BEHAVIORAL HEALTH SERVICES ACT COUNTY POLICY MANUAL

Module 4

DRAFT FOR PUBLIC COMMENT

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Note to Stakeholders

This release of the BHSA County Policy Manual for public comment includes proposed updates to the BHSA County Policy Manual. Specifically, DHCS is proposing updated text in:

- Chapter 3 – County Integrated Plan
  - Section E.3 Process for Requesting Exemptions
    - Section E.3.1 Eligible Exemptions
    - Section E.3.3 Acceptance Criteria
- Chapter 7 – BHSA Components and Requirements
  - Section A.7 Early Intervention Programs
    - Section A.7.1 Early Intervention
    - Section A.7.6 Biennial List of Evidence-Based Practices and Community-Defined Best Practices
  - Section B. Full Service Partnership
    - Section B.3.4 Full Service Partnership Exemptions
    - Section B.6 Foundational Requirements for Full Service Partnership Evidence Based Practices

Updates to Chapters 3 and 7 are noted in **bold underlined text** for proposed new text and **bold, underlined, ~~strikethrough~~ text** where DHCS proposes to remove text.

Chapter 9 – BHSA Oversight and Enforcement is entirely new.

Appendix E – Behavioral Health Services Act Biennial Early Intervention Evidence-Based Practices and Community-Defined Evidence-Based Practices List is entirely new.

Please note that bold hyperlinks point to sites outside of the BHSA County Policy Manual; non-bold hyperlinks point to other content in the BHSA County Policy Manual.

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3. COUNTY INTEGRATED PLAN

E. Guidance for Completing the Integrated Plan

E.3 Process for Requesting Exemptions

E.3.1 Eligible Exemptions

Counties, if eligible, are allowed to request exemptions from some requirements for the BHSA **Housing Interventions** and **FSP** components. (All counties, regardless of population size, will be exempt from certain FSP requirements for the FYs 2026-2029 IP. ~~**For the IP covering FYs 2029-2032, counties with a population of less than 200,000 are permitted to request FSP exemptions.**~~) Please see Chapter 7, Section 7.C.6.2 for information regarding Housing Intervention exemptions and Chapter 7, Section 7.B.3.4 FSP Exemptions for information regarding FSP exemptions. For information about funding transfers, please see Chapter 6, Section B.4.

E.3.2 Exemptions Submission

Counties, if eligible, requesting an exemption from **Housing Intervention** and/or **FSP** requirements must submit the request through the county portal as part of the draft IP by March 31 of the fiscal year prior to the fiscal year covered in the IP (i.e., exemption requests for the 2026-2029 IP must be submitted to DHCS by March 31, 2026). Counties must begin their community planning process prior to submitting an exemption request to determine local priorities to make the exemption requests responsive to local needs. Exemption requests are only valid for the duration of the three-year plan. For each subsequent three-year plan submission, counties must submit updated exemption requests for DHCS approval.

E.3.3 Acceptance Criteria

DHCS will review the information provided in the county's IP and determine whether the exemption request aligns with the exemption criteria outlined in the Policy Manual. Counties requesting an exemption to either increase or decrease the required funding allocations for Housing Intervention programs must provide information that meets the criteria for Housing Intervention exemption requests in Chapter 7, Section 7.C.6.2. **Counties requesting one or more FSP exemptions must provide information that meets the criteria for FSP exemption requests in** Chapter 7, Section 7.B.3.4.

7. BHSA COMPONENTS AND REQUIREMENTS

A. Behavioral Health Services and Supports

A.7 Early Intervention Programs

Early Intervention funds may also be used to provide supports and services to parents and caregivers. However, these services do not count toward the 51% requirement spent on individuals who are 25 years and younger **unless the service is provided as part of an Early Intervention Evidence-Based Practice and Community-Defined Evidence-Based Practice (EBP and CDEP). Services that are provided as part of Early Intervention EBPs and CDEPs that support parents and caregivers count towards the 51% requirement, even if the child/youth is not present, as long as the service is for the benefit of that child/youth.** EI funds can also be used to support **innovative behavioral health pilots and projects** within these parameters to build the evidence base for the effectiveness of new statewide strategies.

A.7.1 Early Intervention

Early Intervention services may be provided to individuals lacking a specific diagnosis. Indicated prevention interventions focus on BHSA eligible at-risk individuals who are at risk or ~~**and**~~ experiencing early signs of a mental health or substance use disorder or who have experienced known risk factors for poor behavioral health outcomes, such as trauma, Adverse Childhood Experiences, or involvement with child welfare or corrections system. This at-risk individual may not yet meet the criteria of a diagnosable mental health or substance use disorder. Indicated prevention is the only prevention intervention that is allowable under Early Intervention, as shown in Figure 7.A.1. Examples of indicated interventions include, but are not limited to, outreach, training, and education for high-risk individuals and/or families who are at risk ~~**and**~~ **or** experiencing early signs of a mental health or substance use disorder. Indicated interventions are preventive and often provided before an individual receives or meets diagnostic criteria for a behavioral health diagnosis. Case identification includes assessment, diagnoses, brief interventions, and activities needed to create access and linkages to care that connect individuals to the appropriate care.

A.7.6 Biennial List of Evidence-based Practices and Community-Defined Best Practices

DHCS ~~**will**~~ develop**ed** a non-exhaustive list of **Early Intervention EBPs and CDEPs**. The biennial list is an optional reference tool to support each county behavioral health

department's community planning process discussions regarding which practices to implement locally. **The biennial list of EBPs and CDEPs can be found in Appendix E.**

The only EBP that counties are required to provide as a part of Early Intervention is a CSC for FEP program, beginning July 2026. However, **DHCS may require a county to implement a particular EBP or CDEP from the DHCS biennial list.**

~~**Counties can include other county-specific CDEPs and can innovate and implement emerging and promising practices that are not included on the biennial list of EBPs and CDEPs provided by DHCS in their IP.**~~

~~**An Early Intervention EBP or CDEP on the biennial list may include population-based prevention elements. Counties will still be able to fund EBPs and CDEPs that may have very limited population-based prevention components in full with BHSS funds only if the EBP or CDEP is on the biennial list developed by DHCS.**~~

EBPs and CDEPs included on this list address mental health, substance use, and co-occurring disorders. The EBPs and CDEPs on this list address at least one aspect of the required BHSA EI program components which include outreach, access and linkage to care, and mental health and substance use disorder treatment services and supports.

To develop this list, DHCS drew from the sources below:

~~**DHCS leverages the following sources to identify EBPs and CDEPs:**~~

1. **BH-CONNECT**
2. **Children and Youth Behavioral Health Initiative's (CYBHI) EBPs and CDEPs grant program**
3. **Family First Prevention Services Act**
4. **Blueprints for Healthy Youth Programs**
5. **The Athena Forum created by Washington State Health Care Authority**
6. **CDPH's California Reducing Disparities Project**
7. **Evidence-based Practices Resource Center developed by the Substance Abuse and Mental Health Services Administration**
8. **The Cognitive-Behavioral Interventions for Substance Use curriculum designed by the University of Cincinnati**
9. **California Evidence-Based Clearinghouse for Child Welfare**

10. **The County of Los Angeles Department of Mental Health, Prevention and Early Intervention EBPs, Promising Practices, and CDEPs Resource Guide 2.0. created by the California Institute for Mental Health**

DHCS also solicited input from CDPH, the Commission for Behavioral Health, stakeholders representing behavioral health providers, California's tribal communities, county departments of behavioral health and public health, and other subject matter experts. DHCS assessed the proposed EBPs and CDEPs based on the following criteria for inclusion in the biennial list:

- **Availability of public materials and information about the EBP or CDEP, including an overview of the evidence base, details on how the program or intervention is structured, and information on how to implement.**
- **Availability of trainings on implementing the EBP or CDEP or sufficient informational resources for counties to replicate locally. While CDEPs may not specifically offer training information, those included in this list provide enough information for counties to be able to adapt the EBP or CDEP for their local needs.**
- **Primary focus of the EBP or CDEP is on EI, as defined in the BHT Policy Manual, and fits in a category of Indicated (prevention) or Case Identification (treatment) on the Institute of Medicine's Continuum of Care and Spectrum of Early Intervention Services, as shown in Figure 7.A.1. EBPs and CDEPs may include some population-based prevention or treatment/recovery elements but are primarily focused on key areas of EI for individuals. Counties will still be able to fund EBPs and CDEPs that may have very limited population-based prevention components or treatment/recovery elements in full with BHSS funds only if the EBP or CDEP is on this list.**

The EBPs and CDEPs are organized into the following categories based on population served: Children and Youth; Family-Centered; Adults and Older Adults; and General. In addition, within those categories, EBPs and CDEPs are organized by condition addressed: Mental Health; Substance Use; and Co-Occurring. Counties may innovate and implement emerging and promising practices that are not included on this list. Programs listed with an asterisk indicate a CDEP.

B. Full Service Partnership

B.3 Full Service Partnership Program Requirements

B.3.4 Full Service Partnership Exemptions

Fiscal Year (FY) 2026-2029 Integrated Plan

State law permits counties with a population of less than 200,000 to request an exemption from the FSP requirements in W&I Code section 5887, subdivision (a)(2). For the first Integrated Plan covering FYs 2026-2029, all counties, regardless of their size, will be exempt from the EBP fidelity requirements for ACT, FACT, IPS Model of Supported Employment, and HFW. Therefore, counties do not need to request an exemption from FSP EBP requirements in their first Integrated Plan. DHCS will make available training, technical assistance, and fidelity monitoring supports for counties as they implement FSP EBPs: ACT, FACT, IPS and HFW. Counties are still required to begin offering the required EBPs by July 1, 2026.

To meet FSP EBP requirements, between July 1, 2026, and June 30, 2029, **~~all~~** counties must:

- Participate in ongoing training and technical assistance for all FSP EBPs.
- Understand gaps to fidelity for each FSP EBP by December 31, 2027.
- Complete full fidelity reviews and demonstrate counties are implementing all FSP EBPs with fidelity by June 30, 2029.

DHCS will make available training, technical assistance, and fidelity monitoring supports for counties as they implement FSP EBPs: ACT, FACT, IPS and HFW.

~~**FY 2029-2032 Integrated Plan**~~

~~**Subject to DHCS approval, for the second Integrated Plan covering fiscal years 2029- 2032, small counties (population less than 200,000) may request an exemption from the ACT and FACT EBP. Small counties may also request an exemption from IPS and HFW[71] EBP fidelity requirements.**~~

State law permits counties with a population of less than 200,000 to request exemptions from these requirements for ACT, FACT, and/or IPS, consistent with W&I Code section 5887, subdivision (a)(2). Exemptions are not available for HFW because it is a mandatory Medi-Cal service pursuant to the Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit.

The criteria for FSP exemption requests include:

- Limited workforce (e.g., **qualified** providers)

- Limited need (e.g., the **estimated population with a clinical need for an EBP ~~number of individuals eligible is too small for the county to support the required EBP staffing for fidelity~~**)
- Other **~~considerations~~ hardships**, subject to **~~evidence requirements and~~** DHCS review

~~Counties may use the findings from COE fidelity reviews and other data to determine whether they will seek an exemption in fiscal year 2029.~~ Exemption requests must include: documentation demonstrating that one or more of the criteria for exemption are met (e.g., workforce or county demographic data, **information from a** COE **~~informational fidelity review findings~~ consultation**). **Counties must request exemptions from each FSP EBP (ACT, FACT, and/or IPS) individually and provide corresponding documentation.**

~~A description of how counties will work towards improving fidelity scores or for counties that may never meet fidelity requirements, an explanation of why.~~

B.6 Foundational Requirements for Full Service Partnership Evidence Based Practices

To meet FSP EBP requirements, counties must begin offering FSP EBPs by July 1, 2026 (to fidelity not required) and demonstrate they are implementing FSP EBPs with fidelity by June 30, 2029.

In addition to the FSP EBP requirements in Section B.3.4 Full Service Partnership Exemptions, counties must do all of the following:

- **Complete county consultations with the respective Center of Excellence (COE) for each EBP;**
- **Ensure practitioners meet specified training, technical assistance, fidelity monitoring, and data collection standards; and**
- **Meet specified implementation milestones to demonstrate services are delivered with fidelity to the evidence-based models.**

Details about each of these requirements for ACT, FACT and IPS are in the DHCS EBP Training, Technical Assistance, Fidelity Monitoring and Data Collection Policy Guide (link forthcoming). Details about requirements for HFW are forthcoming.

B.6.1 FSP EBP Service Capacity

Counties that do not qualify for or receive exemptions must establish teams of behavioral health practitioners to deliver each FSP EBP. Counties will use the IP and Annual Update (AU) to project the number of multidisciplinary ACT, FACT, IPS, and HFW teams the county will establish between 2026 and 2029.

DHCS recognizes that counties are starting from different places and have varying resources available to implement FSP EBPs. DHCS also understands it takes time to implement high-quality EBP programs to fidelity. Counties should assess internal capacity, use available data, and work with COEs to determine an appropriate number of ACT, FACT, IPS, and HFW teams the county aims to staff and train over the first IP period.

DHCS provided counties with data-driven estimates of the total number of BHSA-eligible individuals in the county who may have a clinical need for each EBP, and the number of FTE practitioners and multidisciplinary teams that would be required to serve that entire population. These estimates are one data point to support county planning. The estimates do not account for county-specific resources and the time it takes to recruit, hire and train behavioral health practitioners. *DHCS is not requiring counties to staff the number of teams required to serve the entire BHSA-eligible population with a clinical need for each EBP.*

In the 2026 IP, counties must project the number of FTE practitioners (including county-operated and county-contracted providers) and multidisciplinary teams they will staff to provide ACT, FACT, IPS and HFW in FYs 2026-2027, 2027-2028, and 2028-2029. Counties may adjust staffing projections as needed as part of the AU process. Projected staffing must account for both current practitioners and new practitioners the county intends to hire and/or contract with to deliver FSP EBPs. Counties that are requesting an exemption from ACT, FACT and/or IPS should input "0" for the projected number of FTE practitioners and teams for those EBPs in the IP/AU.

B.6.2 FSP EBP Fidelity Standards

The projected number of teams identified in the IP/AU for FY 2026-2027 must achieve Fidelity Designation as defined in the DHCS EBP Training, Technical Assistance, Fidelity Monitoring and Data Collection Policy Guide (link forthcoming) on the following timeline:

- **The FY 2026-27 projected number of teams delivering each EBP must complete baseline fidelity assessments and receive Baseline Fidelity Designation no later than December 31, 2027;**
- **The FY 2026-27 projected number of teams delivering each EBP must complete their first fidelity assessments and achieve Minimum Fidelity Designation no later than June 30, 2028; and**
- **The FY 2026-27 projected number of teams delivering each EBP must complete a second fidelity assessment and achieve Full Fidelity Designation no later than June 30, 2029.**

Counties must ensure all teams of practitioners delivering EBPs also meet the training, technical assistance, fidelity monitoring, and data collection requirements outlined in the DHCS EBP Training, Technical Assistance, Fidelity Monitoring and Data Collection Policy Guide (link forthcoming).

Counties that are unable to ensure their projected teams of practitioners meet the fidelity requirements for the respective EBPs must consult with the respective COEs and establish county-specific EBP fidelity plans to meet DHCS' fidelity standards.

For example, if a county projects that it will have four ACT teams in FY 2026-2027 but only one ACT team completes a baseline assessment before December 31, 2027, the county must work with the ACT COE to establish a plan for expanding their ACT program and completing the requisite fidelity assessments for the remaining three teams. If a county projects that it will have four ACT teams in FY 2026-2027 and four ACT teams complete the baseline assessment in 2027, but only one ACT team achieves Minimum Fidelity Designation by June 2028, the county must also work with the ACT COE on a county-specific EBP fidelity plan to improve fidelity implementation for the remaining three teams. Counties must be prepared to share their county-specific EBP fidelity plans with DHCS upon request.

In the IP/AU, counties must also project the number of teams they will staff for each EBP for FYs 2027-2028 and 2028-2029. DHCS does not expect all teams established after FY 2026-2027 to achieve Full Fidelity Designation by June 2029; rather, all new teams must progress through the Fidelity Designation levels at the intervals specified in the DHCS EBP Training, Technical Assistance, Fidelity Monitoring and Data Collection Policy Guide (link forthcoming).

9. BHSA OVERSIGHT AND ENFORCEMENT

A. Overview

One of the goals of Behavioral Health Transformation (BHT) is to increase accountability for publicly funded county-administered behavioral health services. This chapter describes the Department of Health Care Services' (DHCS') approach for monitoring county compliance with program requirements under the Behavioral Health Services Act (BHSA) and, where necessary, imposing administrative or monetary sanctions for noncompliance.

After describing DHCS' guiding principles for BHSA oversight and enforcement, this chapter reviews DHCS' policies and procedures for:

- Periodic BHSA compliance reviews, including DHCS' plans to streamline and align county compliance reviews across publicly funded behavioral health programs.
- Enforcement mechanisms for county noncompliance, including administrative sanctions such as corrective action plans (CAPs) and monetary sanctions.
- County oversight of BHSA-funded providers, including overarching provider standards and county monitoring of providers.

In addition, DHCS' monitoring and oversight will draw on the new BHSA reports: the Integrated Plan (IP), the Annual Update (AU), the Intermittent Update (IU) (if applicable) and the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR). Prior chapters discuss the contents for these reports, as well as the processes and timelines for county submission and DHCS review and approval.

B. Guiding Principles for BHSA Oversight

DHCS recognizes that counties are currently implementing ambitious reforms under BHT and other county-administered behavioral health programs. For BHSA, program requirements are set forth in state law, this Policy Manual, and the County Performance Contract (in accordance with **Welfare and Institutions (W&I) Code section 5897)**.

DHCS' oversight policies are informed by the following guiding principles.

- DHCS will align BHSA oversight with existing Medi-Cal policies wherever it is legally permissible and programmatically appropriate to do so. In addition to capitalizing on lessons learned from the Medi-Cal context, standardizing oversight policies will enhance efficiency for both county and state officials, as well as behavioral health providers, consistent with BHT goals and recent amendments to **W&I Code section 14197.7**.
- DHCS will lead with technical assistance and encourage proactive collaboration on implementation challenges, particularly in the early years of BHT implementation and when counties seek DHCS assistance to address concerns about appropriate implementation of program requirements. As with all county-administered programs, DHCS encourages counties to contact DHCS with questions about program requirements or concerns about county-specific issues. Additionally, counties may refer to DHCS resources and attend technical assistance webinars and other collaborative learning opportunities. When deciding whether to impose administrative or monetary sanctions for noncompliance, DHCS will consider whether counties proactively disclosed compliance concerns and worked with DHCS in good faith to resolve them (among other factors).
- In various sections of the IP and the AU templates, DHCS has provided space for counties to disclose implementation challenges or concerns with certain requirements under BHSA, and other programs and funding sources administered by counties. These self-disclosures are optional, and DHCS does not view these disclosures as an automatic admission of noncompliance. Rather, DHCS seeks to gather data on common concerns to inform technical assistance efforts, whether targeted to specific counties or published as general guidance for all counties.
    - As with all DHCS communications, these IP and AU self-disclosures may inform DHCS' oversight of each county, such as decisions about which issues to focus on in the county's next scheduled compliance review. As noted, if DHCS does confirm instances of county noncompliance, DHCS' decisions about administrative or monetary sanctions will take into account whether the county proactively disclosed that issue to DHCS, whether through the IP or other means.

- These self-disclosures should focus on new information. For example, if the county is under an active CAP to address 24/7 access line issues, there is no need for the county to disclose those specific issues via the IP. However, if the county has identified emerging 24/7 access line issues beyond the scope of DHCS's prior findings and the county's existing CAP, the county may wish to self-disclose that emerging issue.

» DHCS will escalate oversight and enforcement for serious or persistent violations. DHCS intends to lead with technical assistance, as noted above, and to begin with administrative sanctions before imposing temporary withholds or monetary sanctions for counties with persistent compliance issues (e.g., lack of good faith effort to implement an existing CAP). However, as described in the following sections, DHCS may move through these steps more quickly for serious violations that impair access to care, threaten individual health or safety, or create a risk of fraud or other program integrity concerns.

Note: Unlike in Medi-Cal, BHSA monetary sanctions imposed on a county will be returned to the county once it comes into compliance. For further discussion of monetary withholds and monetary sanctions, see Policy Manual Chapter 9, Section D.2 below.

C. Compliance Reviews

DHCS will conduct periodic reviews to assess each county's compliance with BHSA program requirements, as DHCS currently does for Mental Health Services Act (MHSA) and other county-administered behavioral health programs, and as required under **W&I Code section 5897, subdivision (d)**.

DHCS currently anticipates conducting annual compliance reviews, with an onsite review occurring at least once every three years. DHCS anticipates beginning these routine compliance reviews no sooner than State Fiscal Year (SFY) 2027-2028, reviewing the reporting period of SFY 2026-2027 (the first program year under the 2026 IP). In addition, DHCS may initiate targeted ad hoc reviews at any time as necessary to address a serious or urgent compliance concern.

The process for BHSA compliance reviews is modeled on the existing process for Medi-Cal compliance reviews, as described in **Behavioral Health Information Notice (BHIN) 23-044**. These reviews encompass four phases, described further below:

1. Review Preparation, including pre-review planning, document submissions, and DHCS desk review.

2. Compliance Review, including an onsite or virtual component.
3. Post Review Evidence & Exit Process, including opportunity for discussion of draft findings.
4. Findings Report, including any recommended corrective actions needed to achieve compliance.

To the greatest extent possible, DHCS intends to align the timing and procedures for each county's reviews across BHSA, Medi-Cal, the Community Mental Health Services Block Grant (MHBG), and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG).

Currently, as outlined in Table C.1 below, DHCS conducts three separate compliance reviews for county behavioral health programs:

- Medi-Cal Specialty Mental Health Services (SMHS): Once every three years.
- Concurrent reviews for Drug Medi-Cal (DMC), DMC Organized Delivery System (DMC-ODS), and SUBG: Every year.
- Concurrent reviews for MHBG and MHSA: Every three years.

Under the CalAIM initiative for **Behavioral Health Administrative Integration**, once counties adopt integrated Medi-Cal contracts, DHCS intends to conduct combined Medi-Cal compliance reviews for SMHS and DMC/DMC-ODS, plus concurrent review of SUBG.

Furthering that vision, DHCS is now considering the possibility of conducting a single compliance review for each county each year, either virtually or onsite. This concurrent review would simultaneously assess BHSA and the other county-administered programs listed above. By consolidating these reviews, DHCS aims to enhance efficiency at both the county and state level by avoiding duplicative requests for pre-review document submissions, aligning similar requirements across programs where feasible, and streamlining the review process itself to the extent possible.

As DHCS continues developing policies for combined and aligned reviews, DHCS will conduct additional stakeholder engagement and release further guidance.

Table C.1 Aligning Compliance Reviews Across County Behavioral Health Programs

Phase	Number of Reviews	Reviews
Current State	3 Reviews	1. **Medi-Cal (SMHS):** Triennial. 2. **Medi-Cal (DMC/DMC-ODS) + SUBG:** Annual Concurrent Reviews. 3. **MHBG + MHSA:** Triennial Concurrent Reviews.
Intermediate State	2 Reviews	1. **Medi-Cal (SMHS + DMC/DMC-ODS) + SUBG:** Annual Concurrent Reviews. 2. **BHSA:** Annual review (concurrent MHBG review if county is due that year).
Future State	1 Review	1. **Single annual review for all programs, including BHSA** (MHBG included if county is due that year).

SMHS = Specialty Mental Health Services; MHSA = Mental Health Services Act; DMC = Drug Medi-Cal; DMC-ODS = Drug Medi-Cal Organized Delivery System. Integrated, annual Medi-Cal reviews will begin the year after counties adopt integrated contracts under Behavioral Health Administrative Integration, to the extent DHCS resources allow. 17 counties voluntarily adopted integrated contracts effective January 1, 2025. The remaining counties will adopt integrated contracts effective January 1, 2027.

C.1 Review Preparation

In this phase, DHCS determines which issues to focus on in each county's review, gathers the necessary documents, and performs a desk review ahead of the compliance review.

C.1.1 Review Planning

The BHSA compliance reviews may assess any program requirements that are defined under this Policy Manual, the County Performance Contract, and state laws, including:

- Allocation of funds and other BHSA fiscal policies;
- Stakeholder engagement;
- Program requirements for each BHSA component (Behavioral Health Services and Supports (BHSS), Housing Interventions, and Full-Services Partnerships (FSPs));

- Note: BHSA compliance reviews will not focus on assessing the fidelity of evidence-based practices under BHSA. Those fidelity assessments will be conducted by Centers of Excellence, as described in Chapter 7.
- Coverage and authorization of services;
- BHSA provider oversight, workforce strategy and availability of services, as defined under **W&I Code section 5963.02, subdivisions (c)(8)(A), (C)–(G), and (I)**;
- Program integrity;
- Reporting requirements; and
- Administration.

Prior to each county's BHSA compliance review, DHCS will identify priority areas for review. DHCS aims to review all program areas at least once every three years but may review certain issues more frequently. DHCS identifies priority areas for each county based on factors such as:

- The county's compliance history under MHSA/BHSA and other programs (e.g., unresolved CAPs);
- Issues identified based on DHCS' review of the IP, AU, BHOATR, and other county reports; and
- DHCS' assessment of potential impacts on individuals receiving BHSA-funded services and risks to program integrity.

C.1.2 Document Collection

Prior to the review, DHCS will notify the county of the areas the review will focus on and the documentation that will be required. For example, required documentation may include county policies and procedures, evidence of practice, or sample language from BHSA provider contracts. Counties will submit all documentation to demonstrate compliance as requested to DHCS prior to the virtual or onsite review. In the future, as DHCS finalizes the policies for aligned compliance reviews across county-administered behavioral health programs, DHCS will release additional guidance regarding the timelines and procedures for submitting pre-review documents. To improve efficiency, DHCS will aim to reduce redundant document requests across various programs.

C.1.3 Desk Review

DHCS will review the documents submitted by the county, as well as additional documents available to DHCS (e.g., the IP and BHOATR), to determine which areas to

focus on during the compliance review, and whether the compliance review should be conducted virtually or in person. As noted, DHCS anticipates conducting an onsite review at least once every three years but may conduct onsite reviews more often if deemed necessary.

C.2 Compliance Review (Virtual or Onsite)

During the BHSA compliance review, DHCS will interview key county personnel to assess compliance and evaluate the county's administration of BHSA programs. DHCS may request additional supporting documents as needed throughout the interview portion and may include review of client charts to assess provider services.

Unlike the current MHSA review process, but consistent with current Medi-Cal reviews, DHCS' compliance reviews will not generally include discussions with contracted service providers, program visits, client meetings, or housing visits. Counties will be responsible for monitoring their contracted providers, as described in Section E below. DHCS will review whether counties are effectively monitoring their providers for compliance. Effective monitoring will include adopting a monitoring schedule for BHSA-funded providers that includes periodic site visits; preserving provider monitoring records—including monitoring reports, county-approved provider CAPs, and confirmations of CAP resolutions; and providing monitoring records to DHCS at any time, upon DHCS' request.

C.3 Post Review Evidence/Exit Process

At the conclusion of the review, DHCS will share draft review findings with the county, at which point the county has a formal opportunity to discuss the draft findings with DHCS.

Specifically, a county will have 15 business days after receipt of the draft findings to indicate whether they agree, disagree, or partially agree with the findings (including any recommended corrective action) via a DHCS-provided template, as well as to submit any additional information or documentation for DHCS' review and consideration. This 15-day period is a formal timeframe available to counties in addition to the option to submit documentation at any time during the desk review or compliance review.

After a county submits the completed template and any additional information or documentation, DHCS will respond, make adjustments as it deems necessary and appropriate, and issue a final Findings Report, as described below.

C.4 Findings Report

DHCS will provide a final written Findings Report describing any findings of noncompliance and any recommended corrective actions. CAPs are discussed in Section D.1.1, below. DHCS will post all Findings Reports on the DHCS website.

To the extent possible, DHCS intends for the BHSA Findings Report to emphasize common issues identified across the county's behavioral health programs, such as compliance findings relating to access to services, provider oversight, or documentation. DHCS will clearly distinguish between BHSA-specific compliance findings and cross-program themes.

D. Enforcement: Administrative and Monetary Sanctions

If DHCS determines that a county is out of compliance with BHSA requirements, as set forth in state law, this Policy Manual, and the County Performance Contract, DHCS may pursue various enforcement actions including:

- Administrative sanctions, such as imposing a CAP or requiring a county to revise its IP or AU; and
- Temporary monetary withholds or monetary sanctions.

These enforcement actions, which are described further below, are authorized by W&I Code **section 5897, subdivision (e); section 5963.04, subdivision (e);** and **section 14197.7**. DHCS may impose administrative or monetary sanctions based on findings from a routine compliance review and may also impose these sanctions on an ad hoc basis.

DHCS' BHSA enforcement actions will generally follow the same procedures as under Medi-Cal, as described in **BHIN 23-044** and **BHIN 25-023** or subsequent guidance. However, there will continue to be certain differences in approach due to differences in DHCS's legal authority and policy decisions. For example, for BHSA, DHCS has not developed an equivalent to the Medi-Cal Enforcement Tiers for network adequacy and timely access, as described in the Attachments to **BHIN 25-023**.

As noted above, in the early years of BHSA implementation, DHCS expects to focus on training, technical assistance, and administrative enforcement mechanisms rather than imposing monetary sanctions. In general, DHCS expects to begin with administrative sanctions before progressing to temporary monetary withholds and monetary sanctions; However, for serious or persistent violations, DHCS will consider imposing temporary

monetary withholds and monetary sanctions in lieu of, or combined with, a CAP or other administrative sanctions.

D.1 Administrative Sanctions

D.1.1 Corrective Action Plans

When a county is out of compliance with BHSA requirements, DHCS may require the county to submit a CAP for DHCS' review and approval or may impose a DHCS-defined CAP on the county. The following CAP requirements and procedures are consistent with current Medi-Cal practices as described in **BHIN 23-044** and **BHIN 25-023**.

D.1.1.A Cap Contents

A BHSA CAP shall include the following information, in accordance with DHCS' CAP template:

- Description of corrective actions that will be taken by the county to address identified findings, including actions required of contracted providers when applicable, and incremental milestones the county will achieve in order to reach full compliance.
- Timeline for implementation and/or completion of corrective actions.
    - In general, DHCS requires counties to resolve CAPs within 90 calendar days from the date of DHCS' acknowledgment of receipt of the CAP or, if DHCS imposes a defined CAP, within 90 days of the date DHCS provides the CAP to the county. DHCS may approve an extended timeline for resolution if necessary and appropriate.
- Proposed evidence of correction that will be submitted to DHCS.
    - If the county has evidence to support correction at the time the CAP is due, the county shall submit the actual evidence of correction to DHCS.
- Mechanism for monitoring the effectiveness of corrective actions over time.
- Behavioral Health Director or designee (e.g., compliance administrator) name, and the date of their approval of the CAP.

DHCS will publish all BHSA CAPs on its website, as required under **W&I Code section 5897, subdivision (e)(2)**.

D.1.1.B CAP Process Following a Compliance Review

For CAPs following a compliance review, counties shall, within 60 calendar days of receipt of the Findings Report, submit a proposed CAP to DHCS for all identified

findings. Upon receipt of the CAP, DHCS will provide an Acknowledgement Letter within five business days.

D.1.1.C CAP Resolution and Ongoing Monitoring Activities

DHCS will determine when the county has resolved the CAP and will issue a Resolution Letter to inform counties of the successful completion of the CAP. If CAPs are not resolved within the determined timeline for resolution, DHCS will consider heightened oversight including:

- Monitoring calls;
- Statewide/regional technical assistance and training;
- Focused technical assistance; and
- Focused ad hoc compliance review, which may be desk, virtual, or onsite, in addition to the county's routine compliance reviews.

D.1.2 Directing Counties to Revise their IP or AU

In certain circumstances, DHCS may require a county to revise its IP or AU as an administrative sanction. Specifically, as authorized under **W&I Code section 5963.04, subdivisions (e)(1) & (2)**, DHCS may require a county to revise its IP or AU if:

- The submitted IP or AU fails to adequately address local needs, as described under **W&I Code section 5963.02, subdivision (b)(2)** and Policy Manual Chapter 3, Section E.4.2; or
- The county has failed to make adequate progress in meeting performance measures under BHSA, Medi-Cal, or other county-administered behavioral health programs, as defined in **W&I Code section 5963.04, subdivision (b)**.
    - DHCS does not intend to exercise this authority until DHCS releases "Phase 2" performance measures which, as described in Chapter 2, Section C.1.A of this Policy Manual, are intended to be used for monitoring and accountability purposes.
    - DHCS can exercise this authority outside the standard IP/AU submission timeline, including after BHOATR submission.

D.2 Monetary Withholds and Monetary Sanctions

DHCS has the authority to impose temporary monetary withholds and monetary sanctions for certain types of BHSA program violations. This section describes:

- Potential bases for DHCS to impose temporary monetary withholds and monetary sanctions;
- Maximum Temporary Monetary Withholds;
- Maximum Monetary Sanctions;
- Factors DHCS Will Consider When Imposing Temporary Withholds or Monetary Sanctions; and
- Notice and Appeal Rights.

If DHCS imposes temporary monetary withholds or monetary sanctions on a county, the county shall continue to comply with all BHSA program requirements unless directed otherwise. Generally, DHCS intends to begin with temporary withholds, but may escalate to sanctions for severe or repeat violations.

D.2.1 Bases for Temporary Monetary Withholds and Monetary Sanctions

Pursuant to **W&I Code section 5963.04, subdivision (e)(3)**, DHCS has express authority to impose BHSA withholds or monetary sanctions if a county:

- Fails to follow stakeholder engagement requirements for the IP or the 30-day comment period for the AU and intermittent updates, as described **in W&I Code section 5963.03** and Chapter 3, Section B of this Policy Manual.
- Fails to allocate BHSA funds in accordance with statutory requirements, as set forth at **W&I Code section 5892** and Chapter 6, Section B of this Policy Manual.
- Fails to submit a complete, accurate, and timely BHOATR in accordance with **W&I Code section 5963.04** and Chapter 4 of this Policy Manual. Specifically, if DHCS notifies a county of an overdue BHOATR and the county fails to submit the BHOATR within a reasonable time (as defined in DHCS' notice to the county), DHCS may withhold 25 percent of the county's monthly allocations from the Behavioral Health Services Fund (BHSF) until the county comes into compliance. This is consistent with DHCS' current approach for MHSA withholds in response to a late Annual Revenue and Expenditure Report.
- Spends BHSA funds in a manner that significantly varies from its budget in the IP, AU, or intermittent update. (This standard does not apply to any of the non-BHSA funding sources identified in the IP budget.)

- In the short term, DHCS does not intend to define quantitative standards for "significant variance." For example, if a county's planned allocations to a particular service line over or underestimate actual spending, DHCS will not impose monetary sanctions. Rather, DHCS plans to use data from the initial IP period to inform a standard that reflects county experiences and spending patterns.
- As a reminder, once approved in the IP, counties are not permitted to adjust their allocation of funding across BHSA components during the IP period except in emergencies, as described in Policy Manual Chapter 6, Section B.5.1. However, counties may adjust their suballocations within each component via an AU or any time needed outside of the submission timeframe for an AU or IP through an intermittent update (IU).

These sanction authorities apply over and above "any other applicable law that authorizes the department to impose sanctions or otherwise take remedial actions against a county" for BHSA violations, per **W&I Code section 5963.04, subdivision (f)**.

D.2.2 Maximum Monetary Withholds

For a sanctionable violation, DHCS may temporarily withhold a portion of a county's monthly BHSF allocations until the county comes into compliance, as authorized under **W&I Code § 5963.04, subdivision (e)(3)**.

The statute authorizes DHCS to withhold an amount of funds that DHCS "deems necessary to ensure the county…comes into compliance," pursuant to **W&I Code § 5963.04, subdivision (e)(3)(C)**. To avoid undue financial hardship for the county, DHCS will withhold no more than 25 percent of a county's monthly BHSF allocations; depending on the circumstances, DHCS may withhold less than 25 percent after considering the factors enumerated below in section D.2.4. This maximum aligns with the statutory cap on monetary sanctions.

Any payments from the sanctioned county's BHSF shall be deposited into the Behavioral Health Services Act Accountability Fund. In accordance with **W&I Code § 5963.04, subdivision (e)(3)(D)**, all monetary withholds imposed on a county shall be released to the county once DHCS determines that the county has come into compliance.

D.2.3 Maximum Monetary Sanctions

For a sanctionable violation, DHCS may impose monetary sanctions pursuant to W&I Code section **5963.04, subdivision (e)(3)** and **section 14197.7, subdivision (n)(5)**.

As under Medi-Cal, DHCS may impose monetary sanctions of up to $25,000 per violation for a first violation, up to $50,000 for a second violation, and up to $100,000

for each subsequent violation, in accordance with **W&I Code section 14197.7, subdivision (f)**; depending on the circumstances, DHCS may impose smaller monetary sanctions after considering the factors enumerated below in section D.2.4.

- For a deficiency that impacts individuals receiving BHSA-funded services, each member impacted constitutes a separate violation.
- DHCS may separately and independently assess a monetary sanction for each day the county fails to correct an identified deficiency.

DHCS may collect monetary sanctions by withholding up to 25 percent of the county's monthly allocations from the BHSF. DHCS shall continue to offset the amount attributable to the sanction each month until it collects the full amount of the sanction. Any payments from the sanctioned county's BHSF shall be deposited into the Behavioral Health Services Act Accountability Fund.

In accordance with **W&I Code § 5963.04, subdivision (e)(3)(B)**, all monetary sanctions imposed on a county shall be returned to the county once the county comes into compliance.

D.2.4 Factors DHCS Will Consider When Imposing Temporary Withholds or Monetary Sanctions

In alignment with current Medi-Cal practices under **BHIN 25-023** and **W&I Code section 14197.7, subdivision (g)**, when determining the amount of a temporary withhold or monetary sanction, DHCS will consider the following non-exhaustive factors:

- The nature, scope, and gravity of the violation, including the potential harm or impact on individuals eligible for BHSA-funded services.
- The good or bad faith of the county.
- The willfulness of the violation.
- The nature and extent to which the county:
    - Cooperated with DHCS' investigation;
    - Aggravated or mitigated any injury or damage caused by the violation; and
    - Has taken corrective action to ensure the violation will not recur.
- The county's financial status, including whether the sanction will affect the county's ability to come into compliance.

- The financial cost of the health care service that was denied, delayed, or modified, if applicable.
- Whether the violation is an isolated incident.
- The county's history of violations under BHSA and MHSA, including unresolved CAPs. In addition, for BHSA only, DHCS will take into account the county's history of similar violations under other behavioral health programs.
- The amount of the penalty necessary to deter similar violations in the future.
- Other mitigating factors presented by the county.

In connection with these factors, DHCS will consider whether the county proactively disclosed implementation challenges through the IP or other means, as described above in Section B. Although not required by statute, DHCS expects to consider similar factors when deciding whether to progress from administrative sanctions to monetary sanctions.

D.2.5 Notice and Appeal Rights

The notice and appeal rights for BHSA temporary withholds and monetary sanctions are identical to the current Medi-Cal procedures outlined in **W&I Code § 14197.7, subdivisions (h), (k), (l) and (m)** and **BHIN 25-023**.

D.2.5.A Notice

Except in exigent circumstances when DHCS determines that there is an immediate risk to the health of individuals receiving BHSA-funded services, DHCS will send a notice of sanction at least 30 calendar days before the sanction's effective date. The notice will identify the sanction's effective date, duration, and rationale, as well as details of county appeal rights.

- A county may request to meet and confer with DHCS regarding a proposed sanction. DHCS shall grant all requests submitted no later than two business days after a county's receipt of DHCS' notice of intent to impose a temporary withhold or monetary sanction.
- DHCS, at its discretion, may alert other persons and organizations that may be impacted or interested in the sanction.

D.2.5.B Filing an Appeal

A county has the right to appeal a temporary withhold or monetary sanction by filing a written appeal, with a copy of the sanctions notice, to the address specified in the notice.

For an appeal of a temporary withhold, the county must file the appeal within 30 calendar days from the date it receives notice of the withhold (or if the county requests a meet and confer with DHCS, within 30 calendar days from the date the county receives the final sanction notice following the meet and confer). The appeal shall be conducted in accordance with **Health & Safety (H&S) Code section 100171** and **W&I Code section 14197.7, subdivisions (k)**.

For a monetary sanction, the county must request a hearing within 15 working days after the date the county receives the notice of the sanction (or if the county requests a meet and confer with DHCS, within 15 working days from the date the county receives the final sanction notice following the meet and confer). The appeal shall be conducted in accordance with **H&S Code section 100171**.

D.2.5.C Stay of Temporary Withhold or Monetary Sanction

Temporary withholds and monetary sanctions shall be stayed until the hearing is completed and DHCS has made a final determination, in accordance with **W&I Code section 14197.7, subdivision (k)(7)** (temporary withholds) and **subdivision (l)(2) and (3)** (sanctions).

E. BHSA Provider Standards and County Oversight

Each county must "ensure its county and noncounty contracted behavioral health workforce is well-supported and culturally and linguistically concordant with the population to be served, and robust enough to achieve the statewide and local behavioral health goals and measures," as described in **W&I Code section 5963.02(c)(8)**. In support of that function, counties are responsible for ensuring that their BHSA-funded providers comply with applicable requirements. This applies to non-county providers that contract with the county as well as providers that are owned or operated by the county. This section discusses:

- The contracts that counties execute with non-county BHSA providers (i.e., providers that are not owned or operated by the county), as well as the corresponding policies and procedures for county providers.
- Overarching requirements for BHSA providers, beyond the program requirements that apply to specific BHSA-funded services.
- County monitoring of BHSA providers.

As with BHSA compliance reviews and enforcement, DHCS seeks to promote alignment with Medi-Cal standards and processes wherever it is feasible and appropriate to do so.

E.1 BHSA Provider Contracts and Policies

E.1.1 Contracts with Non-County Providers

Counties must execute a contract with each non-county provider (i.e., providers that are not owned or operated by the county) that receives BHSA funds, consistent with historical MHSA practices. These written agreements play an important role in counties' oversight of BHSA providers, and in DHCS' oversight of counties to ensure appropriate use of BHSA funds. The county must also maintain records of actual expenditures sufficient to comply with BHOATR requirements. These provider contracts must:

- Specify the services for which the provider is receiving BHSA funds, as described in Chapter 7 of this Policy Manual.
- Require the provider to comply with:
  - All program requirements applicable to the provider's BHSA-funded services;
  - The BHSA fiscal policies on Medi-Cal participation and seeking reimbursement from Medi-Cal and other payers (if applicable to the provider's services), as set forth in Chapter 6, Section C of this Policy Manual;
  - The general provider standards described below in section E.2;
  - The county's BHSA provider monitoring activities, as discussed below in section E.3; and
  - Any requests for records, information, or onsite access by the county, DHCS or their designees for purposes of BHSA oversight. (In general, DHCS expects that counties will monitor BHSA providers, while DHCS monitors counties. However, DHCS reserves the right to directly monitor BHSA providers as needed.)

Counties must make a good faith effort to execute a provider's contract before the provider begins delivering BHSA-funded services. If a county is unable to execute a contract before the delivery of BHSA-funded services—e.g., due to good-faith delays in contract execution, or when a non-contracted provider has delivered emergency services eligible for BHSA funding—the county must execute the contract within 120 calendar days from the commencement of BHSA-funded services, consistent with the time limit for provisional SMHS provider contracts.

E.1.2 Policies and Procedures for County Providers

Counties are not required to execute BHSA contracts with providers owned or operated by the county because these providers are subject to all the same requirements as the

county itself. Counties must, however, maintain records of expenditures sufficient to comply with BHOATR requirements, and must maintain policies and procedures to ensure compliance with all the same requirements enumerated above.

E.2 General Standards for BHSA Providers

In the IP, counties must describe how they will ensure that BHSA-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner, as specified under **W&I Code 5963.02(c)(8)(C)–(F)**. To satisfy this requirement and promote alignment across programs, effective July 1, 2027, DHCS recommends that counties require BHSA-funded providers to comply with the same standards as Medi-Cal providers with respect to:

- Minimum provider qualifications for licensure, certification, training, experience, and credentialing, as applicable for each type of service. This requirement focuses on minimum standards to provide BHSA-funded services, and so does not incorporate standards specific to Medi-Cal.
- Nondiscrimination requirements, including ensuring physical access, reasonable accommodations, and accessible equipment for people with disabilities.
- Delivering services in a culturally competent manner to all individuals, including those with limited English proficiency and diverse cultural and ethnic backgrounds and disabilities, regardless of age, religion, sexual orientation, and gender identity.

As a reminder, under state law, BHSA and Medi-Cal providers are already subject to many of the same standards on provider qualifications and nondiscrimination. In addition, by July 1, 2027, most BHSA providers that offer Medi-Cal coverable services should already be participating in the county Medi-Cal Behavioral Health Delivery System and should already be complying with Medi-Cal requirements. For additional details on this requirement, see Chapter 6, Section C.2 of this Policy Manual.

When filling out their IP, counties may check a box to indicate that they will require BHSA-funded providers to comply with the same Medi-Cal standards outlined above, either for all BHSA-funded providers or only for the subset of BHSA providers that also participate in Medi-Cal. If a county elects not to hold all BHSA providers to Medi-Cal standards, the county must describe its county-specific approach for ensuring provider qualifications, nondiscrimination, and cultural competence.

Regardless of the approach counties take, the applicable standards must be codified in counties' BHSA provider contracts and policies and procedures, as described above under section E.1.

E.3 County Monitoring of BHSA Providers

In the IP, per **W&I Code § 5963.02, subdivision (c)(8)(I)**, counties must describe how they will conduct oversight of BHSA providers to ensure compliance with all applicable federal and state laws, and as described in this Policy Manual. Effective July 1, 2027, counties must:

1. Adopt a monitoring schedule for BHSA-funded providers that includes periodic site visits;
2. Preserve provider monitoring records, including monitoring reports, county-approved provider CAPs, and confirmations of CAP resolutions; and
3. Provide monitoring records to DHCS at any time, upon DHCS' request.

As with the provider standards discussed in the prior section, DHCS recommends that counties adopt the same provider monitoring schedule for BHSA and Medi-Cal. Consistent with the integrated SMHS/SUD Medi-Cal contracts that all counties will adopt effective January 1, 2027, this would entail:

- Monitoring compliance at least annually for all BHSA provider locations; and
- Performing onsite monitoring at least once every three years.

DHCS encourages counties to implement efficient monitoring processes that minimize administrative burden for contract providers. For example:

- Under an aligned monitoring schedule, a county may simultaneously monitor providers for compliance with requirements under Medi-Cal, BHSA, and any other applicable programs.
- If a provider furnishes BHSA-funded services in multiple counties, one county may rely on monitoring performed by another county, consistent with current practices for Medi-Cal provider monitoring.

When filling out their IP, counties may check a box to indicate that they will use the same provider monitoring schedule for BHSA and Medi-Cal, whether for all BHSA-funded providers or only for the subset of BHSA providers that also participate in Medi-Cal. If a county elects not to follow the Medi-Cal monitoring schedule for all BHSA-funded providers, the county must describe its county-specific monitoring approach,

which must include the elements outlined above (periodic site visits and preservation of monitoring records).

APPENDIX E: BEHAVIORAL HEALTH SERVICES ACT BIENNIAL EARLY INTERVENTION EVIDENCE-BASED PRACTICES AND COMMUNITY-DEFINED EVIDENCE-BASED PRACTICES LIST

1. Children and Youth EBPs and CDEPs

Programs listed with an (*) below indicate a CDEP.

Mental Health

*A.C.O.R.N. Youth Wellness Program

AFFIRM Youth

*Aunties and Uncles Program

Blues Program

Bounce Back

CBT for PTSD

Child and Family Traumatic Stress Intervention (CFTSI)

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Crossover Youth Practice Model

Depression Treatment Quality Improvement (DTQI)

Felton Institute (re)MIND® Central

Honoring Children, Mending the Circle (HC-MC)

Incredible Years

Infant and Early Childhood Mental Health Consultation

Mental Health SkillBuilding and Mood Intervention

Mobile Response and Stabilization Services (MRSS)

OCAPICA Project HOPE

Pediatric Primary Care Behavioral Health (Pediatric PCBH)

Reconnecting Youth Program (RY)

*Safe Passages Law and Social Justice Life Coaching Project

Strong Beginnings

*T.R.I.B.E. (Turning Resilience Into Brilliance for Eternity)

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

UCLA Training, Intervention, Education, Services (TIES) Transition Model

Substance Use Disorder

Adolescent Community Reinforcement Approach-Assertive Continuing Care (ACRA-ACC)

Assertive Continuing Care (ACC)

Brief Alcohol Screening and Intervention of College Students (BASICS)

*Brief Risk Reduction Interview and Intervention Model (BRRIIM)

Early Risers "Skills for Success" Risk Prevention Program

Marijuana Brief Intervention

Teen Intervene

Co-Occuring

Curriculum-Based Support Group (CBSG) Program

Early Psychosis Prevention and Intervention Centre (EPPIC)

Multisystemic Therapy (MST)

Residential Student Assistance Program (RSAP)

2. Family-Centered EBPs and CDEPs

Programs listed with an (*) below indicate a CDEP.

Mental Health

Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)

Child Parent Psychotherapy (CPP)

Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT)

EarlyStart Wellness Initiative

Effective Black Parenting Program

Family Acceptance Project

Family Centered Treatment

Family Check-up

Family Connections (FC)

Family Spirit

Foothill Family's Healthy Futures Program

Functional Family Therapy (FFT)

Mom Power®

Multidimensional Treatment Foster Care (MTFC)

Parent Child Interaction Therapy (PCIT)

Parenting Wisely

Portland Identification Early Referral Model (PIER)

*Positive Indian Parenting

Reflective Parenting Program (RPP)

The Strengthening Families Programs (SFP)

Structured Sensory Intervention for Traumatized Children, Adolescents, and Parents (SITCAP-ART)

Triple P - Positive Parenting Program (Triple P)

Substance Use Disorder

Caregiver Guide: Healthy Youth: Early Intervention Services for Youth At Risk of Substance Use Behaviors

Celebrating Families (CF)

Community Reinforcement and Family Training (CRAFT)

Creating Lasting Family Connection (CLFC)

Co-occuring

Brief Strategic Family Therapy (BSFT)

Culturally Informed and Flexible Family Treatment for Adolescents (CIFFTA)

Homebuilders

Integrated Co-Occurring Treatment (ICT)

Multisystemic therapy (MST)

Multidimensional Family Therapy (MDFT)

Nurturing Parenting Program (NP)

3. Adults and Older Adults EBPs and CDEPs

Programs listed with an (*) below indicate a CDEP.

Mental Health

Acceptance and Commitment Therapy (ACT)

Attachment and Biobehavioral Catch-Up (ABC)

Cognitive-Behavioral Interventions for Substance Use Adult (CBI-SUA)

Cognitive Behavioral Therapy (CBT) for Anxiety

Cognitive Behavioral Therapy (CBT) for Depression

Cognitive Behavioral Therapy (CBT) for Late Life Depression

Cognitive Behavioral Therapy (CBT) for Psychosis

Collaborative Care Model

*Convivencia

FamilyWell: A Prevention and Early Intervention Initiative

Interpersonal Therapy (IPT)

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

The Mothers and Babies Course "Mamás y Bebés"

Parents as Teachers (PAT)

Prevention of Suicide in Primary Care Elderly (PROSPECT)

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders

SafeCare

Written Exposure Therapy (WET)

*The Zoosiab Program

Substance Use Disorder

Contingency Management (CM)

The Matrix Model

Motivational Enhancement Therapy (MET) / Motivational Interviewing

Parent Child Assistance Program (PCAP)

Screening, Brief Intervention, Referral to Treatment (SBIRT)

Twelve-Step Facilitation Therapy (TSF)

Co-occuring

Trauma Recovery and Empowerment (TREM)

4. General EBPs and CDEPs

Programs listed with an (*) below indicate a CDEP.

Mental Health

*Culture as Treatment

*The Community Wellness Program

*Cultura y Bienestar Program

Dialectical Behavior Therapy

Eye Movement Desensitization and Reprocessing (EMDR)

*Gender Health Center

*Living With Love

*Mending Broken Hearts

*Menta Sana, Vida Sana Project

Mentalization Based Therapy (MBT)

*Native Talking Circles

Problem Solving Therapy (PST)

*Traditional Healer Services and Natural Helper Services

Substance Use Disorder

Drug counseling (individual and group)

*Drum-Assisted Recovery Therapy for Native Americans (DARTNA)

Co-occuring

Collaboration Leading to Addiction Treatment and Recovery from Other Stresses Manual (CLARO)

*Gathering of Native Americans (GONA)

Hazelden Co-occurring Disorders Program

Seeking Safety (SS)