LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

COMMUNITY PLANNING PROCESS

Los Angeles County Department of Mental Health

CPT SESSION

March 19, 2024 | 9:30 AM - 12:30 PM

KEY ANNOUNCEMENTS

Recording + Sign In + Materials + ASL + CART + Interpretation + Chat Box + Participation + Self-Care + Support

#1 RECORDING

This is a public meeting.

We are recording today’s session.

#2 ONLINE SIGN-IN SHEET

If you are viewing the meeting online, please use the Chat Box to sign into today's session.

If you are a CPT member, put your name followed by CPT, e.g., Rigo Rodriguez – CPT.

#3 MEETING MATERIALS

Access today's materials via the link in the Chat Box.

Email Contact

communitystakeholder@dmh.lacounty.gov

#4 AMERICAN SIGN LANGUAGE

- ASL interpreters are provided in-person and/or visible on screen.
- If you're online, PIN the ASL interpreter by hovering over their picture, then click the 'THREE DOTS' and select 'PIN FOR ME.'

#5 CART SERVICE

COMMUNICATION ACCESS REAL-TIME TRANSLATION (CART) service is provided available via the SCREEN.

For **ONLINE** participants, CART service can be accessed by pressing the link in the Chat Box.

If you cannot access the link via Chat Box, please send email at communitystakeholder@dmh.lacounty.gov.

#6 LANGUAGE INTERPRETATION

LANGUAGE INTERPRETATION is provided in Spanish and Korean in person and online.

For **ONLINE** participants, please access language interpretation via the telephone lines in the Chat Box.

#6 LANGUAGE INTERPRETATION

CPT Spanish Language Line

Call in (audio only)

+1 323-776-6996,,181171509#

Phone Conference ID: 181 171 509#

CPT Korean Language Line

Call in (audio only)

+1 323-776-6996,,969734100#

Phone Conference ID: 969 734 100#

#7 CHAT BOX

CHAT BOX is available mainly to:

- ACCESS Links for CART services, telephone lines for interpreters, materials, or
- COMMUNICATE with us in case something is happening with these services.

#7 CHAT BOX

Please do not use the **CHAT BOX** for other purposes unless instructed as part of the process.

If you cannot access the links in the **CHAT BOX,** email us at:

communitystakeholder@dmh.lacounty.gov

#8 PARTICIPATION

CPT MEMBERS

+

MEMBERS OF THE PUBLIC

#9 SAFE & CREATIVE SPACE

EXPECTATIONS

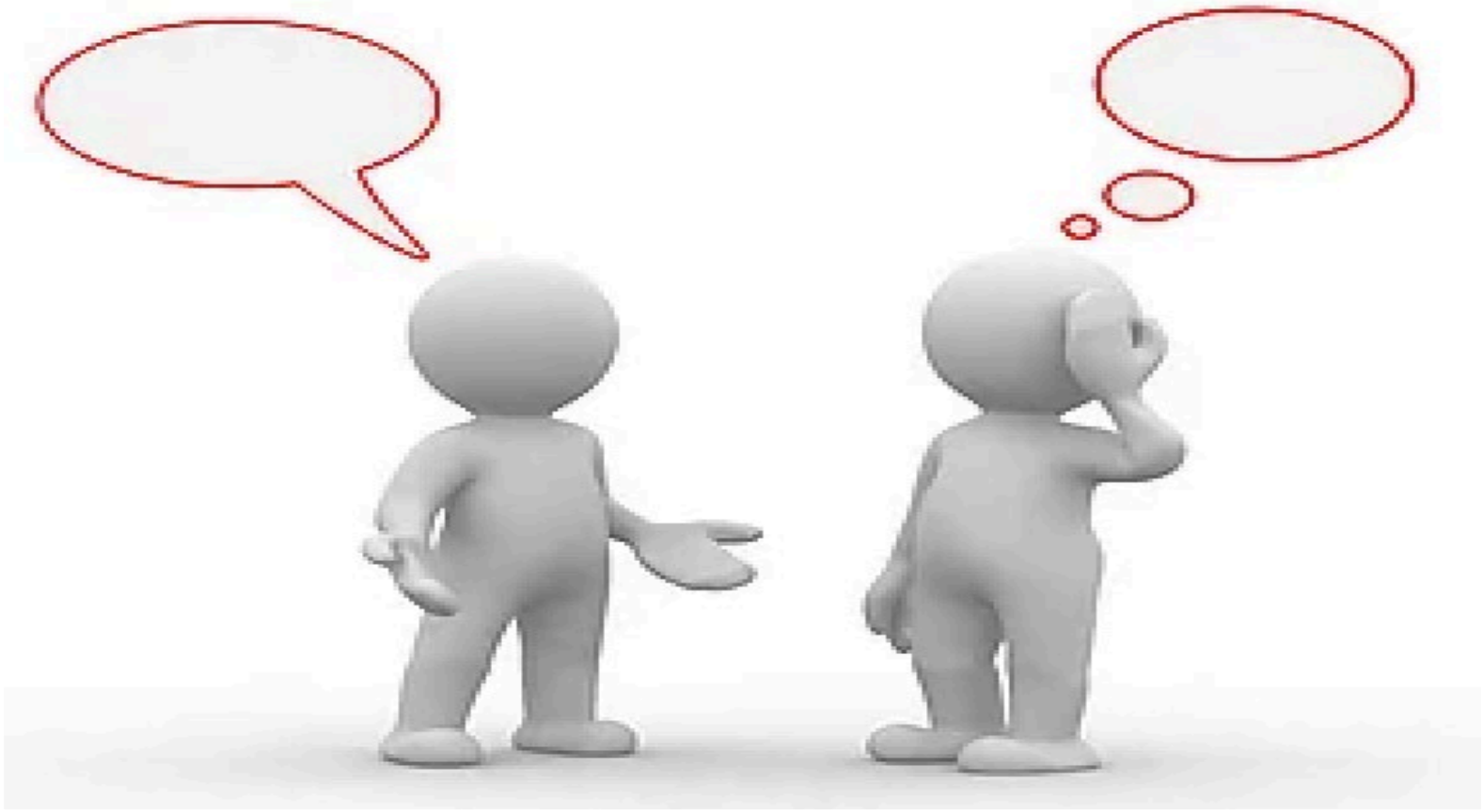
1. BE PRESENT
2. SPEAK FROM YOUR OWN EXPERIENCE
3. PRACTICE CONFIDENTIALITY
4. STEP UP, STEP BACK
5. SEEK TO UNDERSTAND AND THEN BE UNDERSTOOD

#10 SELF CARE & SUPPORT

TAKE CARE OF SELF & SEEK SUPPORT

- If during the session you find yourself feeling uneasy with the topic or dialogue, we encourage you to take care of yourself and seek support. Please reach out to if you need assistance with processing your thoughts and feelings.

QUESTIONS



WELCOME

DR. DARLESH HORN, DPA
Division Chief
MHSA Administration
MHSAAdmin@dmh.lacounty.gov

PURPOSE

Transition the Community Planning Team towards an implementation monitoring role.

OBJECTIVES

1. Review the approach to transition the CPT into an implementation monitoring role.
2. Provide an update on *Proposition 1: Behavioral Health Services Act*.
3. Obtain input on videos to increase participation in community stakeholder groups.

TRANSITIONING

FROM PLANNING TO IMPLEMENTATION MONITORING

MHSA PLANNING TO IMPLEMENTATION

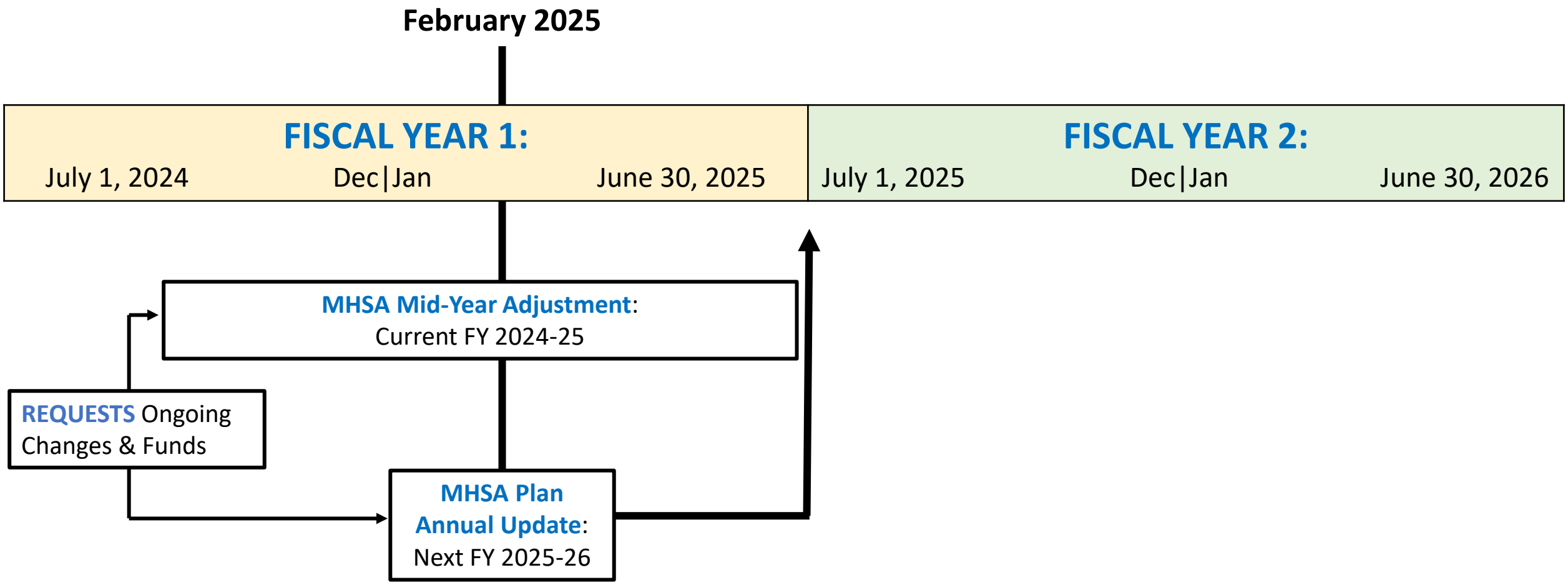
MHSA Community Stakeholder **PLANNING** → *MHSA 2-Year Plan: FY 2024-25 & 2025-26*

Fiscal Year 1:	**Fiscal Year 2:**
July 1, **2024** - June 30, **2025**	July 1, **2025** - June 30, **2026**

IMPLEMENTATION MONITORING:
MHSA Mid-Year Adjustments & MHSA Annual Plan Updates

KEY QUESTIONS: Did we do what we said we would do? How well did we do it? Is anyone better off? What changes are needed?

MHSA CALENDAR – MONITORING & MAKING CHANGES



PROGRAM-LEVEL DATA

OUTPUT	ACCESS	OUTCOME
How much did we do?	Who accessed services?	Is anyone better off?

DISAGGREGATED DATA: EQUITY

PROGRAM-LEVEL DATA

DISAGGREGATED DATA: EQUITY

OUTPUT

How much did we do?

ACCESS

Who accessed services?

OUTCOME

Is anyone better off?

AGGREGATED	DISAGGREGATED
ALL	Disability(ies)
	Gender(s)
	Language
	LGBTQIA+
	Race/Ethnicity/Tribal Affiliation
	Region/Geography
	Age
	Other: Homeless, Veterans, etc.

UNSERVED

Who is unserved?

UNDERSERVED

Who is underserved?

INAPPROPRIATELY SERVED

Who is inappropriately served?

EXAMPLE: COMMUNITY SUPPORTS CONTINUUM

KEY CONCERNS	GOALS
1. Emergency Response	*Improve Emergency Response*
2. Psychiatric Beds	*Improve Support for Persons Needing Psychiatric Beds*
3. Full Service Partnerships	*Improve Access to & Efficacy of Full Service Partnerships (FSPs)*
4. Access to Quality Care	*Increase Access to Quality Care*

COMMUNITY SUPPORTS CONTINUUM

GOAL 1
Improve Emergency Response

GOAL 1: SAMPLE RECOMMENDED MHSA PROGRAMS, SERVICES, INTERVENTIONS

1. **EXPAND** the Call Center and strengthen the triage process to improve the client experience, based on review key metrics and qualitative data.
2. **EXPAND** the Psychiatric Mobile Response Team (PMRT) service, **PROVIDE** cultural competence training to all PMRT staff, and **PRIORITIZE** hiring culturally competent individuals reflective of their communities.
3. **EXPAND** the Law Enforcement Teams (LET), Mental Evaluation Teams (MET), and Systemwide Mental Assessment Response Teams (SMART) and **PROVIDE** sensitivity training to Law Enforcement partners.

CONCERN
Poor Emergency Response

PROGRAM LEVEL DATA

OUTPUT: How much did we do?

ACCESS: Who accessed services?

OUTCOME: Is anyone better off?

DISAGGREGATED DATA

- Disability, Gender, Immigration, Language, LGBTQIA+, Race/Ethnicity, Region/Geography, etc.

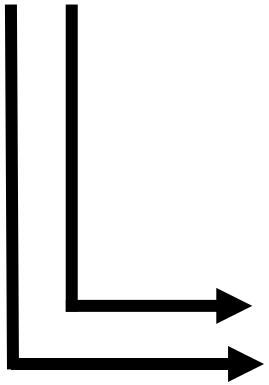
MATRIX – UsCCs & Peer Advisory Councils (PACs)

A. PROGRAM, SERVICE, AND/OR INTERVENTION RECOMMENDATIONS (PSI)

1. EXISTS ALREADY: Expand and/or Improve Existing PSI

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	STAKEHOLDER GROUPS							
			ACCESS	AI/AN	API	BAH	EE/ME	LATINO	LGBTQIA2 -S	PAC
1	Call Center & Triaging	1. Expand the call center and strengthen the triage process to improve the client experience, based on review key metrics and qualitative data.								
1	PMRT	2. Expand the Psychiatric Mobile Response Team (PMRT) service, provide cultural competence training to all PMRT staff, and prioritize hiring culturally competent individuals reflective of their communities.						L.4.C.20		
1	LET, MET & SMART	3. Expand the Law Enforcement Teams (LET), Mental Evaluation Teams (MET), and Systemwide Mental Assessment Response Teams (SMART) and provide sensitivity training to Law Enforcement partners.						L.4.C.21		
1	Therapeutic Transport	4. Improve the collaboration between the Los Angeles County Fire Department staff, peers, and mental health specialists responding to mental health calls.								
1	MH Training-Law Enforcement	5. Provide sensitivity training to Law Enforcement on working with individuals with mental illness.								
1		6. Provide trainings that build the capacity of community leaders and community-based organizations to provide support during psychiatric emergencies, e.g., Mental Health First Aid and Suicide Prevention and Grief Training								

Pressing the hyperlink takes you to the section where the specific recommendations and/or critical issues are documented.



	C. CULTURAL COMPETENCY
CPT	1. Increase/improve linguistic access (API populations).
CPT	2. Provide culturally competent services.
BAH	3. A BAH review panel for BAH related care court cases, so the people in these cases are not being taken advantage of by the process.
CPT	4. Increase peer supports.
CPT	5. Increase 24/7 emergency services staffed by peers/professionals.
CPT	6. Increase hiring peers to address staff shortages.
CPT	7. Increase peer support (7% of budget)
CPT	8. Reduce systemic bias in order to access services.
CPT	9. Integrate more CBOs, community leaders, faith-based organizations within DMH to represent community they serve (from outside, in).
LATINO	10. Lack of sufficient crisis services in Spanish and that are culturally responsive.
API	11. During a crisis intervention, use culturally sensitive strategies; need to train PMRT people on more culturally specific strategies when dealing with underserved communities.
EE/ME	12. Increase the number of clinicians who are bilingual and bi-cultural; increase language interpreters.
EE/ME	13. It will be effective to have more Middle Eastern therapists/psychologists/psychiatrists who have cultural and linguistic knowledge.
API	14. Use a peer to peer model to engage API community members into mental health services
EE/ME	15. DMH should be more proactive and create a bridge between itself and the Armenian Community. If DMH wants to serve the community, they must know the community structure. Also, DMH staff must be knowledgeable and know how to reach out to the EE/ME Communities for Mental Health.
EE/ME	16. The Armenian Community lacks the capacity to better serve underserved groups.
API	17. Continue to fund the innovation projects in all the ethnic communities under CSS including the ISM.
API	18. Increase staffing patterns proficient in all API languages.
LATINO	19. A culturally responsive review panel for Latino related CARE Court cases, so the people in these cases are not being taken advantage of by the process.
LATINO	20. All CSC services, including PMRT should be linguistically and culturally responsive (Spanish and Indigenous languages).
LATINO	21. For LET, build upon LAPD's & CIELO's work on training LET on responding to crisis calls of people who speak Latin American Indigenous languages.
API	22. Have an access line for each of the 13 threshold languages.
LATINO	23. Develop framework/plan to provide mental health services for undocumented immigrants, including and particularly, around FSP. This should include undocumented LAC residents involved in immigration proceedings especially those with SMI and SUD dual diagnosis.

CROSSWALK TABLE – UsCCs & PACs

A. PROGRAM, SERVICE, AND/OR INTERVENTION RECOMMENDATIONS (PSI)

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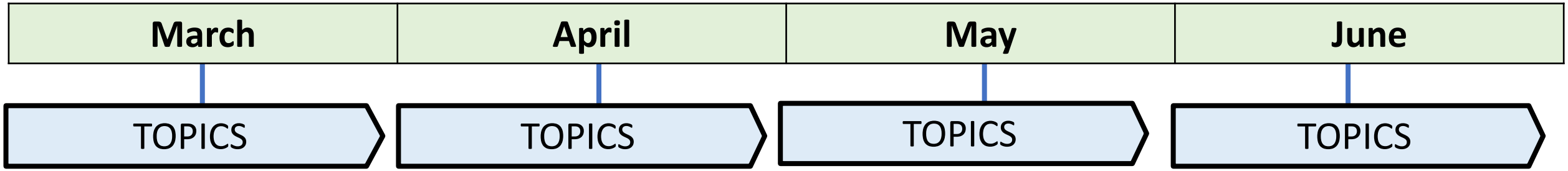
IMPLEMENTATION MONITORING: 2024



- **PROPOSITION 1/ BHSA:** Update
- **MHSA/BHSA**: Outreach & Education Videos Input

CAPACITY BUILDING: DATA 101

1. Outcomes:
   a. Definition
   b. Program vs Population
2. Measures/Metric
3. Baselines/Change Over Time

CALL CENTER: Focus Group Discussion

CAPACITY BUILDING: DATA 201

1. Data Sources
2. Equity Division
3. Navigating Data Sources

PROGRAM FOCUS:

- Full Service Partnerships, Part 1

UPDATE

PROPOSITION 1 - BHSA

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Behavioral Health Services Act Update

Formerly Proposition 1

MARCH 2024

LOS ANGELES COUNTY
DEPARTMENT OF
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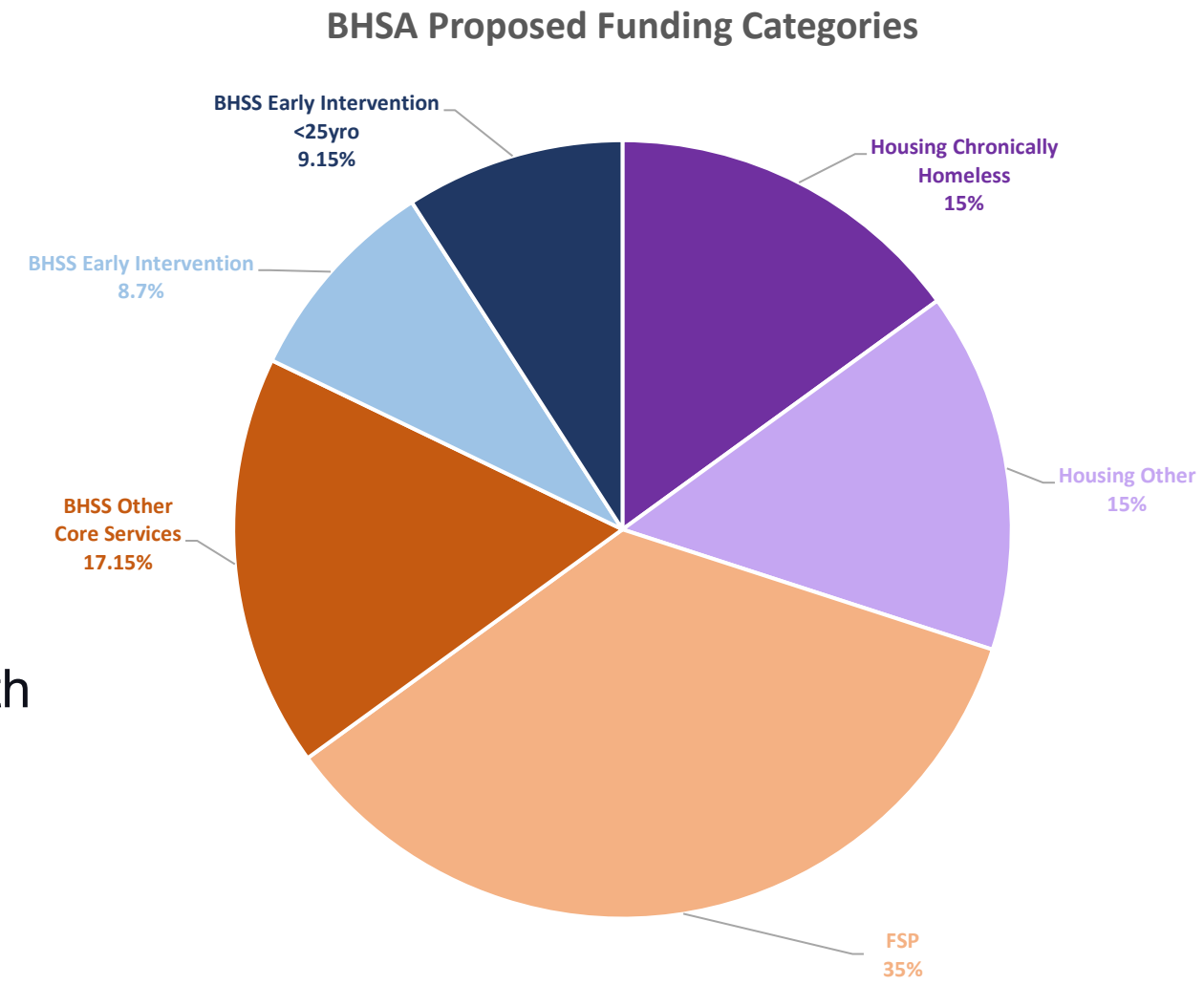
Behavioral Health Services Act Overview

- Proposed by California State Legislature, supports Gov. Newsom's vision to "modernize behavioral health"
- Senate Bill (SB) 326 and Assembly Bill (AB) 531 have passed legislature and were signed by Gov. Newsom on October 12, 2023. Combined they became Proposition (Prop) 1 on the March 2024 ballot
- Will rename the Mental Health Services Act the Behavioral Health Services Act (BHSA)
- Programmatic changes will begin July 1, 2026. Administrative funding for the new community planning process will begin January 2025.
- Adds a $6.3B Housing bond to fund treatment facilities and housing for homeless (AB531)
- Proposes significant shifts in MHSA allocations, impacting funding from core mental health services (Outpatient, Crisis, Linkage) to create a new housing category (SB 326)

Behavioral Health Services Act Updates
(Formerly Proposition 1)

- New: Proposed Allocations include
  - Housing: 30%;
  - FSP: 35%;
  - Behavioral Health Services and Supports (BHSS) 35%
    - Flexible : 17.15%;
    - Early Intervention: 17.85%

- Allows for a 7% shift from a single category with a maximum shift of 14% total with State approval.



Behavioral Health Services Act Updates
(Formerly Proposition 1)

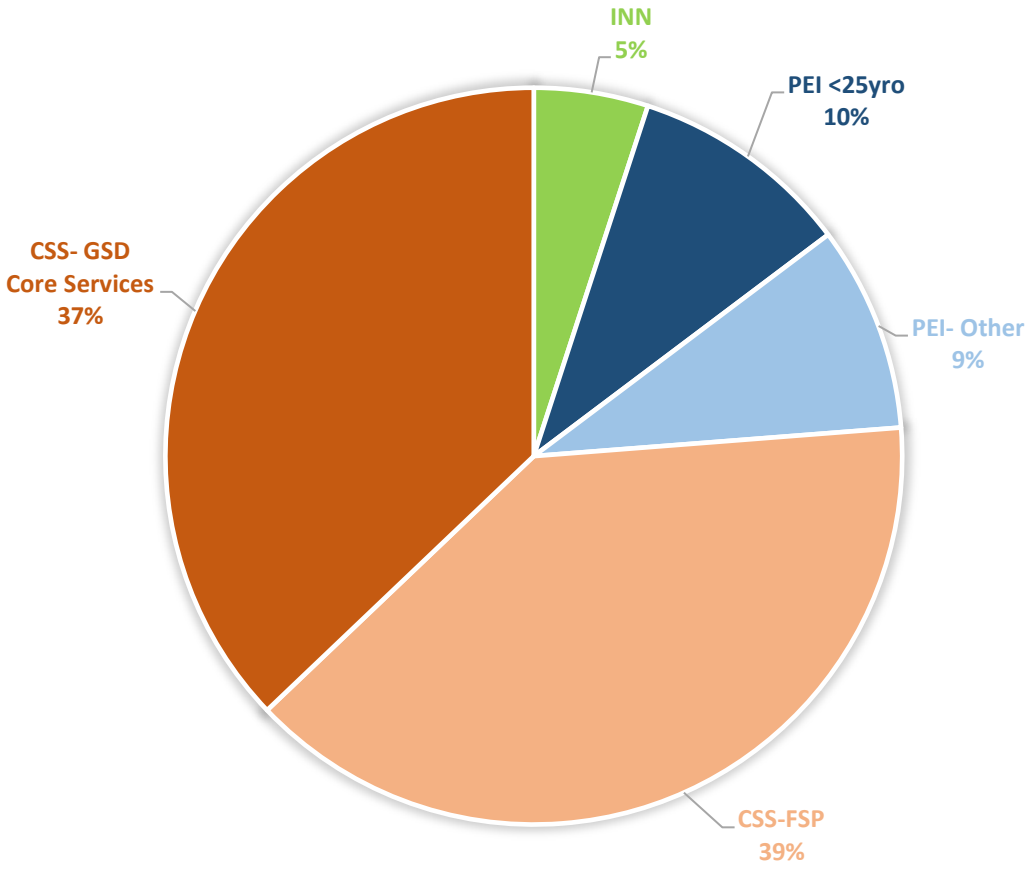
- Requires counties to provide new Substance Use Disorder (SUD) services to SUD-only populations, no additional funding will be added
- No specific allocation for Prevention, Suicide Prevention, Anti Stigma, Workforce Education and Training, and Capital Facilities and Technological Needs which are current funding categories under MHSA
- Prevention funds and services will be administered by the State
- Workforce Education and Training will be administered by the State

$6.38B General Obligation Bond for Housing
Formerly AB 531 and included in Proposition 1

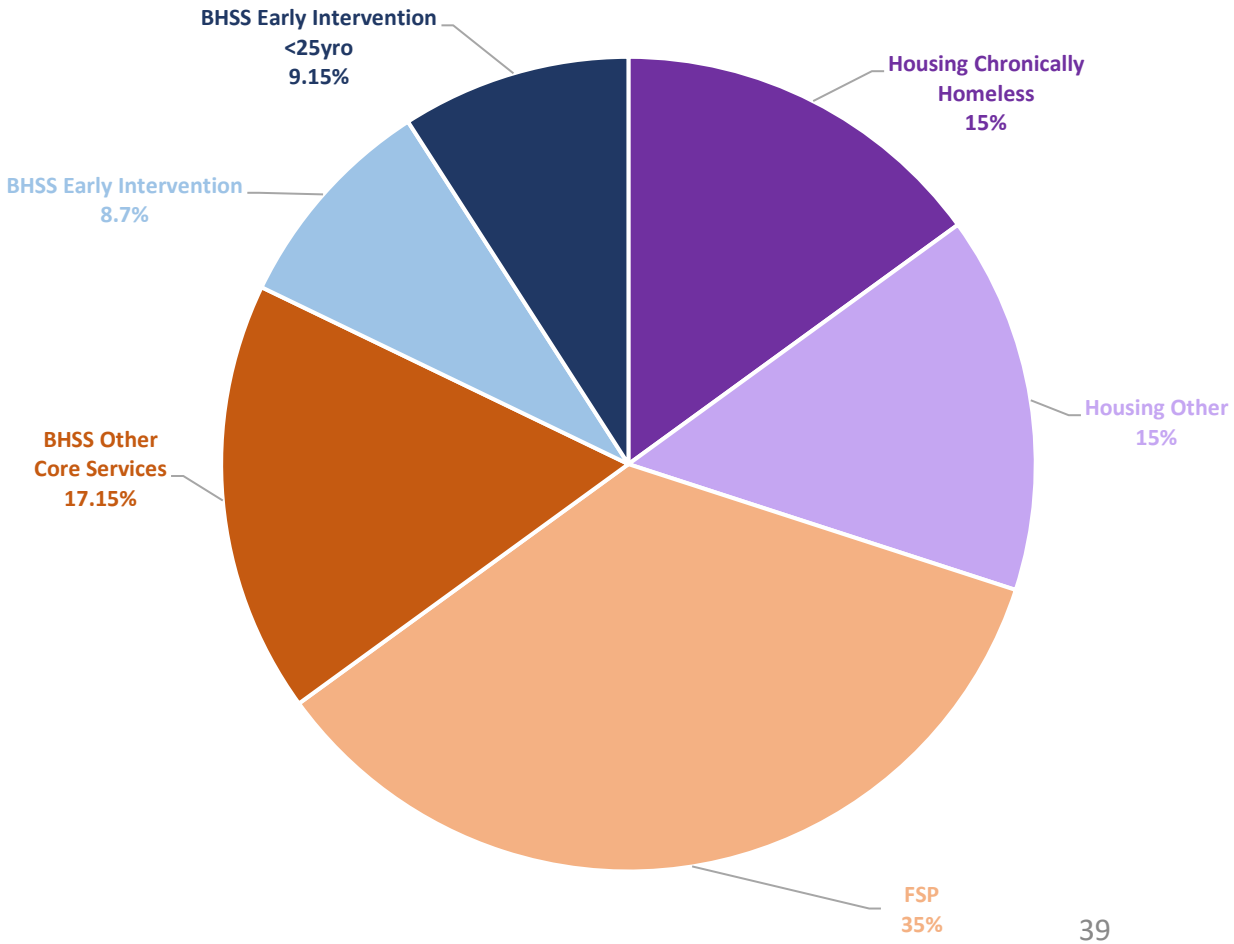
- The State has identified $4.4B for grants for behavioral health treatment and residential settings
  - Of this $1.5B will be awarded to counties, cities, and tribal entities for behavioral health treatment and residential settings
- The State has identified $1.065B of housing investments for veterans who are at risk of homelessness, experiencing homelessness, or experiencing chronic homelessness who have behavioral health needs or a substance use disorder
- The State has identified $922 million worth of investments for Californians (not specifically for veterans) who are at risk of homelessness, experiencing homelessness, or experiencing chronic homelessness who have behavioral health needs or a substance use disorder

MHSA Components vs. BHSA Categories

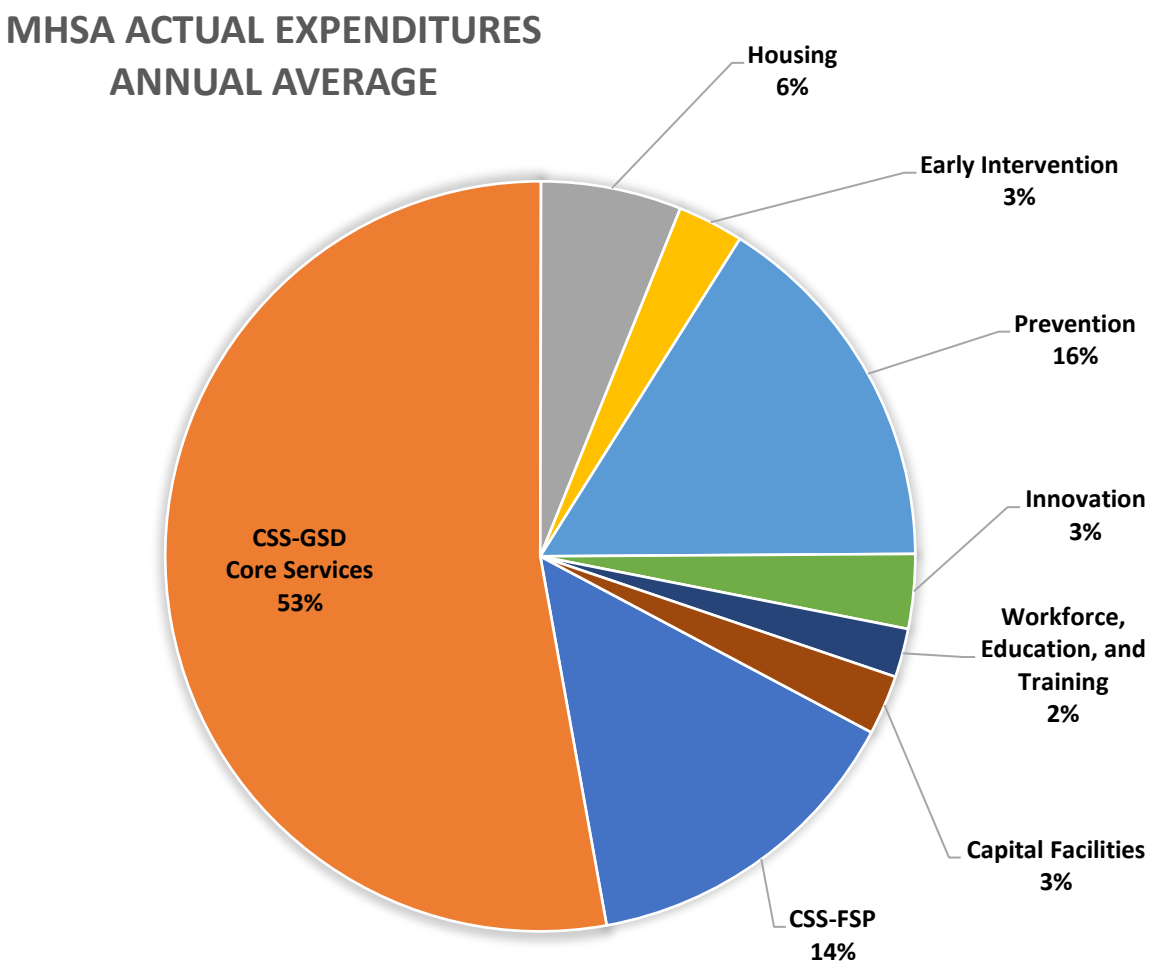
Current MHSA Funding Components

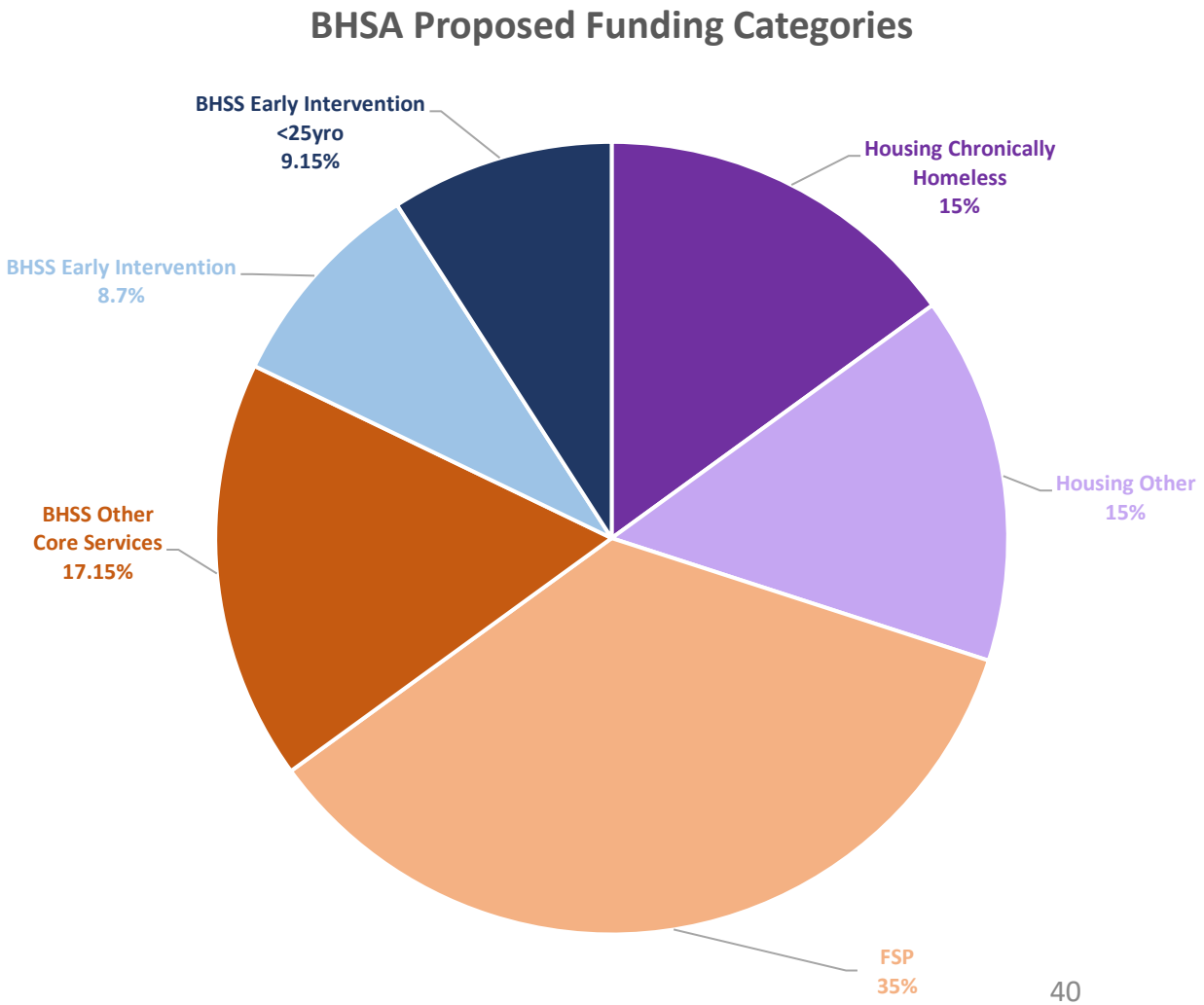


BHSA Proposed Funding Categories

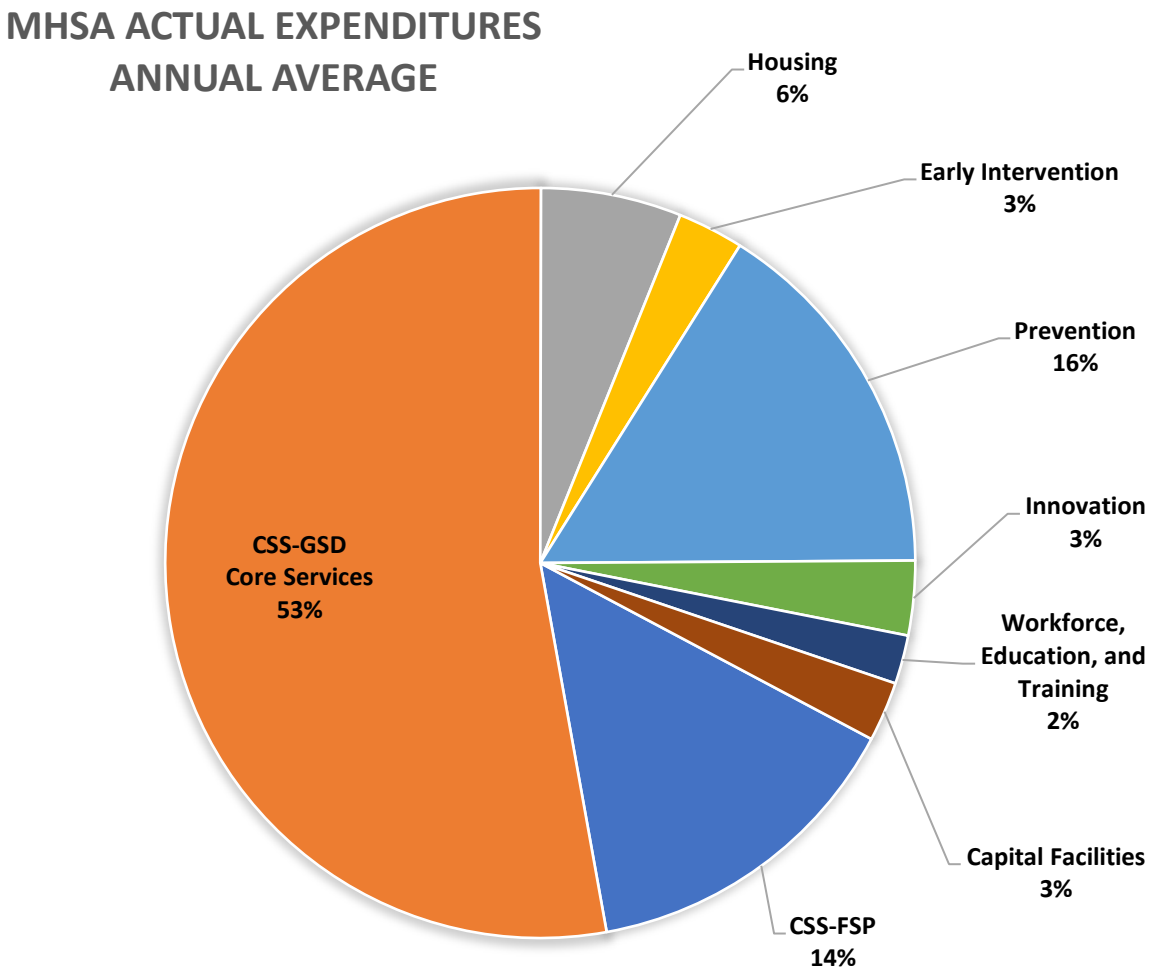


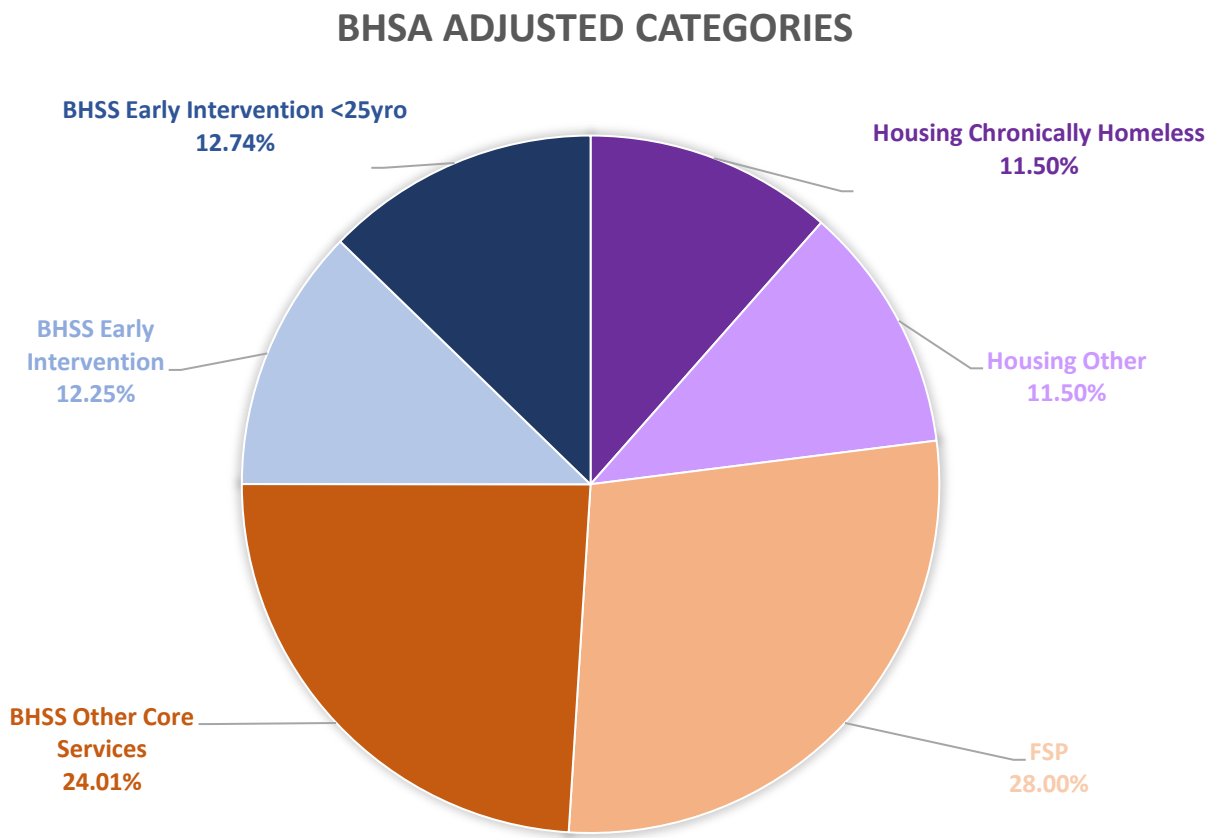
MHSA Actuals vs. BHSA Categories





MHSA Actuals vs. BHSA Adjusted Categories





BHSA Category Comparison

BHSA Comparison: Percentage

Category	Current Expenditure	Future Allocation	Difference
Full Service Partnerships	14.39%	28.00%	13.61%
Housing	6.06%	23.00%	16.94%
Early Intervention	2.84%	24.99%	22.15%
Prevention	15.96%	0.00%	-15.96%
Innovation	3.21%	0.00%	-3.21%
Workforce, Education, and Training	2.10%	0.00%	-2.10%
Capital Facilities and Technological Needs	2.57%	0.00%	-2.57%
Core Services	52.86%	24.01%	-28.85%

- The State will retain 10 percent of total MHSA revenues for state directed purposes.
  - 4 percent minimum for population-based prevention
  - 3 percent minimum for workforce
  - Remaining 3 percent for broad state directed purposes

Estimated BHSA Expenditure Shifts

BHSA Comparison: Estimated Dollar Impact

Category	Current Expenditure	Future Allocation	Difference
Full Service Partnerships	$106,806,000	$207,832,000	$101,026,000
Housing	$44,985,000	$170,719,000	$125,734,000
Early Intervention	$21,103,000	$185,490,000	$164,387,000
Other	$176,969,000	-	($176,969,000)
Core Services	$392,393,000	$178,215,000	($214,178,000)
Total	$742,256,000	$742,256,000	-

*Based on three-year revenue average. Does not reflect shift to prudent reserve or SUD only expenditures

BHSA Comparison: Estimated Dollar Impact w/ State Share

Category	Current Expenditure	Future Allocation	Difference
Full Service Partnerships	$106,806,000	$196,401,000	$89,595,000
Housing	$44,985,000	$161,329,000	$116,344,000
Early Intervention	$21,103,000	$175,288,000	$154,185,000
Other	$176,969,000	-	($176,969,000)
Core Services	$392,393,000	$168,414,000	($223,979,000)
State	$37,113,000	$77,937,000	$40,824,000
Total	$779,369,000	$779,369,000	-

*Based on three-year revenue average FY 20-21 to FY 22-23. Does not reflect shift to prudent reserve or SUD only expenditures

What is included in Core Services?

The "Core Services" category refers to all non-FSP programs under Community Services and Supports which will be reduced to 17% of expenditures.

- Outpatient Programs: Directly Operated and Contracted, all age groups
- Urgent Care Centers
- Psychiatric Mobile Response Teams
- Crisis Residential Treatment Programs
- Planning, Outreach, and Engagement

What is Included in “Other”?

The other category includes funded programs for which there is no designated funding:

- Prevention: 16% of the MHSA expenditures – Includes Prevention, Suicide Prevention, and Anti-Stigma and Discrimination
- Innovation: 3.21% of the MHSA expenditures
- Workforce Education and Training (WET): 2.1% of MHSA Expenditures
- Capital Facilities: 2.6% of MHSA Expenditures

What is Different with these BHSA Categories?

All categories are inclusive of individuals who are substance use only.

Full-Service Partnership:

- Assertive Community Treatment Model (ACT) and Forensic Assertive Community Treatment Model (FACT), Individual Placement and Support Model, and High-Fidelity Wraparound

- Ongoing outpatient to continue to meet needs for enrolled participants

- Ongoing engagement services necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and non-clinical services

What is Different with these BHSA Categories?

Early Intervention (EI):

- Biennial list of evidence-based and community defined evidence practices published by DHCS will guide services
- EI programs must be individualized, no population-based approaches

- EI programs must emphasize reduction of:
  - Disparities in behavioral health
  - Suicide and self harm, incarceration, school suspension/expulsion/failure to complete– including early childhood 0-5,
  - Unemployment,
  - Prolonged suffering,
  - Homelessness,
  - Removal of children from homes,
  - Overdose, and
  - Mental illness in children and youth from social, emotional, developmental, and behavioral health needs in early childhood

What is Different with the New Housing Category?

Housing Category

- Includes, but not limited to, rental subsidies, operating subsidies, shared housing, family housing
- Does NOT include mental health services and supports.
- May include capital development at a maximum of 25% of this category, beginning FY 32/33
- Counties can use BHSA for housing supports as defined by DHCS for non-Medi-Cal where managed care plans have not elected to cover housing
- 51% to support individuals defined as Chronically Homeless per the TBD State definition

Community Planning

- Expansion to include unions, large city representation, managed care plans, “Tribal and Indian Health program designees” established for Medi-Cal Tribal consultation purposes, and youth
- Expansion to include review of Substance Use Services resources and community plan
- LA County DMH to participate in planning processes for the Community Health Plan and the Managed Care plans
- Requires at least one meeting annually

Community Planning:
Planning, Reporting and Accountability

Includes but is not limited to:

- Planning and reporting will cover the services and budgets for ALL funding sources, not just BHSA
- Review and report efforts to reduce identified disparities in all funding sources
- Identify local metrics and provide a description of how the plan/annual update aligns with local goals and outcome measures for behavioral health and reduction of disparities
- Description of how the county considered unique needs of LBGTQ+ youth, justice involved youth, child welfare involved, justice involved adults, and older adults in the BHSA Housing and FSP.
- Description of workforce strategy to include actions the county will take to ensure its county and non county contracted behavioral health workforce is well-supported and culturally and linguistically concordant with the population served.

Community Planning: Mental Health Commission

- Mental Health Commission must reflect diversity of the County, fifty percent (50%) shall be consumers or family members of consumers, include a veteran, one shall be from a local education agency, and a youth under 25 years old
- The role of the commission is to:
  - Review both the public mental health and the public substance abuse system.
  - Advise the governing body on community mental health and substance use disorder services delivered by the local mental health agency
- Mental Health Commission Hearing and 30-day posting is required for the Three- Year Plan

Community Planning

- Community Planning team must meet at least once annually.
- The Three-Year plan must be approved by the Board of Supervisors by June 30 of the year prior to plan implementation.
- Planning for BHSA implementation in July of 2026 will begin early calendar year 2025.

Strategies Going Forward

Consider Outpatient programs that can be funded with FSP:

- Multiple levels of FSP: ACT, FSP, Lower Level of FSP
- Outpatient services for individuals at risk of hospitalization, homelessness, justice involvement, and child welfare involvement
- Linkage services which serve individuals how are, or at risk of hospitalization, homelessness justice involvement, and child welfare involvement

Consider Prevention and Outpatient programs that can be funded with Early Intervention:

- Review Prevention programs which provide direct contact, and can provide claimable services

Review other sources of funding

State Clarification Needed for Further Analysis

Full Service Partnership

- Inclusive of Crisis Services?
- Regulations change for lower levels of care?
  - Outcome Measures
  - 24/7 Field Response

Early Intervention

- Will there be revised regulations, and will they accommodate services current included in outpatient and linkage?
- Will there be a change in the 18-month limit in services?

Housing

- Bill language references Community Supports Policy Guide, can these services be claimed as non Medi-Cal services?

Prevention

How will prevention funds be disseminated to communities?

Principles and Considerations for BHSA

- Maintain engagement with the workforce and community throughout the process
  - Stakeholder townhalls
  - Stakeholder workgroups
- Questions to consider:
  - What strategies and resources are available to ensure continuity of care in outpatient, crisis, and linkage services?
  - How can we ensure Peer services continue to play a role in all levels of care?
  - What strategies and resources can be implemented to support the needs of underserved communities, children, youth, and families served in Prevention programming?

Engaging the Provider and Stakeholder Communities

- Updates to be provided in the Stakeholder Meetings
  - March 19 Stakeholder meeting will provide an update, next steps, and offer opportunity for input. (St. Annes 9:30-12:30)
- Continued updates in Provider Meetings
- Provider Workgroups
- Goal is Continuity
- DMH will continue to advocate for flexibility

Thank you!

Your feedback is helpful. Do you have concerns or questions, please take our survey:

- https://forms.office.com/g/kJQd7iEf2x

BREAK

MHSA/BHSA OUTREACH & ENGAGEMENT VIDEOS

PART 1: INPUT

BACKGROUND

- **FALL 2022**: The CLT Ad Hoc Team & MHSA Stakeholders highlighted the need to better coordinate Outreach & Engagement staff and materials increase participation and leadership in SALTs and UsCCs and access to services.

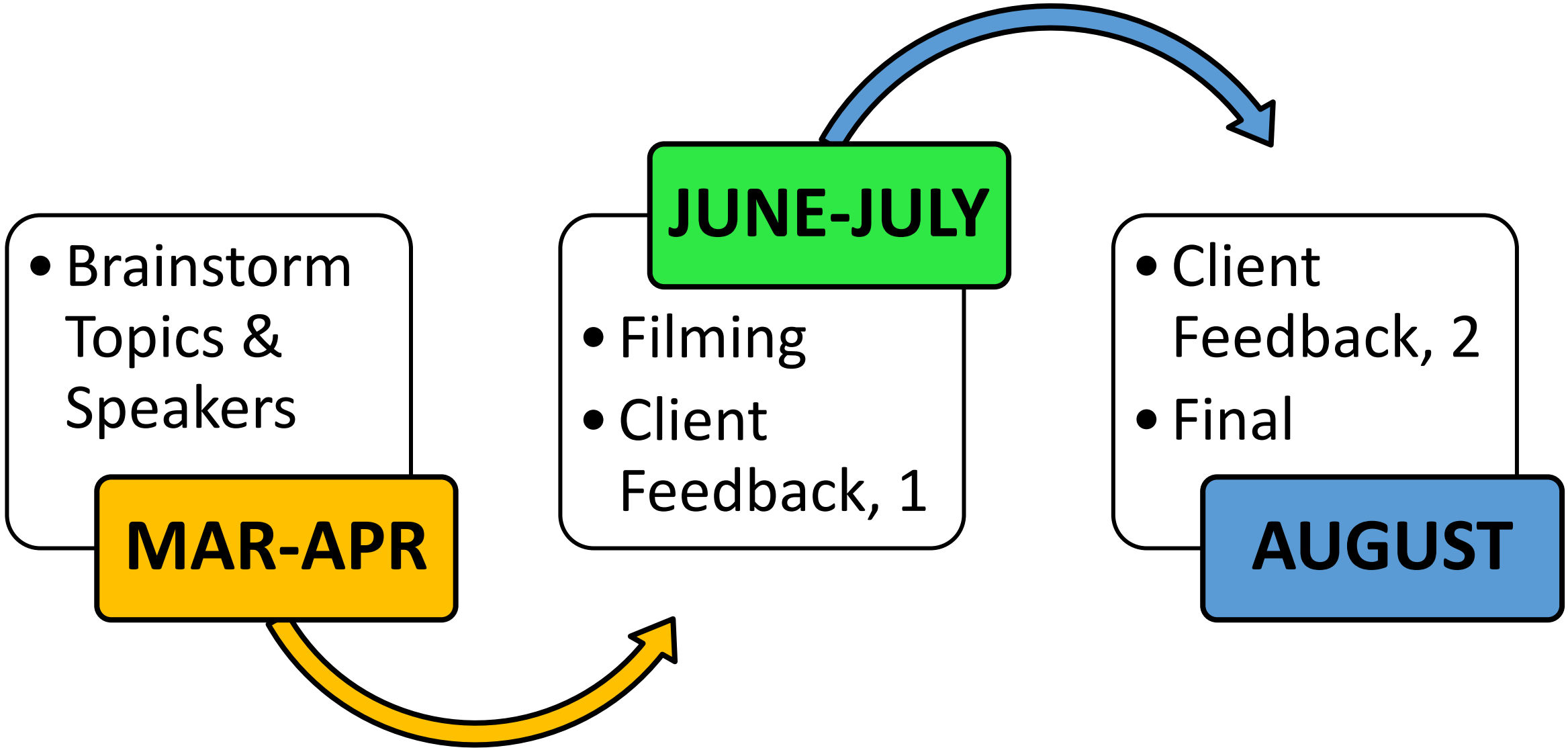
- **FALL 2023**: CPT members/MHSA stakeholders underscored the need provide culturally congruent and linguistically specific information to community members about how to access mental health services.

BACKGROUND

- **FALL 2023**: CalMHSA contracted Wondros to develop set of eight videos (approximately 5 minutes each) to support Outreach & Engagement efforts to increase access to services and participation in community stakeholder groups.

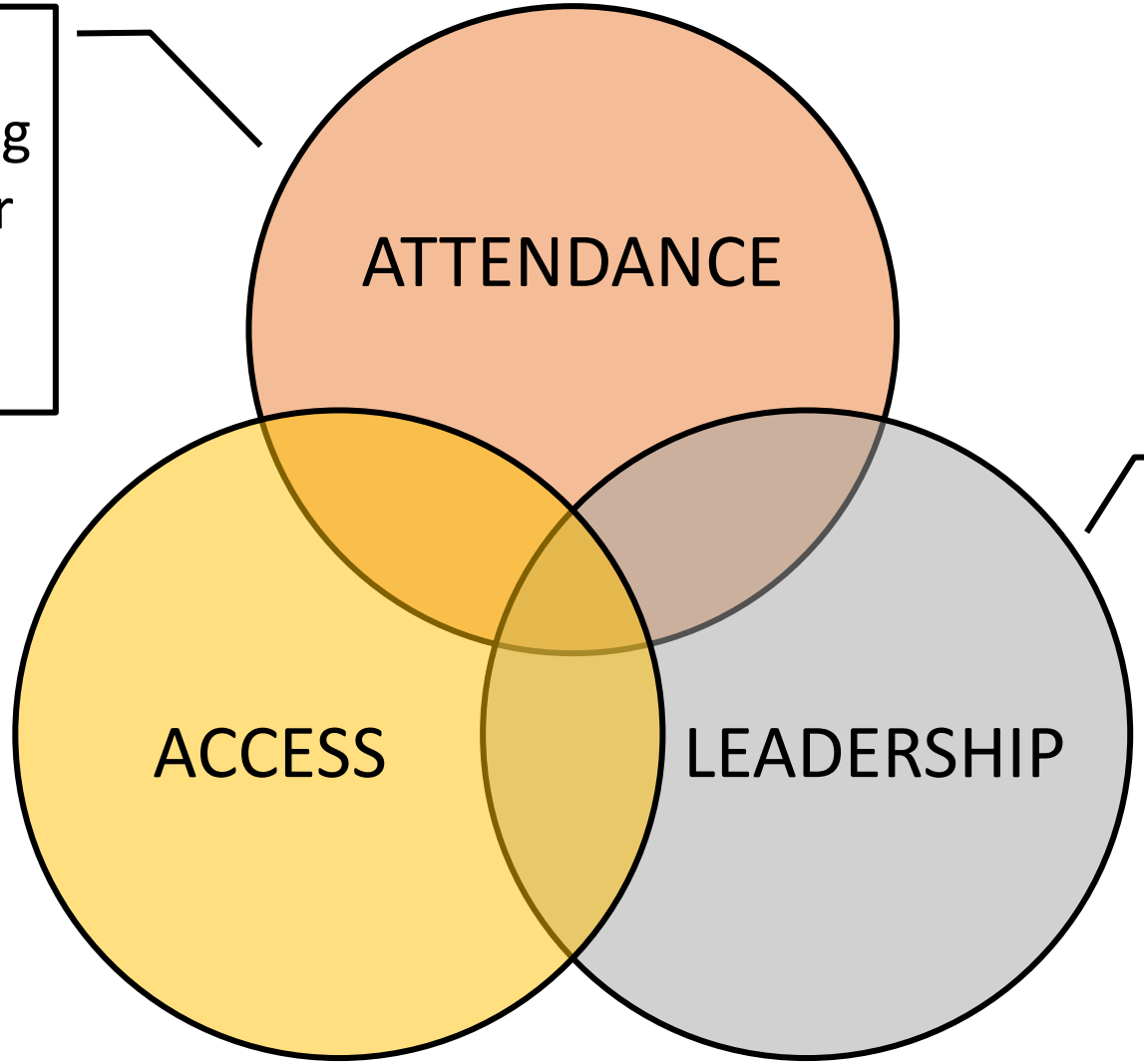
- **SPRING/SUMMER 2024**: Wondros will work with the CPT members to identify content and identify speakers to tell your stories in a culturally and linguistically congruent way.

TIMELINE


• Brainstorm Topics & Speakers
MAR-APR
JUNE-JULY
• Filming
• Client Feedback, 1
• Client Feedback, 2
• Final
AUGUST

AUDIENCES & GOALS

- People who might be interested in attending SALTs, UsCCs, or other community stakeholder group(s)



- People who might be need resources.

- People already involved in community stakeholder groups

QUESTIONS (15 min)

If you have eight videos (5 minutes each), what topic would you assign to each video to motivate people to:

1. Access mental health resources?
2. Attend SALTS, UsCCs, or other MHSA community stakeholder groups?
3. Become more involved in a community stakeholder group?

SHARING (30 min)

Each Table has 3 minutes to present its ideas, followed by large group discussion on common topics and ideas.

CLOSING

UPCOMING CPT MEETINGS

DATE
Tuesday, April 2 (In-Person)
Friday, April 26 (Online)
Tuesday, May 7 (In-Person)
Friday, May 24 (Online)
Tuesday, June 4 (In Person)
Friday, June 28 (Online)

NOTE:

TUESDAYS: IN-PERSON

FRIDAYS: ONLINE

MEETING EVALUATION

ENGLISH

SPANISH