Siskiyou County **Health and Human Services Agency, Behavioral Health**

SISKIYOU COUNTY BEHAVIORAL HEALTH

Behavioral Health Services Act (BHSA)

THREE-YEAR INTEGRATED PLAN

Fiscal Year 2026-2029

Siskiyou County Behavioral Health Website:
https://www.siskiyoucounty.gov/behavioralhealth

Siskiyou County Behavioral Health

BHSA 3-YEAR INTEGRATED PLAN AND BUDGET

Fiscal Years 2026/2027 through 2028/2029

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Siskiyou County Behavioral Health

BHSA 3-YEAR INTEGRATED PLAN AND BUDGET

Fiscal Years 2026/2027 through 2028/2029

Introduction

The Behavioral Health Services Act (BHSA) (Senate Bill (SB) 326, Chapter 90, Statutes of 2023) requires all county Behavioral Health Departments to submit a three-year Integrated Plan for Behavioral Health Services and Outcomes outlining intended use of funds and a budget for behavioral health programs administered, beginning with Fiscal Years (FY) 2026-2029 (July 1, 2026 – June 30, 2029).

BHSA Overview

The Mental Health Services Act (MHSA) was passed by California voters in 2004 and funded by a 1% income tax on personal income over $1 million per year. It was designed to expand and transform California's behavioral health system to better serve individuals with, and at risk of, serious mental health issues, and their families. In 2024, voters passed Proposition 1, which replaced the MHSA with the Behavioral Health Services Act (BHSA) and introduced important changes for counties.

In Siskiyou County, we previously used MHSA funds to support programs in the adult and children system of care, including Full Service Partnerships (FSP), a wraparound, whatever-it-takes approach for those with severe mental illness. Under BHSA, we are required by the state to update how we plan, invest, and deliver services moving forward.

Summary of Changes

There are some important shifts we want you to know about as we move into this next chapter:

1. We have created one coordinated plan across all our funding.Instead of creating separate plans by funding stream, there is one Integrated Plan to align services, reduce duplication, and design a more connected system of care.
2. We're investing more intentionally in housing interventions.A greater portion of BHSA funds will now go toward housing interventions. This presents a meaningful opportunity to sustain stable housing options for individuals with behavioral health needs.
3. We're focusing on people with the most significant behavioral health needs.The new funding guidelines focus on individuals with serious mental health and substance use conditions, helping us direct support where it's needed most.
4. We are setting clear goals, tracking what's working, defining outcomes, and reporting on our progress. This will help us see what's working, make adjustments, collaborate across other systems, and build trust by showing we're using public dollars thoughtfully.

The Integrated Plan shared in this document details how we are meeting state requirements in using BHSA and other funds to administer behavioral health services in Siskiyou County.

General Information

County, City, Joint Powers, or Joint Submission:

- County Submission

Entity Name:

- Siskiyou County

Behavioral Health Agency Name:

- Siskiyou County Behavioral Health

Behavioral Health Agency Mailing Address:

- 2060 Campus Drive, Yreka, CA 96097

Primary Mental Health Contact:

- **Name:** Sarah Collard, PhD, Health and Human Services Agency Director
- **Email:** scollard@co.siskiyou.ca.us
- **Phone:** 530.841.4802

Secondary Mental Health Contact:

- **Name:** Shannon Clymer, LCSW, Siskiyou County Behavioral Health Deputy Director
- **Email:** sclymer@co.siskiyou.ca.us
- **Phone:** 530.841.2232

Primary Substance Use Disorder Contact:

- **Name:** Loraine Wisler, CCAPP, AOD Administrator
- **Email:** lwisler@co.siskiyou.ca.us
- **Phone:** 530.842.8785

Secondary Substance Use Disorder Contact:

- **Name:** Alora Sutcliffe, Program Manager
- **Email:** asutcliffe@co.siskiyou.ca.us
- **Phone:** 530.340.5751

Primary Housing Interventions Contact:

- **Name:** Maddelyn Bryan, Program Manager (Housing)
- **Email:** mcbryan@co.siskiyou.ca.us
- **Phone:** 530.841.2748

Compliance Officer for Specialty Mental Health Services (SMHS):

- **Name:** Dee Barton, Program Manager Compliance
- **Email:** dbarton1@co.siskiyou.ca.us

Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS):

- **Name:** Dee Barton, Program Manager Compliance
- **Email:** dbarton1@co.siskiyou.ca.us

BHSA Coordinator:

- **Name:** Sarah Evans, BHSA Coordinator
- **Email:** soevans@co.siskiyou.ca.us

SAMHSA Liaison:

- **Name:** Loraine Wisler
- **Email:** lwisler@co.siskiyou.ca.us

Quality Assurance / Quality Improvement Lead:

- **Name:** Elvia Amezcua, LCSW
- **Email:** eamezcua@co.siskiyou.ca.us

Medical Director:

- Vacant

Exemptions Requests

Individual Placement and Support (IPS) Support Employment Exemption Request

Please select which FSP exemptions criteria the county meets:

- Limited workforce
- Other Hardship

Justification for the exemption request:

Siskiyou County Behavioral Health respectfully requests an exemption from the requirement to implement Individual Placement and Support (IPS) within its Full Service Partnership (FSP) program due to significant structural and economic barriers unique to our rural region. Siskiyou County is a geographically expansive and frontier county with a small and declining employer base. Over recent years, the region has experienced ongoing business closures, reductions in retail and commercial operations, limited industry diversification, and seasonal or unstable employment patterns. The local economic infrastructure does not provide a sufficient number or variety of employers capable of partnering in a structured IPS model that requires active job development and sustained employer engagement.

The County is also experiencing a continued loss of employers due to economic contraction in rural industries, workforce migration out of the region, infrastructure limitations, and geographic isolation that impacts commercial sustainability. As employers close or scale back operations, competitive employment opportunities diminish further. These conditions create structural barriers that are outside the control of Behavioral Health services and substantially limit the feasibility of implementing an IPS model that relies on rapid placement into competitive employment and ongoing employer partnerships.

In addition to labor market limitations, Siskiyou County spans a large geographic area with limited public transportation infrastructure. Many FSP participants reside in remote or frontier communities and lack reliable personal transportation. Significant travel distances to the few existing employment centers create additional barriers to job matching, placement, and retention. Even when employment opportunities exist, transportation constraints make sustained competitive employment unrealistic for many individuals served through FSP.

The FSP population in Siskiyou County frequently presents with high behavioral health acuity, co-occurring substance use disorders, justice involvement, and housing instability. In an already constrained labor market, these factors further reduce employment competitiveness and limit the availability of employers willing or able to provide opportunities aligned with IPS fidelity standards. Without a robust and expanding employer base, IPS placement goals would be difficult to achieve and sustain in a manner consistent with program expectations.

Implementing IPS with fidelity requires dedicated employment specialists, structured employer outreach, and ongoing job development and retention services. Given the limited labor market and shrinking employer pool, allocating FSP resources toward a model unlikely to achieve intended outcomes would not represent effective stewardship of public funds. Siskiyou County remains committed to supporting recovery-oriented employment goals through alternative strategies that

are better aligned with local realities, including vocational readiness support, skills development, education and certification pathways, volunteer and community integration opportunities, and collaboration with regional workforce development entities where feasible.

Funding Transfer Requests

Counties with populations under 200,000 can assume that their request to reduce Housing Intervention Component funds from the required 30 percent is approved when completing the table below.

Counties may transfer no more than 7 percent of total funds from each component to another component, with a maximum of 14 percent of total funds transferred.

If the county allocates any Housing Interventions outreach and engagement funds up to 7 percent, the amount of funds the county can transfer out of the Housing Interventions allocation component must be decreased by the corresponding amount.

The base percentage for Housing Interventions may be higher or lower for small counties requesting a Housing Interventions exemption.

Table 1. Proposed Allocation Adjustments for Each Funding Component

Table 1. Proposed Allocation Adjustments for Each Funding Component	Plan Year One	Plan Year Two	Plan Year Three
Behavioral Health Services and Supports [Base 35%]	49%	49%	49%
Full Service Partnership [Base 35%]	28%	28%	28%
Housing Interventions [Base 30%]	23%	23%	23%
Housing Interventions for Outreach & Engagement	0%	0%	0%

Table 2. Behavioral Health Services & Supports Transfers

Table 2. Behavioral Health Services & Supports Transfers	Plan Year One	Plan Year Two	Plan Year Three
Dollars transferred from Full Service Partnerships	$321,706.00	$315,217.00	$313,153.00
Dollars transferred from Housing Interventions	$321,707.00	$315,216.00	$313,152.00
Dollars transferred into Full Service Partnerships	0	0	0
Dollars transferred into Housing Interventions	0	0	0

For BHSS, please include a rationale for the funding allocation transfer request:

- Siskiyou County Behavioral Health proposes transferring seven percent (7%) from the Housing allocation and seven percent (7%) from the Full Service Partnership (FSP) allocation to the Behavioral Health Services and Supports (BHSS) component to better align funding with local implementation capacity and community need.

Table 3. Full Service Partnerships Transfers

Table 3. Full Service Partnerships Transfers	**Plan Year One**	**Plan Year Two**	**Plan Year Three**
Dollars transferred from Behavioral Health Services and Supports		0	0
Dollars transferred from Housing Interventions		0	0
Dollars transferred into Behavioral Health Services and Supports	$321,706.00	$315,217.00	$313,153.00
Dollars transferred into Housing Interventions	0	0	0

For FSP, please include a rationale for the funding allocation transfer request:

- Siskiyou County Behavioral Health proposes transferring seven percent (7%) from the Housing allocation and seven percent (7%) from the Full Service Partnership (FSP) allocation to the Behavioral Health Services and Supports (BHSS) component to better align funding with local implementation capacity and community need.

  As a rural and frontier county, Siskiyou faces significant constraints in housing development, including limited construction capacity, infrastructure challenges, and a small development pipeline. While housing remains a priority, the County does not currently have the scale or readiness to fully deploy the Housing allocation within required timelines. A modest transfer allows the County to maintain housing efforts while ensuring timely and effective use of BHSA funds.

  Similarly, workforce shortages and recruitment challenges limit the County's ability to expand FSP enrollment beyond current operational capacity. Increasing FSP funding without sufficient staffing would not meaningfully improve access. Adjusting the allocation allows the County to sustain high-fidelity FSP services while redirecting a portion of funds to strengthen broader system capacity.

  Investment in BHSS will expand outpatient, field-based, and early intervention services, improving access to care across the continuum and reducing reliance on higher levels of care. In a geographically large county with transportation barriers and limited provider networks, strengthening core treatment infrastructure has a system-wide impact.

  This reallocation reflects responsible fiscal stewardship and ensures BHSA funding is implemented in a manner that is sustainable, practical, and responsive to Siskiyou County's rural realities, while maintaining the County's commitment to housing stability and high-acuity populations.

Table 4. Housing Interventions Transfers

Table 4. Housing Interventions Transfers	**Plan Year One**	**Plan Year Two**	**Plan Year Three**

Dollars transferred from Behavioral Health Services and Supports	0	0	0
Dollars transferred from Full Service Partnerships	0	0	0
Dollars transferred into Behavioral Health Services and Supports	$321,707.00	$315,216.00	$313,152.00
Dollars transferred into Full Service Partnerships	0	0	0

For HI, please include a rationale for the funding allocation transfer request:

- Siskiyou County Behavioral Health proposes transferring seven percent (7%) from the Housing allocation and seven percent (7%) from the Full Service Partnership (FSP) allocation to the Behavioral Health Services and Supports (BHSS) component to better align funding with local implementation capacity and community need.

  As a rural and frontier county, Siskiyou faces significant constraints in housing development, including limited construction capacity, infrastructure challenges, and a small development pipeline. While housing remains a priority, the County does not currently have the scale or readiness to fully deploy the Housing allocation within required timelines. A modest transfer allows the County to maintain housing efforts while ensuring timely and effective use of BHSA funds.

  Similarly, workforce shortages and recruitment challenges limit the County's ability to expand FSP enrollment beyond current operational capacity. Increasing FSP funding without sufficient staffing would not meaningfully improve access. Adjusting the allocation allows the County to sustain high-fidelity FSP services while redirecting a portion of funds to strengthen broader system capacity.

  Investment in BHSS will expand outpatient, field-based, and early intervention services, improving access to care across the continuum and reducing reliance on higher levels of care. In a geographically large county with transportation barriers and limited provider networks, strengthening core treatment infrastructure has a system-wide impact.

  This reallocation reflects responsible fiscal stewardship and ensures BHSA funding is implemented in a manner that is sustainable, practical, and responsive to Siskiyou County's rural realities, while maintaining the County's commitment to housing stability and high-acuity populations.

County Behavioral Health System Overview

Populations Served by County Behavioral Health System

Children and Youth

The table below, indicates the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row. Counts may be duplicated as individuals may be included in more than one category.

Table 5. Children and Youth Served

Number served who received Medi-Cal specialty mental health services	402
Number served who received at least one SUD prevention/early intervention service	47
Number served by DMC-ODS plan or received DMC services	47
Number served by both MHP MH/SUD and DMC county or DMC-ODS plan	30
Number accessing EPI Plus Program/CSC or similar EBPs/CDEPs	0
Number chronically homeless/experiencing homelessness/at risk	37
Number in juvenile justice system	4
Number reentering community from youth correctional facility	2
Number served by MHP and had an open child welfare case	51
Number served by the DMC County or DMC-ODS plan and had an open child welfare case	5
Number who received acute psychiatric care	12

Adults and Older Adults

The table below, indicates the number of adults and older adults (21 and older) served by the county behavioral health system who meet the criteria listed in each row. Counts may be duplicated as individuals may be included in more than one category.

Table 6. Adults and Older Adults Served

Number dual-eligible Medicare & Medicaid	190
Number who received Medi-Cal specialty mental health services	1129
Number served by DMC-ODS plan or received DMC services	400
Number who received both MH and SUD services from the MHP and DMC county or DMC-ODS plan	212
Number chronically homeless/experiencing homelessness/at risk	13
Number experiencing unsheltered homelessness	19
Number moved from unsheltered to sheltered	No data available
Number of those from unsheltered to sheltered, moved into permanent housing	No data available
Number who were in justice system (on parole/probation)	205
Number incarcerated	79
Number reentering community from prison/jail	35
Number who received acute psychiatric care	77

Number of persons admitted or detained for 72-hour evaluation and treatment:

- Count: 139

Number of persons admitted for 14-day and 30-day intensive treatment:

- Count: 0

Number of persons admitted for 180-day post-certification intensive treatment:

- Count: 0

Total population enrolled in Department of State Hospitals (DSH) Lanterman-Petris-Short (LPS) Act programs:

- Count: 4

Total population enrolled in DSH community solution projects (e.g., community-based restoration, diversion programs):

- Count: 47

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?

- No

Description of local data used during the planning process:

- There are certain data points that are being requested that the county is currently unable to provide. For example, questions around homelessness cannot be answered as our Electronic Health Record does have some of the categories requested above and we cannot differentiate between such categories as Moved from unsheltered homelessness to being sheltered, Moved from unsheltered homelessness to being sheltered, etc. Siskiyou is establishing solutions to address how this data is captured in the EHR. Data regarding clients who were part of the justice system is also not comprehensive.

County Behavioral Health Technical Infrastructure

Does the county behavioral health system use an Electronic Health Record (EHR)?

- Yes

EHR systems used:

- SmartCare

Does the county behavioral health system participate in a Qualified Health Information Organization (QHIO)?

- Yes

QHIOs used:

- Connex; SacValley MedShare

Application Programming Interface (API) Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

Link to the county's API endpoint:

- Behavioral Health Services | Siskiyou County California

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

- No

Does the county wish to disclose any implementation challenges or concerns with admission, discharge, and transfer data-sharing requirements (BHINs 23-056, 23-057, 24-016)?

- No

Service Delivery Landscape

For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction.

SAMHSA Projects for Assistance in Transition from Homelessness (PATH)

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?

- No

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?:

- N/A

Community Mental Health Services Block Grant (MHBG)

Will the county participate in MHBG set-asides during the Integrated Plan period?

- Yes

MHBG set-asides selected:

- Discretionary/Base Allocation
- Dual Diagnosis Set-Aside
- First Episode Psychosis Set-Aside

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

- No

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Will the county participate in SUBG set-asides during the Integrated Plan period?

- Yes

SUBG set-asides selected:

- Adolescent/Youth Set-Aside
- Discretionary
- Perinatal Set-Aside
- Primary Prevention Set-Aside

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

- No

Opioid Settlement Funds (OSF)

Will the county have planned OSF expenditures during the Integrated Plan period?

- Yes

OSF Exhibit E set-asides selected:

- Address the Needs of Criminal Justice-Involved Persons
- Connect People Who Need Help to the Help They Need (Connections to Care)
- Support People in Treatment and Recovery
- Treat Opioid Use Disorder (OUD)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

- No

Bronzan-McCorquodale Act (BMA)

BMA-funded services selected:

- Other Programs and Services: case management, evaluation/assessment, group and individual services, medication education/management, crisis services, rehab/support services, residential services, services for homeless individuals, 24-hour treatment services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

- No

Public Safety Realignment (2011 Realignment)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

- No

Medi-Cal Specialty Mental Health Services (SMHS)

SMHS services selected (as of June 30, 2026):

- Assertive Community Treatment (ACT)
- Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
- Forensic Assertive Community Treatment (FACT)
- Peer Support Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

- No

Drug Medi-Cal Organized Delivery System (DMC-ODS)

DMC-ODS Medi-Cal SUD services selected (as of June 30, 2026):

- Inpatient Services
- Peer Support Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

- Regional model; partnership administration; county assessing future selection to meet needs while evaluating operational impacts.

Other Programs and Services

Additional programs and services provided through other federal or county mental health/SUD programs:

- N/A

Care Transitions

Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth)?

- Yes

Does the county's MOU include a description of the system used to transition a member's care between the mental health plan and managed care plan?

- Yes

Statewide Behavioral Health Goals

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C. Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook. As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation. Please Note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories to strengthen their evaluation and better understand community needs.

Priority Statewide Behavioral Health Goals for Improvement

Counties are required to address the six priority statewide behavioral health goals in this section. For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Access to Care: Primary Measures

Specialty Mental Health Services (SMHS) Penetration Rates, FY 2023

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

- Above

How does your county status compare to the statewide rate for children/youth?

- Below

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

- Age
- Race / Ethnicity
- Sex

Non-Specialty Mental Health Services (NSMHS) Penetration Rates, FY 2023

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

- Above

How does your county status compare to the statewide rate for children/youth?

- Below

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

- Age
- Race / Ethnicity
- Sex

Drug Medi-Cal (DMC) Penetration Rates, FY 22/23

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

- N/A

How does your county status compare to the statewide rate for children/youth?

- N/A

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

- N/A

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates, FY 22/23

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

- Above

How does your county status compare to the statewide rate for children/youth?

- Above

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

- Race / Ethnicity

Access to Care: Supplemental Measures

Initiation of SUD Treatment (IET-INI), FY 2023

How does your county status compare to the statewide rate?

- Below

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

- No Disparities Data Available

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

- To assess equity in access to care, the County utilized CalMHSA's behavioral health equity dashboards to analyze access-to-care measures across key demographic variables. The dashboards were reviewed to identify patterns related to various demographic data and access measure outcomes. CalMHSA dashboard data were disaggregated by demographic group to identify differences in access to care measures. Comparative review of these measures revealed uneven access across population groups, with certain racial and ethnic communities, specific age groups, and differences by sex. For Siskiyou County SMHS data the average for adults was above the state average for adults and below for children and patterns we identified showing discrepancies between race and ethnicity, age, and sex categories. For the NSMHS data it has the same penetration pattern and the same discrepancies. Lastly, the DMC-ODS penetration rates showed that the county was above the state average for both youth/children and adult penetration rates. These findings were supported by trend and comparative data within the CalMHSA dashboards, which allowed for visualization of disparities across demographic categories and informed targeted planning discussions. The dashboard analysis served as the primary data source for identifying equity gaps and directly informed the development of outreach, field-based, and early engagement strategies intended to reduce barriers to access, increase youth-based access points and improve equity in service delivery.

- **Non-Specialty Mental Health:** NSMHS penetration rates among adults enrolled in a Medi-Cal MCP varied by age group, race and ethnicity, and sex (disaggregated data is from FY22). Adults aged 33–44 (18.6%) and 45–56 (18.5%) had rates above the county rate of 16.8%, while those aged 21–32 (16.6%) fell just below it. The lowest rates were observed among older adults: 15.3% for those aged 57–68 and 13.0% for those 69 and older. This suggests that NSMHS services reached middle-aged adults more effectively than younger or older populations. Among racial and ethnic groups with at least 500 Medi-Cal MCP enrollees, white individuals had the highest penetration rate (18.4%). In contrast, Alaska Native and American Indian enrollees (14.8%) and Hispanic enrollees (13.0%) had rates below the county rate. Gender disparities were also evident: female enrollees had a significantly higher penetration rate (21.4%) than male enrollees (11.7%). Despite these variations, Siskiyou County's overall adult NSMHS penetration rate for FY23 (15.4%) remained above the statewide mean and median. NSMHS penetration rates among youth enrolled in a Medi-Cal MCP varied by demographic, with youth aged 12-17 having the highest penetration rates (17.1%), followed by youth aged 18-20 (13.6%) and aged 6-11 (12.7%), all greater than the countywide rate of 11.8% in FY22. Youth aged 3-5 and 0-2 had low penetration rates, 5.0% and 2.1% respectively. Among racial and ethnic groups with at least 500 Medi-Cal MCP enrollees, white youth had a higher penetration rate (13.2%) compared to Hispanic enrollees (10.0%). There was essentially No difference observed between male

(11.8%) and female (11.9%) youth penetration rates. Siskiyou County's overall youth NSMHS penetration rate for FY23 (14.5%) was slightly lower than the statewide mean and median.

- **Specialty Mental Health**: SMHS penetration rates among Medi-Cal eligible adults varied by age group, race and ethnicity, and sex (disaggregated data is from FY21). Adults aged 21-44 had slightly higher SMHS penetration (7.3%) compared to adults aged 45-64 (6.4%) and those 65+ (4.1%); comparatively the county overall rate was 6.5%. Among racial and ethnic groups with at least 500 Medi-Cal eligible individuals, white individuals had the highest SMHS penetration rate (7.0%). In contrast, Alaska Native and American Indian enrollees (5.7%) and Hispanic enrollees (3.9%) had rates below the county rate. Rates among female and male adults were similar, 6.7% and 6.2% respectively. Siskiyou County's SMHS penetration rate for FY23 (5.5%) is higher than the statewide mean and median. SMHS penetration rates among Medi-Cal eligible youth varied by demographic, with youth aged 18-20 having the highest penetration rates (6.6%) compared to the county rate of 4.2%; youth aged 6-11 had a penetration rate of 3.5% and youth aged 3-5 had a penetration rate of 2.2%. Data for youth aged 12-17 and 0-2 were suppressed due to low numbers. Among racial and ethnic groups with at least 500 Medi-Cal eligible individuals, white youth had a higher penetration rate (4.9%) compared to Hispanic youth (3.0%). Female youth similarly had higher penetration (4.8%) compared to male youth (3.6%). Siskiyou County's overall youth SMHS penetration rate for FY23 (3.7%) was slightly lower than the statewide mean and median.

- **DMC/DMC ODS:** DMC ODS penetration rates among adults and youth enrolled in a Medi-Cal MCP vary by race and ethnicity, with Native American (1.9%) and white (1.6%) individuals having penetration rates above the county average of 1.5% (disaggregated data is from FY22), and Hispanic/LatiNo (1.2%) and Black (1.0%) and those reporting "other" race/ethnicity (1.0%).

Access to Care: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes).

- To directly address these disparities, the system has implemented two early intervention programs focused on proactive and early engagement, particularly for populations less likely to access traditional services. These programs emphasize low-barrier entry points, timely outreach, and culturally responsive engagement strategies. The County has also designated a portion of BHSS funding to implement youth-focused evidence-based practices and early intervention services through local agencies selected via an RFP process. These investments intentionally expand youth-centered access points and promote early identification, engagement, and connection to appropriate services for

children, youth, and young adults. In addition, an Outreach Coordinator and field-based service models support engagement in community settings where individuals already access services, including shelters, housing programs, wellness centers, pop-up sites, and other community-based locations. These field-based programs are designed to reach individuals who have not previously been connected to care, reduce logistical and cultural barriers, and improve access for populations disproportionately impacted by the identified disparities. Together, these strategies are intended to increase equitable access to care, improve early identification and engagement, and reduce the likelihood that individuals enter the system only at crisis levels of need.

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

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- Community Mental Health Block Grant (MHBG)
- Substance Use Block Grant (SUBG)

Homelessness: Primary Measures

People Experiencing Homelessness Point-in-Time Count (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?

- Above

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

- Age
- Gender
- Race / Ethnicity

Homeless Student Enrollment by Dwelling Type (CDE), 2023–2024

How does your county status compare to the statewide rate?

- Above

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

- Gender

- Race / Ethnicity

Homelessness: Supplemental Measures

PIT Count Rate of People Experiencing Homelessness with Severe Mental Illness (HUD), 2024

How does your county status compare to the statewide rate?

- Above

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

- No Disparities Data Available

PIT Count Rate of People Experiencing Homelessness with Chronic Substance Abuse (HUD), 2024

How does your county status compare to the statewide rate?

- Above

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

- No Disparities Data Available

People Experiencing Homelessness Who Accessed CoC Services (BCSH), 2023

How does your local CoC's rate compare to the average rate across all CoCs?

- Below

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

- Age
- Gender
- Race / Ethnicity

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

- To assess disparities related to homelessness and housing instability, the County utilized CalMHSA behavioral health and homelessness-related dashboards to analyze patterns across demographic data. The analysis revealed disproportionate representation of individuals experiencing homelessness among certain racial and ethnic groups, gender designation, specific age populations, and by sex, indicating inequities in both housing stability and access to timely behavioral health services. The county identified disparities in age, race and ethnicity, and gender for PIT count

and service access by those experiencing homelessness. The homeless student prevalence, which was higher than the state average, also had disparities along gender and race and ethnicity groups. Multiple measures lacked data that could be examined for disparities; in response, the county relied on those able to identify disparities to determine areas of focus.

- **PIT Count:** In the Northern California Continuum of Care (CoC), the 2024 Point-in-Time (PIT) count revealed disparities in homelessness rates per 10,000 residents across age, gender, and race/ethnicity. Adults aged 35–44 had the highest PIT rate (143 per 10,000), followed by those aged 18–34 (98 per 10,000)—both exceeding the overall CoC rate of 78 per 10,000. In contrast, individuals aged 45 and older (70 per 10,000) and children under 18 (34 per 10,000) had lower rates. Gender disparities were also evident: males had a higher PIT rate (98 per 10,000) than females (58 per 10,000). Among racial and ethnic groups, Native American and Alaska Native individuals had the highest rate (336 per 10,000), followed by Black individuals (160 per 10,000), Native Hawaiian and Pacific Islander individuals (151 per 10,000), and those reporting multiple races (95 per 10,000). White individuals had a rate similar to the overall CoC average (77 per 10,000), while Hispanic/Latina/e/o (22 per 10,000) and Asian and Asian American individuals (15 per 10,000) had the lowest rates. It is important to note that the 2024 PIT Count in this CoC only included the sheltered homeless population, and thus is an undercount of the total homeless population in the CoC.

- **Students Experiencing Homelessness:** During the 2023–2024 academic year, the proportion of K–12 public school students experiencing homelessness in Siskiyou County varied across demographic groups. Among racial and ethnic groups with at least 500 students, 7.0% of students identifying as two or more races experienced homelessness—higher than the county-wide rate of 5.5%. Hispanic/Latino students (5.3%) and white students (4.9%) had rates closer to the overall average. Homelessness rates were similar by gender: 5.6% of male students and 5.4% of female students experienced homelessness. (Fewer than 500 non-binary students were enrolled, so data for this group is not reported.) Among students with disabilities, 5.2% experienced homelessness, aligning closely with the county-wide rate.

- **Homeless Service Utilization**:In the Northern California CoC, the rate of homelessness service utilization per 10,000 differs by gender, age, and race/ethnicity. Men (91 per 10,000) had a higher rate of service utilization compared to women (77 per 10,000). Individuals under 18 and those aged 35-44 had the highest utilization rates (117 per 10,000 for both), compared to those aged 45-54 (98 per 10,000), 25-34 (97 per 10,000), 55-64 (87 per 10,000), and 18-24 (79 per 10,000). Adults over 65 had the lowest utilization rate of all age groups, with 25 per 10,000. Among racial and ethnic groups, Black residents had the highest utilization rate (200 per 10,000), followed by Native American, Alaska Native, or Indigenous (188 per 10,000) and Native Hawaiian or Pacific Islander residents (164 per 10,000). Comparatively,

white individuals (77 per 10,000), Hispanic or Latino (58 per 10,000), and Asian and Asian American individuals (25 per 10,000) had lower rates.

Homelessness: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes).

- Based on the identified disparities, the County's primary strategy for addressing homelessness-related inequities is to implement and coordinate housing-focused programs that increase access to stable housing and supportive services for individuals experiencing homelessness or housing instability. Housing programs serve as the central intervention for this population and are complemented by field-based service models that meet individuals where they are, including shelters, encampments, transitional housing sites, and other community settings. Field-based teams focus on engagement, relationship-building, and linkage to key resources, including housing programs, behavioral health services, medical care, and other essential supports. These field-based programs are intentionally structured to reduce barriers related to transportation, system navigation, and service readiness, and to support individuals who have not previously been connected to housing or behavioral health systems. Together, housing programs and field-based outreach work in coordination to improve equitable access to housing and supportive services and to reduce disparities identified through the CalMHSA dashboard analysis.

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

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- Community Mental Health Block Grant (MHBG)
- Substance Use Block Grant (SUBG)

Institutionalization: Primary Measures

Inpatient Administrative Days (DHCS), FY 2023

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

- N/A

How does your county status compare to the statewide rate for children/youth?

- N/A

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

- N/A

Institutionalization: Supplemental Measures

Involuntary Detention Rates (FY 2021–2022)

14-day involuntary detention rate compared to statewide average:

- N/A

30-day involuntary detention rate compared to statewide average:

- N/A

180-day post-certification involuntary detention rate compared to statewide average:

- N/A

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

- N/A

Conservatorships (FY 2021–2022)

Temporary conservatorships compared to statewide average:

- N/A

Permanent conservatorships compared to statewide average:

- N/A

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

- N/A

SMHS Crisis Service Utilization (DHCS), FY 2023

Crisis Intervention for Adults/Older Adults:

- Above

Crisis Intervention for Children/Youth:

- Below

Crisis Residential Treatment for Adults/Older Adults:

- N/A

Crisis Residential Treatment for Children/Youth:

- N/A

Crisis Stabilization for Adults/Older Adults:

- N/A

Crisis Stabilization for Children/Youth:

- N/A

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

- No Disparities Data Available

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

- To assess disparities related to institutionalization, the County utilized CalMHSA behavioral health equity dashboards to analyze patterns across demographic data with a specific focus on individuals. CalMHSA dashboard data were disaggregated by demographic group to examine indicators associated with institutional involvement, such as crisis-driven service utilization. This analysis identified no disparities in institutionalization across population groups due to limited data. Crisis intervention data was the only data the county has a significant amount of to determine a comparison to the state average. For adults Siskiyou County was above the state average for crisis interventions and for youth it was below. With the limited analysis available on these measures the county has determined that the crisis continuum needs to be enhanced with an emphasis on increasing youth engagement and coordination with more diverse access points.

- The only available institutionalization measure for Siskiyou County is SMHS Crisis Service Utilization, reported as minutes per active adult beneficiary. In 2022,

Hispanic adults averaged 256.81 minutes of crisis services per beneficiary, slightly higher than white adults, who averaged 248.57 minutes. Data for all other racial and ethnic groups were suppressed due to small sample sizes.

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)

- The county has none of these centers within its borders but contracts with other counties for MHRC, ARTS, SNF, etc.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes).

- In response to the data examined, the County's early intervention programs are intentionally designed to engage individuals who are involved with or at risk of institutionalization, with the goal of reducing unnecessary entry into restrictive settings and promoting community-based alternatives. These early intervention programs focus on direct engagement, rapid assessment, and timely linkage to appropriate behavioral health services, MAT referrals and linkage, and supportive resources. Programs coordinate closely with community partners and institutional stakeholders to identify individuals at risk of institutionalization and support diversion from inpatient or justice-based settings when clinically appropriate. Field-based components further enhance these efforts by meeting individuals in community and institutional-adjacent settings, supporting continuity of care, and facilitating transitions back into the community. Together, early intervention and field-based strategies aim to address identified equity gaps, reduce disparities in institutional involvement, and improve access to timely, least-restrictive behavioral health services.

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

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)

- Community Mental Health Block Grant (MHBG)
- Substance Use Block Grant (SUBG)

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (DOJ), 2023

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

- Above

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

- Above

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

- Age
- Race / Ethnicity
- Sex

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (CDCR), FY 2019–2020

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

- Below

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

- No Disparities Data Available

Incompetent to Stand Trial (IST) Count (DSH), FY 2023

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

- Above

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

- No Disparities Data Available

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

- To assess disparities related to justice involvement, the County utilized CalMHSA behavioral health equity dashboards to analyze patterns across race and ethnicity, age, and sex, with a focus on individuals who are justice-involved or at risk of justice involvement. CalMHSA dashboard data were disaggregated by demographic group to identify inequities in justice involvement. The analysis revealed that certain population groups were disproportionately represented among justice-involved individuals. While state averages were present for each measure, the only data set that was able to be examined for disparities was arrest rates. Arrest rates showed that not only was the county above the average for both the adults and youth/children but that there were disparities across age, race and ethnicity, and sex.
- **Arrests**: In 2024, arrest rates per 100,000 residents in Siskiyou County varied by sex, age, and race/ethnicity. Among adults, males had a significantly higher arrest rate (6,858 per 100,000) than females (2,927 per 100,000), with an overall adult rate of 4,868 per 100,000. By age group—limited to populations with at least 5,000 individuals—residents aged 40–69 had an arrest rate of 4,776 per 100,000, while those aged 70 and older had a much lower rate of 222 per 100,000. Across youth and adult populations, white residents had an arrest rate of 3,953 per 100,000, compared to 3,272 per 100,000 for Hispanic residents.
- Disparities data for recidivism and IST are not presented due to insufficient sample sizes.

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)/

- In response to the identified disparities, and informed directly by the CalMHSA dashboard analysis, the County is developing a dedicated forensic behavioral health unit to improve engagement, continuity of care, and diversion for justice-involved individuals. As part of this effort, the County has selected the Forensic Assertive Community Treatment (FACT) evidence-based practice as a targeted strategy to address the complex needs of individuals with serious behavioral health conditions who are involved with the justice system. The decision to implement FACT reflects the County's analysis of local data demonstrating disproportionate justice involvement among specific populations and a need for intensive, community-based, multidisciplinary services that reduce reliance on incarceration and other restrictive system responses. FACT is designed to support individuals through active outreach, assertive engagement, collaboration with justice partners, and coordinated treatment planning, with the goal of reducing recidivism and promoting stability in the community. In addition, the County's early intervention programs

seek to engage individuals at risk of justice involvement before deeper system involvement. These programs emphasize early identification, voluntary engagement, and timely linkage to behavioral health services and supports. Field-based components further support this work by meeting individuals in community and justice-adjacent settings and facilitating connections to treatment, housing, and other key resources. Together, the forensic unit, FACT implementation, early intervention, and field-based strategies represent a coordinated, data-informed approach to reducing justice-involvement disparities and advancing equitable access to community-based behavioral health care.

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

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- Community Mental Health Block Grant (MHBG)
- Substance Use Block Grant (SUBG)
- Other: CalAIM PATH JI Grant

Removal of Children from Home: Primary Measures

Children in Foster Care (CWIP), January 2025

How does your county status compare to the statewide rate?

- Above

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

- No Disparities Data Available

Removal of Children from Home: Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

How does your county status compare to the statewide rate?

- Below

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

- No Disparities Data Available

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?

- Above

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

- Age
- Race / Ethnicity
- Sex

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

- To assess disparities related to the removal of children from the home, the County utilized CalMHSA behavioral health equity dashboards to analyze trends across demographic information among children, youth, and families involved with child-serving systems. CalMHSA dashboard data were disaggregated by demographic group to identify inequities in child welfare involvement and family disruption. In comparison to the state, Siskiyou county was above the state average for both children in foster care rates and child maltreatment substantiations. For SMHS penetration rates, Siskiyou county was below the state average. Only the child maltreatment substantiations had available disparity information, showing that there were discrepancies across age, race and ethnicity and sex.

- Disparities data for the Foster Care Point-in-Time (PIT) count and open child welfare case penetration are not presented due to insufficient sample sizes.

- **Child Maltreatment Substantiation.** Child maltreatment substantiation rates per 1,000 children vary by age, race/ethnicity, and sex at birth. In 2024, children aged 1–2 had the highest substantiation rate (23.4 per 1,000), followed by those aged 3–5 (13.6 per 1,000), both exceeding the overall rate of 11.5 per 1,000. Children aged 6–10 and 11–15 had lower rates, at 10.9 and 9.8 per 1,000 respectively. Data for children under age 1 and those aged 16–17 were suppressed due to small sample sizes. By race and ethnicity, Native American youth had the highest substantiation rate (37.2 per 1,000), higher than that of white youth (13.3 per 1,000). Data for all other racial and ethnic groups were suppressed due to small sample sizes. Gender disparities were also present: female youth had a higher substantiation rate (12.7 per 1,000) than male youth (10.4 per 1,000).

Removal of Children from Home: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of

justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes).

- In response to the identified disparities, and informed directly by the CalMHSA dashboard analysis, the County is strengthening its Children's Behavioral Health continuum through the implementation of evidence-based, family-centered practices designed to prevent unnecessary removal of children from the home and to support safe family preservation whenever possible. The Children's Department is implementing High Fidelity Wraparound (HFW) as a core evidence-based practice to address the complex needs of children and families involved in child-serving systems. HFW emphasizes family voice and choice, individualized team-based planning, cultural responsiveness, and coordination across systems, with the goal of stabilizing families and reducing reliance on out-of-home placements. In addition to HFW, the County is implementing and strengthening other evidence-based practices (EBPs) within the Children's Department to address caregiver and youth behavioral health needs that contribute to child welfare involvement. These EBPs are designed to intervene earlier, provide intensive supports in the home and community, and improve coordination between behavioral health, child welfare, and community partners. Together, these strategies represent a coordinated, equity-driven approach to reducing disparities in child removal, strengthening family stability, and improving outcomes for children and youth through proven, data-informed interventions.

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

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- Community Mental Health Block Grant (MHBG)
- Substance Use Block Grant (SUBG)

Untreated Behavioral Health Conditions: Primary Measures

Follow-Up After ED Visits for Substance Use (FUA-30), 2022

How does your county status compare to the statewide rate?

- Above

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

- No Disparities Data Available

Follow-Up After ED Visits for Mental Illness (FUM-30), 2022

How does your county status compare to the statewide rate?

- Below

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

- No Disparities Data Available

Untreated Behavioral Health Conditions: Supplemental Measures

Adults Needing Help for Emotional/Mental Health or Alcohol/Drug Use With No Visits in Past Year (CHIS), 2023

How does your county status compare to the statewide rate?

- Above

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

- Age
- Race / Ethnicity
- Sex

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

- To assess disparities related to untreated behavioral health conditions, the County utilized CalMHSA behavioral health equity dashboards to analyze patterns across demographic data with a focus on individuals who had limited or no prior engagement with behavioral health services. The analysis examined indicators related to crisis-driven access, and unmet need, which are commonly associated with untreated behavioral health conditions. CalMHSA dashboard data were disaggregated by demographic group to identify inequities in service access and utilization. The analysis revealed that certain racial and ethnic communities, specific age groups, and differences by sex were more likely to report that they had emotional/mental health problems or use of alcohol and drugs but had not had a visit for those issues within the past year.

- **Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year:** Using pooled data from 2021–2023, the proportion of adults who needed help for mental health or substance use but had no related visits in the past year varied by age, race/ethnicity, and sex. Gender differences were modest: 42.0% of males and 39.7% of females had no visits. However, disparities were more pronounced across age and racial groups. Adults aged 25–64 had the highest rate of unmet need (41.5%), while both young adults (18–24) and older adults (65+) had lower rates—15.2% and 15.9%, respectively. Racial disparities were more substantial; among adults with identified need, 82.2% of American Indian and Alaska Native individuals had no visits for mental health or substance use, compared to 43.5% of white adults and 23.4% of Latino adults. Data for other racial and ethnic groups were excluded due to small sample sizes.

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes).

- In response to the identified disparities, and informed by the CalMHSA dashboard analysis, the County is strengthening its capacity to engage individuals with untreated behavioral health conditions through field-based services, targeted outreach, and enhanced collaboration with local health agencies. Field-based programs are designed to meet individuals where they are, including community settings such as shelters, housing programs, wellness centers, pop-up sites, and other non-traditional service locations. These services reduce barriers related to transportation, stigma, and system navigation and prioritize engagement for individuals who have not previously accessed or sustained connection to behavioral health care. An Outreach Coordinator supports proactive engagement efforts and facilitates coordination across behavioral health, public health, primary care, and community-based organizations. Collaboration with local health agencies enhances warm handoffs, shared outreach efforts, and coordinated referrals, allowing individuals with untreated needs to access timely assessment, treatment, and ongoing supports. Together, these strategies represent a coordinated, equity-driven approach to reducing untreated behavioral health conditions, increasing early engagement, and improving access to culturally responsive, community-based services for populations disproportionately impacted by barriers to care.

Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal.

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- Community Mental Health Block Grant (MHBG)
- Substance Use Block Grant (SUBG)

Additional Statewide Behavioral Health Goals for Improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals. In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

Care Experience

Perception of Cultural Appropriateness / Quality Domain Score (CPS), 2024

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

- N/A

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

- Above

Quality Domain Score (Treatment Perception Survey – TPS), 2024

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

- Above

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

- N/A

Engagement in School

Twelfth Graders Who Graduated High School on Time (Kids Count), 2022

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

- Same

Meaningful Participation at School (CHKS), 2023

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

- Below

Student Chronic Absenteeism Rate (DataQuest), 2022

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

- Above

Engagement in Work

Unemployment Rate (CA EDD), 2023

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

- Above

Unable to Work Due to Mental Problems (CHIS), 2023

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

- Below

Overdoses

All Drug-Related Overdose Deaths (CDPH), 2022

How does your county status compare to the statewide rate/average for the full population measure?

- Above

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

- N/A

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

- N/A

All-Drug-Related Overdose Emergency Department Visits (CDPH), 2022

How does your county status compare to the statewide rate/average for the full population measure?

- Above

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

- N/A

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

- N/A

Prevention and Treatment of Co-Occurring Physical Health Conditions

Adults' Access to Preventive/Ambulatory Health Services & Child/Adolescent Well-Care Visits (DHCS), 2022

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

- Below

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

- Below

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotics & Metabolic Monitoring for Children/Adolescents on Antipsychotics (DHCS), 2022

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

- Above

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

- Below

Quality of Life

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average for the full population measure?

- Above

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

- Above

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

- Above

Poor Mental Health Days Reported (BRFSS), 2024

How does your county status compare to the statewide rate/average for the full population measure?

- Above

Social Connection

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average for the full population measure?

- Above

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

- Above

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

- Above

Caring Adult Relationships at School (CHKS), 2023

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

- Below

Suicides

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average for the full population measure?

- Above

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

How does your county status compare to the statewide rate/average for the full population measure?

- Above

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

- N/A

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

- N/A

County-Selected Statewide Population Behavioral Health Goals

For related policy information, refer to 3.E.6 Statewide Behavioral Health Goals. Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.

- Suicide

Please describe why this goal was selected.

- Following a comprehensive review of historical data and ongoing community input, Siskiyou County Behavioral Health selected suicide reduction as a key strategic priority. The decision reflects both the demonstrated need within the county and the community's expressed concern regarding rising suicide risk, particularly among youth and isolated rural residents. This focus will guide the county's early intervention programming under BHSA to ensure resources are directed where they can have the greatest impact.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis.

- In reviewing the CalMHSA data dashboards, the data sets for suicide do currently identify disparities. Siskiyou County is, on average, much higher than other counties in the state, not only with fatal suicide but also with self-harm and crisis cases. The measures and input from county surveys and engagement highlight the need for higher-level engagement to reduce suicide and high-risk behaviors.

- Disparities for age adjusted suicide deaths in Siskiyou county are not presented due to insufficient sample sizes.

- Non-Fatal ED Visits Due to Self-Harm/ Non-Fatal ED visits per 100,000 vary by sex and age. In 2023, there were 159.1 visits per 100,000 for females compared to 79.0 per 100,000 for males. There were 601.2 Non-Fatal ED visits per 100,000 for individuals aged 15-19, compared to 159.3 for individuals aged 25-44. Other age groups were not available in the data.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of suicides and refer to any data that was used to make this decision (e.g., developing an intervention targeting a subpopulation in which data demonstrates they have poorer outcomes).

- Based on analysis of available data and community input, the County identified a need to strengthen early identification and engagement for populations experiencing a higher risk of suicide, particularly individuals who are not consistently connected to behavioral health services prior to crisis. Data and stakeholder feedback indicated that suicide risk is often identified at later points of system contact, underscoring the need for proactive, upstream engagement strategies. In response, the County is implementing a new High-Risk Program focused on early engagement of individuals at elevated risk of suicide through peer-led outreach and support. This program prioritizes early connection, relationship-building, and ongoing engagement, recognizing the role of peers in reducing stigma and increasing trust among individuals who may be hesitant to access traditional services. To further strengthen early identification, the County is integrating the Columbia Suicide Severity Rating Scale (C-SSRS) into its access and assessment processes. Incorporating standardized, evidence-based suicide screening into initial points of contact improves the County's ability to identify suicide risk early, ensure appropriate triage, and connect individuals to timely and appropriate levels of care. In addition, the County is investing in early intervention models and field-based programming designed to meet individuals where they are and reduce barriers to care. Field-based teams engage individuals in community settings and provide timely linkage to behavioral health services, crisis supports, and ongoing care, with a focus on prevention and continuity. Together, these strategies reflect a coordinated, data-driven approach to suicide prevention that emphasizes early identification, peer engagement, and community-based service delivery to reduce suicide risk and improve outcomes for high-risk populations.

Please identify the categories of funding that the county is using to address this goal.

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- Community Mental Health Block Grant (MHBG)

- Substance Use Block Grant (SUBG)

Community Planning Process

Stakeholder Engagement

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

Table 7. Stakeholder Engagement Type and Date

Type of Engagement	Dates Engaged
Focus group discussions	11/17/2025; 11/18/2025
Key informant interviews with subject matter experts	10/28/2025; 10/30/2025; 11/17/2025; 11/18/2025; 11/19/2025; 11/20/2025; 11/21/2025; 11/25/2025; 12/1/2025; 12/2/2025; 12/3/2025; 12/4/2025; 12/5/2025; 12/8/2025; 12/11/2025; 12/17/2025; 12/19/2025
Survey participation	11/12/2025; 11/13/2025; 11/14/2025; 11/15/2025; 12/17/2025; 12/18/2025; 12/20/2025; 12/23/2025; 12/31/2025; 1/1/2026; 1/2/2026; 1/5/2026; 1/7/2026
Training, education, and outreach related to community planning	10/8/2025; 10/9/2025; 10/10/2025; 10/14/2025; 10/15/2025; 10/16/2025; 10/17/2025; 10/21/2025; 10/22/2025; 10/27/2025; 10/28/2025; 10/29/2025; 10/30/2025; 11/3/2025; 11/5/2025; 11/6/2025; 11/7/2025; 11/10/2025; 11/17/2025; 11/18/2025; 11/19/2025; 11/20/2025; 11/21/2025; 11/25/2025; 12/1/2025; 12/2/2025; 12/3/2025; 12/4/2025; 12/5/2025; 12/8/2025; 12/11/2025; 12/17/2025; 12/19/2025
Workgroups and committee meetings	10/2/2025; 10/16/2025; 10/30/2025; 12/3/2025; 12/19/2025; 1/15/2026
Other (Community events)	11/17/2025; 11/19/2025; 11/20/2025; 12/1/2025

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals.

- Shasta-Cascade Health Centers
- Quartz Valley Tribe
- McCloud Community Resource Center
- First 5 Siskiyou
- Child Abuse Prevention Council of Siskiyou County
- Mercy Mt. Shasta Medical Center

- Scott Valley School District
- College of the Siskiyous
- Fairchild Medical Center
- Planning and Service Area 2 Area Agency on Aging
- Siskiyou County Public Health
- Siskiyou County Behavioral Health
- Yreka Community Resource Center
- Siskiyou Sheriff Department
- Juvenile Justice Coordinating Council
- Six Stones Wellness Center
- Siskiyou County Office of Education
- Siskiyou Domestic Violence and Crisis Center
- Siskiyou County Social Services
- Siskiyou County Child Welfare
- Siskiyou County Veteran's Services
- Karuk Tribe of California
- Weed Community Resource Center
- Dunsmuir Family Resource Center
- Tiny Mighty Strong
- Mt Shasta Ambulance Service
- Butte Valley School District
- Siskiyou Union High School District
- Disability Action Center
- Partnership Health Plan
- Siskiyou OUTreach
- Yreka Union High School District
- NorCal CoC – Siskiyou Advisory Board
- Far Northern Regional Center
- Organized Employees of Siskiyou County
- Remi Vista

Which required stakeholder groups were engaged?

- Area agencies on aging
- BHSA eligible adults and older adults (individuals with lived experience)
- Community-based organizations serving culturally and linguistically diverse constituents
- Continuums of care, including representatives from the homeless service provider community
- County social services and child welfare agencies
- Early childhood organizations
- Emergency medical services
- Families of BHSA eligible children and youth, eligible adults, and eligible older adults (with lived experience)
- Higher education partners
- Health care organizations, including hospitals
- Health care service plans, including Medi-Cal managed care plans
- Independent living centers
- Individuals with behavioral health experience, including peers and families
- Labor representative organizations
- LGBTQ+ communities
- Local education agencies
- Local public health jurisdictions
- Organizations specializing in working with underserved racially and ethnically diverse communities
- People with lived experience of homelessness
- Providers of mental health services
- Providers of substance use disorder treatment services
- Public safety partners, including county juvenile justice agencies
- Regional centers
- Tribal and Indian Health Program designees
- Veterans and representatives from veterans' organizations
- Victims of domestic violence and sexual abuse

- Youth from historically marginalized communities
- Youths (individuals with lived experience), youth mental health organizations, or youth SUD organizations

If any stakeholder/group is not selected in the list above, please indicate whether you engaged stakeholders from this group during the planning process.

- Disability Insurers (Attempted but did not receive a response)
- The five most populous cities in counties with a population greater than 200,000 (Stakeholder group is not applicable to county)

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities.

Siskiyou County's CPP took place between July 2025 and January 2026 and engaged approximately 300 residents, stakeholders, and partners across sectors to inform the IP. To meet DHCS requirements and ensure that community members and stakeholders are aware of BHSA changes, and that community perspective and lived experience meaningfully shape the IP, Siskiyou County partnered with Third Sector, a non-profit consulting organization, to co-lead the CPP process. This included key informant interviews and small group discussions, community events and meetings, and distribution of a community survey. More details about the CPP process, including documentation of how stakeholder viewpoints were integrated and community-identified strengths, needs, and priorities, are described in the attached CPP Report (See Appendix B).

While direct consultation with the disability insurer was not feasible during the Community Planning Process (CPP), the county incorporated consideration of this stakeholder and the population they serve in alignment with California Department of Health Care Services Behavioral Health Services Act (BHSA) guidance. This included reviewing applicable coverage frameworks, coordination of benefits requirements, and system interfaces impacting individuals receiving disability-related insurance, as well as gathering indirect input from providers, care coordinators, and community-based organizations serving this population. Consistent with BHSA's emphasis on equitable access, early intervention, and cross-system collaboration, the CPP prioritized strategies to reduce fragmentation, strengthen care coordination, and ensure individuals with moderate and complex needs—who may not meet criteria for higher levels of care—can access appropriate services through the most suitable payer source. The disability insurer has also been identified as a key partner for ongoing engagement during implementation to support alignment, clarify roles, and improve continuity of care across systems.

Local Health Jurisdiction (LHJ)

Collaboration

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP)? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.

- Yes

Describe how the county engaged with LHJs and MCPs across collaboration, data-sharing, and stakeholder activities.

The county is working with the LHJ to develop a plan for the CHA and CHIP development going forward. We will also be engaging the MCP in the discussion. We are looking to line up stakeholder activities so they are not duplicative and could create a unified set of goals for each agency based upon evidence from shared data. The only specific activities have been meetings to discuss process and data sharing capacities.

Did the county utilize the County–LHJ–MCP Collaboration Tool?

- No

How the county collaborated with the LHJ

- Attended key CHA and CHIP meetings as requested.
- Served on CHA and CHIP governance structures and/or subcommittees as requested.

Data-Sharing

Statewide Behavioral Health Goals identified for data-sharing to support behavioral health related focus areas of the CHA or CHIP.

- Other: None have been requested.

Was data shared?

- No

Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development.

- Other: They were not part of data sharing.

Was data shared?

- No

Stakeholder Activities

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

- Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.

Has the county considered the LHJ's most recent CHA/CHIP or strategic plan in preparing its IP?

- Yes. In alignment with California Department of Health Care Services BHSA CPP expectations, findings from the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) directly informed the county's planning priorities and strategies. Identified needs related to social connectedness led to the inclusion of community-based engagement, peer support, and wellness activities designed to reduce isolation and strengthen protective factors. Data highlighting untreated behavioral health needs informed decisions to expand early identification, outreach, and access points, including low-barrier services and enhanced care coordination for individuals with mild to moderate conditions. Additionally, the prevalence of chronic physical health conditions shaped strategies to better integrate behavioral and physical health services, including collaboration with primary care providers and managed care partners. Collectively, these priority areas guided resource allocation and program design to ensure services are responsive to community-identified needs and align with BHSA's focus on early intervention, and whole-person care.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes.

- Partnership HealthPlan

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?

The CPP process highlighted the need for more investment in expanding services into more regions throughout the county due to size, remoteness, and lack of transportation. This has influenced the MCP plans and the BHSA implementation planning.

Comment Period and Public Hearing

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

- The Integrated Plan will be released for stakeholder comment on 3/18/2026. The public comment period will close on 4/16/2026.
- The behavioral health board public hearing on the draft Integrated Plan will be held on 4/20/2026.

Stakeholder input and associated revisions will be summarized and included in this section of the Integrated Plan after the close of the public comment period.

County Provider Monitoring & Oversight

Medi-Cal Quality Improvement Plans

For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027.

- See appendix A.

Does the county operate a standalone DMC-ODS program?

- Yes

Please upload the standalone DMC-ODS QIP for SFY 2026–2027.

- See appendix A.

Contracted BHSA Provider Locations (Non-Housing Services)

As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Table 4. Contracted BHSA Provider Locations Offering Non-Housing Services

Services Provided	Number of Contracted BHSA Provider Locations
Mental Health (MH) services only	3
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	0

Contracted BHSA Provider Locations Participating in Medi-Cal BHDS

Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26

Table 5. Contracted BHSA Provider Locations that Participate in Medi-Cal BHDS

Services Provided	Number of Contracted BHSA Provider Locations
Mental Health (MH) services only	1
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	0

All BHSA Provider Locations

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS Note: DHCS will provide each county with a list of their SMHS providers that also contract with MCPs. Counties will then calculate a final percentage after excluding SMHS providers that do not offer any services that may be covered as NSMHS.

- 0%

If percent to answer above (D20) is under 60%, please describe the county's plans to enhance rates of MCP contracting starting July 1, 2027, and over the subsequent two years among the BHSA provider locations that are providing services that can/should be reimbursed by Medi-Cal MCPs.

- The county will enhance rates of Managed Care Plan (MCP) contracting beginning July 1, 2027, and over the subsequent two years by intentionally aligning BHSA provider capacity with Medi-Cal reimbursement opportunities and requirements established by the California Department of Health Care Services. The county is expanding access points through BHSA-funded provider locations delivering non-specialty mental health services (NSMHS), which increases opportunities for MCP engagement and contracting by creating a broader,

community-based network of eligible providers. In parallel, the county is actively supporting agencies in obtaining Medi-Cal certification and meeting applicable documentation, billing, and compliance standards, thereby positioning more providers to contract with MCPs. Technical assistance will also include guidance on contracting processes, rate structures, and coordination of benefits to ensure providers are prepared to successfully establish and sustain MCP agreements. Together, these strategies are designed to increase the number of BHSA provider sites able to bill MCPs, improve payer alignment, and expand access to reimbursable behavioral health services for Medi-Cal beneficiaries.

To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)

1. **Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening;**
2. **Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and**
3. **Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding.**

Does the county wish to describe implementation challenges or concerns with these requirements?

- no

Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county. Does the county intend to adopt this recommended monitoring schedule for BHSA funded providers that:

also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)

- Yes

do not participate in the Medi-Cal BHDS?

- Yes

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to 7.A.1 Behavioral Health Services and Supports Expenditure Guidelines

General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan.

a. Children's System of Care (non-FSP)
b. Adult and Older Adult System of Care (non-FSP)
c. Early Intervention Programs (EIP)
d. Outreach and Engagement (O&E)
e. Workforce, Education and Training (WET)
f. Capital Facilities and Technological Needs (CFTN)

Children's System of Care (Non-FSP)

Program – Service Type

- Mental Health services
- Supportive services
- Substance Use Disorder treatment services

Please describe the specific services provided:

- Children's System of Care (CSOC) provides Specialty Mental Health Services (SMHS) for eligible youth. Services include a 7-domain CalAIM assessment, plan development for treatment, individual therapy, psychosocial rehabilitation, and case management services.

Provide the projected number of individuals served during the plan period by fiscal year (FY) in the Table below:

Table 8. Number of Individuals in the Children's System of Care (Non-FSP)

Plan Period by FY	Projected Number of Individuals Served
FY 2026-2027	50
FY 2027-2028	55

FY 2028-2029	61

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care.

- Projections relied on an approximate 8.9% increase after analyzing previous years' non-FSP growth rate through service data from FY 23/24 and FY 24/25. Although the projection depends on the efficiency of FSP and EI programs in engaging a portion of this percent increase, and being able to mitigate prior to the member reaching the need for this type of care. The county is also focused on increasing the penetration rate with this group, which will result in higher estimations due to funding direction towards youth engagement.

Adult & Older Adult System of Care (Non-FSP)

Program– Service Type

- Mental Health services
- Supportive services
- Substance Use Disorder treatment services

Please describe the specific services provided:

- Adults system of care will provide the following services as clinically determined: Assessment, Individual and group therapy, Case management/Rehab services, Crisis services, Under 21 TBS and EPSDT, Coordination of and referral to Psychiatric and/or SUD services if needed. This also includes Six Stones Wellness Center which offer peer support, non-traditional support services, advocacy, and opportunities for social connection.

Provide the projected number of individuals served during the plan period by fiscal year (FY) in the Table below:

Table 9. Number of Individuals in the Adult/Older Adult System of Care (Non-FSP)

Plan Period by FY	Projected Number of Individuals Served
FY 2026-2027	901
FY 2027-2028	918
FY 2028-2029	927

Please describe any data or assumptions your county used to project the number of individuals served through the Adult/Older Adult System of Care

- Projections relied on an approximate 3.8% increase after analyzing previous years non-FSP growth rate through service data from FY 23/24 and FY 24/25. In addition the data provided by Six Stones Wellness Center was placed on top of this total although there is acknowledgement of areas that may be duplicated. This increase was also balanced by projection data of Siskiyou County population decreases and engagement with early intervention that will impact those needing long-term non-FSP SMHS care. Penetration rates are already significant and steady for adults in Siskiyou County allowing for a reliable estimation for projections. Although the projection depends on the efficiency of FSP and EI programs in engaging a portion of this percent increase (efficiency of placement in alternative was set at 58%).

Program– Service Type

- Mental Health services
- Supportive services
- Substance Use Disorder treatment services

Coordinated Specialty Care – First Episode Psychosis (CSC)

CSC Program Name

- EPI Program

CSC Program Description

- The CSC-EPI Program aims to provide timely, evidence-based intervention for youth and young adults experiencing first episode psychosis by delivering coordinated specialty care that supports clinical stabilization, functional recovery, family engagement, and improved long-term outcomes. The EPI program offers culturally responsive, recovery-oriented services designed to reduce hospitalization, increase engagement in school and work, and promote long-term stability and community inclusion. Grounded in the CSC model required by BHSA, the program integrates therapy, psychiatric care, family peer, and case management services to ensure that underserved youth and young adults, as well as their families, have access to treatment and support.

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

Table 10. Estimated Number of Individuals Eligible for CSC

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	8
Number of Uninsured Individuals	1

Table 11. Estimated Number of Staff needed for CSC

Category	Estimate
Number of Practitioners Needed	4.25
Number of Teams Needed	1

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

Table 12. Total Number of CSC Practitioners and Teams

Fiscal Year	Total Practitioners	Total Teams
FY 26/27	7 people (1.11 FTE)	1
FY 27/28	7 people (1.11 FTE)	1
FY 28/29	7 people (1.11 FTE)	1

Supplemental funding

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

- No

Outreach and Engagement (O&E)

O&E Program or Activity

- SCBH Outreach

Program Description

- Siskiyou County's Outreach and Engagement (O&E) program is led by a dedicated Outreach and Engagement Coordinator who operates primarily in the field and prioritizes direct engagement with individuals who are at high risk for behavioral health conditions, including those experiencing housing instability, justice involvement, substance use disorders, and co-occurring conditions. Outreach occurs in shelters, encampments, wellness centers, healthcare sites, and other community locations. The program provides education, preliminary screening, warm handoffs, and follow-up to ensure linkage to appropriate services.

Provide the projected number of individuals served during the plan period by fiscal year (FY) in the Table below:

Table 13. Estimated Number of Individuals Served in O&E Programs

Plan Period by FY	Projected Number of Individuals Served
FY 2026-2027	163
FY 2027-2028	179
FY 2028-2029	197

Please describe any data or assumptions your county used to project the number of individuals served through O&E Programs.

- Projections relied on an approximate 10% increase after analyzing previous years' outreach rate through calendar/fiscal data from FY 23/24 and FY 24/25, including data from housing projects where outreach was provided, and adding in some extra increase due to local economic strain and future federal policy that may create a greater need in the county.

Workforce, Education, and Training (WET)

WET Program or Activity – Description

- Consistent with BHSS guidance, Siskiyou County will utilize Workforce, Education, and Training (WET) activities to increase the racial, ethnic, and geographic diversity of the behavioral health workforce, including the intentional incorporation of individuals with lived

experience into service delivery roles across the system of care. As a rural county with documented workforce shortages, Siskiyou County is implementing a comprehensive "grow-your-own" workforce strategy designed to recruit, train, and retain local residents who reflect the communities served. This includes developing accessible career pathways at multiple entry points — including peer support, case management, clinical trainees, and licensed professionals — with structured supervision, training and advancement opportunities to support long-term career development. Particular emphasis is placed on recruiting individuals from historically underserved communities and individuals with lived experience of behavioral health conditions, substance use disorders, justice involvement, housing instability, and family system involvement. These efforts are designed to build a culturally and linguistically competent workforce capable of meeting the behavioral health needs of individuals of all backgrounds, while strengthening long-term workforce sustainability in a rural setting. By embedding workforce diversification strategies across all WET initiatives, Siskiyou County advances equity, improves access to care, and promotes community trust within its behavioral health system.

Please select which of the following categories the activities fall under.

- Continuing Education
- Internship and Apprenticeship Programs
- Professional Licensing and/or Certification Testing and Fees
- Workforce Recruitment, Development, Training, and Retention

Capital Facilities and Technological Needs (CFTN)

CFTN Project Name

- Siskiyou County Behavioral Health – New Building (BHCIP2)

CFTN Type of Project

- Capital facilities project

CFTN Project Description

- Siskiyou County's Bond Behavioral Health Continuum Infrastructure Program (BHCIP) Round 2: Unmet Needs project will support development of the Siskiyou Integrated Wellness Center, a new behavioral health outpatient clinic serving individuals with mental health and substance use disorders. The project will expand access to integrated, person-centered care in a county-owned facility, improving coordination across programs and reducing barriers to treatment. The new outpatient clinic will create capacity for over 90 new mental health slots and over 40 new outpatient substance use disorder slots, helping meet critical community needs. Bond funding is anticipated to be available in February 2027, with groundbreaking tentatively planned for Spring of 2027 and construction expected to be completed in October 2029. Once completed, the Siskiyou

Integrated Wellness Center will enhance the county's ability to provide timely, comprehensive outpatient services for clients with complex and co-occurring needs.

If capital facilities project, please indicate which of the following categories the project falls under

- meeting match requirements for BHCIP award

CFTN Project Name

- Siskiyou County Behavioral Health – Technological Needs

CFTN Type of Project

- Technological needs project

CFTN Project Description

- The Siskiyou Behavioral Health Technology Needs Project is a coordinated infrastructure investment to modernize and integrate the County's behavioral health technology systems in alignment with BHSA and CalAIM priorities. The project will enhance data exchange and interoperability across the electronic health record (EHR), state systems, and community partners to support whole-person, coordinated care. Core components include a secure, HIPAA-compliant EHR; a centralized data warehouse; strengthened data security; expanded imaging and paper-to-digital conversion; real-time monitoring tools; and enhanced telemedicine services. The project also includes accessible online resources, improved web/mobile accessibility, personal health record capabilities, and ongoing system maintenance.

If Technological Needs Project, please select the focus area(s) of the project.

- Data exchange and interoperability
- Data security and privacy
- Data warehouse
- Electronic health record system
- Imaging/paper conversion
- Monitoring
- Online information resources for individuals/families
- Personal health record system
- Resources to support web content and mobile app accessibility
- System maintenance c*osts*
- Telemedicine

Early Interventions

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program / Service Name: Enhanced Peer Engagement Services

Please select which of the three EI components are included as part of the program or service.

- Outreach
- Access and Linkage: Screenings
- Access and Linkage: Assessments
- Access and Linkage: Referrals
- Treatment Services and Supports: Services to address first episode psychosis
- (FEP)
- Treatment Services and Supports: Services that prevent, respond to, or treat a
- behavioral health crisis or decrease the impacts of suicide
- Treatment Services and Supports: Services to address co-occurring mental
- health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs).

- Yes

If yes, please select the EBPs and CDEPs that apply.

- Mobile Crisis, including use of tools such as the Columbia Suicide Severity Rating Scale or Stanley Brown Safety Plan, Mobile Response.

Please describe intended outcomes of the program or service

- Siskiyou County aims to promote early access and timely linkage to care for individuals at high risk for behavioral health conditions, SUD, suicide, overdose, justice involvement, and institutionalization. Proactive outreach, screening, and rapid connection to care are used to intervene before crises occur. Structured peer support enhances engagement, navigation, and care coordination. Peers with lived experience help reduce barriers, build trust, and support access to treatment and community supports. The model seeks to reduce disparities, prevent avoidable hospitalizations, incarceration, and out-of-home placements, and improve long-term recovery outcomes. Part of the goals and outcomes of this program is the enhancement of our ED warm handoff/ care coordination process for

those in crisis including both mental health and SUD crisis. The Peer program includes SUD and Mental Health trained peers and case managers to create an early intervention program that meets the needs of the Behavioral health population as a whole by providing peer support, warm handoffs, linkage to services, and appropriate care transitions.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual

- No

Please provide the total projected number of individuals served for EI during the plan period

Table 14. Estimated Number of Individuals Served

Fiscal Year	Projected Number Served
FY 2026-2027	675
FY 2027-2028	743
FY 2028-2029	817

Please describe any data or assumptions used to project the number served

- Data projections included crisis continuum numbers unduplicated for number of individuals with a 5% total increase on top for expansion to all high-risk criteria including SUD crisis with the notion that some may be SUD-only and some may be co-occuring..

Program / Service Name: Behavioral Health Early Access and Navigation Team

Please select which of the three EI components are included as part of the program or service

- Outreach
- Access and Linkage: Screenings
- Access and Linkage: Assessments
- Access and Linkage: Referrals
- Treatment Services and Supports: Services to address first episode psychosis
- (FEP)
- Treatment Services and Supports: Services that prevent, respond to, or treat a
- behavioral health crisis or decrease the impacts of suicide
- Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs).

- No

Please describe intended outcomes of the program or service

- Siskiyou County is strengthening early identification and response to emerging or escalating behavioral health needs through the implementation of standardized, culturally responsive screening practices and timely assessment processes. Individuals who meet early intervention criteria are connected to appropriate levels of care without unnecessary delay, including prevention, outpatient, crisis, and specialty services based on individualized need. Clear referral pathways, effective warm handoffs, and coordinated follow-up processes support engagement, continuity of care, and shared service planning across providers and systems. This approach reduces service gaps and duplication through closed-loop communication and data-informed referral practices, while improving equity in access and outcomes. By addressing barriers related to geography, culture, language, system involvement, and social determinants of health, the County ensures services are responsive and accessible to all communities. Consistent cross-system collaboration, defined roles, and shared accountability further strengthen coordination and improve overall system effectiveness.

Please indicate if the county identified additional priority uses of BHSS EI funds

- No

Please provide the total projected number of individuals served for EI during the plan period

Table 15. Estimated Number of Individuals Served

Fiscal Year	Projected Number Served
FY 2026-2027	537
FY 2027-2028	590
FY 2028-2029	650

Please describe any data or assumptions used to project the number served

- Numbers reflect unduplicated new clients with a projected 10% annual increase.

Program / Service Name: Youth Early Intervention EBP Care Team

Please select which of the three EI components are included as part of the program or service

- Outreach
- Access and Linkage: Screenings
- Access and Linkage: Assessments
- Access and Linkage: Referrals
- Treatment Services and Supports: Services to address first episode psychosis
- (FEP)
- Treatment Services and Supports: Services that prevent, respond to, or treat a
- behavioral health crisis or decrease the impacts of suicide
- Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs).

- Yes

If yes, please select the EBPs and CDEPs that apply.

- MST, FFT PCIT, and MATCH

.**Please describe intended outcomes of the program or service**

- The Youth Early Intervention EBP Care Team is designed to support early recognition of emerging behavioral health needs among children, adolescents, and transition-age youth,and to ensure that youth and families are connected rapidly and equitably to appropriate behavioral health services and supports. The team's work aligns with SCBH's mission of promoting wellness, recovery, cultural respect, and prevention of serious mental illness,and with BHSA Early Intervention (EI) goals of reducing disparities, stigma, and barriers to care.
- Primary intended outcomes include:
    - Increased Early Identification of Behavioral Health Needs: Youth at risk for emerging or escalating mental health or substance use challenges are identified through standardized, culturally responsive screening and assessment practices, enabling intervention before conditions become more severe. This includes implementing evidence-based screening tools in community-facing settings such as schools, family resource centers, clinics, and partner agencies to detect needs early.
    - Timely Access and Linkage to Appropriate Care: Once identified, youth and their caregivers receive rapid referral and warm hand-off to medically necessary care and evidence-based practices that best meet their needs. The team works collaboratively with referring partners to ensure seamless transitions to services including prevention supports, outpatient treatment, case management, and other community resources.

  - Enhanced Care Coordination Across Systems: The team coordinates with SCBH programs (e.g., Children's System of Care, EPSDT services), schools, primary care, community organizations, and family support networks to reduce fragmentation. By sharing information and developing unified care plans, the team strengthens continuity and avoids duplication of services.
  - Reduced Barriers and Increased Engagement: Through outreach, culturally competent engagement, and responsive care planning, the team aims to reduce systemic and community-level barriers that prevent youth from accessing early supports — including stigma, language, transportation, and rural service gaps.
  - Improved Youth Functioning and Long-Term Outcomes: Ultimately, the team's work is intended to help youth achieve better emotional, social, academic, and family functioning by intervening early and linking them to supports.

Please indicate if the county identified additional priority uses of BHSS EI funds

- No

Please provide the total projected number of individuals served for EI during the plan period

Table 16. Estimated Number of Individuals Served

Fiscal Year	Projected Number Served
FY 2026-2027	325
FY 2027-2028	357
FY 2028-2029	393

Please describe any data or assumptions used to project the number served

- Data analysis of FY 23/24 and FY 24/25 youth and TAY populations, with assumptions of annual increases and multiple contracted providers.

BHSA Full Service Partnerships (FSP)

Full Service Partnership (FSP) – Estimated Eligible Populations

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding

and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to 7.B.3 Full Service Partnership Program Requirements and 7.B.4 Full Service Partnership Levels of Care]

Please review the total estimated number of individuals who may be eligible for each of the following Full Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide, the Policy Manual Chapter 7, Section B, and forthcoming High Fidelity Wraparound (HFW) Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below.

Table 17. Estimated Number of Individuals Eligible for Full Service Partnership Services (Adult Population)

Category	Estimate
Number of Medi-Cal Enrolled Individuals	169
Number of Uninsured Individuals	21
Number of Total FSP-Eligible Individuals with Some Justice-System Involvement	89

Assertive Community Treamtent (ACT) & Forensic Assertive Community Treamtent (ACT) Eligible Population

Please input the estimates provided to the county in the table below.

Table 18. Estimated Number of Individuals Eligible for ACT and FACT

Category	ACT Estimate	FACT Estimate
Number of Medi-Cal Enrolled Individuals	29	29
Number of Uninsured Individuals	4	4

Table 19. Total Number of ACT and FACT Practitioners and Teams

Category	Estimate
Number of Practitioners Needed	10
Number of Teams Needed	1

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county-operated and county- contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

Table 20. Total Number of ACT & FACT Practitioners and Teams

Fiscal Year	Practitioners	Teams
FY 26/27	5	1
FY 27/28	7	1
FY 28/29	7	1

FSP Intensive Case Management (ICM) Eligible Population

Please input the estimates provided to the county in the table below.

Table 21. Estimated Number of Individuals Eligible for FSP ICM

Category	Estimate
Number of Medi-Cal Enrolled Individuals	126
Number of Uninsured Individuals	15

Table 22. FSP ICM Practitioners and Teams Needed

Category	Estimate

Number of Practitioners Needed	10
Number of Teams Needed	2

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county-operated and county-contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

Table 23. Total Number of FSP ICM Practitioners and Teams

Fiscal Year	Practitioners	Teams
FY 26/27	5	1
FY 27/28	7	1
FY 28/29	7	1

High-Fidelity Wraparound (HFW) Eligible Population

Table 24. Estimated Number of Individuals Eligible for FSP HFW

Category	Estimate
Number of Medi-Cal Enrolled Individuals	59
Number of Uninsured Individuals	6

Table 25. FSP HFW Practitioners and Teams Needed

Category	Estimate
Number of Practitioners Needed	22
Number of Teams Needed	1

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county-operated and county-contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

Table 26. Total Number of HFW Practitioners and Teams

Fiscal Year	Practitioners	Teams
FY 26/27	1.65	1
FY 27/28	1.65	1
FY 28/29	1.65	1

Individual Placement and Support (IPS) Eligible Population

Please input the estimates provided to the county in the table below.

Table 27. Estimated Number of Individuals Eligible for IPS

Category	Estimate
Number of Medi-Cal Enrolled Individuals	227
Number of Uninsured Individuals	28

Table 28. IPS Practitioners and Teams Needed

Category	Estimate
Number of Practitioners Needed	17.5
Number of Teams Needed	7

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county-operated and county-contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

Table 29. Total Number of IPS Practitioners and Teams

Fiscal Year	Practitioners	Teams
FY 26/27	0	0
FY 27/28	0	0
FY 28/29	0	0

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?

- Yes

If answered "yes," please describe how the estimated practitioners will provide more than one EBP

- Siskiyou County anticipates some overlap of staff between ACT, FACT, ICM, and High Fidelity Wraparound (HFW) programs. Peer-certified staff will be utilized across all evidence-based practices (EBPs) that incorporate peer support to maximize engagement and service continuity. Clinical staff are expected to be cross-trained in multiple EBPs to optimize capacity and provide redundancy in the event of workforce shortages. This flexible staffing approach is intended to support evolving service needs and demand over the initial three-year period while making the most efficient use of limited workforce resources. Additionally, ICM staff may be shared with ACT, FACT, and HFW programs to facilitate step-down care and continuity of services for clients transitioning between levels of care. With limited staffing Siskiyou County anticipates the need for staff to be versatile in their ability to transition between EBP teams when necessary. We are also looking at incorporating employment support services into the teams in the future when and if staff capacity allows for it.

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports

- Siskiyou County employs a whole-person, trauma-informed approach by addressing the full spectrum of behavioral health needs—emotional, physical, social, and environmental—while

recognizing the impact of trauma on development, behavior, and overall well-being. In a rural context, where geographic isolation, limited transportation, and workforce shortages can create barriers to care, the County emphasizes place-based, field-delivered services that meet clients where they are. Staff are trained in trauma-informed care principles, ensuring services are safe, culturally responsive, and designed to avoid re-traumatization. The County actively partners with families, caregivers, and an individual's natural supports to strengthen engagement, build resilience, and leverage local networks. Care planning integrates family involvement, peer support, and community-based resources, ensuring interventions are grounded in the realities of rural life and accessible within local neighborhoods and community settings. By combining trauma-informed practices with place-based, collaborative approaches, Siskiyou County works to improve continuity of care, reduce service gaps, and support sustainable outcomes for individuals and families across the county.

Please describe the county's efforts to reduce disparities among FSP participants

- Siskiyou County prioritizes addressing barriers to access, engagement, and service outcomes for historically underserved populations. Efforts include targeted outreach to high-risk communities, including rural residents, individuals with justice involvement, children in the child welfare system, and older adults, to ensure they are aware of and able to access FSP services. The County incorporates culturally and linguistically responsive practices, trauma-informed care, and peer support into FSP programs to improve engagement and retention across diverse populations. Data-driven monitoring is used to identify gaps in service delivery and outcomes by race, ethnicity, geography, and other social determinants of health, informing program adjustments and resource allocation. The County also collaborates with families, natural supports, and community-based organizations to tailor services to participant needs and promote equitable outcomes. Through these efforts, Siskiyou County aims to reduce disparities, prevent crisis escalation, and ensure that all FSP participants have timely access to the comprehensive supports necessary for long-term stability and recovery.

Select which goals the county is hoping to support based on the county's allocation of FSP funding

- Access to care
- Homelessness
- Institutionalization
- Justice involvement
- Removal of children from home
- Untreated behavioral health conditions
- Care experience
- Engagement in school
- Engagement in work
- Overdoses
- Prevention of co-occurring physical health conditions
- Quality of life

- Social connection
- Suicides

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

- Siskiyou County provides ongoing engagement services to individuals receiving FSP ICM through a combination of field-based, person-centered, and trauma-informed strategies designed to maintain continuous connection and support. Intensive Case Managers regularly meet participants in their homes, community locations, or other natural settings to reduce barriers related to transportation, geography, and stigma. Engagement includes regular check-ins, individualized service planning, care coordination, and connection to behavioral health, medical, social, and community resources. Peer support specialists are integrated into ICM teams to enhance engagement, build trust, and provide lived-experience guidance for navigating services. The County also uses flexible, adaptive approaches—such as telehealth, mobile outreach, and collaborative partnerships with schools, shelters, housing programs, and justice agencies—to maintain contact and respond promptly to emerging needs. These activities ensure continuity of care, strengthen therapeutic alliances, and support participants in achieving their recovery goals while reducing the risk of crisis events, hospitalization, or other system involvement.

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)

- In Siskiyou County, FSP teams, clinic staff, and system partners meet weekly to review individual cases, ensuring coordinated, client-centered care. Meetings focus on graduation planning, refining case management, eligibility verification using Cal-AIM assessments, new referrals, and step-downs. A shared FSP Interdisciplinary care plan tracks client status, acuity, priorities, and potential waitlists, supporting timely, trauma-informed, and culturally responsive services. These meetings strengthen cross-system collaboration, reduce service gaps, and improve continuity of care for high-need participants.

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

a. Primary substance use disorder (SUD) FSPs

- No

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

b. Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP

- No

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

c. Other recovery-oriented services

- No

If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams. If no additional FSP services, use "N/A"

- N/A

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's FSP program (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

a. In, or at-risk of being in, the juvenile justice system

- The County engaged in a comprehensive review of data analytics and countywide system information to inform program development for children and youth. This included analysis of behavioral health service utilization, crisis encounters, out-of-home placements, justice involvement trends, and cross-system data in collaboration with Public Health and other child-serving agencies. Public Health data, including indicators related to substance use, suicide risk, adverse childhood experiences (ACEs), and social determinants of health, were incorporated to better understand risk factors and disparities impacting children and youth across the county. In addition to quantitative analysis, the County conducted structured stakeholder engagement to ensure program selection reflects community-identified needs. This included collaboration with Probation, Child Welfare, schools, Public Health, community-based organizations, families, and youth with lived experience. Through this engagement process, the County identified service gaps, barriers to access, and opportunities for early intervention and diversion for youth who are involved in or at risk of involvement in the juvenile justice system. The selected programs are intended to provide evidence-based, developmentally appropriate, and culturally responsive services that promote stabilization, reduce recidivism, prevent deeper system involvement, and improve long-term behavioral health and life outcomes for children and youth.

b. LGBTQ+ children and youth

- The County conducted a comprehensive review of countywide data, behavioral health utilization trends, Public Health indicators, school climate data, and community needs assessments to better understand disparities impacting LGBTQ+ youth. This analysis included review of suicide risk, depression, substance use trends, crisis encounters, housing instability, and school-based behavioral health referrals. Public Health data and statewide research consistently demonstrate elevated rates of suicide ideation, self-harm, bullying, family rejection, and homelessness among LGBTQ+ youth, underscoring the need

for targeted prevention and early intervention strategies within the local system of care. In addition to quantitative data analysis, the County engaged stakeholders to ensure program development reflects the lived experiences and identified needs of local youth. This included consultation with youth-serving providers, school partners, community-based organizations, behavioral health staff, and individuals with lived experience. Through this engagement, the County identified gaps in affirming care, barriers related to stigma and geographic isolation, and the need for culturally responsive, trauma-informed, and identity-affirming services. As a result, selected programs prioritize safe and inclusive service environments, workforce training in LGBTQ+ cultural humility, structured peer support opportunities, and improved access to early intervention and crisis services. These efforts are designed to reduce disparities, improve engagement and outcomes, and prevent escalation to crisis, system involvement, or long-term institutionalization among LGBTQ+ youth.

c. Children and youth in the child welfare system

- The County conducted a comprehensive review of behavioral health utilization data, placement trends, crisis encounters, psychotropic medication patterns, and child welfare system data to better understand the needs of children and youth involved in or at risk of involvement in the child welfare system. This analysis was conducted in partnership with Child Welfare Services, Public Health, Probation, and other child-serving partners to identify service gaps, disparities, and drivers of placement instability, congregate care utilization, and re-entry into higher levels of care. Data indicated elevated rates of trauma exposure, behavioral health conditions, and service fragmentation among this population, reinforcing the need for coordinated, trauma-informed, and family-centered interventions. In addition to quantitative review, the County engaged stakeholders — including Child Welfare leadership, caregivers, service providers, community-based organizations, and individuals with lived experience — to inform program selection and system design. Through this engagement, the County identified barriers related to timely access to services, placement disruptions, cross-system communication, and continuity of care. As a result, selected strategies prioritize early identification, evidence-based and trauma-informed practices, care coordination, and structured collaboration between behavioral health and child welfare partners. These efforts are intended to improve placement stability, reduce crisis episodes and higher levels of care, strengthen family and caregiver support, and promote positive long-term behavioral health outcomes for children and youth involved in the child welfare system.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's FSP (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

a. Older adults

- The County conducted a comprehensive review of behavioral health utilization data, crisis response encounters, hospitalizations, substance use trends, and Public Health indicators

impacting older adults. This analysis included examination of suicide rates, social isolation, co-occurring medical and behavioral health conditions, housing instability, and service access barriers, particularly for older adults residing in rural and geographically isolated areas. Data demonstrated increased risk of depression, suicide, and unmet behavioral health needs among older adults, as well as challenges related to mobility, transportation, stigma, and limited specialized geriatric behavioral health services. In addition to quantitative analysis, the County engaged stakeholders, including Public Health, primary care providers, aging services, long-term care facilities, caregiver networks, and community-based organizations serving older adults. Through this engagement process, the County identified service gaps related to early identification, integrated care coordination, caregiver support, and culturally responsive outreach to isolated or homebound individuals. In response, selected strategies prioritize enhanced screening and early intervention, field-based and home-based services where appropriate, improved coordination between behavioral health and medical providers, and targeted outreach to reduce isolation and stigma. These efforts are designed to improve access, reduce disparities, prevent avoidable crises or institutionalization, and promote stability and quality of life for older adults within the community.

b. LGBTQ+ adults

- The County conducted a comprehensive review of countywide data, behavioral health utilization trends, Public Health indicators, and community needs assessments to better understand disparities impacting LGBTQ+ youth. This analysis included review of suicide risk, depression, substance use trends, crisis encounters, housing instability, and behavioral health referrals. Public Health data and statewide research consistently demonstrate elevated rates of suicide ideation, self-harm, substance use and homelessness among LGBTQ+ community, underscoring the need for targeted prevention and early intervention strategies within the local system of care. In addition to quantitative data analysis, the County engaged stakeholders to ensure program development reflects the lived experiences and identified needs of LGBTQ+ community. This included consultation with community-based organizations, behavioral health staff, and individuals with lived experience. Through this engagement, the County identified gaps in affirming care, barriers related to stigma and geographic isolation, and the need for culturally responsive, trauma-informed, and identity-affirming services. As a result, selected programs prioritize safe and inclusive service environments, workforce training in LGBTQ+ cultural humility, structured peer support opportunities, and improved access to early intervention and crisis services. These efforts are designed to reduce disparities, improve engagement and outcomes, and prevent escalation to crisis, system involvement, or long-term institutionalization among LGBTQ+ community members.

c. Adults in, or at risk of being in, the justice system

- The County engaged in a comprehensive review of data analytics and countywide system information to inform program development for forensic involved adults. This included analysis of behavioral health service utilization, crisis encounters, justice involvement trends, and cross-system data in collaboration with Public Health, Probation and the Public

Defenders Office. Public Health data, including indicators related to substance use, suicide risk, poverty, and social determinants of health, were incorporated to better understand risk factors and disparities impacting children and youth across the county. In addition to quantitative analysis, the County conducted structured stakeholder engagement to ensure program selection reflects community-identified needs. This included collaboration with Probation, Sheriff's Department, Public Defender's Office, Public Health, community-based organizations, families, and youth with lived experience. Through this engagement process, the County identified service gaps, barriers to access, and opportunities for early intervention and diversion for youth who are involved in or at risk of involvement in the juvenile justice system. The selected programs are intended to provide evidence-based, developmentally appropriate, and culturally responsive services that promote stabilization, reduce recidivism, prevent deeper system involvement, and improve long-term behavioral health and life outcomes.

Assertive Field-Based SUD Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services.

Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

Table 30. Existing Programs for Assertive Field-Based SUD Treatment Services

Table 30. Existing Programs for Assertive Field-Based SUD Treatment Services					
Requirement	**Existing Program**	**Program Description**	**Current Funding Source**	**BHSA Changes to Existing Program(s) to Meet BHSA Requirements**	**Expected Timeline of Operation**
Targeted Outreach	SUD Outreach	SUD outreach is currently provided at local shelter which includes information, skill development and group facilitation.	PSLF	SUD outreach will be changed to a more inclusive, data driven Field-Based program	This change will occur in July 2026.
Mobile Field-Based Program(s)	N/A	N/A	N/A	N/A	N/A

Open-Access Clinic(s)	N/A	N/A	N/A	N/A	N/A

Table 31. New Programs for Assertive Field-Based SUD Treatment Services

Table 31. New Programs for Assertive Field-Based SUD Treatment Services					
Requirement	**New Program**	**Program Description**	**Planned Funding**	**Planned Operations**	**Expected Timeline of Implementation**

Targeted Outreach	Field-Based SUD Connections Program	The Field-Based SUD Connections Program is a data-driven, mobile outreach and field response model designed to increase timely access to substance use disorder (SUD) treatment. Services are delivered directly in community settings and high-need locations identified through local utilization and overdose data. The program integrates proactive outreach, screening, brief intervention, and mobile SUD crisis stabilization with immediate referral and on-site appointment scheduling for medications for addiction treatment (MAT), detoxification, withdrawal management, and other levels of care. By providing real-time connection to services in the field, the program reduces barriers to care, prevents unnecessary emergency department and law enforcement involvement, and strengthens continuity across the local SUD treatment continuum.	PSLF, OSF, BHSA FSP, DMC-ODS	The program will deploy field-based SUD staff to priority community locations and crisis settings based on data trends and identified service gaps. Services may include screening and brief assessment, harm reduction education, de-escalation and stabilization during SUD-related crises, and immediate referral with on-site appointment scheduling for MAT and other treatment services. Staff will coordinate closely with crisis partners, healthcare providers, shelters, housing programs, and community-based organizations to ensure warm handoffs and follow-up engagement. Operations will emphasize low-barrier access, trauma-informed and culturally responsive in the field practices, and measurable outcomes related to treatment linkage, reduced crisis utilization, increased MAT engagement, and improved continuity of care.	Starts 07/01/2026

Mobile Field-Based Program(s)	Field-Based SUD Connections Program	The Field-Based SUD Connections Program is a data-driven, mobile outreach and field response model designed to increase timely access to substance use disorder (SUD) treatment. Services are delivered directly in community settings and high-need locations identified through local utilization and overdose data. The program integrates proactive outreach, screening, brief intervention, and mobile SUD crisis stabilization with immediate referral and on-site appointment scheduling for medications for addiction treatment (MAT), detoxification, withdrawal management, and other levels of care. By providing real-time connection to services in the field, the program reduces barriers to care, prevents unnecessary emergency department and law enforcement involvement, and strengthens continuity across the local SUD treatment continuum.	PSLF, OSF, BHSA FSP, DMC-ODS	The program will deploy field-based SUD staff to priority community locations and crisis settings based on data trends and identified service gaps. Services may include screening and brief assessment, harm reduction education, de-escalation and stabilization during SUD-related crises, and immediate referral with on-site appointment scheduling for MAT and other treatment services. Staff will coordinate closely with crisis partners, healthcare providers, shelters, housing programs, and community-based organizations to ensure warm handoffs and follow-up engagement. Operations will emphasize low-barrier access, trauma-informed and culturally responsive in the field practices, and measurable outcomes related to treatment linkage, reduced crisis utilization, increased MAT engagement, and improved continuity of care.	Starts 07/01/2026

Open-Access Clinic(s)	Field-Based SUD Connections Program	The Field-Based SUD Connections Program is a data-driven, mobile outreach and field response model designed to increase timely access to substance use disorder (SUD) treatment. Services are delivered directly in community settings and high-need locations identified through local utilization and overdose data. The program integrates proactive outreach, screening, brief intervention, and mobile SUD crisis stabilization with immediate referral and on-site appointment scheduling for medications for addiction treatment (MAT), detoxification, withdrawal management, and other levels of care. By providing real-time connection to services in the field, the program reduces barriers to care, prevents unnecessary emergency department and law enforcement involvement, and strengthens continuity across the local SUD treatment continuum.	PSLF, OSF, BHSA FSP, DMC-ODS	The program will deploy field-based SUD staff to priority community locations and crisis settings based on data trends and identified service gaps. Services may include screening and brief assessment, harm reduction education, de-escalation and stabilization during SUD-related crises, and immediate referral with on-site appointment scheduling for MAT and other treatment services. Staff will coordinate closely with crisis partners, healthcare providers, shelters, housing programs, and community-based organizations to ensure warm handoffs and follow-up engagement. Operations will emphasize low-barrier access, trauma-informed and culturally responsive in the field practices, and measurable outcomes related to treatment linkage, reduced crisis utilization, increased MAT engagement, and improved continuity of care.	Starts 07/01/2026

Medications for Addiction Treatment (MAT) Details

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs.

- To assess the gap between current medication for addiction treatment (MAT) resources and the level needed to meet estimated population demand, the county will implement a focused, multi-source data analysis approach aligned with guidance from the California

Department of Health Care Services. Primary quantitative sources will include Medi-Cal claims and encounter data, Drug Medi-Cal (DMC/DMC-ODS) utilization, provider network capacity (including MAT prescribers and service slots), and public health indicators such as overdose and emergency department data. The county will also leverage Medi-Cal Connect dashboards and data to analyze service utilization, access trends, and beneficiary needs. These data will be used to compare current MAT access and capacity against estimated prevalence of substance use disorders to identify geographic and population-level gaps.

This quantitative analysis will be complemented by targeted qualitative input from client surveys, providers, and system partners to identify barriers such as timeliness of access (including same-day availability), workforce capacity, and care coordination challenges. Findings will be synthesized to identify priority gaps and directly inform strategies to expand timely and equitable access to MAT services. This review will be crucial during the regional model shifts that will occur during this time allowing for an understanding of current and developing resources available around MAT.

Select the following practices the county will implement to ensure same day access to MAT.

- Contract directly with MAT providers in the county
- Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal

BHSA Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations.

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question.

No Gap	Small Gap	Medium Gap	Large Gap
Single and multi-family home Accessory dwelling units, including junior	Housing in mobile home communities (Permanent) Single room occupancy units	Apartments, including master-lease apartments (Interim) Single room	Supportive housing (Permanent) Recovery/sober living housing, including

accessory dwelling units	(Permanent) Tiny homes	occupancy units Shared housing (Interim) Recovery/sober living housing, including recovery-oriented housing Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care) License-exempt room and board Hotel and Motel stays Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)	recovery-oriented housing Non-congregate interim housing models Recuperative Care Short-Term Post-Hospitalization housing (Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units Peer Respite Permanent rental subsidies Housing supportive services

What additional non-BHSA resources or funding sources will the county behavioral health system utilize to expand supply and/or increase access to housing for BHSA-eligible individuals?

- As a small rural County, Siskiyou County Health and Human Services (SCHHSA) has few or no opportunities to direct local funds towards housing assistance. However, the Agency is highly active in pursuing state sources to augment housing assistance and the supply of units. This includes numerous one-time grants as well as a few ongoing funds from DHCS, CDSS, HCD, and the BSCC (BHBH, HHIP, HHAP, Prop 47, HSP, HDAP, Home Safe, BFH, HNMP, THP, CCE Preservation, and PLHA). These one-time grants sustain and increase access to housing for BHSA-eligible individuals in a variety of settings such as motels, interim tiny homes, congregate shelter, market-rate rentals, licensed residential care facilities, shared housing models, and Permanent Supportive Housing units.

The Agency plans to continue applying for one-time and ongoing housing grants as available. Specifically with the PLHA program through HCD, the County partnered with eight local incorporated cities to delegate their annual PLHA allocations to SCHHSA for a specified period. These allocations, along with the County's own allocation, are a significant portion of the Agency's sustainability plan for PSH and interim housing services for BHSA-eligible individuals. The County hopes to renew this partnership with the local cities indefinitely. Additionally, SCHHSA connects BHSA-eligible individuals to federal resources through the NorCal Continuum of Care, which currently offers a limited voucher program for individuals experiencing chronic homelessness.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA-eligible individuals?

- The County will maximize the use of other housing funds for this population as possible. BHSA will primarily strengthen the continuum of housing support by sustaining existing projects with expiring funding or projects that are currently funded by MHSA. Other funds will supplement BHSA, particularly in areas where BHSA is not an allowable use (for example, congregate housing projects). BHSA will continue/supplement funding for an interim tiny home village, several shared housing projects, board and care patches, and two PSH projects (one in operation and another in construction). If BHSA funds are not exhausted with existing projects, or other sources are sufficient for current services, BHSA will expend the housing supports available via motel vouchers and rental assistance.

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

- County staff and contractors will assist individuals who are receiving BHSA Housing Interventions to complete a Coordinated Entry (CES) assessment as early as possible for consideration on the By-Name List. Case managers and/or the County's Housing Navigator will support individuals to navigate permanent housing resources, including submitting applications, liaising with the Housing Authority, and following up on CES referrals. Staff will collaborate with clients to find a placement that is sustainable and appropriate for their specific needs. After moving into permanent placements, staff offer ongoing life-skill building to support housing retention.

What actions or activities is the county behavioral health system engaging in to connect BHSA-eligible individuals to and support permanent supportive housing (PSH)?

- As mentioned above, Behavioral Health is an active participant as well as an access point for CES, connecting individuals to PSH projects through that process. Behavioral Health provided capital funding for development of two new PSH projects. One is already in operation and the other is in construction with an expected opening date in late 2026. The County will provide supportive services directly as well as via contractors, operating subsidies to property partners, and rental subsidies to PSH tenants as needed for housing retention.

How will the county behavioral health system ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services?

- Behavioral Health is both a direct service provider and has a contracted housing service provider that offers supportive services to the County's housing projects. Services include both clinical and non-clinical supports and are offered at all BHSA housing sites.

Eligible Populations

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

- The County will take a two-pronged approach. Behavioral Health screens for housing instability as part of its assessment process and connects individuals with housing instability to the CES. The Agency also accepts BHSA-eligible referrals from CES to its housing projects. In both cases, the CES is used to prioritize individuals based on greatest need/vulnerability, especially in times when resources are limited compared to the need.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only?

- Yes

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

1. **In, or at-risk of being in, the juvenile justice system**
    - Several previous housing service plans informed Behavioral Health's Housing Intervention services. As a leading member of the NorCal Continuum of Care, Behavioral Health staff significantly participated in the drafting of all HHAP Local Housing Action Plans and Regionally Coordinated Homeless Action Plans. Additionally, the County developed a Ten Year Plan to End Homelessness as part of the No Place Like Home program and conducted a housing analysis in anticipation of the Behavioral Health Bridge Housing application and other grants. The process for all these plans and the BHSA community planning involved reviewing Point-In-Time Count data, analyzing HMIS data, reviewing research on best practices, conducting focus groups with subpopulations with lived experience of homelessness and mental health challenges, and engaging stakeholders with expertise in specific populations. These stakeholders included law enforcement, Probation, the Public Defender's Office, and more.
2. **Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)**
    - Several previous housing service plans informed Behavioral Health's Housing Intervention services. As a leading member of the NorCal Continuum of Care, Behavioral Health staff significantly participated in the drafting of all HHAP Local Housing Action Plans and Regionally Coordinated Homeless Action Plans. Additionally, the County developed a Ten Year Plan to End Homelessness as part of the No Place Like Home program and conducted a housing analysis in anticipation of the Behavioral Health Bridge Housing application and other grants. The process for all these plans and the BHSA community planning involved reviewing

Point-In-Time Count data, analyzing HMIS data, reviewing research on best practices, conducting focus groups with subpopulations with lived experience of homelessness and mental health challenges, and engaging stakeholders with expertise in specific populations. These stakeholders included organizations that support LGBTQ+ youth such as Youth Empowerment Siskiyou.

3. **In the Child Welfare system**
    - Several previous housing service plans informed Behavioral Health's Housing Intervention services. As a leading member of the NorCal Continuum of Care, Behavioral Health staff significantly participated in the drafting of all HHAP Local Housing Action Plans and Regionally Coordinated Homeless Action Plans. The County developed a Ten Year Plan to End Homelessness and conducted a housing analysis for multiple grants. Stakeholder engagement included Youth Empowerment Siskiyou and close collaboration across SCHHSA units, as the agency includes the child welfare system.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

1. **Older adults**
    - Several previous housing service plans informed Behavioral Health's Housing Intervention services. As a leading member of the NorCal CoC, Behavioral Health staff participated in drafting HHAP plans and the Ten Year Plan to End Homelessness. The planning process included reviewing PIT and HMIS data, research, focus groups, and stakeholder engagement. Stakeholders included Adult Protective Services, the Disability Action Center, and a licensed elderly residential care facility.
2. **In, or at-risk of being in, the justice system**
    - Several previous housing service plans informed Behavioral Health's Housing Intervention services. As part of the NorCal CoC, Behavioral Health staff engaged in drafting HHAP plans and the Ten Year Plan to End Homelessness. The planning process included PIT and HMIS data review, research, focus groups, and stakeholder engagement with law enforcement, Probation, the Public Defender's Office, and others.
3. **In underserved communities**
    - Several previous housing service plans informed Behavioral Health's Housing Intervention services. As part of the NorCal CoC, Behavioral Health staff engaged in drafting HHAP plans and the Ten Year Plan to End Homelessness. The County focused on reaching underserved communities in outlying areas by engaging a broad network of partners. Staff also involved local tribes to address the needs of Native Americans, a historically underserved population in Siskiyou County.

Local Housing System Engagement

How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?

- SCHHSA is an exceptionally active member of the NorCal Continuum of Care (NorCal CoC), which includes seven Northern California counties. An Executive Board governs the CoC, with a Behavioral Health staff member representing Siskiyou County. Behavioral Health also participates in the local Advisory Board, HMIS/CES Committee, PIT Count Committee, and other workgroups. The Agency is an access point and consistent participant for CES. Staff attend CES meetings and receive referrals from the By-Name List to fill units in the Agency's housing projects.

Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions.

1. **Local CoC**
    - Behavioral Health is highly involved in the NorCal CoC through multiple functions. SCHHSA provides administrative support and serves on the local Advisory Board. Through this Board, Behavioral Health staff coordinate with housing partners, including Partnership HealthPlan, ECM providers, and Community Supports providers.
2. **Public Housing Agency**
    - Siskiyou County is part of a multi-county Housing Authority administered by Shasta County. Behavioral Health collaborates with the Housing Authority to host staff trainings and application workshops. Staff monitor Housing Authority communications to stay aware of application openings.
3. **MCPs**
    - SCHHSA participates on the local CoC Advisory Board, coordinating with Partnership HealthPlan, ECM providers, and Community Supports providers. Behavioral Health leadership also meets regularly with the MCP for ongoing coordination.
4. **ECM and Community Supports Providers**
    - SCHHSA collaborates with ECM and Community Supports providers through the CoC Advisory Board and related workgroups.
5. **Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)**
    - SCHHSA collaborates with a wide range of partners including service providers, hospitals, tribes, faith groups, nonprofits, and community organizations. As a super-agency that includes CalWORKs, TANF, and child welfare, SCHHSA leadership teams coordinate closely across disciplines.

How will the county behavioral health system work with Homekey+ and supportive housing sites?

- Although there are no Homekey+ sites located in the County, Behavioral Health provided capital contributions to the only two PSH projects within its jurisdiction (including one in operation and one in the construction phase). Behavioral Health has current MOUs in place with the developers/owners of both projects. These MOUs detail Behavioral Health's

commitments to providing supportive services and coordinating on referrals. Strategies include the use of CES as well as regular team meetings with Behavioral Health and property management staff.

Did the county behavioral health system receive HHAP Round 6 funding?

- SCHHSA submitted an HHAP-6 application but has not yet received an award.

If yes, how will the county coordinate HHAP dollars to support BHSA-eligible individuals?

- SCHHSA will braid HHAP-6 funding with BHSA to ensure full funding for existing projects and services, particularly where eligible uses differ.

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed) For more information, please see 7.C.9.

Is the county providing the Rental Subsidies intervention?

- Yes

If answered 'yes' (D51), please answer this and all below rental subsidy questions (rows 54-64). Is the county providing this intervention to chronically homeless individuals?

- Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?

- 87

How many individuals of the number above (D54) will receive rental subsidies for permanent housing on an annual basis?

- 65

How many individuals of the number above (D54) will receive rental subsidies for interim housing on an annual basis?

- 22

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?

- The County estimated based on current beds funded with rental subsidies (including ongoing rental assistance plus lighter one-time assistance) using fiscal data and grant data tracked in the Housing Department. The County added an additional 10% for tenant-based subsidies in rental units and motels.10% was determined as the increase based on

population measurements, capacity allocations, procedural enhancements, and the inclusion of SUD-only clients accessing the resources.

For which setting types will the county provide rental subsidies?

- Non-Time-Limited Permanent Settings:
  - Supportive housing
  - Apartments, including master-lease apartments
  - Single and multi-family homes
  - Housing in mobile home communities
  - Shared housing
  - Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
- Time Limited Interim Settings:
  - Hotel and motel stays

Will this Housing Intervention accommodate family housing?

- Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

- BHSA Housing Interventions primarily will support the continuation of existing projects and programs. Specifically, BHSA funds will provide light rental assistance as needed for a move-in, or to prevent an eviction from, one of the County's two PSH apartment complexes. Other current projects include large houses that the County master-leases for rental assistance to multiple households in a shared housing setting. Assistance may include security deposits, pet deposits, rent or partial rent, back rent, and other supports. If funds are not exhausted by project-based rental assistance, the County will provide tenant-based rental assistance in settings such as apartment units and motel rooms.

Will the county behavioral health system provide rental assistance through project-based or tenant-based subsidies?

- Project-based
- Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA-eligible individuals?

- The County behavioral health system identifies and maintains a diverse portfolio of housing units for BHSA-eligible individuals through coordinated partnerships and active housing development strategies. In 2025, Behavioral Health hired a Housing Navigator to build and maintain relationships with landlords across affordable and market-rate properties, supporting access to scattered-site units.

The County partners with local cities, Tribal entities, and community-based organizations, including Youth Empowerment Siskiyou, to develop and expand housing opportunities. These partners, along with other providers, collaborate through the Continuum of Care (CoC) to identify available units, prioritize placements through the Coordinated Entry System (CES), and maintain shared visibility of housing resources through HMIS.

Behavioral Health coordinates with the housing authority, other county departments, and state and federal housing programs to support access to project-based housing, Permanent Supportive Housing (PSH), and low-income units. As the administrator of a majority of housing projects in the county, Behavioral Health aligns these resources directly with the needs of BHSA-eligible individuals.

The County also utilizes master leasing of single-family homes to provide shared housing and continues to expand Landlord outreach strategies to increase access to private market units. Additionally, PSH developments include non-PSH low-income units, and staff support BHSA-eligible individuals in applying for both.

Through these partnerships and strategies—spanning scattered-site, project-based, and master leasing approaches—the County maintains a flexible and coordinated housing portfolio.

Total number of units funded with BHSA Housing Interventions per year

- 70

Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units

- The County funds some tenant-based rental subsidies that are not tied to specific units. These are provided only as funding allows and when the assistance is likely to lead to sustainable housing for the client.

Operating Subsidies

Is the county providing the Operating Subsidies intervention?

- Yes

If answered 'yes' (D51), is the county providing this intervention to chronically homeless individuals?

- Yes

How many individuals does the county behavioral health system expect to serve with operating subsidies on an annual basis?

- 78

How many individuals of the number above (D54) will receive operating subsidies for permanent housing on an annual basis?

- 43

How many individuals of the number above (D54) will receive operating subsidies for interim housing on an annual basis?

- 35

What is the county's methodology for estimating total operating subsidies and total number of individuals served in interim and permanent settings on an annual basis?

- The County estimated the number of individuals served in permanent housing based on the numbers served last year in current PSH units and assumed additional numbers based on new units expected to become available. Interim housing estimates were based on the bed inventory receiving operating subsidies, assuming 50% annual turnover.

For which setting types will the county provide operating subsidies?

- Non-Time-Limited Permanent Settings:
    - Supportive housing
    - Apartments, including master-lease apartments
    - Single and multi-family homes
    - Shared housing
- Time Limited Interim Settings:
    - Non-congregate interim housing models
    - Tiny homes, emergency sleeping cabins, emergency stabilization units

Will this Housing Intervention accommodate family housing?

- Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.

- BHSA Housing Interventions primarily will support the continuation of existing projects and services. Specifically, BHSA funds will provide operating subsidies for current PSH apartment projects, an interim tiny home village, and shared housing in large, single-family homes. The interim tiny home village and shared housing projects will receive subsidies to maintain the safe and effective operation of these temporary housing sites. Due to the extremely low rent collected at PSH projects (typically 30% of a tenant's income which can be as low as $0.00 per month), these apartment complexes may have insufficient income to sustain the maintenance and management of the property. Operating subsidies for PSH units will fill gaps in operating costs to ensure long-term viability, accessibility, and success of the program. Operating subsidies will not be used to top off Transitional Rent. They will be provided directly to the housing provider for general operating expenses and not tied to

the rent received on behalf of specific individuals. The County will carry out programs both directly and through contractors.

Will the county behavioral health system provide operating subsidies through project-based or tenant-based subsidies?

- Project-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA-eligible individuals?

- BHSA operating subsidies will fund continuation of existing projects and unit/bed inventory. Staff will assist individuals with applications and referrals for all available services. The Agency already has established relationships with all interim housing projects and PSH apartments in the County.

Total number of units funded with BHSA Housing Interventions per year

- 51

Landlord Outreach and Mitigation Funds

Is the county providing this intervention?

- Yes

Is the county providing this intervention to chronically homeless individuals?

- Yes

Anticipated number of individuals served per year

- 25

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.

- The County is budgeting a small amount of funds to incentivize landlord partnerships and mitigate property owner risks resulting from damages. This intervention will particularly target units identified for tenant-based assistance (market-rate units, scattered-site placements) and for populations facing the greatest challenges to securing a housing placement. Incentives will be used flexibly to account for differences in property partner and clients' needs. Options include outreach and relationship-building materials/activities, signing bonuses, holding fees, and repairs for damages beyond reasonable wear-and-tear.

Total number of units funded with BHSA Housing Interventions per year

- 9

Please provide additional details if the county is providing landlord outreach and mitigation funds that are not tied to a specific number of units

- The landlord outreach and mitigation funds are not tied to a specific unit.The intention is to increase housing options in a competitive rental and housing market. Funds will encourage participation from private landlords and support successful placement of tenants in scattered-site and market-rate housing.

Participant Assistance Funds

Is the county providing this intervention?

- Yes

Is the county providing this intervention to chronically homeless individuals?

- Yes

Anticipated number of individuals served per year

- 20

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

- Participant Assistance funds will address immediate needs and remove barriers to obtaining and retaining housing. Funds will be flexible and time-limited. Allowable uses include application fees, security deposits, transportation for housing search, modest furnishings, credit fees, documentation, utility start-up, and essential household goods.

Housing Transition Navigation Services & Tenancy Sustaining Services

Is the county providing this intervention?

- Yes

Is the county providing this intervention to chronically homeless individuals?

- Yes

Anticipated number of individuals served per year

- 35

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

- Housing Transition and Navigation Services will support BHSA individuals to obtain and maintain housing stability.Staff will facilitate placement in appropriate interim and permanent housing. Activities include housing assessments, support plans, locating and matching units, completing applications, preparing documentation, and problem-solving barriers. After housing is obtained, staff will assist with move-in planning, lease education, life-skill building, and landlord mediation.

Housing Interventions Outreach and Engagement

Is the county providing the Housing Interventions Outreach & Engagement?

- No

If answered 'No' to above question, please explain why the county is not providing this intervention.

- Siskiyou County will be providing this service through other funding categories.

Capital Development Projects

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?

- No

If answered 'No' to above question, please explain why the county is not providing this intervention.

- In the last few years, Behavioral Health contributed capital development funds to two PSH apartment complexes as well as two new, year-round shelters. Three of these projects have opened in the last two years and one is expected to open within a year. With this rapid expansion, limited staff capacity, and inconsistent funding levels, the Agency is reorienting efforts toward sustainability of prior investments rather than new projects.

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge Housing)

- BHSA Housing Intervention Funds will primarily sustain existing programs where present funding is ending, insufficient, or currently supported by MHSA. Projects include two PSH apartment complexes, a tiny home village, and shared housing in large homes (permanent

housing, master-leased models, and interim housing models). Funds remaining after sustaining these projects will provide tenant-based interim and permanent housing assistance in motels, rental units, mobile home communities, board and care facilities, or other settings that meet the unique needs of a given household.

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

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?

- None

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

- None

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)?

- The County behavioral health system identifies Medi-Cal members eligible for housing-related Community Supports through coordinated clinical assessments, behavioral health intake, outreach services, and participation in Coordinated Entry through the NorCal CoC. These processes ensure timely identification of individuals experiencing or at risk of homelessness.

  Upon identification of housing needs, behavioral health providers and housing staff coordinate directly with the MCP, Partnership HealthPlan of California, to confirm eligibility for Community Supports, including Transitional Rent, using defined MCP criteria. Referrals are initiated immediately following identification of unmet housing needs to ensure timely access to services.

  The County and the MCP are finalizing standardized eligibility verification and referral workflows, including established referral protocols, designated points of contact, and data-sharing procedures.

  Currently, the MCP does not have a contracted provider for Transitional Rent services. The County Behavioral Health Plan is actively evaluating its capacity to serve in this role in coordination with the MCP.

  With a provider secured, the County will operationalize fully integrated referral processes for all housing-related Community Supports, including Transitional Rent. Until that time, the County continues to execute identification and eligibility processes and refers Medi-Cal members to available Community Supports without delay.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county

- Behavioral Health staff meet multiple times a month with Partnership HealthPlan to coordinate services and share updates on housing programs. Both entities attend local CoC Board meetings where partners share updates on housing programs and services.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports?

- Yes

If answered yes, please describe the county behavioral health system's coordination efforts to align network development

- Behavioral Health and Housing staff meet weekly with the Agency's contracted housing provider to align system development. This provider is in the process of contracting with Partnership HealthPlan to provide Transitional Rent, which will support integration and coordination. Siskiyou County will continue coordinating with Partnership to identify which housing providers are or will become Community Supports providers.

What processes does the county behavioral health system have in place to ensure Medi-Cal members with significant behavioral health conditions do not experience gaps in service once MCP housing services are exhausted?

- The County has established a structured transition process to ensure Medi-Cal members do not experience gaps in housing or behavioral health services as MCP housing services are exhausted. This process is operationalized through coordinated care planning, proactive transition timelines, and EHR-based tracking mechanisms.

  The County will track all Medi-Cal members eligible for BHSA Housing Intervention (HI) services within its Electronic Health Record (EHR) system, including those receiving MCP housing supports such as transitional rent. Through coordination with Partnership HealthPlan and Continuum of Care (CoC) partners, the County will maintain real-time visibility into members' housing status through participation in Coordinated Entry System (CES) meetings and HMIS.

  To ensure timely transitions, the EHR will be configured to generate automated alerts at key service milestones—at 3, 4, 5, and 6 months during the course of MCP housing services. These alerts will prompt care teams to initiate and progressively intensify transition planning activities to prepare for continuity of housing supports.

  At each milestone:

  - 3 months in service: Care teams identify Medi-Cal members eligible for BHSA HI services and begin assessing ongoing housing needs and eligibility requirements.

    - 4 months in service: Transition planning is formally incorporated into the member's treatment plan, including identification of appropriate BHSA HI services or alternative housing resources.
    - 5 months in service: Referrals to BHSA-funded housing supports are initiated, and coordination with housing providers and system partners is formalized.
    - 6 months in service: Final transition arrangements are confirmed to ensure continuity of housing and services without interruption as MCP housing services conclude.

Additionally, the EHR will require ongoing updates to each member's treatment plan to reflect housing-related needs, goals, and interventions. This ensures that housing stability is continuously monitored as a core component of behavioral health treatment and that progress toward securing ongoing housing is documented throughout the transition period.

Through comprehensive tracking of all eligible Medi-Cal members, structured milestone-driven planning, and cross-system coordination, the County will ensure seamless transitions from MCP housing services to BHSA HI services, minimizing the risk of service gaps to the extent resources are available.

Flexible Housing Subsidy Pools

Is there an operating Flex Pool in the county?

- No

Please explain why the county is not participating in the Flex Pool

- N/A

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

- N/A

If 'Operator' was not selected, what organization is serving as the Operator?

- N/A

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

- N/A

If answered 'yes,' which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?

- N/A

If answered 'no' to whether a Flex Pool exists, is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?

- No

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool

- N/A

BHS Fund: Innovative Behavioral Health Pilot and Projects

Does the county's plan include the development of innovative programs or pilots?

- No

Workforce Strategy

Maintain Adequate Network of Qualified & Culturally Responsive Providers

The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

1. Maintains and monitors a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and

2. Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.

3. The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual. Does the county intend to adopt this recommended approach for BHSA-funded providers that:

a. **also participate in the county's Medi-Cal Behavioral Health Delivery System?**
    - Yes

b. **do not participate in the county's Medi-Cal Behavioral Health Delivery System?**
    - Yes

Build Workforce to Address Statewide Behavioral Health Goals

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

Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?

- 59%

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates.

- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Professional Clinical Counselor
- Medi-Cal Certified Peer Support Specialist
- Mental Health Rehabilitation Specialist

Please describe any other key workforce gaps in the county.

- Siskiyou County faces unique workforce challenges due to its rural and geographically isolated context. The limited presence of colleges and universities in the region constrains local access to higher education and professional training programs, which in turn impacts the availability of licensed behavioral health staff. This educational gap makes it difficult to develop a local pipeline of clinicians and other licensed professionals, increasing reliance on recruitment from outside the region. The County also experiences heightened workforce instability due to frequent natural disasters, including wildfires, droughts, and floods. These events disrupt community infrastructure, displace residents, and contribute to staff turnover, making retention of skilled personnel particularly challenging. Compounding these issues are limited housing availability and affordability, as well as slow economic growth, which reduce the attractiveness of the region for new staff and make long-term retention difficult. Collectively, these factors create ongoing recruitment and retention challenges for the behavioral health system, emphasizing the need for targeted workforce development strategies, incentives for retention, and flexible staffing models that can adapt to environmental and economic pressures.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

- Over the next three fiscal years, Siskiyou County anticipates significant workforce pressures as new requirements under Behavioral Health Transformation (BHT) and BH-CONNECT are implemented. The expansion of evidence-based practices, including High Fidelity Wraparound, FACT/ACT, and peer-delivered interventions, will require specialized staff with certification and supervision capacity that the County currently struggles to recruit and retain due to rural workforce shortages, limited local training programs, and competition with urban areas. These workforce constraints may directly impact clients, resulting in longer wait times for services, reduced availability of specialized interventions, and limited access to field-based or mobile engagement services for high-risk populations. The County's rural geography, ongoing housing shortages, and the effects of natural disasters further hinder recruitment and retention, which may affect continuity of care and timely service delivery. While strategies such as "grow-your-own" pipelines, supervision supports, and targeted recruitment will be employed, Siskiyou County expects that workforce limitations could create gaps in care, slow full program

implementation, and challenge the County's ability to meet the full intent of BHT and BH-CONNECT in the near term.

Address Workforce Gaps

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

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

- yes

Please explain any actions or activities the county is engaging in to leverage the program.

- Encourage providers to apply

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

- yes

Please explain any actions or activities the county is engaging in to leverage the program.

- Encourage providers to apply

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?

- no

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

- no

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

- no

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training.

- The county does not have any established plans for further efforts beyond what is discussed in prior sections. Once these are fully implemented the county may consider further efforts if capacity allows.

Budget and Prudent Reserve

Please upload the completed budget template.

- See Appendix C.

Amount Over Maximum Prudent Reserve Limit

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

Behavioral Health Services & Supports (BHSS)

- N/A

Full Service Partnership (FSP)

- N/A

Housing Interventions

- N/A

Prudent Reserve Assessment

Date of last prudent reserve assessment

- 06/30/2025

Alignment with Integrated Plan Goals

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

BHSS

- N/A

FSP

- N/A

Housing Interventions

- N/A

Plan Approval & Compliance

This section will be included in the final Integrated Plan submitted to DHCS for review and approval.

APPENDIX A. QUALITY IMPROVEMENT PLAN

Appendix B. Community Planning Process Report

Appendix C. Budget Template