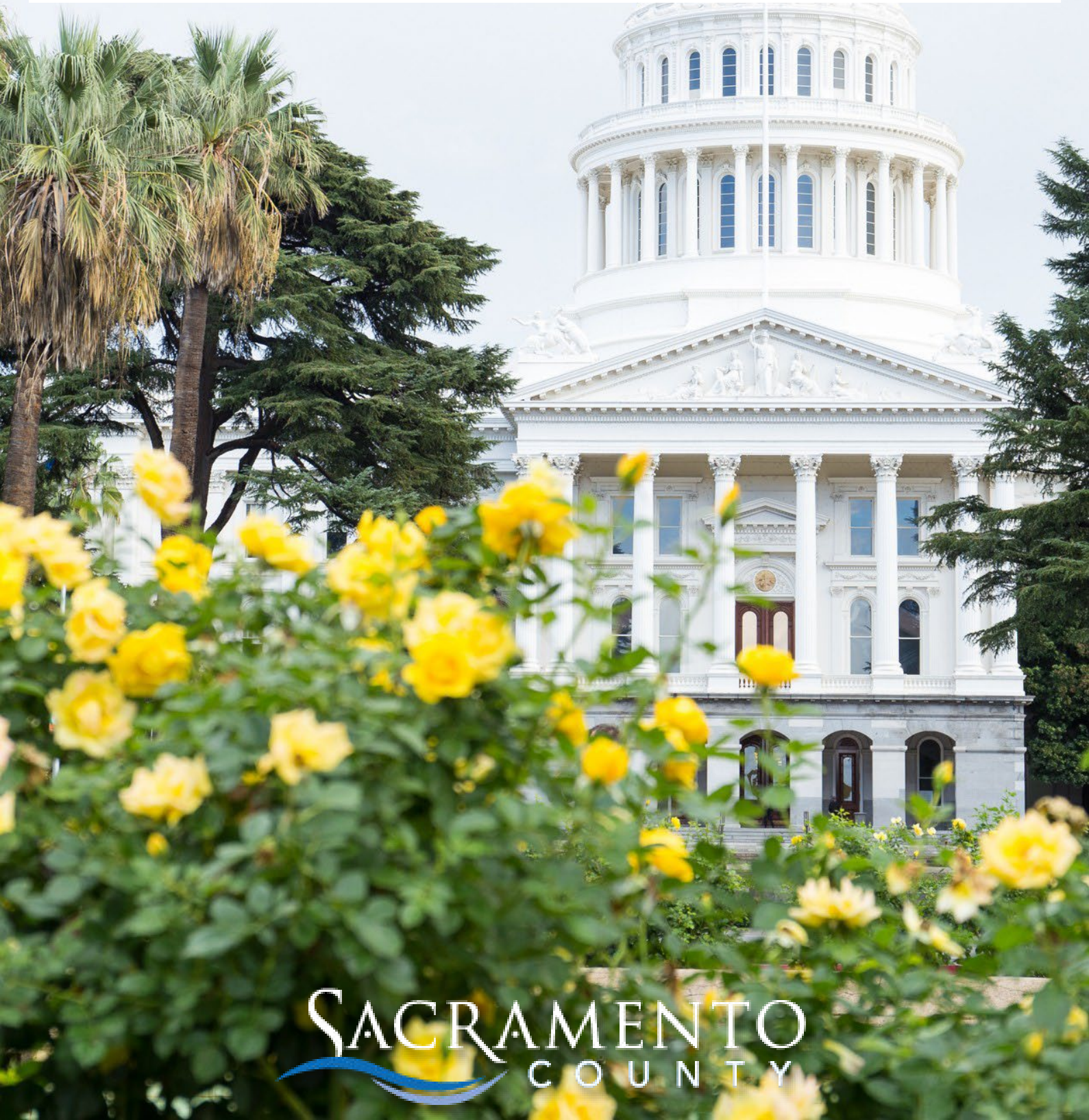
Behavioral Health Services Act Integrated Plan for Fiscal Years 2026 - 2029



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2026 - 2029 Integrated Plan

Sacramento County

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan .

General Information

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

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
County of Sacramento

Behavioral Health Agency Name
Sacramento County Department of Health Services, Behavioral Health Services

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County Behavioral Health System Overview

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

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

Populations Served by County Behavioral Health System

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

Children and Youth

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

Criteria	**Number of Children and Youth Under Age 21**
Received Medi-Cal Specialty Mental Health Services (SMHS)	10789
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	1179
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	399
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	229

Criteria	Number of Children and Youth Under Age 21
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	176
Were chronically homeless or experiencing homelessness or at risk of homelessness	358
Were in the juvenile justice system	951
Have reentered the community from a youth correctional facility	857
Were served by the Mental Health Plan and had an open child welfare case	1392
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	<11*

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	561

Adults and Older Adults

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

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	2910
Received Medi-Cal SMHS	18914
Received DMC or DMC-ODS services	5627
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	1467
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	4391

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	2500
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	924
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	546
Were in the justice system (on parole or probation and not currently incarcerated)	1589
Were incarcerated (including state prison and jail)	306
Reentered the community from state prison or county jail	3859
Received acute psychiatric services	3045

Input the number of persons in designated and approved facilities who were

Admitted or detained for 72-hour evaluation and treatment rate

10836

Admitted for 14-day and 30-day periods of intensive treatment
5637

Admitted for 180-day post certification intensive treatment
54

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
17

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
110

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
Yes

Please explain
For total population enrolled in DSH community solution projects, this includes individuals who are linked to our community based Department of State hospital Felony Incompetent to Stand Trial (IST) diversion program.

Please describe the local data used during the planning process
Local data used during the planning process drew from multiple quantitative and qualitative sources to ensure planning was responsive, equitable, and grounded in Sacramento County's unique demographics and service system realities. Data for this section were obtained from a range of local sources, including the County's Electronic Health Record (EHR), Full Service Partnership (FSP) Data Collection and Reporting (DCR) data, and SB 929 Involuntary Hold data, as well as other internal reporting and monitoring systems.
These data sources informed a comprehensive review of prior MHSA plans and annual updates, along with outcomes and utilization data across the behavioral health continuum. Population-level, demographic, and geographic indicators were analyzed to identify trends, service gaps, and priority populations, and to better understand disparities in access, service use, and outcomes—particularly among culturally and linguistically diverse communities, including refugee and immigrant populations.
The planning process was further informed by the County's Cultural Competency Plan, which provided essential guidance related to language access, cultural responsiveness, and the needs of emerging communities. Additional local inputs included community feedback gathered through community forums, surveys, and partner engagement, as well as internal program monitoring data and quality improvement

findings.
Together, these local data sources were used to validate community priorities, assess system strengths and gaps, and guide the development of strategies that are data-informed, culturally responsive, and aligned with both community input and system performance.

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

Local CARE Act Implementation

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

The County implements a range of service components designed to support CARE Court participants, including specialty mental health services, Full Service Partnerships, crisis response, substance use treatment, and CalAIM-aligned care coordination and housing supports. CARE participants receive priority access through expedited triage, dedicated Couty CARE Court Clinicians and Peers, and streamlined cross-system collaboration that ensures timely linkage to clinical treatment, case management, and housing resources. Specialized multidisciplinary teams provide individualized, field-based support, while formalized prioritization within residential treatment, interim housing like BHBH, and permanent supportive housing ensures that participants can rapidly obtain needed placements. CARE Court timelines and reporting structures are fully integrated into county workflows, enabling consistent monitoring, rapid response to changing needs, and specialized coordination across the broader behavioral health continuum, including housing when appropriate.

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

CARE referral pathways are fully integrated into Sacramento County's existing behavioral health referral and service infrastructure by leveraging the county's established BHS-SAC, outreach, crisis, housing, and outpatient systems to coordinate timely engagement and linkage. When individuals enter through the CARE process, staff utilize existing referral workflows—including connections to Full-Service Partnerships, behavioral health linkages via Homeless Engagement and Response Team, interim housing via BHBH, and other specialty mental health and substance use programs—to ensure seamless movement across the continuum of care. These pathways support early identification, rapid stabilization, and ongoing service coordination regardless of whether a CARE petition is filed, accepted, or ultimately pursued. By embedding CARE activities within existing access, triage, and service-delivery structures, Sacramento County enhances continuity of care, reduces fragmentation, and ensures that individuals experience a unified behavioral

health system rather than a separate or parallel process.

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

When individuals are screened and appear potentially eligible for CARE but a formal petition is not required or appropriate, Sacramento County redirects them to the most suitable behavioral health or housing pathway using existing BHS-SAC, outreach, crisis, and Full-Service Partnership (FSP) referral workflows through the Intensive Placement Team. Staff assess clinical presentation, level of care needs, risk factors, engagement readiness, and immediate stabilization or housing needs to determine whether connection to outpatient services, FSPs, CORE outreach, mobile crisis response, or housing navigation and stabilization resources is the most appropriate alternative. Staff evaluate clinical needs, level of care, willingness to engage, and immediate stabilization or housing needs to determine whether linkage to outpatient services, FSPs, mobile crisis response, CORE outreach, or housing navigation is the most appropriate alternative. For individuals redirected from CARE, the County confirms and documents successful linkage using established SmartCare documentation processes and care coordination protocols. This includes recording referral details, provider acceptance, warm handoffs, and follow up contacts to verify that the individual has engaged with the receiving program. Staff maintain ongoing communication with partnering providers to ensure the referral results in active service connection, supporting continuity of care and reducing the likelihood of service gaps across the behavioral health system.

County Behavioral Health Technical Infrastructure

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

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

Yes

Please select which of the following EHRs the county uses

SmartCare

County participates in a Qualified Health Information Organization (QHIO)?
Yes

Please select which QHIO the county participates in
Connex

Application Programming Interface Information

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

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://dhs.saccounty.gov/BHS/BHS-EHR/Documents/Sacramento%20County%20-%20Accessing%20Member%20Health%20Information.pdf

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

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

County Behavioral Health System Service Delivery Landscape

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

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

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?
Yes

Please select all services the county behavioral health system plans to provide under the PATH grant
Community Mental Health Services
Habilitation and Rehabilitation Services
Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services
Outreach services
Staff Training, including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services
Case Management Services

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

Community Mental Health Services Block Grant (MHBG)

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

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

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

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

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

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

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

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?
Yes

Please check all set asides the county behavioral health system participates in under OSF Exhibit E
Address The Needs of Criminal Justice-Involved Persons
Connect People Who Need Help to The Help They Need (Connections to Care)
Leadership, Planning, and Coordination
Prevent Misuse of Opioids
Prevent Overdose Deaths and Other Harms (Harm Reduction)
Support People in Treatment and Recovery
Treat Opioid Use Disorder (OUD)

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

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).
a. Case Management
b. Comprehensive Evaluation and Assessment
c. Group Services
d. Individual Service Plan
e. Medication Education and Management
f. Pre-crisis and Crisis Services
g. Rehabilitation and Support Services
h. Residential Services
i. Services for Homeless Persons
j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:
Other Programs and Services

Please describe
All Sacramento County 1991 Realignment is supporting inpatient services in the current budget.

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

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)

a. Drug Courts
b. Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
c. Regular and Perinatal Drug Medi-Cal Services
d. Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
e. Regular and Perinatal Non-Drug Medi-Cal Services

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

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).
a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services
j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management
m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21
q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21
s. Therapeutic Behavioral Services for individuals under the age of 21
t. Therapeutic Foster Care for individuals under the age of 21
u. All Other Medically Necessary SMHS for individuals under the age of 21

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?

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

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

No

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

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

Drug Medi-Cal Organized Delivery System (DMC-ODS)
The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition). (no action required)
a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
f. Mobile Crisis Services
g. Recovery Services
h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
i. Traditional Healers and Natural Helpers
j. Withdrawal Management Services
k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21
l. Early Intervention for individuals under age 21

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

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

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs

Program or service
Substance Treatment Enrichment Program (STEP), funded by SAMHSA grant, is designed to provide comprehensive, evidence-based services for court-involved individuals with DUI offenses & co-occurring mental health conditions. It emphasizes whole-person care through an integrated approach that includes: 1. Individualized Treatment Plans- address substance use & mental health needs. 2. Drug Testing & Monitoring - to support accountability & recovery. 3. Case Management Services- ensuring coordination of care & access to resources. 4. Peer Support -to foster engagement & sustained recovery. 5. Family Engagement Activities- to strengthen support systems & promote long-term success. 6. Comprehensive Behavioral Health Services- addressing substance use & mental health challenges. 7. Sober Living Housing -to provide a stable, recovery-oriented environment. 8. Aims to reduce recidivism, improve health outcomes, & enhance community safety by delivering holistic, person-centered care.

Care Transitions

Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services **(Adult and Youth)?**

Yes

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

Yes

Statewide Behavioral Health Goals

All fields must be completed unless marked as optional. You don't need to finish everything at once-your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to, please see 3.E.6 Statewide behavioral health goals

Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C.

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories.

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

Mark page as complete

Priority statewide behavioral health goals for improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County. For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Access to care: Primary measures

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

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

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

Access to care: Supplemental Measures

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

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

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

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
For both adults and children in the SMHS, Sacramento County has a lower penetration rate compared to the Statewide Rate and Median. Adults are over 1% lower, and children are just under 1% lower than the Statewide Median. The DMC-ODS penetration is slightly below the Statewide Rate and Median, at 0.3% lower than the median, while the children's penetration rate matches the median. In regards to Initiation of Substance Use Disorder Treatment, Sacramento County is almost 8% higher than the Statewide Rate and over 10% higher than the Median.

Regarding SMHS penetration rates for children, we have noted that certain zip codes are more vulnerable to suicide attempts, poverty, housing instability/homelessness, child deaths, and CPS calls, and have areas with large Medi-Cal–eligible populations. As a result, we are rolling out targeted outreach campaigns that started in January 2025 and that we are incorporating into our upcoming procurements.

Regarding SMHS penetration rates for adults, Sacramento County has CORE sites regionally located across

the County with outreach workers to improve access to care. BHS-SAC Integration has integrated its team to provide a more seamless initial experience for individuals seeking mental health or substance use services. It strengthened its approach to working with individuals by ensuring that all clinical staff are dually trained to administer both mental health (DHCS Screening Tools: Youth and Adults) and substance use service screening tools (BQuIP). The program has also strategically worked with internal and external partners to ensure staff are knowledgeable about the unique challenges faced by individuals seeking mental health and substance use needs to ensure they are adequately linked to the right level of care. This integrated approach has ensured a more coordinated, responsive and timely response to services, thus eliminating initial barriers to access to care.

Penetration rates for FY 23/24 for BHS indicate Asian/Pacific Islanders are highly underrepresented in both mental heath and substance use services compared to the general Medi-Cal eligible population, at a rate of 1.8% for mental health and 0.2% for substance use compared to the overall penetration rate (3.9% for mental health and 0.9% for substance use). Disparities are also present in penetration rates measured by primary language, with penetration rates for mental health services lower in all non-English threshold languages compared to English, ranging from 0.6% (Russian) to 2.0% (Hmong) compared to 4.7% for English. The same disparity is present in substance use services, ranging from less than 0.01% (Vietnamese, Cantonese, Farsi, Arabic) to 0.4% (Hmong), compared to 1.1% for English.

The Behavioral Health Racial Equity Collaborative (BHREC) was established to address behavioral health inequities rooted in systemic racism and social determinants of health that disproportionately affect Black and Hispanic communities. Through a targeted universalism approach, BHREC partnered with B/AA/AD community members to co-design the County's first Racial Equity Action Plans (REAPs), informed by surveys, focus groups, and analysis of local and state data. This early work built trust, strengthened authentic partnerships, and developed shared goals between BHS, providers, and community leaders.

Following the conclusion of the B/AA/AD pilot in 2022, BHS continued implementation through the internal BHREC AA/B/AD workgroup to refine, track, and advance the REAP objectives across BHS systems. Building on the success of the AA/B/AD work, BHREC expanded to include the Latino/Latinx/Latine/Hispanic community after data revealed low utilization of mental health and SUD services despite representing a large portion of Sacramento County's population. This expansion included new learning collaboratives, a bilingual Steering Committee structure, and community-driven relationship-building strategies aimed at improving cultural alignment, increasing access, and reducing inequities in care. Across both populations, BHREC's accomplishments include increased trust between BHS and community partners, clearer equity goals, more culturally responsive practices, and the integration of racial-equity-focused committees into the broader BHS Cultural Competence and Quality Improvement structures.

The ROOM for Dads program was created through the Family Treatment Drug Court to expand access to gender-specific, trauma-informed substance use disorder (SUD) treatment for fathers involved in the child welfare and dependency court system. The program integrates evidence-based curricula—including

Helping Men Recover, Living in Balance, Hazelden H.E.L.P., and Celebrating Families!—to address male-specific trauma, socialization, parenting skills, and co-occurring behavioral health needs. Its core purpose is to improve father engagement in treatment, reduce barriers to participation, and increase family reunification outcomes. As part of the program expansion, gender-specific recovery housing for fathers is designed to remove barriers historically faced by men in treatment. These recovery residences provide sober housing aligned with treatment participation, offering structured support, relapse-prevention skills, peer accountability, and father-centered programming. Housing was specifically added to ensure that fathers—who often lacked access to child-friendly or male-specific recovery environments—could stabilize, participate fully in treatment, and strengthen family functioning. The recovery housing model complements outpatient and intensive outpatient services, forming a continuum that supports fathers from early recovery through reunification.

Access to care: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

BHS utilized a combination of local Child Welfare, behavioral health, epidemiologic, and internal performance datasets to identify needs across Sacramento County and to inform the development and refinement of programs serving children, youth, families, perinatal individuals, and justice involved populations. Data from Child Safety Forward Sacramento (Applied Survey Research, January 2026) documented 180 child abuse and neglect deaths or critical injuries between 2009–2022. Although fatalities declined slightly, critical injuries increased, signaling that families are reaching crisis points before stabilization services are accessed. Children ages 0–5 comprised 81% of cases, with infants representing the largest proportion (38%). Substantial racial disproportionality was present: Black/African American children represented 37% of cases while comprising 9% of the population, and Native American children represented 3% of cases but only 0.3% of the county population. Additionally, 76% of affected families had prior Child Welfare contact, indicating that system involvement did not consistently result in behavioral health connection. Nearly 60% of incidents clustered in high need ZIP codes including 95823, 95828, 95822, 95824, 95821, 95608, 95825, 95838, 95815, 95842, 95841, 95833, and 95660, with parental mental health and substance use serving as prevalent contributing factors.

Internal CWS analyses (FY 2022–23) further identified pronounced disparities: Black youth ages 6 and older were disproportionately represented at all stages of CPS involvement, with ZIP code 95823 ranking first

across every category. Recurrent high need ZIP codes (95823, 95838, 95670, 95828, 95608, 95815, 95824, 95822, 95843) aligned with CCWIP findings that infants had investigation rates of 56–60 per 1,000—more than double rates for school aged children. BHS syndromic surveillance data (2016–2023) identified suicide as the third leading cause of death among youth ages 10–24. Ages 14–17 had the highest rates of non fatal ED treated suicide attempts, male youth were disproportionately represented in fatal attempts, and Multiracial, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander youth were overrepresented. ZIP codes 95823, 95828, and 95608 showed the highest concentrations of youth suicide attempts, overlapping with CPS hotspots.

These data collectively informed the structure and implementation requirements for ATLAS (MHC/039), launching July 1, 2026. ATLAS requires contractors to operate hub clinics in priority ZIP codes—95608, 95660, 95670, 95815, 95821, 95822, 95823, 95824, 95825, 95828, 95833, 95838, 95842, and 95843—and to co locate with trusted community partners while maintaining countywide responsibility. ATLAS provides the full array of children's SMHS, integrated SUD treatment for co occurring needs, BHSA funded Early Intervention, and MH MAA outreach, reducing geographic and structural barriers. The model embeds integrated SUD treatment within SMHS to ensure youth receive coordinated, whole person care through a single entry point.

For justice involved youth, FSPW (MHC/037) requires service delivery within the Youth Detention Facility and active discharge planning for reentry. The CalAIM Justice Involved initiative activates Medi Cal coverage 90 days pre release, enabling earlier service engagement and reducing gaps. Across the broader system, BHS is expanding walk in assessment availability, strengthening integration through BHS SAC, and sustaining 24/7 mobile crisis response via the Community Wellness Response Team. Provider contracts beginning FY 2026–27 incorporate performance based financial incentives tied to HEDIS measures—including ED follow up for mental illness and SUD—with outcomes tracked through continuous quality improvement.

The Healthy Beginnings Perinatal Program (HBPP), launching July 1, 2026, creates a trauma informed, family centered continuum for pregnant and postpartum individuals affected by SUD. The program aims to advance birth equity, improve early identification and engagement, and integrate behavioral health, clinical, social, and maternal/infant supports—addressing populations that experience persistent disparities.

Local performance data identified a critical service gap: the absence of SUD residential beds for adolescent males. This gap contributes to long wait times, unmet need, out of county placements, and increased crisis service utilization. The new youth residential program will provide trauma informed, evidence based SUD treatment (MI, CBT SUD, family interventions), educational and recreational services, peer support, and coordinated discharge planning. The program is expected to improve timely access, continuity of care, and long term recovery outcomes.

BHS SUPT teams are advancing countywide fentanyl response initiatives emphasizing early identification,

screening, assessment, and treatment linkage. SUPT conducts in custody SUD screenings and assessments, coordinating with jail partners, Probation, Public Defenders, and clinical staff to determine appropriate levels of care and ensure warm handoffs to community providers upon release.

The BHS SAC team has strengthened access to care through hiring additional clinicians, resulting in referral processing within 0–2 business days; training staff to process both MH and SUD requests; implementing monthly workflow huddles; developing enhanced procedures with internal/external partners; ensuring crisis, SUD, MH, justice involved, and specialty service training for frontline staff; collaborating quarterly with MCPs; and working closely with Kaiser Permanente to streamline referrals across systems.

SUPT tracks BQuIP screenings and outreach attempts across regional CORE Sites, which include on site outreach workers and Senior Mental Health Counselors who coordinate with partners to support timely and appropriate linkage to care. These efforts have strengthened system responsiveness and reduced initial barriers. Additionally, two mobile harm reduction programs provide outreach to vulnerable populations, immediate MAT services, and connection to SUD treatment.

Penetration and access data from DAT show Sacramento County remains below statewide averages for Adult Access to Care/Penetration Rates, and for Adult, Older Adult, and Youth DMC ODS penetration rates. These findings underscore the need for expanded access points, integrated service delivery, enhanced provider accountability, and ongoing system improvement—needs addressed through the strategies outlined above.

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

BHSA Behavioral Health Services and Supports (BHSS)
BHSA Full Services Partnership (FSP)
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
Substance Abuse and Mental Health Services Administration(SAMHSA) Projects for Assistance in Transition from Homelessness(PATH)
Community Mental Health Block Grant (MHBG)
Substance Use Block Grant (SUBG)

Homelessness: Primary measures

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

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

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

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

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

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

Homelessness: Supplemental Measures

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

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

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

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

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

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

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

How does your local CoC's rate compare to the average rate across all CoCs?
Below

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

Homelessness: Disparities Analysis

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

According to the 2024 Point-in-Time (PIT) Count conducted by Sacramento Steps Forward, an estimated 6,615 people were experiencing homelessness in Sacramento County, a 28.7% decrease from the 2022 count, reflecting the impact of sustained investments in shelter and housing. Sacramento County's homelessness rate of 41.8 remains below both the statewide rate of 48.0 and the statewide median of 42.7. For individuals with serious mental illness (SMI), Sacramento County's rate of 5.2% is substantially below the statewide rate of 11.5% and the statewide median of 9.8%. For those with substance use disorders, Sacramento County's rate is 8 percentage points below the statewide rate and 6.2 percentage points below the median.

Despite these comparatively favorable aggregate rates, significant racial and ethnic disparities persist within Sacramento County's homeless population. The 2024 PIT Count found that Black/African American individuals represented 33–35% of the homeless population while comprising approximately 9% of the

county's general population, making Black individuals 3.7 times more likely to experience homelessness than the average Sacramentan. This overrepresentation has worsened since 2022, when Black individuals represented 31% of the homeless population, and exceeds the statewide average of 26% for Black individuals experiencing homelessness. Nearly 60% of homeless individuals in households with children were Black, reflecting particularly acute disparities for Black families. American Indian/Alaska Native individuals, while representing approximately 0.3% of the county population, represented 2% of the homeless population and are 5.6 times more likely to experience homelessness than the average Sacramentan. Hispanic/Latino individuals represented 15% of the homeless population. By gender, males accounted for the majority of the homeless population.

The 2024 PIT Count also found that 46.9% of adults experiencing homelessness reported a serious mental illness and 31.6% reported a substance use disorder, underscoring the deep intersection between behavioral health needs and housing instability, and the critical role of behavioral health services in both preventing and resolving homelessness.

Homelessness: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

BHS is implementing targeted behavioral health and housing stabilization initiatives to reduce homelessness among individuals experiencing severe mental illness and/or severe substance use disorder. These efforts are informed by PIT Count findings describing population-level disparities and by Homeless Management Information System (HMIS) analyses identifying geographic concentrations of homelessness and service gaps, particularly in ZIP codes 95838 and 95823. The 2024 PIT Count demonstrates that behavioral health needs are prevalent among people experiencing homelessness in Sacramento County. Patterns in the PIT count indicate persistent barriers to accessing and sustaining engagement in traditional behavioral health services and directly inform the County's planned focus on unsheltered populations with complex needs.

The PIT Count also identifies pronounced racial disparities. African American residents are substantially over-represented among people experiencing homelessness compared to their share of the county's general population and are disproportionately represented among unsheltered adults. These disparities

are mirrored in high-need areas such as ZIP codes 95838 and 95823, reinforcing the need for culturally responsive approaches that address both behavioral health needs and structural inequities. While PIT data describe population characteristics, HMIS analyses identified ZIP codes 95838 and 95823 as having among the highest concentrations of homelessness. In response, the County is implementing initiatives in both ZIP codes that deliver community-defined, culturally rooted specialty mental health services. These initiatives emphasize peer-led engagement, integration of behavioral health treatment with housing navigation, and flexible supports to reduce barriers to housing stability. All participants will be tracked through HMIS and behavioral health data systems to monitor reductions in unsheltered homelessness and returns to homelessness.

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

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
Other

Please describe other

MHSA Innovation

Institutionalization

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

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

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

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

14-day involuntary detention rates per 10,000
Above

30-day involuntary detention rates per 10,000
Above

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

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

Conservatorships, FY 2021 - 2022

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

Temporary Conservatorships
Below

Permanent Conservatorships
Below

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

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023
Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

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

Crisis Intervention

For adults/older adults
Below

For children/youth
Below

Crisis Residential Treatment Services

For adults/older adults
Above

For children/youth
Above

Crisis Stabilization

For adults/older adults
Same

For children/youth
Above

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

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Sacramento County exhibits a notably lower incidence of crisis intervention services. However, the provision of crisis stabilization services is higher for both adults and children in this region. Adults receiving Crisis Residential services have an average of 23.3 days of service, surpassing the Statewide Rate of 22.8 days and the Statewide Median of 22.7 days. Similarly, children averaged 23.7 days of service, compared to the Statewide Rate of 21.6 days and the Statewide Median of 19.5 days.

FY 23/24 data was analyzed utilizing the County Electronic Health record based on services provided. Regarding youth, there were no significant differences in the number of youth served in crisis compared to outpatient. Adults show slight differences, with African Americans utilizing crisis services at a slightly higher rate compared to outpatient (24.3% crisis vs 23.4% outpatient). No other significant disparities were seen for clients served within Sacramento County BHS.

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)
In March 2022, Sacramento County Department of Health Services (DHS) obtained an evaluation report

from the RAND Corporation analyzing California's shortfall in adult psychiatric bed capacity. The report highlighted significant shortages in subacute and community residential beds in Sacramento County, resulting in longer wait times and extended stays for hard-to-place populations (e.g., individuals with prior convictions). DHS contracted RAND for a follow-up analysis specifically focusing on Sacramento County, including Substance Use Disorder (SUD) beds. The report estimated a shortfall of 146 adult SUD beds in Sacramento County, placing it below the state average (12.0 beds per 100,000 adults) and the national average (8.5 beds per 100,000 adults). It was recommended to focus on beds available for Sacramento County residents, including Medi-Cal recipients, with additional beds designed to reach high-needs populations currently being missed. In response to that study, Sacramento County BHS has expanded our subacute continuum, including MHRC beds and continue to have capacity in our acute facilities – creating flow for those in need of acute and subacute services in order to further stabilize before stepping down to the community. BHS tracks the number of individuals in subacute services at any point in time as well as how many individuals and days in these facilities for the FY.

File Upload

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

Day Treatment Intensive (DTI) is expected to go live in early summer 2026, filling a critical gap for teens stepping down from or diverting from psychiatric hospitalization. Without DTI, youth face a stark choice between outpatient services and residential placement with nothing in between. DTI will provide structured treatment 3–5 days per week to stabilize functioning related to a mental health condition.

Beginning July 1, 2026, Sacramento County continues to invest in intensive, field-based models delivering multidisciplinary care in homes and communities to reduce reliance on inpatient and congregate care settings.

Sacramento County's decision to expand and restructure its Full Service Partnership continuum for youth is directly informed by data demonstrating that populations most at risk of institutionalization are concentrated in specific geographic and demographic groups. Internal syndromic surveillance data (2016–2023) shows suicide is the third leading cause of death among youth ages 10–24, with youth 14–17 having the highest non-fatal attempt rates treated in county EDs. Male youth have disproportionately higher fatal outcomes, and Multiracial, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander youth are overrepresented in fatal attempts. Internal EHR data for FY 2023/24 documents that African

American youth represent 36.5% of children in justice-involved settings compared to 20.7% in outpatient services, signaling that Black youth are disproportionately escalating to higher levels of care. CCWIP and internal CWS/CMS analysis confirms that ZIP codes with the highest CPS involvement are the same communities producing the highest rates of youth justice involvement and psychiatric crisis, indicating insufficient access to intensive community-based services is a primary driver of institutionalization.

In direct response, FSPW (MHC/037), launching early fall 2026, integrates High Fidelity Wraparound (HFW) into the FSP continuum for youth under 21 and their caregivers. Currently wraparound is limited to child welfare dependents; under FSPW it expands to any youth with high-intensity outpatient needs, designed to stabilize youth in their homes before escalation to residential or inpatient settings becomes necessary. The overrepresentation of African American youth in justice-involved settings, combined with the geographic concentration of suicide attempts and CPS involvement in ZIP codes 95823, 95828, 95838, and 95608, informed the requirement for FSPW contractors to serve these communities and extend HFW eligibility beyond the dependent population.

Sacramento County is also adding Multi-Systemic Therapy (MST) to the FSP continuum through FSPW. MST is an intensive, home- and community-based model for youth with serious behavioral challenges at risk of placement, justice involvement, or school failure, working simultaneously with family, school, and broader environment. MST is short-term (3–5 months), highly structured, and accountability-driven, with therapists available 24/7. The decision to add MST was informed by elevated youth arrest rates in Sacramento County (405.3 per 100,000, exceeding the statewide rate of 371.5 and median of 394.8), the overrepresentation of Black youth in justice settings, and the YDF average daily census declining from 235 in 2010 to 125 in 2025, reflecting diversion impact and creating capacity to serve youth earlier before institutional placement becomes necessary.

Suicide prevention remains a core institutionalization-reduction strategy. Financial incentives initiated in FY 2025–26 tied to suicide risk assessment and post-crisis care will continue and expand in FY 2026–27, informed by surveillance data showing youth 14–17 have the highest ED-treated attempt rates and that ZIP codes 95823, 95828, and 95608 have the highest concentrations of youth suicide attempts and deaths. Incentives require evidence-based risk assessment practices, written policies for ongoing care of at-risk youth, annual staff training and competency assessments, and guidelines for reassessment, safety planning, and monitoring.

In February, 2026, CWRT received 272 calls, with the112 needing an in-person response. Of those, 38% of the crises were resolved in the community and 28% were linked to needed services, such as medical, or psychiatric services.

This new youth residential program directly addresses a longstanding service gap. At present, the County has no dedicated SUD residential beds for adolescent males, resulting in high rates of unmet need, prolonged wait times, frequent out-of-county placements, and an overreliance on acute/crisis services.

Local performance measures confirm that youth SUD treatment access and early engagement fall below statewide averages, with families reporting significant barriers related to availability, transportation, care coordination, and culturally responsive services. This program will offer trauma-informed and evidence-based SUD treatment (including Motivational Interviewing, CBT-SUD, and family-based interventions), educational and recreational programming, peer support, and coordinated discharge planning. By expanding the continuum to include residential care for adolescent males, the County anticipates substantial improvements in timely access to treatment, continuity of care, and long-term recovery outcomes.

Sacramento County's Substance Use Prevention & Treatment (SUPT) continues to implement service expansions and data-informed strategies to reduce institutionalization, increase access to community-based care, and improve outcomes among populations whose performance measures fall below statewide averages. SUPT's improvements reflect review of utilization patterns, CalOMS data, HEDIS measures, program feedback, community input, and outcomes specific to priority sub-populations (e.g., Southeast Asian communities, older adults).

SUPT is strengthening crisis response pathways through enhanced coordination and documentation standards within the EHR (transition from Avatar to SmartCare). The underlying policy and P&P redesign efforts are actively underway across multiple administrative and treatment areas. These efforts ensure timeliness, continuity of care, and proper level-of-care placement.

SUPT is expanding perinatal treatment capacity with a focus on enhancing access, engagement, and retention. This initiative aims to:
- Increase early identification and engagement during pregnancy.
- Reduce crises and institutional care through integrated care pathways.
- Improve culturally responsive perinatal SUD services

SUPT continues to refine the implementation of flexible housing and support funds (Flex Pool), used to prevent homelessness and housing instability—both major contributors to institutionalization risk.

SUPT is focusing on areas where performance indicators show lower-than-statewide outcomes, such as:
- Initial access to care
- Continuity of care
- Treatment completion rates
- Early identification for high-risk populations
- Housing stability and social determinants

The Healthy Beginnings Perinatal Program was created to address significant unmet needs among pregnant and postpartum individuals with substance use disorders. Sacramento County identified long-standing gaps in coordinated perinatal SUD care, including limited trauma-informed services,

inconsistent transitions between pregnancy and postpartum supports, and fragmented collaboration across hospitals, MCPs, CPS, and behavioral health. State feedback emphasized that existing systems lacked the specificity and integrated design required to meet the unique and complex needs of this population, particularly around continuity of care and transitional supports. HBPP was developed to fill these gaps by creating a unified, cross-agency continuum that aligns with updated DHCS Transitional Care Services and Perinatal Practice Guidelines.

Additionally, the RAND Study data was used to determine additional need for SUD residential treatment beds. Based on that data, BHS SUPT is planning and preparing for additional residential and withdrawal management beds to reduce hospitalizations. We have 3 contracted providers who are projected to add approximately 320 more beds over the next two fiscal years.

File Upload

Please identify the category or categories of funding that the county is using to address the institutionalization goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Justice-Involvement: Primary Measures

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

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

For adults/older adults
Above

For juveniles
Above

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

Justice-Involvement: Supplemental Measures

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

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

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

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023
Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

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

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

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Sacramento County's adult arrest rate is slightly higher than the Statewide Rate but lower than the Median (2,459.1 vs 2,440.2 vs 2,645.8). Children's arrest rates exceed both the Statewide Rate and Median (405.3 vs 371.5 vs 394.8). Adult recidivism rates are almost 2 percentage points higher than the Statewide Rate and Median. The rate of incompetent to stand trial is 1.1 percentage points above the Statewide Rate but 2.3

percentage points below the Median (percentage points reflect the direct difference between two rates).

FY 23/24 data was analyzed utilizing the County Electronic Health record based on services provided. There were significant disparities seen in the justice involved population compared to the clients served in outpatient. African Americans are highly overrepresented in justice involved vs outpatient, with 36.5% of children and 29.6% of adults served in justice settings vs overall 20.7% of youth and 23.4% of adults. No other significant disparities were seen for clients served within Sacramento County BHS.

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Sacramento County's strategies to reduce justice involvement for individuals with behavioral health needs are informed by data demonstrating persistent racial disparities and geographic concentration of risk, operationalized through procurement requirements, cross-system partnerships, and evidence-based programs.

Internal EHR data for FY 2023/24 documents significant racial disparities in the justice-involved population. African American youth represent 36.5% of children in justice-involved settings compared to 20.7% in outpatient services; African American adults represent 29.6% of adults in justice-involved settings compared to 23.4% in outpatient. CCWIP and internal CWS/CMS analysis confirms that ZIP codes with the highest CPS involvement—95823, 95838, 95670, 95828, 95608, 95815, 95822, 95824, and 95843—also show elevated youth justice involvement, confirming that limited access to community-based behavioral health services in these communities drives escalation into law enforcement contact rather than early intervention.

Sacramento County's children's arrest rate (405.3 per 100,000) exceeds both the statewide rate (371.5) and median (394.8), reinforcing the urgency of targeted intervention. In response, ATLAS (MHC/039), launching July 1, 2026, requires contractors to establish hub clinic sites co-located with trusted community partners in the fourteen highest-need ZIP codes, directly targeting communities where data shows the greatest concentration of youth justice risk and designed to divert youth from justice pathways before escalation to law enforcement contact.

For youth who are already justice-involved, Sacramento County maintains an active behavioral health presence within the Youth Detention Facility (YDF). Since July 2023, the county-operated SacCo-YDF program has served 3,534 youth across 19,559 service encounters delivered by 69 clinicians, with 104 youth currently enrolled. The YDF average daily census has declined from 235 in 2010 to 125 in 2025, reflecting both juvenile justice trends and the impact of diversion and community-based alternatives. The YDF serves general population prejudicated youth and VOYA-adjudicated youth ages 14–25. Dominant clinical presentations include Disruptive and Impulse Control disorders, Trauma and Stressor-Related disorders, and Neurodevelopmental disorders, informing evidence-based intervention priorities. The clinical workforce has grown from 20 to 25 clinicians since FY 2023-24, with expanded emphasis on therapy alongside rehabilitation and care coordination.

SUPT provides weekly SUD psychoeducation groups, ASAM-aligned assessments, and MAT for youth 16+, with strong coordination with onsite behavioral health staff and collaboration with SCOE for prevention and school-based campaigns.
FSPW (MHC/037) explicitly requires contractors to deliver services within the YDF and develop active transition plans to community-based care upon release, ensuring continuity of intensive behavioral health services across custody and community settings beginning July 1, 2026.

ZIP codes 95823 and 95838 have the highest concentrations of homelessness and overlapping justice involvement risk per 2024 HMIS data. Following extensive community outreach—including over 300 interviews with individuals in encampments, shelters, and public settings, and 13 focus groups and listening sessions—BHS developed INN projects serving all ages, designed to bring culturally rooted, peer-led, community-defined wellness approaches directly to individuals rather than requiring high-risk populations to navigate traditional service entry points. Projects prioritize flexible funding for concrete needs, outreach-first engagement, and a pathway to long-term Medi-Cal SMHS sustainability, directly responding to data showing African American youth and adults are disproportionately represented in justice-involved settings and that these ZIP codes represent the highest convergence of poverty, housing instability, child welfare involvement, and justice risk in the county.

The CalAIM Justice-Involved benefit activates Medi-Cal coverage 90 days prior to release from county jail and YDF, enabling earlier initiation of behavioral health services while individuals are still in custody and reducing the gap between release and community engagement that drives recidivism and justice reinvolvement.

For adult justice-involved individuals, BHS collaborates with Correctional Health through the ROAR program (Prop 47), supporting unhoused individuals transitioning from jail into transitional housing and community services. BHS meets regularly with justice partners including the Public Defender's Office, District Attorney's Office, Courts, IST providers, and DSH to support Mental Health Diversion eligibility. BHS collaborates with Court partners and outpatient providers on CARE Court referrals and participates in

regular coordination with Correctional Health to support CalAIM JI 90-day prerelease services and community transitions.

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Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal
BHSA BHSS
BHSA Housing Interventions
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Removal Of Children from Home: Primary Measures

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

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

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

Removal Of Children from Home: Supplemental Measures

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

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

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

Child Maltreatment Substantiations (CWIP), 2022

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

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

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Sacramento County's rates for Children in Foster Care, Open Child Welfare Cases SMHS penetration rates and Child Maltreatment Substantiations are all lower than the Statewide Rate and Median.

According to ccwip.berkeley.edu, the number of children in foster care in Sacramento County has decreased dramatically overall. There still remains to be slight disparities when it comes to race/ethnicity. Point in Time counts for January 2026 indicate African American Children represent almost 34% (33.9%) of the children in foster care. Followed by Hispanic/Latino at 31%. In regards to age, TAY (ages 18-21) are the highest at just over 22%.

Removal Of Children from Home: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes
Sacramento County's strategies to reduce the removal of children from their homes are informed by data documenting persistent racial disparities in the foster care population and operationalized through cross-system structural agreements, prevention-focused programming, and targeted procurement.

CCWIP and internal CWS/CMS analysis confirm that while overall foster care numbers have decreased significantly, racial disparities persist. As of January 2026, African American children represent

approximately 33.9% of children in foster care despite comprising approximately 9% of the county population; Hispanic/Latino children represent 31%. Transition-age youth (ages 18–21) represent over 22% of the foster care population, signaling need for sustained intensive support for older youth. These disparities, combined with Child Safety Forward Sacramento data showing 76% of families involved in child abuse and neglect deaths and critical injuries had prior CPS contact, underscore that earlier and more effective behavioral health intervention is essential to keeping families together before removal occurs.

Sacramento County BHS participates as a voting member of the Interagency Placement Committee (IPC), established under WIC §4096 and governed by a formal MOU among BHS, DCFAS, Probation, Alta California Regional Center, and SCOE. The IPC authorizes all STRTP, CTF, and out-of-state placements, and BHS's voting role ensures behavioral health expertise and less restrictive alternatives are actively considered before any child enters congregate care. The IPC's mandate is to identify the lowest level of care meeting each child's individualized needs, directly supporting family preservation. BHS has collaborated with IPC partners to update wraparound policies and procedures to ensure community-based intensive supports are consistently available as placement alternatives.

BHS participates as a core member of the Sacramento Children, Youth and Family System of Care (CYFSOC), operating under a formal Operational Agreement (2023–2026) per AB 2083. BHS serves as a voting member of the CYFSOC Interagency Leadership Team, meeting monthly to determine strategy for coordinated services with an explicit commitment to reducing racial and ethnic disproportionality in child welfare and juvenile justice. The CYFSOC agreement identifies seven neighborhoods with the highest numbers of African American child deaths and directs partners to work with Community Incubator Lead organizations and Family Resource Centers to address disparities through prevention and early intervention. Guiding principles include reducing entry and length of stay in out-of-home placement, collaborative financing redirecting spending from congregate to home and community-based care, and a No Wrong Door approach. The BHS Deputy Director serves on the CYFSOC Advisory Team, meeting monthly to identify barriers, review data trends, and recommend practice improvements.

BHS participates in the Child Safety Forward Sacramento Prevention Cabinet, a multidisciplinary executive leadership body operating under a formal MOU to implement cross-systems strategies preventing child abuse and neglect deaths and critical injuries. BHS's collaboration rating increased from 2.1 in 2021 to 2.8 in 2025 on a four-point scale, reflecting deepening partnership. The Prevention Cabinet's work is grounded in data showing geographic and racial concentration of child maltreatment risk, and BHS's participation ensures behavioral health resources are integrated into the county's primary prevention infrastructure.

Sacramento County invested child welfare funding into prevention-focused wraparound services for families identified as vulnerable to dependency before removal occurs. This program began with 10 point-in-time slots in approximately 2018 and has grown to 34 current slots—more than tripling capacity—reflecting demonstrated effectiveness and sustained commitment to upstream family preservation.

Beginning July 1, 2026, ATLAS (MHC/039) will expand access to outpatient SMHS in the fourteen ZIP codes where data consistently shows the highest concentrations of CPS involvement, child welfare risk, and racial disparities: 95608, 95660, 95670, 95815, 95821, 95822, 95823, 95824, 95825, 95828, 95833, 95838, 95842, and 95843. By co-locating hub clinic sites with trusted community partners, ATLAS is designed to increase timely access to behavioral health services for families before crises escalate to child welfare involvement and removal, directly responding to the geographic concentration of removal risk documented in CWS/CMS data and Child Safety Forward Sacramento findings.

FSPW (MHC/037), also launching July 1, 2026, strengthens family preservation infrastructure by explicitly extending mental health services to caregivers under the same service umbrella as the child or youth, improving care coordination and addressing family-level behavioral health needs that frequently contribute to removal decisions. By treating the family as the unit of intervention, FSPW directly supports reunification and permanency goals. Sacramento County also invests SB163 dollars in wraparound programming to support permanency for children involved in child welfare and juvenile justice, providing intensive, flexible, family-centered services to stabilize placements, support reunification, and prevent unnecessary out-of-home placement or reentry into congregate care.

Sacramento County will continue strengthening its continuum of care by expanding and refining programs and partnerships designed to reduce unnecessary child removals and improve equitable access to supportive services. A central component of this work is the ongoing implementation and enhancement of Sacramento's Family Treatment Court (FTC) models, which provide a coordinated, multidisciplinary response for families affected by substance use, mental health needs, and safety risks.

Sacramento's FTC models bring together the courts, Child Protective Services, behavioral health providers, and community-based organizations to ensure parents receive timely access to treatment, support services, and case management. Over the past several years, FTC participation has contributed to higher engagement in treatment, improved family stability, and reductions in entries into foster care. Beginning in FY 2026–27, the county will continue to refine FTC practice through:
Enhanced care coordination: Strengthening collaboration between CPS, substance use disorder (SUD) providers, and the Behavioral Health Services Division to expedite assessments, reduce wait times, and ensure service plans are matched to family needs.
• Targeted interventions for sub-populations: Utilizing locally collected data—including disparities in outcomes for families experiencing SUD, mental health challenges, or prenatal substance exposure—to tailor supports, expand culturally responsive services, and improve outcomes for groups that have shown lower performance relative to statewide averages.
• Data-driven continuous improvement: Sacramento maintains active interdisciplinary workgroups that meet regularly to review FTC outcomes, CPS case trends, and prevention metrics. These workgroups use real-time data to identify gaps, adjust workflows, and implement practice improvements designed to

reduce risk factors that contribute to removal.
• Strengthening CPS Informal Supervision pathways: Most families in this pathway remain safely intact. We're expanding collaboration with community partners to increase: The county continues to prioritize prevention strategies and voluntary supports through CPS Informal Supervision.

These initiatives are informed by county-level data showing that early engagement in services—particularly among families affected by substance use—correlates with decreased removals, increased family stability, and improved treatment outcomes. Sacramento will continue using these data trends to guide system enhancements and ensure families receive timely access to appropriate care, with a focus on improving measures where county performance falls below statewide averages or medians.

Sacramento County is convening a monthly workgroup with emergency response units and mobile medication units. Workgroup members are sharing and learning about respective services and developing contact lists, resource lists, a centralized shared resource repository, and a mobile medicine website. The goal is to increase collaboration among all mobile units with the ultimate goal of increasing linkages to behavioral health services for vulnerable.

The Interagency Youth Collaborative is a multi-agency workgroup convened by Behavioral Health Services to strengthen coordination across Sacramento County's child-, youth-, and family-serving systems. The workgroup's purpose is to better address the complex behavioral health, substance use, child welfare, education, and probation needs of local youth. The Collaborative brings together partners from BHS, CPS, Probation, DHA, SCOE, providers, and the Alta Regional Center to share updates, identify system barriers, coordinate care, and align efforts with the county's High Fidelity Wraparound Plan and the broader Child, Youth, and Family System of Care (CYFSOC). Its purpose is to create an ongoing space for collective problem-solving, improve referral pathways, respond to emerging trends such as youth substance use and complex needs, and raise issues to the Advisory Team and Interagency Leadership Team for county-level decision-making.

File Upload

Please identify the category or categories of funding that the county is nusing to address the removal of children from home goal
BHSA FSP
BHSA Housing Interventions
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Untreated Behavioral Health Conditions: Primary Measures

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

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

For the full population measured
Above

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

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

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

For the full population measured
Above

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

Untreated Behavioral Health Conditions: Supplemental Measures

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

How does your county status compare to the statewide rate?

For the full population measured
Below

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

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Sacramento County's Follow-Up After ED Visit for Substance Use is 1.5 percentage points higher than the Statewide Rate, but the same as the Median at 30.3%. The County rate for Follow-Up After ED Visit for Mental Illness is higher than both the Statewide Rate and the Median (40.8% vs 38.2% vs 37.3%).

According to the Sacramento County MY2024 Descriptive Analysis done by CalMHSA, American Native/American Indians had the lowest percent of follow-ups after ED visits for substance use at 45.5%, compared to an overall performance 59.6%. African Americans and Hispanic/Latino were slightly lower than the overall average for follow-up after hospitalization at 43.9% (Hispanic/Latino) and 44.4% (African American) compared to an over performance of 46.3%. Males had a slightly lower percentage for follow-up after hospitalization compared to the over performance (44.1% vs 46.3%. Disparities were also present for follow-up after hospitalization for languages other than English, with the lowest rate seen in East Asian languages at 36.4% compared to 46.2% overall. The "Other Non-English" category had the lowest rates of follow-up after emergency room visits for substance use, at 42.9% compared to 59.6% overall.

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
Sacramento County's internal syndromic surveillance data (2016–2023) show that among children and youth, those ages 14–17 experience the highest rates of non fatal suicide attempts treated in emergency departments. Female youth have higher non fatal attempt rates, while male youth have higher fatality rates. Multiracial, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander youth are disproportionately represented among fatal attempts. Sacramento County's internal CWS/CMS analysis (FY 2022/23) also identifies that Black youth ages six and older are overrepresented at every CPS contact point, with ZIP code 95823 ranking first for Black youth across all categories. Additionally, Child Safety Forward

Sacramento's 2026 Five Year Update notes that 76% of families involved in child abuse and neglect deaths or critical injuries had prior CPS contact, indicating that system involvement without timely behavioral health connection leaves conditions unaddressed until crisis. Age stratified data from the California Child Welfare Indicators Project (ccwip.berkeley.edu) further show that infants under age one face investigation rates of 56–60 per 1,000—more than double that of school age children—highlighting the urgency of early identification and intervention.

In response, Sacramento County's children's Specialty Mental Health Services procurement (ATLAS, MHC/039), launching July 1, 2026, expands outpatient capacity through required hub clinic sites co located with trusted community partners in fourteen high need ZIP codes: 95608, 95660, 95670, 95815, 95821, 95822, 95823, 95824, 95825, 95828, 95833, 95838, 95842, and 95843. These locations consistently demonstrate high unmet behavioral health needs, racial disparities, and crisis risk. The hub and spoke model is designed to reduce geographic and structural barriers that prevent children and families from accessing services early. The procurement also includes BHSA funded Early Intervention services and Mental Health Medi Cal Administrative Activities to support early identification, engagement, and prevention of crisis level conditions requiring emergency or inpatient care.
Over the past year, BHS has implemented targeted strategies to strengthen access and timeliness using Timely Access Data Tool (TADT) data and HEDIS measures. Dedicated workgroups—comprising BHS staff and community based providers—have been reviewing system gaps, collaborating with emergency departments and psychiatric hospitals to improve post discharge outpatient access, and examining agency processes to identify effective practices for systemwide standardization. These workgroups will continue to evaluate TADT and HEDIS trends to implement strategies that improve timely access for Medi Cal beneficiaries, with a focus on individuals discharging from acute psychiatric facilities and emergency rooms.

Youth Medication Assisted Treatment (MAT) services at the Sacramento County Health Center operate within the County's Substance Use Prevention & Treatment (SUPT) System of Care. SUPT maintains coordinated referral pathways connecting youth to culturally responsive and clinically appropriate SUD services. Youth MAT services at Sacramento County funded Narcotic Treatment Programs generally include assessments, medical determination for MAT eligibility, FDA approved medications, and care coordination for withdrawal stabilization. Youth may also receive Suboxone at YDF. The Health Center participates in a broader network of MAT providers offering supportive services to stabilize youth, reduce justice involvement, and connect them to long term recovery supports.
A key initiative currently in development is a Youth SUD Residential Treatment Program for boys ages 12–17, scheduled to launch within the BHSA FY 2026–2029 planning period. This program addresses a longstanding service gap: the County currently has no dedicated SUD residential beds for adolescent males, resulting in unmet need, long waits, out of county placements, and increased reliance on crisis services. Local performance measures show that youth SUD access and early engagement remain below statewide averages, with families reporting barriers including availability, transportation, care coordination, and culturally responsive services. The new program will provide trauma informed, evidence based

treatment (including Motivational Interviewing, CBT SUD, and family based interventions), along with educational and recreational programming, peer support, and coordinated discharge planning. Expanding the continuum in this way is expected to improve timely access, continuity of care, and long term recovery outcomes for youth.

SUPT continues to strengthen services and outreach for older adults experiencing SUD, reflecting the growing number of individuals over age 50 impacted by opioid, methamphetamine, and polysubstance use. In FY 23–24, the most common SUDs among older adults were opioid use disorder, stimulant use disorder, alcohol use disorder, amphetamine use disorder, and cocaine use disorder. The SUPT continuum offers outpatient, intensive outpatient, withdrawal management, MAT, residential treatment, recovery residences, and field based engagement. These services are accessible through countywide referral pathways, including Older Adult Shelters, community access points, and partnerships with entities serving individuals experiencing homelessness.

SUPT also collaborates with homeless shelters and multidisciplinary teams to identify older adults with untreated or emerging SUD needs, provide onsite or field based screenings, and offer rapid linkage to treatment. Training initiatives—including coordination with Adult Protective Services (APS)—enhance early identification by equipping APS workers with skills to recognize substance related risks, administer screenings, and complete warm handoffs to SUPT programs. This approach improves access to timely interventions addressing health, safety, and housing related needs while reducing engagement barriers.

In alignment with DHCS Network Adequacy Certification feedback, which identified a need to strengthen youth MAT availability, BHS SUPT has expanded services across both NTP and non NTP providers. Sacramento County recently added Transitions Buprenorphine Clinic of Sacramento—a community based outpatient addiction medicine program offering MAT, counseling, and harm reduction services with a low barrier, flexible approach. Transitions collaborates closely with Sac Fire's Street Overdose Response Team, which provides direct referrals for high risk individuals. While primarily serving adults, Transitions can also serve youth ages 12–17 depending on clinical need, under medical discretion and in accordance with MAT prescribing regulations.

To meet NACT standards, Sacramento County will release a competitive selection process for providers offering Youth Withdrawal Management Residential Treatment. To ensure an informed procurement, BHS SUPT has been consulting with counties statewide to gather information on effective strategies and planned approaches for youth withdrawal management. In the interim, Sacramento County maintains a highly coordinated process ensuring youth experiencing withdrawal receive timely and clinically appropriate care, including standardized assessment procedures determining the appropriate level of care. These procedures support rapid response, seamless transitions, and alignment with policy and best practice guidelines.

File Upload

Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal
BHSA BHSS
BHSA FSP
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Additional statewide behavioral health goals for improvement

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

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

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

Care Experience: Primary Measures

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

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

For adults/older adults
Below

For children/youth
Above

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

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

For adults/older adults
Above

For children/youth
Below

Engagement In School: Primary Measures

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

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

Engagement In School: Supplemental Measures

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

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

Student Chronic Absenteeism Rate (Data Quest), 2022

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

Engagement In Work: Primary Measures

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

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

Engagement In Work: Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023

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

Overdoses: Primary Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

Overdoses: Supplemental Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

Prevention And Treatment of Co-Occurring Physical Health Conditions: Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022

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

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)
Below

For children/youth (specific to Child and Adolescent Well-Care Visits)
Below

Prevention And Treatment of Co-Occurring Physical Health Conditions: Supplemental Measures

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS), 2022

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

For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)
Same

For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)
Same

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

For the full population measured
Below

For adults/older adults
Below

For children/youth
Below

Quality Of Life: Supplemental Measures

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

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

For the full population measured
Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

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

For the full population measured
Below

For adults/older adults
Below

For children/youth
Same

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides: Primary Measures

Suicide Deaths, 2022

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

For the full population measured
Above

Suicides: Supplemental Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

County-selected statewide population behavioral health goals

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

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

Engagement in work

Please describe why this goal was selected
The County's identified priority goal is to increase the number of clients who identify employment as a treatment goal and, among those clients, to increase the number who successfully obtain employment. This initiative originated from a recommendation by the Mental Health Board and led to the implementation of the Individualized Placement Support (IPS) model within Full Service Partnerships (FSPs).
Building on this foundation, BHS will continue to strengthen and expand employment-focused interventions. Broader implementation of IPS principles and employment supports will occur through BH-CONNECT and BHSA initiatives, with the intent of increasing access, consistency, and effectiveness of employment services across the behavioral health system.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
No data is available.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Engagement in work and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Beginning July 1, 2026, Sacramento County will strengthen engagement in work across Adult outpatient and FSP programs by grounding program improvements in county level employment and service utilization data. Analysis of FY 2022–23 outcomes shows that fewer than 18% of adults entering outpatient behavioral health services report any employment at admission, and only 9–12% achieve competitive or supported employment during treatment.

Using this data, Sacramento County will prioritize actions that directly improve employment outcomes, including:

• Implementing Individual Placement and Support (IPS) Supported Employment, with fidelity monitoring to ensure adherence to the evidence based model.

• Integrating employment services into Adult outpatient and FSP workflows, including co located vocational staff and warm handoff referral pathways.

• Strengthening partnerships with workforce focused agencies, including vocational rehabilitation, transitional employment providers, and workforce development programs.

• Enhancing employment readiness supports, such as benefits counseling, skills training, and job retention assistance.

These targeted actions directly respond to employment related disparities identified in the County's data and advance the statewide behavioral health goal of improving engagement in work for adults with significant behavioral health needs.

This employment centered focus is consistent with Sacramento County's Mental Health Board Report released in November of 2022, which emphasized increasing effective employment as a critical system priority. By expanding supported employment models, strengthening cross system partnerships, and improving job readiness and retention supports, the County is advancing the report's broader vision to modernize employment strategies, move away from less effective approaches, and improve workforce participation among adults receiving behavioral health services.

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

BHSA BHSS
BHSA FSP
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Community Planning Process

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

Stakeholder Engagement

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

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

County outreach through social media
Focus group discussions
Meeting(s) with county
Survey participation
County outreach through townhall meetings
Public e-mail inbox submission
Training, education, and outreach related to community planning
Workgroups and committee meetings
Other

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

Community Conversations and Survey links were also shared through our provider network and email distribution lists.

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

Type of engagement

County outreach through social media

Date
9/28/2025

Type of engagement
County outreach through social media

Date
10/3/2025

Type of engagement
County outreach through social media

Date
11/4/2025

Type of engagement
County outreach through social media

Date
11/7/2025

Type of engagement
County outreach through townhall meetings

Date
7/17/2025

Type of engagement
County outreach through townhall meetings

Date
7/30/2025

Type of engagement
Focus group discussions

Date
11/12/2025

Type of engagement
Focus group discussions

Date
11/13/2025

Type of engagement
Meeting(s) with county

Date
7/10/2025

Type of engagement
Public e-mail inbox submission

Date
7/30/2025

Type of engagement
Public e-mail inbox submission

Date
11/13/2025

Type of engagement
Survey participation

Date
9/25/2025

Type of engagement
Workgroups and committee meetings

Date
7/9/2025

Type of engagement
Workgroups and committee meetings

Date
7/17/2025

Type of engagement
Workgroups and committee meetings

Date
8/7/2025

Type of engagement
Workgroups and committee meetings

Date
8/14/2025

Type of engagement
Workgroups and committee meetings

Date
8/19/2025

Type of engagement
Workgroups and committee meetings

Date
8/22/2025

Type of engagement
Workgroups and committee meetings

Date
8/26/2025

Type of engagement
Workgroups and committee meetings

Date
8/27/2025

Type of engagement
Workgroups and committee meetings

Date
10/1/2025

Type of engagement
Other

Date
7/24/2025

Type of engagement
Other

Date
9/25/2025

Type of engagement
Other

Date
10/24/2025

Type of engagement
Other

Date
11/13/2025

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
CalAIM Steering Committee
Child, Youth, and Family System of Care Interagency Leadership Team
Child Abuse Prevention Council
Criminal Justice Cabinet Executive Committee
Housing & Families First Collaborative
City Managers Collaborative
BHS Cultural Competence Committee
BHS Systemwide Community Outreach and Engagement Committee
African American/Black/African Descent Ad Hoc Committee community members
Latino/Latinx/Latine/Hispanic Behavioral Health Racial Equity Collaborative
Community Health In Action Mental Health Subcommittee
Student Mental Health & Wellness Collaborative
Peer Providers
Adult Peer Support Committee
Youth Peer Support Committee
Parent, Caregiver and Family Peer Support Committee
Community Health Improvement (CHIA) Committee
Supporting Community Connections providers
Community Responsive Wellness Program providers
BHS Staff

What are the five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State)

	City name
1	Sacramento
2	Elk Grove
3	Folsom
4	Citrus Heights
5	Rancho Cordova

Were you able to engage all required stakeholders/groups in the planning process?
Yes

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities
Sacramento County Behavioral Health Services (BHS) designed the CPP in two phases. Phase One spanned July through early October 2025, and Phase Two took place in November 2025.

In Phase One, BHS engaged hundreds of community members and partners through in-person meetings, virtual forums, focus groups, and input sessions. These gatherings brought together diverse perspectives—including individuals with lived experience, providers, advocates, and community organizations. BHS also developed and distributed a survey to gather additional input. To ensure inclusivity, the County also distributed surveys translated into Sacramento's seven threshold languages—Arabic, Chinese, Farsi, Hmong, Russian, Spanish, and Vietnamese—gathering additional feedback from communities historically underrepresented in planning processes.

Nearly 2,000 individuals were invited to attend multiple events in person and virtually, including agendized presentations at regularly scheduled meetings. A follow up email shared the survey version of the input session with the same partners, asking that it be also shared widely with their community contacts. The public events and survey were featured on both the Sacramento County Facebook and Instagram pages, whose followers total over 100,000. Over 500 individuals participated in events, and more than 200

responded to the surveys.

The community and system partners were asked to identify the Glows (what is working well) and Grows (areas for improvement) with BHS. The insights gathered will guide future planning and resource allocation, ensuring that behavioral health services reflect the priorities and needs of Sacramento's diverse communities.

Phase Two was two events where BHS shared a summary of the key findings gathered during Phase One asked the community to validate the information and include any additional feedback. This was used to inform the development of the first BHSA Integrated Plan.

Upload File
2025 CPP Phase 2 Report.pdf
BHSA CPP Phase 1 Report.pdf

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP) ? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.
Yes

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities
Behavioral Health Services (BHS) engaged with the Local Health Jurisdiction (LHJ) and Medi-Cal Managed Care Plans (MCPs) across collaboration, data-sharing, and stakeholder activities to inform development of the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).

Collaboration: BHS actively participated in LHJ- and Community Health in Action Coalition-led CHA/CHIP committees and subcommittees, which supported planning discussions, priority setting, and review of

assessment findings. Collaboration included recurring workgroup meetings and coordinated planning sessions with LHJ and MCPs, including through the CalAIM Steering Committee and LHJ subcommittees, where partners aligned on population health goals and cross-system strategies.

Data-Sharing: BHS supported data-sharing efforts by providing behavioral health indicators, service utilization trends, and identified community needs to the LHJ to inform the CHA. BHS also supplied relevant behavioral health data to MCPs to support development of their Population Health Management Strategic Plans.

Stakeholder Activities: BHS engaged with LHJ and MCPs in stakeholder activities, including CalAIM-related discussions, community forums, and focus groups. These efforts supported the collection of community input, identification of service gaps, and incorporation of MCP perspectives through direct participation in planning processes.

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

Collaboration

Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as requested.
Served on CHA and CHIP governance structures and/or subcommittees as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP
Access to Care
Care Experience
Engagement in School
Engagement in Work
Homelessness
Institutionalization
Justice Involvement
Overdoses

Prevention of Co-Occurring Physical Health Conditions
Quality of Life
Removal of Children from Home
Social Connection
Suicides
Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Was data shared?
Yes

Data-Sharing from MCPS and LHJs to Support IP development

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

Please describe
Discussions are currently underway with the MCPs.

Was data shared?
No

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities)
Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.
Co-hosted community sessions, listening tours, and/or other community events that can be used to strengthen stakeholder engagement for both the IP and CHA/CHIP.
Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.

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

Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP ? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3
Yes

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP
BHS is using the most recent Community Health Improvement Plan (CHIP) and the Community Health Assessment (CHA) as a foundational guide in the development of its BHSA Integrated Plan. The CHA/CHIP identifies persistent health disparities and inequities driven by historical and ongoing policy decisions related to housing, employment, land use, and access to care, recognizing that neighborhood conditions often have a greater influence on health outcomes than individual factors. These findings inform the Integrated Plan's emphasis on addressing the social and structural drivers of behavioral health needs through policy-aligned, population-level strategies. Building on the CHA/CHIP, the County is prioritizing approaches that strengthen the local "power ecosystem"—the network of community-based organizations, relationships, and infrastructure that elevate community voice and agency. The robust community engagement processes used to develop the CHA/CHIP are being leveraged to ensure that populations historically marginalized by racial and economic inequities meaningfully inform priorities, investments, and implementation strategies within the Integrated Plan. In this way, the Integrated Plan reflects continuity with the CHA/CHIP's equity-centered framework while translating its goals into coordinated, actionable behavioral health investments.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes
BHS worked with all four local MCPs (Anthem, Health Net, Kaiser, and Molina) to inform their respective reinvestment planning.

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?
BHS shared community input captured through the draft BHSA Integrated Plan to inform the MCP Community Reinvestment Plan.

The MCPs have engaged the County in a collaborative Community Reinvestment planning process and have committed to sharing their draft MCP Community Reinvestment Plan with the County for review prior to submission to DHCS by the September 1, 2026 due date.

Comment Period and Public Hearing

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

Comment Period and Public Hearing

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

Confirm that the data is up to date and reflects the correct information for a Final Plan

Date the draft Integrated Plan (IP) was released for stakeholder comment
2/16/2026

Date the stakeholder comment period closed
3/18/2026

Date of behavioral health board public hearing on draft IP
3/18/2026

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

Please provide the link to the public posting
https://dhs.saccounty.gov/BHS/Documents/Advisory-Boards-Committees/Behavioral-Health-Commission/2026-Mtgs/AG-BHS-BHC-2026-03-18-Gen-Mtg-Agenda.pdf

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page
https://dhs.saccounty.gov/BHS/Pages/BHSA/BHSA.aspx

File Upload

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

Attach email
2026-02-16 email--Public Comment Open – Draft BHSA Three-Year Integrated Plan (FY 2026–2029).pdf

Please specify the other process the draft plan was circulated to stakeholders
The Public Notice for the Draft Integrated Plan was published in the Legal Notices section of the Sacramento Bee on the official posting date, in accordance with applicable requirements. The notice was translated into Sacramento County's seven threshold languages, and all eight language versions were posted online in multiple locations on the Sacramento County Behavioral Health Services (BHS) website to ensure broad public access.

The Draft Integrated Plan and Public Notice were also broadly disseminated to providers and community partners through multiple engagement channels, including town hall meetings, collaborative meetings, distribution across all BHS email distribution lists, and via BHS social media platforms to maximize awareness and opportunity for public review and input.

Physical copies of the Draft Integrated Plan were printed and made available for public review. Physical copies were also distributed to the Behavioral Health Commission during both general and Executive Committee meetings and were offered to members of the public in attendance. Additional copies were placed on display in the BHS lobby with signage to support ongoing public access.

A presentation of the Draft Integrated Plan was provided at the Sacramento County Behavioral Health Services Cultural Competence Committee meeting on February 17, 2026. Public comment was accepted following the presentation. Committee members were also encouraged to submit written comments and to attend and provide input at the Public Hearing.

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table

Stakeholder group that provided feedback
(B) Families of eligible children and youth, eligible adults, and eligible older adults, as defined in Section 5892.

Summarize the substantive revisions recommended this stakeholder during the comment period

Commenters provided feedback across multiple domains, including budget clarity, housing investments, workforce projections, service reductions, and data transparency. Overall, commenters emphasized the need for improved alignment between identified community needs and proposed investments.

Key themes included:

• Requests for greater clarity in budget and program data, including housing investments and service allocations.
• Concerns regarding the classification and level of funding for permanent supportive housing (PSH), and the overall proportion of housing investments relative to community need.
• Concerns about proposed service reductions, particularly the elimination or reduction of peer respite and warmline services, with recommendations to identify alternative funding sources.
• Concerns that workforce projections and staffing assumptions may not be feasible or aligned with current system capacity, including recruitment and retention challenges.
• Recommendations to strengthen culturally responsive and trauma-informed data collection practices, particularly for communities with lower trust in government systems.
• Advocacy for expanded non-law enforcement crisis response models and increased investment in culturally responsive, community-based, and peer-driven services across the continuum of care.

Stakeholder group that provided feedback

(C) Youths or youth mental health or substance use disorder organizations.

Summarize the substantive revisions recommended this stakeholder during the comment period

Commenters recommended the development of a countywide network of youth-driven Wellness Centers located on high school campuses, particularly in high-need areas.

Stakeholder group that provided feedback

(D) Providers of mental health services and substance use disorder treatment services.

Summarize the substantive revisions recommended this stakeholder during the comment period

Providers emphasized the need to strengthen racial equity throughout the Plan, with a particular focus on improving outcomes for Black women, youth, and communities.

Key recommendations included:

• Establishing clear goals, metrics, and accountability structures using disaggregated, intersectional data.
• Increasing investment in culturally rooted, community-based organizations and Community-Defined Evidence Practices (CDEPs).
• Expanding workforce diversity through targeted pipeline programs, peer roles, and training initiatives.
• Improving access in high-need geographic areas through place-based strategies and supportive services (e.g., childcare, housing, transportation).
• Strengthening prevention and early intervention efforts, particularly for maternal, perinatal, and youth mental health.
• Enhancing community engagement through ongoing advisory structures and transparent reporting.
• Clarifying funding methodologies and distinctions between evidence-based practices (EBPs) and CDEPs.

Overall, commenters emphasized the importance of intentional investment, transparency, and community leadership to advance equitable outcomes.

Stakeholder group that provided feedback
(G) Higher education partners.

Summarize the substantive revisions recommended this stakeholder during the comment period
Commenters recommended expanding the Plan to address tobacco use as a behavioral health concern and to strengthen cross-sector collaboration.

Recommendations included incorporating tobacco-related measures into performance metrics, integrating screening and cessation interventions into service delivery, and aligning with existing clinical quality measures.

Commenters also encouraged the establishment of ongoing cross-sector partnerships with public health, education, and Medi-Cal managed care entities to support coordinated implementation efforts.

Stakeholder group that provided feedback
(L) Veterans.

Summarize the substantive revisions recommended this stakeholder during the comment period
Commenters recommended increased outreach to veterans and organizations serving veterans during planning processes, as well as the inclusion of targeted behavioral health services for veterans within the Plan.

Stakeholder group that provided feedback
(M) Representatives from veterans' organizations.

Summarize the substantive revisions recommended this stakeholder during the comment period
Commenters recommended leveraging existing reports and best practices to strengthen engagement with veteran communities and to inform planning efforts.

Additionally, commenters encouraged the designation of dedicated funding for veteran mental health services to ensure culturally competent care and sustained partnerships with veteran-serving organizations.

Stakeholder group that provided feedback
(X) Community-based organizations serving culturally and linguistically diverse constituents.

Summarize the substantive revisions recommended this stakeholder during the comment period
Commenters raised concerns regarding barriers to access, persistent disparities, and the need for stronger investment in community-based approaches.

Key themes included:

• Reduce reliance on or perceived connections to the criminal legal system to improve access and trust among impacted communities.
• Racial and linguistic disparities in service access, with recommendations for targeted strategies to improve equity.
• More specific and robust workforce strategies to recruit and retain culturally and linguistically responsive providers.
• Increased recognition and sustained funding for Community-Defined Evidence Practices (CDEPs) and community-based organizations.
• Strengthening partnerships, communication, and funding pathways for community-based providers.
• Expanding culturally and linguistically appropriate outreach, services, and language access infrastructure.
• Enhancing data transparency, equity accountability, and evaluation practices.

Stakeholder group that provided feedback
Other

Summarize the substantive revisions recommended this stakeholder during the comment period

Additional comments highlighted the need to further strengthen workforce development strategies, including clearer role definitions, increased supervision capacity, and targeted incentives to support recruitment and retention of culturally responsive providers.

Commenters also emphasized the importance of improving transparency in community partnership processes, increasing recognition and investment in community-defined practices, and expanding early intervention and trauma-informed services for youth.

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

Substantive recommendations

• The Sacramento County Behavioral Health Commission provided input on the Draft Integrated Plan which informed revisions to the Plan and the design of programming. However, the following substantive recommendations and areas of emphasis raised by Commission members were not incorporated into Preservation and expansion of peer-based services, including peer respite and warmline programs, with recommendations to identify alternative funding sources to sustain these services.
• Strengthening of non-law enforcement crisis response approaches, including increased support for community-based crisis response models.

These recommendations were carefully considered and documented and will inform future planning, funding opportunities, and ongoing engagement with the Behavioral Health Commission.

County Behavioral Health Services Care Continuum

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

County Behavioral Health Services Care Continuum

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

Mark section as complete

County Provider Monitoring and Oversight

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

Medi-Cal Quality Improvement Plans

Cities submitting their Integrated Plan independently from their counties do not have to complete this section or Question 1 under All BHSA Provider Locations.

For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027

Sacramento County 25-26 BHS Integrated_QAPI Annual Workplan.pdf

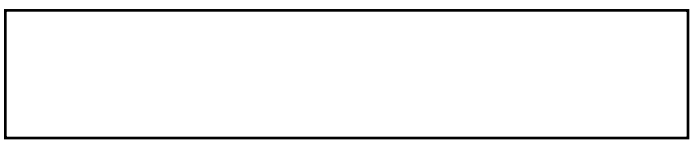
Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?

No

Contracted BHSA Provider Locations

As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Services Provided



Number of contracted BHSA provider locations

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	41
Substance Use Disorder (SUD) services only	35
Both MH and SUD services	76

Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	40
DMC/DMC-ODS only	35
Both SMHS and DMC/DMC-ODS systems	75

All BHSA Provider Locations

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

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?

0

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

Beginning July 1, 2027, and over the subsequent two years, the County will pursue a multi-pronged strategy to enhance rates of Medi-Cal Managed Care Plan (MCP) contracting among Behavioral Health Services Act (BHSA) provider locations that deliver services eligible for MCP reimbursement.

The County and its provider network does not contract with MCPs for Non-Specialty Mental Health Services (NSMHS). Instead, through Memoranda of Understanding (MOUs) with MCPs, individuals requiring NSMHS levels of care are referred or transitioned to MCPs for treatment within the MCP provider network.

To increase MCP contracting rates, the County has actively facilitated connections between MCPs and BHSA-funded providers to encourage direct contracting and will continue to provide this facilitation for interested providers. Most recently, in November 2025, the County convened a meeting linking interested providers with an MCP to explore Enhanced Care Management (ECM) and Community Supports contracting opportunities. Similar convenings and technical assistance efforts will continue as part of the County's ongoing strategy.

In addition, the County plans to support SMHS provider community-based organizations (CBOs) in proactively registering for and participating in the 2026 PATH Collaborative Planning and Implementation (CPI) process. Participation in PATH CPI is intended to strengthen relationships between providers and MCP representatives, increase provider readiness, and expand opportunities for MCP contracting.

Through these combined strategies—facilitation, relationship-building, technical support, and exploration of billing infrastructure—the County aims to steadily increase MCP contracting rates across BHSA provider locations between July 1, 2027, and June 30, 2029, while ensuring continuity of care and appropriate reimbursement for Medi-Cal-eligible services.

The County confirms that there are currently zero BHSA-funded SMHS provider locations (county-operated or contracted) delivering services at the Non-Specialty Mental Health Services (NSMHS) level of care. BHSA-funded providers operate within the Specialty Mental Health Services (SMHS) delivery system and do not provide NSMHS directly.

Consistent with the No Wrong Door policy BHIN 22-011, BHS providers must ensure that all medically necessary SMHS are available during the assessment period prior to determination of a diagnosis or confirmation of SMHS access criteria. Providers must not deny or restrict SMHS on the basis that a client is concurrently receiving NSMHS through a Medi-Cal Managed Care Plan. When a client meets criteria for both SMHS and NSMHS, services must be coordinated between the Behavioral Health Plan and the applicable Medi-Cal Managed Care Plan to ensure services are clinically appropriate and non-duplicative. The system

initiating services remains responsible for ensuring continuity of care until a coordinated transition is completed. Transitions between delivery systems must be documented, clinically justified, client-centered, and include confirmation that referrals have been accepted and services initiated prior to transition.

To that end, the County will support BHSA-funded providers with linkage to MCP contracting points of contact throughout FY 2026–27 to facilitate potential contracting opportunities for NSMHS delivery.

To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)
a. **Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening**
b. **Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and**
c. **Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding**

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

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

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

Yes

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

Yes

Behavioral Health Services Act/Fund Programs

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

Behavioral Health Services and Supports (BHSS)

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

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General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan
Children's System of Care (non-Full Service Partnership (FSP))
Adult and Older Adult System of Care (non-FSP)
Early Intervention Programs (EIP)

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

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

Please select the service types provided under Program
Mental health services

Please describe the specific services provided
Child Protective Services – Behavioral Health Support Team

The Child Protective Services-Behavioral Health Support Team (CPS-BHST) is a collaborative partnership

between Behavioral Health Services (BHS) and Child Protective Services (CPS) that focuses on supporting the behavioral health needs of children and youth within the Child Welfare system. This Partnership project serves children and youth from birth through age 20 and aligns with the implementation of Continuum of Care Reform. CPS ensures that a Child and Family Team (CFT) is provided to all children entering the Child Welfare system, aiming to decrease entry or re-entry into the child welfare system. CPS-BHST clinicians work alongside children, youth, and families who are not linked to a Behavioral Health Services provider, or under the age of 6, to complete the Child and Adolescent Needs and Strengths (CANS) tool. This tool helps evaluate the behavioral health needs and strengths of children and adolescents and is integrated into the CFT to support the youth and family in telling their story while better identifying their strengths and needs. Additionally, the CPS-BHST offers voluntary behavioral health assessments for parents and caregivers linking them to care, consultation for child welfare social workers, and other short-term behavioral health services. The team is also deployed to assist CPS with supporting children and families when urgent needs arise, provides consult to CPS social workers regarding trauma informed interventions, and acts to ensure coordinated linkage to care, and warm hand off to ongoing behavioral health treatment.

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

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	1169
FY 2027 – 2028	1376
FY 2028 – 2029	1618

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

Overview: Between July 2023 and November 2025, CPS-BHST enrollments experienced a median monthly increase of 17.65%, with fluctuations ranging from -3.51% to 141.46%. Fiscal Year 2025/2026 Performance: From July 2025 through November 2025, the median increase surged to 60.29%, indicating accelerated growth compared to the prior trend. Projection Basis and Justification: Projections are based on the historical 17-month median growth rate of 17.65%, which provides a conservative and data-driven estimate of future enrollment trends. While recent months show higher growth (60.29%), using the longer-term average helps mitigate the impact of short-term volatility and ensures projections remain realistic and sustainable. Additionally with forthcoming mandates for CPS, we will likely see increases in need for support and partnership.

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

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

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

Capital Star Crisis Residential Program (CRP) The Stay
The Capital Star Crisis Residential Program (CRP) – The STAY provides short-term, voluntary, 24/7 mental health support for Transitional Age Youth (TAY) and young adults ages 18–29. The program offers a safe, homelike, unlocked environment for individuals experiencing psychiatric crisis who do not require inpatient hospitalization. The STAY serves up to 15 residents at a time, with length of stay up to 30 days. The STAY is designed to help young adults stabilize, build coping skills, and transition successfully back into the community. Residents receive individualized and group counseling, psychiatric services, and support in addressing the underlying issues contributing to their crisis, including depression, anxiety, trauma, and co-occurring challenges. Core services include:

- 24/7 voluntary admissions and continuous staff support
- Individual, group, and peer-led counseling rooted in recovery principles
- Psychiatric assessment and medication support
- Development of individualized Wellness Recovery Action Plans (WRAP)
- Culturally responsive care, including affirming services for LGBTQIA+ young adults
- Transition and discharge planning, with linkages to outpatient behavioral health, housing programs, education, employment, healthcare, and community supports
- Skill-building and life-skills coaching to support independence and long-term stability
- Access regardless of insurance status, including those with or without Medi-Cal

The STAY fills a critical service gap for young adults who need structured, short-term support in a therapeutic setting to prevent hospitalization, reduce reliance on emergency departments, and promote long-term wellness.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	151
FY 2027 – 2028	159
FY 2028 – 2029	167

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

Projections were based on service data from July–September 2025, during which the program served 36 individuals (an average of 12 per month). This was annualized to a baseline estimate of 144 individuals per year. For future years, I applied a modest 5% annual growth rate, reflecting typical fluctuations in referrals, seasonal increases, and expected community need. This assumption also accounts for stable staffing and capacity, along with continued collaboration with hospital and community partners. These data and assumptions were used to project the estimated number of individuals the program will serve in FY 2026–2027, 2027–2028, and 2028–2029

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

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

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

Flexible Integrated Treatment/Therapeutic Behavioral Services (FIT/TBS) Program

The FIT/TBS Program helps young people and their families get care quickly and safely. Families can visit program hub sites or co-locations in the community, making it easier to access services. Services include therapy, case management, psychiatric support, and working with other county departments and community groups like Child Protective Services. FIT also helps families find safe housing to reduce homelessness. Through TBS, youth and families learn skills to manage behaviors, cope with stress, and build healthy habits. The program works with community partners, so families get complete support, not just mental health care. FIT uses proven methods like Functional Family Therapy (FFT), which helps families talk better, solve problems together, and strengthen relationships. The goal is to help youth make real progress, lower serious problems, and make sure no one leaves the program while still in crisis.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	9200
FY 2027 – 2028	9400
FY 2028 – 2029	9600

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

From July 1, 2024, through June 30, 2025 (FY 24/25), Sacramento County's FIT program served about 9,000 youth. Over the next three years, we expect the program census to stay close to this number based on historical trends, with slight increases due to added outreach and early intervention services through BHSA. These increases reflect expanded BHSA services and the natural population growth in Sacramento County.

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

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

Adult Systems of Care .

Please select the service types provided under Program
Mental health services
Supportive services
Substance Use Disorder treatment services

Please describe the specific services provided
Wind Youth Services: Rejuvenation Haven

The Rejuvenation Haven provides short-term Behavioral Health Services for eligible youth seeking relief from overwhelming stress and/or as a diversion from an emergency room visit or inpatient care. Services include individual and group, assessment and referral to appropriate services and resources. Target population is unserved and underserved youth ages 13-25.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1199
FY 2027 – 2028	1319
FY 2028 – 2029	1451

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care
The county looked at the number of clients served in past years and assumed a 5-10% increase from the previous year to project how many people the program would reach.

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

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

Adult Systems of Care .

Please select the service types provided under Program
Supportive services

Please describe the specific services provided
The Crisis Navigation Program (CNP) provides short-term, community-based support and system navigation for children, youth, and transition-age youth (TAY) experiencing a behavioral health crisis or who recently experienced a crisis resulting in hospitalization or an Emergency Department (ED) visit. The program offers rapid intervention, stabilization, and coordinated linkage to ongoing services.

CNP operates 24 hours a day, 7 days a week, ensuring timely access to support. Services include triage, recovery-oriented crisis intervention, de-escalation, peer support, and collaborative safety planning. Staff work with youth and families to stabilize the immediate crisis while identifying underlying needs, including family dynamics, school-related stressors, and social challenges.

The program supports coordination with caregivers, schools, outpatient providers, and other child-serving systems to ensure appropriate care transitions. CNP also links youth to Sacramento County's Mental Health Plan (MHP), outpatient behavioral health services, and community-based resources. The goal is to stabilize youth in crisis and connect them to ongoing, developmentally appropriate services that support long-term well-being.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	364
FY 2027 – 2028	382
FY 2028 – 2029	401

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care
To project the number of individuals served, the program's enrollment data from July–September 2025 was annualized. A modest annual growth rate of 5% each year was applied to reflect increasing community

need and seasonal referral patterns.

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

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

Please select the service types provided under Program
Mental health services

Please describe the specific services provided
Adult Psychiatric Support Services Clinic

Sacramento County's Adult Psychiatric Support Services (APSS) Clinic provides trauma-informed, recovery-oriented outpatient behavioral health services to adult residents who are Medi-Cal eligible and meet criteria for specialty mental health care. The program collaborates with participants and their supportive communities to foster a professional, respectful, compassionate, and safe environment that empowers clients to develop and achieve individualized goals. Services and supports offered by the program include comprehensive behavioral health assessments, level of care linkage where indicated, treatment planning, case management, peer support services, and group and individual therapy. Psychiatric evaluation and medication management are provided through thorough psychiatric assessments and ongoing medication support. Individual and group counseling services are tailored to recovery goals and incorporate trauma-informed care and clinical best practices. Dual diagnosis services are offered in-house or referred out to the Substance Use Prevention and Treatment (SUPT) team, depending on level of acuity. Peer support services engage clients through recovery-focused assistance from individuals with lived experience. Case management and linkage services help clients navigate and coordinate access to housing, employment, legal aid, and other community resources. Hospital discharge coordination expedites linkage to crucial services for individuals discharging from the inpatient setting, including those experiencing homelessness. Lastly, referral pathways for justice-involved clients provide specialized navigation and crisis services for individuals transitioning from correctional settings.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1851
FY 2027 – 2028	1907
FY 2028 – 2029	1964

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

The projections are based on census changes from FY23/24 and FY24/25. Of the four APSS programs, utilization has both increased and decreased. APSS-Sac-Edapt offers medication-only services for clients seen at UC Davis Sac Edapt clinic. Capacity is 10 clients, with two of the last three transferring to APSS Outpatient after aging out. Currently, no clients are engaged in APSS Sac Edapt.
SacCo-APSS-CalWORKs-Stockton, also medication-only for clients in CalWORKs Wellness therapy, had consistent numbers (37 to 38) between FY23/24 and FY24/25, but dropped to 14 in FY25/26—a 63% decrease. SacCo-APSS-OP-Stockton and SacCo-APSS-Post Hosp-Jail Assessment have increased utilization over the last two fiscal years. Post Hospital-Jail Assessment provides single-contact assessments for unlinked clients after hospitalization or incarceration, referring them for ongoing services. Starting in FY22/23, projections use FY23/24 data. Clients rose 2.1% from 1,261 (FY23/24) to 1,288 (FY24/25), remaining consistent in FY25/26. SacCo-APSS-OP-Stockton offers case management, therapy, medication, crisis intervention, and peer services. Closed to referrals prior to FY22/23, it reopened in 2023. Census grew 5.5% from 396 (FY23/24) to 418 (FY24/25), driven by CORE clinic referrals, Post Hospital Assessment, and walk-in hours. APSS total census: 1,697 clients in FY23/24, increasing to 1,745 in FY24/25 (2.8%). Based on this, a 3% annual increase is reasonable, excluding potential new specialty programs.

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

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

Please select the service types provided under Program
Mental health services

Please describe the specific services provided
Adult Residential Treatment Program

The Adult Residential Treatment Program (ARTP) provides comprehensive, culturally competent, strength-based, recovery-oriented, outpatient specialty mental health services and 24-hour residential services to adult beneficiaries who meet medical necessity criteria as defined by county policy. ARTP outpatient services are provided a campus model, co-located to their licensed residential facilities as part of the sub-acute continuum. ARTPs are a less restrictive environment than a Skilled Nursing Facility (SNF), Mental Health Rehabilitation Center (MHRC), Neurobehavioral SNF, Institute of Mental Disease (IMD), Psychiatric Health Facility (PHF) or State Hospitals. ARTP residential facilities maintain licensure from the Community Care Licensing Division. Residential services are provided in a structured home environment that supports improving the recovery and independent living skills of individuals living with co-occurring medical and/or substance use disorders along with a psychiatric condition, for the purpose of community integration and transition to a lower level of care.
The goals of ARTP are to provide an alternative to more restrictive residential levels of care for individuals who typically have not responded well to traditional outpatient mental health/psychiatric treatment. Also to provide services necessary to reduce and prevent negative outcomes, such as avoidable emergency room utilization, psychiatric hospitalization, or incarceration. And finally, to provide services that will increase the individual's ability to function at optimal levels and as independently as possible, with the end of services in mind toward the goal of wellness, including reducing and preventing homelessness, maintaining housing stability.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	30
FY 2027 – 2028	34

Plan Period by FY	Projected Number of Individuals Served
FY 2028 – 2029	38

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

Projections are based on historical program growth (14 individuals in FY 22/23 and 17 in FY 23/24), the FY 24/25 budget constraint that reduced capacity to 11 individuals, and the projected rebound to 27 individuals in FY 25/26. Future fiscal year estimates assume a moderate annual growth rate of approximately 10–15% based on historical trends and anticipated system demand.

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

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

Please select the service types provided under Program

Mental health services
Supportive services
Substance Use Disorder (SUD) treatment services

Please describe the specific services provided

Community, Outreach, Recovery, Engagement, Community Wellness Center (CORE)

Community Outreach Recovery Empowerment (CORE) is comprised of two co-located components across 11 sites in Sacramento County: CORE Outpatient Program and CORE Community Wellness Center (CWC). The CORE Outpatient shall serve up to 7700 individuals and provide flexible, member-driven, recovery-oriented, strength-based, trauma-informed, culturally and linguistically responsive, comprehensive community-based specialty mental health (MH) services and supports to adults, age 18 years and older, meeting target population, as defined by the Sacramento County, BHS. The program model includes a phased approach, offering FSP Intensive Case Management (ICM) level of care including outpatient support, initially focused on intensive engagement and assessment services for MH members who are either in, or discharged from, acute care settings or who are in need of intensive services for

stabilization with the goal of assisting individuals in transitioning to a lower level of service intensity over time and eventual successful completion of services from the Mental Health Plan (MHP). CORE provides homeless resource support services, such as housing stability and homeless prevention for members at-risk of homelessness or experiencing homelessness. CORE CWC shall serve up to 6600 individuals and be co-located to the CORE Outpatient Programs and be available to Sacramento County community members, age 18 years and older. CWC provides a welcoming environment that is reflective of the diversity of the residents in the neighborhood and shall offer meaningful activities, including peer-led activities, groups, and experiences that promote principles of wellness, recovery and resiliency. CWCs shall serve as both an entry point for individuals who need mental health (MH) services and supports as well as ongoing support for individuals stepping down from intensive services or transitioning from CORE Outpatient MH services and supports as well as ongoing support for individuals stepping down from intensive services or transitioning from CORE Outpatient MH services.

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

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	7184
FY 2027 – 2028	7327
FY 2028 – 2029	7473

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

From July 1, 2024, through June 30, 2025 (FY 24/25), Sacramento County's CORE Outpatient program served about 11,973 members. In 26/27, CORE programs will serve about 40% of their population though FSP ICM support, roughly leaving about 7184 non-FSP members approximately served. Over the next three years, we expect the program census to stay close to this number based on historical trends and increase about 2% per year. These increases reflect expanded BHSA services and the natural population growth in Sacramento County.

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

For each program or service type that is part of the county's BHSS funded Adult and Older Adult

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

Please select the service types provided under Program
Supportive services

Please describe the specific services provided
Bay Area Community Services, (BACS) Crisis Navigation Program

The Crisis Navigation Program (CNP) provides short-term, community-based support and system navigation for adults and older adults experiencing a behavioral health crisis or who recently experienced a crisis resulting in hospitalization or an Emergency Department (ED) visit. The program supports individuals who require rapid intervention, stabilization, and linkage to ongoing services.

CNP operates 24 hours a day, 7 days a week, ensuring individuals can receive immediate support at any time. Services include triage, recovery-focused crisis intervention, de-escalation, peer support, and collaborative safety planning. Staff work to stabilize the immediate crisis while identifying barriers to care, including housing instability, substance use, and access to ongoing treatment.

The program provides system navigation and direct linkage to Sacramento County's Mental Health Plan (MHP), outpatient behavioral health providers, and community resources such as housing, benefits support, and substance use treatment. CNP also coordinates with hospitals, outpatient programs, and community partners to support safe and timely transitions of care. The overall goal is to help individuals stabilize, access the appropriate level of care, and engage in longer-term services that support recovery and stability.

SUPT program continues to strengthen services and outreach for older adults experiencing SUD, recognizing the growing number of individuals over age 50 who are impacted by opioid, methamphetamine, and polysubstance use.

Older Adult – Most Common Substance Use Disorder: FY 23-24
1. Opioid Use Disorder
2. Other Stimulant Use Disorder
3. Alcohol Use Disorder
4. Amphetamine Use Disorder
5. Cocaine Use Disorder

The SUPT continuum of care includes specialized services for adults and older adults, spanning outpatient, intensive outpatient, withdrawal management, Medication-Assisted Treatment (MAT), residential care, recovery residences, and field-based engagement. These services remain accessible to older adults through countywide referral pathways, including Older Adult Shelters, community access points, and partnerships designed to reach individuals experiencing homelessness.

SUPT collaborates with homeless shelters and multidisciplinary teams (MDTs) to identify older adults with untreated or emerging SUD needs, provide on-site or field-based screenings, and facilitate rapid linkage to treatment. In alignment with the county's approach to culturally responsive and age-inclusive services, staff conduct targeted outreach, deliver SUD education, and support navigation to care across the SUPT continuum. Training efforts—including coordination with Adult Protective Services (APS)—strengthen early identification of SUD among older adults by equipping APS workers with the skills to recognize substance-related risk factors, administer screenings, and complete warm handoffs to SUPT programs. This approach ensures that older adults receive timely, coordinated interventions that address safety, health needs, and housing instability while reducing barriers to engagement.

In collaboration with the District Attorney's Office and Coroner's Office, SUPT participates in the monthly Elder Death Review Team to identify behavioral trends that contribute to older adult deaths.

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

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	1455
FY 2027 – 2028	1528
FY 2028 – 2029	1604

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

To project the number of individuals served, the program's enrollment data from July–September 2025 was annualized. A modest annual growth rate of 5% each year was applied to reflect increasing community need and seasonal referral patterns.

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

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

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

Turning Point Community Programs Sacramento Crisis Residential Program (CRP)

The Crisis Residential Program (CRP) provides short-term crisis stabilization services in a voluntary, home-like residential setting as an alternative to, or step-down from, inpatient psychiatric hospitalization. CRP serves adults (18+) who are experiencing a psychiatric crisis and would benefit from structured support, supervision, and therapeutic services to safely stabilize and reintegrate back into the community. The program operates 24 hours a day, 7 days a week, offering a supportive environment designed to help individuals reduce symptoms, increase coping abilities, and establish a plan for ongoing recovery. Services include: Medication support and management, including assessment, prescribing, and monitoring by licensed clinical staff. Individual therapy, focusing on crisis stabilization, safety planning, and development of coping strategies. Group therapy, offering skill-building, psychoeducation, and peer support. Case management, including coordination of care, linkage to outpatient mental health providers, benefits assistance, and discharge planning. Crisis intervention, providing immediate support to help clients manage acute symptoms and maintain safety. CRP staff work collaboratively with individuals to identify personalized goals, build daily living skills, strengthen wellness strategies, and connect residents to community-based supports such as psychiatry, housing resources, substance-use services, and ongoing behavioral health care. The program emphasizes person-centered, recovery-oriented, and trauma-informed approaches to support stabilization and successful transition back to the community supports such as psychiatry, housing resources, substance-use services, and ongoing behavioral health care. The program emphasizes person-centered, recovery-oriented, and trauma-informed approaches to support stabilization and successful transition back to the community.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	388
FY 2027 – 2028	400
FY 2028 – 2029	412

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

The projected number of clients served was based on three months of actual service data (July–September 2025) from all three Crisis Residential Program sites. Each site's total enrollments for the period were converted to a monthly average and then annualized to estimate yearly capacity. This method assumes stable referral patterns, consistent operational staffing, and no major program changes. Using this approach, the three programs collectively are projected to serve approximately 388 individuals per fiscal year.

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

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

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

Turning Point Community Programs Mental Health Urgent Care Clinic

Flexible, client-driven, recovery-oriented, strength-based, trauma-informed, culturally and linguistically responsive, comprehensive community-based Treatment Services, Peer Support Services, Intensive Coordination, Crisis Response, and Medication Support are amongst the specific services provided by TPCP MHUCC.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	550
FY 2027 – 2028	570
FY 2028 – 2029	580

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

The county utilized previous data markers from the TPCP MHUCC dashboard and numbers from the provider's Data team to project the number of individuals served through the Adult and Older Adult System of Care.

Early Intervention (EI) Programs

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

Program or service name
Flexible Integrated Treatment/Therapeutic Behavioral Health (FIT/TBS Early Intervention (EI) Program

Please select which of the three EI components are included as part of the program or service
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please select the EBPs and CDEPs that apply
Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)
Cognitive Behavioral Therapy (CBT) for Psychosis
Dialectical Behavior Therapy
Functional Family Therapy (FFT)
Incredible Years
Multisystemic Therapy (MST)
Parent Child Interaction Therapy (PCIT)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Parent-Child Care (PC-CARE)
Coping Cat

ART (Aggression Replacement Training)

Team Aim High

Latino MultiFamily Group (LMFG)

Cultura de Salud

Family Based Therapy (FBT)

Coordinated Specialty Care (CSC)

High Fidelity Wraparound (HFW)

Please describe intended outcomes of the program or service

a. Click or tap here to enter text. Youth get help early, before problems become crises or require higher levels of care.
b. Quickly improve daily functioning at home, school, and in relationships.
c. Families learn skills to support their child and prevent escalation.
d. Young people build coping tools and confidence that reduce future reliance on crisis or inpatient services.
e. Overall mental health recovery time shortens because support happens closer to the first signs of struggle.
f. Risks like suicidality, substance use, or out-of-home placement are reduced through timely, targeted support.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2006
FY 2027 – 2028	2126
FY 2028 – 2029	2272

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

Sacramento County Behavioral Health Services (BHS) served approximately 9,000 youth in the FIT program from July 1, 2024, to June 30, 2025. FIT served all youth with specialty mental health. We are integrating Early Intervention Services into FIT (soon to be ATLAS) and are expecting to see a new stream of clients with EI needs

Early Intervention (EI) Programs

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

Program or service name

Sacramento LGBT Community Center-Q Spot

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or

decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please select the EBPs and CDEPs that apply
Motivational Enhancement Therapy (MET) / Motivational Interviewing
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Late Life Depression
Cognitive Behavioral Therapy (CBT) for Psychosis
Mental Health SkillBuilding and Mood Intervention
Dialectical Behavior Therapy

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
LGBT Affirmative Therapy
Solution Focused Brief Therapy

Psychodynamic

Somatic

Family Systems

Self-Care

Peer Support

Trauma Informed Care

Please describe intended outcomes of the program or service

As part of providing short-term behavioral health supportive services for eligible youth and transition age youth, the program aims to foster a strong sense of connectedness and reduce isolation; improve knowledge of how to access services, reduce risk factors and the need for crisis interventions; strengthen protective factors; and decrease utilization of emergency rooms, psychiatric hospitals, and jail, all while respecting and supporting each individual's cultural beliefs and value.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	4278
FY 2027 – 2028	4470
FY 2028 – 2029	4662

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

The county looked at the number of clients served in past years and assumed a 5-10% increase from the previous year to project how many people the program would reach.

Early Intervention (EI) Programs

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

Program or service name
Capital Adoptive Families Alliance (CAFA) Respite Program

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
A. Decrease stress and burnout among adoptive parents and caregivers by providing planned, predictable respite opportunities that interrupt chronic stress and caregiver fatigue.

B. Improve caregiver coping capacity and emotional regulation, enabling parents to respond more effectively to behavioral, emotional, and developmental challenges experienced by adoptive children.

C. Increase participants' sense of well-being and resilience, as measured through participant-reported outcomes related to stress reduction, coping ability, and overall wellness.

D. Strengthen family functioning and stability by supporting healthy parent–child relationships and reducing conditions that may contribute to placement disruption, crisis escalation, or entry into higher-intensity behavioral health services.

E. Increase awareness of and connection to behavioral health resources, including Medi-Cal specialty

mental health services, through outreach, education, and referrals when additional support is needed.

F. Prevent escalation into behavioral health crises by addressing upstream stressors and providing non-clinical supports that promote early intervention and protective factors for children and families

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	240
FY 2027 – 2028	240
FY 2028 – 2029	240

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
This is the number of individuals currently served by the program. Sacramento County is expecting that this program maintain the current level of individuals served to support this specific population

Early Intervention (EI) Programs

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

Program or service name
Supporting Community Connections

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

Yes

Please select the EBPs and CDEPs that apply

Gathering of Native Americans (GONA)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Centro de Apoyo Latino

Please describe intended outcomes of the program or service

Supporting Community Connections (SCC): A constellation of community-based agencies working collaboratively throughout the County to prevent mental illnesses and substance use disorders from becoming severe and/or disabling while reducing disparities in behavioral health by providing cultural, ethnic, and age-specific support services. Programs are designed to increase access to and linkage with needed services; improve self-reported life satisfaction and well-being; reduce risk factors and enhance of protective factors; divert from crisis services or decrease need for crisis services; decrease suicide risk; increase knowledge of available resources and supports; and enhance connectedness and reduce isolation. Each program is specifically tailored to meet the needs of their respective communities. There are programs for the Afghan, American Indian/Alaska Native/Indigenous, Arabic-speaking, Black/African American/African Descent, Cantonese/Hmong/Vietnamese-speaking, Farsi-speaking, Russian-speaking/Slavic, Spanish-speaking, Iu Mien, and Youth/TAY communities, as well as a Ukrainian Phone Support line.

SCC Early Intervention focuses on approaching eligible high-risk individuals within BHSA priority populations, including older adults and youth, in culturally, ethnically, linguistically, and age-appropriate ways; assessing and identifying their individual access and linkage needs, assessing eligibility and interest, and connecting those who are both interested and eligible directly to access and linkage programs and/or to mental health and substance use disorder treatment services and supports

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	5060
FY 2027 – 2028	5060
FY 2028 – 2029	5060

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

The projection includes a combined estimate from all the SCCs, of all outreach and support services and is based on a historical review of individuals served in prior years.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to 7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis .

Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program

CSC program name

Sacramento Early Diagnosis and Preventive Treatment (SacEDAPT), operated by UC Davis Department of Psychiatry

CSC program description

The SacEDAPT program helps individuals who are experiencing psychosis for the first time. Psychosis means seeing or hearing things that aren't real or having thoughts that don't make sense. This program gives individuals and their families the support they need early, so things don't get worse. SacEDAPT uses a team approach which includes doctors, therapists, and peer supporters who work together to make a plan that fits everyone's needs. Individuals get help with school, work, and relationships, and they learn ways to manage their symptoms. Families also get support so they can understand what's happening and help their family member. The goal is to help individuals feel better, stay safe, and get back to doing things they enjoy. They make a plan that fits the individual's needs and help them stay in school, get a job, and feel better. The team checks in often and changes the plan if needed. SacEDAPT also works with other programs and hospitals to make sure youth don't fall through the cracks. SacEDAPT utilizes the CSC program to start early, give lots of support, and help individuals recover and live a better life.

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population. These projections are not binding and are for planning purposes. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements

Please review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county in the table below.

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	261
Number of Uninsured Individuals	19

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	30
Number of Teams Needed to Serve Total Eligible Population	7

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	7	20	30
Total Number of Teams	1	3	7

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

Yes

Please list the other funding source(s)

SAMHSA MHBG (Mental Health Block Grant), Medi-Cal Reimbursement from Specialty Mental Health Plan

Full Service Partnership Program

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

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

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	4842
Number of Uninsured Individuals	438

Total Adult FSP Eligible Population	Estimates
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	1743

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

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

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	679
Number of Uninsured Individuals	61

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	339
Number of Uninsured Individuals	31

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	120
Number of Teams Needed to Serve Total Eligible Population	12

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	100	111	111
Total Number of Teams	10	11	11

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

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

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	3824
Number of Uninsured Individuals	346

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	170
Number of Teams Needed to Serve Total Eligible Population	34

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	155	155	155

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Teams	31	31	31

High Fidelity Wraparound (HFW) Eligible Population

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	0
Number of Uninsured Individuals	0

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	0
Number of Teams Needed to Serve Total Eligible Population	0

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	39	49	49
Total Number of Teams	35	42	42

Individual Placement and Support (IPS) Eligible Population

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

IPS Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	6328
Number of Uninsured Individuals	589

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	433
Number of Teams Needed to Serve Total Eligible Population	173

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	25	408	408
Total Number of Teams	10	163	163

Full Service Partnership (FSP) Program Overview

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

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?

No

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

The county's approach to FSP is grounded in trauma-informed, whole-person care, which emphasizes emotional and physical safety, empowerment, transparency, and culturally responsive practice. Providers incorporate natural supports, including families, caregivers, and other meaningful figures, throughout assessment, treatment planning, and crisis planning. This approach aligns with the RFA's expectation that FSP services address the interconnected needs of health, housing, purpose, and community. The redesigned system integrates behavioral health, physical health coordination, housing stability services, employment supports, substance-use support, and community resource navigation so that clients receive care that reflects the full context of their lives. Working collaboratively with natural supports is a key strategy for strengthening engagement, reducing isolation, and supporting long-term recovery.

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

The county's planning process intentionally focused on reducing disparities by engaging diverse community members, reviewing pertinent data, and identifying priority populations who experience barriers to care. Through community conversations, stakeholder meetings, and cultural listening sessions, the county gathered insights from Black and African American communities, Latino communities, Asian and Pacific Islander communities, Refugee and New American populations, LGBTQ+ residents, older adults, and individuals with justice involvement. These insights shaped the expectations placed on providers related to cultural and linguistic responsiveness, diverse staffing, trauma-informed care, flexible engagement practices, and field-based services. The redesigned FSP model includes requirements that aim to improve access, strengthen cultural alignment, and ensure that services are delivered in ways that reduce inequities in outcomes.

Select which goals the county is hoping to support based on the county's allocation of FSP funding

Access to care
Homelessness
Institutionalization
Justice involvement
Removal of children from home
Untreated behavioral health conditions
Care experience
Engagement in school
Engagement in work
Overdoses
Prevention of co-occurring physical health conditions
Quality of life
Social connection

Suicides

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

To support ongoing engagement in ICM, the county ensures that providers maintain the intensive field-based and relationship-driven practices required in the RFA. This includes frequent in-person contact, flexible scheduling, rapid crisis response, and assertive follow-up when clients disengage. Program Coordinators oversee fidelity and training to ensure that engagement expectations are met across all FSP programs. Providers are expected to coordinate care with MCPs, hospitals, shelters, jails, and other community partners, especially following major events such as hospitalizations or incarcerations. The county's system-level oversight, data monitoring, and technical assistance help ensure that providers maintain continuous, person-centered engagement even when symptoms or life circumstances create barriers.

Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW.
Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP

Beyond the engagement activities required by ACT, FACT, IPS, and HFW, the county supports additional strategies that promote continuity and stability. Providers may strengthen engagement by connecting with clients during discharge from inpatient psychiatric units, the jail psychiatric unit, the Mental Health Urgent Care Clinic, or other crisis settings. Some programs may offer peer-run recovery groups, culturally specific engagement activities, wellness supports, or benefit-navigation assistance. These additional strategies help maintain momentum, reinforce the therapeutic relationship, and reduce avoidable crises while supporting long-term recovery goals.

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)

The county will comply with the required levels of care by implementing the structure outlined in the RFA, which includes ten FSP sites operated by five organizations. Each program will offer both ACT and ICM within one integrated team, consistent with the requirement that approximately forty percent of clients receive ACT and sixty percent receive ICM. Providers will maintain the multidisciplinary staffing needed for ACT fidelity while also delivering IPS, peer services, ECHW support, housing stabilization services, and field-based substance-use engagement. Clients will move between ACT and ICM based on clinical need and medical necessity. The county will monitor fidelity, provide oversight, and ensure that team composition and staffing ratios align with BHSA requirements throughout implementation.

Please indicate whether the county FSP program will include any of the following optional and allowable services
N/A

Primary substance use disorder (SUD) FSPs
No

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)
Yes

Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program
FSP outreach is conducted through field-based engagement in the community, including shelters, encampments, hospitals, emergency departments, and crisis settings. Providers use assertive strategies to connect with individuals who have significant behavioral health needs and may be disconnected from traditional care. This includes meeting people where they are, coordinating with partners who regularly encounter high-need populations, and maintaining intensive engagement.

Other recovery-oriented services
Yes

Please describe the other recovery-oriented services the county's FSP program will include
In addition to required EBPs, the FSP system includes recovery-oriented supports such as wellness activities, peer support, cultural and affinity-based groups, housing stabilization services, benefits advocacy, and SSI/SSDI application assistance.

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

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

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

In developing the FSP program, BHS reviewed relevant data, engaged key system partners, and incorporated evidence-based research to understand and address the unique needs of youth who are in, or at risk of entering, the juvenile justice system.

Partners Consulted

Input was gathered from partners during meetings, like the interagency leadership committee and conversations who work directly with youth experiencing or at risk of juvenile justice involvement, including Sacramento County Probation staff providing firsthand insight into youth supervision needs and system gaps; mental health clinicians, supervisors, and program coordinators serving youth in the Youth Detention Facility, who contributed information on presenting behavioral health needs and barriers to service access; and Child Protective Services, education representatives, and community-based organizations who participated in collaborative planning discussions through the CYFSOC Interagency Leadership Team and Advisory Team, the Cross Systems Steering Committee, and the Juvenile Justice Subcommittee.

Research and Evidence Considered

BHS reviewed evidence-based interventions appropriate for high-risk youth, including Multisystemic Therapy (MST) and High Fidelity Wraparound (HFW). MST has a strong evidence base for reducing recidivism, out-of-home placement, and psychiatric hospitalization among justice-involved youth with serious behavioral challenges. HFW is an evidence-based model with demonstrated effectiveness in stabilizing high-needs youth in their homes and communities. Both models were selected because the local data — showing Black youth disproportionately represented in justice settings, elevated arrest rates, and geographic concentration of risk in specific ZIP codes, pointed to the need for intensive, family-centered, community-based interventions that could reach youth before or immediately upon justice contact rather than after placement or institutionalization.

Together, these data sources, stakeholder perspectives, and research supported models informed the development of the FSP program to ensure it effectively meets the needs of eligible children and youth who are in, or at risk of entering, the juvenile justice system.

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

In developing the FSPW program, BHS reviewed data, engaged stakeholders, and incorporated evidence-based research to understand and address the unique needs of eligible children and youth who are LGBTQ+.

BHS reviewed MHSA Prevention and Early Intervention (PEI) program data, which documented consistent participation by LGBTQ+ youth in early intervention services alongside persistent disparities related to identity-based stress, stigma, and safety concerns. These patterns reinforced the need for affirming, trauma-informed approaches within intensive services, not only prevention programming. BHS also reviewed state and national research on LGBTQ+ youth mental health, including the California Department of Public Health Office of Suicide Prevention's 2023 Youth Suicide Prevention Program Highlights, which identifies LGBTQ+ youth as a population disproportionately impacted by suicide and a target population for California's statewide Never a Bother suicide prevention campaign. Notably, Sacramento County was identified by CDPH as one of ten high-priority counties for the Youth Suicide Reporting and Crisis Response Pilot Program based on elevated rates of self-harm ED visits and youth suicide, reflecting the urgency of the local need. National data from the CDC's 2023 Youth Risk Behavior Survey further documented that LGBTQ+ youth are at substantially elevated risk, 41% seriously considered suicide in the past year and 20% attempted suicide, compared to their cisgender and heterosexual peers. The Trevor Project's 2023 National Survey found that 56% of LGBTQ+ young people who wanted mental health care were unable to access it, establishing that access barriers to affirming, intensive behavioral health services are a documented and significant gap for this population. Together these data sources confirmed that LGBTQ+ youth with high behavioral health acuity require access to intensive, affirming services at the FSP level of care, not only prevention programming.

Input was gathered through the CYFSOC Interagency Leadership Team and Advisory Team, community-based organizations serving LGBTQ+ youth, MHSA PEI program providers, and advisory groups, who collectively identified gaps in intensive services for LGBTQ+ youth and emphasized the importance of affirming, trauma-informed approaches in high-acuity settings. Community feedback highlighted that LGBTQ+ youth with serious behavioral health needs require the same intensive, "whatever it takes" service approach as other FSP populations, and that stigma and identity-based barriers are particularly pronounced when youth are transitioning across systems or at risk of higher levels of care.

Research and Evidence Considered

BHS reviewed evidence-based practices and culturally responsive service frameworks appropriate for LGBTQ+ youth in intensive outpatient settings, including trauma-informed approaches that address minority stress, family rejection, and identity-based discrimination as clinical drivers of behavioral health need at the FSP level of intensity. Research consistently documents that affirming care, including providers who respect gender identity and sexual orientation, physical environments where youth feel safe, and service models that explicitly address identity-based stressors, significantly improves engagement and outcomes for LGBTQ+ youth in behavioral health services.

These data sources, partner input, and research findings directly informed the development of the FSPW program (MHC/037). The FSPW RFA explicitly names LGBTQ+ youth as a required priority population for specialized interventions. The RFA requires FSPW contractors to provide an emotional and physical environment where people of all cultures, ages, sexual orientation, gender identity, and gender expression feel welcome and cared for, to collect data disaggregated by gender and sexual orientation, and to actively collaborate with LGBTQ+ communities to design culturally appropriate outreach, engagement, and behavioral health services. Cultural competence requirements in the FSPW contract explicitly extend to LGBTQ+ identity as a dimension of culturally responsive care, with providers required to promote equity in service utilization by sustaining meaningful participation of LGBTQ+ communities in program planning and evaluation. The contract further requires providers to create physical environments that ensure people of all sexual orientations and gender identities and expressions feel welcome and cared for, and to provide services without discrimination based on gender identity, gender expression, or sexual orientation.

In the child welfare system

The county considered the needs of children and youth involved in the child welfare system by partnering closely with Child Protective Services to support shared planning, timely communication, and alignment with initiatives such as Continuum of Care Reform, the Family First Prevention Services Act, and BH CONNECT. The county emphasized the use of Child and Family Team (CFT) meetings to ensure coordinated care. These meetings bring together the youth, their family, CPS, schools, health providers, Alta Regional, Substance Use Prevention and Treatment, and other child-serving systems. CFTs are facilitated in accordance with EBP guidelines and occur as needed to support safety, stability, and cross-system collaboration for youth in the child welfare system.

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

Older adults

When the county redesigned the FSP system, it reviewed data and community feedback that highlighted the unique needs of older adults living with serious mental illness. Many individuals in this group experience complex medical conditions, cognitive decline, mobility challenges, and long-term housing instability. The county considered these factors by strengthening expectations around integrated physical and behavioral health coordination, ensuring that ACT and ICM teams include the capacity to work closely with MCPs, primary care providers, and hospitals. Stakeholders emphasized the importance of aging-friendly engagement practices and field-based services, which shaped the county's focus on trauma-informed care, flexible outreach, and individualized recovery planning. These considerations helped ensure that the redesigned FSP model supports older adults with both behavioral health and age-related needs.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
The county also examined the needs of LGBTQ+ adults by incorporating feedback from community conversations, culturally specific stakeholders, and local advocacy groups. Many individuals in this population face heightened exposure to trauma, discrimination, family rejection, and social isolation. The county integrated these insights by requiring providers to demonstrate their experience with serving the needed of the LBGTQ+ community.

In, or are at risk of being in, the justice system
The county considered the needs of adults who are currently involved or at risk of entering, the justice system by incorporating stakeholder feedback from our justice partners and those being service and including Forensic Assertive Community Treatment (FACT) into its planning. By including FACT, the county ensured that high-risk adults have access to services that strengthen functioning, improve engagement, and support stability in the community.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs
BHS SUPT and MH County Staff, the Opioid Coalition members, CORE sites (Community Wellness Centers), SANE and Harm Reduction Providers, HEART, Omni Youth Programs, Public Health Institute, and the Narcan Distribution Project.

Program descriptions

Sacramento County meets assertive field based requirements. Eligible members can access services through BHS SAC or directly from a provider site that includes business and drop in hours. 10 FSP programs are specifically designed to provide field based co-occurring services and quicky assess and connect members to additional SUPT services, includinge MAT providers. We have 9 MAT providers at 11 locations providing MAT services on demand. Additional field based alternatives include mobile medical teams, Sacramento fire, mobile integrated teams, Sacramento street medicine teams, and harm reduction mobile teams that service the greater Sacramento area. These teams do rapid screening and induction of MAT services with linkage to a community based provider for ongoing care.

SUPT also partners with the BHS HEART Team, which, targets individuals experiencing chronic homelessness within encampments and shelters. This teams conducts BQUiP screenings and referral SUD treatment. Much of their outreach locations are decided in partnership with City and other County departments.

Youth Full Service Partnership Wraparound program launching July 1, 2026, will ensure that Assertive Field-Based Initiation for SUD Treatment Services is available to all FSP-enrolled youth through a defined coordination pathway with Sacramento County's existing SUPT assertive field-based infrastructure. FSPW contract requirements will be amended to require contractors to screen enrolled youth for SUD needs using the Brief Questionnaire for Initial Placement (BQuIP) tool. Individuals identified with lower-complexity co-occurring SUD needs will receive integrated SUD treatment within the FSP model. Youth identified as requiring assertive field-based engagement, MAT initiation, or higher-intensity SUD services will be referred through a formal referral pathway to Sacramento County SUPT's assertive field-based programs. This coordinated model ensures that FSP-enrolled youth have access to the full continuum of assertive field-based SUD initiation services without duplication of infrastructure, and that no individual in the FSP system encounters a barrier to MAT access due to their enrollment in a mental health-primary FSP program.

Current funding source

DMC-ODS, Opioid Settlement Funds

BHSA changes to existing programs to meet BHSA requirements

Already established within existing Programs.

Expected timeline of operation

Already established and will continue efforts.

Mobile-field based programs

Existing programs
SANE and Harm Reduction Services (HRS) are programs that offer mobile field based services.

BHS SUPT held a Mobile Medicine Summit to build a partnership among the Sacramento Fire Department, Mobile Medicine Teams, and Sacramento County Behavioral Health Services – Substance Use Prevention and Treatment Services in which we were able to come together to learn more about our respective services, we discussed current trends, exchanged knowledge, and shared/developed innovative ideas.

Program descriptions
SANE and Harm Reduction Services (HRS) are in the field and ensure quick access to FDA-approved MAT at Transitions Clinic of Sacramento who has individual prescribers providing MAT and including NTPs to ensure access to methadone.

Additionally, we partner with Sacramento Fire Department has a Street Overdose Response Team (SORT) and
Sac Metro Fire has a Mobile Integrated Health (MIH) Teams. Both of these teams provide mobile field based services including (Responding in real time to overdose related incidents, Coordinated Response with Department of Community Response, Outreach to the community, Harm reduction kits, Leave behind Narcan, Fentanyl testing strips, Follow up Case Management, Partnerships with Transitions, BAART, Hope Cooperative and SANE.) These programs were present at the Mobile Medicine Summit.

Current funding source
DMC-ODS, Opioid Settlement Funds

BHSA changes to existing programs to meet BHSA requirements
We will continue to explore potential opportunities for mobile NTP programs. We are planning another Mobile Medicine Summit for 2026 where we will discuss possibilities.

Expected timeline of operation
By December 31, 2026.

Open-access clinics

Existing programs
Sacramento County Substance Use Prevention and Treatment has a continuum of providers who provide MAT services. These are the MAT Providers: Aegis Treatment Centers, Bi-Valley Medical Clinic, C.O.R.E. Medical Clinic, MedMark Treatment Centers, Sunrise Health and Wellness, Transitions Buprenorphine Clinic of Sacramento, Treatment Associates, WellSpace Health. Note that some of the organizations have multiple contracted sites. We also have SANE and Harm Reduction Services (HRS) who provide open access MAT and harm reduction services.

Program descriptions
Medication-Assisted Treatment (MAT) includes the same components as Outpatient Services with the inclusion of medical psychotherapy consisting of face-to-face discussion conducted by a physician on a one-on-one basis with an individual. Medication-Assisted Treatment includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Opioid and alcohol dependence, in particular, have well established medication options. Medication assisted treatment may include (varies by clinic): methadone, buprenorphine, naloxone and disulfiram. Sacramento County MAT Providers all have Medication Units. Our licensed NTPs dispense methadone and other MAT at their sites. Patients can be seen on the same day they “drop-in” or request to be seen. Additionally, the MAT providers ensure care coordination, link people to primary care, and other behavioral health treatment.

Current funding source
DMC-ODS, Opioid Settlement Funds

BHSA changes to existing programs to meet BHSA requirements
Already established within existing Programs.

Expected timeline of operation
Already established and will continue efforts.

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

New programs
Sacramento County Substance Use Treatment Providers were offered an incentive FY25/26 to focus on targeted outreach expansion.

Program descriptions

Sacramento County SUPT is targeting outreach for particular populations for current prevention and treatment efforts (deaf and hard of hearing, Russian, Farsi, Iu Mien, Afghani, and Hispanic/Latino/a/x, African American.) Data was collected through high risk overdose areas and aligned that through collaborative system of care efforts with Child Welfare and Probation's service gap areas. The engagement and outreach are also occurring throughout Opioid Coalition partnership. Outreach and engagement have taken place with local leaders in identified zip code areas that service these populations via meetings, outreach events, community listening sessions and more.

We will be having existing and new FSP providers implementing these program elements. For new providers, Sacramento County's Full Service Partnership Wraparound program and Adult Full Services Partnership programs will ensure that Assertive Field-Based Initiation for SUD Treatment Services is available to all FSP-enrolled youth and FSP-enrolled adults through a defined coordination pathway with Sacramento County's existing SUPT assertive field-based infrastructure. All adult FSP and FSPW contractors will be required to screen enrolled individuals for SUD needs using the Brief Questionnaire for Initial Placement (BQuIP) tool. Individuals identified with lower-complexity co-occurring SUD needs will receive integrated SUD treatment within the FSP model. Individuals identified as requiring assertive field-based engagement, MAT initiation, or higher-intensity SUD services will be referred through a formal referral pathway to Sacramento County SUPT's assertive field-based programs, which include mobile medical teams, Sacramento Fire mobile integrated teams, Sacramento Street Medicine teams, harm reduction mobile teams, and nine MAT providers across eleven locations providing open-access, on-demand MAT services throughout the greater Sacramento area. This coordinated model ensures that FSPW-enrolled youth have access to the full continuum of assertive field-based SUD initiation services without duplication of infrastructure, and that no individual in the FSP system encounters a barrier to MAT access due to their enrollment in a mental health-primary FSP program.

Planned funding

CalAIM Incentive Funding

Planned operations

This incentive will be continued moving forward and will be available for treatment providers so they may continue those outreach and engagement efforts.

Expected timeline of implementation

Already established and will continue efforts.

Mobile-field based programs

New programs
N/A

Program descriptions
N/A

Planned funding
N/A

Planned operations
N/A

Expected timeline of implementation
N/A

Open-access clinics

New programs
Pilot co-occurring FSP Program within an existing Behavioral Health FSP Program.

Program descriptions
Sacramento County BHS SUPT will be working with the FSPs to ensure that once a member is screened for MAT the member is immediately linked to appropriate care. There are 9 MAT providers in 11 locations and will support members with accessing assertive field-based programs currently operational as described in the previous section. All MAT providers are open access for assessment and treatment. Additionally, all new FSP staff will be trained in providing the BQuIP Training so they may screen and place individuals into the appropriate care. Clinical staff are also providing screening/assessments and linkage to SUD treatment at our Safe Stay programs which are temporary housing programs.

Sacramento County BHS SUPT has recently added a new non-NTP MAT Program, Transitions Buprenorphine Clinic of Sacramento. Transitions is a community-based outpatient and addiction medicine program committed to delivering comprehensive, compassionate care to individuals affected by substance use. The program offers a full spectrum of outpatient services, and medications for addiction treatment (MAT), counseling, and supportive harm reduction services, regardless of the substance involved. Transitions maintains a harm reduction approach and emphasizes low-barrier, flexible care. The program works closely with Sac Fire Department: Street Overdose Response Team, which provides referrals directly

from the community, helping to reach individuals at high risk and connect them to timely, life-saving services. Transitions continues to evolve while staying rooted in its mission: to provide the best, most complete addiction care to all patients, regardless of circumstance. This program's primary population is to serve adults; however, they are able to serve youth (ages 12-17) as well depending on the need. That would be up to the doctor's discretion and the provider would follow the regulations in regard to prescribing MAT.

Two harm reduction programs provide targeted outreach in the community to vulnerable populations and provide the induction of MAT and linkage to MAT network providers.

Sacramento County provides Medication-Assisted Treatment (MAT) within both adult and youth correctional settings as part of the county's Justice-Involved continuum. Individuals are screened and assessed for SUD needs while in custody, and when clinically appropriate, are inducted on FDA-approved MAT medications to stabilize withdrawal symptoms and support recovery, consistent with DHCS justice-involved treatment requirements. Upon release, SUPT conducts SUD assessments and links individuals to community NTPs and DMC-ODS providers to ensure continuation of MAT without interruption, following the system goal of "zero days without medications" during transitions in care. SUPT staff coordinate closely with probation, jail health partners, and community providers so that individuals leave custody with a warm handoff, a confirmed treatment appointment, and an active MAT plan, minimizing gaps in dosing and reducing overdose risk during reentry.

Planned funding
Specialty Mental Health Services and DMC-ODS

Planned operations
We will explore existing mental health FSPs with the possibility of adding co-occurring care including addressing SUDs.

Expected timeline of implementation
July 1, 2029

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

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
The County will undertake a comprehensive gap analysis to assess whether existing Medication-Assisted Treatment (MAT) resources adequately address the needs of the community. This analysis will encompass:

• Evaluating youth MAT network adequacy standards against existing MAT provider network capacity.
• Evaluating adult MAT network adequacy standards against existing MAT provider network capacity.
• Examining timeliness of services provided to youth by existing MAT network providers.
• Examining timeliness of services provided to adults by existing MAT network providers.
• Analyzing SmartCare MAT treatment data to identify unserved and underserved populations by age, race/ethnicity, other special populations, and zip code.
• Pinpointing areas within the County that exhibit high rates of opioid overdoses and fatalities, utilizing data from Overdose Detection Map and the Sacramento Coroner's Office. We will partner with Sacramento County Public Health and EMS regarding the ODMap data and cross compare that with our existing MAT Programs and services to take a look at where service gaps exist, identify underserved areas, and determine where additional MAT capacity or new service sites may be needed to effectively respond to community needs.
• Mapping the locations of existing MAT network providers to determine if current distribution throughout Sacramento County aligns with community needs.
• Formulating a targeted, strategic plan specifying precise steps, resource allocation, and timelines necessary to address identified gaps.

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

Contract directly with MAT providers in the County
Leverage telehealth model(s)
Contract with MAT providers in other counties
Other strategy

Please provide the names of other counties the contracted MAT providers are located in

We currently contract with MAT Providers located in other neighboring counties: Yolo, El Dorado, San Joaquin.

Please explain what other strategy the county will use

We are already providing same day, walk in MAT services at all of our MAT Provider locations. We partner with community teams such as SORT and MIH who are offering mobile MAT and referral to our SUPT MAT providers. We also have BHS Teams offering engagement and outreach within the community and in our community wellness centers to engage and refer people to MAT services.

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

Housing Interventions

Planning

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

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question.

Supportive housing
Medium gap

Apartments, including master-lease apartments
Medium gap

Single and multi-family homes
Medium gap

Housing in mobile home communities
Small gap

(Permanent) Single room occupancy units
Medium gap

(Interim) Single room occupancy units
Medium gap

Accessory dwelling units, including junior accessory dwelling units
Medium gap

(Permanent) Tiny homes
Medium gap

Shared housing
Small gap

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

(Interim) Recovery/sober living housing, including recovery-oriented housing
Medium gap

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Medium gap

License-exempt room and board
Medium gap

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Medium gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)
Medium gap

Recuperative Care
Medium gap

Short-Term Post-Hospitalization housing
Large gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Medium gap

Peer Respite
Medium gap

Permanent rental subsidies
Medium gap

Housing supportive services
Medium gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals **?**
BHS will leverage non-BHSA local, state, and federal housing resources, including Behavioral Health Bridge Housing (BHBH) to expand housing supply and access for BHSA-eligible individuals. Core county partnerships include the Department of Homeless Services and Housing (DHSH), which administers shelter housing programs, and homelessness prevention and capital resources such as HHAP. DHSH also operates Safe Stay and other interim housing beds funded by BHS, supporting the delivery of BHBH-funded bridge housing on BHS's behalf. This coordination allows BHSA to focus on behavioral health-specific housing navigation, tenancy supports, and care coordination while DHSH funds site operations.
BHS will coordinate closely with the Sacramento Housing and Redevelopment Agency (SHRA) to increase access to Housing Choice Vouchers, Project-Based Vouchers, Emergency Housing Vouchers, and

SHRA-funded multifamily developments. BHSA providers will support eligibility preparation, referrals, and tenancy stabilization for participants.
Local flexible funding sources will be used to support security deposits, rental arrears, landlord incentives, and other housing related expenditures not covered by the the Managed Care Plans (MCPs). For Medi-Cal beneficiaries, Community Supports, including Transitional Rent, Housing Navigation, and Tenancy Sustaining Services, will serve as primary or supplemental funding mechanisms, with BHSA and BHBH (when applicable) filling gaps for individuals who are not Medi-Cal eligible, are pending enrollment, or have exhausted Community Supports.
BHS will also leverage HUD CoC programs, including PSH and Rapid Rehousing. Data sharing agreements and referral pathways through HMIS, BH Connect, and the local Coordinated Access System will support identification and placement of BHSA-eligible individuals. BHS will further partner with hospital systems to support discharge planning into recuperative care, interim housing, and permanent housing resources.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?
BHSA Housing Interventions will intersect with existing local, state, federal, and CalAIM housing resources through intentional coordination, role clarity, and service alignment to strengthen and expand the continuum of housing supports available to BHSA-eligible individuals. BHSA resources will be used strategically to fill gaps not covered by other systems, extend housing pathways, and provide behavioral health–specific supports that improve housing access, stability, and retention.
BHS will coordinate closely with the Department of Homeless Services and Housing (DHSH), which administers shelter, interim housing, motel programs, and housing capital resources, to ensure BHSA Housing Interventions are integrated with countywide homelessness response efforts. This coordination allows DHSH to focus on site operations and housing infrastructure, while BHSA-funded providers deliver outreach, housing navigation, tenancy supports, and behavioral health services.
BHSA Housing Interventions will also align with Sacramento Housing and Redevelopment Agency (SHRA) programs, including Housing Choice Vouchers, Project-Based Vouchers, Emergency Housing Vouchers, and SHRA-funded developments. BHSA providers will support eligibility preparation, documentation, referrals, and tenancy stabilization to facilitate access to permanent housing opportunities.
For Medi-Cal beneficiaries, CalAIM Community Supports—including Housing Navigation, Housing Deposits, Tenancy Sustaining Services, and Transitional Rent—will serve as primary or supplemental funding sources. BHSA and BHBH resources will be reserved for individuals who are not Medi-Cal eligible, are pending enrollment, or have exhausted Community Supports. Additional coordination with HUD Continuum of Care programs, hospitals, Managed Care Plans, and reentry partners will support timely placements, reduce duplication, and ensure continuity of care across housing and behavioral health systems.

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

BHSA Housing Interventions will be integrated with local, state, federal, and regional housing systems to promote permanent housing and long-term stability for BHSA-eligible individuals. BHS will deploy BHSA-funded housing outreach, navigation, tenancy supports, and care coordination to accelerate exits from homelessness, support successful lease-up, and reduce returns to homelessness. BHSA Housing Interventions will be delivered in coordination with BHBH housing administered by BHS and with Safe Stay and other shelter and interim housing programs operated by DHSH. While DHSH funds site operations and infrastructure, BHSA will provide behavioral health–focused housing navigation, case management, and tenancy supports that prepare participants for permanent housing, support transitions from interim settings, and sustain housing once placed.

BHS will coordinate with SHRA, CoC partners, and housing providers to facilitate referrals to permanent housing, including vouchers, subsidized units, and PSH. BHSA providers will support eligibility preparation, documentation, referrals, unit searches, and tenancy stabilization for participants accessing these resources.

BHSA services will be aligned with MCPs and CalAIM Community Supports, including Transitional Rent, Housing Navigation, and Tenancy Sustaining Services. For Medi-Cal beneficiaries, BHSA will coordinate service delivery with MCP providers to avoid duplication, ensure continuity, and maintain housing stability. BHSA will also fill service gaps for individuals who are not Medi-Cal eligible, pending enrollment, or have exhausted Community Supports.

Coordinated referral pathways and data sharing through HMIS, BH Connect, and the local Coordinated Access System will support prioritization, placement tracking, and retention monitoring. BHS will also partner with hospital systems to support discharge planning into interim and permanent housing, reducing unnecessary institutional stays and improving housing outcomes.

What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?

BHS uses a coordinated approach to connect BHSA-eligible individuals to PSH and support long-term housing stability. BHS providers identify PSH-appropriate individuals through coordinated assessment, clinical screening, and review of homelessness history using HMIS and BHS data systems. In partnership with the local CoC, individuals meeting PSH eligibility, including chronic homelessness and disabling conditions, are prioritized through the Coordinated Access System (CAS) and case conferencing processes and matched to PSH opportunities including Sacramento Housing and Redevelopment Agency (SHRA)-administered voucher-based PSH, No Place Like Home (NPLH) units, and CoC-funded PSH projects. BHSA-funded teams support applications, landlord engagement, and move-in coordination.

Once housed, BHS provides ongoing supportive services aligned with best practices for individuals with

serious mental illness or co-occurring disorders. Services include behavioral health treatment, psychiatry, peer support, substance use services, and tenancy supports focused on lease compliance, conflict resolution, and community integration. Providers intervene to address tenancy risks and coordinate closely with property management to prevent evictions and support long-term retention.

BHS partners with the SHRA to leverage Project-and tenant based vouchers and other rental subsidies. County flexible housing resources support deposits, arrears, furnishings, and other placement barriers when allowable. These efforts complement operating subsidies associated with Homekey and NPLH projects.

BHSA Housing Interventions are coordinated with Community Supports, including Housing Navigation, Tenancy Sustaining Services, and Transitional Rent, while reserving BHSA resources for individuals not Medi-Cal eligible or have exhausted Community Supports. Cross-system coordination with hospitals, MCPs, and reentry partners supports timely and efficient unit matching, and continuous quality improvement.

Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services

This is achieved through an integrated service delivery model that embeds behavioral health staff within housing programs, aligns service expectations across providers, and coordinates closely with the countywide specialty mental health, substance use disorder, and Medi-Cal Managed Care systems. BHSA housing providers are required to offer or facilitate clinical assessment, ongoing treatment, crisis intervention, housing navigation, tenancy supports, and care coordination to ensure continuity of care.

BHS employs multidisciplinary teams that include clinicians, peers, case managers, and housing specialists to provide onsite or field-based behavioral health engagement and stabilization. Services include assessment, therapeutic interventions, medication support, relapse prevention, crisis de-escalation, and linkage to psychiatric care. Providers maintain flexible service hours, and tailor interventions based on participant acuity and functional need. BHSA-funded housing operates as an extension of the behavioral health system, not a stand-alone housing program.

In addition to clinical care, providers deliver or coordinate intensive housing services to support transitions to permanent housing and long-term stability. These include housing navigation, documentation, income and benefits coordination, landlord engagement, move-in support, and Housing Support Plans aligned with CalAIM Community Supports and BHSA expectations. Tenancy-sustaining services emphasize problem-solving, mediation with property managers, and early intervention to prevent housing loss, consistent with a Housing First approach.

Consistency is reinforced through standardized contract scopes, staffing requirements, and caseload expectations, and required linkages to specialty mental health clinics, substance use disorder providers, MCPs, hospitals, and crisis systems Data-sharing agreements, case conferencing, and coordination through HMIS and SmartCare support monitoring and outcome tracking.

Eligible Populations

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

Individuals are identified through multiple access points, including outpatient mental health clinics, substance use disorder programs, crisis services, hospitals, jails, street outreach, community-based providers, and housing programs operated by the DHSH.

BHS leverages internal clinical systems such as SmartCare and external data sources including HMIS, MCP care plans, and Coordinated Access System (CAS) to proactively identify individuals with serious mental illness or co-occurring disorders who are experiencing homelessness. Screening is conducted through structured clinical and housing assessments evaluating behavioral health acuity, functional impairment, homelessness status, housing history, and barriers to stability. Providers also assess Medi-Cal eligibility and coordinate access to CalAIM Community before or alongside BHSA Housing Interventions, ensuring BHSA resources are targeted to individuals with unmet or specialized behavioral health needs.

Once eligibility is confirmed, providers initiate referrals using standardized workflows that integrate clinical documentation, care coordination protocols, and cross-system communication. Referrals may include BHSA-funded interim housing, navigation services, tenancy supports, PSH pathways, or other local, state, or federally funded housing resources. Providers collaborate with the local CoC through the Coordinated Access System to access to regional housing opportunities, including Permanent Supportive Housing, Rapid Rehousing, and SHRA-administered voucher programs. When immediate stabilization is needed, referrals may include Behavioral Health Bridge Housing, DHSH shelter programs, or medically supported interim housing.

BHS supports timely and coordinated referrals through multidisciplinary case conferencing, warm handoffs, shared care plans, and documentation in SmartCare and HMIS ensuring individuals are efficiently matched to housing interventions aligned with clinical need and long-term housing goals.

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

Yes

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

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

BHS conducted targeted planning activities to understand and address the unique housing and behavioral health needs of youth involved in, or at risk of involvement in, the juvenile justice system. BHS reviewed cross-system data from SmartCare, and HMIS to examine patterns related to homelessness, frequent crisis service utilization, involvement in the justice system, and barriers to stable housing following justice

contact. Research reveals that youth exiting detention or court-ordered placements often experience abrupt service disruptions, limited family supports, and high rates of behavioral health conditions that complicate their transition to stable housing. BHS engaged Probation partners, juvenile court representatives, and youth-serving organizations to understand the systemic gaps youth face including safety concerns, lack of transitional housing options, and the need for intensive, developmentally appropriate behavioral health services. These engagements highlighted the importance of early identification, coordinated discharge planning, and flexible housing interventions that address both criminogenic and clinical needs. Based on this planning, BHSA Housing Interventions incorporate trauma-informed and developmentally responsive services, prioritize warm handoffs from detention settings to behavioral health providers, and strengthen connections with probation case managers to ensure continuity of care and stability during high-risk transition periods.

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

Sacramento County BHS undertook extensive activities to ensure that BHSA Housing Interventions reflect the unique needs of LGBTQ+ youth, who experience disproportionately high rates of homelessness, family rejection, discrimination, and behavioral health challenges. BHS reviewed national and state research, including findings from HUD, SAMHSA, the Trevor Project, and youth homelessness studies, which consistently demonstrate that LGBTQ+ youth require identity-affirming, culturally responsive, and trauma-informed housing supports to ensure safety and stability. BHS held listening sessions that included LGBTQ+-focused organizations, youth advocates, and providers experienced in serving LGBTQ+ populations to understand barriers such as unsafe shelter environments, fear of disclosure, and the need for affirming behavioral health care. Youth with lived experience were engaged to identify service gaps, recommend preferred housing models, and offer insights into staff training needs. Input from these stakeholders emphasized the importance of ensuring that all BHSA Housing Intervention settings maintain LGBTQ+-affirming policies, adopt nondiscrimination standards, provide staff training in gender-affirming and culturally competent practices, and promote housing programs that ensure safety and belonging. These efforts informed the development of housing services that intentionally address the specific behavioral health, identity, and safety needs of LGBTQ+ youth and reduce pathways into chronic homelessness.

In the child welfare system

To ensure that BHSA Housing Interventions reflect the needs of youth involved in the child welfare system, BHS conducted detailed data analysis and engaged in extensive coordination with Child Welfare Services, Independent Living Programs, foster family agencies, and community-based youth service providers. BHS reviewed data on youth exiting foster care, youth placed in congregate care, and youth with repeated residential instability, identifying patterns of homelessness risk, behavioral health needs, and service discontinuities during major transitions. National research—including reports from the Annie E. Casey Foundation and studies on foster youth housing outcomes—was analyzed to understand best practices for promoting stability, rapid reunification, and long-term housing success for youth aging out of care. BHS

also convened discussions with caregivers, foster parents, and youth with lived experience to gather insights on barriers to services, the need for trauma-informed supports, gaps in housing options, and the unique vulnerabilities faced by youth without permanent family connections. These engagements highlighted the importance of early planning for housing before youth age out of care, stronger integration between mental health providers and child welfare staff, and pathways that support rapid placement into safe, developmentally appropriate housing. As a result, BHSA Housing Interventions incorporate tailored navigation supports, family engagement strategies when appropriate, age-appropriate tenancy supports, and cross-system care coordination to ensure that youth involved in the child welfare system receive coordinated, effective, and stable housing interventions.

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

Older adults

In developing BHSA Housing Interventions, BHS undertook targeted planning activities to understand the unique needs of older adults experiencing or at risk of homelessness. BHS reviewed demographic and utilization data from SmartCare, HMIS, Adult Protective Services (APS), hospitals, and crisis programs to identify patterns related to aging, chronic health conditions, cognitive impairments, and housing instability. This analysis showed that older adults often experience accelerated aging, higher rates of co-occurring medical and behavioral health conditions, and increased vulnerability in congregate or unsupervised housing settings. BHS engaged stakeholders including APS, senior service providers, hospital geriatric teams, disability advocates, long-term care ombudsman staff, and organizations specializing in aging populations to understand gaps in available housing options, accessibility barriers, safety concerns, and service needs. Research from SAMHSA, the CDC, and aging-services literature was reviewed to identify best practices for supporting older adults with serious mental illness, including the need for integrated medical–behavioral care, mobility accommodations, and environments that support cognitive and functional limitations. These insights informed the development of Housing Interventions that incorporate age-appropriate supports, warm handoffs between medical and behavioral health systems, accommodations for physical and cognitive disabilities, and strengthened coordination with APS to ensure that older adults receive safe, stable, and supportive housing services tailored to their complex needs.

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

Sacramento County BHS also undertook extensive planning activities to understand the unique housing and behavioral health needs of adults involved in, or at high risk of involvement in, the justice system. BHS analyzed data from the jail system, reentry programs, probation, SmartCare, and crisis services to examine patterns of homelessness, recidivism, co-occurring disorders, and service disruptions associated with incarceration. These data showed that individuals cycling between homelessness and the justice system disproportionately experience untreated behavioral health conditions, significant trauma histories, and

elevated barriers to securing stable housing. To address these needs, BHS engaged justice partners including Probation, the Public Defender's Office, jail mental health teams, reentry navigators, courts, and community-based reentry programs to identify high-risk transition points, opportunities for early intervention, and gaps in pre-release planning. BHS also reviewed research on criminogenic risk factors, housing retention barriers for justice-involved individuals, and best practices in forensic behavioral health and supportive housing. These activities highlighted the need for enhanced housing navigation tied to reentry, immediate post-release stabilization options, closer coordination between jail-based and community-based behavioral health providers, and Housing First pathways that do not penalize individuals for past justice involvement. These findings directly shaped the design of BHSA Housing Interventions to ensure that justice-involved adults receive coordinated, stigma-free, and clinically responsive housing supports that reduce recidivism and promote long-term stability.

In underserved communities

To address the needs of adults from underserved communities, Sacramento County BHS engaged in a multi-layered planning process that analyzed disparities in access to behavioral health care, homelessness services, and housing outcomes. BHS examined data disaggregated by race, ethnicity, language, disability status, geographic area, and sexual orientation/gender identity (SOGI), identifying significant disparities in service utilization, crisis encounters, housing instability, and successful exits to permanent housing. BHS engaged culturally specific community-based organizations, peer-led groups, advocates, and trusted messengers from underserved communities—including Black, Latine, Asian American/Pacific Islander, Indigenous, LGBTQ+, immigrant, and refugee communities—to understand barriers such as discrimination in housing, linguistic and cultural mismatches with providers, fear of system involvement, and insufficient culturally responsive housing and behavioral health supports. BHS also reviewed research on social determinants of health, cultural humility, community-defined practices, and effective models for reducing housing inequities. Through this process, BHS identified the need for culturally responsive housing navigation, accessible service locations, bilingual and bicultural staffing, community partnership models, and trauma-informed, culturally rooted approaches that affirm identity and reduce inequities. As a result, BHSA Housing Interventions include expectations for culturally responsive service delivery, embedded partnerships with culturally specific organizations, and practices designed to reduce disparities and improve housing outcomes for adults from historically underserved communities.

Local Housing System Engagement

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

BHS coordinates closely with the CoC to integrate BHSA Housing Interventions into the homelessness response system and ensure referrals are streamlined, consistent, and targeted to individuals with behavioral health needs. BHS engages in ongoing system-level coordination with Sacramento Steps Forward (SSF), the CoC lead agency, including participation in CAS) design, committees, and planning

efforts. Through shared data systems and established protocols, BHS receives referrals from CAS, outreach providers, shelter operators, and housing programs.

BHS providers use CAS data, clinical screening tools, and homelessness histories to help determine eligibility for BHSA Housing Interventions and align service intensity with clinical and housing needs. BHS providers are expected as indicated in their contracts, to support housing referrals, engagement, and progression toward housing stability. Consistent with data-sharing agreements, BHS shares relevant information through HMIS to ensure individuals engaged in the behavioral health system are visible for housing prioritization, including those who may benefit from PSH, BHSA-funded housing, navigation, or tenancy services.

Through multidisciplinary case conferencing, BHS collaborates with SSF, SHRA, outreach teams, and shelter providers to coordinate referrals across BHSA interventions and CoC-funded housing resources. BHS screens individuals receiving behavioral health services for housing needs and refers eligible individuals into CAS. This coordination ensures individuals are matched to the appropriate housing intervention, whether funded through BHSA, CoC, SHRA, CalAIM Community Supports, or local resources.

BHS and SSF maintain regular leadership-level communication to align eligibility standards, address system challenges, improve throughput, and ensure BHSA Housing Interventions complement rather than duplicate CoC resources , strengthening system efficiency for individuals with behavioral health needs.

Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

Local CoC

BHS collaborates closely with the local Continuum of Care (CoC), led by Sacramento Steps Forward (SSF), through the Regionally Coordinated Homeless Action Plan (RCHAP), which establishes shared regional goals, strategies, and performance measures for reducing homelessness, to ensure BHSA Housing Interventions are aligned with regional priorities and integrated into Coordinated Access System processes. BHS participates in CoC planning committees, case conferencing meetings, and policy development to strengthen alignment between behavioral health needs and housing prioritization. Through established data-sharing agreements and routine system-level communication, BHS and SSF coordinate on referrals, vulnerability assessments, and prioritization lists for interim and permanent housing opportunities, including PSH and Rapid Rehousing. BHS ensures that individuals with serious mental illness or co-occurring disorders are visible within CoC processes by sharing relevant information from SmartCare and provider assessments, while CE access points and CoC outreach teams refer clients with behavioral

health needs directly to BHSA-funded interventions. This collaboration ensures that housing and behavioral health supports operate as a unified system, reducing duplication and improving access to housing for individuals requiring high levels of services.

Public Housing Agency

BHS maintains partnership with SHRA, the region's Public Housing Agency, to expand access to voucher-based housing, Project-Based Voucher (PBV) units, and other affordable housing opportunities for BHSA-eligible individuals. BHS collaborates with SHRA to identify voucher opportunities, including Emergency Housing Vouchers (EHVs), Housing Choice Vouchers (HCVs), PBVs tied to supportive housing, and special-purpose vouchers for justice-involved or high-acuity populations, and supports clients through the application, documentation, and lease-up process.

As part of this partnership, BHS provides in-kind supportive services that strengthen SHRA's HUD funding applications and ongoing program operations, including outreach and engagement, behavioral health assessments, care coordination, tenancy-sustaining services, and crisis response capacity. These in-kind commitments are incorporated into HUD and other competitive grant applications such as PBV, EHV utilization plans, NPLH, and Permanent Supportive Housing proposals, to demonstrate service readiness, cross-system coordination, and long-term housing stability for high-need households.

Coordination includes eligibility verification, case conferencing, unit search support, and alignment between SHRA housing pathways and BHSA tenancy-sustaining services. This partnership enables BHS to leverage federal housing resources to our clients with significant behavioral health needs, expand access to permanent housing without duplicating services, and ensure that behavioral health-eligible households are prioritized and successfully housed. BHS also participates in planning efforts for SHRA-funded affordable housing developments, including NPLH and PSH projects, by committing supportive services that ensure long-term tenancy stability. Through these activities, the partnership with SHRA strengthens the availability, accessibility, and effectiveness of permanent housing options for individuals with behavioral health needs.

MCPs

BHS collaborates with Medi-Cal Managed Care Plans (MCPs)—including Anthem, Molina, Kaiser, and any new MCPs entering the region—to align BHSA Housing Interventions with CalAIM Community Supports and Enhanced Care Management (ECM). BHS and MCPs engage in joint case conferencing, cross-system care coordination, and the development of shared workflows for identifying members eligible for HTNS, HTSS, Housing Deposits, Recuperative Care, Short-Term Post-Hospitalization Housing, and (beginning in 2026) Transitional Rent. MCPs provide clinical and administrative support to ensure Medi-Cal members receive housing services funded through Community Supports, preserving BHSA resources for individuals without Medi-Cal eligibility or for services that exceed the scope of Community Supports. BHS and MCPs also collaborate to improve hospital discharge planning, reduce avoidable utilization, and support high-acuity shared beneficiaries transitioning into BHSA Housing Interventions or PSH. Through shared data

agreements and operational coordination, MCPs and BHS maintain a unified approach to addressing behavioral health and housing needs.

ECM and Community Supports Providers

BHS coordinates closely with ECM providers and organizations delivering CalAIM Community Supports to ensure that BHSA Housing Interventions are integrated with Medi-Cal-funded services and that participants receive seamless, non-duplicative supports. ECM providers engage in multidisciplinary care planning with BHSA teams, offering intensive case management, care transitions, and linkage to medical, behavioral health, and housing services for high-acuity members. BHS providers and Community Supports providers coordinate referrals for HTNS, HTSS, and Housing Deposits, aligning Housing Support Plans and avoiding unnecessary duplication of services. Collaboration includes warm handoffs, shared case notes (when permitted), and coordinated crisis planning. This integration ensures that Medi-Cal members receive all available housing supports through Community Supports while BHSA resources are focused on individuals ineligible for Medi-Cal or requiring specialized behavioral health interventions beyond the scope of ECM and Community Supports.

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

Sacramento County BHS collaborates with a wide network of additional housing partners—including CalWORKs/TANF housing programs, Child Welfare housing resources, PSH developers, transitional housing operators, faith-based programs, and culturally specific organizations—to expand the breadth of housing pathways available to BHSA-eligible individuals. With CalWORKs, BHS coordinates to support families with behavioral health needs who require short-term stabilization or longer-term permanent housing pathways. Collaboration with Child Welfare ensures transition-age youth and families with child welfare involvement receive developmentally appropriate housing supports and tenancy services. BHS also partners with PSH developers and affordable housing operators, including those participating in Homekey, NPLH, VHHP, and other state capital programs, to embed supportive services in new and existing units serving individuals with behavioral health needs. These partners provide critical expansion of the overall housing inventory, and BHS aligns its service commitments, referral pathways, and tenancy supports to ensure long-term stability and successful occupancy. Through these relationships, the County ensures a holistic, multi-sector approach to housing implementation that serves diverse populations and enhances the system's overall capacity.

"Other housing partners" refers to County departments, public agencies, community organizations, and housing providers that operate outside the Continuum of Care (CoC), Public Housing Agency (PHA), and Medi-Cal Managed Care Plan (MCP) systems, but who play a critical role in expanding and supporting housing pathways for BHSA-eligible individuals. These partners include, but are not limited to, CalWORKs/TANF housing programs, child welfare housing programs, organizations serving transition-age youth and families, permanent supportive housing (PSH) developers and operators, affordable housing

developers, faith-based housing programs, culturally specific community-based organizations, reentry and justice-involved housing programs, and specialized residential or transitional housing providers. This category encompasses both existing partners with established housing resources and prospective developers or service providers that may contribute to future PSH expansion or specialized housing models.

Together, these "Other" partners provide essential housing opportunities, targeted supports, capital development, service-rich environments, and culturally responsive housing pathways that complement BHSA Housing Interventions and broaden the overall housing continuum available to individuals with behavioral health needs.

How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?

BHS will work closely with Homekey+ sites and supportive housing developments to ensure BHSA-eligible individuals receive the behavioral health services, housing supports, and referrals necessary for long-term stability. Homekey+ sites provide housing for individuals experiencing homelessness, including those with serious mental illness or co-occurring disorders. BHS will partner with these sites by embedding or deploying multidisciplinary behavioral health teams to deliver onsite or mobile clinical services like clinical assessments and crisis intervention. Services will be coordinated with property management and supportive housing providers to align interventions with tenancy expectations and participant needs.

BHS will coordinate referrals to Homekey+ and supportive housing sites using structured eligibility screening and cross-system referral pathways developed in collaboration with SSF, the DHSH, SHRA, and MCPs. BHSA-eligible individuals will be referred through CAS, homelessness service partners, inpatient and crisis facilities, and BHSA-funded outreach. BHS will ensure individuals receive housing navigation, documentation support, and move-in assistance, leveraging BHSA funds alongside non-BHSA resources such as CalAIM Community Supports, HHAP, NPLH, and other housing subsidies.

BHS will align BHSA Housing Intervention funding with Homekey+ operating subsidies and other housing resources to maximize unit availability and sustainability. BHSA funds may support tenancy services, short-term bridge assistance, and enhanced case management, while Homekey+ funds site operations. Data-sharing agreements, multidisciplinary case conferencing, and routine communication with operators, MCPs, and crisis systems will support shared care planning and rapid intervention to prevent housing loss. Through this coordination, BHS ensures Homekey+ and supportive housing sites are equipped to serve BHSA-eligible individuals and integrate behavioral health services into operations.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
No

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed).
For more information, please see 7.C.9 Allowable expenditures and related requirements

Rental Subsidies (Chapter 7. Section C.9.1)
The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?
Yes

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

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
700.

Rental subsidies are a key tool for supporting individuals and families experiencing homelessness by making housing affordable, reducing barriers to entry, and promoting stability. By covering a portion of rent, subsidies allow people to move directly from shelters, interim housing, or unsheltered settings into stable housing, even when they have little or no income. This is particularly important for individuals with disabilities, behavioral health needs, or caregiving responsibilities. Rental subsidies also support housing retention by stabilizing monthly costs and reducing eviction risk, enabling households to meet basic needs and maintain housing.

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

700

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

175

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

The County's estimates for total rental subsidies and number of individuals served annually are based on an analysis of prior fiscal year utilization of flexible housing funds, as tracked in SmartCare, which is the county's electronic health record, and cross-referenced with documented housing and homelessness status.

Specifically, the County analyzed:

- Total expenditures used for rental subsidies during the prior fiscal year
- The number of unique individuals receiving rental assistance, identified through SmartCare service codes and financial tracking fields
- Duration of assistance per individual (including those exceeding six months), based on service start and end dates
- Participant housing status transitions (e.g., homeless to housing), as recorded in SmartCare housing and special population fields
- Length of stay in interim housing settings (including BHBH and other interim placements), and the extent to which rental assistance or flex funds were required to support placement, stabilization, and transition to permanent housing

This analysis showed that approximately 700 individuals required rental subsidies beyond six months, with total expenditures of $2,972,714 in the prior fiscal year.

Using this baseline, the County projected annual need by:

- Maintaining a comparable service level assumption based on consistent demand for housing supports among the Behavioral Health Services population experiencing homelessness
- Accounting for ongoing inflow of newly eligible participants and continued needs of existing participants
- Incorporating utilization patterns across interim housing settings, including average length of stay, transition timelines to permanent housing, and associated subsidy needs
- Aligning projections with expected system capacity across both interim (time-limited) and permanent housing settings

Based on this methodology, the County estimates funding at least $3 million annually in rental subsidies, serving a similar number of individuals across interim and permanent housing settings.

The County will continue refining these estimates over time using SmartCare and HMIS data, including housing status, length of stay in interim and permanent settings, and service utilization, as well as incorporating emerging data from CalAIM Community Supports (e.g., Transitional Rent) as those benefits become fully operational.

For which setting types will the county provide rental subsidies?

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

Will this Housing Intervention accommodate family housing?

Yes

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

Rental subsidies under BHSA Housing Interventions provide financial assistance to help BHSA-eligible individuals and families with school age children obtain and maintain housing when paired with appropriate behavioral health and housing-related supports. For Medi-Cal–enrolled individuals, CalAIM Community Supports, Housing Transition Navigation Services, Housing Deposits, and Transitional Rent are the required first source of funding. BHSA funds are not used to duplicate or supplement these benefits. BHSA rental assistance may be used when an individual is not eligible for Community Supports, or after such benefits are exhausted.

In alignment with BHSA policy requirements, Sacramento County will ensure that at least 50 percent of Housing Interventions funding is directed toward individuals experiencing chronic homelessness, as defined by HUD. The County is strengthening targeting, tracking, and prioritization processes to meet this requirement, including alignment with Coordinated Entry prioritization and enhanced data monitoring across SmartCare and HMIS.

BHSA Housing Interventions funding for rental subsidies may be used for:
• Time-limited and targeted homelessness prevention for individuals and families experiencing housing instability when such costs are not covered by CalAIM benefits
• Time-limited or permanent rental assistance for individuals who are not eligible for Transitional Rent or who require continued support after Transitional Rent ends, for as long as funding is available until a sustainable housing subsidy or income source is secured
• Security deposits and required move-in costs, coordinated with CalAIM Housing Deposits when applicable, to avoid delays in lease-up
• Rental arrears to prevent eviction and maintain housing stability when such costs are not covered by CalAIM benefits
• Short-term rental assistance to secure or retain permanent housing while alternative permanent subsidy arrangements or income sources are being finalized.

For Medi-Cal–enrolled participants, BHS prioritizes referral to MCPs for CalAIM housing benefits, including Transitional Rent and Housing Deposits, as core housing resources. BHSA rental subsidies are structured to complement these benefits, provide continuity during transitions, and ensure no gaps in housing support for individuals with significant behavioral health needs.

Priority for BHSA-funded rental subsidies will be given to individuals experiencing chronic homelessness, with additional consideration for those with the highest behavioral health acuity and longest durations of homelessness. Resource allocation and service delivery will be regularly monitored to ensure compliance with the 50 percent requirement and to adjust targeting strategies as needed.

All BHSA-funded rental subsidies are individualized and designed to support housing stability until the

individual can transition to an alternative permanent housing subsidy, income source, or self-sufficiency.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?
Project-based
Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in
BHS will maintain a diverse and flexible portfolio of housing units for BHSA-eligible individuals through coordinated partnerships and strategic use of flexible housing resources. BHS will partner closely with the Sacramento County Department of Homeless Services and Housing (DHSH), the Sacramento Housing and Redevelopment Agency (SHRA), and other County agencies to align BHSA Housing Interventions with existing shelter, interim, transitional, and permanent housing inventories. This includes coordination around housing programs funded through HHAP, Homekey, the Continuum of Care (CoC), and other local, state, and federal resources.

Contracted providers support individuals through housing navigation, unit identification, application assistance, coordination with landlords, developers, and property managers, lease-up, and move-in. Providers continue to deliver tenancy-sustaining and behavioral health services to promote long-term housing stability and recovery, in coordination with MCP-funded Community Supports when applicable.

BHS collaborates with developers, property owners, and property managers to identify new and existing units, coordinate unit set-asides, and support successful tenancy. Flexible Housing Pool (Flex Pool) models, administered by Brilliant Corners as the County's Flex Pool operator, uses strategies such as master leasing and centralized landlord engagement to reduce barriers to access and expand housing options. BHS continuously monitors housing supply, utilization, and outcomes to strengthen partnerships and ensure BHSA Housing Interventions remain responsive to system needs and local market conditions.

Total number of units funded with BHSA Housing Interventions per year
700

Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units
The County will use BHSA Housing Interventions to fund flexible rental subsidies that are not tied to a fixed number of units in order to expand access to housing and remove barriers for BHSA-eligible individuals.

These flexible subsidies are designed to respond to local market conditions and individual needs, particularly where unit-based subsidies are limited or unavailable.

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
600

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Operating subsidies support the ongoing housing-related operating costs of programs serving BHSA-eligible individuals and are used to ensure that housing remains viable, safe, and accessible to people with significant behavioral health needs. Through BHSA Housing Interventions, the County will use operating subsidy funds only for allowable non-capital housing-related costs, consistent with Policy Manual Section 7.C.9.2, across interim, transitional, and permanent supportive housing settings.

In alignment with BHSA requirements, Sacramento County will ensure that at least 50 percent of operating subsidy funding supports housing interventions serving individuals experiencing chronic homelessness. This includes prioritizing sites and programs that serve or dedicate units to chronically homeless individuals, consistent with HUD definitions and Coordinated Entry prioritization.

BHSA Housing Interventions funding will be used to support allowable housing-related operating expenses necessary to maintain habitable and functional housing environments. These may include facility operations, utilities, maintenance, security, furnishings, unit turnover costs, and other property-related expenses required to sustain occupancy and housing stability. Operating subsidies will be strategically directed to housing settings with higher concentrations of chronically homeless individuals and those with the greatest behavioral health needs Operating subsidies will not be used for behavioral health services or service delivery staffing, including clinical services, case management, tenancy supports, peer services, care coordination, or crisis response.

Sacramento County will implement this intervention by allocating operating subsidy funds to contracted housing providers based on documented operating gaps after accounting for all other funding sources.

Allocation decisions will incorporate the proportion of chronically homeless individuals served, length of homelessness, and behavioral health acuity to ensure alignment with the 50 percent requirement. Providers will be required to demonstrate that BHSA funds are used solely for eligible housing-related costs and are not duplicative of other sources such as Homekey, Continuum of Care, local housing funds, or CalAIM Community Supports. This approach ensures compliance with payer-of-last-resort requirements while stabilizing housing inventory and preserving access for BHSA-eligible populations.

The County will monitor funding distribution and occupancy data through SmartCare, HMIS, and Coordinated Entry systems to ensure compliance with the chronic homelessness targeting requirement and will adjust allocations as needed to maintain compliance over time.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Supportive housing

Will this be a scattered site initiative?
No

Will this Housing Intervention accommodate family housing?
Yes

Total number of units funded with BHSA Housing Interventions per year
583

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

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

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
225

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
The Landlord Outreach and Mitigation Funds intervention is designed to expand access to housing for BHSA-eligible individuals by reducing landlord risk, increasing landlord participation, and removing common barriers to leasing for individuals with behavioral health needs. Through this intervention, the County will use BHSA Housing Interventions funding to engage private market landlords and support successful placement and retention of tenants in scattered-site and market-rate housing.

BHSA funds may be used to support landlord outreach and engagement activities, including relationship-building, education about available supports, and coordination between landlords, housing providers, and behavioral health teams. Mitigation funds may be used to address landlord concerns by covering eligible costs such as security deposits beyond standard amounts, holding fees, vacancy loss during unit preparation, damages beyond normal wear and tear, unpaid rent in limited circumstances, and other allowable tenant-related risks.

Landlord Outreach and Mitigation Funds will be paired with housing navigation, tenancy-sustaining services, and ongoing behavioral health supports to promote lease compliance and housing stability. This intervention complements rental subsidies and other housing resources, increases housing options in competitive rental markets, and enables the County to secure and retain housing units for BHSA-eligible individuals who might otherwise be denied access to housing.

Total number of units funded with BHSA Housing Interventions per year
1500

Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units
The County will provide landlord outreach and mitigation funds through BHSA Housing Interventions that are not tied to a fixed number of housing units. These flexible funds are intended to respond to local rental market conditions and reduce barriers to leasing for BHSA-eligible individuals, particularly in the private rental market.

BHSA landlord outreach and mitigation funds may be used on a case-by-case basis to engage and recruit landlords, address landlord concerns, and facilitate timely lease-up. Allowable uses include landlord engagement activities, unit holding fees, security deposits or deposit enhancements, vacancy loss during unit preparation, damage mitigation beyond normal wear and tear, limited rent loss, and other eligible

costs that reduce perceived risk and increase landlord willingness to rent to program participants. Because these funds are not tied to specific units, the County can deploy them strategically to secure housing opportunities as they arise and to address individualized leasing barriers.

These funds will be paired with housing navigation, tenancy-sustaining services, and behavioral health supports to promote successful placement and housing stability. The County will coordinate BHSA landlord mitigation funds with other housing resources, including rental subsidies, CalAIM Community Supports, and local flexible housing pools, to avoid duplication and maximize impact. This flexible, non–unit-based approach expands housing options, increases landlord participation, and supports rapid access to housing for BHSA-eligible individuals with complex behavioral health needs.

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

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
1600

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Participant Assistance funds support BHSA-eligible individuals by addressing practical, participant-level barriers that interfere with accessing or maintaining housing. Through BHSA Housing Interventions, the County will use Participant Assistance Funds to provide flexible, time-limited supports that help individuals successfully enter housing, stabilize, and remain housed.

BHSA Housing Interventions funding may be used for allowable participant-level costs such as move-in assistance, basic furnishings and household goods, utility start-up or arrears, transportation related to housing placement, document replacement fees, and other essential items necessary to secure or sustain housing. These funds may also be used to address short-term needs that, if unmet, could jeopardize housing stability or delay housing placement.

Participant Assistance funds are paired with housing navigation, tenancy-sustaining services, and behavioral health supports to ensure assistance is targeted, appropriate, and connected to a Housing Support Plan. This intervention complements rental subsidies and landlord mitigation efforts, reduces

preventable barriers to housing, and supports timely transitions into stable housing for individuals with significant behavioral health needs.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)
Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2) **, BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
675

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Housing Transition Navigation Services and Tenancy Sustaining Services support BHSA-eligible individuals in securing housing and maintaining long-term housing stability. Through BHSA Housing Interventions, the County will fund these services to ensure individuals with behavioral health needs receive hands-on assistance before, during, and after housing placement.

Housing Transition Navigation Services focus on preparing individuals for housing and facilitating successful placement. BHSA Housing Interventions funding may be used to support activities such as housing assessments, development of Housing Support Plans, housing search and unit identification, application assistance, documentation support, coordination with landlords and housing providers, and move-in planning. These services help individuals overcome barriers to accessing housing and ensure timely transitions from homelessness to interim or permanent housing.

Tenancy Sustaining Services focus on helping individuals remain housed once placed. BHSA funding may be used to support ongoing tenancy supports such as education on lease requirements, budgeting and household management support, conflict resolution and mediation with landlords or property managers, coordination of repairs or reasonable accommodations, early identification of behaviors that may jeopardize housing, and linkage to behavioral health and community-based services. These services are

delivered in a Housing First, person-centered framework and are coordinated with clinical and behavioral health supports as needed.

Together, Housing Transition Navigation Services and Tenancy Sustaining Services ensure BHSA-eligible individuals are supported throughout the housing process, reduce the risk of housing loss, and promote long-term stability and recovery.

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

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
We do not anticipate using our Housing Intervention funds for outreach and engagement activities. We use MH MAA, other county funds and grants, for outreach and engagement.

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

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
Yes

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

How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?
2

Capital Development Project

Capital Development Project Specific Information
Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project

The name of the project has not been identified yet.

What setting types will the capital development project include?
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)
30

Will this project braid funding with non-BHSA funding source(s)?
Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources
120

Total number of units funded with Housing Interventions funds only
30

Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units
n/a

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)
7/1/2029

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
200000

Have you utilized the “by right” provisions of state law in your project?
Yes

Other Housing Interventions

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

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

Anticipated number of individuals served per year

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
BHSA Housing Interventions (HI) funding will be used to support the transition and continuation of selected interim housing programs currently funded through Behavioral Health Bridge Housing (BHBH), which are anticipated to sunset.

In alignment with BHSA policy requirements, Sacramento County will ensure that at least 50 percent of Housing Interventions funding is directed toward individuals experiencing chronic homelessness, as defined by HUD. The County is strengthening targeting, tracking, and prioritization processes to meet this requirement, including alignment with Coordinated Entry prioritization and enhanced data monitoring across SmartCare and HMIS.

These projects primarily consist of interim housing and shelter-based settings that serve individuals experiencing homelessness with behavioral health needs, including those with serious mental illness and/or substance use disorders.
BHSA HI funding will be used to:
• Sustain interim housing capacity for individuals who continue to meet BHSA eligibility criteria and require a structured, supportive setting prior to permanent housing placement
• Support housing-related services and supports within these settings, including coordination with behavioral health treatment, housing navigation, and tenancy preparation activities
• Ensure continuity of care and prevent disruption in housing and services for individuals currently served in BHBH-funded programs
• Align program operations with BHSA requirements, including allowable settings, service expectations, and documentation (e.g., housing support plans where applicable)
These programs will be transitioned to operate under BHSA Housing Interventions guidelines, with a

continued emphasis on:
• Time-limited stays in interim settings
• Active and ongoing efforts to transition individuals to permanent housing options
• Coordination with CalAIM Community Supports (e.g., Housing Transition Navigation Services, Housing Deposits, and Transitional Rent) to ensure Medi-Cal–eligible individuals access available benefits prior to or alongside BHSA resources.

BHSA funding will not be used to indefinitely sustain interim housing, but rather to bridge and stabilize the system during the transition from BHBH to BHSA, ensuring that individuals are supported in moving from homelessness to permanent housing in a coordinated and compliant manner.

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

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

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
None of the Above

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

Housing Transition Navigation Services
No

Housing Deposits
No

Housing Tenancy and Sustaining Services
No

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
No

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)?
Behavioral health providers, care coordinators, and homeless outreach teams will proactively identify Medi-Cal members experiencing homelessness or housing instability through clinical assessments, intake screenings, ongoing service encounters, and coordination with homelessness response systems (e.g., Coordinated Access System, street outreach, and crisis services). Housing need indicators documented in the electronic health record (EHR) will trigger consideration for housing-related Community Supports. Individuals not linked to Medi-Cal will be referred to Medi-Cal and MCP linkage to support eligibility to housing-related Community Supports.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county
The County Behavioral Health System maintains ongoing coordination efforts to ensure that its contracted provider network for Housing Interventions is known, current, and consistently shared with all Medi-Cal Managed Care Plans (MCPs) serving the county. The county regularly updates and disseminates its behavioral health housing intervention provider roster, including service descriptions and eligibility parameters, to MCP partners. This information is routinely reviewed and discussed during quarterly coordination meetings between the County Behavioral Health System and MCPs, which serve as a primary forum for aligning operational processes related to Care Coordination and Housing Interventions.

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

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

Yes. The county behavioral health system tracks which contracted housing and service providers are also contracted with Medi-Cal Managed Care Plans (MCPs) to deliver housing-related Community Supports. Sacramento County Behavioral Health Services (BHS) monitors provider contracting status through coordination with the Department of Homeless Services and Housing (DHSH), Managed Care Plans, and, as applicable, the third-party administrator overseeing the Flexible Housing Pool.

This tracking supports care coordination, appropriate referrals, and alignment of Housing Support Plans across BHSA Housing Interventions and CalAIM Community Supports. It also helps ensure services are not duplicative, that Medi-Cal–eligible individuals are connected to MCP-funded Community Supports when available, and that BHSA resources are targeted to individuals who are not Medi-Cal eligible or whose needs exceed the scope of Community Supports.

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?

Sacramento County Behavioral Health Services (BHS) has established clear processes to ensure Medi-Cal members with significant behavioral health conditions do not experience gaps in housing-related services when MCP housing benefits, including Transitional Rent and other Community Supports, are exhausted. The County's approach is grounded in proactive planning, payer sequencing, and continuity of care, and includes the following:

1. Upfront housing sustainability planning:
Providers are required to develop and maintain a Housing Support Plan (HSP) beginning at intake. The HSP must include anticipated duration of MCP-funded services, transition planning for when those services end, and identification of alternative housing resources. For individuals experiencing chronic homelessness, the HSP must also include long-term housing stabilization strategies, recognizing the increased likelihood of extended or ongoing support needs. This ensures that planning for post-MCP support occurs well before benefits are exhausted.

2. Active monitoring of time-limited benefits:
BHS requires providers to track utilization of MCP housing services, including the six-month limit for Transitional Rent. Providers are expected to begin transition planning well in advance of benefit exhaustion and document next steps in the HSP.

3. Structured case conferencing across systems:
The County is implementing routine case conferencing between BHS providers, MCPs, and Community Supports providers to coordinate care for shared clients. Case conferencing is used to review housing

status, track benefit utilization timelines, and proactively plan transitions before MCP housing services end. Case conferencing prioritizes individuals experiencing chronic homelessness and those with the longest durations of homelessness to ensure early identification of ongoing housing needs and appropriate resource allocation. This ensures all partners are aligned on roles, next steps, and funding sources, and reduces the risk of service disruption.

4. Step-down and transition to alternative funding sources:
As individuals near six months of Transitional Rent benefit use or have utilized their Housing Deposit, they will be identified through structured case conferencing and if support past six months is needed, transition planning begins. When MCP housing services are exhausted, BHS-funded resources, including BHSA Housing Interventions and, where applicable, BHBH or other local funding, will be used to provide continued rental assistance, deposits, or housing stabilization support, to the extent resources are available. Consistent with BHSA requirements, priority for these resources will be given to individuals experiencing chronic homelessness to ensure that at least 50 percent of Housing Interventions funding is directed to this population. These funds are structured to ensure continuity and avoid disruption in housing. BHS will coordinate with the Community Supports provider to ensure there is no interruption in services or supports.

5. Continued access to behavioral health and tenancy supports:
Even when MCP-funded housing services end, individuals continue to receive Specialty Mental Health Services (SMHS), care coordination, and case management through BHS providers. BHS may also fund tenancy-sustaining services that are not otherwise covered or no longer available through MCP Community Supports.

6. Care coordination with MCPs and system partners:
BHS providers maintain ongoing coordination with MCPs, DHSH, and Continuum of Care partners to ensure smooth transitions between funding sources and service systems. This includes shared care planning, coordinated referrals, and alignment of service responsibilities.

7. Data tracking and oversight:
The County uses SmartCare and HMIS to monitor housing status, service utilization, and timing of benefit use. These systems are also used to track chronic homelessness status and ensure compliance with the BHSA requirement that at least 50 percent of Housing Interventions funding is directed to individuals experiencing chronic homelessness. This allows BHS to identify individuals at risk of service gaps and intervene proactively through provider direction or resource allocation.

Through these processes, Sacramento County ensures that individuals do not experience abrupt loss of housing or services when MCP benefits end, and that housing and behavioral health supports continue in a coordinated and clinically appropriate manner while prioritizing and targeting resources to individuals experiencing chronic homelessness in alignment with BHSA requirements.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource . Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools .

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
Yes

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

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

What organization is serving as the Operator?
Brilliant Corners

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

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?
Rental Subsidies
Operating Subsidies
Landlord Outreach and Mitigation Funds

Participant Assistance Funds
Housing Transition Navigation Services and Tenancy and Sustaining Services

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above

Sacramento County's Behavioral Health Services (BHS) will serve as a funder and collaborator for the County's Flex Pool. The County's Department of Homeless Services and Housing (DHSH) will serve as the lead entity with Brillant Corners serving as the third-party administrator and operator of the Flex Pool. BHS will play key roles to support the launch, operation, and scaling of the Flex Pool model.

BHS will support system design and implementation by working closely with the DHSH, Brilliant Corners, and MCPs to align policies, eligibility criteria, referral workflows, and documentation requirements. This coordination ensures BHSA Housing Interventions delivered through the Flex Pool are integrated with CalAIM Community Supports, Continuum of Care (CoC) resources, and other local housing programs, with clearly defined and non-duplicative roles.

BHS will provide clinical and housing subject matter expertise to inform Flex Pool operations, including guidance on serving individuals with serious mental illness and co-occurring disorders, aligning Housing Support Plans with clinical care plans, and embedding Housing First, trauma-informed, and culturally responsive practices. BHS will also support provider readiness through training, technical assistance, and cross-system learning activities.

BHS will help identify eligible individuals through its contracted provider network, outreach teams, and clinical programs, and coordinate warm handoffs into Flex Pool–administered services. BHS will participate in multidisciplinary case conferencing with DHSH, Brilliant Corners, MCPs, and housing providers to prioritize high-acuity individuals and resolve barriers to housing.

BHS will further support oversight and continuous improvement by participating in governance and operational meetings, sharing data, and using HMIS, SmartCare, and partner data to monitor utilization, outcomes, equity, and service gaps.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

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

Does the county's plan include the development of innovative programs or pilots?

No

Workforce Strategy

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

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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

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

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

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

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

Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
10

Upload any data source(s) used to determine vacancy rate

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Licensed Clinical Social Worker
Licensed Marriage and Family Therapist
Licensed Professional Clinical Counselor
Medi-Cal Certified Peer Support Specialist
Registered nurse

Please describe any other key workforce gaps in the county
As of 11/6/2025, Sacramento County BHS current staffing allocation is 690 FTE's. Currently, there are 65 FTE vacancies, and 46 FTE's (70.76%) are positions designated as permanent clinical/direct service positions. Overall, Sacramento County BHS vacancy rate totals 10.61%, which is lower than last fiscal year's vacancy rate of 12.01%. The positions with the greatest vacancy rate are Senior Mental Health Counselor (26 FTE's), Mental Health Counselor (6 FTE's), and Behavioral Health Peer Specialist (6 FTE's).

No other workforce gaps exist outside of permanent clinical and/or direct service behavioral health positions. These numbers only reflect Sacramento County Behavioral Health Services staffing and do not include contracted providers. We are unable to report on their vacancy rates.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

As the County transitions from MHSA to BHSA, new mandates will require expanded capacity, specialized training, and culturally responsive staffing. Starting July 2026, BHSA requires that 35% of funding be allocated to Full Service Partnership (FSP) programs implementing evidence-based practices (EBPs) such as High Fidelity Wraparound (HFW), Multisystemic Therapy (MST), Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT) and Individual Placement and Support (IPS). These models demand fidelity monitoring, participation in learning collaboratives, and technical assistance from Centers of Excellence. To meet these requirements, the County will need to recruit and retain clinicians trained in EBPs and build an administrative infrastructure to support data collection and outcome reporting. Sacramento County's integrated planning efforts emphasize culturally and linguistically responsive services, streamlined program descriptions, and client-centered language. Additionally, BHSA's focus on early intervention and outreach will increase demand for peer support specialists, community health workers, and staff skilled in engaging underserved populations. To support these shifts, the County is leveraging internal planning tools such as staffing templates and high-needs maps to guide recruitment and training priorities. Sacramento County remains committed to building a resilient, culturally competent workforce capable of delivering high-quality, equitable behavioral health services under BHSA.

While the County is implementing new BHSA mandates, Quality Assurance staff will continue to submit the required 274 information to the Department of Health Care Services (DHCS) and will monitor staffing to maintain the network adequacy ratios outlined in DHCS BHIN 25-013 Network Certification Requirements.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

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

Yes

Please explain any actions or activities the county is engaging in to leverage the program
Sacramento County Behavioral Health Services will share the Medi-Cal Behavioral Health Scholarship Program with contracted providers and county-operated programs/staff. The WET Coordinator subscribes to HCAI newsletters and attends HCAI related Scholarship and Loan Repayment Program webinars to share with contracted providers and county-operated programs/staff. The WET Coordinator will send a detailed email to the BHS contracted and county-operated programs/staff when HCAI Scholarship Program is open for applications. The WET Coordinator also includes the eligibility guide and any related webinars.

The majority of contracted providers and county-operated programs qualify as eligible sites.

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

Please explain any actions or activities the county is engaging in to leverage the program
Sacramento County Behavioral Health Services will share the Behavioral Health Student Loan Repayment Program with contracted providers and county-operated programs/staff. The WET Coordinator subscribes to HCAI newsletters and attends HCAI related Scholarship and Loan Repayment Program (LRP) webinars to share with contracted providers and county-operated programs/staff. The WET Coordinator will send a detailed email to the BHS contracted and county-operated programs/staff when HCAI LRP Programs are open for applications. The WET Coordinator also includes the eligibility guide and any related webinars.

The majority of contracted providers and county-operated programs qualify as eligible sites.

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

Please explain any actions or activities the county is engaging in to leverage the program
Sacramento County Behavioral Health Services will share the Behavioral Health Recruitment and Retention Program with contracted providers and county-operated programs/staff. The WET Coordinator subscribes to HCAI newsletters and attends HCAI related program webinars to share with contracted providers and county-operated programs/staff. The WET Coordinator will send a detailed email to the BHS contracted programs/staff when the HCAI Behavioral Health Recruitment and Retention Program is open for applications. The WET Coordinator also includes the eligibility guide and any related webinars. The majority of contracted providers qualify as eligible sites.

If the County is eligible to apply, the County will consider submitting an application.

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

Please explain any actions or activities the county is engaging in to leverage the program
Sacramento County Behavioral Health Services will share the Behavioral Health Community-Based Provider Training Program with contracted providers and county-operated programs/staff. The WET Coordinator subscribes to HCAI newsletters and attends HCAI related program webinars to share with contracted providers and county-operated programs/staff. The WET Coordinator will send a detailed email to the BHS contracted programs/staff when the HCAI Behavioral Health Community-Based Provider Training Program is open for applications. The WET Coordinator also includes the eligibility guide and any related webinars. The majority of contracted providers qualify as eligible sites.

If the County is eligible to apply, the County will consider submitting an application.

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

Please explain any actions or activities the county is engaging in to leverage the program
Sacramento County Behavioral Health Services will consider leveraging the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP. This may include applying for and/or encouraging providers to apply for the BH-CONNECT workforce programs. The Mental Health and Substance Use Prevention and Treatment leadership will discuss and review opportunities, including, sending a detailed email to the BHS contracted programs/staff when opportunities are available.

If the County is eligible to apply, the County will consider submitting an application.

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training
The County does not have additional efforts planned.

Budget and Prudent Reserve

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve .

Budget and Prudent Reserve

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

Please upload the completed budget template
BU-BHS-Integrated-Plan-FY26-27_FY27-28_FY28-29.xlsx

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template

Behavioral Health Services and Supports (BHSS)
N/A

Full Service Partnership (FSP)
N/A

Housing Interventions
N/A

Enter date of last prudent reserve assessment
4/14/2026

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan

BHSS
N/A

FSP
N/A

Housing Interventions
N/A

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template
Behavioral Health Director Certification2.27.26.pdf
Behavioral Health Director Certification Final IP.pdf

County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template
County Administrator or Designee Certification Signed.pdf

Board of supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section

Please upload the completed Board of supervisor certification template

Board of Supervisors Certification Final IP.pdf

Confirm that the data is up to date and reflects the correct information for a Final Plan

Data Suppression Notice:

Values marked with "*" have been suppressed per DHCS de-identification standards. Counts between 1–10 are displayed as "<11*"

DHCS | County Portal

Behavioral Health Director Certification

Certification

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

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

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

   - ○ Yes
   - ◉ No

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

County Behavioral Health Agency Director contact information

3. County Name

Sacramento County

4. Certification for

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

4a. Submission type

- ( ) Draft
- (•) Final

5. County Behavioral Health Agency Director name

Ryan Quist, PhD

6. County Behavioral Health Agency Director phone number

[redacted]

7. County Behavioral Health Agency Director email

QuistR@saccounty.gov

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

8. Name

9. Title

10. Phone

11. Email

County Behavioral Health Agency Director signature

12. Print name
Ryan Quist, PhD

13. Title
Behavioral Health Director

14. Date
6/09/2026

15. Signature

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

16. Print name

17. Title

18. Date

19. Signature

DHCS | County Portal

Board of Supervisors Certification

Certification

1. County of Sacramento Board of Supervisors certifies the following:

   ☑ County of Sacramento Board of Supervisors has reviewed and approved this Integrated Plan for the period of [26-29]

   ☑ County will meet its realignment obligations pursuant to W&I Code section 14197, including but not limited to time or distance standards and appointment time standards set forth in W&I Code section 14197 or other applicable guidance, without utilizing waitlists

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

   ○ Yes

   ◉ No

a. If answered yes above, please describe any implementation challenges or concerns with their realignment obligations (optional)

Signature

3. Printed name

   Ryan Quist, PhD

4. Title

   Behavioral Health Director on behalf of Sacramento County Board of Supervisors

5. Date

   6/09/26

6. Signature