Sonoma County Behavioral Health Division Gap Analysis Report

BHSA Implementation Project

March 2025

MISSION CONSULTING

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Background

The Sonoma County Department of Health Services (DHS), Behavioral Health Division (BHD) engaged Mission Consulting to support its transition from the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA) recently established by the state as a result of Proposition 1. This Gap Analysis is the first phase of the project and includes assessments of the current MHSA environment and new BHSA environment, identifies gaps in compliance, service delivery, and stakeholder engagement, and proposes a plan for Sonoma County going forward.

Executive Summary

The State of California and its counties face a complex and deep-rooted behavioral health crisis. Sonoma County, despite recent progress, continues to face notable challenges, particularly in health disparities among rural and minority groups across areas including food security, education, and housing. Recent sharp increases in Sonoma County's homeless rate due to factors such as economic pressure, housing affordability, behavioral health issues, and aging, have all but negated progress made earlier this decade. These factors place continued pressure on the County and its partner organizations to reevaluate and improve their services within fiscal and regulatory bounds.

The Behavioral Health Division has multiple sources of funding including Realignment tax revenue, Federal Financial Participation, state grants, federal grants, and local Measure O tax. Sonoma County passed Measure O in 2020, representing a substantial 20-year commitment of tax revenues to help address critical issues related to mental health, addiction, and homelessness. However, nearly a quarter of Sonoma County DHS funds for behavioral health come from the state and have been tied to the objectives and requirements of the Mental Health Services Act (MHSA) for the past two decades. Within the MHSA framework, Sonoma County has worked with and funded dozens of programs to deliver a wide range of services to the community.

In 2024 California voters passed Proposition 1, also known as the Behavioral Health Services Act (BHSA), the successor of the MHSA. The transition from MHSA to BHSA represents a significant policy shift, particularly in funding allocations. BHSA is a key component of California's comprehensive effort to modernize its behavioral health system by improving access, care coordination, and equity, working in tandem with BH Connect, CalAIM, and CARE Court. The BHSA moves towards an increased focus on housing solutions, prioritizes services for individuals with severe behavioral health needs, and integrates substance use disorder treatment. This change will require counties, including Sonoma, to restructure programs, ensure compliance, and align services with the new funding model before the July 1, 2026 implementation date.

Ensuring the transition from MHSA to BHSA addresses the growing behavioral health challenges in Sonoma County requires a multifaceted approach. A primary focus should be placed on expanding and integrating housing interventions with behavioral health support services. This includes addressing the needs of individuals experiencing chronic homelessness and those living in encampments. Workforce development must also be strengthened by increasing efforts to fill critical vacancies and providing essential training in evidence-based practices. Leveraging state workforce initiatives will be crucial in attracting and retaining behavioral health professionals. Early intervention strategies should be enhanced, with an emphasis on targeted prevention and intervention efforts for at-risk populations, particularly youth. Culturally responsive programs must be developed to address disparities in service utilization.

Additionally, DHS should conduct a comprehensive review of existing behavioral health expenditures to align resources with BHSA mandates and coordinate implementation with other state initiatives such as CalAIM and BH-CONNECT. A clear and effective communication strategy is essential to inform all stakeholders, including DHS program staff, contracted providers, and community members, about changes under BHSA. Engaging the community will be key to refining the transition process and ensuring alignment with local needs.

Sonoma County stands at a critical juncture in reshaping its behavioral health system. While challenges such as workforce shortages and shifting funding priorities present notable obstacles, strategic planning and stakeholder engagement can help ensure a smooth transition to BHSA. By focusing on housing, workforce development, and improved service coordination, DHS can continue to support the well-being of Sonoma County residents amid this policy transformation.

Current Environment

California and its Counties Face a Behavioral Health Crisis

California is facing a deepening crisis at the intersection of mental illness and homelessness. Across the state, over 1.2 million adults live with a serious mental illness, and 1 in 13 children experiences a serious emotional disturbance.[1] At the same time, mental health challenges are a driving factor in the state's growing homeless population – 66% of Californians experiencing homelessness report having a serious mental health condition, and 1 in 10 Californians meets the criteria for a substance use disorder.[2]

The lack of adequate behavioral health services has left thousands without the support they need, often forcing them into cycles of homelessness, incarceration, and emergency

[1] National Alliance on Mental Illness (NAMI): Mental Health in California.
[2] California Health Care Foundation: Mental Health in California Almanac — 2022 Edition.

room visits. The state simply does not have enough psychiatric beds, crisis intervention teams, or outpatient treatment programs to meet the demand. As a result, many individuals with untreated mental illness find themselves on the streets, struggling to survive in an environment that only worsens their conditions.[3]

For too many, law enforcement has become the default response to behavioral health crises. Instead of receiving medical care, individuals experiencing severe psychiatric episodes are often arrested, further entrenching them in the criminal justice system. Without stable housing and proper treatment, the path to recovery becomes even more difficult.[4]

California has made strides in expanding behavioral health services, but the gaps remain vast. There is an urgent need for more supportive housing, which provides not just a place to live but also integrated behavioral health and addiction treatment services. Addressing this crisis requires a shift in priorities - moving away from reactive, emergency-based responses and toward a system that ensures access to quality, long-term care for those struggling with behavioral health challenges and homelessness.

Snapshot of Sonoma County

Sonoma County has developed a broad system of care based on federal, state and local funding sources yet it is difficult to maintain progress amidst growing community needs. This section provides a high-level summary of Sonoma County's current behavioral health status and services based on the most recent county-issued reports and data.

Despite recent progress, Sonoma County faces notable challenges, particularly in health disparities, for which it is implementing its Community Health Improvement Plan.

The 2023 Sonoma County Community Health Assessment and Improvement Plan is a comprehensive document that evaluates the health status of Sonoma County residents and outlines strategic initiatives to address identified health priorities.[5] Phase 1 of this report serves as a roadmap for enhancing community health outcomes through collaborative efforts and targeted interventions.

Sonoma County, home to a population of 481,812 residents, centers much of its activity around Santa Rosa, the County's largest city. The County has a median age of 42.5 years, reflecting an older demographic compared to the California state average (37.3 years). Its population comprises 61.7% White residents and 27.5% Latinos. Life expectancy in the

[3] Stanford Institute for Economic Policy Research: Homelessness in California: Causes and Policy Considerations.
[4] California Health Care Foundation: Mental Health in California Almanac — 2022 Edition.
[5] Sonoma County Community Health Assessment & Improvement Plan (2023).

County averages 82.2 years but reveals stark disparities: Black residents face significantly lower life expectancy at 71 years.

Despite its strengths, Sonoma County faces notable challenges, particularly in health disparities. BIPOC and rural communities in Sonoma experience higher rates of mortality, chronic diseases, and mental health burdens. There's a current lack of Spanish-speaking and culturally responsive clinicians available in Sonoma County which impacts access to care.[6] Across California, systemic barriers, including fragmented care systems and a lack of culturally relevant/aware services, exacerbate these inequities. Mental health also remains a critical issue, particularly for LGBTQ+ youth, as suicide ranks as the 10th leading cause of death in the County, with youth mental health concerns steadily rising.

The report does not explicitly state a percentage for overall behavioral health service utilization in Sonoma County. However, it does mention that nearly half (49%) of 1,679 survey respondents in the Area Agency on Aging 2023 Needs Assessment reported not knowing what services were available to them. The report also highlights the fact that Sonoma County Behavioral Health Division has a 18% staff vacancy rate, which impacts service availability.

Amid these challenges, Sonoma County demonstrates remarkable resilience through its robust community support systems. Food assistance programs, such as the Redwood Empire Food Bank and CalFresh, provide essential resources for residents facing food insecurity.[7] Collaborative health initiatives, like the Teen Health Advocacy Coalition, support youth by increasing access to counseling and other vital services. Additionally, the County's ongoing efforts to diversify the healthcare workforce aim to bridge cultural and linguistic gaps in service delivery.[8]

The report includes a Community Health Assessment (CHA) which systematically collects and analyzes data on health indicators, determinants, and outcomes within Sonoma County and utilizes quantitative data from health records, surveys, and statistical databases, alongside qualitative insights from community focus groups and stakeholder interviews. The CHA identified five key takeaways regarding the most pressing challenges facing Sonoma County:

- Increased wildfire risks and environmental hazards significantly impact housing, mental health, and healthcare systems.
- Food insecurity affects 33% of residents, with rural and low-income populations facing the most challenges.
- Disparities exist in income levels and housing access, with Latinos earning far less per capita and having lower homeownership rates.

[6] Sonoma County Community Health Assessment & Improvement Plan (2023).
[7] Sonoma County Behavioral Health.
[8] SoCoYouthHub.

- Only 22% of children were kindergarten-ready in 2022, a sharp decline from previous years, highlighting a need for improved early education support.
- Systemic inequities in education, incarceration rates, and healthcare access disproportionately affect BIPOC communities.

The Community Health Improvement Plan (CHIP) provides a strategic framework to address the critical health disparities identified in the Community Health Assessment. Through its comprehensive approach, the plan focuses on four key strategies to enhance equity and well-being across Sonoma County.[9]

The first priority of the 2023 CHIP centers on addressing structural and institutional racism, recognizing its role as a root cause of health inequities. Efforts include implementing racial equity training for staff, increasing workforce diversity, and developing fairer housing assessment processes. Progress will be measured by improvements in housing access for BIPOC communities and achieving racial equity benchmarks within the County's workforce.

The second strategy aims to improve residents' connections to resources. Emphasizing navigation support, stable housing, and culturally responsive services, the plan seeks to ensure all community members can effectively access the health and social services they need.

The third priority focuses on improving system-of-care coordination. By enhancing coordination between public health, behavioral health, and homelessness services, the CHIP fosters collaboration among healthcare providers, government agencies, and community organizations. This approach aims to create a seamless network of care, ensuring that no resident falls through the cracks.

Finally, the CHIP prioritizes strengthening behavioral health services. This includes expanding treatment capacity, integrating preventive measures, and addressing the ongoing overdose crisis. The plan highlights the need for expanded substance use disorder and mental health treatment services, particularly for individuals with co-occurring condition and underscores the importance of harm reduction and broadening service accessibility to support those in need.

Looking ahead, the County's health improvement efforts will continue to evolve. Phase 2 of the Community Health Improvement Plan is intended to engage grassroots organizations and community members to refine strategies and ensure they address the needs of those most affected by inequities. Regular evaluations will monitor progress and help align strategies with the County's overarching goal of achieving health equity and improving well-being for all residents.

[9] Sonoma County Community Health Assessment & Improvement Plan (2023).

Recent sharp increases in Sonoma County's homeless rates, due to factors including economic pressure, housing affordability, behavioral health issues, and aging, have negated much of the progress made this decade.

The 2024 Sonoma County Homeless Point-in-Time (PIT) Count provides a comprehensive snapshot of homelessness in the region, highlighting trends, demographics, and contributing factors.

The count identified 2,522 individuals experiencing homelessness, marking an 11% increase from 2023's figure of 2,266. Of the total, 37% (945 individuals) were in emergency shelters, while 63% (1,577 individuals) were unsheltered, residing in places not meant for human habitation. Santa Rosa accounted for 54% of the County's homeless population, with an 18% increase from the previous year.[10]

A significant portion of the homeless population is aging, with 77% aged 25 or older and 14% aged 50 or older. The majority identified as male (65%), followed by female (34%), and a small percentage identifying as non-binary or transgender. While 66% identified as White, there is a notable overrepresentation of Black/African American individuals at 9%, compared to their proportion in the general population. The primary causes of homelessness reported include job loss (28%), inability to afford rent (25%), and eviction (13%). Substance use issues were reported by 34% of respondents, and 28% reported mental health issues, indicating significant behavioral health challenges within the homeless population.

The report estimates that over the course of a year, approximately 5,591 individuals experience homelessness in Sonoma County, reflecting a 20% increase from 2023. Despite the recent increase, there has been a 19% reduction in homelessness in Sonoma County since 2015, indicating long-term progress amidst short-term challenges.

Comparatively, in 2023 the national average for homelessness in the United States is estimated at around 582,500 individuals experiencing homelessness on a given night, according to the U.S. Department of Housing and Urban Development (HUD).[11] California has approximately 173,000 individuals experiencing homelessness, about .44% of the total population, making it the state with the largest homeless population in the U.S.[12]

The 2024 PIT Count underscores the persistent and evolving nature of homelessness in Sonoma County. The increase in numbers suggests that economic pressures, housing affordability, and behavioral health issues continue to drive homelessness. The aging

[10] Sonoma County 2024 Point-in-Time Count Results.
[11] HUD 2023 Point-in-Time Count Report.
[12] California Department of Housing and Community Development: Housing Open Data Tools.

demographic highlights the need for age-appropriate services and interventions. To address these challenges, the report recommends:

- Expanding affordable housing options to meet the growing demand.
- Integrating mental health and substance use treatment with housing solutions.
- Implementing job training and employment services to address economic factors contributing to homelessness.
- Developing specialized programs to address systemic disparities.

Sonoma County's Measure O has been a significant local commitment to addressing critical issues related to mental health, addiction, and homelessness.

Measure O, approved by Sonoma County voters in November 2020, is a quarter-cent sales tax dedicated to funding mental health, addiction, and homelessness services over a 10-year period.[13]

The revenue from Measure O is distributed across five key service categories:

- Development and maintenance of infrastructure to support mental health and addiction services.
- Enhancement of immediate response services for individuals experiencing mental health crises.
- Expansion of outpatient programs addressing mental health and substance use disorders.
- Integration of behavioral health services with homelessness support to provide comprehensive care.
- Provision of housing solutions for individuals facing homelessness, particularly those with behavioral health challenges.

The Sonoma County Department of Health Services (DHS) is responsible for implementing Measure O, establishing the necessary infrastructure to support its initiatives. A Citizens' Oversight Committee has been formed to ensure transparency and accountability in the allocation and utilization of funds.[14]

In the fiscal year 2022-2023, Measure O provided $22.4 million in funding for various projects and programs Additionally, the DHS issued a Notice of Funding Availability (NOFA) for Measure O: Behavioral Health and Homelessness Community Solutions, inviting proposals to further the measure's objectives.

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[13] Sonoma County Behavioral Health: Measure O.
[14] Sonoma County Behavioral Health: Measure O Citizens' Oversight Committee.

Since its inception, Measure O has been instrumental in bolstering mental health and homelessness services within Sonoma County. The measure has exceeded expected revenue, providing new opportunities for expansion and innovative solutions to meet ongoing challenges. The funding has supported a range of programs, from crisis response to services for the unsheltered, demonstrating significant positive effects across the community. Measure O represents a substantial commitment by Sonoma County to address critical issues related to mental health, addiction, and homelessness. Through sustained funding and community engagement, the measure aims to enhance the well-being of residents and provide essential services to those in need.[15]

California has embarked on a remarkable transformation of its behavioral health system in recent years, recognizing the growing need for comprehensive mental health and substance use disorder care

California has embarked on a remarkable transformation of its behavioral health system in recent years, recognizing the growing need for comprehensive mental health and substance use disorder care. These changes have been driven by an urgent awareness of the critical gaps in behavioral health services, exacerbated by the COVID-19 pandemic and the state's escalating homelessness crisis. Through significant reforms and investments, California has sought to modernize its behavioral health care system, address longstanding inequities, and create a more integrated and person-centered approach to care.

The 2024 passage of the Behavioral Health Services Act (BHSA) marked a pivotal moment in this transformation. Building on the foundation of the Mental Health Services Act (MHSA), which had been funded since 2004 by a 1% tax on high-income earners, the BHSA expanded its scope to better reflect the needs of Californians. For the first time, substance use disorder treatment was elevated as a priority alongside mental health care, ensuring parity between these interconnected issues. The act also focuses on providing housing interventions for individuals experiencing homelessness, addressing a root cause of behavioral health crises. In addition, significant investments will be made in workforce development to address critical shortages of behavioral health professionals, while new accountability measures will strengthen oversight to ensure that funds are used effectively and equitably.[16]

Complementing this effort was the launch of the Community Assistance, Recovery, and Empowerment (CARE) Court program in 2023. This initiative created a new pathway for addressing the needs of individuals with severe mental illness, particularly those at risk of institutionalization or incarceration. CARE Court allows families, clinicians, and first

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[15] Sonoma County Behavioral Health: Measure O Expenditure Plan.
[16] California Budget Center: Proposition 1 and Behavioral Health System Reform.

responders to refer individuals to a system of court-ordered care plans, which included comprehensive treatment and housing support.[17]

The California Advancing and Innovating Medi-Cal (CalAIM) initiative, introduced in 2021, further exemplified the state's commitment to system-wide reform. By transforming Medi-Cal, the state's Medicaid program, into a more integrated and holistic system, CalAIM aimed to address the social determinants of health and better serve individuals with complex needs.[18] Enhanced Care Management (ECM) provided coordinated care for those with behavioral health challenges, while Community Supports offered services such as housing navigation, food assistance, and sobering centers. Behavioral health integration under CalAIM attempts to ensure that mental health and substance use disorder services were delivered seamlessly, reducing barriers to care.

A key component of this reform is the 'Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment', or BH-CONNECT, an initiative aimed at enhancing access to behavioral health services across the state. BH Connect serves as a centralized system that connects individuals with appropriate care, improving coordination among providers and ensuring that individuals with behavioral health needs receive the right services at the right time.[19] Through BH-CONNECT, individuals can be more easily matched with care providers who meet their specific needs. The initiative provides training for County staff in evidence based practices, utilizes technology to streamline referrals, facilitate communication, and reduce barriers to care, ultimately improving the timeliness and effectiveness of treatment.

Youth behavioral health has been another focal point of California's reforms. Through the multi-billion-dollar Children and Youth Behavioral Health Initiative (CYBHI), the state prioritized prevention, early intervention, and digital tools to create a comprehensive system of care for individuals aged 0 to 25.[20] This initiative was complemented by significant expansions in school-based mental health services, ensuring that young people could access care in familiar and supportive environments.

Recognizing that the behavioral health workforce is the backbone of these reforms, California plans to make historic investments in training, recruitment, and retention efforts. Scholarships, loan forgiveness programs, and financial incentives have been implemented to increase the number of behavioral health professionals while also promoting workforce diversity to reflect the cultural and linguistic needs of California's population.

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[17] California Department of Health Care Services: CARE Act.
[18] CalAIM: Medi-Cal Transformation.
[19] California DHCS: BH-CONNECT Initiative.
[20] Children and Youth Behavioral Health Initiative.

Addressing the intersection of behavioral health and homelessness has been another priority for the state. Programs like Project Homekey have converted motels and other properties into permanent supportive housing for individuals with behavioral health challenges, while Encampment Resolution Grants have provided housing and services to those living in encampments.[21] These efforts have underscored the state's commitment to providing stable housing as a foundational element of recovery and wellness.

At the heart of these reforms are guiding principles that emphasize equity, prevention, and community-based care. California has sought to reduce disparities by prioritizing historically underserved communities, including communities of color and rural populations. The state has also shifted its focus from crisis response to early intervention, aiming to improve long-term outcomes and reduce the need for more costly and disruptive services.

California's behavioral health transformation represents one of the most ambitious state-led efforts in the nation. While challenges remain such as workforce shortages and ensuring consistent implementation across its county led behavioral health system, California's reforms offer a bold and hopeful vision for the future of systems of care.

Mental Health Services Act (MHSA)

The Mental Health Services Act (MHSA), enacted in California in 2004 through Proposition 63, marked a transformative shift in the state's approach to addressing mental health needs. This landmark legislation was created in response to the long-standing challenges stemming from the deinstitutionalization of mental health care in the 1960s.[22] The closure of state hospitals left many individuals with severe mental illnesses without access to adequate community-based care, contributing to a significant rise in homelessness and unmet mental health needs.

The MHSA was designed to rebuild the mental health care system with a focus on comprehensive, community-centered solutions. Funded by a 1% tax on personal incomes exceeding $1 million, the act provided a stable and significant source of funding dedicated to mental health services. Its vision emphasized recovery, resilience, and wellness, while prioritizing services for individuals living with serious mental illnesses.

The MHSA includes programs like Community Services and Supports (CSS), which provides direct assistance to individuals in crisis, and Prevention and Early Intervention (PEI), aimed at addressing mental health issues before they became severe and disabling. The Workforce Education and Training (WET) component seeks to build a robust pipeline of trained professionals to meet the growing demand for mental health care, while the

[21] California Department of Housing and Community Development: Homekey.
[22] Mental Health Services Act (MHSA).

Capital Facilities and Technological Needs (CFTN) initiative invests in infrastructure to enhance service delivery. Another groundbreaking feature of the act is the Innovation (INN) component, which encourages the testing of new, experimental approaches to mental health care.

Oversight of the MHSA was entrusted to the Mental Health Services Oversight and Accountability Commission (MHSOAC), which aimed to ensure that funds are used effectively.[23] The act also prioritized cultural competence and community collaboration to address the diverse needs of California's population.

Proposition 1 and the Introduction of BHSA

In 2024, the Behavioral Health Services Act replaces the original MHSA, building on its foundation to better meet the evolving needs of Californians. The updated act expanded its scope to include substance use disorder treatment, enhanced housing interventions for individuals experiencing homelessness, and prioritized services for those with the most significant behavioral health needs. It also placed a stronger emphasis on workforce development and improving accountability and transparency at both the state and local levels.

After the passage of BHSA (SB 326) in 2023, it was placed on the ballot in the form of Proposition 1, which was passed by California voters in March 2024 and aimed to enhance the state's behavioral health system by authorizing a $6.38 billion general obligation bond.[24] The bond funds designate $4.4 billion administered by the Department of Health Care Services (DHCS) for grants to public and private entities. Of this, $1.5 billion is reserved for counties, cities, and tribal entities, with $30 million specifically for tribes. In addition, $1.972 billion is allocated to be managed by the California Department of Housing and Community Development (HCD) to support permanent supportive housing for individuals at risk of or experiencing homelessness with behavioral health challenges.[25] This includes $1.065 billion allocated to veterans. Key reforms under Prop. 1 include:

- Incorporating treatment for substance use disorders alongside mental health services.
- Mandating the use of evidence-based treatment practices for individuals with the most significant mental health needs.
- Expanding housing solutions for those with behavioral health challenges.
- Increasing the behavioral health workforce to meet growing demands.

[23] Mental Health Services Oversight and Accountability Commission (MHSOAC).
[24] California Budget Center: Proposition 1 and Behavioral Health System Reform.
[25] California Department of Health Care Services: Proposition 1 FAQ.

- Enhancing transparency and reporting requirements at state and local levels to include the entire behavioral health system of care.

While implementation timelines and specific allocation details are still being developed, the successful implementation of Prop. 1 is expected to provide over 11,150 new behavioral health treatment beds and supportive housing units, addressing critical needs for individuals experiencing or at risk of homelessness with behavioral health challenges, including dedicated housing investments for veterans.

Future Environment: BHSA

Overview

The Behavioral Health Services Act (Senate Bill 326, 2023) outlines several specific responsibilities for counties in California to improve the delivery and accountability of behavioral health services. The legislation requires counties to submit reimbursement claims to the State Department of Health Care Services for behavioral health services that qualify under federal programs like Title XIX or XXI of the Social Security Act.[26] This ensures that services funded in part or wholly by the BHSA maximize federal financial contributions.

Additionally, the bill revises the allocation of Mental Health Services Act funds, now under the BHSA, to direct resources toward housing interventions. Counties are mandated to allocate a portion of these funds to address the critical intersection of homelessness and behavioral health by supporting housing solutions for individuals requiring behavioral health services.

A key priority under SB 326 is the focus on Full-Service Partnerships (FSPs), which are comprehensive, community-based programs designed to support individuals with serious behavioral health impairments or emotional disturbances. Counties are required to prioritize funding for these partnerships, ensuring integrated and tailored care for individuals with the most acute needs.

The legislation also expands the scope of services to include treatments for substance use disorders, emphasizing the importance of an integrated approach to addressing both mental health and substance use challenges. Counties are tasked with ensuring that their behavioral health programs comprehensively address these intertwined issues.
Finally, the bill enforces strong accountability and transparency measures. Counties are required to report on the outcomes of all their behavioral health programs and

[26] SB 326: The Behavioral Health Services Act.

demonstrate how BHSA funds are being used effectively.[27] This transparency is intended to ensure that resources are allocated efficiently, and that progress is made in addressing the behavioral health needs of their communities.

The Behavioral Health Services Act is the first major structural reform of the Mental Health Services Act since 2004. Building on the investments made under Proposition 1, BHSA expands and increases the types of supports available to Californians in need by focusing on gaps and priorities.

- Focuses on the most vulnerable and at-risk, including set-asides for children and youth.
- Broadens the target population to include individuals with substance use disorder.
- Updates allocations for local services and state directed funding categories, including housing supports.
- Clearly advances community-defined practices as a key strategy of reducing health disparities and increasing community representation.
- Revises and expands county processes for planning and reporting.
- Improves transparency and accountability.

BHSA expands eligible services beyond those for serious mental illness to include treatment for SUD for children, youth, adults and older adults. Unlike past reforms, BHSA notes that housing is an essential component of behavioral health treatment, recovery, and stability – and targets eligible adults, children and youth who are chronically homeless or experiencing homelessness or are at risk of homelessness. The BHSA framework supports children and youth who have serious mental illness and behavioral health needs and prioritizes intervening early in the life course to prevent and reduce the possibility of having mental health or substance use disorders needs in the first place. The act emphasizes advancing community-defined practices as a key strategy for reducing health disparities and increasing community representation. Additional guidance is still expected to be passed down from the Department of Health Care Services (DHCS) on operationalize many of the commitments and expectations included within the BHSA.[28]

BHSA also requires counties to submit Integrated Plans for all Behavioral Health Services and Outcomes and Behavioral Health Outcomes, Accountability, and Transparency Reports.[29] California counties with populations exceeding 200,000 are required to collaborate with the five most populous cities within their jurisdiction. This collaboration, which applies to Sonoma County, extends to managed care plans and continuums of care, aiming to outline comprehensive behavioral health strategies and ensure cohesive service delivery across the County. This includes all services funded by BHSA, Medi-Cal, county

[27] California Association of Local Behavioral Health Boards and Commissions: Behavioral Health Services Act.
[28] California Department of Health Care Services: Behavioral Health Transformation.
[29] SB 326: The Behavioral Health Services Act.

realignment and other funds. Counties must conduct ongoing community and system engagement to inform plan and policy creation. This process ensures that the needs and perspectives of diverse community members are considered in the development and implementation of behavioral health services.

Specifically, counties are required to engage in tribal consultation to ensure that behavioral health services are inclusive and effective for Native American communities. This mandate aligns with broader state policies emphasizing government-to-government relationships with federally recognized tribes, including Assembly Bill 153 (AB 153) which established a process through tribal consultation with federally recognized tribes to engage and coordinate the implementation of System of Care MOUs.[30] BHSA continues these efforts to ensure tribal perspectives are integrated into county behavioral health systems.

Community Care Facilities

California's Behavioral Health Services Act also requires counties to establish community care facilities to support individuals with mental health needs. These facilities are designed to provide a stable and supportive environment for those who need assistance with daily living due to mental health challenges.

These facilities offer a range of services, including supervision, room and board, structured activities, and meal provisions. They operate under strict state regulations, ensuring compliance with the California Community Care Facilities Act, which sets licensing standards, resident rights, and operational guidelines. Legislation like Senate Bill 1082 further specifies that some facilities, such as Adult Community Residential Facilities (ACRFs), should accommodate a maximum of six residents and meet federal requirements for care. Residents in these facilities are to receive personalized support, guided by individualized Needs and Services Plans, which outline their specific care requirements.[31] The goal is to provide a community-based alternative to institutionalization, allowing individuals with mental health conditions to live in integrated settings that foster independence, social connection, and long-term recovery.

Local Service Funding Categories

Housing Component

Within BHSA, a total of 30% is allocated for housing interventions for children and families, youth, adults, and older adults living with SMI/SED and/or SUD who are experiencing or at

[30] Guidance on Tribal Participation in System of Care MOU per AB 153.
[31] California Legislative Information: Senate Bill 1082.

risk of homelessness. 50% of the housing component (15% of total BHSA funding) is prioritized for housing interventions for the chronically homeless with BH challenges. This includes rental subsidies, operating subsidies, shared and family housing, capital, and the non-federal share for certain transitional rent. This is not limited to Full Service Partnership clients or people enrolled in Medi-Cal. Of note, there may be additional flexibility forthcoming for the remaining counties commencing on the 2032-2035 planning cycle on the 30% requirement based on DHCS criteria.

35% of funding under BHSA is earmarked for Full-Service Partnerships (FSP) Programs. These includes mental health, supportive services, and SUD treatment services such as Medication-Assisted Treatment (MAT). FSP programs establish standards of care with levels based on criteria and under BHSA are required to include Assertive Community Treatment /Forensic Assertive Community Treatment, Supported employment, & High Fidelity Wraparound (HFW). FSP also includes outpatient behavioral health services, both clinic or field based, necessary for ongoing evaluation and stabilization of an enrolled individual. Ongoing engagement services are provided under BHSA to maintain enrolled individuals in their treatment plan inclusive of clinical and non-clinical services, including services to support maintaining housing.

Behavioral Supports and Services Component

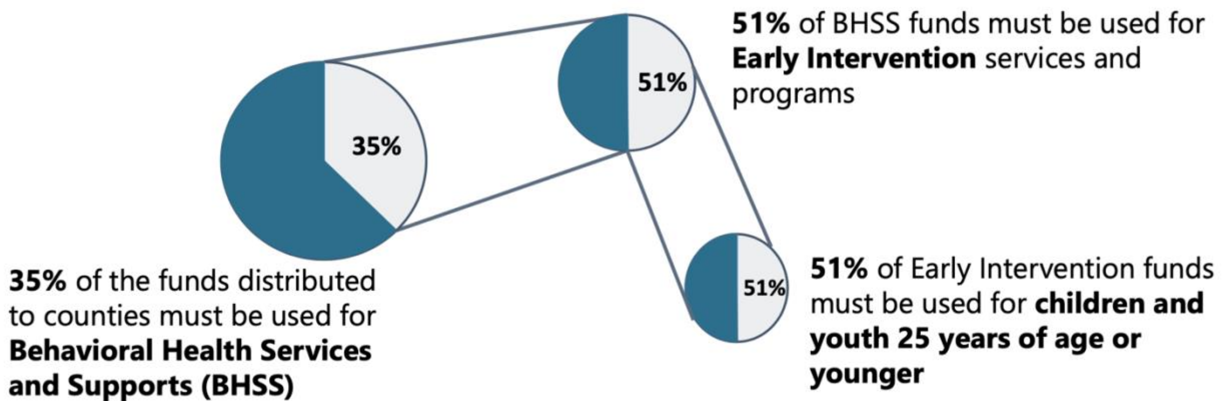
Behavioral Health Services and Supports (BHSS) make up 35% of total funding under the new BHSA framework. Per WIC Section 5892[32], behavioral health services and supports include:

- Early Intervention
- Children's, Adult, and Older Adult Systems of Care
- Outreach and Engagement
- Workforce, Education, and Training
- Capital Facilities and Technological Needs
- Innovative behavioral health pilots and projects

Other than Early Intervention, counties are not required to fund any of the listed program categories. Counties have the flexibility to fund any category according to local needs. Of note, MHSA fund balance may be allocated into any or all the components mandated under BHSA. In Sonoma County, this is estimated to be $19 million on June 30, 2026.

[32] California Welfare and Institutions Code § 5892.

Figure 1. BHSS Fund Requirements Under BHSA (DHCS)



Counties have the flexibility to transfer 7% of funds from BHSS into another funding category (FSP or Housing Interventions) for a maximum total shift of 14% into a single funding category. Changes are subject to DHCS approval and can only be made during the 3- year plan cycle. The first three-year cycle of BHSA is Fiscal Years 2026-2029.[33]

Early Intervention (EI)

Given that population-based prevention programs will now have dedicated funding under CDPH (WIC 5892(f)(1)(E)), the following outlines a proposed approach to prevention and early intervention within the BHSA program based on WIC 5840. This proposed approach acknowledges the overlap between prevention and early intervention services and differentiates programs under CDPH and BHSA based on the population level (i.e., the program targets a whole population versus individuals and those who are at risk).

Population-based prevention under CDPH is defined as targeting a whole population, not just those at risk and aims to prevent a mental health or substance use disorder from ever developing. Alternatively, BHSA BHSS early intervention under DHCS targets those at risk of or showing early signs of a mental health or substance use disorder and aims to prevent mental health or substance use disorder from becoming severe and disabling.

Under this framework, counties will be allowed to continue to fund prevention activities as long as they're not directed at the whole population. Early intervention would include selective and indicated prevention, as well as case identification. Of note, it is currently unknown if this framework provides the flexibility needed to ensure that counties are able to continue funding needed prevention activities that are critical to meeting the aims of early intervention.

[33] California Department of Health Care Services: Behavioral Health Transformation.

SB 326[34] requires that Early Intervention programs focus on reducing the likelihood of certain adverse outcomes such as suicide and self-harm, incarceration, school suspension, unemployment, prolonged suffering, homelessness, overdose, removal of children from home, and mental illness in children and youth from needs in early childhood.

Early Intervention programs may target high-risk individuals and members of groups who are identified as at-risk, including members of the individual's support system, such as parents and/or caregivers, in order to meet the aims of early detection and linking to services in BHSA. Under BHSA, these programs must target at risk populations and/or high-risk individuals showing early danger signs and who require screening and treatment.

Early intervention strategies may include, but is not limited to, the following: Outreach, Counseling, Family, Peer and Individual Skill Building, Screenings, Referrals, Brief Intervention, Direct Care, and Case management. The following strategies cannot be included when provided on a population- wide basis: Health Education, Public stigma reduction campaigns, Policy and Systems Change, Social marketing, Community organizing, Coalition-building, Collaborative Care, and Surveillance.

BHSA attempts to strengthen prioritization of resources to serve children and youth with its dedicated allocation of early intervention funds. 51% of Early Intervention funds must be used for children and youth 25 years of age or younger. Early interventions funds must prioritize childhood trauma early intervention to mitigate the early origins of mental health and substance use disorder needs, including strategies focused on youth experiencing homelessness, justice-involved youth, child welfare-involved youth with a history of trauma, other populations at risk of developing serious emotional disturbance or substance use disorders, and children and youth in populations with identified disparities in behavioral health outcomes.[35]

BHSA adds additional priorities for county Early Intervention programs targeting early childhood 0-5 years of age, including infant and childhood mental health consultation, advancing equity and reduce disparities. BHSA encourages counties to address the needs of individuals at high risk of crisis through programs that include community-defined evidence-based practices and mental health and substance use disorder treatment services similar to programs that have been effective and successful in the past. Counties may add priorities for the use of their early intervention funds based on their community planning process.

WIC § 5840(b) requires that county Early Intervention Programs include three components: outreach, access and linkage to care, and mental health and substance use disorder treatment services. The early intervention services provided must fall into one of these

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[34] SB 326: The Behavioral Health Services Act.
[35] California Welfare and Institutions Code § 5892.

component categories. Of note, DHCS has indicated they may include additional components.[36]

“Outreach” is a process of engaging, encouraging, educating, and/or training, and learning about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness and/or substance use disorders. Outreach can be targeted to:

- Families
- Employers
- Primary care health care providers
- Behavioral health urgent care
- Hospitals, inclusive of emergency department
- Education, including early care and learning, Tk-12, and higher education, etc.

Early intervention programs must contain a component that focuses on access and linkage to medically necessary care provided by county behavioral health programs as early in the onset of these conditions as practicable. Access and linkage to care includes, but is not limited to:

- Scaling of and referral to:
  - Early Psychosis Intervention (EPI) Plus Program
  - Coordinated Specialty Care
  - Other similar EBPs and CDEPs for Early psychosis and mood disorder detection and intervention programs
- Activities with a primary focus on screening, assessment, referral
- Telephone help lines
- Mobile response

The third component includes mental health and substance use disorder treatment services that are effective in preventing mental health illnesses and substance use disorders from becoming severe, and that have been successful in reducing the duration of untreated serious mental health illnesses and substance use disorders and assisting people in quickly regaining productive lives. Under BHSA, this must include services that are demonstrated to be effective at meeting the cultural and linguistic needs of diverse communities and may include services to address first episode psychosis and services that prevent, respond, or treat a behavioral health crisis or activities that decrease the impacts of suicide.

[36] California Welfare and Institutions Code § 5840.

EI Evidence-Based and Community-Defined Evidence Practices

Some early intervention EBPs and CDEPs have population prevention components. DHCS is developing a list of EBPs and CDEPs for Early Intervention (EI) Programs. Counties will still be able to fund EBPs and CDEPs with population prevention components with BHSS funds, if the EBP or CDEP is on the EI list developed by DHCS.

Of note, Stigma and Discrimination Reduction programs align with population-based prevention activities, which will be funded by other funding sources (including SAMHSA Block Grants, CDPH BHSA funding, other prevention dollars). 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 or seeking mental health services. DHCS is working collaboratively with CDPH on the guidance on the BHSA population-based prevention funding.

DHCS will leverage the following sources to identify EBPs and CDEPs:

- Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH- CONNECT) Medicaid Section 1115 Demonstration
- The Children and Youth Behavioral Health Initiative (CYBHI)
- Family First Prevention Services Act (FFPSA)[37]
- Early intervention EBP's identified by the Prevention and Youth Branch (ex: UCLA, National Registry of Evidence-based Programs and Practices, Blueprints Programs, Athena Forum, programs implemented through SUBG)
- Community-Defined Evidence Practices identified through the California Reducing Disparities Project (CRDP)[38]

BHSS Systems of Care

Children's, Adult, and Older Adult Systems of Care services for individuals who are not enrolled in an FSP and that do not include housing interventions may be funded under BHSS. Under MHSA, systems of care services for non-FSP enrollees were funded under CSS (Community Services and Supports) GSD (General System Development).[39] The activities counties may fund under BHSS systems of care will largely remain the same as what counties were funding under MHSA CSS GSD, with a few distinctions that are not BHSS specific, including the addition of SUD services and modified eligible and priority populations.

[37] California Department of Social Services: Family First Prevention Services Act (FFPSA) Part IV Overview.
[38] California Reducing Disparities Project (CRDP).
[39] Mental Health Services Act (MHSA).

Outreach and Engagement

Outreach and Engagement is included under the BHSS funding component. Under MHSA, Outreach and Engagement was categorized under CSS. BHSA newly defines Outreach and Engagement activities as those that reach, identify, and engage individuals and communities in the behavioral health system, including peers and families, and to reduce disparities. BHSS Outreach and Engagement activities are distinct from those that may be funded through Early Intervention or within Full-Service Partnerships (FSP).

BHSS Outreach and Engagement activities do not require regular or ongoing funding, but this program type does allow for broad engagement of unserved and underserved populations in the behavioral health system when they are not part of an FSP or EI program. BHSS Outreach and Engagement activities can also cover outreach activities for housing navigation. The Housing Component funding cannot be used for outreach and engagement activities.

Workforce, Education, and Training

There are no longer distinct funding categories within workforce, education and training (WET). BHSA includes a non-exhaustive list of WET activities that counties may fund in accordance with county needs to support employment in the Public Behavioral Health System:

- Workforce Recruitment, Development, Training, and Retention
- Professional Licensing and/or Certification Testing and Fees
- 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

Under MHSA, counties were required to submit a Workforce Needs Assessment every five years. Under BHSA, Counties will be required to report on workforce needs and strategy every three years as part of the Integrated Plan. Counties should align their strategy with statewide workforce goals and will be required to describe efforts to leverage, and not duplicate, available workforce investments, including BH-CONNECT. BHSA will not require a separate Workforce Needs Assessment beyond what is included in the Integrated Plan, and Counties will use planning dollars, as opposed to BHSS WET funding, to assess workforce needs as part of their Integrated Plan. Counties may, but are no longer required, to fund a WET Coordinator.

Capital Facilities and Technological Needs

Under BHSA, capital facilities and technological needs (CFTN) is included under the BHSS funding component and is no longer a separate component to be funded by transferring CSS funding. CFTN projects do not require a separate plan or proposal, and for restrictive setting projects, do not require the least restrictive settings demonstration. Under MHSA, to fund a restrictive setting project, counties are required to demonstrate that the needed services could not be performed in a less restrictive setting. Counties may use their CFTN funds as the required match for Bond BHCIP awards.

Technological needs projects should: 1) increase client and family empowerment and engagement by providing the tools for secure access to health information and 2) modernize and transform clinical and administrative information systems. These include:

- Electronic Health Record System Projects
- Client and Family Empowerment and Engagement Projects (including access to computing resources, personal health record system, and online information resource projects)
- Other Technological Needs Projects (including telemedicine and monitoring of new programs)

Capital facilities funds should be used for land and buildings, including administrative offices, which enable the county to meet objectives outlined in its Integrated Plan. Specific allowable uses include:

- Acquire and build upon land that will be county-owned
- Acquire, construct, or renovate buildings that are or will be county-owned
- Establish a capitalized repair/replacement reserve for buildings, including administrative offices, which enable the county to meet objectives outlined in its Integrated Plan and/or personnel cost directly associated with a capital facilities project
- Renovate buildings that are privately owned if the building is dedicated and used to provide behavioral health services
- Acquire facilities not secured to a foundation that is permanently affixed to the ground (i.e. buses, trailers, or recreational vehicles).

Innovative Pilots and Projects

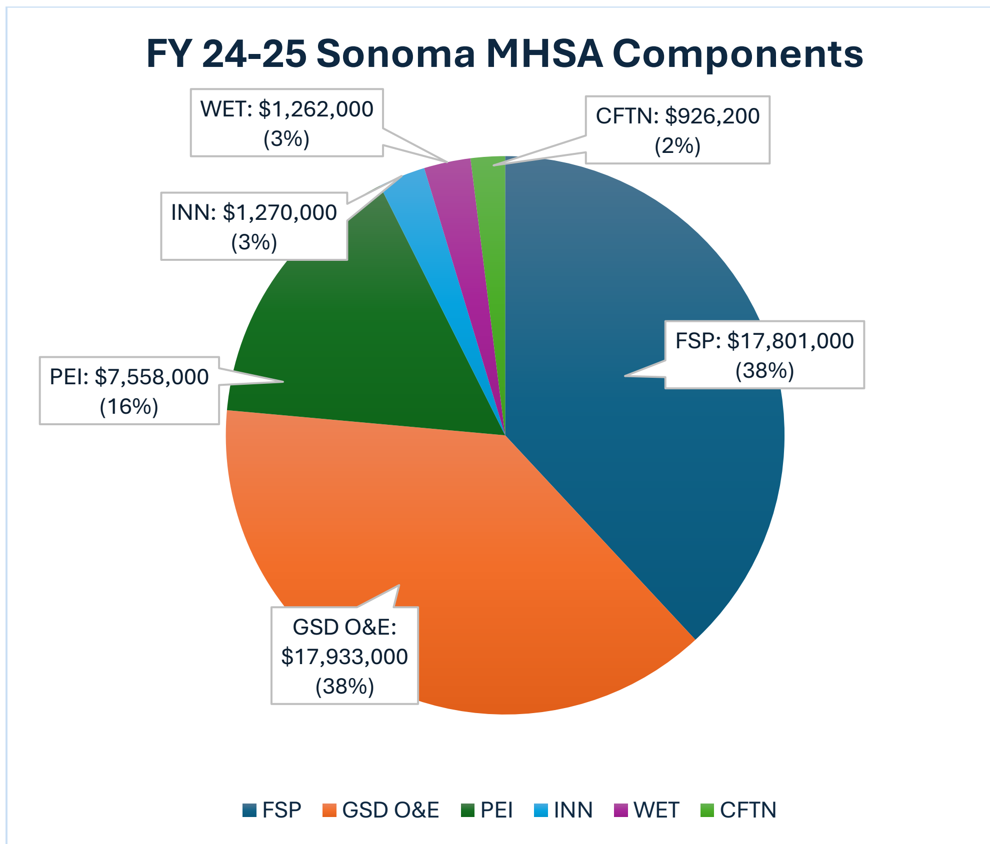
Under BHSA, counties may pilot and test innovative behavioral health models of care programs or innovative promising practices for programs in all funding components (BHSS, FSP, Housing Interventions). These innovative promising practices will be funded through each component. The goal of innovative pilots and projects is to build the evidence base

for the effectiveness of new statewide strategies. Innovative pilots and projects do not require a separate plan or approval. Pilots and projects will be subject to review as part of a County's Integrated Plan, Annual Update, and BHOATR.

Impacts on Sonoma's Systems of Care

The shift from MHSA to BHSA represents a pivotal moment in behavioral health funding. While the increased focus on housing is a positive development, the reduction in FSP funding and the decrease of CSS General System Development funds raises questions about long-term sustainability. Ensuring that services remain accessible and effective amidst these funding changes will be crucial for Sonoma County's behavioral health system.

Figure 2 FY 24-25 Sonoma County MHSA Components and Allocations

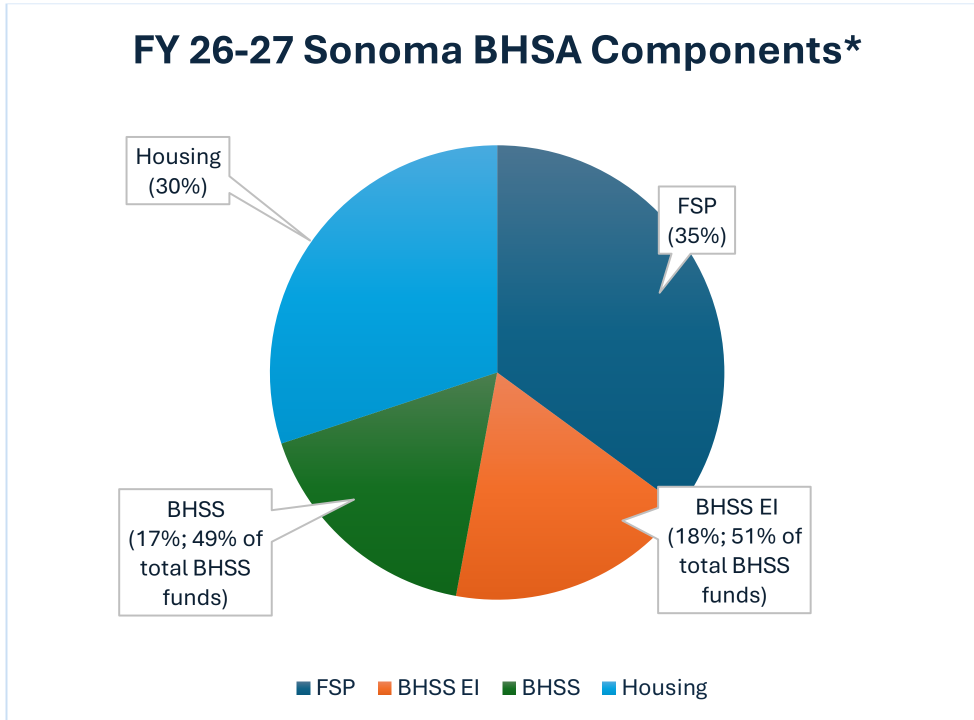


Sonoma County's FY 24-25 MHSA Expenditure plan is comprised of FSP, GSD O&E, PEI, INN, WET, and CFTN funds with a total of $46,750,200 and an estimated fund balance of $19,000,000 to be utilized under the FY 26-27 BHSA Component Allocations.[40] As

[40] Sonoma County's FY 24-25 MHSA Expenditure plan.

discussed throughout this report, the components required under BHSA do not wholly align with those required under MHSA. A smaller annual FSP budget (from 38% to 35%), the 51% reduction of CSS General Services Development, the removal of prevention services, and integration of housing dollars all pose challenges to be further assessed in the coming months in collaboration with key stakeholders.

Figure 3 FY 26-27 Sonoma County BHSA Components and Proposed Allocations



*Final expenditure amounts for Sonoma BHSA components will be determined based on projections for fiscal year 2026-2027.

Coordination with Local Initiatives

The implementation of BHSA must be coordinated with the roll out of other county initiatives that also seek to address systematic inequities and integrating systems of care. For example, the Sonoma County Agenda for Action[41], a collaborative, equity-focused initiative designed by Health Action Together and Equity First Consulting, calls on local governments, funders, and community partners to prioritize transformative investments in the County's most disinvested communities, specifically targeting the Bicentennial, Comstock, Roseland, and Sheppard neighborhoods. These communities, identified through the 2021 update of the *Portrait of Sonoma County*[42], have some of the lowest

[41] Health Action Together: Agenda for Action Report.
[42] The Portrait of Sonoma County.

Human Development Index (HDI) scores in the region, reflecting significant disparities in health, education, and income compared to the County average.

The agenda urges stakeholders to mobilize resources and implement culturally responsive, community-led solutions. The initiative emphasizes the necessity of addressing systemic disinvestment, structural violence, and community-level trauma to improve health outcomes, educational opportunities, and economic stability. It highlights the importance of dismantling racist policies and practices that perpetuate inequities and calls for sustainable, collaborative efforts to create equitable opportunities for all residents. The agenda outlines a five-year implementation plan beginning in 2025, which includes phases of foundation-building, pilot programming, scaling up successful initiatives, and institutionalizing long-term changes.

Community engagement is at the heart of the agenda. Through extensive listening sessions and participatory research, residents from the four target neighborhoods shared their lived experiences and identified key challenges. These include economic instability due to stagnant wages and soaring living costs, lack of affordable housing, inadequate mental health services, unsafe public spaces, and systemic racism in education, law enforcement, and social services. Residents also expressed the need for culturally and linguistically accessible resources, safe recreational spaces, and community hubs to foster collaboration, support, and resilience.[43]

The report identifies several core findings. It underscores how structural violence manifests in these neighborhoods through chronic stress, unaddressed mental health challenges, and a lack of safety, both in public spaces and within the home. It also highlights how disinvestment in infrastructure, transportation, and community services exacerbates economic instability and limits access to opportunities. Additionally, systemic racism and exclusionary policies further entrench these disparities, creating barriers to education, housing, and social services for communities of color.
To address these issues, the agenda proposes specific interventions tailored to each neighborhood, guided by the insights of local residents. It calls for the expansion of affordable, high-quality health services; investments in mental health care; improved educational and workforce development programs; and the creation of safe, functional public spaces.

Ultimately, the *Sonoma County Agenda for Action* and *Sonoma Community Health Improvement Plan*[44] serves as a blueprint for communicating with community in an inclusive and equitable way. By centering on the voices of those identified in the report to be most affected by systemic inequities, the Department can leverage targeted campaigns to communicate landscape changes under BHSA to the general public.

[43] Health Action Together: Agenda for Action Report.
[44] Sonoma County Community Health Assessment & Improvement Plan (2023).

Recommendations

- *Leveraging Key Stakeholders Throughout BHSA Transition.* To effectively advance behavioral health initiatives in Sonoma County, it is essential to actively engage the BHSA Stakeholder Committee and the BHSA Community Program Planning Subcommittee. This includes soliciting feedback through surveys and focus groups, ensuring that stakeholders have a meaningful role in shaping plans and recommendations. A Stakeholder Listening Session scheduled for May 7th, 2025 presents an important opportunity to gather additional insights and build consensus around these critical issues.

- *Understanding Intersection with Federal, State, and Local Initiatives.* Additionally, greater efforts should be made to understand the intersection of County Behavioral Health initiatives with other state programs, such as CalAIM and BH-CONNECT, as well as the potential implications of a change in federal administration on behavioral health dollars.

- *Exploring Options to Support Housing.* Within the Sonoma County Department of Health Services (DHS), leaders must focus on prioritizing funding for housing solutions tailored to individuals with behavioral health challenges, particularly those who are chronically unhoused or living in encampments. There is also a growing need for longer-term housing options specifically designed for behavioral health clients. To ensure a comprehensive approach, DHS should conduct a thorough assessment of existing housing programs and expenditures to identify gaps and opportunities for strategic investment.

- *Strengthening Early Intervention.* Additionally, early intervention strategies must be strengthened, recognizing that prevention programming may face funding limitations. This could impact both prevention and certain treatment programs, necessitating careful consideration of resource allocation.

- *Cultivating Workforce Development.* Another critical priority is workforce development, including hiring additional staff and providing necessary training in evidence-based practices (EBPs). Ensuring that the workforce is equipped with the skills and resources required to deliver high-quality care is essential for the long-term success of behavioral health initiatives such as BHSA.

- *Minimizing the Impacts of FSP and General System Development Cuts.* Furthermore, adjustments to the budget must be managed carefully to minimize adverse effects on treatment programs and service delivery.

- *Maximizing the Impact of Remaining MHSA Funds*. DHS should take special consideration of the opportunities presented by one-time rollover MHSA funds to help soothe the transition and loss of behavioral health programmatic funds.

- *Prioritizing Timely and Effective Communication with the Community*. As these transitions take place, it is imperative to develop a clear and effective communication strategy to keep all stakeholders informed. This includes direct outreach to DHS program staff, contracted providers, the Sonoma Board of Supervisors, and community members at large. Transparent and consistent communication will be essential in ensuring alignment, fostering trust, and maintaining momentum in achieving Sonoma County's behavioral health goals.

What's Next

Building on the insights of the high-level gap analysis, the Fiscal Year 2022-2025 tri-annual Capacity Assessment will further explore ways in ensure that Sonoma County has the necessary infrastructure, staffing, and resources to support BHSA's goals. Through extensive data collection, community engagement, and system mapping, the county can identify operational bottlenecks and service gaps. The final Capacity Assessment Report will provide actionable recommendations to enhance service delivery, workforce capacity, and system integration, ensuring that behavioral health services are effectively aligned with BHSA mandates.

Sonoma County Behavioral Health Services Act (BHSA) Implementation Plan

The transition from the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA) represents a significant policy shift. This implementation plan outlines Sonoma County's approach to ensuring a seamless transition while addressing key behavioral health challenges, including housing, workforce shortages, and service integration.

Objectives

1. Develop and execute a comprehensive communication and stakeholder engagement plan.
2. Ensure compliance with BHSA regulations and funding requirements.
3. Expand housing solutions for individuals with behavioral health challenges.
4. Strengthen workforce capacity to meet service demand.
5. Enhance early intervention strategies for at-risk populations.
6. Improve system-wide service coordination and integration.

Implementation Timeline

Phase 1: Planning & Assessment (January 2025 - June 2025)

- Conduct a comprehensive review of current MHSA programs and expenditures.
- Engage key stakeholders, including the BHSA Stakeholder Committee and the BHSA Community Program Planning Subcommittee.
- Align BHSA implementation with other state initiatives (e.g., CalAIM, BH-CONNECT).
- Identify housing program gaps and potential investment opportunities.
- Communicate BHSA expenditure plan outline with stakeholders.

Phase 2: Infrastructure & Capacity Building (July 2025 - June 2026)

- Launch workforce development initiatives, including training in evidence-based practices and recruitment efforts.
- Expand supportive housing options, leveraging Measure O and BHSA funds.
- Develop and implement culturally responsive behavioral health programs.
- Enhance early intervention services, with focus on youth and high-risk populations.
- Conduct RFPs for contracted service providers.

Phase 3: Full Implementation & Monitoring (July 2026 - June 2027)

- Implement new service models aligned with BHSA priorities.
- Monitor program performance and compliance with BHSA reporting requirements.
- Address emerging gaps through adaptive policy and funding adjustments.
- Maintain active community engagement and stakeholder communication.

Key Issue Areas & Strategies

Stakeholder Engagement & Communication

- Conduct public information campaigns to inform the community about BHSA changes.
- Host stakeholder forums, listening sessions, and advisory meetings.
- Establish feedback mechanisms to ensure continuous community input.

Housing & Homelessness Solutions

- Allocate at least 30% of BHSA funds to housing interventions.
- Expand permanent supportive housing for individuals with behavioral health needs.
- Strengthen partnerships with local housing authorities and service providers.

Workforce Development

- Implement recruitment incentives and professional development programs.

- Utilize state workforce initiatives to increase the supply of behavioral health professionals.
- Enhance diversity and cultural competency within the workforce.

Early Intervention & Prevention

- Develop targeted intervention programs for high-risk youth and families.
- Increase screening and referral processes for early detection of behavioral health conditions.
- Integrate behavioral health services into schools and community organizations.

Service Coordination & System Integration

- Strengthen collaboration among DHS, local health providers, and community organizations.
- Leverage technology to improve care coordination and streamline service delivery.
- Align funding streams and program priorities with state-level behavioral health initiatives.

Evaluation & Reporting

- Establish measurable outcomes to track progress in housing, workforce, and service delivery.
- Conduct annual reviews and adjust strategies as needed to align with BHSA goals.
- Submit required BHSA reports detailing financial allocations, program performance, and community impact.

Conclusion

Sonoma County stands at a critical point in transforming its behavioral health system. Through strategic planning, community engagement, and coordinated efforts, the county can successfully transition to BHSA while addressing key behavioral health needs and ensuring long-term sustainability of services.

Key Terms & Acronyms Index

1. **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)** – A state-led initiative aimed at improving access to and coordination of behavioral health services through technology and provider networks.
2. **Behavioral Health Division (BHD)** – The Sonoma County Department of Health Services' division responsible for managing mental health and substance use programs.
3. **Behavioral Health Services Act (BHSA)** – A 2024 policy initiative replacing the Mental Health Services Act (MHSA), shifting funding toward housing solutions and prioritizing services for individuals with severe behavioral health needs.
4. **Black, Indigenous, and People of Color (BIPOC)** – A term used to describe historically marginalized racial and ethnic groups, often the focus of targeted health equity efforts.
5. **California Advancing and Innovating Medi-Cal (CalAIM)** – A state initiative designed to reform Medi-Cal by integrating health and social services, particularly for individuals with complex needs, including behavioral health conditions.
6. **California Department of Health Care Services (DHCS)** – The state agency responsible for overseeing Medi-Cal and other public health initiatives, including the implementation of BHSA.
7. **California Department of Housing and Community Development (HCD)** – The state agency that manages housing-related funding, including Proposition 1 allocations for supportive housing.
8. **California Department of Public Health (CDPH)** – The state agency overseeing disease prevention, public health programs, and behavioral health initiatives.
9. **Capital Facilities and Technological Needs (CFTN)** – A funding category under MHSA and BHSA used for infrastructure improvements, such as clinic renovations and health technology upgrades.
10. **Community-Defined Evidence Practices (CDEP)** – Culturally responsive treatment approaches that address the unique needs of diverse populations, often complementing evidence-based practices.
11. **Community Health Assessment (CHA)** – A data-driven evaluation that identifies the health challenges and needs of Sonoma County residents, guiding local public health initiatives.
12. **Community Health Improvement Plan (CHIP)** – A strategic framework developed by Sonoma County to address public health disparities and improve access to healthcare and social services.
13. **Community Services and Supports (CSS)** – A major MHSA funding category that provided resources for direct mental health services and system development, now integrated into BHSA funding streams.

14. **Department of Health Services (DHS)** – The Sonoma County agency overseeing public health, behavioral health, and community health initiatives.
15. **Early Intervention (EI)** – Programs designed to identify and address mental health and substance use concerns before they become severe and disabling.
16. **Early Psychosis Intervention (EPI)** – Specialized mental health services aimed at identifying and treating early symptoms of psychosis to prevent long-term impairment.
17. **Enhanced Care Management (ECM)** – A CalAIM initiative that provides coordinated case management for individuals with complex medical, behavioral, and social needs.
18. **Full-Service Partnership (FSP)** – A comprehensive, community-based mental health program aimed at providing wraparound services to individuals with severe mental illness or serious emotional disturbances.
19. **General System Development (GSD)** – A funding category under MHSA and now BHSA that supports the improvement of mental health service infrastructure, workforce capacity, and program development to enhance access and quality of care for individuals with behavioral health needs.
20. **High Fidelity Wraparound (HFW)** – A team-based, person-centered planning process that provides comprehensive support for youth with complex behavioral health needs and their families. HFW focuses on building strengths, fostering community connections, and coordinating services to improve long-term outcomes.
21. **Human Development Index (HDI)** – A composite measure used to evaluate the well-being of a community based on factors such as life expectancy, education, and income.
22. **Innovation (INN) Programs** – MHSA-funded initiatives designed to test and evaluate new and innovative approaches to mental health service delivery.
23. **Mental Health Services Act (MHSA)** – A California law passed in 2004 under Proposition 63, which provided funding for mental health services through a 1% tax on high-income earners. It has been replaced by BHSA.
24. **Medication-Assisted Treatment (MAT)** – The use of medications, in combination with counseling and behavioral therapies, to treat substance use disorders, particularly opioid addiction.
25. **Notice of Funding Availability (NOFA)** – An official announcement issued by government agencies to solicit applications for grants and funding opportunities.
26. **Outreach and Engagement (O&E)** – Programs designed to connect underserved individuals with behavioral health services and provide education on available resources.
27. **Point-in-Time (PIT) Count** – An annual survey that estimates the number of individuals experiencing homelessness on a single night in January, helping communities track trends and allocate resources.
28. **Prevention and Early Intervention (PEI) Programs** – Programs that aim to reduce the risk of developing serious mental illness through early identification and intervention strategies.

29. **Substance Use Disorder (SUD)** – A medical condition characterized by the excessive use of substances such as drugs or alcohol, requiring treatment and rehabilitation services.
30. **U.S. Department of Housing and Urban Development (HUD)** – A federal agency providing funding and policy guidance for housing programs, including homelessness initiatives.
31. **Welfare and Institutions Code (WIC)** – The legal framework that governs California's public health and social services programs, including BHSA funding and requirements.
32. **Workforce Education and Training (WET)** – A program aimed at addressing workforce shortages in the behavioral health sector by providing training, scholarships, and loan repayment assistance.