Behavioral Health Services Act (BHSA)

Community Planning Process Report

2026-2029 Behavioral Health Integrated Plan

EVALCORP
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ACKNOWLEDGEMENT

San Benito County Behavioral Health (SBCBH) deeply appreciates every community member and system partner who contributed to the Community Planning Process. Your perspectives, lived experiences, and expertise were fundamental in developing this plan and will remain central to our ongoing planning efforts.

It is important for readers of this report to appreciate that the responses are from community members who have likely experienced interactions or services from a range of organizations within San Benito County, many of whom intersect with services of SBCBH. SBCBH plan to share this report with all our County and Community partners in an effort to foster a culture of continuous improvement for all services across the county.

Community feedback is really important to SBCBH, and the comments made have been noted. Every effort will be made to correct or improve services and practices within our department's scope and budget, and in accordance with the legislation under which we operate.

INTRODUCTION

California's behavioral health system has evolved from the Mental Health Services Act (MHSA/Proposition 63, 2004) to the Behavioral Health Services Act (BHSA) through the passage of Proposition 1 in March 2024.

The BHSA mandates that counties develop comprehensive Behavioral Health Integrated Plans (IP) for 2026-2029, requiring consultation with broader and more diverse stakeholder populations. This expansion prioritizes establishing partnerships with communities that have historically been underrepresented in planning processes.

San Benito County Behavioral Health (SBCBH)'s inaugural IP delineates a three-year strategy for BHSA fund allocation, developed through systematic community engagement with individuals with lived experience, families, service providers, public safety and education partners, healthcare organizations, veterans, Tribal representatives, and stakeholders representing diverse racial, ethnic, cultural, and linguistic backgrounds.

The plan reflects San Benito's commitment to implementing recovery-oriented, client- and family-centered, culturally responsive programming through authentic cross-sector collaboration.

COMMUNITY ENGAGEMENT PLANNING

SBCBH's Community Planning Process (CPP) advances the county's established work to engage residents, workers and system partners, build community trust, and respond to evolving local needs. SBCBH collaborated with EVALCORP to design and execute this process.

The CPP was deliberately designed to advance accessibility, equity, and responsiveness through diverse participation pathways, centering the perspectives of individuals and communities that have been historically marginalized. This approach sought to strengthen partnerships and create an enduring infrastructure for collaborative service design and delivery.

The CPP was implemented over a five-month period spanning July through November 2025, organized into three distinct phases.

1. **Baseline Analysis and Planning (July–August 2025)** The process began by examining Statewide Behavioral Health Goals, SBCBH performance data, and prior Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) to identify service gaps, access and outcome disparities, and populations facing inequities. These findings shaped engagement strategies, outreach priorities, and key themes for community input.
2. **Community Launch (September 2025)** In September 2025, stakeholder mapping identified representatives across all 29 state-mandated groups. The county then developed a comprehensive, multi-modal Community Engagement and Data Collection Plan offering accessible participation options for diverse stakeholders. The CPP officially launched in Fall 2025 through two virtual Community Education and Engagement Meetings: an English-language session on September 16 and a Spanish-language session on October 22. Participants learned about BHSA requirements, funding modifications, new plan elements and forthcoming engagement activities. A question-and-answer session ensured clarity and readiness for continued involvement.

3. **Data Collection (September–November 2025)** Between September 16 and November 13, 2025, SBCBH employed mixed-methods engagement, reaching 302 participants through:

    - **Community Education and Engagement Meetings** – Virtual public settings via Zoom for information sharing, education on BHSA requirements and community input
    - **Community Behavioral Health Survey** – Online and paper-based survey available in English and Spanish, designed to gather perspectives on behavioral health needs, service experiences and community priorities
    - **Focus groups** – Facilitated dialogues with individuals and families with lived experience of behavioral health challenges
    - **In-depth key informant interviews** – Individual conversations via Zoom with system partners on service delivery, opportunities for collaboration, and system enhancement
    - **System Partner Surveys –** Online survey distributed to county agencies and partner organizations to assess system capacity, challenges and priorities

This multi-method approach accommodated diverse participation preferences regarding language, technology access, scheduling and format.

Table 1 summarizes participation across all activities. Detailed participant demographics are provided in **Appendix A**. This Stakeholder engagement document is included in the 2026-2029 Integrated Plan and is available upon request.

Table 1. Community Planning Process: Engagement Activities and Participation

Engagement Activity	Format	Number of Activities	Number of Participants
Community Education and Engagement Meeting	Virtual (Zoom)	2	43
Community Behavioral Health Survey	Online and Hardcopy	1	152
Focus Groups	In-Person	4	36
System Partner Survey	Online	1	58
Key Informant Interviews	Virtual (Zoom)	13	13
Totals		**21**	**302**

This report is organized by engagement methodology, presenting findings sequentially from the Community Behavioral Health Survey, Focus Groups, System Partner Survey, and Key Informant Interviews, followed by conclusions and recommendations.

COMMUNITY BEHAVIORAL HEALTH SURVEY

The Community Behavioral Health Survey was provided to all participants at each of the BHSA Community Education and Engagement meetings, and available online and in hard copy in the two threshold languages, English and Spanish. A total of 152 respondents completed the survey. Respondents were asked about their perceptions of the most pressing behavioral health challenges, the availability of mental health, substance use, housing services, barriers to accessing care and recommendations for improving access to support.

The findings below reflect community perspectives and highlight opportunities for improvement in San Benito County's behavioral health system.

Survey respondents were comprised of a majority (71%) who identified as women, with men representing approximately one-quarter (24%) of participants and a small percentage exploring their gender identity or preferring to self-describe (7%). Regarding sexual orientation, more than 8 out of every 10 respondents (81%) identified as heterosexual, while the remaining participants identified across a spectrum including asexual (4%), bisexual (2%), demisexual (2%), gay (2%), lesbian (1%), and pansexual (1%), with approximately 10% preferring not to disclose.

Approximately three-quarters (79%) of respondents fell within the age range of 26 to 60+, representing a predominantly adult sample. The survey captured considerable racial and ethnic diversity: Latino, Hispanic, or Caribbean individuals represented the largest group at approximately 3 out of every 5 respondents (60%), followed by White or European American respondents at 30%, with smaller percentages identifying as Asian or Asian American (4%), Native North American or Alaska Native (4%), and other racial or ethnic backgrounds. The majority of respondents (67%) reported not experiencing a disability, while more than one-fifth (22%) indicated they do experience a disability. Detailed respondent demographics are provided in **Appendix A**.

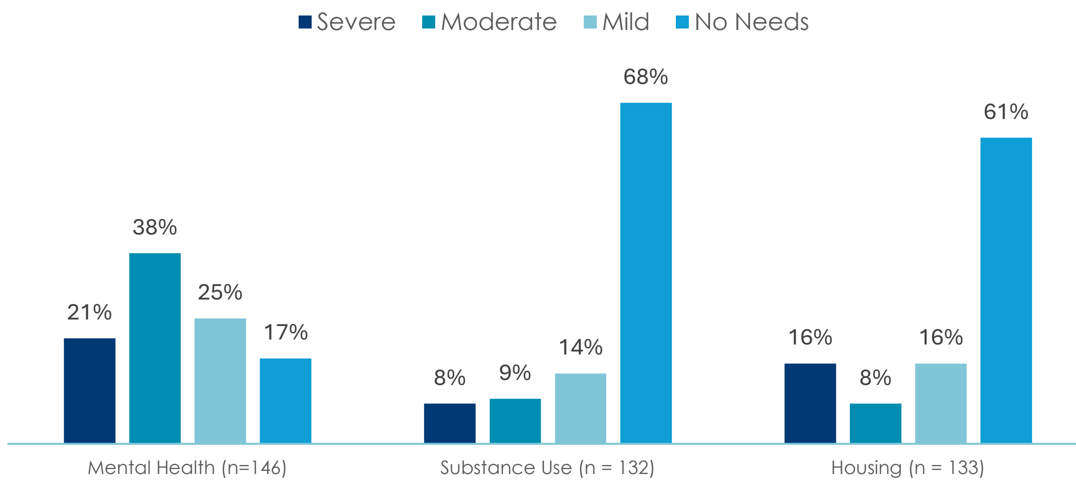
Table 2 presents the diverse identities and roles of Community Behavioral Health Survey respondents. The majority of respondents identified as community members (55%), followed by individuals with lived experience of mental health challenges (40%). Nearly one-quarter (24%) reported lived experience of domestic violence or sexual assault, while 19% identified as community advocates or volunteers and an equal proportion (19%) had lived experience of homelessness. Family members or caregivers of individuals with behavioral health challenges represented 16% of respondents.

Table 2. Other Identities of Community Behavioral Health Survey Respondents (N=132)

Population Descriptions	Percent*
Community Member	55%
Person with lived experience of mental health challenges	40%
Person with lived experience of domestic violence or sexual assault	24%
Community advocate or volunteer	19%
Person with lived experience of homelessness	19%
Family member or caregiver of someone with behavioral health challenges	16%
Behavioral health provider	9%
Probation/justice system staff	9%
Healthcare provider	8%
School services provider	8%
Other	5%
Law enforcement	2%
Tribal services	2%
Others include:	
▪ Nonprofit staff member	
▪ Customer service	

*Column Percent exceeds 100% as survey respondents were instructed to select all that apply.

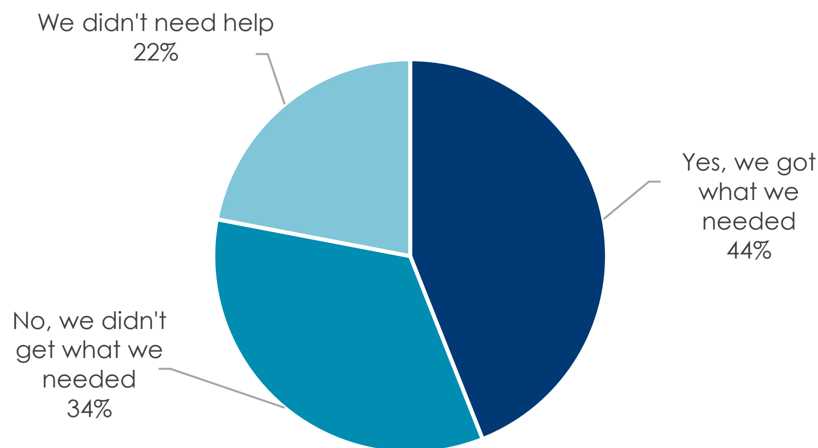
Figure 1 shows the current behavioral health needs, ranging from severe to no need. Mental health emerged as the most pressing concern, with 21% of respondents reporting severe needs, compared to 8% for substance use and 16% for housing.



Mental Health Needs

Figure 2 shows that while 44% of respondents reported receiving the mental health services they needed, a combined 56% either did not receive needed services or felt they did not need help. Among the 34% who reported not receiving the services they needed, **Figure 3** shows the barriers they experienced when attempting to access mental health resources. The most commonly reported obstacles were lack of available providers or providers not accepting new patients (49%), followed by scheduling conflicts with work hours (39%) and cost concerns (35%).[1] Structural barriers such as not knowing where to find help (33%) and inconvenient location (31%) also presented significant challenges, while personal factors including discomfort sharing personal information (22%), lack of insurance (18%), and fear of judgment (16%) were reported at lower but still substantial rates.

Figure 2. Mental Health Service Received
(N = 148)



[1] Reported barriers to accessing behavioral health services reflect respondents' experiences across the broader service landscape and are not attributable to any single provider or system. Respondents may have encountered these obstacles through various entry points, including private providers, community organizations, and managed care plans. The MCP currently maintains open capacity with no waitlist for services.

Figure 3. Barriers to Accessing Mental Health Resources in the County
(N = 49)

Substance Use Needs

Figure 4 shows that only 23% of respondents reported receiving the substance use services they needed, while a combined 77% either did not receive needed services or felt they did not need help. Among the 23% who reported not receiving the services they needed, **Figure 5** shows the barriers they experienced when attempting to access substance use resources. The most frequently cited challenges were not knowing where to find help (43%), fear of being judged (27%), and concerns about receiving this type of help (27%). Previous negative experiences (23%), cost concerns (23%), and lack of insurance (23%) were also reported as substantial barriers. Structural issues such as scheduling conflicts with work hours (17%) and inconvenient location (13%) presented additional challenges, while lack of available providers (13%) and discomfort sharing personal information (7%) were reported at lower rates.

Figure 4. Substance Use Service Received
(N = 142)

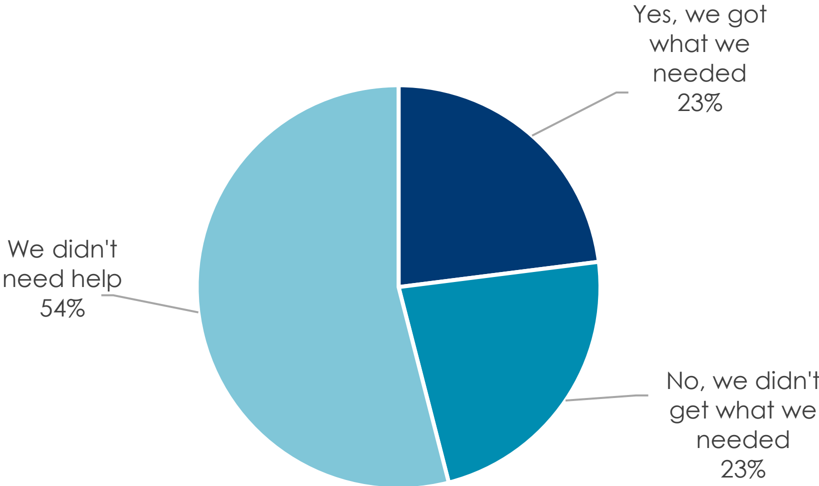
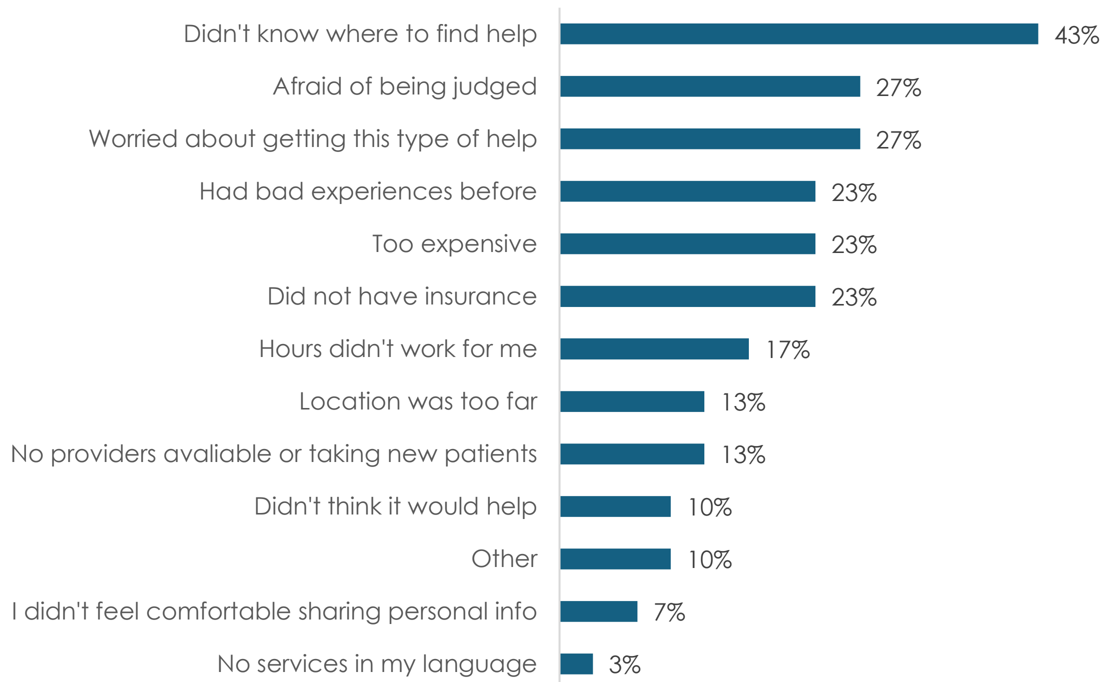


Figure 5. Barriers to Accessing Substance Use Resources in the County
(N = 30)



Housing Needs[2]

Figure 6 shows that only 11% of respondents reported receiving the housing services they needed, while a combined 89% either did not receive needed services or felt they did not need help. Among the 41% who reported not receiving the services they needed, **Figure 7** shows the barriers they experienced when attempting to access housing resources. The most commonly reported barrier was long waiting lists for affordable housing (73%), followed by no available options (48%) and lack of qualification for available help (45%). Structural barriers such as not knowing where to find help (36%), inability to find housing in desired locations (29%), and lack of pet-friendly housing (23%) also presented considerable challenges. Previous negative experiences (20%), inability to find housing for entire families (14%), and personal factors including fear of being judged (13%) and discomfort sharing personal information (13%) were reported at lower rates.

[2] Since its inception in 2004, the primary focus of MHSA was to provide Specialty Mental Health Services. Housing clients with the greatest needs was available on an extremely limited basis, although SBHBH often referred clients to County Partners who were better equipped and experienced to assist clients with housing needs.
In 2023, the Bridges to Housing Grant was made available, providing separate funding from MHSA and, recognizing the client need, SBCBH successfully applied and received this grant. The demand was high and the grant was quickly expended by providing permanent supportive housing to 24 of our behavioral health clients and their families.
The recognition that mental wellness is often associated with safe and stable housing has been built into the BHSA, due to commence in July 2026. SBCBH will be making every effort to utilize the BHSA redistribution of our County's existing funding allocation for Housing Intervention to the benefit of as many clients as this funding will allow.

Figure 6. Housing Service Received
(N = 141)

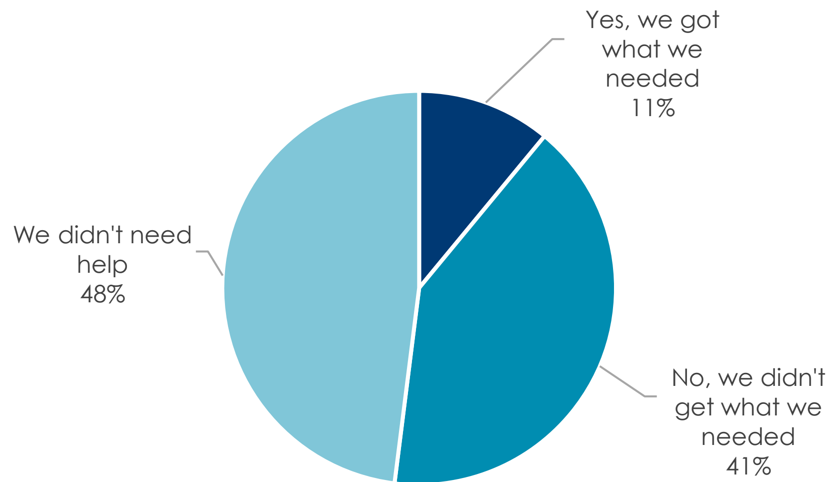


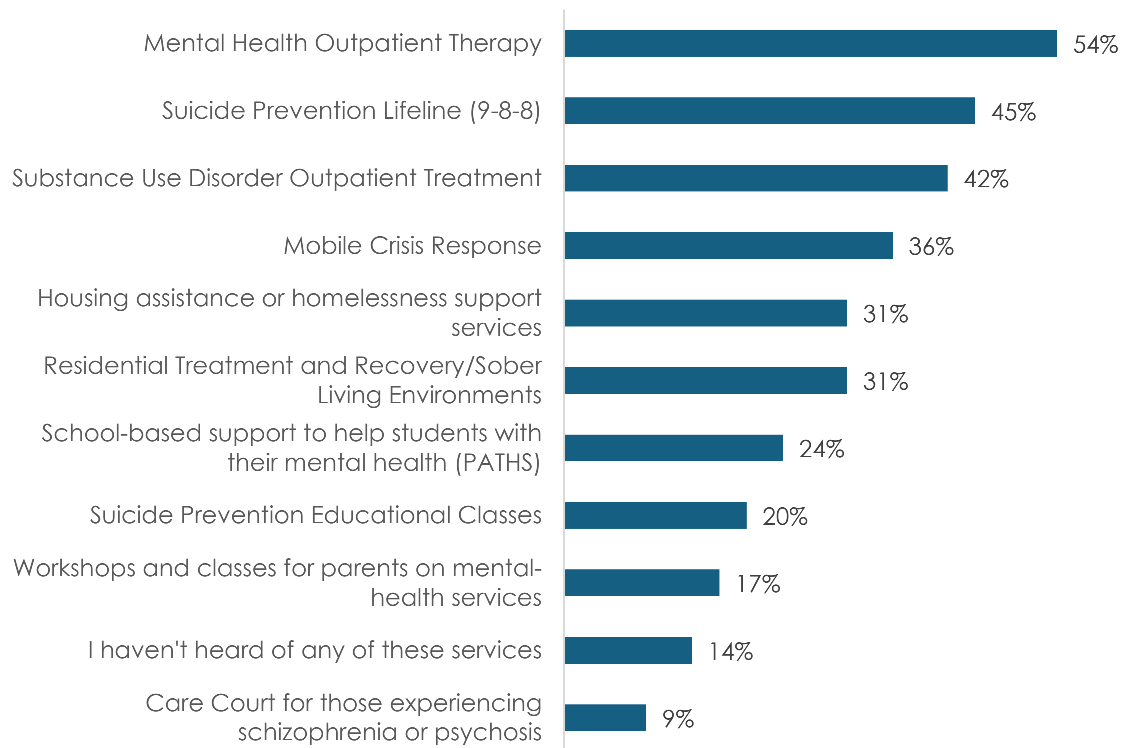
Figure 7. Barriers to Accessing Housing Resources in the County
(N = 30)

Behavioral Health Programs

Figure 8 illustrates the familiarity of survey respondents with various behavioral health programs available in the county. Mental Health Outpatient Therapy was the most widely recognized program, with 54% of respondents reporting familiarity, followed by the Suicide Prevention Lifeline (45%) and Substance Use Disorder Outpatient Treatment (42%). Mobile Crisis Response services were familiar to just over one-third of respondents (36%), while Housing assistance or homelessness support services and Residential Treatment and Recovery/Sober Living Environments were each recognized by 31% of participants.[3] Familiarity rates were lower for school-based mental health support programs (24%), Suicide Prevention Educational Classes (20%), and workshops for parents on mental health services (17%). Particularly, 14% of respondents reported not having heard of any of these services, and only 9% were familiar with Care Court for those experiencing schizophrenia or psychosis, suggesting potential gaps in awareness of specialized behavioral health resources.

[3] The Mobile Crisis Response was a program recently launched in April 2025 and SBCBH has consistently promoted its availability at every outreach event, via social media and SBCBH's website and placing business cards in many prominent public locations. Similarly, the Care Court program was introduced in October 2023 and implemented at SBCBH in March 2024. This program is aimed at a very specific population via referral, so it is to be expected that so few members of the community are familiar based on the timing and need for this service. The same is true of school-based support, particularly since the predominant age of the respondents to the surveys were adults; unless the respondents have children attending local schools, it is likely they would be unaware of this service.

Figure 8. Programs Survey Respondents Are Familiar With
(N = 140)



Community Priorities

In **Table 3**, respondents emphasized both crisis support and stability resources. Nearly half identified affordable housing programs as their top priority, followed by quick access to counseling and therapy to prevent suicide. More than one-third prioritized 24/7/365 crisis help and family support services. Additional priorities included programs for children and teens, job training and employment help, early intervention programs, emergency housing shelters, peer support programs, support groups, and community centers.

Respondents also provided written responses highlighting additional needs, including specialized support groups (such as domestic violence and grief), wellness classes, substance use counseling, preventive programs for youth and seniors, transportation to medical appointments, flexible drop-in hours, and safe gathering spaces with access to resources and activities.

Table 3. Top Priorities Identified by Community Behavioral Health Survey Respondents (N=130)

Priorities	Percent*
Affordable housing programs	49%
Quick access to counseling and therapy to prevent suicide	41%
24/7/365 crisis help (urgent assistance)	38%
Family support services	38%
Programs for children and teens	35%
Job training and employment help	29%
Early intervention programs	18%
Emergency housing shelter	14%
Peer support programs	7%
Support groups	6%
Community centers	5%

*Column Percent exceeds 100% as survey respondents were instructed to select all that apply.

FOCUS GROUPS

To inform planning for the County's behavioral health and homelessness response systems, four focus groups were conducted with individuals who have firsthand experience navigating these services. Participants represented several key lived-experience groups whose perspectives are essential for understanding service strengths, gaps and opportunities for improvement. These groups included people with lived experience of:

- Housing instability or homelessness
- Housing instability or homelessness (youth-specific)
- Substance use challenges and mental health conditions (seniors)
- Substance use challenges and mental health conditions (adults)
- Caregiving for youth navigating substance use challenges and mental health conditions

The insights shared in these conversations reflect personal knowledge of how systems function in practice and highlight which supports are most meaningful, which barriers remain, and which changes participants believe would create more accessible, compassionate, and effective services. Their contributions underpin the themes and recommendations presented in this report.

Participants joined these focus groups for deeply personal and community-oriented reasons, reflecting their commitment to systems change. Many described their participation as an extension of their own recovery journeys: a way to give back after benefiting from behavioral health services that helped them through crises, including homelessness, depression, and suicidal ideation. Others came as experienced advocates and peer leaders who believe that programs must be shaped by those most affected. Participants also identified significant resource gaps that they have personally navigated, particularly in terms of housing access, and saw this as a rare opportunity to influence planning processes. Whether referred by trusted providers, motivated by curiosity, or driven by a desire to represent community members who cannot speak for themselves, participants demonstrated a shared readiness to collaborate on solutions that could improve behavioral health and housing supports in San Benito County.

Community Perceptions of Mental Health, Substance Use, and Homelessness

Participants shared how mental health, substance use, and homelessness are viewed in their communities. Their reflections highlight complex layers of stigma, misinformation, cultural norms, system gaps, and emotional barriers that influence whether individuals seek help and how they are treated.

1. Pervasive Stigma and Social Judgment

Participants described widespread stigma affecting both how others treat them and how they see themselves. They recounted situations where disclosing homelessness led to sudden social rejection, including instances where friendships ended once someone learned the participant had stayed in a shelter. Others described how many people view themselves as failures or burdens when they seek help, believing they should be able to pull their weight and not need services. Cultural taboos around mental health were also prominent, particularly in communities where seeking support is associated with being "crazy" or weak, making individuals reluctant to acknowledge struggles or pursue care.

2. Misunderstandings About Service Affordability and Accessibility

Participants identified widespread misconceptions about the cost, purpose, and availability of services. Some community members believe services are unaffordable: "They assume it's an expensive process… they don't understand that Medi-Cal does covers it." Others described low awareness of mental health programs, preventing people from accessing care, even when resources are available.

> "They assume it's an expensive process… they don't understand that Medi-Cal does cover it."

3. Cultural and Community Barriers to Help-Seeking

Cultural norms, especially within Hispanic and Latino communities, play a role in discouraging individuals from accessing support through fear of gossip and community judgment. One explained that "…Hispanic people don't want to go, because in your mind you think, 'What is my neighbor going to say? What is my family going to say?'" Others described a pattern of internal denial, even when they recognized the need for help. These accounts point to the weight that community perception and family expectations carry in shaping whether someone reaches out for services and suggest that outreach strategies for these communities may need to address stigma at the family and neighborhood level, not just the individual level.

4. Vulnerability and Systemic Failures

Participants highlighted how individuals who are older, disabled, unhoused, or isolated face heightened risks and insufficient protection. They shared stories of seniors losing housing due to family exploitation, as in the example of an older adult whose family "took charge and she's out at the homeless shelter…because

she gave her conservatorship to her daughter." Others emphasized how "the tipping point for at-risk individuals… is very thin," especially when legal, housing, and mental health systems fail to coordinate.

5. Emotional Journey of Service Utilization
Participants described a trajectory of fear, uncertainty, and eventual acceptance when accessing behavioral health services. For many, the first visits felt intimidating. One participant said it was "very, very, very scary… even when I walk into those buildings… it's like walking into the courthouse [on] probation." Over time, however, experiences often shifted toward appreciation and motivation. Another shared, "I kind of look forward to it because it gets me motivated… gives you a boost to get back on track."

What Makes Mental Health and Support Services Actually Work

Participants shared what distinguishes helpful mental health and support services from those that feel ineffective or insufficient.

1. Authentic Human Connection and Genuine Care
Participants emphasized that helpful services included staff who were warm, sincere, and genuinely invested in their wellbeing. Providers "…really want to know how you're doing with behavioral health and how you're dealing with everything," and counselors who were "down to earth" and "keeps it 100" made the time feel worthwhile. Even brief interactions mattered, such as being greeted with "hey, how's your day?" which helped people "feel valued." Front desk staff were repeatedly mentioned as essential, with clerks who "go out of their way to help you… if they can."

2. Lived Experience and Peer Connection
Services were more effective when they involved people with lived experience of mental health or substance use challenges. Having counselors with lived experience "was really helpful because they could relate more." Peer groups offered powerful understanding and solidarity. In a men's group, one participant felt safe to open up: "other men could give me insight on how to deal with it" without feeling judged or "dissected." The community center environment helped people connect with others "suffering the same illness" without fear of stigma.

3. Practical, Hands-On Support Beyond Traditional Therapy
Services were most effective when providers helped with practical, real-world challenges. One strong example involved a provider who helped with finances, childcare navigation, and forms: "she would sit with me, go over finances… she went with me to the daycare places… and showed me how to navigate." The participant noted, "I've never seen anybody do that… she really went above and beyond." Other examples included help interpreting Medi-Cal mail where staff were "very client directed" and accommodated whatever issue the participant brought forward.

4. Creating Safe, Non-Judgmental Environments
Participants described relief when counselors created an atmosphere where they felt safe to talk about what they were going through. Environmental cues influenced comfort, relaxing music in waiting rooms helped reduce anxiety: "Sometimes they have this relaxing music playing… it's a good environment." Staff demeanor mattered as much as physical space. Participants appreciated when "people [were] kind and not with a frown face" because entering a service environment while struggling can intensify fears of judgment.

5. Empowerment and Voice in Services
Participants felt empowered when services actively sought their input and treated them as partners. Consumer meetings provided space to "tell them what you like about the place and how to improve it." Therapeutic relationships that supported self-understanding were valued. One participant explained their counselor "helped me get my power back" and understand why they reacted strongly in situations.

> "My [counselor] helped me get my power back."

Housing Support Needs and Barriers

Participants described their experience navigating housing programs and seeking stable housing in San Benito County.

1. Systemic Barriers and Gatekeeping
Participants emphasized that housing programs are challenging to access due to restrictive eligibility criteria, minimal public information, and extremely long waiting lists. Programs like Section 8 were functionally out of reach: "the waiting list is years… it's years," with timelines far beyond what people in crisis can endure. Even highly engaged community members or service providers were unaware of certain programs because information was so limited.[4] Others described being placed on waiting lists, knowing their temporary housing would expire long before assistance became available.

> "The waiting list is years…it's years."

[4] Section 8, or the Housing Choice Voucher Program, is a federal rental assistance program funded by HUD. While it is administered separately from SBCBH, the county recognizes housing access as a factor in behavioral health outcomes and continues to coordinate with housing partners to support community members navigating these systems.

2. Income Paradox and Affordability Crisis
Participants described earning too little to afford market-rate housing yet too much to qualify for assistance.[5] One explained that many "don't make enough to really make it on our own… but make right over the mark where we can get any kind of help." Program rules requiring proof of income were unrealistic for people still stabilizing their health, employment, or recovery.[6]

3. Family Separation and Pet Barriers
Policies force families to choose between maintaining unity and accessing shelter. One participant noted, "there's not a shelter for below the age of 18," meaning parents must separate from children to enter available shelters. Another declined housing because of a beloved pet, explaining they "weren't gonna put him in a shelter" with no family to help.

4. Systemic Delays and Communication Failures
Participants experienced delays in communication and decision-making that created unnecessary setbacks. They described long waiting periods for returned calls, housing decisions arriving months too late, and the absence of updates during critical moments. These delays added emotional strain and sometimes forced individuals to find housing on their own without program support.

5. Service Provider Disconnection from Client Reality
Participants described administrative errors, disorganization, and unrealistic expectations. Some were told applications were lost after staff changes: "This person doesn't work here anymore. Your application wasn't on the list." Others were denied housing because income records did not reflect pending assistance. Wait times for appointments often exceeded the value of the interaction.

Crisis Response Experiences

Participants described a wide range of experiences with crisis response systems, including emergency departments, behavioral health crisis services, and informal supports.

1. Systemic Stigma and Labeling in Healthcare Settings
Participants described feeling judged or dismissed when seeking emergency care at the hospital, mainly when their records reflected substance use histories. Several shared that hospital staff treated them as if they were "a doper and a

[5] Throughout this section, participants described experiences navigating services across multiple county touchpoints. In some cases, it was not possible to determine whether they were referring specifically to Behavioral Health or to other agencies involved. Some participants themselves were unclear about which entity they were interacting with. This feedback is included because it reflects patterns relevant to any county agency involved in behavioral health and housing services, including Behavioral Health.
[6] While housing assistance eligibility thresholds are set at the federal and state level, the county recognizes this gap as a barrier for community members and is exploring local strategies to expand access to housing support.

bum," and that drug use disclosure created a "permanent label" shaping every subsequent encounter. Others described being treated as an inconvenience, sensing frustration from staff at repeated visits.

2. Flexible Boundaries and After-Hours Support Save Lives
Participants emphasized the importance of lifesaving support extending beyond standard business hours. One described calling a counselor after-hours during a relapse, emphasizing that "a little more flexibility with boundaries… could really save someone's life." Others highlighted crisis staff consistently available to "talk [them] out of certain situations" and case managers who checked on them later the same day to ensure safety.

3. Loss of Control and Inadequate Communication
Participants described crisis situations in hospital settings where they were stripped of autonomy with little explanation. One repeatedly told they would be released was unexpectedly placed on a 5150. They explained that if hospital staff had communicated this possibility earlier, it would have prevented significant fear and confusion. Others described individuals being discharged from the hospital without medication or transported out of county without adequate support for children left behind.

4. Geographic and Resource Barriers to Timely Care
Participants encountered barriers related to insurance coverage, distance, and rural infrastructure. One participant reported that after relocating from Santa Clara County to San Benito County, their Medi-Cal had not yet transferred locally, so their family drove them to the ER outside the county for fear of being turned away locally. Others described slow response times in rural areas where crisis staff must travel long, narrow one-way roads, arriving only after the person in crisis had worsened. Lacking transportation made it "very hard" to access emergency or follow-up care.

5. Positive Experiences with Respectful, Responsive Care
Participants shared examples of effective crisis response, including SBCBH responders who arrived "within 15 minutes," were discreet, and knocked softly rather than aggressively. When expressing suicidal thoughts, crisis staff acted quickly, arranging same-day or next-day support and following up. Some described positive experiences at the local hospital where nurses and doctors treated them with respect and care.

Transitions Between Care and Services

Participants described transitions between behavioral health, housing, and social service programs as crucial periods in their recovery.

1. Housing as a Critical Foundation for Success
Participants identified housing stability as the most important factor determining whether someone can successfully move between services. They explained that without a stable place to live, people lose hope and are at higher risk of returning to substance use or experiencing another crisis, even after making progress in treatment. Others shared that even when they were motivated and actively engaged in services, they still could not secure housing because their income was too low to meet rental requirements.

2. Gaps in Service Continuity and Coordination
Participants described abrupt disruptions in care when SBCBH mental health therapy programs ended, funding changed, or referrals were delayed. One person explained that their therapist's funding "got cut off" in the middle of a personal crisis, leaving them without services after meeting twice a week. Others described long wait periods between services, noting that many people cannot maintain stability while waiting "30 to 60 days" for the next step. Participants expressed the need for someone to "build the bridge" between programs so care does not simply stop and restart.

3. Need for Individualized, Flexible Planning
Participants emphasized the importance of transition plans that fit their circumstances rather than rigid, uniform processes. Some noted that funding and program eligibility should be "case-based, individually based for that person." Others described wanting clearer, step-by-step pathways tailored to their unique needs, envisioning a process where "this is your situation, these are your pathways… follow A, B, C and you'll get here." These reflections underscore the need for individualized transition planning.

Engaging Individuals Who Are Hesitant to Seek Services

Participants provided insight into what helps build trust and engagement for people who are reluctant to use traditional services.

1. Genuine Care vs. Performative Service
Participants demonstrated a nuanced ability to distinguish between authentic care and providers who appeared to be simply completing tasks. They said they can "see the genuineness" in people who truly want to help and noted that some shelters and programs felt supportive because staff were sincere, while others felt cold or disengaged. Another participant valued a staff member who went out of their way to help directly rather than repeatedly referring them elsewhere.

2. The Harm of Provider Judgments and Bias
Participants described feeling frustrated and even traumatized when providers approached them with preconceived ideas about who they were or how their progress should unfold. One person described how some providers "already have their mind made up," assuming they understand a person's story based on limited information. These experiences erode trust and discourage future engagement.

3. Recognition of Effort and Incremental Progress
Participants stressed the importance of having their hard work and growth recognized, even when progress is gradual or imperfect. One described how meaningful it felt when staff acknowledged that they work hard and continue to try, explaining that such encouragement helped them feel seen and motivated. Others shared that counseling boosted their self-esteem, particularly during moments when they felt unlike themselves. That sense of reinforcement made it easier to stay engaged with services.

4. Holistic, Non-Medical Approaches to Healing
Participants valued diverse pathways to healing beyond traditional clinical approaches, including creative activities like coloring, drawing, writing, and art or cooking classes. Others highlighted physical activities such as swimming, going to the gym, or walking. Spiritual and faith-based practices were necessary for some, including reading the Bible or books about saints and connecting with religious communities. Participants emphasized that humor, laughter, karaoke, and social activities helped them cope and feel a sense of belonging. Group activities like meditation classes, Spanish classes, trivia, and community field trips strengthened wellbeing by offering routine and connection.

Barriers to Accessing Services

Participants were asked to describe the challenges they face when trying to access behavioral health, housing, and supportive services.

1. Lack of Employment Opportunities and Economic Stability
Participants emphasized that limited job opportunities make it difficult to meet basic needs and simultaneously create psychological distress. Without stable income, people struggle to qualify for housing, cover transportation costs, or meet program requirements. One participant noted that "here they don't have… help getting a job," while another described how constant job searching contributes to "anxiety and depression" because of the stress it creates. Participants also expressed a desire for employment training and higher-paying jobs to support long-term stability. These economic barriers directly affect the ability to access and sustain engagement in services.

2. Transportation and Geographic Isolation
Transportation emerged as a persistent barrier. Participants explained that many people "don't have transportation means" and no one available to drive them, making even a single appointment difficult to attend. They described San Benito

County as lacking "major bus transportation," leaving people isolated even within the county. While some rely on "call the car" services, these require advance scheduling and are unreliable for same-day needs. In one case, a Lyft arranged through the service never arrived. These transportation gaps limit access to timely care, employment, and community connection.

3. Information Access and Service Awareness
A barrier lies in knowing what services exist and how to access them. Participants explained that without someone to guide them, they often do not know "where to start." Participants suggested using social media more effectively to share information about programs like needle exchange or harm reduction. In some cases, lack of clear, accessible information prevents people from entering the service system.

4. Policies Misaligned with Client Needs
Participants described bureaucratic processes that delay access to care and create additional stress. Some participants specifically highlighted shelter rules and administrative policies that felt punitive or unnecessary. They described situations in which shelter staff appeared to pressure residents to "self-exit," effectively pushing them to leave rather than assisting them through challenges. Participants also reported strict treatment and housing program requirements that did not account for mental health needs, transportation limitations, or the lack of available housing options. These practices left some feeling scrutinized instead of supported, creating an environment where people felt unwelcome in the programs.

Reimagining Mental Health and Substance Use Services

Participants were asked to share their ideas for how mental health and substance use services could be redesigned to better meet community needs.

1. Accessibility Through Strategic Placement and Innovative Outreach
Participants emphasized that services should be easy to find, easy to reach, and visible in the places community members already spend time. They envisioned outreach that delivers information directly to high-traffic, everyday locations, so people do not have to navigate complex systems to learn what is available. One participant suggested "putting up posters near hot spots like schools, downtown, even the movies," so the information is "there in a common area." Another recommended tabling at food truck events, and street fairs with "a banner with the QR code… advertising free county services." Others envisioned a small satellite office downtown to improve walk-in access. These ideas highlight a desire for outreach that is integrated into daily community life rather than isolated in clinical settings.

2. Community-Centered Support Groups and Peer Connection
Participants described the value of groups, either staff or peer-led, to address grief, trauma, loneliness, and shared challenges. One participant envisioned

support groups that address many forms of loss, "not just grieving a death, but… grieving a breakup… a job," offering coping strategies in a supportive environment. Another noted that people often feel safer in groups where others "are going through the same thing" and can engage "on their own terms." Participants also highlighted the importance of community as a protective factor, with one saying, "They need a community… to have discussions, to have support socially," and another emphasizing that groups help people "not feel isolated." These groups were framed as both therapeutic and humanizing.

3. Seamless Care Transitions and Continuity

Participants expressed frustration with having to retell their stories and rebuild trust with new providers repeatedly. They described how repeating their entire history to each new clinician felt exhausting and retraumatizing. One participant wished their information could transfer more easily, saying, "I have to explain my whole entire life to someone new… ideally, they would have your file so you wouldn't have to start from the beginning every time." Others emphasized the need for warm handoffs during wait periods, suggesting that short-term contacts could "bridge that gap" so clients "still feel seen and not ignored."

4. Culturally Responsive and Population-Specific Services

Participants noted that different groups need tailored mental health and substance use approaches. Their reflections illustrate how culturally grounded and population-specific programming can reduce barriers and improve engagement.

- **Spanish-Speaking Community:** Spanish-speaking participants expressed the need for services offered in their preferred language. One senior participant recommended bringing "a professional person to speak to them… once a week" so that mental health information could be delivered consistently and in an accessible way at the senior center, a place they already visit regularly. Participants noted that language-appropriate outreach and groups would make it easier for Spanish-speaking residents to understand resources and feel comfortable seeking help.
- **Seniors:** Participants described social isolation among seniors. One participant explained that older adults often have nowhere to gather, talk, or receive support. Tailored programming, such as senior discussion groups, community activities, or on-site outreach, was seen as helpful for reducing loneliness and improving emotional wellbeing.
- **Families and Parents:** Participants highlighted the need for support designed for families managing parenting stress, conflict, and intergenerational challenges. They expressed interest in groups that provide education on "patience or anger management or family," noting that many parents face complex emotional and behavioral dynamics at home. Family-centered programming could help caregivers strengthen relationships and cope more effectively.

- **People Coping with Trauma:** Participants also noted that people who have experienced trauma benefit from environments and groups tailored to their emotional needs. Trauma-informed supports, whether through peer groups, coping skills education, or culturally relevant healing spaces, were viewed as important additions to traditional services.

5. Hope, Healing, and Opportunities for a Fresh Start

Participants expressed a deep sense of hope rooted in their own healing journeys and the support that helped them begin again. Several described how behavioral health counseling and substance use treatment programs were "very helpful" and gave them the foundation they needed to rebuild their lives. Others emphasized the importance of everyday activities that spark joy, such as movement, socializing, and laughter, as meaningful ways to cope and stay emotionally grounded.

SYSTEM PARTNER SURVEY

A system partner survey was distributed to county agencies, behavioral health staff, community-based providers, and other stakeholders working with San Benito County's behavioral health and housing systems. The survey gathered perspectives on current system strengths, collaboration barriers, service gaps, and priority populations requiring enhanced support. Respondents provided feedback through both structured questions and open-ended responses, offering insights into operational challenges and improvement opportunities from those directly involved in service delivery and systems coordination. The findings are summarized in the following section.

Strengths and Needs

Figure 9 displays the San Benito County System Partners' responses regarding the county's biggest strength in behavioral health (N=58). Early Intervention was identified as the top strength by 26% of respondents, followed closely by Serving High-Need Priority Populations at 24%. Workforce Development garnered 10%, System Integration & Coordination 9%, and Housing Intervention & Homelessness Prevention received the lowest response at 3%. This distribution highlights that early intervention and targeted services for high-need populations are viewed as the county's primary strengths in behavioral health.

Respondents also had the opportunity to explain why they viewed their selected area as a strength. Responses revealed additional perspectives spanning workforce quality, service responsiveness, and resource limitations as described below:

- **Workforce Competency & Community Connection:** Respondents appreciated that competent staff personally know or relate to families served, which helps create connections and trust within the community. This personal connection in a small community setting was viewed as particularly valuable for behavioral health effectiveness.
- **Quick Response & Crisis Support:** Respondents highlighted the county's ability to act quickly when families and adults need immediate mental health support, with rapid access being especially valued given high demand for crisis services.
- **Resource & Capacity Limitations:** Respondents who chose none of the options expressed concern that budget and staffing constraints prevent consistent quality of care, with gaps in cultural humility and uneven access for rural residents, bilingual families, and individuals with co-occurring conditions.

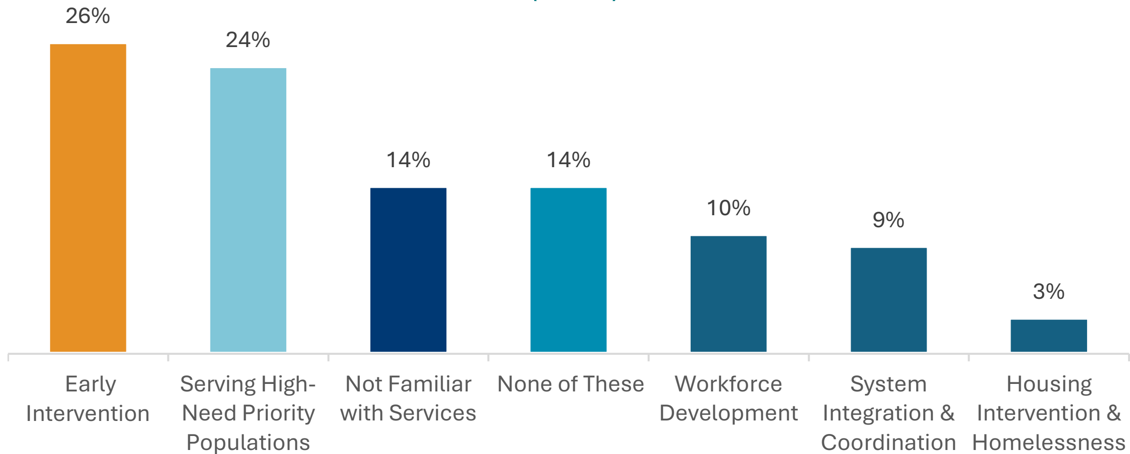


Figure 10 details the San Benito County System Partners' responses regarding the county's biggest improvement need in behavioral health (N=55). Three areas tied as the top improvement need at 20% each: Housing Intervention & Homelessness Prevention, Serving High-Need Priority Populations, and System Integration & Coordination. Early Intervention and Workforce Development each received 15% of responses, while Not Familiar with Services garnered 7%, and None of These received the lowest response at 4%. This distribution highlights that housing support, targeted services for high-need populations, and system coordination are viewed as the primary areas requiring improvement in the county's behavioral health system.

Respondents also explained why they selected their area as needing improvement. Their responses highlighted three major concerns:

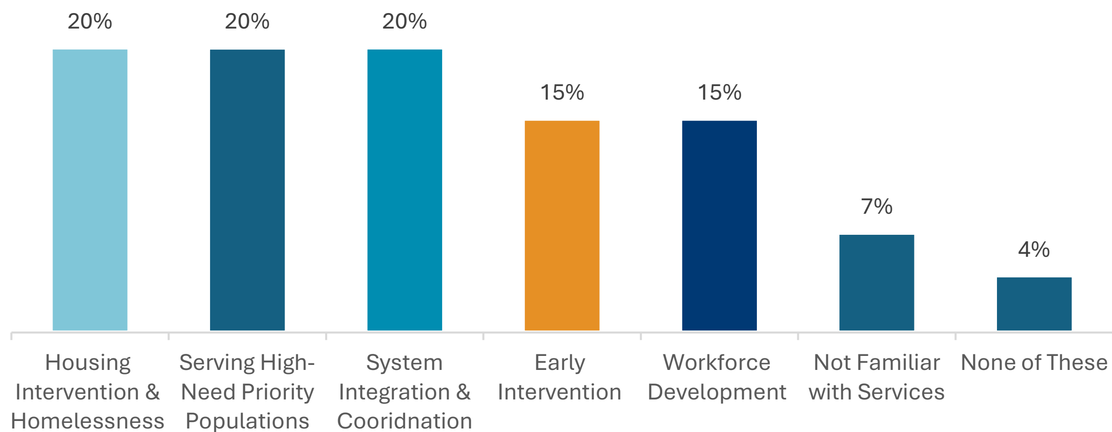
- **Workforce Development & Cultural Competency:** Workforce gaps create the biggest barrier to timely prevention, crisis navigation, and post-crisis support. Outreach and education roles are understaffed, especially for Spanish and Indigenous language services, with limited coverage in rural areas and after hours. High turnover and vacancies slow referrals and follow-up. Clients shared they frequently encountered staff who lack bilingual capacity or lived-experience perspectives.

- **System Fragmentation & Communication Breakdowns:** System partners described how services across health, housing, social support, and schools often operate in silos. Families and clients are frequently asked to repeat their stories or fall through gaps due to limited communication between agencies. Without shared systems or clear referral protocols, smooth handoffs between providers remain difficult, and collaboration across

agencies is inconsistent. One partner whose work intersects with the justice system raised a question about whether behavioral health services extend to individuals who are incarcerated, suggesting this may represent an underserved segment of the broader community. This perspective, while reflecting one partner's experience, may warrant further exploration as the county considers how it defines access and reach across populations.

- **Limited Community Awareness & Accessibility:** Available resources remain unknown to community members until they reach crisis. Behavioral health services lack visibility and clear referral processes. Seniors, isolated individuals, and those transferring Medi-Cal face significant barriers accessing essential services and medication. Many noted that promoting services more actively could help residents get support before reaching desperate circumstances.

Figure 10. San Benito County System Partners' Response to the County's Biggest Improvement Need in Behavioral Health
(N=55)



Priority Populations

Table 4 displays the populations San Benito County stakeholder survey respondents reported should be prioritized when expanding behavioral health services. Youth/Adolescents were identified as the top priority by 53% of respondents, followed by individuals involved with criminal or juvenile justice systems (40%). People experiencing homelessness were prioritized by 35% of respondents, while individuals with co-occurring disorders and older adults each received 29%. Individuals who are institutionalized were identified by 22% of respondents as needing priority. Communities of specific racial/ethnic groups, residents in rural areas, and individuals with LGBTQ+ identities each received 15%, 15%, and 13% respectively. Other populations specified by respondents were identified by 13%.

Respondents also explained why certain populations should be prioritized and suggested additional groups needing attention. Several emphasized the importance of early life services for children 0-8 and their families, including speech, occupational therapy, and ABA services, noting that early intervention shapes lifelong outcomes. Others highlighted underserved populations facing significant barriers, including residents in rural areas experiencing geographic isolation and limited providers, individuals with LGBTQ+ identities lacking affirming care, and people served by San Andreas Regional Center. Additional groups mentioned as often overlooked included fathers, young adults transitioning to independence, and older adults facing high rates of isolation and depression.

Table 4. Populations San Benito County Stakeholder Survey Respondents Report Prioritizing Expanded Behavioral Health Services (N=55)

Population Descriptions	Count	Percent*
Youth/Adolescents	29	53%
Individuals involved with criminal or juvenile justice systems	22	40%
People experiencing homelessness	19	35%
Individuals with co-occurring disorders	16	29%
Older adults	16	29%
Individuals who are institutionalized	12	22%
Communities of specific racial/ethnic, please specify	8	15%
Residents in rural areas	8	15%
Individuals with LGBTQ+ identities	7	13%
Other, please specify	7	13%

*Column Percent exceeds 100% as survey respondents were instructed to select up to three groups.

Organizations Collaborating with San Benito Behavioral Health

Table 5 displays the organizational descriptions of San Benito County system partner respondents. Organizations serving adults with mental health/substance use needs represented the largest proportion at 33%, followed by Early Childhood Services at 31% and Aging Services at 25%. Homeless Services and organizations serving youth with mental health/substance use needs each accounted for 21% of respondents. Developmental disability services, emergency medical services, public health or behavioral health initiatives, and social services/child welfare also represented notable proportions. Additional sectors included healthcare organizations providing Medi-Cal behavioral health services, law enforcement, education, and veteran organizations. This diverse representation reflects the diverse sectors San Benito County Behavioral Health collaborates with to provide services to the community.

Table 5. System Partner Respondents' Organization Description (N=48)

Organizations	Count	Percent*
Organization serving adults with mental health/substance use needs	16	33%
Early Childhood Services	15	31%
Aging Services	12	25%
Other, please specify	11	23%
Homeless Services	10	21%
Organization serving youth with mental health/substance use needs	10	21%
Developmental disability services	9	19%
Emergency medical services	9	19%
Public health on behavioral health initiatives	7	15%
Social services/child welfare	7	15%
Healthcare organization that provides Medi-Cal behavioral health services	5	10%
Law enforcement, probation, or juvenile detention facilities	5	10%
K-12 Education	4	8%
Higher Education	3	6%
Veterans' Organization	3	6%
Health insurance or managed care organization that provides behavioral health coverage	2	4%

*Column Percent exceeds 100% as survey respondents were instructed to select all that apply.

Table 6 displays the types of collaboration between San Benito County organizations and the County Behavioral Health Department. Direct Referrals represented the most common form of collaboration at 43%, followed by Case Coordination at 37%. Joint Programming was reported by 27% of respondents, while Training/Consultation accounted for 22%. Notably, 20% of respondents indicated No Collaboration with the County Behavioral Health Department. Data Sharing was reported by 18% of organizations, and Shared Funding/Contracts by 14%. This distribution suggests that while direct service connections are well-established, opportunities may exist to strengthen collaborative partnerships in areas such as joint programming and shared resources.

Respondents also specified other types of collaboration not captured in the listed categories. These included community outreach and education efforts, post-crisis follow-up coordination, information sharing with partners such as Public Assistance programs and the Aging & Long-Term Care Commission, child passenger safety initiatives, and engagement activities. Some noted they are behavioral health staff themselves or work within the behavioral health system. Several respondents indicated they were unsure of their collaboration type or noted limited partnerships with early childhood services (0-3) that primarily involve referring families to behavioral health as a general resource.

Table 6. Organizations' Collaboration with County Behavioral Health Department (N=49)

Collaboration Type	Count	Percent*
Direct Referrals	21	43%
Case Coordination	18	37%
Joint Programming	13	27%
Other, please specify	12	25%
Training/Consultation	11	22%
No Collaboration	10	20%
Data Sharing	9	18%
Shared Funding/Contracts	7	14%

*Column Percent exceeds 100% as survey respondents were instructed to select all that apply.

Barriers

Figure 11 shows the barriers to making progress on BHSA goals as identified by San Benito County stakeholders (N=53). Funding limitations emerged as the most significant barrier at 68%, followed closely by Staff shortages at 64%. Lack of coordination Between Services was identified by 49% of respondents, while Housing Availability was cited by 40%. This distribution highlights that resource constraints, both financial and human capacity, represent the primary challenges to advancing behavioral health goals in the county.

Respondents also identified additional barriers beyond those listed. Common concerns included limited service hours, high staff turnover, inadequate training in housing navigation and cultural competency, and low reimbursement rates. As a smaller rural community, fewer nonprofit partnerships are available. Several noted that agencies work in silos rather than collaborating, creating coordination breakdowns and placing burdens on other providers. Some expressed concern that the current political climate may discourage immigrant and Hispanic communities from seeking help, and others questioned the gap between policy commitments and actual service delivery.

Figure 11. Barriers to Making Progress on BHSA Goals
(N=53)

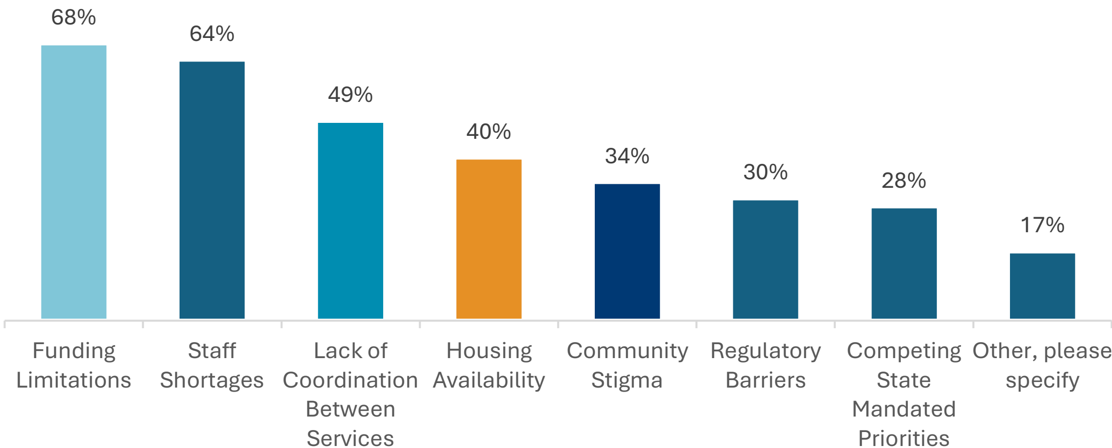
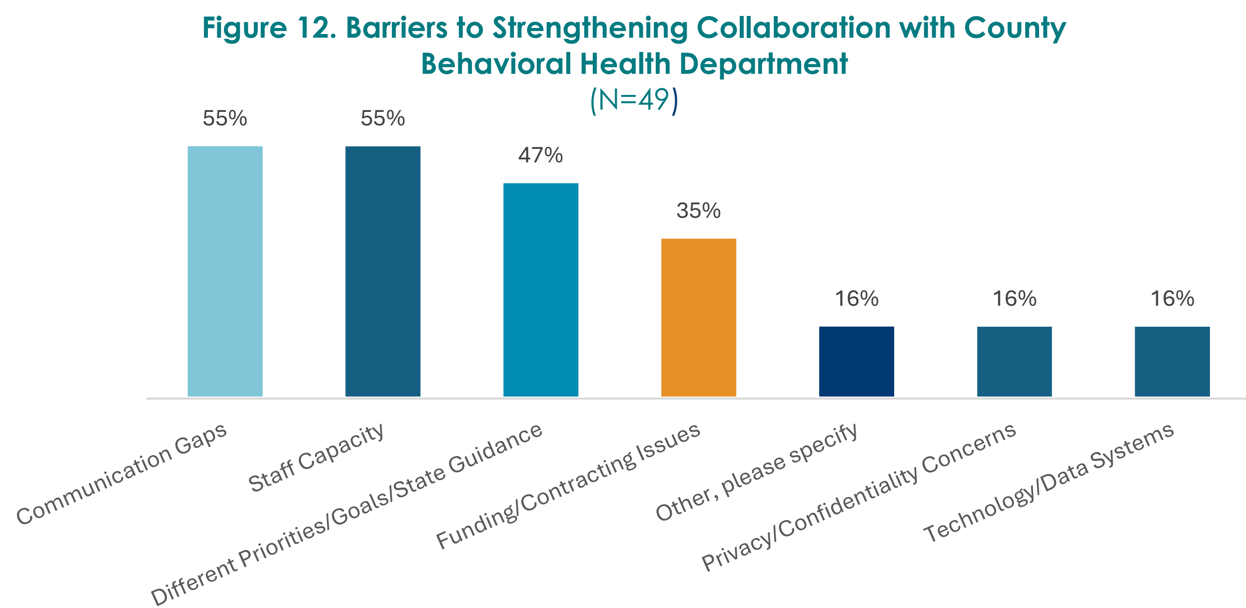


Figure 12 displays the barriers to strengthening collaboration with the County Behavioral Health Department as identified by San Benito County system partners (N=49). Communication Gaps and Staff Capacity emerged as the most significant barriers, each identified by 55% of respondents. Different priorities/goals/state guidance was cited by 47%, while Funding/Contract Issues was recognized by 35% of respondents. Other barriers were selected by 16% of respondents. This distribution indicates that addressing communication challenges and capacity constraints represents the primary opportunity for strengthening collaborative partnerships with the County Behavioral Health Department.



System Improvement Priorities

Survey respondents identified collaboration and operational challenges within San Benito County's behavioral health system through open-ended questions. While the survey focused on behavioral health, many of the concerns raised reflect system-wide dynamics that extend across county departments.

The most consistent theme was a need for stronger communication and coordination between agencies. Multiple respondents described county departments as operating in silos and called for regular multi-agency meetings, designated points of contact, and shared planning around common goals and populations. Several respondents noted they were unsure whom to contact to initiate collaboration, suggesting that even willing partners face barriers to entry.

Respondents also called for shared infrastructure across county systems, including standardized release of information forms, data-sharing agreements or MOUs, unified or interoperable electronic health records, and clear warm handoff protocols with feedback loops to prevent clients from falling between agencies. Some highlighted the value of including people with lived experience in planning and evaluation to keep the focus on client needs rather than agency boundaries.

Additional themes included the need for more staffing to support overstretched clinicians and case managers, flexible or braided funding models, and greater transparency around referral processes and service capacity. Some respondents expressed interest in cross-county partnerships and strategic alignment of resources where programmatic overlap exists.

A smaller number of respondents raised concerns about organizational culture and professionalism within county systems, describing a desire for greater openness to feedback, cooperation among providers, and willingness to engage beyond mandated priorities. These observations came from partners across multiple systems.

To improve services, respondents prioritized enhanced community outreach, particularly for underserved populations with transportation or mobility barriers. They suggested community health workers (promotoras) conduct door-to-door outreach and increase visibility in schools. Respondents also called for service expansion, including specialized programming for older adults, crisis services, and people experiencing homelessness, alongside simplified referral processes and transparent communication about wait times and outcomes. The overarching message emphasized the need for a "no wrong door" approach, characterized by streamlined access, cross-sector collaboration, and genuine cultural transformation, with a focus on client-centered care.

KEY INFORMANT INTERVIEWS

This section synthesizes findings from thirteen Key Informant Interviews (KIIs) with system partners working closely with the Behavioral Health Department. Conducted via Zoom or phone, these interviews captured perspectives from organizations across the behavioral health ecosystem to identify service needs, gaps, strengths, and opportunities for system improvement.

Participants represented diverse sectors, including public safety, K–12 and higher education, public health, child welfare, emergency medical services, health care plans, aging services, homeless services, domestic violence programs, LGBTQ+ organizations, veterans' services, and medication-assisted treatment providers. Their tenure ranged from a few years to over twenty years, with several serving 15+ years, reflecting deep institutional knowledge and community commitment. Many hold multiple roles across agencies, a common adaptive strategy in rural counties with limited staffing.

Findings are organized thematically, accompanied by illustrative examples and partner insights. These perspectives will directly inform the department's three-year strategic planning by highlighting priorities for collaboration, service delivery, equity, and system coordination.

Enablers to Meeting Priority Goals

1. Strategic Partnerships and Cross-Sector Collaboration

Strong, trust-based relationships between hospitals, behavioral health organizations, schools, community organizations, and health plans enable rapid responses, coordinated care, and effective problem-solving. Partners described Behavioral Health as "an exceptional partner," noting that the department is consistently present and valuable in joint planning efforts. Multi-agency coordination (including joint homeless outreach, Point-in-Time Count participation, and coordinated street teams) leverages diverse organizational strengths. As one respondent emphasized, "The more organizations we partner with, the better chance we have to really support the community."

> "The more organizations we partner with, the better chance we have to really support the community."

2. Innovation and Technology-Enabled Access

Telemedicine has significantly expanded access to care, particularly for residents in geographically isolated areas. One provider explained, "we now have telemedicine…I can see them in Monterey, order the shot, and the nurses… can give it. They do a visit with me and they'll get the shot whenever it is convenient." Cross-county suicide prevention protocols demonstrate successful standardized practice. Willingness to innovate and combine expertise across programs creates opportunities to reach underserved populations and address service gaps in creative ways.

3. Community Networks and Grassroots Engagement

Formal and informal networking structures, including the Chamber, Downtown Association, and countywide mental health providers network, strengthen communication, reduce duplication, and build collective capacity. During monthly collaborative meetings, "all entities come to the table… including Behavioral Health and substance abuse," creating space for coordination and shared problem-solving. These networks are particularly valuable in a small rural county where relationships and word-of-mouth significantly influence service delivery.

Challenges to Meeting Priority Goals

1. Workforce Instability and Provider Shortages

Severe staffing shortages, high turnover, and inability to compete with neighboring counties' compensation create a persistent crisis.[7] Staff gain experience locally, then leave for higher-paying positions, leaving the department "just barely in survival mode" and forcing reliance on contracted providers. Provider shortages are particularly acute in specialized roles and among bilingual, culturally competent professionals. One respondent described it bluntly: "For behavioral health, the lack of providers… social workers, psychologists, psychiatrists, and other specialties — there is a dearth…very, very few." Rural location compounds recruitment challenges, undermining service capacity and training investments.

2. Resource Scarcity and System Capacity Gaps

Service capacity falls significantly short of community need across behavioral health, substance use treatment, developmental services, and basic supports like childcare. As one participant stated, "On the substance use side…that population definitely there is still a need, and we are not meeting that need as a county." Funding constraints limit expansion, particularly for incarcerated youth, where Medi-Cal billing is unavailable. Short-term grants without sustained grant-writing capacity create instability. Affordable housing shortages (especially affecting seniors) delay or interrupt treatment, with some individuals remaining unhoused rather than accepting restrictive program conditions.

3. Fragmentation and Coordination Breakdowns

Services operate in silos with insufficient structures for integration, leaving clients to navigate complex systems independently. One respondent observed, "a lot of services are siloed… justice programs… homeless services…substance abuse [are] its own wheelhouse," resulting in "putting our client essentially at the center of figuring everything out." Critical breakpoints occur during transitions (reentry from jail,

> "A lot of services are siloed… justice programs, homeless services, substance abuse services are each in their own wheelhouse…putting our client essentially at the center of figuring everything out."

[7] These workforce challenges are consistent with statewide trends documented in HCAI's Behavioral Health Workforce Supply and Demand Modeling, which projects continued shortages across key behavioral health disciplines in California.

hospital discharge, post-overdose) where "things fall apart, or there are gaps in services." While agencies align on goals, consistent implementation and follow-through remain challenging. Crisis response stays reactive rather than preventive.

4. Geographic Isolation and Access Barriers

Rural geography and limited in-county provider networks force residents to travel to other counties for specialized care, creating transportation, cost, and scheduling barriers. One participant noted that substance use treatment options within the county remain limited, with much of that care happening out of county, which creates additional barriers for people seeking services. These delays interrupt continuity and push some residents toward unsafe online alternatives without clinical oversight. Long wait times and fragmented service pathways compound access challenges across all populations.

5. Cultural Barriers, Stigma, and Historical Trauma

Multiple interconnected factors discourage help-seeking: stigma (particularly in Latino communities where mental health support "is considered a weakness"), privacy concerns in a small community where "word spreads like wildfire," immigration fears, and historical institutional trauma—especially among Indigenous communities experiencing "hundreds and thousands of years of anger and hurt and betrayal." Complex, intimidating entry points create structural barriers. Trust-building requires intentional, sustained effort. As one provider noted, "You gotta gain that trust… then they open up." Peer support models (particularly for veterans) prove more accessible than traditional clinical approaches.

Partnership, Coordination, and Vision for the Behavioral Health Department

Stakeholders across San Benito County identified both strengths and challenges in their partnerships with the Behavioral Health Department while articulating a shared vision for a more accessible, integrated, and community-centered system.

1. Communication and Relationship Infrastructure

Effective partnerships require consistent communication structures, designated contacts, and intentional relationship-building from all parties involved, elements that interviewees identified as currently underdeveloped. Many reported that communication structures that previously supported effective coordination have weakened over time, with stakeholders noting decreased visibility into referral outcomes and reduced bidirectional information-sharing compared to prior

years. The absence of regular touchpoints, clear contact persons, and predictable information-sharing mechanisms undermines day-to-day coordination.

Participants emphasized that simple, consistent practices would significantly strengthen partnerships. Suggestions included quarterly check-ins, designated liaisons for partner organizations, and routine information-sharing meetings. One interviewee suggested that having a direct contact person would make coordination more efficient. Turnover further disrupts relationships across the system, as new staff often lack existing connections with partner organizations and must rebuild relationships from scratch.

Beyond bilateral partnerships, several interviewees expressed interest in broader coordination efforts and regional collaboration. Some described a desire to strengthen cross-county partnerships with neighboring regions like Monterey County. Others identified gaps with specific communities, particularly tribal populations where relationship-building has been ongoing but remains an area for continued investment and mutual engagement. One veteran services partner captured this sentiment: "If San Benito County creates a systems-of-care coalition or partnership network, I would love to be at the table." These perspectives reflect a shared desire across partners for more structured, intentional relationship-building across the entire behavioral health ecosystem, moving from ad hoc connections to a formalized network that supports coordinated care and mutual accountability.

2. Resource and Capacity Limitations

Limited staffing, funding, and infrastructure constrain both internal service delivery and the department's ability to engage in collaborative efforts with partners. Participants consistently described Behavioral Health as a "small organization" managing a "big lift" from diverse, high-need populations across the entire county. Provider shortages, compensation disparities that drive qualified staff to higher-paying counties, and unpredictable funding cycles that "ebb and flow" create ongoing capacity challenges that ripple throughout the system.

"If San Benito County creates a systems-of-care coalition or partnership network, I would love to be at the table."

These resource constraints directly impact partner organizations and the clients they serve. Several interviewees shared that services they once relied on

disappeared during COVID and were never reinstated, such as twice-weekly counseling contracts that "never got renewed", forcing organizations to find and fund their own behavioral health services independently. The county's broader resource limitations compound these challenges, with one interviewee noting, "The county does not have a lot of medical resources… It is a tough county." Infrastructure gaps, including the absence of alternate mental health facilities for crisis transport, further limit the system's ability to respond effectively to community needs.

Despite these constraints, interviewees remain committed to creative problem-solving and innovation. Partners described promising approaches such as telehealth pods that allow residents to access providers "in a private, confidential setting" and other adaptive models designed to maximize limited resources. One interviewee noted that limited resources force teams to find creative workarounds. This resilience reflects the community's dedication to meeting behavioral health needs, even within a constrained environment. However, interviewees made it clear that sustainable improvements will ultimately require adequate funding and staffing.

3. Gaps in Service Coordination and Continuity of Care

Critical gaps exist in care coordination during key transition points and across systems, creating fragmented care pathways that leave vulnerable populations without adequate support. Interviewees identified disconnected referral processes, lack of follow-up after referrals are made, and unclear crisis response protocols as fundamental barriers to effective coordination.

Structural barriers further complicate coordination efforts. Physical separation between agency offices creates practical obstacles to collaboration. Disconnected technology systems hinder information sharing and care coordination. The absence of alternate mental health facilities means that "we cannot transport directly to a mental health facility," limiting emergency response options. These infrastructure gaps, combined with the absence of clear pathways for referrals and crisis response, create a system where coordination depends heavily on individual relationships rather than reliable structures.

4. Vision for an Accessible, Integrated, and Community-Centered System

Despite current challenges, interviewees articulated a clear and ambitious vision for the Behavioral Health Department's ideal role in the community: one that emphasizes early intervention, accessibility, integration, and human-centered care.

Early Intervention Focus: Interviewees expressed strong support for shifting from crisis-driven services to proactive early identification, particularly in schools and youth-serving environments. One interviewee stressed that addiction often begins between ages 11 and 13, and that shifting toward early intervention could reach young people before they enter the crisis system.

Central Hub and System Integration: Many interviewees view Behavioral Health as the natural center of a coordinated countywide mental health system, uniquely positioned to unify efforts across public health, social services, justice, education, and community organizations. As one participant articulated, "Mental and behavioral health cross many programs… It should be central because it is everywhere."

Successful Partnership Examples: Several interviewees highlighted positive collaborations that demonstrate what is possible when relationships are active and intentional. Examples include Behavioral Health's participation in community resource fairs, co-hosted LGBTQ+ events and Pride celebrations, joint suicide prevention trainings with the Sheriff's Department, and integrated care contracts. These examples demonstrate that meaningful collaboration can occur and should be further developed with adequate support and structured coordination mechanisms.

Human-Centered Values and Community Partnership: Interviewees shared a desire for Behavioral Health to remain visible, connected, and grounded in compassion and community-centered values. They called for a renewed focus on empathy and the recognition that providers and clients alike are navigating challenges. One interviewee emphasized that Behavioral Health should continue being perceived as "a department that is accessible to everyone… and to continue the same spirit of partnership."

CONCLUSIONS AND RECOMMENDATION

This section synthesizes key findings from San Benito County's BHSA Community Planning Process and presents actionable recommendations. These findings align with and build upon priorities identified in the county's 2023 Community Health Assessment (CHA) and 2023-2024 Community Health Improvement Plan (CHIP), creating an integrated approach to addressing behavioral health needs across the community.

Cross-Cutting Themes

The CPP revealed several interconnected priorities that emerged consistently across all engagement activities:

System Integration and Coordination. Community stakeholders described a behavioral health system that operates in silos, with fragmented referral pathways, inconsistent communication structures, and limited coordination during critical transitions. Partners identified several specific opportunities to strengthen cross-agency coordination, including developing formal referral pathways and warm handoff protocols between organizations serving similar populations; designating cross-agency liaison roles to support coordination and follow-up; creating shared data systems to track client outcomes across service providers and; establishing regular inter-agency meetings to identify service gaps and coordinate resources.

Access and Equity. CPP participants identified multiple barriers to accessing behavioral health services, including insurance limitations, geographic distance, transportation challenges, language access, cultural stigma, and limited-service availability. Participants emphasized that not all residents have equal access to care and called for expanded outreach, flexible service delivery models, and culturally responsive programming.

Early Intervention. Feedback consistently prioritized shifting from crisis-driven services to proactive early intervention, particularly in schools and youth-serving environments. Community stakeholders noted that early identification and intervention could reduce downstream crisis demand and improve long-term outcomes.

Housing as a Foundation for Behavioral Health. CPP participants across all engagement activities identified housing stability as a fundamental aspect of behavioral health recovery and wellness. Without stable housing, individuals face heightened vulnerability to crisis, relapse, and system cycling, regardless of the quality of clinical services provided.

Relationship-Centered Care. Community stakeholders emphasized that authentic human connection, genuine care, peer support, and trauma-informed approaches are more important to service effectiveness than any specific clinical technique. Services that address practical needs alongside emotional support were consistently identified as most helpful.

Workforce and Capacity. Participants identified staffing shortages, compensation disparities, and high turnover as key barriers to service delivery and coordination. Leadership stability was recognized as crucial to partnership effectiveness, as turnover disrupted momentum and eroded institutional knowledge.

Priority Recommendations

Short-Term Actions

Strengthen Communication Infrastructure

- Restore referral confirmation and follow-up protocols to ensure partners receive timely updates on client status
- Designate liaison roles within Behavioral Health to serve as consistent points of contact for key partner organizations
- Establish quarterly partner meetings with structured agendas to address coordination challenges proactively

Expand Crisis Access

- Implement same-day access options and walk-in crisis services to reduce wait times and meet urgent needs
- Improve follow-up procedures so crisis encounters are paired with short-term check-ins within 24-48 hours
- Provide anti-stigma and bias training for emergency department and crisis response staff

Enhance Service Environments

- Train all staff, including front desk personnel, in trauma-informed, relationship-based communication
- Improve physical accessibility and welcoming elements such as clear signage, calming music, and greeting protocols
- Implement clear communication scripts explaining involuntary holds, timelines, and next steps

Address Housing Barriers

- Create family-inclusive shelter options to prevent parent-child separation during crises
- Implement clear communication standards for housing programs, including response timelines and routine status updates
- Expand income-flexible housing assistance that allows people to access support while stabilizing employment

Medium-Term Strategies

Early Intervention

- Expand K-12 mental health early intervention programs and school-based services
- Develop peer ambassador programs that use lived experience to reduce stigma in community settings, schools, and faith-based organizations
- Launch targeted public education campaigns that normalize mental health treatment and clarify service accessibility

System Integration

- Develop formal cross-system coordination protocols between behavioral health, housing, probation, medical care, and community programs
- Invest in interoperable technology systems to improve information-sharing while protecting client confidentiality
- Establish standardized warm handoff protocols for all major transitions between services

Workforce Development

- Hire and integrate peer support specialists across behavioral health programs with defined roles in care teams
- Create staff cross-training programs to build mutual understanding across partner organizations
- Provide ongoing training on cultural humility, shared decision-making, and person-centered practices

Service Expansion

- Deploy mobile outreach teams to reach rural and underserved areas
- Expand group support programming, including grief groups, men's groups, senior social groups, and other peer-centered offerings
- Pilot embedded behavioral health positions in high-referring partner organizations such as schools and probation

Long-Term Vision

Strategic Positioning

- Position Behavioral Health as the central coordinating hub for countywide mental health services
- Build a sustainable workforce pipeline through partnerships with educational institutions to address long-term staffing needs
- Develop innovative, evidence-based service delivery models that integrate prevention, treatment, and recovery support

Housing and Stability

- Invest in affordable housing expansion, including units that accommodate pets and multi-generational households
- Build a countywide housing stability framework integrating prevention, rapid rehousing, transitional support, and long-term affordability
- Develop landlord partnership programs with incentives for accepting tenants with nontraditional income or in-transition support

Comprehensive System Transformation

- Create a fully integrated peer workforce strategy, including training pipelines, certification support, and career advancement pathways

- Institutionalize client voice in program governance through advisory boards with authentic influence over planning and policy
- Build lasting partnerships with cultural leaders, faith-based groups, and community networks to normalize mental health care and reduce intergenerational stigma

Infrastructure and Capacity

- Address compensation disparities to improve staff retention and competitiveness with neighboring counties
- Develop dedicated funding streams to support coordination activities and partnership infrastructure
- Strengthen coordination between behavioral health, housing, social services, and childcare systems to provide seamless support for complex needs

Conclusions

The findings from San Benito County Behavioral Health's Community Planning Process align closely with priorities identified through the county's 2023 Community Health Assessment (CHA) and subsequent 2023-2024 Community Health Improvement Plan (CHIP) (see **Appendix B**). The CHA documented critical behavioral health challenges, including rising rates of poor mental health (12.4% of adults reporting 14+ days of poor mental health per month); 30% of caregivers of young children reporting depression symptoms; 43% of 11th graders reporting current alcohol or drug use and increasing fentanyl-related overdose deaths. These data reinforce the urgency of addressing behavioral health systemically, a priority that emerged independently through both the CHIP process and the current BHSA community engagement.

Both the CHIP and BHSA CPP identified behavioral health and support for families with young children as critical areas that require a coordinated community response. The CHIP identified key activities, including developing countywide stigma reduction campaigns, clarifying referral pathways, identifying evidence-based programs, expanding bilingual services, and increasing collaboration among partners. These strategies mirror recommendations emerging from the current BHSA CPP. The CHA's documentation of economic hardship, housing instability and, low enrollment in support programs like CalFresh, further validates community voices heard in BHSA focus groups and interviews about the critical intersection of behavioral health, housing, economic security, and service access.

This multi-year alignment demonstrates consistency in community-identified priorities and creates opportunities to leverage existing CHIP partnerships, coordinate implementation efforts with ongoing CHA/CHIP initiatives, and build upon collaborative infrastructure already established in the community. The convergence of data-driven needs assessment (CHA), community-driven priority-setting (CHIP), and comprehensive stakeholder engagement (BHSA CPP) strengthens the evidence base for recommended actions and enhances accountability for addressing long-standing disparities in access, outcomes, and equity.

SBCBH would like to remind readers of this report that it is important to understand that the responses are from community members who have likely experienced interactions or services from a range of organizations within San Benito County, many of whom intersect with services of SBCBH. SBCBH plan to share this report

with all our County and Community partners in an effort to foster a culture of continuous improvement for all services across the county.

Community feedback is really important to SBCBH and the comments made have been noted and every effort will be made to correct or improve services and practices within our department's scope, budget and in accordance with the legislation under which we operate.

APPENDIX A – PARTICIPANT DEMOGRAPHICS

Community Behavioral Health Survey Respondents Demographics

Table 7. Demographic Data for Community Behavioral Health Survey Respondents

Demographics		Percent
Race* (N = 139)	Latino/a/e, Hispanic, or Caribbean (e.g., Colombian, Cuban, Guatemalan, Mexican, Puerto Rican, Salvadoran, Southern American, etc.)	60%
	White or European American (e.g., English, German, Irish, Italian, Polish, Russian, etc.)	30%
	Prefer not to answer	7%
	Asian or Asian American (e.g., Chinese, Filipino, Indian, Japanese, Korean, Vietnamese etc.)	4%
	Native North American or Alaska Native (e.g., Chumash, Inuit, Kumeyaay, Miwok, Pomo, Tongva, Yurok, etc.)	4%
	Some other race, ethnicity, origin	4%
	Black of African American (e.g., Ethiopian, Ghanaian, Jamaican, Nigerian, Somali, etc.)	1%
	Middle Eastern or Arab American (e.g., Algerian, Egyptian, Iraqi, Jordanian, Lebanese, Moroccan, etc.)	1%
Gender (N=132)	Woman	70%
	Man	24%
	I prefer to self-describe	5%
	Exploring gender identity	2%
	Gender expansive/non-binary	1%
	Two-Spirit	1%
Disability (N= 135)	Yes	67%
	No	22%
	Prefer not to answer	10%
Birth Sex (N=139)	Female	71%
	Male	25%
	Prefer not to answer	4%
Sexual Orientation* (N=124)	Heterosexual/Straight	81%
	Prefer not to answer	10%
	Asexual	4%
	Bisexual	2%
	Demisexual	2%
	Gay	2%
	I prefer to self-describe	2%
	Lesbian	1%
	Pansexual	1%

*Column Percent exceeds 100% as respondents selected multiple options.

Focus Group Demographic Form

This section summarizes demographic data for participants who completed a demographic form after participating in the Community Focus Groups. Demographic data were analyzed using descriptive statistics. Across the 4 focus groups conducted, a total of 32 out of 36 individuals completed a demographics survey at the conclusion of their participation. This discrepancy is normal, as completing a demographic survey is encouraged but not required. More details of participants' demographic and background characteristics are outlined below and presented in **Table 8.**

The focus group participants were racially and ethnically diverse, with 59% identifying as Hispanic/Latino/a/e, 41% as White, 6% as Asian, 3% as Native North American or Alaska Native, and no participants identifying as Black/African American, American Indian/Alaska Native, Indigenous to Central or South American, Middle Eastern, Multiracial, Other Indigenous, or Native Hawaiian/Other Pacific Islander. The majority of focus group participants (65%) were women, followed by men (27%), and two-spirit individuals (4%), with 4% preferring not to answer. Most participants were adults between the ages of 26-59 (47%), followed by older adults 60+ (31%), and transition age youth (TAY, 16-25) at 22%. In terms of sexual orientation, 84% identified as heterosexual/straight, 4% as asexual, 4% as bisexual, and 4% as gay, with 8% preferring not to answer.

Table 8. Demographic Data for Focus Group Participants Who Completed the Demographic Survey

Demographics		Percent
Race* (N=32)	American Indian/Alaska Native	0%
	Asian	6%
	Black/African American	0%
	Hispanic/Latino/a/e	59%
	Indigenous to Central or South American	0%
	Middle Eastern	0%
	Multiracial	0%
	Other Indigenous	0%
	White	41%
	Native Hawaiian/Other Pacific Islander	0%
	Native North American or Alaska Native	3%
	Prefer not to answer	0%
	Prefer to self-describe	0%
Gender (N=26)	Woman	65%
	Man	27%
	Transgender	0%
	Non-binary	0%
	Genderqueer	0%
	Two-Spirit	4%
	Prefer not to answer	4%
Age Group (N= 32)	Adults (26-59)	47%
	Older Adults (60+)	31%
	Transition Age Youth (TAY, 16-25)	22%
Birth Sex (N=32)	Female	72%
	Male	28%
Sexual Orientation* (N=25)	Asexual	4%
	Bisexual	4%
	Demisexual	0%
	Queer	0%
	Heterosexual/Straight	84%
	Gay	4%
	Lesbian	0%
	Pansexual	0%
	Exploring sexual orientation	0%
	Prefer not to answer	8%
Disability Status (N=30)	Yes	35%
	No	55%
	Prefer not to answer	10%
Veteran Status (N=30)	Yes	3%
	No	90%
	Prefer not to answer	7%

*Column Percent exceeds 100% as respondents selected multiple options.

Table 9. Community Participation Representation Data

Fields/Sectors Represented	Percent*
Serious mental/emotional health condition	48%
Family member of someone with mental health conditions	24%
Alcohol or substance use disorder	31%
Work in behavioral health, substance use, or housing services	17%
Physical or chronic health condition	14%
Caregiver for an adult family member	10%
Unstable housing/unhoused	31%
LGBTQ+ Community	3%
Developmental or learning disability	7%
Parent/caretaker of a child under 18	7%
Survivor of domestic or sexual violence	21%
Other	10%

APPENDIX B – OTHER PLANNING PROCESS

San Benito County Public Health Services, a division of the Health and Human Services Agency, developed the 23-24 Community Health Assessment (CHA), which examines the overall health status of county residents and identifies significant health needs and disparities. Findings from this assessment informed the development of the 2023-2024 San Benito County Community Health Improvement Plan (CHIP), a strategic, multi-year, community-driven initiative to address priority public health challenges through cross-sector collaboration and evidence-based interventions.