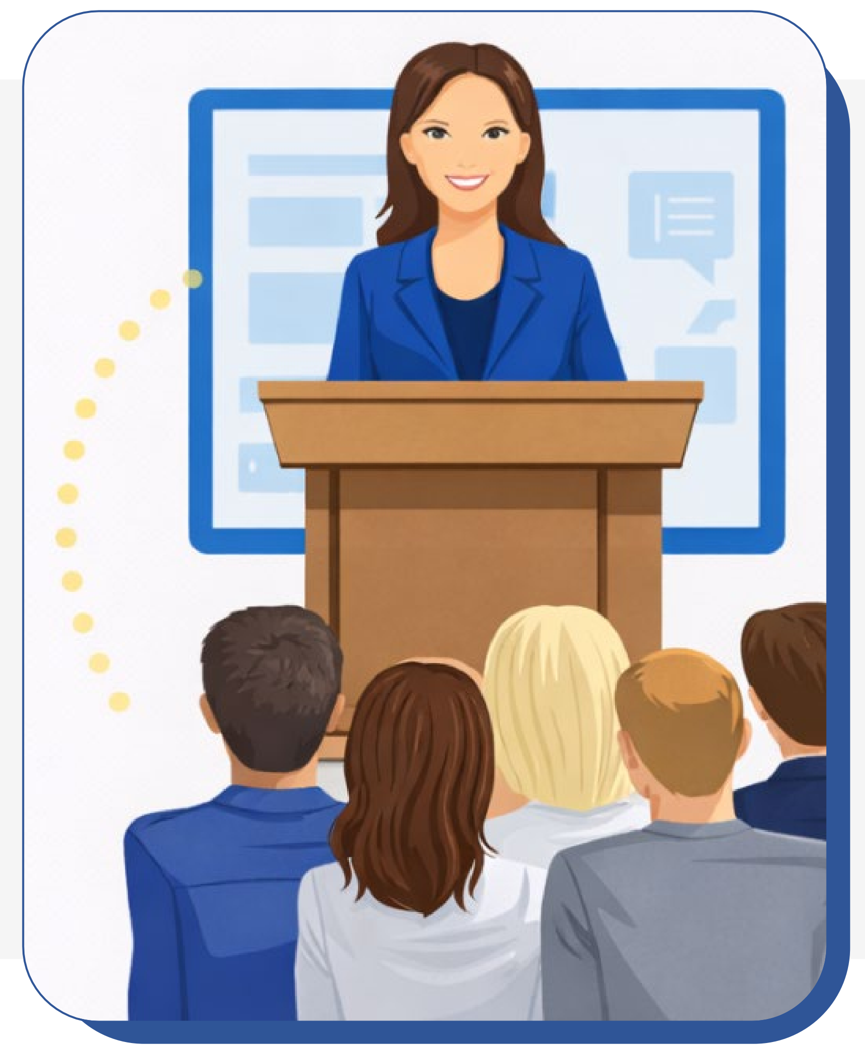
Los Angeles County

Behavioral Health Services Act (BHSA)

Three-Year Integrated Plan (FY 2026-2029)

Why We're Here Today

Sharing plan priorities and gathering public input before final approval



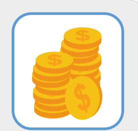
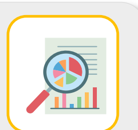
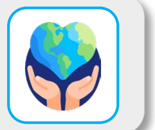
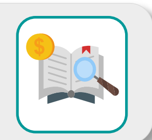
Plan Overview
Share an overview of the County's Behavioral Health Integrated Plan

Community Input
Explain how community needs and input shaped the plan

Public Comment
Receive public comment before final adoption

Why the Integrated Plan Matters

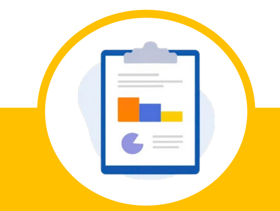
Guides how behavioral health funds are planned, spent, and evaluated

1. Three-year roadmap for how counties use all behavioral health funding
2. Combines state, federal, and local dollars into one coordinated plan 
3. Uses local data to identify mental health and substance use needs 
4. Outlines services, spending priorities, and program goals
5. Focuses on timely, high-quality, culturally responsive care 
6. Works to reduce disparities and address unmet community needs
7. Increases transparency in how funds are used 
8. Supports tracking progress toward local and statewide goals

What the BHSA Integrated Plan Includes

Three-Year Plan

How the County plans behavioral health services and funding



What's in the Plan

High-level summary of information reported

Why It Matters

Goals, priorities, and improvements we're working toward

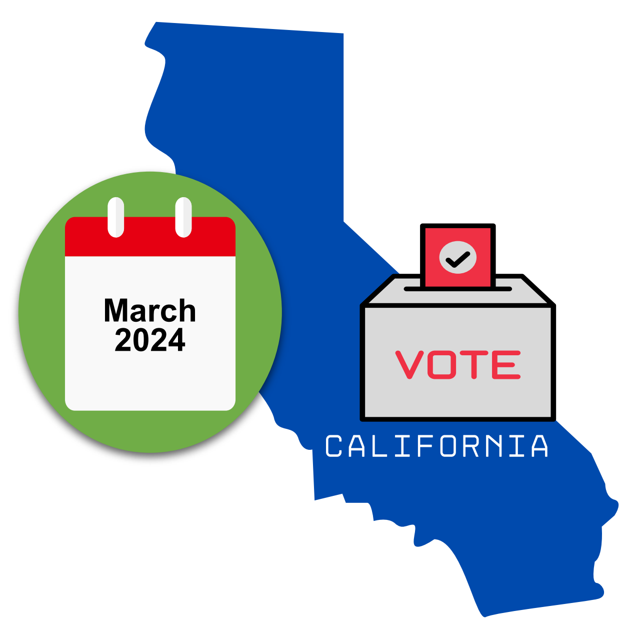
Required Under BHSA

- ✓ Required county-level plan outlining strategies and projected spending
- ✓ Aligns with the **DHCS six priority behavioral health goals**
- ✓ Mandated under the **Behavioral Health Services Act (BHSA)**
- ✓ Counties must submit:
  - **Three-Year Integrated Plan (IP)**
  - **Budget**
- ✓ First cycle covers **FY 2026–2029** (July 1, 2026 – June 30, 2029)
- ✓ Plan continues on a **recurring three-year cycle**

Behavioral
Health Services Act Overview

Key Changes Under Proposition 1

BHSA expands scope, shifts funding, and increases accountability starting July 1, 2026



March 2024: California voters passed Proposition 1, replacing Mental Health Services Act (MHSA) with Behavioral Health Services Act.

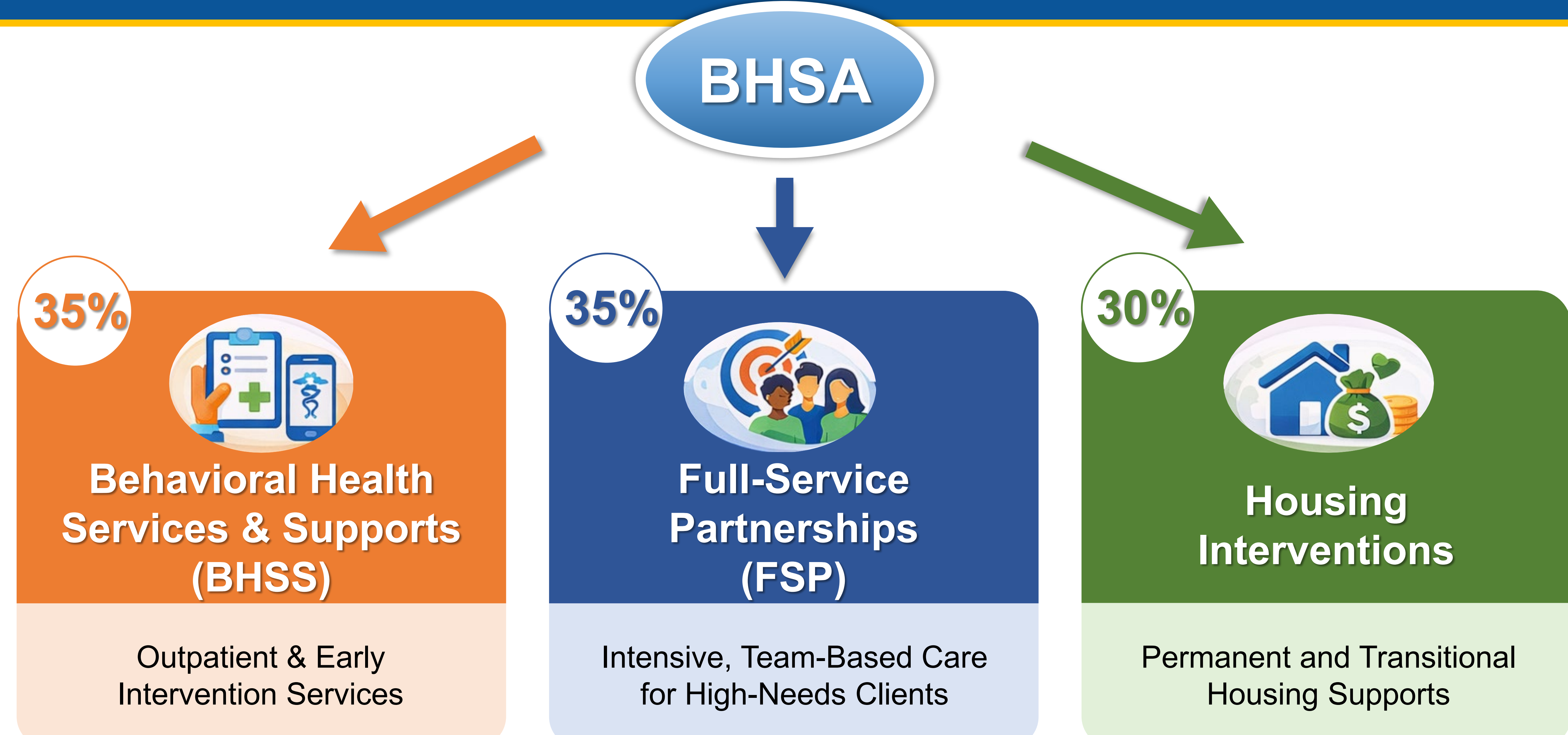
What Stayed the Same

- **MHSA Foundation Preserved**
  - Core community mental health services continue
  - Counties remain primary administrators

What Changed

- **Expanded Services**
  - Allows for investment in **substance use disorder (SUD) only** services
  - Major new **investment in housing**
  - Stronger **community engagement** requirements
- **Expanded Eligibility**
  - Expands eligible populations to include **SUD only**
- **Funding Shifts**
  - Redirects some MHSA funding from outpatient/crisis services
  - Creates **new housing funding category**
  - Transitions population-based prevention funding to the state
- **Planning & Reporting**
  - Counties must now report on **all behavioral health programs**
  - Includes mental health and substance use services
- **Oversight Expansion**
  - Behavioral Health Commission oversees mental health and substance use services
- **Implementation**
  - **Program changes begin July 1, 2026**

How BHSA Funding is Allocated



Major Program Changes Under BHSA

BHSA strengthens support for individuals with higher needs through expanded intensive services, housing investments, and early intervention, while maintaining outpatient care as part of the overall continuum.

BHSS shift towards Full-Service Partnership (FSP)

- Greater emphasis on **intensive, team-based care** for individuals with the highest needs
- Expanded eligibility, which includes SUD only, means **more adults and children** currently in outpatient care may transition into FSP

Housing as core system component

- Housing becomes a dedicated funding category with **required allocations, and expands to allow for SUD only (i.e. recovery-oriented housing)**
- Priority is **permanent housing** paired with behavioral health services, especially for people experiencing chronic homelessness

Changes to Prevention and Early Intervention

- Universal and selective prevention are no longer funded at the county level
- Counties may continue "indicated" early intervention for individuals at high risk of developing serious mental illness and substance use disorders

Outpatient service transformation

- Reduced BHSA funding for traditional outpatient services
- Outpatient care increasingly serves as an entry point or step-down from FSP rather than the primary model

Integrated Plan Development and Structure

Plan Development Process

Built through community planning, public review, and required approvals

December 2025

Community Planning & Preparation

- Engaging stakeholders and community partners through the development process
- Completing required IP and budget sections
- Developing cost estimates for each BHSA program component

01

January 2026

Draft IP & Early Review

- Behavioral Health Commission Presentation (January 8, 2026)
- Submit draft approval to the County Administrative Officer (CAO) for signature
- Submit draft IP to DHCS
- Post IP for public comment

02

April 2026

Public Hearing & Updates

- Behavioral Health Commission hosts public hearing (April 9, 2026)
- Community Feedback Reviewed
- Revise IP based on public comment/feedback

03

May - June 2026

Final Approval & Submission

- Submit the IP to the Board for approval
- Submit final IP to DHCS by June 30, 2026
- Post final IP to DMH website

04

Integrated Plan Foundations and System Context

Major sections that describe the county's system, needs, and priorities

Integrated Plan Template Structure organized into 8 high-level categories

Focus:
Foundations & System Context

01

General Information
- Key department contact information
- Who is responsible for the plan
- Basic county behavioral health identifiers

02

Funding Flexibility & Financial Requests
- Exemption requests available for small counties
- Requests to shift funding percentages based on local needs
- How counties align funding with community priorities

03

County Behavioral Health System Overview
- How the county's mental health & substance use systems operate
- Populations served (youth, adults, older adults)
- Data systems, technology, and reporting tools used
- Types of services offered across the continuum

04

Statewide Planning Requirements
- Six statewide behavioral health goals
- Population-level measures all counties must use
- How these measures guide planning and resource allocation

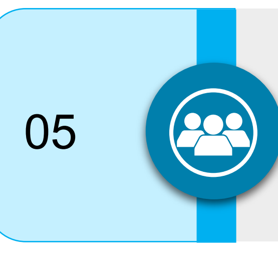
Integrated Plan Implementation and Accountability

How services are delivered, funded, and held accountable

Integrated Plan Template Structure organized into 8 high-level categories

Focus:
Implementation & Accountability

05



Community Engagement & Transparency
- Required stakeholder engagement
- Community input across planning stages
- Public comment and hearing process

06

County Behavioral Health Service System
- Full care continuum (prevention → outpatient → crisis → housing)
- Oversight and monitoring of contracted providers
- BHSA-funded services and programs provided locally

07

Workforce & Fiscal Stability
- Workforce planning, recruitment & retention
- Peer roles, clinicians, support staff
- Budget allocation and prudent reserve requirements

08

Approval & Compliance
- Required county approvals (Behavioral Health Board, Board of Supervisors)
- State-level compliance and submission processes
- Required certifications and accountability steps

Priority Statewide Behavioral Health Goals & Los Angeles County Status

Statewide Behavioral Health Goals

- Care Experience
- Access to Care
- Prevention & Treatment of Co-Occurring Physical Health Conditions
- Quality of Life
- Social Connection
- Engagement in School
- Engagement in Work

GOALS FOR REDUCTION

- Suicides
- Overdoses
- Untreated Behavioral Health Conditions
- Institutionalization
- Homelessness
- Justice Involvement
- Removal of Children from Home

Health equity will be incorporated in each of the behavioral health goals

NOTE: Blue = State Mandated; Green = Locally Selected.

Access to Care for Adults and Older Adults

Adult & Older Adults Served (21 and older)

5,082	117,900	29,800	29,591
Were dual-eligible Medicare and Medicaid members	Received Medi-Cal Specialty Mental Health Services (SMHS)	Received DMC or DMC-ODS services	Received MH and SUD services from the MHP and DMC county or DMC-ODS plan

Priority Statewide Behavioral Health Goal for Improvement

Primary Measures

Above Statewide: Specialty Mental Health Services (SMHS) Penetration Rates, FY 2023

Below Statewide: Non-Specialty Mental Health Service (NSMHS) Penetration Rates, FY 2023

Below Statewide: Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates, FY 2022-2023

**Adults & Older Adults count may be duplicated as Individuals may be included in more than one category.*

Access to Care for Children and Youth

Children and Youth Served (under 21)

85,000
Received Medi-Cal Specialty Mental Health Services (SMHS)

971
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan

115
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

162
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service

2,092
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services

Priority Statewide Behavioral Health Goal for Improvement

Primary Measure

Above Statewide: Specialty Mental Health Services (SMHS) Penetration Rates, FY 2023

Below Statewide: Non-Specialty Mental Health Service (NSMHS) Penetration Rates, FY 2023

Below Statewide: Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates, FY 2022-2023

**Children & Youth served count may be duplicated as Individuals may be included in more than one category.*

Disparities in Access to Care

Access to Care
Demographic Group Disparities

Specialty Mental Health Services (SMHS)

Adults/Older Adults

- **Race/Ethnicity:** Hispanic & Asian/Pacific Islander
- **Sex:** Female

Children/ Youth

- **Race/Ethnicity:** White
- **Sex:** Female

Non-Specialty Mental Health Services (NSMHS)

Adults/Older Adults

- **Race/Ethnicity:** Hispanic & Asian/Pacific Islander
- **Sex:** Male

Children/ Youth

- **Race/Ethnicity:** White, Black, & Asian/Pacific Islander
- **Sex:** Female

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

Adults/Older Adults

- **Race/Ethnicity:** Latinx
- **Sex:** No Disparities Data Available

Children/ Youth

- No Disparities Data Available

Stakeholder Perspectives on Access to Care

Factors Driving Disparities

- Discrimination and stigma create significant barriers, discouraging individuals from seeking or remaining engaged in services.
- Limited provider competency, including a lack of affirming care for LGBTQ+ individuals, further compounds these challenges.
- Insufficient culturally appropriate and affirming treatment options contribute to ongoing accessibility gaps.
- Lack of coordination between homeless services and mental health and substance use programs undermines continuity of care.
- Complex entry systems particularly documentation requirements restrict timely access to treatment.

Overarching Solutions

- Enhance housing, outpatient, and supportive services to reduce barriers to engagement.
- Increase outreach and engagement efforts beyond existing client populations.
- Improve provider competencies through targeted training to expand affirming care, particularly for underserved groups.
- Strengthen collaboration across housing, mental health, and substance use systems to improve care integration and continuity.
- Provide flexible, low-barrier care options that meet individuals where they are.
- Ensure accurate and inclusive data collection to improve understanding of the LGBTQ+ population and inform responsive service planning.

Homelessness Among Children & Youth and Adults & Older Adults

Children & Youth Served (under 21)

6,277
were chronically homeless or experiencing homelessness or at risk of homelessness

Adults & Older Adults Served (21 and older)

29,076
Were chronically homeless, or experiencing homelessness, or at risk of homelessness

16,374
Experienced unsheltered homelessness

7,575
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)

337
Of those who moved from unsheltered homelessness to being sheltered, transitioned into permanent housing within the DPH-SAPC system

Priority Statewide Behavioral Health Goal for Reduction

Primary Measures

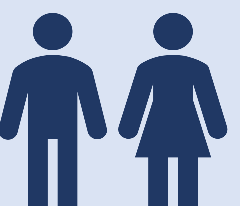
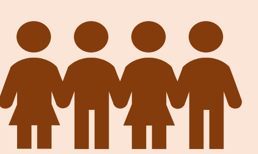
Above Statewide: People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

Below Statewide: Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 – 2024

**Children & Youth and Adults & Older Adults count may be duplicated as individuals may be included in more than one category.*
***These figures may not include clients served by LACDMH.*

Disparities in Homelessness

Homelessness
Demographic Group Disparities

People Experiencing Homelessness Point-in-Time Count	Homeless Student Enrollment by Dwelling Type
 • **Race/Ethnicity:** Latino & Asian/Pacific Islander • **Gender:** Women (Girl if child)	 • **Race/Ethnicity:** Asian/ Pacific Islander & White • No Gender Data Available

Stakeholder Perspectives on Homelessness

Factors Driving Disparities

- Substance use trends, including ease of access to marijuana and alcohol for minors, with early use often linked to trauma, poverty, and peer pressure.
- Economic barriers, including high cost of living, limited affordable housing, and ongoing financial instability that undermine housing stability.
- Gaps in mental health care and substance use treatment, particularly for youth and transitional-age populations with limited access to age-appropriate services.
- Challenges navigating complex systems, including long wait times, confusing enrollment processes, and limited transportation.
- Workforce shortages, with insufficient trained and culturally competent providers and reduced program capacity due to staffing constraints.
- Systemic racism and inequality including income disparities, disproportionate involvement with the justice and child welfare systems, and provider bias that perpetuate housing instability and unequal access to care.

Overarching Solutions

- Develop strong community partnerships with trusted organizations and faith-based groups to deliver culturally informed services in safe, accessible settings.
- Expand youth prevention programs that provide early education on fatherhood, financial literacy, and substance use risks, incorporating engaging activities such as sports and the arts.
- Increase transparency and accountability within housing systems and funding models through clear public reporting.
- Expand mobile outreach and peer support, including street-based teams and peer-run recovery programs, to connect individuals to care earlier and prevent crises.
- Improve data collection through partnerships with community-based organizations to gather accurate, disaggregated data by race, age, and family status.
- Address economic and housing instability through investments in vocational training, trauma-informed care, interim housing solutions such as tiny home villages, and strengthened tenant protections, including “Know Your Rights” education and enhanced legal safeguards.

Institutionalization Among Children & Youth and Adults & Older Adults

Adults & Older Adults Served

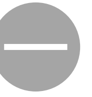
19,167
Received acute psychiatric services

Children & Youth Served

4,158
Have received acute psychiatric services

Priority Statewide Behavioral Health Goal for Reduction

Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023	
Adults & Older Adults	Above Statewide
Children & Youth	 N/A

Adult and Older Adult Demographic Disparities

Inpatient administrative days (DHCS) rate, FY 2023

- **Race/Ethnicity:** Hispanic
- **Sex:** Female

No disparities data available for children & youth

Stakeholder Perspectives on Institutionalization

Factors Driving Disparities

- Incomplete data systems, including high numbers of “unknown” entries and missing demographic categories, obscure who is most in need of services.
- Exclusion in reporting, particularly of Asian Pacific Islander communities and certain age groups, limits accurate identification of inequities.
- Weak discharge planning, with patients leaving institutional settings without stable housing, follow-up appointments, or a clear recovery plan.
- Administrative bottlenecks that prolong hospital stays and limit access for new admissions.
- Communication gaps among hospitals, families, and community-based care teams, resulting in fragmented care.
- Limited availability of specialized services for older adults, individuals with dementia or traumatic brain injuries, and those with severe substance use disorders.
- Quality-of-care concerns, with institutional settings often emphasizing containment rather than treatment and recovery.
- Misaligned performance metrics that prioritize time in care over meaningful recovery outcomes and long-term community stability.

Overarching Solutions

- Improve data quality by collecting complete demographic information including race, ethnicity, age, and language reducing “unknown” categories, and ensuring consistent inclusion of historically undercounted communities.
- Strengthen discharge and care transitions by requiring clear housing plans, timely follow-up visits, continuity of medications, and meaningful family involvement.
- Reduce excessive administrative days through operational strategies such as daily placement huddles, fast-track pathways for complex cases, and real-time bed inventories.
- Expand system capacity by investing in geriatric behavioral health beds, co-occurring substance use disorder programs, and flexible funding mechanisms to increase placements.
- Build stronger community-based supports, including Full-Service Partnerships, peer support groups, and self-help connections, to reduce rehospitalizations and promote long-term stability.
- Improve care quality within institutional settings by requiring active treatment components, including therapy, group services, and individualized recovery goals.
- Align measurement and financing with meaningful outcomes, including tracking readmissions, timely follow-up, community tenure, and patient-stated goals, with data disaggregated by race, age, and language, alongside fair and sustainable provider funding.

Justice Involvement Among Children & Youth and Adults & Older Adults

Children and Youth Served

526
Were in the Juvenile Justice System

2,340
Have Reentered the community from a youth correctional facility

Adults and Older Adults Served

11,774
Were in the justice system
(on parole or probation and not currently incarcerated)

58,349
Were incarcerated
(including state prison and jail)

31,980
Reentered the community from state prison or county jail

Statewide Behavioral Health

Priority Statewide Behavioral Health Goal for Reduction

Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023		
Adults & Older Adults		Below Statewide
Children & Youth		Below Statewide

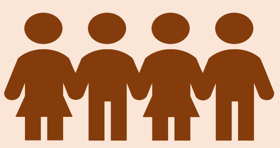
Disparities in Justice-Involvement

Justice-Involvement
Demographic Disparities

Arrests: Adult Rates

- **Race/Ethnicity:** African Americans
- **Gender:** Female

Arrests: Juvenile Rates



- **Sex:** Female

Stakeholder Perspectives on Justice-Involvement

Factors Driving Disparities

- Systemic racism in policing, with Black and Latino communities experiencing disproportionately high arrest rates rooted in historical inequities, over-policing, and racial profiling in low-income neighborhoods.
- Criminalization of mental health conditions and substance use disorders, resulting in law enforcement responses to issues better addressed through health and social services.
- Limited access to high-quality legal defense for low-income individuals and families, increasing the likelihood of adverse justice outcomes.
- Family-level factors, including trauma, absence of positive role models, and economic pressures on caregivers that limit supervision and support for youth.
- Gender disparities in arrest rates, with men disproportionately impacted and growing arrest rates among women.
- Lack of community-based supports such as stable housing, educational opportunities, and access to healthcare that reinforces justice system involvement.

Overarching Solutions

- Expand diversion programs and decriminalize mental health and substance use–related issues to reduce reliance on punitive responses.
- Increase access to mental health courts, SUD court-based diversion programs, and restorative justice programs that prioritize treatment, accountability, and healing over incarceration.
- Expand community-based resources for youth and families, including free after-school programs and childcare services to reduce exposure to crime and justice involvement.
- Strengthen family supports through counseling, legal assistance, and housing stability services to address underlying stressors.
- Improve data collection by disaggregating arrest data by race, age, and socioeconomic status and integrating data across probation, treatment, and law enforcement systems.
- Shift funding from prisons and law enforcement toward prevention, treatment, and community-based programs, while tailoring evidence-based practices to the cultural and contextual needs of specific populations and increasing outreach to reduce stigma and improve program awareness.

Removal of Children from Home and Disparities

Children and Youth Served

17,562	Were served by the Mental Health Plan and had an open child welfare case
110	Were served by the DMC County or DMC-ODS plan and had an open child welfare case

Priority Statewide Behavioral Health Goal for Reduction

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

Above Statewide

Demographic Disparities

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

- **Race/Ethnicity:** White & Asian/ Pacific Islander
- **Sex:** Female

Stakeholder Perspectives on Removal of Children from Home

Factors Driving Disparities

- Systemic racism, including biased standards for parenting and cultural misunderstandings, contributing to higher rates of child removal in communities of color.
- Socioeconomic challenges such as poverty, single-parent households, literacy gaps, and limited access to adequate nutrition and prenatal care that increase family vulnerability.
- Reporting practices, including unsubstantiated reports from schools and educators that nonetheless trigger child welfare involvement.
- Persistent data gaps, including missing contextual information and unclear definitions that obscure root causes of system contact.
- The enduring impact of historical harm, including past practices of removing children from marginalized communities, which continue to shape current policies, perceptions, and outcomes.

Overarching Solutions

- Expand culturally responsive services through partnerships with trusted community-based and faith-based organizations, including the use of cultural advocates and brokers.
- Strengthen collaboration across agencies including DCFS, schools, and community organizations to align practices and reduce siloed decision-making.
- Enhance navigation support to help families access services without stigma or unnecessary barriers.
- Reevaluate child removal standards, expand diversion programs, and reduce unnecessary removals whenever safe and appropriate.
- Improve service accessibility through in-home and virtual services, low-barrier clinics, and culturally specific options tailored to family needs.
- Increase workforce diversity to ensure greater representation of staff from communities most impacted, strengthening trust and improving outcomes.

Untreated Behavioral Health Conditions

Statewide Behavioral Health

Priority Statewide Behavioral Health
Goal for **Reduction**

Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30) 2024

Below Statewide

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

Below Statewide

Substance Use (Age 13+)

- About 26% received follow-up care within 30 days
- Above the state minimum (21%)
- Below the high-performance target (32%)

Mental Health / Self-Harm (Age 6+)

- 36–39% received follow-up care within 30 days
- Well below the state minimum (55%)
- Far below the high-performance target (72%)

Stakeholder Perspectives on Untreated Behavioral Health Conditions

Factors Driving Disparities

- Insufficient care coordination, with emergency departments and outpatient providers operating in silos and limited data sharing.
- Weak discharge planning, with patients leaving without scheduled follow-up appointments or clear, actionable care plans.
- System performance gaps, including inconsistent achievement of minimum and high-performance benchmarks for timely follow-up care.
- Stigma and misdiagnosis, which discourage treatment engagement and may result in ineffective or inappropriate care.
- Structural barriers such as housing instability, lack of transportation, and limited access to phones or digital communication.
- Workforce shortages, including insufficient trained staff and low compensation, limiting service availability and follow-up support.

Overarching Solutions

- Use policy levers and financial incentives such as performance-based contracts, increased reimbursement rates, and targeted policy changes to strengthen timely follow-up outcomes.
- Adopt a whole person care approach that addresses social determinants of health, including housing stability, employment, and community support.
- Increase staffing and system supports by embedding care navigators, peer specialists, and community health workers in emergency departments to facilitate follow-up connections.
- Implement targeted interventions for higher-need populations, including mothers with substance use disorders, youth, and individuals experiencing homelessness.
- Expand access through telehealth, mobile outreach, appointment reminders, and culturally responsive service delivery.
- Reduce stigma by engaging peers with lived experience, expanding public and provider education, and normalizing conversations about mental health and substance use recovery.

Engagement in School

Additional Statewide Behavioral Health

Reason for Goal Selection

- Engagement in School shows a **1% gap**, larger than Engagement in Work (0.2%) and Prevention & Treatment of Co-Occurring Physical Health Conditions.
- Graduation rates reflect outcomes for youth impacted by both **mental health** and **substance use challenges**.
- This goal also directly **focuses on children and adolescents** who are BHSA eligible.
- DMH and DPH-SAPC have **established partnerships** with school systems and prevention programs to support improvement.

Priority Statewide Behavioral Health Goal for Improvement

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

Below Statewide

- State Improved: **80% → 87% (2013–2022)**
- County Improved: **77% → 86% (2013–2022)**
- County remains slightly below State, but **gap has narrowed over time**

Stakeholders Perspectives on Engagement in School

Factors Driving Disparities

- Socioeconomic challenges including poverty, food insecurity, transportation barriers, and homelessness that limit consistent attendance and engagement.
- Environmental trauma, including exposure to violence, housing instability, and lack of routine trauma screening, contributing to disengagement, particularly among African American youth.
- Safety concerns related to commuting, school shootings, and lack of psychological safety.
- Systemic racism within educational settings, including anti-Blackness, biased curricula, and limited racial and cultural representation among educators, undermining student belonging.
- Data limitations, including incomplete, siloed, or inconsistent data collection that impedes accurate identification of disparities and tracking of engagement over time.

Overarching Solutions

- Create safe, culturally affirming, and trauma-informed learning environments that connect academic content to students lived experiences and future opportunities.
- Strengthen collaboration across education, health, housing, justice, and social service systems to address student needs holistically.
- Leverage Community-Defined Evidence Practices (CDEPs) that are culturally responsive and validated to address trauma and behavioral health needs, particularly among African American youth.
- Expand targeted supports, including resources for students experiencing homelessness, recovery schools, and alternative pathways to graduation.
- Strengthen countywide, inclusive data systems that capture all school types, student identities, and relevant risk factors.
- Reduce stigma and promote early intervention through prevention programs, expanded behavioral health supports, and sustained community partnerships to keep students engaged.

Behavioral Health Services Act/ Fund Programs

Behavioral Health Continuum of Care

Los Angeles County

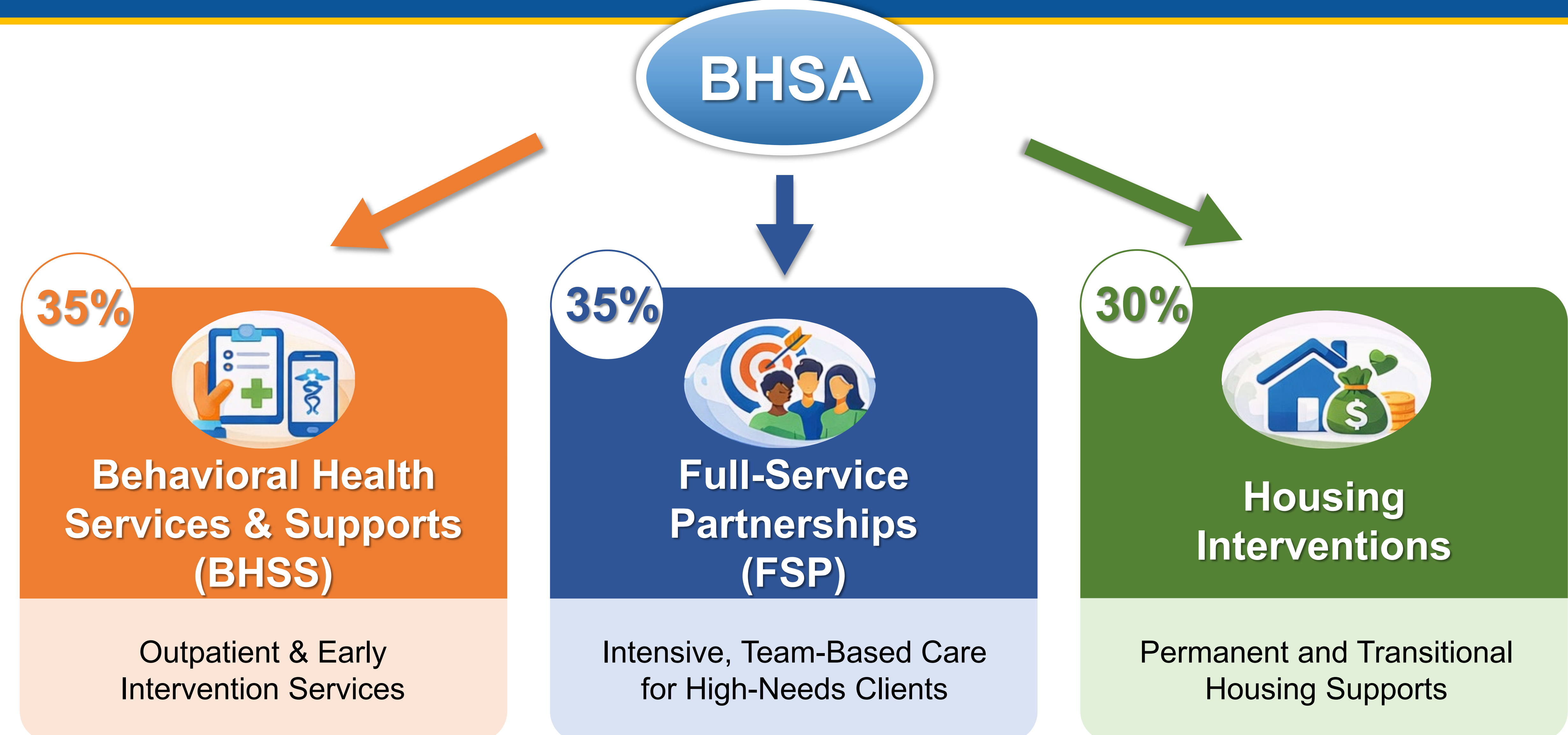
LOS ANGELES COUNTY MENTAL HEALTH CONTINUUM

Primary Prevention Services	Early Intervention Services	Outpatient Services	Intensive Outpatient Services	Crisis Receiving & Stabilization Up to 24 hours (licensed: except sobering center)	Acute Inpatient/ Subacute Hospital level care (licensed)	Crisis Residential/ Extended Residential Residential (with onsite clinical/ treatment services - licensed)	Housing Intervention Services

LOS ANGELES COUNTY SUD CONTINUUM

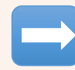
<table>
<tr><td rowspan="3">Primary Prevention Services</td><td colspan="7">MAT</td></tr>
<tr><td>Harm Reduction Services</td><td rowspan="2">Early Intervention Services</td><td rowspan="2">Outpatient Services and Opioid Treatment Program</td><td rowspan="2">Intensive Outpatient Services</td><td rowspan="2">Residential Treatment Services</td><td rowspan="2">Inpatient Services Withdrawal Management</td><td rowspan="2">Housing Intervention Services</td></tr>
<tr><td>Field-Based Services</td></tr>
</table>

Behavioral Health Services Act / Fund Programs



Behavioral Health Services and Supports (BHSS)

Required Allocation: 35% of BHSA Funds



What BHSA funds

1. Adult and Older Adult System of Care (Non-FSP):
   - Outpatient Care Services
   - Mobile Response
2. Early Intervention Programs*:
   - Children and Youth Wellbeing Services
   - Screening and Linkage
   - Outreach and Engagement
   - Mobile Response
   - Coordinated Specialty Care for First Episode Psychosis (CSC for FEP) Program
4. Outreach and Engagement (O&E): Navigation
5. Workforce, Education, and Training (WET) Program
6. Capital Facilities and Technological Needs (CFTN)

Requirement

- Of the **35%** BHSS allocation:
  - **51%** must be spent on Early Intervention
  - Of that, **51%** must serve youth ages 25 and under

Takeaway

BHSS preserves system-wide outpatient and early intervention services with required youth investment.

Under the BHSA, Early Intervention is funded through the Behavioral Health Services and Supports (BHSS) category.

How BHSS Supports Our Community

How BHSS funding helps provide care, support, and connection for people across our community.

How BHSS Supports Our Community

Early Intervention

- First Episode Psychosis (youth)
- Perinatal mental health support
- Birth-to-5 relationship-based care
- Suicide prevention support

Community-Based Support

- Outpatient mental health care
- Medication for addiction treatment
- Substance use treatment and recovery services
- Clubhouses (daily community support and skill-building)
- Peer respite programs
- Promotores (community outreach)

Crisis Support

- 24/7 crisis stabilization
- Mobile response teams
- Alternatives to emergency rooms
- Crisis residential programs

Who BHSS Supports

- ✓ Children and youth
- ✓ Adults and older adults
- ✓ People experiencing homelessness
- ✓ Justice-involved individuals
- ✓ People with mental health, substance use, and co-occurring mental health and substance use disorders
- ✓ Families in crisis
- ✓ Underserved and historically impacted communities

How BHSS Makes a Difference

- ✓ **Reduce** emergency room visits
- ✓ **Prevent** homelessness
- ✓ **Support** people before crisis
- ✓ **Increase** access to substance use treatment
- ✓ **Increase** access to culturally and linguistically appropriate services
- ✓ Make services **more accessible** across all communities

Services Included in Early Intervention

Early Intervention

Short-term (less than a year), low-intensity intervention/support for individuals and families to improve behavioral health and prevent the need of more extensive mental health and substance use disorder treatment.

Covered

- **Children's Specialty** Mental Health Services
- **Youth and Transition Age Youth** Substance Use Disorder services
- **Crisis care** including field-based crisis responses
- Existing **clinic-based** evidence-based practice services
- **Outreach services** will be allowed

Not Covered

- BHSA funds **cannot** be used for universal prevention programs.
  - **Universal prevention** programs will be managed by the State.
  - DMH will **review current MHSA prevention programs** to see which can be funded as Early Intervention.

Comparison of Early Intervention Under MHSA and BHSA

MHSA

Target Population

- Participants' risk of a potentially serious mental illness, either based on individual risk or
- Membership in a group or population with greater than average risk of a serious mental illness i.e. the condition, experience, or behavior associated with greater than average risk
- 50% must be focused on child and youth

Services

- Promotes recovery for a mental illness early in its emergence, includes relapse prevention
- Time limited (Short-term, usually less than 18 months) – except for first psychotic break
- Relatively low intensity intervention
- May include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable

BHSA

Target Population

- Individuals presenting with or at-risk mental health and/or substance use disorders, early in its emergence
- Individuals in crisis
- Community members who are "potential responders" for someone presenting with mental health and/or substance use disorder
- Members of the individual's support system (parents and/or care givers)
- 50% must be focused on child and youth

Services

- Focused on children and youth
- Reduce disparities in health care
- Programs emphasize Outreach, Access and Linkage, and MH, SUD, and co-occurring disorders
- MH, SUD, and co-occurring disorder services may be provided to individuals to prevent disorders from becoming severe and/or disabling.

Changes in Outpatient Care Services (OCS)

Outpatient Care Services

- OCS offers community, clinic, and field-based services that support recovery.
- Services are available for all age groups.
- OCS also works to make sure care is culturally sensitive and in the right language for each person.

Changes in Outpatient Care Services

Reduced BHSA Funding: Outpatient services will be funded by BHSA and other funding source.

New Assessment Tools: Clinics will use Level of Care tools to determine treatment.

Intensive Services: Clients will be assessed for Full-Service Partnership Intensive Case Management (FSP-ICM) programs.

Provider Shift: Some outpatient providers may need to shift to delivering Full-Service Partnership Services.

Workforce Education & Training and Capital Facilities &Technological Updates

Workforce Education & Training (WET) Plan

Goal: Build a behavioral health workforce that is culturally aware, family- and consumer-focused, and supports recovery, resilience, and wellness

Focus: Recruit, train, and re-train staff to meet these goals

Purpose: Transform mental health and substance use disorder services to be stronger and more supportive

Capital Facilities & Technology (CFTN)

What it is: Projects for land, buildings, or technology to support behavioral health services

What it's not: Does **not** fund housing projects

Funding: County moved money from CSS account to CFTN to pay for these projects

WET & CFTN Updates

Funding: DMH will manage WET and CFTN funds and decide how much to spend each year based on community needs.

Funding Limits: WET funds will come from BHSS, the most limited source of BHSA funds

New State Initiative: BH-Connect will provide some workforce incentives to workers in Los Angeles County but does not cover all local workforce training and hiring needs.

Full-Service Partnership (FSP) Overview

FSP is the County's highest level of **outpatient behavioral health care**, supporting residents with **the most complex needs** to achieve **stability, housing, and recovery**.

Who FSP Serves

- ✓ Individuals living with serious mental health needs and co-occurring disorders
- ✓ People experiencing homelessness
- ✓ Justice-involved individuals
- ✓ Residents frequently using ER or inpatient psychiatric care

What Makes FSP Different

- ✓ Small caseloads and highly personalized care
- ✓ Multidisciplinary teams (clinicians, case managers, peers)
- ✓ Services delivered in homes and community settings
- ✓ 24/7 crisis response and ongoing engagement
- ✓ Integrated housing and employment supports

Why it Matters: FSP helps reduce **hospitalizations and incarceration**, increases **housing stability**, and supports **long-term recovery** in the community.

Full-Service Partnership Changes under BHSA

Full-Service Partnership

- FSP provides personalized team-based care for people with serious mental health needs with co-occurring disorders
- Services focus on recovery, healing, and stability, using a "whatever it takes" approach.
- Support is built around each person's needs and includes families or natural supports.

FSP Changes

Increase Funding: A greater percentage (35%) of BHSA funds will support FSP, with possible program expansion.

New Services: Implementation of the Assertive Community Treatment (ACT) Services.

Co-Occurring Capabilities: Programs are required to implement specific components of integrated care per ASAM 4th Edition Criteria, including MAT services, screening, referrals, training, billing, etc.

Develop a Step-Down Program: Two levels of FSP to support people transitioning out of ACT services to less intensive care.

Youth & Families: Implementation of High-Fidelity Wraparound for Children and Youth.

Jobs & Recovery: Individual Placement and Support (IPS) Employment Services included into FSP services.

More Outreach: Outreach now allowed as part of FSP services.

Full-Service Partnership under BHSA

BHSA REQUIREMENTS

Counties must allocate 35% of BHSA funds for FSP

Required Services:

- ✓ Mental Health Services, Supportive Services, and Substance Use Disorder (SUD) Services
- ✓ Assertive Community Treatment (ACT)
- ✓ Forensic ACT (FACT)
- ✓ FSP Intensive Case Management (ICM)
- ✓ Individual Placement and Support (IPS) Model of Supported Employment
- ✓ High Fidelity Wraparound (HFW)
- ✓ Assertive Field-Based Initiation for SUD
- ✓ Outpatient Behavioral Health Services for Evaluation and Stabilization
- ✓ Ongoing Engagement Services
- ✓ Service Planning
- ✓ Housing Interventions (funded under the Housing Interventions Category)

ADULT FSP LEVELS OF CARE

Full-Service Partnership Eligible

Level 2: Assertive Community Treatment (ACT)
Stand-Alone EBP for Highest Need Adults & Older Adults

Level 1: FSP Intensive Case Management (ICM)
Higher Need Adults and Older Adults

BHSS Eligible

Outpatient MH and SUD Services
Individuals stepping down from FSP ICM no longer meet the threshold for FSP and should receive MH and SUD services, as needed.

Level of Intensity

Takeaway: FSP remains the largest investment, focused on high-acuity populations.

Comparison of FSP under MHSA and BHSA

MHSA

Adult FSP

- ✓ Age 21+
- ✓ Single Level of FSP care
- ✓ 1:10 staff-to-client ratio

Child FSP

- ✓ Age 0-20
- ✓ General Child/YA, IFCCS, and WRAP

BHSA

Adult FSP

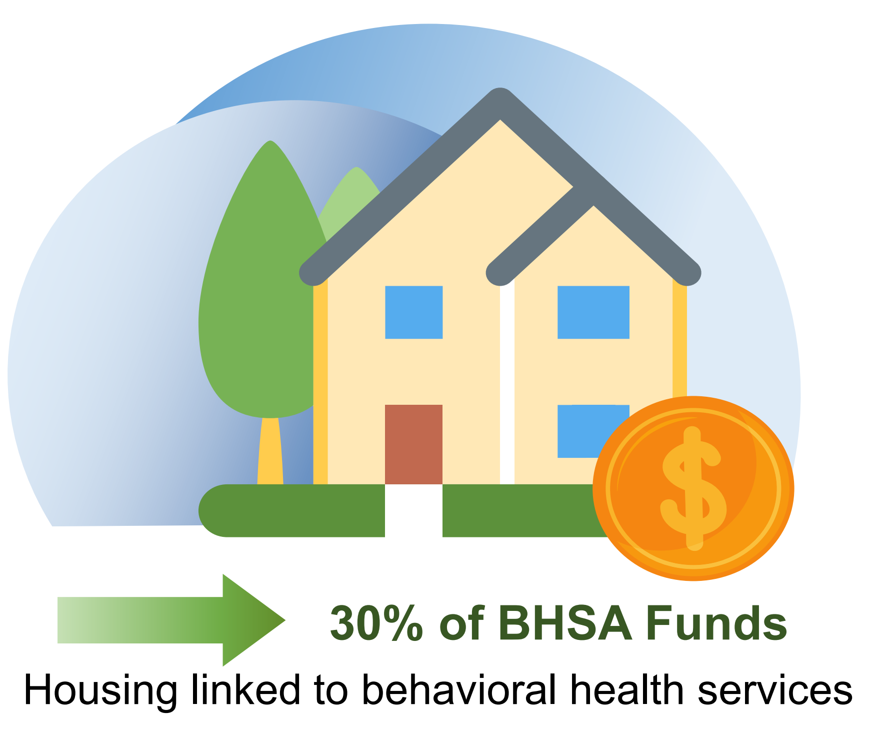
- ACT & FACT– 1:10 staff-to-client ratio
- FSP-ICM (lowered criteria) – 1:25 staff-to-client ratio
- Inclusion of COD and IPS
- Can serve TAY if clinically appropriate
- Eligible BHSA Adults and Older Adults
- Ages 18+ (may include TAY ages 18-25 if clinically appropriate)

Child FSP

- FSP- HFW
- All Child FSP programs incorporate High Fidelity Wraparound (HFW) as an EBP
    - Child Welfare/Justice Involved
    - Children with SED
    - Eligible BHSA Child and Youth
    - Age 0-25 including TAY age

Housing Interventions Requirements Under BHSA

Required Allocation: 30% of BHSA Funds



30% of BHSA Funds

Housing linked to behavioral health services

Usage Rules

- **50%** must serve **chronically homeless people**
  - ✓ Focus on encampments
- **No more than 25%** may be used for capital development

Key Priorities

- Permanent housing
- Housing must be paired with behavioral health supports

Takeaway: Housing becomes a core, dedicated funding component of the behavioral health system.

Housing Under BHSA

Housing

- DMH and DPH-SAPC offer housing and support services for people experiencing homelessness with serious mental health, substance use, and co-occurring needs.
- This includes temporary and permanent housing, move-in help, eviction prevention, and case management.
- DMH and DPH-SAPC also manage funds to build, improve, and maintain housing.

Housing Changes

What's Included, but not limited to:

- ✓ Rental help
- ✓ Utilities
- ✓ Repairs
- ✓ Leasing Costs
- ✓ Tax
- ✓ Insurance
- ✓ Shared Housing
- ✓ Family Housing

Limitations on Funding:

- ✓ **Mental health and substance use disorder services** and supports.
- ✓ **Under certain circumstances**, BHSA housing funds may be used for **outreach**.
- ✓ **Transitional rent** must be utilized before use of BHSA funds

Collaboration:

- Counties may need to work with **Managed Care Plans (MCP's)** for clients who have access to housing benefits.
- **BHSA funds can only** be used once managed care housing benefits are used or if not available.

How Housing Supports Stability and Recovery

Multi-Pronged Housing Strategy

This approach brings together **different housing supports** to help people **stabilize** and **connect to permanent housing** based on what they need most.

- ✓ Invest in permanent supportive housing and rental subsidies
- ✓ Expand interim and bridge housing (tiny homes, sleeping cabins, stabilization units, recovery bridge housing)
- ✓ Support transitions from residential care to independent housing
- ✓ Strengthen landlord partnerships and mitigation supports
- ✓ Coordinate referrals through Coordinated Entry System (CES) and behavioral health teams

Housing Supports

- ✓ People experiencing chronic homelessness
- ✓ People with serious behavioral health needs
- ✓ Justice-involved populations
- ✓ Underserved communities

How Housing Makes a Difference

- ✓ **Increased permanent** housing placement and retention
- ✓ **Reduced unsheltered homelessness** among people with SMI and/or SUD
- ✓ **Decreased** crisis utilization and inpatient stays
- ✓ **Improved** coordination between housing and behavioral health services

Help people move from crisis to **stable, permanent housing** with the right support along the way.

Budget and Prudent Reserve

DMH: FY 2025-2026 Revenue Sources

32% State and Federal Medi-Cal ($1,406.04M)
Funds specialty mental health services (SMHS) for eligible clients who meet medical necessity criteria for Medi-Cal. Entitlement program.

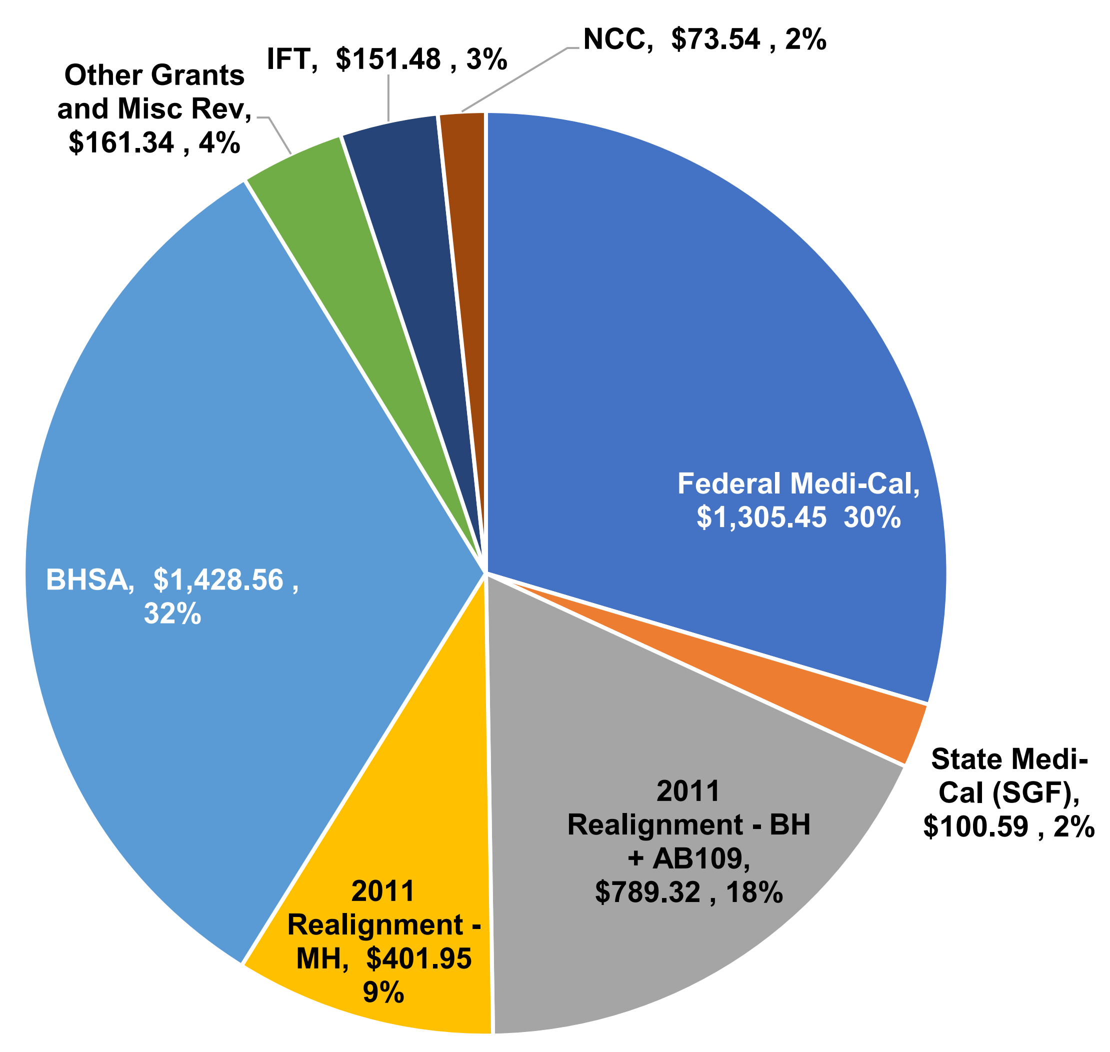
32% BHSA ($1,428.56M)
Funds community mental health services in unlocked settings, which includes Full-Service Partnerships, Prevention and Early Intervention, Housing, Innovations, Workforce Education and Training, Capital Facilities and Technological Needs. May be used as a local match for federal Medi-Cal revenue.

18% 2011 Realignment – BH, AB109 ($789.32M)
Provides the local match for Medi-Cal SMHS, including the Early and Periodic Screening, Diagnosis, and Treatment Program and mental health managed care.

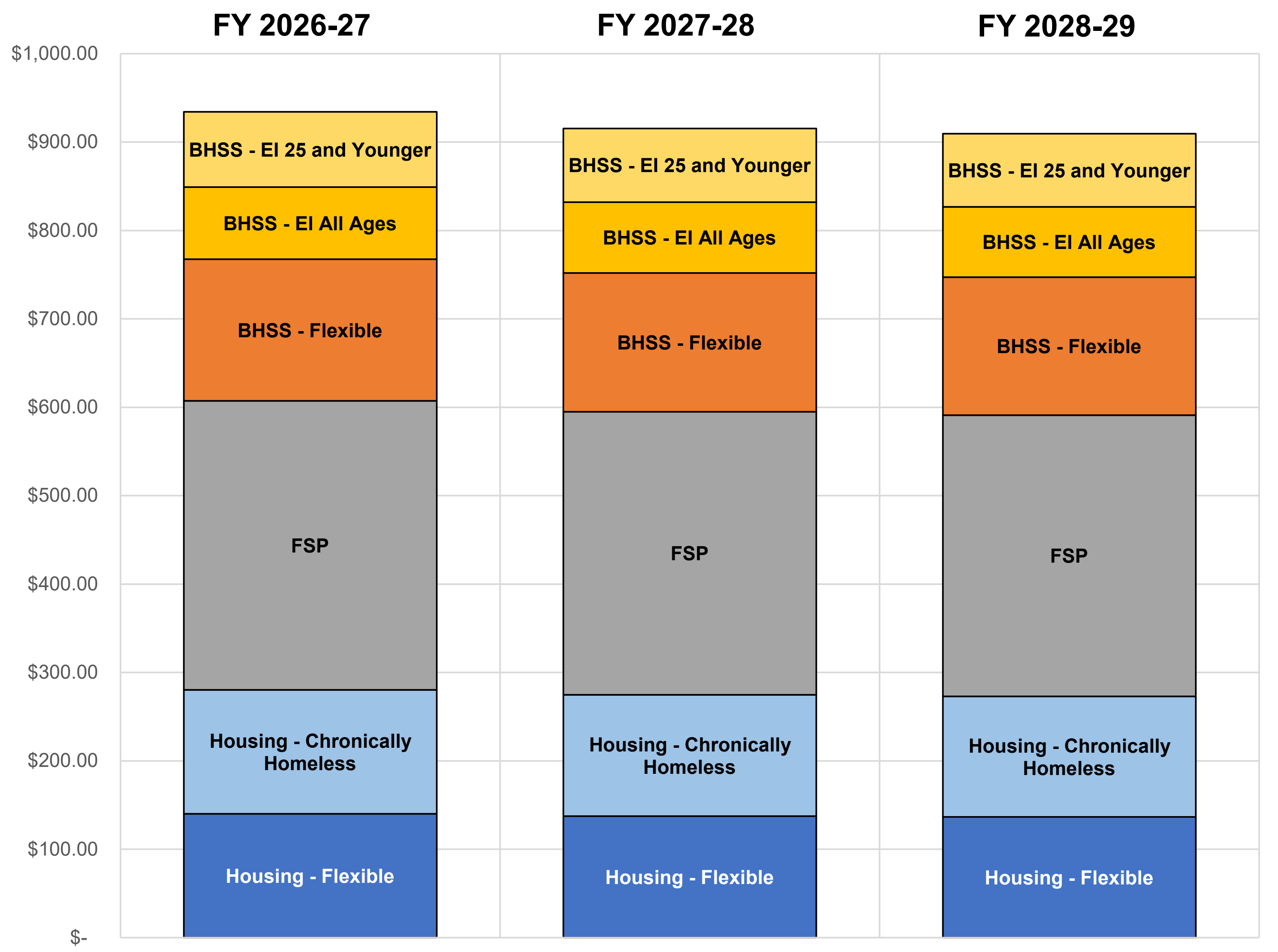
9% 2011 Realignment – MH ($401.95 Million)
Community MHS, including acute psychiatric inpatient hospital services provided in Institutions for Mental Diseases (IMDs).

7% Grants and Miscellaneous Revenues ($312.82 M)
BHBH, CCE, Disaster Grants (SERG, RSP), SAMHSA, PATH, MHSSA, patient fees, parking fees, and estate fees, NPLH, and other miscellaneous revenues.

2% NCC ($73.54 Million)
Maintenance of Effort for SMHS and discretionary funds for PG Probate, Jail MHS, emergency shelter, Project 50, and other homeless prevention programs.



Estimated BHSA Funding Amounts



- 5-year revenue average based on actuals through FY 2025-26 is $862 million
- DMH estimates receiving:
  - $934.1 million in FY 2026-27
  - $915.4 million in FY 2027-28
  - $909.4 million in FY 2028-29
- This estimate is based on statewide revenue estimates approved in the 2025 Budget Act
- Revenue estimates are subject to change

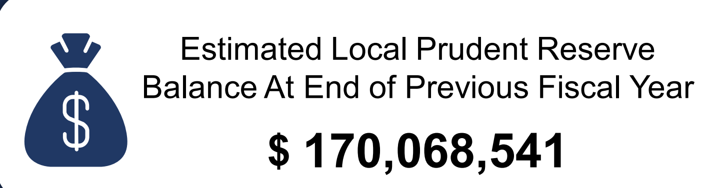
Continuum of Care Projected Expenditures for DMH

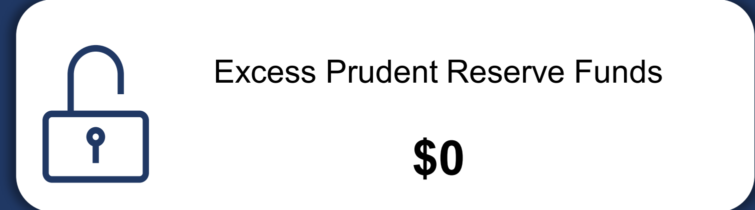
Continuum of Care	Adult			Child/Youth		
	Fiscal Year 26/27	Fiscal Year 27/28	Fiscal Year 28/29	Fiscal Year 26/27	Fiscal Year 27/28	Fiscal Year 28/29
Primary Prevention Services	$30,275,000.00	$31,425,000.00	$32,431,000.00	$0.00	$0.00	$0.00
Early Intervention Services	$95,975,000.00	$99,622,000.00	$102,810,000.00	$931,822,000.00	$967,231,000.00	$997,747,000.00
Outpatient and Intensive Outpatient Services	$1,087,932,000.00	$1,129,037,000.00	$1,164,106,000.00	$121,387,000.00	$124,018,000.00	$127,987,000.00
Crisis Services	$259,178,000.00	$269,028,000.00	$277,637,000.00	$20,470,000.00	$21,248,000.00	$21,928,000.00
Residential Treatment Services	$44,393,000.00	$46,080,000.00	$47,555,000.00	$4,611,000.00	$4,786,000.00	$4,939,000.00
Hospital and Acute Services	$405,857,000.00	$421,280,000.00	$434,761,000.00	$109,059,000.00	$113,203,000.00	$116,825,000.00
Subacute and Long-Term Care Services	$213,434,000.00	$221,544,000.00	$228,633,000.00	$3,404,000.00	$3,533,000.00	$3,646,000.00
Housing Intervention Component Services	$292,232,000.00	$294,115,000.00	$263,506,000.00	$10,497,000.00	$14,880,000.00	$15,776,000.00

* Projected expenditures are estimates and subject to change

DMH Prudent Reserve And Unspent Funding

Estimated Local Prudent Reserve Balance





Projected Expenditures - Unspent MHSA and BHSA Funding Only

MHSA Component	Full-Service Partnership	BHSS	Unspent Balance (Year 1)
MHSA Unspent Balance (CSS and PEI)	$130,000,000	$604,045,000	$734,045,000

DPH–SAPC: FY 2025-2026 Revenue

- **67% Drug Medi-Cal ($501.2M)**
  Funds specialty SUD treatment services for Medi-Cal eligible adolescents and adults.

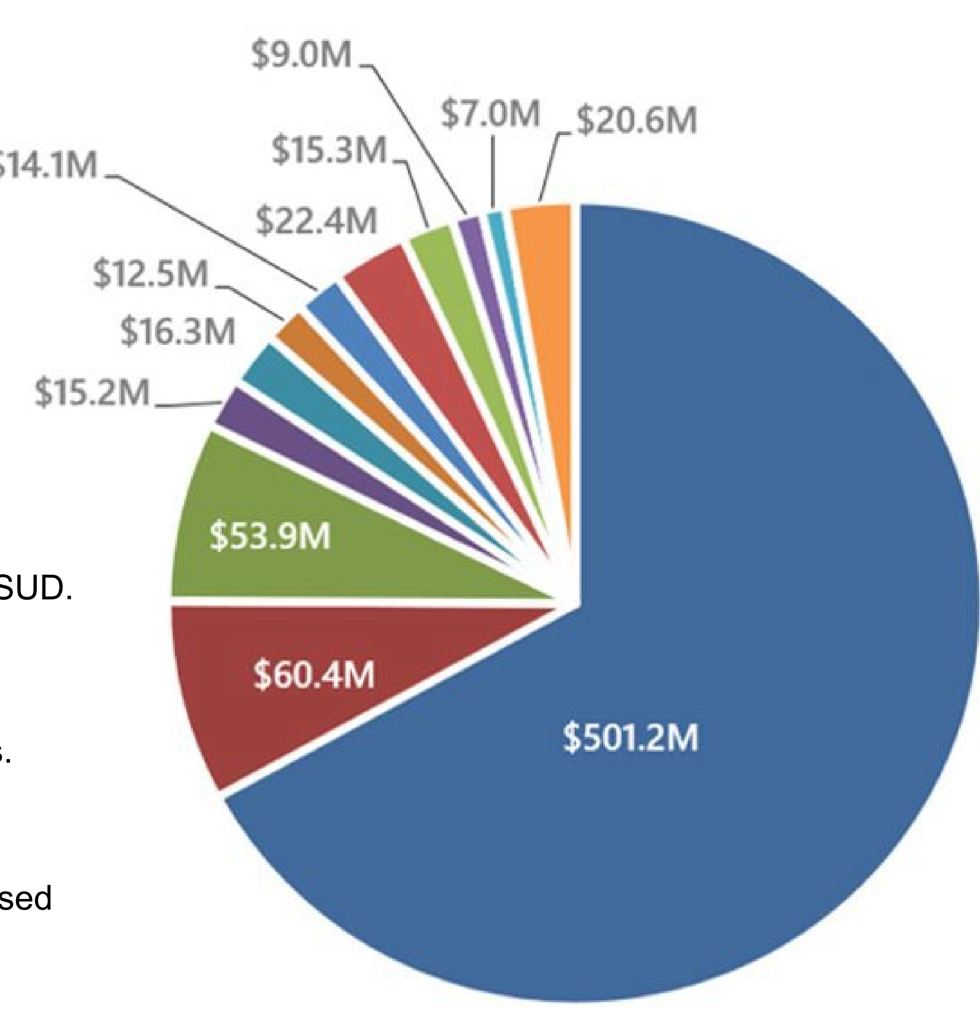
- **8% Substance Use Block Grant ($60.4M)**
  Funds comprehensive SUD planning, implementation, and evaluation of prevention, treatment, and recovery services.

- **7% 2011 Realignment ($53.9M)**
  Funds public safety, mental health, and social services programs, including substance abuse treatment, from the state to counties.

- **2% Behavioral Health Bridge Housing (BHBH) ($15.2M)**
  Provides bridge housing for homeless individuals with serious behavioral health conditions and SUD.

- **2% Measure H ($16.3M)**
  Funds homeless prevention, education, screening, and referrals for SUD treatment and services.

- **2% Care First, Community Investment ($12.5M)**
  Redirects funds from incarceration towards community-based mental health, SUD, and court-based diversion programs for justice-involved individuals.



DPH–SAPC: FY 2025-2026 Revenue (cont'd)

- **2% AB 109 ($14.1M)**
  Funds SUD treatment and recovery services for justice-involved individuals who may not be eligible for Medi-Cal.

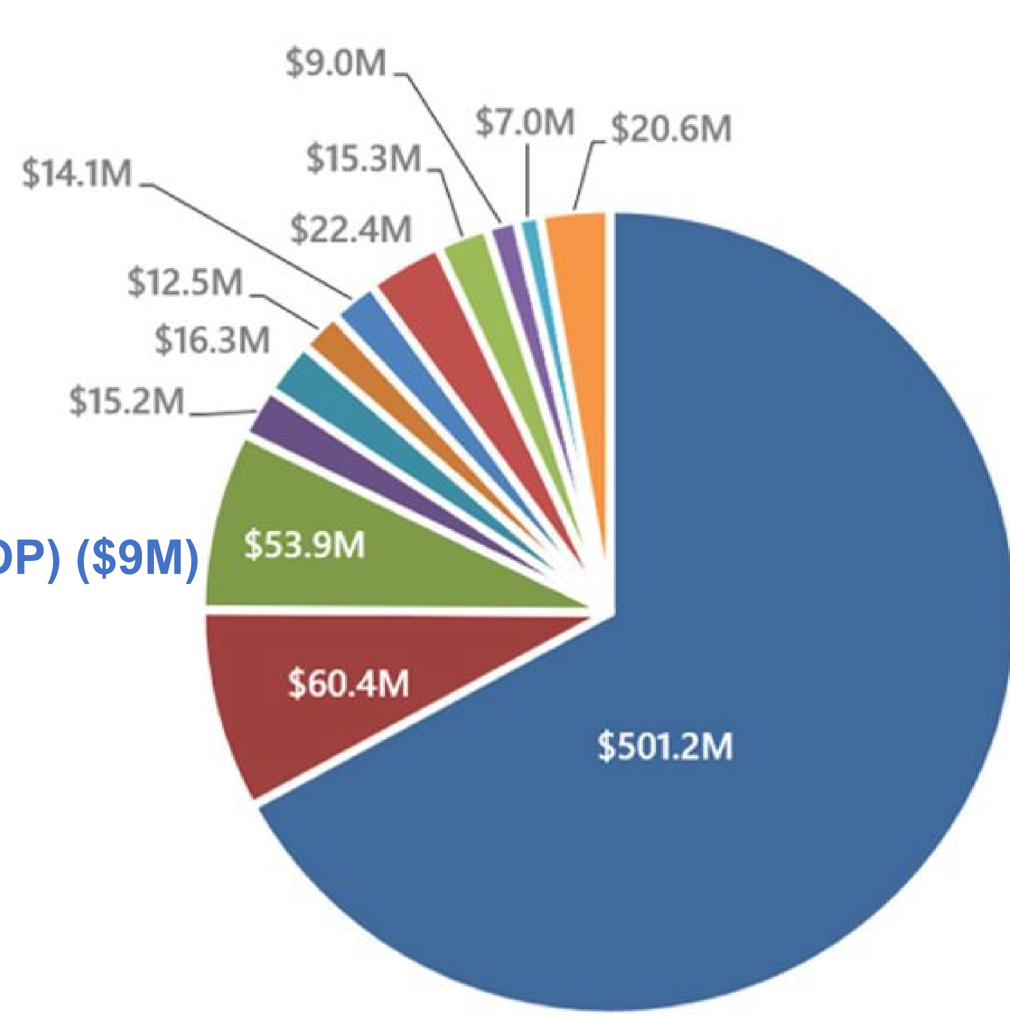
- **3% Opioid Settlement Funds ($22.4M)**
  Expands and implements opioid prevention and treatment services following pharmaceutical settlements.

- **2% DPSS: General Relief and CalWorks ($15.3M)**
  Provide cash aid for rent, food, and utilities for individuals in SUD treatment.

- **1% Innovations Grant – Interim Housing Outreach Program (IHOP) ($9M)**
  Funds SUD outreach, screening, MAT, and referrals within housing sites for individuals . experiencing homelessness.

- **1% Juvenile Justice Grants (JJCP & JJRBG) ($7M)**
  Funds screening, early intervention, counseling, and treatment referrals for probation-involved youth to prevent substance use and reduce recidivism.

- **3% Other Funding ($20.6M)**



Continuum of Care Projected Expenditures for DPH-SAPC

Continuum of Care	Adult			Child/Youth		
	Fiscal Year 26/27	Fiscal Year 27/28	Fiscal Year 28/29	Fiscal Year 26/27	Fiscal Year 27/28	Fiscal Year 28/29
Primary Prevention Services	$6,166,000.00	$6,166,000.00	$6,166,000.00	$25,661,000.00	$25,661,000.00	$25,661,000.00
Early Intervention Services	$0.00	$0.00	$0.00	$304,000.00	$314,000.00	$330,000.00
Outpatient Services	$132,713,000.00	$136,866,000.00	$143,986,000.00	$8,523,000.00	$8,790,000.00	$9,247,000.00
Intensive Outpatient Services	$76,208,000.00	$78,593,000.00	$82,682,000.00	$3,837,000.00	$3,957,000.00	$4,163,000.00
Crisis and Field Based Services	$21,758,000.00	$22,439,000.00	$23,606,000.00	$335,000.00	$346,000.00	$364,000.00
Residential Treatment Services	$291,989,000.00	$301,124,000.00	$316,790,000.00	$5,941,000.00	$6,127,000.00	$6,446,000.00
Inpatient Services	$30,353,000.00	$31,303,000.00	$32,931,000.00	$199,000.00	$205,000.00	$216,000.00
Housing	$44,665,000.00	$52,205,000.00	$46,265,000.00	$451,000.00	$527,000.00	$467,000.00

* Projected expenditures are estimates and subject to change

DMH and DPH-SAPC

Projected Housing Expenditures (FY 26/27-FY 28/29)

Projected BHSA Housing Funds at 30% of BHSA Allocation	Fiscal Year 26/27	Fiscal Year 27/28	Fiscal Year 28/29
	$ 254,661,000.00	$ 286,098,000.00	$ 303,702,000.00
Non-Time Limited Permanent Housing			
Rental Subsidies	$42,487,000.00	$43,621,000.00	$35,505,000.00
Operating Subsidies	$9,402,000.00	$9,402,000.00	$9,401,000.00
Bundled Rental and Operating Subsidies	$60,832,000.00	$63,396,000.00	$53,446,000.00
Time Limited/Interim Settings			
Rental Subsidies	$38,105,000.00	$45,721,000.00	$39,721,000.00
Bundled Rental and Operating Subsidies	$107,420,000.00	$118,269,000.00	$120,657,000.00
Other Housing Interventions			
Other Housing Supports: Landlord Outreach and Mitigation Funds)	$5,137,000.00	$137,000.00	$137,000.00
Other Housing Supports: Participant Assistant Funds	$6,021,000.00	$6,037,000.00	$5,898,000.00
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services	$31,857,248.00	$32,358,248.00	$26,192,248.00
Capital Development Projects	$40,268,000.00	$15,130,000.00	$1,041,000.00
MHSA Innovation Projects	$12,510,000.00	$12,510,000.00	$12,510,000.00
Housing Administration	$25,961,000.00	$24,275,000.00	$21,895,000.00
Total	**$ 380,000,248.00**	**$ 370,856,248.00**	**$ 326,403,248.00**

* Projected expenditures are estimates and subject to change

Community Planning Process

BHSA CPP - Highlights

ENGAGEMENT Activities

26 BHSA CPT sessions and forums focused on BHSA-related content (3-hour sessions).

- All meetings provided CART services, ASL interpretation, Korean/Spanish materials and interpretation, and in-person and online options.

Stipends were provided to clients and community representatives (e.g., SALT and UsCC Co-Chairs).

STAKEHOLDER Reach

- **All 30 DHCS identified stakeholder groups were engaged** in the BHSA CPT or through a BHSA-related forum or focus group.

- **Over 450 unduplicated people** representing **224 unduplicated organizations** participated in at least one session or forum from January to December 2025.

PARTICIPATION Snapshot

71% of CPT members identified as individuals with lived experience*

- **Consumers** of MH, SUD, or COD services
- **Family Members** of MH, SUD, COD consumers
- **Caregivers** of consumers of MH, SUD, COD consumers
- **Persons Experiencing Homelessness**
- **Survivors of Domestic Violence**
- **Veterans**

NOTE: 78 of the 110 BHSA CPT members who turned in their Member Information Form (MIF) selected one of these categories as their primary identification of lived experience. This is an unduplicated number.

All Service Areas were represented, with the greatest representation from Service Areas 4 and 6.

BHSA Community Planning Process (BHSA CPP)

PURPOSE OF ENGAGEMENT

Gather broad community input

Reach priority & underserved populations

Inform BHSA Integrated Plan priorities

FOCUS

- Behavioral Health Continuum of Care
- Statewide Population Behavioral Health Goals

PARAMETERS

- State: ‘What’
- Counties: ‘How’

COMMUNITY PLANNING PROCESS

- Time: January – December 2025
- Phases: Foundation Setting + Stakeholder Input + Stakeholder Feedback

STAKEHOLDER ENGAGEMENT

- DHCS' 30 Stakeholder Groups
- Diverse Community Planning Team

BHSA CPP - Journey

FOUNDATION SETTING

Jan – Feb – Mar

1. Generated stakeholder definition of behavioral health.
2. Identified similarities and differences among mental health and SUD stakeholders.
3. Reviewed DHCS' definition of behavioral health.
4. Developed frameworks for the BHSA CPP: membership, timeline, commitments, etc.
5. Formed initial BHSA Community Planning Team (CPT) and launched the BHSA CPP.

STAKEHOLDER INPUT

Apr – May – Jun – Jul - Aug

1. Used client-centered scenarios to review and understand the local behavioral health continuum of care (BHCoC).
2. Identified unmet needs & service gaps for Prevention, Early Intervention, Outpatient & Intensive Outpatient, and Housing Interventions.
3. Produced and reviewed disparity data for seven statewide behavioral health goals.
4. Identified factors driving disparities for each goal proposed stakeholder solutions to reduce disparities.
5. Expanded, diversified, and onboarded BHSA CPT.

STAKEHOLDER FEEDBACK

Sep – Oct – Nov - Dec

1. Reviewed BHSA-funded and non-BHSA-funded programs and services across the BHCoC.
2. Held 7 BHSA CPT sessions led by Subject Matter Experts to provide in-depth descriptions of specific programs and services across the BHCoC.
3. Held 1 BHSA CPT Forum to discuss content for Behavioral Health Prevention.
4. Held 2 BHSA Forums to discuss Housing Interventions content and obtain stakeholder input.
5. Held 3 youth-centered focus groups.

BHSA Community Planning Team (CPT)

THE BHSA CPT INCLUDED REPRESENTATIVES FROM DHCS' 30 STAKEHOLDER GROUPS

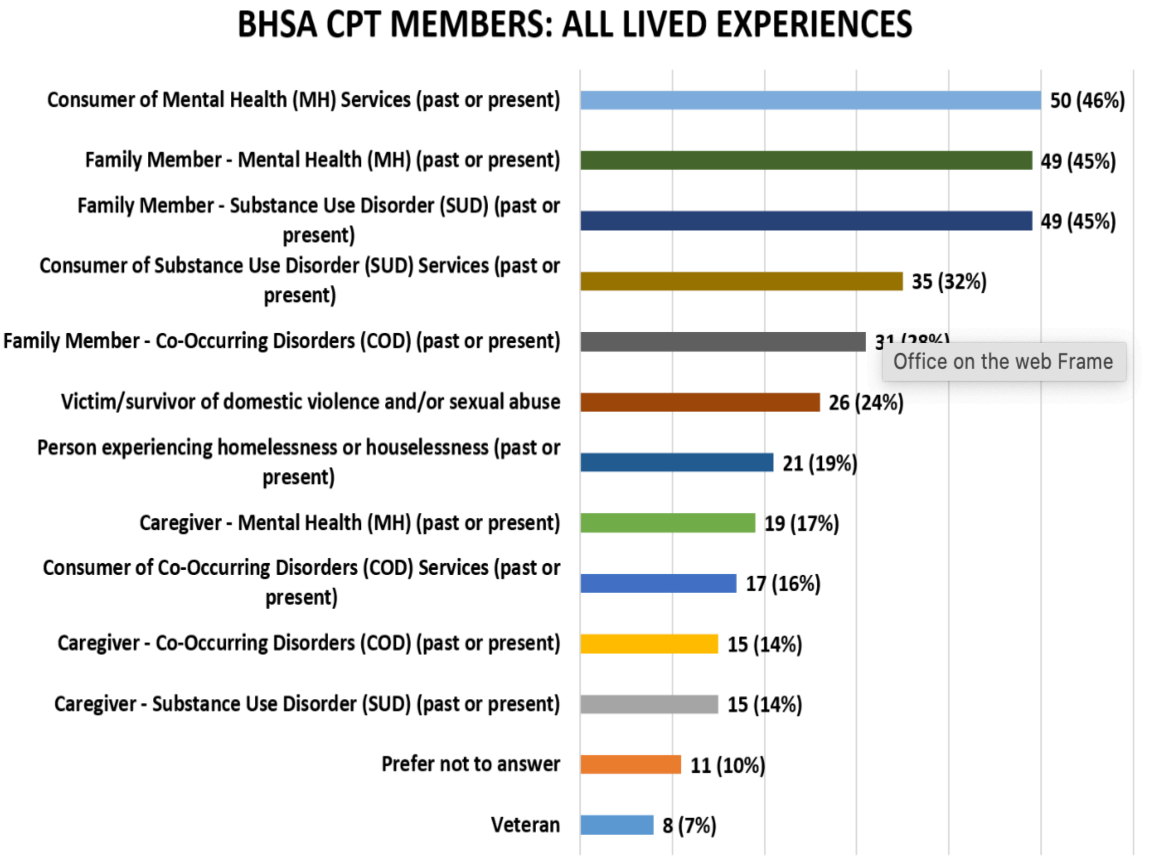
1. Area Agencies on Aging
2. BHSA Eligible Adults and Older Adults (Individuals With Lived Experience)
3. Community-Based Organizations Serving Culturally and Linguistically Diverse Constituents
4. Continuums of Care, including Representatives from the Homeless Service Provider Community
5. County Social Services and Child Welfare Agencies
6. Disability Insurers
7. Early Childhood Organizations
8. Emergency Medical Services
9. Families of BHSA Eligible Children and Youth, Eligible Adults, and Eligible Older Adults (With Lived Experience)
10. Higher Education Partners
11. Health Care Organizations, including Hospitals
12. Health Care Service Plans, including Medi-Cal Managed Care Plans
13. Independent Living Centers
14. Individuals with Behavioral Health Experience, including Peers and Families
15. Labor Representative Organizations
16. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+) Communities
17. Local Education Agencies
18. Local Public Health Jurisdictions
19. Organizations Specializing in Working with Underserved Racially and Ethnically Diverse Communities
20. People with Lived Experience of Homelessness
21. Providers of Mental Health Services
22. Providers of Substance Use Disorder Treatment Services
23. Public Safety Partners, including County Juvenile Justice Agencies
24. Regional Centers
25. The Five Most Populous Cities in Counties with A Population Greater Than 200,000
26. Tribal and Indian Health Program Designees Established for Medi-Cal Tribal Consultation Purposes
27. Veterans and Representatives from Veterans' Organizations
28. Victims of Domestic Violence and Sexual Abuse
29. Youth from Historically Marginalized Communities
30. Youths (Individuals With Lived Experience), Youth Mental Health Organizations, or Youth Substance Use Disorder Organizations

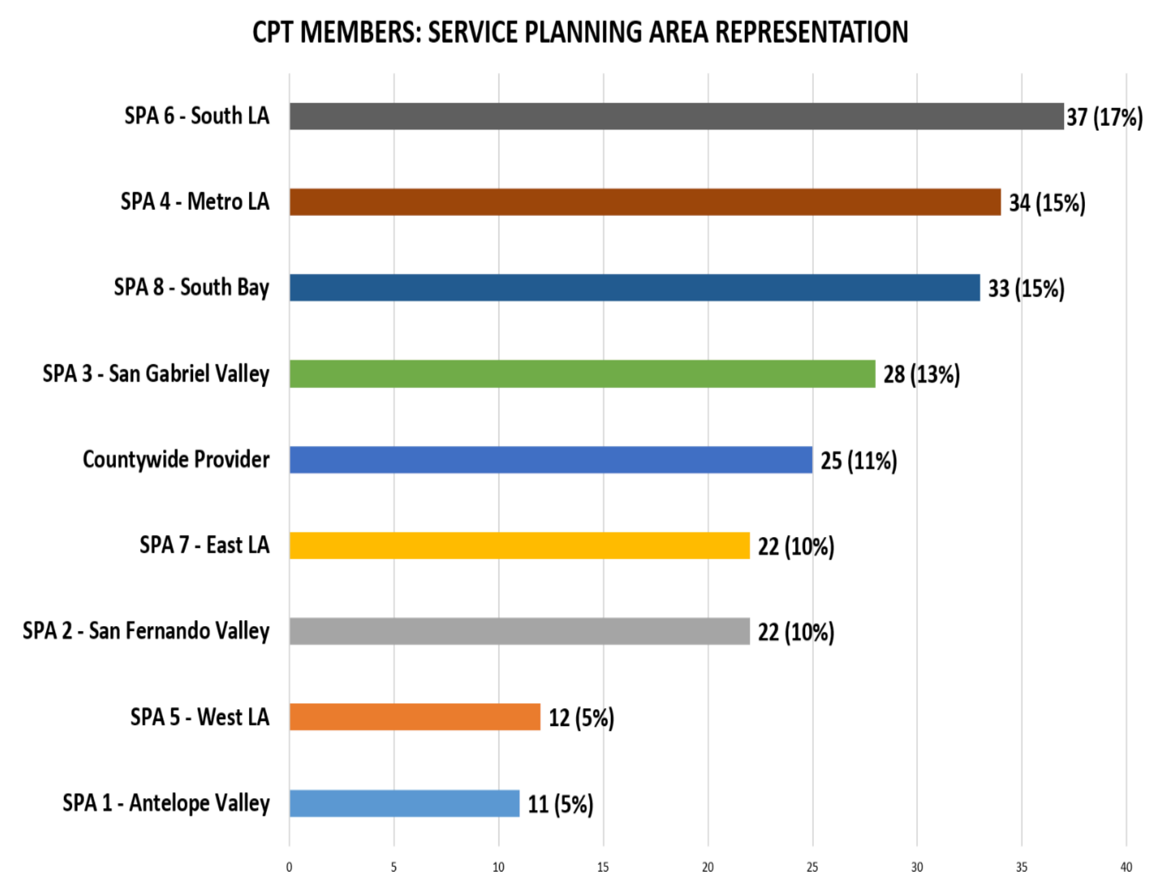
HIGHLIGHTS

- All DHCS stakeholder groups were engaged in the BHSA CPT or through a BHSA-related forum or focus group.
- From January to December 2025, over 450 unduplicated people representing 224 unduplicated organizations participated in at least one session or forum.

BHSA CPT Stakeholder Diversity

PEOPLE WITH LIVED EXPERIENCE & SERVICE AREA REPRESENTATION

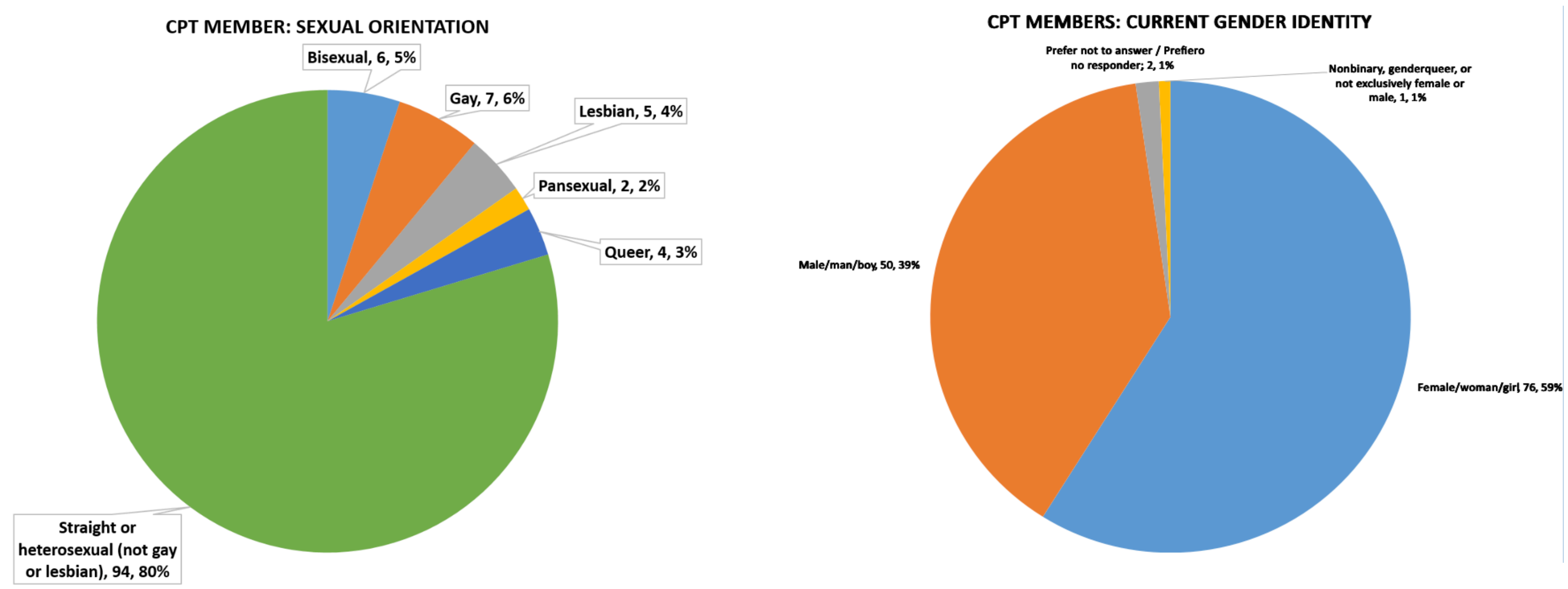




NOTE: This information comes from 109 of 139 CPT members that submitted their Member Information Form.

BHSA CPT Stakeholder Diversity

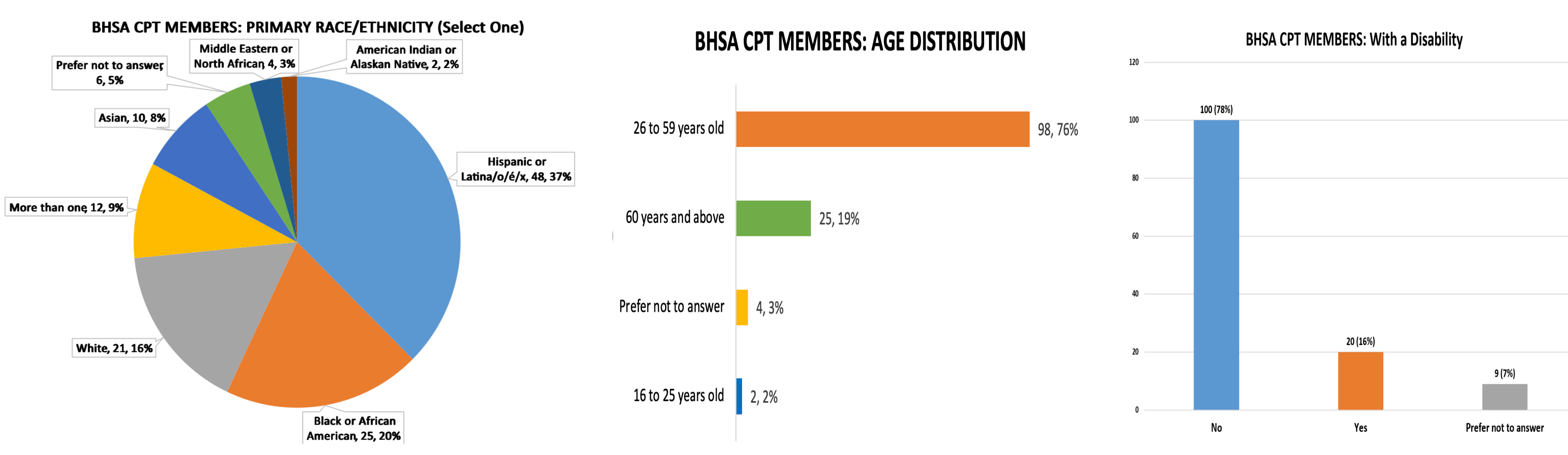
SEXUAL ORIENTATION AND GENDER IDENTITY



NOTE: This information comes from 109 of 139 CPT members that submitted their Member Information Form..

BHSA CPT Stakeholder Diversity

RACE/ETHNICITY, AGE DISTRIBUTION, AND DISABILITY



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Thank you