I/DD. These numbers are documented in both the County and cities’ Housing Elements Plans as part of their Extremely Low-Income population requiring permanent supportive housing. In addition, their ELI populations include those with mental health issues reported from the One Point in Time homeless count. However, the adult children with SMI living with families are not part of the planning tools because there is no data on their numbers.

  We understand the serious need for housing our homeless population who live on the streets with mental health issues. They need to be housed with the support that they need to stay housed and live safely and securely. The BHSA Plan demonstrates collaboration with various housing and service providers to address the needs of this population.

  In her presentation to the BHC on February 4th, I was pleased to hear Doris Estremera mention the z-codes written on page 35, under At-Risk of Homelessness, to begin the documentation of the number of at-risk adults supported by parents as part of this 3-year Plan. As our parents are aging, reaching past 60 and into

their 70's and 80's, they are feeling a sense of urgency. Time is running out as they continue their jobs as caregivers. Our younger parents are equally worried about the future for their adult children with SMI.

To adequately address the need, our adult children need to be counted. Some can live more independently in permanent supportive housing units. Others will need a stepped-up residential situation where medication can be administered and monitored by support staff.

The job ahead is challenging. It is our hope that the BHSA Plan can better address the needs of ALL our mentally ill in San Mateo County, including those who have been historically invisible and uncounted.

- **Comment**: Thank you for seeking feedback on your 3 year BHSA plan. I'm a 63 year old family member (mother, sister and aunt) for whom SMI has played a prominent role for most of my adult life. I also have the good fortune of having been born a realistic and pragmatic optimist. I think I speak for my entire extended family in saying that 'enthusiastic' does not begin to describe how much we welcome the goals, treatments and newly required housing supports that the BHSA aims to usher in for those living with SMI. Since the time my lived experience with SMI began, in the mid 70's, my family has lived through decades of inadequate resources for our highly vulnerable and severely disabled family members, as has been the norm across California and perhaps beyond. Indeed, the burden of support and survival has rested wholly and squarely on the shoulders of those living with these disabling illnesses, along with their families (when possible), for far too long resulting in intense family-wide stress, despair, economic hardship, and the inability to keep loved ones safe and consistently cared for in conditions that promote health and wellbeing for all. But I suspect this is not news to those of you in the field.
  The year 2004 and the MHSA brought some relief. And the strengthening of the Americans with Disabilities Act for mental health conditions that was signed into law in 2009 layered on a bit more, followed by still more key protections in the Affordable Care Act in 2014. Yet despite these past laws, too many of our most vulnerable family members with serious mental illness continued to fall through the cracks, or just walk away from what felt like a tone deaf system of care.

  But the BHSA?… now this has the potential to really fix things, and to right some of the the most significant and longstanding injustices that have existed throughout my lifetime, at least here in California.

  I have intimate, decades long experiences with Bipolar-1 and Schizoaffective disorders, in addition to Anorexia Nervosa, OCD and episodic anxiety and depression. This is where pragmatism and optimism have served me well: to channel what could have easily become 'swamped overwhelm' into determined supportive action. But, I'm not alone. There are lots of other supportive family members like me out there.

  So, yes. I support your Integrated Plan. Yet, while I found the Plan very detailed in a prescriptive way, perhaps due to the State's survey format, it lacks an over-arching mission statement. And it would be useful to include this sort of 'North Star' principle against which all services provided could be evaluated on a performance level. Something like this:

  > "San Mateo County views housing and ongoing robust well-care as core components of treatment and recovery for people with serious mental illness and/or substance use disorders. The strategy centers on the idea that maintaining stable housing and a healthy lifestyle are the foundation which enables behavioral health treatment to be effective, and vice versa. The overall goal is to link people quickly to whichever piece of this multi-pillared health structure is missing or insufficient so they can move forward to lead healthy productive lives."

  My 63 years have made it very clear to me that adversity is not the problem. It's how we respond to adversity that decides the longer term outcome. That said, SMI's are SIGNIFICANT disabilities because these conditions, when under-treated, disrupt and distort perception and cognition impairing one's ability

to consistently respond or act in one's own best interest more than ANY other health condition. Therefore, special — even extraordinary — supports like: permanent supportive housing, robust and comprehensive well-care, and assistance with treatment planning, administration, and coordination are not only essential health services for those living with SMI, we owe it to this community if we hope to even approximate the claim of being an equitable society. So, here are my short takes on the Plan:

1. I think you are grossly under-estimating the need for permanent supportive housing (PSH) as there are many BHSA eligible individuals currently forced to live with aging parents (likely in the thousands county-wide!) because there are not enough PSH units and Augmented Board & Care beds in our county. So in reference to Table 6 on Page 10: the numbers in this chart do not accurately point to the actual immediate need for quality PSH units. And given these 'currently invisible' disabled adult children are between 30 and 60 years old, it's not difficult to infer that their aging caregiving parent(s) are between 60 and 90 years old. Ignoring this urgent re-housing need is unwise to say the least.

2. More funding needs to go to Aspire House, Heart & Soul, and similar programming so that social and vocational opportunities can be expanded for the SMI community. Places like these bring purpose and joy into the lives of folks living with SMI, and this is a vital human need.

3. Having had direct experience with a loved one in the criminal justice system, I can attest with certainty that it is imperative to provide a structured and comprehensive rehabilitative treatment step-down program for all individuals with an SMI who are leaving jail. This is an especially vulnerable time for these individuals. The mere fact that they were in jail is proof that they were inadequately supported in the past. Having an SMI is not a criminal offense and we need to stop treating it like it is.

In closing, my family members living with SMI are kind, empathetic, intelligent, creative, quality work oriented, skilled, warm, generous and helpful people. I love them. And it pains me to have seen how society and many of our revered institutions have treated them over the years — rife with discrimination and misplaced judgement. But things ARE getting better. And the BHSA, if well implemented with heart-felt integrity, truly has the potential to make things right.

- **Comment:** I am a 75 year old single mom who is an **advocate for URGENT permanent supportive housing for the "invisible population"** which includes my 48 year old daughter.
  At the age of 20, my child was diagnosed with severe bipolar illness which has affected every aspect of her life and mine as well.

  Fortunately she has never had drug or alcohol issues. She has never been involved with the criminal justice system. She takes her prescribed meds consistently. She is a caring, loving, extremely intelligent woman when her illness is not controlling her.

  My daughter has been in a constant state of mental as well as physical decline for the past eight years. Her many physical conditions require my care and support. There is no one else to provide for her. We have only each other. Her emotional and physical needs have significantly increased which include but not limited to major mobility issues resulting from her morbid obesity which is directly related to her taking prescription psychiatric medications over the past 28 years.

  One aspect of my care is medication management which involves:
    - scheduling psychiatric as well as medical appointments
    - accompanying her to all appointments
    - picking up medications at the pharmacy
    - filling up her pill containers
    - supervising her taking all medical and psychiatric medications at the right times

- making sure that she is taking the correct dose of each medication
- being alert for side effects

During her manic episodes, I often am called upon to communicate daily with her psychiatrist. At these times I am forced to rely on friends to do my grocery shopping, pick up medications at the pharmacy, and perform any other tasks that require my leaving my daughter alone since I must be with her 24/7. In addition, I work with her psychiatrist continually to develop a plan to decrease the likelihood that she will be admitted to a psychiatric hospital.

My daughter's experiences with these hospitals have been far below adequate. For example, when she was hospitalized in October, 2025, the clothes that she was wearing were "lost" and the clothes that I brought from home were "accidentally thrown away". For two weeks she wrapped herself in a bedspread.

THIS WAS COMPLETELY DEMORALIZING AND UNACCEPTABLE!

The discharge plan was for her to be transferred to a transitional residential care facility. However, upon arriving at the facility, she was denied admission because of her physical disabilities. Apparently the staff at the psychiatric hospital failed to communicate that my daughter requires a bariatric walker and is unable to climb stairs. The residential care facility sent her home in an Uber! She had no phone, no keys, no money, and no one was home to receive her as I was not notified the facility would be sending her home. Clearly there was little if any communication between the hospital, the residential facility, and ME! THIS WAS GROSS NEGLIGENCE OF THE WORST MAGNITUDE!

If I dropped dead tomorrow or became incapacitated and required care, who would be there to care for my adult child? Who would be the "me" for my daughter? She will require Permanent Supportive Housing and it doesn't exist! SHE IS WORTHY OF LIVING A MEANINGFUL, SAFE, AND DIGNIFIED LIFE!

Who will be her case manager for her physical and emotional needs?
Who will manage her housing needs?
Who will be responsible for her medication management?
Who will be there to coordinate care with her psychiatrist when she has manic episodes?
Who will provide food and meal preparation?
Who will provide clothing?
Who will provide money management?
Who will provide for her physical needs?
WHO WILL BE HER ADVOCATE?
She requires a housing situation with 24/7 qualified on-site staff able to meet her psychiatric, emotional and medical needs.

Clearly she is at high risk for homelessness. I AM HER ONLY CARE GIVER. WITHOUT ME, SHE HAS NO ONE. My daughter and I are terrified about what will happen to her when I die or are unable to care for her. It is imperativ to provide supportive housing for a very vulnerable invisible population.

There is a tsunami of aging parents that will no longer be able to care for their adult children.

Thank you for your consideration to this very dire issue.

- **Comment:** Supportive Housing for my daughter is my top priority. I am a 75 year old single mother and my daughter is 29 years old. My health is fragile, as I have blood clots, a heart condition, chronic obstructive, pulmonary artery disease (COPD), and severe arthritis.
My daughter is not able to work full-time due to a serious back injury and she suffers from diagnosed clinical depression.

She has always lived with me. On my retirement income I supply her with housing, food, medicine, and clothing. She will require some form independent housing situation that would have supportive services such as food, clothing, housing, health management and financial management. She enjoys music, art, and animal therapy.

My daughter needs permanent supportive housing. When I die, my daughter could be homeless and become a financial burden to the county.

My family members are aging and not able to provide housing or meet her other needs.

Thank you for your thoughtful consideration of this urgent matter.

- **Comment:** I am a 66 year old parent supporting a 31 year old son who lives with schizophrenia. I am a member of NAMI-SMC and supporter of Solutions for Supportive Homes. My son is part of the "Invisible Population" who needs a place to live and be cared for.
  For the last 18 months my son has been living in his inoperable car in a parking lot in Half Moon Bay. He cannot live effectively in housing without support. I try to see him every day that I am in town. Because he does not have awareness of his condition he has refused treatment and medication. Currently, I am his only meaningful connection and source of emotional support.
  The most appropriate housing for my son/daughter would be a single style apartment with full-time on-site support. He could not live effectively without this support.

  Like much of this population, he is very intelligent, sensitive and sweet. Please help me. The longer he remains homeless, the further he descends into his psychosis. I am so afraid that if he remains unsupported much longer, I could lose him forever.

- **Comment:** I am a concerned parent and advocate for finding housing for those who require more supportive care with their living situation due to severe mental illness. My son has been living with bipolar disorder since 2006 and has been homeless three times due to his lack of insight and inability to care for himself. He has been caught in a societal situation that makes it difficult to find housing that fits his mental health needs. Care for those with mental illness was deregulated in the 1980's and necessary federal funding was repealed. Infrastructure to help that population was never really replaced by states. The burden of care generally fell on members for financial and social support. My family supports 100 percent of my son's needs including food, clothing, medical care, and housing. In theory, he could get donated clothes and food from food banks, but housing must be paid for by someone.

  My son as well as our family both feel this burden every day. He is not a good candidate for many board and care facilities because his needs will not be adequately met. Staff typically care for older residents that have dementia or cognitive impairment from a stroke, not younger clients diagnosed with severe mental illness.

  I fully support housing that can provide a supportive atmosphere that encourages growth in all areas to provide a meaningful life. These solutions are possible when we make this "invisible population" a priority. This can also assist with decreasing homeless rates in California for those who are at greater risk through no fault of their own.

  Thank you for your consideration of the proposal.

- **Comment:** I currently live in Santa Clara County, but because my husband has Parkinson's Disease and we live in a two-story house, we may relocate to San Mateo County in the future. This is why I am submitting a

comment on the proposed SMC BHSA 3-Year Integrated Plan. I currently serve on the Santa Clara County BHSA Stakeholders Advisory Committee and submit this comment based on my lived experience as a family caregiver.

For over ten years, my husband (age 67) and I (age 62) have been caring at home for our 32-year-old son who has schizophrenia - a brain disease, not a behavioral problem. We have both ended our careers prematurely and made significant sacrifices—we cannot leave our son alone for extended periods and therefore do not take vacations together—to keep him safe and well-cared for within the constraints of a fragmented mental health system.

Our son now has cognitive challenges; this is common among individuals with schizophrenia. Therefore, we provide 24/7 support for all tasks that require executive functioning skills including medication management, financial and benefits management, shopping, cooking, cleaning, transportation, crisis intervention, appointment coordination, and social/emotional support. But where will our son live after we pass away, and who will care for him? THERE IS A CRITICAL GAP IN CARE. California already has a proven model for supporting individuals with cognitive challenges: and it is through the Regional Centers. I believe that young adults like my son, who became disabled a little later in life (not at birth), deserve access to the same level of benefits and services that Regional Center beneficiaries receive.

While my husband and I are still alive and capable, we could facilitate our son's transition to a quality home with 24/7 care provided by qualified, compassionate people whom our son could learn to trust. This could be an appropriate group home or supportive housing with 24/7 care and community integration - my son has explicitly stated that he does not want to live alone. Without this support, my son is AT RISK FOR HOMELESSNESS. When he is lucid, he even asks me, "Where will I live when you die, Mom?"

Do California counties even track this INVISIBLE POPULATION: adult children with serious mental illness (SMI) living in their childhood bedrooms, cared for by their AGING parents? What happens when these parents can no longer provide support? This is a LOOMING CRISIS in which vulnerable adults could face homelessness or lose vital structure and stability. I urge the county to gather data on the percentage of adults with SMI who live at home with aging parents or other family caregivers. Is this statistic currently tracked, or could it be derived from existing sources such as BHSD client records, Medi-Cal claims, or local survey data? Understanding the scope of this population is essential for adequate planning.

Parents in this situation find advocacy nearly impossible as they are already overwhelmed by daily caregiving responsibilities. There is an URGENT need for formal succession planning and expanded housing options—such as quality supervised group living environments—for individuals who cannot live independently and have relied entirely on family care throughout their lives.

Please include a clear pathway of housing support for people like my son in this historic and transformative plan.

- **Comment:** I live in San Mateo County in the unincorporated area of Ladera.

  I write to express my support that funds and efforts be directed to finding permanent supportive housing for those living with disabling serious mental illness ("SMI"). No one can successfully engage in treatment without this fundamental need being met.

- **Comment:**

  To the Behavioral Health Commission,

  The parent of an adult child with schizophrenia, I submitted my comments regarding the BHSA three year plan via the survey form provided on your website. However, I neglected to mention my continued support for institutions such as Cordilleras Mental Health Rehab Center (MHRC) where my son has

received such good care over the years, Most recently he emerged from a period of approximately 5 years on the third floor and then Sage House, largely due to Covid and his challenging condition, a new person. The stabilization achieved after long term care and fine tuning of medication led to his ability to successfully live in the community. He now resides in a board and care, takes the bus daily, participates most week days in a clubhouse of his peers, visits our home regularly to play music, manages a phone and a wallet, takes himself to medical appointments when he needs to, and basically comports himself as a responsible member of the community. I am very proud of him. If not for the hard work of Cordilleras staff, the continuity of care and comfort of familiar and safe surroundings at the MHRC, and his own dedication to improving his life, i wonder if he would be where he is now. Please include more such facilities where people can have a solid period of stabilization before they must take on the difficulties of living in the community.

BHC meeting (3/4/26), vote to close public comment period on 3/6/2026 and public hearing.

Members of the Public – Comments/Questions

- **Comment:** Ensure that youth voice is included in shaping youth BH and SUD services in the plan.

- **Comment (translated from Spanish to English):** Good afternoon and thank you for the opportunity to comment on the BHSA Three-Year Integrated Plan. My name is Lourdes Briseno and Catalina Maya Martinez and we are speaking as members of the BHRS Health Ambassador Program.

  Health Ambassadors are 106 community leaders with lived experience and behavioral health education. We serve as a bridge between the community and BHRS services, helping residents understand how to access care and reducing stigma around mental health and substance use.

  We respectfully request the formal integration of Alcohol and Other Drug services into the Health Ambassador Program while maintaining HAP within the Office of Diversity and Equity.

  Remaining in ODE is critical because it allows Ambassadors to continue learning and practicing cultural humility, trauma-informed care, equity, and inclusive community engagement. The leadership of the ODE director, with clinical expertise, together with the program coordinator's experience in communication and whole-person care, has elevated HAP into a model for system improvement.

  Ambassadors collaborate across youth, adult, and older adult programs and help strengthen community trust in the behavioral health system.

Our impact is measurable. During the pandemic, Ambassadors produced public service announcements in multiple languages, worked in COVID vaccination clinics, and helped connect families with behavioral health information. We also hosted four Facebook Live events reaching more than 15,000 people, according to County communications.

In 2025, Ambassadors delivered 30 “Know the Signs” suicide prevention workshops in Spanish, reaching 390 families across nine cities in the county. We also conduct test ACCESS calls to help ensure the County meets state requirements for timely connection to care.

Today, Ambassadors are participating in the BHSA planning process and providing public comment in Spanish, which is another example of system change. Some Ambassadors now serve on County commissions and others have entered the behavioral health workforce.

The Health Ambassador Program builds community trust, strengthens prevention, and serves as a workforce pipeline into behavioral health.

We respectfully ask that the Health Ambassador Program remain in the Office of Diversity and Equity and that AOD services be integrated into the program, and that HAP be recognized in the BHSA Plan as the BHRS trusted bridge between the community and access to care, and as a workforce pipeline into behavioral health.

- **Comment:** Pending legislation SB1600 would prohibit facilities like the Horizon substance use treatment facility within 1000 feet of a school. It seems reasonable that county should pause to see how this plays out. The sobering and detox components of the facility raise the greatest concern given promites to schools, daycares and senior housing. Please remove these components from the site.

- **Comment:** Horizon facility is close to school and daycares, part of residential area that is already congested, and there is no parking. Reconsider location.

- **Comment:** Location and scale is a mismatch. No community engagement. Please extend public comment from 60 days. Remove from BHSA plan.

- **Comment:** I oppose the site location due to proximity of the Horizon facility due to location to schools and retirement centers. Proposed site is near a walking path, a substance use facility would change the dynamic of the community and cause a safety risk.

- **Comment:** Located only one block from downtown San Mateo, heart and soul of the city. The area currently feels safe and that may change with addicted and mentally ill patients of detox center would make it feel unsafe.

- **Comment:** Extend public comment period to allow for further public education, comment and engagement on this issue.

- **Comment:** There is always resistance to these facilities in neighborhoods. They don’t want them in their neighborhoods. The community is worked up about this because we didn’t know about it, haven’t had enough time to learn about it, and we owe the community a chance to get our questions answered.

- **Comment:** I have a brother that suffered from mental health and addiction issues. Some days he was fine, other days it could be scary. Given unpredictable nature of these behaviors and triggers, it doesn't make sense to look at a facility of this type in a location near schools, daycares and senior centers.

- **Comment:** I strongly oppose the Horizon facility. I have a 7-year old that attends the elementary shcool a half mile away. It is surrounded by multiple schools and elder care facilities. The lot itself is small, less than 0.5 acres, roughly the size of 3 single family homes. Discharging individuals for these short-term voluntary holds directly into this pedestrian gateway creates an unacceptable safety risk.

- **Comment:** We recognize the importance of the integrated plan and these kind of facilities. However, the size of the proejct requires a clear transparent framework with consideration for the safety of children that are less than a thousand feet from the proposed location. There is a gap between the proposal and community's understanding of its impact. We understand pressures of Prop 1 timelines, but urgency is not a substitute for transparency. Moving forward without meaningful engagement with neighbors undermines the process.

- **Comment:** I have 3 kids that attend the Day School. I support expanding mental health and addiction treatment services in the county, but I am deeply troubled by the lack of transparency surrounding the Horizon project at El Cerrito, particularly given its sensitive receptors such as children and seniors. BHCIP requires that we run a transparent process. The applicant has to say that they have run an engagement process in order to be considered launch ready, and yet County funding and the grant application were approved and submitted to the State in October of last year. The County committed $2Mto this project in October. The neighborhood, schools and churches were not notified until February. Why? That's not community engagement. Moving forward without critical engagement erodes trust.

- **Comment:** Please grant a 60-day extension. I am supportive of mental health facilities and support services. Lack of trust and community engagement is our biggest challenge here, so I'd like you to vote to extend the comment period and separate the BHSA plan from this particular site location. Prop 1 funding is not site-specific, so you can approve the plan and find another site that would be more appropriate based on comments that other residents have given.

- **Comment:** I am head of school at Epsicopal Day School. Our school is grounded in values of compassion, inclusion and service. We support expanding mental health and recovery services in our county, but a facility of this scale and intensity deserves community conversation. Our campus is intentionally open. We do not have fates and fences. Please extend the public comment period and remove the Horizon facility from the plan so a thoughtful, transparent process can occur.

- **Comment:** I represent over 200 residents in the neighborhood where this project is planned. I request that you decouple this from the plan for lack of transparency and lack of public process engagement. If this is the right project in the right place, then transparency will prove it.

- **Comment:** Individuals struggling with behavioral health issues and drug dependency require treatment environmnets that prioritize safety, privacy and therapeutic containment. Placing detox services in a highly visible downtown location may inadvertently increase stigma, compromise confidentiality, and expose patients to unnecessary external triggers.

- **Comment:** Agree with everything that has been said. I'm disappointed in the lack of transparency that has occurred, very disappointed in the leadership of County and State. This is a classic example of perfect service, wrong location. Please do not push this forward.

- **Comment:** The County communicated with Councilmember Nash to let her know that we will share a Horizon FAQ and have a meeting on March 24th in the San Mateo Library.

- **Comment:** I strongly oppose this. I i believe this is the wrong location. None of us were notified. I can't imagine having a rehab center in a residential neighborhood, near a school, in that congested area. There are so many vacant buildings around here. Why did they close down the old one? Can we build on that?

- **Comment:** The Horizon location is close to many young children and seniors. A more appropriate location would be in area of warehouses or office buildings, such as east of Highway 101. The size of the facility is also a problem. The Horizon Detox Center on Palm Ave needed police resposne 33 times in 2025, and that facility only have 17 beds. This facility would have 69 beds.

- **Comment:** I am a former emplyee of the sobering station we had with StarVista. The multiple service bilding in South City is vacant, and it's right by Kaiser. That would be a great place.

- **Comment:** Wrong place. Horizon does not care about children. If they did, they wouldn't put their facility near all these schools.

- **Comment:** I have close family members who have benefited from these services, and I support them. I attended Zoom call led by Supervisor Corzo, and it wasn't community outreach. It was an ad campagin for Horizon. No questions were taken; no follow-ups were available. This location poses a safety risk. If you cannot separate this approval from the entire plan, then I suggest you wait until all our questions are answered before you submit the plan.
- **Comment:** I am a mother of a first grader at Episcopal Day school He and his classmates play on the open lawn that is one block away from the proposed site. It makes zero sense for facility of this size to be located than 1,000 ft away from schools, daycares and senior centers. It is disgraceful that community members have not been engaged. My understanding is that the county needs to provide a letter of support for the application. If it hasn't yet been submitted, when is it planned for?

- **Comment:** We just think it is wrong location. My children go to school near the property. The safety concerns are paramount, and the traffic and congestion that it's going to create.

- **Comment:** PLease extend the comment period and remove the location from this process. There is more evaluation that takes place when someone does a remodel in their home in our nehighborhood. Have there been studies on traffic, environmental impact, parking, on other protected citizens who are in proximity. There has been zero transparency or resident input.

- **Comment:** I support the need for this type of facility. I am concerned about the location, proximity to schools, elderly, daycare. That corner is dangerous in terms of traffic. I ask that public comment be extended and alternative location is identified.

- **Comment:** I live less than a block from this site. A project of this scale is unprecedented in this kind of area. We should be fully informed of this project as community members. Please extend public comment period so we can understand the project.
-
- **Comment:** I live within a block of the facility, have children at the schools nearby. This will create more traffic, and police or ambulance activity could lead to accidents.

- **Comment:** I am a father of two children that attended school less than a thousand feet away. I want to push back on a comment that Supervisor Corzo gave to the Daily Journal yesterday about how there are schools and senior centers and residential areas all over our city and county and only a few viable locations where you can be less than a certain distance from those facilities. That is absurd. I invite everyone to look at where StarVista's old site is to see how misplaced the proposed location is.

- **Comment:** I don't live in the area, but the lack of transparency on this project is my main concern. You should give us the opportunity to have 60 days to provide the transparency that is needed.

- **Comment:** I'm a mom and live next door to the facility, and we are absolutely terrified by this project. I ask that you extend public comment and give county to find a more appropriate lot. We cannot solve one problem and create another one in the community.

- **Comment:** I know you're going to make the right decision to extend this because this location is a big problem, and we need more time to understand the project. I am here because I saw a social media post about this project. I hear more about my neighbor's remodeling plan through the ADRB than I did about this, and that's not right.

- **Comment:** I am on the Council but am speaking in my personal capacity right now. We want compassionate, effective services for everyone, but we also want the community to have the information necessary to build consensus on the project.

- **Comment:** When talking about a 69-bed, 24/7 intake facility with law enforcement drop offs, location matters, especially when it's within walking distance of schools, daycares, etc. A regional scale facility doesn't belong in the middle of a dense residential neighborhood. We ask for a level of transparency.

- **Comment:** When we get our extension, I would like some questions to be answered by Horizon. What happens after clients complete treatment? Where do they get discharged? I could see bad circumstances occurring if they simply walked out the door. Horizon should explain this to us for transparency's sake.

- **Comment:** My husband and I moved here 3 years ago, and we moved here because it is safe. It's a family-oriented area. This facility should never even be discussed, going in with children in this kind of community, where the prices we pay for our homes, the property taxes we pay for our homes. Do they care if our property values go down because that facility is ruining the community?

- **Comment:** Think of the mental health of our community. We all moved here for a reason. Take that into consideration. I would be happy to volunteer if there are any committees or in evaluating the process.

- **Comment:** Echoing everyone's concern that it is about the location, not the center itself. I promote this type of service, as a psychologist. I have worked with this population, and it will cause disruption to the surrounding neighbors, and it will be disturbing to children and adults in the area.

Commissioners – Comments/Questions

- **Question:** If the BHSA Integrated Plan is approved today and then by the Board of Supervisors, what commitment does it make? Does it commit us to a specific location, or around funding?
  - **Counsel Response:** It does not make a commitment around a location. Some funding has already been committed, and the plan mentions that, but it doesn't commit the County to additional funding. If the comment period closes now, the next step is for the plan to go to the Board of Supervisors.

- **Question:** Does submitting the Integrated Plan to the Board of Supervisors also constitute the approval of a specific facility?
  - **Counsel Response:** No

- **Question:** If you submit this plan now, then this can proceed to the State, and the State can see that the County has approved the 10% match, right?
  - **Supervisor Corzo Response:** The 10% match was approved by the Board of Supervisors in October 2025. The Horizon project is governed by Proposition 1, which was passed by the voters statewide in March 2024 and which allows Horizon to apply for this grant. The County plays no role in approving this project. If the State approves the grant, it will go to city council and their planning for approval. Horizons reached out to Councilmember Nash in September 2025 to ask for support on this project and reached out 2 weeks later. The city and city manager were notified of this in September. The city encouraged the County and Horizon to reach out to residents. Horizons had a meeting in February, and I was invited to be a part of that meeting. We are going to have another meeting about this project to

answer any questions. My understanding is that approval of this plan plays no role in the State's decision to approve the grant.

- **Question:** What is the negative impact of extending the public comment period?
  - **Dr. Souter Response:** This is a Proposition 1 required plan that we must submit to the State, and there are timelines for submission that allow us to fund all of our mental health and substance use services, from prevention to treatment. Not closing the comment period would jeopardize every program the county has for mental health and substance use.

- **Question:** What are the forums for the public, and what is the remaining approval process for the public to engage on the location of the facility?
  - **Supervisor Corzo Response:** The location is in the incorporated city of San Mateo. The City will approve whatever Proposition 1 requires them to approve, and if they don't, they open themselves to litigation from the State or anyone who wants to bring that litigation.
- **Question:** Is the city approving the location of the facility?
  - **Supervisor Corzo Response:** No. The State will score the grant application that Horizon submitted and choose to award the money or not. This is more a question for the San Mateo City Council and their city attorney for what tools they have or what the process looks like for their city to approve or not approve this project.

- **Comment:** The only opportunities for us (San Mateo City Council) to provide input on is whether it the project meets objective design standards, which has nothing to do with the content.

- **Comment:** All these comments will be included in the Integrated Plan that is going to the Board of Supervisors. We are closing the comment period in terms of the Commission. All of your comments will go to the Board of Supervisors.

- **Comment:** I want to clarify that we are voting on the plan itself, not the specific project.

- **Question:** What happens if we extend comment period for 60 days?
  - **Doris Estremera Response:** We are required to provide an update to DHCS feedback by March 15th. We will then submit the plan to the Board of Supervisors for approval followed by Controller's certification. If we extend the public comment period for 60 days, we may not be able to meet the deadlines for submission of the plan and will not be in compliance. My understanding is that DHCS can withhold our funding when we do not submit our plans in a timely manner.

- **Comment:** I am shocked that none of these neighbors feel that they have had been able to comment on this, and we are getting mixed messages.
  - **Follow-up:** Even if we extend public comment, there was a commitment to the BHCIP grant application. That cannot be removed from the plan.

- **Comment:** I would like to understand the BHCIP process if I am voting on this.

- **Comment:** From what I have heard, our vote on this plan doesn't have any bearing on the commitment the County made to BHCIP. It is important that we should figure out the process, but I don't think this plan has anything to do with what happens.

- **Comment:** When I read what our obligation is as a commission, this is exactly what it is – to assure that County and BHRS is serving its mission with regards to its population. I appreciate that we do tours and have presentations, but I am still trying to get a lot of information about how things even work.

- **Comment:** I don't agree with fast-tracking. However, I do want to advocate for the reality of what you already have in your neighborhoods. Do your homework and understand what is in your neighborhood now to understand what you are compromising because a lot of that stuff already exists. Be aware that when you make statements to the public, commissioners and the Board of supervisors that you don't want this in your backyard. The Ascension building at 9th avenue, Project 90 used to be there. You also have Palm Avenue Detox. They are already there.

- **Comment:** I don't think we need to share our opinions here unless it helps with your vote.

- **Question:** Do Frieda's comments get added to the draft, or how does that get incorporated?
  - **Doris Estremera Response:** I will update the public comment document with a response on how the suggestions will be incorporated. You can vote to submit plan including the changes that Frieda requested.

- **Question:** What is the next step if/when this gets submitted to the County Supervisor? What is the timeline?
  - **Doris Estremera Response:** By March 15th we will submit an updated draft to the State. It will then go to the Board of Supervisors, we are targeting May, followed by Controller's Office certification.

- **Question:** Who decided Horizon would provide these services?
  - **Doris Estremera Response:** Horizon applied for the grant from the State.

- **Question:** The County had no say about it?
  - **Supervisor Corzo Response:** Staff recommended to the County that this was an identified need, a gap in our continuum of care for residents in this county. I was notified by our County Executive that there was a non-profit interested in bringing this to the County and then brought to the Board of Supervisors the request for the $2M match, and it was approved by the Board in October 2025. Horizon decided on the location. The State understands that there is always concerns about these kinds of programs, no one wants it in their neighborhoods, which makes it hard to have enough supply. To address that challenge, Proposition 1 streamlined the approval process so that the only thing the City will be approving is what the building will look like.

BHC meeting (2/4/26), opening of public comment period.

Members of the Public – Comments/Questions:

- **Comment:** Addressing concern of homelessness, I was pleased to see the addition of the Z codes and your comment that this would be something that's ongoing because I didn't see it in the 20 pages of homeless interventions. I am the President of the Solution for Supportive Homes, which started in 2019 and now it is 2026, and I am beginning to feel scared. How much longer do we wait for supportive homes, board and care, residential care. This is an invisible population because the children are not on the streets but what will happen when we're gone or when we need caregivers.
    - **Question:** As a follow-up to the previous comment, there are a lot of adult children who are completely dependent on their aging parents. They cannot function successfully on their own. What would happen to a 43-year-old adult with schizophrenia who is currently housed but has good reason to fear that they will be unhoused within the next 30-60 days – where should they go to seek advice on finding housing supports?
    - **Response:** If the adult is connected to BHRS, their treatment team can be consulted about housing opportunities such as project-based MHSA Housing, Canyon Vista Housing, Full Service Partnership (FSP) Housing or other housing programs. A release of information will be needed to provide any detailed information. The Office of Consumer and Family Affairs (OCFA) can also be of support to aging parents whose adult children are connected with BHRS. OCFA Phone number is (800) 388-5189 Additionally, if they are a dependent adult with intellectual disability and there is concern regarding self-neglect, a call to Adult Protective Services (APS) could be appropriate as APS has a program Home Safe to help with housing navigation. The client has to be an APS client first. The parents of the adult child could call the APS Hotline and they would also be referred to the CORE Service Agencies or other Housing programs. The APS Hotline is: 1-844-868-0938.

- **Comment:** I am a health ambassador of BHRS, and I have had many challenges, and know that I needed to help myself first. Then I realized that I support my family, and I have to put own care to the side. My husband was facing mental health and substance use addition. Today he is better than I am. The community is very aware of stigma around substance use and bullying, and that we as immigrants don't get the support of many mental health and substance use organizations unless I knock the doors of the organizations to receive that information and support. I have had depression, my son has autism and severe depression, daughter with psychosis and other son with bipolar disorder.

Commissioners – Comments/Questions:

- **Question:** Does the website give us more detail about the health strategies and programming?

  Response: Yes. The Integrated Plan linked on the website provides the Statewide Behavioral Health Goals section beginning on page 21 and includes the proposed strategies for each goal. For example, "Access to Care" priority goal, strategies include having culturally responsive services provided by peers or health navigators to reach the communities that are not currently engaged in services.

- **Question:** You mentioned that each area of focus has a lead. Is that information publicly available, or who does we contact if we have follow-up questions.

  Response: There is a dedicated email address that you can send questions to about the Integrated Plan, MHSA@smcgov.org. Please send requests here and we will connect you to the appropriate individual.

- **Question:** What is the delineation between early intervention and prevention?

  Response:

- Prevention is population-based strategies targeting the public at large. For example, communication campaigns, mental health first aid trainings, anyone can attend and benefit from these strategies. These population-based prevention strategies raise awareness, education and reduce stigma. Population-based prevention will become the responsibility of our public health department, and 4% of the millionaires tax is going to go to CA Department of Public Health to support this work statewide.
- Early intervention is targeted to high-risk populations, juvenile-involved youth, cultural groups that are underserved or specific zip codes, neighborhoods or individuals at high risk for developing a serious behavioral health disorder due to experiencing trauma. The idea is to develop strategies that meet high-risk individuals where they are and provide evidence-based interventions.

- **Question:** Where do we see our biggest impact in the immediate future? What group is going to be affected and benefiting most from the funding?

  Response: Proposition 1 is intended to target individuals living with serious mental illness and/or substance disorder, so it's shifting our resources as a behavioral health department to serve those most vulnerable populations. Housing is another big priority and being able to fund permanent supportive housing strategies. Substance use in another area of biggest impact, under MHSA we were not allowed to use the funding for substance use programming unless there was a primary mental health diagnosis; this is no longer the case under BHSA.

  - **Follow-up:** Does that mean we are serving people with dual diagnosis?

    Response: The intent of the legislation is that our services and programs are integrated to meet the needs of clients with substance use and/or mental health disorders. Under MHSA, we had had to show that a client receiving substance use services also had a mental illness as a primary diagnosis, and that is no longer the case under BHSA. We will be able to serve clients with a substance use disorder as a primary diagnosis.

- **Question:** What organizations are doing early intervention?

  Response: We have existing early intervention programs, such as the Cariño Project on the Coastside, the Allcove Center, music therapy for Asian/Asian Americans, Primary Care Interface. We will need to bring in more providers and will publish a request for proposals (RFP) to allow providers to apply and propose how to address some of these gaps for youth ages 0-25.

  - **Follow-up:** How can the community and family participate in the process?

    Response: For the RFP review process, BHRS includes individuals in proposal review processes that represent clients or family members. The panel review proposals submitted and make recommendations for the organization(s) that will deliver the services.

- **Question:** How does the BHRS transformation crosswalk in terms of the requirements of BHSA requirements, reporting or percentage of Medi-Cal recipients being served?

  Response: It is completely aligned. As part of Proposition 1, the state has identified data points such as "MediCal penetration rates" – eligible individuals receiving our services. These data points will be used to assess impact and progress. We know demographics of individuals accessing our services and where there are disparities and gaps. Proposition 1 also drove a lot of thinking that went into our transformation journey. One of the requirements for Early Intervention services funded by BHSA is that eligible services are billed to Medi-Cal. Early Intervention providers will be required to screen participants for eligibility and support enrollment when appropriate. Requirements include: targeted, culturally responsive outreach, billing for interventions when possible and providing linkages to care for individuals that are eligible. We

are working closely with Health Plan of San Mateo because they are responsible for mild-to-moderate services, which are interventions often provided by Early Intervention providers. We have a project called PIVOT that is working with Early Intervention providers to develop infrastructure for Medi-Cal billing.

- **Question:** What agency or group from the State is reviewing the plan?

  Response: Department of Health Care Services (DHCS)

  - **Follow-up:** What are the actions they [DHCS] can make in reviewing the plan?

    Response: Unsure. We are one of the first cohort counties to submit but anticipate questions related to missing information or requesting clarity.

- **Question:** The first question for each of the priority goals asks what our status is relative to the average, so how does our scoring on those impact our budget allocations?

  Response: Firstly, Counties must meet the broader BHSA percentage allocation requirements regardless of what the data. For example, we allocate 30% for housing regardless of our "Homelessness" status compared to other counties. However, we are also required to identify strategies within the priority goals to make improvements in areas where the data identified gaps or where we are not doing as well as other counties. So, this is where budget allocations will be targeted within the required BHSA components.

- **Question:** Is there going to be more money under BHSA compared to MHSA? In slide 17, the BHSA Allocation look like a net positive gain for BHSA.

  Response: No. Overall, there is 5% less funding coming to counties. BHSA shifts money to make room for new activities the State is requiring. We had to find other revenue to cover a lot of our outpatient treatment programs because they cannot be funded under BHSA for example. The BHSA Allocation does not account for ~$8M in prevention and innovation that we are no longer allowed to fund out of BHSA.

- **Question:** Looking at slide 16, BHRS's budget allocation for the next fiscal year is $380.6M? I don't see a breakdown of the spenddown in the plan.

  Response: Yes, that is the full BHRS budget allocation amount. The integrated plan budget is in the appendix, and it does not get into detail how much money is going toward a specific program. This is how DHCS requested to see the budget and our allocations.

- **Question:** There was a strategy on page 67 around youth advisory boards. Can that be changed to "action" boards so there is a sense of agency and decision making at the table versus purely advisory?

  Response: Yes, that can be changed.

- **Comment:** I'm pleased to see social connection in the plan, as well as examples like the Pride Center and allcoves as wonderful gathering spaces.

- **Comment:** I know we worked with probations and others in the past but am curious about the level of involvement and engagement with the Juvenile Justice Prevention Commission, because there is so much overlap as it revolved around justice involved youth. Maybe there could be joint sessions as it related to awareness of rights, how the behavioral health plan is changing, the frequency of young people going in without a substance use challenge and coming out with one, definitely trauma.

- **Question:** How can we as the commission know that the comments made are going to shape the final decisions being made? What is the plan for incorporating community feedback?

  Response: As we collect public comments, we are documenting it. If it is substantive comment defined as requiring a change to the plan, we will address it and provide a response and details on any changes we

are making. These will be presented to the Commission when we close 30-day public comment. We will also be sharing ALL public comment received with the Commission via email and posted on our website for the public.

- **Question:** Can the Commission receive the comments in real time? I think many people may make similar comments or ask similar questions in the public comment space. If we as a Commission have a grasp on what is being said, we won't need to ask the same question, and we might be able to shape the responses.

  Response: We could put together a bundle, maybe not in real time, but I can find a way to keep you all informed more regularly.

- **Question:** Do you have a plan for all of the state priority goals or just the seven that are starred?

  Response: Just the seven that are starred in slide 12, which are required for County behavioral health departments. The 14 priority goals are for the entire state, and involve other organizations, not just Behavioral Health departments. Some of these goals may fall under the responsibility of managed care plans, or public health or other organizations, for example.

- **Question:** Who will be addressing suicide?

  Response: Public Health. This is now a requirement for the BHSA funding being allocated to County Public Health departments. BHRS will partner with public health.

- **Question:** I see removal of children from home is a priority, as is family engagement and youth. Is there any crossover or collaboration with other departments?

  Response: Yes. There is a group that meets regularly (Children and Youth System of Care - CYSOC) that includes BHRS, Human Services Agency (HSA), Children and Family Services, County office of Education, and Probation, so there is coordination happening to address removal of children from home. In addition, BHRS convenes a weekly Interagency Placement Review Committee (IPRC), where providers and system partners review cases, discuss interventions, and explore alternatives aimed at preventing out-of-home placement or placement options. Representatives from the relevant departments participate to ensure coordinated decision-making. Ongoing Multidisciplinary Team (MDT) and Child and Family Team (CFT) meetings further support collaborative treatment planning among system partners, providers, youth, and families. These meetings focus on identifying strengths, aligning services, and exploring interventions and alternative options to safely maintain youth in their home and community whenever possible.

  - **Follow-up:** Is it [CYSOC] a public meeting? How can we provide input into strategies being developed through these cross-department collaborations?

    Response: It is not a public meeting. However, the Behavioral Health Commission's Youth Committee is one important avenue where youth and family voices can help shape strategies, because it is facilitated by the Commission and connected to CYSOC through the Deputy Director who sits on both bodies.

Enclosure 1 – Comments Received, SUD Treatment Facility

Email #1 (x 100):

I am a resident of the **City of Hillsborough/City of San Mateo/City of Burlingame** and write to formally object to the proposed Behavioral Health Services Act (BHSA) Three-Year Integrated Plan for Fiscal Years 2026–2029, specifically as it includes the proposed 69-bed Horizon Services facility at 101 N. El Camino Real.

My objection applies directly to the March 4, 2026 "New Business" action items on your agenda

SMC BHS Commission Meeting Agenda, including:

- The proposed vote to close the 30-day public comment period on March 5, 2026; and
- The proposed vote to submit the BHSA Integrated Plan to the Board of Supervisors.

The draft Plan explicitly references (but only simply) the Horizon project (pp. 108 and 125), describing a campus including sobering beds, ASAM 3.2 detox beds with IMS, and ASAM 3.5 residential treatment beds. This is a comparatively large, high-intensity, 24/7 behavioral health facility proposed in a dense residential corridor within approximately 1,000 feet of schools, daycares, senior living facilities, and established neighborhoods. The following concerns remain unresolved:

1. Insufficient Public Information: To date, there has been minimal disclosure of site designs, operational details, safety protocols, intake standards, transportation management, or neighborhood mitigation measures.
2. Lack of Meaningful Site-Specific Community Engagement: There has been no robust, location-focused community planning process involving directly impacted residents, schools, and businesses prior to inclusion of this project in the Plan.
3. Unprecedented Scale: At 69 beds, this facility is reportedly far larger than comparable Bay Area facilities and represents a regional outlier in size and service concentration.
4. Site Sensitivity: The immediate proximity of less than 1,000 feet to an elementary school and that of vulnerable populations such as daycares, senior living facilities, and residential neighborhoods require heightened transparency and analysis.

Closing the public comment period under these conditions would be premature and inconsistent with the spirit of transparent stakeholder engagement required under the Behavioral Health Services Act. Additionally, moving forward with the as-is proposed BHSA plan for 2026-29 without separating out and excluding just the Horizon 101 N. ECR project puts the entire BHSA plan in collective jeopardy of legal challenge.

Accordingly, I respectfully urge the Commission to consider one or all of the following actions:

- ALTERNATIVE ACTION 1: Vote against closing the public comment period and instead vote to extend it for 180 days to allow for meaningful, site-specific review and community engagement before submitting the Plan to the Board of Supervisors. This would also include voting against submitting this plan to the Board of Supervisors.
- ALTERNATIVE ACTION 2: Proceed with submission of the current as-is proposed broader BHSA Integrated Plan for Fiscal Years 2026-29 but only if the Commission votes to decouple and exclude the 101 N. El Camino Real Horizon project from the Plan.

In addition to the BHC adopting either Alternative Action 1 or 2, I highly encourage the BHC to establish an Ad Hoc Subcommittee to:

- Assemble and disseminate all project plans and details;
- Conduct site-specific review;

- Engage directly impacted stakeholders;
- Evaluate alternative sites;
- Analyze scale, concentration, and compatibility concerns;
- Report back with recommendations.

Section 6.4 of the BHC Bylaws empowers the Commission to form such subcommittees where appropriate. A project of this magnitude warrants separate, transparent review — not inclusion within a comprehensive countywide plan without focused scrutiny.

The Commission has an opportunity to demonstrate leadership, transparency, and responsiveness. Excluding or pausing this single project does not undermine behavioral health services countywide — it ensures they are implemented responsibly and with community trust.

I respectfully request that this email be entered into the public record for the BHC Meeting on March 4, 2026.

Email #2 (x 216):

I am writing during the 30-day public comment period to formally object to the BHSA Three-Year Integrated Plan as it relates to the proposed funding and development of the Horizon Center facility at 101 North El Camino Real. This email is specifically in regards to Action Item 1 on the agenda for the upcoming March 4th meeting to "close the comment period" for the BHSA Three Year Integrated Plan. I am formally objecting to the Behavioral Health Services Act Integrated Plan for Fiscal Years 2026-29, based on the inclusion of the proposed 69-bed facility at 101 N. El Camino Real, otherwise referenced on pages 108 and 125 of the plan as the proposed SUD Campus by BHRS contractor provider, Horizon Services.

This project represents an unprecedented regional outlier in size, reportedly 300 percent larger than the Bay Area average, and is located within 1,000 feet of schools, daycares, senior living facilities, and residential neighborhoods. To date, there has been no meaningful, site-specific community planning process with directly impacted community members, stakeholders, and schools. I respectfully request the following:

- A 60-day extension of the public comment period, which is a vote against closure of the comment period
- Establishment of an Ad Hoc Subcommittee to engage stakeholders and analyze the site setting
- Decoupling of 101 N. El Camino Real from the BHSA Integrated Plan for FY 2026-29
- Identification of an alternative site that is not directly adjacent to schools, childcare centers, senior facilities, and dense residential neighborhoods

Pursuant to Section 6.4 of the BHC Bylaws, I formally request that the Behavioral Health Commission establish an Ad Hoc Subcommittee for Horizon Center oversight. The current Three-Year Integrated Plan lists Community Program Planning and Data Review as core pillars. A project of this scale warrants a transparent, data-driven, and site-specific review process.

- **Comment:**

  I am writing during the 30-day public comment period to formally object to the BHSA Three-Year Integrated Plan as it relates to the proposed funding and development of the Horizon Center facility at 101 North El Camino Real. This email is specifically in regards to Action item 1 on the agenda for the upcoming March 4th meeting to "close the comment period" for the BHSA Three Year Integrated Plan.

  While the plan broadens the scope of behavioral health services, its current framework fails to meet the state-mandated requirements for transparency and community planning in the following ways:

1. Violation of the Community Program Planning (CPP) Process: The Integrated Plan claims to be informed by a robust CPP process. However, the residents directly impacted by the proposed high-density facility at 101 N. El Camino Real were excluded from the "Transition Taskforce" and "Input Sessions". This lack of "community engagement at every stage" invalidates the plan's claim of broad stakeholder support.
2. Inappropriate Use of AB 531 Infrastructure Funds: The plan identifies capital infrastructure as a key funding component. However, the proposed Horizon facility lacks "Launch Ready" status due to a fluctuating bed count (58 vs. 69) and an increase in building footprint that would disqualify it from the CEQA exemption required by AB 531. Funding a project with such significant legal and zoning inconsistencies is a fiscally irresponsible use of Proposition 1 bond dollars.
3. Negative Impact on Neighborhood Quality of Life: The plan lists "Quality of Life" and "Social Connection" as primary goals for improvement. The introduction of a 24/7/365 acute behavioral health facility 850 feet from an elementary school fundamentally undermines these goals for local families and residents. The plan fails to provide any objective mitigation strategies for the operational intensity of such a facility in a residential core.

Request for Action: I urge the San Mateo County and the Behavioral Health Commission to defer approval of the Integrated Plan until a dedicated public study session is held for the 101 N. El Camino Real project. The County must demonstrate that this specific project meets the "Objective Standards" and "Community Planning" requirements before any further BHSA or BHCIP funds are allocated.

I also request the county to extend the 30 day public comment period for the BHSA Integrated Plan to 60 more days. On March 4th, 2026, there is an agenda item to vote to close the comment period. Residents in San Mateo have not been properly informed regarding the proposed project at 101 North El Camino Real. There has been no public comment period, only a "listening" session held by Horizon Services on February 17th where residents could not speak.

Pursuant to Section 6.4 of the BHC Bylaws, I formally request that the Behavioral Health Commission establish an Ad Hoc Subcommittee for Horizon Center oversight. The current Three-Year Integrated Plan lists Community Program Planning and Data Review as core pillars. A project of this scale warrants a transparent, data-driven, and site-specific review process.

- **Comment:**

  I live two blocks away and this is not the appropriate site for a 69 bed substance abuse and 24/7 sobering facility.

  We never received notice of this plan until last week and it seems that this is being ramrodded through to satisfy Gov Newsom's agenda of adding more beds.

  Clearly there must be some better locations in our county for this rather than near several schools and pre schools. Driving south on El Camino past hwy 92, there are several vacant buildings that could serve the need and have less impact on residents that pay a lot of money on property taxes.

  I drove around Sunday morning and found a much better property for sale at 1021 S El Camino. It is a larger lot and $1.6M LESS at $4,880,000. Why are taxpayers paying more for a less desirable place??

  Please spend our money wisely. This does not align to your fiduciary responsibility for our community.

- **Comment:** I am a resident of the City of San Mateo and write to formally object to the proposed Behavioral Health Services Act (BHSA) Three-Year Integrated Plan for Fiscal Years 2026-2029, specifically as it includes the proposed 69-bed Horizon Services facility at 101 N. El Camino Real.

I am a commercial real estate broker and manage properties out of state. Two of them are near like facilities and we have had endless problems with the facilities and their residents. I know there is a need for the project but can tell you from my personal experience they should not be located in a residential neighborhood. This is simply the wrong location, not a bad facility.

- **Comment:** Please accept this email as a formal objection to the proposed project at El Cerrito and El Camino. There are better sites in much more appropriate locations!

- **Comment**: I am a resident of the City of San Mateo and a parent at Episcopal Day School. I write during the 30-day public comment period to formally object to the Behavioral Health Services Act (BHSA) Three-Year Integrated Plan for Fiscal Years 2026-2029 as it relates to the proposed funding and development of the Horizon Services facility at 101 North El Camino Real.

  This objection specifically concerns the March 4, 2026 agenda item to close the public comment period and to advance the Integrated Plan to the Board of Supervisors.

  The draft Plan explicitly references the proposed 69-bed SUD Campus by Horizon Services (pp. 108 and 125), describing a facility that includes sobering beds, ASAM 3.2 detox beds with IMS, and ASAM 3.5 residential treatment beds. This represents a high-intensity, 24-7 behavioral health facility of a scale that appears to be a regional outlier. The facility would be one of the largest of its kind in Northern California.

  While expanding treatment capacity is a legitimate public policy objective, the scale, siting, and process surrounding this project raise serious concerns.

  Site Sensitivity and Proximity to Vulnerable Populations

  The proposed location sits within less than 1,000 feet of multiple sensitive uses, including elementary schools, childcare centers, senior living facilities, public library facilities, and established residential neighborhoods. The Episcopal Day School is within roughly 800 feet. Several childcare providers are even closer.

  Pending state legislation SB 1060 proposes a 1,000-foot buffer between high-intensity treatment facilities and schools or daycare centers. Whether enacted or not, it reflects a growing statewide recognition that siting standards matter, particularly for facilities operating 24-7 with sobering intake and potential law enforcement drop-offs. Advancing a project that would fall within the buffer contemplated by pending legislation creates foreseeable policy conflict and long-term instability.

Agenda

1. The Peninsula Regent Senior Living - approx 530 ft
2. The Modern Day School - approx 600 ft
3. Kids Connect - approx 620 ft
4. Chal Jewish Preschool - approx 720 ft
5. Episcopal Day School - approx 800 ft
6. Little Wonders - approx 940 ft
7. Versellios Senior Living - approx 990 ft
8. Kinder Academy - approx 1,630 ft
9. Main Library - approx 1,900 ft
10. Kiddo Adventure Playground - approx 2,300 ft
11. Field Middle School - approx 2,400 ft
12. South Hillsborough Elementary School - approx 2,500 ft
13. Central Park - approx 2,600 ft
14. San Mateo Park Elementary School - approx 3,200 ft

Red - the proposed drug treatment site of Horizon

Green - Schools or childcare

Cyan - Senior Living

Purple - Major public infrastructure with large children focus

Emergency Services and Public Safety Considerations

The justification for this site has included proximity to emergency services. However, the nearest full-service hospitals capable of handling complex medical emergencies are approximately four miles away in either direction. The San Mateo Police Department is approximately 3.5 miles from the site. For a 24-7 sobering center and detox facility serving acute cases, distance to emergency and law enforcement response capacity should be carefully analyzed and publicly documented.

Questions Regarding Site Selection

Public statements attributed to Horizon leadership suggest that this location was not necessarily their preferred or optimal site. If this was not the operator's most desired location, the Commission should ask why this specific parcel was selected and whether it was driven primarily by property availability or funding mechanics rather than comprehensive siting criteria.

Was a formal Site Compatibility and Alternative Site Analysis completed?
If so:

- On what date was it completed?
- What criteria were used?
- What alternative sites were evaluated?
- Please provide the full analysis for public review.

If no such analysis was conducted, that omission alone warrants delaying advancement of the Plan as it relates to this site.

Lack of Meaningful Community Engagement

Equally troubling is the absence of meaningful community engagement.

The applicant and the County have failed to conduct robust, site-specific outreach. Holding a single informational call less than 2 weeks ago and merely notifying property owners within a 1,000-foot radius is not sufficient for a County-sponsored project of this magnitude. This project is embedded within the County's Behavioral Health Services planning framework and proposes to use substantial taxpayer funding. Schools, directly impacted families, senior communities, local businesses, and residents beyond an arbitrary radius should have been engaged early and transparently before this project was incorporated into a three-year funding plan.

Closing the public comment period under these conditions would be premature and inconsistent with the spirit of transparent stakeholder engagement contemplated under the Behavioral Health Services Act.

Accordingly, I respectfully request that the Commission consider the following actions:

1. Vote against closing the public comment period and extend it by at least 60 days to allow meaningful, site-specific review and community engagement.
2. Establish an Ad Hoc Subcommittee pursuant to Section 6.4 of the BHC Bylaws to assemble and disseminate all project materials, conduct a data-driven site compatibility analysis, engage directly impacted stakeholders, evaluate alternative sites, and report back with recommendations.

3. Decouple and exclude 101 N. El Camino Real from the BHSA Integrated Plan for FY 2026-2029.
4. Identify and evaluate alternative sites that are not directly adjacent to schools, childcare centers, senior living facilities, or dense residential neighborhoods.
5. Publicly release any Site Compatibility and Alternative Site Analysis that has been conducted.

The Integrated Plan lists Community Program Planning and Data Review as core pillars. A project of this magnitude warrants exactly that - a transparent, data-driven, and site-specific review process before public funding is advanced.

I respectfully request that this letter be entered into the public record for the March 4, 2026 meeting.

- **Comment**

Dear Members of the Behavioral Health Commission (BHC),

I am a resident of the City of San Mateo and write to formally object to the proposed Behavioral Health Services Act (BHSA) Three-Year Integrated Plan for Fiscal Years 2026-2029, specifically as it includes the proposed 69-bed Horizon Services facility at 101 N. El Camino Real.

My objection applies directly to the March 4, 2026 "New Business" action items on the San Mateo County Behavioral Health Commission Meeting Agenda, including:

- The proposed vote to close the 30-day public comment period on March 5, 2026; and
- The proposed vote to submit the BHSA Integrated Plan to the Board of Supervisors.

The draft 3-Year Integrated Plan explicitly references the Horizon project (pp. 108 and 125), describing a campus that includes sobering beds, ASAM 3.2 detox beds with IMS, and ASAM 3.5 residential treatment beds. This represents a comparatively large, high-intensity, 24/7 behavioral health facility proposed in a dense residential corridor within approximately 1,000 feet of schools, daycares, senior living facilities, and established neighborhoods. As I understand it from the very sparce information available, the Horizon Services Inc. plan proposes:

- 16 Sobering Beds
- 17 Residential ASAM 3.2 Detox (IMS)
- 36 Residential Treatment ASAM 3.5 beds
- Low-barrier, walk-in same-day MAT access

<u>I hereby submit my formal objection to this Horizon plan on the following grounds:</u>

<u>I. BHSA STATUTORY NONCOMPLIANCE</u> (Welfare & Institutions Code §§ 5847, 5848, 5898)

A. Failure to Conduct a Lawful Community Program Planning Process (CPPP)

Under WIC § 5848(a), counties must conduct a Community Program Planning Process that includes:

- Meaningful stakeholder participation
- Transparency
- Public hearings prior to plan adoption
- Documentation of local input influencing final plan decisions

There is no evidence in the Draft Proposed 3-Year Plan concerning this project that:

- Location-specific community outreach occurred before BHCIP submission
- Residents adjacent to 101 N. El Camino Real were engaged prior to funding commitments
- Alternative sites were evaluated with public input

Advancing a site-specific capital campus without documented CPPP compliance constitutes a procedural defect under §§ 5847–5848.

B. Predetermination / Funding Commitment Before Public Process

The Plan indicates BHRS committed $2 million in opioid settlement funds toward the BHCIP proposal. If financial commitments were made prior to the following, then the County engaged in impermissible predetermination

- Completion of the CPPP
- Publication of operational details
- Location-specific impact analysis

A public process conducted after funding commitments are locked in does not satisfy statutory intent.

C. Failure to Provide Sufficient Information for Meaningful Comment

The description of the campus on Page 125 is materially deficient.

Absent from the Plan are:

- Security protocols
- Intake standards
- Justice-involved referral policy
- Law enforcement drop-off policy
- On-site supervision model
- Neighborhood mitigation measures
- Traffic and transportation impacts
- Emergency response planning
- Data reporting and incident disclosure

Without this information, meaningful public review under § 5848(b) is impossible.

<u>II. CEQA VIOLATION – UNLAWFUL SEGMENTATION & PRECOMMITMENT (Cal. Pub. Res. Code § 21000 et seq.)</u>

The Horizon campus constitutes:

- A capital facilities expansion
- A 24/7 residential behavioral health operation
- A low-barrier sobering center with walk-in access

Under CEQA, this is a "project" because it may cause:

- Traffic impacts
- Public safety impacts
- Noise impacts
- Concentration of services impacts
- Land use compatibility impacts

Yet:

- No Initial Study has been circulated.
- No Notice of Exemption has been filed.

- No Mitigated Negative Declaration has been issued.
- No Environmental Impact Report (EIR) has been prepared.

If the County has applied for state capital funding and committed match funds prior to CEQA compliance, that constitutes unlawful pre-commitment under CEQA case law (Save Tara v. City of West Hollywood).
Public agencies may not commit to a project in a manner that forecloses environmental review. If BHCIP applications and funding commitments have effectively locked in this site, CEQA has been violated.

III. IMPROPER PIECE-MEALING / SEGMENTATION

The Plan describes:

- Sobering center reopening
- Residential detox expansion
- Mobile NTP exploration

If these components are part of a larger campus expansion but are evaluated separately, that may constitute unlawful segmentation under CEQA.
The entire operational footprint must be analyzed as a single project.

IV. BROWN ACT EXPOSURE

If:

- Funding commitments were approved via Consent Agenda
- No meaningful discussion occurred
- Location details were not disclosed

there may be Brown Act transparency concerns regarding:

- Adequacy of agenda description
- Public's ability to comment meaningfully

Any prior County Board action tied to this site must be fully disclosed.

V. CONCENTRATION / EQUITY IMPACT CONCERN

The County must demonstrate:

- Equitable geographic distribution of high-intensity behavioral health services
- Avoidance of disproportionate burden in specific corridors

Failure to analyze service concentration effects may violate both CEQA and BHSA equity objectives.

VI. FORMAL DEMAND

Accordingly, I demand:

1. Immediate suspension of inclusion of the Horizon planned project in the BHSA Plan pending:
    a. Full CPPP compliance documentation
    b. Site selection analysis disclosure
    c. CEQA review initiation
2. Public release of:
    a. All BHCIP application materials
    b. All site acquisition documents
    c. All funding commitments
    d. All communications between BHRS and Horizon regarding this location
3. A stand-alone public hearing specific to 101 N. El Camino Real.

4. Written confirmation that:
    a. No legally binding commitments have been made
    b. No CEQA pre-commitment has occurred

Failure to cure these defects before Plan adoption will preserve all rights to challenge approval on procedural and environmental grounds.

I look forward to your response.

- **Comment:**

I'm a resident of the City of San Mateo and I write you to formally object to the proposed Behavioral Health Services Act (BHSA) Three-Year Integrated Plan for Fiscal Years 2026–2029, specifically as it includes the proposed 69-bed Horizon Services facility at 101 N. El Camino Real in San Mateo.

My objection applies directly to the March 4, 2026 "New Business" action items on your agenda SMC BHS Commission Meeting Agenda, a) The proposed vote to close the 30-day public comment period on March 5, 2026; and b) The proposed vote to submit the BHSA Integrated Plan to the Board of Supervisors.

Although I fully support rehabilitation efforts for those in need, I believe the proposed Horizon facility at 101 N. El Camino in San Mateo is in the wrong location and of the wrong size.

1) The corner of El Camino Real and El Cerrito Ave has already more than its fair share of traffic issues and accidents. El Cerrito Ave carries a large amount of traffic from our neighbors in Hillsborough.

2) This area has restricted street parking. Unless the proposed facility is designed to accommodate parking for all its staff and guests, this development will make street parking even worst.

3) I understand, at 69 beds, the proposed Horizon center will be among the largest in the whole Bay Area. I understand the typical size of these facilities in the Bay Area is around 21 beds. So if the county sticks to that average and break down the 69 proposed facility in 3 locations not only it will be easier to locate suitable parcels but will spread those facilities over different cities within the county and hopefully closer to those folks in need of such services.

4) There are already several facilities that provide similar services that are located in the City of San Mateo. Horizon has a facility on 2251 Palm Avenue. Healthright360 has residential facilities at 900 Laurel Ave and 202 E Bellevue Ave. Project Ninety has a location on 416 2nd Ave. I'm not aware of any other city within the county that has more facilities. So why to add another one on the same city? Not only one more but one of the largest in the whole Bay Area? This is not only unfair to us residents of city of San Mateo hosting these facilities but to those patients that need and use those services and are located in other cities within the county.

5) There are several childcare centers and an elementary school near the proposed location. The fact that there is current statutory barriers for location of dispensaries and there is proposed legislation (SB1060) to prevent this type of facilities within 1000 feet from schools and day care centers speaks about the sensitivity of this matter.

Unfortunately as a Resident that lives very close to the proposed Facility, and therefore a clear stakeholder on this project, the first time I learned about this project was a few weeks ago when Horizon notified me about a "Listening Session" they were going to have on February 19, 2026 This is well AFTER they had already submitted their application to a grant to finance this project and secured a resolution from SM Board of Supervisors with a 10% match..

Accordingly, I respectfully urge the Commission to consider one or all of the following actions:

ALTERNATIVE ACTION 1: Vote against closing the public comment period and instead vote to extend it for 60 days to allow for meaningful, site-specific review and community engagement before submitting the Plan to the Board of Supervisors. This would also include voting against submitting this plan to the Board of Supervisors.

ALTERNATIVE ACTION 2: Proceed with submission of the current as-is proposed broader BHSA Integrated Plan for Fiscal Years 2026-29 but only if the Commission votes to decouple and exclude the 101 N. El Camino Real Horizon project from the Plan.

In addition to the BHC adopting either Alternative Action 1 or 2, I highly encourage the BHC to establish an Ad Hoc Subcommittee to:
- Assemble and disseminate all project plans and details;
- Conduct site-specific review;
- Engage directly impacted stakeholders;
- Evaluate alternative sites;
- Analyze scale, concentration, and compatibility concerns;
- Report back with recommendations.

I respectfully request that this email be entered into the public record for the BHC Meeting on March 4, 2026.

Thank you for your consideration.

- **Comment:** In addition to our community letter. I wanted to share my own thoughts… While I do recognize the need for such a facility, if I'm being honest, it does not belong where it is proposed. Smack in the middle of single family and multi- family residential, a number of elementary schools, and retirement homes etc…

  Because of the nature of operating this facility and its scale at 69 beds…. It belongs adjacent to other public services and away from families that live , work, and pay taxes and elect our officials to protect us all from the potential harm such a facility brings long term. Sorry if that's a bit harsh.

  Most all want to be compassionate , but also, we need common-sense community planning. This corner and its zoning, when put in place over ½ a century ago or more , did not contemplate this intense, problematic use would ever fall under its scope. The fact they have landed here and have any support at all feels like our community planners are hiding behind outdated zoning and the states mandates for such facilities.

  In addition, the intersection of El Cerrito and ECR already exceeds and reasonable persons level of traffic flow, with left hand turn lanes , bus stops, crowing of the street, phone transformers blocking visibility. The close proximity of the proposed use's ingress/egress points only add to this issue. The intersections

current conditions already creates too many accidents and hazards. The cement Ballards and the number of broker light standards clearly demonstrate the safety issues at hand.

In closing… The County has land, SMC Fair grounds or up by Tunnel Road just to name a few would be appropriate and I would like to believe supported by reasonable community leaders and residents alike.

Thanks for hearing me out..

- **Comment:** I am a long-time resident of San Mateo County. I am just hearing of the proposal to open a large-scale drug rehab center down the street from several preschool and elementary/middle schools. I am strongly opposed to this proposal and ask that a more appropriate location be considered.
  If you look at Yelp reviews of the Cherry Hill Detox / Rehabilitation Center in San Leandro, which is a comparable size and management, you will read that they release people from their center into the streets at all hours. This would mean high numbers of drug-addicted people released in a neighborhood of schools and children.

  I drove around the proposed location yesterday, and within 3 blocks saw several groups of children. One was a group of 3 girls (approximately 11-13 years old) walking alone, another was two approximately 10-12 year old boys walking alone. There were also two play areas with larger groups of kids playing outside, and two ~3 year olds playing outside near South preschool while their mothers talked nearby. My own children used to bike alone on El Cerrito near the proposed site regularly when they were younger. This is not an appropriate area for a large drug detox and rehab center.I ask that you consider the safety and impact to the children of San Mateo County when determining the location of this center.

- **Comment:** I am a parent at South and a resident directly impacted by the proposed Horizon Center at 101 North El Camino Real. I formally object to the BHSA Three-Year Integrated Plan as it relates to this facility, and I urge this Commission to vote against closing the public comment period today."

1. UNPRECEDENTED SCALE — A REGIONAL OUTLIER

   - This is not a typical sobering center. At 69 beds (16 sobering, 17 detox, 36 residential treatment), this facility is reportedly 300% larger than the Bay Area average. Most California sobering centers operate with 10–24 beds. San Luis Obispo's center has 10–12 beds. This would be one of the largest combined SUD campuses in the region.
   - No comparable facility of this size exists this close to schools anywhere in the Bay Area. This would be one of the largest combined SUD campuses sited adjacent to schools and residential neighborhoods in the region. The scale alone demands heightened scrutiny and community input.

2. PROXIMITY TO SCHOOLS AND VULNERABLE POPULATIONS

   - Within 1,000 feet of schools, daycares, and senior facilities. Kids Konnect preschool and Episcopal Day School are approximately two blocks away. Baywood Elementary and other schools are in the immediate vicinity. Senior living facilities are also within the impact zone.
   - State legislators are now pushing for a 1,000-foot buffer. Senator Valladares has introduced SB 1060, legislation establishing a statewide standard requiring large residential rehab facilities to be located at least 1,000 feet from schools and daycares. This proposed facility would violate that standard. San Mateo County should not be racing ahead of what the state legislature is actively trying to prevent.

3. FAILURE OF COMMUNITY PROCESS

- No meaningful, site-specific community engagement has occurred. Residents only learned about this proposal weeks ago, despite the county moving forward since last year. Councilmember Lisa Diaz Nash reported receiving over 150 emails—none in favor. The single community meeting on February 19 was described by attendees as 'shockingly uninformative,' and many neighbors were not notified.
- The BHSA Integrated Plan itself calls for community planning. Pages 108 and 125 of the plan reference this facility. The plan's own core pillars include Community Program Planning and Data Review. A project of this scale demands a transparent, data-driven, and site-specific review—none of which has occurred.
- The county claims it cannot control where Horizon buys property. But the county is providing matching funds and including this facility in its official BHSA plan. If the county is funding and endorsing the project, it has a responsibility to ensure proper community engagement and appropriate site selection.

4. PROPOSITION 1 DOES NOT REQUIRE THIS SITE — THERE IS NO REASON TO RUSH

- Prop 1 has two separate components, and neither mandates 101 N. El Camino Real. Proposition 1 consists of: (1) the BHSA, which restructures county behavioral health services funding, and (2) the BHIBA ($6.38 billion bond), which funds infrastructure through the BHCIP competitive grant program. These are distinct funding streams. The BHSA Integrated Plan is a global spending plan for services and programs—it is not a capital infrastructure plan. Nothing in the BHSA framework requires a county to name a specific facility address in its Integrated Plan.
- The DHCS Integrated Plan template is organized by service category—not by site. The official BHSA Integrated Plan template issued by DHCS (October 2025) requires counties to report planned expenditures along the Behavioral Health Care Continuum by program category—such as SUD Residential Treatment or Crisis Services. It does not require, or even provide a field for, specific facility addresses. The inclusion of 101 N. El Camino Real on pages 108 and 125 of San Mateo's plan was a county choice, not a state requirement. The county could just as easily describe its commitment to expanding SUD residential capacity without endorsing a site that has not completed community review.
- BHCIP infrastructure grants are separate, competitive, and site-flexible. The Prop 1 bond dollars flow through BHCIP competitive grant rounds administered by DHCS—not through the county's BHSA Integrated Plan. Round 1 (Launch Ready) closed in December 2024 with awards announced May 2025. Round 2 (Unmet Needs, $800M+) closed October 2025 with awards expected spring 2026. These are applicant-driven processes. The county's BHSA plan does not control or lock in a BHCIP grant site.
- The 'we'll lose funding' argument is misleading. Horizon CEO Jaime Campos has claimed this is San Mateo County's 'final chance' to secure Prop 1 funding. But BHCIP grants are awarded to the applicant (Horizon), not dictated by the county's Integrated Plan. Decoupling this site from the BHSA plan does not forfeit any state bond funding. It simply means the county is not prematurely endorsing a specific site before community review is complete. The county can support the need for SUD infrastructure in its plan without naming an address that has not undergone proper vetting.
- AB 531 makes getting this right now even more critical. Under AB 531, behavioral health facilities funded by the state bond may be treated as 'by right' uses, subject only to ministerial review. Once this site is locked into both the BHSA plan and a BHCIP grant, the city may have no discretionary authority to deny it. The BHSA comment period is quite possibly the last meaningful checkpoint the community has. That is why we are here.

5. WE SUPPORT TREATMENT — NOT THIS SITE

- This is not opposition to behavioral health services. San Mateo County urgently needs a sobering center and SUD treatment. DUI bookings have more than doubled since StarVista closed. We fully support funding these services. The objection is to the site, not the mission.
- Alternative sites exist that don't endanger children. The county should identify locations that are not directly adjacent to schools, childcare centers, senior facilities, or dense residential neighborhoods. Responsible siting is not an obstacle to treatment—it is a prerequisite for community trust and long-term success.
- Rushing this risks losing community support entirely. The threat of losing Proposition 1 funding is not a valid reason to bypass responsible planning—especially when, as I've explained, the BHSA plan is not the mechanism that controls BHCIP grant funding. If this facility opens without community buy-in, it will face ongoing opposition that undermines its effectiveness and the county's broader behavioral health goals.

CLOSING

"I respectfully request four specific actions:"

1. Vote AGAINST closing the public comment period today. Grant a 60-day extension.

2. Establish an Ad Hoc Subcommittee under Section 6.4 of the BHC Bylaws for Horizon Center oversight and stakeholder engagement.

3. Decouple 101 N. El Camino Real from the BHSA Integrated Plan for FY 2026–29.

4. Direct the identification of an alternative site that is not within 1,000 feet of schools, daycares, or senior facilities.

- **Comment:** Last night's meeting of the San Mateo County Behavioral Health Services Commission to ostensibly discuss the proposed plan to build one of the largest Behavioral Health Facilities in the Bay Area at 101 N El Camino Real raised even more concerns/questions than existed before the meeting.
  - How could the Board of Supervisors have approved essentially a blank check for $2M without designating a specific site?
  - When all the meeting participants were limited to 40 seconds of speaking time (a time far too short by any reasonable standard to make all the salient points), why was the single proponent of the project among the speakers allowed to use her 40 seconds and then move to the table at the end of the meeting and continue making her pitch in an unlimited fashion?
  - Amongst the misleading statements made by the proponent was the fact that Horizon Health Services, as an independent business, has the right to purchase and operate in any building they want. While that may be true if they were spending their own money, this is a completely different situation when they are spending taxpayer dollars.
  - Why were the concerns raised by around 300 affected residents (dense residential neighborhood, exacerbation of existing traffic congestion, safety of children and elderly, close proximity to establishments that sell alcohol, etc.) almost completely ignored?
  - In a community where a resident can't even build a second story on their own home without formal approval from neighbors, why was a controversial project of this magnitude shrouded in secrecy with a complete lack of transparency?

- What kind of community engagement process do we have around here when County Supervisors can agree to a controversial project like this and City Council Members become aware months ago, but no one bothers to inform the general public and they are left to find out by chance through social media well after the fact? We should be embarrassed as a community that our elected leaders spent more time in the meeting pointing fingers at each other, than actually working to get the answers that people were requesting.
- One speaker cited the staggering number of times the police had to be called to a much smaller 17-bed facility. Did anyone even consider that a 69-bed facility would likely come with an exponential increase in police visits?
- What other locations were considered and why were they rejected? In the meeting, several larger, more cost-effective options were proposed and if the deadline were extended, undoubtedly more suitable locations could have been identified.
- Why was there no opportunity for residents to ask questions in the meeting when most just found out about the project a few days before?

Given the unpredictable nature of the behaviors of the patients, it just doesn't make sense to locate a facility of this type at this location near families, schools, day care centers and senior living facilities when there are many alternate locations that are more cost effective and safer for all involved. The potential unintended consequences are too high. Considering there is so much valid local opposition to this location, please reconsider the decision to move forward. Thank You.

- **Comment**: We live in Hillsborough as I believe you do and are VERY concerned regarding the proposed 69 bed Rehab Center being proposed by Horizon Treatment Center on El Cerrito Ave, in San Mateo given it's within 1,000 of a preschool, South School, a Senior Center and several other schools.
  We attended a City Council meeting last night and were shocked at the lack of transparency afforded to the community with regards to the project and what little we as residents are able to do given Prop. 1.
  SB-1060, (the proposed bill to keep these types of facilities 1,000 ft. from schools, etc.) seems like our only hope to help find another, much better suited site for this project. I voted for Prop. 1 and am a donor to many of you, but was unaware at the time how little say the community would have in the location chosen for such a place.
  We fully support treatment centers of this nature and whatever our tax dollars are able to do to help, but this is simply the Wrong Location for such a facility.
  There are other sites much better suited for this within the county. Several residents have suggest other locations that are significantly less money as well.
  We ask that you do whatever you're able to do in order to help see the passage of SB-1060 if possible and help give our community some voice in what we feel is a most serious issue and to hear back from you soon.

Enclosure 2

HAP Public Comment 02/27/2026

In Response to the BHSA Three-Year Integrated Plan 2026-2029– San Mateo County

As members of the BHRS Health Ambassador Program (HAP), we recognize and appreciate the BHSA Three-Year Integrated Plan's strong commitment to equity, access to integrated services, reduction of disparities, and strengthening a diverse, trauma-informed behavioral health workforce.

The Plan appropriately identifies gaps in access to care—particularly for Latino, Black, and youth populations—as well as the need for culturally appropriate outreach and promotora, peer, and navigator models.

The Health Ambassador Program is already, in practice, a strategy aligned with these priorities.

Who We Are

BHRS Health Ambassadors are not Family Partners, and we are not only peers. We are 106 BHRS Messengers of Hope with lived experience and education in behavioral health.

We are a mobile outreach office for BHRS services and a direct bridge between the San Mateo County community and the pathway to recovery and whole-person wellness.

We support:

- ACCESS system call navigation and screening support
- Outreach and education about BHRS services
- Workforce pathway development into behavioral health careers

Were born in China, the Philippines, and several Latin American countries, and have lived in the United States and San Mateo County for over 15 years. Some of us were born in the USA to immigrant parents and identify as Afro-Latine, African American, Caucasian, Asian, and multiracial. We speak Chinese, Spanish, Tagalog, English, and the Indigenous Zapotec language.

We represent the racial, cultural, and linguistic diversity that the BHSA Plan identifies as a workforce priority.

Community Wellness Initiatives

Since 2019, Health Ambassadors have demonstrated flexibility, leadership, and community trust:

- Multilingual Public Service Announcements during COVID-19, including in Zapotec.
- Distribution of mental health resources at vaccination clinics.
- Facebook livestreams with physicians to educate the community about County services.
- Cross-promotion partnerships with community-based organizations.
- Healing circles and grief support spaces, especially during COVID and in moments of community loss.

These actions directly reflect the BHSA Plan's prioritized strategies of Targeted Outreach and Community Approaches.

Suicide Prevention: Measurable Impact

In 2025, the Health Ambassador Program delivered 30 suicide prevention workshops titled *"Recognize the Signs"* in 9 cities across the County, reaching 390 Spanish-speaking community members.

The impact was measurable:

- Belief that suicide is preventable increased from 71% to 94%.
- Confidence in talking about suicide increased from 59% to 89%.
- Awareness of crisis resources (988 and 211) nearly doubled.
- 96% learned practical conversation skills.
- 95% felt culturally included and respected.

One Health Ambassador reported directly supporting six individuals experiencing suicidal ideation using skills gained from the training.

In a county where suicide continues to disproportionately impact youth, men, LGBTQ+ residents, and communities facing stigma or isolation, this work is essential. When one person learns to recognize, respond, and refer, they can save a life.

Prevention becomes personal.
And community becomes the solution.

Work with Schools and Youth

The Health Ambassador Program has collaborated with school districts across San Mateo County and with Youth Leadership Institute (YLI) to provide parents with education on vaping and cannabis.

Through HAP-Y, we have also engaged youth who identify as having lived or family experience with mental health and substance use challenges, strengthening youth leadership and early prevention.

This work aligns directly with:

- **Early Intervention strategies**
- **Youth access priorities (ages 0–25)**
- **Culturally grounded engagement**
- **Community-defined practices**

PROPOSAL

Formal Integration of Alcohol and Other Drug (AOD) Services into the Health Ambassador Program

We propose that the Health Ambassador Program be formally integrated into the BHSA Three-Year Plan strategies to expand outreach and connection to BHRS Alcohol and Other Drug (AOD) services.

Rationale

1. Authentic Lived Experience

Many Health Ambassadors—both men and women—have faced challenges related to alcohol use, self-medication, and substance use disorders; we are uniquely positioned to deliver education that is culturally grounded, nonjudgmental, and rooted in hope.

Testimony:

"I had to confront my own stigma, accept that I was falling into substance use, and seek help. I first had to reach mental clarity to accept my condition as an alcoholic. Four of the six individuals I supported last year who were experiencing suicidal thoughts had also faced substance use challenges."

2. The Mental Health–Substance Use Connection

Integrating AOD education into the Health Ambassador Program strengthens the services across multiple levels: 1. Earlier Identification 2. Whole-Person Conversations 3. Reduced Stigma 4. Stronger Referral Pathways

Understanding DMC-ODS and AOD treatment options allows Ambassadors to connect individuals more effectively to integrated services rather than referring only to mental health or crisis lines.

3. Stigma Reduction

Health Ambassadors have broken stigma in their own lives by seeking help. We serve as visible models of recovery and resilience within our communities.

4. Culturally Responsive Model

The BHSA Plan prioritizes:

- Community navigators
- Promotora models
- Linguistically appropriate services
- Targeted outreach to Latino and Black communities

HAP already fulfills these criteria.

5. Workforce Development and Equity

The Health Ambassador Program creates a pathway into behavioral health careers and aligns with:

- Workforce Recruitment, Development, Training, and Retention
- Career Pathways initiatives
- Workforce equity priorities

Health Ambassadors are a lived-experience workforce pipeline.

Specific Recommendations

- Provide expanded AOD education and training to Health Ambassadors.
- Formally integrate HAP within DMC-ODS access and culturally grounded outreach strategies.
- Include HAP within the new Early Intervention RFP framework as a proven community model.
- Fund stipends and certification pathways for Ambassadors pursuing AOD credentials.
- Incorporate HAP impact metrics into BHSA access and equity indicators.

Conclusion

The BHSA Three-Year Integrated Plan acknowledges that closing access gaps requires culturally rooted, equity-driven, lived-experience- and trauma-informed community models.

The Health Ambassador Program is already that model.

We are not just volunteers.
We are not only peers.

We are a diverse community workforce pipeline.
We are prevention.
We are bridge-builders.
We are hope in action.

Formal integration of the Health Ambassador Program into the BHSA Plan will strengthen access, reduce disparities, and save lives in San Mateo County.

We are ready to continue serving—and to expand our impact.

Appendix 4. Quality Improvement Plan, FY 2024-25

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Quality Improvement Work Plan for Mental Health & SUDS July 2024 - June 2025 (Start July 2024)

System (SYS)	
DMC	DMC-ODS
MHP	Mental Health
JT	Joint DMC-ODS and Mental Health Goal

Core QM Staff (as of 3/20/23)	
QM Manager	Betty Ortiz-Gallardo
QM Unit Chief	Claudia Tinoco-Elizondo
QM Program Specialist	Jessica Zamora WOC
QM Program Specialist	Annina Altomari
QM Program Specialist	Eri Tsujii
Medical Office Specialist	Mercedes Medal
Clinical Analyst	Laurie Bell

Category (CAT)	
QI	Quality Improvement Activities
PIP	Performance Improvement Projects
UT	Utilization and Timeliness to Service Measures
AC	Access and Call Center
GN	Monitoring Grievances, Notice of Adverse Benefits Determination and Appeals
CS	Client Satisfaction and Culturally Competent Services
DMC	DMC-ODS Pilot

Core DMC-ODS Staff (as of 3/20/23)	
Deputy Director of SUD Services	Clara Boyden
SUD Clinical Services Manager	Mary Taylor Fullerton
SUD Supervisor	Desirae Walker
SUD Supervisor	Eliseo Amezcua
SUD Health Services Manager	Sheryl Uyan
SUD Program Specialist	Tracey Chan

For additional staff listed in this document, please see BHRS Organization Chart

SYS	CAT	#	Goal Description	Intervention	Measurement	Responsible Persons	Due Date	Outcomes
MH	QI	1	Maintain compliance with HIPAA, Fraud, Waste and Abuse (FWA), and Compliance training mandates.	Staff will complete online HIPAA, FWA & Compliance Training at hire and annually.	Track training compliance, HIPAA, & FWA of new staff and current staff. Current staff: Goal = or > 90% for each training. New Staff: Goal = 100% <u>Annual Required Compliance Bundle: BHRS Staff Only:</u> The assigned months for each training will be December • Annual: BHRS Compliance Mandated Training – December 2024 • Annual: BHRS Fraud, Waste, & Abuse Training – December 2024 • Annual: BHRS: Confidentiality & HIPAA for Mental Health and AOD– December 2024 • Annual: BHRS Critical incident Tracking – December 2024 • Annual: BHRS AB210 Brief Overview-December 2024	QM Staff	June 2025	
MH	QI	2	Improve clinical documentation and quality of care.	• Maintain clinical documentation training program for all current and new staff. • Train staff and contractor providers on new CalAIM requirements	Report on trainings provided via live webinar, specialty training, and online training modules Include attendance numbers where applicable.	QM Staff	June 2025	
MH	CAT	3	Implement monthly internal audits to assess compliance with new CalAIM documentation requirement with an adherence of 90% by June of 2025	• Adhere to the new CalAIM documentation standards • Contractor Audit Team will conduct internal audits of BHRS providers and contractors.	Internal Chart audits Less than 10% disallowance per BHRS program and contractors.	Audit Team	June 2025	
JT	QI	4	Create a Quality-of-Care Committee (QCC) to address system-wide quality of care issues that arise from client/beneficiary experience.	• Establish committee membership • Review quality of care concerns within committee follow-up with appropriate guidance and interventions • Review the results of these quality-of-care concerns at least annually	Create a tracker of the quality-of-care concerns raised for SOC. Annual Report to QIC and/or to the Executive Team.	Betty Ortiz-Gallardo	June 2025	
JT	QI	5	Monitor staff satisfaction with QI activities & services	• Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management Department.	Percentage of staff reporting satisfied/somewhat satisfied with QM support = or > 90%. • Are you satisfied with the help that you received from the Quality Management staff person? • Baseline:	Betty Ortiz-Gallardo QM Staff	June 2025	

					○ FY 23-24 Very Satisfied=38.87% Satisfied=43.55% Somewhat satisfied= 4.84%, Very Dissatisfied= 4.84% Total responses 62			
JT	QI	6	Create and update policies and procedures in BHRS for Mental Health and SUD	• Update current policies and procedures for new managed care rules. • Update policy Index. • Maintain internal policy committee to address needed policies and procedures. • Retire old/obsolete policies. • Create new, amend existing, and retire obsolete policies • Update policies and procedures to comply with CalAIM	• # of Policies Created • # of Policies Retired • # of Policies Amended	Policy Committee QM Staff DMC-ODS Staff	June 2025	
JT	QI	7	Comply with QIC Policy and maintain voting membership that represents all parts BHRS	• Review/amend QIC Policy as necessary. • Maintain QIC membership that represents BHRS system	• Ensure compliance with QIC Policy: communicate with QIC members as necessary. • Verify and document QIC members that represents BHRS system by 6/2021 (continuous)	Betty Ortiz-Gallardo Annina Altomari QM Staff	June 2025	
JT	QI	8	Tracking Incident Reports (IR)	• Continue to monitor and track all Incident reports. • Report trends and current data.	Report to QIC	QM Staff	June 2025	
JT	QI	9	Tracking of timeliness data for Mental Health Plan (MHP) Substance Use (SUDS) and Foster Care (FC) clients. (see definition of a new client)	• Include data for BHRS and contract agencies serving SDMC clients. • Report to Executive Team and QIC, timeliness data annually.	• % of clients being offered or receiving an assessment appointment 10 days from request to first appointment. • % of new clients receiving Psychiatry Services within 15 days from request/assessment to first psychiatric service. • Track Timeliness from request for Urgent appointment to actual encounter. (48 hrs for non-authorized service; 96 hrs for pre- authorized services)	Betty Ortiz-Gallardo Eri Tsujii Chad Kempel	June 2025	
JT	AC	10	Improve customer service and satisfaction for San Mateo County Access Call Center for MH/SUD	• Review and Revise, as needed, standards for answering calls • Provide training for Optum call center staff on standards for answering calls.	• Test calls and call logs 90% test call rated as positive	Access Call Center QM Staff	June 2025	
JT	AC	11	Monitor 24/7 access to care through Call Center and Optum. 100% of calls will be answered. 100% of test callers will be provided information on how/where to obtain services if needed.	• Make 4 test calls quarterly to 24/7 toll-free number for AOD and Mental Health services. • Make 1 test call in another language and 1 for AOD services • QM will report to call center the outcome of test calls	• 95 % or more calls answered • 95 % or more test calls logged. • 100% of requested interpreters provided • 75% of call will be rated satisfactory (Caller indicated they were helped)	QM Staff	June 2025	
JT	GN	12	Grievances will be resolved within 90 days of receipt of grievance and appeals within 30-day timeframe, expedited appeals will	• Grievance and appeals regularly addressed in Grievance and Appeal Team (GAT) Meeting.	• Annual reports on grievances, appeals, and State Fair Hearings to QIC. • Annual report with % of issues resolved to client/family member fully favorable or favorable.	GAT Team	June 2025	

			be resolved within 72 hours after receipt of expedited appeal in 100% of cases filed.		• Annual report with % grievances/appeals resolved within 90/30 days.			
JT	GN	13	Ensure that providers are informed of the resolution of all grievances and given a copy of the letter within 90 days of the grievance file date. This will have documented in the GAT file 100% of the time.	• Audit the grievance resolution folders quarterly to ensure that there is evidence that providers have been informed of the resolution.	• 80% of providers will receive the grievance resolution at the time the client is informed. This will be documented in the GAT file. • (Baseline 50%)	GAT Team Claudia Tinoco	June 2025	
JT	GN	14	Ensure that Grievance and NOABD process follow Policies and procedures for handling grievances.	• GAT will review all relevant revisions to the 2019 (Policy 19-01) Grievance Protocol and make any changes required. • Train BHRS staff and contractors on new grievance procedures • Track compliance with new Grievance and NOABD policy	• # of successfully issued NOABDs • # of Appeals completed with outcome % for favorable outcomes for client • # of successfully completed Grievances	GAT Team Claudia Tinoco	June 2025	
JT	GN	15	Decision for client's requested Change of Provider within 2 weeks	• Change of Provider Request forms will be sent to Quality Management for tracking. • Review nature of complaints, resolutions, and COP requests	Annual review of requests for change of provider: type of complaints and resolutions.	QM Staff	June 2025	
JT	CS	16	Providers will be informed of results of the beneficiary/family satisfaction surveys semi-annually.	• Inform providers/staff of the results of each survey within a specified timeline. (MHP = 2x per year, ODS = 1x per year)	• Notify programs, according to MHP/ODS requirements, consumer survey results • Presentation and notification of the results yearly.	QM Manager Scott Gruendl Clara Boyden	June 2025	
JT	CS	17	Improve cultural and linguistic competence	• "Working Effectively with Interpreters in Behavioral Health" refresher course training will be required for all direct service staff every 3 years.	• 100% of new staff will complete in-person "Working Effectively with Interpreters in Behavioral Health" • 75% of Existing staff who have taken the initial training will take the refresher training at lease every three years.	Maria Lorente-Foresti Doris Estremera Claudia Tinoco	June 2025	
JT	CS	18	Improve Linguistic Access for clients whose preferred language is other than English	• Services will be provided in the clients preferred language	• % Of clients with a preferred language other than English receiving a service in their preferred language	Doris Estremera Maria Lorente-Foresti Chad Kempel Claudia Tinoco	June 2025	
JT	CS	19	Enhance Understanding and Use of Cultural Humility as an effective practice when working with diverse populations.	• All staff will complete mandatory training on cultural humility	• 65% of staff will complete the Cultural Humility training.	Doris Estremera Maria Lorente-Foresti Claudia Tinoco	June 2025	
DMC	DMC	20	Continued utilization of Youth and Adult SUD Assessment tool.	• Work with clinical consultants and youth SUD treatment providers to develop an ASAM-based SUD Assessment tool specific to youth ages 12-17 and 18-21, and adults. Train contracted providers on its usage in Avatar EMR.	• Monitoring of youth and adult SUD Assessment tool. • Continuous training with providers serving youth 17 and under, with providers serving young people 18-21, and providers serving adults. • % of client charts audited with a completed Youth and completed Adult SUD Assessment tool.	DMC-ODS Staff IT Manager	June 2025	
DMC	DMC	21	Continued utilization of Youth Health Screening Tool	• Work with clinical consultants, youth SUD treatment providers, and medical directors to develop a youth health screening tool specific to youth ages 12-17 and 18-21.	• Monitoring of a youth health screening tool. • Continued training with providers serving youth 17 and under, and with providers serving young people 18-21. • % of client charts audited with a completed youth health screening tool.	DMC-ODS Staff	June 2025	

DMC	DMC	22	Care Coordination: Strategies to avoid hospitalizations and improve follow-up appointments. Clients discharged from residential detox services are referred and admitted follow-up care.	• ASAM evaluation and treatment referral completed prior to residential detox discharge. • Coordinate the detox discharge and subsequent admission/appointment to appropriate follow-up care.	• # of Res Detox discharges • % of clients admitted to a subsequent follow up appointment/treatment with 7 days of residential detox discharge • % of clients re-admitted to detox within 30 days	Eliseo Amezcua Mary Taylor Fullerton Sheryl Uyan	June 2025	
DMC	DMC	23	Monitor Service Delivery System: Increase treatment provider compliance with DMC-ODS documentation regulations.	• Design and implement a plan for County review of SUD treatment provider Medi-Cal beneficiary charts to allow remote monitoring for COVID-19 safety practices. • Develop an audit tool and protocols in for remote chart audits in conjunction with QM; may include auditing in Avatar and scanning charts. • Pilot Audit with each of the DMC-ODS providers	• # of charts reviewed for each DMC-ODS providers	Sheryl Uyan Desirae Walker	June 2025	
DMC	DMC	24	Develop and Implement a Training Plan for provider direct service staff that complies with DMC-ODS STC requirements around Evidenced-Based Practices (EBPs.)	• Review BHRS Standards of Care (SOC,) DMC-ODS Special Terms and Conditions (STC,) the Intergovernmental Agreement • Develop of an annual Training Plan that incorporates Evidenced-Based Practices. • Implement training plan	• Copy of training plan protocol • # of trainings offered	WET Director Sheryl Uyan Mary Fullerton Michelle Sudyka	June 2025	
DMC	DMC	25	80% of all provider direct service staff will be trained in at least 2 Evidenced-Based Practices as identified in the DMC-ODS STCs.	• Implement Training Plan for provider clinicians, counseling and supervisory staff. • Conduct personnel file reviews to confirm evidence of training on at least 2 EBPs. • Explore with BHRS Workforce Education and Training Coordinator and with Providers possible methods to improve access and compliance with EBP training requirements.	• % of all provider clinicians, counseling staff, and supervisors will be trained in at least 2 EBPs. • FY 18-19 performance is 28%	Sheryl Uyan WET Director Michelle Sudyka	June 2025	
DMC	DMC	26	All providers who are Licensed Practitioners of the Healing Arts (LPHA) clinicians will receive at least 5 hours of Addiction Medicine Training annually.	• Implement a Training Plan for provider clinicians.	• % of all provider LPHA clinicians will receive at least 5 hours of addiction medicine training annually. • FY 17/18 baseline is 35%. • FY 18/19 = 55%.	Sheryl Uyan	June 2025	
DMC	DMC	27	Monitor Service Delivery System: Create AVATAR reports needed to monitor and evaluate DMC-ODS in relation to established performance measures and standards	• Implement Avatar SUD enhancements to collect data for measures. • Identified reports are created in Avatar • Reports are reviewed quarterly for monitoring system quality and performance as sufficient data is available within the system.	• List of reports developed that meet reporting requirement for DMC-ODS	Scott Gruendl Clara Boyden Sheryl Uyan Mary Fullerton Eddie Lau Dave Williams Chad Kempel	June 2025	

DMC	DMC	28	Timeliness of first contact to first appointment:
			BHRS will track time from first request to first appointment for Outpatient SUD and Opioid Treatment Programs.
				• Develop a process to analyze timeliness data quarterly for:
				  ○ Outpatient SUD services (excluding Opioid Treatment Programs)
				  ○ Opioid Treatment Programs
				• Share data for BHRS programs and contractor agencies serving DMC-ODS clients
				• NRT providers will monitor and track timely access to services, from the time of first request to the time of first appointment.
				• Report timeliness data annually with NACT Submission on April 1, 2022.
					• % of client's receiving an Outpatient SUD Service within 10 days from request to first appointment.
					• % of clients admitted to treatment within 24 hours of making a request for Narcotic Replacement Therapy. (County Standard)
					• % of clients starting an Opioid Treatment Programs within 3 days from request to first appointment. (State measure/reference only; data not reported as County standard is more stringent).
						Chad Kempel
						Mary Taylor Fullerton
						Eri Tsujii
						Sheryl Uyan
						Alberto Ramos
							June 2025	

DMC	DMC	29	Comply with SABG requirements for Pre-Award Risk Assessments	• Complete SABG Pre-Award Risk Assessment tools annually, prior to renewing or starting a new contract.	• % of contracted SUD treatment programs receiving SABG funding with a completed Risk Assessment prior to contract renewal.	Sheryl Uyan Desirae Walker	June 2025	
DMC	DMC	30	Care Coordination: Care will be coordinated with physical health and mental health service providers.	• Implementing contract standard for physical health and mental health care coordination of services at the provider level • Audit charts to monitor compliance with standard • Develop system-wide coordination meeting with providers • Analyze TPS client survey data to monitor client satisfaction with care coordination	• % of audited client charts which comply with DMC ODS physical health examination requirements. • % of MD reviewed physical health examinations with a subsequent referral to physical health services. • % of audited client charts with a completed ACOK screening • % of positive AC OK Screens with a subsequent referral to mental health services.	Sheryl Uyan Desirae Walker Eliseo Amezcua Mary Fullerton	June 2025	

DMC	DMC	31	Assess client experience of SUD services through annual survey.	• Conduct annual TPS Survey with all provider/beneficiaries
				• Analyze TPS data and share findings with providers and stakeholders.
					• % percent of clients surveyed who indicate “staff were sensitive to my cultural background (race, religion, language, etc.)” on an annual treatment perceptions survey.
					  ○ FY 19/20: 88.8 % (N=228) – baseline
					• % of clients surveyed who indicated “I chose my treatment goals with my provider’s help” as determined by the annual SUD treatment perception survey.
					  ○ FY 19/20: 90.8 % (N=228) – baseline
					• % of clients surveyed who indicated, “As a direct result of the services I am receiving, I am better able to do the things that I want to do” as determined by the annual SUD treatment perception survey
					  ○ FY 19/20: 90.8% (N=228) - baseline
						Sheryl Uyan
						Desirae Walker
						Mary Fullerton
							June 2025	

MH	PIP	32	BHRS will continue to work on two on-going Performance Improvement Projects (PIP) for the MHP	• Continue with second year of current non-clinical PIP (BHQIP FUM PIP) • Develop an additional clinical MH PIP • Analyze data to measure progress on the clinical and non-clinical PIPs.	• Development of 2 PIP’s that are rated as active and meet EQRO standards • Committee Minutes	Eri Tsujii	June 2025	

				• Ensure that FUM PIP meets both EQRO and BHQIP requirements. • Identify additional interventions to address the identified problem(s).				
DMC	PIP	33	BHRS will continue to work on two on-going Performance Improvement Projects (PIP) for the DMC-ODS.	• Continue with second year of current clinical and non-clinical BHQIP PIPs (FUA and POD) • Analyze data to measure progress on the clinical and non-clinical PIPs. • Ensure that PIPs meet both EQRO and BHQIP requirements. • Identify additional interventions to address the identified problem(s).	• Development of 2 PIP's that are rated as active and meet EQRO standards • Committee Minutes	Eri Tsujii Clara Boyden Consultant	June 2025	

Appendix 5. Integrated Plan Budget

Table One: Behavioral Health Care Continuum Projected Expenditures									
	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults			Total Projected Expenditures on Children/Youth (under 21)			Projected Individuals to be Served Annually (May be duplicated)	
		Year One	Year Two	Year Three	Year One	Year Two	Year Three	Eligible Adults and Older	Eligible Children/TAY
Substance Use Disorder (SUD) Services									
Primary Prevention Services		$ 8,955,462.00	$ 9,410,122.00	$ 9,954,848.00	$ 868,378.00	$ 898,233.00	$ 939,238.00	192	48.00
Early Intervention Services		$ 983,431.00	$ 1,022,768.00	$ 1,063,679.00	$ 1,287,746.00	$ 1,339,256.00	$ 1,392,826.00	203.00	129.00
Outpatient Services		$ 19,378,185.00	$ 20,644,671.00	$ 21,925,859.00	$ 200,000.00	$ 208,000.00	$ 216,320.00	1389.00	59.00
Intensive Outpatient Services		$ 5,276,811.00	$ 5,487,883.00	$ 5,707,399.00	$ -	$ -	$ -	378.00	23.00
Crisis and Field-Based Services		$ 175,000.00	$ 182,000.00	$ 189,280.00	$ 100,000.00	$ 104,000.00	$ 108,160.00	684.00	36.00
Residential Treatment Services		$ 9,539,451.00	$ 10,192,962.00	$ 11,244,735.00	$ 135,000.00	$ 140,400.00	$ 151,857.00	125.00	3.00
Inpatient Services		$ -	$ -	$ -	$ -	$ -	$ -	0.00	0.00
Mental Health (MH) Services									
Primary Prevention Services		$ 1,430,748.00	$ 1,516,897.00	$ 1,612,277.00	$ 500,000.00	$ 520,000.00	$ 540,800.00	48	48
Early Intervention Services		$ 2,832,465.00	$ 3,120,630.00	$ 3,245,455.00	$ 3,317,020.00	$ 3,274,834.00	$ 3,405,828.00	4212	3980
Outpatient and Intensive Outpatient Services		$ 71,776,501.33	$ 81,758,332.00	$ 87,583,420.00	$ 60,039,795.00	$ 64,068,725.00	$ 67,873,092.00	6687	2788
Crisis Services		$ 10,045,250.00	$ 10,729,124.00	$ 11,497,929.00	$ 392,189.00	$ 407,877.00	$ 424,192.00	1499	323
Residential Treatment Services		$ 16,160,579.00	$ 16,807,002.00	$ 17,479,282.00	$ 6,598,093.00	$ 7,609,899.00	$ 8,823,746.00	936	274
Hospital and Acute Services		$ 12,906,430.00	$ 13,082,430.00	$ 13,265,470.00	$ -	$ -	$ -	702	0
Subacute and Long-Term Care Services		$ 27,822,607.00	$ 28,638,554.00	$ 29,487,139.00	$ -	$ -	$ -	365	0
Housing Services (MH + SUD)									
Housing Intervention Component Services		$ 19,034,874.00	$ 20,012,289.00	$ 21,067,620.00	$ -	$ -	$ -	412	0
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)	-	$ 206,317,794.33	$ 222,605,664.00	$ 235,324,392.00	$ 73,438,221.00	$ 78,571,224.00	$ 83,876,059.00	17832	7711

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures**		
	Year One	**Year Two**	**Year Three**
Capital Infrastructure Activities	$ 23,318,289.00	$ 14,650,921.00	$ 7,467,742.00
Workforce Investment Activities	$ 3,807,766.94	$ 3,998,154.00	$ 5,013,356.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 66,899,291.00	$ 60,572,903.00	$ 49,835,351.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs	$ 6,797,233.00	$ 7,137,094.00	$ 7,422,228.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 100,822,579.94	$ 86,359,072.00	$ 69,738,677.00

Table Three: Projected Annual Expenditures by County BH Funding Source			
	Total Annual Projected Expenditures (Year One)	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
BHSA	$ 84,996,652	$ 80,205,667	$ 76,782,070
1991 Realignment (Bronzan-McCorquodale Act)	$ 33,323,715	$ 33,424,483	$ 33,424,483
2011 Realignment (Public Safety Realignment)	$ 34,250,207	$ 37,037,477	$ 37,037,477
State General Fund	$ 12,172,967	$ 12,781,615	$ 12,781,615
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 76,710,774	$ 80,546,313	$ 84,573,628
Projects for Assistance in Transition from Homelessness (PATH)	$ 147,276	$ 147,276	$ 147,276
Community Mental Health Block Grant (MHBG)	$ 1,842,697	$ 1,842,697	$ 1,842,697
Substance Use Block Grant (SUBG)	$ 4,711,261	$ 4,711,261	$ 4,711,261
Commercial Insurance	$ 25,000	$ 25,000	$ 25,000
County General Fund	$ 70,650,475	$ 70,650,745	$ 70,650,745
Opioid Settlement Funds	$ 8,772,567	$ 9,211,195	$ 9,671,755
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ -	$ -	$ -
Other state funding (including DSH funding)	$ 19,581,314	$ 20,560,380	$ 23,542,963
Other county mental health or SUD funding	$ 33,393,690	$ 33,189,155	$ 33,748,158
Other foundation funding	$ -	$ -	$ -
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)	$ 380,578,595	$ 384,333,264	$ 388,939,128
Total projected unspent BHSA funds	$ (0)	$ 0	$ 0
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 279,756,015	$ 297,974,192	$ 319,200,451
Auto-validation: Table 2: Other County Expenditures	$ 100,822,580	$ 86,359,072	$ 69,738,677

Table Four: BHSA Transfers Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Year One				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 18,149,539.00	$ 21,174,462.00	$ 21,174,462.00	$ 60,498,463.00
Year Two				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 18,149,539.00	$ 21,174,462.00	$ 21,174,462.00	$ 60,498,463.00
Year Three				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 18,149,539.00	$ 21,174,462.00	$ 21,174,462.00	$ 60,498,463.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ 21,433,881.00	$ 8,383,046.00	$ 40,333,635.00	$ 70,150,562.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Component Percentage**	**Housing Intervention Funds**
Base Percentage	30%	$ 18,149,539.00
Amount Transferring Out	0%	$ -
Amount Transferring In	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 18,149,539.00
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage	35%	$ 21,174,462.00
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 21,174,462.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	
Base Percentage	35%	$ 21,174,462.00
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 21,174,462.00

Funding Transfer Request Allocations			
Year 1			
	Housing Intervention Component (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%
Amount Transferring Out	0%	0%	0%
Amount Transferring In	0%	0%	0%
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%
Year 2			
	Housing Intervention Component (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%
Amount Transferring Out	0%	0%	0%
Amount Transferring In	0%	0%	0%
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%
Year 3			
	Housing Intervention Component (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%
Amount Transferring Out	0%	0%	0%
Amount Transferring In	0%	0%	0%
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%

MHSA Transfers to BHSA				
MHSA Component	**Available Unspent BHSA Funds**	**Transferred to Housing Intervention Component**	**Transferred to Full-Service Partnership**	**Transferred to Behavioral Health Services and Support**
CSS	$ 38,238,562.00	$ 5,581,330.00		$ 32,157,232.00
PEI	$ 18,852,551.00	$ 15,852,551.00	$ 3,500,000.00	$ -
INN	$ 4,883,046.00	$ -	$ 4,883,046.00	
WET	$ 2,793,800.00			$ 2,793,800.00
CFTN	$ 5,382,603.00			$ 5,382,603.00
Total (auto-populated)	$ 70,150,562.00	$ 21,433,881.00	$ 8,383,046.00	$ 40,333,635.00

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	$ 5,355,145.00
Local Prudent Reserve Maximum (2)	$ 11,088,088.00
Excess Prudent Reserve Funding that must be transferred	**$ (5,732,943.00**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

Table Five: BHSA Components						
Total Housing Interventions Funding (1)						
	Year 1	**Year 2**	**Year 3**			
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 18,149,539.00	$ 18,149,539.00	$ 18,149,539.00			
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 7,144,627.00	$ 7,144,627.00	$ 7,144,627.00			
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 25,294,166.00	$ 25,294,166.00	$ 25,294,166.00			
	Projected Expenditures - Unspent MHSA and BHSA Funding Only			**Projected Expenditures - All Other Funding Sources**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ 3,661,400.00	$ 3,661,400.00	$ 3,661,400.00	$ -	$ -	$ -
Operating Subsidies	$ 3,540,627.00	$ 3,540,627.00	$ 3,540,627.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 1,162,142.00	$ 1,162,142.00	$ 1,162,142.00	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						

Rental Subsidies	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ -	$ -	$ -
Operating Subsidies	$ 2,182,327.00	$ 2,182,327.00	$ 2,182,327.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 1,461,764.00	$ 1,461,764.00	$ 1,461,764.00	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Other Housing Supports: Landlord Outreach and Mitigation Funds) (2)	$ 689,111.00	$ 689,111.00	$ 689,111.00	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 558,414.00	$ 558,414.00	$ 558,414.00	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 2,239,754.00	$ 2,239,754.00	$ 2,239,754.00	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)				$ -	$ -	$ -
Capital Development Projects	$ 6,152,822.00	$ 6,100,000.00	$ 6,100,000.00	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -			
Subtotal (auto-populated)	$ 22,648,361.00	$ 22,595,539.00	$ 22,595,539.00	$ -	$ -	$ -

Housing Interventions Component Administrative Information	Year 1	Year 2	Year 3
Housing Interventions Component Administration	$ 1,779,181.00	$ 1,779,181.00	$ 1,779,181.00
Total Housing Interventions Expenditures (auto-populated)	$ 24,427,542.00	$ 24,374,720.00	$ 24,374,720.00
Housing Interventions Populations to be Served	**Year 1**	**Year 2**	**Year 3**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 12,900,024.66	$ 12,900,024.66	$ 12,900,024.66
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ -	$ -	$ -
Housing Interventions Transfer Information	**Year 1**	**Year 2**	**Year 3**
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	24%	24%	24%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	51%	51%	51%
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY	45	45	45
Eligible Adults/Older Adults	367	367	367

Table Six: BHSA Components

Total Full Service Partnership (FSP) Funding	Year 1	Year 2	Year 3
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 21,174,462.00	$ 21,174,462.00	$ 21,174,462.00
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ 6,369,210.00	$ 1,000,000.00	$ 1,013,836.00
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 27,543,672.00	$ 22,174,462.00	$ 22,188,298.00

Full Service Partnership Category (1)									
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - Federal Financial Participation**			**Projected Expenditures - All Other Funding Sources**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 2,598,571.00	$ 2,598,571.00	$ 2,355,484.00	$ 1,299,285.50	$ 1,299,285.50	$ 1,177,742.00	$ -	$ -	$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 1,470,011.00	$ 1,470,011.00	$ 1,226,924.00	$ 735,005.50	$ 735,005.50	$ 613,462.00	$ -	$ -	$ -
FSP Intensive Case Management	$ 3,455,049.00	$ 3,455,049.00	$ 3,455,049.00	$ 2,997,502.50	$ 2,997,502.50	$ 1,727,524.50	$ -	$ -	$ -
High Fidelity Wraparound	$ 4,150,984.20	$ 4,150,984.20	$ 4,150,984.20	$ 3,459,153.50	$ 3,459,153.50	$ 2,075,492.10	$ -	$ -	$ -
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 1,117,954.00	$ 1,117,955.00	$ 1,117,954.00	$ 558,977.00	$ 558,977.50	$ 558,977.00	$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$ 1,236,164.00	$ 750,000.00	$ 750,000.00	$ 375,000.00	$ 375,000.00	$ 375,000.00	$ -	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Drop In Center, Flex Funds, Enhanced Education	$ 6,931,907.00	$ 6,931,908.00	$ 6,931,907.00	$ -	$ -	$ -	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc,.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Innovative FSP Pilots and Projects	$ -	$ -	$ -						
Subtotal (auto-populated)	$ 20,960,640.20	$ 20,474,478.20	$ 19,988,302.20	$ 9,424,924.00	$ 9,424,924.50	$ 6,528,197.60	$ -	$ -	$ -
FSP Administrative Information	**Year 1**	**Year 2**	**Year 3**						
Full Service Partnership Administration	$ 1,847,131.00	$ 1,847,131.00	$ 1,847,131.00						
Total Full Service Partnership Expenditures (auto-populated)	$ 22,807,771.20	$ 22,321,609.20	$ 21,835,433.20						
FSP Transfer Information	**Year 1**	**Year 2**	**Year 3**						
Transfers into FSP component from Local Prudent Reserve	$ -	$ -	$ -						
Transfers out of FSP component into Local Prudent Reserve	$ 2,883,046.00	$ 2,000,000.00	$ -						
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**						
Eligible Children/TAY	120	120	120						
Eligible Adults/Older Adults	485	485	485						

Table Seven: BHSA Components									
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - Federal Financial Participation**			**Projected Expenditures - All Other Funding Sources**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 21,174,462.00	$ 21,174,462.00	$ 21,174,462.00						
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 12,282,603.00	$ 7,900,000.00	$ 6,900,000.00						
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 33,457,065.00	$ 29,074,462.00	$ 28,074,462.00						
Behavioral Health Services and Supports Category (1)									
BHSS Programs/Services									
Children's System of Care-Non FSP	$741,706.00	$741,706.00	$741,706.00	$ -	$ -	$ -	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)((1) and 5892(a)((2)-Non FSP	$8,454,006.00	$7,700,694.00	$7,405,694.00	$ 845,400.00	$ 770,000.00	$ 740,500.00	$ -	$ -	$ -
Early Intervention Expenditures	$17,268,952.00	$15,103,118.00	$13,989,785.00	$ 1,700,000.00	$ 3,000,000.00	$ 2,700,000.00	$ -	$ -	$ -
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$8,838,067.00	$7,923,367.00	$7,371,567.00	$ 838,000.00	$ 792,300.00	$ 737,160.00	$ -	$ -	$ -
Coordinated Specialty Care for First Episode Psychosis	$1,185,638.00	$1,185,638.00	$1,185,638.00	$ 592,819.00	$ 592,819.00	$ 592,819.00	$ -	$ -	$ -
Outreach and Engagement	$394,380.00	$394,380.00	$394,380.00	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Education and Training (WET)	$900,000.00	$900,000.00	$900,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds				$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ 900,000.00	$ 900,000.00	$ 900,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 5,382,603.00	$ 4,230,000.00	$ 2,830,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds		$ 4,230,000.00	$ 2,830,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ 5,382,603.00			$ -	$ -	$ -	$ -	$ -	$ -
Innovative BHSS Pilots and Projects	$ -	$ -	$ -						
Subtotal (auto-populated)	$ 33,141,647.00	$ 29,069,898.00	$ 26,261,565.00	$ 2,545,400.00	$ 3,770,000.00	$ 3,440,500.00	$ -	$ -	$ -

BHSS Administrative Information	**Year 1**	**Year 2**	**Year 3**
Behavioral Health Services and Supports Administration	$ 2,251,081.00	$ 2,070,831.00	$ 1,941,731.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 35,392,728.00	$ 31,140,729.00	$ 28,203,296.00
BHSS Prudent Reserve Transfer Information	**Year 1**	**Year 2**	**Year 3**
Transfers into BHSS component from Local Prudent Reserve	$ -	$ -	$ -
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	68%	56%	52%
Youth-Focused Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	51%	52%	53%
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY	5275	6275	6275
Eligible Adults/Older Adults	5712	5712	5712
Projected BHSS Funds transferred to WET or CF/TN	**Year 1**	**Year 2**	**Year 3**
BHSS transfer to WET	$ -	$ -	$ -
BHSS transfer to CF/TN	$ -	$ 4,230,000.00	$ 2,830,000.00
Projected MHSA-Origin WET and CF/TN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
Estimated MHSA WET Funds	$ 2,793,800.00	$ 1,893,800.00	$ 993,800.00
Estimated MHSA CF/TN Funds	$ 5,382,603.00	$ -	$ -

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year 1**	**Year 2**	**Year 3**
Total Projected Improvement and Monitoring Expenditures	$ 1,234,662.00	$ 1,234,662.00	$ 1,234,662.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 1,133,947.00	$ 1,133,947.00	$ 1,133,947.00
New and Ongoing Administrative Costs	$0.00	$0.00	$0.00
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 61,733,124.00	$ 61,733,124.00	$ 61,733,124.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	2%	2%	2%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	2%	2%	2%
Supplemental BHT Implementation Funding (1)	$ -	$ -	$ -

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	$ 5,355,145.00
Local Prudent Reserve Maximum (1)	$ 11,088,088.00
Excess Prudent Reserve Funds (auto-populated)	$ (5,732,943.00)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reservice funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	DOES NOT EQUAL
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ 4,883,046.00
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	**Full-Service Partnerships**	**Behavioral Health Services and Supports**	**Total**
Allocation Percentage, with Transfers	30%	35%	35%	100%
Year One Component Allocations	$ 18,149,539.00	$ 21,174,462.00	$ 21,174,462.00	$ 60,498,463.00
Year Two Component Allocations	$ 18,149,539.00	$ 21,174,462.00	$ 21,174,462.00	$ 60,498,463.00
Year Three Component Allocations	$ 18,149,539.00	$ 21,174,462.00	$ 21,174,462.00	$ 60,498,463.00
BHSA Funding Summary	**Housing Interventions**	**Full Service Partnerships**	**Behavioral Health Services and Supports**	**Totals**
Year One				
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) ***(Unspent Carryover MHSA Funds)***	$ 21,433,881.00	$ 8,383,046.00	$ 40,333,635.00	$ 70,150,562.00
Estimated Year One Component Allocations ***(BHSA Funding Only)***	$ 18,149,539.00	$ 21,174,462.00	$ 21,174,462.00	$ 60,498,463.00
Transfers Into PR	$ -	$ 2,883,046.00	$ -	$ 2,883,046.00
Transfers From PR	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year One	$ 39,583,420.00	$ 26,674,462.00	$ 61,508,097.00	$ 127,765,979.00
Estimated Total Year One Expenditures	$ 24,427,542.00	$ 22,807,771.20	$ 35,392,728.00	$ 82,628,041.20
Year Two				
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 15,155,878.00	$ 3,866,690.80	$ 26,115,369.00	$ 45,137,937.80
Estimated New Year Two Component Allocations ***(BHSA Funding Only)***	$ 18,149,539.00	$ 21,174,462.00	$ 21,174,462.00	$ 60,498,463.00
Transfers Into PR	$ -	$ 2,000,000.00	$ -	$ 2,000,000.00
Transfers from PR	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year Two	$ 33,305,417.00	$ 23,041,152.80	$ 47,289,831.00	$ 103,636,400.80
Estimated Total Year Two Expenditures	$ 24,374,720.00	$ 22,321,609.20	$ 31,140,729.00	$ 77,837,058.20
Year Three				
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 8,930,697.00	$ 719,543.60	$ 16,149,102.00	$ 25,799,342.60
Estimated New Year Three Component Allocations ***(BHSA Funding Only)***	$ 18,149,539.00	$ 21,174,462.00	$ 21,174,462.00	$ 60,498,463.00
Transfers Into PR	$ -	$ -	$ -	$ -
Transfers from PR	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year Three	$ 27,080,236.00	$ 21,894,005.60	$ 37,323,564.00	$ 86,297,805.60
Estimated Total Year Three Expenditures	$ 24,374,720.00	$ 21,835,433.20	$ 28,203,296.00	$ 74,413,449.20