Behavioral Health Services Act: Population-Based Prevention Program Guide Draft

California Department of Public Health

Contents

Behavioral Health Services Act: Population-Based Prevention Program Guide

Draft

California Department of Public Health

A. Purpose of the Behavioral Health Services Act Population-Based Prevention Program Guide

This Guide is being released in two parts.

- Phase 1: The following sections of the Guide released on June 19, 2025 are one component of a comprehensive plan to be released by CDPH during the summer of 2025. This Guide provides information about the Behavioral Health Services Act, Population-Based Prevention Program requirements, statewide goals, and state level leadership and alignment activities. The development of Phase 1 is rooted in community input including 12 listening sessions and feedback regarding the priority goals and populations of focus reflected in the statewide prevention strategies.
- Phase 2: Following a public comment process on Phase 1, Phase 2 guidance will address the operational and administrative components to execute activities to achieve intended objectives, goals, and outcomes. Phase 2 will also be guided by community input and will include specific funding levels and implementation activities per strategy.

Together the final Plan will cover BHSA Population Based Prevention Strategies 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, as needed, for coordinated and complementary approaches.

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

B. Behavioral Health Transformation

1. 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 problems start.

Behavioral Health Transformation is the 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 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 health prevention including, but not limited to:

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

- Coordinate and align statewide suicide prevention efforts and resources through programs like the Office of Suicide Prevention.

2. Priority Populations[1]

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

3. Statewide Population Behavioral Health Goals

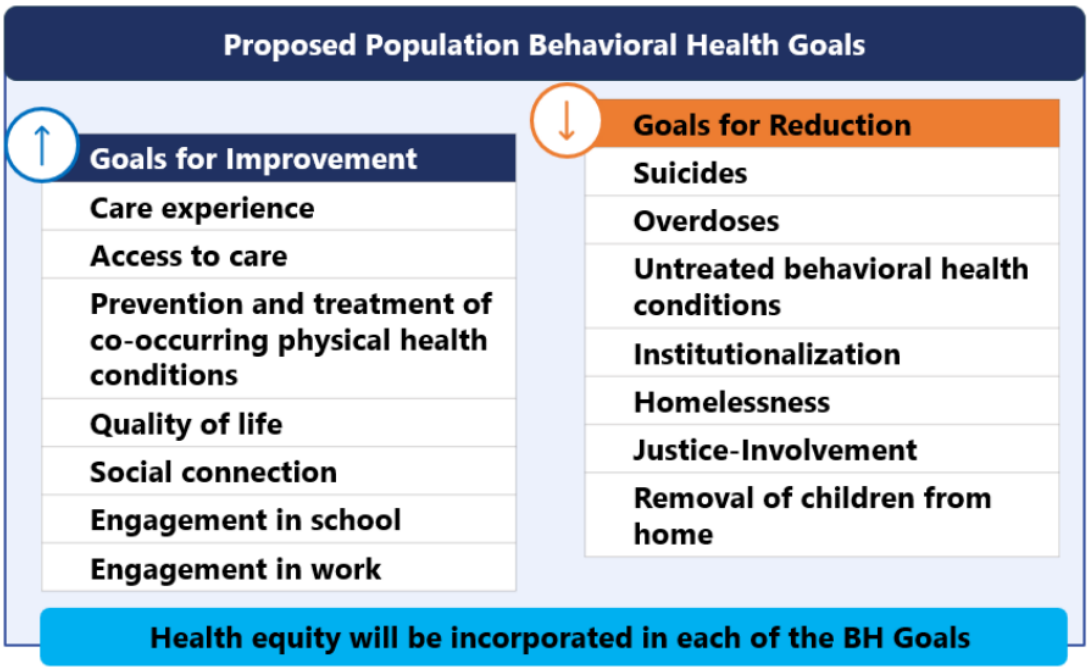
While BHSA priority populations have high needs, behavioral health transformation as part of California's Mental Health for ALL is making sure every Californian—especially people who have had the hardest time getting help—can get high-quality mental health and substance use treatment when and where they need it. To achieve this, California has established 14 statewide behavioral health goals under the leadership of DHCS, in consultation with stakeholders and subject matter experts (see 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 improving 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.

---

[1] **W&I Code §5892, subdivision (d)**

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.



4. Alignment Across the Behavioral Health System

It is expected that BHSA population-based prevention (led by CDPH) and early intervention programming (led by DHCS) will work in tandem across the entire spectrum of prevention and early intervention to create a stronger and more equitable behavioral health system that supports individual needs.

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 such strategies as raising public awareness, reducing stigma, and ensuring access to activities and resources that support well-being (World Health Organization,

2005). 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.

- **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 condition is significantly higher than average, as evidenced by biological, psychological or social risk factors (Kirkbride et al., 2024).

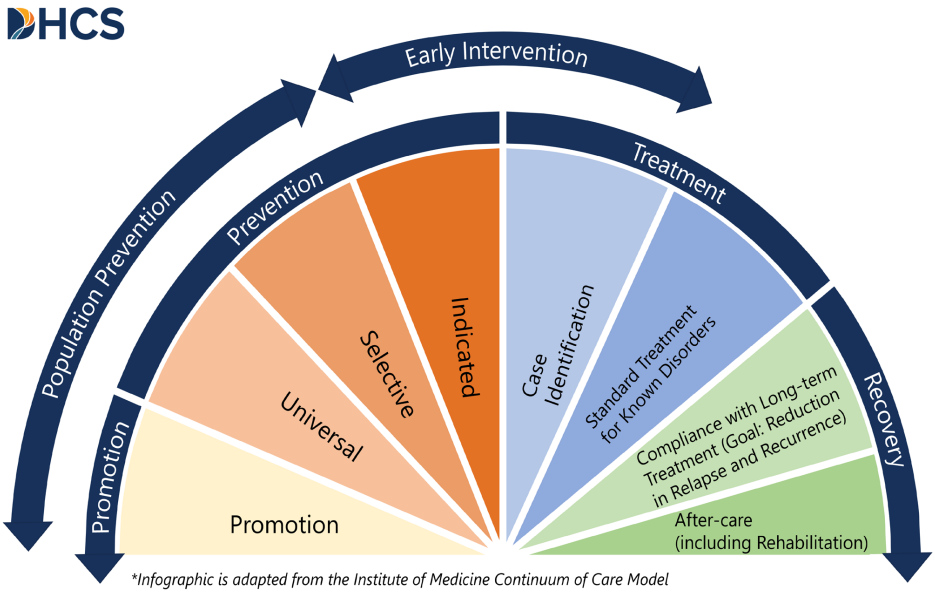
Early Intervention – Led by DHCS

- **Early Intervention** is the proactive approach of identifying and addressing behavioral health concerns in their early stages before they escalate into more severe, disabling or chronic conditions. Under the adapted Institute of Medicine's Continuum of Care Model, Early Intervention includes indicated prevention and case identification.
- **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 - the CDPH Population-Based Prevention Program Guide 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 counties may be funding population prevention services through other sources (e.g., Substance Abuse and Mental Health Administration (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), opioid settlement, Realignment, etc.) that will be captured as part of the county 3-year Integrated Planning process. So, while BHSA funds for population prevention programs are directed to CDPH, it is critical that

alignment and understanding of state-level policy work and local planning efforts[2] happens on an ongoing basis to ensure that healthcare systems, behavioral health, local public health, and community-based organizations across the systems are complementary and unified in 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 investment in a statewide population-based prevention program. This facet involves two major shifts: 1) establishing dedicated resources focused on population-

[2] CDPH and DHCS are working closely to align local planning efforts currently underway, including Local Health Department-led Community Health Assessment / Improvement Plans, Medi-cal Managed Care Population Needs Assessments, and County 3-year Integrated Plans. Further information will be provided in the Phase II Guide. For more information, see the **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)

based prevention and 2) improving the impact of prevention efforts through statewide leadership and alignment.

1. Statutory Requirements

As part of the broader BHSA, dedicated ongoing resources for population-based prevention were established to lead 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:

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.

a. Populations of Focus

Of the five conditions that statute stipulates BHSA population-based prevention programs must meet, two are specific to 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 discrimination[3].

b. Cultural Responsiveness[4]

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

[3] W&I Code § 5892 (f) (1) (E)
[4] W&I Code § 5840.6

historically underrepresented and/or marginalized, as partners in planning, developing, implementing, and evaluating programs and strategies.

c. Use of Evidence-Based, Promising, or Community-Defined Evidence Practices[5]

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 challenges and resulting conditions. Population-based prevention programs must also be responsive to the cultural and linguistic needs of diverse communities.

d. 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 challenges, being diagnosed with a mental illness 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 population-based prevention program, CDPH has identified core strategies for the BHSA Statewide Population-Based Prevention Program that will ensure alignment of population-based prevention activities and contribute to achieving the 14 BHT population health goals.

1. Statewide Prevention Planning

In planning for the development of the Population-Based Prevention Program to meet the intended outcomes and goals of the BHSA, 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.

[5] W&I Code § 5892 (f) (1) (E) (ii)

This process also included review of reports and research[6] 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 in 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 (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) and youth aged 10–18 had the highest rates of self-harm emergency department visits and experienced the largest increase (23.2%) from 2020-2021.

CDPH's approach considers needs and gaps, data, statutory requirements, and input from community partners, to identify population areas for initial strategic investment. They include:

a. Black, Indigenous, and other people of color
b. Children, youth, and families
c. Immigrant and refugee populations
d. Justice-involved populations
e. LGBTQ+ populations
f. Older adults
g. People experiencing economic and/or housing insecurity
h. People with disabilities
i. Rural populations
j. Socially isolated populations
k. Tribal communities
l. Veterans

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

[6] California State of Public Health Report 2024 and Office of Suicide Prevention Youth Suicide Prevention Program Highlights 2023

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[7]

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 with community services addresses 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, 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.

2. Statewide Prevention Strategies

Based on the statewide prevention planning efforts and the input received as part of engagement with subject matter experts, community members with lived experience, and extensive feedback and learnings from those in the behavioral health field working on these issues, CDPH developed the following statewide prevention strategies for implementation. These strategies will create alignment across the state to ensure that the population-based prevention program is focused on advancing statewide BHSA goals and meets the intended outcomes to prevent suicide and overdose. These will be developed with a focus on:

- Leveraging existing capacity, assets and expertise within CDPH and other system partners to build synergy across programs and the state and maximize scalability. For example, development of prevention strategies will start with utilizing the existing expertise of the CDPH Office of Suicide Prevention, California's Strategic Plan for Suicide Prevention *Striving for Zero*, CDPH Office of School Health, and the Overdose Prevention Initiative. It will also leverage the groundbreaking California Reducing Disparities Project (CRDP) and the DHCS Behavioral Health Prevention Plan and others as foundations for this work.

[7] See Appendix B for examples of key prevention strategies that have surfaced through the planning and community engagement process that present opportunities for prevention work to contribute to the population goals and address the BHSA statutory requirements.

- An understanding of key system partner roles and assets to ensure coordination and complementary functions for successful implementation. For example, coordinating with the DHCS Centers of Excellence and the Advance Behavioral Health Prevention California (which provides no-cost technical assistance and training for behavioral health prevention in California) as CDPH considers their implementation of technical assistance and training for behavioral health prevention activities. Leveraging existing statewide efforts, plans, and other system partners in prevention (including those within DHCS, the California Department of Aging, the California Department of Social Services, and the California Department of Education and others) to fill gaps and avoid duplication of efforts.

Statewide Prevention Strategies:

- **Statewide Policy Initiatives**: Recommendations of policy, systems, and environmental actions to advance statewide goals, including reducing suicide, self-harm, and overdose for state and local policymakers to protect Californians.
  Examples include:
  - Developing statewide policy platforms (as part of implementation of AB 1282) to reduce the mental health risks associated with the use of social media by children and youth
- **Focused Statewide Behavioral Health Prevention Strategic Plan:** A focused set of strategies that advance the Statewide BHSA population behavioral goals to ensure implementation alignment across the state. These strategies will be informed by the Statewide Policy Initiatives to drive aligned and complementary efforts across the state.
  Examples include:
  - Strategies (in coordination with the statewide ACEs Aware Policy Initiative) to prevent adverse childhood experiences (ACEs) and promote positive childhood experiences (PCEs) by creating protective environments and strengthening supports for families
- **Statewide Awareness Campaign**: An integrated set of mutually reinforcing public awareness and education campaigns to educate all Californians about mental health illnesses and substance use disorders, including addressing suicide and overdose prevention, stigma reduction around seeking help and opportunities for treatment, promotion of connectedness to raise behavioral health awareness, and support social norms change. These statewide campaign assets can be tailored to local needs and will be informed by Statewide Policy Initiatives to drive aligned and complementary efforts across the state.
  Examples include:
  - Working with trusted partners to deliver locally tailored messages, especially for communities at risk for suicide and/or mental health or substance-induced crises.
  - Uplifting state and local resources, such as warmlines, peer supports, digital self-help resources, and crisis lines and services.

- **Prevention Training and Technical Assistance**: Programmatic technical assistance and subject matter expertise that will equip health professionals, 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. Examples include:
    - Best practice clearinghouse for public health approaches to behavioral health promotion, including strategies to address shared risk and protective factors and reduce stigma
    - Training in behavioral health awareness, including mindfulness, coping, and resiliency strategies, self-regulation, development of protective factors, calming strategies, and communication skills for schools, families, communities, etc., with a focus on suicide and overdose prevention
    - Technical assistance for creating and sustaining behavioral health peer to peer
    - Promotion of community-defined evidence practices and other community-driven, culturally responsive healing practices
    - Support programs, including establishing inclusive safe digital and physical spaces.
    - Training designed to help individuals working with children and youth recognize and respond to signs of trauma and stress.
    - Universal and selective school-based prevention and wellness education, including SEL and behavioral health literacy learning collaboratives and other training for educators
    - Integrated training and systems of support for teachers and school administrators designed to mitigate suspension and expulsion practices and assist with classroom management.
    - Training on group coaching and consultation, designed to prevent substance misuse.
- **Community Engagement and Coalition Building**: Developing relationships with and amongst community to create stigma-free environments and provide ongoing support through proactive outreach and relationship building. Examples include:
    - Develop formal advisory committee to support collective statewide planning and continuous improvement
    - Work with local organizations that focus on suicide and overdose prevention/harm reduction and mental health awareness to engage people where they are and in the communities in which they live.
    - Work with communities impacted by systemic racism and discrimination to develop a deeper understanding of the challenges and experiences to inform a system-wide approach and strategies.
    - Community visits to foster relationships, coordinate prevention strategies, and disseminate resources.
    - Community events and listening sessions to elevate prevention best practices, uplift stories from people with lived experience, and identify opportunities for improving community conditions, including healing circles, restorative justice, and other inclusive practices.

    - Partner with local groups to promote opportunities for volunteerism, civic engagement, intergenerational mentorship, and youth leadership.
- **Data and Evaluation**: Establish an aligned system of metrics, in conjunction with other behavioral system partners, to develop an evaluation framework 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.
  Examples include:
    - Evaluation of CDPH's BHSA population prevention objectives, including key results and impact outcomes.
    - Evaluation of how public attitudes about behavioral health and perceptions of suicide, self-harm, and overdose have changed over time.
    - Data collection and visualization on suicide, self-harm, and overdose, particularly from marginalized communities, to strengthen prevention strategies and inform local interventions and investments.
    - County/local profiles with disaggregated data to support local prevention efforts.

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.*

1. *Population-based prevention programs are activities designed to reduce the prevalence of mental health and substance use disorders and resulting conditions.*
2. *Population-based prevention programs shall incorporate evidence-based promising or community-defined evidence practices and meet one or more of the following conditions:*
    a. *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.*
    b. *Target specific populations at elevated risk for a mental health, substance misuse, or substance use disorder.*
    c. *Reduce stigma associated with seeking help for mental health challenges and substance use disorders.*
    d. *Target populations disproportionately impacted by systemic racism and discrimination.*
    e. *Prevent suicide, self-harm, or overdose.*
3. *Population-based prevention programs may be implemented statewide or in community settings.*
4. *Population-based prevention programs shall* ***not*** *include the provision of early intervention, diagnostic, and treatment for individuals.*
5. *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.*
6. *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:*
    a. *School-based health centers, student wellness centers, or student well-being centers.*
    b. *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.*

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

d. Student mental health first aid programs designed to identify and prevent suicide or overdose.

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

7. 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

This table highlights examples of key prevention strategies that have surfaced through the planning process. Implementation of the statewide program with an emphasis on these strategies reflect opportunities for prevention work to contribute to the population goals and address the BHSA statutory requirements.

STATEWIDE PROGRAM	PREVENTION STRATEGIES*	BHT POPULATION GOALS
• Statewide policy initiatives • Focused statewide prevention strategies • Statewide awareness campaigns • Training and technical assistance • Community engagement and coalition building • Data and evaluation ***All of these components will be based on the foundations already established by the Office of Suicide Prevention (OSP); the Overdose Prevention Initiative; the Office of School Health; the California Reducing Disparities Project and other existing work.***	**Social connection and belonging** • Opportunities for social connection and belonging for all priority populations, with a focus on youth and families • Restorative justice and harm reduction • Community-driven, intergenerational, and culturally based healing • Relationship-promoting infrastructure within key institutions • Promoting positive childhood experiences (PCEs) by creating protective environments and strengthening support for families **Quality of Life: Mental health and well-being awareness and development** • Universal and selective school-based prevention and wellness education • Peer-to-peer support programming • Training on behavioral health awareness for schools, families, communities, etc. • Public education and awareness campaigns	**Goals for Improvement** • Care experience • Access to care • Prevention and treatment of co-occurring physical health conditions • Quality of life • Social connection • Engagement in schools • Engagement in work **Goals for Reduction** • Suicides • Overdoses • Untreated behavioral health conditions • Institutionalization • Homelessness • Justice-involvement • Removal of children from home