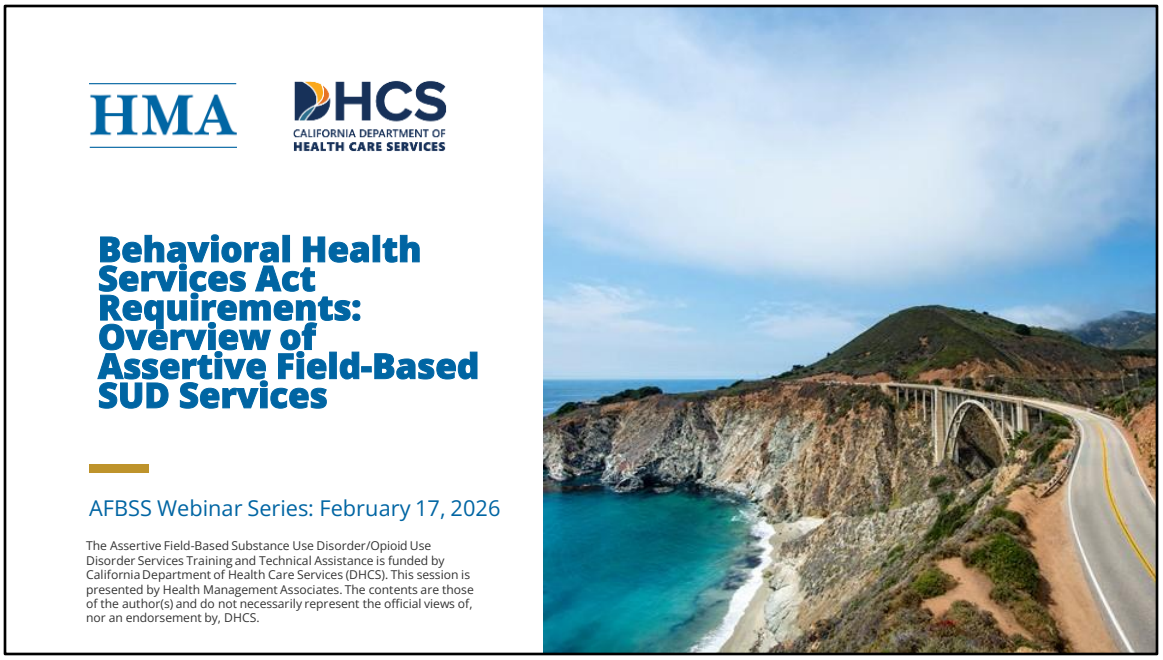

[Slide Image Description: This cover slide introduces the title of this webinar. It contains the logos for California Department of Health Care Services and Health Management Associates.]

Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.

Disclosures

Faculty	Nature of Commercial Interest
Charles Robbins, MBA	Mr. Robbins discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
Helen DuPlessis, MD	Dr. DuPlessis discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. She is also a board member of Ascendiun and the Blue Shield of CA Health Plan.
Nai Kasick, MPH	Ms. Kasick discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
Jeanene Smith, MD, MPH, CME Reviewer	Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

HMA discloses all relevant financial relationships with companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients.

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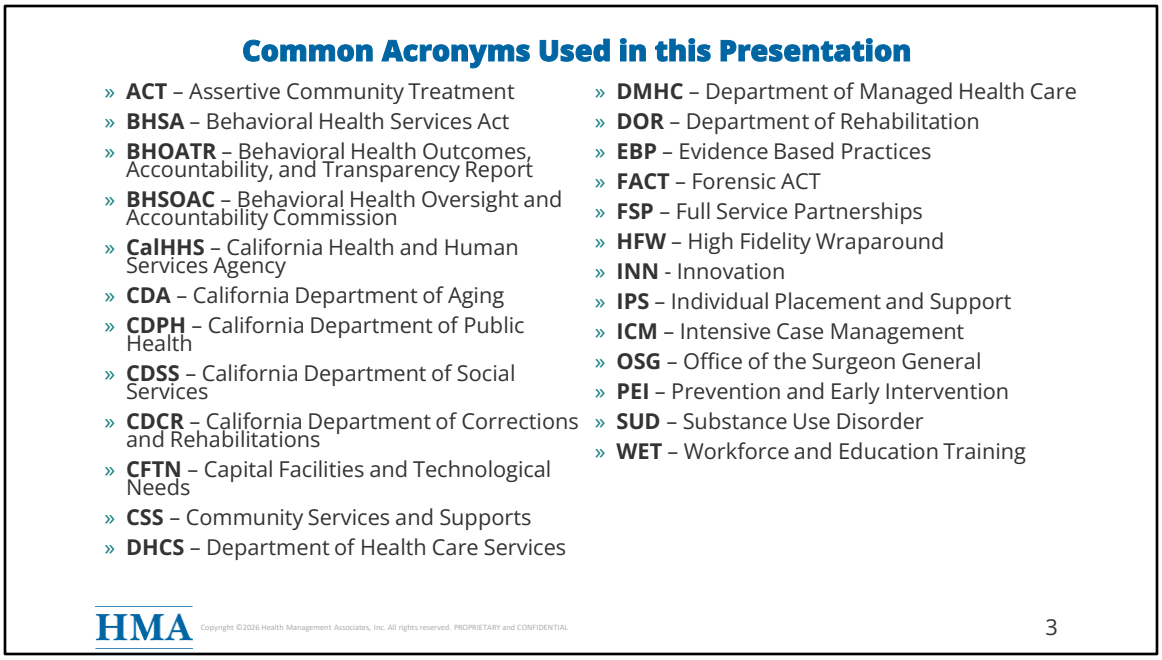
- [Slide Image Description: This slide shows Continuing Education disclosures.]

- Charles Robbins, MBA: Mr. Robbins discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
- Helen DuPlessis, MD: Dr. DuPlessis discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
- Nai Kasick, MPH: Ms. Kasick discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
- Jeanene Smith, MD, MPH: Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.



[Slide Image Description: This slide includes a list of common acronyms used in this presentation.]

Common Acronyms Used in this Presentation:

- ACT – Assertive Community Treatment
- BHSA – Behavioral Health Services Act
- BHOATR – Behavioral Health Outcomes, Accountability, and Transparency Report
- BHSOAC – Behavioral Health Oversight and Accountability Commission
- CalHHS – California Health and Human Services Agency
- CDA – California Department of Aging
- CDPH – California Department of Public Health
- CDSS – California Department of Social Services
- CDCR – California Department of Corrections and Rehabilitations
- CFTN – Capital Facilities and Technological Needs
- CSS – Community Services and Supports
- DHCS – Department of Health Care Services
- DMHC – Department of Managed Health Care
- DOR – Department of Rehabilitation

- EBP – Evidence Based Practices
- FACT – Forensic ACT
- FSP – Full Service Partnerships
- HFW – High Fidelity Wraparound
- INN - Innovation
- IPS – Individual Placement and Support
- ICM – Intensive Case Management
- OSG – Office of the Surgeon General
- PEI – Prevention and Early Intervention
- SUD – Substance Use Disorder
- WET – Workforce and Education Training

Presenters

Charles Robbins, MBA
Principal
Health Management Associates (HMA)

Helen DuPlessis, MD
Physician Principal
Health Management Associates (HMA)

Nai Kasick, MPH
Principal
Health Management Associates (HMA)

HMA

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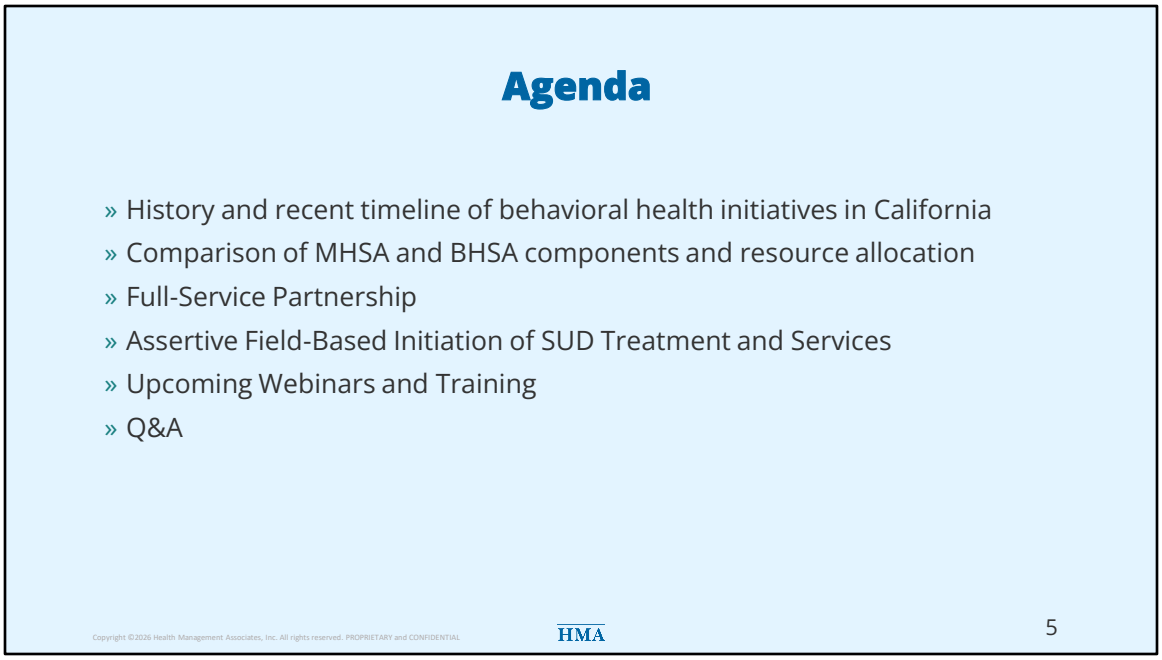
[Slide Image Description: This slide includes images of the presenters of this webinar on a light blue background.]

Charles Robbins has been transforming communities for the past three decades. His extensive community-based organization career spans healthcare, child welfare, housing and homelessness, mental health, suicide prevention, harm reduction, and substance use disorder, with a forte in advocacy, strategic planning, organizational development, leadership development, and capacity building.

Dr. Helen DuPlessis is an accomplished physician executive who brings extensive leadership experience and a wealth of in-depth knowledge about public sector health programs to HMA. She has a rich history of involvement in healthcare administration for a variety of organizations, expertise in program and policy development, practice transformation, public health, maternal, and child health policy, community systems development, performance improvement, and managed care. With a proven track record in understanding and implementing innovative and effective health programs and performance improvement activities, she

has served as an advocate of community capacity-building, staff and professional development.

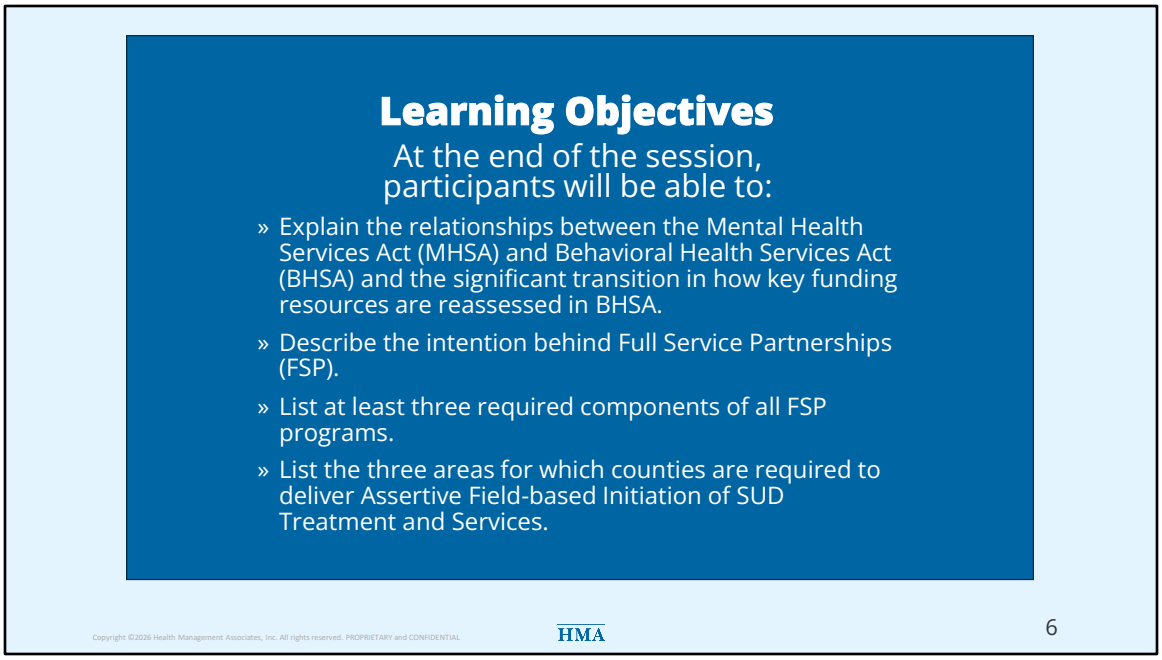
A mission-driven transformational leader, Nai Kasick advances healthcare equity and access through operational, technological and programmatic improvement strategies. With over a decade of executive experience in program development, community and provider engagement, quality improvement and health equity, Nai leverages her background in health plan operations to foster healthier communities and positively impact lives.



[Slide Image Description: This slide shows the major sections of this webinar on a light blue background.]

Today's session will cover the following topics:

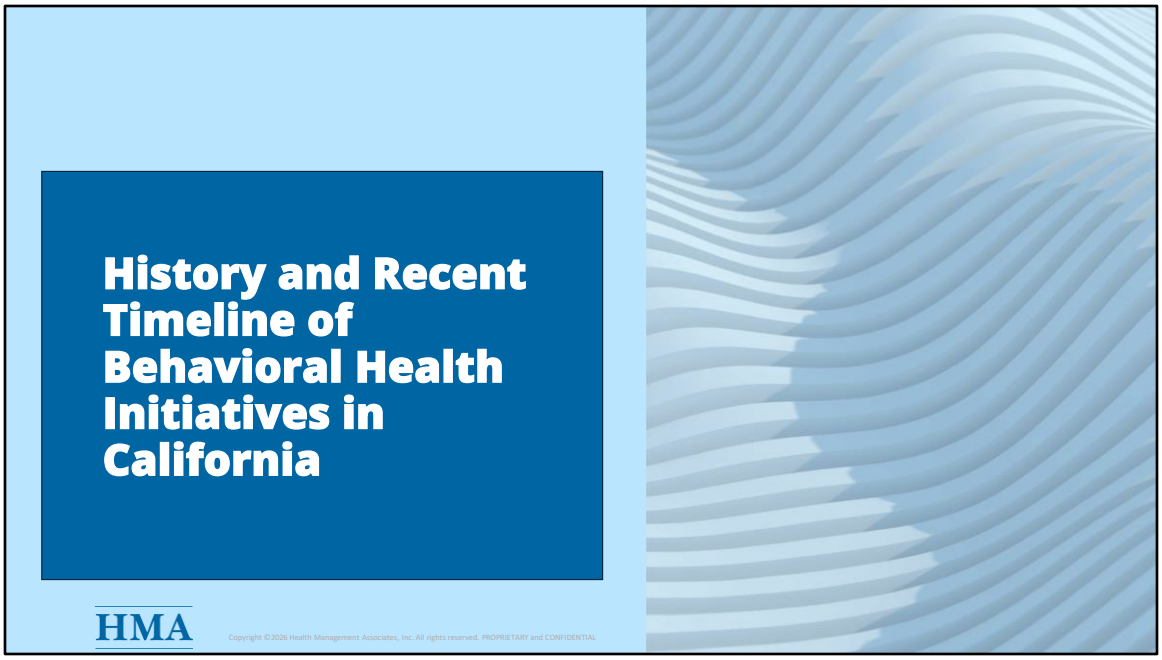
- History and recent timeline of behavioral health initiatives in California
- Comparison of MHSA and BHSA components and resource allocation
- Full-Service Partnership
- Assertive Field-Based Initiation of SUD Treatment and Services
- Upcoming Webinars and Training
- Q&A



[Slide Image Description: This slide shows the learning objectives for this webinar with a light blue background.]

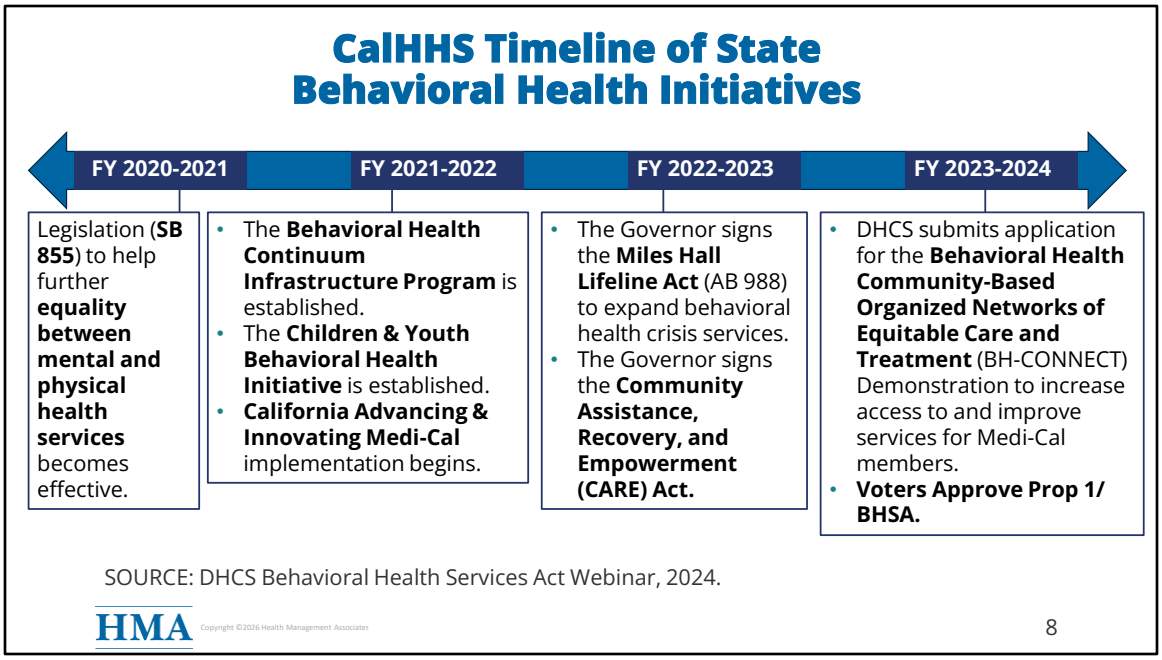
At the end of the session, participants will have an increased ability to:

- Explain the relationships between the Mental Health Services Act (MHSA) and Behavioral Health Services Act (BHSA) and the significant transition in how key funding resources are reassessed in BHSA.
- Describe the intention behind Full Service Partnerships (FSP).
- List at least three required components of all FSP programs.
- List the three areas for which counties are required to deliver Assertive Field-Based Initiation of SUD Treatment and Services.



[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This first section covers the history and recent timeline of behavioral health initiatives in California.



[Slide Image Description: This slide shows a timeline of state behavioral health initiatives. It contains decorative icons and arrows.]

For context, this slide depicts a timeline of the various behavioral health initiatives in California over the past five years, including the roll out of the various behavioral health initiatives, starting from the 2020 legislation to mandate state-regulated health plan coverage of medically necessary behavioral health services on par with physical health.

Across the timeline, the various initiatives related to behavioral health include the following:

- FY 2020 – 2021: Legislation (SB 855) to help further equality between mental and physical health services becomes effective, with a goal of improving access, quality, and accountability.
- FY 2021 – 2022:
    - The Behavioral Health Continuum Infrastructure Program is established.
    - The Children & Youth Behavioral Health Initiative is established.
    - California Advancing & Innovating Medi-Cal implementation

begins.
    - This combined goals including reducing homelessness and housing insecurity; investing in infrastructure; going upstream – prevention/early intervention and innovation; reimagining behavioral health for children and youth; and improving access, quality, and accountability.
- FY 2022 – 2023:
    - The Governor signs the Miles Hall Lifeline Act (AB 988) to expand behavioral health crisis services.
    - The Governor signs the Community Assistance, Recovery, and Empowerment (CARE) Act.
    - This combined goals including developing a robust and adaptive crisis care continuum and supporting vulnerable populations.
- FY 2023 – 2024:
    - DHCS submits application for the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration to increase access to and improve services for Medi-Cal members.
    - Voters Approve Prop 1/ BHSA.
    - This combined goals including reducing homelessness and housing insecurity; investing in infrastructure; going upstream – prevention/early intervention and innovation; reimagining behavioral health for children and youth; improving access, quality, and accountability; developing a robust and adaptive crisis care continuum; supporting vulnerable populations; and advancing diversity, equity, and inclusion.

And to the far right, the current focus of the state, including the CMS-approved BH-CONNECT demonstration and the voter approved Prop1/Behavioral Health Services Act (BHSA).

SOURCE: DHCS Behavioral Health Services Act Webinar, 2024.

Proposition 1

1. **Authorizes a $6.38 billion Behavioral Health Infrastructure Bond (AB 531)**
   - Funding behavioral health (BH) treatment beds, supportive housing, and community sites
   - Funding for housing for veterans with BH needs and persons experiencing homelessness

2. **Amends the MHSA (SB 326)**
   - Renames Mental Health Services Act (MHSA) (passed by proposition in 2004) the **"Behavioral Health Services Act"** (BHSA); adds Substance Use Disorder (SUD) so it's both Mental Health (MH) and SUD
   - Modifies how MHSA funds are allocated
   - Changes eligible population
   - Changes to oversight, accountability, and the community planning process

SOURCE: DHCS, 2026.

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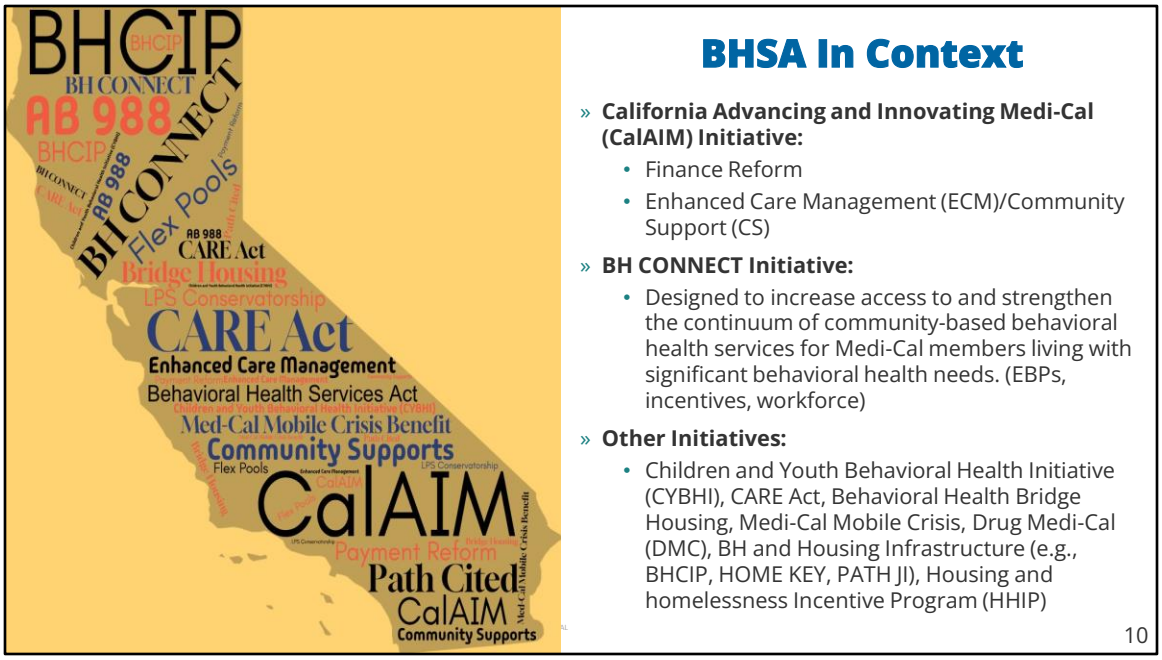
[Slide Image Description: This slide shows an overview of DHCS Proposition 1, with an image of a government building.]

This slide overviews DHCS Proposition 1 – Behavioral Health Transformation.

First, Proposition 1 authorizes a $6.38 billion Behavioral Health Infrastructure Bond (AB 531). This provides funding for behavioral health (BH) treatment beds, supportive housing, and community sites, as well as funding for housing for veterans with BH needs and persons experiencing homelessness.

Second, Proposition 1 amends the MHSA (SB 326), by renaming the Mental Health Services Act (MHSA) (passed by proposition in 2004) the "Behavioral Health Services Act" (BHSA). Proposition 1 also adds Substance Use Disorder (SUD), so the act includes both Mental Health (MH) and SUD. Proposition 1 in turn modifies how MHSA funds are allocated, changes the eligible population, and includes changes to oversight, accountability, and the community planning process.

SOURCE: DHCS, 2026.



[Slide Image Description: This slide shows BHSA in context, with an image of the state of California with relevant initiatives listed.]

Consider BHSA in the context of existing California state initiatives:

- California Advancing and Innovating Medi-Cal (CalAIM) Initiative:
    - Finance Reform
    - Enhanced Care Management (ECM)/Community Support (CS)
- BH CONNECT Initiative:
    - Designed to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. (EBPs, incentives, workforce)
- Other Initiatives:
    - Children and Youth Behavioral Health Initiative (CYBHI)
    - CARE Act
    - Behavioral Health Bridge Housing
    - Medi-Cal Mobile Crisis
    - Drug Medi-Cal (DMC)
    - BH and Housing Infrastructure (e.g., BHCIP, HOME KEY, PATH JI)
    - Housing and homelessness Incentive Program (HHIP)

BHSA: Purpose and Goals

» Purpose
- Reform, modernize, and expand the MHSA to address homelessness, substance use disorder, and systemic gaps.

» Core Goals
- Improve access to integrated behavioral health care.
- Expand housing interventions for vulnerable populations.
- Enhance transparency and equity in outcomes.

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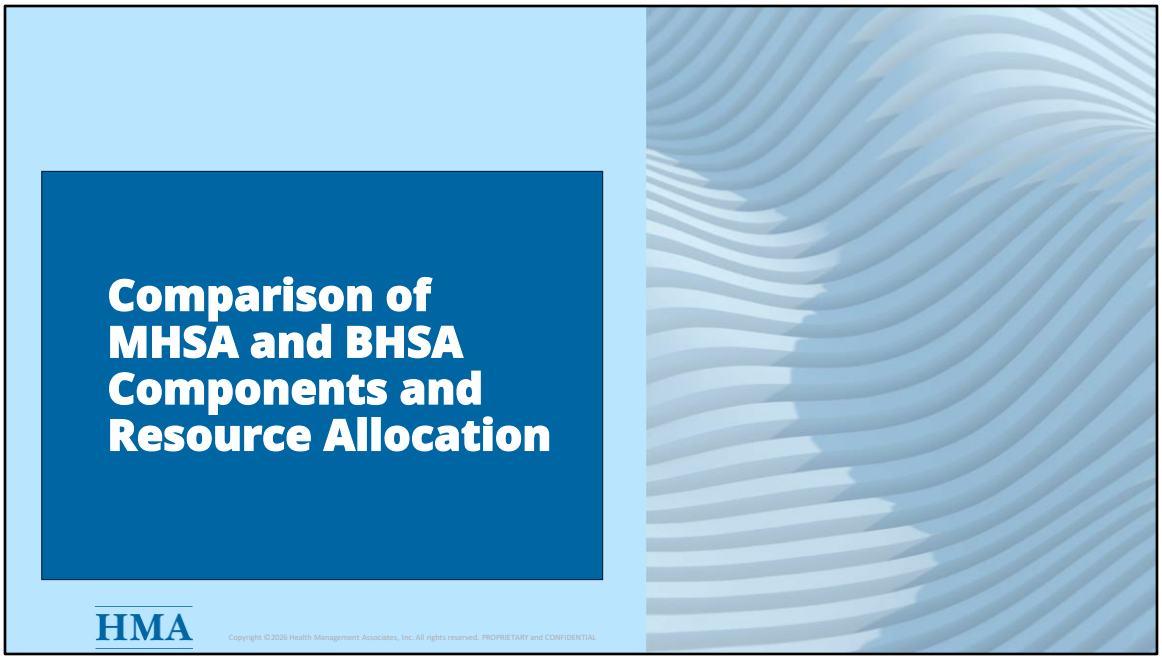
[Slide Image Description: This slide shows the purpose and goals of the BHSA, with an image of people walking along a spiral staircase.]

The BHSA's purpose is to reform, modernize, and expand the MHSA to address homelessness, substance use disorder, and systemic gaps. The BHSA is part of a larger effort to "modernize" behavioral health.

The BHSA's core goals include:
- Improving access to integrated behavioral health care.
- Expanding housing interventions for vulnerable populations.
- Enhancing transparency and equity in outcomes.



[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This second section compares the components and resource allocation of the MHSA and BHSA.

High Level Overview of Changes

Category	MHSA	BHSA
Scope	Mental health only	**MH + SUDs** (no co-occurrence required)
Funding	Five components (PEI, INN, WET, CSS, CFTN)	**Three components**: FSP (35%), BHSS (35%), Housing (30%)
Expenditure Reporting	Annual expenditure reports	**Annual BHOATR:** Reporting on **ALL** county BH funding sources, not just BHSA, as well as relevant outcomes and measures
Equity	General equity language	**Mandated disparity reduction** using stratified data and aligned to population level health goals

SOURCE: DHCS, n.d.

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[Slide Image Description: This slide shows a table detailing high level overview of changes between MHSA and BHSA.]

Scope:
- MHSA: Mental health only
- BHSA: MH and SUDs (no co-occurrence required)

Funding:
- MHSA: Five components:
    - Community Services and Supports (CSS) (76%)
    - Prevention and Early Intervention (PEI) (19%)
    - Innovation (Inn) (5%)
    - Workforce and Education Training (WET)
    - Capital Facilities and Technological Needs (CFTN)
- BHSA: Three components:
    - Full Service Partnerships (FSP – no longer under CSS) (35%),
    - Behavioral Health Services and Supports (BHSS) (35%)
    - Housing Interventions (30%)

Expenditure Reporting:
- MHSA: Annual expenditure reports

- BHSA: Annual Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) reporting on ALL county BH funding sources, not just BHSA, as well as relevant outcomes and measures

Equity:

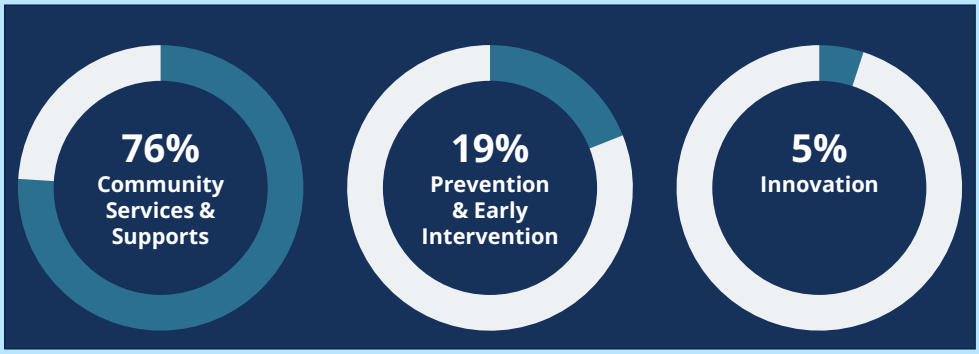
- MHSA: General equity language
- BHSA: Mandated disparity reduction using stratified data and aligned to population level health goals

Requirements to keep in mind:

- SUD treatment funded under BHSA is no longer optional (MHSA focused only on mental health).
- Eligibility includes individuals with moderate to severe SUDs, even without mental health diagnosis.
- While BHSA eligibility is aligned with Medi-Cal criteria, eligible individuals do not need to be enrolled in Medi-Cal.
- Train workforce on SUD evidence-based practices (e.g., MAT, contingency management).
- Integrate SUD data into existing mental health systems.

SOURCE: DHCS, n.d.

Three Key Former MHSA Funding Buckets



SOURCE: California Legislative Information, 2026.

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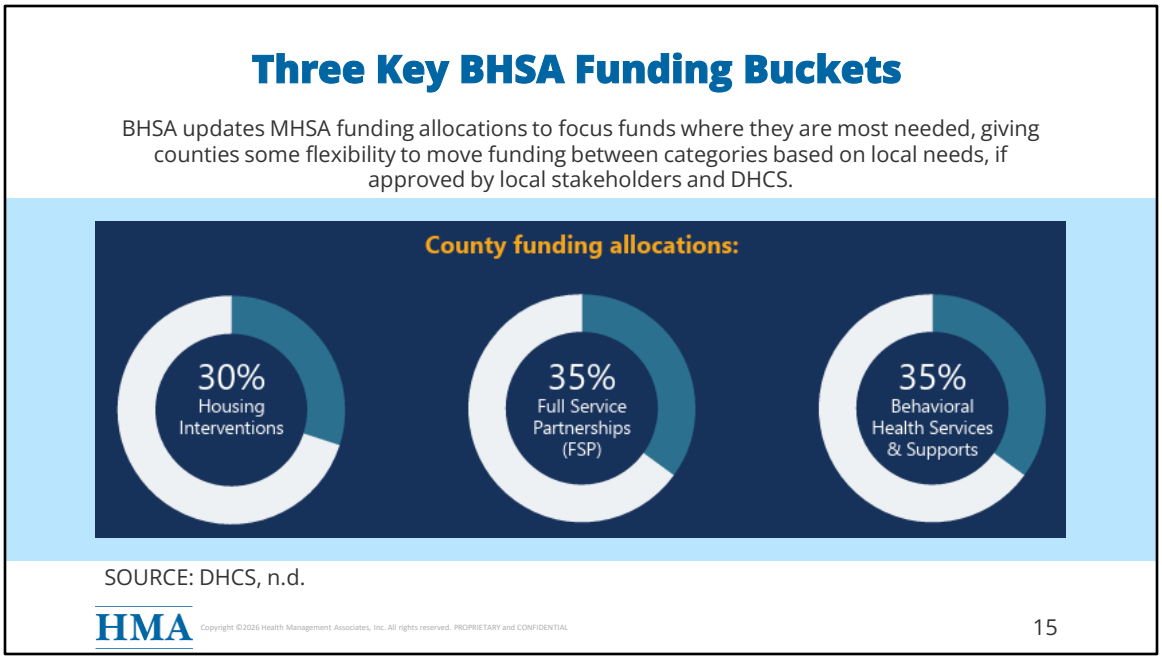
[Slide Image Description: This slide shows the key MHSA funding buckets, with colorful charts.]

This chart represents a way to think about funding changes overall. It visually restates the funding allocations of the former Mental Health Services Act.

- Community Services & Supports – 76% of budget
- Prevention and Early Intervention – 19% of budget
- Innovation – 5% of budget

SOURCE: California Legislative Information, 2026.



[Slide Image Description: This slide shows the key BHSA funding buckets, with colorful charts.]

BHSA updates MHSA funding allocations to focus funds where they are most needed, giving counties some flexibility to move funding between categories based on local needs, if approved by local stakeholders and DHCS.

- Housing Interventions – 30% of budget
    - For people with the most significant mental health and substance use disorder treatment needs who are experiencing or at risk of homelessness.
    - 51% for chronic homelessness.
    - Up to 25% for building housing.
- Full Service Partnerships (FSP) – 35% of budget
    - Comprehensive and wraparound services that optimize Medi-Cal

billing and strengthen the range of services individuals, families, and communities need.

- BHSS – 35% of budget
    - Comprehensive and intensive care for people of any age with the most complex needs through treatment, housing, employment, and other services.
    - 51% directed toward early intervention.
        - 51% of that for early intervention for children and youth 25 and younger.

65% of BHSA funding is focused on the Most Severely Behavioral Health Individuals.

This change builds upon current and ongoing efforts to support vulnerable populations living with the most significant mental health conditions and substance use disorders.

SOURCE: DHCS, n.d.

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This third section covers Full Service Partnership.

Full Service Partnership (FSP)

What it is:

» FSP programs provide individualized, team-based care to individuals living with significant behavioral health needs through a "whatever it takes" approach.

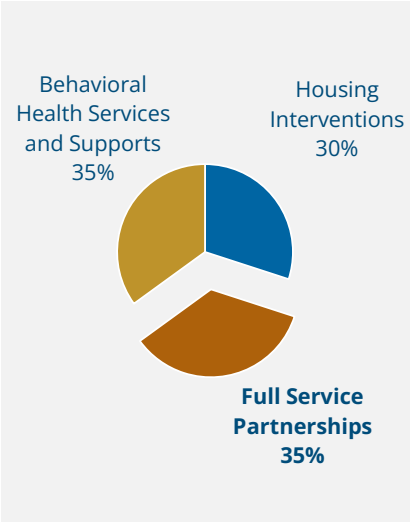
Key Features:

» 35% of county BHSA funding.

» FSP programs must make the full FSP continuum available (see next slide).

» Integration of SUD treatment.

» Initiation of Assertive Field-Based SUD Services



SOURCE: DHCS, 2026 BHSA PM v1.3.2.2

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[Slide Image Description: This slide describes Full Service Partnerships, with a pie chart representing funding.]

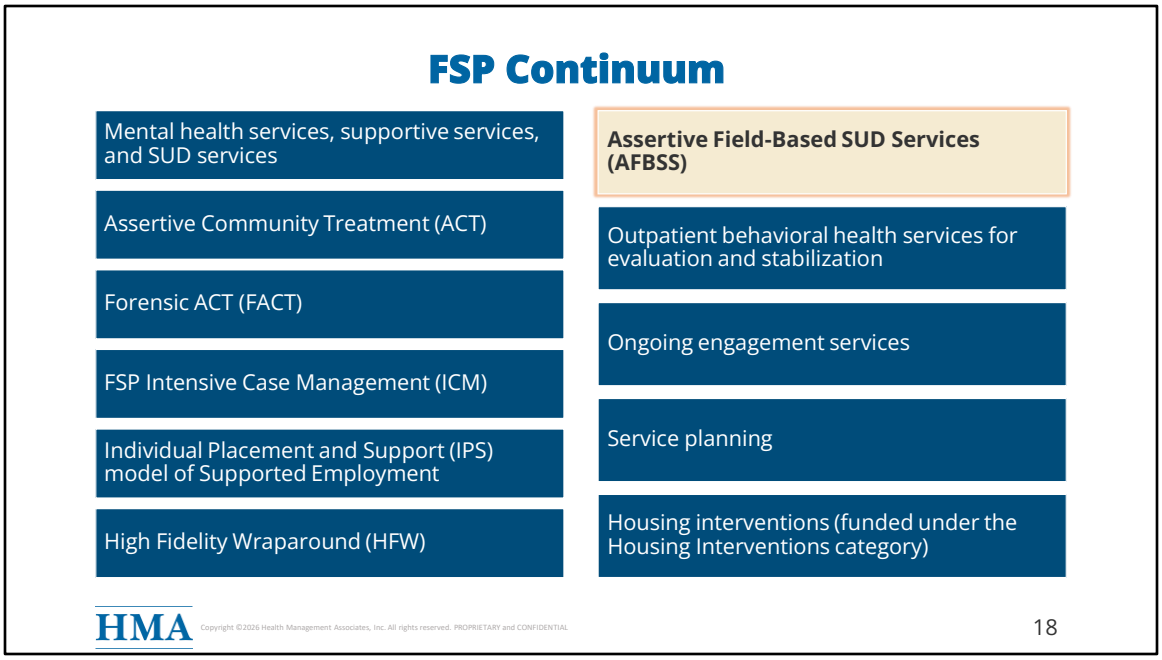
Full Service Partnerships (FSP) include intensive, community-based services for individuals with severe mental illness or severe emotional disturbance, and co-occurring disorder. FSP leverages a "whatever it takes" approach, including counseling, crisis support, and other supports.

FSP makes up 35% of county BHSA funding. New Requirements:

- Evidence-Based Models: ACT, ICM, or other DHCS-approved practices.
- Standardized Levels of Care: Tailored to acuity (e.g., high-need justice-involved individuals).
- Focus Populations: Homelessness, institutionalization risk, SUDs.

MHSA FSP was flexible; BHSA mandates specific delivery models according to standardized "tiers".

SOURCE: DHCS, 2026 BHSA PM v1.3.2.2



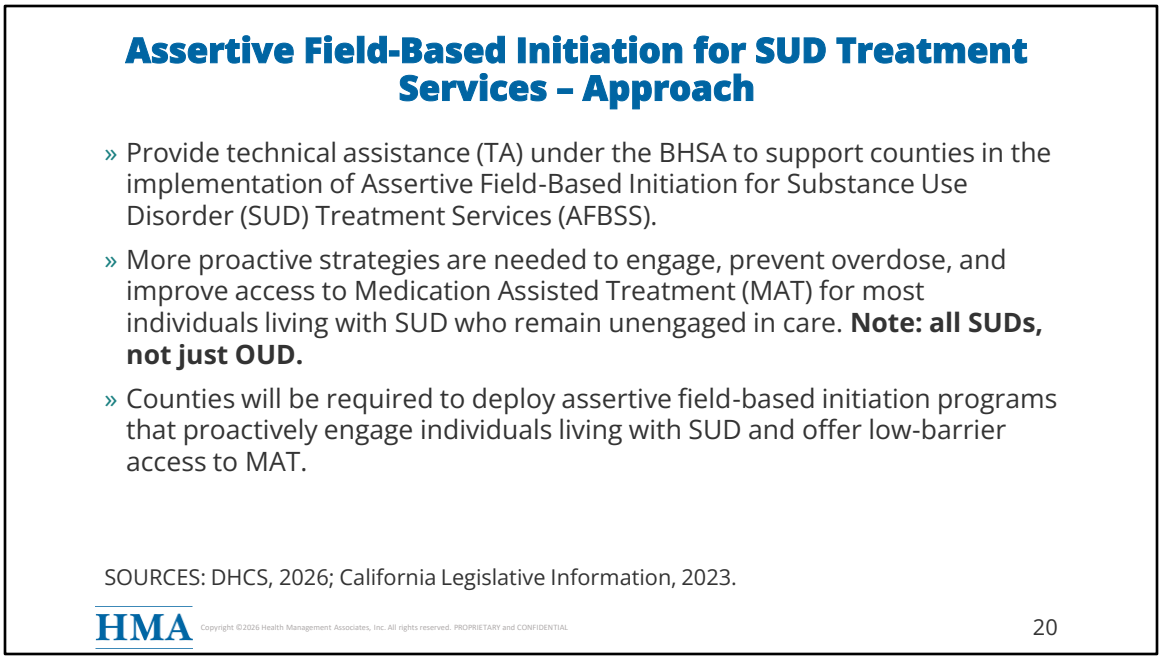
[Slide Image Description: This slide lists the FSP continuum.]

The FSP Continuum includes the following:

- Mental health services, supportive services, and substance use disorder (SUD) services
- Assertive Community Treatment (ACT)
- Forensic ACT (FACT)
- FSP Intensive Case Management (ICM)
- Individual Placement and Support (IPS) model of Supported Employment
- High Fidelity Wraparound (HFW)
- Assertive Field-Based initiation for SUD
- Outpatient behavioral health services for evaluation and stabilization
- Ongoing engagement services
- Service planning (county FSP programs are expected to adhere to the service planning process outlined in California Welfare and Institutions Code (W&I Code) sections 5806 and 5868 and do not require documentation in a "standalone" treatment plan or service plan)
- Housing interventions (funded under the Housing Interventions category)

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This fourth section covers Assertive Field-Based Initiation of SUD Treatment and Services.



[Slide Image Description: This slide lists the AFBSS approach.]

Assertive Field-Based Initiation for SUD Treatment Services (AFBSS) Approach:

- Provide technical assistance (TA) under the Behavioral Health Services Act (BHSA) to support counties in the implementation of Assertive Field-Based Initiation for Substance Use Disorder (SUD) Treatment Services (AFBSS).
- More proactive strategies are needed to engage, prevent overdose, and improve access to MAT for most individuals living with SUD who remain unengaged in care. Note: all SUDs, not just OUD.
- Pursuant to the BHSA and in accordance with W&I Code section 5887(a)(3), counties will be required to deploy assertive field-based initiation programs that proactively engage individuals living with SUD and offer low-barrier access to MAT.

SOURCES: DHCS, 2026; California Legislative Information, 2023.

Assertive Field-Based Initiation for SUD Treatment Services – Approach (Continued)

- Assertive field-based initiation promotes a proactive "no wrong door" approach to connect more individuals living with SUD to MAT on a voluntary basis, similar to assertive, field-based models that promote proactive engagement and treatment of individuals living with serious mental illness (SMI).
- Counties are encouraged to identify these populations, including people who are unhoused/housing insecure, justice-involved, and individuals with co-occurring mental health needs.
- Assertive field-based initiation requires counties to conduct ongoing, targeted outreach to engage and initiate individuals living with SUD into MAT (or other treatment services) in any community-based and low-barrier setting.

[Slide Image Description: This slide lists the AFBSS approach.]

Assertive field-based initiation promotes a proactive "no wrong door" approach to connect more individuals living with SUD to MAT on a voluntary basis, similar to assertive, field-based models that promote proactive engagement and treatment of individuals living with serious mental illness (SMI).

Counties are encouraged to identify these populations, including people who are unhoused/housing insecure, justice-involved, and individuals with co-occurring mental health needs.

Assertive field-based initiation requires counties to conduct ongoing, targeted outreach to engage and initiate individuals living with SUD into MAT (or other treatment services) in any community-based and low-barrier setting.

Assertive Field-Based Initiation for SUD Treatment Services – Approach (Continued)

- Community-based low-barrier settings include:
  - The street
  - Shelters
  - Homeless encampments
  - Consumer-operated wellness centers
  - Drop-in centers
  - Syringe service programs
  - Medication and mobile narcotic treatment programs
  - Other easily accessed locations to reach people where they are

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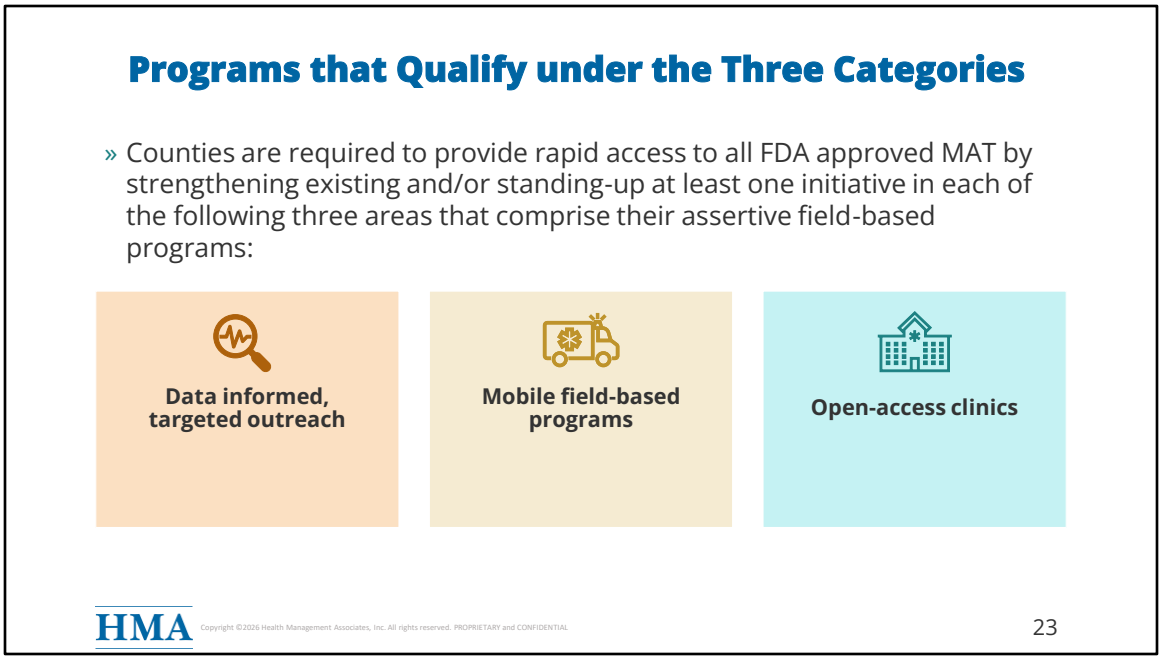
[Slide Image Description: This slide lists the AFBSS approach.]

Community-based low-barrier settings include the street, shelters, homeless encampments, consumer-operated wellness centers, drop-in centers, syringe service programs, medication and mobile narcotic treatment programs, and other easily accessed locations to reach people where they are.



[Slide Image Description: This slide lists programs that qualify under the three categories, with three colorful boxes and icons.]

As previously stated, counties are required to provide rapid access to all FDA-approved MAT by strengthening existing and/or standing-up at least one initiative in each of the following three areas that comprise their assertive field-based programs:

1. Data-informed, targeted outreach on an ongoing basis to BHSA-eligible individuals with SUD needs to engage them in SUD services, including MAT, if needed
2. Mobile field-based programs.
3. Open-access clinics.

Counties' assertive field-based programs are required to serve BHSA-eligible individuals living with SUD treatment needs and prioritize those who are at higher risk of overdose, including those known to have experienced overdose reversals, or who are experiencing homelessness and/or justice-involvement.

Since counties are required to conduct ongoing targeted outreach, DHCS is encouraging counties to collaborate with various partners (like EMS, MCPs, FQHC/RHS, etc.) to obtain data on their regions and populations with the highest rates of overdose, overdose reversals, drug-related arrests, and other relevant statistics. This is where the data-informed piece comes in—and where DHCS sees some TA also coming in to aid counties in connecting with these partners, understanding the data, and using it effectively.

Ideas in Action

» List any current activities that your county is providing that would demonstrate:
- Targeted data informed outreach
- Mobile field-based programs
- Open-access clinics

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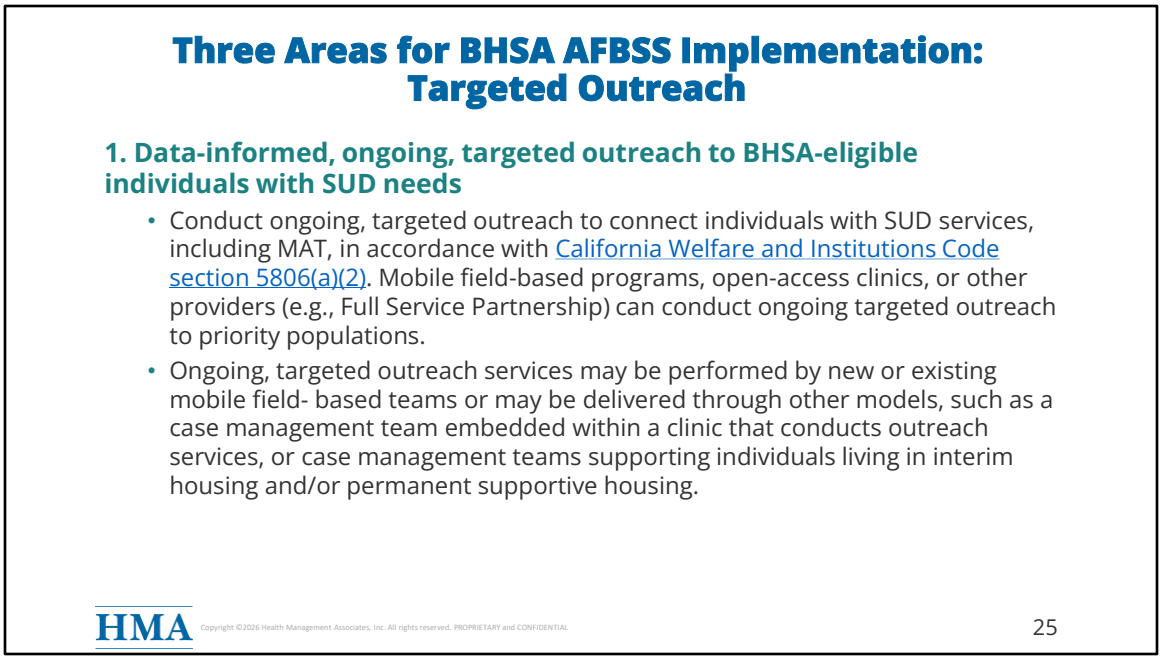
[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

List any current activities that your county is providing that would demonstrate:
- Targeted data informed outreach
- Mobile field-based programs
- Open-access clinics



[Slide Image Description: This slide details three areas for county BH AFBSS implementation.]

1. Data-informed, targeted outreach to BHSA-eligible individuals with SUD needs

Conduct ongoing, targeted outreach to connect individuals with SUD services, including MAT, in accordance with California Welfare and Institutions Code section 5806(a)(2). Mobile field-based programs, open-access clinics, or other providers (e.g., Full Service Partnership) can conduct ongoing targeted outreach to priority populations.

Ongoing, targeted outreach services may be performed by new or existing mobile field- based teams or may be delivered through other models, such as a case management team embedded within a clinic that conducts outreach services, or case management teams supporting individuals living in interim housing and/or permanent supportive housing.

Three Areas for BHSA AFBSS Implementation: Targeted Outreach (Continued)

1. Data-informed, ongoing, targeted outreach to BHSA-eligible individuals with SUD needs

- To identify the highest-need outreach locations, counties are encouraged to collaborate with:
  - Emergency Medical Services (EMS)
  - Law enforcement
  - Managed care plans (MCPs)
  - Health systems and hospitals
  - Federally Qualified Health Centers (FQHC)
  - Rural Health Clinics (RHCs)
  - Individuals with living or lived experience
  - Other partners to obtain data on regions and populations with high rates of overdose, overdose reversals, drug-related arrests, and other relevant statistics on a regular basis.

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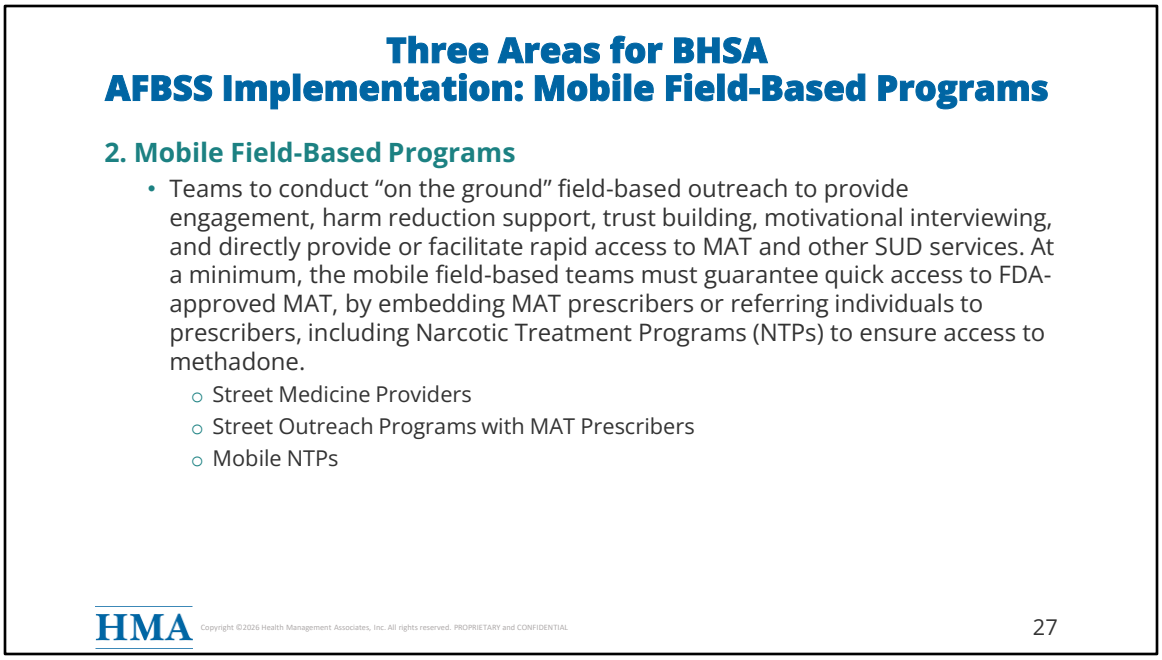
[Slide Image Description: This slide details three areas for county BH AFBSS implementation.]

1. Data-informed, targeted outreach to BHSA-eligible individuals with SUD needs

To identify the highest-need outreach locations, counties are encouraged to collaborate with Emergency Medical Services (EMS), law enforcement, managed care plans (MCPs), health systems and hospitals, Federally Qualified Health Center (FQHC), Rural Health Clinics (RHCs), individuals with living or lived experience, and other partners to obtain data on regions and populations with high rates of overdose, overdose reversals, drug-related arrests, and other relevant statistics on a regular basis.

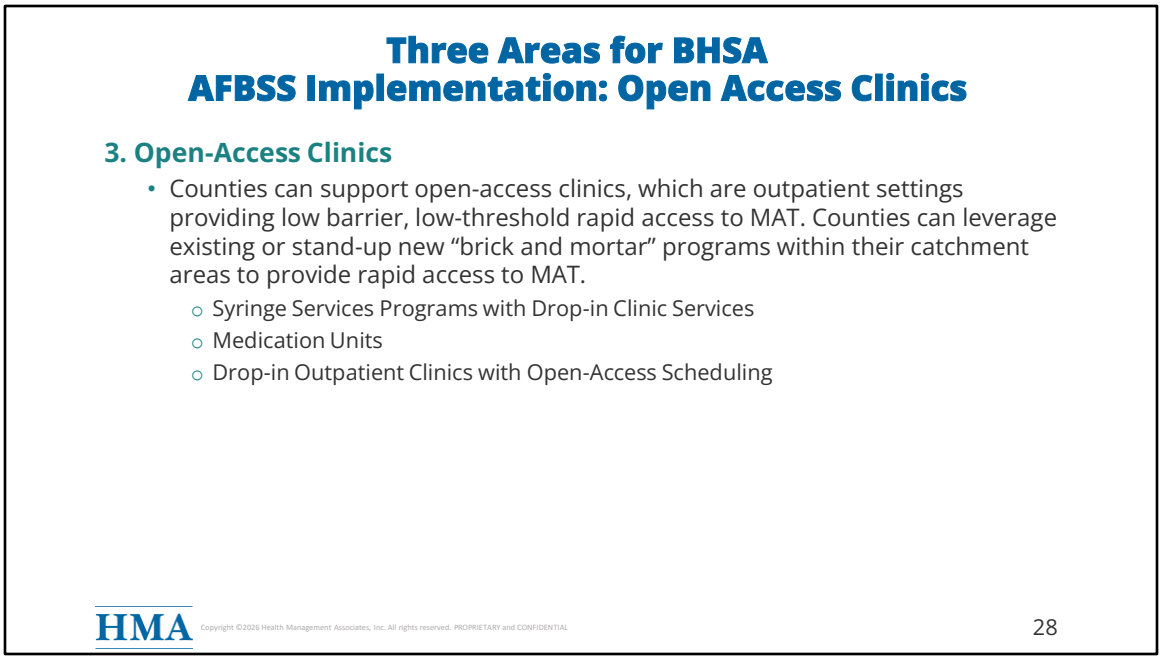


[Slide Image Description: This slide details three areas for county BH AFBSS implementation.]

2. Mobile Field-Based Programs

Teams to conduct “on the ground” field-based outreach to provide engagement, harm reduction support, trust building, motivational interviewing, and directly provide or facilitate rapid access to MAT and other SUD services. At a minimum, the mobile field-based teams must guarantee quick access to FDA-approved MAT, by embedding MAT prescribers or referring individuals to prescribers, including Narcotic Treatment Programs (NTPs) to ensure access to methadone.

- Street Medicine Providers
- Street Outreach Programs with MAT Prescribers
- Mobile NTPs



[Slide Image Description: This slide details three areas for county BH AFBSS implementation.]

3. Open-Access Clinics

Counties can support open-access clinics, which are outpatient settings providing low barrier, low-threshold rapid access to MAT. Counties can leverage existing or stand-up new “brick and mortar” programs within their catchment areas to provide rapid access to MAT.

- Syringe Services Programs with Drop-in Clinic Services
- Medication Units
- Drop-in Outpatient Clinics with Open-Access Scheduling

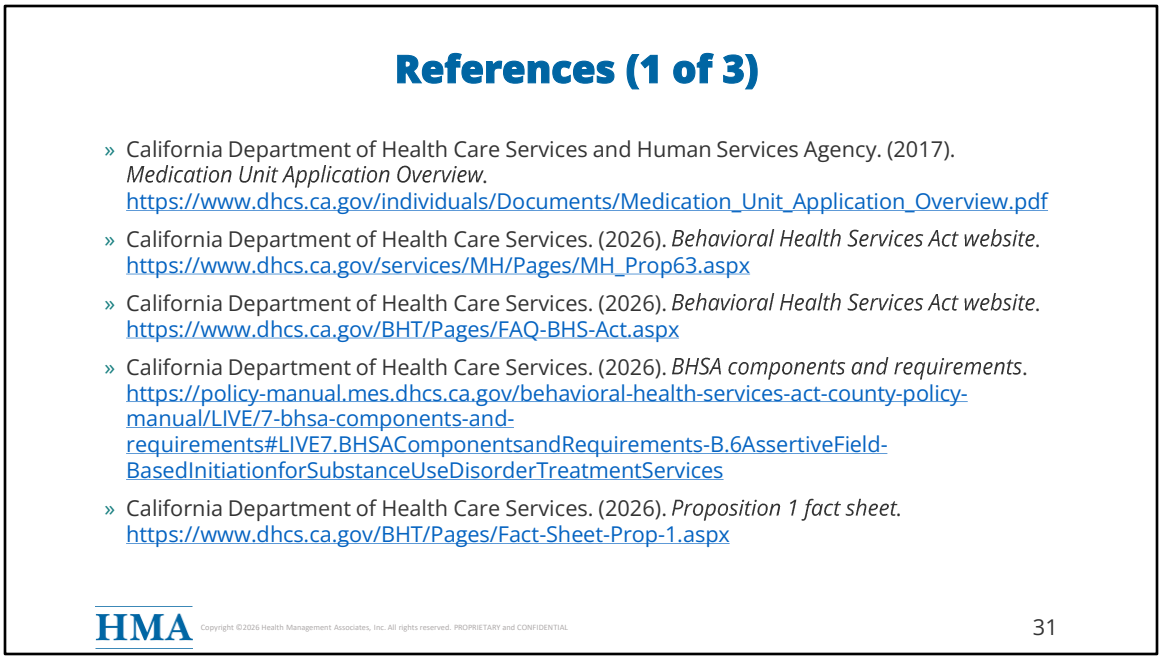
[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

Based on the definitions, list activities you foresee in your BHSA initiative for:

- Data informed, targeted outreach
- Mobile field-based programs
- Open-access clinics

[Slide Image Description: This slide shows the AFBSS email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing AFBSS. Our email address is **info@afbsstraining.org**.

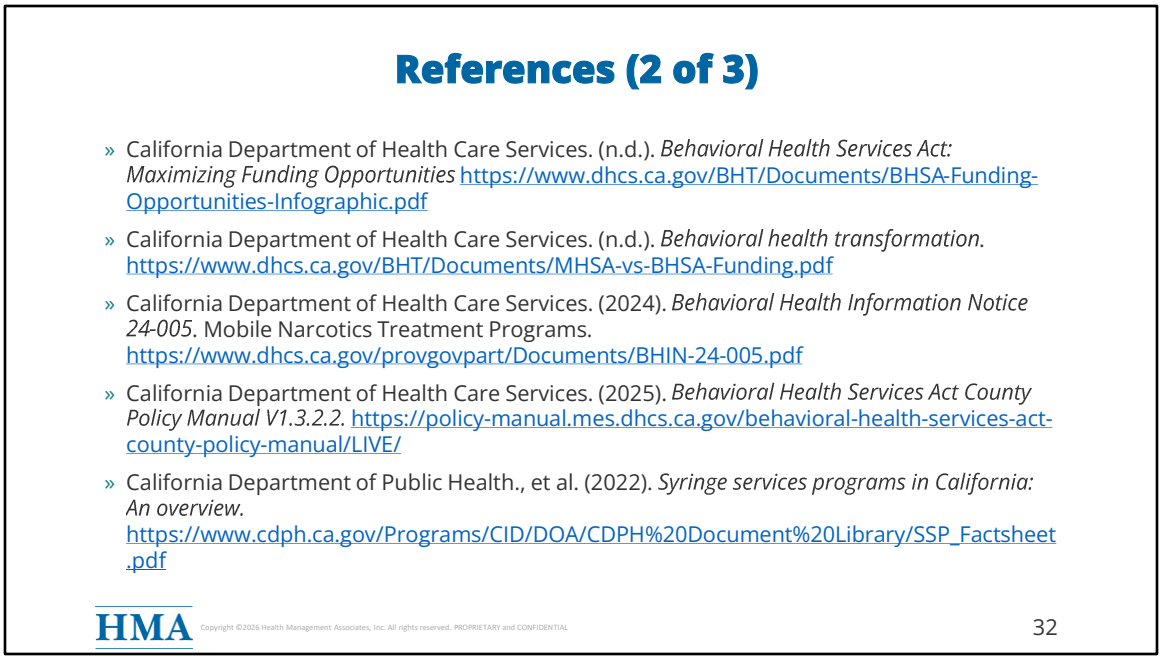


[Slide Image Description: This slide lists webinar references.]

References:

- California Department of Health Care Services and Human Services Agency. (2017). *Medication Unit Application Overview*. https://www.dhcs.ca.gov/individuals/Documents/Medication_Unit_Application_Overview.pdf
- California Department of Health Care Services. (2026). *Behavioral Health Services Act website*. https://www.dhcs.ca.gov/services/MH/Pages/MH_Prop63.aspx
- California Department of Health Care Services. (2026). *Behavioral Health Services Act website*. https://www.dhcs.ca.gov/BHT/Pages/FAQ-BHS-Act.aspx
- California Department of Health Care Services. (2026). *BHSA components and requirements*. https://policy-manual.mes.dhcs.ca.gov/behavioral-health-services-act-county-policy-manual/LIVE/7-bhsa-components-and-requirements#LIVE7.BHSAComponentsandRequirements-B.6AssertiveField-BasedInitiationforSubstanceUseDisorderTreatmentServices

- California Department of Health Care Services. (2026). *Proposition 1 fact sheet*. https://www.dhcs.ca.gov/BHT/Pages/Fact-Sheet-Prop-1.aspx

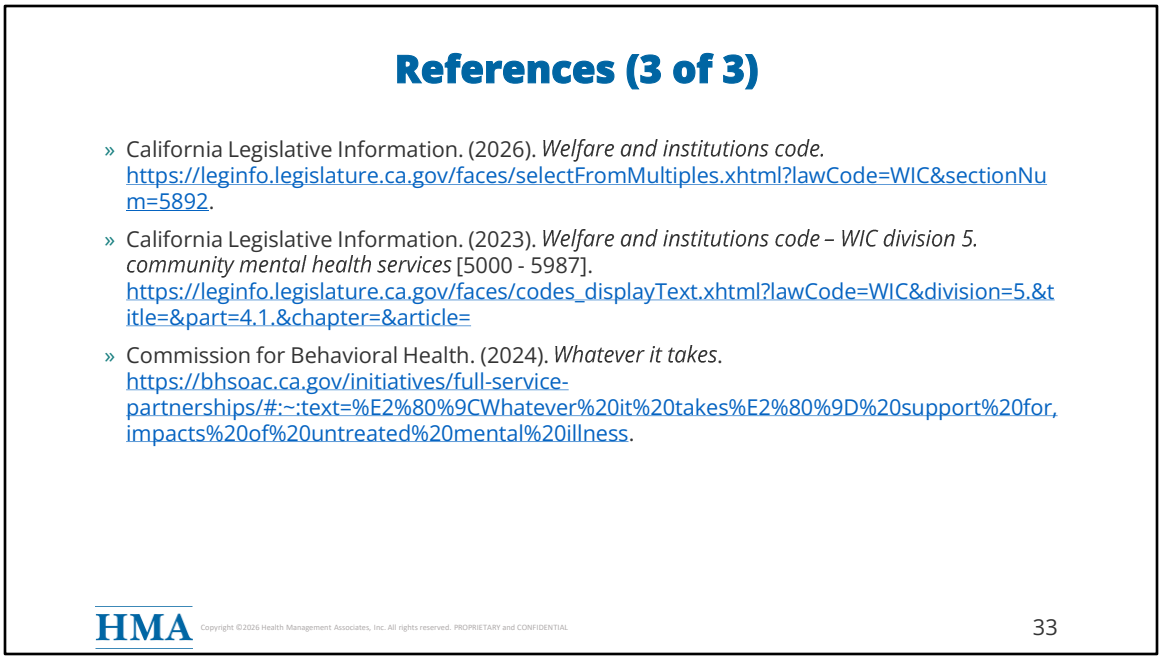


[Slide Image Description: This slide lists webinar references.]

References:

- California Department of Health Care Services. (n.d.). *Behavioral Health Services Act: Maximizing Funding Opportunities* https://www.dhcs.ca.gov/BHT/Documents/BHSA-Funding-Opportunities-Infographic.pdf
- California Department of Health Care Services. (n.d.). *Behavioral health transformation*. https://www.dhcs.ca.gov/BHT/Documents/MHSA-vs-BHSA-Funding.pdf
- California Department of Health Care Services. (2024). *Behavioral Health Information Notice 24-005*. Mobile Narcotics Treatment Programs. https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-24-005.pdf
- California Department of Health Care Services. (2025). *Behavioral Health Services Act County Policy Manual V1.3.2.2.* https://policy-manual.mes.dhcs.ca.gov/behavioral-health-services-act-county-policy-manual/LIVE/
- California Department of Public Health., et al. (2022). *Syringe services programs in California: An overview.*

  https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/SSP_Factsheet.pdf



[Slide Image Description: This slide lists webinar references.]

References:

- California Legislative Information. (2026). *Welfare and institutions code.* https://leginfo.legislature.ca.gov/faces/selectFromMultiples.xhtml?lawCode=WIC&sectionNum=5892.
- California Legislative Information. (2023). *Welfare and institutions code – WIC division 5. community mental health services* [5000 - 5987]. https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=4.1.&chapter=&article=
- Commission for Behavioral Health. (2024). *Whatever it takes*. https://bhsoac.ca.gov/initiatives/full-service-partnerships/#:~:text=%E2%80%9CWhatever%20it%20takes%E2%80%9D%20support%20for,impacts%20of%20untreated%20mental%20illness.