Riverside University HEALTH SYSTEM Behavioral Health

BHSA

Integrated Plan

2026-2029






Behavioral Health Services Act (BHSA) Integrated Plan

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2026 - 2029 Integrated Plan

Riverside 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
Riverside County

Behavioral Health Agency Name
Riverside University Health System - Behavioral Health, Riverside County Department of Mental Health Substance Abuse Prevention and Treatment Programs

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Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

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Behavioral Health Services Act (BHSA) Coordinator

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Substance Abuse and Mental Health Services Administration (SAMHSA) liaison

Name	Email address
Rhyan Miller	rmiller@ruhealth.org

Quality Assurance or Quality Improvement (QA/QI) lead

Name	Email address
Mary Walsh	mwalsh@ruhealth.org

Medical Director

Name	Email address
Christopher Benitez	c.benitez@ruhealth.org

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)	17825
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	635
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	738
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	367

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	30
Were chronically homeless or experiencing homelessness or at risk of homelessness	136
Were in the juvenile justice system	1019
Have reentered the community from a youth correctional facility	444
Were served by the Mental Health Plan and had an open child welfare case	3204
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	81

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	1908

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	4065
Received Medi-Cal SMHS	28983
Received DMC or DMC-ODS services	11073
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	4005
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	3218

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	2475
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	527
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	299
Were in the justice system (on parole or probation and not currently incarcerated)	1019
Were incarcerated (including state prison and jail)	9860
Reentered the community from state prison or county jail	1683
Received acute psychiatric services	3561

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

Admitted or detained for 72-hour evaluation and treatment rate

4773

Admitted for 14-day and 30-day periods of intensive treatment
2106

Admitted for 180-day post certification intensive treatment
0

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
51

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
42

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
The data in Table 1 for youth, adults, and older adults served were primarily derived from the RUHS-BH electronic health record (EHR). Information on individuals served through Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS), Substance Use Disorder (SUD) prevention (Level 0.5), Early Psychosis Coordinated Specialty Care, inpatient psychiatric, and dual eligibles were queried from the RUHS-BH electronic health record where these services are documented. Data on RUHS-BH youth served with an open child welfare case was determined from the EHR and Department of Public Social Services open child welfare cases that are provided to RUHS-BH through a monthly data exchange. A matching process is used to link the client ids from both systems. Youth in the juvenile justice system data was derived from multiple sources in the RUHS-BH EHR. Data on youth served in juvenile justice facilities was drawn from RUHS-BH EHR and included youth served while detained in multiple Riverside County juvenile justice facilities, including the Indio Juvenile Hall, Southwest Juvenile Hall, and Alan M. Croagan Youth Treatment and Education Center. Data on youth served after leaving a detention facility was also used but was limited to youth actually served by RUHS-BH while in the facility to query if additional services in the behavioral health continuum occurred when the youth left the facility. Probationary status or prior probationary status for youth served in the broader behavioral health system was more challenging to reliably collect, CSI data collected on admission was used, however the CSI values only denote a juvenile court ward not a probation status where the youth is not a ward. Additional data for youths on probation and served in the behavioral health service system was derived from youth served in the RUHS-BH Wraparound program where probation legal status was collected with a more reliable

method. RUHS-BH EHR admissions data also includes some information on legal status and referral source which was queried for any admission records where probation was selected as legal status and/or Juvenile Hall was indicated as the referral source for those youth served in FY23/24. The California Outcomes Measurement System Treatment (CalOMS) data was also queried for criminal justice status for youth served by RUHS-BH DMC-ODS. The total youth in juvenile justice that were served used all of the sources previously noted to obtain an unduplicated count of justice involved youth served in the FY23/24.

RUHS-BH Housing data was determined from both the RUHS-BH EHR and the HMIS Clarity system. Data on those at risk of homelessness and unsheltered homelessness were derived from EHR progress note data fields including; at risk of homelessness, living in a place not meant for habitation, and living in a shelter or emergency housing. The progress note data while useful could be an undercount as staff utilization of these additional data fields on the progress note can vary. Clarity HMIS data was used to derive data on unsheltered homelessness, and movement from unsheltered homelessness to emergency shelter, transitional housing, and permanent housing. Moving forward, data collection on housing status and movement to various types of housing options will be further developed to ensure accurate and complete counts for clients served. Accurately collecting data on clients who are on probation or parole presents several challenges. Individuals may seek behavioral health treatment independently, without probation or parole being a condition of service, and may choose not to disclose their supervision status. Additionally, capturing this information in the electronic health record (EHR) is difficult because probation and parole status can change over time. Tracking updated status is further complicated by the fact that clients may engage with the behavioral health system at varying levels of care, including very short-term services.

Data on individuals who were incarcerated reflects counts of those served by Behavioral Health Department staff while housed in an adult jail and/or County correctional facility. These individuals may or may not engage in behavioral health services following their release. The County correctional system's TechCare health record data is provided to RUHS–Behavioral Health through periodic data extracts, which are stored on RUHS servers and are available for querying. The reported counts include only individuals who received a behavioral health service while in a detention facility.

Accurately capturing data on individuals who re-enter the community is also challenging. The data currently reported represent only those individuals who are known to have been released from a detention facility and subsequently received services within the mental health system. This figure likely represents an undercount. Improving the accuracy and completeness of this data will be a focus of enhanced tracking efforts under the upcoming Justice Initiatives.

Data for those that received psychiatric services was derived from inpatient psychiatric admissions in the RUHS-BH EHR.

IST diversion data reflects internal RUHS-BH tracking and includes those open IST diversion or in IST diversion and closed during the FY.

Please describe the local data used during the planning process

A variety of data sources were utilized for the BHSA IP planning process including RUHS-BH department reports, the RUHS-BH Public Health Community Health Assessment (CHA), State Department of Finance population data, Medi-Cal eligibility, inpatient psychiatric hospital use, crisis utilization and U.S. Census data. The RUHS-BH organizational structure has Research and Evaluation units with analytic staff responsible for producing a variety of data reports, including state reporting, grant reporting, client satisfaction, service utilization, demographics and outcomes. These reports provided much of the local data used during the planning process. The reports are regularly used to inform the department and stakeholders and are presented in a variety of meetings and department forums. for example, the department Who We Serve report is an annual summary of all clients served in the behavioral health system, including SMHS, Drug-MediCal ODS and clients served in detention settings. The Who We Seve (WWS) client profile report includes the total unduplicated clients served in each part of the behavioral system with characteristics of the population served including age groups, race/ethnicity, sex, history of trauma recorded, substance use history in mental health clients, mental illness in substance use clients, and diagnosis overall and diagnosis by age group. The WWS report includes Riverside County overall population data by age group and race/ethnicity for comparison purposes to better under if the population served is aligned with the characteristics of the general population. California State Department of Finance is used regularly to update demographic data on race/ethnic groups and age distributions in the County and has been used along with census data to summarize the overall population of Riverside County. Department reports on service utilization provided key information on service usage across the department's adult and children clinic sites. Additional examples of data used to inform the planning process include dashboards and reports developed by RUHS-BH and RUHS-PH which included: Suicide Deaths and Attempts in Riverside County data brief, Youth 0-25 Suicide Deaths and Attempts Monthly Dashboard, Riverside County Overdose Deaths to Action Monthly Surveillance Report, Crisis Support System of Care Annual Report and Crisis Facilities Utilization Dashboard, HEDIS metrics 2024 and hospital follow-up reports. In addition, annual Full Service Partnership FSP reports were utilized which include demographics, service utilization, and outcomes data. Children's reports on Trauma-Focused CBT outcomes, Parent Child Interaction Therapy Report, Juvenile Hall Mental Health Services Summary, Wraparound Annual Outcomes report and Child Welfare Open Cases Performance Outcome Report were also useful for planning purposes.

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.

Care participants in Riverside County will benefit from the full continuum of behavioral health care, with priority access to FSP Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT), Intensive Case Management services, and Housing Interventions. The Riverside County Care Court team will work with Care participants to address their complex and significant behavioral health and treatment needs and assist in identifying Medi-Cal eligibility. Additionally, the team will ensure priority access by assisting participants with scheduling appointments, transportation to appointments, and attending initial appointments alongside participants to facilitate linkage. CARE participants will also be connected to services within Riverside County's comprehensive adult and older adult system of care, including linkage to care for participants' families, where appropriate.

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

The RUHS-BH community access line is the primary source for the community seeking assistance with a CARE Court referral. The access line staff complete an integrated referral for interested parties which is sent to the CARE Court team for follow-up to ensure the community receives the help they need. Additionally, all RUHS-BH outpatient clinics can send an Integrated Referral to the CARE court team directly. RUHS-BH also collaborates with the Riverside County criminal courts, which serve as another source for CARE act referrals.

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

The RUHS-BH community access line serves as an entry point to behavioral health care. Staff are trained to screen for behavioral health needs and connect individuals to the appropriate level of care. For individuals who are potentially eligible for CARE court and for whom a formal petition is not required or appropriate, they are linked to the broader continuum of behavioral health services. Access line staff utilize the RUHS-BH electronic health record (EHR) to document CARE court inquiries through a Communication Log as well as the completion of an Integrated Referral Form when appropriate. Successful connections to services can be confirmed through the documentation of referrals and direct service data entry in the EHR.

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
Netsmart
Epic Systems
Other

Please describe
TechCare

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

Please select which QHIO the county participates in
Manifest MedEx

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://www.ruhealth.org/sites/default/files/2024-09/patient-access-and-provider-directory-apis-base-urls-09302024.p

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?
Yes

Please describe these challenges and concerns

Historically, data sharing and validation across multiple systems and agencies has presented challenges due to differences in platforms, processes, and regulatory requirements. RUHS is actively collaborating with the MCPs to meet the admission, discharge, and transfer data sharing requirements outlined in the BHIN guidance. While progress is being made, the County recognizes the complexity of aligning data systems among large organizations, each operating under distinct confidentiality standards and compliance obligations to protect member information.

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

Case Management Services
Community Mental Health Services
Outreach services
Referrals for Primary Health Care, Job Training, Educational Services, and Housing 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
Discretionary/Base Allocation
Dual Diagnosis Set-Aside
First Episode Psychosis Set-Aside

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?
Yes

Please describe these challenges or concerns:
The SUBG programs are fully implemented in Riverside County.
We have identified a few areas where additional guidance from DHCS would be beneficial. One being where regulations may misalign between the SUBG and DMC-ODS policies. Additionally, challenges can arise due to inflexibility to move funds between set asides. Riverside would appreciate any TA or guidance from DHCS on how to better navigate these issues to ensure we can best meet the needs of the community.

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)
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:
Assertive Community Treatment (ACT)
Community Health Worker Services (CHW)
Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
Forensic Assertive Community Treatment (FACT)
Individual Placement and Support (IPS) Model of Supported Employment
Other Programs and Services

Please describe

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?

CSC for FEP
ACT
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?
Yes

Please describe these challenges or concerns
Riverside University Health System – Behavioral Health has identified two implementation challenges; the workforce scarcity in specialty behavioral health services, and public purchasing processes. These aspects may affect the pace of expansion due to the structured timelines required to ensure transparency and accountability.
We will work to address challenges through early planning and phased, strategic implementation. As additional guidance is provided by DHCS, RUHS will also continue to monitor quality and outcomes to ensure services are delivered effectively, sustainably, and in a manner that remains responsive to community needs.

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?

Inpatient Services (ASAM Levels 3.7 & 4.0)
IPS Supported Employment
Partial Hospitalization Services (ASAM Level 2.5)
Peer Support Services
Recovery Incentives Program (Contingency Management)

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

Yes

Please describe these challenges or concerns

Riverside University Health System – Behavioral Health has identified two implementation challenges; the workforce scarcity in specialty behavioral health services, and public purchasing processes. These aspects may affect the pace of expansion due to the structured timelines required to ensure transparency and accountability.
We will work to address challenges through early planning and phased, strategic implementation. As additional guidance is provided by DHCS, RUHS will also continue to monitor quality and outcomes to ensure services are delivered effectively, sustainably, and in a manner that remains responsive to community needs.

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

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

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?
Race or Ethnicity
Sex
Age

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?
Other

Please describe other
N/A

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
Same

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

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?
Below

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
This disparity analysis uses data from CalMHSA dashboards based on DHCS Phase 1 population workbooks. Riverside County exceeds state NSMH penetration rates for both adults and youth. NSMH utilization varies by age, with adults 21–32, 57–68 and 69+showing rates below the state average. Youth NSMH utilization is lowest for ages 3–5, 6–11, and 18–20. Among adults, Hispanic/Latinx and Asian/Pacific Islander populations have the lowest utilization, while Black and Other groups are above the countywide rate but still below White and American Indian/Alaska Native rates. White youth were the only group with rates above the countywide average; all other youth racial/ethnic groups were below it. Disparities for sex were found for adult males whose NSMH utilization rate fell slightly below the state average. NSMH utilization was lower among non-English written language populations, particularly Spanish, which is the only county threshold language. The county penetration rate for SMHS is below the state average rate (4.2%) for both youth (2.9%) and adults (3%). Age disparities were found for adults age 65+ and youth age 0-11 which were below the state averages, other age groups exceeded the state average. Disparities by race/ethnicity were noted for Hispanic/Latinx and Asian/Pacific Islander adults. Youth showed disparities for Asian/Pacific Islanders. Both adults and youth had lower rates for those with a race designation of Other. More adult males accessed SMHS than females, but for youth slightly more females accessed services.

Penetration rates for DMC State plan/DMC Organized Delivery System for adults were slightly lower than the state average while for youth the rate equaled the state average. Penetration rates by race/ethnicity found disparities for Black, Hispanic/Latinx and Asian/Pacific Islander groups. Initiation of substance use disorder treatment (IET-INT) was below the state average (33.8% vs. 36.6%) and was below the minimum performance level of 44.3%.

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

Programs designed to expand access to care are expected to increase the County's Specialty Mental Health Services (SMHS) penetration rate, which is currently below the state average for both adults and children, as well as the Drug Medi-Cal Organized Delivery System (DMC-ODS) penetration rate, which remains below the state average for adults. Multiple planned program components are anticipated to advance the statewide Access to Care goal for both SMHS and DMC-ODS. These initiatives include targeted efforts for children and youth, as well as programs serving adult and older adult populations. The RUHS-BH Children and Youth Wellness Campus will significantly expand access through the addition of multiple service sites and levels of care, thereby increasing the number of children and youth receiving behavioral health services. The campus will include an integrated child and youth outpatient mental health and substance use disorder clinic, a 16-bed children's Psychiatric Residential Treatment Facility (PRTF) facility, a children's mental health urgent care, a 6-bed Short-Term Residential Therapeutic Program (STRTP), and a 30-bed adolescent residential substance use disorder treatment program. The Wellness Campus will be adjacent to a 48-bed Department of Social Services short-term emergency shelter is expected to particularly benefit vulnerable, child welfare–involved youth by facilitating timely access to coordinated care. the RUHS-BH Mead Valley Wellness Village will further increase access to care for both children and adults through a comprehensive campus-based model. Children and youth services will include a children's Crisis Residential Program (CCRP), a children's mental health urgent care, a Short Term Residential Treatment Placement (STRTP), and an adolescent Intensive Outpatient Program for eating disorders. Adult services at the Wellness Village will also expand access through a new outpatient behavioral health clinic, a Mental Health Rehabilitation Center, substance use disorder recovery residences, transitional housing, a sobering center, residential substance use disorder treatment services, and an Adult Residential Facility (ARF) with Recuperative Care services, among other community-based amenities. Collectively, these programs are expected to enhance engagement and participation in mental health and substance use disorder services. in addition to these

new campuses, enhancements within the adult Non–Full Service Partnership (Non-FSP) system of care are also expected to improve access. A new walk-in crisis walk in clinic will open in the Desert region, a more rural area of the County currently served by only one County-operated outpatient mental health clinic. This clinic will provide low-barrier, timely access for individuals experiencing a behavioral health crisis, reducing the need to travel to crisis stabilization units. A key focus of the clinic will be linkage to ongoing outpatient care to promote continued stability and recovery. RUHS-BH also supports multiple programs that serve as entry points to the behavioral health system. The Community Access, Resources, Education, and Support (CARES) access line is staffed by multidisciplinary teams that screen and link adults and children to the RUHS-BH continuum of services, including residential substance use disorder treatment. Clinicians assigned to CARES focus specifically on facilitating timely outpatient follow-up for adults discharged from hospitals. Outreach and Engagement programs for adults, children and youth, and parents and caregivers play a critical role in normalizing help-seeking behaviors, fostering engagement, and promoting recovery. The Consumer Peer Support, Parent Support and Training, Emergency room and hospital navigation teams, and Family Advocate outreach and engagement programs further enhance access by providing one-on-one support, community education on mental health topics, and system navigation assistance. Together, these strategies are expected to have a meaningful impact on increasing access to and engagement in behavioral health care across the County.

File Upload

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)
Other

Please describe other
CalAIM Community Supports

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?
Age

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

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
Spoken Language
Gender
Other

Please describe other
Grade Level

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?
Age
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
The data for this disparity analysis comes from CalMHSA dashboards based on DHCS Phase 1 population workbooks. The Point In Time (PIT) rate of people experiencing homelessness in Riverside County is well below the state rate. Adults aged 18-34 and 35-44 had higher rates than the county rate. Disparities were highest for American Indians, Native Hawaiian/Other Pacific Islanders, and Black/African Americans whose rates were 3.2.-2.7 times the county rate, while Multiracial and White had lower rates at 1.7-1.23 times higher than the county rate. Hispanic/Latinx and Asian had rates much lower than the County rate. The County rate of SMI in the PIT count was very low at 2 while the SUD PIT rate at 9 was closer to the state rate of 11, this data was more than likely impacted by the inherent limitations in PIT count data collection. Data on people who accessed homeless services showed Riverside County had a rate 1.7 times lower than the state rate. Youth under 18 and adults 25-34 had the highest rates of accessing homeless services, followed closely by those 35-44. The rates among these 3 groups varied between 73-70, well above the county rate. Black/African Americans, American Indians, and Native Hawaiian/Pacific Islanders accessed homelessness services at rates much higher than White, Hispanic/Latinx and Asian people which could indicate greater need among these groups with higher rates. The percentage of K-12 students experiencing homelessness in the county at 4.2% was lower than the state 5.3% rate. Racial and ethnic disparities were evident, as Black/African American, American Indian/Alaska Native, Pacific Islander, and Hispanic/Latinx students experienced homelessness at rates that exceeded the county's 4.2% average. English learners had higher homelessness rates as did youth reported as non-binary gender. Rates were highest for students in primary grades with the highest in kindergarten, followed by transitional kindergarten, first, second and third grade.

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)

Riverside University Health System–Behavioral Health (RUHS-BH) is advancing a comprehensive, multi-year strategy to reduce homelessness among individuals with serious mental illness (SMI), severe substance use disorder (SUD), and co-occurring conditions by significantly expanding housing capacity, bed availability in all levels of care, strengthening partnerships, and integrating housing with supportive services. Over the next three years, RUHS-BH will invest in more housing than at any point in its history, recognizing stable housing as a cornerstone of recovery and long-term wellness. This expansion includes the opening of the renovated Hulen Place in 2026, which will provide 31 beds, followed by the Mead Valley Wellness Village in 2027, adding 90 adult residential facility beds. In addition, RUHS-BH supports 299 transitional living apartment units that offer individuals and families a critical bridge from homelessness to permanent housing. RUHS-BH is leveraging strong partnerships with local and state agencies, utilizing federal funding sources such as the Continuum of Care Program, and collaborating closely with the local housing authority to increase access to housing vouchers, including Housing Choice Vouchers and Project-Based Voucher opportunities. The County is also actively pursuing supplemental funding from both public and private sources to support innovative housing models and address funding gaps that can delay or limit housing development. A key component of this strategy has been the department's aggressive pursuit of No Place Like Home (NPLH) funding, which has already resulted in a significant expansion of affordable permanent housing for individuals with behavioral health needs across Riverside County. While most of these NPLH developments are now complete and fully occupied, two additional NPLH-funded projects remain under development and will further increase permanent housing options in the near future. To ensure individuals can access these housing opportunities, RUHS-BH staff are trained to complete Coordinated Entry System (CES) assessments and are working to ensure timely assessments for all eligible members. Beyond assessment, staff actively support diversion and housing stabilization efforts by assisting individuals with employment searches, applications for mainstream benefits, reconnection with natural supports, and enrollment in services that promote housing stability. These include Enhanced Care Management, Community Supports, and a wide range of mainstream and community-based affordable housing options. RUHS-BH also provides Housing Navigation, Housing Deposits, Housing Tenancy Sustaining Services, Short Term Post Hospitalization Housing, and Recuperative Care to help individuals successfully obtain housing and maintain it over time. The department anticipates further expanding these Community Supports services in FY26/27 in order to reduce homelessness amongst those with severe SMI/SUD and to extend the

reach of BHSA Housing Interventions funding. Together, these coordinated investments in housing infrastructure, funding, partnerships, and supportive services reflect RUHS-BH's commitment to reducing homelessness and improving outcomes for some of Riverside County's most vulnerable residents.

File Upload

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

BHSA BHSS
BHSA Housing Interventions
SAMHSA PATH
Other

Please describe other

HUD Continuum of Care, Homeless Housing Assistance Program (HHAP), Behavioral Health Bridge Housing (BHBH), and Encampment Resolution Funds (ERF), MediCal CalAIM Community Supports.

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
Below

For children/youth
Below

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

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
Below

30-day involuntary detention rates per 10,000
Below

180-day post-certification involuntary detention rates per 10,000
Below

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
Above

Crisis Residential Treatment Services

For adults/older adults
Below

For children/youth
Below

Crisis Stabilization

For adults/older adults
Below

For children/youth
Same

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

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
This disparity analysis uses data from CalMHSA dashboards based on DHCS Phase 1 population workbooks. Riverside County's adult inpatient administrative days were below the state rate. White and Black adults had rates above the county average, while Hispanic/Latinx adults were below it; other groups had samples too small to report. All racial and ethnic groups remained below the state average. Adults ages 45–56 had the highest rates, and males used administrative days at 1.89 times the rate of females. Adult crisis intervention average minutes (231.8) were slightly below the state average (240.1), while youth minutes (280.5) were above the youth state average (266.8). Adults 69+ had the highest use. Adults ages 21–44 were below these groups but still above the county average. Youth aged 12-17 had the highest average minutes above the overall youth rate. More female youth used crisis services then males. Asian/Pacific Islander adults had the highest average minutes despite lower use in other crisis services, and Asian/Pacific Islander youth also showed higher averages. Hispanic and White adults and youth were above the county average, while Black adults fell below it and Black youth exceeded it. Adults used more crisis stabilization services (23.7 hours per member) than youth (18.6). Adults age 33-56 exceeded the county average the most, along with youth aged 18–20. White, Black, and Hispanic/Latinx youth all exceeded the county average. Among adults, all racial/ethnic groups except Asian/Pacific Islanders exceeded the county average; American Indian/Alaska Native adults had the highest use, followed by Black adults. More males used crisis stabilization than females.average days of crisis residential services were well below the state rate for adults and slightly below for youth. Adults ages 57–68 had the highest rates, followed by those 33–56, both above the county average but still below the state average.

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)

The RUHS–Behavioral Health continuum of care includes the availability of facilities licensed as Mental Health Rehabilitation Centers (MHRCs). There are two MHRC facilities located within Riverside County, as well as several out-of-county facilities that may be utilized as needed. In FY 2023–2024, a total of 163 individuals were served by the two MHRC facilities located in Riverside County. An additional 35 individuals were served in out-of-county MHRC facilities. Combined, the unduplicated total number of clients served in an MHRC during FY 2023–2024 was 194. Placement in skilled nursing facilities (SNFs) or Institutions for Mental Disease (IMDs) is also utilized for Riverside County conservatees. In FY 2023–2024, an unduplicated total of 244 conservatees were served in IMD/SNF placements. Because some clients may transition between MHRC and IMD/SNF placements during the fiscal year, the unduplicated combined total number of clients served in either of these placement types in FY 2023–2024 was 404. This represents less than 1% of the total clients receiving Specialty Mental Health Services (SMHS) during the same period.

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)

County institutionalization rates reported in the state data workbook are below the state average across all measures, with the exception of crisis intervention for children, where utilization exceeds the state average. This higher rate of crisis intervention may be attributable to increased crisis response capacity within Riverside University Health System–Behavioral Health (RUHS-BH). RUHS-BH is expanding access to outpatient mental health services for children and youth through new programming at the Children and Youth Wellness Campus. The Wellness Campus model offers a coordinated continuum of care, including mental health urgent care and crisis residential services co-located on the same campus with outpatient services, this includes an SUD Residential for youth (and Withdrawal management) plus a PRTF (Psychiatric Residential Treatment Facility). This integrated approach facilitates timely step-down care, promotes recovery, and reduces reliance on institutional settings. The Mead Valley Wellness Village will further contribute to reductions in institutionalization through a comprehensive campus-based model that offers nearly the full continuum of care in the least restrictive settings possible. In particular, the Crisis Residential

Treatment (CRT) and Adult Residential Facility (ARF) programs will provide critical step-down options for individuals transitioning from hospitals and, in some cases, long-term institutional care. Additionally, recovery residences and transitional housing located on the campus will offer further step-down opportunities from higher levels of care, supporting sustained community integration. Reductions in institutionalization are also supported by early intervention programs and outpatient services for both children and adults, including Non–Full Service Partnership (Non-FSP) and Full Service Partnership (FSP) programs. The Youth Connect early intervention program provides timely follow-up and service linkage for hospitalized children and youth, connecting them to the RUHS-BH continuum of care, including outpatient services and forthcoming crisis residential treatment resources. Youth Connect works in close collaboration with the Youth Hospital Intervention Program (YHIP), which delivers ongoing outpatient services for youth following psychiatric hospitalization to promote engagement in care and prevent repeat hospitalizations and crisis encounters. Within the adult system of care, RUHS-BH utilizes liaisons embedded in County hospitals and crisis stabilization units to facilitate appropriate linkage and enrollment into FSP programs for hospitalized adults. The Long-Term Care Case Management program provides ongoing support for adults at high risk of prolonged institutionalization. Multidisciplinary teams monitor progress and coordinate services with the goal of transitioning individuals to the least restrictive settings possible. When appropriate, staff plan for discharge from locked facilities to community-based housing, supporting recovery, independence, and continued oversight. Further, the department funds street-based homeless outreach teams to engage members with a focus on the chronically homeless living in encampments who have severe mental illness, substance use disorder and co-occurring disorders into needed behavioral health services and housing. This intervention reduces institutionalization by preventing unnecessary law enforcement contact and/or psychiatric hospitalizations. Collectively, these programmatic strategies are expected to have a meaningful and sustained impact on reducing institutionalization across the County.

File Upload

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

BHSA BHSS
SAMHSA PATH

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
Below

For juveniles
Below

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

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?
Same

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

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?
Below

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
The data used in this disparity analysis was derived from the CalMHSA dashboards created from the state Phase 1 population workbooks. Adult arrest rates in Riverside County vary by age, with the highest rates among adults 30–39 and 20–29, at 1.92 and 1.42 times the countywide rate. Rates are lower for ages 18–19 and 40–69, at 29% and 26% below the county rate and more than twice as low as the 30–39 group. Data on arrests rates by race/ethnicity showed Black/African Americans had 2.15 times greater arrest rate than Hispanic/Latinx and a 2.35 times greater arrest rate than the White population in the County. Females have far fewer arrests than males; the male arrest is 2.5 times higher than the female arrest rate. Recidivism data from the California Department of Corrections & Rehabilitation equity dashboard shows the highest rates among adults 20–24 (55.1%), 25–29 (47.9%), and 30–34 (42.5%). Those with a mental health designation served by the CDCR Enhanced Outpatient Program have a higher recidivism rate at 47.8% than the overall County rate of 39.6%. Recidivism also varies by race/ethnicity: American Indian/Alaska Native individuals have the highest rate (45.2%), though the group size is very small, followed by Hispanic/Latinx (41.1%). Whites (39%) and Black/African Americans (37.7%) have lower rates. Females showed a lower rate of recidivism then males who were above the County overall rate at 40.1%. The rate of incompetent to stand trial at 10 per 100,000 is well below the state rate of 14.

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)
Riverside University Health System–Behavioral Health (RUHS-BH) is advancing a comprehensive, treatment-centered strategy to reduce justice involvement among individuals with significant behavioral health needs by shifting responses away from incarceration and toward prevention, diversion, and

sustained community-based care. A cornerstone of this approach are the Mental Health Collaborative Court programs, which provide individuals with active criminal cases before the Riverside Superior Court access to structured, treatment-focused alternatives. Participants receive a full biopsychosocial assessment conducted by a Clinical Therapist, along with a substance use disorder screening by a certified drug and alcohol counselor. These assessments inform the development of individualized, comprehensive treatment plans tailored to each person's behavioral health and recovery needs. Ongoing case management ensures participants are linked to the appropriate services across the RUHS-BH continuum of care, supporting stability and reducing further justice system involvement. Additionally, RUHS-BH operates Assisted Outpatient Treatment (aka Laura's Law) and Community Assistance, Recovery, and Empowerment (CARE) court programs. While these programs operate in the civil court they provide important diversionary services to prevent members from ending up in the criminal court system and / or to serve as diversionary programs for individuals already in the criminal court system. RUHS-BH also operates specialized outpatient programs designed specifically for justice-involved adults. The Riverside New Life Clinic and the San Jacinto New Life Clinic serve adults ages 18 to 60 and focus on reducing recidivism into jails, prisons, inpatient psychiatric hospitals, and emergency departments. These programs offer a robust array of services, including individual therapy, intensive case management, field-based services, skills-building and process groups, art therapies, relapse and recovery supports, 12-step and self-help groups, and access to sober living housing. After-hours crisis hotline support further ensures continuity of care and rapid response to emerging needs, helping participants remain engaged in treatment rather than cycling back into crisis or custody. For youth and families involved with the justice system, RUHS-BH's Wraparound Programs provide a family-centered, individualized, and community-based approach to care. These programs emphasize strengths and are driven by the unique needs of each family. Multidisciplinary teams—comprised of Clinical Therapists, Behavioral Health Specialists, and Parent Partners—work closely with Probation Officers, nurses, and community members to align behavioral health treatment with probation requirements and family goals, promoting stability and reducing further justice involvement. Behavioral health services are also embedded within adult and juvenile detention facilities to ensure early identification and treatment of mental health needs. RUHS-BH provides evaluations, medication management, and follow-up referrals for outpatient care, supporting continuity of treatment during custody and facilitating smoother transitions back to the community. Building on these existing efforts, RUHS-BH is strengthening a coordinated set of diversion, reentry, and community-based behavioral health initiatives. These efforts include expanding pre-arrest and court-based diversion programs, enhancing Medi-Cal reentry and continuity of care services, increasing access to Enhanced Care Management and supportive housing, and deepening cross-system partnerships among Behavioral Health, Probation, the Sheriff's Department, Housing and Workforce Solutions department, and community-based providers. Together, these initiatives represent a systemwide shift from crisis-driven, justice-based responses to a prevention- and treatment-focused model of care—reducing unnecessary incarceration, improving behavioral health outcomes, supporting long-term stability, and enhancing community safety.

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Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal
Other
BHSA FSP
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Please describe other
other state revenue

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?
Above

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?
Age
Race or Ethnicity

Child Maltreatment Substantiations (CWIP), 2022

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

What disparities did you identify across demographic groups or special populations?
Age
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
The data for this disparity analysis comes from CalMHSA dashboards based on DHCS Phase 1 population workbooks. Riverside County foster care rates are highest among the youngest children, with infants and toddlers (under 1 and ages 1–2) entering care at over 1.4–1.6 times the countywide rate. Rates for children ages 3–5 and 16–17 are below the state rate. Youth ages 11–15 and 18-21had the lowest rates. Data from the Child Welfare Indicators Project showed Black/African American children and Native American children are most disproportionately represented in foster care, while White and Hispanic/Latinx children are represented proportionate to their share of the county population. Black children are15.4% of foster care population versus a County population of 5.3%.SMHS penetration rates showed disparities for younger children with lower rates for 0–2-year-olds (12.8%) and children age 3-5 at 39.8%. For youth age 12-17 and age 6-11 the SMHS rate was considerably higher than the state rate (43%) at 55.3% and 52.8% respectively. SMHS penetration rates by race/ethnicity showed disparities for Black/African American youth with a rate of 38.6% compared to the rate for White and Hispanic/Latinx youth at 43.4% and 41.9% respectively. Substantiations of allegations of maltreatment in Riverside County vary by age. Given the vulnerabilities of very young children, the highest rate of substations was among children age 0-2 year old, and 3 to 5 years old. The rate for children 6 to 10 nearly matched the countywide rate while youth older than 10 were below the countywide 9.6 rate. The only rate falling below the state rate were youth age 16 to 17. Substantiations of maltreatment vary by race and ethnicity with the highest rates reported for Native Americans and Black/African American. substantiations for White and Hispanic/Latinx were slightly below the county wide rate at 8.9 and 9.4, respectively. Disparities in gender were not available for comparison.

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

Riverside University Health System–Behavioral Health (RUHS-BH) is implementing a coordinated, prevention-focused approach to reduce the removal of children from their homes by strengthening family supports, intervening early in crises, and closely aligning behavioral health services with child welfare, probation, and juvenile justice partners. Central to this strategy is the Children and Transition-Age Youth (TAY) Systems of Care, which work in close coordination with child welfare to ensure timely referrals, ongoing treatment, and shared planning for children at risk of removal. Through this collaboration, RUHS-BH supports families involved in the Family Preservation Court, emphasizing treatment and services that allow children to safely remain in or return to their homes whenever possible. The Assessment and Consultation Team plays a critical role by receiving referrals from parents entering the child welfare system and rapidly connecting them to appropriate behavioral health and supportive services to promote stabilization and reunification. The Therapeutic, Residential Assessment and Consultation Team partners with child welfare to ensure that youth who are not receiving behavioral health services have representation in Child and Family Team meeting and are connected to appropriate behavioral health and supportive services. Additionally, the MOMS Perinatal Program is an intensive outpatient treatment program for pregnant and parenting substance abusing women. Transportation is provided for women and their children. A child learning laboratory is provided as part of treatment, where women learn hands-on parenting skills. Groups cover a variety of topics specific to pregnant and parenting mothers. Special speakers are also used to provide information and referrals to other community programs available for women. RUHS-BH also embeds behavioral health services at key intervention points within the child welfare system. The department provides initial behavioral health assessments for all children and youth detained by the Department of Public Social Services (DPSS), ensuring early identification of needs and immediate linkage to treatment. RUHS-BH staff are stationed at Harmony Haven, a short-term transitional housing program operated by child welfare for children awaiting placement, where they provide on-site behavioral health support to help stabilize children and reduce the length and intensity of out-of-home placements. To strengthen families and reduce the likelihood of removal, RUHS-BH operates the Parent Support and Training program, which offers parenting classes and works closely with child welfare to make these services accessible to parents involved in the system. These classes equip caregivers with skills to manage behavioral health challenges, improve family functioning, and meet child welfare requirements that support family preservation. In addition, each RUHS-BH children and Transition Age Youth programs have Parent Partners providing parenting classes and on other supports to reduce stressors and improve

skills and relationships to reduce the risk of out of home placement. Crisis intervention and stabilization are also key components of RUHS-BH's prevention strategy. Mobile crisis teams respond to behavioral health emergencies in foster homes, helping prevent placement disruptions and additional trauma for children and youth. RUHS-BH has also established ongoing relationships with hospitals throughout Riverside County and responds to emergency departments to evaluate children and youth experiencing behavioral health crises, often diverting them from unnecessary inpatient stays or further system involvement. For children and youth with more complex needs, RUHS-BH collaborates closely with the Department of Public Social Services (DPSS) and Probation to provide Wraparound services that address significant behavioral health challenges while supporting placement stability. Probation partners with DPSS and RUHS-BH for youth in dual status programs, ensuring coordinated care across systems. RUHS-BH's long-standing collaboration with Probation ensures that youth detained in the county's three juvenile halls receive appropriate screening, assessment, treatment, and crisis intervention. This cross-system coordination is further strengthened through the monthly Juvenile Justice Involved Youth Collaborative, which RUHS-BH has convened for more than four years to align services for youth involved in the juvenile justice system. Finally, RUHS-BH supports continuity of care during critical transitions through programs such as Youth Connect, which serves children and youth in psychiatric inpatient settings. Youth Connect works with families and caregivers prior to discharge to link them to community-based services and supports, reducing the risk of re-hospitalization and subsequent child welfare involvement. Together, these integrated efforts reflect RUHS-BH's commitment to keeping children with serious mental illness safely connected to their families, reducing unnecessary removals from the home, and promoting long-term stability through early intervention, coordinated care, and strong cross-system partnerships.

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

Please describe other

other state revenue

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
Below

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?
Gender
Race or Ethnicity

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
The data for this disparity analysis comes from CalMHSA dashboards based on DHCS Phase 1 population workbooks. The Riverside County rate for follow-up after an emergency department visit for substance use at 24.4% is below the statewide rate of 28.8%, while follow-up after an emergency visit for mental illness is above the state rate. Data on age,race/ethnicity and gender was not available for emergency department visit metrics. County California Health Interview Survey (CHIS) data on the rate of adults that reported a need for help with an emotional/mental or drug/alcohol problem and had no visits for mental/drug/alcohol issues in the past year showed the Riverside county rate (43.7%) was below the state average of 48.4% indicating the county is doing somewhat better than the state overall. However, disparities were found for race/ethnicity particularly when the data was stratified by gender and race/ethnicity. Comparisons of race/ethnicity revealed only the Hispanic/Latinx population (57.6%) had a rate of not accessing needed care well above the state rate of 48.4% and the countywide rate. All the other race/ethnic groups alone had rates below the countywide rate. However, when the data is stratified by race/ethnicity and gender the disparities for other race/ethnic groups are found. Black/African American males had the highest rate (62.9%) of not accessing care, followed by Latina females (59.1%), Latino males (55.2%), and Multiracial females (52.5%). All other race/ethnicity by gender groups were below the countywide rate. Examining disparities for gender alone did not show disparities. There were no disparities found between the age groups of 18-24, 25-64 and 65+.

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)
Riverside University Health System–Behavioral Health (RUHS-BH) is implementing a comprehensive, equity-driven strategy to reduce the incidence of untreated behavioral health conditions by expanding

access to culturally informed services, strengthening community engagement, and ensuring continuity of care across all levels of the behavioral health system. Recognizing that the highest rates of untreated behavioral health conditions in Riverside County occur among underserved and underrepresented cultural groups, RUHS-BH is prioritizing culturally responsive outreach and treatment. At the center of this effort is the department's structured Cultural Competency Program (CCP), which plays an integral role in Behavioral Health Services Act (BHSA) community planning and outreach activities. The CCP is dedicated to eliminating barriers to care and increasing access through core values that include equal access for diverse populations; wellness, recovery, and resilience; client- and family-driven care; strength-based and evidence-based practices; community-driven approaches; innovation and outcome-driven strategies; and cultural humility and inclusivity. The CCP not only guides how RUHS-BH engages the community but also ensures that internal operations and service delivery are culturally humble and informed. Through the collective efforts of CCP staff, Cultural Community Liaisons, and Cultural Advisory Committees, RUHS-BH leverages lived experience, cultural knowledge, and community expertise to design and deliver services that are respectful of and responsive to the needs of Riverside County's diverse populations. These efforts are critical to promoting equity, reducing health disparities, and improving access to high-quality, integrated behavioral health care. A key component of this work is the Cultural Competency Reducing Disparities (CCRD) Advisory Committee, which brings together RUHS-BH staff, members of cultural subcommittees, community-based organizations, community leaders, and consumers. The CCRD identifies cultural barriers, service gaps, and unmet needs among underrepresented populations and collaborates with Workforce Education and Training to promote and host targeted workforce training. These trainings strengthen the capacity of the behavioral health workforce to deliver culturally responsive care, thereby reducing missed opportunities for engagement and treatment. RUHS-BH also expands access and reduces stigma through its Peer Support programs, which include peers, family members, caregivers, and parents with lived experience. These programs provide outreach, education, and ongoing support that normalizes the behavioral health recovery process, and help-seeking They build trust within communities, and increase both initial engagement and sustained participation in behavioral health services. To address untreated conditions during times of acute need, RUHS-BH's Crisis System of Care offers mobile crisis response in the community as well as voluntary walk-in locations where individuals can receive immediate support. Crisis services are designed not only to stabilize individuals in the moment, but also to provide continued monitoring and follow-up until a successful connection to outpatient care is established. Additionally, RUHS-BH staff actively engage individuals before and during discharge from psychiatric hospitalization to maintain continuity of care and prevent gaps in treatment that often lead to untreated or worsening conditions. Together, these integrated strategies—culturally informed outreach, community-driven planning, peer support, crisis intervention, workforce development, and strong care transitions—reflect RUHS-BH's commitment to reducing untreated behavioral health conditions and ensuring that all residents of Riverside County have equitable access to timely, effective, and culturally responsive behavioral health services.

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

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
Above

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
Below

For children/youth
Above

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?
Above

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?
Same

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
Below

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)
Above

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

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

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

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)
Below

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

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
Above

For adults/older adults
Above

For children/youth
Above

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
Above

For adults/older adults
Above

For children/youth
Above

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
Same

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.
Overdoses

Overdoses

Please describe why this goal was selected
Reducing overdose deaths in Riverside County is an important focus for the department. RUHS-BH is a collaborative partner of the Riverside Overdose Data to Acton (RODA) program established and led by RUHS-PH. RODA began after a rapid rise in overdose deaths in 2019 with a goal of using enhanced surveillance data to guide overdose prevention efforts. Although there have been some declines in overdose deaths in Riverside County over the last two years, according to the California Department of Health Care Services (DHCS) 2022 data, Riverside County recorded an overdose death rate of 34.1 per 100,000 residents, compared to the statewide rate of 28.8 per 100,000. Preventing unnecessary deaths due to overdoses has a significant and measurable impact on the community. It preserves life, reduces the incidence of severe and long-term health complications, supports affected families, alleviates pressure on healthcare and emergency services, and contributes to improved public health and community safety.

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
The data used for this disparity analysis were drawn from CalMHSA dashboards based on DHCS Phase 1 population workbooks, supplemented with local data. In 2022, Riverside County's rate of all drug-related deaths was 34.1 per 100,000, exceeding the state average of 28.8 per 100,000. Disparities by sex were evident, with the overdose death rate among males (53.3 per 100,000) substantially higher than the female

rate. The male rate exceeds the County overall rate, while the female rate is less than half of the County average. Racial and ethnic disparities were also observed, with Native American/Alaska Native, White, and Black/African American populations experiencing overdose death rates higher than the overall County rate. Age-related disparities showed elevated overdose death rates among adults aged 29 to 69 years, all exceeding the County average. While youth aged 20–25 years had higher rates compared to other younger age groups, their rate remained well below the County overall rate. In contrast, the County rate for all drug-related overdose emergency department (ED) visits in 2022 was 145.2 per 100,000, which is below the state average. Sex-based disparities were again apparent, with males experiencing higher ED visit rates than females. The male rate exceeded the County average, while the female rate remained below it. Racial and ethnic disparities were observed, with the highest ED visit rates among White individuals (231.5 per 100,000), followed by Black/African Americans (200.0 per 100,000). Rates among Hispanic, Native American/Alaska Native, and Asian/Pacific Islander populations were all below the County average, although Hispanic individuals had higher rates than the latter two groups. Overdose-related ED visit rates also varied by age group. Youth aged 15–19 years and adults aged 25–39 years experienced the highest rates, well above the County average, ranging from 220.6 to 236.8 per 100,000. Youth aged 20–24 years and adults aged 25–29 years also had rates above the County average, at 175.4 and 196.7 per 100,000, respectively. All other age groups had rates below the County average. More recent local data from the Public Health RODA program provide updated insights into overdose deaths and ED visits. Most notably, overdose deaths have shown a downward trend, with a 39% decrease when comparing the 12-month period from January 2023 to January 2024 (580 deaths) to January 2024 through January 2025 (350 deaths). Racial and ethnic disparities in the local data mirror those reported in the DHCS workbooks, and sex-based disparities persist, with overdose deaths remaining higher among males than females. Over the past three years, methamphetamine-related overdose deaths have exceeded those involving fentanyl.

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 Overdoses 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)

Riverside University Health System–Behavioral Health (RUHS-BH) is implementing a comprehensive, data-driven, and person-centered strategy to reduce overdoses across Riverside County by expanding access to evidence-based treatment, strengthening care transitions, advancing harm-reduction efforts, and deploying assertive, field-based outreach to reach individuals at highest risk. At the core of this strategy is the countywide expansion of Medications for Addiction Treatment (MAT). RUHS-BH has rolled out MAT across all outpatient behavioral health clinics, adult detention facilities, crisis programs, and substance use disorder (SUD) residential treatment settings for individuals with moderate to severe opioid or alcohol use disorders. This ensures that life-saving medications are accessible at multiple points of contact, including during incarceration and immediately following release. To further strengthen reentry and continuity of care, RUHS-BH established a dedicated SUD/MAT referral system through its Substance Abuse Prevention and Treatment Administration, in coordination with BH LINKS, to support timely referrals from jails and

prisons into community-based treatment. Hospital-based interventions play a critical role in overdose prevention. The SUD Bridge Program at RUHS Medical Center operates directly within the Emergency Department to address urgent opioid-related needs. Individuals presenting with overdose or opioid-related concerns receive rapid assessment, brief intervention, and motivational engagement, with initiation of MAT—including buprenorphine—when clinically appropriate. The program emphasizes warm handoffs to ongoing SUD treatment, reducing overdose risk during the high-vulnerability period following emergency department discharge and strengthening continuity of care. SUD and Mental Health Navigation Teams stationed at RUHS Medical Center and private hospitals in the desert region further enhance these transitions. Navigators provide bedside engagement, screening, education on treatment options, and coordination of follow-up care. They assist with scheduling appointments and connecting individuals to withdrawal management, residential treatment, or outpatient services, serving as vital links between hospital systems, behavioral health programs, and community-based providers. Beyond hospital settings, RUHS-BH deploys assertive, community-based outreach to re-engage individuals with repeated emergency or inpatient utilization. Mobile Psychiatric Services (MPS), a Full Service Partnership outreach team, focuses on individuals with complex behavioral health and addiction needs, addressing housing instability, mental health conditions, and substance use while facilitating linkage to lower levels of outpatient care. This proactive engagement reduces crisis-driven service use and overdose risk. Riverside County continues to strengthen its continuum of care for SUD through coordinated efforts among RUHS Medical Center, RUHS community clinics, private hospitals, community-based organizations, and the Behavioral Health Department. These partnerships support responsive, evidence-based interventions across hospital, community, and street-level settings, ensuring individuals have timely access to MAT and comprehensive treatment resources. Harm reduction and overdose surveillance are also key components of the county's approach. Through the Riverside Overdose Data to Action (RODA) initiative, RUHS Public Health and Behavioral Health collaborate to track and analyze overdose trends using EMS and monthly overdose reports. These data are shared with community partners, providers, and staff to identify overdose "hot spots" and inform the placement of new outpatient or Narcotic Treatment Programs based on demonstrated community need. The County's public overdose dashboard further promotes transparency and data-informed decision-making. RUHS-BH distributes naloxone (Narcan) widely through Department of Health Care Services programs, with distribution centers at Substance Abuse Prevention and Treatment Administration offices and RUHS Medical Center. All field-based teams and clinics are supplied with Narcan, ensuring rapid overdose reversal capacity throughout the system. Additional harm-reduction efforts include fentanyl test strip distribution, community education campaigns such as Faces of Fentanyl events, and school-based fentanyl and opioid education assemblies through the Fentanyl No Longer (FNL) initiative. The expansion of FNL services in South and Mid-County, supported through an approved Opioid Settlement Fund project, will further extend prevention and education efforts. Targeted partnerships enhance outreach to individuals at the highest risk of overdose. In Moreno Valley, Opioid Settlement Funds support Mobile Crisis Management Teams that conduct high-risk street outreach and SUD screening, connection, and placement. In the City of Riverside, the Public Service Engagement Team (PSET) operates an assertive, field-based care coordination model, engaging unsheltered individuals in encampments and public spaces. PSET staff provide harm-reduction education, crisis intervention, and direct connections to

MAT through in-person outreach and telehealth, coordinating mobile providers, transportation, and follow-up care. Palm Springs similarly leverages Opioid Settlement Funds to support a County Behavioral Assessment Team clinician focused on SUD needs. Collectively, these integrated strategies—expanded MAT access, hospital-based bridge programs, navigation support, harm reduction, real-time overdose surveillance, and persistent street-level engagement—demonstrate RUHS-BH's commitment to reducing overdoses, improving treatment engagement, and delivering equitable, recovery-oriented substance use services across Riverside County.

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

2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SUBG

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

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

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

Type of engagement

Training, education, and outreach related to community planning

Date

9/17/2025

Type of engagement

Workgroups and committee meetings

Date

9/3/2025

Type of engagement
Workgroups and committee meetings

Date
9/4/2025

Type of engagement
Training, education, and outreach related to community planning

Date
9/9/2025

Type of engagement
Meeting(s) with county

Date
7/16/2025

Type of engagement
Meeting(s) with county

Date
8/11/2025

Type of engagement
Other

Date
8/20/2025

Type of engagement
Training, education, and outreach related to community planning

Date
9/9/2025

Type of engagement
Training, education, and outreach related to community planning

Date
9/11/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/11/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/9/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/16/2025

Type of engagement
Training, education, and outreach related to community planning

Date
9/16/2025

Type of engagement
Training, education, and outreach related to community planning

Date
9/17/2025

Type of engagement
Training, education, and outreach related to community planning

Date
9/17/2025

Type of engagement
Meeting(s) with county

Date
9/17/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/18/2025

Type of engagement
Meeting(s) with county

Date
9/23/2025

Type of engagement
Meeting(s) with county

Date
9/23/2025

Type of engagement
Provided data to county

Date
9/23/2025

Type of engagement
Training, education, and outreach related to community planning

Date
9/24/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/29/2025

Type of engagement
Workgroups and committee meetings

Date
10/1/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/1/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/8/2025

Type of engagement
Training, education, and outreach related to community planning

Date
10/8/2025

Type of engagement
Workgroups and committee meetings

Date
10/14/2025

Type of engagement
Workgroups and committee meetings

Date
10/14/2025

Type of engagement
Workgroups and committee meetings

Date
10/14/2025

Type of engagement
Training, education, and outreach related to community planning

Date
10/16/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/20/2025

Type of engagement
Meeting(s) with county

Date
10/20/2025

Type of engagement
Meeting(s) with county

Date
10/21/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/21/2025

Type of engagement
Meeting(s) with county

Date
10/22/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/23/2025

Type of engagement
Training, education, and outreach related to community planning

Date
10/27/2025

Type of engagement
Workgroups and committee meetings

Date
10/28/2025

Type of engagement
Other

Date
10/29/2025

Type of engagement
Training, education, and outreach related to community planning

Date
10/29/2025

Type of engagement
Workgroups and committee meetings

Date
10/30/2025

Type of engagement
Workgroups and committee meetings

Date
11/5/2025

Type of engagement
Provided data to county

Date
11/6/2025

Type of engagement
Workgroups and committee meetings

Date
11/6/2025

Type of engagement
Training, education, and outreach related to community planning

Date
11/7/2025

Type of engagement
Provided data to county

Date
11/12/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/13/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/20/2025

Type of engagement
Training, education, and outreach related to community planning

Date
12/3/2025

Type of engagement
Other

Date
10/27/2025

Type of engagement
Other

Date
11/4/2025

Type of engagement
Meeting(s) with county

Date
10/27/2025

Type of engagement
Workgroups and committee meetings

Date
1/8/2026

Type of engagement
Key informant interviews with subject matter experts

Date
11/12/2025

Type of engagement
Training, education, and outreach related to community planning

Date
1/8/2026

Type of engagement
Meeting(s) with county

Date
2/17/2026

Type of engagement
Meeting(s) with county

Date
3/17/2026

Type of engagement
County outreach through social media

Date
1/24/2026

Type of engagement
Public e-mail inbox submission

Date
1/24/2026

Type of engagement
Survey participation

Date
1/24/2026

Type of engagement
Workgroups and committee meetings

Date
3/16/2026

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
Behavioral Health Commission, Native American sub-committee, Western Regional Board, Desert Regional Board, Cultural Competency Reducing Disparities Committee, "CAGSIE Community Advocating for Gender & Sexuality Inclusion/Equity - sub-committee" ,Adult System of Care BHC committee, Legislative BHC Committee, Wellness & Disability Equity Alliance sub-committee, Veterans BHC Committee , RUHS-BH Director's Meeting, Housing BHC Subcommittee, Older Adult SOC Advisory Committee, Suicide Prevention Coalition - Higher Education sub-committee, "Asian Pacific Islander Desi American & Native Hawaiian sub-committee", Criminal Justice BHC Committee, TAY Collaborative Desert, Middle Eastern & North African sub-committee, Deaf and HoH sub-committee, Children's BHC Committee, TAY Collaborative Mid County, PEI Collaborative, Hispanic, Latinx Advisory sub-committee, "SPIRITUALITY &FAITH-BASED sub-committee", Children's Coordinators, African American Family Wellness Advisory Group sub-committee, Inland Empire Behavioral Health Collaborative Convening - Hospital Association of Southern California, Interagency

Leadership, Team RCOE AB2083, Cultural Competency All Staff Meeting, SAPT Criminal Justice Providers, DPSS Adult Services, Continuum of Care, Bereavement Counseling Providers, Student Services Collaborative , Emergency Medical Care Committee (EMCC) , Inland Regional Center-Enhanced Services Coordination Team,Bi-Annual PDSS Tribal TANF, Western Collaborative, Peers Collaborative Mid-County, Peers Collaborative Western, Behavioral Health Collective, Tribal Alliance, DPSS Children/ Managers meeting, RUHS Medical Director's regional meetings, Union Meeting Liuna, Union Meeting SEIU, BHSA Presentation for BH staff, Population Health Management Steering Committee, Mid-County Regional Board BHC Committee, Public Hearings, Countywide Supervisors Meeting , Inland Coalition on Aging

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	Riverside
2	Moreno Valley
3	Corona
4	Menifee
5	Temecula

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
Throughout the development of the Integrated Plan, diverse stakeholder viewpoints were intentionally incorporated through a series of committee meetings, subcommittee discussions, and cross-departmental collaboration. These engagement efforts ensured that the plan reflects a comprehensive understanding of countywide needs, strengths, and priorities from multiple perspectives. . The RUHS-BH Cultural Competency program includes the formal structure of the Cultural Competency and Reducing Disparities (CCRD) Committee. This committee is designed to be a bridge between the behavioral health department and 9 target underserved cultural communities identified in Riverside County. CCRD has 9 sub-committees

each targeting one of the 9 identified cultural groups (Latinx, African American, Native American, Asian American/Pacific Islander, LGBTQ+, Deaf and Hard of Hearing, Middle Eastern/North African, People with Disabilities, and Faith-Based/Spirituality). CCRD and its sub-committees are a central component in the community planning process and provide ongoing opportunities for discussion related to the needs of each of these communities as it relates to behavioral health concerns, identifying access and linkage barriers, and work together to make recommendations for improvements. Additionally, the Behavioral Health Commission includes several committees focused on various key stakeholder groups identified through the BHSA community planning process. The Veterans cultural group is managed through the Behavioral Health Commission's Veteran's Committee. The year-round efforts of these groups inform the development of the BHSA plan and overall departmentwide service implementation. The attached meeting minutes provide documentation of these discussions. Stakeholders included representatives from Public Health (PH), the Department of Public Social Services (DPSS), Probation, the District Attorney's office, law enforcement, housing services and developers, Tribal Alliance partners, local managed care plans (IEHP, Molina, Kaiser), school districts, emergency services, community-based organizations, contract providers, peer and family advocates, county program staff, and individuals with lived experience. Each group contributed unique insights that helped identify cultural, regional, and service-specific priorities. These engagements also brought forward community-identified strengths such as trusted outreach teams, successful early intervention efforts, and strong partnerships between county departments and community organizations. During these meetings, participants identified needs including improved access to behavioral health care, expanded culturally and linguistically responsive services, greater support for underserved and rural regions, strengthened coordination across departments, workforce development needs, and clearer pathways for system navigation. Priorities such as integration of housing supports and expansion of early intervention resources were emphasized across stakeholder groups. All collected input was reviewed and incorporated into the Integrated Plan to ensure the final document accurately reflects the community's priorities. Meeting minutes or Agendas attached serve as formal documentation.

Upload File

HR and Local Union meeting and attendance.pdf
Tribal TANF and Tribal Alliance plus sign in sheet.pdf
10-20-25 Minutes - Higher Education Subcommittee Meeting.pdf
09182025 Bereavement Counseling - Meeting Notes.pdf
ILT , DPSS, EMCC, HASC, PHM Meeting Minutes and Agendas.pdf
PHM Meeting Agenda 07.09.25.pdf
IE Behavioral Health Collaborative - Meeting Agenda 8.20.25.pdf
CCRD and Cultural Competency (10) meeting minutes.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

In this initial BHSA community planning process, RUHS-BH met with our local health jurisdiction, RUHS-Public Health (PH), to begin our partnership regarding the CHA/CHIP. We met with PH leadership to review the regulatory changes in BHSA and how they interact with planning processes PH and the local managed care plans already have in place. PH completed their most recent CHA in 2024; therefore, we utilized this for the purposes of our planning. Behavioral Health did have Department representatives participate in the CHIP process, which was completed in March 2025. As a result of statewide changes across our agencies, and with the newly released CHA, PH developed a Population Health Management Steering Committee with workgroups. Membership includes Public Health and local managed care plans (IEHP, Molina, and Kaiser). Behavioral Health joined the Steering Committee which includes representation on the Data workgroup in early 2025. BH and PH are part of the same larger RUHS system and have many data sharing processes in place. We will continue to build upon these existing processes to further our work together via the CHIP. Utilizing the Riverside Health Coalition, PH will structure community workgroups that focus on the 3 areas identified in the CHA: Access to Care, Behavioral Health, and Housing. BH will co-lead the Behavioral Health workgroup alongside reps from PH and an MCP. This group will be one avenue to meet with community stakeholders and identify strategies to address the BH needs identified.

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
Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)
Removal of Children from Home

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
Removal of Children from Home

Was data shared?
Yes

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 with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process. 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
In developing the IP, inclusion of the goals/objectives of the CHA/CHIP was easily done as the identified priority areas align well within the focus of BHSA. The three priority areas: Mental and Behavioral Health, Housing, and Access to Equitable and Just Care and Resources support many of the requirements and goals within the BHSA. The top priority in the CHIP is Behavioral Health focusing on reducing disparities in access to care through improved staff training in cultural competence and improving collaboration between partners. The RUHS-BH Workforce Education and Training unit designs an annual quality evidence-based training plan for all levels of Department staff including required cultural competence training ensuring our workforce is adequately prepared and capable of serving a diverse consumer population. The IP includes engagement with cultural communities through our robust and well-established Cultural Competency and Reducing Disparities group. The efforts of this group and its sub-committees aim to increase education of mental illness and substance use disorders to increase the likelihood of help-seeking from those who need it the most.with BHSA's increased focus on housing for individuals with a mental illness and/or substance use disorder, the programming we have included in the plan will positively impact the goals of the CHIP. The CHIP lists the need to increase transitional housing units and shelter beds in Riverside County by prioritizing vulnerable populations and integrating housing with healthcare and support services. The IP includes funding support both of these for individuals with behavioral health challenges.

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

The county collaborated with the following Managed Care Plans (MCPs) to support and inform their community reinvestment planning and decision-making processes: Inland Empire Health Plan (IEHP), Kaiser Permanente, and Molina Healthcare.

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?

IEHP did not meet the income requirements for the calendar year and, therefore, is not required to submit a Community Reinvestment Plan to DHCS in 2026.Kaiser Foundation Health Plan's (KFHP) Medi-Cal line of business does not meet the financial threshold outlined in DHCS APL 25-004 that would require the development of a Community Reinvestment Plan. Applicable reinvestments based on CY 2024 (January–December 2024) are expected to be disbursed over a three-year investment period from 2027 through 2029, with contributions potentially beginning at the end of 2026. Thereafter, DHCS will annually provide revenue for reinvestment in Q2, with MCPs required to submit updates on investments in Q3 of each year. Molina has established a formal process that allows providers to request and access reinvestment funds. Molina utilizes the DHCS-identified categories and permits providers to submit proposals that align with one of the five categories. Proposals are reviewed by Molina's internal Community Reinvestment Committee to ensure alignment with community reinvestment guidelines and priorities and to determine appropriate allocation of funds. The committee is comprised of senior leaders from multiple departments across the organization, including Quality and Community Engagement. As noted earlier, RUHS-BH is in the early stages of developing partnerships with the MCPs for purposes related to BHSA. As these collaborations continue to evolve, activities will be more clearly identified and aligned through the CHIP process.

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
1/17/2026

Date the stakeholder comment period closed
3/13/2026

Date of behavioral health board public hearing on draft IP
3/12/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
PDF,image,or other document

Please upload the PDF, image, or other file documenting the public posting
Cultural Competency Liaisons.png
Prevention and Early intervention Collaborative Contact list.png
Suicide Prevention Coalation.png
County Wide.png
BH SOCIAL MEDIA.pdf
Cultural Competency Reducing Disparitis.pdf
Behavioral Health 2.png
Behavioral Health.png
LIUNA Screenshot 2026-01-22 094042.png

SEIU Screenshot 2026-01-22 093946.png

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page
https://www.ruhealth.org/behavioral-health/BHSA

File Upload
RUHS-BH Boosted Posts Campaign Report.pdf
Behavioral Health Services Act Public Hearings (2).pdf

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

Attach email
Behavioral Health 2.png
Behavioral Health.png

Please specify the other process the draft plan was circulated to stakeholders
Information about the BHSA Integrated Plan posting and Public Hearings was sent out to a variety of emails lists including:
• A countywide email distribution
• All RUHS-BH
• Cultural Competency & Reducing Disparities Committee and its sub-committees, with formal invitations distributed by the CCP Liaisons to their respective community groups
• The Behavioral Health Commission and its sub-committees
• Prevention and Early Intervention email distribution list
• Suicide Prevention Coalition email distribution list
• Anyone we presented to over the course of the stakeholder presentations
• Additionally, advertisement on social media (Facebook and Instagram) with boosted posts - Targeting all of Riverside, plus a special focus on areas with poverty levels >20%: Hemet, Perris, Banning, Coachella, Desert Hot Springs, Cathedral City, Blythe, Indio, Palm Springs, San Jacinto (TOTAL IMPRESSIONS 413,683)
• Advertisement through Next Door community pages
The draft posting information and public hearing events were added to the Riverside County Radar system as well as to our RUHealth landing page and events page

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
Individuals with Lived Experience (Adults and Older Adults)

Summarize the substantive revisions recommended this stakeholder during the comment period
Individuals with lived experience emphasized the need for improved access to behavioral health services, housing stability, crisis services, and transportation support. Many respondents highlighted challenges with long wait times, limited service availability, and the need for stronger peer support and recovery-oriented services.

Stakeholder group that provided feedback
Families of Children, Youth, Adults, and Older Adults with Lived Experience

Summarize the substantive revisions recommended this stakeholder during the comment period
Families highlighted the importance of prevention and early intervention services, particularly school-based mental health services, trauma-informed care, and support for caregivers navigating behavioral health systems. Families also emphasized housing stability, care coordination, and resources to support family members experiencing behavioral health and substance use challenges.

Stakeholder group that provided feedback
Youth and Youth-Serving Organizations

Summarize the substantive revisions recommended this stakeholder during the comment period
Youth stakeholders emphasized the need for accessible school-based mental health services, crisis supports for young people, prevention and stigma reduction programs, and services addressing trauma, suicide prevention, and substance use among youth.

Stakeholder group that provided feedback
Behavioral Health and Substance Use Providers

Summarize the substantive revisions recommended this stakeholder during the comment period

Providers identified workforce shortages, high caseloads, and the need for additional treatment capacity, including residential treatment, crisis stabilization services, and recovery housing. Providers also emphasized the importance of culturally responsive services and stronger coordination between systems of care

Stakeholder group that provided feedback

Health Care Organizations and Managed Care Plans

Summarize the substantive revisions recommended this stakeholder during the comment period

Health care partners highlighted the need for stronger care coordination between physical health and behavioral health systems, improved access to specialty behavioral health services, and expanded crisis response and community-based supports

Stakeholder group that provided feedback

Public Health and Justice System Partners/ Social Services, Public Health, and Aging Services Partners

Summarize the substantive revisions recommended this stakeholder during the comment period

Public safety partners emphasized the need for crisis intervention resources, diversion programs, and improved coordination between behavioral health services and justice system partners to better support individuals experiencing behavioral health crises.

Stakeholders highlighted the importance of coordinated services across systems, including child welfare, aging services, and public health programs, to support individuals and families with complex behavioral health needs

Stakeholder group that provided feedback

Education Partners (Local Education Agencies, Higher Education, Early Childhood Organizations

Summarize the substantive revisions recommended this stakeholder during the comment period

Education partners emphasized expanding school-based behavioral health services, prevention and early intervention programs, and partnerships between schools and behavioral health providers to support students and families.

Stakeholder group that provided feedback
Housing and Homelessness Service Providers (Continuums of Care, Housing Organizations)

Summarize the substantive revisions recommended this stakeholder during the comment period
Housing and homelessness partners highlighted the importance of supportive housing, transitional housing, and integrated behavioral health and housing services to address the needs of individuals experiencing homelessness and behavioral health challenges.

Stakeholder group that provided feedback
Community-Based Organizations and Cultural Community Representatives, including Veterans and Veteran-serving Organizations/

Summarize the substantive revisions recommended this stakeholder during the comment period
Community members and partner organizations emphasized ongoing challenges in accessing behavioral health services, particularly in communities that already face structural barriers such as transportation limitations, lack of nearby service locations, and long wait times for appointments. Participants expressed the importance of maintaining easily accessible community-based services and ensuring that individuals can connect to care in a timely and supportive manner.

Stakeholders representing culturally and linguistically diverse communities highlighted the continued need for services delivered in preferred languages and in culturally responsive ways. Community partners noted that language access, culturally informed outreach, and trusted community messengers remain essential to ensuring that residents feel comfortable seeking behavioral health support.

Many participants expressed concern about maintaining prevention and early intervention services during the transition to the BHSA funding structure. Community members emphasized that prevention programs, youth education, and early outreach efforts play a critical role in reducing stigma, identifying concerns early, and preventing behavioral health conditions from escalating into crisis situations.

Community-based organizations expressed interest in understanding how they will continue to partner with the County under the BHSA framework. Participants emphasized the importance of maintaining strong collaboration between the County and community organizations that already have established relationships with underserved populations. Stakeholders noted that community-based partners often serve as trusted entry points for individuals seeking services and play a key role in outreach, education, and service navigation.

Cultural Community Liaisons shared perspectives based on their direct engagement with communities

across the County. Liaisons emphasized that their role helps bridge communication gaps between the behavioral health system and communities that may not traditionally engage with government services. During the discussions, questions were raised about how the BHSA transition may impact liaison outreach activities and community engagement efforts. Participants emphasized the importance of sustaining these trusted relationships and ensuring that outreach and community education remain part of the County's behavioral health strategy.

Veterans and veteran-serving organizations emphasized the need for behavioral health services tailored to veterans, including trauma-informed care, peer support, and improved coordination between county and veteran service systems.
In addition to formal public hearings, RUHS–Behavioral Health conducted multiple outreach presentations and listening sessions with community partners, cultural community liaisons, and organizations serving underserved and historically marginalized populations across Riverside County. These discussions provided important feedback regarding community priorities, concerns related to the BHSA transition, and recommendations for maintaining access to services.
Several key themes emerged during these engagements.

Overall, these conversations reinforced the importance of maintaining strong community partnerships, improving culturally responsive services, and ensuring that behavioral health system changes under BHSA continue to support access, prevention, and trust within underserved communities.

Stakeholder group that provided feedback
Survey/ Public comment period/ Public Hearing – Western Region, desert, mid county

Summarize the substantive revisions recommended this stakeholder during the comment period
Stakeholders provided extensive feedback regarding behavioral health and substance use service needs in Riverside County, as well as perspectives on the proposed temporary transfer of funding during the Behavioral Health Services Act (BHSA) transition. Input was collected through surveys, public meetings, and community engagement activities, and reflects the perspectives of community members, service providers, advocates, and individuals with lived experience. Overall, stakeholders identified ongoing gaps in behavioral health and substance use services, particularly related to housing stability, access to timely care, workforce capacity, and services for vulnerable populations.

Housing was frequently identified as a critical need. Many respondents noted the ongoing challenges individuals face in securing and maintaining stable housing, particularly for people experiencing homelessness, youth and transition-age youth, pregnant women, families, and individuals transitioning from inpatient treatment, residential substance use programs, or incarceration. Stakeholders emphasized the importance of expanding supportive housing options, transitional housing, and integrated housing

models that combine behavioral health services with long-term housing stability. Several respondents also highlighted the need for additional inpatient and residential behavioral health services, crisis stabilization programs, and specialized services for populations such as youth, older adults, individuals with autism spectrum disorders, and individuals experiencing severe mental illness.

Access to behavioral health services was another common theme. Stakeholders noted workforce shortages, limited availability of clinicians and therapists, and long wait times for appointments. Respondents recommended expanding peer support programs, strengthening culturally responsive and community-based services, and increasing workforce capacity to improve service access and continuity of care. Prevention and early intervention were also identified as important priorities, particularly school-based behavioral health programs, trauma and grief services for youth and families, and community education efforts that help reduce stigma and increase awareness of available resources. Transportation barriers and geographic disparities were also mentioned, particularly in areas such as the High Desert, Banning, Beaumont, and other parts of the county where services may be less accessible.

With regard to substance use services, stakeholders identified the need for expanded treatment capacity, including residential treatment programs, sober living and recovery housing, and medication-assisted treatment. Respondents also emphasized improving coordination between providers, increasing prevention and education programs, and supporting families impacted by substance use disorders. Services for youth, individuals experiencing homelessness, and individuals reentering the community following incarceration were also identified as areas where additional support may be beneficial. Stakeholders also shared feedback regarding the proposed transfer of funds during the BHSA transition. Many respondents indicated support for the temporary flexibility if it helps maintain existing programs and prevents service disruptions during implementation of the new BHSA structure. Stakeholders emphasized maintaining key services such as mobile crisis response programs, prevention and early intervention services, school-based mental health programs, and community-based outreach and navigation services. At the same time, several respondents expressed concern about reducing housing investments, noting that housing instability continues to be one of the most significant barriers to recovery for many individuals receiving behavioral health services.

Several respondents recommended ensuring that housing and behavioral health services remain closely connected and that any temporary funding transfers include ongoing monitoring and evaluation. Additional suggestions included strengthening partnerships with schools and community-based organizations, improving culturally responsive services, supporting workforce retention, and ensuring that funded programs include clear outcomes and accountability measures. Overall, stakeholders emphasized the importance of maintaining continuity of care, protecting access to services for vulnerable populations, and continuing to strengthen the behavioral health system as Riverside County transitions to the BHSA framework.

During the Western Region public hearing, community members, family advocates, and nonprofit representatives provided input reflecting both lived experience and system-level perspectives. Family

members of individuals living with serious mental illness shared concerns about communication barriers with conservators and treatment teams, emphasizing that families play a critical role in supporting recovery and should be more consistently included in care coordination and updates. Comments also highlighted the ongoing challenges faced by individuals experiencing homelessness and serious mental illness, including the need for stable housing paired with comprehensive wraparound services such as case management, behavioral health treatment, and family support. A representative from the forensic Family Advocate Program expressed support for the BHSA Integrated Plan's housing investments, noting that initiatives such as Mead Valley Wellness Village and expanded housing beds could significantly improve outcomes for justice-involved individuals and families navigating homelessness and grave disability. Community-based organization representatives also emphasized the importance of continued collaboration between the County and nonprofit partners to ensure that planning updates, services, and funding opportunities are communicated effectively.

Public comments during the Desert Region hearing reflected strong participation from individuals with lived experience, community liaisons, and local nonprofit partners. Several residents of the Rescue Mission shared personal experiences with homelessness and recovery, expressing appreciation for the support received through Riverside University Health System – Behavioral Health programs and emphasizing the importance of maintaining housing stability and supportive services during the BHSA transition. Individuals also highlighted the positive impact of programs such as Wraparound services and recovery supports that have helped families maintain stability and strengthen family relationships. Cultural Community Liaisons representing the disability and Hispanic communities raised important considerations related to service accessibility, culturally responsive outreach, and the need to reduce systemic barriers that may limit access to behavioral health resources. One liaison conveyed concerns from individuals with disabilities regarding ongoing access challenges and suggested expanding inclusive community engagement opportunities that support social connection and skill development. Representatives from Peace from Chaos also spoke about the importance of prevention efforts, suicide awareness, and strong community partnerships. Their comments highlighted improvements in collaboration with the County over the past year while emphasizing the need for continued outreach, prevention services, and equitable access to behavioral health resources across all regions of Riverside County.

Stakeholders providing comment during the Mid-County public hearing included medical professionals, nonprofit leaders, recovery advocates, and cultural community representatives. Several speakers emphasized the importance of prevention and early intervention services within the behavioral health system. A physician highlighted the critical role of prevention programs in reducing the progression of behavioral health conditions and encouraged continued investment in community-based prevention efforts. Representatives from the National Alliance on Mental Illness (NAMI) noted the value of evidence-based family education programs that support families following behavioral health crises and recommended that these programs be considered as part of early intervention strategies. Recovery advocates also emphasized the importance of strengthening recovery infrastructure, including Recovery Community Organizations and peer-led recovery services, which provide support before treatment, between treatment episodes, and after formal treatment concludes. Additionally, a Cultural Community Liaison representing the Latinx community highlighted the importance of culturally responsive outreach

and community-based education to help residents better understand how to access behavioral health services. The speaker noted that many families want to seek help but may face barriers due to lack of awareness, cultural stigma, or limited trust in traditional systems. Overall, comments from this region reinforced the importance of prevention, community engagement, culturally responsive services, and expanded recovery support networks within the behavioral health system.

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

N/A

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

QI Work Plan Goals - B.Jacobs 9-17-25.pdf

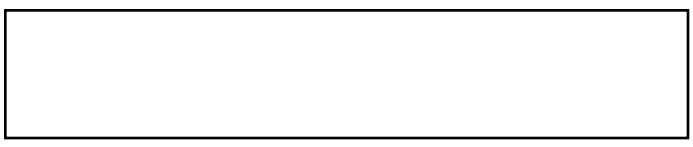
Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?

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	231
Substance Use Disorder (SUD) services only	47
Both MH and SUD services	6

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	231
DMC/DMC-ODS only	26
Both SMHS and DMC/DMC-ODS systems	6

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?

10

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

Approximately 10 percent of SMHS BHSA provider locations also have a MCP contracted NSMHS provider. RUHS-BH plans to encourage existing SMHS providers to contract with the MCPs in our county (IEHP, Molina and Kaiser) to expand availability of Medi-Cal NSMHS to Riverside County members. In addition, RUHS-BH will continue to collaborate with our managed care partners to develop strategies to meet the full range of behavioral and physical health needs of Riverside County members. While MCPs are responsible for developing and maintaining their own provider networks, Riverside County can suggest avenues for expansion as part of our on-going partnerships with each.

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

Outreach and Engagement (O&E)
Workforce, Education and Training (WET)
Capital Facilities and Technological Needs (CFTN)
Early Intervention Programs (EIP)
Adult and Older Adult System of Care (non-FSP)
Children's System of Care (non-Full Service Partnership (FSP))

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

RUHS-Behavioral Health (RUHS-BH) operates a comprehensive outpatient system of care for children and youth ages 0–21 experiencing emotional or behavioral challenges. Services are delivered throughout Riverside County through both County-operated and contracted providers, ensuring accessible care in clinic, community, home, school, and residential settings. Programs offer a full range of Specialty Mental Health Services, including assessments, individual, group, and family therapy, Intensive Care Coordination (ICC), In-Home Behavioral Services, case management, parent and peer support, psychiatric evaluation, medication support, crisis stabilization, and linkage to community resources. Youth may also be referred for Therapeutic Behavioral Services which are behavioral coaching interventions provided in home and community settings. Treatment planning incorporates the Child and Adolescent Needs and Strengths (CANS) tool to identify focus areas and guide care. For youth receiving ICC, staff facilitate Child and Family Team meetings to collaboratively establish goals and action steps. Children's outpatient services are delivered by multidisciplinary teams, including licensed and license-waivered Clinical Therapists, Psychiatrists, Nurses, Behavioral Health Specialists, Transition Age Youth Peer Specialists, and Parent Partners. All programs implement evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Family-Based Therapy (FBT) for eating disorders, Dialectical Behavioral Therapy (DBT), and Motivational Interviewing (MI). RUHS-BH programs coordinate closely with child-serving systems including Child Welfare, Juvenile Probation, schools, and the Inland Regional Center to ensure integrated and responsive care. Service locations are evaluated regularly to ensure equitable access and adequate capacity to meet the behavioral health needs of youth and families across Riverside County.

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	16500
FY 2027 – 2028	16750
FY 2028 – 2029	17000

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

RUHS-BH Children's Non-FSP service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal AutoRegressive Integrated Moving Average (SARIMA) model was fit

to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produced conservative, interpretable projections suitable for planning and funding purposes.

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

RUHS-BH operates three established TAY Drop-In Centers, each located in different regions of Riverside County, ensuring broad coverage and access for youth across the county. "TAY Desert Flow" is located in La Quinta, "The Arena" is in Perris and "Stepping Stones" is in Downtown Riverside. Each center is conveniently situated near a bus stop, making it easily accessible to youth. The centers are staffed by a diverse, multidisciplinary team composed of individuals with both professional expertise and lived experience, providing a comprehensive, empathetic approach to youth services. The TAY Drop-In Centers offer a wide range of activities and services designed to support the physical, emotional, and social well-being of youth. The centers offer daily support groups, held both inside and outside the center, where youth can engage in peer discussions and skill-building activities. Individual and family therapy is available, offering therapeutic support tailored to meet the unique needs of both the youth and their families. Therapists provide various modalities including specialty evidence-based practices. Psychiatric and nursing support, ensuring that youth receive the necessary medical and mental health care including medication evaluations and prescribed medications to manage a behavioral health condition(s). Case management and intensive care coordination, providing personalized support to help youth navigate the complex systems they may encounter. Peer support services - at each TAY Drop In Center, we employ Parent Partners, Family Advocates and TAY Peer Specialists. All have lived experience of either overcoming a behavioral health challenge or navigating a child or loved one's behavioral health challenges. Transportation assistance is provided for youth without access to services or means of transport. Each program has a fleet of vehicles and a full-time Community Services Assistant whose main responsibility is to transport TAY members in need.

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	450
FY 2027 – 2028	500
FY 2028 – 2029	525

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

RUHS-BH TAY Drop in center service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal AutoRegressive Integrated Moving Average (SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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

The Children's Crisis Residential Program (CCRP) is a short-term, community-based mental health treatment service for children and adolescents experiencing an acute psychiatric crisis who require a higher level of care than outpatient services but do not need inpatient hospitalization. The CCRP provides a safe, structured, and therapeutic residential setting designed to stabilize symptoms, reduce immediate risk, and support a rapid return to the child's home or community placement. Services are trauma-informed, culturally responsive, and family-centered, with 24-hour supervision and support. Youth receive a comprehensive assessment, individualized treatment planning, psychiatric evaluation and medication support as indicated, and intensive therapeutic interventions, including individual, group, and family therapy. The program emphasizes skill-building in emotional regulation, coping strategies, and crisis prevention. CCRP staff collaborate closely with families, caregivers, schools, child welfare, probation, and other community partners to ensure continuity of care and successful transition planning. Discharge planning begins at admission and focuses on connecting youth to ongoing outpatient, school-based, or community services to maintain stability and prevent future crises. The overarching goal of the CCRP is to provide timely stabilization in the least restrictive setting while promoting safety, resilience, and long-term recovery.The intended outcomes of a California Children's Crisis Residential Program are to:

1. Stabilize acute behavioral health crises.
2. Provide a safe alternative to psychiatric hospitalization.
3. Rapidly assess and initiate treatment.
4. Engage families and support systems.
5. Transition youth quickly back to community-based care.
6. Reduce repeated crisis episodes and system involvem

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	60
FY 2027 – 2028	100
FY 2028 – 2029	100

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

Since this is a new program projected bed capacity was used to project the number to be served.

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

Crisis Stabilization Unit – Children & Youth (Ages 5-15)

The Children's and Youth Crisis Stabilization Unit (CSU) provides immediate, short term, developmentally responsive intervention for children and adolescents experiencing acute behavioral health or cooccurring substance-use related crises. The program operates as a diversion from emergency departments and higher levels of care by offering rapid triage, assessment, psychiatric evaluation, nursing support, safety monitoring, and crisis planning in a trauma informed, family centered environment. Services emphasize early engagement, stabilization, and warm hand offs to community based supports, including youth outpatient behavioral health services, case management, peer and family support, school based mental health programs, substance use treatment services, and when clinically indicated, residential or intensive outpatient treatment. The goal is to reduce the need for psychiatric hospitalization, prevent justice system involvement, strengthen family stability, and promote resilience, recovery, and long term wellness for youth and their caregivers.

Crisis Stabilization Unit – TAY (Ages 16–25)

TAY Crisis Stabilization Unit provides immediate, short term crisis intervention for transitional age youth experiencing significant behavioral health or co occurring substance use crises. Recognizing the unique developmental needs of TAY, the program incorporates youth centered engagement strategies, strengths based assessments, psychiatric and nursing services, and individualized safety planning. The CSU helps stabilize acute symptoms, reduce suicide and self harm risk, and promote early connection to TAY appropriate services, including outpatient behavioral health, peer support, case management, SUD treatment, supported education, supported employment, and housing navigation. The program emphasizes empowerment, skill building, and warm linkages to ongoing supports to prevent hospitalization, reduce crisis recurrence, and strengthen transitions into adulthood.

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	420
FY 2027 – 2028	440
FY 2028 – 2029	480

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

The Crisis Stabilization service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal AutoRegressive Integrated Moving Average (SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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

The Long Term Care and Representative Payee programs includes multiple activities and functions. These programs are available to all ages eighteen (18) and older, including Transitional Aged Youth aged 18 - 25 years of age. Due to the typical age of onset of many psychotic disorders (i.e. early 20s) there are relatively few youth aged 18 - 25 enrolled in these programs relative to an older aged cohort. However, the full suite of services described below are provided to youth enrolled in either the Long Term Care and / or Representative Payee program. Assessment & Care Planning Teams evaluate, or link for evaluation, the conservatee's psychiatric, medical, and social needs, then develop individualized care plans in collaboration with the LPS conservator. Placement & Transitions, They arrange placements in appropriate facilities such as psychiatric hospitals, Institutes for Mental Disease (IMDs), or residential board-and-care homes. The goal is to move individuals from acute hospitalization toward long-term or community-based settings when possible. Case Management & Coordination Clinicians, case managers, and peer staff provide ongoing support, monitor progress, and coordinate with the Public Guardian's office. They ensure services are consistent across providers and settings. Therapeutic & Supportive Services Teams may offer group therapy, skills training, and linkage to peer support to help conservatees stabilize and prepare for community reintegration. Rights & ProtectionsUnder the Lanterman-Petris-Short (LPS) Act, conservatees retain certain rights. Case managers help safeguard these rights while balancing treatment needs, ensuring care is provided in the least restrictive environment. Discharge & Community Integration
When appropriate, staff plan for discharge from locked facilities to community-based housing, supporting recovery and independence while maintaining oversight.The Representative Payee (RP) Program embedded within Riverside University Health System – Behavioral Health (RUHS-BH) provides voluntary money management services to clients who are unable to manage their own finances due to mental illness, disability, age, or legal incompetence. The program is designed to support the most vulnerable individuals—those who are young, elderly, disabled, or otherwise incapable of managing their Social Security benefits independently Key functions include:

• Receiving and managing SSA benefits (Social Security and Supplemental Security Income) on behalf of clients.

• Ensuring financial stability by issuing checks and managing funds responsibly.

• Time-limited support, with the goal of transitioning clients to independent financial management or to another responsible third party.

• Collaboration with County clinics, where each RP client maintains an open episode and is assigned a case manager for treatment coordination.

• Accounting services are provided by the RP staff, while mental health treatment and case management are handled separately

The RP Program is part of a broader continuum of care that includes Long-Term Care, Public Guardian services, and transportation, and is integrated within the Forensics division of RUHS-BH. It plays a critical role in supporting clients' financial well-being while complementing therapeutic and case management efforts. The Representative Payee program is also available to members who are not on conservatorship but who would benefit from assistance in managing their funds.

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	21
FY 2027 – 2028	25
FY 2028 – 2029	30

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

LTC program service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal AutoRegressive Integrated Moving Average (SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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

The Mindful Body and Recovery program is a continuing MHSA-encumbered INN project. Mindful Body and Recovery eating disorder intensive outpatient program is comprised of three components: treatment, training, and community outreach targeting culturally diverse and underserved populations. The treatment component focuses on improving the mental and physical health of members with an eating disorder diagnosis and symptoms. The services are provided by well-trained multidisciplinary team that use different treatment milieus that include individual therapy, group therapy, family therapy, nutritional and dietary counseling, nursing services, psychiatry services, intensive case management services (ICC), in-home behavioral services (IHBS) and consultation. Members enrolled in the program are expected to participate for a minimum of 12 weeks and up to 36 weeks. The program is designed to treat adolescents and TAY age individuals between the ages of 12 and 26 years old. For the training component, the goal is to increase department staff and contract providers' knowledge and skills to treat members with eating disorder-related diagnosis. Ongoing training on Dialectal Behavioral Therapy and Family-Based Therapy for eating disorders by subject matter experts is provided on a continuous basis.

For the outreach component of the program, IOP Mindful Body and Recovery staff participate in community events year-round to share information on eating disorders and resources to increase the public's awareness of eating disorders. The outreach is done in all communities but especially in communities that are historically under-served and that have underutilized mental health services in Riverside County.

In 2025, outreach activities engaged a total of 4,247 community members across presentations, tabling events, workshops, and provider meetings. In 2026, outreach efforts continued to expand as of April 2026, reaching 2,012 individuals through culturally responsive education, community engagement, and professional training. These activities support early identification, reduce stigma, and strengthen community connections to specialized eating disorder 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	50
FY 2027 – 2028	55
FY 2028 – 2029	60

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

Data assumptions on the number of youths that would need the IOP level of care came from data on

diagnosis in the electronic health record and data on referrals to SMHS services from the County managed care plans. The data was used in the development of the original MHSA innovation project plan. This is a level of care that was previously unavailable in the County so data for projecting future service use was limited.

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
The RUHS-BH adult and older adult System of Care (SOC) provides outpatient specialty mental health services through a network of regionally based, county operated behavioral health clinics. The SOC clinic sites are central to the behavioral health continuum of care, ensuring accessible, coordinated, recovery-oriented services for adults and older adults across the county. The clinics' service array includes assessments, diagnosis, full behavioral health treatment planning including substance use disorder services, individual and group therapy, psychiatric and medication services, peer support, psychoeducation groups, case management, crisis intervention, and supportive services. Peer support services include family advocacy to assist family members and other natural supports with supporting members in their recovery. Evidence-based practices utilized in the SOC outpatient clinics include but are not limited to Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Motivational Interviewing (MI), Seeking Safety, and Solution Focused Therapy (SFT). Services are provided by multi-disciplinary staff including clinical therapists, behavioral health specialists, nurses, psychiatrists, and peer-support specialists. Staff coordinate services and collaborate on care to address needs, monitor progress, and promote whole-person wellness. Coordination to higher levels of care also occurs for members needing the more intensive mental health services provided in FSP-ICM or ACT/FACT services. Clinic staff will be trained in the LOCUS level of care tool to support clinical decision making when a member needs to step up to a higher level of care or needs to step down to a lower level of care. Supportive services focus on recovery-oriented engagement and the development of natural supports to increase empowerment and reduce barriers to

care. Peer Support Specialists and Behavioral Health Specialists (functioning as case managers) provide life skills coaching, wellness planning, linkage to housing and employment resources, benefits navigation (CalFresh, Social Security, Medi-Cal, Supplemental Security Income), referrals, and system navigation to assist with accessing primary health care and other county or community-based resources. County service providers are required to participate in Trauma Informed Systems training to ensure an understanding of the nature and impact of trauma on clients and the workforce, and to cultivate a healing organization with trauma informed service delivery. Cultural competency training is also required for all staff annually. Clinic staffing is diverse and representative of the community and includes service providers fluent in non-English languages, especially Spanish which is the only county threshold language. Interpretation services are always available when needed. Clinic members receiving services are also encouraged to participate in culturally responsive clinic events to increase connection and reduce stigma. Substance Use Disorder (SUD) services are incorporated into the clinic practice through screening, brief intervention, counseling, and recovery support. Staff use the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model, motivational enhancement, and relapse-prevention strategies. Members needing a higher level of SUD care are referred to the RUHS-BH substance abuse prevention and treatment (SAPT) network of providers for intensive outpatient or residential treatment. Collaborative coordination with SAPT providers ensures integrated dual-diagnosis treatment, with a strong focus on continuity of care as members receive concurrent services or transition from primary SUD services back to the SOC clinic. Peer Support Specialist staff also facilitate relapse-prevention groups and connect members to community programs such as 12-Step and SMART Recovery.

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	12000
FY 2027 – 2028	12250
FY 2028 – 2029	12600

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

RUHS-BH Older Adult and Adult Non-FSP service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal AutoRegressive Integrated Moving Average

(SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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
Pathways to Success is a supportive services program for vocational rehabilitation. Funding from BHSA and a contract with the California Department of Rehabilitation will make it possible to offer these services to adult system of care clients. Pathways to Success vocational rehabilitation program is designed to promote sustainable employment and career advancement for those coping with mental health challenges, co-occurring disorders, and other barriers to workforce entry or retention. The program emphasizes integrated support and alignment with Department of Rehabilitation's Pathway to Success model. Each member receives a comprehensive assessment of interests, aptitudes, skills, work history, and employment barriers. Employment Service Counselors (ESCs), Behavioral Health Specialists (BHS), and Peer Support Specialists (PSS) guide members through career exploration, goal setting, and individualized employment planning.

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	90
FY 2027 – 2028	90
FY 2028 – 2029	90

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

Prior fiscal year Vocational program service patterns were used to project the unduplicated number of clients that will be served in vocational services over the course of the Integrated Plan.

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

The Mental Health Collaborative Court programs (Mental Health Court, Mental Health Diversion, Veterans Treatment Court, Military Diversion Court, and HOME Court) offer a variety of treatment focused services to members of our community who presently have criminal matters before the Riverside Superior Court. These services include a full biopsychosocial assessment with a Clinical Therapist as well as a substance use disorder screening with a certified drug and alcohol counselor, from which a comprehensive treatment plan is developed, and tailored to meet the individual needs of each member. The member is provided case management and linkage to the RUHS-BH continuum of care based on needs. Homeless Outreach

Mediation & Education (HOME) Court AKA Homeless Court is a criminal court program that works collaboratively with probation and the legal system to assist members who struggle with homelessness and need assistance in mental health and/or substance use treatment. The HOME court behavioral health team completes an evaluation and determines the level of treatment that can assist the member in recovery and help link to housing resources. When in the program (that can be up to 2 years), case management is provided to help keep the members on track and linked to services. Assisted Outpatient Treatment (AOT) aka Laura's Law is a voluntary outreach program to provide additional linkage and support to members of the community who struggle with stabilization and multiple hospitalizations due to their mental health. AOT provides an outlet for family members and first responders to initiate a referral to assist the member. The AOT team will attempt outreach and engagement with the members to reduce barriers to treatment due to their lack of engagement in services. It potentially can involve the civil court if needed to help provide an outside motivator for treatment for a 6-month period. Once a course for treatment has been agreed upon, members are then linked to the various services outlined in their plan, which can range from residential treatment, intensive outpatient, or outpatient services. Members may also receive case management services as part of their comprehensive treatment plan, which provides them with an additional array of services, consisting of housing support, assistance with applying or reapplying for qualified benefits, transportation assistance to and from appointments, as well as someone who can provide guidance with any future educational or vocational aspirations they may have. Members also have the option to take advantage of Peer Support services, a unique service that provides the member with direct access to someone who has lived experience and who can likely relate to many of the same challenges the member is going through, while emphasizing hope, understanding and compassion. Once they are accepted into one of our programs, the staff continue to ensure that the members treatment plan remains relevant to their current needs, making recommendations and adjustments as needed, to ensure that the member is receiving the optimal level of treatment and support while they are in the program. Additionally, staff also act as advocates between the member and the court, further explaining how treatment can benefit the consumer both in the short and long term.

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	2700

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	2850
FY 2028 – 2029	2900

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

Collaborative court service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal AutoRegressive Integrated Moving Average (SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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

The Long Term Care and Representative Payee programs includes multiple activities and functions. These programs are available to all ages eighteen (18) and older. Assessment & Care Planning Teams evaluate, or link for evaluation, the conservatee's psychiatric, medical, and social needs, then develop individualized care plans in collaboration with the LPS conservator. Placement & Transitions, They arrange placements in appropriate facilities such as psychiatric hospitals, Institutes for Mental Disease (IMDs), or residential board-and-care homes. The goal is to move individuals from acute hospitalization toward long-term or

community-based settings when possible. Case Management & Coordination Clinicians, case managers, and peer staff provide ongoing support, monitor progress, and coordinate with the Public Guardian's office. They ensure services are consistent across providers and settings. Therapeutic & Supportive Services Teams may offer group therapy, skills training, and linkage to peer support to help conservatees stabilize and prepare for community reintegration. Rights & ProtectionsUnder the Lanterman-Petris-Short (LPS) Act, conservatees retain certain rights. Case managers help safeguard these rights while balancing treatment needs, ensuring care is provided in the least restrictive environment. Discharge & Community Integration When appropriate, staff plan for discharge from locked facilities to community-based housing, supporting recovery and independence while maintaining oversight.The Representative Payee (RP) Program embedded within Riverside University Health System – Behavioral Health (RUHS-BH) provides voluntary money management services to clients who are unable to manage their own finances due to mental illness, disability, age, or legal incompetence. The program is designed to support the most vulnerable individuals—those who are young, elderly, disabled, or otherwise incapable of managing their Social Security benefits independently Key functions include:

• Receiving and managing SSA benefits (Social Security and Supplemental Security Income) on behalf of clients.

• Ensuring financial stability by issuing checks and managing funds responsibly.

• Time-limited support, with the goal of transitioning clients to independent financial management or to another responsible third party.

• Collaboration with County clinics, where each RP client maintains an open episode and is assigned a case manager for treatment coordination.

• Accounting services are provided by the RP staff, while mental health treatment and case management are handled separately

The RP Program is part of a broader continuum of care that includes Long-Term Care, Public Guardian services, and transportation, and is integrated within the Forensics division of RUHS-BH. It plays a critical role in supporting clients' financial well-being while complementing therapeutic and case management efforts. The Representative Payee program is also available to members who are not on conservatorship but who would benefit from assistance in managing their funds.

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**

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	663
FY 2027 – 2028	700
FY 2028 – 2029	736

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

LTC program service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal AutoRegressive Integrated Moving Average (SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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

Crisis Residential Treatment (CRT) programs are voluntary alternative facilities for psychiatric hospitalization. CRT programs provide a home-like environment with an enriched peer to peer community focusing on recovery. Services are intended for members experiencing acute psychiatric episodes with or without co-occurring disorders with substance use. There is a CRT located in each of the three county regions and one out of county located in El Centro. Adult CRT facilities are licensed by Community Care

Licensing as a Social Rehabilitation Program (SRP). Consumers are offered up to a 21-day length of stay with extension options up to 30 days not to exceed 60 days. The CRTs serve 15-16 Adults at a time from the ages 18 and up. These programs are utilized to provide crisis stabilization, prevent unnecessary hospitalizations, to step down from psychiatric hospitalization and to assist consumers with stabilizing symptoms before transitioning to other types of treatment such as residential substance use treatment and traditional outpatient services. Services include assessment, plan development, medication services, nursing therapeutic services, peer-to-peer support, case management and discharge planning. An additional Social Rehab Program is the Adult Residential Treatment Program which provides a therapeutic environment for members needing more time to stabilize and find recovery than in the CRT. Members' length of stay will be determined by the assessed needs and not to exceed one year. The program focuses on continued stabilization and assisting members in enhancing interpersonal skills, independent livings and developing a personal community support system when discharging to minimize the risk of hospitalization.

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	675
FY 2027 – 2028	700
FY 2028 – 2029	725

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

CRT service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal AutoRegressive Integrated Moving Average (SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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

Crisis Stabilization Unit – Adults & Older Adults
The Crisis Stabilization Units offer Adult and Older Adult immediate, short duration behavioral health and cooccurring substance use crisis intervention for individuals experiencing acute psychiatric distress. The CSU provides rapid triage, comprehensive clinical assessment, psychiatric evaluation, continuous nursing and safety monitoring, and short term stabilization services in a secure, recovery oriented setting. The program is designed to reduce acute psychiatric symptoms, mitigate suicide risk, and promote stabilization through early intervention and coordinated care. CSU staff facilitate rapid linkages to appropriate follow up services, including outpatient behavioral health programs, medication support, case management, peer support, supportive housing resources, substance use disorder treatment, and residential treatment programs. Services prioritize client safety, dignity, empowerment, and culturally responsive care, while aiming to reduce unnecessary hospitalizations and incarcerations and strengthen continuity of care for adults and older adults.

System Facts: Our CSU, MHUC, CWIC providers are surrounded by our Crisis System of Care Oversight for appropriate follow up, linkage, and ongoing care coordination needs including, but not limited to, provider and BH care management and coordination meeting, onsite reviews and 24/7 case consultation.

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	880
FY 2027 – 2028	860
FY 2028 – 2029	1300

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 Crisis Stabilization service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal AutoRegressive Integrated Moving Average (SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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

This program has been moved to CSOC

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

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
NA

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	0
FY 2027 – 2028	0
FY 2028 – 2029	0

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

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
Youth Hospital Intervention Program (YHIP)

Please select which of the three EI components are included as part of the program or service
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
The Youth Hospital Intervention Program (YHIP) is a field-based, time-limited, and intensive behavioral health program designed to serve youth who are being discharged from psychiatric hospitalization, as well as those at risk of requiring such care. YHIP consists of three regional teams strategically located in Indio, Perris, and Riverside to ensure comprehensive countywide coverage. Each team provides mobile, community-based services to youth and families within its assigned region. YHIP delivers a wide range of supports, including comprehensive risk and clinical assessments, short-term individual and family therapy, skills-building groups, parenting education, case management, peer and parent support, and linkage to community resources. The primary goal of YHIP is to promote stabilization and prevent re-hospitalization by providing immediate, short-term therapeutic interventions and connecting youth to ongoing outpatient behavioral health services for long-term treatment and recovery. Clinical Therapists are trained in evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Family-Based Therapy (FBT), Dialectical Behavior Therapy (DBT), and Motivational Interviewing (MI). In addition to therapeutic services, the program assists families with transportation and collaborates closely with RUHS-BH outpatient programs to coordinate medication and follow-up care. Through its collaborative and trauma-informed approach, YHIP supports youth and families in achieving stability, resilience, and successful reintegration into their home and community environments.

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	325
FY 2027 – 2028	350
FY 2028 – 2029	375

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

YHIP service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal AutoRegressive Integrated Moving Average (SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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

Youth Connect

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

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

The Youth Connect Program is dedicated to empowering youth who have experienced one or more psychiatric hospitalizations by providing comprehensive support and resources tailored to their unique needs. Engagement with the youth and family begins while the youth is inpatient with staff going to the inpatient settings to meet the youth and also outreach to the family. The program mission is to facilitate a seamless transition to ongoing needed aftercare services, ensuring that youth and their families have access to vital behavioral health services as well as addressing additional needs related to social determinants of health. Identification of needs across the domains allows for Youth Connect staff to work with the youth and their caregivers in meeting needs that impact them as a whole and thus reducing stressors that may exacerbate their behavioral health needs. This may include such needs as food insecurity, housing insecurity and unmet physical health needs. Teams strive to promote stability and resilience while fostering a collaborative environment where families feel equipped and supported in their journey toward recovery and wellness. Through assessments, continuous engagement, and case management, teams aim to connect youth with the care they need to thrive in their communities. Services are primarily provided in the community and in the youth's homes.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	400
FY 2027 – 2028	425
FY 2028 – 2029	450

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

Youth Connect projected individuals to be served did not have enough years of data for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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

Transforming Our Partnerships for Student Success (TOPSS)

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: Other

Please specify "other" type of Treatment Services and Supports

The Transforming Our Partnerships for Student Success (TOPSS) program provides students and family wellness through collaborative behavioral health partnerships with local school districts that increase access to behavioral health services by providing services on school sites and coordinating care within partner district(s). Staff provide direct behavioral health services and coordinate care with community partners via referral networks and systems of care. Services provided include:Mental Health Services which include culturally appropriate assessments, individual, collateral and group treatment. Services are provided on school sites, in homes and in the community. Clinical Therapists provide therapy and evidence-based treatments including Trauma Focused Cognitive Behavioral Therapy to reduce symptoms of trauma and Dialectical Behavior Therapy to assist with emotional regulation. Several staff also have specialized training in working with eating disorders. Peer Support Services include support for caregivers of youth in caring for children with specialized needs and alleviating barriers to treatment including parenting support classes and linkage to resources within the community as well as Transition Age Youth Peers to engage and support the youth from their lived experience. Case Management Services include linkages to resources for the youth and families. Attention is given to basic needs for food, clothing, and shelter.

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

Dialectical Behavior Therapy
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Dialectical Behavior Therapy

Trauma Focused CBT

Please describe intended outcomes of the program or service

The Transforming Our Partnerships for Student Success (TOPSS) program provides students and family with behavioral health services as well as connection to community resources and supports to address needs related to social determinants of health. The population served are youth 13 to 18 years old and their families, with an emphasis on providing services to underserved and vulnerable populations such as members of ethnic minority groups, homeless, and LGBTQ+ youth. The program focuses on meeting needs to have an overall impact on wellness, which, in turn, has a positive impact on the behavioral health needs of the youth as well as their families. This is achieved by coordinating care with community partners via referral networks and systems of care. Additionally, staff provide trainings to school staff and caregivers to improve knowledge of behavioral health diagnoses and symptoms, increase awareness of signs of suicide and interventions, and reduce stigma of mental health illnesses

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	100
FY 2027 – 2028	100
FY 2028 – 2029	100

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

TOPSS projected individuals to be served did not have enough years of data for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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
Youth and Family Community Services

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: Other

Please specify "other" type of Treatment Services and Supports
The Youth Family and Community Services (YFCS) program provides Intensive Care Coordination (ICC) services to court-dependent youth with complex behavioral health needs. These youth are typically placed at the Riverside County Department of Social Services, Children's Services Division emergency shelter, or in Short-Term Residential Therapeutic Programs (STRTPs) throughout California. Clinical staff conduct comprehensive assessments to identify each youth's unique strengths, challenges, and treatment needs. Given the complexity of these cases and their frequent involvement with multiple service systems, care coordination emphasizes the integration of information from all relevant sources to ensure informed, collaborative decision-making regarding treatment planning and placement. Clinicians work closely with STRTP staff and Children's Services Division Social Service Practitioners to ensure that each youth's behavioral health and support needs are appropriately addressed. Collaboration occurs through regular participation in Child and Family Team (CFT) meetings, Multidisciplinary Team (MDT) meetings, and state-facilitated Technical Assistance calls. In addition, clinicians conduct Qualified Individual Assessments as required under the Family First Prevention Services Act (FFPSA) for youth under probation consideration for STRTP placement. This process includes gathering historical records, assessing current functioning, and identifying strengths and needs to determine the most appropriate and least restrictive level of care.

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
The overarching program goal is to work collaboratively with youth, families, placing agencies and residential placements to promote stability, healing, and positive outcomes for youth in the child welfare and juvenile justice systems. The program staff work with the youth and those in support of the youth to identify the least restrictive level of care.

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	220
FY 2027 – 2028	240
FY 2028 – 2029	260

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Youth and Community Services projected individuals to be served did not have enough years of data for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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
Preschool 0-5 Programs

Please select which of the three EI components are included as part of the program or service
Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports
Preschool 0 – 5 Programs provide early intervention services to children ages zero to approximately 7 years of age throughout Riverside County. Services are provided in the clinics, on mobile units in the community and at school sites across the county. Services include Parent-Child Interaction Therapy (PCIT), Teacher-Child Interaction Training (TCIT), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Incredible Kids (IK), Positive Parenting Program (Triple P), PC-Care, and Incredible Years groups. They also provide expert consultation for providers who serve children ages 0 – 7.

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
Triple P - Positive Parenting Program (Triple P)
Parent Child Interaction Therapy (PCIT)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Incredible Years

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Triple P
Parent Child Interaction Therapy

Trauma Focused CBT

Please describe intended outcomes of the program or service

The Preschool Program focuses on supporting the emotional, social, and developmental well-being of young children while preparing them for successful engagement in school and community environments. Specifically, outcomes include emotional regulation and coping skills, positive social skills and peer interactions, behavioral improvement, cognitive and language development, family engagement and support, readiness for school, and early identification and intervention.

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	200
FY 2027 – 2028	225
FY 2028 – 2029	250

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

Preschool 0-5 service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the

month of first service. A Seasonal AutoRegressive Integrated Moving Average (SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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
Therapeutic and Residential Assessment and Consultation (TRAC) Team

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

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
The Therapeutic & Residential Assessment & Consultation(TRAC) staff participate in Interagency Placement Screenings with Children's Services Division and Probation to make recommendations on treatment needs of youth in care. They also make recommendations of level of care needs based on youth's clinical needs and ability of placement to meet identified needs. Clinicians refer eligible youth for Therapeutic Behavioral Services to foster skill building as an adjunct service to other specialty mental health services. They also monitor provision of TBS to ensure alignment with clinical needs and goals. Some of the staff are co-located in regional Child Welfare offices to provide mental health consultation services; and to participate in Child and Family Team Meetings prior to youth being connected to specialty mental health

services.

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	220
FY 2027 – 2028	240
FY 2028 – 2029	260

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
TRAC program projected individuals to be served did not have enough years of data for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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
Assessment and Consultation Team (ACT)

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

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

The Assessment and Consultation Team (ACT) is the point of referral for youth as they are initially removed from caregivers by child welfare and for youth that are in the custody of child welfare and in need of behavioral health services. ACT Clinicians consult with assigned Social Service Practitioners from child welfare to gather relevant history and refer to outpatient clinics and contracted providers for clinical assessments and ongoing specialty mental health services as clinically appropriate. ACT Clinicians complete some of the biopsychosocial assessment and complete the Child and Adolescent Needs and Strength (CANS) tool. They refer biological parents for clinical services when mandated by the courts for reunification and provide authorizations for court ordered psychological evaluations. Clinicians are embedded in regional Child Welfare offices to provide behavioral health consultation services. ACT Clinicians regularly participate in Child and Family Team Meetings to share behavioral health expertise and provide additional resources. Clinicians also facilitate Emergency Placement Screenings for Child Welfare. The overarching goal of the program is to assess and connect youth to needed behavioral health services in a timely manner.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	625
FY 2027 – 2028	625
FY 2028 – 2029	625

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

ACT projected individuals to be served did not have enough years of data for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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

Inland SoCal 211+ Helpline

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

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

No

Please describe intended outcomes of the program or service

The Inland SoCal 211+ Helpline (available 24/7 by calling 951-686-HELP) is a crisis intervention service to prevent suicide, de-escalate emotional distress, and make a warm connection to RUHS-BH crisis mobile services in Riverside County. The Helpline provides crisis and suicide intervention services including counseling and emergency assistance by maintaining a twenty-four (24) hour hotline. The service is a bilingual hotline staffed by highly trained and compassionate crisis counselors who are as diverse and representative as the Inland SoCal region. They assist with emotional support, suicide assessment and prevention, coping skills, resource referrals and warm hand-off for mental health services. Crisis counselors also help with a range of other mental health related crises and experiences such as suicide loss grief support, abuse, domestic violence, struggles with identity and relationships, and other sensitive topics. They provide counseling as needed to encourage callers to contact appropriate mental health and substance abuse programs, and other resources. When appropriate, callers are provided with referrals for ongoing services in both Riverside University Health System-Behavioral Health (RUHS-BH) service system and outside agencies. The intended outcomes of this service are to screen and assess for suicide risk, provide appropriate levels of care to those in crisis and reduce suicides in Riverside County.

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	8000
FY 2027 – 2028	8300
FY 2028 – 2029	8500

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

Helpline projected individuals to be served did not have the type of data needed for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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
Cognitive Behavioral Therapy for Late Life Depresson (CBTLLD)

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
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Outreach

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
Cognitive Behavioral Therapy (CBT) for Late Life Depression

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Cognitive Behavioral Therapy for Late Life Depression

Please describe intended outcomes of the program or service
Cognitive Behavioral Therapy for Later-Life Depression (CBT-LLD) is designed to treat depression in older adults aged 60 and over. Services can be provided in-home or in another community-based setting, as well

as via telehealth. Services are provided in 16-20 sessions by a licensed or licensed-eligible mental health clinician. The goal of the program is to reduce depressive symptoms, increase pleasant activities through behavioral activation, restructure and reframe common thinking errors to create more adaptive thoughts, improve coping skills, and increase resiliency.

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	80
FY 2027 – 2028	100
FY 2028 – 2029	120

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
CBTLLD projected individuals to be served did not have the type of data needed for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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
Program to Encourage Active & Rewarding LiveS (PEARLS)

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
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Outreach

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

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

Please describe intended outcomes of the program or service

The Program to Encourage Active and Rewarding LiveS (PEARLS) is an evidence-based program designed for people aged 60 years or older who are experiencing depression or dysthymia. PEARLS is an in-home intervention that utilizes an empowering, skill-building approach based on three core elements: (1) problem-solving treatment (PST); (2) social and physical activation; and (3) pleasant-activity scheduling. These three elements contribute to the empowerment of participants by encouraging them to engage in behaviors that will help them reach their goals. The PEARLS is provided over a 19-week period. Each session is structured and designed to help participants define and solve their problems, become more socially and physically active, and engage in more enjoyable activities. The goals of PEARLS are to reduce symptoms of depression, increase social connectedness/reduce isolation, increase coping skills and physical activity.

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	75
FY 2027 – 2028	80
FY 2028 – 2029	90

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

PEARLS projected individuals to be served did not have the type of data needed for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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

Mothers & Babies/Mamás y Bebés

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
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Outreach

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
The Mothers and Babies Course "Mamás y Bebés"

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Mamás y Bebés (Mothers and Babies)

Please describe intended outcomes of the program or service
Mothers & Babies/Mamás y Bebés serves pregnant and postpartum women who are experiencing symptoms of perinatal or postpartum depression. Mothers & Babies/Mamás y Bebés is provided in a group setting over 8 weeks. During the program, pregnant and post-partum women learn CBT-based skills for mood management, managing negative thoughts, reducing stressors, and increasing self-care and social support. The program aims to reduce symptoms of depression, increase coping skills and support, and improve maternal and infant well-being.

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	200

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	225
FY 2028 – 2029	300

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

Mamás y Bebés projected individuals to be served did not have the type of data needed for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

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
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Outreach

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

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Please describe intended outcomes of the program or service

CBITS is a school-based program for youth ages 10-15 that uses cognitive behavioral therapy techniques to help students cope with the harmful effects of trauma exposure. The program uses a group format comprised of 10 sessions that teach skills to help students reduce symptoms of PTSD and depression and is facilitated by master's level clinicians. Students learn relaxation, stress management, how to challenge negative/unhelpful thinking, exposure therapy, and problem solving. Students also meet 1:1 with a clinician to process their specific trauma narrative. The program also includes curriculum for caregivers and educators. The primary goals are to reduce symptoms of PTSD and depression while also increasing functioning at home and at school, enhancing coping skills, and building peer and caregiver 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	225
FY 2027 – 2028	250

Plan Period by FY	Projected Number of Individuals Served
FY 2028 – 2029	300

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

CBITS projected individuals to be served did not have the type of data needed for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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

Bounce Back

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
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Outreach

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
Bounce Back

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Bounce Back

Please describe intended outcomes of the program or service
Bounce Back is a trauma-focused, school-based program for elementary school students, ages 5-11. The program uses cognitive behavioral therapy techniques to teach students coping skills, feelings identification, relaxation, problem solving, and social support. Services are provided over 10 sessions in a group setting by master's level clinicians and also include individual sessions with students to process their specific trauma narrative and conjoint sessions with caregiver(s). The goals of Bounce Back include reducing symptoms of PTSD, anxiety and depression while simultaneously increasing coping skills, resilience and peer and caregiver 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	25
FY 2027 – 2028	25
FY 2028 – 2029	25

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Bounce Back is a new program and prior year actuals were not available. Projections were derived from expected groups and took into account training needs and Medi-Cal certification process.

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
Stress And Your Mood (utilizing the Blues program curriculum)

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
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Outreach

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
Blues Program

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Blues program

Please describe intended outcomes of the program or service
Stress And Your Mood (SAYM) uses cognitive behavioral therapy interventions, through the curriculum of the Blues Program, to reduce symptoms of depression in youth (14-19 year olds). Services are provided by

master's level clinicians in group or individual settings. Services are provided in a school-based setting. The program teaches clients how to identify their symptoms, track their mood, reframe negative/unhelpful thoughts, communication skills, and problem solving. The goals of SAYM are to reduce symptoms of depression, increase coping skills, improve problem solving, and communication skills, and improve emotional resilience.

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	75
FY 2027 – 2028	75
FY 2028 – 2029	75

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Stress And Your Mood projected individuals to be served did not have the type of data needed for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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
Seeking Safety

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
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
Outreach

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

Seeking Safety (SS)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Seeking Safety

Please describe intended outcomes of the program or service

Seeking Safety is a supportive, evidence-based program designed to help people find healing from trauma and substance use. It focuses on building practical skills for coping with life's challenges in healthy, empowering ways – without needing to revisit painful past experiences in detail. By being present-focused, it allows individuals to discover ways to establish safety in their lives and create a foundation from which they can heal from the effects of trauma and/or substance use. Through guided discussions and activities, provided in either individual or group formats, participants learn tools for managing emotions, improving relationships, setting boundaries, and creating a sense of safety in their daily lives. There is a total of 25-session treatment topics that group counselors and program participants can choose from to tailor the program. The program has identified 6 of these as core treatment topics that are especially foundational and are often recommended when programs can only offer a shorter version. The primary outcomes of the Seeking Safety program include reduced trauma-related symptoms, decreased substance use, improved coping and emotional regulation, enhanced sense of safety and control, better relationships and communication, increased hope and self-efficacy, and positive program satisfaction.

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	100
FY 2027 – 2028	125
FY 2028 – 2029	150

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

Seeking Safety projected individuals to be served did not have the type of data needed for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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

Behavioral Health Navigation Team

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

Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports

The Behavioral Health Navigation Team provides timely access and linkage services for individuals referred from emergency departments and inpatient hospital units who present with behavioral health needs. Upon referral, staff conduct early identification, screening, and comprehensive assessments to determine the appropriate level of care and service needs. The team collaborates closely with hospital social workers, discharge planners, and medical providers to ensure a coordinated transition from hospital to community-based behavioral health care. Clients are linked to ongoing outpatient mental health or substance use treatment, primary care, housing, and recovery-oriented support services. Navigators provide warm handoffs and follow-up contact to promote successful engagement and reduce readmission risk. The team's work emphasizes continuity of care, reduction of barriers, and improved access to community resources to support client stability and recovery post-discharge. The Behavioral Health Navigation Team delivers evidence-based interventions and intensive case management for individuals transitioning from hospital settings to the community. Services focus on engagement, stabilization, and linkage to long-term behavioral health supports. Staff utilize motivational interviewing, brief cognitive-behavioral strategies, and solution-focused techniques to enhance client readiness and self-management.

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

The intended outcomes of the Behavioral Health Navigation Team are to reduce preventable hospitalizations and emergency department visits associated with mental health, behavioral health, and substance use crises by providing timely linkage, engagement, and follow-up support. The program focuses on assisting individuals identified in hospital and emergency settings to connect with ongoing, residential treatment, outpatient behavioral health care, recovery services, and community supports that promote long-term stability.

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	2000
FY 2027 – 2028	2250
FY 2028 – 2029	2400

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

The Behavioral Health Navigation Team projected individuals to be served did not have the type of data needed for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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

Mobile Crisis

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

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

Mobile Crisis Teams have been in operation since 2014 and have continued to expand and evolve. The program serves the community and all stakeholders in the community. Some of these stakeholders include Law Enforcement, Hospital Emergency Department, Community Health Care Clinics, Schools, Outpatient programs, Adult protective Services, Child Protective Services and many more. Mobile Crisis Response teams meet the needs of the community by providing an immediate supportive crisis response focused on successfully diverting consumers in crisis away from emergency departments, law enforcement, incarceration, and psychiatric hospitalizations whenever possible. Mobile crisis response teams are focused on de-escalating, supporting, collaborating with support persons and developing strong safety plans for all individuals and families that are served. Mobile crisis response teams are typically teams of two staff and any combination of a clinical therapist, a peer support specialist, a case manager and a substance use counselor. These staff have specialty training in crisis intervention, risk assessment, peer support, intensive case management services to include homeless outreach and housing as well as substance abuse assessment, counseling, and linkage to residential treatment. While mobile crisis teams respond to crisis calls in the community, they can also provide short term treatment while assisting consumers in establishing connections to longer term treatment services. Staff also engage in outreach activities and events in an effort to engage homeless and unengaged individuals into services. The primary focus of mobile crisis is to provide immediate crisis support and assist community members staying safely in the community. This is evident as the diversion rate for mobile crisis response is approximately 70%.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	5250
FY 2027 – 2028	5500
FY 2028 – 2029	5700

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

Mobile crisis projected individuals to be served were derived from prior years actuals and were used to derive a reasonable projection.

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

Mental Health Urgent Care

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

No

Please describe intended outcomes of the program or service

Mental Health Urgent Care (MHUC) is a 24/7 voluntary crisis receiving facility. Members can participate in the program for up to 23 hours and 59 minutes. The average length of stay is 8-14 hours. Members can receive peer navigation, peer support, counseling, nursing, medication services and other behavioral health services. The goal is to assist and support members in stabilizing the immediate crisis and return the members safely to the community such as their home. If members need additional crisis services staff can assist with linkage to a Crisis Residential Treatment Program. MHUCs are a crucial component of the Crisis Support System of Care and effectively impact reducing unnecessary contacts with law enforcement involvement, incarceration, and psychiatric hospitalization. Stakeholders such as mobile crisis teams, law enforcement, crisis hotlines, and community-based agencies often rely on MHUCs as crisis receiving facilities for those members encountered in crisis who could benefit from additional services and supports. This results in more recovery-oriented service delivery and cost savings from unnecessary higher levels of care. MHUCs also serve as crisis support for walk-in self/family referrals. There are currently three facilities in Riverside County. The western region facility provides services to adults aged 18 and older. The Mid-County and Desert regional locations have the capacity to serve adolescents (ages 13-17) as well as adults aged 18 and older. There will be a fourth location in Indio starting early 2026. This location will provide all of the above mentioned services and will serve members age 5 and up. The MHUCs assist members at discharge with linkage to outpatient services.

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	7200

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	7500
FY 2028 – 2029	8000

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

MHUC service data from prior fiscal years was used to project the number of clients to be served over the Integrated Plan period. Where sufficient historical data was available, a cumulative monthly time-series model was applied, in which each client was counted once per fiscal year and assigned to the month of first service. A Seasonal Auto Regressive Integrated Moving Average (SARIMA) model was fit to this cumulative monthly series to capture recurring seasonal patterns and multi-year cyclical behavior. The final model selection was based on back-testing performance against the most recent completed fiscal year, and projected annual totals were derived from the forecasted fiscal-year end values. This approach produces conservative, interpretable projections suitable for planning and funding purposes.

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

Community Behavioral Assessment Team (CBAT)

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

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

The Community Behavioral Assessment Team (CBAT) is a co-responder team comprised of a clinical therapist and a law enforcement officer (Sheriff or Police Department). Recognizing the role of law enforcement and the mental health needs of community members, this particular crisis response model was first implemented over 10 years ago starting with one team and has significantly expanded. CBAT functions as a special unit that responds to 911 behavioral health related crisis calls, mental health emergencies/5150, substance abuse and homeless related crisis. CBAT serves all populations. CBAT provides rapid response field-based risk assessment, crisis intervention and de-escalation, linkage and referrals. One of the goals of CBAT is to provide field officers with a resource for calls that require more time and specialized attention. In addition, the goals of CBAT are to divert and decrease unnecessary psychiatric inpatient hospitalizations, decrease incarceration, decrease emergency department admissions, reduce repeat patrol calls, make appropriate linkages to care and resources and strengthen partnerships between the community, law enforcement, and behavioral health. There are currently 21 teams operating throughout the county. CBAT, co-responding model, embodies the value in emergency response with regards to timeliness to a crisis, the value of two professions working together to address the clinical and legal ramifications, diversion, stigma reduction and linkage to continued care when possible. This long-standing partnership and requests from Law Enforcement partners to expand speaks to the program's success.

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	2800

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	2900
FY 2028 – 2029	3000

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

CBAT projected individuals to be served did not have the type of data needed for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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

Public Safety and Engagement Team (PSET)

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
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

Yes

Please select the EBPs and CDEPs that apply

Motivational Enhancement Therapy (MET) / Motivational Interviewing

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Brief Cognitive -Behavioral Strategies
solution-focused techniques

Please describe intended outcomes of the program or service

The Public Safety Engagement Team aims to improve the well-being and stability of individuals experiencing homelessness through early intervention and coordinated support. Intended outcomes include increased access to housing and behavioral health services, reduced interactions with law enforcement and emergency services, and improved connection to long-term community resources. The program seeks to promote safety, enhance quality of life, and support successful transitions from homelessness to stable housing and self-sufficiency. The team connects directly with the unhoused population, building trust and helping them access support. They link individuals to housing, behavioral health, and other essential services. They often respond to individuals in crisis situations, helping to de-escalate and connect them with appropriate care rather than enforcement. These components work together to provide early, compassionate, and coordinated help for vulnerable community members. The program provides alternatives to those at risk of injury or death by directly offering services in the community in collaboration with local law enforcement and city outreach teams. The program reduces incarcerations and involuntary behavioral health treatment and/or hospitalizations for individuals whose behavior is influenced by a behavioral health disorder or a crisis. The program works to divert individuals with behavioral health (mental health and/or substance use disorders) complications into appropriate community services and Supports and engages hard to reach homeless individuals who suffer from behavioral health disorders and link them to all available RUHS-BH and community resources in a coordinated and effective manner. The Public Safety Engagement Team provides a range of individualized supports designed to promote stability and self-sufficiency among unhoused individuals. These include street-based case management, housing navigation assistance, and linkage to behavioral health and substance use treatment services. The program also offers basic needs support such as food, hygiene supplies, and transportation resources, as well as life skills coaching to prepare clients for long-term housing stability and community reintegration.

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	100
FY 2027 – 2028	125
FY 2028 – 2029	150

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

PSET projected individuals to be served did not have sufficient years of data needed for the autoregression model, so prior year actuals were used to derive a reasonable projection.

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

Functional Family Therapy

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

Treatment Services and Supports: Other

Please specify “other” type of Treatment Services and Supports

Functional Family Therapy (FFT) is an evidence-based, short-term treatment model designed to support children and adolescents who are experiencing behavioral challenges, including delinquency, substance use, truancy, and family conflict. FFT is grounded in family systems theory and views problematic behaviors as occurring within the context of family relationships. The primary goal of FFT is to strengthen family functioning by improving communication, increasing positive interactions, and reducing patterns of blame, negativity, and conflict that contribute to youth behavioral issues. FFT is typically delivered in phases that guide the therapeutic process. Services are highly individualized and often provided in the family’s home or other natural settings to reduce barriers to participation. FFT emphasizes cultural responsiveness, respect for family strengths, and collaboration with caregivers as the primary agents of change. Therapists work closely with families to develop practical solutions that fit their unique circumstances while addressing risk and protective factors within the family system. FFT is time-limited, typically lasting three to four months, with sessions occurring weekly or more frequently as needed. Ongoing assessment and fidelity monitoring ensure that interventions are effective and aligned with the model. Research has demonstrated that FFT reduces recidivism, substance use, and out-of-home placements while improving family relationships, youth behavior, and overall functioning.

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

Functional Family Therapy (FFT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Functional Family Therapy

Please describe intended outcomes of the program or service

Functional Family Therapy (FFT) is an evidence-based, short-term intervention with strong outcomes for youth with behavioral challenges and their families. Key outcomes include reduced delinquency, aggression, substance use, and truancy; decreased recidivism and justice system involvement; and fewer out-of-home placements. FFT improves family functioning by strengthening communication, reducing conflict, and increasing parental supervision and consistency. Caregivers gain confidence and effective parenting skills, while youth show improved emotional regulation, accountability, and pro-social behavior. FFT is associated with better school attendance and engagement, improved community functioning, and

sustained outcomes over time when delivered with fidelity. It is also cost-effective, reducing reliance on high-cost services such as detention, residential treatment, and emergency care.

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	60
FY 2027 – 2028	70
FY 2028 – 2029	80

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
FFT is a new program implementation so projected number to be served was derived from an understanding of program requirements for staffing and caseload capacity.

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
Multisystemic Therapy

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

Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports

Multisystemic Therapy (MST) is an intensive, evidence-based treatment designed to help adolescents with serious behavioral problems, including chronic delinquency, substance abuse, aggression, and difficulties at home or school. Rather than focusing solely on the individual youth, MST addresses the multiple interconnected systems that influence a young person's behavior—namely the family, peers, school, and broader community.MST therapists work primarily with caregivers to strengthen parenting skills, improve family relationships, and increase the family's ability to manage current and future challenges. Interventions are highly individualized, practical, and goal-oriented, targeting specific factors that contribute to the youth's difficulties, such as inconsistent discipline, association with delinquent peers, academic failure, or lack of structure at home. A defining feature of MST is its intensive and flexible service delivery model. Therapists typically carry small caseloads, provide services in the family's natural environment (such as the home or school), and are available to families 24/7 for crisis support. Treatment is time-limited, usually lasting three to five months, but involves frequent contact and active collaboration with schools, probation officers, and other community resources when appropriate. MST places a strong emphasis on accountability and measurable outcomes. Interventions are continuously evaluated to ensure they are effective, and treatment plans are adjusted based on progress. Research has consistently shown that MST can reduce youth criminal behavior, substance use, and out-of-home placements, while improving family functioning and school engagement.

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

Multisystemic Therapy (MST)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Multisystemic Therapy

Please describe intended outcomes of the program or service

Multisystemic Therapy (MST) is an evidence-based, intensive, home- and community-based intervention for youth with serious behavioral problems. Outcomes include significant reductions in delinquency, violent behavior, substance use, and re-arrest rates, as well as fewer out-of-home placements and psychiatric hospitalizations. MST improves family functioning by strengthening caregiver supervision, consistency, and problem-solving skills. Youth demonstrate improved emotional regulation, school attendance, and academic engagement, along with decreased association with delinquent peers. MST also improves coordination across family, school, and community systems, leading to more sustainable behavior change. When delivered with fidelity, MST produces long-term positive outcomes and is cost-effective by reducing reliance on juvenile justice, child welfare, and inpatient services.

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	24
FY 2027 – 2028	50
FY 2028 – 2029	50

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

MST is a new program implementation so projected number to be served was derived from an understanding of program requirements for staffing and caseload capacity.

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
Parent Support and Education

Please select which of the three EI components are included as part of the program or service
Outreach
Treatment Services and Supports: Other
Access and Linkage: Referrals

Please specify "other" type of Treatment Services and Supports
Parent Support Education is offered by RUHS-BH certified Peers who serve in the capacity of Parent Partners. Parent Partners assist parents and caregivers raising children who experience behavioral health challenges. The program operates from a family-centered and parent-directed approach, recognizing that caregivers are the most consistent advocates in their children's lives. Its primary goal is to equip families with the education, tools, and emotional support needed to promote stability, resilience, and recovery. The program's foundation is built on peer-to-peer connection. Families are linked with others who share similar experiences, fostering understanding, compassion, and hope. Parent Partners provide a menu of evidence-based and evidence-informed programs that include the following: Nurturing Parenting is an evidence based 10-week interactive course that will help parents better understand their role as a parent. This program helps to strengthen the parent/child relationship and bond. Parents learn new strategies and skills to improve their child's concerning behavior and develop self-care, empathy, and, self-awareness. Triple P/Triple P Teen is an evidence-based program that consists of 8 -classes, 2 - hours each class, that suggests simple routines and small changes that can make a big difference for a family. It helps parents understand the way their family works and uses the things they already say, think, feel and do in new ways that create a supportive & safe environment, encourage behavior you like, deal positively, consistently, and decisively with problem behavior, build positive relationships with your children, so that conflict can be resolved, plan ahead to avoid or manage potentially difficult situations, and take care of yourself as a parent. Education, Equipment, and Support (EES) is an evidence-based program that consists of 13 sessions, each two hours long, and is offered exclusively to parents or guardians raising a child or

adolescent with emotional and mental health challenges. The classes are designed to provide parents and guardians with general education about childhood mental illnesses, peer support, and community resources. Nurturing Fathers Program is an evidence - based, 13-week course designed to teach parenting and nurturing skills to men. Each 2 ½-hour class provides proven, effective skills for healthy family relationships and child development. Participants will learn the secrets for creating safe, loving, stable, and nurtured families. Positive discipline tools taught through a uniquely father-friendly method for successful child behavior management include effective family communication techniques to strengthen the father-child and father-mother relationships, how to stop fighting and arguing by using proven-effective strategies for conflict resolution and problem solving, and how to achieve cooperation and teamwork in family life. The Incredible Years is a 14-week, 2-hour evidence-based early intervention parenting program focused on strengthening parenting competencies and fostering parent involvement in children's school experiences, to promote children's academic, social, and emotional skills and reduce conduct problems. The parent intervention programs are delivered to groups of parents/caregivers according to their child's age group. Preschoolers (3-6 years) - The Preschool Parenting Program (Basic) strengthens positive parent-child interactions and attachment, reducing harsh discipline and fostering parents' ability to promote children's social, emotional, and language development. Parents also learn how to build school readiness skills and are encouraged to partner with teachers and daycare professionals so they can promote children's emotional regulation and social skills. School age (6-12 years) - The School Age Parenting Program (Basic) strengthens parent-child interactions and attachment, reducing harsh discipline and fostering parents' ability to promote children's social, emotional, and academic development. Parents learn how to: monitor children after school, set rules regarding TV, computer, and drug use, support children's homework, and partner with teachers so that they can promote children's academic, social, and emotional skills.

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

Incredible Years
Triple P - Positive Parenting Program (Triple P)
Nurturing Parenting Program (NP)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Incredible Years
Triple P

Nurturing Parenting Program

Please describe intended outcomes of the program or service

These parenting programs strengthen caregiver knowledge, parenting skills, and family protective factors to prevent behavioral health conditions from becoming more severe. These programs support early identification through routine screening and increased caregiver recognition of developmental, emotional, and behavioral concerns, while reducing disparities by expanding access to culturally and linguistically responsive services in underserved communities. They also promote successful linkage to care through referrals and warm handoffs to behavioral health, school-based, and community supports, resulting in earlier help-seeking, improved family functioning, and increased connection to appropriate services before crisis or diagnosis occurs.

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	220
FY 2027 – 2028	220

Plan Period by FY	Projected Number of Individuals Served
FY 2028 – 2029	220

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

Previous years Parent Support and Education, records on class attendance were used to project the number of parents to be served.

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

Bereavement Counseling for Suicide Loss Survivors

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

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

This is short-term grief counseling for survivors of suicide loss provided at no cost to residents of Riverside County. This program offers 6-8 free sessions to suicide loss survivors through community-based clinicians who are trained in a specific approach to support suicide bereavement. The manual was developed specifically for Riverside County by Dr. Sally Spencer-Thomas, a leader in the field of suicide prevention and bereavement. This is the first program of its kind in the country. PEI partnered with IEHP to train several of

their providers to offer this as a benefit to their members. Through compassionate, trauma-informed care, individuals are guided
through their grief, helped to navigate their feelings of guilt, shame, or responsibility, and supported in rebuilding their lives. Professional intervention offers survivors a space to process the overwhelming emotional, mental, and sometimes even physical responses they may be experiencing in the wake of such loss. Suicide loss survivors are at increased risk of suicide. Early intervention to address the complicated bereavement of suicide loss can support individuals to safety and reduce the risk of additional suicides.

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	15
FY 2027 – 2028	20
FY 2028 – 2029	25

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Among all residents in Riverside County, suicide was the fifteenth leading cause of all deaths in 2022. However, suicide was the second leading cause of death among all aged 20-29 years, third among 30-39 years and sixth among under 20 years in 2022. The survivors of a suicide loss are at increased risk for suicide themselves. Active postvention includes reducing barriers to accessing bereavement support for the complicated loss of suicide. This service has been available in Riverside County for almost two years. Although initial participation has been low, outreach and engagement efforts through the TIP program show improvements in referrals to the program.

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

Trauma Intervention Program (TIP) of Riverside County - TIP, in partnership with the Riverside County Suicide Prevention Coalition will include a focus on Local Outreach to Suicide Survivors (LOSS), in addition to typical TIP services (provision of Psychological First Aid). This includes both Active Postvention response – responding on scene with first responders when a suicide has occurred. As well as delayed response – responding within days after a suicide has occurred to survivors. Response includes the provision of a LOSS kit. A LOSS kit will have printed materials with information about what to expect after a loss to suicide, resources, and emotional support from a TIP volunteer in person or by telephone. TIP provides emotional support to survivors of trauma in the immediate aftermath of the event to residents of Riverside County on a 24/7/365 basis. TIP provides on-site suicide trauma intervention services in the community to family members of suicide loss, victims, witnesses, and any others who have been traumatized by a traumatic event twenty-four hours a day, seven days a week. Additionally, a resource of community-based and county referrals are provided. TIP also serves as the point of contact for community interest/referral for Clinical Bereavement Counseling for Suicide Loss.

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

Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
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

No

Please describe intended outcomes of the program or service

Active postvention for suicide loss and Psychological First Aid (PFA) stabilize individuals immediately after a traumatic event, reducing the risk that acute distress develops into more severe or chronic behavioral health conditions. Postvention services for suicide loss provide timely outreach, grief support, and monitoring for suicide risk among survivors, which reduces isolation, complicated grief, depression, and suicide contagion while encouraging early help-seeking. Psychological First Aid offers practical coping strategies, emotional stabilization, and assessment of immediate needs following crisis or trauma, helping individuals regain a sense of safety and control. Both approaches promote early identification of those at

heightened risk, reduce disparities by bringing support directly into affected communities, and facilitate rapid linkage to ongoing behavioral health and community services before symptoms escalate to crisis levels.

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	750
FY 2027 – 2028	750
FY 2028 – 2029	750

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
TIP has been expanding in Riverside County with more contracts with local law enforcement agencies and a new partnership with the American Medical Response. Law enforcement can contact the TIP dispatch line to request a volunteer 24/7 to respond on scene after a traumatic incident to provide support and resources. In 2024 TIP had 687 calls to dispatch, 70 were for a suicide loss. In 2025 TIP had 755 calls to dispatch, 68 were for a suicide loss.

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

RUHS-BH First Episode Psychosis Program

CSC program description

First Episode Psychosis (FEP) is a Specialty Mental Health Program serving members 12-26 years-old with a recent onset of psychosis, both affective and non-affective. Services are provided for an initial 2-year period and can extend up to 4 years based on needs. FEP uses an enhanced screening and referral process to identify eligible FEP youth and provides supportive services to the member and their identified supports. FEP uses the Coordinated Specialty Care model with a multidisciplinary team working together to coordinate care and maximize support for youth and their families by providing the following Treatment Services and Supports: Initial assessment and Screening, Individual Therapy using CBT for Psychosis, Family Therapy, Crisis Intervention, Case Management (access, linkage, and referrals), Medication Management, Peer Support, Parent Support, Psychoeducation, 24/7/365 After Hours Support Line, and weekly treatment team meetings. Additional services may also include cognitive remediation, substance use disorder treatment services, and group therapy. The FEP team works to reduce barriers to treatment by providing services in the member's identified language when possible, engaging/outreaching underserved populations, and providing services in a variety of settings including in the clinic, home, school, and community settings. Services are provided at three sites (Riverside, La Quinta, and Perris) to cover all Riverside County. The First Episode Psychosis Program serves youth experiencing a recent onset of psychosis by focusing on managing symptoms/distress, increasing independence, providing supported education/employment services, and providing psychoeducation to families to reduce stigma and risk of future hospitalizations.

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

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	423
Number of Uninsured Individuals	45

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	51
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 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	13	13	13
Total Number of Teams	3	3	3

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

Yes

Please list the other funding source(s)
Medi-Cal, MHBG,2011 Realignment

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name
Peer Resources and Support Centers

Please describe the program or activity
The Peer Resource Centers are dedicated to supporting our Riverside County community through wellness-focused groups that encourage connection, growth, and recovery. Open to the public for walk-in and scheduled support, Peer Support Specialists at the PSRCs walk alongside individuals on their wellness journeys, offering understanding, encouragement, and a safe space where everyone feels welcome. These services are available as interim support for engaged members in behavioral health treatment as well as those coming in via word of mouth and curiosity of the services. We offer a variety of groups that promote emotional, physical, and social well-being. Our activities focus on building healthy coping skills, supporting daily wellness routines, encouraging creativity, and helping participants strengthen social connections. Each group is designed to meet people where they are and support them in developing confidence and resilience. Programs like "Taking Action to Manage Anger" taken SAMHSA's Whole Health Action Management (WHAM), provides participants the opportunity to set realistic goals and build habits that support long-term emotional wellbeing. To ensure support is accessible, we proudly serve the community from three locations: Riverside, Indio, and Temecula. Monthly group calendars are shared with the public so community members can easily stay connected and informed. RUHS-BH Peer Resource Centers are here to help individuals feel supported and empowered. We believe wellness is a journey best traveled together, and we are honored to serve our community every step of the way.

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	750
FY 2027 – 2028	850
FY 2028 – 2029	900

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

Previous FY service data was used to project the number of clients to be served; there were insufficient number of years to use an autoregression.

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name

Consumer Peer Services

Please describe the program or activity

The Consumer Peer Services Program provides person-centered support for adults aged 18 and older who are managing mental health and substance use challenges. The program's mission is to promote long-term recovery and overall wellness by fostering environments that are inclusive, empowering, and grounded in proven peer-support principles. At the heart of the program are Peer Support Specialists—individuals who have lived experience with their own recovery. Their personal understanding allows them to connect authentically with participants, offering empathy, encouragement, and practical guidance that traditional clinical models often cannot provide. The Peer Support Specialist workforce is a multicultural team of people with lived experiences that meet people from all walks of life right where they are and with world views that support cultural and linguistic needs of the community. The program delivers culturally responsive services system wide at all outpatient clinics, crisis teams and at the Emergency Treatment

Services facility, through both in-person and virtual support. They provide creative ways to approach the recovery journey at the Peer Support and Resource Centers, where individuals can access information, learn new skills, and connect with others. The "Take My Hand" live peer chat offers immediate, confidential support, while structured Peer Support Specialist training and participation in the Medi-Cal Peer Certification Program ensure that staff maintain professional standards and evidence-based practices. Peer Support Specialists provide individualized support focused on empowerment, resource navigation, and wellness planning. This may include assistance with housing, employment, healthcare, and social connection to reduce isolation. By centering on shared experience, empathy, and self-determination, the Consumer Peer Services Program helps individuals strengthen their recovery, achieve personal goals, and improve their overall quality of life.

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	500
FY 2027 – 2028	500
FY 2028 – 2029	500

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

Consumer Peer Services Manager provided the information necessary to determine a reasonable projection on the number expected to be served. Prior years information and expected activities was used.

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name

Family Advocate

Please describe the program or activity

The Family Advocate Program provides compassionate support to families affected by an adult loved one's mental health or substance use challenges. The program recognizes that behavioral health conditions often impact the entire household and ensures families receive the education, guidance, and connection needed to foster healing and understanding. Services in clinics and the community are designed to meet families where they are, offering a blend of group-based and individualized support. Programs such as Sibling Support, Substance Abuse Family Support, and Coffee for the Soul offered in English and Spanish create safe spaces for sharing experiences and building community. Educational courses like Family-to-Family, Meet-the-Doctor, and Taking Action to Manage Anger, equip participants with practical tools to improve communication, manage stress, and better support their loved one's recovery journey. Family Advocates have personal experience navigating similar challenges offer direct, individualized assistance through the Family Advocate 800 number for emotional support, crisis email communication, and connection to critical resources system wide. Their empathy and insight provide a level of trust and understanding that fosters resilience and empowerment. By helping families navigate complex systems, like the justice system, Mental Health Court, Drug Court, and CARE Court. Their alliances build confidence for families to access appropriate services. The Family Advocate Program strengthens relationships and promotes well-being overall, outreaching to vulnerable communities. Family Advocates take part in the activities, such as community meetings and culturally specific committees (AFWAG, Asian Pacific Islander, PFLAG, CAGSIE, CCRD and Deaf and Hard of Hearing) within Cultural Competency spectrum of services. There are Family Advocates embedded on the Cultural Competency team. The Family Advocate Program functions as a supportive community built on shared experience, empowering families to find balance, hope, and confidence in their path toward recovery.

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	500
FY 2027 – 2028	500
FY 2028 – 2029	500

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

Family advocate projections were derived from service data, logs and community class records to project a reasonable number of individuals to be served.

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name
Parent Support & Training

Please describe the program or activity
The Parent Support and Training Program assists parents and caregivers raising children who experience behavioral health challenges. The program operates from a family-centered and parent-directed approach, recognizing that caregivers are the most consistent advocates in their children's lives. Its primary goal is to equip families with the education, tools, and emotional support needed to promote stability, resilience, and recovery. The program's foundation is built on peer-to-peer, or parent-to-parent connection. Families are linked with Parent Partner Peer Support Specialists who share similar experiences, fostering understanding, compassion, and hope. Through this approach, caregivers learn to manage challenges more effectively and build confidence in supporting their children's needs. Services include specialized support and advocacy groups such as Open Doors, Autism Support, and Transitional-Age Youth (TAY) Parent Support. Educational opportunities like Behavioral Management and practical strategies for effective communication, positive discipline, and stress management. Group, one-on-one and educational opportunities are offered in English and Spanish. There are Parent Partners embedded in the Cultural Competency team to provide family connections with vulnerable communities. A cornerstone of the program is the Parent Partner role—parents who have successfully navigated similar paths and now mentor others navigating the trails and challenges of having interactions with CPS, the juvenile justice system, foster care and DPSS. They offer guidance, empathy, and real-world strategies that extend beyond clinical instruction. By strengthening families and empowering parents to advocate effectively, the program improves mental health outcomes for children and enhances overall family 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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1000
FY 2027 – 2028	1000
FY 2028 – 2029	1000

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

Parent Support and Training projections were derived from service data, logs and community class records to project a reasonable number of individuals to be served.

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name

Take My Hand

Please describe the program or activity

The Take My Hand Program brings Medi-Cal Certified Peer Support Specialists to service provision, working to engage the public in utilizing technology to enhance their recovery experiences. The TMH Team is a group of people with personal lived experience of recovery from behavioral health challenges who man the CSAC award-winning TakemyHand™ Live Peer Chat to provide emotional support, resource linkage, and skill-building for members of the public who prefer to remain anonymous to explore emotional wellbeing. This live text-based interface challenges the idea that behavioral health stigma keeps people from engaging in services. The framing of behavioral health treatment on the website and smartphone app is focused on marketing toward addressing a person's emotional wellbeing as a human condition that needs attention from time to time. The TMH Team also supports people with the unique challenge of auditory hallucinations by introducing them to the A4i (App For Independence) smartphone app which includes ambient sound technology that allows the user to determine in the sounds they are hearing, are internal or external. A4i has its own social media component to facilitate community-building for these individuals, creating a sense of belonging in that community. With functionality that allows a person to set medication

reminders, interact with their care team and post to their own social media community, A4i plays an important role for people working toward recovery and wellness. Additionally, the TMH Team teaches 10-week classes at clinics system wide on Digital Mental health Literacy, introducing people to the importance of digital safety online and effective communication using technology to promote hope and overall wellbeing.

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	1250
FY 2027 – 2028	1500
FY 2028 – 2029	1650

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

TakeMyHand projections were derived from service data, logs and community class records to project a reasonable number of individuals to be served.

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name

Homeless Outreach

Please describe the program or activity

RUHS-BH has a network of street-based outreach and engagement teams that provide services to chronically homeless and homeless individuals, with an emphasis on those living in encampments. These multidisciplinary staff focus on both engaging individuals into needed behavioral health and primary care services, as well as screening and linking individuals into the Coordinated Entry System and other housing

interventions. Activities performed by these teams include outreach to directly reach and engage individuals who may benefit from behavioral health services and engagement to support and encourage ongoing participation of the eligible population in behavioral health treatment. This includes building relationships either through one-on-one engagement or by conducting regularly scheduled broad outreach in high-need areas in conjunction with community partners. The purchase and distribution of items like food, hygiene products, clothing, blankets, and water to provide immediate support and foster future service engagement. Providing immediate, onsite direct navigation to housing resources. Coordinating behavioral health service and housing resources for unsheltered individuals in collaboration with other outreach and engagement efforts. Travel by outreach workers, social workers, medical professionals, or other service providers during the provision of eligible street outreach services. Also includes the costs of transporting unsheltered people to emergency shelters or other service facilities. Harm reduction activities and the distribution of harm reduction supplies.

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	1100
FY 2027 – 2028	1100
FY 2028 – 2029	1100

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

Homeless Outreach projections were derived from prior years data to make a reasonable projection of the number of individuals to receive outreach.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be

addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
WET WORKFORCE STAFFING SUPPORT (G)

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Workforce Education and Training (WET) is compromised of staff that support, train, coordinate and develop efforts surrounding staff recruitment and retention. This administrative and staffing structure supported the WET plan under Mental Health Services Act (MHSA) and will transition efforts to be in line with the Behavioral Health Services Act (BHSA) transformation. Such recruitment efforts include promoting careers in behavioral health, which support the local career pipeline, provide accurate mental health information, and reduce stigma in the communities Riverside Unified Health System Behavioral Health (RUHS-BH) serves. The focus is on hard-to-recruit roles, increasing exposure in underserved areas, and engaging emerging professionals from diverse cultural and socioeconomic backgrounds, this initiative addresses workforce disparities under BHSA. There is also a focus on retention efforts that surround training, supervision and recognition. Such programs include, Clinical Licensure Advancement and Support (CLAS) program which is actively working to address disparities within its programs. Helping our pre-licensed staff to become licensed mental health practitioners is a strategy intended to address the shortage of qualified individuals working for our department while also encouraging the retention of skilled and valued members of our team. The unit also has a tracking program that supports to ensure that pre-licensed staff obtain state mandated supervision. The unit also works to recognizes staff as a retention effort with the county's Employee Recognition Program which is an intentional strategy to strengthen workforce morale, belonging, and retention across the behavioral health system. Recognizing that disparities in retention often stem from inequities in workplace recognition, inclusion, and advancement, this program seeks to celebrate and affirm the diverse contributions of behavioral health staff at all levels.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
WET TRAINING AND TECHNICAL ASSISTANCE

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Workforce Education &Training (WET) Training & Technical Assistance (T.A.) is to strengthen staff capacity, serve diverse populations effectively, ensuring that services are inclusive, equitable, & grounded in the lived realities of the communities we serve& to offer trainings that translate into meaningful change in service delivery. Trainings help staff deliver high-quality services that reduce disparities& promote wellness. WET offers ongoing education, specialized workshops, leadership development & community-informed T.A. On going trainings consist of foundational training around suicide, department mandated or BBS required training, cultural specific trainings & workshops that focus on humility, equity & trauma informed care, advanced trainings to assist with skill development & trainings that work to reduce violence against staff & consumers. WET also supports EBPs. T. A., consulting, coaching, resource development & evaluation to assess the effectiveness of training & to identify areas for improvement. WET support has an impact on both the workforce & the community. Staff report increased confidence in serving diverse populations, improved cultural responsiveness & greater awareness of equity issues. Clients benefit from inclusive, respectful, & effective services. The program contributes to workforce retention by creating a supportive environment where staff feel valued & equipped to succeed. Also employed are several cross-cutting strategies to

address disparities in the workforce by supporting with policy alignment: & sustainability efforts. Centralized Individual & group clinical supervision are provided which ensures that all pre-licensed staff have access to supervision necessary to meet the state mandate & to support with licensure. Structural barriers are removed that disproportionately affect staff in underserved programs. Supervision supports retention by allowing unlicensed clinicians to continue advancing in their careers without leaving RUHS-BH.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
WET FINANCIAL INCENTIVES

Please select which of the following categories the activity falls under
Retention Incentives and Stipends

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
WET's provides& promotes financial incentives to encourage career development& retention & to help fill hard-to-fill positions. These incentives consist of state financial initiatives, department incentives & programing as well. The department offers The PASH & 20/20 Program to support staff who have obtained their bachelor's degree to pursue higher graduate study in preparation for Clinical Therapist I (CTI) positions. This program has 2 phases for employees. The PASH (Paid Academic Support Hours) phase is for individuals who are in the process of obtaining their master's degree but are not in active internship. The second phase is the 20/20 phase in which the interns work 20 hours at their primary worksite& 20 hours at their internship placement. In this phase they are in a internship in a RUHS-BH program, gaining their hours.

Upon graduation they are required to promote to CTIs & have a work commitment for RUHS-BH for a period of 5-years after hire. CLAS is also offered & staff are provided a study program that they need to pass the test that typically cost about $300. Loan repayment programs (LRPs) are promoted& help address workforce disparities by reducing financial barriers that affect staff from underrepresented or economically disadvantaged backgrounds. LRPs & forgiveness programs make careers in BH more attainable & supports retention, while also advancing racial, ethnic & geographic diversity w/in the workforce. WET has the Textbook & Tuition Reimbursement program a partnership with the Human Resources' Educational Support Program (ESP). This program has Part A & B. A, creates a promotional pathway for those pursuing a degree or certificate into a hard-to-fill position & B, is for the individual desiring to take a class or course not intended as a requirement for a degree or certificate that will enhance their knowledge necessary work duties. WET also collaborated with CBU to offer a program that off set staff salary & pays for licensure related costs.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
LEHMAN STUDENT TEACHING CLINIC (A, B, F, G)

Please select which of the following categories the activity falls under
Internship and Apprenticeship Programs

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
The Lehman Center (TLC) has 2 teaching clinics for student practitioners and staff to learn how to effectively

serve public behavioral health consumers (children, families and adults). The program recruits culturally diverse student interns from the Graduate, Intern, Field, Trainee (GIFT) and 20/20 department internship programs, to represent the population served, including interns that are bilingual Spanish speaking. This program helps to support department wide programs by accepting referrals for clients, when caseloads are high in the local program, which supports the department's timeliness of service goals. Interns trained at the TLC, help to support with our retention and recruitment efforts because once completing the internship program with the department and graduating from their master's program they met the criteria for a permanent Clinical Therapist I position within RUHS-BH. TLC's supervisor and clinicians provide group and individual clinical supervision department wide, for Clinical Therapist I's (pre-licensed staff) accumulating hours in clinics with disenfranchised and high need populations. They also facilitate a group for Senior Clinical Therapist, who provide clinical supervision, to ensure the therapist have the skill to teach and oversee the clinical work of pre-licensed staff. TLC provides continuing education unit (CEU) trainings focusing on an array of topics which can include trainings that support staff to diagnose and be productive with assessing, planning and note writing, trainings with the focus on use of culture to benefit clients, and trainings around underserved communities, including local LGBTQ and Latino communities. These trainings are designed to improve clinician skill level and maintain licensed staff.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
WET RESIDENCY/GIFT

Please select which of the following categories the activity falls under

Internship and Apprenticeship Programs

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

WET's Graduate Internship, Field, and Traineeship (GIFT) Program remains to be one of the largest internship programs in the Inland Empire for the disciplines of MSW, MFT, PCC, &BSW students & is a highly competitive & sought after program by students in the field. Students meet the values of the department workforce needs, MHSA values,& those who demonstrate a passion for public recovery-oriented services. They exhibited a commitment to the underserved, those with lived experience or had cultural and linguistic knowledge required to serve the consumers of RUHS-BH. The students receive both individual & cohort training. Students in the GIFT Program receive weekly individual supervision provided by our staff & join a WET supervision group. WET also provides monitoring &support of our students & staff involved in the program. GIFT was designed to help the needs of our growing field, but also it provides a way as a pathway to employment for our hard-to-fill position of CTI. Students are placed in internship sites throughout our county in outpatient programs or Macro students in WET. The Alcohol and Other Drugs (AOD) internship program provides a way to combine the academic learning with hands on treatment skills. This combination of learning with application develops the confidence & competence of basic skills, as well as the values & ethics that help to grow them as a professional. At the end of their internship, they are prepared to enter the role of BHS III. WET assists these students in becoming not only employable recruits but gives them the opportunity to become recovery-oriented, well-rounded, & successful in their field of study. WET also collaborates with Substance Abuse & Prevention Treatment (SAPT) for placement & supervision. WET has developed partnership with universities, colleges, & substance counselor programs to establish Affiliation Agreements to place students so they get an enriched learning experience, in hopes that they join the county.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button.

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

Program or activity name
Adult Psychiatry Residency Program

Please select which of the following categories the activity falls under
Internship and Apprenticeship Programs

Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Riverside University Health System-Behavioral Health (RUHS-BH) Adult Psychiatry Residency Program plays a vital role as the only psychiatry program in Riverside County to spend a vast majority of their training in this safety-net system providing to those Medi-Cal members or the uninsured. Our residency program has worked closely with the Behavioral Health team to create new and innovative ways to recruit faculty to decrease physician shortages and provide evidence-based care to our community. We started our program with 6 residents in 2020 and starting in July of 2026 we will have 12 residents per class. Over their four years of psychiatric training, we are focused on culturally competent care in underserved populations both in outpatient clinics and in inpatient facilities who treat around 2,000 patients per year, and our emergency psychiatry services who treat over 6,500 patients per year. Our residents staff these hospital units 24 hours a day, seven days per week. Our faculty and staff also help to provide training to psychiatric residents from UCR and beginning in July of 2026 we will provide training for psychiatry residents from Eisenhower as well. We also have a Forensic Psychiatry Fellowship and a Child and Adolescent Fellowship (CAP). The CAP Fellowship offers psychiatrists a chance to hone their skills in prevention, early intervention, and treatments. Fellowships allow us to improve our didactic and clinical education as well as allow us to integrate clinical experiences like working within the jail, working in our first episode psychosis clinic, providing psychoeducation and treatment at local schools, and participating in the partial hospitalization program for children with eating disorders. We hope to start several more fellowships in the future: Consult Liaison, Geriatric, and Addiction. Many of our psychiatric patients suffer from comorbid substance abuse problems, and so we have made this a priority in the education of our general psychiatrist as our substance clinics treat over 12,500 people suffering from substance use disorder annually. In the outpatient setting we are operating at a greater than 40% provider deficit and have hired contractors to fill this gap. With this program we continue to try to decrease this shortage. In 2022 we established the Resident Education and Continuity Clinic (RECC). This is a facility where our second, third- and fourth-year residents provide services that include therapy and medication services. We have a team of psychologists that assist with training in different therapy modalities. Residents work closely with interdisciplinary teams including Clinical Therapists, Peer Support staff, patient advocate representatives, and nurses to provide evidence-based care. We are also targeting the needs of our population and have incorporated innovative treatments that

previously had not been available to our Medi-Cal and uninsured populations. One such treatment is providing transcranial magnetic stimulation (TMS) to those patients with treatment resistant depression. In the future we hope to expand our interventional services to ECT and esketamine. We recognize the psychosocial struggle of our patients and incorporate this into the curriculum. We started a telehealth clinic to serve a remote forensic population in San Jacinto, which previously could not provide psychiatric services. We also anticipate providing a track for services in the future not typically offered to Medi-Cal recipients like lifestyle medicine, medically complex consultation, and sports psychiatry.
We are a program invested in the community. We provide clinical rotations in psychiatry to three local medical schools and provide education on psychiatry. In the past we have gone to local high school AVID programs to answer questions about how to become a doctor. We have had residents work directly with our local NAMI chapter to volunteer, participate in walks, and provide a lecture series available both in-person and virtually, to those suffering from or family members of those suffering with mental illness. We also encourage our residents to work at the Free Clinic in Downtown Riverside to provide care. We have started a community psychiatry thread in our didactic curriculum residents receive while working on the Mobile Psychiatry Services program. This community-based rotation is designed to give wraparound care both in the hospital and in outpatient settings, to identify barriers to care for our highest utilizers. We have nearly 4,000 identified people who are chronically homeless in Riverside County, but at different times this number can reach upwards to 18,000. Our program works with HHOPE Housing to go out in the field and provide psychiatric care to the people identified as homeless, who cannot engage in traditional treatment, like accessing a clinic. Finally, Behavioral Health is building the Wellness Village, a facility that will provide outpatient and residential services for mental health and substance use disorders, primary healthcare, and behavioral health urgent care serving youth, families, veterans, and others. This facility will offer an innovative perspective on wellness with a focus on a wholistic approach and address cultural and other barriers in access to mental health care. Our hope is the residents will play an integral role in this innovative approach to mental health care. We are so fortunate to work with such a dedicated and passionate team of faculty and staff that all share in our mission of providing the highest quality of evidence based, culturally competent care to our underserved community, as well as a dedication to educating the next generation of psychiatrists.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).

For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Crisis Intervention Training (CIT)

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
The program focuses on training emergency services personnel including firefighters and emergency medical technicians (EMTs) to recognize the signs and symptoms of mental disorders and how to safely de-escalate crisis situations involving individuals with a mental illness and provide education on resources available in the community for individuals with a mental illness and other relevant resources. Training material will consist of national-approved and evidence-based crisis intervention training (CIT) curriculum. The main objectives of the program are to increase awareness of the most common mental illnesses, symptoms and behaviors; understand the dynamics of dealing with an individual with a mental illness; identify specific community resources; identify de-escalation skills to reduce potential crisis situations.

Capital Facilities and Technological Needs (CFTN) Program

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

Project name
Indio Monroe Park TI Project

Please select the type of project
Capital facilities project

If capital facilities project, please indicate which of the following categories the project falls under
Acquiring, renovating, or constructing buildings that are or will be county-owned. The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.

Please indicate if the project involves leasing or renting to own a building
No

Please describe the project
RUHS-BH Indio Monroe Park TI Project located at 44199 Monroe Street in Indio, California will accommodate staff and clients, and the relocation will provide convenient bus transportation to treatment services. The RUHS-BH Indio Monroe Park TI Project will provide screening, assessment services, and counseling for adults and adolescents for substance abuse prevention.

Capital Facilities and Technological Needs (CFTN) Program

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

Project name
Clinic Expansion

Please select the type of project
Capital facilities project

If capital facilities project, please indicate which of the following categories the project falls under
Renovating or constructing buildings that are privately owned

Please describe the project

RUHS has identified a critical need to expand behavioral health infrastructure across Riverside County in order to strengthen the continuum of care, improve access to treatment, and address persistent gaps in services for individuals with serious mental illness and co-occurring behavioral health conditions. Existing residential and outpatient behavioral health resources throughout the region remain insufficient to meet current and projected demand, resulting in extended wait times, unnecessary utilization of higher-acuity settings, and barriers to timely access to clinically appropriate care.

The allocation of BHSA capital funding for the development of a behavioral health facility will support the County's long-term strategy to enhance community-based behavioral health capacity and improve access to services in underserved areas of the County. The proposed investment is intended to support both residential and outpatient behavioral health services and is deliberately structured to preserve flexibility regarding final program configuration, operational model, and level(s) of care as community needs, regulatory guidance, and funding opportunities continue to evolve.

Additional residential capacity is essential to addressing systemwide bottlenecks and expanding access to behavioral health services for individuals who require structured therapeutic environments but may not need hospitalization. Increased residential infrastructure will help create more seamless transitions across the continuum of care, support diversion from emergency departments and institutional settings, and improve the County's ability to provide treatment in the least restrictive and most clinically appropriate setting possible.

In addition, RUHS has identified geographic disparities in access to outpatient behavioral health services, particularly in rapidly growing and historically underserved communities where residents may experience significant travel barriers and limited availability of local behavioral health resources. The inclusion of outpatient mental health services within the proposed capital investment will help address regional access gaps, improve early intervention opportunities, and expand the availability of community-based care closer to where individuals live and work. Expanding outpatient access is expected to improve continuity of care, reduce delays in treatment, and strengthen coordination across the broader behavioral health system.

The proposed capital investment aligns with statewide behavioral health priorities emphasizing expanded community-based care, increased treatment access, and development of infrastructure that supports long-term behavioral health system sustainability. By reserving BHSA capital dollars for this purpose, the County will be better positioned to respond to unmet behavioral health needs, pursue future partnership and funding opportunities, and strategically develop facilities that improve outcomes for individuals and families throughout Riverside County.

This investment reflects the County's commitment to building a modern, integrated behavioral health system capable of serving a growing and diverse population while addressing longstanding shortages in residential behavioral health capacity and outpatient access across the region.

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	6884
Number of Uninsured Individuals	976

Total Adult FSP Eligible Population	Estimates
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	2349

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	801
Number of Uninsured Individuals	114

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	401
Number of Uninsured Individuals	57

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	140
Number of Teams Needed to Serve Total Eligible Population	14

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	30	30	30
Total Number of Teams	3	3	3

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	5683
Number of Uninsured Individuals	806

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	260
Number of Teams Needed to Serve Total Eligible Population	52

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	202	202	202

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

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	2447
Number of Uninsured Individuals	332

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	918
Number of Teams Needed to Serve Total Eligible Population	18

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	48	48	48
Total Number of Teams	3	3	3

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	10235
Number of Uninsured Individuals	1475

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	732.5
Number of Teams Needed to Serve Total Eligible Population	293

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	8	8	8
Total Number of Teams	1	1	1

Full Service Partnership (FSP) Program Overview

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

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

Yes

Please describe how the estimated practitioners will provide more than one EBP

RUHS-BH plans to operate three regional Full-Service Partnership (FSP) programs that will be responsible for implementing multiple evidence-based practices (EBPs), including Assertive Community Treatment (ACT), Forensic ACT (FACT), and FSP ICM. dedicated ACT/FACT practitioners will be fully trained through the Centers of Excellence to deliver ACT/FACT in accordance with fidelity standards. Historically, FSP staff are cross-trained to support individuals across diagnostic spectrums including co-occurring conditions and are skilled in motivational interviewing (MI), trauma-informed care, harm reduction, and recovery-oriented service delivery, including MAT. These approaches will continue to be embedded within FSP ICM and will also be integrated into the new ACT/FACT teams, across both clinic operations and community-based outreach. Beyond core ACT services, clinicians providing ACT/FACT or FSP ICM may integrate additional evidence-based practices—such as Cognitive Behavioral Therapy (CBT) or Seeking Safety—along with wellness coaching. These combined approaches support individuals with severe and persistent mental illness (SPMI), whose needs are often complicated by histories of incarceration, homelessness, or repeated psychiatric hospitalizations. Given the acuity of members utilizing intensive services, practitioners must remain flexible, often delivering multiple interventions in the same encounter, for example, a nurse may conduct medication education, while a CT offers psychoeducation using CBT or MI principles. This integrated, team-based approach ensures that individuals with the most complex needs receive layered, coordinated, and person-centered care. Staff receive ongoing supervision and coaching to ensure high-quality implementation across all modalities of care. RUHS-BH currently operates High Fidelity Wraparound programs, and these will expand under BHSA. The model allows for ancillary services to be provided to the youth. Program staff provide Trauma Focused Cognitive Behavioral Therapy as well as Motivational Interviewing. All services are documented according to Medi-Cal standards and the program will be working closely with the COE for fidelity standards.

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

RUHS-BH employs a whole-person, trauma-informed approach across its FSP programs, tied to the Psychiatric Health Facility (PHF) and Mental Health Rehabilitation Centers (MHRC) and grounded in safety, trust, empowerment, and collaboration. Services recognize the impact of trauma on adults with serious mental illness, individuals that are justice involved, and youth with complex behavioral health needs, as well as their families, and strive to support healing and recovery in all interactions. Staff engage individuals, families, and natural supports through consistent case coordination, regular family contact (with consent), and inclusion in care planning and recovery goal setting. Member voice and choice remain core program principles. Each FSP program uses a multidisciplinary team—therapists, Behavioral Health Specialists, nurses, peer support specialists, and psychiatrists—to deliver holistic, culturally responsive care tailored to each participant's values and preferences. The Long-Term Care program supports individuals under LPS conservatorship by helping them step down to the least restrictive level of care and terminate conservatorship when appropriate. Identifying natural supports, including family, is central to this process.The county promotes community and clinic-based engagement events such as Mental Health

Month, The Longest Night, and Recovery Happens, which honor lived experience, reduce stigma, and elevate client voice. Staff assess mental health, physical health, substance use, housing stability, trauma history, legal involvement, and social determinants of health. Teams collaborate with housing providers, justice partners, and medical homes when appropriate.
By centering recovery in community and culture, FSP programs ensure individuals feel respected, included, and empowered throughout their treatment journey. Trauma-informed principles guide daily interactions, documentation, and organizational culture.

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

RUHS-BH is committed to addressing disparities among FSP participants through targeted outreach, culturally responsive services, and data-informed practices. The county prioritizes equity in access, engagement, and outcomes for individuals from historically marginalized populations including Black, Latinx, LGBTQ+, individuals experiencing frequent hospitalizations, justice-involvement, and being unhoused. Efforts to reduce disparities is supported by data from various data reports. Annual FSP reports are used to review demographic characteristics of members served including age, gender, race/ethnicity and diagnosis. Teams collaborate with RUHS's internal Equity Committee to apply findings to program improvement. Staffing reflects the diversity of the community, with bilingual and bicultural providers serving high-density Spanish-speaking and multilingual populations. Interpreters and culturally specific resources are readily available. Programs also maintain close partnerships with local organizations serving specific subpopulations, including reentry programs, faith-based organizations, LGBTQ+ resource centers, and tribal health partners. ACT/FACT and HFW teams will be trained to be responsive to cultural norms, historical trauma, and systemic barriers. Cultural competency training is an established RUHS-BH practice. Peer specialists with lived experience of incarceration or mental health recovery are embedded in RUHS-BH service delivery to foster trust and support navigation of complex systems. Forensic ACT is designed to reduce recidivism and institutional cycling among justice-involved adults with SPMI, a population disproportionately affected by structural inequities. In addition, RUHS-BH engages communities directly through town halls, stigma-reduction events, and family education initiatives. These efforts aim to build trust, normalize mental health treatment, and strengthen protective factors.

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

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

RUHS – BH is committed to ongoing engagement strategies within its FSP ICM programs to promote long-term wellness, recovery, and retention in care for individuals with serious mental illness. FSP-ICM clinics integrate a multidisciplinary approach that includes clinical, vocational, housing, and peer-driven services to maintain participant involvement beyond intake. Staff engage clients in the field, in hospitals, and in-person at the clinic, based on their preferences, with services designed around client-defined goals. Frequent check-ins, flexible scheduling, and low-barrier access ensure responsiveness to fluctuations in acuity or readiness. Mobile Psychiatric Services provides supports and intervention for Substance Use Disorder only consumers. For individuals struggling with consistent engagement, warm outreach is conducted in collaboration with peer support specialists, community partners, and natural supports. To reduce isolation and promote connection, the county hosts ongoing community-based events such as Mental Health Month celebrations, Recovery Happens, and The Longest Night. These culturally inclusive events normalize participation, reduce stigma, and foster social bonds among FSP clients. Peer Support Specialists and Community Therapists conduct wellness calls, home visits, and appointment coordination as a standard practice. Engagement is also supported using motivational interviewing, harm reduction, and strength-based interventions, which help to center care around hope and autonomy. Furthermore, RUHS-BH collaborates with housing providers, public guardians, medical systems, and justice partners to ensure that FSP ICM participants maintain access to critical supports that prevent disengagement or service gaps.

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

N/A

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.)

RUHS-BH is actively aligning its service delivery model with the Full Service Partnership (FSP) levels of care policy by establishing new Assertive Community Treatment (ACT) teams and restructuring existing FSPs programs to better meet the needs of high-acuity populations. RUHS-BH is implementing a dual approach: transitioning a few identified FSPs teams into dedicated ACT/FACT teams and aligning existing FSPs into FSP-ICM. The new ACT/FACT teams will be formed where the greatest need is identified and will focus on smaller caseloads, service intensity, field-based service delivery, and multidisciplinary staffing to meet eligibility requirements and full ACT/FACT fidelity criteria. In the Western Region, the Jefferson Wellness FSP site has been identified as a prime location for the launch of a new ACT/FACT team based on existing infrastructure, staffing capacity, and population need. This site will serve as the initial implementation location for one of the new ACT/FACT teams and will receive training and fidelity support through the

Centers of Excellence (COE).Simultaneously, existing Adult and Older Adult FSP programs at regional clinics—including the Transition Age Youth (TAY) Journey FSP—will continue operating and will transition to FSP-ICM teams and will align operations with BHSA FSP-ICM policy. This alignment will focus on staffing ratios, eligibility criteria, and the use of both clinical and data-driven methods to ensure that service intensity appropriately matches client acuity.This tiered model will be replicated in the Desert and Mid-County service regions, with one new ACT team established in each region while maintaining access to existing FSP services through FSP-ICM. Staff at all levels will receive structured training and technical guidance to support the transition from traditional FSP practices to the new two-tiered system of FSP care. RUHS-BH will implement the LOCUS level-of-care assessment tool and integrate diagnostic, hospitalization, and justice-system involvement data into planning and decision-making processes to identify individuals most appropriate for ACT/FACT or FSP-ICM services.This approach will enable programs to effectively step-up or step-down clients based on need and ensures that transitions are not just organizational, but also clinically appropriate and client centered. In addition, Individual Placement and Support (IPS) employment services will be implemented across both ACT and FSP-ICM levels of care, providing a flexible, evidence-based vocational component that ensures continuity of employment services as individuals transition between levels of care.

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 accomplished through a variety of pathways. These pathways to FSP referral and/or direct linkage are accomplished through partnerships with community-based services, other RUHS-BH programs and with FSP staff conducting direct outreach in the community. The focus of outreach is to connect with priority populations: those experiencing homelessness, incarceration, or frequent hospitalizations. FSP programs including ACT/FACT and FSP-ICM staff will conduct direct outreach at acute psychiatric care settings such as IMDs and crisis stabilization units to engage individuals before they are discharged from the hospital. FSP liaisons have developed collaborative partnerships at multiple hospitals and at County

5150 designated crisis stabilization units and go into those facilities to directly engage potential clients, facilitating direct enrollment into FSP programs. ACT/FACT & ICM service providers will also conduct street and field outreach in many other settings including encampments, shelters, board & cares, homes and other community settings. This will be achieved by making repeated field attempts at different days and times to establish contact and begin engagement. ACT/FACT teams will utilize assertive field-based initiation techniques to engage hard to locate, hard to engage individuals building relationships and directly connecting to FSP services and other services as appropriate. This approach will be proactive and flexible to locate, connect, and enroll individuals with serious behavioral health challenges who are not accessing services through traditional means. FSP programs work closely with other RUHS-BH programs to engage with clients referred to or directly linked to the FSP. Potential FSP clients are often referred/linked from CARE Court, Mental Health Court, Homeless Outreach, Mobile Crisis response teams, law enforcement CBAT teams, probation, Enhanced Care Management (ECM) Teams, Justice Outreach teams and other community service navigation teams. Teams also will work collaboratively with contracted providers and other community-based organizations that serve those who would benefit from ACT/FACT & ICM levels of care. It is expected that High Fidelity Wraparound (HFW) under this plan will continue the current Wraparound programs practice of actively conducting outreach to youth and families referred to the program. This outreach includes meeting youth and families in their homes and communities to provide an orientation to the HFW model that emphasizes youth voice and choice, explains the phases of treatment, and introduces the multidisciplinary team. This engagement approach helps youth and families feel informed and empowered, which supports increased enrollment and sustained participation.

Other recovery-oriented services
No

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
To understand and address the unique needs of children and youth who are in, or at risk of being in, the juvenile justice system, RUHS-BH conducted a comprehensive review of local data and engaged stakeholders across youth-serving systems. RUHS-BH has for many years maintained a collaborative partnership with the Riverside County youth probation department. This partnership has resulted in the

provision of services to justice involved youth in the outpatient children's system of care particularly Wraparound services. The county analyzed trends among justice-involved youth currently enrolled in Wraparound programs and used the DHCS draft HFW decision-making tool to estimate the number of youths served by the mental health plan who may be eligible for High-Fidelity Wraparound (HFW) under the FSP model. This analysis helped identify service gaps, levels of need, and the intensity of support required for this population. Wraparound and Juvenile Hall data reports also provided insights into the youth served that are wards or who have been served by RUHS-BH in juvenile detention facilities. Stakeholder engagement was a key component of this process. Input was gathered through ongoing collaboration with Probation, law enforcement partners, and community-based organizations that work directly with justice-involved youth and their families. These partners provided valuable insights regarding risk factors, barriers to treatment, and the need for coordinated, trauma-informed care strategies. Additionally, discussions through the county's CPPP process reinforced the importance of cross-system alignment and early intervention. RUHS-BH incorporated this feedback into the development of FSP approaches that emphasize family engagement, cultural responsiveness, and seamless coordination between behavioral health, juvenile justice, and community supports. This collaborative and data-driven process ensured that the needs of justice-involved youth are reflected in the service design and implementation of the county's FSP program.

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

In developing the FSP program for LGBTQ+ children and youth, RUHS-BH relied on strong cross-system collaboration and meaningful stakeholder participation. Through review of behavioral health data, school indicators, and lived-experience feedback, the county identified service gaps and needs specific to LGBTQ+ youth, including barriers to care, safety concerns, and the need for culturally affirming services. Stakeholder engagement played a central role, including input gathered through monthly Children's Providers meetings, regular coordination meetings with DPSS Children's Services, and discussions within the Behavioral Health Commission's Children's Subcommittee. RUHS-BH programs coordinate closely with child-serving systems—including Child Welfare, Juvenile Probation, local schools, and the Inland Regional Center—to ensure integrated, trauma-informed, and responsive care. These partnerships help identify service gaps and shape strategies that support early identification, family engagement, and continuity of care. Additionally, community voices, including parents, caregivers, school representatives, and LGBTQ+ advocates, contributed feedback on service needs and best practices. This collective input guided the development of FSP strategies that emphasize safety, inclusion, cultural humility, and affirming supports for LGBTQ+ children and youth.

In the child welfare system

Insights from cross-system partners played a key role in helping RUHS-BH understand and address the needs of children and youth involved in the child welfare system during FSP planning. RUHS-BH used a data driven approach and engaged partners across multiple child-serving systems. Data from performance outcomes reports was used to understand mental health service utilization and penetration rates among

youth with an open child welfare case. The county reviewed trends among child welfare–involved youth currently participating in Wraparound programs and used the DHCS draft decision-making tool to estimate the number of youths receiving mental health services who may be eligible for High-Fidelity Wraparound (HFW). This assessment provided insight into service intensity needs, system involvement patterns, and gaps in supportive services. Stakeholder collaboration played a central role in shaping the county's approach. Through the CPPP process, RUHS-BH engaged with the Department of Social Services, Riverside County Office of Education, local school districts, and community-based organizations that support children and families impacted by the child welfare system. These partners contributed valuable perspectives on barriers to stability, placement disruptions, family support needs, and opportunities for earlier intervention. This integrated feedback helped inform FSP strategies that emphasize caregiver engagement, prevention of system re-entry, culturally responsive practices, and coordination across behavioral health, education, and child welfare systems. By combining data analysis with ongoing cross-system collaboration, RUHS-BH ensured the FSP model reflects the complex and multifaceted needs of child welfare–involved children and youth.

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

RUHS–Behavioral Health (RUHS-BH) has recognized the rapid growth of the Older Adult population (ages 60 and older) in Riverside County over the past decade. Riverside County's older adult population is growing significantly faster than other age groups and is projected to double in the coming decades, with particularly substantial increases among individuals ages 65+ and 85+. This growth is driven by overall county population expansion and increased life expectancy, creating a corresponding rise in demand for age-responsive behavioral health services. In response, RUHS-BH established an Older Adult Integrated System of Care several years ago to address the unique needs of this population through its Wellness & Recovery for Mature Adults program. This program operates across eight clinic locations throughout Riverside County, including the Western, Mid-County, and Desert regions. Services are delivered through five standalone Wellness & Recovery Clinics for Mature Adults and three additional satellite clinics where Older Adult services are embedded within adult clinics. The standalone outpatient clinics offer both Full Service Partnership (FSP) and non-FSP tracks. Program data has consistently informed planning and service development for Older Adult programming. RUHS-BH utilizes the annual "Who We Serve" fiscal year summary report to assess system-wide demand for Older Adult services and to track the number of individuals age 60 and older served each year. This report includes comparisons between the age distribution of individuals served and the overall county population. In addition, RUHS-BH completes annual Older Adult FSP reports that summarize enrollment, demographics, diagnoses, service intensity, and FSP outcomes. These data are routinely shared in community forums, including Behavioral Health Commission meetings, monthly Older Adult Integrated System of Care committee meetings, and regional

Behavioral Health meetings in the Western, Mid-County, and Desert regions. These venues provide opportunities for feedback, collaboration, and meaningful engagement with community stakeholders. RUHS-BH's organizational structure includes an Older Adult Administrative Manager who provides oversight of Older Adult clinic programs and serves as a liaison to community agencies and initiatives focused on aging populations, including the County Office on Aging and the Inland Coalition on Aging. These partnerships strengthen stakeholder engagement and support ongoing assessment of emerging needs within the Older Adult community.

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

To ensure the county's FSP planning reflects the unique needs of eligible LGBTQ+ adults, the Behavioral Health system incorporated multiple ongoing activities focused on inclusive engagement and data-informed decision-making. The Cultural Competency Program facilitates regular bi-monthly LGBTQ+ stakeholder meetings, creating a consistent space for community members, providers, and advocates to share lived experiences, emerging concerns, and service gaps. These discussions directly inform FSP design, priority areas, and culturally responsive practices. In addition, the county conducts monthly TAY (Transitional Age Youth) meetings across all three regions, allowing for regional input on challenges faced by LGBTQ+ young adults transitioning into adulthood, including housing instability, family rejection, stigma, and access to affirming care. Information gathered from these meetings is reviewed alongside program utilization data, research on LGBTQ+ behavioral health disparities, and community-identified needs to guide planning. Feedback is used to refine service approaches, strengthen trauma-informed and gender-affirming practices, and identify supports such as peer connection, crisis stabilization, and wraparound resources. Through these ongoing engagement efforts, the county ensures its FSP programs are responsive, equitable, and aligned with the specific needs and strengths of LGBTQ+ adults.

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

To ensure the county's FSP planning reflects the unique needs of adults who are currently in, or at risk of involvement in, the justice system, the Behavioral Health system engages in continuous, structured stakeholder activities. The county participates in the monthly Justice-Involved Subcommittee under the Behavioral Health Commission, which is an open community forum for individuals with lived experience, family members, advocates, law enforcement partners, and service providers. These meetings create a consistent space for participants to share needs, identify barriers, and highlight gaps in services such as re-entry support, housing stability, crisis intervention, and access to treatment during and after incarceration. Feedback from this subcommittee is reviewed alongside data on justice-involved service utilization, recidivism risks, and behavioral health disparities, helping the county identify priority areas for FSP design. Input from community members is used to strengthen coordinated care with courts, probation, and correctional partners; improve continuity of services; and expand evidence-based, trauma-informed supports aimed at reducing justice involvement. Through these regular engagement efforts and data-driven review, the county ensures that FSP programs are responsive to the unique needs, risks, and strengths of justice-involved adults.

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

Public Service Engagement Team (PSET)

Program descriptions

Intensive, Field-Based SUD Outreach and MAT Linkage in the City of Riverside. The Behavioral Health Department also operates an assertive, field-based care coordination team dedicated to serving individuals with severe SUD who are unsheltered or otherwise disconnected from traditional service settings. This team provides intensive street outreach throughout the City of Riverside, engaging individuals in encampments, public spaces, and other high-need areas. Staff deliver harm-reduction education, crisis intervention, field-based assessment, and direct connections to MAT through in person street outreach and telehealth options. Through persistent engagement, this team helps individuals initiate treatment even in non-clinical environments by coordinating mobile providers, facilitating transportation to clinics or the ED Bridge Program, and supporting follow-up care. Their outreach model emphasizes low-barrier access, cultural humility, and ongoing relationship-building to reach individuals who are at highest risk for overdose and hospitalization.

Current funding source
DMC ODS and OSF Funds from City of Riverside

BHSA changes to existing programs to meet BHSA requirements
N/A

Expected timeline of operation
Currently operating

Mobile-field based programs

Existing programs
Mobile Psychiatric Services, Homeless Outreach, Justice Outreach Team

Program descriptions
"Mobile Psychiatric Services (MPS) is a Full Service Partnership outreach team aimed at re-engaging high utilizers of inpatient or emergency services. The MPS Team re-engages consumers to address their housing, behavioral health, and addiction needs with the ultimate goal of linkage to lower level outpatient care. Mobile Psychiatric Services (MPS) team includes a psychiatrist, licensed clinician, behavioral health specialist, and peer support specialist. This team focuses on engaging the consumers with frequent crisis and inpatient admissions and attempts to transition them to an outpatient setting by providing services including but not limited to short term case management, short term direct clinical and psychiatric services, follow-up calls, and housing support. The team then links the consumer to ongoing outpatient services within the County, which in turn can reduce emergency hospitalizations, provide on-going services, resources and any other assistance needed. Engagement in outpatient services provides the best opportunity to improve consumers overall quality of life and recovery. Who does the mobile psychiatric team serve? The MPS outreach team seeks to primarily serve “at risk” consumers who have the greatest number of admissions to ETS, CSU, MUHCs and ITF over a one year period. RUHS-BH generates a list of consumers with high utilization to provide the team with a monthly “Top 40” high utilizers list, so that the MPS can team can intervene. The initial list is further refined to account for consumers that may be inaccessible due to placement circumstances, and may not include the initial top 40 high utilizers. A final list of consumers to target for engagement is prepared each month. The team reviews ELMR and EPIC databases (County’s electronic health records), to gather as much information about the whereabouts of the consumer as possible and does their best to engage the consumer. This includes going to the hospitals, consumers’ home, and other locations in the community. The MPS team attempts to interact with the consumer in any way possible including; going to the hospital, contacting the consumer by phone, or even locating the consumer at their place of residence, or in the community if they are homeless to try to engage them in services. The team also talks to the families to locate the consumer, if the consumer has a release

of information on file. The team may check jail records, to see if the consumer is incarcerated within the County. In this three-year plan as the team encounters an individual who would benefit from MAT services, the psychiatrist will be able to prescribe MAT in the field or by telehealth with the nurse in the field as clinically necessary.

RUHS-BH through its homeless outreach teams has a history of providing Assertive Field-based Substance Use Disorder (SUD) Services (AFBSS). These teams provide assertive field-based initiation services that proactively engage individuals living with SUD and offer low-barrier access to MAT and connection to services for those at the highest risk of overdose. Drug and alcohol counselors, peer supports specialists, as well as licensed clinical therapists provide assertive field-based engagement, using a proactive "no wrong door" approach to connect more individuals living with SUD to MAT. These teams conduct ongoing, targeted outreach to engage and initiate individuals living with SUD into MAT (or other treatment services) in multiple community-based and low-barrier settings. In addition to substance use disorder screenings (ASAM) in the field, these teams provide transportation to the RUHS-BH Sobering Center, transportation to both outpatient clinics appointments as well as transportation to residential treatment settings, and employees distribute both Narcan and educational materials. These outreach services reach people who are unhoused/housing insecure, justice-involved, and individuals with co-occurring mental health needs.

The Justice Outreach Team (JOT) works closely with Probation/Parole/PSET and other community partners. The goal is to connect consumers with mental health and/or substance abuse services with a focus on our homeless and justice involved populations. JOT also does in-reach working with the courts and Public Defenders office. The program provides substance use disorder screenings (ASAM criteria) to link members to the appropriate level of care. The Justice Outreach Team is comprised of a Behavioral Health Specialist III (substance abuse counselor) and a Peer Support Specialist. There are two teams in each of the county's three regions (Western, Mid-County and Desert). JOT supports Prop 36 by offering screenings, placements, and court correspondence as well. In addition to substance use disorder screenings (ASAM) in the field, these teams provide transportation to the RUHS-BH Sobering Center, Bridge Programs, Opioid Treatment Programs and transportation to both outpatient clinics appointments as well as transportation to residential treatment settings. Employees distribute both Narcan and educational materials. These outreach services reach people who are justice-involved and individuals with co-occurring mental health needs. To support the justice involved, the courts, and the Public Defender's Office individuals in county jails are also screened and arrangements for residential treatment upon their release is coordinated, as appropriate, along with transportation to treatment. The program assists members in overcoming barriers to enter/begin treatment services. This includes obtaining any mental health or bio-medical clearance they may need as well as obtaining medications they require. JOT works very closely with the RUHS mental health team embedded in the jails as well to support the consumer.

RUHS-BH is focused on adding access to Field-based and/or Telehealth prescribers to outreach teams to prescribe and induct individuals on MAT when medically appropriate and reduce barriers to MAT medications."

Current funding source
DMC ODS, MHSA, SUBG braided sources, PATH, SAMHSA, State homelessness grants such as HHAP and ERF

BHSA changes to existing programs to meet BHSA requirements
Mobile Psychiatric Services (MPS) will transition into ICM to meet BHSA requirements.

Expected timeline of operation
Current to indefinitely as long as funding available.

Open-access clinics

Existing programs
SUD Bridge, BH Navigation, Mental Health Urgent Care (MHUC), Substance Abuse and Prevention Treatment Clinics (multiple locations)

Program descriptions
To support referrals from jails and prisons, a SUD/MAT referral pathway was established through BH LINKS. The SUD Bridge Program at RUHS Medical Center operates in the Emergency Department to address urgent opioid-related needs, ensuring rapid assessment and initiation of MAT—including buprenorphine—when appropriate. The program provides brief intervention, motivational engagement, and warm handoffs to ongoing SUD treatment, reducing risks following ED discharge and strengthening continuity of care. SUD and Mental Health Navigation Teams at RUHS Medical Center and Desert-region private hospitals further enhance care transitions by providing bedside engagement, screening, brief intervention, education on treatment options, and coordination of warm handoffs to community providers. Navigators help schedule follow-up care and connect individuals to withdrawal management, residential, or outpatient services, serving as vital links between hospital systems, Behavioral Health programs, and contracted providers. RUHS BH also works with our RUHS Community Health Care Clinics (FQHC's) for open access to MAT. Currently 2 of our RUHS CHC's offer MAT inductions for ongoing MAT needs for members. Along with the CHC sites RUHS also provides Express Care Clinics (Urgent Care for Physical Health) inside our various CHC sites. These 7 RUHS Express Cares offer MAT bridge medications and prescribing for members in urgent needs. Mental Health Urgent Care (MHUC) is a 24/7 voluntary crisis receiving facility. Members may participate in the program for up to 23 hours and 59 minutes with an average length of stay of 8-14 hours. MHUC provides a range of services, including peer navigation, peer support, counseling, nursing care, medication services including Medication Assisted Treatment (MAT) and other behavioral health services. The goal is to help individuals stabilize during an immediate mental health and/or substance use crisis and return the members safely to the community. If additional support is needed staff can assist with linkage to a to a Crisis Residential Treatment Program. MHUCs are a vital component of the Crisis Support System of Care, helping to reduce unnecessary contacts with law enforcement involvement, incarceration, and

psychiatric hospitalization. Stakeholders such as mobile crisis teams, law enforcement, crisis hotlines, and community-based organizations often rely on MHUCs as crisis receiving facilities for individuals who would benefit from additional services, care and support. This approach results in more recovery-oriented services and reduces reliance on higher, often unnecessary, levels of care. MHUCs also serve as crisis support for walk-in self/family referrals. Currently, there are three facilities in Riverside County: The Western region facility provides services to adults aged 18 and older. The Mid-County and Desert regional locations have the capacity to serve adolescents (ages 13-17) as well as adults aged 18 and older. The substance abuse and prevention treatment outpatient clinics provide personal and private screening, assessment, and placement services. We also provide individual and family prevention services. The clinics provide substance use treatment, individual counseling and therapy as well as group counseling and education. Within our clinics, a member can find a wide variety of services which includes intensive outpatient, outpatient, and recovery services. We also offer Medication for Addiction Treatment (MAT) and a Recovery Incentives program. We offer MAT in conjunction with all ASAM outpatient LOC's as well as a standalone service to enable any member seeking services and recovery to receive.

Current funding source
AB109 Funds, Medi-Cal, MHSA/BHSA, DMC-ODS, SUBG

BHSA changes to existing programs to meet BHSA requirements
N/A

Expected timeline of operation
Currently operating

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
N/A

Program descriptions
N/A

Planned funding
N/a

Planned operations
N/A

Expected timeline of implementation
N/A

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
Crisis Walk-In Center (Mental Health Urgent Care) - MAT services only

Program descriptions
Beginning July 2026, RUHS Behavioral Health (RUHS-BH), under its Behavioral Health Integration contract with DHCS, will expand access to Medication-Assisted Treatment (MAT) within crisis walk-in and mental health urgent care centers across Riverside County. This initiative supports RUHS-BH's vision of delivering a unified, person-centered system of care—eliminating traditional silos between mental health and substance use services—and complements its existing 24/7 Mobile Crisis Response and walk-in urgent care offerings. Embedding MAT in crisis settings ensures rapid stabilization during opioid or alcohol-related emergencies, reduces avoidable emergency department use, and fosters timely engagement in ongoing recovery pathways in alignment with evidence-based crisis care models fostered under CalAIM. This

strategy directly advances California's Behavioral Health Services Act (BHSA) mandates by broadening access to substance use disorder treatment, prioritizing individuals with co-occurring conditions, and enhancing accountability through integrated plans due July 1, 2026. By co-locating MAT with mental health urgent care, RUHS-BH demonstrates operational integration—key to CalAIM's administrative and clinical reforms—and delivers core components of whole-person, no-wrong-door care. It reinforces BHSA's focus on high-needs populations, including the homeless and justice-involved, delivering equitable, recovery-focused interventions at points of crisis and ensuring continuity of care across the behavioral health system.

Planned funding
SMH Medi-Cal

Planned operations
Beginning in July 2026 one site will be open with the goal of additional sites in 2027.

Expected timeline of implementation
July 1, 2026

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
Riverside County benefits from the Public Health Department's Riverside Overdose Data to Action (RODA) project, which provides monthly surveillance data to partners across the county. This data helps agencies identify gaps in care and areas of unmet need as it includes all overdose issues occurring in the county regardless of payor. The RODA reports include a wide range of indicators, such as the types of drugs involved in overdoses, the number of naloxone administrations by EMS, trends in overdose occurrences over time, and geographic concentrations of incidents. RUHS BH uses this information to identify subpopulations and regions at elevated risk. The data also help county partners evaluate the impact of initiatives aimed at reducing substance use and overdose risk.
Additionally, RUHS BH will use the Medi Cal Connect dashboards to monitor improvements in POD and OUD performance measures. Member level data will be reviewed to assess how effectively the department is engaging individuals in DMC ODS services. Another tool for assessing gaps includes feedback from member and provider surveys. RUHS BH recently launched a new marketing and education campaign to increase awareness of the benefits of MAT among both the public and providers, and surveys are being used to evaluate the impact of these materials. Insights from this feedback are expected to guide future

efforts to further engage Riverside County residents in MAT services.

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

Contract directly with MAT providers in the County
Operate MAT clinics directly
Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
Leverage telehealth model(s)

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

Buprenorphine
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

Large gap

Apartments, including master-lease apartments
Large gap

Single and multi-family homes
Small gap

Housing in mobile home communities
Small gap

(Permanent) Single room occupancy units
Large gap

(Interim) Single room occupancy units
Medium gap

Accessory dwelling units, including junior accessory dwelling units
Large gap

(Permanent) Tiny homes
No 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)
Large gap

License-exempt room and board
Medium gap

Hotel and Motel stays
No gap

Non-congregate interim housing models
Small 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
Large gap

Short-Term Post-Hospitalization housing
Medium gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
No gap

Peer Respite
Small gap

Permanent rental subsidies
Large 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 **?**
To support the goal of expanding supply and increase access to housing for BHSA eligible individuals, the county behavioral health system will attempt to leverage a variety of non-BHSA resources. These include partnerships with local and state agencies, utilization of federal funding programs such as the Continuum

of Care Program, and collaborations with the local housing authority to access housing vouchers. When appropriate, data sharing agreements with other county departments and local service providers will be explored to streamline referral processes and better track housing needs and outcomes. Additionally, the county will seek to secure supplemental funding from both public and private sources to support innovative housing projects and bridge funding gaps. By combining these resources with BHSA funding, the county aims to create a more robust housing continuum that addresses the diverse needs of BHSA eligible individuals. All of these strategies are uncertain, however, in the current environment in which the HUD CoC program is under drastic redesign, the State HHAP annual allocation was reduced by 50%, and certain housing community supports have uncertain futures in light of needed Medicaid waiver renewals.

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 will be used where allowable and appropriate to either pay for housing needs that cannot be covered by other sources or when other sources are exhausted. RUHS-BH already anticipates using BHSA in FY 26/27 and beyond to support expanded housing options at the Mead Valley Wellness Village that is currently under construction.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?
RUHS-BH has pursued several strategies in this regard. The department aggressively pursued NPLH funding and this has led to an expanded number of affordable permanent housing apartments in Riverside County. Most of these projects have completed construction and are full, but there are two remaining projects still under development. Further, RUHS-BH has a significant number of staff who are trained in the use of the local Coordinated Entry assessment and who complete these assessments with members in order to place members on the waiting list for various Continuum of Care (CoC) funded opportunities. Additionally, RUHS-BH housing staff are trained to assist members in various diversion activities such as seeking employment, applying for mainstream benefits, reuniting with natural supports, and applying for any other supports that may assist them in housing stability including Enhanced Care Management, Community Supports, and mainstream housing opportunities such as the Housing Choice Voucher program, Project Based Voucher opportunities, or other community-based affordable housing. Additionally, the department provides services such as Housing Navigation and Housing Tenancy Sustaining Services to assist with housing placement and retention.

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)?

RUHS-BH assists individuals in utilizing their own resources, supports, and mainstream benefits to access PSH. Additionally, RUHS-BH staff assist clients with accessing the Coordinated Entry System in order to access PSH. Further, RUHS-BH will use BHSA to cover portions of client rental assistance and related ancillary costs in scattered-site PSH, project-based PSH, and RUHS-BH will use BHSA funds to provide housing tenancy sustaining staff to provide supportive services at over 15 project-based PSH sites.

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

Through a variety of access points the department uses screening tools such as a level of care tool or ASAM assessment to identify appropriate needed behavioral health services and supports. Many of the department's Housing Intervention settings include onsite behavioral health care services. For those that do not, clients are assisted in making appointments at appropriate behavioral health clinic settings relative to their needs; additionally the department has a variety of programs that provide transportation to clients and/or assist clients in identifying other transportation options that they are able to utilize including managed care plan ride services and low-cost/no-cost public transportation.

Eligible Populations

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

The department collects housing status through its electronic health record. When clients share a housing problem (such as homelessness or being at risk of homelessness) department staff are trained to assist clients in identifying their own options and resources to solve these problems. If, however, the client and service provider are not able to identify an appropriate solution to divert the individual into self-resolution, the staff will contact the department's housing program to seek formal assistance with housing. Based on consultation with client and treating staff the housing program assists to link clients to appropriate and available housing interventions.

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

The department, through MOUs with Riverside County Probation, provides all behavioral health services inside the county's juvenile institutions. This collaboration and direct service provision serve as invaluable stakeholder engagement to inform the department's knowledge of the needs of youth in or at-risk of juvenile justice involvement. Additionally, the department engages in a variety of forums such as youth justice committees, AB-109 committees, and provides services to justice involved youth. All of these examples further serve to inform the department about the needs of youth and their families who are justice involved or at-risk.

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

The department engages in multiple stakeholder forums that increase its knowledge of the housing needs of LGBTQ+ clients. These include participation as a member agency in the homeless continuum of care, service delivery in settings that attract a large number of such clients (e.g. Transitional Aged Youth (TAY) drop-in centers), and the lived experience of department staff and leadership who serve as Peer Consumers, Parent Partners, and Family Advocates. These staff groups as well as various Cultural Competency committee activities have provided additional insights about the needs of LGBTQ+ clients.

In the child welfare system

Similarly, RUHS-BH engages in multiple multi-disciplinary team (MDT) meetings with the Department of Public Social Services and other stakeholder agencies that provide child welfare services. Additionally, RUHS-BH through its Children's division provides direct treatment services to children in the child welfare system in a variety of settings. Through these avenues, as well as through the input of children, their families, and department experts such as Parent Partners and Family Advocates, the department receives input about the housing needs of children 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 Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults

RUHS-BH reviewed local data, engaged with aging-focused partners, and consulted directly with Older Adult Behavioral Health programs to understand the unique housing challenges faced by adults 60+. Older adults disproportionately experience fixed-income poverty, mobility impairments, and medical vulnerabilities that limit their access to appropriate housing. The department participates in multidisciplinary teams with the Office on Aging and Adult Protective Services, which provide insight into the overlap between behavioral health conditions, cognitive decline, and risk of homelessness. Additionally, RUHS-BH reviewed the local Housing Inventory Count and Annual Homeless Assessment Report data to assess availability of age-appropriate housing stock and identified significant gaps in assisted living, affordable units, and PSH that can meet the needs of older adults with complex behavioral health conditions. These activities have informed the design of Housing Interventions that include tenancy

supports, connections to health and social services, and coordination with Aging and Disability Resource Centers.

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

RUHS-BH considered the needs of adults involved with the justice system by reviewing data shared through AB-109 committees, participating in reentry councils, and consulting with both Probation and the Sheriff's HOPE Team. These efforts highlight the high rates of behavioral health conditions and homelessness among justice-involved adults. The department's Forensic Behavioral Health division provided direct input on gaps in immediate post-release housing, the need for stabilization supports, and barriers to accessing permanent housing. RUHS-BH also reviewed program outcomes from reentry-focused interventions to identify system gaps in case management, benefits enrollment, linkage to CoC resources, and housing retention. This analysis guided the development of Housing Interventions that prioritize warm handoffs, tenancy supports, and linkages to PSH and non-congregate interim housing when possible.

In underserved communities

To understand the needs of underserved communities, RUHS-BH used multiple approaches including review of racial equity data within the CoC, analysis of service utilization patterns, and participation in California Interagency Council on Homelessness working groups. These efforts consistently show disproportionate rates of homelessness among Black, Native, and LGBTQ+. These findings informed Housing Interventions that emphasize equitable access, culturally responsive services, mobile engagement, and strong coordination with community partners located in historically underserved areas.

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?

RUHS-BH will coordinate closely with the local CoC through established referral pathways connected to the Coordinated Entry System (CES). Department staff trained in CES assessments will identify eligible clients and ensure they are added to the community queue for housing interventions. The CoC case conferencing and matching process will be used to route referrals to BHSA Housing Interventions when appropriate. RUHS-BH also participates in CoC committees, data quality workgroups, and system mapping activities that support strong coordination and reduce duplication. As the CES lead agency, RUHS-BH is able to ensure timely matching and will maintain open referral channels for both internal and external partners to connect eligible individuals.

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

RUHS-BH collaborates with the CoC through participation in governance committees, Coordinated Entry case conferencing, and system performance workgroups. The department uses these channels to align BHSA Housing Interventions with CoC priorities, share data, coordinate referrals, and ensure eligible clients are captured in community housing opportunities. RUHS-BH will continue to engage in planning efforts, participate in the annual Notice of Funding Opportunity process, and use CES to support equitable access for BHSA-eligible individuals

Public Housing Agency

RUHS-BH partners with local housing authorities by supporting clients in completing applications for Housing Choice Vouchers, Project-Based Vouchers, and special-purpose vouchers such as Emergency Housing Voucher or Veteran Affairs Supportive Housing where eligible. The department engages in case conferencing with Public Housing Authority staff, collaborates on reasonable accommodation requests, and provides documentation needed to support eligibility. RUHS-BH coordinates housing navigation and tenancy supports to ensure clients transitioning into Permanent Supportive Housing units maintain housing stability. The department will continue strengthening this partnership through joint trainings, data sharing where appropriate, and aligned application processes.

MCPs

RUHS-BH collaborates with MCPs through Enhanced Care Management (ECM), Community Supports, and shared care planning efforts. MCPs frequently fund medically necessary housing supports, and RUHS-BH care teams work closely with MCP representatives to coordinate housing navigation, tenancy supports, and clinical care. Regular case reviews, shared documentation (where permitted), and participation in joint operational meetings support alignment between BHSA Housing Interventions and MCP-funded services. This collaboration helps maximize braided funding and reduces duplication of efforts, promoting long-term stability for BHSA-eligible individuals.

ECM and Community Supports Providers

] RUHS-BH collaborates with ECM and Community Supports providers through coordinated case planning, housing navigation, and tenancy support activities. The department refers eligible clients to ECM or housing-related Community Supports and participates in case conferences to ensure alignment of behavioral health services and housing goals. ECM providers frequently assist with benefits acquisition, care

coordination, and transitions of care, which complement BHSA Housing Interventions. This collaborative structure helps expand the continuum of housing support for individuals with complex behavioral health needs.

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

RUHS-BH collaborates with a wide network of partners including CalWORKs Housing Support Program, FSP housing programs, DPSS child welfare units, and PSH developers operating No Place Like Home (NPLH) or tax-credit projects. These partnerships provide opportunities for information sharing, coordinated referrals, and leveraging external housing resources. The department engages developers during planning and construction phases to ensure supportive services can be integrated into new housing sites. RUHS-BH also collaborates with child welfare housing programs to support families experiencing homelessness and coordinates with TANF to align interventions for shared clients.

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?

We are dedicated to ensuring BHSA-eligible individuals receive coordinated, housing-focused behavioral health services. Behavioral health staff are embedded within or assigned to PSH and Homekey projects to provide intensive case management, care coordination, mental health and substance use disorder services, and linkage to primary care and benefits. Through interdisciplinary collaboration with housing operators, property management, and community-based providers, the county supports housing stability by addressing clinical needs, promoting tenancy skills, and responding proactively to crises. Referrals are coordinated through established county systems, including Homeless Management Information System (HMIS) and behavioral health referral pathways, ensuring timely access to housing and services. Funding is braided across behavioral health, housing, and entitlement resources to support ongoing service delivery and long-term housing retention.

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?

6015

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

1015

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

5000

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 methodology at this point in time is to analyze historical usage patterns, where they are known. This includes an analysis on voucher payments for direct rent costs, client utilities, one time assistance payments, deposit assistance, rental arrears, credit checks & holding fees. We also included an anticipated costs that may need to be BHSA-funded due to the expiration of other grant funding. The county is using our electronic health record (EHR) data as well as homeless management information system (HMIS) data to estimate the total number of individuals with a service need. Costs are estimated using historical payment data for the various housing types. For clients in emergency settings thirty (30) days of subsidy is presumed for estimation purposes while in interim settings six (6) months of subsidy is usually presumed for calculations and for those in permanent settings twelve (12) months of subsidy is presumed for cost estimation purposes.

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

The department anticipates using Housing Interventions to provide rental assistance in a variety of permanent and interim settings. BHSA funds will be used for members who do not have Community Supports & Transitional Rent eligibility or after such eligibility is exhausted or for needed allowable expenses that are not covered under Community Supports. The intervention needed will vary depending on client choice, client needs, and availability. The department anticipates providing rental subsidies for all allowable uses and settings (both permanent and time-limited).

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?
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
The department is pursuing unit identification through a variety of strategies. Chiefly, the department allows client choice and attempts to provide housing assistance at locations identified by clients themselves. Additionally, the department engages many vendors through both contracts and vendor agreements for a variety of settings including essentially all settings identified in the BHSA Policy Manual including but not limited to motels, license exempt room and board, recovery housing, adult residential facilities, SROs, shared housing and apartments/homes. Additionally, our department not only participates in the local homeless Continuum of Care as a participating agency but also serves as the lead agency for Coordinated Entry in the county. The department leverages these relationships to identify additional available units to connect clients to appropriate housing interventions.

Total number of units funded with BHSA Housing Interventions per year
6015

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

Operating Subsidies (Chapter 7, Section C.9.2)

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
725

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

The department seeks to be as flexible as possible in the administration of housing interventions including rental subsidies, operating subsidies, and potentially mixed models. The department provides a variety of operating subsidies to support the operating expenses of needed housing interventions in both non-time limited and time limited settings. These settings include but are not limited to permanent supportive housing, assisted living, short term post hospitalization housing, and non-congregate interim housing models. Operating subsidies are anticipated to be used at settings including The Path (a permanent supportive housing location in Palm Springs), at adult residential facilities (including Roy's Desert Springs, Desert Sage ARF, & Franklin Residential Care), as well as at facilities under development including a new transitional housing facility on Hulen Place in Riverside, and at the Mead Valley Wellness Village campus (both interim housing and adult residential facility).

For which setting types will the county provide operating subsidies?

Non-Time-Limited Permanent Settings: Supportive housing
Time Limited Interim Settings: Recuperative Care
Time Limited Interim Settings: Short-Term Post-Hospitalization housing
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)

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

725

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

The county does not anticipate using operating subsidies at this time that are not tied to a specific number of units. The county does anticipate using operating subsidies at fixed-sites, but based upon member and department need it is possible that operating subsidies will also be used in scattered site settings.

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
100

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Landlord outreach and mitigation funds will be used for landlord administrative onboarding costs, holding feeds, damage mitigation funds, eviction prevention assistance, unit repair reimbursements, landlord support services, and enhanced incentives for high barrier households.

Total number of units funded with BHSA Housing Interventions per year
100

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
No, the county will not be providing landlord outreach and mitigation funds that are not tied to a specific unit. The anticipated number of individuals to be served is 100 but will be updated based upon member needs and funding availability. Likewise, in reference to Question 5 the anticipated number of units for which landlords might receive outreach and mitigation funds is estimated at 100 due to the estimated number of members to be served but will be updated over time dependent on member need and funding availability.

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
250

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
RUHS-BH intends to use Housing Interventions funds to establish Participant Assistance Funds to remove barriers to housing and support people in meeting their immediate housing needs. Support provided will be based on individualized assessment of needs. Examples of services and activities to be covered under a Participant Assistance Fund may include, but would not be limited to costs associated with obtaining government-issued identification and other vital documents, housing application fees, fees for credit reports, security deposits, utility deposits, storage fees, pet deposits and other pet fees, move-in costs, including costs associated with establishing a household such as: transportation, food, hygiene products, moderate furnishings (including but not limited to items such as a bed, tables and chairs, cleaning tools, and other supplies that people need to settle into housing), as well as rent and utility arrears.

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
2500

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

RUHS-BH will fund Housing Transition Navigation Services and Housing Tenancy Sustaining Services for individuals not eligible for these services through a Medi-Cal MCP or for those individuals who have already exhausted their MCP benefit. Additionally, RUHS-BH is a contracted Community Supports provider to provide Housing Transition Navigation Services and Housing Tenancy Sustaining Services to individuals enrolled in Medi-Cal. Experience as a provider has illustrated that many individuals who qualify for specialty behavioral health services require far longer durations of housing navigation and tenancy sustaining services than covered by the Medi-Cal benefit. Thus, there is a significant need for ongoing Navigation & Tenancy services as well as a need for Navigation and Tenancy Services for members who are uninsured or denied by their insurer.

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

This activity will be funded through our BHSS funding allocation. Activities are described in our narrative response in that corresponding section.

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?

No

Please explain why the county is not providing this intervention

Housing Interventions funds are fully subscribed providing other activities existing housing navigation, housing tenancy sustaining services, rental assistance, and operating subsidies. Additionally RUHS-BH is expanding housing options to include the 399 new units of interim housing and recuperative care at the Mead Valley Wellness Village.

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?
Anticipated number of individuals served per year
0

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)
RUHS-BH is currently providing interim housing, assisted living, and an apartment-based "rapid rehousing" style rental assistance program using BHBH funds. The department anticipates that all rental assistance participants will have transitioned to self-sustainment of their rent by the end of the Behavioral Health Bridge Housing (BHBH) period. However, the interim housing and assisted living facility needs being covered with BHBH funds will continue. The department anticipates using BHSA funds to continue to meet these needs. Similarly, the department currently provides permanent support housing using HUD CoC funds. With the future of the HUD CoC program in question at this time, the department is preparing for a possible scenario in which BHSA funds may be needed to sustain current participants housing until they can be transferred to other subsidy programs (e.g. Housing Choice Vouchers, No Place Like Home or Homekey units, etc.) or can become self-sufficient.

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?
Housing Transition Navigation Services
Housing Deposits
Housing Tenancy and Sustaining Services
Short-Term Post-Hospitalization Housing
Recuperative Care

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
1/1/2022

Housing Deposits
No

Housing Tenancy and Sustaining Services
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
1/1/2022

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
Undecided

Transitional Rent
Undecided

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)?**
The county behavioral health system will use a coordinated, multi-step process to identify, confirm eligibility for, and refer Medi-Cal members to housing-related Community Supports offered by Managed

Care Plans (MCPs), including Transitional Rent. Identification begins at all key access points—clinical programs, crisis services, outreach teams, care coordination units, and contracted providers—where staff will screen for housing instability using standardized tools and social needs assessments. Members who present with homelessness, risk of homelessness, or housing-related barriers to treatment will be flagged for further review.

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

RUHS-BH shares data as requested with all Managed Care Plan partners. Work is ongoing through frequent coordination meetings to ensure understanding of the Housing Interventions available.

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)?

No

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?

RUHS-BH through a variety of specialty teams typically has a case manager assigned to members with complex determinations of health needs such as homelessness. Part of this case manager's role is to identify client supports (e.g. Community Supports) and to identify the benefits and limitations of such supports. In the case of MCP benefits, case managers work with clients to identify when these benefits will end and to promote client self-sufficiency in identifying appropriate next steps to avoid services gaps when MCP benefits end. However, significant needs still exist in this area due to the high costs and low availability of housing relative to the earned income, SSI/SSDI, and / or subsidized housing resources available in the community.

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)?

No

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

No

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

There is no Flex Pool in Riverside County at this time. RUHS-BH is open to future conversations with relevant stakeholders about the viability of creating a Flex Pool and whether the effort and cost to launch a Flex Pool are outweighed by the potential benefits.

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?
No

If not, please describe how the county will ensure that BHSA-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner
Each of the providers contracted with the County undergoes a contracting process and annual contract monitoring review. The County will ensure that each of Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner by FY 2027-2028.

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)?
15

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 Psychologist
Nurse practitioner
Psychiatric Technician (PT)
Psychiatrist
Registered nurse

Please describe any other key workforce gaps in the county

There is an approximate 15% vacancy rate in Behavioral Health Specialist Positions, Clinical Therapist Positions, and Peer Positions in County positions. We currently do not collect this data for contracted providers.

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)?

"RUHS-BH has made targeted adjustments to existing programs to support the implementation of new evidence-based practices (EBPs) associated with BHSA, including BHT and BH Connect initiatives. These adjustments include restructuring existing Full Service Partnership (FSP) programs and shifting staffing configurations to support the phased implementation of Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Individual Placement and Support (IPS) models. In addition, the County is already implementing Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP) and High Fidelity Wraparound (HFW) within its continuum of care to better serve children and youth with complex behavioral health needs.

The County is also strengthening its system of care for children, youth, and families by working with contract providers to deliver Multisystemic Therapy (MST) and Functional Family Therapy (FFT), and by expanding Parent-Child Interaction Therapy (PCIT) both within County-operated programs and through contracted providers to ensure sufficient capacity and access. Using a provider network to deliver these EBPs helps negate the present challenges with recruiting and retaining staff for these specific EBPs. Additionally, Assertive Field-Based Substance Use Disorder Services (AFBSS) has been integrated into existing programs as a model of care, with a focus on expanding field-based MAT services. Prescribers supporting these efforts are being identified and provided with additional training and clinical supports through partnerships with HMA.

In addition to these programmatic changes, RUHS-BH has made strategic staffing adjustments and added select positions through careful fiscal planning to ensure adequate capacity to implement and sustain these EBPs.

Significant emphasis is being placed on training both existing and newly hired staff to align with BHSA requirements and EBP fidelity standards. Current staff are working with the COEs and consultant groups like HMA to support transitions to ACT, FACT, IPS, CSC/FEP, HFW, AFBSS, and other EBPs.

Newly hired staff will participate in structured onboarding that includes BHSA orientation, EBP-specific training, and ongoing coaching and supervision to support model fidelity.

RUHS-BH's Workforce Development and Training (WET) and Quality Improvement (QI), and Research & Evaluations teams are making significant structural and operational adjustments to support these efforts, including designating dedicated staff to oversee EBP-specific training, fidelity monitoring, and continuous quality improvement. These teams will collaborate with the COEs to align training with model requirements, monitor implementation through data and fidelity reviews, and provide ongoing feedback to

inform continuous workforce development."

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?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?
No

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
The County plans to leverage BH Connect resources and initiatives to strengthen recruitment and retention efforts by first ensuring leadership is well informed and equipped to promote these opportunities department-wide. These resources will help direct funding to service areas where data indicate gaps, supporting the development of a more qualified workforce in those communities. BH Connect will also enhance recruitment for hard-to-fill positions by highlighting the financial and professional benefits available to applicants, while service-commitment incentives support staff retention within the department. The initiatives will further complement the department's internship program by informing graduating students of available incentives when working for the County or with community-based organizations, encouraging more applicants to pursue public sector roles. This approach will also strengthen collaboration with community-based organizations through increased communication and shared promotion of BH Connect programs. The department will actively disseminate promotional materials and announcements to ensure staff can access available workforce supports. Additionally, BH Connect funding will help address training needs by supporting required, specialized, and skill-development trainings that help staff feel prepared and confident to provide high-quality services.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
No

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
RUHS-BH coordinated with the RUHS Foundation to apply for and was subsequently awarded under the HCAI Behavioral Health Residency Program funding opportunity that will benefit the RUHS-BH residency program, helping recruitment and retention efforts

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 department operates a volunteer program that helps fill service gaps across the department when vacant positions are unavailable. In some cases, volunteers later obtain paid positions after gaining relevant experience and applying when opportunities become available. Additionally, the department may contract with retirees to temporarily support teams they previously worked with until permanent staff are hired, a practice most commonly used for hard-to-fill positions. The County also utilizes social media to advertise departmental job openings. These platforms allow individuals who are not yet employees to learn about the department's work, which may encourage them to apply. Furthermore, the department partners with other agencies to host an interagency symposium focused on careers in behavioral health, increasing awareness of available roles and supporting recruitment efforts. Lastly, Human Resources and Outreach staff attend career and job fairs at local colleges to promote behavioral health careers, which has proven effective in addressing workforce gaps.

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
Integrated-Plan-Budget-Template_v3 04.06.26 (RUHS 06.03.26 Final).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)
This does not apply, our prudent reserve is under the maximum.

Full Service Partnership (FSP)
This does not apply; our prudent reserve is under the maximum.

Housing Interventions
This does not apply; our prudent reserve is under the maximum.

Enter date of last prudent reserve assessment
1/16/2026

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

This does not apply; our prudent reserve is under the maximum.

FSP

This does not apply; our prudent reserve is under the maximum.

Housing Interventions

This does not apply; our prudent reserve is under the maximum.

Instructions

Counties shall report their planned expenditures for all behavioral health funding sources, not limited to only BHSA, along the Behavioral Health Care Continuum in Tab One.
For Annual Updates, counties should review and make updates only to the next fiscal year. For Intermittent Updates, counties should review and make updates to the current fiscal year.
Column C: counties shall indicate whether they provide each category of services using the check box.
Columns D through I: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs by each Behavioral Health Care Continuum category. Counties should consider children/youth as 21 and under for Columns G - I.
Columns J and K: counties shall input their estimated total count of all individuals served through the county behavioral health system across all funding sources/programs. These counts may be duplicated. Counties should consider eligible children/youth as 21 and under for Column K.
Row 38: the total projected expenditures in columns D through I and total projected individuals served annually in columns J and K will be auto-populated from rows 20 through 36.
Note: For a list of all funding streams that should be included in the projected expenditures calculation for each BH Care Continuum Category, please see the Behavioral Health Services Act (BHSA) County Policy Manual Chapter 3, Section A.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table One: Behavioral Health Care Continuum Projected Expenditures

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (Year One)	Total Projected Expenditures On Adults and Older Adults (Year Two)	Total Projected Expenditures On Adults and Older Adults (Year Three)	Total Projected Expenditures on Children/Youth (under 21) (Year One)	Total Projected Expenditures on Children/Youth (under 21) (Year Two)	Total Projected Expenditures on Children/Youth (under 21) (Year Three)	Projected Individuals to be Served Annually (May be duplicated) Eligible Adults and Older Adults	Projected Individuals to be Served Annually (May be duplicated) Eligible Children/Youth (under 21)
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 256,802.96	$ 264,507.05	$ 272,442.26	$ 4,879,256.29	$ 5,025,633.98	$ 5,176,403.00	1202.00	248.00
Early Intervention Services	☑	$ 109,727.76	$ 113,019.59	$ 116,410.18	$ 164,591.64	$ 169,529.39	$ 174,615.27	1752	2628.00
Outpatient Services	☑	$ 46,775,058.88	$ 49,704,582.22	$ 51,488,652.87	$ 1,625,943.73	$ 1,674,722.04	$ 1,724,963.70	12064	1478.00
Intensive Outpatient Services	☑	$ 5,962,814.98	$ 6,141,699.43	$ 6,325,950.42	$ 306,301.67	$ 315,490.72	$ 324,955.45	1049	48.00
Crisis and Field-Based Services	☑	$ 655,568.78	$ 1,345,031.69	$ 1,485,312.57	$ 34,503.62	$ 49,208.03	$ 52,723.66	1569	10.00
Residential Treatment Services	☑	$ 65,079,233.39	$ 70,103,159.81	$ 72,628,079.71	$ 3,325,933.85	$ 3,488,396.36	$ 3,601,657.12	2670	125.00
Inpatient Services	☑	$ 1,586,038.28	$ 1,633,619.43	$ 1,682,628.01	$ 5,013.17	$ 5,163.57	$ 5,318.48	177	1.00
Mental Health (MH) Services									
Primary Prevention Services	☑	$ -	$ -	$ -		$ -	$ -		
Early Intervention Services	☑	$ 14,290,948.03	$ 14,719,676.47	$ 15,161,266.76	$ 20,130,045.17	$ 20,733,946.53	$ 21,355,964.93	3802	1894
Outpatient and Intensive Outpatient Services	☑	$ 132,561,105.55	$ 137,138,032.19	$ 141,489,640.32	$ 157,918,102.30	$ 165,401,690.51	$ 170,699,609.08	19846	14841
Crisis Services	☑	$ 64,505,249.09	$ 68,439,950.37	$ 70,740,293.32	$ 24,117,358.32	$ 27,074,740.32	$ 28,090,038.41	10637	4008
Residential Treatment Services	☑	$ 1,900,000.00	$ 1,957,000.00	$ 2,015,710.00	$ 100,000.00	$ 103,000.00	$ 106,090.00	148	6
Hospital and Acute Services	☑	$ 104,296,337.00	$ 107,425,227.11	$ 110,647,983.92	$ 23,529,956.21	$ 24,235,854.90	$ 24,962,930.55	2874	548
Subacute and Long-Term Care Services	☑	$ 65,009,647.17	$ 71,757,211.83	$ 74,511,588.27	$ 1,514,629.89	$ 1,623,749.43	$ 1,680,448.55	950	39
Housing Services (MH + SUD)									
Housing Services	☑	$ 86,078,339.00	$ 96,319,060.20	$ 102,631,850.70	$ 1,758,893.00	$ 2,452,408.42	$ 2,691,633.38	2398	45
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 589,066,870.87	$ 627,061,777.39	$ 651,197,809.32	$ 239,410,528.87	$ 252,353,534.20	$ 260,647,351.57	61138	25919

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activities, other than those that are part of the Behavioral Health Care Continuum in Tab Two.

Rows 17 through 20: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Tab One, "BH CoC Expenditures."

Row 22: total projected expenditures will be auto-populated from rows 17 through 20.

For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures (Year One)**	**Total Projected Expenditures (Year Two)**	**Total Projected Expenditures (Year Three)**
Capital Infrastructure Activities	$ 7,500,000.00	$ 7,500,000.00	$ 10,000,000.00
Workforce Investment Activities	$ 2,939,038.00	$ 3,027,209.14	$ 3,118,025.41
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 33,247,893.43	$ 34,245,330.23	$ 35,272,690.14
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 76,847,089.86	$ 79,152,502.55	$ 81,527,077.63
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 120,534,021.28	$ 123,925,041.92	$ 129,917,793.18

Instructions

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Tab Three.

Rows 18 through 33: counties shall report projected expenditures for each funding source/program.

Row 21: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 26: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 35: total expenditures will be auto-populated from rows 18 through 33.

Row 36: will be auto-validated by DHCS against rows 35, 37, and 38. Validation: total projected expenditure variance should total out to $0.

Rows 37 and 38: will be auto-validated by DHCS against total projected expenditures in Tabs One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Three: Projected Annual Expenditures by County BH Funding Source			
	Total Annual Projected Expenditures (Year One)	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
BHSA	$ 218,393,888.00	$ 196,463,052.00	$ 209,092,468.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 62,348,688.00	$ 62,348,688.00	$ 62,348,688.00
2011 Realignment (Public Safety Realignment)	$ 110,000,000.00	$ 138,300,000.00	$ 142,449,000.00
State General Fund	$ 20,000,000.00	$ 20,000,000.00	$ 20,000,000.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 374,549,635.84	$ 402,699,494.46	$ 414,863,116.31
Projects for Assistance in Transition from Homelessness (PATH)	$ 325,127.00	$ 325,127.00	$ 325,127.00
Community Mental Health Block Grant (MHBG)	$ 4,107,213.00	$ 4,107,213.00	$ 4,107,213.00
Substance Use Block Grant (SUBG)	$ 10,518,821.00	$ 10,518,821.00	$ 10,518,821.00
Commercial Insurance	$ 1,200,000.00	$ 1,200,000.00	$ 1,200,000.00
County General Fund	$ 29,570,382.00	$ 35,670,382.00	$ 35,670,382.00
Opioid Settlement Funds	$ 6,025,132.00	$ 6,025,132.00	$ 6,025,132.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 4,077,491.00	$ 4,077,491.00	$ 4,077,491.00
Other state funding (including DSH funding)	$ 77,047,449.00	$ 87,047,449.00	$ 94,547,449.00
Other county mental health or SUD funding	$ 30,847,594.00	$ 34,557,503.85	$ 36,538,066.55
Other foundation funding	$ -	$ -	$ -

Summary	Total Annual Projection (Year One)	Total Annual Projection (Year Two)	Total Annual Projection (Year Three)
Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 949,011,420.84	$ 1,003,340,353.31	$ 1,041,762,953.86
Total Projected Expenditure Variance	$ (0.19)	$ (0.20)	$ (0.21)
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 828,477,399.75	$ 879,415,311.59	$ 911,845,160.89
Auto-validation: Table 2: Other County Expenditures	$ 120,534,021.28	$ 123,925,041.92	$ 129,917,793.18

Instructions

Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet.**

Rows 38-40: input your county's base BHSA funding allocation by component and year.

Rows 43-54: this section will be auto-populated from the sections below it.

Rows 43, 49, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.

Rows 44, 50, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Row 45: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.

Row 46: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.

Rows 58, 80, and 102: the base funding amount for Housing Interventions will auto-populate from Column C, rows 38-40.

Rows 59, 81, and 103: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value. It will automatically display as a negative value in the cell.

Rows 60, 82, and 104: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions. Enter this percentage as a positive value.

Rows 63, 85, 107: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 38-40.

Rows 68, 90, 112: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 38-40.

Rows 64, 69, 86, 91, 108, and 113: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.

Rows 65, 70, 87, 92, 109, and 114: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.

Rows 74, 96, 118: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."

Rows 75, 97, 119: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."

Rows 76, 98, 120: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."

Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 75) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.

Rows 77, 99, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."

Rows 124-130: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information.

Row 130: the total dollar amount of MHSA Transfers to BHSA is auto-populated.

Row 133: enter the dollar amount of prior year prudent reserve ending balance

Row 134: enter the prudent reserve maximum for your county.

Row 135: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. **Negative values indicate no transfer is necessary.**

Rows 136-138: enter the amount of excess prudent reserve funds allocated to each component.

Row 139: the total transferred excess prudent reserve is auto-populated.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Four: BHSA Transfers				
	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$ 58,600,454.00	$ 68,367,196.00	$ 68,367,196.00	$ 195,334,846.00
Year Two Component Allocation (dollars)	$ 58,600,454.00	$ 68,367,196.00	$ 68,367,196.00	$ 195,334,846.00
Year Three Component Allocation (dollars)	$ 58,600,454.00	$ 68,367,196.00	$ 68,367,196.00	$ 195,334,846.00
BHSA Transfers Year One Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	23%	39%	38%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 44,927,014.73	$ 76,180,589.83	$ 74,227,241.37	$ 195,334,845.93
Unspent Mental Health Services Act (MHSA) to BHSA	$ -	$ 25,000,000.00	$ 90,000,000.00	$ 115,000,000.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -
BHSA Transfers Year Two Summary (auto-populated)				

	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	27%	37%	36%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 52,740,408.60	$ 72,273,892.91	$ 70,320,544.46	$ 195,334,845.97

BHSA Transfers
Year Three Summary (auto-populated)

	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	27%	37%	36%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 52,740,408.60	$ 72,273,892.91	$ 70,320,544.46	$ 195,334,845.97

Funding Transfer Request Allocations

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption
(Ability to change component's overall percentage) (Year One)

Base Component (Year One)	Housing Intervention Percentage (Year One)	Housing Intervention Funds (Year One)
Base Percentage and Funding	30%	$ 58,600,454.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 58,600,454.00
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**
Base Percentage and Funding	35%	$ 68,367,196.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 68,367,196.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year One)**	**Behavioral Health Services and Support Funding (Year One)**
Base Percentage and Funding	35%	$ 68,367,196.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 68,367,196.00

Funding Transfers (Year One)

	Housing Intervention (Year One) (1)	Full-Service Partnership (Year One)	Behavioral Health Services and Support (Year One)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-7%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	4%	3%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	23%	39%	38%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)		
Base Component (Year Two)	**Housing Intervention Percentage (Year Two)**	**Housing Intervention Funds (Year Two)**
Base Percentage and Funding	30%	$ 58,600,454.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 58,600,454.00
Transferred To/From	**Full Service Partnership Percentage (Year Two)**	**Full Service Partnership Funds (Year Two)**
Base Percentage and Funding	35%	$ 68,367,196.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 68,367,196.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Two)**	**Behavioral Health Services and Support Funding (Year Two)**
Base Percentage and Funding	35%	$ 68,367,196.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 68,367,196.00

Funding Transfers (Year Two)				
	Housing Intervention (Year Two) (1)	**Full-Service Partnership (Year Two)**	**Behavioral Health Services and Support (Year Two)**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-3%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	-2%	-1%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	27%	37%	36%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)		
Base Component	**Housing Intervention Percentage (Year Three)**	**Housing Intervention Funds (Year Three)**
Base Percentage and Funding	30%	$ 58,600,454.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 58,600,454.00
Transferred To/From	**Full Service Partnership Percentage (Year Three)**	**Full Service Partnership Funds (Year Three)**
Base Percentage and Funding	35%	$ 68,367,196.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 68,367,196.00

Transferred To/From	Behavioral Health Services and Support Percentage (Year Three)	Behavioral Health Services and Support Funding (Year Three)
Base Percentage and Funding	35%	$ 68,367,196.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 68,367,196.00

Funding Transfers (Year Three)

	Housing Intervention (Year Three) (1)	Full-Service Partnership (Year Three)	Behavioral Health Services and Support (Year Three)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-3%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	-2%	-1%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	27%	37%	36%	Row Equals 100%

MHSA Transfers to BHSA

MHSA Component	Available Unspent BHSA Funds	Transferred to Housing Intervention	Transferred to Full-Service Partnership	Transferred to Behavioral Health Services and Support
CSS	$ 20,000,000.00	$ -	$ 10,000,000.00	$ 10,000,000.00
PEI	$ 30,000,000.00	$ -	$ 15,000,000.00	$ 15,000,000.00
Encumbered INN	$ 15,000,000.00	$ -	$ -	$ 15,000,000.00
Unencumbered INN		$ -	$ -	$ -
WET	$ -			$ -
CFTN	$ 50,000,000.00			$ 50,000,000.00
Total (auto-populated)	$ 115,000,000.00	$ -	$ 25,000,000.00	$ 90,000,000.00

Excess Prudent Reserve to BHSA Components

Transfer from Prudent Reserve to BHSA Component Allocation	Amount
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 24,217,189.00
Local Prudent Reserve Maximum (2)	$ 34,833,835.59
Excess Prudent Reserve Funding that must be transferred	**$ (10,616,646.59)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.
2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).
3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.

Instructions

Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Tab Five.

Rows 39-42: input the estimated total Housing Intervention component allocation received for each year. Row 39 will auto-populate from Tab Four in the BHSA Transfers tab Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-populate the sum of rows 40-42 to account for total funding.

Row 40: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 136 that you will be transferring excess PR funds to Housing Interventions please report them here.

Rows 47-64: input the projected expenditures for each Housing Intervention component service category or program for each year.

Row 46: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent through their Medi-Cal MCP.

Row 51: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns F, G, and H.

Row 63: input expenditures for BHSA-funded innovation pilots or projects.

Row 64: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 65: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools

Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 69 enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs)

Row 70: the overall total of Housing Intervention expenditures will be auto-populated from rows 65, 67, and 69.

Row 72: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. This amount should equal 50% of Housing Interventions component allocation.

Row 73: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 72

Row 75: the proportion of funds dedicated to capital development will be auto-populated.

Row 76: the proportion of funds dedicated to the chronically homeless population will be auto-populated.

Row 77: the proportion of funds dedicated to Outreach and Engagement will be auto-populated.

Rows 79-80: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

Row 82: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Five: BHSA Components

	Total Housing Interventions Funding (Year One)	Total Housing Interventions Funding (Year Two)	Total Housing Interventions Funding (Year Three)
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 44,927,014.00	$ 52,740,408.00	$ 52,740,408.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -

Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 44,927,014.00	$ 52,740,408.00	$ 52,740,408.00			
Housing Interventions Category						
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)**	**Projected Expenditures - All Other Funding Sources (Year One)**	**Projected Expenditures - All Other Funding Sources (Year Two)**	**Projected Expenditures - All Other Funding Sources (Year Three)**
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ 5,772,362.85	$ 5,945,533.73	$ 6,123,899.75	$ 4,122,769.87	$ 4,246,452.97	$ 4,373,846.55
Operating Subsidies	$ 1,394,372.43	$ 1,436,203.60	$ 1,479,289.71	$ 383,197.40	$ 394,693.32	$ 406,534.12
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 16,266,905.66	$ 19,272,214.26	$ 16,678,682.79	$ 17,610,076.62	$ 18,138,378.92	$ 22,682,530.29
Operating Subsidies	$ 14,430,780.49	$ 18,893,665.14	$ 19,479,114.75	$ 6,056,001.26	$ 7,989,538.30	$ 10,831,272.74
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ 295,200.00	$ 304,056.00	$ 313,177.68	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 147,600.00	$ 152,028.00	$ 156,588.84	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 1,534,324.98	$ 1,580,354.73	$ 1,627,765.38	$ 4,639,971.05	$ 4,779,170.18	$ 4,922,545.28
Other Housing Supports: Outreach and Engagement (2)	$ -	$ -	$ -	$ -	$ -	$ -
Capital Development Projects	$ -	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 39,841,546.42	$ 47,584,055.47	$ 45,858,518.89	$ 32,812,016.20	$ 35,548,233.69	$ 43,216,728.99
Housing Interventions Transfer Information	**Year One**	**Year Two**	**Year Three**			

Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Administrative Information	**Year One**	**Year Two**	**Year Three**
Housing Interventions Component Admin Expenses	$ 4,384,435.79	$ 4,515,968.86	$ 4,651,447.93
Total Housing Interventions Expenditures (auto-populated)	$ 44,225,982.21	$ 52,100,024.34	$ 50,509,966.82
Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 30,000,000.00	$ 30,900,000.00	$ 31,827,000.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 3,531,406.78	$ 3,637,348.98	$ 3,746,469.45
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	0.0%	0.0%	0.0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	66.8%	58.6%	60.3%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	0.0%	0.0%	0.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	6676	6676	6676
Eligible Adults/Older Adults	5753	5753	5753
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References
1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.

2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.
3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.
4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.
5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).
6. W&I Code § 5892, subdivision (b)(2).
7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development.
8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Instructions

Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six.

Rows 24-27: input the total estimated FSP component allocation received for each year. Row 24 will auto-populate from Tab Four in the BHSA Transfers tab.

Input unspent MHSA dollars carried over to this component into row 26. Row 27 will auto-populate the sum of rows 24-26 to account for total funding.

Row 26: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable. If you reported on Tab 4, row 137 that you will be transferring excess PR funds to FSP please report them here.

Rows 31-40: input the projected expenditures for each FSP service category or program for each year.

Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 31-36. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 37-38, accordingly.

Row 39: input expenditures for BHSA-funded innovation pilots or projects.

Row 40: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 41: the subtotal of FSP programs/services will be auto-populated from rows 31-40.

Row 43: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.

Row 45: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 46: total projected expenditures for FSP for each year will be auto-populated from rows 41, 43, and 45.

Rows 48 and 49: input the estimated unduplicated count of individuals that will be served across all FSP programs.

Row 51: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA FSP component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Six: BHSA Components

	Total Full Service Partnership (FSP) Funding (Year One)	Total Full Service Partnership (FSP) Funding (Year Two)	Total Full Service Partnership (FSP) Funding (Year Three)
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 76,180,589.00	$ 72,273,892.00	$ 72,273,892.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ 25,000,000.00	$ -	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 101,180,589.00	$ 72,273,892.00	$ 72,273,892.00

Full Service Partnership Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 1,467,455.51	$ 1,511,479.17	$ 1,556,823.55	$ 5,651,831.95	$ 5,821,386.91	$ 5,996,028.52	$ -	$ -	$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 366,864.13	$ 377,870.06	$ 389,206.16	$ 1,412,957.99	$ 1,455,346.73	$ 1,499,007.13	$ -	$ -	$ -
FSP Intensive Case Management	$ 66,055,026.76	$ 53,458,757.89	$ 57,593,515.23	$ 46,429,985.00	$ 47,822,884.55	$ 49,257,571.09	$ 46,291,995.00	$ 67,119,630.41	$ 67,211,871.45
High Fidelity Wraparound	$ 703,707.12	$ 724,818.33	$ 746,562.88	$ 5,145,749.58	$ 5,300,122.07	$ 5,459,125.73	$ 5,519,472.66	$ 5,685,056.84	$ 5,855,608.54
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 263,547.32	$ 271,453.73	$ 279,597.35	$ 1,015,038.77	$ 1,045,489.93	$ 1,076,854.63	$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$ -	$ -	$ -	$ 98,205.71	$ 101,151.88	$ 104,186.43	$ 505,406.42	$ 520,568.62	$ 536,185.68

Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ 4,536,309.28	$ 4,672,398.56	$ 4,812,570.52	$ -	$ -	$ -	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 73,392,910.11	$ 61,016,777.74	$ 65,378,275.68	$ 59,753,768.99	$ 61,546,382.06	$ 63,392,773.52	$ 52,316,874.08	$ 73,325,255.87	$ 73,603,665.66

FSP Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -

FSP Administrative Information	**Year One**	**Year Two**	**Year Three**
FSP Component Admin Expenses	$ 10,077,234.25	$ 10,379,551.28	$ 10,690,937.82
Total Full Service Partnership Expenditures (auto-populated)	$ 83,470,144.36	$ 71,396,329.02	$ 76,069,213.49

Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	4628	4628	4628
Eligible Adults/Older Adults	7955	7955	7955

Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References
1. W&I Code § 5892, subdivision (a)(2)(A) states 35% of BHS funds distributed to counties shall be used for Full Service Partnership Programs.
2. May be bundled or un-bundled depending on county BH-CONNECT opt-in.

Instructions

Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Seven

Row 26-29: input the total estimated BHSS component allocation received for each year. Row 26 will auto-populate from Tab Four in the BHSA Transfers tab

Row 27: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 138 that you will be transferring excess PR funds to BHSS please report them here

Input unspent MHSA dollars carried over to this component into row 28. Row 29 will auto-populate the sum of rows 26-28.

Rows 33-46: input the projected expenditures for each BHSS service category or program for each year. Rows 35, 39, and 42 auto-populate from their sub rows

Row 45: input expenditures for BHSA-funded innovation pilots or projects.

Row 46: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 47: the subtotal for projected expenditures will be auto-populated from rows 33 - 35, 38, 39, 42, 45, and 46.

Row 49: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.

Row 51: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs)

Row 52: the total for projected BHSS expenditures will be auto-populated from rows 47, 49, and 51.

Row 54: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures

Row 56: the proportion of EI funds will auto-populate from rows 29 and 35. Note: MHSA WET, INN, and CF/TN funds in Rows 65-67 will be deducted from the revenue (excluded from the denominator)

Row 57: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 35 and 54.

Rows 59-60: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.

Rows 62-63: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year

Rows 65-67: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc

Table Seven: BHSA Components

	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 74,227,241.00	$ 70,320,544.00	$ 70,320,544.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 37,500,000.00	$ 12,500,000.00	$ 40,000,000.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 111,727,241.00	$ 82,820,544.00	$ 110,320,544.00

Behavioral Health Services and Supports Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ 15,020,471.00	$ 5,653,672.52	$ 6,816,990.44	$ 58,088,789.00	$ 60,246,265.94	$ 62,011,182.07	$ 50,159,086.00	$ 61,819,157.43	$ 62,698,379.49
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 22,578,927.00	$ 16,919,261.15	$ 18,180,413.50	$ 42,374,375.00	$ 44,020,064.57	$ 45,488,846.03	$ 28,072,982.00	$ 35,477,840.26	$ 35,877,888.60
Early Intervention Expenditures	$ 32,558,946.00	$ 35,387,079.07	$ 37,163,997.64	$ 16,067,131.00	$ 19,959,823.16	$ 20,600,579.09	$ 11,233,896.00	$ 12,535,620.48	$ 12,964,605.37
Coordinated Specialty Care for First Episode Psychosis	$ 698,342.00	$ 719,292.00	$ 740,870.00	$ 919,530.00	$ 947,116.00	$ 975,529.00	$ -	$ -	$ -
All Other EI Expenditures	$ 31,860,604.00	$ 34,667,787.07	$ 36,423,127.64	$ 15,147,601.00	$ 19,012,707.16	$ 19,625,050.09	$ 11,233,896.00	$ 12,535,620.48	$ 12,964,605.37

Outreach and Engagement	$ 1,737,955.00	$ 1,790,093.65	$ 1,843,796.46	$ 125,310.66	$ 129,069.98	$ 132,942.08	$ 495,833.00	$ 510,707.99	$ 526,029.23
Workforce Education and Training (WET)	$ 1,748,059.00	$ 1,800,501.00	$ 1,854,516.00	$ 855,786.51	$ 881,460.11	$ 907,903.91	$ 72,293.31	$ 74,462.10	$ 76,695.97
Dedicated BHSA WET funds	$ 1,748,059.00	$ 1,800,501.00	$ 1,854,516.00	$ 855,786.51	$ 881,460.11	$ 907,903.91	$ 72,293.31	$ 74,462.10	$ 76,695.97
Dedicated MHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 7,500,000.00	$ 7,500,000.00	$ 10,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ 7,500,000.00	$ 7,500,000.00	$ 10,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 5,000,000.00	$ 5,000,000.00	$ 5,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 86,144,358.00	$ 74,050,607.39	$ 80,859,714.05	$ 117,511,392.17	$ 125,236,683.75	$ 129,141,453.18	$ 90,034,090.31	$ 110,417,788.26	$ 112,143,598.65

BHSS Prudent Reserve Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -

BHSS Administrative Information	**Year One**	**Year Two**	**Year Three**
BHSS Component Admin Expenses	$ 7,685,526.00	$ 7,916,091.78	$ 8,153,574.53
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 93,829,884.00	$ 81,966,699.17	$ 89,013,288.58

Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 16,686,883.00	$ 18,180,778.83	$ 19,173,741.70

Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	69.7%	116.7%	52.8%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	51.3%	51.4%	51.6%

Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	19024	19024	19024
Eligible Adults/Older Adults	22258	22258	22258

Projected BHSS Funds transferred to WET or CF/TN	**Year One**	**Year Two**	**Year Three**
BHSS transfer to WET	$ 1,717,055.22	$ 1,768,566.88	$ 1,821,623.88
BHSS transfer to CF/TN	$ -	$ -	$ -

Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
Estimated MHSA WET Funds	$ -	$ -	$ -
Estimated MHSA CF/TN Funds	$ 50,000,000.00	$ 42,500,000.00	$ 35,000,000.00
MHSA "Encumbered" INN	$ 15,000,000.00	$ 10,000,000.00	$ 5,000,000.00

References

1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).
2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.
3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.
4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.
5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Instructions

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in Tab Eight.

Row 27: the total dollar-amount of BHSA component allocations dedicated to improvement and monitoring activities, including plan operations, quality and outcomes, data reporting pursuant to W&I Code § 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants by year. Under W&I Code § 5892 (e)(2)(B), the total amount shall equal 2% or less of total projected annual revenues of the local behavioral health services fund for counties with a population over 200,000 or 4% of the total projected annual revenues of the local behavioral health services fund for counties with a population of less than 200,000. Any costs that exceed that amount will be included in the governor's budget. Administrative costs for improving and monitoring will only be reported on this tab, not the BHSA component tabs.

Row 28: input amounts of BHSA component allocations dedicated to county Integrated Plan annual planning costs, including stakeholder engagement in planning and local Behavioral Health Board activities by year. Under W&I Code § 5892 (e)(1)(B), this amount shall be 5% or less of total projected annual revenues of the local behavioral health services fund. Any costs that exceed that amount will be included in the governor's budget. Planning costs will only be reported on this tab, not the BHSA component tabs.

Row 29: input total dollar amount of new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 30: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately.

Row 32: total projected annual revenues of the Local Behavioral Health Services Fund.

Row 33: the proportion of funding used for improvement and monitoring will be auto-populated from rows 32 and 27.

Row 34: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 32.

Row 36-38: based upon the county population size selected in row 31, this calculator will auto-populate any Improvement and Monitoring expenditures that exceed (2%/4%) of the total projected annual revenues of the Local Behavioral Health Services Fund and any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund.

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ 1,920,270.00	$ 1,958,675.40	$ 1,974,107.91
Total Projected County Integrated Plan Annual Planning Expenditures	$ 2,066,155.00	$ 1,948,360.10	$ 1,887,327.30
New and Ongoing Administrative Costs	$ 300,000.00	$ 306,000.00	$ 312,120.00
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 257,834,844.00	$ 207,834,844.00	$ 235,334,844.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	0.7%	0.9%	0.8%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	0.8%	0.9%	0.8%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -

Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

References
1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision.

Instructions

Counties shall report their estimated local prudent reserve maximums for each allocation component in Tab Nine.

Rows 18-19: dollar amounts will be auto-populated from Tab 4 rows 133-134.

Row 20: total excess prudent reserve dollars will be auto-populated from rows 18-19.

Rows 21-23: total dollar amounts will be auto-populated from Tab 4, rows 136-138.

Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21-23.

Row 25: auto-validates from rows 20 and 24 to check if the county has "No Excess" or if county must "Reduce Excess" prudent reserve.

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations across all plan years will be auto-populated from Tab 5 row 67, Tab 6 row 43, and Tab 7 row 49.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations across all plan years will be auto-populated from Tab 5 row 40, Tab 6 row 25, and Tab 7 row 27.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 24,217,189.00
Local Prudent Reserve Maximum (1)	$ 34,833,835.59
Excess Prudent Reserve Funds (auto-populated)	$ (10,616,646.59)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -

References
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).

Instructions

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 43, 49, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26.

Rows 36, 44, and 52: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Rows 38, 46, and 54: estimated total available funding will be auto-populated from rows 35-37, 43-45 and 51-53.

Rows 39, 47, and 55: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 67; Tab 6, row 43; and Tab 7, row 49.

Rows 40, 48, and 56: estimated expenditures for each component will be auto-populated from Tab 5, row 70; Tab 6, row 46; and Tab 7, row 52.

Rows 45 and 53: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.

Rows 59-61: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	Full-Service Partnerships	Behavioral Health Services and Supports	Total
Year One				
Allocation Percentage, with Transfers	23%	39%	38%	100%
Component Allocations	$ 44,927,014.00	$ 76,180,589.00	$ 74,227,241.00	$ 195,334,844.00
Year Two				
Allocation Percentage, with Transfers	27%	37%	36%	100%
Component Allocations	$ 52,740,408.00	$ 72,273,892.00	$ 70,320,544.00	$ 195,334,844.00
Year Three				
Allocation Percentage, with Transfers	27%	37%	36%	100%
Component Allocations	$ 52,740,408.00	$ 72,273,892.00	$ 70,320,544.00	$ 195,334,844.00

BHSA Funding Summary (Year One)				
	Housing Interventions (Year One)	Full Service Partnerships (Year One)	Behavioral Health Services and Supports (Year One)	Year One Totals
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 44,927,014.00	$ 76,180,589.00	$ 74,227,241.00	$ 195,334,844.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ -	$ 25,000,000.00	$ 37,500,000.00	$ 62,500,000.00
Estimated Total Available Funding for Year One	$ 44,927,014.00	$ 101,180,589.00	$ 111,727,241.00	$ 257,834,844.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 44,225,982.21	$ 83,470,144.36	$ 93,829,884.00	$ 221,526,010.57

BHSA Funding Summary (Year Two)				
	Housing Interventions (Year Two)	Full Service Partnerships (Year Two)	Behavioral Health Services and Supports (Year Two)	Year Two Totals
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 52,740,408.00	$ 72,273,892.00	$ 70,320,544.00	$ 195,334,844.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 701,031.79	$ 17,710,444.64	$ 30,397,357.00	$ 48,808,833.43
Estimated Total Available Funding for Year Two	$ 53,441,439.79	$ 89,984,336.64	$ 100,717,901.00	$ 244,143,677.43
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 52,100,024.34	$ 71,396,329.02	$ 81,966,699.17	$ 205,463,052.53

BHSA Funding Summary (Year Three)				
	Housing Interventions (Year Three)	Full Service Partnerships (Year Three)	Behavioral Health Services and Supports (Year Three)	Year Three Totals

Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 52,740,408.00	$ 72,273,892.00	$ 70,320,544.00	$ 195,334,844.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 1,341,415.45	$ 18,588,007.62	$ 58,751,201.83	$ 78,680,624.90
Estimated Total Available Funding for Year Three	$ 54,081,823.45	$ 90,861,899.62	$ 129,071,745.83	$ 274,015,468.90
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 50,509,966.82	$ 76,069,213.49	$ 89,013,288.58	$ 215,592,468.89

BHSA Plan Admin Expenses

Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	$ 1,920,270.00	$ 1,958,675.40	$ 1,974,107.91	$ 5,853,053.31
Total Projected County Integrated Plan Annual Planning Expenditures	$ 2,066,155.00	$ 1,948,360.10	$ 1,887,327.30	$ 5,901,842.40
Total Projected New and Ongoing Administrative Expenditures	$ 300,000.00	$ 306,000.00	$ 312,120.00	$ 918,120.00

Budget Template Updates			
Version	**Revision Date**	**Description of Changes**	**Effective Date of Change**
2.0	10/25/2025	Tab 10 (BHSA Summary): Formula updated to avoid double counting of MHSA unspent carryover funds.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): EI Threshold calculation should exclude MHSA transferred WET and CFTN funds as they are exempt from suballocation requirements, formula revised to remove WET and CFTN. Added a BHSS transfer to WET/CFTN for reversion tracking	10/25/2025
2.0	10/25/2025	Tab 8 (BHSA Plan Admin): Updated instructions to clarify DHCS will not pre-populate data for "Total Projected Annual Revenues of BHSF". Counties must enter in the data.	10/25/2025
2.0	10/25/2025	Tab 5, 6, 7 (BHSA Conponents): Added unspent MHSA funds row for year 1, 2 and 3.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): Added separate rows for unspent MHSA WET/CFTN expenditures.	10/25/2025
2.0	10/25/2025	Tabs 1-10: Fixed formula and instruction errors	10/25/2025
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added Year 2 and Year 3 for exemption requests	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added validation check for funding transfers	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added two new rows for unspent MHSA “Encumbered” INN Funds and unspent MHSA “Unencumbered” INN Funds.	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Moved transfers from prudent reserve into the BHSA component funding section to be included with total revenue	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026

3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Added a row for projected MHSA "Encumbered" INN Project expenditures.	2/18/2026
3.0	2/18/2026	Tab 5 (Housing Interventions): Removed projected encumbered MHSA INN fund expenditures from the 50% HI funds dedicated to chronically homeless suballocation requirement calculation.	2/18/2026
3.0	2/18/2026	Tab 7 (BHSS): Removed projected encumbered MHSA INN fund expenditures from the 51% BHSS funds dedicated to Early Intervention suballocation requirement calculation	2/18/2026
3.0	2/18/2026	Tab 8 (BHSA Plan Admin): Updated to include a validation check for "Improvement and Monitoring" (2% or 4%) and "Planning" (5%)	2/18/2026
3.0	2/18/2026	Tab 9 (Prudent Reserve Assessment): Updated PR validation checks to "No Excess" or "Reduce Excess"	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Included component percentage breakdowns for all three years	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Include total administrative and planning expenditures from tab 8	2/18/2026

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 Certification Template 1 (3).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
DHCS Certification - JVW 2026.03.17.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

SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM: 3.36
(ID # 30512)
MEETING DATE:
Tuesday, June 02, 2026

FROM : RUHS-BEHAVIORAL HEALTH

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM - BEHAVIORAL HEALTH: Adopt the Behavioral Health Services Act (BHSA) Integrated Plan (IP), All Districts. [Total Cost $0]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Adopt the Behavioral Health Services Act (BHSA) Integrated Plan (IP) for Fiscal Year 26/27 - 28/29;

2. Authorize the Chair of the Board of Supervisors to sign the attached DHCS County Portal Board of Supervisor Certification Form; and

3. Authorize the Riverside County Behavioral Health Director, or designee, to submit the plan to the California Department of Health Care Services (DHCS) and make any necessary corrections, clarifications, and modifications that do not change the intent of the plan.

ACTION:Policy

Matthew Chang
Matthew Chang, Director 5/15/2026

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Medina, seconded by Supervisor Gutierrez and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Medina, Spiegel, Washington, Perez, and Gutierrez
Nays:	None
Absent:	None
Date:	June 2, 2026
xc:	RUHS-BH

Kimberly A. Rector
Clerk of the Board
By: _____
Deputy

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$0	$0	$0	$0
NET COUNTY COST	$0	$0	$0	$0

SOURCE OF FUNDS: N/A	**Budget Adjustment:** No
	For Fiscal Year: 26/27-28/29

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

In March 2024, California voters approved Proposition 1, which included the Behavioral Health Services Act, a transformation of the Mental Health Services Act (MHSA), which takes effect July 1, 2026. BHSA continues to be funded through a 1% tax on individuals earning over $1 million annually. Recent statewide efforts to modernize behavioral health funding through the Behavioral Health Services Act (BHSA) build upon MHSA's framework and emphasize increased accountability, transparency, and alignment of resources to address homelessness, serious mental illness, and substance use disorders.

Pursuant to California Welfare & Institutions Code Sections 5847–5848 and Title 9 of the California Code of Regulations, Section 3310, counties are required to develop and submit a Three-Year Behavioral Health Services Act (BHSA) Plan, followed by Annual Updates.

The FY26/27 BHSA Three-year plan highlights Riverside University Health System – Behavioral Health's (RUHS-BH) continued efforts to expand and improve behavioral health services across Riverside County. The goal of BHSA is to modernize how California funds and delivers behavioral health care. It shifts the focus to treating behavioral health as specialty care and aims to create a more integrated, coordinated system that meets people where they are and provides care that is timely and culturally responsive.

Therefore, the Riverside County Board of Supervisors is requested to adopt the FY26/27-28/29 BHSA Three-Year Plan to meet state requirements and authorize its submission to DHCS, supporting the continued enhancement of behavioral health services in Riverside County.

Impact on Residents and Businesses

These services are a component of the Department's system of care, aimed at improving the health and safety of the communities of Riverside County. BHSA services target the most vulnerable individuals with chronic and severe mental illness with the goal of providing high quality evidence-based care to support their continued productive involvement in community while reducing burdens on healthcare, justice, and crisis systems.

Additional Fiscal Information

No funds are required to adopt the BHSA Plan update.

Attachments

Attachment A.	Board of Supervisors Certification Signature Form
Attachment B.	BHSA Executive Brief Link: https://www.ruhealth.org/behavioral-health/BHSA
Attachment C.	BHSA Executive Brief (hardcopy)
Attachment D.	BHSA Integrated Plan

Jacqueline Ruiz

Jacqueline Ruiz, Principal Analyst 5/27/2026

DHCS | County Portal

Board of Supervisors Certification

Certification

1. County of Riverside Board of Supervisors certifies the following:

   ☑ County of Riverside Board of Supervisors has reviewed and approved this Integrated Plan for the period of [2026-2029]

   ☑ 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

   KAREN SPIEGEL

4. Title

   CHAIR, BOARD OF SUPERVISORS

JUN 0 2 2026 3.36

5. Date

JUN 0 2 2026

6. Signature

Karen S. Spiegel

COUNTY COUNSEL:
Approved as to form
By: Gregg Gu
Deputy County Counsel

ATTEST:
KIMBERLY A. RECTOR, Clerk
By _____ DEPUTY

JUN 0 2 2026 3.36

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County Administrator or Designee Certification

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

Certification

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

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

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

Signature

3. Print name
   Jeffrey A. Van Wagenen, Jr.
4. Date
   March 17, 2026
5. Signature
   Jeffrey A. Van Wagenen, Jr. Digitally signed by Jeffrey A. Van Wagenen, Jr. Date: 2026.03.17 16:07:22 -07'00'

Contact information

6. County Name
   Riverside
7. Certification for
   - (•) Three-Year Integrated Plan
   - ( ) Annual Update
8. County Chief Administration Officer Name
   Jeffrey A. Van Wagenen, Jr.
9. County Chief Administration Officer Phone number
   951-955-1110
10. County Chief Administration Officer Email
    jvanwagenen@rivco.org

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Behavioral Health Director Certification

Certification

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

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

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

   - ○ Yes
   - ◉ No

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

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County Behavioral Health Agency Director contact information

3. County Name
   Riverside
4. Certification for
   - (•) Three-Year Integrated Plan
   - ( ) Annual Update
5. County Behavioral Health Agency Director name
   Matthew Chang, MD, MMM, Director
6. County Behavioral Health Agency Director phone number
   9513584501
7. County Behavioral Health Agency Director email
   matthew.chang@ruhealth.org, sdvargas@ruhealth.org (Executive Assistant to Dr. Chang)

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

Matthew Chang, MD, MMM, Director

13. Title

Director of Behavioral Health - County of Riverside

14. Date

3/17/2026

15. Signature

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

16. Print name

17. Title

18. Date

19. Signature

Please upload the completed Board of supervisor certification template

26.27-28.29 BHSA Integrated Plan - Board Cert.pdf

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

Requests

Funding Transfer Request

Please enter the proposed allocation adjustments to the tables below

	Plan year one	**Plan year two**	**Plan year three**
Behavioral Health Services and Supports (Base 35%)	38	36	36
Full Service Partnership (Base 35%)	39	37	37
Housing Intervention (Base 30%)	23	27	27
Housing Interventions for Outreach and Engagement	0	0	0

Behavioral Health Services and Supports Transfers

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

	Plan year one	Plan year two	Plan year three
Dollars transferred from Full Service Partnerships	0	0	0
Dollars transferred from Housing Intervention	5860045	1914447	1892103
Dollars transferred into Full Service Partnerships	0	0	0
Dollars transferred into Housing Intervention	0	0	0

For Behavioral Health Services and Supports, please include a rationale for the funding allocation transfer request

Revisions to funding allocations under the Behavioral Health Services Act (BHSA) have resulted in a net reduction in funding for the programs included in this component. Despite these reductions, RUHS–Behavioral Health remains firmly committed to sustaining critical services to the greatest extent possible. The proposed transfer of funds is a strategic investment to support the systemwide transition to BHSA by enabling programs to meet new regulatory requirements and expand Medi-Cal billing capacity,

thereby strengthening long-term fiscal stability. In addition, housing outreach activities are administered within the Behavioral Health Services and Supports (BHSS) component under Outreach and Engagement; this transfer will also ensure the continued support of these essential services.

Full Service Partnership Transfers

Enter the proposed dollars transferred into/from Full Service Partnerships (Base 35 percent)

	Plan year one	**Plan year two**	**Plan year three**
Dollars transferred from Behavioral Health Services and Supports	0	0	0
Dollars transferred from Housing Intervention	7813394	3828894	3784206
Dollars transferred into Behavioral Health Services and Supports	0	0	0

	Plan year one	Plan year two	Plan year three
Dollars transferred into Housing Intervention	0	0	0

For Full Service Partnership, please include a rationale for the funding allocation transfer request

The changes in funding allocation under BHSA have resulted in a reduction in total funding for the programs included in this component. RUHS-BH is committed to maintaining as many services as possible, and the transfer of funds will support the transition to BHSA by assisting programs as they navigate new regulatory requirements and expand Medi-Cal billing to ensure long-term sustainability.

Housing Interventions Transfers

Enter the proposed dollars transferred into/from Housing Interventions (Base 30 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Behavioral Health Services and Supports	0	0	0

	Plan year one	Plan year two	Plan year three
Dollars transferred from Full Service Partnerships	0	0	0
Dollars transferred into Behavioral Health Services and Support	5860045	1914447	1892103
Dollars transferred into Full Service Partnerships	7813394	3828894	3784206

For Housing Intervention, please include a rationale for the funding allocation transfer request

RUHS-BH plans to leverage BHSA funding in combination with grant dollars to support the development of the new Mead Valley Wellness Village. The Wellness Village will provide outpatient and residential services for mental health and substance use disorders, primary healthcare, and behavioral health urgent care. It will serve children, youth, families, veterans, and other priority populations, and will house the first behavioral health urgent care center for children in Riverside County. The facility is scheduled to open in 2027; therefore, funding to support its operations will be needed in years one, two and three of this three-year plan, as the programs work towards full implementation. As a result, transferring funds allows resources to be more effectively utilized within the BHSS component during the initial planning period. Additionally worth noting, despite this funding transfer, RUHS-BH will be funding more housing in this next three-year plan than ever before. Starting in FY26/27 RUHS-BH will have 430 additional housing beds available through several initiatives such as Mead Valley Wellness Village and other transitional housing locations.

Supporting Information and Data

How does the funding transfer request respond to community needs and input?

Stakeholders provided thoughtful feedback regarding the proposed transfer of funds during the BHSA transition, with many expressing support for temporary flexibility if it helps sustain existing programs and prevent service disruptions as the new structure is implemented. Respondents emphasized the importance of maintaining critical services, including mobile crisis response, prevention and early intervention efforts, school-based mental health programs, and community-based outreach and navigation services. At the same time, some stakeholders raised concerns about potential reductions in housing investments, underscoring that housing instability remains a significant barrier to recovery for individuals receiving behavioral health services. Many recommended ensuring that housing and behavioral health services remain closely aligned, with any temporary funding transfers accompanied by ongoing monitoring and evaluation. Additional input highlighted the need to strengthen partnerships with schools and community-based organizations, enhance culturally responsive care, support workforce retention, and ensure clear outcomes and accountability for funded programs. Overall, stakeholders stressed maintaining continuity of care and protecting access for vulnerable populations as the county pursues a strategic, time-limited transfer of funds from the Housing component to FSP and BHSS to support BHSA implementation, expand Medi-Cal billing capacity, and promote long-term fiscal stability. Importantly, despite this transfer, the county will expand its housing investments over the next three-year plan, with plans to add 430 new housing beds beginning in FY 2026–27 through initiatives such as Mead Valley Wellness Village and other transitional housing developments.

Please include local data supporting the funding transfer request

Funding Transfers community feedback.pdf