DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

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Chief Medical Officer

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Chief Deputy Director

June 09, 2026

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

ADOPT THE DEPARTMENT OF MENTAL HEALTH'S
THREE YEAR INTEGRATED PLAN FOR BEHAVIORIAL HEALTH SERVICES AND OUTCOMES
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health's Three-Year Integrated Plan for Behavioral Health Services and Outcomes for Fiscal Years 2026-27 through 2028-29.

IT IS RECOMMENDED THAT THE BOARD:

1. Adopt the Department of Mental Health's (DMH) Three-Year Integrated Plan (IP) for Behavioral Health Services and Outcomes for Fiscal Years (FYs) 2026-27 through 2028-29.

2. Delegate authority to the Director of Mental Health, or designee, to amend the IP in Recommendation 1 to reflect administrative revisions, statutory and/or policy changes as requested by the State.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

In March 2024, voters approved Proposition 1 to reform the Mental Health Services Act and fund needed behavioral health facility infrastructure, thus transitioning to the Behavioral Health Services Act (BHSA). The primary goals of the BHSA are to improve access to care, increase accountability and transparency for publicly funded, county-administered behavioral health services, and expand the capacity of behavioral health care facilities across California. BHSA requires that counties

develop and submit a three-year IP for Behavioral Health Services and Outcomes and Annual Updates consistent with BHSA Policy Manual, and any other applicable DHCS guidance, Welfare and Institutions (W&I) Code §§ 5963, et seq.

In accordance with W&I Code § 5963.02, DMH in collaboration with Department of Public Health (DPH), will prepare and submit the IP to the County Board of Supervisors for adoption. Board approval of the recommended action will allow DMH to submit the IP to the State of California's Department of Health Care Services and the Behavioral Health Services Oversight and Accountability Commission per W&I Code § 5963.02.

W&I Code § 5963.03 requires the County's DMH to post the draft IP, for at least 30 days, for stakeholders and the public to review and provide comments. As such, DMH posted the draft IP on its website on February 11, 2026. At the close of the 30-day public review period, DMH and the Behavioral Health Commission convened a Public Hearing on April 9, 2026, where DMH presented the IP to stakeholders and the public.

The IP has been certified by DMH's Director, the Director of DPH Substance Abuse Prevention and Control Bureau, and the Chief Executive Officer (CEO), to meet specified BHSA requirements in accordance with W&I Code § 5963.02.

Implementation of Strategic Plan Goals

The recommended action is consistent with the County's Strategic Plan North Star 1 (Make Investments that Transform Lives), via Focus Area Goal A. (Healthy Individuals and Families) and County's Strategic Plan North Star 3 (Realize Tomorrow's Government Today), via Goal A. Communication and Public Access).

FISCAL IMPACT/FINANCING

There is no net County cost impact associated with the recommended action.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Senate Bill (SB) 326 requires all county behavioral health departments, which in Los Angeles County consists of the Departments of Menal Health and Public Health, to submit an IP outlining intended use of funds and a budget for behavioral health programs administered, beginning with FYs 2026-27 through 2028-29.

Each county mental health program must prepare an IP which is to be adopted by the Board and submitted to the Behavioral Health Services Oversight and Accountability Commission and the State Department of Health Care Services.

The public hearing requirements referenced in W&I Code § 5963.03 have been fulfilled and are recorded in the IP. The Director of DMH and the Director of DPH have both signed the Behavioral Health Director Certification form attesting that the County of Los Angeles has complied with all applicable statutes, regulations, and guidelines and adheres to fiscal accountability and stakeholder participation requirements. The CEO has signed the County Administrator Certification form attesting to the use of BHSA funding. Both forms are included in the BHSA IP. As a final condition for submitting the IP, the Board will need to sign the attached Certification (Attachment II) indicating

that the Board has reviewed and approved the IP and attests that the County will meet the realignment obligation pursuant to W&I Code § 14197.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the IP will ensure compliance with SB 326 requirements and ensure clients have timely access to appropriate services.

Respectfully submitted,

LISA H. WONG, Psy.D.
Director

LHW:RH:KN:RR:SK:ZW:atm

Enclosures

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel
Chairperson, Behavioral Health Commission

LOS ANGELES COUNTY: BEHAVIORAL HEALTH SERVICES ACT INTEGRATED PLAN RESPONSES

Submitted to the State Department of Health Care Services: January 2026

Posted for Public Review: February 11,2026-March 13, 2026

Table of Contents

Introduction 5

General Information 6

County Behavioral Health System Overview 8

Populations Served by County Behavioral Health System 8

County Behavioral Health Technical Infrastructure 12

County Behavioral Health System Service Delivery Landscape 13

Care Transitions 17

Statewide Behavioral Health Goals 18

Population-Level Behavioral Health Measures 18

Priority Statewide Behavioral Health Goals for Improvement 18

Additional Statewide Behavioral Health Goals for Improvement 59

County-Selected Statewide Population Behavioral Health Goals 62

Community Planning Process 69

Stakeholder Engagement 69

Local Health Jurisdiction (LHJ) 73

Medi-Cal Managed Care Plan (MCP) Community Reinvestment 76

Comment Period and Public Hearing 77

County Behavioral Health Services Care Continuum 90

County Provider Monitoring and Oversight 91

Medi-Cal Quality Improvement Plans 91

Contracted BHSA Provider Locations 91

All BHSA Provider Locations 92

Behavioral Health Services Act/Fund Programs 94

Behavioral Health Services and Supports (BHSS) 94

Full Service Partnership Program 107

Housing Interventions 123

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects 154

Workforce Strategy 155

Maintain an Adequate Network of Qualified and Culturally Responsive Providers . 155
Build Workforce to Address Statewide Behavioral Health Goals . 155
Budget And Prudent Reserve . 159
Plan Approval and Compliance . 160
Behavioral Health Director Certification . 160
County Administrator or Designee Certification . 161
Appendices . 162

Introduction

The Behavioral Health Services Act (BHSA) (Senate Bill (SB) 326, Chapter 90, Statutes of 2023) requires all county Behavioral Health Departments to submit a three-year Integrated Plan for Behavioral Health Services and Outcomes outlining intended use of funds and a budget for behavioral health programs administered, beginning with Fiscal Years (FY) 2026-2029 (July 1, 2026 – June 30, 2029).

General Information

1. **County, City, Joint Powers, or Joint Submission**
   County
2. **Entity Name (county, city, joint powers, or other)**
   Los Angeles
3. **Behavioral Health Agency Name**
   Los Angeles County Department of Mental Health
   Substance Abuse Prevention and Control, Los Angeles County Department of Public Health
4. **Behavioral Health Agency Mailing Address**
   Mental Health: 510 S. Vermont Avenue, Los Angeles, CA 90020
   SUD: 313 N. Figueroa St., Los Angeles, CA 90012
5. **Primary Mental Health Contact**
   a. **Name:** Lisa Wong, PsyD
   b. **Email:** lwong@dmh.lacounty.gov
   c. **Phone:** (213) 947-6770
6. **Secondary Mental Health Contact**
   a. **Name:** Kalene Gilbert, LCSW
   b. **Email:** kgilbert@dmh.lacounty.gov
   c. **Phone:** (213) 943-8233
7. **Primary Substance Use Disorder Contact**
   a. **Name:** Gary Tsai, MD
   b. **Email:** gtsai@ph.lacounty.gov
   c. **Phone:** (626) 299-4595
8. **Secondary Substance Use Disorder Contact**
   a. **Name:** Michelle Gibson, MPH
   b. **Email:** migibson@ph.lacounty.gov
   c. **Phone:** (626) 299-4595
9. **Primary Housing Interventions Contact**
   a. **Name:** Maria Funk, PhD
   b. **Email:** mfunk@dmh.lacounty.gov
   c. **Phone:** (213) 943-8465
10. **Compliance Officer for Specialty Mental Health Services (SMHS)**
    a. **Name:** Venezia Mojarro
    b. **Email:** vmojarro@dmh.lacounty.gov
11. **Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services**
    a. **Name:** Setareh Yavari
    b. **Email:** syavari@ph.lacounty.gov
12. **Behavioral Health Services Act (BHSA) Coordinator**

Name	Email Address
Kalene Gilbert	Kgilbert@dmh.lacounty.gov

13. **Substance Abuse and Mental Health Services Administration (SAMHSA) liaison**

Name	Email Address
Stephanie Chor	schor@dmh.lacounty.gov
Gary Tsai, MD	gtsai@ph.lacounty.gov

14. **Quality Assurance or Quality Improvement (QA/QI) lead**

Name	Email Address
Jennnifer Hallman, LCSW, MPA	jhallman@dmh.lacounty.gov
Brian Hurley, MD	bhurley@ph.lacounty.gov

15. **Medical Director**

Name	Email Address
Curley Bonds II, MD	cbonds@dmh.lacounty.gov
Brian Hurley, MD	bhurley@ph.lacounty.gov

County Behavioral Health System Overview

Please provide the city/county behavioral health system (inclusive of mental health and substance use disorder) information listed throughout this section. The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins (i.e., for 2026-2029 IP, data from FY 2023-2024 should be used).

Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook. For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan.

Children and Youth

1. In the table below, please report the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row.
   Counts may be duplicated as individuals may be included in more than one category.

Table 1. Number of Children and Youth Served

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	85,700
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	162
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	2,092
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	971
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	115
Were chronically homeless or experiencing homelessness or at risk of homelessness	6,277[1]
Were in the juvenile justice system	526[2]
Have reentered the community from a youth correctional facility	2,340[3]
Were served by the Mental Health Plan and had an open child welfare case	17,562
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	110

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	4,158[4]

[1]Data Source: LACDMH used the population data for persons in households with at least one adult and one child, children under age 18 and persons in household with only children from the HUD 2024 Continuum of Care Homelessness Assistance Programs Homeless Populations and Subpopulations Report. These figures may not include clients served by LACDMH
[2]Data Source: California Board of State and Community Corrections (BSCC) Juvenile Detention Profile Survey Dashboard
County Probation Department data: Average Daily Population for 2025. These figures may not include clients served by LACDMH.
[3]Data Source: California Board of State and Community Corrections (BSCC) Jail Population Survey Dashboard. Average number of youth discharged per month in 2024 was 195.
[4]Fiscal Year 2024-25

Adults and Older Adults

1. In the table below, please report the number of adults and older adults (21 and older) served by the county behavioral health system who meet the criteria listed in each row. Counts may be duplicated as individuals may be included in more than one category.

Table 2. Adults and Older Adults Served

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	5,082
Received Medi-Cal SMHS	117,900
Received DMC or DMC-ODS services	29,800
Received MH and SUD services from the MHP and DMC county or DMC- ODS plan	29,591
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	29,076[1]
Experienced unsheltered homelessness	16,374[2]
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	7,575[3]
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	337[4] This number represents SAPC only, DMH does not collect this data
Were in the justice system (on parole or probation and not currently incarcerated)	11,774[5]
Were incarcerated (including state prison and jail)	58,349[6]
Reentered the community from state prison or county jail	31,980[7]
Received acute psychiatric services	19,167[8]

[1]Data Source: LACDMH used the population data for severely mentally ill (SMI) from the HUD 2024 Continuum of Care Homelessness Assistance Programs Homeless Populations and Subpopulations Report: 15,666. This figure was combined with SAPC: 13,410. These figures may not include clients served by LACDMH.
[2]Data Source: LACDMH used the population data for severely mentally ill (SMI) from the HUD 2024 Continuum of Care Homelessness Assistance Programs Homeless Populations and Subpopulations Report: 11,263. This figure was combined with SAPC: 5,111. These figures may not include clients served by LACDMH.
[3]Data Source: LACDMH used the population data for severely mentally ill (SMI) from the HUD 2024 Continuum of Care Homelessness Assistance Programs Homeless Populations and Subpopulations Report: 4,403. This figure was combined with SAPC: 3,532. These figures may not include clients served by LACDMH.
[4]The number reported is only for SAPC. LACDMH does not have any numbers to report.
[5]Data Source: LACDMH clients included are those served in AB109, the Community Reintegration Program and those with a justice involved focal population in Full Service Partnership program. This count represents an undercount, given that many justice-involved clients receive services through additional outpatient programs.5,877
[6]Data Source: California Board of State and Community Corrections (BSCC) Jail Population Survey Dashboard: Calendar Year 2024
[7]Data Source: Data pulled 12/18/2025 from the Los Angeles County: Chief Information Office: Justice Data Center: Released Person

Dashboard Subtracted. Number derived using the average number released to custody (27,612) subtracted from the average number of inmates released (59,592). These figures may not include clients served by LACDMH.SAPC reported 182. Time frame: January 2025-October 2025.
[8]Fiscal Year 2024-25

2. **Input the number of persons in designated and approved facilities who were**
   a. **Admitted or detained for 72-hour evaluation and treatment rate:** 50,507
   b. **Admitted for 14-day periods of intensive treatment:** 32,492
   c. **Admitted for 30-day periods of intensive treatment:** 3,317
   d. **Admitted for 180-day post certification intensive treatment:** N/A
3. **Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs:** 1,814
4. **Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs):** N/A
5. **Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?** No
6. **Please describe the local data used during the planning process:**

   The local data included Medi-Cal client counts by age, race and ethnicity to inform planning and help identify disparities.
7. **If desired, provide documentation on the local data used during the planning process:** N/A

Local CARE Act Implementation

1. **Identify the specific service components within your 3-year Integrated Plan that will support CARE participants. Explain how the county will ensure these individuals receive priority access and specialized coordination within the broader behavioral health continuum, including housing if appropriate.**

   The integrated components within the 3-year plan that will serve CARE participants will include the following:
   - Full-Service Partnership (FSP) (ACT, and/or ICM), Outpatient Services, other intensive field-based services and/or Peer Support Services.

   The CARE Court Program may be layered upon any of the above integrated plan (IP Components) to provide appropriate and comprehensive mental health services. These components will support each individual's unique needs by providing tailored and comprehensive mental health services to support recovery and goal attainment. The services overall are field based and intensive in nature and work across both Court, Behavioral Health, and other system partners.

   The county will ensure CARE Court participants receive priority access and specialized coordination within the broader behavioral health continuum, including housing by maintaining a specialized CARE Court Program which can both provide and coordinate direct services to this specialized and unique population. This enables CARE Court participants to be prioritized and not experience any substantial delays in receiving comprehensive field-based mental health services. As it relates to housing, the CARE Court Team regularly coordinates with the DMH Housing division to ensure that CARE

Court clients experience seamless and expedited pathways to the full continuum of housing resources.

2. **Describe how CARE referral pathways will be integrated into existing referral and service pathways within the county behavioral health system.**

   CARE referral pathways are integrated into existing referral and service pathways within the county Behavioral Health System by leveraging the department wide Service Requests Tracking System (SRTS) and Universal Entry. The DMH 24/7 Access Help Line also serves as an important avenue that funnels CARE Court referrals and inquiries to the CARE Court team. These pathways allow for “no wrong door” access to DMH services while at the same time promoting the tracking and disposition of each request for services.

3. **Describe the process for identifying and redirecting individuals who are potentially eligible for CARE to alternative pathways when a formal petition is not required or appropriate. For individuals redirected from CARE, describe how the county will confirm and document successful connection to services.**

   The process for identifying and redirecting individuals who are potentially eligible for CARE to alternative pathways when a formal petition is not required or appropriate includes the following:

   - Referral review of potential CARE Court clients by clinical staff which may include clinical interview, review of pertinent records, and/or information from collaterals.
   - Evaluation of client’s readiness to accept appropriate and needed mental health services without court oversight
   - Consultation and linkage to an appropriate mental health service that meets the client’s needs

   Individuals who are redirected from the CARE Court program are referred to other available mental health services that will meet and address their specific needs. Referrals received from the community may be transferred to an appropriate provider via SRTS where a disposition is tracked and required. Referrals received from mental health providers that are not appropriate for CARE Court will receive consultation and navigation support to promote effective linkage to the needed mental health services. These dispositions are tracked through the department wide SRTS and universal entry systems.
   Successful connection to mental health services will be documented in the SRTS and/or Universal Entry tracking systems.

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

1. **Does the county's behavioral health system use an Electronic Health Record (EHR)?** Yes
    a. **The County uses the following EHR:** Netsmart
2. **Does the county behavioral health system participate in a Qualified Health Information Organization (QHIO)?** Yes
    a. **The County participates in the following QHIO:** Los Angeles Network for Enhanced Services (LANES)

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

1. **Please provide the link to the county's API endpoint on the county behavioral health plan's website:**
    - https://hidex.dmh.lacounty.gov/provider/metadata
    - Patient Access API: https://pax.sapc.ph.lacounty.gov/swagger/index.html
    - Provider Directory API: https://pdex.sapc.ph.lacounty.gov/swagger/index.html
2. **Does the county wish to disclose any implementation challenges or concerns with these requirements?** No
3. **Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056, 23-057, and 24-016. Does the county wish to disclose any implementation challenges or concerns with these requirements?** No

County Behavioral Health System Service Delivery Landscape

For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction.

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH) Grant

1. **Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?** Yes
    a. The county behavioral health system plans to provide the following services under the PATH grant:
        - Alcohol or Drug Treatment Services
        - Case Management Services
        - Community Mental Health Services
        - Habilitation and Rehabilitation Services
        - Outreach Services
        - Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services
        - Screening and Diagnostic Treatment Services
        - Staff Training, including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services
2. **The County's referrals for Primary Health Care, Job Training, Educational Services, and Housing Services are the following:**
        - Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations
        - Improving the Coordination of Housing Services
        - One-time Rental Payments to Prevent Eviction
        - Planning of Housing
        - Security Deposits
        - Technical Assistance in Applying for Housing
3. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?** No

Community Mental Health Services Block Grant (MHBG)

1. **Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period?** Yes
    a. **The county behavioral health system plans to participate in the following under the MHBG:**
        - Children's System of Care Set-Aside
        - Discretionary/Base Allocation
        - Dual Diagnosis Set-Aside
        - First Episode Psychosis Set-Aside
        - Integrated Services Agency Set-Aside

2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?** No

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

1. **Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period?** Yes
    a. **The county behavioral health system participates in the following set-asides under SUBG:**
        - Adolescent/Youth Set-Aside
        - Discretionary
        - Perinatal Set-Aside
        - Primary Prevention Set-Aside
2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?** No

Opioid Settlement Funds (OSF)

1. **Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?** Yes
    a. **The county behavioral health system participates in the following set asides under OSF Exhibit E:**
        - Address The Needs of Criminal Justice-Involved Persons
        - Address The Needs of Pregnant or Parenting Women and Their Families, Including Babies with Neonatal Abstinence Syndrome
        - Connect People Who Need Help to The Help They Need (Connections to Care)
        - First Responders
        - Leadership, Planning, and Coordination
        - Prevent Misuse of Opioids
        - Prevent Overdose Deaths and Other Harms (Harm Reduction)
        - Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
        - Support People in Treatment and Recovery
        - Treat Opioid Use Disorder (OUD)
        - Training

2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?** No

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).

- Case Management
- Comprehensive Evaluation and Assessment
- Group Services
- Individual Service Plan
- Medication Education and Management

- Pre-crisis and Crisis Services
- Rehabilitation and Support Services
- Residential Services
- Services for Homeless Persons
- Twenty-four-hour Treatment Services
- Vocational Rehabilitation

1. **In addition, BMA funds may be used for the specific services identified in the list below. Services that are funded with BMA funds include:** N/A
2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?** No

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment):

- Drug Courts
- Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
- Regular and Perinatal Drug Medi-Cal Services
- Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
- Regular and Perinatal Non-Drug Medi-Cal Services

1. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?** No

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority:

- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Residential Treatment Services
- Crisis Stabilization
- Day Rehabilitation
- Day Treatment Intensive
- Mental Health Services
- Medication Support Services
- Mobile Crisis Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Functional Family Therapy for individuals under the age of 21
- High Fidelity Wraparound for individuals under the age of 21
- Intensive Care Coordination for individuals under the age of 21
- Intensive Home-based Services for individuals under the age of 21
- Multisystemic Therapy for individuals under the age of 21
- Parent-Child Interaction Therapy for individuals under the age of 21
- Therapeutic Behavioral Services for individuals under the age of 21

- Therapeutic Foster Care for individuals under the age of 21
- All Other Medically Necessary SMHS for individuals under the age of 21

1. **The county behavioral health system has opted to provide the specific Medi-Cal SMHS identified as of June 30, 2026:**
    - Clubhouse Services
    - Enhanced CHW Services
    - Peer Support Services

2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?** No

Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS)

1. **The county behavioral health system participates in the following:**
   DMC-ODS Program

Drug Medi-Cal Organized Delivery System (DMC-ODS)

The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the).

- Care Coordination Services
- Clinician Consultation
- Outpatient Treatment Services (ASAM Level 1)
- Intensive Outpatient Treatment Services (ASAM Level 2.1)
- Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
- Mobile Crisis Services
- Recovery Services
- Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
- Traditional Healers and Natural Helpers
- Withdrawal Management Services
- All Other Medically Necessary Services for individuals under age 21
- Early Intervention for individuals under age 21

1. **The county behavioral health system has opted to provide the specific Medi-Cal SUD services identified as of June 30, 2026:**
    - Enhanced Community Health Worker (CHW) Services
    - Inpatient Services (ASAM Levels 3.7 & 4.0)
    - Peer Support Services
    - Recovery Incentives Program (Contingency Management)

2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?** No

Other Programs and Services

1. **The following is a list of other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs:**
   SAPC Programs:
    - Non-DMC-ODS SUD prevention, youth, and perinatal services (funded through

the federal Substance Use Block Grant.

- Overdose surveillance and reporting (funded through the federal CDC Overdose Data to Action grant)
- Women and Children's Residential Treatment Services (funded through state AB188/SB1020)
- Recovery bridge housing programming for up to 180 days in a 12-month period, with the possibility of an additional 180 days if they have not yet secured permanent/stable housing, to people experiencing homelessness who choose abstinence-based housing (LA County Measure H Funding)
- Permanent Supportive Housing rental subsidies and services including on-site outreach, assessment, and service navigation (LA County Measure H funding)
- Juvenile Justice Programs that provide screening, counseling, family engagement and supportive services, leadership and mentoring (funded through Juvenile Justice Crime Prevention Act, Probation Dept. Juvenile Justice Realignment Block Grant (JJRBG), and DOJ funds)
- Driving Under the Influence (DUI) programs (funded through state DUI funds)
- Interim Housing Outreach Program (IHOP) services: education, engagement, navigation, and harm reduction services (funded through MHSA innovations funding)

DMH programs:

- Mental Health Wellness Grant Program for Children and Youth (CY Grant Program) for Crisis Stabilization Units, Martin Luther King, Olive View Restorative Care Villages, and High Desert Restorative Care Village
- Housing and Homelessness Incentive Program
- Child and Youth Behavioral Health Initiative Grant
- Community Care Expansion Preservation Grants Program
- Temporary Personnel Services-SAMHSA Emergency Response Grant
- Mental Health Student Services Act Grant (MHSSA Grant)
- SAMHSA-SERG Grant: Los Angeles County Recovery Efforts and Building Urgency into Implementation of Long-Term Disaster Support

Care Transitions

1. **Has the county implemented the state-mandated Transition of Care Tool for Medi- Cal Mental Health Services (Adult and Youth)?** Yes
2. **Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?** Yes

Statewide Behavioral Health Goals

Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C.

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below.

Counties may also use local data to conduct additional analyses beyond these demographic categories to strengthen their evaluation and better understand community needs.

Priority Statewide Behavioral Health Goals for Improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County. For related policy information, refer to **E.6.2 Primary and Supplemental Measures**.

Access To Care

Access to Care: Primary Measures

Specialty Mental Health Services (SMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

1. **How does your county status compare to the statewide rate?**
    a. **For adults/older adults:** above
    b. **For children/youth:** above
2. **What disparities did you identify across demographic groups or special populations?**
   Race or Ethnicity and Sex

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

1. **How does your county status compare to the statewide rate?**
    a. **For adults/older adults:** below

b. **For children/youth:** below

2. **What disparities did you identify across demographic groups or special populations?** Race or Ethnicity and Sex

Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

1. **How does your county status compare to the statewide rate?**
   a. For adults/older adults: N/A
   b. For children/youth: N/A

2. **What disparities did you identify across demographic groups or special populations?** No disparities data available

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

1. **How does your county status compare to the statewide rate?**
   a. **For adults/older adults:** below
   b. **For children/youth**: below
2. **What disparities did you identify across demographic groups or special populations?** No disparities data available

Access to Care: Supplemental Measures

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023

1. **How does your county status compare to the statewide rate?** above

2. **What disparities did you identify across demographic groups or special populations?** No disparities data available

Access to Care: Disparities Analysis

1. **For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis.**
   Measure 1 examines disparities in penetration rates for adults ages 21 and over who received one or more Specialty Mental Health Services through a Medi-Cal Mental Health Plan in Los Angeles County in 2022, disaggregated by race and ethnicity. The data show that Asian Pacific Islander and Hispanic adults are underrepresented in service penetration, with rates of 0.64 and 0.69, respectively. In contrast, Alaska Native/American Indian, Black, and White adults are overrepresented, with penetration rates of 3.49, 2.29, and 1.66, respectively.

   Measure 2 examines disparities in penetration rates among children and youth under age 21 who received one or more Specialty Mental Health Services through a Medi-Cal Mental Health Plan in Los Angeles County in 2022, disaggregated by race and ethnicity. The data indicate that Asian Pacific Islander and White children and youth are underrepresented in service penetration, with rates of 0.28 and 0.54, respectively. In contrast, Alaska Native/American Indian, Hispanic, and Black children and youth are overrepresented, with penetration rates of 25.09, 1.21, and 1.15, respectively.

Measure 3 examines disparities in penetration rates for adults ages 21 and over who received one or more non-specialty mental health services through a Mental Health Plan in Los Angeles County in 2022, disaggregated by race and ethnicity. The data show that Hispanic and Asian Pacific Islander adults are underrepresented in non-specialty mental health service penetration, with rates of 0.79 and 0.86, respectively. In contrast, Alaska Native/American Indian, White, and Black adults are overrepresented, with penetration rates of 2.05, 1.86, and 1.34, respectively.

Measure 4 examines disparities in penetration rates among children and youth under age 21 who are enrolled in a Medi-Cal managed care plan and received one or more non-specialty mental health services in 2022, disaggregated by race. The data indicate that White, Black, and Asian Pacific Islander children and youth are underrepresented in non-specialty mental health service penetration, with rates of 0.62, 0.76, and 0.79, respectively. In contrast, Hispanic and Alaska Native/American Indian children and youth are overrepresented, with penetration rates of 1.19 and 1.09, respectively.

In terms of SUD specific services, LA County's adult population falls below (0.9%) the statewide Drug Medi-Cal Organized Delivery System (DMC-ODS) median penetration rate (1.5%). Additionally, in LA County Latinxs consistently accounted for the largest proportion of all SUD treatment admissions, which also increased from 48% in FY17-18 to 56% in FY22-23. Moreover, among those receiving SUD services, at admission, 54.5% of patients reported having mental health issues, 42.3% were homeless, and 20.0% were involved in the criminal justice system for FY-23-24.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified various interrelated factors driving disparities in access to care. Discrimination and stigma continue to create significant barriers for some populations, discouraging individuals from seeking or remaining engaged in services. Limited provider competency further compounds these challenges, particularly due to a lack of affirming care for LGBTQ+ individuals. In addition, poor accessibility persists as a result of insufficient culturally appropriate and affirming treatment options. Stakeholders also noted a lack of coordination between homeless services and mental health and substance use programs, which undermines continuity of care. Finally, complex entry systems—especially documentation requirements—present additional barriers that restrict timely access to treatment.

Overarching Solutions: Stakeholders identified several overarching solutions to address these factors and increase access to care. These include enhancing housing, outpatient, and other supportive services to reduce barriers that limit individuals' ability to engage in care. Stakeholders also emphasized the importance of increasing outreach and engagement efforts to reach communities beyond existing client populations. Improving provider competencies through targeted training was identified as a critical strategy for expanding access to affirming care, particularly for underserved groups. In addition, strengthening collaboration across systems of care—such as housing, mental health, and substance use services—was seen as essential for improving care integration and continuity. Stakeholders further highlighted the need to provide more flexible, low-barrier care options that meet people where they are. Finally, ensuring accurate and inclusive data

collection was identified as a key step in improving understanding of the LGBTQ+ population and informing more responsive service planning.

Access to Care: Cross-Measure Questions

1. **Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)**

DEPARTMENT OF MENTAL HEALTH (DMH)

Data used to inform DMH programming and interventions:

- Countywide police and mental health co-responder teams in Los Angeles County (LACDMH staff with local police): demographics, incident counts, and hospitalization data to evaluate interventions for a diverse population.
- Mobile crisis response teams: analysis of incidents by service area, time of day, referral source, demographics, and incident outcomes; evaluations for involuntary detention and triage of high-risk or mentally ill individuals.
- California Institute of Behavioral Health Services (CIBHS) SDR Program Participant Questionnaire: data from the Stigma Discrimination Reduction program assessing participants' attitudes, knowledge, and behaviors related to stigma, plus program quality and demographics.
- California Institute of Behavioral Health Services (CiBHS) SP Program Participant Questionnaire: a multiple-choice survey measuring the impact of programs on participants' attitudes, knowledge, and behaviors related to suicide, program quality, and participant demographics. Cost and utilization data from a preliminary analysis comparing clients in early psychosis versus standard care.
- Level of Care Utilization System (LOCUS)
- Universal Entry Referral form

LACDMH has implemented usage of the DHCS Screening Tool within our 24/7 call center and has been conducting analysis of the screeners completed by call agents. The Quality Assurance Unit has implemented procedures to identify agents who may be skipping the completion of the screener and evaluating the reasons for lack of completion. The DHCS Screening Tool usage is critical in ensuring Members are accessing the most appropriate system of care (SMHS/NSMHS) to best meet their behavioral health needs. In addition, LACDMH has implemented the LOCUS to assist clinical teams in identifying clients whose recovery has progressed in a way to no longer need SMHS and may be transitioned to NSMHS. LACDMH is finalizing Clinical Practice Parameters to aid in the transitioning of clients to NSMHS.

DMH is working to improve access to care through the following programs and services:

- Clubhouse: By providing local locations for clients to visit daily to foster a sense of community, belonging, and empowerment, while teaching skills transferable to employment, the Clubhouse creates a new access point within our care system. Clubhouses offer voluntary lifelong membership, a "work ordered day," supported employment and education, holistic support beyond clinical care, peer support and social connection, and a reduction in hospitalizations.

- Full-Service Partnership (ACT/FACT & FSP-ICM)
    - Assertive Community Treatment (ACT): Multidisciplinary, community-based teams support individuals with SMI or co-occurring SMI and SUD who are homeless, high utilizers, and/or justice-involved with significant functional impairments. The goal is to help individuals manage symptoms, function in the community, obtain/maintain employment and housing, and build social ties.
    - Forensic ACT (FACT): An ACT variant for justice-involved individuals, with enhanced training and staffing, including a team member with lived criminal-justice experience. In many cases, ACT and FACT are delivered by the same teams.
    - Full-Service Partnership – Intensive Case Management (FSP-ICM): A team-based, recovery-focused model with lower intensity than ACT/FACT, serving individuals with SMI or co-occurring SMI/SUD who are homeless, high utilizers, justice-involved, or at risk, and experiencing moderate functional impairments.
- Peer Respite: Peer respites expand access points across the county, offering non-traditional, distress-focused care for individuals not yet in crisis, and providing a local avenue for support.
- Crisis Residential Treatment Program (CRTP) CRTPs provide stabilization as an alternative to emergency services and inpatient psychiatric care, enabling timely access to higher-acuity settings for those in greater need. They offer therapeutic activities and skills to support transitions back to community living.
- Crisis Stabilization: Provides immediate, 24/7 crisis access, including walk-ins, Psychiatric Mobile Response Teams (PMRTs), Law Enforcement Drop Off, and Urgent Care Centers (UCCs). The goal is to de-escalate crises, connect clients to services, and avoid higher levels of care. Follow-up within 24 hours ensures ongoing connections or in-home/phone support to link clients to services.
- Enriched Residential Services (ERS): ERS serves as a step-down in the mental health care continuum from inpatient and locked treatment settings, maintaining engagement with services and stability in the community, and creating capacity for longer-term residential treatment when needed.
- Law Enforcement Teams (LET): LETs respond to 911 calls related to mental health with the aim of connecting individuals to services, reducing subsequent calls, and preventing hospitalizations.
- Day Treatment Intensive/Day Rehabilitation (DTI/DR): DTI/DR assists clients transitioning from acute/crisis care to higher-intensity outpatient stabilization, enhancing the continuum of care with intensive community-based intervention when routine outpatient visits are insufficient.
- EPI-LA Program/Coordinated Specialty Care – First Episode Psychosis Service: Serving youth and adults ages 12–40 experiencing attenuated psychosis or a first psychotic episode, EPI-LA prioritizes rapid intake and timely access to medications when needed. The program has eight provider sites and plans to expand to high-need areas. Funding: MHSA/BHSA Early Intervention + EPSDT/Medi-Cal.
- Child Medical Hubs: Co-located mental health services within Medical HUB Clinics to ensure access for DCFS-involved children and youth undergoing medical examinations. Services include screenings, crisis intervention, and case management.
- Specialized Foster Care (SFC): SFC provides mental health services and service linkage for child welfare-involved youth and families, aiming to prevent removals or reduce placements. Funding: EPSDT.

- Multidisciplinary Assessment Team (MAT): MAT delivers timely, comprehensive, strength-based assessments for children and youth 0–18 years old to improve early access, coordination, and safety for those in out-of-home placement.
- Hollywood 2.0: A groundbreaking pilot in Hollywood, inspired by Trieste, Italy, and led by the LA County DMH and Hollywood 4WRD. Teams of clinicians, case managers, and community partners deliver comprehensive, person-centered care for people with severe mental illness, leveraging outpatient clinics, interim/permanent housing, and a network of supports to create a recovery-oriented system.
- Veteran & Military Family Services (VMFS): VMFS connects county departments, nonprofits, the VA, and city programs to provide emotional support and specialty mental health services, addressing the needs of veterans and their families.
- Women's Wellbeing (WWC): WWC offers a women-centered space designed around peer support, with Community Health Workers guiding daily stressors, mental health therapy, and occupational therapy to support well-being and vocational goals. Inclusive of transgender and gender-diverse individuals.
- Therapeutic Shelter Homes (TSHs): TSHs provide up to 10 days of temporary residential care for children and youth who have experienced abuse or neglect (WIC Section 300), with option to serve NMDs ages 18–21 in LA County.
- Qualified Individual (QI): QI assessments determine the most appropriate, least restrictive setting for children/youth/NMDs in child welfare or probation systems, supporting family-based placement and long-term stability.
- DYD - Credible Messengers: This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services. Services are targeted to Youth 18-25 and include training of messenger peers, needs assessment of youth to paired mentors, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral and resource linkage.
- First 5 - Home Visitation: Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. The programs offer home visits delivered weekly or every two weeks to promote positive parent– child relationships and healthy attachment. This Home Visiting Program will prioritize areas where data indicates there is a high number of families involved with child protective services.
- DCFS - Prevention and Aftercare: Ten leading community agencies proving a variety of services to the community to empower, advocate, educate, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of ACEs and social determinants of health.
- Dept. of Arts & Culture - Creative Wellbeing: A non-traditional, arts and culture–based approach for promoting mental health in young people and caregivers. The model offers non-traditional strategies for promoting mental health and wellness that include culturally relevant, healing-centered, arts-based workshops for youth, as well as professional development, coaching, and emotional support for the adults who work with them. Project activities support positive cognitive, social, and emotional development, and encourage a state of wellbeing.
- Antelope Valley Community Family Resource Centers (CFRC on wheels): The Centers are intended to reimagine service delivery, create career pathways, reduce stigma while also reducing risk factors, improving protective factors and to embrace children, families and communities as change agents. The AV CFRC is designed to create a coordinated

(public/private) community owned and driven space, or network of spaces, where families and individuals in the AV can easily access the services they need to enhance their wellbeing.

- CFRCs (Supervisorial Districts 1 - 5): The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and families in the community it serves.
- Friends of the Children (FOTC): FOTC aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at highest risk of entering foster care. FOTC provides professional 1:1 mentorship to children for 12+ years; starting around the age of 4-6 years old. Mentors are trained to support caregivers, promote self-advocacy and create opportunities for culturally responsive community and peer-to-peer connections.
- Wolf Connection: This is a youth empowerment program, wolfdog rescue center, and sanctuary. Wolf Connection offers unique education and empowerment programs that transform lives via experiential relationships and interactions with rescued wolves and the natural environment. Wolf The “Power of the Pack” program is an immersive digital education and empowerment experience for students aged 11-18. This is a hybrid online/in-person programming with 12 online education lessons and empowerment program for youth. Wolf Connection Team visits sites to facilitate wolf-based education (with or without wolves). Single-day visit onsite at the Wolf Heart Ranch are used as an incentive or as a celebration of the completion of the online program.
- Promotores: The United Mental Health Promoters Program aims to lessen mental health stigma throughout Los Angeles County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with the Department of Mental Health and other resources through culturally sensitive methods. Their services encompass community outreach, facilitating mental health workshops to combat stigma, making referrals to mental health services, and providing mental health support and triage services based on community needs.
- Community Partners - United MH Promoters: A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services (e.g., outreach/engagement, training). Focuses on strengthening our communities and creating career paths for community members The program provides for eight UMHP teams/contractor agencies per Supervisory District with nine staff members per team.
- NAMI Urban LA & Greater LA: Provides Countywide community-based prevention programs and approaches and supports to reduce stigma and discrimination targeting people living with mental illness, their families, friends and communities. Activities/services include supports to families and communities navigating mental health treatment and recovery resources, evidence-based education classes, training, and advocacy.
- SEED LA : The SEED School of Los Angeles (SEED LA) is the county’s first public, charter, college-preparatory, tuition-free boarding high school for at-risk youth. The curriculum, grounded in science, technology, engineering, and mathematics (STEM), will prepare youth for career and college pathways in the transportation and infrastructure industry. The school while provide on-site support, wellness services and socio-emotional counseling for students.
- Birth to Five Mental Health: The Birth-to-5 Team provides capacity building support

including workshops, technical assistance, and reflective consultation to help clinicians effectively support young children and their families. These supports increase access to early relationship centered care and strengthen clinicians' ability to identify developmental and behavioral health needs and connect families to appropriate resources. By addressing concerns early and strengthening caregiver child relationships the Birth-to-5 Team helps prevent escalation to crisis driven responses such as higher levels of care or later justice or DCFS involvement. This early intervention stabilizes families and supports children in remaining safely at home and promotes stronger engagement in early learning and school settings.

- Parental Perinatal Mental Health: The Parental Perinatal Mental Health (PPMH) Program is a countywide, multi-layered clinical support initiative designed to strengthen perinatal mental health care in directly operated clinics. The program provides comprehensive training, ongoing coaching, reflective supervision, and technical assistance to support high-quality implementation. PPMH offerings include foundational and advanced web-based courses, evidence-based interventions, specialized trainings to support families during the perinatal period, monthly consultation calls, and a certification pathway to build long-term expertise and sustainability in perinatal mental health care.
- Parent Partner Academy: Parent Partner training improves the skills of the Peer Support Specialists (PSS) working with the parents/caregivers of the children receiving services. Improved training of the PSS improves parent/caregiver ability to access needed programs, resources, and additional support which reduces risks of child being removed from home and justice involvement/institutionalization. PSS are better trained to help families access programs to receive treatment for untreated BH health conditions such as Regional Center and increase School Engagement
- Suicide Prevention, Intervention and Postvention: Partners in Suicide Prevention (PSP) is a program focused on suicide prevention, intervention, and postvention across communities and service systems. The program strengthens awareness, early identification of suicide risk, and create linkages/referrals. PSP also supports effective postvention efforts to promote healing, reduce stigma, and prevent future suicide risk through educational workshops, resources, and partnership.
- Co-Occurring Intellectual/Developmental Disabilities: Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.
- UMHP: This project invests in communities through contracting with agencies serving high and highest need areas across the county. Agencies, leveraging their position within the hyperlocal area, recruit, hire, and train staff to serve as trusted representatives and "community member with lived experience." The project utilizes training to build staff skills and support community members' pathway towards goals outlined within the context of Population Health Measures (e.g. reduction in homelessness, institutionalization, justice involvement, removal of children from home,

untreated behavioral health conditions and increased school engagement). A composite of services are provided to address community needs such as, outreach/engagement, referral/linkage, psychosocial support activities, and client support services (e.g. housing assistance, household goods, food assistance, diapers, utilities, and other necessities of life).

DEPARTMENT OF PUBLIC HEALTH – SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC)

Data used to inform DPH-SAPC programming and interventions:

- The California Outcome Measurement System (CalOMS) - a data collection and reporting system for substance use disorder (SUD) treatment services. It provides admission, discharge, and annual update data for SUD treatment services.
- DPH-SAPC Claims Data – claims data for SUD treatment services submitted by DPH-SAPC providers.
- Los Angeles County Helpline for Mental Health and Substance Use Services Call Log - the Helpline is a toll-free call line that helps connect individuals (youth, young adults, and adults), who are seeking MH and SUD services with appropriate providers throughout Los Angeles County. The call log provides a record of calls made to the helpline to help assess demand for SUD and MH services.
- Client Engagement and Navigation Services (CENS) Call Log –The CENS call log provides a record of calls made to CENS providers to help assess demand for services.
- Medications for Addiction Treatment (MAT) consultation line Data - The call line fields between 600-700 calls annually, showing level of demand for MAT services.
- American Society of Addiction Medicine (ASAM) Level of Care Data - ASAM criteria-based screening and assessment data to monitor appropriate use of ASAM criteria in the DMC-ODS.
- Listening Sessions with DPH-SAPC Providers and Youth – DPH-SAPC led listening sessions to gather feedback that informed RYSE program development.
- Bureau of Labor Statistics Data – provides data on SUD provider workforce to inform to determine training and capacity building needs.
- Substance Abuse and Mental Health Services Administration (SAMHSA) Report on the 2019 National Survey on Drug Use and Health (NSDUH) – a summary of key findings for national indicators of substance use and mental health among the civilian, noninstitutionalized population aged 12 or older in the United States.
- DPH-SAPC Provider Data – information on DPH-SAPC providers from the LA County SUD EHR information system that includes clinical documentation, data collection, and claims.
- DPH – SAPC Annual Report – An annual overview of clients who received SUD treatment in publicly funded treatment programs in Los Angeles County.

DPH-SAPC is working to improve access to care through the following existing programs, services, partnerships, and/or initiatives:

- DPH-SAPC's Reaching the 95% (R95) Initiative focuses on reaching the 95% of people with SUD who either do not think they need help or are not interested in services by enhancing outreach and engagement and establishing lower barrier care across the

SUD system. SAPC also has an open contracting process to increase service capacity.

- DPH-SAPC's Client Engagement and Navigation Services (CENS) provide in-person SUD services including education, outreach and engagement, screening and referral, and service navigation to facilitate access to care and completion of SUD treatment. SAPC is expanding CENS by better leveraging Medi-Cal and other funding sources.
- DPH-SAPC's field-based SUD services team partners with existing field-based teams to ensure LA County residents experiencing homelessness have access to SUD services in field-based settings. SAPC is actively adding field-based SUD service sites.
- DPH-SAPC's MAT Consultation Line and the California Bridge program, a statewide independent program, work with hospital EDs to provide immediate access to MAT to anyone seeking help and provide care navigation to increase likelihood of completing follow-up treatment.
- DPH-SAPC's Reimagining Youth SUD Engagement (RYSE) initiative aims to transform youth SUD by tailoring youth SUD services to enhance engagement and retention in care, which can prevent the need for institutionalization.

The following are related initiatives and programs that will increase DPH-SAPC's overall system capacity to serve individuals with SUDs.

- The Tuition Incentive Program (TIP) offers individuals an opportunity to become a certified-eligible SUD Counselor while gaining practical in-the-field experience. The program helps increase the availability of registered and certified SUD counselors, who can support effective, long-term recovery and increase access to care for those affected by substance use in Los Angeles County.
- DPH-SAPC provides Capacity Building Payment funds to a treatment provider in advance to ensure start-up funds to provide services or after the fact to compensate a treatment provider for completing work. The funds support DPH-SAPC's provider network in workforce development, access to care, and fiscal and operational efficiency to prepare for changes resulting from the CalAIM initiative and the movement towards value-based care under payment reform.
- DPH-SAPC provides start-up funds as part of the Residential Capacity Building Pilot for staffing to increase co-occurring capabilities and withdrawal management in residential settings. Additional staffing helps increase access to care.

For the access to care measure, DPH-SAPC recognizes the gap between LA County's DMC-ODS penetration rate and the statewide rate and has implemented programs to address systematic barriers to care for the community and for priority populations (i.e. people experiencing homelessness, youth and transition aged youth, and co-occurring disorders). DPH-SAPC uses SUD treatment admissions data, SUD provider and claims data, and SUD client level data among other sources to develop a holistic baseline and guide programmatic roadmaps and will incorporate statewide behavioral health goal measures in our ongoing data driven decision-making processes.

Firstly, recognizing that only ~5% of individuals with SUD are accessing treatment services, DPH-SAPC launched the Reaching the 95% initiative (R95), which aims to move the SUD treatment system to lower barrier and on-demand care. This long-term initiative seeks to increase treatment provider capacity and enhance demand for services from the community through incentives, network capacity building, and public campaigns and education – contributing to increased penetration rates. This will also address community

feedback through the Community Planning Process regarding ongoing stigma and lack of awareness that may result in less engagement with SUD services.

For youth and transition-aged youth, DPH-SAPC's Rethinking Youth SUD Engagement (RYSE) recognizes the low penetration rate among youth and aims to reimagine and tailor youth SUD services to enhance engagement and retention. Applying a service design approach, DPH-SAPC is leveraging insights and data gleaned from youth listening sessions and providing one-time CBO funds to enhance engagement and retention.

DPH-SAPC's Annual Treatment Reports also highlight other gaps and priority populations. The data in this report goes down to the supervisorial district level, aiding in planning for areas of most need. According to the FY '24-'25 report, 58% of clients served reported having mental health issues and 44.1% were experiencing homelessness. DPH-SAPC has addressed these known needs by building co-occurring capacity through workforce development programs, including the Residential Capacity Building Pilot, and by continuing to expand recovery-oriented housing capacity, including Recovery Bridge Housing (RBH), Recovery Housing (RH), and Permanent Supportive Housing (PSH), and navigation services through CENS to facilitate access to care and completion of SUD treatment. BHSA housing intervention funds will partially contribute to these housing programs.

Finally, to improve access to SUD services for adult, child, and youth populations, DPH-SAPC continues to establish and evaluate program outcomes, conduct needs assessments and expand or adjust SUD programs to increase SUD penetration rates. Understanding service utilization, emerging trends, and unmet needs helps SAPC continue to engage in data driven decision-making, increasing SUD care access and retention.

2. **The following is a category or categories of funding that the county is using to address the access to care goal:**
    - BHSA Behavioral Health Services and Supports (BHSS)
    - BHSA Full Services Partnership (FSP)
    - BHSA Housing Interventions
    - 2011 Realignment
    - Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
    - Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH)
    - Community Mental Health Block Grant (MHBG)
    - Substance Use Block Grant (SUBG)
    - Other: County General Fund, EPSDT/Medi-cal, Medicaid Expansion, MCHIP

Homelessness

Homelessness: Primary Measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

1. **How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?** above

2. **What disparities did you identify across demographic groups or special populations?** Gender and Race or Ethnicity

Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 - 2024

1. **How does your county status compare to the statewide rate?** below
2. **What disparities did you identify across demographic groups or special populations?** Race or Ethnicity

Homelessness: Supplemental Measures

PIT Count Rate of People Experience Homelessness with Severe Mental Illness, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

1. **How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?** above
2. **What disparities did you identify across demographic groups or special populations?** Gender and Race or Ethnicity

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

1. **How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?** above
2. **What disparities did you identify across demographic groups or special populations?** Gender and Race or Ethnicity

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.)

1. **How does your local CoC's rate compare to the average rate across all CoCs?** above
2. **What disparities did you identify across demographic groups or special populations?**

   Gender and Race or Ethnicity

Homelessness: Disparities Analysis

1. **For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis**

   Measure 1 presents disparity data for persons experiencing homelessness by race and ethnicity based on the January 24, 2024, Point-in-Time Count. The findings indicate that Asian Pacific Islander and Hispanic individuals are underrepresented among the population experiencing homelessness, with disparity ratios of 0.19 and 0.75, respectively. In contrast, American Indian/Native American, Black, and White individuals are overrepresented, with disparity ratios of 14.83, 2.97, and 1.61, respectively.

   Measure 2 presents disparity data for persons experiencing homelessness by gender based on the January 24, 2024, Point-in-Time Count. The data indicate that women are underrepresented among individuals experiencing homelessness, with a disparity ratio of 0.62. In contrast, men are overrepresented, with a disparity ratio of 1.38.

Measure 3 examines disparities in substance use disorder (SUD) treatment admissions among people experiencing homelessness in Los Angeles County by race and ethnicity, using disparity ratios based on homeless population counts. Drawing on FY 2023–24 treatment admission data from the California Outcome Measurement System and the Los Angeles County Participant Reporting System and comparing these data to population estimates from the 2024 Greater Los Angeles Homeless Count, the analysis reveals notable inequities in treatment access and engagement. Hispanic and White individuals are overrepresented among SUD treatment admissions relative to their representation in the homeless population, with disparity ratios of 1.26 and 1.20, respectively. Asian Pacific Islander individuals are slightly overrepresented, with a ratio of 1.06. In contrast, Black individuals and Alaskan Native or American Indian individuals are underrepresented in SUD treatment admissions, with disparity ratios of 0.58 and 0.54, respectively. Individuals categorized as "Other" are the most underrepresented, with a disparity ratio of 0.19.

Measure 4 examines disparities in substance use disorder (SUD) treatment admissions among people experiencing homelessness in Los Angeles County by race and ethnicity, using disparity ratios based on homeless population counts. Using FY 2023–24 treatment admission data from the California Outcome Measurement System and the Los Angeles County Participant Reporting System, and population estimates from the 2024 Greater Los Angeles Homeless Count, the measure highlights persistent inequities in access to SUD treatment. The data show that Hispanic and White individuals are overrepresented among SUD treatment admissions relative to their representation in the homeless population, with disparity ratios of 1.26 and 1.20, respectively. Asian Pacific Islander individuals are also slightly overrepresented, with a disparity ratio of 1.06. In contrast, Black individuals and Alaskan Native or American Indian individuals are underrepresented in treatment admissions, with disparity ratios of 0.58 and 0.54, respectively. Individuals categorized as "Other" are the most underrepresented, with a disparity ratio of 0.19.

Measure 5 examines disparities in substance use disorder (SUD) treatment admissions among people experiencing homelessness in Los Angeles County by age group, using disparity ratios based on homeless population counts. The analysis draws on FY 2023–24 treatment admission data from the California Outcome Measurement System and the Los Angeles County Participant Reporting System, compared against age-specific population estimates from the 2024 Greater Los Angeles Homeless Count. The data show substantial variation in treatment admissions across age groups. Young adults ages 18–24 and 25–34 are notably overrepresented in SUD treatment admissions, with disparity ratios of 1.77 and 1.81, respectively. Adults ages 35–44 are also overrepresented, with a ratio of 1.39. In contrast, children and youth ages 0–17 are almost entirely absent from treatment admissions, with a disparity ratio of 0.01. Older adults are consistently underrepresented, including those ages 45–54 (0.72), 55–64 (0.51), and 65 and older (0.28).

Measure 6 examines disparities in substance use disorder (SUD) treatment admissions among people experiencing homelessness in Los Angeles County by gender identity, using disparity ratios based on homeless population counts. This analysis draws on FY 2023–24 treatment admission data from the California Outcome Measurement System and Los Angeles County Participant Reporting System, compared against gender-specific population estimates from the 2024 Greater Los Angeles Homeless Count. The data indicate that males are slightly overrepresented in SUD treatment admissions, with a disparity ratio of 1.05, while females are slightly underrepresented, with a ratio of 0.94. Transgender individuals are substantially overrepresented, with a disparity ratio of 11.48, indicating a

markedly higher rate of SUD treatment admissions relative to their representation in the homeless population. In contrast, individuals categorized as “Other” are significantly underrepresented, with a disparity ratio of 0.05.

Measure 7 examines substance use disorder (SUD) treatment admissions among people experiencing homelessness in Los Angeles County by LGBTQ+ status, using FY 2023–24 data from the California Outcome Measurement System and the Los Angeles County Participant Reporting System. The data show that the majority of individuals admitted to SUD treatment identified as heterosexual, accounting for 85.3 percent of admissions. Smaller proportions of admissions were reported among individuals identifying as bisexual (3.5 percent), gay (2.8 percent), lesbian (1.1 percent), and transgender (1.0 percent). An additional 1.2 percent identified as questioning or unsure, while 5.3 percent of records were categorized as “prefer not to state” or not available. While heterosexual individuals comprise the largest share of admissions, the presence of LGBTQ+ individuals—particularly those identifying as bisexual, gay, lesbian, transgender, or questioning—highlights the importance of affirming and inclusive SUD treatment services.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified several factors driving these disparities. Substance use trends were highlighted as a key concern, including the ease of access to marijuana and alcohol for minors. Early substance use, often beginning in middle school, is frequently linked to experiences of trauma, poverty, and peer pressure. Economic barriers also play a significant role, as the high cost of living, limited availability of affordable housing, and ongoing financial instability make it difficult for families to remain stably housed. In addition, gaps in mental health care and substance use treatment persist, particularly for youth and transitional-age populations who face limited access to age-appropriate services. Stakeholders further noted challenges in navigating complex systems, such as long wait times, confusing enrollment processes, and limited transportation options, all of which impede access to support. Workforce shortages were identified as another critical issue, with insufficient numbers of trained and culturally competent providers and programs often forced to reduce hours or close early due to staffing constraints. Finally, systemic racism and inequality—including income disparities, disproportionate involvement with the justice and child welfare systems, and provider bias—continue to perpetuate housing instability and unequal access to care.

Overarching Solutions: To address these disparities, stakeholders proposed a set of overarching solutions focused on prevention, access, and accountability. Central to these recommendations is the development of strong community partnerships with trusted organizations and faith-based groups to deliver culturally informed services in spaces where individuals and families feel safe. Stakeholders also emphasized expanding youth prevention programs that provide early education on topics such as fatherhood, financial literacy, and the risks associated with substance use, while incorporating engaging activities like sports and the arts to strengthen participation and connection.

In addition, stakeholders called for greater transparency and accountability within housing systems and funding models, including clear public reporting to ensure resources are effectively reaching those most in need. Mobile outreach and peer support were identified as critical strategies, with street-based teams and peer-run recovery programs helping to connect individuals to care earlier and prevent crises from escalating. Improving data

collection was also highlighted as a priority, particularly through partnerships with community-based organizations to gather accurate, disaggregated data by race, age, and family status to better identify and close service gaps.

Finally, stakeholders underscored the importance of addressing economic and housing instability through investments in vocational training, trauma-informed care, and interim housing solutions such as tiny home villages. Strengthening tenant protections was also recommended, including expanded "Know Your Rights" education and enhanced legal safeguards to prevent evictions and housing discrimination.

Homelessness: Cross-Measure Questions

1. **Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)**

DEPARTMENT OF MENTAL HEALTH (DMH)

Data used to inform DMH programming and interventions:

- Demographics of clients served across DMH housing programs in Los Angeles County, by race and ethnicity. Source: Los Angeles Homeless Services Authority (LAHSA) 2024 Greater Los Angeles Homeless Count. Includes the number of clients served by DMH housing programs by Service Area and a comparison of DMH Service Areas with the 2024 LAHSA Count.
- Demographics of clients served in MHSA and other dedicated Permanent Supportive Housing (PSH) units.
- Federal Housing Subsidies Unit (FHSU): demographics of clients served and housing retention rates for LACDMH clients in federally subsidized units.
- Demographics of clients served by Housing Supportive Services Program (HSSP) and DMH-funded Intensive Case Management Services (ICM).
- Los Angeles County Homeless Initiative Impact Dashboard: dashboard tallies derived from data maintained by multiple housing and service providers, standardized and analyzed by the Los Angeles County Chief Information Office.

DMH is working to improve homelessness through the following programs and services:

- Housing Investments: As outlined in the housing section, housing investments include but are not limited to: Interim Housing, Behavioral Health Bridging Housing, Community Care Expansion Preservation Program, Federal subsidies including Continuum of Care, and Housing Choice Vouchers through 11 active contracts with the Housing Authority of the City of Los Angeles and Los Angeles County Development Authority.
- Full-Service Partnership
    - ACT: Community-based, multidisciplinary teams support individuals with SMI or co-occurring SMI/SUD who are homeless, high utilizers, and/or justice-involved with significant functional impairments.

    - FACT: An ACT variant with additional training and staffing to serve justice-involved members; teams often deliver both ACT and FACT.
    - FSP-ICM: A team-based, recovery-focused model with lower service intensity than ACT/FACT.
- Peer Respite: Peer respites increase access points across the county, offering non-traditional, distress-focused care for individuals not yet in crisis and providing a local avenue for support.
- Crisis Residential Treatment Program (CRTP): CRTPs provide stabilization as an alternative to emergency services and acute psychiatric care, enabling timely access to higher-acuity settings for those in greater need, offering therapeutic activities and skills to support transitions back to community living.
- Crisis Stabilization: Provides immediate, 24/7 crisis access (walk-ins, Psychiatric Mobile Response Teams, Law Enforcement Drop Off, Urgent Care Centers) to reduce mental health-related ER visits. The goal is to de-escalate crises, connect clients to services, and avoid higher levels of care. Follow-up within 24 hours ensures continued connections or in-home/phone support to link clients to services.
- Law Enforcement Teams (LET): LETs respond to 911 calls related to mental health to connect individuals with services, reduce repeat calls, and prevent hospitalizations.
- Enriched Residential Services (ERS): ERS provides a safety-focused, stable, step-down intervention within the mental health continuum to break cycles of homelessness, crises, and re-hospitalization.
- Homeless Outreach & Mobile Engagement (HOME): HOME serves adults 18+ experiencing chronic unsheltered homelessness with profound mental health needs. It delivers specialized mental health services to secure and sustain housing, addressing deficits in daily living, hygiene, and engagement.
- Prevent Homelessness & Promote Health $(PH)^2$: PH^2 is a joint program by DMH and Housing for Health to address risk factors and build skills that support permanent housing stability and homelessness prevention.
- Veteran & Military Family Services (VMFS): VMFS connects county departments, nonprofits, the VA, and city programs to provide emotional support and specialized mental health services for veterans and families.
- Hollywood 2.0: Hollywood 2.0 is a pioneering pilot in Hollywood, led by LACDMH and Hollywood 4WRD. Multidisciplinary teams collaborate with community partners to deliver comprehensive, person-centered care for people with severe mental illness, leveraging outpatient clinics, interim/permanent housing, and housing-related supports to create a recovery network focused on the person rather than the diagnosis.
- Skid Row Concierge Outreach (SRC): SRC connects individuals experiencing homelessness and mild-to-moderate mental health symptoms in Skid Row to mental health treatment and shelter through field-based care teams and integrated housing case management.
- Interim Housing Outreach Program (IHOP): IHOP deploys multidisciplinary field teams to serve people experiencing homelessness in interim housing sites, addressing gaps in behavioral and physical health treatment, supporting interim housing stability, and facilitating transitions to permanent housing. Services span eight service areas.
- Library Engagement & Access Program (LEAP): LEAP acts as a liaison between LA County Library, DMH, and partner agencies to connect patrons experiencing homelessness and mental illness (and/or co-occurring SUD) to shelter, food, clothing, mental health treatment, and other supports.

- Promotores: The United Mental Health Promoters Program aims to lessen mental health stigma throughout Los Angeles County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with the Department of Mental Health and other resources through culturally sensitive methods.
- Community Partners - United MH Promoters (contracted): A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services.
- UMHP: This project invests in communities through contracting with agencies serving high and highest need areas across the county. Agencies, leveraging their position within the hyperlocal area, recruit, hire, and train staff to serve as trusted representatives and "community member with lived experience." The project utilizes training to build staff skills and support community members' pathway towards goals outlined within the context of Population Health Measures (e.g. reduction in homelessness, institutionalization, justice involvement, removal of children from home, untreated behavioral health conditions and increased school engagement). A composite of services are provided to address community needs such as, outreach/engagement, referral/linkage, psychosocial support activities, and client support services (e.g. housing assistance, household goods, food assistance, diapers, utilities, and other necessities of life).
- Co-Occurring Intellectual/Developmental Disabilities: Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools.

DEPARTMENT OF PUBLIC HEALTH (DPH) – SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC)

Data used to inform DPH-SAPC programming and interventions:

- The Los Angeles Homeless Services Authority (LAHSA) Greater Los Angeles Homeless Count – the annual point-in-time census to estimate the number of people experiencing homelessness.
- DPH – SAPC Annual Report – An annual overview of clients who received SUD treatment in publicly funded treatment programs in Los Angeles County.
- The California Outcome Measurement System (CalOMS) - a data collection and reporting system for substance use disorder (SUD) treatment services. It provides admission, discharge, and annual update data for SUD treatment services.
- DPH-SAPC Claims Data – claims data for SUD treatment services submitted by DPH-SAPC providers.
- LA County Health and Human Services Data - Provides data about health, public health, and services provided to individuals, children, and families.
- LA County Annual HIV Surveillance Report - describes the status of the local HIV epidemic and demonstrates the use of HIV surveillance data to inform prevention,

care, and treatment programs in Los Angeles County.

DPH-SAPC is working to reduce homelessness by growing housing options for individuals with SUD through the following existing programs, services, partnerships, and/or initiatives:

- DPH-SAPC has invested in expanding Recovery Bridge Housing (RBH) and Recovery Housing (RH). These benefits offer PEH concurrently participating in SUD treatment services with up-to 360 days of RBH, and those that have engaged in SUD treatment and/or RBH in the last 90 days at a SAPC provider agency for up-to 365 days of RH. While it is encouraged, concurrent enrollment in treatment is not a condition of residing in RH.
- DPH-SAPC introduced Housing Navigation Services in FY 2024-25 to support and connect PEH to stable housing options. Housing navigators help individuals prepare, find, move into, and retain affordable and permanent housing opportunities.

The following are related services and programs that enable DPH-SAPC to engage with PEH and connect them to housing and housing navigation services:

- DPH-SAPC's Harm Reduction programs remove barriers to treatment and housing services so that the SUD population can access the services needed to transition towards stable housing.
- DPH-SAPC's Directly-Operated Field-Based SUD Services team partners with existing field-based teams to ensure LA County residents experiencing homelessness have access to SUD services in field-based settings.

2. **The following is a category or categories of funding that the county is using to address the homelessness goal:**
    - BHSA Behavioral Health Services and Supports (BHSS)
    - BHSA Full Services Partnership (FSP)
    - BHSA Housing Interventions
    - 2011 Realignment
    - Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
    - Substance Use Block Grant (SUBG)
    - Community Mental Health Block Grant (MHBG)
    - Other: Opioid Settlement Funds (OSF), Measure J: Care First Community Investment (CFCI), Tobacco Settlement Funds, Federal Grant: CDC OD2A

Institutionalization

[Context text: Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.

Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no

longer – the least restrictive environment. (no action)]

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

1. **How does your county status compare to the statewide rate/average?**
    a. **For adults/older adults:** above
    b. **For children/youth:** N/A
2. **What disparities did you identify across demographic groups or special populations?** Race or Ethnicity and Sex

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

1. **How does your county status compare to the statewide rate/average?**
    a. **14-day involuntary detention rates per 10,000:** N/A
    b. **30-day involuntary detention rates per 10,000:** N/A
    c. **180-day post-certification involuntary detention rates per 10,000:** N/A
2. **What disparities did you identify across demographic groups or special populations?** No disparities data available

Conservatorships, FY 2021 - 2022

1. **How does your county status compare to the statewide rate/average?**
    a. **Temporary Conservatorships:** above
    b. **Permanent Conservatorships:** above
2. **What disparities did you identify across demographic groups or special populations?** No disparities data available

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023

1. **How does your county status compare to the statewide rate/average?**
    a. **Crisis Intervention**
        i. **For adults/older adults:** above
        ii. **For children/youth:** above
    b. **Crisis Residential Treatment Services**
        i. **For adults/older adults:** above
        ii. **For children/youth:** same
    c. **Crisis Stabilization**
        i. **For adults/older adults:** below
        ii. **For children/youth:** below
2. **What disparities did you identify across demographic groups or special populations?** Race or Ethnicity and Sex

Institutionalization: Disparities Analysis

1. **For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis**

Measure 1 examines disparities in average inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over in Los Angeles County in 2022, disaggregated by race. The data indicate that Hispanic adults are underrepresented, with an average of 0.44 inpatient administrative days. In contrast, Black and White adults are overrepresented, with averages of 2.87 and 2.09 inpatient administrative days, respectively.

Measure 2 examines disparities in average inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over in Los Angeles County in 2022, disaggregated by sex. The data show that women are underrepresented, with an average of 0.84 inpatient administrative days. In contrast, men are overrepresented, with an average of 1.18 inpatient administrative days.

Supplemental Measure 1 compares the average number of inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over between Los Angeles County and the statewide average. In 2022, Los Angeles County reported an average of 35.3 inpatient administrative days, which exceeds the statewide average of 25.6 days

Supplemental Measure 2 examines average inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over by race in 2022, comparing Los Angeles County with statewide averages. Hispanic adults in Los Angeles County experienced an average of 24.54 inpatient administrative days, slightly higher than the statewide average of 23.1 days. White adults had an average of 27.32 days in the county, compared to 22.68 days statewide. Black adults averaged 24.73 inpatient administrative days in Los Angeles County, exceeding the statewide average of 20.62 days. Individuals with unknown race had an average of 30.17 inpatient administrative days in the county, which is lower than the statewide average of 32.78 days.

Supplemental Measure 3 examines average inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over by sex in 2022, comparing Los Angeles County with statewide averages. In Los Angeles County, males experienced an average of 26.84 inpatient administrative days, compared to a statewide average of 24.48 days. Females in the county had a higher average of 29.22 inpatient administrative days, substantially exceeding the statewide average of 21.93 days.

Supplemental Measure 4 presents average inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over by age group in 2022, comparing Los Angeles County with statewide averages. Adults ages 21‑32 in Los Angeles County experienced an average of 24.73 inpatient administrative days, higher than the statewide average of 19.81 days. Those ages 33‑44 averaged 24.63 days in the county, compared to 21.11 days statewide. For adults ages 45‑56, the county average was 26.28 days, slightly below the statewide average of 26.75 days. A pronounced disparity is observed among adults ages 57‑68, who experienced an average of 52.59 inpatient administrative days in Los Angeles County, substantially exceeding the statewide average of 33.42 days. Data for adults age 69 and older were not available at the county level, while the statewide average for this age group was 25.88 days.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified several factors driving these disparities across the system of care. Incomplete data systems, including high numbers of "unknown" entries and missing demographic categories, obscure who is most in need of services. Exclusion in reporting further compounds this issue, as Asian Pacific Islander communities and certain age groups are not consistently counted or disaggregated. Weak discharge planning was also cited as a significant concern, with patients often leaving institutional settings without stable housing, follow-up appointments, or a clear recovery plan.

In addition, administrative bottlenecks contribute to prolonged hospital stays, as lengthy placement processes keep beds occupied and limit access for new admissions. Stakeholders also noted persistent communication gaps among hospitals, families, and community-based care teams, resulting in fragmented and poorly coordinated care. Limited availability of specialized services—particularly for older adults, individuals with dementia or traumatic brain injuries, and those with severe substance use disorders—further exacerbates inequities. Concerns about the quality of care were also raised, with institutional settings frequently emphasizing containment rather than treatment and recovery. Finally, stakeholders highlighted misaligned performance metrics, noting that existing dashboards prioritize time spent in care rather than meaningful recovery outcomes or long-term community stability.

Overarching Solutions: To address these disparities, stakeholders proposed a comprehensive set of system-level solutions focused on data integrity, care transitions, capacity, and accountability. First, they emphasized the need to improve data quality by collecting complete demographic information–including race, ethnicity, age, and language–and reducing the use of "unknown" categories through staff training and the use of clear, standardized data-collection scripts. Ensuring that Asian Pacific Islander and other historically undercounted communities are consistently included in all datasets and reports was also identified as essential for accurately identifying and addressing inequities.

Stakeholders further highlighted the importance of strengthening transitions from inpatient and institutional settings by requiring clear housing plans, scheduled follow-up visits within seven days of discharge, continuity of medications, and meaningful family involvement prior to discharge. To reduce excessive administrative days, they recommended operational strategies such as daily placement huddles, fast-track pathways for complex cases, and real-time bed inventories to improve system flow and reduce unnecessary delays.

Expanding system capacity was another priority, with calls to invest in geriatric behavioral health beds, co-occurring substance use disorder programs, and flexible funding mechanisms to open additional placements more quickly. Building stronger community-based supports—including expanded Full-Service Partnerships, peer support groups, and self-help connections—was identified as a strategy to reduce rehospitalizations and support long-term stability. Stakeholders also stressed the need to improve care quality within institutional settings by requiring active treatment components, such as therapy, group services, and individualized recovery goals, rather than focusing solely on containment.

Finally, stakeholders underscored the importance of aligning measurement and financing with desired outcomes. They recommended tracking meaningful indicators such as

readmissions, timely follow-up, community tenure, and patient-stated goals, with data disaggregated by race, age, and language. In parallel, they called for fair and sustainable provider funding, including increased reimbursement rates and the use of block contracts or flexible funding, to enable community-based programs to rapidly add staff and expand service capacity.

Institutionalization: Cross-Measure Questions

1. **What additional local data do you have on the status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)**

   DMH tracks use of locked facilities (such as SNF-STP, MHRC and State hospital beds). These facilities are primarily used when a judge orders a locked treatment setting, as a step down from State hospital, or a hospital when it is medically necessary.

2. **Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the county is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes**)

   DMH

   DMH is working to reduce institutionalization through the following programs and services:

   - Clubhouse: The Clubhouse model is an evidence-based psychosocial rehabilitation approach that reduces institutionalization by providing community-based supports, meaningful work, and social connection for people with SMI.
   - Full-Service Partnership:
     - ACT: Community-based, multidisciplinary teams support individuals with SMI or co-occurring SMI/SUD who are homeless, high utilizers, and/or justice-involved with significant functional impairments.
     - FACT: An ACT variant with additional training and staffing to serve justice-involved members; teams often deliver both ACT and FACT.
     - FSP-ICM: A team-based, recovery-focused model with lower service intensity than ACT/FACT.
   - Peer Respite: The Peer Respite program reduces hospitalizations by offering a voluntary, less-coercive alternative to acute care in a safe, home-like environment, with support from peers who have lived experience. Research shows peer respite participants are less likely to use inpatient or emergency services and often experience improved recovery outcomes.
   - Crisis Residential Treatment Program (CRTP): CRTPs provide stabilization as an alternative to emergency services and acute psychiatric facilities, ensuring access to higher-acuity settings for those in greater need. They offer therapeutic activities and skills to support transitions back to community living.
   - Crisis Stabilization: Provides immediate, 24/7 crisis access (walk-ins, Psychiatric Mobile Response Teams [PMRTs], Law Enforcement Drop Off, Urgent Care Centers [UCCs])

to reduce mental health–related ER visits. The goal is to de-escalate crises, connect clients to services, and avoid higher levels of care. Follow-up within 24 hours ensures ongoing connections or in-home/phone support to link clients to services.

- Day Treatment Intensive/Day Rehabilitation (DTI/DR): DTI/DR provides an alternative to hospitalization and helps individuals live within the community. Intensive Outpatient Services support semi-independent or independent living for those with chronic psychiatric impairments.
- EPI-LA Early Psychosis/Coordinated Specialty Care – First Episode Psychosis: Serving youth and adults aged 12–40 with attenuated psychosis or a first-episode psychosis, EPI-LA prioritizes rapid intake and timely access to medications when needed. The program currently spans eight provider sites with plans to expand. Funding: MHSA/BHSA Early Intervention + EPSDT/Medi-Cal.
- Enriched Residential Services (ERS) provides a safety-focused, stable, step-down intervention within the mental health continuum to break cycles of homelessness, crises, and re-hospitalization.
- Homeless Outreach & Mobile Engagement (HOME) HOME serves adults 18+ experiencing chronic unsheltered homelessness with profound mental health needs. These individuals may have deficits in food security, clothing, shelter, hygiene, and communication, and are often highly avoidant of services. HOME provides specialized mental health services to secure and sustain housing. Funding: MHSA, Medi-Cal.
- Community Re-entry Programs (soon to be FACT): CRP is a forensic program addressing the needs of formerly incarcerated individuals with mental illness and co-occurring substance use issues. The goal is reintegration through mental health treatment, peer support, employment/education opportunities, and strengthened family/social connections.
- Suicide Prevention, Intervention and Postvention: Partners in Suicide Prevention (PSP) is a program focused on suicide prevention, intervention, and postvention across communities and service systems. The program strengthens awareness, early identification of suicide risk, and create linkages/referrals. PSP also supports effective postvention efforts to promote healing, reduce stigma, and prevent future suicide risk through educational workshops, resources, and partnership.
- Co-Occurring Intellectual/Developmental Disabilities: Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.

3. **The following is a category or categories of funding that the county is using to address the institutionalization goal:**
    - BHSA Behavioral Health Services and Supports (BHSS)
    - BHSA Full Services Partnership (FSP)
    - BHSA Housing Interventions

- Community Mental Health Block Grant (MHBG)
- Other: EPSDT/Medi-cal

Justice-Involvement

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023

1. **How does your county status compare to the statewide rate/average?**
    a. **For adults/older adults:** below
    b. **For juveniles:** below
2. **What disparities did you identify across demographic groups or special populations?** Race or Ethnicity and Sex

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

1. **How does your county status compare to the statewide rate/average?** below
2. **What disparities did you identify across demographic groups or special populations?** Gender and Race or Ethnicity

Incompetent to Stand Trial (IST) Count (Department of State Hospitals (DSH)), FY 2023

Note: The IST count includes all programs funded by DSH, including state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

1. **How does your county status compare to the statewide rate/average?** above
2. **What disparities did you identify across demographic groups or special populations?** No disparities data available

Justice-Involvement: Disparities Analysis

1. **For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis**

    Primary Measure 1 presents disparity data for arrest counts for felony and misdemeanor offenses among adults ages 18 and older who are under probation supervision in Los Angeles County in 2022, disaggregated by race. The data indicate that Hispanic adults are underrepresented in arrest counts, with a disparity ratio of 0.93. In contrast, Black and White adults are overrepresented, with disparity ratios of 2.12 and 1.45, respectively.

    Primary Measure 2 presents disparity data for arrest counts for felony and misdemeanor offenses among adults ages 18 and older under probation supervision in Los Angeles County in 2022, disaggregated by sex. The data show that females are underrepresented in

arrest counts, with a disparity ratio of 0.40. In contrast, males are overrepresented, with a disparity ratio of 1.67.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified multiple, interrelated factors driving disparities in arrest outcomes. Systemic racism in policing was cited as a primary contributor, with Black and Latino communities experiencing higher arrest rates than other groups. These patterns are rooted in historical inequities, including long-standing over-policing and racial profiling in low-income neighborhoods. Stakeholders also pointed to the criminalization of mental health conditions and substance use disorders, which often results in law enforcement responses in situations that would be better addressed through health and social services. Limited access to high-quality legal defense for low-income individuals and families further exacerbates these disparities, increasing the likelihood of adverse justice outcomes. Family-level factors were also noted, including trauma and the absence of positive role models, which can contribute to early and ongoing justice system involvement among youth. Economic pressures on caregivers—many of whom work multiple jobs—can leave young people with limited supervision and support. Stakeholders additionally highlighted gender disparities in arrest rates, with men disproportionately impacted, alongside growing arrest rates among women. Finally, a lack of community-based supports, such as stable housing, educational opportunities, and access to healthcare, was identified as a structural driver that reinforces justice system involvement.

Overarching Solutions: To address these disparities, stakeholders proposed a comprehensive set of solutions focused on prevention, diversion, and community investment. Central to these recommendations is the expansion of diversion programs and the decriminalization of mental health and substance use–related issues, reducing reliance on punitive responses. Stakeholders also emphasized increasing access to mental health courts and restorative justice programs as alternatives that prioritize treatment, accountability, and healing over incarceration.

Additional strategies include expanding community-based resources for youth and families, alongside free after-school programs and childcare services to reduce young people's exposure to crime and justice system involvement. Strengthening family supports was also identified as critical, with recommendations to provide counseling, legal assistance, and housing stability services to address underlying stressors. Stakeholders highlighted the importance of improving data collection by disaggregating arrest data by race, age, and socioeconomic status, and by integrating multiple data sources—such as probation, treatment, and law enforcement—to gain a more comprehensive understanding of disparities.

Finally, stakeholders called for a shift in funding away from prisons and law enforcement and toward prevention, treatment, and community-based programs. Tailoring evidence-based practices to the cultural and contextual needs of specific populations, combined with ongoing outreach efforts to reduce stigma and increase awareness of available programs, was identified as essential to advancing equity and reducing justice system disparities.

Justice-Involvement: Cross-Measure Questions

1. **Please describe what programs, services, partnerships, or initiatives the county is**

planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Department of Mental Health (DMH)

Data used to inform DMH programming and interventions:

- Early Psychosis Learning Healthcare Network: Cost and utilization data from a preliminary analysis comparing clients in Early Psychosis care with those receiving Standard Care.
- Countywide police and mental health co-responder teams in Los Angeles County (LACDMH staff with local police): demographics, incident counts, and hospitalization data to evaluate interventions for a diverse population.
- Los Angeles County Office of Diversion and Reentry (ODR) metrics and outcomes:
  - Misdemeanor Incompetent to Stand Trial (MIST) Diversion
  - Felony Incompetent to Stand Trial Program (FIST) Program
- County of Los Angeles Equity Explorer: Criminal justice and safety (detentions, referrals, crisis interventions)
- Los Angeles County data sources from state and local justice and corrections agencies, including:
  - California Board of State and Community Corrections (BSCC) data.
  - Los Angeles County Justice Data Center data.
  - Los Angeles County Probation Department annual reports.
  - Los Angeles County Sheriff's Department custody reports.

LACDMH provides an alternative crisis response option designed to reduce interactions with the justice system for individuals experiencing a mental health crisis. The department tracks trends using data from alternative crisis response pathways to inform program and service investments which includes IST incidence and transitions (court to restoration to hospital vs. community care), bed occupancy, engagement in community treatment, and recidivism indicators. This is a hypothetical, non-causal exploration intended to guide planning with the aim of potentially reducing court involvement and overall IST numbers, though such outcomes fall outside the LACDMH's purview. We incorporate upstream prevention signals (e.g., Early Psychosis) as potential levers to reduce crisis events, while acknowledging measurement challenges.

DMH is working to decrease justice involvement through the following programs and services:

- Full-Service Partnership (ACT/FACT & FSP-ICM)
  - ACT (Assertive Community Treatment): Multidisciplinary, community-based teams support individuals with SMI or co-occurring SMI/SUD who are homeless, high utilizers, and/or justice-involved with significant functional impairments. ACT helps

individuals manage symptoms, function in the community, obtain/maintain employment and housing, and build strong social relationships.
    - FACT (Forensic ACT): An ACT variant with additional training and staffing to address the needs of justice-involved members. In many cases, teams deliver both ACT and FACT, and FACT teams include a member with lived criminal-justice experience.
    - FSP-ICM: A team-based, recovery-focused model with lower intensity than ACT/FACT. Services are delivered by multidisciplinary teams to individuals with SMI or co-occurring SMI/SUD who are homeless, high utilizers, justice-involved, at risk, or with moderate functional impairments.
- Peer Respite: Peer respites focus on crisis diversion by providing a space for individuals in distress that avoids hospitalization or law-enforcement involvement.
- CRP is a forensic program addressing the needs of formerly incarcerated individuals with mental illness and co-occurring substance use issues. The goal is reintegration through mental health treatment, peer support, employment/education opportunities, and strengthened family/social connections.
- Clubhouse: The Clubhouse model provides community-based supports, employment opportunities, and social connections for people with SMI by addressing social isolation and unemployment—two major factors in recidivism. Through meaningful work and employment support, members develop skills, dignity, and a sense of purpose. A study in the Psychiatric Rehabilitation Journal found that criminal justice system involvement was substantially diminished during and after Clubhouse membership.
- Crisis Residential Treatment Program (CRTP): CRTPs offer a therapeutic setting for individuals experiencing mental health crises who might otherwise be incarcerated, providing stabilization and a pathway to community reintegration.
- Crisis Stabilization: Crisis Stabilization Units provide immediate, 24/7 access to de-escalate crises and connect families/caregivers to services, offering Crisis Stabilization as an alternative destination to jail. When appropriate, families can transport loved ones to de-escalate crises without 911 involvement.
- Law Enforcement Teams (LET): LETs deliver real-time crisis response and connection to mental health services in the community, aiming to reduce arrests and hospitalizations.
- Mental Health Court Linkage: Collaboration with the courts to guide individuals to needed care as an alternative to incarceration settings
- Day Treatment Intensive/Day Rehabilitation (DTI/DR): DTI/DR expands non-institutional, community-based treatment, enabling individuals to engage in care, learn new skills, and reduce involvement with the criminal justice system.
- EPI-LA Early Psychosis / Coordinated Specialty Care – First Episode Psychosis: Serving youth and adults aged 12–40 with attenuated psychosis or first-episode psychosis, EPI-LA prioritizes rapid intake and timely access to medications as needed. The program currently spans eight provider sites and plans to expand to high-need areas. Funding: MHSA/BHSA Early Intervention + EPSDT/Medi-Cal.
- Enriched Residential Services (ERS): ERS addresses root causes of justice involvement—untreated mental illness and housing instability—by providing a community-based, intensive treatment setting as an alternative to jail for individuals with behavioral health needs who are deemed incompetent to stand trial or charged with low-level, non-violent offenses. ERS supports stabilization and a successful transition to community living.

- DYD - Credible Messengers: This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services. Services are targeted to Youth 18-25 and include training of messenger peers, needs assessment of youth to paired mentors, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral and resource linkage.
- Community Partners - United MH Promoters (contracted): A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services (e.g., outreach/engagement, training) Focuses on strengthening our communities and creating career paths for community members The program provides eight UMHP teams/contractor agencies per Supervisory District with nine staff members per team.
- UMHP: This project invests in communities through contracting agencies serving high and highest need areas across the county. Agencies, leveraging their position within the hyperlocal area, recruit, hire, and train staff to serve as trusted representatives and "community member with lived experience." The project utilizes training to build staff skills and support community members' pathway towards goals outlined within the context of Population Health Measures (e.g. reduction in homelessness, institutionalization, justice involvement, removal of children from home, untreated behavioral health conditions and increased school engagement). A composite of services is provided to address community needs such as, outreach/engagement, referral/linkage, psychosocial support activities, and client support services (e.g. housing assistance, household goods, food assistance, diapers, utilities, and other necessities of life).
- Co-Occurring Intellectual/Developmental Disabilities: Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.

DEPARTMENT OF PUBLIC HEALTH-SAPC

Data used to inform DPH-SAPC programming and interventions:

- The California Outcome Measurement System (CalOMS) - a data collection and reporting system for substance use disorder (SUD) treatment services. It provides admission, discharge, and annual update data for SUD treatment services.
- DPH-SAPC Claims Data – claims data for SUD treatment services submitted by DPH-SAPC providers.
- In-Custody to Community Referral Program (ICRP) Source List – a list of partners and organizations that ICRP works with to link clients to SUD services.
- Co-Occurring Integrated Care Network (COIN Program) Source List - a list of partners and organizations that COIN works with to link clients to SUD services.

DPH-SAPC is working to reduce the level of justice involvement for those living significant behavioral health needs by participating in the following existing programs, services, partnerships, and/or initiatives:

- DPH-SAPC and its providers work with LAC-Probation to navigate the protocols at Juvenile Halls/Camps and advocate for appropriate youth SUD services. DPH-SAPC collaborates with probation to provide direct referrals and ensure that SUD treatment for in-custody individuals transitioning to the community are coordinated and delivered with a warm handoff.
- The Alternatives to Incarceration (ATI) Rapid Diversion Program (RDP) is led by the LA County CEO's Alternatives to Incarceration office in partnership with DPH-SAPC contracted providers, Public Defender, City Attorney, District Attorney, and LA Superior Courts. RDP supports defendants experiencing mental health illness, SUD, and co-occurring disorders by diverting them from the justice system into treatment. If the defendant successfully completes treatment, criminal charges will be dismissed.
- DPH-SAPC partners with Community Collaborative Courts (CCC), multi-disciplinary and resource intensive responses to addressing the needs of veterans, persons experiencing chronic homelessness, individuals with a mental illness, victims of sex trafficking, transitional age at-risk youth, and individuals with a SUD.
- In-Custody to Community Referral Program (ICRP) is a partnership program between DPH-SAPC and the Department of Health Services, Correctional Health Services and Whole Person Care, aimed at initiating connections to SUD treatment services and referral of inmates transitioning from custody into the community. DHS-CHS counselors collaborate with SAPC's provider network, coordinating the reintegration of inmates and ensuring a warm handoff to the appropriate level of care.
- Law Enforcement Assisted Diversion (LEAD) Program is a pre-arrest community-based diversion model led by the Office of Diversion and Reentry, with DPH-SAPC contracted providers, the Sherriff's Department and select community-based organizations. LEAD diverts individuals with repeated low-level drug related offenses at the earliest contact with law enforcement to harm reduction-based case management and social services as an alternative to incarceration. CENS counselors provide substance use disorder screening and linkage to treatment at designated co-locations.
- Sentenced Offender Drug Court (SODC) was established in 1998 as an intensive SUD treatment approach. This program includes a mandatory in-custody treatment approach for 90-days in county jail followed by community based, court supervised SUD residential and/or outpatient treatment services for convicted, non-violent felony offenders who are at high risk of returning to incarceration.
- The Los Angeles County Adult Drug Court (ADC) Program addresses the SUD needs of individuals cycling through the justice system. Through a partnership with the Los Angeles Superior Court, District Attorney's Office, Pubic Defenders' Office and DPH-SAPC contracted Community-Based SUD treatment providers, the ADC provides integrated drug treatment to promote long-term recovery and reduce costs through collaborative efforts of multiple judicial and treatment entities. The ADC addresses the needs of substance abusing individuals who are convicted of felonies and misdemeanors placed on formal probation in lieu of incarceration.
- DPH-SAPC, Probation and DMH implemented the Co-Occurring Integrated Care Network (COIN) program in 2015. COIN provides integrated SUD and mental health treatment to AB 109 participants who have a chronic SUD and severe and persistent mental illness. Clients are referred by the Los Angeles County Superior Court, Revocation Court (Division 83), for residential treatment.
- The Substance Treatment and Re-entry Transition Community (START-Community)

program offers eligible inmates the opportunity to complete the final 90 days of their sentence in a community-based SUD residential treatment facility. Individuals participating in START-Community will remain under the supervision of the Los Angeles County Sheriff's Department for the duration of their treatment. Upon completion/release, step down services including outpatient treatment and/or recovery support services are offered on a voluntary basis.

The following are related services and programs that address at risk or justice-involved populations:

- DPH-SAPC media and education campaigns serve an essential purpose in exposing individuals and communities to messaging that promotes risk reduction of substance use and encourages positive behavior change. These media campaigns use data and community-driven strategies to provide effective traditional, social and other marketing approaches that target high-risk geographic areas. Raising awareness and education can help prevent behaviors that increase the risk of justice involvement.
- DPH-SAPC's BRIDGE program (Building Relationships, Inspiring Development, Growing Engagement) is a family-focused initiative that enhances providers' capacity to deliver supportive services for caregivers and families of youth, particularly youth with complex needs, juvenile-justice involved youth, and those recently released from detention or secure facilities.

2. **The following is a category or categories of funding that the county is using to address the justice-involvement goal:**
   - BHSA Behavioral Health Services and Supports (BHSS)
   - BHSA Full Services Partnership (FSP)
   - BHSA Housing Interventions
   - Community Mental Health Block Grant (MHBG)
   - Substance Use Block Grant (SUBG)
   - Other: Opioid Settlement Funds, Care First Community Investment (CFCI), Tobacco Settlement Funds, Federal Grant: CDC OD2A, AB 109, Juvenile Justice Crime Prevention Act & Youthful Offender Block Grant, MacArthur Foundation's Safety and Justice Challenge, SAPC in-kind funding, AB 10

Removal Of Children from Home

Removal of Children from Home: Primary Measures

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025

1. **How does your county status compare to the statewide rate?** above
2. **What disparities did you identify across demographic groups or special populations?** Race or Ethnicity and Sex

Removal of Children from Home: Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

1. **How does your county status compare to the statewide rate?** above
2. **What disparities did you identify across demographic groups or special populations?**

Race or Ethnicity and Sex

Child Maltreatment Substantiations (CWIP), 2022

1. **How does your county status compare to the statewide rate?** above
2. **What disparities did you identify across demographic groups or special populations?** Race or Ethnicity and Sex

Removal of Children from Home: Disparities Analysis

1. **For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis**

   Measure 1 examines disparities in point-in-time and in-care counts of children in foster care, including all children with an open child welfare or probation-supervised placement episode in the system. The data show that White and Asian/Pacific Islander children are underrepresented in foster care, with disparity ratios of 0.76 and 0.18, respectively. In contrast, Alaskan Native/American Indian, African American, and Hispanic children are overrepresented, with disparity ratios of 3.96, 2.83, and 1.01, respectively.

   Measure 2 examines disparities in point-in-time and in-care counts of children in foster care, including all children with an open child welfare or probation-supervised placement episode in the system, disaggregated by sex. The data indicate that female children are slightly underrepresented, with a disparity ratio of 0.97. In contrast, male children are slightly overrepresented, with a disparity ratio of 1.04.

   STAKEHOLDER PERSPECTIVES

   Factors Driving Disparities: Stakeholders identified several factors driving disparities in child welfare system involvement. Systemic racism was cited as a foundational issue, with biased standards for parenting and cultural misunderstandings contributing to higher rates of child removal in communities of color. Socioeconomic challenges—including poverty, single-parent households, literacy gaps, and limited access to adequate nutrition and prenatal care—were also identified as significant risk factors that increase family vulnerability. In addition, stakeholders raised concerns about reporting practices, noting that reports from schools and educators are often unsubstantiated yet still trigger child welfare involvement. Persistent data gaps further complicate efforts to understand and address disparities, as missing contextual information and unclear definitions obscure the root causes of system contact. Finally, stakeholders emphasized the enduring impact of historical harm, including past practices of removing children from marginalized communities, which continue to shape present-day policies, perceptions, and outcomes.

   Overarching Solutions: To address these disparities, stakeholders proposed a set of solutions centered on cultural responsiveness, coordination, and family support. Key recommendations include expanding culturally responsive services through partnerships with trusted community-based and faith-based organizations and incorporating cultural advocates and brokers to better support families from diverse backgrounds. Stakeholders also emphasized the importance of stronger system collaboration across agencies such as DCFS, schools, and community organizations to share resources, align practices, and

reduce siloed decision-making. In addition, stakeholders called for enhanced navigation support to help families access needed services more easily and without stigma or unnecessary barriers. Policy and practice changes were also recommended, including reevaluating child removal standards, expanding diversion programs, and reducing unnecessary removals whenever safe and appropriate. Improving service accessibility was identified as another priority, with suggestions to offer in-home and virtual services, low-barrier clinics, and culturally specific options tailored to family needs. Finally, stakeholders underscored the need to strengthen workforce diversity by increasing representation of staff from communities most impacted by the child welfare system, in order to build trust and improve outcomes.

Removal of Children from Home: Cross-Measure Questions

1. **Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of the removal of children from home. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)**

DMH

Data used to inform DMH programming and interventions:

- Mobile crisis response teams: incident data by service area, time of day, referral source; demographics; incident outcomes; evaluations for involuntary detention and triage of high-risk or mentally ill individuals.
- PAPF data: Los Angeles County data collected using the Parents' Assessment of Protective Factors (PAPF).
- Full Service Partnership (FSP) data: client-level information including hospitalizations, education level, physical health, and justice involvement, tracked before and after FSP services.
- Brief Universal Prevention Program Survey (BUPPS): data from this LACDMH tool measuring protective factors to assess the impact of prevention programs on individuals who accessed prevention services.
- County of Los Angeles Equity Explorer: Education, Department of Children and Family service investigations, referrals, and removals.

DMH is working to decrease removal of children from home through the following programs and services:

- Specialized Foster Care (SFC): SFC offers mental health services and linkage for child welfare–involved youth and families in the community and directly operated clinics. The program aims to prevent removals or minimize multiple placements for youth already removed from home.
- Children's Full-Service Partnership including High Fidelity Wraparound.
- Children and Youth Wellbeing Services (CYWS): CYWS provides targeted, comprehensive care for children, youth, and TAY (Transition Age Youth) ages birth through 25 years identified with complex mental health conditions who meet criteria

to access Specialty Mental Health Services. The services are tailored to address severe behavioral health disorders, improve functional impairment, and increase developmentally appropriate coping skills. Services are delivered by multidisciplinary staff in clinic and field-based settings utilizing evidence-based and community defined practices. Outpatient specialty mental health services aim to decrease symptoms, prevent the necessity for higher level of care, and promote wellbeing, all while supporting children, youth, and TAY, to remain integrated within their families and communities. Family Preservation (FP): FP serves families at risk of or experiencing problems in family functioning, with the goal of reducing out-of-home placement by delivering mental health services and a range of community-based supports to the child/youth and family.

- First 5 - Home Visitation: Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. The programs offer home visits delivered weekly or every two weeks to promote positive parent– child relationships and healthy attachment. This Home Visiting Program will prioritize areas where data indicates there is a high number of families involved with child protective services.
- DCFS - Prevention and Aftercare: Ten leading community agencies proving a variety of services to the community to empower, advocate, educate, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of ACEs and social determinants of health.
- Antelope Valley Community Family Resource Centers (CFRC on wheels): The Centers are intended to reimagine service delivery, create career pathways, reduce stigma while also reducing risk factors, improving protective factors and to embrace children, families and communities as change agents. The AV CFRC is designed to create a coordinated (public/private) community owned and driven space, or network of spaces, where families and individuals in the AV can easily access the services they need to enhance their wellbeing.
- CFRCs (Supervisorial Districts 1 - 5): The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and families in the community it serves.
- Friends of the Children: FOTC aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at highest risk of entering foster care. FOTC provides professional 1:1 mentorship to children for 12+ years; starting around the age of 4-6 years old. Mentors are trained to support caregivers, promote self-advocacy and create opportunities for culturally responsive community and peer-to-peer connections.
- Promotores: The United Mental Health Promoters Program aims to lessen mental health stigma throughout Los Angeles County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with the Department of Mental Health and other resources through culturally sensitive methods. Their services encompass community outreach, facilitating mental health workshops to combat stigma, making referrals to mental health services, and providing mental health support and triage services based on community needs.

- Community Partners - United MH Promoters (contracted): A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services (e.g., outreach/engagement, training) Focuses on strengthening our communities and creating career paths for community members.
- Birth to Five Mental Health: The Birth-to-5 Team provides capacity building support including workshops, technical assistance, and reflective consultation to help clinicians effectively support young children and their families. These supports increase access to early relationship centered care and strengthen clinicians' ability to identify developmental and behavioral health needs and connect families to appropriate resources. By addressing concerns early and strengthening caregiver child relationships the Birth-to-5 Team helps prevent escalation to crisis driven responses such as higher levels of care or later justice or DCFS involvement. This early intervention stabilizes families and supports children in remaining safely at home and promotes stronger engagement in early learning and school settings.
- Perinatal Parental Mental Health: The Parental Perinatal Mental Health (PPMH) Program is a countywide, multi-layered clinical support initiative designed to strengthen perinatal mental health care in directly operated clinics. The program provides comprehensive training, ongoing coaching, reflective supervision, and technical assistance to support high-quality implementation. PPMH offerings include foundational and advanced web-based courses, evidence-based interventions, specialized trainings to support families during the perinatal period, monthly consultation calls, and a certification pathway to build long-term expertise and sustainability in perinatal mental health care.
- Parent Partner Training Academy: Parent Partner training improves the skills of the Peer Support Specialists (PSS) working with the parents/caregivers of the children receiving services. Improved training of the PSS improves parent/caregiver ability to access needed programs, resources, and additional support which reduces risks of child being removed from home and justice involvement/institutionalization. PSS are better trained to help families access programs to receive treatment for untreated BH health conditions such as Regional Center and increase School Engagement.
- UMHP: This project invests in communities through contracting with agencies serving high and highest need areas across the county. Agencies, leveraging their position within the hyperlocal area, recruit, hire, and train staff to serve as trusted representatives and "community member with lived experience." The project utilizes training to build staff skills and support community members' pathway towards goals outlined within the context of Population Health Measures (e.g. reduction in homelessness, institutionalization, justice involvement, removal of children from home, untreated behavioral health conditions and increased school engagement). A composite of services are provided to address community needs such as, outreach/engagement, referral/linkage, psychosocial support activities, and client support services (e.g. housing assistance, household goods, food assistance, diapers, utilities, and other necessities of life).
- Co-Occurring Intellectual/Developmental Disabilities: Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven

measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.

- Crisis Teams: PMRT provides community-based crisis services for child welfare youth and families, with the aim of preventing families from entering the Child Welfare System or avoiding additional placements for families already involved.

DEPARTMENT OF PUBLIC HEALTH – SAPC

Data used to inform DPH-SAPC programming and interventions:

- The California Outcome Measurement System (CalOMS) - a data collection and reporting system for substance use disorder (SUD) treatment services. It provides admission, discharge, and annual update data for SUD treatment services.
- DPH-SAPC Claims Data – claims data for SUD treatment services submitted by DPH-SAPC providers.

DPH-SAPC is working to reduce removal of children from home through the following existing programs, services, partnerships, and/or initiatives:

- DPH-SAPC's Pregnant and Parenting Women (PPW) network offers SUD treatment, housing and supportive services, that includes dedicated recovery bridge housing (RBH) beds for PPW clients and their children countywide. RBH is available for up-to five accompanying children (aged 0-16) with a benefit of up-to 360 days. These services are provided to the parent and child(ren) in accordance with DHCS's Substance Use Disorder Perinatal Practice Guidelines. Services under the PPW program include expanded services to pregnant, postpartum, and parenting women and their dependent children, ensuring access at all levels of care, inclusive of dedicated services available to the children, which include care coordination, child-care, and transportation services. Increasing availability and access to care ensures a child's well-being and decreases the risk of child removal from the home.
- DPH-SAPC participates in Recovery Support Court, which assists Department of Children and Family Services involved parents in abstaining from substance use and maintaining recovery. Parents receive counseling in different areas including SUD counseling, and mental health services. These services help reduce the risk of being removed from the home for at risk children.
- DPH-SAPC initiated the Recovery Bridge Housing for fathers with dependent children (RBH-DADS) in April 2025. Like RBH for the PPW population, the RBH-Dads is designed to provide temporary housing for men who are receiving outpatient SUD treatment with up to five accompanying children (aged 0-16). The program is intended to support families affected by SUD to remain together, and for those with involvement with the Department of Children and Family Services (DCFS), to work towards reunification. The RBH-DADS program is planned for full implementation across the county by calendar year 2026.

2. **The following is a category or categories of funding that the county is using to address the removal of children from home goal**
    - BHSA Behavioral Health Services and Supports (BHSS)
    - 2011 Realignment

- Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
- Substance Use Block Grant (SUBG)
- Other: EPSDT/Medi-cal

Untreated Behavioral Health Conditions

Untreated Behavioral Health Conditions: Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022

1. **How does your county status compare to the statewide rate/average?**
    a. **For the full population measured:** below
2. **What disparities did you identify across demographic groups or special populations?**
   No disparities data available

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022

1. **How does your county status compare to the statewide rate/average?**
    a. **For the full population measured:** below
2. **What disparities did you identify across demographic groups or special populations?**
   No disparities data available

Untreated Behavioral Health Conditions: Supplemental Measures

Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year (CHIS), 2023

1. **How does your county status compare to the statewide rate/average?**
    a. **For the full population measured:** below
2. **What disparities did you identify across demographic groups or special populations?**
   Race or Ethnicity and Sex

Untreated Behavioral Health Conditions: Disparities Analysis

1. **For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis**

   Primary Measure 1 assesses the percentage of emergency department (ED) visits among members age 13 and older with a principal diagnosis of substance use disorder or any diagnosis of drug overdose that received a follow-up service within 30 days of the ED visit (31 total days), also known as the FUA-30 measure. In this analysis, Health Net Community Solutions, Inc. reported a follow-up rate of 25.83 percent, while LA Care Health Plan reported a slightly higher rate of 26.15 percent. Both plans exceeded the Department of Health Care Services (DHCS), which established minimum performance level of 21.24 percent; however, neither reached the DHCS high performance benchmark of 32.38 percent.

   Primary Measure 2 evaluates the percentage of emergency department (ED) visits among members age 6 and older with a principal diagnosis of mental illness or any diagnosis of intentional self-harm that received a mental health follow-up service within 30 days of the

ED visit (31 total days), referred to as the FUM-30 measure. In this analysis, Health Net Community Solutions, Inc. reported a follow-up rate of 39.35 percent, while LA Care Health Plan reported a rate of 35.70 percent. Both plans performed well below the Department of Health Care Services (DHCS) established minimum performance level of 54.51 percent and the high-performance benchmark of 72.01 percent.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified several factors contributing to disparities in follow-up care after emergency department visits. Insufficient care coordination was cited as a major challenge, as emergency departments and outpatient providers often operate in silos with limited communication and inadequate data sharing. Weak discharge planning further compounds this issue, with patients frequently leaving hospitals without scheduled follow-up appointments or clear, actionable care plans. Stakeholders also pointed to system performance gaps, noting that health plans are not consistently meeting minimum or high-performance benchmarks for timely follow-up care. Stigma and misdiagnosis were identified as additional barriers, as negative perceptions of mental illness and substance use can discourage individuals from seeking treatment, while inaccurate diagnoses may result in ineffective or inappropriate care. Structural barriers such as housing instability, lack of transportation, and limited access to phones or digital communication further reduce individuals' ability to attend follow-up appointments. Finally, workforce shortages, including insufficient numbers of trained staff and low compensation—were highlighted as significant constraints that limit service availability and follow-up support.

Overarching Solutions: To address these disparities, stakeholders proposed a set of coordinated solutions that focus on system accountability, holistic care, and improved access to follow-up services. Key recommendations include using policy levers and financial incentives—such as performance-based contracts, increased reimbursement rates, and targeted policy changes—to strengthen follow-up outcomes after emergency department visits. Stakeholders also emphasized adopting a whole person care approach that addresses social determinants of health, including housing stability, employment, and community support, alongside medical and behavioral health treatment.

In addition, stakeholders recommended increasing staffing and system supports by placing care navigators, peer specialists, and community health workers directly in emergency departments to facilitate timely connections to follow-up care. Targeted interventions were also proposed for populations with higher needs, such as mothers with substance use disorders, youth, and individuals experiencing homelessness, to ensure services are responsive and appropriately tailored. Expanding access options through telehealth, mobile outreach, appointment reminders, and culturally responsive service delivery was identified as a critical strategy to reduce logistical and structural barriers. Finally, stakeholders underscored the importance of reducing stigma by engaging peers with lived experience, expanding public and provider education, and normalizing conversations about mental health and recovery.

Untreated Behavioral Health Conditions: Cross-Measure Questions

1. **Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026, that may decrease your**

county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

DEPARTMENT OF MENTAL HEALTH (DMH)

Data used to inform DMH programming and interventions:

- Countywide police–mental health co-responder data: Data describe LACDMH staff collaboration with local police in Los Angeles County. The dataset covers demographics, incident counts, and hospitalization data to evaluate interventions across the county's diverse population. Additional analyses examine incidents by service area, time of day, referral source, demographics, and incident outcomes for the mobile crisis response teams, which conducted evaluations for involuntary detention and triaged high-risk or mentally ill individuals.
- Early Psychosis Learning Healthcare Network: Cost and utilization data from preliminary analyses comparing clients in early psychosis programs to those receiving standard care.
- Los Angeles County Urgent Care Center data: Metrics include new admissions by age group; clients who received a psychiatric emergency assessment within 30 days of an UCC assessment; clients returning to UCC within 30 days of a prior UCC visit; and clients who were homeless at admission to UCCs.

DMH is working to decrease untreated behavioral health conditions through the following programs and services:

- Crisis Stabilization: A Crisis Stabilization Unit may serve as the initial supportive environment for individuals with emerging psychiatric conditions and can provide linkage to ongoing care. Resolving a crisis without hospitalization is less disruptive and can improve the help-seeking experience.
- Crisis Residential Treatment Program (CRTP): CRTPs provide stabilization as an alternative to emergency services and acute psychiatric facilities, ensuring access to higher-acuity settings for those in greater need. They offer therapeutic activities and skills to support transitions back to community living.
- Law Enforcement Teams (LET): LETs provide crisis services in the community, connecting individuals to mental health services so they can receive ongoing treatment, rather than defaulting to emergency responses.
- EPI-LA Early Psychosis: The EPI-LA Program serves youth and adults aged 12–40 experiencing attenuated psychosis or a first psychotic episode. Clinics contact youth and families within two days of referral for screening; if eligible, intake occurs within 10 business days, with priority for medication services when needed. The program has expanded to eight provider sites and plans to grow further in high-need areas.
- Short-Term Residential Therapeutic Programs (STRTPs): STRTPs provide specialized, intensive care and supervision, supports, and short-term 24-hour care for children/youth/NMDs whose needs cannot be safely met in a family setting.
- Intensive Services Foster Care (ISFC): ISFC is a California Child Welfare Program, a collaboration among DCFS, Probation, and DMH, delivering intensive community-based care for youth with serious emotional and behavioral challenges through specially trained Foster Family Agency teams and Resource Parents. Services are

tailored to the underlying needs of the child/youth and family, with culturally and linguistically humble, respectful delivery.

- DYD - Credible Messengers: This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services. Services are targeted to Youth 18-25 and include training of messenger peers, needs assessment of youth to paired mentors, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral and resource linkage.
- First 5 - Home Visitation: Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. The programs offer home visits delivered weekly or every two weeks to promote positive parent– child relationships and healthy attachment. This Home Visiting Program will prioritize areas where data indicates there is a high number of families involved with child protective services. DCFS - Prevention and Aftercare: Ten leading community agencies proving a variety of services to the community to empower, advocate, educate, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of ACEs and social determinants of health.
- Antelope Valley Community Family Resource Centers (CFRC on wheels): The Centers are intended to reimagine service delivery, create career pathways, reduce stigma while also reducing risk factors, improving protective factors and to embrace children, families and communities as change agents. The AV CFRC is designed to create a coordinated (public/private) community owned and driven space, or network of spaces, where families and individuals in the AV can easily access the services they need to enhance their wellbeing.
- CFRCs (Supervisorial Districts 1 - 5): The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and families in the community it serves.
- Promotores: The United Mental Health Promoters Program aims to lessen mental health stigma throughout Los Angeles County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with the Department of Mental Health and other resources through culturally sensitive methods. Their services encompass community outreach, facilitating mental health workshops to combat stigma, making referrals to mental health services, and providing mental health support and triage services based on community needs.
- Community Partners - United MH Promoters (contracted): A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services (e.g., outreach/engagement, training) . Focuses on strengthening our communities and creating career paths for community members The program provides for eight UMHP teams/contractor agencies per Supervisory District with nine staff members per team.
- Perinatal Parental Mental Health: The Parental Perinatal Mental Health (PPMH) Program is a countywide, multi-layered clinical support initiative designed to strengthen perinatal mental health care in directly operated clinics. The program provides comprehensive training, ongoing coaching, reflective supervision, and technical assistance to support high-quality implementation. PPMH offerings include foundational

and advanced web-based courses, evidence-based interventions, specialized trainings to support families during the perinatal period, monthly consultation calls, and a certification pathway to build long-term expertise and sustainability in perinatal mental health care.

- Suicide Prevention, Intervention and Postvention: Partners in Suicide Prevention (PSP) is a program focused on suicide prevention, intervention, and postvention across communities and service systems. The program strengthens awareness, early identification of suicide risk, and create linkages/referrals. PSP also supports effective postvention efforts to promote healing, reduce stigma, and prevent future suicide risk through educational workshops, resources, and partnership.
- Co-Occurring Intellectual/Developmental Disabilities: Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.

DEPARTMENT OF PUBLIC HEALTH – SAPC

Data used to inform DPH-SAPC programming and interventions:

- The California Outcome Measurement System (CalOMS) - a data collection and reporting system for substance use disorder (SUD) treatment services. It provides admission, discharge, and annual update data for SUD treatment services.
- DPH-SAPC Claims Data – claims data for SUD treatment services submitted by DPH-SAPC providers.
- DPH-SAPC Provider Data – information on DPH-SAPC providers from the LA County SUD EHR information system that includes clinical documentation, data collection, and claims.
- DPH – SAPC Annual Report – An annual overview of clients who received SUD treatment in publicly funded treatment programs in Los Angeles County.
- American Society of Addiction Medicine (ASAM) Level of Care Data - ASAM criteria-based screening and assessment data to monitor appropriate use of ASAM criteria in the DMC-ODS.
- LA County Health and Human Services Data - Provides data about health, public health, and services provided to individuals, children, and families.
- Provider Progress Notes – DPH-SAPC provider notes for patients receiving SUD treatment services.
- LA County Annual HIV Surveillance Report - describes the status of the local HIV epidemic and demonstrates the use of HIV surveillance data to inform prevention, care, and treatment programs in Los Angeles County.

DPH-SAPC is working to decrease untreated behavioral health conditions throughout LA County through capacity building initiatives across all levels of care, including residential and non-residential services, in the following existing programs, services, partnerships,

and/or initiatives:

- DPH-SAPC is increasing the number of licensed clinicians prepared to assess / treat co-occurring conditions and psychiatric medical clinicians that provide medication support, in order to augment the capacity of outpatient and intensive outpatient services to serve clients with co-occurring mental health conditions in SUD settings.
- DPH-SAPC's Workforce Development and Value-Based Incentives programs are building provider agency capacity to treat residential co-occurring populations in preparation for the ASAM 4th Edition. DPH-SAPC is also communicating that all levels of care must be co-occurring capable at a minimum. Increasing workforce capacity helps reduce the likelihood of untreated BH conditions.
- DPH-SAPC provides start-up funds as part of the Residential Capacity Building Pilot to increase staff capabilities delivering co-occurring and withdrawal management services in 24-hour settings. These funds help increase capabilities of service providers to decrease the chance of untreated BH conditions.

DPH-SAPC is also reducing the level of untreated behavioral health conditions by reaching individuals where they are through the following existing programs, services, partnerships, and/or initiatives:

- DPH-SAPC's Directly-Operated Field-Based SUD Services team partners with existing field-based teams to ensure LA County residents experiencing homelessness have access to SUD services in non-traditional / community-based settings.
- DPH-SAPC's Harm Reduction programs often serve people that are not connected with the county BH system. Awareness, anti-stigma, and education campaigns address entry-barriers to care and increase awareness of treatment options.
- DPH-SAPC offers ASAM 3.3 Population Specific High Intensity residential services in specialty facilities intended for those with significant cognitive impairments, such as traumatic brain injury, related to their SUD or co-occurring mental health disorder. Treatment focuses on rehabilitation and stabilization with an emphasis on building daily living skills. Meeting these specific needs helps decrease the likelihood of untreated BH conditions.
- DPH-SAPC partners with California Bridge, a statewide independent program, which works with hospital EDs to provide immediate access to MAT to anyone seeking help and provide care navigation to increase likelihood of completing follow-up treatment. This program is funded outside of the county behavioral health system but contributes to addressing untreated BH conditions in hospital EDs.

2. **The following is a category or categories of funding that the county is using to address the untreated behavioral health conditions goal:**
    - BHSA Behavioral Health Services and Supports (BHSS)
    - 2011 Realignment
    - Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
    - Substance Use Block Grant (SUBG)
    - Other: Behavioral Health Pilot Project, and the CalBridge Behavioral Health Navigator Program (State Opioid Response – SOR grant, SAMHSA), Opioid

Settlement Funds, Care First Community Investment (CFCI), Tobacco Settlement Funds, Federal Grant: CDC OD2A., EPSDT/Medi-cal, County General Fund

Additional Statewide Behavioral Health Goals for Improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals.

In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

Care Experience

Care Experience: Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024

1. **How does your county status compare to the statewide rate/average?**
    a. **For adults/older adults:** above
    b. **For children/youth:** above

Quality Domain Score (Treatment Perception Survey (TPS)), 2024

1. **How does your county compare to the statewide rate/average?**
    a. **For adults/older adults:** above
    b. **For children/youth:** above

Engagement In School

Engagement in School: Primary Measures

Twelfth Graders who Graduated High School on Time (Kids Count), 2022

1. **How does your county status compare to the statewide rate/average?** below

Engagement in School: Supplemental Measures

Meaningful Participation at School (California Health Kids Survey (CHKS)), 2023

1. **How does your county status compare to the statewide rate/average?** below

Student Chronic Absenteeism Rate (Data Quest), 2022

1. **How does your county status compare to the statewide rate/average?** above

Engagement In Work

Engagement in Work: Primary Measures

Unemployment Rate (California Employment Development Department (CA EDD)), 2023

1. **How does your county status compare to the statewide rate/average?** above

Engagement in Work: Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023

1. **How does your county status compare to the statewide rate/average?** below

Overdoses

Overdoses: Primary Measures

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH)), 2022

1. **How does your county status compare to the statewide rate/average?**
    a. **For the full population measured:** below
    b. **For adults/older adults:** below
    c. **For children/youth:** below

Overdoses: Supplemental Measures

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022

1. **How does your county status compare to the statewide rate/average?**
    a. **For the full population measured:** below
    b. **For adults/older adults:** below
    c. **For children/youth:** below

Prevention And Treatment of Co-Occurring Physical Health Conditions

Prevention and Treatment of Co-Occurring Physical Health Conditions: Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022

1. **How does your county status compare to the statewide rate/average?**
    a. **For adults (specific to Adults' Access to Preventive/Ambulatory Health Service):** below
    b. **For children/youth (specific to Child and Adolescent Well-Care Visits):** below

Prevention and Treatment of Co-Occurring Physical Health Conditions: Supplemental Measures

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS), 2022

1. **How does your county status compare to the statewide rate/average?**
    a. **For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications):** above
    b. **For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glucose and Cholesterol Testing):** above

Quality Of Life

Quality of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

1. **How does your county status compare to the statewide rate/average?**
    a. **For the full population measured:** above
    b. **For adults/older adults:** above
    c. **For children/youth:** above

Quality of Life: Supplemental Measures

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS)), 2024

1. **How does your county status compare to the statewide rate/average?**
    a. **For the full population measured:** above

Social Connection

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

1. **How does your county status compare to the statewide rate/average?**
    a. **For the full population measured:** same
    b. **For adults/older adults:** above
    c. **For children/youth:** same

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

1. **How does your county status compare to the statewide rate/average?** below

Suicides

Suicides: Primary Measures

Suicide Deaths, 2022

1. **How does your county status compare to the statewide rate/average?**
    a. **For the full population measured:** below

Suicides: Supplemental Measures

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

1. **How does your county status compare to the statewide rate/average?**
    a. **For the full population measured:** below
    b. **For adults/older adults:** below
    c. **For children/youth:** below

County-Selected Statewide Population Behavioral Health Goals

For related policy information, refer to 3.E.6 Statewide Behavioral Health Goals.

Based on your county's performance or inequities identified, select **at least one additional goal** to improve on as a priority for the county for which your county is performing below the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below. [multi-select dropdown of statewide goals for improvement and reduction, excluding statewide priority goals] [logic: populate questions below for each goal selected]

1. **Goal #1:** Engagement in School

    a. **Please describe why this goal was selected**

    There is a larger gap between County and State performance for Engagement in School (1%) than for Engagement in Work (0.2%) and for Prevention & Treatment of Co-Occurring Physical Health Conditions. The primary measure for Engagement in School—12th grade graduation rates—is broad enough to encompass both mental health and substance use disorder (SUD) populations. Engagement in School specifically targets children and adolescents who are BHSA eligible and priority populations. DMH and SAPC maintain strong partnerships with school systems and prevention programs to address these populations.

    b. **What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis.**

    Measure 1 tracks the percentage of twelfth graders who graduated from high school on time, using data from the California Department of Education (January 2024). At the state level, on-time graduation rates increased from 80 percent in 2013 to 87 percent in 2022, reflecting a steady overall upward trend despite minor fluctuations across years. County-level graduation rates followed a similar pattern, rising from 77 percent in 2013 to 86 percent in 2022. While the county consistently trailed the state by a small margin throughout the period, the gap narrowed over time, particularly by 2022. No data were reported by the state for the years 2015 and 2021, limiting year-to-year comparisons for those periods.

    Measure 2 examines on-time high school graduation rates for twelfth graders in Los Angeles County by race and ethnicity, using data from the California Department of Education (January 2024). Across all racial and ethnic groups, graduation rates increased between 2019 and 2022, indicating overall progress over time. Asian students consistently demonstrated the highest on-time graduation rates, rising from 91 percent in 2019 to 92 percent in 2022. White students also showed strong outcomes, increasing from 86 percent in 2019 to 90 percent in 2022. Latino students experienced steady improvement, with on-time graduation rates increasing from 81 percent in 2019 to 85 percent in 2022. Graduation rates for Black students rose from 76 percent in 2019 to 79 percent in 2022, reflecting progress but remaining lower than other groups. Students categorized as "Other" also saw gains over time, increasing from 72 percent in 2019 to 82 percent in 2022.

    Measure 3 examines the student chronic absenteeism rate for K–12 public schools

in 2022. The data show that the county's chronic absenteeism rate was 22.0 percent, exceeding the statewide rate of 20.4 percent.

Measure 4 presents Los Angeles County's student chronic absenteeism rates for the 2023–24 academic year, disaggregated by race and ethnicity. Significant disparities are evident across student groups. In California, chronic absenteeism eligible enrollment includes students enrolled for at least 31 instructional days during the academic year, and students are classified as chronically absent if they miss 10 percent or more of the school days they are expected to attend. African American students experienced the highest chronic absenteeism rate at 33.9 percent, followed closely by Pacific Islander students at 31.9 percent and American Indian or Alaska Native students at 29.8 percent. Hispanic or Latino students also had elevated absenteeism, with nearly one in four students (24.6 percent) identified as chronically absent. In contrast, Asian students had the lowest chronic absenteeism rate at 6.4 percent, followed by Filipino students at 9.4 percent. White students and students identifying as Two or More Races had similar rates, at 15.7 percent and 15.8 percent, respectively. Students with race or ethnicity not reported had a chronic absenteeism rate of 22.3 percent.

Measure 4, Meaningful Participation at School, draws on the California Healthy Kids Survey (2023) for grades 7, 9, 11, and non-traditional settings and reflects the Los Angeles County average percentage of students who reported "Strongly Agree" or "Agree" that they experience meaningful participation at school. The data show a clear downward trend across all grade levels over time. Among seventh graders, reported meaningful participation declined from 41 percent in 2013–2015 to 25 percent in 2021–2023. Similar patterns are observed for ninth and eleventh graders, with ninth-grade responses decreasing from 35 percent to 22 percent and eleventh-grade responses declining from 36 percent to 24 percent over the same period. Students in non-traditional school settings consistently reported the lowest levels of meaningful participation, decreasing from 28 percent in 2013–2015 to 22 percent in 2021–2023. While the steepest declines occurred between the 2015–2017 and 2017–2019 periods, the most recent data indicate persistently low levels of perceived participation across all groups.

Measure 5 examines meaningful participation at school using data from the California Healthy Kids Survey for 2021–2023, showing the Los Angeles County average percentage of students who reported "Strongly Agree" or "Agree," disaggregated by sexual orientation and grade level. Across most grade levels, students who identified as straight or heterosexual reported higher levels of meaningful participation compared to students who identified as gay, lesbian, bisexual, or not straight, as well as those who were unsure of their sexual orientation. Among seventh graders, 26 percent of straight students reported meaningful participation, compared to 20 percent of students identifying as not straight and 22 percent of students who were unsure. Similar patterns are observed in ninth grade, where 23 percent of straight students reported meaningful participation, compared to 19 percent among not straight students and 21 percent among those who were unsure.

In eleventh grade, reported participation declined across all groups, with straight and not straight students both reporting 25 percent, while students who were unsure

reported lower levels at 19 percent. In non-traditional school settings, patterns differed somewhat, with students who were unsure of their sexual orientation reporting the highest level of meaningful participation at 28 percent, compared to 22 percent among not straight students and 21 percent among straight students.

Measure 6 examines meaningful participation at school using data from the California Healthy Kids Survey (2021–2023), reflecting the Los Angeles County average percentage of students who reported “Strongly Agree” or “Agree,” disaggregated by race/ethnicity and grade level. The data reveal notable variation across racial and ethnic groups, as well as differences by grade. Overall, reported levels of meaningful participation tend to be higher in seventh and eleventh grades and lower in ninth grade across most groups.

American Indian and Pacific Islander students reported some of the widest variation. American Indian students showed relatively high levels of participation in seventh and eleventh grades (33–34 percent), but substantially lower levels in ninth grade (14 percent). Pacific Islander students reported the highest participation among eleventh graders at 38 percent, while ninth-grade participation was markedly lower at 12 percent. Asian students also demonstrated declines in ninth grade, with participation dropping from 29 percent in seventh grade to 22 percent in ninth grade, before increasing again in eleventh grade and non-traditional settings. Latino/a students consistently reported lower levels of meaningful participation compared to other groups, ranging from 20 to 23 percent across grade levels. African American students reported moderate levels of participation, with rates between 23 and 27 percent, while White students reported relatively stable participation across grades, ranging from 24 to 29 percent. Students identifying as Mixed or Other Ethnicity generally reported participation levels in the mid- to high-20 percent range, with some variation by grade.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified several factors driving disparities in school attendance and engagement. Socioeconomic challenges including poverty, food insecurity, transportation barriers, and homelessness were cited as major obstacles that limit students’ ability to attend school consistently and remain engaged. Environmental trauma also plays a significant role, as exposure to violence, housing instability, and the absence of routine trauma screening contribute to disengagement, particularly among African American youth. Safety concerns were identified as another critical factor, with risks related to commuting, school shootings, and a lack of psychological safety discouraging regular attendance. Stakeholders further highlighted systemic racism within educational settings, including anti-Blackness, biased curricula, and limited racial and cultural representation among educators, all of which perpetuate inequities and undermine student belonging. Finally, data limitations—such as incomplete, siloed, or inconsistent data collection—were noted as barriers to identifying disparities accurately and tracking student engagement over time.

Overarching Solutions: To address these disparities, stakeholders proposed a set of integrated solutions focused on safety, cultural responsiveness, and cross-system coordination. Central to these recommendations is the creation of safe and engaging

learning environments that are culturally affirming and trauma-informed, and that connect academic learning to students' lived experiences and future opportunities. Stakeholders also emphasized the importance of collaboration across education, health, housing, justice, and social service systems to address student needs holistically and reduce barriers to engagement. In addition, stakeholders recommended leveraging Community-Defined Evidence Practices (CDEPs) that are validated and culturally responsive, particularly to address trauma and behavioral health needs among African American youth. Expanding access to targeted supports was also identified as a priority, including resources for students experiencing homelessness, recovery schools, and alternative pathways to graduation. Strengthening data systems was highlighted as essential to advancing equity, with calls for countywide, inclusive data collection that captures all school types, student identities, and relevant risk factors. Finally, stakeholders underscored the need to reduce stigma and promote early intervention by investing in prevention programs, mental health supports, and sustained community partnerships to keep students engaged in school.

c. **Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Engagement in Schools and refer to any data that was used to make this decision.**

DMH

DMH is working to increase engagement in schools through the following programs:

- Crisis Teams – School Threat Assessment Response Team (START): provides services to children and youth at schools to ensure they receive the supports they need and to help them access additional school-system resources to fully participate in school activities.
- DYD - Credible Messengers: This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services.
- First 5 - Home Visitation: Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family.
- DCFS - Prevention and Aftercare: Ten leading community agencies proving a variety of services to the community to empower, advocate, educate, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of ACEs and social determinants of health.
- Antelope Valley Community Family Resource Centers: The Centers are intended to reimagine service delivery, create career pathways, reduce stigma while also reducing risk factors, improving protective factors and to embrace children, families and communities as change agents.
- CFRCs (Supervisorial Districts 1 - 5): The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing.

- Friends of the Children (FOTC): FOTC aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at highest risk of entering foster care.
- Promotores: The United Mental Health Promoters Program aims to lessen mental health stigma throughout Los Angeles County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with the Department of Mental Health and other resources through culturally sensitive methods.
- Community Partners - United MH Promoters (contracted): A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services (e.g., outreach/engagement, training). Focuses on strengthening our communities and creating career paths for community members
- SEED LA: The SEED School of Los Angeles (SEED LA) is the county's first public, charter, college-preparatory, tuition-free boarding high school for at-risk youth. The curriculum, grounded in science, technology, engineering, and mathematics (STEM), will prepare youth for career and college pathways in the transportation and infrastructure industry. The school while provide on-site support, wellness services and socio-emotional counseling for students.
- UCLA Public - Public Partnership for Wellbeing: The University of California provides training and educational activities consistent with BHSA for DMH staff, trainees, family members, and peers that strengthens DMH's ability to deliver services to underserved populations in Los Angeles County.
- Birth to Five Mental Health: The Birth-to-5 Team provides capacity building support including workshops, technical assistance, and reflective consultation to help clinicians effectively support young children and their families. These supports increase access to early relationship centered care and strengthen clinicians' ability to identify developmental and behavioral health needs and connect families to appropriate resources. By addressing concerns early and strengthening caregiver child relationships the Birth-to-5 Team helps prevent escalation to crisis driven responses such as higher levels of care or later justice or DCFS involvement. This early intervention stabilizes families and supports children in remaining safely at home and promotes stronger engagement in early learning and school settings.
- Perinatal Parental Mental Health: The Parental Perinatal Mental Health (PPMH) Program is a countywide, multi-layered clinical support initiative designed to strengthen perinatal mental health care in directly operated clinics. The program provides comprehensive training, ongoing coaching, reflective supervision, and technical assistance to support high-quality implementation. PPMH offerings include foundational and advanced web-based courses, evidence-based interventions, specialized trainings to support families during the perinatal period, monthly consultation calls, and a certification pathway to build long-term expertise and sustainability in perinatal mental health care.
- Parent Partner Training Academy: Parent Partner training improves the skills of the Peer Support Specialists (PSS) working with the parents/caregivers of the children receiving services. Improved training of the PSS improves parent/caregiver ability to access needed programs, resources, and additional support which reduces risks of child being removed from home and justice involvement/institutionalization. PSS are better trained to help families access

programs to receive treatment for untreated BH health conditions such as Regional Center and increase School Engagement

- Suicide Prevention, Intervention and Postvention: Partners in Suicide Prevention (PSP) is a program focused on suicide prevention, intervention, and postvention across communities and service systems. The program strengthens awareness, early identification of suicide risk, and create linkages/referrals. PSP also supports effective postvention efforts to promote healing, reduce stigma, and prevent future suicide risk through educational workshops, resources, and partnership.
- Co-Occurring Intellectual/Developmental Disabilities: Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.

DEPARTMENT OF PUBLIC HEALTH – SAPC

DPH-SAPC is working to improve engagement in school through the following existing youth focused programs, services, partnerships, and/or initiatives:

- DPH-SAPC contractors offer field-based treatment services on 76 school campuses to help ensure that a student's needs are being met and they remain engaged in school. In addition, DPH-SAPC directly-operated 43 Student Wellbeing Centers on high school campuses that are safe, accessible environments where students can receive guidance, resources, and education on substance use and other related health and social topics to support their physical, emotional, and social wellbeing and reduce substance use. Providing resources at school sites improves access and facilitates engagement in school.
- DPH-SAPC funds LA County Our SPOT (Social Places & Opportunities for Teens), a free, after school teen program offered at county parks, that provides youth ages 12 to 18 with a safe, structured space to build community, develop life skills, and explore leadership, wellness, and career pathways through daily programming, field trips, and special events. Participants can connect with resources and opportunities that reduce risk factors and strengthen protective factors for SUD, while encouraging continued engagement in school.
- DPH-SAPC's Community Engagement Team provides spaces where anyone can come to get information and resources on how to prevent alcohol and substance use and know where to go for

services. Access to prevention resources protect youth from substance use and promote engagement in school.

- DPH-SAPC works with CBOs to provide Prevention Education Programs for substance use health promotion and education services in community settings (e.g., schools, faith-based locations). These programs reinforce positive support systems and community connections, which support greater engagement in school.
- DPH-SAPC funds Friday Night Live, a youth-adult partnership program focused on positive and healthy youth development and creating opportunities for engagement on substance use topics, both of which contribute to increased engagement in school.

d. **The following is a category or categories of funding that the county is using to address the Engagement in School goal:**

- BHSA Behavioral Health Services and Supports (BHSS)
- Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System DMC/DMC-ODS)
- Substance Use Block Grant (SUBG)
- Other: Opioid Settlement Funds, EPSDT/Medi-cal

Community Planning Process

Stakeholder Engagement

For related policy information, refer to 3.B.1 Stakeholder involvement

1. Stakeholder Involvement Type and Date

Stakeholder Involvement Type	Date (s) for Involvement
Focus group discussions	1/14/2025, 2/11/2025, 2/28/2025, 4/8/2025, 4/25/2025, 5/13/2025, 7/25/2025, 8/29/2025, 10/14/2025, 10/17/2025, 10/31/2025, 11/18/2025
Key informant interviews with subject matter experts	7/8/2025, 7/25/2025, 10/28/2025, 10/31/2025
Public e-mail inbox submission	1/14/2025,1/31/2025, 2/11/2025, 2/28/2025, 3/11/2025, 3/28/2025, 4/8/2025, 4/25/2025, 5/13/2025, 5/30/2025, 6/10/2025, 6/27/2025, 7/8/2025, 7/25/2025, 9/9/9/2025, 9/26/2025, 9/29/2025, 10/14/2025, 10/17/2025, 10/31/2025, 11/14/2025, 11/18/2025,11/19/2025,12/9/2025
Survey participation	1/14/2025, 1/31/2025, 3/11/2025, 4/25/2025, 7/25/2025, 8/29/2025, 9/9/2025, 9/29/2025, 10/14/2025, 10/17/2025, 10/28/2025,10/31/2025, 11/14/2025, 11/18/2025, 11/19/2025, 12/9/2025
Training, education, and outreach related to community planning	1/14/2025, 1/31/2025, 2/11/2025, 2/28/2025, 3/11/2025, 3/28/2025, 4/8/2025, 4/25/2025, 4/25, 5/13/2025, 5/30/2025, 6/10/2025, 6/27/2025, 7/8/2025, 7/25/2025, 8/29/2025, 9/9/2025, 9/29/2025, 10/14/2025, 10/17/2025, 10/28/2025, 10/31/2025,11/14/2025, 11/18/2025, 11/19/2025, 12/9/2025
Workgroups and committee meetings	6/10/2025, 7/8/2025, 7/25/2025, 8/29/2025, 9/9/2025, 9/29/2025, 10/14/2025, 11/19/2025, 12/9/2025

2. The following are a list of stakeholder organizations that were engaged in the planning process:

Stakeholder Organizations	
• Avalon Carver Community Center • Aviva Family and Children's Services • Barbour and Floyd Medical Associates • Bartz-Altadonna Community Health Center • Bayfront Youth & Family Services • Bayfront Youth & Family Services • Behavioral Health Advisory Board Rehab (BHAB Rehab) • Behavioral Health Commission- Commissioner District 5 • Behavioral Health Services, Inc. (BHS) • BHAB Rehab • Bienestar Harm Reduction Center, East L.A. • Bienestar Human Services • Boys & Girls Clubs of Carson • Boys & Girls Clubs of LAUSD • Breaking Stigmas Treatment Operation • Bridges Inc • Bridges, Inc. – Community Treatment Services • CA Bridge (Emergency medicine OUD treatment initiative) • CA Bridge and Emergency Medicine providers and Olive View-UCLA	• Los Angeles County Department of Health Services • Los Angeles County Department of Health Services (DHS) • Los Angeles County Department of Mental Health (LACDMH) • Los Angeles County Department of Mental Health (Quality Improvement Unit) • Los Angeles County Department of Mental Health Outpatient • Los Angeles County Department of Military and Veterans • Los Angeles County Department of Public Health • Los Angeles County Department of Youth Development • Los Angeles County DMH PAC • Los Angeles County Fire Department • Los Angeles County Justice, Care and Opportunities (JCOD) • Los Angeles County Library • Los Angeles County Library - Woodcrest Library • Los Angeles County Office of Child Protection (OCP) • Los Angeles County Office of Education (LACOE) • Los Angeles County Office of the Public Defender • Los Angeles County Parks and Recreation • Los Angeles County Probation Department • Los Angeles County Public Defender • Los Angeles Department of Mental Health • Los Angeles Homeless Services Authority (LAHSA) • Los Angeles LGBT Center

Stakeholder Organizations

- California Association of Alcohol and Drug Program Executives (CAADPE)
- California Black Women's Health Project (CAWHP)
- California Opioid Maintenance Providers (COMP)
- California State University Long Beach
- California State University, Los Angeles
- Campro
- Center for Integrated Family & Health Services (CIFHS)
- CFGC
- Child & Family Center
- Child Care Resource Center
- Children's Hospital Los Angeles - Community Behavioral Health
- Children's Hospital Los Angeles (CHLA)
- Children's Institute, Inc.
- Chinatown Service Center
- City of Glendale
- City of Lancaster
- City of Long Beach
- City of Long Beach Department of Mental Health
- City of Los Angeles
- City of Pasadena
- City of Santa Clarita
- City of Santa Monica
- Claremont Graduate University
- Clarvida
- Coach Afi G
- Coalition for Responsible Community Development
- Community Clinic Association of Los Angeles County (CCALAC)
- Community Family Guidance Center (CFGC)
- Compton Family Mental Health Clinic
- CRI-Help
- CTC AV & The WOW Flower Project
- Dangerfield Institute of Urban Problems (DIUP)
- Day One
- Didi Hirsch Mental Health Services
- Disability Rights California
- DMH-SBCAP
- Exodus Recovery Inc.
- Faith Base Advocacy Council
- Families Uniting Families
- First 5 LA
- Fred Brown's Recovery Services
- Friends of the Children
- Futuro Health
- Girls Club LA
- Grace UMC
- Grandview Foundation
- HAI
- Hamburger Home
- Healing-Informed Art Center
- Healthcare in Action
- Helpline Youth Counseling
- Helpline Youth Counseling (HYC)
- HMG LA
- Homeless Health Care Los Angeles (HHCLA)
- Institute for Multicultural Counseling & Educational Services (IMCES)
- Inner-Development Life Coaching
- Los Angeles Unified School District
- Los Angeles Valley College
- Maryvale
- Meals on Wheels West
- Measure of America
- Mental Health Advocacy Services
- Mental Health America of Los Angeles (MHALA)
- Mental Health Hook Up
- Mind-1-1
- Molina Healthcare
- Morris-Young Legacy House
- NAMI
- NAMI Greater Los Angeles County
- NAMI South Bay
- NAMI Westside Los Angeles
- National Alliance on Mental Illness
- Nuevo Amanecer Latino Children Services
- Olive Support Services
- Olive View-UCLA Medical Center and Emergency Medicine physicians
- Pacific Asian Counseling Services (PACS)
- Pacific Clinics - Asian Pacific Family Center
- Para Los Niños
- Parents Anonymous
- PARS Equality Center
- Patents Anonymous
- Pax House Recovery, Pasadena and A Child's Dream Altadena
- PCS Family Services
- Peacemakers, Inc
- Peer Self-Advocacy Program at Disability Rights California
- Phoenix House of Los Angeles
- Planned Parenthood Los Angeles (PPLA)
- Precise Behavioral Health
- Procultural Group Counseling Services
- Project Impact USA
- Project Return Peer Support Network
- Providence (Southern California)
- Public Defender
- Pueblo Y Salud
- Reality Center
- Roots Through Recovery
- Sacred Path Indigenous Wellness Center
- SALT 6
- San Fernando Valley Partnership (SFVP)
- San Gabriel Pomona Regional Center
- Southern California Health & Rehabilitation Program (SCHARP)
- Search to Involve Pilipino Americans (SIPA)
- Self-Help and Recovery Exchange (SHARE)
- SHIELDS for Families
- Sistah Friends
- Social model recovery systems
- Soul Enrichment Ministries
- South Bay Children's Health Center (SBCHC)
- Southern California Grantmakers
- Special Service for Groups (SSG)
- SRD Straightening Reins
- SSG – Asian Pacific Counseling & Treatment Centers (APCTC)
- SSG (Special Service for Groups) SILVER
- Homeless Outreach Program Integrated Care System (SSG HOPICS)
- St. John's Community Health
- Star View Community Services
- Stars Behavioral Health Group
- Step Up
- Step Up on Second
- Straightening reins

Stakeholder Organizations	
• International Rescue Committee (IRC) • Joe Torre Safe At Home Foundation • Just Whole Care • Kaiser Permanente Southern California • Koreatown Youth & Community Center • L.A. CADA - Los Angeles Centers for Alcohol & Drug Abuse • L.A. Care Health Plan • Los Angeles County Department of Mental Health ARISE UsCC • Life Adjustment Team/LAT Intensive Outpatient Programs • Los Angeles Centers for Alcohol & Drug Abuse (LA CADA) • Los Angeles County DMH - PEI Admin • Los Angeles County DMH + UCLA • Los Angeles County DMH SPA 1 Administration, SALT 1 Liaison • Los Angeles County PROBATION DEPARTMENT • Los Angeles County API UsCC • Los Angeles County Board of Supervisors • Los Angeles County CEO - Budget and Operations Management Branch • Los Angeles County Chief Executive Office (CEO) • Los Angeles County Department of Children and Family Services (DCFS) • Los Angeles County Department of Education	• Supportive Housing Alliance (Los Angeles County) • Sycamores • Tarzana Treatment Center • TCMHA • The Joe Torre Safe At Home Foundation • The People Concern • The Sidewalk Project • The Village Family Services • The Wall Las Memorias Project • The Whole Child • Tia Chucha's Centro Cultural & Bookstore • Transform Health • Tri-City Mental Health Authority • UCLA Health - Population Behavioral Health • UMMA Community Clinic • University of Southern California Chan Division of Occupational Science and Occupational Therapy • Variety Boys & Girls Club • Wellnest – Emotional Health & Wellness • Westside Infant-Family Network (WIN) • Wherewithal Development Foundation • Wolf Connection • You Star Foundation • Youth Commission • Youth Guidance - BAM Los Angeles • Youth With A Purpose • YWCA San Gabriel Valley

a. **For counties with a population greater than 200,000, the following is a list of the five most populous cities in the county:**
   - Los Angeles
   - Long Beach
   - Santa Clarita
   - Glendale
   - Lancaster

3. **Were you able to engage all required stakeholders/groups in the planning process?** Yes

4. **Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities**

   The Los Angeles County Behavioral Health Services Act (BHSA) Community Planning Process (CPP) was conducted through a structured, four-phase approach designed to support inclusive engagement and shared understanding and emphasizing transparency, accessibility, and continuous community participation to align local priorities with statewide behavioral health goals.

   Phase 1: Foundation Building (January–March 2025) focused on establishing the structures, relationships, and shared frameworks needed to support meaningful community engagement. Participants worked collaboratively to develop a shared definition of behavioral health and an integrated behavioral health system and

also emphasized building a collective identity among participants by identifying shared values, lived experiences, and differences to be honored throughout the process. Governance frameworks—including Community Planning Team (CPT) roles and shared agreements—were finalized, and recruitment efforts were launched to recruit 160 members for the Community Planning Team (CPT), representing all the state-required stakeholder groups and the county social and cultural diversity. This phase concluded with a formal kickoff and onboarding session in late March.

Phase 2: Stakeholder Input (April–August 2025) centered on gathering broad stakeholder input across the behavioral health continuum and the statewide behavioral health goals. In April and May, participants defined and reviewed the local behavioral health continuum and identified unmet needs and service gaps across primary prevention, early intervention, outpatient and intensive outpatient services, and housing interventions. From June through August, the process shifted to statewide behavioral health goals, focused on preparing disparity data and facilitating discussions on disparities related to access to care, homelessness, justice involvement, institutionalization, child removal, untreated behavioral health needs, and engagement in schools. Stakeholder identified factors driving disparities and proposed overarching solutions. Their input was documented and shared with subject matter experts for both departments to prepare their program presentations during Phase 3.

Phase 3: Stakeholder Feedback (September–December 2025) emphasized transparency and accountability by presenting proposed BHSA and non-BHSA-funded programs, responding to stakeholder questions from Phase 2, and gathering structured feedback. Sessions were held twice a month to review programs, supplemented by additional forums on Behavioral Health Prevention, Housing Interventions, and Youth Engagement focus groups. Regular updates were also provided to the Behavioral Health Commission to ensure alignment and oversight. Altogether, representatives from over 225 organizations and department offices participated in these sessions.

Phase 4: Closing and Preparing for Implementation (January–June 2026) will focus on the formal approval of the BHSA Integrated Plan and readiness for implementation. This phase includes a BHSA Integrated Plan forum for the BHSA Community Planning Team members, followed by 30-day posting period in March, a public hearing in April, and a final approval by the Board of Supervisors in May. Capacity building sessions will also be held during these six months to prepare the BHSA CPT shift toward monitoring the implementation of the BHSA Integrated Plan.

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes.

1. **Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP)? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.**: Yes

2. **Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities:**

   DPH-SAPC contributed to the LA County Department of Public Health's CHA and CHIP processes by sharing data, attending key meetings, and collaborating on surveys in the following ways:

   - SAPC analyzed data for multiple indicators from 179 places in LA County. The data was included under the behavioral health theme of the Community Health Profiles (CHPs) data platform, which is the cornerstone of DPH's CHA.
   - As a result of this work, the LHJ in LA County incorporated substance use questions into the LA County Health Survey. The data was featured heavily in the CHPs.
   - SAPC reviewed and edited narrative text included in the CHPs about the importance of the included SUD indicators and highlighted the work SAPC is doing. Links back to SAPC were included.
   - SAPC provided funding support for the LHJ for this effort and also contributed to the CHIP survey.

3. **Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?** No

Collaboration

1. **Please select how the county collaborated with the LHJ**
   - Attended key CHA and CHIP meetings as requested.
   - Served on CHA and CHIP governance structures and/or subcommittees as requested.
   - Other: We are meeting with LA County DPH (the LHJ in LA County), Long Beach, and City of Pasadena (which have their own Public Health Departments in LA County) and the MCPs to discuss how we can be involved in future CHA/CHIP planning efforts, including sharing data and attending meetings.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

1. **The following were Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP:**
    - Overdoses
    - Other: We have initiated conversations with our MCPs and LHJs to discuss the statewide behavioral health goals and data sharing requirements so that we can plan for future IPs. We were not able to share data for the first IP due to timing. Specifically, we have identified and aligned on three behavioral health goals across the MCPs as part of the PHM strategy deliverable (access to care, homelessness, and untreated behavioral health conditions).

2. **Was data shared?** No

Data-Sharing from MCPS and LHJs to Support IP development

1. **Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development**:
   Other: We have initiated conversations with our MCPs and LHJs to discuss the statewide behavioral health goals and data sharing requirements so that we can plan for future IPs. We were not able to share data for the first IP due to timing. Specifically, we have identified and aligned on three behavioral health goals across the MCPs as part of the PHM strategy deliverable (access to care, homelessness, and untreated behavioral health conditions).

2. **Was data shared?** No

Stakeholder Activities

1. **Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities):**
   Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.

Most Recent Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) or Strategic Plan

1. Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3 [Yes/No radio buttons]
    a. Yes: We reviewed the CHA and CHIP for disparities and focus areas and have engaged our LHJs in planning discussions in align the CHA/CHIP with the statewide behavioral health goals for future Integrated Plans. Key findings are as follows and align with data and discussions with CPT members regarding disparities found in

other data sources and their own lived experiences:

- Untreated behavioral health conditions disproportionately affect Black/African American, low-income, and other marginalized groups. County data shows higher overdose and suicide mortality rates among Black/African American and low-income residents. According to the CHEIP, 58% of gender non-binary adults have depression, and suicide ideation affects 48% of gender non-binary, non-confirming, and Queer populations. There are significant disparities in suicide rates among gender non-binary, non-conforming, and Queer individuals, with 29.6% of these individuals reporting suicide attempts. Additionally, youths are hospitalized for suicide attempts at rates 2-10 times higher than older adults.
- The Los Angeles County CHEIP reveals that certain behavioral health and socioeconomic factors increasing the risk of children being removed from their homes disproportionately affect specific communities. Parental mental health, such as depression, affects 8% of caregivers overall, but affects 11% parents/caregivers in poverty. Additionally, data from Los Angeles County Health Assessments (CHA) reports 37% of families experience childcare access difficulties, with rates reaching 45% in Metro areas and low-income families.
- Crime data indicates that some communities may have disproportionate involvement with the justice system. The Community Health Assessment reports violent crime rates reached 525.9 per 100,000 countywide in predominately Black/African American, Latinx, and low-income communities in South LA (SPA 6) and Metro LA (SPA 4). The CHEIP reflects a disproportionally high homicide rate for Black/African American residents, who experience a homicide rate of 33.4 per 100,000 compared to the County rate of 8.1.
- The CHEIP reveals housing instability among LA County residents. Racial and socioeconomic disparities exist among the 524,000 LA County adults who have experienced homelessness or unstable housing in the past 5 years. Black/African Americans face the highest rates of homelessness (16%) followed by American Indian/Alaska Natives (14%), and US-born Latinx (10%). Gender disparities also exist with 36% of transgender females and 16% of gender non-binary individuals experiencing housing instability. Adults with disabilities report 11% homelessness versus 5% without disabilities. Geographic disparities also differ with 13% in SPA 1 (Antelope Valley) compared to 3% in SPA 5 (West).
- According to the LA county Community Health Equity Improvement Plan (CHEIP) 25% of adults reported difficulty accessing needed medical care, and 21% reported not having a regular source of health care. Furthermore, 49% of gender non-binary individuals, 37% of Latinx, and 33% of individuals with disabilities struggle to access care. The CHEIP utilized data from several data sources including, the Community Health Profiles, the LA County Health Survey, and program specific data.
- The pregnancy related mortality ratio (PRMR) reported in the CHEIP also indicates disparities in access to care, as the PRMR for Black/African American mothers is over 3 times that of White mothers and remains consistently higher than other racial/ethnic groups.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to **B.2 Considerations of Other Local Program Planning Processes**.

1. **Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes.**

   DPH-SAPC and DMH initiated conversations with LA Care, Health Net, and Kaiser Permanente about their community reinvestment planning efforts starting October 2025 and continue to engage in meetings to discuss and align areas of shared focus, such as three behavioral health goals that were identified under the PHM strategy deliverable. Both DPH-SAPC and DMH shared their strategies, programs, and gaps under the identified behavioral health goals to inform MCP planning efforts.

2. **Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?**

   As of October 2025, the Los Angeles County Department of Mental Health and the Department of Public Health – Substance Abuse and Prevention Control are engaging with MCPs to discuss goals and explore collaboration on the community investment plan. We are at the early stages of these conversations.

   MCP reinvestment planning is ongoing and we expect to have more details in Q1 of 2026.

Comment Period and Public Hearing

For related policy information, refer to **B.3 Public Comment and Updates to the Integrated Plan**.

1. **Date the draft Integrated Plan (IP) was released for stakeholder comment**: 02/11/2026
2. **Date the stakeholder comment period closed:** 03/13/2026
3. **Date of behavioral health board public hearing on draft IP**: 04/09/2026
    a. Please provide proof of a public posting with information on the public hearing: See Attachment #A
4. **If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page:** BHSA Announcements - Department of Mental Health
5. **Please select the process by which the draft plan was circulated to**
6. **stakeholders**
    - Public posting
    - Email outreach, see Attachment #B
7. **Please specify the other process the draft plan was circulated to stakeholders:** N/A
8. **Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table**

Table 3. Stakeholder Input:

Feedback received during public comment period	
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Health care organizations, including hospitals; Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita) Other: California Association of Alcohol and Drug Program Executives (CAADPE)
Summarize the substantive revisions recommended this stakeholder during the comment period	1. Embed SUD language in every section that currently references "behavioral health" but only describes mental health service: Add explicit references to SUD needs, SUD service pathways, and co-occurring disorder considerations in the County Behavioral Health System Overview, Care Transitions, and Statewide Behavioral Health Goals sections. This ensures parity and avoids reinforcing the mental health only framing that appears throughout the draft. 2. Expand the "Populations Served" section to include deeper SUD specific demographic Insights: The draft provides detailed mental health penetration disparities but minimal SUD specific disparities. Add SUD prevalence, unmet need, overdose trends, and demographic disparities to match the depth of mental health analysis. 3. Strengthen the Care Transitions section by explicitly describing SUD specific- transition Pathways. Include transitions from: • Withdrawal management → residential → outpatient • ED → MAT initiation → community follow-up • Jail/prison → community SUD care. The current section is almost entirely mental health focused.

Feedback received during public comment period	
	4. Add SUD integration requirements to all crisis-related program descriptions. Crisis Residential, PMRT, UCCs, and CRTPs are described only in mental health terms. Add: SUD screening in crisis settings, MAT initiation and Harm reduction services and Warm handoffs to DMC-ODS providers 5. Strengthen the Workforce Strategy by explicitly addressing SUD workforce shortages. The draft focuses heavily on mental health workforce development. Add: SUD counselor pipeline expansion, MAT prescriber recruitment, cross-training for co-occurring disorders and Integration of SUD competencies into all clinical and peer training. 6. Integrate SUD considerations into all housing an homelessness: The Housing Interventions section currently emphasizes mental health. Add: • Low barrier- SUD services in interim and permanent supportive housing • Field based- SUD teams embedded in homeless outreach • MAT access in shelters and encampments • Harm reduction supply distribution 7. Require co-occurring disorder capability across all programs described in the plan: Many programs (e.g., Clubhouses, Day Treatment, Peer Respite, CFRCs) are described as mental health--only. Add a requirement that all programs: screen for SUD, provide brief interventions, offer warm handoffs to SUD treatment, and train staff in co-occurring disorder competencies 8. Add SUD specific performance measures to the -County Selected- Goals and Statewide Goals sections. The plan currently includes detailed mental health metrics, but few SUD metrics. Add measures such as: • MAT initiation and retention • SUD treatment penetration • Overdose mortality and non-fatal overdose rates • Youth SUD engagement and retention o Co-occurring disorder treatment rates 9. Strengthen the description of SUD prevention and early intervention: Prevention is mentioned but not integrated into the broader system narrative. Add: • Youth SUD prevention strategies • School based- SUD screening • Community level- prevention partnerships • Overdose prevention education in all BHSS programs 10. Ensure every program narrative includes a clear SUD component. For each major program category (e.g., FSP, crisis services, youth programs, community partnerships), add: How SUD services are incorporated, How co-occurring needs are addressed, How SUD outcomes will be measured and How SUD providers will collaborate with DMH programs. This creates a consistent, integrated behavioral health narrative rather than a mental health dominant one.
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Health care organizations, including hospitals; Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita) Other: California Association of Alcohol and Drug

Feedback received during public comment period	
	Program Executives (CAADPE)
Summarize the substantive revisions recommended this stakeholder during the comment period	Recommendations for Integrating Primary Care 1. Embed primary care integration into the "County Behavioral Health System Overview." Add a subsection describing how primary care settings serve as behavioral health access points. Include language on co-location, warm handoffs, and shared care models between DMH, SAPC, and primary care clinics. This ensures primary care is framed as part of the core behavioral health ecosystem, not an external partner. 2. Strengthen the "Care Transitions" section by adding primary care- -specific pathways. Describe transitions such as: • ED → primary care follow-up for behavioral health needs • SUD or MH discharge → primary care for chronic disease management • Primary care → specialty behavioral health via standardized screening This aligns with the state's emphasis on whole person- care and closes a major gap in the current draft. 3. Add primary care integration requirements to the "Service Delivery Landscape." Include primary care as a formal service setting where: • SUD screening (SBIRT) occurs • MAT can be initiated • Depression, anxiety, and SUD brief interventions are delivered This section currently lists many programs but does not explicitly include primary care as a behavioral health delivery site. 4. Integrate primary care roles into the "Statewide Behavioral Health Goals" and performance measures. Add metrics such as: o Percent of primary care clinics conducting behavioral health screenings • MAT initiation in primary care • Warm handoffs from primary care to DMH/SAPC This ensures primary care is not only mentioned but measured and accountable. 5. Add primary care partnerships to the "Workforce Strategy" section. Include strategies to: • Train primary care providers in behavioral health competencies • Expand integrated care teams (CHWs, peers, SUD counselors) in primary care • Support cross training- between DMH/SAPC and primary care networks. This section currently focuses heavily on mental health workforce needs; adding primary care strengthens whole person's- care alignment.
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience); Providers of mental health services and substance use disorder treatment services; Community-based organizations serving culturally and linguistically diverse constituents; Women Centered Trauma Informed Care Services
Summarize the substantive revisions recommended this stakeholder during the comment period	The stakeholder is emphasizing the need for the County to prioritize equity and accessibility by creating transparent pathways for small, community-based organizations to enter and grow within the Medi-Cal behavioral health system. There is a strong call to

Feedback received during public comment period	
	move beyond established contractors by pairing workforce development with targeted technical assistance in areas like billing, compliance, and recruitment. By providing specific support such as loan repayment and tuition assistance for smaller nonprofits, the County can ensure that capacity-building efforts reach neighborhood-rooted providers who are often best positioned to serve those "closest to the ground." Furthermore, the feedback highlights a necessity for better integration of co-occurring (mental health and substance use) care and stronger alignment between residential settings, community-based day programs, and housing. Stakeholders are looking for clear, publicly reported benchmarks to track the effectiveness of BHSA investments in reducing institutionalization, particularly for older adults. To achieve this, they recommend leveraging the Prudent Reserve for innovation and ensuring that BHSA funds are seamlessly coordinated with CalAIM and other funding streams to create a unified, non-fragmented system of care.
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience);Health care service plans, including Medi-Cal Managed Care Plans (MCPs);Community-based organizations serving culturally and linguistically diverse constituents;CRTP
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are seeking clear guidance and enhanced support for Crisis Residential Treatment Programs (CRTPs) to prepare for the evolving continuum of care, specifically requesting more frequent feedback from the Department of Mental Health. Key recommendations include increasing the current 16-bed capacity limit, providing additional funding for facility expansion, and delivering better training on CRTP guidelines and clinical interventions to improve stabilization rates.
Stakeholder group that provided feedback	Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience);Youths (individuals with lived experience) or youth mental health or substance use disorder organizations; Providers of mental health services and substance use disorder treatment services; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita);Community-based organizations serving culturally and linguistically diverse constituents
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are urging the County to address a critical mortality crisis among Asian and Pacific Islander (API) youth, for whom suicide is the #1 leading cause of death in Los Angeles County, outranking both homicides and motor vehicle accidents. The feedback highlights a lethal "Mortality-Utilization Gap," noting that while API students show high "Engagement in School," this academic success often masks severe distress. Despite having the highest suicide risk, this group has a staggering 0.28 service utilization rate, the lowest in the County. To address this, the suggestion is to shift away from broad "BIPOC" categories and fund "Selective Prevention" strategies that specifically target the unique cultural drivers of ideation within the API community. To bridge this gap, the stakeholder recommends allocating the 4% Population-Based Prevention budget using a formula weighted by mortality-to-utilization ratios rather than universal distribution. They propose funding Community-Defined Evidence Practices (CDEPs)

Feedback received during public comment period	
	in trusted spaces like cultural centers and schools to reach "non-system involved" youth who fall outside traditional Medi-Cal eligibility. Additionally, the plan calls for a specialized Suicide Prevention Pipeline to recruit API providers trained to navigate the "Model Minority" pressure and intergenerational stigma. By focusing on these "hidden" high-risk groups, the County can proactively reach youth who are currently dying at disproportionate rates before they ever enter a formal clinical facility.
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Continuums of care, including representatives from the homeless service provider community
Summarize the substantive revisions recommended this stakeholder during the comment period	Recovery residences should be explicitly recognized within statewide goal implementation strategies as structured stabilization environments for individuals with: • Serious mental illness (SMI) • Co-occurring substance use disorders • Frequent emergency department utilization • Repeated psychiatric hospitalization • Justice system involvement • Housing instability or homelessness Recovery housing can support statewide goals by functioning as: • Step-down from inpatient psychiatric hospitalization • Step-down from residential SUD treatment • Diversion alternative to higher-cost crisis settings • Reentry stabilization following incarceration • Structured transition from homelessness to permanent housing In addition, recovery residences should be considered part of the County's equity strategy. Structured recovery housing models can prioritize access for disproportionately impacted communities, justice-involved individuals, and chronically unhoused populations who experience elevated behavioral health disparities. Incorporating culturally responsive programming within residential stabilization settings supports statewide goals related to health equity, access, and long-term recovery outcomes. Structured recovery housing may also function as a preventative intervention by reducing relapse, psychiatric decompensation, and re-hospitalization, supporting long-term system stabilization and cost avoidance. Clarification and strengthening of the following areas would improve implementation: 1. Recognition of Recovery Residences Under Housing Interventions: Licensed or certified sober living recovery residences should be explicitly identified as eligible housing intervention partners. Recovery housing provides structured stabilization and should not be viewed solely as general housing. Funding eligibility should include operating subsidies, staffing support for peer recovery services, and capital improvements to increase bed capacity. 2. Integrated Service Model Recognition: Recovery residences operating under a BHSA-aligned framework may incorporate: • Individualized care plans • Time-bound recovery goals • Case management and care coordination • Peer recovery support • Medication management coordination • Clinical oversight (as appropriate)

Feedback received during public comment period	
	• Structured programming • Warm handoffs to outpatient behavioral health services Recognizing this integrated model allows recovery housing to function as part of the behavioral health continuum rather than solely as a housing intervention. 3. Full Service Partnership (FSP) Alignment; Recovery residences may function in coordination with or as structured extensions of Full Service Partnership (FSP) models for individuals requiring residential stabilization. Integrating recovery housing into FSP care plans can support individuals who need structured environments while maintaining community-based service alignment. 4. Crisis System Integration: Recovery residences may serve as post-crisis stabilization environments aligned with the County's broader crisis response system, including 988 response pathways, crisis stabilization units, psychiatric emergency services, and CARE Court placements. Recognizing recovery housing as part of crisis diversion and step-down infrastructure strengthens the behavioral health continuum and reduces reliance on higher-cost acute settings. 5. Braided and Bundled Funding Flexibility: The Integrated Plan should allow for braided and bundled funding models combining housing operating support with behavioral health service delivery. This enables comprehensive stabilization services within a coordinated framework and reduces system fragmentation. 6. Formal Partnerships: Structured referral pathways and contractual partnerships between County behavioral health programs and certified recovery residences should be encouraged to ensure coordinated care transitions from hospitals, treatment facilities, crisis systems, and carceral settings. BHSA workforce investments should explicitly be available to residential recovery settings, including: • Peer workforce pipeline development • Training stipends • Clinical supervision support • Retention incentives • Ongoing professional development Supporting workforce development within residential stabilization settings strengthens system capacity, improves service quality, and aligns with statewide workforce expansion goals. Recovery residences serving high-acuity populations should also be incorporated into County data collection and performance reporting systems. Participation in outcome tracking, utilization monitoring, and quality reporting ensures transparency and strengthens the County's ability to measure the impact of residential stabilization models within the broader behavioral health network. The Budget and Expenditure sections would benefit from additional clarity regarding: • Allocation of Housing Intervention funds • Capital vs. operating funding structures • Eligibility for service-integrated residential models • Multi-year operating commitments for high-acuity stabilization settings • Capital Expansion BHSA housing funds should support: • Acquisition of residential properties • Rehabilitation and code compliance • ADA accessibility improvements

Feedback received during public comment period	
	• Safety and security upgrades Capital investment pathways will enable scalable bed expansion while maintaining quality and regulatory compliance. Multi-Year Operating Stability Multi-year operating commitments enable responsible scaling, workforce retention, and infrastructure investment. To ensure sustainable system integration, the County should consider how recovery residences may participate in future funding opportunities, Requests for Proposals (RFPs), and implementation guidance tied to housing and stabilization services. Structured stakeholder engagement with certified recovery residence providers during future funding design will improve program effectiveness and operational feasibility.
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience); Providers of mental health services and substance use disorder treatment services; Veterans
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are calling for expanded resources and clearer guidelines to improve coordination between mental health agencies and law enforcement, ensuring reliable hospital transportation for individuals under LPS holds across all programs, including AB109.
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience);Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience);Youths (individuals with lived experience) or youth mental health or substance use disorder organizations; Providers of mental health services and substance use disorder treatment services; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita);Continuums of care, including representatives from the homeless service provider community; Community-based organizations serving culturally and linguistically diverse constituents; Peer Run Agency and Peer Run Programs
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are concerned that requiring nonprofit, peer-run agencies operating under Community Outreach Services (COS) funding to transition to Medi-Cal models could negatively impact service delivery and undermine the unique value of the peer-run approach.
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience);One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Regional centers;SA-8, SALT-8
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are calling for the establishment of a dedicated funding stream to serve individuals who fall outside of strict "priority population" definitions, ensuring the BHSA Final Plan remains inclusive. Additionally, they advocate for the use of Outreach and Engagement (O&E) funds to support client enrichment, emphasizing that enhancing quality of life is a fundamental pillar of mental health care.
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Health care organizations, including hospitals; Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or

Feedback received during public comment period	
	Santa Clarita)
Summarize the substantive revisions recommended this stakeholder during the comment period	In regards the Statewide Population Behavioral Health Goals: • Add explicit SUD strategies within statewide goals (homelessness, justice involvement, school engagement). • Prioritize harm reduction/low-barrier care, overdose prevention, and MAT/diversion pathways. • Add SUD performance measures (MAT initiation/retention, treatment penetration, overdose outcomes, youth engagement, co-occurring treatment rates). • Expand SUD data/disparities analysis and strengthen co-occurring disorder discussion. • Use "behavioral health" consistently to mean both mental health and SUD (parity). In regards to Behavioral Health Services Act/Fund Programs: • Rebalance the BHSA plan so SUD are co-equal with mental health throughout. • Clarify DMH–SAPC integration (shared governance, planning, data, QI, unified metrics). • Expand SAPC/SUD program descriptions to match mental health detail (capacity, MAT, field-based care, etc.). • Build SUD into crisis/housing/care transitions (screening, MAT initiation, harm reduction, warm handoffs). • Require co-occurring capability and strengthen whole-person integration by embedding primary care in BH settings. In regards to Workforce Strategy: o Address parity: specify SUD workforce challenges alongside mental health. • Add SUD workforce strategies (pipeline/certification, recruitment/retention, harm reduction staffing, peers). • Expand MAT prescriber capacity and readiness across settings. • Resource cross-training for co-occurring disorders across roles. o Add primary care partnerships to support integrated teams.
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Local public health jurisdictions; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Continuums of care, including representatives from the homeless service provider community
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders have expressed significant concern that the Integrated Plan lacks a universal data collection mechanism, making the current behavioral health goals and baselines appear inaccurate. Without a concrete plan to rectify data silos or integrate sharing across systems of care—including the often-fragmented coordination between LACDMH, SAPC, and local Continuum of Care providers—true accountability and transparency remain out of reach. The feedback emphasizes that valid outcome measurement is impossible without first building a foundational infrastructure for tracking progress across the County's vast geographical and departmental landscapes. Furthermore, the draft is criticized for failing to provide a clear blueprint for how the County will actually integrate services, particularly regarding the massive allocation of BHSA housing

Feedback received during public comment period	
	funds. Despite the creation of the new Homeless Services and Housing Department, there is a lack of detail on how systems will reduce duplication of services, maximize funding efficiency, or align with local health assessment processes. Stakeholders argue that for a county as complex as Los Angeles, the plan must move beyond separate departmental responses and establish a unified strategy for cross-system collaboration to support vulnerable populations who move between jurisdictions and service providers.
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience);Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience);Youths (individuals with lived experience) or youth mental health or substance use disorder organizations; Providers of mental health services and substance use disorder treatment services; Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita)
Summarize the substantive revisions recommended this stakeholder during the comment period	The International Rescue Committee (IRC) - Los Angeles urges the County to explicitly include "newcomers" and forcibly displaced individuals as a target population within the BHSA, noting that up to 90% of young newcomers face unaddressed trauma and significant barriers to care. The stakeholder highlights that current strategies are overly reactive, focusing on crisis response while neglecting primary prevention and mental health literacy for those not yet in dire need. To address this, they recommend reallocating funds toward "solution-oriented" programming—such as trauma-informed case management, financial coaching, and housing navigation—that tackles the underlying stressors of displacement rather than simply providing referrals to overcapacity external systems. Furthermore, the IRC advocates for a shift from basic cultural sensitivity to true cultural responsiveness, integrating gender-specific strategies and diverse household structures into service delivery. They emphasize that workforce development must move beyond technical training to equip staff with the tools to navigate immigration backgrounds, language barriers, and documentation hurdles. By leveraging the expertise of deeply embedded partners like the IRC, the County can build a specialized workforce of housing and employment specialists who provide the practical, culturally resonant support necessary to foster long-term self-sufficiency and prevent the deterioration of mental health among Los Angeles's newest residents.
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Community-based organizations serving culturally and linguistically diverse constituents
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholder is urging the inclusion of Managing and Adapting Practices (MAP) in the list of approved Evidence-Based Practices, noting that their established train-the-trainer model allows for sustainable, in-house implementation despite the loss of PEI training funds. Beyond specific programming, there is significant concern that the Integrated Plan serves more as a regulatory requirement than a functional roadmap, as it lacks critical details on the strategy, timing, and methodology for realigning services. Providers are calling for greater transparency regarding operational data points—such as caseload expectations and budget impacts—to allow for effective implementation planning and a clearer

Feedback received during public comment period	
	understanding of how the County will bridge current system gaps.
Stakeholder group that provided feedback	Early childhood organizations, First 5 County Commission
Summarize the substantive revisions recommended this stakeholder during the comment period	First 5 LA is urging the County to ensure that the unique needs of families with young children and pregnant individuals are not overshadowed by the focus on individual adults within the BHSA housing and homelessness strategies. Citing research that links housing insecurity to higher rates of maternal morbidity and preterm births, the stakeholder advocates for prioritizing families in program eligibility and shoring up housing supports specifically designed for those with infants and toddlers. They emphasize that while the plan acknowledges systemic disparities, it must go further by disaggregating "Asian" and "Pacific Islander" data to reveal distinct outcomes and by explicitly defining how each goal area will address the root causes of systemic racism. Regarding the workforce and early intervention, stakeholders are calling for a more coordinated, prenatal-to-five mental health approach that prevents the developmental needs of the youngest children from being diluted within broad 0–25 initiatives. They recommend a targeted workforce strategy to increase cultural and linguistic representation, suggesting models like the Parental Perinatal Mental Health e-consultation to extend specialized expertise to community sites. Finally, First 5 LA requests transparent funding breakdowns and a direct comparison to prior MHSA allocations to ensure that the shift to BHSA does not result in an unintended reduction of resources or service disruptions for the County's most vulnerable young children and their caregivers.
Stakeholder group that provided feedback	Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita);Youths (individuals with lived experience) or youth mental health or substance use disorder organizations
Summarize the substantive revisions recommended this stakeholder during the comment period	The California Black Women's Health Project expresses profound disappointment with the Integrated Plan, highlighting a troubling "escalation gap" where Black residents are overrepresented in severe mental health services but underrepresented in mild-to-moderate care. This disparity indicates a systemic failure in prevention; Black community members often only enter the system once their needs have reached a crisis level due to structural barriers and a lack of early outreach. The stakeholder argues that the plan's failure to account for socioeconomic realities—such as disproportionately high rates of unemployment, housing instability, and incarceration—results in an incomplete understanding of community needs and misaligned resource allocation. To achieve true equity, the stakeholder demands the explicit inclusion of Community-Defined Evidence Practices (CDEPs), which leverage lived experience and cultural wisdom to build trust in marginalized communities. They also criticize the current budget allocation, noting that funding for Substance Use Disorder (SUD) services disproportionately outweighs mental health funding despite higher utilization rates for the latter. The feedback calls for a total revision of the plan to prioritize early intervention for Black communities, integrate structural determinants of health into all assessments, and rebalance funding to reflect actual service demand and population needs.

Feedback received during public comment period	
Stakeholder group that provided feedback	Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Eligible adults and older adults (individuals with lived experience); Early childhood organizations
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are raising urgent questions regarding the transition from MHSA to BHSA, specifically seeking clarity on how existing services for parents, children, and youth will be protected. There is a notable concern over the lack of transparency regarding the "quantity of recipients" who may lose access to care and which community-based organizations (CBOs) will be impacted. Feedback highlights that while the plan identifies ambitious statewide goals, it fails to provide the data used to select specific programs or a roadmap for how the 51% of Early Intervention funds mandated for youth will be distributed beyond "legacy" contractors. Without structured data on capacity-building pathways, stakeholders fear the system will remain limited to large, established providers, excluding the smaller, grassroots, and minority-led organizations that often hold the most community trust. To bridge these gaps, stakeholders recommend a dedicated infrastructure and technical assistance strategy to help smaller providers navigate fiscal modeling, claims readiness, and CalAIM-aligned workflows. There is also a call for a more realistic workforce strategy that addresses the 20% vacancy rate and explicitly supports non-licensed roles—such as parent partners, doulas, and "credible messengers"—who are essential for upstream engagement. Furthermore, providers are seeking a "plain-language" budget narrative to explain the allocation of $900 million in unspent funds and a clear plan to improve the 22% Managed Care Plan contracting rate among BHSA providers. By aligning community reinvestment dollars with these goals and providing specialized technical assistance, the County can ensure a sustainable, inclusive, and financially viable behavioral health ecosystem for underserved families.
Stakeholder group that provided feedback	Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Providers of substance use prevention services
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders with decades of experience in high-need areas like Skid Row are expressing concern that the shift of prevention programming to the state may undermine effective local, population-based efforts. While the state-level language emphasizes social connection and equity, the local Integrated Plan lacks clear pathways for sustaining established substance use prevention initiatives. The feedback highlights that strong relational ties and community-based prevention are foundational to reducing addiction risk and building long-term stability, yet these "upstream" strategies feel less explicit in the current County roadmap compared to clinical interventions. To rectify this, stakeholders are calling for prevention to be recognized as a permanent, core component of the behavioral health spectrum with an equitable share of resources. They specifically point out that the current 4% minimum allocation for population-based prevention is extremely low given its cost-effectiveness and reach. Recommendations include making multi-year investments to protect prevention during budget transitions,

Feedback received during public comment period	
	integrating lived experience to dismantle systemic racism, and utilizing community-defined evidence practices to meet vulnerable populations where they are. The goal is to move beyond crisis management and toward a system that builds community resilience through radical connection and civic engagement.
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Local public health jurisdictions; Community-based organizations serving culturally and linguistically diverse constituents; Health care organizations, including hospitals
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are calling for the BHSA Integrated Plan to move beyond broad geographic goals and prioritize authentic, neighborhood-level investment in high-need Latinx communities such as East LA, South LA, and South Central. There is a strong emphasis on funding nurse-led and community health worker (CHW) models—specifically promotoras—as frontline strategies rather than secondary outreach tools. Critics point out that while Latinx residents are severely underrepresented in specialty mental health services, the current plan relies heavily on licensed clinical roles within the County system, effectively overlooking the bilingual, community-rooted workforce that already serves as a trusted bridge to care for those skeptical of formal institutions. To ensure accountability, stakeholders demand that the County provide disaggregated outcome data by Service Planning Area (SPA), language, and ethnicity to track whether service gaps are actually narrowing. They also urge the creation of a "plain-language" budget summary in both English and Spanish, arguing that the current jargon-heavy documentation creates a health literacy barrier that excludes the public from meaningful engagement. Recommendations include establishing a dedicated subcontracting pipeline for small, BIPOC-led organizations and setting a "community reinvestment floor" to ensure a defined percentage of funds reaches grassroots providers who are already culturally and linguistically embedded in underserved neighborhoods.

9.

9. **Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update.**

Clinical and Service: The Behavioral Health Commission (Commission) strongly advocates prioritizing early intervention in childhood mental health, particularly for children ages 0–5. It emphasizes that proactive consultation at the preschool level can prevent more severe issues in adolescence and adulthood. Regarding LGBTQ+ youth — with particular attention to transgender, gender diverse, and intersex (TGI) young people — the Commission urges concrete measures to ensure authentic access to gender-affirming hormone therapy, surgical navigation support, and care that is authentically affirming, trauma-informed, and culturally sensitive, moving beyond policy declarations toward comprehensive, system-wide implementation. The Commission recommends that the County protect and fund community-defined outreach pathways for Transitional-Aged Youth (TAY) to bridge the barriers they face in engaging with early interventions.

The need for extensive training in withdrawal management for all therapists was also emphasized, addressing a deficiency in specialized care often missing from standard clinical

education. The Commission recommends specifying which clinician categories are covered, what certification or competency standard applies, the funding source, and a reporting mechanism for training completion.

To enhance stabilization and minimize barriers to care, the Commission recommends eliminating intake restrictions on weekends and Fridays and promoting better integration so that SAPC and LACDMH facilities can mutually enhance their nursing and stabilization capabilities. Furthermore, the importance of monitoring and supporting underserved populations, including Black men, men in their late 20s to 40s, older adult women, non-English speakers, TGI individuals, and seniors, was highlighted, with a recommendation to establish dedicated services for these high-risk groups and for DMH and SAPC to report service utilization, engagement, and outcome data, disaggregated by these demographics, on a recurring basis. Lastly, the Commission recommends the use of community-defined evidence practice on par with evidence-based practice and the need for a Behavioral Health Unit for minors that serves the San Fernando, Santa Clarita, and Antelope Valleys.

Bureaucracy: The Commission's recommendations on bureaucracy focus on making it easier for smaller Community-Based Organizations (CBOs) and grassroots groups to participate. To achieve this, the Commission recommends establishing clear steps and providing technical support so these organizations can navigate complex county insurance and approval rules. Simplifying these processes aims to encourage more groups to provide services and increase the number of providers in the system.

Workforce: The Commission's workforce recommendations aim to support and recognize skilled clinicians and peers in the behavioral health system. The Commission recommends establishing Advanced Level Practitioner (ALP) classifications, also known as "career ladders," so expert therapists can earn higher pay for their clinical skills without moving into administrative roles. The recommendations also focus on DMH and SAPC helping peer professionals with certification and renewal and on ensuring they receive a living wage, recognizing their importance to care delivery, and should include recruitment pathways for bilingual and culturally concordant clinicians, structured supervision hours for associate-level staff, and peer specialist advancement tracks tied to the living-wage recommendations in this letter.

Housing and Infrastructure: To address the housing subsidy crisis, the Commission identifies the urgent need for a clear transition plan, including timelines, identified replacement resources, and client-level contingency protocols, to support the estimated 200+ clients at risk of losing housing when Emergency Housing Vouchers (EHV) expire by year's end. The Commission also recommends appointing an Inspector General to oversee billions allocated to housing development, ensuring accountability and preventing cost overruns or misuse of funds. In response to the closure of acute inpatient beds at facilities such as Martin Luther King Hospital and UCLA Resnick, the Commission expresses concern about increased pressure on psychiatric emergency rooms and urges departments to address the growing gap in inpatient care.

With regard to Adult Residential Facilities (ARFs) in California, the Commission recommends an improved rate for licensed ARFs to support ARFs and to encourage and incentivize their expansion.

Additionally, the Commission requests that LACDMH provide regular updates on issues and

opportunities as they arise throughout the BHSA implementation.

Community-Centered Behavioral Health Planning: The Commission issues the following recommendations to strengthen behavioral health planning and service delivery. First, the Commission urges that all major decisions, such as the closure of Martin Luther King beds, include comprehensive community input and transparency, as a lack of engagement has contributed to service gaps and left vulnerable patients without timely care. The Commission strongly advises against reducing high-acuity inpatient psychiatric beds, which are essential and cannot be replaced by lower levels of care without jeopardizing patient safety and increasing strain on emergency departments. The Commission recommends that a Beilenson hearing be held as part of the formal process and that robust participation from public safety personnel, including police, and from psychiatric emergency, hospital, urgent care, and substance abuse providers be integrated into planning efforts. Their involvement is particularly important as new mandates expand service demands. Finally, the Commission calls for ongoing efforts to integrate behavioral health and substance abuse services, including a review and revision of regulatory requirements, to achieve comprehensive, community-responsive care.

Access and Participation: The Commission recommends that all DMH stakeholder groups review opportunities to support broader participation, including providing hybrid (in-person and virtual) meeting options, moving meeting locations and times, and redefine their purpose to align with the integration of Behavioral Health Services in Los Angeles County.

Fiscal Accountability and Outcomes: To promote fiscal responsibility and improve outcomes, the Commission recommends more closely aligning funding allocations with state-mandated objectives to mitigate the recurring problem of substantial unspent funds at the end of three-year cycles. The Commission also strongly advocates that LACMH optimize federal matching opportunities, such as Medicaid Administrative Activities (MAA), thereby freeing funds for BHSA to support direct services. The Commission recommends that DMH and SAPC report how these benefits will be distributed across directly operated clinics, contract providers, community-based organizations, and other legal entities. The Commission expresses concern about the current low percentage of the budget allocated to SAPC, which is only 2%, and recommends increasing this investment to more effectively address the needs of the substance use disorder population.

In addition, the Commission requests regular, transparent updates from LACDMH and SAPC on financial performance tied to outcomes, ideally quarterly or semiannually, including detailed variance reports comparing budgeted and actual expenditures. This practice would enhance accountability, ensure resources are fully utilized as intended, and provide transparency to the public. Regular reporting would also support the county's outcomes-based budgeting mandate and maximize the impact of allocated funds.

County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

County Provider Monitoring and Oversight

Cities submitting their Integrated Plan independently from their counties do not have to complete the Medi-Cal Quality Improvement Plan questions or Question 1 under All BHSA Provider Locations. Otherwise, all fields must be completed unless marked as optional. For related policy information, refer to **6.C.2 Securing Medi-Cal Payment**.

Medi-Cal Quality Improvement Plans

1. **For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027**

   See Attachment #C

2. **Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?** Yes

   a. See Attachment #C for the county's current QIP for SFY 2026-2027

Contracted BHSA Provider Locations

1. As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26, i.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Table 4. Contracted BHSA Provider Locations Offering Non-Housing Services

Services Provided	Number of Contracted BHSA Provider Locations
Mental Health (MH) services only	766
Substance Use Disorder (SUD) services only	168
Both MH and SUD services	0

2. **Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26**

Table 5. Contracted BHSA Provider Locations that Participate in Medi-Cal BHDS

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	624
DMC/DMC-ODS only	168
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

For related policy information, refer to **B.2 Considerations of Other Local Program Planning Processes**.

1. **Among the county's BHSA-funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?** 22%
    a. **Please describe the county's plans to enhance rates of MCP contracting starting July 1, 2027, and over the subsequent two years among the BHSA provider locations that are providing services that can/should be reimbursed by Medi-Cal MCPs**

    Through the Program Improvements for Valued Outpatient (PIVOT) project, LACDMH has an opportunity to engage providers about available opportunities, with Managed Care Plans, (MCPs) invited to participate. LACDMH is committed to expanding the number of providers delivering services tailored to our racially and ethnically diverse populations, and the diversity of our provider network strengthens our ability to meet clients' needs. LACDMH will also continue to engage its providers in our recurring provider meetings to encourage contracting with the MCPs for NSMHS and will survey a sample of our high-volume providers to learn what it would take for them to contract with the MCPs.

2. **To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)**
    a. Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening;
    b. Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and
    c. Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding.
        i. **Does the county wish to describe implementation challenges or concerns with these requirements?** No
3. **Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a**

monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county.

Does the county intend to adopt this recommended monitoring schedule for BHSA-funded providers that:

a. **Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements):** Yes

b. **Do not participate in the county's Medi-Cal Behavioral Health Delivery System?**:Yes

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to 7.A.1 Behavioral Health Services and Supports Expenditure Guidelines

General

1. **The following Behavioral Health Services and Supports (BHSS) are included in the plan**:
    - Adult and Older Adult System of Care (non-FSP)
    - Early Intervention Programs (EIP)
    - Outreach and Engagement (O&E)
    - Workforce, Education and Training (WET)
    - Capital Facilities and Technological Needs (CFTN)

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP))

Program #1: Outpatient Care Services

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information.

1. **Please select the service type provided under Program One:** Mental health services
2. **Please describe the specific services provided:**
   Outpatient Care Services (OCS) provides a broad, integrated array of clinic based, community-based (i.e. schools, residential settings), and field-based services as clinically appropriate within a recovery-focused system of care. This service is part of the mental health continuum and serves adults and older adults, who have mental health needs and co-occurring substance abuse needs, delivering mental health services that may include evidence-based or community-defined evidence-based practice and supports in a timely manner and in the most appropriate setting to meet each client's needs. Training and equipment are essential to support these evidence-based practices.

   OCS is inclusive and culturally sensitive, offering linguistically appropriate services to meet the diverse communities of Los Angeles County. OCS aims to meet clients where they are, engaging them in services and guiding them toward recovery and self-determined, meaningful goals that promote connectedness, mental and physical wellbeing, and purposeful use of time. Core services include crisis stabilization, assessments, individual and/or group therapy, crisis intervention, case management, employment support, peer support, co-occurring disorders treatment, MSS, and MAT. The intensity, location (community/field or office/clinic), and duration of services are tailored to each client's needs and may change over time. While many clients move from more intensive to less intensive services, some may require extended higher-intensity supports due to factors such as higher acuity needs, treatment non-adherence, substance use, trauma exposure, or external stressors (housing, employment, relationships, or legal issues). The primary goal is engaged, active participation in the treatment journey toward recovery.

3. **Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below**

Table 6. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	117,925
FY 2027 – 2028	119,104
FY 2028 – 2029	120,295

4. **Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care**
   Included individuals projected to be served in outpatient. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

Program #2: Mobile Crisis Response

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information.

1. **Please select the service type provided under Program One:** Mental health services
2. **Please describe the specific services provided:** Services are delivered by LACDMH clinicians who evaluate individuals at risk of self-harm, harm to others, or inability to meet basic needs; triage and de-escalation in the community; and coordination and dispatch of response teams to avoid hospitalization, incarceration, or injury. The approach emphasizes caring, trauma-informed intervention and strives to reduce stigma while supporting clients and families.
3. **Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below**

Table 7. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	12,968
FY 2027 – 2028	13,097
FY 2028 – 2029	13,227

4. **Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care**

   Included individuals served by Mobile Crisis Response. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

Early Intervention Program:

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "add" button. For related policy information, refer to **7.A.7 Early Intervention Programs**.

1. **Program or service name #1: Children and Youth Wellbeing Services (CYWS)**

   The Children and Youth Wellbeing Services (CYWS) program provides targeted, comprehensive care for children, youth, and TAY (Transition Age Youth) ages birth through 25 years identified with complex mental health conditions who meet criteria to access Specialty Mental Health Services. The services are tailored to address severe behavioral health disorders, improve functional impairment, and increase developmentally appropriate coping skills. Services are delivered by multidisciplinary staff in clinic and field-based settings utilizing evidence-based and community defined practices. Outpatient specialty mental health services aim to decrease symptoms, prevent the necessity for higher level of care, and promote wellbeing, all while supporting children, youth, and TAY, to remain integrated within their families and communities.

   CYWS represents a critical component of the behavioral health continuum of care, bridging the gap between community-based support, and more intensive treatment options. CYWS Program's partnerships with entities whose focus is children, youth, and TAY ensures a comprehensive holistic treatment approach. The goal of the program is for youth and families to be provided with the most appropriate level of care and services for their needs.

   Also included:

   - Outpatient services at Kedren Community Health Center to help bring holistic, cohesive care that addresses the whole child and family's needs to ensure a full continuum of care.
   - Providing Access to Treatment, Health, Wellness and Youth Support (P.A.T.H.W.A.Y.S.) This project aims to enhance organizational capacity, achieve Medi-Cal certification, and ensure the long-term sustainability of programs by claiming Medi-Cal. This project will create a pathway ending in new CBOs contracting with the LACDMH to deliver claimable services, through a contract that is not the traditional SD M/C contract.

   The following EI components are included as part of the program or service:

   - Outreach
   - Access and Linkage: Screenings
   - Access and Linkage: Assessments
   - Access and Linkage: Referrals
   - Treatment Services and Supports: Services to address first episode psychosis (FEP)
   - Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
   - Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

2. **Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs:** Yes

    a. The following is a list of EBPs that apply:
    - Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)
    - Brief Strategic Family Therapy (BFST)
    - Child and TAY
    - Child-Parent Psychotherapy (CPP)
    - Cognitive Behavioral Intervention for Trauma in School
    - Depression Treatment Quality Improvement (DTQI)
    - Family Centered EBPs
    - Family Connections (FC)
    - Functional Family Therapy (FFT)
    - Incredible Years (IY)
    - Multidimensional Family Therapy (MDFT)
    - Multisystemic Therapy (MST)
    - Nurturing Parenting (NP)
    - Parent-Child Interaction Therapy (PCIT)
    - Portland Identification and Early Referral (PIER)
    - Reflective Parenting Program (RPP)
    - Strengthening Families (SF)
    - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
    - Triple P Positive Parenting Program (Triple P)
    - UCLA Ties Transition Model (UCLA TTM)

3. **Please describe intended outcomes of the program or service**
    - Access to Care: Increase timely access to appropriate mental health services
    - Institutionalization: Reduce time spent in institutional settings.
    - Justice-Involvement: Decrease the number of youth with behavioral health needs who become or remain involved with the justice system.
    - Removal of Children from Home: Prevent unnecessary removal of children from their
    - Untreated Behavioral Health Conditions: Increase identification and timely treatment of behavioral health conditions, reducing progression, and improving functioning.
    - School Engagement: Enhance students' school engagement by preventing and treating behavioral health conditions, promoting consistent attendance, participation, graduation rates, and overall well-being.

4. **Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2:** No

5. **Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below**

Table 8. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	83,040

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	83,870
FY 2028 – 2029	84,708

a. **Please describe any data or assumptions the county used to project the number of individuals served through EI programs**
Included individuals projected to be served in Early Intervention. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

6. **Program or service name #2: Screening and Linkage**

This distinct program ensures that care can be provided as early as practicable in the onset of a behavioral health condition, with referrals for medical and social services as needed. It encompasses activities that support screening, assessment, and referral to behavioral health services through accessible channels such as telephone help lines, and supportive services. In addition, programming such as Wolf Connection and Friends of the Family aligns with Screening and Linkage efforts by providing complementary prevention and family-support activities: Wolf Connection offers experiential education and empowerment for youth via wolf-assisted learning, including the Power of the Pack digital education program and on-site visits; Friends of the Children delivers early family-centered mental health support, utilizing EBPs like PCIT and other family-focused interventions to reduce crises and strengthen family resilience. The integrated approach aims to improve early identification, facilitate timely access to care, and leverage community partnerships to support individuals and families across the care continuum.

7. **The following EI components are included as part of the program or service:**
   - Access and Linkage: Screenings
   - Access and Linkage: Assessments
   - Access and Linkage: Referrals

8. **Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs:** No

9. **Please describe intended outcomes of the program or service**
   - Access to Care: Increase timely access to appropriate mental health services
   - Justice-Involvement: Decrease the number of youth with behavioral health needs who become or remain involved with the justice system.
   - Removal of Children from Home: Prevent unnecessary removal of children from their
   - Untreated Behavioral Health Conditions: Increase identification and timely treatment of behavioral health conditions, reducing progression, and improving functioning.
   - School Engagement: Enhance students' school engagement by preventing and treating behavioral health conditions, promoting consistent attendance, participation, graduation rates, and overall well-being.

10. **Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2:** No

11. **Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below**

Table 9. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	9,053
FY 2027 – 2028	9,143
FY 2028 – 2029	9,234

a. **Please describe any data or assumptions the county used to project the number of individuals served through EI programs**
Included individuals served in programs listed above. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

12. **Program or service name #3: Outreach and Engagement**

This distinct program activates a multi-faceted approach to outreach, engagement, and early intervention across age groups, with a focus on caregivers, older adults, and youth. It prioritizes connections to community-based mental health and substance use services, leverages evidence-based practices (EBPs) and Community-Defined Evidence Practices (CDEPs) and seeks to reduce disparities in access for underserved and diverse populations. The program includes targeted outreach to aging networks and organizations serving older adults, as well as integrated youth services and school-based initiatives to support early identification, intervention, and referral.

Programs such as the United Mental Health Promoters (UMHP), TAY Drop-In Centers, and Community Resource Center are access-and-linkage programs in Los Angeles County. The UMHP aims to reduce mental health stigma in underserved cultural and linguistic communities by training and deploying community members to engage residents, connect them with the Department of Mental Health and other resources through culturally sensitive outreach, and provide stigma-reduction workshops, referrals, and frontline mental health support and triage. This county-wide outreach and empowerment effort delivers prevention services, engagement activities, and training to strengthen communities while creating career pathways for participants. The program supports eight UMHP teams (one contractor agency per Supervisory District) with nine staff per team, ensuring broad coverage and local presence.

13. **The following EI components are included as part of the program or service:**
    - Outreach
    - Access and Linkage: Screenings
    - Access and Linkage: Assessments
    - Access and Linkage: Referrals
14. **Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs:** No
15. **Please describe intended outcomes of the program or service**
    - Access to Care: Increase timely access to appropriate mental health services
    - Justice-Involvement: Decrease the number of youth with behavioral health needs

who become or remain involved with the justice system.
- Removal of Children from Home: Prevent unnecessary removal of children from their
- Untreated Behavioral Health Conditions: Increase identification and timely treatment of behavioral health conditions, reducing progression, and improving functioning.
- School Engagement: Enhance students' school engagement by preventing and treating behavioral health conditions, promoting consistent attendance, participation, graduation rates, and overall well-being.

16. **Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2:** No

17. **Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below**

Table 10. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	171,000
FY 2027 – 2028	172,710
FY 2028 – 2029	174,437

a. **Please describe any data or assumptions the county used to project the number of individuals served through EI programs** Grew projected number of individuals served by 1% over the course of the next 2 fiscal years, Promotores reported 150,967 and Community Family Resource Center, 19,877. Total is 170,844, rounded up to 171,000 to account for the missing TAY Drop in center numbers.

18. **Program or service name #4: Mobile Response**

These distinct services are delivered by LACDMH clinicians who evaluate individuals at risk of self-harm, harm to others, or inability to meet basic needs; triage and de-escalation in the community; and coordination and dispatch of response teams to avoid hospitalization, incarceration, or injury. The approach emphasizes caring, trauma-informed intervention and strives to reduce stigma while supporting clients and families.

19. **The following EI components are included as part of the program or service:**
- Access and Linkage: Screenings
- Access and Linkage: Assessments
- Access and Linkage: Referrals
- Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
- Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

20. **Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs:** No

21. **Please describe intended outcomes of the program or service**
    - Access to Care: Increase timely access to appropriate mental health services
    - Justice-Involvement: Decrease the number of those with behavioral health needs who become or remain involved with the justice system.
    - Removal of Children from Home: Prevent unnecessary removal of children from their
    - Untreated Behavioral Health Conditions: Increase identification and timely treatment of behavioral health conditions, reducing progression, and improving functioning.
    - School Engagement: Enhance students' school engagement by preventing and treating behavioral health conditions, promoting consistent attendance, participation, graduation rates, and overall well-being.

22. **Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2:** No

23. **Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below**

Table 11. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	5,693
FY 2027 – 2028	5,749
FY 2028 – 2029	5,806

a. **Please describe any data or assumptions the county used to project the number of individuals served through EI programs**
Included individuals served by existing Mobile Response services. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to 7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis.

1. **Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program**

    a. **CSC program name:** Coordinated Specialty Care for First Episode Psychosis (formerly known as PIER and EPI-LA)

    b. **CSC program description:** An evidence-based, team and community-based service for Specialty Mental Health Service clients who have exhibited the onset of psychotic symptoms within the past five years; or who exhibit attenuated psychosis symptoms that meet criteria for clinical high-risk syndrome. Service age range:12-40 years of

age. DMH has 8 current provider sites. 5 of the 8 have gone through fidelity reviews as part of our involvement in the EPICAL project. Our services were initially focused on clients ages 12-26, however, due to DHCS guidance we are expanding the age group to age 40.

2. **Please input the estimates provided to the county in the table below.**

Table 12. Estimated Number of Individuals Eligible for CSC and Estimated Number of Teams Needed to Serve Total Eligible Population

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	1,604
Number of Uninsured Individuals	218
CSC Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	196
Number of Teams Needed to Serve Total Eligible Population	46

3. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the total number of teams and Full-Time Equivalents (FTEs) (county-operated and county-contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

Table 13. Total Number of CSC Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	50	60	75
Total Number of Teams	8	10	13

4. **Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?** Yes
    a. **Please list the other funding source(s):** Medi-cal and EPSDT

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs, provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to **7.A.3 Outreach and Engagement**.

1. **Program or activity name #1:** Navigation
2. **Please describe the program or activity**: Activities include the following:
   Engagement with community referral sources to assist individuals in accessing outpatient care, including linkage to the Full Service Partnership program.

   Care Coordination/ Hospital Liaison: Care Coordination provides higher-touch support for individuals who are at risk of falling through the cracks in the system. This service involves more intensive engagement and follow-up to ensure clients successfully connect with and remain engaged in needed services. Hospital Liaison will go further that referral and linkage to include some service delivery. Assessment and testing when needed. This program priority population is the unhoused unlinked high utilizers that present with MH,

SUD or co-occurring disorders across our system in the emergency departments and locked LPS units. The goal is to ensure clients are not only referred to services, but that the connection is successful and sustained.

3. **Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below**

Table 14. Estimated Number of Individuals Served in O&E Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2,874
FY 2027 – 2028	2,902
FY 2028 – 2029	2,931

4. **Please describe any data or assumptions the county used to project the number of individuals served through O&E programs**
   Included individuals receiving outreach from Service Area Navigation teams and Veterans' program. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH- CONNECT and other state-administered workforce programs whenever possible.

Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).

For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training.

1. **Program or activity name #1**: Training and Technical Assistance
2. **The activity falls under the following category:** Workforce Recruitment, Development, Training and Retention
3. **Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9** Trainings focus on increasing clinical competencies across our diverse workforce. While training and technical assistance does not address the diversity of the workforce itself, which is more related to recruitment, DMH delivers comprehensive training that ensures that practitioners have the clinical competencies to deliver culturally relevant and competent services that are clinically effective and informed by the Department's cultural competence plan and array of cultural competence training. DMH also funds an annual Multi-Cultural Conference.
4. **Program or activity name #2**: Residency and Internship
5. **The activity falls under the following category:** Internship and Apprenticeship Program

6. **Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can be found in Policy Manual Chapter 7, Section A.4.9** Charles Drew University is located in South LA and serves a large African American and Latino client base. The Pathways to Health program specifically serves to expose African American and Latino high school students to career opportunities in public mental health. The majority of student trainees in the Student Professional Development Program identify as Latino or African American. DMH has utilized recruitment campaigns, including social media postings that feature mental health staff of various ethnicities to demonstrate DMH's focus on inclusiveness. In addition, DMH has been working with 2 Historically Black Colleges and Universities to establish academic affiliation agreements to serve as training sites for their graduate students.
7. **Program or activity name #3**: Financial Incentives
8. **The activity falls under the following category:** Retention Incentives and Stipends
9. **Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can be found in Policy Manual Chapter 7, Section A.4.9** These programs assist individuals from diverse backgrounds to consider public Specialty Mental Health employment. DMH has utilized recruitment campaigns, including social media postings that feature mental health staff of various ethnicities to demonstrate DMH's focus on inclusiveness. In addition, DMH has been working with 2 Historically Black Colleges and Universities to establish academic affiliation agreements to serve as training sites for their graduate students.
10. **Program or activity name #4**: Mental Health Career Pathways
11. **The activity falls under the following category:** Workforce Recruitment, Development, Training and Retention
12. **Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can be found in Policy Manual Chapter 7, Section A.4.9**

    This program prepares and enhances the skills for peer and parent providers who serve to enhance Specialty Mental Health Service delivery and provide meaningful roles for peers and parent partners. Recruitment efforts prioritize individuals with lived experience and individuals from historically underserved communities to support culturally responsive service delivery. Peer and Parent Partner Training provided through the programs include culturally responsive engagement, trauma-informed approaches, and strategies for working effectively with diverse populations. In addition, the programs encourage recruitment of bilingual Peer and Parent Partners to enhance language access and improve engagement with linguistically diverse communities.

Capital Facilities and Technological Needs (CFTN)

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5.

Capital Facilities Projects:

1. **Project name (#1):** High Desert CRTP
2. **The capital facilities project falls into the following category:** Meeting match

requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award

3. **Project Description:** The Crisis Residential Treatment Program will be the first adult CRTP in the Antelope Valley and will house 16 beds and provide a short-term alternative to hospitalization, serving 275 to 400 adults annually.
4. **Project name (#2):** Jacqueline Avant Children and Family Center
5. **The capital facilities project falls into the following category:** Acquiring, renovating, or constructing buildings that are or will be county- owned. The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.
6. **Does the project involve leasing or renting to own a building:** N
7. **Project Description:** The project was an expansion of the current outpatient service capacity located at Martin Luther King (MLK). The Children's Outpatient Program, a children and youth crisis stabilization unit (CSU) will also be housed on the third (3rd) floor of the MLK Jacqueline Avant Children and Family Center Pediatric Outpatient Center and CSU.
8. **Project name (#3):** LA General Urgent Care Center (UCC)
9. **The capital facilities project falls into the following category:** Acquiring, renovating, or constructing buildings that are or will be county- owned. The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.
10. **Does the project involve leasing or renting to own a building:** N
11. **Project Description:** The UCC provides immediate, walk-in access to behavioral health services for people in crisis, acting as an alternative to hospital ERs for psychiatric needs, offering assessments, counseling, medication help, and stabilization to connect patients with ongoing care without requiring overnight stays, The UCC facility would operate on a 24/7 basis, and its clients can remain in the facility for a duration not to exceed 24-hours. If a client is not able to safely return to their previous environment, they may be transferred to one of the LA General CRTPs across the shared driveway for short-term residential care. Likewise, its proximity to Los Angeles General Medical Center is of importance. Clients at the proposed MHUCC in need of further medical care or inpatient mental health care may be transferred to the Medical Center.
12. **Project name (#4):** East San Gabriel Valley Clubhouse
13. **The capital facilities project falls into the following category:** Acquiring, renovating, or constructing buildings that are or will be county- owned. The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.
14. **Does the project involve leasing or renting to own a building:** N
15. **Project Description:** A Club House provides a non-clinical therapeutic community for people living with serious mental illness who work in partnership with our members to ensure they are at the center of their own recovery.
16. **Project name (#5):** Urgent Care Center (UCC)
17. **The capital facilities project falls into the following category:** Renovating or constructing buildings that are privately owned.
18. **Project Description:** Psychiatric UCCs are Medi-Cal certified and Lanterman Petris Short (LPS) designated free-standing crisis stabilization units that provide rapid access to mental health evaluation and assessment, crisis intervention and medication support 24-hours per day, 7 days per week. UCCs also provide case management for individuals experiencing

psychological distress and/or psychiatric crisis. UCC services, including integrated services for co-occurring disorders, are focused on stabilization and linkage to recovery-oriented community-based resources. Clients are permitted to stay in the UCC chair 23 hours and 59 minutes that are licensed by the California Department of Health Care Services.

19. **Project name (#6):** Tenant Improvement
20. **The capital facilities project falls into the following category:** Establishing a capitalized repair or replacement reserve.
21. **Project Description:** Funds will be utilized to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded BHSA programs which includes the purchasing of equipment and furniture.

Technological Needs Projects:

1. **Project name (#1):** System Maintenance and Upgrades
2. **The following are the focus area(s) of the project:**
    - Data exchange and interoperability
    - Data security and privacy
    - Data warehouse
    - Electronic health record system
    - Imaging/paper conversion
    - Monitoring
    - Online information resources for individuals/families
    - Personal health record system
    - Resources to support web content and mobile app accessibility
    - System maintenance costs
    - Telemedicine

3. **Please describe the project:** Reserve of funds needed to maintain and upgrade system State requirements and local County needs. This investment will enable seamless data exchange and interoperability, strong data security and privacy, and robust data analytics. Funding supports a centralized data warehouse for reporting and decision support, a core Electronic Health Record (EHR) system for patient encounters and care plans. It also covers continuous monitoring for system and security oversight, and user-friendly online information resources for individuals and families.

Full Service Partnership Program

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to **7.B.3 Full Service Partnership Program Requirements** and **7.B.4 Full Service Partnership Levels of Care**]

1. Please review the total estimated number of individuals who may be eligible for each of the following Full Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide, the Policy Manual Chapter 7, Section B, and forthcoming High Fidelity Wraparound (HFW) Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below

Table 15. Estimated Number of Individuals Eligible for Full Service Partnership Services

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	29,452
Number of Uninsured Individuals	5,027
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	9,615

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Eligible Population

1. Please input the estimates provided to the county in the table below

Table 16. Estimated Number of Individuals Eligible for ACT and FACT and Estimated Number of Teams Needed to Serve Total Eligible Population

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	3,817
Number of Uninsured Individuals	652
FACT Eligible Population (ACT with Justice-System Involvement)	**Estimates**
Number of Medi-Cal Enrolled Individuals	1,909
Number of Uninsured Individuals	2,235
ACT and FACT Practitioners and Teams Needed	**Estimates**

Number of Practitioners Needed to Serve Total Eligible Population	680
Number of Teams Needed to Serve Total Eligible Population	68

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county-operated and county- contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

Table 17. Total Number of ACT and FACT Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	160	472	785
Total Number of Teams	16	47	78

Full Service Partnership (FSP) Intensive Case Management (ICM) Eligible Population

1. **Please input the estimates provided to the county in the table below**

Table 18. Estimated Number of Individuals Eligible for FSP ICM and Estimated Number of Teams Needed to Serve Total Eligible Population

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	23,726
Number of Uninsured Individuals	4,049
FSP ICM Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	1,115
Number of Teams Needed to Serve Total Eligible Population	223

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county-operated and county-contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

Table 19. Total Number of FSP ICM Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	475	682	893
Total Number of Teams	73	105	137

High Fidelity Wraparound (HFW) Eligible Population

1. **Please input the estimates provided to the county in the table below**

Table 20. Estimated Number of Individuals Eligible for HFW and Estimated Number of Teams Needed to Serve Total Eligible Population

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	14,166
Number of Uninsured Individuals	989
HFW Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	5,312
Number of Teams Needed to Serve Total Eligible Population	106

1. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county-operated and county-contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

Table 21. Total Number of HFW Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	5,312	5,312	5,312
Total Number of Teams	106	106	106

Individual Placement and Support (IPS) Eligible Population

1. **Please input the estimates provided to the county in the table below**

Table 22. Estimated Number of Individuals Eligible for IPS and Estimated Number of Teams Needed to Serve Total Eligible Population

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	3,172
Number of Uninsured Individuals	1,269
IPS Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	222
Number of Teams Needed to Serve Total Eligible Population	111

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county-operated and county-contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

Table 23. Total Number of IPS Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	30	60	100
Total Number of Teams	15	30	50

Full Service Partnership (FSP) Program Overview

Please provide the following information about the county's BHSA FSP program

1. **Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?** Yes
    a. **Please describe how the estimated practitioners will provide more than one EBP**: Some FSP, ACT and FACT practitioners may also be trained in IPS or any other EBP determined to be appropriate to serve the population. Within ACT and FACT, the expectation is that practitioners are fully dedicated to ACT and FACT, so EBPs would be provided to the ACT/FACT population.
2. **Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports:**

    Los Angeles County Full Service Partnership (FSP) programs are recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe mental illness often with a history of criminal justice involvement and repeat hospitalizations.

    FSP programs were designed to serve people in the community rather than in locked state hospitals. By engaging mental health consumers in their own care and providing services tailored to their stated individual needs, FSPs can incorporate family and supports as identified by individual clients during the treatment planning. FSP Adult delivers multidisciplinary, team-based care designed to address the whole person. Teams may include licensed clinicians, psychiatrists, case managers, nurses, substance use specialists, and peer staff. Decisions are collaborative, with ongoing risk assessment and individualized treatment planning that prioritizes safety. The integrated model targets psychiatric symptoms, substance use, medical issues, housing instability, legal involvement, and psychosocial stressors through multiple modalities such as individual therapy, crisis intervention, medication management, harm reduction, case management, and field outreach.

    The program emphasizes flexible funding to meet urgent needs that affect mental health stability. Examples include assisting with benefits applications, covering essential needs like groceries and clothing, and supporting sober living placements. This approach aims to prevent rapid decompensation, re-incarceration, and hospitalization by addressing basic needs alongside clinical care.

    Persistent outreach and family collaboration are core components. The FSP Adult model prioritizes ongoing engagement, including locating missing clients, re-engaging those who disengage, and maintaining contact with hospitals, jails, shelters, and encampments. When appropriate, the team involves families and natural supports in treatment planning, crisis prevention, and safety planning, while respecting client autonomy and consent. The overarching goal is a trauma-informed, whole-person approach that integrates clinical care with social supports to promote recovery and stability.

    DMH can also ensure providers are employing a whole-person, trauma informed approach by ensuring training, and ensuring whole person approaches are reflected in policy.

3. **Please describe the county's efforts to reduce disparities among FSP participants**

The Los Angeles County Department of Mental Health (LACDMH) is engaged in various efforts to address and reduce disparities in mental healthcare access and outcomes for underserved populations. Key strategies and initiatives include but are not limited to prioritizing hiring of individuals with language capabilities reflective of client needs, partnering with mission driven providers who provide culturally competent care, and dialoging and training on cultural competency. Countywide strategies include Cultural Competency and Responsiveness; Mental Health promoters to reduce stigma in underserved communities by raising awareness and resources; Community Engagement and Outreach; Efforts are made to integrate physical health, mental health, and substance abuse services; LACDMH utilizes evidence-based practices and community defined evidence based practices to improve service delivery for ethnic populations.

Each Fiscal Year (FY), several activities are implemented and tracked to determine disparities in access to mental health services across three MHSA Plans including Community Services and Support (CSS), Workforce, Education, and Training (WET), and Prevention Early Intervention (PEI). FSP disparities are represented in the CSS component of our MHSA Plan. With that said, we've identified disparities in our African American (AA), Asian Pacific Islander (API), Latino, and American Indian/Alaska Native (AI/AN) populations. We've used several data sources that are delineated in our 2025 Cultural Competency Plan including but not limited to Medi-Cal enrolled population. Additional data sources specific to FSP have included the following:

- Integrated Behavioral Health Information System (IBHIS) is equipped to provide reports on "Active" clients through various COGNOS reports which reflect basic demographic information to assist, support or enhance other data sets and sources with ability to analyze disparity populations served.
- Outcomes Division provides data on comprehensive demographics for disparity analysis and comparison across populations. Through this reporting system we can evaluate what disparities exist and how they are being served.
- Our DMH NAPA system provides data on provider programs and specialty mental health services available to ensure FSP cases are assigned to providers that have the capacity and staff to deliver linguistic, age and culturally sensitive services.
- Referral Tracking System (RTS) provides FSP specific data in which demographics are reflected in our semi-monthly reports and denotes client demographics related to ethnicity, legal and housing. In addition, RTS also provides data on language, gender and gender identity.
- Through our coordination with UCLA Center of Excellence, Public Mental Health Partnership we are able to provide resources and recommend trainings for providers to ensure they have the access to the most current and updated trainings for outreaching, engaging, delivering culturally sensitive services across various populations including Latinx, African American, LGBTQ+, Older Adults.
- Systemwide strategies to reduce disparities have also assisted in reducing those same disparities in FSP. Those include but are not limited to the following:
    - Community Education Multi-media campaigns FSP-Countywide Networks
    - FSP-Ethnic Targets
    - EBPs/CDEs for Ethnic Populations
    - Field-Based Services
    - FSP-Enrollment Flexibility
    - Language Assistance Services

- Multi-cultural Staff Development
- Outreach and Engagement Activities
- Integrated Services (Physical, Mental Health and Substance Use)
- Specific Ethnic/Language Groups
- Provider Communication/Support
- Training/Case Consultation

Specific examples of how we are addressing disparities in FSP have included the following: We collaborate with AAPI Equity Alliance to ensure API community mental health needs are being met by having several therapists with a variety of API language capabilities such as Mandrin, Cantonese, Japanese, Filipino, Vietnamese, Cambodian, and Korean to reflect most common spoken languages in the Los Angeles County as well as other API languages.

Our Service Area (SA) Navigators are subject matter experts when determining programs, linkage needs, and providers equipped to deliver services for clients with one or more qualities related to disparities. For example: we have specialty FSP providers that have expertise in working with a particular age group or populations including but not limited to Social Model Recovery and Tarzana Treatment Center to serve COD/SUD clients; Starview that serves LGBTQ+ and TAY clients; American Indian Counseling Center; Long Beach API Family Mental Health Center, Coastal API Family Mental Health Center, Asian Pacific Counseling and Treatment Center, and Heritage who serve older adult clients. When a referral comes in with a particular need we are able to route them accordingly, if available in that service area.

4. **The following are goals the County is hoping to support based on the county's allocation of FSP funding** :

   Access to care, Homelessness, minimize time in institutional settings, reducing justice involvement, reducing removal of children from the home, reducing untreated behavioral health conditions, and increase engagement in schools

5. **Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM**

   LACDMH FSP programs employ "relentless engagement" efforts whenever possible to ensure those vulnerable populations are engaged and enrolled in treatment. Once enrolled, the service model requires regular case review by the team, as well as a minimum of 4 services per month, ensuring regular engagement. In addition, motivational interviewing and other practices are used to support individuals on their road to recovery.

   a. **(Optional) Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW. Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP**

      In addition to the strategies outlined above for FSP ICM, DMH has some programs that engage in proactive outreach to engage or re-engage individuals in care including the Homeless Outreach Mobile Engagement (HOME) team as well as the Interim Housing Outreach Program (IHOP) which proactively engages individuals residing in transitional housing settings to engage or re-engage them in services.

6. **Please describe how the county will comply with the required FSP levels of care**

(e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)

LACDMH has implemented the use of the Levels of Care Utilization System (LOCUS), which is a standardized assessment tool used to determine the appropriate level of care for individuals with mental health or substance use disorders. The LOCUS will be used throughout all LACDMH programming/services including FSP levels of care. LACDMH has also completed a needs assessment for ACT/FACT, FSP-ICM, and HFW, and plan to transition existing FSP providers into doing FSP-ICM and ACT. We plan on phasing in our providers and assessing additional need for FSP levels of care as we go. We may release a solicitation process for both programs should the need arise.

7. **Please indicate whether the county FSP program will include any of the following optional and allowable services**:
    a. **Primary substance use disorder (SUD) FSPs**: No
    b. **Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section):** Yes
        i. **Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program**
        Los Angeles County has multiple outreach teams some of which are DMH funded and some of which are not, but coordinate with DMH to refer to care. DMH has developed a universal referral form these community and homeless outreach teams, use to refer for DMH services. DMH also uses screening tools with Managed care to ensure the correct level of care for referrals to specialty mental health. DMH partners with entities in justice involvement settings who refer to FSP care, and finally, DMH employs hospital liaisons that assist in referring individuals to the right level of care within the DMH system of care. LACDMH has regional navigation teams who are responsible for connecting these referrals with the most appropriate FSP provider.
        In addition, DMH has some programs that do proactive outreach to engage or re-engage individuals in care including the Homeless Outreach Mobile Engagement (HOME) team as well as the Interim Housing Outreach Program which proactively engages individuals residing in transitional housing settings to engage or re-engage them in services.

    c. **Other recovery-oriented services**: Yes
        i. **Please describe the other recovery-oriented services the county's FSP program will include**: LACDMH will be expanding the Individual Placement and Support (IPS) as part of FSP programming to assist individuals with Severe Mental Illness (SMI) with finding and maintaining competitive employment.

8. **If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams.**

    Other FSP services include:

    Clubhouse Model

DMH is building Clubhouse model programs across LA County which can complement care.

Hollywood 2.0

Hollywood 2.0 is a pilot program that will help build the evidence base for new statewide behavioral health strategies by testing a holistic, community-based continuum of care model that integrates psychosocial rehabilitation with flexible, person-centered service delivery. The pilot is designed to assess whether an integrated “clinic without walls” model can improve outcomes for individuals with severe mental illness compared to more traditional, siloed systems of care.

H20 is inspired by the public mental health system in Trieste, Italy which incorporates a community-based approach to support individuals living with severe mental illness. This method is fundamentally different from existing services in the Department of Mental Health (DMH) in two key ways:

1. Care is organized as a continuous, integrated system rather than as separate programs with rigid eligibility and referral criteria; and
2. Services prioritize functional recovery, autonomy, and community participation alongside clinical treatment.

Through the Hollywood Mental Health Cooperative, the H20 pilot integrates a full array of services, including outpatient care, intensive field services, urgent care, housing navigation, employment support, and other social services, within a single multidisciplinary team structure. This model increases flexibility to match individuals to the appropriate level and type of care as needs change, reducing service fragmentation and barriers to engagement.

By tracking outcomes related to service engagement, housing stability, crisis and emergency service utilization, and functional recovery, the H20 pilot will generate actionable data and implementation lessons that can inform effectiveness, scalability, and replication of similar community-based mental health strategies.

Interim Housing Outreach Program (IHOP)

The program is a collaborative project between LA County Departments of Mental Health (DMH), Public Health-Substance Abuse Prevention and Control (DPH-SAPC), and Health Services-Housing for Health (DHS-HFH). This Innovative Project will help build the evidence base for the effectiveness of new statewide strategies by testing a coordinated, cross-department service delivery model embedded within interim housing settings.

By integrating specialty mental health, substance use disorder, and physical health services within interim housing, the program will generate evidence on whether multi-disciplinary, field-based teams can improve access to care, address functional impairments, support transitions to permanent housing, improve health outcomes, and reduce returns to homelessness.

Specialty mental health services provided through the IHOP include outreach & engagement, triage, peer support, screening/assessment, individual and group rehabilitation and therapy, medication evaluation/administration, intensive case management, and crisis intervention. Substance use disorder (SUD) treatment delivered by DPH-SAPC includes individual and group support sessions, psychoeducation on substance use, linkage to medication for addiction treatment (MAT), and harm reduction services, (e.g. fentanyl test strips, naloxone, syringe services etc.). For residents in need of more intensive SUD services, the IHOP teams can facilitate admission to detox and residential treatment programs.

Data collected on service utilization, housing outcomes, health and behavioral health indicators, and participant engagement will inform the effectiveness, feasibility, and scalability of this model. Findings from the pilot will support decision-making around replication of integrated, housing-based service models and the development of future statewide approaches to addressing homelessness, behavioral health, and health equity.

Transformation from Peer Resource Centers to Clubhouses

LACDMH will continue to transform the existing Peer Resource Centers into the Clubhouse model, assuring alignment with BHSA and BH Connect. To support and facilitate this system-wide transformation, LACDMH will contract with a consultant to assess the system's readiness for these changes, evaluate and identify effective strategies, and successfully redesign and implement the Clubhouse model.

The project will establish clubhouses by supporting, educating, and providing centralized technical assistance to providers. The goal is to phase in an expansion of billable revenue streams.

Consultation Services for FSP

The FSP program provides a wide array of services and supports, guided by a commitment by providers to do "whatever it takes" within the resources available to help the highest acuity clients within defined populations make progress on their paths to recovery and wellness. This project will allow for technical assistance and support for outpatient providers transitioning to become Full Service Partnership providers and will support any newly contracted Full Service Partnership providers.

9. **What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's FSP program (e.g., review data, engage with stakeholders, analyze research, etc.) who are**:
    a. **In, or at-risk of being in, the juvenile justice system**
    DMH has reviewed data related to TAY in need of services under FSP.
    DMH has developed an "Office of TAY" and has developed a TAY field based FSP program which serves TAY and their unique needs. DMH has an existing TAY drop in center allowing for ongoing engagement of at risk youth. In addition, DMH has robust non-MHSA/BHSA funded programming within the Juvenile Justice settings, and discharged youth in need are referred to FSP upon release.

    b. **Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)**
    Representatives from the LGBTQ+ community and advocacy groups participated in the Community Planning process when the FSP, ACT, and FACT programs were presented. DMH is committed to ensuring that FSP-HFW programming is inclusive and responsive to the needs of all youth populations, including LGBTQ+ youth. LGBTQ+ youth who experience disproportionate behavioral health and housing instability risks. DMH is working with their BHSA administration to engage LGBTQ+ youth in the community planning processes and is collaborating with the Youth Commission and the Commission of Children and Families to incorporate youth voice into program development. These efforts will strengthen culturally responsive and affirming services within HFW-FSP programs.
    c. **In the child welfare system**
    DMH reviewed data related to children and youth in the child welfare system with

stakeholders, identifying regional concentrations where services are most needed. DMH partners closely with the Child Welfare System to triage care and provide care attuned to the unique needs of children and youth in or at risk of being in the child welfare system. DMH has a non MHSA/BHSA funded program titled Specialized Foster Care which partners directly with DCFS offices regionally, provides screening and linkage. All FSP providers deliver ICC and IHBS services and will be trained to deliver HFW under BHSA.

10. **What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's FSP (e.g., review data, engage with stakeholders, analyze research, etc.) who are:**
    a. Older adults: DMH has established FSP contracts with mission driven providers who specialize in services to the older adult population. DMH will also be transforming our Genesis program to FSP ICM, this program specifically provides outreach and focused on older adults who are home bound.
    b. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+): DMH has established FSP contracts with mission driven providers who specialize in services to the LGBTQ+ population. DMH will continue to expand service delivery to this population in the coming years.
    c. In, or are at risk of being in, the justice system: DMH has established FSP contracts with mission driven providers who specialize in services to the justice involved population. In addition, we have partnerships with the Office of Diversion and Re-entry to facilitate individuals leaving the justice system and support their transition to housing and enrollment in the FSP program. Finally, DMH has the Men's and Women's wellbeing program which will transform to FSP ICM in FY 26/27. This program is dedicated to serving individuals coming out of the justice system with the goal or promoting recovery and preventing recidivism.

       In addition, one of the cornerstones of the Mental Health Services Act (MHSA) is to empower underrepresented ethnic/cultural groups and to give them a voice in the stakeholder process. The term **Underserved Cultural Communities (UsCC)** refers to communities historically unserved, underserved and inappropriately served, in terms of mental health services. As a result of MHSA, UsCC subcommittees have been developed by LACDMH to address the needs of targeted ethnic/cultural communities.

       The UsCC subcommittees are an important part of the community stakeholder engagement process. The UsCC subcommittees work closely with community partners and consumers to increase the capacity of the public mental health system and to develop culturally competent recovery-oriented policies and services specific to the UsCC communities. Through our regular monthly meetings with stakeholders, we've shared data and presented how BHSA will change FSP landscape. Through this process, we've looked at the unique needs of Children, Adults, Older Adults, LGBTQ+, and those that are criminal justice involved. Robust discussions and analysis of existing data have led to developing the county's FSP program.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to **7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services**.

1. **Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.**

   LACDMH will leverage existing SUD treatment services for all field-based programs including FSP to ensure clients have rapid access to Medication Assisted Treatment (MAT) and promote a person-centered approach to provide access to lifesaving care, prevent overdose and improve the quality of life for individuals living with SUDs. LACDMH has already trained directly operated Psychiatry providers in MAT and intend to expand this training to increase MAT access within FSP under FSP ICM, ACT, and FACT. In addition, LA has a robust availability of MAT services, including a hotline that can assess and prescribe MAT immediately and offer linkage to ongoing MAT services. LACDMH will prioritize expanding MAT capabilities within teams, while also helping providers access community based services. LACDMH will expand MAT capacity and training starting July 1, 2026, in order to meet the assertive field-based SUD program requirements.

Table 24. Existing Programs for Assertive Field-Based SUD Treatment Services: Targeted Outreach

Existing Program
CA Bridge Hospitals; Syringe exchange programs; Harm Reduction Vending Machines
Program Description
• CA Bridge Hospitals: Ensures that every hospital in California provides 24/7 access to evidence-based care, treating substance use disorder (SUD) like any other life-threatening condition. CA Bridge is working with hospital emergency departments (EDs) to provide immediate access to medications for addiction treatment (MAT) to anyone seeking help. • Syringe Exchange Programs: Syringe services programs have been operating in California, providing sterile syringes, collecting used ones, and acting as points of access to health education and care for people who inject drugs Harm Reduction Vending Machines: are an evidence-based strategy to provide essential harm reduction supplies to people who use drugs. Harm reduction vending machines are similar to drink or snack vending machines, but may be stocked with supplies such as naloxone, sterile injection equipment, condoms, sharps containers, first aid kits, and pregnancy tests.
Current Funding Source
Los Angeles County Department of Public Health and other Non BHSA funding
BHSA Changes to Existing Program(s) to Meet BHSA Requirements
N/A
Expected Timeline of Operation
Currently Active

Table 25. Existing Programs for Assertive Field-Based SUD Treatment Services: Mobile-Field Based Programs

Existing Program
Homeless Outreach & Mobile Engagement (HOME), Full Service Partnership
Program Description
• HOME: The Homeless Outreach & Mobile Engagement (HOME) Program serves unhoused adults with severe mental illness who decline other services. The program aims to meet the most vulnerable and disengaged in the community where they are at and do whatever it takes to help them move towards housing and recovery. • FSP: Adult FSP programs assist with housing, employment and education in addition to providing mental health services and integrated treatment for individuals who have co-occurring mental health and substance abuse disorder. Services can be provided to individuals in their homes, the community and other locations. Embedded in Full Service Partnerships is a commitment to deliver services in ways that are culturally and linguistically competent and appropriate. HOME team has developed several innovations in field-based space. HOME Team staff psychiatrists are expertly trained street psychiatrists who are extensively trained in working with unhoused individual with SMI and cooccurring SUD. All street psychiatry evaluations are completed in-person, which allows for culturally and structurally informed treatment planning that is completed within the realities of each individual's living conditions. Medication regimens are designed to be practical and sustainable in the street. Prescriptions are sent to pharmacies that can pre-package oral medications (including oral MAT) in individual bubble packs. This allows HOME staff to deliver daily medication doses to clients in the field and directly observe compliance with all medications including MAT. Protocols to complete phlebotomy in the field have also been developed. Mobile labs can thus be completed by HOME street psychiatrists to screen for health conditions and monitor psychiatric/MAT treatment appropriately. HOME team has nursing support within their multidisciplinary teams with training and experience to complete vital signs and administer long-acting injections (including injectable MAT) in the field. Licensed medication rooms for each HOME team have been created where psychiatric medications including MAT can be stored and rapidly delivered/administered to clients who accept treatment. HOME also provides linkage to housing and residential services to address homelessness and support recovery beyond the streets. For clients who are too impaired to be treated on the street or outpatient settings, HOME has developed partnerships with hospitals and admit clients who meet criteria for acute stabilization and inpatient initiation of MAT. HOME team has created avenues of collaboration between street medicine, primary care, specialty medical providers, and drop-in centers in the community to link clients for additional SUD services (including MAT) whenever needed. All field-based teams within our system will be trained on the HOME Team model and incorporate their innovations when appropriate. They will also be trained in delivering AFBSS, COD/SUD treatment, and deliver MAT services via staff psychiatrist or link to MAT via DHS MAT hotline or connect individuals to street medicine providers and open access clinics that are available in the community. All members of the field-based team will be trained in COD/SUD services in addition to having SUD counselor as part of the team.
Current Funding Source
• HOME: MHSA Linkage Services • FSP: MHSA FSP
BHSA Changes to Existing Program(s) to Meet BHSA Requirements
Both of these programs will be aligned with BHSA FSP requirements to ensure IPS, AFBSS/MAT, and COD/SUD service delivery. Both of these programs will be aligned with BHSA FSP requirements to ensure IPS, AFBSS/MAT, and COD/SUD service delivery. LACDMH will implement intensive training with existing Full Service Partnership providers to

enhance Co-occurring disorder services and outreach skills. Training will include conducting an ASAM screening, psychiatry training to deliver MAT, understanding the network of available MAT services in LA County, and team based care and documentation for individuals with co-occurring disorders. LACDMH will train psychiatrists and expand its capacity to deliver MAT across both directly operated and contracted services, while mapping resources to ensure rapid access to partner services, including FQHCs and non-DMH entities.
Expected Timeline of Operation
Currently Active

Table 26. Existing Programs for Assertive Field-Based SUD Treatment Services: Mobile-Open-access clinics

Existing Program
Homeless Outreach & Mobile Engagement (HOME), Full Service Partnership
Program Description
DMH offers open access field based MAT through its HOME team street psychiatrists. DMH FSP also refers to open access clinics present in Los Angeles County, examples include FQHCs and partnership with health street teams. HOME team has developed several innovations in field-based space. HOME Team staff psychiatrists are expertly trained street psychiatrists who are extensively trained in working with unhoused individual with SMI and cooccurring SUD. All street psychiatry evaluations are completed in-person, which allows culturally and structurally informed treatment planning that is completed within the realities of each individual's living conditions. Medication regimens are designed to be practical and sustainable in the street. Prescriptions are sent to pharmacies that can pre-package oral medications (including oral MAT) in individual bubble packs. This allows HOME staff to deliver daily medication doses to clients in the field and directly observe compliance with all medications including MAT. Protocols to complete phlebotomy in the field have also been developed. Mobile labs can thus be completed by HOME street psychiatrists to screen for health conditions and monitor psychiatric/MAT treatment appropriately. HOME team has nursing support within their multidisciplinary teams with training and experience to complete vital signs and administer long-acting injections (including injectable MAT) in the field. Licensed medication rooms for each HOME team have created where psychiatric medications including MAT can be stored and rapidly delivered/administered to clients who accept treatment. HOME also provides linkage to housing and residential services to address homelessness and support recovery beyond the streets. For clients who are too impaired to be treated on the street or outpatient settings, HOME has developed partnerships with hospitals and admit clients who meet criteria for acute stabilization and inpatient initiation of MAT. HOME team has created avenues of collaboration between street medicine, primary care, specialty medical providers, and drop-in centers in the community to link clients for additional SUD services (including MAT) whenever needed. All field-based teams within our system will be trained on the HOME Team model and incorporate their innovations when appropriate. They will also be trained in delivering AFBSS, COD/SUD treatment, and deliver MAT services via staff psychiatrist or link to MAT via DHS MAT hotline or connect individuals to street medicine providers and open access clinics that are available in the community. All members of the field-based team will be trained in COD/SUD services in addition to having SUD counselor as part of the team.
Current Funding Source
• HOME: MHSA Linkage Services • FSP: MHSA FSP • Non-behavioral health services funding
BHSA Changes to Existing Program(s) to Meet BHSA Requirements
N/A

Expected Timeline of Operation
Currently Active

Table 27. New Programs for Assertive Field-Based SUD Treatment Services: Targeted Outreach

New Program(s)
ACT/FACT, FSP-ICM
Program Description
DMH will identify the highest-need outreach locations by collaborating with Emergency Medical Services (EMS), law enforcement, managed care plans (MCPs), health systems and hospitals, FQHC/RHS', individuals with living or lived experience, and other partners to obtain data on regions and populations with high rates of overdose, overdose reversals, drug-related arrests, and other relevant statistics on a regular basis.
Planned Funding
BHSA FSP
Planned Operations
Both of these programs will be aligned with BHSA FSP requirements to ensure IPS, AFBSS/MAT, and COD/SUD service delivery. LACDMH plans to train Full Service Partnership providers to enhance Co-occurring disorder services and outreach skills. Training will include conducting an ASAM screening, psychiatry training to deliver MAT, understanding the network of available MAT services in LA County, and team based care and documentation for individuals with co-occurring disorders.
Expected Timeline of Operation
July 1, 2027

Table 28. New Programs for Assertive Field-Based SUD Treatment Services: Mobile-Field Based Programs

New Program(s)
IHOP, VMFS, HSSP, GENESIS, TAY Field Based Teams
Program Description
• Interim Housing Outreach Program (IHOP): is a field-based, multidisciplinary teams that are specifically dedicated to serving people experiencing homelessness (PEH) who are living in interim housing. The project is designed to address current gaps in behavioral health, including substance use, and physical health services, support interim housing stability, facilitate transition to permanent housing and prevent a return to homelessness. • Veteran Military Family Services (VMFS): VMFS's are a peer-driven approach that fosters trust, encouraging veterans to seek support for housing, employment, education, and trauma-related needs. These services are delivered by field based multi-disciplinary teams • Housing and Supportive Services Program (HSSP): A program that provides comprehensive and intensive field-based specialty mental health services designed to meet the unique needs of formerly unhoused individuals living in tenant-based or project-based PSH that have a Serious Mental Illness (SMI) or Severe Emotional Disturbance (SED) • GENESIS: The GENESIS Older Adult Program offers field-based outpatient mental health services for older adults who are living with a severe mental illness and are unable to access services due to impaired mobility, frailty, or other limitations. GENESIS provides specialized services to meet the unique needs of people ages 60 years and above. • TAY Field Based Teams: These are multi-disciplinary teams that provide outreach and engagement to transitional age youth (ages 16-25) that have SMI/SED and need specialty mental health services and linkage to other services such as housing, employment, etc.
Planned Funding

BHSA FSP
Planned Operations
LACDMH will provide compressive training to providers to enhance Co-occurring disorder services and outreach skills. Training will include an conducting an ASAM screening, psychiatry training to deliver MAT, understanding the network of available MAT services in LA County, and team based care and documentation for individuals with co-occurring disorders.
Expected Timeline of Operation
July 1, 2026

Table 29. New Programs for Assertive Field-Based SUD Treatment Services: Open-access clinics

New Program(s)
N/A
Program Description
N/A
Planned Funding
N/A
Planned Operations
N/A
Expected Timeline of Operation
N/A

Medications for Addiction Treatment (MAT) Details

1. **Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs**

   The gap will be assessed using the DHCS provided number for the calendar year of 2024, which is 54.11% (7,972 of 14,732 Medi-Cal members with (OUD) in LA County received MOUD). This number represents met and unmet need. We will also use Medi-Cal claims data (MCP, SMHS, DMC-ODS) where an OUD (F11.*) or AUD (F10.*) was documented and then compare this with Medi-Cal Rx and DMC-ODS data on MOUD and MAUD receipt. Currently, 2,904 (40%) of FSP clients have a occurring SUD, and are receiving co-occurring care. As we get closer to BHSA implementation, we will be providing training on Assertive Field Based Initiation of SUD services for all our field-based programs, specifically FSP. We hope that this will increase engagement and linkage to Medication for Addiction Treatment (MAT) for those in need. We will also avail ourselves, and leverage, when possible, other resources such as DHS Hotline for MAT services to ensure clients are linked as soon as possible. Expanding our open access clinics to ensure clients are connected to MAT countywide is also a goal. In addition, MAT training for psychiatrists who will be providing services as part of a field-based team will be essential; as well as training the entire team in treating co-occurring substance use clients. By using some of the above strategies we hope to address unmet needs of those individuals who are not yet in our system.

2. **The county will implement the following practices to ensure same day access to MAT:**
   - Contract directly with MAT providers in the county
   - Operate MAT clinics directly

- Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
- Leverage telehealth model(s)
- Other strategy: The plan to meet this need includes: providing start-up funding to DMC-ODS certified clinics to hire medical clinicians so these settings have medical clinicians on staff can provide addiction medication services to clients. We plan to support agencies with medical clinicians working collaboratively with agencies who don't have this staffing to enable cross-coverage between treatment agencies. For settings where such access remains not immediately feasible, DPH-SAPC is supporting an open-access telephone line to which provides same-day access to addiction medication services.

3. **Utilizing the strategies indicated above, the county will provide the following forms of MAT:**
   - Buprenorphine
   - Methadone
   - Naltrexone
   - Other:

Acamprosate	Disulfiram	Topiramate	Gabapentin
Baclofen	Ondansetron	Varenicline	Bupropion
Benzodiazepines	Barbiturates	Anticonvulsants	Mirtazapine
Modafinil	Topiramate	Methylphenidate	Modafinil
N-acetyl cysteine	Nicotine Replacement	Dextroamphetamine/ Amphetamine	

Housing Interventions

Planning

For related policy information, refer to **7.C.3 Program priorities** and **7.C.4 Eligible and priority populations**.

System Gaps

1. Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question. [For each, counties select from dropdown: no gap, small gap, medium gap, large gap.]

Table 30. System Gaps

No Gap	Small Gap	Medium Gap	Large Gap
Accessory dwelling units, including junior accessory dwelling units	Housing in mobile home communities	Apartments, including master-lease apartments	Supportive Housing
(Permanent) Tiny homes	(Permanent) Single room occupancy units	Single and multi-family homes	(Permanent) Recovery/sober living housing, including recovery-oriented housing
	(Interim) Single room occupancy units	Hotel and Motel stays	(Interim) Recovery/sober living housing, including recovery-oriented housing
	Shared housing	Peer Respite	Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
	License-exempt room and board	Recuperative Care	Permanent rental subsidies
	Short-Term Post-Hospitalization housing		Housing supportive services
	(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units		
	Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)		
	Non-congregate interim housing models		

2. **What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system**

utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals?

a. DMH leverages a wide range of non-BHSA housing resources to assist clients in securing housing resources. These include the following:
   - Behavioral Health Bridge Housing (BHBH) for short to mid-term housing, including interim housing, rental assistance, and Enriched Residential Care (ERC) - Plus
   - Community Care Expansion Preservation Program - Operating Subsidy Payments for licensed residential care facilities through DMH's ERC program
   - Substance Abuse and Mental Health Services Administration for licensed residential care facilities through DMH's ERC program and PATH for Housing Assistance such as security deposits, furniture and utilities in permanent supportive housing.
   - Federal subsidies including Continuum of Care (CoC) and Housing Choice Vouchers through 11 active contracts with the Housing Authority of the City of Los Angeles (HACLA) and Los Angeles County Development Authority (LACDA). DMH also has agreements with HACLA for Homeless Section 8 and Tenant-Based Supportive Housing; however, they are currently in short-fall so these resources are not currently available. Also, the CoC program is in jeopardy because of Federal priority changes to the program.
   - Mental Health Services Act capital investments in PSH since 2008
   - Net County Cost for the DMH Interim Housing Program
   - 2011 State Realignment for the DMH Housing Assistance Program (HAP)
   - Homekey+ investments will also increase access to housing
   - CalAIM Community Supports resources including the Housing Trio and Transitional Rent (TR).

b. Los Angeles County has the Measure A sales tax and State HHAP which funds a variety of housing resources that that DMH clients may be able to access, depending on eligibility criteria. Also, DMH clients can access other housing resources through a variety of investments by the 85 cities in Los Angeles (this excludes the three cities in the Tri-City area).

c. DPH-SAPC leverages a range of non-BHSA resources and partnerships to expand access to housing for BHSA-eligible individuals:
   1. Local Resources:
      - Measure H/A: Funds interim housing, Recovery Bridge Housing (RBH) for people experiencing homelessness with SUD. DPH-SAPC continues to advocate for additional funding to expand.
      - Care First Community Investment: Funds interim housing, RBH, for justice involved individuals experiencing homelessness with SUD.
      - Other braided funding sources, including General Relief.
   2. State Resources
      - Project Homekey+: Provides funding to support the development of permanent supportive housing for veterans and individuals at risk of or experiencing homelessness and with mental health or substance use challenges. LA County and partnering developers have applied for the grant, including units dedicated for individuals/families with behavioral health conditions and awaiting award notifications from the State.

- Behavioral Health Bridge Housing (BHBH): Funding to operate bridge housing settings to address the immediate housing needs of people experiencing homelessness who have serious behavioral health conditions, including serious mental illness (SMI) and/or substance use disorder (SUD). BHBH is strategically aligned with BHSA goals and directly serves BHSA-eligible populations.
- Other braided funding sources, including Assembly Bill 109 and California Work Opportunity and Responsibility to Kids.

3. Federal Resources
   - Substance Abuse Prevention, Treatment, and Recovery Services Block Grant (SUBG): Funding to support SUD services directly or by contracting with local SUD providers. The SUBG Program's objective is to help plan, implement, and evaluate activities that prevent and treat SUDs. Funding can be utilized for SUD services, including RBH.
   - Transitional Rent: This program will provide coverage for rent and temporary housing as a Medi-Cal service, aimed at supporting members experiencing or at risk of homelessness. SAPC will utilize this Medi-Cal benefit for RBH residents.
4. Data Sharing
   - DPH-SAPC and County partners use platforms like LAHSA's Homeless Management Information System (HMIS) to coordinate care and improve housing placement targeting.

3. **How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?**

   Many of the non-BHSA housing resources listed above are currently braided with MHSA funds and will be braided with BHSA funding and are used in coordination with the other providers and government entities. For example, DMH's interim housing will braid BHSA, CalAIM Transitional Rent and BHBH funding until BHBH ends. Clients living in interim housing and housing funding through most of BHSA funded Housing Interventions are also receiving specialty mental health services through BHSA and non-BHSA funded specialty SUD services. Also, the PSH integrated service model in Los Angeles includes BHSA funded specialty mental health services, non-BHSA funded specialty SUD services, CalAIM Tenancy Sustaining Services (TSS) and Measure A funded Intensive Case Management Services (ICMS) through the Department of Homeless Services and Housing (HSH), Client Engagement and Navigation Services (CENS) and Recovery Bridge Housing through Department of Public Health Substance Abuse Prevention and Control (DPH-SAPC) which is funded through a variety of sources. Also, PSH includes rental subsidies funded through BHSA, Measure A or Project Based Vouchers through the local Housing Authority. The SAMHSA funding for ERC is braided with BHSA and CCE funds. The HK+ funds are braided with BHSA capital and/or rental subsidies and other County and City funding for capital and/or rental subsidies. The 2011 Realignment funding for HAP is braided with BHSA and CalAIM Housing Deposits. Other areas of integration include integrated referral processes and pathways in place with other funders with similar housing types such as interim housing, ERC and PSH including the Coordinated Entry System (CES). Also DMH and DPH-SAPC will leverage HSH's Transitional Rent contracts with the Managed Care

Plans (MCPs) and their Flexible Housing Subsidy Pool (FHPS) to implement TR and Housing Deposits. HSH, DMH and DPH-SAPC are engaged in meetings with the MCPs to leverage these MediCal benefits and are establishing Memorandums of Agreement, and developing workflows for referrals, payments and other practices. DPH-SAPC is looking to strengthen integration with interim and recovery housing and establishing access to permanent supportive housing for those with SUD.

4. **What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?**

   DMH employs a multi-pronged approach to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions. This approach includes significant investments in permanent housing resources through the local FHSP, such as licensed residential care facilities and PSH, as well as intentional efforts to identify unhoused DMH clients, develop short-and long-term housing plans, and support clients in securing appropriate housing. DMH housing resources are accessed through case managers across the system, who connect their clients to DMH-administered housing supports. DMH reinforces this process by providing trainings, a monthly Housing Liaison meeting and clear guidance on its public-facing website on available resources and how to access them.

   For BHSA-funded PSH resources, DMH has made investments in: 1) the Rental Assistance Program (RAP) prioritizes individuals that are not eligible for Federal housing subsidies due to justice involvement and/or legal status; 2) Housing For Mental Health (HFMH) is allocated to specific Full Service Partnership (FSPs) programs and prioritizes individuals with high acuity needs and those that do not qualify for Federal subsidies; 3) Housing for Empowered Adult Living (HEAL) supports individuals living in licensed residential care facilities who no longer require that level of care and seek to transition into a subsidized apartments but do not qualify for Federal subsidies; 4) Homekey+ for which BHSA HI funding is used as local match to support project-based PSH rental subsidies administered by the California Housing and Community Development Department; and 5) the Housing Assistance Program (HAP) supports individuals transition from homelessness into PSH by covering security and utility deposits and providing essential household items, such as furniture.

   In addition to these PH investments, DMH also administers the ERC Program, which provides rental subsidies and enhanced services rates for DMH clients residing in licensed residential care facilities who lack sufficient income to cover the full Non-Medical Out-of-Home Care (NMOHC) rate and who have complex service needs.

   DMH actively participates in Los Angeles County's CES, which is used to prioritize unhoused individuals for housing resources. Through CES, unhoused individuals are assessed to determine their level of acuity and the type of housing support needed. When PSH is indicated, case managers complete the CES assessment tool known as the Los Angeles Housing Assessment Tool (LA HAT), and enter it into the Homeless Management Information System (HMIS). Case managers also ensure clients are "document ready," meaning required identification and Social Security documentation are uploaded into HMIS, which, in accordance with CES policy, allows clients to be placed on the CES queue.

   For clients participating in DMH's IHP, DMH requires the IHP providers to deliver housing

navigation services, develop individualized long-term housing plans, and submit monthly reports on each client's housing status. These reports include CED scores, documentation readiness, and whether the client has been matched to a PSH resource. DMH's IHP administrative team reviews these reports to confirm that clients are appropriately enrolled in CES and to support navigation to suitable PSH placements.

In addition to providing SMHS, including assistance with accessing housing through BHSA HI, DMH continues to provide SMHS services after clients are housed to support housing retention and broader recovery goals.

DPH-SAPC's strategy to promote permanent housing placement and retention for BHSA Housing Intervention participants centers on these key pillars:

1. Low-Barrier Housing Model with Behavioral Health Integration
   The County ensures individuals can access housing without requiring sobriety or treatment compliance, integrating voluntary SUD treatment with housing options.
2. Cross-Agency Collaboration and Data Sharing
   DPH-SAPC collaborates closely with DMH, LAHSA, DHS and Housing for Health to coordinate care and housing placements, adhering to applicable State and federal laws and regulations, including the use of HMIS.
3. Housing Navigation and Case Management
   Through BHBH funding, contracted agencies assist individuals in Recovery Bridge Housing (RBH) and Recovery Housing (RH) with unit searches, landlord negotiations, lease support, and securing stable housing upon discharge.
4. Housing Retention Through Wraparound Support
   Once housed, clients can continue receiving field-based behavioral health services, including outpatient SUD treatment, recovery services, and peer support to maintain housing stability.
5. Continuous Quality Improvement and Outcome Monitoring
   DPH-SAPC conducts regular audits, utilizes client feedback, engages in learning collaboratives to refine housing strategies and close service gaps.

5. **What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?**

Building on the strategies and investments described in Questions 2, 3 and 4, DMH has invested more than $1 billion in the capital development of PSH for unhoused individuals with Serious Mental Illness (SMI) across Los Angeles County. These investments have been made through: No Place Like Home (NPLH), Special Needs Housing Program (SNHP), MHSA Housing Program, Mental Health Housing Program and the Alternative Funding Model. To date, these investments have supported 165 project-based housing developments, resulting in 4,726 PSH units ranging from studio to four-bedroom apartments. In addition, DMH provides operating subsidies in select developments through the MHSA Housing Program Capitalized Operating Subsidy Reserve (COSR), administered by the California Housing Finance Agency and through the DMH RAP program.

These housing developments are located across all eight Service Planning Areas in Los Angeles County and include dedicated units for Transition Age Youth, Older Adults,

Veterans, Adults and Families. To continue this work under the Proposition 1 Homekey+ Program, LACDMH recently committed $30 million in Behavioral Health Services Act (BHSA) funds for capital investments, along with $15 million a year for five years to support rental subsidies. These commitments will serve as the local match for developers seeking funding through the Homekey+ Notice of Funding Availability released by the California Department of Housing and Community Development.

All of these housing resources are matched with eligible clients through CES. DMH is a key partner in the CES system and holds a seat on the CES Policy Council, which develops policies in accordance with U.S. Department of Housing and Urban Development (HUD) requirements. DMH also collaborates closely with other PSH funders to coordinate investments, oversight, and program monitoring. DMH provides SMHS specialty mental health services to individuals residing in its PSH-funded units through its Housing Support Services Program, which is transitioning into an FSP-ICM under BHSA. These services are delivered in coordination with ICMS funded through the LA County HSH and DPH-SAPC CENS. Together, these services support residents' recovery, housing stability, and community integration. DMH meets regularly with partner County departments to oversee this integrated model and to intervene when issues arise in the PSH buildings, addressing issue that could threaten clients' housing or the overall living environment.

In addition, DMH currently maintains 11 active contracts with the two largest Public Housing Authorities in Los Angeles County, HACLA and LACDA, to administer CoC and Section 8 resources. These tenant-based resources are matched through the CES. DMH determines eligibility for all individuals matched to these subsidies, supports clients through the lease up process and provides retention services. In addition, DMH has a seat on the CoC Board and works closely with LAHSA, which administers the nation's largest CoC.

DPH-SAPC is actively engaged in multiple strategies to connect BHSA-eligible individuals—especially those with SUD and experiencing homelessness—to permanent supportive housing (PSH) and services. These efforts are grounded in partnerships across County agencies and community-based providers and are designed to address both clinical and housing stability needs.

1. Connection to PSH and Housing Navigation
   - DPH-SAPC contracted providers offer housing navigation services to clients in Recovery Bridge Housing (RBH) and Recovery Housing (RH), including support with accessing the Coordinated Entry System and linkage to permanent housing settings, including connection to rental subsidies through housing authorities and partner agencies.
2. Supportive Services for Individuals in Permanent Housing
   - DPH-SAPC funds ongoing outpatient SUD treatment and recovery support services that can follow clients into permanent housing through field-based services. Services include counseling, care coordination, relapse prevention, and benefits assistance, supporting both recovery and housing retention.
   - DPH-SAPC partners with PSH providers to deliver onsite SUD services where needed and commits provider capacity to support residents long-term. This ensures continuity of care and wraparound services that promote housing stability for BHSA-eligible individuals.

These efforts are part of a broader cross-agency strategy to integrate behavioral health

treatment and housing supports for vulnerable populations.

6. **Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services.**

DMH response:

a. DMH implements the Housing First Model in its housing programs. Most clients referred to BHSA HI settings are already actively receiving outpatient SMHS. For those who are not, DMH actively connects them to SMHS to ensure they have the supports necessary to manage their SMI and achieve housing stability. To facilitate access, services are often provided on-site or through field-based outreach. To ensure consistent access to clinical and supportive behavioral health care and housing services across all HI, DMH will implement the following measures:
b. Provide programmatic guidelines and housing program guidelines that include information about the supportive services DMH providers are expected to offer clients accessing BHSA HI. This includes clear Program Service Exhibits that specify the behavioral health and housing support they will provide, staff roles, processes to assist clients with accessing housing, how payments are made, guidelines and procedures on how onsite and clinical staff are providing services to clients, and requirements for home visits to clients, policies on warm handoff and collaboration parameters with other service providers to clients including those provided by the MCPs service providers for Enhanced Care Management and Community Supports.
c. Provide clients and DMH providers information about how to access care on a 24-hour basis.
d. Conduct integrated care planning to share information while protecting client's health information.
e. Provide Technical Assistance to housing operators to ensure compliance with BHSA regulations, and offer guidance to landlords and clients on strategies to promote housing stability and retention.
f. Conduct Quality Assurance to monitor performance and implement corrective actions as needed.

DPH-SAPC response:

DPH-SAPC is committed to ensuring that all housing intervention settings—whether interim or permanent—offer timely, coordinated access to clinical SUD treatment and supportive behavioral health and housing services. This is achieved through a multi-layered approach that integrates field-based service delivery, cross-departmental collaboration, and system navigation support. DPH-SAPC employs a field-based model to bring outpatient SUD treatment and support services directly into housing settings. These services include outreach, engagement, referral to treatment, and interventions for individuals at risk of relapse or overdose. In collaboration with the Department of Health Services (DHS) and Department of Mental Health (DMH), DPH-SAPC works to ensure wraparound care is available within both permanent supportive housing and interim housing environments. Housing Navigators play a key role in this system, helping clients in Recovery Bridge Housing (RBH) and Recovery Housing (RH) connect to long-term housing and essential behavioral health services. Additionally, DPH-SAPC provides training and technical assistance to contracted housing providers to strengthen their capacity to respond to behavioral health needs. Topics include harm reduction, overdose response, trauma-

informed care, and recovery-oriented housing practices. These trainings are available to SAPC providers, other County departments, and community partners.

Eligible Populations

1. **Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions**

   DMH primarily relies on its network of providers to identify, screen and refer individuals eligible for BHSA HI. In addition, DMH collaborates with many other homeless service system partners across the County to identify individuals who are unhoused and who may have an SMI. Approximately 40% of the individuals that DMH houses with SMI also have a dual diagnosis. DMH provides several access points for SMHS including the following:

   a. The DMH public-facing website includes an interactive provider directory. https://dmh.lacounty.gov/pd/
   b. The 24/7 Los Angeles County Helpline for Mental Health and Substance Use Services: A toll-free, 24/7 call center with trained professionals to screen and link callers to appropriate SUD treatment agencies.
   c. Universal Application Portal. Initially developed for City of Los Angeles homeless outreach workers to refer their clients to DMH, this portal has expanded to include other homeless service providers, county and city partners. Managed Care Plans can use this Universal Application Form to identify individuals that may be BHSA eligible
   d. All referrals are triaged to determine BHSA eligibility and to determine the appropriate level of care. Eligible clients are referred to the appropriate program, typically an FSP, which are field-based. DMH service providers then outreach the client, engage them in SMHS, assess both treatment and housing needs, and support them in accessing appropriate housing.
   e. DMH has Homeless Outreach and Engagement (HOME) Teams: Serve those with the most acute needs who are unhoused and have SMI, providing outreach and engagement and housing support. DMH also has other specialized outreach teams that focus on the unhoused population, including the Care Act teams, Veteran and Military Family Services, Library Engagement and Access Programs, Skid Row Concierge, Hollywood 2.0, Interim Housing Outreach Program and Re-Entry programs that conduct outreach to the unhoused population to assess BHSA eligibility and housing needs.
   f. For all referrals to BHSA HI funded housing resources, DMH's Housing Division confirms BHSA eligibility, including tracking homeless status to ensure 50% of the funding serves individuals who meet chronic homeless criteria. The DMH Housing Division will also follow workflows to refer clients to housing interventions funded through other MediCal including Community Supports Transitional Rent and the Housing Trio prior to utilizing BHSA HI funds. This process will require significant updates to referral forms, workflows and database systems.

   DPH-SAPC plays a key role in ensuring that individuals with substance use disorders who are experiencing or at risk of homelessness are connected to appropriate housing resources through housing navigation and participant assistance funds. Individuals are also connected to SUD treatment resources, according to need and recommended level of care (e.g., outpatient, withdrawal management, residential services). Identification, screening, and referral of individuals eligible for BHSA Housing Interventions and supportive services will occur at all SUD service access points including:

- The 24/7 Los Angeles County Helpline for Mental Health and Substance Use Services: A toll-free, 24/7 call center with trained professionals to screen and link callers to appropriate SUD treatment agencies.
- Client Engagement and Navigation Services (CENS): In-person staff that can perform SUD outreach, engagement, screenings, linkages to treatment and ancillary services, including housing interventions, and at at-risk interventions.
- Direct SUD provider: Individuals can access SUD treatment by contacting an agency directly. All treatment agencies can identify, screen, and refer individuals eligible for Housing Interventions.

2. **Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only?:** Yes
3. **What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:**
    a. **In, or at-risk of being in, the juvenile justice system:** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of eligible children and youth in the development of the County's Housing Interventions.

    The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing individuals in, or at risk of being in, the juvenile justice system.

    The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

    The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

    With this foundational information in place, the County organized second forum on October 17, 2025, 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of individuals in, or at risk of being in, the juvenile justice system. At the BHSA CPT meeting on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained additional input on Housing Interventions sections for the BHSA Integrated Plan.

    The fourth step consisted of sharing the entire draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026, to obtain additional feedback prior to the 30-day posting period and public hearing.

b. **Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+):** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of eligible children and youth in the development of the County's Housing Interventions.

The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing LGBTQ+ individuals.

The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

With this foundational information in place, the County organized second forum on October 17, 2025, 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of LGBTQ+ individuals. At the BHSA CPT meeting on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained additional input on Housing Interventions sections for the BHSA Integrated Plan.

The fourth step consisted of sharing the entire draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026, to obtain additional feedback prior to the 30-day posting period and public hearing.

c. **In the child welfare system:** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of eligible children and youth in the development of the County's Housing Interventions.

The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing individuals in the child welfare system.

The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

With this foundational information in place, the County organized second forum on October 17, 2025, 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of individuals in the child welfare system. At the BHSA CPT meeting on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained additional input on Housing Interventions sections for the BHSA Integrated Plan.

The fourth step consisted of sharing the entire draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026, to obtain additional feedback prior to the 30-day posting period and public hearing.

4. **What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:**
    a. **Older adults:** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of older adults, individuals in, or at risk of being in, the justice system, and individuals from underserved communities in the development of the County's Housing Interventions.

    The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing older adults.

    The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

    The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

    With this foundational information in place, the County organized an interactive, participatory session on October 17, 2025, from 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of older adults. Moreover, on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained input on additional sections on Housing Interventions.

The fourth step was to share the draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026. Additional feedback will be obtained during the 30-day posting period and public hearing.

b. **In, or are at risk of being in, the justice system:** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of older adults, individuals in, or at risk of being in, the justice system, and individuals from underserved communities in the development of the County's Housing Interventions.

   The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing individuals in, or at risk of being, in the justice system.

   The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

   The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

   With this foundational information in place, the County organized an interactive, participatory session on October 17, 2025, from 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of individuals in, or at risk of being, in the justice system. Moreover, on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained input on additional sections on Housing Interventions.

   The fourth step was to share the draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026. Additional feedback will be obtained during the 30-day posting period and public hearing.

c. **In underserved communities:** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of older adults, individuals in, or at risk of being in, the justice system, and individuals from underserved communities in the development of the County's Housing Interventions.

   The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing individuals from underserved communities.

   The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members

participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

With this foundational information in place, the County organized an interactive, participatory session on October 17, 2025, from 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of individuals from underserved communities. Moreover, on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained input on additional sections on Housing Interventions.

The fourth step was to share the draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026. Additional feedback will be obtained during the 30-day posting period and public hearing.

Local Housing System Engagement

3. **How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?**

DMH has a long history of working with the four CoCs in Los Angeles County, which include Long Beach, Pasadena, Glendale and Los Angeles and receiving referrals through CES for housing. All four CoCs participate on the CES Policy Council alongside DMH, where they collaborate to develop CES policies. Among the four, LAHSA, a joint powers authority of the City and County of Los Angeles, is the largest and serves as the CES lead. LAHSA is responsible for managing the CES queue and providing matches for most PSH resources. DMH works closely with LAHSA and HSH to coordinate homeless system services, including interim housing, outreach and PSH. In addition to receiving CES referrals from the CoC, DMH receives referrals from other system partners including HSH. DMH participates in numerous regular coordination meetings with system partners to align resources and maximize utilization of housing resource, address system challenges and problem solving, and minimize duplication of efforts. These meetings include Housing Central Command, Service System Partners, and Interim Housing Partner Monthly meetings.

Regarding Interim Housing referrals, DMH conducts daily Air Traffic Control (ATC) meetings with LAHSA and HSH to help navigate unhoused individuals to the appropriate interim or other housing resource. DMH also holds a Skid Row-focused ATC, including the co-location of staff a few days a week at the Skid Row Care Campus to coordinate referrals. Staff are additionally co-located at the Emergency Centralized Response Center to assist with outreach and direct unhoused people to housing resources, including DMH's BHSA HI.

DMH also operates some MHSA-funded PSH projects with project-based vouchers in Long Beach, for which referrals are received through the Long Beach CES system. Currently, DMH does not have PSH projects in Pasadena or Glendale; however, DMH is actively working with the City of Pasadena to secure permits for a new Interim Housing site in Pasadena.

DPH-SAPC maintains strong and ongoing coordination with the Los Angeles CoC, currently administered by the Los Angeles Homeless Services Authority (LAHSA).

Coordinated Entry System (CES) Integration
DPH-SAPC contracted providers are trained to conduct CES assessments, complete housing documentation, and refer clients with SUD—especially those experiencing or at risk of homelessness—into CES for housing placement.

Bidirectional Referral Flow
Referrals occur in both directions. Clients in DPH-SAPC services are connected to CES for housing navigation, while individuals identified through CES or LAHSA outreach who present with SUD needs are referred to DPH-SAPC for screening and linkage to BHSA-eligible services.

Data Integration and Tracking
DPH-SAPC utilizes the Homeless Management Information System (HMIS) with appropriate data-sharing authorizations to track referrals, placements, and outcomes in coordination with LAHSA and CoC partners.

4. **Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions**

    a. **Local CoC:** As outlined in Question 3 above, DMH has strong collaborative partnerships with the four local CoCs and provided several examples illustrating our partnerships. In addition, DMH uses HMIS which is managed by LAHSA and is also used by the other three CoCs to look up client information and to enter interim housing, BHBH, CoC and No Place Like Home data to meet the AB 977 requirements. As required by BHSA, DMH will expand its use of HMIS. Discussions are already underway with LAHSA regarding meeting these new requirements to include all required BHSA HI information in HMIS. DMH's Chief Information Office (CIO) has led conversations with LAHSA about developing data system interoperability for data sharing and necessary MOUs. While these efforts will require significant coordination, they are particularly challenging given the recent changes in Los Angeles County, including the County removing most of their funds from LAHSA and the Federal CoC changes by HUD. Despite these challenges, DMH remains committed to ensuring data integration and compliance to support BHSA HI.
    b. **Public Housing Agency:** DMH currently holds 11 active contracts with the two largest PHAs in Los Angeles County, HACLA and LACDA, some of which date back to the 1990's. DMH's Housing Division's Federal Housing Subsidy Unit (FHSU) collaborates daily with HACLA and LACDA to administer these contracts, which provide subsidies to DMH clients. Potential clients are matched to these resources through CES, and DMH

confirms eligibility. DMH or ICSM case managers assist clients in completing housing applications. FHSU oversees contract administration, including reviewing the applications for completeness, submitting them to the PHAs, responding to requests from the PHAs for corrections or additional information, tracking application and following up on delays. FHSU also ensures case managers support clients through the lease-up process and continue to provide SMHS after lease-up. In addition, FHSU gathers and meets all PHA/HUD data and reporting requirements and advocates with the PHAs on behalf of our clients to ensure housing retention. DMH maintains ongoing collaboration with the PHAs through participation in key governing bodies such as the CoC Board, CES Policy Council, and Housing Central Command.

c. **MCPs:** DMH has data sharing agreements with six of the eight MCPs in LA County and is currently working with the MCPs and intercounty agencies to develop workflows for TR, HD, and BHSA HI. These efforts include identifying necessary updates to data sharing agreements to establish workflows and ensure bi-directional data exchange is in place to support member transitions and housing services. Rather than contracting directly with the MCPs to provide CalAIM Community Supports TR and HD, DPH-SAPC and DMH will partner with the County Department of HSH through a Memorandum of Understanding. This partnership leverages HSH's existing contracts with the MCPs as well as their workflows, policies and procedures, claiming system and payment and reimbursement procedures.

d. **ECM and Community Supports Providers:** DMH has contracts with four MCPs to provide ECM services. For clients served by DMH with BHSA or other funding that are also receiving ECM or Community Supports services from other providers, DMH will work with them to coordinate care. Our data sharing agreements with the MCPs include data elements that will assist us with identifying who is receiving ECM and/or Community Supports services and the name and contact information of the service provider.

e. **Other (e.g., CalWORKs/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.):**

    i. DMH collaborates with a variety of partners to ensure clients have access to housing resources managed by other entities to which they are entitled or eligible. For example, DMH coordinates with the Department of Public Social Services, which manages housing funds for CalWORKs and General Relief participants, to ensure DMH clients can utilize these resources. Similarly, DMH works with the Department of Children and Family Services (DCFS) to support the child welfare population in accessing services not covered by Medi-Cal, including housing assistance. DMH also assists disconnected former foster youth to help them access housing through DCFS housing programs, such as the Independent Living Program, while providing necessary mental health supports.

    ii. Since 2008. DMH has invested over $1 billion for the capital development of PSH and maintains MOUs with 49 different PSH developers, representing approximately 4,716 units that target unhoused individuals with SMI. DMH works closely with other funders of PSH such as the Los Angeles Housing Department and various homeless service providers, many of whom are funded through the County's Measure A tax.

5. **How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that**

support and house BHSA eligible individuals?

DMH response:
As noted above, since 2008, over $1 billion in MHSA funding has been committed in LA County for the capital development of PSH through programs such as the MHSA Housing Program and No Place Like Home. Each development fills its units using the CES, and DMH has established processes to ensure our unhoused clients are included on the CES Community Queue. For example, DMH's Housing Division's Referral, Access and Data (RAD) team works with DMH housing leads in each SPA to identify unhoused clients and submit their names to LAHSA. DMH's RAD team also confirms the eligibility of the tenants that are matched to MHSA-funded PSH units and DMH offers/provides specialty mental health services to eligible tenants.

DMH has led the County's efforts to implement HK+ in partnership with other County Departments including HSH, Department of Military and Veteran Affairs and the LACDA, which is the lead HK+ applicant on behalf of the County. DMH committed $30 million of MHSA/BHSA funds for capital match and $15 million each year for five (5) years for rental subsidies, which were allocated through various solicitation processes to award eligible projects. DMH contracted with Le Sar Development Consultants to support our implementation HK+. In addition, DMH wrote letters of support for all HK+ projects in Los Angeles County including those in which other jurisdictions, such as the City of LA, were the lead applicant. In the letters of support, DMH also provided a commitment to provide SMHS for eligible tenants. CES will be used to fill the HK+ units and DMH's RAD team will verify the eligibility of all clients that move into HK+ assisted units and identify a SMHS provider.

DPH-SAPC response:
DPH-SAPC will provide rental subsidies and participate in DHS's Flexible Housing Subsidy Pool (FHSP). In addition, supportive services will be provided by contracted SUD treatment providers who will deliver onsite and field-based services tailored to support long-term tenancy and behavioral health stabilization. DPH-SAPC will align its treatment and recovery services with supportive housing operations by leveraging Drug Medi-Cal (DMC-ODS) and coordinating with Medi-Cal Managed Care Plans to connect individuals to Community Supports. DPH-SAPC also works closely with LAHSA, DHS, DMH, LACDA, and the CEO's office to ensure service delivery is integrated into new housing developments. These planning efforts emphasize client-centered care, cross-system coordination, and data-informed decision-making to support housing retention and recovery for BHSA-eligible individuals.

6. **Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?** No

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed) For more information, please see 7.C.9 Allowable expenditures and related requirements].

Rental Subsidies (Chapter 7. Section C.9.1)

The intent of Housing Interventions is to provide rental subsidies in permanent

settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

1. **Is the county providing this intervention?** Yes
2. **Is the county providing this intervention to chronically homeless individuals?** Yes
3. **How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis**? 5,699[1]

   [1]Approximately 5,699 of individuals are expected to be served with rental subsidies. This includes 4,480 served with bundled rental and operating subsidies and 1,219 served with only rental subsidies. Since the budget template has a bundled rental and operating subsidy category and the BHSA Integrated Plan (IP) does not, those receiving bundled subsidies are included in the rental subsidy and operating subsidy sections. Although this results in duplicated data, they are clearly indicated as such. These numbers also reflect only those individuals expected to be served in FY 2026-27 and do not reflect additional clients that we anticipate serving in FY 2027-28 and FY 2028-29 once certain categorical funding sources end. Those estimates of clients served will be in future BHSA IPs

   a. **How many of these individuals will receive rental subsidies for permanent housing on an annual basis?** 3,418[1]

      [1]Approximately 3,418 of the 5,699 individuals will receive rental subsidies for permanent housing. This includes 2,231 served with bundled rental and operating subsidies and 1,187 served with only rental subsidies.

   b. **How many of these individuals will receive rental subsidies for interim housing on an annual basis?** 2,731[1]

      [1]Approximately 2,281 of the 5,699 individuals will receive rental subsidies for interim housing. This includes 2,249 served with bundled rental and operating subsidies and 32 served with only rental subsidies. SAPC: 450 subsidies for individuals with SUD for RBH + RH

4. **What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?**
   To estimate the total number of individuals expected to be served with rental subsidies, DMH first calculates the total number of dedicated units/beds for each housing program. Using the average annual retention rate for each housing type, DMH then estimates the number of additional clients anticipated to be served due to turnover and adds this number to the number of dedicated units/beds.

   Programs are classified as either providing interim or permanent housing, with interim housing including DMH's interim Housing, Emergency Enhanced Shelter Program, motels and short-term rental assistance. Permanent housing includes DMH's Enriched Residential Care (ERC) program, which provides rental and operating subsidies for licensed residential care facilities and project-based/tenant-based permanent supportive housing through DMH's Rental Assistance Program (RAP), Housing For Mental Health Program (HFMH) and Housing for Empowered Adult Living (HEAL). This classification was then used to determine the total number of individuals served in interim and permanent settings.

   BHSA Housing Intervention funding for DPH-SAPC will support approximately 450 Recovery Bridge Housing and Recovery Housing beds when the BHBH grant sunsets in June 2027.

5. **For which setting types will the county provide rental subsidies?**
   - Non-Time-Limited Permanent Settings: Supportive housing
   - Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
   - Non-Time-Limited Permanent Settings: Shared housing
   - Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including

recovery-oriented housing

- Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care
- Time-Limited Interim Settings: Hotel and motel stays
- Time-Limited Interim Settings: Non-congregate interim housing models
- Time-Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) (does not include behavioral residential treatment settings)
- Time-Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
- Time-Limited Interim Settings: Other settings identified under the Transitional Rent benefit

6. **Will this Housing Intervention accommodate family housing?** Yes
7. **Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding**
    a. DMH has four programs funded through BHSA HI: Rental Assistance, ERC, RAP, HFMH and HEAL. These programs provide tenant-based and project-based rental subsidies to clients that are homeless, chronically homeless or at risk of homelessness. RAP, HFMH, and HEAL provide rental subsidies in PSH and make housing affordable for those with extremely low or no income. The client portion of the rent is 30% of their income and the subsidy pays the balance of the rent using Housing Urban Development's Fair Market Rent (FMR). These subsidies are available for DMH clients receiving SMHS, prioritizing those with SMI that are not eligible for Federal Subsidies due to legal status, criminal convictions or otherwise deemed ineligible by the PHA.
    b. The ERC program provides subsidies equivalent to the NMOHC rate, including personal and incidental funds, for individuals with no income residing in licensed residential care facilities. The ERC program also provides enhanced services operating subsidies based on the needs of the client using a tiered-rate system. The funding for these programs are managed through a local Flexible Housing Subsidy Pool (FHSP) and are administered by Brilliant Corners (BC), a third-party administrator. All referrals are submitted by case managers to DMH's Housing Division which reviews referrals for appropriateness and compliance with BHSA homeless criteria and that 50% of the funds are used on those that are chronically homeless. Individuals who are in encampments will be prioritized.
    c. For those that are approved for a DMH RAP subsidy, the case manager will submit a FHSP application, which is reviewed by BC to ensure income and other eligibility is met. BC has a unit acquisition department, which can assist with unit acquisition or the case manager/client will locate a unit. For PSH, BC ensures the unit rent meets the FMR standard and will enter into an agreement with the landlord to make payments. BC will calculate both the client's portion of the rent and the BHSA-funded subsidy. The BC subsidy will be paid directly to the landlord each month, and BC will serve as the primary contact for the landlord regarding any tenant-related concerns, notifying DMH to follow up as needed.
    d. DPH-SAPC: Project Homekey+ provides funding to support the development of permanent supportive housing for individuals at risk of or experiencing homelessness

and with mental health or substance use challenges. LA County and partnering developers have applied for the grant, including units dedicated for families with behavioral health conditions and awaiting award notifications from the State. The HK+ funds are braided with BHSA capital and/or rental subsidies and other County and City funding for capital and/or rental subsidies. SAPC's PSH services also include rental subsidies funded through BHSA, Measure A or Project Based Vouchers through the local Housing Authority. SAPC will also provide rental subsidies and participate in DHS's Flexible Housing Subsidy Pool (FHSP).

8. **Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?**
    a. **Project-based:** Yes
    b. **Tenant-based:** Yes
9. **How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in**
    a. DMH has several ways it identifies a portfolio of available units to assist BHSA-eligible clients to secure housing. As mentioned above, our third party administrator, BC, manages the FHSP and has an unit acquisition team that proactively outreaches to landlords to secure units for clients accessing FHSP funds, including DMH clients. For BHSA eligible individuals that have PHA issued vouchers, they use the PHA's list of landlords that are interested in accepting Section 8. DMH SMHS provider also assists their clients with identifying units/beds in partnership with the clients. Many case managers have an expertise in housing navigation and long-standing relationships with landlords that lease to DMH clients and the landlords notify them of vacancies.
    b. Approximately 260 of DMH's RAP subsidies are in project-based buildings, which will increase when HK+-funded buildings are ready for occupancy. DMH partners with LAHSA and HSH which have funding to master lease or similarly secure units that target individuals with tenant-based subsidies. These units are listed in a portal called Padmission, which can be accessed by partnering providers. For the ERC beds, DMH has an ERC provider directory on its public-facing website to assist case managers with locating licensed residential care facilities. Finally, DMH's significant investments in capital development of PSH comprise 165 PSH project-based buildings with 4,726 PSH units dedicated to DMH clients.
10. **Total number of units funded with BHSA Housing Interventions per year:** 4,510[1]

    [1]Approximately 4,060 housing resources will be funded with BHSA Housing Interventions rental subsidies per year. This includes 1,322 dedicated beds/units and 2,738 rental subsidies. Due to the inclusion of those receiving bundled subsidies, there is overlap between this and the housing resource count for operating subsidies. DPH-SAPC Response: 450 units for RBH + RH beginning FY '27-28.

11. **[Optional question] Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units**

    The County operates several in which the number of individuals served is determined by available funding rather than by contracted beds or dedicated units. Examples include the ERC Program, where participants have the freedom to use their subsidy at any eligible licensed residential care facility, as well as the RAP, HEAL and HFMH, which provides tenant-based local subsidies to eligible individuals.

DPH-SAPC Response: BHSA funding will continue to support SAPC Housing Navigation services upon BHBH sunsetting.

Operating Subsidies (Chapter 7, Section C.9.2)

1. **Is the county providing this intervention?** Yes
2. **Is the county providing this intervention to chronically homeless individuals?** Yes
3. **Anticipated number of individuals served per year:** 4,593[1]

   [1]Approximately 4,593 individuals are expected to be served with operating subsidies. This includes 4,480 served with bundled rental and operating subsidies and 113 served with only operating subsidies. Due to the inclusion of those receiving bundled subsidies, there is overlap between this and the rental subsidies count. These numbers also reflect only those individuals expected to be served in FY 2026-27 and do not reflect additional clients that we anticipate serving in FY 2027-28 and FY 2028-29 once certain categorical funding sources end.
4. **Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding**

   a. Bundled rental and operating subsidies will be used for interim housing, which is funded through a daily bed rate. Given the requirement to use CalAIM TR, which only pays for the rent and utilities, DMH is separating the interim housing bed rates into a bundled rate, made up of a rental and operating subsidy. The operating subsidy portion of the bed rate will include all Interim Housing costs other than the rent/mortgage and utilities, including program supplies such as furniture, linens, food, vehicle costs, parking, office supplies; and client supports such as clothing, transportation, program activities; staffing including employee benefits and administrative staff and operating overhead.
   b. A bundled rental and operation subsidy will also be used for DMH's Enriched Residential Care (ERC) program. ERC provides rental subsidies to individuals without an income to pay the NMOHC rate and an enhanced services operating subsidy to cover the operating expenses specific to the complex needs of the client, which is determined through a four-tier system. Operating expenses can include additional staff and supplies needed to support the client's needs.

5. **For which setting types will the county provide operating subsidies? [multi-select dropdown of allowable settings included in the BHSA Policy Manual Housing Interventions Chapter (Chapter 7, SectionC.9.3 Allowable Settings)]**

   - Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care
   - Time-Limited Interim Settings: Hotel and motel stays
   - Time-Limited Interim Settings: Non-congregate interim housing models
   - Time-Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) (does not include behavioral residential treatment settings)
   - Time-Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units

6. **Will this be a scattered site initiative**? Yes
7. **Will this Housing Intervention accommodate family housing?** Yes
8. **Total number of units funded with BHSA Housing Interventions per year:** 2,953[1]

   [1]Approximately 2,953 housing resources will be funded with BHSA Housing Interventions operating subsidies per year. This includes 1,042 beds/units and 1,911 operating subsidies. Due to the inclusion of those receiving bundled subsidies, there is overlap between this and the housing resource count for rental subsidies.
9. **[Optional question] Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a**

specific number of units

DMH's ERC program includes one project-based site – the Crocker Care Campus ERC—an RCFE with 24 DMH-dedicated beds. All other ERC funding for bundled rental and operating subsidies is not tied to specific beds but is used in a scattered-site model, covering the NMOHC rate and an enhanced services rate for clients in any licensed residential care bed that will accept the client.

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

1. **Is the county providing this intervention?** Yes
2. **Is the county providing this intervention to chronically homeless individuals?** Yes
3. **Anticipated number of individuals served per year**: 1,608[1]
   [1] Approximately 1,608 individuals will be served per year through landlord outreach and mitigation funds.
4. **Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding**

   DMH has operated the Housing Assistance Program (HAP) for many years, funded through multiple funding sources including BHSA. This program provides support for housing and utility deposits, household goods, and prevention. In addition, DMH administers other rental assistance programs through the FHSP, such as HFMH, HEAL, and RAP which also include support for security and utility deposits, household goods and damage mitigation. Based on stakeholder feedback, under BHSA, DMH plans to expand the funding and allowable uses under HAP by including the following Landlord Outreach and Mitigation Funds categories: holding fees, damage reimbursement outside of normal wear and tear and eviction prevention which includes financial assistance, back-rent, mediation, tenant education, legal costs and connection to resources. There has been a well-documented need for funding for damage reimbursement outside of usual wear and tear by the Supportive Housing Alliance which has membership from non-profit developers of PSH for many years. DMH has frequently been approached by developers' request to pay for damages caused by DMH clients but DMH has not had funding allocated for this purpose. The supportive housing alliance surveyed their members, and they reported that the average cost of damages from DMH tenants on a per unit/per year basis over a three-year period was $7,132.
5. **Total number of units funded with BHSA Housing Interventions per year:** 1,608[1]
   [1]Approximately 1,608 units will be funded per year through landlord outreach and mitigation funds.
6. [Optional question] **Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units:** N/A

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

1. **Is the county providing this intervention?** Yes
2. **Is the county providing this intervention to chronically homeless individuals?** Yes
3. **Anticipated number of individuals served per year:** 5,558[1]
   [1]Approximately 1,558 individuals will be served per year through participant assistance funds. DPH-SAPC responded with approximately 4,000.
4. **Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding**

DMH has operated the Housing Assistance Program (HAP) for many years, funded through multiple funding sources including BHSA. This program provides support for housing and utility deposits, household goods, and eviction prevention. Under BHSA, DMH will now need to update workflows to include accessing CalAIM Community Supports Housing Deposits funding for eligible clients prior to using this funding. In addition, under BHSA—and with strong support from DMH stakeholders—DMH plans to expand the funding and allowable uses under HAP to include all of the allowable uses under Participant Assistance Funds. This will allow us to add categories of funding including those related to obtaining government-issued identification and other vital documents required to obtain housing, housing application fees, fees for credit reports, storage fees, pet deposits, transportation, food and hygiene products.

DPH-SAPC response: Participant Assistance Funds (PAF) are available through Los Angeles County's Housing Navigation program, in an effort to connect individuals with substance use disorders to housing opportunities and supportive services. While PAF is currently funded through BHBH, funding through BHSA Housing Interventions would be needed to sustain the service. PAF serves as a complementary resource that supports BHSA-eligible individuals by addressing immediate housing-related barriers that cannot be met through other funding streams.

Uses of PAF to support BHSA-eligible individuals include:

- Application and administrative fees for housing (e.g., credit checks, background checks)
- Security deposits and utility deposits (when no other source is available)
- Short-term motel stays to bridge to a more stable housing placement
- Transportation assistance to housing appointments or move-ins
- Basic furnishings and household supplies needed for move-in
- Moving and storage costs, including costs that would otherwise delay housing access

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)

[Context text: Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)].

1. **Is the county providing this intervention?** Yes
2. **Is the county providing this intervention to chronically homeless individuals?** Yes
3. **Anticipated number of individuals served per year:** 5,684[1]

   [1]Anticipated number of individuals served per year [numeric response] Currently, DMH funds Intensive Case Management Services (ICMS) through HSH for DMH clients living in 1,124 PSH units through an MOU with HSH. An additional 560 clients are funded through an MOU with Department of Health Services Office of Diversion and Re-Entry. HSH claims these services to the MCPs under CalAIM Community Supports TSS. However, due to reconciliation difficulties with the MCPs over the past three years, the number of clients that we would expect to be funded through the MCPs is unknown. Under BHSA, DMH will continue to work with HSH to ensure CalAIM Community Supports for TSS is claimed prior to providing these services through BHSA and to reconcile the claims. DPH-SAPC response, approximately 4,000.
4. **Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding**

   ICMS services include housing supports necessary to assist clients with retaining their housing including life skills training, assistance with establishing benefits and securing employment, assessing legal needs and referring for legal assistance, assessing client service needs and referring to appropriate service providers such as mental health,

physical health and substance use disorder services, adjusting with activities of daily living, providing transportation, supporting community connections and providing other housing retention services such as working with property management to resolve issues that threaten housing stability.

DPH-SAPC response: DPH-SAPC provides Housing Navigation Services to individuals in Recovery Bridge Housing (RBH) and Recovery Housing (RH) who are transitioning to permanent housing. This service is funded by BHBH and BHSA funding is needed to sustain these services beyond the BHBH grant, particularly for individuals not eligible for housing transition services through their Medi-Cal Managed Care Plan (MCP).

These services are primarily delivered by Housing Navigators, who assist individuals with substance use disorders, many of whom are chronically homeless or at risk of homelessness, with navigating the housing system and securing stable placements. Activities include identifying housing options, assembling required documentation (e.g., ID, income verification), coordinating transportation for housing-related appointments, and facilitating communication with landlords and housing agencies.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

1. **Is the county providing this intervention?** No
   a. **Please explain why the county is not providing this intervention**
      Outreach and engagement will be funded under Full Service Partnership.

Capital Development Projects (Chapter 7, Section C.10)

1. **Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?** Yes
2. **Is the county providing this intervention to chronically homeless individuals?** Yes
3. **How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?** 16[1]

[1]DMH has committed $30 million of capital development funding as capital match for HK+ PSH. None of the HK+ applications submitted to the California Housing and Community Development (HCD) Department have been approved.

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

1. **Name of Project #1**: Daimaru Hotel
2. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Supportive housing
3. **Capacity (Anticipated number of individuals housed at a given time)** 10
4. **Will this project braid funding with non-BHSA funding source(s)?** Yes
5. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 26
6. **Total number of units funded with Housing Interventions funds only:** 10
7. **Anticipated date of unit availability:** 04/01/2027
8. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)** $475,479 per unit, BHSA portion: $100,000
9. **Have you utilized the "by right" provisions of state law in your project?** No

a. **If you have not incorporated use of the "by right" provisions into your project, please explain why:** The project will not trigger discretionary entitlements like Site Plan Review because there is no increase in floor area and the use remains residential. The project will be an Affordable Housing Project as defined by the Los Angeles Housing Department with reference to CA H&SC 50079.5, 50105, and 50106 therefore is exempted from the City of LA's SRO Ordinance.

10. **Name of Project #2**: Huntington Villas
11. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Supportive housing
12. **Capacity (Anticipated number of individuals housed at a given time)** 52
13. **Will this project braid funding with non-BHSA funding source(s)?** Yes
14. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 53
15. **Total number of units funded with Housing Interventions funds only:** 52
16. **Anticipated date of unit availability:** Unknown at this time
17. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)** $392,453
18. **Have you utilized the "by right" provisions of state law in your project?** Unsure due to LA City jurisdiction
    a. **If you have not incorporated use of the "by right" provisions into your project, please explain why:** N/A
19. **Name of Project #3**: Casa Bella
20. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Supportive housing
21. **Capacity (Anticipated number of individuals housed at a given time)** 62
22. **Will this project braid funding with non-BHSA funding source(s)?** Yes
23. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 62
24. **Total number of units funded with Housing Interventions funds only:** 61
25. **Anticipated date of unit availability:** 05/01/2027
26. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)** $424,804, BHSA portion: $121,311
27. **Have you utilized the "by right" provisions of state law in your project?** No
    a. **If you have not incorporated use of the "by right" provisions into your project, please explain why:** The conversion from hotel to permanent supportive housing will be reviewed ministerially.
28. **Name of Project #4**: St. Vincent Supportive Community
29. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Supportive housing
30. **Capacity (Anticipated number of individuals housed at a given time)** 170
31. **Will this project braid funding with non-BHSA funding source(s)?** Yes
32. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 172
33. **Total number of units funded with Housing Interventions funds only:** 170
34. **Anticipated date of unit availability:** 04/01/2027
35. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the**

project must be equal to or less than $450,000) $495,582, BHSA portion: $91,465

36. **Have you utilized the "by right" provisions of state law in your project?** No
    a. **If you have not incorporated use of the "by right" provisions into your project, please explain why:** The conversion from hotel to permanent supportive housing will be reviewed ministerially.
37. **Name of Project #5**: Founders House of Hope Inc.
38. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
39. **Capacity (Anticipated number of individuals housed at a given time)**: 98
40. **Will this project braid funding with non-BHSA funding source(s)?** No
41. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 98
42. **Total number of units funded with Housing Interventions funds only:** 98
43. **Anticipated date of unit availability:** 5/1/2026
44. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
45. **Have you utilized the "by right" provisions of state law in your project?** Yes
46. **Name of Project #6**: Long Beach Residential
47. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
48. **Capacity (Anticipated number of individuals housed at a given time)**: 49
49. **Will this project braid funding with non-BHSA funding source(s)?** No
50. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 49
51. **Total number of units funded with Housing Interventions funds only:** 49
52. **Anticipated date of unit availability:** 5/1/2026
53. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
54. **Have you utilized the "by right" provisions of state law in your project?** Yes
55. **Name of Project #7**: Fair Oaks Manor III
56. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
57. **Capacity (Anticipated number of individuals housed at a given time)**: 30
58. **Will this project braid funding with non-BHSA funding source(s)?** No
59. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 30
60. **Total number of units funded with Housing Interventions funds only:** 30
61. **Anticipated date of unit availability:** 5/1/2026
62. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
63. **Have you utilized the "by right" provisions of state law in your project?** Yes
64. **Name of Project #8**: Sunnyside Retirement Center

65. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
66. **Capacity (Anticipated number of individuals housed at a given time):** 48
67. **Will this project braid funding with non-BHSA funding source(s)?** No
68. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 48
69. **Total number of units funded with Housing Interventions funds only:** 48
70. **Anticipated date of unit availability:** 5/1/2026
71. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
72. **Have you utilized the "by right" provisions of state law in your project?** Yes

73. **Name of Project #9**: The Grandview LLC
74. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
75. **Capacity (Anticipated number of individuals housed at a given time)**: 215
76. **Will this project braid funding with non-BHSA funding source(s)?** No
77. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 215
78. **Total number of units funded with Housing Interventions funds only:** 215
79. **Anticipated date of unit availability:** 5/1/2026
80. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
81. **Have you utilized the "by right" provisions of state law in your project?** Yes

82. **Name of Project #10**: Beverly Hills Terrace
83. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
84. **Capacity (Anticipated number of individuals housed at a given time):** 100
85. **Will this project braid funding with non-BHSA funding source(s)?** No
86. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 100
87. **Total number of units funded with Housing Interventions funds only:** 100
88. **Anticipated date of unit availability:** 5/1/2026
89. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
90. **Have you utilized the "by right" provisions of state law in your project?** Yes

91. **Name of Project #11**: Woodruff Care Home, Inc.
92. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
93. **Capacity (Anticipated number of individuals housed at a given time):** 88
94. **Will this project braid funding with non-BHSA funding source(s)?** No
95. **Total number of units in project, inclusive of BHSA and non-BHSA funding**

sources: 88

96. **Total number of units funded with Housing Interventions funds only:** 88
97. **Anticipated date of unit availability:** 5/1/2026
98. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
99. **Have you utilized the "by right" provisions of state law in your project?** Yes

100. **Name of Project #12**: Villa Stanley
101. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
102. **Capacity (Anticipated number of individuals housed at a given time):** 80
103. **Will this project braid funding with non-BHSA funding source(s)?** No
104. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 80
105. **Total number of units funded with Housing Interventions funds only:** 80
106. **Anticipated date of unit availability:** 5/1/2026
107. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
108. **Have you utilized the "by right" provisions of state law in your project?** Yes

109. **Name of Project #13**: Crystal Manor Residential Care Home, LLC
110. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
111. **Capacity (Anticipated number of individuals housed at a given time):** 26
112. **Will this project braid funding with non-BHSA funding source(s)?** No
113. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 26
114. **Total number of units funded with Housing Interventions funds only:** 26
115. **Anticipated date of unit availability:** 5/1/2026
116. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
117. **Have you utilized the "by right" provisions of state law in your project?** Yes

118. **Name of Project #14**: LTG Holding, Inc. Dba Gilmar Manor
119. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
120. **Capacity (Anticipated number of individuals housed at a given time)**: 78
121. **Will this project braid funding with non-BHSA funding source(s)?** No
122. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 78
123. **Total number of units funded with Housing Interventions funds only:** 78
124. **Anticipated date of unit availability:** 5/1/2026
125. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
126. **Have you utilized the "by right" provisions of state law in your project?** Yes

127. **Name of Project #15**: Pasadena Adult Living Center
128. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
129. **Capacity (Anticipated number of individuals housed at a given time)**: 136
130. **Will this project braid funding with non-BHSA funding source(s)?** No
131. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 136
132. **Total number of units funded with Housing Interventions funds only:** 136
133. **Anticipated date of unit availability:** 5/1/2026
134. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
135. **Have you utilized the "by right" provisions of state law in your project?** Yes
136. **Name of Project #16**: Bay Breeze Care, Inc.
137. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
138. **Capacity (Anticipated number of individuals housed at a given time):** 76
139. **Will this project braid funding with non-BHSA funding source(s)?** No
140. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 76
141. **Total number of units funded with Housing Interventions funds only:** 76
142. **Anticipated date of unit availability:** 5/1/2026
143. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000):** $14,648
144. **Have you utilized the "by right" provisions of state law in your project?** Yes

Housing Interventions (Optional)

1. **If the county is providing another type of Housing Interventions not listed above, please describe the intervention:**
    a. **Is the county providing this intervention to chronically homeless individuals?** Yes
    b. **Anticipated number of individuals served per year:** 468

Continuation of Existing Housing Programs

1. **Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)**

   DMH plans to use BHSA HI funds to continue our investments made through two State funded programs that have sunset dates, including BHBH and CCE Operating Subsidies. DMH has used BHBH to make significant investments in DMH's interim housing program, RAP and ERC programs and is committed to continuing once the funding ends. DMH received an extension from DHCS for the BHBH program through June 30, 2029, which DMH greatly appreciates. However, this extension increases the complexity of ensuring that 30% of BHSA funds are spent on housing beginning in FY 2026-27, while maintaining BHSA HI on-going funding commitments that incorporate BHBH and CCE Operating

Subsidy Program funds (which has a sunset date of March 31, 2029) once those programs end.
DMH also plans to use housing-interventions funding to support the interim and permanent housing components of both the Hollywood 2.0 and IHOP programs.

DPH-SAPC provides Housing Navigation Services to individuals in Recovery Bridge Housing (RBH) and Recovery Housing (RH) who are transitioning to permanent housing. This includes a total of approximately 450 RBH and RH beds and Housing Navigation Services to assist residents in RBH and RH transition to permanent housing settings. This service is funded by BHBH and BHSA funding is needed to sustain these services beyond the BHBH grant, particularly for individuals not eligible for housing transition services through their Medi-Cal Managed Care Plan (MCP).

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see **7.C.7 Relationship to Medi-Cal Funded Housing Services**

1. **Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?** Transitional Rent
2. **For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?**
    a. Housing Transition Navigation Services: Undecided
    b. Housing Deposits: No
    c. Housing Tenancy and Sustaining Services: No
    d. Short-Term Post-Hospitalization Housing: No
    e. Recuperative Care: No
    f. Day Habilitation: No
    g. Transitional Rent: Yes, 1/1/2026, the county behavioral health system plans to become an MCP-contracted provider.
3. **How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)?**
    Rather than contracting directly with the MCPs to be a CalAIM Community Supports TR and HD provider, DMH will partner with the Los Angeles County Department of HSH through an MOU. This partnership leverages HSH's existing contracts with the MCPs as well as their workflows, policies and procedures, claiming system and payment and reimbursement procedures. DMH has been working with HSH and the MCPs to develop workflows, forms and a common understanding of the DHCS guidance on TR. For all clients that are accessing DMH housing resources for which we are required to leverage TR or HDs, DMH will confirm through the Aves system whether the client has Medi-Cal and their MCP. A Housing Support Plan and authorization form will be developed and submitted to HSH, who will submit the authorization to the MCP. DMH is in discussions with the MCP plans and DHCS to determine the workflow for referrals to determine BHSA eligibility for individuals referred for TR that do not originate from DMH.

    DPH-SAPC will coordinate referrals for Transitional Rent Community Supports with MCPs to confirm eligibility, including service authorization, time remaining for this benefit for each eligible individual, and invoicing for this benefit. Transitional Rent will be used for eligible

individuals who are residing in RBH.

4. **Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county**
   DMH plans to centralize the referral process for DMH clients accessing BHSA HI housing resources to TR and HD. DMH will pay for the housing while waiting for MCP authorization approval and payment and will then reconcile on the back end. DMH intends to make this a seamless process for the BHSA HI housing network and as such the payment structure will not impact them. DMH will provide information to the MCPs about our contracted network, if it is helpful to them, but as mentioned the referrals will come from DMH through HSH rather than from our contracted network.

   DPH-SAPC participates in countywide CalAIM and Community Supports coordination efforts, and regular meetings with the two largest MCPs in LA County where information on the behavioral health housing provider network is shared. DPH-SAPC began implementation of Transitional Rent as an MCP-contracted provider on 01/2026, and completed the following planning activities:
   - Mapping existing SAPC-contracted housing providers
   - Sharing updated network lists and service descriptions with MCPs
   - Developing a referral pathway and shared point-of-contact protocols for future implementation of Transitional Rent
5. **Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?** No
6. **What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?**

   DMH response:
   It is our understanding that the MCPs must ensure there is a funding commitment at the end of the TR subsidy for any clients approved for TR, which if followed should ensure there is no gap. For all clients accessing DMH BHSA HI-funded housing resources that are referred for TR, DMH will make a commitment to continue to fund their housing if TR is denied or once it ends since they will already be in our housing for which we have contracts.

   Rather than contracting directly with the MCPs to be a CalAIM Community Supports TR and HD provider, DMH will partner with the Los Angeles County Department of HSH through an MOU. This partnership leverages HSH's existing contracts with the MCPs as well as their workflows, policies and procedures, claiming system and payment and reimbursement procedures. DMH been working with HSH and the MCPs to develop workflows, forms and a common understanding of the DHCS guidance on TR. For all clients that are accessing DMH housing resources for which we are required to leverage TR or HDs, DMH will confirm through the Aves system whether the client has Medi-Cal and their MCP. A Housing Support Plan and authorization form will be developed and submitted to HSH, who will submit the authorization to the MCP. DMH is in discussions with the MCP plans and DHCS to determine the workflow for referrals to determine BHSA eligibility for individuals referred for TR that do not originate from DMH.

DPH-SAPC response: To avoid service gaps once Transitional Rent or other MCP housing supports are exhausted, DPH-SAPC utilizes other non-Medi-Cal funding sources and/or coordinates with the county's broader housing system, including LAHSA, the Department of Mental Health, DHS Housing for Health, and other housing-focused departments to minimize any service gaps.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource. Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to **7.C.8 Flexible Housing Subsidy Pools**.

1. **Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?** Yes
    a. **Is the county behavioral health system participating in or planning to participate in the Flex Pool?** Yes
    b. **What role does the county behavioral health system have or plan to have in the Flex Pool?** Funder and Housing Supportive Services Provider
    c. **What organization is serving as the Operator?** Brilliant Corners for DMH.
    d. **Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?** Yes
        i. Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?
            - Rental Subsidies
            - Operating Subsidies
            - Landlord Outreach and Mitigation Funds
            - Participation Assistance Funds
2. **Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above**

    DMH will work with Brilliant Corners and BHSA HI providers to ensure they understand what TR and HD are, inform them of our workflows to ensure there is no duplication of effort.

    DPH-SAPC plays a key collaborative and funding support role in Los Angeles County's Flex Pool infrastructure. While not a Lead Entity or Operator, DPH-SAPC contributes to the broader system by:
    - Referring BHSA-eligible individuals to housing units or subsidy opportunities managed by the Flex Pool.
    - Participating in multi-agency coordination meetings, including the BHSA workgroup, CalAIM implementation teams, and countywide housing planning efforts to ensure alignment between BHSA Housing Interventions and the operational scope of the Flex Pool.

DPH-SAPC will continue to engage in policy and systems-level planning to improve how BHSA Housing Interventions integrate with the existing Flex Pool, including future considerations for joint funding applications, data sharing agreements, and system-wide outcomes tracking.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information.

1. **Does the county's plan include the development of innovative programs or pilots?** No

Workforce Strategy

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

1. Maintains and monitors a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and
2. Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.
3. The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.
    a. **Does the county intend to adopt this recommended approach for BHSA- funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System?** Yes
    b. **Does the county intend to adopt this recommended approach for BHSA- funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?** Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

Assess Workforce Gaps

1. **What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?** 20%
2. **Upload any data source(s) used to determine vacancy rate**: N/A
3. **For county behavioral health (including county-operated providers), the following five positions have the greatest vacancy rates for LACDMH:**
    - Licensed Clinical Social Worker
    - Licensed Psychologist
    - Psychiatric Technician (PT)
    - Psychiatrist
    - Other qualified provider
4. **Please describe any other key workforce gaps in the county**

    The Department annually assesses workforce training needs which will become more challenging to provide with the loss of dedicated WET funds. Historically DMH has delivered and procured training to ensure the workforce has access to clinical best practices.

5. **How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?**

   There will be an increased focus on the training, delivery and sustainability of EBP practice use. LA County DMH will build upon its 20+ year history of delivering EBPs to our client population, utilizing Implementation Science principles and learning.
   DMH will work with the COEs to ensure the workforce delivering the BH-CONNECT/BHSA EBPs are supported in their work. E-CHWs will be supported by the Chief of Peer Services. DMH will build upon identifying workforce training needs through the annual training plan process.

   There will also be an increased need for DPH-SAPC specific roles including more MAT prescribers, more co-occurring treatment capacity, and additional SUD counselors. To address these needs, DPH-SAPC offers incentives including value-based payments to support MAT prescriber capacity expansion, value-based payments to support LPHA capacity expansion, and Tuition Incentive Programs along with value-based payments to support SUD counselor capacity expansion.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

1. **Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?** Yes
   a. **Please explain any actions or activities the county is engaging in to leverage the program:** DPH-SAPC and DMH have been promoting the Behavioral Health Scholarship Program to DMC-ODS certified agencies for eligible practitioners. DMH sent out information on the BH Scholarship program to graduate programs that we have academic affiliation agreements with. DPH-SAPC sent out two notifications to the DMC-ODS provider network describing the program including eligibility and links on how to access HCAI's website, how to register for the webinar, and how to apply. The HCAI website with BH Connect workforce programs has also been shared to SAPC's Provider Advisory Committee on Workforce.
2. **Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?** Yes

   a. **Please explain any actions or activities the county is engaging in to leverage the program:** DPH-SAPC and DMH have been promoting the Behavioral Health Student Loan Payment Program to DMC-ODS certified agencies and DMH provider network to support practitioners eligible for loan repayment. DMH sent out a link to HCAI's website to its workforce and to our contracted providers. DPH-SAPC sent out

notifications to the DMC-ODS provider network describing the program including eligibility and links on how to access HCAI's website, how to register for the webinar, and how to apply. The HCAI website with BH Connect workforce programs has also been shared to SAPC's Provider Advisory Committee on Workforce.

3. **Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?** Yes

    a. **Please explain any actions or activities the county is engaging in to leverage the program:** DPH-SAPC and DMH will promote the Behavioral Health Recruitment and Retention Program to DMC-ODS certified agencies to support behavioral health recruitment and retention. DMH has sent relevant information out to its workforce. DPH-SAPC intends to send out notifications to the DMC-ODS provider network on this program when the application and deadlines are available. DPH- SAPC shared this opportunity in advance to contracted training providers that supports SUD counselors in locating internship placements in advance of the release of application. The HCAI website with BH Connect workforce programs has also been shared to SAPC's Provider Advisory Committee on Workforce.

4. **Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?** Yes

    a. **Please explain any actions or activities the county is engaging in to leverage the program:** DPH-SAPC and DMH will promote the Behavioral Health Community-Based Provider Training Program to DMC-ODS certified agencies to support community-based provider training. DPH-SAPC sends notifications to its provider network describing the program including eligibility and links on how to access HCAI's website, how to register for the webinar, and how to apply. The HCAI website with BH Connect workforce programs has also been shared to SAPC's Provider Advisory Committee on Workforce.

5. **Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?** No

6. **Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training**

    As the data indicate, LACDMH faces a substantial vacancy rate for psychologists in particular. Competition for psychologists is extremely high, with attractive alternatives such as private practice delivered via telehealth, university-based research positions, and recruitment from the VA.

    LACDMH has maintained a recruitment presence at the American Psychological Association and California Psychological Association conventions for the last three years and is posting job opportunities through Division 18 (Public Service) of the American Psychological Association. In addition, LACDMH has conducted lunch-and-learn talks at local psychology schools. Recently, LACDMH has dedicated a psychologist leader to reach out to each applicant who applies for the Clinical Psychology I and II positions, to engage them on opportunities within LACDMH.

    As described in the above section specific to addiction medications, DPH-SAPC is

applying incentive funding from its value-based reimbursement approach under CalAIM Behavioral Health Payment Reform to DMC-ODS certified agencies to support their recruitment of medical clinicians and licensed behavioral health clinicians to ensure addiction medications, psychiatric support, and integrated co-occurring clinical capability is available from the staff serving clients in DMC-ODS settings.

Budget And Prudent Reserve

1. **Please upload the completed budget template:** See Attachment #D
2. **Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template:**
    a. Behavioral Health Services and Supports (BHSS): N/A
    b. Full Service Partnership (FSP): N/A
    c. Housing Interventions: N/A
3. **Enter date of last prudent reserve assessment:** 01/08/2026
4. **Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan**
    a. BHSS: N/A
    b. FSP: N/A
    c. Housing Interventions: N/A

Plan Approval and Compliance

Behavioral Health Director Certification

1. I hereby certify that **Los Angeles County** has complied with all statutes, regulations, and guidelines in preparing and submitting this Three-Year Integrated Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that (please select all below) [multi-select list]
    a. The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
    b. I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
    c. The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
    d. Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
    e. BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
    f. The IP was submitted to the local behavioral health board
2. **Does the county wish to disclose any implementation challenges or concerns with these requirements?** No

Contact information

1. **County Name:** Los Angeles
2. **Certification for:** Three-Year Integrated Plan-Draft
3. **County Behavioral Health Agency Director Name:** Lisa Wong, Psy.D.
4. **County Behavioral Health Agency Director Phone Number:** (213) 947-6770
5. **County Behavioral Health Agency Director Email:** lwong@dmh.lacounty.gov
6. **SUD Director:** Gary Tsai, MD
7. **Title**: Director, Substance Abuse Prevention and Control (SAPC) Bureau
8. **Phone:** (626) 299-4595
9. **Email:** gtsai@ph.lacounty.gov

County Behavioral Health Agency Director Signature and SUD Director: See Attachment #E

County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

1. I hereby certify that (please select all below)
    a. The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
    b. Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
    c. BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
2. **Does the county wish to disclose any implementation challenges or concerns with these requirements?** No

Contact information

3. **County Name**: Los Angeles
4. **Certification for**: Three-Year Integrated Plan-DRAFT
5. **County Chief Administration Officer Name:** Joseph M. Nicchitta
6. **County Chief Administration Officer Phone Number:** (213) 974-1101
7. **County Chief Administration Officer Email:** jnicchitta@ceo.lacounty.gov

Signature: See Attachment #F

From: County of Los Angeles <lacounty@subscriptions.lacounty.gov>
Sent: Monday, March 23, 2026 4:08 PM
To: Robin Ramirez
Subject: Resources to assist with understanding the BHSA Integrated Plan (IP) and Save the Date for the IP Public Hearing - April 9, 2026 10a-1:30p

Dear Stakeholders,

DMH is providing three concise documents (attached to this message) to support your understanding of the BHSA Integrated Plan (IP). Use them as a supplement to your review of the IP. The attached materials are intended to clarify concepts, summarize key sections, and illustrate budget-related considerations. We hope that these documents are helpful in your review.

DMH continues to seek as many stakeholder perspectives as possible in review and input of our BHSA IP. We hope that you are able to participate in the Public Hearing for the IP, which will take place at the **Behavioral Health Commission Meeting** scheduled for Thursday, April 9, 2026 from 10:00 a.m. – 1:30 p.m.

The hearing will be held in person at 510 S. Vermont Ave, Los Angeles, CA 90020, on the Terrace Level. You can also participate in the meeting virtually at the MS Teams link below. Please note that the meeting starts at 10a (an hour earlier than the regular Commission meeting).

Join the meeting now

Meeting ID: 249 974 756 863 67

Passcode: rY2gx389

Dial in by phone

+1 323-776-6996,,618916441# United States, Los Angeles

Find a local number

Phone conference ID: 618 916 441#

Requests for interpretation services in languages other than Spanish and Korean must be submitted in writing to communitystakeholder@dmh.lacounty.gov no later than Monday, March 30, 2026.

Sincerely,

Dr. Darlesh K. Horn, Division Chief

Behavioral Health Services Act (BHSA) Administration Division

Community & Stakeholder Engagement

County of Los Angeles – Department of Mental Health

BHSA Budget Explanation-Spanish.pdf

BHSA Budget Explanation-Korean.pdf

BHSA Budget Explanation-English.pdf

Executive Summary-English.pdf

ExecutiveSummary-Korean.pdf

Executive Summary-Spanish.pdf

Integrated Plan Overview-English.pdf

Integrated Plan Overview-Korean.pdf

Integrated Plan Overview-Spanish.pdf

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This email was sent using GovDelivery Communications Cloud to rramirez@dmh.lacounty.gov on behalf of: County of Los Angeles, California - 500 W. Temple St. - Los Angeles 90012

From: County of Los Angeles
To: Robin Ramirez
Subject: FRIENDLY REMINDER: Public Hearing for the Draft BHSA Integrated Plan on Thursday, April 9, 2026, 10 AM to 1:30 PM
Date: Wednesday, April 1, 2026 5:13:17 PM

A continuación encontrarás este mensaje en español.

아래에서 이 메시지는 한국어로 되어 있습니다.

DEAR BHSA STAKEHOLDERS,

The Los Angeles County Behavioral Health Commission will have a public hearing on the *Draft BHSA Integrated Plan* on Thursday, April 9, 2026, from 10:00 to 1:30 PM at the DMH Headquarters, 9th Floor Terrace, located at 510 S. Vermont, Los Angeles, CA 90020.

The meeting is open to the public. The public can attend in person or watch the live stream using this link: Join event. If you want to offer public comments remotely, please use these lines:

English: 844-291-6362 | Access Code: 4972277 Spanish: 323-776-6996 | Conference ID: 444855048 Korean: 323-776-6996 | Conference ID: 228880303

Materials for the session can be accessed by clicking this link: BHSA Announcements - Department of Mental Health (lacounty.gov).

Please hold the following dates for BHSA CPT meetings in 2026: May 12, June 9, July 14, August 11, September 8, October 13, November 10, and December 8. All meetings are on the second Tuesday of each month from 9:30-12:30.

If you have any questions about this message, please contact us at communitystakeholder@dmh.lacounty.gov

Sincerely

DARLESH HORN, *Division Chief*

BHSA Administration Division

Community & Stakeholder Engagement

County of Los Angeles - Department of Mental Health

RECORDATORIO AMISTOSO: Audiencia pública para el Borrador del Plan Integrado de la BHSA el jueves 9 de abril de 2026, de 10:00 a 13:30

ESTIMADOS GRUPOS DE INTERÉS DE LA BHSA,

La Comisión de Salud Conductual del Condado de Los Ángeles celebrará una audiencia pública sobre el *Borrador del Plan Integrado de la BHSA* el jueves 9 de abril de 2026, de 10:00 AM a 1:30 PM en la sede del DMH, 9ª planta Terrace, situada en 510 S. Vermont, Los Ángeles, CA 90020.

La reunión es abierta al público. El público puede asistir en persona o ver la retransmisión en directo usando este enlace: Únete al evento. Si desea ofrecer comentarios públicos de forma remota, por favor utilice estas líneas:

Inglés: 844-291-6362 | Código de acceso: 4972277

Español: 323-776-6996 | ID de conferencia: 444855048

Coreano: 323-776-6996 | ID de conferencia: 228880303

Pueden obtener los materiales para la sesión haciendo clic en este enlace: Anuncios BHSA - Departamento de Salud Mental (lacounty.gov).

Por favor, fije las siguientes fechas para las reuniones CPT de la BHSA en 2026: 12 de mayo, 9 de junio, 14 de julio, 11 de agosto, 8 de septiembre, 13 de octubre, 10 de noviembre y 8 de diciembre. Todas las reuniones se celebran el segundo martes de cada mes de 9:30 a 12:30.

Si tiene alguna pregunta sobre este mensaje, por favor contáctenos en communitystakeholder@dmh.lacounty.gov

Atentamente

DARLESH HORN, *Jefe de División*

División de Administración de la BHSA

Participación de la comunidad y los grupos de interés

Condado de Los Ángeles - Departamento de Salud Mental

친절한 알림: 2026년 4월 9일 목요일 오전 10시부터 오후 1시 30분까지 BHSA 통합 계획 초안에 대한 공개 청문회가 열립니다

친애하는 BHSA 이해관계자 여러분,

로스앤젤레스 카운티 행동 건강 위원회는 *2026*년 *4*월 *9*일 목요일 오후 *10*시부터 *1*시 *30* 분까지 DMH 본부 9층 테라스(주소: 510 S. Vermont, LA 90020)에서 BHSA 통합 계획 초안에 대한 공개 청문회를 개최할 예정입니다.

이 회의는 일반인에게 공개되어 있습니다. 일반인은 직접 참석하거나 이 링크를 통해

라이브 스트림을 시청할 수 있습니다: 행사 참여. 원격으로 공개 의견을 제공하고 싶으시다면, 다음 문구를 사용해 주세요:

영어: 844-291-6362 | 접근 코드: 4972277

스페인어: 323-776-6996 | 컨퍼런스 ID: 444855048

한국어: 323-776-6996 | 컨퍼런스 ID: 228880303

세션 자료는 다음 링크를 클릭하여 접근할 수 있습니다: BHSA 공지사항 - 정신건강부(lacounty.gov).

2026년 BHSA CPT 회의 날짜는 5월 12일, 6월 9일, 7월 14일, 8월 11일, 9월 8일, 10월 13일, 11월 10일, 12월 8일로 기다려 주시기 바랍니다. 모든 모임은 매월 둘째 주 화요일 오전 9시 30분부터 12시 30분까지 열립니다.

이 메시지에 대해 궁금한 점이 있으시면 언제든지
communitystakeholder@dmh.lacounty.gov 로 연락해 주세요

진심을 담아

달레시 혼 박사, 부서장

BHSA 행정부

지역사회 및 이해관계자 참여

로스앤젤레스 카운티 - 정신건강부

- PPT - IP Summary_Curated_KOR_FINAL.pdf
- PPT - IP Summary_Curated_ENG_FINAL.pdf
- PPT - IP Summary_Curated_SPN_FINAL.pdf

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BEHAVIORAL HEALTH COMMISSION
MONTHLY MEETING

WHY JOIN?

This meeting is a wonderful chance to get involved in the annual Behavioral Services Act (BHSA) public hearing. We encourage you to share your thoughts, concerns, and ideas about the new BHSA. Your input is valuable and will help the Commission create a letter of recommendations to the Departments of Mental Health (DMH), Public Health Substance Abuse Prevention and Control Bureau, and the Los Angeles Board of Supervisors. We look forward to hearing from you and working together to make a positive impact!

NEXT MEETING

THURSDAY
APRIL 09, 2026

10:00 AM

510 S. Vermont Ave.
Los Angeles, CA 90020

CALL-IN INFORMATION

English line: 844-291-6362
participant code 4972277

Spanish line: 323-776-6996
conference ID 444855048

Korean line: 323-776-6996
conference ID 228880303

Watch live stream at
dmh.lacounty.gov/bhc-teams-link

CONTACT US
213-947-6487 or 213-948-2463
mhcommission@dmh.lacounty.gov

Robin Ramirez

From: County of Los Angeles <lacounty@subscriptions.lacounty.gov>
Sent: Wednesday, February 11, 2026 4:50 PM
To: Robin Ramirez
Subject: Notice of Public Comment Period for Los Angeles County Draft BHSA Integrated Plan

Mensaje en español después del mensaje en inglés
한국어 메시지는 끝에 있습니다

The Los Angeles County Department of Mental Health (DMH) and Department of Public Health-Substance Abuse Prevention and Control (DPH-SAPC) invite members of the public to submit comments on Los Angeles County's *draft* Behavioral Health Services Act Integrated Plan (BHSA IP) for fiscal years 2026-2027 through 2028-2029. Two versions are posted:

- The state version follows the California Department of Health Care Services' formatting and word limits per section.
- The local version is more reader-friendly, containing all the content in the state version, while providing more details per section.

The public can provide comments on one or both versions using this Public Comment Form covering four key sections of the BHSA IP:

1. Statewide Population Behavioral Health Goals
2. Behavioral Health Services Act/Fund Programs
3. Workforce Strategy
4. Budget and Prudent Reserve

The Public Comment Form also offers a 'General Comments' box at the end where the public can add comments on any other BHSA IP sections not covered in the four sections listed above.

After you complete the Public Comment Form, please indicate which stakeholder group(s) you represent. Add your contact information at the end if you want to receive a notification of DMH's and DPH-SAPC's response(s) to your comment(s).

The Public Comment period begins on **Wednesday, February 11, 2026**, and ends at **11:59 PM on Friday, March 13, 2026**.

If you have any questions about this notice, email us at communitystakeholder@dmh.lacounty.gov

DR. DARLESH HORN
Division Chief, MHSA Division of Administration
Los Angeles County Department of Mental Health

ASUNTO: Aviso de periodo de comentarios públicos para el borrador del Plan Integrado de la BHSA del condado de Los Ángeles

ESTIMADOS INTERESADOS DE LA COMUNIDAD BHSA,

El Departamento de Salud Mental del Condado de Los Ángeles (DMH) y el Departamento de Salud Pública – Prevención y Control del Abuso de Sustancias (DPH-SAPC) invitan al público a presentar comentarios sobre el *borrador* del Plan Integrado de la Ley de Servicios de Salud Conductual del Condado de Los Ángeles (BHSA IP, por sus siglas en inglés) para los años fiscales 2026-2027 a 2028-2029. Se publican dos versiones:

- La versión **estatal** sigue el formato y los límites de palabras por sección del Departamento de Servicios de Salud de California.
- La versión **local** es más fácil de leer, contiene todo el contenido de la versión estatal, y además ofrece más detalles por sección.

El público puede proporcionar comentarios sobre una o ambas versiones utilizando este Formulario de Comentarios Públicos que cubre cuatro secciones clave del BHSA IP:

1. Objetivos estatales de salud conductual de la población
2. Ley de Servicios de Salud Conductual/Programas del fondo
3. Estrategia de Fuerza Laboral
4. Presupuesto y Reserva Prudente

El Formulario de Comentarios Públicos también ofrece una casilla de 'Comentarios Generales' al final donde el público puede añadir comentarios sobre cualquier otra sección del BHSA que no esté cubierta en las cuatro secciones mencionadas anteriormente.

Después de completar el Formulario, por favor indique qué grupo(s) de interesados representa. Añade tu información de contacto al final si quieres recibir una notificación de la respuesta de DMH y DPH-SAPC a tu(s) comentario(s).

El período de comentarios públicos comienza el **miércoles 11 de febrero de 2026** y finaliza a las 11:59 p.m. del **viernes 13 de marzo de 2026.**

Si tiene alguna pregunta sobre este aviso, envíenos un correo electrónico a communitystakeholder@dmh.lacounty.gov

DR. DARLESH HORN
Jefe de División, División de Administración de MHSA
Departamento de Salud Mental del Condado de Los Ángeles

제목: 로스앤젤레스 카운티 BHSA 통합 계획(초안)에 대한 공개 의견 수렴 기간 안내

BHSA 커뮤니티 이해관계자 여러분께,

로스앤젤레스 카운티 정신건강국(DMH)과 공중보건국–약물남용 예방 및 관리국(DPH-SAPC)은 시민 여러분께서 로스앤젤레스 카운티의 행동건강서비스법(BHSA) 통합 계획 *초안*(2026-2027 회계연도부터 2028-2029 회계연도까지)에 대한 의견을 제출해 주시기를 요청 드립니다. 현재 두 가지 버전이 게시되어 있습니다:

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2. 행동건강서비스법/기금 프로그램
3. 인력 전략
4. 예산 및 적정 예비금

또한, 의견 제출 양식 하단에는 '일반 의견'란이 마련되어 있어, 위에서 언급한 네 가지 섹션 외에 다른 BHSA 통합 계획 섹션에 대한 의견도 자유롭게 추가하실 수 있습니다.

공개 의견 제출 양식을 작성하신 후, 본인이 대표하는 이해관계자 그룹(들)을 표시해 주시기 바랍니다. 또한 의견에 대한 DMH 및 DPH-SAPC의 답변 통지를 받고자 하시는 경우, 마지막에 연락처 정보를 입력해 주세요.

대중 의견 수렴 기간은 2026년 2월 11일 수요일에 시작하여 2026년 3월 13일 금요일 오후 11시 59분에 종료됩니다.

본 공지와 관련하여 질문이 있으시면 아래 이메일로 문의해 주시기 바랍니다:
communitystakeholder@dmh.lacounty.gov

DARLESH HORN 박사, *과장*
MHSA 행정과(MHSA Division of Administration)
로스앤젤레스 카운티 정신건강국(Los Angeles County Department of Mental Health)

- Los Angeles County BHSA Integrated Plan Local Version 2-11-2026 (Spanish) with attachments.pdf
- Los Angeles County BHSA Integrated Plan Local Version 2-11-2026 (Korean) with attachments.pdf
- STATE-Los Angeles County BHSA Integrated Plan 2026-29.pdf
- Los Angeles County BHSA Integrated Plan Local Version 2-11-2026 (English) with attachments.pdf

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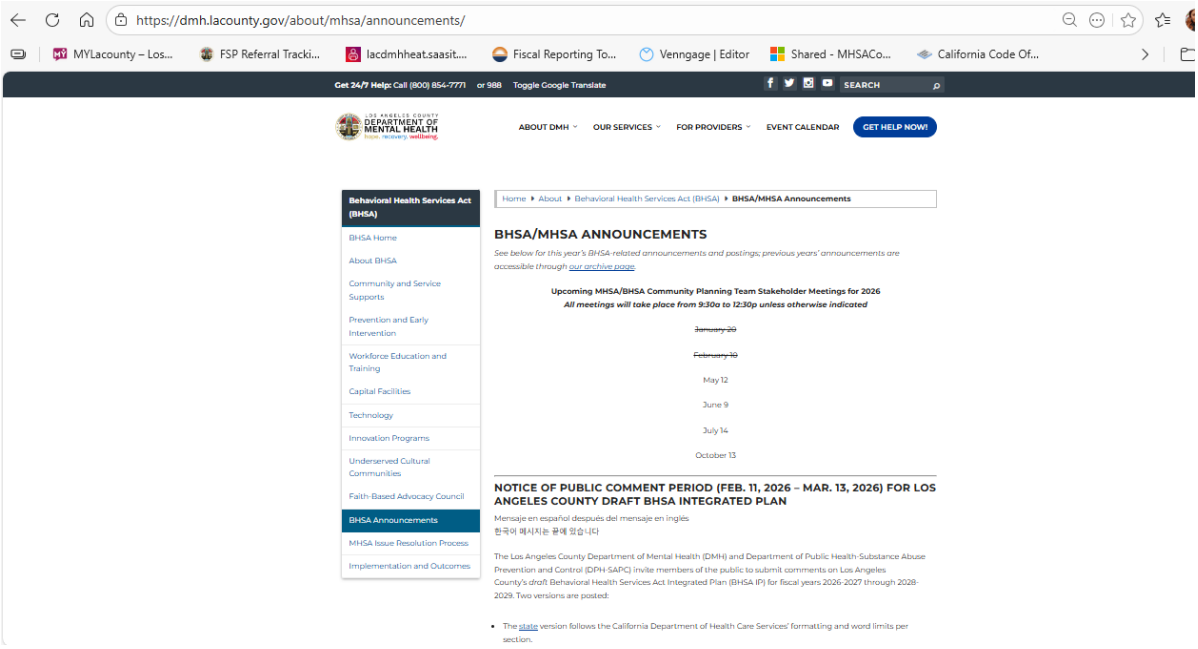


Quality Assessment and Performance Improvement (QAPI) Work Plan January 2026- June 2027

March 2026

Presented By:

Los Angeles County Department of Mental Health
Quality, Outcomes, and Training Division, Quality Improvement Unit

Los Angeles County Department of Public Health
Substance Abuse Prevention and Control, Quality Improvement Branch

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

COUNTY OF LOS ANGELES Public Health
Substance Abuse Prevention and Control

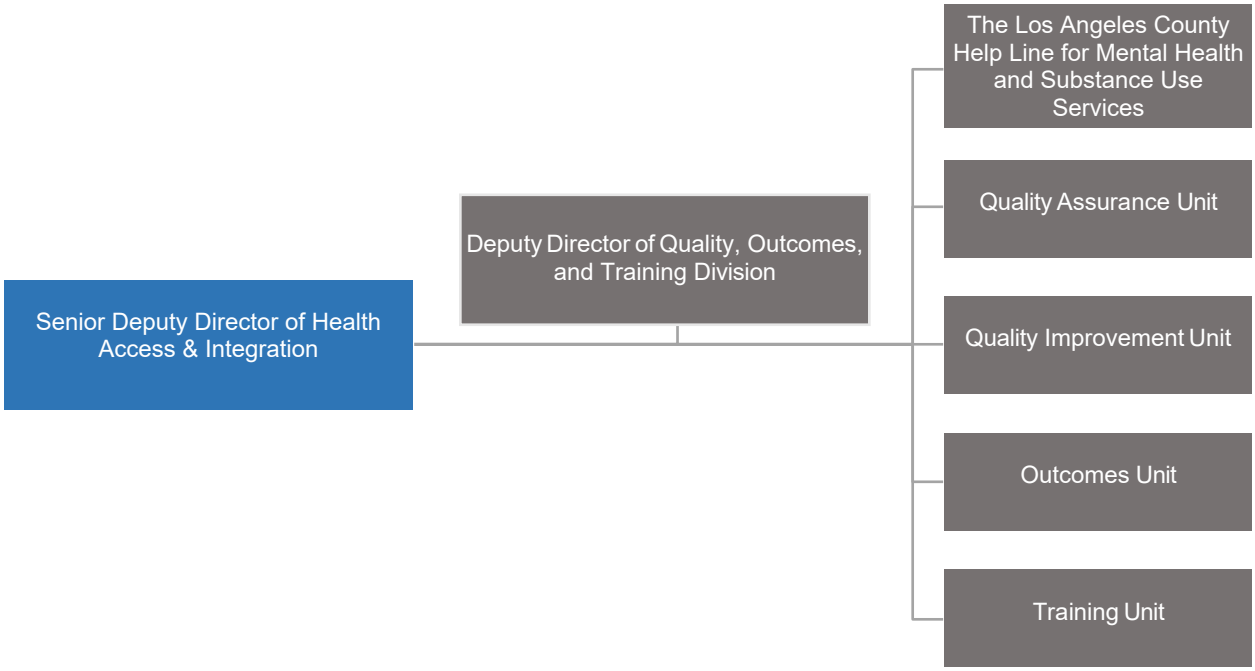
CONTENTS

QUALITY IMPROVEMENT (QI) PROGRAM PURPOSE AND SCOPE 2
Department of Mental Health 2
Department of Public Health – *Substance Abuse Prevention and Control* 5
QUALITY IMPROVEMENT COMMITTEE AND STRUCTURE 7
Department of Mental Health 7
Department of Public Health – *Substance Abuse Prevention and Control* 11
QUALITY IMPROVEMENT WORKPLAN 14
Department of Mental Health 14
Department of Public Health – *Substance Abuse Prevention and Control* 16

QUALITY IMPROVEMENT (QI) PROGRAM PURPOSE AND SCOPE

Department of Mental Health

Under the leadership of the Senior Deputy Director of Health Access and Integration, the Deputy Director of Quality, Outcomes, and Training Division (QOTD) oversees the units responsible for assessing accessibility of services, assessing member satisfaction, establishing qualitative measures to assess performance, identifying areas in need of improvement, and overall monitoring of the quality of the Department's services in conformance with Federal, State, and local QI requirements. These units include Quality Assurance (QA), Quality Improvement, Outcomes, Training, and The Los Angeles County Help Line. QOTD's organizational structure facilitates a downward and upward communication loop between Specialty Mental Health Services (SMHS) providers countywide, various units within the department responsible for monitoring performance throughout the operations of the Los Angeles County Department of Mental Health (LACDMH), and LACDMH executive management.



The Los Angeles County Help Line for Mental Health and Substance Use Services

LACDMH and Los Angeles County Department of Public Health Substance Abuse Prevention and Control collaboratively operate a centralized 24/7 Help Line that simplifies the road to recovery for those seeking care for mental health and/or substance use disorders. This serves as the entry point for mental health and substance use services in Los Angeles County. While the majority of calls are for information and referral, the line also facilitates the deployment of Field Intervention Teams (FITs), has a dedicated emotional support line and serves as the gatekeeper for acute inpatient psychiatric beds, interpreter services, and emergency member transportation to psychiatric emergency rooms. For more information visit: https://dmh.lacounty.gov/blog/2024/08/welcome-l-a-county-help-line-for-mental-health-and-substance-use-services/

Quality Assurance Unit

The QA Unit ensures the adherence of the County Mental Health Plan's (MHP) directly operated (DO) and contracted providers to federal, state, and local laws, regulations, and requirements associated with the provision, documentation, and claiming of Medi-Cal SMHS. The QA Unit develops policies and guidelines; monitors adherence to governmental mandates; provides training and technical support; certifies the MHP's SMHS providers; supports the clinical functions of the Department's electronic health record (EHR) system; oversees the integrity, retention, and release of the Department's clinical records; acts as a liaison between the MHP and the State Department of Health Care Services (DHCS) including during the DHCS Triennial System/Chart review and Short/Doyle Medi-Cal Hospital audits; and advocates for the MHP's position on SMHS-related issues with DHCS, the County Behavioral Health Director's Association (CBHDA), and other entities. The QA Unit ensures adherence to prescribed site review protocols and timelines, such as those assigned during triennial oversight reviews and External Quality Review Organization (EQRO) audits. In addition, the QA Unit is responsible for the credentialing of clinical staff across the Specialty Mental Health System and manages the electronic data platforms that track and report on timely access and Network Adequacy. The QA unit is responsible for the Department's Annual Test Calls to identify areas in need of improvement with regards to cultural and linguistic responsiveness, customer service, referrals to SMHS, tracking/monitoring, and appropriate documentation of call information. They are also responsible for Medi-Cal certification of sites, LPS designation and State Fair Hearings. For more information visit: https://dmh.lacounty.gov/qa/

Quality Improvement Unit

The QI Unit in conformance with Federal, State, and local QI requirements oversees technical reporting related to the annual Quality Assurance and Performance Improvement (QAPI) Work Plan and Evaluation Report, coordinates efforts to assess member/family satisfaction by implementing the annual Consumer Perception Surveys (CPS) and evaluates and reports member/family satisfaction data. The QI unit is responsible for the state-mandated Performance Improvement Projects (PIPs) and their validation during External Quality Review (EQR) audits. PIP committee members are chosen by the QI Unit who have relevant experience and/or expertise with the PIP topic to ensure that improvement plans and strategies are well informed and that improvement efforts are coordinated. The QI Unit is also responsible for coordinating the Quality Improvement Committee (QIC) meetings, evaluating the population of consumers served and the services delivered to identify areas in need of improvement, and coordinate with other departmental units to develop quality improvement plans and strategies to address these areas. Additionally, the QI unit provides technical assistance, consultation, and training around the professional use of QI practices and strategies to promote a culture of Continuous Quality Improvement (CQI) and to support QI efforts where they occur. For more information visit: https://dmh.lacounty.gov/qid/.

Outcomes Unit

The Outcomes Unit is responsible for selecting, developing, disseminating, training, collecting, and reporting outcome measures associated with the Department's mental health programs, including mandated ones. The Outcomes Unit provides operational elements and business rules to the Chief Information Office Bureau (CIOB) to develop or customize data collection and reporting systems. The Outcomes Unit conducts data queries and creates dashboards to display outcomes and other data elements. For more information visit: https://dmh.lacounty.gov/outcomes/

Training Unit

The Training Unit is responsible for workforce development, ensuring a diverse workforce reflective of the members served, education, and providing training and technical assistance for the clinical and non-clinical public mental health workforce. For more information visit: https://dmh.lacounty.gov/for-providers/clinical-tools/training-workforce-development/

Additional Units and Divisions Outside of QOTD

Chief Information Office Bureau (CIOB)

A large portion of the Department's CQI work requires ongoing coordination with CIOB, namely:

- Compiling countywide information on members served and member populations; and
- Developing an internal application to collect and report annual member satisfaction data electronically in multiple languages.

CIOB's Clinical Informatics team holds essential roles in both PIPs, from aggregating data to offering technical assistance to the clinical PIP lead tasked with analyzing the data. They are also tasked with calculating LACDMH's Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Cultural Competency Unit (CCU)

CCU is part of the Anti-Racism, Inclusion, Solidarity, and Empowerment (ARISE) Division and is overseen by the Ethnic Services Manager (ESM). The ESM provides technical assistance to the Cultural Competency Committee (CCC) and is a standing member of the Departmental QIC. This structure facilitates communication and collaboration for attaining the goals outlined in the QAPI Work Plan and Cultural Competency (CC) Plan to reduce disparities, increase capacity, and improve the quality and availability of services. Additional information on the CCU and its functions, the CCC, the Institute for Cultural Linguistic Inclusion and Responsiveness (ICLIR), a tri-Countywide Cultural and Linguistic Competency workgroup, and our most recent CC Plan is available via the CCU website at https://dmh.lacounty.gov/ccu/.

Patient's Rights' Office (PRO)

The Patient's Rights Office is responsible for investigating and responding to grievances and complaints about inpatient and outpatient mental health services. They review the data from member grievances, appeals, and expedited appeals. PRO also manages all Change of Provider (COP) requests and Senate Bill (SB) 929 data. For more information visit: https://dmh.lacounty.gov/our-services/patients-rights/

Office of the Chief Medical Officer

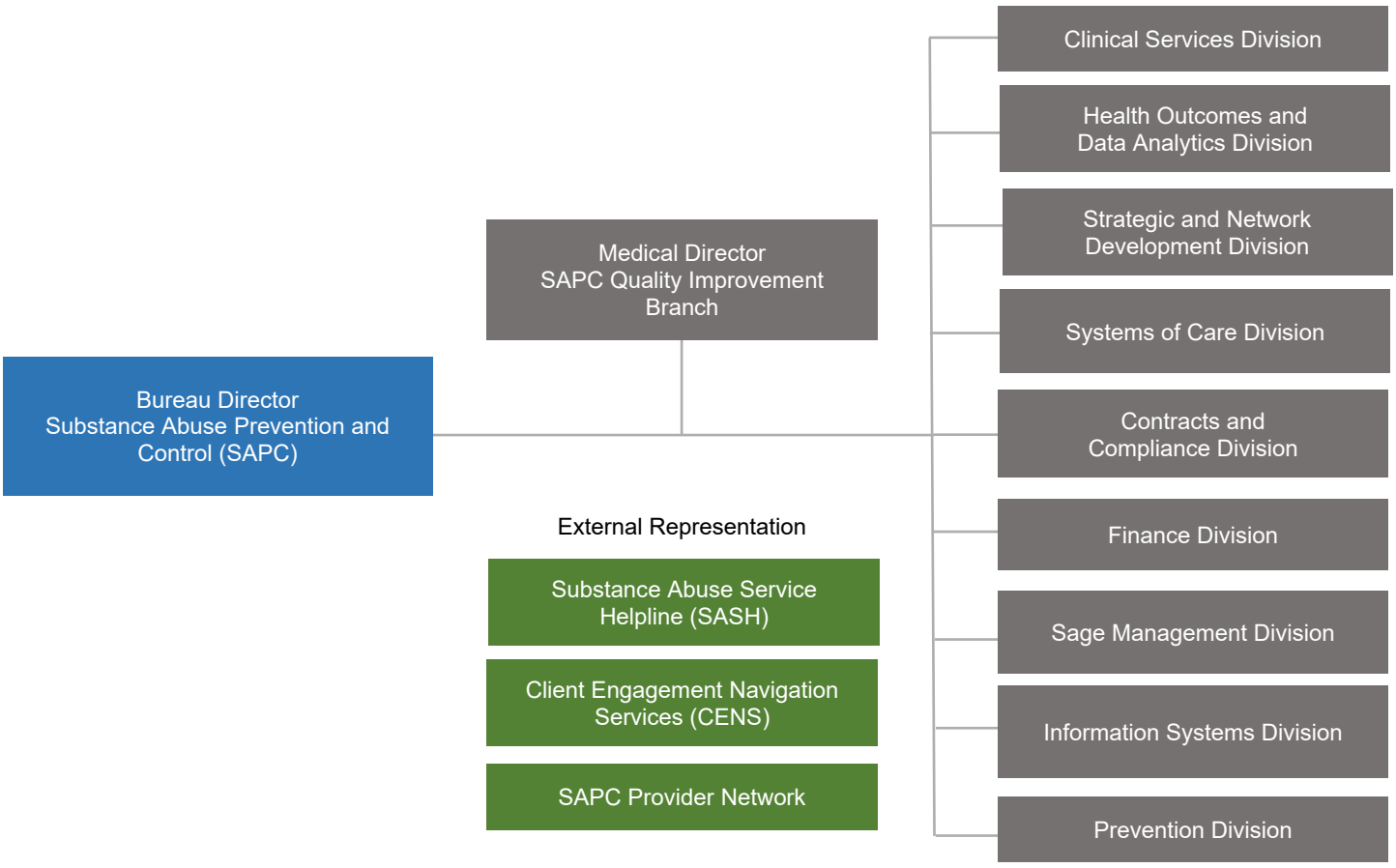
The Office of the Chief Medical Officer is responsible for ensuring practice guidelines/ parameters are based on valid and reliable clinical evidence or a consensus of health care professionals in the field, consider the needs of our members, are adopted in consultation with network providers, and are reviewed every two years and updated as appropriate. They also monitor the safety and effectiveness of medication practices and oversee the Clinical Risk Management Unit.

Department of Public Health – *Substance Abuse Prevention and Control*

Los Angeles County specialty substance use disorder (SUD) system is managed by the Substance Abuse Prevention and Control Bureau within the Department of Public Health (SAPC). SAPC's provider network offers specialty SUD treatment services for youth and adults who are enrolled or eligible for Los Angeles County Medi-Cal, and/or participating in another eligible County funded program. This program continues to focus on quality improvement within the treatment network focused on:

1. Integrating physical and mental health service needs with SUD services;
2. Training quality standards to improve health outcomes;
3. Providing the full continuum of SUD services to meet the needs of patients;
4. Establishing a single benefit package for publicly funded SUD services regardless of referral source or insurance plan; and
5. Solidifying SUD's status as a chronic health condition rather than as an acute condition.

These enhancements enable SUD patients to receive quality services that match their individualized needs and preferences and overall improve health and social outcomes.



Quality Improvement Branch

SAPC's Quality Improvement (QI) Branch is focused on the identification and development of quality improvement projects, specifically including the identified Performance Improvement Projects (PIPs). The QI Division conducts provider-interfacing quality improvement around access to priority clinical services (such as MAT), conducts biannual documentation review of key quality metrics, and holds member focus groups to learn more about the patient perspective on treatment delivered by the SAPC provider network. The branch centralizes the process of clinical grievances and appeals (G&A) and spends a portion of their time processing authorizations for treatment in collaboration with SAPC's overall Clinical Services Division. The QI Branch interfaces with other key SAPC units to carry forward SAPC's quality improvement initiatives (such as harm reduction and access to care).

Quality Improvement Accountability, Governing Body, and Committee Structure

SAPC's Quality and Risk Management Committee provides a forum for discussion and the provision of direction to the other units with SAPC and is the framework for organizational quality improvement and oversight responsibilities. Most committees are internal and attended by SAPC branch representatives and relevant parties. There are two committees that include external stakeholders, including member referral services and representatives from the SAPC provider network. Each committee is independently governed but report to the Quality Improvement & Risk Management Committee as lead committee.

QUALITY IMPROVEMENT COMMITTEE AND STRUCTURE

Behavioral Health Administrative Integration QI Steering Committee

Statement of Purpose

The purpose of the Behavioral Health Administrative Integration (BHAI) QI Steering Committee is for both LACDMH and LACDPH SAPC to coordinate efforts to improve service delivery for members in need of SMHS and SUD services in Los Angeles with special attention to members with co-occurring needs.

Committee Membership

LACDMH:

- QOTD Deputy
- QA Unit
- QI Unit
- Clinical Informatics

LACDPH SAPC:

- QI Branch
- Health Outcomes and Data Analytics Division

Department of Mental Health

Quality Improvement Committee (QIC) - Statement of Purpose

The purpose of the QIC is to monitor the appropriateness and quality of services provided to LACDMH members with the aim of improving the processes of providing care and better meeting the needs of our members. The QIC is a central part of LACDMH's Quality Assessment and Performance Improvement Program and shall recommend policy decisions; review and evaluate the results of QI activities, including PIPs; institute needed QI actions; ensure follow-up of QI processes; and document QAPI Committee meeting minutes regarding decisions and actions taken. LACDMH holds two types of QIC meetings, the Countywide QIC meeting and the Regional QIC meeting. In addition, there are various other meetings focused on quality improvement activities and efforts. Those meetings will be described in further detail below. The Countywide and Regional QIC meetings provide opportunities to:

- Review and evaluate data;
- Identify QI issues and projects;
- Foster an environment where stakeholders can discuss QI activities;
- Identify possible best practices; and
- Ensure performance standards align with the Department's mission and strategic plan.

Countywide QIC

The Countywide (CW) QIC meetings occur on a monthly basis and are led by the QI Unit, which is responsible for reviewing service delivery and quality of care data, evaluating the results of QI activities including QAPI WP goals, recommending system improvements, and recommending policy changes. Effective by the end of the first quarter of 2026, the CW QIC will be subsumed by the QAPI Leadership Committee (renamed from Access to Care Leadership Committee as described below).

Committee Membership

LACDMH Quality Improvement Committee membership reflects the diverse perspectives of members from administrative programs and providers from throughout the county. SAPC began attending DMH CW QIC meetings last year in efforts to integrate QI endeavors and ensure quality improvement activities around members with co-occurring substance use disorders are addressed. The Cultural Competency Unit supervisor is a standing member of the QIC which supports integration of cultural competency goals and quality improvement efforts such as reducing disparities and improving the quality and availability of culturally responsive and linguistically appropriate services throughout the county. The QIC membership includes representatives from:

- Child Welfare
- Clinical Informatics
- Clinical Risk Management
- Compliance, Privacy, and Audit Services
- Contracts, Management and Monitoring Division
- Cultural Competency Unit
- Emergency Outreach and Triage Division
- Forensic Services
- Managed Care Operations
- Managed Plan Operations
- The Los Angeles County Help Line for Mental Health and Substance Use Services
- Mental Health Services Act (MHSA)
- Outcomes
- Outpatient Care Services
- Patients' Rights Office
- Peer Services
- Pharmacy/ Psychiatry
- Quality Assurance Unit
- Quality Improvement Unit
- Training

Authority

A licensed mental health professional supervises the QI Unit and serves as the Departmental CW QIC Chair. The QIC Chair is responsible for chairing and facilitating meetings and ensuring members receive timely and relevant information.

Regional QIC Meetings

Regional QIC meetings are convened on a quarterly basis. The Northern Regional QIC encompasses Service Areas 1-4 and Southern Regional QIC has members from Service Areas 5-8. QI Unit staff co-lead the meetings along with a SA Lead. LACDMH providers are required to identify a QI staff from their agency or clinic to attend and participate in Regional QIC meetings. Many of the staff in attendance are also practitioners within their clinics. The Regional QIC includes sharing data on quality improvement efforts such as the PIPs, CPS, and WP goals and solicitation of QIC members' input/feedback to improve our system of care. Each committee meeting provides a structured forum for identifying QI opportunities to address challenges and barriers unique to their respective SA or region. Providers are asked to share quality improvement projects in their SAs or clinics. This approach fosters integrative discussions of departmental QA goals in concert with QI practices. Meeting minutes and recordings (when applicable) are posted online at https://dmh.lacounty.gov/qid/ for public review.

Additional QAPI Committees and Meetings

Access to Care Leadership Committee (will be renamed QAPI Leadership Committee)

The Access to Care Leadership committee is comprised of core managers from various sectors of LACDMH's system of care. The committee meets bimonthly, with system-wide data review occurring at least monthly. The committee members work collaboratively to address the external (systemic) factors contributing to timely access challenges seen in the data or identified by providers with the goal of improving overall access to care. The Access to Care Leadership committee's developers ensured QI Unit presence early to bring QI strategies to the workgroup. This inclusion was part of an effort to promote a culture of quality improvement within the Department. This collaboration has evolved, beginning with developing a Performance Improvement Project focused on timeliness. The Access to Care Leadership committee has also become a platform for reviewing service and outcome data and gaining leadership recommendations and direction on performance improvement. The group meets twice monthly to address access and timeliness performance across Specialty Mental Health. In March 2026 it will be broadened to include metrics the MHP is responsible for reporting on and achieving.

Access to Care Action Committee (will be renamed QAPI Action Committee)

This committee meets every other month and is inclusive of network providers who work jointly with DMH leadership to identify strategies to improve performance on timely access to care and follow up access to care, network adequacy and system capacity. This committee provides valuable input into developing adult and child levels of outpatient care and has been a partner in mapping CANS data to child levels of care and LOCUS implementation for adult clients.

Stakeholder Engagement

The QICs encourage stakeholder involvement in all QI activities. Service Area Leadership Teams (SALTs), MHSA Community Planning Team (CPT), and Underserved Cultural Community (UsCC) meetings are all avenues for feedback from stakeholders around quality improvement needs.

All Programs of Excellence (APEX)

APEX is a forum that brings together supervisors, managers, and multiple divisions to address areas of the Outpatient Care Services (OCS) Performance Dashboard indicators where improvement is needed. OCS organizes APEX meetings by SA and program. Types of services provided, number of new assessments completed, active and inactive clients, hospitalization and 30 day rehospitalization rates, access to care rates, service location (telehealth, telephone, or in person), overdue UMDAPs, denied claims reasons, mental health diagnoses and co-occurring SUD diagnoses, percent of clients with SUD diagnosis who receive Medication Assisted Treatment (MAT) services, Child and Adolescent Needs and Strengths (CANS), Level of Care Utilization System (LOCUS), Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder-7 (GAD-7), Needs Evaluation Tool (NET), and housing status data are provided at each session by month. The APEX process is grounded in the following values: maintain a problem-solving approach, support positive change, remove systemic challenges, enhance coordination and communication between divisions, share evolving procedures, scale best practices, and provide excellent customer service (internal/external).

Department of Public Health – *Substance Abuse Prevention and Control*

Quality Improvement and Risk Management Committee

In accordance with the Special Terms and Conditions (STCs) of California's Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, and the Quality Improvement (QI) and Utilization Management (UM) sections of the Provider Manual, the purpose of the QI & RM Committee is to provide a forum by which various relevant divisions across the organization can regularly meet to discuss issues related to network performance, outcomes, capacity, training, and concerns, all with the overarching goal of optimizing outcomes and minimizing the possibility of adverse outcomes or loss. In doing so, the QI & RM Committee will request, review, and lead the administrative and clinical quality improvement activities within SAPC, including problem identification and the formulation of quality improvement plans. The QI & RM Committee meets every other month with representatives from all SAPC areas responsible for managing the SAPC SUD treatment provider network.

COMMITTEE RESPONSIBLITIES

Core responsibilities of the **QI & RM Committee** include the following:

- Establish and maintain an integrated strategy to ensure patient safety and satisfaction, quality of care, and organizational efficiencies.
- Review and evaluate the results of quality improvement activities.
- Develop, implement, and manage the two PIPs that counties are required to implement on an annual basis, with one PIP focusing on a clinical issue and another PIP focusing on a non-clinical issue.
- Track, monitor, prepare, and ensure compliance with EQRO and other State requirements by reviewing subcommittee reports on a biannual basis.
- Review targeted clinical records associated with flagged complaint/grievance and appeals filed by patients, their representatives, and/or providers.
- Recommend policy decisions related to quality improvement and risk management.

COMMITTEE STRUCTURE

The QI & RM Committee shall be led by a chair (SAPC Director) and co-chair (SAPC Deputy Director) (or their designees as needed). Members of the Committee shall be decided by consensus of the Committee, under the leadership of the chair and co-chair.

Members of the QI & RM Committee shall represent the following SAPC Branches and Divisions:

- Executive Office (SAPC Director and Deputy Director of Treatment)
- Clinical Service Division
- Health Outcome and Data Analytics Division
- Strategic and Network Development Division
- Systems of Care Division
- Contracts and Compliance Division
- Finance Division
- SAGE Management (Electronic Health Record) Division
- Information Systems Division
- Prevention Division

External representation will include:

- The Los Angeles County Help Line for Mental Health and Substance Use Services
- Client Engagement Navigation Services (CENS)
- SAPC Provider Network

PROCEDURES

The procedures for the QI & RM Committee are indicated below:

Meetings. The Committee chairs, in consultation with other members of the Committee, will determine the frequency and length of the Committee meetings. However, the Committee shall meet at minimum every other month. The committee will meet regularly on dates that are announced in advance and the agenda will be developed by the chairs of the Committee in consultation with the Committee's membership. Attendees of meetings will be at the discretion of the Committee in consultation with involved stakeholders.

Reports. Meeting minutes serve to document the Committee's activities and may include information regarding outcomes, recommendations, actions taken, and follow up items from previous meetings. Minutes shall be circulated during and/or prior to the scheduled Committee meetings.

Performance Improvement Projects. The Committee will develop, implement, and manage the two PIPs that counties are required to implement on an annual basis, with one PIP focusing on clinical issues and another PIP focusing on non-clinical issues.

External Quality Review Organization (EQRO) Responsibilities. The Committee will track, monitor, prepare, and ensure compliance with EQRO and other State requirements.

Oversight. The Committee will review and monitor the following provider submissions:

- Reportable Incidents: Reportable incidents are patient safety events that result in death, permanent harm, severe temporary harm, and/or intervention required to sustain life. Reportable Incidents must be reported to the SAPC Contracts and Compliance Division, which will then ensure that the appropriate entities within SAPC are included and raise this to the QI & RM Committee. Additionally, the Risk Management Committee at the provider agency level is also required to investigate Reportable Incidents.
- Adverse Events: Adverse Events are incidents that have a direct or indirect impact on the community, patients, staff, and/or the entire provider agency. Adverse Events must be addressed by the Risk Management Committee at the provider agency level and are submitted to SAPC at provider discretion. If the SAPC Contracts and Compliance Division deems an Adverse Event as requiring input from the QI & RM Committee, it can be submitted to the Committee for review.
- Complaint/Grievance: A complaint or grievance from patients or providers are an expressed dissatisfaction with elements of care including, but not limited to, quality of care, services, and/or treatment. These occurrences will be addressed as a component of the SAPC Contracts and Compliance Division and typically will not be reviewed by the QI & RM Committee unless a specific complaint/grievance is identified and rises to the level of requiring involvement of the QI & RM Committee.

Record Keeping. Documentation and reviews of Reportable Incidents, and applicable Adverse Events and Complaints/Grievances will be maintained, and such records may be kept in hard copy, electronically, or both. In either case, sufficient safeguards will be established (e.g., locked cabinets for hard copy files, password protection and encryption for electronic files, access for authorized staff only) to maintain confidentiality.

Committee Findings. Notable findings of the QI & RM Committee will be incorporated into provider educational programs, the re-credentialing and contracting process, and annual review evaluations. All quality improvement and risk management activities and resulting actions will be documented to demonstrate the Committee's impact on improving service delivery across the SAPC network. Additionally, quality improvement and risk management activities will recognize the importance of constructive outcomes as well as correcting instances of deficient practice. In instances of deficient practice, written Corrective Action Plans (CAPs) will be submitted to and reviewed by the Committee. CAPs will fall into one of three categories: systems actions, educational actions, or individual follow-up and will detail what was done, who was responsible, and the timeframe for completion and follow-up.

Confidentiality. All activities and findings of the QI and RM Committee are confidential under CA Evidence Code Section 1157.6 related to Peer Review Activities and Government Code 825 related to Personnel Records and as a Patient Safety Work Product under the Patient Safety Organization (PSO): An entity established pursuant to the Patient Safety and Quality Improvement Act of 2005, Pub. L. 109-41, 42 U.S. C. 299b-21—b26 (Reference 2) and the regulations that interpret it, 42 CFR Parts 2 and 3. All SAPC contracted providers are required to comply with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations (Confidentiality of Alcohol and Drug Abuse Patient Records).

QUALITY IMPROVEMENT WORKPLAN

Department of Mental Health

DMH reviews metrics for the following areas for improvement opportunities at least quarterly:

- Timeliness of first initial contact to face-to-face appointment or synchronous video or audio-only interaction, consistent with BHIN 23-018 or any subsequent Departmental guidance.
- Frequency of follow-up appointments.
- Access to after-hours care.
- Responsiveness of the member access line.
- Strategies to reduce avoidable hospitalizations.
- Coordination of physical, mental health, and SUD services at the provider level.
- Assessment of the members' experiences.
- Telephone access line and services in the prevalent non-English languages.
- Member grievances, appeals, expedited appeals, State Hearings, expedited State Hearings, provider appeals, and clinical records reviews as required by 9 C.C.R. section 1810.440(a)(5) and 42 C.F.R. section 438.416(a) and our Contract.
- Evidence that QI activities, including PIPs, have contributed to meaningful improvement in clinical care and member service.

DMH's QAPI Work Plan for 2026- 27 is organized into six significant domains: Service Delivery Capacity, Member Satisfaction, Clinical Care, Continuity of Care, Accessibility of Services and Performance Improvement Projects. Each domain is designed to address service needs and service quality. Work Plan goals are identified based on feedback from Triennial audits, External Quality Reviews, member satisfaction data, quality metrics, and other reports indicating areas needing improvement. For 2026-27, Accessibility of Services is the focus of the Non-clinical Performance Improvement Project.

The QAPI Work Plan is a living document. The Department's QIC will review QAPI Work Plan goals and related progress bi-annually to ensure coverage of all components of the QAPI Work Plan. Moreover, the QI Unit and QICs will be tasked with reviewing and assessing the results of QAPI Work Plan activities, recommending policy decisions, and monitoring the progress of the clinical and non-clinical PIPs. Stakeholders can use the following QAPI Work Plan as a resource for informed decision-making and planning. A detailed version of DMH's Work Plan for 2026- 27 is available in Appendix A.

DMH's Work Plan 2026- 27

NO.	DOMAIN	GOAL
1A.	Service Delivery Capacity	Improve language accessibility for our members and community stakeholders.
1B.	Service Delivery Capacity	80% or more of ACCESS mental health-related calls are answered within 1 minute or less, measured monthly.
2A.	Member Satisfaction	Increase Social Connectedness and Perception of Functioning domain scores for Adult Consumer Perception Surveys (CPS) to 80%.
2B.	Member Satisfaction	Increase the number of Consumer Perception Surveys received by 5% from prior year.
2C.	Member Satisfaction	Monitor grievances, appeals and requests for a Change of Provider (COP) to identify areas of improvement in our system.
3A.	Clinical Care	100% of adult outpatient Specialty Mental Health providers will utilize the LOCUS as directed in QA Bulletin 24-09R as a clinical decision aid to identify service frequency and intensity.
3B.	Clinical Care	Meet or exceed Minimum Performance Levels set by DHCS for key Healthcare Effectiveness Data and Information Set (HEDIS) measures.
3C.	Clinical Care	Evaluation of the Quality Assurance and Performance Improvement (QAPI) Program.
4A.	Continuity of Care	Reduce Adult 7 and 30-day rehospitalization rates.
4B.	Continuity of Care	Develop Population Health Management (PHM) Strategy and Evaluate PHM Plan.
5.	Accessibility of Services	Ensure 100% of Psychiatry Data is Captured to Calculate Timeliness of Urgent and Routine Psychiatry Appointments for Members 0-20 and 21+.
6A.	Performance Improvement Projects	Clinical PIP for 2026- 27 will continue to aim to improve the Follow-up After Emergency Department Visit for Mental Illness (FUM) 30-day measurement rate.
6B.	Performance Improvement Projects & Accessibility of Services	Non-clinical PIP for 2026- 27 will continue to aim to improve access from first contact from any referrals source to first offered appointment for any outpatient non-urgent non-psychiatry SMHS for 0–20-year-olds.

SAPC's Quality Improvement & Risk Management (QI/RM) Committee meets every other month, and our QI Branch meets every other week to identify opportunities to improve quality of services, manage compliance and risk management, review complaints/grievances and appeals, ensure cross-division collaboration and information exchange, and support provider-level quality improvement.

We adopted this QI Work Plan for 2026- 27 and updated QI Program Goals and Objectives to describe our plan to assess SAPC-network performance against best practice guidelines and implement interventions which ensure that SUD services follow generally accepted standards of clinical practice. We elaborated three specific focus areas to this end: our EQRO Process Improvement Plans, our use of the QI/RM committee and QI Branch to compile and review positive and negative variances in quality, and to ensure collaboration and information exchange related to QI within SAPC in accordance with priority metrics.

We specifically align the QI Program metrics to accord with the DMC-ODS STCs and DHCS BHIN 24-001, as described above, and will review and update these metrics with subsequent revisions to the DMC-ODS terms and conditions. We prioritized measures in the areas of access to care, timeliness of care, quality of provider documentation, quality of provider care, compliance with utilization management timeframe and standards, and care outcomes.

SAPC's QI Branch collaborates with the Contracts and Compliance Division to process grievances and appeals in accordance with SAPC policies and procedures related to processing grievances, including those described within current version of the SAPC provider manual, and with all applicable state policies.

SAPC's QI Branch reviews each grievance and appeal from provider agencies resulting from adverse determinations related to patient financial eligibility and documentation to identify reasons for overturning these adverse determinations to identify instances where there was retrospective resolution to financial eligibility, including instances where the transition of the patient's county of residence, where there were adjudication errors, where there were technology errors, and in instances where retrospective changes in state policy resulted in changes in patient eligibility for services.

SAPC's QI Branch further conducts a twice-a-year review of a sample of patient charts from the contracted provider network to review the following additional documentation metrics for CY 2026- 27:

- Percent of charts reviewed with late documentation (in accordance with BHIN 23-068)
- Percent of charts reviewed where there was missing documentation of LPHA involvement and review of Problem List or Treatment Plan.
- Percent of admissions where service hours did not align with the provided level of care.
- Percent of admissions where there was lack of alignment between ASAM Assessment and the documented plan of care.

- Percent of admissions where we identified the providers did not refer to appropriate mental health, physical health, housing, legal (DCFS, Court, Probation, etc.)
- Percent of admissions where there was not adequate discharge planning.
- Percent of care coordination notes that did not describe appropriate care coordination services.
- Percent of admissions where appropriate release of information documentation was missing.
- Percent of admissions for withdrawal management where medications for withdrawal during the treatment episode were documented
- Percent of admissions where provider agencies document that they prevented or discouraged the patient from accessing medications for addiction treatment.
- Percent of admissions for patients with opioid use disorder where medications for opioid use disorder were discussed and offered.
- Percent of admissions for patients with opioid use disorder where medications for opioid use disorder were provided, directly or through referral.
- Percent of admissions for patients with alcohol use disorder where medications for alcohol use disorder were discussed and offered.
- Percent of admissions for patients with alcohol use disorder where medications for alcohol use disorder were provided, directly or through referral.
- Percent of admissions for patients with tobacco use disorder where medications for alcohol use disorder were discussed and offered.
- Percent of admissions for patients with tobacco use disorder where medications for alcohol use disorder were provided, directly or through referral.

These documentation metrics are reviewed and revised twice annually as additional documentation trends and issues are identified by QI Branch staff.

The QI Branch's identification of documentation and quality findings are stratified by agency and are used during SAPC's monitoring of our provider agencies to inform the application of appropriate corrective action plans. SAPC's recoupment is limited to instances where there was evidence of fraud waste and/or abuse. For instances of documentation noncompliance, SAPC issues corrective action plans that include the provision of technical assistance and intensification of trainings and updating training content, and other appropriate non-recoupment administrative sanctions.

The SAPC QI Branch, along with the existing SAPC Quality Improvement & Risk Management (QI/RM) Committee, will continue to update and revise the SAPC QI Work Plan throughout 2026- 27.

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
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Appendix A – Department of Mental Health (DMH) Quality Assessment and Performance Improvement (QAPI) Detailed Work Plan

Reporting Period January 2026- June 2027

Presented By:

Los Angeles County Department of Mental Health
Quality, Outcomes, and Training Division, Quality Improvement Unit

Monitoring Service Delivery Capacity

Service Equity

Goal 1a.	Improve language accessibility for our members and community stakeholders.
Objective(s)	1. Update Departmental Language Accessibility Plan (DLAP). 2. Administer Needs Assessment survey around language accessibility needs amid staff and stakeholders. 3. Continue to assess member satisfaction with American Sign Language (ASL) interpreter services. 4. Increase language access for languages other than English members and family members including ASL.
Population	Los Angeles County members and families who receive outpatient SMHS from LACDMH DO and LE/Contracted providers who speak languages other than English and those who are deaf or hard of hearing
Performance Indicator(s)	1. Report on Provider Language Capacity 2. Report on findings from language Needs Assessment 3. Rate of member satisfaction with ASL interpreter services 4. Number of language accessibility resources from prior year to present
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Anti-Racism, Inclusion, Solidarity, and Empowerment (ARISE) Division/ Cultural Competency Unit (CCU), Program Manager III and Health Program Analyst III

Goal 1b.	80% or more of ACCESS mental health-related calls are answered within 1 minute or less, measured monthly.
Objective(s)	1. Staffing & scheduling (work closely with Workforce Management- WFM): a. Hire all vacant positions b. Analyze call volume data to create optimized schedules 2. Call workflow Improvements: a. Upload quick reference guides for common questions into Agent Assist 3. Accountability & Monitoring: a. Analyze call metrics daily to determine barriers b. Monitor the Verizon Contact Center (VCC) during peak hours to adjust skill sets c. Evaluate staff performance by utilizing weekly team performance reports
Population	All Los Angeles County Residents
Performance Indicator(s)	1. Percent of vacancies filled 2. Percent of calls answered within 60 seconds 3. Average speed of calls answered
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	ACCESS Program Manager IIs

Monitoring Member Satisfaction

Goal 2a.	Increase Social Connectedness and Perception of Functioning domain scores for Adult Consumer Perceptions Surveys (CPS) to 80%.
Objective(s)	1. QAPI Leadership Committee and Regional QICs will identify key drivers and interventions to increase satisfaction for Adults in Social Connectedness and Perception of Functioning domains.
Population	DO and LE/Contracted members/families receiving outpatient SMHS
Performance Indicator(s)	1. Satisfaction rates in Social Connectedness and Perception of Functioning domains for Adults
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QI Unit Supervising Psychologist

Goal 2b.	Increase the number of total Consumer Perception Surveys received by 5% from prior year.
Objective(s)	1. Increase provider participation by identifying providers who did not submit any surveys during the 2025 CPS survey period and offer technical support. 2. Work with DO and LE providers as well as TAY Division and Peer Services to identify interventions to increase participation.
Population	DO and LE/Contracted members/families receiving outpatient SMHS
Performance Indicator(s)	1. Rate of provider participation 2. Rate of participation in survey by age groups
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QI Unit Supervising Psychologist

Member Grievances, Appeals, and Change of Provider Requests

Goal 2c.	Monitor grievances, appeals and requests for a Change of Provider (COP) to identify areas of improvement in our system.
Objective(s)	1. Work with CIOB on updating applications for Grievances and Appeals to meet State requirements. 2. Review the nature of complaints, resolutions, and COP requests for significant trends that may warrant policy recommendations or system-level improvement strategies. 3. Utilize data captured in Grievances and Appeals and COP application to identify practitioners or facilities who continuously receive grievances and appeals and COP requests. 4. Continue to develop PowerBI Dashboard to visualize trends in data.
Population	Los Angeles County residents engaging in DMH services [outpatient, inpatient, Fee for Service (FFS)]
Performance Indicator(s)	1. Total number of complaints and resolutions by type in Year 2026-27 2. COP requests by type in Year 2026-27
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Patient's Rights Office, Mental Health Program Manager I

Monitoring Clinical Care

Level of Care

Goal 3a.	100% of adult outpatient Specialty Mental Health providers will utilize the LOCUS as directed in QA Bulletin 24-09R as a clinical decision aid to identify service frequency and intensity.
Objective(s)	1. Review LOCUS aggregate data monthly with DMH leaders and managers as well as Legal Entity providers for trends, recommended policy and practice changes and systemic capacity issues. 2. At that program and practitioner level, utilize LOCUS information to inform case conceptualizations, treatment planning and decisions on when and how to transition clients to higher or lower levels of care.
Population	Adult members, ages 21 and above, receiving outpatient services
Performance Indicator(s)	1. Number of staff who have completed LOCUS training by provider site 2. Percent of clients at each level of care 3. Percent of clients scoring level 0 or 1 (non-Specialty Mental Health levels of care) 4. Percent of clients with repeated administration of the LOCUS with levels of care that are higher, lower or with no change
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Outcomes Unit Program Manager II and III

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

Goal 3b.	**Meet or exceed Minimum Performance Levels set by DHCS for key Healthcare Effectiveness Data and Information Set (HEDIS) measures.**
Objective(s)	1. Track and assess progress on the following County MHP Priority Performance Measures: • Follow Up After Emergency Department Visit for Mental Illness (FUM) • Follow Up After Hospitalization for Mental Illness (FUH) • Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) • Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) • Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) • Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (ADD) • Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) 2. Continue to develop Power BI Dashboards that track HEDIS measures. 3. Continue to collaborate with Managed Care Plans (MCPs) on data exchange for timely interventions. 4. Utilize QAPI Leadership and Action Committees for any measures below Minimum Performance Level (MPL) to plan for interventions designed to improve performance.
Population	All Medi-Cal members that meet criteria to be included in any of the above HEDIS measures
Performance Indicator(s)	1. Meet MPLs set by DHCS 2. Reports produced to demonstrate HEDIS Measure performance
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	CIOB Clinical Informatics Supervising Data Scientist and Clinical Pharmacy, Pharmacy Services Chief III

Goal 3c.	Evaluation of the Quality Assessment and Performance Improvement (QAPI) Program.
Objective(s)	1. Develop and deliver a survey to evaluate satisfaction with the QI team's processes and support to providers and other departmental units that are part of the QAPI.
Population	DMH staff and DO/LE Providers
Performance Indicator(s)	1. Rate of satisfaction of Countywide QIC/ QAPI Leadership Committee, Regional QIC, QI website, and support from QI Unit
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QI Unit Program Manager I

Monitoring Continuity of Care

Goal 4a.	Reduce Adult 7 and 30-day rehospitalization rates.
Objective(s)	1. Build a 7 and 30-day rehospitalization PowerBI dashboard that analyzes areas of improvement by service areas and individual providing hospitals. 2. Implement Hospital Liaisons in each SA to coordinate care from inpatient to outpatient services. 3. Implement Care Coordination Teams and trainings in each SA on best practices for coordinating care. 4. Work with Managed Care Plans and Clinical Informatics team to identify high utilizers to target interventions towards. 5. Complete chart reviews on high utilizer clients to identify themes that may be impacting higher rates of rehospitalization.
Population	LACDMH members who are high utilizers of hospitals defined as those who are rehospitalized at 7 and 30 days after last discharge.
Performance Indicator(s)	1. Rate of 7-and 30-day rehospitalizations 2. Rate of 7- and 30-day follow-up with mental health services after discharge from hospital
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Outpatient Care Services, Supervising Psychologist

Goal 4b.	Develop Population Health Management (PHM) Strategy and Evaluate PHM Plan.
Objective	1) Create a comprehensive documented PHM strategy that focuses on and has goals for the following: a) Keeping members healthy. b) Managing members with emerging risk. c) Patient safety or outcomes across settings. d) Managing multiple chronic illnesses. 2) Conduct a comprehensive analysis of the impact of the PHM strategy that includes: a) Quantitative results for relevant clinical, cost/utilization and experience measures. b) Comparison of results with a benchmark or goal. c) Interpretation of results.
Population	LACDMH members
Performance Indicator(s)	1. PHM Strategy disseminated to members 2. PHM Strategy Analysis Report
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QOTD Deputy Director

Accessibility of Services

Goal 5.	Ensure 100% of Psychiatry Data is Captured to Calculate Timeliness of Urgent and Routine Psychiatry Appointments for Members 0-20 and 21+.
Objective	1. Increase number of Legal Entity CSI Assessment submissions for psychiatry data by identifying providers who have submitted no records in a 3-month period and requiring an action plan by the provider to begin submitting.
Population	Members aged 0-20 and 21+ requesting psychiatry appointments.
Performance Indicator(s)	1. Rate of Timely Urgent and Routine Psychiatry Appointments for Members 0-20 and 21+
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Quality Assurance Program Manager I

Monitoring Performance Improvement Projects

Goal 6a.	Clinical PIP for 2026- 27 will aim to improve the Follow-up After Emergency Department Visit for Mental Illness (FUM) 30-day measurement rate.
Objective	1. Complete barrier analysis utilizing QI tools (fishbone diagram etc.). 2. Continue to work collaboratively with PIP committee members to identify and implement at least one intervention. 3. Work with Clinical Informatics team to ensure accurate numerator and denominator.
Population	Members age 6+ who visit an emergency department for mental illness or intentional self-harm.
Performance Indicator(s)	1. Rate of 7-and 30-day FUM
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Quality Improvement Psychologist II, Clinical Informatics, Supervising Psychologist

Monitoring Performance Improvement Projects & Accessibility Of Services

Goal 6b.	Non- clinical PIP for 2026- 27 will aim to improve access from first contact from any referral source to first offered appointment for any outpatient non-urgent non-psychiatry SMHS for 0–20-year-olds.
Objective	1. Complete barrier analysis utilizing QI tools (fishbone diagram etc.). 2. Continue to work collaboratively with PIP committee members to identify and implement at least one intervention. 3. Work with Clinical Informatics team to ensure accurate numerator and denominator.
Population	Children accessing SMHS through DO and LE/Contracted providers
Performance Indicator(s)	1. Number of Child non-psychiatry routine appointments offered within 10 business days
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Quality Assurance, Program Manager II and Quality Improvement Clinical Psychologist II

Table One: Behavioral Health Care Continuum Projected Expenditures									
	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (Year One)	Total Projected Expenditures On Adults and Older Adults (Year Two)	Total Projected Expenditures On Adults and Older Adults (Year Three)	Total Projected Expenditures on Children/Youth (under 21) (Year One)	Total Projected Expenditures on Children/Youth (under 21) (Year Two)	Total Projected Expenditures on Children/Youth (under 21) (Year Three)	Projected Individuals to be Served Annually (May be duplicated) Eligible Adults and Older Adults	Projected Individuals to be Served Annually (May be duplicated) Eligible Children/Youth (under 21)
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 6,166,000.00	$ 6,166,000.00	$ 6,166,000.00	$ 25,661,000.00	$ 25,661,000.00	$ 25,661,000.00	42,000	158,000
Early Intervention Services	☑	$ -	$ -	$ -	$ 304,000.00	$ 314,000.00	$ 330,000.00	0	142
Outpatient Services	☑	$ 132,713,000.00	$ 136,866,000.00	$ 143,986,000.00	$ 8,523,000.00	$ 8,790,000.00	$ 9,247,000.00	22,118	2,134
Intensive Outpatient Services	☑	$ 76,208,000.00	$ 78,593,000.00	$ 82,682,000.00	$ 3,837,000.00	$ 3,957,000.00	$ 4,163,000.00	9,613	498
Crisis and Field-Based Services	☑	$ 21,758,000.00	$ 22,439,000.00	$ 23,606,000.00	$ 335,000.00	$ 346,000.00	$ 364,000.00	4,373	90
Residential Treatment Services	☑	$ 291,989,000.00	$ 301,124,000.00	$ 316,790,000.00	$ 5,941,000.00	$ 6,127,000.00	$ 6,446,000.00	16,598	485
Inpatient Services	☑	$ 30,353,000.00	$ 31,303,000.00	$ 32,931,000.00	$ 199,000.00	$ 205,000.00	$ 216,000.00	2,991	36
Mental Health (MH) Services									
Primary Prevention Services	☑	$ 30,275,000.00	$ 31,425,000.00	$ 32,431,000.00	$ -	$ -	$ -	4,325	0
Early Intervention Services	☑	$ 95,975,000.00	$ 99,622,000.00	$ 102,810,000.00	$ 931,822,000.00	$ 967,231,000.00	$ 997,747,000.00	51,300	81,404
Outpatient and Intensive Outpatient Services	☑	$ 1,087,932,000.00	$ 1,129,037,000.00	$ 1,164,106,000.00	$ 121,387,000.00	$ 124,018,000.00	$ 127,987,000.00	116,992	17,421
Crisis Services	☑	$ 259,178,000.00	$ 269,028,000.00	$ 277,637,000.00	$ 20,470,000.00	$ 21,248,000.00	$ 21,928,000.00	17,190	11,096
Residential Treatment Services	☑	$ 44,393,000.00	$ 46,080,000.00	$ 47,555,000.00	$ 4,611,000.00	$ 4,786,000.00	$ 4,939,000.00	2,298	60
Hospital and Acute Services	☑	$ 405,857,000.00	$ 421,280,000.00	$ 434,761,000.00	$ 109,059,000.00	$ 113,203,000.00	$ 116,825,000.00	18,373	4,341
Subacute and Long-Term Care Services	☑	$ 213,434,000.00	$ 221,544,000.00	$ 228,633,000.00	$ 3,404,000.00	$ 3,533,000.00	$ 3,646,000.00	1,721	54
Housing Services (MH + SUD)									
Housing Services	☑	$ 336,897,000.00	$ 346,320,000.00	$ 309,771,000.00	$ 10,948,000.00	$ 15,407,000.00	$ 16,243,000.00	12,316	355
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 3,033,128,000.00	$ 3,140,827,000.00	$ 3,203,865,000.00	$ 1,246,501,000.00	$ 1,294,826,000.00	$ 1,335,742,000.00	322,208	276,116

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures (Year One)**	**Total Projected Expenditures (Year Two)**	**Total Projected Expenditures (Year Three)**
Capital Infrastructure Activities	$ 81,268,000.00	$ 56,130,000.00	$ 42,041,000.00
Workforce Investment Activities	$ 49,254,000.00	$ 49,417,000.00	$ 49,588,000.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 643,931,000.00	$ 672,146,000.00	$ 690,081,000.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 176,182,000.00	$ 181,946,000.00	$ 186,985,000.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 950,635,000.00	$ 959,639,000.00	$ 968,695,000.00

Table Three: Projected Annual Expenditures by County BH Funding Source			
	Total Annual Projected Expenditures (Year One)	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
BHSA	$ 1,195,995,000.00	$ 1,257,319,000.00	$ 1,232,126,000.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 533,253,000.00	$ 553,517,000.00	$ 571,230,000.00
2011 Realignment (Public Safety Realignment)	$ 838,351,000.00	$ 874,354,000.00	$ 906,378,000.00
State General Fund	$ 137,938,000.00	$ 143,733,000.00	$ 149,203,000.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 1,940,955,000.00	$ 2,029,935,000.00	$ 2,182,501,000.00
Projects for Assistance in Transition from Homelessness (PATH)	$ 1,663,000.00	$ 1,663,000.00	$ 1,663,000.00
Community Mental Health Block Grant (MHBG)	$ 27,817,000.00	$ 27,817,000.00	$ 27,817,000.00
Substance Use Block Grant (SUBG)	$ 60,259,000.00	$ 60,259,000.00	$ 60,259,000.00
Commercial Insurance	$ 1,875,000.00	$ 1,946,000.00	$ 2,008,000.00
County General Fund	$ 72,785,000.00	$ 72,785,000.00	$ 72,785,000.00
Opioid Settlement Funds	$ 15,851,000.00	$ 15,851,000.00	$ 15,851,000.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 6,811,000.00	$ 6,948,000.00	$ 7,067,000.00
Other state funding (including DSH funding)	$ 170,210,000.00	$ 115,703,000.00	$ 39,868,000.00
Other county mental health or SUD funding	$ 226,501,000.00	$ 233,462,000.00	$ 239,546,000.00
Other foundation funding	$ -	$ -	$ -
Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**
Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 5,230,264,000.00	$ 5,395,292,000.00	$ 5,508,302,000.00
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 4,279,629,000.00	$ 4,435,653,000.00	$ 4,539,607,000.00
Auto-validation: Table 2: Other County Expenditures	$ 950,635,000.00	$ 959,639,000.00	$ 968,695,000.00

Table Four: BHSA Transfers				
	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$ 254,661,000.00	$ 297,105,000.00	$ 297,105,000.00	$ 848,871,000.00
Year Two Component Allocation (dollars)	$ 286,098,000.00	$ 333,781,000.00	$ 333,781,000.00	$ 953,660,000.00
Year Three Component Allocation (dollars)	$ 303,702,000.00	$ 354,319,000.00	$ 354,319,000.00	$ 1,012,340,000.00

BHSA Transfers Year One Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 254,661,000.00	$ 297,105,000.00	$ 297,105,000.00	$ 848,871,000.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ 37,531,000.00	$ 286,075,000.00	$ 1,124,045,000.00	$ 1,447,651,000.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -

BHSA Transfers Year Two Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 286,098,000.00	$ 333,781,000.00	$ 333,781,000.00	$ 953,660,000.00

BHSA Transfers Year Three Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 303,702,000.00	$ 354,319,000.00	$ 354,319,000.00	$ 1,012,340,000.00

Funding Transfer Request Allocations

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)		
Base Component (Year One)	**Housing Intervention Percentage (Year One)**	**Housing Intervention Funds (Year One)**
Base Percentage and Funding	30%	$ 254,661,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 254,661,000.00
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**
Base Percentage and Funding	35%	$ 297,105,000.00

Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 297,105,000.00

Transferred To/From	Behavioral Health Services and Support Percentage (Year One)	Behavioral Health Services and Support Funding (Year One)
Base Percentage and Funding	35%	$ 297,105,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 297,105,000.00

Funding Transfers (Year One)

	Housing Intervention (Year One) (1)	Full-Service Partnership (Year One)	Behavioral Health Services and Support (Year One)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)

Base Component (Year Two)	Housing Intervention Percentage (Year Two)	Housing Intervention Funds (Year Two)
Base Percentage and Funding	30%	$ 286,098,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 286,098,000.00

Transferred To/From	Full Service Partnership Percentage (Year Two)	Full Service Partnership Funds (Year Two)
Base Percentage and Funding	35%	$ 333,781,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 333,781,000.00

Transferred To/From	Behavioral Health Services and Support Percentage (Year Two)	Behavioral Health Services and Support Funding (Year Two)
Base Percentage and Funding	35%	$ 333,781,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 333,781,000.00

Funding Transfers (Year Two)

	Housing Intervention (Year Two) (1)	Full-Service Partnership (Year Two)	Behavioral Health Services and Support (Year Two)	Validation

Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)		
Base Component	**Housing Intervention Percentage (Year Three)**	**Housing Intervention Funds (Year Three)**
Base Percentage and Funding	30%	$ 303,702,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 303,702,000.00
Transferred To/From	**Full Service Partnership Percentage (Year Three)**	**Full Service Partnership Funds (Year Three)**
Base Percentage and Funding	35%	$ 354,319,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 354,319,000.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Three)**	**Behavioral Health Services and Support Funding (Year Three)**
Base Percentage and Funding	35%	$ 354,319,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 354,319,000.00

Funding Transfers (Year Three)				
	Housing Intervention (Year Three) (1)	**Full-Service Partnership (Year Three)**	**Behavioral Health Services and Support (Year Three)**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

MHSA Transfers to BHSA				
MHSA Component	**Available Unspent BHSA Funds**	**Transferred to Housing Intervention**	**Transferred to Full-Service Partnership**	**Transferred to Behavioral Health Services and Support**
CSS	$ 661,228,000.00	$ -	$ 130,000,000.00	$ 531,228,000.00
PEI	$ 238,772,000.00	$ -	$ -	$ 238,772,000.00
Encumbered INN	$ 212,249,000.00	$ 37,531,000.00	$ 156,075,000.00	$ 18,645,000.00
Unencumbered INN	$ -	$ -	$ -	$ -
WET	$ 155,600,000.00			$ 155,600,000.00
CFTN	$ 179,800,000.00			$ 179,800,000.00
Total (auto-populated)	$ 1,447,649,000.00	$ 37,531,000.00	$ 286,075,000.00	$ 1,124,045,000.00

Excess Prudent Reserve to BHSA Components	
Transfer from Prudent Reserve to BHSA Component Allocation	**Amount**
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 170,068,541.70
Local Prudent Reserve Maximum (2)	$ 172,412,205.15
Excess Prudent Reserve Funding that must be transferred	**$ (2,343,663.45)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

Table Five: BHSA Components			
	Total Housing Interventions Funding (Year One)	**Total Housing Interventions Funding (Year Two)**	**Total Housing Interventions Funding (Year Three)**
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 254,661,000.00	$ 286,098,000.00	$ 303,702,000.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 254,661,000.00	$ 286,098,000.00	$ 303,702,000.00

Housing Interventions Category						
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)**	**Projected Expenditures - All Other Funding Sources (Year One)**	**Projected Expenditures - All Other Funding Sources (Year Two)**	**Projected Expenditures - All Other Funding Sources (Year Three)**
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ 30,370,000.00	$ 31,822,000.00	$ 32,427,000.00	$ 12,117,000.00	$ 11,799,000.00	$ 3,078,000.00
Operating Subsidies	$ -	$ -	$ 2,350,000.00	$ 9,402,000.00	$ 9,402,000.00	$ 7,051,000.00
Bundled Rental and Operating Subsidies	$ 45,556,000.00	$ 48,120,000.00	$ 38,170,000.00	$ 15,276,000.00	$ 15,276,000.00	$ 15,276,000.00
% of Rental and Operating Subsidies Administered through Flex Pools	87%	88%	86%	78%	78%	69%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 4,633,000.00	$ 20,051,000.00	$ 14,051,000.00	$ 33,472,000.00	$ 25,670,000.00	$ 25,670,000.00
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 38,687,000.00	$ 70,614,000.00	$ 119,250,000.00	$ 68,733,000.00	$ 47,655,000.00	$ 1,407,000.00
% of Rental and Operating Subsidies Administered through Flex Pools	74%	86%	92%	100%	100%	100%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ 5,070,000.00	$ 70,000.00	$ 70,000.00	$ 67,000.00	$ 67,000.00	$ 67,000.00
Other Housing Supports: Participant Assistant Funds (2)	$ 5,025,000.00	$ 5,050,000.00	$ 4,950,000.00	$ 996,000.00	$ 987,000.00	$ 948,000.00

Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 24,482,000.00	$ 32,358,000.00	$ 26,192,000.00	$ 7,375,000.00	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ -	$ -	$ -	$ -	$ -	$ -
Capital Development Projects	$ 14,860,000.00	$ -	$ -	$ 25,408,000.00	$ 15,130,000.00	$ 1,041,000.00
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects						
MHSA INN Projects	$ 12,510,000.00	$ 12,510,000.00	$ 12,510,000.00	$ -	$ -	$ -
Subtotal (auto-populated)	$ 181,193,000.00	$ 220,595,000.00	$ 249,970,000.00	$ 172,846,000.00	$ 125,986,000.00	$ 54,538,000.00

Housing Interventions Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -

Housing Interventions Component Administrative Information	**Year One**	**Year Two**	**Year Three**
Housing Interventions Component Admin Expenses	$ 25,961,000.00	$ 24,275,000.00	$ 21,895,000.00
Total Housing Interventions Expenditures (auto-populated)	$ 207,154,000.00	$ 244,870,000.00	$ 271,865,000.00

Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 129,465,000.00	$ 156,580,000.00	$ 162,382,000.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 4,269,000.00	$ 27,062,000.00	$ 21,062,000.00

Housing Interventions Component Funds Validation (auto-populated based on inputs above)	Year One	Year Two	Year Three
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	6.8%	0.0%	0.0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	59.6%	60.0%	55.8%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	0.0%	0.0%	0.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	298	384	455
Eligible Adults/Older Adults	8296	7590	7600
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ 37,531,000.00	$ 25,021,000.00	$ 12,511,000.00

Table Six: BHSA Components			
	Total Full Service Partnership (FSP) Funding (Year One)	Total Full Service Partnership (FSP) Funding (Year Two)	Total Full Service Partnership (FSP) Funding (Year Three)
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 297,105,000.00	$ 333,781,000.00	$ 354,319,000.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ 130,000,000.00	$ -	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 427,105,000.00	$ 333,781,000.00	$ 354,319,000.00

Full Service Partnership Category (1)									
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)**	**Projected Expenditures - Federal Financial Participation (Year One)**	**Projected Expenditures - Federal Financial Participation (Year Two)**	**Projected Expenditures - Federal Financial Participation (Year Three)**	**Projected Expenditures - All Other Funding Sources (Year One)**	**Projected Expenditures - All Other Funding Sources (Year Two)**	**Projected Expenditures - All Other Funding Sources (Year Three)**
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 11,654,000.00	$ 12,097,000.00	$ 12,484,000.00	$ 19,892,000.00	$ 20,648,000.00	$ 21,309,000.00	$ 8,223,000.00	$ 8,535,000.00	$ 8,808,000.00
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 5,265,000.00	$ 5,465,000.00	$ 5,640,000.00	$ 8,718,000.00	$ 9,049,000.00	$ 9,339,000.00	$ 3,604,000.00	$ 3,741,000.00	$ 3,861,000.00
FSP Intensive Case Management	$ 72,876,000.00	$ 75,645,000.00	$ 78,066,000.00	$ 206,187,000.00	$ 214,022,000.00	$ 220,871,000.00	$ 85,236,000.00	$ 88,475,000.00	$ 91,306,000.00
High Fidelity Wraparound	$ 51,503,000.00	$ 53,460,000.00	$ 55,171,000.00	$ 55,762,000.00	$ 57,881,000.00	$ 59,733,000.00	$ 11,498,000.00	$ 11,935,000.00	$ 12,317,000.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 32,059,000.00	$ 33,277,000.00	$ 34,342,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$ 5,807,000.00	$ 6,028,000.00	$ 6,221,000.00	$ 8,278,000.00	$ 8,593,000.00	$ 8,868,000.00	$ 3,422,000.00	$ 3,552,000.00	$ 3,666,000.00
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 51,196,000.00	$ 51,159,000.00	$ 53,720,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 230,360,000.00	$ 237,131,000.00	$ 245,644,000.00	$ 298,837,000.00	$ 310,193,000.00	$ 320,120,000.00	$ 111,983,000.00	$ 116,238,000.00	$ 119,958,000.00

FSP Transfer Information	Year One	Year Two	Year Three
Transfers out of FSP component into Local Prudent Reserve	$ 2,343,000.00	$ -	$ -
FSP Administrative Information	**Year One**	**Year Two**	**Year Three**
FSP Component Admin Expenses	$ 55,832,000.00	$ 57,954,000.00	$ 59,809,000.00
Total Full Service Partnership Expenditures (auto-populated)	$ 288,535,000.00	$ 295,085,000.00	$ 305,453,000.00
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	3703	3740	3777
Eligible Adults/Older Adults	10443	10547	10652
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ 156,075,000.00	$ 104,879,000.00	$ 53,720,000.00

Table Seven: BHSA Components			
	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	**Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)**	**Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)**
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 297,105,000.00	$ 333,781,000.00	$ 354,319,000.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 604,045,000.00	$ 520,000,000.00	$ -
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 901,150,000.00	$ 853,781,000.00	$ 354,319,000.00

Behavioral Health Services and Supports Category (1)									
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)**	**Projected Expenditures - Federal Financial Participation (Year One)**	**Projected Expenditures - Federal Financial Participation (Year Two)**	**Projected Expenditures - Federal Financial Participation (Year Three)**	**Projected Expenditures - All Other Funding Sources (Year One)**	**Projected Expenditures - All Other Funding Sources (Year Two)**	**Projected Expenditures - All Other Funding Sources (Year Three)**
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 43,471,000.00	$ 45,123,000.00	$ -	$ 425,540,000.00	$ 441,711,000.00	$ 455,846,000.00	$ 790,949,000.00	$ 821,005,000.00	$ 893,844,000.00
Early Intervention Expenditures	$ 295,199,000.00	$ 306,416,000.00	$ 316,222,000.00	$ 607,021,000.00	$ 630,088,000.00	$ 650,251,000.00	$ 516,598,000.00	$ 536,229,000.00	$ 553,388,000.00
Coordinated Specialty Care for First Episode Psychosis	$ 6,400,000.00	$ 6,643,000.00	$ 6,856,000.00	$ -	$ -	$ -	$ -	$ -	$ -
All Other EI Expenditures	$ 288,799,000.00	$ 299,773,000.00	$ 309,366,000.00	$ 607,021,000.00	$ 630,088,000.00	$ 650,251,000.00	$ 516,598,000.00	$ 536,229,000.00	$ 553,388,000.00
Outreach and Engagement	$ 1,625,000.00	$ 1,687,000.00	$ 1,741,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 35,000,000.00	$ 35,000,000.00	$ 35,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ 35,000,000.00	$ 35,000,000.00	$ 35,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 41,000,000.00	$ 41,000,000.00	$ 41,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ 41,000,000.00	$ 41,000,000.00	$ 41,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 6,215,000.00	$ 6,215,000.00	$ 6,215,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 422,510,000.00	$ 435,441,000.00	$ 400,178,000.00	$ 1,032,561,000.00	$ 1,071,799,000.00	$ 1,106,097,000.00	$ 1,307,547,000.00	$ 1,357,234,000.00	$ 1,447,232,000.00

BHSS Prudent Reserve Transfer Information	Year One	Year Two	Year Three
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -
BHSS Administrative Information	**Year One**	**Year Two**	**Year Three**
BHSS Component Admin Expenses	$ 240,561,000.00	$ 239,702,000.00	$ 210,771,000.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 663,071,000.00	$ 675,143,000.00	$ 610,949,000.00
Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 238,531,000.00	$ 247,595,000.00	$ 255,518,000.00
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	54.0%	52.7%	192.0%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	80.8%	80.8%	80.8%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	83040	83870	84708
Eligible Adults/Older Adults	117925	119104	120295
Projected BHSS Funds transferred to WET or CF/TN	**Year One**	**Year Two**	**Year Three**
BHSS transfer to WET	$ -	$ -	$ -
BHSS transfer to CF/TN	$ -	$ -	$ -
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
Estimated MHSA WET Funds	$ 155,600,000.00	$ 120,600,000.00	$ 85,600,000.00
Estimated MHSA CF/TN Funds	$ 179,800,000.00	$ 138,800,000.00	$ 97,800,000.00
MHSA "Encumbered" INN	$ 18,645,000.00	$ 12,430,000.00	$ 6,215,000.00

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ 17,589,420.00	$ 19,738,080.00	$ 20,944,440.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 13,012,000.00	$ 13,506,000.00	$ 13,938,000.00
New and Ongoing Administrative Costs	$ -	$ -	$ -
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 879,471,000.00	$ 986,904,000.00	$ 1,047,222,000.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	2.0%	2.0%	2.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	1.5%	1.4%	1.3%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 170,068,541.70
Local Prudent Reserve Maximum (1)	$ 172,412,205.15
Excess Prudent Reserve Funds (auto-populated)	$ (2,343,663.45)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ 2,343,000.00
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -
References	
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).	

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	**Full-Service Partnerships**	**Behavioral Health Services and Supports**	**Total**
Year One				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 254,661,000.00	$ 297,105,000.00	$ 297,105,000.00	$ 848,871,000.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 286,098,000.00	$ 333,781,000.00	$ 333,781,000.00	$ 953,660,000.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 303,702,000.00	$ 354,319,000.00	$ 354,319,000.00	$ 1,012,340,000.00

BHSA Funding Summary (Year One)				
	Housing Interventions (Year One)	**Full Service Partnerships (Year One)**	**Behavioral Health Services and Supports (Year One)**	**Year One Totals**
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 254,661,000.00	$ 297,105,000.00	$ 297,105,000.00	$ 848,871,000.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ -	$ 130,000,000.00	$ 604,045,000.00	$ 734,045,000.00
Estimated Total Available Funding for Year One	$ 254,661,000.00	$ 427,105,000.00	$ 901,150,000.00	$ 1,582,916,000.00
Transfers from Component Into PR	$ -	$ 2,343,000.00	$ -	$ 2,343,000.00
Estimated Total Year One Expenditures	$ 207,154,000.00	$ 288,535,000.00	$ 663,071,000.00	$ 1,158,760,000.00

BHSA Funding Summary (Year Two)				
	Housing Interventions (Year Two)	Full Service Partnerships (Year Two)	Behavioral Health Services and Supports (Year Two)	Year Two Totals
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 286,098,000.00	$ 333,781,000.00	$ 333,781,000.00	$ 953,660,000.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 47,507,000.00	$ 138,570,000.00	$ 758,079,000.00	$ 944,156,000.00
Estimated Total Available Funding for Year Two	$ 333,605,000.00	$ 472,351,000.00	$ 1,091,860,000.00	$ 1,897,816,000.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 244,870,000.00	$ 295,085,000.00	$ 675,143,000.00	$ 1,215,098,000.00

BHSA Funding Summary (Year Three)				
	Housing Interventions (Year Three)	Full Service Partnerships (Year Three)	Behavioral Health Services and Supports (Year Three)	Year Three Totals
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 303,702,000.00	$ 354,319,000.00	$ 354,319,000.00	$ 1,012,340,000.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 88,735,000.00	$ 177,266,000.00	$ 416,717,000.00	$ 682,718,000.00
Estimated Total Available Funding for Year Three	$ 392,437,000.00	$ 531,585,000.00	$ 771,036,000.00	$ 1,695,058,000.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 271,865,000.00	$ 305,453,000.00	$ 610,949,000.00	$ 1,188,267,000.00

BHSA Plan Admin Expenses				
Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	$ 17,589,420.00	$ 19,738,080.00	$ 20,944,440.00	$ 58,271,940.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 13,012,000.00	$ 13,506,000.00	$ 13,938,000.00	$ 40,456,000.00
Total Projected New and Ongoing Administrative Expenditures	$ -	$ -	$ -	$ -

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Behavioral Health Director Certification

Certification

1. I hereby certify that Los Angeles has complied with all statuses, regulations, and guidelines in preparing and submitting this Three-Year Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that:

   - ☑ The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
   - ☑ I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
   - ☑ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
   - ☑ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
   - ☑ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
   - ☑ The IP was submitted to the local behavioral health board

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?

   - ○ Yes
   - ◉ No

a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

N/A

County Behavioral Health Agency Director contact information

3. County Name

Los Angeles

4. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

4a. Submission type

- (•) Draft
- ( ) Final

5. County Behavioral Health Agency Director name

Lisa H. Wong, Psy.D.

6. County Behavioral Health Agency Director phone number

(213) 947-6670

7. County Behavioral Health Agency Director email

lwong@dmh.lacounty.gov

Additional contact information for counties with separate MH and SUD directors (optional)

8. Name

Gary Tsai

9. Title

Director, Substance Abuse Prevention and Control Bureau; Los Angeles County Depa

10. Phone

gtsai@ph.lacounty.gov

11. Email

gtsai@ph.lacounty.gov

County Behavioral Health Agency Director signature

12. Print name

Lisa H. Wong, Psy.D.

13. Title

Director, Los Angeles County Department of Mental Health

14. Date

1/7/2026

15. Signature

Lisa H. Wong Digitally signed by Lisa H. Wong Date: 2026.01.07 13:28:30 -08'00'

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

Gary Tsai

17. Title

Director, Substance Abuse Prevention and Control Bureau; Los Angeles County Depa

18. Date

1/13/26

19. Signature

Gary Tsai Digitally signed by Gary Tsai Date: 2026.01.13 17:06:51 -08'00'

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County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Certification

1. I hereby certify that:
   - ☑ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
   - ☑ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
   - ☑ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   - ○ Yes
   - ◉ No

a. If answered yes above, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

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Signature

3. Print name

Joseph M. Nicchitta

4. Date

January 30, 2026

5. Signature

Joseph Nicchitta

Contact information

6. County Name

Los Angeles

7. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

7a. Submission type

- (•) Draft

8. County Chief Administration Officer Name

Joseph M. Nicchitta, Acting Chief Executive Officer

9. County Chief Administration Officer Phone number

213-974-1101

10. County Chief Administration Officer Email

jnicchitta@ceo.lacounty.gov

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Board of Supervisors Certification

Certification

1. Board of Supervisors certifies the following:

   Board of Supervisors has reviewed and approved this Integrated Plan for the period of

   County will meet its realignment obligations pursuant to W&I Code section 14197, including but not limited to time or distance standards and appointment time standards set forth in W&I Code section 14197 or other applicable guidance, without utilizing waitlists

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?

   Yes

   No

a. If answered yes above, please describe any implementation challenges or concerns with their realignment obligations (optional)

Signature

3. Printed name

4. Title

5. Date

6. Signature