Final

California Department of Public Health Population-Based Prevention Strategy Resource Guide: Community-Defined Evidence Practices in Social and Behavioral Health

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CDPH
California Department of Public Health

Table of Contents

Introduction and Purpose 2
Resource Overview 4
BHSA Population-Based Prevention Requirements 4
Focused Strategies for Population-Based Prevention 5
Community-Defined Evidence Practices (CDEPs) Overview 5
Developing, Implementing, and Evaluating CDEPs 6
Eligible community-defined evidence practices 8
Eligible intended outcomes 11
Eligible service populations 14
Additional Resources 15
Appendix A: Practice List of CDEPs with Population Prevention Components only 16
Appendix B: Population-Based Prevention vs Early Intervention Factsheet 31

Introduction and Purpose

As part of the Behavioral Health Services Act (BHSA), the California Department of Public Health (CDPH) has been allocated funding to address behavioral health prevention.[1] On March 11, 2026, CDPH released its CDPH-BHSA-Population-Based-Prevention-Final-Plan.pdf. The Final Plan provides the community and other behavioral health partners CDPH's Final Plan (Plan) and strategic approach to implement Behavioral Health Transformation, which incorporates Community-defined Evidence Practices (CDEPs), as defined by BHSA statute.[2] "Community-defined evidence practices" is defined as an alternative or complement to evidence-based practices, that offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. 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. [W&I Code §5892 (k) (6)]

The CDPH approach to population-based prevention focuses on coordinated, state-led, statewide approaches that are grounded on social drivers of health and broad prevention strategies. These are intended to reduce poor outcomes using strategies such as increasing public awareness, reducing stigma, and supporting well-being, which cultivate environments and conditions that benefit health and the ability to withstand challenges. It encompasses promotion, universal prevention and selective prevention. As dictated by the BHSA, population-based prevention programs do **not** include the provision of early intervention, diagnostic, and treatment for individuals.[3] The Department of Health Care Services (DHCS) has developed a separate Children and Youth Evidence-Based Practices and Community-Defined Evidence Practices (EBP/CDEP) Resource Guide specific for early intervention and various other services and should be considered separate and apart from this Guide. The guide DHCS released outlines Medi-Cal billing options for EBPs and CDEPs supported through the Children and Youth Behavioral Health Initiative (CYBHI), - California Code, WIC 5961 Family First Prevention Services Act (FFPSA), particularly focused on children, youth, and families.

CDPH and DHCS both recognize 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,

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

[2] W&I Code § 5892 (f) (1) (E)

[3] Population-based prevention programs shall not include the provision of early intervention, diagnostic, and treatment for individuals. W&I Code § 5892 (f) (1) (E) (iv)

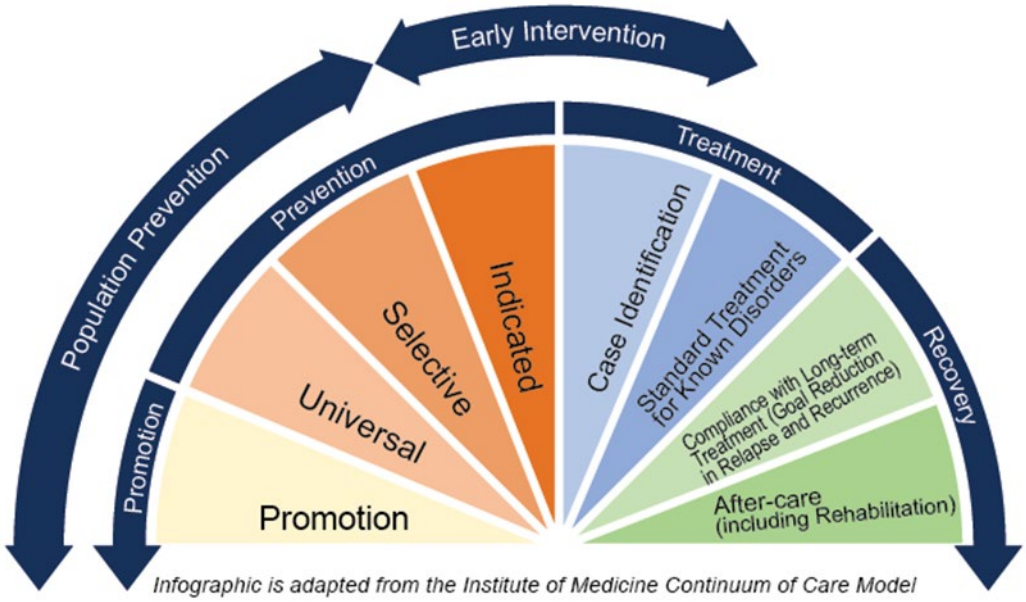
adapted from the Institute of Medicine, Continuum of Care Model). The efforts of CDPH and DHCS are expected to be complementary and aligned to ensure a coordinated approach to behavioral promotion, prevention and early support along the prevention continuum to reinforce protective factors, limit exposure to risk factors and provide services and supports to address the behavioral health impacts affecting our communities.[4] Please see Appendix A as well as the CDPH website for FAQ around population-based prevention and early intervention.

The BHSA also transforms local planning process into a broader county and regional planning process, with a focus 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. County behavioral health, MCPs, and Local Health Jurisdictions (LHJs) 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. DHCS and CDPH are implementing a cohesive set of policies to align community planning processes among county behavioral health, LHJs and MCPs.

CDPH also recognizes that many CDEPs currently implemented in California offer a mix of prevention and early intervention services, offering a more holistic approach. CDPH encourages communities to consider ways to leverage funding across multiple sources, or braid funding, to meet their community needs.[5]

[4] The Biennial List for BHSA Population-Based Prevention – Community-defined Evidence Practices provided by CDPH is 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. This list was developed and disseminated separate and apart from the biennial list issued by DHCS (which is specific to EBPs and CDEPs for Early Intervention efforts).

[5] The DHCS EBP-CDEP-Resource-Guide offers considerations for Medi-Cal reimbursement of CDEP components that do not meet the definition of population-based prevention as defined by BHSA. For more on alternative funding sources that can be leveraged, see the CDPH/DHCS Prevention vs Early Factsheet.



Infographic is adapted from the Institute of Medicine Continuum of Care Model

Resource Overview

This resource guide is intended to serve as an optional reference tool for local partners and Local Health Jurisdiction (LHJ) coordination efforts. CDEPs described in this guide address unique behavioral health issues impacting diverse California communities. Both LHJs and Community-Based Organizations (CBOs) receiving CDPH BHSA funding for population-based prevention programming should use this resource as an opportunity to inform local coordination, develop local suicide prevention plans, and implement culturally responsive services to meet the social and behavioral health needs of their populations.

BHSA Population-Based Prevention Requirements

Through BHSA, CDPH aims to fund population-based prevention efforts designed to reduce the number of Californians experiencing mental health and substance use disorders.

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 (EBPs) or CDEPs 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[6] and meet one or more of the following criteria[7]:

1) benefit the entire population of the service area,
2) serve populations at elevated risk,
3) reduce stigma associated with help seeking mental health challenges and substance use disorders,
4) serve populations disproportionately affected by systemic racism and discrimination, or
5) prevent suicide, self-harm, or overdose.

All funded CDPH Population-based prevention strategies must aim to reduce stigma and discrimination. For additional details see here: Behavioral Health Services Act (BHSA): Population-Based Prevention Program Final Plan

Focused Strategies for Population-Based Prevention

CDPH has developed a focused set of strategies that advance the statewide BHSA population behavioral health goals to prevent suicide, self-harm and overdose. CDPH identified strategies from peer-reviewed studies, government and non-profit reports, review of strategic plans from similar initiatives, and consultation with subject matter experts focused on advancing the statewide BHSA goals. The use of CDEPs are effective strategies for addressing behavioral health disparities and complement evidence-based practices. CDEPs offer culturally anchored interventions that reflect the values, practices, histories, and lived experiences of the communities they serve. 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.[8]

Community-Defined Evidence Practices (CDEPs) Overview

“Community-defined evidence practices” is a broad term that covers a range of programs, projects, services, and supports that share three characteristics (Hawai’i Strategic Prevention Framework, 2026):

a) culturally grounded practices,
b) community-driven development, and
c) effectiveness demonstrated through real-world experience.

The use of CDEPs is an effective strategy for addressing behavioral health disparities. CDEPs complement EBPs, that offer culturally anchored interventions that reflect the

[6] W&I Code § 5892 (f) (1) (E)
[7] W&I Code § 5892 (f) (1) (E) (ii)
[8] W&I Code § 5892 (k) (6)

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. CDEPs have been shown to be effective across a range of health outcomes including increased awareness and knowledge of substance abuse, reduction in school dropout rates, increased self-esteem, and increased sense of social support (Echo-Hawk, 2011). By comparison, EBPs are manualized interventions that have demonstrated evidence through positive outcomes in rigorous testing through multiple studies—often including randomized controlled trials.

CDEPs were largely practices which communities used, regardless of formal testing, and were determined through community consensus over time to reach a level of acceptance of positive benefit (Martinez, 2008).

With an increasing awareness of the benefits of community-driven solutions, communities have explicitly set out to develop CDEPs. In 2009, CDPH initiated the California Reducing Disparities Project (CRDP) to identify solutions for historically unserved, underserved, and inappropriately served communities. CRDP funded 35 different CDEPs across five priority populations, specifically African Americans, Asian and Pacific Islander Americans, Latine Americans, Native Americans, and the Lesbian, Gay, Bisexual, Transgender, and Queer communities. A statewide evaluation found that CRDP CDEPs increased access to mental health services and improved mental health among participants, strengthened communities' capacity to respond to their own mental health needs, and yielded a return of approximately five dollars for every dollar invested in prioritizing prevention and early intervention (Psychology Applied Research Center, 2022). The Community-Defined Evidence Practices Program, also known as the *Community-Driven Behavioral Health Initiative* builds on the successes and lessons learned from the CRDP.

Developing, Implementing, and Evaluating CDEPs

Rather than serving as a program model that others can replicate in their community, a CDEP is a prevention strategy that heals through a community's unique culture by fostering cultural connection and community building; capitalizing on their cultural beliefs, values, and practices; and engaging the expertise of community members in its design, implementation, and evaluation.

Communities can develop CDEPs by:

1) adapting an EBP to meet their community's needs,
2) adapting another CDEP to meet their community's needs, or
3) implementing a long-standing community accepted practice.

Regardless of origin, CDEPs must be developed locally with significant community input. Development criteria include practices that the community considers successful, perceives and rates positively, or has assisted in creating.

When developing or modifying CDEPs, the following essential elements must be included (Callejas, 2019).

- Acknowledge people living in the same environment (in all forms) the centrality of the family (in all forms), including participating families when possible.
- Address individual needs holistically
- Address stigma, using culturally relevant terms
- Provide services in comfortable and familiar practice settings.
    - To maximize accessibility, CDPH encourages community identification of implementation settings and/or meeting the community where they already gather (e.g., community centers, healthcare facilities, religious and faith-based institutions, schools).
- Provide collective healing or group-centered practice implementation.
- Establish and maintain ongoing dialogue with program participants and other community members.
- Increase community connections.

CDEPs have several considerations for implementation. CDEPs require evidence using culturally- and/or community-based metrics of efficacy, so incorporating users' worldview, cultural context, and personal interpretation is paramount to the intervention's success. Given the centrality of community in interpretations of success, implementation should consider the intended population's historical and current trauma, immigration and generational status, socioeconomic status, preferred language and communication styles, and practices of traditional beliefs, values, rituals, and spirituality.

Evaluations of CDEPs are based on the service users determining whether a practice works for them through its acceptance and sustained use, and through evidence of positive outcomes that the service users define—based on their own parameters and priorities—as constituting success (Martinez et al., 2010). As effective and culturally appropriate practices may not have undergone empirical study or formal documentation (Callejas et al., 2010), CDEPs should be implemented with robust data collection, implementation monitoring, and evaluation.

The benefits of CDEPs include their support of positive cultural attributes of the local community rather than reliance on dominant worldviews, development and implementation of practices tailored to and approved by the communities served, vested interest from the community through their input and collaboration, and drawing from a community's expertise based on life experience and historical trauma, and knowing

what works for them (Psychology Applied Research Center, 2022). Given that communities influence their development, CDEPs are more likely to cultivate trust, engender engagement, and foster enduring change (Echo-Hawk, 2011).

CDEP Eligibility for CDPH Funding

CDPH is committed to improving social and behavioral health and wellbeing across California communities through a collective impact approach. A collective impact approach requires a common agenda, shared measurement, mutually reinforcing activities, continuous communication and supporting infrastructure. This section defines the reinforcing activities (i.e., CDEP practices) and the common agenda (i.e., outcomes and priority populations) that will guide this program. Applicants are required to include the practices, outcomes, and priority populations outlined in the sections below in their proposed CDEP.

Eligible CDEPs

CDPH identified the following set of CDEPs components eligible for BHSA population-based behavioral health prevention funding. These CDEPs were identified by:

- reviewing the list of CDEPs from the Community-Defined Evidence Project (Callejas, 2008; Martinez et al. 2010), a partnership between the National Latino Behavioral Health Association and the National Network to Eliminate Disparities that informed the CDEP typology for the CRDP;
- reviewing evaluation reports from CRDP grantees to determine which CDEP components had the strongest evidence to support intended outcomes. Strength of evidence was determined by summing five qualifications:
    - used pre-post treatment data,
    - used standardized or locally adapted metrics,
    - compared pre-post results using t-tests,
    - produced statistically significant quantitative results at $p<.05$, and
    - produced qualitative results that complemented the quantitative results;
- reviewing the literature on causal and prevention pathways related to substance use, self-harm and suicide to identify relevant intermediary outcomes and strategies for prevention focus; and,
- identifying CDEP strategies focused on population-based prevention activities.

CDEPs funded through CDPH must include both strategies A and B and at least one other strategy from C-F.

Required Strategies:

A. **Raise awareness about behavioral health**. These practices focus on raising awareness and decreasing stigma across a range of behavioral health services and challenges and doing so in ways that are broadly accessible and culturally relevant. This may look like providing a community-tailored mental health resource guide like in the CRDP-funded Healthy Heritage Movement project, or providing education on mental health, stress, and coping using resources from California's Take Space to Pause campaign adapted to your community.

B. **Conduct community outreach.** These practices focus on the various bi-directional efforts used to connect with community and populations of focus. These practices may be used to increase reach, identify needs, or provide follow-up by meeting community members where they are. This may look like community members and trusted messengers conducting outreach and education in community spaces (schools, church, senior centers, streets) or at events (fairs, concerts, sport) such as in the CRDP-funded Health Right 360 Asian American Recovery Services. These practices also include the ongoing community and participant feedback cycle needed for CDEP implementation.

Must include at least one of the following strategies:

C. **Conduct innovative engagement.** These practices focus on activities designed to establish rapport between grantees and participants and to increase grantee knowledge of what is important and relevant to participants. Often, these practices are culturally grounded, for example, the workshops teaching traditional artistic activities such as music and dance provided by the CRDP United American Indian Involvement program, providing shared benefits for participants and grantees.

D. **Organizational Trauma-Informed Practices**. Organizational trauma-informed practices are implemented within organizations to enhance and build knowledge of trauma-informed principles, health equity principles, and community history. These practices are vital for the development of culturally relevant prevention strategies and to diminish cultural misunderstandings in the development of programming and services for the communities they serve. This foundational knowledge is vital for providing trauma-informed programming as well as assessing organizational policies and processes that may also induce or reinforce trauma. This may also include cultivating acceptance training for teachers, school administrators and other school staff in order to create safe, supportive learning environments for culturally competent social, emotional learning, as seen in the CRDP-funded San Joaquin Pride Center.

E. **Strengthen pathways for accessing culturally informed behavioral health education and prevention supports.** These practices are focused on connecting, facilitating, and encouraging participants to access supportive and resilience-building services by increasing awareness of resources, trust in support available, and willingness to engage with local behavioral health care services to complement their CDEP participation and provide more holistic care. An example of using this strategy is the CRDP funded Latino Service Provider's Youth *Promotores* Program which seeks to raise awareness of behavioral health services, break down cultural and systemic barriers, and guide peers toward help-seeking behaviors, doing so by combining career pathway exposure, community education, and youth-centered leadership.

F. **Build community capacity or increase individual civic engagement.** These practices include a broad range of activities designed to strengthen behavioral health by building connections within local communities, promoting shared responsibility, and offering helpful information. Practices to improve the capacity of the community may look like West Fresno Health Care Coalition's CRDP-funded program teaching youth about sweet potato farming and business skills to foster community-level entrepreneurialism. Practices to increase individual civic engagement may look like the CRDP-funded Village Project's funded summer program teaching children about African cultural values of communalism and collective power. Practices to build community capacity and civic engagement may look like the CRDP-funded California Black Women's Health Project's program, Sisters Mentally Mobilized, through their 10-week cohort, educating and equipping Black women in mental health first aid, community engagement and training participants on how to cultivate a powerful presence in civic spaces.

Note: Communities proposing to implement a locally adapted EBP or program model must include required strategies A, B and at least one from C-F to be eligible for funding. See below for Figure 1.

CDEPs funded under Community-Defined Evidence Based Practices and Evidence Based Practices Program must include Strategy A and B and at least one or more from strategies C-F.

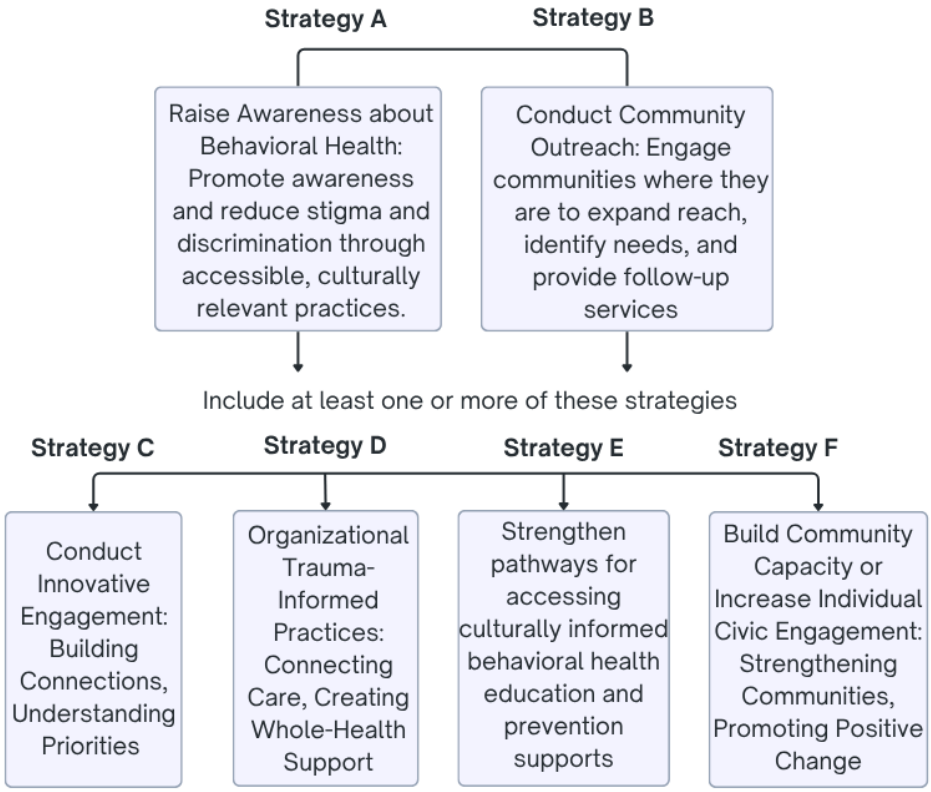


Figure 1: CDPH Population-Based Prevention CDEP Required Strategies

Eligible intended outcomes

BHSA aims to address 14 population behavioral health goals (Figure 2). CDPH recognizes that these goals are interconnected, bidirectional, and represent conditions and prevention pathways across the continuum of behavioral health needs.

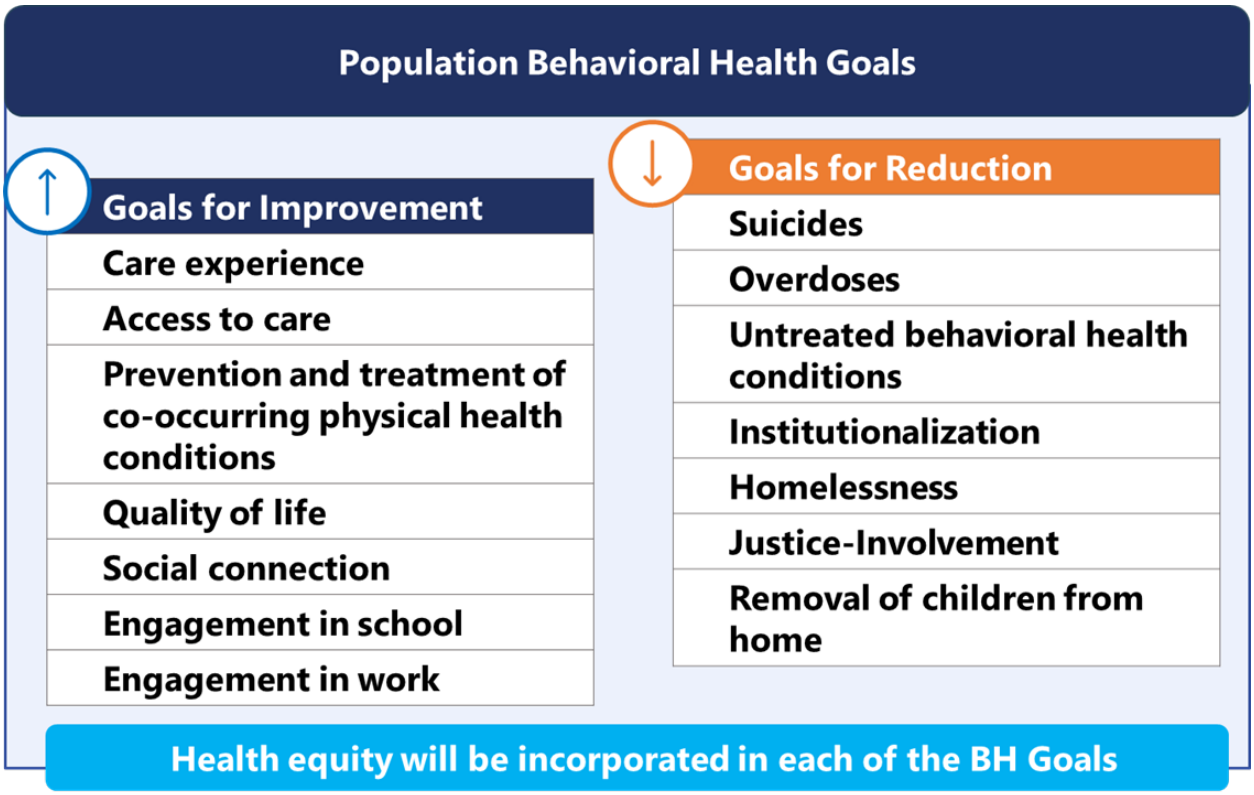


Figure 2: Statewide Population Behavioral Health Goals

To improve the likelihood of observing a collective impact of the CDPH BHSA CDEP funding, CDEPs eligible for CDPH prevention funding must aim to prevent suicide, self-harm and overdose, and reduce stigma associated with help-seeking behavior[9].

There are extensive bodies of research and centuries of community wisdom on prevention pathways for overdose and suicide. While these outcomes share some common causes, others are unique. With a focus on population-based prevention, CDEPs must include efforts to reduce stigma and discrimination and increase behavioral health knowledge (see non-exhaustive list of community-defined evidence practices). Programs are encouraged to address additional outcomes along the prevention pathway and will be required to describe how addressing those outcomes will advance the statewide behavioral health goals. For example, the CRDP-funded Native American Health Center implements a community event called “Gathering of Native Americans”, a manualized curriculum that aims to improve cultural connection and sense of self. By improving cultural connection and sense of self, the Native American Health Center program seeks to address mental health stigma, family health,

[9] W&I Code § 5892 (f) (1)

violence, suicide and other mental health and substance use disorder conditions. Other shared contributors to positive behavioral health outcomes include:

- **Emotion regulation** is the ability to exert control over one's own emotional state. Effective emotion regulation reduces anxiety, depression, and impulsiveness, fostering healthier connections, better coping, and greater life satisfaction. Development of emotional regulation begins in the first year of life through a co-regulation process between infants and caregivers. Some strategies for improving emotion regulation include promoting mindfulness and meditation, supportive relationships, restorative practices (e.g., sleep, physical activity, nourishment), and cognitive reappraisal strategies. Cognitive reappraisal strategies focus on modifying cognitive schemas, or the collections of basic knowledge about a concept or entity that serve as a guide to perception, interpretation, imagination, or problem solving. Schemas develop over time through experience. Promoting positive experiences can also serve to modify schemas as individuals learn new ways to interact and think about the world.
- **Social connection.** Humans are a social species. Those with strong interpersonal connections experience greater health and well-being. In the brain, the emotional experience of social pain is governed by the same systems that respond to physical pain. Strategies for reducing social isolation and loneliness promote authentic human connecting, such as promoting pro-social activities (e.g., volunteering, sports, church) and other cultural and social connections, while emphasizing the importance of one-on-one time to build relationships within the planned activities.
- **Trauma-informed care (including cognitive and emotional regulation)**. Experience of stress activates the body's hypothalamic-pituitary-adrenal axis, the body's central response system, resulting in a series of physical, cognitive and emotional responses. Sustained stress damages the body, creating lasting impacts. Stress can come in many forms, including daily hassles, major life events, and traumatic events. Some strategies for addressing trauma and stress include improving positive childhood experiences and limiting adverse childhood experiences, providing education on the body's stress response and coping mechanisms, promoting cognitive reappraisal strategies, social connections, and restorative practices (e.g., sleep, physical activity, nourishment), reducing environmental hazards, improving individual resources, promoting pro-social activities (e.g., volunteering, sports, church), and improving planning and organizational skills.
- **Sense of Purpose, Autonomy, and Growth.** Human behavior is goal-directed. People thrive best when they have a clear sense of purpose in life, can express their own will, have personal autonomy over life outcomes, and have opportunities for continued growth. Some strategies for improving sense of purpose, autonomy and

growth include promoting pro-social activities (e.g., volunteering, sports, church), promoting cultural and social connections, and providing opportunities for peer-leadership, participant-governance and individual skill development.

The pathways outlined here are not meant to be exhaustive or prescriptive. Proposed CDEPs do not need to address these specific prevention pathways but must be able to describe how the strategies and activities they implement will advance the statewide behavioral health goals.

Eligible service populations (Populations of focus)

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[10]. 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 discrimination:
    a. Black, Indigenous, Latino, Asian and 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
    f. Tribes
    g. Veterans

[10] W&I Code §5892 (d)

CDPH will prioritize CDEPs designed with and serving communities that are at the intersection of two or more focus populations (e.g., older veterans, refugee families, Tribal youth).

Additional Resources

For an overview of CDPH's BHSA planning efforts, please visit the Transforming Behavioral Health webpage, which includes:

- **CDPH BHSA Population-Based Prevention Final Plan**
- **CDPH BHSA Population-Based Prevention Final Plan FAQ**
- **BHSA Prevention versus Early Intervention Factsheet**

For more information about the CRDP visit: www.CultureIsHealth.org

Appendix A: Practice List of CDEPs with Population Prevention Components only

Below is a non-exhaustive list of previously funded CDEPs that meet the funding requirements of BHSA Population-Based Prevention CDEPs:

CDEP Name / Website/ Key Populations	CDEP Service Area by Region/ County	Population Prevention CDEP Description
WEST FRESNO FAMILY RESOURCE CENTER https://www.wfresnofrc.org/ Key Population: African American youth ages 12-15	**Region: Southern** San Joaquin Valley **County:** Fresno	The Sweet Potato Project works directly with African American youth ages 12-15 in Southwest Fresno to reduce and prevent school dropout, gang involvement, and substance use initiation. This culturally responsive program stems from the historical and cultural roots of Black farmers. By teaching youth how to plant seeds, harvest crops, and apply entrepreneurial and business skills to market and sell their products, the Sweet Potato Project decreases internalized oppression and hopelessness while increasing a positive Black identity, collective economic activity, college intentions, and leadership development.
UNITED AMERICAN INDIAN INVOLVEMENT https://uaii.org/ Key Population: AI/AN families	**Region/County:** Los Angeles	The Native American Drum, Dance and Regalia (NADDAR) program recognizes the need to reduce mental health disparities among urban American Indian/ Alaska Native Families in Los Angeles County by incorporating culturally sensitive and community-based methods to address mental health issues (e.g., depression, anxiety, isolation, and substance use) and strengthen community/ cultural connectedness, spirituality, cultural identity, and family cohesion. The workshops are centered around important healing practices of AI/AN culture and history (e.g., drumming, dancing, regalia making) that have been utilized for many centuries among indigenous populations to promote wellness and self-expression.
TWO FEATHERS NATIVE AMERICAN FAMILY SERVICES	**Region:** North Coast **Counties:** Del Norte, Humboldt	The Stick Game and Flower Dance projects were created to help the Native American Community recover from the historical trauma associated with forced assimilation, genocide and disconnection from family, community and spirituality by

www.twofeathers-nafs.org Key Population: AI youth ages 6-18 including their families and community at large		connecting American Indians with ancestral, culturally based wellness practices. The stick Game and athletic activity integrate cultural teachings with gameplay. The Flower Dance is a celebratory acknowledgment of young girls' transition into womanhood. Year-long preparations for both events involve the entire community in activities such as stick game, tool making, team exercises, cultural mindfulness and singing.
NATIVE AMERICAN HEALTH CENTER (lead agency) www.nativehealth.org Grant Partners: Fresno Indian Health Project; San Diego Indian Health Project Key Population: Urban Indian youth and their families	**Region:** San Francisco/ Bay Area, Southern San Joaquin Valley, Superior CA, San Diego Imperial **Counties:** Alameda, Contra Costa, Fresno, King, Sacramento, San Diego, San Francisco, San Mateo	Gathering of Native Americans (GONA) addresses mental health stigma, family health, violence, suicide, and other mental health conditions, including the strengthening of protective factors in Urban Indian communities. The GONA brings youth and their families together for a four-day retreat to guide their experiences in healing from historical, intergenerational trauma that has led to increased mental illness and trauma among Native communities. GONA participants actively work to identify approaches to healing the community, a process that results in self-reflection, increased understanding of the root causes of health disparities in Native communities and increased individual healing and resiliency.
INDIAN HEALTH COUNCIL www.indianhealth.com Key Population: Native American youth and families	**Region:** San Diego **Imperial County:** San Diego	REZolution was designed to increase healthy self-expression through the performing and fine arts among individuals and families who may be at risk for early onset mental illness. Through a series of community-wide events, REZolution integrates cultural practices, tribal traditions, and tribal values into mental health services. REZolution restores wellness and balance to families and youth, and reduces high rates of domestic abuse, suicide, school failure, and severe mental illness among Native American families.

HEALTH RIGHT 360 ASIAN AMERICAN RECOVERY SERVICES www.healthright360.org/agency/asianamerican-recoveryservices Key Population: Samoan and Tongan families	**Regions:** San Francisco/ Bay Area **Counties:** San Francisco, San Mateo	The Essence of MANA serves Samoan and Tongan families in Northern San Mateo County, which has the highest proportion of Native Hawaiian and Pacific Islander families among all counties in California. It provides a space for families to discuss culturally tailored topics, socialize, and increase their community involvement. Additional outreach activities help raise awareness surrounding mental health conditions through engagement with individuals and families, distribution of bilingual materials, and facilitation of access to mental health resources. MANA aims to improve communication skills among family members, build leadership skills and community involvement, increase knowledge of mental health issues, reduce stigma surrounding mental health challenges, and increase access to culturally supportive care and services.
African Communities Public Health Coalition https://africancoalition.org/youth-ambassadors/ Key Population: Ages 13-17, Young adults/TAY	**Region:** Los Angeles	The Let's Do It! Youth Mental Health Ambassador Campaign engages youth ages 13–24 in education and outreach to advance mental health awareness in underserved communities. Ambassadors receive training to lead culturally responsive events that promote wellness, reduce stigma, and increase access to resources. Activities include art workshops, wellness retreats, and educational forums designed to meet the diverse needs of young people across communities.
Aspiranet https://www.aspiranet.org/thrive Young adults/TAY, Foster Youth	**Regions / Counties** San Joaquin, Stanislaus	Aspiranet's Thrive Together campaign engages youth and young adults—particularly those who are Latino, Black, LGBTQ+, in foster care, or justice-involved—to challenge stigma and strengthen mental well-being. Led by an active Youth Council, the campaign has built a strong online presence through social media platforms that foster connection and dialogue. In addition to its digital engagement, Thrive Together reaches youth directly through in-person outreach, community events, and educational presentations—linking them to valuable mental health resources. Additionally, Thrive Together videos are now playing in Stockton

		and Modesto theaters as movie theater pre-movie ads and campaign messages are installed in the community on local buses and at bus shelters.
CalPride https://calpride.org/ Ages 6-12, Ages 13-17, Young adults/TAY, Caregivers of children ages 6-12, Caregivers of adolescents ages 13-17, African American or Black persons, Latino or Hispanic persons, LGBTQ+ persons, Foster Youth	**Region/County** Amador, Calaveras, Madera, Mariposa, Merced, Stanislaus, Tuolumne	Call Up a Friend is a youth-driven initiative developed through CalPride's Children and Youth Behavioral Health Initiative – Community Alliances for Local Impact (CYBHI CALI) grant. The campaign focuses on young adults (ages 14–25), especially LGBTQ+ individuals, helping them initiate caring and affirming conversations with peers experiencing emotional challenges. Call Up a Friend encourages a culture of care within LGBTQ+ communities—where young people feel equipped and empowered to check in with friends, share resources, and strengthen mental health support networks across the Central Valley. By blending personal storytelling and inclusive conversation tools, the campaign advances CalPride's mission of honoring diverse identities, reducing stigma, and uplifting LGBTQ+ youth wellness.
CAPSLO https://calpride.org/https://capslo.org/ ages 13-17, Caregivers of adolescents ages 13-17, Latino or Hispanic persons, LGBTQ+ persons	**Region/County** San Luis Obispo, Santa Barbara	The Rise Together – Youth Mental Health Ambassador Project—a youth-led effort focused on promoting mental health awareness among LGBTQ+ and Latino youth ages 12 to 18 in Northern Santa Barbara and San Luis Obispo counties. The project convenes a team of Youth Mental Health Ambassadors who co-create culturally responsive marketing campaign designed to spark open conversations about mental well-being between youth and their caregivers. By sharing authentic stories and connecting families to local mental health resources, the campaign aims to reduce stigma, strengthen support networks, and foster healing in the community.
CORE https://www.coreresponse.org/thrive/	**Region/County** Los Angeles, Ventura	The THRIVE (Transformative Help for Reducing Inequalities and Valuing Emotions) campaign is advancing youth mental health across Los Angeles and Ventura counties. Designed to increase literacy, reduce stigma, and foster open conversations, THRIVE is guided by a Youth Advisory Board of young leaders ages 14–

Young adults/TAY, Caregivers of children ages 0-5, Caregivers of children 6-12, Caregivers of adolescents ages 13-17, African American or Black persons, Asian or Pacific Islander or Native Hawaiian persons, Latino or Hispanic persons, LGBTQ+ persons, Immigrants		17 who shape outreach, messaging, and storytelling. As part of the campaign, CORE launched Mind Your Mind, a youth-led initiative featuring the Mind Your Mind Podcast, where board members explore identity, stress, family dynamics, and resilience. Elevating youth voices, the campaign strengthens awareness, reduces stigma, and builds community connection. THRIVE also offers Parent and Guardian Workshops in partnership with Calmura Counseling at high schools and CORE's Los Angeles headquarters, giving caregivers a safe space to learn, share, and support adolescents ages 13–17.
El Sol Neighborhood Educational Center https://www.elsolnec.org/ Ages 13-17, Young adults/TAY	**Region/County** San Bernardino	El Sol Neighborhood Educational Center's Children and Youth Behavioral Health Initiative (CYBHI)-supported program, "Cultural Connect – Intercultural Inland Youth Wellness Initiative," is dedicated to empowering youth to be advocates and influencers for mental, emotional, and behavioral health. "Cultural Connect" focuses on destigmatizing mental health while fostering awareness and providing a safe space for youth. The program hosts 12 youth interns (14 to 22 years old) in each intern cohort to be mental health advocates through its internship program. The interns undergo a training program that focuses on three foundational aspects – stigma reduction and youth influencing. These trainings provide the groundwork for their youth to lead with confidence and intention.
Healing Early Adverse Relationships, Transforming Systems Ages 13-17, Young adults/TAY, Caregivers of adolescents ages 13-17, Latino or Hispanic persons, LGBTQ+ persons, Foster Youth, Immigrants	**Region/County** Los Angeles	Healing Early Adverse Relationships, Transforming Systems launched the Empowering Latino Youth and Families Through Media Arts campaign, an initiative that positions youth as leaders and storytellers in the movement to de-stigmatize mental health for nearly five million Latinos living in Los Angeles County—particularly adolescents and Transitional-Age Youth. Through hands-on training and creative collaboration, participants use media arts to produce short digital stories of resilience and recovery that reflect their lived experiences. These youth-created narratives form the foundation of a social media campaign

		designed to raise awareness, promote culturally sensitive resources, and spark conversations about mental health within Latino families and communities.
Hlub Hmong Center https://www.hlubhmongcenter.org/ Ages 6-12, Ages 13-17, Young adults/TAY, Caregivers of children ages 0-5, Caregivers of children ages 6-12, Caregivers of adolescents ages 13-17, Asian or Pacific Islander or Native Hawaiian persons, Foster Youth	**Region/County** Merced	Hlub Hmong Center maintains a Southeast Asian Youth Program, SEA Rise (now Hloov Hauv), to promote a healthier community for Southeast Asian youth in Merced. SEA Rise supports transition-aged youth (ages 14-25 years old) in their personal and professional development. SEA Rise is operated by approximately four to six Youth Leaders (YLs) and six Youth Members (YMs). YLs and YMs receive training on community organizing. The SEA Rise team meets biweekly to plan and implement programming, including workshops, cultural events, field trips, and educational activities
Indian Health Council https://www.indianhealth.com/wethrive Ages 0-5, Ages 6-12, Ages 13-17, Young adults/TAY, American Indian or Alaska Native persons	**Region/County** San Diego	We Thrive is a youth-led campaign that honors the lived experiences, cultural identities, and mental and emotional health journeys of the region's Tribal youth—celebrating their pride, strength, and resilience. At the heart of this work is Generation Indigenous, a program that engages Native youth as "Youth Change Makers" through focus groups, creative workshops, and listening sessions. Together, the youth and IHC staff co-create content that raises awareness about mental, emotional, and behavioral health challenges, reduces stigma, and builds connection through storytelling. The campaign is present through San Diego County on billboards, banners, and pole flags and offers resources through the We Thrive website and resource hub, such as their Empowering Native Wellness Podcast.

Institute for Public Strategies https://publicstrategies.org/ Ages 6-12, Ages 13-17, Young adults/TAY, Caregivers of adolescents ages 13-17, Latino or Hispanic persons, Immigrants	**Region/County** San Diego	The “It Starts with Me” campaign aims to enhance behavioral health literacy, reduce stigma, and promote help-seeking behaviors among Latine youth in San Diego County’s Border Region. Using Social Justice Youth Development and Youth Participatory Action Research, the campaign co-creates a digital mental health platform and a #SanDiegoVibes youth-driven social media initiative, incorporating visuals, storytelling, music, and creative arts to ensure culturally relevant and scalable support.
The Los Angeles Trust for Children's Health (The LA Trust) https://www.thelatrust.org/ African American or Black persons, Latino or Hispanic persons	**Region/County** Los Angeles	The Los Angeles Trust is running the “Where You At” campaign through its Wellness Youth Advocates (WYA) program, which includes approximately 12 youth each (14-17 years old) from six different high schools in Los Angeles Unified School District (for an approximate total of 64 WYAs overall). The WYA program follows the Wellness Youth Advocacy Model, where each school site has an adult ally who trains students on various public health topics 1-2 times per week after school. The topics covered in these sessions include education about Wellness Centers and their offerings, understanding the role of social workers in schools, and learning about community resources outside of school
Latino Service Providers https://latinoserviceproviders.org/ Ages 13-17, Young adults/TAY	**Region/County** Marin, Mendocino, Solano, Sonoma	Corazón y Mente: Fostering Healthy Mental, Emotional, and Behavioral Habits in Youth *Promotores* is a youth-led campaign launched by Latino Service Providers (LSP). The initiative builds upon LSP’s flagship Youth Promotor Internship Program to promote mental, emotional, and behavioral (MEB) health literacy and reduce stigma within the Latino/a/x community. At the heart of the campaign is a comprehensive “Action Planning” process that empowers Youth *Promotores* to become advocates and change agents in their communities. These young leaders co-create outreach efforts that raise awareness of MEB health services, break down cultural and systemic barriers, and guide peers toward support and healing. By combining career pathway

		exposure, community education, and youth-centered leadership, Corazón y Mente envisions a thriving, resilient Sonoma County—where every young person has access to culturally sensitive behavioral health resources and the tools to shape a healthier future.
LTSC Community Development Corps (Little Tokyo Service Center) https://www.ltsc.org/ Ages 13-17, Young adults/TAY, Caregivers of adolescents ages 13-17, Asian or Pacific Islander or Native Hawaiian persons, Immigrants	**Region/County** Los Angeles, Orange	Little Tokyo Service Center (LTSC) is running several concurrent campaigns to serve the Asian American and Pacific Islander community. The first element is a Japanese-language campaign meant to engage parents, caregivers, and high school students in the Japanese-speaking community. Campaign activities targeting these groups include caregiver workshops, a high school volunteer program at Japanese language schools, and Japanese and Korean-language public service announcements. LTSC has also assembled a youth advisory program that works on special projects, with several cohorts of ambassadors rotating through the program. The Ambassadors (ages 14-25 years old) are involved in various campaign activities such as hosting workshops (e.g., financial literacy and end-of-life planning), in-person collaborations with artists, a mental health conference, and a “Ripple Effect Walk” for suicide prevention. Additional activities include Public Service Announcements, print media placements, high school service learning programs, social media marketing, and digital resource production.
Rainbow Pride Youth Alliance https://rainbowprideyouthalliance.org/ Ages 13-17, Young adults/TAY, Caregivers of adolescents ages 13-17, African American or Black persons, Latino or	**Region/County** Riverside, San Bernardino	The "Say It Out Loud" campaign aims to reimagine systems that support behavioral health and wellness for children, youth, and their caregivers/families in Riverside and San Bernardino counties. The focus is on reducing stigma, increasing awareness, and promoting help-seeking behaviors, particularly among LGBTQ+ youth and their families in the Inland Region.

Hispanic persons, LGBTQ+ persons		
RYSE, INC https://rysecenter.org/ Ages 13-17, Young adults/TAY, Caregivers of adolescents ages 13-17, African American or Black persons, Asian or Pacific Islander or Native Hawaiian persons, Latino or Hispanic persons, Middle Eastern/North African persons, LGBTQ+ persons, Justice Juvenile youth, Foster Youth, Immigrants	**Region/County** Contra Costa	RYSE is activating our new Health Justice Center (HJC) for BIPOC youth and Transitional Age Youth (TAY). As a community health organization that nurtures BIPOC youth-led media and narrative, we propose a multimedia (healing circles, podcast, social media, performance) County-wide campaign to amplify young people's vision for the HJC and learnings about what healing justice looks like in practice, centering TAY with lived experiences with disabilities, systems impacts, substance use, gun violence, housing insecurity.
Sacramento LGBT Community Center https://saccenter.org/ Ages 13-17, Young adults/TAY, African American or Black persons, American Indian or Alaska Native persons, Asian or Pacific Islander or Native Hawaiian persons, Latino or Hispanic persons	**Region/County** El Dorado, Placer, Sacramento, Yolo	Pop! The Stigma is an LGBTQ+ youth-driven, social marketing campaign across Sacramento and three adjacent counties that aims to raise awareness about mental health, how to access affirming resources, and uses messaging that destigmatizes mental health and help-seeking and amplifies hope and wellness, resulting in increased service uptake among LGBTQ+ youth. The campaign was co-developed by the Youth Advisory Board who consult on material development and plan community events that center mental health. Through the campaign's mascot, Bubbles The Unicorn, Pop! The Stigma spreads messages and engages community in dialogue around mental health through social media and community event activations.

Safe Passages https://safepassages.org/ Ages 13-17, Young adults/TAY, African American or Black persons, Asian or Pacific Islander or Native Hawaiian persons, Latino or Hispanic persons, LGBTQ+ persons, Juvenile Justice youth, Foster youth, Immigrants	**Region/County** Alameda	Mindfulness for Future is a youth-led multipronged effort is designed to reduce stigma around mental, emotional, and behavioral (MEB) health, while building behavioral health literacy and fostering youth leadership. Through this initiative, Safe Passages aims to engage 2,000 African American and Latinx youth, ages 7 to 25, in co-designing campaign content and programming that speaks directly to their lived experiences. The campaign encourages positive identity development, emotional resilience, and help-seeking behaviors—empowering young people to lead conversations about MEB health in their communities.
San Joaquin Pride Center https://sjpride.center/ Ages 6-12, Ages 13-17, Young adults/TAY, Caregivers of adolescents ages 13-17, African American or Black persons, Asian or Pacific Islander or Native Hawaiian persons, Latino or Hispanic persons, LGBTQ+ persons, Foster youth	**Region/County** San Joaquin	The “Cultivating Acceptance” program is focused on supporting and empowering LGBTQ+ youth, as well as promoting inclusivity in schools and communities. The funding also allows for the establishment of Youth Advisory Committees (YAC) to create content for “Cultivating Acceptance.” There are two YACs, including one with younger (ages 12-18 years old) and older (ages 19-25 years old) adolescents.

San Ysidro Health https://www.syhealth.org/ Ages 13-17, African American or Black persons, Asian or Pacific Islander or Native Hawaiian persons, Latino or Hispanic persons	**Region/County** San Diego	The Open Minds Project seeks to challenge stigma and encourage young people to openly discuss mental, emotional, and behavioral health. Through school and community events, social media, a podcast, and outreach materials, the campaign promotes the message “Silence Isn’t Strength,” inspiring youth to share their experiences and access support. Focusing on adolescents ages 13–17 and young adults/transitional age youth between 18–25, the campaign builds awareness, fosters confidence, and equips participants with practical tools to engage with mental health resources and peer support.
Sacramento Native American Health Center https://snahc.org/ Ages 13-17, Young adults/TAY, American Indian or Alaskan Native persons	**Region/County** Sacramento	The SPARK Program mentors American Indian/Alaska Native youth ages 14–18 with communications professionals to design and implement social marketing campaigns. Youth are trained in social marketing principles to ignite change in their communities. The program includes field trips, guest speakers, campaign creation, and community outreach activities. In summer 2024, SPARK youth developed three campaigns: (1) Project Next Gen Coloring Book – amplifying the “For Us, By Us” model and celebrating youth resilience and creativity. (2) It Starts With You Video – exploring intergenerational trauma through symbolic storytelling. (3) Take the First Step Video – highlighting signs of self-harm and encouraging youth to seek help.
Special Services Group (Asian Pacific Counseling and Treatment Center) https://www.ssg.org/ Ages 13-17, Young adults/TAY	**Region/County** Riverside	APCTC’s “Voices Educating the Local City” (VELOCity) campaign is a youth-focused program designed to educate young people about mental health topics and equip them with the tools to create an arts and media-driven mental health awareness campaign. The campaign focuses on increasing mental health literacy among AAPI youth in Riverside County through the students’ creations. Youth cohorts (from Riverside and Eastvale) lead VELOCity programming. The cohorts undergo capacity training to develop campaign assets, which include art training (e.g., mural design, digital content creation, film production), event planning training, mental health workshops

		(e.g., on anxiety, depression, cultural stigma, and healthy coping), and team-building exercises (e.g., fostering collaboration, leadership skills). The cohorts meet weekly to design campaign concepts and build essential skills.
The Alliance for Community Wellness Dba La Familia Ages 13-17, Young adults/TAY, Caregivers of children ages 0-5, Caregivers of children ages 6-12, Caregivers of adolescents ages 13-17, African American or Black persons, Asian or Pacific Islander or Native Hawaiian persons, Latino or Hispanic persons, LGBTQ+ persons, Juvenile Justice youth, Foster youth, Immigrants	**Region/County** Alameda, Contra Costa, Stanislaus	The With Us Project is a youth-led campaign that works to dismantle stigma around mental, emotional, and behavioral health while empowering young people to lead change through storytelling and education. La Familia's With Us Project implements a diverse set of scalable strategies to increase behavioral health literacy among vulnerable community members across different neighborhoods and cities. The initiative integrates La Familia's comprehensive 4 Corners Framework, which includes: (1) Prevention Education, (2) Youth Advocacy and Leadership Development, (3) Collaboration and Partnership, and (4) Resource Navigation.
The Village Project https://www.villageprojectinc.org/copy-of-projects/stigmareductioncampaign African American or Black persons	**Region/County** Monterey, Santa Cruz	The MindShift Initiative is a youth-led public health campaign focused on reducing stigma, strengthening mental health literacy, and cultivating transformative leadership across Monterey County. MindShift redefines what youth engagement looks like—positioning young people as architects of civic change, not passive recipients of services. Through its innovative Squad Model and leadership pedagogy rooted in clinical design, civic participation, and peer governance, ambassadors develop skills that build both personal confidence and public impact.

Youth Transforming Justice (Opening the World) https://www.openingtheworld.org/ Young adults/TAY, African American or Black persons, Latino or Hispanic, Juvenile Justice youth	**Region/County** Marin	Opening the World launched Meet Me Where I'm At: Empathy Heals, a youth-led campaign focused on reducing stigma and increasing access to mental health and substance use resources. The campaign engages youth and transitional-age young adults across the Bay Area—particularly Latino, LGBTQ+, foster, and justice-impacted youth—through creative media arts and community-building activities. Each month, youth leaders host events that blend education with connection, helping youth develop self-care skills, share personal stories, and strengthen peer support networks. The campaign also maintains an active social media presence to share resources, promote local events, and amplify youth voices statewide.
Hmong Cultural Center of Butte County https://hmongculturalcenter.net/ Ages 13-17, Young adults/TAY, Asian or Pacific Islander or Native Hawaiian persons, LGBTQ+ persons, Immigrants	**Region/County** Butte County	The Koomtes Youth Program (KYP) provides a safe and supportive space for youth ages 12–24, focusing on Substance use prevention, Mental health awareness, Advocacy, and Cultural preservation. KYP is youth-centered and culturally rooted, empowering Asian youth through mentorship and leadership development. The program promotes mental health well-being, addresses substance use disorder and celebrates Hmong cultural heritage. By creating an environment that honors identity and builds resilience, KYP equips youth to thrive in all aspects of their lives. Through workshops, peer mentorship, and culturally grounded programming, KYP strengthens both individual capacity and community cohesion—ensuring that Hmong youth can lead, advocate, and flourish while preserving the traditions and values that define their heritage.

SAC Connect https://www.thesacconnect.org/ Ages 13-17, Young adults/TAY, African American or Black persons	**Region/County** Sacramento	The SPACE Campaign is a community outreach and social media campaign targeting communities of color, particularly the Black Community and transitional aged/foster and justice-involved youth, striving to improve outcomes in Black and Brown communities by enhancing behavioral health literacy and delivering services and education that is responsive and culturally sensitive.

References

Abe, J., Grills, C., Ghavami, N., Xiong, G., Davis, C., & Johnson, C. (2018). Making the invisible visible: Identifying and articulating culture in practice-based evidence. *American Journal of Community Psychology*, *62*(1-2), 121-134.

Callejas, L. M. (2008). *Community Defined Evidence Project.* National Latino Behavioral Health Association.

Callejas, L. M., Hernandez, M., Nesman, T., & Mowery, D. (2010). Creating a front porch in systems of care: Improving access to behavioral health services for diverse children and families. *Evaluation and Program Planning*, *33*(1), 32-35.

Callejas, A., Pacheco-Unguetti, A. P., Acosta, A., & Lupiáñez, J. (2010). Attention and Anxiety: Different Attentional Functioning Under State and Trait Anxiety: Different Attentional Functioning Under State and Trait Anxiety. *Psychological Science*, *21*(2), 298-304.

Community-Defined Evidence Practices. (2026, January 7). Hawai'i Strategic Prevention Framework. https://www.spfhawaii.org/community-defined-evidence-practices

Department of Health Care Services. (2025). Behavioral Health Services Act County Policy Manual. California Health and Human Services.

Echo-Hawk, H. (2011). Indigenous Communities and Evidence Building. *Journal of Psychoactive Drugs*, *43*(4), 269–275.

Martinez, K. (2008). *Community defined evidence: What is it? And what can it do for Latinas/os?* El Boletín: The Newsletter of the National Latina/o Psychological Association.

Martinez, K., Callejas, L., & Hernandez, M. (2010). Community-defined evidence: A bottom-up behavioral health approach to measure what works in communities of color. *Report on Emotional and Behavioral Disorders in Youth*, *10*(1), 11-16.

Psychology Applied Research Center at Loyola Marymount University (2022). *Statewide Evaluation of The California Reducing Disparities Project Phase 2 Executive Summary*. California Department of Public Health, Sacramento, California.

Appendix B: Population-Based Prevention vs Early Intervention Factsheet

Overview

In March 2024, voters passed Proposition 1, a transformation of California's behavioral health system, strengthening California's ability to meet the needs of individuals living with behavioral health needs. The proposition includes two parts: the Behavioral Health Services Act (BHSA) and a $6.4 billion Behavioral Health Bond for community infrastructure and housing with services.

The BHSA, which goes into effect on July 1, 2026, replaces the Mental Health Services Act (MHSA) of 2004. Specifically, the shift from Prevention and Early Intervention (PEI) to population-based prevention represents a move toward statewide strategies aimed at the general population rather than solely focusing on individuals at risk of developing mental health disorder.

In collaboration with the California Health and Human Services Agency (CalHHS), the California Department of Public Health (CDPH) and the Department of Health Care Services (DHCS) have partnered to publish this fact sheet to clarify this shift from PEI to population-based prevention.

General Questions

Q1: What does the shift from MHSA to BHSA mean for prevention and early intervention?

Under the Mental Health Services Act, Prevention and Early Intervention component included programs and strategies for prevention, early intervention, outreach for increasing recognition of early signs of mental illness, access and linkage to treatment, stigma and discrimination reduction, and suicide prevention.

With the shift to BHSA, funding for population-based prevention is led by CDPH to provide statewide population-based prevention strategies. Population-based prevention includes universal prevention strategies directed at the general population and selective prevention interventions for specific subgroups of the general population at higher risk of developing a mental health or substance use disorder. This includes the prevention of *onset* of a mental

health or substance use disorder at a population or community level by addressing risk and protective factors.

The BHSA maintains early intervention funding under the Behavioral Health Services and Supports (BHSS) component, requiring counties to spend at least 51% of their BHSS funding allocation on Early Intervention. Early Intervention must focus on strategies and activities that are directed to an eligible individual, including indicated prevention and case identification. Please see the DHCS BHSA County Policy for more information (Section A.7. and A.7.1).

This shift from MHSA to BHSA simply rebalances funding priorities without abandoning prevention, including prevention and early intervention services for individuals at risk of a mental health or substance use disorder who do not have a diagnosis. The BHSA aims for a more integrated system where early intervention works in concert with intensive services, and prevention is coordinated and monitored effectively for statewide population health.[11]

Q2: Who oversees Population-Based Prevention and Early Intervention programs?

Population-Based Prevention programs are overseen by CDPH, while Early Intervention programs are overseen by DHCS with county-level implementation and reporting.

Importantly, both CDPH and DHCS are working in concert to provide guidance through the CDPH Population-based Prevention Program Final Plan and the DHCS BHSA County Policy Manual. While these documents are distinct, they reflect the closely aligned roles of both departments across the continuum of prevention and early intervention.

Q3: What are the five statutory requirements for the implementation of BHSA's Population-Based Prevention Programs? [12]

Population-based prevention programs must incorporate evidence-based practices (EBP) or community-defined evidence practices (CDEP) and meet one or more of the following:

1. Focus on the entire population of the state, county, or particular community
2. Focus on specific populations at elevated risk for a mental health or substance use disorder

[11] BHSA Myths vs. Reality
[12] W&I Code §5892, subdivision (d)

3. Reduce stigma associated with seeking help for mental health challenges and substance use disorders
4. Focus on populations disproportionately impacted by systemic racism and discrimination
5. Prevent suicide, self-harm, or overdose

Q4: What is the main difference between Population-Based Prevention[13] and Early Intervention?

Population-Based Prevention focuses on the entire population or specific subgroups, aiming to reduce risk factors and promote and strengthen conditions that support overall behavioral health and well-being before any signs of disorder appear. It includes strategies like public awareness campaigns, policy initiatives to promote safe use of technology among children and youth, and community coalition building to reduce stigma. See CDPH Population-Based Prevention Program Final Plan for more information.

Population-based prevention programs in the BHSA do **not** include the provision of early intervention, diagnostic, and treatment for individuals.[14]

Early Intervention is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health and is a service delivered to a specific person, not a group or broad population. These individuals often have experienced known risk factors for poor behavioral health outcomes, such as trauma, Adverse Childhood Experiences, or involvement with child welfare or the corrections system.

Early Intervention programs must be directed towards individuals who are already experiencing early signs of a mental health or substance use disorder and may include their families or caregivers. These individuals have been identified not to be in need of treatment, but would benefit from programming designed to mitigate harm and intervene early before worsening of their behavioral health condition. Early Intervention Programs should also include the ability to screen, navigate and refer individuals to the appropriate level of care, when necessary, as indicated prevention and case identification, services are provided to individuals, generally in an individual or small group setting who are lacking a specific diagnosis.[15] DHCS has adapted the **Institute of Medicine's Continuum of Care**

[13] W&I Code §5892, subdivision (F)(1)(e)
[14] W&I Code §5892, subdivision (F)(1)(e)
[5] DHCS County Policy Manual (v.1.3.2.2): 7. BHSA Components and Requirements

model (see Figure 1 below) to clarify the types of behavioral health services and supports that can be funded under BHSS Early Intervention programs.[16]

Additionally, DHCS Managed Care Plans (MCPs) are responsible for providing preventive, non-specialty mental health services to Medi-Cal members with less complex or significant mental health needs, such as screenings, psychoeducation, and outpatient therapy. Under the CalAIM initiative, MCPs use standardized tools for early identification, ensuring "no wrong door" access, and coordinating care with county partners for higher-level needs.

For example, the Children and Youth Behavioral Health Initiative (CYBHI) offers early intervention services at no cost to children, youth, and families through BrightLife Kids and Soluna, where parents and caregivers of children 0-12 and individuals 13-25 can access coaching, coping tools, and other behavioral health resources. The CYBHI Fee Schedule program sets the reimbursement rate across Medi-Cal and commercial insurance for a certain set of outpatient, school-linked services rendered to students who meet program criteria. These outpatient services include psychoeducation, screenings and assessments, psychotherapy, and case management or care coordination.

Q5: How do Population-Based Prevention and Early Intervention programs work together?

Both programs aim to create a stronger and more equitable behavioral health system and to produce better health outcomes for Californians. Population-Based Prevention focuses on creating supportive environments and efforts around public health promotion, universal, and selective prevention, while Early Intervention serves individuals to identify early signs and symptoms and prevent conditions from becoming severe. Early intervention includes indicated prevention case identification and early treatment and support. Indicated interventions are preventive and often provided before an individual receives or meets diagnostic criteria for a behavioral health diagnosis. Together, they provide a comprehensive approach to behavioral health and are complementary, and not competing, strategies.[17]

It is important to note that other sources of funds that support prevention activities, such as the Community Mental Health Services Block Grant (MHBG), Substance Use Disorder Block Grant (SUBG), 1991 and 2011 Realignment, and Opioid Settlement Funds, are not impacted by BHSA and continue to support primary prevention activities. Additional

[16] DHCS County Policy Manual (v.1.3.2.2): A7.1 Early Intervention

[17] DHCS County Policy Manual (v.1.3.2.2): 7. BHSA Components and Requirements

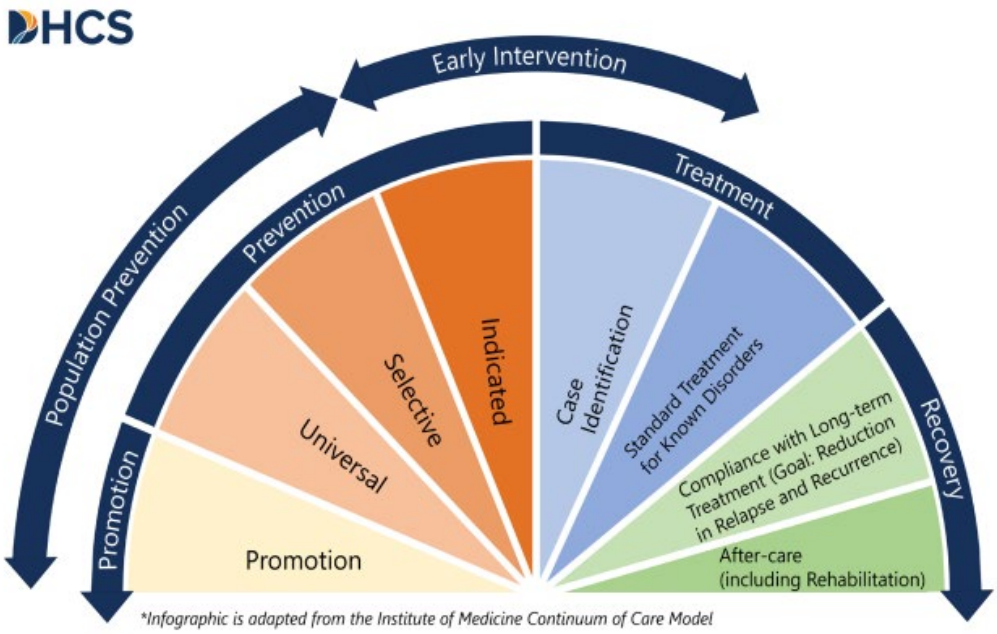
clarifications on how BHSA funding complements other funding sources can be found here: BHSA-Myths-Reality

At the local level, these components will be implemented through collaborative partnerships, between public health departments, behavioral health departments community-based organizations, healthcare system providers, and other key partners to support community-based efforts to achieve equitable health outcomes.

For example, the California Department of Public Health's (CDPH) selective prevention efforts might focus on supporting a network of trusted messengers to reduce cultural stigma around mental health in diverse communities. These efforts can increase awareness of resources, trust in support available, and willingness to engage with local behavioral health care services funded.

These strategies ensure a continuum of care that spans from prevention to early identification and support, aligned with the Institute of Medicine's Continuum of Care model.

Figure 1: The Institute of Medicine's Continuum of Care and Spectrum of Early Intervention Services



Q6: How does the Institute of Medicine define promotion, universal prevention, selective prevention, and indicated prevention in the Continuum of Care model document?[18,19]

Promotion: is the process of enabling people to increase control over, and to improve, their health and well-being.

Examples: Strategies such as teaching social-emotional skills, communication and resilience, initiatives that encourage community and social supports, workplace wellness programs and campaigns to reduce mental health stigma, promote help-seeking behavior and educate on mental well-being offered to the population at large. Together these strategies improve population well-being and strengthen protective factors.

Universal prevention: is prevention services/activities for the public or a whole population group that has not been identified based on individual risk.
Examples: Social Emotional Learning (SEL), self-regulation and skill-building, and problem-solving curricula delivered broadly in school or community settings that strengthen competencies across the whole population and elevate protective factors (for example, emotion regulation, conflict resolution, decision-making) or universally accessible training on effective parenting to enhance communication and reduce family stress.

Selective prevention: is prevention services/activities for individuals or a subgroup of the population whose risk of developing mental health or substance use disorders are significantly higher than average.

Examples: Behavioral health prevention education for immigrant families living in poverty with young children or support for older adults experiencing isolation and loneliness.

Indicated prevention: is prevention services/activities for high-risk individuals who are identified as having minimal but detectable signs or symptoms that foreshadow a mental health or substance use disorder, as well as biological markers that indicate a

[18] National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; O'Connell ME, Boat T, Warner KE, editors.
Washington (DC): National Academies Press (US); 2009.

[19] DHCS Primary Prevention Data Quality Standards and Definitions, February 2025

predisposition in a person for such a disorder but who does not meet diagnostic criteria at the time of the intervention.

Examples: Screening, brief intervention, and referral, interventions for youth demonstrating signs of depression and anxiety, student assistance programs that include individualized counseling for youth demonstrating early signs of a substance use disorder, but not in need of treatment.

Population-Based Prevention

Q7: What are the key components of the CDPH Population-Based Prevention Program Final Plan?

Key components include:

- *Statewide Policy Initiatives* – to address new and emerging behavioral issues and threats, and novel and emerging substance misuse
- *Focused Statewide Behavioral Health Strategies* – includes the investment in CalHOPE Warmline and Redline 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 Disorder 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.

Q8: Which are the populations of focus under BHSA's Population-based Prevention Program Final Plan?

Of the five conditions that statute stipulates BHSA population-based prevention programs must meet,[20] two are specific to populations of focus. Those populations include:

1) populations at elevated risk for a mental health or substance use disorder;
2) populations disproportionately impacted by systemic racism and discrimination.

In consideration of statute, a review of data 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, CDPH has defined the following populations of focus for strategic investment.

a. Black, Indigenous, Latinx, 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[21]
h. Veterans

Q9: How is Population-Based Prevention funded?

Population-Based Prevention Program is funded by allocating 4% of the Behavioral Health Services Fund, with 51% of those funds directed towards populations 25 years and younger. Funding for population-based prevention must be used to strengthen population-based strategies. 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 funding for services and supports for which ongoing funding is available.[22]

[20] **W&I Code §5892, subdivision (d)**
[21] Tribal entities refer to federally recognized Tribes, Indian Health Clinics/Indian Health Programs, and Urban Indian Organizations.
[22] 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."

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 of the CDPH Population-Based Prevention Program Final Plan.

Q10: How will state and local funding be used for Population-based Prevention Program?

CDPH has been allocated dedicated funding to implement population-based behavioral health prevention strategies under the BHSA, with at least 51% of funds directed at individuals who are 25 years of age or younger.

State-level funding is directed toward building a system-wide infrastructure, shaping policy, identifying priority populations and focused strategies that create synergy and alignment across both state and local level partners to reduce duplication and create complementary approaches that work across the continuum of care – all with the intent of advancing the 14 statewide behavioral health goals. State-level funding is also directed at building state-level capacity and expertise to support the success of local efforts through technical assistance and training and developing public campaigns that can be implemented widely across the state. Additionally, it supports the development and execution of a statewide evaluation framework to monitor impact and ensure accountability.

Local funding is intended to expand reach of statewide efforts through locally trusted messengers, implement statewide focused strategies at the local/regional level, provide resources for historically marginalized and under-resourced communities and scaling of CDEPs , and ensuring strong coordination across the myriad of diverse local partners to facilitate communication, foster collaboration, share data as appropriate, and support the community-based efforts to achieve equitable health outcomes

Q11: What are some examples of additional funding sources that can be leveraged to support population-based behavioral health prevention efforts at the local level?

Population-based behavioral health prevention efforts are expected to extend beyond BHSA funding alone. Other funding sources can and should be leveraged to support and enhance a comprehensive population-based prevention response at the local level. Utilizing blending and braiding of funding from multiple sources can also be an effective model for increasing sustainability, expanding and integrating services and supports, and increasing flexibility.

- SAMHSA Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG): These grants provide funding to states and other grantees to plan, implement, and evaluate activities that prevent and treat substance use disorders. These grants have the flexibility to distribute the SUBG funds to local government entities, such as municipal, county, or intermediaries, including administrative service organizations.
- Opioid Settlement Funds: These are funds from national opioid litigation settlements, which are monitored and reported annually by DHCS, and are used for EBP/CDEP-based prevention, treatment, and recovery services.
- Local Control and Accountability Plan (LCAP): This is a planning and funding tool for local educational agencies (LEAs) to improve student outcomes, where LEAs can allocate LCAP funds to mental health and wellness programs in schools.
- Proposition 10 (CA Children and Families Act of 1998): Funds are used to improve early care and education, child health, family resilience, and community awareness. Specific Areas Funded include:
    - Early Childhood Education: Programs supporting child care and learning.
    - Child Health & Development: Health screenings and developmental support.
    - Family Resiliency: Parenting education, family literacy, and support services.

- Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule: The CYBHI Fee Schedule program enables Transitional Kindergarten (TK)-12th grade local educational agencies (LEAs) and public institutions of higher education (IHEs) to be reimbursed for behavioral health services.

- Hospital Community Benefits: Not-for-profit hospitals assume a social obligation to provide community benefits, in exchange for federal tax exemptions governed by the Internal Revenue Service. These hospitals are required to provide a description in a community benefit plan of the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community.

- CalAIM: Medi-Cal members will have access to new and improved services to get well-rounded care that goes beyond the doctor's office or hospital and addresses all of their physical and mental health needs. These changes are part of a broad transformation of Medi-Cal to create a more coordinated, person-centered, and

equitable health system that works for all Californians.

- Managed Care Plans (MCPs): MCPs are responsible for the provision of preventative services for their members in accordance with Bright Futures/AAP periodicity schedule. MCPs are also required to provide basic population health management for all MCP members, which includes basic care coordination for all members. There are several key components within MCPs for access to preventative services. Primary care providers within MCP networks must conduct behavioral health screenings to identify needs early. Additionally, MCPs provide non-specialty services such as individual and group therapy, psychological testing and medication management with individual with mild to moderate mental health issues in accordance with APL 26-002 and primary care screening for substance abuse in accordance with APL 21-014,

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): Under EPSDT, MCPs provide screenings for members under the age of 21 following Bright Futures recommendations.

- DHCS Community Reinvestment Policy (APL 25-004): DHCS' Community Reinvestment Policy requires that MCPs invest a share of their annual net income in activities intended to address the social drivers of health. Community reinvestment plans must be informed by community needs identified in local health departments' Community Health Assessments and must be approved by DHCS before investments may begin. MCPs will submit their first investment plans to DHCS in September 2026, for the 2027 – 2029 investment period.

- 1991 and 2011 Realignment

Q12: What are some examples of Population-Based Prevention strategies?

Examples include public awareness campaigns, policy recommendations, and training for prevention partners. Some examples include, but are not limited to, the following:

- Training in behavioral health awareness, including mindfulness, coping, and resiliency strategies, self-regulation, and communication skills for schools, families, communities, etc., with a focus on suicide and overdose prevention, and promotion of help-seeking behaviors and reduction of stigma associated with accessing behavioral health support.

- Developing statewide policy platforms (as part of implementation of AB 1282)[23] to reduce the mental health risks associated with the use of social media by children and youth.
- Population-based prevention programs provided on a schoolwide or classroom basis and may be provided by a community-based organization off campus or on school grounds.

Early Intervention

Q13: What are the key components of Early Intervention programs?

Key components include:

1. **Outreach**: the process of engaging, encouraging, educating, training, and learning about ways to recognize and respond effectively to early signs of potentially severe and disabling mental health and substance use disorders. Outreach activities funded under BHSS Early Intervention must meet the following requirements:
   - Be directed towards eligible high-risk individuals within BHSA priority populations, including older adults and youth.
   - Have the goal of identifying individuals for access and linkage to services and support.
   - Connect eligible individuals directly to access and linkage programs or to mental health and substance use disorder treatment services and supports, should an individual wish to be connected to services.
2. **Access and Linkage to Care:** to ensure that care can be provided by county behavioral health programs as early in the onset of behavioral health conditions as practicable, and that referrals for medical and social services are provided as needed. It may include the following:
   - Activities that support screening, assessment, and referral to behavioral health services, such as telephone help lines, mobile response teams, and supportive services such as Enhanced Care Management and Community Supports available to Medi-Cal members.
   - Activities must also include the scaling of and referral to the Early Psychosis Intervention (EPI) Plus Program, including Coordinated Specialty Care, or other EBPs

[23] California Assembly Bill (AB) 1282, related to mental health, focuses on addressing the negative impacts of social media on youth mental health.

and CDEPs for early psychosis and mood disorder detection and intervention programs

3. **Mental Health and Substance Use Disorder Services and Supports:** Any treatment services and supports provided under Early Intervention must be proven to reduce the duration of untreated serious mental health illnesses and substance use disorders and assist people in quickly regaining productive lives.

(Detailed guidance on each component can be found under Section 7 of the DHCS BHSA County Policy Manual)

Q14: How is Early Intervention funded?

Counties must allocate 35% of their BHSA funds to Behavioral Health Services and Supports (BHSS), with 51% of those funds for Early Intervention programs, and 51% of Early Intervention funds for individuals 25 years and younger.

Q15: Which groups are considered priority populations under BHSA's Early Intervention Strategies?

Eligible children and youth who satisfy one of the following:[24]

- 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

However, access to BHSA services is not limited to these priority populations.

Q16: What are some examples of Early Intervention strategies?

[24] 4 DHCS County Policy Manual (v.1.3.2.2): Section 2, B.3

DHCS has released a draft Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices (CDEPs) Resource Guide to support the implementation of Early Intervention activities. This list provides examples of strategies that counties and partners may choose to implement based on local needs and populations served.

Additional Information

Q17: How are the effectiveness and outcomes of these programs measured?

Population-Based Prevention programs are evaluated through state audits, data collection on public attitudes and behavioral health outcomes, and performance measures.

Early Intervention programs require county reporting on planned and actual expenditures and outcomes in the Integrated Plan and Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR).

Additionally, the efficacy of these expenditures will be measured in the BHT Performance Measures. These measures align priorities and desired outcomes across the behavioral health delivery system, payers (e.g., Medi-Cal MCP Non-Specialty Mental Health Services (NSMHS) and Medi-Cal Specialty Mental Health Services (SMHS)), and initiatives and funding sources, including **BHSA**. DHCS expects to use performance measures to support transparency, planning, population health, and accountability. The measures are organized by fourteen population behavioral health goals, and examples of measures focusing on early intervention include: depression screening and measuring service utilization for Coordinated Specialty Care for First Episode Psychosis.

To Learn more about Population-Based Prevention and Early Intervention, please follow these links:

- CDPH Population-Based Prevention Program Final Plan
- BHSA County Policy Manual
    - Early Intervention Programs

Table 1: Side-by-Side Factsheet on Population-based Prevention vs. Early Intervention

	Population-Based Prevention Programs	**Early Intervention (EI) Programs**[25]
Purpose	Decrease the proportion of individuals experiencing mental health issues and substance use disorders, along with their associated conditions.	Prevent mental illnesses and substance use disorders from becoming severe and disabling, and reduce adverse outcomes.
Entity Responsible	CDPH	DHCS
Program Focus	Broader statewide, community, and school-based programs.	Specific strategies for eligible individuals.
Funding	4% of total state funding to CDPH for population-based prevention programs, with 51% of those funds for populations 25 years and younger.	Counties must allocate 35% of their BHSA funds to BHSS, with 51% of those funds for EI programs, and 51% of EI funds for individuals 25 years and younger.
Priorities for Use of Funds	- **Entire Population**: Reducing the risk of developing mental health or SUD. - **Specific High-Risk Populations**: Targeting those at elevated risk for mental health or substance use disorder. - **Stigma Reduction**: Reducing stigma associated with seeking mental health or substance use help. -**Systemic racism and discrimination**: Targeting	- **Indicated Behavioral Health Needs**: Strategies targeting children, youth, and their families. -**Childhood Trauma Early Intervention and Crisis Identification** **EBPs/CDEPs** - **Early Psychosis and Mood Disorder Detection**: Programs across the lifespan. -**Outreach and engagement strategies** that target early childhood zero to five, out-of-school youth, older adults

[25] DHCS County Policy Manual (v.1.3.2.2): 7. BHSA Components and Requirements

	Population-Based Prevention Programs	Early Intervention (EI) Programs[25]
	populations disproportionately impacted. **- Suicide and Overdose Prevention**: Programs to prevent suicide, self-harm, or overdose. - **Early Childhood Programs**: Population-based prevention programs for children 0 to 5 years of age.	and secondary school youth. - **Culturally Responsive Interventions**: Addressing the needs of the diverse individuals and families served. - **Equity and Disparities**: Strategies to advance equity and reduce disparities which are evidence-based - **High-Risk Individuals**: Addressing the needs of individuals at high risk or identified to be in crisis.
Program Components	**-Statewide Policy Initiatives**: • Recommendations for policy, systems, and environmental actions to advance statewide goals, including reducing suicide, self-harm, and overdose. • **-Statewide Behavioral Health Prevention Strategies**: Strategies to advance statewide BHSA population behavioral goals. • **-Statewide Awareness Campaign**: Public awareness and education campaigns to educate Californians about mental health and substance use disorders. • **-Prevention Training, Capacity Building, and Technical Assistance**: Equipping health professionals, educators, and	-**Outreach:** • Engage and educate high-risk individuals within BHSA priority populations for early intervention services. • Identify individuals for access and linkage to services. • Target groups: families, caregivers, healthcare providers, urgent care, hospitals, schools, and community-based provider organizations. • Older Adults: Focus on caregivers, isolated individuals, and elder service organizations. • Youth: Direct linkages and referrals to the appropriate level of services, support for underserved populations, reduce racial

	Population-Based Prevention Programs	Early Intervention (EI) Programs[25]
	community leaders with tools to promote behavioral health awareness and prevent suicide, self-harm, and overdose. • **-Community Engagement and Coalition Building**: Developing relationships with communities to create stigma-free environments and provide ongoing support. • **-Data and Evaluation**: Establishing a system of metrics to evaluate the effectiveness of strategies and policies.	disparities, and provide counseling, case management, cognitive behavioral interventions and other behavioral techniques intended to mitigate problem behaviors and improve decision making. -**Access and Linkage to Care:** • Provide early care and referrals for medical and social services. • Activities: screening, assessment, referral, help lines, mobile response teams, Enhanced Care Management, Community Supports, and Early Psychosis Intervention (EPI) Plus Program. -**Mental Health and Substance Use Disorder Services and Supports:** • Reduce duration of untreated illnesses and help individuals regain productive lives. • Culturally and linguistically responsive services. • Services: treatment for first episode psychosis, crisis response, co-occurring issues, and support for high-risk children and youth.

Table 2: Illustrative Examples: Population-Based Prevention vs. Early Intervention

Table 2 provides some ***illustrative*** examples of population-based prevention strategies and early intervention services that act in a complementary manner, providing a comprehensive approach to behavioral health that ensures a continuum of care that spans from prevention to early identification and support. These examples are intended solely for illustrative purposes.

Approach	Population-Based Prevention	Early Intervention (Refer to DHCS Behavioral Health Services Act County Policy Manual-V.1.3.0-20250630)
Harm reduction	A **statewide campaign** that promotes awareness of free naloxone to prevent opioid overdose and expand access in communities. A **statewide Substance Use Disorder Prevention and Education Campaign** focused on countering misinformation, dispelling stigma and misconceptions and encouraging help-seeking behavior	**Screening and Referral:** Assessing severity of use and referring to either a further treatment assessment and referral to specialty care or an indicated prevention EBP/CDEP if the behaviors can be addressed at that level of care. **Brief Intervention**: Increasing insight using cognitive behavioral techniques and motivational enhancement therapies toward behavioral change. **Mobile Response and Stabilization Services:** crisis services for children and youth experiencing acute behavioral health issues and are in crisis.
Cultural & social connections	**Senior volunteer & mentorship (intergenerational):** Programs that connect older adults with youth for tutoring, mentoring,	**Outreach strategies for Older Adults:** Outreach to older adults who are isolated and/or lonely.

	and community service to reduce isolation and increase belonging. **Creating positive social orientation for youth** (healthy personal development, community values, identifying with school and promoting relationships with friends who don't use harmful substances)	
Social-emotional learning and emotional regulation, resilience & stronger school relationships	**Peer-led program** that boosts protective factors (family support, positive friends, mentors, healthy activities) to strengthen help-seeking and resilience. (*Source*: Sources of Strength)	**Youth Outreach and Engagement:** Providing strategies and programs for youth with signs of behavioral or emotional needs or substance misuse who have had, or are at risk of having, contact with the child welfare or juvenile justice system.
Behavioral health awareness, identification & engagement trainings	**Mental Health First Aid (MHFA), Teen MHFA, MHFA for Older Adults:** Teaches community members to recognize signs, offer initial support, and connect people to help. (*Source:* MHFA) **safeTALK**: Training to identify invitations of suicide and connect a person with help. (*Source:* SAMHSA safeTALK)	**Education for high-risk individuals** and/or families who are at risk and experiencing early signs of a mental health or substance use disorder **Youth Outreach and Engagement:** Providing school employees and students with education and training in early identification, intervention, and referral of students with behavioral health needs

	Safe Spaces: Training 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).	**Access and Linkage to Care:** Access and linkage to care may include activities that support screening, assessment, and referral to behavioral health services, such as telephone help lines, mobile response teams,
Stigma & discrimination reduction	Peers Helping Peers – Aimed to reduce mental health stigma and improve mental wellness for youth and young adults Promote peer led initiatives to reduce stigma related to substance use	**Stigma and discrimination reduction programs align with population-based prevention activities and cannot be funded with Early Intervention funding.**
Promotion of Protective Factors & Positive Childhood Experiences (PCEs)	**Parent-child relationship curricula:** Training that strengthens attachment, routines, positive discipline, and stress-management skills. Strategies that **promote Positive Childhood Experiences** and the development of safe, stable and nurturing environments.	**Childhood Trauma Early Intervention Programs:** target BHSA eligible children and youth exposed to, or who are at risk of exposure to, adverse childhood experiences (ACEs) and traumatic childhood events, environmental trauma including community violence, generational trauma, institutional trauma, and prolonged toxic stress. This may include: • Implementation of appropriate trauma and developmental screening and assessment tools with linkages to evidence-based and community-defined early intervention

		services to eligible children and youth who qualify for these services • Multigenerational family engagement, education, and support for navigation and service referrals across systems that decrease problem behaviors and increase child behavioral and emotional self-regulation and improve family functioning.
Early Childhood & Parenting Programs	**Power of Play in Early Childhood:** Play-based approaches that support socio-emotional, language, and cognitive development. (*Source:* American Academy of Pediatrics) Fatherhood engagement programs that promote positive parenting, mental health, and involvement in early childhood development	**Childhood Trauma Early Intervention Programs**[26] Implementation of appropriate trauma and developmental screening and assessment tools with linkages to early intervention services to eligible children and youth who qualify for these services. **Strategies targeting the mental health needs of eligible children and youth**, as defined in W&I Code section 5892, who are zero to five years of age, including, but not limited to, infant and early childhood mental health consultation.

[26] W&I Code § 5840.6, subdivision (c)