Coalition Feedback and Recommendations on the Children, Youth & TAY Behavioral Health Continuum Framework – *Optimal Care Pathways*

Submitted to the San Diego County Board of Supervisors and Behavioral Health Services

March 23rd, 2026

SECTION 1 — WHO WE ARE

The Strategic Behavioral Health Initiative (SBHI) was established to strengthen San Diego County's behavioral health system for children and youth. Following a comprehensive needs assessment, SBHI developed 51 recommendations across nine interconnected strategies to guide the creation of a coordinated, equitable, and sustainable continuum of care. Over the past year we have established a permanent Regional Council to coordinate advocacy, policy alignment, and implementation across San Diego County and at the state level. For reference, we attached an SBHI factsheet.

SBHI Mission:
To transform and enhance the region's pediatric behavioral health system through collaborative leadership, advocacy, and systemwide coordination — promoting prevention and timely, equitable access to the right quality care at the right time so that every child, youth, and family can achieve optimal behavioral and developmental well-being.

The SBHI Constituency collectively serves nearly every San Diego County child and youth (672,955) ages 0–18 through the programs and services we provide in healthcare, school-based, community, and family-serving systems, frequently engaging with families at multiple points across the continuum of care. This collective reach provides the coalition with direct insight into system demand, service gaps, and community outcomes.

Many of our partners are current County-contracted providers, and several participated in the Youth OCP stakeholder engagement process.

SECTION 2 — THE YOUTH OPTIMAL CARE PATHWAY PLAN

The Youth Optimal Care Pathways (OCP) framework represents an important step toward strengthening youth behavioral health capacity planning in San Diego County. The Strategic Behavioral Health Initiative (SBHI) recognizes and appreciates the Youth OCP framework’s commitment to equity, accessibility, and culturally responsive service delivery. We found the OCP’s stakeholder engagement findings particularly valuable, highlighting 4 key insights that we agree should guide the plan:

- Early concerns are most often identified in family, pediatric practices and school settings
- Services should be relational, culturally responsive, and accessible
- Need for coordinated systems across schools, providers, CBOs
- School (*and primary care)* is a trusted entry point for early mental health support

SBHI offers this feedback in the spirit of partnership and a shared commitment to successful implementation, using these four guiding insights as the foundation for our recommendations.

SECTION 3 — OUR COLLECTIVE RESPONSE TO THE OCP

We support the framework's direction; the SBHI collective of providers and subject matter experts believe that the following areas require additional attention to ensure successful and equitable implementation.

1 Ensure the Youngest Children Are Visible in This Framework

The OCP model includes ages 0–5 as one of four age strata, but the investments proposed in today's action — school-based programs, MCRT, IOP/PHP — largely begin at school age. The three existing programs serving children ages 0–5 (Para Las Familias, Incredible Years, KidSTART) reach approximately 525 children annually combined. The framework defaults to models built around older youth and does not address infant-parent mental health, dyadic care, or home visiting integration.

Using "children" as a catch-all term consistently results in the 0–5 population being deprioritized in implementation. We recommend revising language throughout to explicitly include "infants and young children (birth to 5 years old)" alongside youth and families. This is not a semantic distinction — it signals clear prioritization and ensures the youngest children are not overlooked.

A compelling argument missing from the framework is that **the roots of adolescent mental health crises most often begin in early childhood**. The most cost-effective and humane intervention point is the 0–5 window, not after symptoms have escalated into the Emergency Department or inpatient system. For infants and toddlers, dyadic and relational health is not a supplement to treatment — it is the treatment. The Zero to Three and Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC:0-5) diagnostic frameworks are the clinical standard of care for this age group and are not referenced anywhere in the Board letter.

The Board letter heavily emphasizes schools as the primary access point, which structurally excludes children under 5. Entry points for this age group are pediatric primary care, WIC, home visiting programs, childcare and preschool settings, and the child welfare system — these should be named explicitly alongside schools. Critically, infants and toddlers are disproportionately represented in child welfare and face the highest risk from early relational trauma and adverse childhood experiences. This equity argument for explicit 0–5 investment is absent from the framework.

▶ RECOMMENDATIONS

- → Revise language throughout the framework to include infants and young children (birth to 5 years old) alongside youth and families.
- → Develop a dedicated Early Childhood (0–5) behavioral health investment plan, including expansion of KidSTART/PCIT, infant-parent mental health specialists, dyadic and relational health services grounded in Zero to Three and DC:0-5 frameworks, caregiver screening in OB/pediatric offices, IECMH consultation services for children ages 0–8, expanded home visiting with behavioral health integration, and universal developmental and trauma screening beginning at birth.

2 Strengthening How We Measure and Achieve Access for San Diego's Children & Youth

San Diego County's current SMHS penetration rate for children stands at 3.0% — below the California state average — with only 19,000 of an estimated 67,000 eligible youth (28%) receiving one BHS service in FY 2024–25. Simply reaching the statewide average would require serving nearly 5,000 additional youth annually, a 36% increase over current levels. We recognize this represents an ambitious goal in itself, and we are committed to partnering with the county to achieve it. At the same time, we believe San Diego has both the will and the opportunity to set its sights higher.

The County's own data — a 24% increase in emergency department encounters for suicide attempts and self-harm among youth ages 10–17 between 2019 and 2023, and 10% of San Diego students reporting they considered suicide in the past year — makes a compelling case for why meeting the state average, while necessary, may not be sufficient to address the full scale of community need. We share the County's commitment to doing more than the minimum, and we would welcome a conversation about what a more ambitious access standard might look like for San Diego.

The November 2023 Medi-Cal Mental Health Audit identified system-wide access challenges — including long wait times, network adequacy gaps, and fragmented referral pathways — that affect counties across California, including San Diego. Addressing these structural barriers alongside penetration targets will be essential to ensuring that expanded access translates into children and families receiving timely, appropriate care.

We also see an important opportunity to strengthen how access is measured. Counting only BHS specialty services understates the full picture of what youth are receiving across the system. Incorporating data from MCP mild-to-moderate services, School IDEA, the State School Behavioral Health Initiative, Juvenile Probation, and CFWB early intervention would give San Diego — and potentially the State — a far more accurate and actionable measure of where youth are being reached and where gaps remain. Data-sharing agreements among County departments and other payers like Medi-Cal managed care would set a strong foundation for building a more complete picture, and we look forward to supporting that work.

▶ RECOMMENDATIONS

- → Develop access targets aligned with the full documented population need — the 67,000-youth identified as requiring specialty-level services — disaggregated by acuity, race/ethnicity, geography, and system involvement, with the statewide average serving as a near-term milestone on the path toward truly meeting community need.
- → Pair penetration targets with measurable quality standards for timeliness, network adequacy, and continuity of care — ensuring that increased volume translates into children and families receiving timely, appropriate services.

→ Create data-sharing agreements with a phased implementation timeline with clear milestones — beginning with BHS, CFWB, and Probation integration, and expanding over time to include Medi-Cal managed care plans, schools, and other youth-serving systems — toward a comprehensive cross-system picture of access that could serve as a model for the State.

3 The Scale of the Goal Requires a Committed Implementation Plan

The Board letter states that 48,000 youth with identified specialty behavioral health needs are not currently receiving care. The County's own OCP targets a 164% increase in crisis response capacity, a 72% increase in intensive community-based care, and a 29% increase in outpatient services over five years — growth described as dependent on "sustainable revenue sources" that are not specified in today's action. Without a committed implementation plan, these targets risk remaining aspirational.

▶ RECOMMENDATION

→ Develop a multi-year implementation plan tied to the OCP targets, with annual milestones, accountability measures, and a reporting structure. The SBHI coalition will continue to partner with the County to support that planning process.

4 High Fidelity Wraparound and Intensive Services Require a Clear Capacity Roadmap

High Fidelity Wraparound is prominently named as a priority throughout the Board letter and framework. The County's own BHSA Integrated Plan estimates 2,344 youth are eligible for HFW and that 15 teams are needed to serve them. The OCP plan projects only 2 teams in FY 2026–27 and 3 by FY 2028–29 — serving an estimated 13–20% of the eligible population. No committed roadmap exists to close this gap over the OCP's five-year horizon.

Annual slot capacity for HFW, IOP, and PHP should be tied to a defined percentage of the youth population requiring intensive community-based services, with a geographic distribution strategy to ensure equitable access, particularly for families in regions without local programs.

The reported low IOP admission conversion rate — only 30% of clinically appropriate referrals currently result in admission — indicates that capacity expansion alone is insufficient. The specific barriers driving non-admission must be understood before scaling IOP/PHP slots, to ensure new investment translates into youth actually receiving care.

▶ RECOMMENDATIONS

- → Develop a funded HFW expansion roadmap with a minimum target by FY 2028–29, developed in collaboration with providers and inclusive of explicit admission and discharge criteria and step-down transition protocols.
- → Estimate, in collaboration with providers, the number of IOP and PHP slots that may be required and incorporate a geographic distribution strategy to ensure equitable access.
- → Assess the specific barriers driving the low IOP/PHP admission conversion rate before scaling capacity, to ensure new investment translates into youth receiving care.

5 Youth Substance Use Treatment Has Effectively Collapsed

The Board letter estimates 40,000 youth ages 12–25 need substance use treatment. Only 765 youth ages 12–17 received SUD services through BHS in FY 2024–25 — approximately 1.9% of the estimated need for this age group.

The OCP document states, " for substance use treatment, increasing the total population served while shifting 5% of residential admissions to PHP would result in an estimated 122 youth accessing residential care, a 42% increase over FY23-24". However, according to San Diego youth SUD providers, as of FY 2026, there are zero SUD residential treatment beds. More detail would be helpful for a better understanding of where clients currently obtain services and how this deficit affects projections.

▶ RECOMMENDATION

- ⟶ Verify and update the projected figures for youth substance use residential care to ensure they reflect current provider capacity and available levels of care.

6 Residential Treatment — The PRTF Model Deserves Greater Emphasis

The Board letter proposes opening a 16-bed Children's Crisis Residential Program (CCRP), despite current underutilization of Short-Term Residential Treatment Program (STRTP) beds and the well-documented funding limitations associated with CCRPs, particularly the lack of reimbursement for room and board. The proposal also suggests diverting 5% of inpatient volume to Psychiatric Residential Children's Crisis Residential Treatment Facilities (PRTFs) without providing a clear rationale for this target.

PRTFs offer significant clinical and financial advantages compared to CCRPs and STRTPs. They are federally recognized inpatient-level services for individuals under 21, exempt from the IMD exclusion and

fully reimbursable under Medi-Cal. Unlike CCRPs, they cover the full cost of care, including room and board. In addition, PRTFs can serve both Medi-Cal and commercially insured youth and are accessed based on clinical need rather than system involvement, making them a more flexible and sustainable component of the continuum of care.

▶ RECOMMENDATIONS

- Assess PRTF as a more sustainable and clinically appropriate residential alternative to CCRPs and STRTPs, as proposed under AB 1579 (Ramos).
- Explicitly define the priority populations most likely to benefit — youth with co-occurring SUD, complex trauma, and preteen and adolescent populations — and develop a geographically distributed model to ensure equity.
- To assess the number of PRTF beds that may be needed, work collaboratively with providers to estimate the percentage of youth receiving SMHS who may require this level of care, using CSU, Emergency Department, and inpatient utilization data.

7 Hybrid Adult-Youth Crisis Stabilization Units Raise Serious Clinical Concerns

The Board letter proposes exploring hybrid Crisis Stabilization Unit (CSU) programs that serve both adults and youth in the same facility as a strategy to improve access and financial sustainability. While the coalition understands the practical motivation behind this proposal, we have significant clinical concerns about this model.

Children and adolescents in behavioral health crisis have fundamentally different clinical, developmental, and trauma-informed care needs than adults. The treatment environment, staff training, programming, and physical space design for youth crisis stabilization must be purpose-built for this population. Most existing CSU facilities are designed around adult communal spaces — shared waiting areas, group rooms, and milieu environments — that are not developmentally appropriate for children and that make meaningful separation of adult and youth populations operationally impractical. Placing children in crisis in adult psychiatric settings is contraindicated clinically and risks re-traumatization.

▶ RECOMMENDATION

- Any expansion of crisis stabilization capacity for youth should be achieved through dedicated youth-serving CSU capacity, not through hybrid adult-youth models. If geographic or financial constraints make standalone youth CSUs infeasible in certain regions, design standards, programming requirements, and physical separation of youth from adults must be explicitly defined and enforced before any hybrid model is authorized.

8 Care Coordination Pathways and Pediatric Primary Care Integration Are Undefined

The framework describes what the continuum of care should include but does not specify how youth move through it — who authorizes level-of-care transitions, what step-up and step-down protocols look like, and what happens when a youth falls between systems. Engagement outside the FQHC system with community pediatric practices and primary care providers is not addressed, despite primary care being one of the most accessible and trusted entry points for children and families.

The roles of Medi-Cal Health Plans, Optum (the ACL line), BH Utilization Management, emergency departments, and specialty provider networks in care coordination and referral are not elaborated in the Board letter. Clear bidirectional transition protocols between MCP mild-to-moderate services and specialty care, shared performance metrics, and defined roles for Enhanced Care Management and Community Supports in bridging these systems are essential for the framework to function as desired. Referral pathways between CYBHI Fee Schedule-funded school services and specialty care also need to be specified, including step-up and step-down protocols.

We also note that not all children want to receive behavioral health care at school. For some youth, school-based services carry stigma concerns — they do not want peers to know they are receiving mental health support. School hours also constrain parent and family participation, particularly for working families. School-based services are a critical access point but should not be the exclusive or default entry into care.

▶ RECOMMENDATIONS

- → Develop a system-wide written care coordination protocol specifying transition criteria between levels and systems of care, the roles of all system actors including Health Plans, Optum, and specialty providers, and rapid referral pathways from community pediatric and primary care practices to specialty services.
- → Clarify and support the expanded roles ECM and Community Supports can play in facilitating care transitions between MCPs and SMHS.
- → Leverage Medi-Cal Dyadic Care, SB 855, and SB 1320 to strategically support the development and sustainability of integrated behavioral health services in pediatric primary care settings, ensuring these services are reimbursable for both commercially insured and Medi-Cal–enrolled youth, while expanding care coordination infrastructure beyond specialty settings.

9 Families Are Under-Resourced and Under-Recognized

The framework appropriately emphasizes family-centered approaches, but does not acknowledge the structural barriers that prevent many families from engaging with services at all. Many families of youth who need behavioral health services are simultaneously managing housing instability, food insecurity,

safety concerns, legal issues, and caregiving responsibilities across multiple children and generations. The family itself often cannot engage in services — or cannot support the child in engaging — because of competing survival demands. Family support must be framed as part of the treatment itself, not as an optional complement to child-focused care.

▶ RECOMMENDATION

- Explicitly recognize whole-family need as a core design principle throughout the framework, and ensure competitive procurements include provisions for family stabilization supports — not only child-directed services. This is particularly critical for CFWB-involved families, where the complexity of family circumstances is most acute.

SECTION 5 — OVERARCHING SYSTEM LEVEL RECOMMENDATIONS

The following recommendations cut across multiple areas of the framework and are offered as system-level priorities that do not fit within a single programmatic gap.

1. Establish a permanent, multi-sector implementation oversight structure — bringing together providers, families, youth, and community organizations — to monitor OCP progress, identify State non-mandated evidence-based practices and community-informed practices, and provide ongoing input. This coalition is prepared to actively participate and support this effort.

2. Establish annual public reporting to the Board on OCP progress metrics disaggregated by age group (0–5, 6–11, 12–17, 18–25), race/ethnicity, service type, and region, with the first report due within [X months]. Metrics should include not only the number of youth served but timeliness of access, network adequacy, and care continuity measures.

3. Ensure all new competitive procurements include explicit equity requirements for reaching the highest-need and most underserved communities — including children of color, LGBTQ+ youth, foster-care-involved youth, justice-involved youth, and children with co-occurring SUD and mental health needs. Programs should demonstrate alignment with promising and community-defined practices appropriate for the populations they serve, not solely programs with formal EBP designations.

4. Develop a comprehensive cross-system penetration rate methodology that counts utilization from all relevant payers and service systems — BHS specialty, MCP mild-to-moderate, School IDEA, the State School Behavioral Health Initiative, Juvenile Probation, and CFWB — to produce an accurate picture of who is and is not being reached across the full 0–25 population.

SECTION 6 — CLOSING STATEMENT

SBHI and the County share the same goal — every child and youth in San Diego County getting the behavioral health support they need, when they need it. The OCP framework is genuine progress toward making this a reality.

The Youth OCP provides a valuable framework for capacity planning but currently emphasizes primarily volume expansion over systemic integration as recommended by the stakeholder input. To ensure equitable, timely, and sustainable access, implementation must strengthen care coordination across managed care and specialty settings, expand school-based coordination without making it the only pathway, deepen primary care engagement and integrated care, close critical gaps in early childhood and SUD services, and build accountability structures that hold the system responsible for timely access and outcomes — not just utilization counts.

SBHI is a resource for implementation planning, future stakeholder engagement, and technical assistance.

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