2026 - 2029 Integrated Plan

Los Angeles County

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan .

General Information

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.A. General Information .

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
Los Angeles County

Behavioral Health Agency Name
Los Angeles County: Department of Mental Health and Department of Public Health: Substance Abuse Prevention and Control

Behavioral Health Agency Mailing Address
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Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

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Behavioral Health Services Act (BHSA) Coordinator

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Substance Abuse and Mental Health Services Administration (SAMHSA) liaison

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Quality Assurance or Quality Improvement (QA/QI) lead

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Medical Director

Name	Email address
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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).

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.E.2 General Requirements.

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

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**.

Criteria	**Number of Children and Youth Under Age 21**
Received Medi-Cal Specialty Mental Health Services (SMHS)	85700
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	2092
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

Criteria	Number of Children and Youth Under Age 21
Were chronically homeless or experiencing homelessness or at risk of homelessness	6277
Were in the juvenile justice system	526
Have reentered the community from a youth correctional facility	2340
Were served by the Mental Health Plan and had an open child welfare case	17562
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	110
Have received acute psychiatric care	4158

Adults and Older Adults

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**.

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	5082

Criteria	Number of Adults and Older Adults
Received Medi-Cal SMHS	117900
Received DMC or DMC-ODS services	29800
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	9482
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	29076
Experienced unsheltered homelessness	16374
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	7575
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	337
Were in the justice system (on parole or probation and not currently incarcerated)	11774
Were incarcerated (including state prison and jail)	58349

Criteria	Number of Adults and Older Adults
Reentered the community from state prison or county jail	31980
Received acute psychiatric services	19167

Input the number of persons in designated and approved facilities who were

Admitted or detained for 72-hour evaluation and treatment rate
50507

Admitted for 14-day and 30-day periods of intensive treatment
35809

Admitted for 180-day post certification intensive treatment
000

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
1814

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
000

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

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.

If desired, provide documentation on the local data used during the planning process

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Does the county behavioral health system use an Electronic Health Record (EHR)?
Yes

Please select which of the following EHRs the county uses
Netsmart

County participates in a Qualified Health Information Organization (QHIO)?
Yes

Please select which QHIO the county participates in
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.

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/

Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

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

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

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?
Yes

Please select all services the county behavioral health system plans to provide under the PATH grant
Alcohol or Drug Treatment Services
Case Management Services
Community Mental Health Services
Habilitation and Rehabilitation Services
Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services
Outreach 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

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)

Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period?
Yes

Please select all set asides that the county behavioral health system plans to participate in 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

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)

Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period?
Yes

Please select all set-asides that the county behavioral health system participates in under SUBG
Adolescent/Youth Set-Aside
Discretionary
Perinatal Set-Aside
Primary Prevention Set-Aside

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

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?
Yes

Please check all set asides the county behavioral health system participates in 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
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
Connect People Who Need Help to The Help They Need (Connections to Care)

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).
a. Case Management
b. Comprehensive Evaluation and Assessment
c. Group Services
d. Individual Service Plan
e. Medication Education and Management

f. Pre-crisis and Crisis Services
g. Rehabilitation and Support Services
h. Residential Services
i. Services for Homeless Persons
j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:
Not Applicable

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

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 (no action required).

a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services
j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management
m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21
q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21
s. Therapeutic Behavioral Services for individuals under the age of 21
t. Therapeutic Foster Care for individuals under the age of 21
u. All Other Medically Necessary SMHS for individuals under the age of 21

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?

Clubhouse Services
Enhanced CHW Services
Peer Support Services

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)

Select which of the following services the county behavioral health system participates in 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 American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition). (no action required)
a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
f. Mobile Crisis Services
g. Recovery Services
h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
i. Traditional Healers and Natural Helpers
j. Withdrawal Management Services
k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21
l. Early Intervention for individuals under age 21

Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below 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)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs

Program or service
DMH - 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

DMH - Housing and Homelessness Incentive Program

DMH - Child and Youth Behavioral Health Initiative Grant

DMH - Community Care Expansion Preservation Grants Program

DMH - Temporary Personnel Services-SAMHSA Emergency Response Grant

DMH - Mental Health Student Services Act Grant (MHSSA Grant)

DMH - SAMHSA-SERG Grant: Los Angeles County Recovery Efforts and Building Urgency into Implementation of Long-Term Disaster Support

SAPC -Non-DMC-ODS SUD prevention, youth, and perinatal services (funded through the federal Substance Use Block Grant.

SAPC -Overdose surveillance and reporting (funded through the federal CDC Overdose Data to Action grant)

SAPC -Women and Children's Residential Treatment Services (funded through state AB188/SB1020)

SAPC - 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)

SAPC- Permanent Supportive Housing rental subsidies and services including on-site outreach, assessment, and service navigation (LA County Measure H funding)

SAPC-Driving Under the Influence (DUI) programs (funded through state DUI funds)

SAPC - 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)

SAPC - Interim Housing Outreach Program (IHOP) services: education, engagement, navigation, and harm reduction services (funded through MHSA innovations funding)

Care Transitions

Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services **(Adult and Youth)?**
Yes

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

All fields must be completed unless marked as optional. You don't need to finish everything at once-your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to, please see 3.E.6 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.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures.

Mark page as complete

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: Primary measures

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity
Sex

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

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity
Sex

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

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

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

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Access to care: Disparities Analysis

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

Access to care: Cross-Measure Questions

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

DMH is working to improve access to care through the following programs and services: Clubhouse Full-Service Partnership (ACT/FACT & FSP-ICM) Peer Respite Crisis Residential Treatment Program (CRTP) Crisis Stabilization Enriched Residential Services (ERS) Law Enforcement Teams (LET) Day Treatment Intensive / Day Rehabilitation (DTI/DR) RPI-LA Program/Coordinated Specialty Care – First Episode Psychosis Service Child Medical Hubs Specialized Foster Care (SFC) Multidisciplinary Assessment Team (MAT) Hollywood 2.0 Veteran & Military Family Services (VMFS) Women's Wellbeing (WWC) Therapeutic Shelter Homes (TSHs) Qualified Individual (QI) TAYD - Credible Messengers First 5 - Home Visitation DCFS - Prevention and Aftercare Dept. of Arts & Culture - Creative Wellbeing Antelope Valley Community Family Resource Centers (CFRC on wheels) Community Family Resource Centers Friends of the Children (FOTC) Wolf Connection Promotores Community Partners - United MH Promoters NAMI Urban LA & Greater LA NEED LA Birth to Five Mental Health Parental Perinatal Mental Health Parent Partner Academy Suicide Prevention, Intervention and Postvention Co-Occurring Intellectual/Developmental Disabilities MHP 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 are 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

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Please identify the 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

Please describe other
County General Fund, EPSDT/Medi-cal, Medicaid Expansion, MCHIP

Homelessness: Primary measures

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

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

What disparities did you identify across demographic groups or special populations?
Gender
Race or Ethnicity

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

How does your county status compare to the statewide rate?
Below

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

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

What disparities did you identify across demographic groups or special populations?
Gender
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

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

What disparities did you identify across demographic groups or special populations?
Gender
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.)

How does your local CoC's rate compare to the average rate across all CoCs?
Above

What disparities did you identify across demographic groups or special populations?
Gender
Race or Ethnicity

Homelessness: Disparities Analysis

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: Cross-Measure Questions

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)

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 FACT: 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. SP-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: PH2 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

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Please identify the category or categories of funding that the county is using to address the homelessness goal

BHSA FSP
BHSA BHSS
BHSA Housing Interventions
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SUBG
MHBG
Other

Please describe other

Opioid Settlement Funds (OSF), Measure J: Care First Community Investment (CFCI), Tobacco Settle Funds, Federal Grant: CDC OD2A

Institutionalization

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

How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity
Gender

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

14-day involuntary detention rates per 10,000
Not Applicable

30-day involuntary detention rates per 10,000
Not Applicable

180-day post-certification involuntary detention rates per 10,000
Not Applicable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Conservatorships, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

Temporary Conservatorships
Not Applicable

Permanent Conservatorships
Not Applicable

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
Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

How does your county status compare to the statewide rate/average?

Crisis Intervention

For adults/older adults
Above

For children/youth
Above

Crisis Residential Treatment Services

For adults/older adults
Above

For children/youth
Same

Crisis Stabilization

For adults/older adults
Below

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Sex
Race or Ethnicity

Institutionalization: Disparities Analysis

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

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current 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.

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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 count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

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/FACT & FSP-ICM) 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. ACT helps individuals manage symptoms, function in the community, obtain and maintain employment and housing, and build strong social relationships. FACT: An ACT variant with additional training and staffing to address the needs of justice-involved members; teams often deliver both ACT and FACT. FACT includes a team 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: 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

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Please identify the category or categories of funding that the county is using to address the institutionalization goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
MHBG
Other

Please describe other
EPSDT/Medi-cal

Justice-Involvement: Primary Measures

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

How does your county status compare to the statewide rate/average?

For adults/older adults
Below

For juveniles
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity
Sex

Justice-Involvement: Supplemental Measures

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

How does your county status compare to the statewide rate/average?
Below

What disparities did you identify across demographic groups or special populations?
Gender
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.

How does your county status compare to the statewide rate/average?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Justice-Involvement: Disparities Analysis

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. ☒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

Justice-Involvement: Cross-Measure Questions

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)

DMH is working to decrease justice involvement through the following programs and services:•Full-Service Partnership (ACT/FACT & FSP-ICM)•ACT •FACT (Forensic ACT)•FSP-ICM•Peer Respite.•ICRP •Clubhouse•Crisis Residential Treatment Program •Crisis Stabilization•Law Enforcement Teams •Mental Health Court Linkage•Day Treatment Intensive/Day Rehabilitation (DTI/DR)•FEPI-LA Early Psychosis/Coordinated Specialty Care – First Episode Psychosis•Enriched Residential Services•TAY - Credible Messengers•Community Partners - United MH Promoters (contracted)•CMHP: •Co-Occurring Intellectual/Developmental Disabilities •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

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Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
MHBG
SUBG
Other

Please describe other
Opioid Settlement Funds, Care First Community Investment (CFCI), Tobacco Settle 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: Primary Measures

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

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity
Sex

Removal Of Children from Home: Supplemental Measures

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

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity
Sex

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Removal Of Children from Home: Disparities Analysis

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 PERSPECTIVESactors 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.verarching 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

Removal Of Children from Home: Cross-Measure Questions

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

DMH is working to decrease removal of children from home through the following programs and services:•Specialized Foster Care 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 FSP including High Fidelity Wraparound.•Children and Youth Wellbeing Services provides targeted, comprehensive care for children, youth, and TAY ages birth through 25 years identified with complex mental health conditions who meet criteria to access Specialty Mental Health Services.•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 and Parents as Teachers are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. 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 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 are 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. 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 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.•The United Mental Health Promoters program aims to lessen mental health stigma throughout LA County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with DMH 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 HealthTeam provides capacity building support including workshops, technical assistance, and reflective consultation to help clinicians effectively support young

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Please identify the category or categories of funding that the county is nusing to address the removal of children from home goal
BHSA BHSS
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SUBG
Other

Please describe other
EPSDT/Medi-cal

Untreated Behavioral Health Conditions: Primary Measures

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

How does your county status compare to the statewide rate/average?

For the full population measured
Below

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

How does your county status compare to the statewide rate/average?

For the full population measured
Below

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

How does your county status compare to the statewide rate?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity
Sex

Untreated Behavioral Health Conditions: Disparities Analysis

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 PERSPECTIVESactors 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

Untreated Behavioral Health Conditions: Cross-Measure Questions

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 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 count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

DMH is working to decrease untreated behavioral health conditions through the following programs and services: •Crisis Stabilizationmay 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 provides stabilization as an alternative to emergency services and acute psychiatric facilities, ensuring access to higher-acuity settings for those in greater need.•Law Enforcement Teams (LET) 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 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 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 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 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) 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.• 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

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Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal
BHSA BHSS
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SUBG
Other

Please describe 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 Settle 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.

For related policy information, refer to E.6.2 Primary and Supplemental Measures .

Care Experience: Primary Measures

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

How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For children/youth
Above

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

How does your county status compare to the statewide rate/average?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Engagement In School: Primary Measures

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

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

How does your county status compare to the statewide rate/average?
Below

Student Chronic Absenteeism Rate (Data Quest), 2022

How does your county status compare to the statewide rate/average?
Above

Engagement In Work: Primary Measures

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

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

How does your county status compare to the statewide rate/average?
Below

Overdoses: Primary Measures

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

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Overdoses: Supplemental Measures

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

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

How does your county status compare to the statewide rate/average?

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)
Below

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

How does your county status compare to the statewide rate/average?

For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)
Above

For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)
Above

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Not Applicable

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Quality Of Life: Supplemental Measures

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

How does your county status compare to the statewide rate/average?

For the full population measured
Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Not Applicable

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

How does your county status compare to the statewide rate/average?
Below

Suicides: Primary Measures

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

Suicides: Supplemental Measures

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

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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.
Engagement in school

Engagement in school

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.

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

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 school and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

DMH is working to increase engagement in schools through the following programs: risis 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. YD - 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. irst 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. CFS - 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.ntelope 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. FRCs (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. riends 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. romotores: 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. ommunity 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 EED 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. CLA 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.irth 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.erinatal 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

Please identify the category or categories of funding that the county is using to address this goal

BHSA BHSS
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SUBG
Other

Please describe other

Opioid Settlement Funds, EPSDT/Medi-cal

Community Planning Process

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.B Community Planning Process .

Stakeholder Engagement

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

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Please indicate the type of engagement used to obtain input on the planning process

Training, education, and outreach related to community planning
Survey participation
Public e-mail inbox submission
Focus group discussions
Key informant interviews with subject matter experts
Workgroups and committee meetings

Include date(s) of stakeholder engagement for each type of engagement

Type of engagement

Training, education, and outreach related to community planning

Date

6/10/2025

Type of engagement

Training, education, and outreach related to community planning

Date

6/27/2025

Type of engagement
Training, education, and outreach related to community planning

Date
7/8/2025

Type of engagement
Training, education, and outreach related to community planning

Date
7/25/2025

Type of engagement
Training, education, and outreach related to community planning

Date
8/12/2025

Type of engagement
Training, education, and outreach related to community planning

Date
8/29/2025

Type of engagement
Training, education, and outreach related to community planning

Date
9/9/2025

Type of engagement
Training, education, and outreach related to community planning

Date
10/14/2025

Type of engagement
Training, education, and outreach related to community planning

Date
10/31/2025

Type of engagement
Training, education, and outreach related to community planning

Date
11/14/2025

Type of engagement
Training, education, and outreach related to community planning

Date
11/18/2025

Type of engagement
Training, education, and outreach related to community planning

Date
1/14/2025

Type of engagement
Training, education, and outreach related to community planning

Date
12/9/2025

Type of engagement
Training, education, and outreach related to community planning

Date
1/28/2026

Type of engagement
Training, education, and outreach related to community planning

Date
9/29/2025

Type of engagement
Training, education, and outreach related to community planning

Date
10/17/2025

Type of engagement
Training, education, and outreach related to community planning

Date
4/25/2025

Type of engagement
Training, education, and outreach related to community planning

Date
4/8/2025

Type of engagement
Training, education, and outreach related to community planning

Date
3/11/2025

Type of engagement
Training, education, and outreach related to community planning

Date
1/31/2025

Type of engagement
Training, education, and outreach related to community planning

Date
1/14/2025

Type of engagement
Workgroups and committee meetings

Date
12/9/2025

Type of engagement
Workgroups and committee meetings

Date
11/19/2025

Type of engagement
Workgroups and committee meetings

Date
10/14/2025

Type of engagement
Workgroups and committee meetings

Date
9/9/2025

Type of engagement
Workgroups and committee meetings

Date
8/29/2025

Type of engagement
Workgroups and committee meetings

Date
7/25/2025

Type of engagement
Workgroups and committee meetings

Date
7/8/2025

Type of engagement
Workgroups and committee meetings

Date
6/10/2025

Type of engagement
Survey participation

Date
1/14/2025

Type of engagement
Survey participation

Date
1/31/2025

Type of engagement
Survey participation

Date
3/11/2025

Type of engagement
Survey participation

Date
4/25/2025

Type of engagement
Survey participation

Date
7/25/2025

Type of engagement
Survey participation

Date
8/29/2025

Type of engagement
Survey participation

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Survey participation

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Survey participation

Date
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Type of engagement
Survey participation

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Type of engagement
Survey participation

Date
1/14/2025

Type of engagement
Public e-mail inbox submission

Date
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Type of engagement
Public e-mail inbox submission

Date
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Type of engagement
Public e-mail inbox submission

Date
3/11/2024

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Public e-mail inbox submission

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Type of engagement
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Public e-mail inbox submission

Date
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Type of engagement
Public e-mail inbox submission

Date
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Type of engagement
Public e-mail inbox submission

Date
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Public e-mail inbox submission

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Date
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Type of engagement
Public e-mail inbox submission

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Type of engagement
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Date
10/14/2025

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Date
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Type of engagement
Public e-mail inbox submission

Date
11/14/2025

Type of engagement
Public e-mail inbox submission

Date
11/18/2025

Type of engagement
Public e-mail inbox submission

Date
11/19/2025

Type of engagement
Public e-mail inbox submission

Date
12/19/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/28/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/31/2025

Type of engagement
Key informant interviews with subject matter experts

Date
7/25/2025

Type of engagement
Key informant interviews with subject matter experts

Date
7/8/2025

Type of engagement
Focus group discussions

Date
1/14/2025

Type of engagement
Focus group discussions

Date
2/11/2025

Type of engagement
Focus group discussions

Date
2/28/2025

Type of engagement
Focus group discussions

Date
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Type of engagement
Focus group discussions

Date
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Type of engagement
Focus group discussions

Date
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Type of engagement
Focus group discussions

Date
7/25/2025

Type of engagement
Focus group discussions

Date
8/29/2025

Type of engagement
Focus group discussions

Date
10/14/2025

Type of engagement
Focus group discussions

Date
10/17/2025

Type of engagement
Focus group discussions

Date
10/31/2025

Type of engagement
Focus group discussions

Date
11/18/2025

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
•Avalon Carver Community Center Aviva Family and Children's Services Harbour and Floyd Medical Associates Hartz-Altadonna Community Health Center Hayfront Youth & Family Services Hayfront 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 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

What are the five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State)

	City name
1	Los Angeles
2	Long Beach
3	Santa Clarita
4	Glendale
5	Lancaster

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

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

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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 .

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

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.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?

No

Collaboration

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.

Please describe the other way the county collaborated with LHJs and MCPs in developing the CHA/CHIP
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

Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP
Overdoses
Other

Please describe
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).

Was data shared?
No

Data-Sharing from MCPS and LHJs to Support IP development

Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development
Other

Please describe
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).

Was data shared?
No

Stakeholder Activities

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

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

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP

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 .

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.

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

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Comment Period and Public Hearing

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

Date the draft Integrated Plan (IP) was released for stakeholder comment
2/11/2026

Date the stakeholder comment period closed
3/13/2026

Date of behavioral health board public hearing on draft IP
4/9/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
Link

Please provide the link to the public posting
https://dmh.lacounty.gov/about/mhsa/announcements/

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
https://dmh.lacounty.gov/about/mhsa/announcements/

File Upload

Please select the process by which the draft plan was circulated to stakeholders
Other

Please specify the other process the draft plan was circulated to stakeholders
The draft Integrated Plan (IP) will be posted publicly on February 11, 2026. The draft IP will be circulated to stakeholders through public posting and email outreach. The IP Portal will be updated accordingly.

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table

Stakeholder group that provided feedback
N/A

Summarize the substantive revisions recommended this stakeholder during the comment period
N/A

Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A.

Substantive recommendations
N/A

County Behavioral Health Services Care Continuum

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

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.

Mark section as complete

County Provider Monitoring and Oversight

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 6.C.2 Securing Medi-Cal Payment .

Medi-Cal Quality Improvement Plans

Cities submitting their Integrated Plan independently from their counties do not have to complete this section or Question 1 under All BHSA Provider Locations.

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

Los Angeles County QAPI Work Plan 2025.pdf

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

For standalone DMC-ODS, please upload a copy of the county's current QIP for SFY 2026-2027

Los Angeles County QAPI Work Plan 2025.pdf

Contracted BHSA Provider Locations

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.)

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

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

Services Provided	**Number of Contracted BHSA Provider Locations**
SMHS only	624
DMC/DMC-ODS only	168

Services Provided	Number of Contracted BHSA Provider Locations
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 .

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?

23

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

In alignment with CalAIM TOC, clients who no longer meet specialty mental health criteria should be transitioned back to the MCPs (i.e., specialty services would be denied). If ongoing work with the client is desired, the provider must contract with the MCPs to become a NSMH (Non-Specialty Mental Health) provider. This transition would enhance continuity of care for clients.

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**

Does the county wish to describe implementation challenges or concerns with these requirements?

No

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:

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

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

Behavioral Health Services Act/Fund Programs

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

Behavioral Health Services and Supports (BHSS)

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

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General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan

Workforce, Education and Training (WET)
Capital Facilities and Technological Needs (CFTN)
Adult and Older Adult System of Care (non-FSP)
Outreach and Engagement (O&E)
Early Intervention Programs (EIP)

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

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. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services

Please describe the specific services provided

Program #1: Outpatient Care Services 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, 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, housing, 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.

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

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	117925
FY 2027 – 2028	119104
FY 2028 – 2029	120295

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.

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

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. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program
Mental health services

Please describe the specific services provided
Program #2: Mobile Crisis Response 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.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	12968
FY 2027 – 2028	13097
FY 2028 – 2029	13227

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 (EI) Programs

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 .

Program or service name
Children and Youth Wellbeing Services (CYWS)

Please select which of the three 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

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

Please select the EBPs and CDEPs that apply
Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)
Brief Strategic Family Therapy (BSFT)
Child Parent Psychotherapy (CPP)
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Depression Treatment Quality Improvement (DTQI)
Family Centered Treatment
Family Connections (FC)
Functional Family Therapy (FFT)
Incredible Years
Multidimensional Family Therapy (MDFT)
Multisystemic Therapy (MST)
Nurturing Parenting Program (NP)
Parent Child Interaction Therapy (PCIT)
Portland Identification Early Referral Model (PIER)
Reflective Parenting Program (RPP)
The Strengthening Families Programs (SFP)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
N/A

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.

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

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	83040
FY 2027 – 2028	83870
FY 2028 – 2029	84708

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.

Early Intervention (EI) Programs

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 .

Program or service name
Screening and Linkage

Please select which of the three EI components are included as part of the program or service
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals

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

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.

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

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	9053
FY 2027 – 2028	9143
FY 2028 – 2029	9234

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.

Early Intervention (EI) Programs

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 .

Program or service name
Outreach and Engagement

Please select which of the three EI components are included as part of the program or service
Access and Linkage: Screenings
Outreach
Access and Linkage: Assessments
Access and Linkage: Referrals

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

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.

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

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	171000
FY 2027 – 2028	172710
FY 2028 – 2029	174437

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. Numbers were derived using reporting from previous MHSA Annual Update for Prevention programming.

Early Intervention (EI) Programs

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 .

Program or service name
Mobile Response

Please select which of the three 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

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

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.

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

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	5693
FY 2027 – 2028	5749
FY 2028 – 2029	5806

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Included individuals served by Mobile Response. 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 .

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

CSC program name

Coordinated Specialty Care for First Episode Psychosis (formerly known as PIER and EPI-LA)

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.

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. 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. These projections are not binding and are for planning purposes. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements

Please review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county in the table below.

CSC Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	1604
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

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 and non-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.

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

Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?
Yes

Please list the other funding source(s)
Medi-cal, 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 .

Program or activity name
Navigation

Please describe the program or activity
Engagement with community referral sources to assist individuals in accessing outpatient care, including linkage to the Full Service Partnership program.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2874
FY 2027 – 2028	2902
FY 2028 – 2029	2931

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 .

Program or activity name

Training and Technical Assistance

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

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.

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 .

Program or activity name
Residency and Internship

Please select which of the following categories the activity falls under
Internship and Apprenticeship Programs

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
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.

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 .

Program or activity name
Financial Incentives

Please select which of the following categories the activity falls under
Retention Incentives and Stipends

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
These programs assist individuals from diverse backgrounds to consider public Specialty Mental Health employment.

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 .

Program or activity name
Mental Health Career Pathways

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

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
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.

Capital Facilities and Technological Needs (CFTN) Program

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 .

Project name
High Desert CRTP

Please select the type of project
Capital facilities project

If capital facilities project, please indicate which of the following categories the project falls under
Meeting match requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award

Please describe the project
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.

Capital Facilities and Technological Needs (CFTN) Program

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 .

Project name
Jacqueline Avant Children and Family Center

Please select the type of project
Capital facilities project

If capital facilities project, please indicate which of the following categories the project falls under
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.

Please indicate if the project involves leasing or renting to own a building
No

Please describe the project
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.

Capital Facilities and Technological Needs (CFTN) Program

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 .

Project name
LA General Urgent Care (UCC)

Please select the type of project
Capital facilities project

If capital facilities project, please indicate which of the following categories the project falls under
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.

Please indicate if the project involves leasing or renting to own a building
No

Please describe the project
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.

Capital Facilities and Technological Needs (CFTN) Program

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 .

Project name
East San Gabriel Valley Clubhouse

Please select the type of project
Capital facilities project

If capital facilities project, please indicate which of the following categories the project falls under

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.

Please indicate if the project involves leasing or renting to own a building

No

Please describe the project

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.

Capital Facilities and Technological Needs (CFTN) Program

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 .

Project name

System Maintenance and Upgrades

Please select the type of project

Technological needs project

If Technological Needs Project, please select 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

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

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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

Total Adult FSP Eligible Population	**Estimates**

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	29452
Number of Uninsured Individuals	5027
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	9615

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

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

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	3817
Number of Uninsured Individuals	652

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	1909
Number of Uninsured Individuals	2235

ACT/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

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 and non-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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	340	510	680
Total Number of Teams	34	51	68

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

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

FSP ICM Eligible Population	Estimates

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	23726
Number of Uninsured Individuals	4049

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	1115
Number of Teams Needed to Serve Total Eligible Population	223

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 and non-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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	400	800	1115
Total Number of Teams	80	160	223

High Fidelity Wraparound (HFW) Eligible Population

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	14519
Number of Uninsured Individuals	2902

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	2316
Number of Teams Needed to Serve Total Eligible Population	579

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 and non-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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	2316	2316	2316
Total Number of Teams	579	579	579

Individual Placement and Support (IPS) Eligible Population

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

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	3172
Number of Uninsured Individuals	1269

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

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 and non-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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	74	148	222
Total Number of Teams	37	74	111

Full Service Partnership (FSP) Program Overview

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

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?

Yes

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.

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. 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.

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.

Select which goals the county is hoping to support based on the county's allocation of FSP funding

Access to care
Homelessness
Institutionalization
Justice involvement
Removal of children from home
Untreated behavioral health conditions
Engagement in school

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.

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.

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.

Please indicate whether the county FSP program will include any of the following optional and allowable services

N/A

Primary substance use disorder (SUD) FSPs

No

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

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.

Other recovery-oriented services
Yes

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.

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. If no additional FSP services, use "N/A"
DMH is building Clubhouse model programs across LA County which can complement care.

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:

In, or at-risk of being in, the juvenile justice system
DMH has reviewed data related to TAY in need of services under FSP. MH 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.

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.

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.

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**

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.

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.

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

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.

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs

DPH-SAPC Directly Operated Field-Based SUD Services

Program descriptions

This interdisciplinary team of LA County staff partners with existing field-based teams to ensure LA County residents experiencing homelessness have access to SUD services in priority geographies.

Current funding source

Approximately $3M/year in DPH-SAPC funding

BHSA changes to existing programs to meet BHSA requirements

Provides consultation to existing field-based teams

Expected timeline of operation

Began December 2025

Mobile-field based programs

Existing programs
DPH-SAPC Directly Operated Field-Based SUD Services

Program descriptions
This interdisciplinary team of LA County staff partners with existing field-based teams to ensure LA County residents experiencing homelessness have access to SUD services in priority geographies.

Current funding source
Approximately $3M/year in DPH-SAPC funding

BHSA changes to existing programs to meet BHSA requirements
Provides consultation to existing field-based teams.

Expected timeline of operation
Began December 2025

Open-access clinics

Existing programs
On-Demand Telehealth Addiction Medication Access

Program descriptions
Provides on-demand telehealth access to medical providers who can assess and prescribe addiction medicine.

Current funding source
$500,000/year of opioid settlement funding

BHSA changes to existing programs to meet BHSA requirements
Operates on-call service staffed with medical clinicians.

Expected timeline of operation
Began March 2020

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
N/A

Program descriptions
N/A

Planned funding
N/A

Planned operations
N/A

Expected timeline of implementation
N/A

Mobile-field based programs

New programs
N/A

Program descriptions
N/A

Planned funding
N/A

Planned operations
N/A

Expected timeline of implementation
N/A

Open-access clinics

New programs
N/A

Program descriptions
N/A

Planned funding
N/A

Planned operations
N/A

Expected timeline of implementation
N/A

Medications for Addiction Treatment (MAT) Details
Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029.

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 through review of the treatment need(s) based on clients' OUD (F11.*), AUD (F10.*), and TUD (F17.*) diagnoses and receipt of medication services.

Select the following practices the county will implement 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

Please explain what other strategy the county will use
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.

What forms of MAT will the county provide utilizing the strategies selected above?
Buprenorphine
Methadone
Naltrexone
Other

Please specify other forms of MAT
Acamprosate, Disulfiram, Topiramate, Gabapentin, Baclofen, Ondansetron, Nicotine Replacement, Varenicline, Bupropion, Benzodiazepines, Barbiturates, Anticonvulsants, Bupropion, Mirtazapine, Topiramate, Methylphenidate, Dextroamphetamine/ Amphetamine, Modafinil , N-acetyl cysteine

Housing Interventions

Planning

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

System Gaps

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.**

Supportive housing
Large gap

Apartments, including master-lease apartments
Medium gap

Single and multi-family homes
Medium gap

Housing in mobile home communities
Small gap

(Permanent) Single room occupancy units
Small gap

(Interim) Single room occupancy units
Small gap

Accessory dwelling units, including junior accessory dwelling units
No gap

(Permanent) Tiny homes
No gap

Shared housing
Small gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing
Large gap

(Interim) Recovery/sober living housing, including recovery-oriented housing
Large gap

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Large gap

License-exempt room and board
Small gap

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Small gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)
Small gap

Recuperative Care
Medium gap

Short-Term Post-Hospitalization housing
Small gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Small gap

Peer Respite
Medium gap

Permanent rental subsidies
Large gap

Housing supportive services
Large gap

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). 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). DPH-SAPC leverages a range of non-BHSA resources and partnerships to expand access to housing for BHSA-eligible individuals: 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. 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. 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. 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.

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.

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

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. 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. 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

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: 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 Hb., DMH will implement the following measures: 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 visd. s 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. Provide clients and DMH providers information about how to access care on a 24-hour basis. onduct integrated care planning to share information while protecting client's health information. 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. onduct Quality Assurance to monitor performance and implement corrective actions as needed. PH-SAPC response: PH-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

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. DMH provides several access points for SMHS including the following: The DMH public-facing website includes an interactive provider directory. https://dmh.lacounty.gov/pd/ Access Centers operating on a 24/7 basis to determine eligibility. 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 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. 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. 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 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.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only?
Yes

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:

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.

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

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. nThe 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. oWith 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. dThe 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.

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

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

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. pThe 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.iThe 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.nWith 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. sThe 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.

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. pThe 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.iThe 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.nWith 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

Local Housing System Engagement

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) IntegrationDPH-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 FlowReferrals 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 TrackingDPH-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.

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

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.

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.

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.

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.

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

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. 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.

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

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)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
5699

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
3418

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
2731

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.

For which setting types will the county provide rental subsidies?

Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit
Time Limited Interim Settings: Non-congregate interim housing models
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: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units

Will this Housing Intervention accommodate family housing?

Yes

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. 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. 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. . 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).

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?

Project-based
Tenant-based

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. . 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.

Total number of units funded with BHSA Housing Interventions per year

4510

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

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
4593

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. ☒. 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.

For which setting types will the county provide operating subsidies?
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)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units

Will this be a scattered site initiative?
Yes

Will this Housing Intervention accommodate family housing?
Yes

Total number of units funded with BHSA Housing Interventions per year
2953

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)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
1608

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 to potentially include all the allowable uses under Landlord Outreach and Mitigation Funds. Some stakeholder feedback included eliminating holding fees; however, Brilliant Corners' unit acquisition strategy includes holding fees. DMH has been working with another stakeholder group, the Supportive Housing Alliance with membership from non-profit developers of PSH for many years. There has been a well-documented need for funding for damage reimbursement outside of usual wear and tear by this group and others. 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. Including this category of funding will help us address this need and another significant concern by the housing developer community: rapidly increasing insurance costs. The Supportive Housing Alliance members are experiencing annual insurance cost increases of at least 25% with some as high as 550%, and deductibles rising from $10,00 to as much as $250,000 per claim. Unlike market rate developers, PSH developers cannot raise the rents to offset these costs, which has destabilized the PSH sector. Rising insurance costs and damage-related expenses contribute to financial stress, leading to troubled PSH assets and risks of bankruptcy, as seen with Skid Row Housing Trust. This funding will help protect DMH's $1 billion

Total number of units funded with BHSA Housing Interventions per year
1608

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)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
5558

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. PH-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)

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)**

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year

5684

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, assisting 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)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
Outreach and engagement will be funded under Full Service Partnership.

Anticipated number of individuals served per year
000

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
N/A

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

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

Is the county providing this intervention to chronically homeless individuals?
Yes

How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?
000

Capital Development Project

Capital Development Project Specific Information
Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project
N/A - DMH committed $30 million as capital match for HK_ projects. Although several projects have been submitted to HCD, none have been approved. Therefore we are unable to answer the following questions.

What setting types will the capital development project include?
Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments

Capacity (Anticipated number of individuals housed at a given time)
000

Will this project braid funding with non-BHSA funding source(s)?
No

Total number of units in project, inclusive of BHSA and non-BHSA funding sources
000

Total number of units funded with Housing Interventions funds only
000

Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)
7/1/2027

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
000

Have you utilized the “by right” provisions of state law in your project?
No

If you have not incorporated use of the “by right” provisions into your project, please explain why
N/A

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
The County has committed BHSA funding as the required 10% local match for the Community Care Expansion Capital Projects program.

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
468

Continuation of Existing Housing Programs

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. 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

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
Transitional Rent

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services
Undecided

Housing Deposits
No

Housing Tenancy and Sustaining Services
No

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
1/1/2026

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 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. PH-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

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

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

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 .

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

Is the county behavioral health system participating in or planning to participate in the Flex Pool?
Yes

What role does the county behavioral health system have or plan to have in the Flex Pool?
Funder
Housing Supportive Services Provider

What organization is serving as the Operator?
Brilliant Corners for DMH

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?
Yes

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
Participant Assistance Funds

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. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects .

Does the county's plan include the development of innovative programs or pilots?

Yes

Program

What Behavioral Health Services Act (BHSA) component will fund the innovative program?

Full Service Partnership

Please describe how the innovative program or pilot will help build the evidence base for the effectiveness of new statewide strategies

Hollywood 2.0 (H20): The H20 pilot 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: Care is organized as a continuous, integrated system rather than as separate programs with rigid eligibility and referral criteria; and 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 the effectiveness, scalability, and replication of similar community-based mental health strategies.

Please describe intended outcomes of the project

By implementing proposed Innovation project, LACDMH intends to provide specialized, holistic care for people with severe mental illness to help them regain stability and rebuild a sense of purpose within themselves and the community. The intended outcomes of the pilot fall into seven categories: Improved Quality of Life including increased participation in employment and education domain as well as enhanced social connectedness and community engagement. Reduction in Adverse Events, such as decreased use of emergency room utilization, hospitalization, and involvement with the criminal justice system. Improved Functional Status, with participants demonstrating greater independence, self-coordination of care, and ability to manage daily living activities. Improved Member Satisfaction with Care, reflecting increased trust, engagement, and perceived responsiveness of services to individual needs. Improved Staff Job Satisfaction, resulting from team-based care, reduced burnout and alignment with recovery-oriented practice principles. Improved Family and Larger Community Satisfaction, through better communication, reduced crisis burden, and stronger partnerships with community stakeholders. Reductions in the Overall Cost of Care, achieved by shifting from high-cost crisis services to proactive, community-based interventions that promote long-term recovery.

Program

What Behavioral Health Services Act (BHSA) component will fund the innovative program?

Full Service Partnership

Please describe how the innovative program or pilot will help build the evidence base for the effectiveness of new statewide 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.

Please describe intended outcomes of the project

By implementing the proposed Innovation project, LACDMH intends to advance a CalAIM aligned, person-centered, whole-person care mode for people experiencing homelessness (PEH) and supporting their transition to permanent housing. This approach is intended to strengthen service delivery, improve system integration, and support housing stability through the following outcomes: Increased timely access to specialty mental health services (SMHS), physical health and co-occurring SUD treatment, including improved warm handoffs and engagement for interim housing residents. Improved access to and coordination with non-specialty mental health care provided through managed care plans. Increased linkages to SUD outpatient and residential treatment services. Increased transitions from interim housing to permanent housing placements, including permanent supportive housing and other long-term housing resources. Reduced returns to homelessness following exit from interim housing, supporting housing stability and continuity of care. Decreased reliance on crisis, emergency services, and inpatient psychiatric services through earlier intervention, stabilization, and coordinated care planning. Increased workforce capacity among interim housing provider staff, including enhanced behavioral health literacy, trauma-informed care practices, and confidence in serving individuals with severe mental illness, complex health and SUDs. Improved care coordination amongst county departments, managed care organizations, and community partners. Improved system-level capacity to match residents to the appropriate level of care and permanent housing resources. Enhanced quality and consistency of care delivered within interim housing settings, aligned with person-centered, culturally

Program

What Behavioral Health Services Act (BHSA) component will fund the innovative program?

Behavioral Health Services and Supports

Please describe how the innovative program or pilot will help build the evidence base for the effectiveness of new statewide strategies

Children's Community Care Village (CCCV):

Please describe intended outcomes of the project

The Innovative Project is intended to establish a comprehensive children's mental health continuum of care through the creation of a co-located children's care village that integrates interim family housing with coordinated health and behavioral health services. The intended outcomes include:Improved access to and coordination of appropriate levels of mental health care for children, youth, and their families, resulting in improved clinical and functional outcomes.Reduced psychiatric crises and high-acuity service utilization, including decreased emergency department use and inpatient psychiatric hospitalization.Increased engagement in mental health services, including specialty mental health services, supported by intensive care coordination and the availability of culturally responsive and non-traditional therapeutic supports (e.g., creative wellbeing, neurofeedback, vocal modulation, drumming circles, peer to peer services, etc.).Improved continuity and quality of care, including smoother and timelier transitions between levels of care and reduced gaps in services.Improved educational stability and outcomes, including increased ability for children to remain in their school of origin and improved academic engagement and performance.Increased family stabilization, particularly for families experiencing crisis or homelessness, contributing to improved mental health outcomes and overall family functioning.Reduced involvement with child welfare and justice systems, including fewer out-of-home placements and decreased risk of foster care or juvenile justice involvement.Reduced family homelessness and housing instability, including fewer days of homelessness and increased pathways to stable housing.Reduced access barriers to care, including transportation-related barriers, leading to improved follow-up, continuity, and engagement in services.

Workforce Strategy

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.C.2 Securing Medi-Cal Payment.

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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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:

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**

Meets federal and state standards **for timely access to care and services, considering the urgency of the need for services.**

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.**

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

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

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
20

Upload any data source(s) used to determine vacancy rate

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Licensed Clinical Social Worker
Licensed Psychologist
Psychiatrist
Psychiatric Technician (PT)
Other qualified provider

Please describe any other key workforce gaps in the county
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.

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. High quality clinical supervision will be critically important, as a greater percentage of our clinical workforce are unlicensed and newly degreed. Our clinical workforce will need to utilize clinical data optimally to deliver high quality interventions to support recovery and facilitate movement to lower levels of care and/or graduation from Specialty Mental Health Care.

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.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?

Yes

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

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?

Yes

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

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
Yes

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.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
Yes

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.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
No

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

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve .

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section

Please upload the completed budget template
Integrated Plan Budget Template Version 1-29-26 (combined).xlsx

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

Behavioral Health Services and Supports (BHSS)
N/A

Full Service Partnership (FSP)
N/A

Housing Interventions
N/A

Enter date of last prudent reserve assessment
1/8/2026

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

BHSS
N/A

FSP
N/A

Housing Interventions
N/A

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template
Behavioral Health Director Certification Form_LAC_DRAFT IP.pdf

County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template
LAC County Administrator Form.pdf

Board of supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section

Please upload the completed Board of supervisor certification template

Mark page as complete