Health, Housing &
Community Services Department
Mental Health Division - Administration

Greetings!

Your input and comments are invited on the City of Berkeley, Draft Behavioral Health Services Act (BHSA) Fiscal Years (FY) 2026/2027 – 2028/2029 Three Year Integrated Plan which has been posted on the website for a 30-day Public Review and comment period. The 30-day Public Review period is being held from Wednesday, March 25th through Thursday, April 23rd to provide the opportunity for input on BHSA funding and programming. If you would like to provide input on this Three Year Plan, please respond by **5:00pm on Thursday, April 23rd.**

You can directly send your feedback via email or phone to:
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MHSA Coordinator
City of Berkeley Mental Health
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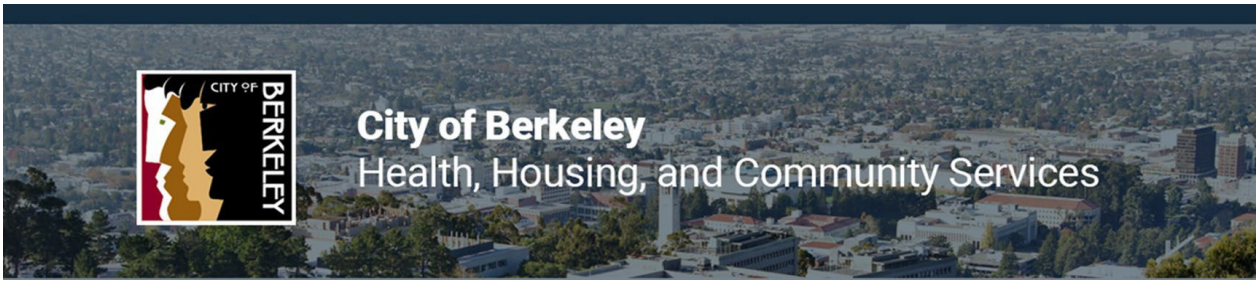
Immediately following the end of the 30-Day Public Review period, a Public Hearing will be held at 7:00pm on Thursday, April 23rd during the Behavioral Health Commission meeting which will be held at the North Berkeley Senior Center, 1901 Hearst Ave., Berkeley.

I want to take this opportunity to thank everyone who provided input during the planning for this BHSA Integrated Plan. Your valuable input was used to inform priorities in this first BHSA Integrated Plan and will be retained and revisited for current and future programming strategies and needs.



City of Berkeley Behavioral Health Services Act (BHSA)

FY26/27 – 28/29

Draft Integrated Plan

City of Berkeley
Draft BHSA FY26/27 – 28/29 Integrated Plan
Table of Contents

2026 - 2029 Integrated Plan

City of Berkeley

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

County, City, Joint Powers, or Joint Submission
City

Entity Name
City of Berkeley

Behavioral Health Agency Name
City of Berkeley, Department of Health, Housing & Community Services, Mental Health Division

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Quality Assurance or Quality Improvement (QA/QI) lead

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Yvette Katuala	YKatuala@berkeleyca.gov

Medical Director

Name	Email address
Jeff Johns	JJohns@berkeleyca.gov

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).

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). 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)	86
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	<11*
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	N/A
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	N/A
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	<11*

Criteria	Number of Children and Youth Under Age 21
Were chronically homeless or experiencing homelessness or at risk of homelessness	<11*
Were in the juvenile justice system	<11*
Have reentered the community from a youth correctional facility	<11*
Were served by the Mental Health Plan and had an open child welfare case	<11*
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	N/A
Have received acute psychiatric care	<11*

* Values marked with "*" have been suppressed per DHCS de-identification standards. Counts between 1–10 are displayed as "<11"

Adults and Older Adults

In the table below, please report the number of adults and older adults (21and 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	198
Received Medi-Cal SMHS	362
Received DMC or DMC-ODS services	18
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	18
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	173
Experienced unsheltered homelessness	70
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	17

Criteria	Number of Adults and Older Adults
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	17
Were in the justice system (on parole or probation and not currently incarcerated)	24
Were incarcerated (including state prison and jail)	43
Reentered the community from state prison or county jail	41
Received acute psychiatric services	48

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

Admitted or detained for 72-hour evaluation and treatment rate
0

Admitted for 14-day and 30-day periods of intensive treatment
N/A

Admitted for 180-day post certification intensive treatment
N/A

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

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

N/A

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
No

Please describe the local data used during the planning process
The local data used was from the FY23/24 timeframe.

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.

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.

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?
No

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.

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
Same

For children/youth
Same

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

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

How does your county status compare to the statewide rate?
For adults/older adults
Below

For children/youth
Below

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

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

How does your county status compare to the statewide rate?
For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

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

How does your county status compare to the statewide rate?
For adults/older adults
Same

For children/youth
Same

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

Access to care: Supplemental Measures

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

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

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

Access to care: Disparities Analysis
For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis.

Berkeley's Local Data:
In FY24-25, Berkeley Mental Health served 466 individuals through Specialty Mental Health Services (SMHS), including 94 children and youth and 372 adults and older adults. These service counts represent local service engagement within the Medi-Cal population residing in Berkeley, highlighting the population potentially eligible for specialty behavioral health services. Youth service utilization is generally proportional to the size of the youth Medi-Cal population. Children and youth represent approximately 21% of the

Medi-Cal population in Berkeley and account for approximately 20% of SMHS clients served. Adults and older adults represent approximately 79% of the Medi-Cal population and account for approximately 80% of SMHS clients served. Overall, Berkeley service distribution is aligned with population need. In general, service utilization of Berkeley Mental Health programs align with statewide SMHS penetration trends. Service utilization by race and ethnicity shows disparities in access to Specialty Mental Health Services in Berkeley.

Children and Youth (Race & Ethnicity)

Black or African American youth make up the largest share of those served with 39 youth (41%), despite representing a much smaller share of the Medi-Cal population (approximately 16%). This community appears to be overrepresented in SMHS services relative to their share of the Medi-Cal population, suggesting higher levels of service engagement or greater behavioral health needs within this population.

Hispanic or Latino and Asian or Pacific Islander youth appear to be underrepresented in SMHS services relative to their share of the Medi-Cal population. Hispanic or Latino youth account for 18 clients (19%), which is still slightly above their share of the Medi-Cal population (approximately 16%). White youth represent 12%, compared to about 22% of the Medi-Cal population. These patterns suggest that both White and Asian youth are underrepresented among those receiving services. Additionally, 20 youth (approximately 21%) are categorized as Other or Unknown, which limits the ability to fully assess disparities across all groups.

Overall, while some populations are accessing services at higher rates, others may face barriers to care. This highlights the importance of strengthening culturally responsive outreach, language access, and early engagement strategies to ensure more equitable access to services.

Adults and Older Adults (Race & Ethnicity Disparities)

White adults represent a larger portion of those served, with 158 clients (42%), compared to approximately 22% of the Medi-Cal population, suggesting higher levels of engagement relative to population size. Adults identifying as Black or African American

also represent a high number among SMHS clients relative to their share of the Medi-Cal population, accounting for 151 clients (41%), significantly higher share of the Medi-Cal population (approximately 16%).

Conversely, Hispanic or Latino adults represent only 15 clients (4%), despite accounting for approximately 16% of the Medi-Cal population. Asian adults represent 24 clients (6%) compared to about 10% of the population. These patterns indicate that both

Latino and Asian adults are underrepresented in service utilization.

A smaller number of clients are identified as Other or Unknown (approximately 14% combined), which may reflect limitations in demographic reporting. These findings suggest that while Berkeley Mental Health programs are effectively reaching some populations, there are clear gaps in access for others. Addressing these disparities will require continued focus on culturally responsive services, targeted outreach, and strengthening pathways to care for underserved communities.

Age Groups

Children and Youth (Ages 0–20):

In FY24-25, Berkeley Mental Health served 94 children and youth. Service utilization is heavily concentrated among adolescents. Youth ages 13–17 accounted for 64% of clients served, followed by ages 6–12 (19%) and transition-age youth (18–20, captured within the 18–25 category) at approximately 16%. These patterns suggest that adolescents are more likely to access specialty mental health services, while younger children may be underrepresented in service utilization which may reflect barriers related to early identification, referral pathways, and caregiver and family engagement. Overall, this data highlights the importance of strengthening early childhood screening and intervention, expanding school-based and adolescent-focused services, and improving transition planning for youth aging into adult systems of care.

Adults and Older Adults (Ages 21+)

In FY24-25, Berkeley Mental Health served 372 adults and older adults, representing approximately 2% of the Medi-Cal eligible adult population (ages 21+). Service utilization is distributed across age groups, with higher concentrations among middle-aged and older adults. Individuals ages 60–69 accounted for 24% of clients served, followed by ages 40–49 (22%) and ages 50–59 (19%). In contrast, younger adults ages 18–29 accounted for a relatively small proportion of clients served (approximately 8% combined), suggesting lower engagement among this population. Adults ages 30–39 represented 17% of clients, while older adults ages 70+ accounted for 11%.

These patterns suggest that middle-aged and older adults are more likely to access specialty mental health services, while younger adults may be underrepresented relative to their presence in the Medi-Cal population. Overall, these findings indicate a need to strengthen outreach and engagement strategies for younger adults, while continuing to support the needs of older adults who demonstrate higher levels of service utilization. Expanding transition-age youth services, early adult intervention programs, and community-based outreach may help improve access among younger populations.

Gender

Children and Youth (Ages 0–20)

SMHS utilization among children and youth in Berkeley indicates variation in service engagement across gender identity groups. In FY24-25, female youth accounted for 48% of clients served, while male youth represented 39%. The remaining 13% of clients were distributed across categories including missing or unknown responses, including those who identified as gender non-conforming and transgender youth. These patterns suggest that female youth may be more likely to engage in specialty mental health services compared to male youth The presence of diverse youth within the system, while representing a small proportion of clients, highlights the importance of ensuring services are inclusive and responsive to diverse gender identities. Overall, these findings highlight the need to continue strengthening gender-responsive and inclusive services, including outreach strategies that engage male youth and support for gender diverse populations.

Adults and Older Adults (Ages 21+)

In FY24-25, male adults represented the largest proportion of clients served (51%), followed by female adults (39%). A smaller proportion of clients identified using pronoun-based categories and clients representing across additional gender identity categories. The presence of individuals identifying across a range of gender identities highlights the importance of maintaining culturally responsive, inclusive services. Additionally, the use of both traditional gender categories and pronoun-based reporting indicates evolving data collection practices, which may affect comparability across groups. Overall, these findings suggest the need to continue strengthening gender-responsive service delivery, including targeted outreach and engagement strategies, while also improving the consistency and completeness of gender identity data collection.

Data Findings

Service utilization among adults is broadly distributed across age groups, with higher engagement observed among middle-aged and older adults, suggesting sustained connection to care among individuals with ongoing behavioral health needs.

Equity Analysis

Analysis of demographic data indicates disparities in access to and engagement with behavioral health services across multiple population groups. Racial and ethnic disparities are evident relative to the share of the Medi-Cal population. Age-related disparities are also observed, with higher engagement among adolescents and older adults, and lower participation among young children and younger adults. These patterns suggest potential gaps in early identification of behavioral health needs and

challenges in engaging individuals during key transition periods, particularly among transition-age youth and young adults. Gender-based differences in service utilization further indicate variation in engagement across the lifespan, with female youth more likely to access services compared to male youth, while male adults are more represented among adult service populations.

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.

The Behavioral Health Statewide dataset that was provided to mental health jurisdictions to use for the BHSA Integrated Plan, did not include City specific data. As such, the Department of Health Care services (DHCS) was instructed to use Alameda Counties measures for all of the BH Statewide Data, and where possible to add in any Berkeley local data that may align with each of the six Behavioral Health Priority goals.

Alameda County's data measures are shown in the Access to Care Primary and Secondary Measures of this section. Since these measures are comprised of a combination of all the Cities within the larger County, it is not possible to evaluate how Berkeley is doing within the dataset. Berkeley specific information is reflected in the Access to Care Disparities Analysis Section, and the Cross-Measures Questions.

Access to Care (Specialty/Non-Specialty Mental Health Service Penetration) is a priority goal within all programs at Berkeley Mental Health. While Berkeley has an Access Team that serves as an entry point into the system, the City receives referrals from community partners to all level of care services and a "no wrong door approach" is embraced within all three Full Service Partnership programs. In order to strengthen the City's level of access to care, Berkeley will undergo a process with each program to assess where current practices may need to be shifted and/or new ones implemented. This process may also include evaluating the feasibility and utility of whether local data

collection measures should be added to better understand how Berkeley is doing with Access to Care goals.

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

1991 Realignment
BHSA Full Services Partnership (FSP)
BHSA Behavioral Health Services and Supports (BHSS)
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
State General Fund

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?

Above

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

Age
Gender
Race or Ethnicity
Other:
Veterans, Unaccompanied youth

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
Other: African American, Hispanic/Latino, and Pacific Islander students are overrepresented in unstable and emergency housing situations.

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?
Above

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

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?

Same

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

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
Gender
Race or Ethnicity
Sex

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.

In Berkeley, homelessness and behavioral health are deeply interconnected. The City of Berkeley Homeless Census and Survey 2024 this reality, with 43% of individuals

experiencing homelessness reporting SMI and 26% reporting SUD, underscoring the central role behavioral health plays in both the causes and consequences of homelessness. In the same report, the Point-in-Time (PIT) Count provides a snapshot of this challenge, identifying 844 individuals experiencing homelessness. More than half of those counted 445 individuals (53%) were living unsheltered, while 399 individuals (47%) were connected to shelter. Compared to Alameda County, where 67% of individuals are unsheltered, Berkeley has a lower rate suggests relatively stronger engagement with the shelter system.

Within this broader landscape, Berkeley Mental Health (BMH) offers a closer look at how individuals move through care. In FY 24-25 across its programs, BMH served 188 adults and older adults who were experiencing or at risk of homelessness. Among them, 79 individuals were living unsheltered, reflecting the level of vulnerability among those who do connect to services. As individuals engaged in care, movement toward stability included 28 individuals that transitioned from unsheltered conditions into sheltered settings, and notably, 26 ultimately secured permanent housing. These outcomes demonstrate that when individuals are connected to services and housing pathways, meaningful progress toward stability is possible.

For children and youth, the number of those experiencing or at risk of homelessness remains fewer than 11. While small, this group reflects ongoing housing instability among youth and families and points to the importance of early intervention and prevention.

Data Comparison

Taken together, the PIT Count and BMH data reflect the reality that many individuals experiencing homelessness, particularly those who are unsheltered, are not yet connected to behavioral health services. At the same time, BMH data reveals what happens once individuals do enter care. Across active clients, a majority are connected to housing or shelter through the Homeless Management Information System (HMIS), suggesting strong alignment with coordinated entry and housing pathways.

Disparities

The PIT count data shows that Black or African American individuals make up 43% of the homeless population, a disproportionate share relative to the general population. Age patterns also tell an important story. Homelessness in Berkeley is most concentrated among adults ages 25 to 64, particularly those ages 35–44 and 55–64, where the largest shares are observed. Younger individuals are less visible in the data youth under 18 account for just 4% but this likely reflects differences in how homelessness presents, often within family systems rather than as unsheltered homelessness. Meanwhile, older adults (65+) account for 12.2%, pointing to signs of vulnerability among aging populations.

Programs Addressing Homelessness

BMH plays a key role within the City's broader continuum of care by supporting individuals at multiple points along their housing journey. Through outreach, field-based teams engage individuals where they are, and BMH partners help individuals move toward stability.

Key Takeaway

Berkeley's behavioral health system is effective in connecting engaged clients to housing and supporting positive outcomes, a significant portion of individuals experiencing homelessness particularly those who are unsheltered remain outside of care. Together, these data points reflect a system that is both functioning and strained. BMH demonstrates clear strengths, once individuals are connected to care, they are frequently linked to housing resources, and outcomes such as the transition into permanent housing show that the system can effectively support movement toward stability. The PIT Count highlights a persistent front-end challenge. Many individuals, particularly those who are unsheltered, remain outside of the system entirely. The presence of 79 unsheltered individuals, even among those already connected to services, further underscores the difficulty of engaging individuals with the highest needs. This suggests that there is more opportunity for improvement in how individuals are reached, connected, and brought into care in the first place.

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).

Alameda County's data measures are shown in the Homelessness Primary and Secondary Measures of this section. Since these measures are comprised of a combination of all the Cities within the larger County, it is not possible to evaluate how Berkeley is specifically doing within the dataset. Berkeley specific information is reflected in the Homelessness Disparities Analysis Section, and the Cross-Measures Questions.

Berkeley is planning to strengthen its collaboration with Alameda County's regional housing collaborative, including the coordination between FSP programs and County flex pool run by Abode Services. Combined with the intensive, wraparound services of

FSP's, Berkeley aims to improve its housing retention rates.Berkeley sponsored and is awaiting California's update to AB210, which will now include Local Health Jurisdictions (like Berkeley) in its ability to establish a homeless multidisciplinary team to share information and support individuals who are unhoused, whereas the previous legislation only allowed this function to be performed by a County. Not only does Berkeley participate in the Alameda County MDT meeting regarding high utilizers of services, but it also has historically held its own with local providers. With the AB210 update, coordination and communication will be strengthened between local providers to support the Berkeley community and its residents in using lowest levels of appropriate care and avoiding unnecessary homelessness, institutionalization, and justice involvement whenever possible.

A three-year Prop 47 grant is being leveraged to stand up Berkeley CareBridge, a diversion program designed to support stabilization of justice involved individuals with mental health, SUD, housing, and supportive service needs. This will help address homelessness, institutionalization, and justice-involvement for the most vulnerable in our community.

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

BHSA Housing Interventions
BHSA
FSP
BHSA
BHSS
1991 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
Other: Prop. 47 Funds

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?

Age
Gender
Race or Ethnicity
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
Above

30-day involuntary detention rates per 10,000
Below

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

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
Above

Permanent Conservatorships
Below

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

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 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
Above

For children/youth
Above

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

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.

Berkeley does not have any local data on Institutionalization.

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)
N/A

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).

The Behavioral Health Statewide dataset that was provided to mental health jurisdictions to use for the BHSA Integrated Plan, did not include City specific data. As such, the Department of Health Care services (DHCS) was instructed to use Alameda Counties measures for all of the BH Statewide Data, and where possible to add in any Berkeley local data that may align with each of the six Behavioral Health Priority goals.

Alameda County's data measures are shown in the Institutionalization Primary and Secondary Measures of this section. Since these measures are comprised of a combination of all the Cities within the larger County, it is not possible to evaluate how Berkeley is doing within the dataset. Berkeley specific information is reflected in Institutionalization Disparities Analysis Section, and the Cross-Measures Questions.

Berkeley is looking to strengthen partnerships with local MCP's Alameda Alliance and Kaiser, leaning on options such as Enhanced Care Management (ECM) as a cross-collaborative tool to keep bringing CalAIM alternatives to the table first and foremost, promoting community supports as alternatives to institutionalization whenever possible and appropriate.

A three-year Prop 47 grant is being leveraged to stand up Berkeley CareBridge, a diversion program designed to support stabilization of justice involved individuals with

mental health, SUD, housing, and supportive service needs. This will help address homelessness, institutionalization, and justice involvement for the most vulnerable in our community.

Berkeley sponsored and is awaiting California's update to AB210, which will now include Local Health Jurisdictions (like Berkeley) in its ability to establish homeless multidisciplinary team (MDT) to share information and support individuals who are unhoused, whereas the previous legislation only allowed this function to be performed by a County. Not only does Berkeley participate in the Alameda County MDT meeting regarding high utilizers of services, but it also has historically held its own with local providers. With the AB210 update, coordination and communication will be strengthened between local providers to support the Berkeley community and its residents in using lowest levels of appropriate care and avoiding unnecessary homelessness, institutionalization, and justice involvement whenever possible.

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

BHSA BHSS
BHSA FSP
1991 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
State General Fund
Other: Prop. 47 Funds

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 - N/A

For juveniles
Below

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

Age
Gender
Race or Ethnicity
Sex

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?
Below

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

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?
Other

Please describe other.
The metric means that fewer individuals in Alameda County are being determined to be incompetent to Stand Trial under DSH funded Hospitals. This could mean that Alameda County has strong diversion practices, behavioral health interventions and differences in determining who is unfit to stand trial.

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.

<u>Berkeley local data on Justice-Involvement:</u>
Within the Berkeley Mental Health system of care:

- 21 individuals were involved in the justice system (on parole or probation, not currently incarcerated)
- 42 individuals were incarcerated (state prison or county jail)
- 39 individuals reentered the community from incarceration

Berkeley-specific system data reveals a continued concentration of justice involvement

within the behavioral health population, particularly among those with complex needs (e.g., co-occurring disorders, homelessness, or limited service engagement). This suggests that even within a comparatively lower-rate county, BMH clients remain disproportionately impacted.

Disparities

While Berkeley-specific demographic breakdowns for justice involvement are limited, broader system data mirror patterns observed across Alameda County behavioral health data, reinforcing the need for culturally responsive and equity-centered interventions.

A portion of the BMH population is cycling between incarceration, community supervision, and reentry, with nearly double the number of individuals incarcerated (42) compared to those on probation/parole (21). A volume of reentry (39 individuals), indicating ongoing system churn. This pattern may suggest both ongoing justice involvement among individuals with behavioral health needs, and a system opportunity (reentry as a critical intervention point). Reentry, in particular, represents a high-leverage moment where coordinated behavioral health services can interrupt recidivism and improve long-term outcomes.

Diversion Programs

Consistent with BHSA priorities, Berkeley's system emphasizes diversion from incarceration into treatment, including:

- Crisis response services (e.g., mobile crisis)
- Field-based engagement
- Connections to outpatient and Full Service Partnership (FSP) programs

These approaches align with statewide goals to reduce unnecessary law enforcement involvement for individuals with behavioral health conditions.

Reentry Services

The data reflects a significant reentry population (39 individuals), underscoring the importance of care coordination upon release, linkage to housing and behavioral health services, establishment of continuity of care.

Future Strategies

Berkeley's data reflects both progress at the county level and ongoing challenges within the behavioral health population, reinforcing the need for continued investment in diversion, reentry, and equity-driven strategies to reduce justice system involvement over time.

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).

The Behavioral Health Statewide dataset that was provided to mental health jurisdictions to use for the BHSA Integrated Plan, did not include City specific data. As such, the Department of Health Care services (DHCS) was instructed to use Alameda Counties measures for all of the BH Statewide Data, and where possible to add in any Berkeley local data that may align with each of the six Behavioral Health Priority goals.

Alameda County's data measures are shown in the Justice Involvement Primary and Secondary Measures of this section. Since these measures are comprised of a combination of all the Cities within the larger County, it is not possible to evaluate how Berkeley is doing within the dataset. Berkeley specific information is reflected in the Justice Involvement Disparities Analysis Section, and the Cross-Measures Questions. Berkeley is looking to strengthen partnerships with local MCP's Alameda Alliance and Kaiser, leaning on options such as Enhanced Care Management (ECM) as a cross-collaborative tool to keep bringing CalAIM alternatives to the table first and foremost, promoting community supports as alternatives to justice involvement whenever possible and appropriate.

A three-year Prop 47 grant is being leveraged to stand up Berkeley CareBridge, a diversion program designed to support stabilization of justice involved individuals with mental health, SUD, housing, and supportive service needs. This will help address homelessness, institutionalization, and justice involvement for the most vulnerable in our community.

Berkeley sponsored and is awaiting California's update to AB210, which will now include Local Health Jurisdictions (like Berkeley) in its ability to establish homeless multidisciplinary team (MDT) to share information and support individuals who are unhoused, whereas the previous legislation only allowed this function to be performed by a County. Not only does Berkeley participate in the Alameda County MDT meeting regarding high utilizers of services, but it also ha
s historically held its own with local providers. With the AB210 update, coordination and communication will be strengthened between local providers to support the Berkeley community and its residents in using lowest levels of appropriate care and avoiding unnecessary homelessness, institutionalization, and justice involvement whenever possible.

Please identify the category or categories of funding that the county is using to address the justice-involvement goal:

BHSA BHSS
BHSA FSP
1991 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
State General Fund
Other: Prop. 47 Funds

Removal Of Children from Home: Primary Measures

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

How does your county status compare to the statewide rate?

Below

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

Age
Sex
Gender

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?

Above

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

Age
Race or Ethnicity
Sex

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?

Below

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

Age
Race or Ethnicity
Gender
Sex

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.

Berkeley does not have any local data on Removal of Children from their Home.

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.

The Behavioral Health Statewide dataset that was provided to mental health jurisdictions to use for the BHSA Integrated Plan, did not include City specific data. As such, the Department of Health Care services (DHCS) instructed City of Berkeley to use Alameda Counties measures for all of the BH Statewide Data, and where possible to add in any Berkeley local data that may align with each of the six Behavioral Health Priority goals.

Alameda County's data measures are shown in the Removal of Children From Their Home Primary and Secondary Measures of this section. Since these measures are comprised of a combination of all the Cities within the larger County, it is not possible to evaluate how Berkeley is doing within the dataset. Berkeley specific information is reflected in the Removal of Children from Their Home Disparities Analysis Section, and the Cross-Measures Questions.

City of Berkeley is strengthening and revamping its Children's FSP model, shifting staffing resources as well as High Fidelity Wraparound (HFW) model standards. While this team has historically treated the entire the family as a unit, the goal will be to bring more staff, collaboration with community resources, Early Intervention services, and connection to housing partners to the equation. As mentioned previously, leaning into collaborations with MCP partners such as Alameda Alliance is one of the planned strategies, supporting the Family Path model to explore resources to protect the household unit, stabilize the environment, and support tenancy sustaining services.

Please identify the category or categories of funding that the county is using to address the removal of children from home goal:
BHSA FSP

BHSA BHSS
1991 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
State General Fund

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
Same

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

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

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

For the full population measured
Above

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

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?
Age
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,

Berkeley does not have any local data on Untreated Behavioral Health Conditions.

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).

The Behavioral Health Statewide dataset that was provided to mental health jurisdictions to use for the BHSA Integrated Plan, did not include City specific data. As such, the Department of Health Care Services (DHCS) instructed City of Berkeley to use Alameda

Counties measures for all of the BH Statewide Data, and where possible to add in any Berkeley local data that may align with each of the six Behavioral Health Priority goals.

Alameda County's data measures are shown in the Untreated BH Conditions Primary and Secondary Measures of this section. Since these measures are comprised of a combination of all the Cities within the larger County, it is not possible to evaluate how Berkeley is doing within the dataset. Berkeley specific information is reflected in the Unteated BH Conditions Disparities Analysis Section, and the Cross-Measures Questions.

Berkeley is looking to strengthen partnerships with local MCP's Alameda Alliance and Kaiser, leaning on options such as Enhanced Care Management (ECM) as a cross-collaborative tool to keep bringing CalAIM alternatives to the table first and foremost, promoting community supports as alternatives to institutionalization whenever possible and appropriate. Berkeley is broadening its SUD services through current partners, expanding current SUD care to the public high schools. The outreach and linkage services will continue to be grown and developed to bring more underserved community members into services through the Mobile Encampment Wellness Center and the Homeless Response Team.

A three-year Prop 47 grant is being leveraged to stand up Berkeley CareBridge, a diversion program designed to support stabilization of justice involved individuals with mental health, SUD, housing, and supportive service needs. This will help address homelessness, institutionalization, and justice involvement for the most vulnerable in our community.

Berkeley sponsored and is awaiting California's update to AB210, which will now include Local Health Jurisdictions (like Berkeley) in its ability to establish a homeless disciplinary team (MDT) to share information and support individuals who are unhoused, whereas the previous legislation only allowed this function to be performed by a County. Not only does Berkeley participate in the Alameda County MDT meeting regarding high utilizers of services, but it also has historically held its own with local providers. With the AB210 update, coordination and communication will be strengthened between local providers to support the Berkeley community and its residents in using lowest levels of appropriate care and avoiding unnecessary homelessness, institutionalization, and justice involvement whenever possible.

Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal:
BHSA BHSS
BHSA FSP
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
1991 Realignment
Other: Prop. 47 Funds

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
Same

Quality Domain Score (Treatment Perception Survey), 2024

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

For adults/older adults
Above

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?
Same

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?
Below

Overdoses: Primary Measures

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

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

For the full population measured
Below

For adults/older adults
Below

For children/youth
Below

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
Below

For adults/older adults
Below

For children/youth
Below

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)
Same

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

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

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

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

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

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

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

For the full population measured
Same

For adults/older adults
Same

For children/youth
Same

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
Same

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
Same

For adults/older adults
Same

For children/youth
Same

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides: Primary Measures

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?
For the full population measured
Below

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
Below

For adults/older adults
Below

For children/youth
Below

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

Please describe why this goal was selected
Although Alameda County is below the Statewide measure in Overdoses, individuals experiencing substance use disorder needs are widely prevalent in both the County and the City. Additionally, according to the 2022 California Overdose Surveillance Dashboard one of the top five zip codes with the highest stable rate of overdoses in Alameda County, is in Central Berkeley. For this reason, Berkeley chose Overdoses as the additional BH Statewide goal.

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.

Overview and Community Context

Available data suggests that overdose is an emerging and meaningful behavioral health concern in Berkeley, with clear implications for both community health and equity. Community input reflects this concern directly. In Berkeley's Community Health Assessment, drugs and alcohol use ranked among the top concerns for youth and Hispanic/Latine/Latinx residents, based on survey responses and community engagement activities (Community Health Assessment, 2025). This indicates that, even where overdose may not yet appear as the highest concern across the full population, specific communities are already experiencing or recognizing its impact more acutely.

At the same time, local mortality data confirms that overdose is not only a perceived issue, but a measurable one. Drug overdose is among the leading causes of death for Black or African American residents in Berkeley, and also appears among the leading causes of death for men and other racial and ethnic groups (Leading Causes of Death Summary, 2022–2024). This points to a pattern where overdose is both a growing health risk and an equity issue, affecting some populations more than others.

Trends

While Berkeley-specific overdose data is limited compared to larger jurisdictions, available indicators show that overdose-related harm has been increasing over time. Emergency department visit rates for opioid-related overdoses increased from 8.7 to 29.2 per 100,000 between 2017 and 2021, representing more than a threefold increase (Biennial Syringe Services Report, 2023). This trend suggests that overdose is not a static issue, but one that has been intensifying in recent years, consistent with broader patterns seen across Alameda County and California, where fentanyl and polysubstance use are driving increases in overdose risk.

Community-level observations reinforce these trends. Information shared across local reports and community sources indicates that overdose risk is particularly visible among youth and people experiencing homelessness, and that awareness of fentanyl-related risk has increased across the community. Together, these patterns suggest that overdose is increasingly recognized not only within systems of care, but also at the community level as a growing and evolving issue.

Response and System Capacity

At the same time, Berkeley has an established and multi-layered response to overdose that are active particularly through community-based harm reduction efforts that appear in street-based outreach, behavioral health services, school and youth settings. Local syringe service programs reported serving over 10,000 individuals combined, 3,955 naloxone kits, and documenting 415 overdose reversals (Biennial Syringe Services Report, 2023).

At the same time, Berkeley has an established and multi-layered response to overdose that are active particularly through community-based harm reduction efforts that appear in street-based outreach, behavioral health services, school and youth settings. Local syringe service programs reported serving over 10,000 individuals combined, distributing 3,955 naloxone kits, and documenting 415 overdose reversals (Biennial Syringe Services Report, 2023). Berkeley's response also extends beyond harm reduction into clinical and youth-serving systems. Berkeley Mental Health provides overdose education, prescribes naloxone, and coordinates with substance use providers. In addition, school-based efforts at Berkeley High School include naloxone distribution and fentanyl test strip access.

Berkeley is not only responding to overdoses, but also building a prevention infrastructure capable of intervening at multiple points along the risk continuum. Overdose in Berkeley is reflected in mortality and increasing emergency department visits. It is also an equity concern, with disproportionate impact on Black or African American residents and heightened concern among youth and Hispanic/Latine/Latinx communities. This is a growing community awareness issue, with residents and local systems increasingly recognizing the risks associated with substance use. At the same time, Berkeley systems are not starting from scratch, the system is already responding but the data suggests a need to continue strengthening early engagement, targeted outreach, and coordination, particularly for populations most at risk.

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).

The Behavioral Health Statewide dataset that was provided to mental health jurisdictions to use for the BHSA Integrated Plan, did not include City specific data. As such, the Department of Health Care services (DHCS) instructed City of Berkeley to use Alameda Counties measures for all of the BH Statewide Data, and where possible to add in any Berkeley local data that may align with each of the six Behavioral Health Priority goals.

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).

The Behavioral Health Statewide dataset that was provided to mental health jurisdictions to use for the BHSA Integrated Plan, did not include City specific data. As such, the Department of Health Care services (DHCS) instructed City of Berkeley to use Alameda Counties measures for all of the BH Statewide Data, and where possible to add in any Berkeley local data that may align with each of the six Behavioral Health Priority goals.

Alameda County's data measures are shown in the Overdoses Primary and Secondary Measures of this section. Since these measures are comprised of a combination of all the Cities within the larger County, it is not possible to evaluate how Berkeley is doing within the dataset. Berkeley specific information is reflected in the Overdoses Disparities Analysis Section, and the Cross-Measures Questions.

Berkeley is looking to strengthen partnerships with local MCP's Alameda Alliance and Kaiser, leaning on options such as Enhanced Care Management (ECM) as a cross-collaborative tools to keep bringing CalAIM alternatives to the table first and foremost, promoting community supports as alternatives to institutionalization whenever possible and appropriate. Berkeley is broadening its SUD services through current partners, expanding current SUD care to the public high schools. The outreach and linkage services will continue to be grown and developed to bring more underserved community members in to services through the Mobile Encampment Wellness Center and the Homeless Response Team.

Berkeley is promoting SUD education in the high schools through the High School Health Center, as well as exploring an incentivized training program for current behavioral health staff to undergo SUD counselor certification.

A three-year Prop 47 grant is being leveraged to stand up Berkeley CareBridge, a diversion program designed to support stabilization of justice involved individuals with mental health, SUD, housing, and supportive service needs. This will help address homelessness, institutionalization, and justice involvement for the most vulnerable in our community.

Berkeley sponsored and is awaiting California's update to AB210, which will now include Local Health Jurisdictions (like Berkeley) in its ability to establish the homeless

multidisciplinary team (MDT) to share information and support individuals who are unhoused, whereas the previous legislation only allowed this function to be performed by a County. Not only does Berkeley participate in the Alameda County MDT meeting regarding high utilizers of services, but it also has historically held its own with local providers. With the AB210 update, coordination and communication will be strengthened between local providers to support the Berkeley community and its residents in using lowest levels of appropriate care and avoiding unnecessary homelessness, institutionalization, and justice involvement whenever possible.

Please identify the category or categories of funding that the county is using to address this goal:
BHSA BHSS
BHSA FSP
Other
State General Fund
1991 Realignment
Other: Opiod Settlement Funds
Prop. 47 Funds

Community Planning Process

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

Stakeholder Engagement

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

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Please indicate the type of engagement used to obtain input on the planning process.
County outreach through Social Media
Meeting(s) with county
Survey participation
Training, education, and outreach related to community planning
Workgroups and committee meetings

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

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

Outreach by email, mail and phone contacts, and training/information shared during meetings.
Dates: 1/13/2026; 1/16/2026; 1/20/2026; 1/22/2026; 1/23/2026; 1/26/2026; 1/27/2026; 2/3/2026; 2/4/2026; 2/5/26; 2/9/26; 2/10/2026; 2/11/2026; 2/17/2026; 2/18/2026; 2/19/2026; 2/23/2026; 2/24/2026; 2/26/2026

Type of engagement
Survey participation: Timeframe BHSA Community Input Survey was available for responses.
Dates: 1/21/2026 through 3/5/26

Type of engagement
Workgroups and committee meetings: MHSA/BHSA Advisory Committee Meeting
Date: 1/22/2026

Type of engagement
Meeting(s) with county: Includes Community, Individual and Staff Meetings held.
Dates: 1/26/2026; 1/27/26; 2/3/2026; 2/4/2026 (2 Meetings); 2/5/2026 (2 Meetings); 2/9/2026; 2/10/2026; 2/11/2026 (2 Meetings); 2/17/2026; 2/18/2026; 2/19/2026; 2/20/2026; 2/23/2026; 2/24/2026; 2/25/2026 (2 Meetings); 2/26/2026 (3 Meetings)

Type of engagement
County outreach through social media: Date that announcements of Community Input opportunities were released on all City of Berkeley Social Media Channels.
Date: 2/5/2026

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals.
A Better Way; African American Holistic Resource Center; Alameda Alliance; Alameda County Network of Mental Health Clients; Bananas; Bay Area Clinical Associates; Bay Area Community Land Trust; Bay Area Community Resources (BACR); Bay Area Community Services (BACS); Bay Area Hearing Voices Network; Bay Children's Services; Bahia Inc.; Berkeley Addition Treatment services; Berkeley Aging Services; Berkeley City Commissions; Berkeley Community Scholars; Berkeley Federation of Teachers; Berkeley Food Network; Berkeley Free Clinic; Berkeley Homeless Response Team; Berkeley Housing and Community Services; Berkeley Human Rights Center; Berkeley Labor Unions; Berkeley Organizing Congregations for Action; Berkeley Police Department; Berkeley Public Health Division; Berkeley Unified School District; Berkeley Youth Alternatives; Big Oaks Learning Center; Biotech Partners; Bonita House; Bread Project; Building Opportunities for Self-Sufficiency; Center for Independent Living; Concentra Urgent Care; Dorothy Day House; Downtown Streets Team; East Bay

community Law Center; East Bay Sanctuary Covenant; Easy Does It Services; Echo Fair Housing; Ecology Center; Emergency Services; Family Violence Law Center; Felton Institute; Foundation Housing; Fred Finch Youth Center; Habitat East Bay Silicon Valley; Healthy Black Families; Homeless Action Center; Insight Housing; Inter-City Services; Friends of Adeline; Jewish Family & Community Services East Bay; Kaiser Permanente; Lifelong Medical Services; Looking Glass; Meals on Wheels; Mental Health Association of Alameda County; Mindfulness Centered Psychotherapy; Narika; Native American Health Center; Nia House; Niroga Institute; OnTrack Program Resources; Options Recovery Services; Pacific Center for Human Growth; Path to Care, Lifelong Street Medicine Team; UC Berkeley; Peer Wellness Collective; Peralta Community College; Psychiatric Alternatives; Resources for Community Development; Rising Sun Center for Opportunity; Satellite Affordable Housing Associates Homes; Soar for Youth; Sutter Health; Tang Center, UC Berkeley; Tool Works; Village of Love; Woman's Cancer Resource Center; Women's Day-Time Drop In Center; Wright Institute; YMCA East Bay; Youth Spirit Artworks; Youth Works.

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)

Were you able to engage all required stakeholders/groups in the planning process?
No

If not, which required stakeholder/groups were you unable to engage in the planning process?
Disability insurers
Regional centers
County social services and child welfare agencies

Please describe
During this process, Berkeley was not able to find a direct contact for Disability Insurers in the City. Additionally, Social Services and Child Welfare agencies, and the Regional Centers, are operated at the County level and Berkeley was not able to find direct contacts to engage these Stakeholders in this process. The City will continue to explore how to outreach to these Stakeholders to attempt to engage them to provide input on the Draft BHSA IP during the 30-Day Public Review.

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.
During the City of Berkeley BHSA Community Program Planning Process (CPPP) 23 meetings were held: Twelve Community Input Meetings, eight Individual Meetings, one

Provider Meeting, one BHSA Advisory Committee Meeting, and one Staff Meeting. Community Input was also collected through an anonymous BHSA Community Input Survey that was open to the public over a six-week period.

Announcements of the Survey and Community Input Meetings were sent on all City of Berkeley Social Media channels, and emailed and/or mailed to BHSA Stakeholders, mental health peers, family members, representatives from community-based organizations, community advocates, individuals from unserved, underserved and inappropriately served populations, BHSA Advisory Committee members, City Staff and Commissioners, and other Berkeley stakeholders and community members.

During the BHSA Advisory, Provider, and Community Input Meetings a presentation was conducted to provide information on the CPPP, and the BHSA background, funding, and program requirements. The presentation also covered information on the City of Berkeley BHSA Integrated Plan to enable opportunities for input from the community. A total of 86 individuals participated in one of the meetings held during this process.

The survey was available online or in-person through Berkeley Mental Health's Wellness Recovery Team and the Family Services Staff; Berkeley High School Health Center; Options Recovery Services; and the Berkeley Mental Health Black History Month Event. Over the six-week period, 228 Survey were collected (159 online, and 69 hand filled). During this timeframe community input was compiled on a weekly basis and provided to the Health, Housing & Community Services Department Director, Deputy Director, Berkeley Mental Health Manager and Assistant Manager to facilitate real-time discussions on community priority needs.

All input received was organized into priority categories based on how often it was mentioned. Per input received, the top six service priorities for the BHSA Integrated Plan were as follows:

- Housing and Homelessness Services
- Transition Age Youth and Youth Mental Health Services
- Peer Support and Wellness Services
- Substance Use Disorder and Co-Morbidity Services
- Prevention and Early Intervention Services

The City of Berkeley is most appreciative of all the valuable and detailed input received in this process, and the time and effort participants put into providing it. All input received was used to inform this first BHSA Integrated Plan and will be re-visited regularly to inform future programs and practices. Additional information on the CPPP, including Survey and Community Input Meeting results can be found in Attachment A.

Local Health Jurisdiction (LHJ)

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

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

The City of Berkeley worked closely with JSI Research & Training Institute, a consulting firm, to convene a Community Steering Committee, who in turn, collaborated closely with City staff to identify priority areas from the CHA and broad goals for the CHIP. MCPs & Steering Committee members, along with other community stakeholders, participated in community meetings to provide additional input on goals and objectives for each priority area. MCPs also provided administrative support in ensuring the CHA and CHIP met accessibilty standards.

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

No.

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, Institutionalization, Overdoses, Social Connection.

Was data shared?
No

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
Access to Care, Institutionalization, Overdoses, Social Connection. Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Was data shared?
No

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities). Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.

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.
Consideration was made by intentionally involving City behavioral health staff in the CHA/CHIP development process, as well as inviting community stakeholders with lived experience to provide input at community meetings.

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.

Consideration was made by intentionally involving City behavioral health staff in the CHA/CHIP development process, as well as inviting community stakeholders with lived experience to provide input at community meetings.

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.

Alameda Alliance for Health, Kaiser Permanente

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?

To address needs identified in our BHSA community planning process, Berkeley established regular collaboration and planning with Alameda Alliance and Kaiser Permanente. This collaboration is governed by specific SMART Objectives aimed at creating seamless referral pathways for our most vulnerable residents. Key activities that will inform future MCP Community Reinvestment Plan (CRP) submissions include: 1) Infrastructure Development: The appointment of MCP point-persons to lead protocol development and data integration; 2) Targeted Data Alignment: Sharing member-level data to refine our focus on chronic illness, maternal health, and low-income families; 3) Validated Referrals: implementation of research-validated screening tools and a shared database to track referral outcomes. These steps ensure that MCP investments

are directly responsive to the service gaps identified in our Integrated Plan and the local City of Berkeley CHA/CHIP.

Comment Period and Public Hearing

Comment Period and Public Hearing

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

Date the draft Integrated Plan (IP) was released for stakeholder comment
3/25/2026

Date the stakeholder comment period closed
4/23/2026

Date of behavioral health board public hearing on draft IP
4/23/2026

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

Please provide the link to the public posting
The link for this BHSA Integrated Plan is located on the following webpage:
City of Berkeley MHSA and BHSA Webpage

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

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

City of Berkeley MHSA and BHSA Webpage

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table.
Stakeholder input received during the 30-Day Public Review and Public Hearing will be added to the final BHSA IP.

Stakeholder group that provided feedback.
This section will be filled out following the 30-Day Public Review and Public Hearing in the final BHSA IP.

Summarize the substantive revisions recommended this stakeholder during the comment period.
This section will be filled out following the 30-Day Public Review and Public Hearing in the final BHSA IP.

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.
This section will be filled out following the 30-Day Public Review and Public Hearing in the final BHSA IP.

Substantive recommendations
This section will be filled out following the 30-Day Public Review and Public Hearing in the final BHSA IP.

County Behavioral Health Services Care Continuum

County Behavioral Health Services Care Continuum

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

County Provider Monitoring and Oversight

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.

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
Mental Health (MH) services only	7
Substance Use Disorder (SUD) services only	1
Both MH and SUD services	0

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	N/A
DMC/DMC-ODS only	N/A
Both SMHS and DMC/DMC-ODS systems	N/A

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?
N/A

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

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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Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan
Adult and Older Adult System of Care (non-FSP)
Outreach and Engagement (O&E)
Workforce, Education and Training (WET)
Early Intervention Programs (EIP)

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.

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

Adult and older Adult Non-FSP Program #1

Representative Payee Program

Please select the service types provided under Program.
Supportive services

Please describe the specific services provided.
This program provides services to individuals who are in need of a payee to assist with money management.

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	66
FY 2027 – 2028	67
FY 2028 – 2029	68

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.

Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Adult and older Adult Non-FSP Program #2

Flexible Funding Services

Please select the service types provided under Program.

Supportive services

Please describe the specific services provided.

This program provides funding for clients across the system for supports such as housing, clothing assistance, food, transportation, etc. This use of funds aids individuals in achieving better stability in areas where they are less capable of addressing their daily living needs. This program is set up to aid any clients in need across the system in a given year.

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	125
FY 2027 – 2028	127
FY 2028 – 2029	130

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.

Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Adult and older Adult Non-FSP Program #3
Benefits Advocacy

Please select the service types provided under Program.
Supportive services.

Please describe the specific services provided.
Resources and supports to assist clients in obtaining public benefits.

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	<11*
FY 2027 – 2028	<11*
FY 2028 – 2029	<11*

* Values marked with "*" have been suppressed per DHCS de-identification standards. Counts between 1–10 are displayed as "<11".

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.
This program serves a fixed number of individuals a year.

Adult and older Adult Non-FSP Program #4
Substance Use Disorder (SUD) Services

Please select the service types provided.
Substance Use Disorder (SUD) treatment services
Supportive services

Please describe the specific services provided.
This program provides services, supports and referrals to BMH clients who experience SUD needs, and staff consultations on SUD 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	31
FY 2027 – 2028	32
FY 2028 – 2029	33

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.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

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 .

Early Intervention Program #1
High School Health Center Program

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
Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports.
Short- and long-term individual therapy; group therapy; crisis follow up and re-entry planning; collateral/case management work with parents/caregivers, school staff, external providers; psychiatry and medication 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.
-Reduced onset and severity of mental illness in children and youth.
-Increased mental health protective factors, and reduced risk factors, including the reduction of school failure and the removal of children from their homes.
-Reduced disparities in access to culturally relevant and linguistically appropriate care for youth.

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	210
FY 2027 – 2028	214
FY 2028 – 2029	218

Please describe any data or assumptions the county used to project the number of individuals served through EI programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Early Intervention Program #2
Mental and Emotional Education Team

Please select which of the three EI components are included as part of the program or service.
Outreach
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.
-Increased knowledge and awareness of mental health resources and how to access them.
-Increased outreach and supports for youth in need.
-Reduced disparities in access to culturally relevant and linguistically appropriate care for youth.
-Increased mental health protective factors, and reduced risk factors, including the reduction of school failure and the removal of children from their 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
FY 2026 – 2027	32
FY 2027 – 2028	33
FY 2028 – 2029	33

Please describe any data or assumptions the county used to project the number of individuals served through EI programs.
Data from previous services was reviewed to project the number of individuals

served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Early Intervention Program #3
Supportive Schools Program

Please select which of the three EI components are included as part of the program.
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: Other

Please specify "other" type of Treatment Services and Supports.
Mental Health Services and Supports for Children and Youth including Individual Counseling and Support Groups

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.
-Reduced onset and severity of mental illness in children and youth.
-Increased mental health protective factors, and reduced risk factors, including the reduction of school failure and the removal of children from their homes.
-Reduced disparities in access to culturally relevant and linguistically appropriate care for youth.

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	436

FY 2027 – 2028	444
FY 2028 – 2029	453

Please describe any data or assumptions the county used to project the number of individuals served through EI programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Early Intervention Program #4
Substance Use Disorder Services for Youth - Provides Early Intervention services, supports and referrals to High School youth who experience SUD needs.

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: Other

Please specify "other" type of Treatment Services and Supports.
Substance Use Disorder Services for Youth

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.
-Reduced onset and severity of substance use disorders in youth.
-Increased protective factors, and reduced risk factors, including the reduction of school failure and the removal of children from their homes.

-Reduced disparities in access to culturally relevant and linguistically appropriate substance use disorder services for youth.

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	110
FY 2027 – 2028	112
FY 2028 – 2029	114

Please describe any data or assumptions the county used to project the number of individuals served through EI programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Early Intervention Program #5
Early Intervention Program for Lesbian, Gay, Bi-sexual. Transgender, Queer, Inter-sex, Agender Plus (LGBTQIA+)

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: Other

Please specify "other" type of Treatment Services and Supports.
Early Intervention Behavioral Health Services and Supports such as Individual Counseling, and Support Groups.

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.
-Reduction in the severity of depression, anxiety, post-traumatic stress disorder and/or other mental health issues.
-Increased mental health Protective factors and reduced risk factors.

-Reduced disparities in access to culturally relevant and linguistically appropriate Behavioral Health services.
-Increased access to services and supports that prevent, respond, and treat a behavioral health crisis.

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	102
FY 2028 – 2029	104

Please describe any data or assumptions the county used to project the number of individuals served through EI programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Early Intervention Program #6
Early Intervention Program for African Americans

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
Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports.
Early Intervention Behavioral Health Services and Supports including Individual Counseling and Support Groups.

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.
-Reduction in the severity of depression, anxiety, post-traumatic stress disorder and/or other mental health issues.
-Increased mental health Protective factors and reduced risk factors.
-Reduced disparities in access to culturally relevant and linguistically appropriate Behavioral Health services.
-Increased access to services and supports that prevent, respond, and treat a behavioral health crisis.

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	102
FY 2028 – 2029	104

Please describe any data or assumptions the county used to project the number of individuals served through EI programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Early Intervention Program #7
Early Intervention Program for Latino/Latina/Latine

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
Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports.

Early Intervention Behavioral Health Services and Supports such as Individual Counseling. and Support Groups

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.

-Reduction in the severity of depression, anxiety, post-traumatic stress disorder and/or other mental health issues.
-Increased mental health protective factors and reduced risk factors.
-Reduced disparities in access to culturally relevant and linguistically appropriate Behavioral Health services.
-Increased access to services and supports that prevent, respond, and treat a behavioral health crisis.

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	102

FY 2028 – 2029	104

Please describe any data or assumptions the county used to project the number of individuals served through EI programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Early Intervention Program #8
Early Intervention Program for Transition Age Youth

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

Please specify "other" type of Treatment Services and Supports.
Early Intervention Behavioral Health Services, such as Individual Counseling, and Support Groups.

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.
-Reduction in the severity of depression, anxiety, post-traumatic stress disorder and/or other mental health issues.
-Increased Protective factors and reduced risk factors.
-Reduced disparities in access to culturally relevant and linguistically appropriate Behavioral Health services.
-Increased access to services and supports that prevent, respond, and treat a behavioral health crisis.

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	102
FY 2028 – 2029	104

Please describe any data or assumptions the county used to project the number of individuals served through EI programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Early Intervention Program #9
Early Intervention Program for Older Adults

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: Other

Please specify "other" type of Treatment Services and Supports.
Early Intervention Behavioral Health Services and Supports, such as Individual Counseling, and Support Groups.

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.
-Reduction in the severity of depression, anxiety, post-traumatic stress disorder and/or other mental health issues.
-Increased Protective factors and reduced risk factors.
-Reduced disparities in access to culturally relevant and linguistically appropriate Behavioral Health services.

-Increased access to services and supports that prevent, respond, and treat a behavioral health crisis.

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	102
FY 2028 – 2029	104

Please describe any data or assumptions the county used to project the number of individuals served through EI programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Early Intervention Program #10
Hearing Voices Support Groups - Provides weekly drop-in Support Groups for individuals who experience voices, visions, special messages, unusual beliefs or extreme states of consciousness. Support groups are co-facilitated by trained group facilitators whom have lived experience in the mental health system. A separate support group for Family Members of individual participants is also provided.

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

Please specify "other" type of Treatment Services and Supports.
Support Group Services

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.
-Increased protective factors and decrease risk factors.
-Increased positive mental health outcomes and supports, and decreased isolation for individuals who are hearing voices, seeing visions, etc.
-Increased knowledge of how to access services and supports that prevent, respond, and treat a behavioral health crisis.

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	1783
FY 2027 – 2028	1818
FY 2028 – 2029	1855

Please describe any data or assumptions the county used to project the number of individuals served through EI programs.
Data from previous services was reviewed to project the number of individuals served.

Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

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 .

Per DHCS, Cities submitting their plans separate from the County who utilize the Counties Coordinated Specialty Care for First Psychosis \\Program, can use the counties program for this requirement. The City uses the Counties program for individuals in need of Coordinated

Specialty Care for First Psychosis services. As such, all information in this section is from the Alameda County BHSA Integrated Plan.

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

CSC program name
Felton Institute: (re)MIND® and BEAM - Early Psychosis Programs (formerly PREP Alameda)

CSC program description
The City of Berkeley utilizes the Alameda County Coordinated Specialty Care for First Episode (CSC) program. All information in this section, including the program description and estimates of eligible individuals, number of Teams and Practitioners, and funding used is from Alameda Counties description of the program.

Program Description: The Felton Early Psychosis Programs - (re)MIND® and BEAM – formerly known as PREP Alameda, provide evidence-based treatment and support for transition age youth (TAY) who are experiencing an initial episode of psychosis or severe mood disorder. The programs provide outreach and engagement, early intervention, and outpatient mental health services that include the following categories: mental health services, case management/brokerage, medication support, crisis intervention. In addition, (re)MIND® and BEAM Alameda also provide Individual Placement and Support (IPS) supported employment and education services. The program goals of (re)MIND® and BEAM Alameda are designed to delay or prevent the onset of chronic and disabling psychosis and mood disorders; reduce individuals' hospitalizations and utilization of emergency services for mental health issues; improve the ability of program participants to achieve and maintain an optimal level of functioning and recovery as measured by functional assessment tools; connect participants with ongoing primary healthcare services and coordinate healthcare services with individuals' primary care providers; increase participants' educational and/or employment success; increase meaningful activity as defined by the individual; decrease social isolation; and assist participants with advocating for adjustment of medications to the minimum amount necessary for effective symptom control.

Target Population: Transition Age Youth (TAY) ages 15-24, who are experiencing the onset of first episode psychosis associated with serious mental illness (SMI) and severe mood disorder.

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e.,

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

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

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	193
Number of Uninsured Individuals	15
Number of Practitioners Needed to Serve Total Eligible Population	25
Number of Teams Needed to Serve Total Eligible Population	6

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	8	8	8
Total Number of Teams	2	2	2

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

Yes

Please list the other funding source(s).
Mental Health Block Grant, Medi-Cal

Outreach and Engagement (O&E) Program

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

Outreach and Engagement Program #1
Multicultural & Diversity Outreach Program

Please describe the program or activity.
Multicultural events are held to promote inclusion, provide cultural awareness, highlight cultural traditions and to outreach to individuals who due to various reasons including stigma may not access traditional mental health services and supports. These open events provide opportunities for individuals, to become knowledgeable of local services and supports, and to engage with City Staff and community-based organizations. The events also strengthen overall community engagement and foster connections by bringing people together with various backgrounds. Overall, these cultural outreach events serve as a platform to engage, educate, honor, identity, build unity, advance inclusive communities, and reduce disparities in access to 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	370
FY 2027 – 2028	377
FY 2028 – 2029	385

Please describe any data or assumptions the county used to project the number of individuals served through Outreach & Engagement programs.
The data assumptions were based on the numbers in previous years plus a 2% increase in participants each year.

Outreach and Engagement Program #2
Family Support Services

Please describe the program or activity.
A Family Service Specialist works with family members, staff, community-based organizations etc. to improve services and supports for BMH clients and their family members on a system-wide level. The program provides both individual and group family services and supports as well as broader system–wide change initiatives.

This family/caregiver-centered program provides information, education, advocacy and support for family/caregivers of children, adolescents, TAY, adults and older adults with serious emotional disturbance or severe mental illness. Services are delivered in a culturally responsive manner ensuring outreach to individuals of diverse ethnicities and language groups.

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	88
FY 2027 – 2028	90
FY 2028 – 2029	91

Please describe any data or assumptions the county used to project the number of individuals served through Outreach & Engagement programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Outreach and Engagement Program #3
Wellness Recovery and Peer Support Services

Please describe the program or activity.
Wellness Recovery and Peer Support Services are designed to create a welcoming experience for individuals accessing services at the Adult Clinic. Team members provide peer support to individuals waiting to be seen at the clinic with the goals of building warm relationships that will assist clients in becoming aware of and engaged in clinic services and supports, wellness group offerings, and other community resources.

Designed to promote self-care and independence, the Wellness Recovery Peer Support Team builds on the talents of consumers, encouraging self-efficacy, psycho-education and motivation through multiple groups and interactions that can spark interest through wellness activities and social interactions. In addition to support group activities one-on-one Peer Supports are provided to individuals in the waiting room of the Adult Clinic, as needed.

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	52
FY 2027 – 2028	53
FY 2028 – 2029	54

Please describe any data or assumptions the county used to project the number of individuals served through Outreach & Engagement programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

Outreach & Engagement Program #4
Transitional Outreach Team

Please describe the program or activity
The Transitional Outreach Team (TOT) follows up with individuals and families and provides interventions that address issues individuals experience either immediately prior to or following a mental health crisis. The goal of the team is brief outreach and engagement to assist the individual and/or family in getting connected to the resources they may 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	60

FY 2027 – 2028	61
FY 2028 – 2029	62

Please describe any data or assumptions the county used to project the number of individuals served through Outreach & Engagement programs.
Data from previous services was reviewed to project the number of individuals served. Additional program adjustments to staff or caseloads shifted projected services in a proportional manner.

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

Workforce Education and Training Program #1
Service name: Workforce Development Coordinator

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

Workforce Education and Training Program #2
Program name: Workforce Development Training Program

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

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	3191
Number of Uninsured Individuals	65
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	1659

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	369
Number of Uninsured Individuals	34

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	184
Number of Uninsured Individuals	17
ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	70
Number of Teams Needed to Serve Total Eligible Population	<11*

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	N/A	N/A	N/A
Total Number of Teams	N/A	N/A	N/A

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	2580
Number of Uninsured Individuals	238

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	115
Number of Teams Needed to Serve Total Eligible Population	23

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	N/A	N/A	N/A
Total Number of Teams	N/A	N/A	N/A

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	N/A
Number of Uninsured Individuals	N/A

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	N/A
Number of Teams Needed to Serve Total Eligible Population	N/A

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	N/A	N/A	N/A
Total Number of Teams	N/A	N/A	N/A

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	4979
Number of Uninsured Individuals	477
IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	342
Number of Teams Needed to Serve Total Eligible Population	137

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	000	000	000
Total Number of Teams	000	000	000

Full Service Partnership (FSP) Program Overview

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

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?
No

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports.
The City of Berkeley has three Full Service Partnership (FSP) programs: Children and Youth FSP; Transition Age Youth, Adult & Older Adult FSP (Adult FSP); and a Homeless FSP.

The Children and Youth FSP uses a trauma informed approach by assessing the trauma histories of the clients who are enrolled in the program. The team provides referrals to services that address trauma and provide pycho-education and therapeutic interventions to support reductions in traumatic symptoms.

The Adult FSP provides intensive, whole-person, trauma-informed services using an Assertive Community Treatment (ACT) model. The program serves adults 18 and older with serious mental illness who experience high system utilization, including frequent psychiatric hospitalizations or emergency department use, justice system involvement, homelessness or housing instability, complex medical needs, co-occurring substance use disorders, and safety concerns.

The program operates with a Housing First mindset and maintains contracts with multiple housing providers, allowing the team to subsidize housing across a range of

settings. Staff provide outreach and support to assist participants with obtaining and maintaining housing while addressing co-occurring mental health, substance use, medical, and functional needs.

Connection to physical health care is a core component of service delivery. FSP staff encourage all participants to engage with primary care and actively support this connection by helping participants enroll in care, schedule appointments, assisting with transportation and attendance, coordinating follow-up visits, and supporting treatment for chronic medical conditions. Approximately 88% of FSP participants had at least one primary care visit in the past year.

Trauma-informed care is embedded throughout the program. Many team staff have completed Adverse Childhood Experiences (ACEs) training, trauma-informed care training, Motivational Interviewing training, and Dialectical Behavioral Therapy (DBT) training. Staff apply a strengths-based, recovery-oriented approach that emphasizes understanding “what happened to you” rather than “what is wrong with you.”

With client consent, staff partner with families and natural supports by maintaining communication, incorporating family input into treatment planning, and providing education and support. Berkeley Mental Health employs a Family Advocate who regularly attends Adult FSP and Comprehensive Community Treatment (CCT) team meetings to support coordination with families and caregivers.

Peer support is integrated into service delivery. Berkeley Mental Health has a Peer Support Team that provides daily wellness groups and services. A Peer Support Team representative regularly attends FSP and CCT team meetings and collaborates with clinical staff to support engagement, recovery, and shared decisiThe Mental Health Division also contracts with a nonprofit provider to offer on-site Substance Use Disorder (SUD) specialty services. FSP staff support clients with co-occurring substance use disorders using an integrated, recovery-oriented approach. Many staff are trained in Motivational Interviewing and support participants in accessing community-based substance use services when appropriate and of interest to the client, including 12-step meetings, sobering center services, detoxification, and residential treatment programs as part of a broader continuum of care. SUD clinicians provide direct services and at times conduct joint field-based work with the team.

The Homeless FSP Staff meet individuals where they are in their recovery process and utilize person-centered, non-judgmental, and exploratory language to provide support during the provision of services. Staff also maintain a welcoming environment, both when

seeing clients in the clinic setting and during field-based services, by creating safety and encouraging the individual to take a role in their care.

Please describe the county's efforts to reduce disparities among FSP participants
The Adult FSP actively works to reduce disparities in health, housing, and socioeconomic outcomes for individuals with serious mental illness who experience high utilization of hospitals, emergency departments, and the justice system, as well as housing instability and unmet medical needs.

A primary focus is addressing disparities in physical health and life expectancy. Research shows that individuals with serious mental illness die approximately 10–20 years earlier than the general population, largely due to preventable and untreated medical conditions. To address this disparity, the FSP prioritizes connection to primary care and ongoing medical follow-up for participants whenever possible.

Staff support clients with connecting to medical providers, scheduling and attending medical appointments, managing follow-up care, coordinating treatment for chronic health conditions, and navigating specialty care when needed. This integrated approach to physical and behavioral health care is intended to improve long-term health outcomes, reduce emergency and inpatient utilization, and prevent premature death.

The program also addresses disparities related to poverty and housing instability by assisting participants with accessing public benefits such as SSI, General Assistance, and Medi-Cal, and by supporting connections to housing subsidies, supportive housing, and In-Home Supportive Services (IHSS). Berkeley Mental Health further works to reduce disparities by maintaining a workforce that reflects the diversity of the communities served, supporting engagement among historically underserved populations.

The Homeless FSP Homeless FSP staff routinely meet with individuals in the community and support them in accessing primary and specialty medical care. Clients are connected to low- to no-cost transportation services so that they can attend support groups, employment sites, and volunteer opportunities.

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
Untreated Behavioral Health conditions
Overdoses

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

The Children and Youth FSP team conducts weekly meetings with involved stakeholders to review case needs, potential referrals, and to coordinate on the care of clients and families.

At the Adult Clinic case management services are provided through the Berkeley Mental Health Comprehensive Community Treatment (CCT) teams, which aligns with the BHSA Intensive Case Management (ICM) service level. These teams serve adults with serious mental illness who experience moderate to high system utilization, housing instability, co-occurring substance use, and functional impairment, but who do not meet admission criteria for, or require the intensity of, the Adult Full Service Partnership.

CCT also serves as a step-down level of care for individuals graduating from the Adult FSP, and as a step-up option for individuals whose needs increase, allowing participants to move fluidly between service levels based on clinical acuity, safety, housing stability, and engagement needs.

CCT teams are multidisciplinary and maintain manageable caseloads, generally serving 20–25 clients per clinician. Services are delivered both in the field and in clinic settings, based on client needs, safety considerations, and engagement preferences.

Services focus on stabilizing mental health symptoms, supporting housing retention, addressing co-occurring substance use, reducing hospitalizations and emergency department use, connecting individuals to primary care, and assisting with benefits acquisition. A Family Services staff and a Peer Support Team representative regularly attend CCT team meetings to support coordinated, whole-person engagement.

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.

The Adult FSP incorporates core Assertive Community Treatment (ACT) practices to support high-acuity participants. These include daily team roll call to review client contact and whereabouts, access to countywide Community Health Record system for alerts when there is contact at psychiatric emergency, inpatient, medical emergency department, and jail contacts, and weekly Level of Care (LOC) meetings to guide assignment and ongoing service intensity.

Level of Care decisions are informed by written criteria and made through multidisciplinary discussion and clinical judgment. Participants in LOC meetings include Mental Health Division leadership, the Adult Mental Health Program Supervisor, the Intake Program Supervisor, the Supervising Psychiatrist, the Compliance Officer, and

Adult Team Supervisors. This structure supports consistent decision-making while allowing flexibility to account for individual clinical complexity, safety considerations, and system utilization patterns.

Services are adjusted over time, allowing participants to graduate from Adult FSP to lower levels of care when stability improves, or move up to Adult FSP from other service teams when clinical acuity, safety, housing instability, or system utilization increases.

While both the Adult FSP and the Homeless FSP teams can serve individuals who are unhoused, the Homeless FSP's primary focus is to work with individuals who are currently unhoused and/or have a history of being unhoused/unstably housed.

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.)

Per DHCS, small counties including Berkeley are automatically exempt from these Evidence Based Practices (EBP's) within this first BHSA Integrated Plan (IP). However, Berkeley Mental Health provides ongoing case management services through its Comprehensive Community Treatment (CCT) teams, which align with the BHSA

Intensive Case Management (ICM) service level. These teams serve adults with serious mental illness who experience moderate to high system utilization, housing instability, co-occurring substance use, and functional impairment, but who do not meet admission criteria for, or require the intensity of, the Adult FSP.

CCT also serves as a step-down level of care for individuals graduating from the Adult FSP, and as a step-up option for individuals whose needs increase, allowing

participants to move fluidly between service levels based on clinical acuity, safety, housing stability, and engagement needs. CCT teams are multidisciplinary and maintain manageable caseloads, generally serving 20–25 clients per clinician. Services are delivered both in the field and in clinic settings, based on client needs, safety considerations, and engagement preferences.

Services focus on stabilizing mental health symptoms, supporting housing retention, addressing co-occurring substance use, reducing hospitalizations and

emergency department use, connecting individuals to primary care, and assisting with benefits acquisition. The Family Advocate and a Peer Support Team representative regularly attend CCT team meetings to support coordinated, whole-person engagement.

Both of the Adult FSP and the Homeless FSP incorporate core Assertive Community Treatment (ACT) practices to support high-acuity participants. The City of Berkeley will not be adding new ACT or ICM FSP's in this BHSA Integrated Plan.

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

The City of Berkeley will include the following optional and allowable services outlined below in the FSP program.

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.
Berkeley Mental Health identifies potential Adult FSP participants through multiple referral pathways, including internal referrals from clinic teams, the county ACCESS line, hospitals, crisis services, and community partners such as shelters and supportive housing providers. The program prioritizes individuals with serious mental illness who experience high system utilization, including frequent psychiatric hospitalizations or emergency department visits, justice system involvement, homelessness or housing instability, and complex medical or co-occurring substance use needs. Initial enrollment

into services occurs through our Crisis, Assessment, and Triage (CAT) team, with final determination of team assignment made during our Level of Care meeting. The CAT team conducts intakes in the clinic and can also complete assessments in field or hospital settings depending on the needs of the individual.

Once an individual is determined to be appropriate for Adult FSP, the team engages in ongoing outreach and engagement activities. These often include field-based work in

shelters, housing sites, hospitals, and other community settings. Staff collaborate closely with inpatient units, emergency departments, and county partners to identify individuals

who may benefit from the intensive services provided through FSP. The program also participates in countywide Level of Care discussions and referral processes to support appropriate placement into FSP services.

Other recovery-oriented services
Yes

Please describe the other recovery-oriented services the county's FSP program will include.
Through this BHSA IP the City will add a new "Guided Peer Support Program" to support TAY in the Adult FSP. FSP/ACT modeled teams employ a "whatever it takes" ethos to engage and support participants in their recovery journey. TAY and youth often fall through the cracks due to stigma, distrust of the institutions, and bureaucracies that do not match with the needs of individuals who are still developing skills and resources to help them navigate these complex systems. This program will leverage FSP/ACT ethos with harm reduction, system fluency, lived experience coaching, and meeting the participants where they're at to support their transformation, empowerment and wellness.

The Adult FSP program also provides a range of recovery-oriented services informed by Assertive Community Treatment (ACT) principles, including team-based care, field-based services, and intensive outreach and engagement for individuals with complex behavioral health needs. As a smaller municipal behavioral health system, Berkeley Mental Health utilizes a generalist team model rather than maintaining dedicated specialty positions such as employment specialists, housing specialists, or substance use counselors that are sometimes included in larger ACT teams. Instead, clinicians provide integrated services across domains while coordinating with other resources within the Mental Health Division and the broader community. Participants benefit from additional supports including a Peer Support Team that offers wellness groups and peer engagement activities, a Family Advocate who supports communication and coordination with families and natural supports, and contracted on-site Substance Use

Disorder (SUD) services that provide specialized treatment and consultation to the team.

Services also include intensive case management, field-based mental health services, medication support, assistance with housing placement and retention, benefits acquisition, connection to primary medical care, and support addressing co-occurring

substance use disorders. Staff also assist participants with daily living skills, transportation to appointments, connection to community resources, and developing meaningful social and community connections. The program emphasizes a trauma-informed, strengths-based approach and prioritizes housing stability, physical health care access, and community integration as core elements of recovery.

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".

There are two FSP-level teams at the Berkeley Mental Health Adult clinic, the Adult FSP and the Homeless FSP. While both teams can serve individuals who are unhoused, the primary focus of the Homeless is to work with individuals who are currently unhoused and/or have a history of being unhoused/unstably housed.

The Adult Full Service Partnership (FSP) incorporates core Assertive Community Treatment (ACT) practices to support high-acuity participants. These include daily team roll call to review client contact and whereabouts, access to countywide Community Health Record system for alerts when there is contact at psychiatric emergency, inpatient, medical emergency department, and jail contacts, and weekly Level of Care (LOC) meetings to guide assignment and ongoing service intensity.

Level of Care decisions are informed by written criteria and made through multidisciplinary discussion and clinical judgment. Participants in LOC meetings include Mental Health Division leadership, the Adult Mental Health Program Supervisor, the Intake Program Supervisor, the Supervising Psychiatrist, the Compliance Officer, and Adult Team Supervisors. This structure supports consistent decision-making while allowing flexibility to account for individual clinical complexity, safety considerations, and system utilization patterns.

Services are adjusted over time, allowing participants to graduate from Adult FSP to lower levels of care when stability improves, or move up to Adult FSP from other service teams when clinical acuity, safety, housing instability, or system utilization increases.

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 consider the unique needs of eligible children and youth including individuals who may be at risk of being or are involved with the juvenile justice system in the

development of the FSP Program, the City of Berkeley has reviewed data and area resources, conducted research and engaged with stakeholders. Since the initial planning for the Children and Youth FSP in the first MHSA Plan, to the Community Program Planning Process for this BHSA Integrated Plan, the City of Berkeley has outreached to, engaged and included input from Community-based organization's and City Staff providing services to children and youth, Transition Age Youth (TAY), individuals from unserved, underserved and inappropriately served populations, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Agender Plus (LGBTQIA+) individuals, Parents, representatives from Berkeley Unified School District, and community advocates. Input received from the current Community Program Planning Process through Community Input Meetings, Individual Meetings, the BHSA Survey, and email was used to inform this BHSA Integrated Plan.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
In considering the FSP/ACT Program needs for LGBTQIA+ youth, the City of Berkeley reviewed data regarding the specific mental health disparities and barriers to care faced by this population. The planning process included, wherever possible, outreach to LGBTQIA+ individuals, advocates, and specialized service providers to ensure their perspectives were heard. Feedback received through individual meetings and the BHSA Survey emphasized the need for gender-affirming, culturally responsive care. This input was used to inform the BHSA Integrated Plan, equipping FSP/ACT staff to support the specific identity-based needs of LGBTQIA+ community members.

In the child welfare system
To consider the needs of children and youth in the child welfare system, in the development of the Children/Youth FSP City reviewed child welfare placement data and area resources focused on foster youth and those at risk of out-of-home placement wherever possible. The City engaged with representatives from the Berkeley Unified School District (BUSD), child welfare advocates, and parents to identify critical transition points where FSP/ACT services could provide stability. Input from the current CPPP—including Community Input Meetings and individual discussions—highlighted the "whatever it takes" approach to prevent placement disruptions and support reunification. This stakeholder feedback was directly integrated into the BHSA plan to ensure the FSP/ACT model provides intensive wraparound support for system-involved 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
To consider the unique needs of older adults in the development of the Adult FSP, the City of Berkeley reviewed data and area resources, conducted data review, and

engaged with stakeholders. Program development has been informed by analysis of medical complexity, hospitalization, and other data specifically across older adult age groups. Since the initial planning for the Adult FSP to the current BHSA Community Program Planning Process (CPPP), the City has whenever possible outreached to and included input from older adults, consumers of mental health and substance use services, and the community-based organizations that provide specialized services to this population. This reflects the long-standing practice of seeking and incorporating community feedback to ensure FSP services address the unmet needs and service gaps unique to the aging population.

The history of community engagement for this type of Adult services dates back to 1999 when the City of Berkeley received a grant from SAMHSA to develop the first iteration of an ACT Team. Program development at that time included multiple community meetings to identify unmet needs and service gaps, as well as consultation with early ACT pioneers from Wisconsin. With the start of the Mental Health Services Act (MHSA), Berkeley Mental Health again engaged in broad community input through meetings and stakeholder discussions to inform service planning and program design. This included a broad range of outreach and incorporating input across the City including but not limited to individuals from unserved, underserved and inappropriately served cultural and ethnic populations, LGBTQIA, Veterans, individuals who have experienced homelessness, representatives from community-based organizations, community advocates, etc. This practice of incorporating community feedback has continued with each MHSA plan update and was a part of the Community Planning process for this first Behavioral Health Services Act (BHSA) Integrated Plan as described above.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
To consider the unique needs of LGBTQ+ individuals in the development of the Adult FSP, the City of Berkeley reviewed data and engaged in targeted outreach through the BHSA CPPP. This included wherever possible collecting input from Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Agender Plus (LGBTQIA+) individuals, community advocates, and specialized community-based organizations. Input received through Community Input Meetings, Individual Meetings, and the BHSA Survey was used to inform this BHSA Integrated Plan, ensuring that FSP services are culturally responsive to the specific challenges faced by the LGBTQIA+ community. By utilizing staff expertise and evidence-informed ACT/FSP practices, the City continues to assess and modify programs to better serve individuals from these underserved, inappropriately served, and vulnerable populations.

In, or are at risk of being in, the justice system
To consider the unique needs of adults who are involved with or at risk of involvement with the justice system the City of Berkeley reviewed program data and outcomes related to incarceration and safety concerns. This planning process built upon Berkeley's history of developing ACT/FSP-style teams to identify service gaps for high-risk individuals. During the current BHSA CPPP, the City engaged with peers who received mental health and substance use services, individuals experiencing homelessness, and the community-based organizations that serve justice-involved populations. Feedback gathered via email, surveys, and stakeholder discussions was integrated into the BHSA Plan to ensure the FSP provides the intensive, evidence-informed support to reduce justice involvement and improve outcomes for this priority group.

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
Options Recovery Center - Encampment-based Mobile Wellness Services
Homeless Response Team (HRT)

Program descriptions
Options Recovery Center, Encampment-based Mobile Wellness Services: This an innovative, peer-led mobile wellness outreach model that provides onsite mental health and SUD supports to encampment areas. It is a low barrier service aimed at chronically unhoused individuals that uses motivational interviewing and rapport building to engage individuals who may avoid or have challenges with traditional clinical or engagement strategies.

Homeless Response Team (HRT): This is a multidisciplinary outreach team designed as an interdepartmental collaboration to support encampment resolution, outreach to

chronically unhoused individuals, and promote linkage to the regional Continuum of Care, treatment services, and other resources in the community.

Current funding source
Options Encampment-Based Mobile Wellness Services is funded through MHSA encumbered INN Funds.

HRT is funded through General Fund, Measure P, Encampment Resolution Funding, Measure W, Medi-Cal Administrative Activities.

HSA changes to existing programs to meet BHSA requirements
Encampment-based Mobile Wellness Services: Yes; ensure connections to open access clinic models, clarify MAT protocols for existing MAT resources; make good faith efforts to integrate any possible Medi-Cal billing into service delivery.

HRT: Yes; ensure connections to open access clinic models, clarify MAT protocols for existing MAT resources; good faith efforts to integrate any possible Medi-Cal billing into service delivery; explicitly integrate SUD services into model.

Expected timeline of operation
Encampment-based Mobile Wellness Services: 7/1/26 - 6/30/29

HRT: These are existing programs, not expected to end, and will be operational 7/1/26-6/30/29 for the purposes of the three-year plan.

Mobile-field based programs

Existing programs
Lifelong Medical Care - Street Medicines Teams

Program descriptions
Provides acute and chronic disease care, behavioral healthcare, dentistry, case management, medication management, housing assessment, and substance use disorder services. Services are accessed by encountering one of our many Street Medicine Teams who have regular scheduled visits to encampments and other sites where chronically unhoused folks are living. Their multidisciplinary team includes medical practitioners who provide MAT on the street.

Current funding source
Medi-Cal, HRSA/HHS/SAMHSA Federal Grants, Alameda County Measure A, 2011 Realignment

BHSA changes to existing programs to meet BHSA requirements
No

Expected timeline of operation
7/1/26-6/30/29

Open-access clinics

Existing programs
New Bridge Foundation Rehabilitation Center; Berkeley Addiction Treatment Services (BATS); Options Recovery Services Clinics

Program descriptions
New Bridge Foundation Rehabilitation Center is an addiction treatment center specializing in detox, short and long-term residential treatment, intensive outpatient SUD programs. Services include addiction treatment for methamphetamines, opioids, alcohol, heroin, and other drugs.

Berkeley Addiction Treatment Services (BATS) is a non-profit open access clinic specializing in detox and opiate dependence. Services include medically supervised withdrawal or medically assisted maintenance therapy utilizing screening, methadone treatment, counseling, harm reduction, medically-assisted withdrawal and maintenance, as well as linkages to related services.

Options Recovery Services has a local SUD outpatient clinic that provides low barrier, walk-in access for integrated services, including counseling, treatment, MAT assessment/referral/linkage, intensive outpatient services. Population of focus is individuals experiencing homelessness, justice involved, and co-occurring disorders.

Current funding source
New Bridge Foundation Rehabilitation Center: Medi-Cal, government grants (SUBG), private insurance, 2011 Realignment, private pay.

Berkeley Addiction Treatment Services (BATS): Medi-Cal, government grants (SUBG), private insurance, 2011 Realignment, private pay.

Options Recovery Services Clinics: Medi-Cal.

BHSA changes to existing programs to meet BHSA requirements
New Bridge Foundation Rehabilitation Center: Yes; This is a traditional outpatient treatment model. Need to ensure that low barrier and rapid access to MAT treatment is available, dynamic problem lists are adopted, integrated co-occurring disorder care is available, ensure coordination with assertive field-based teams (Lifelong Street Medicine), and ensure that non-Medi-Cal individuals with eligible SUD needs are served, despite insurance gaps.

Berkeley Addiction Treatment Services (BATS): Yes; This is a traditional outpatient treatment model. Need to ensure that low barrier and rapid access to MAT treatment is available, dynamic problem lists are adopted, integrated co-occurring disorder care is available, ensure coordination with assertive field-based teams (Lifelong Street Medicine), and ensure that non-Medi-Cal individuals with eligible SUD needs are served, despite insurance gaps.

Options Recovery Services Clinics: No.

Expected timeline of operation
New Bridge Foundation Rehabilitation Center: These are existing programs, not expected to end. They will be operational 7/1/26-6/30/29 for the purposes of the three year plan.

Berkeley Addiction Treatment Services (BATS): These are existing programs, not expected to end. They will be operational 7/1/26-6/30/29 for the purposes of the three year plan.

Options Recovery Services Clinics: These are existing programs, not expected to end. They will be operational 7/1/26-6/30/29 for the purposes of the three-year plan.

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
Integrated Mobile Peer and Crisis Team

Program descriptions
This is a high intensity, integrated crisis team designed to provide clinical mental health and SUD services in the field. By integrating SUD-trained peers with Berkeley's seasoned local mental health crisis team, this program will provide a comprehensive,

field-based response that addresses behavioral health emergencies with any mental health and SUD components. Community crises can be addressed with rapid intervention in the field including assessment, triage, linkage, and 5150 evaluation capabilities.

Planned funding
FSP Funding

Planned operations
The City will execute an Request for Proposal (RFP) process to contract with a community-based Peer Support provider for this work.

Expected timeline of implementation
7/2/27

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
N/A

Program descriptions
N/A

Planned funding
N/A

Planned operations
N/A

Medications for Addiction Treatment (MAT)
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.
Berkeley partners with Alameda County in their regional Alameda Health Systems regional hub. Highland Hospital operates a Bridge Program with high-acuity medical stabilization and MAT initiation that can handle complex co-occurring medical conditions. Services are available 24/7, and include MAT, inpatient stabilization, and specialized outpatient clinic services. Care is coordinated with other partners such as Options Recovery Services and Lifelong Street Medicine Teams.

Berkeley will work with regional and local partners (including Alameda County) to parse the prevalence and utilization data to assess the current baseline needs. Local provider capacity can be assessed, including access and time constraints. Community engagement and feedback will also be key to aligning with community needs. This should help finally determine the gap between the actual capacity of local and regional providers as compared to the estimated or projected need of the community.

Select the following practices the county will implement to ensure same day access to MAT.
-Contract directly with MAT providers in the County.
-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
-Partner with neighboring counties

Please provide the names of the neighboring counties the county will partner with.
Alameda County

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

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
Small gap

Single and multi-family homes
Medium gap

Housing in mobile home communities
Not applicable

(Permanent) Single room occupancy units
Large gap

(Interim) Single room occupancy units
Large gap

Accessory dwelling units, including junior accessory dwelling units
Small gap

(Permanent) Tiny homes
Not applicable

Shared housing
Large gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing
Not applicable

(Interim) Recovery/sober living housing, including recovery-oriented housing
No gap

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

License-exempt room and board
Large gap

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Large 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)
Small gap

Recuperative Care
Large gap

Short-Term Post-Hospitalization housing
Large gap

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

Peer Respite
Large gap

Permanent rental subsidies
Large gap

Housing supportive services
Large 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?
The City of Berkeley offers a robust portfolio of interim and permanent housing for people experiencing homelessness. Since 2018, more than 790 interim housing beds and permanent housing units have been funded and leased up in Berkeley and have served over 2,100 residents. The City has committed funding to build over 1,050 new units, of which 327 units (+44 shelter beds) have been constructed.

Since 2021, Berkeley has more than tripled the number of beds in noncongregate interim housing units, drawing down over $15M in all three rounds of State Encampment Resolution Funding grants. Berkeley has also drawn down over $30M in Homekey funding to create 87 new units of permanent supportive housing for PEH. The City will continue to leverage these resources to serve BHSA-eligible homeless individuals.

Moving forward, City leadership sits on the Task Force for Alameda County's Home Together 2030 stratregic plan creation, the adoption of which will guide the expenditure of an additonal ~$1.4B in local County sales tax (Measure W) funding towards homelessness. In 2024, Berkeley's Homeless Response Team – which directly engages BHSA eligible people living in encampments - became a Coordinated Entry Access Point, meaning the City can directly assist people with assessments for permanent supportive housing, bringing the front door of accessing the City's and County's homeless system directly to the street.

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?
The City of Berkeley has developed a proven strategy for measurably reducing the unsheltered population, coupling targeted, housing-focused outreach to encampments with offers of low-barrier. noncongregate interim housing. This strategy, when funded, is measurably successful, accounting for a 45% drop in unsheltered homelessness in the City between the 2022 and 2024 PIT Counts.

The City Homeless Response Team's encampment outreach data indicate that more than half the homeless population in Berkeley is BHSA eligible, with 56% having a mental health disorder and nearly 90% reporting a substance abuse disorder--meaning this funding can be integrated seamlessly into the team's existing workflow.

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

The City's strategy to promote access to and retention within permanent housing is to actively promote and support the following:
(1) Coordination and information-sharing: The City regularly hosts inter-departmental and inter-agency case conferences to discuss, on a minimum necessary and need-to-know basis, individuals needing wraparound supports and to assign action steps to providers to ensure they have everything they need to be assessed, eliigible for, and referred into permanent housing resources.
(2) the City of Berkeley administers a HUD CoC Shelter Plus Care grant in an amount of over $7.3M providing tenant-based permanent supportive housing subsidies to just under 300 individuals and matches this with roughly $385,000 in General Funds to support tenancy sustaining case management services for these individuals.
(3) Since 2021 the City has used roughly $37.5M in local funding to leverage over $45M in state ERF and Homekey funding to rapidly create over 160 new units of interim and permanent housing, focused especially on people living unsheltered and in encampments.

The City of Berkeley's Inter-departmental Homeless Response Team directly navigates individuals living in encampments to referral pathways for these programs. (4) Berkeley funds a robust homelessness prevention portfolio that, since the pandemic, has served more than 940 rental households with emergency rental assistance, as well as a pilot rental assistance program that provides up to $1,800 a month for up to 3 years to some of our most at-risk residents and some unhoused people who are ineligible for permanent supportive housing. The pilot has served over 50 households and has helped them remain stable.

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)?

The City of Berkeley administers a HUD CoC Shelter Plus Care grant in an amount of over $7.3M providing tenant-based permanent supportive housing subsidies to just under 300 individuals, and matches this with roughly $385,000 in General Funds to

support tenancy sustaining case management services for these individuals. As mentioned, Since 2018 more than 790 interim housing beds and permanent housing units have been funded and leased up and have served over 2,100 residents. Roughly 700 additional units of permanent affordable housing are in the pipeline. The City's Homeless Response team coordinates the various city departments and partner CBOs who provide homeless services on a weekly basis to ensure priority BHSA eligible, vulnerable people living unsheltered, with a special focus on those living in dangerous encampments, are receiving targeted and coordinated care focused on ensuring documents readiness for permanent housing referrals and direct linkages to congregate and nonongregate interim housing.

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.

In partnership with Alameda County and CBO Bay Area Community Services, the City of Berkeley hosts and partially funds a Housing Resource Center that serves as a Coordinated Entry Access Point for Northern Alameda County. At this HRC, housing navigation services for currently homeless and tenancy sustaining services for formerly homeless individuals is provided and assigned to prioritized vulnerable people in need. These resources span the City's portfolio and ensure that BHSA and CalAIM eligible households are quickly linked to an array of clinical and behavioral supports, including mental health and substance abuse treatment resources. Moreover, the City's rapidly growing portfolio of interim noncongregate housing funds robust onsite case management

services, the primary focus of which is connecting people to a variety of supports, including behavioral health supports, as 'barrier busters' to accessing permanent housing.

Eligible Populations

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

As part of the larger regional Alameda County Medi-Cal system, all individuals go through the same screening/referral, assessment, and assignment pathway. Individuals eligible for or assigned to FSP teams in this process will be considered. Next, the FSP client's housing situation and needs will be assessed and considered. These individuals should be entered into all priority lists (CES, S+C, other subsidy options); all non-BHSA housing resources must be exhausted first. The clinical team will help identify the housing needs/gaps that cannot be filled by other means, and these housing interventions will be applied to help stabilize and support the individual.

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
To consider the unique needs of eligible children and youth who may be at-risk of being or are involved with the juvenile justice system in the development of Housing Interventions services in this BHSA Integrated Plan, the City of Berkeley reviewed area housing resources, projected needs, and researched best practices for justice-involved youth housing stability. During the Community Program Planning Process (CPPP), the City of Berkeley outreached to, engaged, and included input from Community-based organizations and City Staff providing services to justice-involved youth, Transition Age Youth (TAY), and individuals from unserved, underserved, and inappropriately served populations. This engagement focused on identifying the specific barriers to stable housing that contribute to system involvement and recidivism. Input received from the current Community Program Planning Process through Community Input Meetings, Individual Meetings, the BHSA Survey, and email—including specific feedback from parents, community advocates, and representatives from the Berkeley Unified School District—was used to inform the Housing Interventions component of this BHSA Integrated Plan.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
To consider the unique needs of eligible children and youth who identify as Lesbian, Gay, Bisexual, Transgender, Plus (LGBTQ+) in the development of Housing Interventions services in this BHSA Integrated Plan, the City of Berkeley reviewed area housing resources, projected needs, and reviewed the specific risks of homelessness and housing instability within the LGBTQ+ youth population. During the Community Program Planning Process, the City of Berkeley, wherever possible, outreached to, engaged, and included input from Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Agender Plus (LGBTQIA+) individuals, advocates, and the community-based organizations that provide specialized housing and behavioral health services to this population. This engagement focused on identifying the need for safe, inclusive, and affirming housing environments for youth. Input received from the current Community Program Planning Process through Community Input Meetings, Individual Meetings, the BHSA Survey, and email was used to inform the Housing Interventions component of this BHSA Integrated Plan.

In the child welfare system

To consider the unique needs of eligible children and youth including individuals who may be involved with the child welfare system in the development of Housing Interventions services in this BHSA Integrated Plan, the City of Berkeley reviewed area housing resources, projected needs, and researched the specific housing stability challenges faced by foster and system-involved youth. During the Community Program Planning Process, the City outreached to, engaged, and included input from Community-based organizations and City Staff providing services to children and youth, Transition Age Youth (TAY), and individuals from unserved, underserved, and inappropriately served populations. This engagement was intended to identify the housing gaps that lead to housing instability or homelessness for youth transitioning out of the child welfare system. Input received from the current Community Program Planning Process through Community Input Meetings, Individual Meetings, the BHSA Survey, and email—including perspectives from Parents, representatives from Berkeley Unified School District, and community advocates—was used to inform the Housing Interventions component of this BHSA Integrated Plan.

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

To consider the unique needs of eligible adults, including older adults, in the development of Housing Interventions services in this BHSA Integrated Plan, the City of Berkeley reviewed area housing resources, projected needs, and researched the specific accessibility and medical characteristics of older adults. During the Community Program Planning Process, the City outreached to, engaged, and included input from Transition Age Youth (TAY), adults, and older adult consumers of mental health services. This engagement specifically targeted individuals experiencing homelessness, consumers of substance use disorder services, and individuals from unserved, underserved, and inappropriately served cultural and ethnic populations. The City also gathered input from Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Agender Plus (LGBTQIA+) individuals, Veterans, community advocates, and the community-based organizations that provide specialized older adult and housing services to these populations. Input received from the current Community Program Planning Process through Community Input Meetings, Individual Meetings, the BHSA Survey, and email—particularly regarding the need for permanent supportive housing and supportive medical services—was used to inform the Housing Interventions component of this BHSA Integrated Plan.

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

To consider the unique needs of eligible adults, including individuals who may be at risk of or have involvement with the justice system, in the development of Housing Interventions services in this BHSA Integrated Plan, the City of Berkeley reviewed area housing resources, projected needs, and researched best practices for reducing recidivism through stable housing. During the Community Program Planning Process, the City outreached to, engaged, and included input from Transition Age Youth (TAY), adults, and older adult consumers of mental health services. This process sought out individuals experiencing homelessness, consumers of substance use disorder services, and individuals from unserved, underserved, and inappropriately served cultural and ethnic populations. The City also gathered feedback from Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Agender Plus (LGBTQIA+), Veterans, community advocates, and the community-based organizations that provide re-entry and housing services to these populations. Input received from the current Community Program Planning Process through Community Input Meetings, Individual Meetings, the BHSA Survey, and email—particularly regarding the need for low-barrier housing and supportive services for justice-involved individuals—was used to inform the Housing Interventions component of this BHSA Integrated Plan.

In underserved communities

To consider the unique needs of eligible adults, including individuals in unserved, underserved, and inappropriately served cultural and ethnic communities, in the development of Housing Interventions services in this BHSA Integrated Plan, the City of Berkeley reviewed area housing resources, projected needs, and researched the specific socioeconomic and systemic barriers to housing equity. During the Community Program Planning Process, the City outreached to, engaged, and included input from Transition Age Youth (TAY), adults, and older adult consumers of mental health services. This engagement focused specifically on individuals from historically marginalized populations, individuals experiencing homelessness, and consumers of substance use disorder services. The City also gathered insights from Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Agender Plus (LGBTQIA+), Veterans, community advocates, and the community-based organizations that provide culturally and linguistically specific housing services to these populations. Input received from the current Community Program Planning Process through Community Input Meetings, Individual Meetings, the BHSA Survey, and email—particularly regarding the need for outreach with cultural humility and low-barrier housing access—was used to inform the Housing Interventions component of this BHSA Integrated Plan.

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?
The City of Berkeley is deeply connected as a partner in the Alameda County Continuum of Care. The coordination strategy utilizes the Coordinated Entry System as the primary holder for all regional housing referrals in our area. By directing all eligible individuals (including clients from our FSP teams) into this system, we ensure that all are identified, assessed, and prioritized for vulnerability in the same framework and then matched accordingly to regional options for housing resources. This also means that we prioritize local housing resources and subsidies (such as Shelter Plus Care, Housing Choice, and project based) before using flexible BHSA housing intervention dollars as a last resort.

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
The City of Berkeley is a part of the local Alameda County Continuum of Care. A "no wrong door" policy is utilized along with a Coordinated Entry System that serves as the main identifying, assessing, and prioritizing process for individuals. BHSA eligible residents are entered into the Homeless Management Information System, and this ensures that all are eligible for regional housing resources, including clients who may benefit from housing outside of Berkeley funded resources. Regular meetings in this system ensure that the highest acuity/vulnerability level clients are prioritized and matched with permanent supportive housing options in the system.

Public Housing Agency
The City of Berkeley closely coordinates with both the Berkeley and Alameda County Housing Authorities. Vouchers are prioritized for stable high needs FSP clients (Move-On, Special Purpose vouchers), and project-based units are also prioritized to individuals who meet the vulnerable and service needs criteria to ensure long term affordability of units to the appropriate clients. BHSA can be used to fund clinical and operating needs gaps.

MCPs
The City of Berkeley continues to maintain a close partnership with Alameda County, and participates in their MOU's with Alameda Alliance and Kaiser, our two MCP's for

Medi-Cal. Care is coordinated with MCP's and clinical teams, looking to reduce high cost and unnecessary care where lower levels can be more appropriate and accessible.

ECM and Community Supports Providers
The City of Berkeley clinical teams coordinate closely with ECM providers, enabling appropriate prioritization of resources and funding to be applied to client needs, including housing navigation, housing deposits, Housing tenancy sustaining services, etc. This allows BHSA funding to remain the payer of last resort for any gaps that may arise in the process.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
The City of Berkeley continues to support and build relationships with non-profit organizations and developers to continue building and managing these resources. Developers such as SAHA, RCD, Jon Stewart continue to build and maintain projects in our community, and Berkeley provides strong support and partnership to ensure that the needs of the vulnerable, prioritized residents are met and the resources can continue operating in challenging environments.

How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?
The City of Berkeley acts as a partner co-applicant for non-profit developers to apply for and receive funding from state funding sources such as Homekey+. The City provides local support and matching to enable these resources to be brought into our community. City clinical teams and non-profit CBO partners provide case management and wraparound care to lower barriers and make these opportunities viable. The coordinated entry system keeps the referred populations prioritized as the most vulnerable individuals in the are, ensuring that the resources and referrals support and house the BHSA eligible individuals.

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?
25

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
0

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
50

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?
Berkeley primarily utilizes its regional partnership with Alameda County's Continuum of Care for permanent, interim, and temporary rental subsidies as well as general housing services. Shelter Plus Care also supplements these needs with permanent subsidies.

The Homeless Response Team utilizes separate funds for temporary and interim shelter. The remaining temporary or interim subsidy needs are based on the annual needs of the FSP teams whose clients may need resources supplemental to all of the other resources cited previously.

For which setting types will the county provide rental subsidies?
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Non-congregate interim housing models

Will this Housing Intervention accommodate family housing?
Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.
BHSA Housing Intervention funding will be utilized as a targeted, flexible intervention specifically for FSP clients who have exhausted or do not qualify for broader community resources. As previously mentioned, City of Berkeley participates as a member of the regional Continuum of Care with Alameda County, and first leverages these resources like the Coordinated Entry System, Housing Resource Center, and Shelter Plus Care. These resources can have extensive waiting lists or challenging eligibility criteria for some clients, so by prioritizing BHSA Housing Intervention funds as a flexible resource will allow those vulnerable individuals with the most significant behavioral health needs can be stabilized more quickly to better support their clinical care.

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

How will the county behavioral health system identify a portfolio of available units forplacing 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.
City of Berkeley will use multiple strategies to help identify a portfolio of available and appropriate units for BHSA eligible individuals. Primarily, Berkeley will continue to participate as a partner in the regional collaborative with Alameda County, including the Alameda County Housing subsidy flex pool. A county contractor operates the flex pool and regional partners are able to gain access to these vetted units for supporting housing. Through this flex pool, master leasing allows barriers to be overcome for clients (such as those in FSP's) that may otherwise not be able to rent in traditional housing. Berkeley continues to partner with affordable housing developers to include affordable/supportive housing units in their developments such as the completed Hope Center and the upcoming People's Park project. Berkeley also utilizes some BHSA funds for its own master lease of a property (McKinley House) in Berkeley for exclusive use by FSP clients. Insight Housing is also funded with BHSA funds to run a licensed board and care home for Berkeley Mental Health clients.

Total number of units funded with BHSA Housing Interventions per year
21

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.
Berkeley will continue to keep BHSA funding available for FSP clients who may need temporary or interim housing subsidy options to bridge the gap that may exist between permanent supportive housing resources. For example, the contract Berkeley keeps with Lakehurst Manor helps keep a flexible, gap-filling option on the table for clients who may need an interim or short term resource. As mentioned before, BHSA housing intervention dollars will remain a flexible option to ensure that targeted housing interventions can be applied to FSP clients in order to stabilize their housing needs to better support clinical care while continuing to access long term resources.

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.
6

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.
Berkeley utilizes BHSA Operating Subsidies to assist in bridging gaps between projected rental income and a building's true realized costs. Such costs may and have included: utility funding, repairs, cleaning, appliance replacement, or pest control to maintain housing standards for the building. Property management, administrative costs, and housing incidentals are also supported for management of complex behavioral health challenges.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments Non-Time-Limited Permanent Settings: Single room occupancy units
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 Time Limited Interim Settings: Hotel and motel stays

Time Limited Interim Settings: Non-congregate interim housing models

Will this be a scattered site initiative?
Yes

Will this Housing Intervention accommodate family housing?
Yes

Total number of units funded with BHSA Housing Interventions per year
21

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.
Berkeley will utilize BHSA funding to stabilize properties that may need temporary or interim support to stay solvent, despite challenging behavioral health barriers. Some properties in scattered sites may occasionally require operational support and while they may not be a fixed property normally funded with BHSA dollars, the flexible nature of this program will continue to be available to maintain their solvency and ability to

serve the vulnerable community. For example, if a communal water heater needs replacement or there is a bedbug infestation in the building, operating funding may not be regularly tied to specific units but could enable the property to continue without risk to their vulnerable clients.

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
12

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Berkeley participates as a member of the regional Alameda County Continuum of Care, and as such, employs a coordinated regional services approach. While the City of Berkeley does not directly manage these funds or services, we are part of the larger comprehensive Alameda County service collaborative that ensures that funds are

used to incentivize property owners to rent to eligible individuals and to offset potential damages. While the county level directs the aforementioned regional services, Berkeley provides local services through the Berkeley Rent Board to educate, refer, and support property owners about these county resources, including other specialized local ones like the Berkeley Property Owners Association. City of Berkeley staff in programs such as Shelter Plus Care and FSP teams also serve as community connectors between local landlords and these regional supports. Again, this regional collaborative model enables Berkeley to not utilize its BHSA funds for this services, and direct its funds instead to maximize direct impact to the most vulnerable populations.

Total number of units funded with BHSA Housing Interventions per year
0

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.
As mentioned previously, City of Berkeley ensures access to landlord mitigation funds through its participation in the Alameda county regional housing collaborative services. These funds are not tied to a specific number of units since they similarly to a flexible mitigation pool, available to any private landlord within the jurisdiction who rents to an eligible individual. This allows Berkeley to support targeted, scattered site housing needs across the jurisdiction without the constraints of specific project-based units.

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
60

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.
Berkeley utilizes Participant Assistance Funds as targeted interventions to overcome immediate barriers to vulnerable clients/populations with significant behavioral health needs. These funds are primarily used in Full Service Partnership or Intensive Case Management Team models where clinical staff can take a "whatever it takes" approach. This integrates with the Alameda County CoC resources (such as rental assistance) to

support the most vulnerable populations, and also allows other funding streams and programs to be braided together to ensure more robust and comprehensive housing services for clients (by leveraging other programs such as federally funded Shelter Plus Care). This also enables participants to overcome barriers quickly to access supportive housing services more effectively and transition from homelessness to permanent housing.

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

Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes 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?
No

Please explain why the county is not providing this intervention.
Berkeley participates as a member of the regional Alameda County Continuum of Care, and will avoid duplicating regional efforts to serve these individuals who are not eligible to receive services through their Medi-Cal MCP. The regional CoC and its coordinated entry system already primarily serves this population, and Berkeley's limited resources in this respect should be utilized instead to maximize the impact of its relatively limited funding. Berkeley providers already coordinate with HRC's and 211 locally to ensure that clients are connected to these services, ensuring that all are directed to the appropriate resource. In this way, Berkeley's limited BHSA housing funds can be targeted towards the most high-need individuals who require intensive housing supports that may go beyond what the CoC system provides.

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

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.
240

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.
City of Berkeley provides comprehensive outreach and engagement for housing interventions through a coordinated regional service model. Berkeley's Homeless Response Team (HRT) serves primarily to reach unsheltered individuals, primarily chronically homeless, particularly in encampments. They build trust, address immediate safety needs, provide referrals to service/care, and warm hand-offs to

Coordinated Entry System and other service providers. The HRT provides initial engagement and referral, and long-term housing navigation and tenancy supports are primarily served by Alameda County Continuum of Care's network of contracted providers. To maximize BHSA Housing fund impact, HRT is funded by braided local general funds and state grants, enabling BHSA dollars for direct housing costs when possible.

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.
Berkeley is in a unique position as a small BHSA jurisdiction within a larger county, that is also one of the most expensive housing markets in the country. The BHSA housing intervention allocation results in a small amount of total funds able to be used for capital development projects, significantly smaller than that which would be required for any single project of any significance. Utilizing these funds as part of a larger project is complex and takes significant planning and time. There are other, significantly larger funding pools available in the region that can lend to coordination and resource pooling in a highly effective manner for capital projects, so smaller amounts of BHSA funding will be more effectively used for immediate direct client services.

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
N/A

Is the county providing this intervention to chronically homeless individuals?
No

Anticipated number of individuals served per year
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)
Berkeley's noncongregate interim housing portfolio, largely funded with one-time State ERF grants, faces a significant fiscal cliff of $6.85M across three programs by 2028. BHSA Housing Intervention funding will be used as a last resort option to bridge gaps in regional interim housing resources as these one-time state funded programs expire and new resources are developed.

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

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

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
None of the Above

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

Housing Transition Navigation Services
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
7/1/2027

Housing Deposits
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
7/1/2027

Housing Tenancy and Sustaining Services
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
7/1/2027

Short-Term Post-Hospitalization Housing
No
Recuperative Care
No

Day Habilitation
No

Transitional Rent
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
7/1/2027

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)?
Alameda County is the Mental Health Plan and as such, holds the agreement with the Managed Care Plans. The City holds a Memorandum of Understanding (MOU) with the County. The City will negotiate with Alameda County on the process which will become a part of the MOU with Alameda County. As a contracted Medi-Cal provider with Alameda County, there are processes already in place for coordination to identify, confirm eligibility, and refer members to these appropriate housing-related Community Supports covered by MCP's.

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.
City of Berkeley will continue to coordinate and negotiate regarding the City of Berkeley MOU with Alameda County.

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 service once any of the MCP housing services are exhausted, to the extent resources are available?
As a contractor of Alameda County's Medi-Cal services, Berkeley utilizes a Medi-Cal resources for eligible clients first, referring to MCP partners for eligible care. Once these caps are reached, additional funding can be used (such as BHSA) to cover needed extensions as resources are available. Berkeley utilizes strategic regional partnerships with CoC, CES, and other local entities to ensure coordination of services and preventing individuals from falling into service gaps. The most vulnerable clients with the highest needs (including chronically homeless) are prioritized into appropriately high level care teams (such as FSPs) to ensure gaps are covered quickly and that the safety net services are quickly brought to bear. The different levels of housing in the continuum of services are utilized to support clients being met at their level of readiness and progress can be made towards the ultimate goal of permanent supportive housing.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource . Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools .

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
Yes

Is the county behavioral health system participating in or planning to participate in the Flex Pool?
Yes

What role does the county behavioral health system have or plan to have in the Flex Pool?
Funder

What organization is serving as the Operator?
Abode Services serves as the operator of the Alameda County flexible housing subsidy pool.

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?
Yes

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?
Rental Subsidies
Operating Subsidies

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.
Berkeley can function as a flexible bridge funder for FSP clients who experience gaps in the other housing streams (MCP Transitional rent, interim housing) that do not mitigate all barriers. It can also continue its assessment/vetting function of ensuring that BHSA housing interventions are directed to the highest level of FSP needs/services, and filling in gaps when authorization or other processes during which the client experiences gaps in services. FSP team clinical staff also provide tenancy sustaining services (including crisis and landlord response, housing support services) for their clients as the provide wraparound service to ensure all client needs are met.

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

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.
The City will include requirements in contracts to ensure BHSA-funded Contractors that do not yet participate in the county's Medi-Cal Behavioral Health Delivery System

are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Additionally, contract monitors will do Site Visits to ensure compliance with City and with State requirements.

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

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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)?
24%

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Substance Use Disorder Counselor
Licensed Clinical Social Worker
Licensed Marriage and Family
Therapist Registered nurse
Psychiatrist

Please describe any other key workforce gaps in the county.
Psychiatric nurses and psychiatrists/prescribers with necessary experience/skills are added by contract due to chronic shortages. SUD certified providers and peers with lived experience are also challenging to recruit and bring onboard to a municipal workforce, particularly with anti-discrimination laws.

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)?
The need for medical staff (both psychiatric nurses and prescribers) will continue to grow, as their skills with MDT's will be more in demand. SUD roles will increase, and this training/provider will become increasingly important, even though the workforce is nascent in its growth. Lived experience will also continue to be sought and integrated, though this is challenging to grow in a municipal workforce with HR constraints about how a job classification cannot discriminate without violating federal/state laws.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Berkeley will promote/encourage current and prospective staff hires to apply for the Medi-Cal Behavioral Health Scholarship Program; Berkeley will promote and fund

training and certification of current workforce (particularly peer specialists and SUD counselors).

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

Please explain any actions or activities the county is engaging in to leverage the Program.
Berkeley will continue to promote/encourage current and prospective staff hires to apply for the student loan repayment program participation for current staff, as its behavioral health sites far exceed the Medi-Cal safety net criteria. Medical practitioners reap the greatest rewards for these programs, and thus can be supported in the low end salaries that this jurisdiction provides.

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.
Berkeley will continue to promote/encourage current and prospective staff hires to apply for the Recruitment and Retention program participation for current staff, as its

behavioral health sites far exceed the Medi-Cal safety net criteria. Staff rewards for these programs can support the low end salaries that this jurisdiction provides.

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

Please explain any actions or activities the county is engaging in to leverage the program.
Berkeley will continue to promote/encourage current and prospective staff hires to apply for the Behavioral Health Community-Based provider training program participation for current staff, as its behavioral health sites far exceed the Medi-Cal safety net criteria. Peer Support and SUD counselor certifications are highly desired and challenging to acquire without additional support. Staff rewards for these programs can support the low end salaries that this jurisdiction provides, and provide breadth to the training and skills that the staff can offer to the community.

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

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
More paid training to keep staff current on evidence-based practices that are culturally

appropriate for clients. Planned SUD certification training for existing staff to bridge the SUD services gap. Partnership with SUD and peer agencies who can also shore up the current gaps while the municipal workforce continues to shift and develop.

Budget and Prudent Reserve

For more information on this section, please see 6.B.3 Local Prudent Reserve .

Budget and Prudent Reserve

Please upload the completed budget template
Copy of Final Integrated Plan Budget Template Version 3.xlsx

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template.

Behavioral Health Services and Supports (BHSS)
N/A

Full Service Partnership (FSP)
N/A

Housing Interventions
N/A

Enter date of last prudent reserve assessment 9/30/2024

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan.

BHSS
N/A

FSP
N/A

Housing Interventions
N/A

Table One: Behavioral Health Care Continuum Projected Expenditures									
	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults			Total Projected Expenditures on Children/Youth (under 21)			Projected Individuals to be Served Annually (May be duplicated)	
		Year One	Year Two	Year Three	Year One	Year Two	Year Three	Eligible Adults and Older Adults	Eligible Children/Youth
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Early Intervention Services	☑				$ 395,976.00	$ 243,618.64	$ 239,954.98		420.00
Outpatient Services	☑	$ 743,227.00	$ 754,425.59	$ 765,960.17				745	
Intensive Outpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Crisis and Field-Based Services	☑	$ 607,241.56	$ 616,378.48	$ 625,789.50	$ 108,847.00	$ 108,290.14	$ 107,927.75	2679	238.00
Residential Treatment Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Mental Health (MH) Services									
Primary Prevention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Early Intervention Services	☑	$ 5,570,602.00	$ 5,654,484.82	$ 5,740,884.21	$ 993,730.60	$ 1,009,416.45	$ 1,025,529.48	1616	420
Outpatient and Intensive Outpatient Services	☑	$ 12,122,827.38	$ 12,305,374.31	$ 12,493,397.96	$ 2,162,571.00	$ 2,196,707.15	$ 2,231,772.57	745	238
Crisis Services	☑	$ 606,776.00	$ 615,912.82	$ 625,323.84	$ 108,241.87	$ 109,950.34	$ 111,705.45	2679	238
Residential Treatment Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Hospital and Acute Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Subacute and Long-Term Care Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Housing Services (MH + SUD)									
Housing Services	☑	$ 3,066,349.04	$ 3,262,516.44	$ 3,461,408.23	$ 584,066.48	$ 621,431.70	$ 659,315.85	84	16
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 22,717,022.98	$ 23,209,092.46	$ 23,712,763.92	$ 4,353,432.95	$ 4,289,414.42	$ 4,376,206.07	8548	1570

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures**		
	Year One	**Year Two**	**Year Three**
Capital Infrastructure Activities	$ 695,658.00	$ 695,658.00	$ 420,657.67
Workforce Investment Activities	$ -	$ -	$ -
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 463,654.00	$ 477,563.89	$ 491,890.80
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ -	$ -	$ -
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 1,159,312.00	$ 1,173,221.89	$ 912,548.47

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	$ 12,723,319.55	$ 13,088,090.36	$ 13,463,804.29
1991 Realignment (Bronzan-McCorquodale Act)	$ 6,610,087.38	$ 6,709,238.69	$ 6,809,877.27
2011 Realignment (Public Safety Realignment)			
State General Fund			
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 7,283,928.00	$ 7,393,186.78	$ 7,504,084.58
Projects for Assistance in Transition from Homelessness (PATH)	$ -	$ -	$ -
Community Mental Health Block Grant (MHBG)	$ -	$ -	$ -
Substance Use Block Grant (SUBG)	$ -	$ -	$ -
Commercial Insurance	$ -	$ -	$ -
County General Fund	$ 1,188,925.00	$ 1,206,212.94	$ 1,223,752.32
Opioid Settlement Funds	$ 275,000.00	$ 275,000.00	$ -
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ -	$ -	$ -
Other state funding (including DSH funding)	$ 148,508.00	$ -	$ -
Other county mental health or SUD funding	$ -	$ -	$ -
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)	$ 28,229,767.93	$ 28,671,728.77	$ 29,001,518.46
Total Projected Expenditure Variance	$ (0.00)	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 27,070,455.93	$ 27,498,506.88	$ 28,088,969.99
Auto-validation: Table 2: Other County Expenditures	$ 1,159,312.00	$ 1,173,221.89	$ 912,548.47

Table Four: BHSA Transfers				
County Base BHSA Funding Allocations				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Total**
Year 1 Component Allocation (dollars)	$ 3,508,611.79	$ 4,093,380.42	$ 4,093,380.42	$ 11,695,372.63
Year 2 Component Allocation (dollars)	$ 3,613,870.14	$ 4,216,181.83	$ 4,216,181.83	$ 12,046,233.80
Year 3 Component Allocation (dollars)	$ 3,722,286.25	$ 4,342,667.29	$ 4,342,667.29	$ 12,407,620.82
Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Year One				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 3,508,611.79	$ 4,093,380.42	$ 4,093,380.42	$ 11,695,372.63
Unspent Mental Health Services Act (MHSA) to BHSA	$ 4,469,442.55	$ 5,214,349.65	$ 8,509,627.65	$ 18,193,419.85
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -
Year Two				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 3,613,870.14	$ 4,216,181.83	$ 4,216,181.83	$ 12,046,233.80
Year Three				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 3,722,286.25	$ 4,342,667.29	$ 4,342,667.29	$ 12,407,620.82

Funding Transfer Request Allocations				
Year 1				
Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)				
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**		
Base Percentage and Funding	30%	$ 3,508,611.79		
Percentage Reduced	0%	$ -		
Percentage Added	0%	$ -		
New Housing Interventions Base Percentage (auto-populated)	30%	$ 3,508,611.79		
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**		
Base Percentage and Funding	35%	$ 4,093,380.42		
Percentage Reduced	0%	$ -		
Percentage Added	0%	$ -		
New FSP Base Percentage (auto-populated)	35%	$ 4,093,380.42		
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**		
Base Percentage and Funding	35%	$ 4,093,380.42		
Percentage Reduced	0%	$ -		
Percentage Added	0%	$ -		
New BHSS Base Percentage (auto-populated)	35%	$ 4,093,380.42		
Transfers				
	Housing Intervention (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

Year 2				
Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)				
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**		
Base Percentage and Funding	30%	$ 3,613,870.14		
Percentage Reduced	0%	$ -		
Percentage Added	0%	$ -		
New Housing Interventions Base Percentage (auto-populated)	30%	$ 3,613,870.14		
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**		
Base Percentage and Funding	35%	$ 4,216,181.83		
Percentage Reduced	0%	$ -		
Percentage Added	0%	$ -		
New FSP Base Percentage (auto-populated)	35%	$ 4,216,181.83		
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**		
Base Percentage and Funding	35%	$ 4,216,181.83		
Percentage Reduced	0%	$ -		
Percentage Added	0%	$ -		
New BHSS Base Percentage (auto-populated)	35%	$ 4,216,181.83		
Transfers				
	Housing Intervention (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

Year 3		
Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 3,722,286.25
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 3,722,286.25
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 4,342,667.29
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 4,342,667.29
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 4,342,667.29
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 4,342,667.29

Transfers				
	Housing Intervention (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	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	$ 11,688,571.31	$ 3,506,571.39	$ 4,090,999.96	$ 4,090,999.96
PEI	$ 3,209,570.54	$ 962,871.16	$ 1,123,349.69	$ 1,123,349.69
Encumbered INN	$ 1,602,400.00	$ -	$ -	$ 1,602,400.00
Unencumbered INN	$ -	$ -	$ -	$ -
WET	$ 430,905.00			$ 430,905.00
CFTN	$ 1,261,973.00			$ 1,261,973.00
Total (auto-populated)	$ 18,193,419.85	$ 4,469,442.55	$ 5,214,349.65	$ 8,509,627.65

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	$ 1,233,738.00
Local Prudent Reserve Maximum (2)	$ 1,779,762.59
Excess Prudent Reserve Funding that must be transferred	**$ (546,024.59)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

Table Five: BHSA Components			
Total Housing Interventions Funding (1)			
	Year 1	**Year 2**	**Year 3**
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 3,508,611.00	$ 3,613,870.00	$ 3,722,286.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ 4,469,442.55	$ -	$ -
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 7,978,053.00	$ 3,613,870.00	$ 3,722,286.00

Housing Interventions Category						
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - All Other Funding Sources**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
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	$ 50,000.00	$ 52,000.00	$ 54,000.00	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 120,000.00	$ 126,013.00	$ 130,000.00	$ -	$ -	$ -
% 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	$ 137,000.00	$ 169,000.00	$ 200,000.00	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
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)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 36,618.00	$ 37,716.00	$ 38,848.39	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 954,395.00	$ 984,026.00	$ 1,012,517.36	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ 1,000.00	$ 1,200.00	$ 1,400.00	$ -	$ -	$ -
Capital Development Projects	$ -	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ 50,000.00	$ 60,771.00	$ 62,594.00	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects		$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 1,349,013.00	$ 1,430,726.00	$ 1,499,359.75	$ -	$ -	$ -

Housing Interventions Transfer Information	Year 1	Year 2	Year 3
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Administrative Information	**Year 1**	**Year 2**	**Year 3**
Housing Interventions Component Admin Expenses	$ 272,828.00	$ 281,013.00	$ 289,442.00
Total Housing Interventions Expenditures (auto-populated)	$ 1,621,841.00	$ 1,711,739.00	$ 1,788,801.75
Housing Interventions Populations to be Served	**Year 1**	**Year 2**	**Year 3**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 1,886,770.00	$ 1,902,130.87	$ 1,933,484.04
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ -	$ -	$ -
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**
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)	23.6%	52.6%	51.9%
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 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)	11	12	13
Eligible Adults/Older Adults	204	206	208
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
MHSA "Encumbered" INN	$ -	$ -	$ -

Table Six: BHSA Components			
Total Full Service Partnership (FSP) Funding			
	Year 1	**Year 2**	**Year 3**
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 4,093,380.00	$ 4,216,181.00	$ 4,342,667.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ 5,214,349.65	$ -	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 9,307,729.00	$ 4,216,181.00	$ 4,342,667.00

Full Service Partnership Category (1)									
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - Federal Financial Participation**			**Projected Expenditures - All Other Funding Sources**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 1,833,828.21	$ 1,888,843.06	$ 1,945,508.35	$ 1,102,747.01	$ 1,102,747.01	$ 1,102,747.01	$ 449,019.19	$ 449,019.19	$ 449,019.19
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ -	$ -	$ -				$ -	$ -	$ -
FSP Intensive Case Management	$ -	$ -	$ -				$ -	$ -	$ -
High Fidelity Wraparound	$ 420,209.85	$ 432,816.15	$ 445,800.64	$ 227,367.57	$ 227,367.57	$ 227,367.57	$ 207,813.18	$ 207,813.18	$ 207,813.18
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ -	$ -	$ -				$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$221,856	227023	235367				$ -	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ 1,124,645.93	$ 1,158,385.31	$ 1,193,136.87	$ 375,620.38	$ 375,620.38	$ 375,620.38	$ 557,279.44	$ 557,279.44	$ 557,279.44
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ 221,856.00	$ 230,000.00	$ 235,367.00	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 3,822,396.00	$ 3,937,067.52	$ 4,055,179.85	$ 1,705,734.96	$ 1,705,734.96	$ 1,705,734.96	$ 1,214,111.81	$ 1,214,111.81	$ 1,214,111.81

FSP Transfer Information	**Year 1**	**Year 2**	**Year 3**
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -

FSP Administrative Information	**Year 1**	**Year 2**	**Year 3**
FSP Component Admin Expenses	$ 270,984.14	$ 279,113.66	$ 287,487.07
Total Full Service Partnership Expenditures (auto-populated)	$ 4,093,380.14	$ 4,216,181.18	$ 4,342,666.93

Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)	294	294	294
Eligible Adults/Older Adults	1832	1832	1832

Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
MHSA "Encumbered" INN	$ -	$ -	$ -

Table Seven: BHSA Components

Total Behavioral Health Services and Supports (BHSS) Funding

	Year 1	Year 2	Year 3
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 4,093,380.00	$ 4,216,181.00	$ 4,342,667.00
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)	$ 5,214,349.65	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 9,307,729.00	$ 4,216,181.00	$ 4,342,667.00

Behavioral Health Services and Supports Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - Federal Financial Participation			Projected Expenditures - All Other Funding Sources		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 483,381.16	$ 497,882.60	$ 512,819.08	$ 449,864.79	$ 449,864.79	$ 449,864.79	$ 307,345.20	$ 307,345.20	$ 307,345.20
Early Intervention Expenditures	$ 776,434.33	$ 799,727.36	$ 823,719.18	$ 283,082.73	$ 283,082.73	$ 283,082.73	$ 182,853.00	$ 34,345.26	$ 34,345.26
Coordinated Specialty Care for First Episode Psychosis	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
All Other EI Expenditures	$ 776,434.33	$ 799,727.36	$ 823,719.18	$ 283,082.73	$ 283,082.73	$ 283,082.73	$ 182,853.00	$ 34,345.26	$ 34,345.26
Outreach and Engagement	$ 744,127.00	$ 766,450.81	$ 789,444.33	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 143,635.00	$ 143,635.00	$ 143,635.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ 143,635.00	$ 143,635.00	$ 143,635.00	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 420,657.00	$ 420,657.00	$ 420,659.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ 420,657.00	$ 420,657.00	$ 420,659.00	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 600,000.00	$ 600,000.00	$ 402,400.00	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 3,168,234.49	$ 3,228,352.76	$ 3,092,676.59	$ 732,947.52	$ 732,947.52	$ 732,947.52	$ 490,198.20	$ 341,690.46	$ 341,690.46

BHSS Prudent Reserve Transfer Information	Year 1	Year 2	Year 3
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -

BHSS Administrative Information	Year 1	Year 2	Year 3
BHSS Component Admin Expenses	$ 280,114.87	$ 288,518.32	$ 297,173.87
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 3,448,349.36	$ 3,516,871.08	$ 3,389,850.45

Youth-Focused Early Intervention Expenditures	Year 1	Year 2	Year 3

Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 1,209,322.98	$ 1,263,601.44	$ 1,314,000.00
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	12.9%	38.4%	24.4%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	155.8%	158.0%	159.5%
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)	669	669	669
Eligible Adults/Older Adults	1457	1457	1457
Projected BHSS Funds transferred to WET or CF/TN	**Year 1**	**Year 2**	**Year 3**
BHSS transfer to WET		$ -	$ -
BHSS transfer to CF/TN	$ -	$ -	$ -
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
Estimated MHSA WET Funds	$ 430,905.00	$ 287,270.00	$ 143,635.00
Estimated MHSA CF/TN Funds	$ 1,261,973.00	$ 841,316.00	$ 420,659.00
MHSA "Encumbered" INN	$ 1,602,400.00	$ 1,002,400.00	$ 402,400.00

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year 1**	**Year 2**	**Year 3**
Total Projected Improvement and Monitoring Expenditures		$ -	$ -
Total Projected County Integrated Plan Annual Planning Expenditures	$ -	$ -	$ -
New and Ongoing Administrative Costs	$ 463,654.26	$ 477,563.89	$ 491,890.80
Select County Population Size:	Less than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 26,593,511.00	$ 12,046,232.00	$ 12,407,620.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	0.0%	0.0%	0.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	0.0%	0.0%	0.0%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 1,233,738.00
Local Prudent Reserve Maximum (1)	$ 1,779,762.59
Excess Prudent Reserve Funds (auto-populated)	$ (546,024.59)
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)	$ -

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	**Full-Service Partnerships**	**Behavioral Health Services and Supports**	**Total**
Year One				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 3,508,611.00	$ 4,093,380.00	$ 4,093,380.00	$ 11,695,371.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 3,613,870.00	$ 4,216,181.00	$ 4,216,181.00	$ 12,046,232.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 3,722,286.00	$ 4,342,667.00	$ 4,342,667.00	$ 12,407,620.00

BHSA Funding Summary	**Housing Interventions**	**Full Service Partnerships**	**Behavioral Health Services and Supports**	**Totals**
Year One				
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 3,508,611.00	$ 4,093,380.00	$ 4,093,380.00	$ 11,695,371.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ 4,469,442.55	$ 5,214,349.65	$ 8,509,627.65	$ 18,193,419.85
Estimated Total Available Funding for Year One	$ 7,978,053.55	$ 9,307,729.65	$ 12,603,007.65	$ 29,888,790.85
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 1,621,841.00	$ 4,093,380.14	$ 3,448,349.36	$ 9,163,570.50
Year Two				
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 3,613,870.00	$ 4,216,181.00	$ 4,216,181.00	$ 12,046,232.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 6,356,212.55	$ 5,214,349.51	$ 9,154,658.29	$ 20,725,220.35

Estimated Total Available Funding for Year Two	$ 9,970,082.55	$ 9,430,530.51	$ 13,370,839.29	$ 32,771,452.35
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 1,711,739.00	$ 4,216,181.18	$ 3,516,871.08	$ 9,444,791.26
Year Three				
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 3,722,286.00	$ 4,342,667.00	$ 4,342,667.00	$ 12,407,620.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 8,258,343.55	$ 5,214,349.33	$ 9,853,968.21	$ 23,326,661.09
Estimated Total Available Funding for Year Three	$ 11,980,629.55	$ 9,557,016.33	$ 14,196,635.21	$ 35,734,281.09
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 1,788,801.75	$ 4,342,666.93	$ 3,389,850.45	$ 9,521,319.13
BHSA Plan Admin Expenses				
Plan Admin Category	**Year One**	**Year Two**	**Year Three**	**Total**
Total Projected Improvement and Monitoring Expenditures	$ -	$ -	$ -	$ -
Total Projected County Integrated Plan Annual Planning Expenditures	$ -	$ -	$ -	$ -
Total Projected New and Ongoing Administrative Expenditures	$ 463,654.26	$ 477,563.89	$ 491,890.80	$ 1,433,108.95

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

Please upload the completed Behavioral health director certification template
Behavioral Health Director Certification Template draft JB signed.pdf

County administrator or designee certification

Please upload the completed County administrator or designee certification template
CountyAdministratorOrDesigneeCertification.pdf

Board of Supervisor certification

For final submission, download and complete the board of supervisor certification template

Following City Council approval of the Final BHSA Integrated Plan in June, the Board of Supervisor Certification will be signed and added to the Final BHSA Integrated Plan.

DHCS | County Portal

Behavioral Health Director Certification

Certification

1. I hereby certify that City of Berkeley 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:

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

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

   - ( ) Yes
   - (•) No

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

County Behavioral Health Agency Director contact information

3. County Name

City of Berkeley

4. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

4a. Submission type

- (•) Draft
- ( ) Final

5. County Behavioral Health Agency Director name

Jeffrey Buell

6. County Behavioral Health Agency Director phone number

510-981-7682

7. County Behavioral Health Agency Director email

jbuell@berkeleyca.gov

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

8. Name

9. Title

10. Phone

11. Email

County Behavioral Health Agency Director signature

12. Print name

Jeffrey Buell

13. Title

Manager of Mental Health Services

14. Date

3/20/2026

15. Signature

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

16. Print name

17. Title

18. Date

19. Signature

DHCS | County Portal

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

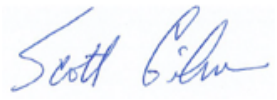
3. Print name

Scott Gilman

4. Date

3/23/2026

5. Signature



Contact information

6. County Name

City of Berkeley

7. Certification for

- (●) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

7a. Submission type

- (●) Draft

8. County Chief Administration Officer Name

Scott Gilman

9. County Chief Administration Officer Phone number

(510) 981-5404

10. County Chief Administration Officer Email

sgilman@berkeleyca.gov

Requests

Assertive Community Treatment (ACT) Evidence-Based Practice (EBP) Exemption Request
For counties seeking an exemption to the requirement to include ACT in the county's FSP program.

Please select which FSP exemptions criteria the county meets
Limited workforce (e.g. qualified providers)
Other hardships

Please provide justification for this FSP exemption request
The City of Berkeley is currently in a hiring freeze and will be facing staff reductions to offset a Budget Deficit.

Supporting Data
Please upload supporting data
City of Berkeley EBP Exemption Justification.pdf

Please select the data source
Other

Please describe
EBP Exemption Justification Document

Forensic Assertive Community Treatment (FACT) Evidence-Based Practice (EBP) Exemption Request
For counties seeking an exemption to the requirement to include FACT in the county's FSP program.

Please select which FSP exemptions criteria the county meets
Limited workforce (e.g. qualified providers) Other hardships

Please provide justification for this FSP exemption request
The City of Berkeley is currently in a hiring freeze and will be facing staff reductions to offset a Budget Deficit.

Supporting Data

Please upload supporting data
City of Berkeley EBP Exemption Justification.pdf

Please select the data source
Other

Please describe
EBP Exemption Justification Document

Individual Placement and Support (IPS) Supported Employment Evidence-Based Practice (EBP) Exemption Request
For counties seeking an exemption to the requirement to include IPS in the county's FSP program

Please select which FSP exemptions criteria the county meets
Limited workforce (e.g. qualified providers)
Other hardships

Please provide justification for this FSP exemption request
The City of Berkeley is currently in a hiring freeze and will be facing staff reductions to offset a Budget Deficit.

Supporting Data

Please upload supporting data
City of Berkeley EBP Exemption Justification.pdf

Please describe
EBP Exemption Justification Document

Individual Placement and Support (IPS) Supported Employment Evidence-Based Practice (EBP) Exemption Request
For counties seeking an exemption to the requirement to include IPS in the county's FSP program

Please select which FSP exemptions criteria the county meets
Limited workforce (e.g. qualified providers)
Other hardships

Please provide justification for this FSP exemption request
The City of Berkeley is currently in a hiring freeze and will be facing staff reductions to offset a Budget Deficit.

Supporting Data

Please select the data source
Other

Please upload supporting data
City of Berkeley EBP Exemption Justification.pdf

Please describe
EBP Exemption Justification Document

City of Berkeley Evidence-Based Practice (EBP) Exemption Justification

The City of Berkeley is experiencing a structural budget deficit of up to $32 million annually and is currently facing layoffs and a hiring freeze. While final decisions on how the City will address the deficit will not be made until April (which is past the due date of this Draft BHSA Integrated Plan), vacant positions at Berkeley Mental Health cannot be filled, and are likely to be cut for this coming fiscal year. A finding in a recent City of Berkeley audit revealed that services are already constrained by challenges with staff recruitment and retention.

EBP's and fidelity to these models requires specialized roles and functions that Berkeley is currently unable to fund or recruit for, due to the current fiscal crisis and BHSA shift of treatment funds into housing interventions. Fidelity to EBP's requires strict multidisciplinary team compositions and ratios that Berkeley cannot currently attain without compromising core services to its most vulnerable residents.

Berkeley has submitted the Engagement Information Form (EIF) to consult with the Centers of Excellence (COE) to see how services can be aligned as closely to fidelity as possible despite constrained service and staffing options. The City will utilize COE technical assistance to develop capacity and staffing projections that are realistic in relation to Berkeley's constrained resources and most vulnerable population needs.

ATTACHMENT A

COMMUNITY INPUT

BHSA Community Input Priorities

During the City of Berkeley's BHSA Community Program Planning Process the priorities that were most commonly mentioned, and ratings of preferences and needs for the BHSA Integrated Plan, were as follows:

Funding Component Allocation Priorities: Input received on the BIHSA Community Input Survey, regarding which BHSA component should be the largest, indicated that the Behavioral Health Services and Supports component should receive the largest amount of funds, with Housing Interventions rated as a close second. Simultaneously, input on which category should be the smallest, showed that a predominant number of responders indicated that they wouldn't make any changes to the funding in any of the components.

Input received through Community Meetings or email regarding housing and the FSP components focused on: the need for additional housing; supporting homeless individuals in housing; converting motels into housing and include a care worker at the dwelling to provide supports; engaging the homeless community in building Tiny Homes, and focusing a portion of housing intervention funds on Transition Age Youth and the LGBTQIA+ population; and concerns there will be a cut to the FSP program as there are a lot of people out there who need that level of help.

Berkeley BHSA Integrated Plan (IP): In order to best align with this diverse community input, Berkeley will not be requesting to transfer funds from one component to another in this BHSA IP.

Mental Health/Behavioral Health Needs and Priorities: While the areas of needs listed below are all vulnerable populations, input received from the BHSA Community Input Survey ranked the needs below (listed in order of rated importance) as follows:

- Transition Age Youth (TAY - Aged 16-25) experiencing mental health needs.
- Children/Youth experiencing mental health needs.
- Adults experiencing mental health needs.
- Older Adults experiencing mental health needs.
- Individuals experiencing behavioral health and housing needs.
- Individuals experiencing substance use disorders or overdoses.
- Individuals from underserved cultural/ethnic populations experiencing mental health needs.
- Veterans experiencing behavioral health needs.
- Family Members of individuals experiencing behavioral health needs.

Input received during Community Input Meetings that was relevant to the Mental Health/Behavioral Health needs listed above focused on: Implementing more prevention

and early intervention services for children; creating more appropriate Behavioral Health services and supports for TAY, and allocating a percentage of funding across each BHSA funding component for services/supports for TAY; Ensuring Older Adults are involved in informing the process and that they are provided with services as their physical and mental health concerns can be forgotten; the need for integrated treatment for co-occurring disorders.

Berkeley BHSA IP: Each area of need will be addressed within the BHSA IP as follows:

- Children, Youth and Transition Age Youth (TAY): The largest number of service programs within this BHSA Integrated Plan will either primarily focus on Children, Youth and TAY or have a component within them that serves the TAY population. The City will also be re-positioning some staff to build additional capacity within the Children's and Youth Full-Service Partnership, and to begin to prepare for the implementation of the required High Fidelity Wraparound Evidence Based Practice (EBP) within the program. The BHSA IP will include a new program that will provide a variety of Peer Supports for TAY within the Adult Full Services Partnership.
- Adults and Older Adults: Berkeley will continue to provide services within this BHSA IP to adults and older adults at the same high rate.
- Housing and Homelessness: By utilizing the full 30% allotment of funds for Housing Interventions, Berkeley will seek to supplement other initiatives that are currently underway in the City in an effort to support more individuals in obtaining housing supports.
- Substance Use Disorder Services: Berkeley will continue its collaboration with Substance Use Disorder community partners who serve individuals at the Adult Clinic and youth in the Berkeley High Schools. An additional focus in this area will be on increasing capacity in the three-year timeframe within Field-Based Substance Use Disorder service programs.
- Underserved Cultural/Ethnic populations: Services specific to the needs of underserved cultural and ethnic populations that were previously funded through Mental Health Services Act (MHSA) Prevention and Early Intervention will transition to Early Intervention in the Behavioral Health Services and Supports funding component of the BHSA IP. The Wellness Team will provide engagement and peer services to individuals across the system, as well as offer opportunities for individuals to participate in affirming groups and activities to increase self-care, and reduce barriers in accessing and staying connected to services. Programs across the system will continue to have a focus on providing services and supports to underserved cultural populations. The efforts through the Multicultural Outreach and Engagement program will also continue in this BHSA IP, to increase community knowledge and awareness of

City services for underserved cultural and ethnic populations and staff trainings to increase knowledge and skillsets around cultural appropriate practices will also continue to be provided.

- Veterans: Although there is not a specific program within this current BHSA IP that solely focuses on the needs of veterans, (as has happened in the past) individuals who identify as a Veteran and meet the eligibility of a given program will qualify to receive services. Berkeley may also refer to a community partner that has expertise in serving Veterans, as needed and appropriate.
- Family Members: This BHSA IP will continue to implement the Family Services program which provides services and supports to Family Members of individuals who have Behavioral Health needs.

Service Priorities: The top six service priorities that were repeatedly mentioned in the Survey and during Community Meetings focused on the following:

- Mental Health Services
- Housing and Homelessness Services
- Transition Age Youth and Youth Mental Health Services
- Peer Support and Wellness Services
- Substance Use Disorder and Co-Morbidity Services
- Prevention and Early Intervention Services

*See Appendix A for all comments received on the Survey and during Community Meetings.

Berkeley BHSA IP : Each service area will be addressed within the BHSA IP as follows:

- Mental Health Services: The Berkeley BHSA IP will enable mental health Early Intervention, Outpatient, Crisis and Treatment services to be implemented or continue for Children, Youth, Transition Age Youth, Adults and Older Adults through Berkeley Mental Health, Berkeley Unified School District, and multiple community partners.
- Housing and Homelessness: By utilizing the full 30% allotment of funds for Housing Interventions, Berkeley will be able to supplement initiatives that are currently underway in the City in an effort to support more individuals in obtaining housing supports.
- Youth and Transition Age Youth Services: The largest number of service programs within this BHSA Integrated Plan will either primarily focus on Youth and Transition Age Youth or have a component within them that serves the TAY population. The City will also be re-positioning staff to build additional capacity within the Children's and Youth Full-Service Partnership, and to begin to prepare for the implementation of the required High Fidelity Wraparound Evidence Based Practice (EBP) within the program.

- Peer and Wellness Services: The City will continue offering Peer and Wellness Services through this BHSA IP. The Wellness Team provides warm welcoming peer engagement to individuals across the system. Team members also offer opportunities for clients to participate in affirming groups and activities to increase their well-being and to reduce barriers in accessing and staying connected to services.
- Substance Use Disorder and Co-Morbidity Services: Berkeley will continue its collaboration with our community partner who provides Substance Use Disorder services to individuals who receive services at the Adult Clinic and to youth in the Berkeley High Schools. Berkeley will also explore an SUD training and certification program for existing staff members to enhance services offered in existing behavioral health teams and settings. An additional focus in this area will be on increasing capacity in the three-year timeframe within Field-Based Substance Use Disorder service programs.
- Prevention and Early Intervention Services: The largest area of programming in Berkeley's BHSA IP is in Early Intervention services. Programs will be implemented for, Children, Youth, Transition Age Youth, Adults, Older Adults and specific programs will focus on individuals in underserved cultural and ethnic populations including LGBTQIA+. Services will be implemented through Berkeley Mental Health, Berkeley Unified School District, and multiple community-based organizations.

BHSA Community Meeting Input

Community Input collected during 12 Community Input Meetings is organized into 6 main themes outlined below:

Housing and Homeless Services

- "It's great to have money for housing, because there are a lot of housing needs."
- "You need to be working with unhoused people that have skills who can build Tiny Homes and have City owned land where unhoused people can use their skills to build Tiny Homes. It could generate income for this population and get them using their skills and working. The City could supply the lumber and building materials and the skilled unhoused individuals could build it which would be way less costly than a big corporation building them."
- "Adopt a homeless person and check in on them and help them out."
- "How can you do housing in a community that creates structure for people who don't work well within a structure?"
- "How do you respect an individual's dignity around the imminent needs that come up when they are unhoused, without institutionalizing them?"
- "Convert motels into housing and have a care worker there who can provide support, help with Medications, etc."

Mental Health Services and Other Supports

- "Need more resources for mental health in Berkeley. Also, need other resources for individuals who have mental health needs such as food pantries. The current food pantries have long lines and are not open every day."
- "Need more prevention and more early intervention services for children."
- "Having housing isn't going to solve the problem, mental health services are a lot more important."
- "I'm concerned if there will be a cut to the FSP program as there are a lot of people out there who need that level of help."
- "Develop mental health services with Trauma-informed and compassionate care approaches."
- "Implement Support Groups for individuals in need and possibly bill Medicare for the support group services."
- "There needs to be more outreach strategies for individuals resistant to services."
- A community member who was a care giver for a friend described difficulty helping them receive services for schizophrenia. Despite multiple attempts, he experienced many challenges in obtaining immediate access to mental health services. Expressed concern that individuals experiencing severe symptoms (e.g., hallucinations/delusions) are not receiving prompt care.

Services for Transition Age Youth

- "For TAY FSP Services, youth are often not "held" in the same way with supports after they reach adult age. It's like services become a "check-off" instead of a "check in". The way of serving TAY should be elongated to the age of 33 to ensure they are not dropped or treated differently when they become an adult."

- “Youth/TAY are never chosen for housing, first in the City. Youth/TAY are not as important for being provided with housing as someone who has been on the street for 50 years.”
- “The City should allocate a percentage of funding across each BHSA funding component for services/supports for TAY.”
- “Some funding should be used through Workforce Development and Training, to support TAY in this area of their lives.”

Wellness Services

- “Berkeley Wellness Center will be closing, it has been a valuable service and a lot of people will continue to need services when it closes and there needs to be a plan for where these individuals will be provided with services when the center closes.”
- In reference to the closing of the Berkeley Wellness Center a couple of additional community members wanted to know where individuals will be served once the Center closes. They talked about previous models that worked well for a long time in Berkeley, such as the “Creative Learning Center” which they indicated was in operation for 42 years and worked well in Berkeley, as individuals could access a variety of wellness activities and obtain other services and supports. They indicated that Berkeley needs to find something like that where individuals of all ages and demographics can access Art, Drama, Dance, etc., and other supports such as one-on-one counseling, NA, AA, and hot lunches.
- One of the community members who talked about the Creative Learning Center shared about her experiences helping students in Arts programs and how the programs are beneficial for self-expression and emotional support. She indicated that Art classes are so important, and they can’t all be done by Zoom, and shared that people need support as a community in an in-person environment, so that they can see they are not the only ones with a mental illness, and that there are different ways of dealing with mental illness. She shared that some people need strong support or they will fall through the wayside. She expressed her concerns about the closing of the Berkeley Wellness Center and other programs across Alameda County and brought an article from the San Francisco Chronicle regarding some services that are closing. She also shared an email from a friend and regarding the value of these services. She reiterated the need for there to be a place where individuals can go to participate in art and wellness type activities and where simultaneously they can receive food, and multiple mental health supports, NA, AA etc., to keep individuals stabilized and promote wellness.
- A community member shared their experience of how the Berkeley Mental Health Wellness Services have been very beneficial to them.

Substance Abuse and Co-Occurring Needs

- “Drugs and alcohol are terrible and can make people act in violent ways and exacerbate the issues for individuals who have mental health needs.”
- ”There is a need for integrated treatment for co-occurring disorders.”
- One Community member talked about his observations of individuals experiencing homelessness who are using methamphetamine and showing severe mental health symptoms. He voiced concerns and observations about people who live with trauma and expressed that he helped people who have experienced mental health issues, and had

difficulty engaging individuals who may not want to seek help or who did not have peer support.

Other

- One community member said that the City should consider using the “Sequential Intercept Model” to assess where to place resources. This model focuses on the points of people’s lives where things go “south”, whether losing housing, being arrested, etc., and places resources to prevent these occurrences and assist people accordingly. This community member also sent information on this model by email.
- “Workforce training in engagement strategies and models to help people who are transitioning from prison back into society.”
- “Make sure Seniors are involved in informing the process and that they are provided with services as their physical and mental health concerns can be forgotten.”
- “I called the “hotline” and got really good services for my friend. Being able to call someone was very helpful.”

City of Berkeley Behavioral Health Services Act Community Input Survey

The City of Berkeley, Health, Housing & Community Services, Mental Health Division invites your input on local Behavioral Health (mental health and substance use disorder) priority needs.

Since 2006, the City of Berkeley Mental Health Division has received State funding through the Mental Health Services Act (MHSA) to implement local mental health programs and services. Beginning, July 1, 2026 the MHSA will be replaced by the new Behavioral Health Services Act (BHSA). Passed in 2024, the purpose of the BHSA is to reform the current MHSA funding components and program allowances to among other things: Prioritize services for individuals with the most significant mental health needs; add services for individuals experiencing substance use disorders; and expand housing interventions.

As with MHSA, in order to utilize BHSA funds, community informed, Three Year Integrated Plans and Annual Updates outlining the use of funds and programming are required to be developed and approved by Berkeley City Council. An added requirement in BHSA is to obtain approval from the California Department of Health Care Services (DHCS).

Berkeley is in the process of transitioning from MHSA to BHSA which will begin with Community Input and the creation of the first Draft BHSA FY2027-2029 Three Year Integrated Plan. Input from the Berkeley community on this survey will inform the decisions that will be made on how to prioritize programs and allocate funds in the first BHSA Three Year Integrated Plan. The survey should take less than 10 minutes and will be open until 5:00pm, Wednesday, March 4th.

1. How informed do you feel about the Behavioral Health Services Act (BHSA) that was passed by voters in March 2024, which will make changes to local mental health funding and program allowances beginning July 1, 2026?

__ Very Informed

__ Somewhat Informed

__ I know a little information

__ Not really informed

__ Unsure

2. Proposition 1, which implements the BHSA changes requires that the California tax collected for this purpose, to be spent on three different categories, according to the descriptions and funding percentages outlined below:

-Full Services Partnership (FSP) - 35%: Intense, wrap-around programs for individuals who experience severe mental illness or serious behavioral health issues, with the care and supports needed to promote better health and well-being.
-Behavioral Health Services & Supports (BHSS) - 35%: Community services for individuals experiencing serious mental health and/or substance use disorder needs. The programs include early intervention services and can be used on outpatient services & supports. Funds may also be utilized on outreach & engagement; staff support & training; major building and technology needs; and on innovative or creative projects.
-Housing Interventions (HI) - 30%: Primarily supports individuals who are experiencing mental health needs and/or substance use disorders and homelessness.

If you could shift 7% of BHSA funds from one category to another (so that one category has a larger amount than the others), which category is most important to you and would you make the largest?:

__ Full Services Partnership Category

__ Behavioral Health Services and Supports Category

__ Housing Interventions Category

__ I wouldn't make any changes.

3. Which category is least important to you and would you make the smallest?

__ Full Services Partnership Category

__ Behavioral Health Services and Supports Category

__ Housing Interventions Category

__ I wouldn't make any changes.

4. Please rank the following 9 areas of needs in Berkeley in order of importance (1 most important - 9 least important) from your perspective:

___Children/Youth experiencing mental health needs.

___Transition Age Youth (aged 16-25 years) experiencing mental health needs.

___Adults experiencing mental health needs.

___Older adults experiencing mental health needs.

___Individuals experiencing substance use disorders or overdoses.

___Veterans experiencing behavioral health needs.

___Family members of individuals experiencing behavioral health needs.

___Individuals experiencing behavioral health and housing needs.

___Individuals from cultural/ethnic populations who experience behavioral health needs.

5. In the previous question, for the area of need that you ranked #1 as most important, please share any ideas, strategies and solutions you may have to help us improve in this area.

6. Is there an area of behavioral health need (i.e. mental health or substance use) in Berkeley that was not mentioned in question #5 above? If so please describe, and share any ideas, strategies and solutions to help us improve in this area.

7. What barriers make it harder for individuals and family members with behavioral health challenges to access needed services. Select all that apply.

☐ Hard to find information on where to go for help.

☐ Do not want help right now.

☐ Embarrassed to ask for help and/or stigma around seeking help.

☐ Services are not close to my home.

☐ Isolated or unable to leave home.

☐ Limited resources (financial, transportation, etc.).

☐ Safety concerns.

☐ Lack of providers who represent my culture, and/or speak in my preferred language.

☐ Providers don't offer the services that are needed.

☐ Long wait to get an appointment.

☐ Other (please specify).

8. Did we miss anything? Please share other behavioral health needs, concerns, or solutions that you may have that haven't been mentioned.

9. If you would like to receive information in the future on BHSA Meetings, Integrated Plans and other related documents, please provide your name, how you would like to be contacted (i.e. email, mail, phone), and your contact information.

Demographic Information

Any demographic information shared in the questions below will be anonymous and helpful to the Mental Health Division in determining which members of our community have engaged with this process, and whose priorities are being highlighted.

10. What is your age?

- ◯ Under 16 years of age
- ◯ 16-25 years of age
- ◯ 26-59 years of age
- ◯ 60+ years of age
- ◯ Prefer not to answer

11. What is your ethnicity/race?

- ◯ American Indian or Alaska Native
- ◯ Asian or Asian American
- ◯ Black or African American
- ◯ Native Hawaiian or other Pacific Islander
- ◯ White
- ◯ More than one race
- ◯ Prefer not to answer
- ◯ Other (please specify)

12. Are you of Hispanic, Latino/Latina/Latinx origin?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

13. Are you a veteran (of the US Armed Forces)?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

14. Which of the following best represents how you identify?

- ◯ Straight/Heterosexual
- ◯ Gay or Lesbian
- ◯ Bisexual
- ◯ Queer
- ◯ Questioning or Unsure
- ◯ Another sexual orientation
- ◯ Prefer not to answer

15. What is your Gender Identity?

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Genderqueer
- ◯ Questioning or Unsure of Gender Identity
- ◯ Other Gender Identity
- ◯ Prefer not to answer

16. Do you identify as having any type of disability?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

17. Which of the following categories do you primarily represent? Please select all that apply

☐ Mental Health Consumer

☐ Substance Use Disorder Services Consumer

☐ Family Member of Mental Health or Substance Use Disorder Services Consumer

☐ Veteran

☐ Homeless Services advocate

☐ Individual who has experienced homelessness

☐ Representative of a Mental Health or Social Services Agency

☐ Representative of Substance Use Disorder Services Agency

☐ Representative of a HealthCare organization

☐ Community Member

☐ Representative of City of Berkeley Commission

☐ City of Berkeley Staff

☐ Student, Parent, Staff or representative of Berkeley Unified School District

☐ Student, Parent, Staff or representative of UC Berkeley or Berkeley College

☐ Representative of Law Enforcement

☐ Faith-based organization representative

☐ Prefer not to answer

☐ Other (please specify)

Thank you for providing input into this process!

Survey Results

1.) How informed do you feel about the Behavioral Health Services Act (BHSA) that was passed by voters in March 2024, which will make changes to local mental health funding and program allowances beginning July 1, 2026? (226 of 228 answered this question)

- 10.62% - Very Informed
- 45.58% - Know a little information, or Somewhat Informed
- 43.80% - Not really Informed, or Unsure

2.) Proposition 1, which implements the BHSA changes requires that the California tax collected for this purpose, to be spent on three different categories, according to the descriptions and funding percentages outlined below:

-Full Services Partnership (FSP) - 35%: Intense, wraparound programs for individuals who experience severe mental illness or serious behavioral health issues, with the care and supports needed to promote better health and well-being

-Behavioral Health Services & Supports (BHSS) - 35%: Community services for individuals experiencing serious mental health and/or substance use disorder needs. The programs include early intervention services and can be used on outpatient services & supports. Funds may also be utilized on outreach & engagement; staff support & training; major building and technology needs; and on innovative or creative projects.

-Housing Interventions (HI) - 30%: Primarily supports individuals who are experiencing mental health needs and/or substance use disorders and homelessness.

If you could shift 7% of BHSA funds from one category to another (so that one category has a larger amount than the others), which category is most important to you and would you make the largest?: (224 of 228 answered this question).

- 38.39% chose Behavioral Health Services & Supports to be the largest category.
- 34.38% chose Housing Interventions to be the largest category.
- 18.75% chose Full Services Partnership to be the largest category.
- 8.48% -indicated they wouldn't make any changes.

3.) Which category is least important to you and would you make the smallest?: (215 of 228 answered this question). Results were as follows:

- 20.00% chose Full Services Partnership to be the smallest category.
- 19.53% chose Housing Interventions to be the smallest category.
- 15.81% chose Behavioral Health Services & Supports to be the smallest category.

- 44.65% indicated they wouldn't make any changes.

4.) Please rank the following 9 areas of needs in Berkeley in order of importance (1 most important - 9 least important) from your perspective:
(223 of 228 answered this question)

Results are outlined below from the highest to the lowest ranked needs (with weighted average scores):

- Transition Age Youth (Aged 16-25) experiencing mental health needs. (6.82)
- Children/Youth experiencing mental health needs. (6.72)
- Adults experiencing mental health needs. (6.13)
- Older Adults experiencing mental health needs. (5.53)
- Individuals experiencing behavioral health and housing needs. (4.91)
- Individuals experiencing substance use disorders or overdoses. (4.62)
- Individuals from underserved cultural/ethnic populations experiencing mental health needs. (3.77)
- Veterans experiencing behavioral health needs. (3.71)
- Family Members of individuals experiencing behavioral health needs. (2.66)

5.) In the previous question, for the area of need that you ranked #1 as most important, please share any ideas, strategies and solutions you may have to help us improve in this area. (172 of 228 answered this question) Responses are outlined below by ranked categories:

Responses that ranked Transition Age Youth (aged 16-25 years) experiencing mental health needs as most important (31 responses):

- Support the African American Holistic Resource Center (AAHRC) and AAHRC's Project Sankofa for the Transition Age Youth (TAY).
- There should be increased focus on Transition Age Youth (TAY) to reduce needs later in adults. Be proactive by addressing TAY because it is a critical age that impacts the future.
- I feel like children's mental health doesn't get represented enough and is ignored "because kids/youth don't have real problems". I think further studies and care could really help.
- Free/low-cost Mental Health Services that are accessible to youth and their families. A day/early evening program to engage in activities for mental health.
- Transition Age Youth is the fastest growing demographic that I feel needs help.

- The City should continue and expand funding for Youth Spirit Artworks' Vocational Arts as a proven model for the 51% youth funding mandate.
- Non-judgmental safe spaces to spend time and get resources for free, no questions asked. Unconditional acceptance and holistic support.
- More community spaces and resources for TAY ages to navigate learning to pay rent, hold work/jobs, develop the skills needed for jobs (without huge upfront costs for training) *Also therapy services that are accessible for all TAY (minimal to no cost) to prevent them from turning to drugs/alcohol/other substances to process and handle their traumas and emotions.
- More theatre programs and Big Brother/Sister mentorship type programs that connect young people and professionals in the community.
- Programs for coping skills; Support Groups; Outreach Programs; Informational Groups about Mental Health.
- I don't have a solution I just know that these kids need help. They are the future.
- Catching and helping youth before they get into adulthood is very important. By dealing with these children before the problem settles in and becomes a habit, they will have a chance to get tools to deal with life.
- The Independent Living Skills Program and Alameda County is(was?) a great program to help the transition process for teens. Learn from them and expand the program.
- Youth, particularly those 16-25, are in need of early intervention and preventive opportunities due to their specific socio-emotional and life skill needs. These youth are still willing to learn/adapt more so than their fellow older adults, but are also at a daily risk of making life altering choices for themselves/community if not addressed sooner. Most importantly these youth will be the next adults, older adults, & veterans etc., and will engage with the world based on what they learned in their transition from teenage to young adult years.
- Invest in TAY organizations like Youth Spirit Artworks. Helping transitional youth helps bring forth healthy adults that can contribute into the economy.
- Veterans should be served with FEDERAL money. Children should be served with USD money. There is never enough to serve anywhere near all of the people who need it. Mental health support needs to be accessible, consistent and known in the community. Outreach! Crisis counselors and therapists should do both jobs so that a person can see and become familiar with the person they will continue to see in office. Hire stable, well-trained, well-paid staff and let them do their thing without too much bureaucracy. Have a goal of keeping clinicians for at least 5 years. The longer they stay, the more familiar they are to residents, and the more trusted they become. I have NEVER managed to get anyone services through Access. It is too indirect and unknown.

- Hire peers.
- Outreach. Seek or inform these community members of the service at high school events, community colleges, trade schools, hiring events, etc. Make people aware of the resource.
- Community programs such as Youth Spirit Artworks really help young adults and teens find community in their struggle, so I think holding space and funding for programs like such would be an effective way to help.
- From 1-9 all Questions are #1.
- Partner with employment training programs.
- Severe mental health needs often become obvious in late teens. Families need to be able to stabilize their family members. Problems with HIPAA and with being able to pay for treatment result in life-long problems.
- More funding for treatment programs and ways of identifying at risk youth, and letting family know (if they would be helpful)
- This is impossible to be asked to rate which is more important! They are all equally important!
- Work with BUSD and BCC to structure help for youth.
- Expand the transition age to 35. When young people first start exhibiting mental health problems, help them with jobs, housing, therapy. Involve the family in the care so the individual can be wrapped in support. People DIE from mental health issues. My beautiful son needed help and all the help available was inadequate. We did everything we could. It was not enough. Emergency rooms, 5150s with Fremont hospital, bright lights, etc., these did not help.
- This is very difficult to complete due to the ranking.
- In a life where being successful is looked upon, it's important to realize that people of all ages need a break from any mental stressful situations or the ability to adjust to time altering tasks as well as making sure to be respectful of each others environment.
- Early intervention. Mobile crisis team was great and should be brought back.
- Catch issues now as a child, fix it build strong adults as it is harder to fix broken adults.
- The earlier you get a person services the better the outcome can be for the future. TAY is a challenging age and there can be many factors happening for youth and normalizing and understanding mental health needs can help a person navigate and get support before it gets worst.

<u>Responses that ranked Children/Youth experiencing mental health needs as most important (39 responses)</u>:

- To develop programs to create early intervention, which I believe will create a greater opportunity for early diagnosis, early treatment and better solutions or progress.

- Don't know right now.
- We need to have facilities open to help them. We need to have people willing to help in every area.
- Children/Older Adults very important.
- N/A
- I would have more classes and be willing to work with the children around the clock.
- More child and parent extracurricular events so the parents are more involved with child's needs.
- Having a sign-in when you enter the program. You are signed in with a Job Placement group, that way when you do leave the program you're leaving the program with a job and longer classes during your job to learn.
- You gotta help the kids.
- I'm not familiar with Berkeley so I think they are all great ideas.
- Listen to children when they say something is wrong.
- Additional funding at sites that promote easy access to services: schools and pediatric practices.
- Provide more positive role models. Provide more afterschool opportunities, sports, school activities.
- Help support kids in foster care and affected by inequities in having better starts to school. A foster child in our TK was the only child without a grown up with him in line to go into the new class in the mornings. He was then the only child with time-outs the first day (and inequities thereafter). Can we set up kids and communities for success?
- Funding to support systems outside of the psychiatric complex should be maintained and increased for non-medical interventions, such as the Hearing Voices Network.
- Early prevention through 3rd spaces, spaces where they are able to have community without a price tag.
- Youth leadership opportunities, Parent classes, Teacher supports based on cultural needs that are non-traditional.
- Continue the funding necessary to keep Youth Spirit Artworks going.
- Early Intervention is absolutely key.
- Perinatal mental health and post partum mental health should be the top focus. Including parent and child interactive therapy.
- I believe more could be done with children and family's partnerships with Mental Health. I think a collaboration with all of the city services-parks and rec; public health, day cares; the Y, including the school district should be a fully wrapped service. It would be important to include all the line staff in and have full community participation rather than management just making decisions.

- I feel that if more funds were given to prevention and awareness that would help.
- Direct involvement with those in most need for severe brain illnesses, such as schizophrenia, bipolar, etc. Have the emphasis be predominately patient focused, rather than systemic focused.
- Holistic wellness curriculum, normalizing therapy for children, age-appropriate services, providing peer supports as they become adults.
- Work with peoples needs is a good way to improve care.
- Best serve the children by also serving their caregiving adults.
- Early Intervention. safe sustainable housing. prevent multifactorial decompensation with substance abuse AND homelessness.
- More support in our school system for all students experiencing mental health needs even if they are doing well academically.
- I would involve the school system. I know that teachers are very overworked, but I believe they are at the frontline of seeing children who need mental health intervention. I would partner BHSA with teachers. If we can reach kids and their families at a young age, we can perhaps curb issues at the teenage level.
- Take care of children first.
- In school resources; parenting psychoeducation (Mental Health First Aid) to identify symptoms and supportive options. Resource directories.
- Increase pay for trained, experienced, mature professionals.
- I would add “Disabled Individuals experiencing mental health needs and housing insecurity” to Top 3.
- Getting the pre-school a more integrated vetting system.
- Work with individuals from underserved communities and their families to support the children with MH needs. School assessment with weekly therapy available in the community and on site support. $$ for therapists to work with children in private practice. Not another institution but subsidies to support children in need of expert care. Eliminate institutional care as it is filled with political and institutional barriers and future uncertainties. Funnel the $$ into private pay subsidies providing therapy based on MH standards of care and eliminates the poor outcomes we see institutionally based on care disparities.
- There is a huge housing need, but I also hope that early intervention can prevent folks from entering homelessness.
- I do not know much about the current services available, but seems like we could always use more support for our youth, especially as the world becomes harder for kids to live in. Ensuring all who want access to therapy and mental health care - both

behavioral and medical - is essential. I hope that it is integrated in schools and readily available in many languages.
- Queer youth are especially at risk.
- Children and young adults are living in a very challenging time, lack of time with parents, over dependence on technology, confusing news, lack of experience in teachers to recognize the difference between mental health /illness and odd behavior..its a fine line. between the two. Put more resources in early intervention, use a wholistic approach with appropriate medication.

Responses that ranked Adults experiencing Mental Health needs as most important (23 responses):
- We should find more funding to help support this population, along with making funding and resources not so hard to obtain for our clientele.
- Adults are more likely responsible to have children and others come to them. If you treat them, they won't spread the challenge (trauma) and they can help others first.
- I would separate (adults experiencing mental health needs) into: Individual high risk and Mid-range community/support. I don't now enough about programs in place for high-risk individuals but I have found that community classes/support/multi-use space seem to have a good "financial/effect" ratio.
- To expand resources for adults including housing, work and financial support.
- Provide more comprehensive care and resources for adults living with mental illness.
- Mental Health is the beginning.
- Giving Gift Cards for people with mental disorders.
- I feel there is a lack of services for families with low incomes. As far as housing and receiving the care needed, housing, medication and treatment programs. I also see in geographical areas resources and treatment are far much different when it comes to lower income families. I also see people of color receive far less.
- Make it easier for people to know about and access.
- The city needs 24/7 mental health services to respond to real time mental health crisis, with an easy way for residents to call for help.
- It’s important to keep mental health Access services available to prevent massive incarceration and continued homelessness.
- The City of Berkeley can strengthen long-term community ownership and housing stability by partnering with community land trusts (CLTs) such as the Supportive Housing Community Land Alliance (SHCLA), which was formed in partnership with Alameda County Behavioral Health to preserve and steward housing for residents with serious mental illness (SMI). Through a CLT structure, land is held in trust permanently for community benefit while homes remain affordable and protected from speculative

market pressures. Berkeley could collaborate with organizations like SHCLA to acquire licensed board-and-care homes and transition them into community-owned assets, creating pathways for SMI residents—particularly those supported by family members—to live independently in stable, supportive environments. This model also improves fiscal efficiency: by retaining public subsidies within community-owned assets rather than allowing subsidy leakage to private landlords, the City can ensure that public investments generate long-term affordability and reinvestment in housing infrastructure.

- While BHSA specifically has funding that's been identified for clients with the highest level of needs (e.g. FSP category), the funding for those who have mental health needs that don't fall into that category fall into the general BHSS category. I would advocate for the focus on those monies to be for adults, older adults, and TAY.
- Adults are the individuals you see the most in the community that is causing residence and businesses issues.
- Our Adult population has the greatest need because they represent the largest group. Staffing is always a need in order to have manageable client/staff ratios.
- Please keep services funded at least as before.
- More housing for all with mental illness.
- Community education about FSP and wraparound programs and how they prioritize the individuals with the highest needs that don't fit into traditional treatment; consider specialized programs to address specific needs (like borderline personality disorder) so that these clients have more appropriate treatment alternatives to FSP's.
- People with severe mental illness must be in an institution/or some sort of respite care and given medication if necessary to deal with their issues. In cases where the person has harmed others they must leave the city and live elsewhere.
- More street outreach and support to get people who are unsafe to themselves and others off the street. It's sad when residents can't feel safe walking around or safe about their teenaged children walking around … I did not feel this way when I moved to Berkeley back in 2010 but do now after being threatened and accosted multiple times in parks, downtown, etc.
- Online support groups for the outreach.
- Funding for peer support groups and drop-in center type services. They can easily infuse these services with linkage to housing services. It can be difficult for people to make genuine connections with providers but peers can provide that rapport building.
- It seems to me that priority should be given to in-home support services for families and those experiencing mental health challenges to avoid more expensive hospitalization and visits to emergency rooms. This would include long-term in-home services with

mental health workers similar to the Open Dialogue process that has successfully kept people out of mental hospitals. For people released from mental hospitals, follow up with a long-term peer-run buddy system to avoid reentry into the mental health system.

Responses that ranked Older Adults experiencing Mental Health needs as most important (13 responses):

- No comment.
- Keep Wellness Centers open for resources and support with actual people (Therapists, Counselors to help) for both mental illness and Drug Addiction.
- Effective support for individuals facing addiction and housing instability requires combining stable, long-term housing with integrated, voluntary and trauma-informed services.
- Glad to see it as a separate area of need. Older adults are often marginalized in this society.
- Berkeley's population is aging - low income, older people with mental health and aging related concerns need more support.
- More boomers need grief counseling.
- This is a very small box. Do outreach, work with the senior centers, work with families. These are the forgotten people in our city. Give them the support they need so they can retain their dignity.
- Traveling Mental Health Specialist who can come do in home assessments and set up wrap-around services for the aging community. Often left to family and service providers scrambling to support older adults - with little to no guidance which significantly increase the older adults chances of destabilizing and impact community.
- Seek information and input from neighbors.
- Many serious mental conditions only require consistent medication to keep the client stable and capable of self-care and employment. Berkeley should definitely keep enough doctors and nurse practitioners to supply these folk, which only requires about an hour of work every 6 months or so. If they are over 65, the city can collect the cost from Medicare. The older lady killed in her house fire, whose neighbors kept contacting the county about, should at least have gotten a visit from a social worker. Medicare and MediCal would have paid for home nurse visits. Chips and MediCal pay for the treatment of children and teens, TriCare for the treatment of Vets, it's merely a case of hooking them up. Then you can move on to the more difficult situations of care for the unhoused mentally ill and substance abusers which may require residential care.
- I would hope Berkeley's well-funded "experts" have plans and ideas.
- It is impossible to rank the most important-they are equally important however, many categories have other funding and service opportunities (currently) i.e. TAY, Veteran,

Children etc. Currently there are no real and tangible homeless services specific to seniors- a fast growing homeless population.

- Older adults tend to be overlooked and isolated.

Responses that ranked Individuals experiencing Behavioral Health and Housing needs as most important (35 responses):

- Access to supportive stable housing allows those experiencing any mental and substance disorders to feel secure enough to do the work; housing counselors and advisors; steps support to maintain housing (check-ins).
- It's important to make the process of obtaining housing as simple as possible. People with behavioral health needs cannot deal with complicated processes and get overwhelmed easily and thus give up. Allow for a case manager to do a lot of the foot work if need be.
- Community focused housing like Tiny Village Spirit so that individuals have that support system.
- Adults with serious mental illness (SMI) cycles repeatedly through psychiatric emergency services, acute inpatient hospitalization, county jails, and emergency shelters — not because treatment is unavailable, but because stable housing is unavailable. Research is unambiguous: housing instability is the primary driver of psychiatric decompensation for people with SMI. Without stable housing, even the most effective psychiatric treatment cannot maintain gains. SHCLA, the Supportive Housing Community Land Alliance, is a community land trust operating, founded in collaboration between supportive service organizations, members living with serious mental illness and their families, and Alameda County Behavioral Health. SHCLA acquires residential properties, removing them from the speculative real estate market permanently, and master-leases them to licensed adult residential facility (ARF) operators at below-market rates. ARF operators house adults with serious mental illness in stable, supported homes with access to mental health services, medication management, and case coordination. SHCLA also acquires multifamily residential properties and offers shared ownership opportunities for SMI adult residents financially supported by their families. SHCLA's models are grounded in the community land trust (CLT) principle: the land trust holds the property in perpetuity, guaranteeing permanent affordability regardless of market conditions. Unlike conventional subsidy-dependent housing that reverts to market rates when subsidies expire, SHCLA properties are permanently affordable — a public asset that compounds in value over time.
- I believe there is a lack of housing support for homeless individuals and mental health. I believe having more housing for people that do not have an income. I think having more

resources would help. I also believe having more support groups and Drop In Centers would really help individuals.

- Individuals experiencing Behavioral Health and Housing needs. There is an epidemic of homelessness on the streets that needs to be addressed.
- Everyone needs support and I feel the cuts will make things worse.
- Homelessness has become an epidemic and Behavioral Health needs, need to be addressed.
- The people in the program need help with housing really bad.
- Offer support with housing and mental health.
- Housing is a definite need. People need to know how and what to do. Places don't even let you know everything they offer.
- Housing, because it is hard to stay sober without housing.
- Immediate housing placement for people with disability and mental health needs.
- No.
- Housing First. Keep at risk folks housed. Connect then with Mental Health and Substance Abuse Prevention services.
- Anything that gets more people into long-term housing.
- Keep offering hotels as transitional housing.
- More robust case management services are needed. I am most familiar with case management through the senior centers. While the case managers do a great job they can only help those who can follow through on referrals themselves. We really need case managers who can provide a higher level of support for people who can't follow through on their own.
- Unhoused people experiencing behavioral health needs have nowhere to experience them but in public, which is degrading to them and also affects the broader community.
- Housing and regular continuous services to maintain them in housing.
- Building supportive housing or other housing/support options (such as protected RV parking) for Berkeley residents experiencing homelessness and mental health issues).
- Without a home, the rest are just band aids.
- Public-private partnerships.
- Homeless people with mental health problems need to be taken care of with mental health care and housing. It is unacceptable to have involuntary homelessness and involuntary need to live in encampments. Housing and transition to jobs need to be provided. Substance abuse in this population should be addressed at the same time. People with substance abuse find it very hard to transition until the substance abuse is addressed. I think it is more important to treat homeless individuals for substance abuse than the general population.

- More services for people who do not want to connect with formal behavioral health, whose housing is at risk due to their unmanaged mental health.
- More housing that includes wraparound services.
- More community-oriented support and preventative care.
- Most bang for the buck is outward facing solutions that help those that need services AND provide "solutions" for (tax payers/funders/voters) make feel like "something in it" for them, which is safety vis a vis programs for those with behavioral challenges. My rankings above apply when "mental health needs" refers to severe mental health issues that prevent an individual from engaging in regular activities: school, work, job, EXCEPT for children/youth whose mental health should be supported as early as possible, before it interferes with regular functioning.
- We need enhanced direct mental health services. The budget has been incrementally slashed over 4 decades, we need to restore adequate funding for all the programs rather than choose which to prioritize and which to cut. That said, it's quite wonderful that in California taxes are being tailored to fill some of the gaps in services, to make up for federal cuts to all social welfare safety net programs -- we need to find even more sources of funding for wrap-around mental health services as well as the excellent preventive programs (mental health services in public schools, early intervention, public education, etc).
- Comparable to assisted living facilities for the elderly, there should be a housing complex with single rooms and onsite services to reduce behavioral as well as mental health issues and substance abuse. There also would be onsite activities for residents to develop useful skills that eventually might lead to job placements. All nine categories above would benefit from that.
- There ought to be more resources to provide both housing and mental health resources to those experiencing homelessness; the City of Austin, for instance, has a Homeless Strategy Office that streamlines and coordinates all programs related to helping people get the help they need, using innovative strategies for engaging with homeless members of the communities.
- More housing with supportive services.
- Nutrition
- Affordable low income and moderate income housing. Housing first programs plus wrap around behavioral health care and substance use services with linkage to employment and academic services with Affordable low income and moderate income housing after Transitional programs. Women and children and (Family including father's and single fathers) 24 hours shelters and transitional housing with behavioral health and substance use services. Children and TAY youth outreach and drop-in centers and

24 hour shelters and transitional housing with behavioral health substance use and academic and employment support. A Return to 2004 where there were services for every age group and family constellation and there were not older unhoused people living on the streets. Berkeley had some of the best homeless and mental health services and now is sub-par due to choices of how money is spent.

- Housing is essential, but it should not be funded at the expense of mental health services. Full-Service Partnerships provide the intensive mental health and case management supports needed for people with severe mental illness to maintain housing and stability. BHSA should preserve strong funding for FSPs and integrated services for the highest-need populations.

Responses that ranked individuals experiencing substance use disorders or overdoses as most important (5 responses):

- Open an all Female Facility.
- More outreach programs to help those out on the streets in need of programs.
- Individuals with substance use disorders which often are a consequence of mental health issues should not excluded from any services.
- There is an unacceptable number of people on the streets of Berkeley who are either high or mentally disturbed, begging or wandering around out of their minds. The majority of whom are Black. I don't know if they suffer substance addiction or mental illness or both, and whether or not they are housed at night. I don't know why so many people sleep on Berkeley streets in doorways. How would I know, or answer intelligently, which should be the priority? There is special funding from other sources for veterans and youth. We should focus on those falling through the cracks. When Berkeley counts the number of unhoused people you ought to determine why.
- Aggressive low-barrier buprenorphine access. Rapid emergency dept and jail linkage. Housing stabilization. Contingency management for stimulant use. Integrated mental health care.

Responses that ranked Individuals from cultural/ethnic populations who experience behavioral health needs as most important: (18 responses):

- Individuals coming from underserved ethnic/cultural populations experiencing increasing concerning mental health needs due with recent political climate changes (race, LGBTQIA+, etc).
- Number one for individuals from cultural/ethnic populations experiencing behavioral health needs and because trauma can be passed through diverse generations of family. We all heal collectively. More events, community engagement to celebrate cultures.

Open talks, film screening, books. More funding for programs. Safe open spaces to talk. Holistic, Psychologists and Psychiatrists.

- Have a Food Drive or something to have an invitation to, so you feel like a special guest, not just another customer.
- I wish there were more services and opportunities for people in recovery to obtain housing.
- LGBTQIA+ populations are facing an increasingly hostile social and political environment. This being the case, our LGBTQIA+ community members need competent and affirming behavioral health support and care. Services oriented towards this population are essential, and they are underfunded. Funding LGBTQIA+ specific care is essential.
- I would continue to fund the programs who are helping the communities.
- Expand culturally competent services, stop gap services that are already overburdened, and services that prioritize holistic wellness rather than medical model.
- Decrease bureaucracy and gate keeping for mental and behavioral services access for minorities. Coordinate with organizations to provide services in the schools.
- More outreach.
- Outreach to institutions where cultural groups frequent such as churches, schools, reentry programs, hospitals and clinics to promote services.
- I hated having to do this but I thought that underserved populations would probably encompass individuals from all other groups.
- They have less resources and their needs have been invisible before MHSA their social locations made more difficult to access services and treatment.
- People from underserved cultural/ethnic populations are not able to access existing programs due to language and cultural barriers. We need navigators who come from that specific community to help community members to understand resources and actively help them to access those services; more support groups led by people from that community; more peer counselors from that community; more pipelines to help people from underserved communities to access existing services.
- Language access, peer counseling, more support for providers from marginalized groups to get training, more group therapy/support for individuals who can't access individual therapy.
- To increase the number of individuals from underserved backgrounds to access mental health services, there needs to be a greater emphasis on language access (including indigenous languages) and more providers from these populations. Case navigators from trusted community organizations are also critical in supporting folks to access existing supports and navigate available resources. Support groups and peer

counselors are also great ways to provide support outside of the traditional mental/behavioral health setting as they are less intimidating and have lower barriers to entry as well as they facilitate community building which increases retention and long-term participation. This also applies to substance use support groups.
- Lower barriers for people from ethnic/language communities that have a hard time learning about and accessing these services More peer counselors and support groups, which are cost-effective and easier to make culturally relevant.
- Active outreach into the community to reach underserved populations that are hesitant to receive help.
- Meeting their basic needs.

Responses that ranked veterans experiencing mental health needs as most important (2 responses):
- I don't feel that veterans get the rightful benefits due them.
- People who served in the military from Vietnam to the present day are not getting support they need; many of the people I met on Harrison St in the camps were veterans without food, water or adequate shelter. I'm 76 years old; the VA didn't tell Vietnam-era veterans they were eligible for Agent Orange benefits. Many people I know have died from cancer due to their exposure, including my brother-in-law; others have had cancer removed but were sickened by radiation-therapy. All of Southeast Asia was affected by Agent Orange; not only Americans who were "in country." Berkeley needs to stop criminalizing homelessness, provide water, food, clothing and shelter until people can be housed. Tiny Houses, shelters with on-site supervision, group homes: whatever it takes. I used to bring what I could to the camps on Harrison between 6th & 8th streets until I too became homeless in October 2025. Until that time, I saw individuals, church groups and others try to help, we can't do it ourselves. Berkeley needs to prioritize people; it's why I loved living in Berkeley. I will be okay someday, but people are dying of exposure and I could have been one of them.

Responses that ranked family members of individuals experiencing behavioral health needs as most important (4 responses):
- I feel we should request more funding to support these families.
- I'm not sure.
- Cause family going through a lot.
- I think it is very important for children and families to have help. Children are our future and families are a major support for those with mental health needs.

Responses that skipped the question ranking areas of importance. (3 Responses):

- Children/Youth need help with things going on in their lives and they need help talking about what's going on.
- I earnestly believe institutions to fundamentally approach this arena in bad footing. Mental health services and the broader industries of psychology/psychiatry are rooted in eugenics theory. Nationwide I see organizations hobbled by fear of lost funding, erring on the side of paternalism. For instance the CTHVN just recently was called out and corrected their internal edict to not share resources that are not under their dominion. The Wildflower Alliance has been notified of online DIY spaces that would enable more grass roots community but has refused to share these free and eager advertising spaces to their newly trained facilitators. It's all rather venial in my eyes. HVN organizations across the world set up spaces online for a few years before needing to shudder their services. I am bothered that these organizations have little desire to cast into motion resources/mechanisms that could outlive themselves. We all ought to seek the means to empower the disenfranchised, I believe the methods to forever push the HVN into a growing grass roots movement that is open source and incapable of answering to any other authority is available to anyone who can use Google or talk to ChatGPT. This is still a project on my horizon, all in due time. The desire for paid leadership to change the world simply is not in the cards in my eyes. Obviously more power to all of you for doing what you can, I and many others stand upon the shoulders of giants who stood in the face of centuries of societal prejudice to make what exists today. Still, it is beyond me that the 3 largest players in the international HVN game will not capitalize off what is by all accounts a "free lunch" that continues to give back. No words for the UK network that actually hides its virtual connections behind email requests and screenings out of fear of being "hacked." Perhaps I can offer the words luddite or deliberate stymie.
- Public help - Public Health all important.

6.) Is there an area of behavioral health need (ie mental health or substance use) in Berkeley that was not mentioned in question #5 above? If so please describe, and share any ideas, strategies and solutions to help us improve in this area. (113 of 228 answered this question).

Responses included one each of: “I believe most situations have been covered”; “I can’t think of any”; “I don’t think so”; “0”; “I Don’t live in Berkeley”; “See above answer”; two “Not Sure”; three “None” or “I have none”; three “not to my knowledge”; seven “No”; thirteen “N/A”. Other responses:

- LGBTQIA+ mental health.
- More focus on harm reduction and trauma related disorders (PTSD and C-PTSD).

- In our growing political situation, I think there needs to be more support for Transgender people and immigrants (particularly those without citizenship).
- Drug prevention in youth, more education, access to narcan and other od preventors, focus on education just as much as drug restriction, because when the substances are accessed anyway (which always happens), what the youth knows and has learned about them will affect how or if they use them.
- The City of Berkeley should consider deploying housing intervention funds as soft or forgivable debt for nonprofit housing developers (CLTs), paired with targeted operating subsidies, to ensure supportive and deeply affordable housing projects can financially pencil and secure additional capital. Early-stage subordinate financing, structured as low-interest, deferred, or forgivable loans, can reduce the overall capital stack burden and enable developers to leverage private debt, or low-interest public financing. In addition, operating subsidies tied to supportive housing or behavioral health services can stabilize long-term project performance, particularly for housing serving residents with extremely low incomes or complex health needs. This strategy allows nonprofit developers to move projects forward more quickly, reduces risk for lenders, and ensures that Berkeley's housing investments unlock additional external capital while preserving long-term affordability and service capacity.
- I believe having more mental health support groups, resources, resource centers, case management, would greatly help.
- Medi-Cal ineligible youth.
- To recognize abuse cases as work related cases. Veterans VFW.
- Program partnerships for seniors, older adults and youth connect to share experiences. Address root cause of Behavioral Health intergenerational programs.
- One-on-One and Group Therapy. More accessible therapists for all ages in this City (minimal to no cost). More accessible Art Therapy Groups. More affordable housing scholarships/support/measures for TAY aged youth who need help paying rent as they transition to adulthood jobs.
- Volunteer opportunities.
- Sound, Meditation, Support Groups.
- No, all needed.
- Wellness and Recovery programs, the psychology of wellness to help with emotional healing.
- Activities for the mentally stressed and group efforts.
- The use of "mental health" seems perhaps, overly broad and not defined. I know that depression is a "slippery" issue and that making low-risk options (that don't have "emotional heavy-lifting" commitment required) available can have positive results. Question: Was nothing done about housing before? Or are the funds for them are now gone (federal?) and so now a chunk of mental health/support funds have to make up the deficit?
- More mental health services.
- I believe that these solutions would greatly help people in Behavioral Health, especially training for counseling and working in Behavioral Health.

- They closed the only all Female Facility.
- All areas of Behavioral Health needs were mentioned.
- Social pressures to fit in with others based on life and society needs.
- More Substance Abuse programs.
- There are no "Depression Living Environments". As a depressed guy I'm housed with substance abuse clients. My primary problem is depression but I'm being treated for substance abuse.
- LGBTQ+ community members experiencing mental/behavioral health needs.
- More resources.
- Trauma informed education and supporting teachers in reducing inequities in school discipline, connecting students with supports instead. See racial disparities in school suspensions starting in elementary school.
- Lack of safe housing creates mental health and substance use problems.
- Support groups of all kinds are essential at all levels of intervention, and pre-intervention.
- Berkeley Mental Health serves those with severe mental illness and community clinics serve those with mild to mid moderate. But there is a gap for individuals on the moderate/severe border. Their needs are too great for community clinics but not great enough for Berkeley Mental Health. I would like to see the resources for Berkeley Mental Health increased so that more individuals can be served.
- We are neighbors to the Berkeley Mental Health Center on MLK Jr. Way, and unhoused people in acute distress are often left to experience a crisis on the street or sidewalk in front of the locked facility when the staff won't let them in, or after hours or on holidays when they have come for help but the facility isn't open and there is no staff on hand. It is not a good triage system, but seems to be forced to function that way.
- Housing for transitional youth.
- I believe LGBTQIA+ populations are represented in "individuals from underserved cultural/ethnic populations...". If this is the case, then I don't have one to add.
- Housing and supports for LGBTQIA population particularly trans persons.
- Don't make too many changes.
- Continue funding the programs: Wellness groups and peer counseling.
- Peer Support Services.
- Peer Support services are an invisible safety net that require more funding and attention. Peer Support Services bridge the gap between potentially inaccessible/unaffordable mental health care and individuals who need a lifeline or starting point.
- Individuals experiencing behavioral health and/or substance use disorders that need support to maintain employment.
- Most of the people we need to assist are homeless with both mental health and drug issues and who knows which of these sparks the others. Your categories don't include the addiction issues. This is a mistake.
- Intervention specialists on the busiest parts of Shattuck Avenue providing care options to the many people there who are experiencing public mental and/or medical crises.

- I need Peers to not lose funding, and this is most important for my mental health recovery.
- Supporting funding for increased integration of MH and SUD services within the BMH setting.
- Meaningful activity for people with behavioral health issues.
- No other area of MENTAL---let's speak more accurately now, though, true, Behavioral is ~40% of the problem---Health or substance use.
- What about the individuals who are not voluntarily engaging in services who may need assertive outreach and incentives to encourage participation? Are contingency management or other similar strategies allowed or resourced?
- Adults and young adults experiencing psychosis for the first time.
- We need a one stop location where people who seek help can go. The whole system is incredibly complicated and unwieldy. Each individual in the community which came to attention regarding mental health and/or substance abuse disorder should be allocated one case worker who coordinates a wrap-around care.
- You haven't provided any data of the problems with which to have opinions or suggestions. You haven't revealed what services Berkeley offers now, to whom, or where there are shortfalls. I hope the City Council is well informed with real data before they make any decisions.
- Strict laws to support clean up and encampment removal.
- Individuals experiencing behavioral health and housing needs who are actively physically harming community - prioritize housing and monitoring.
- Please make sure to include benefits advocacy that is reliable and accurate so people not only know how to apply for benefits, but they also know how to maintain them. Self-esteem and financial flexibility improves when people with disabilities understand what will happen with their benefits and long-term supports and services when they earn money. If they think they have to lie about income, this only adds stress. People will do better if they have an ally and/or a peer who can help interpret the information on the following page that is run by the World Institute on Disability. – www.db101.org
- PEER support services have been an important support to clients and community to have more wellness and recovery options.
- Housing. I applaud assigning 30% of the funds from the tax to housing needs, housing is a core requirement for sustaining mental health. I will mention here, as I did at the excellent community meeting Karen and Andrea facilitated on Feb. 9, the Sequential Intercept Model that could serve to guide the targeting of resources to people who are most in need at the moments' in their life trajectories when the needs are greatest. I am also emailing an article about the method to Karen.
- People who have both mental health issues and drug issues. This category (actually all the categories) can include people with cognitive disabilities.
- We never see anybody going into the mental health buildings on MLK & University. We see homeless people on bus benches less than a block away from these facilities. We never see them getting helped. Help them or turn those buildings into 24/7 shelters.

- Housing. A person who has no housing has a far greater chance of mental health issues than a housed person. If we can identify and find housing for newly displaced people, we can curb their possible future mental health issues.
- Supportive call center for mental health access. Often Berkeley Mental Health states they are only supporting severe cases at this time - which leave a large population out that is headed toward becoming a severe case.
- Children and TAY youth outreach, drop ins and shelter's and Transitional housing non-existent. Services are not available for this population. Number 1 predictor of homelessness besides unaffordable housing is being homeless as a child and or young adult with mental health and or substance use challenges. Prevention is imperative to change the landscape of Berkeley services.
- Having physical disability/mobility issues (body or any of our senses) in addition to behavioral and mental health issues. Strategy: Have experts in these areas visit the housing complex that I described above and meet with the residents.
- Disabled Individuals/IPV Survivors.
- Help for homeless populations.
- Family therapy.
- When I lived in my home before becoming homeless, a mobile crisis unit was assigned to me. They were inadequate and often made my situation worse. Because I'm homeless now, I haven't been able to let Berkeley nor any other entity know how my situation was mishandled. When I read that this agency, who did not serve me was in consideration to handle all of Alameda County as a mobile crisis unit, I was horrified and retraumatized. I'm lucky: I have Kaiser. They are doing everything they can to help me get back to not just surviving but thriving.
- We need Crisis Unit vans on the ground 24/7 to free up the police unless the person is violent presenting an issue requiring the police need to be there. Most times that just escalates a mental health crisis more when the police are there trained mental health workers understand this. San Francisco has 7 24-hour coverage with MOBILE CRISIS UNITS. We need to increase this.
- Some way to get intervention when a person who is having an obvious crisis is shouting and threatening in front of other people's dwelling units.
- Individuals suffering from mental illness should not be grouped with substance abusers. Although there is overlap, putting these two groups together just creates more addicts.
- "No wrong door" means I should not have to go to an institution with poor outcomes and limited funding. Private pay therapy for all! Community based programming for people who are not interested in working or school due to severe disability.
- We need LGBTQ housing, similar to what other cities are doing. Currently some people, especially trans people, are unwilling to use the existing group shelters due to harassment.
- Prevention and wellness recovery services are an essential part of the behavioral health system. Investing in early intervention, peer support, and recovery-focused services

helps prevent crises, reduces the need for higher-level interventions, and supports long-term stability and quality of life.

- One significant behavioral health need that deserves greater attention in Berkeley is the intersection of aging, homelessness, and behavioral health. Older adults experiencing homelessness often lack access to low-barrier, geriatric-informed mental health and substance use services, particularly within shelter and transitional settings. Many do not engage in clinic-based care due to trauma, cognitive decline, mobility limitations, or distrust of systems. Expanding mobile and shelter-based behavioral health supports, with an emphasis on prevention, early intervention, and stabilization, would improve health outcomes, reduce crisis responses, and support successful transitions to housing for one of the City's fastest-growing and most vulnerable populations.
- Prevention of long-term mental health hospitalization and visits to ERs. (See above) Peer run services.
- Socio Emotional is critical and absolutely mental and behavioral.
- There are no AA/NA groups that are accessible in other languages. Also, we need to explicitly address the level of terror, grief, and fear in immigrant communities that are being racially profiled, having family members at risk of abduction, and increasing family separation. The impact on immigrant families will have generational consequences and needs to be addressed on a systemic level. Finally, we need to always have a focus on prevention and early intervention so we can prevent serious mental health problems from occurring. This requires strengthened community supports and safety.
- There are a lot of immigrant community members in Berkeley who are experiencing trauma and fear in this moment, creating a lot of mental health challenges and intergenerational trauma, especially as it pertains to family separation and detention. Specific supports for Berkeley's immigrant communities are critical to making sure families have dedicated support in this moment. Support is also critical as a preventative mechanism, as sustained mental health challenges can lead to substance abuse and houselessness if they are unmet.
- Fears specific to the immigrant community, due to federal raids, etc. People are afraid to leave the house, even to go to the doctor's office.
- Not utilizing policing/post-arrest models as mandatory for entry into care systems. People should be able to get help first, not only as part of post-arrest diversion.
- Queer people are especially disjointed at this point in history. I know too many gay men losing their lives to drugs. More a-religious queer support groups around this are needed, I think.
- Wellness recovery related programing and support.
- Encampments and the homeless.....prevention and access ..we need to be on the ground at the inception of encampments and not when the situation is beyond repair...

7.) <u>What barriers make it harder for individuals and family members with behavioral health challenges to access needed services. Select all that apply. (</u>220 of 228 answered this question).

Results outlined below are in the order of highest rankings:

- 70.45% - Limited resources (financial, transportation, etc.).
- 60.81% - Hard to find information on where to go for help.
- 60.45% - Embarrassed to ask for help and/or stigma around seeking help.
- 51.36% - Long wait to get an appointment.
- 40.00% - Isolated or unable to leave home.
- 40.00% - Lack of providers who represent my culture, and/or speak in my preferred language.
- 35.90% - Providers don't offer the services that are needed.
- 35.00% - Do not want help right now.
- 28.63% - Safety concerns.
- 25.00% - Services are not close to my home.
- 15.00% - Other.

Responses marked as “other” were as follows:

- Not enough help to assist consumer needs.
- As a family member it is also challenging to get all people on the same page and working towards common goals for the mental health consumer.
- Rape cases were underserved.
- Not knowing how to access services or when services should be sought out.
- Culturally appropriate safe space and where to get help where the person feels supported and loved.
- Ineffective treatment history.
- Abuse, neglect or otherwise disrespect by mental health staff. Especially around intersecting identities.
- All are valid reasons.
- Systems and Providers that perpetuate systems harms and inequities.
- Folks want help and support, but they have a limited understanding of the help and support being given, due to symptoms of mental illness.
- Providers need to be known in the community.
- Lack of education on why assessing these services are vital and how they impact the community long term.
- Those needing more intensive services such as Intensive Outpatient services.
- Inadequate services available.
- Our collective acquiescence in the current system which allows the most needy to live short brutal lives on the street because they can’t choose to refuse treatment and services.

- I am a tax payer and don't have any of these barriers, my needs are met through Medicare and Social Security.
- The system is difficult to use and there are lots of hoops to jump through.
- Services don't generally come to the client, the client has to go there.
- Actual lack of support for ongoing, long term, severe mental illness/brain illnesses.
- I wouldn't know but suspect all of these barriers exist for many people.
- People may feel nervous that they will be sent to a mental hospital non-consensually.
- Services are inadequate/unavailable and what is available requires navigating a lot of bureaucracy (including paperwork that reinforces the paternalism and shame of asking for services or assistance).
- I believe the data is more than conclusive on this subject, people who go on medications generally do not attain their former state of Wellness. Community seems to be the only real medicine in this bout. We need more of it, real community with projects and collective goals. Too many HVN Meetings are simply a collection of people taking turns, talking past each other with no real dialogue.
- Unsure.
- Berkeley only offers services in extreme cases. So everyone else suffers and then when no intervention has been allowed, they finally qualify for help. Unbelievably ridiculous. Expensive. Terrible results. Intervene earlier. Make people feel that their not taking services away from people who need them more.
- I don't know, for each category it's different.
- Families can't be informed when an individual is 18 and over. How can family give support when they can't know the diagnosis?
- Institutional politics are reliant on temporary sources of funding. Poorly trained staff with limited accountability for outcomes. Arcane thinking about mental health and what clients need. Belief systems that other mental health clients in the community are creating stigma and dependency.
- Community based organizations are stretched beyond capacity and often are not able to even return a phone call to an impaired community member, especially in other languages. There are huge differences in navigating these systems, especially if one doesn't speak English, is technologically illiterate, doesn't understand the systems, and/or has a lack of trust in government or community systems.
- Overall capacity of free mental health support – many people never hear back from providers at all or are told there is no availability at their agency.
- Difficult to talk to a provider, lack of call backs, no support in navigating resources, or systems for warm referrals.
- Difficult to communicate with providers. Everyone seems to be maxed out.

- Lack of community knowledge.

8.) Did we miss anything? Please share other behavioral health needs, concerns, or solutions that you may have that haven't been mentioned. (94 of 228 answered this question)

Total responses included one each of: “0”; “Nothing missed”; two “I think pretty much everything has been mentioned or covered” or “You've covered it”; two “Not that I know of” or “Not to my knowledge”; two “none”; nine “N/A”; and eleven “No or Nope”. Other responses:

- Life-saving services for the LGBTQIA+ community.
- Overall this feels like a bottom-up approach has been integrated from an ecological lens it’s important to recognize that many health and mental issues are systemically generated & agitated & sustained. How can anyone heal if they don’t feel stable & consistently in a state of survival & trauma.
- Intensive staff training around trauma-informed care, regular checks with patients in intensive care facilities about sexual harassment and abuse, holding staff accountable for bigotry and abuse or neglect.
- Care needs to be voluntary and NON CARCERAL. Housing FIRST.
- One area of behavioral health need that deserves additional focus is the shortage of small-scale, community-integrated housing options for individuals transitioning from institutional or crisis settings, particularly those with serious mental illness who require moderate support but not full clinical facilities. Many residents fall into a gap between intensive treatment environments and fully independent housing, resulting in cycles of hospitalization, homelessness, or unstable living arrangements. Berkeley could address this by supporting licensed board-and-care homes (ARF/RCFE), family-supported cooperative housing models, and scattered-site supportive housing operated through community-based organizations or CLTs. Strategies could include acquisition funds for existing homes, technical assistance for operators to maintain licensing standards, and partnerships with behavioral health providers to deliver mobile support services. Expanding these intermediate housing options would create a more complete continuum of care, helping residents stabilize in the community while reducing reliance on higher-cost emergency and institutional systems.
- I think one of the biggest barriers is lack of funding for individuals to get housing support and lack of Resource Centers for clients to go to, to get the help they need.
- Support the AAHRC.
- Designate more of the 30% of Housing segment for TAY aged youth. Have specific housing facilities for TAY and expand TAY's definition up to age 30. To go from age 25 to

26 and suddenly be on your own health insurance/own rent/own everything is a very hard sudden adjustment. More funding for job training programs/career development needs. Workshops, Training Programs, Scholarships/program sponsorships. More free virtual therapy (1 on 1, group therapy, art therapy). Transportation assistance to Therapy Groups, etc.

- Intergenerational connectivity.
- I'm not equipped to be answering these questions.
- Don't know enough to make a comment.
- What you're doing is great. Other City's need to follow your lead.
- Payees needed.
- Berkeley Mental Health has been much better ever since the Wellness and Recovery Team was formed and I have been helped emotionally and feel a lot better as a result.
- Transition groups; help for the mentally impaired.
- Certain past centers (i.e. Creative Learning Center and Creative Wellness Center) have used a Clubhouse model as opposed to a strict staff-client model with usefulness that extended to a range of mental health problems.
- Getting to see Psychiatrist for Meds.
- Don’t help with housing, it is a big problem.
- All Behavioral Health needs and concerns have been mentioned.
- Help with Substance Abuse. If you are coming to get help to stop using, how can you not use if you have to test clean to get help? It makes things worse.
- The bluntness of the questions.
- Individual issues.
- Please be sure to analyze racial and ethnic disparities in overdose mortality and other outcomes and ensure supports and care go to populations most affected.
- Rather than breaking the needs into cellular groupings, why not offer services that include all groupings. There can be group services for the more specific, cellular differences. In fact, maybe there's real value to keeping everyone together … might help folks to see everyone's got issues … they're not alone.
- Privacy and autonomy in care is sort of an afterthought, after two years at EBAC I could not get clarity on where my heath data was shared, I could not address things, I disagreed with, and I could not receive HIV care without signing a heath sharing policy I had to sign every month in order to get care. I was only ever shown pages two and six of seven on a digital pad to sign when the terms were on the other pages. BPG and langly declined psyche care and no other Medicare Dr would accept new patients. So, trust and access last attempt to get ryan white ADAP at oak LGTBQ resulted in referral forced

testing at out of the closet in Oakland so close but still not really ever seeing a provider Berkeley free clinic = non-new patients.

- Community supports that aren't carceral or include forced medication.
- There are not enough services for caregivers of people with behavioral health needs. And again, more robust case management services.
- The resources being usually short-term support for those who are already in crisis or need more support.
- LGBTQIA+ community members need specific care that serves our cultural needs. There are very few existing services for us, and those that we have access to, need continued funding.
- Integrate behavioral health specialists into vision, dental, and medical practices to provide real-time trauma-informed support, ensuring routine procedures do not become barriers to care for vulnerable patients.
- Great need to educate the community about people living with mental health issues, substance abuse, and homelessness in order to decrease stigma, fear, and marginalization.
- Please fund options for LGBTQ+ and specifically trans youth who have been denied care by family members because of their sexual orientation/gender identity.
- I have a concern that if we cut the programs that are being cut per se Peers People will go astray from their Mental Health recovery and have nothing to fall back on in the community as a functioning person with mental health.
- Better integration of physical health care and behavioral health.
- Yes. Lacking long-term treatment and care for our most severely ill has resulted in terrible loss and suffering.
- Easy access to illegal drugs and substances is a problem. We need more cops who walk beats where addicts hang out. Social workers to frequent places where beggars hang out like Berkeley Bowl on Shattuck & Oregon, on Addison Street after performances, in front of BART stations, etc. Put flyers up on the streets with resources for people in crisis that either people in need or the public can call.
- Regional solutions and pooled resources. Just as Alameda County and City of Berkeley had pooled resources to make a wellness center a possibility, local east bay jurisdictions (Contra Costa, Alameda, Berkeley, etc) should seek to collaborate and pool resources to centralize and flesh out services. People often travel between all of our jurisdictions and don't respect invisible county/city lines.
- I feel that support groups for those that hear voices needs to continue as there are a lot of people that benefit from these groups, BAHVN included.
- More social services assistance (Cal-Fresh, GA).

- Some community members don't have health insurance and could not have access to it.
- Mental health support in the public schools. Emergency mental health support for individuals, families and communities suffering from ICE operations in Berkeley (happily less frequent than in Minneapolis, L.A., Chicago - but who knows when ICE will invade Berkeley).
- Berkeley needs a multipronged approach to behavioral health-addressing homelessness, substance abuse, and mental health issues because one begets the other. the homeless encampments are not safe for anybody and early intervention/ street outreach would be valuable.
- The city must take a tougher stance on those dealing drugs, and those disrupting the public space. It is awful out there to walk around and see people pulling their clothes off drugged out of their minds.
- Outreach is abysmal. You need a communications expert to help. Therapists and administration folks don't have this skillset. They do what they're good at, and a comms person helps people find the help they need. It could be a part-time gig. Maybe the Mayor's new volunteer effort can make this a top priority. Berkeley Corps - be great! Needs 30 days max to ramp up.
- All of these areas are important. It is really hard to rank them.
- Note comment was listed in both #5 and #8 by the respondent: I earnestly believe institutions to fundamentally approach this arena in bad footing. Mental health services and the broader industries of psychology/psychiatry are rooted in eugenics theory. Nationwide I see organizations hobbled by fear of lost funding, erring on the side of paternalism. For instance the CTHVN just recently was called out and corrected their internal edict to not share resources that are not under their dominion, the Wildflower Alliance has been notified of online DIY spaces that would enable more grass roots community but has refused to share these free and eager advertising spaces to their newly trained facilitators for the past 4 years. It's all rather venial in my eyes. HVN organizations across the world set up spaces online for a few years before needing to shudder their services. I am bothered that these organizations have little desire to cast into motion resources/mechanisms that could outlive themselves. We all ought to seek the means to empower the disenfranchised, I believe the methods to forever push the HVN into a growing grass roots movement that is open source and incapable of answering to any other authority is available to anyone who can use Google or talk to ChatGPT. This is still a project on my horizon, all in due time. The desire for paid leadership to change the world simply is not there in my eyes. Obviously more power to all of you for doing what you can, I and many others stand upon the shoulders of giants

who themselves stood in the face of centuries of societal prejudice to make what exists today. Still, it is beyond me that the 3 largest players in the international HVN game will not capitalize off what is by all accounts a "free lunch" that continues to give back. No words for the UK network that actually hides its virtual connections behind email requests and screenings out of fear of being "hacked." Today in the united states and nationwide ALL HVN meetings have forbidden any direct communication between participants in their virtual conferences, this over a single incident. As if we were looking for any excuse to limit what was healthy/organic. Perhaps I can offer the words luddite or deliberate stymie over the current state of the network.

- Community oriented services that provide support and peer counseling strongly prevent people in need from more dire situations like being hospitalized. Hospitalization helps in a crisis, but is not a long-term sustainable solution. Keeping our community members healthy and functioning happily on a daily basis is so important.
- People giving treatment or people making mistakes in treatment.
- The services need to be onsite. If not all feasible, there should be a 24-hour hotline phone number to call.
- Pathologizing services, overstressed staff, decrease in hours of crisis response (Berkeley Mobile Crisis).
- Berkeley needs to put TEAMS of people on the street. Counting the unhoused is a waste of resources; bringing WATER and PORTABLE TOILETS with handwashing stations should be Job One. Food, clothing, shelter, interventions, peer counseling, opening up many abandoned properties with absentee landlords, funding programs that really help: all these and more need to be addressed now. Allowing Bayer Pharmaceuticals to clear out people who had nowhere to go, who had established community and connections to one another happened before I became homeless. I was ashamed to be a Berkeley resident because everyone who works at Bayer could have helped rather than complained that the poor are among us. A rabbi once said, "The poor are always with us;" the reason is that the rich cannot ever realize that they have enough. When I had enough to share, I did until I became unhoused. I'm lucky; I have credit cards. I have some water and food. I have Kaiser for free and they are trying to save me from the despair I have had.
- I think a lot of resources are being wasted on easy cases that don't really need time-consuming care.
- Berkeley needs to get tougher on people doing drugs in public. We need to have a drug court judge and if people are arrested for using in public or selling etc. they need to go to the drug court judge and the judge says to them either you’re going to go to jail or we’re gonna give you an opportunity to get your life back and get clean and sober and

that'll be a sentence. It usually takes at least six months to a year sometimes longer for hard-core users and there will be relapses. It's part of getting sober. The people that don't want help aren't ready to accept help and they want to sit on the corner and get high need to go to jail. You can detox in jail. It's not gonna be nice and actually it's dangerous but what's going on now in the long-standing people that have mental health issues and multiple diagnoses is really scary. this issue is not a Band-Aid. It's a multi Faceted complicated issue many of these people have multiple diagnosis of serious mental health issues for which they need to be medicated and have to take their medication and the only way you can achieve that is either getting them into a program willingly or getting them off the street in a 5150 situation where they have to go to a mental health facility and then see the judge to see if they're able to make decisions on their own. A lot of these people are not able to. They are not able to take care of themselves for many reasons. It's just not a Band-Aid.

- Often, an individual who needs help refuses it. If I'm unconscious, an ambulance will take me to a hospital and I will be treated, even though I'm unconscious and can't consent. A mentally ill person should not have the responsibility to know whether or not they need treatment. All should be treated independently of race, gender identity, etc. We need to treat all with respect and according to their needs.
- Berkeley is not making inroads into mental health homelessness. There are days when I find a person sleeping in every vacant doorway. It is disgusting in this well-endowed place.
- The fact that we treat people based on their ability to pay creates a culture of haves and have nots. It is the same as redlining but for individuals. We choose to invest in those who we deem safe investments rather than supporting individuals with the care they need when they need it. We don't work on underlying issues like institutional poverty but rather treat the symptoms of that disease and when the funding runs out we don't even do that.
- Money has to be shifted to survival needs and connections to ongoing support. Drop Ins with targeted outreach and transportation to shelters and services as Berkeley had in the past. It worked and then funding and services were cut.
- Nutrition.
- It's important that new BHSA priorities strengthen—not dilute—existing mental health services. Housing, prevention, and treatment work best when they are well-resourced and coordinated, with adequate staffing and long-term funding to support people with complex, ongoing needs.
- I am excited and hopeful that the BHSA and other local helping agencies can find ways to work together to help the population with the greatest needs.

- Outreach via ECE and TK to 12 providers, shelters hospitals adult care - find where they are go to them.
- Many services are not accessible to community members who need them the most and there are not enough mental health services, especially for marginalized immigrant communities that don't speak English. Many groups do not have language or culturally competent services to effectively reach marginalized populations. It's critical to partner with people who come from that community to design and implement programs that are accessible and relevant.
- I work a lot with the Maya Mam community, where many people don't speak Spanish or English. I see that there is very little access to mental health services for that community and other speakers of minority languages. People don't know where to go, can't navigate websites or most written information, may not even have a word for mental health in their language, and yet have some of the greatest needs for mental health services and are profoundly affected by the traumas that in many cases forced them to come to the United States and that they continue to live as immigrants in this country.
- Many services are not accessible to underserved community members either for language access reasons or due to bureaucratic/institutional barriers. Culturally competent case workers/peer-navigators are critical to supporting the folks to access these services and continue to use them. Centering practitioners/providers with lived experience of immigration/houselessness is critical to meeting people where they are and designing and implementing programs that are effective.
- Peer Run programs, which were established to build connection, trust, shared experience and much more, are being wiped out. Studies show that recovery services is a result-based practice and this can negatively impact the strives created by the consumer community.
- We have an opportunity to as allowed under the law to be imaginative and be brave and offer alternatives…wellness checks on a regular basis..go to where the people are and get out of your offices.

9.) If you would like to receive information in the future on BHSA Meetings, Integrated Plans and other related documents, please provide your name, how you would like to be contacted (ie. email, mail, phone), and your contact information.

This information was compiled by the Mental Health Division and will be utilized to inform individuals on BHSA Meetings, Integrated Plans and other related information.

Demographics of Participants

Demographic Numbers that are 11 or less are displayed as <11 and/or may have been combined or masked to protect the privacy and confidentiality of individual participants. Further, responses in the "Other" category are not shown, to protect the privacy and confidentiality of individual participants.

10.) What Is Your Age?

(224 of 228 answered this question)

- 64.29% - 16-59 years of Age
- 35.71% - 60+ years of Age, or Prefer not to Answer

11.) What Is Your Race/Ethnicity?

(222 of 228 answered this question)

- 45.95% - White
- 24.32% - More than one Race, or Prefer not to Answer
- 18.92% - Black or African American
- 24.32% - More than one Race, or Prefer not to Answer
- <11% - Asian or Asian American/Native Hawaiian Pacific Islander

12.) Are you of Hispanic, Latino/Latina/Latinx origin?

(220 of 228 answered this question)

- 82.72% - No
- 17.28% - Yes/Prefer not to Answer

13.) Are you a veteran (of the US Armed Forces)?

(223 of 228 answered this question)

- 93.27% - No
- <11% - Yes/Prefer not to Answer

14.) Which of the following best represents how you identify?

(221 of 228 answered this question)

- 61.54% (136) Straight/Heterosexual
- 14.93% (33) Gay/Lesbian, Bisexual, or Another Sexual Orientation
- 11.31% (25) Queer, Questionning/or Unsure
- 12.22% (27) Prefer Not to Answer

15.) Which is your Gender Identity?

(222 of 228 answered this question)

- 59.46% - Female
- 27.03% - Male
- 13.51% - Transgender, Genderqueer, Other Gender Identity, Prefer not to Answer

16.) Do you identify as having any type of disability?
(218 of 227 answered this question)

- 48.62% - No
- 39.91% - Yes
- 11.47% - Prefer Not to Answer

17.) Which of the following categories do you primarily represent? Please select all that apply. (224 of 228 answered this question)

- 58.48% - Community Member
- 36.16% - Mental Health Consumer
- 25.44% - Family Member of Mental Health and/or Substance Use Disorder services Consumer
- 20.98% - Individual who has experienced homelessness
- 17.41% - Representative of a Mental Health or Social Services Agency
- 16.07% - Substance Use Disorder Services Consumer
- 15.18% – Veteran; Other; Prefer not to Answer
- 14.73% - Student, Parent, Staff or Representative of Berkeley Unified School District, UC Berkeley or Berkeley City College
- 13.84% - Homeless Services Advocate
- <11% - Representative of a HealthCare Organization; Representative of Substance Use Disorder Services Agency; Faith-based organization representative
- <11% - City of Berkeley Staff, Representative of City of Berkeley Commission, Representative of Law Enforcement

From: Terry Kupers
To: Klatt, Karen
Subject: BHSA ming. & survey
Date: Wednesday, February 11, 2026 9:22:12 AM
Attachments: Sequential Intercept.pdf
The Sequential Intercept Model (SIM) SAMHSA.pdf

Hi Karen,

I found your presentation at the meeting Monday evening very well-organized and very useful. Thank you. I was only sorry there were not more community members in attendance. As I said Monday, it is very difficult to choose which services are important and which are expendable, because we need them all. Semi-retired, my work these days is with the correctional system as an expert witness in civil rights litigation. As you know, folks with serious mental illness are tragically overrepresented in jails and prisons, and now in ICE facilities. This means that people with mental health disorders and substance abuse problems in Berkeley are very likely to have done time behind bars, and that has worsened their mental health condition and sobriety. I mentioned the Sequential Intercept Model for allocating thin resources to individuals most in need. I attach an article about the method. I am sure it is part of the discussion at meetings of clinicians in Berkeley Mental Health, but I do not know if there are active attempts to institute it locally. It is being implemented robustly elsewhere in the country.

Warm regards,
Terry

Terry A. Kupers, M.D., M.S.P.
Professor, The Wright Institute

NOTE: As we were unable to change the articles that were sent with this email into a Web Based Accessibility Compliant (WBAC) format, they have been omitted from this document.

If you would like to view the articles, please contact Karen Klatt, KKlatt@berkeleyca.gov

From: Tervalon, Tasha
To: Klatt, Karen; Gilman, Scott
Subject: FW: At the February 2, 2026 meeting, the Peace and Justice Commission voted to submit the attached letter to the City Council
Date: Friday, February 20, 2026 11:27:39 AM
Attachments: image001.png
P&J Letter to council Measure W .docx

Hi- Carole Marasovic from Peache and justice asked that send this to you two as an FYI-
So here you go-
Tasha

Tasha Tervalon Norcome, MSW
Assistant to the City Manager
Pronouns: She/Her
City of Berkeley
o- 510.981.5347 | c- 510-409-2329
ttervalon@berkeleyca.gov

From: Tervalon, Tasha
Sent: Tuesday, February 3, 2026 2:18 PM
To: City Clerk <clerk@berkeleyca.gov>
Subject: At the February 2, 2026 meeting, the Peace and Justice Commission voted to submit the attached letter to the City Council

Hi-
Peace and Justice voted to send this letter at the meeting on Feb 2nd.
Thank you for processing.
Tasha

Tasha Tervalon Norcome, MSW
Assistant to the City Manager
Pronouns: She/Her
City of Berkeley
o- 510.981.5347 | c- 510-409-2329
ttervalon@berkeleyca.gov

To: Mayor and Members of the City Council

From: Peace and Justice Commission

Submitted by: Pastor Dwayne Phillips, Chair

Subject: Need to Incorporate services and housing for LGBTQIA+ persons in County Measure W and Berkeley's share of Behavioral Health Services Act funding.

Dear Mayor and Council:

Given the current attacks upon the LGBTQIA+ population at the federal level and the prevalence of hate crimes and hate incidents at home with LGBTQIA+ persons as the second highest number of persons in Berkeley to be targeted as victims of hate, the Peace and Justice Commission urges Council to recommend that County Measure W funds be allocated accordingly and insure that City of Berkeley monies available under the California Behavioral Health Services Act (known as the BHSA, formerly MHSA)including monies for persons experiencing homelessness, mental health trauma and housing monies, address the needs of the LGBTQIA+ population.

The Peace and Justice Commission, while supporting the City's requests to the County for potential uses for County W monies intended for homelessness, homelessness prevention and affordable housing, urges Council of the critical need to insure that homelessness and housing needs among LGBTQIA+ persons be incorporated within every funding component and program need.

The individualized needs of LGBTQIA+ persons include not only access to specialized mental health, housing and homelessness resources but also compel attention to the fact that LGBTQIA+ persons, particularly transgender persons, are frequently subject to bullying, threats to their safety and worse in many traditional homelessness shelter and service settings. The City of Berkeley must insure that if individualized programs addressing the LGBTQIA+ residential settings are not provided that at the minimal, there must be access to individualized linkage and resources within each program and standards established within every program that honor the individual gender identity of every program participant.

The right to safety and respect and freedom from threats to safety shall not be tolerated in any homelessness services or homelessness housing environment. Those rights to safety and respect shall be clearly posted within every program funded by every homelessness services program and housing program in Berkeley.

In the same context, with Proposition 1 having passed and the Behavioral Health Services Act (BHSA) replacing the Mental Health Services Act (MHSA) with 30 percent of monies mandated towards housing and services for persons with mental health issues experiencing homelessness, a component of Berkeley's share should address the LGBTQIA+ population and allocate BHSA monies accordingly to properly serve LGBTQIA+ persons' housing needs.

Last, as the MHSA, now BHSA, contract for mental health trauma monies for the LGBTQIA+ population will be expiring on June 30, 2026, that Council refer to staff to issue another RFP to serve LGBTQIA+ persons under the BHSA subject to the community planning process and state directives for mental health trauma monies.

The following motion was passed as follows:

The Peace and Justice Commission voted on February 2, 2026 as follows:

That the Peace and Justice Commission submit a letter in support of LGBTQIA+ needs to be addressed within County W funding and the City of Berkeley's allocated BHSA funding with the text as incorporated above to City Council:

Motion: Move to adopt letter as written and presented to the commission.

> **M/S/C: Taylor and Morizawa**
> **Ayes: Commissioners Phillips, Sani, McNiel, Lippman, Morizawa, Schwartz, Marasovic, Fink, Taylor, Cassidy, Mascarenhas-Sawn, and Lee**
> **Noes: None**
> **Absent: None**
> **Abstain: Commissioners Remler, Elias and Mencher**
> **Excused: Commissioners Yasavul and Weisberg**

Thank you for your consideration.

Respectfully Submitted:

Pastor Dwayne Phillips, Chair

Peace and Justice Commission

From: Klatt, Karen
To: Klatt, Karen
Subject: FW: Contract Renewals and RFP Processes
Date: Friday, March 20, 2026 1:03:43 PM
Attachments: BHSA Community Input – Behavioral Health Priority Needs (Berkeley) (2).pdf

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From: Lasara Firefox Allen, MSW, Center Executive Officer <executive@pacificcenter.org>
Sent: Thursday, February 26, 2026 3:48 PM
To: Klatt, Karen <KKlatt@berkeleyca.gov>
Cc: Amory Knut <iqa@pacificcenter.org>; Pablo Martinez <clinicaldirector@pacificcenter.org>; Laraine Hutcherson <laraine@pacificcenter.org>
Subject: Re: Contract Renewals and RFP Processes

Dear Karen,

Thank you again for the ongoing coordination and transparency throughout the MHSA to BHSA transition process. I appreciate the opportunity to provide input as the City develops the first BHSA Integrated Plan.

Attached please find Pacific Center for Human Growth's formal community input submission regarding Behavioral Health priority needs in Berkeley, with a particular focus on Early Intervention, continuity of care, and culturally responsive behavioral health access during this period of system restructuring.

As a long-standing community-based LGBTQIA+ behavioral health provider, we are closely observing the regional impacts of MHSA restructuring and the potential for service gaps as programs are modified and rebid. Our input is offered in the spirit of partnership, continuity of care, and system stability during the BHSA transition, with the goal of supporting a stable Early Intervention landscape that minimizes disruption for community members who rely on prevention, peer support, and affirming outpatient services.

We are grateful for the City's inclusive community input process and for the opportunity to contribute a perspective grounded in direct service delivery and community engagement. Please let me know if any additional information would be helpful as the BHSA Integrated Plan is developed.

Warmly,
Lasara

Pacific Center for Human Growth
Lasara Firefox Allen (they/them/Mx.)
Center Executive Officer (CEO)
2130 Center Street, Ste. 200
Berkeley, CA 94704
executive@pacificcenter.org
707-293-5153

Date: February 26, 2026

To whom it may concern:

BHSA Community Input – Behavioral Health Priority Needs (Berkeley)

As Berkeley's long-standing LGBTQIA+ behavioral health organization with deep community trust and sustained service delivery, Pacific Center for Human Growth strongly encourages the City to prioritize Early Intervention (EI) services that preserve continuity of care during the MHSA to BHSA transition. System restructuring of this scale will create gaps in prevention and early intervention services if continuity-focused planning is not intentionally embedded in the BHSA Integrated Plan.

From our vantage point as a long-standing community provider, we are already observing regional shifts in behavioral health funding and service delivery tied to MHSA restructuring. These changes will create access gaps for individuals and families who rely on prevention, early intervention, peer support, and culturally responsive outpatient mental health services, particularly when programs are modified, rebid, or re-scoped.

In FY 2023–2024, Pacific Center delivered 5,262 clinical service hours and 606 community program service hours, while serving over 600 individuals across programs and engaging approximately 9,000 community members through outreach, peer groups, trainings, and linkage to care. Our client population reflects high-need Early Intervention priority groups, with 87% identifying as LGBTQIA+, 74% identifying as low-income, approximately 44% identifying as Black, Indigenous, Multiracial, or People of Color (BIMPOC), and a majority seeking culturally responsive, community-based mental health and early intervention supports. Demand for accessible, affirming early intervention services continues to increase as community members seek care in trusted, community-rooted settings.

Pacific Center is uniquely positioned, in alignment with our Early Intervention-focused service model and coordination with ACBHD Early Intervention systems, to help stabilize access for community members who may fall out of services elsewhere due to MHSA-to-BHSA funding changes. As prevention and early intervention programs are restructured regionally, established community providers will play a critical role in catching and supporting individuals who would otherwise experience service disruption, disengagement from care, or escalation into higher-acuity and crisis systems.

It is also essential that the BHSA Integrated Plan explicitly include culturally responsive and LGBTQIA+-affirming behavioral health services within its Early Intervention framework. LGBTQIA+ individuals, particularly trans and gender-expansive community members, face persistent barriers to accessing affirming mental health care and frequently rely on specialized community-based providers as their primary and safest point of entry into the behavioral health system.

Strong alignment between City-funded services and County Early Intervention investments will be key to reducing fragmentation during this transition. Prioritizing continuity, culturally responsive EI services, and established community-based providers will help mitigate the service gaps that will otherwise emerge during the MHSA to BHSA restructuring and protect vulnerable Berkeley residents from falling out of care.

In solidarity and community,

Lasara Firefox Allen, MSW (they/them/Mx.)
Center Executive Officer (CEO)
Pacific Center for Human Growth

Outlook

BAHVN FY 2026 Budget

From Edwin Herzog <edherzog48@gmail.com>
Date Fri 2/27/2026 9:55 AM
To Klatt, Karen <KKlatt@berkeleyca.gov>; Buell, Jeffrey <JBuell@berkeleyca.gov>

2 attachments (243 KB)
FY 2026 BAHVN PROGRESS REPORT.docx; BMH Budget FY 2026.docx;

Hi Karen and Jeff,
Thanks Karen for talking to me yesterday about my budget questions. I am attaching a rough draft of our FY 2026 budget that also includes our proposed addition of one in person hearing voices group. I am also attaching an overall progress report about our organization.

Please let me know if there is anything I need to add or any questions you might have. As I mentioned we are also interested in talking to Lifelong Health Care about any partnership possibilities. Please let me know if there is someone there who I can discuss this with.

thanks again
Ed Herzog

February 27, 2026

To:
Karen Klatt, MEd
Community Services Specialist 3
City of Berkeley Mental Health, MHSA?BHSA Coordinator
1521 University Ave
Berkeley, CA 94704

From:
Edwin Herzog, MA
Bay Area Hearing Voices Network (BAHVN)
President
1012 Jones Street
Berkeley, CA 94710

2026 BUDGET

PROPOSAL
To renew the Personal Services Contract between the CITY OF BERKELEY MENTAL HEALTH DIVISION and the **BAY AREA HEARING VOICES NETWORK (BAHVN)** a 501c3 corporation doing business at 1012 Jones Street, Berkeley, CA 94710.

SCOPE OF SERVICES
The Bay Area Hearing Voices Network proposes to continue to provide 5 weekly Hearing Voices Network support groups from July 1, 2026 to July 1, 2027, including 2 on-line adult hearing voices groups, 2 family and friends support groups, and one LGBTQ+ group.

YEARLY BUDGET
Support group facilitators
5 hearing voices and family member groups, two facilitators per group, at $75.00 per facilitator per group for 52 weeks.

Sub-total **$39,000.00**

Zoom and IT costs

BAHVN to offer weekly adult hearing voices and family member groups on-line on zoom. Costs include: zoom payments, internet technology , and web maintenance.

Zoom costs @ $37/month	$ 444.00
IT zoom facilitator fees, 2 hrs per day at $25/hr, Mondays and Tuesdays	5200.00
Sub-total	**$5644.00**

Holiday compensation

For the following observed holidays that land on Mondays:
Labor Day, Indiginous People's Day, Veteran's Day, Martin Luther King Jr Day, President's Day, Easter Monday, and Memorial Day.
Facilitator compensation @ $10.00 per facilitator for 8 holidays:

Sub-total	**$320.00**

SUB TOTAL	**$44,964.00**
5% administration	**2,248.00**
TOTAL	**$47,212.22**

PROPOSED: ADDITIONAL ONCE A WEEK IN-PERSON HEARING VOICES GROUP

ONE-YEAR BUDGET

Support group facilitators
Two group facilitators at $75.00 per 1.5 hour group for 52 weeks
$7,800.00

Room rental
Room rental at the North Berkeley Senior Center, one evening a week at $66.00 per night
$3,432.00

TOTAL: $11,332.00

BACKGROUND
Following the COVID epidemic we placed all of our hearing voices groups on line. While it has increased our group attendance dramatically, many of our group participants have requested the ability to attend a group in person. In person groups offer more direct personal support, intimacy, and connection sought by some group participants. While we wish to remain mostly on line, we would like to offer those group members the opportunity to attend a group in person.

FY 2026 BAHVN PROGRESS REPORT

The Bay Area Hearing Voices Network (BAHVN) has been offering hearing voices groups in Berkeley since 2013. We started with one adult group and have expanded to now offer 5 adult hearing voices groups including two separate groups for family members, adult voice hearers, and a LGBTQ+ group.

Since the Covid-19 pandemic we have offered our groups on-line which has dramatically increased our group attendance. Over the last five years, more than 11,000 adults have attended our groups and continue to attend in increasing numbers.

Answering requests from voice hearers, with this budget we also hope to once again offer an in-person, adult hearing voices group at the North Berkeley Senior Center.

STATEMENT OF NEED

Many thousands of Bay Area residents, including 8% of adults, hear voices on a regular basis and greatly benefit from our groups. Many family members, clinicians, and voice hearers themselves are often at a loss how to help their loved ones and clients other than using traditional and expensive emergency measures which often lead to a revolving door of treatment and hospitalization.

Given the threatened cutbacks in Alameda County outpatient treatment programs, access to consistent support by the BAHVN for those experiencing mental health challenges is needed more than ever to help reduce in-patient hospitalization, homelessness and incarceration. They also save the county money, helping voice hearers and others with mental health challenges stay out of expensive, in-patient, hospitalization costing up to $2,000 per day.

PEER DRIVEN SUPPORT

Our hearing voices support groups offer a powerful, peer-driven, and peer co-facilitated framework for engaging and supporting those who hear voices, see visions, hear special messages, and experience alternative realities.

HVN groups are both support groups and social groups. They build extended supportive communities for participants both inside and

outside the groups. They provide a safe place for voice hearers to express what their voices are saying and what they mean to them, often for the first time in their lives because of stigma and fear of hospitalization.

As our surveys show, Hearing Voices groups offer an alternative and effective means of support. The groups teach voice hearers how to influence and understand their voices, visions, and other unusual phenomena. They also offer voice hearers and family members an ongoing community of support, both inside and outside the groups, that they can access during good times and bad.

All HVN group facilitators have lived experience themselves and participate in extensive, 3-day, HVN-USA sponsored trainings that follow the HVN-USA charter. All our group leaders are long term, peer facilitators, having led our weekly groups for over five years. They are a team dedicated to helping those who struggle with their voices and other sometime difficult unusual experiences with love and understanding.

From: Phillip Shelley
To: Buell, Jeffrey; Klatt, Karen
Cc: Doreen Bracamontes; Rosina Keren
Subject: Proposed program redesign for City of Berkeley (BHSA)
Date: Wednesday, March 11, 2026 2:37:22 PM
Attachments: Final draft proposal for program redisign for COB"s BHSSA 2026 (1).docx

Hello Jeff and Karen,

I hope this email finds you well. Please find attached to this email, and linked here, the Berkeley Unified School District's draft proposal for program redesign for the City of Berkeley (BHSA) for 2026. Please provide any feedback as comments on the linked document so we can amend as needed. Thank you.

In Community,

Phillip Shelley, Ed.D.
Director of Student Services

Office: 510.644.6316

Cellphone: 510.725.5041
Fax: 510.644.7712

Email: phillipshelley@berkeley.net

Below, please find BUSD's revised BHSA program descriptions to align with the City of Berkeley's funding, which reflects the strategic shift from universal prevention to **targeted, high-intensity intervention** for students with significant mental health and behavioral needs.

Berkeley Unified's REVISED SCOPE OF BEHAVIORAL HEALTH SERVICES:

Mental Health First Aid and Mental Health Triage Coordination are priorities in common between the City of Berkeley and Berkeley Unified School District. Over the last four years collaboration between the high school health center and BUSD leadership has resulted in honing in on a sustainable mental health and safety program vision and focused, strategic coordination needs that underpin the following proposal and request for funding to facilitate a common goal, centered on student safety, coordination of care, and early intervention for focal students, and their peers, as well as their school behavioral health ecosystem.

Teen Mental Health First Aid Coordinator

Summary: A designated, skilled, credentialed, and/or licensed person would be strategically positioned to work as part of the Student Services team, providing school-based Care Response and Safety Coordination located in the high school wellness centers. This person would function to focus on teen mental health triage and early intervention. This person would be the person responsible for making sure that students who need any tiered intervention or support related to behavioral health, specifically mental health, would be identified, connected to, and involved in an active care plan or safety plan as required to ensure student safety and health was being addressed by clinical services and/or appropriate direct services of BUSD's care team providers (PPS credentialed employees, community partners, certified wellness coaches)

Resource allocation: (Wellness Coordinator) Funding for a skilled individual with school-based experience and possessing a PPSC credentialed (e.g., social worker or school psychologist), preferably with an LCSW. This person would be supervised centrally, via BUSD student services (e.g., Counseling & Wellness Program Manager). Location would be high school Wellness Centers (BHS & BTA).

Cost Estimate: $140,000

Target Population: Students who have an escalating need for targeted mental health service coordination. These students may be identified via a Care Response, Wellness Center Drop-In, school counselor referral, self-referral, or behavioral indicators stemming from the classroom.

Deliverables: Coordination of system-wide care via Safety Planning, Suicide Prevention, Teen Mental Health

A. **Monitor student wellness center screener to identify students needing tiered support:** level 1 = support within a week, level 2= support same day, level 3 = immediate crisis support

B. **Clinical supervision support for state-certified Wellness Coaches:** Provide weekly supervision meetings and day-to-day support for the Wellness Coaches located in the high school wellness centers; wellness coaches operate the drop-in wellness center desks with a student screener to identify the level of need when students walk in. This role assists in mental health triage and works in coordination with the multi-tiered system of support in the school community.

C. **Coordination of Care**: Utilize a care coordination (safety plan) tool to ensure a full wrap-around plan, as appropriate, is in place and that the high school health center is receiving referrals and that the high school wellness center coordinator is also receiving referrals back for school-based supports and interventions not provided by the health center services.

D. **Wellness Center Drop-In:** Ensuring that the high school wellness centers are operating according to hours of operation, staffed providers are scheduled, confidential rooms are utilized and scheduled with tiered service providers such as high school health center 1-1 counseling facilitators, targeted small group behavioral health facilitators, etc.

E. **Care Response**: ensures that the administration and staff are trained in established protocols for calling a Care Response (BUSD's systemic way of identifying a mental health crisis unfolding on campus, and requiring immediate response from a skilled provider). Responds to mental health crisis calls from adults and staff on campus. Implements follow-up with family, health center, school site counselors, and other need-to-know personnel as appropriate (see coordination of care)

F. **Peer Mental Health Educators: Recruit, train, facilitate**

Mental Health Peer Educators in Teen Mental Health First Aid, an evidence-based training for grades 9-12 (ages 14-18) that teaches students to identify, understand, and respond to mental health or substance use challenges in peers. Students in grades 11 and 12 would participate in differentiated ways after being trained. Some would be wellness center helpers providing anxiety-reducing options targeted at lowering students' affective filter with evidence-based calming exercises. All would participate in teen mental health intervention by pushing into classrooms at predictable times of the school year, where student stress and anxiety is heightened and require mental health 101 support and reminders of what to do to avoid escalating mental health experience that can lead to crisis. Students would also do targeted outreach to 9th and 10th grade students who benefit from classroom tours of the wellness center and locating the health center on campus; this helps students access the hub for help when or if they or peers are experiencing behavioral health and acute mental health symptoms The Wellness Coach, trained in teen mental health, and working with the coordinator would facilitate any after school, 7th period student meetings as necessary for a 1x week planning and student training support.

Anticipated Outcomes for identified focal students via direct service and the student population ecosystem

- Show reduced stigma and increased empathy toward those with mental health challenges (including self)
- Know the signs, symptoms and risk factors of mental health and substance use challenges (to seek existing support on campus)
- Show greater confidence and likelihood to help someone in distress (to connect a peer right away to an on-campus resource when signs of distress surface)
- Use their skills and knowledge as First Aiders to manage their own mental wellbeing (reporting increased capacity to notice and use stress and anxiety mitigating skills/strategies, including those written into safety plans)

2. Dynamic Mindfulness (DMind) Program: Trauma Recovery Model

Target Population: Students exhibiting severe signs of PTSD, chronic trauma (ACEs), and significant behavioral challenges (e.g., severe dysregulation, impulse control, or aggression), and/ or high levels of school absenteeism.

Program Redesign:

DMind will move away from universal classroom sessions. The focus is now on **Targeted Clinical Stabilization**.

- **High-Intensity Intervention:** DMind will be used as a primary regulation tool for students with "Higher Level Need" as identified by COST teams, CARB team, and the Wellness Center.
- **Implementation:** Services will be delivered in small-group clinical settings or as a 1-on-1 stabilization technique for students in crisis, specifically to prevent school failure or more restrictive placements.
- **Staff Focus:** Training will center on the Student Welfare and Attendance Liaison (SWA), Wellness Center staff, Safety Officers, and clinicians working with the most vulnerable students to ensure DMind is a core component of their individualized treatment plans.

3. Supportive Schools Program (Elementary): Intensive Behavioral Intervention

Target Population: Elementary students with significant behavioral impairments and families facing extreme stressors.

Program Redesign:

This program will transition from "early intervention" to **Intensive Support**.

- **High-Need Focus:** The $5,000 per school will be dedicated to subcontracting specialized clinicians (BACR, CTI, Lifelong) to provide **intensive individual therapy** and **targeted social-emotional groups** for students identified by the COS team, who are the most emotionally dis-regulated, have poor academic performance and/ or attendance, or challenging behaviors.
- **Clinical Oversight:** The COS Teams and our school psychologists will focus exclusively on the highest-need 5% of the student body, ensuring coordinated care between Special Education supervisors, the COS team, and mental health providers.

Total cost estimate: $55,000

4. African American Success Project (AASP):

Strategic Framework: Cultivating Student Agency and Institutional Wellness

Vision: An Ecosystem of Excellence

This initiative provides a high-leverage response to the specific environmental and psychological pressures that can impact the mental well-being of Black students within traditional institutional structures. By fostering student agency and building institutional competency, we ensure the school environment functions as a robust, supportive environment. This model moves beyond reactive support to create a measurable, data-driven ecosystem of student support and professional learning.

I. Proven Impact and Continuity: 2019 to Present

Since the 2019-20 school year, the City of Berkeley has provided foundational support for the African American Success Project. This sustained investment has allowed BUSD to move beyond traditional, reactive interventions toward a proactive wellness model. Funding use has demonstrated that targeted, affinity-based interventions stabilize students' sense of belonging and strengthen the school's social-emotional climate, and that one-to-one counseling support fulfills critical service gaps. This proposal builds on prior successes by deepening the project's focus on systemic accountability and real-time data.

II. Intent and Focus: Optimizing the School-Student Interface

This work addresses cultural interface—the space where student identity meets institutional norms. In many traditional school settings, the absence of culturally specific protective factors can lead to environmental stress, which impacts a student's mental well-being and engagement.

Funding will support the implementation of an advancement and wellness strategy. We aim to bolster student agency (the internal authority to define one's own path and worth) while simultaneously building adult capacity to recognize and resolve the environmental stressors that inadvertently impact student wellness.

III. Track 1: Direct Student Support

Managed by AASP Manager; Delivered by specialized providers/staff.

- **The Empowerment Affinity Space:** A dedicated, non-clinical space where students process the impact of institutional stressors and build relational trust.
- **Agency-Building Sessions:** Intensive sessions designed to foster internal authority, moving students from coping to thriving by affirming their identity.
- **Precision Wellness Data:** Utilizing real-time SEL tracking to bridge the gap left by universal screeners. We measure:
    - **Climate Optimization:** Ongoing assessment of school climate to identify and mitigate environmental friction before it impacts student health and outcomes.
    - **Resilience Velocity:** Measuring the growth of a student's internal protective mindsets and self-possession.
- **Integrated Transitions:** Facilitating warm hand-offs to behavioral health, basic needs, and academic resources.

IV. Track 2: Institutional Readiness & Professional Excellence

Managed by AASP Manager; Delivered by a Specialized Provider.

To cultivate a school climate rooted in holistic wellness, staff will engage in advanced capacity-building opportunities. Data will identify high-priority sites where professional learning can best support efforts to create welcoming and inclusive school climates.

- **Institutional Wellness Training:** Equipping staff to identify markers of cultural and environmental stress. This shifts the adult response from behavior management to "proactive wellness-alignment.
- **Codifying Excellence:** Documenting and sharing insights on institutional readiness to serve as a strategic roadmap for District-wide practices.

V. Desired Outcomes

- **Student Level:** Measurable growth in student agency and self-reported wellness, evidenced by real-time data collection that tracks resilience and environmental navigation skills.
- **Adult Level:** Documented participation in capacity-building opportunities, resulting in a shift toward wellness-centered environments and proactive student-engagement strategies.
- **Institutional Level:** The delivery of codified success takeaways that provide BUSD with a roadmap for optimizing school climates and strengthening student success.

VI. Executive Summary

Continued investment in the African American Success Project (AASP) enables the evolution of a highly effective, wellness-centered support model. By centering student agency, this initiative equips youth with the internal authority and resilience to navigate and thrive within complex institutional environments.

Simultaneously, the project enhances institutional readiness by building District staff capacity to recognize and mitigate environmental stressors that can inadvertently impact the well-being of Black youth. Through real-time tracking of SEL data and facilitated warm hand-offs for mental health, basic needs, and academic support, this initiative underscores BUSD's commitment to data-driven equity and high support. This is a high-impact investment in the mental health, resilience, and long-term success of Berkeley's African American students.

Total cost estimate: $150,000

2/25/2026 4:19 PM

Text of email shared by a Community Member at 2/26/26 BHSA Community Input Meeting:

(Note email addresses, and name of sender have been removed for confidentiality purposes).

To whom it may concern:

I was a licensed MFT Clinician for 32 years. I have worked in residential and day treatment programs both non profit and for profit. I have worked as a line staff, and also as a program director and manager of these programs. I can tell you from experience that these programs provide a vital link and stepping stone for our vulnerable persistently and chronically mentally ill consumers. These programs provide structure to their days, with appropriate social interactions, engender a feeling of work and accomplishment and allow for medication monitoring and adjustment when needed. Without these valuable programs our consumers would be isolated and e a much larger risk to be hospitalized. Not only is this not cost effective but the human quality of life and well being suffers greatly. I can attest that these programs provide an invaluable link to the community and provide long term stabilization for chronically mentally ill consumers. Elimination of these programs would be catastrophic to our already fragile and woefully inadequate mental health system of care.

A second point I would like to make is that the caregivers who staff these programs are a special breed of devoted mental health professionals. The time it takes to build a cohesive competent team who functions effectively takes years. The closing of grams destroys these community treasures which are not soon if ever rebuilt. I urge you to find funding elsewhere and to not cut or eliminate any of these incredible assets that are now serving this vulnerable population.

Sincerely,