

# NAMI California Advocacy Toolkit

# BHSA

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## How to Download

***On page 4, there is an Impact Statement example and template for download.***

- 1:** Click the “Click Here for Impact Statements” button to be led to a Google Drive folder.
- 2:** Click on the statement you’d like to view, and click the “download” icon in the top right corner to download the item to your computer.
- 3:** To use the template, be sure to follow the instructions for use, which can be found on the document, along with the link to the template.

## Where are we right now with BHSA?

Right now, counties should be engaging in stakeholder engagement to draft County Integrated Plans which are due in draft version to DHCS in March 2026 and final version by June 30, 2026.

Counties need to focus on strategic planning and adaptation, not preemptive cuts that could harm vulnerable populations. Prematurely cutting contracts based on anticipated future resources is not a responsible approach. Counties should engage in careful planning, needs assessment, and stakeholder input before making any decisions about service reductions.

## How to Engage

- **Affiliates should be acquainting themselves with the community planning and stakeholder engagement process at the county level.**
- Please relay any feedback on community planning process at county level to NAMI California to share with state partners.

## The Three Core BHSF Funding Streams under Proposition 1 are:

Full Service Partnerships (FSP), **35%**

Behavioral Health Services and Supports (BHSS), **35%\***

*\*51% of BHSS funds must be used for early intervention programs. 51% of early intervention funding must be used to serve individuals age 25 & younger.*

Housing Interventions, **30%**

**Most NAMI programs** are best aligned with **BHSS**, especially those providing early intervention, education, peer support, and outreach.

**Full Service Partnership (FSP) alignment** is limited to more intensive, wrap-around services. Only a few NAMI programs might fit under FSP if directly involved in care coordination or assertive engagement with high-need populations.

**Innovative and evidence-based practices**, like NAMI Family-to-Family and Peer-to-Peer, are encouraged under BHSS and may qualify for additional grants via the Innovation Partnership Fund (administered by Commission for Behavioral Health).

**Prevention-focused programs for youth and families**, such as Ending the Silence and NAMI on Campus, should be positioned under BHSS—particularly within the 51% Early Intervention requirement, which prioritizes individuals under age 25.

**Training programs** for providers (like NAMI Provider Education) may qualify as workforce or BHSS expenditures but are not a standalone funding category in BHSF. Counties can allocate planning/admin funds (up to 5% + 2–4% extra) for such capacity-building efforts.

# BHSA Funding Streams and NAMI Programs

Access the digital [BHSA Policy Manual PDF](#) here.

NAMI Program	Recommended BHSA Component	Justification	Statutory/Policy Basis
<b>Family-to-Family / De Familia a Familia</b>	BHSS	Evidence-based family education to reduce crisis escalation.	BHSA Manual p. 141-142 (See Appendix A)
<b>NAMI Basics</b>	BHSS (Early Intervention, Youth-Focused)	Caregiver education for youth with SED aligns with youth EI.	BHSA Manual p. 47-48 (See Appendix B)
<b>Family Support Group</b>	<ul style="list-style-type: none"> <li>BHSS</li> <li>Early Psychosis Intervention Plus Programs</li> </ul>	Peer-based support promotes caregiver wellness.	BHSA Manual p. 141-142 (See Appendix A)
<b>Peer to Peer / Persona a Persona</b>	<ul style="list-style-type: none"> <li>BHSS;</li> <li>Early Psychosis Intervention Plus Programs</li> <li>Coordinated Specialty Care for First Episode Psychosis</li> <li>FSP if part of wraparound</li> </ul>	Peer-led recovery curriculum; more intensive models may align with FSP.	BHSA Manual p. 141-142; 148 (See Appendix A and Appendix C)
<b>Connection / Conexión</b>	BHSS (Peer Support, Maintenance)	Ongoing recovery groups fit under wellness services.	BHSA Manual p. 141-142; 148 (See Appendix A and Appendix C)
<b>In Our Own Voice</b>	BHSS (Outreach & Engagement)	Public education combats stigma and increases help-seeking.	BHSA Manual p. 113-115 (See Appendix D)
<b>Provider Education</b>	Workforce Education and Training (WET)	Increases provider empathy; may be categorized under indirect services or capacity-building.	<u>Welfare and Institutions Code § 5892(k)(5)</u> . BHSA Manual p. 116-117 (See Appendix E)

# BHSA Funding Streams and NAMI Programs, Cont.

Access the digital [BHSA Policy Manual PDF](#) here.

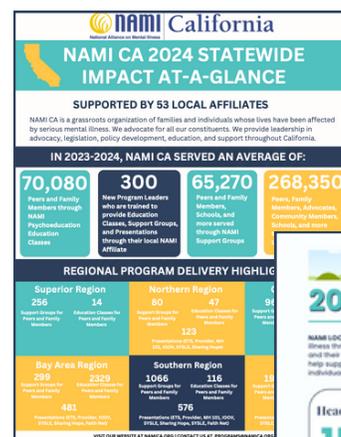
NAMI Program	Recommended BHSA Component	Justification	Statutory/Policy Basis
Ending the Silence (ETS)	BHSS (Youth Early Intervention)	Prevention education directly supports youth mental health.	BHSA Manual p. 129-131 (See Appendix F)
NAMI on Campus / High School	BHSS (Youth Engagement, Early Intervention)	School-based peer outreach aligns with BHSA EI objectives.	BHSA Manual p. 129-131 (See Appendix F)
Mental Health 101	BHSS	Culturally responsive presentations align with BHSA goals to reduce disparities.	BHSA Manual p. 141-142; 148 (See Appendix A and Appendix C)
Warmlines	BHSS (Outreach & Engagement)	Peer-led, non-crisis support services that reduce unnecessary use of crisis systems. Play a role in early intervention, recovery support, and wellness maintenance.	BHSA Manual p. 113-115 (See Appendix D)

## Advocacy Tools

Now is the time to demonstrate our impact. Linked to the left is an example impact statement from NAMI California and a template impact statement for affiliates to customize.

*\*Please be sure to duplicate the template for your affiliates use*

[Click Here for Impact Statements](#)



# Important BHSA Notes related to NAMI

**Emphasize early intervention** for youth in grant proposals and Integrated Plans to align with BHSA's requirement that 51% of BHSS go to early intervention, and 51% of that to youth (under 25).

**Use CDEP framing** (community-defined evidence practices) for peer-led or culturally grounded programs to enhance funding eligibility, especially for non-clinical services.

For intensive programs or wraparound pilots, like targeted Peer-to-Peer expansions for justice-involved adults, **consider FSP if there's robust support service integration.**

## Additional Helpful Links

[BHSA County Policy Manual](#)

[Proposition 1 Fact Sheet](#)

[Comparing Funding Allocations – MHSA vs BHSA](#)

Advocacy resources and materials will evolve as the BHSA process continues. Please email [\*\*advocacy@namica.org\*\*](mailto:advocacy@namica.org) with any questions and make sure you are subscribed to our Quorum Action Center.

**Sign up using the QR code!**



# Appendix A.1

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Early intervention mental health and substance use disorder treatment services and supports to those eligible for BHSa may include:

- Mental health treatment services to address first episode psychosis.
- Mental health and substance use disorder services that prevent, respond, or treat a behavioral health crisis or activities that decrease the impacts of suicide, return
- Individual children and youth at high risk for a behavioral health disorder due to experiencing trauma, as evidenced by scoring in the high-risk range under a trauma screening tool such as an ACEs screening tool,<sup>36</sup> involvement in the child welfare system or juvenile justice system or experiencing homelessness.
- Individual children and youth in populations with identified disparities in behavioral health outcomes.

## **A.7.4 Stigma and Discrimination Reduction**

Stigma and discrimination reduction activities aim to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, substance use disorder or seeking behavioral health services. Stigma and discrimination reduction programs align with population-based prevention activities and cannot be funded with Early Intervention funding.

## **A.7.5 Early Psychosis Intervention Plus Programs<sup>37</sup>**

Early Psychosis Intervention (EPI) Plus programs encompass early psychosis and mood disorder detection and intervention. These programs utilize evidence-based approaches and services to identify and support clinical and functional recovery of individuals by reducing the severity of first, or early, episode psychotic symptoms and other early markers of serious mental illness, such as schizophrenia spectrum disorders and mood disorders, supporting individuals to engage in school or at work, and putting them on a path to better health and wellness.<sup>38</sup> EPI Plus programs may include, but are not limited to, all of the following:

- Focused outreach to at-risk and in-need populations, as applicable.
- Recovery-oriented psychotherapy, including cognitive behavioral therapy focusing on co-occurring disorders.
- Family psychoeducation and support.
- Peer support services.
- Supported education and employment.

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<sup>36</sup> The DHCS [Trauma Informed Care](#) webpage includes the ACEs Aware screening tool and other resources.

<sup>37</sup> [W&I Code § 5835](#)

<sup>38</sup> [W&I Code § 5835, subdivision \(b\)\(2\)](#)

# Appendix A.2

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- Pharmacotherapy and primary care coordination.
- Use of innovative technology for mental health information feedback access that can provide a valued and unique opportunity to assist individuals with mental health needs and to optimize care.
- Case management.

EPI Plus programs must include CSC for FEP and may include other EBPs and CDEPs for early psychosis and mood disorder detection and intervention programs. See CSC for FEP requirements below.

### A.7.5.1 Coordinated Specialty Care for First Episode Psychosis

CSC for FEP is a community-based service that provides timely and integrated support during the critical initial stages of psychosis with the strongest base of evidence among any intervention for improving outcomes for individuals experiencing early psychosis. CSC for FEP reduces the likelihood of psychiatric hospitalization, emergency room visits, residential treatment placements, involvement with the criminal justice system, substance use, and homelessness that are often associated with untreated psychosis.<sup>39,40</sup> Research on CSC for FEP has demonstrated that individuals who receive this service are significantly less likely to develop a significant mental health condition over time compared to those who receive standard care.<sup>41</sup> Individuals who receive CSC for FEP have also reported improved psychopathology and overall quality of life.<sup>42</sup> DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC) have made significant investments in expanding CSC for FEP throughout the state, such as through funding, technical assistance, and policy reforms. These efforts include contracting with University of California, Davis to fund FEP technical assistance for county behavioral health agencies, a \$25 million commitment to further support and expand [EPI-CAL, Assembly Bill \(AB\) 1315](#) establishment of the EPI Plus program,

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<sup>39</sup> [Nossel I., Wall, M., et. al. \(2018\) "Results of a Coordinated Specialty Care Program for Early Psychosis and Predictors of Outcomes." \*Psychiatry Serv.\* 1;69\(8\):863-870.](#)

<sup>40</sup> [Breitborde, N., Bell, E., et. al. \(2023\). "The Early Psychosis Intervention Center \(EPICENTER\): development and six-month outcomes of an American first-episode psychosis clinical service." \*BMC Psychiatry.\* 15\(266\).](#)

<sup>41</sup> [Kane, M., Delbert, G., et.al. \(2015\). "Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes from the NIMH RAISE Early Treatment Program." \*American Journal of Psychiatry.\* 173\(4\).](#)

<sup>42</sup> [Heinssen, R., Goldstein, A., and Azrin, S. \(2023\). "Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care."](#)

# Appendix B.1

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Service Categories	Service Category Definition	Example SUD Services <sup>91</sup>
	medical monitoring for substance use disorder needs.	<ul style="list-style-type: none"> <li>SUD services within a general acute care hospital (GACH), acute psychiatric hospital (APH), psychiatric health facility (PHF), or mental health rehabilitation center (MHRC)</li> </ul>
<b>Housing Intervention Services</b> <i>(reporting is aggregated with the mental health framework)</i>	Includes services and supports designed to enable individuals to remain in their homes or obtain housing to support recovery and improved health outcomes. Services help individuals find and retain housing, support recovery and resiliency, and/or maximize the ability to live in the community.	<ul style="list-style-type: none"> <li>Permanent supportive housing</li> <li>Housing tenancy and sustaining services</li> <li>Recovery residences and sober living homes</li> <li>Rent</li> <li>Interim Settings</li> </ul>

**Table 3.C.2 Mental Health Care Continuum Service Categories, Definitions,<sup>96</sup> and Example Services**

Service Categories	Service Category Definition	Example MH Services
<b>Population Prevention Services</b>	Includes services and activities that educate and support individuals to prevent acute or chronic conditions related to mental health from ever developing. These services/activities may offer communities support in identifying and addressing issues before they turn into problems, tools for	<ul style="list-style-type: none"> <li>Mental health education, such as public health campaigns for suicide prevention or adverse</li> </ul>

<sup>96</sup> Definitions are informed by [DHCS's previous assessment](#) of California's Medi-Cal behavioral health service delivery system and tailored to the county landscape.

# Appendix B.2

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Service Categories	Service Category Definition	Example MH Services
	coping with stressors and information on ways to promote resiliency.	childhood experiences (ACEs) awareness <ul style="list-style-type: none"> <li>• Community Health Workers</li> </ul>
<b>Early Intervention Services</b> <sup>97</sup>	Includes interventions that take a proactive approach to identifying and addressing mental health issues among individuals who are showing early signs, or are at risk, of a mental health disorder. These interventions, such as outreach, access and linkage, and treatment services, help avert the development of a severe and disabling condition, discourage risky behaviors and support individuals in maintaining healthy lifestyles.	<ul style="list-style-type: none"> <li>• Screenings</li> <li>• Evidence-based practices, such as coordinated specialty care for first episode psychosis</li> </ul>
<b>Outpatient<sup>98</sup> &amp; Intensive Outpatient Services</b>	Includes a variety of therapeutic mental health services that can be provided anywhere an individual is located, such as in school, home, clinic, office, field settings (e.g. homeless encampments, shelters, etc.) or other outpatient settings. Also includes services to support individuals living with higher acuity mental health needs who may require assistance at a higher frequency and/or intensity, sometimes via a team-based approach. These services may help avert the need for, or be provided after, crisis care, inpatient or residential treatment and are provided, if necessary, as part of stabilization and continued recovery/ongoing evaluation. They may also offer structure and monitoring when more support than routine outpatient visits is necessary.	<ul style="list-style-type: none"> <li>• Individual therapy</li> <li>• Group therapy</li> <li>• Assertive Community Treatment/ Forensic Assertive Community Treatment (ACT/FACT)</li> <li>• High Fidelity Wraparound (HFW)</li> <li>• Intensive Outpatient Treatment/Day Treatment Intensive</li> </ul>
<b>Crisis Services</b>	Includes a range of services and supports that assess, stabilize, and treat individuals experiencing acute distress. Services are designed to provide	<ul style="list-style-type: none"> <li>• Crisis call centers</li> <li>• Crisis stabilization</li> </ul>

<sup>97</sup> [W&I Code § 5840, subdivisions \(b\)\(1\)-\(3\)](#)

<sup>98</sup> [W&I Code § 5887, subdivision \(a\)\(4\)](#)

# Appendix C

## B.3.2 Baseline Requirements

- Given the expansion to include eligible individuals living with substance use disorder (SUD) in the BHSA, county FSP programs must include SUD treatment services where appropriate. County FSP teams must be capable of supporting FSP participants living with co-occurring mental health and substance use disorder conditions by providing integrated behavioral health care as part of the FSP program, inclusive of mental health, SUD and/or co-occurring services, or by closely coordinating the provision of SUD care for FSP participants.
- FSP services shall be provided in accordance with demonstrated clinical need and in alignment with the required high intensity service models: Assertive Community Treatment (ACT), Forensic ACT (FACT), FSP Intensive Case Management (ICM), and High Fidelity Wraparound (HFW).<sup>62</sup> Please refer to the respective sections for details regarding required services and expectations for co-occurring capabilities.
- County FSP programs must provide ongoing engagement services to FSP participants in order to maintain their continued treatment.<sup>63</sup> These services may include clinical and recovery-oriented services, such as consumer-operated services, peer support services, transportation, and services to support maintaining housing.<sup>64</sup>
- County FSP programs must also include outpatient behavioral health services, either clinic or field based, necessary for the ongoing evaluation, and stabilization and recovery of an enrolled individual. Many of these outpatient behavioral health services are incorporated within the high intensity service models (ACT, FACT, FSP ICM, and HFW) county FSP programs are required to utilize.
- FSP teams are required to coordinate with an FSP program participant's primary care provider as appropriate. Ensuring coordination across systems, including primary care, is critical to participant engagement and satisfaction.<sup>65</sup>

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<sup>62</sup> All of these services are covered Medi-Cal services with dedicated bundled rates (ICM is covered under Medi-Cal but does not have a dedicated bundled rate). DHCS encourages counties to opt-in to provide these services under Medi-Cal. When counties opt-in to provide these services under Medi-Cal, they will receive the bundled rate when providing services to Medi-Cal members and may use FSP funding for the non-federal share.

<sup>63</sup> Providers are responsible for attempting to engage FSP-eligible individuals to ensure they are adequately supported in their recovery. If the team attempts to engage an FSP-eligible individual repeatedly for several months and are unable to engage them, the team should meet and discuss whether that individual should be moved to a lower level of care or disenrolled so that another FSP-eligible individual is able to receive services.

<sup>64</sup> Housing Interventions provided to FSP clients must be funded through the Housing Interventions component. All Medi-Cal billable services must be billed to Medi-Cal pursuant to [W&I Code § 5891\(a\)\(1\)\(G\)\(2\)](#).

# Appendix D.1

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Counties may use shared resources to advance multi-county BHSS projects. Each county will be expected to report on multi-county projects in their respective Integrated Plan.

## A.2 Children’s, Adult, and Older Adult Systems of Care

Counties may use a portion of BHSS funds to provide Children’s, Adult, and Older Adult Systems of Care services, including substance use disorder services, to BHSA eligible and priority populations. System of care services are those pursuant to Part 4 for the Children’s System of Care and Part 3 for the Adult and Older Adult System of Care.<sup>2</sup> Additional information on BHSA eligible and priority populations can be found in [Chapter 2, Section B.3](#).

Children’s, Adult, and Older Adult Systems of Care services funded under BHSS may not include Housing Interventions or services for individuals enrolled in a Full Service Partnership (FSP). Housing Interventions and FSP services should be funded under those components.

## A.3 Outreach and Engagement

Counties may use a portion of BHSS funds for Outreach and Engagement (O&E). BHSS funds may be used for activities intended to reach, identify, and engage individuals, families, and communities in the behavioral health system and reduce disparities.

Counties may include evidence-based practices and community-defined evidence practices in the provision of activities.<sup>3</sup>

BHSS O&E activities involve broad engagement of unserved and underserved populations in the behavioral health system. These activities are distinct from those that may be funded as part of BHSS Early Intervention Programs, Housing Interventions, or FSP programs. County Early Intervention programs must include an outreach component, and counties may use FSP funding for outreach activities to enroll individuals in an FSP. Additionally, counties may utilize up to 7 percent of their Housing Intervention funds on identified Outreach and Engagement activities. O&E activities that are required as a part of as part of BHSS Early Intervention programs or FSP should be

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<sup>2</sup> According to [W&I Code, § 5892 subdivision \(a\)\(3\)\(i\)](#), Children’s System of Care services and requirements are described in Part 4, commencing with [W&I Code, § 5850](#). Adult and Older Adult System of Care services and requirements are described in Part 3, commencing with [W&I Code, § 5800](#). These services do not include Housing Interventions or Full Service Partnership services.

<sup>3</sup> [W&I Code, § 5892 subdivision \(k\)\(4\)](#)

# Appendix D.2

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funded and tracked in county Integrated Plans (IPs) and BHOATRs as part of those programs, rather than under the BHSS O&E category. Additional information on BHSS Early Intervention can be found in [Chapter 7, Section A.7](#) and additional information on FSPs can be found in [Chapter 7, Section B](#).

BHSS funds may be used for O&E activities to engage individuals in housing interventions, if the county is not funding these activities under Housing Interventions. For example, BHSS funds may be used to conduct outreach to individuals in encampments to support connection to housing programs. Additional information on allowable uses of Housing Intervention funds can be found in [Chapter 7, Section C](#).

When the county works in collaboration with other non-behavioral health community programs and/or services, only the costs directly associated with outreach and engagement activities to provide mental health and substance use treatment can be funded under the BHSS O&E category.

Examples of O&E activities that may be supported with BHSS funds include but are not limited to:

- Outreach to and collaboration with individuals and entities that can help reach, identify, and engage individuals and communities in the behavioral health system, which may include but are not limited to:
  - Community-based organizations
  - Housing Agencies
  - Street medicine/field-based service providers
  - Harm reduction/syringe services programs
  - Community leaders
  - Schools
  - Early Care and Learning
  - Tribal communities
  - Primary care providers
  - Senior centers
  - Senior Housing (including affordable senior housing and other types of retirement communities, local Area Agencies on Aging, and the local Aging and Disability Resource Connections)

# Appendix D.3

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- Hospitals (including emergency departments and behavioral health urgent care)
- Federally Qualified Health Centers
- Faith-based organizations
- Outreach to directly reach and engage individuals who may benefit from behavioral health services and engagement to support and encourage ongoing participation of the eligible population in behavioral health treatment, such as:
  - Peer Support Services<sup>4</sup> including resource navigation.
  - Enhanced Community Health Worker services<sup>5</sup> under Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), which include health navigation, health education, support and advocacy, and tailored preventive services for Medi-Cal members living with significant behavioral health needs.
  - Food, clothing, and other basic necessities, when the purpose is to engage unserved individuals and, when appropriate, their families in the behavioral health system. These services should support the ability to provide for the immediate needs of an individual.
- Strategies to reduce ethnic, racial, gender-based, age-based, or other disparities, such as:
  - Engaging individuals, families, and credible messengers from priority communities to design and provide input on outreach strategies and messages so that they meet the unique needs of those populations.
  - Outreach to individuals through community sites that are natural gathering places for priority populations.

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<sup>4</sup> Department of Health Care Services, [BHIN 22-026](#): Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS) and Specialty Mental Health Services (SMHS) Peer Support Services: "Peer Support Services include the following service components: [...] Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transition between levels of care and supporting beneficiaries in developing their own recovery goals and processes."

<sup>5</sup> <https://www.dhcs.ca.gov/CalAIM/Pages/Opt-in-to-BH-CONNECT.aspx>

# Appendix E.1

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## A.4 Workforce Education and Training

Counties may use a portion of BHSS funds for Workforce Education and Training (WET). County-operated and/or county-contracted providers that are employed or volunteer in the county behavioral health delivery system may participate in WET activities.

Counties should incorporate efforts to increase the racial, ethnic, and geographic diversity of the behavioral health workforce, including incorporating individuals with lived experience into the workforce, across all WET activities. BHSS funds for WET activities must be spent within ten years, after which unspent funds will be subject to reversion. All transfers into WET are irrevocable and cannot be transferred out of WET. Additional information on fiscal policies can be found in Chapter 6, [Sections B.7](#) and [B.8](#).

### A.4.1 WET Alignment with Statewide Workforce Initiatives

WET activities must 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 must prioritize available BH-CONNECT and other state-administered workforce programs whenever possible.

BHSS funds must be used to:

- Supplement workforce activities funded through BH-CONNECT and other state-administered programs (e.g., stipends for childcare or transportation to supplement a retention bonus available through the BH-CONNECT workforce initiative).
- Create WET programs within the county that complement state-administered workforce programs.

### A.4.2 WET Allowable Activities

WET activities must only address the needs of the county behavioral health delivery system. Activities that may be supported with BHSS funds include, but are not limited to, the following<sup>6</sup>:

- Workforce recruitment, development, training, and retention
- Professional licensing and/or certification testing and fees

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<sup>6</sup> [W&I Code § 5892, subdivision \(k\)\(5\)](#)

# Appendix E.2

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- Loan repayment
- Retention incentives and stipends
- Internship and apprenticeship programs
- Continuing education
- Efforts to increase the racial, ethnic, and geographic diversity of the behavioral health workforce (e.g., individuals with lived experience)
- Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program.

BHSS funds for WET activities **may not** be used to:

- Address the workforce recruitment and retention needs of systems other than the county behavioral health delivery system, such as criminal justice, social services, and other non-behavioral health systems, although county behavioral health may choose to *partner* with other systems in order to meet the intersecting needs of its clients.
- Pay for staff time spent providing direct behavioral health services.
  - Employers must not be reimbursed for the time an employee takes from their duties to attend training.
- Off-set lost revenues that would have been generated by staff who participate in WET programs and/or activities.

Counties may also use BHSS funds to support administration and coordination of all WET programs and activities (e.g., hiring a WET coordinator).

County-operated and/or county-contracted providers that are employed or volunteer in the county behavioral health delivery system may participate in WET activities. Certain WET activities require a commitment to employment in the county behavioral health delivery system over a certain time. Additional information on WET activities is provided in subsequent sections (Chapter 7, Sections [A.4.3 – A.4.9](#)).

## **A.4.3 Workforce Recruitment, Development, Training, and Retention**

Counties may use BHSS funds for county-operated and county-contracted behavioral health workforce recruitment, development, training, and retention activities that include the following:

### **Recruitment and Retention**

# Appendix F.1

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- Individual and family empowerment projects including but not limited to:
  - Individual/family access to computing resources projects
  - Personal health record system projects
  - Online information resource projects (expansion/leveraging information sharing services)
- Other technological needs projects and expenditures that support behavioral health operations including but not limited to:
  - Telemedicine and other rural/underserved service access methods
  - Pilot projects to monitor new programs and service outcome improvement
  - Data warehousing projects/decision support
  - Imaging/paper conversion projects
  - Multi-county technological needs projects
  - Maintenance costs, such as subscriptions to maintain EHRs or other systems
  - Resources to support compliance with the Americans with Disabilities Act (ADA) Title II requirements for web content and mobile app accessibility, California Government Code Section 11135 and other applicable requirements.

## A.6 Innovative Behavioral Health Pilots and Projects

The goal of innovative behavioral health pilots and projects is to build the evidence base for the effectiveness of new statewide strategies. Counties are encouraged to pilot and test innovative behavioral health pilots and projects in all BHSA funding components (Housing Interventions, FSP, and BHSS).<sup>8</sup> Counties should fund innovative behavioral health pilots and projects under each of those separate funding components.

## A.7 Early Intervention Programs

Under the Mental Health Services Act, Prevention and Early Intervention made up one of the five program components. Now, Early Intervention is covered under BHSS to be

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<sup>8</sup> [W&I Code, § 5892 subdivision \(a\)\(4\)\(A\)](#)

# Appendix F.2

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provided by counties and four percent of total BHSAs funding will be used by the California Department of Public Health (CDPH) for statewide Population-Based Prevention programs and activities.

Under BHSAs, each county must establish and administer an Early Intervention program that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health.<sup>9</sup> At least 51 percent of BHSS funding must be used to fund Early Intervention programs and services. At least 51 percent of the BHSS Early Intervention funding must be used to serve eligible individuals who are 25 years of age and younger, including transitional aged youth.<sup>10</sup> Early Intervention funds may also be used to provide supports and services to parents and caregivers. However, these services do not count toward the 51% requirement spent on individuals who are 25 years and younger. Early Intervention funds can also be used to support innovative behavioral health pilots and projects within these parameters to build the evidence base for the effectiveness of new statewide strategies.<sup>11</sup>

County Early Intervention programs must also include a Coordinated Specialty Care for First Episode Psychosis (CSC for FEP) program beginning July 2026. More information on CSC-FEP requirements can be found in [Chapter 7, Section A.7.5](#).

County Early Intervention programs must emphasize the reduction of the likelihood of the following adverse outcomes for BHSAs eligible individuals:<sup>12</sup>

- Suicide and self-harm
- Incarcerations
- School suspension, expulsion, referral to an alternative or community school, or failure to complete (inclusive of early childhood zero to five years of age, Transitional Kindergarten (TK)-12, and higher education)
- Unemployment
- Prolonged suffering
- Homelessness

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<sup>9</sup> [W&I Code, § 5840 subdivision \(a\)\(1\)](#), [W&I Code, § 5892 subdivision \(a\)\(3\)\(A\)\(ii\)](#)

<sup>10</sup> [W&I Code 5892\(a\)\(3\)\(B\)](#), [W&I Code, § 5892 subdivision \(a\)\(3\)\(B\)\(ii\)](#)

<sup>11</sup> [W&I Code, § 5892 subdivision \(a\)\(4\)\(A\)](#)

<sup>12</sup> [W&I Code § 5840 subdivision \(d\)](#)

# Appendix F.3

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- Removal of children from their homes
- Overdose
- Mental illness in children and youth through social, emotional, developmental, and behavioral services and supports in early childhood

## **Culturally Responsive and Linguistically Appropriate Interventions**

County Early Intervention programs must include culturally responsive and linguistically appropriate interventions. These interventions must be able to reach underserved cultural populations<sup>13</sup> and address specific barriers related to racial, ethnic, cultural, language, gender, sexual orientation, gender identity, religion, age, economic, or other disparities in mental health and substance use disorder treatment services access, quality, and outcomes.<sup>14</sup>

County Early Intervention programs must create critical linkages with community-based organizations, including, but not limited to, service and treatment providers, youth centers, licensed and exempt clinics, facilities and providers licensed or certified by the DHCS, licensed or certified residential substance use disorder facilities, and licensed narcotic treatment programs. Community-based organizations may also include organizations that provide evidence-based practices (EBPs) or community-defined evidence practices (CDEPs).<sup>15</sup>

Counties are encouraged to partner with community-based organizations that specialize in serving specific populations that are underserved and address specific barriers in the above paragraphs. DHCS encourages the use of CDEPs at the local level to address historical behavioral health disparities. CDEPs are an alternative or complement to EBPs, that offer culturally anchored interventions that reflect the values, histories and life experiences of the communities that the provider is providing services. These practices

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<sup>13</sup> Underserved cultural populations means those who are unlikely to seek help from providers of traditional mental health and substance use disorder services because of stigma, lack of knowledge, or other barriers, including members of ethnically and racially diverse communities, members of the 2S/LGBTQ+ communities, victims of domestic violence and sexual abuse, and veterans, across their lifespans.

<sup>14</sup> [W&I Code, § 5840.6, subdivision \(f\)\(1\), W&I Code, § 5840.6, subdivision \(f\)\(2\).](#)

<sup>15</sup> [W&I Code, § 5840.6, subdivision \(f\)](#)