PHASE 2
DRAFT FOR PUBLIC COMMENT

A. BHSA POPULATION-BASED PREVENTION PROGRAM OPERATIONAL COMPONENTS

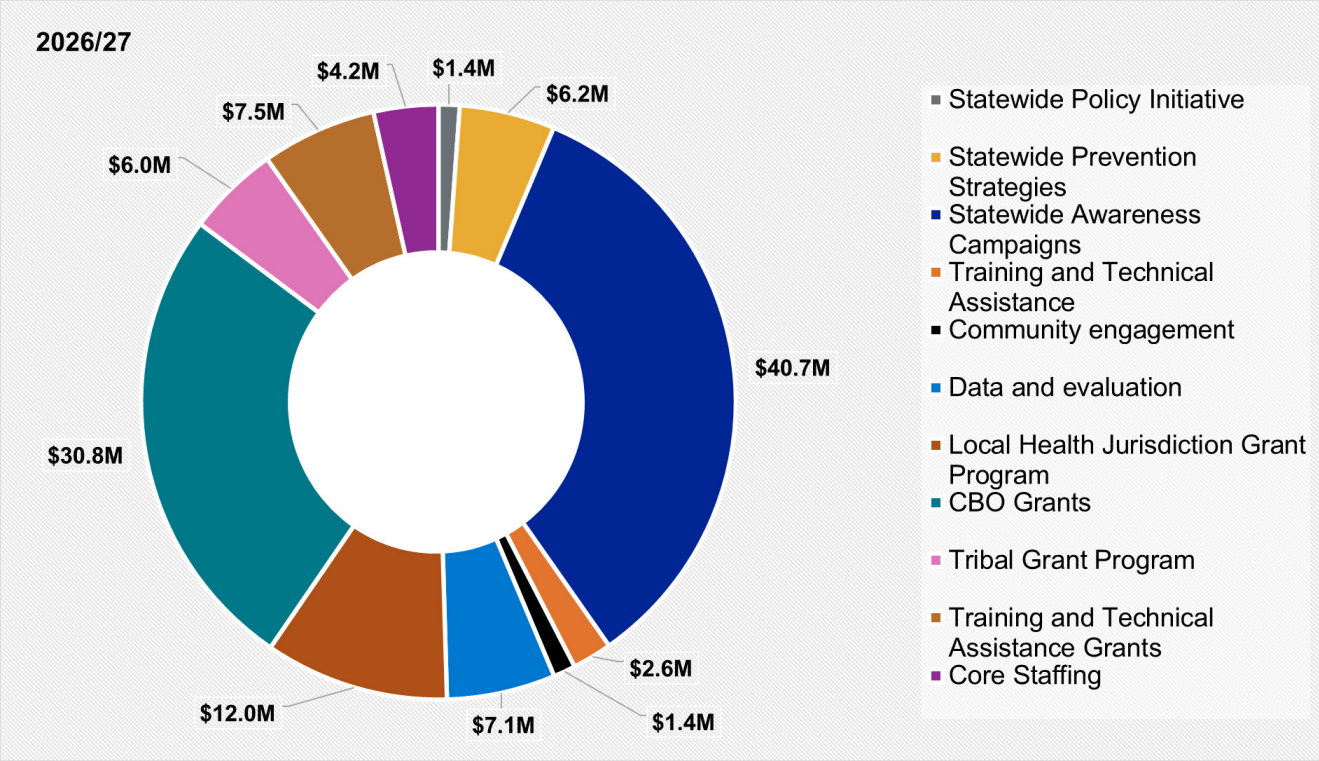
I. Overview and Purpose

This Phase II Guide is intended to act as a complement to the CDPH **Behavioral Health Services Act Population-Based Prevention Program Phase I Guide.** This Guide provides the proposed operational and administrative components to execute the BHSA Population-Based Prevention Program Framework as indicated in Phase I, with the specific activities to be implemented for each of the Statewide Prevention Strategy Components. Each activity is intended to achieve the intended objectives, goals, and outcomes of the BHSA.

This Guide also provides the strategic approach that CDPH will undertake by setting statewide policy direction and focused strategies, and the role of local partners for implementation of statewide policy, strategies in order to advance statewide goals.

Figure I represents the proposed total CDPH investment in BHSA activities for Fiscal Year **2026/27**[1].

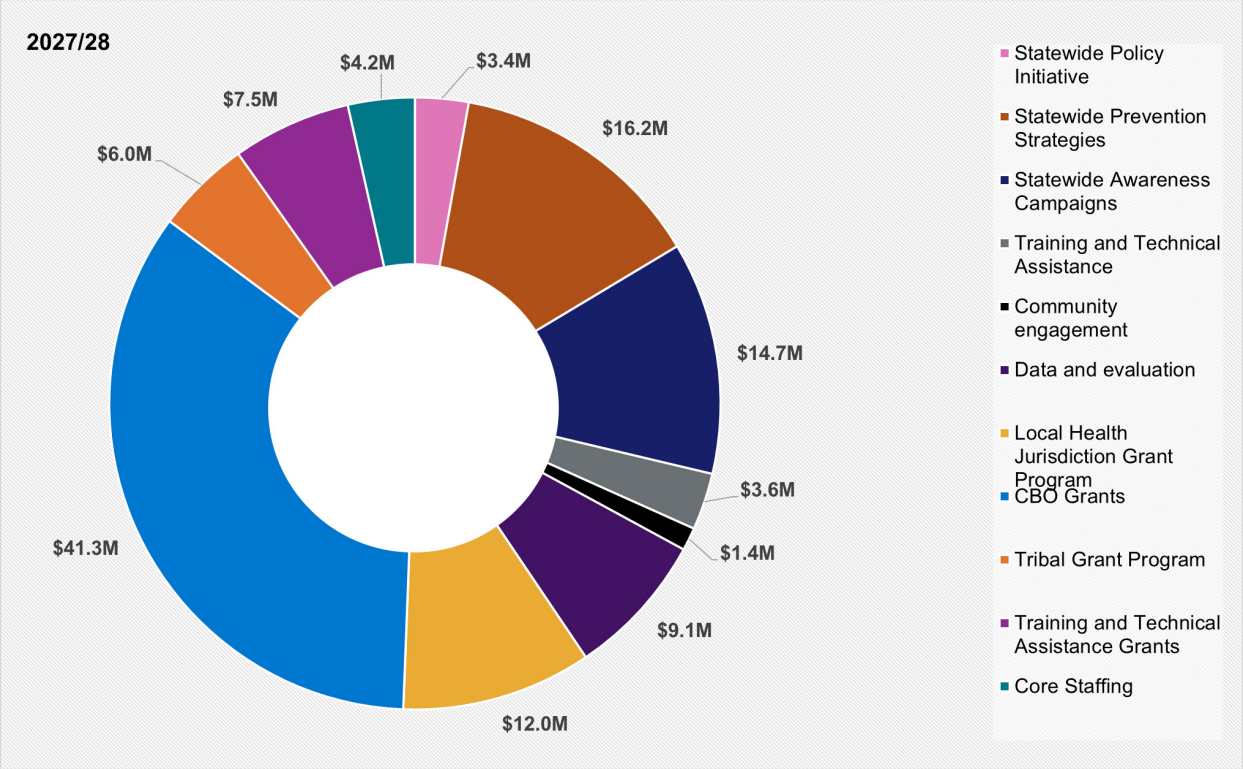
Figure I- CDPH investment in BHSA activities for Fiscal Year 2026/27



[1] A minimum of 4 percent of the BHSA total funds are being allocated to the California Department of Public Health to provide population-based mental health and substance use disorder prevention programs. This is estimated to be approximately $120 million each year.

Figure II represents the proposed total CDPH investment in BHSA activities in Fiscal Year **2027/28 – 2028/29.** The difference between these later years and 2026/27 is the introduction of a new awareness campaign and implementation of the 988 Suicide and Crisis Lifeline Outreach Campaign Grant Program.

Figure II - CDPH investment in BHSA activities in Fiscal Year 2027/28 – 2028/29



See Appendix B for a summary of total investments for each fiscal year.

II. Office of Social and Behavioral Health

To strategically invest BHSA funds with greater efficiency and strong leadership, improved coordination across the vast array of existing CDPH behavioral health related programmatic experience, expertise and initiatives, CDPH is developing a more centralized and coordinated structure through development of a CDPH Office of Social and Behavioral Health [2](Office). CDPH is developing a reorganization plan to establish this office in 2026. This new organizational structure will:

- Provide for a coordinated and centralized approach to behavioral health at CDPH,
- Ensure leadership, alignment, and oversight of behavioral health activities,
- Create efficiencies in the planning, development and delivery of BHSA funded services, and
- Promote behavioral health as a public health priority in California[3].

This new office will not only support strong leadership but ensure the core capacity and infrastructure needed for successful and aligned BHSA population-based prevention functions. As part of the new Office, a dedicated team will provide fiscal and administrative oversight of all funded activities, including those within CDPH. The Office will review and monitor compliance with statute, provide progress reports to the Director's Office and make recommendations for corrective action as needed.

The office will also ensure that an equity-focused lens, including perspectives from Tribes[4] through dedicated engagement, is incorporated into all campaigns, initiatives and strategies – ensuring individuals of all backgrounds, especially those most vulnerable for negative outcomes, receive the interventions they need in the space and languages that are most appropriate for their needs. Their functions will support tracking and monitoring of legislative impacts and emerging issues that can influence and inform planning and strategy development, as well as develop and maintain strong coordination with other state partners (including but not limited to California Health and Human Services Agency (CalHHS) and the other CalHHS

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[2] Aligns with Social and Behavioral Health | ASTHO. The Association of State and Territorial Health Officials work in Social and Behavioral Health acknowledges the "field of public health has an integral role in addressing behavioral health, which encompasses mental health, substance abuse disorders, and behavior change. While acknowledging the importance of a full continuum of services, public health often focuses on primary prevention and addressing the broader community, societal, and systemic factors essential to good health".

[3] Public Health's Role in Mental Health Promotion and Suicide Prevention | ASTHO Public health's role in mental health promotion and suicide prevention is rooted in understanding that mental and physical health are both essential to the overall health of every person.

[4] Tribes as referenced throughout this Guide include Federally recognized Indian Tribes, Urban Indian Organization/Urban Indian Health Programs and Indian Health Clinics/Tribal Health Clinics

departments , as well as other system partners, including but not limited to education, housing, and the California Department of Veterans Affairs) and local partners. The office will also provide project management and leadership related to CDPH's overall behavioral health communications strategy.

III. Statewide Prevention Strategies:

Based on continued statewide prevention planning efforts and the input received as part of release of the Phase I Guide[5] and formal Tribal consultation, CDPH developed the following statewide prevention strategies within each component for implementation. These strategies create alignment across the state to ensure that the population-based prevention program is focused on advancing statewide BHSA goals and meets the intended outcomes to prevent suicide, self-harm and overdose.

Each also leverages and builds upon the existing expertise in CDPH, notably:

- The existing expertise of the Office of Suicide Prevention (OSP), established by AB 2112 , to serve as the designated state entity responsible for coordinating and aligning statewide suicide and self-harm prevention efforts and resources through planning and collaboration across diverse partners and systems, which includes continued work with the Mental Health Services and Oversight & Accountability Commission on California's Strategic Plan for Suicide Prevention
- The Office of School Health which partners with education and health organizations at the state and local levels to support the health, safety, and well-being of California's 7.5 million students, school staff, and school communities in the State's 10,000 TK–12 schools.
- The Substance and Addiction Prevention Branch (SAPB) and the Overdose Prevention Initiative which aims to reduce individual, social, and environmental harms caused by substance-related and addictive disorders through research-driven prevention, education, and treatment in California.
- The Violence Prevention Initiative (VPI) which aims to reduce violence and create safer and healthier communities for all Californians and was established to elevate violence as a departmental priority, and to integrate and align efforts across multiple CDPH programs. The California Public Health Roadmap for Firearm Violence Prevention Report was released in August 2025.

[5] The meeting slide and a video recording of the public comment can be found on the CDPH BHSA - Partner and Community Engagement Webpage

- The Office of Health Equity and the groundbreaking California Reducing Disparities Project, which created a statewide policy initiative to identify solutions for historically unserved, underserved, and inappropriately served communities. The Office of Health Equity will also continue to serve a critical role in ensuring that formal Tribal engagement is embedded within all aspects of BHSA planning and implementation.
- Public health experience and expertise in areas of data and evaluation – notably in areas related to data collection, analysis and the ability to interpret health data in a meaningful way to inform policy and assess program effectiveness, understand health trends and improve health outcomes.

The CDPH expertise was also complemented by the vast amount of expertise and work from current behavioral health prevention experts, including those within county behavioral health and public health, and state level partners, including DHCS and California Department of Aging (CDA), who have a keen interest and knowledge in the prevention of suicide, overdose and substance use disorder.

A key principle and foundational for the CDPH BHSA Prevention Program are the importance of addressing stigma and discrimination in all facets of behavioral health prevention, especially as it relates to race, ethnicity, gender and sexual orientation. Stigma and discrimination can result in avoidance of seeking help, avoidance of treatment, social isolation and loneliness, lower self-worth and quality of life – all resulting in greater risk of negative health outcomes.

IV. PRIORITY POPULATIONS FOR STRATEGIC INVESTMENT

BHSA focuses on reaching and serving populations with the highest need and at greatest risk for negative outcomes along the care continuum. By focusing on these priority populations, the BHSA aims to improve behavioral health outcomes, reduce disparities, and ensure that the most vulnerable and marginalized individuals, including those disproportionately impacted by system racism and discrimination, receive the support they need.

The limited funding provided for population-based prevention dictates a focused approach on addressing the most critical needs and gaps and using data to drive strategic investment. The list of priority populations for strategic investment has been refined to reflect where BHSA funding will specifically be directed, distinct from the "priority populations" defined in statute[6]. These populations reflect the greatest need based on a review of data[7], stakeholder feedback

[6] W&I Code §5892, subdivision (d)

[7] Visit the California Overdose Surveillance Dashboard and EpiCenter, CDPH's interactive data visualization tool on injuries, for more detailed data on drug-related overdose and suicide outcomes.

from our Phase I Guide comment period, and the potential impacts of recent federal policy.[8] They also reflect gaps in existing prevention investment.

Additionally, on July 30, 2025, California Governor Gavin Newsom signed an executive order to address a growing crisis of suicide, mental health, and disconnection among California's young men and boys.

CDPH's list is not an eligibility list, but a strategic framework to guide population-based prevention investments. For purposes of funding statewide prevention strategies, the following **populations of focus for strategic investment include:**

a. Black, Indigenous, and other people of color
b. Children, youth, and families
c. Immigrant and refugee populations
d. LGBTQ+ populations
e. Older adults
f. Tribes
g. Veterans

Note: the list above is represented in alphabetical order and should not be viewed as levels of prioritization.

In accordance with BHSA Statute[9] at least 51 percent of BHSA population-based prevention funds shall be used for programs serving populations who are 25 years of age or younger.

V. STATEWIDE POLICY INITIATIVES

For implementation of Statewide Policy Initiatives, CDPH will focus on developing expertise and resources within the new Office to research and address emerging behavioral health issues and enhance CDPH capacity to respond to novel and emerging substance use or behavioral health threats, including for example, the mental health risks associated with the use of social media in children and youth. For example, in regards to work related to AB 1282 and the recently signed SB 243, this may include conducting research and evaluation regarding digital media and youth behavioral health, specifically regarding:

- school smartphone policies in California and comparable demographics;

[8] For example, the mental health impacts on children and families living in areas affected by immigration raids or the impacts on LGBTQ+ communities facing an increase in anti-trans and anti-LGBTQ+ rights legislation at the federal level.
[9] WIC Section 5892 (f)(1)(E))

- ways to reduce negative and increase positive impacts of social media among children and youth, in collaboration with youth

As part of implementation of SB 243, the CDPH Office of Suicide Prevention will review the data submitted for further policy recommendations.

VI. FOCUSED STATEWIDE BEHAVIORAL HEALTH PREVENTION STRATEGIC PLAN:

To ensure alignment, CDPH has developed a focused set of strategies that advance the statewide BHSA population behavioral health goals. These strategies incorporate recommendations from existing initiatives and leverages the expertise of subject matter experts in fields of suicide and self-harm prevention, substance use disorders, and overdose prevention. They also represent data-informed strategies that look to build resilience for maternal, child and adolescent health populations, and culturally grounded strategies that are more meaningful and effective in addressing the behavioral health needs of California's diverse communities.

Table of Focused Set of Strategies for Investment

The following strategies for implementation (at both the state and local level) have initially been defined from research of the following:

- Striving for Zero: California's Strategic Plan for Suicide Prevention 2020 - 2025;
- Violence Prevention Initiative and Roadmap
- Overdose Prevention Initiative
- Building California's Comprehensive 988-Crisis System: A Strategic Blueprint.
- Master Plan on Aging
- Substance Abuse and Mental Health Resources Administration

CDPH will continue to work closely across state partners to review and incorporate other statewide plans and initiatives that are critical for informing population-based prevention strategies, including any statewide plans for implementation of the recent Executive Order related to men and boys.

The table below outlines example allowable activities for local partners to expand reach of statewide strategies[10]: The list below is not intended to be exhaustive, but are provided as examples, and may be modified based on data and evaluation, or as a result of any further

[10] Community-Defined Evidence-based practices are also strongly encouraged as examples within each of the prevention strategies listed. The Biennial List for BHSA Population-Based Prevention – Community-Defined Evidence Based Practices will be released at a later date.

statewide plans and initiatives that incorporate other population-based prevention strategies with the goal of preventing suicide, self-harm and overdose.

Prevention Strategy	Example
Lethal means safety and harm reduction	• Naloxone Distribution Project • Gun Shop Project
Social and cultural connections	• Senior volunteer and mentorship, particularly those offering intergenerational engagement • Digital literacy for youth and families – focusing on skills like online safety, critical thinking, evaluating information, using privacy settings and promoting ongoing conversations about online behavior and potential risks • Traditional healing practices / Community Healing Circles
Social-emotional learning and emotional regulation, resilience, and stronger school-based relationships	• Sources of Strength in elementary schools, • Youth development and empowerment • Second Step / PATH (Promoting Alternative Thinking Strategies)
Behavioral health awareness and Identification and Engagement Trainings	• Mental Health First Aid Training and Teen Mental Health First Aid • Applied Suicide Intervention Skills Training (ASIST) • safeTALK • QPR (Question, Persuade, Refer) Suicide Prevention Training • WRAPs & Tools - Wellness Recovery Action Plan • Safe Spaces • Training on identifying the signs of drug overdose and administration of naloxone
Stigma and discrimination reduction	• Peers Helping Peers • NAMI In Our Own Voice | National Alliance on Mental Illness (NAMI) • Lived Experience Academy (LEA)
Policy, systems and environmental change	• Districtwide policies that support and sustain mental health clubs on campus • Policies to promote low barrier access to Medically Assisted Treatment options

Prevention Strategy	Example
Promotion of protective factors and Positive Childhood Experiences (PCEs)	• Curricula and training to strengthen parent-child relationships and build family resilience
Early Childhood and Parenting Programs	• Interventions for children 0–5 and their caregivers, including perinatal supports, parenting skill-building, and child development programs. • Fatherhood engagement programs that promote positive parenting, mental health, and involvement in early childhood development • Power of Play in Early Childhood

These strategies are complemented with statewide training and technical assistance to support successful implementation.

CalHOPE

Warmlines are essential for mental health because they offer **preventative, non-crisis support** by providing emotional support and comfort, often staffed by peers with lived experience. They are a critical prevention component by decreasing the use of crisis services, reducing feelings of loneliness, and providing vital support during evenings and overnight when other services are unavailable. Warmlines act as a vital bridge, helping individuals manage everyday challenges and work through mental health recovery processes before a crisis develops. CalHOPE has been a vital resource in our communities since 2020, originally established as a statewide initiative to provide mental health and crisis support to California communities impacted by the COVID-19 pandemic and other disasters. Its purpose was to deliver accessible, prevention-oriented behavioral health and crisis support for communities and individuals, with the goals of building community resilience. It is a recognized and valuable resource that complements the work of CDPH and our local partners in behavioral health and SUD prevention.

CalHOPE Warm Line: (833) 317-HOPE (4673)

The CalHOPE warm line connects callers to people who have persevered through struggles with stress, anxiety, depression—emotions triggered by circumstances and events in everyday life. The peer counselors listen with compassion, provide non-judgmental support, and guide individuals to additional resources that can give hope and help those in crisis cope.

CalHOPE Red Line

The CalHOPE Red Line, a peer support program run by the California Consortium for Urban Indian Health (CCUIH), is a phone, live chat, and video chat service providing National, State, and County resources, referrals, and trauma-informed support for Urban Indian and Tribal populations. These include resources related to stress, anxiety, social services, and financial resources.

Additional CalHOPE resources are also included in this Guide under Technical Assistance and Training.

Community-Defined Evidence Based Practices

The use of Community-Defined Evidence Based Practices (CDEPs) is an effective strategy for addressing historical behavioral health disparities. CDEPs are an alternative or complement to Evidence-Based Practices (EBPs), that offer culturally anchored interventions that reflect the values, histories and life experiences of the communities being served. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

The forthcoming biennial list[11] will be a non-exhaustive list intended to serve as an optional reference tool for use by local partners and as a reference for Local Health Jurisdiction (LHJ) coordination efforts. CDEPs included on this list address the unique behavioral health issues that are impacting our diverse communities. Both LHJs and Community-Based Organizations (CBOs) receiving CDPH BHSA funding for population-based prevention programming should use this list as an opportunity to inform local coordination, development of local suicide plans, and implementation of culturally relevant services to meet the diverse needs of their populations.

These strategies may be amended based on the research and results of statewide Policy Initiatives, as part of the continuous evaluation of CDPH and local implementation of strategies, and as data and emerging issues dictate.

VII. STATEWIDE AWARENESS CAMPAIGNS:

Statewide awareness campaigns are a valuable resource for increasing public understanding of the pressing behavioral health, substance use, and overdose issues across the state. Statewide campaigns also broaden the audience to the entire state and can be effective at changing perceptions and influencing behavioral change on a large scale. It can drive collective action,

[11] The Biennial List for BHSA Population-Based Prevention – Community-Defined Evidence Based Practices will be released at a later date. This list will be developed and disseminated separate and apart from the biennial list issued by DHCS (which is specific to EBPs and CDEPs for Early Intervention efforts). The list to be provided by CDPH will be focused on population-based prevention, intended to meet the goals of preventing suicide, self-harm, overdose and substance-use disorder, with a specific focus for priority populations.

and act as motivation for individuals to act. Public awareness can also mobilize public opinion, influencing policy at the state and local level.

As part of CDPH efforts to create mutually reinforcing public awareness and education campaigns to educate all Californians about mental health illnesses and substance use disorders, including addressing suicide and overdose prevention, stigma reduction around seeking help and opportunities for treatment, promotion of connectedness to raise behavioral health awareness, and support social norms change, CDPH will invest in both the maintenance of assets from existing campaigns as well as develop additional campaigns to meet some of the most urgent needs facing Californians.

Existing Campaign Assets

These campaign assets were chosen because of their already proven effectiveness in reaching priority populations, their continued value, relevance in the community, and the established deepened community connection. These assets continue to align with the values and goals of Behavioral Health Transformation (BHT) and BHSA. These assets should be seen as an opportunity for the community to utilize the messaging and expand their reach through existing networks. These existing campaign assets can be tailored to local needs to deliver locally tailored messages, especially for communities at risk for suicide and/or mental health or substance-induced crises.

- **Never a Bother** resources here (including toolkits, palm cards, videos, suicide prevention awareness month campaign materials, etc.)
- **Take Space to Pause** resources here (including community partner toolkit, LGBTQ+ specific resources, caregiver resources, etc.)
- **Live Beyond** resources here (including ACEs-focused parents and caregiver toolkits, posters, MH awareness activation guide, PCE palm cards, etc.)
- **Facts Fight Fentanyl** resources here (including information on the use of naloxone, resources to dispel myths, how to respond to a suspected overdose, etc.).

Behavioral health conditions in our state are also evolving and as such, CDPH will continue to research emerging issues to identify where strategic partnerships and collaborations can evolve these existing assets to meet the emerging issues that arise.

New Campaigns:

While the existing assets address the needs of our youth, there remains the growing tragedy of isolation and suicide in the state's men and boys and a lack of awareness and understanding of

the 988 Suicide and Crisis Lifeline, especially individuals from historically marginalized communities[12] and barriers reaching out for behavioral health services in general[13] On July 30, 2025, California Governor Gavin Newsom signed an executive order to address a growing crisis of suicide, mental health, and disconnection among California's men and boys.

A comprehensive approach to behavioral health prevention also requires the acknowledgement of both mental health and substance use disorder (SUD) needs. As noted in Phase I feedback, stakeholders emphasized that behavioral health must be framed to include SUD alongside mental health to reflect the full intent of BHSA.

Suicide and Self-Harm Statewide Education and Awareness Campaign

Suicide and self-harm are major preventable public health concerns in California that can have emotional and economic impacts in both the immediate and long-term on individuals, families, and entire communities. Suicide is a significant health burden across most life stages; however, older adults have higher rates compared to other groups, and those aged 85 and older have the highest suicide rates. Disparities in suicide rates also exist by race and ethnicity, gender, and region.[14] In 2023,

- White, Native Hawaiian or Pacific Islander, and American Indian or Alaska Native individuals had higher rates of suicide, while Black or African American individuals had the highest self-harm-related emergency department visits.[15]
- Men had more than 3 times the rate of suicide deaths compared to females in 2023.[15]
- Suicide rates were 1.53 times higher in rural areas than in urban areas.[16]

There is also longstanding heightened suicide risk among veterans, LGBTQ+ individuals, and those with firearms in the household.[17]

- Of all older adult suicide deaths in 2023, approximately 28% were known veterans.[15]

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[12] Building California's Comprehensive 988-Crisis System: A Strategic Blueprint - National polling data indicates that Black/African American and AAPI respondents were less likely to trust 988 (and 9-1-1) than White respondents. For instance, a NAMI/Ipsos poll conducted in June 2024 found that "total trust" in 988 among White respondents was 83% as compared to 80% among Black/African American respondents, 80% for Latino/Latina/Hispanic, and 77% among AAPI respondents. - NAMI/Ipsos 988 Lifeline and Crisis Response Research, July 2024

[13] Building California's Comprehensive 988-Crisis System: A Strategic Blueprint (page 34)

[14] California State of Public Health Full Report 2024

[15] CDPH, Injury and Violence Prevention Branch. (2025, May 1). EpiCenter: California Injury Data Online. https://skylab4.cdph.ca.gov/epicenter

[16] CDPH, Office of Policy and Planning. (2025). California State Health Assessment Core Module 2025 Update. https://skylab.cdph.ca.gov/communityBurden/_w_0758ab0cd1434a9c9426e738dba14587/SOPH/2025/Full%20Report.html

[17] Centers for Disease Control and Prevention. Suicide Prevention. Health Disparities in Suicide. Published March 28, 2024. https://www.cdc.gov/suicide/disparities/index.html.

- Firearms are uniquely fatal and the most commonly used mechanism for suicides. Firearms were used in 45% of male and 19% of female suicides.[15]

To address this urgent, yet preventable issue, CDPH will be launching a new Suicide and Self-Harm Education and Awareness Campaign, which will promote public education on suicide and self-harm prevention, reduce stigma around seeking help, and support social norms change among adults. The campaign will focus on older adults, rural communities, veterans, and other populations with a higher burden of suicide and self-harm, and will uplift resources such as warmlines, peer supports, digital self-help tools, and 988. Messaging will be developed in coordination with CDPH regional suicide prevention hubs.

Public Awareness of 988 Suicide and Crisis Lifeline and Behavioral Health Services:
Public awareness of available services is one key factor that influences access to behavioral health. This campaign will increase awareness and trust of 988 and other behavioral health crisis services and advance the goals and efforts of Building California's Comprehensive 988-Crisis System: A Strategic Blueprint, especially for:

1. populations not reached through national campaigns and/or are distrustful of 988 or other emergency or crisis lines;
2. populations at greatest risk of suicide or other behavioral health crisis;
3. populations that may need or benefit from accommodations.

Substance Use Disorder Statewide Prevention and Education Campaign
Substance use and addiction can result in a range of harmful health outcomes including poisoning, hospitalization, and fatal or non-fatal overdose. Related early life intersections (e.g., Fetal Alcohol Spectrum Disorder and Neonatal Abstinence Syndrome) can have devastating impacts on health trajectories across the life course. Many factors contribute to the sustained drug overdose epidemic. Substance use risks include social isolation, mental health challenges, economic distress, and structural inequities that give rise to systematic social and economic disadvantages.[18] Increased awareness of the impact of substance use on well-being is a critical facet of any substance-use disorder effort.

There is an important gap in accessing treatment for substance use disorder: 9% of Californians aged 12+ met the criteria for a substance use disorder in 2021, yet only 10% of people with SUD received treatment.[19] There were over 11,000 drug-related overdose deaths among California residents in 2023. Nearly 70% of these deaths involved an opioid. Between 2022 and 2023, the rate of increase slowed, but drug overdose death rates continued to increase in 2023, reaching

[18] California State of Public Health Full Report 2024
[19] Substance Use in California, 2022: Prevalence and Treatment

an all-time high. Overdose was the leading cause of death for adults aged 25 to 54 and was the fifth leading cause of death overall in 2023.[20]

- Men are disproportionately impacted by drug overdose. The overdose death rate for men in 2024 was more than three times the rate for women.[21]
- American Indian or Alaska Native individuals have the highest rates of opioid-related overdose deaths, more than 17 times that of Asian individuals, the group with the lowest rate. Black or African American individuals have the second highest rates compared to other racial and ethnic groups in California.

Gaps in access to mental health care and substance use treatment services requires a strong and coordinated prevention-focused approach to addressing substance-use disorder before the need for treatment occurs, and mitigating the potential for adverse outcomes, including death. To address this critical issue, CDPH will be developing a coordinated Substance-Use Disorder Prevention Education and Awareness Campaign[22] to raise awareness about substance misuse and substance use disorder. Messaging will counter misinformation, dispel stigma and misconceptions and encourage help-seeking behavior.

CDPH will also work closely with DHCS to identify existing assets and resources that should be leveraged, and gaps in understanding or information, as part of this campaign. These may include such issues as the level of existing awareness needed regarding opioids, use of medically assisted treatment (MAT) versus more focused efforts regarding low barrier MAT and naloxone use and access, and other harm reduction strategies.

To ensure that assets and resources developed by these campaigns are effective, relevant and can lead to sustainable outcomes, CDPH will involve the community in their co-design.

VIII. PREVENTION TRAINING AND TECHNICAL ASSISTANCE:

Training and technical assistance (TTA) are vital for the success of CDPH behavioral health programming. They are intended to support the success of the policy work and implementation of the prevention strategies by equipping health professionals and other behavioral health prevention stakeholders, educators, and community leaders with the tools to promote

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[20] California State of Public Health Testimony, 2025. https://www.cdph.ca.gov/Programs/OPP/CDPH%20Document%20Library/State-of-Public-Health-Testimony-2025.pdf

[21] California Overdose Surveillance Dashboard. https://skylab.cdph.ca.gov/ODdash/?tab=Home

[22] The SUD Awareness Campaign will begin development in 2027/28. CDPH will work closely with DHCS and other SUD experts during 2026/27 to identify existing SUD related assets and resources that could be leveraged or enhanced as part of development for the new campaign.

behavioral health awareness, reduce stigma, and prevent suicide, self-harm, and overdose, especially among priority populations.

Training and technical assistance will also be provided in unique areas, including:

- Successful implementation of strategies that promote PCEs and the development of safe, stable and nurturing relationships and environments for the maternal, child and adolescent health populations, including age 0-5 populations. TTA will focus on a life course approach to reducing the long-term risk of substance use, overdose, suicide, and self-harm. TTA will elevate evidence-based, evidence-informed, or community-defined practices that promote social connection, reduce stigma, and support the creation of safe, supportive, and nurturing environments that improve mental well-being and resilience among families, children (including Children & Youth with Special Healthcare Needs), adolescents, and young adults. These practices will be shared with local partners and provide training and technical assistance on implementation at the local level, with a specific focus on leveraging existing Maternal, Child and Adolescent Health (MCAH) programming that can use these strategies to complement and enhance the work already underway to serve MCAH populations.
- Working with community organizations and existing overdose coalitions in the development of harm reduction strategies, with focused approaches on stigma and discrimination reduction

TTA also invests in community capacity to implement, scale and sustain population-based prevention CDEPs and EBPs.

CDPH will also be working with statewide entities that can deliver unique technical assistance to support behavioral health prevention in priority populations, including older adults and veterans (see later SECTION C. FUNDING TO MOBILIZE LOCAL REACH OF STATEWIDE STRATEGIES AND POLICY – Training and Technical Assistance), as well as the following TTA resources:

Behavioral Health Literacy Curriculum Development

To support the implementation of recommendations resulting from AB 1282, CDPH will partner with subject matter experts in the development of behavioral health literacy curriculum materials, which may include social media and smart-phone usage. Developed curricula will also include other behavioral health priorities and emerging issues, for use by organizations serving various audiences, including priority populations, children, youth, families, older adults, public health programs, and the medical community.

Safe Spaces

CDPH will invest in maintaining this set of free, two-hour, self-paced training, available in English and Spanish, on trauma-responsive practices for early learning and care and school staff to promote PCEs, improve school climate, and mitigate the impact of adverse childhood experiences (ACEs) by increasing safe, stable, and nurturing environments and relationships (SSNREs), while promoting equity by targeting the inequitable distribution and impact of ACEs. A new, brief, free, self-paced training pursuant to SB 153 is also in production in collaboration with California Department of Education, which will introduce this material to a broader group of school staff and promote connection to additional trainings and resources. Future trainings are also proposed to promote SSNREs for priority groups, including LGBTQ+ youth and immigrant and refugee populations. This is a strategy to support engagement in school and social connection while reducing untreated behavioral health conditions, institutionalization, justice involvement, and removal of children from homes.

The Spanish speaking Safe Spaces resources will also be adapted as a new resource for immigrant and refugee populations, and to ensure that these resources are relevant and effective, CDPH will engage youth, immigrant and refugee populations as part of development. CDPH will also create partnerships and connections with organizations and professionals serving immigrant/refugee families for dissemination and reach.

To ensure that all partners and the community are aware of all learning opportunities, CDPH will create a public facing site that will list dates and topics for ease of access by the community. Additional TTA resources that will be provided through specific contracts with Community-based organizations (CBOs), educational institutions and other external organizations are listed in SECTION C. FUNDING TO MOBILIZE LOCAL REACH OF STATEWIDE STRATEGIES AND POLICY – Training and Technical Assistance.

IX. COMMUNITY ENGAGEMENT AND COALITION BUILDING:

CDPH values open and on-going communication with its partners, stakeholders, Tribes and community members. The goal for CDPH is to create robust, authentic community and partner engagement and coalition building that supports population-based prevention programming development through relationships with and among communities to create stigma-free environments and provide ongoing support through proactive outreach and relationship building. This ongoing engagement will include:

- Working with local organizations that focus on suicide and overdose prevention/harm reduction and mental health awareness to engage people where they are and in the communities in which they live.

- Working with communities impacted by systemic racism and discrimination, and communities that have been impacted by behavioral health conditions, to develop a deeper understanding of the challenges and experiences to inform a system-wide approach and strategies.
- Community visits to foster relationships, coordinate prevention strategies, and disseminate resources.
- Community events and listening sessions to elevate prevention best practices, uplift stories from people with lived experience, and identify opportunities for improving community conditions, including healing circles, restorative justice, and other inclusive practices.
- Working with Tribes through the Tribal Health Equity Advisory Group, to continue ongoing engagement and dialogue on issues related to suicide, substance-use, overdose and stigma.
- Partnerships with local groups to promote opportunities for volunteerism, civic engagement, intergenerational mentorship, and youth leadership.

Additionally, CDPH will invest in the development and management of an Implementation Workgroup, comprised of state and local governmental stakeholders and partners, Tribes, prevention-focused subject-matter experts, community groups, and people with lived experience (including those that have been impacted by behavioral health conditions). This group will act in a complementary fashion to existing advisory councils and provide an avenue for stakeholders and the community to interact directly with CDPH. This group will continuously inform CDPH BHSA statewide program planning and efforts through their unique subject-matter expertise and be a direct avenue for resolving operational and implementation challenges with stakeholders, understanding local emerging issues that arise and act as a solution-oriented workgroup to develop solutions and strategies to mitigate emerging impacts. Integrated into this group will also be dedicated engagement with youth and young adults to ensure that their voices and perspectives help shape and inform targeted youth and young adults campaigns, messaging and strategies. This group will also help to mobilize and expand local reach of statewide prevention strategies.

CDEP Advisory Committee:

BHSA statute states that “Population-based prevention programs shall incorporate evidence-based promising or community-defined evidence practices”. To support our CDEP Grant Program providers and CDPH’s ongoing efforts to evaluate and scale CDEPs as an effective strategy for addressing historical behavioral health disparities, CDPH will support the co-development of a focused CDEP Advisory Committee, in coordination with funded CDEP providers. This committee will be charged with:

- Building robust stakeholder relationships, cultivating trust and open communication with all partners.
- Facilitating Statewide Regional Meetings - Guiding collaborative efforts to prevent behavioral health and mental health issues within vulnerable communities with an equity-first approach.
- Creating learning collaboratives to share best practices, lessons learned related to implementation, evaluation, and other related programmatic issues to help inform continuous quality improvement.

Youth and Family Engagement Network

At least 51 percent of BHSA population-based prevention funds shall be used for programs serving populations who are 25 years of age or younger[23]. Investment in a youth and family engagement network reflects CDPH's ongoing commitment to creating and maintaining an infrastructure for dedicated youth engagement that elevates their input and supports planning and implementation of behavioral health education and messaging to promote behavioral health literacy, equity, and reduce stigma among disproportionately impacted young communities. The network will ensure that the unique voices, needs, and ideas held by California's youth and their families are integrated into all aspects of BHSA prevention programming.

B. STATEWIDE EVALUATION STRATEGY

A critical component of BHT, as part of California's Mental Health for ALL is ensuring every Californian-especially those from historically unserved, underserved, and inappropriately served communities —can get high-quality mental health and substance use treatment when and where they need. To achieve this, California has established 14 statewide behavioral health goals[24] under the leadership of DHCS, in consultation with stakeholders and subject matter experts. State and local agencies must measure how services are working, report outcomes publicly, and show how funds are being used. By focusing on data, transparency, and community feedback, the state is building a system that earns trust and keeps improving.

To increase transparency on outcomes, the effectiveness of strategies and policies, and how funds are being used across the state to prevent suicide, self-harm and overdose, CDPH has developed an evaluation framework that will:

[23] In accordance with Welfare and Institutions Code (WIC) § 5892(f)(1)(E)(ii)
[24] (see DHCS BHSA Policy Manual, section C.2)

- Establish and maintain robust monitoring and evaluation of population-based prevention activities under BHSA and assess statewide impact, including the impacts of the various CDPH Awareness and Education Campaigns and strategies.
- Establish an aligned system of metrics, in conjunction with other behavioral health system partners, that will determine data collection requirements, monitoring and reporting to increase transparency on outcomes, the effectiveness of strategies and policies, and how funds are being used across the state to prevent suicide, self-harm, and overdose.

In addition, CDPH will analyze and disseminate behavioral health data to better understand, respond to, and prevent adverse behavioral health outcomes. This will include:

- An evaluation of how public attitudes about behavioral health and perceptions of suicide, self-harm, and overdose have changed over time.
- Data briefs with visualizations on suicide, self-harm, and overdose, particularly from marginalized communities, to strengthen prevention strategies and inform local interventions and investments.
- Provision of county/local profiles with disaggregated data to support local prevention efforts
- Utilizing data through the lens of health equity to identify racial, ethnic, age, gender, and other demographic disparities and inform disparity reduction efforts.

As part of these efforts, CDPH will explore social determinants of health, health and racial equity, risk and resilience factors, and their impacts on behavioral health outcomes. Deeper knowledge of these impacts will enable CDPH to identify points of intervention, take data-informed action, and craft program and policy recommendations. Results will be disseminated on the CDPH website so that stakeholders can also utilize the findings to inform other local and statewide efforts.

Finally, a better understanding of the disparities across populations also requires disaggregated data – beyond what statewide or utilization data can provide. This disaggregation of data can only come with local data collection efforts. To support this, CDPH will provide technical assistance and evaluation tools to help local partners collect and apply disaggregated data that reflects the cultural, linguistic, and geographic diversity of their communities. This includes ensuring that data systems are capable of capturing disparities across race, ethnicity, language, disability, sexual orientation, and other key demographic factors to inform targeted prevention strategies and measure progress toward equity while also protecting confidentiality. CDPH also recognizes the sovereign rights of Tribes to maintain ownership of Tribal information, including data about Tribal peoples, and will work closely with Tribes to meet their unique needs.

In a coordinated effort with other behavioral health system partners, the evaluation framework will also focus on a cycle of continuous improvement to drive progress on the statewide behavioral health goals.

CDPH recognizes that shifting to a coordinated, data-driven, population behavioral health approach will take time. As such, CDPH will phase in requirements and provide technical assistance to programs and key stakeholders.

C. FUNDING TO MOBILIZE LOCAL REACH OF STATEWIDE STRATEGIES AND POLICY

Mental Health for All is California's plan to build a stronger and more equitable behavioral health system. This work is supported by major investments, new policies, and partnerships with local governments, health plans, care providers, people with lived experience and community organizations.

Every part of this work is guided by health equity—making sure people of all backgrounds can receive care that works for them, in the spaces and languages that are most appropriate for their needs. Achieving health equity also requires broad, upstream initiatives to address the systemic and structural conditions that underlie risk and enhance the conditions that promote wellbeing. Such large-scale change cannot be achieved without participation from multiple partners from various sectors, with alliances at the private, public, state, and local levels, including community-based organizations and Tribes.[25]

To support and complement state level efforts, CDPH will provide funding to mobilize local reach of state-led and state-defined strategies, aligned with the goals and outcomes of BHSA. These locally funded implementation partners will:

- Create an **infrastructure investment** to support:
    - strong coordination across all behavioral health stakeholders to develop a strong and cohesive picture of resources being developed, and remaining gaps in service delivery, and
    - expansion of behavioral health prevention services in communities, especially those that have often faced the greatest barriers and are at greatest risk of negative outcomes.

[25] National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States, Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017). Communities in action: Pathways to health equity. National Academies Press (US)

- Create **cross-cutting efforts** for synergy, enhanced coordination and effectiveness of multiple local level efforts.
- Create **systems change at the local level** – As CDPH works in close coordination and alignment with other state partners to implement varied initiatives at the state level, it is expected that simultaneous implementation at the local level will introduce opportunities to increase multisector collaboration, alignment and integration of BHSA funding with other funding sources, and access to and coordination of care.

It also acknowledges that the need for behavioral health services and supports is particularly notable among historically marginalized populations, underscoring the importance of specifically and directly augmenting resources for these groups, and that behavioral health outcomes also vary significantly by region within California. Local approaches can address the disparities across regions. Communities are also critical to an individual's behavioral health - emphasizing the importance of strong local coordination of efforts and the development of local resources and community-centered supports that are culturally responsive and broadly disseminated.

Local strategies may also be more effective than generalized strategies, especially for particular subpopulations, such as immigrant and AI/AN communities[26] [27] [28]. Optimizing promotion and prevention strategies requires building behavioral health supports across environments, including homes and schools. To ensure relevance, it is important to tailor messaging, supports, and services to align cultural belief and practices, build on strengths, and address diverse local community needs.

CDPH will be using a third-party administrative entity to assist in the procurement, management, coordination and dissemination of funds for certain grant programs described in this section. This process is intended to create efficiencies and streamline access to grant funding by simplifying the application process, and will serve as a single point of contact, support and technical assistance for grant awardees. The third-party entities are also intended to act as a bridge of trust between CDPH and the local communities grant awardees will serve. CDPH will identify third party entities that have established relationships within the

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[26] Rodriguez, D.X., J. Hill, and P.N. McDaniel. "A Scoping Review of Literature About Mental Health and Well-Being Among Immigrant Communities in the United States." Health Promotion Practice, vol. 22, no. 2, March 2021, pp. 181-192. https://journals.sagepub.com/doi/pdf/10.1177/1524839920942511.

[27] Goodkind, J.R., B. Gorman, J.M. Hess, D.P. Parker, and R.L. Hough. "Reconsidering Culturally Competent Approaches to American Indian Healing and Well-Being" Qualitative Health Research, vol. 25, no. 4, April 2015, pp. 486-499. /https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4352372.

[28] Pham, A.V., A.N. Goforth, H. Chun, and S.M. Castro-Olivo, "Acculturation and Help-Seeking Behavior in Consultation: A Sociocultural Framework for Mental Health Service." Journal of Educational and Psychological Consultation, vol. 27, no. 3, March 2017, pp. 1-18.

communities and community-serving CBOs, leveraging the community connections to expand reach, especially in the most underserved and disproportionality impacted communities.

BHSA population-based prevention funding is intended to be used as a **payor of last resort** and may only be used when all other funding sources (public and private) have been exhausted) and may not be used to supplant existing funding[29].

Any specific Request for Proposal that outline the funding requirements and accountability measures for each of the funding investments noted below are forthcoming and will be posted on the CDPH - Transforming Behavioral Health site at a later date.

Community-Defined Evidence Based Practices and Evidence Based Practices Grant Program

Beginning with Fiscal Year 2026/27 and ongoing through FY 2028/29, CDPH is proposing to invest in a Community-Defined Evidence Based Practices (CDEP) and Evidence Based Practices (EBP) Grant Program to distribute grant funds to community-based organizations and Tribes seeking to scale CDEPs/EBPs that improve behavioral health in priority populations, based on robust evidence for effectiveness, impact on racial equity and sustainability. By scaling CDEPs and EBPs across the state, CDPH aims to improve access to critical behavioral health prevention and resiliency for populations that are at greatest risk for negative behavioral health outcomes, especially for those that have traditionally been disproportionately impacted by systemic racism and discrimination.

Trusted Messenger Campaign Grant Program

Beginning with Fiscal Year 2026/27 and ongoing through FY 2028/29, CDPH is proposing to invest in a Trusted Messenger Campaign Grant Program to award contracts to Community-Based Organizations (CBOs) and Tribes.

Trusted messengers are vital in public health because they effectively bridge communication gaps, fostering empathy, understanding, and respect for health information, especially within communities with existing disparities. By building trust, these messengers can deliver public health messages that are more likely to be heard, accepted, and acted upon, leading to improved health outcomes.

[29] W&I Code §5892, subdivision (f)

Regional Policy Research and Development

Beginning with Fiscal Year 2026/27 and ongoing through FY 2028/29, CDPH is proposing to invest in Regional Policy Research and Development to address the prevalence of mental health and substance use disorders.

Policy, systems, and environmental (PSE) change is core to public health efforts for creating healthier communities across the state. This approach addresses the root causes of health inequities, improves population health by reaching large numbers of people, and promotes long-term sustainability by institutionalizing changes to laws, organizational procedures, and the physical environment. The focus is making real, lasting change that helps people feel better and stay well.

By investing in community-driven and derived policy work, CDPH intends to create a system that encompasses four critical factors that can more effectively advance the implementation of PSE solutions, including:

1. The value of community engagement to inform the work
2. Improve measurement of PSE indicators and their effectiveness in advancing BHSA statewide goals – through use of both statewide and localized data
3. Provide additional information and tools that strengthen the real-world implementation of PSE strategies.
4. Determine whether PSE interventions have unintended outcomes and why – the effect of policies in different communities or populations groups, particularly within our priority populations.

Grant awardees will be expected to engage LHJs, Tribes, and other relevant stakeholders within the region to develop community-defined policy recommendations, with a focus on stigma and discrimination reduction, promotion of mental well-being and resilience, and policies that acknowledge and recognize the social determinants of health and their impacts on behavioral health. Recommendations should integrate the unique demographics and environmental factors of that region. Grantees will also provide training and technical assistance to stakeholders on practical steps for implementation, monitoring and scaling.

Regional Implementation of Focused Strategies

Beginning with Fiscal Year 2026/27 and ongoing through FY 2028/29, CDPH is proposing funding for Community-Based Organizations (CBOs) and Tribes for the regional implementation of statewide Focused Set of Strategies and CDEPs.

In a state as vast and diverse as California, there are also key differences and similarities in the regions across the state concerning demographics, health status, experiences with health care, access to food and housing, and civic engagement.

Undertaking a regional approach acknowledges the unique characteristics and health experiences of each region and provides an opportunity to tailor efforts for improved community well-being[30], Regional approaches can also be more strategic and effective in areas such as the rural north[31] or central valley[32], where LHJs are able to pool resources and expertise in a coordinated fashion that allows for economies of scale. The individual jurisdictions can also strengthen their own individual strategies by sharing data and gaining insights from the experiences of their neighbors. This promotes peer learning and the spread of best practices and leverages the existing collaborative work that the various regions initiated during the COVID-19 pandemic.

Grant awardees will be required to engage LHJs, Tribes, and other relevant stakeholders within the region to understand the landscape and priority needs of the region, including the factors that most affect the priority populations to determine the most relevant strategies for implementation. Grant awardees may also work with other stakeholders within the region (especially those focused on serving priority populations) for greater reach and impact. Grant awardees will also be expected to provide TTA on specific strategies and should coordinate these TTA efforts with other statewide TTA efforts for strategic implementation.

Tribal Grant Program

Beginning in Fiscal Year 2026/27 and ongoing, CDPH is proposing to invest a total of $6M annually as dedicated funding to Tribes. This unique grant program acknowledges the jurisdictional challenges and is intended to specifically address the persistent socio-economic disparities faced by Native American communities.

The dedicated Tribal funding formalizes the relationship between tribes and CDPH, respect government-to-government relations, honors Tribal sovereignty and defers to Tribal wisdom to tailor programs, assets, and resources to the specific needs and priorities of their communities, while providing access to crucial resources that have long been denied or limited.

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[30] The Health of California: A Regional Perspective
[31] California's Rural North: Health Equity Landscape Scan | California Center for Rural Policy
[32] Central California - Regional Health Equity Analysis 2025

CDPH will be hosting formal Tribal consultations with Tribes to develop the Request for Proposal and related funding requirements. This information will be posted on the CDPH - Transforming Behavioral Health site at a later date.

Training and Technical Assistance Grants

Beginning in FY 2026/27 and ongoing through FY 2028/29, CDPH is proposing to invest in funding that will allow CDPH to work with community-based organizations, educational institutions and other technical assistance experts across the state to ensure that diverse communities are able to receive technical assistance and training that can specifically be tailored to their unique regional or community needs. These training resources are intended to complement the technical assistance and training resources at the state level, and fill gaps in support and expertise where it is acknowledged that ground level training can more effectively strengthen local capacity, improve equitable access to resources, and build resilience in under-resources communities. Localized technical assistance can focus on the transfer of knowledge and expertise to local staff (equipping communities to manage and address complex challenges independently in the future), increases efficiency, builds trust (by partnering with local organizations that may have greater expertise in the field) and can enhance long-term sustainability. Working with external entities can also provide a more effective and efficient model of training and technical assistance, specific to a variety of areas, including:

- **Older Adult Behavioral Health TTA –** CDPH will work in close partnership with the California Department of Aging to provide TTA focused on two areas: 1) adoption of statewide baseline training for staff and volunteers (e.g. Mental Health First Aid), and 2) promotion of best practices for targeted outreach to underserved and at-risk[33] older adults. The TTA will elevate evidence-based and community-defined practices, as well as models and strategies that embrace volunteerism.
- **Veteran populations –** CDPH will work to identify a state level partner to provide dedicated training and technical assistance to support veteran populations, specifically in areas that can help overcome stigma related to seeking help and understanding how military culture (language, values and norms) impact the mental health of veterans.
- **988 Crisis Services** – CDPH will work with expert consultants and Tribes to provide subject matter expertise, training, and technical assistance tailored to the needs of the 988 Suicide

[33] At-risk is defined as older adults who – due to compounding stigmas, are unlikely to seek traditional, clinical behavioral health supports due to lack of institutional trust, age bias or discrimination, systemic racism, and generational or cultural beliefs about mental health

and Crisis Lifeline Outreach Campaign Grant Program awardees and the audiences they are serving to support.

- **Regional approaches** that can be utilized by smaller jurisdictions to create strategic partnerships and joint interventions across the array of jurisdictions
- **Train-the-trainer models** that create local and sustainable approaches for training and technical assistance
- **CDEP Technical Assistance** to support the successful implementation, scaling and sustainability of CDEPs.
- **School Behavioral Health Resource Hub** to promote social connection and belonging, restorative justice, relationship-promoting infrastructure, PCEs, equity, and protective environments in schools. These efforts will build upon activities initiated under Children and Youth Behavioral Health Initiative (CYBHI) to advance Social and Emotional Learning (SEL) (e.g., CalHOPE Schools, CalHOPE SEL) and provide TTA on school-based prevention and wellness education and training for school staff through:
    - The establishment of a learning community for school staff to support SEL training. Vital partnerships supporting student and staff wellness will also be promoted, including those between school officials and local government agencies (e.g., behavioral health, public health child welfare, probation, regional centers, etc,) and community partners. This may include linkages to the California Community Schools Partnership Program, where appropriate.
    - Providing evidence-based tools to support SEL-related practices in schools. This may include ongoing access to classroom resources developed through CYBHI, intended to reduce the stigma associated with an individual seeking support for their well-being, build supportive environments, and teach how to recognize the signs of stress and duress in colleagues, students, and family members.

Local Health Jurisdiction (LHJ) Grant Program

Beginning in FY 2026/27 and ongoing through FY 2028/29, CDPH is investing $12M annually for a grant program to be directed to the 61 LHJs in California to act as the local behavioral health prevention coordinator and convener across the myriad of BHSA prevention community supports that advance BHT.

The LHJs role as conveners means they will bring together the diverse partners and facilitate communication, foster collaboration, share data as appropriate, and support the community-based efforts to achieve equitable health outcomes. As the convener at the local level, while the

LHJ may not specifically lead the various community level programming and supports, they are required to amplify statewide and other local initiatives by providing support, sharing information, leveraging existing public health programs that serve priority populations to expand reach, and ensuring community-led solutions are heard. LHJs are also able to integrate various sources of data that help communities identify the most effective and relevant dissemination strategies to reach the most impacted communities. They are also likely to bring different sectors to the table to address the behavioral health issues of concern for their jurisdiction.

This coordination can also lead to creating cross-cutting efforts reducing siloed approaches and provides an opportunity for LHJs to work in close collaboration with their county behavioral health partners to meet statewide goals in areas that local behavioral programs may be unfamiliar (i.e. school engagement; children at risk of entering the system; justice involved)

Finally, it is expected that this role of coordination will ultimately advance continued alignment at the local level for on-going Population Health Management efforts by ensuring that behavioral health prevention planning is integrated into Community Health Assessment and Improvement Planning efforts[34] and Community Reinvestment efforts[35]

To ensure alignment of efforts across all local stakeholders to achieve the overall statewide goals and outcomes of BHSA, local health jurisdictions will be required to:

1. Coordinate convenings with the following required stakeholders:
    - County behavioral health department representative
    - Medi-Cal Managed Care Plans serving the jurisdiction
    - Tribes in the jurisdiction
    - Funded CBO entities providing BHSA Prevention services in the jurisdiction across the lifespan
    - Local Areas on Aging
    - Local Education Partners and others that serve children and families

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[34] Memo to LHJ re - Alignment of MCP PNA and LHJ CHA and CHIP - The purpose of this memo is to provide guidance to local health jurisdictions (LHJs) on how to shift local health department Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) to a statewide, synchronized three-year cycle to prepare for a forthcoming requirement that the LHJ CHA be completed by December 2028 and the LHJ CHIP be completed by June 2029, and every three years thereafter.

[35] Community Reinvestment All Plan Letter - The Community Reinvestment program advances DHCS' objectives—as identified in the Comprehensive Quality Strategy5, Population Health Management (PHM) Policy Guide6 — toward improving the health and wellbeing of Members through innovations that are locally driven and adopt a whole-person approach. To ensure MCPs target the unique needs of each community served, MCPs and their Qualifying Subcontractors must demonstrate that Community Reinvestment activities are directly informed by the community needs identified in each LHJ's CHA.
Furthermore, LHJs and County Behavioral Health must be included in the MCPs' and Qualifying Subcontractors' Community Reinvestment planning and decision-making process.

- County Veteran Services Officers or their designee

LHJs are also strongly encouraged to include representatives from the priority populations, those with lived experience, and individuals who represent communities that have been impacted by behavioral health conditions. These convenings should act in a way to identify stakeholder efforts and activities, amongst the focused set of statewide strategies, that address self-harm and suicide prevention, substance use disorder and overdose prevention for their most impacted populations. These convenings should also identify within the CDPH directed priority populations, stakeholder focus for strategic investment. Their work should focus on efforts to address stigma and discrimination, support help-seeking behavior, promote Policy, Systems and Environmental (PSE) change efforts at the local level, and implementation of evidence-based, evidence-informed, or community-defined practices. Their work should be focused on integration and coordination of resources and efforts to reduce duplication, identify continued gaps of investment and/or populations served, and where additional stakeholder work can be leveraged to achieve maximum impact. These convenings should also be used to inform the development or update of local suicide prevention plans and be used strategically to inform any regional work as defined within this Guide

CDPH will work closely with LHJs to ensure that such convenings are not duplicative of any existing convenings or coalitions already established at the local level, but are strategic and inclusive to ensure that the intent is advancement of CDPH and statewide outcomes and goals. LHJs may also elect to use a regional approach to these convening to create synergy and efficiencies.

2. Develop/update a Local Suicide Prevention Plan[36]

Prior to the implementation of BHSA starting on July 1, 2026, prevention efforts at the local level were funded and led by county behavioral health departments. These departments have developed and sustained prevention programs for over 20 years, including those funded through MHSA. Many county behavioral health departments may continue to fund population prevention services through other sources (e.g., Substance Abuse and Mental Health Administration (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), opioid settlement, Realignment, etc.) that will be captured as part of the county three-year Integrated Planning process. It is also recognized that overlap in certain areas of population-based prevention and early intervention (under the direction of DHCS and implemented at the local level by behavioral health departments) may exist. So, integrating county behavioral health

[36] A list of Strategic Plan for Suicide Prevention in California Counties, as of September 2021 can be found here Striving for Zero Suicide Prevention Strategic Planning Learning Collaborative: Modules and Resources - BHSOAC

as part of the local prevention coalition is critical for alignment across this local coordination effort.

The required coordination and coalition development is expected to be integrated into the LHJ Community Health Assessment and Improvement Planning efforts in 2028/29[37] so as to continue to reduce redundancy in community planning efforts and community fatigue, increase efficiency, elevate behavioral health prevention work in public health, strengthen ongoing collaboration and make progress on health equity and outcomes.

988 Suicide and Crisis Lifeline Outreach Campaign Grant Program

Beginning in Fiscal Year 2027/28 through FY 2028/29, CDPH is proposing to invest in a 988 Suicide and Crisis Lifeline Outreach Campaign Grant Program, to award contracts to Community-Based Organizations (CBOs) and Tribes. To complement the broader CDPH led awareness and education campaign described above and assist with dissemination and tailoring of messages at the community level, local grantees will work at the regional level to:

- Identify knowledge, attitudes, beliefs, and perceptions about accessing crisis services among populations at risk for behavioral health crisis and suicide.
- Identify and explore barriers and motivators to accessing crisis services among these populations.
- Inform culturally relevant and responsive messaging to encourage individuals to access 988 in times of crisis or behavioral health support.
- Leverage the insight and networks of trusted messengers and community leaders that specific population groups turn to during behavioral health challenges.
- Help tailor state 988 campaign messaging to align with the local 988 and crisis-support infrastructure.
- Support local, expanded dissemination of 988 campaign messaging and promotion of associated crisis supports.

Crisis hotlines represent an essential part of the suicide, mental health, and substance-induced crisis systems that provide compassionate, appropriate, and easily accessible care to save lives and reduce hospitalizations and deaths. AB 988 (Chapter 747, Statutes of 2022) implemented

[37] CDPH and DHCS are working closely to align local planning efforts currently underway, including Local Health Department led Community Health Assessment / Improvement Plans, Medi-Cal Managed Care Population Needs Assessments, and County 3-year Integrated Plans. Further information will be provided in the Phase II Guide. For more information, see the CDPH December 26, 2023 Memo to All Local Health Jurisdictions, the CalAIM PHM Policy Guide (PDF, p. 8–10) and DHCS BHSA County Policy Manual (section B.2)

the National Suicide Hotline Designation Act of 2020 (NSHD), in compliance with the Federal Communication Commission's rules designating "988" as a three-digit number for the National Suicide Prevention Hotline now known as the 988 Suicide and Crisis Lifeline. Since the enactment of AB 988 (Chapter 747, Statutes of 2022), crisis call centers throughout the state have done extensive work to serve existing needs and communicate about 988, yet gaps still exist. Polls indicate that there continues to be gaps in awareness of 988, and broad lack of understanding about what will happen when someone calls 988, and a lack of understanding on the difference of when to call 988 vs 911. Messaging and barriers (e.g. stigma, language differences and cultural norms) are also distinct among different populations[38] The National Strategy for Suicide Prevention, released in April 2024, suggest that consistent, state-level messaging on 988 should be adapted by local communities to help ensure cultural relevancy, the ability to leverage a diverse landscape of trusted messengers and messaging channels, and alignment with local crisis response service delivery.

D.ALIGNMENT WITH OTHER LOCAL PLANNING PROCESSES

The BHSA transforms the MHSA planning process into a broader county and regional planning process. In this section, CDPH is focused on building bridges across community, public health, managed care plans (MCPs), and county behavioral health delivery systems partners to reduce siloes, increase cross systems collaboration, and enable strategic alignment of funding for coordinated and complementary approaches. While perspectives and focus areas may vary, local integration and partnerships are essential to paving a path toward better understanding the needs of local communities, strategizing appropriate interventions, addressing social determinants of health, and advancing health equity.

County behavioral health, MCPs, and LHJ community planning processes have the power to bring together community voices to collectively identify goals and mobilize local action on targeted interventions. This is critical to achieving statewide behavioral health goals and improving the overall health and wellbeing of California communities. BHSA creates an opportunity to further align these processes, which have traditionally operated independently.

The BHSA funding being directed to CDPH, and the investments being made at the local level also provide a transformational, dedicated investment for population-based behavioral health prevention that provides a unique opportunity for population-based prevention to be integrated into all local planning efforts.

[38] See Building California's Comprehensive 988-Crisis System: A Strategic Blueprint for more information.

To support BHT and population health efforts, DHCS and CDPH are implementing a cohesive set of policies to align community planning processes among county behavioral health, LHJs and MCPs. These policies are being implemented over time in three phases.

Background

Phase I - Aligning LHJ Community Health Assessment and Community Health Improvement Processes with Medi-Cal Managed Care Plans – Population Needs Assessments

While most LHJs, based on Public Health Accreditation Board Accreditation Standards and Measures, complete or update their local Community Health Assessments (CHA)/Community Health Improvement Plans (CHIP) every 5 years, there are variations amongst LHJs who also opt for varying cadences (e.g., every 3 years or 5 years). The variation in timelines creates challenges in coordinating CHA/CHIPs with other community assessment and strategic planning processes accreditation.

For over 20 years, the DHCS has required Medi-Cal Managed Care Plans (MCPs) to conduct Population Needs Assessments (PNA) of their membership and submit data to DHCS.

In December 2023, CDPH issued a memo to LHJs outlining their intent to require all LHJs to complete a CHA by December 2028 and a CHIP by June 2029 and every three years thereafter. In January 2024, DHCS coordinated with CDPH and issued a new policy requiring the MCP PNA to be more closely aligned with LHJ local planning processes.

DHCS and CDPH collaborated to create a regulatory environment that supports effective and efficient joint work on CHAs and CHIPs between LHJs and MCPs. Thus, aligned with CDPH guidance, the cycles for LHJs' CHA and CHIP development will become standardized across California starting in 2028, as previously noted, and as displayed in the timeline below.

This policy direction to align LHJs CHAs/CHIPs with MCP PNAs looks to streamline efforts to reduce duplication, create opportunities for more strategic, efficient and effective use of resources, integrate previously siloed data streams into a cohesive picture of the community's health, and create opportunities for coordination with other sectors that also conduct community health assessments (including non-profit hospitals)

Figure III – Timeline of LHJ and MCP PNA alignment

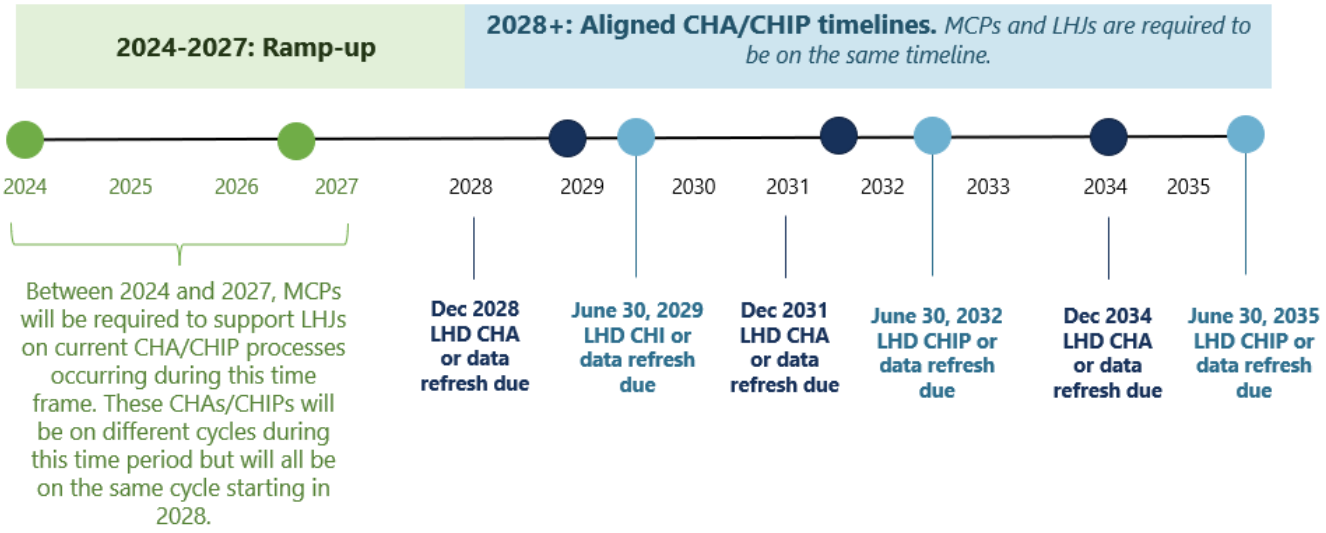


Figure VI provides historical context of the separate and distinct community planning processes of county behavioral health, MCPs and LHJs:

Figure IV – Historical context of MCP, LHJ and county behavioral health community planning processes

Mental Health Services Act (MHSA) Expenditure Plans & Community Program Planning:	Community Health Assessment (CHA) and Community Health Improvement Process (CHIP):	Population Needs Assessment (PNA):
•Mandated by the MHSA to shape mental health services funding. Involved gathering input from various stakeholders—individuals with lived experience, families, providers, and community members to identify needs, evaluate existing programs, and recommending improvements.	•Community-driven processes that involve participation from a broad cross-section of the community and integration of myriad data sources to describe the status of a community's health and set an action plan for improving it. Focus on upstream interventions.	•Deliverable to DHCS that identified (1) priority needs of their local communities and members and (2) health disparities. Required input from MCP community advisory committee.

<u>Phase II – Integration of county behavioral health integrated planning process</u>

County behavioral health departments, LHJs, and MCPs share a common interest in identifying the needs of the populations and communities they serve. Points of integration existed before

SB 326 [39]and associated IP mandate, and some counties, LHJs, and MCPs have been collaborating on CHA/CHIP processes for many years.

And while this first 3-year cycle of BHSA population-based prevention programming requires the development of a separate coalition for BHSA related implementation efforts, the goal ultimately is to align all these various processes into a cohesive and collaborative approach. This is driven by shared guiding principles to advance the achievement of shared goals:

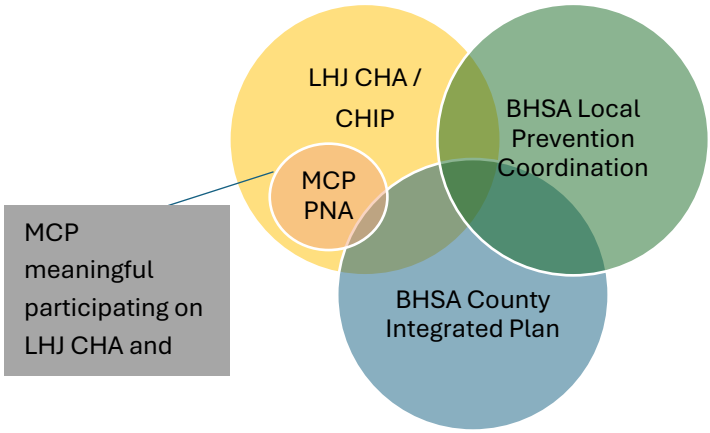
- County behavioral health, LHJs, and MCPs serve overlapping local communities and should collectively be aware of key, population-level needs and challenges.
- There is an opportunity to employ complementary and coordinated strategies and interventions across delivery systems.
- As counties begin to engage in the PNA, CHA, and CHIP processes, alignment should lead to more integrated, upstream, and effective community health initiatives and prevention strategies to improve population health.

Figure VII depicts the expected initial overlap as LHJs work in concert with their county behavioral health partners as part of CHA/CHIP development and their local behavioral health coordination efforts. It also acknowledges that there are currently specific requirements for LHJs as part of their BHSA prevention programming that are distinct from the LHJ CHA/CHIP process and also acknowledges that the timing of LHJ CHAs and CHIPs may not be currently aligned with this Guide[40].

[39] The BHSA was written prior to the 2024 DHCS PNA policy change.

[40] While there is currently no requirement for local health departments to complete a CHA/CHIP, those that do, operate on varying cycles based on public health accreditation, hospital community needs assessments, and/or or other locally determined timelines. Additionally most LHJs, based on PHAB Accreditation Standards and Measures, complete or update their local CHAs/CHIPs every 5 years, there are variations amongst LHJs who also opt for varying cadences (e.g., every 3 years or 5 years).

Figure V – Expected initial overlap in planning and coordination efforts



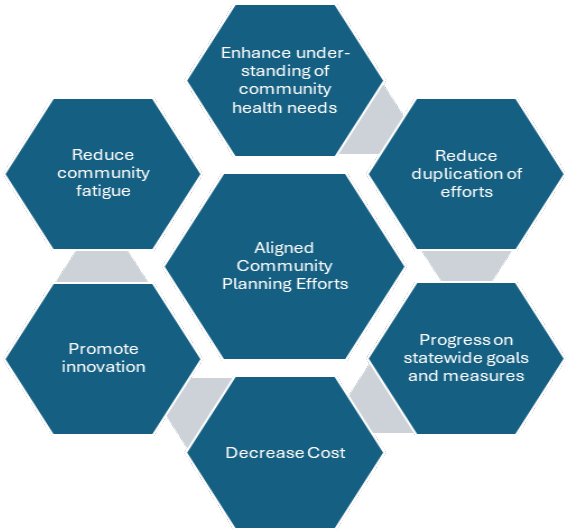
A Vision for Alignment

The overall goal of these alignment and integration efforts is to improve upstream interventions and health outcomes for, and thus more effectively improve the lives of, community members and collectively achieve the statewide behavioral health goals.

These alignment efforts at the local level also reinforce and advance alignment of community reinvestment policies as part of this cohesive community planning framework – to further advance health equity and statewide behavioral health goals. Like community planning, community reinvestment activities have been disparate and not intentionally aligned with supporting the needs of the community.

Aligned community planning provides an opportunity to:

Figure VI – Benefits of aligned community planning processes



Synced timelines and integration of BHSA prevention planning into LHJ CHA/CHIP

Figure IX details the timelines for BHSA prevention planning efforts requirements for integration with LHJ CHA/CHIP[41] – and expected alignment with the Integrated Plan submission.

Figure X also represents the anticipated overlap, with the local BHSA prevention programming integrated fully into the LHJ CHA/CHIP planning process.

Figure VII - Timelines for BHSA prevention planning efforts requirements for integration with LHJ CHA/CHIP

[41] Many LHJ CHA's and CHIPs name mental health, SUD and behavioral health as a priority, including:

- San Francisco Community Health Assessment 2024 – which indicates "mental health repeatedly emerges as an important health issue. Mental health was also a reflected concern in most of the community focus groups conducted for this report"
- Alameda County Community Health Needs Assessment 2022-2025 has identified mental and behavioral health as one of their 5 priority health needs.
- Riverside County (RUHS-PH) Community Health Assessment (CHA) 2024.pdf - Mental Health was an indicator requested by the community as an important indicator for the health of the community over the past few years and has been a cause for concern as RUHS-PH see mental health symptoms rise in all ages.
- Tulare County 2023 Community Health Assessment – Mental health substance use was one of four key themes that remained as a priority for the community.
- The San Bernardino County CHA identified Behavioral Health as one of the three health improvement priorities for San Bernardino County by combining community input and findings from secondary data

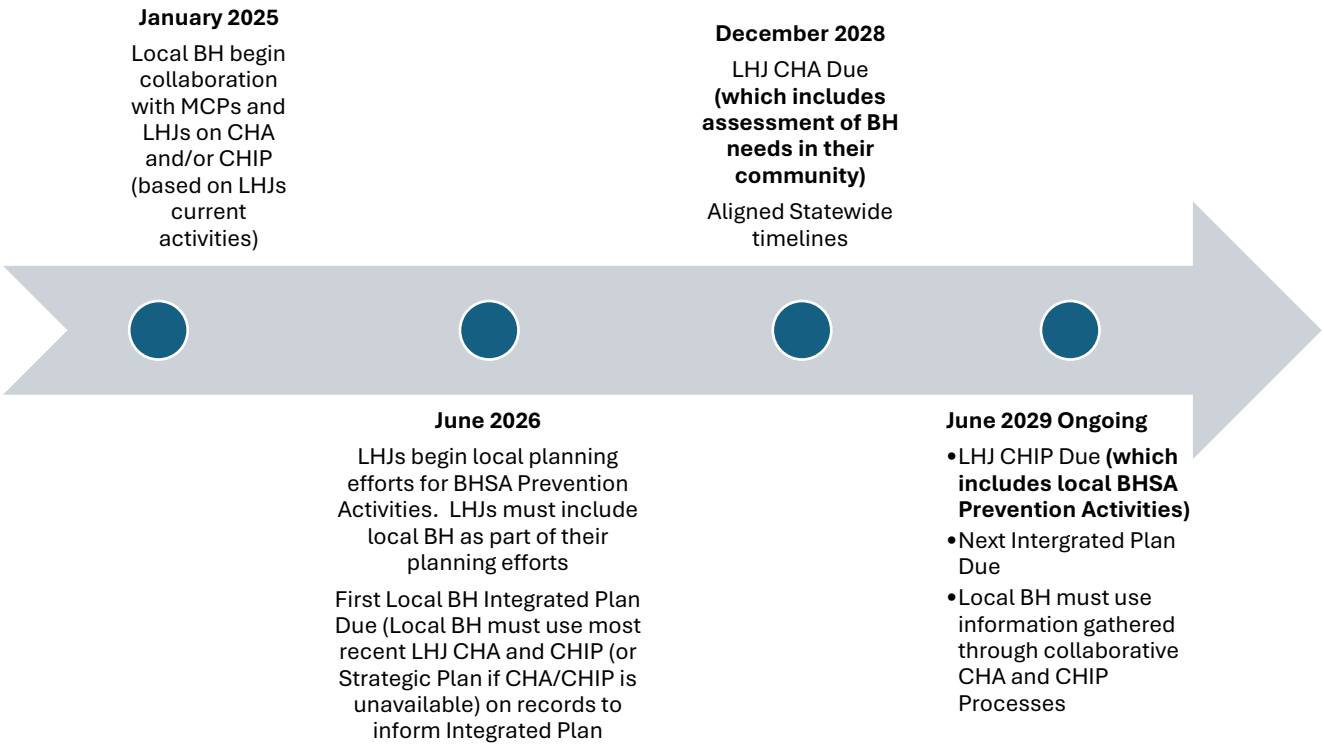
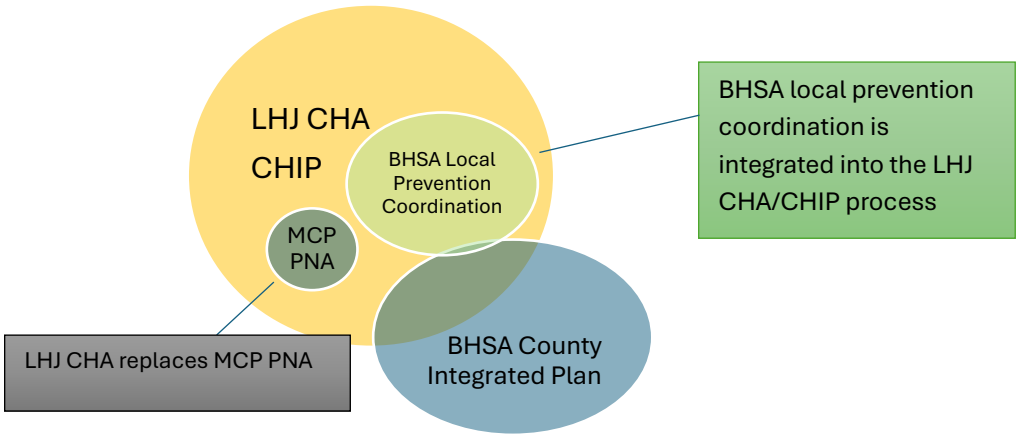


Figure VIII - Anticipated overlap, with the local BHSA prevention programming integrated fully into the LHJ CHA/CHIP planning process



Phase III - Alignment with Community Reinvestment

The Community Reinvestment program advances DHCS' objectives toward improving the health and wellbeing of Members through innovations that are locally driven and adopt a whole-person approach[42]. Community Reinvestment activities are directly informed by the community needs identified in each LHJ's CHA, thereby ensuring that MCP investments target the unique needs of each community. By integrating BHSA Local Prevention Coordination into the LHJ CHA and CHIP,

[42] DHCS Community Reinvestment All Plan Letter 25-004

it will ensure that the BHSA prevention needs of their communities also inform the Community Reinvestment planning process.

For more information regarding the Community Reinvestment process, and the timeline of MCP community reinvestment activities and their relationship with the LHJ CHA/CHIP process, please see DHCS Community Reinvestment All Plan Letter 25-004 (Exhibit 1)

E. NEXT STEPS

After the Public Comment period, CDPH will analyze and integrate public comment into a Final Phase 2 Guide. The Final Phase 1 and Phase 2 Guide will comprise the Final Plan, which is expected to be released in December 2025. The Final Plan will cover BHSA population-based prevention strategies beginning in July 2026 for a three-year period including Fiscal Years 2026–29.

The Plan will be updated regularly to clarify and provide details on the implementation of the Statewide Population-Based Prevention Program. This Plan may also be updated based on outcomes of prevention efforts or as emerging needs and issues arise.

CDPH will also be releasing any specific funding requirements or Request for Proposals (RFPs) related to the various grant opportunities mentioned in this Guide during the early part of 2026.

For more information on those RFPs, please continue to monitor the CDPH Website - Transforming Behavioral Health for more information. You may also sign up for continued updates here.

APPENDIX A – STATUTORY REQUIREMENTS

The following statutory requirements (WIC Section 5892 (f)(1)(E)) outline the level of funding that will be dedicated to prevention programs and how it must be used:

*A minimum of **four percent** of the total funds allocated pursuant to this subdivision shall be distributed to the State Department of Public Health for this purpose. **Of these funds, at least 51 percent shall be used for programs serving populations who are 25 years of age or younger**. The State Department of Public Health shall consult with the State Department of Health Care programs and the Behavioral Health Services Oversight and Accountability Commission to ensure the provision of these programs.*

- *(i) Population-based prevention programs are activities designed to reduce the prevalence of mental health and substance use disorders and resulting conditions.*
- *(ii) Population-based prevention programs shall incorporate evidence-based promising or community-defined evidence practices and meet one or more of the following conditions:*
  - *(I) Target the entire population of the state, county, or particular community to reduce the risk of individuals developing a mental health or substance use disorder.*
  - *(II) Target specific populations at elevated risk for a mental health, substance misuse, or substance use disorder.*
  - *(III) Reduce stigma associated with seeking help for mental health challenges and substance use disorders.*
  - *(IV) Target populations disproportionately impacted by systemic racism and discrimination.*
  - *(V) Prevent suicide, self-harm, or overdose.*
- *(iii) Population-based prevention programs may be implemented statewide or in community settings.*
- *(iv) Population-based prevention programs shall **not** include the provision of early intervention, diagnostic, and treatment for individuals.*
- *(v) Population-based prevention programs shall be provided on a schoolwide or classroom basis and may be provided by a community-based organization off campus or on school grounds.*
- *(vi) School-based prevention supports and programs shall be provided at a school site or arranged for by a school on a schoolwide or classroom basis and shall not provide services and supports for individuals. These supports and programs may include, but are not limited to:*
  - *(I) School-based health centers, student wellness centers, or student well-being centers.*

(II) Activities, including, but not limited to, group coaching and consultation, designed to prevent substance misuse, increase mindfulness, self-regulation, development of protective factors, calming strategies, and communication skills.

(III) Integrated or embedded school-based programs designed to reduce stigma associated with seeking help for mental health challenges and substance use disorders.

(IV) Student mental health first aid programs designed to identify and prevent suicide or overdose.

(V) Integrated training and systems of support for teachers and school administrators designed to mitigate suspension and expulsion practices and assist with classroom management.

(vii) Early childhood population-based prevention programs for children 0 to 5 years of age, inclusive, shall be provided in a range of settings.

APPENDIX B – SUMMARY TABLE OF PROPOSED BHSA FUNDING INVESTMENT

Program Component	FY 2026/27 (in Millions)	Percent of Budget	FY 2027/28 & 2028/29 (in Millions)	Percent of Budget
Statewide Policy Initiative	$1.4M	1%	$3.4M	3%
Statewide Prevention Strategies	$6.2M	5%	$16.2M	14%
Statewide Awareness Campaigns	$40.7M	34%	$14.7M	12%
Training and Technical Assistance	$2.6M	2%	$3.6M	3%
Community engagement	$1.4M	1%	$1.4M	1%
Data and evaluation	$7.1M	6%	$9.1M	8%
CBO Grants	$30.8M	26%	$41.3M	35%
Tribal Grant Program	$6.0M	5%	$6.0M	5%
Training / Technical Assistance Grants	$7.5M	6%	$7.5M	6%
Local Health Jurisdiction Grants	$12.0M	10%	$12.0M	10%
TOTAL Annual (by Component)	**$115.6M**		**$115.2M**	
Core Staffing	$4.2M	4%	$4.2M	4%
Total BHSA Budget	**$119.8M**		**$119.4M**	
Component	**Budget**		**Budget**	
Statewide Strategies	$63.6M	53%	$52.6M	44%
CBO Grants	$30.8M	26%	$41.3M	35%
Dedicated funding for Tribal Entities	$6.0M	5%	$6.0M	5%
Training / Technical Assistance Grants	$7.5M	6%	$7.5M	6%
LHJ Grants	$12.0M	10%	$12.0M	10%