LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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MARVIN J. SOUTHARD, D.S.W.
Director
ROBIN KAY, Ph.D.
Chief Deputy Director
RODERICK SHANER, M.D.
Medical Director

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

18 October 20, 2015

PATRICK OGAWA
ACTING EXECUTIVE OFFICER

October 13, 2015

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

Dear Supervisors:

ADOPT THE DEPARTMENT OF MENTAL HEALTHS MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2015-16

(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Annual Update for Fiscal Year 2015-16.

IT IS RECOMMENDED THAT THE BOARD:

Adopt Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2015-16 (Attachment). The MHSA Annual Update has been certified by the County Mental Health Director and the County Auditor-Controller to meet specified MHSA requirements in accordance with Welfare and Institutions Code (WIC) Section 5847.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Adoption of the MHSA Annual Update is necessary in order for DMH to submit the Plan to the Mental Health Services Oversight and Accountability Commission (Commission) and is required by WIC Section 5847. Recent amendments to the MHSA require that the MHSA Three-Year Program and Expenditure Plan and the Annual Updates be adopted by the County Board of Supervisors. Additionally, it is required that the Three-Year Program and the Annual Updates be certified by the County Mental Health Director and the County Auditor-Controller attesting that the County has

complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the MHSA requirements. Under the MHSA, a draft Three-Year Program and Expenditure Plan and the Annual Updates must be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans. Additionally, the MHSA requires that the Mental Health Commission conduct a Public Hearing on the draft Three-Year Program and Expenditure Plan and the Annual Updates at the close of the 30-day comment period.

In order to fulfill the latter requirements, DMH posted the MHSA Three-Year Program and Expenditure Plan on its web site for 30 days for public comments on March 30, 2015. DMH also convened a Public Hearing on May 28, 2015, where DMH presented the update, addressed public questions and any concerns. The Mental Health Commission voted to approve the MHSA Annual Update for FY 2015-16 at its meeting on June 25, 2015.

Implementation of Strategic Plan Goals

The recommended actions support the County's Strategic Plan Goal 3, Integrated Services Delivery.

FISCAL IMPACT/FINANCING

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Assembly Bill (AB) 1467, chaptered into law on June 27, 2012, implemented changes to the MHSA law. AB 1467 requires each county mental health program to prepare and submit a Three-Year Program and Expenditure Plan and the Annual Updates, adopted by the County Board of Supervisors and submitted to the Commission. It also requires that the Three-Year Program and the Annual Updates be certified by the County Mental Health Director and the County Auditor-Controller. This includes the County Mental Health Director's certification as to the requisite stakeholder participation and compliance with MHSA non-supplantation provisions.

The Commission provided direction to the counties to complete MHSA Annual Updates through a memo dated August 2, 2013, and distributed the MHSA Fiscal Accountability Certification Form to be completed by the County Mental Health Director and County Auditor-Controller.

The public hearing notice requirements referenced in WIC Section 5848, subdivisions (a) and (b) have been fulfilled and are recorded in the MHSA Three-Year Program and Expenditure Plan. The County Auditor-Controller and County Mental Health Director have both signed the MHSA Fiscal Accountability Certification Form included in the Annual Update.

The MHSA Annual Update for FY 2015-16 builds upon the Department's approved MHSA Three-Year Program and Expenditure Plan for each MHSA component. It contains a summary of MHSA programs for FY 2013-14, including clients served by MHSA program and Service Area and program outcomes. In addition, the plan also describes the Department's ongoing planning process and progress on implementing the program expansions from the Three-Year Program and Expenditure Plan for FYs 2015-16 through 2017-18.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Annual Update for FY 2015-16 will ensure compliance with AB 1467 requirements.

Respectfully submitted,

MARVIN J. SOUTHARD, D.S.W.
Director of Mental Health

MJS:DM:DIG:RC:jv

Enclosures

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel
Auditor-Controller
Chairperson, Mental Health Commission

Los Angeles County - Department of Mental Health

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act

Annual Update

Fiscal Year 2015-16

Marvin J. Southard, D.S.W.
Director

Table of Contents

Introduction ……3

Executive Summary ……4-5

MHSA Plan Approval Dates ……6

MHSA County Compliance Certification ……7

MHSA County Fiscal Accountability Certification ……8

Mental Health Commission Approval Letter ……9

Los Angeles County Board of Supervisors Adopted Letter ……10-11

Acronyms ……13-15

Definitions ……16

Community Planning Process ……17-18

Community Services and Supports (CSS) ……19-51

- *CSS Client Counts*
- *CSS Programs*
- *Full Service Partnership Outcomes*
- *Alternative Crisis Services Outcomes*
- *Wellness Center*
- *Crossover Youth Multidisciplinary Team Program-Outcomes*
- *CSS Client Counts by Service Area*

Prevention and Early Intervention (PEI) …… 52-93

- *PEI Client Counts*
- *Evidence Based Practices Delivered*
- *Early Intervention Projects and Implementation*
- *PEI Practices Implemented*
- *PEI Prevention Programs*
- *PEI Outcomes*
- *PEI Client Counts by Service Area*

Innovation ……..94-97

Workforce Education and Training (WET) ……98-104

WET Regional Partnership ……105-106

Technological Needs ……107-108

Capital Facilities ……109

Fiscal Year 2014-15 MHSA Services by Component ……110-115

Budget ……116-123

Appendix ……124

- *I: Crossover Youth Multidisciplinary Team Program……125-141*
- *II: FSP Baseline Exception Reasons ……142-144*
- *III: START Outcomes……145-155*
- *IV: Disenrollment Guidelines……156-158*
- *V: Public Hearing Announcement……159-161*
- *VI: Public Hearing PowerPoint Presentation……162-179*
- *VII: Public Hearing Transcripts……180-196*
- *VIII: Public Comment Forms……197-198*
- *IX: Public Hearing Sign-In Sheets……199-203*

Introduction

Welfare and Institutions Code Section (WIC) 5847 states that county mental health programs shall prepare and submit a Three Year Program and Expenditure Plan followed by Annual Updates for Mental Health Services Act (MHSA) programs and expenditures. The MHSA Three Year Program and Expenditure Plan provides an opportunity for the Los Angeles County Department of Mental Health (Department) to review its MHSA programs and services and obtain feedback from a broad array of stakeholders on those services. Any changes made to the Department's MHSA program would need to be in accordance with the MHSA, current regulations and relevant state guidance.

The Department engaged in individual community planning processes for each component of the MHSA, as guidelines were issued by the California Department of Mental Health. Implementation of each component began after plan approval by either the California Department of Mental Health or the Mental Health Services Oversight and Accountability Commission (MHSOAC):

▪ Community Services and Support (CSS) Plan	*Feb. 14, 2006**
▪ Workforce Education and Training (WET) Plan	*April 8, 2009**
▪ Technological Needs (TN) Plan	*May 8, 2009**
▪ Prevention and Early Intervention (PEI) Plan	*Sept. 27, 2009**
▪ Innovation (INN) Plan	*Feb. 2, 2010**
▪ Capital Facilities (CF) Plan	*April 19, 2010**

**Date Approved by the State*

The programs funded within each component are described in this document, along with the number of clients served and relevant program outcomes.

Through the implementation of the MHSA, the Department has strived to create a service continuum for each age group that spans prevention, early intervention and a broad array of mental health community services and supports. Each component of the MHSA contributes to an array of services that will increase recovery, resiliency and create healthier communities.

Any questions or comments should be directed to:

Debbie Innes-Gomberg, Ph.D.
District Chief, MHSA Implementation and Outcomes Division
Los Angeles County Department of Mental Health
(213) 251-6817 or DIGomberg@dmh.lacounty.gov

MHSA Highlights for services delivered in Fiscal Year (FY) 2013-14

- 102,330 clients received a direct mental health service in a MHSA Community Services and Supports program, up from 97,370 in FY 2012-13.
  - 3 MHSA housing projects were opened, with 154 units
  - 43,765 unique clients received alternative crisis services designed to divert clients from psychiatric emergency departments and hospitals
  - Within 30 days of an UCC visit, only 6% of clients served present for care at an Emergency Department and only 11% are admitted to a psychiatric hospital within 30 days of a UCC visit.
  - Full Service Partnership programs reduce homelessness, incarcerations and hospitalizations and increase independent living for enrollees
  -

FSP Outcome Domain	Clients	Days
Homelessness- Adults	35% reduction	71% reduction
Incarcerations – Adults	13% reduction	50% reduction
Hospitalizations – adults	25% reduction	66% reduction
Independent Living – adults	47% increase	51% increase
Incarcerations – Transition Age Youth	54% reduction	60% reduction
Hospitalizations – Transition Age Youth	43% reduction	26% reduction
Independent Living – Transition Age Youth	39% increase	49% increase
Hospitalizations- children	36% reduction	39% reduction

- 66,628 unique clients received a direct mental health service from a Prevention and Early Intervention program
  - 51 different types of practices and services are offered across 13 different programs that encompass:
    - School-based services
    - Suicide prevention
    - Stigma and discrimination reduction
    - Family education and support
    - Services for at-risk families
    - Trauma services
    - Primary care and mental health service integration
    - Early care and support for Transition Age Youth and for older adults
    - Services geared to minimizing involvement with the criminal justice system
    - Improving mental health access for underserved populations
    - Increased resiliency and coping in the American Indian population

    - Prevention and early intervention practices continue to result in overall improvement when comparing symptoms prior to treatment to those reported at the conclusion of treatment.
- Workforce Education and Training projects have resulted in the following:
    - 106 stipends were awarded to social work, marriage and family therapy and nurse practitioner students
    - 37 individuals were trained at Health Navigators, with 76% self-identifying as being from an under-represented ethnic population and 54% speaking a threshold language other than English.
    - 154 staff participated in the Interpreter Training class
    - 1,083 students and faculty attended trainings on the MHSA to enhance interest in mental health careers
    - 194 staff participated in licensure preparation classes, with 57% of participants self-identifying as from an under-represented ethnic population.
- The Department's first Innovation project has resulted in a completed evaluation of 3 distinct models of integrated health, mental health and substance use care. All 3 models were deemed effective in reducing symptoms in those areas. The final model associated with Innovation 1 is the Peer-Run Model and that will conclude its learning on June 30, 2016.

Status of Implementation of New and Expanded Services Approved in the MHSA 3 Year Program and Expenditure Plan

Programs Already Implemented:

- Transition Age Youth FSP and FCCS expansion
- Wellness Center adjunct services addition, estimated to serve an additional 29,000 clients
- Older Adult FCCS expansion by 456 clients and FSP by 122 slots over the 3 Year Plan implemented in November, 2014
- Client Run Center expansion to each Service Area, expected to serve an additional 500 clients, implemented in April, 2015

Programs Targeted to Begin in May, 2015:

- Implementation of Assisted Outpatient Treatment/Laura's Law Program through the expansion of Full Service Partnerships and IMD Step Down services.
- Expand IMD Step Down by 22 beds to assist with the decompression of Emergency Departments.
- Expand Child FCCS capacity by 300

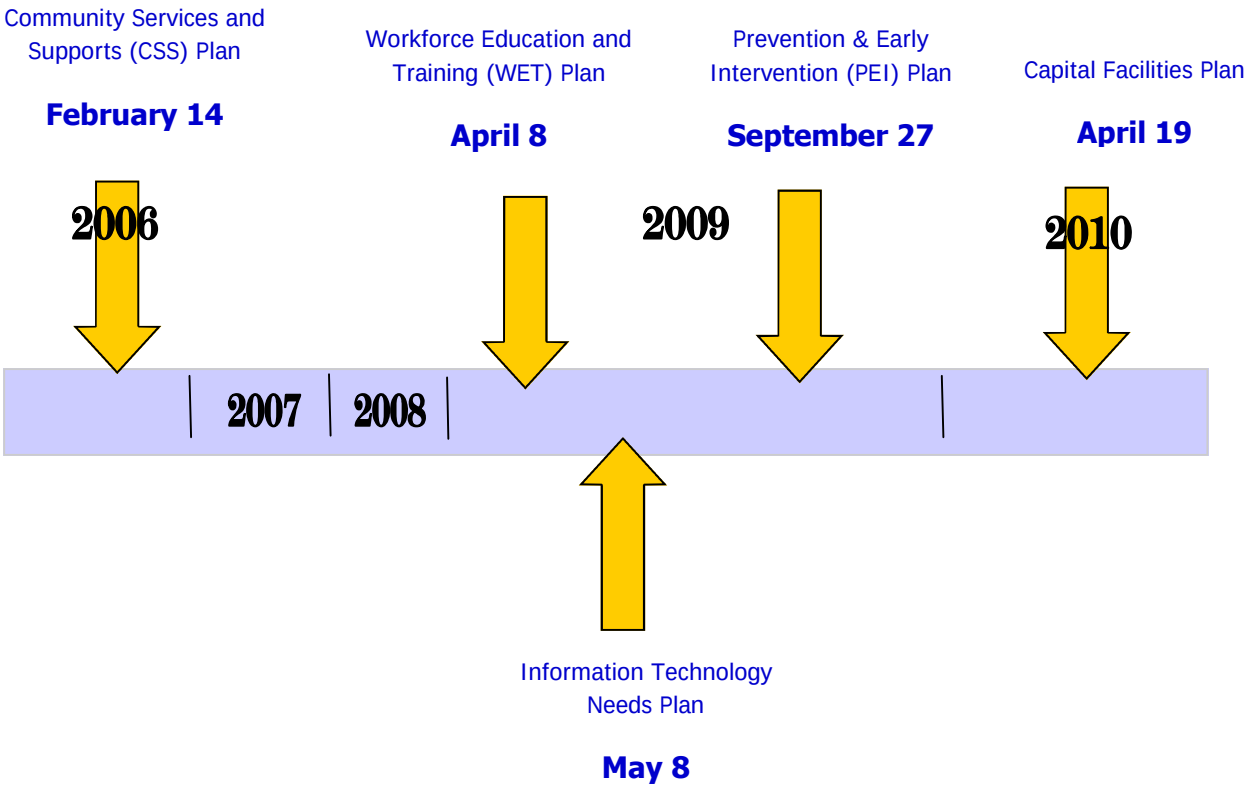
Implementation moved to FY 2015-16:

- TAY Drop-In Centers expansion by 400 clients. The Request for Services (RFS) under review.
- TAY Supported Employment services. The RFS is being drafted.
- Adult FCCS expansion by 50 clients and FSP by 25 slots with a target date of July, 2015
- Wellness Center staff expansion: (a) to add housing specialists, estimated to serve 1,500 clients and implemented in January, 2015; (b) to add 35 peer specialist staff, estimated to be be completed by June, 2015; and, (c) to implement Supported Employment, an evidence-based practice, estimated to begin July, 2015
- Housing Trust Fund utilizing temporary bridge funding completed, with an RFS for FY's 2015-16 and FY 2016-17 in development
- Community Mental Health Promoter/Community Health Worker program- Under Represented Ethnic Population groups informing implementation strategies and models.

Implementation Date to be Determined:

- Service component for 3 additional Mental Health Urgent Care Centers funded through SB 82 –CHFFA. A change in regulation has prompted a delay in implementation.

Mental Health Services Act
Plan Approval Dates by the State



MHSA COUNTY COMPLIANCE CERTIFICATION

County: Los Angeles

☐ Three-Year Program and Expenditure Plan
■ Annual Update

Local Mental Health Director	Program Lead
Name: Marvin J. Southard, D.S.W.	Name: Debbie Innes-Gomberg, Ph.D.
Telephone Number: (213) 738-4601	Telephone Number: (213) 251-6817
Email: msouthard@dmh.lacounty.gov	Email: digomberg@dmh.lacounty.gov

Local Mental Health Mailing Address:

County of Los Angeles - Department of Mental Health
MHSA Implementation and Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Annual Update, including stakeholder participation and nonsupplantation requirements.

This Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Marvin J. Southard, D.S. W.
Local Mental Health Director (Print)

_____
Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Los Angeles

- ☐ Three-Year Program and Expenditure Plan
- ■ Annual Update
- ☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller
Name: Marvin J. Southard, D.S.W.	Name: John Naimo
Telephone Number: (213) 738-4601	Telephone Number: (213) 974-8484
E-mail: msouthard@dmh.lacounty.gov	E-mail: jnaimo@auditor.controller.gov

Local Mental Health Mailing Address:

County of Los Angeles - Department of Mental Health
Program Support Bureau - MHSA Implementation and Outcomes Division
695 S. Vermont Avenue, 8th floor
Los Angeles, CA 90005

I hereby certify that the **Annual Update** is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the state Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the MHSA. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report are true and correct to the best of my knowledge.

Marvin J. Southard, D.S.W.
Local Mental Health Director

Signature 6/8/15 Date

I hereby certify that for the fiscal year ended June 30, 2015 the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892 (f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/16/14 for the fiscal year ended June 30, 2014. I further certify that for the fiscal year ended June 30, 2015, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891 (a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached report are true and correct to the best of my knowledge.

John Naimo
County Auditor-Controller (PRINT)

John Naimo 6/23/15
Signature Date

[1]Welfare and Institutions Code Sections 5847 (b)(9) and 5899 (a)
Three-Year Program and Expenditure Plan, Annual Update County/City Certification Final (07/26/2013)

Mental Health Commission Approval Letter

Los Angeles County
Mental Health Commission
"Advocacy, Accountability and Oversight in Action"

Board of Supervisors

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Mark Ridley-Thomas
Second District
Sheila Kuehl
Third District
Don Knabe
Fourth District
Michael D. Antonovich
Fifth District

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Herman DeBose, PhD
Vice Chair
CALMHBC Representative
Songhai Miguda-Armstead, JD
Secretary
Members-at-Large
Victoria A. Soltis
Lawrence Lue
Héctor Manuel Ramírez, PhD

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Lawrence J. Lue
Cynthia Sanchez

Second District
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Vacant

Health Deputy, 5th District
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Executive Director
Terry G. Lewis, MS, PPS

Commission Staff
Cheyenne Hurd, MBA
Sarah Hutchinson, SPWI

July 23, 2015

Marvin J. Southard, DSW
Director
Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Southard:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING
FISCAL YEAR 2015-16 ANNUAL UPDATE
NOTICE OF PLAN APPROVAL

On June 25, 2015 the Chairman and a quorum of the Los Angeles County Mental Health Commission (Commission) made the following motion following the Public Hearing of the Mental Health Services Act Fiscal Year 2015-16 Annual Update conducted at St. Anne's in Los Angeles County:

MOTION: The Los Angeles County Mental Health Commission moves to approve the Fiscal Year 2015-16 Annual Update.

It is, therefore, with pleasure that the Commission approve your Department's submission of the Fiscal Year 2015-16 Annual Update, which was publically posted on March 30,2015 and presented at the May 28, 2015 Public Hearing. We would also like to commend the Department for continuing to engage the Service Area Advisory Committees in the ongoing planning and implementation of the Mental Health Services Act.

The Commission looks forward to your continued progress improving the lives of clients receiving services in the public mental health system and continuing our partnership.

Sincerely,

Larry Gasco

Larry Gasco, PhD, LCSW
Chairman

LG:DIG:TGL:tgl

550 South Vermont Avenue, 12th Floor, Los Angeles, California 90020 – Phone: 213.738.4772 – Fax: 213.738.2120
Email: mentalhealthcommission@dmh.lacounty.gov
Website: http://wcmprd1.lts.lacounty.gov:10038/wps/portal/dmh/about_dmh/mhc

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Acronyms

ACS:	Alternative Crisis Services	EBP(s):	Evidence Based Practice(s)
ACT:	Assertive Community Treatment	ECBI:	Eyeberg Child Behavioral Inventory
ADLS:	Assisted Daily Living Skills	ECC:	Education Coordinating Council
AF-CBT	Alternatives for Families - Cognitive Behavioral Therapy	EESP:	Emergency Shelter Program
AI:	Aging Initiative	EPSDT:	Early Periodic Screening, Diagnosis and Treatment
AILSP:	American Indian Life Skills Program	ER:	Emergency Room
APF:	American Psychiatric Foundation	FCCS:	Field Capable Clinical Services
ARF:	Adult Residential Facility	FFP:	Federal Financial Participation
ART:	Aggression Replacement Training	FFT:	Functional Family Therapy
ASD:	Anti-Stigma and Discrimination	FOCUS:	Families Overcoming Under Stress
ASIST:	Applied Suicide Intervention Skills Training	FSP(s):	Full Service Partnership(s)
ASL:	American Sign Language	FSP/PSS:	Full Service Partnership
BSFT:	Brief Strategic Family Therapy	FSS:	Family Support Services
CalSWEC:	CA Social Work Education Center	FY:	Fiscal Year
CAPPS:	Center for the Assessment and Prevention of Prodromal States	Group CBT:	Group Cognitive Behavioral Therapy
CBITS:	Cognitive Behavioral Intervention for Trauma in Schools	GROW:	General Relief Opportunities for Work
CBO:	Community-Based Organizations	GVRI:	Gang Violence Reduction Initiative
CBT:	Cognitive Behavioral Therapy	HIPAA:	Health Insurance Portability and Accountability Act
CDE:	Community Defined Evidence	HOME:	Homeless Outreach and Mobile Engagement
CDOL:	Center for Distance and Online Learning	HSRC:	Harder-Company Community Research
CEO:	Chief Executive Office	HWLA:	Healthy Way Los Angeles
CF:	Capital Facilities	IBHIS:	Integrated Behavioral Health System
CFOF:	Caring for our Families	ICC:	Intensive Care Coordination
CiMH:	California Institute for Behavioral Health	ICM:	Integrated Clinic Model
CMHDA:	California Mental Health Directors' Association	IEP(s):	Individualized Education Program
CORS:	Crisis Oriented Recovery Services	IFCCS:	Intensive Field Capable Clinical Services
COTS:	Commercial-Off-The-Shelf	IHBS:	Intensive Home Base Services
CPP:	Child Parent Psychotherapy	ILP:	Independent Living Program
CSS:	Community Services & Supports	IMD:	Institution for Mental Disease
C-SSRS:	Columbia-Suicide Severity Rating Scale	Ind CBT:	Individual Cognitive Behavioral Therapy
CTF:	Community Treatment Facility	IMHT:	Integrated Mobile Health Team
CW:	Countywide	IMPACT:	Improving Mood-Promoting Access to Collaborative Treatment
DBT:	Dialectical Behavioral Therapy	IMR:	Illness Management Recovery
DCES:	Diabetes Camping and Educational Services	INN:	Innovation
DCFS:	DCFS Los Angeles County Department of Children and Family Services	IPT:	Interpersonal Psychotherapy for Depression
DHS:	Department of Health Services	IS:	Integrated System
DMH:	Department of Mental Health	ISM:	Integrated Service Management model
DPH:	Department of Public Health	ITP:	Interpreter Training Program
DTQI:	Depression Treatment Quality Improvement	IY:	Incredible Years

KEC:	Key Event Change
KHEIR:	Korean Health, Education, Information and Research
LACDMH:	Los Angeles County Department of Mental Health
LAPD:	Los Angeles Police Department
LGBTQ:	Lesbian/Gay/Bisexual/Transgender/Questioning
LIFE:	Loving Intervention Family Enrichment
LIHP:	Low Income Health Plan
LPP:	Licensure Preparation Program
MAP:	Managing and Adapting Practice
MAST:	Mosaic for Assessment of Student Threats
MDFT:	Multidimensional Family Therapy
MDT:	Multidisciplinary Team
MFT:	Masters in Family and Therapy
MH:	Mental Health
MHC:	Mental Health Clinic
MHCLP:	Mental Health Court Linkage Program
MHFA:	Mental Health First Aide
MHIP:	Mental Health Integration Program
MHRC:	Mental Health Rehabilitation Center
MHSA:	Mental Health Services Act
MHSOAC:	Mental Health Services Oversight and Accountability Commission
MMSE:	Mini-Mental State Examination
MORS:	Milestones of Recovery Scale
MOU:	Memorandum of Understanding
MP:	Mindful Parenting
MPAP:	Make Parenting a Pleasure
MPG:	Mindful Parenting Groups
MST:	Multisystemic Therapy
NACo:	National Association of Counties
NFP:	Nurse Family Partnerships
OA:	Older Adult
OACT:	Older Adult Care Teams
OASCOC:	Older Adult System of Care
OBPP:	Olweus Bullying Prevention Program
OEF:	Operation Enduring Freedom
OEP:	Outreach and Education Pilot
OND:	Operation New Dawn
OQ:	Outcome Questionnaire
PATHS:	Providing Alternative Thinking Strategies
PCIT:	Parent-Child Interaction Therapy
PDAT:	Public Defender Advocacy Team
PE:	Prolonged Exposure
PEARLS:	Program to Encourage Active, Rewarding Lives for Seniors
PEI:	Prevention and Early Intervention
PEMR(s):	Probation Electronic Medical Records
PE-PTSD:	Prolonged Exposure Therapy for Post-Traumatic Stress Disorder
PMHS:	Public Mental Health System
PMRT:	Psychiatric Mobile Response Team
PRISM:	Peer-Run Integrated Services Management
PRRCH:	Peer-Run Respite Care Homes
PSH:	Permanent Supportive Housing
PSP:	Partners in Suicide Prevention
PST:	Problem Solving Therapy
PTSD:	Post-Traumatic Stress Disorder
PTSD-RI:	Post-Traumatic Stress Disorder – Reaction Index
QPR:	Question, Persuade and Refer
RFS:	Request For Services
RFSQ:	Request For Statement of Qualifications
ROSTCP:	Recovery Oriented Supervision Training and Consultation Program
RPP:	Reflective Parenting Program
RRSR:	Recognizing and Responding to Suicide Risk
SA:	Service Area
SAAC:	Service Area Advisory Committee
SAPC:	Substance Prevention and Control
SED:	Severely Emotionally Disturbed
SF:	Strengthening Families Program
SH:	State Hospital
SLT:	System Leadership Team
SNF:	Skilled Nursing Facility
SPC:	Suicide Prevention Center
SPMI:	Severe and Persistently Mentally Ill
SS:	Seeking Safety
START:	School Threat Assessment And Response Team
TAY:	Transitional Age Youth
TF-CBT:	Trauma Focused-Cognitive Behavioral Therapy
TN:	Technological Needs
Triple P:	Triple P Positive Parenting Program
OMA:	Outcome Measures Application
UC:	Usual Care
UCC(s):	Urgent Care Center(s)
UCLA:	University of California, Los Angeles
UCLA TTM:	UCLA Ties Transition Model

UREP:	Under-Represented Ethnic Populations
USC:	University of Southern California
TSV:	Targeted School Violence
VALOR:	Veterans' and Loved Ones Recovery
WCRSEC:	Women's Community Reintegration Service and Education Centers
WET:	Workforce Education and Training
YOQ:	Youth Outcome Questionnaire
YOQ-SR:	Youth Outcome Questionnaire – Status Report
YTD:	Year To Date

Definitions

Adult Age Group: Age range is 26 to 59 years old.

Child Age Group: Age range is 0 to 15 years old.

Client contacts are based on Exhibit 6 reporting by program leads for FY 2013-14.

Client Run Center counts are based on client contacts using Community Outreach Services billing. Data as of February 9, 2015.

New Community Services and Supports clients may have received a non-MHSA mental health service.

New Prevention and Early Intervention clients may have received a non-MHSA mental health service.

Older Adult Age Group: Age range is 60+.

Transitional Age Youth Age Group: Age range is 16 to 25 years old.

Total client cost calculation is based on Mode 15 services, inclusive of Federal Financial Participation (FFP) & Early Periodic Screening, Diagnosis, and Treatment (**EPSDT**) Program. Not inclusive of community outreach services or client supportive services expenditures. Data as of February 9, 2015.

Unique client means a single client claimed in the Integrated System. Data as of February 9, 2015.

The Department's stakeholder process meets Welfare and Institutions Code 5848 on composition of the System Leadership Team (SLT) and meaningful involvement of stakeholders related to mental health planning, policy, implementation, monitoring, quality improvement, evaluation and budget allocations. The composition of the System Leadership Team (SLT) meetings and California Code of Regulations Section 3300 on stakeholder diversity.

To create meaningful stakeholder involvement, the Department engages three (3) levels of stakeholder involvement in ongoing mental health service delivery planning:

- The 58 member SLT, the Department's stakeholder workgroup to inform the implementation and monitoring of MHSA programs. The SLT's work during FY 2014-15 has been to plan and develop the Innovation 2 proposal on Health Neighborhoods, review the results of the Innovation 1 project on integrated care models and review progress in implementing services added through the MHSA 3 Year Program and Expenditure Plan. The composition of the expanded SLT is as follows:

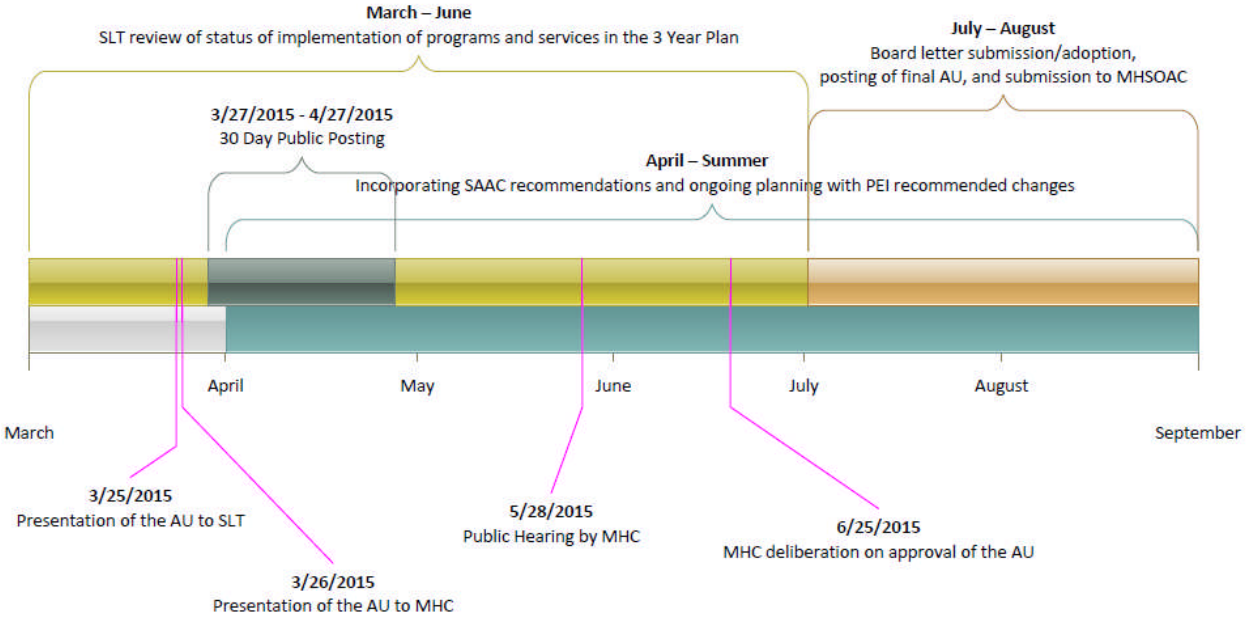
    - *Los Angeles County Chief Executive Office*
    - *Representation from each Service Area Advisory Committee*
    - *Consumer and family member representation, including National Alliance on Mental Illness, self-help and the Los Angeles County Client Coalition*
    - *Los Angeles County Department of Public Social Services*
    - *Health Care, including the Hospital Association and Los Angeles County Department of Public Health, Los Angeles County Department of Health Services*
    - *Los Angeles Police Department*
    - *Los Angeles County Probation*
    - *Housing Development*
    - *Older Adult service providers and Los Angeles County Community and Senior Services*
    - *Under-Represented Ethnic Populations, including Asian Pacific Islanders, American Indian, African American, Latino*
    - *Clergy*
    - *City of Long Beach*
    - *Veterans*
    - *Los Angeles County Mental Health Commission*
    - *Unions*
    - *Co-Occurring Joint Action Council*
    - *Education, including the Los Angeles Unified School District, universities and charter schools*
    - *Lesbian, Bisexual, Gay, Transgender and Questioning (LBGTQ)*
    - *Los Angeles County Department of Children and Family Services*
    - *Los Angeles County Commission on Children and Families*
    - *Junior blind*
    - *Statewide perspective*

- The efforts of the SLT are guided by standing committees formed to address specific issues such as planning, budget mitigation, and outcomes. These standing committees are comprised of volunteers from the SLT and Department managers with responsibility for planning, implementing and managing MHSA programs. The standing committee represented diverse perspectives and was a microcosm of the larger SLT. The standing committee was activated to inform the Department's plan for the second phase of Innovation 2 projects. It will be part of a mid-year adjustment to the Department's MHSA 3 Year Program and Expenditure Plan for Fiscal Years 2014-15 through 2016-17.

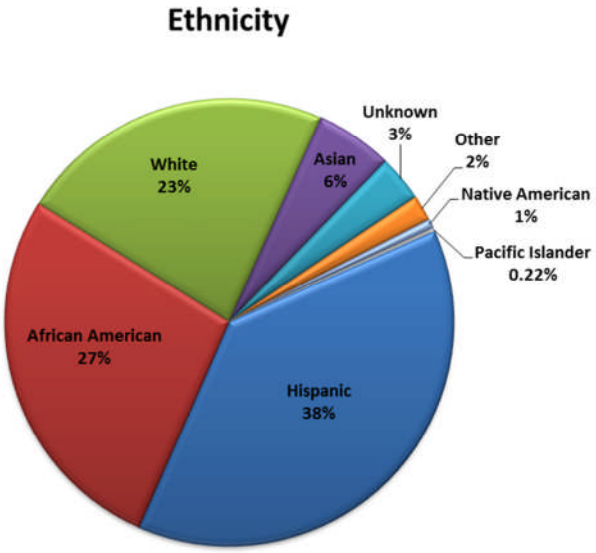
- The Service Area Advisory Committees (SAAC) continued their planning, aided by service utilization and outcome information for MHSA funded services in their service areas.

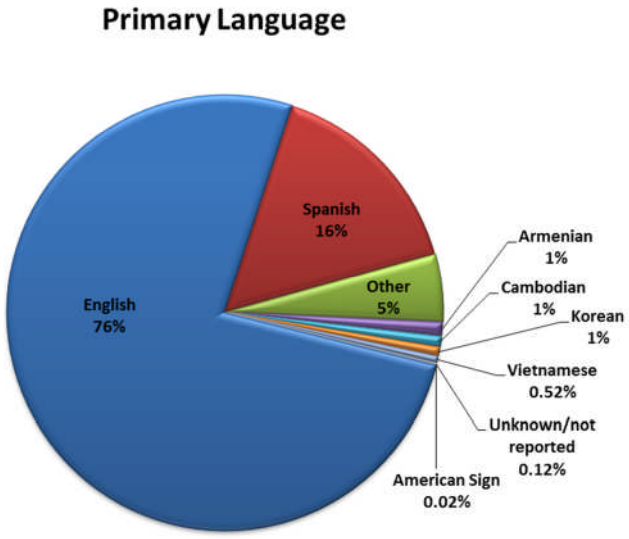
The Department provides training to new System Leadership Team members on the MHSA, the roles and responsibilities of SLT members and DMH services. The most recent orientation was conducted in October 2014. An orientation for new Mental Health Commission members is planned for April 2015.

The SLT heard a summary of data and information from the Annual Update on March 25, 2015. The Mental Health Commission was briefed on the Annual Update on March 26, 2015 and approved the plan on June 25, 2015.

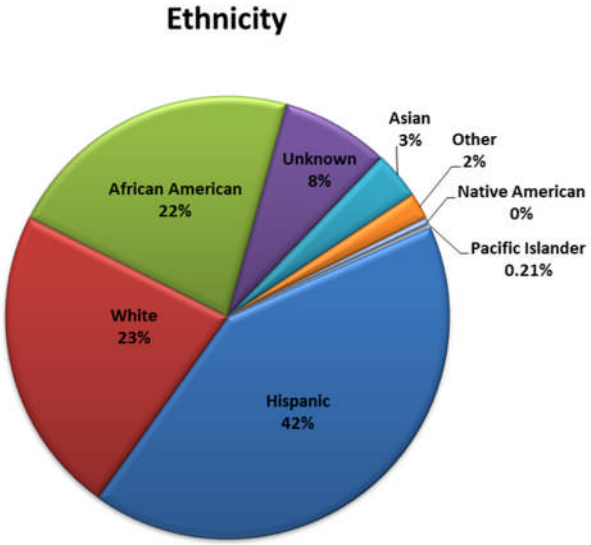


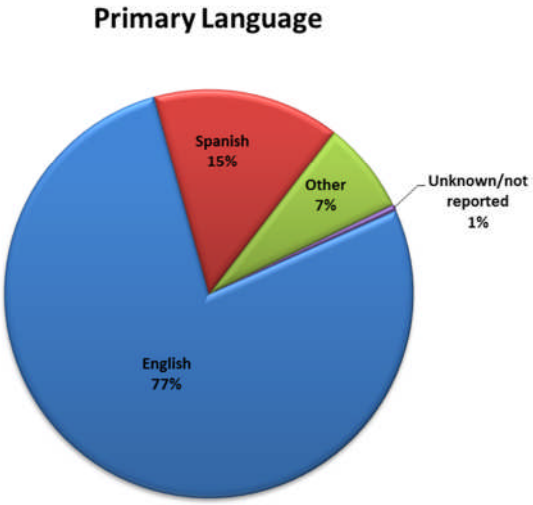
Unique clients receiving a direct Mental Health Service through the Community Services and Supports (CSS) Plan: 102,330





New clients receiving CSS Services Countywide with no previous MHSA Service: 14,405





Adult Full Service Partnership: A-01

Unique Clients Served: 5,453
Cost: $58,457,417
Average Cost per Client: $10,720
Slots Allocated: *4,866* (as of 7/3/2014)

Serves adults, ages 26-59, who have been diagnosed with a severe mental illness and would benefit from an intensive service program, who are homeless, incarcerated, transitioning from institutional settings, or for whom care is provided solely through the family and would be at risk of the above if it were not for the family's support. Services include a wide array of mental health services, medication support, linkage to community resources, housing, employment and money management services and assistance in obtaining needed medical care. Programs target clients from all ethnic communities, with a collaborative focusing specifically on the Asian Pacific Islander communities.

Focal Population Targeted: Homeless; Jail; Institutionalized (State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital); Lives with Family Members.

Full Service Partnership (FSP) Integration Pilot Project: The Los Angeles County Department of Mental Health (LACDMH) and 4 contract providers participated in the California Institute for Mental Health's Increasing Client Service Capacity Learning Collaborative to develop and test out and scale up strategies to increase client flow and increase service access. The learning resulted in the establishment of a pilot to expand the scope of FSP programs to include California Mental Health Directors' Association (CMHDA) Adult System of Care Level of Care 4 and 3 services and serve a slightly broader array of clients.

- As part of a 2 year pilot, six (6) adult mental health providers and two (2) older adult providers fiscally and programmatically integrated Field Capable Clinical Services (FCCS), level 3 into FSP, level 4 services so that all clients are considered FSP, as long as each client meets FSP criteria as defined in the MHSA CSS regulations.
- Eligibility for the newly integrated FSP population is the expanded definition of FSP as defined by the California Department of Mental Health (MHSA CSS Regulations).
- Each client receiving services from a pilot agency is rated monthly on the Milestones of Recovery Scale (MORS) to determine level of recovery as well as rated on 8 care determinants that are matched to level of service need.
- Providers collect FSP outcome data on all clients.
- FCCS funding will be transferred to FSP on each agency's financial summary, to be used consistent with FSP services and consistent with the Recovery Model.
- The Older Adult Pilot was initiated in April, 2013 and the Adult pilot started in July, 2013.
- All clients in the pilot are eligible for Client Supportive Services funding, based on LAC DMH Client Supportive Services Guidelines.
- Priority populations must be aligned with service area needs.

Pilot Goals:

- Reducing distinct financial service categories, broadening the FSP target populations to those defined in regulation will enhance service packages for clients of varying service intensity to best meet client needs.
- Increase access to FSP services.
- Provide the appropriate type and amount of service the client needs in a data-informed manner.
- Increase client program flow (to both improve client functioning and increase service capacity) and determine optimal length of treatment.
    - Flow into the pilot
    - Flow between levels of care
    - Determinants used to inform readiness for transition to a lower level of service
- Ensure services are cost effective.

Assessing Pilot Success:

- Each month providers receive a dashboard report outlining focal population percentages, client ethnicity, number of new enrollments and disenrollments and reason for disenrollments, MORS score summaries, percent of enrolled clients with level 4 service needs vs. level 3, percent of clients endorsing each of eight (8) service determinants, living arrangement and employment status of enrolled clients.
- The determinants of level of care are:
    - Client's current MORS score.
    - Client is unable to manage his/her own financial resources and requires formal or informal money management.
    - The client is not ready or is unable to coordinate his/her own transportation needs to and from appointments, education and occupation activities, and or other meaningful life activities.
    - The client requires formal or informal assistance with two (2) or more of the following Assisted Daily Living Skills (ADLs): hygiene, shopping, feeding, household chores, preparing meals, transferring, walking.
    - The client requires at least once per week contact with staff to coordinate his/her care.
    - The client requires formal or informal assistance or support to manage his/her medication.
    - The client requires assistance or support to manage community relations and minimize disruptive behaviors.
    - The client has been stable at the current MORS score for less than six (6) months.

Learning to be gained on best practices from Pilot:

- Identify reasons why clients are moving both from Level 4 to Level 3 and from Level 3 to Level 2 as a result of the pilot. What are the pilot agencies doing differently from the non-pilot agencies to cause this? A critical part of this analysis is considering the role of the Determinants of Level of Care, and what pilot agencies are doing to improve clients' success in addressing each of the determinants.
- Review and analysis of the differences between the clients who are successfully flowing through the system and those who are not in terms of their performance on the determinants. An analysis will be performed of the data obtained by plotting the success of both the successful and unsuccessful clients in improving on each of the determinants over a six (6) month period.
- Identify which determinants might discriminate between the two (2) groups. For those determinants, staff would attempt to analyze why a sample of 10 successful and 10 unsuccessful clients did better or worse in terms of their improvement on those

determinants. Staff would consider: 1) Did they use a particular successful intervention or practice? 2) What was the duration and frequency of time spent with the client overall and on this particular determinant? 3) Were there other relevant factors to consider?

- Once this initial analysis is completed, the pilot agencies will consider whether there are other factors besides agencies' ability to successfully address the determinants that impact a client's getting better overall.
- Additional analysis will include review of aggregate data showing for each determinant how many total clients went from 1 to 0 (most favorable); 0 to 0 (favorable); 1 to 1 (neutral); and 0 to 1 (unfavorable). The goal is to identify why clients fall in each group by analyzing the following: 1) certain client characteristics (i.e., gender, ethnicity, substance use, diagnosis, overall monthly cost, and length of time in FSP); and 2) factors related to service provision.
- Pilot agencies will also be reviewing and analyzing aggregate data showing the extent of positive change for each determinant to determine how this information might also inform best practices.

Wellness/Client Run Center: A-02

Unique Clients Served: 52,558

Client Contacts: 70,707 *(Services provided at Peer-Run Centers)*

Wellness Centers are programs staffed by at least 51% consumer staff, who provide an array of mental health and supportive services to clients at higher levels of recovery. Services include medication support, linkage to physical health and substance use services, self-help and a variety of peer-supported services, including crisis and self-management skill development.

IMD Step-Down Facilities: A-03

Client Contacts: 867

IMD Step-Down

IMD Step-Down Facility programs are designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities (ARF), and in some instances, assisted living, congregate housing or other independent living situations. The program also assists clients transitioning from acute inpatient and institutional settings to the community by providing intensive mental health, substance abuse treatment and supportive services.

Project 50

Project 50 is a County demonstration project that transitioned 50 of the most vulnerable, chronically homeless persons from the most concentrated area of homelessness in Los Angeles County (Skid Row) to permanent-supportive housing. Project 50 was approved by the Board of Supervisors on November 20, 2007 and is a collaborative effort that includes County departments, the City of Los Angeles, Los Angeles Homeless Services Association, and Veteran's Administration, and other community agencies. The program expanded to serve 74 individuals at any given time in 2010. It offers housing and comprehensive integrated supportive services for program participants.

Chronically homeless individuals with serious mental illness and co-occurring substance abuse disorders and/or complex medical conditions continue to live on the streets, under freeway bridges, and in encampments, parks, or temporary shelters in areas throughout the County. This has led to an expansion of programs for the chronically homeless through replications of Project 50.

Adult Housing Services: A-04

Client Contacts: 1,273

The Adult Housing Services include 14 Countywide Housing Specialists that, as part of a Service Area team, provide housing placement services primarily to individuals and families that are homeless in their assigned Service Area.

MHSA Housing Program

The MHSA Housing Program provides funding for permanent, supportive, affordable housing for individuals and their families living with serious mental illness, who are homeless. It is a Statewide program that includes a partnership with California Housing Finance Agency. DMH provides supportive services including mental health services to tenants living in MHSA funded units.

Below is a list of projects that opened during fiscal year 2013-14 through the MHSA Housing Program:

Countywide Housing, Employment and Education Resource Development (CHEERD)

Project Sponsor	Project Name	Service Area	Supervisorial District	Target Population	MHSA Units	Total Units	Date of Occupancy	MHSA CO Capital HAB Committed	MHSA CO Subsidy HAB Committed	Total HAB Committed
LTSC Community Development Corp.	Larry Itliong Village	4	1	TAY (16-25 ages)	5	45	December 10, 2013	$ 524,150	$ -	$ 524,150
LINC Housing Corporation	Mosaic Gardens	7	1	TAY (16-25 ages)	15	24	January 27, 2014	$ 1,754,318	$ -	$ 1,754,318
Mercy Housing California	Caroline Severance Manor	4	2	Families & Single Adults 18+	48	85	March 19, 2014	$ 8,531,840	$ 500,000	$ 9,031,840
				Total Number of Units	**68**	**154**		**Total**	**$ 500,000**	**$ 11,310,308**

Jail Transition & Linkage Services: A-05

Client Contacts: 3,580

Jail Transition and Linkage Services are designed to perform outreach and engage individuals involved in the criminal justice system who are receiving services from jail or jail related services (e.g. court workers, attorneys, etc.). The goal is to successfully link them to community-based services upon their release from jail. The program addresses the needs of individuals in collaboration with the judicial system by providing identification, outreach, support, advocacy, linkage, and interagency collaboration in the courtroom and in the jail. Jail transition and linkage staff work with the MHSA Service Area Navigators as well as service providers to assist incarcerated individuals with accessing appropriate levels of mental health services and support upon their release from jail, including housing, benefits and other services as indicated by individual needs and situations. The goal of these services is to prevent release to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services.

Adult Field Capable Clinical Services: A-06

Unique Clients Served: 9,984

Cost: $38,260,605

Average Cost per Client: $3,832

The Adult Field Capable Clinical Services (FCCS) program provides an array of recovery-oriented, field-based and engagement-focused mental health services to adults. Providers utilize field-based outreach and engagement strategies to serve the projected number of clients. The goal of Adult FCCS is to build the capacity of DMH to serve this significantly underserved population with specifically trained professional and paraprofessional staff working together as part of a multi-disciplinary team. Services provided include: outreach and engagement, bio-psychosocial assessment, individual and family treatment, evidence-based practices, medication support, linkage and case management support, treatment for co-occurring disorders, peer counseling, family education and support, and medication support.

Children's Full Service Partnership: C-01

Unique Clients Served: 2,352
Cost: $ 31,542,381
Average Cost per Client: $13,411
Slots Allocated: 1,771 (as of 7/1/2014)

Children's Full Service Partnership (FSP) program is comprised of resiliency-focused services created in collaboration with family/caretakers and a multidisciplinary team that develops and implement individualized plans. Child FSPs deliver intensive mental health services and support to children ages 0-15 who are high need, high risk Seriously Emotionally Disturbed (SED) children and their families/caretakers. Focal populations include children 0-5 with a serious emotional disturbance and children with a mental illness involved with Department of Children and Family Services, schools or the probation system.

Focal Population Targeted: Children ages, 0-15 with serious emotional disturbance (SED) and one or more risk factors: 0-5: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder; DCFS or risk of involvement; In transition to a less restrictive placement; experiencing in school: suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation; involved with probation and is on psychotropic medication and transitioning back into a less structured home/community setting.

Family Support Services: C-02

Client Contacts: 255

Family Support Services (FSS) provide access to mental health services such as individual psychotherapy, couples/group therapy, psychiatry/medication support, crisis intervention, case management linkage/brokerage, parenting education, domestic violence and co-occurring disorder services to parents, caregivers, and/or other significant support persons of FSP enrolled children who need services, but who do not meet the criteria to receive their own mental health services.

The Enhanced Respite Care Pilot was launched in April 2013 with families enrolled in Child Full Service Partnerships (FSP). The purpose of the pilot was to provide short-term relief to caregivers/parents that provide care for an FSP enrolled child or youth between the ages of 0-15 years old. Respite Care Services are positive, supportive services intended to help relieve families from the stress and family strain that result from providing constant care for a child with Severe Emotional Disturbance (SED). Eight (8) Child FSP agencies participated in the pilot with an allocation amount of $148,281. Ninety-five (95) families received Respite Care Services during Fiscal Year 2013-2014.

The ongoing process of monitoring includes conducting surveys with caregivers to assess satisfaction with respite services and determine whether changes to the process are needed. A total of 53 surveys were completed, 33 of which were conducted in English, 19 conducted in Spanish, and one (1) conducted in Cantonese. The families surveyed provided the following feedback: 77% of caregivers felt respite services decreased stress from caring for a child with SED. 76% of caregivers felt respite services allowed more time to focus on personal needs and other duties. 91% of the caregivers would recommend services to others, and 83% of caregivers expressed overall satisfaction with services.

Children Field Capable Clinical Services: C-05

Unique Clients Served: 8,879
Cost: $49,348,286
Average Cost per Client: $5,558

Children's Field Capable Clinical Services (FCCS) program provides an array of resiliency-oriented and field-based mental health services to children and families. Children's FCCS programs provide specialized mental health services delivered by a team of professional and para-professional staff. The focus of FCCS is working with community partners to provide a wide range of services that meet individual needs. The program is designed to provide services to individuals who are isolated, unwilling or unable to access traditional mental health outpatient services due to location/distance barriers, physical disabilities, or because of the stigma associated with receiving clinic-based services.

Intensive Field Capable Clinical Services (IFCCS) has been in operation in Los Angeles County since June 1, 2013. These services were developed in direct response to the State's implementation of an array of services called Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) related to the Katie A. lawsuit settlement. The goal of these services is to provide a coordinated child and family team approach to service delivery by engaging children and their families and assessing their strengths as well as their underlying needs. The team is tasked with identifying resources and providing linkage to help meet those needs. In addition they provide the necessary specialty mental health services such as individual and family therapy, individual rehabilitation, as well as psychiatric services and medication support. IFCCS served as the County's first-phase implementation of ICC and IHBS and was intended to serve Department of Children and Family Services involved children who were otherwise difficult to link to mental health services because their symptoms and behaviors often resulted in placement disruptions. Through the implementation of IFCCS, the Child Welfare Division has identified a significant shift associated with crisis intervention and stabilization indicating that the child and family team approach is having a positive influence on developing pro-active plans on working with children.

Older Adult Full Service Partnership: OA-01

Unique Clients Served: 759
Cost: $6,306,588
Average Cost per Client: $8,309
Slots Allocated: 585 (as of 6/30/2014)

The Older Adult (OA) FSP program provides services and support to clients ages 60 and older. The OA FSP assists individuals with mental health and substance abuse issues and ensures linkage to other needed services, such as benefits establishment, housing, transportation, healthcare and nutrition care. OA FSP program works collaboratively with the OA client, family, caregivers, and other service providers and

offers services in homes and the community. OA FSPs place an emphasis on delivering services in ways that are culturally and linguistically appropriate.

Focal Population Targeted: Older Adult ages 60+ with serious mental illness and one or more of the following risks: homeless or at imminent risk of homelessness; hospitalizations; jail or at risk of going to jail; imminent risk for placement in a skilled nursing facility (SNF) or nursing home or being released from SNF/nursing home; presence of a co-occurring disorder; serious risk of suicide or recurrent history; or is at risk of abuse or self-neglect.

Transformation Design Team: OA-02

The Older Adult Transformation Team provides system support to develop the infrastructure of older adult services within MHSA. The team:

- Monitors outcome measures utilized in the FSP & FCCS programs.
- Utilizes performance-based contracting measures to promote program services.

Field Capable Clinical Services: OA-03

Unique Clients Served: 2,653
Cost: $14,609,858
Average Cost per Client: $5,507

An individual must be either 60 years of age and above or be a "transitional age adult (55-59 years) and have a serious and persistent mental illness or have a less severe or persistent Axis I disorder that is resulting in a functional impairment or that places the Older Adult at risk of losing or not attaining a life goal, for example risk of losing safe and stable living arrangement, risk of losing or inability to access services, risk of losing independence.

Services provided include: outreach and engagement, bio-psychosocial assessment, individual and family treatment, medication support, linkage and case management support, treatment for co-occurring disorders, peer counseling, family education and support. FCCS will directly respond to and address the needs of unserved/underserved older adults by providing screening, assessment, linkage, medication support, and geropsychiatric consultation.

Service Extenders: OA-04

Stipend Recipients: 37

Service Extenders include peers in recovery, family members and other individuals interested in providing services to older adults as part of the multi-disciplinary FCCS teams. 40 individuals are targeted for receiving these services.

Older Adult Training: OA-05

The Older Adult Training Program addresses the training needs of existing mental health professionals and community partners by providing the following training topics: field safety, elder abuse, documentation, co-occurring disorders, hoarding, geriatric psychiatry, geropsychiatry fellowship, service extenders and evidence based practices.

Transitional Age Youth Full Service Partnership: T-01

Unique Clients Served: 1,661
Cost: $18,812,359
Average Cost per Client: $11,326
Slots Allocated: 1,250 (as of 6/30/2014)

Transition Age Youth (TAY) FSP program delivers intensive mental health services and support to high need and high-risk Severely Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY ages 16 -25. TAY FSPs place an emphasis on recovery and wellness while providing an array of community and social integration services to assist individuals with developing skill-sets that support self-sufficiency. The foundation of the TAY FSP program is doing "whatever it takes" to assist individuals with accessing mental health services and supports (e.g. housing, employment, education and integrated treatment for those with co-occurring mental health and substance abuse disorders). Unique to FSP programs are a low staff to consumer ratio, a 24/7 crisis availability and a team approach that is a partnership between mental health staff and consumers.

Focal Population Targeted: TAY ages 16-25 with serious emotional disturbance and or/severe and persistent mental illness and one or more of the following risks: homeless or at risk of homelessness; aging out of child mental health system, child welfare system or juvenile justice system; leaving long term institutional care; or experiencing 1st psychotic break.

Transitional Age Youth Drop - In Centers: T-02

Client Contacts: 1,087

TAY Drop-In Centers are intended as entry points to the mental health system for homeless youth or youth in unstable living situations. Drop-In Centers provide "low demand, high tolerance" environments in which youth can find temporary safety and begin to build trusting relationships with staff members who can connect them to the services and supports they need. Drop-In Centers also help to meet the youths' basic needs such as meals, hygiene facilities, clothing, mailing address, and a safe inside place to rest. Generally, these centers are operated during regular business hours. MHSA funding allows for expanded hours of operation of Drop-In Centers during evenings and weekends when access to these centers is even more crucial.

The following are the TAY drop-in center locations:

Pacific Clinics
HOPE Youth Center
13001 Ramona Blvd., Suite I
Irwindale, CA 91706
(626) 337-3828

LA Gay and Lesbian Center
The Youth Center on Highland
1220 N. Highland Ave.
Los Angeles, CA 90038
(323) 860-2280; Toll Free (888) 255-2429

Transitional Age Youth Housing Services: T-03

Client Contacts: 814

Housing related systems development investments for the TAY population include:

- Enhanced Emergency Shelter Program (EESP) (previously, Motel Voucher Program) for TAY that are homeless, living on the streets and in dire need of immediate short-term shelter while more permanent housing options are being explored.
- A team of 8 Housing Specialists develop local resources and help TAY find and move into affordable housing.

Transitional Age Youth Probation Camps: T-04

Client Contacts: 1,915

TAY Probation Camp Services provide services to youth ages 16 to 20 who are residing in Los Angeles County Probation Camps; particularly youth with SED, SPMI, those with co-occurring substance disorders and/or those who have suffered trauma.

A multidisciplinary team of parent/peer advocates, clinicians, probation staff, and health staff provide an array of on-site treatment and support services that include the following: assessments, substance abuse treatment, gender-specific treatment, medication support, aftercare planning and transition services. TAY Probation services fund mental health staff at the following probation camps: Camp Rockey-Paige-Afflerbaugh, Camp Scott-Scudder, Camp Holton-Routh, Camp Gonzales, Challenger Complex and Camp Miller-Kilpatrick.

Transitional Age Youth Field Capable Clinical Services: T-05

Unique Clients Served: 2,443

Cost: $11,176,871

Average Cost per Client: $4,575

The Transitional Age Youth Field Capable Clinical Services (FCCS) program provides an array of resiliency-oriented, field-based and engagement-focused mental health services to TAY and their families. The TAY FCCS program provides specialized mental health services delivered by a team of professional and paraprofessional staff. The focus of the FCCS program is to work with community partners to provide a wide range of services that meet individual needs. The TAY FCCS program is designed to provide services to individuals who are isolated, unwilling or unable to access traditional mental health outpatient services due to location/distance barriers, physical disabilities, or because of the stigma associated with receiving clinic-based services.

Alternative Crisis Services: ACS-01

Client Contacts: 43,765

Alternate Crisis Services (ACS) provides a comprehensive range of services and supports for mentally ill individuals that are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care, reduce homelessness, and prevent incarceration. These programs are essential to crisis intervention and stabilization, service integration, and linkage to community-based programs, e.g. Full Service Partnerships (FSP) and Assertive Community Treatment Programs (ACT),

housing alternatives and treatment for co-occurring substance abuse. ACS provides these services and supports to individuals 18 years of age and older of all genders, race/ethnicities, languages spoken.

Countywide Resource Management:

Responsible for overall administrative, clinical, integrative and fiscal aspects of the programs. Coordinates functions to maximize flow of clients between various levels of care and community-based mental health services and supports.

Residential and Bridging Program:

Involves psychiatric social workers and peer advocates assisting in the coordination of psychiatric services and supports for TAY, Adults, and Older Adults with complicated psychiatric and medical needs. The program ensures linkages to appropriate levels and types of mental health and supportive services through collaboration with Service Area Navigators, Full Service Partnerships, residential providers, self-help groups, and other community providers. Peer advocates provide support to individuals in IMDs, IMD step-down facilities, and intensive residential programs to successfully transition to community living.

The County Hospital Adult Linkage Program is part of the Residential and Bridging program and has a mission to assist in the coordination of psychiatric services for Department of Mental Health (DMH) clients at Department of Health Services (DHS) County Hospitals in order to ensure linkage of clients being discharged with the appropriate level and type of mental health, residential, substance abuse, or other specialized programs. The County Hospital Adult Linkage Program promotes the expectation that clients must be successfully reintegrated into their communities upon discharge and that all care providers must participate in client transitions.

Service Area Navigator: SN-01

Client Contacts: 21,766

Service Area Navigator Teams assist individuals and families in accessing mental health and other supportive services and network with community-based organizations in order to strengthen the array of services available to clients of the mental health system. Such networking creates portals of entry in a variety of settings that would make the Department's long-standing goal of "no wrong door" achievable. The Service Area Navigators increase knowledge of and access to mental health services through the following activities:

- Engaging in joint planning efforts with community partners, including community-based organizations, other County Departments, intradepartmental staff, schools, health service programs, faith-based organizations, self-help and advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services available to clients in the mental health system.
- Promoting awareness of mental health issues and the commitment to recovery, wellness and self-help.
- Engaging with people and families to quickly identify currently available services, including supports and services tailored to a client's particular cultural, ethnic, age and gender identity.
- Recruiting community-based organizations and professional service providers to become part of an active locally-based support network for people in the service area, including those most challenged by mental health issues.
- Following up with people with whom they have engaged to ensure that they have received the help they need.

Planning Outreach & Engagement: POE-01

Client Contacts: 21,209

Homeless Outreach and Mobile Engagement Team (HOME)

Formerly known as HOET, provides county-wide, field-based, and dedicated outreach and engagement services to the most un-served and under-served of the homeless mentally ill population. In this capacity its staff function as the 'first link in the chain' to ultimately connect the homeless mentally ill individual to recovery and mental health wellness services through a collaborative effort with other care giving agencies and county entities. HOME serves predominantly adults and TAY by providing intensive case management services, linkage to health services, substance abuse, mental health, benefits establishment services, transportation, assessment for inpatient psychiatric hospitalizations, and any other services required in order to assist the chronically homeless and mentally ill across gender, cultural and linguistic diversity.

Under-Represented Ethnic Populations (UREP)

Through the use of one time funding, the Department has been able to fund projects aimed at serving unserved, underserved and inappropriately served populations with the goal of reducing racial/ethnic disparities. One such example is training for and services provided by Community Mental Health Promoters. The purpose of the training is to support the development and increase the capacity of Promoters to perform specialized mental health work with the Latino community, including mental health outreach to the Latino indigent population and monolingual Spanish-speaking communities. Similarly, a mental health worker program has been designed to provide professional support for Latino students interested in entering the mental health field. This project enhances existing mental health paraprofessional training programs.

MHSA programs such as the ones mentioned focus on reducing racial/ethnic disparities and providing services to unserved, underserved populations and inappropriately served.

Crossover Youth Multidisciplinary Team Program (MDT)

For several years, DMH has participated in a program, referred to as the Crossover Youth Multi-disciplinary Team Program, in cooperation with the Departments of Children and Family Services (DCFS) and Probation. The purpose of the program is to evaluate youth who are the subject of a WIC§ 241.1 hearing (created for those youth who are part of the Dependency system and then allegedly commit crimes and become simultaneously part of the Delinquency system) and to make recommendations to the juvenile court regarding the legal status of the referred youth and the services and supports necessary to promote the best interests of the youth and the safety of the community. The program originated with one psychiatric social worker servicing the Pasadena Delinquency Court and has now expanded to allow DMH to participate in the program more fully and provide mental health staffing for the multi-disciplinary teams across the county (there currently are a total of ten PSWs to cover the ten delinquency courtrooms across Los Angeles County that are participating in this crossover model). The DMH social workers are co-located in DCFS offices across Los Angeles County. The youth are identified in the same manner as the 241.1 youth (who will now be treated as MDT cases). JCMHS PSWs are required to do the following:

- Review available records of referred youth related to mental health, child welfare, and Probation history. Records will include, but will not be limited to: court files, police reports, current and past mental health reports, Individualized Education Plans (IEPs), psychiatric hospital discharge summaries, and DCFS court reports. Records will be reviewed for the purpose of providing information to the other MDT members during the meetings and for writing reports.

- Consult with case-carrying Children's Social Worker and the assigned Deputy Probation Officer, as well as attorneys, children's advocates, and others on the multi-disciplinary team.

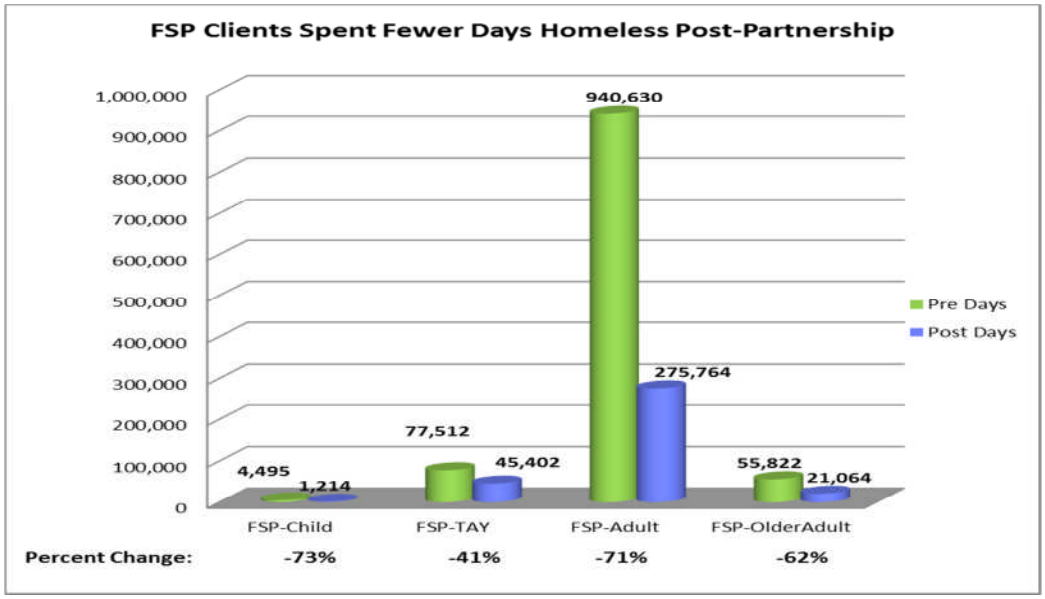
- Conduct comprehensive mental health evaluations of referred youth (when permitted within the guidelines of the multi-disciplinary team) and prepare written reports of findings and recommendations that are then presented to the delinquency judicial officer to assist him/her with disposition.

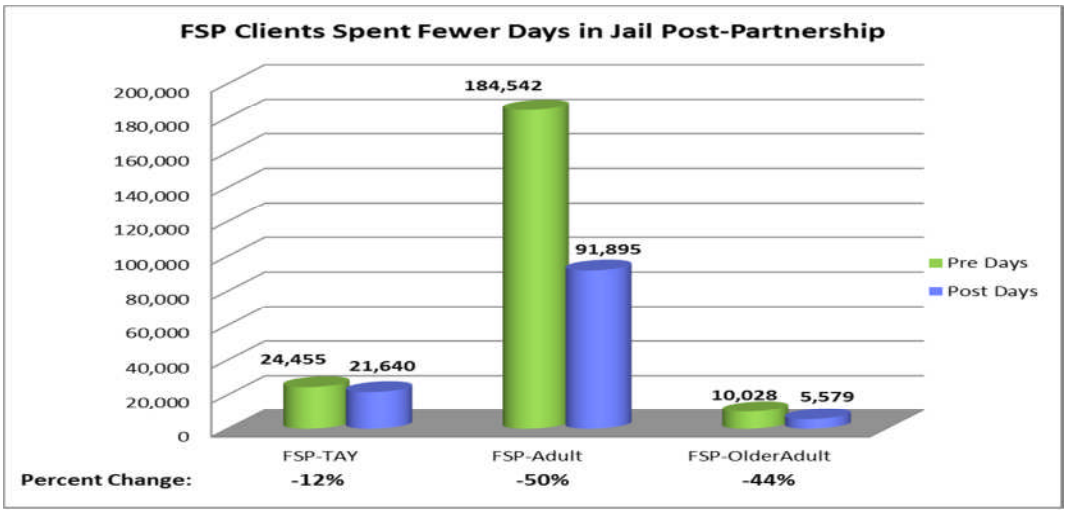
- Participate in multi-disciplinary team meetings to discuss findings and recommendations and appear in juvenile delinquency court hearings as requested.

Please see Appendix I for more information on Crossover Youth Multidisciplinary Team Program outcomes.

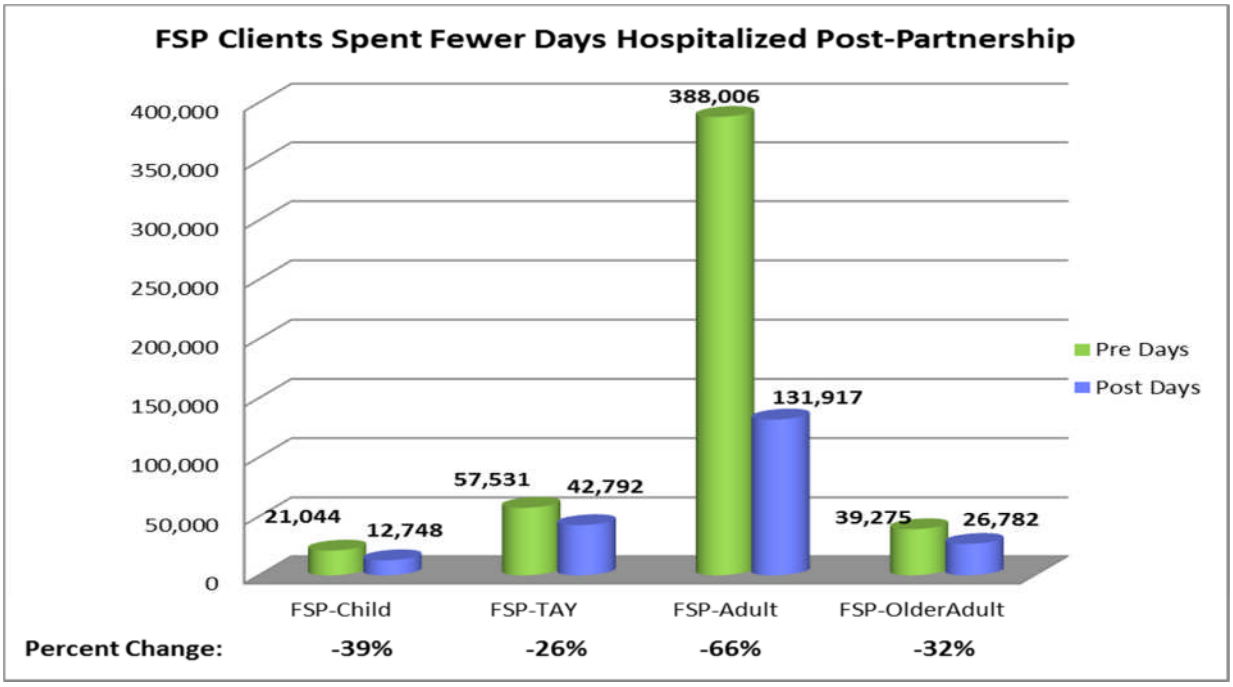
Residential

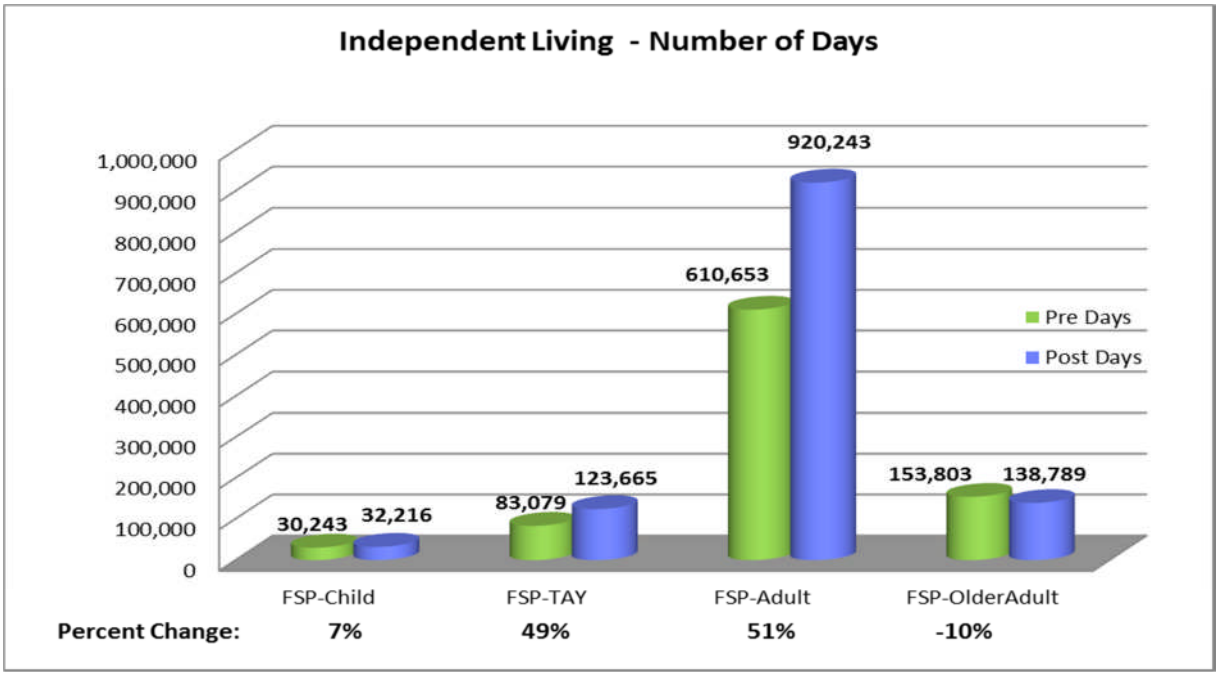
Number of Baselines Included* (N) - Child: 7,074
Transitional Age Youth: 3,328
Adult: 9,836
Older Adult: 1,081

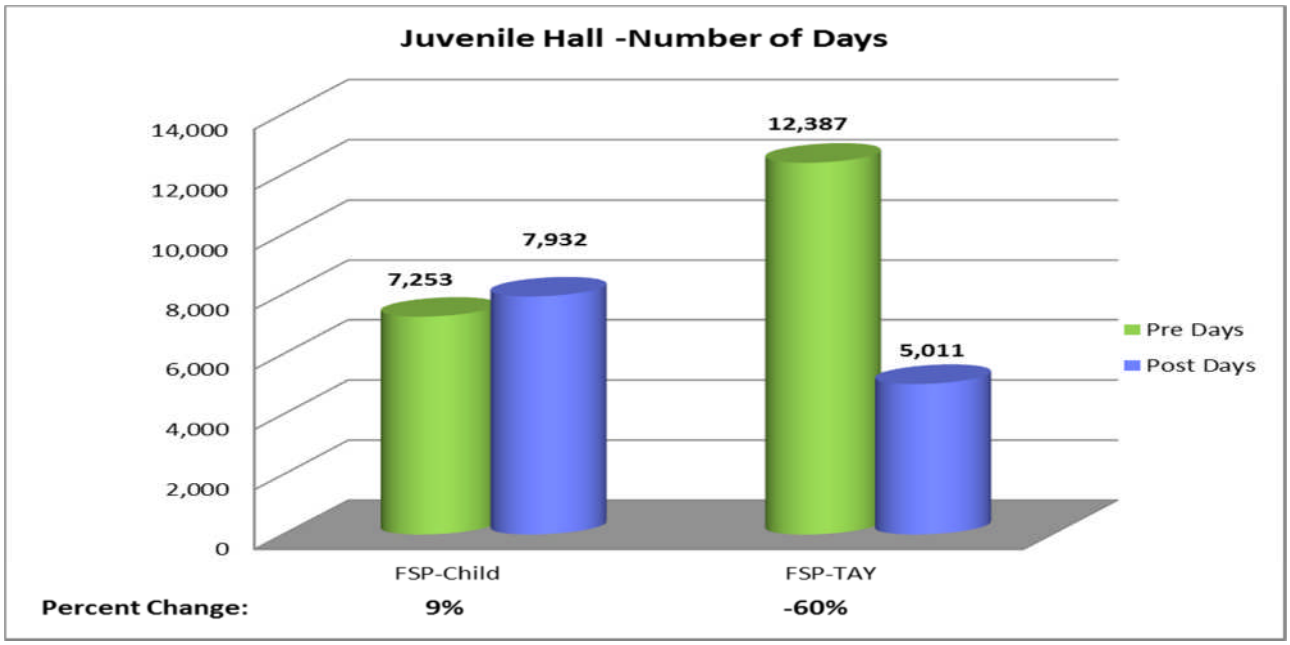


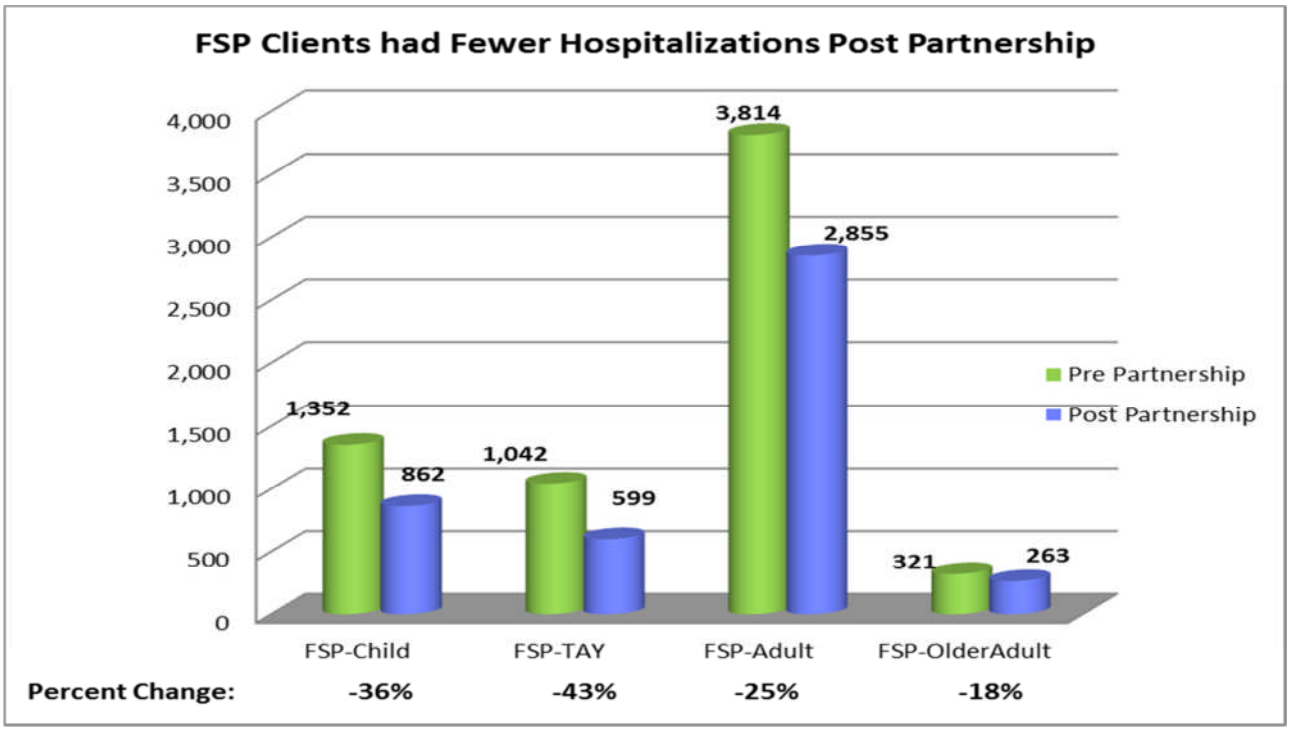


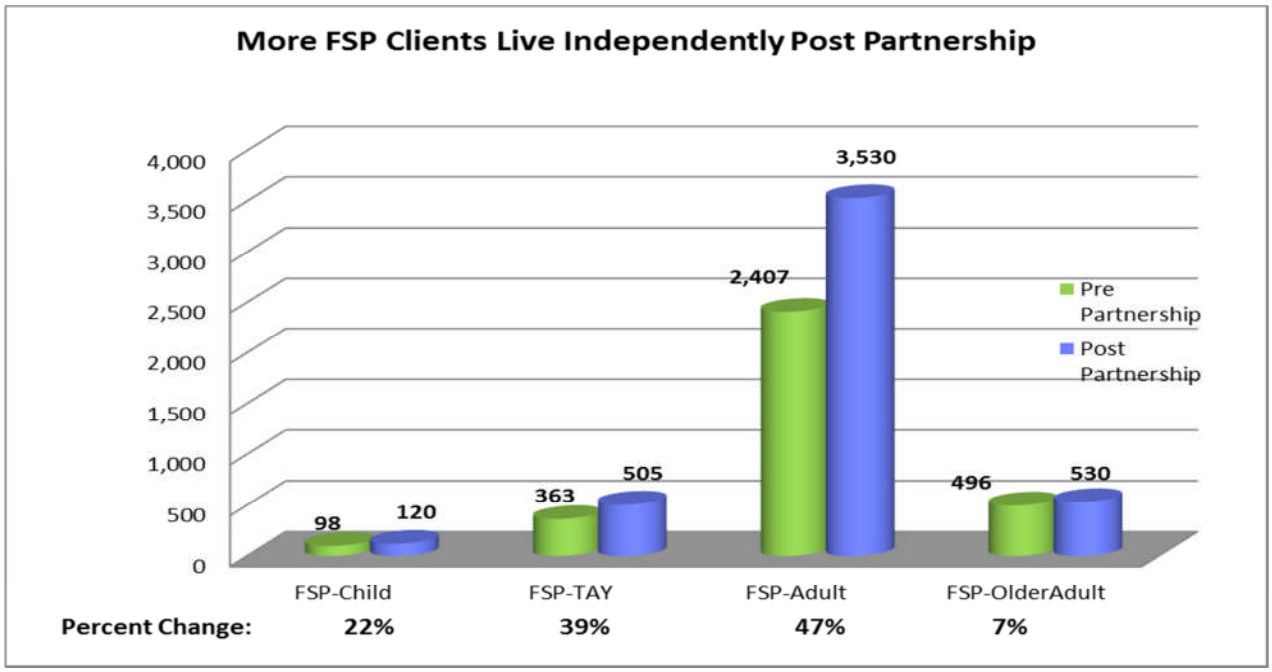
* Baselines are excluded when data does not meet reporting standards. The average baseline inclusion rate for FSP programs is 90%. See Appendix II for a list of reasons data does not meet reporting standards.

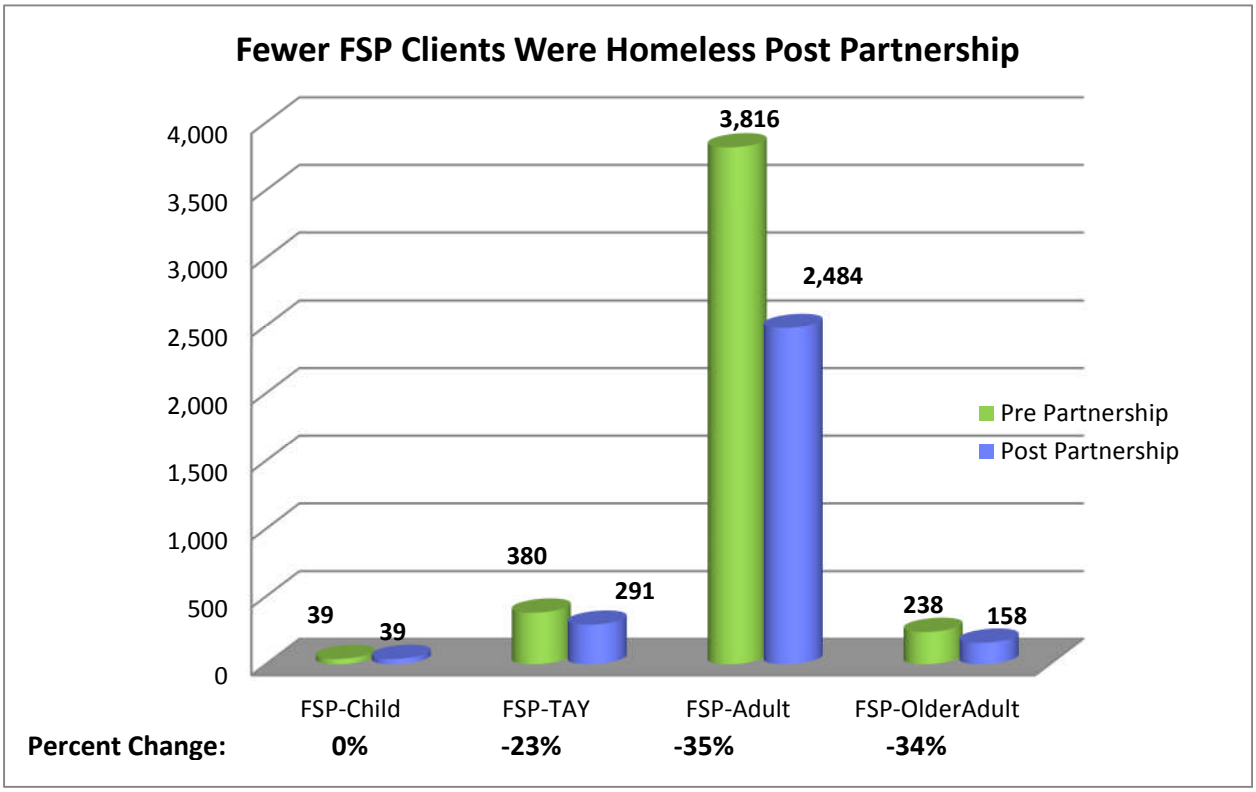

FSP Clients Spent Fewer Days Hospitalized Post-Partnership
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
21,044
12,748
57,531
42,792
388,006
131,917
39,275
26,782
Pre Days
Post Days
FSP-Child
FSP-TAY
FSP-Adult
FSP-OlderAdult
Percent Change:
-39%
-26%
-66%
-32%

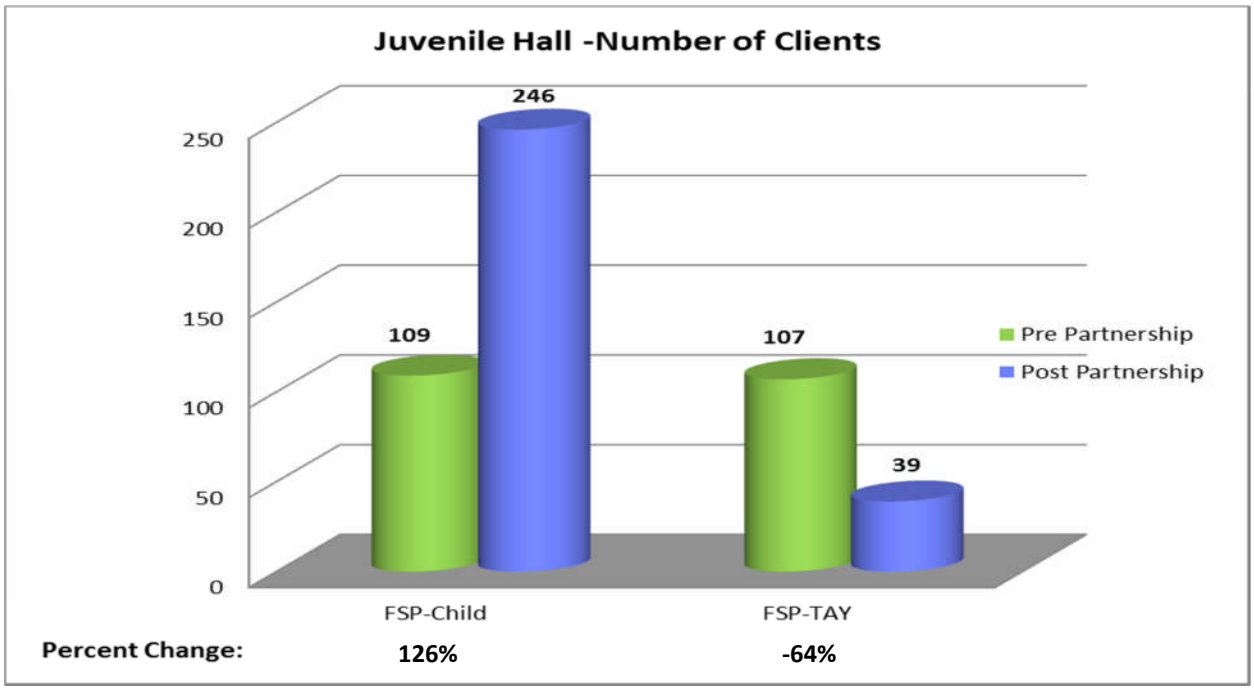

Independent Living - Number of Days
1,000,000
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
30,243
32,216
83,079
123,665
610,653
920,243
153,803
138,789
Pre Days
Post Days
FSP-Child
FSP-TAY
FSP-Adult
FSP-OlderAdult
Percent Change:
7%
49%
51%
-10%

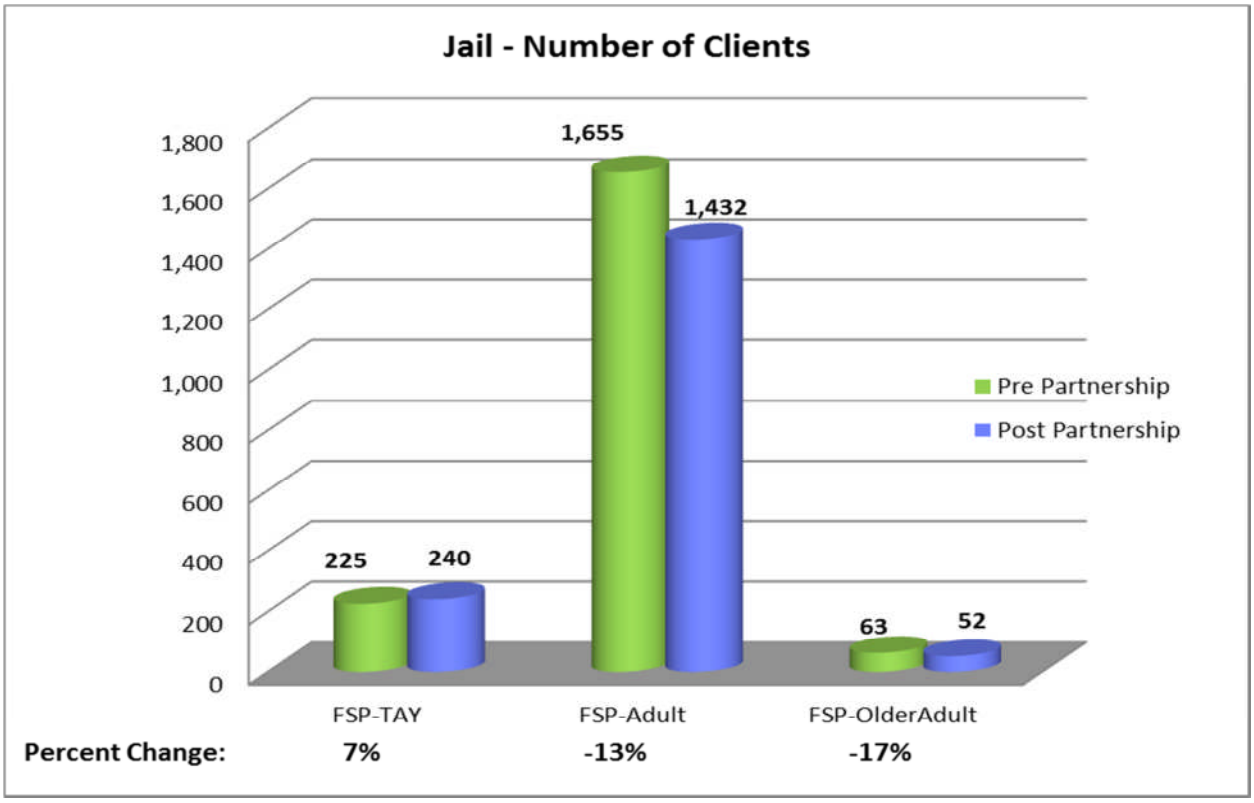

Juvenile Hall -Number of Days
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
7,253
7,932
12,387
5,011
Pre Days
Post Days
FSP-Child
FSP-TAY
Percent Change:
9%
-60%


FSP Clients had Fewer Hospitalizations Post Partnership
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
1,352
862
1,042
599
3,814
2,855
321
263
Pre Partnership
Post Partnership
FSP-Child
FSP-TAY
FSP-Adult
FSP-OlderAdult
Percent Change:
-36%
-43%
-25%
-18%


More FSP Clients Live Independently Post Partnership
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
98
120
363
505
2,407
3,530
496
530
Pre Partnership
Post Partnership
FSP-Child
FSP-TAY
FSP-Adult
FSP-OlderAdult
Percent Change:
22%
39%
47%
7%

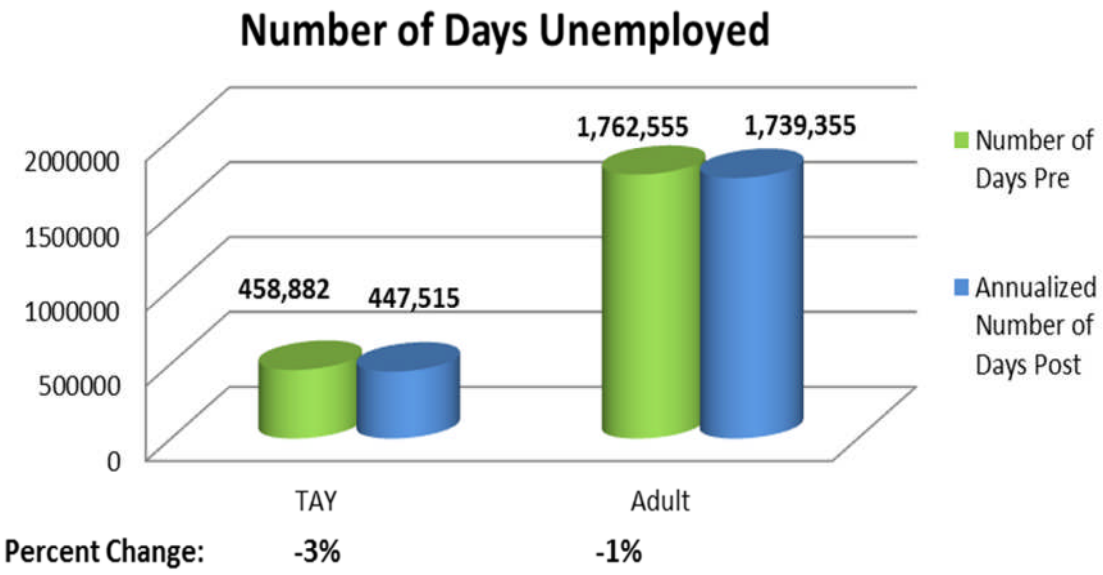

Fewer FSP Clients Were Homeless Post Partnership
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
39
39
380
291
3,816
2,484
238
158
Pre Partnership
Post Partnership
FSP-Child
FSP-TAY
FSP-Adult
FSP-OlderAdult
Percent Change:
0%
-23%
-35%
-34%

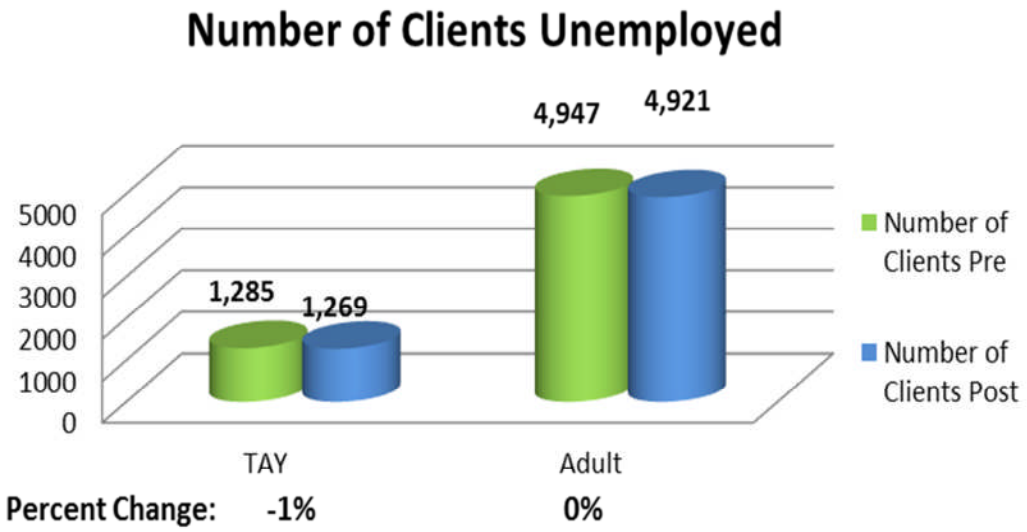

Juvenile Hall -Number of Clients
250
200
150
100
50
0
246
109
107
39
Pre Partnership
Post Partnership
FSP-Child
FSP-TAY
Percent Change:
126%
-64%


Jail - Number of Clients
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,655
1,432
225
240
63
52
Pre Partnership
Post Partnership
FSP-TAY
FSP-Adult
FSP-OlderAdult
Percent Change:
7%
-13%
-17%

Employment

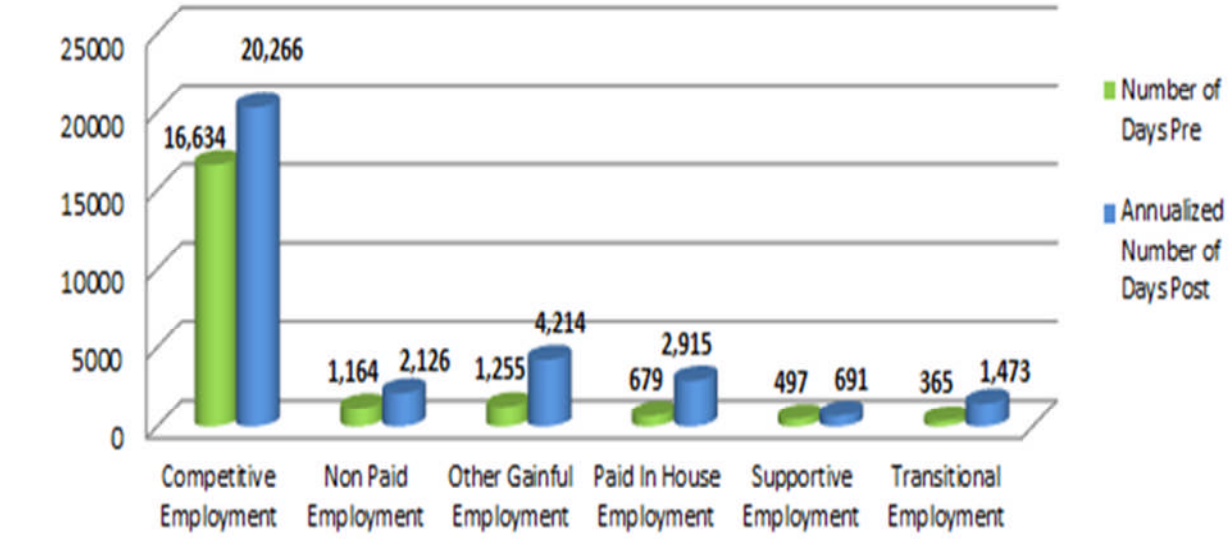
Number of Baselines Include (N) -* Transitional Age Youth TAY: 1,316
Adult: 5,063
Clients may have more than one employment type at any time.





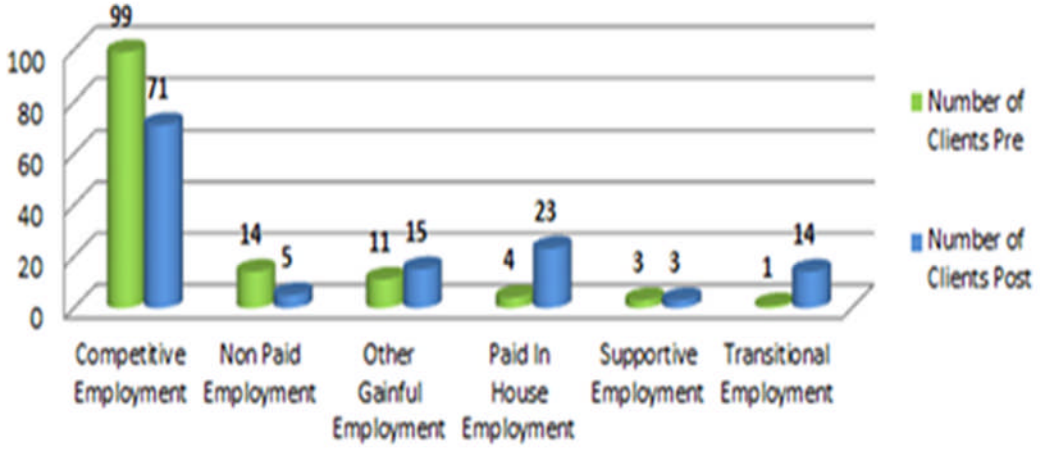
* Baselines are excluded when data does not meet reporting standards. The baseline inclusion rate for Adult FSP program is 88% and for TAY FSP program 64%. See Appendix II for a list of reasons data does not meet reporting standards.

FSP TAY Clients Spent More Days in Positive Employment Post-Partnership

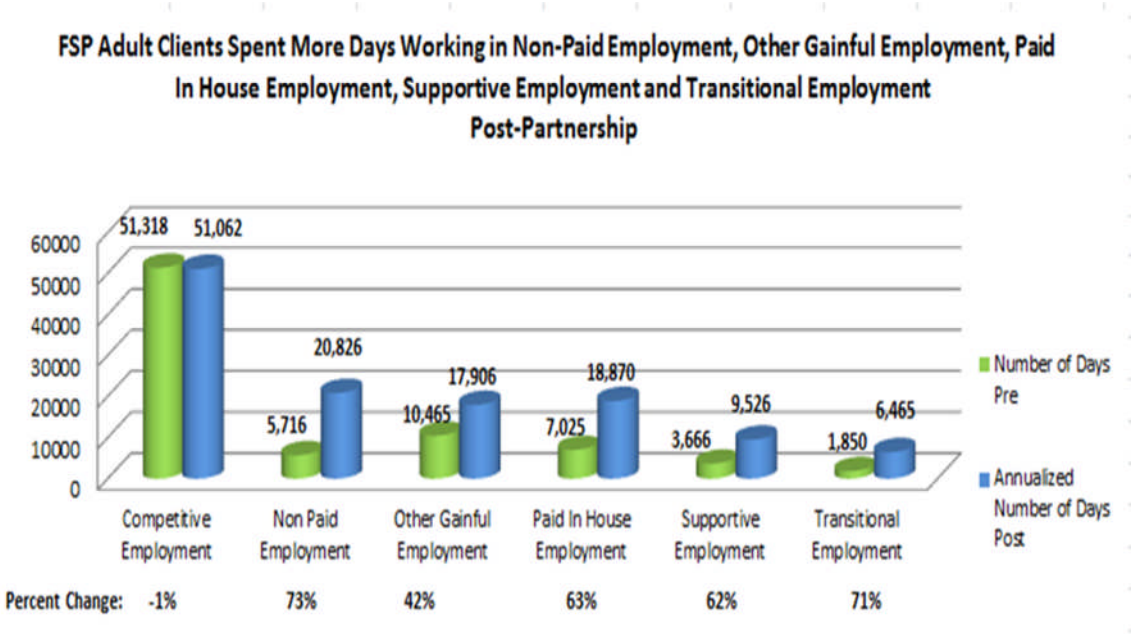


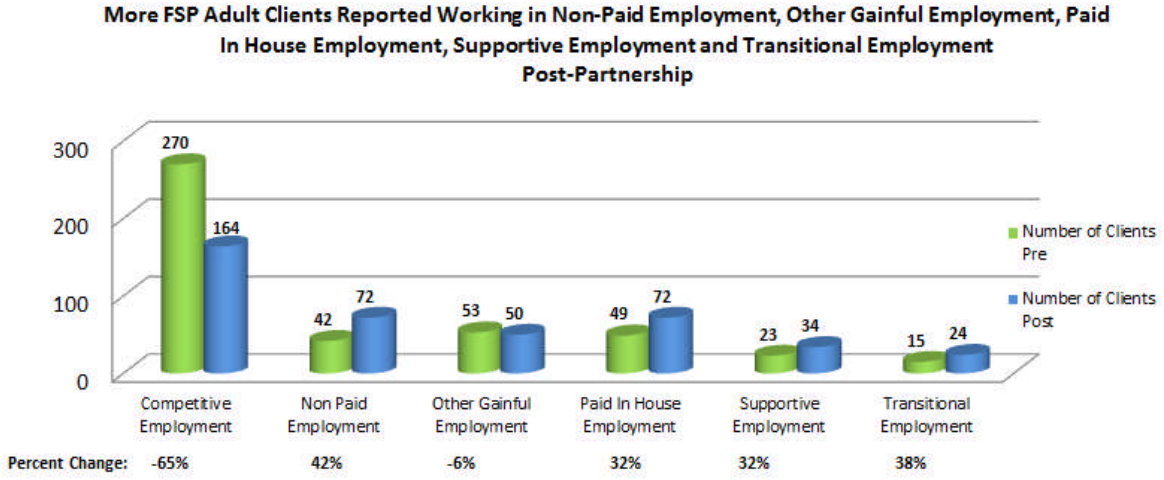
Percent Change:	18%	45%	70%	77%	28%	75%

More FSP TAY Clients Reported Working in Other Gainful Employment, Paid In House Employment, and Transitional Employment Post-Partnership



Percent Change:	-39%	-180%	27%	83%	0%	93%





Employment Status Definitions

Competitive Employment: Paid employment in the community in a position that is also open to individuals without disability.
Supportive Employment: Competitive Employment (see above) with ongoing on-site or off-site job related support services provided.
Transitional Employment / Enclave: Paid jobs in the community that are 1) open only to individuals with a disability AND 2) are either time-limited for the purpose of moving to a more permanent job OR are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business): Paid jobs open only to program participants with a disability. A Sheltered Workshop usually offers sub-minimum wage work in a simulated environment. A Work Experience (Adjustment) Program within an agency provides exposure to the standard expectations and advantages of employment. An Agency- Owned Business serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.
Non-paid (Volunteer) Work: Experience Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.
Other Gainful / Employment Activity: Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR participation in formal structured classes and/or workshops providing instruction on issues pertinent to getting a job. (Does not include such activities as panhandling or illegal activities such as prostitution.)

Full Service Partnership Success Story

Seven year old Brenda Molina has been participating in Foothill Family Service's Child Full Service Partnership Program since July 5, 2012. Following Brenda's Type I diabetes diagnosis in 2011, Brenda's mom noticed a dramatic change in Brenda's behavior. She became aggressive towards her siblings, failed to follow directions and became increasingly defiant towards her mother. Brenda also became depressed and talked about dying.

Members of Brenda's FSP treatment team, therapist, Emma Hernandez, and child specialist, Guadalupe Henriquez, recognized that both Brenda and her family were overwhelmed by the implications and life style changes that resulted from being diagnosed with diabetes and immediately began looking for resources and services that could help Brenda cope and adjust to her condition.

Luckily the treatment team was able to find Camp Conrad---Chinock, located in the San Bernardino Mountains, which offers recreational, social and educational opportunities for youth and families with diabetes.

A primary focus of Diabetes Camping and Educational Services (DCES) is providing residential camping experiences for youth with Type 1, insulin---dependent diabetes and their families. Campers are taught diabetes self---management skills in a fun, interactive, and safe environment.

Using FSP Flex Funds to defray enrollment costs that Brenda's family could not afford, the treatment team was able to send Brenda to Camp Conrad---Chinnock and provide her with her first experience camping and being away from home for more than just a few hours.

Brenda had a positive experience at camp, engaging with other children coping with diabetes and learning diabetes self---management skills in a fun, interactive, and safe environment. "I had so much fun at the camp and I even learned how to inject my own insulin!"

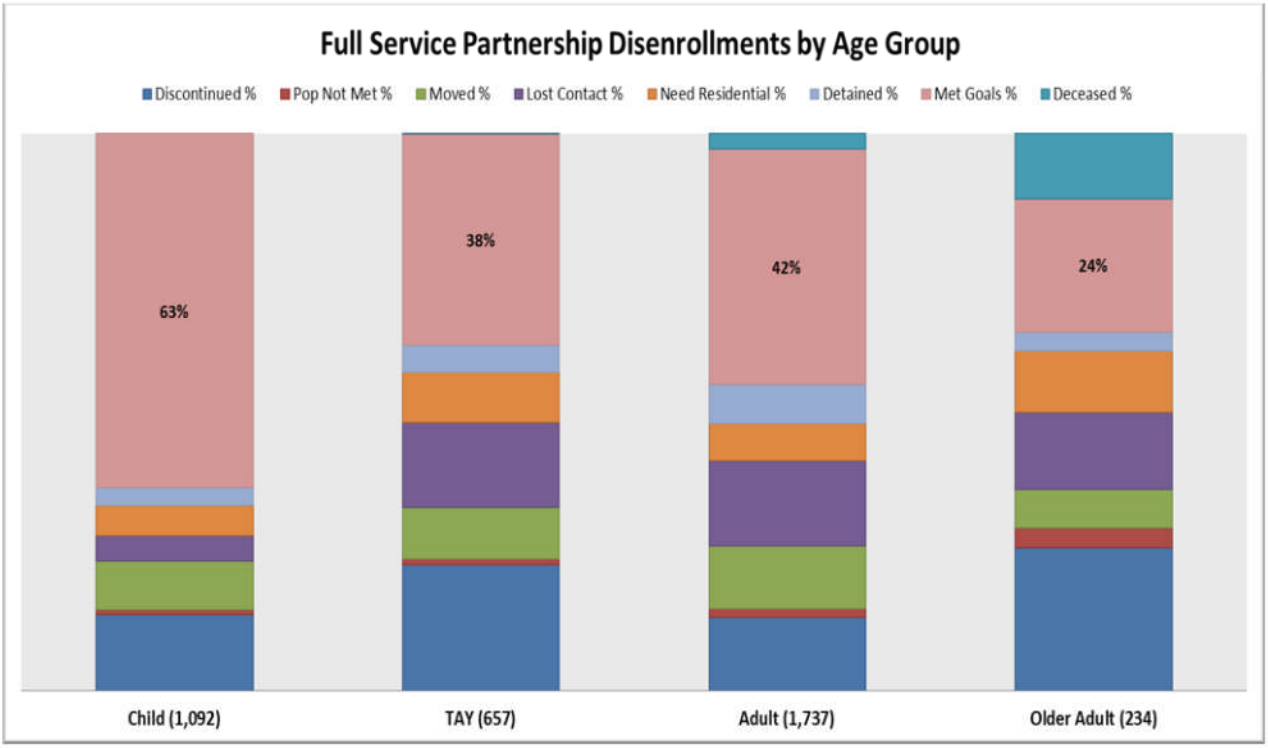
"She found out what is was like to have an insulin pump for a day and learned how to eat properly," Brenda's mother explained, "but most importantly she found out she was not alone or different because there are a lot of other kids in the world who have diabetes just like she does."

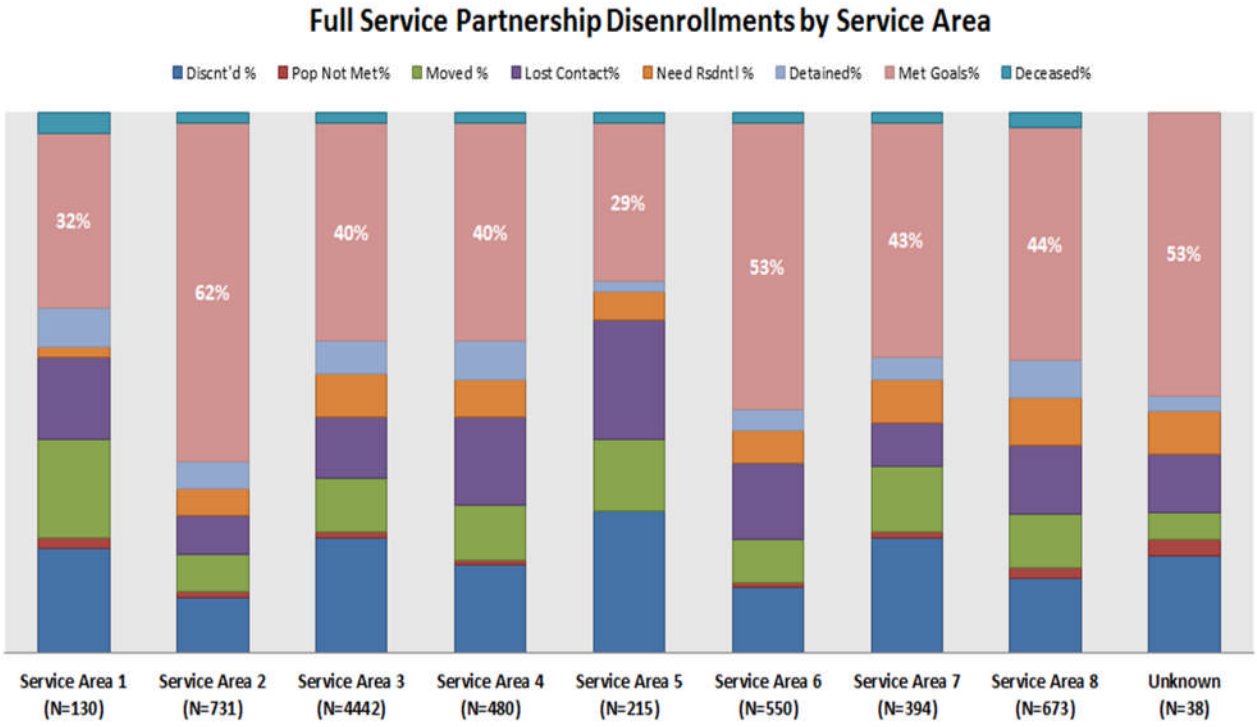
The mission of DCES is committed to providing a safe, educational, and healthy camping experience to all children and families. Their services and facilities are shared with health--- based associations, schools, and community organizations looking to promote self---esteem, spiritual awareness, and moral character within children, including those living with chronic illness, physical disability, or economic hardship.

Whether attending a youth or family camp, a comprehensive educational program provides training in formal and casual settings to teach children how to manage their medication, eat properly, and integrate physical activity into their lifestyle.

Story originally published in the Countywide Child MHSA Newsletter, September 2013 edition.

Full Service Partnership Disenrollment



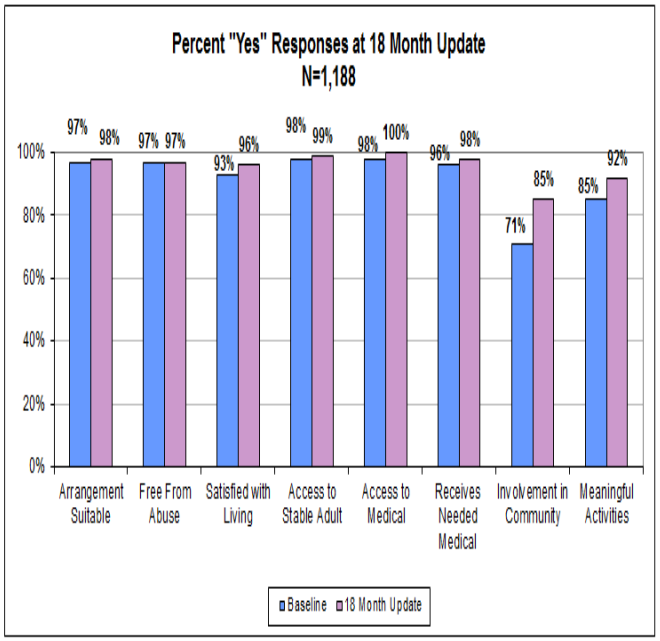


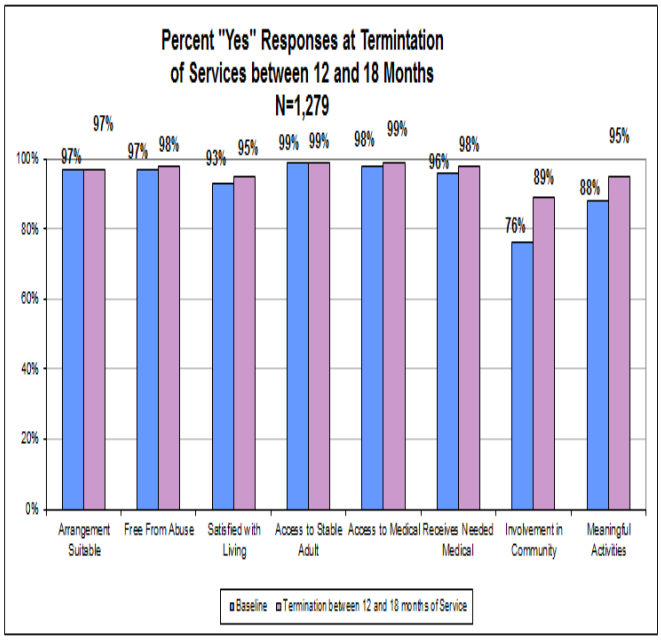
See Appendix IV for disenrollment guidelines.

Field Capable Clinical Services

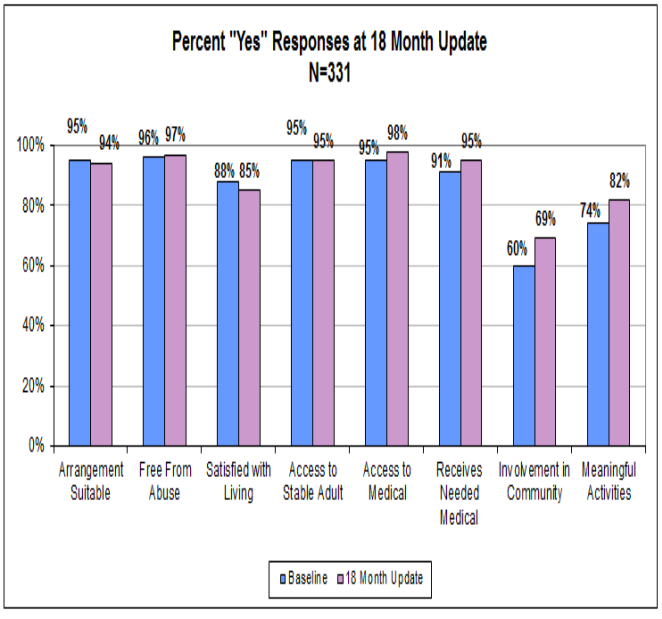
(Data as of February 2, 2015)

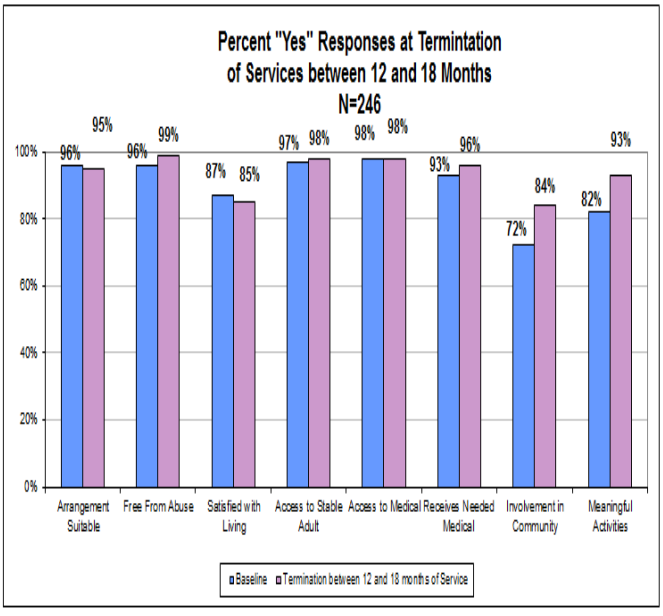
Child Program





TAY Program

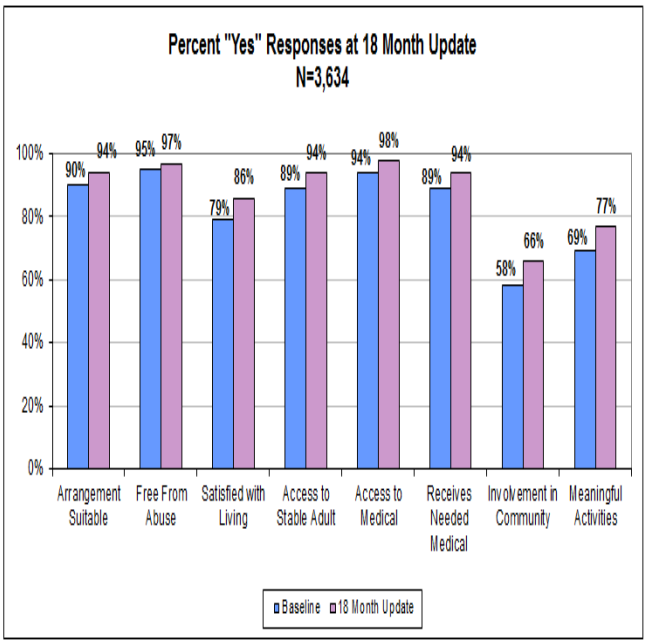


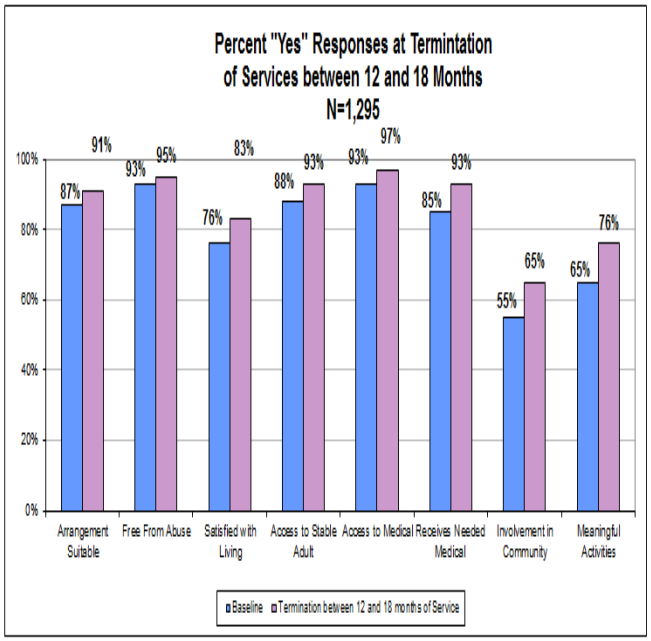


Field Capable Clinical Services

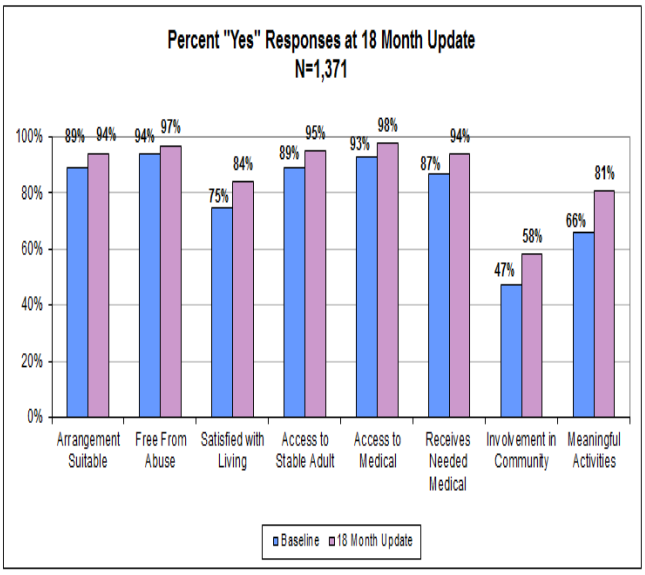
(Data as of February 2, 2015)

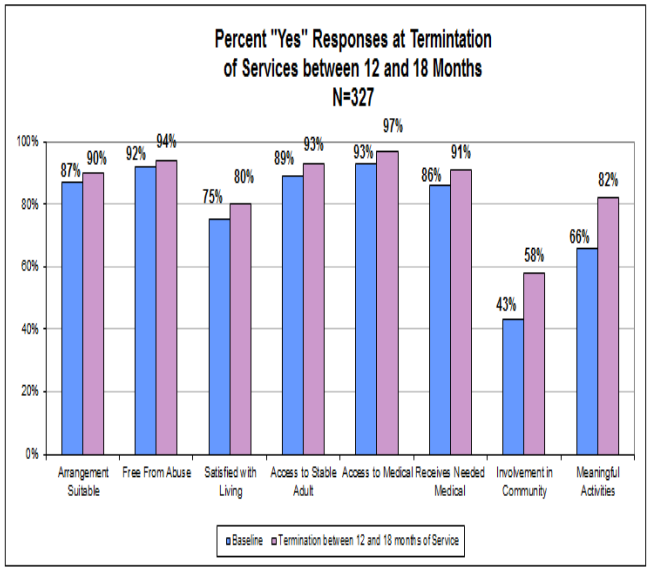
Adult Program





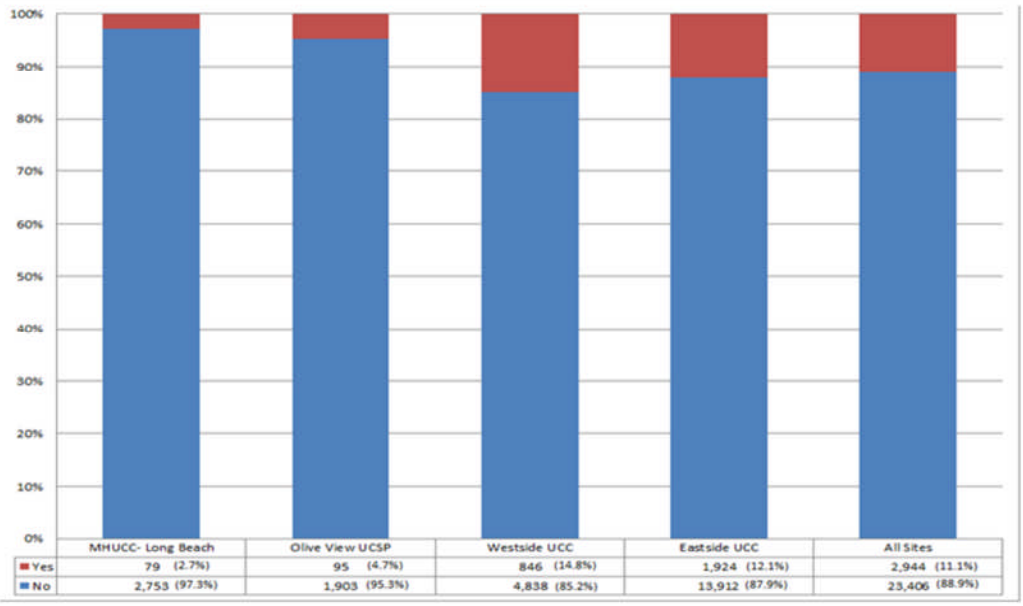
Older Adult Program





July 1, 2013 through June 30, 2014 (FY 2013-14)

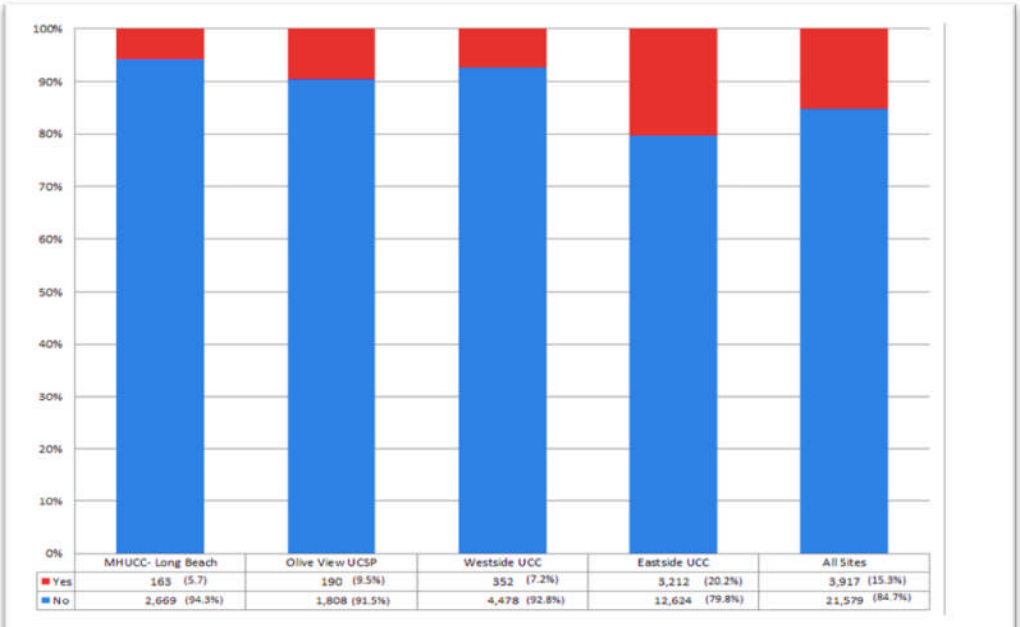
Acute Psychiatric Inpatient Hospitalization within 30 Days of UCC Services



	MHUCC- Long Beach	Olive View UCSP	Westside UCC	Eastside UCC	All Sites
Yes	79 (2.7%)	95 (4.7%)	846 (14.8%)	1,924 (12.1%)	2,944 (11.1%)
No	2,753 (97.3%)	1,903 (95.3%)	4,838 (85.2%)	13,912 (87.9%)	23,406 (88.9%)

*Westside and Eastside UCCs are the only LPS-designated UCCs; many persons are on a 5150 upon admission and transferred to acute inpatient setting therefore their hospitalization rates are higher.

Any Inpatient, PMRT, Psych ER, Jail MH Contact within 30 Days of a UCC Assessment

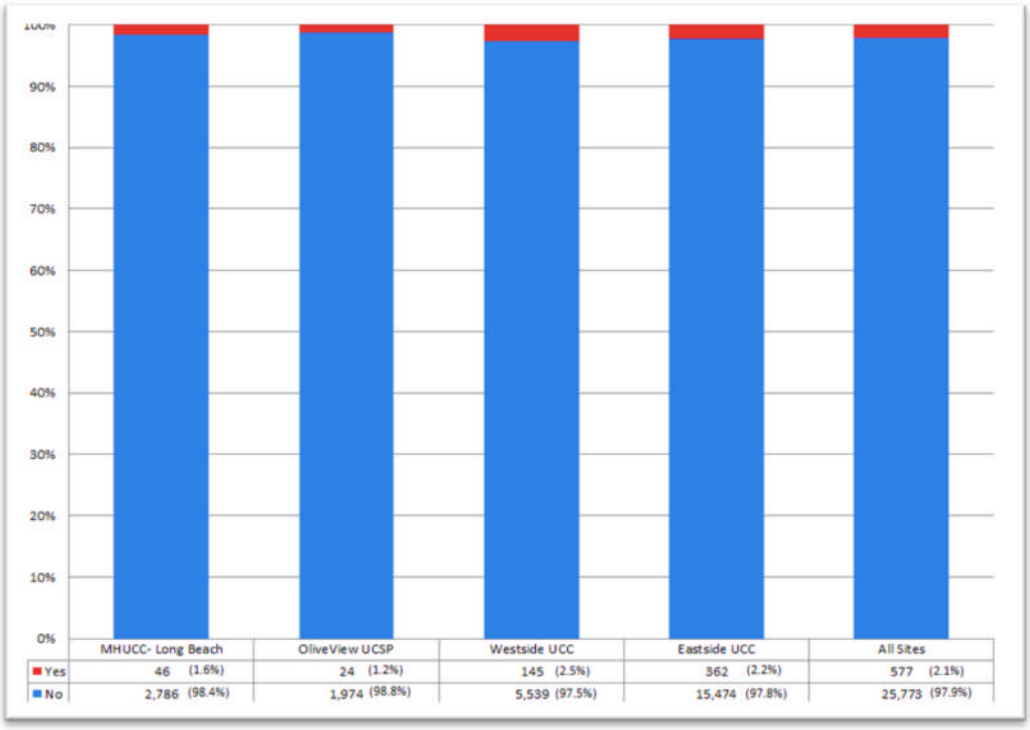


	MHUCC- Long Beach	Olive View UCSP	Westside UCC	Eastside UCC	All Sites
Yes	163 (5.7)	190 (9.5%)	352 (7.2%)	3,212 (20.2%)	3,917 (15.3%)
No	2,669 (94.3%)	1,808 (91.5%)	4,478 (92.8%)	12,624 (79.8%)	21,579 (84.7%)

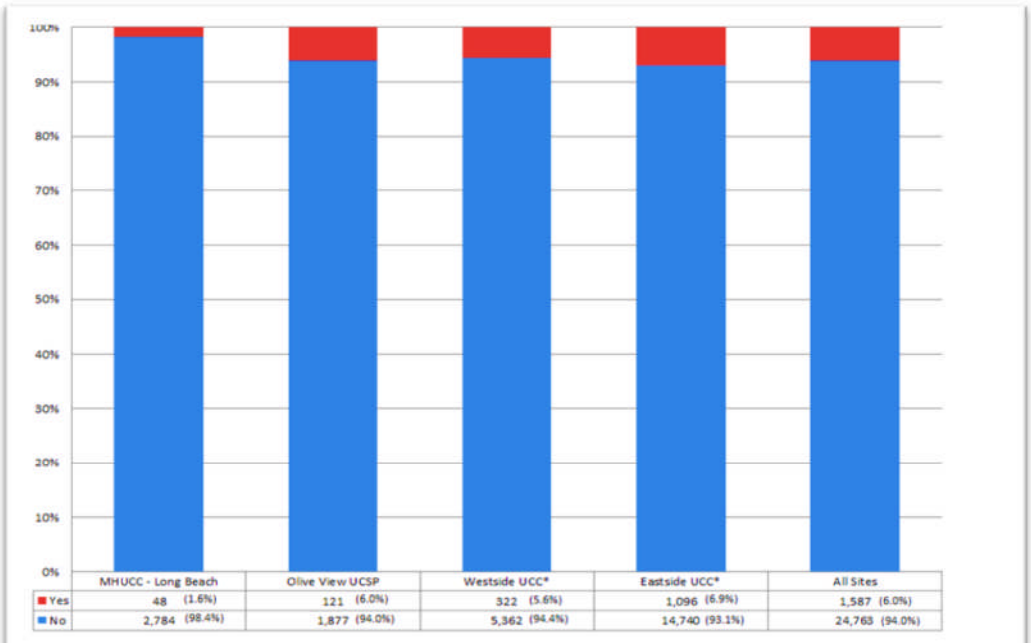
*Westside and Eastside UCCs are the only LPS-designated UCCs; many persons are on a 5150 hold upon admission and are transferred to an acute inpatient setting from the UCC, therefore hospitalization rates are higher from these facilities.

July 1, 2013 through June 30, 2014 (FY 2013-14)

Any Contact with Jail Mental Health Services within 30 Days of Being Seen at a UCC



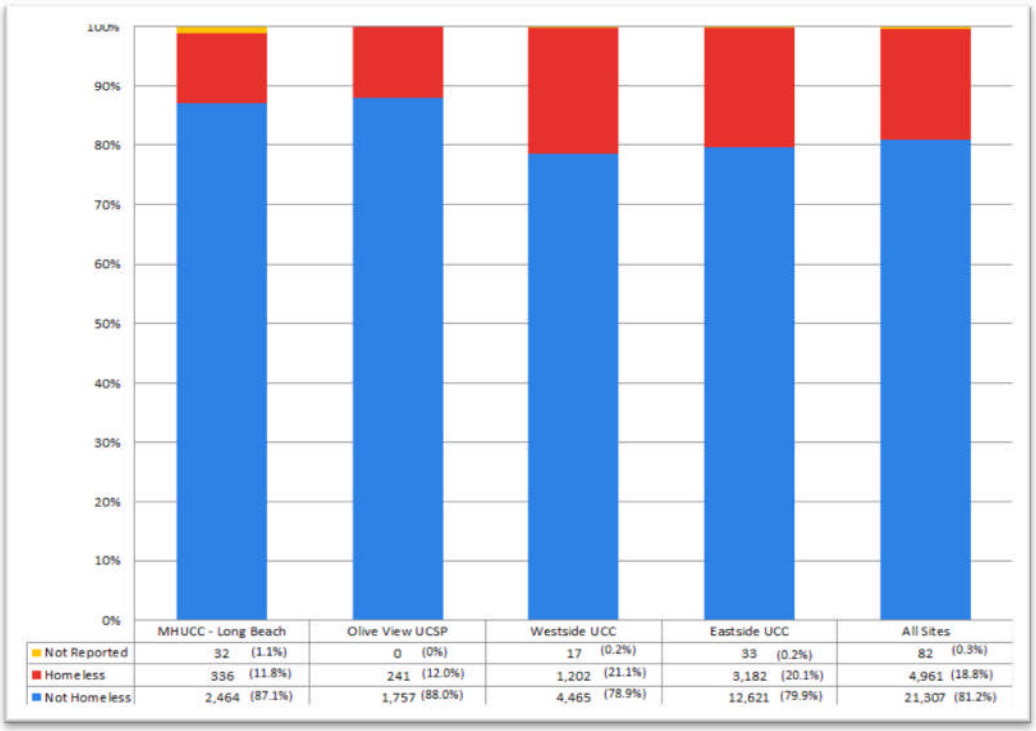
Any Visit to a Psychiatric Emergency Room within 30 Days of Being Seen at a UCC



*Westside and Eastside UCCs are the only LPS-designated UCCs; many persons are on a 5150 hold upon admission and are transferred to an acute inpatient setting from the UCC, therefore hospitalization rates are higher from these facilities.

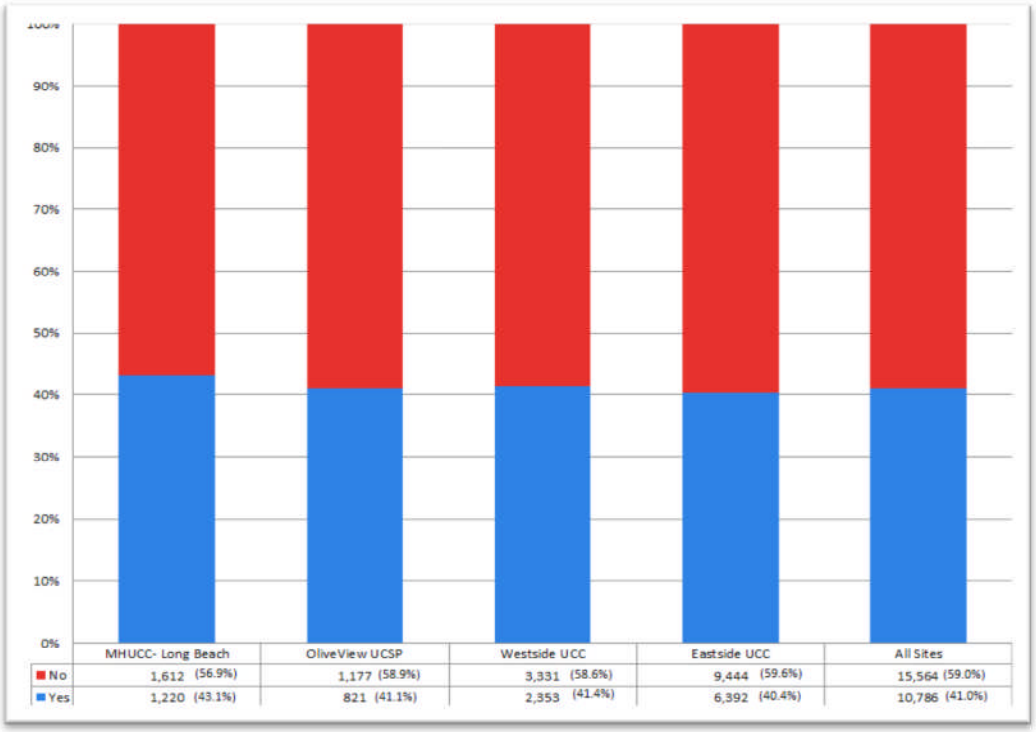
July 1, 2013 through June 30, 2014 (FY 2013-14)

New Admissions at UCCs Who Were Homeless upon Admission



	MHUCC - Long Beach	Olive View UCSP	Westside UCC	Eastside UCC	All Sites
Not Reported	32 (1.1%)	0 (0%)	17 (0.2%)	33 (0.2%)	82 (0.3%)
Homeless	336 (11.8%)	241 (12.0%)	1,202 (21.1%)	3,182 (20.1%)	4,961 (18.8%)
Not Homeless	2,464 (87.1%)	1,757 (88.0%)	4,465 (78.9%)	12,621 (79.9%)	21,307 (81.2%)

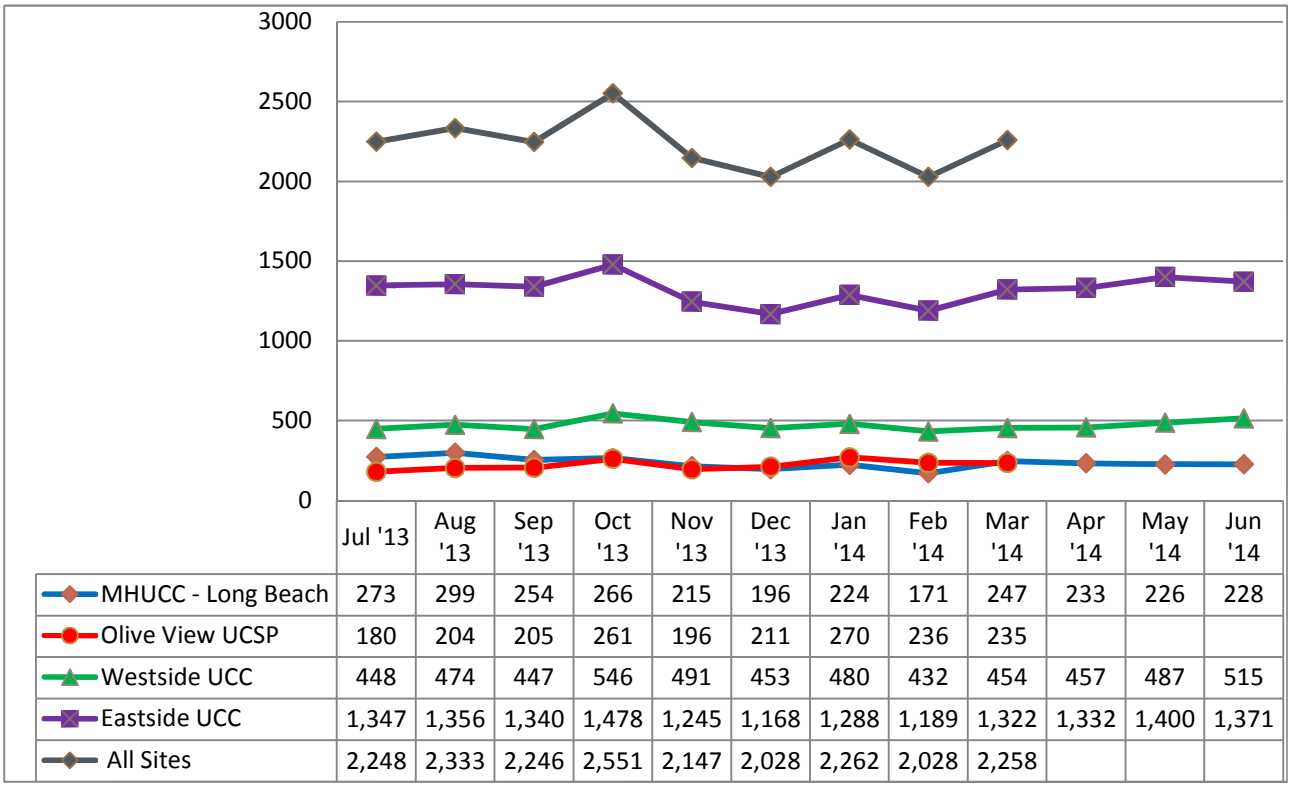
Any Treatment at an Outpatient Clinic within 90 Days of Having Been Seen at a UCC



	MHUCC- Long Beach	OliveView UCSP	Westside UCC	Eastside UCC	All Sites
No	1,612 (56.9%)	1,177 (58.9%)	3,331 (58.6%)	9,444 (59.6%)	15,564 (59.0%)
Yes	1,220 (43.1%)	821 (41.1%)	2,353 (41.4%)	6,392 (40.4%)	10,786 (41.0%)

July 1, 2013 through June 30, 2014 (FY 2013-14)

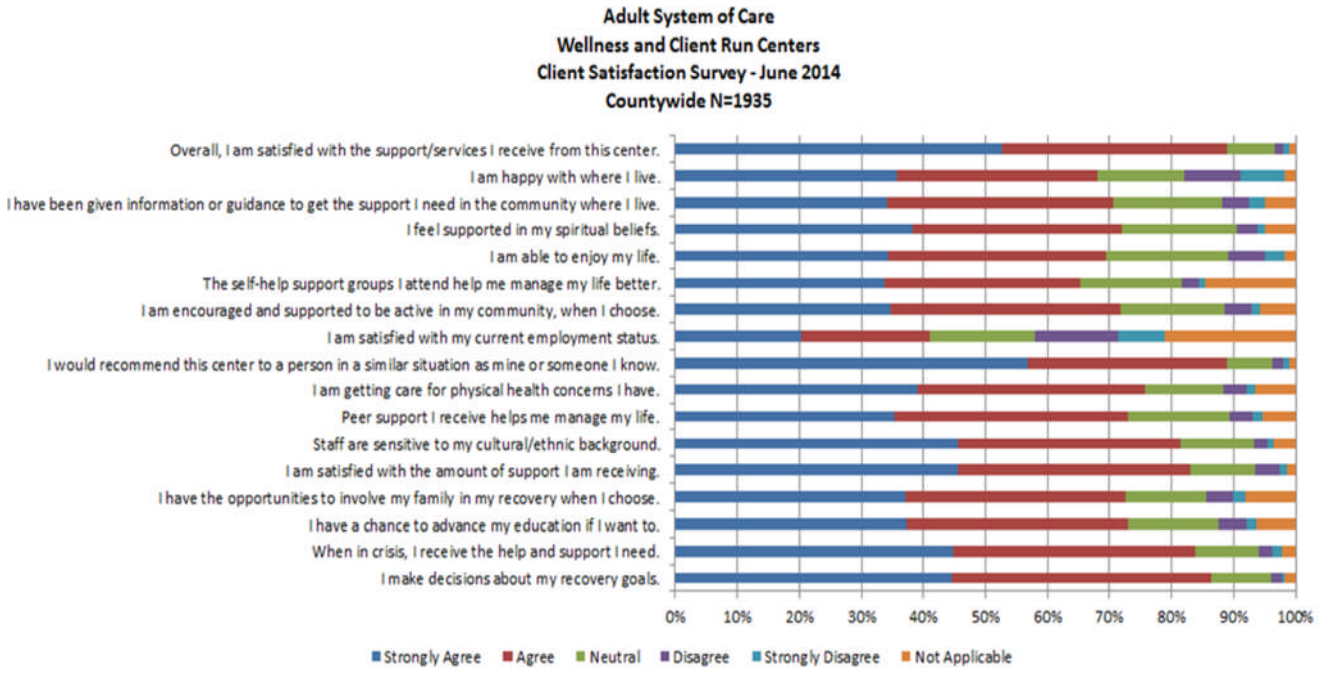
New Admissions to UCCs by Facility

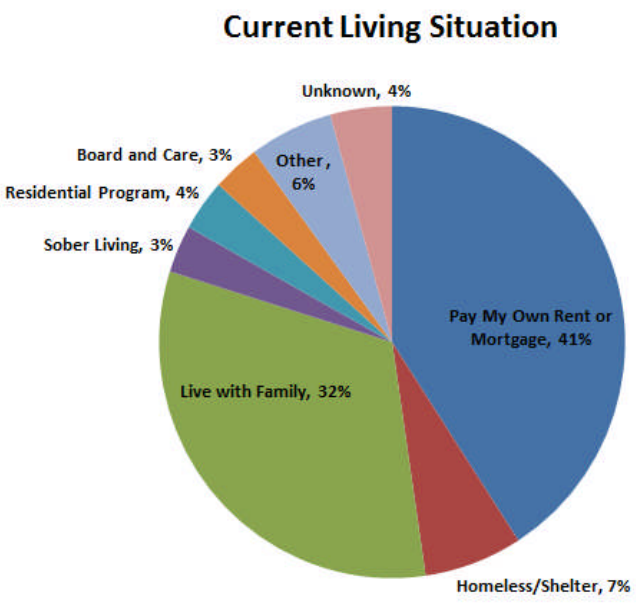


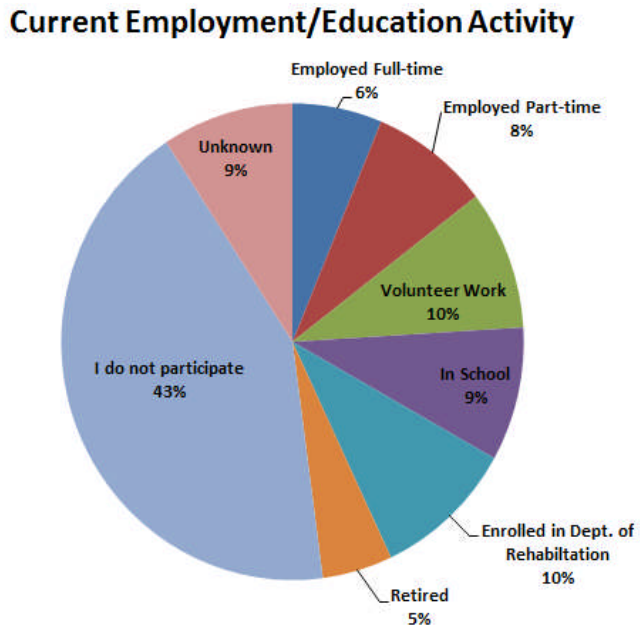
	Jul '13	Aug '13	Sep '13	Oct '13	Nov '13	Dec '13	Jan '14	Feb '14	Mar '14	Apr '14	May '14	Jun '14
MHUCC - Long Beach	273	299	254	266	215	196	224	171	247	233	226	228
Olive View UCSP	180	204	205	261	196	211	270	236	235			
Westside UCC	448	474	447	546	491	453	480	432	454	457	487	515
Eastside UCC	1,347	1,356	1,340	1,478	1,245	1,168	1,288	1,189	1,322	1,332	1,400	1,371
All Sites	2,248	2,333	2,246	2,551	2,147	2,028	2,262	2,028	2,258			

Please note that data is not available after March 2014 For Olive View UCSP and for All Sites, as the LACDMH conversion to the Integrated Behavioral Health Information System (IBHIS) has rendered Olive View electronic data unavailable for the last quarter of 2014.

Wellness Center Outcomes







Crossover Youth Multidisciplinary Team Program - Outcomes

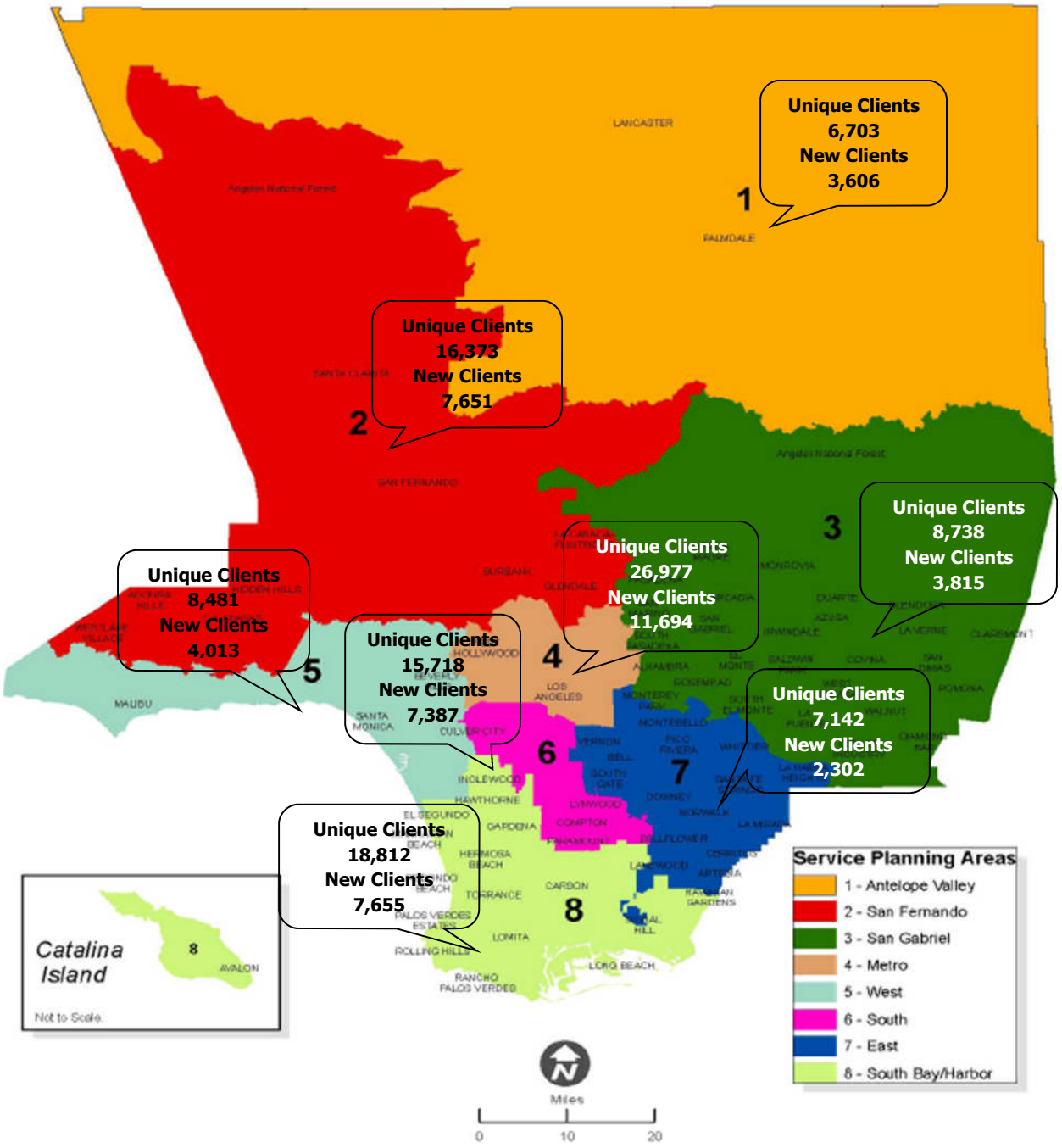
Representatives from Department of Children and Family Services, Probation, LACDMH, and the California State School of Criminal Justice & Criminalistics submitted data regarding 241.1 case referrals via a web-based application. Demographic and outcome data subsequently were collated, tracked, and analyzed by Denise Herz, Ph.D., a faculty member at California State University-Los Angeles. This process began in a systematic manner in October 2013, and the data is updated on a monthly basis.

There are three (3) distinct tracking periods for referred youth, and reports are generated and submitted to the Board of Supervisors for each period.

- Tracking Period 1 covers months 1-4 after legal disposition.
- Tracking Period 2 covers months 5-8 after legal disposition.
- Tracking Period 3 covers months 9-12 after legal disposition.

The report available for FY 2013-2014 is located in Appendix I. This report relates to Tracking Period 1 for youth with legal dispositions in October 2013. The report also includes an "Overview of Data and Methodology" section, as well as some general outcomes from 2012 and 2013 for comparison purposes.

Los Angeles County Clients Served Through CSS by Service Areas Fiscal Year 2013-14



Number of Clients Served by CSS

Service Area 1
Alternative Crisis Services - 56
Client Run Centers- 2,889
Field Capable Clinical Services - 2180
Full Service Partnership - 450
Probation Camp-MHSA - 917
Wellness Centers - 4,265

Service Area 2
Alternative Crisis Services - 3,073
Client Run Centers- 4,106
Family Support Services - 39
Field Capable Clinical Services - 3,839
Full Service Partnership - 1,860
Probation Camp-MHSA - 225
Wellness Centers - 9,195

Service Area 3
Client Run Centers- 9,542
Family Support Services - 39
Field Capable Clinical Services - 4,447
Full Service Partnership - 1,495
IMD Step Down Facilities - Service Area Navigation - 13
Wellness Centers - 3,110

Service Area 4
Alternative Crisis Services - 12,028
Client Run Centers- 11,313
Family Support Services - 57
Field Capable Clinical Services - 4,487
Full Service Partnership - 1,664
IMD Step Down Facilities - 403
Probation Camp-MHSA - 116
Wellness Centers - 9,911

Service Area 5
Alternative Crisis Services - 4,012
Client Run Centers- 6,431
Family Support Services - 4
Field Capable Clinical Services - 1,229
Full Service Partnership - 563
Wellness Centers - 3,551

Service Area 6
Alternative Crisis Services - 615
Client Run Centers- 3,931
Field Capable Clinical Services - 2,714
Full Service Partnership - 1,905
Jail-Transition/Linkage - 685
Wellness Centers - 40,475

Service Area 7
Alternative Crisis Services - 801
Client Run Centers- 27,477
Family Support Services - 28
Field Capable Clinical Services - 2,761
Full Service Partnership - 1,198
IMD Step Down Facilities - 176
Probation Camp-MHSA - 106
Wellness Centers - 2,938

Service Area 8
Alternative Crisis Services - 2,273
Client Run Centers- 5,018
Family Support Services - 38
Field Capable Clinical Services - 2,424
Full Service Partnership - 2,225
Wellness Centers - 12,626

Ethnicity

Service Area 1
African-American –36%
Hispanic – 29%
White – 27%
Other – 2%
Asian – 1%
Unknown – 4%
Native American - 1%
Pacific Islander - <0%

Service Area 2
White – 39%
Hispanic – 38%
African-American –10%
Asian – 5%
Other – 3%
Unknown – 4%
Native American - 1%
Pacific Islander - <0%

Service Area 3
Hispanic – 52%
White – 20%
Asian –12%
African-American –10%
Other –2%
Unknown –3%
Native American -1%
Pacific Islander -<0%

Service Area 4
Hispanic –41%
African-American –28%
White –19%
Asian –7%
Other –2%
Unknown – 2%
Native American -1%
Pacific Islander -<0%

Service Area 5
White –%
African-American –28%
Hispanic – 19%
Unknown – 9%
Other –3%
Asian –2%
Native American - 1%
Pacific Islander- <0%

Service Area 6
African-American – 58%
Hispanic –36%
White – 3%
Unknown – 2%
Other – 0%
Asian – 1%
Native American -0<%
Pacific Islander- 0<%

Service Area 7
Hispanic – 65%
White – 18%
African-American – 8%
Asian – 3%
Native American - 3%
Unknown – 2%
Other – 1%
Pacific Islander- 0<%

Service Area 8
African-American – 31%
Hispanic – 30%
White – 25%
Asian – 8%
Unknown – 3%
Other – 2%
Native American - 0<%
Pacific Islander- 0<%

Primary Language

Service Area 1
English - 87%
Spanish - 9%
Unknown/Not Reported - 3%
Other - 1%

Service Area 2
English - 68%
Spanish - 19%
Armenian - 5%
Farsi – 2%
Unknown/Not Reported - 2%
Other - 2%
Russian - 1%
Pilipino,Tagalog - 1%

Service Area 3
English - 71%
Spanish - 17%
Cantonese - 2%
Unknown/Not Reported - 3%
Other - 3%
Mandarin - 2%
Vietnamese - 2%

Service Area 4
English - 75%
Spanish - 16%
Unknown/Not Reported - 3%
Other - 3%
Korean - 2%
Armenian - 1%

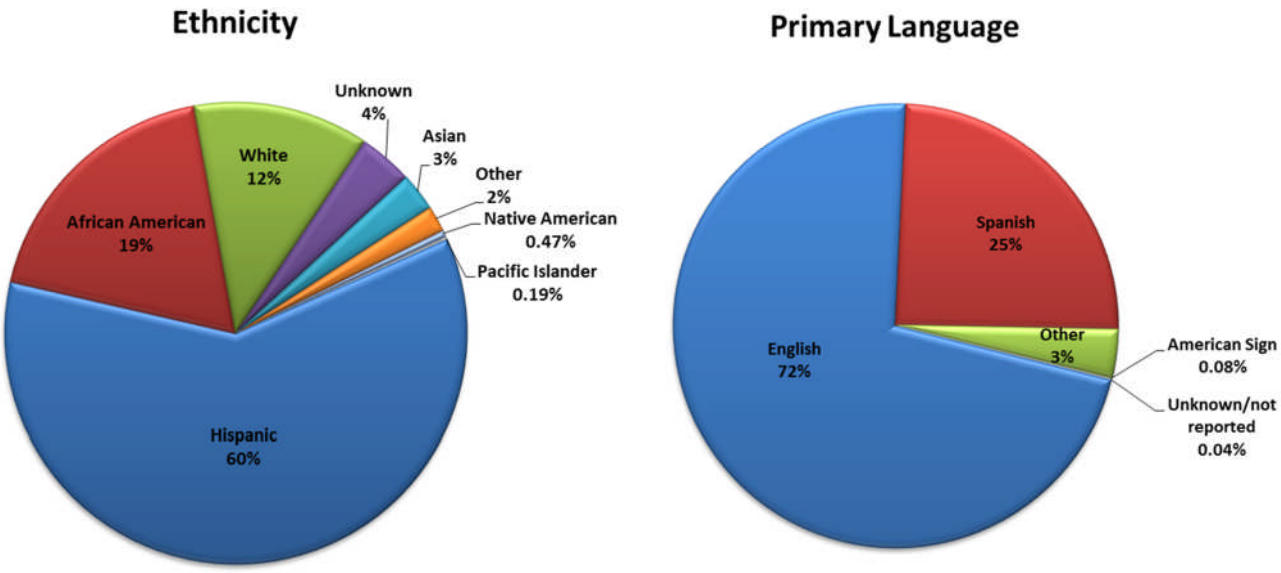
Service Area 5
English -88%
Spanish - 6%
Unknown/Not Reported - 4%
Farsi - 1%
Other - 1%

Service Area 6
English - 80%
Spanish - 18%
Unknown/Not Reported - 2%

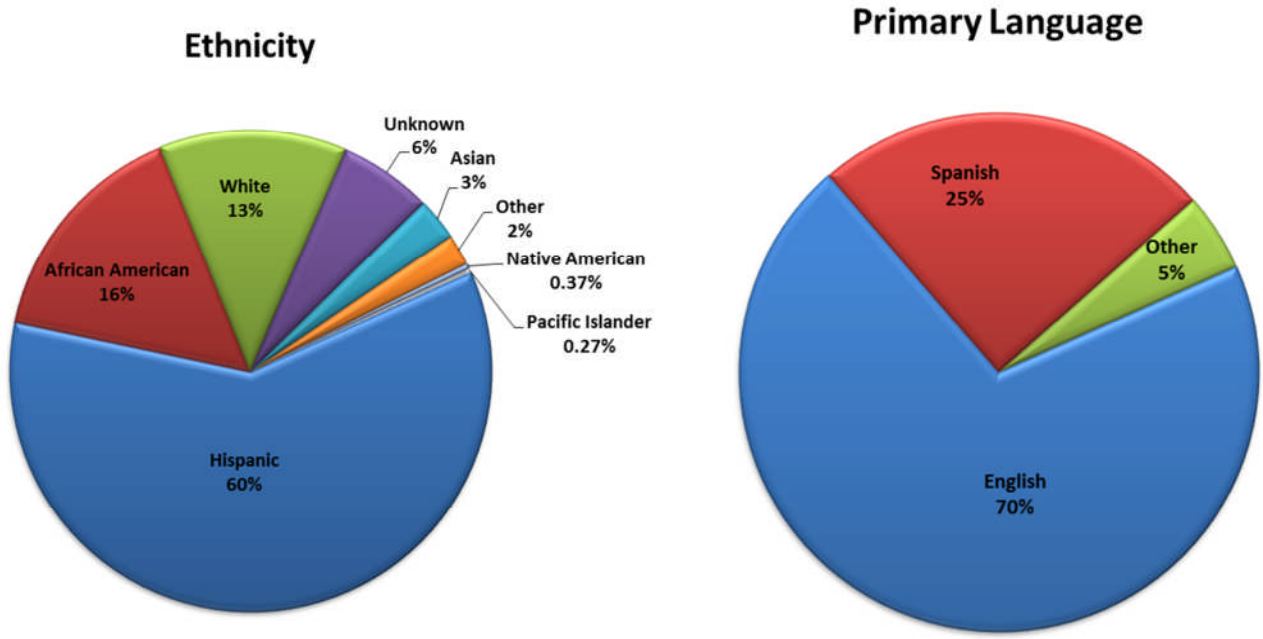
Service Area 7
English - 72%
Spanish - 24%
Unknown/Not Reported - 2%
Other - 1%
Cambodian - 1%

Service Area 8
English - 79%
Spanish - 12%
Cambodian - 4%
Unknown/Not Reported - 2%
Other - 1%
Vietnamese - 1%
Korean - 1%

Unique Clients Receiving a Direct Mental Health Service through the PEI Plan: 66,628



New Clients Receiving PEI Services Countywide with No Previous MHSA Service: 16,741



Evidenced Based Practices (EBPs)

Number of Clients Served by EBP

Top 10 EBPs Delivered in the County

Managing and Adapting Practice
Unique Clients Served: 16,907
Average Cost per Client: $ 4,144

Individual Cognitive Behavioral Therapy
Unique Clients Served: 3,344
Average Cost per Client: $ 1,361

Seeking Safety
Unique Clients Served: 10,118
Average Cost per Client: $ 3,302

Triple P Positive Parenting Program
Unique Clients Served: 3,305
Average Cost per Client: $ 2,678

Trauma Focused CBT
Unique Clients Served: 10,106
Average Cost per Client: $ 3,986

School Threat Assessment Response
Unique Clients Served: 3,119
Average Cost per Client: $ 2,153

Mental Health Integration Program
Unique Clients Served: 3,750
Average Cost per Client: $ 816

Interpersonal Psychotherapy for Depression
Unique Clients Served: 2,700
Average Cost per Client: $ 2,437

Crisis Oriented Recovery Services
Unique Clients Served: 3,614
Average Cost per Client: $ 1,110

Child Parent Psychotherapy
Unique Clients Served: 2,235
Average Cost per Client: $ 4,152

Top 5 EBPs Delivered in the County by Age Group

Children
Managing and Adapting Practice - 14,200
Trauma Focused CBT - 8,596
Triple P Positive Parenting Program - 3,155
Seeking Safety - 2,604
Child Parent Psychotherapy - 2,220

Adult
Seeking Safety - 3,028
Mental Health Integration Program - 3,010
Individual Cognitive Behavioral Therapy - 2,517
Crisis Oriented Recovery Services - 1,404
Interpersonal Psychotherapy for Depression - 850

TAY
Seeking Safety - 4,499
Managing and Adapting Practice - 3,126
Trauma Focused CBT - 1,670
School Threat Assessment Response Team - 928
Aggression Replacement Training - 680

Older Adult
Interpersonal Psychotherapy for Depression - 544
Mental Health Integration Program - 465
Seeking Safety - 400
Problem Solving Therapy - 206
Individual Cognitive Behavioral Therapy - 204

Use the following link to access more PEI Countywide data: claiming, average cost per EBP, and demographics: http://file.lacounty.gov/dmh/cms1_220395.pdf.

(EBP-Evidence-Based Practice; PP-Promising Practice; CDE-Community Defined Evidence Practice)

PEI Early Start-Suicide Prevention: ES-1

The Early Start Suicide Prevention Program provides suicide prevention services through multiple strategies by strengthening the capacity of existing community resources and creating new collaborative and comprehensive efforts at the individual, family, and community level. These services include: community outreach and education in the identification of the suicide risks and protective factors; linking direct services and improving the quality of care to individuals contemplating, threatening, or attempting suicide; access to evidence based interventions trained suicide prevention hotlines; and building the infrastructure to further develop and enhance suicide prevention programs throughout the county across all age groups and cultures.

EBP/PP/CDEs Implemented:

Latina Youth Program: The primary goals of Pacific Clinics' School Based Services for the Latina Special Program are to promote prevention and early intervention for youth to decrease substance use and depressive symptoms which are major risk factors for suicide; increase youth awareness of high-risk behaviors and provide immediate assessment and treatment services; increase access to services while decreasing barriers and stigma among youth in accepting mental health services; increase family awareness about high-risk behaviors and empower families through education about the benefits of prevention and early intervention and health promotion; enhance awareness and education among school staff and community members regarding substance abuse and depression.

The program provided services to 142 students and their families who had open cases. Additionally, the program's staff provided crisis and urgent services as well as preventive activities such as outreach and education to 2,664 contacts, for a total of 2673 contact hours. Participants with open cases ranged in age from 7 to 22 years of age, with the greatest number of participants between the ages of 13 and 18. 37% of participants were male and sixty-three percent female. The students were distributed among grades 2 through 12 with most of them being in the 8th through 10th grades. Participants were uninsured.

The program identified ten (10) risk factors, which were targeted for treatment in addition to diagnosed mental health illnesses. The risk factors include: presence of substance use or abuse; suicidal ideation; past suicide attempts; running away from home; communication problems at home; poor school functioning; difficulty regulating emotions; involvement with the legal system; negative peer relations; and issues related to sexual identity.

Participants who had difficulty regulating emotion and communication problems within the moderately severe to very severe range at intake and who experienced a significant degree of symptom relief were more likely to experience greater reduction in severity of other risk factors and increased functioning. Risk factors associated in the literature with research on suicide were targeted for prevention and intervention. The program has been consistently successful at preventing suicide in the participants. Participants who reported suicide ideation as a significant problem at intake decreased in severity after participating on treatment, based on participant and parent report.

Pacific Clinics is in the process of developing a template to collect outcomes for the outreach presentations they currently do in the schools and community.

Partners in Suicide (PSP) Team for Children, Transition Age Youth (TAY), Adults, and Older Adults: PSP is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. Currently the team is comprised of eight staff representing each of the four age groups, and includes six (6) Spanish-speaking members. The team offers education, identifies appropriate tools, such as evidence-based practices, and provides linkage and referrals to age appropriate services.

PSP Team members participated in a total of 173 suicide prevention events during FY 2013-2014, outreaching to more than 4,700 Los Angeles County residents. These events included countywide educational trainings, participation in suicide prevention community events, and collaboration with various agencies and partners. Highlights included providing five (5) Applied Suicide Intervention Skills Trainings (ASIST) while attaining five (5) new provisional ASIST trainers, which comes to a total of 18 ASIST trainers (7 members of PSP and 11 'adjunct' trainers). PSP provided 69 Question, Persuade and Refer (QPR) Trainings throughout the county. 12 staff members are qualified as QPR trainers, five (5) of whom are members of the PSP team.

Recognizing and Responding to Suicide Risk (RRSR) is a training, offered for the first time this fiscal year. Seven (7) staff completed the Train-the-Trainer program and provided five (5) trainings during this fiscal year. RRSR is an interrelated series of learning events based on a set of 24 core competencies that comprehensively define the knowledge, skill and attitudes required for effective clinical risk assessment and treatment of individuals at risk for suicide. The PSP team also coordinated and hosted the Los Angeles County Suicide Prevention Network which consists of quarterly meetings to increase collaboration and coordination of suicide prevention activities and includes over forty members from a wide variety of organizations.

An additional accomplishment includes launching the Third Annual Suicide Prevention Summit on September 10, 2013 which addressed "Risk Assessment and Safety Planning" and coincided with National Suicide Prevention Week and World Suicide Prevention Day. A total of 219 people participated in the event. Of special note is the Partners in Suicide Prevention program received

The American Psychiatric Foundation (APF) Award for Advancing Minority Health for 2014. This award was established to recognize mental health professionals and mental health programs which are undertaking special efforts to increase public awareness of and secure quality and comprehensive mental healthcare for underserved minorities. The 2014 K.W. Lee Spirit Award was awarded to Jae Kim, LCSW, one of the founding members of PSP, for his efforts in preventing suicide within the Korean American Community.

24/7 Crisis Hotline: The 24/7 Suicide Prevention Crisis Line responded to a total of 24,929 calls, chats, and texts originating from Los Angeles County[1], including Spanish-language crisis hotline services to 1,321 callers. People in crisis can also receive Korean and Vietnamese language services most evenings, from 4:30 pm to 12:30 am. In January 2014, the crisis line became a Core Regional Center for the National Disaster Distress Helpline and in April 2014 it increased its chat operating hours to 8 hours every night. The Suicide Prevention Center also provided support services to 972[2] individuals who have attempted suicide and/or were bereaved by a suicide; assistance and consultation to 263 law enforcement officers and first responders; and trainings in

ASIST and safeTALK to 293 community members to recognize and respond appropriately to suicide.

[1] County location details aren't always available; approximately 5% of call reports are missing county data.
[2] Please note, this number represents the total attendance for all groups, so individuals who have attended multiple sessions and groups are counted multiple times.

DIDI HIRSCH MENTAL HEALTH SERVICES

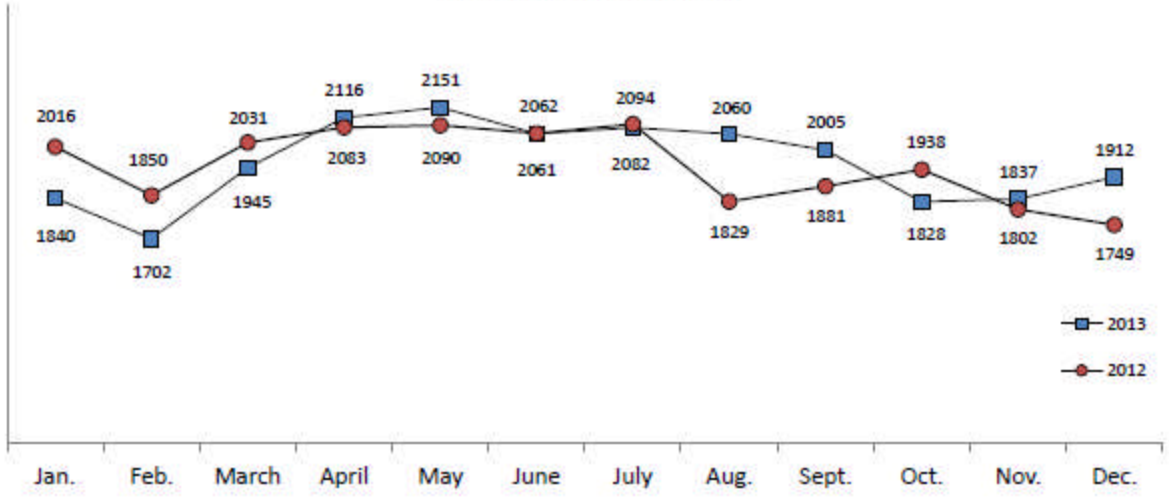
CRISIS LINE MONTHLY REPORT

Summary of Calls: LA County

CALL ANALYSIS for LOS ANGELES COUNTY DECEMBER 2013

	December 2013	Year to Date
TOTAL CALLS	1,912	23,539

Monthly Call Volume



Trends and Analysis for Current Month

In December, LA County's call volume accounted for 53% of calls to SPC from California.

This month, 9% of callers were considered High or High-Moderate risk (N=166).

Outreach

4 Outreach events were conducted by Didi Hirsch staff in LA County this month, including Adult and First Responders presentations.

Total individuals reached:

194

Cities with Highest Call Volume

City	Number	Percentage
Los Angeles	665	35%
Long Beach	110	6%
Burbank	64	3%
Van Nuys	60	3%
Lancaster	44	2%
Beverly Hills	40	2%

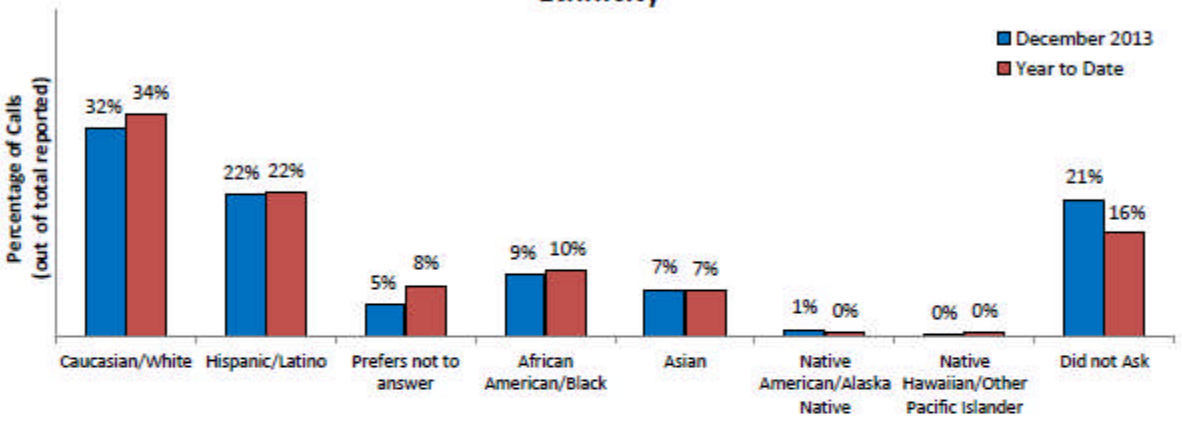
DIDI HIRSCH MENTAL HEALTH SERVICES

CRISIS LINE MONTHLY REPORT

Summary of Calls: LA County

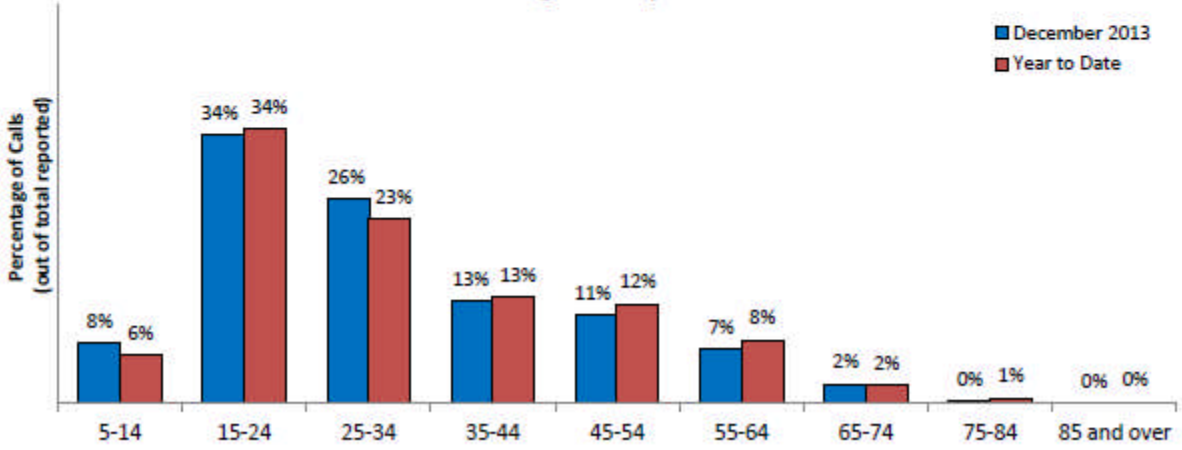
DEMOGRAPHICS FOR DECEMBER 2013		
Gender		
	December 2013	Year to Date
Female	54%	55%
Male	46%	45%

Ethnicity



Note: Total reported refers to calls for which information was obtained.
Data collection for "Did not Ask" category began April 2013. As such, YTD figure does not include previous months.

Age Groups

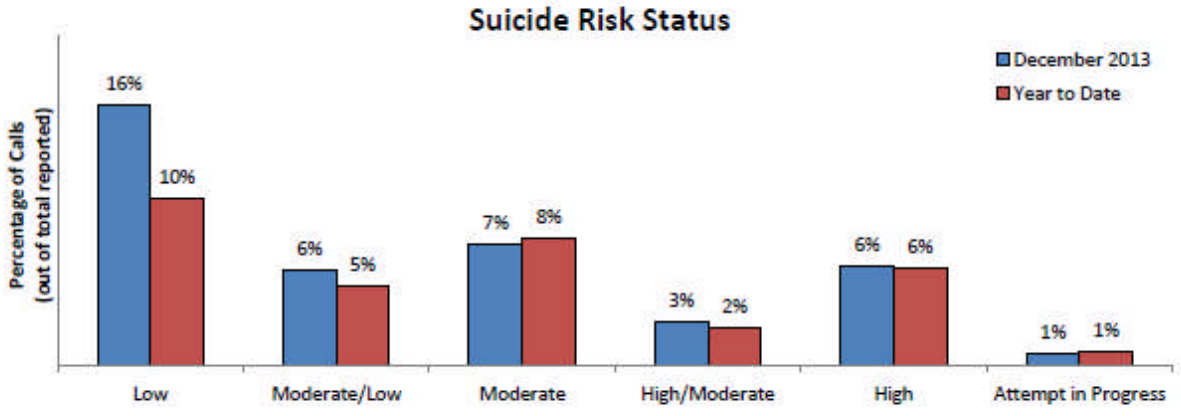


High Risk Categories

*The 45-54 age group has the highest suicide rate in the U.S. (based on 2010 national statistics reported by AAS).

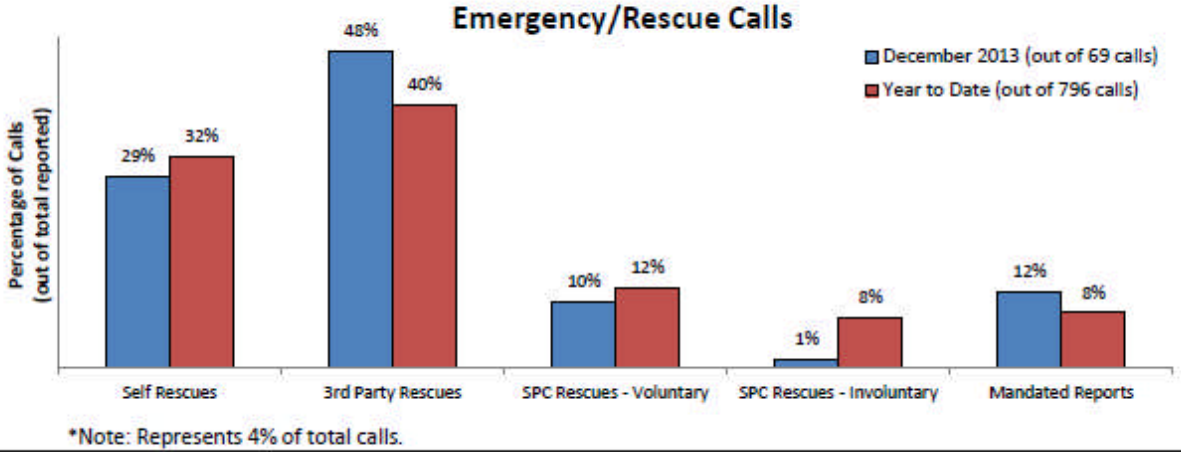
**The suicide rate in the 55-64 age group has steadily increased in the past 10 years.

CALLER RISK AND EMERGENCY CALLS for DECEMBER 2013



*Out of total calls. No risk assigned: December 2013 = 62%; YTD = 68%.

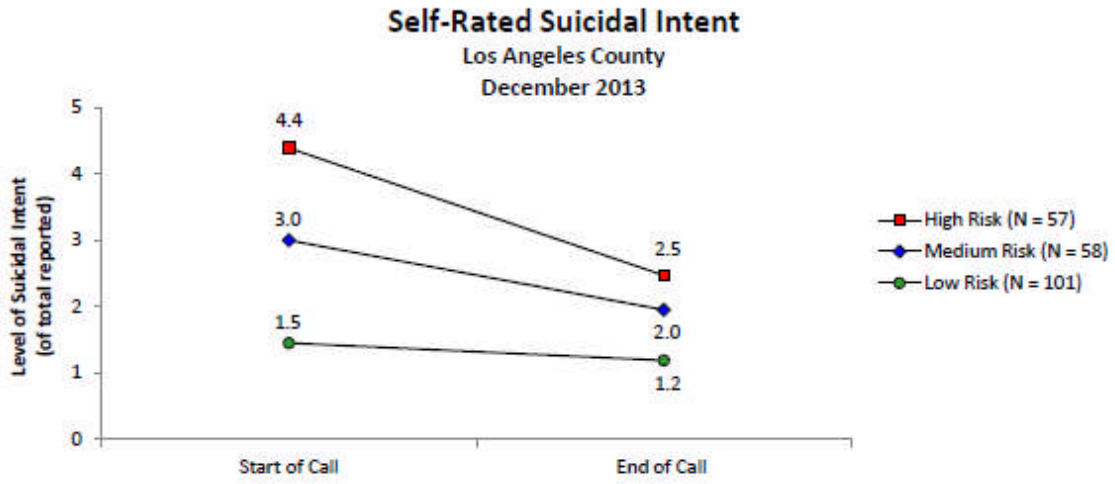
Low Risk	Caller has desire to kill self but has supportive buffers.
Moderate Risk	Caller has desire to kill self and is capable but has buffers; has desire to kill self and intends to but has buffers; is capable of killing self and intends to, but has buffers; or is capable or intends to kill self, but has buffers.
High Risk	Caller has desire to kill self, is capable and intends to kill self (may or may not have buffers); has desire to and is able or intends to kill self (no buffers).
Attempt in Progress	Suicide attempt is imminent.



*Note: Represents 4% of total calls.

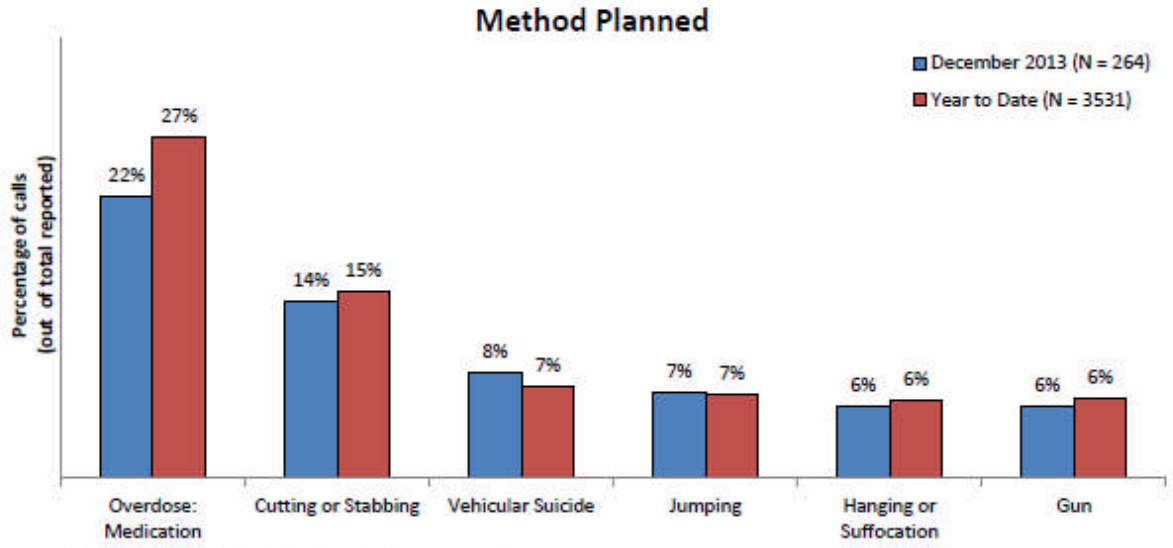
Self-Rescue	Caller decides to go to the ER/call 911/call PMRT on his/her own (or with help from a third party).
Third Party Rescue	Only applies to third party calls; the caller will get person at risk emergency help (911/PMRT/ER).
SPC Initiated Rescue	SPC calls 911 or PMRT on caller's behalf; could be either voluntary or involuntary.
Mandated Report	Includes suspected child abuse, suspected elder/dependent adult abuse, Tarasoff.

SELF-RATED INTENT AND METHOD PLANNED for DECEMBER 2013



Callers are asked to answer the question: "On a scale of 1 to 5, how likely are you to act upon your suicidal thoughts and feelings at this time, where 1 represents 'Not likely' and 5 represents 'Extremely likely'?" Callers rate their intent both at the start and end of the call. Note: This data is on calls for which information was reported.

High or Imminent Risk	Refers to callers who rated their Suicidal Intent at 4 or 5 at the beginning of the call.
Medium Risk	Refers to callers who rated their Suicidal Intent at 3 at the beginning of the call.
Low Risk	Refers to callers who rated their Suicidal Intent at 1 or 2 at the beginning of the call.



*Approximately 41% of callers will not say or do not know.
**Top 6 methods; callers may choose multiple categories.

PRECIPITATING CALLER RISK FACTORS		
Calls for which there is information from caller		
	December 2013	Year to Date
Precipitating Event*		
Suicidal Desire	50%	57%
Relationship/ Family Issues	36%	**
Depression	34%	**
Past Suicidal Ideation/Attempt	31%	**
Anxiety/Stress	27%	**
Mental Illness/ Emotional Problem	27%	31%
*Top 6 Caller Concerns; callers may choose multiple categories. **YTD data not available for new Caller Concern categories. SPC categories modifed to match Common Metric fields.		
Caller-Reported Risk Factors***		
History of Psychiatric Diagnosis	25%	28%
Substance Abuse-past or current	29%	32%
Calls Related to Financial Crisis	15%	19%
Prior Attempt	16%	17%
Suicide Survivor	7%	7%
Access to Gun	2%	2%
***Risk factors do not total 100% due to overlap in categories.		

PEI Early Start-School Mental Health Initiative: ES-2

The Early Start School Mental Health Initiative Program focuses on school mental health needs to reduce and eliminate stigma and discrimination. The program addresses the high need of students with developmental challenges, emotional stressors, and various mental health risks and reduces violence at

educational institutions through collaborative efforts and partnerships with the community. This is a comprehensive prevention and early intervention program to prevent violence in schools and create a safe learning environment. The services include eliminating substance use and abuse; addressing any trauma experiences; development of school-based crisis management teams; and training. Early screening and assessment of students of concern are provided at the earliest onset of symptoms.

EBP/PP/CDEs Implemented:

School Threat Assessment and Response Team (START): The three (3) main objectives for START are the following: Prevention and Reduction of targeted school violence in Los Angeles County, Provision of on-going support and assistance to students at risk, their families/caregivers and schools through interventions, trainings, and consultations and Establishment of partnerships with schools, law enforcement, and other involved community organizations.

START has responded to thousands of incidents where law enforcement officials, school authorities and other individuals had concerns about potential violence in elementary schools, middle schools, high schools, and college campuses. The Program receives service requests 24/7 Countywide. In Fiscal Years 2012-2013 and 2013-2014, START completed more than 4,000 threat assessments and trained at least 2,800 individuals annually.

Below, Table 1 encompasses the percentages of START clients that received crisis intervention involving assessment, crisis intervention, and linkage services in FY 2013-2014. SMART/START Central (14%) provided the highest number of crisis interventions.

Table 1: Percentage of START Clients Received Crisis Intervention[1] (N=4,675)

SMART[2]/ START Central	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	MET[3]	LBMET[4]	HOPE[5]
	Psychiatric Mobile Response Teams (PMRT)										
14%	5%	8%	12%	8%	5%	13%	12%	7%	9%	5%	2%

[1]Source provided by Quality Improvement Division
[2]Los Angeles Police Department System wide Mental Assessment Response Team
[3]Los Angeles County Sheriff's Department Mental Evaluation Team
[4]Long Beach Police Department Mental Evaluation Team
[5]Pasadena Police Department Homeless Outreach Psychiatric Evaluations

START has developed the multi-phased service protocol specific for the target population in the Los Angeles County. The risk assessment represents best practice guidelines from the 2002 Safe School Initiative, the RAGE-V, and the Canadian Center for Threat Assessment and Trauma

Response Group which has worked to develop protocols for a variety of entities and highlighted the importance of identifying disconnected kids or "empty vessels" (Cameron, 2005). The violence threat risk assessment process is dynamic in nature by virtue of the various external and internal factors at play: the students' internal dynamics, the external pressures confronting the student, the unique pressures perceived by the student, and the various risk or protective factors at play. The recognition that risk level can change quickly requires a threat management system that is both flexible and responsive to the new sources of information, and which involves five action service protocols.

The first action is to determine whether or not immediate detention is indicated through law enforcement detention or involuntary psychiatric hospitalization based on the facts available. The

second action is a comprehensive clinical assessment of the student and collateral interviews with significant others including parents, school personnel, counselors, safety officers, local police, campus threat management teams, therapists, neighbors, roommates, and classmates. A third action is gathering factual information with the consent of the responsible parties including a review of the student's backpack, locker, journals, social media accounts, car, home, bedroom, and other storage sites. The fourth action is the development or reinforcement of a safety net and provision of intervention for the student addressing the dynamics or issues propelling the student towards Targeted School Violence as well as for student at risk of being bullied and self-harm. As for those students who become stable and maintain at low risk of self-harm and harm to others, they are referred to appropriate services based on the individuals' needs. The fifth action step is the long term and intensive monitoring. Interventions are rendered on a regular basis determined by individuals' needs. START maintains regular collateral contacts and collaborates with schools and other involved professionals to ensure individuals receive appropriate support and assistance in dealing with their presenting problems.

In summary, the START team conducts an assessment and develops interventions which include intensive case management strategies for individuals with the above criteria. The START team maintains a case open until the individual is reported stable in the following areas: home, school, work, therapy and psychiatry (if psychotropic medication is prescribed). In addition to the five-action service protocol, START has accomplished and completed two important components of our services: training and partnership.

The training component is designed to develop situational awareness, train law enforcement, school campus, threat management teams on violence, threat risk assessment and develop the relationship required to sustain START's effort. START trained 2,885 individuals in Fiscal Year 2013-2014 (Table 2). The START team was invited to provide consultation and services in K-12 schools, and higher learning campuses.

Table 2: Trainings

Training	Students-12th Grade/Under		College Students		Professionals		Parents		Total	
	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees
Targeted School Violence	0	0	3	190	39	2177	0	0	**42**	**2,367**
START Program	0	0	0	0	13	302	0	0	**13**	**302**
Bullying	3	85	0	0	3	101	1	30	**7**	**216**
Total	**3**	**85**	**3**	**190**	**55**	**2,580**	**1**	**30**	**62**	**2,885**

Please see Appendix III for more information on the START program.

Reduction in Suicidal Risk Level

START rated clients low, medium, or high on their suicidal risk levels during the initial assessment as well as after START and other services were provided. Seven (6%) clients remained at the same suicidal risk level, 47 (42%) lowered the risk by one level, and 58 (52%) by two levels.

Table 3

Change in Suicidal Risk Level

Rating	Remained the same level	Lower risk by one level	Lower risk by two levels	Increase risk	TOTAL
Number of Clients	7	47	58	0	112
Percentage	6%	42%	52%	0%	100%

Reduction in Risk Level for Danger to Others

START rated clients low, medium, or high on homicidal risk levels during the initial assessment as well as after START and other services were provided.181 (85%) clients were rated the same risk level for danger to others at pre and post assessments. The 181 clients remained at low homicidal risk level, received brief intervention and were referred to appropriate service agencies. Additionally, 31 clients were provided intensive case management services. Of the 31 clients, 25 (12%) lowered homicidal risk by one level, 4 (2%) by two levels, and 2 (1%) increased by one level.

Table 4

Change in Homicidal Risk Level

Rating	Remained the same level	Lower risk by one level	Lower risk by two levels	Increase risk by one level	TOTAL
Number of Clients	181	25	4	2	212
Percentage	85%	12%	2%	1%	100%

Client Case #1

The START program received a referral for an adolescent male. He was referred by his therapist due to concerns associated with homicidal ideations. He was evaluated for violence threat risk. The client expressed frequent homicidal ideations toward other students. He discussed students who were popular and spoke of his desire to belong, but being rejected. The client reported a history of chronic bullying and described fantasies of how he would kill people by using a knife and torturing his victims.

The START team worked collaboratively with his parents, treatment team, school police, and school staff. The school scheduled a team meeting initiated by START. The team also advocated for the educationally based interventions since he was having a difficult time with academics. A different school setting was agreed upon. Additionally, issues of bullying were identified and addressed with school administrators, and a plan to prevent victimization was created which included monitoring. START monitored the client frequently, particularly during the times of transitions START helped the client identify options for the future and assisted him in obtaining an identification card so that he has the documents necessary to obtain a job. The client eventually reported a source of significant stress regarding gender identity. He never disclosed this information to anyone, but expressed it to the START team approximately 1.5 years after initial contact. The client was provided with information and resources to help him cope with challenges and is no longer expressing homicidal ideations. He is future oriented and interested in pursuing his academics START continues to be involved and is in the process of helping him establish public and other financial resources.

Client Case #2

The client was referred to START by a hospital where the client was placed involuntarily for being a danger to him and others. In an online submission to a university, the client expressed hopelessness and thoughts of hurting others. These thoughts and feelings were triggered after academic failure and the prospect of not being able to attend a university. He sent a threatening email where he expressed hopelessness and anger. In the threat, the client blamed the academic institution for the situation and that the rejection would cause disappointment among his family who had worked tirelessly in his attempts to pursue his academics and that his family had sacrificed everything for him. There was no known history of mental health problems trauma, violence, or substance abuse with the client or within his family.

START became involved when the psychiatric hospital sent a referral upon the client's admission. Police and hospital records of the incident were requested and reviewed. The hospital reported that the client's mother minimized the situation and had a difficult time understanding the need for and agreeing to mental health services.

Rapport and trust was developed with the family which allowed the team to gather collateral information and gain acceptance for mental health services. The team then visited the hospital to interview the client, and gathered information that, along with the hospital assessment and collateral from the client's mother, provided enough to complete a MOSAIC assessment. The team decided that a priority for the client was to link him to mental health services that could address the entire family.

START provided continuing follow-up to check on the client's status and offer additional support while he received therapy treatment. The client was reassessed and determined to present a low level of risk, successfully completed treatment with the therapist stating that the client's symptoms had been addressed and was provided with resources as part of a safety plan in case the client began to experience excessive stress or thoughts of harming himself or others. The lead counselor at the school was informed about the student's potential need for additional support in case the client ever presented to their center.

PEI Early Start-Anti-Stigma Discrimination: ES-3

The purpose of the Early Start Stigma and Discrimination Project is to reduce and eliminate barriers that prevent people from utilizing mental health services by prioritizing information and knowledge on early signs and symptoms of mental illness through client-focused, family support and education and community advocacy strategies. Core strategies have been identified to reduce stigma and discrimination, increase access to mental health services, and reduce the need for more intensive mental health services in the future. The services include: anti-stigma education specifically targeting underrepresented communities through outreach utilizing culturally sensitive and effective tools; educating and supporting mental health providers; connecting and linking resources to schools, families, and community agencies; and client and family education and empowerment.

EBP/PP/CDEs Implemented:

Family-focused Strategies to Reduce Mental Health Stigma and Discrimination

The Los Angeles County Alliance for the Mentally Ill provides prevention services countywide with a focus on reducing mental health stigma seen among and discrimination experienced by consumers' families and parents/caregivers. Services include education about mental illness, treatment, medication, and rehabilitation as well as teach communication and coping skills. The program includes a family support bureau training program, parental support services, and consultative services.

The Adult System of Care Anti-Stigma and Discrimination Team participated in 50 events during FY 2013-2014 and outreached to 970 Los Angeles County community members. These Countywide events provided educational presentations to the faith community and PEI UREP populations. Community events were also held on college campuses. There was also collaboration with various agencies including the jails and the LA County Sheriff Dept.

Children's Stigma and Discrimination Reduction Project

The project provides education to parents and to the community through two distinct curricula. The first is a 10-week course, developed specifically to reduce stigma, includes healing and communication tools to promote mental wellness and creating a world that is empathic to

children. The second is a 12-week curriculum, developed by United Advocates for Children and Families, is an education course on childhood mental illnesses and it also includes grief and loss, and navigating the multiple systems, e.g. mental health, juvenile justice, and DCFS. The parents and community members have responded highly to the presentations that have taken place around the county.

During FY 2013-14 60 trainings on mental illness and bullying were provided to parents, children and community members Countywide.

Older Adults Mental Wellness

In May of 2014 a Service Extender was added. Occasionally, other older adult systems of care staff provide assistance. The OA ASD Team participated in a total of 166 events during the fiscal year 2013-2014, outreaching to more than 2,516 Los Angeles County residents. These events included countywide educational presentation, community events and collaboration with various agencies.

Highlights of OA ASD's accomplishments include:

- Provided over 166 workshops for seniors throughout the county
- Participated in three (3) Health Fairs throughout the county
- Increased number of workshops to five (5) in areas of SA 1
- Identified locations for workshops in the Antelope Valley.
- Rolling out The Mental Health First Aid training for non-clinical staff, volunteers, and people in the community.
- Adding a Service Extender to provide presentation in the Spanish language.
- Added two (2) more presentations giving us a total of 11 topics on our menu.

Profiles of Hope Project

Profiles of Hope are a set of 10-minute inspirational stories that spotlights high-profile individuals who candidly share how they overcame stigma and various obstacles to live successful and productive lives.

Los Angeles County Department of Mental Health
Public Information Office
Presents:

Profiles of Hope 2013

The Los Angeles County Department of Mental Health's (LACDMH) ongoing Emmy Award-winning video series *Profiles of Hope* is an in-depth portrait of individuals who have struggled with mental health issues and are in recovery. Their stories—unfiltered, inspiring and deeply moving—are a testament to the power of hope and finding the path to wellness and recovery.

As LACDMH and our communities continue to defeat the stigma and discrimination associated with persons diagnosed with mental illness, the *Profiles of Hope* series stands as an example of how mental illness does not define an individual. Through the very personal stories in each segment, viewers learn how those profiled have effectively dealt with their challenges; inspiring clients and others suffering from anxiety, depression, mania, psychosis and/or addiction to proactively seek treatment as soon as possible for better outcomes.

Profiles of Hope are a series of 30-minute videos produced by the LACDMH Public Information Office that can be seen on KLCS, the Los Angeles County cable television channel and on YouTube: http://www.youtube.com/user/lacdmhpio.

The series was initiated in 2010 by LACDMH Public Affairs Director, Kathleen Piché, as a vehicle in which to foster dialog and discussion on the issues related to mental health, wellness and recovery. The series is designed to help promote widespread tolerance and acceptance of those diagnosed with mental illnesses and/or addiction. For more information on the *Profiles of Hope* video series, please contact the LACDMH PIO at pio@dmh.lacounty.gov.

The 2013 *Profiles of Hope* feature actor/musician Rick Springfield discussing a lifelong battle with depression, actress/model/writer Mariel Hemingway bravely speaking out about her family legacy of mental illness and producer/director Paris Barclay candidly talking about addiction and suicidal ideation.

School Based Services: PEI-1

The School-Based Services Project is intended to (1) build resiliency and increase protective factors among children, youth and their families; (2) identify as early as possible children and youth who have risk factors for mental illness; and (3) provide on-site services to address non-academic problems that impede successful school progress. These programs provide outreach and education; promote mental wellness through universal and selective prevention strategies; foster a positive school climate; offer early mental health intervention services on school sites; and provide training in mental health evidence-based programs to school personnel and providers working with youth and children.

EBP/PP/CDEs Implemented:

1. Aggression Replacement Training
2. Cognitive Behavioral Intervention for Trauma in School
3. Multidimensional Family Therapy
4. Olweus Bullying Prevention Program
5. Promoting Alternative Thinking Strategies
6. Strengthening Families
7. Why Try? Program

Family Education & Support Services: PEI-2

The purpose of the Family Education and Support Project is to build competencies, capacity and resiliency in parents, family members and other caregivers by teaching a variety of strategies. The project utilizes universal and selective intervention as well as early intervention approaches for children/youth in stressed families. The programs will address the risk factors and protective factors that promote positive mental health, concentrating on parental skill-building through a variety of training, education, individual, group parent, and family interaction methods.

EBP/PP/CDEs Implemented:

1. Caring for Our Families
2. Incredible Years
3. Managing and Adapting Practice*
4. Mindful Parenting*
5. Promoting Alternative Thinking Strategies*
6. Nurse-Family Partnership
7. Nurturing Parenting Program
8. Triple P Positive Parenting Program

Program was added to the PEI Plan after 2009

At Risk Family Services: PEI-3

The At Risk Family Services Project provides training and assistance to families whose children are at risk for placement in foster care, group homes, psychiatric hospitals, and other out of home placements. It builds skills for families with difficult, out of control or substance abusing children who may face the juvenile justice involvement and provides support to families whose environment and history renders them vulnerable to forces that lead to destructive behavior and the disintegration of the family.

EBP/PP/CDEs Implemented:

1. Brief Strategic Family Therapy
2. Child-Parent Psychotherapy
3. Families Over Coming Under Stress (FOCUS)*
4. Group Cognitive Behavioral Therapy for Major Depression
5. Incredible Years
6. Make Parenting a Pleasure
7. Mindful Parenting*
8. Parent-Child Interaction Therapy
9. Reflective Parenting Program
10. Triple P Positive Parenting Program
11. UCLA Ties Transition Model

Program was added to the PEI Plan after 2009

Trauma Recovery Services: PEI-4

The Trauma Recovery Services Project (1) provides short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event; and (2) provides more intensive services to trauma-exposed youth, adults, and older adults to decrease the negative impact and behaviors resulting from the traumatic events. The programs include outreach and education, psychosocial assessment, individual short-term crisis counseling, family counseling, youth and parent support groups, case management, and training for staff that are likely to work with trauma victims.

EBP/PP/CDEs Implemented:

1. Child-Parent Psychotherapy
2. Crisis Oriented Recovery Services
3. Dialectal Behavioral Therapy*
4. Depression Treatment Quality Improvement*
5. Group Cognitive Behavioral Therapy for Major Depression
6. Individual Cognitive Behavioral Therapy*
7. Parent-Child Interaction Therapy
8. Prolonged Exposure Therapy for Posttraumatic Stress Disorder
9. Seeking Safety
10. System Navigators for Veterans
11. Trauma Focused Cognitive Behavioral Therapy

Program was added to the PEI Plan after 2009

Primary Care & Behavioral Health: PEI-5

The Primary Care and Behavioral Health Project develops mental health services within primary care clinics in order to increase primary care providers' capacity to offer effective mental health guidance and early intervention through the implementation of screening, assessment, education, consultation, and referral. The goal of the project is to prevent patients at primary care clinics from developing severe behavioral health issues by addressing their mental health issues early on. Behavioral health professionals skilled in consultation and primary care liaison will be integrated within the primary care system. By offering assistance in identifying emotional and behavioral issues at a clinic setting, the stigma associated with seeking out mental health services will be minimized.

EBP/PP/CDEs Implemented:

1. Alternatives for Families – Cognitive Behavioral Therapy
2. Incredible Years
3. Mental Health Integration Program (formerly IMPACT)
4. Triple P Positive Parenting Program

Early Care & Support for Transition Age Youth: PEI-6

The Early Support and Care for Transition-Age Youth Project (1) builds resiliency, increase protective factors, and promote positive social behavior among TAY; (2) addresses depressive disorders among the TAY, especially those from dysfunctional backgrounds; and (3) identifies, supports, treats, and minimizes the impact for youth who may be in the early stages of a serious mental illness. Emancipating, emancipated, and homeless TAY are a special focus of this project.

EBP/PP/CDEs Implemented:

1. Aggression Replacement Training
2. Center for the Assessment and Prevention of Prodromal States
3. Group Cognitive Behavioral Therapy for Major Depression
4. Interpersonal Psychotherapy for Depression
5. Multidimensional

Juvenile Justice Services: PEI-7

The Juvenile Justice Services Project builds resiliency and protective factors among children and youth who are exposed to risk factors that leave them vulnerable to becoming involved in the juvenile justice system. It also promotes coping and life skills to youths in the juvenile justice system to minimize recidivism and identifies mental health issues as early as possible in order to provide early intervention services. Services are to be provided at probation camps throughout the County, residential treatment facilities, health clinics, community settings, and other non-traditional mental health sites.

EBP/PP/CDEs Implemented:

1. Aggression Replacement Training
2. Cognitive Behavioral Intervention for Trauma in School
3. Functional Family Therapy
4. Group Cognitive Behavioral Therapy for Major Depression
5. Loving Intervention for Family Enrichment
6. Multidimensional Family Therapy
7. Multisystemic Therapy
8. Trauma Focused Cognitive Behavioral Therapy

Early Care & Support for Older Adults: PEI-8

The purpose of the Early Care and Support Project for Older Adults is to (1) establish the means to identify and link older adults who need mental health treatment but are reluctant, are hidden or unknown, and/or unaware of their situation; (2) prevent and alleviate depressive disorders among the elderly; (3) and provide brief mental health treatment for individuals. Services are directed at older adults, their family members, caregivers, and others who interact with and provide services to this senior citizen population.

EBP/PP/CDEs Implemented:

1. Cognitive Behavioral Therapy for Late Life Depression
2. Crisis Oriented Recovery Services
3. Interpersonal Psychotherapy for Depression
4. Program to Encourage Active Rewarding Lives for Seniors (PEARLS)
5. Problem Solving Therapy*

Program was added to the PEI Plan after 2009

Improving Access for Underserved Populations: PEI-9

The Improving Access for Underserved Populations Project is intended to (1) build resiliency and increase protective factors among monolingual and limited English-speaking immigrants and underserved cultural populations, lesbian/gay/bisexual/transgender/ questioning (LGBTQ) individuals, deaf/hard of hearing individuals and blind/visually impaired individuals and their families; (2) identify as early as possible individuals who are a risk for emotional and mental problems; and (3) provide culturally and linguistically appropriate early mental health intervention services. The programs will provide outreach and education as well as promote mental wellness through universal and selective prevention strategies.

EBP/PP/CDEs Implemented:

1. Group Cognitive Behavioral Therapy for Major Depression
2. Nurse-Family Partnership
3. Prolonged Exposure Therapy for Posttraumatic Stress Disorder
4. Trauma Focused Cognitive Behavioral Therapy

American Indian Project: PEI-10

The American Indian Project (1) builds resiliency and increase protective factors among children, youth and their families; (2) addresses stressful forces in children/youth lives, teaching coping skills, and diverting suicide attempts; (3) and identifies as early as possible children and youth who have risk factors for mental illness. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; offer early mental health intervention services at comfortable, non-stigmatizing localities; and involve multi-generations in the American Indian children and youth's lives. An important emphasis is on preventing suicide among American Indian youth, given the high rate among this population.

EBP/PP/CDEs Implemented:

1. American Indian Life Skills
2. Trauma Focused Cognitive Behavioral Therapy: Honoring Children, Mending the Circle

PEI Practices Implemented

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
1	**Aggression Replacement Training (ART)**	ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control training, and training in moral reasoning. Skill-streaming teaches pro-social skills. In anger control training, youths are taught how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others.	Children (ages 5-12) – Skill streaming Only Children (ages 12-15) TAY (ages16-17)	Prevention & Early Intervention	PEI-1 PEI-6 PEI-7
2	**Alternatives for Families – Cognitive Behavioral Therapy (AF-CBT)**	AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.	Children (ages 4-15) TAY (ages 16-17)	Early Intervention	PEI-5
3	**American Indian Life Skills Program (AILSP)**	AILSP is designed to build life skills and increase suicide prevention skills for American Indian high school students. It is designed to promote self-esteem, identify emotions and stress, increase communication and problem solving skills, and recognize and eliminate self-destructive behavior (including substance use). AILSP provides American Indian children and TAY information on suicide and suicide intervention training and helps them set personal and community goals.	Children (ages 14-15) TAY (ages 16-18)	Prevention	PEI-10
4	**Brief Strategic Family Therapy (BSFT)**	BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.	Children (ages 10-15) TAY (ages 16-18)	Prevention & Early Intervention	PEI-3
5	**Caring for Our Families (CFOF)**	Adapted from the "Family Connections" Model, CFOF includes community outreach, family assessment, and individually tailored treatment programs. The goal is to help families meet the basic needs of their children and reduce the risk of child neglect. The core components include emergency assistance/concrete services; home-based family intervention (e.g., outcome-driven service plans, individual and family counseling); service coordination with referrals targeted toward risk and protective factors; and multi-family supportive recreational activities.	Children (ages 5-11)	Prevention & Early Intervention	PEI-2 PEI-3

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
6	**Center for the Assessment and Prevention of Prodromal States (CAPPS)**	The focus of this CAPPS PEI Demonstration Pilot will be to conduct outreach and engagement specifically to those youth who are experiencing their first-break psychosis and early onset of serious mental illnesses with psychotic features. In order to mitigate mental health challenges and reduce the progression of these challenges into mental health diagnoses, this project will also engage families and significant others of the youth as well as the youth themselves in PEI services.	TAY	Prevention & Early Intervention	PEI-6
7	**Child-Parent Psychotherapy (CPP)**	CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma.	Young Children (ages 0-6)	Early Intervention	PEI-3 PEI-4
8	**Cognitive Behavioral Intervention for Trauma in School (CBITS)**	CBITS is an early intervention for children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of Posttraumatic Stress Disorder (PTSD), depression, or anxiety. To improve access to mental health care, services are delivered within the school setting by clinical staff as part of multi-disciplinary treatment teams. CBITS intends to reduce the impact of trauma-related symptoms, build resilience, and increase peer and parental support for students at-risk of school failure.	Children (ages 10-15) TAY	Prevention & Early Intervention	PEI-1 PEI-7
9	**Crisis Oriented Recovery Services (CORS)**	DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed in the future. The psychotherapy component assists individuals who are currently depressed to gain understanding of factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disorder.	Children TAY Adults Older Adults	Prevention & Early Intervention	PEI-4
10	**Depression Treatment Quality Improvement (DTQI)**	DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, dialectical strategies, mindfulness, contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.	Children (ages 12-15) TAY (ages16-20)	Early Intervention	PEI-5 PEI-6

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
11	**Dialectical Behavior Therapy (DBT)**	Didi Hirsch provides 24/7 crisis hotline services in English, Spanish, and Korean. Support services are provided to attempters and/or those bereaved by a suicide, as well as consultation to law enforcement and first responders. This practice builds community capacity by offering evidence-based training in the Applied Suicide Intervention Skills Training (ASIST) and safe TALK models.	TAY (18-25) Adults Older Adults Directly Operated Clinics only	Prevention & Early Intervention	PEI-4
12	**Early Start Suicide Prevention - 24/7 Crisis Hotline**	Didi Hirsch provides 24/7 crisis Hotline services in English, Spanish, and Korean. Support services are provided to attempters and/or those bereaved by a suicide, as well as consultation to law enforcement and first responders. This practice builds community capacity by offering evidence-based training in the Applied Suicide Intervention Skills Training (ASIST) and safe TALK models.	Children TAY Adults Older Adults	Prevention	ES-1
13	**Early Start Suicide Prevention – Latina Youth Program**	Pacific Clinics provides 24/7 bilingual (Spanish) emergency and information telephone counseling, consultation and education to schools regarding suicide risk factors among teens. It also provides education and support services in the community about warning signs and risk factors for suicide among youth. The program has expanded to include male as well as female youth, 14 to 25 years of age, who are identified as being “at risk” for suicide.	Children TAY Adults Older Adults	Prevention	ES-1
14	**Early Start Suicide Prevention – Web-based Training for School Personnel on Suicide Prevention**	The Los Angeles County Office of Education (LACOE), Center for Distance and Online Learning (CDOL) was contracted to design, develop, and maintain a website dedicated to provide critical online information and materials on suicide prevention, intervention, and postvention for school personnel, parents, and students in all 80 K-12 school districts in Los Angeles County. Launched in January 2011, the website has been widely publicized throughout the County, State (through the Office of Suicide Prevention), and at national conferences and meetings of various suicide prevention networks/organizations (including a recent Webinar on “Responding after a Suicide: Best Practices for Schools,” sponsored by the Suicide Prevention Resource Center).	Children TAY Adults Older Adults	Prevention	ES-1
15	**Early Start Suicide Prevention – Partners in Suicide (PSP) Team**	PSP is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The Team offers education, identifies appropriate tools, such as evidence-based practices, and provides linkage and referrals to age-appropriate services. PSP team members participate in suicide prevention events including Countywide educational trainings, suicide prevention community events, and collaboration with various agencies and partners.	Children TAY Adults Older Adults	Prevention	ES-1

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
16	**Early Start School Mental Health – School Threat Assessment Response Team (START)**	The START program developed 21 teams composed of a law enforcement officer and a DMH clinician who partner with educational institutions (K-12 through higher education) school-based mental health programs, substance abuse programs, and other social service providers in the community to prevent school violence. Staff conducts school threat assessments and provides intervention and case management services to those who meet criteria for the START program.	Children TAY Adults Older Adults	Prevention	ES-2
17	**Early Start School Mental Health – Service Area 6 School Mental Health Demonstration Program**	The School Mental Health PEI Demonstration Pilot (SMHPEI Demonstration Pilot) will provide school-based mental health outreach and education, on-site school crisis intervention, a peer support network, and early screening.	Children TAY	Prevention	ES-2
18	**Early Start Stigma and Discrimination – Family-Focused Strategies to Reduce Mental Health Stigma and Discrimination**	The Los Angeles County Alliance for the Mentally Ill is implementing "Family-focused Strategies to Reduce Mental Health Stigma and Discrimination" for consumers' families and parents/caregivers. Services include education about mental illness, treatment, medication, and rehabilitation, as well as teaching communication and coping skills. The program includes a family support bureau training program, parental support services, and consultative services.	Adults Older Adults	Prevention	ES-3
19	**Early Start Stigma and Discrimination – Children's Stigma and Discrimination Reduction Project**	The project provides education to parents and the community through two distinct curricula. A 10-week course developed specifically to reduce stigma includes healing and communication tools to promote mental wellness and creating a world that is empathic to children. A 12-week curriculum, developed by United Advocates for Children and Families on childhood mental illnesses which includes topics such as grief and loss, and navigating the multiple systems, e.g. mental health, juvenile justice, and DCFS.	Adults Older Adults	Prevention	ES-3
20	**Early Start Stigma and Discrimination – Older Adults Mental Wellness**	The Older Adult Anti-Stigma and Discrimination Team (OA ASD) outreaches to residents through countywide educational presentations, community events, and collaboration with various agencies. OA ASD increases awareness on mental well-being for older adults throughout Los Angeles County, particularly among underserved and underrepresented communities. Presentations are available in 5 different languages: English, Spanish, Korean, Chinese and Farsi.	Older Adults	Prevention	ES-3

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
21	**Early Start Stigma and Discrimination – Profiles of Hope Project**	The Profiles of Hope and accompanying Public Service Announcements (PSAs) aim to show that anyone can be subject to the stigma a mental illness has traditionally carried, and change their minds about how they support and view others with a diagnosis of mental illness. "Profiles of Hope," a 60-minute film, promotes an anti-stigma message for those diagnosed with mental illness and has been broadcast on local television stations along with the PSAs.	TAY Adults Older Adults	Prevention	ES-3
22	**Early Start Stigma and Discrimination – Videos**	Six high-profile personalities, experienced and passionate advocates in promoting hope, wellness and recovery, donated their time and talent to create 10-15 minute anti-stigma and discrimination videos that are aired on various television stations, including: Latina boxing champion Mia St. John; CSI-Las Vegas actor and musician Robert David Hall; actress and author Mariette Hartley; psychiatrist in recovery Clayton Chau, M.D., Ph.D.; Veteran General Hospital actor Maurice Bernard; and US Vets CEO Steve Peck, M.S.W.	TAY Adults Older Adults	Prevention	ES-3
23	**Families Over Coming Under Stress (FOCUS)**	Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family as a whole by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.	Children TAY Adults	Prevention &Early Intervention	ES-3
24	**Functional Family Therapy (FFT)**	FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.	Children (ages 11-15) TAY (ages16-18)	Early Intervention	PEI-4 PEI-9
25	**Group Cognitive Behavioral Therapy for Major Depression (Group CBT)**	Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is particularly helpful in challenging distorted perceptions and bringing thoughts more in-line with reality. Cultural tailoring of treatment and case management shows increased effectiveness for low-income Latino and African-American adults.	TAY (ages 18-25) Adults Older Adults	Prevention &Early Intervention	PEI-3 PEI-4 PEI-6 PEI-7 PEI-8

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
26	**Incredible Years (IY)**	IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/emotional competencies. Teacher training intervention focuses on teachers' classroom management strategies, promoting pro-social behaviors and school readiness.	Young Children (ages 2-5) Children (ages 6-12)	Prevention &Early Intervention	PEI-2 PEI-3 PEI-5
27	**Individual Cognitive Behavioral Therapy (Ind. CBT)**	CBT is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psychoeducation, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.	TAY (18-25) Adults Older Adults Directly Operated Clinics only	Prevention &Early Intervention	PEI-3 PEI-4 PEI-5 PEI-6 PEI-7
28	**Interpersonal Psychotherapy for Depression (IPT)**	IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.	Children (ages 9-15) TAY Adults Older Adults	Prevention &Early Intervention	PEI-6 PEI-8
29	**Loving Intervention Family Enrichment Program (LIFE)**	An adaptation of Parent Project, LIFE is a 22-week skills-based curriculum implemented with parenting classes/support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/or school failure.	Children (ages 10-18)	Early Intervention	PEI-7
30	**Make Parenting a Pleasure (MPAP)**	MPAP is a group-based parent training program designed for parents and caregivers of children from birth to eight years of age. The program addresses the stress, isolation, and lack of adequate parenting information and social support that many parents experience. MPAP begins by recognizing the importance of parents as individuals, and builds on family strengths and helps parents develop strong support networks. The curriculum focuses first on the need for self-care and personal empowerment, and then moves from an adult focus to a parent/child/family emphasis.	Children (ages 0-8) TAY Adults Older Adults	Prevention	PEI-2 PEI-3 PEI-6

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
31	**Managing and Adapting Practice (MAP)**	MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP as implemented in L.A County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.	Young Children Children TAY (ages 16-21)	Prevention &Early Intervention	PEI-1 PEI-2 PEI-3 PEI-4
32	**Mental Health First Aid (MHFA)**	MHFA is a public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. An interactive 8-hour course, MHFA presents an overview of mental illness and substance use disorders and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. Participants learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.	TAY Adults Older Adults	Prevention	PEI-2 PEI-9
33	**Mental Health Integration Program (MHIP) formerly known as IMPACT**	MHIP delivers specialty mental health services to Tier 2 PEI and Low-Income Health Plan (LIHP)/Healthy Way LA enrollees with less intense mental health needs who are appropriately served through focused, time-limited early intervention strategies. An integrated behavioral health intervention program is provided within a primary care facility or in collaboration with a medical provider. MHIP is used to treat depressive disorders, anxiety disorders or PTSD, and to prevent a relapse in symptoms.	Adults	Prevention &Early Intervention	PEI-5 PEI-8
34	**Mindful Parenting Groups (MP)**	MP is a 12-week parenting program for parents and caregivers of infant, toddler and preschool children at risk for mental health problems and disrupted adoptions. Parents/caregivers and children are grouped in tight developmental cohorts with no more than 4-6 months difference in age for the children.	Young Children (ages 0-3)	Early Intervention	PEI-3
35	**Multidimensional Family Therapy (MDFT)**	MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with pro-social influences such as schools, peer groups, and recreational and religious institutions.	Children (ages 12-15) TAY (ages 16-18)	Early Intervention	PEI-1 PEI-6 PEI-7

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
36	**Multisystemic Therapy (MST)**	MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family, friends) and removing barriers (e.g. parental substance abuse, high stress).	Children (ages 12-15)TAY (ages 16-17)	Early Intervention	PEI-7
37	**Nurse Family Partnership (NFP)**	Registered nurses conduct home visits to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits may continue until the baby is two years old. Provided in conjunction with the L.A. County Department of Public Health.	Young Children (ages 0-2)	Prevention &Early Intervention	PEI-2 PEI-9
38	**Olweus Bullying Prevention Program (OBPP)**	OBPP is designed to promote the reduction and prevention of bullying behavior and victimization problems for children. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers, and students with the classroom, the school as a whole, and the community. School staff has the primary responsibility for introducing and implementing the program.	Children (ages 6-15)	Prevention	PEI-1
39	**Parent-Child Interaction Therapy (PCIT)**	PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.	Young Children (ages 2-7)	Prevention &Early Intervention	PEI-3 PEI-4
40	**Problem Solving Therapy (PST)**	PST has been a primary strategy in IMPACT/MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.	Older Adults	Early Intervention	PEI-8
41	**Program to Encourage Active Rewarding Lives for Seniors (PEARLS)**	PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.	Older Adults	Prevention &Early Intervention	PEI-8 PEI-9

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
42	**Prolonged Exposure – Post Traumatic Stress Disorder (PE-PTSD)**	PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.	TAY (ages 18-25) Adults Older Adults Directly Operated Clinics Only	Early Intervention	PEI-4 PEI-7 PEI-9
43	**Promoting Alternative Thinking Strategies (PATHS)**	PATHS is a school-based preventive intervention for children in elementary school. The intervention is designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skills concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations.	Children (ages 5-12)	Prevention &Early Intervention	PEI-1
44	**Reflective Parenting Program (RPP)**	RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents /caregivers enhance their reflective functioning and build strong, healthy bonds with their children.	Young Children (ages 2-5) Children (ages 6-12)	Early Intervention	PEI-3
45	**Seeking Safety (SS)**	SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.	Children (ages 13-15) TAY Adults Older Adults	Early Intervention	PEI-4 PEI-6
46	**Strengthening Families (SF)**	SF is a family-skills training intervention designed to enhance school success and reduce substance use and aggression among youth. Sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines, and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences.	Children (ages 3-15) TAY (ages 16-18)	Prevention & Early Intervention	PEI-1
47	**Trauma Focused Cognitive Behavioral Therapy (TF-CBT)**	An early intervention for children who may be at risk for symptoms of depression and psychological trauma, subsequent to any number of traumatic experiences, particularly those individuals who are not currently receiving mental health services. Services are specialized mental health services delivered by clinical staff, as part of multi-disciplinary treatment teams. Program is intended to reduce symptoms of depression and psychological trauma, which may be the result of any number of traumatic experiences (e.g., child sexual abuse, domestic violence, traumatic loss, etc.), for children and TAY receiving these services.	Young Children Children TAY (ages16-18)	Early Intervention	PEI-4 PEI-6 PEI-7 PEI-9

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
48	**Trauma Focused CBT (TF-CBT):** **"Honoring Children, Mending the Circle"**	This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational well-being. Traditional aspects of healing with American Indians and Alaskan natives from their world view are included.	Children	Early Intervention	PEI-10
49	**Triple P Positive Parenting Program (Triple P)**	Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through community-based organizations. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by DMH directly operated and contract agencies.	Young Children (ages 0-5) Children (ages 6-15) TAY (age 16)	Prevention& Early Intervention	PEI-2 PEI-3 PEI-5
50	**UCLA Ties Transition Model (UCLA TTM)**	UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho-educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation).	Young Children (0-5) Children (ages 6-12)	Early Intervention	PEI-3
51	**Veterans System Navigators**	Military veterans engage veterans and their families in order to identify and link them to support and services tailored to the particular cultural, ethnic, age and gender identity of those seeking assistance. Navigators also engage in joint planning efforts with community partners, including veterans groups, veterans administration, community-based organizations, other County Departments, schools, faith-based organizations, etc. with the goal of increasing access to mental health services and strengthening the network of services available to veterans. Provided in conjunction with the L.A. County Department of Military and Veterans Affairs.	TAY Adults Older Adults	Prevention	PEI-4

Prevention Programs Description

Six (6) programs were identified to prevent and minimize the impact of mental health issues for consumers and their families. These include:

- Making Parenting a Pleasure (MPAP) is a promising practice, group-based parent training program designed for parent educators of parents and/or caregivers of children from birth to eight years of age. The program is designed to address the stress, isolation, and lack of adequate parenting information and social support that many parents experience. The curriculum focuses first on the need for self-care and personal empowerment, and moves from an adult focus to a parent/child/family emphasis. Its content is adaptable and flexible to fit a wide range of parent education programs and has broad appeal to families from a wide spectrum of socioeconomic, educational, cultural and geographic backgrounds. Age group is parents of children (ages 0-8 years).
- Outreach and Education Pilot (OEP) for Underserved Populations focuses on assisting racial/ethnic minorities and underserved communities in Los Angeles County. OEP provides community-based outreach, educational workshops, case management, individual counseling, and group sessions delivered by and for targeted communities. Services can occur in culturally appropriate settings, which can range from community events to faith-based organizations, as well as other community-based organizations, primary care settings, community centers, and schools. Such activities are intended to help identify situations in which educational programs may lessen the impact or prevent more serious mental health issues from occurring. Serves all ages.
- Outreach and Education Pilot (OEP) for Transition Age Youth (ages 16-25):at-risk of or involved with juvenile justice system and at-risk for School Failure.
- Outreach and Education Pilot (OEP) for Transition Age Youth (ages 16-25):at-risk or on Probation.
- Outreach and Education Pilot (OEP) for Transition Age Youth (ages 16-25):at-risk of Substance Abuse.

  Services to TAY at-risk populations include community-based outreach, educational workshops, case management, individual counseling and group sessions, to TAY and their caregivers. Service delivery sites include juvenile probation settings, group homes, schools, community centers, community-based organizations, faith centers, and other non-traditional mental health settings.
- Positive Parenting Program (Triple P) is an evidence-based practice that is a multi-level parenting and family support strategy designed to prevent and treat behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills and confidence of parents. While acknowledging and respecting the diversity of family types and cultural backgrounds, the program builds on existing parenting strengths, and focuses on increasing parents' abilities to self-regulate and self-monitor their parenting skills. The Triple P system has interventions for individual families and small to large groups of parents. Interventions are available in a variety of delivery lformats with varying levels of intensity including individual sessions, group sessions, seminars forarge groups, self-help materials (self-help book and a self-directed online application), and mass media outreach and engagement materials. Age group is parents of children (ages 0-12 years).

Each prevention program provides one (1) or more types of services including: case management and/or individual services; workshops or seminars (one-time only services); and group sessions (multiple session services).

Cost

The average cost per client for community-based prevention programs for FY 2013-14 was $128 for case management services and $43 for group services. Averages based on 59,102 client contacts.

Community-Based Organizations Funded for Fiscal Year 2013-14

The agencies listed in the chart below were funded in FY 2012-13 and based on their performance and available one-time monies, were funded for an additional year.

Supervisorial District	Name	Prevention Program
JJ= Juvenile Justice; OEP = Outreach and Education Pilot; Triple P = Positive Parenting Program		
1	1. Bienestar Human Services, Inc.	OEP – Underserved Populations
	2. East Los Angeles Women's Center	OEP – Underserved Populations
	3. Human Services Association	Triple P
	4. Latino Family Institute, Inc.	OEP – Underserved Populations
	5. Little Tokyo Service Center Community Development Corp.	Make Parenting a Pleasure
	6. Los Angeles Centers for Alcohol and Drug Abuse	OEP – TAY Substance Abuse
2	1. Crawford Ministries, Inc.	Make Parenting a Pleasure
	2. Idom Industries, Inc.	Make Parenting a Pleasure
	3. Inner City Industry, Inc.	OEP – TAY JJ/School Failure
	4. Jeffrey Foundation	Make Parenting a Pleasure
	5. Korean American Family Service Center, Inc.	Triple P
	6. Korean Health, Education, Information & Research (KHEIR) Center	OEP – Underserved Populations
	7. Multicultural Service Center	OEP – TAY Substance Abuse
	8. New Hope Drug and Alcohol Program, Inc.	OEP – TAY Substance Abuse
	9. Office of Samoan Affairs, Inc.	OEP – Underserved Populations
	10. Pathways LA	Triple P
	11. Pennacle Foundation, Inc.	OEP – TAY JJ/School Failure
	12. Seeking Peaceful Solutions, Inc.	OEP – TAY Substance Abuse
3	1. El Nido Family Centers	Make Parenting a Pleasure
	2. Friends of the Family	Make Parenting a Pleasure
	3. New Directions for Youth, Inc.	OEP – TAY JJ/School Failure
	4. Unusual Suspects Theatre Company	OEP – Underserved Populations
4	1. Rainbow Services, Ltd.	Triple P
	2. Fleming and Barnes, Inc. dba Dimondale Adolescent Care	OEP – TAY Probation
	3. Cambodian Association of America	OEP – Underserved Populations
	4. Toberman Neighborhood Center, Inc.	Triple P
	5. South Bay Center for Community Development	OEP – TAY JJ/School Failure
	6. United Cambodian Community	Make Parenting a Pleasure
	7. Connecting Mental Health & Education, Inc.	OEP – TAY JJ/School Failure
5	1. Change Lanes	OEP – TAY Probation
	2. Esperanza Charities, Inc.	OEP – Underserved Populations
	3. Rancho San Antonio Boys Home, Inc.	OEP – TAY Probation
	4. YWCA San Gabriel Valley	OEP – Underserved Populations

PEI metrics were chosen based on input from practice developers, a review of the outcome measure literature and input from providers and other stakeholders. In addition, cost, length of instrument and languages an instrument has been translated into were factors related to measures selection.

A general measure and focus of treatment specific measure is administered at the beginning of treatment and at the end of treatment, with pre- and post-treatment changes analyzed. If the treatment lasts greater than six months, both measures are given again at the six-month marker.

The MHSA Implementation and Outcomes Division provides regular training on the use of outcome measures for PEI and use of the PEI OMA web-based application in the form of in-person training as well as webinars and written guides. For more information on PEI outcome user support, use the following link www.dmhoma.pbworks.com.

LACDMH's MHSA Implementation and Outcomes Division has developed opportunities for providers to utilize outcome data to enhance their services and to better understand PEI outcome reports.

LACDMH has staged the production of PEI outcome reports, prioritizing reports developed for Service Area Outcome Data Workgroups and PEI Practice Learning Networks that LACDMH has implemented over the last 2-3 years. Below is a summary of outcomes associated with the PEI practices associated with the Service Area Outcome Data Workgroups or the Learning Networks:

Managing and Adapting Practice (MAP):* This practice encompasses several foci of treatment, including anxiety, trauma, depression and disruptive behavior disorders. While the matched pairs are relatively low at this point, both children and parent/caregivers have endorsed the strongest positive change related to the treatment of disruptive behavior disorders, with **67%** of parents endorsing positive change on the Youth Outcome Questionnaire (YOQ) and **57%** endorsing positive change on the Eyberg Child Behavior Inventory (ECBI), **40%** of children endorsing positive change on the YOQ-SR, and **55%** endorsing positive change on the ECBI. Overall, matched pair results to date indicate that parent/caregivers are endorsing positive change related to MAP **64%** of the time, with a **45%** improvement in functioning achieved and children are endorsing positive change **55%** of the time, with a **41%** improvement in functioning achieved. All comparisons are made at the beginning and at the end of treatment.

Triple P Parenting:* This practice aimed at reducing parenting and family difficulties has resulted in a **38%** positive change as endorsed by parents and a **22%** positive change as endorsed by children on the YOQ-SR. The practice has also demonstrated 58-60% positive reliable change in parent/caregiver ECBI scores.

Trauma Focused Cognitive Behavioral Therapy:* For the 64 agencies providing trauma focused services, **74%** of the recipients of this practice self-identify as Latino. Both children and parent/caregivers have endorsed positive change on the YOQ. Parents endorsed a **38%** improvement in their children's overall functioning, while children reported a **35%** improvement in their overall functioning, representing **51%** and **47%** reliable change percentage, respectively. On average, parents report a **37%** improvement and children report a **42%** improvement in trauma symptoms on the Post Traumatic Stress Disorder Reaction Index (PTSD-RI) after completing Trauma Focused Cognitive Behavioral Therapy.

Incredible Years: This practice, aimed at improving parenting skills and reducing family difficulties, has been implemented at 17 provider sites and has an average client age of 8. Sixty-five percent of clients are male and **81%** are Latino. A comparison between pre and post-average scores for the ECBI and the YOQ shows a reduction in symptoms below the clinical cutoff. Reductions in average scores range from **17% to 33%.**

Group CBT for Depression: This practice aimed at reducing early course depression, implemented by 16 providers, has demonstrated on average a **35%** reduction in symptoms as measured by the PHQ-9 and a **21%** reduction in overall symptoms as measured by the Outcome Questionnaire (OQ-45.2), representing **38% to 43%** positive reliable change respectively.

Individual CBT: 58 providers have implemented this practice for children and adults to treat early course depression, anxiety or trauma.

Aggression Replacement Training (ART): 16 agencies are providing this practice aimed at treating disruptive behavior disorders in 12-17 year olds. When comparing pre and post-treatment average scores for the ECBI, the practice has led to **14 to 25%** reductions in symptoms and **11 to 25%** reductions in average scores pre and post-treatment on the YOQ-Parent and YOQ-SR.

Seeking Safety: A robust implementation involving 87 contract agencies and county-operated programs has demonstrated, as measured by the PTSD-RI and the Outcome Questionnaire/YOQ-SR & YOQ (parent and self-report), significant reductions in trauma. Average symptom reduction after completion of the practice for children and their parent/caregiver ranges from **29% to 35%** depending upon the questionnaire. Average symptom reduction for adults aged 18 and above is **20%**, with reductions seen below the clinical cutoff for the PTSD-RI for adults.

Child Parent Psychotherapy: 37 contract agencies and county operated programs are providing this practice geared to treat trauma in young children ages 0–6 and their parent/caregivers. This practice has yielded a **62%** improvement in trauma symptoms as measured by the YOQ-Parent.

Crisis Oriented Recovery Services (CORS): 38 contract and county operated programs are providing this brief treatment model to address situational crises. Adults and children who completed the six session model experience a **21%** improvement as measured by the OQ 45.2 and YOQ-SR respectively. Parents reported a **33%** improvement in their child's symptoms.

*Due to the conversion of outcome data from California Institute for Behavioral Health Solutions (CiMH) to the LACDMH PEI Outcome Measure Application, these outcomes reported are from the last reports produced by CiMH. It is estimated that the data migration will be completed and a report produced in late spring 2015.

Additional Information on these practices:

Practice	% Male	% Female	% of Clients Dropped Out of Prior to Completion of Practice	Avg. length of treatment in Weeks	Avg. # of sessions
Incredible Years	65%	35%	28%	21	22
Group CBT for Depression	36%	64%	35%	18	14
CORS	48%	52%	23%	10	8
Individual CBT	40%	60%	26%	26	15
Seeking Safety	51%	49%	36%	31	35
Child Parent Psychotherapy	52%	48%	33%	38	32
ART	69%	31%	43%	26	34

Visit http://dmhoma.pbworks.com for the most current version of the PEI-EBP Outcome Measures table.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division
Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

FOCUS OF TREATMENT	EBP, CDE, PP	AGE	GENERAL OUTCOME MEASURE	AGE	SPECIFIC OUTCOME MEASURE	Age	AVAILABLE THRESHOLD LANGUAGES
ANXIETY	Managing and Adapting Practice (MAP) - *Anxiety & Avoidance* **	3 - 19	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	Revised Child Anxiety and Depression Scales (RCADS) - Parent Revised Child Anxiety and Depression Scales (RCADS) - Child	6 - 18 6 - 18	Chinese, English, Spanish, Korean
	Individual Cognitive Behavioral Therapy - Anxiety (CBT-Anxiety)	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Generalized Anxiety Disorder - 7 (GAD-7)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog
	Mental Health Integration Program (MHIP) - Anxiety	18 - 60+	No general measure is required				
TRAUMA	Child Parent Psychotherapy (CPP)	0 - 6	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	Trauma Symptom Checklist for Young Children (TSCYC)	3 - 6	Chinese, English, Korean, Spanish, Armenian
	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	10 - 15	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Parent UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Child/Adolescents	3 - 18 6 - 20	**Adult** - English **Parent** - English, Chinese, Japanese, Russian, Spanish **Child/Adolescent** - English **Child** - Chinese, Farsi, Japanese, Russian, Spanish **Adolescent** - Chinese, Spanish
	Alternatives for Families-Cognitive Behavioral Therapy [formerly: Abuse Focused-Cognitive Behavioral Therapy] (AF-CBT)	6 - 15					
	Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) *	3 - 18					
	Managing and Adapting Practice (MAP) - *Traumatic Stress* **	2 - 18					
	Seeking Safety (SS)	13 - 60+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Parent UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Child/Adolescents UCLA PTSD-Reaction Index (UCLA PTSD-RI) – Adult Short Form	3 - 18 6 - 20 21+	
	Individual Cognitive Behavioral Therapy -Trauma (CBT-Trauma)	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Child/Adolescents UCLA PTSD-Reaction Index (UCLA PTSD-RI) – Adult Short Form	18 - 20 21+	
	Prolonged Exposure for PTSD (PE)	18 - 70	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Posttraumatic Stress Diagnostic Scale (PDS)	18 - 65	English
	Mental Health Integration Program (MHIP)-Trauma	18 - 60+	No general measure is required		PTSD Checklist-Civilian (PCL-C)	18+	Chinese, English, Spanish

The table below lists practice and outcome information for all other PEI outcome practices (Data as of 1/27/2015):

Evidence-Based Practice	Outcomes, Starting July 2011							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Aggression Replacement Training (ART)	66.90%	2,857	38.5% (n=832)	61.5% (n=1329)	YOQ Total Score (n=224)	23.73%	ECBI Intensity Scale (n=213)	9.09%
					YOQ-SR Total Score (n=366)	11.11%	ECBI Problem Scale (n=213)	15.39%
ART Skillstreaming		255	54.1% (n=60)	45.9% (n=51)	YOQ Total Score (n=11)	N<20	ECBI Intensity Scale (n=8)	N<20
					YOQ-SR Total Score (n=3)	N<20	ECBI Problem Scale (n=8)	N<20
Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)	77.48%	737	47.8% (n=218)	52.2% (n=238)	YOQ Total Score (n=147)	47.37%	PTSD-RI Child/ Adolescent Severity Score (n=131)	38.46%
					YOQ-SR Total Score (n=56)	47.06%	PTSD-RI Parent Severity Score (n=132)	45.45%
Brief Strategic Family Therapy (BSFT)	82.58%	157	59.6% (n=59)	40.4% (n=40)	YOQ Total Score (n=40)	51.02%	RBPC Anxiety-Withdrawal Raw Score (n=35)	66.67%
							RBPC Attention Problems-Immaturity Raw Score (n=35)	50.00%
							RBPC Conduct Disorder Raw Score (n=35)	46.15%
					YOQ-SR Total Score (n=20)	41.03%	RBPC Motor Tension Excess Raw Score (n=35)	50.00%
							RBPC Psychotic Behavior Raw Score (n=35)	0.00%
							RBPC Socialized Aggression Raw Score (n=35)	100.00%
Caring for Our Families (CFOF)	57.47%	538	67.8% (n=187)	32.2% (n=89)	YOQ Total Score (n=66)	25.45%	ECBI Problem Scale (n=13)	N<20
							ECBI Intensity Scale (n=13)	N<20

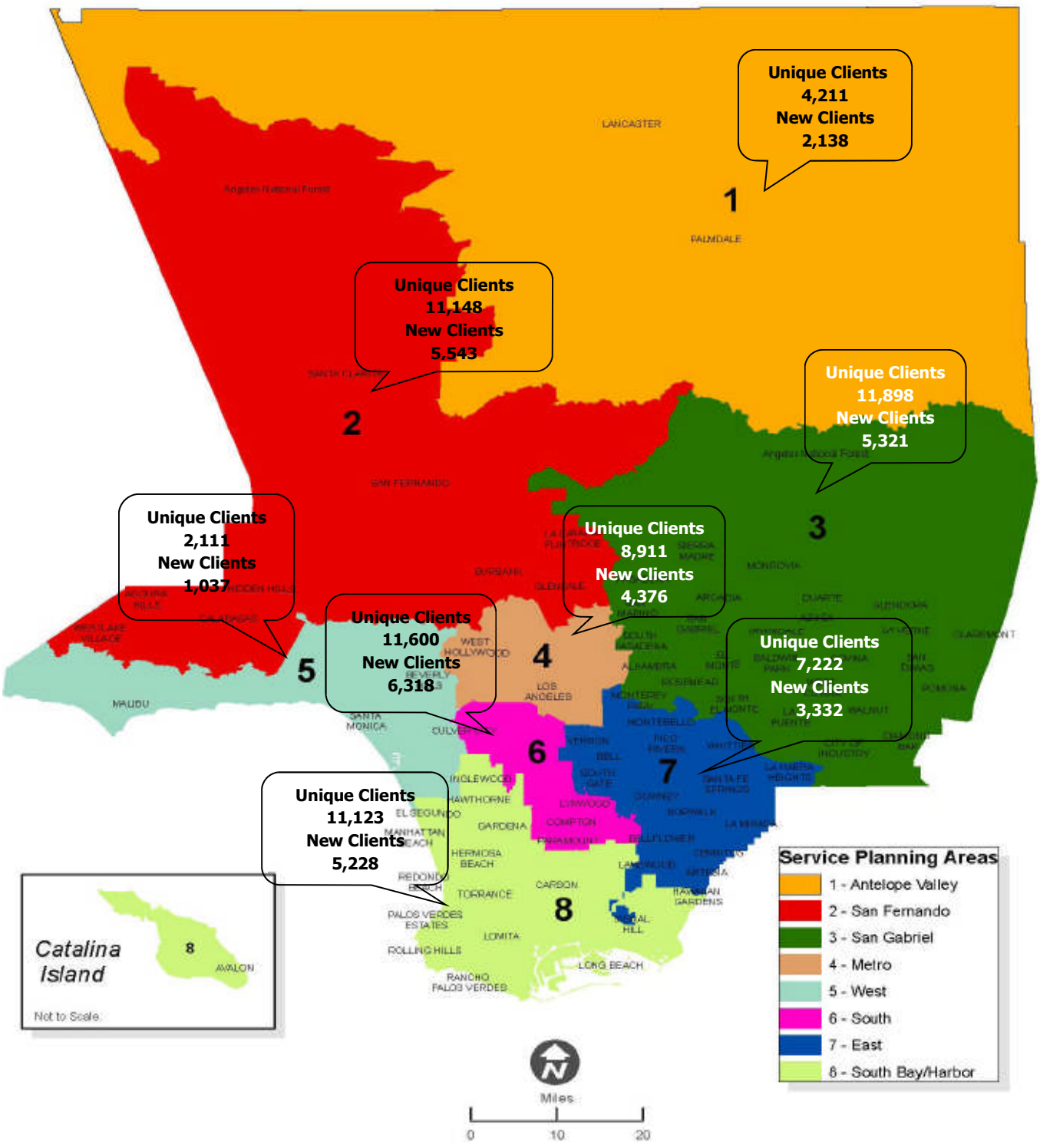
Evidence-Based Practice	Outcomes, Starting July 2011							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Center for the Assessment & Prevention of Prodromal States (CAPPS)	PEI OMA has not been updated to allow data entry for the practice as of 03/03/2015							
Child-Parent Psychotherapy (CPP)	54.18%	2,472	49.0% (n=818)	51.0% (n=851)	YOQ Total Score (n=185)	55.10%	TYCYC PTS Total Score (n=285)	19.05%
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	62.50%	65	85.7% (n=42)	14.3% (n=7)	YOQ Total Score (n=23)	23.68%	PTSD-RI Child/ Adolescent Severity Score (n=24)	17.39%
					YOQ-SR Total Score (n=15)	N<20	PTSD-RI Parent Severity Score (n=17)	N<20
Crisis Oriented Recovery Services (CORS)	24.42%*	2,033	62.9% (n=860)	37.1% (n=507)	OQ Total Score (n=126)	20.55%	No specific outcome measure required for this practice	
					YOQ Total Score (n=409)	30.19%		
					YOQ-SR Total Score (n=176)	32.08%		
Dialectical Behavior Therapy (DBT)	32.75%	56	22.2% (n=2)	77.8% (n=7)	OQ Total Score (n=1)	N<20	DERS Total Score (n=1)	N<20
Depression Treatment Quality Improvement (DTQI)	106.23%	834	50.5% (n=223)	49.5% (n=219)	OQ Total Score (n=3)	N<20	PHQ-9 Total Score (n=140)	62.50%
					YOQ Total Score (n=119)	43.40%		
					YOQ-SR Total Score (n=133)	51.92%		
Families Overcoming Under Stress (FOCUS)	PEI OMA has not been updated to allow data entry for the practice as of 03/03/15							
Functional Family Therapy (FFT)	55.64%	1,173	62.4% (n=566)	37.6% (n=341)	YOQ Total Score (n=443)	30.00%	No specific outcome measure required for this practice	
					YOQ-SR Total Score (n=400)	26.53%		
Group Cognitive Behavioral Therapy for Major Depression (Group CBT)	86.93%	921	41.6% (n=246)	58.4% (n=346)	OQ Total Score (n=149)	21.69%	PHQ-9 Total Score (n=165)	42.86%

Evidence-Based Practice	Outcomes, Starting July 2011							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Incredible Years (IY)	68.83%	1,475	64.1% (n=720)	35.9% (n=404)	YOQ Total Score (n=531)	28.57%	ECBI Intensity Scale (n=441)	17.05%
							ECBI Problem Scale (n=441)	35.29%
Individual Cognitive Behavioral Therapy (Ind CBT)-Anxiety	49.71%	337	28.7% (n=35)	71.3% (n=87)	OQ Total Score (n=17)	N<20	GAD-7 Total Score (n=16)	N<20
Individual Cognitive Behavioral Therapy (Ind CBT)-Depression		1,123	28.1% (n=120)	71.9% (n=307)	OQ Total Score (n=88)	25.00%	PHQ-9 Total Score (n=96)	42.86%
Individual Cognitive Behavioral Therapy (Ind CBT)-Trauma		101	45.2% (n=19)	54.8% (n=23)	OQ Total Score (n=3)	N<20	PTSD-RI Adult Severity Score (n=2)	N<20
					YOQ-SR Total Score (n=5)	N<20	PTSD-RI Child/ Adolescent Severity Score (n=10)	N<20
Interpersonal Psychotherapy for Depression (IPT)	60.76%	2,706	52.3% (n=852)	47.7% (n=778)	OQ Total Score (n=349)	28.77%	PHQ-9 Total Score (n=540)	54.55%
					YOQ Total Score (n=110)	46.43%		
					YOQ-SR Total Score (n=185)	45.45%		
Loving Intervention Family Enrichment Program (LIFE)	75.72%	187	60.5% (n=95)	39.5% (n=62)	YOQ Total Score (n=56)	20.00%	ECBI Intensity Scale (n=32)	14.02%
					YOQ-SR Total Score (n=46)	15.52%	ECBI Problem Scale (n=32)	37.50%
Mental Health Integration Program (MHIP) - Anxiety	113.50%	1,027	10.9% (n=336)	89.1% (n=2754)	No General Measure Required for this Practice		GAD-7 Total Score (n=376)	44.82%
Mental Health Integration Program (MHIP) - Depression		3,805	29.53% (n=1113)	70.47% (n=2754)			PHQ-9 Total Score (n=954)	49.80%
Mental Health Integration Program (MHIP) - Trauma		290	2.90% (n=79)	97.10% (n=2754)			PCL-C Total Score (n=82)	24.95%
Mindful Parenting (MP)	PEI OMA has not been updated to allow data entry for the practice as of 3/3/2015							

Evidence-Based Practice	Outcomes, Starting July 2011							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Multidimensional Family Therapy (MDFT)	51.32	40	89.5% (n=17)	10.5% (n=2)	YOQ Total Score (n=10)	N<20	RBPC Anxiety-Withdrawal Raw Score (n=3)	N<20
							RBPC Attention Problems-Immaturity Raw Score (n=3)	N<20
							RBPC Conduct Disorder Raw Score (n=3)	N<20
					YOQ-SR Total Score (n=12)	N<20	RBPC Motor Tension Excess Raw Score (n=3)	N<20
							RBPC Psychotic Behavior Raw Score (n=3)	N<20
							RBPC Socialized Aggression Raw Score (n=3)	N<20
Multisystemic Therapy (MST)	37.12%	102	72.5% (n=58)	27.5% (n=22)	YOQ Total Score (n=38)	50.79%	Specific outcome measure data for practice is not entered in PEI OMA	
					YOQ-SR Total Score (n=33)	37.50%		
Nurse-Family Partnership (NFP)	Outcome data is not reported in PEI OMA							
Promoting Alternate Thinking Strategies (PATHS)	44.42%	620	37.2% (n=107)	62.8% (n=181)	YOQ Total Score (n=25)	40.00%	ECBI Intensity Scale (n=28)	23.20%
					YOQ-SR Total Score (n=1)	N<20	ECBI Problem Scale (n=28)	37.50%
Parent-Child Interaction Therapy (PCIT)	59.43%	1,206	43.8% (n=329)	56.2% (n=422)	YOQ Total Score (n=161)	53.70%	ECBI Intensity Scale (n=254)	34.29%
							ECBI Problem Scale (n=254)	63.16%
Program to Encourage Active and Rewarding Lives for Seniors (PEARLS)	69.23%	108	45.5% (n=35)	54.5% (n=42)	OQ Total Score (n=16)	N<20	PHQ-9 Total Score (n=27)	54.55%
Prolonged Exposure Therapy for Post-Traumatic Stress Disorder (PE-PTSD)	32.74%	37	50.00% (n=7)	50.00% (n=7)	OQ Total Score (n=4)	N<20	PDS Symptom Severity Score (n=5)	N<20

Evidence-Based Practice	Outcomes, Starting July 2011							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Problem-Solving Therapy (PST)	48.92%	230	57.0% (n=94)	43.0% (n=71)	OQ Total Score (n=53)	28.79%	PHQ-9 Total Score (n=67)	40.00%
Reflective Parenting Program (RPP)	64.00%	96	73.0% (n=65)	27.0% (n=24)	YOQ Total Score (n=32)	16.33%	ECBI Intensity Scale (n=45)	10.48%
					YOQ-SR Total Score (n=3)	16.67%	ECBI Problem Scale (n=45)	14.29%
Seeking Safety (SS)	56.65%	12,026	38.9% (n=2958)	61.1% (n=4640)	OQ Total Score (n=399)	29.49%	PTSD-RI Adult Severity Score (n=249)	25.00%
					YOQ Total Score (n=496)	34.48%	PTSD-RI Parent Severity Score (n=386)	33.33%
					YOQ-SR Total Score (n=1073)	32.08%	PTSD-RI Child/ Adolescent Severity Score (n=875)	28.57%
Strengthening Families (SF)	41.20%	234	88.6% (n=78)	11.4% (n=10)	YOQ Total Score (n=39)	33.93%	RBPC Anxiety-Withdrawal Raw Score (n=15)	N<20
							RBPC Attention Problems-Immaturity Raw Score	N<20
							RBPC Conduct Disorder Raw Score (n=15)	N<20
					YOQ-SR Total Score (n=29)	26.92%	RBPC Motor Tension Excess Raw Score (n=15)	N<20
							RBPC Psychotic Behavior Raw Score (n=15)	N<20
							RBPC Socialized Aggression Raw Score (n=15)	N<20
UCLA Ties Transition Model (UCLA TTM)	91.67%	123	47.9% (n=34)	52.1% (n=37)	YOQ Total Score (n=1)	N<20	ECBI Intensity Scale (n=3)	N<20
							ECBI Problem Scale (n=3)	N<20

Los Angeles County Number of Clients served Through PEI by Service Areas Fiscal Year 2013-14



Ethnicity

Service Area 1
African-American – 31%
Hispanic – 42%
White – 20%
Unknown – 3%
Other – 2%
Asian – 1%
Native American - 1%
Pacific Islander- 0<%

Service Area 2
Hispanic –61%
White –21%
African-American –9%
Other –3%
Asian –2%
Unknown –4%
Native American - 0<%
Pacific Islander- 0<%

Service Area 3
Hispanic –66%
White –12%
African-American –10%
Asian – 5%
Other – 2%
Unknown – 5%
Native American - 0<%
Pacific Islander- 0<%

Service Area 4
Hispanic – 67%
African-American –11%
White –9%
Asian –4%
Other –1%
Unknown – 6%
Native American - 1%
Pacific Islander- 0<%

Service Area 5
Hispanic –45%
White – 26%
African-American – 18%
Other – 4%
Unknown –4%
Asian – 2%
Native American - 0<%
Pacific Islander- 0<%

Service Area 6
Hispanic –51%
African-American –43%
White – 3%
Unknown – 2%
Other – 1%
Asian – 1%
Native American - 0<%
Pacific Islander- 0<%

Service Area 7
Hispanic – 82%
White – 8%
African-American – 4%
Asian – 1%
Native American - 1%
Unknown – 3%
Other – 1%
Pacific Islander- 0<%

Service Area 8
Hispanic –54%
African-American –24%
White –13%
Asian – 3%
Unknown – 3%
Other – 2%
Pacific Islander- 1%
Native American - 0<%

Primary Language

Service Area 1
English - 86%
Spanish - 13%
Unknown/Not Reported - 1%
Other - <0%

Service Area 2
English - 69%
Spanish - 25%
Armenian - 2%
Farsi – 1%
Unknown/Not Reported - 1%
Other - 2%

Service Area 3
English - 74%
Spanish - 22%
Cantonese - 1%
Unknown/Not Reported - 1%
Other - 1%
Mandarin - 1%

Service Area 4
English - 64%
Spanish - 31%
Unknown/Not Reported - 2%
Other - 2%
Korean - 1%

Service Area 5
English -81%
Spanish - 16%
Unknown/Not Reported - 2%
Farsi - 1%
Other - <1%

Service Area 6
English - 73%
Spanish - 25%
Unknown/Not Reported - 1%
Other - 1%

Service Area 7
English - 71%
Spanish - 27%
Unknown/Not Reported - 1%
Other - 1%

Service Area 8
English - 72%
Spanish - 24%
Cambodian - 1%
Unknown/Not Reported - 2%
Other - 1%

Number of Unique Clients Served by PEI Program

by Age Group Plan

Service Area 1
Child - 2,467
TAY - 592
Adult - 577
Older Adult - 14
Special Programs- 661

Service Area 2
Child - 5,992
TAY - 2,190
Adult - 2,119
Older Adult - 225
Special Programs - 904

Service Area 3
Child - 6,875
TAY -2,591
Adult - 2,085
Older Adult - 248
Special Programs - 460

Service Area 4
Child -5,214
TAY -1,873
Adult - 1,196
Older Adult - 393
Special Programs - 422

Service Area 5
Child - 1,281
TAY - 235
Adult - 438
Older Adult - 119
Special Programs - 84

Service Area 6
Child - 6,193
TAY - 1,427
Adult - 3,518
Older Adult - 293
Special Programs - 480

Service Area 7
Child - 4,015
TAY - 1,228
Adult - 1,282
Older Adult - 246
Special Programs - 665

Service Area 8
Child - 6,767
TAY - 1,805
Adult - 2,403
Older Adult - 178
Special Programs - 289

Innovation Program Overview

The overall goal of the MHSA-funded Innovation (INN) Program is to identify new practices with the primary goal of learning and exploring creative and effective approaches that can be applied to the integration of mental health, physical health, and substance use services for uninsured, homeless, and underrepresented populations.

In order to achieve the goals of the INN program, four (4) models of care have been developed, each focusing on innovative recruitment and care delivery services.

- The Integrated Clinic Model (ICM) model is designed to improve access to high quality, culturally competent care for individuals with physical health, mental health, and co-occurring substance use diagnoses by integrating care within both mental health and primary care provider sites.

- The Integrated Mobile Health Team Model (IMHT) model is designed as a client-centered, housing-first approach that uses harm reduction strategies across all modalities of mental health, physical health, and substance abuse treatment. IMHT particularly focuses on individuals who are homeless or recently moved to Permanent Supportive Housing (PSH) and are considered to have vulnerabilities such as age, years homeless, co-occurring substance abuse disorders, and/or physical health conditions.

- The Community-Designed Integrated Services Management Model (ISM) model provides a holistic model of care, the components of which are defined by specific ethnic communities and which promote collaboration and community based partnerships to integrate health, mental health, and substance abuse services together with other needed non-traditional care to support recovery. The ISM model is divided into five ethnic models: African Immigrant/African American, American Indian/Alaskan Native, Asian Pacific Islander, Eastern European/Middle Eastern, and Latino.

- The Integrated Peer Run Model: Peer-Run Integrated Services Management (PRISM) and Peer-Run Respite Care Homes (PRRCH) are peer-operated and member driven community based, recovery oriented, holistic alternatives to traditional mental health programs. PRISM offers linkage to health, mental health, substance abuse, and housing services as part of a program designed to empower individuals to sustain their own recovery. PRRCH offers guests a short-stay voluntary opportunity to grow through distress in a warm, safe, and healing environment while engaging in recovery focused supportive services as desired.

Clients Served in FY 2013-14

Integrated Clinic Model: 1,147
Integrated Services Management Model: 1,535
Integrated Mobile Health Team: 511
Peer-Run Model:
    Peer-Run Integrated Services Management: 96
    Peer-Run Respite Care Homes: 85

The low numbers serve reflect the challenges both peer providers had in starting service delivery and in developing a culture, including the development of policies and procedures, for collecting outcome data. Sufficient data did not exist until January 2015 to perform an analysis of outcome measures based on repeated administrations.

The Evaluation

The ICM, IMHT and ISM models each complete their 3 years of study on June 30, 2015. The Peer Run model's 3rd year ends on June 30, 2016.

In order to evaluate the implementation and attainment of program goals, LACDMH contracted an evaluation team comprising University of California, San Diego's Health Services Research Center (HSRC), Harder-Company Community Research, and the University of Southern California (USC).

Program Outcome Approach

The following outcome measures were selected and are measured at baseline and at regular intervals:

- Level of service integration
- *The Integrated Treatment Tool-Case Western Reserve University*
- Domains: organizational, treatment, care coordination
- Health status improvement
- *PROMIS System-Global Health, Milestones of Recovery Scale*
- Mental Health status improvement
- *Illness Management and Recovery Scale*
- *Milestones of Recovery Scale*
- Substance use
- Client Satisfaction*
- Community Satisfaction
- Self-Stigma*
- Cost effectiveness
- Post outcomes survey*

*At the six month assessment, and every subsequent six months, clients are randomly selected to take either the Satisfaction with Services Survey, the Post-Outcomes Survey, or the Self-Stigma survey.

Overall Outcomes by Model

Each model demonstrated statistically significant reductions in health and mental health symptoms and substance use. To access the final evaluation report for the IMHT, ICM and ISM models, please use the following link: http://file.lacounty.gov/dmh/cms1_226026.pdf

Integrated Clinic Model Outcomes

There were significant improvements on the Illness Management Recovery Scale (IMR), a clinician-rated mental health measure, 6, 12 and 18 months after enrollment in INN services, compared to ratings at baseline:

- The majority of ICM clients had clinically meaningful improvement in Overall IMR scores 6 months (71.0%), 12 months (79.4%) and 18 months (81.8%) after enrolling in services
- There were significant improvements in client-rated physical health outcomes 6, 12 and 18 months after enrollment in INN services, compared to ratings at baseline
- Close to half of ICM clients had clinically meaningful improvement in PROMIS Physical Health scores 6 months (40.7%) and one year (39.9%) after enrolling in services, compared to baseline
- 73.8% of ICM clients had a clinically meaningful improvement in MORS ratings 18 months after enrolling in services, compared to baseline
- 10.3% of ICM clients had a clinically meaningful reduction in drug use 12 months after enrolling in ICM
- There was a significant decrease in use of emergency services 6, 12 and 18 months after enrollment in INN services, compared to baseline.

Integrated Mobile Health Team outcomes

IMHT clients had significant improvements on the IMR, a clinician-rated mental health measure, 6 and 12 months after enrollment in INN services, compared to ratings at baseline:

- Clients continued to significantly improve between 12 and 24 months after first receiving INN services.
- The majority of IMHT clients had clinically meaningful improvement in Overall IMR scores 6 months (65.4%) and 12 months (74.9%) after enrollment.
- The majority of IMHT clients had clinically meaningful improvement in MORS ratings 6 months (60.1%) and one year (72.9%) after enrolling in services, compared to baseline.
- 52.7% of IMHT clients had clinically meaningful improvement in PROMIS Physical Health scores 6 months after enrolling in services, and over half of clients (52.7%) had clinically meaningful improvements 12 months after enrollment when compared to baseline
- 32.5% of IMHT clients had a clinically meaningful reduction in alcohol consumption 12 months after enrolling in services
- 28.2% of IMHT clients had a clinically meaningful reduction in drug use 12 months after enrolling in services
- There was a significant decrease in use of emergency services 6 and12 months after enrollment in INN services, compared to baseline
- More IMHT clients (69.9%) experienced a clinically meaningful reduction one year after enrollment in IMHT.

Integrated Services Management Model outcomes

- The majority of ISM clients had clinically meaningful improvement in Overall IMR scores 6 months (73.1%) and one year (76.2%) after enrolling in services
- 62.1% of ISM clients had a clinically meaningful improvement in MORS ratings 12 months after enrolling in services, compared to baseline
- Many ISM clients had clinically meaningful improvement in PROMIS Physical Health scores 6 months (33.8%) and 12 months (38.3%) after enrolling in services, compared to baseline.
- ISM clients reported a significant increase in paid employment 6 and 12 months after enrollment in INN services. 23.7% of ISM clients reported that they maintained paid employment for the first year of services; 10.7% of ISM clients gained employment within the first year of services.

Using the results of the evaluation in administrative decision-making

An evaluation rubric was developed by the evaluator with DMH and provider input for each model, based on program expectations and the degree of achievement of positive outcomes. An analysis of the evaluation rubric for each model yielded a decision by DMH to continue providers within each of the 3 models that achieved a threshold level of success on the evaluation rubric.

Innovation Evaluation Rubric Weighting Across Models

	IMHT	ICM	ISM
Client Level (60%)			
Quality of Care	59%	59%	40%
Quality of Life	34%	34%	40%
Client Satisfaction	7%	7%	20%
Program Level (40%)			
Data Compliance	15%	10%	11%
Access to Care	30%	25%	26%
Staffing	16%	12%	6%
Cost	0%	24%	0%
Integration	22%	17%	26%
Outreach and Engagement	17%	12%	31%

For more detail on the content of each model's evaluation rubric, use the link to the final evaluation report above.

Spreading the Learning

Learning was central to this Innovation project, with quarterly learning sessions established to promote a learning culture that embraces the use of outcome data. In all, DMH held 10 learning sessions, with each session summarized in a brief that was distributed to all participants.

The Department has developed a packet that summarizes the learning in the form of integrated care best practices that is closely aligned with the elements of the Integrated Treatment Tool, the measure used to identify level of service integration.

The packet also includes a synopsis of all training associated with the Innovation project. The packet will be distributed to Department administrative staff with responsibility for program management, along with Service Area District Chiefs, Service Area Advisory Committee Co-Chairs, the Mental Health Commission and will be posted on the Department's website under MHSA Programs-Innovation.

Workforce Education and Training

The MHSA - Workforce Education and Training Plan, approved April 8, 2009, seeks to address the fundamental concepts of creating and supporting a workforce (both present and future) that is culturally competent, consumer/family driven and promotes the transformation of mental health services to a strength based approach that is inclusive of recovery, resilience and wellness. Such tenets are cornerstones of MHSA. The Plan provides opportunities to recruit, train and re-train public mental health staff to meet those mandates.

For the County of Los Angeles, personnel shortages remain a constant concern, and the needs far outweigh the positions available. In particular, there is a need for personnel that is bilingual and bicultural to provide services to the underserved unserved populations is critical. In addition, there is a shortage of personnel with expertise relevant to working with the following populations: 0 to 5, Children/TAY, LGBTQ, Veterans, and Older Adults.

1 *148 staff trained through the Recover Oriented Practice (formerly known as Public Mental Health Workforce Immersion)*

During FY 2013-14, 148 individual staff members of the public mental health workforce attended the Public Mental Health Workforce Immersion into MHSA.

2 *106 Stipends were awarded to 2nd Year MSW, MFT and Nurse Practitioner Students*

These stipends are awarded in exchange for a one year commitment to work in a hard-to-fill area of the County. Priority is given to individuals representing un- or under- served populations and/or speaking a threshold language.

3 *37 individuals completed the Health Navigator Skill Development Program*

20 have received certification, 17 are working towards the necessary hours for full certification, and 4 participants are no longer active or withdrew from seeking certification.

4 *9 individuals completed Advance Peer Support Training, while another 9 completed the Peer Train-The-Trainer*

These individuals are currently employed in the mental health system in a peer advocate capacity.

5 *23 mental health consumers completed the Core Peer Advocate Training*

These consumers are interested in becoming part of the public mental health workforce as mental health peer advocates.

6 *154* staff members participated in the interpreter training program* Interpreters and clinicians are trained in order to better communicate with and treat monolingual mental health consumers.

**Not unique number as some individuals participated in more than one training component*

7 *1,083 faculty and students attended MHSA presentations or MHSA mini-immersion training*

These individuals were exposed to MHSA core tenets in a efforts to potentially recruit future clinicians in the public mental health system.

8 *159 participants completed the Intensive MH Recovery Specialist Training Program*

These participants are interested in entering the public mental health workforce as mental health rehabilitation specialists.

9 *140 supervisors completed the Recovery Oriented Supervision Training*

These supervisors are currently employed in the mental health system and are trained to effectively implement recovery oriented supervision.

10 *Licensure Examination Preparation*

194 participants were registered in the Licensure Examination Preparation Program.

1-Workforce Education and Training (WET) Coordination

This program provides the funding for the MHSA WET Administrative unit. WET Administration is tasked with implementation and oversight off all WET-funded activities.

2 -WET County of Los Angeles Oversight Committee

The WET County of Los Angeles Oversight Committee was active throughout the development of the WET plans and will continue to provide recommendations. The Committee is composed of various subject matter experts, representing many underserved ethnicities in our County.

3 -Transformation Academy without Walls

Public Mental Health Workforce Immersion into MHSA (Recovery Oriented Practices)

Since 2007-2008, this program offers public mental health staff (i.e., clerical, clinical staff, program administrators) a three day immersion program on the tenets of MHSA. The training incorporates the MHSA experience including consumers sharing their recovery journey. Upon completion, staff is expected to acquire an understanding of the recovery oriented approach and to incorporate these concepts into practice in their work. The delivered curriculum also addresses the integration of mental health, health and co-occurring disorders.

During FY 2013-2014, 148 individual staff members of the public mental health workforce attended this training.

During FY 2014/2015, the program will continue for only six (6) months, ending December 31, 2014. Fifty participants will be trained during this time period.

Licensure Preparation Program (LPP)

This program funds licensure preparation study materials and workshops for unlicensed social workers, marriage and family therapists, and psychologists. All accepted participants must be employed in the public mental health system and have completed the required clinical hours to take the mandatory Part I, and thereafter Part II of the respective licensure board examinations.

The Licensure Preparation Program will continue with no changes for FY 2015-2016.

The number of participants for each specific exam is as follows:

FISCAL YEAR 2013-14					
EXAM	REGISTERED	THRESHHOLD LANGUAGE *(NOT ENGLISH)*	UREP	PASS	FAIL
MSW – Part I	72	42	44	42	13
MSW – Part II	39	27	25	19	8
MFT – Part I	41	22	23	8	14
MFT – Part II	13	8	6	1	7
Psych – Part I	20	14	9	9	2
Psych – Part II	9	6	4	5	3
TOTAL	**194**	**119**	**111**	**90**	**41**

Health Navigator Skill Development Program

In preparation for Health Care Reform, this program trains individuals (Peer Advocates, Community Workers and Medical Case Workers) on knowledge and skills needed to assist consumers navigate and likewise advocate for themselves in both the public health and mental health systems. This 52 hour course uniquely incorporates a seven hour orientation for participants' supervisors and is intended to support the participants' navigator role. During FY 2013/2014, 37 participants completed the training, with 76 % identifying with un- or under- served populations and 54% speaking a threshold language.

While 37 individuals have completed the training, 20 have received certification, 17 are working towards the necessary hours for full certification, and four (4) participants are no longer involved in health navigation duties.

Health Navigator Skill Development Program – This program will continue with no significant changes during FY 2015/2016.

5 - Recovery Oriented Supervision Trainings

The goal of the Recovery Oriented Supervision Training and Consultation Program (ROSTCP) is to increase the capacity of the public mental health system to deliver best practice recovery-oriented mental health services. The ROSTCP is designed for individuals interested in becoming a supervisor, front line supervisor, or manager as they are the primary individuals who assume the important leadership roles to teach, support, and elevate the recovery and resilience philosophies among direct service staff in the public mental health system. The ROSTCP will train supervisors and managers across all age groups and includes all public mental health programs. Total individuals interested in becoming supervisors, existing supervisors and managers to be trained is 240 annually.

During FY 2013/2014, 140 supervisors completed the program. 50% of these participants represented individuals from un- or under- served populations and 46% spoke a second language.

The ROSTCP program will not undergo any changes during FY 2015-2016.

6 - Interpreter Training Program

The Interpreter Training Program (ITP) offers trainings for bilingual staff that currently performs or interested in performing interpreter services to monolingual non-English speaking mental health providers. The use of linguistically and culturally competent interpreters is important to bridging the language and cultural gap in the delivery of services in public mental health. The training opportunities and number of attendees were as follows:

FY 2013/2014 Outcomes:

Training Title	Total
Introduction to Interpreting in MH Settings	71
Increasing Spanish Mental Health in Clinical Terminology	54
Advanced Interpreters Training: Fine Art of Interpreting	15
English Speaking Providers: Bridging Language Gap	14
Total	**154**

7 - Training for Community Partners

Faith Based Roundtable Project

This project is designed for clergy and mental health staff to come together to address the mental health issues of the individuals and communities they mutually serve. It has provided an opportunity for faith-based clergy to understand the essence of mental health services focused on recovery as well as for mental health personnel to understand and integrate spirituality in the recovery process. During FY 2013/2014, planning, outreach and engagement into the community began in Service Areas 1 and 3.

There will be no significant change to the program model during FY 2015/16.

8 - Intensive Mental Health Recovery Specialist Training Program

Mental Health Rehabilitation Specialist Training will prepare consumers and family members with a Bachelor's degree, advanced degree, equivalent certification, to work in the field of mental health as psycho-social rehabilitation specialists. This 12-16 weeks program is delivered in partnership with mental health contractors and the local community colleges. Successful completion of this program ensures that participants are qualified to apply for career opportunities in the public mental health system.

During FY 2013/2014, two (2) contractors delivered this training and 159 individuals interested in employment in the public mental health system completed the training. Of these participants, 76% represented individuals from un- or under- served populations, and 50% spoke a threshold language.

No changes are anticipated during FY 2015/2016.

9 - Expanded Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System

Peer Advocate Training prepares individuals interested in work as mental health peer advocates in the public mental health system. During FY 2013/2014, certificated training included core peer advocate training, advanced peer advocate training, and Train-The-Trainer. This training was designed to train no less than 60 individuals. The targeted population for each training component was:

Core Peer Advocate Training: For mental health consumers interested in becoming part of the public mental health workforce as mental health peer advocates.

Advanced and Train-The-Trainer training: For individuals who are currently employed in the mental health system in a peer advocate capacity.

Program	Total Graduates
Basic Peer Advocate	23
Advanced Peer Advocate	9
Train-the-Trainer	9
TOTAL	**41**

10 - Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System

This training program is intended to provide knowledge and technical skills to Parent Advocates/Parent Partners who are committed to: the work of family support for mental health; supporting the employment of parents and caregivers of children and youth consumers in our public mental health system; and/or promoting resilience and sustained wellness through an emphasis on increasing the availability of a workforce oriented to self-help, personal wellness and resilience techniques that are grounded in parent advocate/parent partner empowerment.

This program will be put out for solicitation with training anticipated to begin FY 2015/2016.

11 - Expanded Employment and Professional Advancement Opportunities for Family Members in the Public Mental Health System

The proposed trainings would prepare family members of consumers to develop or augment skills related to community outreach, advocacy and leadership and decrease barriers to employment. These trainings would include such topics as public speaking, navigating systems, and resource supports for consumers and families. Priority will be given to those family members coming from targeted communities particularly those culturally and linguistically underserved in the County of Los Angeles (i.e., Spanish speaking, Asian Pacific Islanders, etc.).

This program is now funded with MHSA WET dollar effective FY 2013-2014 with the intent to target/outreach family members about mental health services in the community meeting the objective of the program outline in the MHSA-WET Plan above.

Program Name/ Description	Training Goals	Total Trained
Orientation Session for new FSB/PSS Trainings	To prepare new trainers of Family Support and Parent Support Bureau	346
Orientation Session for new FSB/PSS Trainings – UREP	To prepare new trainers of Family Support and Parent Support Bureau representing our UREP population	223
In Our Own Voice Training: Training to establish new In Our Own Voice consumer advocate trainers providing community based trainings in the field.	To prepare new trainers of In Our Own Voice trainings	27
In Our Own Voice Presentation: Consumer driven community based presentation. All tenets of MHSA are incorporated in the training in order to ensure potential staff is ready to deliver services in a recovery-/ strength-based mental health system.		158 trainings, each attended by up to 25 participants.

12 - Mental Health Career Advisors

In the effort to meet the workforce needs of the public mental health system, this program is designed to fund career advisor services. Services will include: the provision of ongoing career advice, coordination of financial assistance, job training, mentoring, tutoring, information sharing and advocacy. The Mental Health Career Advisors will essentially function as a one-stop shop for upward career mobility.

A pilot program began services September 2014 and is designed to assist, at a minimum, a total of 56 individuals across 2 Services Areas (4 and 6).

13- High School through University Mental Health Pathway

The County of Los Angeles will focus on promoting mental health careers to high school, community college and university students, particularly in communities or areas of the County where ethnically diverse populations reside.

A pilot program began implementation during July 2014. During this pilot phase, the goal is to incorporate a mental health model in a high school in Antelope Valley.

15 - Partnership with Educational Institutions to Increase the Number of Professionals in the Public Mental Health System (Immersion of Faculty-MFT, MSW, etc)

The College Faculty Immersion Training Program updates college and graduate school faculty on the current best practices and requirements for the human services workforce in real-world jobs. This program delivers in class presentation to students on the core tenets of MHSA; consultative services with faculty on recovery oriented curriculum enhancement; and MHSA mini immersion training opportunities where students and faculty learn first about the benefits of MHSA and the recovery process.

During FY 2013/2014, a total of 1,083 faculty and students received curriculum consultation, attended the MHSA presentations or MHSA mini-immersion.

This program ceased on December 31, 2014.

16 - Recovery Oriented Internship Development (Recovery Oriented and Integrated Care Internship Training Program)

A component of this program includes establishing training that targets supervising field instructors employed in the public mental health system (PMHS) and their student interns. The purpose of this program is to 1) promote recovery oriented and integrated care principles and 2) establish standards for student training critical for the preparation of the future PMHS workforce. Field instructors will have an opportunity to increase their exposure, knowledge and expertise in recovery oriented and integrated care principles; and augment student interns' classroom instruction through training and supervised direct service experience.

Implementation began during FY 2014/2015, with 10 public mental health facilities participating in the first round of training.

19 - Public Mental Health Workforce Financial Incentive Program

The Public Mental Health Workforce Financial Incentive Program is intended to deliver educational/financial incentives to individuals employed in the public mental health workforce, as well as serve as a potential recruitment tool. This program will provide two (2) different types of awards, as follows:

Tuition Reimbursement Program

This tuition reimbursement program will provide tuition expenses for those individuals interested in enhancing skills relevant to mental health workforce needs. Includes peer advocates, consumers, family members, parent advocates, and professionals employed in directly operated and contracted agencies. Tuition reimbursement students will be expected to make a commitment to continue working in the public mental health system. Additionally, those candidates who are bilingual/bicultural and/or willing to commit to working with unserved and underserved communities in the County will be given priority.

Loan Forgiveness Program

Striving to meet MHSA expectations of a linguistically and culturally competent workforce, Los Angeles County will explore loan forgiveness programs as a supplement to the loan forgiveness programs developed by the State.

This program is expected to be implemented during the second half of FY 2014/2015.

21 - Stipend Program for Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners, and Psychiatric Technicians

LACDMH provides 2nd year students with education stipends in the amount of $18,500 in exchange for a contractual obligation to secure employment in a hard-to-fill area of the county for a minimum of 1 year. This program targets students who are linguistically and/or culturally able to service the traditionally unserved and underserved populations of the County.

During FY 2013/2014 this program was available to 52 MFT, 52 MSW, and four (4) Nurse Practitioners students. During this award cycle, all but two (2) NP stipends were awarded. 75% of all recipients identified from populations recognized as un- or under- served. During the same cycle, 75% spoke a threshold language.

In addition to the stipends, six (6) post-doctoral fellows were likewise funded.

No significant change is expected for this program during FY 2015/16.

Translational Research Program Projects

Project Summary: The Department of Mental Health (DMH)-UCLA Translational Research Program Projects is designed to improve access to and effectiveness of client-centered, culturally competent mental health services in Los Angeles County through investigation of the clinical, socio-cultural, and operational factors that shape policies and practices in public mental health. Through projects involving the application of rigorous, state-of-the-art research methodologies for examination of key Departmental service designs; this Program is designed to generate results that can be feasibly and effectively implemented to improve the quality of public mental health care in Los Angeles County. The program builds upon two decades of strong collaboration between DMH and UCLA to produce clinically relevant research projects that improve care in the Los Angeles County public mental health system.

Status Report: The first of these projects was the Low Income Health Plan (LIHP) Implementation Evaluation, which identified factors contributing to successful integration of mental health care and primary care services, along with problem areas indicating room for improvement. This project found that collaboration worked most smoothly when there was a pre-existing working relationship between mental health and primary care providers that could be built upon. Warm hand-offs were also found to increase patient follow-up on referrals between providers. However, DMH providers reported difficulty identifying the appropriate provider for a consultation in primary care clinics where a team approach was used. Some DMH clinic managers also reported that they received most referrals from clinics where there was overflow, rather than from the assigned partner, so that collaboration was focused more on sharing workload than on providing optimum patient care.

The second of these projects was an evaluation of the Peer Health Navigator Implementation. This project resulted in revisions to the intervention and training manuals, completed by UCLA, and proposed revisions to the implementation manual.

The third and final of these projects was the Qualitative Analysis of MHSA Transformation in DMH Clinics, which examined differences in practice between full-service partnerships (FSPs) and usual care (UC). This project found that both FSP and UC providers considered the recovery model to be the basis for their treatment practices, and focused on holistic care and empowerment with all clients. However, FSP providers had more time to devote to their clients and greater resources at their disposal, allowing them to focus less on crisis management and more on relationship development. As a result they were better able to provide the essential supports and connections their clients needed when compared with UC providers.

CMHDA – CA Social Work Education Center (CalSWEC) Aging Initiative (AI) project

Project Summary: The CalSWEC AI project addressed the components of the Mental Health Services Act (MHSA), the development of a competent, diverse workforce to meet the needs of an increasingly diverse population of aging Californians and their families. This project was designed to assist County Directors in their efforts to recruit and train individuals to serve as leaders of organizations developing and providing social work, health, mental health and other services to older adults. The project had four strategic priorities: 1) The creation of a statewide coalition to promote social work workforce development in aging; 2) The development of core competencies in geriatric social work; 3) The development of workforce development strategies; 4) The development of capacity building and sustainability strategies.

Status Report: Through partnerships with statewide schools of social work, the AI Committee promoted older adult and workforce development issues through activities such as regional meetings, webinars, and work plans to address the needs of the underserved older adult population. On January 23, 2014, CalSWEC AI completed the last of three (3) webinar series on aging and its relationship to health care reform and workforce issues. Additionally, the 2014 Aging Summit, with a focus on geriatric workforce development and curriculum, occurred on February 5, 2014 in Sacramento.

Olive View Psychiatric Residency program

Project Summary: As part of the effort to enhance prevention and early intervention and decrease non-emergent visits in the psychiatric emergency room at Olive View Community Mental Health Urgent Care Center, the Department leveraged psychiatric services through the partial funding of six (6) psychiatry residents at the Center, thereby expanding available mental health services. This increased capacity will facilitate an optimal environment to teach psychiatric residents the various clinical modalities used to treat such clients, namely short-term, crisis-oriented psychopharmacology and psychotherapy.

Status Report: Residents have been successfully integrated into the workforce at San Fernando Mental Health Clinic (MHC) and Olive View Urgent Care Clinic (UCC). Residents at San Fernando MHC provide psychotherapy services to child and adolescent clients. Olive View provides urgent psychiatric care. Residents at both locations have increased clinical access for clients, while the addition of the residency program has increased the number of DMH training sites and opportunities for workforce development. The integration of the residents into service delivery has additionally enhanced system-wide collaboration between the Department of Health Services (DHS) and DMH.

Geropsych Fellowship Services

Project Summary: UCLA Psychiatry fellows will be supervised concomitant with the provision of services as members of Older Adults System of Care (OASOC) multidisciplinary teams.

Status Report: The UCLA Geriatric Psychiatry Fellowship at LACDMH began in July 2011, consisting of two fellows each year for two days a week, 6 months each. The fellows receive formal and informal training in geriatric psychiatry through the LACDMH community mental health program GENESIS. They are integrated into a team approach requiring home visits in a designated geographic area. They are exposed to the Los Angeles County Elder Abuse Forensic Center and receive training in Field Safety, which many have found beneficial. Fellows provide clinical services for LACDMH clients. They do assessments, as well as conducting ongoing therapy and treatment. They attend and participate in a series of Older Adult Care Teams (OACT) trainings (OACT-HQ, OACT-MD and OACT-MD Seminar with case presentation), in addition to CME-approved and informal trainings.

Contract Provider Technology Project (CPTP)

Project Status: Behind Schedule
Budget Status: Within Approved Budget
Project Start Date: 3/19/2008
Project End Date: 6/30/2018

Project Objectives: The primary objective is to provide a means for non-governmental agency Short-Doyle Contract Providers within the LAC-DMH provider network to obtain the funding necessary to fully participate in the County's Integrated Information Systems Infrastructure and address their technological needs consistent with the MHSA Capital Facilities and Technological Needs Guidelines.

Integrated Behavioral Health Information System (IBHIS)

Project Status: Behind Schedule
Budget Status: Within Approved Budget
Project Start Date: 4/1/2009
Project End Date: 6/30/2016

Project Objectives: To acquire commercial-off-the-shelf (COTS) and proven software with the necessary clinical functionality to support the delivery of quality mental health services consistent with the Mental Health Services Act and integrated with administrative and financial functionality.

Personal Health Record Awareness & Education

Project Status: Not Started
Budget Status: N/A
Project Start Date: To be determined
Project End Date: To be determined

Project Objectives: Through the stakeholder process, LAC-DMH received considerable feedback suggesting that many mental health consumers have limited awareness of Personal Health Record (PHR) and how a PHR may be used as a recovery and wellness tool. The written and online PHR awareness and education materials developed through this project will be used to increase consumer/family understanding and awareness. In addition, Mental Health Services Providers are part of the targeted audience to promote a collaborative therapeutic relationship.

Consumer/Family access to Computer Resources

Project Status: On Schedule
Budget Status: Within Approved Budget
Project Start Date: 1/19/2010
Project End Date: 06/30/2018

Project Objectives:

- Promote consumer/family growth and autonomy by increasing access to computer resources, relevant health information and trainings.
- Provide basic computer skills training to consumers allowing them to effectively utilize the computer resources made available to them.
- Provide appropriate access to technical assistance resources when needed.

Data Warehouse Re-Design

Project Status: On Schedule
Budget Status: Within Approved Budget
Project Start Date: July 2013
Project End Date: To be determined

Project Objectives: Redesign the current data warehouse to support the data requirements of the Department of Mental Health's new Integrated Behavioral Health Information System (IBHIS) as well as new data collected from MHSA programs such as Prevention & Early Intervention (PEI), Workforce Education and Training, and Innovation. The re-designed data warehouse will include the full scope of MHSA program and service data including clinical, administrative, and financial and outcomes data.

Telepsychiatry Implementation

Project Status: On Schedule
Budget Status: Within Approved Budget
Project Start Date: 7/1/2010
Project End Date: 6/30/2018

Project Objectives: To address service disparities among remote and underserved populations by implementing networked videoconferencing at multiple service locations to allow provision of direct telepsychiatry treatment services to clients by psychiatrists and specialty tele-consultation between psychiatrists and primary care providers.

Capital Facilities

Below are the capital facilities projects in progress. During the implementation phase of the projects, costs associated with land and materials have increased from the original estimates. A transfer in the amount of $3 million was made to the Technological Need Fund. There is a remaining balance of $38,600,000. Upon completion of the projects above, remaining funds will be reassessed.

Downtown Mental Health Center

Project Description: Purchasing 25,000 sq.ft. building for $3.5 Million and refurbish and retro fit entire building. Construction should be completed by July 2015. Building will house 70 staff and serves approximately 220 clients per day.

Supervisorial District: 2
Cost: *$15,900,000*

Arcadia Mental Health Center

Project Description: Building a new 12,000 sq. ft. clinic in existing parking lot of old clinic, then will tear down old clinic to make way for parking lot. Construction should be completed by June 2015. The Arcadia Mental Health Center provides crisis evaluation and assessment, case management, psycho-social rehabilitation services, referrals, and individual and group therapy for approximately 2,400 clients annually.

Supervisorial District: 5
Cost: *$13,500,000*

Rio Hondo Mental Health Center

Project Description: Purchase current site with adjacent lot for parking. Escrow should close at the end of April 2015. Building currently houses 70 staff and serves approximately 170 clients per day.

Supervisorial District: 4
Cost: *$4,900,000*

Exodus Recovery

Project Description: Refurbishment of Ted Watkins Building for Martin Luther King Psychiatric Urgent Care Center should be completed by May 2015. The Unit will provide intensive outpatient mental health services and will have LPS designated staff.

Supervisorial District: 2
Cost: *$1,300,000*

The Department's Executive Management Team identified a trend of under-spending within the Community Services and Supports (CSS) Plan and asked the System Leadership Team (SLT) for an age group allocation methodology for $30 million in each of the next three (3) Fiscal Years (2014-15 through 2016-17). After reserving $10 million for Board of Supervisor expansion program priorities, the SLT approved the following age group percent distribution of net CSS dollars: Child, 13%, TAY, 13%, Adult, 61% and Older Adult, 13%. This resulted in an additional $2.6 million allocation for child, TAY and Older Adults and $12.2 million for adults for each of the Fiscal Years 2014-15, 2015-16, 2016-17.

The following is a status on the expansion of programs/services recommended by SLT to the Department and to the Mental Health Commission for Fiscal Year 2014-15, proposed through the MHSA Three Year Program and Expenditure Plan Fiscal Years 2014-15 through 2016-17.

BOARD PRIORITIES

1. IMPLEMENTATION OF LAURA'S LAW/ASSISTED OUTPATIENT TREATMENT VIA THE EXPANSION OF ADULT FSP SERVICES, SERVICE AREA NAVIGATION TEAMS AND ALTERNATIVE CRISIS SERVICES.

Work Plans: Adult Full Service Partnership (A-01)
Service Area Navigators (SN-01)
IMD Step-Down Facilities (A-03)

Proposal: Three hundred slots will be added in Fiscal Year 2014-15 to the Adult FSP program. Service Area Navigators will conduct 500 evaluations and the IMD Step-down Facilities will increase their capacity to serve 60 additional clients.

Implementation Status: In process. In developing the implementation plan for this program, the Department made one change to the work plans identified above. Service Area Navigation is being removed as a component of the Laura's Law program. The outreach and engagement prior to enrollment in the FSP will be provided not by Service Area Navigators but by the Department's Emergency Outreach Bureau and will be billed to FSP through a central provider number. The budget for the program will not change as a result of this change nor will any aspects of the program.

Estimated Implementation Date: May 30, 2015

Location: All Service Areas

2. EXPANDING INSTITUTIONS FOR MENTAL DISEASE (IMD) STEP-DOWN PROGRAMS TO HELP DECOMPRESS LOS ANGELES COUNTY HOSPITAL PSYCHIATRIC EMERGENCY SERVICES.

Work Plan: IMD Step-Down Facilities (A-03)

Proposal: Twenty-two beds will be added to the IMD Step-Down program.

Implementation Status: Completed.

Estimated Implementation Date: May 2015

Location: All Service Areas

3. Service component of SB82 California Health Facilities Financing Authority (CHFFA) Grant

Work Plan: Alternative Crisis Services (ACS-01)
Proposal: Request funds from the SB82 CHFFA grant to develop three (3) Urgent Care Centers to be located on the campus of Harbor-UCLA Medical Center, the Antelope Valley and the San Gabriel area to serve 72 individuals at any given time and 35 new Crisis Residential programs to increase capacity by 560 beds countywide.
Implementation Status: Request for Proposals written but needs to be re-adjusted due to changes in regulations.
Estimated Implementation Date: To be determined
Location: Service Areas 1, 3 and 8

Child Services

Work Plan: Child Field Capable Clinical Services (C-05)
Proposal: Expand to serve an additional 330 clients for each Fiscal Year, 2014-15, 2015-16 and 2016-17.
Implementation Status: Department of Mental Health (DMH) Children's Systems of Care Administration proposed to expand Children's Intensive Field Capable Clinical Services (IFCCS) contracts. County counsel reviewed and approved the proposal. DMH reviewed and approved the budget. At present time the IFCCS contracts are in the process of being amended.
Estimated Implementation Date: May 2015
Location: All Service Areas

Transitional Age Youth (TAY) Services

Work Plan: TAY Full Service Partnership (T-01)
Proposal: Expand the number of slots by 18 over the three (3) fiscal years.
Implementation Status: FSP slots were expanded for the Independent Living Program (ILP) agencies to be able to provide the appropriate level of mental health services and supports to TAY to address their mental health and co-occurring substance abuse issues while residing in ILPs. The ILPs provide housing and supportive services for TAY existing Department of Children and Family Services or Probation foster care and who are at risk of becoming homeless.
Implementation Date: October 2014
Location: Service Areas 2, 3 and 6

Work Plan: TAY Drop-In Centers (T-02)
Proposal: Serve an additional 400 clients in FY 2014-15.
Implementation Status: As of March 2015, the draft of the Request for Services (RFS) to solicit TAY Drop-In Center services is being reviewed internally by DMH.
Estimated Implementation Date: Fiscal Year 2015-16
Location: To be determined

Work Plan: TAY Field Capable Clinical Services (T-05)
Proposal: Increase capacity by 36 clients over the three (3) fiscal years.
Implementation Status: FCCS capacity was expanded for the Independent Living Program (ILP) agencies to be able to provide the appropriate level of mental health services and supports to TAY to address their mental health and co-occurring substance abuse issues while residing in ILPs. The ILPs provide housing and supportive services for TAY existing Department of Children and Family Services or Probation foster care and who are at risk of becoming homeless.
Implementation Date: October 2014
Location: Service Areas 2, 3 and 6

Work Plan: New Program - TAY Supported Employment Services (T-06)
Proposal: Proposed funding will be utilized to train current TAY mental health providers in implementing supportive employment services within their existing mental health delivery system.
Implementation Status: Draft of the Request for Services to solicit TAY Supported Employment Services is being developed.
Estimated Implementation Date: Fiscal Year 2015-16
Location: To be determined

ADULT SERVICES

Work Plan: Adult Full Service Partnership (A-01)
Proposal: 25 slots will be added in Fiscal Year 2014-15.
Implementation Status: Request for Services draft complete.
Estimated Implementation Date: July 1, 2015
Location: Service Areas 1 and 5

Work Plan: Wellness/Client Run Centers (A-02)
Proposal: Adjunct services for clients in Wellness Centers who are not in need of intensive services as part of this model will include medication management, non-intensive case management, and peer support. Estimated to serve an additional 29,000 clients in FY's 14/15, 15/16 and 16/17.
Implementation Status: Funding was added to provider budgets. Providers have begun hiring.
Implementation Date: January 2015
Location: All existing Wellness and Client Run Centers

Work Plan: Wellness/Client Run Centers (A-02)
Proposal: Expand staffing to implement Supported Employment, an Evidenced-based Practice, which assists clients to obtain and maintain employment. 150 clients to be served in FY 14/15.
Implementation Status: In the process of developing pilot training programs.
Estimated Implementation Date: July 1, 2015
Location: To be determined

Work Plan: Wellness/Client Run Centers (A-02)
Proposal: Add one (1) Housing Specialist per program. 1,500 clients to be served in FY 14/15.
Implementation Status: Funding was added to provider budgets. Providers have begun hiring.
Implementation Date: January 2015
Location: All existing Wellness and Client Run Centers

Work Plan: Wellness/Client Run Centers (A-02)
Proposal: The addition of 35 peer staff to directly operated Wellness Centers and to contract Client Run Centers to serve an additional 1,750 clients.
Implementation Status: Funding was added to provider budgets. Providers have started hiring as of January 2015.
Implementation Date: January 2015
Location: All existing Wellness and Client Run Centers

Work Plan: Wellness/Client Run Centers (A-02)
Proposal: Expand Client Run Centers to ensure availability in every service area. In FY 14/15 an additional 500 clients would be served.
Implementation Status: Request for Services draft complete.
Estimated Implementation Date: July 2015
Location: Service Areas 3 and 6

Work Plan: Adult Housing Services (A-04)
Proposal: An investment in capital development and operating subsidies to expand the number of affordable, permanent supportive housing units for Department of Mental Health clients.
Implementation Status: A Board Letter is in process to give DMH authority to transfer the new funds to California Housing Finance Agency. DMH released an Expression of Interest on January 9, 2015, requesting Letters of Interest for projects that wanted to be considered for the funding which included the additional $3,050,000 allocated in FY 2014-15. The MHSA Housing Advisory Board met in February and March to review all of the Letters of Interest and recommended that DMH commit funds for four (4) new housing projects.
Estimated Implementation Date: May 2015
Location: To be determined

Work Plan: Adult Housing Services (A-04)
Proposal: Extend the current five (5) year contracts which are ending for some agencies. The funding will allow for the expansion of supportive services to more permanent supportive housing programs.
Implementation Status: Contracts were amended under delegated authority to continue Housing Trust Fund (HTF) contracts for those providers that would have run out of funds this year to allow them to continue to provide services through June 30, 2015. The same will be done for FY 2015-16. In the process of drafting a Board Letter to amend contracts through FY 2015-16 for those contracts that we do

not have delegated authority to add the funds. This allows the current programs to continue providing HTF services while DMH undergoes the solicitation process.

In the process of adding Housing Trust Fund to the Request for Statement of Qualifications (RFSQ) Master Agreement. Also, drafting a Request for Services for the re-designed Housing Trust Fund program and new contracts are planned to be in place by July 1, 2016.

Because less funding was needed for FY 2014-15 than originally projected and delays in implementation of the re-designed HTF program, the Department's recommendation is to invest the remaining one-time funds in the MHSA Housing Program in the estimated amounts below:

- FY 2014-15 $255,492
- FY 2015-16 $1,390,000

Implementation Date: July 1, 2014
Location: To be determined

Work Plan: Adult Field Capable Clinical Services (A-06)
Proposal: Increase clients served by 50 for Fiscal Year 2014-15.
Implementation Status: Board letter is in progress to add staff to the directly operated clinics.
Estimated Implementation Date: July 1, 2015
Location: Service Areas 4 and 5

Older Adult Services

Work Plan: Older Adult Full Service Partnership (OA-01)
Proposal: Expand slots by 122 over the three (3) fiscal years.
Implementation Status: Contracts to add Full Service Partnership (FSP) funding to seven (7) Older Adult FSP providers countywide have been amended. The seven (7) contract providers are Didi Hirsh, Heritage Clinics, Hillview MHC Inc., Pacific Clinics, San Fernando Valley CMHC Inc., Special Services for Groups and Telecare Corporation.
Implementation Date: November 2014
Location: All Service Areas

Work Plan: Field Capable Clinical Services (OA-03)
Proposal: Increase capacity by 456 clients over the three (3) fiscal years.
Implementation Status: Contracts to add Field Capable Clinical Services (FCCS) funding to 16 Older Adult FCCS providers countywide have been amended. The contract providers are Alcott, Alma, Amanecer, Barbour & Floyd, Clontarf Manor, Didi Hirsch, Enki, Heritage Clinics, Hillview MHC Inc., Jewish Family Services of LA, Pacific Clinics, San Fernando Valley CMHC Inc., Special Services for Groups, St. Joseph Center, Telecare Corporation and Tessie Cleveland Community Services Corporation.
Implementation Date: November 2014
Location: All Service Areas

CROSS CUTTING AGE GROUPS

Work Plan: New Program - Community Mental Health Promoter/Community Health Workers
Proposal: Roll out of Promoters/Health Navigator Teams in each Service Area, following an established and tested model, including initial training, coaching and presentations for a small core group of participants. Translate all prepared and available presentations from Spanish to English. Train in-house trainers with the help of Training Consultant to assure sustainability.
Implementation Status: In planning stages to determine culturally relevant strategies with the Under Represented Ethnic Populations (UREP) groups. Systems Leadership Team will be involved with the discussion.
Estimated Implementation Date: The Latino model was implemented in FY 2014-15. Other UREP groups will be implemented in FY 2015-16.
Location: To be determined

Fiscal Year 2015-16 through 2017-18 Three-Year MHSA Expenditure Plan

Funding Summary

County: Los Angeles Date: 3/25/15

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	211,092,529	96,212,705	27,606,858	33,288,792	4,012,679	
2. Estimated New FY2015/16 Funding	325,748,897	82,694,338	21,425,210			
3. Transfer in FY2015/16[a/]	0					
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	536,841,426	178,907,043	49,032,068	33,288,792	4,012,679	
B. Estimated FY2015/16 MHSA Expenditures	384,203,614	114,252,544	4,610,138	13,420,362	3,506,689	
C. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	152,637,812	64,654,499	44,421,930	19,868,430	505,990	
2. Estimated New FY2016/17 Funding	391,338,607	97,976,449	25,738,819			
3. Transfer in FY2016/17[a/]	0					
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	543,976,419	162,630,948	70,160,749	19,868,430	505,990	
D. Estimated FY2016/17 Expenditures	384,203,614	114,252,544	23,008,720	13,420,362	297,763	
E. Estimated FY2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	159,772,806	48,378,404	47,152,029	6,448,068	208,227	
2. Estimated New FY2017/18 Funding	391,338,607	97,976,449	25,738,819			
3. Transfer in FY2017/18[a/]	0					
4. Access Local Prudent Reserve in FY2017/18						0
5. Estimated Available Funding for FY2017/18	551,111,413	146,354,853	72,890,848	6,448,068	208,227	
F. Estimated FY2017/18 Expenditures	384,203,614	114,252,544	23,008,720	6,448,068	208,227	
G. Estimated FY2017/18 Unspent Fund Balance	166,907,799	32,102,309	49,882,128	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2015	160,725,402
2. Contributions to the Local Prudent Reserve in FY 2015/16	0
3. Distributions from the Local Prudent Reserve in FY 2015/16	0
4. Estimated Local Prudent Reserve Balance on June 30, 2016	160,725,402
5. Contributions to the Local Prudent Reserve in FY 2016/17	0
6. Distributions from the Local Prudent Reserve in FY 2016/17	0
7. Estimated Local Prudent Reserve Balance on June 30, 2017	160,725,402
8. Contributions to the Local Prudent Reserve in FY 2017/18	0
9. Distributions from the Local Prudent Reserve in FY 2017/18	0
10. Estimated Local Prudent Reserve Balance on June 30, 2018	160,725,402

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Community Services and Supports (CSS) Component Worksheet

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's Full Service Partnerships	48,083,525	9,181,316	21,308,564	0	17,593,645	0
2. Family Support Services	2,921,877	2,921,877	0	0	0	0
3. Respite Care Program	175,000	175,000				
4. Children-Field-Capable Clinical Services	16,214,585	2,604,224	7,905,148	0	5,705,213	0
5. TAY Full Service Partnerships	29,704,098	15,827,623	9,629,836	0	4,246,639	0
6. Drop-in Centers	612,500	612,500	0	0	0	0
7. TAY Housing Services	1,430,797	1,430,797	0	0	0	0
8. TAY Supportive Employment Services	93,750	93,750	0	0	0	0
9. Probation Camp Services	253,278	253,278	0	0	0	0
10. TAY-Field-Capable Clinical Services	3,261,979	793,971	1,531,156	0	936,524	328
11. Adult Full Service Partnerships	76,335,647	52,381,289	23,893,892	0	60,466	0
12. Wellness/Client Run Centers	31,485,552	22,918,828	7,877,966	0	273,320	415,438
13. IMD Step Down Facilities	9,890,579	6,113,312	3,777,267	0	0	0
14. Adult Housing Services	1,340,457	1,340,457	0	0	0	0
15. Adult Supportive Employment Model Pilot	418,983	205,889	213,095	0	0	0
16. Adult Promotores	52,500	52,500	0	0	0	0
17. Jail transition & Linkage Services	3,794,258	3,668,430	83,250	0	2,808	39,770
18. Adult-Field-Capable Clinical Services	19,579,911	10,691,906	8,883,248	0	1,411	3,346
19. Older Adult Full Service Partnerships	7,852,129	4,891,786	2,960,343	0	0	0
20. Transformation Design Team		0	0	0	0	0
21. Older Adult Field-Capable Clinical Services	6,918,018	4,685,566	2,113,073	0	0	119,379
22. Co-Occurring Disorders	92,260	92,260	0	0	0	0
23. OA Training	39,772	39,772	0	0	0	0
24. OA Service Extenders		0	0	0	0	0
25. Integrated Care Clinic	1,849,876	1,849,876	0	0	0	0
26. Service Area Navigator Teams	10,173,214	10,133,209	30,073	0	9,527	405
27. Planning, Outreach, Engagement		0	0	0	0	0
28. Alternative Crisis Services	73,913,044	45,708,576	28,005,980	0	187,372	11,116
Non-FSP Programs						
29. Children's Full Service Partnerships	0	0	0	0	0	0
30. Family Support Services	0	0	0	0	0	0
31. Respite Care Program	325,000	325,000				
32. Children-Field-Capable Clinical Services	37,834,031	6,076,523	18,445,346	0	13,312,163	0
33. TAY Full Service Partnerships	0	0	0	0	0	0
34. Drop-in Centers	1,137,500	1,137,500	0	0	0	0
35. TAY Housing Services	953,865	953,865	0	0	0	0
36. TAY Supportive Employment Services	31,250	31,250	0	0	0	0
37. Probation Camp Services	4,812,276	4,812,276	0	0	0	0
38. TAY-Field-Capable Clinical Services	7,611,283	1,852,598	3,572,697	0	2,185,223	765
39. Adult Full Service Partnerships	0	0	0	0	0	0
40. Wellness/Client Run Centers	58,473,167	42,563,538	14,630,507	0	507,594	771,528
41. IMD Step Down Facilities	3,296,860	2,037,771	1,259,089	0	0	0
42. Adult Housing Services	5,361,829	5,361,829	0	0	0	0
43. Adult Supportive Employment Model Pilot	139,661	68,630	71,032	0	0	0
44. Adult Promotores	297,500	297,500	0	0	0	0
45. Jail transition & Linkage Services	3,794,258	3,668,430	83,250	0	2,808	39,770
46. Adult-Field-Capable Clinical Services	23,931,003	13,067,885	10,857,304	0	1,725	4,089
47. Older Adult Full Service Partnerships	0	0	0	0	0	0
48. Transformation Design Team	526,663	526,663	0	0	0	0
49. Older Adult Field-Capable Clinical Services	16,142,042	10,932,986	4,930,504	0	0	278,552
50. Co-Occurring Disorders	138,391	138,391	0	0	0	0
51. OA Training	159,086	159,086	0	0	0	0
52. OA Service Extenders	229,500	229,500	0	0	0	0
53. Integrated Care Clinic	10,482,633	10,482,633	0	0	0	0
54. Service Area Navigator Teams	4,359,949	4,342,804	12,888	0	4,083	174
55. Planning, Outreach, Engagement	14,379,336	14,259,353	119,983	0	0	0
56. Alternative Crisis Services	49,301,140	31,418,129	17,691,412	0	186,124	5,475
CSS Administration	31,139,215	30,041,483				1,097,732
CSS MHSA Housing Program Assigned Funds	750,000	750,000				
Total CSS Program Estimated Expenditures	622,095,026	384,203,614	189,886,902	0	45,216,644	2,787,867
FSP Programs as Percent of Total	90.2%					

CSS Component Worksheet (continued)

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's Full Service Partnerships	48,083,525	9,181,316	21,308,564	0	17,593,645	0
2. Family Support Services	2,921,877	2,921,877	0	0	0	0
3. Respite Care Program	175,000	175,000				
4. Children-Field-Capable Clinical Services	16,214,585	2,604,224	7,905,148	0	5,705,213	0
5. TAY Full Service Partnerships	29,704,098	15,827,623	9,629,836	0	4,246,639	0
6. Drop-in Centers	612,500	612,500	0	0	0	0
7. TAY Housing Services	1,430,797	1,430,797	0	0	0	0
8. TAY Supportive Employment Services	93,750	93,750	0	0	0	0
9. Probation Camp Services	253,278	253,278	0	0	0	0
10. TAY-Field-Capable Clinical Services	3,261,979	793,971	1,531,156	0	936,524	328
11. Adult Full Service Partnerships	76,335,647	52,381,289	23,893,892	0	60,466	0
12. Wellness/Client Run Centers	31,485,552	22,918,828	7,877,966	0	273,320	415,438
13. IMD Step Down Facilities	9,890,579	6,113,312	3,777,267	0	0	0
14. Adult Housing Services	1,340,457	1,340,457	0	0	0	0
15. Adult Supportive Employment Model Pilot	418,983	205,889	213,095	0	0	0
16. Adult Promotores	52,500	52,500	0	0	0	0
17. Jail transition & Linkage Services	3,794,258	3,668,430	83,250	0	2,808	39,770
18. Adult-Field-Capable Clinical Services	19,579,911	10,691,906	8,883,248	0	1,411	3,346
19. Older Adult Full Service Partnerships	7,852,129	4,891,786	2,960,343	0	0	0
20. Transformation Design Team	0	0	0	0	0	0
21. Older Adult Field-Capable Clinical Services	6,918,018	4,685,566	2,113,073	0	0	119,379
22. Co-Occurring Disorders	92,260	92,260	0	0	0	0
23. OA Training	39,772	39,772	0	0	0	0
24. OA Service Extenders	0	0	0	0	0	0
25. Integrated Care Clinic	1,849,876	1,849,876	0	0	0	0
26. Service Area Navigator Teams	10,173,214	10,133,209	30,073	0	9,527	405
27. Planning, Outreach, Engagement	0	0	0	0	0	0
28. Alternative Crisis Services	73,913,044	45,708,576	28,005,980	0	187,372	11,116
Non-FSP Programs						
29. Children's Full Service Partnerships	0	0	0	0	0	0
30. Family Support Services	0	0	0	0	0	0
31. Respite Care Program	325,000	325,000				
32. Children-Field-Capable Clinical Services	37,834,031	6,076,523	18,445,346	0	13,312,163	0
33. TAY Full Service Partnerships	0	0	0	0	0	0
34. Drop-in Centers	1,137,500	1,137,500	0	0	0	0
35. TAY Housing Services	953,865	953,865	0	0	0	0
36. TAY Supportive Employment Services	31,250	31,250	0	0	0	0
37. Probation Camp Services	4,812,276	4,812,276	0	0	0	0
38. TAY-Field-Capable Clinical Services	7,611,283	1,852,598	3,572,697	0	2,185,223	765
39. Adult Full Service Partnerships	0	0	0	0	0	0
40. Wellness/Client Run Centers	58,473,167	42,563,538	14,630,507	0	507,594	771,528
41. IMD Step Down Facilities	3,296,860	2,037,771	1,259,089	0	0	0
42. Adult Housing Services	5,361,829	5,361,829	0	0	0	0
43. Adult Supportive Employment Model Pilot	139,661	68,630	71,032	0	0	0
44. Adult Promotores	297,500	297,500	0	0	0	0
45. Jail transition & Linkage Services	3,794,258	3,668,430	83,250	0	2,808	39,770
46. Adult-Field-Capable Clinical Services	23,931,003	13,067,885	10,857,304	0	1,725	4,089
47. Older Adult Full Service Partnerships	0	0	0	0	0	0
48. Transformation Design Team	526,663	526,663	0	0	0	0
49. Older Adult Field-Capable Clinical Services	16,142,042	10,932,986	4,930,504	0	0	278,552
50. Co-Occurring Disorders	138,391	138,391	0	0	0	0
51. OA Training	159,086	159,086	0	0	0	0
52. OA Service Extenders	229,500	229,500	0	0	0	0
53. Integrated Care Clinic	10,482,633	10,482,633	0	0	0	0
54. Service Area Navigator Teams	4,359,949	4,342,804	12,888	0	4,083	174
55. Planning, Outreach, Engagement	14,379,336	14,259,353	119,983	0	0	0
56. Alternative Crisis Services	49,301,140	31,418,129	17,691,412	0	186,124	5,475
CSS Administration	31,139,215	30,041,483				1,097,732
CSS MHSA Housing Program Assigned Funds	750,000	750,000				
Total CSS Program Estimated Expenditures	622,095,026	384,203,614	189,886,902	0	45,216,644	2,787,867
FSP Programs as Percent of Total	90.2%					

CSS Component Worksheet (continued)

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's Full Service Partnerships	48,083,525	9,181,316	21,308,564	0	17,593,645	0
2. Family Support Services	2,921,877	2,921,877	0	0	0	0
3. Respite Care Program	175,000	175,000				
4. Children-Field-Capable Clinical Services	16,214,585	2,604,224	7,905,148	0	5,705,213	0
5. TAY Full Service Partnerships	29,704,098	15,827,623	9,629,836	0	4,246,639	0
6. Drop-in Centers	612,500	612,500	0	0	0	0
7. TAY Housing Services	1,430,797	1,430,797	0	0	0	0
8. TAY Supportive Employment Services	93,750	93,750	0	0	0	0
9. Probation Camp Services	253,278	253,278	0	0	0	0
10. TAY-Field-Capable Clinical Services	3,261,979	793,971	1,531,156	0	936,524	328
11. Adult Full Service Partnerships	76,335,647	52,381,289	23,893,892	0	60,466	0
12. Wellness/Client Run Centers	31,485,552	22,918,828	7,877,966	0	273,320	415,438
13. IMD Step Down Facilities	9,890,579	6,113,312	3,777,267	0	0	0
14. Adult Housing Services	1,340,457	1,340,457	0	0	0	0
15. Adult Supportive Employment Model Pilot	418,983	205,889	213,095	0	0	0
16. Adult Promotores	52,500	52,500	0	0	0	0
17. Jail transition & Linkage Services	3,794,258	3,668,430	83,250	0	2,808	39,770
18. Adult-Field-Capable Clinical Services	19,579,911	10,691,906	8,883,248	0	1,411	3,346
19. Older Adult Full Service Partnerships	7,852,129	4,891,786	2,960,343	0	0	0
20. Transformation Design Team	0	0	0	0	0	0
21. Older Adult Field-Capable Clinical Services	6,918,018	4,685,566	2,113,073	0	0	119,379
22. Co-Occurring Disorders	92,260	92,260	0	0	0	0
23. OA Training	39,772	39,772	0	0	0	0
24. OA Service Extenders	0	0	0	0	0	0
25. Integrated Care Clinic	1,849,876	1,849,876	0	0	0	0
26. Service Area Navigator Teams	10,173,214	10,133,209	30,073	0	9,527	405
27. Planning, Outreach, Engagement	0	0	0	0	0	0
28. Alternative Crisis Services	73,913,044	45,708,576	28,005,980	0	187,372	11,116
Non-FSP Programs						
29. Children's Full Service Partnerships	0	0	0	0	0	0
30. Family Support Services	0	0	0	0	0	0
31. Respite Care Program	325,000	325,000				
32. Children-Field-Capable Clinical Services	37,834,031	6,076,523	18,445,346	0	13,312,163	0
33. TAY Full Service Partnerships	0	0	0	0	0	0
34. Drop-in Centers	1,137,500	1,137,500	0	0	0	0
35. TAY Housing Services	953,865	953,865	0	0	0	0
36. TAY Supportive Employment Services	31,250	31,250	0	0	0	0
37. Probation Camp Services	4,812,276	4,812,276	0	0	0	0
38. TAY-Field-Capable Clinical Services	7,611,283	1,852,598	3,572,697	0	2,185,223	765
39. Adult Full Service Partnerships	0	0	0	0	0	0
40. Wellness/Client Run Centers	58,473,167	42,563,538	14,630,507	0	507,594	771,528
41. IMD Step Down Facilities	3,296,860	2,037,771	1,259,089	0	0	0
42. Adult Housing Services	5,361,829	5,361,829	0	0	0	0
43. Adult Supportive Employment Model Pilot	139,661	68,630	71,032	0	0	0
44. Adult Promotores	297,500	297,500	0	0	0	0
45. Jail transition & Linkage Services	3,794,258	3,668,430	83,250	0	2,808	39,770
46. Adult-Field-Capable Clinical Services	23,931,003	13,067,885	10,857,304	0	1,725	4,089
47. Older Adult Full Service Partnerships	0	0	0	0	0	0
48. Transformation Design Team	526,663	526,663	0	0	0	0
49. Older Adult Field-Capable Clinical Services	16,142,042	10,932,986	4,930,504	0	0	278,552
50. Co-Occurring Disorders	138,391	138,391	0	0	0	0
51. OA Training	159,086	159,086	0	0	0	0
52. OA Service Extenders	229,500	229,500	0	0	0	0
53. Integrated Care Clinic	10,482,633	10,482,633	0	0	0	0
54. Service Area Navigator Teams	4,359,949	4,342,804	12,888	0	4,083	174
55. Planning, Outreach, Engagement	14,379,336	14,259,353	119,983	0	0	0
56. Alternative Crisis Services	49,301,140	31,418,129	17,691,412	0	186,124	5,475
CSS Administration	31,139,215	30,041,483				1,097,732
CSS MHSA Housing Program Assigned Funds	750,000	750,000				
Total CSS Program Estimated Expenditures	622,095,026	384,203,614	189,886,902	0	45,216,644	2,787,867
FSP Programs as Percent of Total	90.2%					

Prevention and Early Intervention (PEI) Component Worksheet

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI Early Start-Suicide Prevention	871,177	271,367	357,492		242,318	
2. PEI Early Start-School Mental Health Initiative	11,566,821	3,603,006	4,746,505		3,217,310	
3. PEI Early Start-Stigma Discrimination	526,688	164,061	216,129		146,498	
4. School-based Services	0					
5. Family Education and Support Services	5,350,000	1,666,498	2,195,400		1,488,102	
6. At-risk Family Services	0					
7. Trauma Recovery Services	0					
8. Primary Care & Behavioral Health	0					
9. Early Care & Support for TAY	592,862	184,673	243,284		164,905	
10. Juvenile Justice Services	100,000	31,149	41,036		27,815	
11. Early Care & Support for Older Adults	0					
12. Improving Access for Underserved Populations	450,000	140,173	184,660		125,167	
13. American Indian Project	46,080	14,354	18,909		12,817	
PEI Programs - Early Intervention						
14. PEI Early Start-Suicide Prevention	0					
15. PEI Early Start-School Mental Health Initiative	0					
16. PEI Early Start-Stigma Discrimination	0					
17. School-based Services	22,482,285	7,003,116	9,225,723		6,253,446	
18. Family Education and Support Services	24,369,828	7,591,077	10,000,286		6,778,466	
19. At-risk Family Services	38,015,113	11,841,513	15,599,700		10,573,901	
20. Trauma Recovery Services	83,939,221	26,146,637	34,444,896		23,347,687	
21. Primary Care & Behavioral Health	19,322,999	6,019,015	7,929,293		5,374,691	
22. Early Care & Support for TAY	53,996,931	16,819,767	22,157,922		15,019,242	
23. Juvenile Justice Services	25,343,887	7,894,491	10,399,996		7,049,400	
24. Early Care & Support for Older Adults	5,589,850	1,741,210	2,293,824		1,554,816	
25. Improving Access for Underserved Populations	13,681,059	4,261,580	5,614,094		3,805,385	
26. American Indian Project	2,201,533	685,766	903,411		612,356	
PEI Administration	18,173,092	18,173,092				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	326,619,427	114,252,544	126,572,560	0	85,794,323	0

PEI Component Worksheet (continued)

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI Early Start-Suicide Prevention	871,177	271,367	357,492		242,318	
2. PEI Early Start-School Mental Health Initiative	11,566,821	3,603,006	4,746,505		3,217,310	
3. PEI Early Start-Stigma Discrimination	526,688	164,061	216,129		146,498	
4. School-based Services	0	0	0		0	
5. Family Education and Support Services	5,000,000	1,557,474	2,051,776		1,390,750	
6. At-risk Family Services	0	0	0		0	
7. Trauma Recovery Services	0	0	0		0	
8. Primary Care & Behavioral Health	0	0	0		0	
9. Early Care & Support for TAY	592,862	184,673	243,284		164,905	
10. Juvenile Justice Services	0	0	0		0	
11. Early Care & Support for Older Adults	0	0	0		0	
12. Improving Access for Underserved Populations	0	0	0		0	
13. American Indian Project	46,080	14,354	18,909		12,817	
PEI Programs - Early Intervention						
14. PEI Early Start-Suicide Prevention	0					
15. PEI Early Start-School Mental Health Initiative	0					
16. PEI Early Start-Stigma Discrimination	0					
17. School-based Services	22,482,285	7,003,116	9,225,723		6,253,446	
18. Family Education and Support Services	24,719,828	7,700,100	10,143,910		6,875,818	
19. At-risk Family Services	38,015,113	11,841,513	15,599,700		10,573,901	
20. Trauma Recovery Services	83,939,221	26,146,637	34,444,896		23,347,687	
21. Primary Care & Behavioral Health	19,322,999	6,019,015	7,929,293		5,374,691	
22. Early Care & Support for TAY	53,996,931	16,819,767	22,157,922		15,019,242	
23. Juvenile Justice Services	25,443,887	7,925,640	10,441,032		7,077,215	
24. Early Care & Support for Older Adults	5,589,850	1,741,210	2,293,824		1,554,816	
25. Improving Access for Underserved Populations	14,131,059	4,401,752	5,798,754		3,930,553	
26. American Indian Project	2,201,533	685,766	903,411		612,356	
PEI Administration	18,173,092	18,173,092				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	326,619,427	114,252,544	126,572,560	0	85,794,323	0

PEI Component Worksheet (continued)

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI Early Start-Suicide Prevention	871,177	271,367	357,492		242,318	
2. PEI Early Start-School Mental Health Initiative	11,566,821	3,603,006	4,746,505		3,217,310	
3. PEI Early Start-Stigma Discrimination	526,688	164,061	216,129		146,498	
4. School-based Services	0					
5. Family Education and Support Services	5,000,000	1,557,474	2,051,776		1,390,750	
6. At-risk Family Services	0					
7. Trauma Recovery Services	0					
8. Primary Care & Behavioral Health	0					
9. Early Care & Support for TAY	592,862	184,673	243,284		164,905	
10. Juvenile Justice Services	0					
11. Early Care & Support for Older Adults	0					
12. Improving Access for Underserved Populations	0					
13. American Indian Project	46,080	14,354	18,909		12,817	
PEI Programs - Early Intervention						
14. PEI Early Start-Suicide Prevention	0					
15. PEI Early Start-School Mental Health Initiative	0					
16. PEI Early Start-Stigma Discrimination	0					
17. School-based Services	22,482,285	7,003,116	9,225,723		6,253,446	
18. Family Education and Support Services	24,719,828	7,700,100	10,143,910		6,875,818	
19. At-risk Family Services	38,015,113	11,841,513	15,599,700		10,573,901	
20. Trauma Recovery Services	83,939,221	26,146,637	34,444,896		23,347,687	
21. Primary Care & Behavioral Health	19,322,999	6,019,015	7,929,293		5,374,691	
22. Early Care & Support for TAY	53,996,931	16,819,767	22,157,922		15,019,242	
23. Juvenile Justice Services	25,443,887	7,925,640	10,441,032		7,077,215	
24. Early Care & Support for Older Adults	5,589,850	1,741,210	2,293,824		1,554,816	
25. Improving Access for Underserved Populations	14,131,059	4,401,752	5,798,754		3,930,553	
26. American Indian Project	2,201,533	685,766	903,411		612,356	
PEI Administration	18,173,092	18,173,092				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	326,619,427	114,252,544	126,572,560	0	85,794,323	0

Innovations Component Worksheet

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Integrated Peer-Run Model	2,533,947	2,533,947	0		0	
2. Evaluation	400,000	400,000	0		0	
INN Administration	1,676,191	1,676,191				
Total INN Program Estimated Expenditures	4,610,138	4,610,138	0	0	0	0

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Evaluation	1,000,000	1,000,000				
2. Estimated Budget per Supervisorial District for Health neighborhood (Solicitation)	20,000,000	20,000,000				
INN Administration	2,008,720	2,008,720				
Total INN Program Estimated Expenditures	23,008,720	23,008,720	0	0	0	0

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Evaluation	1,000,000	1,000,000				
2. Estimated Budget per Supervisorial District for Health neighborhood (Solicitation)	20,000,000	20,000,000				
INN Administration	2,008,720	2,008,720				
Total INN Program Estimated Expenditures	23,008,720	23,008,720	0	0	0	0

Appendix

- ***I:Crossover Youth Multidisciplinary Team Program (MDT)…… 125-141***
- ***II: FSP Baseline Exception Reasons……..142-144***
- ***III: START outcomes……145-155***
- ***IV: Disenrollment Guidelines……156-158***
- ***V: Public Hearing Announcement ……159-161***
- ***VI: Public Hearing PowerPoint……162-179***
- ***VII: Public Hearing Transcripts……180-196***
- ***VIII: Public Comment Forms……197-198***
- ***IX: Public Hearing Sign-In Sheets……199-***

County of Los Angeles
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GLORIA MOLINA
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MARK RIDLEY-THOMAS
Second District
ZEV YAROSLAVSKY
Third District
DON KNABE
Fourth District
MICHAEL D. ANTONOVICH
Fifth District

June 2, 2014

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: Philip L. Browning
Director

ENHANCING SERVICES TO STRENGTHEN 241.1 PROJECT FOR CROSSOVER YOUTH ANNUAL REPORT

A motion by Supervisor Ridley-Thomas directed the Chief Executive Officer (CEO), in conjunction with the Directors of the Departments of Mental Health (DMH), Public Health (DPH), Probation and Children and Family Services (DCFS), to implement the 241.1 Crossover Youth Project recommendations and report annually on the evaluation measures identified in the CEO's November 2012 report.

Per your Board's request, attached is the annual report prepared by Denise Herz, Ph.D., Director and Professor, School of Criminal Justice and Criminalistics, California State University, Los Angeles on our behalf.

If you have any questions, please call me or your staff may contact Aldo Marin, Board Relations Manager at (213) 351-5530.

PLB:RRS:vs

Attachment

c: Executive Officer, Board of Supervisors
Chief Executive Office
Department of Mental Health
Department of Public Health
Probation Department

CALIFORNIA STATE UNIVERSITY, LOS ANGELES

COLLEGE OF HEALTH AND HUMAN SERVICES

School of Criminal Justice and Criminalistics

To: Los Angeles County Board of Supervisors

From: Denise C. Herz, Ph.D., Director and Professor, School of Criminal Justice & Criminalistics, California State University—Los Angeles

RE: Request for 241.1 Multidisciplinary Data Results

Date: May 27, 2014

Per the Board's request in an earlier Board Motion related to the 241.1 Multidisciplinary Team, I am submitting a research report that summarizes the first phase of data findings. These findings will be updated with more cases as they accrue over the course of the year and also for a longer tracking period in the next annual report. Please do not hesitate to contact me with any questions or comments you may have regarding the report at dherz@calstatela.edu or 323-343-4624.

5151 State University Drive, Los Angeles, CA 90032-8163 (323) 3434610 FAX: (323) 3434646
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241.1 Tracking Application and Outcome Data: A Summary of Findings

Denise C. Herz, Ph.D.
School of Criminal Justice & Criminalistics
California State University—Los Angeles

Overview of Data and Methodology

To support data reporting requirements for the 241.1 Multidisciplinary Team (MDT), representatives from Department of Children and Family Services, Probation, the Department of Mental Health, and the School of Criminal Justice & Criminalistics worked together to develop appropriate data collection tools, and DCFS committed resources through their Bureau of Information Systems to build a 241.1 web-based application to facilitate data collection across all agencies.

Data collection for this project began in October 2013 on all 241.1 referrals who received a disposition in October and had an open 300 case at the time of their disposition. Data were collected on these youth at the time they were referred ("Initial Data") to the 241.1 Units; at the post-disposition MDT meeting ("Post-Dispo Data"); and one year after they received a disposition ("Tracking Data"). Tracking Data was and will be collected over three periods of time or until both the dependency and delinquency cases close—whichever comes first. The three periods for data collection are designated as follows:

- Tracking Period 1 Data Collection: Covers months 1-4 after disposition
- Tracking Period 2 Data Collection: Covers Months 5-8 after disposition
- Tracking Period 3 Data Collection: Covers Months 9-12 after disposition

Although the current report only presents findings using the 241.1 referrals that received dispositions in October 2013 (N=23), cases for future analysis will continue to accrue in each subsequent month. The majority of 241.1 tracked youth data was available and entered into the database prior to analysis for this report; however, post-MDT recommendations and educational data at the time of the 241.1 referral were not available and will be included in future reports. In addition to the October 2013 disposition cases, previously collected data on referrals and dispositions for 2012 and 2013 are presented to provide a broader landscape of 241.1 referrals and their outcomes since data collection for this project did not systematically begin until October 2013. Moving forward, the 241.1 application built for this project will provide these data.

Findings for 241.1 Dispositions and the Characteristics of Tracked Youth

How Many 241.1 Referrals Are There and What Dispositions Did They Receive?

Using both "Tracking Data" and data collected for previous research efforts, it was possible to report the number of youth processed and their dispositions for 241.1 referrals in 2012 and 2013 as well as the dispositions for the 241.1 tracked cases.

Some important notes about these data include: (1) the 2012 data only reflects 6 months of data collection, but there is no reason to suspect that the second half of the year would alter the findings of the first half; and (2) because 2013 data were recent at the time of this report, some cases did not have a disposition and were "pending"—missing dispositions for these cases will be recorded and included in future reports. Additionally, it is important to note that only youth with a "fresh" 241.1 referral are reflected in these numbers. For example, 241.1 referrals who received dispositions and were referred for a subsequent MDT meeting after their disposition (also known as a MDT reassessment) are excluded.

What Do the Data in Table 1 Tell Us About 241.1 Referrals and the Dispositions They Receive?

- Regardless of the time period examined, 241.1 youth were most likely to receive a disposition of WIC 790, WIC 725a, or WIC 654. When youth received a WIC 602 disposition, the majority of those dispositions (if not all of them) were dual jurisdiction—i.e., WIC 300/602. Very few 241.1 youth received "straight" WIC 602 dispositions, which would require the immediate termination of their WIC 300 cases.

Table 1: Number of Youth Processed as 241.1 Referrals and the Dispositions They Received in 2012 and 2013

	Jan. 2012-June 2012 All Courts Over Time	2013 All Court Locations	October 2013 Dispositions Tracked Youth
Number of 241.1 Referrals*	**255**	**589**	**23**
241.1 Court Disposition			
Dismissed	7%	4%	0
WIC 654.2	21%	15%	30%
WIC 725(a)	22%	14%	26%
WIC 790	27%	18%	26%
WIC 300/602	17%	14%	17%
WIC 602	3%	9%	0
Other/Pending	3%	27%	0

**NOTES: Data reflect unique youth within a time period rather than referrals—i.e., one youth may have multiple referrals within one timeframe; however, they are only counted once in these data. Pending dispositions for 2013 will be retrieved over time for a complete set of disposition data, and referral and disposition data for 2014 is in the process of being collected and will be displayed in future reports.*

What are the Characteristics of the 241.1 Tracked Youth?

Initial Data include a wide variety of information on 241.1 tracked youth, ranging from their demographics to their involvement with systems to their current status in school and with behavioral problems. Using these data, this section creates a "profile" of 241.1 tracked youth and the challenges they face.

What Do the Data in Table 2 Tell Us about the Socio-Demographic Profile of 241.1 Tracked Youth?

- Approximately two-thirds of the 241.1 tracked youth were male (65%), and a third were female (35%). The proportion of females in this population is higher than in the general juvenile justice system population (typically 20%).
- About half of the 241.1 tracked youth were Latino, and 39% were African-American. Although lower in prevalence compared to Latino youth, African-American youth were over-represented at higher rates in this population (39%) than in the child welfare or juvenile justice systems individually.
- 241.1 tracked youth were 15 years old (on average) at the time of their current arrests.
- These youth were most likely to live in group homes (35%) at the time of their referral followed by relatives (26%), and home (22%). 13% of these youth were AWOL from their living situation at the time of their arrest.
- Most of these youth were from SPA 6 (35%) followed equally by SPAs 1, 2, and 3 (13% each).

Table 2: Characteristics of 241.1 Tracked Youth (N=23)

	%
Demographics	
% Female	35%
% Male	65%
% African-American	39%
% Latino	52%
Rounded Average Age at Time of 241.1 Referral	15 years old
Living Situation at Time of Referral	
Group Home	35%
Relative (Legal Guardian and Not)	26%
Home	22%
Foster Care or Legal Guardian	18%

Table 2: Characteristics of 241.1 Tracked Youth (N=23)

	%
SPA Designation	
SPA 1	13%
SPA 2	13%
SPA 3	13%
SPA 4	4%
SPA 5	4%
SPA 6	35%
SPA 7	9%
SPA 8	9%

What Do the Data in Table 3 Tell Us about Involvement with the Child Welfare System among 241.1 Tracked Youth?

- At the time of their 241.1 referral, the average number of previous referrals to DCFS for 241.1 tracked youth and/or their families was 8.87.
- The average number of years 241.1 traced youth spent in the child welfare system was 5 years, and this time was consecutive for slightly more than half of these youth (56%).
- The permanency plan for 30% of these youth at the time of their 241.1 referral was permanent planned living arrangements followed by reunification (26%), remain at home (22%), and guardianship (22%).

Table 3: Involvement in the Child Welfare System for 241.1 Tracked Youth (N=23)

	%
Average # of Referrals for Youth's Family	8.87 Referrals (SD=6.06 Ref.)
Average Length in the System	4.90 Years (SD=4.10 Years)
Time is Consecutive	56%
Time is Not Consecutive	44%
Has Prior 241.1 Referral	26%
Permanency Goal at Time of Referral	
Remain at Home	22%
Reunification	26%
Guardianship	22%
Permanent Planned Living Arrangements	30%

What Do the Data in Table 4 Tell Us about Involvement with the Juvenile Justice System among 241.1 Tracked Youth?

- 43% of the current charges for 241.1 tracked youth were for property offenses; 35% were violent offenses; and 22% were for other types of charges. Most of these charges were misdemeanors (61%).
- 30% of the charges for 241.1 tracked youth were related to the youth's living situation—43% of these placement related charges occurred at group homes and 43% occurred at home.
- 20% of the charges for 241.1 tracked youth occurred at school.
- 25% of the 241.1 tracked female youth were recommended for the STAR Court—a program specifically designed for sexually exploited youth.
- 39% of youth had a prior criminal charge, and 26% had a prior status offense at the time of their 241.1 referral.

Table 4: Involvement in the Juvenile Justice System for 241.1 Tracked Youth (N=23)

	%
Most Serious Current Charge	
Violent Offense	35%
Property Offense	45%
Other Offense	22%
Type of Charge	
Misdemeanor	61%
Felony	30%
707b Offense	9%
Was Offense Related to Living Situation?	30%
Of those related, % living in group home	43%
Of those related, % living at home	43%
Of those related, % living in foster care	13%
Was Offense Related to School?	22%
Recommendation to STAR Court (% of Female Youth)	25%
Prior Offenses	
Criminal Charges	39%
Status Offenses	26%

What Do the Data in Table 5 Tell Us about the Prevalence of Mental Health and Substance Abuse among 241.1 Tracked Youth?

- All of the 241.1 tracked youth had indication of a mental health and/or a alcohol/drug problem. 61% had indication of co-occurring problems whereas only 26% had indication of a mental health problem only and 13% of an alcohol/drug problem only.
- A third of more of 241.1 tracked youth had a family history of mental illness; had been placed in a psychiatric hospital; experienced suicidal ideation, and/or were prescribed psychotropic medication.
- 74% of tracked youth had some level of problem with drugs and/or alcohol—the drugs of choice were marijuana with or without other drugs and alcohol. 61% had co-occurring problems.

Table 5: The Prevalence of Mental Health and Alcohol/Drug Problems among 241.1 Tracked Youth (N=23)

	%
Mental Health History	
Family History of Mental Illness	42%
Ever Placed in Psychiatric Hospital	30%
Experienced Suicidal Ideation	26%
Ever Attempted Suicide	9%
Prescribed Psychotropic Medication	22%
Current Mental Health and/or Substance Abuse Problems	
No Mental Health or Alcohol/Drug Problem Indicated	0%
Mental Health Problem Only Indicated	26%
Pattern of Alcohol/Drug Use/Misuse, Abuse, or Dependency Only	13%
Both a Mental Health and Alcohol/Drug Problem Indicated	61%

Findings for Probation Conditions Ordered and Services Received

<u>What Services and Probation Conditions did 241.1 Tracked Youth Receive Four Months After Disposition and How Well Were Youth Complying/Participating?</u>

Tracking data collected in the first period provided insight into which services youth received and the extent to which they were participating in those services. Additionally, the data identified which Probation conditions applied to each youth and whether the youth was complying with or violating their conditions. This section provides insight into these issues for each type of service as well as Probation conditions.

What Do the Data in Tables 6 Tell Us about the Mental Health Services Received by 241.1 Tracked Youth During the Tracking Period 1?

- Of all 241.1 tracked youth, 96% received at least one mental health service.
- The top three mental health services received by 241.1 tracked youth were: (1) individual counseling, (2) group counseling, and (3) wraparound programming.
- Approximately two-thirds to three-quarters of 241.1 tracked youth given a medication monitoring plan, group treatment, or individual treatment were participating in those services during this tracking period. Conversely, a third of the youth given group treatment and family therapy were not attending those services.

Table 6: Distribution of Mental Health Services Received by Type and Youth Participation Status at the End of Tracking Period 1

	N (%)	Youth Status in Each Service				
		Referral Only	Participating	Not Attending	Completed	Terminated
Total Number of 241.1 Tracked Youth	23	---	---	---	---	---
Total Number of 241.1 Tracked Youth Receiving Mental Health Services	22 (96%)	---	---	---	---	---
Of Those Who Received Services, What Type of Service Did They Receive?						
Individual Treatment	18 (82%)	33%	61%	6%	---	---
Group Treatment	12 (54%)	---	67%	33%	---	---
Wraparound Services	9 (41%)	22%	56%	11%	11%	---
Medication Monitoring	7 (32%)	---	71%	14%	---	14%
Family Treatment	3 (14%)	33%	33%	33%	---	---
Full Service Partnerships	2 (9%)	100%	---	---	---	---
Therapeutic Behavioral Services	1 (4%)	100%	---	---	---	---

NOTE: "---" denotes "not applicable." Percentages across the types of services do not add to 100% because youth often received more than one type of service.

What Do the Data in Tables 7 Tell Us about the Substance Abuse Services Received by 241.1 Tracked Youth During the Tracking Period 1?

- Of all 241.1 tracked youth, 56% received at least one substance abuse treatment service.
- Most youth who received substance abuse treatment received drug/alcohol education followed by outpatient treatment. Only 4% received inpatient treatment.
- Just under half of the 241.1 tracked youth given drug/alcohol education were attending, but 75% of those given outpatient services were not attending.

Table 7: Distribution of Substance Abuse Services Received by Type and Youth Participation Status at the End of Tracking Period 1

	N (%)	Youth Status in Each Service				
		Referral Only	Participating	Not Attending	Completed	Waitlisted
Total Number of 241.1 Tracked Youth	23	---	---	---	---	---
Total Number of 241.1 Tracked Youth Receiving Substance Abuse Services	13 (56%)	---	---	---	---	---
Of Those Who Received Services, What Type of Service Did They Receive?						
Drug/Alcohol Education	9 (69%)	22%	44%	11%	11%	11%
Drug/Alcohol Outpatient Treatment	4 (31%)	---	25%	75%	---	---
Drug/Alcohol Inpatient Treatment	1 (8%)	---	---	---	---	100%

NOTE: "---" denotes "not applicable." Percentages across the types of services do not add to 100% because youth often received more than one type of service.

What Do the Data in Tables 8 Tell Us about the Behavioral/Social Interventions Received by 241.1 Tracked Youth During the Tracking Period 1?

- Of all 241.1 tracked youth, 70% received at least one behavioral/social intervention service.
- The top three behavior/social interventions received by youth were (1) community service; (2) anger management (Not ART); and (3) independent living services.
- Participation rates were highest for 241.1 tracked youth placed in life skills training, pro-social activities, anger management (Not ART), and Anger Replacement Therapy (ART). Non-attendance/participation was highest among youth given community service (42%). None of the youth referred to/receiving independent living services were participating—two-thirds of youth were referred only and one-third were not attending.

Table 8: Distribution of Behavioral/Social Interventions Received by Type and Youth Participation Status at the End of Tracking Period 1

	N (%)	Youth Status in Each Service				
		Referral Only	Participating	Not Attending	Completed	Terminated
Total Number of 241.1 Tracked Youth	23	---	---	---	---	---
Total Number of 241.1 Tracked Youth Receiving Behavioral Services	16 (70%)	---	---	---	---	---
Of Those Who Received Services, What Type of Service Did They Receive?						
Community Service	12 (52%)	17%	33%	42%	---	---
Anger Management (Not ART)	8 (35%)	13%	63%	13%	13%	---
Independent Living Program	3 (13%)	67%	---	33%	---	---
Anger Replacement Therapy	2 (9%)	---	52%	---	50%	---
Life Skills/Social Skills Training	2 (9%)	---	100%	---	---	---
Pro-Social Activities	2 (9%)	---	100%	---	---	---
Mentoring	1 (4%)	---	100%	---	---	---

NOTE: "---" denotes "not applicable." Percentages across the types of services do not add to 100% because youth often received more than one type of service.

What Do the Data in Tables 9 Tell Us about the Educational Services Received by 241.1 Tracked Youth During the Tracking Period 1?

- Of all 241.1 tracked youth, 83% received at least one educational service.
- The top three educational services received by 241.1 tracked youth were (1) tutoring; (2) getting youth enrolled in school; and (3) credit recovery programs.
- Almost all who were expected to enroll in school were in the process or had completed this expectation. Participation rates were also high for attending a credit recovery program and participating in an attendance monitoring program. Although non-attendance rates were low for educational services overall, it was highest for tutoring services, IEP meetings, and weekly attendance monitoring.

Table 9: Distribution of Educational Services Received by Type and Youth Participation Status at the End of Tracking Period 1

	N (%)	Youth Status in Each Service				
		Referral Only	Participating	Not Attending	Completed	Terminated
Total Number of 241.1 Tracked Youth	23	---	---	---	---	---
Total Number of 241.1 Tracked Youth Receiving Educational Services	19 (83%)	---	---	---	---	---
Of Those Who Received Services, What Type of Service Did They Receive?						
Tutoring	12 (63%)	33%	42%	25%	---	---
Enroll Youth in School	9 (47%)	11%	78%	---	11%	---
Credit Recovery Program	6 (32%)	17%	67%	17%	---	---
Daily Attendance Monitoring	5 (26%)	---	80%	---	20%	---
AB 167 Appropriate	5 (26%)	60%	20%	---	---	---
IEP Team Meeting	5 (26%)	20%	20%	20%	---	---
Weekly Attendance Monitoring	5 (26%)	20%	40%	20%	---	20%

NOTE: "---" denotes "not applicable." Percentages across the types of services do not add to 100% because youth often received more than one type of service.

What Do the Data in Tables 10 Tell Us about the Probation Conditions Ordered by the Court for 241.1 Tracked Youth During the Tracking Period 1?

- Of all 241.1 tracked youth, 100% were given at least one Probation condition by the court.
- The top three Probation conditions received by 241.1 tracked youth were: (1) attend school and maintain grades; (2) participate in counseling; and (3) do not drink alcoholic beverages.
- Adherence rates were highest for school related conditions while violation rates were highest for alcohol and drug related conditions.

Table 10: Distribution of Probation Conditions Received by Type and Youth Participation Status at the End of Tracking Period 1

	N (%)	Youth Status For Each Condition		
		Adhered	Violated	Completed
Total Number of 241.1 Tracked Youth	23	---	---	---
Total Number of 241.1 Tracked Youth Receiving Probation Conditions	23 (100%)	---	---	---
Of Those Who Received Services, What Type of Service Did They Receive?				
9-Attend School and Maintain Grades	23 (100%)	61%	39%	---
30-Participate in Counseling	19 (83%)	58%	32%	11%
17-Not Drink Alcoholic Beverages	17 (74%)	41%	59%	---
8-Perform Community Service	14 (65%)	43%	36%	21%
19-Must Submit to Drug Testing	11 (48%)	36%	54%	---
20-Must be Randomly Tested for Drugs/Alcohol	9 (39%)	44%	56%	---
18-Not Be Around Using or Selling Drugs	8 (35%)	38%	62%	---
9a-Participate in High School Grad/GED/WIN Program	8 (35%)	75%	13%	12%
10-Participate in Afterschool Program/Tutoring	5 (22%)	80%	20%	11%
13b-Not Knowingly Participate in Gang Activity	4 (17%)	75%	25%	---

NOTE: "---" denotes "not applicable." Percentages across the types of services do not add to 100% because youth often received more than one type of service.

Findings for 241.1 Tracked Youth Outcomes

What Are the Outcomes for 241.1 Tracked Youth at the End of Period 1 (4 Months after Disposition)?

Using data collected from the first tracking period, this section reports how youth are doing on the following measures: placement stability, school performance, and new violations and/or arrests.

What Do the Data in Table 11 Tell Us about the Outcomes for 241.1 Tracked Youth at the End of Period 1 (i.e., the First 4 Months after Disposition)?

- Although a quarter of youth experienced placement changes during this period, youth experienced little change in the type of placement they lived in over time—i.e., it appears as if the placement changes occurred with the same type of placement.
- 78% of youth were enrolled at the end of Period 1. 70% were attending school regularly, but only 22% were doing well at school.
- Over 50% of these youth had a court violation or WIC 777 during Period 1.
- 17% were re-arrested for a crime during Period 1.

Table 11: Outcomes for Tracked Youth by the End of Period 1 (N=23)

	At the Beginning of Period 1	At the End of Period 1
Living Situation		
Group Home (DCFS or Probation)	39%	39%
Relative	30%	30%
Home	17%	17%
Foster Home	13%	13%
Legal Guardian	0	0
Enrolled in School at the End of Period 1*		
No	Not Available	4%
Enrolled at Beginning but not the End	Not Available	9%
Enrolled Throughout the Period	Not Available	78%
Enrolled at the End of the Period	Not Available	9%

Table 6: Outcomes for Tracked Youth at the End of period 1 (N=23)

	At the Beginning of Period 1	At the End of Period 1
School Attendance at the End of Period 1*		
Attends Regularly	Not Available	70%
Attends Sporadically	Not Available	17%
Poor Attendance	Not Available	13%
Academic Performance at the End of Period 1*		
Doing Well	Not Available	22%
Doing Average	Not Available	39%
Doing Poorly	Not Available	31%
Unknown	Not Available	9%
Violations During Period 1		
Court Violations During this Period	Not Applicable	39%
WIC 777 Violations During this Period	Not Applicable	17%
New Charges During Period 1		
New Citations During this Period	Not Applicable	17%
New Arrests During this Period	Not Applicable	17%

**NOTE: Educational data at time of referral was not available at the time this report was prepared but will be included in future reports.*

Summary of Findings

The findings from the 241.1 data collected by DCFS, Probation, and the Department of Mental Health provide unprecedented insight into "who" 241.1 youth are, the challenges they face, the services and conditions they receive, their participation/adherence to those services and conditions, and their outcomes. Although the numbers were small for this report, the findings are consistent with previous research completed in Los Angeles County and nationwide on crossover youth. Confidence in these findings and increased insight into these youths' experiences will also grow as the number of 241.1 youth included in analysis for future reports increases over time. In sum, this is what the current findings tell us:

Characteristics

- Females are more likely to be in the crossover population (i.e., WIC 241.1/involved in both child welfare and juvenile justice systems) than in the general juvenile justice population.

- The overrepresentation of African-American youth is greater within the crossover population than in the child welfare and juvenile justice systems individually.

- These youth and their families have multiple contacts with child welfare; the youth often penetrate deeply into the child welfare system; and the youth have long lengths of stay in out-of-home placements.

- By the time they reach the 241.1 referral stage, many of these youth have had previous contact with the juvenile justice system by way of a criminal charge and/or a status offense

- They are most likely to live in a group homes or with relatives; and at least a third of their arrests are related to their living situations—specifically to their group home placements or their home situations.

- These youth are struggling at school and engaged in behavioral problems that often lead to their current arrest (i.e., the charge occurred at school).

- All of these youth have some indication of a mental health problem and/or an alcohol/drug problem. Almost two-thirds of these youth have indication of co-occurring problems.

System Responses

- Almost all of the 241.1 tracked youth received mental health services and were attending those services during Tracking Period 1. Although many youth received family treatment services referrals or services, a third were still in the "referral only" stage and another third were not attended by the end of Tracking Period 1.

- Only half of 241.1 tracked youth received alcohol/drug services, and the majority of these services were for alcohol/drug education. When given outpatient treatment, most 241.1 tracked youth were not attending services.

- Three-quarters of 241.1 tracked youth received behavioral/social interventions, and most youth were participating in those services; however, these youth were less likely to be engaged in community service compared to other behavioral interventions.

- Over three-quarters of 241.1 tracked youth received educational services related to tutoring, enrollment or credit recovery. Most youth were participating in these services.

- With regard to Probation conditions, adherence to conditions was highest among those related to education and lowest for those related to alcohol and drug use.

Outcomes

- About a quarter of 241.1 tracked youth moved placements during Tracking Period 1, but they moved within the same type of placements rather than to a different level of care (i.e., group home to group home rather than group to relative or home).

- Nearly all of 241.1 tracked youth were enrolled in school by the end of Tracking Period 1; most youth were attending school regularly; and academic performance for over half of these youth fell into the "doing average" or "doing well" categories. *NOTE: Once educational data are provided from Initial Data, it will be possible to compare their progress over time.*

- Recidivism as measured by a new arrest during this period was 17%. *NOTE: Once recidivism rates are measured at 1 year after disposition, the performance of these youth can be compared to the recidivism rates of 241.1 youth not served by the MDT (collected from a previous study).*

Taken together, these findings indicate that youth are receiving services related to the challenges they face. However, it appears that substance abuse, particularly as a co-occurring problem with mental health, continues to be an issue for some youth. Such problems can, in turn affect their placement, education, and recidivism outcomes. The results presented in this report raise questions about the appropriateness of treatment and in particular, whether co-occurring problems are identified and connected to appropriate services for these youth. Additionally, it raises questions about the engagement of families in treatment. Family conflict and fragmentation is a critical issue for most of these youth, yet it is an area in which few youth receive services, and when services are identified, the execution of those services is quite low. This finding underscores the need to redefine and broaden the definition of family for youth whose immediate, biological families may not be available for services on a regular and consistent basis.

The literature on effective programming and outcomes for youth with complex needs and risk factors is clear: Effective services require (1) matching youth needs and risks to appropriate levels of service, (2) using multi-modal treatments to address different risks and needs (often related) simultaneously, and (3) meaningfully engaging youth and their families in services. While these data cannot measure all of these issues to their fullest extent, they provide insight into each of these issues and a unique opportunity to examine youths' progress over time. Currently, the findings are based on a small number of youth, but over the next year, the number of youth in the database will grow, and it will be possible to track their trends and learn more about their successes and challenges post-disposition.

FSP OMA Living Arrangement Exception Reasons and Corrections (Revised 1/29/10)

Exception Reason	Explanation of the Exception	Example/ Comment	Type of Correction Needed	Corrective Action
Client has Multiple Baselines/Multiple Baseline within 365 days	Only one baseline should be done for a client unless the client has been disenrolled from FSP for 365 days. The "new start of FSP" must be greater than 365 days from the date of disenrollment (partnership status change) in the disenrollment Key Event Change (KEC). The mistake often involves an agency creating a second baseline or when additional baselines are done for a client when he/she transfers to another agency or re-enrolls back to services when client has not been away for more than 365 days from the status change date on the disenrollment KEC.	Multiple agencies may need to coordinate the correction process. Each agency will have to follow steps outline by MHSA Implementation Unit.	Investigate the problem and determine whether there truly is a duplicate baseline. Once you determine there is a duplicate baseline, you need to identify which baseline you wish to keep and delete the duplicate baseline and any assessments (KEC and 3M's) associated with the duplicate baseline. Often multiple agencies need to coordinate the data correction process when client's data resides in multiple agencies.	Submit a Data Change/Request form to delete duplicate baseline. OMA team will investigate which baseline to keep and any KEC's or 3M's that needed to be re-entered due to the assessments associated with the baseline that needed to be deleted.
Partnership Date on Baseline is Prior to 7/1/2005	July 1, 2005 is the earliest possible start date for FSP in Los Angeles County. The July 1, 2005 start date only pertains to a few directly operated programs, most programs started after December 1, 2006.	When making a change to the partnership date, one must always go back and make sure the baseline information is correctly representing the revised 12 month period.	Partnership dates cannot predate CW authorization date. Discuss with Countywide Age group Authorization unit when necessary. Need to make the partnership date change and change living arrangement date range to match. Changes to the partnership date may change the 3M due dates.	Changes to partnership date and living arrangement ranges can be changed directly in the OMA by the provider. If changing of the partnership date affects the 3M(s) due dates, information on the 3M needs to change to reflect accurate time frame of the 3M assessment(s).
Baseline Disenrolled over 365 Days	If a client is re-enrolling into FSP after having left the program for more than 365 days from the date of disenrollment indicated on a KEC, a new baseline is needed.	A client is enrolled in FSP on 7/1/06 and disenrolls on 8/30/06 according to the KEC. The client returns to FSP on 9/2/07, and the agency does a reestablishment KEC when a new baseline should have been done.	Need to confirm a second baseline is needed for the client.	Delete the KEC that was created for re-establishment and instead create a new baseline for the client
Partnership Date in AdminInfo is null/ blank	The report considers the partnership date as the start of the FSP services. Without the date, the report cannot make the comparison of pre-partnership days and changes that took place after the FSP started.	None	Determine when the client was enrolled in the program. This needs to be the first date of service billed in the IS for the program. For FSP, this date cannot predate the countywide authorization date.	Provider needs to input the partnership date and ensure correct date range for the living arrangement and baseline info.

Exception Reason	Explanation of the Exception	Example/ Comment	Type of Correction Needed	Corrective Action
Maximum "Date To" on Baseline LA Not Equal to Partnership Date - 1	Baseline living arrangement date range must include 365 consecutive, non overlapping days. The last "Date To" date must be the day before the partnership date. The earliest "Date From" date must be 365 days before the partnership date. **Remember that 2008 was a leap year which means there was an extra day in Feb. You need to account for this extra day if your partnership date falls on or between 3/1/08 - 2/28/09.**	If Partnership date= 7/15/09. Date from and to range = 7/15/08 to 7/14/09. Minimum "date from" = 7/15/08. Maximum "date to" = 7/14/09	The most recent "date to" (end date) needs to be one day before the partnership date. Consult the living arrangements example (attached) if needed.	Need to list all the days within the correct date range by the provider. Changes can be made directly in the OMA.
Minimum "Date From" on Baseline LA Not Equal To Partnership Date - 365			The earliest date from (start date) needs to be 365 days before the partnership date. Consult the living arrangements example (attached) if needed.	
Has "Date To" on Baseline LA Greater Than or Equal To Partnership Date			The pre-partnership living arrangements cannot extend into the partnership. The information by definition is based on the 12 months prior to enrollment.	
		Partnership date for leap year =1/15/09. Wrong Date Range= 1/15/08 to 1/1409. This yields 366 days. Correct Date Range= 1/16/08 to 1/14/09, which will yield 365 days	Take into account of the extra day due to a leap year. Need to adjust the range (Move the start date a day later). Affects partnership dates from 3/1/08-2/28/09 inclusive.	
Does Not have a total of 365 Days of Pre-Partnership Living Arrangements	365 days of pre-partnership living arrangements on baseline are required. Validation exists now in OMA to prevent this from occurring. Exclusion due to this reason pertain to very early OMAs that predate the validation.	None	Need to examine the correct date range for the client and ensure all data is captured.	Provider is able to make the changes in the OMA
Residential Type selected Can Not be Checked on Tonight Column	IMD, "Mental Health Rehabilitation Center" (MHRC), Prison, Jail, Community Treatment Facility (CTF)", "California Youth Authority/DOJJ", "Probation Camp/ Ranch", 'lives in a group home (L12), "Lives in a group home (L14), "State Psychiatric Hospital", "Juvenile Hall", "Skilled Nursing Facility (Psychatric)", can not be checked as a residential type in the "tonight" column on baseline. Clients can not be enrolled into FSP until they are discharged from the aforementioned placements. These residential types can be checked in the "Yesterday" column in the baseline LA with other residential types endorsed in the tonight column.	Remember the "tonight" column signifies where the program housed the client on the first day they enrolled in FSP. For example if a client is picked up from jail or a hospital and then housed in an emergency shelter the same night, emergency shelter should be checked in the tonight column.	Mark the appropriate residential setting where the client was housed upon enrollment. If the client was moved around on that first day, pick where the client was at 11:59 as the residential type to record in the "tonight" column.	Provider can make the change by logging onto OMA and checking the appropriate box for a residential type other an those listed in the explanation. Remember that only one living arrangement can be checked to be saved.
Tonight Column Checked for More than one Baseline Living Arrangement	You can only record one residential type in the "tonight column". If the client stayed in multiple locations on the first day of partnership, choose where the client was at 11:59 p.m. The client cannot be in more than one place at 11:59 on the night of partnership.	See above for information on residential types that cannot be selected in the "tonight column".	Select the correct living arrangement type at the start of the partnership.	Provider is able to make the changes in the OMA by ensuring one box and only one box is checked.
Tonight Column Not Checked for any living arrangement	A check in the "tonight" column represents the first residential type the client stays in on the first night of the FSP. This is considered the first "post-partnership" living arrangement of the partnership. A living arrangement must be indicated in the "tonight" column on the baseline.	None	Need to examine the correct living arrangement type the client resides in on the 1st day (at 11:59pm) of the partnership.	Provider is able to make the changes in the OMA
More than one Living Arrangement KEC on the Same Date	Two or more living arragement KEC's filed for the same status change date. Client can only be in one residential placement per night at 11:59pm.	None	Will have to determine which living arrangement KEC(s)is correct and which one(s) need to be deleted .	Submit a Data Change/Request form to delete unneeded residential KEC(s) from the same status change date.

Full Service Partnership Outcomes Measures Application Employment Exception Reasons and Corrections

Baseline Data

- **Total Weeks Not Equal to or Greater than 52:** Assessments where the total number of weeks for all employment statuses including unemployed and retired does not equal 52 weeks or greater.
- **Partnership Date Missing**: The Partnership Date signifies the start of the program (1st day of service claimed). For FSP, Partnership Date = enrollment date and cannot pre-date the Countywide Administration Authorization Date.
- **Duplicate Baseline Detected:** Only one baseline should be done for a client unless the client has been disenrolled from FSP for more than 365 days. The "new start of FSP" must be greater than 365 days from the date of disenrollment (partnership status change) in the disenrollment Key Event Change (KEC). The mistake often involves an agency creating a second baseline or when additional baselines are done for a client when he/she transfers to another agency or re-enrolls back to services when client has not been away for more than 365 days from the status change date on the disenrollment KEC.

Key Event Change (KEC) Data

- **Conflicting Current Employment/Unemployment:** When nothing is reported in all of the Current Employment fields and No is answered to the question: Is the client unemployed at this time?
- **Missing Date of Employment Change:** An employment change is indicated on the KEC but the Date of Employment Status Change is left blank.
- **Conflicting Employment/Unemployment KEC:** When there is nothing reported in all of the Current Employment fields and "No" is answered to the question, "Is the client unemployed at this time?"
- **Missing Partnership Status Change on Disenrollment or Reestablishment:** A disenrollment or reestablishment is indicated on the KEC but the Date of Partnership Status Change is left blank.
- **Employment Change Date on KEC Prior to Partnership Date:** A KEC should not reflect a change that occurred prior to the client's enrollment in the FSP program.
- **Unemployment Reason Reported and Unemployment Not Checked:** The KEC reported a reason for unemployment without indicating the client is unemployed.
- **Unemployment Checked and No Reason Given:** Unemployment is indicated on the KEC but the reasons for unemployment are left blank.
- **Unemployment Reason Conflicts with Unemployment Status:** The KEC indicates the client is employed at the time, but answered the reasons for unemployment.

School Threat Assessment and Response Team Program and Outcomes FY 2013-2014

A. START Program

In response to community concern about the potential for violence in schools, the Los Angeles Police Department (LAPD) in collaboration with the Department of Mental Health (DMH) established a School Threat Assessment and Response Team (START) in 2008 to prevent Targeted School Violence (TSV) in the city of Los Angeles. This collaboration paired law enforcement officers with licensed mental health clinicians dedicated to the prevention of TSV in the city of Los Angeles. The clinicians are certified to place individuals on a 72 hour involuntary psychiatric hold (WIC5150), if they are a danger to themselves, others, or are gravely disabled due to a mental disorder. Clinicians are also trained in violent threat risk assessment. This is the first co-response model dedicated exclusively to the prevention of TSV. In 2009, the DMH Emergency Outreach Bureau secured funding to expand START to the entire county of Los Angeles.

B. Program Objectives

START has three main objectives:

- ✓ Prevention and reduction of targeted school violence in Los Angeles County
- ✓ Provision of on-going support and assistance to students at risk, their families/caregivers and schools through interventions, trainings, and consultations and
- ✓ Establishment of partnerships with schools, law enforcement, and other involved community organizations

C. Accomplishments

START has responded to thousands of incidents where law enforcement officials, school authorities and other individuals had concerns about potential violence on

elementary school, middle school, high school, and college campuses. The Program

takes service requests 24/7 in all eight service areas of Los Angeles County. In FY's 2012-2013 and 2013-2014, START completed more than 4,000 threat assessments and trained at least 2,800 individuals annually.

Table 1 encompasses the percentages of START clients received crisis intervention involving assessment, crisis intervention, and linkage services in FY 2013-2014. SMART/START Central (14%) provided the highest number of crisis interventions, followed by SA 6 PMRT (13%), SA 3 PMRT and SA 7 PMRT (12%), MET (9%), SA 2 PMRT, SA 4 PMRT (8%), SA 8 PMRT (7%), SA 1 PMRT, SA5 PMRT, LBMET (5%), and HOPE (2%).

Table 1

START Clients Received Crisis Intervention*

	SMART/ START Central	SA 1 PMRT	SA 2 PMRT	SA 3 PMRT	SA 4 PMRT	SA 5 PMRT	SA 6 PMRT	SA 7 PMRT	SA 8 PMRT	MET	LBMET	HOPE
%	14%	5%	8%	12%	8%	5%	13%	12%	7%	9%	5%	2%

Source provided by Quality Improvement Division

START has developed the multi-phased service protocol specific for the target population in Los Angeles County. The risk assessment represents best practice guidelines from the 2002 Safe School Initiative, the Risk Assessment Guide for Education-Violence, and the Canadian Center for Threat Assessment and Trauma Response Group which has worked to develop protocols for a variety of entities and highlighted the importance of identifying disconnected kids or "empty vessels" (Cameron, 2005). The violence threat risk assessment process is dynamic in nature by virtue of the various external and internal factors at play: the students' internal dynamics, the external pressures confronting the student, the unique pressures perceived by the student, and the various risk or protective factors at play. The recognition that risk level can change quickly requires a threat management system that is both flexible and responsive to the new sources of information, and which involves five action service protocols which are utilized by START.

The first action is to determine whether or not immediate detention is indicated through law enforcement detention or involuntary psychiatric hospitalization based on the facts available. The threat assessment process typically follows a standard evaluation protocol. As soon as the threat is reported, the START team conducts timely assessment/interviews of the student who made the threat, the recipients of the threat,

and/or other witnesses who have knowledge of the threat. The purpose of the assessment/interview is to evaluate the student's threat in the context, so that the meaning of the threat and intent of the student can be determined.

The START team's criteria for referrals involves an individual who makes a direct threat against an academic institution, a teacher, or school peer/s: when the individual is highly suicidal and not linked to mental health services, when an individual is chronically being bullied or bullies others, and when an individual makes references to and/or is preoccupied with weapons or explosives.

The second action is a comprehensive clinical assessment of the student and collateral interviews with significant others including parents, school personnel, counselors, safety officers, local police, campus threat management teams, therapists, neighbors, roommates, and classmates. These sources provide key information such as educational standing, criminal history, peer and adult relationships, and developmental issues critical to understanding the dynamics unique to each student.

Variables associated with risk include the teams' clinical assessment of the level of risk the student exhibited, scores on the MOSAIC[1] for Assessment of Student Threats (MAST), endorsement of the Menninger Triad[2], Columbia-Suicide Severity Rating Scale (C-SSRS)[3], psychiatric diagnoses, prior psychiatric hospitalizations, and educational ability (as reported by educators)[4], substance abuse[5], history of violence[6], weaponry[7], fascination with violence, and bullying or victimization[8]. The final determination of the individual's level of risk is made by START clinical staff who considers all known information before arriving at a designation of risk.

A third action involves gathering factual information with the consent of the responsible parties including a review of the student's backpack, locker, journals, social media accounts, car, home, bedroom, and other storage sites. This action may occur prior to, during and/or after the comprehensive clinical assessment.

The fourth action is the development of a safety net and provision of intervention for the student addressing the dynamics or issues propelling the student toward TSV, as well as for the student at risk of being bullied and self-harm. A student who becomes stable and maintains at low risk of self-harm and/or harm to others is referred to appropriate services based on the individuals' needs.

The intervention phase involves immediate response to address the safety of the student being assessed as well as their danger to others. A student at imminent risk is placed involuntarily in an inpatient hospital. Follow-up intervention is provided after discharge from the hospital. Intervention and follow-up are uniquely implemented according to whether the student presents with a risk to others, bullying, risk to self and/or whether the risk is low. A brief description of each intervention and follow-up process is provided below.

1. Danger to Others

For the student who presents with a danger to others, START clinicians participate in school individualized education plan meetings, re-entry or team decision making meetings, and campus threat management team meetings. Meetings with parents and therapists are also critical to this process.

2. Bullying

In cases in which a student was a victim of bullying, the student is linked to mental health treatment, intensive case management, referral to a support group, and/or assisting the family, and consultation with parents and school staff. The proposed treatment plan also includes strategies to school personnel on how best to deal with the perpetrators or bystanders.

3. Danger to Self

If the student presents with a high level of suicidality, the START clinicians work with the student, family members, treating therapist, and psychiatric hospitals for discharge planning. START also works with school officials in developing a safety plan. START provides linkage to mental health treatment if the student is not receiving mental health services and provides consultation and collaboration with other service providers to ensure the appropriate level of care.

4. Low Risk of Self-Harm and/or Harm to Other(s)

A student who is identified as low risk for targeted school violence (MOSAIC score less than 4) is discussed and reviewed in START's weekly team case consultation meetings to develop an appropriate treatment plan. This treatment plan is then presented to the appropriate mental health program for discussion and reviewed once accepted or modified. The treatment facility/clinic is advised to contact START should the student exhibit behaviors of concern.

The fifth action step involves long term and intensive monitoring. Interventions are rendered on a regular basis as determined by the individual's needs. START maintains regular collateral contacts and collaborates with schools and other involved professionals to ensure an individual receives appropriate support and assistance in dealing with their presenting problems.

In summary, the START team conducts an assessment and develops interventions which include intensive case management strategies for individuals with the above criteria. The START team maintains an open case until the individual is assessed to be stable in the following areas: home, school, work, therapy and psychiatry (if psychotropic medication is prescribed).

As previously noted, fluidity is a major challenge: the student may not initially follow through with recommendations, the parents may choose denial as a solution and not provide necessary support, the school may not want to invest in the student, or the mental health system might be ill prepared to provide ongoing intervention and treatment. Obstacles may also arise based on faulty interpretations about HIPAA, FERPA, patient-therapist confidentiality, and other right-to-privacy concerns.

In addition to the five action steps described, START has accomplished and added two more components to the services, i.e., training and partnerships.

Training

Training was designed to develop situational awareness, train law enforcement, school campus personnel and, threat management teams on violence/threat risk assessment and develop relationships to sustain START's effort. START trained 2,885 individuals in FY 2013-2014 (see Table 2). As a result of these extensive training efforts, START provided consultation and services in K-12 schools, and high educational campus.

Table 2

Trainings

Training	Students-12th Grade/Under		College Students		Professionals		Parents		Total	
	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees
Targeted School Violence	0	0	3	190	39	2177	0	0	42	2367
START Program	0	0	0	0	13	302	0	0	13	302
Bullying	3	85	0	0	3	101	1	30	7	216
Total	3	85	3	190	55	2580	1	30	62	2885

Partnerships

START has developed partnerships with ten college campuses and numerous law enforcement agencies in Los Angeles County. The ten college campuses include: Los Angeles Mission College, Los Angeles Valley College, Pierce College, Los Angeles Community College, East Los Angeles College, Rio Hondo College, Los Angeles Trade Technical College, Compton College, El Camino College, Santa Monica College and Southwest College. The law enforcement agencies that START is collaborating with include police departments in the cities of Los Angeles, Burbank, Santa Monica, Santa Clarita, Long Beach, Alhambra, and LA County Sheriff.

The collaborations include psychiatric assessments for students in crisis, consultation with threat management teams, and intensive case management for students that present with danger to self or others, monitoring of students of concern and training on threat assessment.

Reduction in Suicidal Risk Level

START rated clients low, medium, or high on their suicidal risk levels during the initial assessment as well as after START and other services were provided. Seven (6%) clients remained at the same suicidal risk level, 47 (42%) lowered the risk by one level, and 58 (52%) by two levels.

Table 4

Change in Suicidal Risk Level

Rating	Remained the same level	Lower risk by one level	Lower risk by two levels	Increase risk	TOTAL
Number of Clients	7	47	58	0	112
%	6%	42%	52%	0%	100%

Reduction in Risk Level for Danger to Others

START rated clients low, medium, or high on homicidal risk levels during the initial assessment as well as after START and other services were provided.181 (85%) clients were rated the same risk level for danger to others at pre and post assessments. The 181 clients remained at low homicidal risk level, received brief intervention and were referred to appropriate service agencies. Additionally, 31 clients were provided intensive case management services. Of the 31 clients, 25 (12%) lowered homicidal risk by one level, 4 (2%) by two levels, and 2 (1%) increased by one level.

Table 5

Change in Homicidal Risk Level

Rating	Remained the same level	Lower risk by one level	Lower risk by two levels	Increase risk by one level	TOTAL
Number of Clients	181	25	4	2	212
%	85%	12%	2%	1%	100%

D. Cases

Case Summary #1

The START program received a referral for an adolescent male. He was referred by his therapist due to concerns associated with homicidal ideations. He was evaluated for violence threat risk. The client expressed frequent homicidal ideations toward other students. He discussed students who were popular and spoke of his desire to belong,

but being rejected. The client reported a history of chronic bullying and described fantasies of how he would kill people by using a knife and torturing his victims.

The START team worked collaboratively with his parents, treatment team, school police, and school staff. The school scheduled a team meeting initiated by START. The team also advocated for the educationally based interventions since he was having a difficult time with academics. A different school setting was agreed upon. Additionally, issues of bullying were identified and addressed with school administrators, and a plan to prevent victimization was created which included monitoring. START monitored the client frequently, particularly during the times of transitions START helped the client identify options for the future and assisted him in obtaining an identification card so that he has the documents necessary to obtain a job. The client eventually reported a source of significant stress regarding gender identity. He never disclosed this information to anyone, but expressed it to the START team approximately 1.5 years after initial contact. The client was provided with information and resources to help him cope with challenges and is no longer expressing homicidal ideations. He is future oriented and interested in pursuing his academics START continues to be involved and is in the process of helping him establish public and other financial resources.

Case Summary #2

The client was referred to START by a hospital where the client was placed involuntarily for being a danger to himself and others. In an online submission to a university, the client expressed hopelessness and thoughts of hurting others. These thoughts and feelings were triggered after academic failure and the prospect of not being able to attend a university. He sent a threatening email where he expressed hopelessness and anger. In the threat, the client blamed the academic institution for the situation and that the rejection would cause disappointment among his family who had worked tirelessly in his attempts to pursue his academics and that his family had sacrificed everything for him. There was no known history of mental health problems trauma, violence, or substance abuse with the client or within his family.

START became involved when the psychiatric hospital sent a referral upon the client's admission. Police and hospital records of the incident were requested and reviewed. The hospital reported that the client's mother minimized the situation and had a difficult time understanding the need for and agreeing to mental health services.

Rapport and trust was developed with the family which allowed the team to gather collateral information and gain acceptance for mental health services. The team then visited the hospital to interview the client, and gathered information that, along with the hospital assessment and collateral from the client's mother, provided enough to

complete a MOSAIC assessment. The team decided that a priority for the client was to link him to mental health services that could address the entire family.

START provided continuing follow-up to check on the client's status and offer additional support while he received therapy treatment. The client was reassessed and determined to present a low level of risk, successfully completed treatment with the therapist stating that the client's symptoms had been addressed and was provided with resources as part of a safety plan in case the client began to experience excessive stress or thoughts of harming himself or others. The lead counselor at the school was informed about the student's potential need for additional support in case the client ever presented to their center.

E. AWARDS

1) In 2012, START was recognized by the Ash Center for Democratic Governance and Innovation at the John F. Kennedy School of Government, Harvard University, as one of the 111 innovative government initiatives, known as Bright Ideas.

2) In 2013, START received an award by the National Association of Counties (NACo). NACo recognizes programs that are innovative, modernizes county government and increases services to county residents.

3) In October 2013, START received a Special Merit Award by the Productivity and Quality Awards Program. The Productivity and Quality Awards Program honors departmental productivity and quality improvement efforts deserving recognition by the Board of Supervisors, Chief Executive Office, Quality and Productivity Commission, and the public.

4) In October 2013, START received the MILES Award at the Miles Conference sponsored by Supervisor Michael Antonovich. This award is presented yearly at the MILES Conference to programs that have gone the extra mile and have developed collaboratives with law enforcement to address the issues of mental health.

References

(1) MOSAIC **threat assessment Systems (MOSAIC)** is a method developed by Gavin de Becker & Associates in the early 1980s to assess and screen threats and inappropriate communications. Walt Risler of Indiana University assisted in the early development of the method, and Robert Martin, founding commander of the Los Angeles

Police Department Threat Management Unit played a role in later development and enhancements. (Martin now heads up the MOSAIC threat assessment Unit at Gavin de Becker & Associates.)The first MOSAIC systems were developed more than twenty-five years ago. The computer-assisted MOSAIC method is now used by the Supreme Court Police to assess threats to the Justices, by the U.S. Capitol Police for threats against Members of Congress, by police agencies protecting the governors of eleven states, by many large corporations, and by more than twenty top universities.

There are different MOSAIC systems for different situations, including:

- Threats and fear in the workplace
- Threats by students
- Threats against judges and other judicial officials
- Threats against public figures and public officials
- Domestic abuse situations

The MOSAIC method poses a series of questions to users, accompanied by a range of possible answers. For every area of inquiry, the system provides a button for "Premise of the Question" – providing immediate on-screen research citations about why that particular area of inquiry is part of the assessment process. MOSAIC calculates the value of the answers selected by the assessor, and expresses the results on a scale of 1 to 10 and a quality score with a maximum value of 200 that is an indication of whether there is enough information about the case for MOSIAC to compare it to other known cases. Unlike most assessment tools, many of which are paper checklists, MOSAIC automatically produces a full written report, describing the factors that were considered and the selections made by the user. MOSAIC's on-line resources include a library of research, publications, and training videos that users can access during an assessment

(2, 3) The Menninger Triad refers to a person's wish to die, wish to kill, and wish to be killed C-SSRS consists of suicidal risk factors ranging from ideation, intent, attempt, method, and plan. It is available in over 100 languages, and takes part in the national and international public health initiative on suicidality assessment. The C-SSRS was originally designed for an NIMH-funded suicide study. Dr. Kelly Posner and her colleagues have established the validity of this assessment tool.

(4) Education ability is defined as average or grade level ability (no special education or advanced placement), or gifted (honor roll, advanced placement, or exceptional capabilities as per the educational record).

(5) Substance abuse is defined as the persistent or severe use of drugs or alcohol.

(6) A history of violence is categorized as either yes or no with yes responses indicating that the individual has a history of attacking others with lethal means, inflicting serious injury on another person, or having maliciously destroyed significant amounts of property as per documented reports.

(7) Weaponry is taken into account what weapons the student personally owned or had ready access to. Guns in the home owned by parents are considered weapons possessed by the student even if they were in a locked safe and the parents report that their child does not have access.

(8) Bullying is measured by self-report, school observations, and the observations of others in the student's life. Bullying is considered to be persistent chronic emotional distress and torment inflicted by others which may or may not include physical tormenting such as being tripped or hit.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
DISENROLLMENT GUIDELINES	**VIII.**	**11/1/2006**	**1 of 3**

PURPOSE: To establish a procedure for the disenrollment of a Full Service Partnership (FSP) client from a FSP program.

DEFINITION: Disenrollment can apply to either an interruption or a discontinuation of service. An interruption of service is defined as a temporary situation in which the client is expected to return to services within twelve (12) months or less from the date of last contact. A discontinuation of service is defined as a long-term situation in which the client is not expected to return to services for more than twelve (12) months from the date of last contact. The reasons for disenrollment are as follows:

1. Target population criteria are not met. Client is found not to meet target population; in most cases, clients who are discovered to have no major mental illness or serious emotional disturbance (SED).

2. Client decided to discontinue Full Service Partnership participation after partnership established. Client has either withdrawn consent or refused services.

3. Client moved to another county/service area. Client relocated to a geographic area either outside or within L.A. County, and has discontinued FSP services.

4. After repeated attempts to contact client, client cannot be located. Client is missing, has not made contact with FSP agency. Agency may request disenrollment of a client after multiple documented outreach attempts for at least thirty (30) days but not more than ninety (90) days.

5. Community services/program interrupted – Client's circumstances reflect a need for residential/institutional mental health services at this time (such as, an Institute for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC) or State Hospital (SH). Client is admitted to an IMD, MHRC or SH.

6. Community services/program interrupted – Client will be detained in juvenile hall or will be serving camp/ranch/ CYA/jail/prison sentence. Client is anticipated to remain in one of these facilities for over ninety (90) days.

7. Client has successfully met his/her goals such that discontinuation of Full Service Partnership is appropriate. Client has successfully met his/her goals, as demonstrated by involvement in meaningful activities, such as, employment, education, volunteerism or other social activities and is living in the least restrictive environment possible, such as an apartment. The client no longer needs intensive services.

8. Client is deceased. This includes clients who died from either natural or unnatural causes after their date of enrollment.

GUIDELINES: Countywide Programs Administration must authorize all requests for client disenrollment from the FSP program prior to an agency officially terminating services.

1. Upon determining that a client meets disenrollment criteria, the FSP agency will complete the Full Service Partnership Disenrollment Request Form and submit it to the age-appropriate Impact Unit Coordinator for pre-authorization of disenrollment.

2. Impact Unit Coordinator will review the disenrollment request within five (5) business days of receipt. Clients that meet FSP disenrollment criteria will be pre-authorized and forwarded to Countywide Programs Administration. For clients that do not meet disenrollment criteria, Impact Unit Coordinator will complete and send Full Service Partnership Disenrollment/ Transfer Request Supplemental Form to FSP program. FSP program must continue services.

3. Countywide Programs staff will review the request for disenrollment and pre-authorization information and will notify the FSP program and Impact Unit of authorization for disenrollment within two (2) business days. Once disenrollment is authorized, the FSP program may close the case in the DMH Integrated System (IS) and relevant Data Collection System (see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

   If Countywide Programs staff does not authorize client for disenrollment they will complete and send Full Service Partnership Disenrollment /Transfer Request Supplemental Form to FSP program and Impact Unit. FSP program must continue services.

4. If FSP agency does not agree with the decision of the Impact Unit or Countywide Programs Administration, then agency may file an appeal (see III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer).

A client transferring from one FSP program to another FSP program is not considered a disenrollment (see V.C. Transfer of Clients Between Full Service Partnership Programs).

FORMS:

- Full Service Partnership Disenrollment Request Form
- Full Service Partnership Disenrollment/Transfer Request Supplemental Form

REFERENCES:

- http://dmhoma.pbwiki.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

MARVIN J. SOUTHARD, D.S.W.
Director
ROBIN KAY, Ph.D.
Chief Deputy Director
RODERICK SHANER, M.D.
Medical Director

MHSA FISCAL YEAR (FY) 2015/2016 ANNUAL UPDATE
AVAILABLE FOR PUBLIC REVIEW

March 30, 2015

The Los Angeles County Department of Mental Health (LACDMH), as required under the Mental Health Services Act (MHSA), is opening a Public Review and Comment period for the MHSA FY 2015/2016 Annual Update. The Public Review and Comment period will begin March 30, 2015 and expires April 29, 2015. During the Public Review and Comment period, an open Public Hearing will be held at St. Anne's, 155 N. Occidental Blvd., Los Angeles, CA 90026. The Public Hearing will be hosted by the Los Angeles County Mental Health Commission on May 28, 2015 and the reception is scheduled to begin at 11:30 AM.

The document under review is posted on the LACDMH website (http://dmh.lacounty.gov/wps/portal/dmh/press_center/announcements), and hard copies are available at the LACDMH MHSA Implementation and Outcomes Division, 695 South Vermont Avenue, 8th Floor, Los Angeles, CA 90005. Any member of the public may request a hard copy of the document by contacting Debbie Innes-Gomberg, Ph.D. at 213-251-6817.

To provide input, recommendations and comments, please email your comments to DIGomberg@dmh.lacounty.gov or submit written comments to:

Los Angeles County Department of Mental Health
MHSA Implementation and Outcomes Division
Attention: MHSA Annual Update FY 2015/2016
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005
Fax: (213) 351-2762

LA COUNTY BOARD OF SUPERVISORS
Hilda L. Solis I Mark Ridley-Thomas I Sheila Kuehl I Don Knabe I Michael D. Antonovich

Los Angeles County Department of Mental Health
Mental Health Services Act (MHSA)
MHSA Fiscal Year (FY) 15/16 Annual Update
30-day Public Review and Comment Period
March 30, 2015 – April 29, 2015

PUBLIC REVIEW

Personal Information (OPTIONAL)	
Name:	
Agency/ Organization:	E-mail address:
Mailing Address:	

Comments

Any member of the public may submit written comments on or before April 29, 2015. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

Los Angeles County Department of Mental Health
MHSA Implementation and Outcomes Division
Attention: Debbie Innes-Gomberg
695 S. Vermont Ave, 8th Floor
Los Angeles, CA 90005
Fax # (213) 351-2762

PUBLIC ANNOUNCEMENT

PUBLIC HEARING OF THE MHSA FISCAL YEAR (FY) 2015/16 ANNUAL UPDATE

LOS ANGELES COUNTY MENTAL HEALTH COMMISSION
Dr. Larry Gasco, Chairperson, Presiding

Thursday, May 28, 2015
11:30 AM – 3:00 PM
St. Anne's Auditorium
155 N. Occidental Blvd.
Los Angeles, CA 90026

Public Hearing Purpose

- An open forum featuring a presentation on the status of programs funded by the Mental Health Services Act and an opportunity for public comments and feedback on the Department's MHSA's programs.

Agenda

11:30 – 12:30 PM	Reception (Lunch provided)
12:30 – 12:45 PM	Opening Session (Welcome & Introductions) - Dr. Gasco
12:45 – 12:50 PM	Overview of Public Hearing Process - Susan Rajlal
12:50 – 1:45 PM	MHSA Annual Update - Dr. Innes-Gomberg
1:45 – 2:50 PM	Public Comments Period - Dr. Gasco
2:50 – 2:55 PM	Close Public Comments Period - Dr. Gasco
2:55 – 3:00 PM	***Next Steps** - June 25, 2015 Full Commission Meeting

- Spanish & Korean translation services will be available
- For American Sign Language and other translation services contact: Cheryl Peterson at (213) 251-6827 by Thursday, May 7, 2015
- MHSA documents and meetings are posted for public review and comments at: http://dmh.lacounty.gov/wps/portal/dmh/press_center/announcements
- Media inquiries: Kathleen Piche, PIO, (213) 738-4041

The Commission will be conducting its regular full meeting on June 25, 2015. At that meeting, the Commission will have its final discussion on the process and propose a motion.

For more information, please contact the Office of the Mental Health Commission at (213) 738-4772 or email your questions to Mentalhealthcommission@dmh.lacounty.gov

LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – MHSA IMPLEMENATION AND OUTCOMES DIVISION

Mental Health Services Act (MHSA) Annual Update Fiscal Year 2015-16 Summary - May 28, 2015

1

MHSA Plan Components

- **Community Services and Support (CSS) Plan:**
  *Feb. 14, 2006**
- **Workforce Education and Training (WET) Plan:**
  *April 8, 2009**
- **Information Technology Needs Plan:**
  *May 8, 2009**
- **Prevention and Early Intervention (PEI) Plan:**
  *Sept. 27, 2009**
- **Innovation (INN) Plan:**
  *Feb. 2, 2010**
- **Capital Facilities Plan:**
  *April 19, 2010**

* Date Approved by the State

3

Purpose and Facts

- The Mental Health Services Act stipulates that counties shall prepare and submit a MHSA Three-Year Program and Expenditure Plan with Annual Updates
- The Plan requires a 30 day public comment period and a Public Hearing
- Mental Health Director and County Auditor Controller certify compliance with laws and regulations
- The plan must be approved by the Mental Health Commission and adopted by the Board of Supervisors
- Information and data presented is from the prior Fiscal Year (FY) 2013-14

2

MHSA Funding Information

MHSA funding is allocated as follows:

Component	Annual Percentage of MHSA	Reversion Period
CSS	80%	3 years
PEI	20%	3 years
INN	5% of CSS + 5% of PEI	3 years*
WET	One time funding	10 years
CF	One time funding	10 years
TN	One time funding	10 years
Housing	One time funding	10 years

*The county is required to utilize 5% of the total funding for CSS and PEI for Innovation Programs
Counties can allocate up to 20% for CF/TN, WET and the Prudent Reserve for any year after 07-08

Content of the MHSA Annual Update

- Introduction
- Executive Summary
- MHSA Plan Approval Dates
- MHSA County Fiscal Accountability Certification
- Acronyms
- Definitions
- Community Planning Process
- Community Services and Supports (CSS)
  - *CSS Client Counts*
  - *CSS Programs*
  - *Full Service Partnership (FSP) Outcomes*
  - *Alternative Crisis Services Outcomes*
  - *CSS Client Counts by Service Area*

5

Content of the MHSA Annual Update

- Innovation
- Workforce Education and Training (WET)
- WET Regional Partnership
- Technological Needs
- Capital Facilities
- Budget
- Appendix

7

Content of the MHSA Annual Update

- Prevention and Early Intervention (PEI)
  - *PEI Client Counts*
  - *Evidence Based Practices Delivered*
  - *Early Intervention Projects and Implementation*
  - *PEI Practices Implemented*
  - *PEI Prevention Programs*
  - *PEI Outcomes*
  - *PEI Client Counts by Service Area*

6

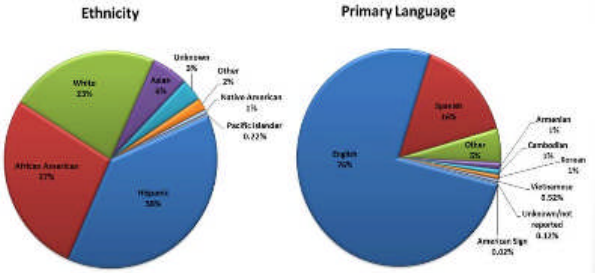
Key Dates

March 25, 2015	Presentation of the Annual Update to the System Leadership Team
March 26, 2015	Presentation of the Annual Update to Mental Health Commission
March 30 – April 29, 2015	Public Posting of Plan for 30 days
March – June 2015	SLT review of status of implementation of programs and services in the 3 Year Plan
April – Summer 2015	Incorporating SAAC recommendations and ongoing planning with 3 Year Plan, including PEI recommended changes requiring additional review and discussion
May 28, 2015	Public Hearing convened by the Mental Health Commission
June 25, 2015	Mental Health Commission deliberation on approval of the Annual Update
July – August 2015	Board letter submission and adoption, posting of final Annual Update on website and submission to the Mental Health Services Oversight and Accountability Commission

8

Community Services and Supports Plan

Unique clients receiving a direct Mental Health Service through the CSS Plan: 102,330



9

CSS Children Full Service Partnership (FSP)

- 2,352 unique clients served
- 1,771 slots allocated by the end of FY 2013-14
- 1,092 clients disenrolled in FY 2013-14
- 63% of disenrolled clients met goals
- $13,441 was the average cost* per client for FY 2013-14

*Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.

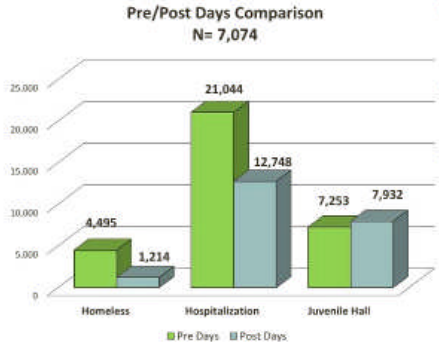
11

CSS Services by Service Area

Service Area	Unique Clients Served	New Clients Served
1	6,703	3,606
2	16,373	7,651
3	8,738	3,815
4	26,977	11,694
5	8,481	4,013
6	15,718	7,387
7	7,142	2,302
8	18,812	7,655

10

FSP Child Living Arrangement Outcomes

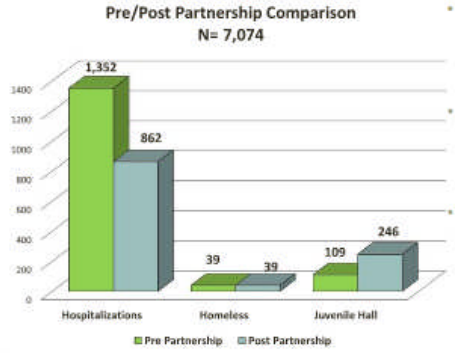


- 73% Reduction in Days Spent Homeless
- 39% Reduction in Days Spent Hospitalized
- 9% Increase in Number of Days Spent in Juvenile Hall

Data annualized through June 30, 2014

12

FSP Child Living Arrangement Outcomes



- 36% Reduction in Number of Clients Hospitalized
- No Change in the Number of Clients Homeless
- 126% Increase in Number of Clients in Juvenile Hall

Data annualized through June 30, 2014

13

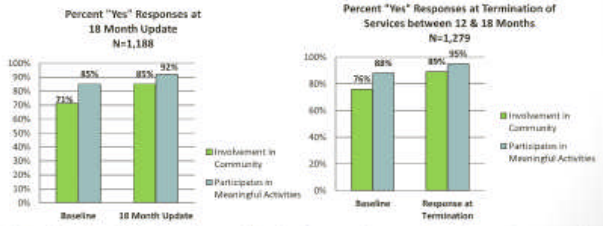
CSS Children FCCS: Implementation Status of MHSA 3 Year Plan Expansion

- **Work Plan:** Child Field Capable Clinical Services (C-05)
- **Proposal:** Expand to serve an additional 330 clients for each FY 2014-15, 2015-16 and 2016-17
- **Implementation Status:** Expand Children's IFCCS contracts. County counsel reviewed and approved the proposal. DMH reviewed and approved the budget. At present time the IFCCS contracts are in the process of being amended.
- **Estimated Implementation Date:** May 2015
- **Location:** All Service Areas

15

CSS Children Field Capable Clinical Services (FCCS)

- 8,879 unique clients served
- $5,558 was the average cost* per client for FY 2013-14
- Intensive Field Capable Clinical Services (IFCCS) began June 1, 2013



*Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.

14

CSS – Children Family Support Services

- 255 families received services
- 95 families received respite care services
  - 53 surveys were completed
  - 77% of caregivers surveyed reported reduced stress after respite care services
  - 83% of caregivers reported overall satisfaction with services
  - 91% of caregivers reported they would recommend it to other caregivers

16

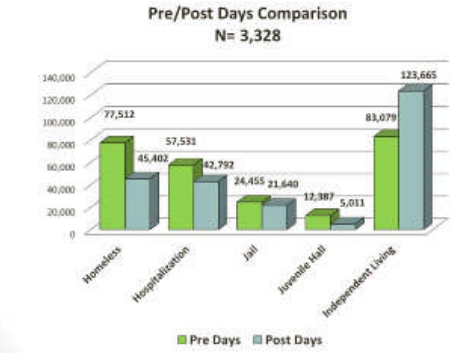
CSS – Transitional Age Youth (TAY) FSP

- 1,661 unique clients served
- 1,250 slots allocated by the end of FY 2013-14
- 657 clients disenrolled in FY 2013-14
- 38% of disenrolled clients met goals
- $11,326 was the average cost* per client for FY 2013-14

*Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.

17

TAY FSP Living Arrangement Outcomes

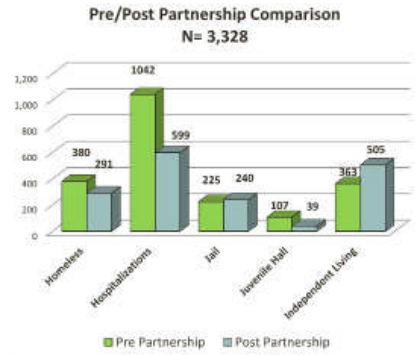


- 41% Reduction in Days Spent Homeless
- 12% Reduction in Days Spent in Jail
- 26% Reduction in Days Spent Hospitalized
- 49% Increase in Number of Days Spent Living Independently
- 60% Reduction in Number of Days Spent in Juvenile Hall

Data annualized through June 30, 2014

18

TAY FSP Living Arrangement Outcomes



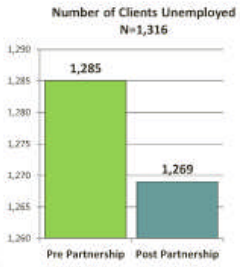
- 43% Reduction in Number of Clients Hospitalized
- 39% Increase in Number of Clients Living Independently
- 23% Reduction in Number of Clients Homeless
- 64% Reduction in Number of Clients in Juvenile Hall
- 7% Increase in Number of Clients in Jail

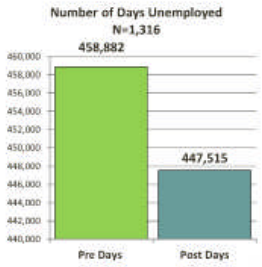
Data annualized through June 30, 2014

19

TAY FSP Employment

- 1% Reduction in Number of Clients Unemployed
- 3% Reduction in Number of Days Unemployed

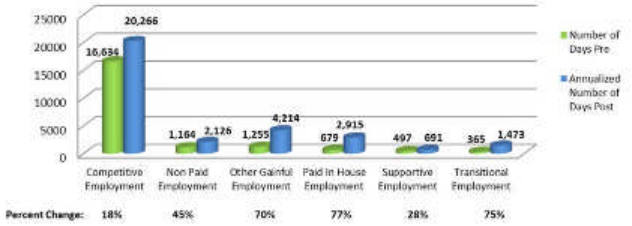




20

TAY FSP Employment

FSP TAY Clients Spent More Days in Positive Employment Post-Partnership



21

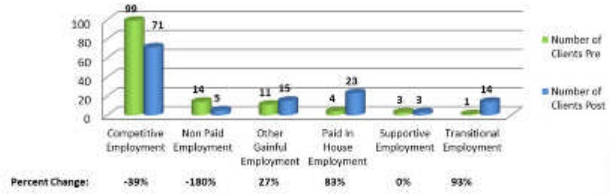
TAY FSP: Implementation Status of MHSA 3 Year Plan Expansion

- **Work Plan:** TAY Full Service Partnership (T-01)
- **Proposal:** Expand the number of slots by 18 over the three (3) fiscal years
- **Implementation Status:** FSP slots were expanded for the Independent Living Program (ILP) agencies to provide the appropriate level of mental health services and support to TAY to address their mental health and co-occurring substance abuse issues while residing in an ILPs. The ILPs will provide housing and supportive services for TAY existing in the Department of Children and Family Services, Probation or foster care and who are at risk of becoming homeless.
- **Implementation Date:** October 2014
- **Location:** Service Areas 2, 3 and 6

23

TAY FSP Employment

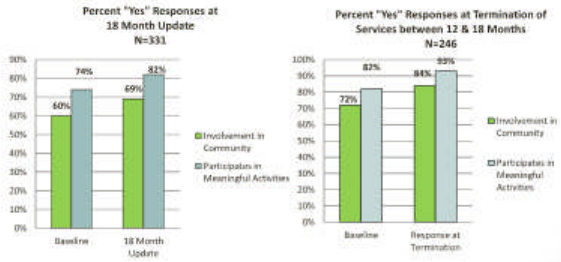
More FSP TAY Clients Reported Working in Other Gainful Employment, Paid In House Employment, and Transitional Employment Post-Partnership



22

CSS TAY FCCS

- 2,443 unique clients served
- $4,575 was the average cost* per client for FY 2013-14



*Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.

24

CSS TAY FCCS: Implementation Status of MHSA 3 Year Plan Expansions

- **Work Plan:** TAY Field Capable Clinical Services (T-05)
- **Proposal:** Increase capacity by 36 clients over the three (3) fiscal years.
- **Implementation Status:** Focus on Independent Living Program (ILP) agencies to be able to provide the appropriate level of mental health services and supports to TAY to address their mental health and co-occurring substance abuse issues while residing in ILPs.
- **Implementation Date:** October 2014

25

CSS TAY Systems Development

- TAY Drop-In Centers: 1,087 individuals served
- Implementation Status of MHSA 3 Year Plan Expansion
  - **Work Plan:** TAY Drop-In Centers (T-02)
  - **Proposal:** Serve an additional 400 clients in FY 2014-15
  - **Implementation Status:** Request for Services (RFS) to solicit TAY Drop-In Center services is being reviewed internally by DMH
  - **Estimated Implementation Date:** FY 2015-16
  - **Location:** To be determined

27

CSS TAY Systems Development

- TAY Housing support: 814 clients served through Enhanced emergency shelter program and by housing specialists
- TAY Probation Camp services: 1,915 clients served by multi-disciplinary teams, including peer/parent advocates providing assessment and comprehensive treatment to TAY with mental illness in 6 camps across the county

26

CSS TAY: Implementation Status of MHSA 3 Year Plan Expansion

- **Work Plan:** New Program - TAY Supported Employment Services (T-06)
- **Proposal:** Train current TAY mental health providers in implementing supportive employment services within their existing mental health delivery system.
- **Implementation Status:** Request for Services (RFS) to solicit TAY Supported Employment Services is being developed.
- **Estimated Implementation Date:** FY 2015-16

28

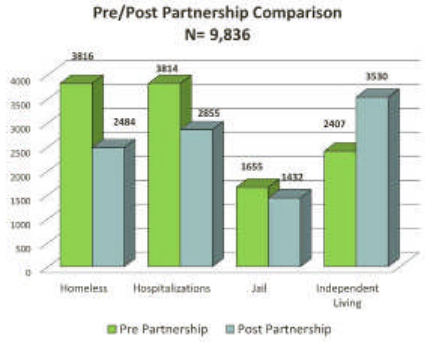
CSS Adult FSP

- 5,453 unique clients served
- 4,866 slots allocated by the end of FY 2013-14
- 1,737clients disenrolled in FY 2013-14
- 42% of disenrolled clients met goals
- $ 10,720 was the average cost* per client for FY 2013-14

*Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.

29

Adult FSP Living Arrangement Outcomes

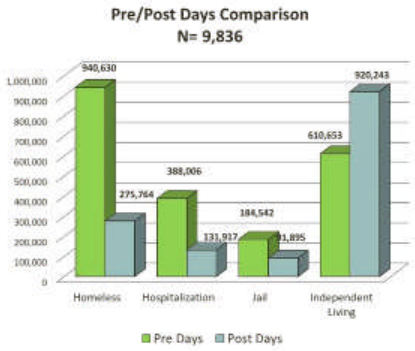


- 25% Reduction in Number of Clients Hospitalized
- 35% Reduction in Number of Clients Homeless
- 47% Increase in Number of Clients Living Independently
- 13% Reduction in Number of Clients in Jail

Data annualized through June 30, 2014

31

Adult FSP Living Arrangement Outcomes



- 71% Reduction in Days Spent Homeless
- 50% Reduction in Days Spent in Jail
- 66% Reduction in Days Spent Hospitalized
- 51% Increase in Number of Days Spent Living Independently

Data annualized through June 30, 2014

30

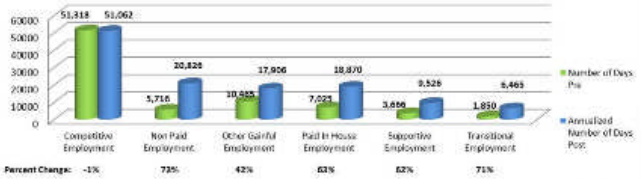
Adult FSP Employment

- 1% Reduction in Number of Clients Unemployed
- No Change in Number of Days Unemployed

32

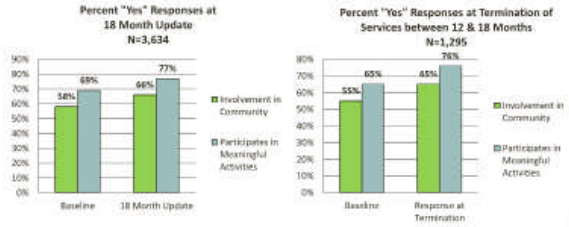
Adult FSP Employment

FSP Adult Clients Spent More Days Working in Non-Paid Employment, Other Gainful Employment, Paid In House Employment, Supportive Employment and Transitional Employment Post-Partnership



CSS Adult FCCS

- 9,984 unique clients served
- $3,832 was the average cost* per client for FY 2013-14



*Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.

Adult FSP: Implementation Status of MHSA 3 year Plan Expansion

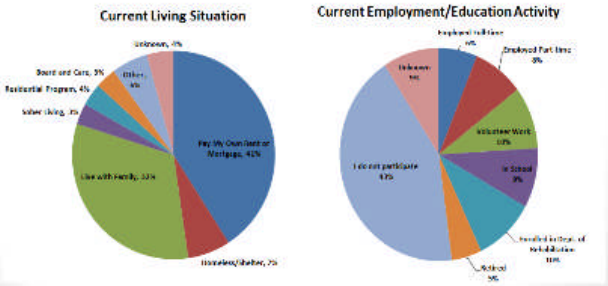
- **Work Plan:** Adult Full Service Partnership (A-01)
- **Proposal:** 25 slots will be added in FY 2014-15
- **Implementation Status:** Request for Services (RFS) draft completed.
- **Estimated Implementation Date:** July 1, 2015
- **Location:** Service Areas 1 and 5

Adult FCCS: Implementation Status of MHSA 3 Year Plan Expansion

- **Work Plan:** Adult Field Capable Clinical Services (A-06)
- **Proposal:** Increase clients served by 50 for FY 2014-15
- **Implementation Status:** Board letter is in progress to add staff to the directly operated clinics.
- **Estimated Implementation Date:** July 1, 2015
- **Location:** Service Areas 4 & 5

CSS Wellness/Client-Run Centers

- Unique clients served with a direct mental health (Mode 15) service: 52,558
- Client contacts (via Mode 45- peer services): 70,707



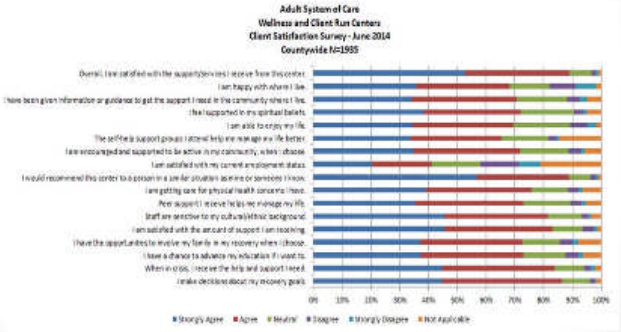
37

Wellness/Client Run Centers: Implementation Status of MHSA 3 Year Plan Expansion

- **Work Plan:** Wellness/Client Run Centers (A-02)
- **Proposal:** Adjunct services for clients in Wellness Centers who are not in need of intensive services as part of this model will include medication management, non-intensive case management, and peer support. Estimated to serve an additional 29,000 clients in FYs 14/15, 15/16 and 16/17.
- **Implementation Status:** Funding was added to provider's budgets. Providers have started hiring.
- **Estimated Implementation Date:** January 2015
- **Location:** All existing Wellness and Client Run Centers

39

CSS Wellness/Client-Run Centers (cont.)



38

Wellness/Client Run Centers: Implementation Status of MHSA 3 Year Plan Expansion (cont.)

- **Work Plan:** Wellness/Client Run Centers (A-02)
- **Proposal:** The addition of 35 peer staff to directly operated Wellness Centers and to contract Client Run Centers to serve an additional 1,750 clients.
- **Implementation Status:** Funding was added to provider's budgets. Providers have started hiring as of January 2015.
- **Estimated Implementation Date:** January 2015
- **Location:** All existing Wellness and Client Run Centers

- **Work Plan:** Wellness/Client Run Centers (A-02)
- **Proposal:** Expand Client Run Centers to ensure availability in every service area. In FY 14/15 an additional 500 clients would be served.
- **Implementation Status:** Request for Services (RFS) draft completed.
- **Estimated Implementation Date:** July 2015
- **Location:** Service Areas 3 and 5

40

Wellness/Client Run Centers: Implementation Status of MHSA 3 Year Plan Expansions

- **Work Plan:** Wellness/Client Run Centers (A-02)
- **Proposal:** Expand staffing to implement Supported Employment, an Evidenced-based Practice, which assists clients to obtain and maintain employment. 150 clients to be served in FY 14/15.
- **Implementation Status:** In the process of developing pilot training programs.
- **Estimated Implementation Date:** July 1, 2015
- **Location:** To be determined

- **Work Plan:** Wellness/Client Run Centers (A-02)
- **Proposal:** Add one Housing Specialist per program. 1,500 clients to be served in FY 14/15.
- **Implementation Status:** Funding was added to provider's budgets. Providers have begun hiring.
- **Implementation Date:** January 2015
- **Location:** All existing Wellness and Client Run Centers

41

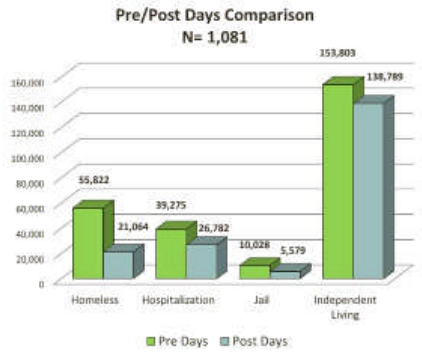
CSS Older Adult FSP

- 759 unique clients served
- 585 slots allocated by the end of FY 2013-14
- 234 clients disenrolled in FY 2013-14
- 24% of disenrolled clients met goals
- $8,309 was the average cost* per client for FY 2013-14

*Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.

42

FSP Older Adult Living Arrangement Outcomes

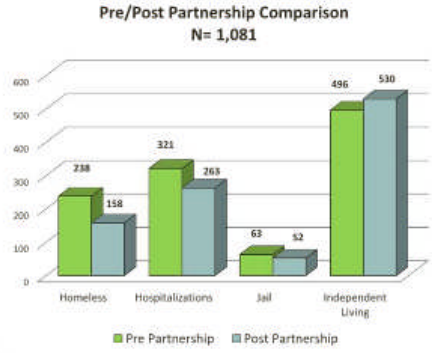


- 62% Reduction in Days Spent Homeless
- 44% Reduction in Days Spent in Jail
- 32% Reduction in Days Spent Hospitalized
- 10% Reduction in Number of Days Spent Living Independently

Data annualized through June 30, 2014

43

FSP Older Adult Living Arrangement Outcomes



- 18% Reduction in Number of Clients Hospitalized
- 34% Reduction in Number of Clients Homeless
- 7% Increase in Number of Clients Living Independently
- 17% Reduction in Number of Clients in Jail

Data annualized through June 30, 2014

44

CSS Older Adult FSP: Implementation Status of MHSA 3 Year Plan Expansion

- **Work Plan:** Older Adult Full Service Partnership (OA-01)
- **Proposal:** Expand slots by 122 over the three (3) fiscal years.
- **Implementation Status:** Contracts to add FSP funding to seven (7) Older Adult FSP providers countywide have been amended
- **Implementation Date:** November 2014
- **Location:** All Service Areas

45

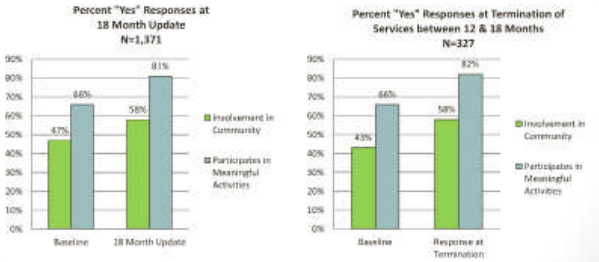
CSS Older Adult FCCS: Implementation Status of MHSA 3 Year Plan Expansion

- **Work Plan:** Field Capable Clinical Services (OA-03)
- **Proposal:** Increase capacity by 456 clients over the three (3) fiscal years
- **Implementation Status:** Contracts to add FCCS funding to 16 Older Adult FCCS providers countywide have been amended.
- **Implementation Date:** November 2014
- **Location:** All Service Areas

47

CSS Older Adult FCCS

- 2,653 unique clients served
- $5,507 was the average cost* per client for FY 2013-14



*Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.

46

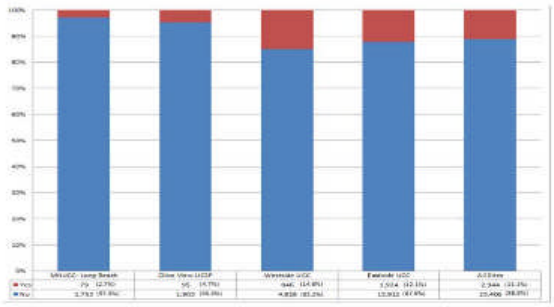
CSS Alternative Crisis Services

- 43,765 clients served
- Countywide resource management coordination
- Residential and bridging program: supportive and linkage services to individuals transitioning out of institutional care
- Mental Health Urgent Care Centers

48

CSS Alternative Crisis Services: Mental Health Urgent Care Centers

Acute Psychiatric Inpatient Hospitalization within 30 Days of UCC Services

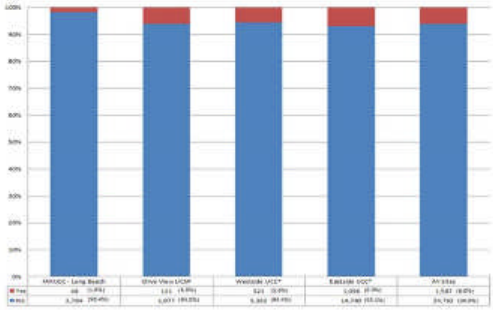


*Westside and Eastside UCCs are the only LPS-designated UCCs; many persons are on a 5150 upon admission and transferred to acute inpatient setting therefore their hospitalization rates are higher.

49

CSS Alternative Crisis Services: Mental Health Urgent Care Centers

Any Visit to a Psychiatric Emergency Room within 30 Days of Being Seen at a UCC



*Westside and Eastside UCCs are the only LPS-designated UCCs; many persons are on a 5150 hold upon admission and are transferred to an acute inpatient setting from the UCC, therefore hospitalization rates are higher from these facilities.

50

CSS Alternative Crisis Services: Implementation Status of MHSA 3 Year Plan Expansion

- Service Component of SB82 California Health Facilities Financing Authority (CHFFA) Grant
- **Work Plan:** Alternative Crisis Services (ACS-01)
- **Proposal:** Request funds from the SB82 CHFFA grant to develop three (3) Urgent Care Centers to be located on the campus of Harbor-UCLA Medical Center, the Antelope Valley and the San Gabriel area to serve 72 individuals at any given time and 35 new Crisis Residential programs to increase capacity by 560 beds countywide
- **Implementation Status:** Request for Proposals written but need to be re-adjusted due to regulation changes
- **Estimated Implementation Date:** TBD
- **Location:** Service Areas 1, 3, and 8

51

CSS IMD Step-Down

- 867 Clients Served for FY 2013-14
- Implementation Status of MHSA 3 Year Plan Expansion: Assisted Outpatient Treatment/Laura's Law
  - **Work Plans:** Adult Full Service Partnership (A-01), Service Area Navigators (SN-01), and IMD Step-Down Facilities (A-03)
  - **Proposal:** Three hundred slots will be added in FY 2014-15 to the Adult FSP program. Service Area Navigators will conduct 500 evaluations and the IMD Step-down Facilities will increase their capacity to serve 60 additional clients.
  - **Implementation Status:** The outreach and engagement prior to enrollment in the FSP will not be provided by Service Area Navigators but by the Department's Emergency Outreach Bureau and will be billed to FSP through a central provider number. The budget for the program will not be impacted as a result of this change nor will any aspects of the program.
  - **Estimated Implementation Date:** May 30, 2015
  - **Location:** All Service Areas

52

CSS IMD Step-Down: Implementation Status of MHSA 3 Year Plan Expansions

- Expanding IMD Step-Down Programs to Help Decompress Los Angeles County Hospital Psychiatric Emergency Services
  - **Work Plan:** IMD Step-Down Facilities (A-03)
  - **Proposal:** 22 beds will be added to the IMD Step-Down program
  - **Implementation Status:** Completed
  - **Implementation Date:** May 2015

53

CSS Adult Housing Services

- **MHSA Housing Program**

Countywide Housing, Employment and Education Resource Development (CHEERD)

Project Sponsor	Project Name	Service Area	Supervisorial District	Target Population	MHSA Units	Total Units	Date of Occupancy	MHSA CO Capital HAB Committed	MHSA CO Subsidy HAB Committed	Total HAB Committed
LTSC Community Development Corp	Larry Hilling Village	4	1	TAY (16-25 ages)	5	45	December 10, 2013	$ 524,150	$ -	$ 524,150
LINC Housing Corporation	Mosaic Gardens	7	1	TAY (16-25 ages)	15	24	January 27, 2014	$ 1,754,316	$ -	$ 1,754,316
Marty Housing California	Caroline Severance Manor	4	2	Families & Single Adults 18+	43	85	March 18, 2014	$ 6,531,640	$ 500,000	$ 9,031,640
				Total Number of Units	68	154		Total	$ 500,000	$ 11,310,306

54

CSS Adult Housing Services: Implementation Status of MHSA 3 Year Plan Expansion

- **Work Plan:** Adult Housing Services (A-04)
- **Proposal:** An investment in capital development and operating subsidies to expand the number of affordable, permanent supportive housing units for Department of Mental Health clients.
- **Implementation Status:** A Board Letter is in process to give DMH authority to transfer the new funds to California Housing Finance Agency.
  - DMH released an Expression of Interest on January 9, 2015.
  - The MHSA Housing Advisory Board recommendation is to commit funds for four new housing projects.
- **Estimated Implementation Date:** May 2015

55

CSS Adult Housing Services: Implementation Status of MHSA 3 Year Plan Expansion

- **Work Plan:** Adult Housing Services (A-04)
- **Proposal:** Extend the current five (5) year contracts which are ending for some agencies. The funding will allow for the expansion of supportive services to more permanent supportive housing programs.
- **Implementation Status:**
  - Contracts amended under delegated authority for current Housing Trust Fund (HTF) providers.
  - A Board Letter is being drafted to amend contracts through FY 2015-16 for those when delegated authority does not exist.
  - In the process of adding HTF to the RFSQ Master Agreements.
  - An RFS is being drafted for the re-designed HTF.
  - New contracts are expected to be in place by July 1, 2016.
  - Due to delays in implementation of the re-designed HTF program and less funding was needed for FY 2014-15 than projected, DMH recommends investing the remaining one-time funds in the MHSA Housing Program in the estimated amounts:
    - FY 2014-15, $255,492
    - FY 2015-16, $1,390,000
- **Estimated Implementation Date:** July 1, 2014

56

CSS Planning, Outreach and Engagement

- 21,209 individual contacts
  - Homeless Outreach and Mobile Engagement Team (HOME): provides county-wide, field-based, and dedicated outreach and engagement services to the most un-served and under-served of the homeless mentally ill population.
  - Under-Represented Ethnic Population (UREP) outreach and engagement projects: aimed at serving unserved, underserved, and inappropriately served populations with the goal of reducing racial/ethnic disparities.

57

CSS Planning, Outreach and Engagement (cont.)

- Crossover Youth Multidisciplinary Team program (MDT): consultation, assessment, team-decision making
- Created for those youth who are part of the Dependency system and then allegedly commit crimes and become simultaneously part of the Delinquency system
- Outcomes for Tracked Youth at the End of Period 1*
  - Data collection began in October 2013 (N=23)
  - 78% of the youth were enrolled in school
  - 70% of youth were attending school regularly
  - 61% of youth were doing either average or above average academically
    - 83% of the youth did not receive any new criminal charges or arrests

*4 months after disposition

58

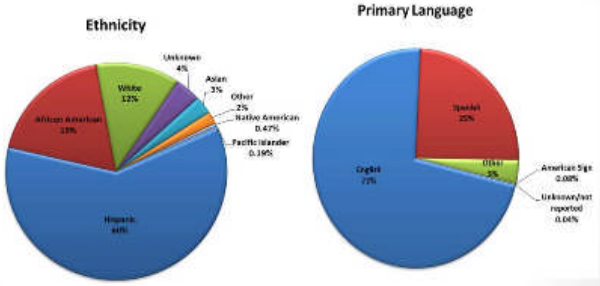
CSS New Program: Implementation Status of MHSA 3 Year Plan Expansion

- **Work Plan:** Community Mental Health Promoter/Community Health Workers
- **Proposal:** Roll out of Promoters/Health Navigator Teams in each Service Area, following an established and tested model, including initial training, coaching and presentations for a small core group of participants. Translate all prepared and available presentations from Spanish to English. Train in-house trainers with the help of Training Consultant to assure sustainability.
- **Implementation Status:** In planning stages to determine culturally relevant strategies with the Under Represented Ethnic Populations groups. Systems Leadership Team will be involved with the discussion.

59

Prevention and Early Intervention (PEI) Plan

Unique clients receiving a direct Mental Health Service through the PEI Plan: 66,628



60

PEI Services by Service Area

Service Area	Unique Clients Served	New Clients Served
1	4,211	2,138
2	11,148	5,543
3	11,898	5,321
4	8,911	4,376
5	2,111	1,037
6	11,600	4,376
7	7,222	3,332
8	11,123	5,228

61

PEI Program Highlights

- Suicide Prevention
  - 24/7 crisis hotline: 24,929 callers (1,321 Spanish speakers)
  - Latina Youth Program: 2,664 contacts and 142 open cases. Decreasing suicide risk by focusing on substance use and depression.
  - Partners in Suicide training: 173 suicide prevention events, outreaching to 4,700 individuals. Trainings include Applied Suicide Interventions Skills Training (ASIST) and Question Persuade and Refer (QPR)

62

PEI Program Highlights (cont.)

- School Mental Health
  - School Threat Assessment and Response Team (START) - reducing the risk of school violence.
    - Out of 112 clients, 42% of contacts with a risk for suicide reduced their risk by one level and 52% by 2 levels
    - Out of 212 clients, 85% of contacts remained at a low homicide risk level, 12% reduced by 1 level, 2% reduced by 2 levels and 1% increased by 1 level

63

PEI Program Highlights (cont.)

- Stigma and Discrimination Reduction (SDR)
  - Children's SDR Project: During FY 2013-14, 60 trainings on mental illness and bullying were provided to parents, children and community members countywide.
  - Older Adults Mental Wellness: The team provided 166 workshops for seniors, participated in 3 health fairs, outreached to more than 2,516 LA County residents and added a service extender to provide presentations in Spanish.
  - Profiles of Hope: A series of 30-minute videos seen on KLCS, LA County's cable TV channel and on YouTube. The 2013 Profiles of Hope feature: Rick Springfield discussing a lifelong battle with depression, Mariel Hemingway bravely speaking out about her family legacy of mental illness and Paris Barclay candidly talking about addiction and suicidal ideation.
  - Family-focused strategies: Provided education about mental illness, treatment, medication, and rehabilitation to consumers' families and parents/caregivers.

64

PEI Program Highlights (cont.)

- Evidence-based practice outcomes for early course treatment of trauma, depression, anxiety, disruptive behaviors, parenting difficulties, severe behavior/conduct disorders
- Example of Pre-treatment vs. post-treatment change analyses include:
  - Trauma Focused Cognitive Behavioral Therapy:
    - Parents have endorsed a 38% improvement in their child's overall functioning and a 37% improvement in trauma symptoms
  - Seeking Safety:
    - 29-35% reduction in symptoms
  - Incredible Years
    - Symptom reduction between 17-33% depending upon measure
- Monitor drop out rates, average length of treatment and number of sessions by practice
- Monitor compliance rates by practice

65

Innovation 1

- 3,374 clients served in FY 13-14 in Integrated care models, including the Peer Run model
- The Integrated Clinic Model, Integrated Mobile Health Team and Integrated Services Management model all demonstrated clinically and statistically significant reductions in mental health, physical health and substance use symptoms
- Link to Innovation 1 final report: http://file.lacounty.gov/dmh/cms1_226026.pdf

66

WET Highlights FY 2013-14

- **Health Navigators Training Program:** 37 trained; 76% represent UREP while 54% spoke a threshold language; To date 26 have been certified
- **Interpreter Training:** 140 (duplicated) participated in the Basic 3 Day and Advanced trainings; 14 monolingual providers enrolled in the monolingual English providers training
- **Intensive Mental Health Recovery Specialist:** 159 participants completed training to qualify as; 76% represent UREP and 50% spoke a threshold language
- **MSW (52)**, **MFT (52)** and **Nurse Practitioner (2) Stipends** awarded with 75% representing UREP and 75% spoke a threshold language
- **Peer Advocates Training :** (duplicated) 41 individuals (23 Basic, 9 Advanced, and 9 Train-The-Trainer)

67

Estimated Budget

	MHSA Funding				
	A	B	C	D	E
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs
A. Estimated FY 2015/16 Funding					
1. Estimated Unspent Funds from Prior Fiscal Years	111,002,520	96,212,705	27,606,858	33,288,792	4,012,679
2. Estimated New FY2015/16 Funding	305,748,897	82,699,308	21,425,210		
3. Estimated Available Funding for FY2015/16	536,841,426	178,907,043	49,032,068	33,288,792	4,012,679
B. Estimated FY2015/16 MHSA Expenditures	384,205,614	114,252,544	4,630,158	18,420,362	8,506,880
C. Estimated FY2016/17 Funding					
1. Estimated Unspent Funds from Prior Fiscal Years	152,637,812	64,654,699	44,421,980	19,964,080	505,990
2. Estimated New FY2016/17 Funding	391,338,607	97,976,449	25,738,819		
3. Estimated Available Funding for FY2016/17	543,976,419	162,630,908	70,160,799	19,964,080	505,990
D. Estimated FY2016/17 Expenditures	384,205,614	114,252,544	23,006,720	13,420,362	297,765
E. Estimated FY2017/18 Funding					
1. Estimated Unspent Funds from Prior Fiscal Years	150,772,806	46,378,404	47,152,023	6,448,088	208,227
2. Estimated New FY2017/18 Funding	391,338,607	97,976,449	25,738,819		
3. Estimated Available Funding for FY2017/18	551,111,413	146,354,853	72,890,846	6,448,088	208,227
F. Estimated FY2017/18 Expenditures	384,205,614	114,252,544	23,006,720	6,448,088	208,227
G. Estimated FY2017/18 Unspent Fund Balance	166,907,799	32,102,309	49,882,128	0	0

B. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2015	160,725,402
2. Estimated Local Prudent Reserve Balance on June 30, 2016	160,725,402
3. Estimated Local Prudent Reserve Balance on June 30, 2017	160,725,402
4. Estimated Local Prudent Reserve Balance on June 30, 2018	160,725,402

68

For More Information on MHSA

Relevant MHSA Guidance

- The Mental Health Services Act
  http://www.dmh.ca.gov/prop_63/mhsa/
- Mental Health Services Act regulations California Code of Regulations Title 9, Div. 1, Chapter 14, Section 3200.010- 3650
- AB 100
- AB 1467

For More Information on LA County MHSA Annual Update

Contact Debbie Innes-Gomberg, Ph.D.
MHSA Implementation and Outcomes Division
Program Support Bureau
Los Angeles County Department of Mental Health
DIGomberg@dmh.lacounty.gov
(213) 251-6817

WELLNESS · RECOVERY · RESILIENCE

70

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THURSDAY, MAY 28, 2015- MHSA FISCAL YEAR 2015-16 ANNUAL UPDATE PUBLIC HEARING
LAC-DMH
155 N. OCCIDENTAL BLVD.
LOS ANGELES, CA 90026
CAPTIONED BY TOTAL RECALL, WWW.YOURCAPTIONER.COM

[MEETING BEGINS AT 12:30 P.M.]

>> PUBLIC MEMBER: ON PAGES 6 AND 7, SLIDES 12 AND 13, THEY'RE A LITTLE BIT DIFFERENT.

>> MARTA ALQUIJAY: SO YOUR PAGES ARE DIFFERENT THAN WHAT IS UP HERE?

>> PUBLIC MEMBER: YES. THEY'RE TWO DIFFERENT SLIDES. GO TO THE ONE SLIDE AND THEN GO TO THE NEXT ONE.

>> MARTA ALQUIJAY: RIGHT. SO, HERE, IN JUVENILE HALL, WE'RE COUNTING DAYS SPENT IN JUVENILE HALL. THAT'S THAT 7,253 TO 7,932.

AND THE NEXT SLIDE, WE'RE COUNTING THE NUMBER OF ENTRANCES. THEY'RE NOT UNIQUE CLIENTS ENTERING, BUT NUMBER OF ENTRANCES. SO IT COULD BE THE SAME CHILD HAVING COME OUT AND GOING BACK IN. IT COULD BE A NUMBER OF THINGS. BUT THAT'S WHAT THIS DATA SHOWS.

>> PUBLIC MEMBER: [INAUDIBLE].

>> MARTA ALQUIJAY: IT'S AN AGGREGATE DATA. SO IT'S NOT AN ACTUAL NUMBER OF INCREASE IN CLIENTS. SO, THIS IS AN AGGREGATE COUNT. SO IT'S NOT THE DIFFERENCE BETWEEN 109 AND 246 IS NOT THE NUMBER OF ACTUAL CLIENTS. IT'S THE NUMBER OF ENTRANCES INTO JUVENILE HALL.

>> PUBLIC MEMBER: [INAUDIBLE].

>> MARTA ALQUIJAY: EXACTLY. IS THAT CLEARER NOW? ALL RIGHT.

>> KARA TAGUCHI: OKAY. HI. SORRY, I'M KARA TAGUCHI. I'M ACTUALLY OVER THE MHSA IMPLEMENTATION AND OUTCOMES DIVISION, SO JUST TO EXPLAIN THE DIFFERENCE BETWEEN THE TWO SLIDES. THE FIRST ONE YOU HAVE IS THE NUMBER OF DAYS. A DIFFERENCE IN DAYS. SO WE LOOK AT THE 12 MONTHS BEFORE PARTNERSHIP AND THEN WHILE THEY'RE IN FSP, EQUIVALENT KIND OF 12 MONTHS, SO IT'S NICE TO SEE A REDUCTION IN HOW LONG PEOPLE ARE IN THOSE DIFFERENT SETTINGS. FOR THE CLIENTS, AND THIS SLIDE, IT ACTUALLY IS THE NUMBER OF CLIENTS THAT HAVE ANY DAYS SPENT IN ANY OF THESE LIVING ARRANGEMENTS. IN THE 12 MONTHS BEFORE OR IN THE 12 MONTHS WHILE THEY'RE IN FSP.

SO, WHEN MARTA WAS TALKING ABOUT WITH THE JUVENILE HALL, THEY INCREASED IN CLIENTS, IT IS – THERE ARE MORE CLIENTS THAT REPORT JUVENILE HALL DAYS WHILE THEY'RE IN FULL SERVICE PARTNERSHIP THAN CLIENTS THAT REPORT IN THE 12 MONTHS PRIOR TO STARTING FULL SERVICE PARTNERSHIP. FOR A VARIETY OF REASONS, THEY HAVE LOOKED INTO THIS. AND I DON'T KNOW IF YOU WANT TO SHARE ANY OF THOSE. IF PEOPLE ARE INTERESTED. YEAH. SO, DO YOU WANT TO SHARE?

>> MARTA ALQUIJAY: WELL, SOME OF THE REASONS HAVE TO DO WITH, WE START OUT WITH 12% OF OUR KIDS COMING INTO FSP BEING AT HIGH- RISK INVOLVEMENT. OR ALREADY HAVE BEEN IN JUVENILE HALL AND COMING DOWN TO A LESS RESTRICTIVE ENVIRONMENT. SO 12, THAT'S A PRETTY SIGNIFICANT PERCENTAGE OF KIDS TO BE DEALING WITH. THE OTHER THING IS THAT AS CHILDREN AGE, BECAUSE OUR SERVICES ARE FOR CHILDREN 0 TO 15, AND PERHAPS BEHAVIORS THAT BEFORE WERE MORE ACCEPTABLE OR DIDN'T GET THEM INTO AS MUCH TROUBLE, THEIR BEHAVIORS BEGIN TO GET WORSE AND WE'RE NOT ABLE TO REALLY MITIGATE THAT. SO NOW, SO MANY EYES ON THEM, THEY DO END UP IN JUVENILE HALL. AND I'M SURE THERE'S MANY OTHER REASONS. BECAUSE THIS IS NOT SPECIFIC TO THIS PROGRAM, THE NUMBER OF KIDS AND MEN OF COLOR GOING INTO THE LEGAL SYSTEM IS INCREASING. WE WERE JUST MEETING WITH THE L.A. COUNTY FOLKS WHO ARE WORKING WITH THE MY BROTHER'S KEEPER INITIATIVE FROM PRESIDENT OBAMA. AND SORT OF LOOKING AT WHAT PROGRAMS CAN DO TO BEGIN TO MAKE DIFFERENCES IN THESE NUMBERS. ALL RIGHT? ANY OTHER QUESTIONS? CONTINUE?

>> DENNIS MURATA: I WAS JUST TOLD THAT WE SHOULD PROBABLY HOLD OUR QUESTION AND COMMENTS UNTIL AFTER, BECAUSE THIS SECTION IS NOT BEING TRANSCRIBED, RIGHT? OKAY. SO IF YOU HAVE A QUESTION OR WANT SOME CLARIFICATION, PLEASE ASK AT THAT POINT, BUT IF YOU DON'T MIND. ACTUALLY, LET'S JUST HOLD OUR QUESTIONS UNTIL AFTER.

>> MARTA ALQUIJAY: ALL RIGHT. SO WE'VE GONE OVER THIS SLIDE.

[CONTINUING WITH THE POWERPOINT PRESENTATION WITH MARTA ALQUIJAY]

[JOO YOON -- TAY]

>> DENNIS MURATA: OKAY, YOU CAN ASK A QUESTION.

>> PUBLIC MEMBER: I PROMISE I'LL SAVE MORE FOR THE END. BUT PAGE 24 IT SAYS INVOLVEMENT IN COMMUNITY AND MEANINGFUL ACTIVITY. WHAT DOES THAT MEAN? I JUST NEED CLARIFICATION.

>> DENNIS MURATA: JOO, DID YOU HEAR THE QUESTION? PAGE 24. IT'S A CLARIFICATION. IT'S NOT A QUESTION, RIGHT? WHAT DOES IT MEAN BY INVOLVEMENT?

>> PUBLIC MEMBER: PAGE 24.

>> PUBLIC MEMBER: SLIDE 24.

>> WENDI TOVEY: OUR FCC OUTCOME MEASURE IS A QUESTION, A SERIES OF QUESTIONS THAT'S JUST YES/NO. AND ONE OF THE QUESTIONS IS DOES THE CLIENT ENGAGE IN MEANINGFUL ACTIVITIES? THE MEANING OF IT IS…

>> PUBLIC MEMBER: WHAT DOES THAT MEAN?

>> WENDI TOVEY: WELL, USUALLY FIELD-CAPABLE CLINICAL SERVICES IS… HOW DO I SAY THIS? IT'S TARGETING FOLKS THAT HAVE DIFFICULTY COMING TO A CLINIC AND WHAT WE WANTED TO DO IS TRY TO FIND A WAY TO MEASURE PEOPLE WHO WERE ENGAGING IN ACTIVITIES THAT THERE WAS A MEANINGFUL WAY FOR THEM TO SPEND THEIR TIME. SO DOES THE CLIENT FEEL THEY ARE SPENDING THEIR TIME IN A MEANINGFUL WAY? AND, ALSO, ARE THEY ENGAGED IN COMMUNITY ACTIVITIES? AND, SO, THOSE TWO THINGS HAVE KIND OF BEEN WHAT WE SEE THE DIFFERENCE ON IN FIELD CAPABLE CLINICAL SERVICES FROM WHAT THEY SAY YES IN THE BEGINNING AND WHAT THEY SAY YES AT DIFFERENT POINTS IN TIME. YEAH.

>> PUBLIC MEMBER: I THINK THE CLARIFICATION, THIS HELPS US ALL. ESPECIALLY ON THIS PART. BUT MAINTAINING SORT OF LIKE THE NARRATIVE DATA, SOME OF THOSE ACTIVITIES THAT ARE ACTUALLY BENEFICIAL IN CASE WE NEED TO REPLICATE THINGS OR MAYBE LATER DEVELOP AROUND IT? BECAUSE THAT WAS VERY VAGUE. WE KNOW FROM THIS MEASURE, THAT ARE VERY GENERAL.

>> PUBLIC MEMBER: CAN YOU PROVIDE AN EXAMPLE OF WHAT THAT MEANS?

>> WELL, SO, THERE WERE PEOPLE THAT -- IF THERE WAS SOMEBODY THAT WAS SITTING IN THEIR HOME AND THEY DIDN'T EVER – THEY DIDN'T WANT TO – THEY WEREN'T ENGAGING IN THEIR COMMUNITY A LOT. BUT YOU KNOW WHAT? THEY GOT OUT OF BED TO WATCH JEOPARDY EVERYDAY AND THAT WAS SOMETHING THAT WAS VERY MEANINGFUL FOR THEM TO GET UP AND DO THAT. AND SO THE THERAPIST MIGHT SAY, YOU KNOW, ARE YOU ENGAGING IN ANY MEANINGFUL ACTIVITIES? IF THE THERAPIST DIDN'T REALLY REALIZE HOW MEANINGFUL THAT WAS TO THE CLIENT. SO IT'S KIND OF DEFINED BY THE CLIENT AS, ARE YOU DOING ANYTHING THAT'S IMPORTANT TO YOU THAT'S MEANINGFUL FOR YOU THAT GETS YOU OUT OF BED, THEY GET YOU INVOLVED WITH THINGS. AS FAR AS THE DETAILS GO, I THINK THAT WE EXPECT THAT THE OUTCOME MEASURES ARE, THEY'RE PRETTY GENERAL. THEY'RE PRETTY, YOU KNOW, VAGUE. BUT ALL OF THE DETAILS ABOUT WHAT IS IMPORTANT OR MEANINGFUL TO THE CLIENT, WHAT ARE THEY ENGAGING IN? THAT ALL KIND OF COMES OUT IN THE THERAPEUTIC RELATIONSHIP.

>> PUBLIC MEMBER: [INAUDIBLE].

>> DENNIS MURATA: OKAY, IF YOU LIKE, I BELIEVE EACH OF THE OF THE AGE GROUP LEADS CAN GIVE YOU SOME EXAMPLES OF WHAT THOSE MEANINGFUL ACTIVITIES ARE. REBA, IT WASN'T FAIR THAT I LET HER ASK A QUESTION. SO GO AHEAD. YOU CAN ASK YOURS.

>> REBA STEVENS: I JUST WANTED TO BE CLEAR. IS THIS AN ERROR ON SLIDE NO. 16 WHERE IT TALKS ABOUT 255 FAMILIES WHO RECEIVED SERVICES? IS THAT ALL OF L.A. COUNTY?

>> DENNIS MURATA: IS THAT IN THE FAMILY SUPPORT?

>> REBA STEVENS: YES, FAMILY SUPPORT SERVICE.

>> DENNIS MURATA: SO KEEP IN MIND. SO THAT IS SPECIFIC TO FAMILIES WHO RECEIVE SERVICES THAT WERE FUNDED BY THAT PARTICULAR ACTIVITY. OKAY?

I MEAN, IF THAT'S ALL WE SAW COUNTYWIDE, THEN I DON'T WE DESERVE TO BE HERE. I MEAN…BUT IT IS COUNTYWIDE, BUT ONLY FOR THAT SPECIFIC PROGRAM. BECAUSE WE SEE IN OUR CONTRACTORS, OR OUR DIRECT OPERATIVE PROGRAMS FOR, ESPECIALLY, FOR OUR CHILDREN SERVICES, A LOT OF THEM ARE FAMILY FOCUSED, SO I WOULD HATE TO GUESS HOW MANY FAMILIES WE ACTUALLY SEE. BUT, NO, IT'S MORE THAN THAT. SO IT'S THIS REPORTING ON THAT PARTICULAR COMPONENT OF THE MHSA.

Note inserted for purposes of clarification: Family Support Services provides time-limited supportive and mental health services to parents or caregivers of children enrolled in FSP who do not meet criteria to receive their own Specialty Mental Health Services. It is an adjuctive service.

>> REBA STEVENS: AND THEN THERE'S ONE OTHER –

>> DENNIS MURATA: I SAID ONLY ONE QUESTION. [JOKING] ALL RIGHT, ALL RIGHT. GO AHEAD.

>> REBA STEVENS: SERVICE AREA 6, WHERE IS THE TAY DROP-IN CENTER? BECAUSE YOU DON'T TELL US WHERE ANY OF THEM ARE LOCATED?

>> DENNIS MURATA: WE CAN GIVE YOU THAT INFORMATION. IT'S IN THE UPDATE? OH. SO IT'S IN THE UPDATE, REBA. SO I GUESS YOU DIDN'T READ THE UPDATE…?

>> REBA STEVENS: CURRENTLY WE DO NOT FUND A DROP-IN CENTER. IT'S NOT IN THE CURRENT UPDATE.

>> DENNIS MURATA: OH, OKAY. BUT WE WILL.

>> REBA STEVENS: CURRENTLY WE DON'T FUND A DROP-IN CENTER IN 6 CURRENTLY.

>> DENNIS MURATA: BUT WE WILL. THAT'S WHAT'S GOING OUT TO BID.

>> TERRI BOYKINS: THAT'S BEING DONE FOR THIS COMING FISCAL YEAR.

>> DENNIS MURATA: AND THAT'S FROM TERRI BOYKINS, THE DEPUTY DIRECTOR OF TAY. SO SHE MADE THAT COMMITMENT. AND SERVICE AREA 6, FOR THOSE OF YOU WHO DON'T KNOW, THAT'S SOUTH LOS ANGELES, THAT AREA? OKAY?

SO, ALL RIGHT. I KNOW, I'M NOT SUPPOSED TO LET PEOPLE ASK QUESTIONS, BUT I'M SORRY.

[LAUGHTER]

NEXT PERSON IS WENDI TOVEY WHO'S GOING TO TALK ABOUT ADULT SYSTEM OF CARE.

[WENDI TOVEY -- ADULT SYSTEM OF CARE POWERPOINT PRESENTATION]

>> PUBLIC MEMBER: THIS IS ALL IN THE WEBSITE?

>> WENDI TOVEY: THIS SHOULD ALL BE IN THE PLAN, YES?

>> PUBLIC MEMBER: WHICH AREAS IS THIS GOING OUT?

>> WENDI TOVEY: [RE:CLIENT RUN CENTER EXPANSION] YES, WE ARE ADDING THEM IN SERVICE AREAS 3 AND 6.

>> PUBLIC MEMBER: IN RESPONSE TO THOSE QUESTIONS, ARE THESE PAID POSITIONS WITH YELLOW BADGES OR GREEN BADGES WHERE THESE CLIENTS ARE RECEIVING STIPENDS ?

>> WENDI TOVEY: THESE ARE POSITIONS. THESE ARE FULL-TIME POSITIONS WITH CONTRACTORS AND D.M.H. I'M TALKING ABOUT BOTH. PAID FULL-TIME POSITIONS.

SO ALL THE DIRECTLY OPERATED, EACH GOT TWO AT EACH WELLNESS CENTER FOR DIRECTED OPERATED. SO IT'S 42 ITEMS ADDED FOR DIRECTLY OPERATED.

>> PUBLIC MEMBER: I WOULD LIKE TO ASK ABOUT THE HOUSING SPECIALISTS? I READ SOME INFORMATION THAT IT'S GOING TO BE REQUIRED TO HAVE A BACHELOR'S DEGREE IN ORDER TO HAVE THAT POSITION. SO I JUST WANTED TO CLARIFY THAT IT'S CORRECT?

>> WENDI TOVEY: THIS IS NOT TRUE. IT IS A MENTAL HEALTH FOR THE DEPARTMENT OF MENTAL HEALTH. WE FUND THAT AT THE LEVEL OF A COMMUNITY WORKER.

>> PUBLIC MEMBER: MY NEXT QUESTION LEADS INTO…

>> DENNIS MURATA: I'M SORRY. CAN EVERYONE HEAR THESE QUESTIONS? DO WE NEED TO REPEAT IT?

>> PUBLIC MEMBER: I CAN'T HEAR IT.

>> PUBLIC MEMBER: MY NEXT QUESTION IS IN REGARDS TO PAGE 34. ON SLIDE 67. HOW MANY OF THESE POSITIONS – [INAUDIBLE].

>> WENDI TOVEY: I'D LIKE TO FINISH MY PRESENTATION. AND THEN WE CAN GET TO THAT. THANK YOU.

[CONTINUING WITH POWERPOINT PRESENTATION]

>> WENDI TOVEY: FOR THE LAST QUESTION, I JUST WANTED TO REPEAT HER QUESTION. IT WAS THAT SHE HAD HEARD THE HOUSING SPECIALIST NEEDED TO HAVE A BACHELOR'S DEGREE AND THAT WAS NOT THE CASE. THEY'RE FUNDED AT A COMMUNITY WORKER. AND IT'S TO BE A PEER POSITION.

NOW THAT'S NOT TO SAY A CONTRACTED FACILITY THAT SOMEONE MAY HAVE A BACHELOR'S THAT IS A PEER. BUT IT IS TO BE A PERSON WITH LIVED EXPERIENCE HELPING OUR CONSUMERS. BECAUSE THAT'S PART OF WHAT WE'RE SUPPOSED TO BE DOING WITH THE MHSA PLAN AS WELL.

>> PUBLIC MEMBER: [INDISCERNIBLE]

>> WENDI TOVEY: OH, THE MIC IS NOT WORKING? I'LL REPEAT WHAT YOU SAY.

>> PUBLIC MEMBER: ALL RIGHT. BASED ON THE WET HIGHLIGHTS 2013 AND 2014, THE BULLET POINT IN REGARDS TO THE HEALTH NAVIGATOR AND INTERPRETER, YOU KNOW, –

>> WENDI TOVEY: CAN I – CAN I STOP YOU FOR ONE SECOND? BECAUSE THIS IS A WET QUESTION. THOSE ARE MY INITIALS, BUT I'M ONLY SPEAKING TO ADULT. SO THE WET PERSON WILL COME UP AND PROBABLY ANSWER YOUR QUESTION BEFORE YOU NEED TO ASK IT. OKAY? THANK YOU SO MUCH.

>> DENNIS MURATA: ALL RIGHT. AND JUST TO LET YOU KNOW, I SHOULD HAVE SAID THIS EARLIER, WHENEVER THE SLIDE TALKS ABOUT IMPLEMENTATION STATUS OF THE MHSA 3-YEAR PLAN EXPANSIONS, THOSE THINGS HAVE ALREADY BEEN APPROVED IN LAST YEAR'S 3-YEAR PLAN. AND THIS IS SIMPLY GIVING YOU AN UPDATE ON WHERE WE ARE ON SOME OF THOSE EXPANSION PROJECTS. BUT I HAVE TO TELL YOU, WHENEVER IT SAYS SOLICITATION OR REQUEST FOR SERVICES, THAT WHOLE PROCESS, IT TAKES MONTHS. WELL OVER A YEAR TO GET THAT OUT AND ON THE STREET AND THEN AWARD IT. SO THAT'S WHY. THIS IS NOT UNUSUAL, CONSIDERING THAT THE PLAN WAS APPROVED ABOUT A YEAR AGO THAT A LOT OF THESE THINGS HAVE NOT HAPPENED.

>> PUBLIC MEMBER: SO JUST FOR CLARIFICATION, WE TALKED ABOUT PROPOSAL [INDISCERNIBLE] IN ADDITION TO THE 35 PEER STAFF, SO THAT'S A PROPOSAL. SO IT WOULD BE ABOUT A YEAR BEFORE THAT ACTUALLY –?

>> DENNIS MURATA: NO, IT DEPENDS. IT DEPENDS. THERE ARE THINGS THAT HAVE TO GO OUT TO BID, BECAUSE THEY'RE RELATIVELY NEW TYPE OF SERVICES THAT HAVE TO BE OPENED IN AN OPEN COMPETITIVE PROCESSES. THERE ARE OTHERS TYPES OF SERVICES THAT ARE ALREADY PART OF A LEGAL ENTITY'S SCOPE OF WORK AND PRACTICE WHERE WE CAN AMEND CONTRACTS AND THOSE TYPE OF THINGS. BUT WHERE IT REALLY TAKES A LONG TIME IS, NOT ONLY IN TERMS OF PUTTING THINGS OUT TO BID, BUT ALSO THE COUNTY PROCESS IN TERMS OF REQUESTING ITEMS AND THOSE KINDS OF THINGS.

SO I WOULD SAY THAT USUALLY, GIVE YOURSELF, OURSELVES AT LEAST 12 MONTHS TO 18 MONTHS OR MORE ON SOME OF THESE NEW PROJECTS TO PUSH THEM FORWARD BUT THERE ARE SOME THINGS WE CAN WITHIN OUR CURRENT CONTRACTS, AND OUR ABILITY TO DO SO, WE CAN AMEND CONTRACTS TO DO THAT.

>> WENDI TOVEY: I JUST WANTED TO STATE THAT ANY CONTRACT POSITION THAT I SPOKE TO, THEIR CONTRACTS WERE UPDATED AND THE DOLLARS ARE IN THERE. SO WE HAVE TWO SOLICITATIONS GOING OUT, BUT ALL THE CONTRACTORS ALREADY HAVE THE DOLLARS TO HIRE. THAT WAS MONTHS AGO.

>> PUBLIC MEMBER: BUT FOR THE 35 PEER STAFF, THEY WERE ASKING QUESTIONS ABOUT, THOSE HAVE ALREADY GONE OUT? OKAY.

>> DENNIS MURATA: AND SOME OF IT IS SIMPLY AN EXPANSION OF SERVICES CURRENTLY GOING ON NOW. BUT THE PROBLEMS THAT WE HAVE IS THAT, SOME OF THESE SERVICES, IT'S JUST THAT YOU CANNOT JUST PUT THOSE THING OUT BY ITSELF, BECAUSE IT NEEDS MORE OF A CONTINUUM OF SERVICES OFFERED BY A PROVIDER. SO, ANYWAY, THOSE USUALLY TAKE A LONGER TIME.

>> PUBLIC MEMBER: SO, FOR EXAMPLE, WITH THE HOUSING, PEER WORKERS, THAT'S FANTASTIC. WE NEED THOSE. CAN WE ALSO GET THE MODIFIED PEER POSITION THAT INTERACT, [INDISCERNIBLE]THEY WILL GET A MODIFIER THAT WORK WITH [INAUDIBLE]. WOULD THAT BE A NEW ITEM OR IS THERE SOMETHING THAT COULD BE, YOU KNOW, INCORPORATED?

>> DENNIS MURATA: ARE YOU TALKING ABOUT THE ITEMS THAT WE'RE GOING TO USE FOR THE DIVERSION PROGRAM OR…?

>> PUBLIC MEMBER: WELL, I'M ASKING FOR CLARIFICATION. IF IT WOULD BE A NEW ITEM TO CREATE POSITIONS LIKE THE HOUSING PEER POSITION TO HAVE A SIMILAR POSITION PERHAPS FOR A PEER THAT INTERACTS

WITH A LAW ENFORCEMENT SERVICES FOR OUR CLIENTS. WOULD THAT BE A NEW ITEM OR WOULD THAT BE A MODIFICATION OF SOMETHING THAT'S ALREADY EXISTING?

>> DENNIS MURATA: WELL, WE HAVE SPECIFIC PLANS IN TERMS OF FOR PROP 47 FOR ASSISTED OUTPATIENT TREATMENT, AND FOR LAW ENFORCEMENT TEAMS, AND THOSE TYPES OF THINGS. SO THOSE ARE FUNDED SEPARATELY, GENERALLY. BUT THE THING IS, IT'S TRYING TO GET SOMEONE THAT KNOWS ENOUGH ABOUT THIS SYSTEM, RIGHT? THAT THEY CAN MAKE THAT OR DO THAT COORDINATION AND THEN MAKE THOSE TYPE OF CONNECTION AND THOSE TYPE OF THINGS.

SO THERE ARE SPECIFIC THINGS I THINK MARY IS GOING TO TALK ABOUT IT AND IRMA CAN TALK ABOUT THE LAW ENFORCEMENT TEAMS AND THOSE TYPE OF THINGS THAT WE WILL FUND. BUT BELIEVE ME, AND I THINK IT WAS SAID TODAY, IN THE MENTAL HOUSE COMMISSION MEETING. I MEAN, THE TOP THREE PRIORITIES, IT'S THE HOMELESS MENTALLY ILL, IT'S TRANSITION AGE YOUTH, AND THERE'S OUR DIVERSION PROGRAM. SO SOME OF THESE THINGS ARE ALREADY PART OF THAT IMPLEMENTATION. BECAUSE THOSE ISSUES HAVE BEEN GOING ON FOR A WHILE. NOW WE NEED TO EXPAND THEM, RIGHT? BECAUSE AS YOU SAW, AS YOU SEE IN SOME OF THE OUTCOMES, SOME OF THE OUTCOMES ARE NOT SO GOOD.

SO THAT'S WHY A LOT OF THESE EXPANSIONS WERE TARGETED TO IMPROVE THOSE AREAS, RIGHT? AND VICKIE, AND I'VE KNOWN VICKIE FOR MANY YEARS. AND EMPLOYMENT IS SOMETHING THAT WE STILL NEED TO WORK ON. IT'S BETTER THAN BEFORE, BUT IT'S NOT WHERE IT SHOULD BE.

>> PUBLIC MEMBER: I KNOW. I'VE BEEN TRYING.

>> DENNIS MURATA: YEAH, YOU HAVE BEEN. OKAY, SO NEXT UP IS MARTIN JONES. HE'S HERE TO TALK ABOUT OLDER ADULTS.

>> PUBLIC MEMBER: CAN SOMEBODY TAKE MY QUESTION ON THE WET?

>> DENNIS MURATA: CAN WE HOLD OFF ON THAT TO WHEN THE WET PRESENTATION IS? OR YOU CAN WRITE IT DOWN AND I'LL MAKE SURE. YOU DON'T WANT TO WRITE IT DOWN?

>> PUBLIC MEMBER: I DON'T WANT TO WRITE IT DOWN. I WANT TO TALK ABOUT IT NOW.

>> DENNIS MURATA: YOU CAN'T.

>> PUBLIC MEMBER: YOU HAVE TO BE PATIENT.

[MARTIN JONES – OLDER ADULTS]

>> PUBLIC MEMBER: QUESTION?

>> MARTIN JONES: SURE.

>> PUBLIC MEMBER: WAS THERE DATA? HOW MANY OF OF OUR OLDER ADULTS ARE LIVING WITH THEIR FAMILY MEMBERS?

>> MARTIN JONES: WE ACTUALLY DO HAVE, BECAUSE OF THE LIVING ARRANGEMENT DATA IS BROKEN DOWN INTO MANY, MANY CATEGORIES, AND, SO, WE DO HAVE THAT INFORMATION. KARA, DID YOU WANT TO SPEAK TO THAT?

>> KARA TAGUCHI: I DIDN'T HEAR THE QUESTION.

>> MARTIN JONES: THE GENTLEMAN WAS ASKING ABOUT IN TERMS OF LIVING ARRANGEMENTS, DO WE HAVE THE DATA FOR HOW MANY ARE LIVING WITH THEIR FAMILIES? AND MY ANSWER WAS THAT WE DO HAVE IT. IT'S BROKEN DOWN INTO MANY, MANY LIVING CATEGORIES, BUT WE DON'T HAVE IT HERE TODAY.

>> KARA TAGUCHI: WE DON'T HAVE IT HERE TODAY, BUT WE DO HAVE IT.

>> PUBLIC MEMBER: IS IT HERE?

>> KARA TAGUCHI: NO.

>> MARTIN JONES: IT'S NOT THERE. NO. WE CAN PROVIDE YOU WITH THAT DATA IF YOU WOULD LIKE IT. OKAY?

ADDED: AT THE END OF THE REPORTING PERIOD, ONLY 1 OLDER ADULT FSP CLIENT WAS LIVING WITH FAMILY

[CONTINUING WITH THE POWERPOINT PRESENTATION]

>> DENNIS MURATA: THANK YOU, MARTIN. MARY MARX WILL BE THE NEXT PERSON TO TALK ABOUT ALTERNATIVE CRISIS SERVICES. AND ALTERNATIVE CRISIS SERVICES INCLUDE THINGS LIKE THE URGENT CARE CENTERS, THE IMD STEP DOWNS AND THOSE TYPE OF PROGRAMS. IS IT COLD IN HERE?

>> ALL: YES!

>> DENNIS MURATA: I SAID TO TURN THE AIR UP TO PEOPLE CAN STAY AWAKE?

>> PUBLIC MEMBER: WE'RE GOING TO DIE.

>> DENNIS MURATA: OH, OKAY. I DON'T WANT THAT TO HAPPEN. SO, CAN WE HAVE THEM –

[MARY MARX – PRESENTATION ON ALTERNATIVE CRISIS SERVICES]

>> PUBLIC MEMBER: QUESTION. DO WE HAVE ANY TYPE OF SIMILAR MECHANISM FOR CATALINA ISLAND CONSTITUENCY WHO ARE SEPARATED BY OCEAN BUT MIGHT STILL NEED SOMETHING LIKE THIS INFORMATION?

>> MARY MARX: OH, CATALINA ISLAND. THE NEAREST URGENT CARE CENTER FOR THEM WOULD BE IN THE HARBOR AREA. WE DON'T HAVE ANYTHING – WE DID NOT HAVE THAT COVERED IN THE GRANT.

>> PUBLIC MEMBER: QUESTION. FOR THE LONG BEACH, IT'S GOING TO BE AT HARBOR GENERAL?

>> MARY MARX: IN THE HARBOR, LONG BEACH AREA, WE DON'T KNOW THE EXACT LOCATION. WE FOUND THAT URGENT CARE CENTERS WORK REALLY MUCH BETTER WHEN THEY'RE IN CLOSE PROXIMITY TO A HOSPITAL. SO, AND THAT'S BEEN ONE –

>> PUBLIC MEMBER: THEY'RE LOOKING FOR THEIR OWN, RIGHT?

>> MARY MARX: THAT'S A SEPARATE THING. NOW, ONE OF THE THINGS ABOUT THEIR URGENT CARE CENTER IS THAT, THEY'RE A CRITICAL PIECE OF THE JAIL DIVERSION PROGRAMS AND THE JAIL POPULATION MANAGEMENT PROGRAMS THAT WE'VE BEEN WORKING ON FOR THE PAST YEAR WITH THE DISTRICT ATTORNEY'S OFFICE AND THE SHERIFF'S DEPARTMENT. AND ONE OF THE THINGS THAT WE WILL PROBABLY BE PILOTING WILL BE A PRETRIAL, OR PREBOOKING DIVERSION PROGRAM AND USING URGENT CARE CENTER AS A STAGING FACILITY FOR THAT WITH PEOPLE IN COLLABORATION WITH THE IRMA CASTENEDA LAW ENFORCEMENT MENTAL HEALTH EVALUATION TEAMS. WE'RE GOING TO BE ABLE TO USE IT FOR STAGING FOR OUR ASSISTED OUTPATIENT PROGRAM.

I JUST WANT TO SAY A LITTLE BIT ABOUT THE CRISIS RESIDENTIAL PROGRAMS. THE MODEL THAT WE'VE PRESENTLY BEEN USING IN THE COUNTY IS A RESPITE CRISIS RESIDENTIAL MODEL. THE CRISIS RESIDENTIAL MODEL WE'LL BE USING FOR THE CHAFFA GRANT WILL BE ON ACUTE DIVERSION MODEL WHICH WILL PROVIDE INTEGRATED HEALTH, MENTAL HEALTH, AND SUBSTANCE ABUSE TREATMENT FOR INDIVIDUALS, AND HOUSING, BUT IT WILL BE THE LENGTH OF STAY WILL BE ANTICIPATED TO BE 10 DAYS TO 21 DAYS.

SO THE IDEA WOULD BE TO STABILIZE PEOPLE FROM THE URGENT CARE OR SERVICE AREAS, AND THEN MOVE THEM BACK INTO COMMUNITY SERVICES AS QUICKLY AS POSSIBLE.

[CONTINUING WITH THE POWERPOINT PRESENTATION]

[REINA TURNER – POWERPOINT PRESENTATION]

>> PUBLIC MEMBER: DO YOU NEED OUR SUPPORT AT THAT MEETING?

>> REINA TURNER: WELL, IT CAN'T HURT.

[LAUGHTER]

>> DENNIS MURATA: REBA, YOU HAVE A QUESTION?

>> REBA STEVENS: I REALLY HAD A QUESTION FOR MS. TURNER. I WOULD LIKE TO KNOW WHAT ARE THE AVAILABILITIES AT THIS TIME FOR ADULT UNITS WHERE THERE IS AN AVAILABILITY? AND I'M CERTAIN THAT YOU HAVE TO BE RECEIVING SERVICES THROUGH THE DEPARTMENT. SO ARE ANY? IS THERE ANYTHING AVAILABLE NOW FOR AN ADULT?

>> REINA TURNER: WE ARE CURRENTLY ACCEPTING CERTIFICATIONS. BECAUSE IN ORDER TO GO INTO A MHSA FUNDED UNIT, YOU MUST BE SERVED BY THE DEPARTMENT, BECAUSE WE ARE THE GATEKEEPER FOR THESE UNITS. WE WANT TO ENSURE THAT THE INDIVIDUALS GOING INTO THESE UNITS ARE ELIGIBLE AND PART OF OUR SYSTEM.

SO, NOW ON OUR WEBSITE, WE DO LIST ALL PROJECTS THAT WE'RE ACCEPTINGLY CERTIFICATIONS FOR. AND FOR ANY TURNOVER UNITS, AS YOU KNOW, HOPEFULLY, YOU ARE ALL AWARE OF THE COORDINATED ENTRY SYSTEM THAT'S BEING IMPLEMENTED ACROSS THE COUNTY. AND, SO, NOW IN ORDER TO QUALIFY FOR A TURNOVER UNIT, YOU MUST BE ENROLLED IN THE CES SYSTEM. AND THAT'S A LONG INVOLVED CONVERSATION. AND I'LL BE HAPPY TO TALK WITH YOU LATER, YOU KNOW, REGARDING THAT PROCESS.

SO, WE DO HAVE SOME TURNOVER UNITS. WE CURRENTLY ARE LOOKING. WE HAVE NINE AVAILABLE UNITS AT OUR PARK VIEW ON THE PARK PROJECT, WHICH IS ACROSS FROM MACARTHUR PARK. AND, SO, WE DO

HAVE NINE VACANCIES THERE, BUT THAT'S FOR OLDER ADULTS. AND WE DO HAVE OTHERS, BUT THAT'S ALL I KNOW OFF THE TOP OF MY HEAD.

>> PUBLIC MEMBER: [INAUDIBLE]. ONGOING DEVELOPMENT?

>> DENNIS MURATA: CAN YOU REPEAT THE QUESTION?

>> REINA TURNER: SO THE QUESTION IS IF THE FUTURE UNITS WILL ALSO HAVE TO GO THROUGH CES? SO WHAT WE'RE DOING AT THE -- WHEN A NEW BUILDING IS INITIALLY OPENED, WE ARE NOT GOING THROUGH CES DIRECTLY FOR NEW UNITS. BUT FOR ALL EXISTING BUILDINGS, IF THERE ARE TURNOVER UNITS, MEANING IF THEY BECOME VACANCIES, YOU DO HAVE TO GO THROUGH THE CES SYSTEM.

>> PUBLIC MEMBER: [INAUDIBLE].

>> REINA TURNER: FOR THE NEW BUILDINGS, WE POST THEM ON OUR WEBSITE, AND WHEN THOSE POSTINGS, WE ACCEPT CERTIFICATIONS FOR THOSE BUILDINGS, AND WE REFER DIRECTLY. WE MEET WITH THE DEVELOPER AND THEIR PROPERTY MANAGEMENT AGENT AND COORDINATE ALL REFERRALS FOR THE MHSA UNITS.

>> PUBLIC MEMBER: SO JUST TO HAVE – JUST FOR CLARIFICATION FOR ME. WHEN YOU SAY CERTIFICATIONS, ARE YOU TALKING ABOUT A VOUCHER OF SOME FORM? OR DOES AN AGENCY WRITE A LETTER? WHAT DOES THAT MEAN?

>> REINA TURNER: WHAT I MEAN BY THE MHSA HOUSING PROGRAM IS A STATEWIDE PROGRAM. AND THE PROGRAM REQUIRES THAT EACH COUNTY CERTIFY, OR, YOU KNOW, BE THE GATEKEEPER FOR THE MHSA FUNDING UNITS. SO THE GUIDELINES REQUESTED THAT THERE IS CERTAIN INFORMATION THAT WE GET, BECAUSE IT'S A HOMELESS PROGRAM. WE ASK – SO WE HAVE AN APPLICATION. IT'S A ONE-PAGE FORM THAT THE CASE MANAGER ASSISTS THE CLIENT TO FILL OUT THAT JUST TALKS ABOUT THEIR HOMELESSNESS, THEIR HISTORY, THEIR CURRENT INCOME, HOW MANY PEOPLE ARE IN THEIR HOUSEHOLD. AND THAT'S ALL IT IS. SO THE ONLY THING WE LOOK FOR IN CERTIFICATION IS THAT THEY'RE A D.M.H. CLIENT AND THAT THEIR HOMELESS.

>> PUBLIC MEMBER: SO THEY MUST BE HOMELESS. SO YOU'RE NOT WORKING WITH PEOPLE THAT ARE ALREADY STABLE AND WHO JUST SIMPLY NEED A PLACE TO LIVE, AND THEY'RE A D.M.H. CLIENT?

>> REINA TURNER: UNFORTUNATELY, THE PROGRAM, BECAUSE MOST OF THE BUILDINGS HAVE A FEDERAL SUBSIDY, AND THAT SUBSIDY REQUIRES THAT THE PERSON BE HOMELESS.

>> PUBLIC MEMBER: WHAT CLASSIFIES ONE TO BE HOMELESS?

>> REINA TURNER: IT'S THE FEDERAL DEFINITION OF HOMELESSNESS.

>> PUBLIC MEMBER: JUST SO I'M CLEAR, ONCE AGAIN, I KNOW RIGHT NOW THIS MEETING IS ONLY ABOUT MHSA'S MONEY, BUT DO YOU HAVE IN YOUR DEPARTMENT, RESOURCES FOR PEOPLE WHO NEED HOUSING WHO ARE NOT HOMELESS?

>> REINA TURNER: WHAT WE CAN DO, WE DON'T HAVE ACTUAL RESOURCES FOR INDIVIDUALS WHO ARE NOT HOMELESS, BUT THERE ARE RESOURCES IN THE COMMUNITY THAT WE CAN MAKE REFERRALS TO.

>> PUBLIC MEMBER: WHAT MIGHT SOME OF THOSE BE?

>> REINA TURNER: FOR EXAMPLE, THERE ARE AFFORDABLE HOUSING UNITS ACROSS THE COUNTY THAT PEOPLE, YOU DO NOT HAVE TO BE HOMELESS, YOU JUST HAVE TO MEET THE INCOME REQUIREMENT.

>> DENNIS MURATA: SO, ALL QUESTIONINGS REGARDING HOUSING AND HOMELESS, REINA IS GOING TO GO BACK TO HER SEAT OVER THERE. YOU'RE WELCOME TO ASK HER. WOULD YOU MIND ASKING HER THE QUESTION? OKAY. SORRY ABOUT THAT. I HATE TO DO THAT.

OKAY. ANYWAY. SO, WE'RE GOING TO RUN THROUGH THE REST OF THIS. I'M GOING TO INTRODUCE THE FOLKS WHO WOULD HAVE SPOKEN BUT WE'RE RUNNING OUT OF TIME, SO I'M JUST GOING TO GO AHEAD AND DO IT. IF YOU HAVE QUESTIONS, YOU CAN TALK WITH THEM. SO WE'RE GOING TO TALK ABOUT THE CSS- PLANNING OUTREACH AND ENGAGEMENT COMPONENT. MIRTALA IS RIGHT THERE IF YOU HAVE ANY QUESTIONS ABOUT ANY OF THESE SERVICES.

AND MARTIN IS ALSO INVOLVED IN THE PLANNING OUTREACH ENGAGEMENT. BUT SIMPLY, THESE ARE JUST NUMBERS IN TERMS OF FOLKS WHO HAVE BEEN CONTACTED THROUGH THE OUTREACH AND ENGAGEMENT EFFORT. HOME WHICH IS AN ACRONYM FOR HOMELESS OUTREACH AND MOBILE ENGAGEMENT TEAM. AND THIS IS THE PRESENTATION AND TYPES OF THINGS THEY DO. BUT ONE OF THE THINGS WE'VE BEEN USING, PLANNING AND OUTREACH ENGAGEMENT DOLLAR IS TO OUTREACH AND ENGAGE UNDER REPRESENTED ETHNIC COMMUNITIES AND WE'VE BEEN DOING THAT QUITE A BIT.

AND, SO, FOR EXAMPLE, A LOT OF WHAT'S NOT BEING REPORTED HERE, FOR EXAMPLE, FOR OUR UNDERREPRESENTED ETHNIC POPULATIONS COMMITTEE AND GROUPS, WE HAVE DONE THINGS, FOR EXAMPLE, FOR THE AFRICAN-AMERICAN COMMUNITY. AND I THINK LAST YEAR, IT WAS TARGETING THE ETHIOPIAN COMMUNITY AND THIS YEAR IS THE SIERRA LEON COMMUNITY. AND THERE'S ALSO BEEN SOME ADAPTATION OF THE OLDER MODEL AND AMERICAN INDIAN. ONCE AGAIN, THAT'S ANOTHER ONE, ANOTHER COMMUNITY THAT'S SEVERELY UNDERSERVED IN OUR SYSTEM THAT WE'VE BEEN KEEPING THESE EFFORTS. OR ACTUALLY INCREASING OUR EFFORTS.

THE OTHER THING IS THAT IN JULY, AND I DON'T KNOW IF YOU WANT TO SAY MUCH ABOUT THIS, THIS HAS TO DO WITH TARGETING THE TRANSITION AGE YOUTH POPULATION. THERE'S A CROSSOVER YOUTH AND THIS IS DEFINED BY – WHAT ARE THEY CROSSING OVER?

>> JOO YOON: THESE ARE TAY [INAUDIBLE]. OH. THERE. THESE ARE TAY WHO ARE INVOLVED WITH DCF AND INDEPENDENT SYSTEM WHO DURING THEIR – WHO ALLEGEDLY COMMITTED A CRIME AND NOT CROSSING OVER TO THE SYSTEM.

>> A RISK OF. 244.1.

>> PUBLIC MEMBER: UNDER WHAT? IT'S UNDER WHAT? PENAL CODE?

>> RISK. 244.1.

>> DENNIS MURATA: SO THAT'S A POPULATION, WHEN WE LOOKED AT THE HOUSING OR ISSUE IN TERMS OF FOLKS WHO ARE OUT OF PROBATION, NOW CAN END UP BEING IN THE JAIL PROGRAMS? IS THAT RELATED TO THAT?

>> THEY MAY, ESPECIALLY, IF THESE ARE THE OLDER KIDS.

>> DENNIS MURATA: OKAY. I'M SORRY, NOW I'M ASKING QUESTIONS. ALL RIGHT. ANYWAY, SO LET'S KEEP GOING. ONCE AGAIN, THIS IS SOMETHING THAT WAS APPROVED LAST YEAR. WHAT WAS APPROVED IN OUR MHSA PLAN WAS TO DO WITH THE EXPANSION OF MENTAL HEALTH OR HEALTH PROMOTERS, BUT IT WAS DONE BY SERVICE AREAS. AND FROM TALKING TO MEMBERS OF SLT, THE SYSTEM LEADERSHIP TEAM AS WELL AS OUR EUROPE COMMUNITIES, OR COMMITTEES, THAT WE WANTED TO INSTEAD OF DOING THINGS BY SERVICE AREA, WE WANTED TO FOCUS ON THE FIVE MAJOR ETHNIC GROUPS.

SO ARMENIAN, MIDDLE EASTERN, EASTERN EUROPEAN, AMERICAN INDIAN, LATINO, API, AND AFRICAN-AMERICAN. BUT SPECIFIC COMMUNITIES WITHIN THOSE GROUPS. SO, FOR EXAMPLE, IT COULD BE ONCE AGAIN, IT COULD BE EMERGING AFRICAN-AMERICAN IMMIGRANT COMMUNITY. IT COULD BE SOUTHEAST ASIAN, CAMBODIAN. THOSE TYPE OF THINGS. SO WE'RE LOOKING AT ADAPTING MODELS. IN TERMS OF OVERALL ACCESS TO THESE TYPES OF SERVICES, WE HAVE HEALTH NAVIGATOR THAT WE'VE BEEN TRAINING FOLKS, SO IT'S NOT JUST SO-CALLED ETHNIC COMMUNITIES, BUT THESE ARE GOING TO FOCUS SPECIFICALLY ON UNDER REPRESENTED COMMUNITIES WITHIN THESE GROUPS.

>> PUBLIC MEMBER: I KNOW FOR SACRAMENTO, WE LOOKED FOR HISPANIC, LGBT, AND TAY. AND I DON'T REALLY SEE THAT AS SOMETHING WE'RE DOING. DO WE HAVE ANY STATISTICS ON THAT PARTICULAR?

>> DENNIS MURATA: SERVING THAT PARTICULAR POPULATION, THERE'S SOME DISCUSSIONS IN TERMS OF OUR PEI EFFORT, RIGHT? MARTA, YOU'RE THE CO-CHAIR AND THE LGBTQ COMMUNITY IN TERMS OF BEING AN UNDERREPRESENTED GROUP OR COMMITTEE, THAT'S SOMETHING RELATIVELY NEW. ALTHOUGH THEY HAVE BEEN MEMBERS OR HAVE BEEN INVOLVED, BUT TO BE PART OF NOW UREP, WHEN WE DID THE PLAN, IT WASN'T FACTORED IN AT THAT TIME. SO THERE'S OTHER OUTREACH AND ENGAGEMENT EFFORTS.

>> PUBLIC MEMBER: I'LL GIVE YOU MY BUSINESS CARD.

>> DENNIS MURATA: SO WE'RE GOING TO MOVE THROUGH PREVENTION AND EARLY INTERVENTION. HERE'S SOME DATA. ONCE AGAIN, SO I CAN ESSAY ON TERMS OF THE NUMBERS. 66,000 FOR INDIVIDUALS WHO RECEIVE – I'M NOT GOING TO SAY THESE ARE PREVENTIONS. THESE ARE EARLY INTERVENTION. FOLKS THAT RECEIVE CLINICAL EARLY INTERVENTION IN OUR SYSTEM. IT'S NOT – DOESN'T COUNT ALL THE FOLKS THAT HAVE BEEN CONTACTED OR ENGAGED THROUGH THINGS WE DO FOR MENTAL HEALTH FIRST AID AND OTHER TYPES OF THINGS THAT ARE MORE PREVENTION. IT DOESN'T INCLUDE ALL OF THE 20 SOMETHING PRIMARY PREVENTION TYPE OF GRANTS WE GAVE TO COMMUNITY ORGANIZATIONS. IT DOES NOT COUNT THOSE. SO 66,000 INDIVIDUALS RECEIVE A CLINICAL EARLY INTERVENTION AND THIS SHOWS YOU BUY ETHNICITY AND BY PRIMARY LANGUAGE. I KEEP DOING THAT. AND, ONCE AGAIN, JUST LIKE WITH CSS, HERE'S THE BREAKOUT. AND I'M AMAZED WITH THE FOLKS COMING INTO OUR SYSTEM.

SUICIDE PREVENTION. MARTIN, DID YOU HAVE ANYTHING YOU WANTED TO ADD IN PARTICULAR WITH THE CRISIS HOTLINE AND LATINO YOUTH PROGRAM AND PARTNERS IN SUICIDE TRAINING? OH, OKAY.

I'M SORRY. JUST READING THAT FOR THE FIRST TIME. PARTNERS IN SUICIDE DOESN'T SOUND GOOD. BOY, THAT'S A BIG WORD TO MISS. OKAY, TRAINING FOR COMMUNITY BUT IN PREVENTION. SUICIDE PREVENTION AND YOU SEE THE NUMBERS THERE. ANYTHING, MARTIN, YOU WANT TO ADD ON THIS? OKAY. VERY GOOD.

NEXT ONE THAT WE HAVE IS, THE ACRONYM IS START. IT'S THE SCHOOL THREAT ASSESSMENT AND RESPONSE TEAM. THIS IS TO REDUCE THE SCHOOL VIOLENCE. IF YOU HAVE ANY QUESTIONS, SHE'S THE PERSON TO TALK TO. NOW, THIS IS FOR K-12 OR INCLUDING COMMUNITY COLLEGES?

>> INCLUDING COMMUNITY COLLEGES AND UNIVERSITIES.

>> DENNIS MURATA: NOW KEEP IN MIND, THE PART WE'RE IN NOW IS FUNDED BY PREVENTION AND EARLY INTERVENTION AND THAT COMPONENT OF MHSA.

IN TERMS OF STIGMA AND DISCRIMINATION REDUCTION, MIKE ALBA. MARTIN JONES, BETH BRISCOE AND AMY ARE PART OF THIS GROUP. AND THOSE ARE ALSO THE PRACTICE LEADS IN TERMS OF OUR EVIDENCE BASE PRACTICES. AND THOSE TYPE OF THINGS. BUT THOSE ARE THE FOLKS HITTING UP OUR PEI EFFORTS.

SO HERE, THE NUMBERS IN TERMS OF DIFFERENT TYPES OF PREVENTION TYPE OF ACTIVITIES. THESE ARE I WOULD SAY ARE TRULY ON THE PREVENTION SIDE. OKAY? AND THESE ARE JUST SOME EXAMPLES OF WHAT'S BEEN FUNDED AND THERE'S MORE TO COME.

AND THEN IN TERMS OF OUR EVIDENCE-BASED PRACTICES, AND HERE ARE SOME OF THE PRE/POST TREATMENT OUTCOMES WE OBSERVED. AT LEAST 3 OF THE EVIDENCE-BASED PRACTICES, TRAUMA FOCUSED CBT, SEEKING SAFETY AND INCREDIBLE YEARS SOME THESE ARE SOME OF THE OUTCOMES THAT WE'RE SEEING AS IT RELATES TO OUR IMPLEMENTATION OF OUR EVIDENCE BASED PRACTICES.

MIKE OR ANYBODY WANT TO MAKE ANY COMMENTS ON ANY OF THIS? GOOD.

IF YOU HAVE ANY QUESTIONS BY AGE GROUP IN TERMS OF THOSE PRACTICES – YES REBA.

>> REBA STEVENS: I'M GOING BACK AND IF THE RECORDING CAN HEAR ME. OKAY. PAGE NO. 61. THAT'S THE ONE WITH THE NUMBERS. THE PEI SERVICE BY SERVICE AREA.

NOW, WHEN WE'RE LOOKING AT THESE NUMBERS, I MEAN, I'M JUST OUT DONE. THIS IS SERVICE AREA 6. AND WE HAVE OVER 4,000 NEW CLIENTS. THAT IS IN WHAT TIME SPAN? IS THAT IN 18 MONTHS?

>> DENNIS MURATA: IT'S WITHIN THE LAST 13/14. SO IN JUNE, THIS IS PEI NOW. THIS IS ONLY PEI. THIS DOES NOT INCLUDE CSS OR ANYONE SERVED BY IF IT WAS.

>> PUBLIC MEMBER: SOMETHING IS WRONG. SO WHEN WE TALK ABOUT A HEALTH NEIGHBORHOOD, MY QUESTION IS, HOW ARE WE LOOKING AT THIS? BECAUSE A HEALTH NEIGHBORHOOD IS GOING TO HELP PEOPLE ARE DOING THAT?

>> DENNIS MURATA: SO HEALTH NEIGHBORHOOD, THESE NUMBERS WILL INCREASE DRAMATICALLY. THEY WILL. YOU DON'T SEEM HAPPY WITH THAT ANSWER.

>> PUBLIC MEMBER: WE ACTUALLY WANT THE NUMBERS TO INCREASE BECAUSE MORE PEOPLE ARE GETTING SERVICES.

>> DENNIS MURATA: NOW KEEP IN MIND, THIS – THIS IS PRE-HEALTH NEIGHBORHOODS. NOW KEEP IN MIND, PREVENTION AND EARLY INTERVENTION IS NOT OUR TRADITIONAL MENTAL HEALTH POPULATION. THE SEVERELY MENTALLY ILL AND SED KIDS. THESE NUMBERS ARE GROWING. OVERALL 66,000, THAT'S REMARKABLE. KEEP IN MIND THESE ARE INDIVIDUALS WHO ARE GOING TO SEEK, FOR THE MOST PART, BRIEF INTERVENTIONS. OKAY? TO GET THEM THROUGH A CRISIS. SO THOSE NUMBERS ARE GOING UP. AND WE SEE THEM GOING UP QUITE A BIT EVERY YEAR. WHERE WAS I? OH, INNOVATION 1.

SO, THIS IS NOT IN YOUR REPORT. BUT WE HAD THIS INNOVATION 1. THEY SERVED ROUGHLY 3,300 CLIENTS. THESE ARE 4 OR 5 DIFFERENT MODELS. INTEGRATED CLINIC MODEL AND INTEGRATED MOBILE HEALTH PROGRAM. THERE WAS A FOURTH ONE AND THAT HAS TO DO WITH THE PEER RUN MODEL. BUT THAT DOESN'T END. THESE 3 ARE ENDING. AND THEY WERE ABLE TO DEMONSTRATE SUCCESSFUL OUTCOMES.

WE'RE GOING TO CONTINUE TO PROVIDE THOSE SERVICES ONGOING. BUT WE ALSO HAD APPROVAL AND WE'RE INCLUDING IN THIS PLAN, THERE WERE CERTAIN PROGRAMS THAT DIDN'T DEMONSTRATE THE TYPE OF OUTCOME BECAUSE THE OUTCOME WAS VERY CLINICAL FOCUSED. AND SOME OF THOSE COMMUNITIES THAT REALLY DID NOT SHOW THOSE TYPES OF OUTCOMES DO NEED ONGOING SUPPORT. ONE OF THEM HAD TO DO WITH THE SAMOAN COMMUNITY. AND THEY STILL NEED A LOT OF OUTREACH AND ENGAGEMENT AND WE'RE

GOING TO CONTINUE TO SUPPORT THEM ON THAT. THERE'S OTHER COMMUNITIES. FOR EXAMPLE, THERE WERE PARTS OF AFRICAN-AMERICAN TRIPLE A, AS WELL AS THE FARSI SPEAKING COMMUNITIES. ALTHOUGH THEY MAY NOT BE PART OF THE FORMAL CONTINUATION OF SOME OF THE INNOVATION PROGRAMS, WE WILL CONTINUE SOME ASPECTS OF IT.

OKAY, OSBE, YOU'VE BEEN PATIENTLY WAITING. DO YOU WANT TO ASK BEFORE MY PRESENTATION? GO AHEAD.

>> PUBLIC MEMBER: I THINK I NEED A MIC.

>> DENNIS MURATA: AND ANGELITA DIAZ-AKAHORI. THAT'S A GREAT NAME. THREE ETHNIC GROUPS IN ONE. SHE'S LEADER OF CLINICAL TRAINING PROGRAM AND WET COMMUNICATION.

>> PUBLIC MEMBER: MY QUESTION IS DIRECTED TOWARDS WET AND TRAINING PROGRAM, PAGE 34, SLIDE 67 IN RELATING BACK TO AND HIGHLIGHTING THE HEALTH NAVIGATOR TRAINING PROGRAM, AND INTENSIVE MENTAL HEALTH RECOVERY SPECIALIST, AND THE ACTUAL CERTIFICATION PROGRAMS AND THE PEER ADVOCATES.

NOW, OUT OF ALL OF THOSE PROGRAMS, WITH THE EXCEPTION OF INTERPRETER TRAINING, I LIKE TO KNOW IN COMPILING YOUR DATA, WHERE DO THE CONSUMERS WITH LIVED EXPERIENCE FIT IN? HOW MANY IN TERMS OF QUALITY?

>> ANGELITA DIAZ-AKAHORI: PART OF IT IS HEALTH NAVIGATOR.

>> PUBLIC MEMBER: DO YOU HAVE A COUNT?

>> DENNIS MURATA: WELL, FIRST OF ALL, INDIVIDUALS WITH LIVED EXPERIENCE CAN BE IN ANY CATEGORY.

>> PUBLIC MEMBER: I UNDERSTAND THAT. BUT WHAT I'M ASKING IS, WHERE'S THE DATA?

>> DENNIS MURATA: OKAY.

>> PUBLIC MEMBER: ARE THEY ALL IN PEER ADVOCATES? OR ARE THEY INTERTWINED IN THE OTHER AREAS OF EXPERTISE? ARE WE COMING OUT WITH PEOPLE WITH DEGREE OR LIVED EXPERIENCE THAT ARE IN THE FIELD WORKING WITH CLIENTS AND CONSUMERS? IF WE'RE NOT, WE NEED TO RECRUIT.

>> ANGELITA DIAZ-AKAHORI: PART OF THE QUESTION IS, PART OF THE ANSWER IS THAT SOME INDIVIDUALS CHOOSE TO DISCLOSE THEY HAVE EXPERIENCE, OTHERS DO NOT. SO WE BASICALLY GO ON WHAT THEY'RE ACKNOWLEDGING TO. SO THAT'S NUMBER ONE.

>> PUBLIC MEMBER: THOSE THAT HAVE ADMITTED. SO WHAT DO YOU HAVE IN TERMS OF DATA?

>> ANGELITA DIAZ-AKAHORI: WE CAN GET IT. THERE'S SOME DATA WE DO HAVE BASED ON THE KNOWLEDGE.

BELOW IS INFORMATION RELATED TO THIS REQUEST FROM WET FUNDED PROJECTS:

		MENTAL HEALTH SERVICES ACT (MHSA) WET PLANS	Total Participants	Self-Identified Peers (Total)	Self-Identified Peers (Percentage)
	3	Transformation Academy Without Walls c. Health Navigators	37	13*	35%
	8	Intensive Mental Health Recovery Specialist Training Program	159	69	43%
	9	Expanded Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System-Peer Training - Peer Advocate Training (Core/Advanced/Train-the-Trainer)	41	41	100%
	11	Expanded Employment and Professional Advancement Opportunities for Family Members Advocates in the Public Mental Health System	884	157	18%

>> PUBLIC MEMBER: THOSE WILLING TO STEP OUT TO A "YES, I AM A CONSUMER WITH LIVED EXPERIENCE" AND THOSE PEOPLE WE NEED MOST DEFINITELY IN THOSE AREAS TO HELP OTHERS?

>> ANGELITA DIAZ-AKAHORI: AND THE HEALTH NAVIGATOR PROGRAM IS SPECIFICALLY FOR PEER SPECIALIST AS WELL AS COMMUNITY WORKERS, AND AS WELL AS COMMUNITY CASE WORKERS. SO PEERS ARE INCLUDED IN THE HEALTH NAVIGATOR TRAINING PROGRAM.

>> DENNIS MURATA: SO WHY DON'T WE POINT OUT WHICH ONE?

>> PUBLIC MEMBER: YOU NEED TO GO TO SOME COLLEGES OR UNIVERSITIES OR COMMUNITY COLLEGES AND DO A RECRUITING.

>> DENNIS MURATA: THING IS OSBY. TO GET INTO THESE PROGRAMS, YOU HAVE TO BE WORKING. WELL, THERE IS A DEMAND.

>> PUBLIC MEMBER: MAYBE WE SHOULD HAVE SOME SET ASIDE. SET ASIDE SOME CERTAIN AMOUNT OF SLOTS. LIKE YOU HAVE CERTAIN AMOUNT OF SLOTS SET ASIDE.

>> DENNIS MURATA: LET ME FINISH.

>> PUBLIC MEMBER: BASED ON YOUR EXPANDING, WELL, THINK ABOUT OUTSIDE THE BOX THAT WE NEED TO HAVE A DATA. IF YOU CAN PROVIDE ME WITH SOME DATA, THAT WOULD BE GREAT.

ANGELITA DIAZ-AKAHORI: THE PEER ADVOCACY TRAINING IS FOR INDIVIDUALS WITH SERVICES. THIS IS A PRIORITY THAT THEY HAVE LIVED EXPERIENCE, BUT IT'S NOT MANDATED, AND WE DO NOT RESERVE SLOTS. THEY JUST GO INTO THE MIX. BUT IT IS A PRIORITY. THE HEALTH NAVIGATOR, LIKE I SAID, IT IS FOCUSED ON AND ORIENTED TOWARDS PEER SPECIALIST. BECAUSE THIS IS A PEER SPECIALIST FOCUSED TRAINING. THEY HAVE TO HAVE CONTACT WITH INDIVIDUALS. BECAUSE THAT'S PART OF THE CERTIFICATION OF THE HEALTH NAVIGATOR, THAT THEY HAVE TO HAVE CERTAIN AMOUNT OF HOURS IN TERMS OF DIRECT SERVICE. BECAUSE THEY GET CERTIFIED. WE DO ALLOW SOME SLOTS FOR VOLUNTEERS, BUT IF THEY ARE VOLUNTEERS, THEY NEED TO HAVE A SUPERVISOR, BECAUSE THE WORK THAT THEY'RE PROVIDING HAS TO BE SUPERVISED. AND THE TRAINING THEY RECEIVE, THEY NEED TO IMPLEMENT THE SKILLS. SPECIFIC CLINICS JOHN BREKKE HAS A PROTOCOL FOR THAT. SO PEER SPECIALISTS ARE INCLUDED. SOME OF THEM ARE PRIORITIES AND OTHERS DEPEND UPON THE NUMBER OF PEOPLE THAT ARE REGISTERED AND THEN IT ALSO DEPENDS UPON THE PROGRAM THROUGH THE MANDATES AND CRITERIA.

>> PUBLIC MEMBER: EXTERNS AND INTERNS, AND CONSIDERATION OF EXPANSION AS WELL, BUT I'M NOT A CONSUMER, BUT I WORK WITH CONSUMERS AND CLIENTS. BUT I THINK SOME OF THEM ARE VERY BRIGHT AND INTELLIGENT PEOPLE. WELL, HIGHLY INTELLIGENT. AND I THINK THEY COULD FIT WITHIN CERTAIN PARAMETERS AND TAKE ADVANTAGE OF THE WET PROGRAM. AND MANY THAT HAVE BEEN HELD BACK HAVE BEEN ABLE TO MOVE FORWARD.

>> DENNIS MURATA: THANK YOU. THE LAST THING ON TODAY'S PRESENTATION HAS TO DO WITH THE ESTIMATED BUDGET. I KNOW YOU CAN'T SEE THIS FROM WHERE YOU ARE. BUT THE GOOD THING TO KNOW IS THAT THE PROJECTION FOR NEXT YEAR AT LEAST, IT'S GOING UP.

UNFORTUNATELY, IT'S NOT GOING UP AS HIGH AS WE THOUGHT IT WAS. THIS IS OUR ONGOING ALLOCATION THAT WE'RE GOING TO GET FROM THE STATE. THIS IS STILL GOING TO BE AN INCREASE FROM THE CURRENT FISCAL YEAR. SO THIS SHOWS YOU BUY THE DIFFERENT COMPONENTS. A IS CSS COMPONENT AND THIS IS IN YOUR CHART. I WILL ASK MAYBE IN THE NEXT MENTAL HEALTH COMMISSION, CFO, KIM, OR I CAN TALK ABOUT THE BUDGET. BUT THE OTHER STATE FUNDING STREAMS, WHAT'S THE DIFFERENCE BETWEEN REALIGNMENT AND THOSE TYPE OF FUNDING VERSUS MHSA. I KNOW THE CATEGORICAL DOLLARS WHICH WE HAVE PLENTY TO DEAL WITH, OKAY?

ALL RIGHT. AND I THINK, I SET THE RECORD THE OTHER WAY BY TAKING THE LONGEST TIME TO DO THE UPDATE. AND WE'RE STILL NOT OVER. THIS IS NOW OPEN FOR PUBLIC COMMENT.

>> LARRY GASCO: THANK YOU, DENNIS. IT TOOK A LITTLE BIT OF TIME BUT IT WAS WELL WORTHWHILE. UNFORTUNATELY, WE LOST MOST OF THE PEOPLE TRYING TO GET FEEDBACK ON THE PLAN. I WANT TO THANK ALL THE NON-ENGLISH-SPEAKERS THAT WERE PRESENT. CLEARLY THERE'S A CONTINUING WORK THAT NEEDS TO BE DONE. AND WHEN THEY'RE NOT HERE, ESPECIALLY, OUR TABLE BACK HERE, ONE YEAR YOU WEREN'T HERE AND I MISSED YOU. SO I'M GLAD YOU'RE HERE IN PARTICULAR. ALSO AN OVERSIGHT, I DIDN'T INTRODUCE MY PEERS ON THE MENTAL HEALTH COMMISSION, TWO TABLES TO MY RIGHT AND THEY WERE INVOLVED IN ASKING QUESTIONS AND STUFF. AND BEING THE BRIGHT GUY THAT I AM, I'M BRIGHT ENOUGH TO KNOW THAT, I'M GOING TO TURN

THIS OVER TO DENNIS AND HAVE US GO THROUGH THE PROCESS OF SECURING ANY COMMENTS YOU WANT. I KNOW WE'RE SCHEDULED TO END AT 3 O'CLOCK. SOME PEOPLE HAVE LEFT ALREADY, AND OTHER PEOPLE WILL HAVE TO LEAVE. SO I THINK THAT IS IMPORTANT TO ADDRESS VARIOUS AVENUES OF PUBLIC COMMENT IS WRITTEN ONES. SO I'M GOING TO TURN IT OVER IT DENNIS AND NOT TAKE ANY MORE TIME.

>> DENNIS MURATA: OKAY.

>> PUBLIC MEMBER: I'LL SPEAK LOUDLY.

>> PUBLIC MEMBER: I JUST WANTED TO CLARIFY THAT THE IF IT WAS FUNDING FOR ALL THE DIFFERENT CATEGORIES INCLUDE THE COST OF HOUSING, CORRECT? SO TAY TALKED ABOUT 11,000?

>> DENNIS MURATA: NO. WHAT WAS MENTIONED QUITE A BIT WAS CLIENT SUPPORTIVE SERVICES DOLLARS ALSO KNOWN AS FLEX FUNDS, AT LEAST FOR THE FSP PROGRAM, THE FULL SERVICE PARTNERSHIP PROGRAM, YOU CAN USE THE FLEX FUNDS FOR HOUSING TYPE OF SUPPORTS. BUT, NO, THAT 11,000 DOES NOT INCLUDE ANY DOLLARS THAT MAY HAVE BEEN USED. ANY FLEX DOLLARS AS IT RELATES TO FIRST AND LAST MONTH'S RENT AND OTHER TYPE OF THING THAT ARE APPROPRIATE FOR HOUSING FOR FLEX FUNDS. NOW, IT DOESN'T INCLUDE THE DOLLARS THAT REINA WAS TALKING ABOUT. THOSE ARE SEPARATE, RIGHT?

>> EACH SLOT IS ALLOCATED IN AMOUNT OF FLEX FUNDS. SO EACH AGENCY GETS AN AMOUNT.

>> DENNIS MURATA: EACH SLOT HAS AN ALLOCATION OF FLEX FUNDS. BUT FLEX FUNDS CAN BE USED FOR A VARIETY OF THINGS, RIGHT?

>> IT CAN BE USED TO HELP WITH FOOD, CLOTHING, SCHOOL BOOKS, MEDICAL CARE, DENTAL CARE, HOUSING, TRANSPORTATION. HOUSING, YEAH.

>> PUBLIC MEMBER: THE FLEX FUNDS CAN.

>> IT COULD BE HOTEL VOUCHERS. HELP WITH THE APARTMENT. SOMETIMES ANYTHING- NON-HOSPITAL BED.

>> PUBLIC MEMBER: SO MY QUESTION SPECIFICALLY, I COME FROM LAW ENFORCEMENT, SO YOU KNOW WHERE MY MIND IS AND IT'S MUCH CHEAPER TO PUT A PERSON IN FSP INSTEAD OF JAIL, SO I'M TRYING TO WRAP AROUND MY MIND AROUND HOW MUCH IT COST PER CLIENT ANNUALLY ON AVERAGE IF WE NEED TO PUT THEM IN BED WITH THE SERVICES.

>> DENNIS MURATA: IT'S STILL SIGNIFICANTLY CHEAPER. $16,000? ROUGHLY? [INAUDIBLE].

>> PUBLIC MEMBER: SO THAT'S $5,000 TO EACH CATEGORY?

>> DENNIS MURATA: YEAH. THAT'S A GOOD THING. $5,000. OTHER QUESTIONS?

>> PUBLIC MEMBER: IN REGARDS TO THE WET PROGRAM, I KNOW, FOR EXAMPLE, THIS IS TO INCREASE THE CAPACITY OF WORKFORCE. BUT I HAVE NOT BEEN ABLE TO SUPPLEMENT CLINICAL LEVEL TRAINING, IS THERE ANY TYPE OF INITIATIVE OR DIALOGUE, I DON'T KNOW IF IT'S IN THIS BUDGET OR NEXT TO FUND THE CONTINUATION OF BACHELOR'S DEGREE FOR THOSE WE HAVE THAT WORKFORCE OF PEER WORKERS THAT NEED TO GET A BACHELOR'S DEGREE, BUT TO GET THEM INTO THAT DIRECTION. BECAUSE THAT IS SOMETHING THAT'S REALLY HOLDING A LOT OF OUR WORKFORCE. NOT BEING ABLE TO AFFORD THAT BECAUSE THAT'S SO EXPENSIVE AND GOING TO THE CLINICAL SETTING WHERE WE DO NEED A GREAT DEAL OF PEOPLE WITH LIVED EXPERIENCES. BUT THAT COMES FROM SPECIFIC CULTURAL BACKGROUND. I KNOW THAT'S WHY A LOT OF OUR WOW WORKERS HAVE GIVEN UP. BECAUSE GETTING PAID FOR 3 HOURS FOR 4 DAYS A WEEK FOR VOLUNTEERING 40 HOURS. IT'S BETTER TO DO NOTHING THAN VOLUNTEER ONE NOWADAYS.

>> DENNIS MURATA: YOU'RE ASKING ABOUT THINGS LIKE TUITION REIMBURSEMENT PROGRAM TO HELP FOLKS GET A DEGREE?

>> ANGELITA DIAZ-AKAHORI: THERE'S COMPONENTS IN THE WET PLAN THAT FINALIZE THE PROGRAM. PART OF PLANNING INCLUDES TUITION REIMBURSEMENT AND ALSO INCLUDES FINANCING OF B.A. HOWEVER, IT'S NOT THE THREE- OR FOUR-YEAR PROGRAM FINANCING YOU'D EXPECT. IT'S GOING TO BE IN THE LAST YEAR. BECAUSE WE'RE NOT GOING TO BE ABLE TO PUT PEOPLE THROUGH FOUR YEARS OF COLLEGE.

WE'RE ALSO PROVIDING THROUGH THIS FINANCIAL INCENTIVE, OPPORTUNITIES FOR INDIVIDUALS THAT WOULD LIKE TO HAVE CERTAIN TYPE OF CERTIFICATION SPECIALTY LIKE OLDER ADULTS. MARTIN, YOU HAVE SENT SOME INFORMATION FOR ONLINE PROGRAMS THAT LOOKED VERY GOOD. AND, SO, WE WOULD PROVIDE ADDITIONAL DOLLARS TO BE ABLE TO FUND INDIVIDUALS THAT ARE INTERESTED IN SPECIALTY KIND OF ONLINE TRAINING. SO THERE ARE DOLLARS AVAILABLE FOR THAT.

>> DENNIS MURATA: AND, ALSO, IN TERMS OF AT LEAST ON THE COUNTY DIRECTLY OPERATED SIDE, THE D.M.H. SIDE, SO, FOR EXAMPLE, THE PART OF SB82 THAT HAS TO DO WITH MOBILE TRIAGE TEAM, THERE'S ABOUT 30 SOMETHING PEER WORKER LEVEL ITEMS THAT ARE BEING REQUESTED? WHAT WAS IT? FOUR 4 SERVICE AREAS?. SO WE FUND THEM AT A COMMUNITY LEVEL WORKER, BUT THEY CAN COME IN AS AN ENTRY LEVEL AND HEALTH COMMUNITY ADVOCATE, AND WE TRY TO CREATE A CAREER PATH SO IT CAN MOVE FROM A MENTAL HEALTH ADVOCATE TO A COMMUNITY WORK, TO A SENIOR COMMUNITY WORKER, BUT WE'RE GOING TO KEEP TRYING.

YES. GO AHEAD.

>> PUBLIC MEMBER: I HAVE A QUESTION AROUND THE CSS TRANSITION AGE YOUTH. AND THE OUTCOME, FROM WHAT I'M UNDERSTANDING- 38% MET THEIR GOALS. SLIDE 17. JUST CURIOUS ABOUT WHAT YOU THINK ATTRIBUTED TO THAT? WHAT THE BENCHMARK WAS? WAS THAT INCREASE OVER PREVIOUS YEARS? I MEAN, IT SEEMS LIKE A LOW PERCENTAGE, ESPECIALLY, COMPARED TO THE OTHER POPULATIONS. SO THAT'S MY QUESTION. IF IT'S BASED ON THAT, IT SEEMS LOWER, BUT I DON'T KNOW IF THERE WAS A BENCHMARK OR INCREASE OVER PREVIOUS YEARS AND WHAT ATTRIBUTES TO THE LOW PERCENTAGE?

>> JOO YOON: WE DIDN'T ESTABLISH ANY BENCHMARKS. ONE OF THE REASONS FOR THE FACTOR IS TRANSITION AGE FOR YOUTH AGING UP STILL NEED SERVICES FOR FSP. SO TREATMENT WOULD NOT HAVE BEEN MET AS ONGOING AS A LATE ADULT AGE RANGE. OTHER FACTORS, TAY POPULATION IS VERY MOBILE. VERY HARD TO ENGAGE. AND THOSE OTHERS.

>> PUBLIC MEMBER: THERE'S A LOT OF FACTORS THAT YOU HAVE BEEN TALKING ABOUT. BUT WHAT WE WANT TO SAY IS THAT, CLEARLY WE DID NOT ESTABLISH OUR BENCHMARK, BUT WE DO FEEL THE NUMBER IS LOW. AND WE'RE ALWAYS LOOKING TO DO A BETTER JOB WITH YOUNG PEOPLE. AND PART OF THE DEPARTMENT AND THE COUNTY MAKING 15/16 FISCAL YEAR TAY A PRIORITY, I THINK IT GIVES US A BETTER CHANCE TO WORK ON SOME OF THOSE AREAS WE FEEL WE CAN BRING UP. EMPLOYMENT. HOUSING. ACCESS TO SERVICES AND ALL THOSE SELF-SUFFICIENCY INDICATORs. SO WE'RE LOOKING TO RAISE THE NUMBER ANY AWAY WE CAN.

>> DENNIS MURATA: THE AFFORDABLE CARE ACT, ESPECIALLY, FOR THE TAY POPULATION, THOSE 21 TO 25, BECAUSE BEFORE THAT, TRADITIONALLY, FOR MEDI-CAL, THEY DIDN'T REALLY QUALIFY FOR ANYTHING UNLESS THEY WERE A PARENT OR THEY HAD A DISABILITY IN SSI. NOW AS A MEDICAID EXPANSION, IT'S AN INCOME AND THEY WOULD HAVE MORE SERVICES.

>> LARRY GASCO: I WOULD LIKE TO GO BACK TO –

>> DENNIS MURATA: CAN I INTERRUPT THE CHAIR AND PUT HIM IN THE QUEUE?

>> PUBLIC MEMBER: I YIELD TO DR. GASCO.

>> LARRY GASCO: THAT'S A FEW OF THE BENEFITS AND THIS IS ONE OF THEM. I WANT TO GO BACK TO ISSUES RAISED BY COMMISSIONER BOYKINS, AND IT'S GOING TO SERVE THE HARBOR AREA. LONG BEACH PREVENTS THEM FROM TREMENDOUS ISSUES, AND I WOULD VENTURE TO SAY THE REVITALIZATION, ESPECIALLY BY THE LAW ENFORCEMENT FROM LONG BEACH WILL BE MINIMAL. BECAUSE YOU'RE TALKING ABOUT A WHOLE A LOT OF TIME AND THEY'RE NOT GOING TO DO IT. I GUESS.

>> PUBLIC MEMBER: I DIDN'T KNOW IF MARY WAS GOING TO RESPOND.

>> DENNIS MURATA: MARY, DO YOU WANT TO RESPOND TO THAT?

>> MARY MARX: WELL, YOU KNOW, FIRST OF ALL, THE – OKAY. IN OUR APPLICATION TO THE STATE, WE ACTUALLY SAID THAT IT WOULD BE IN THE HARBOR SOUTH BAY AREA. SO THAT'S THE AREA THAT HAS BEEN IDENTIFIED AND APPROVED BY THE STATE FOR THAT AREA. BUT I KNOW THAT WE DO HAVE SOME ALTERNATIVES THAT WE'VE BEEN WORKING WITH ONE OF THE HOSPITALS IN LONG BEACH WHO'S INTERESTED IN DOING THE URGENT CARE. SO WE DO HAVE A RECOGNITION AND WE ARE ENGAGING IN CONVERSATIONS AROUND THAT ISSUE.

>> PUBLIC MEMBER: THIS IS FOR MARY AS WELL. IN TERMS OF THE URGENT CARE AND THE CRISIS RESIDENTIAL, IS THERE ANY WAY, OR IF IT'S ALREADY BEEN HAPPENING TO ATTACHING DETOX FOR PEOPLE WITH MENTAL HEALTH CRISIS AND HAVE DETOX SERVICE AND FINDING PLACES CLOSER TO THESE PLACES SO THEY CAN BE TRANSITIONED THERE? AND EACH SERVICE AREA?

>> MARY: WELL, THE CRISIS RESIDENTIAL WILL NOT BE DOING – THEY'RE NOT GOING TO BE DOING DETOX AND NEITHER DO THE URGENT CARE CENTERS. BUT WE ANTICIPATE THERE MAY BE SOME SUBSTANCE ABUSE PROVIDERS WHO WOULD HAVE DETOX SERVICES AVAILABLE THAT WILL POSSIBLY APPLY FOR OUR RFS'S.

>> PUBLIC MEMBER: SO THEY CAN STAY IN TOUCH WITH THE URGENT CARE AND THEY CAN DETOX, AND THEY CAN GET THAT SERVICE. OH, GREAT.

>> MARY: WE'LL BE COORDINATING OUR SERVICE PROVISION WITH THE DEPARTMENT OF PUBLIC HEALTH SEP'S PROGRAM. SO THAT'S A GOOD POSSIBILITY.

>> PUBLIC MEMBER: SCC IS CURRENTLY WORKING WITH THE OFFICE OF THE MEDICAL DIRECTOR, DR. SHANER'S GROUP. AND WE'RE CURRENTLY DOING SOMETHING IN THE SERVICE AREA AROUND DENTAL SERVICES.

BECAUSE THE BOARD DOESN'T LIKE TO CONTINUALLY DO SR'S FOR DENTAL, SO WE'RE TRYING TO FIND PEOPLE THAT ARE WILLING TO PROVIDE DENTAL SERVICES AND GET SPECIAL REQUESTS OR CONTRACTS SET UP PER SERVICE AREAS. SO WE'RE ALSO WORKING. ALTHOUGH THERE'S SOME DIFFICULTIES, BECAUSE DETOX CAN BE FUNDED, BUT IT'S VASTLY NOT AVAILABLE FOR OUR CONSUMERS, SO WE ARE WORKING WITH OMD AT THIS TIME TO PUT THE FSP AND SOLICIT FOR THESE SERVICES. WE'RE IN THE ORIGINAL SERVICES, BUT WE ARE TRYING. BECAUSE WE DO SEE THIS IS SOMETHING THAT OUR CLIENTS AREN'T GETTING AND THEY'RE IN DESPERATE NEED OF.

>> PUBLIC MEMBER: MY QUESTION IS RELATED TO THE INCREASE IN JUVENILE HALL AND JUVENILE HALL IN JAIL FOR BOTH CHILD 13, I GUESS THERE'S A TABLE FOR CHILDREN AND TAY COMMUNITY. ARE YOU ALL TRACKING WHAT THE CHARGES ARE? IS IT RELATED TO THEME OR PETTY THEFT, AND ARE YOU ADDRESSING SOME OF THOSE UNDERLINING ISSUES OF KEEPING THOSE PEOPLE HOUSED?

>> MARTA ALQUIJAY: WE DON'T HAVE THAT DATA, BUT I THINK IT'S AN EXCELLENT IDEA TO LOOK AND DRILL DOWN AND GET IT.

>> PUBLIC MEMBER: WHEN YOU FIND IT, WHO WOULD I FOLLOW-UP WITH? CAN I FOLLOW UP WITH COMMISSION?

>> MARTA ALQUIJAY: YES.

>> PUBLIC MEMBER: THAT WOULD BE GREAT.

>> I THINK PART OF IT IS, WE'RE TRYING TO DETERMINE REALLY IF IT'S A REAL PHENOMENON. LIKE IF THE CLIENTS ARE REALLY BEING INCARCERATED ONCE THEY START FULL PARTNERSHIP AND WHETHER BEING INCARCERATED FOR MORE DAYS WITH WOW. I THINK SOME OF IT, EVERYTHING THEY HAVE BEEN ABLE TO VERIFY IS TRUE SO WE'RE TRYING TO UNDERSTAND THAT. PART OF THE ISSUE IS UNDERREPORTING BEFORE THE YEAR THEY COME IN, SO MAYBE IT'S LIKE NOT – MAYBE IT'S NOT A TRUE INCREASE. BUT WE'RE STILL TRYING TO GET TO THE BOTTOM OF THOSE THINGS. AND I KNOW MARTA IDENTIFIED THE NEW CHARGES AFTER THEY'RE ENGAGED WITH THE IF IT WAS WOULD BE SOMETHING INTERESTING TO LOOK AT.

>> MARTA ALQUIJAY: ONE OF THE THINGS WE'VE INSTITUTED, WE'RE LOOKING AT THEM MORE CLOSELY. ESPECIALLY, THE ONE WITH ANY INVOLVEMENT WITH THE JUVENILE JUSTICE SYSTEM.

>> PUBLIC MEMBER: I WANT TO ADD ONE MORE THING QUICKLY. ONE OF THE THINGS, AND I SAW COUPLE OF PEOPLE, ON JACKIE LACEY COLLABORATIVE, MAYBE WE CAN BE AWARE FOR L.A. COUNTY. THAT'S SOMETHING WE CAN DIRECTLY ADDRESS IF WE HAVE THE STATISTICS. SO.

>> DENNIS MURATA: THANK YOU FOR BEING PATIENT.

>> PUBLIC MEMBER: I'M CONFUSED AND I NEED CLARIFICATION. I'M CONFUSED AND I NEED CLARIFICATION. LAST YEAR WHEN I HEARD ABOUT THIS SB82 PROGRAM, IT WAS PRESENTED AS A STIPEND OF $400. I'M NOT SURE IF THESE PAID POSITIONS YOU'RE ALL TALKING ABOUT IS HOUSING SPECIALIST. IS THIS CONNECTED TO SB82 OR IS IT SEPARATE? IS IT REALLY PAID?

>> DENNIS MURATA: IT'S SEPARATE. I CAN ANSWER IT. BUT I THOUGHT I HEARD SOMEONE ANSWER IT. SO KEEP IN MIND FOR SB82, THERE'S DIFFERENT LEVELS. SO WE HAVE FOCUS WHO WILL BE STIPEND. THIS IS NOT A FULL-TIME PERMANENT POSITION. THESE COULD BE SO-CALLED WOW WORKERS, THEY COULD BE SERVICE EXTENDERS, THEY COULD BE FROM TORRES [SIC] THAT GET A STIPEND FOR WHILE THEY'RE GOING THROUGH THE PROGRAM. SO THAT'S ONE LEVEL. AND I THINK – THAT'S ABOUT 48 OF THOSE DOLLARS? 48 STIPEND POSITIONS AT $400 A MONTH. SO THAT'S STILL IN HERE.

THEN WE ALSO HAVE, ONCE AGAIN, THIS IS MORE THE MOBILE TRIAGE CASE. AND THEN WE HAVE FULL-TIME POSITIONS THAT WE REQUEST AND OVER 30 OF THEM AT THE COMMUNITY WORKER LEVEL AT WHICH THE ENTRY LEVEL CAN ALSO BE A MENTAL HEALTH ADVOCATE AND THEN WHAT WE'RE TRYING NEGOTIATE WITH IS SENIOR COMMUNITY WORKER SO THERE'S A CAREER PATH. I'M SORRY FOR THE CONFUSION. AND SOME THESE

OTHER HOUSING SPECIALIST AND THOSE OTHER POSITIONS, THOSE ARE SEPARATE THAN SB82 AND THOSE WILL BE FULL-TIME POSITIONS.

>> PUBLIC MEMBER: I REALLY LIKE THE DATA THAT YOU PRESENTED. SOME OF THEM REFERRED TO OLDER OR ADULT WITH AGING [INDISCERNIBLE], I'M NOT SURE WHY THE DELIVERABLE NUMBERS WERE SO LOW COMPARED TO THE OTHERS. NOT ONLY DO WE HAVE A SIGNIFICANT LARGER AND GROWING, IT'S GOING TO BE A BUBBLE. A MENTAL HEALTH CONDITION, BUT REGARDLESS OF WHAT THE DATA SAYS ABOUT OUR POPULATION, WE'RE ACTUALLY NOW LIVING LONGER. THOSE OF US THAT HAVE A MENTAL CONDITION, WE'RE NOW LIVING LONGER THAN OUR PREDECESSOR WHO ARE DYING YOUNGER. SO I'M NOT SURE EXACTLY WHY THE DELIVERY RATE WAS SO LOW FOR OUR TARGET POPULATION. WHETHER IT WAS BECAUSE OF RESOURCE PARTICIPATION. BUT I'M WONDERING, BECAUSE THAT'S GOING TO BE THE NEW UNREPRESENTED GROUP.

>> DENNIS MURATA: SO, MARTIN, DO YOU WANT TO ANSWER?

>> MARTIN JONES: I CAN SAY SOMETHING ABOUT THAT. WE WERE FORTUNATE TO BE ABLE TO INCREASE THE CAPACITY OF OLDER ADULTS FCCS, FIELD CAPABLE CLINICAL SERVICE AS WELL AS OLDER ADULT FULL SERVICE PARTNERSHIP PROGRAMS LAST FISCAL YEAR. YOU WILL NOTE THAT WE ARE THE SMALLEST BUREAU.

SO WE ARE THE SMALLEST, HOWEVER, WE ARE INCREASING OVER TIME. AND, SO, WHAT YOU SEE THERE IS REFLECT ACTIVE OF THE RESOURCES OF THIS TIME. OVER THE LAST FISCAL YEAR, WE CONTINUE TO BUILD AND WE CONTINUE TO GROW.

>> PUBLIC MEMBER: SO DO WE NEED TO INCREASE CAPACITY TO MEET NEEDS BUT ALSO TO START DOING EXPONENTIAL PREPARATION SO WE'RE NOT CAUGHT SHORTHANDED?

>> MARTIN JONES: YOU BRING UP A VALID POINT. AND THAT'S WHY DOING THE LAST MHSA 3-YEAR PLANNING PROCESS, THE STAKEHOLDERS AGREED TO BASICALLY, RATHER THAN START NEW PROGRAMS, TO AUGMENT THE EXISTING FCCS AND FSP PROGRAMS BECAUSE THEY'RE GOOD PROGRAMS. AND WE ALSO NEED THE CAPACITY.

>> DENNIS MURATA: AND ALSO HOW THE OLDER ADULTS ACCESS CARE AND IN TERMS OF THE COVERAGE. WE'RE GOING TO SEE AN INCREASE BECAUSE OF CAL-MEDI CONNECT AND ALSO THE POPULATION WE'VE BEEN WE'LL DOING TRADITIONALLY, FOLKS SEVERE AND PERSISTENT MENTAL ILLNESS DON'T LIVE OLDER THAN OTHER FOLKS. IT'S BEGINNING TO CHANGE. AND, HOPEFULLY, WITH INTEGRATED CARE AND BETTER HEALTHCARE AND ACCESSIBILITY HEALTHCARE, SPOKEN ABOUT A MHSA PERSON, I'LL BE AN OLDER ADULT IN AUGUST.

>> MARTIN JONES: OUR OLDER ADULTS THAT HAVE MULTIPLE CHRONIC CONDITIONS. AND, SO, THERE'S A NEED TO MANAGE THOSE. IN ADDITION TO MANAGING THE MENTAL HEALTH CONDITIONS, SO THERE IS A LOT OF JUGGLING THERE. AND I THINK OUR PROGRAMS ARE DOING A GOOD JOB IN SORT OF MOVING FORWARD WITH THIS, WITH THE RESOURCES AND THE CAPACITY WE HAVE AT THIS POINT.

>> DENNIS MURATA: AND IT MAKES A BIG DIFFERENCE AS WE IMPLEMENT HEALTH NEIGHBORHOODS. THOSE PEOPLE MIGHT BE IN A SKILLED NURSING FACILITY OR OTHER TYPE OF SETTING WHO HAVE CHRONIC DEPRESSION OR OTHER TYPES OF THINGS THAT WE DON'T SEE IN THE CLINIC. SO IT WAS IMPORTANT TO SAY, TO DEVELOP THE FIELD CAPABLE SERVICES TO GO OUT TO THE COMMUNITY. YOU'RE THE LAST ONE.

>> PUBLIC MEMBER: THANK YOU FOR ALL THE HARD WORK YOU'RE DOING. I HAVE A QUESTION. I'M A SB82 THROUGH THE WOW. I'M IN THE PROCESS. MY QUESTION IS THIS. IS [INAUDIBLE]. SO I'M ON SSI. AND THIS IS GOING TO AFFECT MY SSI. SO COULD A LADY, WENDI, IS IT EARNED INCOME OR MISCELLANEOUS INCOME? NOW THAT WE'RE BECOMING VENDORS, HOW IS IT GOING TO AFFECT ME AND MY SOCIETY?

>> WENDI TOVEY: SO SCOTT AND ISABELLE, SCOTT HANADA, THEY DID THE DISABILITY 101 TRAINING WITH YOU GUYS. YOU'RE GOING TO BE ON THE STIPEND FOR THE 400. SO WHAT HAPPENS IS, YOU MAKE THE 80, YOUR FIRST $80 IS FREE. AND EVERY $2 YOU MAKE, ONE WILL GO. SO YOU WILL STILL MAKE MORE MONEY.

>> PUBLIC MEMBER: BUT NOW THAT WE'RE BECOMING VENDORS.

>> WENDI TOVEY: IT'S THE SAME AS ALWAYS. YOU DO A 1099 BUT YOU HAD TO DO IT THROUGH THE VILLAGE BEFORE.

>> DENNIS MURATA: THE IRS IS GOING TO GET THE MONEY. EITHER WAY.

>> PUBLIC MEMBER: BEFORE YOU MAKE THE $240, THEY WILL TAKE THE $240 OUT OF YOUR SSI. BUT NOW, --

>> WENDI TOVEY: THEY ONLY SHOULD HAVE TAKEN –

>> DENNIS MURATA: THAT QUESTION –

>> WENDI TOVEY: YOU KNOW WHAT? YOU CAN EITHER CALL ME, WENDI TOVEY, OR --

>> DENNIS MURATA: THAT ISSUE, WE HAVEN'T IGNORED. WE DON'T WANT TO PUT ANYONE'S BENEFIT AT RISK, BUT THERE'S DECISIONS WE HAVE TO MAKE. ALL RIGHT. WELL –

>> PUBLIC MEMBER: YOU CAN DIRECT ME TO THE CORRECT PERSON. I'M CURIOUS. THE BOARD PASSED A MOTION ON TUESDAY RELATED TO HOMELESS CLINICS WHERE THEY'RE GOING TO GO OUT TO THE DIFFERENT SPOTS TO BASICALLY HELP PEOPLE WITH MINOR INFRACTIONS AND MISTAKE DEMEANOR.

>> DENNIS MURATA: IS THIS PART OF PROP 47?

>> PUBLIC MEMBER: IT'S DIFFERENT FUNDING. BUT IT JUST PASSED ON TUESDAY AND IT'S A 3-YEAR PROJECT. AND I'M WONDERING, COULD WE CONNECT WITH POSSIBLY COUPLE OF HOUSING AND SOME OF THESE PEOPLE TO HELP WITH THE CLINIC AND HELP PEOPLE COMING IN? BECAUSE THEY'RE MENTALLY ILL, SUBSTANCE ABUSE, ADDICTIVE, TO WORK ON THAT PROJECT. WHO WOULD I TALK TO ABOUT THAT? A MOTION PASSED BUT THE PROJECT IS ABOUT TO LAUNCH. AND I'M THINKING THIS WOULD BE ANOTHER GREAT OPPORTUNITY.

>> DENNIS MURATA: WE WERE MENTIONED AS PART OF THE MOTION?

>> PUBLIC MEMBER: NO. YOU WERE NOT MENTIONED.

>> PUBLIC MEMBER: -- [INAUDIBLE].

>> PUBLIC MEMBER: SO, I'M ACTUALLY HANDLING IT. I'M WRITING AN MOU. BUT I'M WONDERING IF THIS IS A PARTNER WE CAN SPEAK TO?

>> DENNIS MURATA: WE HAVE TO FIND OUT WHO IN OUR DEPARTMENT IS WORKING ON THAT. SO WE HAVE TO GET BACK TO YOU.

>> PUBLIC MEMBER: NOBODY.

>> DENNIS MURATA: OH, THERE IS. I JUST DON'T KNOW. WE ALWAYS HAVE SOMEBODY.

>> PUBLIC MEMBER: [INAUDIBLE].

>> DENNIS MURATA: IRMA IS GONE. OKAY. YOU KNOW WHAT? IF IT'S INVOLVING LAW ENFORCEMENT, IRMA CASTANEDA. OKAY. BETTY, YOU HAVE THE DISTINCTION OF BEING THE LAST QUESTION ASKED.

>> PUBLIC MEMBER: NOW, THIS IS DIRECTED AT HECTOR. YES, THE MENTAL CONSUMERS ARE DYING 25 YEARS EARLIER THAN THE GENERAL POPULATION. NOW, WE HAVE THE HEALTH NAVIGATORS PROGRAM THAT'S BEEN STARTED AND IT'S WORKING BEAUTIFULLY.

NOW, I'M WORKING WITH THE RESEARCH GROUP WITH UCLA AND THE SPECIFIC CLINICS TO DEVELOP A PROGRAM WHERE WE ARE GETTING THESE HEALTH NAVIGATORS TO DO THEIR JOB AND TO RECORD THE MEDICAL RECORDS OF THE CONSUMERS.

AND TO HAVE IT DONE MORE THAN ONCE A YEAR. NOW I WANTED IT DONE ONCE A MONTH. BUT I HAD TO CONCEDE WITH THE PROFESSIONAL END OF IT TO DO IT ONCE A YEAR. SO WE'VE GONE TO THREE MONTHS.

AND ONCE YOU HAVE THESE RECORDS, YOU CAN THEN GO TO THE CONSUMER AND SAY, LOOK AT HOW MUCH BETTER YOUR BLOOD PRESSURE IS, OR YOUR SUGAR READINGS ARE.

AND THAT WILL ENCOURAGE THEM TO IMPROVE THEIR HEALTH TO CONTINUE GOING TO THE DOCTORS WHICH MOST OF THEM ARE NOT DOING RIGHT NOW.

SO, YES, WE ARE GOING TO IMPROVE THE HEALTH OF OUR PEOPLE, BUT WHO IS DOING IT?

WE ARE DOING IT OBVIOUSLY. WE ARE LOOKING AFTER OBVIOUSLY. AS WE ARE WITH THIS WHOLE THING THAT'S BEEN GOING ON SINCE JANUARY, LORD, LET IT BE OVER SOON. [SIGH]

THANK YOU. AND GOODBYE. AND GOODNIGHT.

>> LARRY GASCO: DENNIS, HAS ALREADY SET THIS STAGE TO COME TO A CLOSE. ALL OF YOU ARE TROOPERS FOR BEING HERE. THERE'S AN ANNOUNCEMENT FROM REBA. I'LL STILL TALK TO YOU. SO THAT WILL BE JUNE 16. AND I ENCOURAGE IRONY TO ATTEND THAT CAN. BUT BRINGING THIS TO A CLOSE TODAY, YOU KNOW, IF YOU HAVE ANY OTHER ISSUES THAT YOU WANT TO BRING TO THE ATTENTION, THE CONTACT PERSON WOULD BE DEBBIE INNES-GOMBERG AT DIGOMBERG@DMH.LACOUNTY.GOV. IT'S IN THE BACK OF YOUR MATERIAL PRESENTATION.

I JUST WANT TO GO OVER THE LAST STEP IN TERMS OF THE APPROVAL PROCESS FOR THE MHSA PLAN UPDATES. BY CONFORMANCE BY STATE LAW, IT'S APPROVED BY THE MENTAL HEALTH ADMISSION PRIOR GOING TO THE BOARD OF SUPERVISORS WHICH HAS A FINAL APPROVAL AUTHORITY AND THEN IT ENDS AND GOES TO THE OVERSIGHT ACCOUNTABILITY COMMISSION AT THE STATE LEVEL, BUT NOT FOR APPROVAL, JUST FOR THEIR FILING

AND STORING INFORMATION ON OUR COMMISSION THAT SERVE ON THAT BODY. SO WITH THAT, THANK YOU VERY MUCH FOR BEING HERE. THANK YOU TO EVERYONE THAT PRESENTED. AND THE RESPONSES YOU GAVE.

AND, SO, I'M GOING TO HAVE YOU STAND AT THE BACK AND CATCH EVERYONE AS YOU LEAVE. BECAUSE WE'RE GOING TO SAY GOODBYE. OKAY? THANK YOU VERY MUCH.

[APPLAUDING]

[MEETING ADJOURNED AT 3:15 P.M.]

Los Angeles County Department of Mental Health
Mental Health Services Act (MHSA)
MHSA Fiscal Year (FY) 15/16 Annual Update
30-day Public Review and Comment Period
March 30, 2015 – April 29, 2015

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Emmanuel Martinez - vice President
Agency/ Organization: DMH - Latino Coalition
E-mail address: siempreperseverare3
[redacted]

Comments

Does SB-82 - Earned Income Miscellenous Income and Vendor Rules one is It does A person that gets SSI. qualifys or Affect.

Any member of the public may submit written comments on or before April 29, 2015. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

Los Angeles County Department of Mental Health
MHSA Implementation and Outcomes Division
Attention: Debbie Innes-Gomberg
695 S. Vermont Ave, 8th Floor
Los Angeles, CA 90005
Fax # (213) 351-2762

Los Angeles County Department of Mental Health
Mental Health Services Act (MHSA)
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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Emmanuel Martinez
Agency/ Organization: los Angeles County Latino Coalition
E-mail address: siempreperseverare3 @gmail.com
Mailing Address:

Comments

I Ask be Ms. Reina about how I can qualify For tax-credit housing.

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Sawako
Agency/ Organization: Asian Coalition
E-mail address: [redacted]
Mailing Address: [redacted]

Comments

I mention about LA Black at commission meeting. LA Black coalition should continue for New hand out organization that we have in the previous meeting because, many Homeless are Black and even though president Obama is black. many black are poor and substance serious crime problem. I support them

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Latino Coalition
Agency/ Organization:
E-mail address:
Mailing Address:

Comments

Thank you for conference because it very good

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Wendy Cabral

Agency/ Organization: Client/Consumer

E-mail address: [redacted]

Mailing Address:

Comments

Are these paid positions as Housing Specialists connected to SB82?
How do we find out the salary?
Clarification: Is SB82 a stipend ($1000)?

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: WENDY CABRAL

Agency/ Organization:

E-mail address: [redacted]

Mailing Address: 4545 E AVE. ST. Lancaster, CA 93536

Comments

What are the programs that don't require the Federal definition of chronicness?

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County of Los Angeles – Department of Mental Health
Mental Health Commission – Public Hearing
May 28, 2015
Sign-In Sheet

Check (✓) applicable category (•)

Name	Interested Citizen	Family Member	Consumer	Other (Please Specify)	Address	Phone Number Fax or Email Address
Jaime Garcia				HASC	575 Figueroa St #1300 LA 90071	jgarcia@hasc.org
Blanca Esthela			✓			323 664 1804
Armida Angeles			✓		7025 Seville Ave. H.P. Ca 90255	323 800 4779
Sawako Nitou			✓		4845 Marionwood DR CC 90230	310 391 0930
Haydee Guevara			✓		5822 Willoughby Ave Rt 101	818 939-6948 Cell
Cindy Kim						
Sydney Woods			✓	✓	12028 Platon St. Norwalk CA 90650	562)413-7477
Marion Elena Juarez			✓		2138 Clinton St #4 LA 90026	217-4841932
[illegible]				✓	506 W. Jackman St, Lancaster 93534	(661) 726-2880
Bishop Hiram L Vaughn			✓		506 W. Jackman St Lancaster 93534	
Martin Karmatz			✓		525 Hg Sycamore Ave #213	
Hector Lamier				LA Co Commission		
Patricia Russell		✓			4465 Katherine Ave Sherman Oaks 91423	818-292-3399 [illegible]

County of Los Angeles – Department of Mental Health
Mental Health Commission – Public Hearing
May 28, 2015
Sign-In Sheet

Check (✓) applicable category (•)

Name	Interested Citizen	Family Member	Consumer	Other (Please Specify)	Address	Phone Number Fax or Email Address
Emmanuel Martinez			✓	Volunteer	622 W. 75th St., Apt #5 LA 90044	(424) 221-3383
April Mitchell				✓ MHA	506 W Jackman St Lancaster 93534	amitchell@Mhala.org
Cheryl Reaves			✓	MHA	N/A	N/A
Celinda Jungkani			✓	SAAC.S	13219-G Fiji Way, Marina del Rey 90292	310 339-8091
Robert [illegible]				MHA	506 W. Jackman St.	661 470-7910
Catherine Lipscomb			✓		—	(323) 335-4155
Betty Dandino			✓		170 E. Walnut St #103 Pasadena 91103	626-688-3601
Linda Young			✓		306 VC on NCAPF	323 261 0943
Barbara Wilson		✓			23638 Lyons Av #214 Newhall 91321	818 517 9902
Sue Han	✓		✓		181 N. La Brea Ave. #8 90046	stouxhan@hotmail.com
[illegible]				MHC		

County of Los Angeles – Department of Mental Health
Mental Health Commission – Public Hearing
May 28, 2015
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Check (✓) applicable category (•)

Name	Interested Citizen	Family Member	Consumer	Other (Please Specify)	Address	Phone Number Fax or Email Address
Tanya Salazar			✓		306 W. Jackman St Lancaster 93534	
Ashla Oh				County		

County of Los Angeles - Department of Mental Health
Mental Health Commission - Public Hearing
May 28, 2015
Sign-In Sheet

DMH Staff

NAME	PROGRAM	EMAIL ADDRESS
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Mike [illegible]	CSOC	MALBA@DMH
Wendi Torrey	ASOC	wtorrey
Urmi N Patel	ASOC	upatel

DMH Staff

County of Los Angeles - Department of Mental Health
Mental Health Commission - Public Hearing
May 28, 2015
Sign-In Sheet

NAME	ORGANIZATION	EMAIL ADDRESS
TERRI BOYKINS	DMH	Tboykins@dmh.lacounty.gov.
Beth Briscoe	DMH	bbriscoe@dmh.lacounty.gov
Sunghai Miguda-Armstead	MH Comm.	sunghai.miguda-armstead@lacounty
OSPEE SPANGLER	BLACCC/BACIC Los Angeles County	Client Coalition slapp4390@yahoo.com
Kevin Tsang	DMH/OASCC	on file
Gordon Bunch	DMH/CIOB	gbunch@dmh.lacounty.gov

TO OBTAIN ADDITIONAL INFORMATION CONTACT:

DEBBIE INNES-GOMBERG, PH.D.
DIGOMBERG@DMH.LACOUNTY.GOV
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