

Policy Explainer: Community-Defined Evidence Practices Under the Behavioral Health Services Act

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Executive Summary

The Behavioral Health Services Act (BHSA) reshapes how California funds, delivers, and evaluates behavioral health services. Within it, community-defined evidence practices — culturally anchored interventions that come from the communities they serve and are validated by community consensus — are recognized in statute and in Department of Health Care Services guidance as a complement to evidence-based practices, and named among the approaches counties must consider to eliminate identified behavioral health disparities.

Those disparities are documented. In FY 2023, Asian and Pacific Islander Medi-Cal members accessed county specialty mental health services at a rate of 1.7 percent and Latino members at 2.4 percent, against 3.4 percent for Medi-Cal members statewide; continued engagement rates were 1.2 percent for Asian and Pacific Islander members and 1.5 percent for Latino members, against 2.2 percent statewide.¹ Asian and Pacific Islander members had the lowest access rates of any racial or ethnic group in each of the four years the report covers.² The workforce shows a gap of its own: only 4 percent of California's licensed behavioral health clinicians speak an Asian or Pacific Islander language, though those communities make up 10 percent of the state's population.³

Community-defined approaches have been found to make mental health services more accessible and to improve outcomes for participants.⁴ Under the California Reducing Disparities Project, 66 percent of adult participants and 49 percent of adolescent participants reported that taking part had lowered their psychological distress.⁵ The project's statewide evaluation estimated a return of \$4.32 to \$5.67 for every dollar invested — a net benefit of roughly \$454 million — driven primarily by projected productivity gains alongside averted health expenditures. Reductions in suicide and incarceration and gains in cultural connection were not priced in, so \$4.32 understates the return.⁶

¹ California Pan-Ethnic Health Network. Landscape of Access: Mental Health Disparities in Medi-Cal. CPEHN, July 2026, Figure 5.

² California Pan-Ethnic Health Network. Landscape of Access: Mental Health Disparities in Medi-Cal. CPEHN, July 2026, p. 18.

³ Stringer, Heather. "Community Health Workers Improve Mental Health Access for Asian Americans, Native Hawaiians, Pacific Islanders." California Health Care Foundation, May 8, 2026.

⁴ Psychology Applied Research Center, Loyola Marymount University. Statewide Evaluation of the California Reducing Disparities Project Phase 2, California Department of Public Health, Office of Health Equity, December 2022, p. 166.

⁵ Psychology Applied Research Center, Loyola Marymount University. Statewide Evaluation of the California Reducing Disparities Project Phase 2, Executive Summary. California Department of Public Health, Office of Health Equity, December 2022, p. 22.

⁶ Psychology Applied Research Center, Loyola Marymount University. Statewide Evaluation of the California Reducing Disparities Project Phase 2, California Department of Public Health, Office of Health Equity, December 2022, Section 8.4, pp. 225–227.

Core Takeaway

BHSA has settled whether community-defined practices belong in California's behavioral health system. It requires them in Full Service Partnerships and directs counties to consider them in planning to reduce disparities. The open question is how counties build them — and because a practice defined by one community's knowledge and history does not transfer intact to another, the answer is not a menu of approved practices. What transfers between counties is the method. The capability to develop practices with communities is what a county can build, fund, and sustain.

Key Findings at a Glance

- **CDEPs are required, not encouraged, in one of the two largest components of county BHSA spending.** Section 5887(c) requires Full Service Partnership programs to employ community-defined evidence practices, and Section 5892(a)(2)(A) directs 35 percent of each county's distribution to that component. The exemption available to counties with fewer than 200,000 residents applies to the evidence-based practice requirement; there is no parallel exemption for CDEPs.
- **Medi-Cal will pay for specialty mental health services delivered by unlicensed staff, but only to people it covers.** An Other Qualified Provider may deliver Specialty Mental Health Services — someone with a high school diploma and two years of related experience, which can include having received services themselves — and a diagnosis is not required. It pays for services delivered to its own beneficiaries, not for programming open to a community regardless of coverage.
- **The state's new measures will not count community-defined practice.** The published measure set includes an intervention measure that counts the delivery of evidence-based practices, but no counterpart for community-defined ones. Measures published from 2026 through 2028 include only Medi-Cal members, and count only core clinical services — a narrower category than the culturally anchored interventions the statute defines.
- **BHSA places CDEPs in five distinct locations with different legal force** — required in Full Service Partnerships and in state population-based prevention, required for consideration in county planning, guided by a state biennial list in Early Intervention, and permitted in Outreach and Engagement. Two of the five are outright requirements; a third requires that CDEPs be considered.

The Policy Context: CDEPs and the BHSA Transition

As California implements BHSA, counties, community-based organizations, and state agencies are navigating significant changes in how behavioral health services are funded, delivered, and evaluated. Building on the foundation of the Mental Health Services Act (MHSA), BHSA expands the scope of behavioral health services to include substance use disorders, strengthens alignment with Medi-Cal, introduces new planning and accountability requirements, and places increased emphasis on measurable outcomes and system performance. At the same time, BHSA continues California's longstanding commitment to equity and early intervention.

CDEPs sit at the intersection of several BHSA priorities – advancing equity, improving culturally responsive care, strengthening community engagement, supporting early intervention, and reducing disparities in behavioral health outcomes. California's prior investment in community-defined approaches through the California Reducing Disparities Project demonstrated that culturally grounded interventions can increase access to mental health services, improve outcomes, and strengthen a community's capacity to respond to its own needs.⁷

What Are CDEPs?

Welfare and Institutions Code Section 5840(f) defines community-defined evidence practices as "an alternative or complement to evidence-based practices, that offers culturally anchored interventions that reflect the values, practices, histories, and lived experiences of the communities they serve. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time."

What a CDEP Looks Like in Practice

The Village Project – Seaside, Monterey County. Founded by licensed clinicians and grown into an independent nonprofit, The Village Project serves children of African ancestry and their families through the Emanyatta Project – Emanyatta is Maasai for "warrior's camp" – combining Saturday cultural education sessions with clinical services, after-school programming, and parent support. The work is built to strengthen racial pride and cultural identity as a way of preventing serious mental health problems. A parent of a participant described the effect on her child this way: "She's become very confident. She feels part of a community where she's cared for, loved, and supported."⁸

⁷ Psychology Applied Research Center, Loyola Marymount University. Statewide Evaluation of the California Reducing Disparities Project Phase 2, California Department of Public Health, Office of Health Equity, December 2022, p. 166.

⁸ Equity and Wellness Institute. California Reducing Disparities Project Historical Storytelling Report. California Department of Public Health, Office of Health Equity, June 2025, p. 24.

Two Feathers Native American Family Services – Humboldt and Del Norte Counties. Two Feathers serves Native youth from the Wiyot, Hupa, Yurok, Karuk, and Tolowa peoples in their ancestral territories. Its youth wellness program is organized around two traditional practices: Stick Game, an inter-tribal competition with multigenerational community participation, taught through camps and trainings that build mentorship bonds; and Flower Dance, a coming-of-age ceremony for young women held in traditional redwood plank houses on tribal lands, supported by workshops on protocol, wellness, and regalia.⁹

Because a CDEP is defined by its origin – the values, practices, histories, and lived experiences of a specific community, validated by that community's consensus over time – it cannot simply be moved from one county to another. A practice imported from elsewhere satisfies none of those conditions for the community receiving it. An activity may exist in many places; what makes it a community-defined evidence practice is that a particular community developed it, validated it, and holds it. This is not a limitation of community-defined practices; it is what makes them what they are. What *can* transfer between counties is the method of developing a practice with a community, rather than the practice itself.

Who This explainer Is For

This explainer is intended to support multiple stakeholder groups involved in BHSA planning, implementation, funding, and oversight.

Stakeholder Group	How This explainer May Be Useful
County Behavioral Health Leadership – directors, BHSA program managers, and cultural competency and ethnic services managers	Understand what BHSA requires regarding CDEPs, where flexibility exists and where it does not, and what capability a county needs to build to meet those requirements locally.
State Agency Staff (DHCS/CDPH)	See how counties are interpreting current policy, which questions they are raising, and where decisions still ahead – on performance measures and the prevention solicitation – will shape what counties can do.
Community-Based Organization Leaders	Understand where CDEPs sit in statute, which reimbursement mechanisms accommodate community-defined work and which do not, and what counties are required to do about contracting and workforce.

⁹ California Reducing Disparities Project, Implementation Pilot Projects. California Department of Public Health, Office of Health Equity.

Statewide Advocacy
Organizations

Understand the five places CDEPs appear in statute and the force of each, where requirements are not matched by measurement or reimbursement, and where the transition puts existing community-defined programs at risk.

Technical Assistance
Providers

See what counties say they need – guidance on developing practices with communities – and where reimbursement and measurement currently leave gaps.

CDEPs in Policy: Where and How BHSA Recognizes CDEPs

BHSA does not establish a standalone CDEP program. It recognizes community-defined practices in five places across existing program components, with different force in each.

Where CDEPs Appear	Force	Citation
Full Service Partnerships	Required	WIC 5887(c)
State population-based prevention (CDPH)	Required	WIC 5892(f)(1)(E)(ii)
County integrated planning	Required consideration, among approaches to eliminate identified disparities	WIC 5963.02(b)(5)
Early Intervention	Counties must use a state biennial list in deciding what to implement; DHCS may require specific practices	WIC 5840(c)(1), (c)(4), (c)(5)
Outreach and Engagement	Permitted	WIC 5892(k)(4)

Early Intervention and Full Service Partnerships, where the requirements are most consequential for counties, are examined below.

Early Intervention Programs

Early Intervention is one of the clearest policy entry points where the BHSA and [Department of Health Care Services \(DHCS\) guidance Chapter 7, Section A.7.1-7.6](#) explicitly recognize CDEPs. DHCS identifies CDEPs as one approach counties may incorporate when designing and implementing Early Intervention services and includes CDEPs within the Biennial List of Early Intervention Evidence-Based Practices and CDEPs. Importantly, DHCS guidance states that this list is not exhaustive and that counties may implement CDEPs not included on it, based on local needs and community preferences – flexibility that rests on Department guidance rather than on the express terms of Section 5840(c)(4), which directs counties to use the list in determining what to implement.

The Early Intervention framework emphasizes culturally and linguistically responsive services, reducing behavioral health disparities, meaningful community engagement, and partnerships with community-based organizations. These priorities are consistent with the defining characteristics of CDEPs and create opportunities for counties to incorporate community-defined approaches while responding to the strengths, priorities, and needs of the communities they serve.

The Early Intervention framework includes its own outreach component. Separately, BHSA establishes Outreach and Engagement as a distinct category of county spending, within which community-defined evidence practices are permitted. Both create room for CDEPs, but they are different provisions with different requirements.¹⁰

Full Service Partnerships (FSPs)

CDEPs are also explicitly recognized within Full Service Partnerships (FSPs). [Welfare and Institutions Code Section 5887\(c\)](#) provides that "Full-service partnership programs shall employ community-defined evidence practices, as specified by the State Department of Health Care Services."¹¹ The requirement is unqualified: unlike the evidence-based practice requirement in the same section, it carries no exemption for smaller counties. Full Service Partnership services are supported by one of the two largest components of county BHSA spending. How counties pay for community-defined practices there – and keep paying for them – is taken up under Funding, Sustainability, and Reimbursement below.

BHSA establishes where CDEPs fit; it does not prescribe how counties implement, evaluate, fund, or sustain them. The sections that follow take up those questions.

¹⁰ California Welfare & Institutions Code 5840(b)(1); 5892(k)(4)

¹¹ Note that Section 5887, at time of publishing, exists in two versions – the current one and a successor operative January 1, 2027 under Chapter 688, Statutes of 2025 – and that subdivision (c) is identical in both.

Implementation Challenges and Emerging Questions

Questions Counties and Partners Are Asking

Drawn from interviews conducted for this explainer.

- Which activities are allowable, and what qualifies under Early Intervention?
- How must a program be structured to qualify for reimbursement, and what level of clinical integration is required?
- How will evaluation expectations be operationalized?
- If prevention dollars now flow to the state, what happens to the community partnerships that prevention funding built – with libraries, parks and recreation, schools, child welfare, and probation?
- As services increasingly prioritize diagnosed and higher-acuity populations, how do practices that historically engaged people before any diagnosis existed continue to reach them?
- How does a county that has not yet implemented a CDEP begin?

These questions run through the rest of the explainer. This section takes up three that shape the others – how much consistency counties should seek, how the work gets paid for, and how community-defined practices fit inside systems built for something else – and Strategic Considerations returns to the rest in terms of what counties, DHCS, and CDPH can each do. A few remain open because the state has not yet decided on them.

Balancing Flexibility and Consistency

The interest in consistency comes from more than one place. Some counties, particularly those without existing community-defined practices, look for models they can adapt from elsewhere. Counties also describe wanting clarity about how their own work will be assessed – which activities are allowable, what qualifies under Early Intervention, how programs must be structured to qualify for reimbursement, and how evaluation expectations will be applied.

This reflects the ordinary condition of early implementation. BHSA authorizes DHCS to implement the act through county letters, information notices, and similar guidance rather than waiting on formal rulemaking, which has allowed implementation to begin promptly, with regulations to follow.¹² At the same time, counties are already accountable under performance contracts that DHCS reviews at least every three years. Counties are therefore building programs while the operational details are still being developed. Where that detail is still emerging, some counties keep the Integrated Plan language broad to preserve room for adaptation.

¹² California Welfare & Institutions Code 5963.05. The department may implement the act by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions without taking further regulatory action; regulations are to be adopted by July 1, 2033.

Funding, Sustainability, and Reimbursement

BHSA does establish a funding pathway for CDEPs and it runs through Full Service Partnerships. Section 5887(c) requires Full Service Partnership programs to employ community-defined evidence practices as specified by the Department; Section 5887(f) requires that services for clients enrolled in a Full Service Partnership be paid from the allocation under Section 5892(a)(2), and Section 5892(a)(2)(A) sets that allocation at 35 percent of each county's distribution from the Behavioral Health Services Fund. CDEPs are therefore required within a component that receives 35 percent of every county's behavioral health allocation. What statute does not prescribe is how counties should structure, price, or sustain them there.

Some of that latitude is deliberate. BHSA leaves it to counties to determine which practices to fund and how to configure them locally, consistent with the premise that community-defined practices are set at the local level rather than statewide.

The distinction that matters is between allocation and reimbursement. Flexibility governs how a county allocates its BHSA distribution. It does not extend to Medi-Cal, which pays for services delivered to its own beneficiaries. Practices like those described earlier combine clinical services with cultural, educational, and family programming; the first is billable, the second is not.

This raises a question counties are asking directly: can community-defined practices be delivered within BH-CONNECT's bundled rates? For five of the six practices, largely not — those rates are available only to programs conforming to a specified model, verified by a Medi-Cal Fidelity Designation or by national accreditation.¹³ But BH-CONNECT is one route among several. Specialty Mental Health Services can be billed fee-for-service, the staff who may deliver them include categories requiring no license or certification, and a diagnosis is not a prerequisite — services are coverable during assessment and before a diagnosis is determined.¹⁴ What Medi-Cal does not pay for is activity that is not a service to an enrolled beneficiary: the cultural and educational programming these practices combine with clinical care. That is funded from the county's allocation rather than billed. The mechanisms are examined in Strategic Considerations below.

Integrating Community-Defined Practices into Existing Behavioral Health Systems

Many CDEPs were developed to address community needs through culturally rooted, relationship-based, and holistic approaches. As these approaches are incorporated into broader behavioral health systems, implementation questions emerge regarding documentation requirements, service definitions, outcome reporting, administrative expectations, and program oversight.

The central implementation challenge is how to integrate CDEPs into existing systems without forcing them into frameworks that diminish community ownership, cultural relevance, or local adaptability. Successful integration requires balancing system accountability with the flexibility necessary to preserve the defining characteristics of community-defined approaches.

¹³ California Department of Health Care Services. Behavioral Health Information Notice 25-009, April 11, 2025.

¹⁴ California Department of Health Care Services. Behavioral Health Information Notice 21-073.

One county described the practical version of this: programs needing to be retrofitted to align with compliance requirements and reimbursement expectations, in ways that may unintentionally shift them away from the flexibility and cultural responsiveness that made them effective.¹⁵

These implementation questions reflect the realities of transitioning from policy recognition to operational practice. While BHSA establishes opportunities for CDEPs, implementation requires counties to navigate questions of flexibility, funding, system integration, and sustainability.

County Implementation Experiences and Emerging Themes

Third Sector interviewed county behavioral health departments and statewide organizations to understand how CDEPs are being interpreted, implemented, and sustained under BHSA. Methodology and participants are described in Appendix A.

Cross-Cutting Implementation Themes

Three themes recurred across the interviews.

1. **Trust is the mechanism, not the outcome.** Counties described community organizations not as vendors delivering a service but as the reason the service reaches anyone at all – providing culturally specific outreach, helping people navigate systems, and building trust with populations that have not engaged with county behavioral health. One county described its partner organizations as critical extensions of the county behavioral health system.
2. **Sustainability is the dominant concern.** Interviewees consistently raised the question of whether community-defined programs built under prior funding will survive the transition. In one county, roughly six programs associated with the Reducing Disparities Project were operating locally; only one appeared likely to be funded through the county's BHSA Integrated Plan. The same concern applies on the prevention side, where population-level prevention funding moves to CDPH under Section 5892(f) and county-level relationships with prevention providers may not transfer with it.
3. **Counties without CDEPs need support in developing CDEPs locally.** Interviewees described counties seeking to import models from other counties and looking for standardized solutions, while lacking frameworks for building culturally grounded interventions locally. As one put it, "there's not really a step-by-step manual explaining how exactly to do that."

¹⁵ See Appendix A: Interview Methodology.

Strategic Considerations for the Future of CDEPs

BHSA places CDEPs in statute but leaves the operational questions to implementation. The considerations below are organized by who holds the decision. Counties build integrated plans and pay for services; DHCS defines accountability; CDPH is standing up population-based prevention.

For counties: build the capability, not a clone of another county's program

Counties must include community-defined evidence-based practices in Full Service Partnerships and they must consider them among the approaches to eliminate identified behavioral health disparities in preparing each Integrated Plan and Annual Update. Boards of supervisors approve those plans by June 30 preceding the fiscal years they cover.¹⁶ Notably, the exemption available to counties under 200,000 residents in subdivision (a) of Section 5887 is written against the evidence-based practice requirement; subdivision (c), covering CDEPs, contains no parallel exemption.

Those requirements specify what a county must include, not where the practice originates. But a program adopted from a neighboring county is not, by itself, community-defined for the community receiving it, because the definition turns on that community's own knowledge and consensus. What a county can borrow is the method — identifying community partners, co-designing with them, and contracting in ways that sustain the work. A county with no community-defined practice yet should start there: find the organizations its communities already trust before deciding what the practice will be.

For counties: use the mechanisms whose logic already fits

BHSA does not establish a reimbursement mechanism specific to community-defined practices, and given the range of practices the term covers, a single mechanism would be difficult to design without narrowing what qualifies. The more practical question is which existing mechanisms accommodate community-defined work—and the answer turns on who may deliver a service, not on what the practice is called.

An Other Qualified Provider may deliver Specialty Mental Health Services: a person at least 18 with a high school diploma or equivalent and two years of related experience, which may be paid or unpaid and may include experience as a service recipient or as the caregiver of one, working under the direction of a licensed, waived, or registered professional. No license, certification, or model fidelity is required, and Other Qualified Providers may deliver the full range of specialty mental health services.¹⁷

Enhanced Community Health Worker services are structured differently. The worker must have lived experience that aligns with and provides a connection to the community being served, and must meet minimum qualifications through the Certificate Pathway or Work Experience Pathway defined in the California Medicaid State Plan, working under a supervising provider enrolled in

¹⁶ California Welfare & Institutions Code 5963.02(a)(3)

¹⁷ California Department of Health Care Services. Attachment 1: Providers of Specialty Mental Health Services (State Plan Amendment 23-0026).

Medi-Cal. There is no fidelity designation and no specified curriculum.¹⁸ Among the categories described here, only Enhanced CHW ties the qualification to a particular community.

Certified peer support services sit between these two. Certification rests on self-identified lived experience with recovery, reflecting a legislative intent that the peer workforce mirror the communities it serves. It also requires a high school diploma or equivalent degree, completion of a curriculum determined by the Department, and passage of a Department-approved examination, with no alternative pathway provided for the diploma requirement.¹⁹ Counties should not assume that a community member with deep local standing can necessarily be certified to deliver reimbursable peer services. Certification governs Medi-Cal billing; a county that does not develop a certification program may still fund peer programs where the applicable funding source allows.²⁰

BH-CONNECT's bundled rates are the narrowest route. Five of its six practices are gated on conformity to a model defined outside the community. Assertive Community Treatment, Forensic ACT, Coordinated Specialty Care, and Individual Placement and Support require a Medi-Cal Fidelity Designation, a fidelity threshold assessed by a Center of Excellence, for ongoing billing. Clubhouse Services require accreditation from Clubhouse International, and billing is permitted while a program works toward it. These are gates of the same kind – conformity to a model defined outside the community, whether the standard is set by the state or by a national body.²¹

These mechanisms reach Medi-Cal members, and CDEPs include a range of services beyond clinical care and serve people whether or not they are enrolled. That is why the Full Service Partnership channel – where CDEPs are required and where funds are distributed under Section 5892(a)(2) – and county contracting practice continue to carry the work that fee-for-service billing does not reach.

For DHCS: the accountability structure fits CDEPs; the measure set does not yet count them

BHSA's accountability architecture largely resolves the apparent tension between state oversight and community-defined design. Counties submit an annual County Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR), and the Department establishes metrics, in consultation with counties and stakeholders, to evaluate the quality and efficacy of county behavioral health programs and to identify demographic and geographic disparities in them.²² Counties must also describe how their Integrated Plan and Annual Update align with statewide goals and outcome measures as defined by the Department.²³ None of this reaches program design. A county is answerable for what its services achieve and for the disparities its data reveal, not for the method by which a community defined a practice.

¹⁸ California Department of Health Care Services. Bedefineshavioral Health Information Notice 25-028, July 8, 2025.

¹⁹ California Welfare & Institutions Code 14045.11(g), 14045.15(a)(2)(SB 803, Ch. 150, Statutes of 2020)

²⁰ California Welfare & Institutions Code 14045.14(b)

²¹ California Department of Health Care Services. Behavioral Health Information Notice 25-009, April 11, 2025.

²² California Welfare & Institutions Code 5963.04(a)(2), (b)

²³ California Welfare & Institutions Code 5963.02(c)(3)(A)

The relationship is, in fact, complementary rather than merely compatible: the metrics exist to identify disparities, and community-defined evidence practices are among the approaches the statute names for eliminating them.

Two features of the current measure set nonetheless bear on CDEPs. The Department has published 51 performance measures across 14 statewide goals, 34 releasing in 2026 and the remainder by 2029.²⁴ That set includes an intervention measure counting delivery of evidence-based practices—the percentage of people with significant mental health needs who received at least one BHSA or BH-CONNECT evidence-based practice, a county-responsible measure to be published in 2029—with no counterpart measure for community-defined practices. And measures published from 2026 through 2028 include only Medi-Cal members, while outreach and engagement are not among the services counted as core clinical services.

The BHOATR reaches further than the measures do. It requires counties to report information on behavioral health services provided to persons not covered by Medi-Cal, and to report all contracted services and their costs by category. Community-defined work delivered outside Medi-Cal or under contract therefore falls within what counties must report—though nothing in the reporting requirement identifies it as community-defined.

For CDPH: the prevention channel is required, and its mechanics are still being built

BHSA moves population-based prevention to the California Department of Public Health, and community-defined evidence practices are required within it.²⁵ CDPH's Final Plan commits \$34.8 million in FY 2026–27 and \$45.3 million in each of the two following years to community-based organizations and Tribes, with \$10 million annually dedicated to Tribes.²⁶ In June 2026, the Department put its CDEP program solicitation process and a draft CDEP Resource Guide out for public comment, and a biennial list of community-defined practices for the prevention program is to follow.²⁷

For counties, the consequence is indirect but real. Prevention funding built county-level relationships with libraries, parks and recreation, schools, child welfare, and probation. Those relationships were held locally; the funding that sustained them now sits with the state, and whether they survive depends on how the state's solicitation is designed.

Conclusion

The choices that will determine how community-defined practices fare under BHSA are being made now. Counties are writing Integrated Plans on an annual cycle. DHCS is publishing performance measures in stages through 2029. CDPH is designing how community organizations will reach prevention funding. None of these will produce a set of practices a county can simply

²⁴ California Department of Health Care Services. Behavioral Health Transformation Phase 2 Performance Measures Supplement, Version 1.

²⁵ California Welfare & Institutions Code 5892(f)(1)(E)(ii)

²⁶ California Department of Public Health. BHSA Population-Based Prevention Program Final Plan

²⁷ California Department of Public Health. Public comment notice, BHSA Population-Based Prevention CDEP Program, June 2026

adopt, because a practice belongs to the community that made it. What a county can build instead is the capability to develop practices with the communities it serves, together with the contracting and partnership infrastructure that keeps them alive. That is the work BHSA leaves to counties, and unlike a practice, it is something a county can build for itself.

Appendix A. Interview Methodology

To complement the policy analysis presented in this explainer, interviews were conducted with county behavioral health departments and statewide organizations to understand better how CDEPs are being interpreted, implemented, and sustained under BHSA. The interviews were designed to provide implementation context beyond statute and policy guidance by exploring how CDEPs are being operationalized across diverse county settings.

Interviews included counties with active CDEPs, counties without active CDEPs, but exploring or preparing for CDEPs implementation, and statewide organizations engaged in behavioral health policy, community engagement, and implementation support. This range of perspectives provided insight into both shared implementation experiences and differences in county readiness, organizational capacity, and local context.

Interview findings were synthesized using a thematic analysis approach. Rather than presenting individual interview summaries, the analysis identified recurring implementation themes, areas of alignment, and meaningful differences across participants. These themes informed the discussion of implementation presented in the County Implementation Experiences and Emerging Themes section and the Strategic Considerations section.

The policy analysis presented throughout this explainer is grounded in California statute, Department of Health Care Services guidance, and other publicly available policy documents as of September 2026. Interview findings were incorporated to provide additional implementation context and illustrate how counties and statewide organizations are navigating CDEP implementation under BHSA. Accordingly, the implementation themes presented in this explainer should be understood as complementary implementation insights rather than interpretations of statutory or regulatory requirements.

Interview Participants

Counties with Active CDEPs

- Fresno County
- Los Angeles County
- Monterey County
- San Mateo County

Counties Without Active CDEPs

- Nevada County
- Santa Barbara County
- Trinity County

Statewide Stakeholder Organizations

- California Pan-Ethnic Health Network (CPEHN)
- Regional Equity and Mental Health Directors Coalition (REMHDCO)

Interview Discussion Framework

Although each interview reflected the participant's unique experiences and local context, conversations were guided by a common discussion framework that explored:

- Understanding and interpretation of CDEPs under BHSA
- Current implementation approaches and county readiness
- Community partnerships and engagement
- Funding, reimbursement, and long-term sustainability
- Technical assistance and implementation support needs
- Opportunities and challenges associated with integrating CDEPs into county behavioral health systems

Using a consistent interview framework facilitated the identification of cross-cutting implementation themes while preserving the unique perspectives and experiences of individual participants.