Behavioral Health Services Act Three-Year Integrated Plan

County of Monterey Health Department Behavioral Health Bureau

Fiscal Year 2026/27 through 2028/29

DRAFT

COUNTY OF MONTEREY
HEALTH DEPARTMENT

MONTEREY COUNTY
BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

County of Monterey Health Department
Behavioral Health Bureau
Behavioral Health Services Act (BHSA)
Three-Year Integrated Plan and Budget
Fiscal Year 2026/27 through 2028/29

Introduction

The County of Monterey Health Department's Behavioral Health Bureau (MCBH) is pleased to present the Fiscal Years 2026/27 through 2028/29 Behavioral Health Services Act (BHSA) Three-Year Integrated Plan. This BHSA Integrated Plan reflects MCBH's continued commitment to strengthening a coordinated, community-informed behavioral health system that supports individuals and families throughout Monterey County.

The Behavioral Health Services Act, established through Proposition 1 and Senate Bill 326 (SB 326), represents a significant statewide transformation in how behavioral health services are funded, structured, and delivered throughout California. The BHSA replaces the Mental Health Services Act (MHSA) framework and introduces new statewide requirements related to funding structure, service categories, accountability, housing interventions, outcomes, and integrated behavioral health planning across mental health and substance use disorder systems.

As part of BHSA implementation, every county in California is required to develop and submit a Three-Year Integrated Plan using standardized Integrated Plan and Budget Templates established by the California Department of Health Care Services (DHCS). The Integrated Plan is intended to support statewide consistency, transparency, and alignment between state behavioral health priorities, local planning efforts, and community identified needs.

Unlike prior MHSA Three-Year Program and Expenditure Plans, the BHSA Integrated Plan represents a broader, systemwide planning and accountability framework that demonstrates how counties will align behavioral health services, funding strategies, statewide priorities, and local needs across the continuum of care. The Integrated Plan is not intended to serve as a comprehensive inventory of all behavioral health programs, services, and activities provided within the community. Rather, its purpose is to document county alignment with the new service delivery, eligibility, and funding requirements established under the BHSA.

This Integrated Plan was developed using the required DHCS Integrated Plan Template and accompanying Budget Templates, consistent with statewide BHSA planning and reporting requirements. The Plan was informed by multiple data sources, including statewide and local secondary data, stakeholder input, and findings from relevant planning and assessment efforts. Several data gaps in County and state-provided data exist. To address identified data gaps, the County will continue strengthening its behavioral health data infrastructure, partner data-sharing processes, and internal reporting workflows over the implementation period. Key resources reviewed during the development of the Plan included the Lead Me Home Plan, the Housing Tools Residential Care Facility Incubator

(RCFI) Final Innovative Project Report, Community Health Needs Assessment (CHNA), and other local and regional reports relevant to behavioral health service delivery, housing, workforce, and community wellbeing. The Plan is intended to support transparency, shared understanding, and alignment between state expectations, local behavioral health priorities, and community-identified needs.

Stakeholder Engagement

This Integrated Plan was developed in accordance with DHCS guidance and informed through the Community Planning Process. This includes community listening sessions, system partner engagement activities, local data review of population health data, and cross-sector collaboration efforts.

Community feedback, system data, and stakeholder input helped inform local priorities, identify service gaps, and shape strategies included throughout this Plan.

MCBH Priorities

The Integrated Plan reflects continued focus on:

- Providing specialized behavioral health treatment and supports for individuals with severe needs that significantly impair daily functioning
- Reducing homelessness among individuals with severe behavioral health conditions
- Addressing disparities in access, engagement, and behavioral health outcomes
- Strengthening coordination and continuity across systems of care
- Maintaining core behavioral health services during a period of significant fiscal and operational transition under BHSA

As reflected throughout this Plan, MCBH remains committed to accessible, coordinated, and community-based behavioral health services for Monterey County residents while thoughtfully navigating the transition from MHSA to BHSA and maintaining continuity of care during a period of significant system change.

Acknowledgement

The County of Monterey extends its sincere appreciation to all community members, partners, stakeholders, providers, advocates, and individuals with lived experience who contributed to the development of this Integrated Plan.

Through continued collaboration and community engagement, MCBH remains committed to promoting wellness, resilience, and recovery through community support and partnering to provide welcoming mental health and substance use care.

Table of Contents

Table of Contents 4

General Information 5

Exemption Requests 6

Funding Transfer Requests 6

County Behavioral Health System Overview 11

Statewide Behavioral Health Goals 24

Community Planning Process 54

Comment Period and Public Hearing 67

County Behavioral Health Services Care Continuum 85

County Provider Monitoring and Oversight 85

Behavioral Health Services Act/Fund Programs 89

Workforce Strategy 129

Budget and Prudent Reserve 133

Plan Approval and Compliance 133

Appendix: Behavioral Health Services and Supports (BHSS) Programs 137

DRAFT

General Information

1. Type of Entity:
   ☒ **County**
   ☐ City
   ☐ Joint Powers
   ☐ Joint Submission
2. Entity Name: County of Monterey
3. Behavioral Health Agency Name: Monterey County Behavioral Health
4. Behavioral Health Agency Mailing Address: 1270 Natividad Rd., Salinas, CA 93906
5. Primary Mental Health Contact
   a. Name: **Melanie Rhodes,**
      Behavioral Health Bureau Chief / Behavioral Health Director
   b. Email: **RhodesM@countyofmonterey.gov**
   c. Phone: **(831) 796-1742**
6. Secondary Mental Health Contact
   a. Name: Fabricio Chombo, Assistant Bureau Chief
   b. Email: **ChomboF@countyofmonterey.gov**
   c. Phone: **(831) 755-4578**
7. Primary Substance Use Disorder Contact
   a. Name: **Deputy Director of Behavioral Health QA/QI – Open Position**
   b. Email: **415-QA@countyofmonterey.gov**
   c. Phone: **(831) 755-4545**
8. Secondary Substance Use Disorder Contact
   a. Name: **Rachel Amerault**
   b. Email: **AmeraultRE@countyofmonterey.gov**
   c. Phone: **(831) 258-8411**
9. Primary Housing Interventions Contact (Optional. Enter if different from those listed above.)
   a. Name: **Phil Sherwood**
   b. Email: **SherwoodP@countyofmonterey.gov**
   c. Phone: **(831) 277-9098**
10. Compliance Officer for Specialty Mental Health Services (SMHS)
   a. Name: **Deputy Director of Behavioral Health QA/QI – Open Position**
   b. Email: **415-QA@countyofmonterey.gov**
   c. Phone:
11. Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services (For some counties the Compliance Officer names will be the same. No compliance officer for DMC State Plan is required.)

DRAFT

a. Name: **Deputy Director of Behavioral Health QA/QI – Open Position**
b. Email: **415-QA@countyofmonterey.gov**
c. Name: Email:

12. Behavioral Health Services Act (BHSA) Coordinator (Minimum one contact required)
    a. Name: **Shannon Castro** Email: **CastroS@countyofmonterey.gov**
    b. Name: Email:
13. Substance Abuse and Mental Health Services Administration (SAMHSA) liaison (Minimum one contact required)
    a. Name: **Rachel Amerault**
    b. Email: **AmeraultRE@countyofmonterey.gov**
    c. Name: Email:
14. Quality Assurance or Quality Improvement (QA/QI) lead (Minimum one contact required)
    a. Name: **Deputy Director of Behavioral Health QA/QI – Open Position**
    b. Email: **415-QA@countyofmonterey.gov**
    c. Name: **Janet Hernandez Barajas, Quality Improvement Services Manager II**
    d. Email: **BarajasJH@countyofmonterey.gov**
15. Medical Director (Minimum one contact required)
    a. Name: **Medical Director – Open Position**
    b. Email:
    c. Name: Email:

Exemption Requests

Not applicable: county population maximum of 200,000 surpassed.

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.

Please enter the proposed allocation adjustments to the tables below.

- Each year column must equal 100 percent.
- Counties may transfer no more than 7 percent from each component to another component, with a maximum of 14 percent of total funds transferred.
- If the county allocates any Housing Interventions outreach and engagement funds up to 7 percent, the amount of funds the county can transfer out of the Housing Interventions allocation component must be decreased by the corresponding amount.

DRAFT

- The base percentage for Housing Interventions may be higher or lower for small counties requesting a Housing Interventions exemption.
- 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.

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%]	42%	42%	42%
Full Service Partnership [Base 35%]	35%	35%	35%
Housing Interventions [Base 30%]	23%	23%	23%
Housing Interventions for Outreach and Engagement	0%	0%	0%

Behavioral Health Services and Supports Transfers

1. Enter the proposed dollars transferred into/from Behavioral Health Services and Supports (Base 35%)

Table 2. Behavioral Health Services and Supports Transfers

BHSA Component	Plan Year One	Plan Year Two	Plan Year Three
Dollars transferred from Full Service Partnerships	$0	$0	$0
Dollars transferred from Housing Interventions	$2,746,839.40	$ 2,829,244.58	$ 2,914,121.92
Dollars transferred into Full Service Partnerships	$0	$0	$0
Dollars transferred into Housing Interventions	$0	$0	$0

2. For Behavioral Health Services and Supports, please include a rationale for the funding allocation transfer request: The County of **Monterey Behavioral Health has historically utilized MHSA funds primarily to support direct behavioral health services across the system of care. Under the Behavioral Health Services Act, the shift in funding structure, combined with the 5 percent statewide allocation, results in an effective 35 percent reduction in locally available service dollars if no transfer authority is exercised. Absorbing a reduction of this magnitude would significantly disrupt existing service capacity, including outpatient treatment, Full-Service Partnerships, and other core supports that individuals and families currently rely**

upon. Maximizing the allowable transfer from the Housing Intervention funding component to the Behavioral Health Services and Supports funding component is necessary to stabilize the local system of care during this transition. The County recognizes the critical role that housing plays in behavioral health recovery and community stability and remains committed to achieving the long-term vision of a fully developed Housing Interventions continuum. At the same time, BHSA implementation requires consideration of the full behavioral health continuum, including prevention and early intervention services, outpatient treatment, intensive community-based services, crisis response, residential care, workforce needs, and housing supports.

Additional planning, analysis, and collaboration with behavioral health providers, housing partners, health care organizations, homelessness response partners, and other community stakeholders is needed to fully evaluate the potential impacts of current funding changes across the broader system of care. During the three-year implementation period, MCBH will continue assessing community needs, service utilization patterns, housing needs, system capacity, and available funding opportunities to help inform future decisions regarding the timing, pace, and approach for aligning with the full BHSA Housing Interventions funding allocation. This process will help ensure that future investments in Housing Interventions are implemented in a manner that strengthens housing resources while maintaining the stability and effectiveness of the broader behavioral health system of care.

Full Service Partnerships Transfers

1. Enter the proposed dollars transferred into/from Full Service Partnerships (Base 35%)

Table 3. Full Service Partnerships Transfers

BHSA Component	Plan Year One	Plan Year Two	Plan Year Three
Dollars transferred from Behavioral Health Services and Supports	$0	$0	$0
Dollars transferred from Housing Interventions	$0	$0	$0
Dollars transferred into Behavioral Health Services and Supports	$0	$0	$0
Dollars transferred into Housing Interventions	$0	$0	$0

2. For Full Service Partnerships, please include a rationale for the funding allocation transfer request: **n/a**

Housing Interventions Transfers

1. Enter the proposed dollars transferred into/from Housing Interventions (Base 30%)

Table 4. Housing Interventions Transfers

BHSA Component	Plan Year One	Plan Year Two	Plan Year Three
Dollars transferred from Behavioral Health Services and Supports	$0	$0	$0
Dollars transferred from Full Service Partnerships	$0	$0	$0
Dollars transferred into Behavioral Health Services and Supports	$2,746,839.40	$ 2,829,244.58	$ 2,914,121.92
Dollars transferred into Full Service Partnerships	$0	$0	$0

2. For Housing Interventions, please include a rationale for the funding allocation transfer request: **While Housing Interventions remain a critical strategy for long-term stability and recovery, the County of Monterey may need to moderate spending from the Housing Intervention funding component during the initial years of BHSA implementation in order to protect the broader behavioral health treatment system. The County's historical reliance on MHSA funds for direct behavioral health services means that the structural fiscal changes under BHSA create a substantial funding reduction for core treatment, outpatient, crisis, and Full-Service Partnership services. Expanding Housing Intervention expenditures without stabilizing the underlying service infrastructure could result in individuals being housed but unable to access sufficient clinical and rehabilitative supports necessary to sustain housing and recovery.**

Supporting Information and Data

1. How does this funding transfer request respond to community needs and input? **The County of Monterey's request to maximize the allowable transfer from the Housing Intervention (HI) component to the Behavioral Health Services and Supports (BHSS) component is grounded in documented community needs and demonstrated service demand.**
   Community planning findings consistently indicate significant gaps in access to mental health and substance use treatment. Residents identified anxiety, alcohol use disorder, and trauma as top concerns, while more than half of respondents reported that mental health services are insufficient to meet community needs. Conversations with community and system stakeholders characterized access to care as a major problem, citing provider shortages, long wait times, limited specialty services, and inadequate language access.

High-need populations, including individuals experiencing housing instability, Medi-Cal recipients, and Indigenous language speakers, reported even greater barriers to accessing services. Community members emphasized that housing alone is not sufficient for long-term stability without integrated behavioral health treatment, crisis response, case management, and culturally responsive supports.

Maximizing the transfer to BHSS allows the County to address documented service gaps, strengthen treatment capacity, and ensure that housing interventions are supported by the behavioral health infrastructure necessary for sustained outcomes.

2. Please include local data supporting the funding transfer request (add/subtract supporting document bullets as needed):
    a. Supporting document file name: 2025 PRC CHNA Report – Monterey County, CA_.pdf 2025 PRC CHNA Report - Monterey County, CA_.pdf
    b. Supporting document file name: MCBH-CPPP-FY25-26_Report_FINAL.pdf
    c. Supporting document file name:

DRAFT

County Behavioral Health System Overview

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

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

Populations Served by County Behavioral Health System

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

Children and Youth

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
Received Medi-Cal Specialty Mental Health Services (SMHS)	**96.7 per 10,000**
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	**1,045 individuals**
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	**2.6 per 10,000**
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC- ODS plan	**1.3 per 10,000**

DRAFT

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	**6 individuals**
Were chronically homeless or experiencing homelessness or at risk of homelessness	**33 individuals**
Were in the juvenile justice system	**301 individuals**
Have reentered the community from a youth correctional facility	**49 individuals**
Were served by the Mental Health Plan and had an open child welfare case	**4.8 per 10,000**
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	**0.02 per 10,000**
Have received acute psychiatric care	**151 individuals**

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	**284 individuals**
Received Medi-Cal SMHS	**146.6 per 10,000**
Received DMC or DMC-ODS services	**39.3 per 10,000**
Received MH and SUD services from the MHP and DMC county or DMC- ODS plan	**18.6 per 10,000**
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	**865 individuals**
Experienced unsheltered homelessness	**000 individuals**
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	**000 individuals**
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	**000 individuals**

DRAFT

Were in the justice system (on parole or probation and not currently incarcerated)	**390 individuals**
Were incarcerated (including state prison and jail)	**57 individuals**
Reentered the community from state prison or county jail	**291 individuals**
Received acute psychiatric services	**509 individuals**

2. Input the number of persons in designated and approved facilities who were:
    a. Admitted or detained for 72-hour evaluation and treatment (rate): **34.2**
    b. Admitted for 14-day periods of intensive treatment: **000**
    c. Admitted for 30-day periods of intensive treatment: **000**
    d. Admitted for 180-day post certification intensive treatment: **000**
3. Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs: **11**
4. Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs): **0**
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** ☐ No

    a. If yes, please explain: **There are data sharing limitations across agencies (i.e. corrections, probation, child welfare, hospitals, etc.). Monterey County Behavioral Health relies on data entered in the EHR or manual counts shared from other entities. Data for the following fields were not available at the time of plan development and therefore are not reported in this Integrated Plan: the number of individuals who experienced unsheltered homelessness; the number who moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing); and, of those who moved from unsheltered to sheltered, the number who transitioned into permanent housing. In addition, the following institutionalization measures are reported as 000 because discrete counts were not available: the number of individuals admitted for 14-day periods of intensive treatment, the number admitted for 30-day periods of intensive treatment, and the number admitted for 180-day post-certification intensive treatment. Data for 14-day and 30-day involuntary holds were combined in the available source data and could not be reliably separated into the required categories.**

6. Please describe the local data used during the planning process: Electronic health record (Avatar) and LPS data from local hospitals (NMC/CHOMP):

DRAFT

County of Monterey used multiple local quantitative and administrative data sources to inform planning for Behavioral Health Services Act (BHSA) implementation. Primary analyses relied on data extracted from the County's behavioral health electronic health record (EHR) and quality improvement reporting systems for Fiscal Year 2024–25, inclusive of county-operated and contracted providers and the full behavioral health population, not limited to MHSA-funded services.

For children and youth, the County reviewed distinct counts of individuals receiving Medi-Cal Specialty Mental Health Services, substance use disorder prevention, early intervention, and treatment services, including Drug Medi-Cal and DMC-ODS. Program-level data were examined for youth involved in justice-involved services, early psychosis and first episode programs, child welfare–associated programs, and those experiencing homelessness or housing instability. Data on youth reentering the community from juvenile justice settings and those receiving acute psychiatric inpatient care were also reviewed.

For adults and older adults, the County analyzed EHR and administrative data on utilization of Medi-Cal Specialty Mental Health Services, DMC and DMC-ODS services, and co-occurring mental health and substance use disorder treatment. Additional analyses focused on populations experiencing homelessness or housing instability, justice involvement including diversion and forensic programs, reentry from incarceration, acute psychiatric inpatient care, and individuals dually eligible for Medicare and Medi-Cal.

The County also reviewed Lanterman-Petris-Short (LPS) Act reporting related to involuntary treatment episodes, Department of State Hospital placements, and community-based restoration programs to assess demand across the crisis continuum of care.

The County recognizes limitations related to cross-system data sharing with hospitals, corrections, probation, and child welfare partners. As a result, some data rely on EHR intake fields or manual counts provided by partner agencies. Despite these limitations, the combined data sources provided a comprehensive local foundation to inform BHSA planning and priority population identification.

7. If desired, provide documentation on the local data used during the planning process (add/subtract supporting document bullets as needed):
    d. Supporting document file name: **N/A**

Local CARE Act Implementation

1. 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.

Under the BHSA 3-year Integrated Plan, the county supports Community Assistance, Recovery, and Empowerment (CARE) Act participants with FSP-ICM and BHSS ASOC funding components by providing a dedicated team of service providers and leveraging existing resources to include Full-Service Partnerships (FSP), integrated dual-diagnosis substance use services, and mobile crisis response teams. To ensure priority access, the county established expedited engagement and assessment procedures, and contractual mandates for community providers to fast-track referrals for CARE participants. Specialized coordination is managed by the CARE Act treatment team that bridges the gap between the participant, behavioral health and housing providers, and the court. Participants receive individualized treatment plans to meet their needs that can include medication support services, individual counseling, therapy, psychosocial rehabilitation, crisis intervention and peer support services with the goal of fostering long-term recovery. Furthermore, the county guarantees priority placement into a tiered housing continuum, funded with BHSA Housing Intervention dollars under rental subsidies, operating subsidies, housing transition services, and tenancy sustaining services. Supports include residential care facilities, transitional and permanent supported housing, and Behavioral Health Bridge Housing at the Hope Housing Marina program which helps homeless / at risk of homeless with serious mental illness and moderate to severe substance use disorders transition into housing and stabilize while being connected to on-site services and help in their transition to secure long-term residential and clinical stability.

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

The entire CARE pathway is seamlessly integrated into our current referral system. Our internal Behavioral Health treatment teams serving those 18 years of age or older have been trained on CARE eligibility criteria by our specialized CARE team. We have set up a consultation model so internal treatment teams can request a case consultation to review CARE eligibility criteria with the team, and our CARE team can move forward with filing petitions in appropriate cases to expedite the process. Information is tracked in our Electronic Health Record (Avatar) system for real-time cross-departmental visibility. We leverage existing systems and workflows and utilize existing mobile crisis units to identify candidates or re-link active persons of care to treatment. To maximize community awareness and seamless entry, we partner closely with external partners / stakeholders such as hospitals, public guardian, county contracted providers, community-based organizations, law enforcement and other first responders, the county jail and their embedded treatment provider. We strive to improve communication and coordination with state entities such as CDCR and DSH around the filing of CARE petitions. We have a dedicated page on our public-facing website that provides information on CARE and has a secure referral mechanism for community members, partners or other interested stakeholders to provide our team information or make a referral to our team to follow-up on. We provided numerous presentations to community, partners, providers, other interested stakeholders leading up to the CARE go-live on 12/1/2024 and continue this work to date. Once identified, CARE participants are connected through the county's existing access, assessment, treatment,

housing, crisis, and care coordination pathways, allowing CARE services to function as an enhancement to existing behavioral health workflows rather than a separate service system.

3. 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.

To identify and redirect individuals who are potentially eligible for CARE to alternative pathways when a formal petition is not required or appropriate, the county utilizes a supportive "warm hand-off" approach. If an individual is determined to be ineligible for CARE court or if a formal petition is deemed inappropriate, the county ensures they are never left to navigate the system alone; instead, dedicated CARE staff immediately step in to link them directly to appropriate level of care resources. This redirection process includes scheduling appointments and supporting linkage of individuals with the Mental Health Plan, Managed Care Plan, and/or DMC-ODS system as clinically indicated. The team also provides referrals and linkages to additional social service and housing resources as appropriate. To confirm and document a successful connection to services, the county tracks each individual's transition through to their initial intake, maintaining a rigorous standard of accountability that has successfully connected every single individual not accepted into the CARE program to an appropriate form of mental health treatment to date.

County Behavioral Health Technical Infrastructure

1. Does the county behavioral health system use an Electronic Health Record (EHR)? ☒ **Yes** ☐ No
   a. If yes, please select which of the following EHRs the county uses (select all that apply):
      i. ☐ Altera Digital Health
      ii. ☐ Athena Health
      iii. ☐ Clinician's Gateway
      iv. ☐ CPSI
      v. ☐ eClinicalWorks
      vi. ☐ Epic Systems
      vii. ☐ GE Centricity
      viii. ☐ Greenway Health
      ix. ☐ MEDHOST
      x. ☐ MediTech
      xi. ☒ Netsmart
      xii. ☐ NextGen Healthcare
      xiii. ☐ Oracle Cerner
      xiv. ☐ Practice Fusion
      xv. ☐ Qualifacts Credible
      xvi. ☐ SmartCare

DRAFT

xvii. ☐ TherapyNotes

xviii. ☐ Other

2. Does the county behavioral health system participate in a Qualified Health Information Organization (QHIO)? ☐ Yes ☒ **No**
   a. If yes, please select which QHIO the county participates in (select all that apply):
      i. ☐ Cozeva
      ii. ☐ Health Gorilla, Inc.
      iii. ☐ Long Health, Inc.
      iv. ☐ Los Angeles Network for Enhanced Services (LANES)
      v. ☒ Manifest MedEx
      vi. ☐ Orange County Partners in Health HIE
      vii. ☐ Serving Communities Health Information Organization
      viii. ☐ San Diego Health Connect
      ix. ☐ SacValley MedShare

Application Programming Interface Information

1. Please provide the link to the county's API endpoint on the county behavioral health plan's website: Provider Directory | County of Monterey, CA
2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   ☐ Yes ☒ **No**
   a. If yes, please describe these challenges and concerns: **N/A**
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?
   ☐ Yes ☒ **No**
   a. If yes, please describe these challenges and concerns: **N/A**

County Behavioral Health System Service Delivery Landscape

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** ☐ No
   a. If yes, please select all services the county behavioral health system plans to provide under the PATH grant (select all that apply):
      i. ☐ Alcohol or Drug Treatment Services
      ii. ☐ Case Management Services
      iii. ☐ Community Mental Health Services

DRAFT

iv. ☒ **Habilitation and Rehabilitation Services**
v. ☒ **Outreach Services**
vi. ☒ **Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services**
vii. ☒ **Screening and Diagnostic Treatment Services**
viii. ☐ 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 service
ix. ☐ Supportive and Supervisory Services in Residential Settings

2. If "Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services" is selected above, please select the county's referrals for Primary Health Care, Job Training, Educational Services, and Housing Services (select all that apply):
   a. ☒ **Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations**
   b. ☐ Improving the Coordination of Housing Services
   c. ☐ Minor Renovation, Expansion, and Repair of Housing
   d. ☐ One-time Rental Payments to Prevent Eviction
   e. ☐ Planning of Housing
   f. ☐ Security Deposits
   g. ☐ Technical Assistance in Applying for Housing
3. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
   ☐ Yes ☒ **No**
   a. If yes, 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** ☐ No
   a. If yes, please select all set asides that the county behavioral health system plans to participate in under the MHBG:
      i. ☒ **Children's System of Care Set-Aside**
      ii. ☒ **Discretionary/Base Allocation**
      iii. ☒ **Dual Diagnosis Set-Aside**
      iv. ☒ **First Episode Psychosis Set-Aside**
      v. ☒ **Integrated Services Agency Set-Aside**
2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? ☐ Yes ☒ **No**

DRAFT

a. If yes, 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** ☐ No
    a. If yes, please select all set-asides that the county behavioral health system participates in under SUBG (select all that apply):
        i. ☒ Adolescent/Youth Set-Aside
        ii. ☒ Discretionary
        iii. ☒ Perinatal Set-Aside
        iv. ☒ Primary Prevention Set-Aside
        v. ☐ Syringe Services Program Allowance
2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? ☐ Yes ☒ **No**
    a. If yes, 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** ☐ No
    a. If yes, please check all set-asides the county behavioral health system participates in under OSF Exhibit E (select all that apply):
        i. ☒ Address The Needs of Criminal Justice-Involved Persons
        ii. ☒ Address The Needs of Pregnant or Parenting Women and Their Families, Including Babies with Neonatal Abstinence Syndrome
        iii. ☒ Connect People Who Need Help to The Help They Need (Connections to Care)
        iv. ☐ First Responders
        v. ☒ Leadership, Planning, and Coordination
        vi. ☒ Prevent Misuse of Opioids
        vii. ☒ Prevent Overdose Deaths and Other Harms (Harm Reduction)
        viii. ☐ Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
        ix. ☐ Research
        x. ☒ Support People in Treatment and Recovery
        xi. ☒ Treat Opioid Use Disorder (OUD)
        xii. ☒ Training

DRAFT

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

   ☐ Yes ☒ **No**

   a. If yes, 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):

- Case Management
- Comprehensive Evaluation and Assessment
- Group Services
- Individual Service Plan
- Medication Education and Management
- Pre-crisis and Crisis Services
- Rehabilitation and Support Services
- Residential Services
- Services for Homeless Persons
- Twenty-four-hour Treatment Services
- 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:
   a. ☐ Assertive Community Treatment (ACT)
   b. ☐ Clubhouse Services
   c. ☐ Community Health Worker Services (CHW)
   d. ☐ Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
   e. ☐ Forensic Assertive Community Treatment (FACT)
   f. ☐ Individual Placement and Support (IPS) Model of Supported Employment
   g. ☐ Other Programs and Services
2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

   ☐ Yes ☒ **No**

   a. If yes, 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):

DRAFT

- Drug Courts
- Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
- Regular and Perinatal Drug Medi-Cal Services
- Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
- 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?

   ☐ Yes ☒ **No**

   a. If yes, 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).

- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Residential Treatment Services
- Crisis Stabilization
- Day Rehabilitation
- Day Treatment Intensive
- Mental Health Services
- Medication Support Services
- Mobile Crisis Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Functional Family Therapy for individuals under the age of 21
- High Fidelity Wraparound for individuals under the age of 21
- Intensive Care Coordination for individuals under the age of 21
- Intensive Home-based Services for individuals under the age of 21
- Multisystemic Therapy for Individuals under the age of 21
- Parent-Child Interaction Therapy for individuals under the age of 21
- Therapeutic Behavioral Services for individuals under the age of 21
- Therapeutic Foster Care for individuals under the age of 21
- 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? (Select all that apply)

   a. ☒ Assertive Community Treatment (ACT)

DRAFT

b. ☐ Clubhouse Services

c. ☒ Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)

d. ☐ Enhanced CHW Services

e. ☒ Forensic Assertive Community Treatment (FACT)

f. ☒ Individual Placement and Support (IPS) Model of Supported Employment

g. ☒ Peer Support Services

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

☐ Yes ☒ **No**

b. If yes, 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 (select one):

a. ☐ DMC Program (if selected populate DMC questions below)

b. ☒ DMC-ODS Program (if selected, populate DMC-ODS questions below)

Drug Medi-Cal Program (DMC)

The county behavior health system is mandated to provide the following services as a part of the DMC Program (no action required).

- All Other Medically Necessary Services for individuals under age 21
- Intensive Outpatient Treatment Services
- Medications for Addiction Treatment (including medication, counseling services, and behavioral therapy) (MAT)
- Mobile Crisis Services
- Narcotic Treatment Program (NTP) Services
- Outpatient Treatment Services
- Perinatal Residential Substance Use Disorder (SUD) Treatment for pregnant women and women in the postpartum period

1. Has the county behavioral health system opted to provide the specific services identified in the list below? (Select all that apply)

a. ☐ Enhanced CHW Services

b. ☐ IPS Supported Employment

c. ☐ Peer Support Services

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

☐ Yes ☒ **No**

a. If yes, please describe these challenges or concerns: **N/A**

DRAFT

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

The county behavior health system is mandated to provide the following services as a part of the DMC Program (no action required).

- Care Coordination Services
- Clinician Consultation
- Outpatient Treatment Services (ASAM Level 1)
- Intensive Outpatient Services (ASAM Level 2.1)
- Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
- Mobile Crisis Services
- Recovery Services
- Residential Treatment Services (ASAM Levels 3.1, 3.3, 3.5)
- Traditional Healers and Natural Helpers
- Withdrawal Management Services
- All Other Medically Necessary Services for individuals under age 21
- 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? (Select all that apply)
   a. ☐ Enhanced Community Health Worker (CHW) Services
   b. ☐ Inpatient Services (ASAM Levels 3.7 & 4.0)
   c. ☐ IPS Supported Employment
   d. ☐ Partial Hospitalization Services (ASAM Level 2.5)
   e. ☒ Peer Support Services
   f. ☐ Recovery Incentives Program (Contingency Management)
2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
   ☐ Yes ☒ **No**
   a. If yes, please describe these challenges or concerns: **N/A**

Other Programs and Services

1. Please list other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs. (Add/subtract bullets as needed.)
   a. Monterey County Probation Department – Behavioral health services for justice-involved individuals, including youth and adults, through programs such as the Juvenile Sex Offender Response Team (JSORT), the Comprehensive Adolescent Learning and Assessment (CALA) program, services supported by the Juvenile Justice Regional Block Grant, and other probation-supported initiatives including AB 109 populations.

b. Public Defender's Office – Behavioral health diversion treatment associated with Proposition 47 Cohort IV funding.
c. Department of Social Services – Specialty Mental Health Services supporting CalWORKs participants.
d. City of Salinas – Partnership supporting a dedicated Mobile Crisis Team serving the City of Salinas.
e. Monterey County Office of Education and local school districts – Mental health services for students through Individualized Education Programs (IEPs) and services supporting the general education population.

Care Transitions

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

Statewide Behavioral Health Goals

Population-Level 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.

DRAFT

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, or same]
    a. For adults/older adults: **Above**
    b. For children/youth: **Below**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
    a. ☒ Age
    b. ☐ Gender
    c. ☒ Race or Ethnicity
    d. ☒ Sex
    e. ☒ Spoken Language
    f. ☐ None Identified
    g. ☐ No Disparities Data Available
    h. ☐ 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, or same]
    a. For adults/older adults: **Below**
    b. For children/youth: **Above**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
    a. ☒ Age
    b. ☐ Gender
    c. ☒ Race or Ethnicity
    d. ☒ Sex
    e. ☒ Spoken Language

f. ☐ None Identified
g. ☐ No Disparities Data Available
h. ☐ Other

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

1. How does your county status compare to the statewide rate? [above, below, or same]
    a. For adults/older adults: **N/A**
    b. For children/youth: **N/A**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
    a. ☐ Age
    b. ☐ Gender
    c. ☐ Race or Ethnicity
    d. ☐ Sex
    e. ☐ Spoken Language
    f. ☐ None Identified
    g. ☒ No Disparities Data Available
    h. ☐ 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, or same]
    a. For adults/older adults: **Below**
    b. For children/youth: **Below**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
    a. ☐ Age
    b. ☐ Gender
    c. ☒ Race or Ethnicity
    d. ☐ Sex
    e. ☐ Spoken Language
    f. ☐ None Identified
    g. ☐ No Disparities Data Available
    h. ☐ 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, or same]

DRAFT

Above

2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
    a. ☐ Age
    b. ☐ Gender
    c. ☐ Race or Ethnicity
    d. ☐ Sex
    e. ☐ Spoken Language
    f. ☐ None Identified
    g. ☒ No Disparities Data Available
    h. ☐ 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: **Across behavioral health service penetration measures, county rates vary in comparison to statewide averages, with differences observed by age, race/ethnicity, sex, and written language. For Specialty Mental Health Services (SMHS), the children and youth rate (3.7%) is below the statewide rate (4.2%), while the adult rate (3.9%) is slightly above (3.8%). Lower penetration is observed among younger children (0–11) and older adults (69+). Asian/Pacific Islander and Hispanic individuals have lower rates than other groups, as do males compared to females. Using written language data, Spanish-speaking individuals have lower penetration than English-speaking individuals. For Non-Specialty Mental Health Services (NSMHS), the children and youth rate (16.6%) is above the statewide average (15.5%), while the adult rate (8.5%) is below (10.6%). Lower penetration is seen among children ages 6–11, young adults (18–20), and older adults (69+). Asian/Pacific Islander, Black, and Hispanic individuals have lower rates than White individuals. Among adults, females have higher penetration than males, while youth rates are similar by sex. Spanish-speaking individuals have lower rates than English-speaking individuals. For Drug Medi-Cal Organized Delivery System (DMC-ODS) services, both children and youth (0.2%) and adults (1.5%) have rates below statewide averages. Within available data, Asian/Pacific Islander and Hispanic youth have lower penetration rates, while Native American and White youth have higher rates. Overall, lower service penetration is observed among Asian/Pacific Islander, Hispanic, and Spanish-speaking populations, as well as among younger children and older adults. Findings should be interpreted cautiously given data limitations and variation in reporting.**
   For several required indicators, including Drug Medi-Cal penetration rates, homelessness, institutionalization measures, conservatorships, and follow-up after emergency department visits for substance use, demographic disparity data were not available through the source

DRAFT

datasets used for this analysis. In these cases, the limitation reflects that the source data either do not report disparities at the required level of detail or the County does not have access to the underlying data needed to produce reliable demographic subgroup analyses. As a result, the County was unable to assess disparities across demographic groups for these measures using a methodology that would be consistent with statewide reporting standards and comparable to analyses conducted by other counties. This limitation reduces the County's ability to fully evaluate equity differences for certain populations and should be considered when interpreting the findings. During the BHSA implementation period, Monterey County Behavioral Health will continue working with state agencies, local partners, and available data systems to identify opportunities to obtain more detailed population-level information and strengthen future equity analyses as additional data become available.

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): **Using BHSA funding, Monterey County Behavioral Health will support a coordinated set of outpatient, crisis, FSP, and community-based services to improve access to behavioral health care, particularly for populations with lower service penetration and higher unmet need. County data indicate access gaps among children and youth, Spanish-speaking residents, adults with SMI and SUD, and individuals who frequently rely on crisis or ED settings for care. To address these gaps, Monterey County Behavioral Health will fund outpatient mental health services across multiple regions that support early identification, timely engagement, and linkage to ongoing care. These services will incorporate bilingual and culturally responsive approaches to address disparities observed among Latino and other underserved populations. Monterey County Behavioral Health will continue to fund FSP and intensive care coordination programs for adults with the highest levels of need. These programs emphasize community-based engagement, individualized service planning, and coordination with housing, medical, and social service partners. Local data showing elevated crisis utilization and repeated ED use among individuals with complex behavioral health needs informed this approach. BHSA funding will also support crisis response and follow-up services that provide assessment, stabilization, and linkage to outpatient care following behavioral health crises. Post-hospital care transition teams will engage individuals discharged from inpatient and ED settings across regions to support medication continuity, appointment follow-through, and warm handoffs to outpatient and FSP services. Workforce training and system-level supports will promote**

consistent practice and coordination across access points, including outpatient, crisis, and community-based settings. These strategies are informed by analysis of service penetration rates, crisis and ED utilization, and community and stakeholder input, and are intended to support timely access to care and equitable service delivery countywide.

2. Please identify the categories of funding that the county is using to address the access to care goal (select all that apply):

   ☒ **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

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, or same]
   Above
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   a. ☐ Age
   b. ☐ Gender
   c. ☐ Race or Ethnicity
   d. ☐ Sex
   e. ☐ Spoken Language
   f. ☐ None Identified
   g. ☒ No Disparities Data Available
   h. ☐ Other

DRAFT

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, or same]
   Above
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   - **a. ☒ Age**
   - b. ☐ Gender
   - **c. ☒ Race or Ethnicity**
   - d. ☐ Sex
   - e. ☐ Spoken Language
   - f. ☐ None Identified
   - g. ☐ No Disparities Data Available
   - h. ☐ Other

Homelessness: Supplemental Measures

PIT Count Rate of People Experience Homelessness with Severe Mental Illness, (Rate per 10,000 people of 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, or same]
   Above
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   - a. ☐ Age
   - b. ☐ Gender
   - c. ☐ Race or Ethnicity
   - d. ☐ Sex
   - e. ☐ Spoken Language
   - f. ☐ None Identified
   - **g. ☒ No Disparities Data Available**
   - h. ☐ Other

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per 10,000 people of 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, or same]
   Above

DRAFT

2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
    a. ☐ Age
    b. ☐ Gender
    c. ☐ Race or Ethnicity
    d. ☐ Sex
    e. ☐ Spoken Language
    f. ☐ None Identified
    g. **☒ No Disparities Data Available**
    h. ☐ Other

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, or same]: **Below**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
    a. ☐ Age
    b. ☐ Gender
    c. ☐ Race or Ethnicity
    d. ☐ Sex
    e. ☐ Spoken Language
    f. ☐ None Identified
    g. **☒ No Disparities Data Available**
    h. ☐ 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: **Across homelessness-related measures, county rates are generally above statewide averages, with some variation by age, grade level, and race/ethnicity. For the Point-in-Time (PIT) Count, the overall homelessness rate (61.3 per 10,000) is higher than the statewide rate (48.0), as are the rates for people experiencing homelessness with serious mental illness (15.5 vs. 11.5) and substance use disorder (12.7 vs. 11.0). The rate of people accessing Continuum of Care (CoC) services is lower (62.3 vs. 91.2), suggesting differences in service engagement or availability. For the Percent of K–12 Public School Students Experiencing Homelessness, the county rate (16.8%) is substantially higher than the statewide rate (5.3%). Within this measure, differences are observed by grade level, with higher rates among younger students (Transitional Kindergarten–Grade 6, 21.1–24.8%)**

compared with middle and high school students (Grades 7–12, 8.4–10.8%). By race and ethnicity, American Indian or Alaska Native (25.1%) and Hispanic (19.0%) students have higher rates of homelessness than other groups, while White (4.0%) and Asian/Pacific Islander (7.2%) students have lower rates. Overall, data show higher rates of homelessness across multiple measures compared to statewide averages, with notable differences by grade level and race/ethnicity among K–12 students. These findings should be interpreted cautiously given potential differences in reporting methods, service access, and regional housing conditions.

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): **Beginning July 1, 2026, Monterey County Behavioral Health will use BHSA funding and local data to strengthen housing-linked behavioral health services, care coordination, and cross-system partnerships intended to reduce homelessness among individuals experiencing serious mental illness (SMI), substance use disorders (SUD), and co-occurring conditions.**

   Monterey County Behavioral Health used Point-in-Time (PIT) Count data, Continuum of Care (CoC) utilization data, emergency department and crisis utilization trends, and local indicators of homelessness among adults and youth to identify areas where local homelessness and behavioral health needs exceed statewide averages or where disparities are present. Data indicating elevated homelessness rates among individuals with SMI and SUD, as well as lower CoC service utilization rates, identified the need to strengthen outreach, engagement, and coordination across behavioral health, housing, and community-based systems. In response to these findings, Monterey County Behavioral Health plans to strengthen partnerships with housing providers, CoC partners, crisis providers, hospitals, and community-based organizations to improve access to housing-linked behavioral health services and continuity of care.

   Local data also identified higher rates of homelessness and behavioral health needs among younger populations and among Hispanic and American Indian or Alaska Native individuals. These findings will be used to inform outreach, engagement, and care coordination

strategies intended to improve access to services for populations experiencing disparities or who have historically been underrepresented within behavioral health and housing systems.

To address the identified needs reflected in local data, Monterey County Behavioral Health will continue funding intensive, community-based behavioral health services that support housing stability for individuals with the highest levels of need. Full Service Partnership (FSP) and care coordination programs will focus on outreach, linkage to treatment, ongoing service engagement, and coordination with housing and supportive service providers for individuals experiencing homelessness or at risk of homelessness. Monterey County Behavioral Health also plans to strengthen coordinated approaches across outpatient, crisis, and housing-related services to support transitions from crisis settings and emergency departments into stable housing and ongoing behavioral health care.

Monterey County Behavioral Health will continue to use available local and statewide data to monitor housing stability outcomes, service utilization, and disparities across populations in order to assess program effectiveness, guide future resource allocation, and inform ongoing adjustments to programs, services, partnerships, and initiatives.

2. Please identify the category or categories of funding that the county is using to address the homelessness goal (select all that apply):

   ☒ **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

Institutionalization

Per 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.

DRAFT

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.

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

1. How does your county status compare to the statewide rate/average? [above, below, or same]
    a. For adults/older adults: **N/A**
    b. For children/youth: **N/A**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
    a. ☐ Age
    b. ☐ Gender
    c. ☐ Race or Ethnicity
    d. ☐ Sex
    e. ☐ Spoken Language
    f. ☐ None Identified
    g. ☒ No Disparities Data Available
    h. ☐ Other

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 – 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]
    a. 14-day involuntary detention rates per 10,000: **Same**
    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? (Select all that apply)
    a. ☐ Age
    b. ☐ Gender
    c. ☐ Race or Ethnicity
    d. ☐ Sex
    e. ☐ Spoken Language
    f. ☐ None Identified
    g. ☒ No Disparities Data Available
    h. ☐ Other

DRAFT

Conservatorships, FY 2021 – 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]
   a. Temporary Conservatorships: **Below**
   b. Permanent Conservatorships: **Above**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   a. ☐ Age
   b. ☐ Gender
   c. ☐ Race or Ethnicity
   d. ☐ Sex
   e. ☐ Spoken Language
   f. ☐ None Identified
   g. ☒ No Disparities Data Available
   h. ☐ Other

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

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

1. How does your county status compare to the statewide rate/average? [above, below, or same]
   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: **Below**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   a. ☒ Age
   b. ☐ Gender
   c. ☒ Race or Ethnicity
   d. ☒ Sex
   e. ☒ Spoken Language
   f. ☐ None Identified
   g. ☐ No Disparities Data Available

DRAFT

h. ☐ 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: **Across institutionalization and crisis service utilization measures, data show variation in service use across age, race/ethnicity, and language groups, though findings should be interpreted with caution due to limited subgroup data availability. For SMHS Crisis Residential Treatment Services (Adults), the county's utilization (41.0 days per beneficiary) is above the statewide rate (22.8). Within this measure, higher utilization is observed among adults ages 33–44 (42.35 days) and 57–68 (43.65 days) compared with younger groups. By race and ethnicity, White adults (45.55 days) have higher utilization than Hispanic adults (35.69 days). Utilization by sex is similar for males and females, and by written language, English-speaking adults (41.0 days) show higher utilization than the statewide average, while data for Spanish speakers were not available. For SMHS Crisis Intervention (Adults), the county's utilization (124.0 minutes per beneficiary) is below the statewide rate (240.1). Within this measure, lower utilization is observed among adults ages 45–56 (145.98 minutes). By race and ethnicity, Hispanic (161.74 minutes) and "Other" (158.20 minutes) adults have lower utilization than White (204.03 minutes) and Black (207.73 minutes) adults. Females (166.01 minutes) receive slightly fewer minutes than males (171.38 minutes), and Spanish-speaking adults (148.59 minutes) receive fewer minutes than English-speaking adults (174.13 minutes). Overall, while county-level utilization varies by measure, subgroup differences are most evident across age, race/ethnicity, and language, with generally lower utilization among Hispanic and Spanish-speaking adults, as well as some middle-age groups. These results highlight patterns worth further review to better understand access and service engagement factors.**

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**
    a. Supporting document file name (optional): **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): **Using BHSA funding, Monterey County Behavioral Health will support community-based, crisis, and**

DRAFT

follow-up services intended to reduce avoidable institutionalization among adults experiencing SMI and co-occurring SUD. County data show higher utilization of Crisis Residential Treatment services compared to statewide averages, alongside lower utilization of Crisis Intervention services, indicating opportunities for earlier intervention and stabilization in less restrictive settings. To address these patterns, Monterey County Behavioral Health will continue to fund outpatient, crisis response, and intensive care coordination programs that support assessment, stabilization, and linkage to ongoing community-based care. Crisis intervention and follow-up services will support continuity following behavioral health crises and are intended to reduce reliance on extended crisis residential stays. FSP and intensive case management services will focus on individuals with repeated crisis utilization or prolonged stays in institutional settings. These programs emphasize individualized service planning, community-based outreach, and coordination with medical, housing, and social service partners. Local utilization data indicating higher crisis residential use among middle-aged and older adults informed this approach. Monterey County Behavioral Health will also support culturally responsive engagement approaches to address lower crisis intervention utilization observed among Hispanic and Spanish-speaking adults. Workforce training and system coordination will promote consistent practice across access points, including outpatient, crisis, and residential settings.

The state-provided data did not include age-group analysis for Crisis Residential Treatment or Crisis Intervention utilization; therefore, MCBH cannot confirm from the available state dataset whether the observed pattern is consistent across all age groups. This limits the County's ability to determine whether lower Crisis Intervention utilization is more pronounced among specific populations, including children/youth, adults, or older adults. MCBH will continue to monitor available state and local data and will assess opportunities to review crisis utilization by age group as local reporting capacity and state-provided measures evolve.

To strengthen earlier intervention and stabilization in less restrictive settings, MCBH will continue implementing Early Intervention programs that support crisis prevention, timely access, and linkage to care. These include Behavioral Health Crisis, Dispatch, and Mobile Response Services; Access Post-Hospital/Crisis Follow-Up; MCHOME Homeless Outreach & Engagement; 211 referral and linkage services; Access to Treatment regional programs; and early childhood, child welfare, youth, and family-serving programs designed to identify needs earlier and connect individuals to appropriate supports.

a. Supporting document file name (optional): **N/A**

3. Please identify the category or categories of funding that the county is using to address the institutionalization goal (select all that apply):

☒ **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: City of Salinas

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, or same]
   a. For adults/older adults: **Below**
   b. For juveniles: **Above**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   a. ☒ Age
   b. ☐ Gender
   c. ☒ Race or Ethnicity
   d. ☒ Sex
   e. ☐ Spoken Language
   f. ☐ None Identified
   g. ☐ No Disparities Data Available
   h. ☐ Other

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, or same] **Above**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   a. ☒ Age
   b. ☐ Gender

c. **☒ Race or Ethnicity**
d. **☒ Sex**
e. ☐ Spoken Language
f. ☐ None Identified
g. ☐ No Disparities Data Available
h. ☐ 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, or same] **Above**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   a. ☐ Age
   b. ☐ Gender
   c. ☐ Race or Ethnicity
   d. ☐ Sex
   e. ☐ Spoken Language
   f. ☐ None Identified
   g. **☒ No Disparities Data Available**
   h. ☐ 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: **Across justice-involvement measures, county rates show differences when compared to statewide averages, with several demographic groups exhibiting variation in arrest and recidivism patterns. For adult and juvenile arrest rates, the county's adult arrest rate (2,085.5 per 100,000) is below the statewide average (2,440.2), while the juvenile arrest rate (530.8 per 100,000) is above the statewide rate (371.5). Within this measure, differences are observed by age, with young adults ages 20–39 (3,190–3,506 per 100,000) showing higher arrest rates than older adults (1,521 per 100,000 ages 40–69). Differences are also seen by race and ethnicity, with Black residents (4,539 per 100,000) having higher arrest rates than Hispanic (1,774 per 100,000) and White (1,275 per 100,000) residents. By sex, both adults and**

youth show higher arrest rates among males (3,150 per 100,000 adults; 655 per 100,000 youth) compared with females (820 per 100,000 adults; 243 per 100,000 youth). For the Adult Recidivism Conviction Rate, the county's rate (45.4%) is higher than the statewide rate (39.6%). Within available data, differences are observed by age, with adults ages 20–44 (51.9–43.6%) showing higher recidivism rates than older adults. Differences are also present by race and ethnicity, with Black residents (50.0%) having higher recidivism rates than Hispanic (47.1%) and White (36.8%) residents. By sex, males (45.6%) show higher recidivism rates than females (42.4%). For the Incompetent to Stand Trial (IST) rate, the county (23.0 per 100,000) is above both the statewide average (14.3) and median (17.7). Demographic subgroup data were not available for this measure, so no disparities could be assessed.

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): **Using BHSA funding, Monterey County Behavioral Health will support community-based behavioral health services and cross-system coordination intended to reduce justice involvement among individuals experiencing SMI, SUD, or co-occurring conditions. Local data show elevated juvenile arrest rates, higher adult recidivism compared to statewide averages, and an Incompetent to Stand Trial rate above both the statewide average and median, indicating opportunities for earlier intervention and diversion. To address these trends, Monterey County Behavioral Health will continue to fund outpatient, crisis, and intensive care coordination services that support identification of behavioral health needs, stabilization, and continuity of care for individuals at risk of justice involvement. These services support follow-up after crises and coordination across behavioral health, social services, and community partners to reduce escalation into the justice system. FSP and intensive case management programs will focus on individuals with repeated justice contact, including young adults and adults with complex behavioral health needs. These programs emphasize sustained engagement, individualized service planning, and coordination with housing, medical, and reentry-related supports. Local arrest and recidivism data indicating higher rates among young adults and males informed this approach. Monterey County Behavioral Health will also support culturally responsive engagement approaches to address disparities observed among Black residents and other disproportionately impacted groups. Workforce training and system coordination will promote consistent screening, referral, and follow-up across access points, including crisis services and community-based programs. These strategies are informed by analysis of arrest**

rates, adult recidivism conviction rates, and Incompetent to Stand Trial data and are intended to support reduced justice involvement through timely access to community-based behavioral health services.

Monterey County Behavioral Health will also continue supporting the Community Crisis Line, 988 coordination, crisis dispatch services, and countywide mobile crisis response teams serving both youth and adults. These services provide opportunities to de-escalate crises, stabilize individuals in the community, and connect them to behavioral health services before justice system involvement occurs.

Monterey County Behavioral Health will continue coordinating behavioral health services across juvenile justice, adult justice, court, and reentry settings to support early identification of behavioral health needs and strengthen continuity of care during transitions back into the community. The County provides direct behavioral health services within juvenile justice settings and collaborates with behavioral health providers serving individuals in the adult jail system to support assessment, treatment engagement, discharge planning, and connection to community-based services. These efforts include coordination with County Access programs, diversion initiatives, court-based collaborations, and CalAIM Justice-Involved Behavioral Health Linkages activities designed to improve continuity of care and reduce gaps in service access following release from institutional settings. Through these partnerships, the County seeks to strengthen pathways to treatment, housing, recovery supports, and other community-based resources for justice-involved individuals with significant behavioral health needs.

a. Supporting document file name (optional): **N/A**

2. Please identify the category or categories of funding that the county is using to address the justice-involvement goal (select all that apply):

☒ **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: Probation**

Removal of Children from Home

DRAFT

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, or same]
   Below
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   - **a. ☒ Age**
   - b. ☐ Gender
   - c. ☐ Race or Ethnicity
   - **d. ☒ Sex**
   - e. ☐ Spoken Language
   - f. ☐ None Identified
   - g. ☐ No Disparities Data Available
   - h. ☐ Other

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, or same]
   Above
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   - **a. ☒ Age**
   - b. ☐ Gender
   - **c. ☒ Race or Ethnicity**
   - **d. ☒ Sex**
   - e. ☐ Spoken Language
   - f. ☐ None Identified
   - g. ☐ No Disparities Data Available
   - h. ☐ Other

Child Maltreatment Substantiations (CWIP), 2022

1. How does your county status compare to the statewide rate? [above, below, or same]
   Below
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   - **a. ☒ Age**
   - b. ☐ Gender

DRAFT

c. **☒ Race or Ethnicity**
d. ☐ Sex
e. ☐ Spoken Language
f. ☐ None Identified
g. ☐ No Disparities Data Available
h. ☐ Other

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: **For Children in Foster Care, the county's rate (149.2 per 100,000) is below the statewide average (525.1). Within this measure, differences are observed by age, with infants under 1 year (394 per 100,000) having higher foster care rates than older age groups (72–190 per 100,000). Differences are also present by sex, as female children (134 per 100,000) have slightly higher rates than male children (115 per 100,000). For Open Child Welfare Case SMHS Penetration Rates, the county's rate (45.9%) is slightly above the statewide rate (43.0%). Within this measure, younger children ages 0–2 (27.2%) and young adults ages 18–20 (31.6%) have lower penetration rates than other age groups (46.1–61.4%). Differences are also observed by race and ethnicity, with Black children (60.1%) showing higher penetration rates than Hispanic (44.2%) and White (56.9%) children. By sex, males (41.6%) have lower penetration rates than females (50.2%). For Child Maltreatment Substantiations, the county's substantiation rate (2.2 per 1,000) is below the statewide rate (5.7). Within available data, infants under 1 year (7.8 per 1,000) have higher substantiation rates than older children (1.7–2.4 per 1,000), though still below statewide rates for infants. Differences are also observed by race and ethnicity, with Black children (10.3 per 1,000) having higher substantiation rates than Latino (2.3 per 1,000) and White (2.0 per 1,000) children. Substantiation rates are similar by sex.**

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): **Using BHSA funding, Monterey County Behavioral Health will support early intervention, outpatient, and family-centered behavioral health services intended to promote child and family stability and reduce the need for removal of children from their homes. County data show foster care**

DRAFT

entry and child maltreatment substantiation rates below statewide averages, while SMHS penetration among children involved in the child welfare system varies by age, race and ethnicity, and sex, indicating opportunities to support early engagement and continuity of care. To address these patterns, Monterey County Behavioral Health will continue to fund outpatient mental health and early intervention services for children, youth, and families, with a focus on timely access, caregiver engagement, and coordination with child welfare partners. These services support identification of behavioral health needs and coordination of care, particularly for infants and young children who show higher rates of foster care placement and substantiated maltreatment. Monterey County Behavioral Health will also support coordination between behavioral health providers and child welfare services to improve access to SMHS for children with open child welfare cases. FSP and intensive care coordination programs will focus on children and transition-age youth with complex needs, emphasizing individualized service planning and family-centered approaches. Local data showing lower SMHS penetration among children ages 0–2 and youth ages 18–20 informed this approach. Culturally responsive and trauma-informed practices will be supported to address disparities observed among Black children and other disproportionately impacted groups. Workforce training and cross-system collaboration will promote consistent referral, engagement, and follow-up across behavioral health and child welfare settings. These strategies are informed by foster care, SMHS penetration, and child maltreatment data and are intended to support family stability through coordinated behavioral health services.

a. Supporting document file name (optional): **N/A**

2. Please identify the category or categories of funding that the county is using to address the removal of children from home goal (select all that apply):

☒ **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:

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, or same]
   a. For the full population measured: **Above**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   a. ☐ Age
   b. ☐ Gender
   c. ☐ Race or Ethnicity
   d. ☐ Sex
   e. ☐ Spoken Language
   f. ☐ None Identified
   g. ☒ No Disparities Data Available
   h. ☐ 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, or same]
   a. For the full population measured: **Same**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   a. ☐ Age
   b. ☐ Gender
   c. ☐ Race or Ethnicity
   d. ☐ Sex
   e. ☐ Spoken Language
   f. ☐ None Identified
   g. ☒ No Disparities Data Available
   h. ☐ 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, or same]
   a. For the full population measured: **Above**
2. What disparities did you identify across demographic groups or special populations? (Select all that apply)
   a. ☒ Age
   b. ☐ Gender

DRAFT

c. ☒ **Race or Ethnicity**
d. ☒ **Sex**
e. ☐ Spoken Language
f. ☐ None Identified
g. ☐ No Disparities Data Available
h. ☐ 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: **For Follow-Up After Emergency Department Visits, the county's follow-up rate for substance use (FUA-30) is above the statewide average (41.4% vs. 28.8%), while the mental illness follow-up rate (FUM-30) is comparable to statewide levels (37.9% vs. 38.2%). Demographic subgroup data were not available for these measures, so no disparities could be assessed. For the Adults with Unmet Need for Mental Health or Substance Use Services measure, the county's rate (65.4%) is above both the statewide average (48.4%) and median (50.5%). Within this measure, differences are observed by age, with adults ages 18–24 (69.8%) reporting higher unmet need than adults ages 25–64 (47.5%) and older adults ages 65+ (43.7%). Differences are also seen by sex, as males (60.1%) report higher unmet need than females (47.3%). By race and ethnicity, available data show variation, with Asian/Pacific Islander (65.3%) and Hispanic (57.4%) adults reporting higher unmet need than Black (37.0%) and White (38.1%) adults.**

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): **The Follow-Up After Hospitalization measures (FUA and FUM) are quality measures that assess whether individuals receive timely follow-up care after a psychiatric hospitalization or emergency department visit for a mental health or substance use condition. These measures are intended to support continuity of care, reduce avoidable crises, and improve recovery outcomes.**
   Consistent with the CalMHSA Data Explainer Series, these measures are shared accountability measures between the county Mental Health Plan (MHP) and Managed Care Plans (MCPs). Performance depends on coordinated efforts across hospitals, behavioral

health providers, primary care providers, care managers, and health plans to ensure members receive appropriate follow-up services within required timeframes.
Because responsibility for care transitions and follow-up services is shared across delivery systems, successful performance on FUA and FUM measures requires strong collaboration, timely communication, and coordinated outreach between Managed Care Plans and Mental Health Plans.
Using BHSA funding, Monterey County Behavioral Health will support early identification, outreach, and access to behavioral health services intended to reduce the prevalence of untreated mental health and substance use conditions. County data show that while follow-up after ED visits for substance use and mental illness is comparable to or exceeds statewide averages, a high proportion of adults report unmet behavioral health needs, particularly young adults, males, and Asian/Pacific Islander and Hispanic residents. To address unmet need, Monterey County Behavioral Health will continue to fund outpatient mental health and SUD services that support timely access, early engagement, and continuity of care. These services are intended to reduce delays between identification of need and initiation of treatment, particularly for populations reporting higher unmet need. Monterey County Behavioral Health will also support crisis response, ED follow-up, and care coordination activities that promote timely linkage to outpatient and ongoing services following acute episodes. Local FUA-30 and FUM-30 performance informed continued use of follow-up and engagement strategies that support treatment initiation and retention. Outreach and engagement efforts will serve all populations, but prioritize populations with elevated unmet need, including young adults and underserved racial and ethnic groups, through culturally responsive and community-based approaches. Workforce training and system coordination will promote consistent screening, referral, and follow-up across access points. These strategies are informed by ED follow-up measures and self-reported unmet need data and are intended to support reduced untreated behavioral health conditions through improved access, engagement, and continuity of care across the system.

2. Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal (select all that apply):
    a. **☒ BHSA BHSS**
    b. ☐ BHSA FSP
    c. **☒ BHSA Housing Interventions**
    d. ☐ 1991 Realignment
    e. **☒ 2011 Realignment**
    f. ☐ State General Fund
    g. **☒ Federal Financial Participation (SMHS, DMC-DMC/ODS)**
    h. ☐ SAMHSA PATH
    i. ☐ MHBG
    j. **☒ SUBG**

k. ☐ Other

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 (CS)), 2024

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

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

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

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, below, or same]
   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? [above, below, or same]
   Below

Student Chronic Absenteeism Rate (Data Quest), 2022

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

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? [above, below, or same]
   Above

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? [above, below, or same]
   a. For the full population measured: **Above**
   b. For adults/older adults: **Same**
   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? [above, below, or same]
   a. For the full population measured: **Same**
   b. For adults/older adults: **Same**
   c. For children/youth: **Same**

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? [above, below, or same]

DRAFT

   a. For adults (specific to Adults' Access to Preventative/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? [above, below, or same]
   a. For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications): **Above**
   b. For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing): **N/A**

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? [above, below, or same]
   a. For the full population measured: **N/A**
   b. For adults/older adults: **N/A**
   c. For children/youth: **N/A**

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? [above, below, or same]
   a. For the full population measured: **Above**

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? [above, below, or same]
   a. For the full population measured: **N/A**
   b. For adults/older adults: **N/A**
   c. For children/youth: **N/A**

DRAFT

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides

Suicides: Primary Measures

Suicide Deaths, 2022

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

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? [above, below, or same]
   a. For the full population measured: **Above**
   b. For adults/older adults: **Same**
   c. For children/youth: **Same**

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 (select one)
   ☐ Care Experience
   ☐ Engagement in School
   ☐ Engagement in Work
   ☒ **Overdose**
   ☐ Prevention and Treatment of Co-Occurring Physical Health Conditions
   ☐ Quality of Life
   ☐ Social Connection
   ☐ Suicides
   a. Please describe why this goal was selected: **Through the BHSA Community Planning Process, the County assessed the statewide population behavioral health goals to determine which goal is best suited to reflect system-wide change as BHSA is**

DRAFT

implemented. The County prioritized goals that aligned with the strategic priorities of system partners and those supported by existing measurement infrastructure that is well-established, regularly updated, and capable of capturing progress across multiple points of the Behavioral Health Continuum of Care. Based on this assessment, the County selected Reduce Overdoses for inclusion in the Integrated Plan.

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: **For all drug-related overdose deaths, Monterey County's rate (31.6 per 100,000) is higher than the statewide rate (28.8 per 100,000). Death rates are low from ages 0–14, then rise in late adolescence and young adulthood, peaking at 25–29 (52.7 per 100,000) and 35–39 (73.6 per 100,000). Adults from the mid-twenties through midlife experience the highest overdose mortality. By race and ethnicity, rates are highest among Black and White residents and lower among Hispanic and Asian/Pacific Islander residents, indicating a need to focus prevention and treatment in Black and White communities while maintaining access for other groups. Rates for Alaskan Native/American Indian residents were not available at the county level. Males have higher overdose death rates than females (46.5 vs. 14.8), so men should be a key focus for outreach and engagement. For all drug-related overdose emergency department (ED) visits, Monterey County's rate (145.4 per 100,000) is slightly higher than the statewide rate (143.8). ED visit rates are highest for ages 25–29 (316.2 per 100,000), 30–34 (244.8 per 100,000), and 35–39 (217.3 per 100,000), with additional peaks among very young children and adolescents/young adults (183.0 for ages 0–4; 202.7 for 15–19; 169.6 for 20–24). Nonfatal overdoses occur across the lifespan but are most concentrated in the late twenties and early thirties. By race and ethnicity, ED visit rates are highest among Black residents (about 737.6) per 100,000, followed by Alaskan Native/American Indian (about 378.6 per 100,000) and White residents (about 163.6 per 100,000), with lower rates among Hispanic (about 131.6) and Asian/Pacific Islander residents (about 47.7 per 100,000). Males also have higher overdose ED visit rates than females (179.2 vs. 106.5), highlighting the need to tailor harm reduction, ED follow-up, and treatment engagement strategies for men in the highest-risk groups.**

The Perception of Functioning Domain Score (CPS) and Perception of Social Connectedness Domain Score (CPS) measures were not available through the data sources provided for the Integrated Plan and therefore could not be reported. MCBH recognizes the importance of these indicators, particularly for older adults and individuals with disabilities, and will continue to monitor opportunities to incorporate these measures into future planning and reporting efforts as data become available.

MCBH will continue supporting services that promote community integration, social connection, recovery, and independent functioning across the behavioral health continuum.

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 the 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): **Monterey County Behavioral Health is implementing a continuum of substance use prevention, treatment, and harm-reduction initiatives that prioritize low-barrier access and populations at highest risk of overdose. Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a spectrum of substance use disorder services for Medi-Cal–eligible youth and adults, including screening, outpatient and residential treatment, withdrawal management, medication-assisted treatment (MAT), case management, and recovery supports with a focus on harm reduction and rapid connection to care. Substance Use Prevention and Early Intervention (PEI) programs, supported by the Substance Use Block Grant (SUBG) and Opioid Settlement Funds (OSF), deliver school-embedded and community-based prevention for children, adolescents, and transition-age youth, offering psychoeducation, skill-building, and evidence-based interventions that strengthen protective factors and reduce progression to substance use disorder and overdose. The Street Medicine and Substance Use Response Team extends overdose prevention and treatment linkage into encampments, shelters, and other non-traditional settings, bringing medical care, harm-reduction services, and connections to MAT directly to people experiencing homelessness, co-occurring conditions, and repeated non-fatal overdoses who face the greatest barriers to clinic-based care. The Emergency Room Substance Use Navigator Program embeds navigators in the hospital emergency department to engage individuals at the point of overdose or substance-related crisis, provide bedside screening, brief intervention, warm handoffs to MAT, and referrals to ongoing substance use and mental health services with short-term follow-up. These strategies will be implemented in collaboration with culturally responsive providers and community-based organizations to help ensure overdose prevention, treatment, and recovery services are accessible and responsive to the needs of diverse populations disproportionately impacted by substance use disorders and overdose. MCBH will monitor available indicators including overdose deaths, emergency department visits related to substance use, follow-up after emergency department visits for substance use, engagement in treatment services, utilization of DMC-ODS services, and other available population health measures to assess progress and inform ongoing quality improvement efforts.**

DRAFT

3. Please identify the category or categories of funding that the county is using to address this goal (select all that apply):

☐ 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: Drug Medi-Cal, Opioid Settlement Funds**

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 (select all that apply):
   a. ☒ **County outreach through social media**
      i. If yes, please include date(s) of stakeholder engagement: **9/15/2025; 9/26/2025; 10/23/2025**
   b. ☒ **County outreach through townhall meetings**
      i. If yes, please include date(s) of stakeholder engagement: **05/13/2025; 05/15/2025; 05/16/2025**
   c. ☒ **County outreach through traditional meetings (e.g., television, radio, newspaper)**
      i. If yes, please include date(s) of stakeholder engagement: **09/15/2025; 09/26/2025; 11/6/2025**
   d. ☒ **Focus group discussions**
      i. If yes, please include date(s) of stakeholder engagement: **10/20/2025; 10/21/2025; 10/22/2025**
   e. ☒ **Key informant interviews with subject matter experts**
      i. If yes, please include date(s) of stakeholder engagement: **06/11/2025, 6/23/2025; 7/09/2025**
   f. ☒ **Meeting(s) with county**

DRAFT

i. If yes, please include date(s) of stakeholder engagement: **09/15/2025; 9/18/2025; 9/23/2025; 9/24/2025; 9/25/2025; 9/26/2025; 10/09/2025; 10/10/2025; 1/9/2025**

g. ☒ **Provided data to county**

   i. If yes, please include date(s) of stakeholder engagement: **10/23/2025; 10/24/2025; 10/27/2025; 10/29/2025; 11/5/2025; 11/20/2025; 11/22/2025;**

h. ☐ Public e-mail inbox submission

   i. If yes, please include date(s) of stakeholder engagement: **N/A**

i. ☒ **Survey participation**

   i. If yes, please include date(s) of stakeholder engagement: **09/15/2025; 09/19/2025; 09/22/2025**

j. ☒ **Training, education, and outreach related to community planning**

   i. If yes, please include date(s) of stakeholder engagement: **10/23/2025; 11/20/2025**

k. ☒ **Workgroups and committee meetings**

   i. If yes, please include date(s) of stakeholder engagement: **10/23/2025; 11/20/2025**

l. ☒ **Other**

   i. Please specify the other strategies that demonstrate the meaningful partnerships with stakeholders: **Distribution of linguistic and culturally sensitive engagement, materials and surveys to community members of traditionally unreached and underserved communities including non-U.S and indigenous languages. Provided assistance with reading and responding in small group communities, as population needs warranted.**

   ii. If yes, please include date(s) of stakeholder engagement: **9/15/2025; 9/26/2025.**

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

- **Monterey County Behavioral Health**
- **Monterey County Department of Social Services**
- **DSS – Aging and Adult Services**
- **Monterey County Public Health**
- **Monterey County Office of Education**
- **Monterey County Veterans Services Office**
- **Monterey County Department of Emergency Management**
- **Monterey County EMS Agency**
- **Monterey County Sheriff's Office**
- **Monterey County Probation Department**
- **City of Pacific Grove**
- **City of Carmel-by-the-Sea**
- **City of Monterey**
- **City of Marina**

- **City of Salinas**
- **City of Seaside**
- **City of Soledad**
- **City of Del Rey Oaks**
- **City Manager (City Administrations)**
- **Salinas Police Department**
- **Marina Police Department**
- **City of Monterey Police Department**
- **Greenfield Police Department**
- **Gonzales Police Department**
- **King City Police Department**
- **Monterey County Sheriff's Office**
- **Monterey County Probation Department**
- **Montage Health**
- **Salinas Valley Memorial Healthcare System**
- **Community Hospital of the Monterey Peninsula**
- **Natividad Medical Center**
- **Mee Memorial Healthcare System**
- **Central California Alliance for Health**
- **Sun Street Centers**
- **Valley Health Associates**
- **Door to Hope**
- **Seneca**
- **The Epicenter**
- **Community Human Services**
- **Nations Finest**
- **Central Coast Overdose Prevention**
- **NAMI (National Alliance on Mental Illness)**
- **Housing Authority of the County of Monterey (HACM)**
- **Housing Resource Center**
- **Community Homeless Solutions**
- **Coalition of Homeless Services Providers**
- **Interim (Housing & Homeless Services Provider)**
- **Harmony at Home**
- **Monterey County Rape Crisis Center**
- **YWCA**
- **Monterey County Domestic Violence Coordinating Council**
- **Alliance on Aging**

DRAFT

- **San Andreas Regional Center**
- **Central Coast Center for Independent Living (CCCIL)**
- **Monterey Peninsula College**
- **CSU Monterey Bay (CSUMB)**
- **CSUMB Personal Growth & Counseling Center**
- **Salinas Union High School District**
- **Monterey County Office of Education**
- **California Employment Development Department (EDD) – Salinas Office**
- **AFLAC**
- **Monterey Bay Labor Council**
- **Pajaro Valley Prevention and Student Assistance (PVPSA)**
- **Partners for Peace**
- **First 5 Monterey County**
- **Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO)**
- **Indian Health Center of Santa Clara Valley**
- **American Indian Health & Services (Santa Barbara)**
- **Veterans Transition Center of California**
- **American Legion Monterey Cypress Post 694**
- **Monterey County Veterans Services Office**
- **Center for Community Advocacy (CCA)**
- **Salinas Valley Health**
- **The Village Project**

3. 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.)
    a. City name: **Salinas**
    b. City name: **Seaside**
    c. City name: **Monterey**
    d. City name: **Soledad**
    e. City name: **Marina**
4. Were you able to engage all required stakeholders/groups in the planning process? ☒ **Yes** ☐ No
    a. If not, which required stakeholder/groups were you unable to engage in the planning process? (Select all that apply)
        i. ☐ Area agencies on aging

            If selected, what was the reason stakeholder was not engaged?

            ☐ Stakeholder declined to participate

            ☐ Attempted but did not receive a response

            ☐ Stakeholder group is not applicable to county

            ☐ Other (please describe): **N/A**

DRAFT

ii. ☐ BHSA eligible adults and older adults (individuals with lived experience)

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

iii. ☐ Community-based organizations serving culturally and linguistically diverse constituents

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

iv. ☐ Continuums of Care, including representatives from the homeless service provider community

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

v. ☐ County social services and child welfare agencies

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

vi. ☐ Disability insurers

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

vii. ☐ Early childhood organizations

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

DRAFT

viii. ☐ Emergency medical services

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

ix. ☐ Families of BHSA eligible children and youth, eligible adults, and eligible older adults (with lived experience)

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

x. ☐ Higher education partners

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

xi. ☐ Health care organizations, including hospitals

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

xii. ☐ Health care service plans, including Medi-Cal managed care plans

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

xiii. ☐ Independent living centers

If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

☐ Other (please describe): **N/A**

xiv. ☐ Individuals with behavioral health experience, including peers and families

DRAFT

If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xv. ☐ Labor representative organizations
If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xvi. ☐ Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+) communities
If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xvii. ☐ Local education agencies
If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xviii. ☐ Local public health jurisdictions
If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xix. ☐ Organizations specializing in working with underserved racially and ethnically diverse communities
If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xx. ☐ People with lived experience of homelessness
If selected, what was the reason stakeholder was not engaged?

☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xxi. ☐ Providers of mental health services

If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xxii. ☐ Providers of substance use disorder treatment services

If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xxiii. ☐ Public safety partners, including county juvenile justice agencies

If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xxiv. ☐ Regional centers

If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xxv. ☐ The five most populous cities in counties with a population greater than 200,000

If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xxvi. ☐ Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes

If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate

DRAFT

☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xxvii. ☐ Veterans and representatives from veterans' organizations
If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xxviii. ☐ Victims of domestic violence and sexual abuse
If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xxix. ☐ Youth from historically marginalized communities
If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

xxx. ☐ Youths (individuals with lived experience), youth mental health organizations, or youth substance use disorder organizations
If selected, what was the reason stakeholder was not engaged?
☐ Stakeholder declined to participate
☐ Attempted but did not receive a response
☐ Stakeholder group is not applicable to county
☐ Other (please describe): **N/A**

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:
A Commitment to Meeting People Where They Are
The County of Monterey implemented a culturally and linguistically responsive engagement strategy to reach communities that are traditionally underserved or underrepresented in behavioral health planning. Outreach included the distribution of translated and culturally appropriate materials and surveys, including in non-U.S. and Indigenous languages, as well as small-group and one-on-one assistance to support individuals who needed help reading, understanding, or completing materials. To further reduce barriers to participation, County

DRAFT

partners conducted outreach directly in community settings, including onsite engagement with farmworkers at agricultural worksites.
In-person engagement was a central feature of this approach. More than half of all BHSA stakeholder engagements took place face-to-face, allowing County partners to meet people in familiar, accessible environments and support real-time dialogue. These in-person interactions helped build trust, clarify complex policy changes, and strengthen the quality of feedback received, particularly from individuals and families with lived experience.

Stakeholder Engagement Through the Behavioral Health Transformation (BHT) Collaborative
In response to countywide stakeholder engagement activities conducted in early 2025, Monterey County Behavioral Health Services established the Behavioral Health Transformation (BHT) Collaborative as the County's primary forum for stakeholder engagement and system alignment for Behavioral Health Services Act (BHSA) implementation. Contacts from all required BHSA stakeholder groups were invited to participate, ensuring broad and inclusive representation across the behavioral health system.
The BHT Collaborative meets monthly to share BHSA updates, identify implementation challenges, and co-develop solutions related to workforce capacity, housing and crisis services, contracting readiness, service redesign, data and reporting, and equity-driven access. Stakeholder input is gathered through facilitated discussions and workgroups, with structured feedback used to inform Integrated Plan development and implementation. Through this structure, the County of Monterey has established a durable, community-centered engagement process that aligns statutory requirements with community priorities and operational realities.

Cross-County Collaboration and Learning
To strengthen BHSA implementation and stakeholder engagement, the County of Monterey participates in an ongoing cross-county learning partnership with Ventura County and Bay Area BHSA coordinators. These monthly coordination sessions provide a structured forum to exchange best practices, troubleshoot implementation challenges, and share tools related to community engagement, fiscal planning, workforce development, and BHSA compliance. This collaboration enables the County of Monterey to benchmark its approach against peer counties, rapidly incorporate proven strategies, and remain aligned with evolving state guidance. Through this peer-to-peer network, the County enhances consistency, accountability, and innovation in its local BHSA implementation while benefiting from the collective experience of multiple regions.

a. Supporting document file name (optional): **N/A**

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**
   - b. ☐ No. The LHJ is not currently working on and/or did not develop a recent CHA and/or CHIP
   - c. ☐ Other
     - i. Please explain why or describe an alternate approach taken: **N/A**
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: Behavioral Health coordinated with the LHJ and hospital partners participating in the CHNA process to support alignment of behavioral health priorities with identified community health needs, including mental health, substance use, housing instability, and access to care. Data-sharing: Behavioral health–related data and system insights were incorporated into the CHNA to inform identification of community needs, service gaps, and populations experiencing disparities, particularly those affected by untreated behavioral health conditions, substance use, and co-occurring physical and behavioral health needs.
   Stakeholder activities: Behavioral Health participated in stakeholder engagement activities conducted as part of the CHNA process, including community input and partner engagement efforts, which helped inform priority-setting and contextual understanding of behavioral health needs relevant to Integrated Plan development.
3. Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?
   ☐ Yes ☒ **No**

Collaboration

1. Please select how the county collaborated with the LHJ (select all that apply):
   - **a. ☒ Attended key CHA and CHIP meetings as requested**
   - b. ☐ Served on CHA and CHIP governance structures and/or subcommittees as requested
   - c. ☐ Other
     - i. Please describe the other way the county collaborated with LHJs and MCPs in developing the CHA/CHIP: **N/A**

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 (select all that apply):
    a. ☒ **Access to Care**
    b. ☐ Care Experience
    c. ☐ Engagement in School
    d. ☐ Engagement in Work
    e. ☒ **Homelessness**
    f. ☐ Institutionalization
    g. ☒ **Justice-Involvement**
    h. ☒ **Overdoses**
    i. ☒ **Prevention of Co-Occurring Physical Health Conditions**
    j. ☒ **Quality of Life**
    k. ☐ Removal of Children from Home
    l. ☒ **Social Connection**
    m. ☒ **Suicides**
    n. ☒ **Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)**
    o. ☐ 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 (select all that apply):
    a. ☒ **Access to Care**
    b. ☐ Care Experience
    c. ☐ Engagement in School
    d. ☐ Engagement in Work
    e. ☒ **Homelessness**
    f. ☐ Institutionalization
    g. ☒ **Justice-Involvement**
    h. ☒ **Overdoses**
    i. ☒ **Prevention of Co-Occurring Physical Health Conditions**
    j. ☒ **Quality of Life**
    k. ☐ Removal of Children from Home
    l. ☒ **Social Connection**
    m. ☒ **Suicides**

DRAFT

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

o. ☐ Other

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). Select all that apply.
   - **a. ☒ Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.**
   - **b. ☒ Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP**
   - **c. ☒ 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**
   - d. ☐ Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement
   - e. ☐ Other

     i. 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

   a. If yes, provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP: **The CHNA provided behavioral health–relevant data and community input on priority needs, including access to care, mental health and substance use conditions, housing instability, overdose risk, and co-occurring physical and behavioral health challenges. CHNA findings and associated implementation priorities informed the county's understanding of population needs, service gaps, and cross-system impacts. These insights were used to support**

DRAFT

alignment of Integrated Plan priorities with broader countywide health conditions while maintaining Behavioral Health's statutory responsibilities under BHSA.

b. If not, please explain why the county did not consider the LHJ's CHA/CHIP or strategic plan when preparing its IP: **N/A**

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: **Central California Alliance for Health**
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?
   The MCP Community Reinvestment Plan (CRP) is only required if the MCP reports net profits. The Central California Alliance for Health (CCAH) anticipates further direction from DHCS on the need for a CRP in early 2026. The County will monitor further guidance from the state and collaborate with CCAH accordingly.

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: ***April 3, 2026***
2. Date the stakeholder comment period closed: ***May 18, 2026***
3. Date of behavioral health board public hearing on draft IP ***May 25, 2026***
   a. Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality:
      i. ☒ Link
         1. If selected, please provide the link to the public posting: https://www.countyofmonterey.gov/home/showpublisheddocument/145811/639128927537070000
      ii. ☐ PDF, image, or other document
         1. If selected, please upload the PDF, image, or other file documenting the public postings (enter file name here): ***n/a***
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 (enter valid link or PDF file name to be uploaded): https://www.countyofmonterey.gov/government/departments-a-h/health/behavioral-health/behavioral-health/about-us/mental-health-services-act

DRAFT

5. Please select the process by which the draft plan was circulated to stakeholders (select all that apply):
   a. ☒ Public posting
   b. ☐ Email outreach
      i. If selected, identify email to be attached: ***Forthcoming***
   c. ☒ Other
      i. If selected, please specify the other processes the draft plan was circulated to stakeholders: ***MCBH employed a bilingual approach to inviting public comments on the draft Integrated Plan for 45 days, 15 days beyond the required 30 days, through a comprehensive outreach strategy that included social media, emails across listservs, radio publication, distribution of flyers at in-person events, and promotion at community events. Online distribution included four mass mailout rounds using Email and Mailchip with County listservs, adding a BHSA resource webpage to the MCBH website, as well as five separate Facebook and Instagram posts.*** **MCBH posted public comment flyers across County of Monterey bulletin boards, an employee newsletter, and provided handouts at four community events and at the County clinic. Additionally, MCBH facilitated eight separate presentations, providing an overview of the Integrated Plan and inviting participation in the public comment process.**
6. Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table.

Table 7. Stakeholder Input

Stakeholder group	Summarize the substantive revisions recommended by this stakeholder during the comment period
Area Agency on Aging	Representatives from the Area Agency on Aging (AAA) recommended that the Integrated Plan include a more explicit, age-specific behavioral health strategy for adults age 65 and older, including culturally and linguistically responsive strategies for Spanish-speaking older adults and other older adults experiencing access barriers. Recommended revisions included creating an Older Adult Specialty Track within BHSS; adding geriatric-focused access and outpatient teams across county regions; expanding home-based and telehealth services for mobility-limited older adults; incorporating or coordinating caregiver support, peer support, support groups, short-term therapy, bilingual psychoeducation, medication reconciliation, cognitive screening, and fall-risk assessment; establishing an Older Adult FSP track and geriatric ACT team; prioritizing older adults with high crisis utilization, housing instability, or medical complexity; adding

	benefits navigation, primary care coordination, step-up/step-down supports, and older adult-focused IPS pathways; developing an older adult crisis response model with RN-led triage, dementia-capable crisis intervention, medication review, brief therapy, psychoeducational groups, and post-crisis or post-ED linkage; expanding field-based and telehealth DMC-ODS/MAT access for older adults in senior housing, rural areas, and mobility-limited settings; and establishing an Older Adult Housing Priority Pathway that includes RCFE/Board and Care placements, housing subsidies, tenancy supports, and partnerships with Social Services and senior service providers. Representatives from the AAA also requested that the Integrated Plan preserve or identify funding for older adult-specific peer counseling and prevention-oriented supports, including the bilingual Senior Peer Counseling Program at Alliance on Aging and other community-based organizations like NAMI. Commenters described this type of peer-delivered support as important for older adults experiencing grief, loneliness, loss of independence, social isolation, depression, and suicide-risk concerns, and expressed concern that loss of these services could increase reliance on crisis intervention, emergency departments, hospitalizations, or other higher-intensity services. Representatives from the AAA further recommended adding age- and language-stratified accountability measures related to older adult penetration rates, Spanish-language disparities, cognitive screening, caregiver engagement, FSP enrollment and retention, crisis response, post-ED follow-up, DMC-ODS/MAT access and retention, housing placements and tenancy retention, ED utilization after placement, telehealth no-shows, caregiver trainings, and participation in peer support, therapy, support groups, and other early support services.
Community-Based Organizations Serving Culturally and Linguistically Diverse Constituents	Representatives from community-based organizations serving culturally and linguistically diverse constituents recommended that the Integrated Plan preserve, prioritize, and expand culturally responsive, community-rooted behavioral health services, including Community-Defined Evidence Practices (CDEPs), prevention and early intervention services, peer-led family support, outreach, education, navigation, support groups, wraparound behavioral health models, and other community-based supports serving historically underserved communities, including African American residents, children, youth, families, individuals experiencing homelessness or housing instability, individuals involved in child welfare systems, older adults, and individuals

	living with mental health and substance use disorder needs. Representatives from these organizations requested that the Integrated Plan explicitly recognize and support culturally congruent, trauma-informed, community-defined behavioral health models such as The Village Project, Emanyatta Saturday School, NAMI Monterey County, Alliance on Aging programs, and other peer and family support programs, and expressed concern that changes associated with BHSA implementation, including narrower eligibility and reduced prevention and early intervention funding, could reduce access to trusted community-based supports and increase reliance on crisis intervention, hospitalization, incarceration, emergency services, homelessness systems, and other higher-intensity systems of care. Recommended revisions included identifying replacement, braided, coordinated, or alternative funding strategies to preserve prevention and early intervention programs and other community-based behavioral health supports; formally recognizing Community-Defined Evidence Practices as part of the behavioral health continuum; prioritizing disparity reduction and culturally responsive service delivery in implementation and funding decisions; strengthening outreach and engagement for underserved populations, including African American residents, older adults, South County communities, Indigenous language speakers, Spanish-speaking residents, and unhoused individuals; investing in transportation, interpretation, support groups, and meaningful community participation opportunities; expanding contracting pathways and Medi-Cal-aligned opportunities for community-based organizations, including Enhanced Care Management and Community Supports; strengthening partnerships with trusted community-based providers and faith-based institutions; involving trusted behavioral health providers in housing-related planning and implementation efforts; protecting peer-led family support, education, outreach, navigation, prevention-oriented services, and support groups as part of the continuum of care; and implementing BHSA changes in a phased and thoughtful manner to avoid disruption of services and community-based infrastructure. Representatives from community-based organizations also requested that implementation and contracting processes avoid creating excessive administrative, billing, monitoring, documentation, or reporting burdens that could unintentionally weaken community-based support systems, culturally responsive providers, and early

	intervention access points. Additional comments recommended stronger operational specificity regarding implementation strategies, cross-system coordination, co-occurring disorder treatment approaches, housing coordination, and data-sharing infrastructure; improved demographic and disparity data collection and transparency; clearer accountability measures and timelines tied to identified disparities and unmet needs; stronger workforce development strategies for serving older adults, infants, toddlers, and underserved communities; preservation of older adult behavioral health and peer counseling services; and clearer planning related to continuity of care for individuals and families who may no longer qualify under revised BHSA eligibility structures. Representatives from community-based organizations further requested more interactive and accessible community engagement opportunities, including Spanish-language information and greater opportunities for community participation in behavioral health planning and implementation discussions.
Continuums of Care / Homeless Service Provider Community	Representatives from the Continuum of Care, the homeless service provider community, and County homelessness leadership recommended that the Integrated Plan strengthen coordination between behavioral health and homelessness response systems by increasing outreach and engagement efforts for individuals experiencing homelessness and embedding behavioral health services within housing settings. Stakeholders recommended development of comprehensive, field-based multidisciplinary outreach models serving unsheltered individuals and encampment populations, including teams composed of behavioral health clinicians, street outreach workers, peer support specialists, substance use disorder providers, and street medicine staff that could connect individuals to Medication-Assisted Treatment (MAT), bridge housing, interim housing, Coordinated Entry, public benefits, Full Service Partnerships, and other housing and treatment supports. Representatives from the Continuum of Care also recommended expanding the County's housing and treatment infrastructure through acquisition and conversion of vacant or underutilized properties into Permanent Supportive Housing (PSH), adaptive reuse and hotel or motel conversion projects, shared housing models, scattered-site and master leasing approaches, recovery-oriented housing, tiny homes, ADUs, safe parking, emergency shelter and interim housing strategies, and expansion of residential treatment services in South County, including consideration of converting the Sendero Interim Housing site into a

DRAFT

	residential treatment facility. Stakeholders recommended restoring Housing Interventions funding toward the State's recommended 30 percent baseline over time and requested that the Integrated Plan include a formal Housing Restoration Strategy with measurable benchmarks, reassessment timelines, public reporting expectations, and clearer explanation of how transferred Housing Intervention funds are intended to stabilize the broader behavioral health system. Additional recommendations included stronger alignment with the Lead Me Home Plan to End Homelessness; formal integration with existing homelessness response infrastructure including Coordinated Entry, HMIS, case conferencing systems, CARS, and homelessness outcome tracking systems; avoiding creation of parallel referral systems; entering into data-sharing agreements with the Coalition of Homeless Service Providers; and strengthening integration and coordination across housing, homelessness, healthcare, behavioral health, managed care, and institutional systems. Stakeholders further recommended stronger operational integration between BHSA and CalAIM-related housing and behavioral health resources, including Enhanced Care Management, Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Transitional Rent, BH-CONNECT initiatives, and managed care coordination through Central California Alliance for Health. Recommended revisions also included stronger operational planning for justice reentry, hospital discharge, and institutional transitions; clearer pathways for same-day behavioral health linkage, housing navigation, transportation coordination, medication continuity, recuperative care transitions, and warm handoffs into behavioral health and housing services; and adoption of "no discharge to homelessness" principles where feasible. Stakeholders additionally recommended a phased interoperability and shared accountability roadmap across Behavioral Health electronic health records, county clinics, hospitals, HMIS, jail health systems, probation, child welfare, and managed care systems; stronger use of peer supports, Community Health Workers (CHWs), and lived-experience workforce pathways; expanded cross-sector workforce development and shared practice standards related to Housing First, trauma-informed care, harm reduction, coordinated care, and housing stabilization; and stronger recovery-oriented employment, education, and economic mobility strategies through partnerships with workforce systems, educational institutions, employers, and supported employment

DRAFT

	programs. Representatives from the Continuum of Care and homelessness response systems also recommended clearer governance structures, implementation ownership, stakeholder representation, implementation leadership roles, measurable performance metrics, public dashboards, accountability frameworks, and regular public reporting regarding housing outcomes, behavioral health outcomes, justice-system outcomes, workforce development, equity outcomes, and implementation progress. Additional comments recommended stronger engagement with housing authorities and affordable housing partners; dedicated housing outreach and engagement infrastructure for unsheltered and high-barrier populations; stronger integration of housing-first practices and homelessness prevention approaches; and additional funding and coordination strategies to support highly vulnerable individuals and families experiencing homelessness or housing instability, including individuals who may not yet meet BHSA serious mental illness or substance use disorder eligibility criteria.
Eligible Adults and Older Adults	Public comments from eligible adults and older adults with lived experience emphasized the importance of maintaining accessible, recovery-oriented behavioral health services and supports that help individuals achieve stability, reduce isolation, manage symptoms, and remain connected to community. Comments from individuals with lived experience consistently highlighted housing stability as foundational to recovery, particularly for individuals living with serious mental illness, substance use disorder needs, trauma, anxiety, depression, PTSD, grief, and social isolation. Stakeholders recommended preserving and strengthening peer-led services, support groups, drop-in and wellness centers, community gathering spaces, counseling, outreach, food access, transportation assistance, employment and volunteer opportunities, recreational and social activities, and culturally responsive support services. Participants described OMNI Wellness Center, Peer Partners for Health, and other peer and community-based behavioral health programs as important sources of companionship, structure, emotional support, coping skills, symptom management, socialization, connection to services, recovery support, and safe spaces where individuals feel accepted and supported. Representatives from eligible adults and older adults also recommended preserving older adult-specific behavioral health services and peer counseling programs; expanding behavioral health approaches specifically designed for

DRAFT

	older adults; improving opportunities for meaningful community participation and engagement in planning processes; increasing Spanish-language information and accessibility; and ensuring that behavioral health services remain easy to access before individuals reach crisis levels. Additional comments from individuals with lived experience emphasized concerns that reductions in prevention, peer support, early intervention, support groups, and community-based recovery services could negatively affect stability, recovery, housing retention, social connection, and overall well-being for individuals currently relying on these services and supports.
Families of Eligible Children, Youth, Adults, and Older Adults	Public comments from families of eligible children and youth, eligible adults, and eligible older adults emphasized the importance of maintaining access to behavioral health services and supports that help children, youth, and families remain engaged in care and achieve positive outcomes. Family members recommended preserving transportation and interpretation services that support access to treatment, maintaining coordinated and team-based approaches to care, and protecting behavioral health services that families described as contributing to improved stability, school functioning, and long-term outcomes for children and youth receiving treatment and medication support.
Health Care Organizations, Including Hospitals	Representatives from health care organizations, including hospitals, recommended that the Integrated Plan include more specific, measurable, achievable, relevant, and time-bound planning related to housing, emphasizing the importance of stable housing in supporting behavioral health outcomes. Representatives from healthcare organizations also recommended strengthening coordination and communication across medical, behavioral health, correctional, and primary care systems through improved interoperability and integration of electronic medical record systems across relevant agencies and care settings, including Monterey County Behavioral Health, Natividad and affiliated clinics, and the county jail. Additional recommendations from healthcare stakeholders included improving continuity of care during transitions between service settings, strengthening whole-person care coordination involving primary care providers and advanced practice clinicians, and increasing system efficiency and stability for individuals living with serious mental illness.
Higher Education Partners	Representatives from higher education partners recommended that the Integrated Plan include greater operational specificity regarding cross-system coordination among behavioral health,

DRAFT

	housing, healthcare, justice, and social service systems, including clarification of lead entities, referral pathways, decision-making structures, shared performance indicators, discharge planning processes, and coordination roles across agencies and care settings. Representatives from higher education partners recommended aligning implementation with existing state and local coordination models and frameworks, including CalAIM and other structured cross-system coordination approaches. Additional recommendations included more explicitly integrating housing stability, caregiver supports, transportation, childcare, economic stressors, and other upstream determinants of health into the behavioral health continuum; strengthening coordination among Full Service Partnerships, Enhanced Care Management, housing systems, and community supports; expanding strategies to address housing supply constraints through approaches such as acquisition and conversion, landlord incentives, master leasing, accessory dwelling units, shared housing, and partnerships with housing authorities and nonprofit developers; clarifying how BHSA-funded housing resources will align with existing coordinated housing and prioritization systems; strengthening reentry planning and coordination for justice-involved individuals with behavioral health needs; and developing a phased cross-system data infrastructure strategy that includes data-sharing agreements, interoperable systems, shared reporting metrics, dashboards, and outcome monitoring across behavioral health, homelessness, healthcare, correctional, and social service systems. Stakeholders also recommended improving transparency regarding how Community Program Planning Process feedback informed funding and policy decisions, including clearer linkage between community priorities and resulting plan actions. Additional comments from higher education partners recommended increasing access to therapists, culturally relevant services, and language access supports; establishing clearer accountability structures with defined benchmarks, baseline measures, timelines, annual milestones, and responsible reporting entities; and preserving peer-led family support, education, outreach, and support services provided through organizations such as NAMI Monterey County for individuals and families affected by serious mental illness.
Local Education Agencies	Representatives from local education agencies recommended strengthening the Integrated Plan's focus on housing, behavioral health, and family stability as interconnected factors affecting student well-being, educational outcomes, and school stability.

DRAFT

	Representatives from local education agencies recommended increasing the specificity of the County's housing strategy; establishing clearer benchmarks, timelines, and decision points for restoration of Housing Interventions funding over the three-year plan period; and recognizing student and family homelessness as a central behavioral health and community stability issue. Additional recommendations from local education agencies included stronger alignment and coordination with existing homelessness and housing systems, including the Lead Me Home Plan to End Homelessness, Coordinated Entry, HMIS, and cross-system case conferencing structures, along with clearer expectations for discharge planning and coordination across hospitals, correctional systems, child welfare systems, schools, and behavioral health providers. Stakeholders also recommend expanding the County's housing strategy to incorporate housing production, acquisition and conversion efforts, rental subsidies, safe parking programs, accessory dwelling units, shared housing models, family-based stabilization supports, and other interim and long-term housing solutions. Representatives from local education agencies further recommended protecting Prevention and Early Intervention services during the transition from MHSA to BHSA; strengthening support for children and families experiencing housing instability, behavioral health needs, and barriers to healthcare access; and providing additional opportunities for Board review, policy direction, and refinement of the Integrated Plan prior to final approval.
Providers of Mental Health and Substance Use Disorder Treatment Services	Providers of mental health services and substance use disorder treatment services expressed support for the goals of the Behavioral Health Services Act while recommending that the Integrated Plan strengthen and preserve prevention and early intervention services, culturally responsive community-based behavioral health supports, and peer and family support services during the transition from MHSA to BHSA. Providers expressed concern that BHSA implementation changes, including narrower eligibility and funding shifts, could reduce access to prevention-focused and community-based services and increase reliance on crisis systems, emergency departments, child welfare systems, justice systems, hospitalization, and other higher-acuity behavioral health interventions. Recommended revisions included formally recognizing and funding Community-Defined Evidence Practices and other culturally grounded behavioral health models as part of the behavioral health continuum; strengthening disparity reduction

DRAFT

	strategies; expanding contracting pathways and Medi-Cal-aligned opportunities for community-based organizations; identifying replacement, braided, coordinated, or alternative funding sources to sustain prevention and early intervention programs and other impacted services; implementing BHSA changes gradually to reduce disruption of services; and preserving peer-led family support, outreach, education, support groups, navigation, and other community-based behavioral health supports. Providers specifically highlighted concerns regarding potential reductions or elimination of programs serving uninsured, undocumented, and vulnerable residents, including outpatient therapy, parenting support, and other prevention-oriented behavioral health services intended to stabilize individuals and families before crises escalate. Additional recommendations from providers included increasing access to therapists, culturally relevant services, transportation, interpretation, and language access supports; improving accessibility and usability of the Integrated Plan and community engagement process; providing clearer specificity regarding implementation strategies, benchmarks, and accountability measures; strengthening services and outreach for South County and North County communities; protecting support groups and youth-focused services; improving accessibility of behavioral health facilities and infrastructure; and maintaining behavioral health services that stakeholders described as contributing to improved family stability, educational outcomes, and long-term community well-being. Additional comments from providers recommended strengthening peer-directed wellness and recovery models; expanding the use of peer providers and community-based navigators within behavioral health access, reentry, and engagement processes; improving continuity of care and warm handoff strategies for justice-involved and high-acuity individuals; reducing administrative and intake barriers that may interfere with treatment engagement following release from custody or crisis events; and strengthening operational approaches to forensic behavioral health coordination and reentry stabilization services.
Public Safety Partners	Representatives from public safety partners recommended that the Integrated Plan strengthen behavioral health crisis response and coordination involving law enforcement, EMS, hospitals, and other first responder systems. Representatives from public safety partners recommended development of a local mental health treatment facility or expanded local treatment capacity for minors

DRAFT

	requiring extended psychiatric holds or inpatient behavioral health treatment in order to reduce out-of-county placements, transportation burdens, reunification challenges for families, and associated financial impacts. Additional recommendations from public safety partners included adding law enforcement and first responder behavioral health training related to crisis response, emergency mental health protocols, and coordination between EMS and law enforcement agencies; improving consistency and alignment between law enforcement and EMS mental health policies and procedures; clarifying roles and responsibilities during behavioral health emergencies and 5150-related responses; strengthening oversight and review of behavioral health crisis response practices; and improving coordination, documentation, transportation practices, and data collection related to behavioral health emergency responses and involuntary psychiatric holds.
Youths or Youth Mental Health or Substance Use Disorder Organizations	Public comments from youth and youth mental health or substance use disorder organizations recommended that the Integrated Plan maintain and strengthen youth behavioral health awareness, prevention, and early intervention supports within schools and community settings, including youth education, open discussion of mental health topics, and accessible support systems that allow students to recognize symptoms, seek help early, and connect peers to behavioral health support before conditions escalate. Representatives from youth-serving organizations also recommended increasing the Plan's focus on children ages 0–5 and their families, including adding more specific data on young children in the populations served section; identifying the impacts of MHSA-to-BHSA funding changes on early childhood and family-serving programs; and strengthening strategies to address disparities affecting young children and families. Additional recommended revisions from youth-serving stakeholders included addressing access barriers for Indigenous language speakers separately from Spanish-speaking residents; identifying geographic disparities in access to care, including South County resource gaps; highlighting families with children ages 0–5 experiencing homelessness as a population of focus; partnering with communities most impacted by disparities, including African American families with young children, to co-develop implementation and funding strategies; and adding workforce training focused on the unique behavioral health and developmental needs of infants and toddlers.

General Community Members	Public comments from the general public emphasized the importance of protecting and maintaining funding for mental health services and supports and recommended that behavioral health resources continue reaching individuals and communities in need of care. Members of the public expressed support for continued investment in counseling, crisis response, treatment, recovery, and community-based behavioral health services that help prevent hospitalization, incarceration, and individuals falling through service gaps. General public comments also recommended protecting and prioritizing prevention and early intervention programs during the transition from MHSA to BHSA, expressing concern that stricter eligibility requirements and reductions in lower-acuity services could delay access to care until individuals experience crisis-level conditions. Additional comments from members of the public recommended ensuring behavioral health services remain accessible, culturally responsive, stigma-free, and easy to navigate for community members before crises escalate; maintaining supports for youth, transitional age youth, underserved populations, and adults experiencing behavioral health challenges; and strengthening psychiatric leadership and clinical oversight within Behavioral Health planning and implementation processes, including concerns regarding development and implementation of the Integrated Plan without a permanent Medical Director.
Monterey County Board of Supervisors	Public comments from the Monterey County Board of Supervisors recommended that the Integrated Plan more clearly explain how Monterey County will use BHSA as an opportunity to redesign the behavioral health system rather than attempting to preserve the prior MHSA structure unchanged. Supervisors emphasized the need for greater clarity on how BHSA, Realignment, Medi-Cal, opioid settlement funds, local funds, increased productivity revenue, and other funding sources are reflected in the Integrated Plan, including whether non-BHSA or increased revenue sources could help sustain prevention, early intervention, and community-based services no longer aligned with BHSA funding rules. Members of the Board of Supervisors recommended adding clearer framing or explanatory material to help the public understand the purpose, limits, and context of the Integrated Plan; identifying which services and contracts are being maintained through BHSS and other funding sources; and clarifying how the transition from MHSA to BHSA will affect existing programs, staffing, service capacity, and populations with serious mental illness and substance use disorder needs. Supervisors also recommended

DRAFT

	strengthening the housing section by providing more specific implementation detail, including how Housing Interventions dollars will be spent, how the County will partner with housing and homelessness system agencies, whether and how the County will restore Housing Interventions funding toward the 30 percent baseline over time, and what decision points or benchmarks will guide future funding shifts. Additional housing recommendations from Supervisors included stronger alignment with the Lead Me Home Plan, HMIS, Coordinated Entry, case conferencing, discharge planning, universal or streamlined housing application pathways, housing navigation, family stabilization supports, Flexible Housing Subsidy Pool models, and a broader housing continuum that could include rental subsidies, capital development, acquisition, operating supports, safe parking, tiny homes or sleeping cabins, ADUs/JADUs, shared housing, room-and-board or license-exempt models, and family-hosted stabilization supports where appropriate. Supervisors further recommended deeper cross-system coordination with the County's homelessness response system, affordable housing partners, hospitals, Natividad, county clinics, jail health services, probation, corrections, child welfare, public safety, cities, and community-based organizations. Comments from Supervisors requested stronger data-sharing and interoperability strategies, including clearer next steps, timelines, responsible departments, and milestones for improving coordination across electronic health records, HMIS, jail health, hospitals, clinics, managed care, probation, corrections, and child welfare. Supervisors also recommended more explicit planning for justice-involved BHSA-eligible individuals, including individuals exiting jail or other institutional settings, with attention to placement barriers, reentry, discharge planning, family reunification, caregiver support, and alignment with criminal justice population needs. Additional comments emphasized the need for broader and more meaningful stakeholder engagement during implementation, including clearer identification of which stakeholder groups and implementation partners will be included moving forward, how the Behavioral Health Commission and Behavioral Health Transformation Collaborative will participate, and how stakeholder input will shape implementation decisions. Supervisors also recommended greater transparency regarding public hearing dates, governance roles, stakeholder participation, and future planning processes, while acknowledging that the Integrated Plan is a state-required planning

DRAFT

	document that may need to preserve flexibility and be updated as implementation, funding, and community needs evolve.

**Duplicate if needed

7. 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.
    a. Recommendation: **Consider re-instating funding for programs for underserved racial and ethnic populations such as those offered by the Center for Community Advocacy and The Village; and for agencies serving older adults such as the Alliance on Aging and the Senior Companions program.**
    MCBH Response: MCBH recognizes the important role that community-based organizations play in promoting behavioral health, strengthening community connections, and addressing local needs through culturally responsive and trusted services. While some of these services may no longer align with BHSA funding requirements, MCBH acknowledges their value to the communities they serve and remains committed to supporting their long-term sustainability. As part of ongoing implementation efforts, MCBH will continue to share information, facilitate connections, and support opportunities for community-based organizations to pursue alternative funding sources, including programs administered by the California Department of Public Health and community-based services and supports available through Central California Alliance for Health (CCAH). MCBH will also continue engaging these partners in planning and coordination efforts to help strengthen the broader behavioral health continuum of care in Monterey County.
    b. Recommendation: **Provide age-specific analysis and reporting for older adults whenever possible, recognizing older adults as a BHSA priority population and a historically underserved group.**
    MCBH Response: MCBH appreciates this recommendation and agrees that greater visibility into the behavioral health needs and experiences of older adults would strengthen planning and transparency efforts. While the Integrated Plan reflects statewide data sources and the data structure required by the state, the County recognizes the value of disaggregating adult populations into more specific age groups, including older adults. The County is hopeful that future enhancements to the Behavioral Health Outcomes, Accountability, and Transparency Reporting (BHOATR) framework, as well as improvements to state-provided population and service utilization data, will support more detailed age-based analyses.
    c. Recommendation: **Describe how MCBH plans to improve care experience, including planned strategies and methods for monitoring progress.**
    MCBH Response: MCBH understands the importance of care experience in specialty treatment services. During development of the Integrated Plan, MCBH utilized

DRAFT

available data, stakeholder feedback, and input from the Behavioral Health Transformation Collaborative to identify a limited number of priority areas for enhanced local planning focus. Although care experience remains important to MCBH's ongoing quality improvement efforts, it was not selected through this process as a priority area requiring additional goal-setting, disparity analysis, or new implementation strategies during the FY 2026-2029 planning period. MCBH will continue to monitor available care experience data and may consider additional planning activities in future Integrated Plan updates as priorities, data availability, and community needs evolve.

d. Recommendation: **Provide additional information regarding Monterey County's plans for participation in a Flexible Housing Subsidy Pool, including anticipated decision-making considerations, implementation factors, and interim approaches to housing coordination if participation is not currently planned.**
   MCBH Response: MCBH appreciates the recommendation. At this time, the County has not established an expected timeline or decision point regarding participation in a Flexible Housing Subsidy Pool. The County will continue implementing Housing Interventions through the approaches described in the Integrated Plan while coordinating with housing, healthcare, homelessness response, and other system partners. The recommendation will be taken under advisement and considered as part of ongoing Housing Interventions planning, implementation, and coordination efforts throughout the BHSA implementation period.
e. Recommendation: **Provide additional information regarding planned strategies, staffing, timelines, and milestones to address health information exchange (HIE), interoperability, and data analytics capacity needs that support BHSA reporting, performance monitoring, and equity analysis.**
   MCBH Response: MCBH appreciates the recommendation and recognizes the importance of health information exchange, interoperability, data analytics, reporting infrastructure, and equity monitoring in supporting successful BHSA implementation. The Integrated Plan template does not include a section dedicated to operational implementation plans, staffing models, timelines or milestones related to health information exchange, interoperability, or analytics infrastructure. These activities are being addressed through ongoing planning, coordination and implementation efforts involving MCBH, providers, managed care partners, technology vendors, and other system partners. As BHSA implementation progresses and state reporting requirements continue to evolve, MCHB will assess and refine workforce, technology, and data infrastructure needs to support reporting, performance monitoring, quality improvement, and equity analysis. Considerations related to interoperability, data-sharing capabilities, analytics capacity and reporting infrastructure will continue to inform implementation planning throughout the BHSA implementation period.

DRAFT

f. Recommendation: **Improve transparency regarding projected service volumes by clarifying whether planned-to-serve counts represent duplicated or unduplicated individuals and whether projections are annual or across the full plan period. Consider providing more detailed age-group reporting, particularly distinguishing adults and older adults, to better understand how planned services align with identified disparities and unmet needs.**
MCBH Response: MCBH agrees that more detailed service projections and age-group reporting may strengthen future planning and accountability efforts. The current Integrated Plan reflects the reporting structure and data available during plan development. While MCBH does not plan to revise the current Integrated Plan to further disaggregate projected service counts, the County will continue working with providers to improve the consistency, accuracy, and interpretability of projected service utilization information. MCBH will also explore opportunities to provide more detailed age-group reporting, including distinctions between adults and older adults, in future planning and reporting processes, including the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) and future Integrated Plans, where state reporting requirements, templates, and available data systems support such reporting.

g. Recommendation: **Restoring Housing Interventions funding toward the statutory 30 percent allocation and requested a clearer long-term housing investment strategy.**
MCBH Response: MCBH recognizes the critical role that housing plays in behavioral health recovery and community stability. At the same time, BHSA implementation requires consideration of the full behavioral health continuum, including prevention **and early intervention services, outpatient treatment, intensive community-based services, crisis response, residential care, workforce needs, and housing supports. The County believes additional planning, analysis, and collaboration with behavioral health providers, housing partners, health care organizations, homelessness response partners, and other community stakeholders are needed to fully evaluate the potential impacts of future funding changes across the broader system of care. During the three-year implementation period, MCBH will continue assessing community needs, service utilization patterns, housing needs, system capacity, and available funding opportunities to help inform future decisions regarding long-term alignment with the BHSA funding framework.**

h. Recommendation: **Increase transparency regarding stakeholder engagement by clearly documenting which stakeholder groups participated in the planning process, how and when engagement occurred, key concerns and recommendations raised, how stakeholder input influenced the Integrated Plan, and the membership and participation of the Behavioral Health Transformation Collaborative.**
MCBH Response: MCBH agrees that transparency regarding stakeholder engagement

DRAFT

is important. The Community Planning Process section of the Integrated Plan documents a broad and extensive engagement effort that included community members, individuals with lived experience, family members, providers, healthcare organizations, public agencies, housing and homelessness partners, educational partners, public safety representatives, and other required stakeholder groups. The Integrated Plan also includes summaries of stakeholder engagement activities, participating organizations, public comments received, and substantive revisions recommended during the public comment period.

While MCBH does not plan to revise the current Integrated Plan to include the additional stakeholder engagement matrix described in the recommendation, the County recognizes the value of further documenting how stakeholder input informed planning decisions and implementation priorities. This recommendation will be used to inform future Community Planning Process activities, stakeholder engagement documentation, and data collection efforts for future Integrated Plans. MCBH will continue working to strengthen transparency regarding stakeholder participation, feedback received, and the ways in which community and system partner input informs behavioral health planning and implementation efforts.

i. Recommendation: **Identify additional funding sources and transition strategies to preserve effective Prevention and Early Intervention (PEI) programs that may be impacted by the transition from MHSA to BHSA, particularly programs serving individuals at the lowest levels of intervention and populations experiencing unmet behavioral health needs.**

MCBH Response: MCBH recognizes the important role that Prevention and Early Intervention programs have played in supporting community members before behavioral health needs escalate to higher levels of care. The transition from MHSA to BHSA reflects significant statewide policy and funding changes that affect how prevention, early intervention, specialty behavioral health services, and housing-related supports are funded and organized. Throughout the planning process, MCBH has prioritized continuity of care and has worked closely with providers and system partners to identify alternative funding sources and prepare for these changes. The County recognizes that implementation is occurring within a broader environment that includes significant pressures on both behavioral health and housing systems, including funding uncertainty for some shelter and interim housing programs, existing housing shortages, and substantial waitlists for housing resources. The County will continue working with its contracted provider network and community partners to assess program continuity, identify service and housing gaps that may emerge during implementation, and explore opportunities to support effective community-based services and housing resources through available funding sources and partnerships. MCBH remains committed to supporting providers and communities throughout the

transition and will continue monitoring implementation impacts as part of ongoing BHSA planning, housing coordination, and implementation efforts.

j. Recommendation: **Consider a broader range of housing models and housing continuum options, including safe parking, tiny homes or sleeping cabins, accessory dwelling units (ADUs/JADUs), shared housing, room-and-board arrangements, license-exempt housing models, and family-supported housing approaches, where clinically and operationally appropriate for BHSA-eligible individuals.**
MCBH Response: MCBH appreciates the recommendation and recognizes the potential value of a diverse range of housing models in addressing the varying needs of individuals experiencing homelessness or housing instability. The County acknowledges that housing solutions may extend beyond traditional supportive housing approaches and that innovative housing models may play an important role within the broader community housing continuum. While MCBH does not plan to revise the current Integrated Plan to incorporate specific commitments regarding these housing models, the County remains interested in ongoing collaboration with housing providers, homelessness response partners, local governments, healthcare organizations, and other community stakeholders to explore opportunities that may strengthen housing access and stability for BHSA-eligible individuals. These concepts will be taken under advisement and may inform future planning, partnership development, and housing system coordination efforts as local needs, resources, and implementation opportunities continue to evolve.

County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

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 (enter file name here): QI Workplan FY 26-27.docx

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** ☐ No
   a. If yes, for standalone DMC-ODS, please upload a copy of the county's current QIP for SFY 2026-2027 (enter file name here):

Contracted BHSA Provider Locations

1. As of the date this report is submitted, in Table 8, 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.[1]

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

Services Provided	Number of Contracted BHSA Provider Locations
Mental Health (MH) services only	**50**
Substance Use Disorder (SUD) services only	**0**
Both MH and SUD services	**0**

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	**41**
DMC/DMC-ODS only	**0**
Both SMHS and DMC/DMC-ODS systems	**0**

All BHSA Provider Locations

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

[1] Note: 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.

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?[2] **38%**
    a. If the estimate is less than 60%, 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: **The County of Monterey will provide guidance to BHSA-funded providers and other community-based organizations regarding MCP billing requirements and encourage participation in MCP contracting where clinically appropriate and operationally feasible. These efforts are intended to improve coordination of care, reduce duplication of funding streams, and ensure BHSA resources are reserved for individuals who meet SMHS medical necessity criteria, while supporting integrated and fiscally responsible service delivery.**
2. To maximize resource efficiency, counties must, as of July 1, 2027, (with certain exceptions) require their BHSA providers to:
    - 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;
    - Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and
    - 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.

    a. Does the county wish to describe implementation challenges or concerns with these requirements?
    ☐ Yes ☒ **No**
        i. If yes, please describe any implementation challenges or concerns with the requirements for BHSA providers: **N/A**
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

[2] 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.

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 ☒ **No**

   i. If not, please describe how the county will monitor these providers for compliance with BHSA requirements:

   Beginning SFY 2027–2028, Monterey County Behavioral Health (MCBH) will implement a provider monitoring schedule for BHSA-funded providers that includes quarterly data review, annual program monitoring, and site visits at least once every three years. Monitoring activities will include review of BHSA Compliance Forms completed by providers; collection and analysis of participant engagement, process, and outcome performance data; and review of compliance with applicable BHSA requirements, state law, regulations, and county contract requirements.

   MCBH's Quality Improvement (QI) Department will continue conducting program monitoring in accordance with County Policy 422, Utilization Review, while incorporating BHSA-specific monitoring requirements into the existing monitoring structure. When compliance issues are identified, providers will be required to implement corrective action plans (CAPs), and MCBH will monitor resolution of identified issues. Monitoring records, including monitoring reports, county-approved CAPs, and documentation of CAP resolution, will be maintained and made available to DHCS upon request.

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

   ☐ Yes ☒ **No**

   i. If not, please describe how the county will monitor these providers for compliance with BHSA requirements:

   Beginning SFY 2027–2028, Monterey County Behavioral Health (MCBH) will implement a provider monitoring schedule for BHSA-funded providers that do not participate in the County's Medi-Cal Behavioral Health Delivery System. Monitoring activities will include quarterly data review, annual program monitoring, and site visits at least once every three years.

Monitoring of non-Medi-Cal BHSA-funded providers will be conducted by a BHSA Monitoring Analyst and will include review of BHSA Compliance Forms; collection and analysis of participant engagement, process, and outcome performance data; and review of compliance with applicable BHSA requirements, state law, regulations, and county contract requirements. When compliance issues are identified, providers will be required to implement corrective action plans (CAPs), and MCBH will monitor resolution of identified issues.

Monitoring records, including monitoring reports, county-approved CAPs, and documentation of CAP resolution, will be maintained and made available to DHCS upon request.

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS) - See Appendix A

Full Service Partnership Program

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

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 10. Estimated Number of Individuals Eligible for Full Service Partnership Services

Total Adult FSP Eligible Population	Estimates

Number of Medi-Cal Enrolled Individuals	**1,403**
Number of Uninsured Individuals	**289**
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	**516**

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 11. 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	**173**
Number of Uninsured Individuals	**36**
Number of Total ACT Eligible Individuals with Some Justice-System Involvement	**516**

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	**87**
Number of Uninsured Individuals	**18**

ACT and FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**40**
Number of Teams Needed to Serve Total Eligible Population	**4**

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, in Table 18 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.

DRAFT

Table 12. Total Number of ACT and FACT Practitioner and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	16.5	16.5	16.5
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 13. 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	**1,143**
Number of Uninsured Individuals	**235**

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**60**
Number of Teams Needed to Serve Total Eligible Population	**12**

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, in Table 20 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 14. Total Number of FSP ICM Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	32	32	32
Total Number of Teams	27	27	27

High Fidelity Wraparound (HFW) Eligible Population

DRAFT

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 15. 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	*585*
Number of Uninsured Individuals	*60*

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	*219*
Number of Teams Needed to Serve Total Eligible Population	*4*

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, in Table 22 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 16. Total Number of HFW Practitioners and Teams

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

Individual Placement and Support (IPS) Eligible Population

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

Table 17. 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	**2,418**
Number of Uninsured Individuals	**506**

DRAFT

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**185**
Number of Teams Needed to Serve Total Eligible Population	**74**

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 18. Total Number of IPS Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**3.5**	**3.5**	**3.5**
Total Number of Teams	**1**	**1**	**1**

Full Service Partnership (FSP) Program Overview

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

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 ☒ No
   a. If yes, please describe how the estimated practitioners will provide more than one EBP:
      N/A
2. Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports:
   The County of Monterey employs a whole-person, trauma-informed approach to Full Service Partnership services that recognizes the interconnected nature of behavioral health, physical health, housing stability, and social and community supports. Services are delivered in a manner that emphasizes safety, trust, respect, and choice, and are responsive to the lived experiences and strengths of individuals and families served.
   FSP services are designed to engage individuals in their communities and address needs across multiple life domains, including mental health, substance use, physical health, housing, and social supports. Providers are expected to use trauma-informed practices that minimize re-traumatization, promote engagement, and adapt services to meet individuals where they are.

DRAFT

The County supports active partnership with families and individuals' natural supports, consistent with client preference and consent. Families, caregivers, and other natural supports are engaged in service planning, care coordination, and ongoing support to promote stability and recovery. For children, youth, and families, this includes family-driven planning and coordination across systems that support youth and caregivers. Coordination with community-based organizations, physical health providers, housing partners, and other system partners further supports a whole-person approach. Through these practices, the County of Monterey promotes integrated, person-centered services that support recovery, wellness, and long-term stability.

3. Please describe the county's efforts to reduce disparities among FSP participants:
   The County of Monterey is committed to reducing disparities among Full Service Partnership participants by promoting equitable access to services and culturally and linguistically responsive care. Equity considerations are incorporated into program design, service delivery expectations, and ongoing implementation activities.
   The County supports outreach and engagement strategies that are responsive to the cultural, linguistic, geographic, and socioeconomic diversity of the community. This includes adapting engagement approaches, service locations, and service delivery methods to reduce barriers related to language access, transportation, housing instability, and stigma.
   The County of Monterey emphasizes the inclusion of peer and family support roles and values lived experience as a critical component of service delivery. These roles support trust-building and engagement, particularly for individuals from historically underserved communities.
   The County also uses available data and stakeholder input to identify disparities in access, engagement, and outcomes among FSP participants. Information from service utilization data, community input, and provider feedback is used to inform adjustments to outreach strategies, training priorities, and partnerships with community-based organizations, supporting continuous improvement and equity across FSP services.

4. Select which goals the county is hoping to support based on the county's allocation of FSP funding (select all that apply):
   a. ☒ **Access to Care**
   b. ☒ **Care Experience**
   c. ☒ **Engagement in School**
   d. ☒ **Engagement in Work**
   e. ☒ **Homelessness**
   f. ☒ **Institutionalization**
   g. ☒ **Justice-Involvement**
   h. ☒ **Overdoses**

DRAFT

i. ☒ **Prevention of Co-Occurring Physical Health Conditions**
j. ☒ **Quality of Life**
k. ☒ **Removal of Children from Home**
l. ☒ **Social Connection**
m. ☒ **Suicides**
n. ☒ **Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental 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**:**
The County of Monterey provides ongoing engagement services for individuals receiving Full Service Partnership Intensive Case Management through consistent, relationship-based, and community-centered practices. Engagement is treated as a continuous process that supports access, retention, and meaningful participation in services. FSP ICM teams maintain regular contact using flexible, individualized strategies that reflect client needs, preferences, and circumstances, including community-based contacts, flexible scheduling, and outreach in settings identified by the individual.

   Engagement activities are integrated with service planning and care coordination. Staff work collaboratively with individuals to identify goals, address barriers to participation, and adjust services as needs change. When individuals experience periods of disengagement, teams use respectful and persistent re-engagement approaches that prioritize trust, choice, and continuity of care. Ongoing engagement is further supported through multidisciplinary team structures, inclusion of peer support roles, and coordination with housing, physical health, and community-based partners to promote stability and recovery.

   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**: N/A**

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.):
The County of Monterey will comply with required Full Service Partnership levels of care by ensuring that FSP services are delivered at the appropriate intensity to meet individual needs and are aligned with evidence-based practices and defined levels of care. The County will differentiate service expectations for Full Service Partnership Intensive Case Management and Assertive Community Treatment and will align staffing, team structure, and service delivery accordingly.
The County will assess existing FSP ICM capacity and community need to determine the appropriate mix of FSP ICM and ACT services. As needed, this may include transitioning FSP

ICM teams to ACT models, standing up new ACT teams, and or establishing additional FSP ICM teams to maintain a balanced continuum of care. Decisions will be guided by clinical need, provider readiness, and fidelity requirements.
The County will support implementation through workforce training, coordination with contracted providers, and use of data to monitor service delivery, transitions between levels of care, and continuity of services.

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
      ☐ Yes ☒ **No**
      i. If yes, please describe: **N/A**
   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 ☒ **No**
      i. If yes, please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program: **N/A**
   c. Other recovery-oriented services
      ☐ Yes ☒ **No**
      i. If yes, please describe the other recovery-oriented services the county's FSP program will include: **N/A**
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. If no additional FSP services, use "N/A": **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: **The County considered the needs of justice-involved and at-risk children and youth through review of service utilization data and coordination with probation, education, and community-based providers. Planning activities emphasized trauma-informed engagement, continuity of care during system transitions, and coordination across behavioral health, juvenile justice, and family-serving systems to support stability and reduce system involvement.**
   b. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+): **The County incorporated equity-focused planning and stakeholder input to address the needs of LGBTQ+ children and youth in FSP program development. Engagement with providers and community-based organizations informed expectations related to affirming practices,**

confidentiality, culturally responsive engagement, and workforce training to ensure services are accessible, respectful, and responsive.

  c. In the child welfare system: **The County reviewed behavioral health and child welfare data and engaged system partners to understand coordination challenges affecting children and youth involved in the child welfare system. Planning efforts focused on strengthening cross-system collaboration, supporting continuity of care, and promoting family and caregiver involvement in service 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: **The County reviewed demographic and service utilization data and engaged providers serving older adults to inform FSP program development. Planning considerations focused on co-occurring health needs, accessibility, housing stability, and coordination across behavioral health, physical health, and social service systems.**
    b. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+): **The County incorporated equity-focused planning and stakeholder input to consider the needs of LGBTQ+ adults in FSP program development. Engagement with providers and community-based organizations informed expectations related to affirming practices, culturally responsive engagement, and workforce training.**
    c. In, or are at risk of being in, the justice system: **The County reviewed behavioral health and justice-related data and engaged justice system partners to identify service gaps and transition challenges for justice-involved adults. Planning activities emphasized coordination across behavioral health, justice, housing, and community-based systems to support continuity of care and community reentry.**

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. In Tables 25 and 26, 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.

DRAFT

Table 19. 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	**Youth-Focus Prevention Programming through Opioid Remediation Uses**	***See below***	***See below***	***See below***	***See below***
Mobile Field-Based Program(s)	**Central Coast Overdose Prevention (CCODP) Substance Use Response Team (SURT)**	***See below***	***See below***	***See below***	***See below***
Open-Access Clinic(s)	**Opioid (Narcotic) Treatment Program (ASAM OTP Level 1); Outpatient Services (ASAM Level 1, 2.1, MAT Med Support, Recovery Services, Clinician Consultation, Peer Support Services, and Care Coordination)**	***See below***	***See below***	***See below***	***See below***

Existing Programs for Assertive Field-Based SUD Treatment Services

1. Targeted Outreach
    a. Existing Program(s): **Youth-Focus Prevention Programming through Opioid Remediation Uses**
    b. Program Description(s): **Youth-Focus Prevention Programming is a trauma-informed program that focuses on preventing youth substance use through evidence-based strategies that strengthen resilience, promote leadership development, and expand access to prevention and early intervention resources. It engages students in high-risk educational and juvenile justice settings and provides caregiver and educator workshops, as well as prevention, harm-reduction, intervention, and treatment youth corps trainings. The program is designed to reduce risk and support healthy development among youth populations.**

c. Current Funding: **Medi-Cal reimbursement for allowable services; County SUD funding**
d. BHSA Changes to Existing Program(s) to Meet BHSA Requirements: **Under BHSA, the County will work to further align and coordinate existing outreach activities to function as part of a structured AFBI model. This includes clarifying referral pathways, strengthening coordination with mobile field-based services and open-access clinics, and ensuring outreach practices support timely engagement and initiation of treatment, including MAT, consistent with BHSA requirements.**
e. Expected Timeline of Operation: **Ongoing, with continued alignment and integration during the BHSA implementation period**

2. Mobile Field Based Program(s)
   a. Existing Program(s): **Central Coast Overdose Prevention (CCODP) Substance Use Response Team (SURT) Program**
   b. Program Description(s): **SURT provides mobile outreach throughout the County to deliver street medicine services and provide SUD assessment, engagement, and care coordination in community settings outside of traditional clinic environments. The program is staffed by a multidisciplinary team of healthcare professionals, including a qualified licensed practitioner (e.g., physician or physician assistant) and Medi-Cal–certified peer support specialists/Community Health Workers. Using a patient-centered approach, the program meets individuals where they are—on the streets, in shelters, or other temporary accommodations—and supports transitions of care through partnerships with harm reduction organizations and local behavioral health resources, linking individuals to outpatient, residential, and MAT services as appropriate.**
   c. Current Funding: **Opioid Settlement Dollars.**
   d. BHSA Changes to Existing Program(s) to Meet BHSA Requirements: **To meet BHSA AFBI requirements, the County will further integrate existing mobile field-based services with targeted outreach and open-access treatment entry points. This alignment will focus on strengthening coordination, improving timeliness of service initiation, and supporting structured handoffs to MAT providers and ongoing SUD treatment programs as part of a cohesive AFBI service program.**
   e. Expected Timeline of Operation: **Ongoing, with continued refinement and alignment under BHSA implementation**
3. Open-Access Clinic(s): Program #1
   a. Existing Program: **Opioid (Narcotic) Treatment Program (SAM OTP Level 1)**
   b. Program Description: **This program provides outpatient clinic based and mobile based narcotic treatment services, including methadone, buprenorphine, disulfiram, and naloxone to alleviate withdrawal. Operating at the ASAM service level, it offers comprehensive SUD care, including on demand screening, assessment, care coordination, counseling, family therapy, medical psychotherapy, medication management, patient education, drug screening, crisis**

intervention, and recovery support services. The program is designed to provide accessible, clinic-based and mobile based NTP treatment to individuals seeking outpatient SUD care.

c. Current Funding: **Medi-Cal reimbursement; County SUD funding; DMC-ODS.**
d. BHSA Changes to Existing Program(s) to Meet BHSA Requirements: **As part of BHSA implementation, the County will align existing access points to function more explicitly as open-access components within an AFBI framework. This includes strengthening coordination with outreach and mobile field-based teams, supporting rapid or same-day initiation of treatment where feasible, and ensuring streamlined referral pathways to MAT and ongoing SUD services.**
e. Expected Timeline of Operation: **Ongoing, with continued alignment and coordination during the BHSA implementation period.**

4. Open-Access Clinic(s): Program #2
   a. Existing Program: **Outpatient Services (ASAM Level 1, 2.1, MAT Med Support, Recovery Services, Clinician Consultation, Peer Support Services, and Care Coordination)**
   b. Program Description: **The program delivers outpatient substance use disorder treatment, including ASAM Level 1 and 2.1 services, MAT medication support, recovery services, peer support, and care coordination through clinic-based services and mobile MAT units. Participants attend 2–3 times per week over a four-month period, receiving group and individual sessions focused on recovery skills, relapse prevention, and stress management. The program uses evidence-based approaches, including motivational enhancement and cognitive behavioral therapy, and is staffed by a multidisciplinary team of licensed clinicians, counselors, and peer recovery specialists.**
   c. Current Funding: **Medi-Cal reimbursement; County SUD funding.**
   d. BHSA Changes to Existing Program(s) to Meet BHSA Requirements: **As part of BHSA implementation, the County will align existing access points to function more explicitly as open-access components within an AFBI framework. This includes strengthening coordination with outreach and mobile field-based teams, supporting rapid or same-day initiation of treatment where feasible, and ensuring streamlined referral pathways to MAT and ongoing SUD services.**
   e. Expected Timeline of Operation: **Ongoing, with continued alignment and coordination during the BHSA implementation period.**

Table 20. 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	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Mobile Field-Based Program(s)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Open-Access Clinic(s)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Medications for Addiction Treatment (MAT) Details

Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029.

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:
   To understand where existing MAT resources may fall short of meeting community needs, the County of Monterey Behavioral Health will take a practical, implementation-focused look at how current programs and providers are functioning in relation to expected demand. This will include considering provider capacity, geographic availability, utilization patterns, and timeliness of access alongside available information on substance use disorder prevalence and anticipated referrals from AFBI and other access points. These insights will be used to inform ongoing contracting, referral coordination, and operational adjustments to support sufficient access to MAT services.

2. Select the following practices the county will implement to ensure same day access to MAT (select all that apply):
   - **a. ☒ Contract directly with MAT providers in the county**
   - b. ☐ Operate MAT clinics directly
   - c. ☐ 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
   - **d. ☒ Leverage telehealth model(s)**
   - e. ☐ Partner with neighboring counties
     - i. If selected, please provide the names of the neighboring counties: **N/A**
   - f. ☐ Contract with MAT providers in other counties
     - i. If selected, please provide the names of neighboring counties: **N/A**
   - g. ☐ Other strategy
3. What forms of MAT will the county provide utilizing the strategies selected above?
   - **a. ☒ Buprenorphine**
   - **b. ☒ Methadone**
   - **c. ☒ Naltrexone**

d. ☒ **Other**
    i. If selected, please specify other forms of MAT: **Disulfiram**

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: **Medium Gap**
    b. Apartments, including master-lease apartments: **Medium Gap**
    c. Single and multi-family homes: **Medium Gap**
    d. Housing in mobile home communities: **N/A**
    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: **N/A**
    h. (Permanent) Tiny homes: **Medium Gap**
    i. Shared housing: **Medium 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: **Large Gap**
    n. Hotel and Motel stays: **Medium Gap**
    o. Non-congregate interim housing models: **Medium 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): **Medium Gap**
    q. Recuperative Care: **N/A**
    r. Short-Term Post-Hospitalization housing: **N/A**

DRAFT

s. (Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units: **Large Gap**
t. Peer Respite: **Large Gap**
u. Permanent rental subsidies: **Large Gap**
v. Housing supportive services: **Medium 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? **The county behavioral health system will leverage a range of non-BHSA resources, contracted and County partnerships, and other funding sources to expand housing supply and increase access for BHSA-eligible individuals. These include state funding programs such as the Behavioral Health Bridge Housing Program (including any future competitive rounds), and the Community Care Expansion (CCE) Grant, with prior awards supporting capital and operating stabilization of residential care facilities. Partnerships with the CoC facilitated Coalition of Homeless Services Providers, specifically the Lead Me Home Leadership Council, County of Monterey Medi-Cal Managed Care Plan, Central California Alliance for Health, will support ongoing coordination with local homelessness response infrastructure, including housing navigation, case conferencing, data-sharing efforts where appropriate, interim housing supports, discharge planning and transition coordination across hospitals, correctional settings, probation, child welfare, and other institutional partners, and pathways to permanent housing for BHSA-eligible individuals. Additional resources include federal Community Development Block Grant (CDBG) funding, local housing developers and nonprofit operators, Interim, Inc. and other supportive housing providers, and housing navigation and low-barrier housing partners. The county will also utilize programs through Monterey County Works and Monterey-Salinas Transit to further support housing access and stability.**

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? **Coalition of Homeless Services Providers (the Lead Me Home Leadership Council): Coordinate BHSA Housing Interventions with the Lead Me Home initiative and associated homelessness response strategies to strengthen alignment between behavioral health, housing, and homeless service systems. Support collaborative housing navigation, case conferencing, housing placement, and system coordination efforts that improve access to housing opportunities and promote long-term housing stability for BHSA-eligible individuals.**

Behavioral Health Bridge Housing Program (including any future competitive rounds): Coordinate interim and bridge housing resources with BHSA Housing Interventions to stabilize placements and support transitions from crisis or interim settings into longer-term residential and supportive housing options without disruption to care or housing stability. These efforts will strengthen continuity of care, support hospital discharge planning and

justice reentry efforts, and promote seamless pathways from crisis response and interim housing to recovery-oriented and permanent housing opportunities.

Community Care Expansion (CCE) Grant (prior awards supporting capital and operating stabilization of RCFs): Build on prior CCE-funded capital and operating stabilization of residential care facilities by aligning BHSA Housing Interventions to help preserve capacity, prevent closures, and support long-term financial sustainability beyond time-limited grant periods. These efforts will help sustain residential care resources that support recovery, community integration, and housing stability for BHSA-eligible individuals.

Central California Alliance for Health (County of Monterey Medi-Cal Managed Care Plan): Coordinate BHSA Housing Interventions with CalAIM Enhanced Care Management, Community Supports (where offered), Transitional Rental Assistance, and workforce and equity initiatives to reduce operational strain on housing providers, improve care coordination, and strengthen housing stability for Medi-Cal beneficiaries. Coordination across these resources will help support housing navigation, transitions between levels of care, and access to housing-related services that promote long-term stability and recovery.

Community Development Block Grant (CDBG) funding: Align CDBG-funded ADA accessibility and health and safety improvements with BHSA Housing Interventions to ensure rehabilitated units remain usable, accessible, and financially viable for BHSA-eligible individuals, including older adults and individuals with physical limitations.

County of Monterey Continuum of Care (CoC): Coordinate housing interventions with CoC-funded permanent supportive housing, HMIS-informed planning efforts, and other HUD resources to strengthen pathways between interim, residential, and permanent housing options for BHSA-eligible individuals experiencing homelessness or housing instability. MCBH will coordinate with the Continuum of Care to support referral processes, housing navigation activities, case conferencing efforts, and housing outcome tracking for BHSA-eligible individuals experiencing homelessness, chronic homelessness, or risk of homelessness. These efforts are intended to strengthen alignment between behavioral health services, housing resources, and homelessness response systems while supporting ongoing planning and coordination regarding future housing system integration opportunities.

Local housing developers, nonprofit operators, and supportive housing providers: Partner with developers and nonprofit operators to advance facility acquisition, conversion, and development strategies identified in the RCFI study, while using BHSA Housing Interventions to support operating sustainability, referrals, and access for BHSA-eligible populations.

DRAFT

Coordination with housing partners may include exploration of adaptive reuse, recovery-oriented housing, shared housing, master leasing, and other housing approaches that strengthen the local housing continuum.

Housing navigation and low-barrier housing partners: Coordinate BHSA Housing Interventions with housing navigation and low-barrier housing options to improve access for individuals who face barriers to traditional residential care facilities, including individuals with co-occurring substance use disorders. These partnerships will support engagement of individuals experiencing homelessness, including those living in unsheltered settings, and help connect them to housing opportunities that promote stability, recovery, and long-term community integration.

Monterey County Works: Align workforce development and training resources with BHSA Housing Interventions to strengthen staffing capacity at residential care facilities and supportive housing settings. By supporting workforce recruitment, training, and retention efforts, these partnerships will help preserve housing and treatment capacity, reducse service disruptions, and program long-term stability and continuity of care for BHSA-eligible individuals.

Monterey-Salinas Transit programs: Coordinate housing placements supported by BHSA Housing Interventions with transit programs (e.g., taxi vouchers, navigation support) to improve access to behavioral health services, medical appointments, employment, education, and other community resources. These efforts will help reduce transportation barriers, improve access for individuals living in underserved areas, support community integration, and promote housing stability and successful placement outcomes.

Lastly, and consistent with BHSA requirements, Monterey County Behavioral Health will implement the Individual Placement and Support (IPS) model of supported employment to fidelity funded with both non-BHSA and BHSA Full Service Partnership dollars. IPS services are intended to help individuals with serious mental illness and co-occurring conditions obtain and maintain competitive employment while receiving behavioral health services. In addition to supporting recovery and community integration, IPS is expected to strengthen economic stability by increasing access to earned income, employment opportunities, and workplace supports. MCBH recognizes that economic security can be an important contributor to long-term housing stability and retention. Through implementation of IPS and coordination with housing, benefits, and supportive service partners, the County will support individuals in pursuing employment goals that may strengthen their ability to obtain and maintain stable housing over time.

DRAFT

4. What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions? **Monterey County Behavioral Health's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions is to strengthen the stability and continuity of housing options across the behavioral health housing continuum. The County will focus on preserving and expanding viable housing capacity, reducing barriers that contribute to housing disruption, and supporting alignment between housing, services, and system partners.**

   In alignment with one of the top goals of the Lead Me Home Plan, a central component of this strategy is the preservation and expansion of permanent supportive housing opportunities for individuals with serious mental illness, substance use disorder needs, co-occurring conditions, and histories of homelessness. The County currently partners with housing providers such as Interim, Inc. and Front Street to support a continuum of housing opportunities that include permanent supportive housing, transitional housing, and residential care settings. Through these partnerships, BHSA Housing Interventions will support housing access, housing retention, housing navigation, tenancy sustaining services, rental subsidies, operating subsidies, and coordination with behavioral health services. Recognizing the significant housing shortage and limited availability of affordable and supportive housing options within Monterey County, the County has intentionally designed its Housing Interventions strategy to include a combination of rental subsidies, operating subsidies, housing navigation and tenancy supports, participant assistance funds, and capital development investments. This balanced approach is intended to address both immediate housing access needs and longer-term housing capacity challenges. Rental subsidies, operating subsidies, and housing support services help individuals obtain and maintain housing in the near term, while capital development investments help preserve and expand housing opportunities available to future BHSA-eligible individuals. Together, these investments are intended to maximize the impact of limited Housing Interventions resources by supporting both immediate housing stability and long-term expansion of the local behavioral health housing continuum.

   The County will also utilize BHSA Housing Interventions to preserve existing housing capacity and support future housing development opportunities. This includes planned investments in capital development projects designed to expand housing resources available to BHSA-eligible individuals and strengthen the long-term sustainability of the local behavioral health housing continuum.

   By combining housing infrastructure investments, supportive housing partnerships, behavioral health services, and housing stability supports, the County seeks to promote successful transitions from homelessness, crisis settings, institutional care, and housing instability into long-term community living. This approach emphasizes housing stability,

DRAFT

recovery, community integration, and long-term sustainability while maintaining flexibility to adapt to emerging needs, available resources, and evolving state guidance.

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)? **County of Monterey Behavioral Health supports connection to permanent supportive housing by coordinating behavioral health services, housing referrals, and care transitions for individuals with serious mental illness and related needs. The County recognizes that stable housing outcomes depend on effective pathways from residential and interim settings into permanent housing options, particularly for individuals who face barriers to traditional placements. Current service contracts, including those supporting community-based and field-based behavioral health services, provide infrastructure for outreach, engagement, care coordination, and ongoing support that facilitate successful linkage to PSH and continuity of care once housed.**
   In addition to rental subsidies, operating subsidies, and supportive housing services, MCBH is utilizing BHSA Housing Interventions to support strategic capital development investments intended to expand long-term housing capacity for BHSA-eligible individuals. Planned projects include the development of additional board-and-care capacity and recovery-oriented housing opportunities designed to serve individuals with significant behavioral health needs who face substantial barriers to obtaining and maintaining stable housing. These investments are intended to preserve and expand the local behavioral health housing continuum, increase access to supportive housing settings, and create additional pathways from homelessness, institutional settings, and housing instability into long-term community-based housing. MCBH will continue coordinating these efforts with housing providers, homelessness response partners, healthcare organizations, and other community stakeholders to maximize the impact of limited capital resources and leverage additional housing development opportunities where feasible.
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: **County of Monterey Behavioral Health's approach to Housing Interventions emphasizes integration of housing with access to clinical and supportive behavioral health services. Housing stability is closely linked to the availability of coordinated mental health services, case management, and culturally responsive supports. Through contracted behavioral health providers and system partnerships, the County supports service models that include assessment, treatment, care coordination, and linkage to community resources, helping ensure individuals in Housing Interventions settings can access appropriate clinical and supportive services while maintaining flexibility to adapt service delivery based on setting type, individual need, and evolving state guidance.**

DRAFT

Eligible Populations

1. Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions: **County of Monterey Behavioral Health will identify, screen, and refer individuals eligible for BHSA Housing Interventions through routine behavioral health service delivery, outreach, and care coordination activities. Individuals are identified through clinical assessment, field-based engagement, and ongoing contact with county-operated and contracted behavioral health providers. Screening processes incorporate clinical need, functional impairment, housing status, and service history to determine appropriateness for Housing Interventions. Referrals are coordinated through care teams and system partners to support timely connection to housing resources and ongoing behavioral health services, with flexibility to adapt referral pathways based on individual needs, available housing options, and evolving state guidance. MCBH will utilize culturally responsive engagement and referral approaches tailored to the needs of population groups with elevated unmet behavioral health and housing needs, including older adults and other priority populations, and will monitor and report implementation progress across age groups throughout the plan period to help ensure equitable access to Housing Interventions.**
2. Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only?

   ☐ Yes ☒ **No**

   a. If not, 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 (select all that apply):

      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)

         If selected, please explain why there is insufficient need to provide BHSA-funded Housing Interventions living with a SUD only: N/A

      ii. ☐ Insufficient resources

         If selected, please explain why there are insufficient resources to provide BHSA-funded Housing Interventions to individuals living with an SUD only: N/A

      iii. ☒ Other

         If selected, 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: **During the initial BHSA implementation period, Housing Intervention resources are not being deployed specifically for individuals with an SUD diagnoses without a co-occurring serious mental illness. Given the**

abbreviated planning and implementation timeframe associated with BHSA transition, the County prioritized continuation and stabilization of existing housing interventions while initiating targeted planning for additional populations.

This does not preclude the continuation of existing SUD population-focused housing programs, such as Hope Housing Marina. The County is actively convening planning discussions with SUD providers and system partners to better understand the housing needs, service models, and funding coordination considerations for SUD-only populations, including coordination with MCP TRA and other housing supports. These discussions will inform future BHSA planning cycles and potential expansion of Housing Intervention strategies in subsequent years.

iv. Please upload supporting data (enter supporting document file name): **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: County of **Monterey Behavioral Health considered the unique needs of diverse populations in the development of Housing Interventions through a combination of data review, community and system partner engagement, and cross-system planning activities that have been implemented to support BHSA transition and Integrated Plan development. This work drew on findings from the Community Program Planning Process (CPPP), Community Health Needs Assessment (CHNA), BHSA Transition Plan, stakeholder collaboration activities, and system partner forums to identify housing access barriers, service gaps, and equity considerations relevant to individuals with behavioral health needs across the County.**

   In considering the needs of children and youth involved in the juvenile justice system, the County reviewed stakeholder input and system partner perspectives highlighting the intersection of housing instability, justice involvement, and behavioral health needs. Engagement with cross-system partners emphasized the importance of housing options that support continuity of care, reduce system involvement, and align with developmentally appropriate and family-centered supports for youth transitioning between systems.

   These planning and engagement activities informed the County's approach to Housing Interventions by ensuring that population-specific needs, access barriers, and equity considerations were meaningfully considered within a flexible and integrated framework. This approach supports the development of housing

interventions that can adapt to diverse needs while strengthening coordination across behavioral health, housing, and other systems serving BHSA-eligible individuals.

b. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+): County of **Monterey Behavioral Health considered the unique needs of diverse populations in the development of Housing Interventions through a combination of data review, community and system partner engagement, and cross-system planning activities that have been implemented to support BHSA transition and Integrated Plan development. This work drew on findings from the Community Program Planning Process (CPPP), Community Health Needs Assessment (CHNA), BHSA Transition Plan, stakeholder collaboration activities, and system partner forums to identify housing access barriers, service gaps, and equity considerations relevant to individuals with behavioral health needs across the County.**

   For LGBTQ+ children and youth, the County reviewed CPPP data and stakeholder input identifying heightened risks related to housing instability, discrimination, and barriers to culturally responsive services. These insights informed consideration of housing interventions that emphasize safety, inclusivity, and access to affirming behavioral health supports, particularly for youth who may be disconnected from family or traditional support systems.

   These planning and engagement activities informed the County's approach to Housing Interventions by ensuring that population-specific needs, access barriers, and equity considerations were meaningfully considered within a flexible and integrated framework. This approach supports the development of housing interventions that can adapt to diverse needs while strengthening coordination across behavioral health, housing, and other systems serving BHSA-eligible individuals.

c. In the child welfare system: County of **Monterey Behavioral Health considered the unique needs of diverse populations in the development of Housing Interventions through a combination of data review, community and system partner engagement, and cross-system planning activities that have been implemented to support BHSA transition and Integrated Plan development. This work drew on findings from the Community Program Planning Process (CPPP), Community Health Needs Assessment (CHNA), BHSA Transition Plan, stakeholder collaboration activities, and system partner forums to identify housing access barriers, service gaps, and equity considerations relevant to individuals with behavioral health needs across the County.**

   In addressing the needs of children and youth involved in the child welfare system, the County considered input from system partners and community stakeholders describing the housing challenges faced during placement transitions, reunification efforts, and aging out of care. Planning activities emphasized the importance of coordination across child-serving systems and housing interventions that support stability, continuity of services, and alignment with behavioral health and family

DRAFT

supports.

These planning and engagement activities informed the County's approach to Housing Interventions by ensuring that population-specific needs, access barriers, and equity considerations were meaningfully considered within a flexible and integrated framework. This approach supports the development of housing interventions that can adapt to diverse needs while strengthening coordination across behavioral health, housing, and other systems serving BHSA-eligible individuals.

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: **County of Monterey Behavioral Health considered the unique needs of diverse populations in the development of Housing Interventions through a combination of data review, community and system partner engagement, and cross-system planning activities that have been implemented to support BHSA transition and Integrated Plan development. This work drew on findings from the Community Program Planning Process (CPPP), Community Health Needs Assessment (CHNA), BHSA Transition Plan, stakeholder collaboration activities, and system partner forums to identify housing access barriers, service gaps, and equity considerations relevant to individuals with behavioral health needs across the County.**

      For older adults, the MCBH reviewed CPPP findings and community feedback highlighting accessibility barriers, limited housing options, and the need for integrated behavioral health and supportive services. These considerations informed planning for housing interventions that address mobility, health complexity, and the importance of stable, accessible housing environments that support aging with dignity and continued community connection.

      These planning and engagement activities informed the County's approach to Housing Interventions by ensuring that population-specific needs, access barriers, and equity considerations were meaningfully considered within a flexible and integrated framework. This approach supports the development of housing interventions that can adapt to diverse needs while strengthening coordination across behavioral health, housing, and other systems serving BHSA-eligible individuals.

   b. In, or are at risk of being in, the justice system: County of **Monterey Behavioral Health considered the unique needs of diverse populations in the development of Housing Interventions through a combination of data review, community and system partner engagement, and cross-system planning activities that have been implemented to support BHSA transition and Integrated Plan development. This work drew on findings from the Community Program Planning Process (CPPP), Community Health Needs Assessment (CHNA), BHSA Transition Plan, stakeholder collaboration activities, and system partner forums to identify housing access barriers, service gaps, and equity**

considerations relevant to individuals with behavioral health needs across the County. In considering justice-involved adults, the County incorporated stakeholder input and system partner perspectives emphasizing the role of housing stability in reducing recidivism and supporting behavioral health recovery. Planning activities highlighted the need for housing interventions that facilitate reentry, support continuity of care, and coordinate with justice, housing, and behavioral health partners to address complex service needs.

These planning and engagement activities informed the County's approach to Housing Interventions by ensuring that population-specific needs, access barriers, and equity considerations were meaningfully considered within a flexible and integrated framework. This approach supports the development of housing interventions that can adapt to diverse needs while strengthening coordination across behavioral health, housing, and other systems serving BHSA-eligible individuals.

c. In underserved communities: County of **Monterey Behavioral Health considered the unique needs of diverse populations in the development of Housing Interventions through a combination of data review, community and system partner engagement, and cross-system planning activities that have been implemented to support BHSA transition and Integrated Plan development. This work drew on findings from the Community Program Planning Process (CPPP), Community Health Needs Assessment (CHNA), BHSA Transition Plan, stakeholder collaboration activities, and system partner forums to identify housing access barriers, service gaps, and equity considerations relevant to individuals with behavioral health needs across the County. For adults in underserved communities, including those facing geographic, cultural, linguistic, or economic barriers, the County reviewed data and engagement findings identifying disparities in access to housing and behavioral health services. These insights informed consideration of housing interventions that promote equity, improve access in underserved regions, and support culturally and linguistically responsive approaches aligned with community-identified needs.**

These planning and engagement activities informed the County's approach to Housing Interventions by ensuring that population-specific needs, access barriers, and equity considerations were meaningfully considered within a flexible and integrated framework. This approach supports the development of housing interventions that can adapt to diverse needs while strengthening coordination across behavioral health, housing, and other systems serving BHSA-eligible individuals.

Local Housing System Engagement

1. How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services? **The County of Monterey Behavioral Health system will coordinate with the local Continuum of Care through ongoing communication, information sharing, and alignment of referral pathways. Referrals for Housing Interventions**

DRAFT

may be received through existing homeless response system processes, care coordination activities, and collaboration with providers and partners engaged in CoC-supported services. Coordination will focus on ensuring referrals are appropriate, timely, and aligned with eligibility criteria and available housing resources, while maintaining flexibility to adapt processes as local systems and state guidance evolve.

2. 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: **The County of Monterey Behavioral Health system's approach to collaborating with the local CoC emphasizes alignment of housing priorities, coordination across systems, and shared understanding of roles related to housing and behavioral health services. Collaboration may include participation in cross-system discussions, alignment of planning efforts, and coordination around housing availability and service needs. This approach supports a coordinated housing continuum while allowing the County to adapt collaboration activities based on capacity, resources, and local needs.**
    b. Public Housing Agency: **The County of Monterey Behavioral Health system will collaborate with Public Housing Agencies through information sharing, coordination around housing resources, and alignment of housing supports for BHSA-eligible individuals. This collaboration may include coordination related to housing opportunities, tenant support needs, and referral processes, as appropriate. The County's approach is intended to support access to housing while maintaining flexibility to respond to evolving housing availability and program requirements.**
    c. MCPs: **The county behavioral health system will collaborate with Medi-Cal managed care plans to support coordination between housing interventions and Medi-Cal-covered benefits. This collaboration will focus on aligning roles related to care coordination, service access, and housing-related supports, while ensuring BHSA Housing Interventions complement and do not duplicate Medi-Cal benefits. Ongoing communication will support shared understanding of eligibility, service boundaries, and opportunities for coordination.**
    d. ECM and Community Supports Providers: **The county behavioral health system's approach includes coordination with ECM and Community Supports providers to align housing-related activities with care management and supportive services.**
    e. Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.): **The county behavioral health system will collaborate with housing partners, including permanent supportive housing developers, nonprofit housing providers, and supportive housing operators, to support the implementation**

of Housing Interventions. Collaboration may include coordination related to housing development opportunities, service integration, referrals, and ongoing communication about housing needs and system capacity. This approach supports alignment across housing and behavioral health systems while allowing flexibility in how partnerships evolve over time.

3. 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? **The county behavioral health system will work with Homekey+ and supportive housing sites through coordination of referrals, alignment of behavioral health services, and communication regarding housing availability and resident support needs. BHSA Housing Interventions may be used, as appropriate, to complement existing housing resources by supporting access to services and housing stability. This approach emphasizes coordination rather than prescriptive program design and allows the County to adapt to changing housing and funding conditions.**
4. Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?

   ☒ **Yes** ☐ No

   a. If yes, how will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community? **The County will coordinate the use of HHAP dollars to support the housing needs of BHSA-eligible individuals by aligning HHAP-funded activities with BHSA Housing Interventions and broader system planning. This includes using HHAP funds to enhance access to permanent housing, strengthen connections between outreach and housing placement, and support stable housing outcomes for individuals experiencing or at risk of homelessness. Coordination will be pursued through cross-system communication, alignment with continuum-wide priorities, and referral pathways that complement BHSA-focused housing resources, while maintaining flexibility to respond to changing local needs and available funding.**

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding. For more information, please see **7.C.9 Allowable expenditures and related requirements.**

Rental Subsidies (Chapter 7, Section C.9.1)

The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source.

1. Is the county providing this intervention?

   ☒ **Yes** ☐ No

a. If not, please explain why the county is not providing this intervention: **N/A**
b. If yes, proceed to the following questions.

2. Is the county providing this intervention to chronically homeless individuals?
☒ **Yes** ☐ No
3. How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis? **470**
    a. How many of these individuals will receive rental subsidies for permanent housing on an annual basis? **300**
    b. How many of these individuals will receive rental subsidies for interim housing on an annual basis? **170**
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? **Estimates are based on available BHSA Housing Interventions funding, blended average monthly subsidy assumptions informed by local rental costs, and anticipated lengths of stay for permanent and interim housing settings.**
5. For which setting types will the county provide rental subsidies? (Select all that apply)
    a. ☒ Supportive housing
    b. ☒ Apartments, including master-lease apartments
    c. ☒ Single and multi-family homes
    d. ☐ Housing in mobile home communities
    e. ☒ Single room occupancy units
    f. ☐ Accessory dwelling units, including Junior Accessory Dwelling Units
    g. ☐ Tiny homes
    h. ☒ Shared housing
    i. ☒ Recovery/sober living housing, including recovery-oriented housing
    j. ☒ Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
    k. ☐ License-exempt room and board
    l. ☐ Other settings identified under the transitional rent benefit
    m. ☒ Hotel and motel stays
    n. ☒ Non-congregate interim housing models
    o. ☒ 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)
    p. ☐ Recuperative care
    q. ☐ Short-term post-hospitalization housing
    r. ☒ Tiny homes, emergency sleeping cabins, emergency stabilization units
    s. ☐ Peer respite

DRAFT

t. ☐ Other settings identified under the Transitional Rent benefit

6. Will this Housing Intervention accommodate family housing?

   ☒ **Yes** ☐ No

7. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding: **BHSA Housing Interventions rental subsidies will be used to support BHSA-eligible individuals in accessing and maintaining housing in both non-time-limited permanent settings and time-limited interim settings. Rental subsidies may be provided for as long as needed to stabilize housing or until individuals can transition to another permanent housing option or rental subsidy source. Funds may be used to offset monthly rent costs, including master-leased units and scattered-site placements, where other funding sources are insufficient or unavailable. Priority will be given to individuals experiencing chronic homelessness, who often require longer subsidy durations and higher levels of support to achieve housing stability.**

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? (Select all that apply)

   a. ☒ **Project-based**

   b. ☒ **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: **The County of Monterey Behavioral Health will identify and maintain a portfolio of housing units through collaboration with local housing providers, community-based organizations, landlords, and county partners involved in housing and homelessness response efforts. Key partners may include the Monterey County Department of Social Services, Coordinated Entry System partners, housing navigation providers, interim housing providers, permanent supportive housing providers, and behavioral health service providers serving individuals experiencing homelessness or housing instability.**

   Strategies may include coordination with existing housing programs, scattered-site leasing arrangements, landlord engagement activities, and collaboration with providers operating interim and permanent housing settings. The County will work with partners to support unit identification, referrals, housing navigation, and service coordination to assist BHSA-eligible individuals in accessing and maintaining housing placements.

   While the County does not currently operate a formal Housing Flex Pool, it will continue exploring and utilizing coordination approaches that support housing placement and stability, including functions similar to master leasing and housing navigation coordination, where feasible and appropriate.

The County anticipates further developing and formalizing this housing portfolio approach during FY 2026–27, contingent upon partner collaboration, funding availability, housing market conditions, and program capacity.

10. Total number of units funded with BHSA Housing Interventions per year: **400**
11. Optional: 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** ☐ No

   a. If not, please explain why the county is not providing this intervention: **N/A**
   b. If yes, proceed to the following questions.
2. Is the county providing this intervention to chronically homeless individuals?

   ☒ **Yes** ☐ No
3. Anticipated number of individuals served per year: **521**
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding: **Operating subsidies will be used to stabilize housing settings serving BHSA-eligible individuals, particularly those experiencing chronic homelessness with higher service and operational cost needs. Subsidies may support staffing, utilities, maintenance, and other eligible operating expenses not covered by rental subsidies or other funding sources and may be paired with rental subsidies where appropriate.**
5. For which setting types will the county provide operating subsidies? (Select all that apply)

   a. ☒ Supportive housing
   b. ☒ Apartments, including master-lease apartments
   c. ☒ Single and multi-family homes
   d. ☐ Housing in mobile home communities
   e. ☐ Single room occupancy units
   f. ☐ Accessory dwelling units, including Junior Accessory Dwelling Units
   g. ☐ Tiny homes
   h. ☐ Shared housing
   i. ☒ Recovery/sober living housing, including recovery-oriented housing
   j. ☒ Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
   k. ☐ License-exempt room and board
   l. ☐ Other settings identified under the transitional rent benefit
   m. ☐ Hotel and motel stays
   n. ☒ Non-congregate interim housing models

o. **☒ 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)**
p. ☐ Recuperative care
q. ☐ Short-term post-hospitalization housing
r. **☒ Tiny homes, emergency sleeping cabins, emergency stabilization units**
s. ☐ Peer respite
t. ☐ Other settings identified under the Transitional Rent benefit

6. Will this be a scattered site initiative?
   ☒ **Yes** ☐ No
7. Will this Housing Intervention accommodate family housing?
   ☒ **Yes** ☐ No
8. Total number of units funded with BHSA Housing Interventions per year: **500**
9. Optional: 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** ☐ No
   a. If not, please explain why the county is not providing this intervention: **N/A**
   b. If yes, proceed to the following questions.
2. Is the county providing this intervention to chronically homeless individuals?
   ☒ **Yes** ☐ No
3. Anticipated number of individuals served per year: **40**
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding: **Landlord outreach and mitigation funds will be used to recruit and retain landlords willing to house BHSA-eligible individuals, particularly those with higher acuity needs. Funds may support risk mitigation, damages, vacancy loss, and other eligible expenses to reduce barriers to housing access and increase unit availability.**
5. Total number of units funded with BHSA Housing Interventions per year: **40**
6. Optional: 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** ☐ No
   a. If not, please explain why the county is not providing this intervention: **N/A**
   b. If yes, proceed to the following questions.

DRAFT

2. Is the county providing this intervention to chronically homeless individuals?
   ☒ **Yes** ☐ No
3. Anticipated number of individuals served per year: **150**
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding: **Participant assistance funds will be used to address one-time or short-term barriers to housing stability for BHSA-eligible individuals when other benefits are not available. Allowable uses may include security deposits, application fees, utility arrears, furnishings, transportation related to housing placement, and other supports necessary to obtain or maintain housing.**

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

Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select "Yes" for Question 1 only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP.

1. Is the county providing this intervention?
   ☒ **Yes** ☐ No
   a. If not, please explain why the county is not providing this intervention: **N/A**
   b. If yes, proceed to the following questions.
2. Is the county providing this intervention to chronically homeless individuals?
   ☒ **Yes** ☐ No
3. Anticipated number of individuals served per year: **698**
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding: **Housing transition navigation and tenancy sustaining services will support BHSA-eligible individuals who are not eligible for Medi-Cal MCP housing services. Services may include housing search and placement assistance, coordination with landlords, tenancy skill-building, lease compliance support, crisis intervention related to housing stability, and coordination with behavioral health services to support long-term housing retention.**

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

1. Is the county providing this intervention?
   ☐ Yes ☒ **No**
   a. If not, please explain why the county is not providing this intervention: **Outreach and engagement activities for BHSA-eligible individuals are already provided through existing county and system partner programs. These programs include active, field-based outreach teams and referral pathways that connect individuals experiencing homelessness and housing instability to behavioral health services and housing**

resources. Given the presence of these established outreach functions, the County is not using BHSA Housing Interventions funding to duplicate outreach and engagement activities. Instead, BHSA Housing Interventions resources will be focused on housing-related subsidies and supports that are not otherwise funded, including rental subsidies, operating subsidies, participant assistance, and tenancy-focused services. Outreach programs will continue to serve as the primary access point to the target population and will coordinate referrals into BHSA-funded housing interventions as appropriate.

   b. If yes, proceed to the following questions.

2. Is the county providing this intervention to chronically homeless individuals?
   ☐ Yes ☐ No
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** ☐ No
   a. If not, please explain why the county is not providing this intervention: **N/A**
   b. If yes, proceed to the following questions.
2. Is the county providing this intervention to chronically homeless individuals?
   ☒ **Yes** ☐ No
3. How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions? **2**

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: **Recovery Residence**
2. What setting types will the capital development project include? (Select all that apply)
   a. ☐ Supportive housing
   b. ☐ Apartments, including master-lease apartments
   c. ☐ Single and multi-family homes
   d. ☐ Housing in mobile home communities
   e. ☐ Single room occupancy units
   f. ☐ Accessory dwelling units, including Junior Accessory Dwelling Units
   g. ☐ Tiny homes

DRAFT

h. ☐ Shared housing
i. ☐ Recovery/sober living housing, including recovery-oriented housing
j. ☐ Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
k. ☐ License-exempt room and board
l. ☐ Other settings identified under the transitional rent benefit
m. ☐ Hotel and motel stays
n. ☐ Non-congregate interim housing models
o. ☒ 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)
p. ☐ Recuperative care
q. ☐ Short-term post-hospitalization housing
r. ☐ Tiny homes, emergency sleeping cabins, emergency stabilization units
s. ☐ Peer respite
t. ☐ Other settings identified under the Transitional Rent benefit

3. Capacity (Anticipated number of individuals housed at a given time): **12**
4. Will this project braid funding with non-BHSA funding source(s)?
   ☐ Yes ☒ No
5. Total number of units in project, inclusive of BHSA and non-BHSA funding sources: **6**
   a. If number provided, total number of units funded with Housing Interventions funds only: **6**
6. Optional: 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**
7. Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe): **July 2028**
8. Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000): **$104,000**
9. Have you utilized the “by right” provisions of state law in your project?
   ☒ **Yes** ☐ No
   a. If not, please explain why: **This will depend on the contractor and building location that we choose through a competitive bid. The building(s) will be required to be up to standard and zoning requirements, and may or may not need to utilize the "by right" provisions.**

If the county plans to fund more than one capital development project with BHSA Housing Interventions, this template section may be copied and duplicated to generate more cases:

1. Name of Project: **Board and Care Expansion**
2. What setting types will the capital development project include? (Select all that apply)
   a. ☐ Supportive housing

DRAFT

b. ☐ Apartments, including master-lease apartments
c. ☐ Single and multi-family homes
d. ☐ Housing in mobile home communities
e. ☐ Single room occupancy units
f. ☐ Accessory dwelling units, including Junior Accessory Dwelling Units
g. ☐ Tiny homes
h. ☐ Shared housing
i. ☐ Recovery/sober living housing, including recovery-oriented housing
j. ☒ Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
k. ☐ License-exempt room and board
l. ☐ Other settings identified under the transitional rent benefit
m. ☐ Hotel and motel stays
n. ☐ Non-congregate interim housing models
o. ☐ 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)
p. ☐ Recuperative care
q. ☐ Short-term post-hospitalization housing
r. ☐ Tiny homes, emergency sleeping cabins, emergency stabilization units
s. ☐ Peer respite
t. ☐ Other settings identified under the Transitional Rent benefit

3. Capacity (Anticipated number of individuals housed at a given time): **30-50**
4. Will this project braid funding with non-BHSA funding source(s)?
   ☒ **Yes** ☐ No
5. Total number of units in project, inclusive of BHSA and non-BHSA funding sources: **15-25**
   i. If number provided, total number of units funded with Housing Interventions funds only: **15**
6. Optional: 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**
7. Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe): **July 2028**
8. Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000): **$41,500**

9. Have you utilized the "by right" provisions of state law in your project?

   ☒ **Yes** ☐ No

   i. If not, please explain why:

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. If another type of intervention is provided, is the county providing this intervention to chronically homeless individuals?

      ☐ Yes ☐ No

   b. If another type of intervention is provided, record anticipated number of individuals served per year: **N/A**

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): **N/A**

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

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

1. Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of? (Select all that apply)

   a. ☐ Housing Transition Navigation Services

   b. ☐ Housing Deposits

   c. ☐ Housing Tenancy and Sustaining Services

   d. ☐ Short-Term Post-Hospitalization Housing

   e. ☐ Recuperative Care

   f. ☐ Day Habilitation

   g. ☐ Transitional Rent

   h. ☒ **None of the above**

2. For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of? (Select all that apply)

   a. Housing Transition Navigation Services

      ☐ Yes ☒ **No** ☐ Undecided

   b. Housing Deposits

      ☐ Yes ☒ **No** ☐ Undecided

   c. Housing Tenancy and Sustaining Services

      ☐ Yes ☒ **No** ☐ Undecided

d. Short-Term Post-Hospitalization Housing

☐ Yes ☒ **No** ☐ Undecided

e. Recuperative Care

☐ Yes ☒ **No** ☐ Undecided

f. Day Habilitation

☐ Yes ☒ **No** ☐ Undecided

g. Transitional Rent

☐ Yes ☒ **No** ☐ Undecided

i. If yes, when does the county behavioral health system plan to become an MCP-contracted provider? **N/A**

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)?
   County of Monterey Behavioral Health will identify Medi-Cal members who may benefit from housing-related Community Supports through routine engagement, outreach, and assessment activities that inform individualized care planning. Eligibility will be reviewed and confirmed in alignment with DHCS guidance and applicable BHSA policy requirements. Referrals will be coordinated with CCAH through collaborative and efficient referral processes across relevant county departments, recognizing that CCAH is responsible for authorizing, delivering, and reimbursing Community Supports, including housing-related assistance such as transitional rent or housing deposits.
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:
   County of Monterey Behavioral Health maintains ongoing coordination with Medi-Cal managed care plans through established communication and collaboration structures that support shared understanding of services, providers, and system priorities. These efforts include regular meetings with MCP partners to exchange information, provide updates, and discuss care coordination, referral needs, collaboration effectiveness, and opportunities to address service overlap or gaps. Through these processes, the County shares information about its behavioral health service array and contracted provider network, including housing-related services, and communicates updates as new programs or services are implemented.

   In addition, information about the County's behavioral health services and contracted providers is made available through publicly accessible resources, which are shared with MCP partners to support awareness and coordination. Ongoing engagement at both operational and executive levels provides opportunities to align understanding of available services and strengthen collaboration over time. This approach supports transparency and coordination while allowing flexibility as service offerings and Housing Interventions continue to evolve.

DRAFT

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 ☒ **No**

   a. If yes, please describe the county behavioral health system's coordination efforts to align network development: **N/A**

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? **County of Monterey Behavioral Health will use care coordination, ongoing engagement, and cross-system communication to help minimize gaps in behavioral health services when time-limited Medi-Cal housing supports end. As appropriate and to the extent resources are available, the County will support continuity of care through coordination with providers, CCAH, and housing partners, and by considering other available behavioral health and housing resources.**

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)?

   ☐ Yes ☒ **No**

   a. If yes, is the county behavioral health system participating in or planning to participate in the Flex Pool?

      ☐ Yes ☐ No

      i. If no, please explain why the county is not participating in the Flex Pool: **N/A**

      ii. If yes, what role does the county behavioral health system have or plan to have in the Flex Pool? (Select all that apply)

         1. ☐ Lead Entity
         2. ☐ Operator
         3. ☐ Funder
         4. ☐ Housing Supportive Services Provider

5. If “Operator” is not selected, what organization is serving as the Operator? **N/A**

iii. If yes, does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?

☐ Yes ☒ **No**

1. If yes, which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool? (Select all that apply)
    a. ☐ Rental subsidies
    b. ☐ Operating subsidies
    c. ☐ Allowable settings
    d. Other housing supports
        i. ☐ Landlord outreach and mitigation funds
        ii. ☐ Participant assistant funds
        iii. ☐ Housing transition navigation services and tenancy and sustaining services
        iv. ☐ Outreach and engagement (up to 7 percent)
    e. ☐ Other housing interventions requirements
    f. ☐ Capital development projects

b. If no, is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?

☐ Yes ☒ **No**

i. If yes, what role does the county behavioral health system plan to have in the Flex Pool? (Select all that apply)
    1. ☐ Lead Entity
    2. ☐ Operator
    3. ☐ Funder
    4. ☐ Housing Supportive Services Provider
    5. If “Operator” is not selected, have you identified an Operator of the Flex Pool?

    ☐ Yes ☐ No

        a. If yes, what organization will serve as the Operator? **N/A**

ii. If yes, does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?

☐ Yes ☐ No

1. If yes, which Housing Interventions does the county plan to administer through or in coordination with a Flex Pool? (Select all that apply)
    a. ☐ Rental subsidies
    b. ☐ Operating subsidies

c. ☐ Allowable settings
d. Other housing supports
    i. ☐ Landlord outreach and mitigation funds
    ii. ☐ Participant assistant funds
    iii. ☐ Housing transition navigation services and tenancy and sustaining services
    iv. ☐ Outreach and engagement (up to 7 percent)
e. ☐ Other housing interventions requirements
f. ☐ Capital development projects

2. 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: **At this time, the County of Monterey does not have an operating Flex Pool, as the Flex Pool model represents a new set of requirements that involve cross-system fiscal coordination, intermediary functions, and housing portfolio development that are still being defined and operationalized at the state and local levels. The County is monitoring DHCS guidance and emerging implementation models and will consider participation in future planning cycles once roles, governance structures, and operational processes are sufficiently established to support effective implementation.**

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovation program or pilot provide the following information.

1. Does the county's plan include the development of innovative programs or pilots? (If Yes, proceed to following questions)
   ☒ **Yes** ☐ No
   a. What Behavioral Health Services Act (BHSA) component will fund the innovative program? (Select one)
       i. ☐ Housing Interventions
       ii. ☐ Full Service Partnership
       iii. ☒ Behavioral Health Services and Supports
   b. Please describe how the innovation program or pilot will help build the evidence base for the effectiveness of new statewide strategies: The Rainbow Connections Innovation pilot, funded by encumbered MHSA Innovation funds, is developing a system of care to serve the needs of LGBTQ youth, TAY and their families through an adapted version of the evidence-based Positive Behavioral Interventions and Supports (PBIS) model. Services offered through this program primarily align at the level of Early Intervention with focused identity-affirming outreach to at-risk and in-need populations, family psychoeducation and support, care management, and clinical care coordination. Additionally, a major component of this program is the development of peer supports for youth and TAY, and

workforce, education and training for mental and physical health clinicians, school staff and faculty, and other professionals responsible for the wellbeing and development of youth to become familiar with the issues faced by LGBTQ youth and to become enabled to make meaningful referrals to care. This multi-pronged approach to deliver culturally responsive care can then be scalable and replicable across other counties to similarly serve LGBTQ populations or other distinct BHSA eligible populations.

c. Please describe intended outcomes of the project: The intended outcomes of the Rainbow Connections project include increased engagement of LGBT youth and their families in behavioral health services, improved perceptions of cultural responsiveness within county-supported programs, and reduced barriers to accessing timely support. The project aims to strengthen protective social and family connections, enhance early intervention through peer connections and gender-affirming training for professionals and adults, reduce negative outcomes such as suicide, substance abuse and homelessness, and improve participant-reported wellbeing and community belonging. In addition, the project seeks to generate clear learnings about which outreach methods, peer-support structures, and service pathways are most effective for this population, ultimately informing future programming and guiding recommendations for sustainable, longer-term system improvements for LGBTQ and other identified BHSA eligible populations.

2. Does the county's plan include the development of innovative programs or pilots? (If Yes, proceed to following questions)

   ☒ Yes ☐ **No**

   a. What Behavioral Health Services Act (BHSA) component will fund the innovative program? (Select one)
      i. ☐ Housing Interventions
      ii. ☐ Full Service Partnership
      iii. ☒ Behavioral Health Services and Supports
   b. Please describe how the innovation program or pilot will help build the evidence base for the effectiveness of new statewide strategies: The Psychiatric Advance Directives (PADs) Phase II pilot, funded by encumbered MHSA Innovation funds, expands on the Phase I of the PADs project wherein a digital PAD was developed and successfully piloted within select populations. In Phase II, access to the digital PAD platform is expanded to BHSA eligible adult populations throughout the county, with additional and complimentary workforce education and training efforts being performed for first responder, law enforcement, emergency department and other crisis response professionals. The PADs program contributes to the evidence base of BHSA statewide strategies by increasing peer workforce capacity, creating an additional supportive practice to wraparound models, and improving the quality of care and outcomes during crisis response. Findings from this project will inform statewide replication of the use of PADs to reduce involuntary

DRAFT

hospitalization, justice involvement and homelessness among individuals with serious mental illness.

c. Please describe intended outcomes of the project: The PADs Phase II program supports a statewide movement to create a standardized, sustainable PAD process. The goal of the Innovation project is to help counties improve access to personal, health, and daily life care, the appropriateness and quality of care, preservation of the individual's life goals and preferences, and to improve positive outcomes for people at risk of involuntary care, homelessness, unnecessary hospitalizations, and involvement with the criminal justice systems, at all stages of life.

3.

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 ☒ **No**
      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**: The County does not intend to adopt a uniform requirement that BHSA-funded providers comply with all Medi-Cal provider standards solely based on funding source. Instead, the County will ensure that BHSA-funded providers are qualified to deliver services, comply**

with nondiscrimination requirements, and deliver services in a culturally competent and linguistically responsive manner through established contracting and oversight procedures. These procedures include review and verification of provider qualifications and organizational capacity at the onset of agreements, incorporation of nondiscrimination and cultural responsiveness requirements into contract terms, and periodic monitoring throughout the agreement period to ensure continued alignment with applicable requirements and community needs.

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 ☒ **No**

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**: The County does not intend to require BHSA-funded providers that do not participate in the Medi-Cal Behavioral Health Delivery System to meet all Medi-Cal provider standards. The County will ensure provider qualification, compliance with nondiscrimination requirements, and culturally competent service delivery through provider-specific contracting, onboarding, and monitoring processes. The County will work collaboratively with each provider to establish clear expectations related to nondiscrimination, cultural and linguistic responsiveness, and service quality at the initiation of agreements and will conduct periodic reviews throughout the contract term to support ongoing compliance and alignment with BHSA requirements.**

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)? **37%**
2. Optional: Upload any data source(s) used to determine vacancy rate (supporting file document name): **Vacancy FY 26 -with Summary (FY 19 to FY 26).xlsx**
3. For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates (select all that apply):
   a. ☐ Advanced Emergency Medical Technicians
   b. ☐ Certified Nurse Specialist

DRAFT

c. ☐ Community Health Workers (CHW) defined in the Enhanced Community Health Workers Services benefit
d. ☐ Community Paramedics
e. ☐ Emergency Medical Technicians
f. ☒ Licensed Clinical Social Worker
g. ☐ Licensed Marriage and Family Therapist
h. ☐ Licensed Professional Clinical Counselor
i. ☐ Licensed Psychologist
j. ☐ Licensed Vocational Nurse
k. ☐ Medical assistant
l. ☐ Medi-Cal Certified Peer Support Specialist
m. ☒ Mental Health Rehabilitation Specialist
n. ☒ Nurse practitioner
o. ☐ Occupational Therapist
p. ☐ Pharmacist
q. ☐ Physician
r. ☐ Physician assistant
s. ☐ Psychiatric Technician (PT)
t. ☐ Psychiatrist
u. ☒ Registered nurse
v. ☐ Substance Use Disorder Counselor
w. ☒ Other qualified provider

4. Please describe any other key workforce gaps in the county: **In addition to direct service staffing needs, the County has identified workforce gaps related to data and administrative functions. These include limited staffing with expertise in health information exchange (HIE), data sharing, and interoperability, as well as limited data analytics capacity. The County also has ongoing gaps in general administrative support, including contract management, fiscal processing, and program administration, which affect day-to-day operations for BHSA-funded programs.**

a. Optional supporting file document name: **N/A**

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)? **Over the next three fiscal years, the County anticipates shifts in workforce needs driven by new and forthcoming requirements under Behavioral Health Transformation (BHT) and BH-CONNECT. There will be increased demand for staff trained in evidence-based practice (EBP) fidelity and team-based service models, including peer specialists, employment specialists, and program supervisors**

responsible for operationalizing fidelity standards and outcomes monitoring. The County also anticipates greater need for field-based staff to support community-centered and mobile service delivery models. In addition, expanded administrative and support capacity will be needed, including quality improvement and data analytics staff, training and workforce development infrastructure, and personnel with documentation and claims expertise to support tracking of outcomes and EBP delivery.

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 ☒ **No**

   a. If yes, please explain any actions or activities the county is engaging in to leverage the program: **N/A**

2. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?

   ☒ **Yes** ☐ No

   a. If yes, please explain any actions or activities the county is engaging in to leverage the program**: The county is leveraging the BH-CONNECT workforce initiative by supporting staff participation in the Behavioral Health Student Loan Payment Program. County-employed and contracted behavioral health staff are encouraged to participate as part of recruitment and retention efforts. The county conducts outreach to raise awareness, shares information on eligibility and timelines, and supports participation. Current employees are actively using the program, which helps strengthen and stabilize the local behavioral health workforce.**

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

   ☐ Yes ☒ **No**

   a. If yes, please explain any actions or activities the county is engaging in to leverage the program: **N/A**

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

   ☐ Yes ☒ **No**

   a. If yes, please explain any actions or activities the county is engaging in to leverage the program: **N/A**

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

   ☐ Yes ☒ **No**

   a. If yes, please explain any actions or activities the county is engaging in to leverage the program: **N/A**

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**: The County will continue to leverage BHSS-funded Workforce Education and Training (WET) and related workforce initiatives to support recruitment, retention, training, and upskilling of both county-operated and contracted provider staff. Workforce planning efforts will remain iterative and responsive, allowing the County to adapt staffing strategies as BHT and BH-CONNECT requirements are further clarified and operationalized over the next three fiscal years.**

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section.

1. Please upload the completed budget template.
   a. Affirm that the completed budget template has been uploaded by providing initials: SC
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 would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template. If not applicable, enter N/A here: **n/a**
   a. Behavioral Health Services and Supports (BHSS):
   b. Full Service Partnership (FSP):
   c. Housing Interventions:
3. Enter date of last prudent reserve assessment: 10/01/2024
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. If not applicable, enter N/A here: **n/a**
   a. BHSS:
   b. FSP:
   c. Housing Interventions:

Plan Approval and Compliance

Behavioral Health Director Certification

1. I hereby certify that the **County of Monterey** has complied with all statutes, regulations, and guidelines in preparing and submitting this Three-Year Integrated Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that (please select all below):

DRAFT

a. ☒ The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
b. ☒ 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
c. ☒ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
d. ☒ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
e. ☒ 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)
f. ☐ 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. If yes, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements: **n/a**

Contact Information

1. County Name: **County of Monterey**
2. Certification for (select one):
   a. ☒ Three-Year Integrated Plan
   b. ☐ Annual Update
3. County Behavioral Health Agency Director Name: **Melanie Rhodes, LMFT (44636), LPCC (103), CCISM**
   Behavioral Health Bureau Chief / Behavioral Health Director
4. County Behavioral Health Agency Director Phone Number: **(831) 796-1742**
5. County Behavioral Health Agency Director Email: **RhodesM@countyofmonterey.gov**
6. Optional additional contact for counties with separate MH and SUD Directors:
   a. Name: **n/a**
   b. Title: **n/a**
   c. Phone: **n/a**
   d. Email: **n/a**

County Behavioral Health Agency Director Signature

1. Printed Name:

DRAFT

2. Title:
3. Date:
4. Signature:

Optional Additional Signature for Counties with Separate MH and SUD Directors

1. Printed Name:
2. Title:
3. Date:
4. Signature:

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.

1. I hereby certify that (please select all below):
   a. ☐ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
   b. ☐ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
   c. ☐ 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 yes, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements:

Signature

1. Printed Name:
2. Date:
3. Signature:

Contact Information

1. County Name:

DRAFT

2. Certification for (select one):
    a. ☐ Three-Year Integrated Plan
    b. ☐ Annual Update
3. County Chief Administration Officer Name:
4. County Chief Administration Officer Phone Number:
5. County Chief Administration Officer Email:

Board of Supervisors Certification

Optional file upload (enter file document name here):

1. Click here to add entity name Board of Supervisors certifies the following (please select all below):
    a. ☐ [Entity name] Board of Supervisors has reviewed and approved this Integrated Plan for the period of FY Click here to add fiscal year
    b. ☐ County will meet its realignment obligations pursuant to W&I Code section 14197, including but not limited to time or distance standards and appointment time standards set forth in W&I Code section 14197 or other applicable guidance, without utilizing waitlists
2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
    ☐ Yes ☐ No
    a. If yes, please describe any implementation challenges or concerns with their realignment obligations:

Signature

1. Printed Name:
2. Title: Designated Representative, Click here to add entity name Board of Supervisors:
3. Date:
4. Signature:

DRAFT

Appendix: Behavioral Health Services and Supports (BHSS) Programs

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 (select all that apply):
    a. ☒ **Children's System of Care (non-Full Service Partnership (FSP))**
    b. ☒ **Adult and Older Adult System of Care (non-FSP)**
    c. ☒ **Early Intervention Programs (EIP)**
    d. ☒ **Outreach and Engagement (O&E)**
    e. ☒ **Workforce, Education and Training (WET)**
    f. ☒ **Capital Facilities and Technological Needs (CFTN)**

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

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 One: CS JJ Silver Star Resource

1. Please select the service types provided under Program One (select all that apply):
    a. ☒ **Mental health services**
    b. ☒ **Supportive services**
    c. ☐ Substance Use Disorder treatment services
2. Please describe the specific services provided:
   Silver Star is a collaborative, "one-stop" youth center where probation, education, behavioral health, and community partners provide prevention and intervention services for at-risk, probation, and gang-involved youth and their families, including counseling and groups. The program offers coordinated case management, pro-social and educational activities, and family supports in a centralized location to address behavioral health needs, reduce justice involvement, and promote safer, healthier outcomes for youth.

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

DRAFT

Table 1. 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	**197**
FY 2027 - 2028	**197**
FY 2028 - 2029	**197**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Two: MCSTART 6-11

1. Please select the service types provided under Program One (select all that apply):
   a. ☒ **Mental health services**
   b. ☒ **Supportive services**
   c. ☐ Substance Use Disorder treatment services
2. Please describe the specific services provided:
   MCSTART 6–11 provides specialty mental health services for children ages 6–11 with moderate to severe behavioral health needs and trauma histories, including prenatal substance exposure and ongoing family or environmental stressors. Services include psychological assessment, individual and family therapy with an attachment and trauma-informed focus, implementation of evidence-based practices such as Parent–Child Interaction Therapy (PCIT), occupational and rehabilitation therapies, case management, and coordination with schools and child-serving systems to support emotional, behavioral, and educational functioning.

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

DRAFT

Table 2. 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	**50**
FY 2027 - 2028	**50**
FY 2028 - 2029	**50**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Three: Access to Outpatient Services

1. Please select the service types provided under Program One (select all that apply):
   a. ☒ **Mental health services**
   b. ☒ **Supportive services**
   c. ☐ Substance Use Disorder treatment services
2. Please describe the specific services provided:
   Community Human Services' ACCESS to Outpatient Services program provides short- to moderate-term outpatient mental health services for Monterey County Medi-Cal beneficiaries authorized by the Behavioral Health Bureau, delivered through Family Service Centers in Salinas, Seaside, and South County. Services include comprehensive assessment, group counseling, collateral services, and case management, offered in person and via telehealth using evidence-informed approaches such as Cognitive Behavioral Therapy and Solution-Focused therapy to reduce symptoms, improve functioning, and support recovery. The program serves children and youth as an accessible entry point to outpatient mental health care, with priority on timely access, cultural and linguistic responsiveness (including services in Spanish), and coordination with county-operated and contracted providers to support appropriate level-of-care transitions and step-down planning.

DRAFT

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

Table 3. 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	**133**
FY 2027 - 2028	**133**
FY 2028 - 2029	**133**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Four: CS MHSA TIP AVANZA

1. Please select the service types provided under Program One (select all that apply):
   a. ☒ **Mental health services**
   b. ☒ **Supportive services**
   c. ☐ Substance Use Disorder treatment services
2. Please describe the specific services provided:
   The MHSA TIP Avanza program empowers youth and young adults (ages 16 to 25 years) with mental health disorders through comprehensive case management, therapy, groups, and positive social interactions. It helps remove mental health-related barriers and supports youth in pursuing their goals in employment, education, independent living skills, and personal functioning. The program connects Transition Age Youth (TAY) with community resources, job opportunities, and education.
   Psychoeducation and support are also extended to family members, recognizing their crucial role in a young adult's support system and success. Collaborative partners include TAY, family members, community-based youth organizations, probation, education, and social services.

DRAFT

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

Table 4. 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	**216**
FY 2027 - 2028	**216**
FY 2028 - 2029	**216**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Five: USC Telehealth

1. Please select the service types provided under Program One (select all that apply):
   - **a. ☒ Mental health services**
   - b. ☐ Supportive services
   - **c. ☒ Substance Use Disorder treatment services**
2. Please describe the specific services provided:
   The USC Telehealth Program provides virtual outpatient mental health services to Monterey County residents who live in underserved geographic areas. Services are delivered via secure, HIPAA-compliant video conferencing by MSW graduate student interns and licensed-eligible clinicians under the supervision of California-licensed LCSWs. The program serves adolescents and transition-age youth with presenting concerns including emotional and behavioral challenges, trauma, family and academic stressors, substance use, and co-occurring conditions. Services are time-limited and episode-based, with each client receiving up to 6–12 sessions (maximum 600 minutes), including assessment, treatment planning, intervention, and planned termination. Evidence-based and promising practices used include CBT, Motivational

Interviewing, Problem Solving Therapy, Crisis Oriented Recovery Services, and Mindfulness. The program is designed to increase access, timeliness, engagement, and completion of care, particularly for individuals facing geographic or access barriers.

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

Table 14. Number of Individuals in the Children's Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**18**
FY 2027 – 2028	**18**
FY 2028 - 2029	**18**

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

Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

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

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

Program One: Access to Outpatient Services

1. Please select the service types provided under Program One (select all that apply):
   a. ☒ **Mental health services**
   b. ☒ **Supportive services**
   c. ☐ Substance Use Disorder treatment services

2. Please describe the specific services provided:

Community Human Services' ACCESS to Outpatient Services program provides short- to moderate-term outpatient mental health services for Monterey County Medi-Cal beneficiaries authorized by the Behavioral Health Bureau, delivered through Family Service Centers in Salinas, Seaside, South County, and an LGBTQ+-focused clinic. Services include comprehensive assessment, individual, family, and group counseling, collateral services, and case management, offered in person and via telehealth using evidence-informed approaches such as Cognitive Behavioral Therapy and Solution-Focused therapy to reduce symptoms, improve functioning, and support recovery. The program serves adults and families as an accessible entry point to outpatient mental health care, with priority on timely access, cultural and linguistic responsiveness (including services in Spanish), LGBTQ+affirming care, and coordination with county-operated and contracted providers to support appropriate level-of-care transitions and step-down planning.

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

Table 5. 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	**217**
FY 2027 - 2028	**217**
FY 2028 - 2029	**217**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Two: Manzanita's Adult Crisis Residential

1. Please select the service types provided under Program One (select all that apply):

a. **☒ Mental health services**
b. **☒ Supportive services**
c. ☐ Substance Use Disorder treatment services

2. Please describe the specific services provided:
   Manzanita House ("Manzanita") is a short-term crisis residential treatment program that provides community-based rehabilitative services in a structured, non-institutional setting for adults in the Monterey County Behavioral Health system who are experiencing an acute psychiatric episode or crisis but do not require inpatient hospitalization or nursing-level medical care. Licensed by the California Department of Social Services Community Care Licensing as a Social Rehabilitation Facility and certified by the Department of Health Care Services as a Crisis Residential Treatment Services facility, Manzanita focuses on symptom reduction, medication and functional stabilization through behavioral health assessment, individual and group counseling, treatment and discharge planning, and development of natural and community supports, with psychiatric and medication services provided by Interim's psychiatric team.

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

Table 6. 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	**214**
FY 2027 - 2028	**214**
FY 2028 - 2029	**214**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

DRAFT

Program Three: Bridge House Adult Residential Board and Care

1. Please select the service types provided under Program One (select all that apply):

    a. ☒ **Mental health services**
    b. ☒ **Supportive services**
    c. ☒ **Substance Use Disorder treatment services**

2. Please describe the specific services provided:
   Bridge House ("Bridge") is a transitional residential treatment program for adults with cooccurring serious mental illnesses and substance use disorders. Staff utilize Motivational Interviewing and Harm Reduction in providing counseling services and other activities. Clients' goals are focused behavioral health wellness and substance use recovery principles. Clients work to improve symptom management, personal, social and family functioning, and gain substance use recovery skills. Services are provided on an individual, group, and milieu basis. Therapeutic groups are offered during day hours Monday-Friday. The program is licensed by the California Dept. of Social Services, Community Care Licensing as a social rehabilitation facility and certified by the Department of Healthcare Services for transitional residential treatment. Clients are referred by the Monterey County Behavioral Health Bureau or by Interim care coordinators.

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

Table 7. 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	**51**
FY 2027 - 2028	**51**
FY 2028 - 2029	**51**

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

Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Four: Community Housing: Housing Supports

1. Please select the service types provided under Program One (select all that apply):
   a. **☒ Mental health services**
   b. **☒ Supportive services**
   c. ☐ Substance Use Disorder treatment services
2. Please describe the specific services provided:
   Community Housing provides community-based behavioral health services for adults with serious and persistent psychiatric disabilities living in independent and supportive housing settings. Services include care coordination, case management, crisis intervention, and mental health rehabilitation services delivered in accordance with state rehabilitation option guidelines. Interventions are designed to support behavioral health stability, reduce functional impairment, and maintain independent living through skill development, symptom management, and linkage to behavioral health and community resources.

   Services are delivered using evidence-based and trauma-informed approaches, including Motivational Interviewing, Harm Reduction, Seeking Safety, Wellness Recovery Action Planning (WRAP), and Cognitive Behavioral Therapy (CBT). BHSS funding supports behavioral health services only and does not fund housing interventions such as rental subsidies, housing navigation, tenancy-sustaining services, participant assistance funds, or housing costs.
3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below.

Table 8. 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	**107**

FY 2027 - 2028	**107**
FY 2028 - 2029	**107**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Five: Interim Rockrose Gardens

1. Please select the service types provided under Program One (select all that apply):
   - **a. ☒ Mental health services**
   - **b. ☒ Supportive services**
   - c. ☐ Substance Use Disorder treatment services
2. Please describe the specific services provided:
   Rockrose Gardens provides community-based behavioral health services for low-income adults with serious mental health diagnoses who reside in independent or supportive housing settings. Services include case management, care coordination, crisis intervention, and mental health rehabilitation services delivered in accordance with state rehabilitation option guidelines. Interventions are designed to support behavioral health stability, reduce functional impairment, and maintain independent living through symptom management, skill development, and linkage to behavioral health and community resources.

   Services are delivered using evidence-based and trauma-informed approaches, including Motivational Interviewing, Harm Reduction, Seeking Safety, Wellness Recovery Action Planning (WRAP), and Cognitive Behavioral Therapy (CBT). BHSS funding supports behavioral health services only and does not fund housing-related costs or interventions, including rental subsidies, housing navigation, tenancy-sustaining services, participant assistance funds, or housing operations.
3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below.

DRAFT

Table 9. 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	**21**
FY 2027 - 2028	**21**
FY 2028 - 2029	**21**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Six: Interim Co-occurring Integrated Care (Keep it Real)

1. Please select the service types provided under Program One (select all that apply):

   a. ☒ Mental health services
   b. ☐ Supportive services
   c. ☒ Substance Use Disorder treatment services

2. Please describe the specific services provided:
   Keep It Real (formerly Dual Recovery Services) is an outpatient, harm-reduction psychotherapy and social rehabilitation program for adults with co-occurring serious mental illness and substance use disorders. The program is staffed by mental health clinicians, counselors, and Wellness Navigators who help participants build dual-recovery skills, improve community living, and pursue substance use goals using harm reduction strategies. Services include individual and group psychotherapy, counseling, clinical assessments and evaluations, rehabilitation, and mental health services, delivered with evidence-based practices such as Motivational Interviewing, Trauma-Informed Care, and Harm Reduction. The program also offers outreach and groups in county behavioral health clinics and community settings through a Community Outreach Navigation team that engages adults, including TAY and those exiting emergency or inpatient settings, to reduce barriers related to mental illness

and substance use and link them to appropriate care. Keep It Real is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

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 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	**137**
FY 2027 - 2028	**137**
FY 2028 - 2029	**137**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Seven: Interim Wellness and Recovery Academy

1. Please select the service types provided under Program One (select all that apply):
   a. **☒ Mental health services**
   b. **☒ Supportive services**
   c. **☒ Substance Use Disorder treatment services**
2. Please describe the specific services provided:
   The Wellness & Recovery Academy is a state-certified Day Rehabilitation program that serves adults with serious mental illness and co-occurring substance use disorders, providing at least four hours per day of structured, trauma-informed treatment as a step-down or alternative to residential care. Services include skills-building and psychoeducational groups, group therapy and process groups, community meetings, therapeutic milieu, collaborative service plan development, community outings, and adjunctive therapies, with

flexible, longer-term participation (up to two years) to support dual recovery and successful community reintegration.

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	**73**
FY 2027 - 2028	**73**
FY 2028 - 2029	**73**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Eight: Independent Living

1. Please select the service types provided under Program One (select all that apply):
   - **a. ☒ Mental health services**
   - **b. ☒ Supportive services**
   - c. ☐ Substance Use Disorder treatment services
2. Please describe the specific services provided:
   Central Coast Center for Independent Living (CCCIL) provides cross-disability, consumer-centered independent living services to Monterey County residents with physical, mental health, and cognitive disabilities across all age groups. Services include benefits assistance for financial and medical programs, individual advocacy, housing assistance, independent living skills training, assistive technology supports including a device lending library, information and referral, and group sessions coordinated with Behavioral Health ACCESS

DRAFT

services. The program emphasizes self-determination, community integration, and skill building to support independent living.

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

Table 12. 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	**80**
FY 2027 - 2028	**80**
FY 2028 - 2029	**80**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Nine: Access Medication Support Services

1. Please select the service types provided under Program One (select all that apply):
   a. ☒ **Mental health services**
   b. ☐ Supportive services
   c. ☐ Substance Use Disorder treatment services
2. Please describe the specific services provided:
   Access Medication Support Services provide clinic- and community-based psychiatric medication services for individuals enrolled in Monterey County Behavioral Health Access and specialty programs at multiple regional clinic sites. A multidisciplinary team (psychiatrists, psychiatric nurse practitioners, and nursing staff) delivers medication assessment, prescribing, monitoring, education, and coordination with treating clinicians to promote symptom stabilization, treatment adherence, and continuity of care, with an emphasis on

informed consent, culturally responsive care, and alignment with each person's treatment goals.

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

Table 13. 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	**23**
FY 2027 - 2028	**23**
FY 2028 - 2029	**23**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Ten: USC Telehealth

1. Please select the service types provided under Program One (select all that apply):
   - **a. ☒ Mental health services**
   - b. ☐ Supportive services
   - **c. ☒ Substance Use Disorder treatment services**
2. Please describe the specific services provided:
   The USC Telehealth Program provides virtual outpatient mental health services delivered via secure, HIPAA-compliant video conferencing. Services are provided by MSW graduate student interns and licensed-eligible clinicians under the supervision of California-licensed LCSWs. The program is designed to increase access to timely, evidence-based mental health services for individuals in underserved geographic areas.

For adult and older adult populations, the program provides time-limited, episode-based outpatient mental health services to Monterey County residents ages 18 and older. Services include assessment, treatment planning, individual psychotherapy, crisis intervention, and planned termination, with each client typically receiving up to 6–12 sessions (maximum 600 minutes). Presenting concerns include depression, anxiety, trauma, co-occurring substance use disorders, and other behavioral health conditions impacting daily functioning and community stability. Evidence-based and promising practices include Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Problem Solving Therapy, Crisis Oriented Recovery Services, and Mindfulness-based interventions.

The program is designed to support engagement in care, improve access to services for individuals facing geographic or transportation barriers, and promote symptom reduction and functional improvement through structured, short-term outpatient treatment.

Services for children, adolescents, and transition-age youth (ages 12–17 and TAY) are provided through the same telehealth model but are reported and described separately under the Children's System of Care (Non-FSP Program) section, in alignment with DHCS guidance.

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

Table 14. 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	**282**
FY 2027 – 2028	**282**
FY 2028 - 2029	**282**

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

Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program 11: Adult Services Outpatient Salinas, King City, Soledad, and Coastal Region Program

1. Please select the service types provided under Program One (select all that apply):
    a. ☒ **Mental health services**
    b. ☒ **Supportive services**
    c. ☒ **Substance Use Disorder treatment services**
2. Please describe the specific services provided:
   Monterey County Behavioral Health's Adult Services Salinas, King City, Soledad, and Coastal Region Outpatient programs provide a range of services to adults with a serious mental health diagnosis to support recovery and help individuals live in the least restrictive environment possible. These outpatient services serve adults including those with co-occurring substance use disorders and offer outreach and engagement through a welcoming/engagement team. The programs function as intensive outpatient mental health and co-occurring treatment focusing on client's recovery goals with an emphasis on keeping the client in community-based care for adults with serious mental illness.
3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below.

Table 15. 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	**482**
FY 2027 - 2028	**482**
FY 2028 - 2029	**482**

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program 12: Electroconvulsive Therapy Services

1. Please select the service types provided under Program One (select all that apply):

   a. **☒ Mental health services**
   b. ☐ Supportive services
   c. ☐ Substance Use Disorder treatment services

2. Please describe the specific services provided:
   Electroconvulsive Therapy (ECT) services include psychiatric evaluation to determine medical necessity and appropriateness for treatment, administration of ECT procedures in inpatient or outpatient settings under general anesthesia, and ongoing clinical monitoring throughout the course of care. Services may also include evaluation and management visits, psychotherapy when clinically indicated, and inpatient clinic visits related to ECT treatment and capacity assessment. All services are provided in accordance with applicable specialty mental health requirements and established medical necessity standards.

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

Table 15. 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	**5**
FY 2027 - 2028	**5**
FY 2028 - 2029	**5**

DRAFT

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

   For the 3-year Integrated Plan period, projections were based on projected utilization given annual budget.

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. For related policy information, refer to **7.A.7 Early Intervention Programs.**

Program One

1. Program or service name: **MCHOME Homeless Outreach & Engagement**
2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☒ **Outreach**
   b. ☒ **Access and Linkage: Screenings**
   c. ☐ Access and Linkage: Assessments
   d. ☒ **Access and Linkage: Referrals**
   e. ☒ **Access and Linkage: Other**
      i. If selected, please specify "other" type of Access and Linkage: **Navigation, care coordination support, and assistance overcoming barriers to accessing services**
   f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   g. ☒ **Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
   h. ☒ **Treatment Services and Supports: Services to address co-occurring mental health and substance use issues**
   i. ☒ **Treatment Services and Supports: Other**
      i. If selected, please specify "other" type of Treatment Services and Supports: **Peer counseling and non-clinical support to improve engagement and successful connection to services and resources.**

DRAFT

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: ☐ Yes ☒ **No**
    a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**
4. Please describe intended outcomes of the program or service: **Intended outcomes for Interim's McHome include increasing engagement of adults with serious mental illness experiencing homelessness in behavioral health services and improving linkage to ongoing outpatient mental health treatment and supportive services. The program also aims to reduce psychiatric crises, emergency department utilization, and jail involvement, while improving psychiatric stability, functioning, and community integration through intensive outreach, engagement, case management, and treatment services.**

    Through early intervention strategies, the program seeks to increase sustained participation in behavioral health services among individuals who have historically been difficult to engage due to homelessness, co-occurring conditions, or system involvement. These outcomes are intended to support improved behavioral health stabilization and reduced reliance on higher levels of acute care.

    Any housing-related services or interventions are not funded or provided under this Early Intervention program and are addressed under the Housing Interventions Component in accordance with BHSA Policy Manual Chapter 7.C.
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:
    ☐ Yes ☒ **No**
    a. If yes, indicate additional priority name(s): **N/A**
    b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
        i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	169
FY 2027 - 2028	169
FY 2028 - 2029	169

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Two

1. Program or service name: Pajaro Valley Prevention and Student Assistance Program
2. Please select which of the three EI components are included as part of the program or service (select all that apply):
    - **a. ☒ Outreach**
    - **b. ☒ Access and Linkage: Screenings**
    - **c. ☒ Access and Linkage: Assessments**
    - **d. ☒ Access and Linkage: Referrals**
    - e. ☐ Access and Linkage: Other
        - i. If selected, please specify "other" type of Access and Linkage: **N/A**
    - f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
    - g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
    - h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
    - i. ☐ Treatment Services and Supports: Other
        - i. If selected, please specify "other" type of Treatment Services and Supports: **N/A**
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: ☐ Yes ☒ **No**

DRAFT

    a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**

4. Please describe intended outcomes of the program or service: The program focuses on identifying, assessing, and treating mental health conditions in children affected by developmental, social/emotional, and behavioral disorders. Services include individual, dyadic, family, and group therapies designed to reduce mental health challenges and improve functioning related to development, learning, self-regulation, and family relationships. Program activities may include assessment, treatment plan development, therapy, case management and linkage, rehabilitation, and collateral support services.
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:

   ☐ Yes ☒ **No**

    a. If yes, indicate additional priority name(s): **N/A**
    b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
        i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**120**
FY 2027 - 2028	**120**
FY 2028 - 2029	**120**

    a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
    Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Three

1. Program or service name: **Outreach and Aftercare**
2. Please select which of the three EI components are included as part of the program or service (select all that apply):
    a. ☐ Outreach
    b. ☐ Access and Linkage: Screenings
    c. ☐ Access and Linkage: Assessments
    d. ☒ Access and Linkage: Referrals
    e. ☐ Access and Linkage: Other
        i. If selected, please specify "other" type of Access and Linkage: **N/A**
    f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
    g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
    h. ☒ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
    i. ☐ Treatment Services and Supports: Other
        i. If selected, please specify "other" type of Treatment Services and Supports: **N/A**
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: ☐ Yes ☒ **No**
    a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**
4. Please describe intended outcomes of the program or service: **Interim's Outreach and Aftercare is intended to help adults with co-occurring serious mental illness and substance use disorders move toward dual recovery by engaging earlier in the change process, reducing harmful substance use, and stabilizing mental health symptoms. The program also aims to reduce relapse and rehospitalization by offering a softer entry point and step-down aftercare from intensive dual recovery services, so people stay connected to supports, maintain gains from treatment, and remain safely housed and involved in community life.**
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:
   ☐ Yes ☒ **No**
    a. If yes, indicate additional priority name(s): **N/A**

DRAFT

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
   i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**100**
FY 2027 - 2028	**100**
FY 2028 - 2029	**100**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Four

1. Program or service name: **211**
2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☐ Outreach
   b. ☐ Access and Linkage: Screenings
   c. ☐ Access and Linkage: Assessments
   d. ☒ Access and Linkage: Referrals
   e. ☐ Access and Linkage: Other
      i. If selected, please specify "other" type of Access and Linkage: **N/A**
   f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

i. ☐ Treatment Services and Supports: Other

  i. If selected, please specify "other" type of Treatment Services and Supports: **N/A**

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: ☐ Yes ☒ **No**

  a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**

4. Please describe intended outcomes of the program or service: **211 is a free phone and digital network provided by United Way Monterey County that connects residents in need of assistance to community health and social services. The program is intended to increase awareness of and connection to available behavioral health and social services, especially for residents who do not know where to turn. It also aims to improve successful follow-through on referrals and coordination between agencies, reducing unmet needs and barriers to accessing mental health, SUD, and basic-needs supports.**

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:
☐ Yes ☒ **No**

  a. If yes, indicate additional priority name(s): **N/A**

  b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:

    i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**6,047**
FY 2027 - 2028	**6,047**
FY 2028 - 2029	**6,047**

DRAFT

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Five

1. Program or service name: **Behavioral Health Crisis, Dispatch, and Mobile Response Services**

2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☐ Outreach
   b. ☒ Access and Linkage: Screenings
   c. ☒ Access and Linkage: Assessments
   d. ☒ Access and Linkage: Referrals
   e. ☒ Access and Linkage: Other
      i. If selected, please specify "other" type of Access and Linkage: **Crisis call coordination, dispatch, and professional routing that support the functioning of crisis and linkage workflows.**
   f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   g. ☒ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   i. ☐ Treatment Services and Supports: Other
      i. If selected, please specify "other" type of Treatment Services and Supports: **N/A**

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: ☐ Yes ☒ **No**
   a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**

4. Please describe intended outcomes of the program or service: **Behavioral Health Crisis, Dispatch, and Mobile Response Services is a coordinated early intervention program that supports individuals experiencing behavioral health**

DRAFT

crises through both system coordination functions and direct client-facing crisis response services.

The program includes Access and Linkage activities such as screenings, assessments, referrals, and crisis call coordination, dispatch, and professional triage to ensure timely routing of individuals to appropriate levels of care. These functions support rapid identification of behavioral health needs and facilitate connection to appropriate crisis and treatment services.

The program also includes direct Treatment Services and Supports, including crisis intervention and mobile response services that prevent, respond to, and stabilize behavioral health crises, including situations involving risk of suicide or acute psychiatric distress. Services are delivered in real time to de-escalate crises, provide immediate clinical support, and connect individuals to ongoing behavioral health treatment and services.

These combined system coordination and direct service activities are designed to reduce reliance on emergency departments, law enforcement, and inpatient hospitalization by providing timely behavioral health crisis intervention and linkage to ongoing care.

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:
   ☐ Yes ☒ **No**
   a. If yes, indicate additional priority name(s): **N/A**
   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**
      i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**7,739**

FY 2027 - 2028	**7,739**
FY 2028 - 2029	**7,739**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
The projected number of individuals served through Early Intervention crisis services is based on recent crisis system utilization data from Calendar Year 2025. During this period, the County of Monterey recorded approximately 7,739 calls to crisis lines, including the Community Crisis Line operated by the Family Service Agency of the Central Coast (6,949 calls) and the Seneca Crisis Warm Line serving children and youth (790 calls). These crisis lines serve as the primary entry points for telephonic crisis intervention, screening, assessment, referral, and linkage to mobile crisis services when appropriate.

Because crisis services are recorded as calls and responses rather than unique individuals, the county used the total number of crisis line contacts as a proxy for individuals served through Early Intervention crisis services. In addition to telephonic crisis intervention, some calls result in mobile crisis field responses, including approximately 1,839 in-person mobile crisis responses in CY 2025 across Seneca Children and Youth Mobile Response Teams, Sierra Mental Wellness Group mobile crisis teams, and Monterey County Behavioral Health mobile crisis teams.

The county assumes that overall crisis system utilization will remain relatively stable over the three-year plan period. Therefore, the CY 2025 crisis call volume of 7,739 contacts was used as the projected annual number of individuals served through this Early Intervention crisis services program for FY 2026-2027 through FY 2028-2029.

Program Six

1. Program or service name: **The Family Assessment Support and Treatment (FAST) program**

2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☐ Outreach
   b. ☐ Access and Linkage: Screenings

DRAFT

c. ☐ Access and Linkage: Assessments
d. ☐ Access and Linkage: Referrals
e. ☐ Access and Linkage: Other
    i. If selected, please specify "other" type of Access and Linkage:
f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
i. ☒ Treatment Services and Supports: Other
    i. If selected, please specify "other" type of Treatment Services and Supports: **Intensive outpatient mental health treatment and case management (individual, attachment-focused, group, and family therapy) for Dependency Court/Child Welfare–involved children and families.**

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: ☐ Yes ☒ **No**
    a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**
4. Please describe intended outcomes of the program or service: **The Family Assessment Support and Treatment (FAST) program team offers mental health treatment and case management services to children and families involved in the Monterey County Dependency Court and Child Welfare system due to severe abuse and neglect. FAST is intended to reduce trauma and behavioral symptoms for children impacted by severe abuse and neglect and to improve their emotional, social, and developmental functioning. The program also aims to strengthen caregiver capacity and family stability, support safer permanency outcomes in Dependency Court, and decrease the need for higher levels of care.**
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:
    ☐ Yes ☒ **No**
    a. If yes, indicate additional priority name(s): **N/A**
    b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
        i. Priority (1): **N/A**

DRAFT

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**588**
FY 2027 - 2028	**588**
FY 2028 - 2029	**588**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Seven

1. Program or service name: **CS Archer Child Advocacy Center**

2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☐ Outreach
   b. ☒ Access and Linkage: Screenings
   c. ☒ Access and Linkage: Assessments
   d. ☒ Access and Linkage: Referrals
   e. ☐ Access and Linkage: Other
      i. If selected, please specify "other" type of Access and Linkage: **N/A**
   f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

DRAFT

i. ☒ **Treatment Services and Supports: Other**

   i. If selected, please specify "other" type of Treatment Services and Supports: **Trauma-informed mental health treatment and case coordination for children exposed to abuse/violence, plus assessment and referral for ongoing services.**

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: ☐ Yes ☒ **No**
   a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**
4. Please describe intended outcomes of the program or service: **Archer Child Advocacy Center provides forensic interviews and trauma-informed mental health services for children who are suspected victims of abuse or who have witnessed violence, in a child-friendly setting coordinated with law enforcement, child welfare, medical providers, and the courts to minimize trauma and repeat interviews. The Intended outcomes are to reduce trauma symptoms and support emotional recovery for children exposed to abuse or violence, while enhancing safety and stability in the home. The program also aims to minimize system-related retraumatization through coordinated forensic interviewing and timely linkage to ongoing services.**
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:
   ☐ Yes ☒ **No**
   a. If yes, indicate additional priority name(s): **N/A**
   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
      i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**236**
FY 2027 - 2028	**236**

DRAFT

FY 2028 - 2029	**236**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Eight

1. Program or service name: **CS MCSTART**
2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☐ Outreach
   b. ☒ Access and Linkage: Screenings
   c. ☒ Access and Linkage: Assessments
   d. ☒ Access and Linkage: Referrals
   e. ☐ Access and Linkage: Other
      i. If selected, please specify "other" type of Access and Linkage: **N/A**
   f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   i. ☒ Treatment Services and Supports: **Other**
      i. If selected, please specify "other" type of Treatment Services and Supports: **Early, trauma-focused mental health treatment for ages 0-5 with prenatal substance exposure/trauma, aiming to prevent later school failure, higher levels of care, and justice/child welfare involvement.**
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: ☐ Yes ☒ **No**
   a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**

DRAFT

4. Please describe intended outcomes of the program or service: **Monterey County Behavioral Health's CS MCSTART program provides specialty mental health services for families and children ages 0-5 years who meet moderate to severe criteria and often have trauma histories, including in utero exposure to drugs or alcohol. MCSTART is intended to identify and address developmental, emotional, and behavioral impacts of early trauma and prenatal substance exposure as early as possible, improving children's functioning and developmental trajectories. The program also seeks to strengthen caregiver–child attachment and caregiver capacity, reducing risk for later school failure, higher levels of care, and justice or child welfare involvement.**
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:

   ☐ Yes ☒ **No**
   - **a.** If yes, indicate additional priority name(s): **N/A**
   - b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
     - **i.** Priority (1): **N/A**

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

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

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Nine

1. Program or service name: DTH **MCSTART 0-5**
2. Please select which of the three EI components are included as part of the program or service (select all that apply):
    a. ☐ Outreach
    b. **☒ Access and Linkage: Screenings**
    c. **☒ Access and Linkage: Assessments**
    d. **☒ Access and Linkage: Referrals**
    e. ☐ Access and Linkage: Other
        i. If selected, please specify "other" type of Access and Linkage: **N/A**
    f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
    g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
    h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
    i. **☒ Treatment Services and Supports: Other**
        i. If selected, please specify "other" type of Treatment Services and Supports: **Early trauma/prenatal substance exposure treatment for 0–5 and caregivers, focused on attachment, regulation, developmental functioning, and preventing later serious MH conditions, school problems, and child welfare involvement.**
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: ☒ **Yes** ☐ No
    a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **Parent Child Interactive Therapy (PCIT)**
4. Please describe intended outcomes of the program or service: **Door to Hope's MCSTART 0–5 program provides early specialty mental health services for infants and young children ages 0–5 who have experienced trauma and/or prenatal exposure to alcohol or other drugs, along with their caregivers. The intended outcomes of the program are to improve caregiver–child attachment and relationship quality; enhance children's emotional and behavioral regulation and developmental functioning; reduce the long-term impacts of early trauma and prenatal substance exposure; and decrease later risk of serious mental health conditions, school difficulties, and child welfare involvement.**

DRAFT

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:
   ☐ Yes ☒ **No**
   a. If yes, indicate additional priority name(s): **N/A**
   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
      i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**200**
FY 2027 - 2028	**200**
FY 2028 - 2029	**200**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Ten

1. Program or service name: **Kinship Center Seneca First Five Trauma**

2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☐ Outreach
   b. ☒ **Access and Linkage: Screenings**
   c. ☒ **Access and Linkage: Assessments**
   d. ☒ **Access and Linkage: Referrals**
   e. ☐ Access and Linkage: Other
      i. If selected, please specify “other” type of Access and Linkage:

f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
i. ☒ Treatment Services and Supports: Other
  i. If selected, please specify "other" type of Treatment Services and Supports: **Intensive early childhood mental health, attachment-based and trauma-informed services across settings.**

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: ☐ Yes ☒ **No**
  a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**

4. Please describe intended outcomes of the program or service: **Seneca Family of Agencies Early Childhood Treatment Program provides outpatient specialty mental health services to infants and young children from birth through age five and their families, targeting early emotional and behavioral dysregulation, attachment disruption, and trauma-related symptoms that could interfere with development, learning, and long-term functioning. The intended outcomes of the program are to improve early social-emotional functioning and developmental progress, reduce trauma and behavioral symptoms, and prevent disruption in home and early learning settings. The program also aims to decrease parental stress and strengthen caregiver capacity, thereby reducing the likelihood of higher levels of care, foster placement disruption, or school failure later on.**

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:
☐ Yes ☒ **No**
  a. If yes, indicate additional priority name(s): **N/A**
  b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
    i. Priority (1): **N/A**

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

DRAFT

Table 29. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

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

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Eleven

1. Program or service name: **Access Post-Hospital/Crisis Follow-Up**
2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. **☒ Outreach**
   b. **☒ Access and Linkage: Screenings**
   c. **☒ Access and Linkage: Assessments**
   d. **☒ Access and Linkage: Referrals**
   e. ☐ Access and Linkage: Other
      i. If selected, please specify "other" type of Access and Linkage: **N/A**
   f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   g. **☒ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
   h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   i. ☐ Treatment Services and Supports: Other
      i. If selected, please specify "other" type of Treatment Services and Supports: **N/A**

DRAFT

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: ☐ Yes ☒ **No**
    a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**
4. Please describe intended outcomes of the program or service: **Access Post-Hospital and Crisis Follow-Up provides timely outreach and short-term support to individuals following psychiatric hospitalization, emergency department visits, or behavioral health crises. The intended outcomes are to reduce psychiatric rehospitalization and repeat crises by ensuring people receive timely follow-up contact, safety planning, and linkage to outpatient care after discharge. The program also aims to improve continuity and engagement in treatment so that individuals maintain medication and care plans, stabilize in the community, and experience lower suicide risk and better overall recovery.**
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:
    ☐ Yes ☒ **No**
    a. If yes, indicate additional priority name(s): **N/A**
    b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
        i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**419**
FY 2027 - 2028	**419**
FY 2028 - 2029	**419**

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

Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Twelve

1. Program or service name: **Access to Treatment Salinas**
2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☐ Outreach
   b. ☒ Access and Linkage: Screenings
   c. ☒ Access and Linkage: Assessments
   d. ☒ Access and Linkage: Referrals
   e. ☐ Access and Linkage: Other
      i. If selected, please specify "other" type of Access and Linkage: **N/A**
   f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   i. ☒ Treatment Services and Supports: Other
      i. If selected, please specify "other" type of Treatment Services and Supports: **Short-term outpatient mental health treatment (therapy, psychiatry, CM, coordination) following screening/assessment.**
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: ☐ Yes ☒ **No**
   a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**
4. Please describe intended outcomes of the program or service: **The program is intended to improve timely, equitable access to county behavioral health services for Medi-Cal beneficiaries in the Salinas area and to ensure individuals are assigned to the right service track on first contact. It also aims to strengthen engagement and continuity by providing brief services during the transition to ongoing treatment, thereby reducing symptom escalation and avoidable crises.**

DRAFT

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:
   ☐ Yes ☒ **No**
   a. If yes, indicate additional priority name(s): **N/A**
   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
      i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**2,978**
FY 2027 - 2028	**2,978**
FY 2028 - 2029	**2,978**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Thirteen

1. Program or service name: **Access to Treatment King City**

2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☐ Outreach
   b. ☒ **Access and Linkage: Screenings**
   c. ☒ **Access and Linkage: Assessments**
   d. ☒ **Access and Linkage: Referrals**
   e. ☐ Access and Linkage: Other

        i. If selected, please specify "other" type of Access and Linkage: **N/A**

f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
i. ☒ Treatment Services and Supports: Other
    - **i.** If selected, please specify "other" type of Treatment Services and Supports: **Short-term outpatient mental health and substance use treatment (therapy, medication support, case management, MH rehab) following EI screening/assessment and referral.**

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: ☐ Yes ☒ **No**
    - **a.** If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**

4. Please describe intended outcomes of the program or service: **Intended outcomes include improving early identification of behavioral health and SUD needs in South County and speeding connection to appropriate county or community services. The program also seeks to reduce geographic and language barriers, increasing ongoing engagement in care and early stabilization for rural residents.**

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:
☐ Yes ☒ **No**
    - **a.** If yes, indicate additional priority name(s): **N/A**
    - b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
        - **i.** Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**363**
FY 2027 - 2028	**363**
FY 2028 - 2029	**363**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Fourteen

1. Program or service name: **Access to Treatment Soledad**
2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☐ Outreach
   b. ☒ Access and Linkage: Screenings
   c. ☒ Access and Linkage: Assessments
   d. ☒ Access and Linkage: Referrals
   e. ☐ Access and Linkage: Other
      i. If selected, please specify "other" type of Access and Linkage: **N/A**
   f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   i. ☒ Treatment Services and Supports: Other
      i. If selected, please specify "other" type of Treatment Services and Supports: **Short-term outpatient mental health and substance use treatment (therapy, medication support, case management, MH rehab, collateral) focused on stabilization and engagement after EI triage/assessment.**

DRAFT

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: ☐ Yes ☒ **No**
   a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**
4. Please describe intended outcomes of the program or service: **Intended outcomes include improving early identification of behavioral health and SUD needs in South County and speeding connection to appropriate county or community services. The program also seeks to reduce geographic and language barriers, increasing ongoing engagement in care and early stabilization for rural residents.**
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:
   ☐ Yes ☒ **No**
   a. If yes, indicate additional priority name(s): **N/A**
   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
      i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**762**
FY 2027 - 2028	**762**
FY 2028 - 2029	**762**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Fifteen

1. Program or service name: **Access to Treatment Coastal Region**
2. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☐ Outreach
   b. ☒ Access and Linkage: Screenings
   c. ☒ Access and Linkage: Assessments
   d. ☒ Access and Linkage: Referrals
   e. ☐ Access and Linkage: Other
      i. If selected, please specify "other" type of Access and Linkage: **N/A**
   f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   i. ☒ Treatment Services and Supports: Other
      i. If selected, please specify "other" type of Treatment Services and Supports: **Short-term outpatient mental health and substance use treatment (individual/group therapy, medication support, case management, MH rehab, collateral) following EI screening/assessment and linkage.**
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: ☐ Yes ☒ **No**
   a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**
4. Please describe intended outcomes of the program or service: **The program is intended to improve timely access to clinically appropriate mental health and substance use services for residents of the Monterey Peninsula and surrounding coastal areas and to reduce gaps between initial contact, assessment, and initiation of care. It aims to provide screening, triage, and comprehensive assessment to determine level of care, deliver short-term outpatient treatment when appropriate, and link individuals to county specialty behavioral health, substance use disorder, and community-based services, in**

DRAFT

order to support engagement, continuity of care, and early stabilization of behavioral health conditions.

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:
   ☐ Yes ☒ **No**
   a. If yes, indicate additional priority name(s): **N/A**
   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
      i. Priority (1): **N/A**

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**827**
FY 2027 - 2028	**827**
FY 2028 - 2029	**827**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

Program Sixteen

7. Program or service name: **Veterans Reintegration Transition Program**

8. Please select which of the three EI components are included as part of the program or service (select all that apply):
   a. ☒ **Outreach**
   b. ☐ Access and Linkage: Screenings
   c. ☐ Access and Linkage: Assessments

d. ☐ Access and Linkage: Referrals
e. ☐ Access and Linkage: Other
    i. If selected, please specify "other" type of Access and Linkage: **N/A**
f. ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
g. ☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
h. ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
i. ☒ Treatment Services and Supports: Other
    i. If selected, please specify "other" type of Treatment Services and Supports: **In addition to outreach and education activities, the program provides individualized access and linkage support, benefits navigation, court-based service coordination, and pre-release reentry linkage to facilitate timely connection to mental health and healthcare services for veterans and eligible dependents.**

9. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs: ☐ Yes ☒ **No**
    a. If yes, please indicate the EBPs and CDEPs that apply (please refer to the Draft EBP/CDEP Resource Guide (Dec 2025) for guidance): **N/A**

10. Please describe intended outcomes of the program or service: **The intended outcomes of the Veterans Reintegration Transition Program are aligned with Early Intervention outreach requirements by focusing on the identification and engagement of high-risk veterans, transitioning service members, and eligible dependents within BHSA priority populations, including older adults and youth. The program seeks to increase awareness of early signs of mental health and substance use concerns and improve participants' understanding of available behavioral health and supportive services.**
Through targeted outreach and individualized engagement, the program is designed to identify veterans who may be experiencing or at risk of developing serious mental health or substance use conditions and to facilitate timely access to appropriate services.

11. 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:
☐ Yes ☒ **No**
    a. If yes, indicate additional priority name(s): **N/A**

DRAFT

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program:
   i. Priority (1): **N/A**

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

Table 37. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**1209**
FY 2027 - 2028	**1209**
FY 2028 - 2029	**1209**

b. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projected numbers served were based on recent utilization and BHSS budget estimates.

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: **CS First Episode Psychosis Program (TAY Services)**
   b. CSC program description: **Wellness Navigators provide peer support for MCBHB Avanza Transitional Age Youth (TAY) clients with serious mental illness/First Episode Psychosis who are in need of behavioral health services and supports; this expansion utilizes the Coordinated Specialty Care ("CSC") model. As well as provide attuned and culturally relevant engagement.**

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.

2. 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 38. 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	**83**
Number of Uninsured Individuals	**12**

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**12.75**
Number of Teams Needed to Serve Total Eligible Population	**3**

3. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, in Table 14 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 39. Total Number of CSC Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**4.5**	**4.5**	**4.5**
Total Number of Teams	**1**	**1**	**1**

1. Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)? ☒ **Yes** ☐ No
    a. If yes, please list the other funding source(s): **SAMHSA Block Grant; billable services**

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs, provide the following information. For related policy information, refer to **7.A.3 Outreach and Engagement.**

Program One

1. Program or activity name: **CS TAY Post Hospital**
2. Please describe the program or activity: **The Post Hospital Team provides support to beneficiaries who are transitioning from hospital inpatient or emergency department care due to a primary psychiatric or substance use condition and are in need of establishing new outpatient Behavioral Health services. The Post Hospital Team provides discharge coordination support for adults newly referred to Behavioral Health to help ensure timely access and linkage to follow-up outpatient Behavioral Health care by providing assessment, short term case management, linkage, referrals, medication management, and other supportive services to help individuals access needed resources to help them stabilize in the community following discharge from a hospital setting. Established clients will be redirected to their existing treatment teams for ongoing care coordination and discharge planning support.**
3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below.

Table 40. Estimated Number of Individuals Served in O&E Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	**142**
FY 2027 - 2028	**142**
FY 2028 - 2029	**142**

DRAFT

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

   Projected numbers served were based on recent utilization and BHSS budget estimates. For the 3-year Integrated Plan period, projections match the estimated numbers served in FY 2025–2026, assuming stable demand and capacity.

County Workforce, Education, and Training (WET) Programs

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. For related policy information, refer to **7.A.4 Workforce Education and Training.**

Program One

1. Program or activity name: **Family and Community Counseling and Consulting**
2. Please select which of the following categories the activity falls under (select one):
   a. ☐ Continuing Education
   b. ☐ Internship and Apprenticeship Programs
   c. ☐ Loan Repayment
   d. ☐ Professional Licensing and/or Certification Testing and Fees
   e. ☐ Retention Incentives and Stipends
   f. ☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program
   g. ☒ Workforce Recruitment, Development, Training, and Retention
   h. 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.):

Monterey County Behavioral Health advances workforce equity by recruiting and supporting bilingual and culturally responsive professionals and offering career-pathway training for underrepresented communities. This project supports that goal by expanding training and development that strengthen cultural responsiveness and build a diverse, community-reflective workforce.

Program Two

1. Program or activity name**: Cultural Competence Training**
2. Please select which of the following categories the activity falls under (select one):
    a. ☐ Continuing Education
    b. ☐ Internship and Apprenticeship Programs
    c. ☐ Loan Repayment
    d. ☐ Professional Licensing and/or Certification Testing and Fees
    e. ☐ Retention Incentives and Stipends
    f. ☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program
    g. ☒ Workforce Recruitment, Development, Training, and Retention
    h. 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.):
    County of Monterey Behavioral Health addresses disparities in the behavioral health workforce by strengthening cultural humility and cultural competence among its clinical and administrative staff. Through structured training and consultation, staff develop skills to effectively engage and serve individuals from diverse racial, ethnic, cultural, and linguistic communities. These activities strengthen workforce capacity and support the development of a culturally responsive behavioral health system that reflects and responds to the needs of Monterey County's diverse communities.

Program Three

1. Program or activity name: **Career Awareness**
2. Please select which of the following categories the activity falls under (select one):
    a. ☐ Continuing Education

b. ☐ Internship and Apprenticeship Programs
c. ☐ Loan Repayment
d. ☐ Professional Licensing and/or Certification Testing and Fees
e. ☐ Retention Incentives and Stipends
f. ☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program
g. ☒ Workforce Recruitment, Development, Training, and Retention
h. 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.):
County of Monterey Behavioral Health advances workforce equity by recruiting and supporting bilingual and culturally responsive professionals and offering career-pathway training for underrepresented communities. This project supports that goal by expanding training and development that strengthen cultural responsiveness and build a diverse, community-reflective workforce.

Capital Facilities and Technological Needs (CFTN) Programs

For each project that is part of the county's CFTN project, provide the following information. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5.

2. Project name: **Technology Modernization**
3. Please select the type of project (select one):
   a. ☐ Capital facilities project
   b. ☒ Technological needs project
4. If capital facilities project, please indicate which of the following categories the project falls under (select one):
   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.*
      i. If selected, please indicate if the project involves leasing or renting to own a building:
         ☐ Yes ☐ No
         1. If yes, please explain why purchase of the building was not possible:

DRAFT

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

5. If Technological Needs Project, please select the focus area(s) of the project (select all that apply):
   a. ☒ Data exchange and interoperability
   b. ☒ Data security and privacy
   c. ☒ Data warehouse
   d. ☒ Electronic health record system
   e. ☐ Individual/family access to computing resources
   f. ☒ Imaging/paper conversion
   g. ☒ Monitoring
   h. ☐ Online information resources for individuals/families
   i. ☐ Personal health record system
   j. ☐ Resources to support web content and mobile app accessibility
   k. ☐ System maintenance costs
   l. ☒ Telemedicine
   m. ☐ Other

6. Please describe the program: **This activity supports the replacement and upgrade of outdated computer hardware to modernize and strengthen behavioral health clinical and administrative information systems. The new equipment will enhance data security and privacy by supporting current operating systems, security patches, encryption standards, and multi-factor authentication requirements necessary to safeguard protected health information (PHI) and ensure compliance with federal and state regulations. Upgraded hardware will also improve system performance, reduce downtime, and increase efficiency in clinical documentation, electronic prescribing, reporting, and outcome monitoring activities.**

DRAFT