



CDPH BHSA Population-Based Prevention Program Final Plan

Executive Summary

Introduction

The California Department of Public Health's (CDPH) Final Plan (Plan) provides the community and other behavioral health stakeholders and partners with the department's strategic approach to implement Behavioral Health Transformation. The Plan also contains information about the Behavioral Health Services Act (BHSA) statutory requirements. The CDPH Behavioral Health Services Act: Population-Based Prevention Program Final Plan is comprised of Phase 1 and 2 Guides and incorporates community and partner input (including input received from formal Tribal Consultations). The Plan represents the final operational and administrative components, including the implementation strategies and funding investments for each component beginning in July 2026 for a three-year period including Fiscal Years 2026-2029. This timeline, as part of the broader BHSA, aligns with the [3-year County Integrated Planning effort](#) to facilitate cross-systems collaboration and support strategic alignment at the state and local level for coordinated and complementary approaches.

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 the Office of Social and Behavioral Health (Office) in 2026. This office aims to centralize and coordinate behavioral health activities, ensuring leadership, compliance, oversight, and alignment across various programs, and promotes behavioral health as a public health priority.

Priority Populations for Strategic Investment

The BHSA emphasizes serving populations with the highest needs and at greatest risk for negative outcomes along the behavioral health care continuum. Limited funding provided for population-based prevention dictates a focused approach on addressing the most critical needs and gaps and

using data and community input to drive strategic investment. The Final Plan outlines the following list of specific populations for strategic investment¹:

- Black, Indigenous, Latino, Asian and Pacific Islander and Middle Eastern populations;
- Children, youth, and families;
- Immigrant and refugee populations;
- LGBTQIA+ populations;
- Older adults;
- People with Intellectual and Development Disabilities
- Tribes²; and
- Veterans.

CDPH will also continue to monitor the prevalence of negative behavioral health outcomes in other populations that have experienced systemic racism and discrimination.

Statewide BHSA Population-Based Prevention Program Plan

CDPH developed statewide prevention strategies to align with the statewide BHSA behavioral health goals. These strategies leverage existing expertise from various offices within CDPH to ensure comprehensive and effective interventions, with a focus on stigma and discrimination reduction. The Final Plan outlines details for the following program components:

- *Statewide Policy Initiatives* – to address new and emerging behavioral issues and threats, and novel and emerging substance use
- Focused Statewide Behavioral Health Strategies – includes the investment in CalHOPE and an established set of focused strategies
- *Statewide Awareness Campaigns* – includes investment in maintenance of ongoing campaign assets (Never a Bother; Take Space to Pause; Live Beyond and Facts Fight Fentanyl) and development of three new awareness campaigns:
 - Suicide and Self-Harm Prevention – focused on young adults, older adults and veterans
 - 988 Suicide and Crisis Lifeline and Behavioral Health Services
 - Substance Use Prevention
- *Training and Technical Assistance* – supports CDPH expertise to ensure success of policy work and implementation of prevention strategies
- *Community Engagement* – includes development of an Implementation Workgroup
- *Statewide Evaluation* – dedicated staff and resources to monitor the effectiveness of all BHSA population-based prevention activities, including those within CDPH. This includes data collection, analysis, and reporting to ensure transparency and continuous improvement in behavioral health outcomes.

¹ The list is represented in alphabetical order and should not be viewed as levels of prioritization.

² Tribal entities refer to federally recognized Tribes, Indian Health Clinics/Indian Health Programs, and Urban Indian Organizations.

Funding to Mobilize Local Reach of Statewide Strategies

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. Locally funded implementation partners will support infrastructure for strong coordination, cross-cutting efforts, and systems change at the local level. The Final Plan outlines the following funding to develop local reach of statewide strategies:

Community-Based Organizations and Tribes: \$34.8M in 2026/27; \$45.3M in 2027/28-2028/29

- Community-Defined Evidence Based Practices (CDEP) and Evidence-Based Practices Program
- Trusted Messenger Campaign Program
- Regional Policy Research and Development
- Regional Implementation of Focused Strategies
- 988 Suicide and Crisis Lifeline Outreach Campaign Program

Dedicated Funding for Tribes - \$10M

Training and Technical Assistance Funding (open to CBOs and other non-governmental entities) - \$8.5M

- To support statewide training and technical assistance in specialized areas and unique populations, including:
 - Older Adults
 - Veterans
 - 988 Crisis Services

Local Health Jurisdictions - \$12M:

- *Local Health Jurisdiction (LHJ) Program*: Funding for the 61 LHJs to act as Local Prevention Coordinators and convene local prevention coalitions.

Aligning Local Planning Processes

The BHSA framework and CDPH Final Plan emphasize the integration of local prevention coordination into the LHJ Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) processes. As part of the funding directed to LHJs, they will be required to integrate the convening and coalition process into the required LHJ CHA/CHIP by 2028/29 – to continue to advance ongoing alignment of local planning processes, in coordination with Medi-Cal Managed Care Plans and county behavioral health departments.

Next Steps

During Spring 2026, CDPH intends to release specific funding requirements or Request for Proposals (RFPs) related to the various funding opportunities mentioned in the Final Plan. CDPH will also release a Community-Defined Evidence Practices (CDEPs) resource guide and host a CDEP public webinar to support local implementation partners.

During Summer 2026, CDPH will also release the application process for participation in the Implementation Workgroup. By late 2026, CDPH will release a comprehensive evaluation framework to provide detailed guidance on statewide evaluation measures. CDPH will host a public webinar and release the framework for public comment.

This information will be publicly posted on the [CDPH website](#) and announced via the [BHSA email distribution list](#). Individuals are encouraged to sign up for the BHSA email list to receive updates directly.

Table 1: Total CDPH Investment in BHSA Budget for 2026/27 – 2027/28 and 2028/29

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	\$5.7M	4%	\$15.7M	12%
Statewide Awareness Campaigns	\$40.3M	30%	\$14.3M	11%
Training and Technical Assistance	\$5.0M	4%	\$6.5M	5%
Community Engagement	\$1.5M	1%	\$1.5M	1%
Data and Evaluation	\$7.9M	6%	\$9.9M	7%
Local Health Jurisdiction Program	\$12.0M	9%	\$12.0M	9%
CBO Funding	\$34.8M	26%	\$45.3M	34%
Tribal Program	\$10.0M	7%	\$10.0M	7%
Training and Technical Assistance Grants	\$8.5M	6%	\$8.5M	6%
TOTAL Annual (by Component)	\$127.0M		\$127.0M	
Core Staffing	\$7.8M	6%	\$7.8M	6%
Total BHSA Budget	\$134.8M		\$134.8M	
Component	Budget		Budget	
Statewide Strategies	\$69.5M	52%	\$59.0M	44%
Local Health Jurisdiction Funding	\$12.0M	9%	\$12.0M	9%
CBO Funding	\$34.8M	26%	\$45.3M	34%
Dedicated funding for Tribal Entities	\$10.0M	7%	\$10.0M	7%
Training and Technical Assistance	\$8.5M	6%	\$8.5M	6%
Total	\$134.8M		\$134.8M	

Behavioral Health Services Act: Population-Based Prevention Program Final Plan

California Department of Public Health

Contents

A. PURPOSE OF THE BEHAVIORAL HEALTH SERVICES ACT POPULATION-BASED PREVENTION PROGRAM FINAL PLAN	8
B. BEHAVIORAL HEALTH TRANSFORMATION	9
I. Introduction to Behavioral Health Transformation	9
II. Priority Populations	11
III. Alignment Across the Behavioral Health System	13
C. BHSA POPULATION-BASED PREVENTION	15
I. Statutory Requirements.....	16
II. Populations of Focus.....	16
III. Cultural Responsiveness.....	17
IV. Use of Evidence-Based, Promising, or Community-Defined Evidence Practices	17
V. Stigma and Discrimination Reduction.....	17
D. BHSA POPULATION-BASED PREVENTION PROGRAM FRAMEWORK.....	17
I. Statewide Prevention Planning	18
II. Populations of Focus for Strategic Investment	19
E. BHSA POPULATION-BASED PREVENTION PROGRAM OPERATIONAL COMPONENTS 21	
I. Office for Social and Behavioral Health	24
II. Statewide Prevention Strategies:	25
A. STATEWIDE POLICY INITIATIVES	26
B. FOCUSED STATEWIDE BEHAVIORAL HEALTH PREVENTION STRATEGIC PLAN:	27
C. STATEWIDE AWARENESS CAMPAIGNS:.....	33
D. PREVENTION TRAINING AND TECHNICAL ASSISTANCE:.....	37
E. COMMUNITY ENGAGEMENT AND COALITION BUILDING:.....	39
F. STATEWIDE EVALUATION STRATEGY	42

G. FUNDING TO MOBILIZE LOCAL REACH OF STATEWIDE STRATEGIES AND POLICY	43
Community-Defined Evidence Based Practices and Evidence Based Practices Program ...	46
Trusted Messenger Campaign Program	47
Regional Policy Research and Development	47
Regional Implementation of Focused Strategies	48
Tribal Program	49
Training and Technical Assistance Funding	49
CDPH will ensure that TTA providers have demonstrated effectiveness in working with populations of focus, and ensure cultural competency and accessibility is core in their work.	51
Local Health Jurisdiction (LHJ) Program	51
988 Suicide and Crisis Lifeline Outreach Campaign Funding Program.....	54
H. ALIGNMENT WITH OTHER LOCAL PLANNING PROCESSES	55
Background	56
I. NEXT STEPS	61
APPENDIX A – STATUTORY REQUIREMENTS	62
APPENDIX B – SUMMARY TABLE OF BHSA FUNDING INVESTMENTS	64

A. PURPOSE OF THE BEHAVIORAL HEALTH SERVICES ACT POPULATION-BASED PREVENTION PROGRAM FINAL PLAN

This Final Plan provides the community and other behavioral health stakeholders and partners the California Department of Public Health’s (CDPH) Final Plan (Plan) and strategic approach to implement Behavioral Health Transformation. The Plan also contains information about the Behavioral Health Services Act (BHSA) statutory requirements. Throughout this Plan, there are footnote references to relevant CDPH webpages, Welfare & Institutions Code, data sources and other relevant information.

On June 19, 2025, CDPH released **Phase 1** of the BHSA Population-Based Prevention Program (CDPH BHSA Prevention Program) Guide for public comment. CDPH also hosted a webinar on June 30, 2025, to gather stakeholder and community input from the 449 unique participants that joined. Phase 1 provided information about the CDPH BHSA Program statutory requirements, statewide goals, and state level leadership and alignment activities.

CDPH received public comments through Microsoft Forms and direct email submissions, summarized below:

Summary – Phase I Comments Received	
Total Received	121
Type of Organization	Count of Unique Organizations
Community Based Organization (CBO)	52
Statewide Advocacy Organization	29
Local Health Jurisdiction (LHJ)	17
Academic	4
State Government	2
Total Organizations	104

On November 10, 2025, CDPH released **Phase 2** of the CDPH BHSA Prevention Program Guide for public comment. CDPH also hosted a webinar on November 13, 2025, to gather stakeholder and community input from the 928 unique participants that joined. Phase 2 addressed the operational and administrative components and implementation activities to achieve intended objectives, goals, and outcomes.

CDPH received public comments through Microsoft Forms and direct email submissions, summarized below:

Summary – Phase 2 Comments Received	
Total MS Forms Responses	249
Type of Organization	Count of Unique Organizations
Community Based Organization (CBO)	79
Statewide Advocacy Organization	30
K-12 Education Sector	22
Local Health Jurisdiction (LHJ)	9
Local Government	5
Academic	5
State Government	4
County-Level Behavioral Health Department	3
Total Organizations	157

On October 9, 2025, and November 7, 2025, CDPH conducted formal **Tribal Consultations** focused on the CDPH BHSA Program Guide Phase 1 and Phase 2. During Consultation #1, CDPH focused on introducing and soliciting feedback on Phase 1 including defining Tribal entities eligible for CDPH BHSA funding and gathering ideas on accessible and inclusive solicitation and procurement processes for Tribes. During Consultation #2, CDPH focused on presenting and gathering feedback on the BHSA Phase 2 Guide.

This Plan is comprised of Phase 1 and 2 Guides, and the stakeholder and community input received. The Plan represents the final operational and administrative components, including the implementation strategies and funding investments for each component beginning in July 2026 for a three-year period including Fiscal Years 2026-2029. This timeline, as part of the broader BHSA, aligns with the [3-year County Integrated Planning effort](#) to facilitate cross-systems collaboration and support strategic alignment at the state and local level, as needed, for coordinated and complementary approaches.

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

B. BEHAVIORAL HEALTH TRANSFORMATION

I. Introduction to Behavioral Health Transformation

Behavioral Health Transformation is part of [California’s Mental Health for All](#) – a 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. The state is also focused on prevention and early support – so individuals can get help before behavioral health conditions develop.

Behavioral Health Transformation is an effort that will implement the ballot initiative known as Proposition 1 to modernize the behavioral health delivery system, improve accountability and increase transparency, and expand the capacity of behavioral health care facilities for Californians. Behavioral Health Transformation complements and builds on California's other major behavioral health initiatives including, but not limited to, [California Advancing and Innovating Medi-Cal \(CalAIM\) initiative](#), the [California Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment \(BH-CONNECT\) Demonstration proposal](#), the [Children and Youth Behavioral Health Initiative \(CYBHI\)](#), [Medi-Cal Mobile Crisis, 988 expansion](#), and the [Behavioral Health Continuum Infrastructure Program \(BHCIP\)](#).

Proposition 1, passed by California voters in March 2024, is a two-bill package that drives the statewide reform and expansion of California's behavioral health system. It includes:

1. [Behavioral Health Services Act \(BHSA\)](#)
 - Modernizes the state's behavioral health care delivery system by focusing on people with the most serious mental health and substance use disorder needs. It expands treatment, housing, and workforce capacity, while increasing equity and accountability.
2. [Behavioral Health Infrastructure Bond Act](#)
 - Provides \$6.4 billion in funding for behavioral health treatment beds, residential care, supportive housing, community sites, and housing with a special emphasis on veterans with behavioral health needs.

Together, the BHSA and the Bond Act build on California's broader efforts to reimagine and strengthen the entire behavioral health system—connecting services, expanding access, and improving outcomes for all Californians.

As part of the BHSA, the **California Department of Public Health (CDPH)** has been allocated dedicated funding to address behavioral health³ prevention including, but not limited to:

- Implement population-based mental health and substance use disorder prevention programs.

³ Consistent with the Behavioral Health Services Act ([SB 326](#)), 'behavioral health' refers to the combined system of mental health and substance use disorder services.

- Implement population-based behavioral health prevention strategies under the BHSA, with the majority of funds directed at individuals who are 25 years of age or younger.
- Manage public awareness efforts to educate Californians about mental health and substance use disorders and opportunities for treatment.
- Work to enhance school-based/linked health services and supports for students and staff designed to identify and prevent suicide and substance misuse, and reduce stigma associated with seeking help for mental health and substance use disorder challenges.
- Coordinate and align statewide suicide prevention efforts and resources through programs like the [Office of Suicide Prevention](#).

II. Priority Populations⁴

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 individuals receive the support they need.

BHSA prioritizes the following populations listed below:

Eligible children and youth who satisfy one of the following:

- Are chronically homeless or experiencing homelessness or at risk of homelessness
- Are in, or at risk of being in, the juvenile justice system
- Are reentering the community from a youth correctional facility
- Are in the child welfare system pursuant to W&I Code sections [300](#), [601](#), or [602](#)
- Are at risk of institutionalization

Eligible adults and older adults who satisfy one of the following:

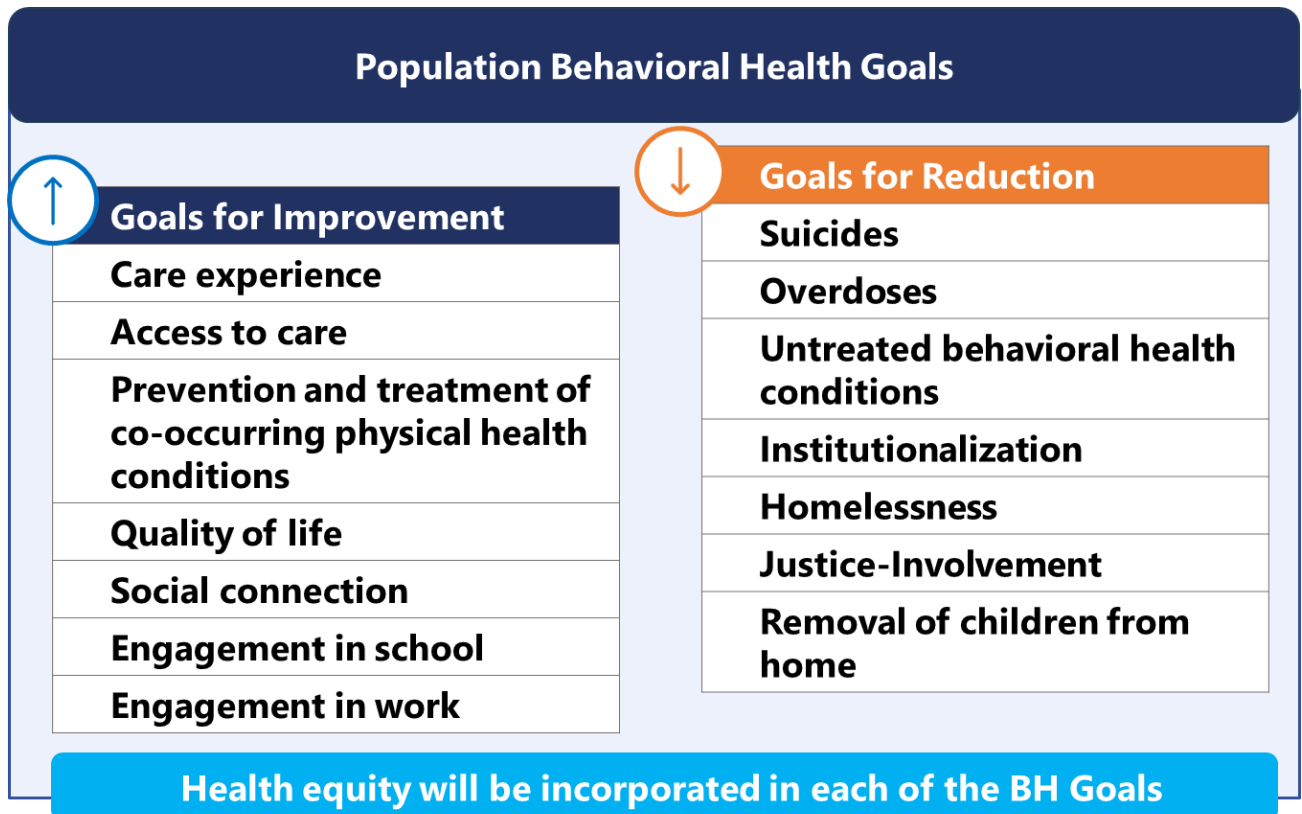
- Are chronically homeless or experiencing homelessness or at risk of homelessness
- Are in, or at risk of being in, the justice system
- Are reentering the community from state prison or county jail
- Are at risk of conservatorship
- Are at risk of institutionalization

⁴ [W&I Code §5892, subdivision \(d\)](#)

Statewide Population Behavioral Health Goals

While BHSA populations have high needs, behavioral health transformation, as part of [California's Mental Health for ALL](#), is focused on making sure every Californian—especially people who have had the hardest time getting help—can access high-quality, mental health disorder and substance use treatment, when and where they need it. To achieve this, California has established 14 statewide behavioral health goals under the leadership of Department of Health Care Services (DHCS), in consultation with stakeholders and subject matter experts (see graphic below and [DHCS BHSA Policy Manual, section C.2](#)). These goals lay out the vision that the state, counties, managed care plans, and other key partners will work toward to improve the overall well-being and behavioral health outcomes of Californians. As statewide goals, it is not expected that BHSA funding alone will move the needle on these indicators, but rather, will take strong cross-service delivery system collaboration and partnership to achieve improved outcomes for all Californians. These behavioral health goals will also be used to inform state and local planning and prioritization of BHSA resources.

Health equity is foundational to the public health approach and central to each goal. Population measures associated with each goal for monitoring and accountability are forthcoming. The Department of Healthcare Services (DHCS) and CDPH, in consultation with behavioral health stakeholders, subject matters experts, and implementation partners will work together to define specific population measures for statewide behavioral health goals and participate in a cycle of continuous improvement to drive progress on the statewide behavioral health goals. CDPH-led efforts for population-based prevention under the BHSA will contribute to achieving these goals.



III. Alignment Across the Behavioral Health System

It is expected that BHSA population-based prevention (led by CDPH) and early intervention programming (led by DHCS and administered at the county level) will work in tandem across the prevention continuum (see figure below, adapted from the Institute of Medicine, Continuum of Care Model). While CDPH and DHCS have distinct responsibilities under BHSA, their efforts are complementary and aligned to ensure a coordinated approach to behavioral health promotion, prevention, and early support. Below are definitions of each area led by CDPH and DHCS, with the goal that the coordinated and integrated work between CDPH and DHCS along the prevention continuum will promote protective factors, prevent exposure to risk factors, and provide services and supports to address the behavioral health impacts affecting Californians.

Population Prevention – Led by CDPH

- Promotion** strives to improve the well-being of whole communities through strategies such as raising public awareness, reducing stigma, and ensuring access to activities and resources that support well-being. In behavioral health, promotion strategies are designed to create environments and conditions that support behavioral health and the ability of individuals and communities to withstand challenges. Promotion strategies

focus on the general public and/or entire populations and aim to enhance individuals' ability to achieve developmentally appropriate competencies and a positive sense of self-esteem, mastery, and well-being([World Health Organization, 2005](#)).

- **Universal prevention** focuses on the general public or a whole population that has not been identified on the basis of increased risk ([Kirkbride et al., 2024](#)).
- **Selective prevention** focuses on individuals or subgroups of the population whose risk of developing a mental health and/or substance use disorder is significantly higher than average, as evidenced by biological, psychological or social risk factors ([Kirkbride et al., 2024](#)).

Early Intervention – Led by DHCS

- **Early Intervention**⁵ is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health.
 - **Indicated prevention** interventions focus on BHSA eligible at-risk individuals who are at risk of and experiencing early signs of a mental health or substance use disorder or who have experienced known risk factors for poor behavioral health outcomes, such as trauma, Adverse Childhood Experiences, or involvement with child welfare or corrections system. This at-risk individual may not yet meet the criteria of a diagnosable mental health or substance use disorder. Examples of indicated prevention interventions include outreach, training, and education for high-risk individuals and/or families who are at risk and experiencing early signs of a mental health or substance use disorder.
 - **Case identification** includes assessment, diagnoses, brief interventions, and activities needed to create access and linkages to care that connect individuals to appropriate care.

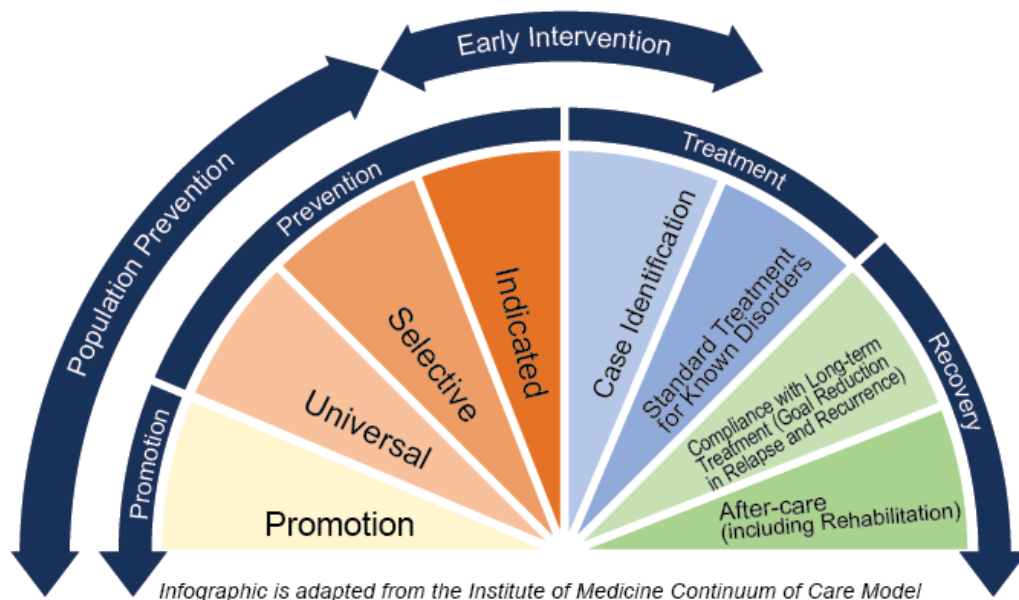
Under the specific context for BHSA, both CDPH and DHCS are working in concert to each provide guidance through the CDPH Prevention Program Final Plan and the [DHCS Behavioral Health Services Act County Policy Manual](#). While the two guidance documents may be distinct, it is recognized that overlap in certain areas may exist, and both CDPH and DHCS have closely related roles along the spectrum of population prevention and early intervention.

For example, many county behavioral health agencies may be funding population prevention services through other sources (e.g., Substance Abuse and Mental Health Services Administration (SAMHSA); Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG); opioid settlements; Realignment; etc.) that will be captured as part of the county 3-year Integrated Planning process. While BHSA funds for population prevention programs are

⁵ [7. BHSA Components and Requirements](#) and [WIC 5840\(a\)\(1\)](#)

directed to CDPH, it is critical that alignment and understanding of state-level policy work and local planning efforts⁶ happens on an ongoing basis so that health care systems, behavioral health, local public health, and community-based organizations (CBOs) are recognized as key system partners working in a complementary and unified approach.

The figure below (adapted by DHCS) from the Institute of Medicine’s Continuum of Care Model illustrates the spectrum of approaches within BHSA population-based prevention and early intervention that include several levels of prevention on a continuum with treatment and recovery.



C. BHSA POPULATION-BASED PREVENTION

Behavioral health challenges are on the rise in part due to early life adversity and exposure to harms from behavioral addictions, chemical substances, and negative digital stimuli. BHSA presents a renewed opportunity to address significant population health burdens and disparities related to behavioral health and well-being through a coordinated, statewide population-based prevention approach. The BHSA is foundational to California’s commitment to transform our behavioral health systems and achieve positive behavioral health and well-being for all. CDPH is leading the new BHSA investments in a statewide BHSA Prevention Program. This facet involves

⁶ 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. For more information, see the [California Department of Public Health December 26, 2023 Memo to All Local Health Jurisdictions](#), the [CalAIM PHM Policy Guide](#) (p. 8-10) and [DHCS BHSA County Policy Manual](#) (section B.2)

two major shifts: 1) establishing dedicated resources focused on population-based prevention and 2) improving the impact of prevention efforts through statewide leadership and alignment.

I. Statutory Requirements

As part of the broader BHSA, dedicated ongoing resources for population-based prevention were established to create a strategic population health approach to behavioral health prevention designed to reduce the prevalence of mental health and substance use disorders and resulting conditions. A minimum of 4 percent of the BHSA funding is allotted to CDPH for population-based prevention and **at least 51 percent of the funds must be used for populations who are 25 years old or younger**. Population-based prevention programs must incorporate evidence-based practices or promising community-defined evidence practices and meet one or more of the following:⁷

1. Benefit the entire population of the state, county, or particular community
2. Serve identified populations at elevated risk for a mental health or substance use disorder
3. Aim to reduce stigma associated with seeking help for mental health challenges and substance use disorders
4. Serve populations disproportionately impacted by systemic racism and discrimination
5. Prevent suicide, self-harm, or overdose

The full statutory requirements for the BHSA population-based prevention funding can be found in Appendix A.

II. Populations of Focus

BHSA statute stipulates that BHSA population-based prevention programs must meet five conditions, two of which are specific to populations of focus. These populations are:

- populations at elevated risk for a mental health, substance misuse, or substance use disorder.
- populations disproportionately impacted by systemic racism and discrimination.⁸

⁷ [W&I Code § 5892 \(f\) \(1\)](#)

⁸ [W&I Code § 5892 \(f\) \(1\) \(E\)](#)

III. Cultural Responsiveness⁹

All population-based prevention programs must be culturally responsive and linguistically appropriate to the community served. These programs must be able to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, sexual orientation, age, economic, or other disparities in mental health and substance use disorder. Integral to cultural responsiveness is the recruitment and engagement of well-trained staff who reflect the diversity and lived experiences of the communities served. Additionally, population-based prevention programs must engage communities, especially community members who are historically underrepresented and/or marginalized, as partners in planning, developing, implementing, and evaluating programs and strategies.

IV. Use of Evidence-Based, Promising, or Community-Defined Evidence Practices¹⁰

Population-based prevention programs shall incorporate evidence-based, promising, or community-defined evidence practices designed to reduce the impact of mental health and substance use disorder challenges and resulting conditions. Population-based prevention programs must also be responsive to the cultural and linguistic needs of diverse communities.

V. Stigma and Discrimination Reduction

All population-based prevention strategies must aim to reduce stigma and discrimination, which seek to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to expressing emotion, dealing with mental health disorder challenges, being diagnosed with a mental health or substance use disorder, or seeking mental health or substance use disorder services.

D. BHSA POPULATION-BASED PREVENTION PROGRAM FRAMEWORK

As the lead state entity for the CDPH BHSA Prevention Program, CDPH has identified core strategies for the CDPH BHSA Prevention Program that will ensure alignment of population-based prevention activities and contribute to achieving the 14 statewide behavioral health goals.

⁹ [W&I Code § 5840.6 \(g\)](#)

¹⁰ [W&I Code § 5892 \(f\) \(1\) \(E\)](#)

I. Statewide Prevention Planning

In planning for the early development of the CDPH BHSA Prevention Program and the Phase 1 and 2 Guides, CDPH conducted a planning process to bring together information about the existing landscape of behavioral health initiatives and opportunities, such as activities implemented through MHSA Prevention and Early Intervention, [CHHS California Plan for a Comprehensive 988-Crisis System](#), and the [Children and Youth Behavioral Health Initiative \(CYBHI\)](#), that could be built on or leveraged for further impact. The existing landscape included CDPH's own programs and expertise that could be leveraged to meet the goals and outcomes of BHSA, including the Office of Health Equity's [California Reducing Disparities Project](#), the [Office of Suicide Prevention](#), the [Office of School Health](#), the [Substance and Addiction Prevention Branch's Overdose Prevention Initiative](#).

This process also included a review of reports and research¹¹ and data analysis to understand the trends in suicide, self-harm and overdose.

A comprehensive review of data, for example, indicates that while the highest rates of youth suicide are among Native American and Alaska Native and Native Hawaiian and Pacific Islander youth, the largest increases in suicide are among Black youth, followed by Latino youth (California Community Burden of Disease and Cost Engine (CCB), 2025). Additionally, suicide rates vary by region, with rural communities in Northern regions generally experiencing higher mortality rates (CCB, 2025).

Data also demonstrates that while the rate of increase has slowed, drug overdose death rates continued to increase in 2023, reaching an all-time high ([CCB, 2025](#)). Drug overdose is the leading cause of premature death, fifth leading cause of death overall for Californians, and the leading cause of death for ages 25 to 54 ([CCB, 2025](#)). Youth aged 10 to 18 had the highest rates of self-harm emergency department visits and experienced the largest increase (23.2%) from 2020-2021.

Additionally, CDPH reviewed state and local programs plans (including existing [MHSA Prevention work](#)), academic research, community-defined evidence practices, as well as reports that center youth and community voice. Part of the planning process also involved conducting interviews with subject matter experts and facilitation of engagement events to garner input from community partners. Panelists during the community engagement events also included experts serving populations with documented and emerging behavioral health needs

¹¹ [California State of Public Health Report 2024 and Office of Suicide Prevention Youth Suicide Prevention Program Highlights 2023](#)

such as veterans and older adults to ensure that those perspectives and voices were elevated as part of the planning process.

Subject matter experts and community engagement surveys also identified two potential focal areas as effective strategies to address behavioral health challenges that should be considered when developing statewide prevention strategies:

- Increasing social connection and belonging
- Increasing mental health and well-being awareness and development

The review of existing prevention-focused behavioral health initiatives also highlighted that:

- Approaches designed and implemented in collaboration with communities (rather than done “to” or “for”) and that are tailored to community and cultural context increase effectiveness.
- Integrating mental health and substance use disorder treatment with community services address multiple areas of well-being.
- Strategies that center compassionate and dependable relationships—within communities, among staff, and across systems—foster healing and well-being.
- Peer-led interventions enhance outcomes, particularly in older and youth populations and other underserved and inappropriately served groups.

Finally, an assessment of current and emerging policy issues has also highlighted opportunities where prevention programs might be complementary and mutually reinforcing with statewide policy initiatives, including, for example, implementation of [AB 1282 \(Statutes of 2024\)](#), which requires CDPH to develop a strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth.

II. Populations of Focus 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 populations of focus for strategic investment reflects where BHSA funding will specifically be

directed, distinct from the “priority populations” defined in statute.¹² Statute also stipulates BHSA population-based prevention programs populations of focus. Those populations are:

- populations at elevated risk for a mental health, substance misuse, or substance use disorder
- populations disproportionately impacted by systemic racism and discrimination¹³.

Additionally, on July 30, 2025, California Governor Gavin Newsom signed an [executive order](#) to address a growing crisis of suicide, mental health disorder, and disconnection among California’s young men and boys.

In consideration of statute, a review of data¹⁴ to determine populations at elevated risk, stakeholder feedback from our Phase 1 and 2 Guides’ comment period, and the potential impacts of recent federal policy (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), CDPH has defined the following populations of focus for strategic investment.

CDPH’s list is not an eligibility list, but a strategic framework to guide population-based prevention investments.

- a. Black, Indigenous, Latino, Asian Pacific Islander and Middle Eastern populations
- b. Children, youth, and families
- c. Immigrant and refugee populations
- d. LGBTQIA+ populations
- e. Older adults
- f. People with Intellectual and Development Disabilities
- g. Tribes
- h. Veterans

Note: The list above is represented in alphabetical order and should not be viewed as levels of prioritization. CDPH will also continue to monitor the prevalence of negative behavioral health outcomes in other populations that have experienced systemic racism and discrimination.

¹² [W&I Code §5892 \(d\)](#)

¹³ [W&I Code § 5892 \(f\) \(1\) \(E\)](#)

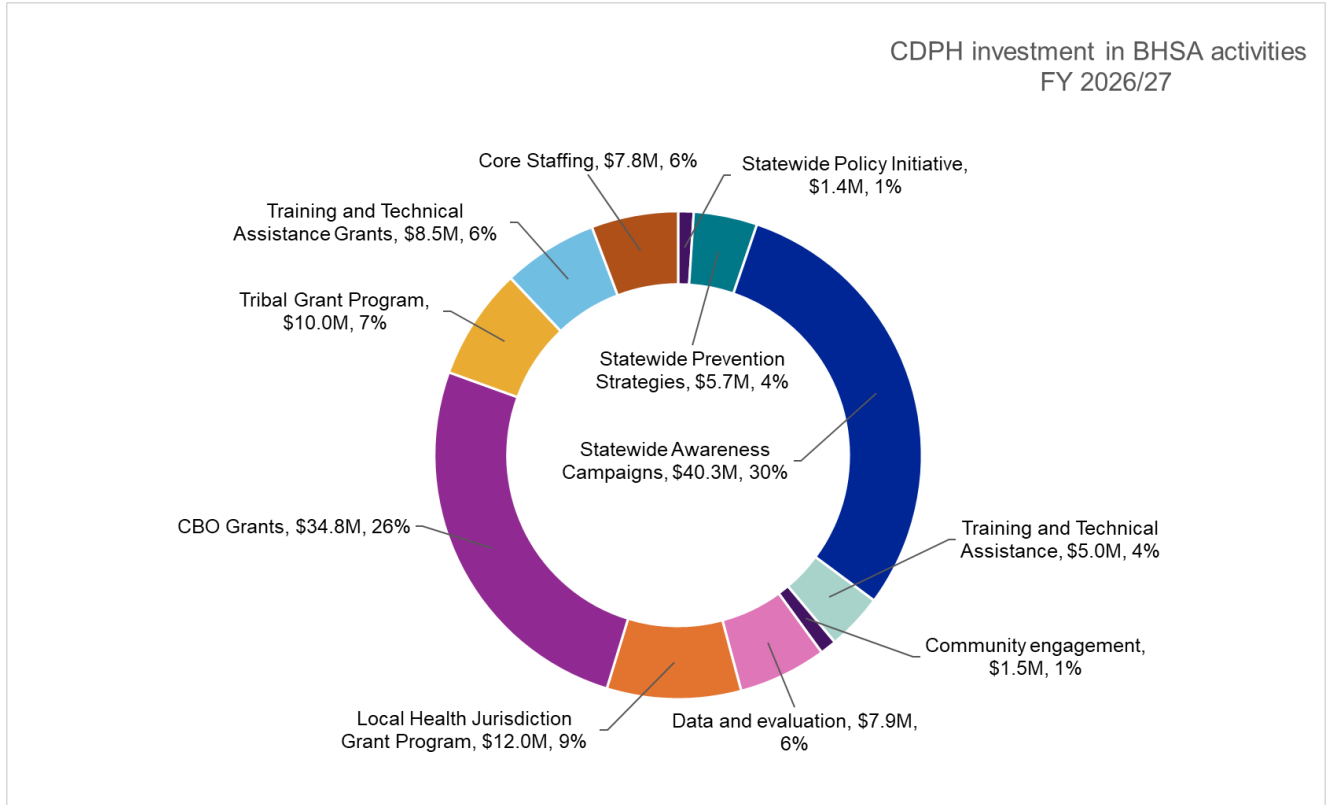
¹⁴ Visit the [California Overdose Surveillance Dashboard](#) and [EpiCenter](#), CDPH’s interactive data visualization tool on injuries, for more detailed data on drug-related overdose and suicide outcomes.

E. CDPH BHSA POPULATION-BASED PREVENTION PROGRAM OPERATIONAL COMPONENTS

The operational components described in this section reflect CDPH's statewide operational and administrative strategies and activities to execute the CDPH BHSA Prevention Program. Each activity noted within the various components is intended to achieve the objectives, goals and outcomes of BHSA, and also reflect the input received from stakeholders.

Figure I represents the total CDPH investment in BHSA Prevention Program activities for Fiscal Year **2026/27**¹⁵.

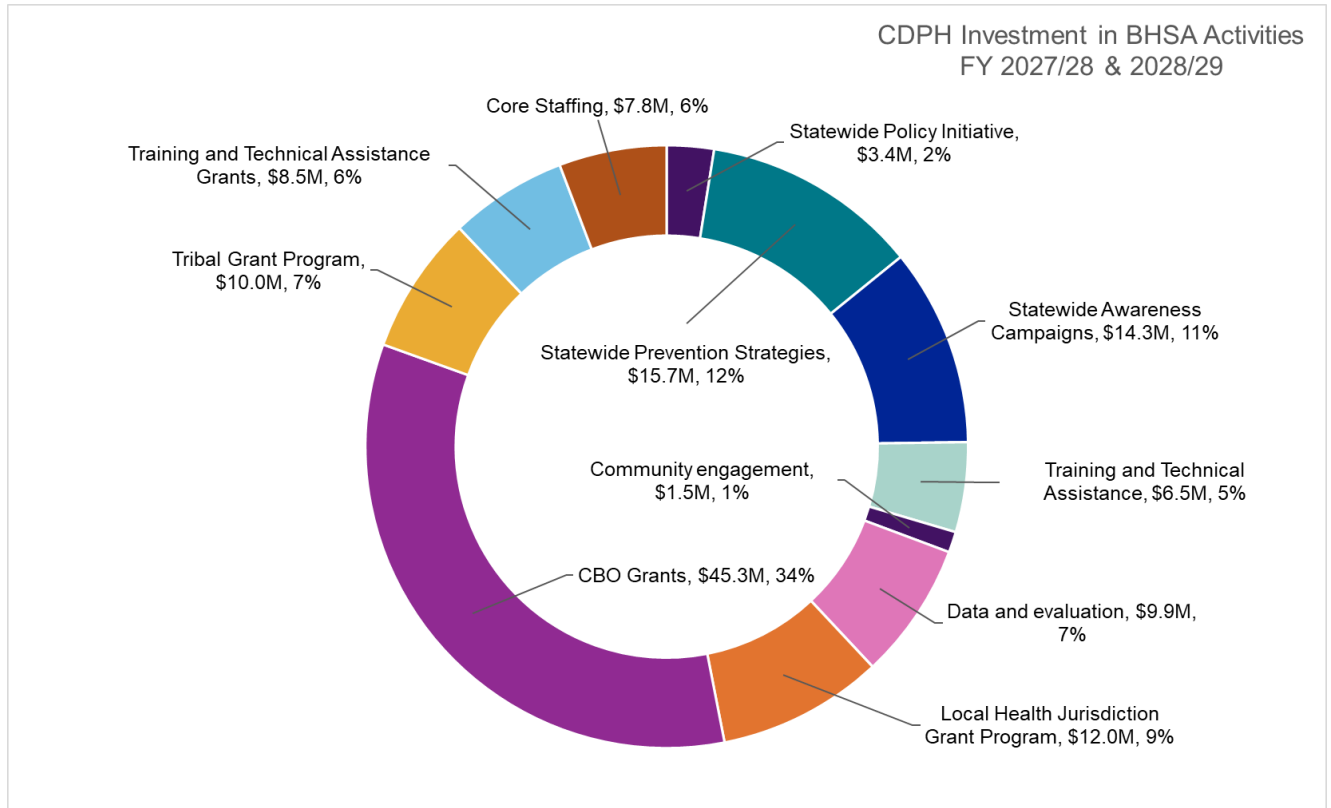
Figure I - CDPH investment in BHSA activities for Fiscal Year 2026/27



¹⁵ 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 \$134 million each year.

Figure II represents the total CDPH investment in BHSA Prevention Program 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 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.

I. Office for 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 the development of a CDPH Office for Social and Behavioral Health (Office).¹⁶ 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 by centralizing existing CDPH behavioral health related programs (including the Office of Suicide Prevention, the Substance Abuse and Prevention Branch, and the Injury and Violence Prevention Branch among others) to create synergy and alignment across the array of CDPH behavioral health programming,
- 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.¹⁷

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 and other non-BHSA behavioral health funded programs. 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 Tribes¹⁸ 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

¹⁶ 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”.

¹⁷ [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.

¹⁸ Tribes as referenced throughout this Final Plan include Federally recognized Indian Tribes, Urban Indian Organization/Urban Indian Health Programs and Indian Health Clinics/Tribal Health Clinics

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 developing and maintaining strong coordination with other state partners (including but not limited to the California Health and Human Services Agency (CalHHS) and the other CalHHS 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.

II. Statewide Prevention Strategies

Based on continued statewide prevention planning efforts and the input received as part of release of the [Phase 1 and 2 Guides](#)¹⁹ and formal Tribal consultations, CDPH developed the following statewide prevention strategies within each component for implementation. These strategies create alignment across the state to ensure that the CDPH BHSA 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 \(Statutes of 2020\)](#), 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

¹⁹ The meeting slides and a video recordings of the public comment for Phase 1 and Phase 2 can be found on the [CDPH BHSA - Partner and Community Engagement Webpage](#).

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.

- The Office of Health Equity and the groundbreaking [California Reducing Disparities Project](#) and [The California Reducing Disparities Project - Evaluation](#), 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 in and knowledge of 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.

A. STATEWIDE POLICY INITIATIVES

For implementation of Statewide Policy Initiatives, CDPH will focus on developing expertise and resources within the new Office to identify, prioritize, 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, with regards to [AB 1282 \(Statutes of 2024\)](#) and [SB 243 \(Statutes of 2025\)](#), this may include conducting research and evaluation regarding digital media and youth behavioral health, specifically regarding:

- school smartphone policies in California and comparable demographics;
- ways to reduce negative and increase positive impacts of social media among children and youth, in collaboration with youth

As part of [SB 243](#)²⁰ implementation, the CDPH Office of Suicide Prevention will review the data submitted for further policy recommendations for integration into the CDPH BHSa Prevention Program.

B. 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 leverage 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 and cultivate wellness 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 been defined after review of various statewide and local plans and initiatives, including but not limited to:

- [Violence Prevention Initiative and Roadmap](#)
- [Overdose Prevention Initiative](#)
- [Striving for Zero: California's Strategic Plan for Suicide Prevention 2020 – 2025](#)
- [Building California's Comprehensive 988-Crisis System: A Strategic Blueprint.](#)
- [Governor Newsom's Master Plan for Kids' Mental Health](#)
- [Children and Youth Behavioral Health Initiative - 2024 Annual Report](#) and [California's Children and Youth Behavioral Health Initiative Evaluation Interim Report](#)
- [2026 California Children's Report Card](#)
- [Master Plan on Aging](#)
- [Master Plan for Development Services](#)
- [Prevention of Substance Use | SAMHSA \(Substance Abuse and Mental Health Services Administration\)](#) and [Focus On Prevention](#) (Strategies and Programs to Prevent Substance Use)
- [Stigma: Beyond the Numbers | Stop Overdose | Centers for Disease Control](#)

²⁰ California SB 243 (2025-2026), enacted in October 2025, regulates "companion chatbots" by requiring clear disclosure that the AI is not human, particularly for minor users. It mandates safety protocols against self-harm content, restricts manipulative rewards, and allows for civil actions. This bill would, beginning July 1, 2027, require an operator to annually report to the Office of Suicide Prevention certain things, including protocols put in place to detect, remove, and respond to instances of suicidal ideation by users, and would require the office to post data from that report on its internet website.

- [DISRUPTING STIGMA: How Understanding, Empathy, and Connection Can Improve Outcomes for Families Affected by Substance Use and Mental Disorders](#)
- [National Strategy for Preventing Veteran Suicide](#)

CDPH will continue to work closely across state and local 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. CDPH will also continue to research and assess efforts, plans and evaluations that have been undertaken and are underway at the local level, understanding and acknowledging the vast history of prevention related work that is often first implemented at the local level.

The table below outlines examples of allowable activities for local partners to expand reach of statewide strategies. Each of the strategies should also ensure that disability inclusion (including use of plain language, ease of accessibility, and minimizing barriers to access of the strategy or resource) is incorporated within. 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 statewide plans and initiatives that incorporate other population-based prevention strategies with the goal of preventing suicide, self-harm and overdose.

Community-Defined Evidence-Based Practices are also strongly encouraged as examples within each of the prevention strategies listed. The Biennial List²¹ for the CDPH BHSA Prevention Program – Community-Defined Evidence Based Practices will be released at a later date.

Prevention Strategy	Example
Lethal means safety and harm reduction	<ul style="list-style-type: none"> • Naloxone Distribution Project • Gun Shop Project • Suicide Prevention and the Safe Storage of Firearms – a collection of courses that covers the topics of suicide prevention and safe firearm storage. The courses were created and are narrated by clinical psychologists and Veteran gun owners with the single purpose of raising awareness about the importance of safe firearm storage.

²¹ 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.

Prevention Strategy	Example
Cultural and social connections	<ul style="list-style-type: none"> • 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 • Digital connections for older adults (that emphasizes civic and cultural participation, employment, lifelong learning and access to essential services) • Traditional healing practices / Community Healing Circles and culturally responsive activities for older adults (for example, knitting circles) • Enhancing connectedness, especially among Veterans who may be isolated or marginalized, focusing on ensuring that social support is more widely available from peers and others • Creating positive social orientation for youth (engaging in activities that contribute to healthy personal development, community values, identifying with school and promoting relationships with friends who don't use harmful substances) • School and community-based peer engagement and leadership programs for youth and families that provide alternatives to substance use.
Social-emotional learning and emotional regulation, resilience, and stronger school-based relationships	<ul style="list-style-type: none"> • Sources of Strength in elementary schools, • Youth development and empowerment • Second Step / PATH (Promoting Alternative Thinking Strategies) • Adult/youth mentorship school-based programs
Behavioral health awareness / Identification and Engagement Trainings	<ul style="list-style-type: none"> • Mental Health First Aid Training, Teen Mental Health First Aid and Mental Health Training for Older Adults • Applied Suicide Intervention Skills Training (ASIST) • safeTALK

Prevention Strategy	Example
Stigma and discrimination reduction	<ul style="list-style-type: none"> • QPR (Question, Persuade, Refer) Suicide Prevention Training • WRAPs & Tools – Wellness Recovery Action Plan • Safe Spaces • Specialized Substance Use Disorder training for older adults • Training on identifying the signs of drug overdose and administration of naloxone • Evidence-based curriculum that teaches social-emotional skills, refusal skills, and accurate information about substance risks • Life Skills Training – designed to prevent substance use and violence through drug awareness and resistance skills, personal self-management and social skills. • The Basics of Veteran Suicide Prevention • Peers Helping Peers • NAMI In Our Own Voice National Alliance on Mental Illness (NAMI) • Lived Experience Academy (LEA) • Promote peer led initiatives to reduce stigma related to substance use
Policy, systems and environmental change	<ul style="list-style-type: none"> • Districtwide policies that support and sustain mental health clubs on campus • Policies to promote low barrier access to Medication for Addiction Treatment options • The development of local coalitions and community groups aimed at mobilizing community leaders to identify and respond to the drug problems unique to their community and change local community environmental conditions tied to substance use (Drug-Free Communities (DFC) Overdose Prevention CDC) • Local and statewide policies that limit concentration and access to locations that increase access and accessibility of unregulated and/or illicit substances.
Promotion of protective factors and Positive Childhood Experiences (PCEs)	<ul style="list-style-type: none"> • Curricula and training to strengthen parent-child relationships and build family resilience • Strengthening protective factors to help prevent suicide by promoting physical, mental,

Prevention Strategy	Example
Early Childhood and Parenting Programs	<p>emotional, and spiritual wellness (for example, building the problem-solving skills and social support of service members transitioning from the military can help them better cope with future challenges as a veteran)</p> <ul style="list-style-type: none"> • Providing education for parents on monitoring, communication, and setting rules to reduce youth substance use. • 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 weekends and evenings when other services may be limited or unavailable. Warmlines act as a vital bridge, helping individuals manage everyday challenges and work through mental health disorder 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 is 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 prevention.

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

The CalHOPE Warm Line is a peer-run warm line operated by Mental Health Association of San Francisco (MHASF) offering free, confidential emotional support to Californians through phone, text, or chat. 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.

Additionally, CDPH will assess and monitor the role of warm lines as part of its prevention strategy (with a particular emphasis on the role warm lines play in mitigating isolation and loneliness and creating social connections), to gain a better understanding of their impact and develop recommendations for statewide approaches that support greater impact and contribute to population-based prevention priorities.

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

[Community-Defined Evidence Based Practices](#)

The use of Community-Defined Evidence Practices (CDEPs) are effective strategies 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 list²² 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 CBOs receiving CDPH BHSA funding

²² The Biennial List for the CDPH BHSA Prevention Program – 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.

as part of the CDPH BHSA Prevention Program 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.

C. 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, 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 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. Campaign development will ensure that youth voice is integrated as part of co-design to ensure relevance and impact for youth.

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 of suicide and/or mental health disorders 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, Positive Childhood Experiences (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.).

As with the acknowledged relevance and value of the campaign assets noted above, CDPH will also continue to work with state and local partners to learn more from their vast array of knowledge and experience in the prevention field to constantly assess and understand the most strategic approaches to population-based prevention efforts. This will include continued learning and coordination to identify if other assets are available that can be capitalized and leveraged to advanced statewide prevention messaging, especially for specific populations of focus (for example, older adults and veterans)

These types of efforts will also be a focus of the BHSA Implementation Workgroup, with the expectation that partners will bring forward best practices and their resulting impacts as part of that Workgroup’s mission to continuously inform CDPH BHSA statewide program planning. For more information about the Implementation Workgroup, see Section E: Community Engagement and Coalition Building.

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. There is also a lack of awareness and understanding of the 988 Suicide and Crisis Lifeline, especially among individuals from historically marginalized communities,²³ and barriers to reaching out for behavioral health services in general.²⁴ On July 30, 2025, California Governor Gavin Newsom signed an [executive order](#) to address a growing crisis of suicide, mental health disorder, and disconnection among California’s men and boys.

²³ [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](#)

²⁴ [Building California's Comprehensive 988-Crisis System: A Strategic Blueprint](#) (page 34)

A comprehensive approach to behavioral health prevention also requires the acknowledgement of both mental health and substance use disorder needs. As noted in Phase 1 and 2 Guides feedback, stakeholders emphasized that behavioral health must be framed to include substance use disorder alongside mental health disorder 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 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.²⁵ 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.²⁶
- Men had more than 3 times the rate of suicide deaths compared to females.²⁶
- Suicide rates were 1.53 times higher in rural areas than in urban areas.²⁷

There is also longstanding heightened suicide risk among veterans, LGBTQ+ individuals, and those with firearms in the household.²⁸

- Of all older adult suicide deaths in 2023, approximately 28% were known veterans.²⁶
- Firearms are uniquely fatal and the most commonly used mechanism for suicides. Firearms were used in 45% of male and 19% of female suicides.²⁶

To address this urgent, yet preventable issue, CDPH will launch 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.

Public Awareness of 988 Suicide and Crisis Lifeline and Behavioral Health Services:

²⁵ [California State of Public Health Full Report 2024](#)

²⁶ CDPH, Injury and Violence Prevention Branch. (2025, May 1). EpiCenter: California Injury Data Online. <https://skylab4.cdph.ca.gov/epicenter>

²⁷ 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

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

Public awareness of available services is one key factor that influences access to behavioral health. CDPH will launch a new campaign to 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 disorder challenges, economic distress, and structural inequities that give rise to systematic social and economic disadvantages.²⁹ Increased awareness of the impact of substance use on well-being is a critical facet of any effort to decrease substance use.

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 substance use disorder received treatment.³⁰ 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 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 2023.³¹

- Men are disproportionately impacted by drug overdose. The overdose death rate for men in 2024 was more than three times the rate for women.³²
- 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

²⁹ [California State of Public Health Full Report 2024](#)

³⁰ [Substance Use in California, 2022: Prevalence and Treatment](#)

³¹ California State of Public Health Testimony, 2025.

<https://www.cdph.ca.gov/Programs/OPP/CDPH%20Document%20Library/State-of-Public-Health-Testimony-2025.pdf>

³² California Overdose Surveillance Dashboard. <https://skylab.cdph.ca.gov/ODdash/?tab=Home>

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 disorder care and substance use treatment services require a strong and coordinated prevention-focused approach to address substance use disorder before the need for treatment occurs, and to mitigate 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 Campaign³³ 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) and other lifesaving overdose and infectious disease prevention and response services.

To ensure that assets and resources developed by these campaigns are effective, relevant and can lead to sustainable outcomes, CDPH will ensure that the messaging also supports normalizing mental health disorder as a critical protective factor by reducing stigma, encouraging help-seeking behavior and fostering resilience against stressors. The unique campaigns will also act in complementary approaches, reducing intersectional stigma for individuals with co-occurring disorders. CDPH will also involve the community in their co-design to ensure messaging is culturally relevant, trusted, and effective by incorporating local knowledge and lived experiences.

D. 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 prevention strategies by equipping health professionals and other behavioral health prevention stakeholders, educators, and community leaders with the tools to promote 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:

³³ The Substance Use Disorder Awareness Campaign will begin development in 2027/28. CDPH will work closely with DHCS and other substance use disorder experts during 2026/27 to identify existing substance use disorder related assets and resources that could be leveraged or enhanced as part of development for the new campaign.

- 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 those aged 0-5. 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 behavioral health focused coalitions in the development of harm reduction strategies, with focused approaches on stigma and discrimination reduction
- Strength-based resilience training – This training/consultation will be provided to schools, CDEPS, and existing CDPH programs that serve youth populations or other populations of focus. This training will also explore opportunities to expand Safe Spaces curriculum to add caregivers and settings relevant for 0-5 population, and young college-aged students and community colleges. This training will focus building knowledge of trauma-informed principles, health equity principles, and community history. This foundational knowledge is vital for providing trauma-informed programming as well as assessing their organizational policies and processes that may also induce trauma.

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

CDPH will 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 G. 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](#) (Statutes of 2024), 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](#) (Statutes of 2024) is also in production in collaboration with the 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 will also 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 Safe Spaces resources will also be adapted as a new resource for immigrant and refugee populations. 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.

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 CBOs, educational institutions and other external organizations are listed in [SECTION G. FUNDING TO MOBILIZE LOCAL REACH OF STATEWIDE STRATEGIES AND POLICY – Training and Technical Assistance](#).

E. 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. Community engagement efforts will ensure that the voices of populations historically underserved, inappropriately served and unserved are elevated. This ongoing engagement will include:

- Working with local organizations that focus on suicide and overdose prevention/harm reduction and mental health disorder 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 that integrate peers as critical resources for building trust, reducing stigma, and creating community connections and opportunities to uplift stories from people with lived experience. These sessions will also elevate prevention best practices, by identifying opportunities for improving community conditions, including healing circles, restorative justice, and other inclusive practices.
- Working with Tribes through the Tribal Health Equity Advisory Group and ongoing formal Tribal consultation, 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 (including county behavioral health and local health jurisdictions) 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, with the expectation that workgroup partners will bring forward best practices and existing assets and their resulting impacts, and lessons learned from history and experience, all as part of the workgroup's mission to continuously inform CDPH BHSA statewide program planning. They are intended to 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. There 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 adult campaigns, messaging and strategies. This group will help to mobilize and expand local reach of statewide prevention strategies.

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.³⁴ 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. This network will also be a resource for the Implementation Workgroup – acting as the dedicated forum to address youth related issues and inform youth focused solutions and messaging and support monitoring of all BHSA related efforts to ensure that at least 51 percent of BHSA population-based prevention funds are used for programs serving populations who are 25 years of age or younger.

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 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:

- Ensuring that CDEP providers and initiatives are community-driven and maintain cultural affirmation amongst the communities being served.
- Building robust stakeholder relationships, cultivating trust and open communication with all partners.
- Facilitating Statewide Regional Meetings - Guiding collaborative efforts to prevent behavioral 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.

³⁴ In accordance with [WIC § 5892\(f\)\(1\)\(E\)\(ii\)](#)

F. 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 disorder and substance use treatment when and where they need. To achieve this, California has established 14 statewide behavioral health goals³⁵ 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 will be developing an evaluation Framework that will:

- 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

³⁵ (see [DHCS BHSA Policy Manual, section C.2](#))

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, age, ethnicity, language, disability status, 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 and measure progress in addressing behavioral health disparities in populations of focus

CDPH recognizes that shifting to a coordinated, data-driven, population behavioral health approach will take time³⁶. As such, CDPH will phase in requirements and provide technical assistance to programs and key stakeholders.

G. 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.

³⁶ To ensure that the Evaluation Framework is culturally relevant and supports transparency and accountability in its work, CDPH intends to host a webinar and open the DRAFT Evaluation Framework for public comments to create opportunities for feedback and discussion before release of any Final Framework.

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 CBOs³⁷ and Tribes.³⁸

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 the 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.
- 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 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.
- Create and support **culturally rooted community-driven and community informed activities and solutions** recognizing that culturally grounded and community-defined practices from trusted partners with strong local ties are essential for reaching marginalized groups and addressing disparities in behavioral health outcomes. This includes supporting culturally responsive outreach and education.

³⁷ For purposes of BHSA population-based prevention funding, Community-based Organizations are defined as: Non-profit entities (typically 501(c)(3) or fiscally sponsored by one) with strong local ties, providing essential health, social, or support services to underserved communities, to address social determinants of health (SDoH) beyond traditional clinical settings. They act as trusted partners connecting people to resources, filling gaps in care, and helping meet people where they are.

³⁸ 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)

The funding 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, which requires 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.^{39 40 41} 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.

Small and Rural Jurisdictions

The presence of CBOs and CBO infrastructure in smaller and rural jurisdictions is often limited – due to scarcity in funding, capacity challenges that create barriers to sustainability making overly burdensome administrative requirements challenging to comply with, and low population densities that limit an organization's ability to achieve economies of scale. Given these challenges, CDPH will design funding opportunities to ensure that small and rural jurisdictions are still served and funding remains accessible.

Third Party Administrator

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.

³⁹ 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>.

⁴⁰ 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>.

⁴¹ 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.

CDPH will identify third party entities that have established relationships within the 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 operate using **payor of last resort** principles. The limited BHSA funding provided for population-based prevention dictates a focused approach on addressing the most critical needs and addressing gaps in current investments for population-based prevention services populations of focus. BHSA funding should only be used if the ability to access other funding sources for the activity has been exhausted and may not be used to supplant other funding⁴².

Funded implementation partners will be responsible for documenting the investment gaps that BHSA funding is intended to fill. In addition, funded implementation partners must demonstrate how funded activities address priority populations, reduce stigma, and improve equitable access to prevention supports, consistent with statewide goals and the populations of focus established in Section B.

The specific amounts available for each of the funding opportunities noted below [with the exception of the dedicated Tribal Program and the Local Health Jurisdiction (LHJ) Program] will be released within each specific Request for Proposal, which will also include the funding requirements and accountability measures for each of the funding investments noted below. Any unique criteria for serving small and rural jurisdictions will also be incorporated. They are anticipated to be released in early 2026, will be posted on the [CDPH - Transforming Behavioral Health](#) site.

Community-Defined Evidence Based Practices and Evidence Based Practices Program

Beginning with Fiscal Year 2026/27 and ongoing through FY 2028/29, CDPH is investing in a Community-Defined Evidence Based Practices (CDEP) and Evidence Based Practices (EBP) Program to distribute funds to CBOs 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.

⁴² BHSA funds should not supplant other available funding sources, per California Welfare and Institutions Code (WIC) Section 5892: "(viii) Funding under this provision must comply with Section 5891 and shall be used to strengthen population-based strategies and not supplant funding for services and supports for which ongoing funding is available through Children and Youth Behavioral Health Initiative **or other sources.**"

Trusted Messenger Campaign Program

Beginning with Fiscal Year 2026/27 and ongoing through FY 2028/29, CDPH is investing in a Trusted Messenger Campaign Program to award contracts to 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.

These funds will also include dedicated funding and support for [988 Crisis Centers](#), which support behavioral health prevention by acting as a trusted source for those in immediate need, providing immediate, compassionate and tailored support, and building and fostering resilience and empowering individuals to stay connected to care.

Regional Policy Research and Development

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

In a state as vast and diverse as California, there are 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-being⁴³.

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, including those from historically marginalized communities and those with lived experience.

⁴³ [The Health of California: A Regional Perspective](#)

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.

Funded entities 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. Awardees 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 investing funding for CBOs and Tribes for the regional implementation of statewide Focused Set of Strategies and CDEPs.

Because of the vast diversity of the state, regional approaches can often be more strategic and effective in areas such as the rural north⁴⁴ or central valley⁴⁵, 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.

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. Awardees may also work with other stakeholders within the region (especially those focused on serving priority populations) for greater reach and impact. 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.

⁴⁴ [California's Rural North: Health Equity Landscape Scan | California Center for Rural Policy](#)

⁴⁵ [Central California - Regional Health Equity Analysis 2025](#)

Tribal Program

Beginning in Fiscal Year 2026/27 and ongoing, CDPH is investing a total of \$10M annually as dedicated funding to Tribes. This unique program acknowledges the jurisdictional challenges and is intended to specifically address the persistent socio-economic disparities faced by Native American communities.

This funding also includes the use of a Third-Party Administrator and Intermediary that meets the CDPH definition of Tribal Entity. This intermediary will specifically support the needs of Tribal awardees by:

- Providing implementation support – that specifically addresses the challenges of Tribes, including financial and grant management support.
- Providing tailored training and technical assistance that is culturally relevant and driven by the unique needs of Tribes.
- Providing support and expertise in development of an evaluation framework for the Tribal Program that addresses data sovereignty and acknowledges the rights of Tribes to govern the collection, ownership, application and sharing of their data. This support will also ensure that an evaluation framework is culturally relevant is able to contextualize data that reflect Tribal realities.

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.

This Tribal Program is a unique set-aside for Tribes, but Tribes are also eligible entities for other funding opportunities as defined within this section.

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 Funding

Beginning in FY 2026/27 and ongoing through FY 2028/29, CDPH is investing in funding that will allow CDPH to work with CBOs, Tribes, 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), increase efficiency, build 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-risk⁴⁶ 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.
- **People with intellectual and developmental disabilities (I/DD) TTA** – CDPH, in collaboration and coordination with the California Department of Developmental Services, will work to identify a state level partner to provide dedicated TTA for CBOs and other local partners serving the I/DD community, with a focus on the intersection of I/DD and behavioral health.
- **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 and Crisis Lifeline Outreach Campaign 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

⁴⁶ 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

- **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.

CDPH will ensure that TTA providers have demonstrated effectiveness in working with populations of focus, and ensure cultural competency and accessibility is core in their work.

Local Health Jurisdiction (LHJ) Program⁴⁷

Beginning in FY 2026/27 and ongoing through FY 2028/29, CDPH is investing \$12M annually for a funded 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 BHTA prevention community supports that advance BHT.

As conveners, LHJs 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. 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

⁴⁷ Health and Safety Code: [CA Health & Safety Code § 101185](#) (2024)
For a list of eligible Local Health Jurisdictions, [Local Health Services/Offices](#)

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 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 efforts⁴⁸ and Community Reinvestment efforts.⁴⁹

To ensure alignment of efforts across all local stakeholders to achieve the overall statewide goals and outcomes of BHSA, LHJs 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 Area Agencies on Aging
 - Local Education Partners and others that serve children and families
 - County Veteran Services Officers or their designee
 - Regional Centers or other organizations serving the I/DD community

LHJs are also strongly encouraged to include representatives from the priority populations, those with lived experience, and individuals who represent communities that have been

⁴⁸ [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.

⁴⁹ [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.

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 Final Plan.

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 Plan⁵⁰

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 Services 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. Integrating county behavioral health as part of the local prevention coalition is critical for alignment across this local coordination effort. LHJs may also elect to request their county behavioral health department to act as co-leads in these coordinated convenings, especially when prevention intersects referral pathways or crisis response and/or when prevention efforts should align and

⁵⁰ 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](#)

coordinate with other prevention efforts that may be funded by Substance-Use Block Grants or [Drug-Free Communities](#) funded organizations.

The required coordination and coalition development is expected to be integrated into the LHJ Community Health Assessment and Improvement Planning efforts in 2028/29⁵¹ 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. To that effect, LHJs should, where appropriate and feasible, align with and support on-going population-health management efforts as part of their coordination efforts.

[988 Suicide and Crisis Lifeline Outreach Campaign Funding Program](#)

Beginning in Fiscal Year 2027/28 through FY 2028/29, CDPH is investing in a 988 Suicide and Crisis Lifeline Outreach Campaign Funding Program, to award contracts to 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 awardees 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.

⁵¹ 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. 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 \(section B.2\)](#)

Crisis hotlines represent an essential part of the suicide, mental health disorder, 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 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 populations⁵² 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.

H. 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.

⁵² See [Building California's Comprehensive 988-Crisis System: A Strategic Blueprint](#) for more information.

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.

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

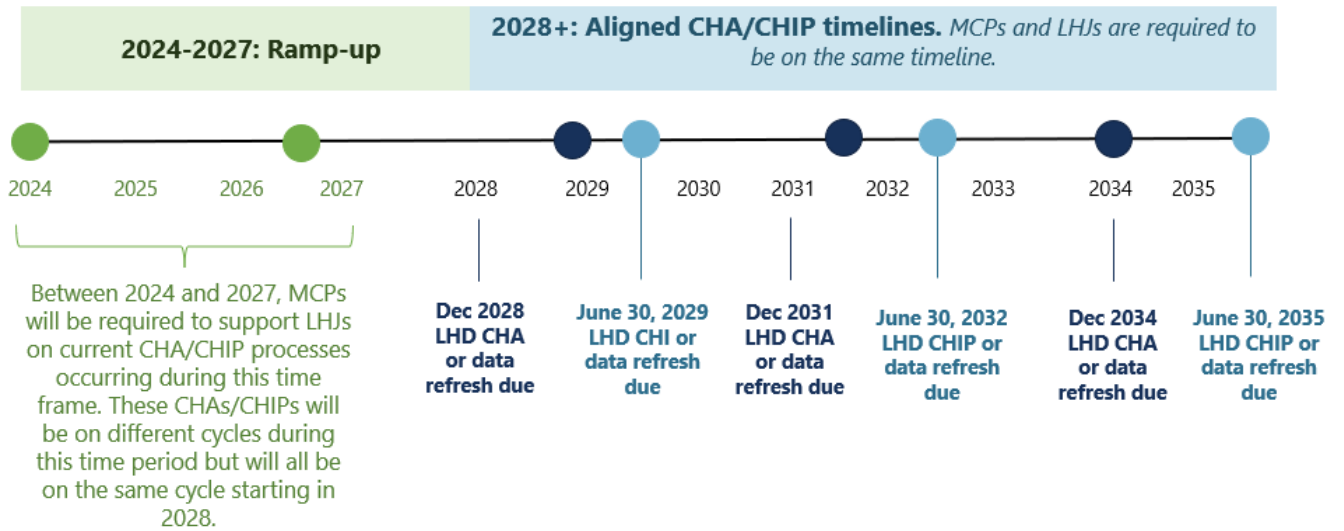


Figure IV – Historical context of MCP, LHD and county behavioral health community planning processes

Mental Health Services Act (MHSA) Expenditure Plans & Community Program Planning:	Community Health Assessment (CHA) and Community Health Improvement Process (CHIP):	Population Needs Assessment (PNA):
<ul style="list-style-type: none"> •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. 	<ul style="list-style-type: none"> •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. 	<ul style="list-style-type: none"> •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.

Phase II – Integration of county behavioral health integrated planning process

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](#) (Statutes of 2023)⁵³ 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 the CDPH BHSAs Prevention Program requires the development of a separate coalition for BHSAs related implementation efforts, the goal ultimately

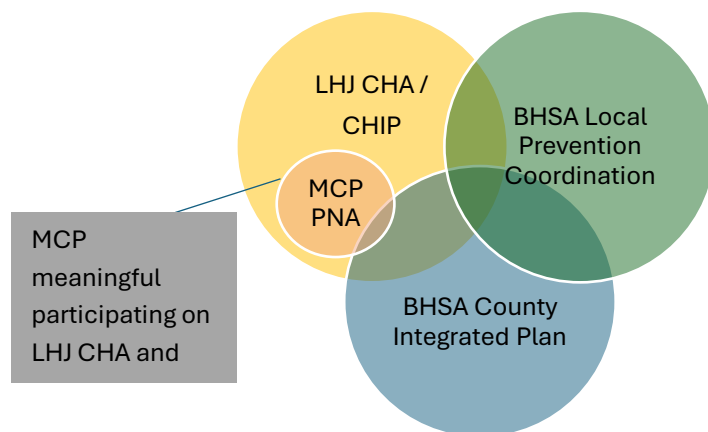
⁵³ The BHSAs was written prior to the 2024 DHCS PNA policy change.

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 V 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 BNSA 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 Final Plan⁵⁴.

Figure V– *Expected initial overlap in planning and coordination efforts*



A Vision for Alignment

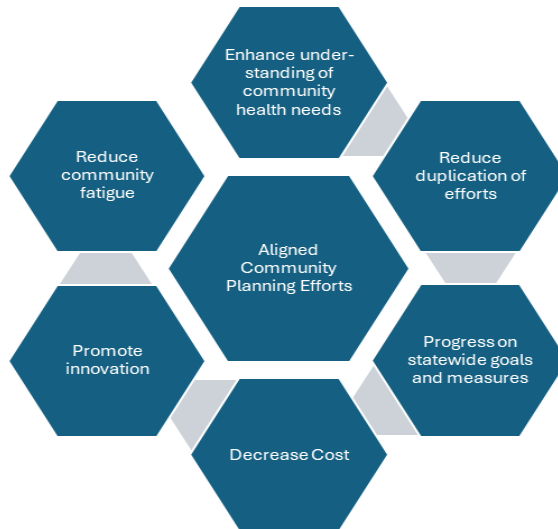
The overall goal of these alignment and integration efforts is to improve upstream interventions and health outcomes for, and thus more effectively improve the lives of, community members and collectively achieve the statewide behavioral health goals.

⁵⁴ 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 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).

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 VII details the timelines for BHSA prevention planning efforts requirements for integration with LHJ CHA/CHIP⁵⁵ – and expected alignment with the Integrated Plan submission.

⁵⁵ Many LHJ CHAs and CHIPs name mental health disorder, substance use disorder 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 and substance use disorder 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

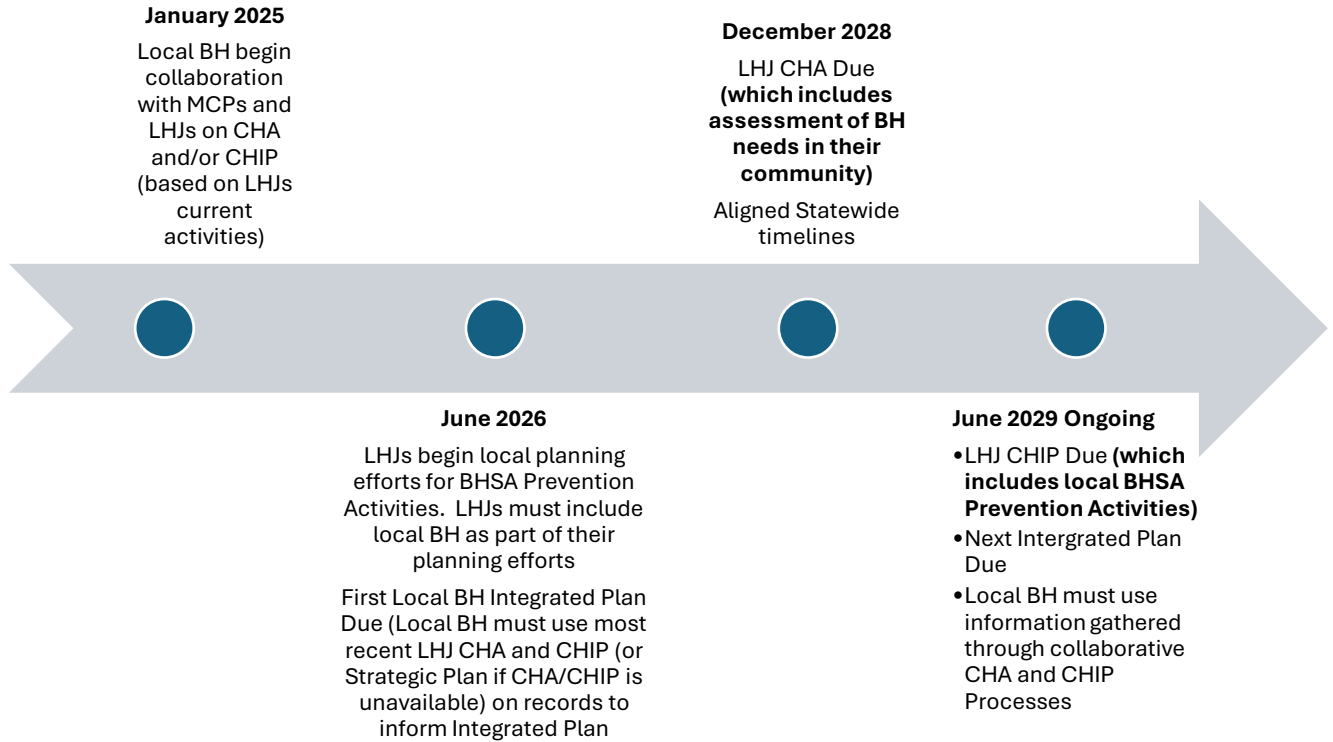
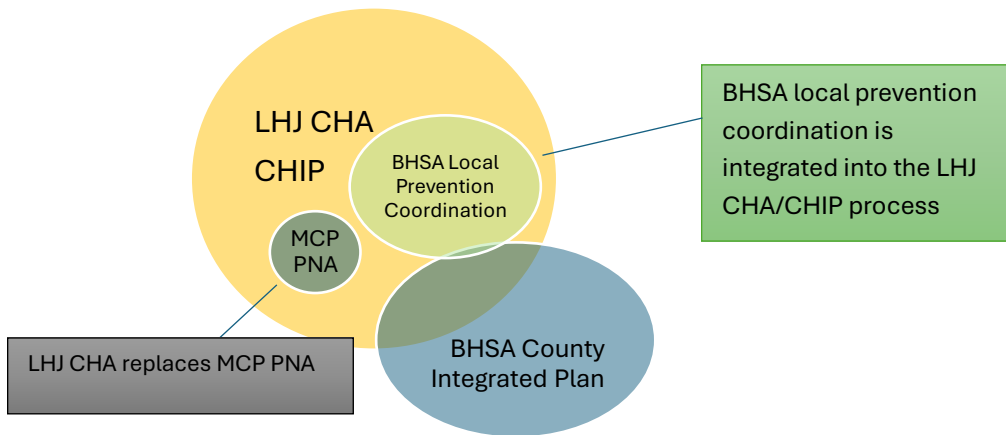


Figure VIII also represents the anticipated overlap, with the local BHTSA prevention programming integrated fully into the LHJ CHA/CHIP planning process.

Figure VIII - Anticipated overlap, with the local BHTSA 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

approach⁵⁶. 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 BHSAs Local Prevention Coordination into the LHJ CHA and CHIP, it will ensure that the BHSAs 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).

I. NEXT STEPS

CDPH will also be releasing any specific funding announcements related to the various funding opportunities mentioned in this Plan during the early part of 2026.

For more information on forthcoming funding announcements, please continue to monitor the [CDPH Website - Transforming Behavioral Health](#) for more information. You may also sign up for continued updates [here](#).

⁵⁶ [DHCS Community Reinvestment All Plan Letter 25-004](#)

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 BHSA FUNDING INVESTMENTS

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	\$5.7M	4%	\$15.7M	12%
Statewide Awareness Campaigns	\$40.3M	30%	\$14.3M	11%
Training and Technical Assistance	\$5.0M	4%	\$6.5M	5%
Community engagement	\$1.5M	1%	\$1.5M	1%
Data and evaluation	\$7.9M	6%	\$9.9M	7%
Local Health Jurisdiction Grant Program	\$12.0M	9%	\$12.0M	9%
CBO Grants	\$34.8M	26%	\$45.3M	34%
Tribal Grant Program	\$10.0M	7%	\$10.0M	7%
Training and Technical Assistance Grants	\$8.5M	6%	\$8.5M	6%
TOTAL Annual (by Component)	\$127.0M		\$127.0M	
Core Staffing	\$7.8M	6%	\$7.8M	6%
Total BHSA Budget	\$134.8M		\$134.8M	
Component	Budget		Budget	
Statewide Strategies	\$69.5M	52%	\$59.0M	44%
LHJ Grants	\$12.0M	9%	\$12.0M	9%
CBO Grants	\$34.8M	26%	\$45.3M	34%
Dedicated funding for Tribal Entities	\$10.0M	7%	\$10.0M	7%
Training and Technical Assistance Grants	\$8.5M	6%	\$8.5M	6%
Total	\$134.8M		\$134.8M	