LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

MHSA Community Planning Team (CPT)

AGENDA

DATE & LOCATION	LINK TO MEETING
Tuesday, January 14, 2025 | 9:30 – 12:30 PM St. Anne's Conference and Event Center 155 N. Occidental Blvd, Los Angeles 90026	Click **Join the meeting now** Meeting ID: 221 101 411 058 | Passcode: Cq94iB3k Dial in by phone +1 323-776-6996,,255407060# Phone conference ID: 255 407 060#

OBJECTIVES	1. Share updates on MHSA-related administrative items. 2. Present the MHSA Mid-Year Adjustment for FY 2024-25 and obtain feedback. 3. Hold a listening session to shape the Behavioral Health Service Act Community Planning Process (BHSA CPP).
TIME	**ITEMS**
9:30 – 9:40	I. SESSION OPENING A. Land and Labor Acknowledgement B. Announcements & Communication Expectations C. Agenda Review
9:40 – 9:50	II. UPDATES ON MHSA-RELATED ADMINISTRATIVE ITEMS A. Update: Dr. Darlesh Horn, DPA, Division Chief, MHSA Administration & Oversight Division, LACDMH
9:50 – 10:30	III. PRESENTATION & FEEDBACK: MHSA MID-YEAR ADJUSTMENT (FY 24-25) A. Presentation (10 min): Kalene Gilbert, LCSW, Mental Health Program Manager IV, MHSA Administration & Oversight Division, LACDMH B. Feedback (30 min)
10:30 – 12:25	IV. LISTENING SESSION: BHSA COMMUNITY PLANNING PROCESS (2025) A. Part 1: Shared Understanding (45 min) 1. Small Group Discussion: Behavioral Health, Integrated Behavioral Health System, Opportunities & Challenges 2. Report Outs & Synthesis B. Break (10 min) C. Part 2: Review and Feedback (60 min) 1. Small Group Discussion: Stakeholder Groups & Engagement Agreements 2. Report Outs & Synthesis
12:25 – 12:30	V. CLOSING A. Next Steps B. Meeting Evaluation
12:30	VI. ADJOURN

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

MHSA Community Planning Team (CPT)

WORKSHEET 1
MHSA MID-YEAR ADJUSTMENT (FY 2024-25)

NAME & EMAIL (OPTIONAL):

1. What questions and/or feedback to you have regarding the MHSA Mid-Year Adjustment for FY 2024-25?

WORKSHEET A - BHSA CPP

PART 1: SHARED UNDERSTANDING –
BEHAVIORAL HEALTH & INTEGRATED BEHAVIORAL HEALTH SYSTEM

NAME & EMAIL (OPTIONAL):

STEP 1: INDIVIDUALLY OR IN PAIRS

1. What comes to mind when you hear the following terms?

   (A) Behavioral Health

   (B) Integrated Behavioral Health System

2. What opportunities and/or challenges do you see, if any, in the shift towards an Integrated Behavioral Health System?

   (A) Opportunities

   (B) Challenges

STEP 2: GROUP DISCUSSION

1. What is your shared understanding of (A) 'Behavioral Health' and (B) 'Integrated Behavioral Health System'?

2. Based on your shared understanding, what opportunities and/or challenges do you see, if any, in the shift towards an Integrated Behavioral Health System?

3. Any other observation(s)?

WORKSHEET B – BHSA CPP

PART 2: STAKEHOLDERS AND ENGAGEMENT AGREEMENTS

NAME & EMAIL (OPTIONAL):

1. Proposed Stakeholder Categories, Groups, and Diversity:
    A. What do you like about the proposed stakeholder categories, groups, and diversity?

    B. What questions and/or suggestions do you have?

2. Engagement Agreements:
    A. Collaborative Practices:
        1. What do you like about the existing Collaborative Practices?

        2. What questions and/or suggestions do you have?

    B. Communication Expectations:
        1. What do you like about the existing Communication Expectations?

        2. What questions and/or suggestions do you have?

DRAFT PROPOSAL: BHSA STAKEHOLDERS

BEHAVIORAL HEALTH SERVICES ACT COMMUNITY PLANNING PROCESS:
STAKEHOLDER CATEGORIES & GROUPS

The California Department of Health Care Services requires the following twenty-four stakeholder groups to be involved in the Behavioral Health Services Act Community Planning Process (BHSA CPP).[1]

1. Eligible adults and older adults, as defined in Section 5892.[2]
2. Families of eligible children and youth, eligible adults, and eligible older adults, as defined in Section 5892.[3]
3. Youths or youth mental health or substance use disorder organizations.
4. Providers of mental health services and substance use disorder treatment services.
5. Public safety partners, including county juvenile justice agencies.
6. Local education agencies.
7. Higher education partners.
8. Early childhood organizations.
9. Local public health jurisdictions.
10. County social services and child welfare agencies.
11. Labor representative organizations.
12. Veterans.
13. Representatives from veterans organizations.
14. Health care organizations, including hospitals.
15. Health care service plans, including Medi-Cal managed care plans as defined in subdivision (j) of Section 14184.101.[4]
16. Disability insurers.
17. Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes.
18. The five most populous cities in counties with a population greater than 200,000.
19. Area agencies on aging.
20. Independent living centers
21. Continuums of care, including representatives from the homeless service provider community.
22. Regional centers.
23. Emergency medical services.
24. Community-based organizations serving culturally and linguistically diverse constituents.

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[1] W&I Code §5963.03, subdivision (e) and W&I Code §5963.03, subdivision (a)(1)

[2] W&I Code §5892, subdivision (d)(1)

[3] W&I Code §5892, subdivision (d)

[4] W&I Code §14184.101, subdivision (j)

In addition, the state also requires the participation of diverse stakeholders, including but not limited to:

1. Representatives from youth from historically marginalized communities.
2. Representatives from organizations specializing in working with underserved racially and ethnically diverse communities.
3. Representatives from LGBTQ+ communities.
4. Victims of domestic violence and sexual abuse.
5. People with lived experience of homelessness.

The main proposal is to transform the current MHSA Community Planning Team (MHSA CPT) into the BHSA Community Planning Team (BHSA CPT) by adding the BHSA-required stakeholder groups and diversity and ensuring robust representation of lived-experience perspectives and service providers for substance use prevention, harm reduction, and treatment.

The MHSA CPT already represents the perspectives, experiences, and interests across stakeholder categories:[5]

1. *Community Leadership Team:* Includes the co-chairs of the Service Area Leadership Teams (SALTs) and Underserved Cultural Communities (UsCCs), which are community-driven planning and advisory bodies for the public mental health.

2. *Community Stakeholder Groups:* Includes (a) clients, consumers, caregivers, and/or family members; (b) mental health and/or substance abuse planning, advisory, and advocacy bodies; (c) mental health and/or substance abuse service providers supporting different consumer populations; and (d) people with lived and living experience working within specific roles in the mental health and/or substance use systems (i.e., Peer Specialists, Community Health Workers/Promotoras, etc.). This category also includes Health Neighborhoods, which are collaborative networks of mental health, substance use, and other health and human services providers operating within specific neighborhood areas across Los Angeles County.

3. *County Departments:* Includes County entities that play a critical role collaborating with DMH and Department of Public Health (DPH) to deliver mental health and substance use services and supports to consumers, clients, family members, and caregivers.

4. *Education System*: Includes K-12 school districts and institutions of higher education are critical partners in the delivery of mental health services, workforce development strategies, research, and among other important functions.

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[5] Based on input from DPH SAPC representatives, we updated these stakeholder categories to include substance use perspectives and providers.

5. *Local Government/Quasi-Government Agencies:* Includes (1) city governments with their own health jurisdiction; (2) city governments with the largest populations in the county; and (3) quasi-governmental entities that play critical planning, coordination, or resource management functions that impact mental health and substance use services.

The number of representatives assigned to each stakeholder group is based on the following logic:

a. Stakeholder groups represented by a council or committee were allocated two representatives. These councils or committees represent multiple stakeholder groups.

b. Stakeholder groups represented by one organization (e.g., NAMI, First 5 Los Angeles, etc.) or a network of services providers (i.e., Health Neighborhoods) were allocated one representative. These entities represent a specific stakeholder group (e.g., an organizations, a network of service providers, etc.).

c. Stakeholder groups that are not represented by an entity (i.e., Community health Workers/*Promotoras*, Peer Support Specialists, Veterans, etc.) were allocated two representatives to ensure diverse voices for these groups.

d. Stakeholder groups representing people with lived and/or living experience with mental health issues (and now with substance use challenges) and/or caregivers, family members, partners, etc., were allocated two representatives to ensure diverse voices and perspectives.

STAKEHOLDER CATEGORIES & REPRESENTATIVES

Stakeholder Category	Number
1. Community Leadership Team	30
2. Community Stakeholder Groups	53
3. County Departments	17
4. Education System	5
5. Government/Quasi-Government Agencies	13
Total	118

STAKEHOLDER CATEGORY 1: COMMUNITY LEADERSHIP TEAM

1. **Service Area Leadership Teams (SALTs)**

Service Area Leadership Teams (SALT)	Number
1. Service Area Leadership Team 1	2
2. Service Area Leadership Team 2	2
3. Service Area Leadership Team 3	2
4. Service Area Leadership Team 4	2
5. Service Area Leadership Team 5	2
6. Service Area Leadership Team 6	2
7. Service Area Leadership Team 7	2
8. Service Area Leadership Team 8	2
Total	16

2. **Underserved Cultural Communities (USCCs*)***

Underserved Cultural Communities	Number
1. Access 4 All	2
2. American Indian/Alaskan Native	2
3. Asian Pacific Islander	2
4. Black and African Heritage	2
5. Eastern European/Middle Eastern	2
6. Latino	2
7. LGBTQIA2-S	2
Total	14

STAKEHOLDER CATEGORY 2: COMMUNITY STAKEHOLDERS[6]

1. Community Stakeholder Groups

Community Stakeholder Groups	Number
2. Area Agencies on Aging	1
3. Association of Community Human Service Agencies (ACHSA)	1
4. Community Health Workers/*Promotoras*	2
5. Cultural Competency Committee	2
6. Eligible Adults	2
7. Eligible Older Adults	2
8. Faith-Based Advocacy Council	2

[6] The state-required Independent Living Centers are included as part of the Housing stakeholder groups and Emergency Medical Services are included as part of the Hospitals and Firefighters/First Responders stakeholder groups.

9. Families and/or caregivers of eligible children and youth, eligible adults, and eligible older adults	2
10. First 5 Los Angeles/Early Childhood Organizations	1
11. Homelessness/People Experiencing Homelessness	2
12. Housing Providers	2
13. Housing System (Housing First & Recovery-Oriented Housing	2
14. Los Angeles County Client Coalition	1
15. Los Angeles County Mental Health Commission	2
16. National Alliance for Mental Illness (NAMI)	1
17. Peer Advisory Council (Mental Health)	2
18. Peer Support Specialists	2
19. People with lived experience with substance use (inclusive of family and/or partner representation)	6
20. Service Providers (Non-ACHSA)	2
21. Substance Use Prevention	2
22. Substance Use Harm Reduction	1
23. Substance Use Treatment	3
24. Unions/Labor Representative Organizations	4
25. Veterans	2
26. Veterans Organization	1
27. Youth Mental Health Council (25 and under)	2
28. Youth Substance Use Peer Council (25 and under)	2
Total	53

2. Health Neighborhoods

Health Neighborhoods	Number
1. SA 1 – Health Neighborhood	1
2. SA 2 – Health Neighborhood (Northeast San Fernando Valley)	1
3. SA 2 – Health Neighborhood (Panorama City/Van Nuys)	1
4. SA 3 – Health Neighborhood (El Monte)	1
5. SA 3 – Health Neighborhood (East San Gabriel Valley)	1
6. SA 4 – Health Neighborhood (Boyle Heights)	1
7. SA 5 – Health Neighborhood (Palms/Mar Vista)	1
8. SA 5 – Health Neighborhood (Venice/Marina Del Rey)	1
9. SA 5 – Health Neighborhood (Pico/Robertson)	1
10. SA 6 – Health Neighborhood	1
11. SA 7 – Health Neighborhood	1
12. SA 8 – Health Neighborhood	1
Total	12

STAKEHOLDER CATEGORY 3: COUNTY DEPARTMENTS

County Departments	Number
1. CEO	1
2. CEO Anti-Racism, Diversity & Inclusion	1
3. Department of Aging and Disability	1
4. Department of Children and Family Services	1
5. Department of Health Services	1
6. Department of Justice, Care & Opportunities Department	1
7. Department of Military and Veterans Affairs	1
8. Department of Public Health	2
9. Department of Public Social Services	1
10. Department of Youth Development	1
11. Firefighters/First Responders	1
12. Libraries	1
13. Parks and Recreation	1
14. Probation/Juvenile Justice	1
15. Public Defender	1
16. Sheriff	1
Total	17

STAKEHOLDER CATEGORY 4:
EDUCATION SYSTEM

Entities	Number
1. California State University	1
2. Los Angeles County Office of Education	1
3. Los Angeles Community College District	1
4. Los Angeles Unified School District	1
5. University of California	1
Total	5

STAKEHOLDER CATEGORY 5:
LOCAL GOVERNMENTS AND/OR QUASI-GOVERNMENTS

Local Governments and/or Quasi-Governments	Number
Local Public Health Jurisdictions	
1. Long Beach	1
2. Pasadena	1
Most Populous Cities	
1. Glendale	1
2. Lancaster	1

3. Long Beach	1
4. Los Angeles	1
5. Santa Clarita	1
Quasi-Governments	
1. Disability Insurers	1
2. Health Care Organizations/Hospitals	1
3. Los Angeles Homeless Services Authority	1
4. Managed Care Plans	1
5. Regional Centers	1
6. Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes	1
Total	13

PROPOSAL: ENGAGEMENT AGREEMENTS

COLLABORATIVE PRACTICES & COMMUNICATION EXPECTATIONS

Over the course of the past three years, the MHSA CPT members have developed and used the following 'collaborative practices' and 'communication expectations' to encourage and support respectful, creative, and productive interaction among all BHSA CPT members, including County staff. The Collaborative Practices cover four areas to guide the relationship between DMH (and now DPH) and CPT members.

Areas	Practices
Meaningful Engagement	Engage community stakeholders in a meaningful way that includes the following conditions: 1. Establish a clear purpose, phases, and objectives for the overall community planning process; 2. Reach out to a broad range of community and systems stakeholders to participate in the process; 3. Involve stakeholders in generating data, analyzing information, and issuing recommendations versus simply asking them to endorse already made decisions; 4. Provide enough information on a given proposal in order to issue an informed recommendation (e.g., population served, geographical area, funding amount, budget, etc.); 5. Give participants enough time to review materials in advance of meetings; 6. Make progress from meeting to meeting towards the stated objectives within a reasonable timeline, so that participants are not rushed to making decisions; 7. Ensure respect and decorum during the meetings, free of personal attacks; and 8. Loop back with community stakeholder groups to communicate a decision and/or plan.
Effective Communication & Efficient Coordination	Meaningful participation depends heavily on effective communication and efficient coordination that includes: 1. Enough advance notice of meeting dates and times; 2. Sufficient and relevant information in plain language; 3. Translated materials at the same time as English materials; 4. Information provided on a timely basis at least one week before the meetings; 5. Avoid setting meetings that structurally conflict with existing community stakeholder meetings that are known to the DMH (e.g., SALT meetings, UsCC meeting, etc.). 6. A centralized email address where a staff person can answer questions;

	7. Maintain an updated, centralized list of participants to ensure everyone is receiving information.
Accessible Meetings	Ensure the following conditions at all meetings to eliminate barriers to full participation: 1. Offer financial support to consumers/clients to offset costs of participation (e.g., transportation, etc.). 2. Use different ways to engage each other in meetings, e.g., different locations and times, and modes of access (e.g., in-person, online, etc.). 3. Offer interpretation (ASL, Spanish, Korean, and other threshold languages) and CART services at every meeting. 4. Provide materials in the appropriate font size for those who request it. 5. Ensure contrast between text and background (avoid light text on light background, or dark text on dark background). 6. Embed titles/descriptions when using pictures (including graphs and diagrams). 7. Provide food if meetings are more than two hours.

The Communication Expectations guide the interaction and communication among everyone involved in the CPT meetings.

1. BE PRESENT: Be on time and do your best to participate and engage each other in the spirit of conversation and learning.

2. SPEAK FROM YOUR OWN EXPERIENCE: Sharing views that are rooted in your experiences helps us build community. It helps all of us find areas where we can relate and connect with each other.

3. PRACTICE CONFIDENTIALITY: The practice of respecting and protecting sensitive information that people share with you helps to builds trust.

4. STEP UP, STEP BACK: To ‘step up’ means to being willing to share your thoughts and experiences with others so that your voice is part of the conversation. To ‘step back’ means being aware and mindful that others also need time to speak, and that some people take a little longer to compose their thoughts.

5. SEEK TO UNDERSTAND AND THEN BE UNDERSTOOD: Ask questions to understand someone’s view before expressing your view. This helps everyone feel heard and prevent misunderstandings.