MENTAL HEALTH SERVICES ACT
ANNUAL UPDATE
FISCAL YEAR 2018-19

LACDMH
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WELLNESS • RECOVERY • RESILIENCE

Los Angeles County – Department of Mental Health
Jonathan E. Sherin, M.D., Ph.D., Director

LOS ANGELES COUNTY BOARD OF SUPERVISORS
ADOPTED ON JUNE 6, 2018

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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):

MHSA Component	Dates Approved by the State
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)	INN I-Feb. 2, 2010
	INN 2-May 28, 2015
Capital Facilities (CF) Plan	April 19, 2010

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:

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Los Angeles County Department of Mental Health
(213) 738-2756 or DIGomberg@dmh.lacounty.gov

Director's Message

Since its passage in 2004, the Mental Health Service Act (MHSA) has offered an unparalleled opportunity for public mental health (MH) systems to engage communities across California in developing and promoting the best plans for serving those in need. In Los Angeles, all of us at the Department of Mental Health (DMH) rely on and greatly appreciate input from Service Area Advisory Councils, the Systems Leadership Team and the MH Board (Commission) -- core stakeholder groups that are key partners in such planning. Given our charge to facilitate this engagement, a variety of efforts are underway to simplify the means for getting input from the broadest set of constituents.

Key service expansions under development now and in the coming years include:

- Increasing awareness of treatments for mental illness and reducing stigma to improve access to care
- Growing support systems for traumatized families, households and neighborhoods
- Leveraging community access points (including schools, libraries and parks) to identify those in need, mitigate the development of serious mental illnesses, and prevent deterioration for those already suffering
- Reaching individuals with mental illness who are languishing without care on our streets, lack access to safe and supportive living environments in shelters and jails. We must also foster more supportive environments for these individuals in urgent care centers, hospitals and across the health care system
- Expanding personal recovery and community reintegration through peer support services

To accomplish these goals, we are committed to optimizing the assets and expertise of DMH and our partners across all sectors to improve the match between resources and needs throughout our great County.

In collaboration,

Jon

Executive Summary

This Annual Update of Los Angeles County Department of Mental Health Mental Health Services Act (MHSA) funded programs reports on the programs serving clients during Fiscal Year (FY) 2016-17 and includes a proposed spending plan for accumulated MHSA funds.

FY 2016-17 Programs

Community Services and Supports Plan

- 131,106 clients served
- 43,108 additional clients were outreached and engaged into services
- 11,449 clients were served in Full Service Partnership (FSP)
  - 6,828 FSP slots have been added (or in process) since the July 1, 2016
- 39,293 clients were served in Mental Health Urgent Care Centers (UCC), as an alternative to psychiatric inpatient or emergency department use
  - 94% of clients served at a UCC did not present for psychiatric inpatient or emergency department services within 30 days of the UCC visit.
- 192 housing units in Service Areas 1,2,3 and 6 were created in FY 2016-17

A Deeper Analysis of FSP Outcomes

- Most clients experience the greatest amount of progress during the first year in an FSP program but continue to see improvement in outcomes during subsequent years.
- FSP programs should focus on sustaining engagement and providing services and supports that result in clients remaining as an FSP for at least one year.
- Moderate relationships exist between client having lost contact and homelessness. Data suggests a moderate relationship between field-based work and a client not losing contact with an FSP team, resulting in a disenrollment

Impact on school functioning:

- Child and TAY all improve their grade distribution over two years in partnership but experience the most change during the first year in partnership.
- 38% of child FSP clients reported experiencing truancy or sporadic attendance, suspension or expulsion and/or failing classes at school as one of the reasons for referral

Living with family as a protective factor:

- Living with family is negatively correlated with justice involvement and with homelessness for Transition Age Youth.

Impact on Homelessness:

- 46% of the TAY FSP clients reported homeless as one of the reasons for referral
  - 39% reduction in days homeless
  - 23% reduction in clients homeless
- 69% reduction in days homeless for adult FSP clients
- 30% reduction in Adult FSP clients homeless
- 59% reduction in days homeless for Older Adult FSP clients
- 31% reduction in Older Adult FSP clients homeless

Impact on Psychiatric Hospitalizations for Children:

- 45% reduction in days hospitalized
- 36% reduction in the number of clients hospitalized

Impact on Psychiatric Hospitalizations for Transition Age Youth:

- 25% reduction in days hospitalized
- 45% reduction in the number of clients hospitalized

Impact on Psychiatric Hospitalizations for Adults:

- 67% reduction in days hospitalized
- 25% reduction in the number of clients hospitalized

Impact on Living Independently for Adults:

- 46% increase in days living independently
- 47% increase in the number of clients living independently

Executive Summary (continued)

Prevention and Early Intervention

- 41,962 clients were served in Prevention and Early Intervention programs.
  - 69% of services were delivered to children
  - 63% of services were delivered to Latino clients
- Evidence-Based Practices have resulted in improved functioning and reduced mental health symptoms:
  - Depression
    - 55% reduction after completing Managing and Adapting Practice
    - 54% reduction after completing Interpersonal Psychotherapy
    - 53% reduction after completing Cognitive Behavioral Therapy
  - Trauma
    - 46% reduction after completing Managing and Adapting Practice
    - 51% reduction after completing Trauma-Focused Cognitive Behavior Therapy
  - Family Functioning
    - 50% reduction after completing Families Over Coming Under Stress
  - Disruptive behaviors
    - 47% reduction after completing Managing and Adapting Practice
    - 50% reduction after completing Triple P Parenting
- Mental Health First Aid training has resulted in 34% more recipients reporting moderate to extreme knowledge of mental illness signs and symptoms.
- Suicide Prevention Hotline use results in decreased self-rated suicide intent at the conclusion of the hotline contact, for clients at all risk levels

Proposed Spending Plan for Accumulated MHSA Funds

Since the adoption of the Department's MHSA 3 Year Program and Expenditure Plan for Fiscal Years 2017-18 through 2019-20, the Department has developed a proposed spending plan for accumulated MHSA funds that includes funding a series of mid-year adjustments to that plan that will expand Prevention and Early Intervention services and new Innovation projects. Broadly, the proposed spending plan aims to address seven key Board of Supervisors and LA County priorities:

- Improving access to crisis services, including Psychiatric Mobile Response Team expansion to engage the unengaged and increased outreach and engagement capacity
- Expanding the Department's inventory of critical care environments, including Urgent Care Center expansion and infrastructure
- Full Service Partnership program expansion to serve individuals with a mental illness who are homeless, using inpatient psychiatric resources, incarcerated or on conservatorship with intensive service needs
- Resourcing directly operated clinics to improve access to care by adding prescribers (psychiatrists, nurse practitioners, pharmacists) and infrastructure for more robust community-based services across the County
- Investing in the development of recovery- and reintegration-focused resources for client, family and community Wellbeing, including introducing child wellbeing services, the addition of funding in Recovery, Resilience and Reintegration programs for rental subsidies that will help clients attain and maintain independent living, expansion of Transition Age Youth Drop-In Centers and supported employment for Transition Age Youth

Executive Summary (continued)

Proposed Spending Plan for Accumulated MHSA Funds (continued)

- Developing our prevention capacity through education initiatives, awareness campaigns, early illness identification at strategic access points such as the Medical Hubs, parks, community centers and libraries and trauma mitigation services
- Building and/or acquiring residential treatment and living environments, including permanent supportive housing, for those in need
- Enhancing Board and Care facility ability to meet the needs of resident clients through the introduction of a residential treatment need assessment
- Addressing treatment disparities within under-served cultural communities
- Shoring up departmental infrastructure
- Further enhancement of the public mental health workforce through the continuation of Workforce Education and Training

The full spending plan was posted on February 16, 2018 for public comment on the Department's website and is contained in the following pages of this Annual Update (pages 9-28).

Proposed Spending Plan for Accumulated MHSA Funds

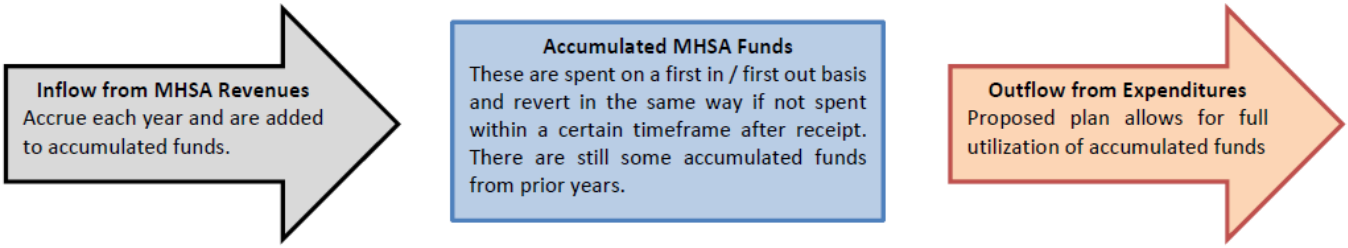
The LACDMH Proposed Spending Plan for Accumulated MHSA Funds was posted to the DMH website for public comment on February 16, 2018: http://dmh.lacounty.gov/wps/portal/dmh/press_center/announcements.

County of Los Angeles – Department of Mental Health

Proposed Spending Plan for Accumulated MHSA Funds

Over prior years, the Los Angeles County Department of Mental Health (DMH) has accumulated Mental Health Services Act (MHSA) funds, some of which must be spent this current fiscal year 2017-18, and others which must be spent over the next two fiscal years by June 30, 2020. For this current fiscal year, MHSA dollars associated with $57.931 million in Community Services and Support funding; $90.133 million in Prevention and Early Intervention; $24.200 million Workforce Education and Training; and $16.500 million Capital Facilities/Information Technology are subject to reversion to the State if not spent by June 30, 2018.

The current Three-Year Plan, previous Mid-Year Adjustments, and other public updates reflect allocations for programs and projects based on these accumulated funds which, if spent according to plan, would utilize them quickly enough to prevent any funds from reverting. In order to fully utilize all accumulated MHSA funds, DMH is proposing a spending plan containing new and/or expanded programs and projects, as an addition to the current spending plan associated with previous allocations.



Both the previous allocations in the current spending plan, as well as the proposed new and/or expanded programs and projects reflected in this document aim to address seven key DMH priorities that align with Board-approved County initiatives:

1. improve access to crisis services;
2. expand the inventory of critical care environments;
3. resource directly operated clinics with additional prescribers (psychiatrists, nurse practitioners, pharmacists), full-service partnerships and infrastructure to improve access to care and provide more robust community-based services across the County;
4. invest in the development of recovery- and reintegration-focused resources for client, family and community well-being;

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5. develop prevention capacity through education initiatives, awareness campaigns, early illness identification, and trauma mitigation services;
6. build and/or acquire residential treatment and living environments for those in need; and
7. shore up departmental infrastructure.

This draft proposal is organized according to these key priorities, with the current and proposed spending plans for each priority broken down by their constituent MHSA funding categories shown below. The programs and projects listed in this draft proposal may also receive funding from current and future MHSA revenues and/or other funding sources. The table below shows the total amount of these accumulated MHSA funds by spending category, as well as the dollar amounts associated with the current and proposed spending plans.

- **CSS:** Community Services and Support
- **PEI:** Prevention and Early Intervention
- **INN:** Innovation
- **WET:** Workforce Education and Training
- **CF/IT:** Capital Facility and Information Technology

	CSS	PEI	INN	WET	CF/IT	Total*
Total Accumulated MHSA Funds from Prior Years	$453,800,000	$272,737,000	$129,720,000	$24,200,000	$16,500,000	$896,957,000
Less: Total Current Spending Plan *Previously allocated programs/projects*	262,869,000	110,260,000	129,720,000	24,200,000	16,500,000	$543,549,000
Total Proposed Spending Plan *New and/or expanded programs/projects*	$190,931,000	$162,477,000	$ -	$ -	$ -	$353,408,000

**Does not include the mandated allocation to Prudent Reserve*

Please note **this is still a draft proposal.** DMH is seeking feedback and input from its stakeholders, especially on the proposed spending plan for new and/or expanded programs/projects, so as to revise and strengthen it over the coming weeks. Please direct your feedback to our Deputy Director of Strategic Communications, Mimi McKay (MMMcKay@dmh.lacounty.gov).

I. Crisis Services

Strategic, visible and highly accessible outreach, engagement and triage services at key access points funded through CSS.

	Current Spending Plan: *Previously allocated programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
	Total Previously Allocated	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
	Proposed Spending Plan: *New and/or expanded programs/projects*	**CSS**	**PEI**	**INN**	**WET**	**CF/IT**	**Total**
1	Psychiatric Mobile Response Team (PMRT) Expansion for Engage the Disengaged (Supervisor Barger Motion)	$16,295,000	$ -	$ -	$ -	$ -	**$16,295,000**
2	Mobile Triage Teams and Administration (SB 82)	12,095,000					**$12,095,000**
3	Crisis Transition Specialists Non-Governmental Agency (SB 82)	834,000					**$834,000**
4	California Health Facilities Financing Authority (CHFFA) Mobile Team (SB 82)	2,726,000					**$2,726,000**
5	Assisted Outpatient Treatment - Expansion	7,450,000					**$7,450,000**
	Total Proposed New and/or Expanded	**$39,400,000**	**$ -**	**$ -**	**$ -**	**$ -**	**$39,400,000**
	CRISIS SERVICES Grand Total Spending Plan	**CSS**	**PEI**	**INN**	**WET**	**CF/IT**	**Total**
		$39,400,000	**$ -**	**$ -**	**$ -**	**$ -**	**$39,400,000**

Descriptions – Previously Allocated Programs/Projects

None

Descriptions – Proposed New and/or Expanded Programs/Projects

(1) Psychiatric Mobile Response Team expansion through the development of dedicated multi-disciplinary care teams to engage disengaged clients utilizing person-centered outreach and triage strategies that connect and refer clients for treatment, including Assisted Outpatient Treatment teams.

(2) Continuation of SB 82 Mobile Triage teams and administration, including crisis transition specialists who provide intensive case management for up to 60 days after discharge from Urgent Care Centers.

(3) Augmentation of the Los Angeles County Department of Health Services (DHS) diversion programs for at-risk youth by educating and training potential responders, such as families, school personnel, community service providers, and law enforcement personnel.

(4) Same as (3) above.

(5) Expansion of outreach and engagement capacity for Assisted Outpatient Treatment.

II. Critical Care Environments

Outpatient or short-term residential services for those in urgent need to avoid unnecessary psychiatric inpatient care.

	Current Spending Plan: *Previously allocated programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
	Total Previously Allocated	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
	Proposed Spending Plan: *New and/or expanded programs/projects*	**CSS**	**PEI**	**INN**	**WET**	**CF/IT**	**Total**
1	Harbor Urgent Care Clinic (UCC) Capital Improvement, Start-Up and Operating Costs	$16,093,000	**$ -**	**$ -**	**$ -**	**$ -**	**$16,093,000**
2	UCCs Capital Improvement & Start-Up Costs (3 UCCs with Star View)	4,720,000					**$4,720,000**
	Total Proposed New and/or Expanded	**$20,813,000**	**$ -**	**$ -**	**$ -**	**$ -**	**$20,813,000**
	CRITICAL CARE ENVIRONMENTS Grand Total Spending Plan	**CSS**	**PEI**	**INN**	**WET**	**CF/IT**	**Total**
		$20,813,000	**$ -**	**$ -**	**$ -**	**$ -**	**$20,813,000**

Descriptions – Previously Allocated Programs/Projects

None

Descriptions – Proposed New and/or Expanded Programs/Projects

(1-2) Expansion of the urgent care system to fund capital improvements, startup costs and operating costs for new urgent care clinics.

III. Outpatient Treatment and Stabilization

Outpatient mental health services focused on treatment and stabilization of clients.

	Current Spending Plan: *Previously allocated programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
1	Full Services Partnerships (FSP) - Housing, Homeless, Whole Person Care, Incarcerated, Public Guardian, including INN 5 - Peer FSP	$104,290,000	$ -	$7,015,000	$ -	$ -	**$111,305,000**
2	Financial Incentive Programs - Mental Health Psychiatrists				12,787,000		**$12,787,000**
3	INN 4 - Transcranial Magnetic Stimulation (TMS)			1,982,000			**$1,982,000**
4	Interpreter Training Program				120,000		**$120,000**
5	Stipend Program for MSWs, MFTs, and NPs				6,127,000		**$6,127,000**
6	Harbor-UCLA Post Doctorate Fellowship Program				500,000		**$500,000**
7	WET Administration Staff Costs				2,367,000		**$2,367,000**
	Total Previously Allocated	**$104,290,000**	**$ -**	**$8,997,000**	**$21,901,000**	**$ -**	**$135,188,000**

	Proposed Spending Plan: *New and/or expanded programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
8	Service Extenders	$189,000	$ -	$ -	$ -	$ -	**$189,000**
9	Directly Operated Clinics Expansion	19,883,000					**$19,883,000**
10	Vehicles for Various Field-Based Programs	1,146,000					**$1,146,000**

	Proposed Spending Plan (cont'd): *New and/or expanded programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
11	Services in Board and Care Facilities	27,725,000					**$27,725,000**
12	Underserved Populations	8,316,000					**$8,316,000**
	Total Proposed New and/or Expanded	**$57,259,000**	**$ -**	**$ -**	**$ -**	**$ -**	**$57,259,000**

OUTPATIENT TREATMENT & STABILIZATION Grand Total Spending Plan	CSS	PEI	INN	WET	CF/IT	Total
	$161,549,000	**$ -**	**$8,997,000**	**$21,901,000**	**$ -**	**$192,447,000**

Descriptions – Previously Allocated Programs/Projects

(1) Through a solicitation and enhancement of directly operated programs, 5,156 FSP slots are being added for clients ages 18 and above, with a focus on serving clients with intensive psychiatric service use who: are homeless or recently homeless and recently housed; have recent (including current) incarceration histories; and are in adult residential settings. This includes Innovation 5: Peer FSP.

(2) Financial incentive program that offers an education loan repayment incentive to eligible Mental Health Psychiatrists at the end of each year of continuous service for a maximum of five years.

(3) Innovation 4 will allow Transcranial Magnetic Stimulation (TMS) to be delivered to clients in Board and Care Facilities with treatment resistant depression.

(4) Training for bilingual staff to provide interpreter services for clinical sessions, as well as monolingual clinicians on how to use interpreters properly.

(5) Stipend program for Masters of Social Work (MSW), Marriage and Family Therapists (MFT), and Nurse Practitioners (NP). Funding is for second-year students in the above programs in exchange for a minimum of one-year work commitments in hard-to-fill geographic areas of the County.

(6) Post-doctoral fellowships are offered to participants who are interested in pursuing education in a subspecialty. These particpants will have finished their psychiatry residency and are Board-eligible to work as psychiatrists.

(7) Funding to cover administrative overhead for the WET Program.

Descriptions – Proposed New and/or Expanded Programs/Projects

(8) Service Extenders are peers (clients in recovery), family members or interested individuals who serve as volunteer members of a clinical team providing mental health services to older adults. Service Extenders provide home visits, supports and resources to clients served. PEI funding is needed to provide service extenders with stipends to cover expenses such as food, parking, and travel while providing services as a part of the clinical team.

(9) Additional prescriber capacity in the directly operated clinics throughout the County mental health care system.

(10) Funding will provide for the purchase of vehicles for field-based services programs - Assisted Outpatient Teams, Law Enforcement Teams and the Mental Health Court Linkage Program.

(11) Enhancement of service capacity in Board and Care facilities guided by the use of the Multnomah Community Functioning Scale to assess and inform the level of residential treatment need.

(12) Funding will allow for expansion of services to address treatment disparities for the Asian Pacific Islander, African immigrant and other under-served cultural communities.

IV. Outpatient Recovery

Outpatient mental health services and supports to promote client and community wellbeing.

	Current Spending Plan: *Previously allocated programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
1	Child Well-Being Services	$2,922,000	$ -	$ -	$ -	$ -	**$2,922,000**
2	Directly Operated Expansion of Recovery, Resiliency & Reintegration (RRR) Services	29,894,000					**$29,894,000**
3	Intensive Mental Health Recovery Specialist Core Training Program				739,000		**$739,000**
4	Recovery Oriented Internship Training				200,000		**$200,000**
	Total Previously Allocated	**$32,816,000**	**$ -**	**$ -**	**$939,000**	**$ -**	**$33,755,000**

	Proposed Spending Plan: *New and/or expanded programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
5	Women's Re-entry and Re-Integration Program	$4,832,000	$ -	$ -	$ -	$ -	**$4,832,000**
6	Flex Funds for Housing for Clients in Recovery	21,915,000					**$21,915,000**
7	Additional Awards for Transition Age Youth (TAY) Supported Employment Pilot Project	1,124,000					**$1,124,000**
8	New/Expanded TAY Drop-In Center Services	9,721,000	5,134,000				**$14,855,000**
9	North Hollywood Health Center Project	1,349,000					**$1,349,000**
	Total Proposed New and/or Expanded	**$38,941,000**	**$5,134,000**	**$ -**	**$ -**	**$ -**	**$44,075,000**

PROPOSED SPENDING PLAN

OUTPATIENT RECOVERY Grand Total Spending Plan	CSS	PEI	INN	WET	CF/IT	Total
	$71,757,000	$5,134,000	$ -	$939,000	$ -	$77,830,000

Descriptions – Previously Allocated Programs/Projects

(1) Expansion of Recovery, Resilience and Reintegration (RRR) services designed for children and youth who are stepping down from more intensive services, yet continue to require some medically necessary clinical services, support groups, and resources within the community.

(2) Expansion of directly operated RRR services to provide a low level of care for clients stepping down from more intensive services.

(3) The Intensive Mental Health Recovery Specialist Core Training Program prepares participants with core knowledge and experience to work in the public mental health system as Recovery Specialists.

(4) The Recovery Oriented Internship Training promotes recovery oriented and integrated core principles, and provides student training critical to their work in the public mental health system.

Descriptions – Proposed New and/or Expanded Programs/Projects

(5) Mental health treatment focused on mentally-ill women released from the Los Angeles County correctional facility. Services are geared toward re-establishing meaningful and productive roles, including education, employment, family reunification, and community integration.

(6) Client Supportive Services Flex funding that is for use with clients in RRR programs. These funds can pay for rental subsidies, as well as other recovery supports.

(7) Supported employment expansion that provides services and training to enable TAY clients to obtain and maintain employment.

(8) Expansion of TAY Drop-In Centers that will amend existing agreements to add funding for a series component for youth diversion programming, as well as program monitoring and oversight of the drop-in centers.

(9) Co-location with Los Angeles County Health Agency departments - DHS and Department of Public Health (DPH) at the new North Hollywood Health Center to provide health, public health and mental health care.

V. Prevention

These projects seek to expand the array, approach and foci of prevention, early identification and early intervention efforts in Los Angeles County. These programs aim to prevent mental illness by addressing risk factors associated with mental illness, increasing protective factors associated with mental health and resilience, intervening early in the course of a mental illness, promoting stigma and discrimination reduction, preventing suicide, and strategic outreach for increasing early recognition of mental illness.

	Current Spending Plan: *Previously allocated programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
1	Veterans Community Colleges	$ -	$2,054,000	$ -	$ -	$ -	**$2,054,000**
2	Veteran Peer Services - Directly Operated Program (Battle Buddies)		3,492,000				**$3,492,000**
3	Victims of Commercial Sexual Exploitation (CSECY) and Human Trafficking Trauma Unit		1,496,000				**$1,496,000**
4	PEI Supportive Services for Clients in Supportive Housing		4,725,000				**$4,725,000**
5	Boys and Girls Club - Project Learn		4,109,000				**$4,109,000**
6	LGBTQ Dialogue Series		42,000				**$42,000**
7	Domestic and Intimate Partner Violence Prevention		2,054,000				**$2,054,000**
8	Promotores - Directly Operated Programs		6,186,000				**$6,186,000**
9	Promotores - Subcontract with Community Based Organizations		2,465,000				**$2,465,000**
10	Hub Enhancement (Expansion to all Hubs, Prevention & Aftercare Network, Home Visiting, Youth Diversion Program)	2,143,000	83,637,000				**$85,780,000**
11	INN 2 - Community Capacity Building			83,269,000			**$83,269,000**

	Current Spending Plan (cont'd): *Previously allocated programs/projects*	**CSS**	**PEI**	**INN**	**WET**	**CF/IT**	**Total**
12	INN 2 - Evaluation			4,454,000			**$4,454,000**
13	INN 3 - Technology Suite			33,000,000			**$33,000,000**
14	Health Navigators (Adult and Family)				400,000		**$400,000**
15	Peer Training				400,000		**$400,000**
16	Underserved Cultural Communities Recruitment				560,000		**$560,000**
	Total Previously Allocated	**$2,143,000**	**$110,260,000**	**$120,723,000**	**$1,360,000**	**$ -**	**$234.486,000**

	Proposed Spending Plan: *New and/or expanded programs/projects*	**CSS**	**PEI**	**INN**	**WET**	**CF/IT**	**Total**
17	LA Unified School District	$ -	$5,695,000	$ -	$ -	$ -	**$5,695,000**
18	School Based Services		20,543,000				**$20,543,000**
19	Library Services		23,420,000				**$23,420,000**
20	Los Angeles County of Education - Project Fatherhood		82,000				**$82,000**
21	Didi Hirsch Suicide Prevention Projects		2,905,000				**$2,905,000**
22	Federally Qualified Health Centers Services to the Uninsured		8,217,000				**$8,217,000**
23	African American Conference		123,000				**$123,000**
24	CalMHSA Media Campaigns		15,407,000				**$15,407,000**
25	MTA Outdoor Media Campaigns Underserved Community Media Program		11,504,000				**$11,504,000**

	Proposed Spending Plan (cont'd): *New and/or expanded programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
26	CalMHSA Joint Powers Agreement		6,379,000				**$6,379,000**
27	Implicit Bias and GARE Training		637,000				**$637,000**
28	Cultural Competency		2,671,000				**$2,671,000**
29	Parks After Dark Expansion		8,382,000				**$8,032,000**
30	Modular Structures for Office/Clinic Space		10,272,000				**$10,272,000**
31	NAMI Psychosis Services		24,652,000				**$24,652,000**
32	Family Finding		16,454,000				**$16,454,000**
	Total Proposed New and/or Expanded	**$ -**	**$157,343,000**	**$ -**	**$ -**	**$ -**	**$157,343,000**

PREVENTION Grand Total Spending Plan	CSS	PEI	INN	WET	CF/IT	Total
	$2,143,000	**$267,603,000**	**$120,723,000**	**$1,360,000**	**$ -**	**$391,829,000**

Descriptions – Previously Allocated Programs/Projects

(1) Funding will allow for case management services offered to veterans and their families who suffer from Post-Traumatic Stress Disorder or other mental health conditions resulting from recent combat duty. Services will be provided on community college campuses.

(2) Mental health support offered to veterans that leverages the "battle buddy" peer support approach.

(3) The Victims of Commercial Sexual Exploitation (CSECY), Domestic Violence, Trafficking, and Lesbian, Bisexual, Gay, Transgender and Questioning (LGBTQ) youth unit will coordinate DMH's efforts to address and inform agencies in providing appropriate trauma-informed services to current and former victims of CSECY, Domestic Violence, and Human Trafficking.

(4) Delivery of PEI services to residents of permanent supportive housing that targets risk factors with the goal of increasing protective factors. Services will be provided onsite whenever possible, including mentoring/coaching, school help, life skills, and renting skills.

(5) Boys and Girls Club - Project Learn is an afterschool program for specific service areas that offer parenting workshops, college information, and other supports which engage youth in learning to improve academic outcomes.

(6) Opportunities to improve services for LBGTQ individuals, including reducing disparities and increasing access to mental health services.

(7) Domestic and Intimate Partner Violence Prevention is a community-based outreach and engagement, educational prevention program to reduce and/or eliminate domestic abuse, spousal abuse, battering, family violence, and intimate partner violence, patterns and behavior. Raising educational awareness is important for at-risk individuals in group and peer support meetings, as well as educational training for service providers working with these victims.

(8) The Promotores program includes the use of community health workers who are not certified health care professionals but have been trained to promote health or provide preventive healthcare services within their community, including educational and awareness building activities.

(9) Same as (8) above.

(10) Expansion of mental health services, in the form of trauma and depression focused mental health interventions, to children and youth at County-operated Medical Hubs. Services include identification of children and youth in the County Department of Children and Family Services (DCFS) Prevention Aftercare Networks who are at risk of developing mental illness; intervention by increasing protective factors and addressing identified risk factors; expansion of DPH and First 5 home visiting services as a way to assess and protect against the impact of adverse childhood experiences. This also includes expansion of mental health services to youth at risk of entering the criminal justice system through programming and training of staff providing supports, as well as youth diversion programming.

(11) Innovation 2: Community Capacity Building to address and prevent trauma.

(12) Same as (11) above.

(13) Innovation 3: DMH, in conjunction with several other counties is part of a technology collaborative to improve access to mental health care and detect mental health symptoms earlier. The technology suite of applications will allow for early detection of mental illness.

(14) Funding is for training peers known as health navigators to navigate and advocate for clients in the public health and mental health systems.

(15) Peer training that is designed to develop the knowledge, skills and abilities to work in the public mental health system.

(16) Underserved Cultural Communities (UsCC) Recruitment of BA degree level individuals from underserved communities interested in working in the public mental health system.

Descriptions – Proposed New and/or Expanded Programs/Projects

(17) Expansion of services with Los Angeles Unified School District to deliver the evidence-based practice FOCUS (Families Overcoming Stress).

(18) Comprehensive prevention, early intervention and treatment services on school campuses that promote social and emotional development and school achievement for children and youth that include mental health consultation, family engagement, behavioral supports, restorative justice, early intervention in the forms of social skills groups and case management, and other more intensive services.

(19) Infusion of additional mental health services and supports to the County library system.

(20) Funding for the Los Angeles County Office of Education to deliver Project Fatherhood (Prevention Practice identified as part of the Three Year Plan) services in Head Start Programs.

(21) Expansion of suicide hotline services, as well as development of a new suicide prevention center to address the steady increase in calls.

(22) Early Intervention mental health services delivered by Federally Qualified Health Centers (FQHCs) to uninsured clients.

(23) An annual conference focused on training topics that are culturally relevant for identifying and providing mental health care and supports to African and African American communities.

(24) Development of mental health prevention-oriented media campaigns.

(25) Same as (24) above.

(26) Joint Powers Agreement with CalMHSA for Statewide PEI Initiatives focused on sustaining PEI programs. The agreement will provide planning, development, implementation and sustenance of current and ongoing projects related to stigma and discrimination reduction, suicide prevention, and infusion of mental health services and supports on school campuses.

(27) Implicit Bias and Government Alliance on Race and Equity (GARE) training is an initiative to optimize cultural competence that serves to prevent mental illness and emotional problems in individuals who likely have social determinant risk factors exacerbated by often long held attitudes, beliefs and corresponding actions of mental health staff related to gender, ethnicity and sexual orientation.

(28) Additional cultural competence training to support a culturally competent workforce.

(29) Expansion of mental health services and hours for at-risk youth and families at 23 existing and 10 new County parks.

(30) Modular structures that are converted into office/clinic space which will be used to provide and expand mental health services at the Medical Hubs and school-based centers.

(31) National Alliance for the Mentally Ill (NAMI) - Expansion of early psychosis services through PIER model and activities promoting stigma discrimination reduction and outreach.

(32) Expansion of mental health services and supports for DCFS involved children to identify permanent homes through family and care givers.

VI. Treatment and Living Environments

Investments in housing infrastructure for public mental health clients that range from short-term residential environments to permanent supportive housing.

	Current Spending Plan: *Previously allocated programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
1	Community Development Commission (CDC) Housing	$112,382,000	$ -	$ -	$ -	$ -	**$112,382,000**
2	California Housing Finance Agency (CalHFA) Housing Developments	11,238,000					**$11,238,000**
	Total Previously Allocated	**$123,620,000**	**$ -**	**$ -**	**$ -**	**$ -**	**$123,620,000**
	Proposed Spending Plan: *New and/or expanded programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
3	Crisis Residential Treatment Program Capital Improvements & Start-Up Costs	$10,002,000	**$ -**	**$ -**	**$ -**	**$ -**	**$10,002,000**
4	Restorative Care Villages on DHS campuses Capital Improvements	17,419,000					**$17,419,000**
5	Whole Person Care II Community Care Residential Facilities	3,585,000					**$3,585,000**
6	TAY Enhanced Emergency Shelter Program	3,512,000					**$3,512,000**
	Total Proposed New and/or Expanded	**$34,518,000**	**$ -**	**$ -**	**$ -**	**$ -**	**$34,518,000**
	TREATMENT & LIVING ENVIRONMENTS	CSS	PEI	INN	WET	CF/IT	Total
	Grand Total Spending Plan	**$158,138,000**	**$ -**	**$ -**	**$ -**	**$ -**	**$158,138,000**

17

Descriptions – Previously Allocated Programs/Projects

(1-2) Development of permanent supportive housing through a Community Development Commission Notice of Funding Availability and through the California Housing Finance Authority (CalHFA).

Descriptions – Proposed New and/or Expanded Programs/Projects

(3) Crisis residential treatment programs provide safe, home-like community environments that offer programming and services that promote the well-being and recovery of the individuals transitioning from UCCs, psychiatric emergency departments and inpatient units, as well jails. Funding is for capital development and start-up costs.

(4) The Restorative Care Villages will provide a full continuum of integrated programming and services for patients/clients/consumers who require physical health, mental health, substance use disorder treatment and housing related services and supports. Funding is for capital improvements to develop these villages on DHS campuses.

(5) Community care residential facilities will expand access for residential care for Whole Person Care clients. Support services will be enhanced by providing additional staff and supervision to give more support for lower level care to these clients stepping down from intensive care.

(6) TAY enhanced emergency shelter expansion to increase bed capacity.

VII. Departmental Infrastructure

	Current Spending Plan: *Previously allocated programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
1	Downtown MHC Parking Lot	$ -	$ -	$ -	$ -	$4,000,000	$4,000,000
2	Information Technology - IBHIS					12,500,000	$12,500,000
	Total Previously Allocated	$ -	$ -	$ -	$ -	$16,500,000	$16,500,000

	Proposed Spending Plan: *New and/or expanded programs/projects*	CSS	PEI	INN	WET	CF/IT	Total
	Total Proposed New and/or Expanded	$ -	$ -	$ -	$ -	$ -	$ -

DEPARTMENTAL INFRASTRUCTURE Grand Total Spending Plan	CSS	PEI	INN	WET	CF/IT	Total
	$ -	$ -	$ -	$ -	$16,500,000	$16,500,000

Descriptions – Previously Allocated Programs/Projects

(1) Funding is for a parking lot for clients of the Mental Health Center in downtown Los Angeles.

(2) Funding is for IBHIS maintenance, upgrades and support.

Descriptions – Proposed New and/or Expanded Programs/Projects

None

Grand Totals

	CSS	PEI	INN	WET	CF/IT	Total*
Total Current Spending Plan *Previously allocated programs/projects*	$262,869,000	$110,260,000	$129,720,000	$24,200,000	$16,500,000	$543,549,000
Total Proposed Spending Plan *New and/or expanded programs/projects*	190,931,000	162,477,000	-	-	-	$353,408,000
Grand Total Spending Plan	$453,800,000	$272,737,000	$129,720,000	$24,200,000	$16,500,000	$896,957,000

**Does not include the mandated allocation to Prudent Reserve*

Community Planning Process

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, and evaluation and budget allocations. The composition of the System Leadership Team meets the California Code of Regulations Section 3300 on stakeholder diversity.

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

- The 56 member System Leadership Team (SLT) is the Department's stakeholder workgroup to inform the implementation and monitoring of MHSA programs. The composition of the expanded SLT is as follows:
  - LA County Chief Executive Office
  - Service Area Advisory Committee (SAAC) leadership
  - Consumer and family member representation, including NAMI, self-help and the LA County Client Coalition
  - Housing development and the Corporation for Supportive Housing Providers
  - Under-Represented Ethnic Populations, including Asian Pacific Islanders, American Indian, African American, Latino and Eastern European/Middle Eastern
  - Clergy, Faith Based Advocacy Council
  - Union of American Physicians and Dentist (UAPD)
  - Veterans
  - Los Angeles County Commission on Children and Families
  - Greater Los Angeles Agency on Deafness, Inc. (GLAD)
  - Los Angeles County Public Defender
  - Los Angeles Police Department
  - Health Care, including the Hospital Association and Los Angeles County Department of Public Health, Los Angeles County Department of Health Services
  - Older Adult service providers and LA County Community and Senior Services
  - Education, including the LA Unified School District, universities and charter schools
  - LA County Mental Health Commission
  - Lesbian, Bisexual, Gay, Transgender and Questioning (LBGTQ)
  - Unions
  - Statewide perspective
  - Office of Child Protection
- The efforts of the SLT are guided by ad hoc committees and work groups. Committees and work groups are comprised of volunteers from the SLT, any interested individuals, including clients and family members, provider staff, Service Area Advisory Committee members, Mental Health Commissioners and Department managers with responsibility for planning, implementing and managing MHSA programs. Work groups and committees represented diverse perspectives and are considered a microcosm of the larger SLT.
- 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 SLT heard a summary of data and information from the Annual Update on January 17, 2018 and endorsed the Department to move forward with plan development and posting. The plan was publically posted on the Department's website on February 20, 2018 and remains publically posted.

The Public Hearing was convened by the Mental Health Commission on March 22, 2018. At its next regularly scheduled meeting on April 26, 2018, the Commission approved the Department's Annual Update.

MHSA County Compliance Certification

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Los Angeles

☐ Three-Year Program and Expenditure Plan
■ Annual Update

Local Mental Health Director	Program Lead
Name: Jonathan E. Sherin, M.D., Ph.D.	Name: Debbie Innes-Gomberg, Ph.D.
Telephone Number: (213) 738-4108	Telephone Number: (213) 738-2756
Email: JSherin@dmh.lacounty.gov	Email: digomberg@dmh.lacounty.gov
Local Mental Health Mailing Address: County of Los Angeles - Department of Mental Health Program Development and Outcomes Bureau 550 S. Vermont Avenue, 3rd Floor Los Angeles, CA 90020	

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 **June 6, 2018**.

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.

Jonathan E. Sherin, M.D., Ph.D.
Local Mental Health Director (Print)

Signature

6/11/18
Date

MHSA County Fiscal Accountability Certification

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: Jonathan E. Sherin, M.D., Ph.D.	Name: John Naimo
Telephone Number: (213) 738-4601	Telephone Number: (213) 974-8484
E-mail: JSherin@dmh.lacounty.gov	E-mail: jnaimo@auditor.controller.gov

Local Mental Health Mailing Address:

County of Los Angeles - Department of Mental Health
Program Development and Outcomes Bureau
550 S. Vermont Avenue, 3rd Floor
Los Angeles, CA 90020

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 Mental Health Services Act. 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 is true and correct to the best of my knowledge.

Jonathan E. Sherin, M.D., Ph.D.
Local Mental Health Director

Signature 5/11/18
Date

I hereby certify that for the fiscal year ended June 30, 2017, 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 12/15/17 for the fiscal year ended June 30, 2017. I further certify that for the fiscal year ended June 30, 2017, 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 MSHA 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 is true and correct to the best of my knowledge.

John Naimo
County Auditor Controller (PRINT)

John Naimo 5/15/18
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

Mental Health Commission Approval Letter

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

April 26, 2018

Jonathan Sherin, MD, PhD
Director
Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Sherin:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING
FISCAL YEAR 2018-19 ANNUAL UPDATE
NOTICE OF PLAN APPROVAL

On April 26, 2018 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 2018-19 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 2018-19 Annual Update.

It is, therefore, with pleasure that the Commission approve your Department's submission of the Fiscal Year 2018-19 Annual Update, which was publically posted on February 20, 2018 and presented at the March 22, 2018 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 and on the outcomes you are achieving.

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,

Lawrence J. Lue
Acting Chair
LL:DIG:

550 South Vermont Avenue, 12th Floor, Los Angeles, California 90020 ~ Phone: 213.738 4772 ~ Fax: 213 738 2120
Website: http://wcmprd1.its.lacounty.gov:10039/wps/portal/dmh/about_dmh/mhc

Los Angeles County Board of Supervisors Adopted Letter

Los Angeles County
DEPARTMENT OF MENTAL HEALTH

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES
28 June 6, 2018

CELIA ZAVALA
ACTING EXECUTIVE OFFICER

June 06, 2018

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
AND AB 114 PROPOSED SPENDING PLAN FOR FISCAL YEAR 2018-19
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Annual Update and AB 114 Spending Plan for Fiscal Year 2018-19.

IT IS RECOMMENDED THAT THE BOARD:

1. Adopt Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2018-19 (Attachment I). 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 Section 5847.

2. Adopt DMH MHSA Spending Plan (Attachment II) to fully expend Prevention and Early Intervention (PEI) and Innovation (INN) funds subject to reversion as of July 1, 2017 pursuant to Assembly Bill (AB) 114 (Chapter 38, Statutes 2017) and the Department of Health Care Services (DHCS) Information Notice 17-059.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

The MHSA Annual Update for FY 2018-19 builds upon DMH's approved MHSA Three-Year Program

and Expenditure Plan for each MHSA component. It contains a summary of MHSA programs for FY 2016-17, including clients served by MHSA program and Service Area and program outcomes. In addition, the Annual Update also describes DMH's ongoing planning process and progress on implementing the program expansions from the Three-Year Program and Expenditure Plan for FYs 2017-18 through 2019-20.

Board adoption of the MHSA Annual Update is required by law and necessary for DMH to submit the Annual Update for FY 2018-19 to the Mental Health Services Oversight and Accountability Commission (Commission). Additionally, the Welfare and Institutions Code requires the following: 1) the MHSA Three-Year Program and Expenditure Plan and the Annual Updates be certified by the County Mental Health Director and the County Auditor-Controller attesting that the County has complied with all fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the MHSA requirements; 2) a draft MHSA Three-Year Program and Expenditure Plan and the Annual Updates 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; and, 3) the Mental Health Commission conduct a Public Hearing on the draft MHSA Three-Year Program and Expenditure Plan and the Annual Updates at the close of the 30-day comment period.

In accordance with these requirements, DMH, on February 20, 2018, posted the MHSA Annual Update on its website for 30 days for public comment. The Mental Health Commission also convened a Public Hearing on March 22, 2018, where DMH presented the update, addressed public questions, and any concerns. The Mental Health Commission voted to approve the MHSA Annual Update for FY 2018-19 at its meeting on April 26, 2018.

Board adoption of the DMH MHSA Spending Plan is necessary for DMH to comply with AB 114 (Chapter 38, Statutes of 2017) and the DHCS Information Notice 17-059. This legislation and State instruction specifically requires DMH to post the plan on its website for 30 days for public comment and obtain Board adoption of the plan within 90 days of its posting. DMH posted the plan on March 23, 2018.

DMH has identified $83,637,000 in PEI and $78,300,000 in INN funds that were subject to reversion as of July 1, 2017. These PEI and INN funds have been reallocated to the county and must be fully expended by June 30, 2020.

Implementation of Strategic Plan Goals

The recommended action is consistent with the County Strategic Plan Goal III (Realize Tomorrow's Government Today), specifically Strategy III.4 (Engage and Share Information with Our Customers, Communities and Partners), as well as County Strategic Plan Goal I (Make Investments that Transform Lives), specifically, Strategy I.2 (Enhance our Delivery of Comprehensive Interventions).

FISCAL IMPACT/FINANCING

There is no fiscal impact associated with the adoption of the MHSA Annual Update. The Department utilizes the budget process to appropriate the MSHA funds for use during the respective fiscal year.

The adoption of the MHSA Spending Plan for PEI and INN, pursuant to AB 114, will allow DMH to maintain $83,637,000 in MHSA PEI and $78,300,000 in MHSA INN funds that were subject to reversion as of June 30, 2016. The MHSA Spending Plans include additional unspent MHSA PEI and

MHSA INN funds that are available to support the INN project proposals and expansion of mental health services to At-Risk Children/Youth/Families and Surrounding Communities. The total MHSA Spending Plans for MHSA PEI and MHSA INN are $105,543,000 and $113,312,000, respectively.

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

AB 1467, chaptered into law on June 27, 2012, implemented changes to the MHSA law. More specifically, AB 1467 amended the Welfare and Institutions Code in order to require each county mental health program to prepare a MHSA Three-Year Program and Expenditure Plan and Annual Updates, which were to be adopted by the County Board of Supervisors and submitted to the Commission. AB 1467 also amended the Welfare and Institutions Code in order to require that the MHSA Three-Year Program and Expenditure Plan and Annual Updates be certified by the County Mental Health Director and the County Auditor-Controller. This requirement includes the County Mental Health Director's certification as to the requisite stakeholder participation and compliance with MHSA non-supplantation provisions. Additionally, the statute was amended in order to require that the MHSA Three-Year Program and Expenditure Plan and Annual Updates be circulated for public review/comment and that a public hearing be conducted at the close of the comment period. The Commission most recently provided direction to the counties to complete MHSA Annual Updates through a memo dated April 24, 2015, 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 Welfare and Institutions Code Section 5848 (a) and (b), have been satisfied and are recorded in the MHSA Annual Update for FY 2018-19. Additionally, the certification requirements referenced in Welfare and Institutions Code Section 5847(b)(8) and (9) have also been complied with and are recorded in the MHSA Annual Update for FY 2018-19 via a signed MHSA Fiscal Accountability Certification Form.AB 114, chaptered into law on July 10, 2017, amended the MHSA by requiring any funds subject to reversion as of July 1, 2017, to be reallocated to the county of origin for the purposes for which they were originally allocated. The bill provides that as a county receives approval from the Commission of a plan for innovative programs, the funds identified in the plan would not revert back until three years after the date of approval. Additionally, by July 1, 2018, counties are required to have a plan to spend these funds by July 1, 2020, (Attachment II), and to annually publish a report on their Internet Web site relating to funds subject to reversion, as specified.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Annual Update for FY 2018-19 and AB 114 Spending Plan will ensure compliance with the MHSA, as amended by AB 1467 and AB 114 – DHCS Info Notice 17-059 requirements.

Respectfully submitted,

JONATHAN E. SHERIN, M.D., Ph.D.
Director

JES:GP:DIG:SK:pd

Enclosures

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

Acronyms and Definitions

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

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 December 2017.
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 December 2017.
Unique client means a single client claimed in the Integrated Behavioral Health Information System. Data as of December 2017.

Community Services & Supports

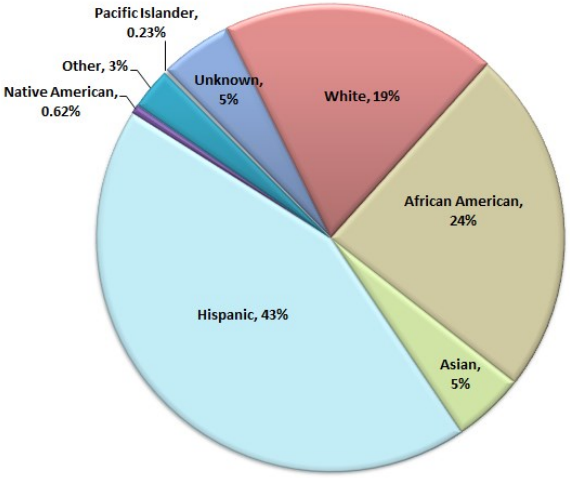
Full Service Partnership - Recovery Resilience & Reintegration - Alternative Crisis Services - Linkage - Housing - Planning Outreach & Engagement

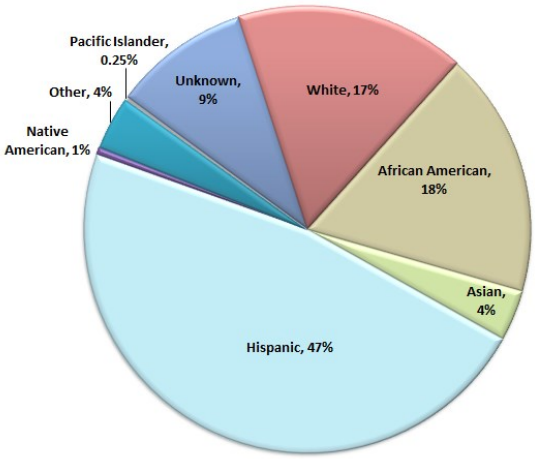
CLIENTS

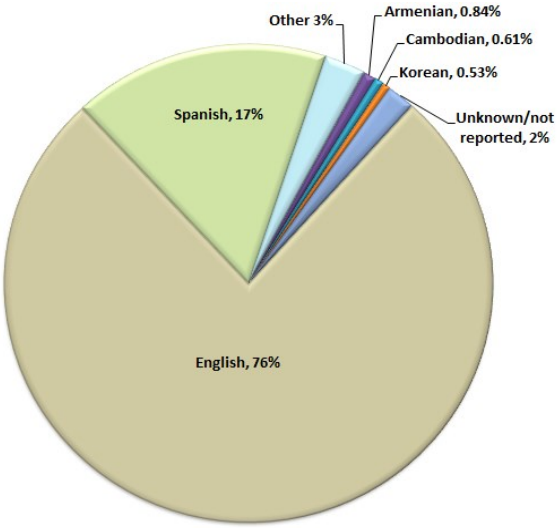
- 131,106 clients received a direct mental health service
- 43% of the clients are Hispanic
- 24% of the clients are African American
- 19% of the clients are White
- 5% of the clients are Asian
- 76% have a primary language of English
- 17% have a primary language of Spanish

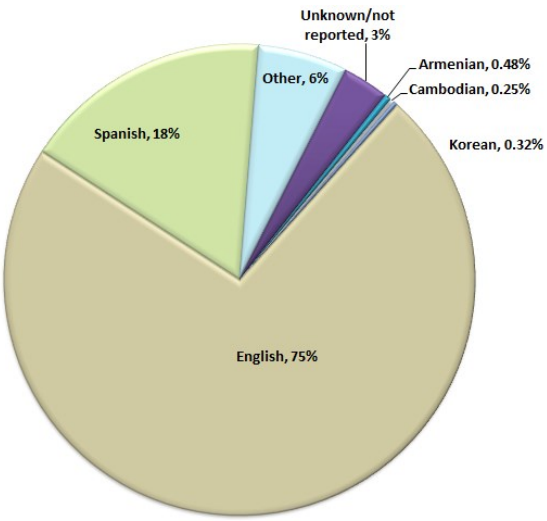
NEW CLIENTS

- 44,639 new clients receiving CSS services Countywide with no previous MHSA service
- 47% of the new clients are Hispanic
- 18% of the new clients are African American
- 17% of the new clients are White
- 75% have a primary language of English
- 18% have a primary language of Spanish

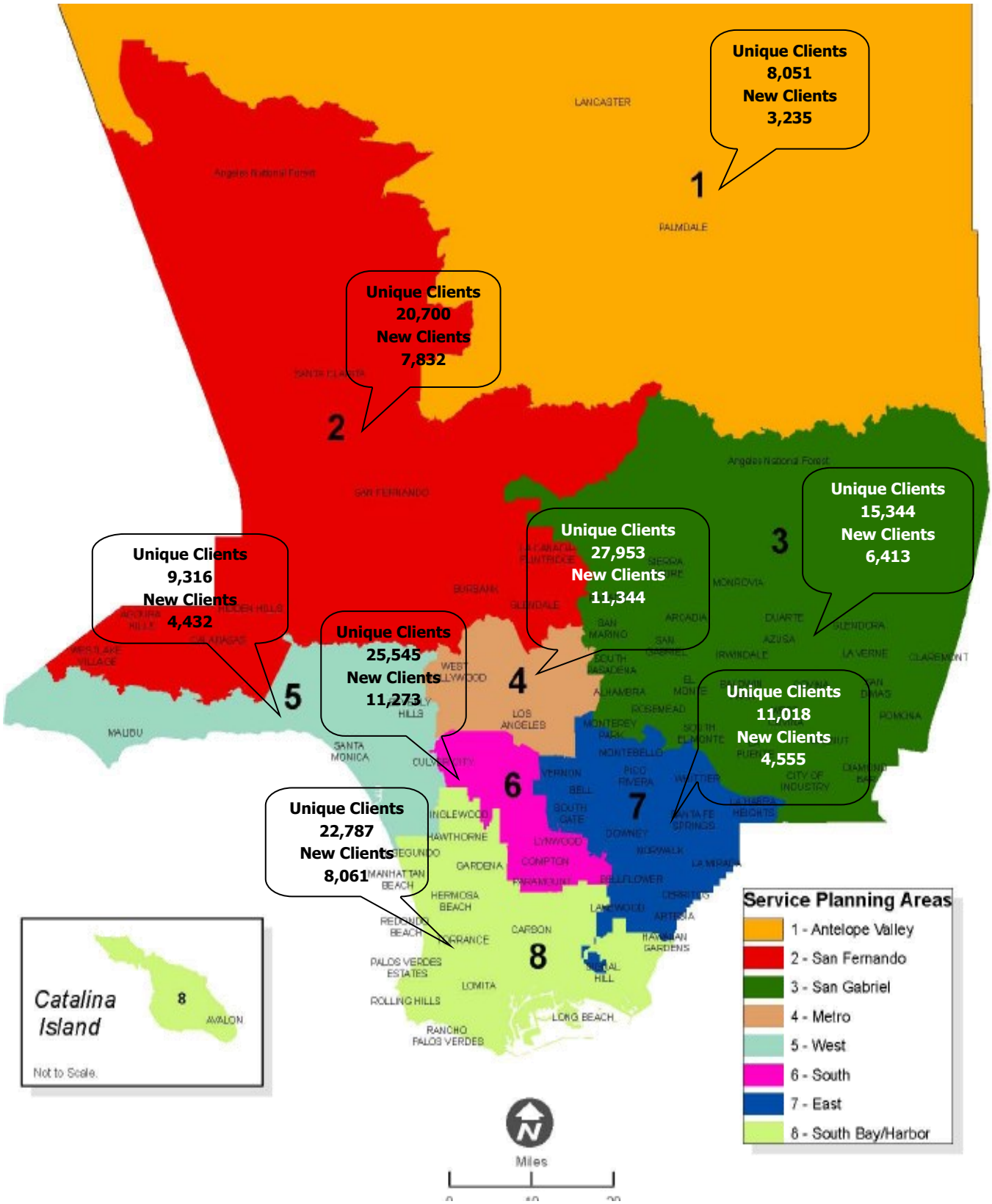




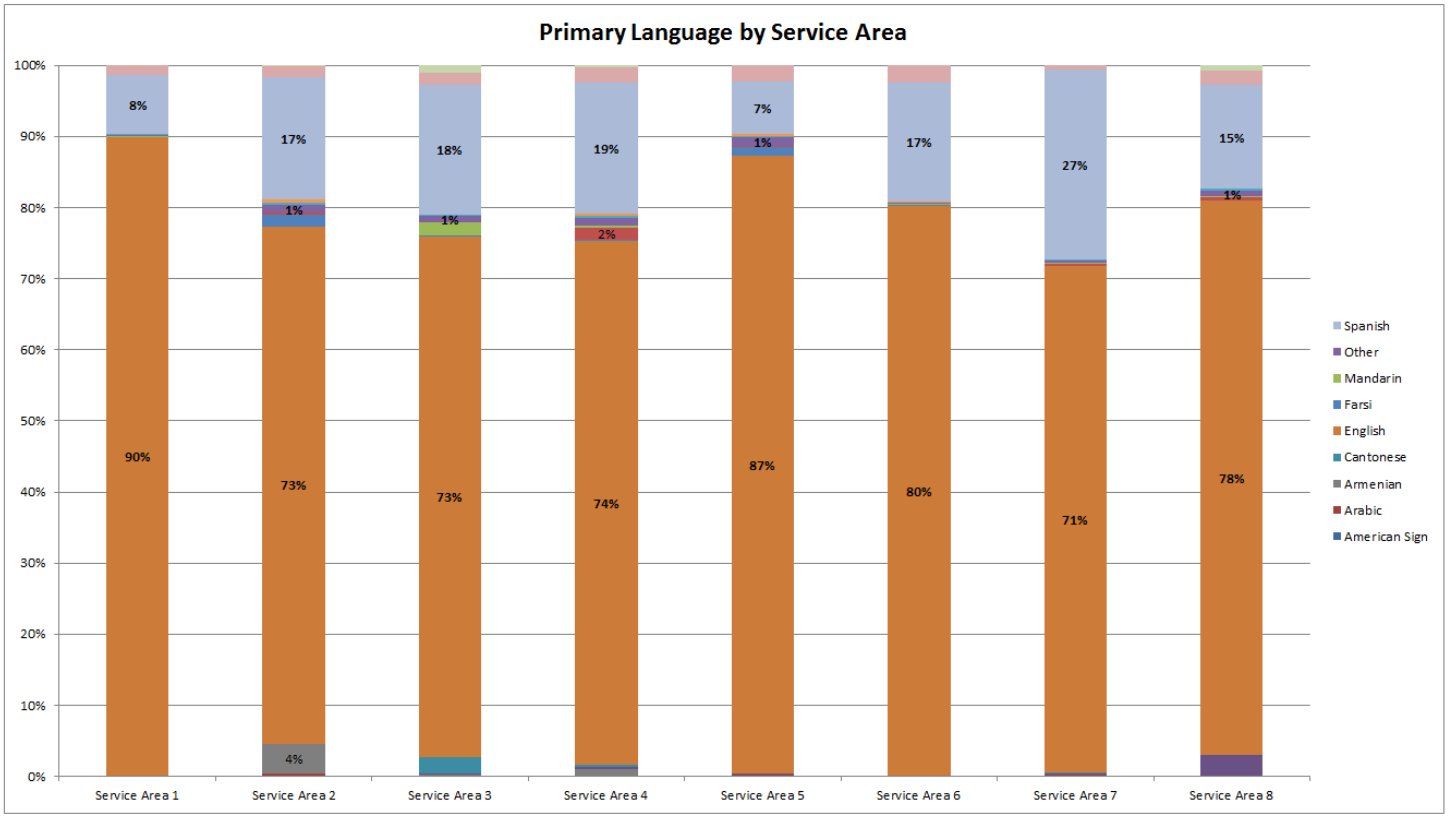


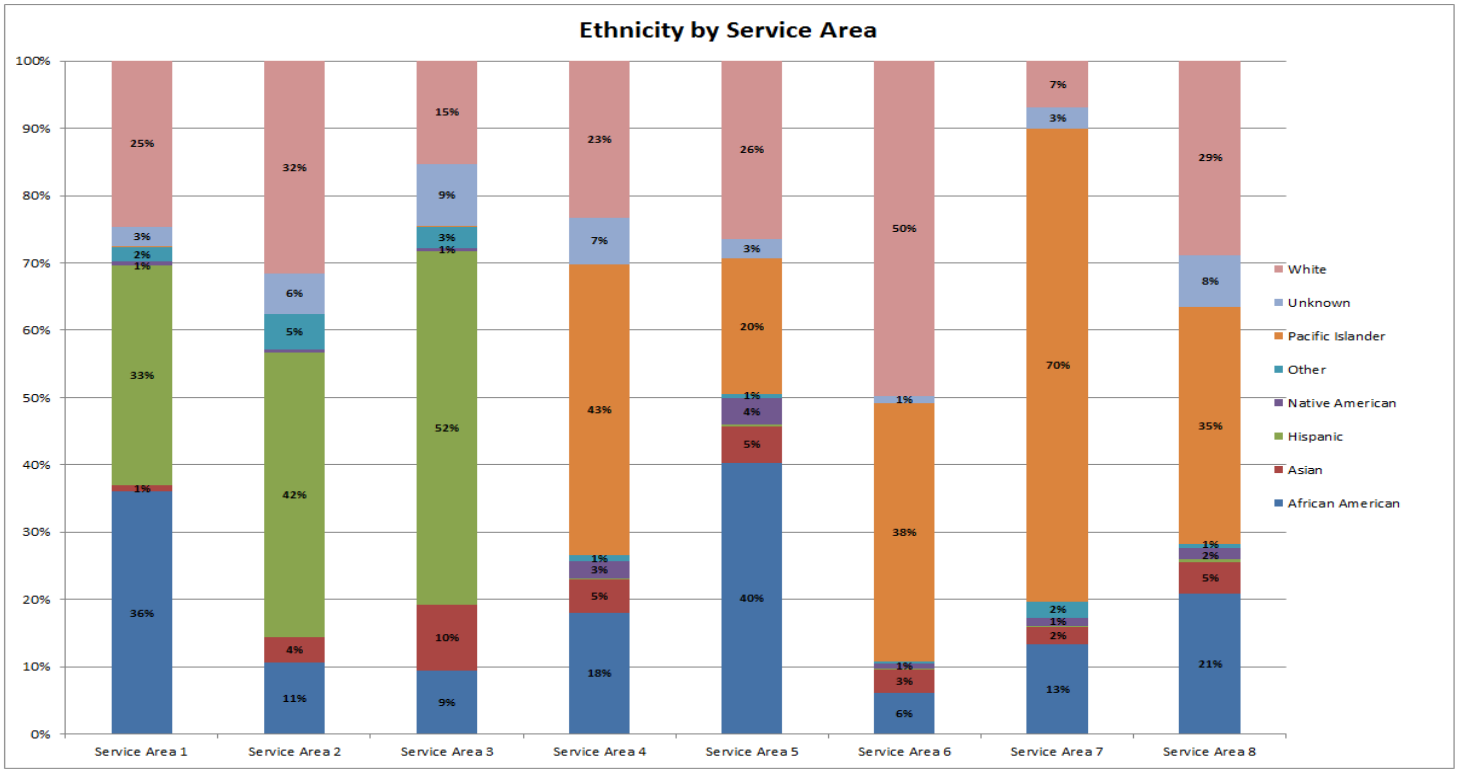


Los Angeles County Clients Served Through CSS by Service Areas Fiscal Year 2016-17



Los Angeles County Clients Served Through CSS by Service Areas Fiscal Year 2016-17





FULL SERVICE PARTNERSHIP

WORK PLANS: CHILDREN (C-01), TRANSITION AGE YOUTH (T-01), ADULT (A-01), OLDER ADULT (OA-01)

WHAT DID WE LEARN?

- Most experience the greatest benefit the first year in partnership.
- Older adults experience most improvement in acute hospitalizations over 3 years.
- Adult, TAY and older adults experience the most improvement in employment over two years.
- Child and TAY all improve their grade distribution over two years in partnership but experience the most change during the first year in partnership.
- Possibly explore outcomes within service areas against the background of tenure length and population characteristics.
- In all programs that have enough data to make observations, client meeting goals for treatment becomes the dominate reason for disenrollment during the first (full) year in partnership. Client having met goals seems to mirror actual success in outcomes.
- Moderate relationships exist between client having lost contact and homelessness. Data suggests a moderate relationship between field based work and a client not losing contact.

PROGRAMS & SLOTS

PROGRAM	SLOTS[1]
Children	2,083
Wraparound Child	523
Intensive Field Capable Clinical Services*	765
TAY	1,395
Wraparound TAY	226
Adult	5,305
Integrated Mobile Health Team	300
Assisted Outpatient Treatment	300
Forensic*	300

*Services implemented FY 2017-18

UNIQUE CLIENTS SERVED
Children[3] - 3,491
TAY[4] - 1,873
Adult[5] - 6,019
Older Adult - 1,322

AVERAGE COST PER CLIENT[2]
Children - $14,867
TAY - $12,001
Adult - $11,469
Older Adult - $8,725

[1] Slot allocation for FY 2017-18.
[2] Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.
[3] Children: unique clients served inclusive of Child and Wraparound Child FSP programs.
[4] TAY: unique clients served inclusive of TAY and Wraparound TAY FSP programs.
[5] Adult: unique clients served inclusive of Adult, Assisted Outpatient Treatment (AOT) & Integrated Mobile Health Team (IMHT) FSP programs.

FOCAL POPULATION

Children, Ages 0-15
with serious emotional disturbance (SED) and

- 0-5 who is 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 is transitioning back into a less structured home/community setting.

Transition Age Youth, 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.

Adult, Ages (26-59)
with serious mental illness and involved with one or more of the following:

- Homeless;
- Jail;
- Institutionalized (State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital);
- living with family members without whose support the individual should be at imminent risk of homelessness, jail or institutionalization.

Older Adult, Ages (60+)
serious mental illness and one or more of the following risks:

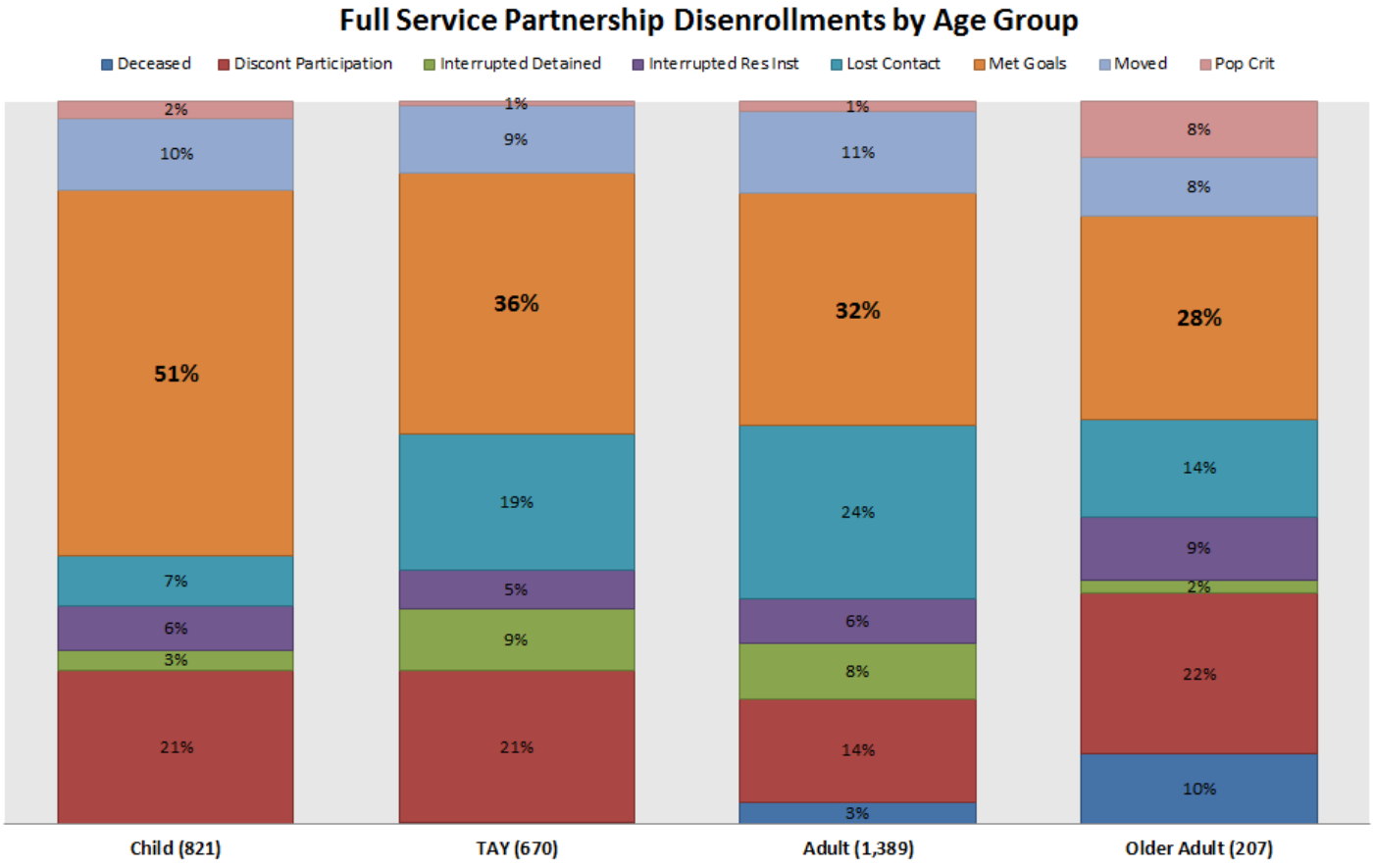
- homeless or at imminent risk of homelessness;
- hospitalizations; jail or at risk of going to jail;
- imminent risk for placement in a skilled nursing facility (SNF) or nursing home or being released from SNF/nursing home;
- presence of a co-occurring disorder;
- serious risk of suicide or recurrent history;
- or is at risk of abuse or self-neglect

FULL SERVICE PARTNERSHIP

DISENROLLMENTS

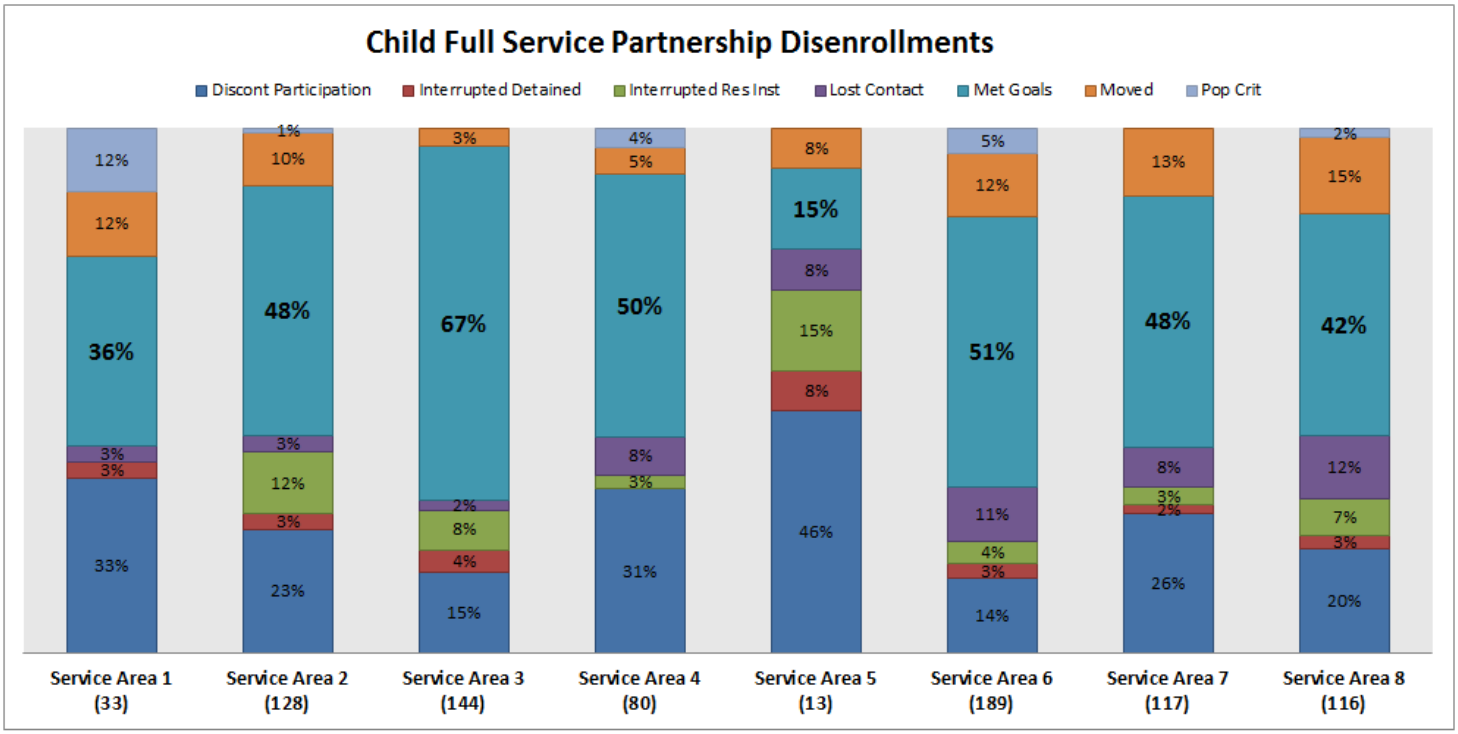
Disenrollment can apply to either an interruption or a discontinuation of service. An interruption of service is defined as a temporary situation in which the client is expected to return to services within twelve (12) months or less from the date of last contact. A discontinuation of service is defined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

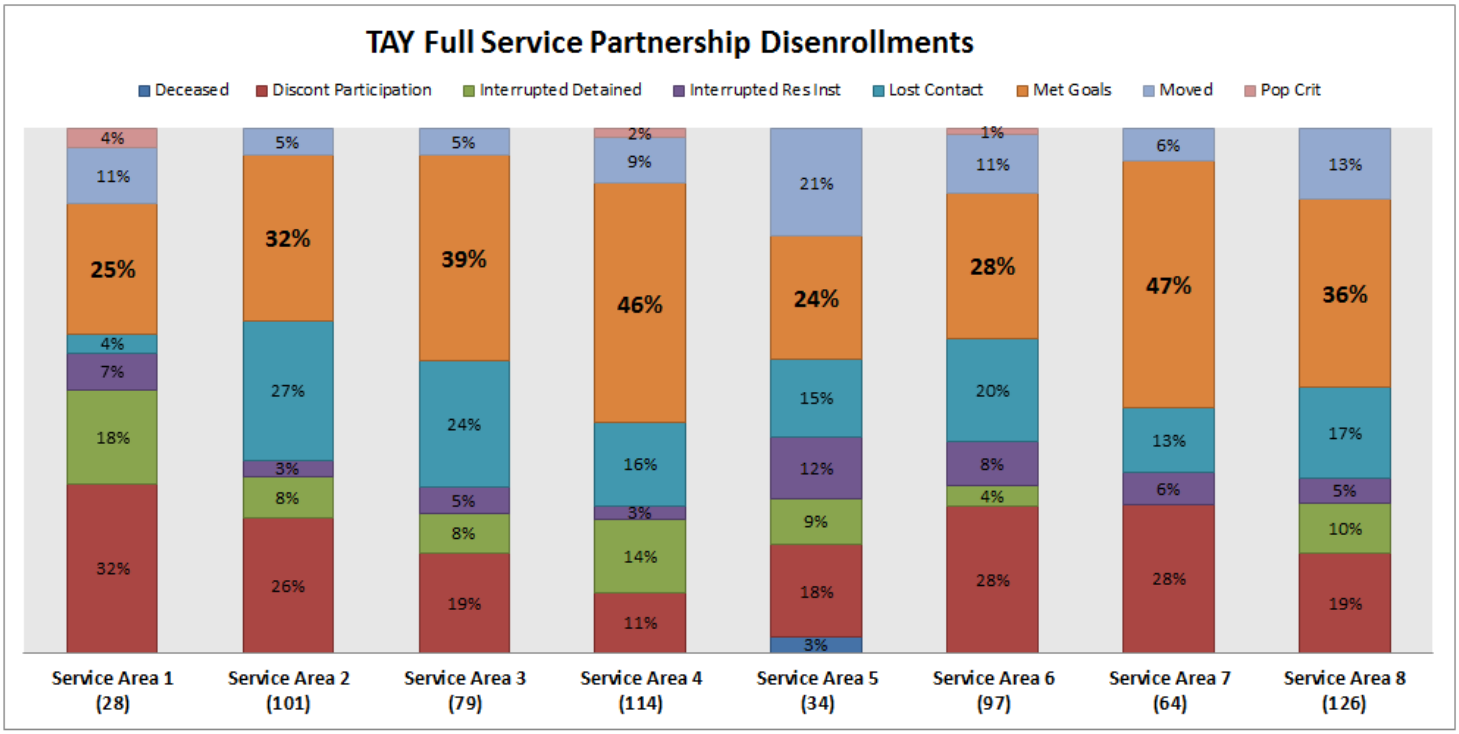
1. Target population criteria are not met. Client is found not to meet target population; in most cases, clients who are discovered to have no major mental illness or serious emotional disturbance (SED).
2. Client decided to discontinue Full Service Partnership participation after partnership established. Client has either withdrawn consent, refused services after enrolling, or no longer wishes to participate in FSP.
3. Client moved to another county/service area. Client relocated to a geographic area either outside or within L.A. County, and will not be receiving FSP services of any type anywhere in Los Angeles County.
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/DOJJ/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 and is ready to receive services at a lower level of care.
8. Client is deceased. This includes clients who died from either natural or unnatural causes after their date of enrollment.



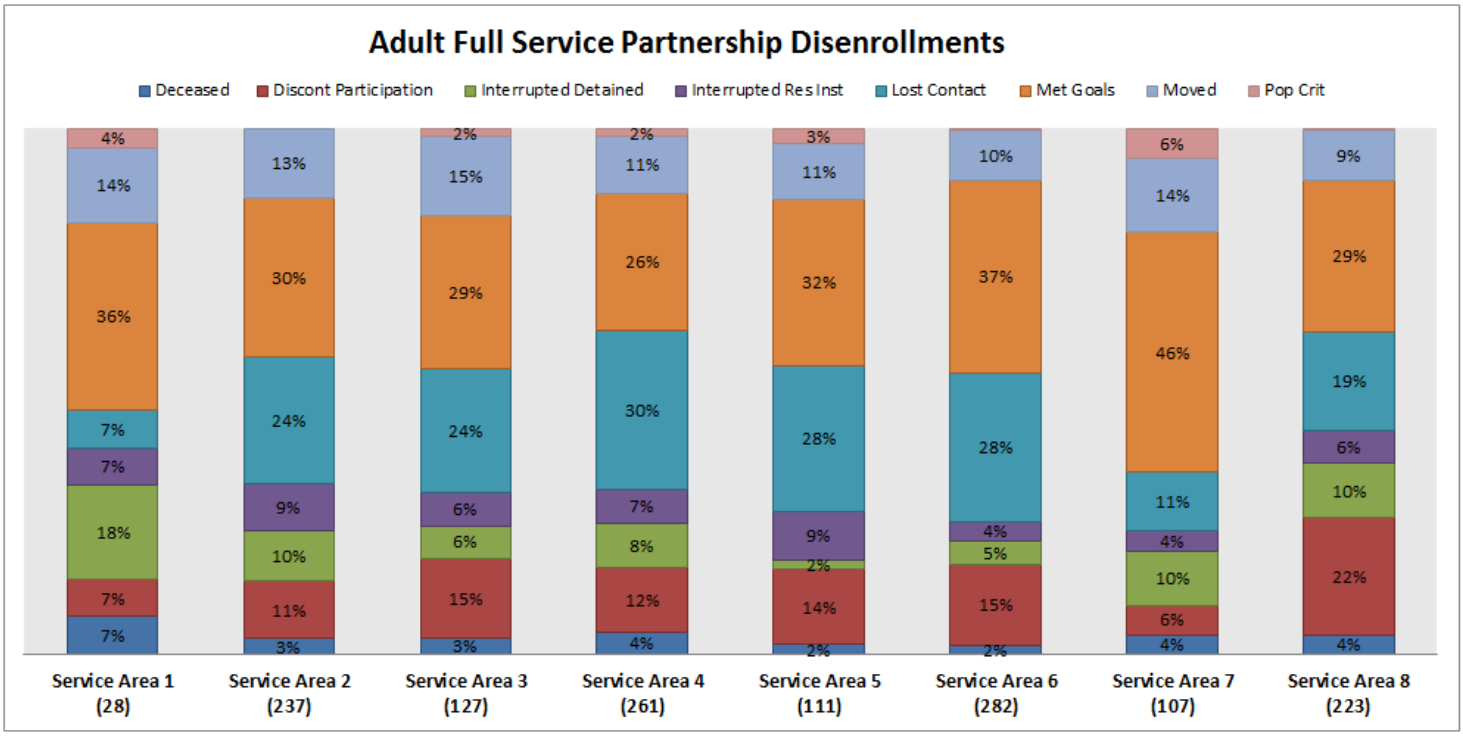
FULL SERVICE PARTNERSHIP

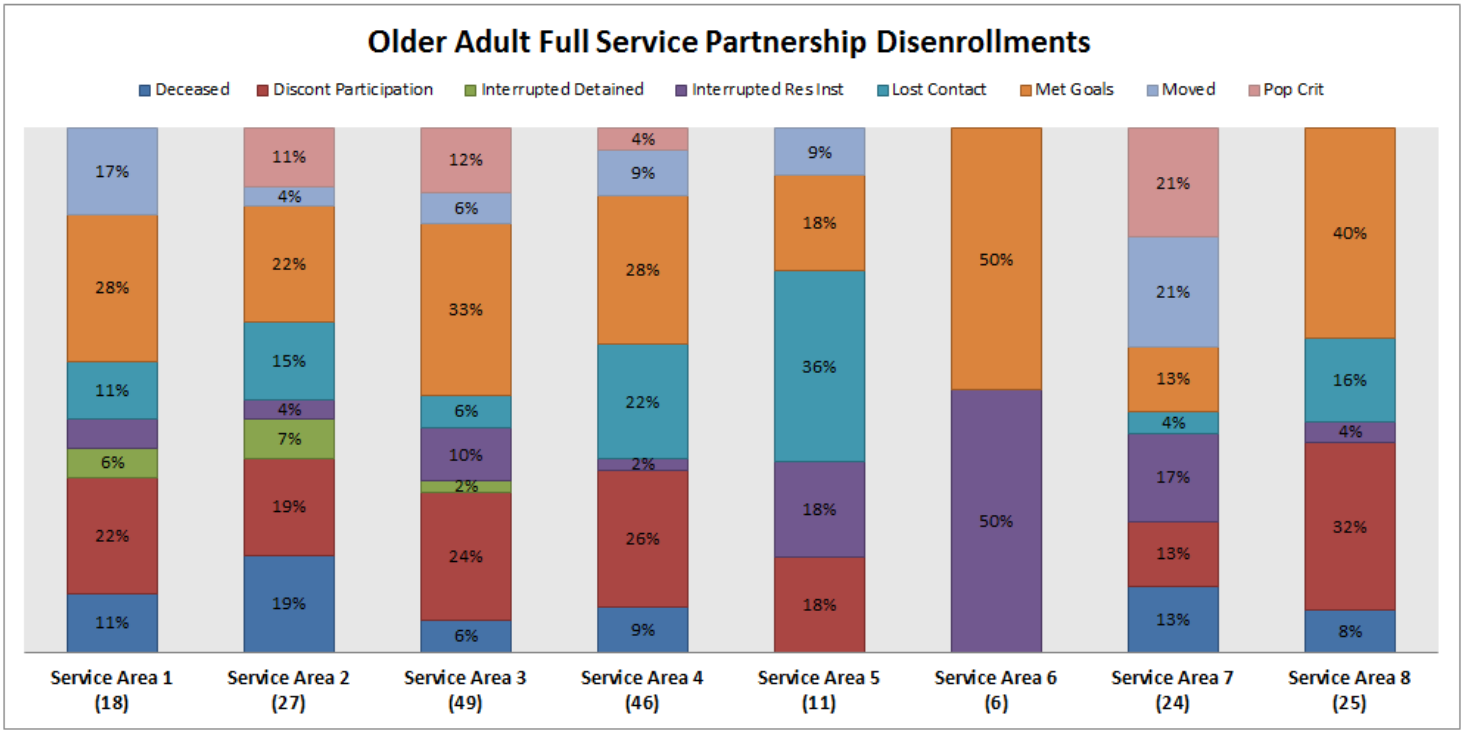
DISENROLLMENTS CONTINUED





DISENROLLMENTS CONTINUED





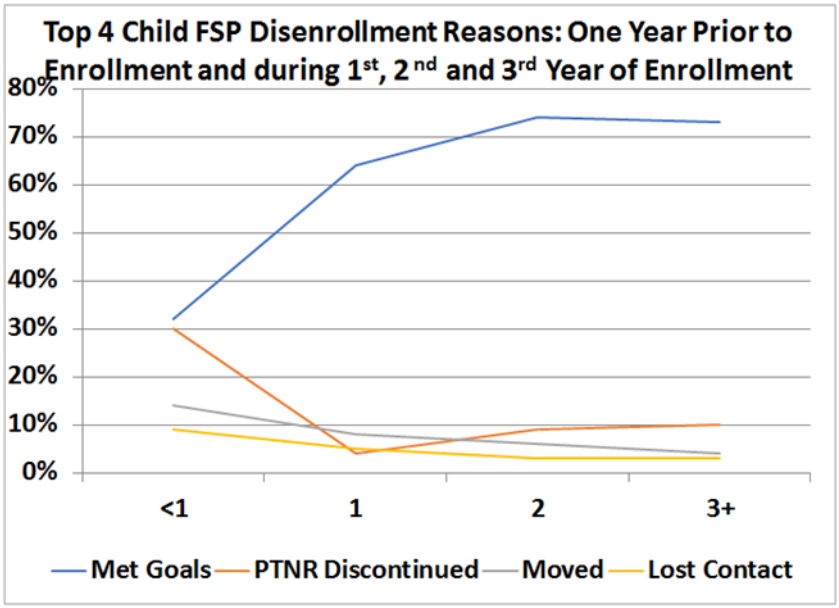
DISENROLLMENTS CONTINUED

CHILD

Child FSP Disenrollment Reason	Years Enrolled			
	< 1 year (n=4003)	1 Year (n=3317)	2 Years (n=1248)	3+ Years (n=358)
Met Goals	32%	64%	74%	73%
Pop Not Met	2%	1%	2%	1%
Ptnr Discontinued	30%	14%	9%	10%
Moved	14%	8%	6%	4%
Lost Contact	9%	5%	3%	3%
Need Residential	9%	4%	4%	7%
Detained or Jail	4%	3%	2%	2%
Deceased	0%	0%	0%	0%
Total	100%	100%	100%	100%

Child FSP Disenrollment Reasons by Number of Years Enrolled

- Met goals is the top disenrollment reason provided for those leaving the partnership within less than 1 year
- Met goals is the top disenrollment reason provided for those enrolled 1, 2 and 3 years



- Percentage of met goals becomes the predominate reason for disenrollment during the first year of partnership. With less than one year in partnership, disenrollment is seemingly a "toss-up" between goals met and partner discontinued.
- Since so many benefits are associated with at least one year of treatment, finding a way to keep clients in Child FSP for at least one year and, perhaps longer, is essential to maximize the help experienced by clients.

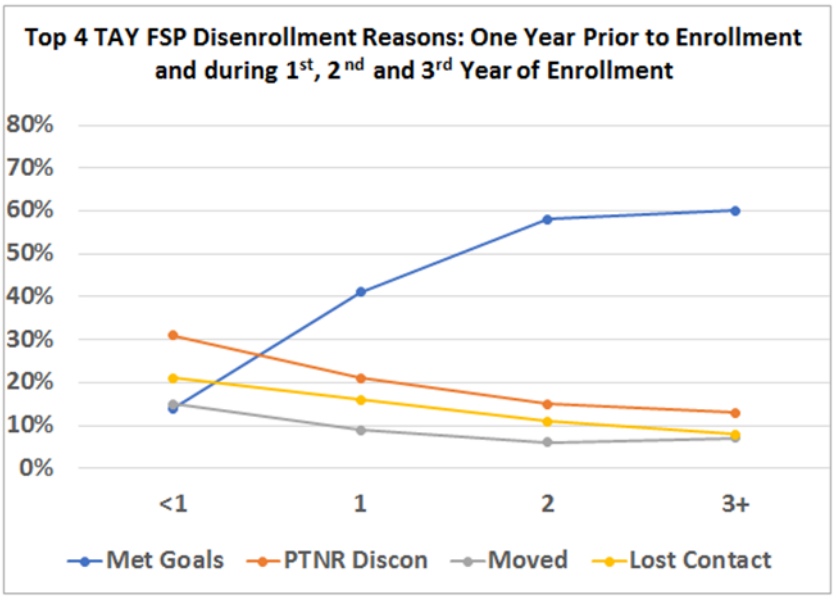
The disenrollment data was gathered from the FSP Referral Tracking Database as of 9/11/2017.

DISENROLLMENTS CONTINUED

TAY

TAY FSP Disenrollment Reason	Years Enrolled			
	< 1 year (n=2736)	1 Year (n=1925)	2 Years (n=879)	3+ Years (n=566)
Met Goals	14%	41%	58%	60%
Pop Not Met	2%	2%	2%	1%
Ptnr Discontinued	31%	21%	15%	13%
Moved	15%	9%	6%	7%
Lost Contact	21%	16%	11%	8%
Need Residential	7%	5%	5%	4%
Detained or Jail	8%	6%	3%	7%
Deceased	1%	1%	0%	0%
Total	100%	100%	100%	100%

- Lost Contact is the top disenrollment reason provided for those leaving the partnership within less than 1 year
- Met Goals is the top disenrollment reason provided for those enrolled 1, 2 and 3 years



- Percentage of met goals predominates as a reason for disenrollment during the first year of partnership. Even PTNR discontinued and Lost contact fall well below met goals by year one.
- Since so many benefits are associated with at least one year of treatment, finding way to keep clients in TAY FSP for at least one year and, perhaps longer, may be essential to help maximize the help experienced.

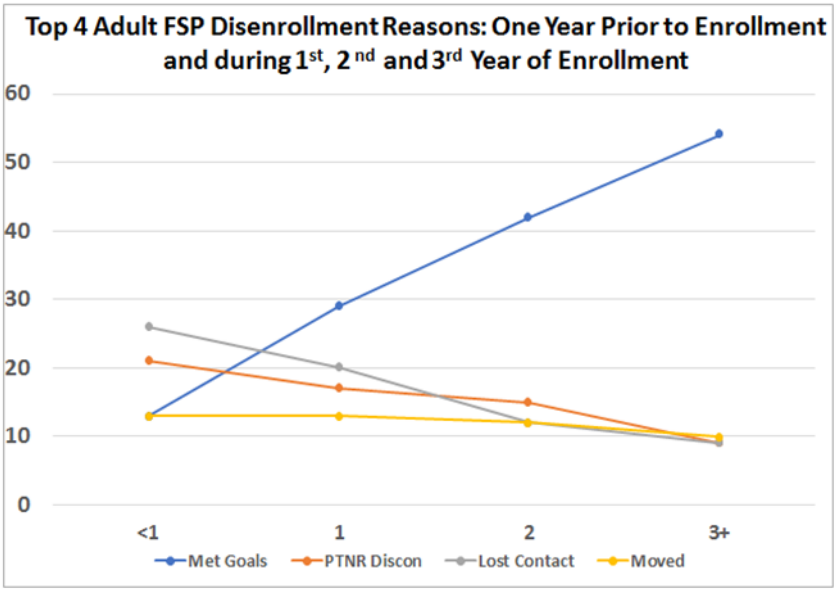
The disenrollment data was gathered from the FSP Referral Tracking Database as of 9/11/2017.

DISENROLLMENTS
CONTINUED

ADULT

Adult FSP Disenrollment Reason	Years Enrolled			
	< 1 year (n=5003)	1 Year (n=3096)	2 Years (n=1895)	3+ Years (n=2609)
Met Goals	13%	29%	42%	54%
Pop Not Met	5%	1%	2%	2%
Ptnr Discontinued	21%	17%	15%	9%
Moved	13%	13%	12%	10%
Lost Contact	26%	20%	12%	9%
Need Residential	10%	8%	7%	6%
Detained or Jail	10%	8%	6%	4%
Deceased	2%	3%	4%	5%
Total	100%	100%	100%	100%

- Lost Contact is the top disenrollment reason provided for those leaving the partnership within less than 1 year
- Met Goals is the top disenrollment reason provided for those enrolled 1, 2 and 3 years



- Percentage of Met Goals becomes the predominate reason for disenrollment and not other reasons, two of which could be associated with treatment failure.
- Since so many benefits are associated with at least one year of treatment, finding ways to keep clients in Adult FSP for at least one year and, perhaps longer, is essential to maximize the help experienced by clients.

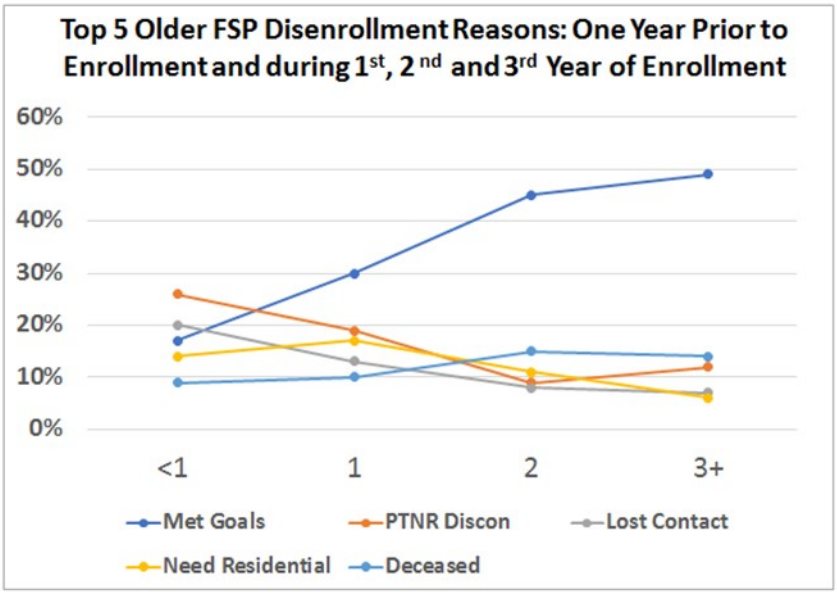
The disenrollment data was gathered from the FSP Referral Tracking Database as of 9/11/2017.

DISENROLLMENTS CONTINUED

OLDER ADULT

Older Adult FSP Disenrollment Reason	Years Enrolled			
	< 1 year (n=655)	1 Year (n=347)	2 Years (n=207)	3+ Years (n=226)
Met Goals	17%	30%	45%	49%
Pop Not Met	5%	2%	5%	5%
Ptnr Discontinued	26%	19%	9%	12%
Moved	7%	7%	7%	6%
Lost Contact	20%	13%	8%	7%
Need Residential	14%	17%	11%	6%
Detained or Jail	2%	1%	0%	1%
Deceased	9%	10%	15%	14%
Total	100%	100%	100%	100%

- Lost Contact is the top disenrollment reason provided for those leaving the partnership within less than 1 year
- Met Goals is the top disenrollment reason provided for those enrolled 1, 2 and 3 years



- With less than one year in partnership, disenrollment is more likely to be because of PTNR discontinued or losing contact with the client. Percentage of Met Goals becomes the predominate reason for disenrollment during the first year in partnership.
- Since so many benefits are associated with at least one year of treatment, finding way to keep Older Adults in FSP for at least one year and, likely longer, is essential.

The disenrollment data was gathered from the FSP Referral Tracking Database as of 9/11/2017.

RESIDENTIAL OUTCOMES

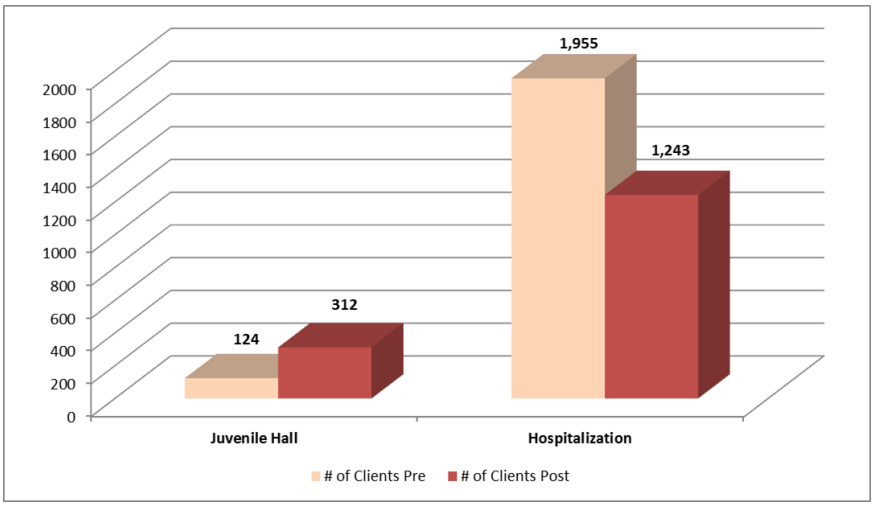
Comparison of residential data for 12 months immediately prior to receiving FSP services (pre-partnership) and for 12 months of residential status while receiving FSP services (post-partnership) for client's outcomes entered through June 30, 2017. Data is adjusted (annualized) by a percentage based on average length of stay in the FSP program. Data must meet data quality standards to be included in the analysis. See Appendix for a list of reasons data does not meet reporting standards.

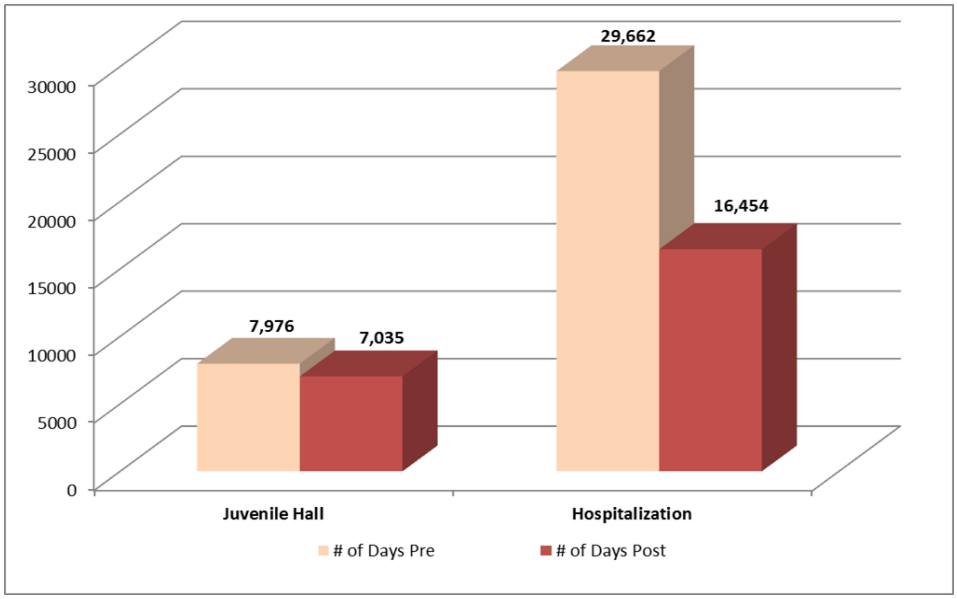
CHILD FSP

NUMBER OF BASELINES: 8,920
NUMBER OF CLIENTS: 8,690

- 45% reduction in days hospitalized
- 11% reduction in days in juvenile hall
- 36% reduction in the number of clients hospitalized
- 152% increase in the number of clients in juvenile hall*

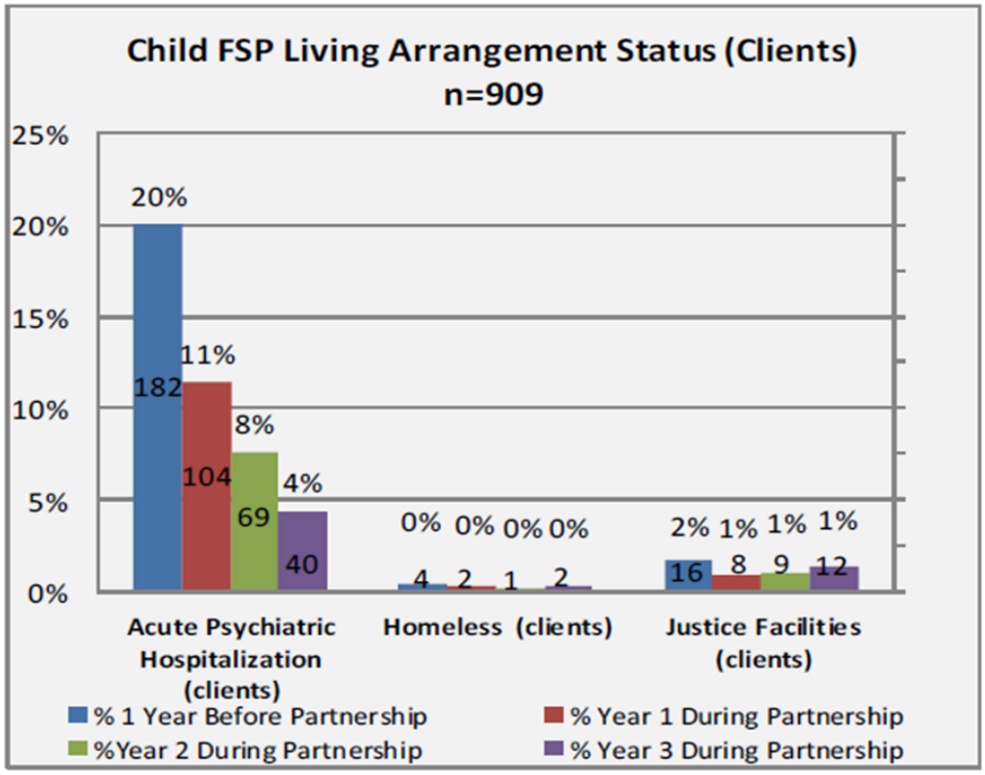
* There was a 152% increase in the number of clients in juvenile hall post-partnership. Data indicates 124 children (approximately 1% of the baselines included) reported being in juvenile hall 365 days prior to partnership and 312 children (approximately 3% of the baselines included) after partnership was established.



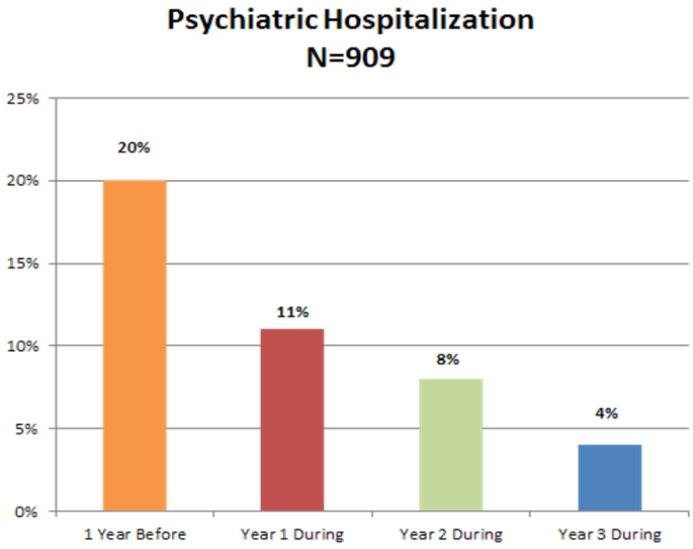


FULL SERVICE PARTNERSHIP

The following information is taken from the Child FSP Outcomes Report - One Year Data, September 2017



Child FSP has been found to be effective in decreasing the number of clients residing in Acute Psychiatric facilities. There is very little data about homeless or justice facility living arrangements. This may change over time.



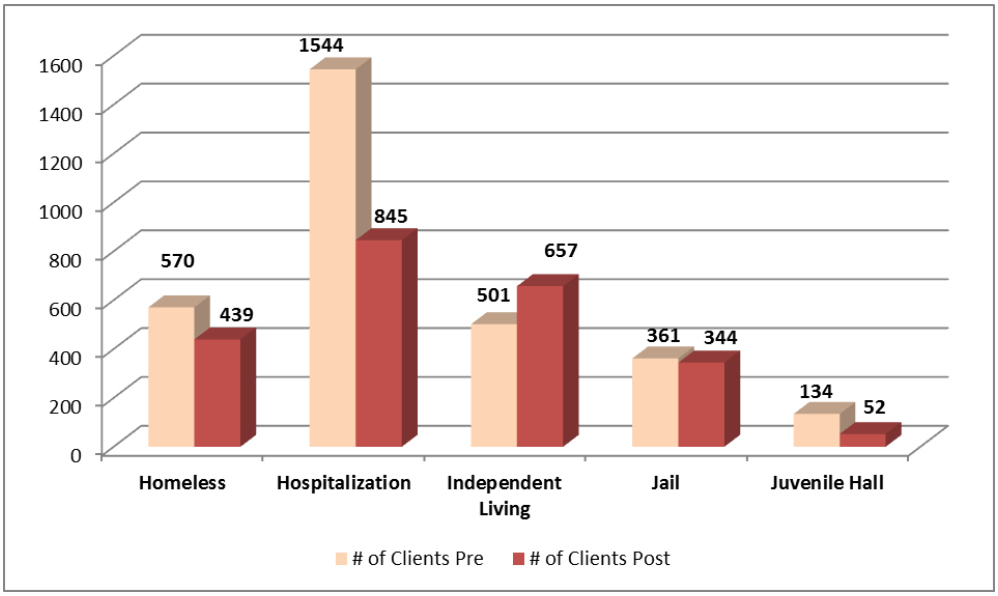
Year to Year Percent Reduction in Psychiatric Hospitalizations	
Year before partnership to 1st Year	43%
During 1st year of partnership to 2nd year	34%
During 2nd year of partnership to 3rd+ year	42%
Year before partnership to year 3	78%

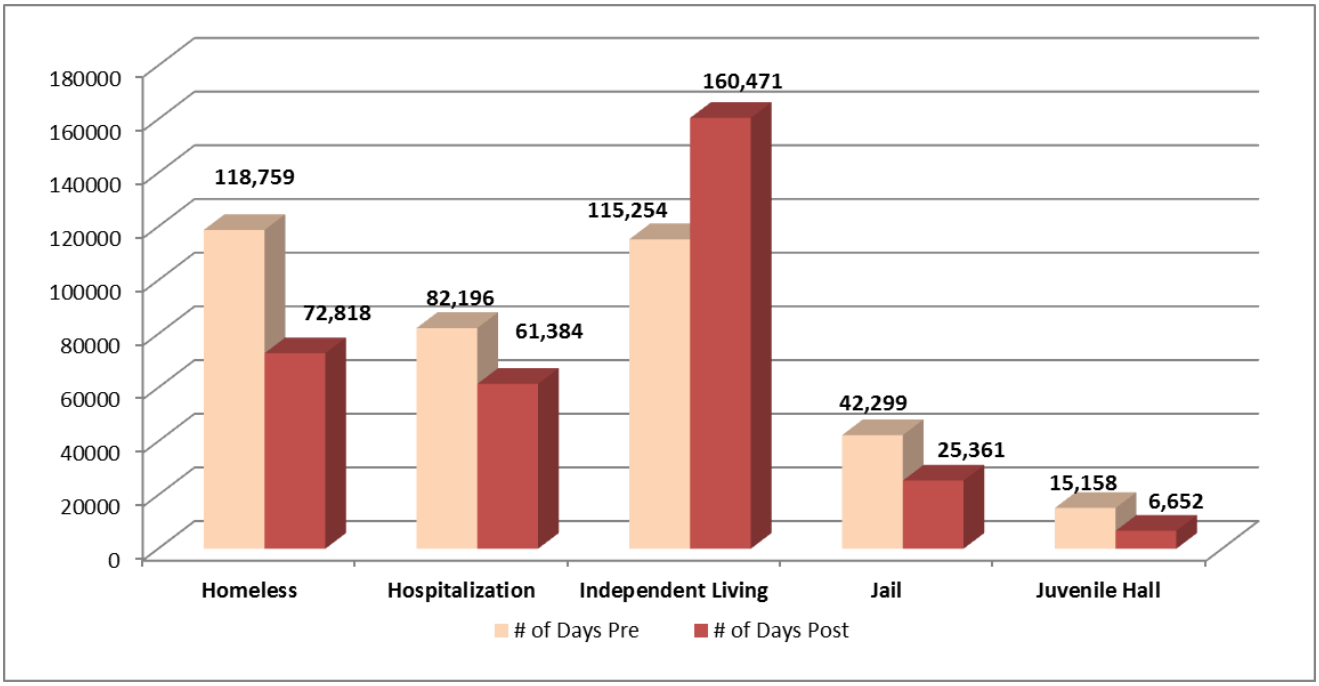
The biggest drop in psychiatric hospitalizations occurred during the first and third year of partnership

RESIDENTIAL OUTCOMES
CONTINUED

TAY FSP
NUMBER OF BASELINES: 4,584
NUMBER OF CLIENTS: 4,454

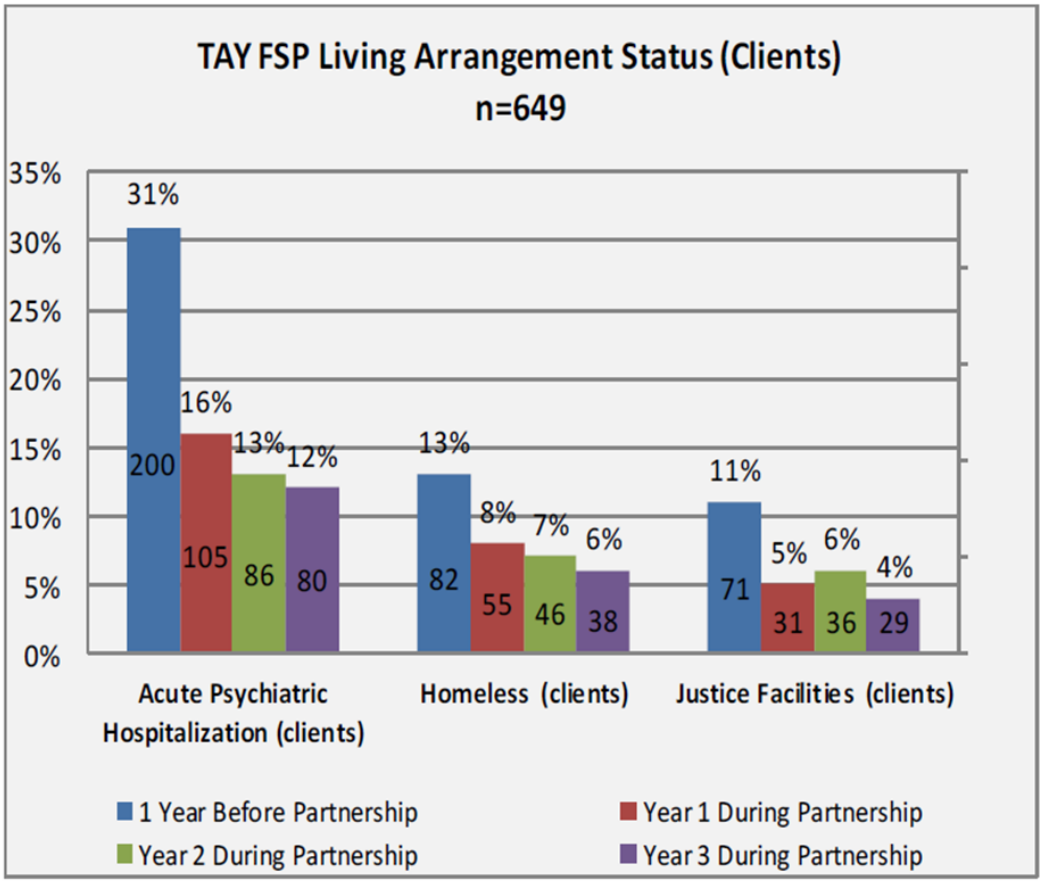
- 39% reduction in days homeless
- 25% reduction in days hospitalized
- 40% reduction in days in jail
- 39% increase in days living independently
- 56% reduction in days in juvenile hall
- 23% reduction in clients homeless
- 45% reduction in clients hospitalized
- 5% reduction in clients in jail
- 31% increase in clients living independently



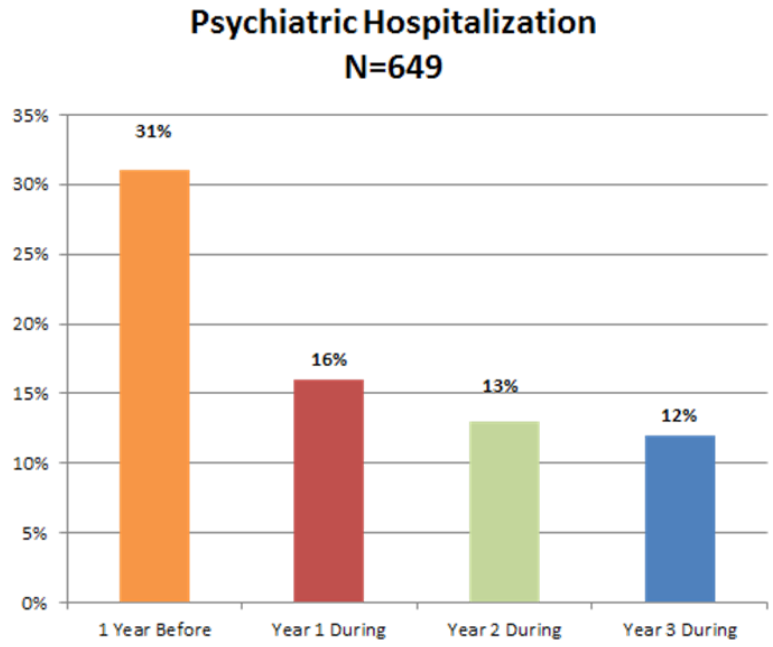


FULL SERVICE PARTNERSHIP

The following information is taken from the TAY FSP Outcomes Report - One Year Data, September 2017



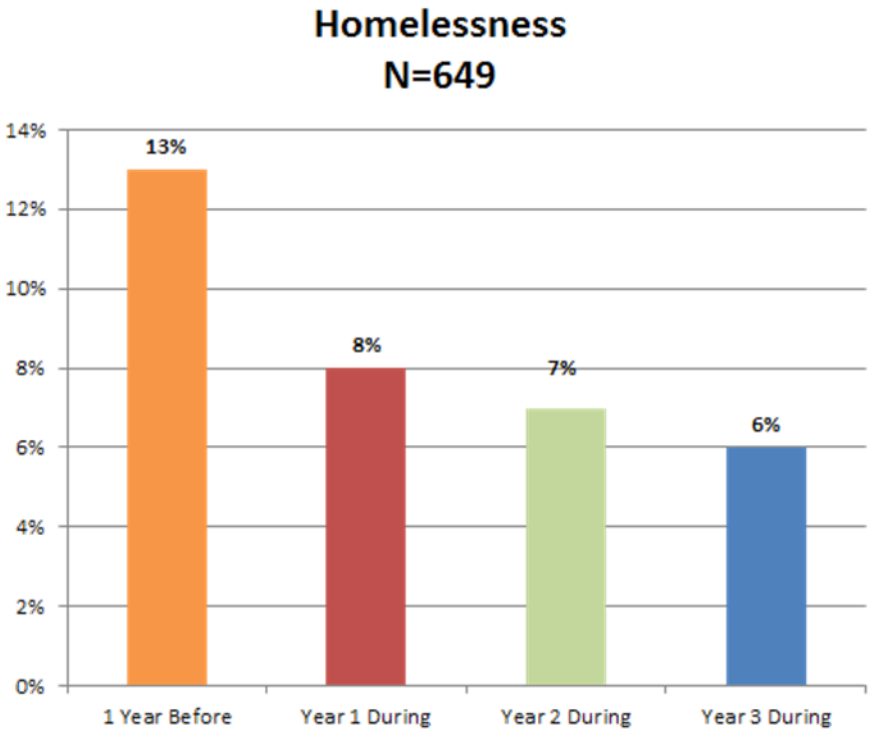
TAY FSP has been found to be effective in decreasing the number of clients residing in acute psychiatric facilities, reduced the percentage of clients reported to be homeless and the percentage of those residing in justice facilities.



Year to Year Percent Reduction in Psychiatric Hospitalizations	
Year before partnership to 1st Year	48%
During 1st year of partnership to 2nd year	18%
During 2nd year of partnership to 3rd+ year	7%
Year before partnership to year 3	60%

The biggest drop occurred in the first year of the partnership

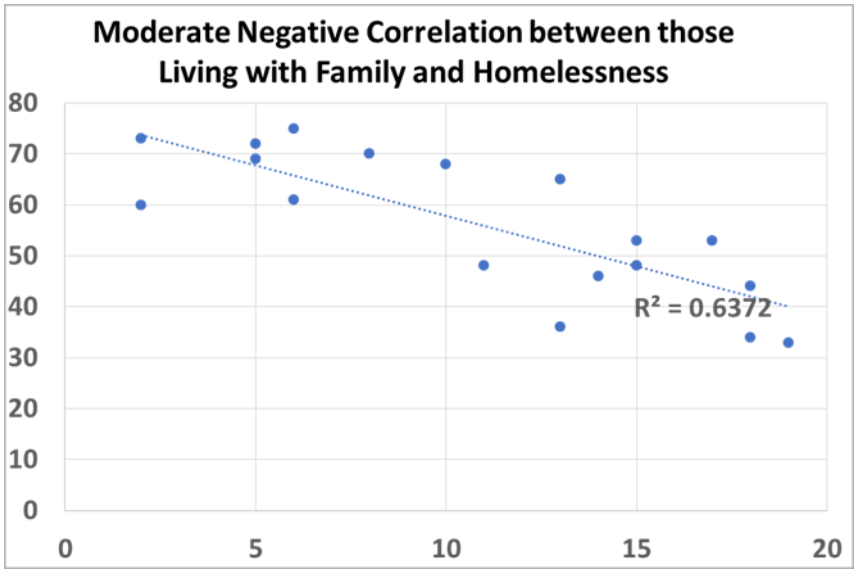
TAY RESIDENTIAL OUTCOMES
CONTINUED



Year to Year Percent Reduction in Homelessness	
Year before partnership to 1st Year	33%
During 1st year of partnership to 2nd year	16%
During 2nd year of partnership to 3rd+ year	17%
Year before partnership to year 3	54%

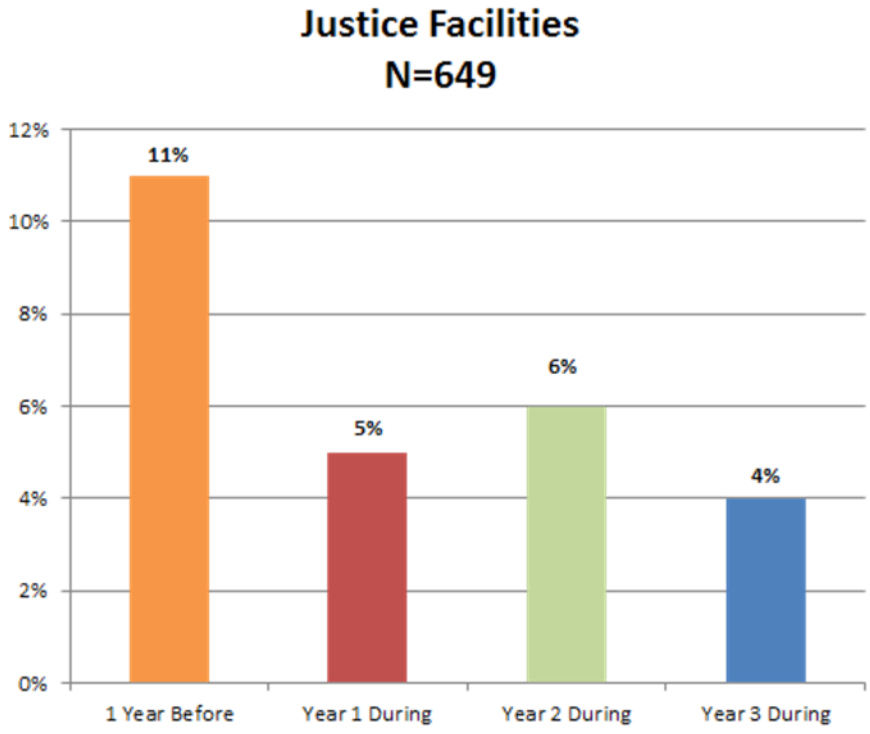
The biggest drop occurred in the first year of the partnership.

Homelessness – Explorative analysis of the relationship between several factors in 18 TAY FSP programs with at least 18 disenrollments over the past 12 months.



- There is a moderate negative correlation between homelessness and clients living with their families.
- This moderate correlation suggests that homelessness may be partly addressed by seeking family reunification through adding family education, family treatment and support and helping to bridge the gap between client and family if possible.

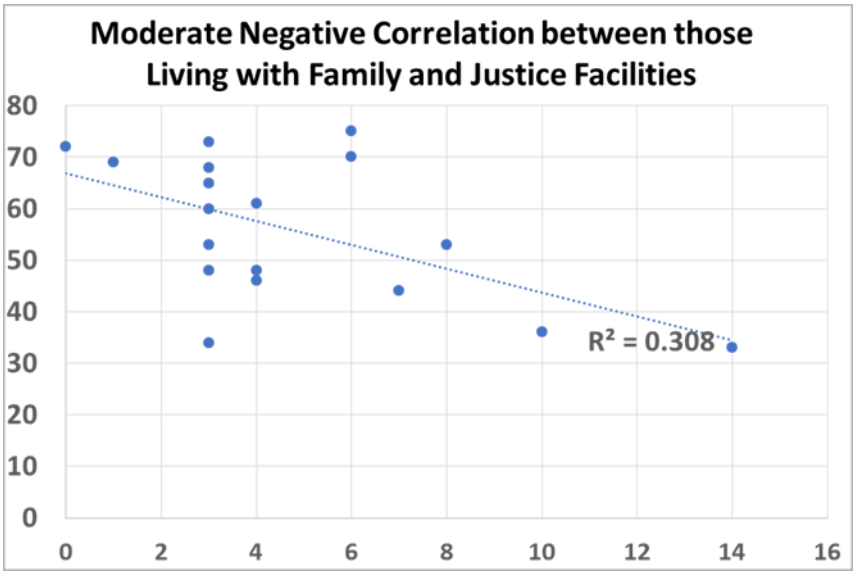
TAY RESIDENTIAL OUTCOMES
CONTINUED



Year to Year Percent Reduction in Justice Facilities	
Year before partnership to 1st Year	56%
During 1st year of partnership to 2nd year	+20%
During 2nd year of partnership to 3rd+ year	19%
Year before partnership to year 3	59%

The biggest drop occurred in the first year of the partnership.

Justice Facilities – Explorative analysis of the relationship between several factors in 18 TAY FSP programs with at least 18 disenrollments over the past 12 months.

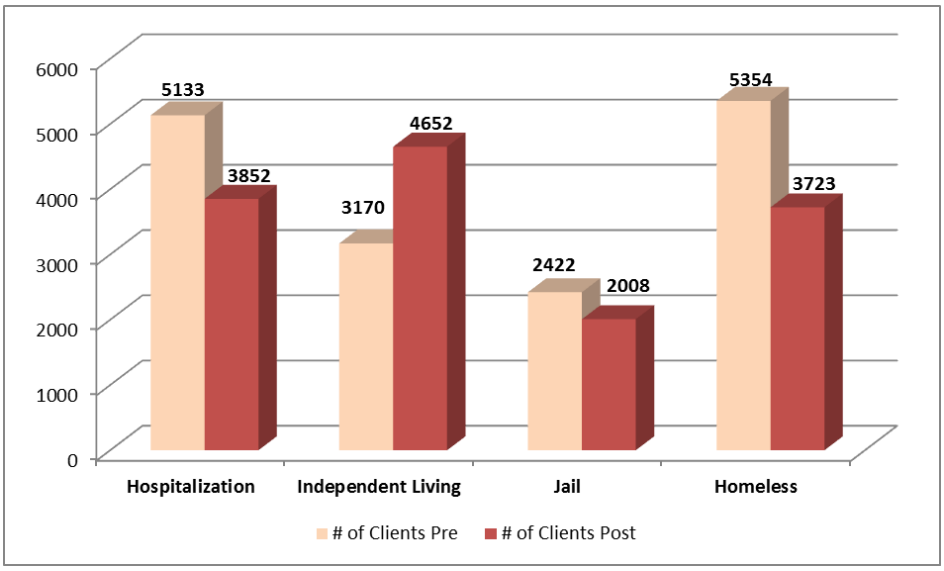


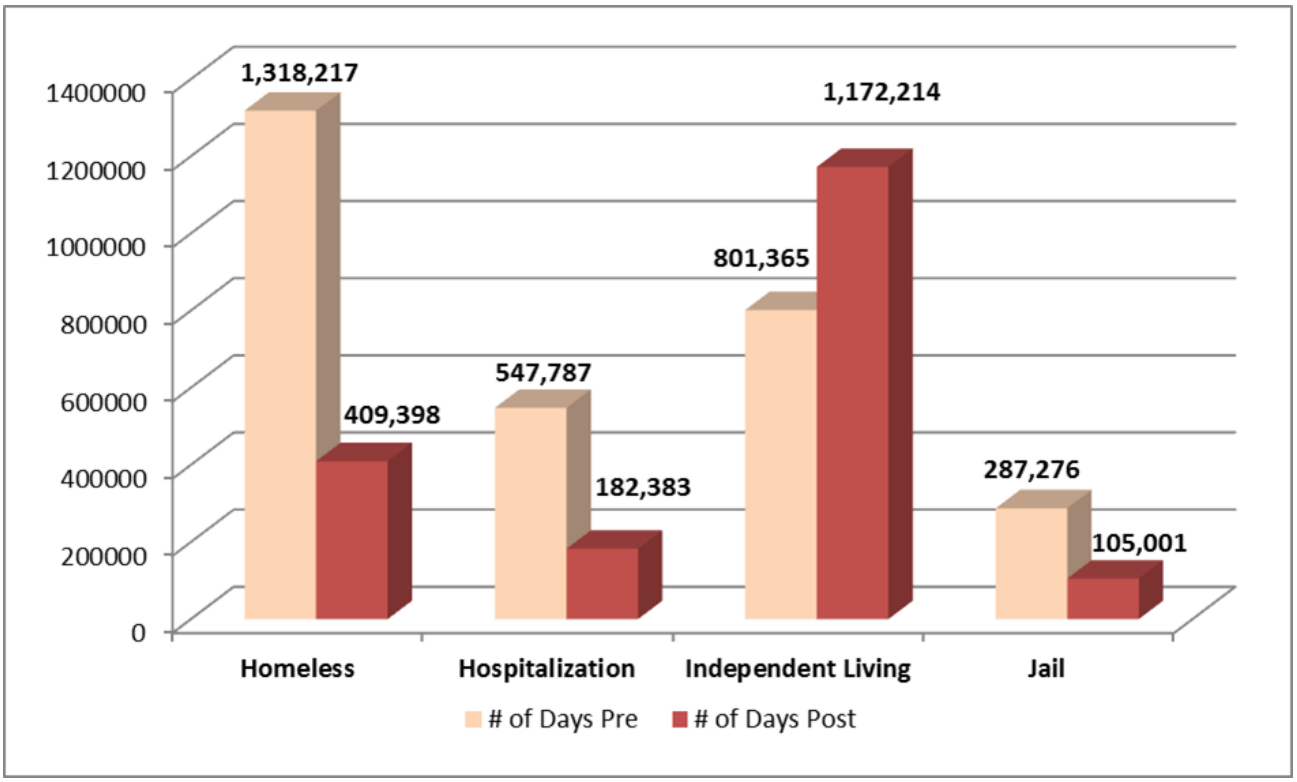
- A moderate negative correlation exits living with family and living in a justice facility.
- This moderate correlation suggests that justice vulnerability may be partly addressed by seeking family reunification through adding family education, family treatment and support and helping to bridge the gap between client and family if possible.

RESIDENTIAL OUTCOMES
CONTINUED

ADULT FSP
NUMBER OF BASELINES: 13,481
NUMBER OF CLIENTS: 12,807

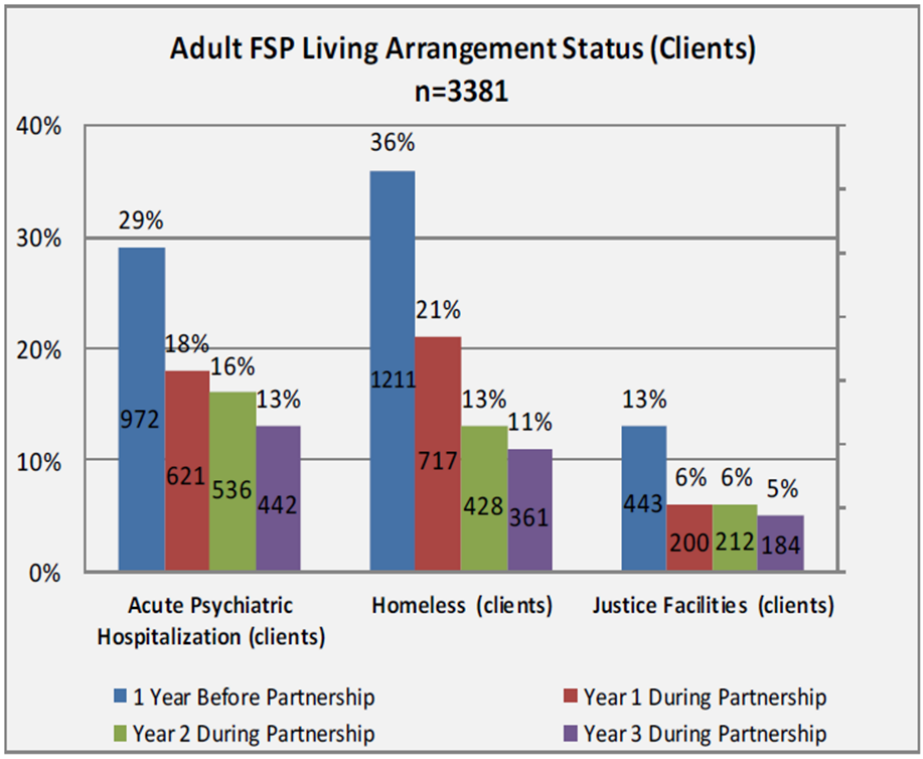
- 69% reduction in days homeless
- 67% reduction in days hospitalized
- 63% reduction in days in jail
- 46% increase in days living independently
- 30% reduction in clients homeless
- 25% reduction in clients hospitalized
- 17% reduction in clients in jail
- 47% increase in clients living independently



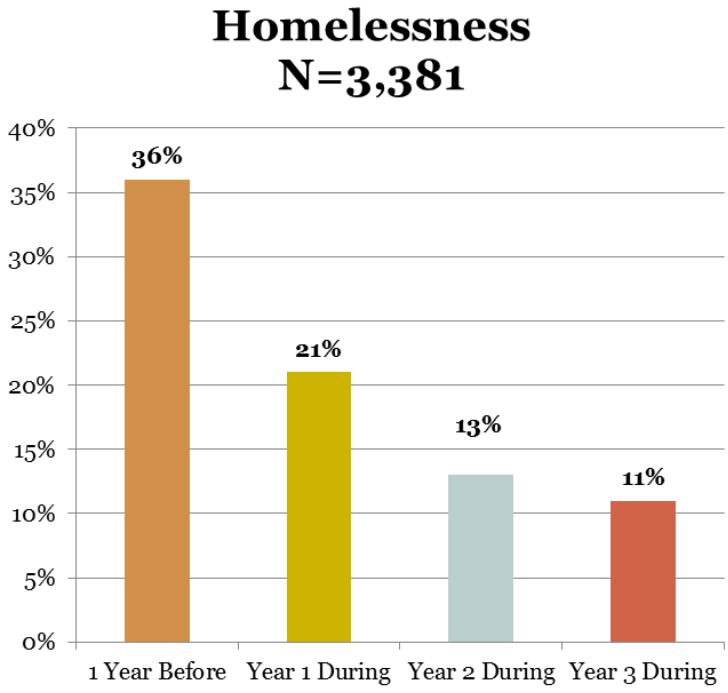


FULL SERVICE PARTNERSHIP

The following information is taken from the Adult FSP Outcomes Report - One Year Data, September 2017



Adult FSP has been found to be effective in decreasing the number of homeless, the number of those residing in acute psychiatric facilities and in criminal justice facilities in LA County.

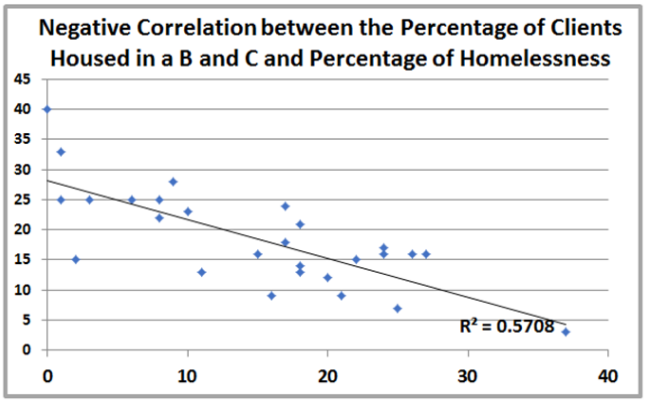


Year to Year Percent Reduction in Homelessness	
Year before partnership to 1st Year	41%
During 1st year of partnership to 2nd year	40%
During 2nd year of partnership to 3rd+ year	16%
Year before partnership to year 3	70%

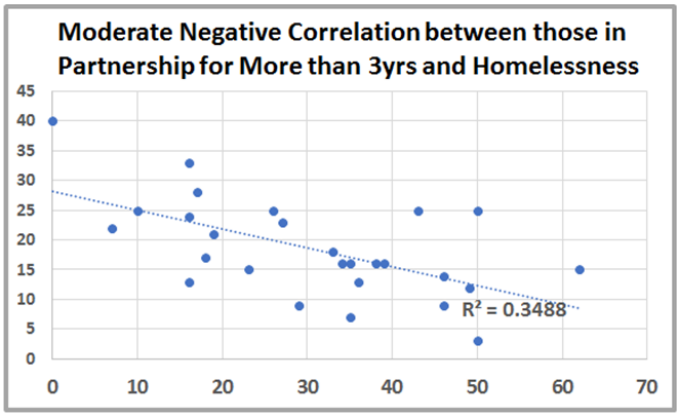
The biggest drop in homelessness occurred during the first and second year of the partnership.

ADULT RESIDENTIAL OUTCOMES
CONTINUED

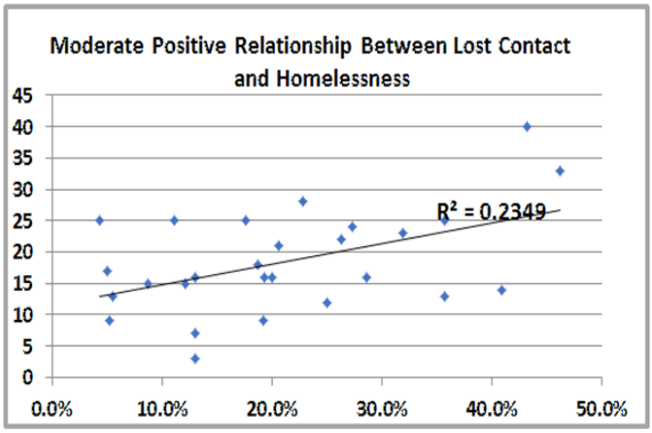
Homelessness – Explorative analysis of the relationship between several factors in 27 Adult FSP programs with at least 18 disenrollments over the past 12 months.



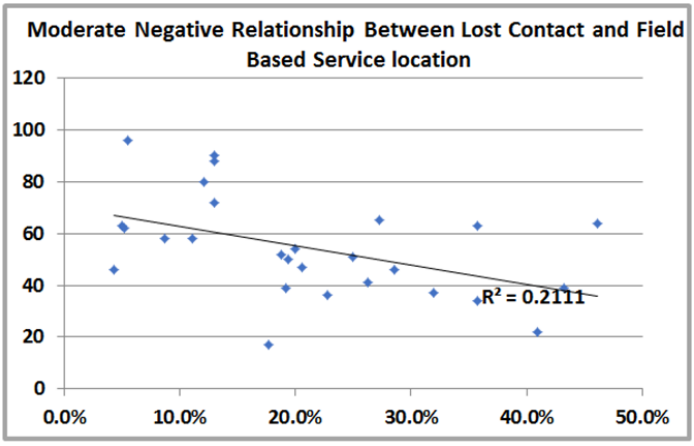
While the biggest year-to-year drop in homelessness occurs between baseline and the 1st year in partnership, many will require additional time to transition



Having available options for housing (B & C for example) seems to be strongly associated with a reduction in homelessness and may indicate the kind of emphasis that is needed countywide

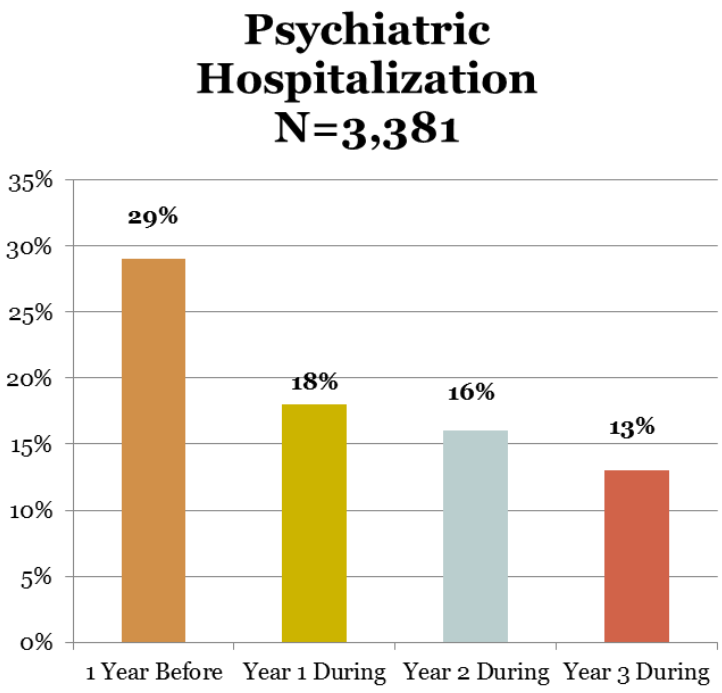


The moderate positive relationship between lost contact as a disenrollment reason and homelessness suggests that the failure to maintain relationship increases the risk of not having, not maintaining or not securing housing.



The moderate negative relationship between lost contact and field based service location suggests that investing in treatment outside the clinic may play a role in helping to moderate the tendency for clients to go missing.

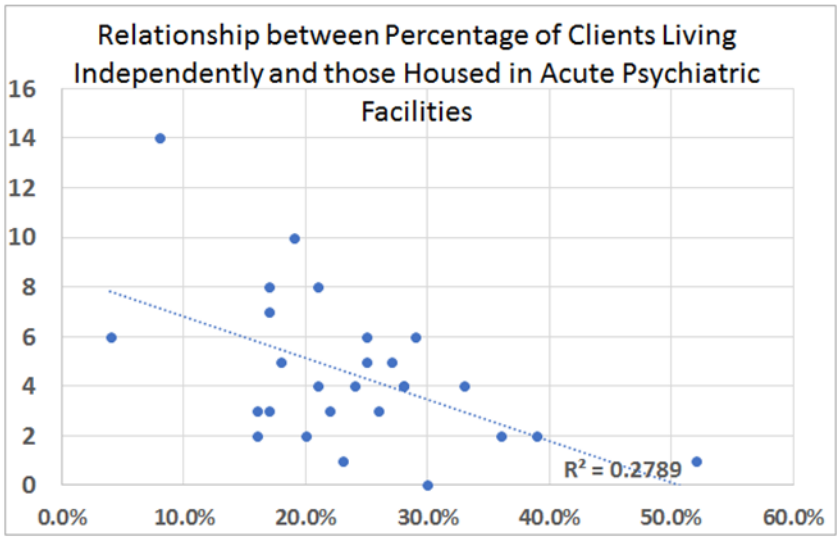
ADULT RESIDENTIAL OUTCOMES
CONTINUED



Year to Year Percent Reduction in Psychiatric Hospitalizations	
Year before partnership to 1st Year	36%
During 1st year of partnership to 2nd year	14%
During 2nd year of partnership to 3rd+ year	18%
Year before partnership to year 3	55%

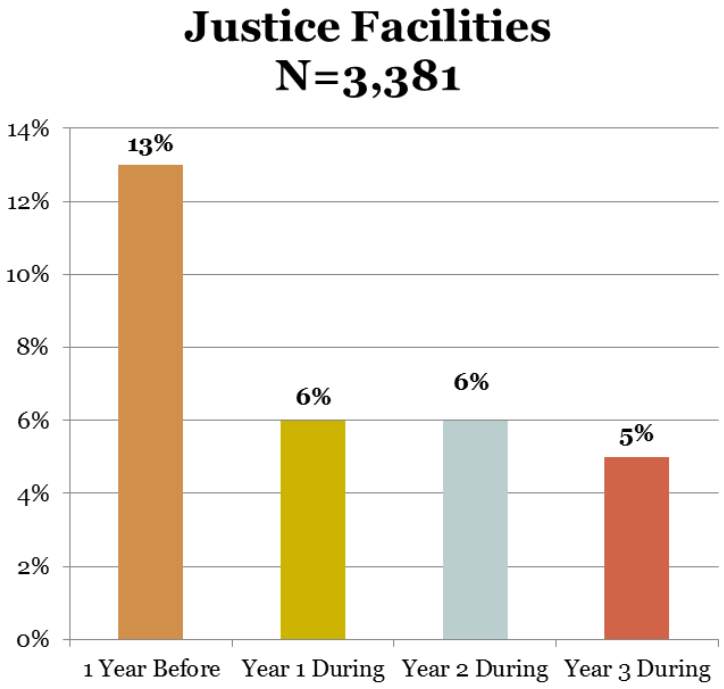
The biggest drop occurred in the first year of the partnership.

Psychiatric Hospitalization – Explorative analysis of the relationship between several factors in 27 Adult FSP programs with at least 18 disenrollments over the past 12 months.



- There is a moderate relationship between the percentage of clients living independently and those housed in acute psychiatric facilities.
- Living independently maybe the most viable option to being housed in a psychiatric facility provided the client is afforded the necessary skills to succeed.

ADULT RESIDENTIAL OUTCOMES
CONTINUED



The biggest drop occurred in the first year of the partnership.

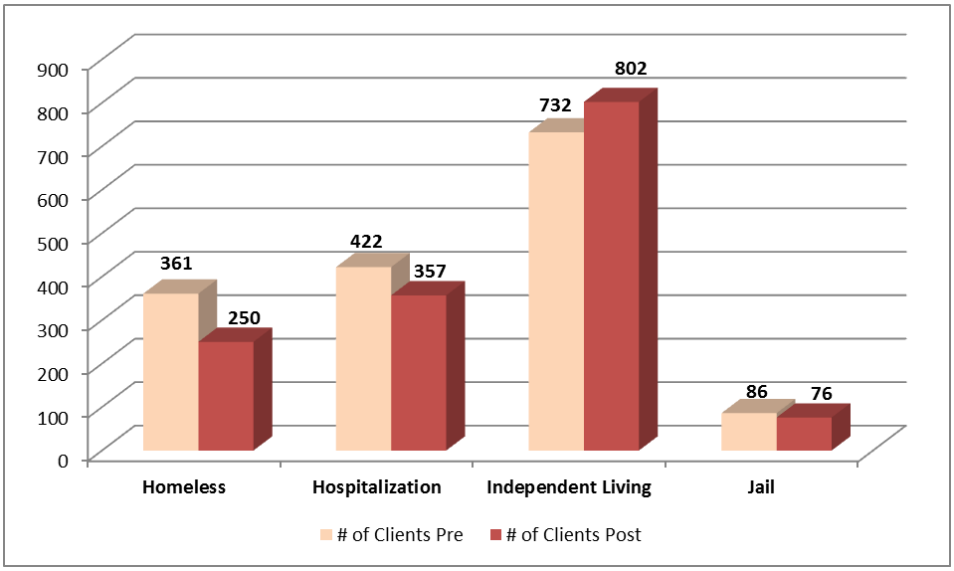
Year to Year Percent Reduction in Justice Facilities	
Year before partnership to 1st Year	55%
During 1st year of partnership to 2nd year	+6%
During 2nd year of partnership to 3rd+ year	13%
Year before partnership to year 3	58%

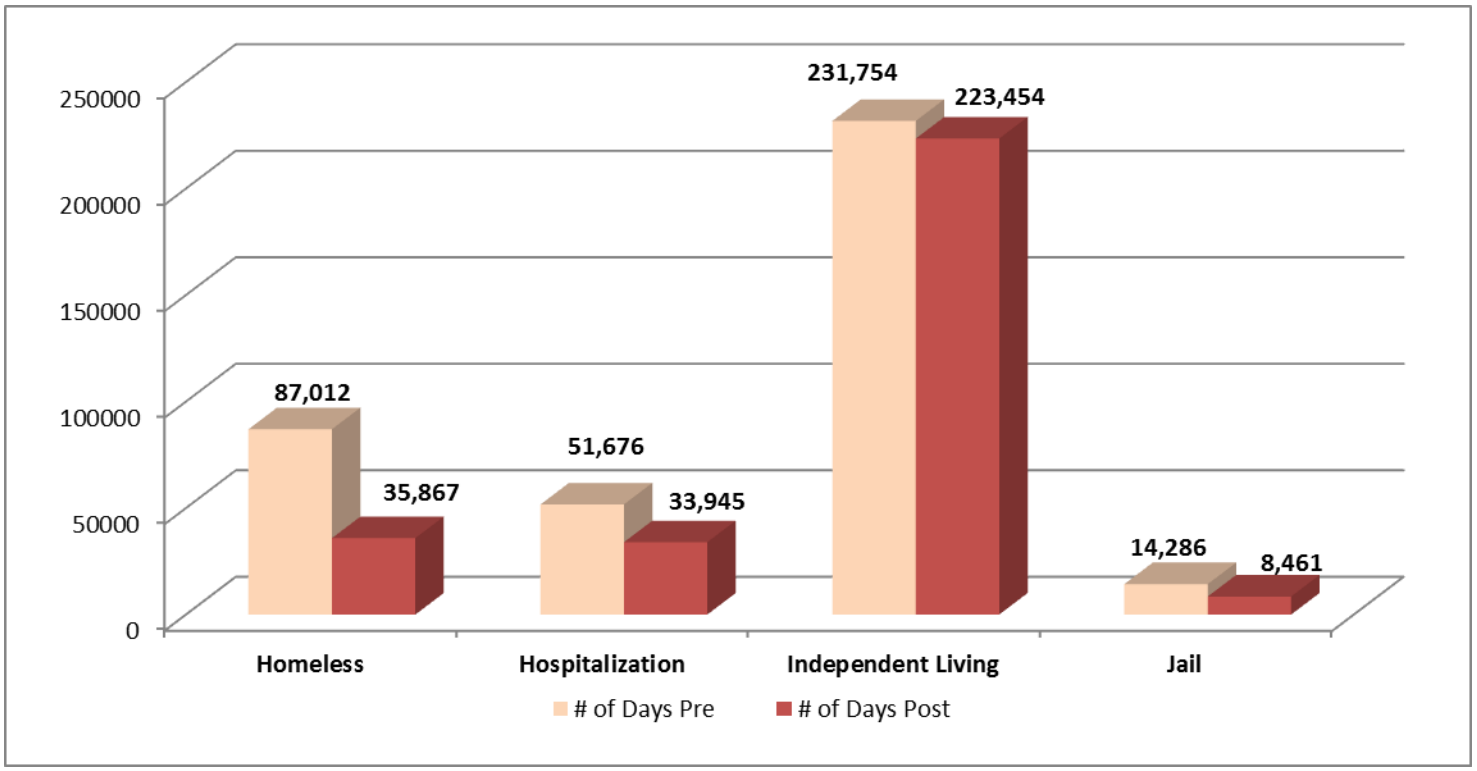
RESIDENTIAL OUTCOMES
CONTINUED

OLDER ADULT FSP

NUMBER OF BASELINES: 1,643
NUMBER OF CLIENTS: 1,606

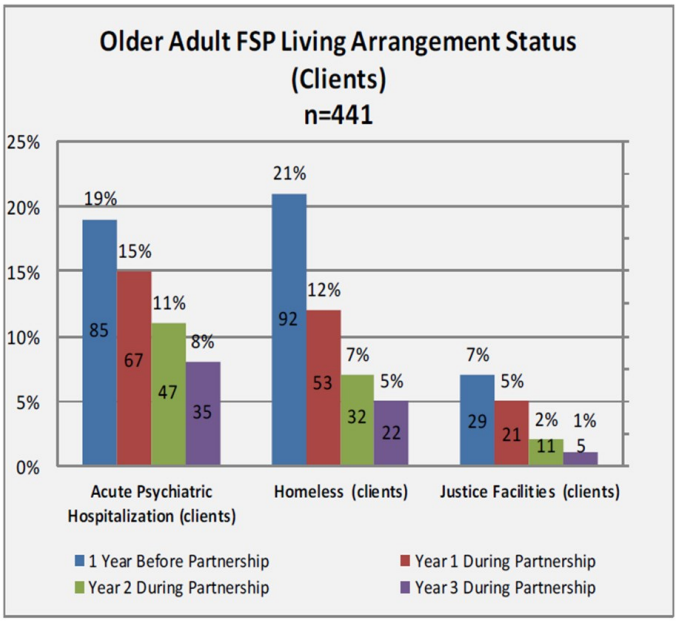
- 59% reduction in days homeless
- 34% reduction in days hospitalized
- 4% increase in days living independently
- 41% reduction in days in jail
- 31% reduction in clients homeless
- 15% reduction in clients hospitalized
- 10% increase in clients living independently
- 12% reduction in clients in jail



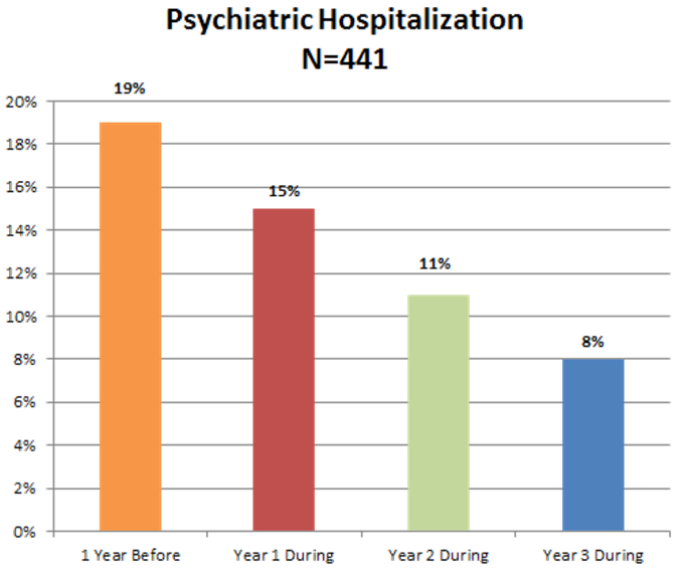


FULL SERVICE PARTNERSHIP

The following information is taken from the Older Adult FSP Outcomes Report - One Year Data, September 2017



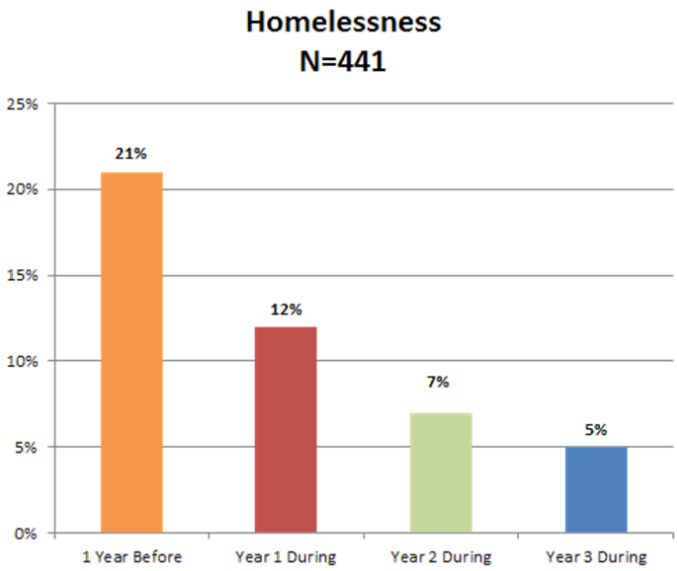
Older Adult FSP has been found to be effective in decreasing the number of clients residing in Acute Psychiatric facilities, reduced the percentage of clients reported to be homeless and the percentage of those residing in justice facilities



Year to Year Percent Reduction in Psychiatric Hospitalizations	
Year before partnership to 1st Year	21%
During 1st year of partnership to 2nd year	30%
During 2nd year of partnership to 3rd+ year	26%
Year before partnership to year 3	59%

The biggest drop occurred during the second and third year of the partnership although progress in reducing psychiatric hospitalization seems to be fairly consistent over three years.

OLDER ADULT RESIDENTIAL OUTCOMES
CONTINUED



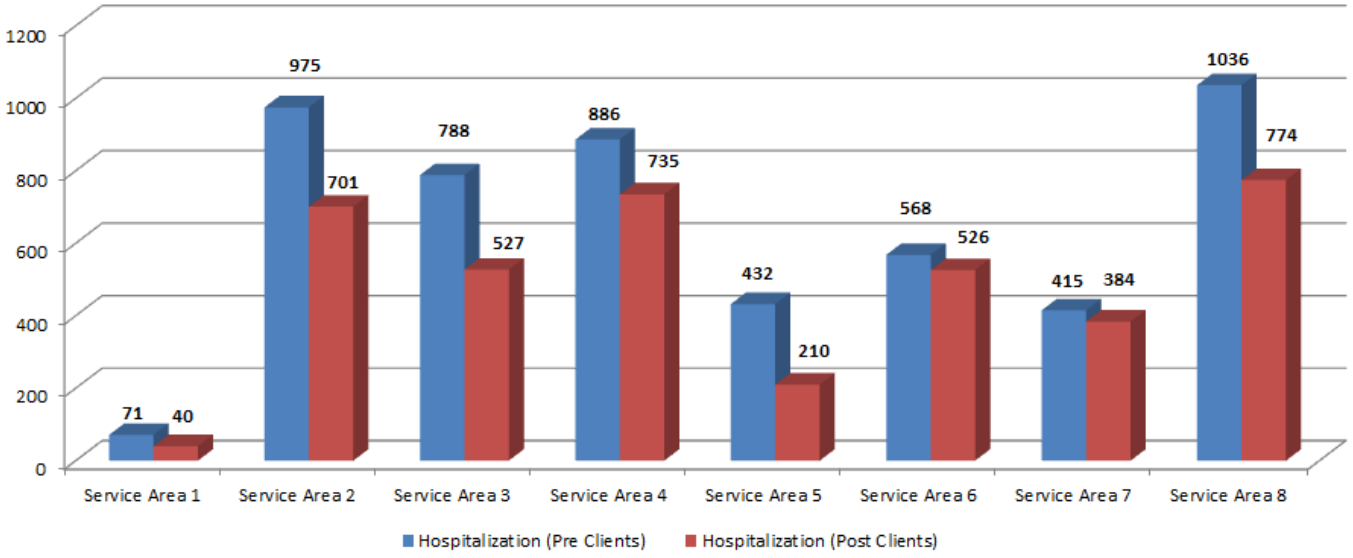
Year to Year Percent Reduction in Homelessness	
Year before partnership to 1st Year	42%
During 1st year of partnership to 2nd year	40%
During 2nd year of partnership to 3rd+ year	31%
Year before partnership to year 3	76%

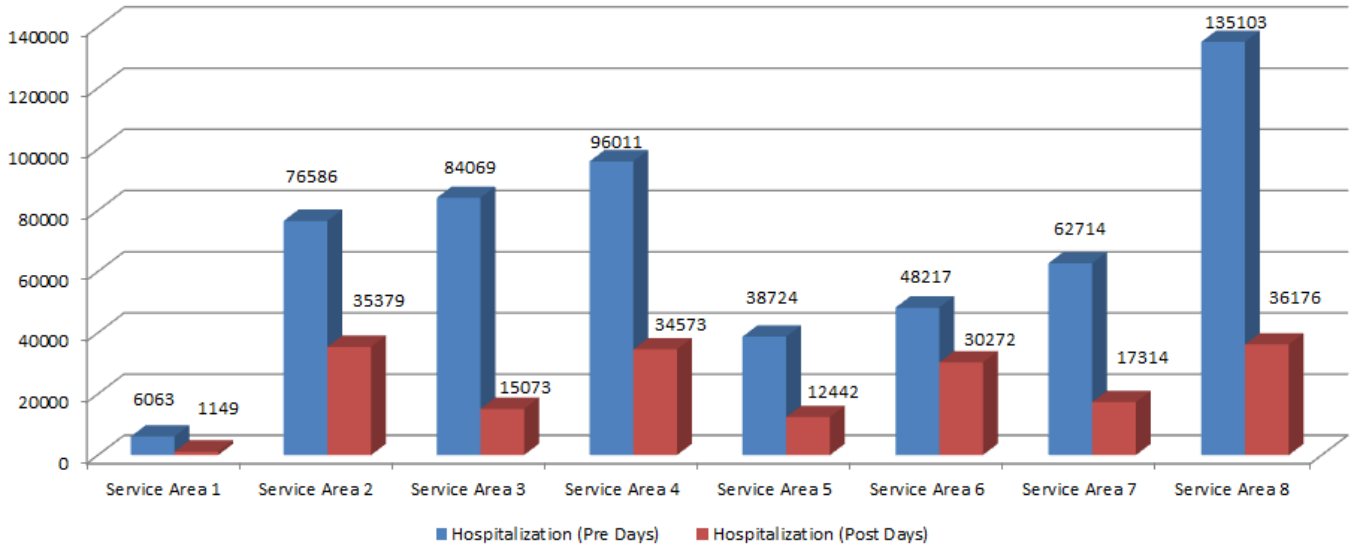
The biggest drop in homelessness occurred during the first and second year of the partnership.

RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT HOSPITALIZATIONS

- ◊ All Service Areas report a reduction in clients and days hospitalized post-partnership
- ◊ Service Area 5 has the highest percent (51%) reduction in clients hospitalized post-partnership
- ◊ Service Area 3 has the highest percent reduction (82%) in hospital days post-partnership

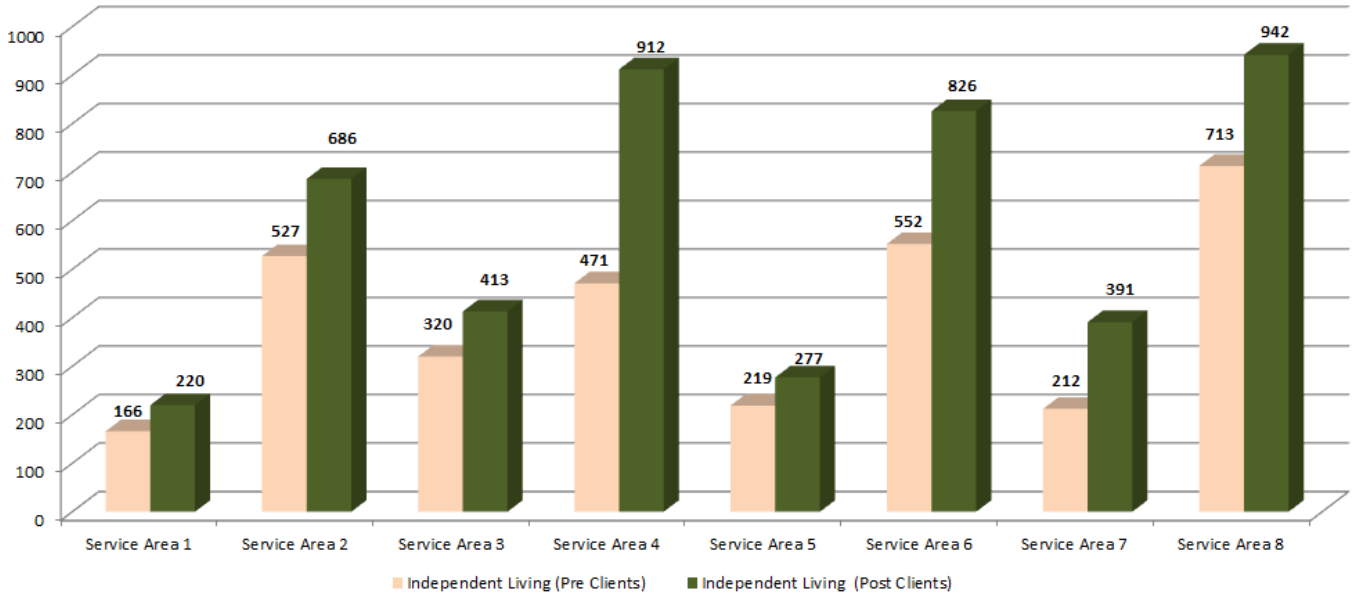


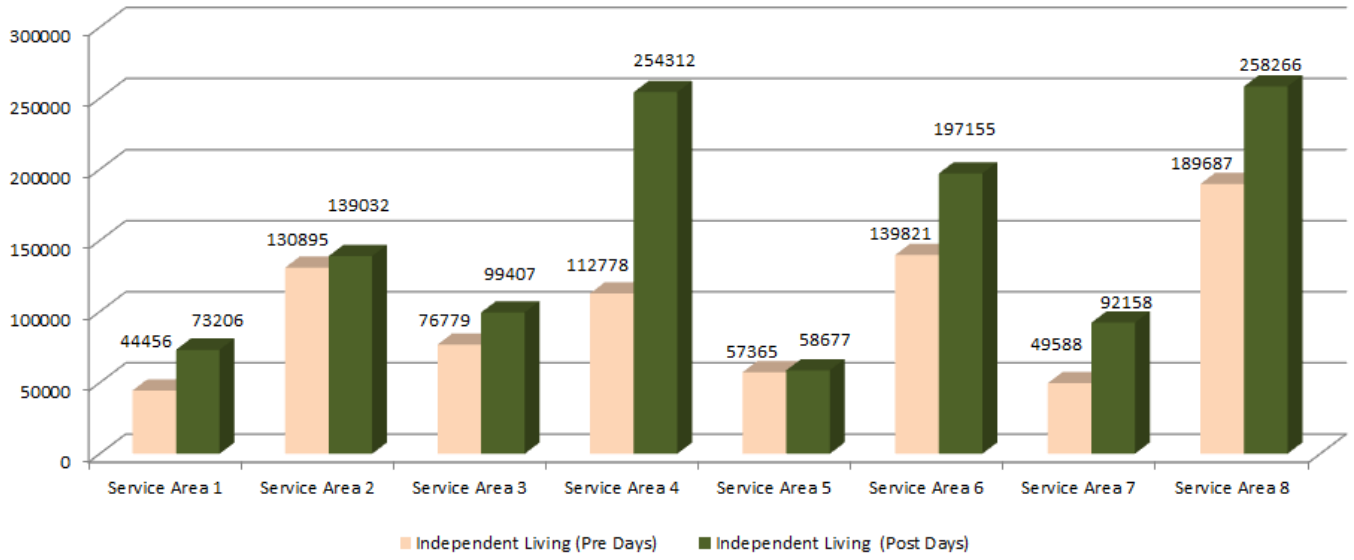


RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT INDEPENDENT LIVING

- All Service Areas report an increase in clients and days living independently post-partnership
- Service Area 8 has the highest number of clients living independently post partnership, 942, and Service Area 4 has the most percent increase in clients living independently, 94%
- Service Area 4 has the most percent increase in days living independently, 125%

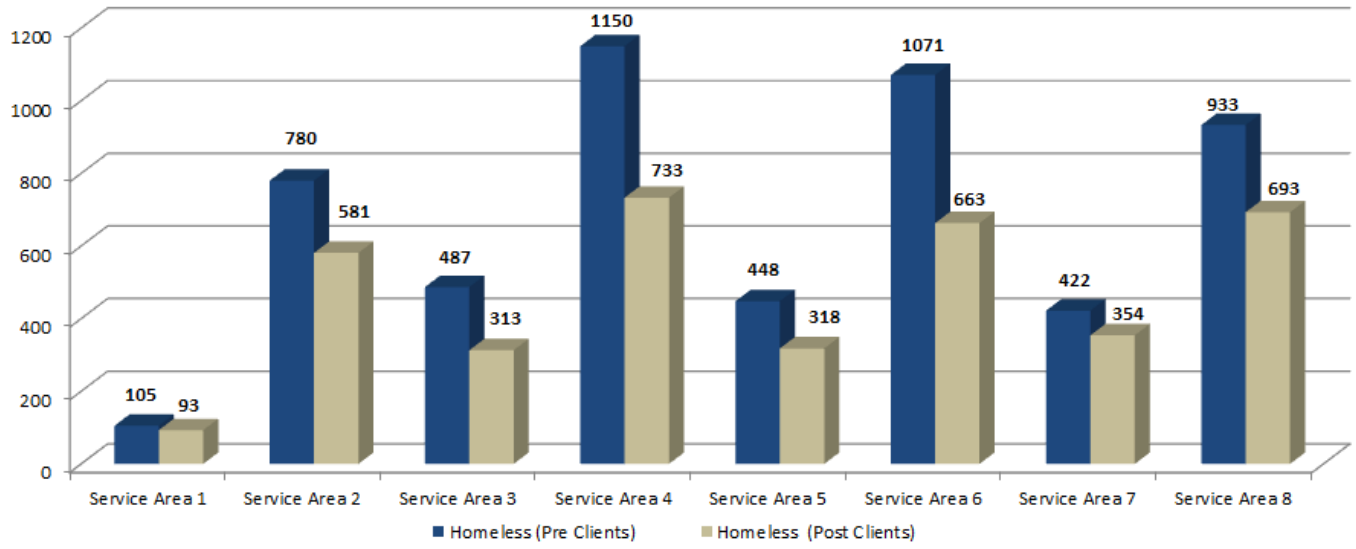


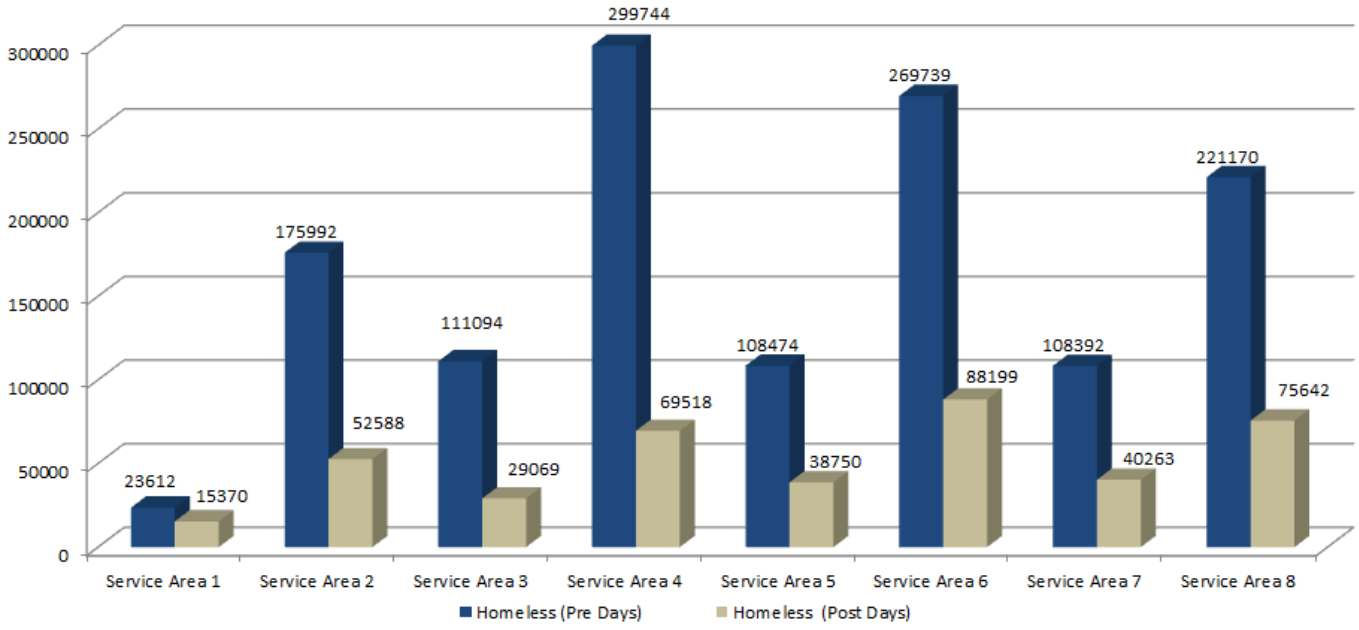


RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT HOMELESS

- ◊ All Service Areas report a reduction in clients and days homeless post-partnership
- ◊ Service Area 6 has the highest percent (38%) reduction in clients homeless post-partnership
- ◊ Service Area 4 has the highest percent (77%) reduction in days homeless post-partnership

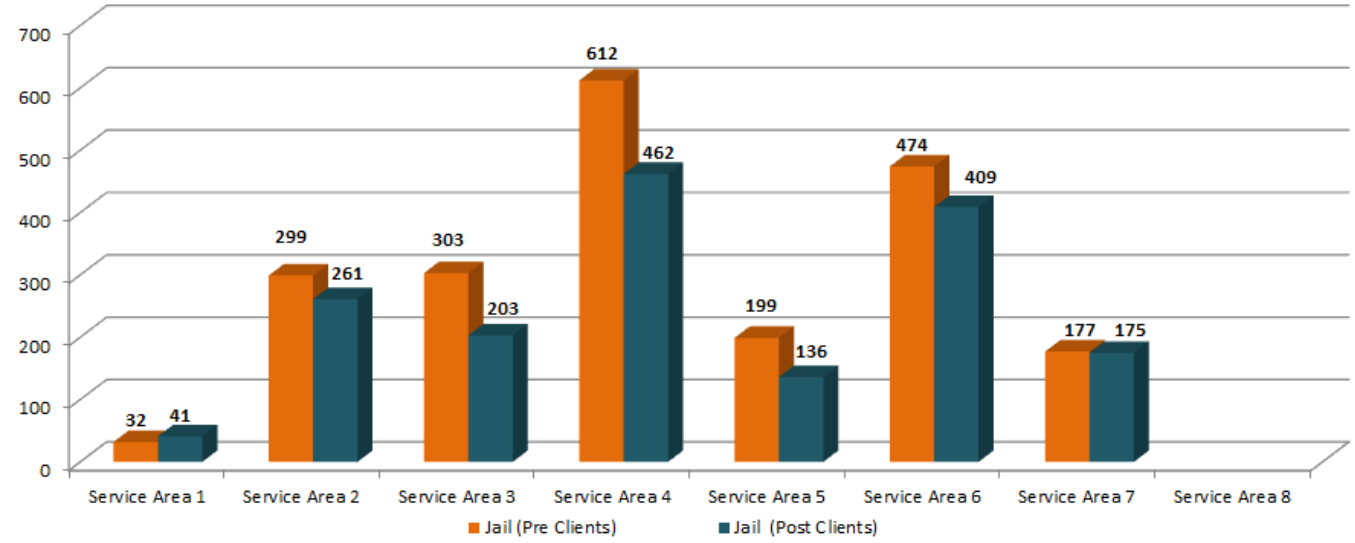


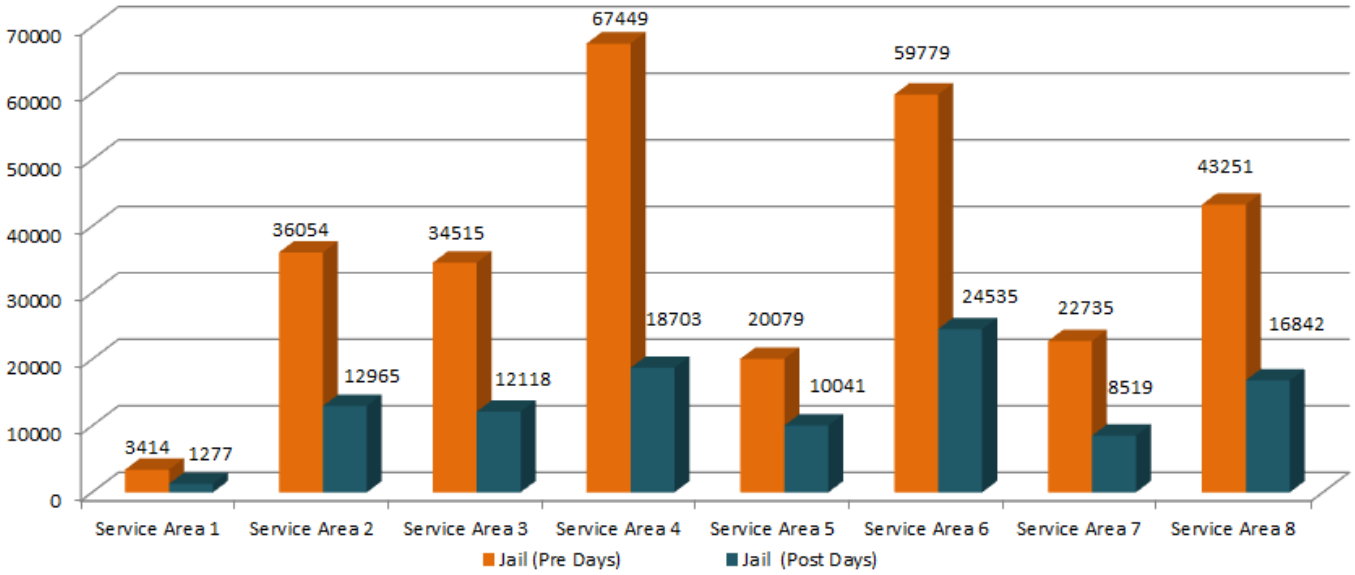


RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT JAIL

- ◊ All Service Areas report a reduction of days spent in jail post-partnership
- ◊ Service Area 3 has the highest percent (33%) reduction of clients in jail post-partnership
- ◊ Service Area 4 has the highest percent (72%) reduction of days spent in jail post-partnership

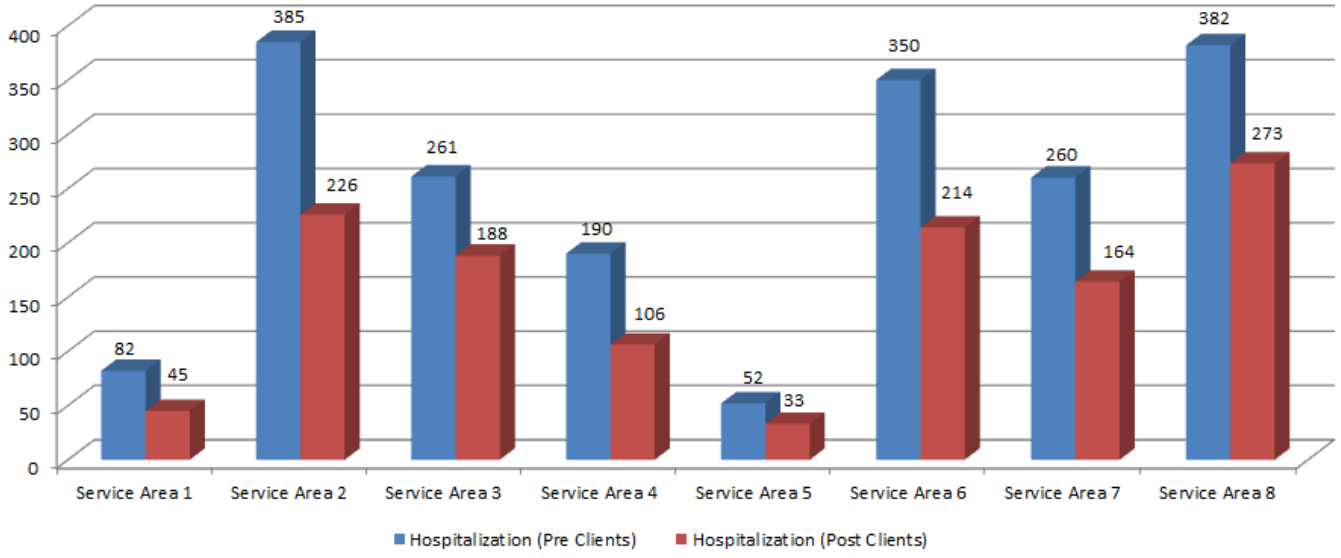


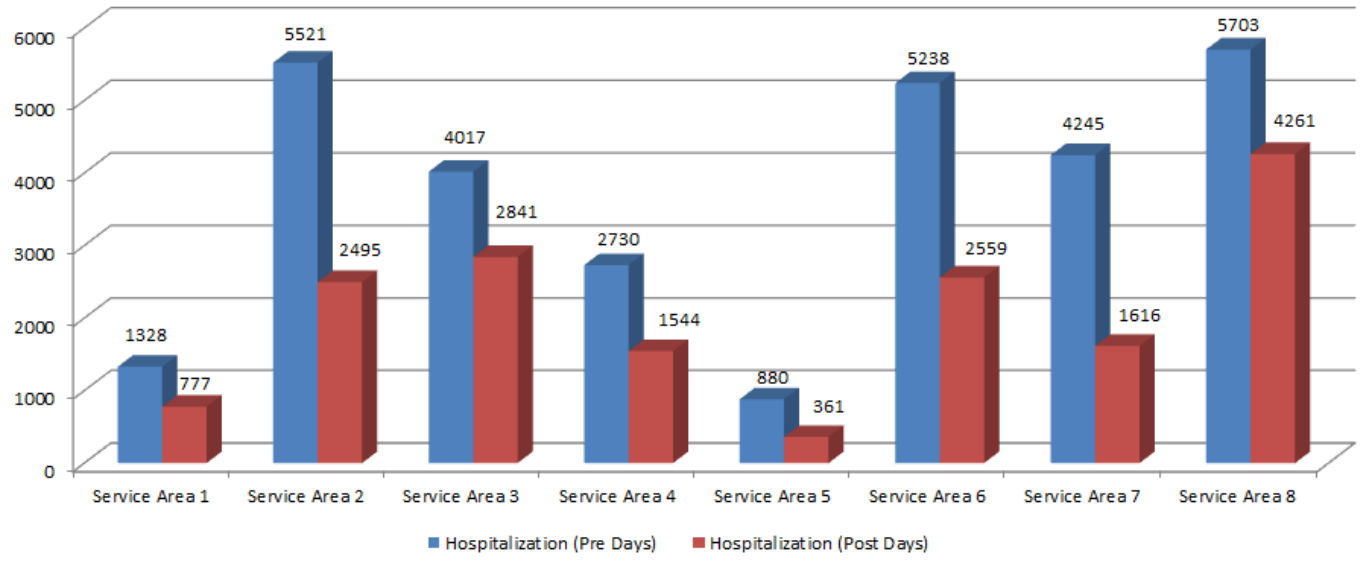


RESIDENTIAL OUTCOMES BY SERVICE AREA

CHILD HOSPITALIZATIONS

- ◊ All Service Areas report a reduction in clients and days hospitalized post-partnership
- ◊ Service Area 1 has the highest percent (45%) reduction in clients hospitalized post-partnership
- ◊ Service Area 7 has the highest percent reduction (62%) in hospital days post-partnership

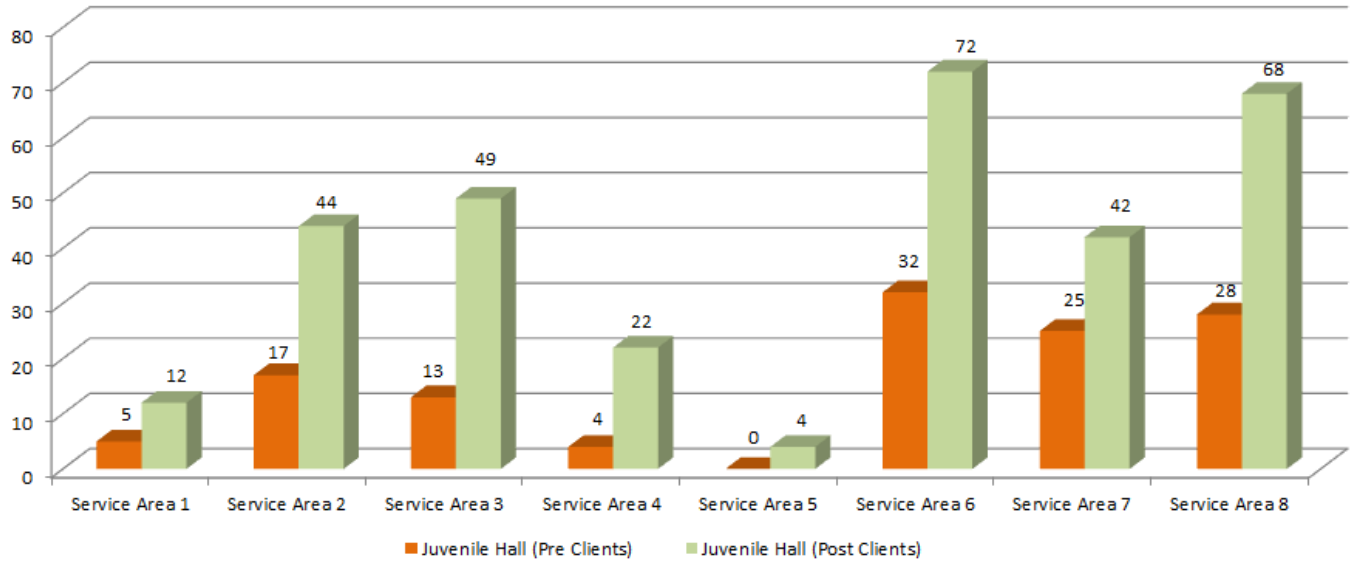


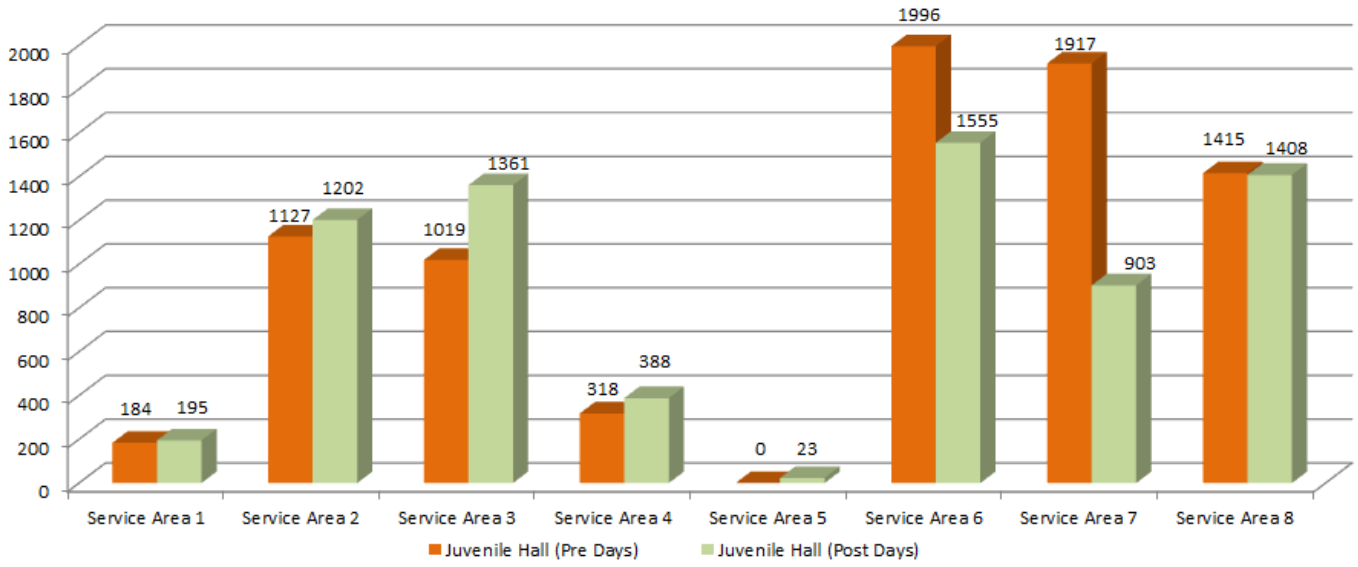


RESIDENTIAL OUTCOMES BY SERVICE AREA

CHILD JUVENILE HALL

- Service Area 6 and 8 has the most increase in the number of clients in juvenile hall from pre to post.
- Service Area 7 has the most reduction in the number of days in juvenile hall from pre to post.

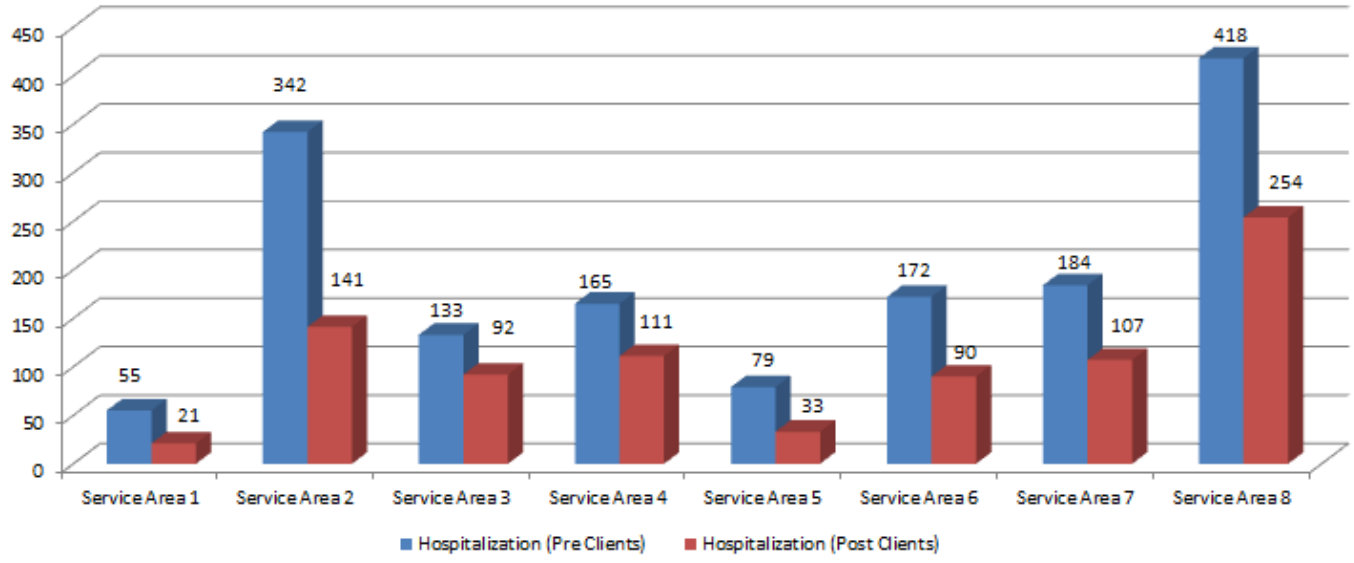


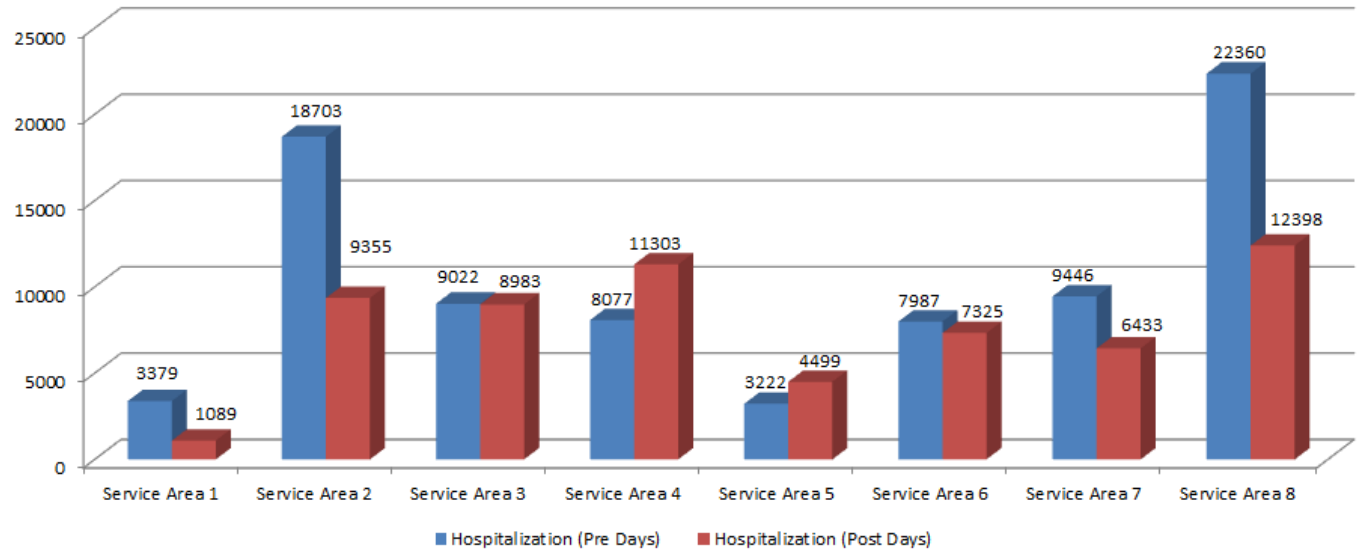


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY HOSPITALIZATIONS

- ◊ All Service Areas report a reduction in clients hospitalized post-partnership
- ◊ Service Area 1 has the highest percent (62%) reduction in clients hospitalized post-partnership
- ◊ Service Area 8 has the most clients hospitalized pre-partnership (418) and post-partnership (254) with a 39%percent reduction
- ◊ Service Area 1 has the highest percent reduction (68%) in hospital days post-partnership
- ◊ Service Area 8 has the most days spent in hospitalized pre-partnership (22,360) and post-partnership (12,398) with a 45% percent reduction.

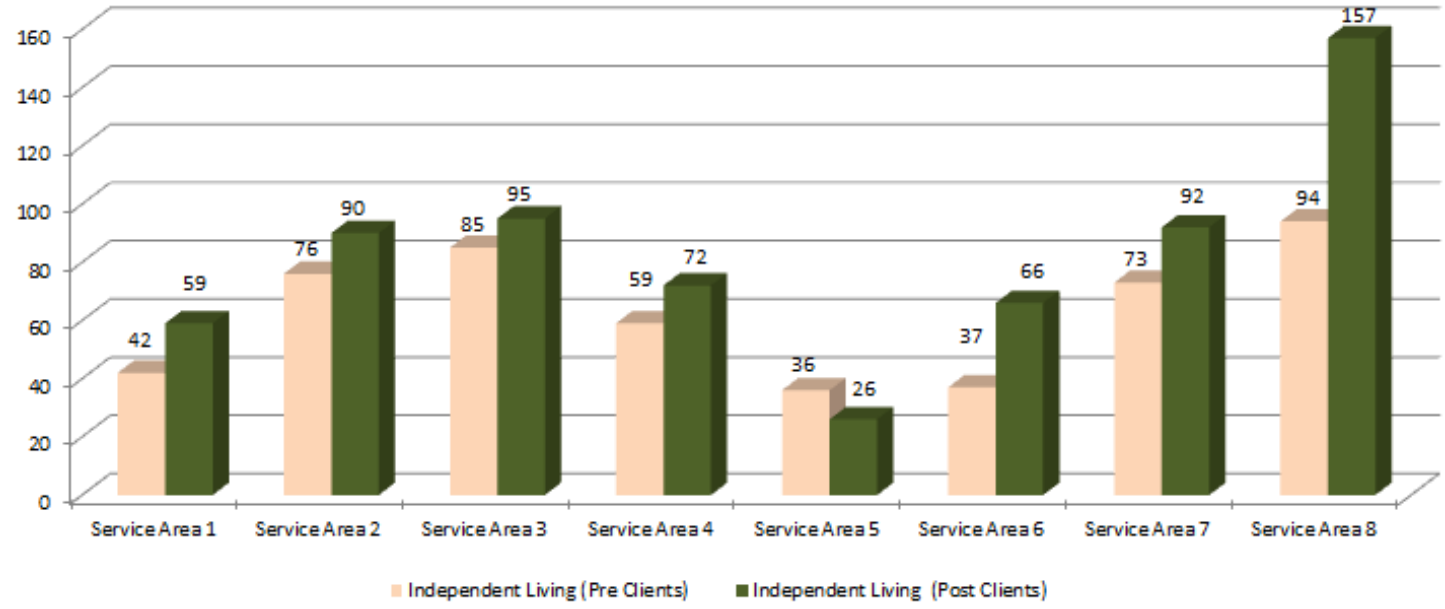


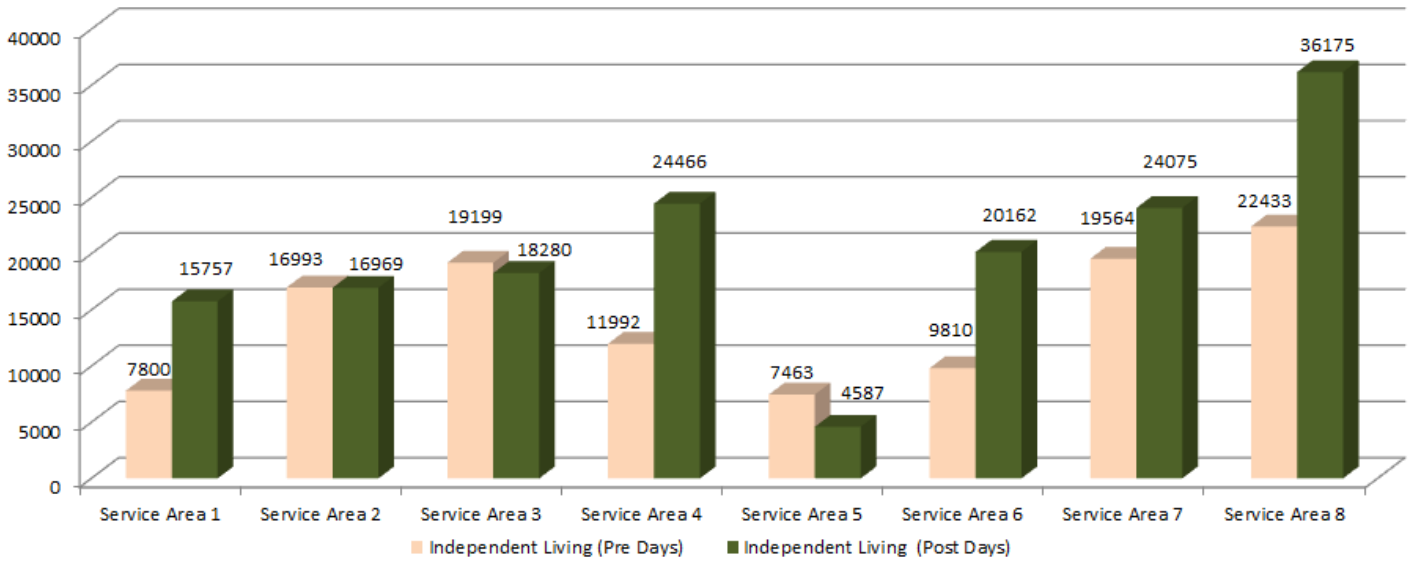


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY INDEPENDENT LIVING

- ◊ Service Area 8 has the highest number of clients living independently post partnership, 157
- ◊ Service Area 6 has the most percent increase in clients (78%) and days (106%) living independently post-partnership

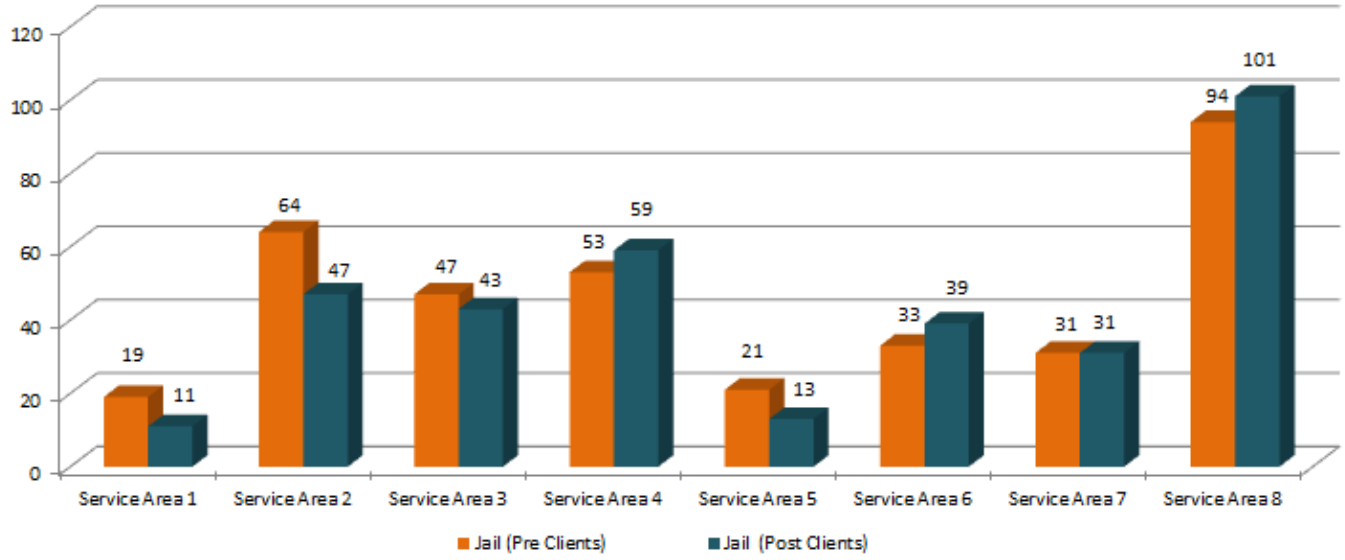


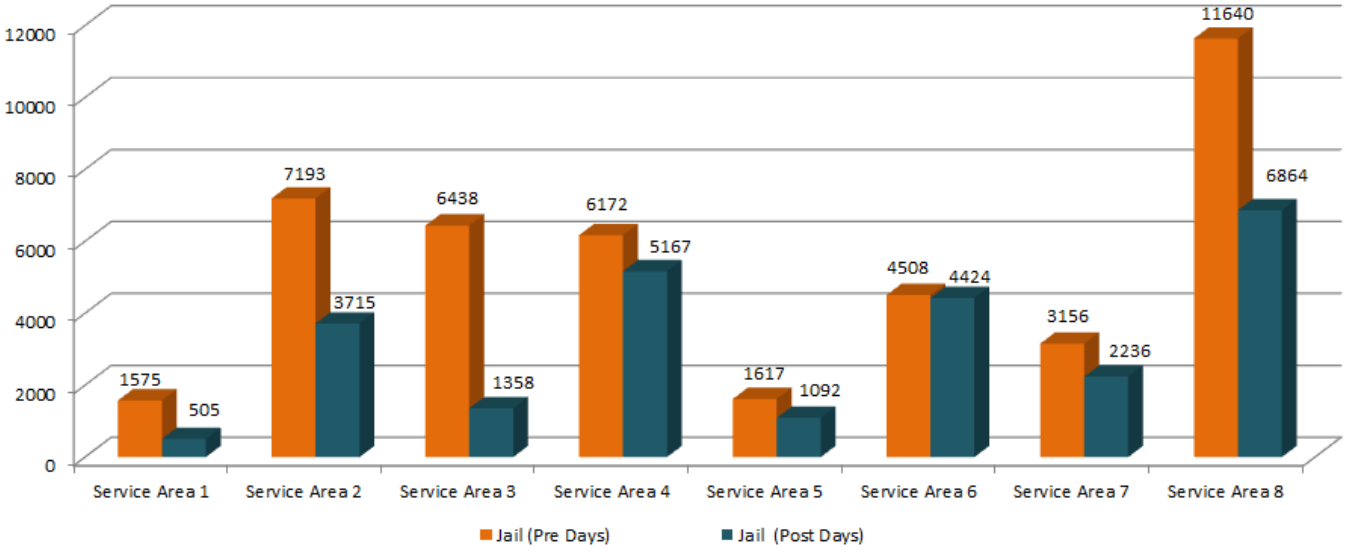


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY JAIL

- Service Area 1 has the highest percent (42%) reduction of clients in jail post-partnership
- Service Area 4 has the highest percent (79%) reduction of days spent in jail post-partnership

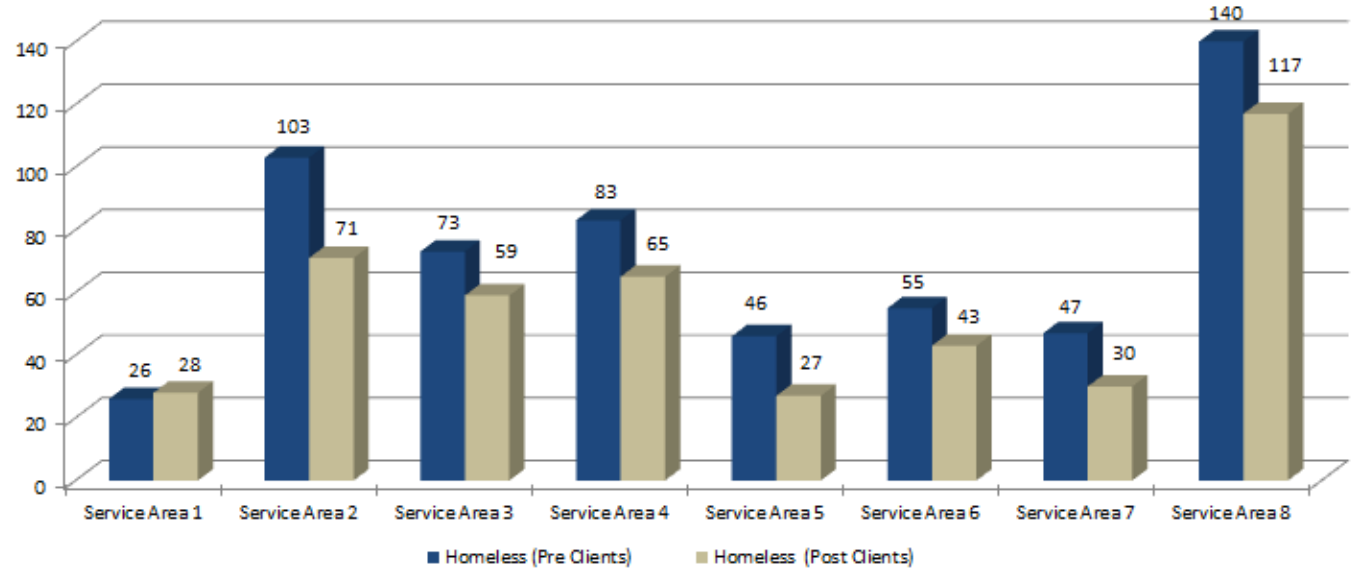


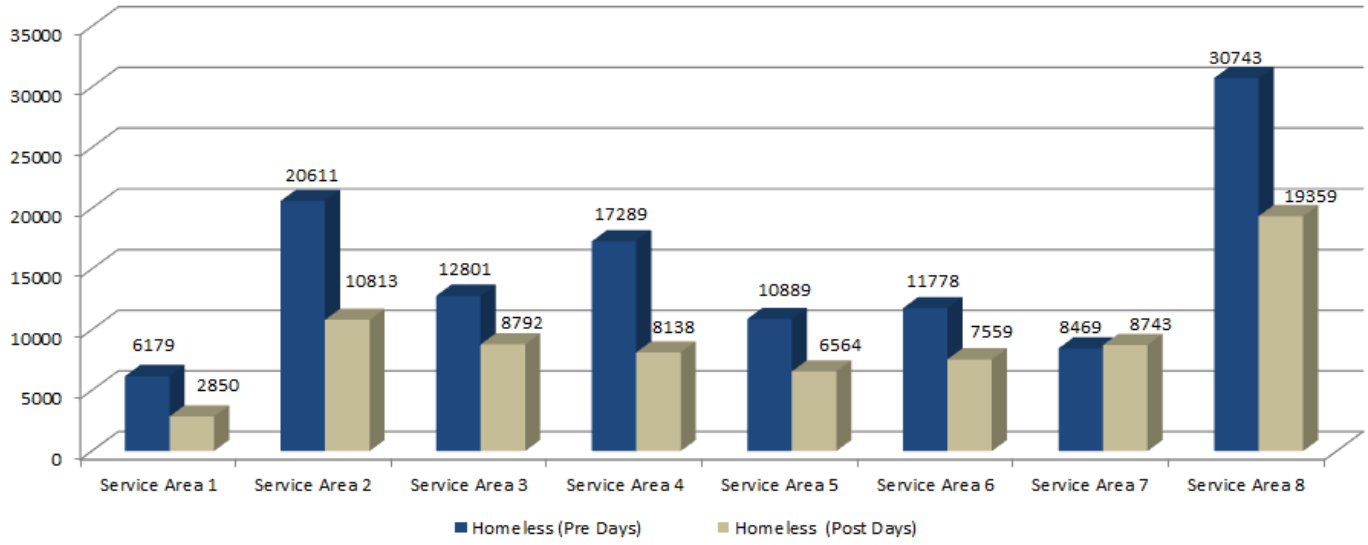


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY HOMELESS

- Service Area 5 has the highest percent (41%) reduction in clients homeless post-partnership
- Service Area 1 has the highest percent (54%) reduction in days homeless post-partnership
- Service Area 8 has the most clients homeless pre-partnership (140) and post-partnership (117) with a 16% percent reduction
- Service Area 8 has the most days spent homeless pre-partnership (30,743) and post-partnership (19,359) with a 37% percent reduction

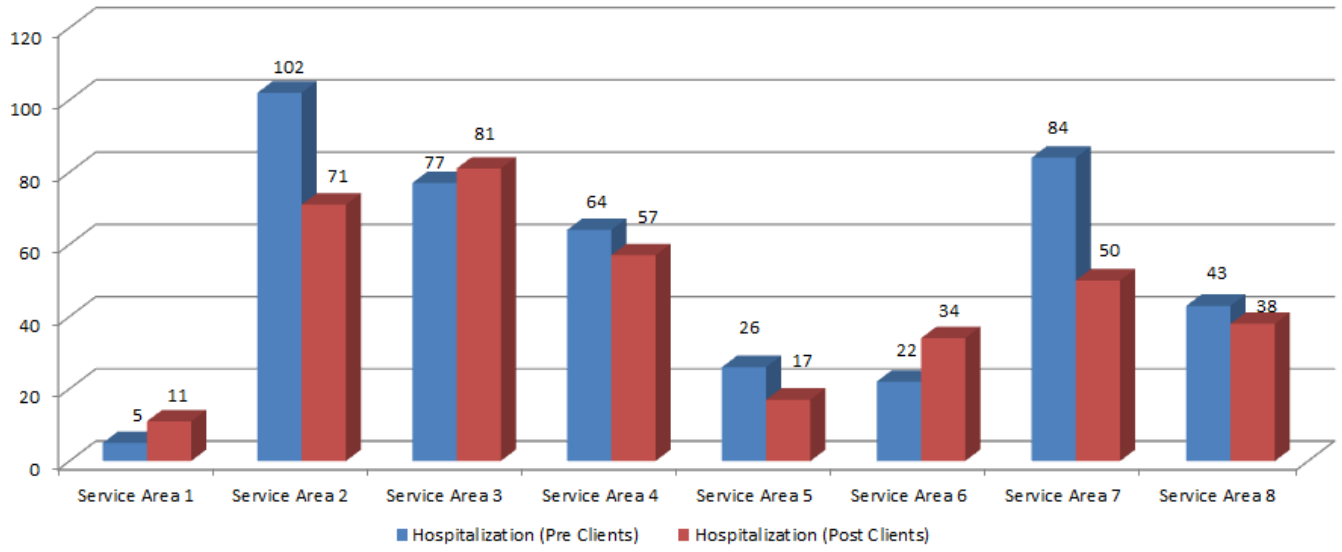


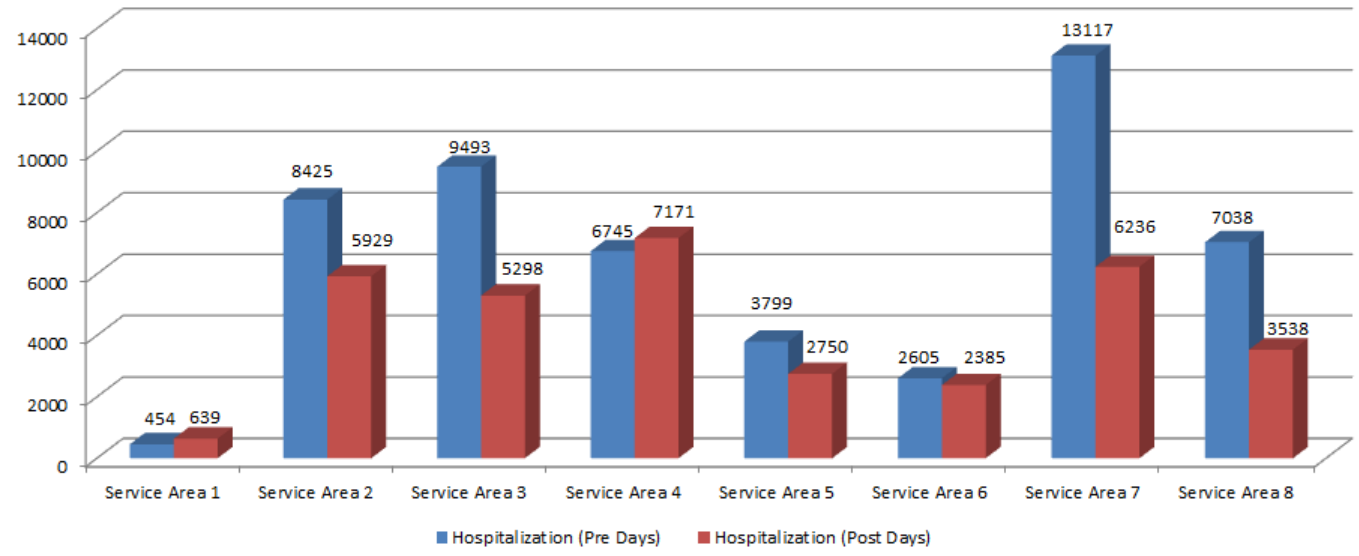


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT HOSPITALIZATION

◊ Service Area 7 has the highest percent reduction in clients (40%) and days (52%) spent hospitalized post-partnership

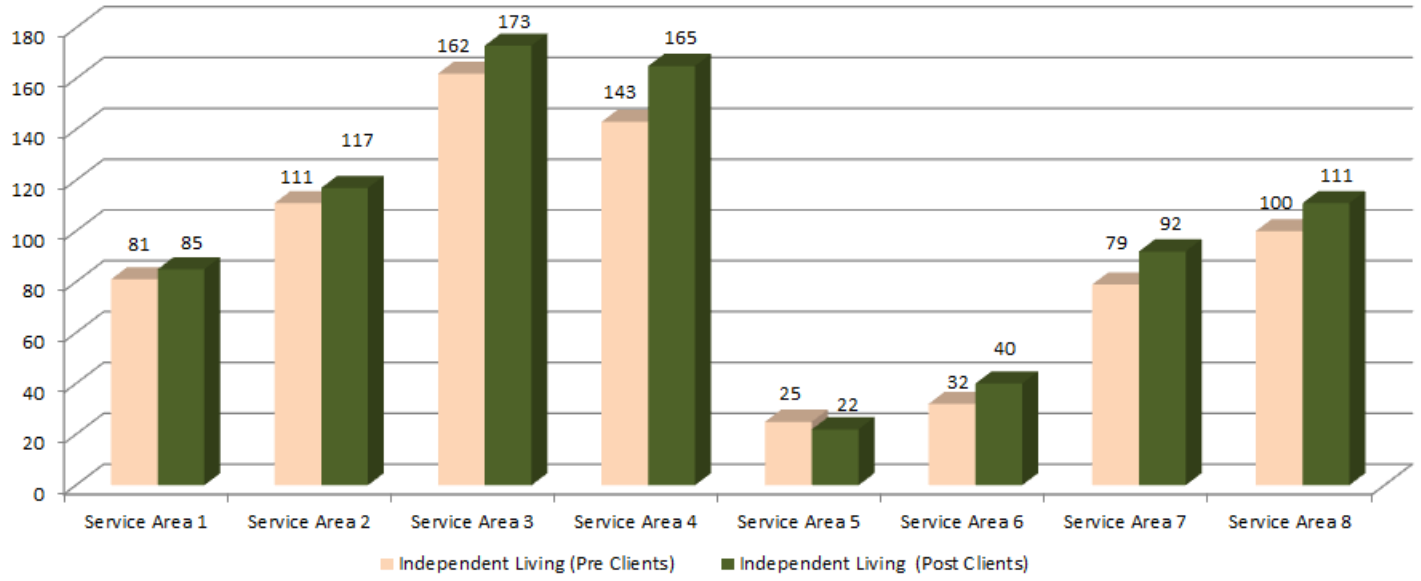


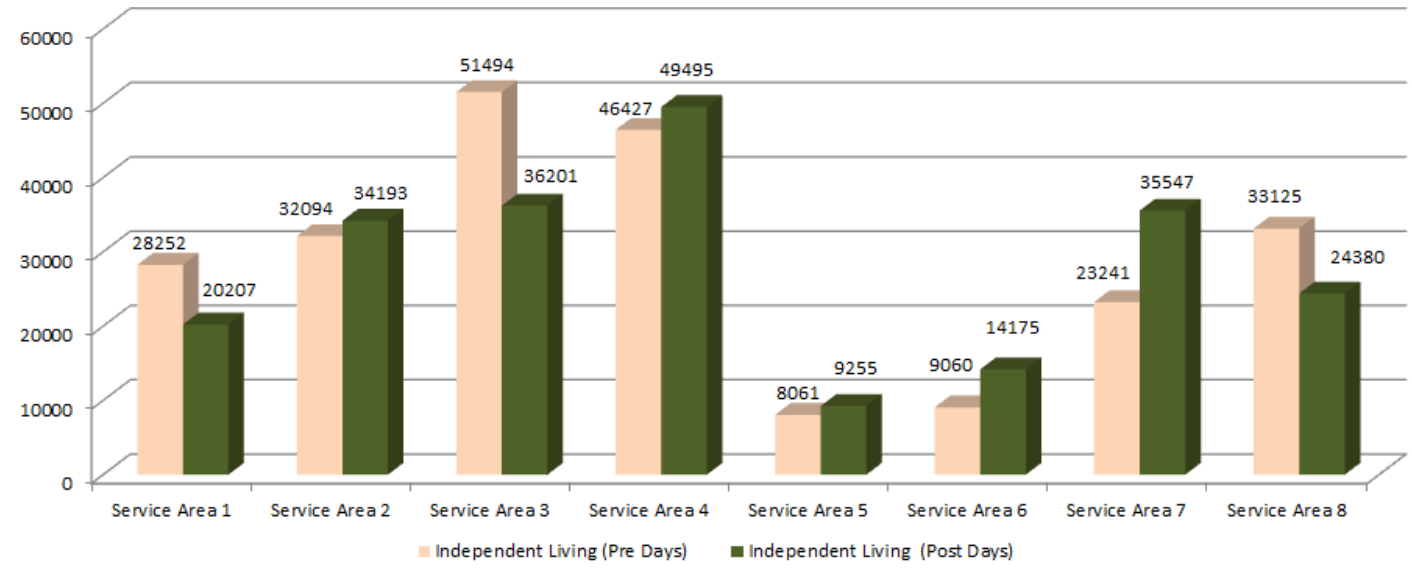


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT INDEPENDENT LIVING

- Service Area 3 has the highest number of clients living independently post partnership, 173
- Service Area 6 has the most percent increase in days (56%)and clients (25%) living independently

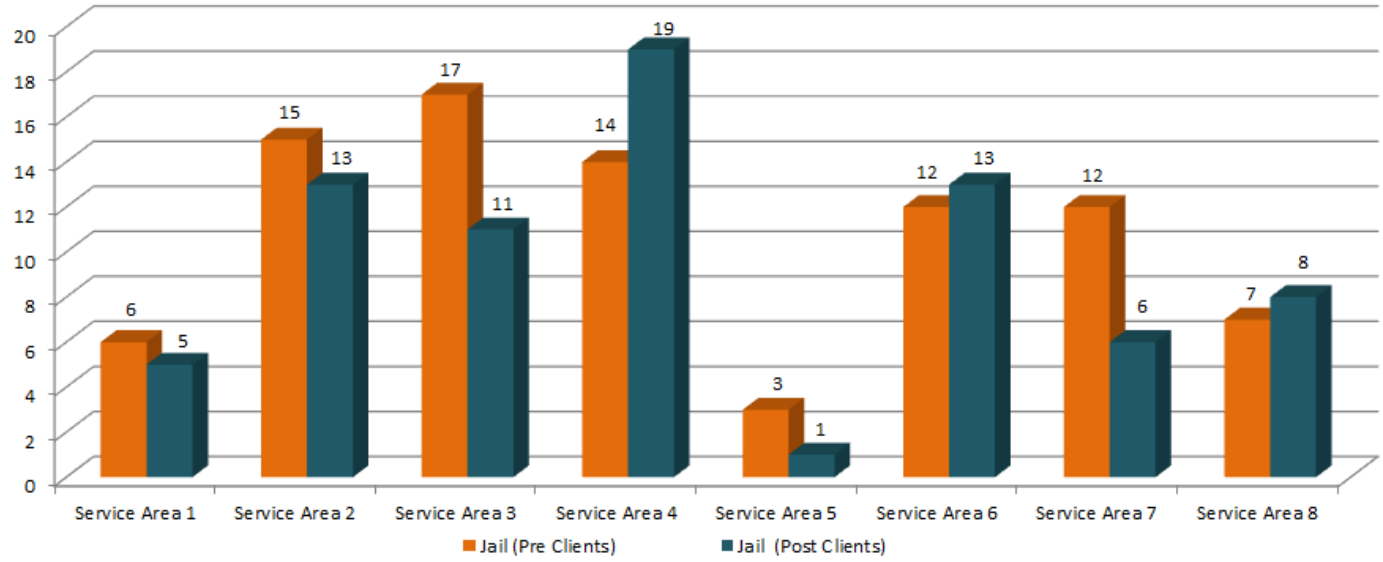


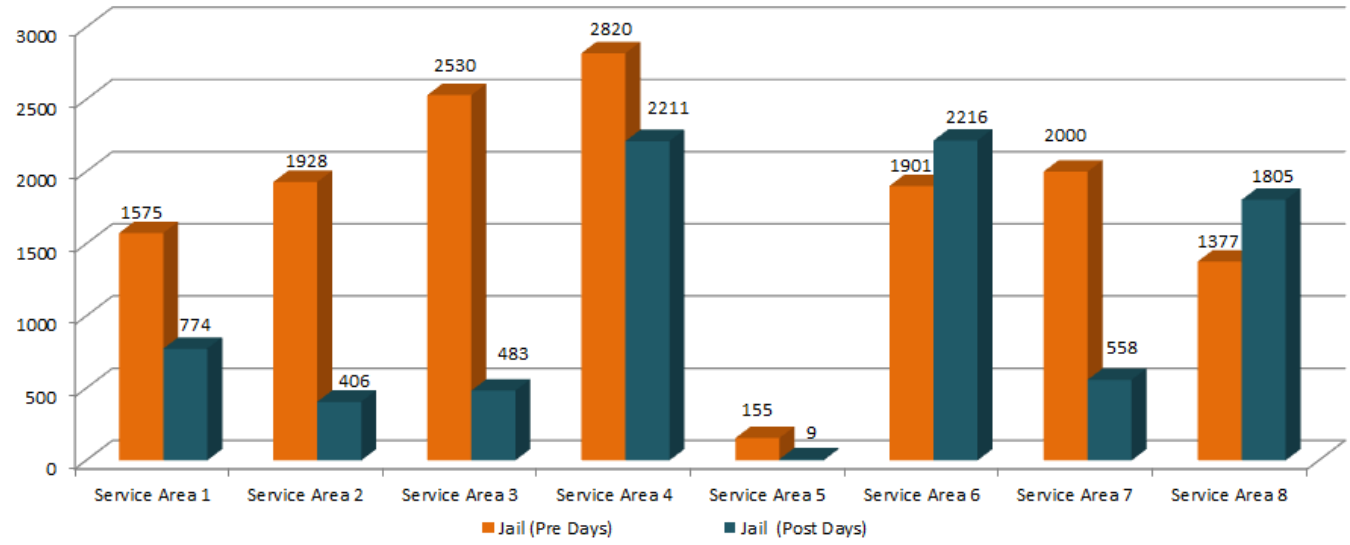


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT JAIL

◊ Service Area 5 has the highest percent (67%) reduction of clients in jail post-partnership
◊ Service Area 5has the highest percent (94%) reduction of days spent in jail post-partnership

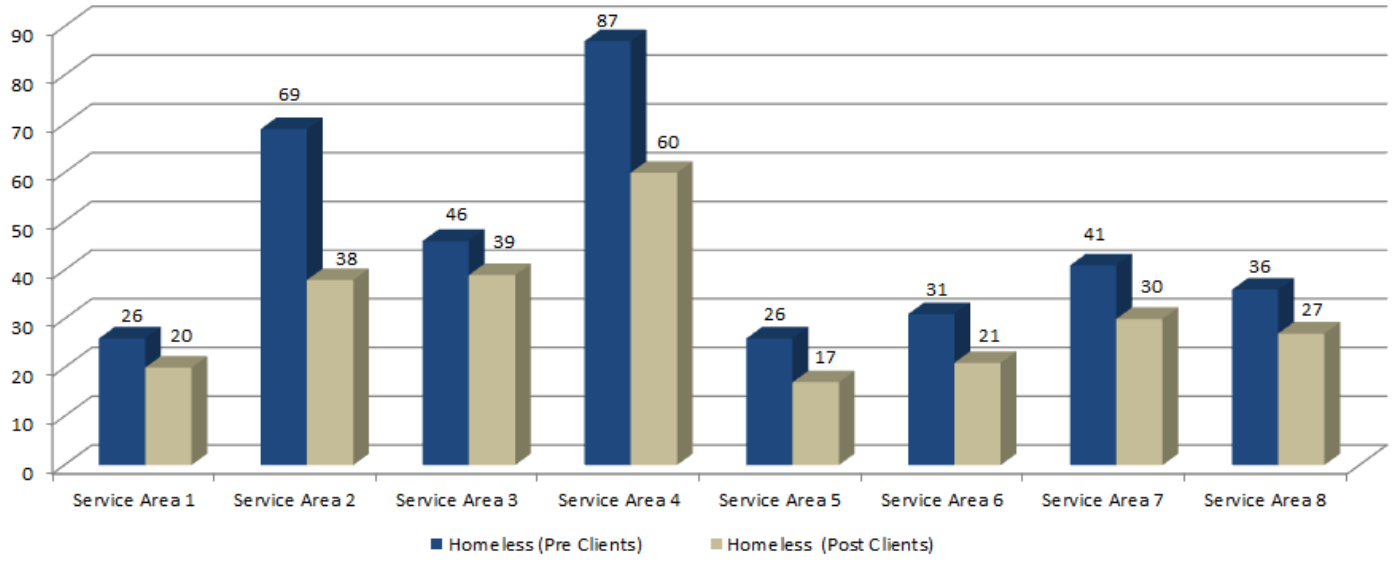


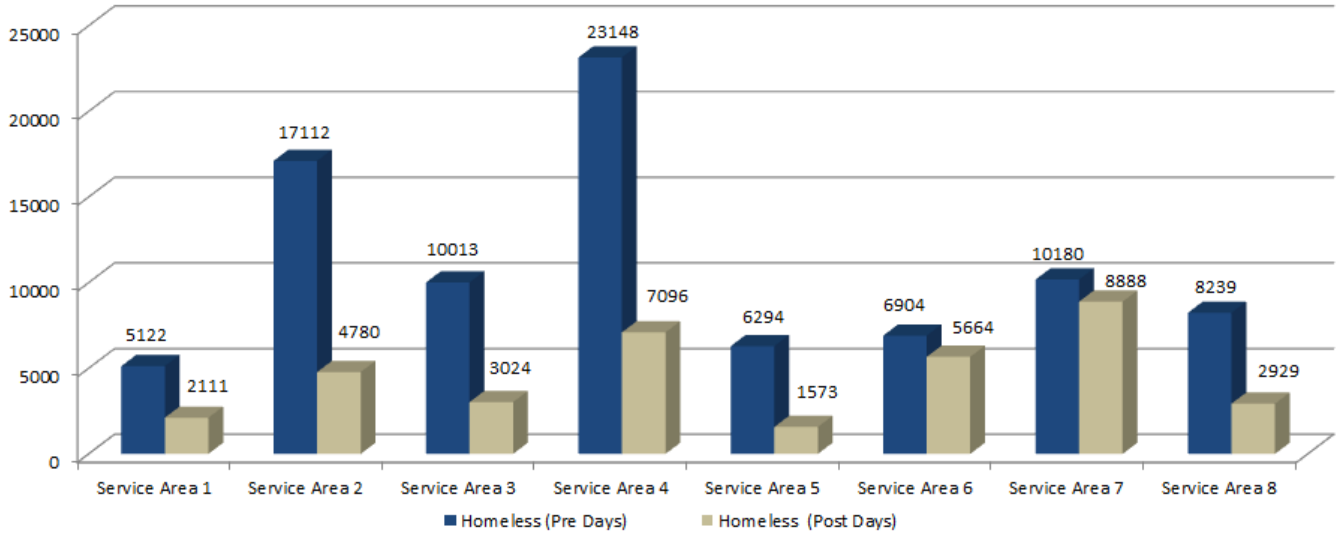


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT HOMELESS

- ◊ Service Area 2 has the highest percent (45%) reduction in clients homeless post-partnership
- ◊ Service Area 5 has the highest percent (75%) reduction in days homeless post-partnership
- ◊ Service Area 4 has the most clients homeless pre-partnership (87) and post-partnership (60) with a 31% percent reduction
- ◊ Service Area 4 has the most days spent homeless pre-partnership (23,148) with a 69% percent reduction

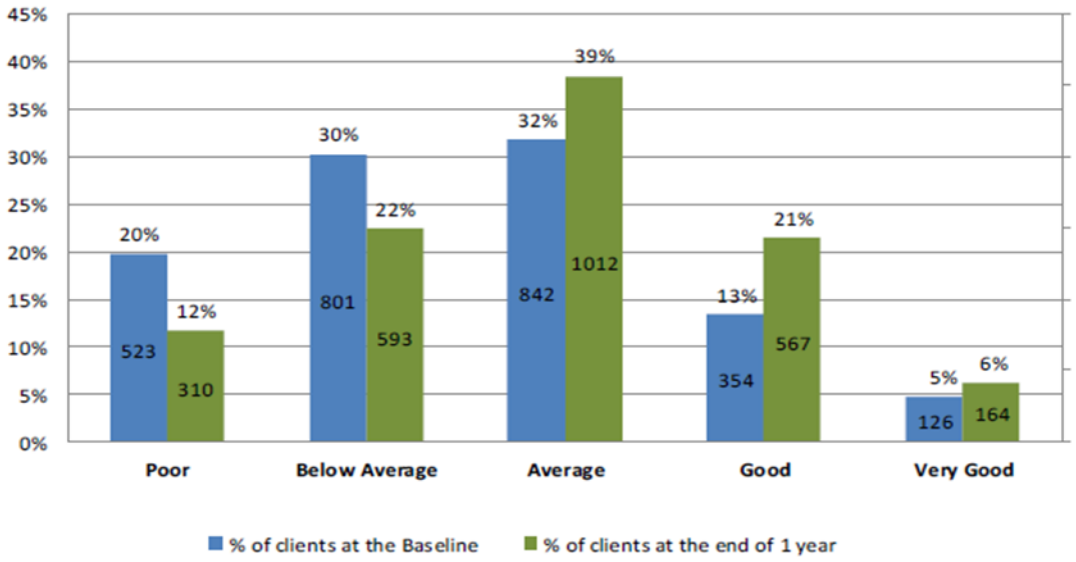




EDUCATION OUTCOMES

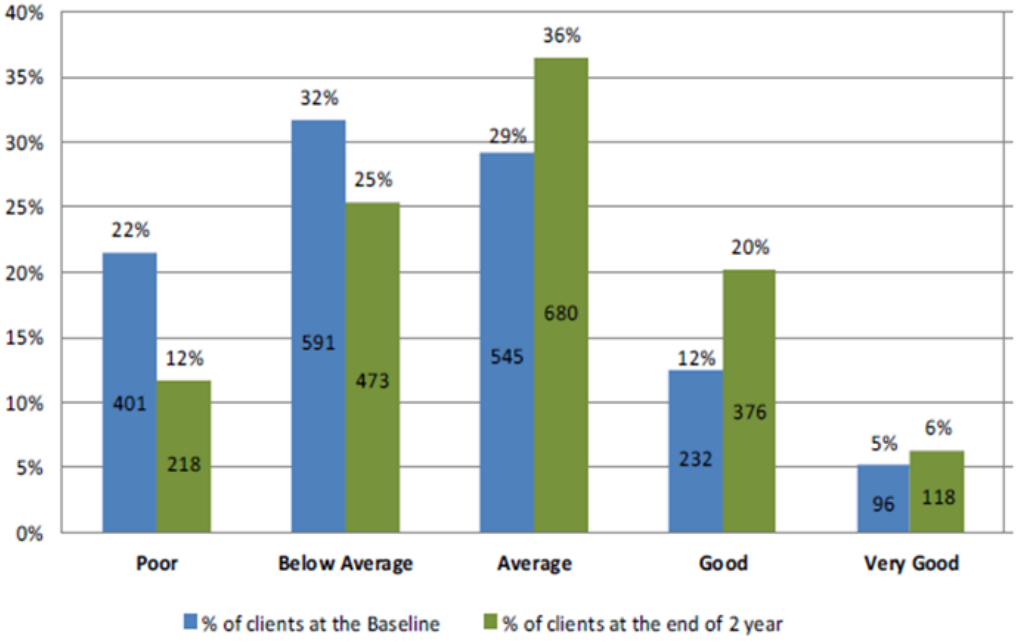
The following information is taken from the Child FSP Outcomes Report - One Year Data, September 2017

Child FSP Distribution of Grades at the Baseline and at the End of the 1st Year (n=2,646)



Each grade category is shown to be moving in the correct direction (e.g. Poor grades are less frequent while average, good and very good grades appear more often)

Child FSP Distribution of Grades at the Baseline and through the End of 2nd Year (n=1,865)



- All grade categories are shown to continue to be moving in the hoped-for direction (e.g. Poor and below average grades are less frequent while average, good and very good grades appear more often).
- Poor grade performance is down over 45% compared to baseline.
- Average grades are up by over 24% compared to 22% during the 1st year in partnership.
- Good grade performance is up over 67% compared to 62% improvement in the first year of partnership

RECOVERY, RESILIENCE AND REINTEGRATION

FIELD CAPABLE CLINICAL SERVICES (FCCS) : CHIILDREN (C-05), TAY, (T-05), ADULT (A-06), OLDER ADULT (OA-3)

UNIQUE CLIENTS SERVED	AVERAGE COST PER CLIENT
Children - 24,868	Children - $6,324
TAY - 8,117	TAY - $5,436
Adult - 8,690	Adult - $4,671
Older Adult - 3,275	Older Adult - $5,826

OUTCOMES

After 12 months of Children FCCS services (N=5,918), clients showed a positive change in the following areas:

- 13% increase with their involvement in the community
- 8% increase in their participation in meaningful activities

For those terminating between 6 and 12 months (N=13,320), Children FCCS clients showed a positive change in the following areas:

- 13% increase with their involvement in the community
- 8% increase in their participation in meaningful activities

After 6 months of IFCCS services (N=89), clients showed a positive change in the following areas:

- 63% increase with their involvement in the community
- 44% increase in their participation in meaningful activities

For those terminating between 0 and 6 months (N=146), IFCCS clients showed a positive change in the following areas:

- 13% increase with their involvement in the community
- 23% increase in their participation in meaningful activities

After 18 months of TAY FCCS services (N=680), clients showed a positive change in the following areas:

- 19% increase with their involvement in the community
- 12% increase in their participation in meaningful activities

For those terminating between 12 and 18 months (N=942), TAY FCCS clients showed a positive change in the following areas:

- 20% increase with their involvement in the community
- 11% increase in their participation in meaningful activities

Data as of 10/10/2017. Client's data is excluded when it does not meet reporting requirements.

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.

Intensive Field Capable Clinical Services (IFCCS) was 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. It has been in operation in Los Angeles County since June 1, 2013. 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 to minimize psychiatric hospitalizations, out-of-home placements, and/or placement in juvenile detention centers. The IFCCS team is tasked with identifying resources and providing linkage to help meet those needs. For example, IFCCS providers have collaborated with the Federal Bureau of Investigations (FBI) and the specialized DCFS CSEC units to engage CSEC youth, deliver support, and identify resources. Through the implementation of IFCCS, the Child Welfare Division (CWD) has identified a significant shift associated with crisis intervention and stabilization indicating that the child and family team approach has a positive influence on developing pro-active plans on working with children.

Transition Age Youth 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.

FCCS CONTINUED

OUTCOMES

After 18 months of Adult FCCS services (N=6,100), clients showed a positive change in the following areas:

- 15% increase with their involvement in the community
- 12% increase in their participation in meaningful activities

For those terminating between 12 and 18 months (N=2,406), Adult FCCS clients showed a positive change in the following areas:

- 21% increase with their involvement in the community
- 17% increase in their participation in meaningful activities

After 18 months of Older Adult FCCS services (N=2,117), clients showed a positive change in the following areas:

- 26% increase with their involvement in the community
- 23% increase in their participation in meaningful activities

For those terminating between 12 and 18 months (N=733), Older Adult FCCS clients showed a positive change in the following areas:

- 32% increase with their involvement in the community
- 18% increase in their participation in meaningful activities

Data as of 10/10/2017. Client's data is excluded when it does not meet reporting requirements.

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.

FCCS offers an alternative to traditional mental health services for older adults who may be unable to access services due to impaired mobility, frailty or other limitations. For individuals who may be uncomfortable seeking services in a traditional clinic, FCCS may be a welcome alternative.

FCCS are specialized services designed to meet the unique needs of older adults, ages 60 and above, as well as some transitional age older adults, age 55 and above.

Services and support are provided in home and in the community in settings such as senior centers or health care provider offices. Currently there are 29 agencies, both directly-operated and contracted, who provide OA FCCS and are monitored by our team. Services provided include outreach and engagement, bio-psychosocial assessment, individual and family treatment, medication support, linkage and case management support, and treatment for co-occurring disorders. FCCS will directly respond to and address the needs of unserved/ underserved older adults by providing screening, assessment, linkage, medication support, and gero-psychiatric consultation.

RECOVERY, RESILIENCE AND REINTEGRATION

WELLNESS/CLIENT RUN CENTER (A-02)

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.

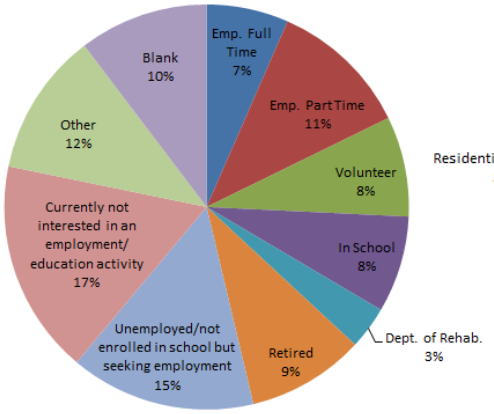
UNIQUE CLIENTS SERVED
60,785

NUMBER OF CLIENT CONTACTS
71,504
(Services provided at Peer Run Centers)

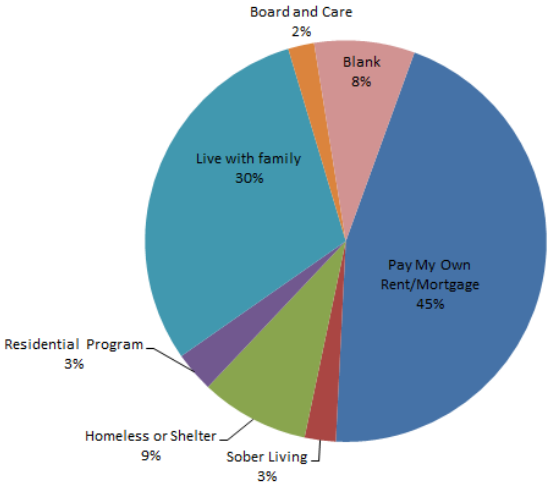
According to a sample survey from 51providers and 2,993 clients, Wellness/Client Run Centers' consumers reported improvement in their daily and experienced the following:

- 74% usually or sometimes did well in work/ school/ preferred activities.
- 85% usually or sometime made progress in wellness/ recovery goals.
- 19% worked part or full time
- 68% usually or sometime able to manage symptoms.
- 87% usually or sometime felt welcomed and respected by staff.
- 44% involved in meaningful activities.
- 72% usually or sometime have opportunities to join social, spiritual, and/ or recreational activities in their life.
- 87% usually or sometime satisfied with their role in making decisions about their care.
- 75% reported living in their own place (house, apartment, etc.), living with family, or living with roommates.

Employment/Education Status



Living Arrangement



PRRCH LOCATIONS

Hacienda of Hope in Long Beach

SHARE! In Monterey Park

Peer-Run Respite Care Homes (PRRCH) are peer-operated and member driven community based, recovery oriented, holistic alternatives to traditional mental health programs. 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.

Out of 540 clients who were served in FY 2016-17 in the 2 Peer Run Respite Houses:

- 51% participate in self-help activities regularly
- 48% had personal goals
- 15% reported completing a personal goals by the time they left the PRRCH
- 3.4% were homeless upon admission
- 38% of the homeless clients where linked to housing serves
- .01% of clients were linked to hospital services
- 79% had family involved in their mental health treatment
- 68% reported having meaningful roles in their community (ex., working, volunteering, school, etc.…)

TAY PROBATION CAMPS (T-04)

PROBATION CAMPS:

- Rockey
- Paige Afflerbaugh
- Scott-Scudder
- Gonzales
- Challenger
- Miller

CLIENT CONTACTS
1,082

Department of Mental Health (DMH) staff provides MHSA-funded services to youth in Los Angeles County Probation Camps, including youth with Severe Emotional Disturbance/Severe and Persistence Mental Illness. DMH staff and contract providers are co-located in the Probation Camps along with Probation, Juvenile Court Health Services (JCHS), and Los Angeles County Office of Education (LACOE). Within the Probation Camps this inter-departmental team provides coordinated care to the youth housed there.

Youth housed in the Probation Camps receive an array of mental health services, including: Assessments; Individual Group, and Family Therapy; Medication Support; Aftercare and Transition Services. These services are individually tailored to meet the youth's needs, including co-occurring disorders and trauma. Interventions include evidence-based practices such as Aggression Replacement Training (ART), Adapted Dialectical Behavior Therapy (DBT) and Seeking Safety (SS). MHSA funding has made it possible for youth to be housed in a broader array of camps and still receive psychotropic medications.

TAY DROP-IN CENTERS (T-05)

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.

CLIENT CONTACTS: 2,979

SERVICE AREA	AGENCY NAME – Drop-in Center Name	ADDRESS
1	Penny Lane Centers – Yellow Submarine	43520 Division Street Lancaster, CA 93535
2	The Village Family Services -TVFS TAY Drop-In Center	6801 Coldwater Canyon Blvd. North Hollywood, CA 91606
3	Pacific Clinics – Hope Drop-In Center	13001 Ramona Blvd. Irwindale, CA 91706
4	Los Angeles LGBT Center – Youth Center On Highland	1220 N. Highland Ave. Los Angeles, CA 90038
5	Daniel's Place - Step-Up on Second Street, Inc.	1619 Santa Monica Blvd Santa Monica, CA 90405
6	Good Seed Church of God in Christ, Inc.- Good Seed Youth Drop-in Center	2814 W. Martin Luther King Jr. Blvd. Los Angeles, CA 90008
7	Penny Lane Centers – With A Little Help From My Friends	5628 East Slauson Ave. Commerce, CA 90040
8	Good Seed Church of God In Christ, Inc. Good Seed on Pine Youth Drop-In Center	1204 Pine Avenue Long Beach, CA 90813

INTEGRATED CARE PROGRAM (A-07)

Integrated Care Programs (ICP) are designed to integrate mental health, physical health, substance abuse, and other needed care such as nontraditional services to more fully address the spectrum of needs of individuals. The ICP service array will support the recovery of individuals with particular attention to those who are homeless, uninsured, and/or members of UREP. ICPs promote collaboration and partnerships by and between service providers and community-based organizations utilizing an array of services that may include traditional and non-traditional services.

The target population for the ICP is individuals with Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED) that meet the Medi-Cal medical necessity criteria for receiving specialty mental health services, including those with co-occurring substance abuse and/or physical health issues, who are economically disadvantaged or uninsured, and/or members of a UREP.

TRANSFORMATION DESIGN TEAM (OA-2)

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.

The Older Adult Systems of Care Bureau (OASOC) Transformation team is comprised of two health program analysts. The goal of the team is to ensure that our OA consumers receive appropriate and timely mental health services from our provider agencies, and they do this by providing data and analytic support to the Program Manager and the Client Supportive Services (CSS) team as they complete their regular site visits. Additionally, the Transformation Team reviews all aspects related to contracts, compliance, service delivery, operations, and budgets, and generates detailed reports to evaluate programmatic design and effectiveness.

SERVICE EXTENDERS (OA-04)

Service Extenders are volunteers and part of the Older Adult FCCS inter-disciplinary team. They are consumers in recovery, family members, or other individuals interested in working with Older Adults. They receive specialized training to serve as members of the team and are paid a small stipend. Service extenders receive supervision from professional clinical staff within the program in which they are placed.

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.

Training	Description
Older Adult Consultation Medical Doctor's (OACT-MD) Series	OA Systems of Care conducted OACT-MD Series for training and consultation for psychiatrists, nurse practitioners, nurses & mental health clinicians to improve the accessibility and quality of mental health services for Older Adults.
Community Diversion & Re-Entry Program for Seniors (CDRP): Training & Consultation Series.	OA Systems of Care conducted training and consultation series, as part of the Older Adult Training & Consultation Team, offered to mental health staff with professional expertise in geriatric medicine, gero-psychiatry, case management/community resources, substance use, and other resources. The training & consultation was designed to upgrade the training knowledge base and skills of all mental health staff through case presentation and consultation.
Older Adult Legal Issues/Elder Law Trainings and Consultation	OASOC as part of ongoing multi-disciplinary Older Adult Consultation team trainings, provided training and Elder Law consultation, curriculum training development and coordination on Elder Law for DMH and DMH-contracted clinical and non-clinical staff on best practices for working with Older Adult populations.
Public Speaking Club Graduate Curriculum	OASOC held Speaker Club graduate programs for consumers who successfully completed Public Speaking curriculum to enhance and practice on their public speaking skills. These took place on the 3rd Friday of every month throughout the fiscal year.
Speaker Club Workshop Training Curriculum	This 7 week training session course provided peers with tools and skills to educate the community and advocate for hope, wellness and recovery.
The Use of Cognitive Screening Measures: The Mini Mental Status Exam (MMSE)	The purpose of this training is to provide an overview of cognitive screening tool using The Mini Mental State Exam (MMSE). 9-12-2016

Training	Description
Conducting Grief and Loss Support Groups	This training addressed issues related to grief in older adults, and process for developing and conducting grief and loss support groups. 12-6-2016
16th Annual Gero-Psychiatric Breakfast	L.A. County Department of Mental Health in collaboration with L.A. Care, and Health Net, provided the 16th Annual Gero-psychiatry Breakfast a free continuing medical education activity for primary care physicians and psychiatrists, focusing on adult behavioral health. 12-15-2017
The Use of Cognitive Screening Measures: The Montreal Cognitive	The purpose of this training is to provide an overview of The Montreal Cognitive Assessment (MoCA) a cognitive screening tool. 12-21-2016
Medical/Legal Aspects of Older Adults: Capacity, Undue Influence and Abuse	This 4 night training series was facilitated and taught by our geriatrician as well as attorneys to inform and educate on the needs of older adults with mental illness particularly around issues of conservatorship and other legal concerns. January 4-January 7, 2017
Advanced Grief and Loss	This 4 night training series was facilitated and taught by our geriatrician as well as attorneys to inform and educate on the needs of older adults with mental illness particularly around issues of conservatorship and other legal concerns. January 4-January 7, 2017
Advanced Grief and Loss	The training focused on ways to effectively work with older adults facing complicated grief and loss. 1-24-2017
Medical Social Emotional Arts Program	The Medical Social Emotional Arts (MedSEA) Program training, integrates mental health practices with the innate social emotional benefits of art, movement, music, and writing. 4-20-2017
Post Trauma: Moving Forward	The goal of this training was to provide participants with an in-depth review of the impacts of trauma from a cultural, societal, and familial perspective. 5-10-2017
Community Re-entry Part: Assessment & Treatment	The training identified mental health conditions for those exiting criminal justice systems. 6-22-2017

ALTERNATIVE CRISIS SERVICES

ALTERNATIVE CRISIS SERVICES (ACS-01)

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 serves individuals 18 years of age and older of all genders, race/ethnicities, and languages spoken.

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.

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.

CLIENT CONTACTS
66,663

The following is a status on the development of four (4)Urgent Care Centers: The development was recommended by System Leadership Team (SLT) to the Department and to the Mental Health Commission proposed through the MHSA Three Year Program and Expenditure Plan Fiscal Years 2014-15 through 2016-17. The Board letter to execute the service contracts for the UCCs was adopted on December 6, 2016. The UCCs will be located in the following areas:

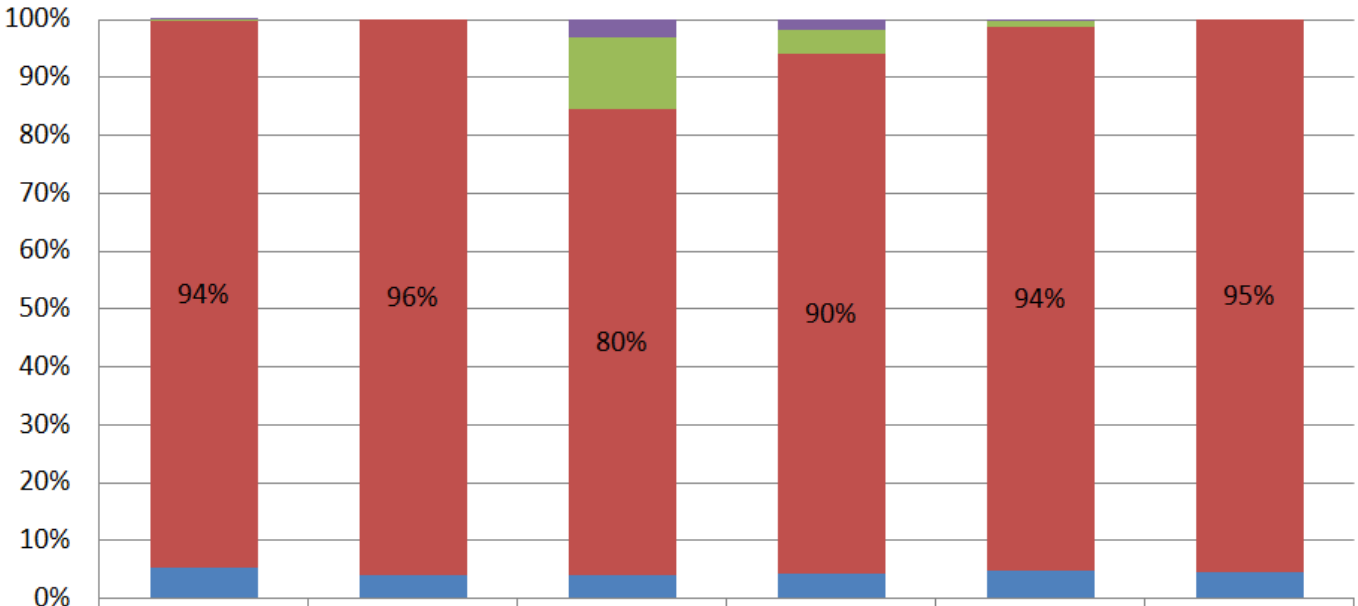
- Antelope Valley: Stars Behavioral Health Group (Stars) has been awarded a service contract to operate a UCC in the Antelope Valley. DMH and Stars are currently working collaboratively with the Supervisorial District to find an appropriate site to house the UCC.
- San Gabriel UCC: Stars was awarded a service contract to operate a UCC in the City of Industry and has obtained a Conditional Use Permit for their site. The UCC is projected to be operational in June of 2018.
- Long Beach UCC: Stars was awarded a service contract to operate a UCC in Long Beach. The provider has been working with the City of Long Beach Planning Department and has obtained a Conditional Use Permit for their site. The UCC is projected to be operational in May or June of 2018.
- Harbor-UCLA Medical Center UCC: Exodus Recovery, Inc. is developing an UCC on the campus of Harbor-UCLA Medical Center in Torrance in close proximity to the Psychiatric Emergency Services (PES) to provide PES decompression and increased capacity for community-based crisis care. The UCC is projected to be operational in April or May of 2018.

ALTERNATIVE CRISIS SERVICES

The following is a status on the development of 23 new Crisis Residential Treatment Programs (CRTP) that will increase capacity by 364 beds Countywide: The development was recommended by System Leadership Team (SLT) to the Department and to the Mental Health Commission proposed through the MHSA Three Year Program and Expenditure Plan Fiscal Years 2014-15 through 2016-17.

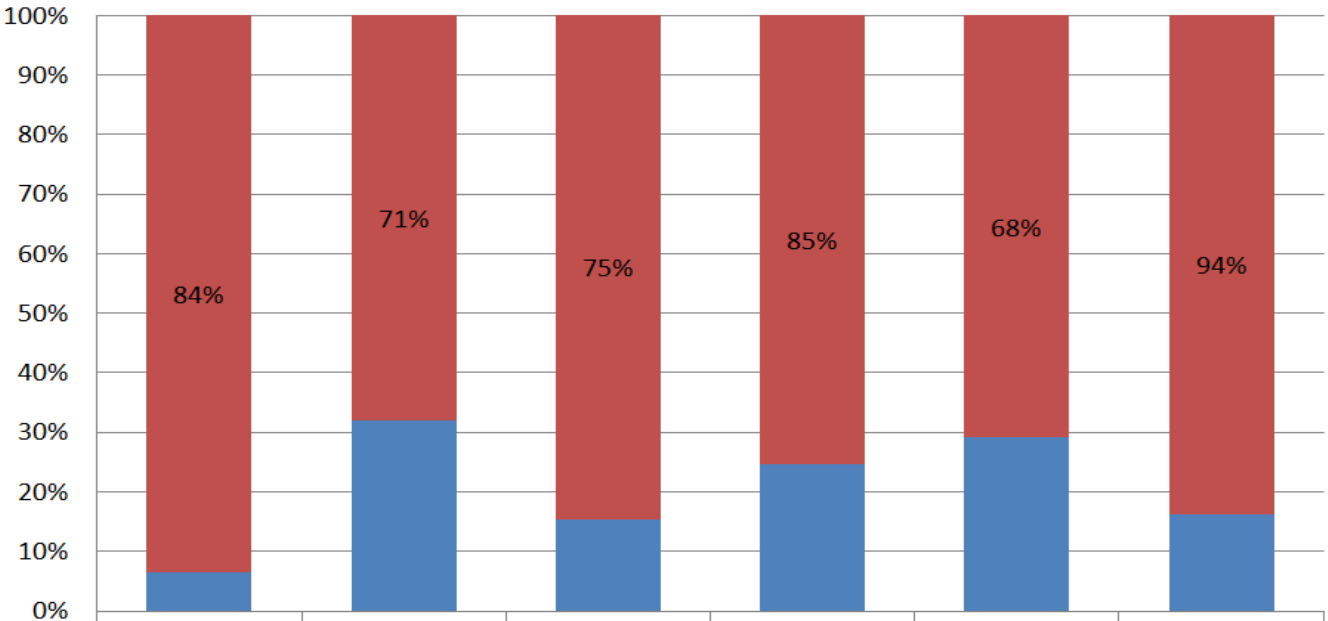
- DMH is currently working with eight (8) service providers selected through a competitive solicitation to establish CRTPs throughout the County that will be funded by the County and develop a total of 124 beds.
- DMH intends to develop fifteen (15) unique CRTPs for a total of 240 beds in close proximity to five County-operated hospitals: LAC+USC Medical Center, Olive View-UCLA Medical Center, Rancho Los Amigos National Rehabilitation Center, Martin Luther King (MLK) Jr. Medical Campus, and High Desert Regional Health Center. The CRTPs are a critical component of the Intentional Communities the Health Agency is building that will support behavioral health initiatives.

NEW ADMISSIONS AT URGENT CARE CENTERS (UCCS) BY AGE CATEGORY



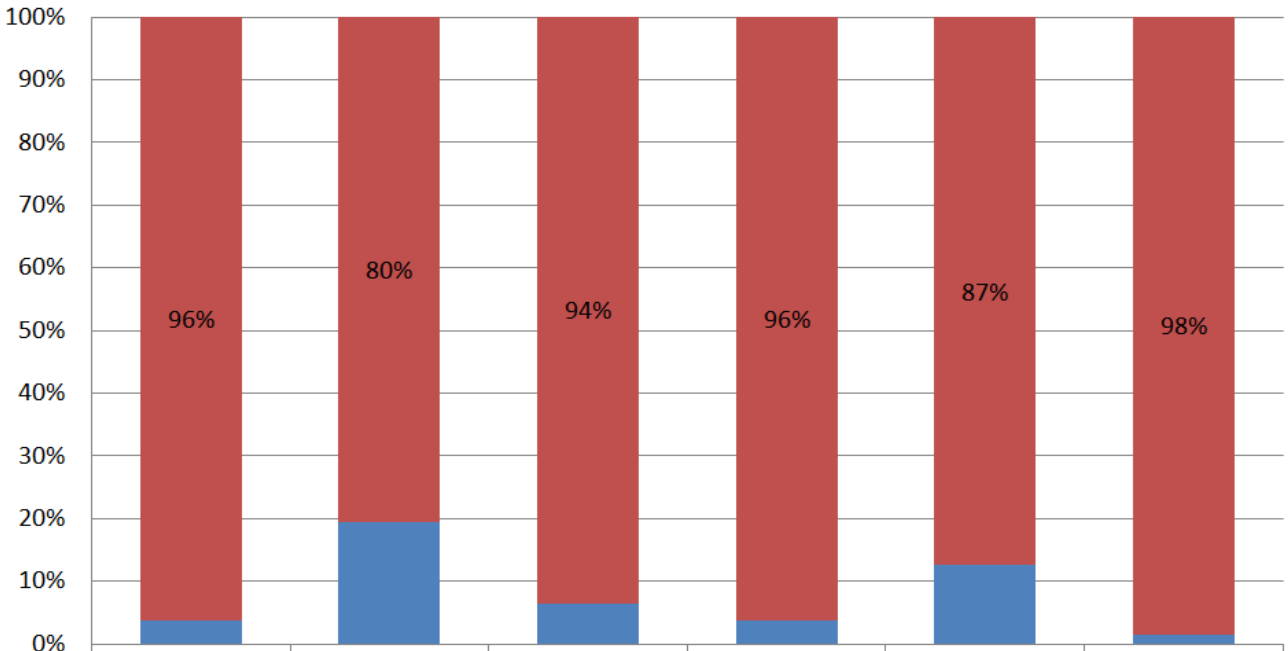
	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
Child	1	0	334	249	9	0
TAY	15	0	1404	583	45	0
Adult	4974	1680	9029	12730	4420	2097
Older Adult	281	70	452	601	220	99

NEW ADMISSIONS AT UCCS WHO WERE HOMELESS UPON ADMISSION



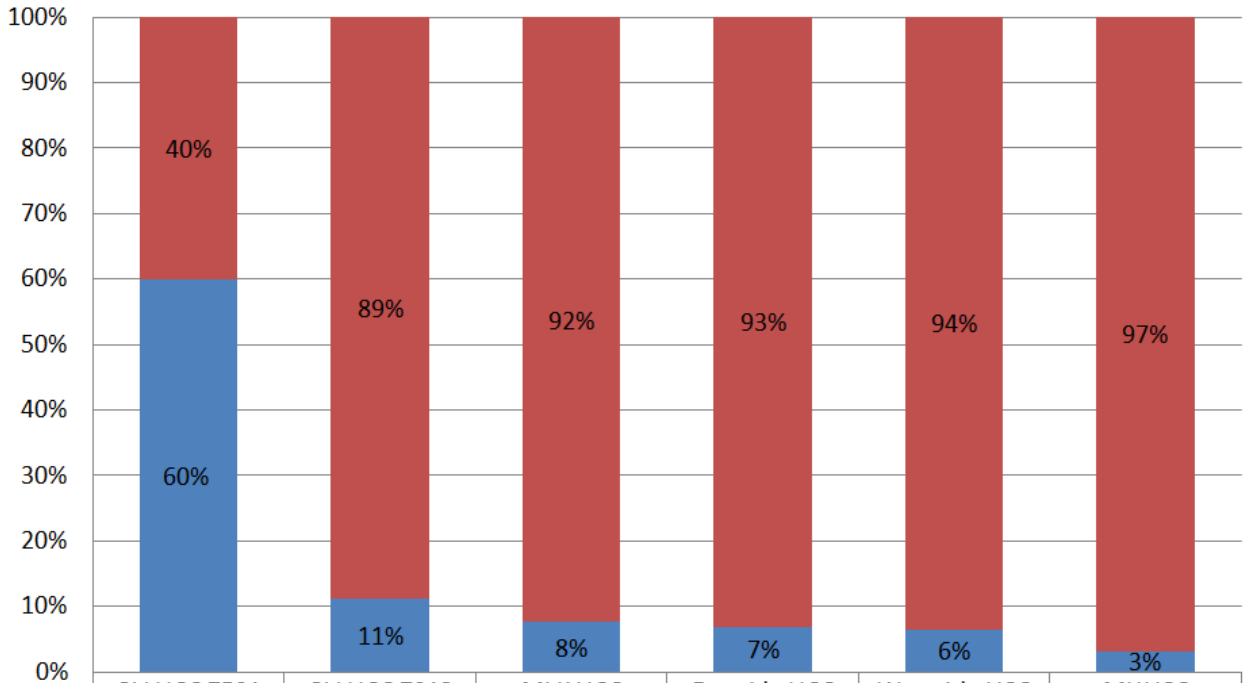
	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
No	4933	1190	9487	10679	3327	1838
Yes	338	560	1732	3484	1367	358

PERCENT OF THOSE WITH AN ASSESSMENT AT A PSYCHIATRIC EMERGENCY ROOM WITHIN 30 DAYS OF A UCC ASSESSMENT



	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
No	5072	1408	10490	13620	4105	2162
Yes	199	342	729	543	589	34

PERCENT OF THOSE WHO RETURN TO A UCC WITHIN 30 DAYS OF A UCC ASSESSMENT



	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
No	2113	1554	10367	13198	4393	2126
Yes	3158	196	852	965	301	70

ALTERNATIVE CRISIS SERVICES

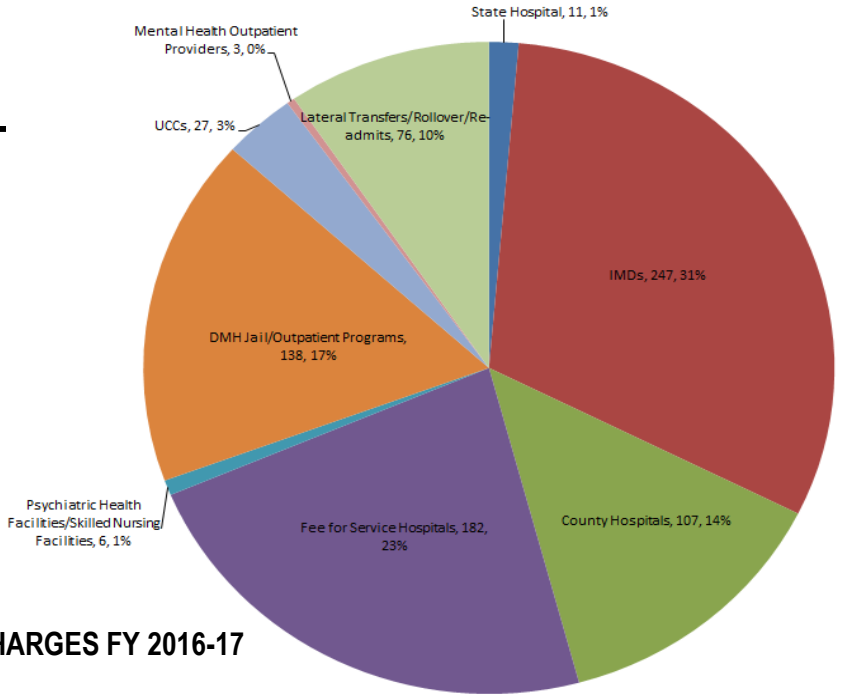
IMD STEP-DOWN FACILITIES (A-03)

ENRICHED RESIDENTIAL SERVICES

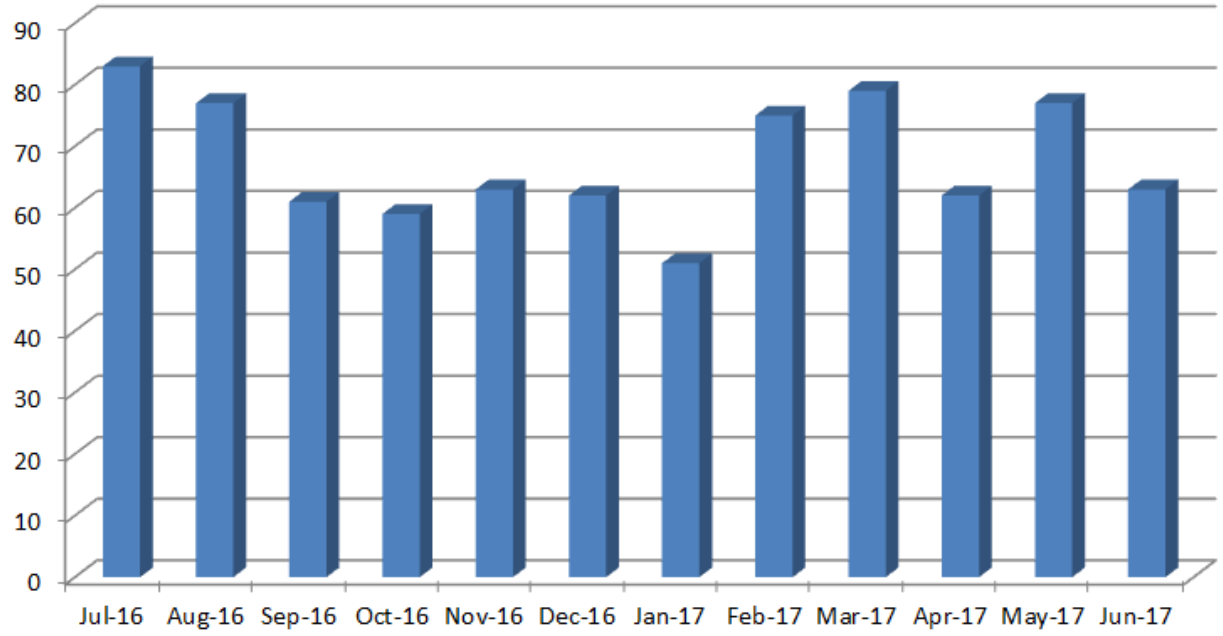
Enriched Residential Services are designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities (ARF), and in some instances, assisted living, congregate housing or other independent living situations. The program also assists clients transitioning from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

UNIQUE CLIENT COUNT: 1,036

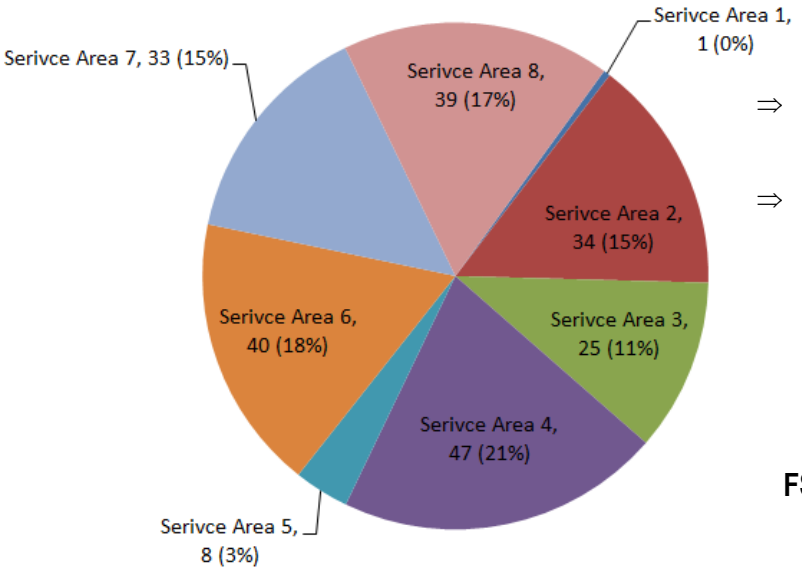
ENRICHED RESIDENTIAL SERVICES ADMISSION SOURCES FY 2016-17



ENRICHED RESIDENTIAL SERVICES DISCHARGES FY 2016-17



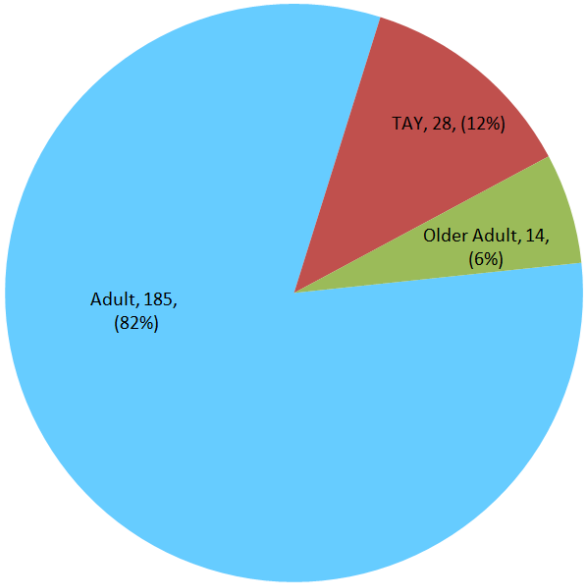
FSP REFERRALS FROM IMD STEP - DOWN SERVICES BY SERVICE AREA, FY 2016-17



⇒ Service Area 4 receives the most FSP referral from IMD Step-down services.

⇒ Service Area 1 receives the least amount of FSP referral from IMD Step-down services.

FSP REFERRALS FROM IMD STEP - DOWN SERVICES BY AGE GROUP, FY 2016-17



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 and offers housing and comprehensive integrated supportive services for chronically homeless individuals with serious mental illness and co-occurring substance abuse disorders and/or complex medical conditions.

HOUSING SERVICES

HOUSING SERVICES (A-04)

MHSA HOUSING PROGRAM

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.

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.

CLIENT CONTACTS:
7,384

1,130 MHSA units to date

192 TOTAL UNITS OPENED DURING FY 2016-17

Project Sponsor	Project Name	Service Area	Supervisorial District	Target Population	MHSA Units	Total Units	Date of Occupancy
David & Margaret Home, Inc.	Cedar Springs	3	5	TAY (16-25 ages)	10	36	07/26/16
Meta Housing Corporation	Winnetka Senior Apartments	2	3	Older Adults (60+)	15	95	07/29/16
Alternative Living for the Aging	Lancaster Shared Housing	1	5	Single Adults 18+	12	12	11/10/16
A Community of Friends	Silver Star	6	2	Single Adults 18+; Older Adults60+	8	49	06/07/17

TAY HOUSING SERVICES (T-03)

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.

UNIQUE CLIENT COUNT:
1,197

PLANNING, OUTREACH & ENGAGEMENT
POE-1

UNDERSERVED CULTURAL COMMUNITIES (UsCC)

Projects are aimed at serving unserved, underserved and inappropriately served populations with the goal of reducing racial/ethnic disparities

PROJECT: AFRICAN/AFRICAN AMERICAN (AAA) UsCC SUBCOMMITTEE

Black Male Mental Health Awareness Campaign: This project will increase mental health awareness and spread learning through community presentations in Los Angeles County. The project will outreach to Black males 16 years old and older via community presentations. It will target those who are not currently involved in the public mental health system, but would benefit from learning more about mental health.

Outcomes:

- A town hall meeting was held on November 16, 2016 and 144 community members attended.
- 18 community members were recruited at the town hall, who agreed to be trained to become mental health advocates
- Each mental health advocate facilitated 2 community presentations to promote mental health awareness and educate AAA males
- 36 community presentations were completed with outreach to 360 AAA males
- This project was completed by May 31, 2017

PROJECT: ASIAN PACIFIC ISLANDER (API) UsCC SUBCOMMITTEE

The API Family Member Mental Health Outreach, Education and Engagement Program: This project was implemented on August 17, 2015 and was completed on August 30, 2016. The purpose of this project was to increase awareness of mental illness signs and symptoms for API families so that they know when and how to connect family members to mental health services. The ethnic communities that were targeted included the following: Chinese community (Cantonese and Mandarin-speaking), Vietnamese community, Korean community, South Asian (Indian/Hindi-speaking) community, Cambodian community, and the Samoan community.

Outcomes:

- There were 12 Outreach, Education and Engagement (OEE) events (two per target population)
- 451 API family members and community members were reached, which consisted of the following API subgroups: 80 Chinese, 66 Vietnamese, 84 Korean, 84 South Asian, 57 Cambodian, and 80 Samoan.

PROJECT: EASTERN EUROPEAN/MIDDLE EASTERN (EE/ME) UsCC SUBCOMMITTEE

The Arabic-Speaking Community Mental Health Project: This project was funded to increase mental health awareness among Arabic-speaking community members in the County of Los Angeles. This project provided outreach and engagement services by partnering with faith-based and other community-based organizations to conduct mental health presentations targeting Arabic-speaking community members. This project was extremely difficult to implement due to the high level of mental health stigma in this community. As a result of this, the project was extended three times and it took 17 months to be implemented.

Outcomes:

- A total of 28 community presentations and in-home meetings were completed in a period of 17 months
- A total of 227 community members were outreached to
- Approximately 95% of the community presentations and in-home meetings took place after the San Bernardino Terrorist shooting
- There was a stronger than anticipated level of stigma and fear from the Arabic-speaking community and it required multiple attempts for individuals and organizations to agree to participate in the mental health presentations and in the in-home meetings
- It was very difficult for the presenters to build positive rapport and engage this community and as a result, presentations were cancelled and instead private meetings took place in people's homes

PROJECT: AMERICAN INDIAN/ALASKA NATIVE (AI/AN) UsCC SUBCOMMITTEE

American Indian/Alaska Native (AI/AN) National Mental Health Awareness Month Media Outreach Campaign: The media outreach campaign consisted of advertisements that aired on two local television channels (CBC and KCAL) and one radio stations (KNX1070) in order to increase awareness of mental health issues faced by the Native American community and to provide community resources. The advertisements aired throughout the month of May 2016, which was National Mental health Awareness Month. The media campaign also included a digital media campaign on the CBSLA.com website. Additionally, an interview of Mirtala Parada Ward, LCSW, Mental Health Clinical Program Head, was conducted by Tami Heidi of the CBS Radio public service broadcast show, Openline. The interview was approximately 8 minutes long and was broadcast 5 times.

Outcomes:

- The television advertisements on CBS and KCAL aired a total of **196** times
- The radio advertisements on KNX1070 aired a total of **170** times
- The CBS report shows that **89.3%** of the Los Angeles households were reached, with a total of **12,202,000** Impressions (the total number of times households were exposed to the commercials). These households saw the TV exposure with a frequency of 2.5 times
- The advertisements that ran on KNX 1070 delivered **4,649,600** Impressions and reached **1,539,900** unduplicated adults (age 18+) an average of 3 times during the campaign period
- The digital media campaign on CBSLA.com provided a total of **153,641** Impressions
- The Openline program delivered to an estimated **61,000** additional listeners

PROJECT: LATINO SUBCOMMITTEE

Latino 2016 National Mental Health Awareness Month Media Outreach Campaign: This Media Campaign promoted mental health services and increased the outreach to the Latino community. Univision Communications, Inc. was contracted to launch this Media Campaign that included TV, Radio and Digital elements. This campaign aired throughout the month of May 2016, which was National Mental health Awareness Month. In total, 99 commercials, billboards, PSAs, News integration and Digital elements (Banners, Takeovers, and Social Media) were delivered. The advertisements were aired 26 times on television (KMEX – Channel 34) and 69 on radio (KLVE-FM). Further, a twenty-five (25) minute Public Service Announcement pertaining to mental health was recorded and aired on four different local Spanish speaking radio stations. As an added value to this campaign, a 3-minute mental health information segment called, "Una Mente, Una Vida" aired during the local 11 pm Nightly News Broadcast.

Outcomes:

- The KMEX report indicated the television campaign delivered a total of 2,853,000 Impressions (the total number of times household were exposed to the commercials) from viewers ages 18 and above
- The KLVE-FM report indicated the radio campaign delivered a total of 2,636,400 Impressions from viewers ages 18 and above
- The online rotating media that included the Homepage Takeover and Social Media Post delivered a total of 60,809 Impressions from viewers 18 and above
- A gross total of 5,550,209 Impressions were delivered from viewers and listeners ages 18 and above.

PROJECT: LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUESTIONING, INTERSEX, TWO-SPIRIT (LGBTQI2-S) UsCC SUBCOMMITTEE

Youth Speak Your Mind Academy Mental Health Outreach Project: This is a two component project, which will train 50 LGBTQI2-S Youth Advocates (ages 18-25) from all eight (8) Service Areas served by LACDMH and once trained; the Advocates will conduct two community mental health presentations each. The objective of the LGBTQI2-S Youth Speak Your Mind Academy mental Health Outreach Project is to engage, empower, enlist, and enlighten the LGBTQI2-S Youth community, as well as to promote mental health services, reduce stigma, and increase outreach to this community. This project was implemented on September 15, 2016 and was completed by May 31, 2017.

Outcomes:

- 25 LGBTQI2-S Youth Advocates, aged 18-25 from all eight Service Areas were recruited, trained, and graduated from the Speak Your Mind Academy. These Advocates are facilitating community mental health presentations countywide
- A total of 50 mental health community presentations targeting LGBTQ youth were completed
- A total of 900 community members had been outreached by the end of this project

SERVICE AREA OUTREACH & ENGAGEMENT HIGHLIGHTS

Outreach and Activities As Reported by the Service Areas

Client Contacts: 43,108

SERVICE AREA 1
ANTELOPE VALLEY

- Homeless Coalition
- Antelope Valley Alcohol Preventions Coalition
- Palmdale School District Health Fair
- Penny Lane Community Resource Fair
- Coat Drive
- Tri-Valley Foster Meeting
- Back to School Event
- Emergency Preparedness Fair
- Antelope Valley College/Job Fair

SERVICE AREA 2
SAN FERNANDO VALLEY

- Homeless Connected Day
- NAMI Pathways Conference
- Best Start LA/ First Five LA
- Resources Government Fair
- LA Care Family Resources Presentation
- Our Lady of Valley Health Fair
- California Domestic Violence Summit

SERVICE AREA 3
SAN GABRIEL VALLEY

- Interfaith Summit on Homelessness
- Whole Person Care Community Engagement Event
- 48th Assembly District Community Health Fair
- MILES Conference with Law Enforcement

SERVICE AREA 4
METRO

- Angelus Plaza Senior Healthcare Fair
- Mes de la Salud Mexican Consulate Fair Event
- 43rd Annual Los Angeles Korean Festival
- Goodwill Health Fair/Training
- Kaiser Permanente's Family Violence Awareness Day

SERVICE AREA 5
WEST

- Winter Celebration: What's Going Right a celebration of young people's recent successes
- The Summer Celebration: Healing Through Music
- Homeless Summit Event
- Hope and Discovery Conference
- Domestic Violence Training
- Resource Table at Grace Lutheran Church, and Our House Grief Support

SERVICE AREA 6
SOUTH

- National Night Out LAPD
- First 5 Health Fair
- Lynwood Homeless Connect Day
- Compton PTA Health Fair
- H. Claude Hudson Comprehensive Health Center Health Fair
- The Source Community Fair

SERVICE AREA 7
EAST

- Eastman Elementary Resource Fair
- Centro Mariposa Open House
- Huntington Park Church Outreach
- Enki Resource Fair
- DCFS Belvedere Resource Fair
- Promotora Outreach
- Disability Expo Resource Fair

SERVICE AREA 8
HARBOR

- Change Direction Global Summit on Mental Health Culture Change
- Tri League of Women Voters of the Beach Cities hosted a Mental Health Forum
- Annual Interfaith Conference
- Care Enough Forums Inglewood

LINKAGE SERVICES

JAIL LINKAGE & TRANSITION (A-5) AND SERVICE AREA NAVIGATION (SN-01)

JAIL LINKAGE & TRANSITION (A-05)

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.

WOMEN'S COMMUNITY REINTEGRATION SERVICES AND EDUCATION CENTER

The Women's Community Reintegration Services and Education Center (WCRSEC) was established over nine years ago with the intent to serve women with co-occurring mental health and substance use disorders being released from the Women's Lynwood Jail. During the fiscal year in review, the program has additionally provided services to women walking in from the community-at-large or referred through other County Departments co-located in the same building as WCRSEC such as the Department of Child and Family Services (DCFS) and Department of Public Supportive Services (DPSS).

MENTAL HEALTH COURT PROGRAM

The Mental Health Court Linkage Program has two sub-programs funded by MHSA:

1) The Court Liaison Program is a problem-solving collaboration between the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County Superior Court. It is staffed by a team of mental health clinicians who are co-located at courts countywide. This recovery based program serves adults with a mental illness or co-occurring disorder who are involved with the criminal justice system. The objectives of the program are to increase coordination and collaboration between the criminal justice and mental health systems, improve access to mental health services and supports, and enhance continuity of care. The Court Liaison Program further aims to provide ongoing support to families and to educate the court and the community at large regarding the specific needs of these individuals. Participation is voluntary and available to those 18 and above. Services include on-site courthouse outreach to defendants , individual service needs assessment, informing consumers and the Court of appropriate treatment options, developing diversion, alternative sentencing, and post-release plans that take into account best fit treatment alternatives and Court stipulations, Linking consumers to treatment programs and expediting mental health referrals, advocating for the mental health needs of consumers throughout the criminal proceedings, and supporting and assisting to defendants and families in navigating the court system.
2) The Community Reintegration Program (CRP) offers an alternative to incarceration for defendants with a mental illness including those with co-occurring substance abuse. The goal of the Community Reintegration Program (CRP) and its participating providers is to reintegrate clients into the community with the skills and resources necessary to maintain stability and avoid re-arrest. The Community Reintegration Program provides admission to two specialized mental health contract facilities for judicially involved individuals with mental illness who voluntarily accept treatment in lieu of incarceration.

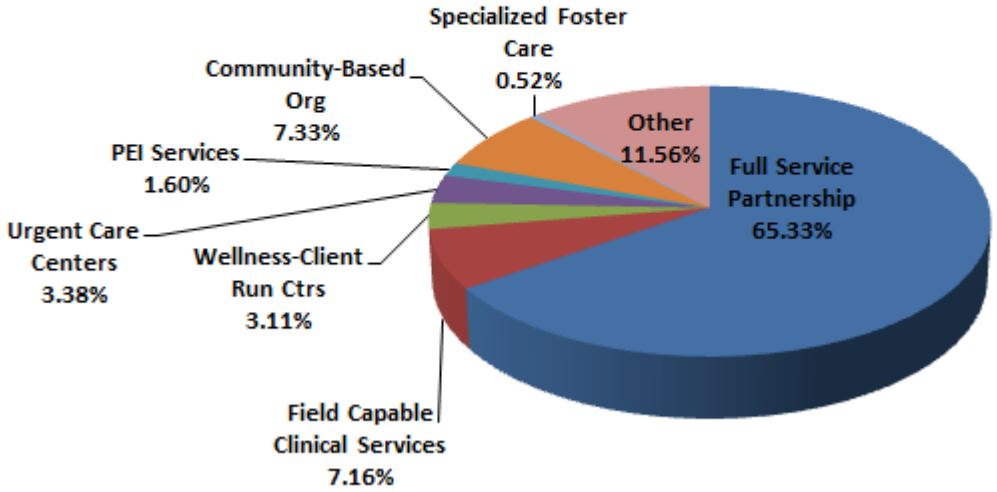
SERVICE AREA NAVIGATION (SN-01)

Client Contacts: 19,469

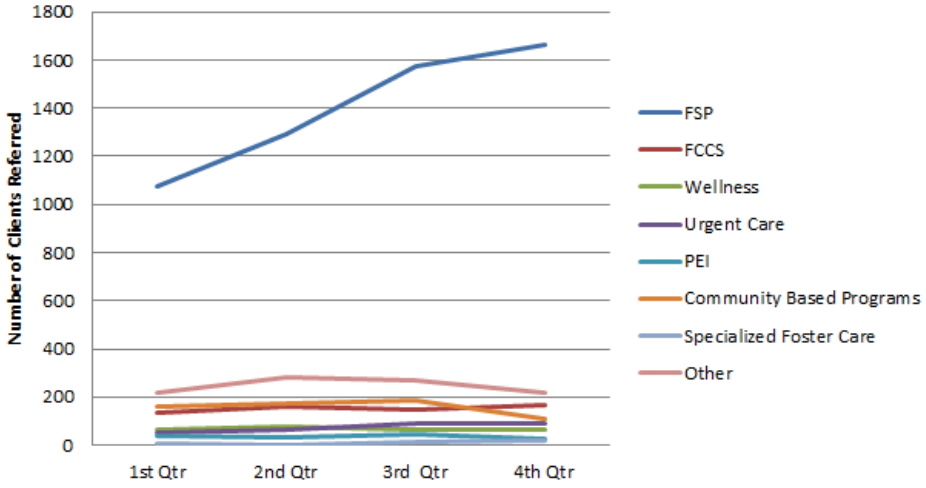
Service Area Navigator Teams assist individuals and families in accessing mental health and other supportive services and network with community-based organizations in order to strengthen the array of services available to clients of the mental health system. Such networking creates portals of entry 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, and 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.

Referrals by Program
Countywide Fiscal Year 2016-17
N=19,469

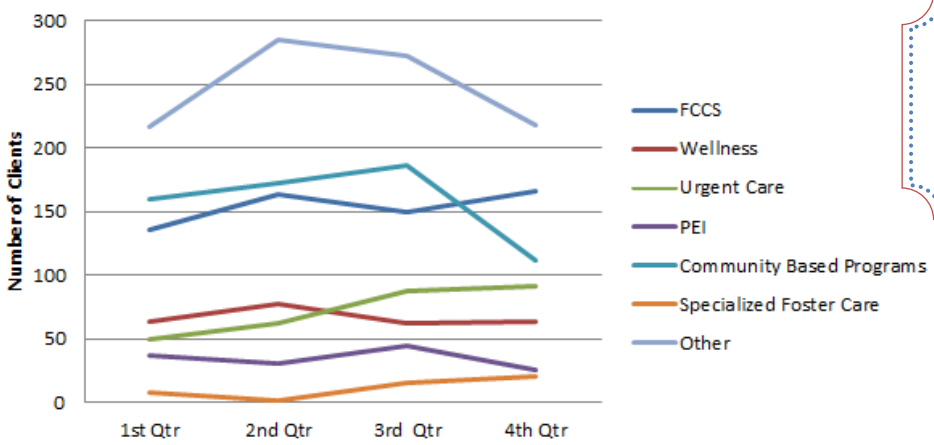


Clients Referred to Services in FY 16-17



Referrals to the Full Service Partnership program steadily increased each quarter.

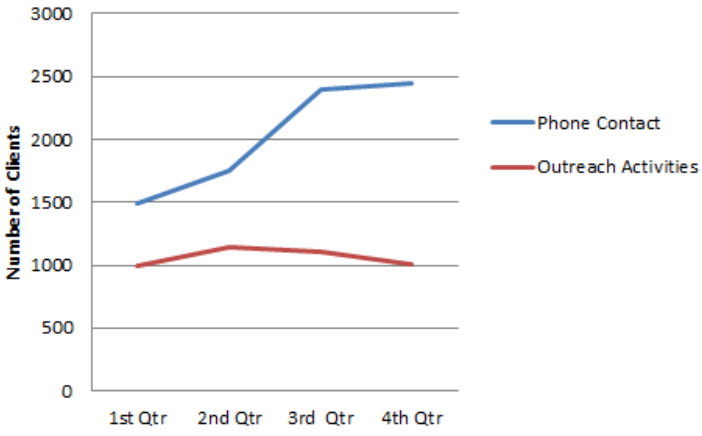
Clients Referred to Services other than FSP in FY 16-17



Referrals to the Urgent Care Centers increased each quarter.

Phone contacts increased each quarter.

Phone Contacts and Outreach Activities in FY 16-17



Prevention and Early Intervention

Prevention - Early Intervention - Stigma & Discrimination - Suicide Prevention

During Fiscal Year 2016-17, the Department further consolidated its PEI programs, mapping 13 PEI programs to the components associated with the PEI as articulated in the regulations. The following is a summary of the mapping:

- Prevention
- Stigma and Discrimination Reduction
- Early Intervention:
  - School-based services
  - Family education and support
  - At risk families
  - Trauma reduction
  - Primary care and behavioral health
  - Transition age youth early intervention
  - Juvenile justice
  - Older Adult early intervention
  - Increase access to under-served populations
- Suicide Prevention

While the PEI has historically focused extensively on early intervention services, prevention activities geared at identifying and reducing risk factors associated with trauma, depression and other behavioral indicators of childhood mental illness will be much more prominent beginning in Fiscal Year 2018-19.

These changes have been reflected in Mid-Year Adjustments to the Department's MHSA 3 Year Program and Expenditure Plan for Fiscal Years 2017-18 through 2019-20 as well as a plan embedded in this Annual Update that proposes to spend PEI funds subject to reversion on June 30, 2017 by June 30, 2020.

Prevention and Early Intervention

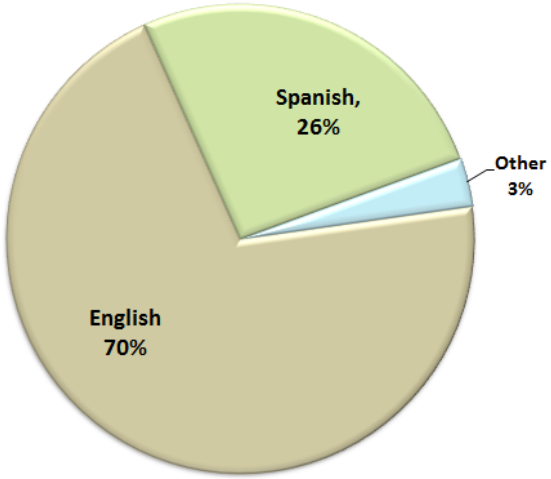
Prevention - Early Intervention - Stigma & Discrimination - Suicide Prevention

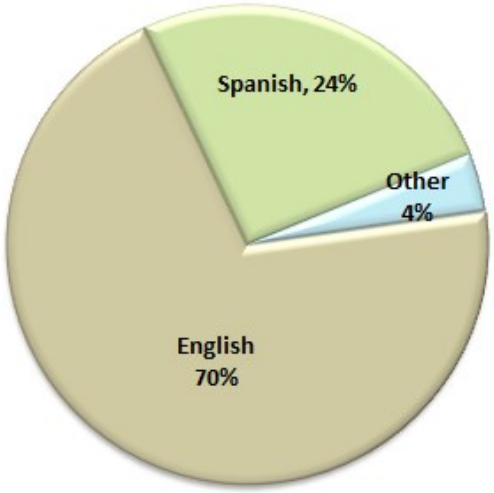
CLIENTS

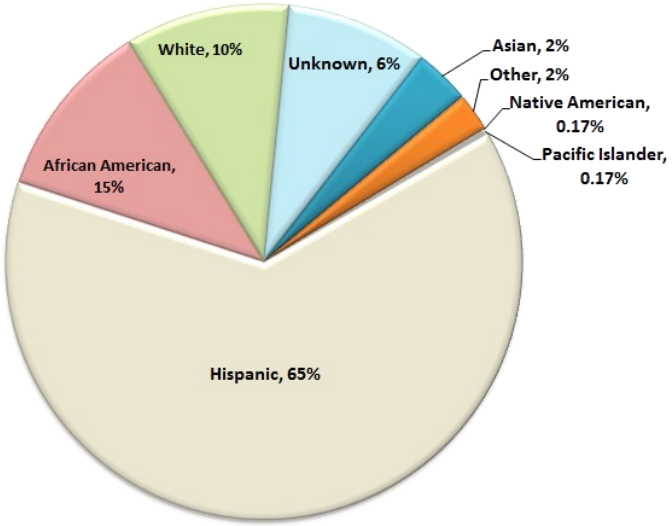
- 41,962 clients received a direct mental health service
- 69% of the clients are children
- 19% of the clients are TAY
- 10% of the clients are Adult
- 2% of the clients are Older Adult
- 63% are Hispanic
- 70% have a primary language of English

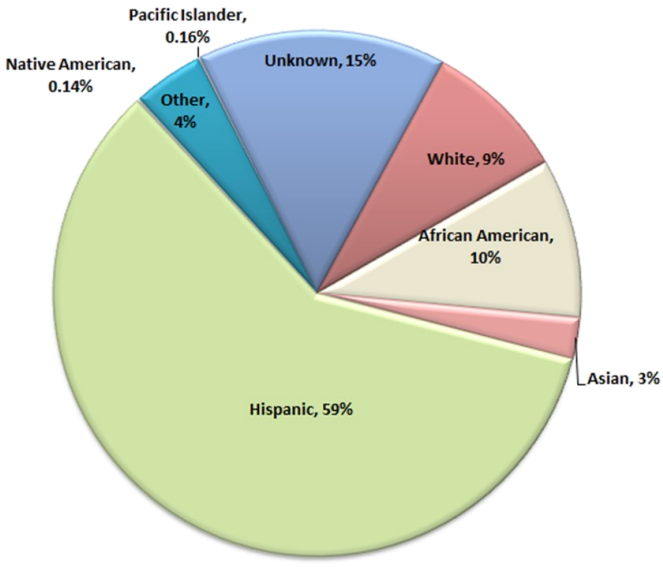
NEW CLIENTS

- 26,082 new clients receiving PEI services Countywide with no previous MHSA service
- 59% are Hispanic
- 70% have a primary language of English

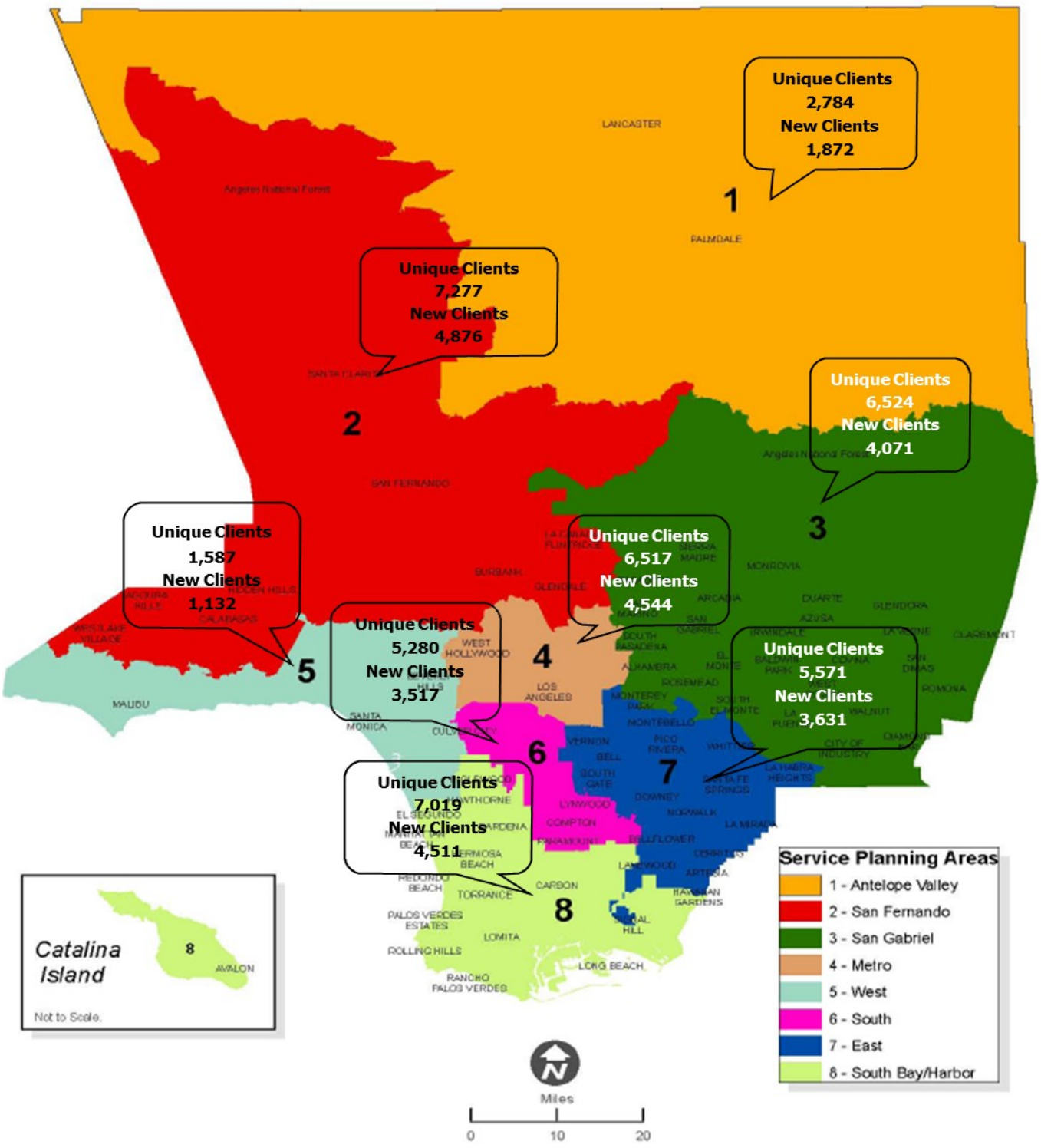




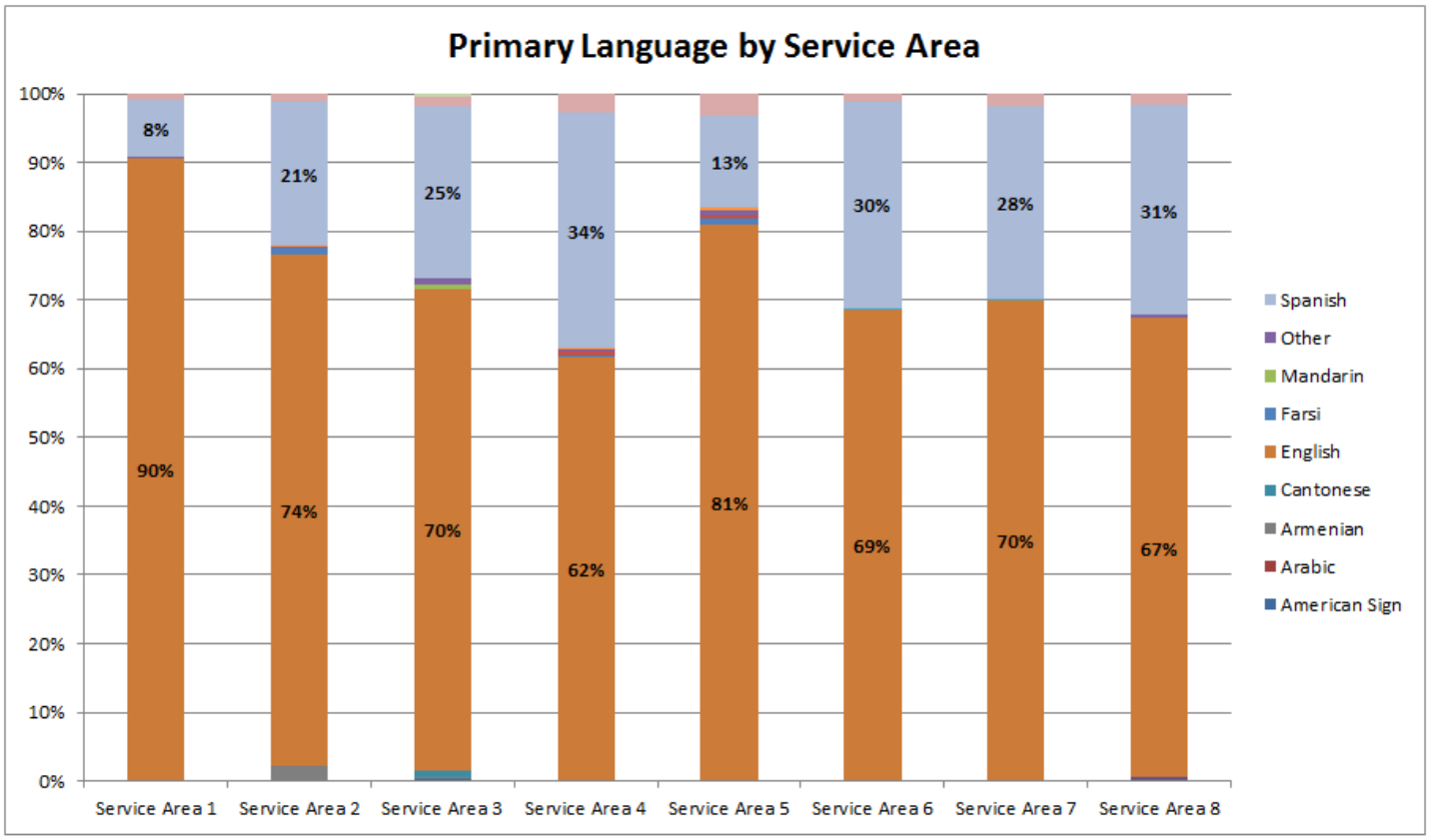


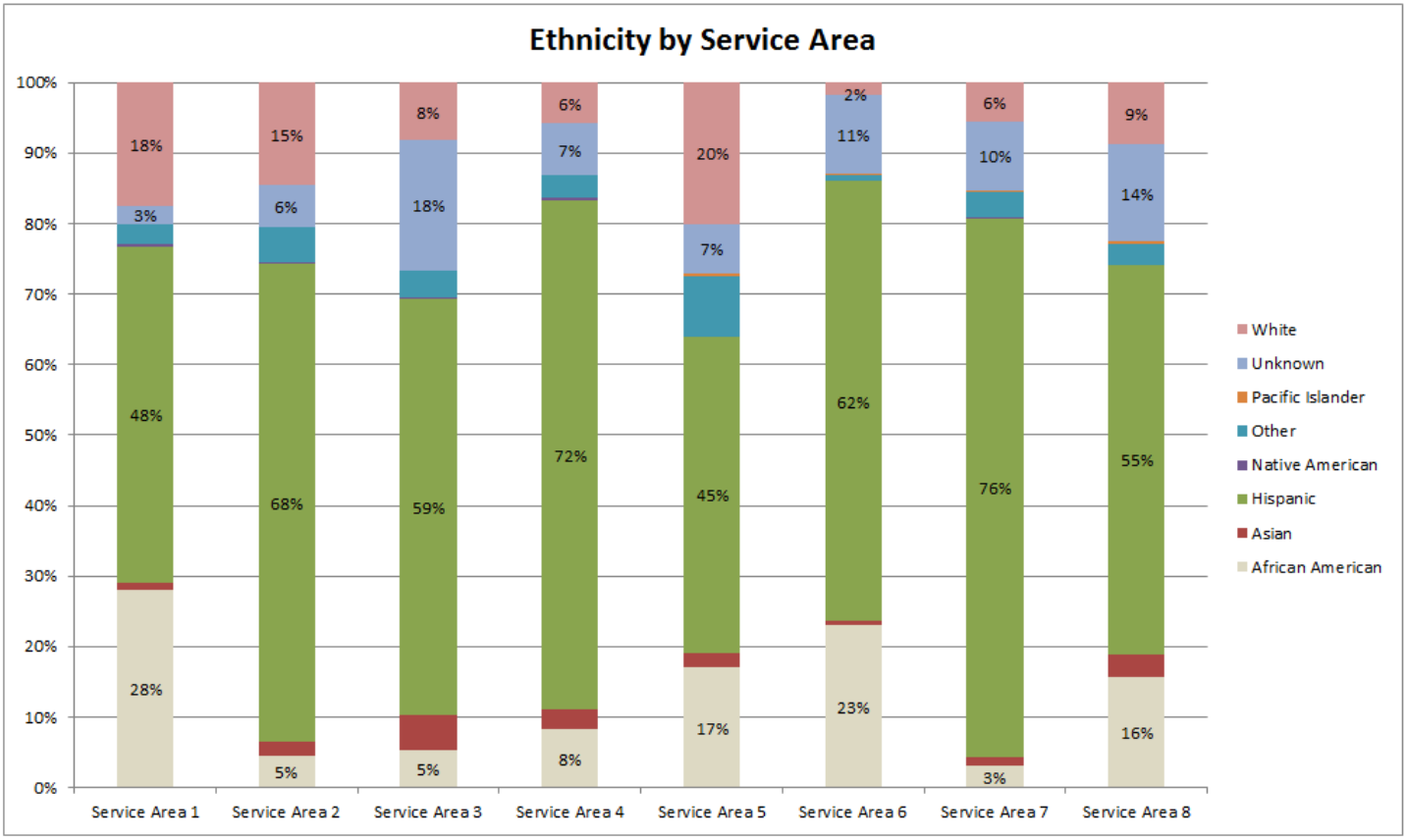


Los Angeles County Clients Served Through PEI by Service Areas Fiscal Year 2016-17



Los Angeles County Clients Served Through PEI by Service Areas Fiscal Year 2016-17



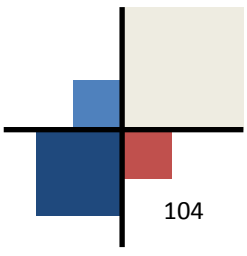


EARLY INTERVENTION

In order to submit an evidence-based, promising or community defined practice for consideration to be practiced in PEI programs, an application must be completed and submitted to the Department's PEI Evidence-Based Practice Committee, comprised of representatives of the 4 age groups, the MHSA Implementation and Outcomes Division, a children's mental health services expert consultant and chaired by the Department's Children's Medical Director and the Program Manager III overseeing PEI Administration. In addition, experts in the field familiar with peer reviewed literature are used to review applications and inform decisions.

In consultation with practice developers and local stakeholders, the Department established a general outcome measure for children and for adults and a focus of treatment, specific measure for practices that treat trauma, depression, anxiety, situational crises, parenting and family difficulties, conduct or disruptive disorders and emotion regulation. The general and focus of treatment specific measures are collected at the beginning of a PEI practice and at the end of the practice. The outcomes for each practice presented in this Annual Update are from individuals who completed a practice and completed both the beginning and end of treatment measures.

Outcome measures are selected through an initial review of measures in use for particular age groups related to particular foci of treatment. The results of the literature review are then presented to a joint provider-Department committee and a decision is made on which measures will be used to assess outcomes. Factors that are considered are the cost of measure, the length of the measure, the languages the measures come in and whether the developer allows for translation to additional languages (for measures completed by clients), and more recently, whether the measure is able to be used within electronic health records. The outcome measures associated with each practice are listed in the Appendix.



EARLY INTERVENTION

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

EARLY INTERVENTION

The following Early Intervention programs were identified for implementation through the development of the PEI Three-Year Plan for Fiscal Years 2017-18 to 2019-20 and are currently in the stages of development:

COORDINATED SPECIALTY CARE MODEL FOR EARLY PSYCHOSIS (CSC-EP)

Age Group: Children (12-15), TAY (16-25) **Target Population:** At-risk Youth

CSC-EP is a team-based, multi-element approach to treating early psychosis. CSC-EP serves youth experiencing the symptoms of early psychosis including: onset of psychotic symptoms in the past year, subthreshold symptoms of psychosis, and recent deterioration in youth with a parent/sibling with a psychotic disorder. This collaborative, recovery based treatment approach involves clients and treatment team members as active participants. The program includes various treatment components that focus on reducing and managing symptoms and distress and improving individuals' ability to achieve success in independent roles. Services include comprehensive clinical assessment, medication management, case management, individual and family psychoeducation and support groups including multifamily therapy, and peer and family advocate support. CSC-EP emphasizes shared decision making as a means for addressing the unique needs, preferences, and recovery goals of individuals with early psychosis. CSC services are also highly coordinated with primary medical care, with a focus on optimizing a client's overall mental and physical health.

GROUP INDIVIDUAL PSYCHOTHERAPY (GROUP IPT)

Age Group: Children (15), TAY (16-25), Adult (26-59) & Older Adult (60+) **Target Population:** Individuals & Family Under Stress

Group IPT is most effective when the group members all have a similar diagnosis or problem area, such as depression, cancer, or PTSD. Groups designed to prevent postpartum depression or depression during pregnancy, or groups for high-risk adolescents would also be highly suitable for treatment with IPT. The similarity in treatment focus fosters rapid development of group cohesion and support. Both are fostered within the group as quickly as possible; later sessions are designed to generalize these skills to the client's family and community, where they can apply them to interpersonal relationships to identify and develop the support they need during crises, and to resolve interpersonal conflicts or manage difficult transitions or losses.

THE MOTHERS AND BABIES COURSE, MAMAS Y BEBES

Age Group: Children (13-15), TAY (16-25), Adult (26-59) & Older Adult (60+) **Target Population:** Individuals & Family Under Stress

Developed in both Spanish and English, prenatal intervention is designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The explicit goal of the intervention is to help participants create a healthy physical, social, and psychological environment for themselves and their infants. The program consists of a 12-week mood management course and four booster sessions conducted at approximately 1, 2, 6, and 12 months postpartum. The program is specifically designed to be culturally sensitive and linguistically appropriate for immigrant, low-income Latinas.

EARLY INTERVENTION: EVIDENCE BASED PRACTICES

AGRESSION REPLACEMENT TRAINING (ART)

Children (ages 5-12) –Skill Streaming Only
Children (ages 12-15), TAY (ages 16-17)

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.

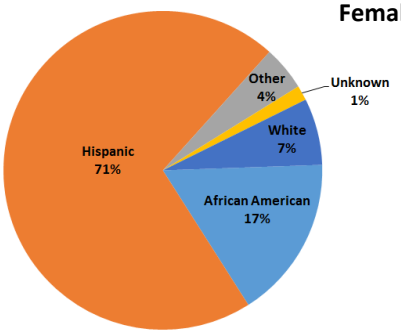
OUTCOMES

* 3,339 Treatment Cycles
* 42% reported completing the EBP
* 24% Improvement in mental health functioning
* 21% Reduction in disruptive behaviors

ETHNICITY & GENDER

ART
N=133

Male: 62%
Female: 38%



ALTERNATIVES FOR FAMILIES COGNITIVE BEHAVIORAL THERAPY (AF-CBT)

Children (ages 4-15), TAY (ages 16-17)

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.

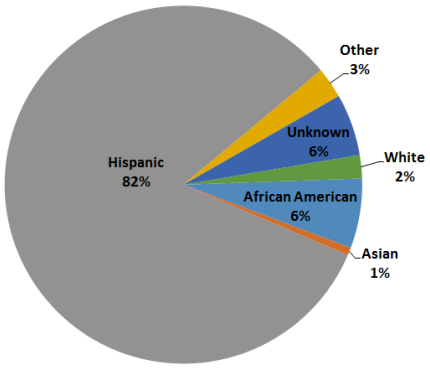
OUTCOMES

* 1,139 Treatment Cycles
* 49% reported completing the EBP
* 50% Improvement in mental health functioning
* 53% Reduction in symptoms related to posttraumatic stress

ETHNICITY & GENDER

N=143

Male: 60%
Female: 40%



*Data as of 9/18/2017. Outcomes entered July 2011 through September 2017. Percentage of clients completing the EBP was determined by what was entered in the PEI OMA. Age is calculated at the date of the first EBP. Outcome data based on fewer than 20 clients are not reported.

EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Brief Strategic Family Therapy (BSFT)

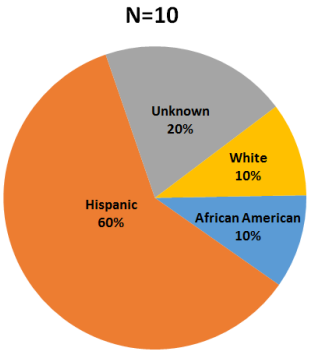
Children (ages 10-15), TAY (ages 16-18)

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.

OUTCOMES

* 182 Treatment Cycles
* 65% reported completing the EBP
* 49% Improvement in mental health functioning
* 50% Reduction in behavioral problems

ETHNICITY & GENDER



Male: 30%
Female: 70%

Caring for Our Families (CFOF)

Children (ages 5-11)

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.

OUTCOMES

* 728 Treatment Cycles
* 68% reported completing the EBP
* 23% Improvement in mental health functioning
* 30% Reduction in disruptive behaviors

EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Center for the Assessment and Prevention of Prodromal States (CAPPS)

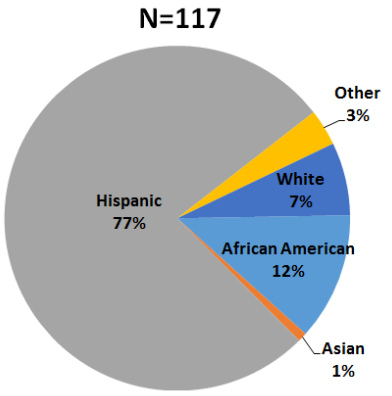
TAY

The focus of CAPPS is 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.

OUTCOMES

* 186 Treatment Cycles
* 43% reported completing the EBP
* 30% Improvement in mental health functioning
* 60% Reduction in prodromal symptoms

ETHNICITY & GENDER



Male: 56%
Female: 44%

Child-Parent Psychotherapy (CPP)

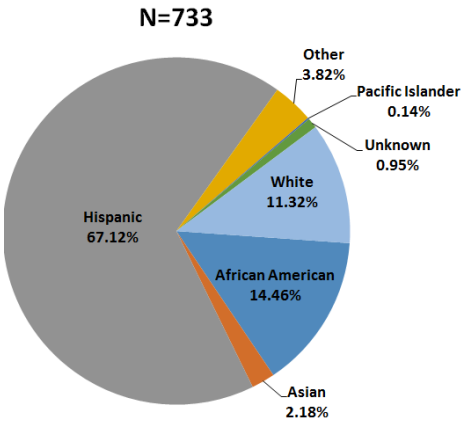
Young Children (ages 0-6)

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.

OUTCOMES

* 4,719 Treatment Cycles
* 47% Reported completing the EBP
* 55% Improvement in mental health functioning
* 16% Reduction in child's mental health functioning following a traumatic event

ETHNICITY & GENDER



Male: 52%
Female: 48%

EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Cognitive Behavioral Intervention for Trauma in School (CBITS)

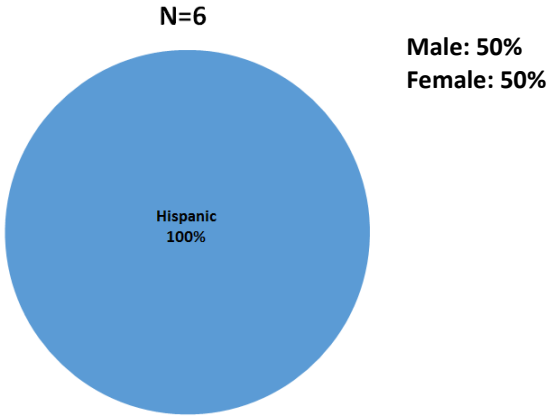
Children (ages 10-15), TAY

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 .

OUTCOMES

* 118 Treatment Cycles
* 68% reported completing the EBP
* 31% Improvement in mental health functioning
* 28% Reduction in symptoms related to posttraumatic stress

ETHNICITY & GENDER



Crisis Oriented Recovery Services (CORS)

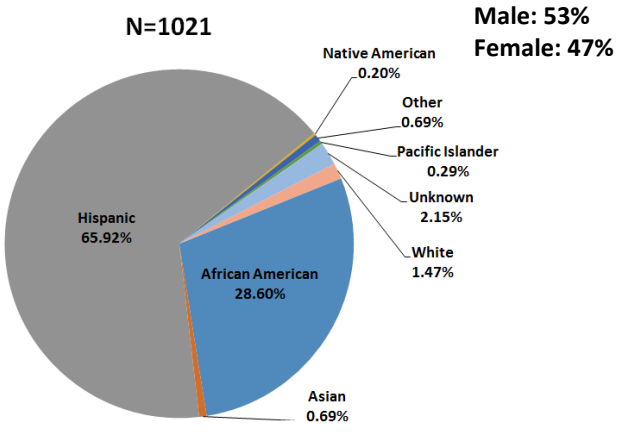
Children , TAY, Adults,, Older Adults

CORS is a short-term intervention designed to provide immediate crisis intervention, address identified case management needs, and assure hard linkage to ongoing services. The primary objective is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress or psychological harm. It promotes the development of coping strategies that individuals can utilize to help restore them to their previous level of functioning prior to the crisis event.

OUTCOMES

* 3,728 Treatment Cycles
* 59% reported completing the EBP
* 28% Improvement in mental health functioning

ETHNICITY & GENDER



EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Dialectical Behavior Therapy (DBT)

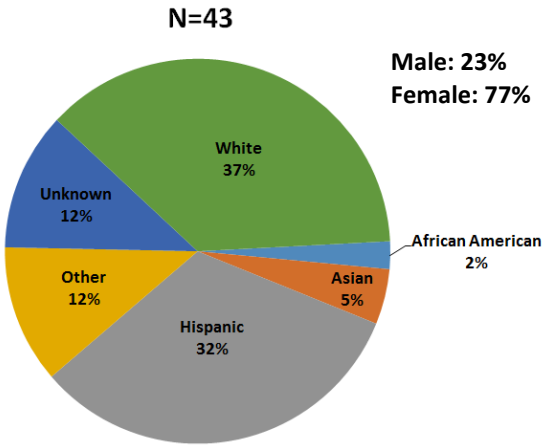
Children (ages 12-15) TAY (ages 16-20)

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.

OUTCOMES

* 93 Treatment Cycles
* 44% reported completing the EBP

ETHNICITY & GENDER



Depression Treatment Quality Improvement (DTQI)

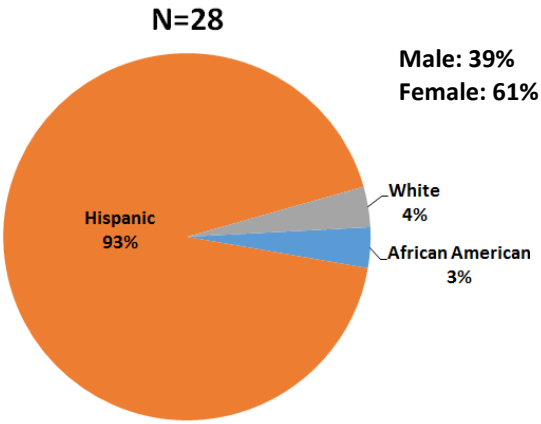
Children , TAY , Adults , Older Adults

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.

OUTCOMES

* 1,045 Treatment Cycles
* 62% reported completing the EBP
* 48% Improvement in mental health functioning
* 62% Reduction in symptoms related to depression

ETHNICITY & GENDER



EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Families Over Coming Under Stress (FOCUS)

Children , TAY , Adults

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.

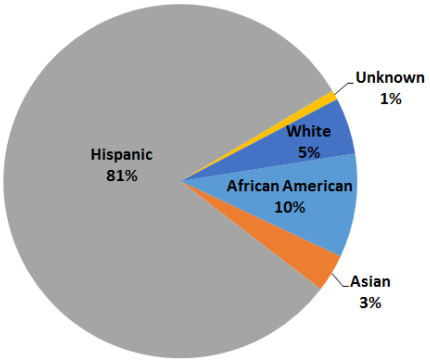
OUTCOMES

* 346 Treatment Cycles
* 72% reported completing the EBP
* 39% Improvement in mental health functioning
* 50% Improvement in family functioning

ETHNICITY & GENDER

N=116

Male: 59%
Female: 41%



Functional Family Therapy (FFT)

Children (ages 11-15) TAY (ages 16-18)

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.

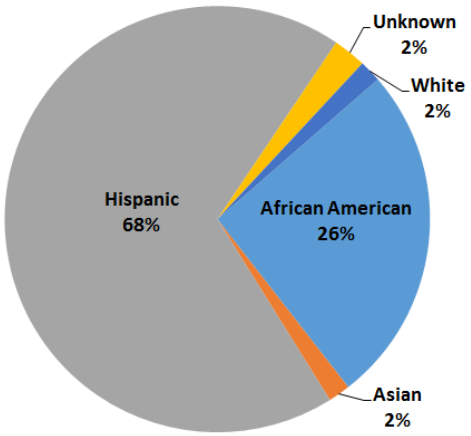
OUTCOMES

* 1,607 Treatment Cycles
* 65% reported completing the EBP
* 31% Improvement in mental health functioning

ETHNICITY & GENDER

N=120

Male: 68%
Female: 32%



EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Group Cognitive Behavioral Therapy for Major Depression (Group CBT)

TAY (ages 18-25), Adults, , Older Adults

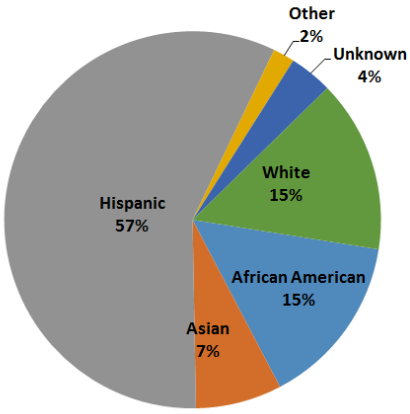
Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is 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.

OUTCOMES

* 1,069 Treatment Cycles
* 43% reported completing the EBP
* 21% Improvement in mental health functioning
* 42% Reduction in symptoms related to depression

ETHNICITY & GENDER

N=54



Male: 20%
Female: 80%

Incredible Years (IY)

Young Children (ages 2-5)
Children (ages 6-12)

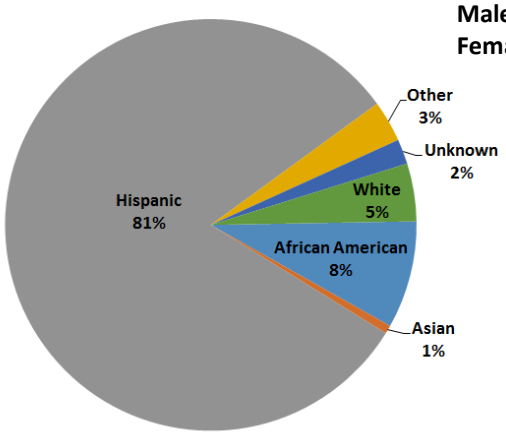
IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/ emotional competencies. Teacher training intervention focuses on teachers' classroom management strategies, promoting pro-social behaviors and school readiness.

OUTCOMES

* 2,337 Treatment Cycles
* 64% reported completing the EBP
* 27% Improvement in mental health functioning
* 35% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=154



Male: 68%
Female: 32%

EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Individual Cognitive Behavioral Therapy (Ind. CBT)

TAY (ages 18-25) , Adults , Older Adults , Directly Operated Clinics only

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.

OUTCOMES

Anxiety:

* 1,547 Treatment Cycles
* 42% reported completing the EBP
* 37% Improvement in mental health functioning
* 54% Reduction in symptoms related to anxiety

Depression:

* 4,035 Treatment Cycles
* 40% reported completing the EBP
* 34% Improvement in mental health functioning
* 53% Reduction in symptoms related to depression

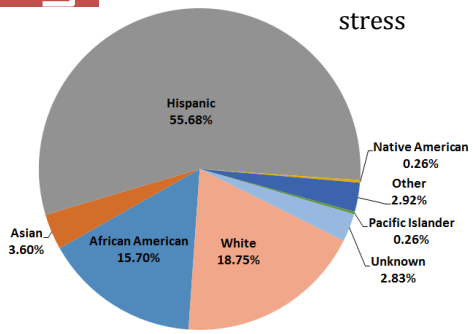
Trauma:

* 482 Treatment Cycles
* 48% reported completing the EBP
* 41% Improvement in mental health functioning
* 60% Reduction in symptoms related to posttraumatic stress

ETHNICITY & GENDER

N=2331

Male: 33%
Female: 67%



Interpersonal Psychotherapy for Depression (IPT)

Children (ages 9-15) TAY , Adults , Older Adults

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.

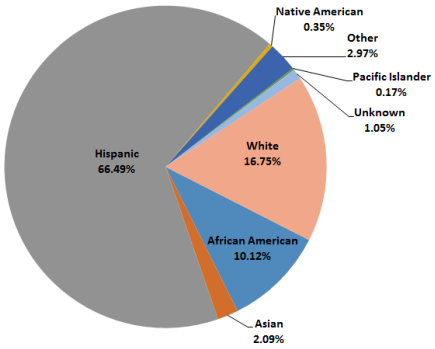
OUTCOMES

* 4,837 Treatment Cycles
* 47% reported completing the EBP
* 31% Improvement in mental health functioning
* 54% Reduction in symptoms related to depression

ETHNICITY & GENDER

N=573

Male: 75%
Female: 25%



EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Loving Intervention Family Enrichment Program (LIFE)

Children (ages 0-8)

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.

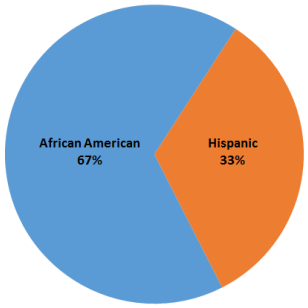
OUTCOMES

* 390 Treatment Cycles
* 65% reported completing the EBP
* 33% Improvement in mental health functioning
* 50% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=3

Male: 33%
Female: 66%



Managing and Adapting Practice (MAP)

Young Children , Children , TAY (ages 16-21)

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.

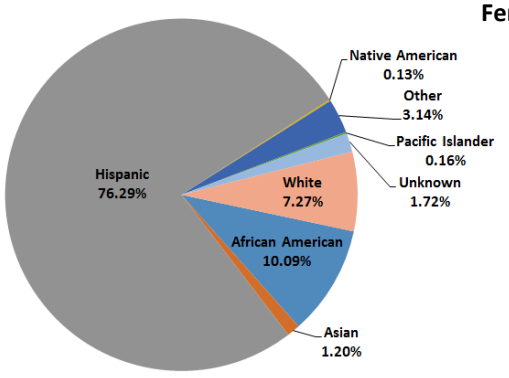
OUTCOMES

* 37,003 Treatment Cycles
* 54% reported completing the EBP
* 44% Improvement in mental health functioning
* 47% Reduction in disruptive behaviors
* 55% Reduction in symptoms related to depression
* 41% Reduction in symptoms related to anxiety
* 46% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N=7520

Male: 56%
Female: 44%



EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Mental Health Integration Program (MHIP) formerly known as IMPACT

Adults

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.

OUTCOMES

MHIP-Anxiety

* 1,706 Treatment Cycles
* 39% reported completing the EBP
* 50% Reduction in symptoms related to anxiety

MHIP-Depression

* 5,085 Treatment Cycles
* 34% reported completing the EBP
* 53% Reduction in symptoms related to depression

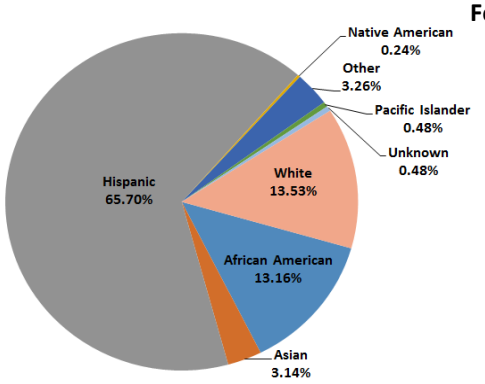
MHIP-Trauma

* 297 Treatment Cycles
* 29% reported completing the EBP
* 24% Reduction in symptoms associated with exposure to trauma

ETHNICITY & GENDER

N=828

Male: 27%
Female: 73%



Mindful Parenting Groups (MP)

Young Children (ages 0-3)

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.

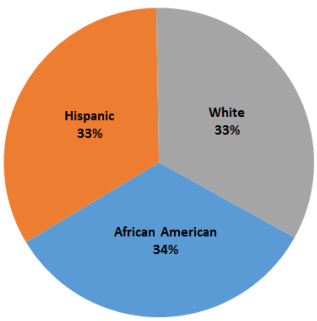
OUTCOMES

* 16 Treatment Cycles
* 100% reported completing the EBP

ETHNICITY & GENDER

N=3

Male: 100%
Female: 0%



EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Multidimensional Family Therapy (MDFT)

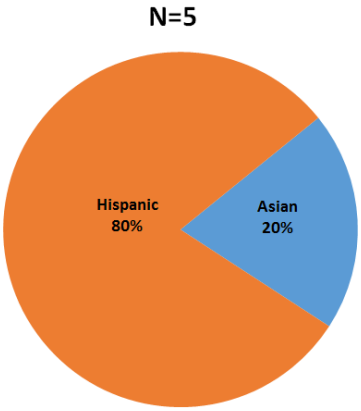
Children (ages 12-15) TAY (ages 16-18)

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.

OUTCOMES

* 74 Treatment Cycles
* 89% reported completing the EBP
* 25% Improvement in mental health functioning

ETHNICITY & GENDER



Male: 20%
Female: 80%

Multisystemic Therapy (MST)

Children (ages 12-15) TAY (ages 16-17)

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).

OUTCOMES

* 126 Treatment Cycles
* 72% reported completing the EBP
* 46% Improvement in mental health functioning

EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Parent-Child Interaction Therapy (PCIT)

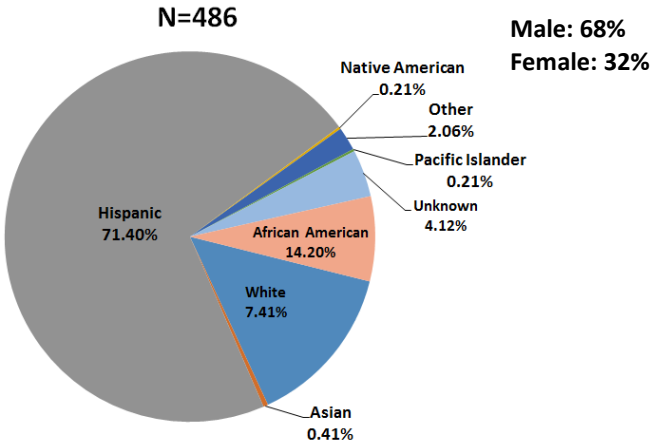
Young Children (2-7)

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.

OUTCOMES

* 2,516 Treatment Cycles
* 42% reported completing the EBP
* 57% Improvement in mental health functioning
* 63% Reduction in disruptive behaviors

ETHNICITY & GENDER



Problem Solving Therapy (PST)

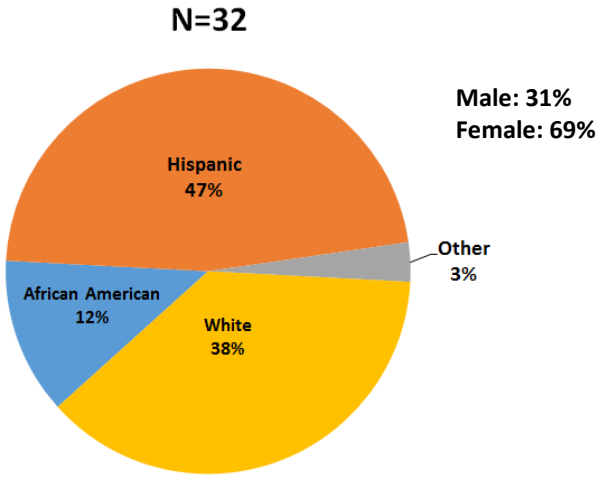
Older Adults

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.

OUTCOMES

* 366 Treatment Cycles
* 61% reported completing the EBP
* 28% Improvement in mental health functioning
* 45% Reduction in symptoms related to depression

ETHNICITY & GENDER



EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Program to Encourage Active Rewarding Lives for Seniors (PEARLS)

Older Adults

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.

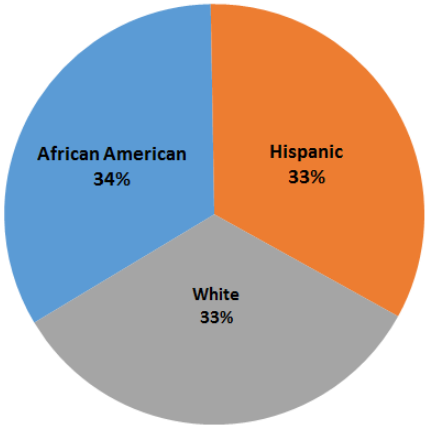
OUTCOMES

* 162 Treatment Cycles
* 49% reported completing the EBP
* 24% Improvement in mental health functioning
* 45% Reduction in symptoms related to depression

ETHNICITY & GENDER

N=3

Male: 100%
Female: 0%



Prolonged Exposure – Post Traumatic Stress Disorder (PE-PTSD)

TAY (ages 18-25) Adults , Older Adults , Directly Operated Clinics Only

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.

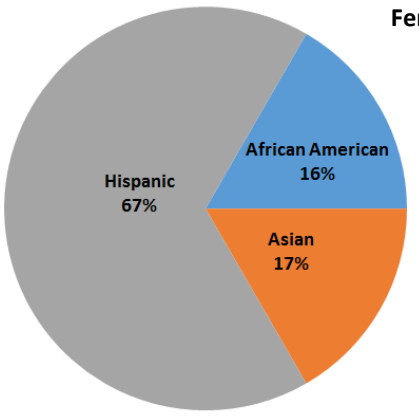
OUTCOMES

* 51 Treatment Cycles
* 56% reported completing the EBP

ETHNICITY & GENDER

N=6

Male: 67%
Female: 33%



EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Promoting Alternative Thinking Strategies (PATHS)

Children (5-12)

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.

OUTCOMES

* 743 Treatment Cycles
* 33% reported completing the EBP
* 37% Improvement in mental health functioning
* 33% Reduction in disruptive behaviors

Reflective Parenting Program (RPP)

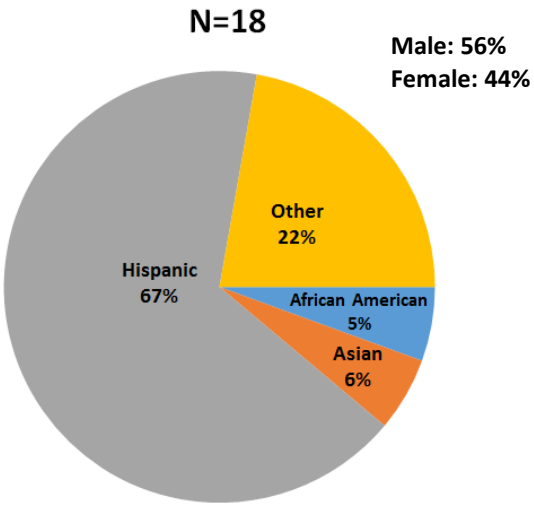
Young Children (ages 2-5)
Children (ages 6-12)

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.

OUTCOMES

* 209 Treatment Cycles
* 74% reported completing the EBP
* 9% Improvement in mental health functioning
* 15% Reduction in disruptive behaviors

ETHNICITY & GENDER



EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Seeking Safety (SS)

Children (13-15) TAY , Adults, Older Adults

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.

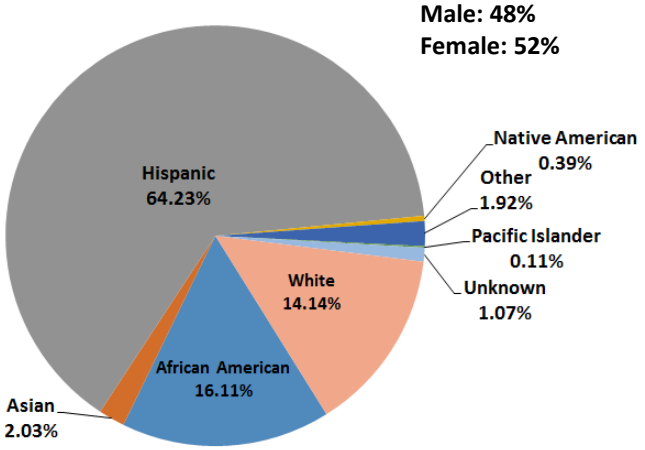
OUTCOMES

* 17,372 Treatment Cycles
* 40% reported completing the EBP
* 36% Improvement in mental health functioning
* 31% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N=1775

Male: 48%
Female: 52%



Strengthening Families (SF)

Children (ages 3-15) TAY (ages 16-18)

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.

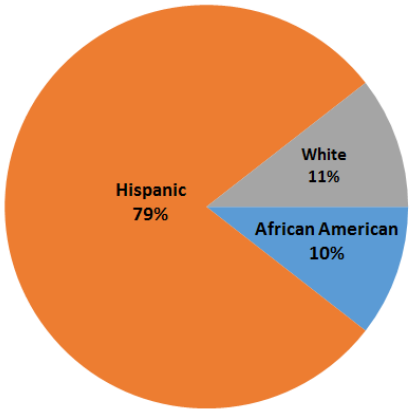
OUTCOMES

* 237 Treatment Cycles
* 89% reported completing the EBP
* 32% Improvement in mental health functioning

ETHNICITY & GENDER

N=19

Male: 53%
Female: 47%



EARLY INTERVENTION: EVIDENCE BASED PRACTICES

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Young Children , Children , TAY (ages 16-18)

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.

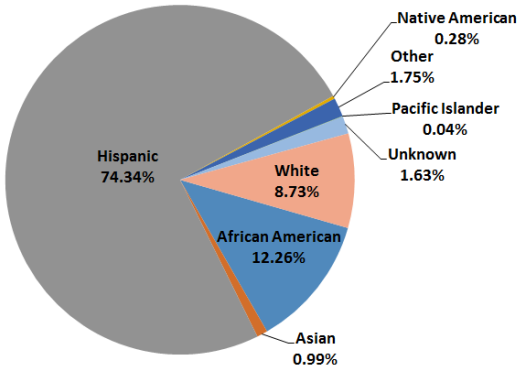
OUTCOMES

* 16,987 Treatment Cycles
* 55% reported completing the EBP
* 47% Improvement in mental health functioning
* 51% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N=2521

Male: 45%
Female: 55%



Triple P Positive Parenting Program (Triple P)

Young Children (ages 0-5)
Children (ages 6-15) TAY (age 16)

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.

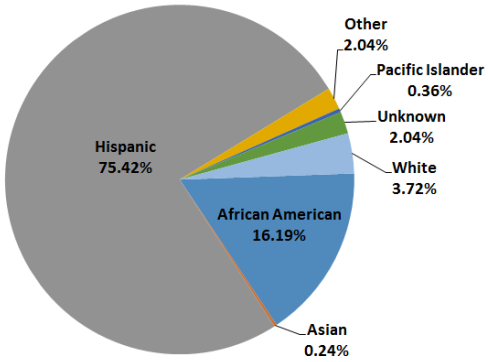
OUTCOMES

* 5,029 Treatment Cycles
* 58% reported completing the EBP
* 42% Improvement in mental health functioning
* 50% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=834

Male: 68%
Female: 32%



UCLA Ties Transition Model (UCLA TTM)

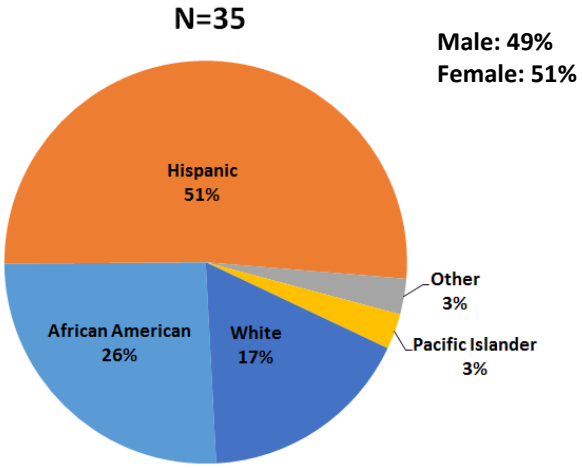
Young Children (ages 0-5)
Children (ages 6-12)

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).

OUTCOMES

* 183 Treatment Cycles
* 51% reported completing the EBP

ETHNICITY & GENDER



STIGMA AND DISCRIMINATION REDUCTION

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.

Children's Stigma and Discrimination Reduction Project

The project provides trainings to increase public awareness, social acceptance, and inclusion of people with mental health challenges. The Children's Anti Stigma and Discrimination project also known as A Reason to Care and Connect (ARCC) provides education to parents and to the general community through four trainings in both English and Spanish:

- It Takes a Community (ITC) is a 10-week course, developed by LA County DMH in consultation with Ruth Beaglehole specifically to reduce stigma, which includes healing and communication tools to promote mental wellness and create a world that is empathic to children.
- Educate, Equip and Support (EES) is a 13-week curriculum, developed by United Advocates for Children and Families (UACF), which is a general overview of childhood mental health disorders and strategies aimed at improving the lives of children with mental health needs and their families. It also includes grief and loss, and how to navigate the mental health, juvenile justice, special education and the child welfare systems.
- Youth Mental Health First Aid (YMHFA), created by the National Council for Behavioral Health, is 8-hour training for parents, neighbors, teachers, and the general community to help a youth (ages 12-18) who is experiencing a mental health or addictions challenge. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations.
- Anti-bullying presentations created to raise awareness of the serious problem of bullying within our youth, which includes the importance that the bully, the bullied and the bystander roles play. It also includes identifying early signs and helpful prevention and intervention strategies on dealing with the three different roles as parents, and as a community member.

During FY 2016-17, sixty-nine (69) trainings on ITC, EES, YMHFA, and Bullying were provided to parents, children and community members countywide.

Family-focused Strategies to Reduce Mental Health Stigma and Discrimination

During FY 2016-2017, the Adult System of Care (ASOC) Stigma and Discrimination Reduction (SDR) team participated in 56 events in 7 out of 8 service areas in Los Angeles County (LAC). Over 1300 LAC community members including families and care-givers of mental health consumers, clergy members and faith based communities, college students and school district staff as well as law enforcement were provided with educational presentations. The SDR team also collaborated with various agencies and programs throughout the County such as Department of Rehabilitation, Department of Public Social Services, US Veterans, Union Rescue Mission, LA Metro, YWCA Greater Los Angeles, and League of Women Voters to name a few.

Older Adults Mental Wellness

For the majority of FY 2016-17, the Older Adult Anti-Stigma and Discrimination Team (OA ASD) was comprised of a Community Services Counselor, a social work intern, a Community Worker, and a Service Extender. Additional Older Adult System of Care Bureau staff provide assistance, particularly if there is more than one presentation on a given day, or if there is a need for a specific language. The OA ASD Team participated in a total of 273 events during the fiscal year 2016-2017, outreaching to more than 4,519 Los Angeles County residents. This is almost 18% higher than in the previous fiscal year, and can be attributed to these events including countywide educational presentations, community events and collaboration with various agencies.

Highlights of OA ASD's accomplishments include:

- Outreached to over 4,519 individuals in Los Angeles County
- Provided over 262 presentations for seniors throughout the county
- Participated in five Health Fairs throughout the county, one Senior Summit, five groups for "Know the 5 signs" campaign in "A Day To Change Direction."
- Increased number of workshops in Service areas of 1 and 8
- Developed two new presentations "How to be Intelligent about your own Emotions" and "Managing your Stress" to be added to the menu of topics for our Mental Wellness Series.

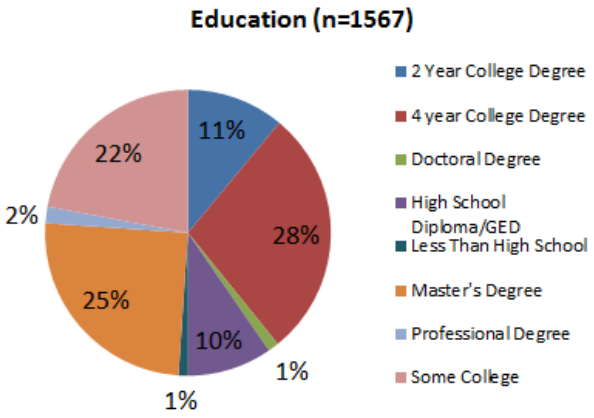
OUTCOMES -ANTI-STIGMA DISCRIMINATION

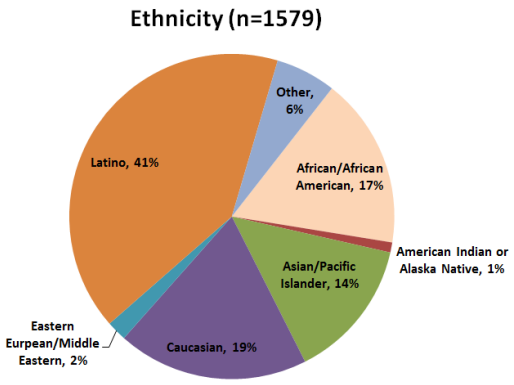
Through training and education, the Los Angeles County Department of Mental Health has shown positive results in increasing knowledge and reducing stigma and discrimination related to mental illness. Stigma and Discrimination Reduction (SDR) Training Outcomes Surveys were administered at the beginning and at the end of the training to measure changes in the following areas: awareness of stigma against persons who have mental illness; attitudes and behavior towards persons with mental illness; and knowledge about mental health. There are 2 versions of the SDR survey, one for Children/Adolescents and another for Adults (ages 18+). Since all of the training participants who submitted surveys were adults, only Adult Survey data are being reported.

Through training and education, the Los Angeles County Department of Mental Health has shown positive results in increasing knowledge and reducing stigma and discrimination related to mental illness. Stigma and Discrimination Reduction (SDR) Training Outcomes Surveys were administered at the beginning and at the end of the training to measure changes in the following areas: awareness of stigma against persons who have mental illness; attitudes and behavior towards persons with mental illness; and knowledge about mental health. There are 2 versions of the SDR survey, one for Children/Adolescents and another for Adults (ages 18+). Since all of the training participants who submitted surveys were adults, only Adult Survey data are being reported.

The following are results from the 1,729 surveys received for FY 16-17:

- The average age of trainees who submitted a SDR Survey was 44 (age range 20-94).
- Gender (n=1,617): 74% Female, 24% Male
- Have You Ever Received Mental Health Services (n=1,589): 29% responded Yes, 67% responded No and 4% would rather not answer
- Primary Language (n=1,575): 85% English, 7% Spanish, 2% Korean and 6% Other





STIGMA AND DISCRIMINATION REDUCTION

Mental Health First Aid (MHFA) is an interactive 8-hour evidence based training that provides knowledge about the signs and symptoms of mental illness, safe de-escalation of crisis situations and timely referral to mental health services. The use of role-playing and other interactive activities enhance the participants' understanding and skill set to assess, intervene and provide initial help pending referral/linkage to a mental health professional. Participants are also provided information about local mental health resources that include treatment, self-help and other important social supports.

The SDR survey includes six items that assess attitudes towards persons with mental illness. Scores from the six items are added together to provide a total score, which gives some indication whether the person completing it tends to have negative or positive perceptions of persons with mental illness. The total score can fall into one of four ranges: Very Negative, Negative, Positive, and Very Positive. An increase in the total scores from "pre" to "post" suggests having more positive perceptions about persons with mental illness.

- Prior to the training, 99% of participants' total scores were in either the Positive range (499) or Very Positive range (587). At "post" training, 99% of participants were still in either the Positive range (349) or Very Positive range (742). These results are very similar to the results from FY 15-16. In that year, 96% of participants had "pre" scores in either the Positive or Very Positive range and 98% had "post" scores in either the Positive or Very Positive range.
- Prior to training, 54% of participants' (587) scored in the Very Positive range. At "post", 68% of participants' scored in the Very Positive (742), an increase of 14%.
- Prior to the training, the average total score was in the Positive range; at "post" training, the average total score was in the Very Positive range.

Attitudes towards persons with mental illness: 14% increase in the participants attitude from pre to post training

Current level of knowledge about mental health: 34% increase in the knowledge from pre to post training

The SDR Survey includes a seventh item, "Please rate your current level of knowledge about mental health," which has five possible responses: Not at all Knowledgeable, Somewhat Knowledgeable, Moderately Knowledgeable, Very Knowledgeable, and Extremely Knowledgeable. An increase in the Knowledge from "pre" to "post" suggests a participant has gained knowledge about mental illness.

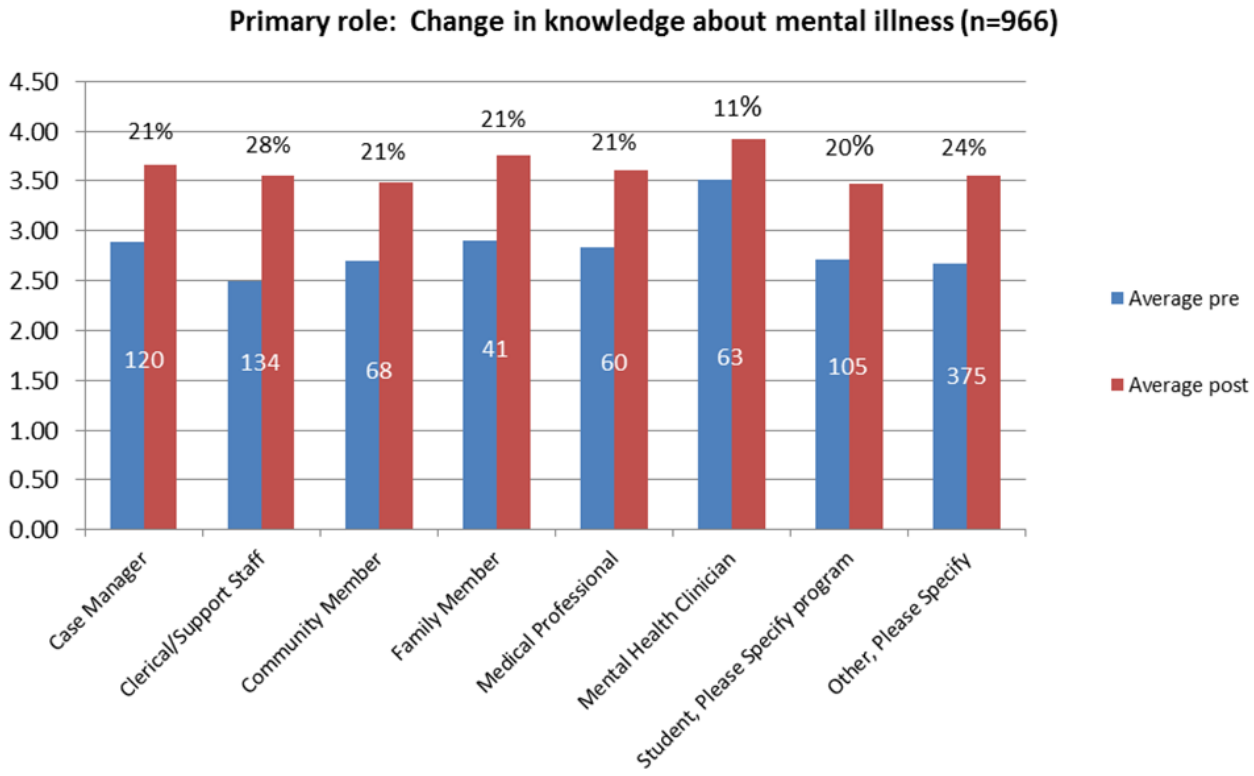
- Ninety-one percent (91%) of participants (1008) either increased their knowledge about mental illness or showed no change because they were already knowledgeable on the subject matter.
- Prior to the training, 60% of participants selected Moderately, Very, or Extremely Knowledgeable. "Post" training, 94% of participants selected Moderately, Very, or Extremely Knowledgeable, an increase of 34%.
- Prior to the training, 462 participants selected the response, Moderately Knowledgeable. Sixty percent (60%) of these participants selected either Very Knowledgeable (247) or Extremely Knowledgeable (30), at "post" training.

These results suggest:

1. The great majority of participants had positive perceptions about people with mental illness prior to attending the training and their positive perceptions were either maintained or increased following training
2. Training helped many participants increase their knowledge about mental health, even among participants who had a moderate level of knowledge prior to attending the training.

STIGMA AND DISCRIMINATION REDUCTION

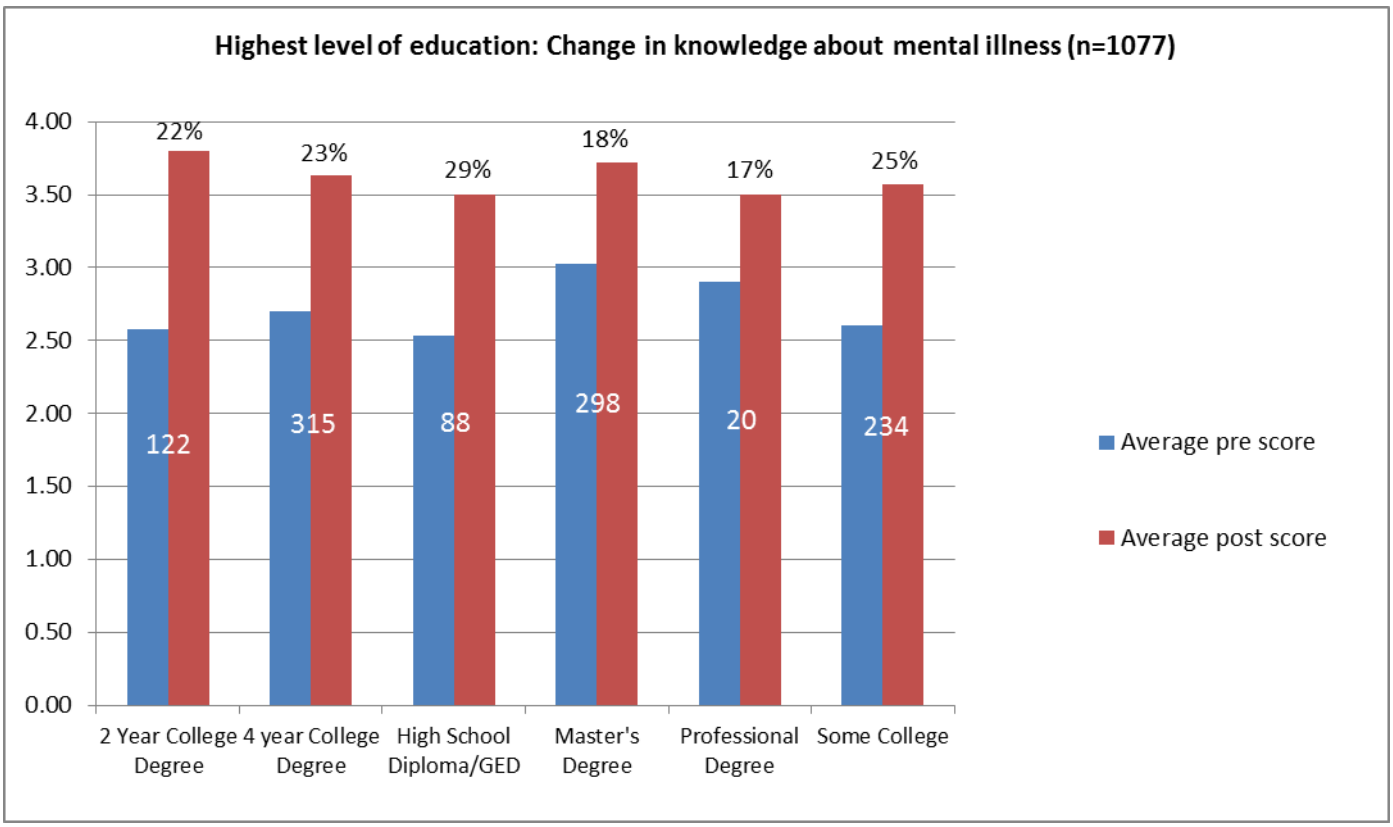
Demographic comparison charts are included when at least one of the following 2 criteria are met: 1) the average percent change in score from "pre" to "post", for at least one group within the category is at least 10% higher/lower than the average percent change for another group. For example, in the Primary Role category, the average percent change for Mental Health Clinician is at least 10% less than 6 other groups 2) the average percent change in score from "pre" to "post", for at least one group within the category is at least double the percent change of another group. For example, in the Primary Role category, the average percent change for the groups, Clerical/Support Staff (28%) and Other, Please Specify (24%), are more than twice as large as the of the average percent change for the group, Mental Health Clinician (11%).



Note: Results for primary roles that had fewer than 20 matched "pre" and "post" SDR surveys (Law Enforcement, Mental Health Consumer, Substance Abuse Counselor, Clergy-Faith Based) are not included in the chart

Knowledge about mental health, Primary role

- Participants who selected the primary role, Mental Health Clinician, had the lowest average percent change (11%) in knowledge about mental health score, from "pre" to "post"; participants who selected Clerical/Support Staff had the highest (28%).
- Participants who selected the primary role, Mental Health Clinician, had the highest average "pre" (3.51) and "post" (3.92) score; participants who selected Clerical/Support Staff had the lowest average "pre" (2.49) score and participants who selected Student, Please Specify Program had the lowest average "post" (3.47) score.
- Participants who selected the role, Mental Health Clinician, probably, show the least change in knowledge from "pre" to "post" due to have more knowledge about mental health than other participants prior to attending the training



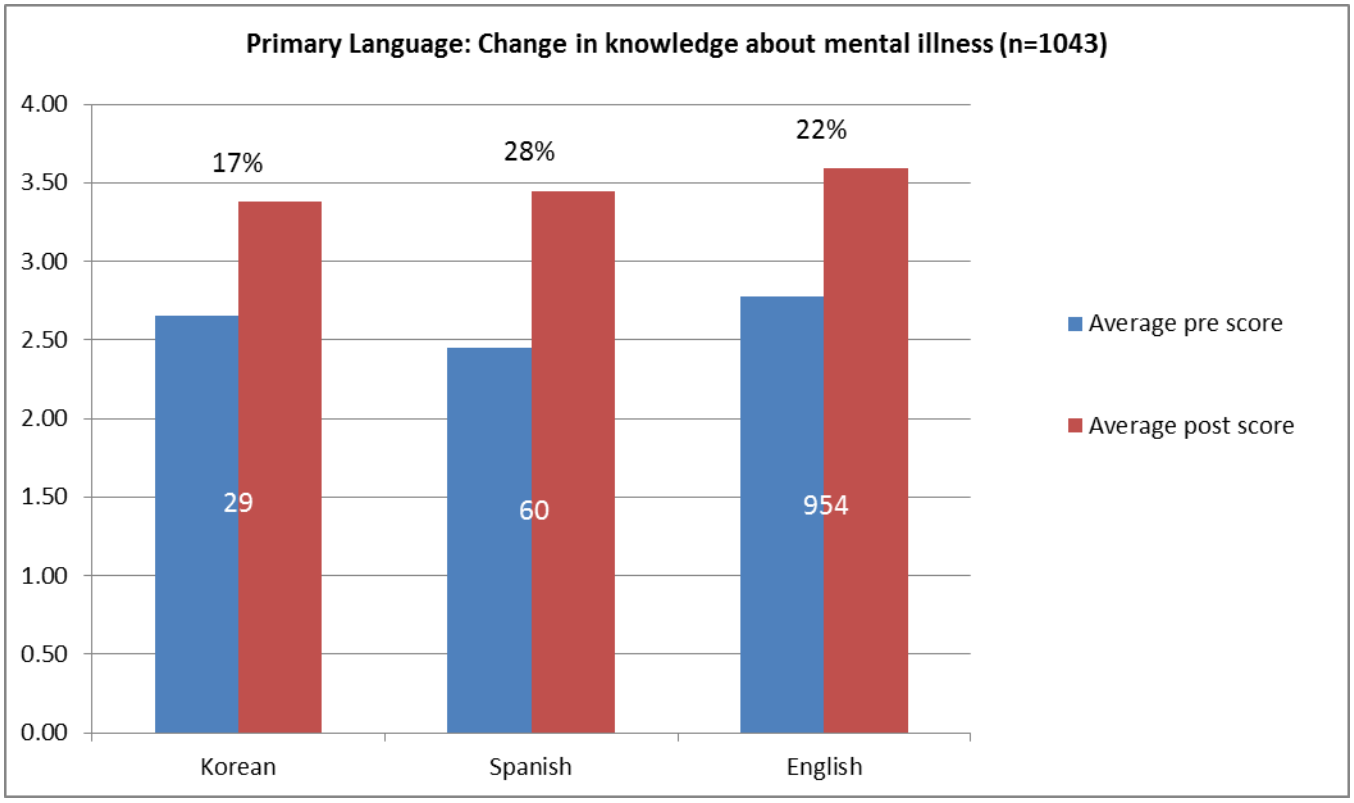
Note: Results for highest level of education that had fewer than 20 matched "pre" and "post" SDR surveys (Less than High School, Doctoral Degree) are not included in the chart

Knowledge about mental health, Highest level of education

- Participants who selected the highest level of education, Professional Degree, had the lowest average percent change (17%) in knowledge about mental health score, from "pre" to "post"; participants who selected High School Diploma/GED had the highest (29%).

- Participants who selected the highest level of education, Master's Degree, had the highest average "pre" (3.03) and "post" (3.72) score; participants who selected High School Diploma/GED had the lowest average "pre" (2.53) score and participants who selected Two Year College Degree had the lowest average "post" (3.35) score.

Participants with an advanced degree, in this case defined as either a master's, doctoral or professional degree, likely showed the least change in knowledge from "pre" to "post" due to having more education, training, and work experience related to mental health than other participants, prior to attending the training. This hypothesis is supported by the finding that the majority, 53%, of participants with advanced degrees also selected a primary role in a behavioral health care field (e.g., Mental Health Clinician, Substance Abuse Counselor).

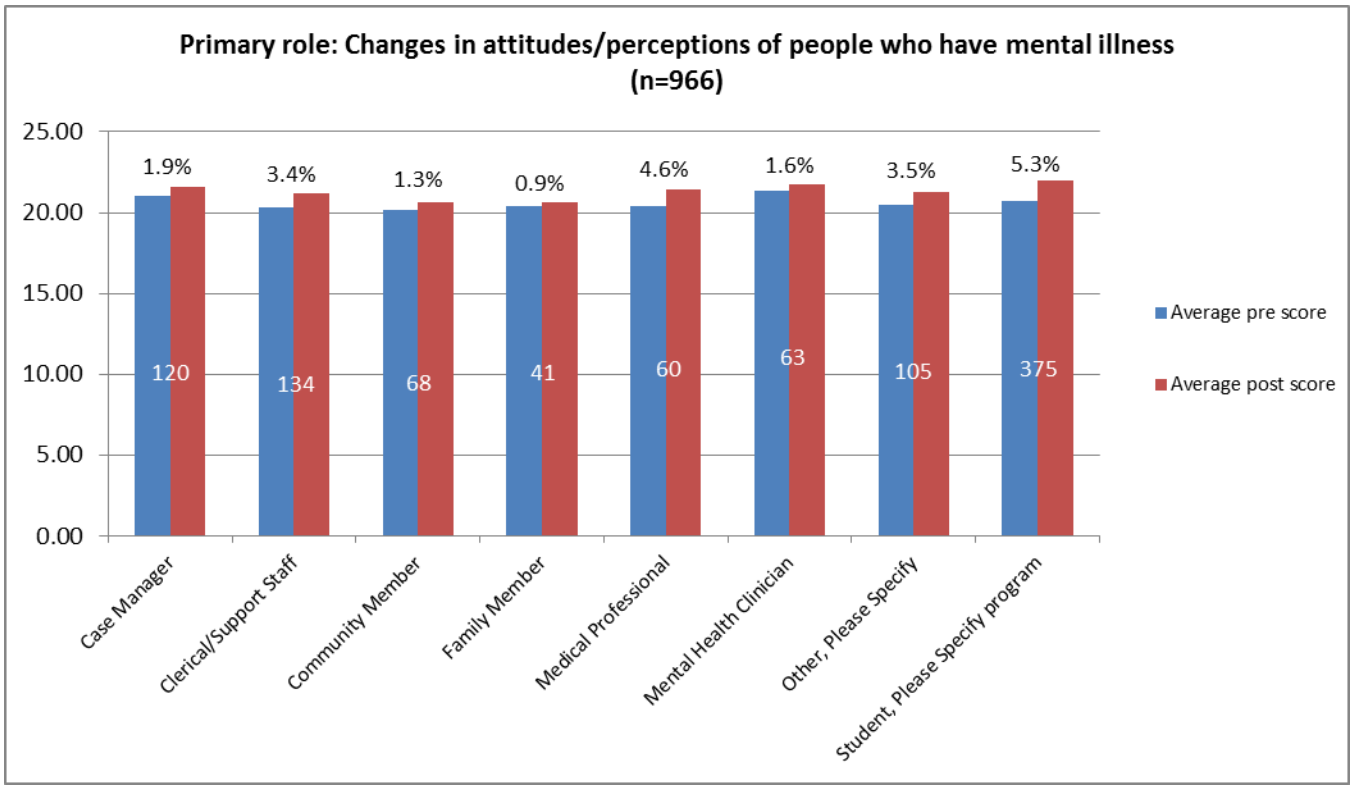


Note: Results for primary languages that had fewer than 20 matched "pre" and "post" SDR surveys (Arabic, Armenian, Cambodian, Cantonese, Farsi, Mandarin, Other Chinese, Russian, Tagalog, Vietnamese) are not included in the chart

Knowledge about mental health, Primary language

- Participants who selected the primary language, Korean, had the lowest average percent change (17%) in knowledge about mental health score, from "pre" to "post"; participants who selected Spanish had the highest (28%).

- Participants who selected the primary language, English, had the highest average "pre" (2.77) and "post" (3.59) score; participants who selected Spanish had the lowest average "pre" (2.45) score and participants who selected Korean had the lowest average "post" (3.38) score.

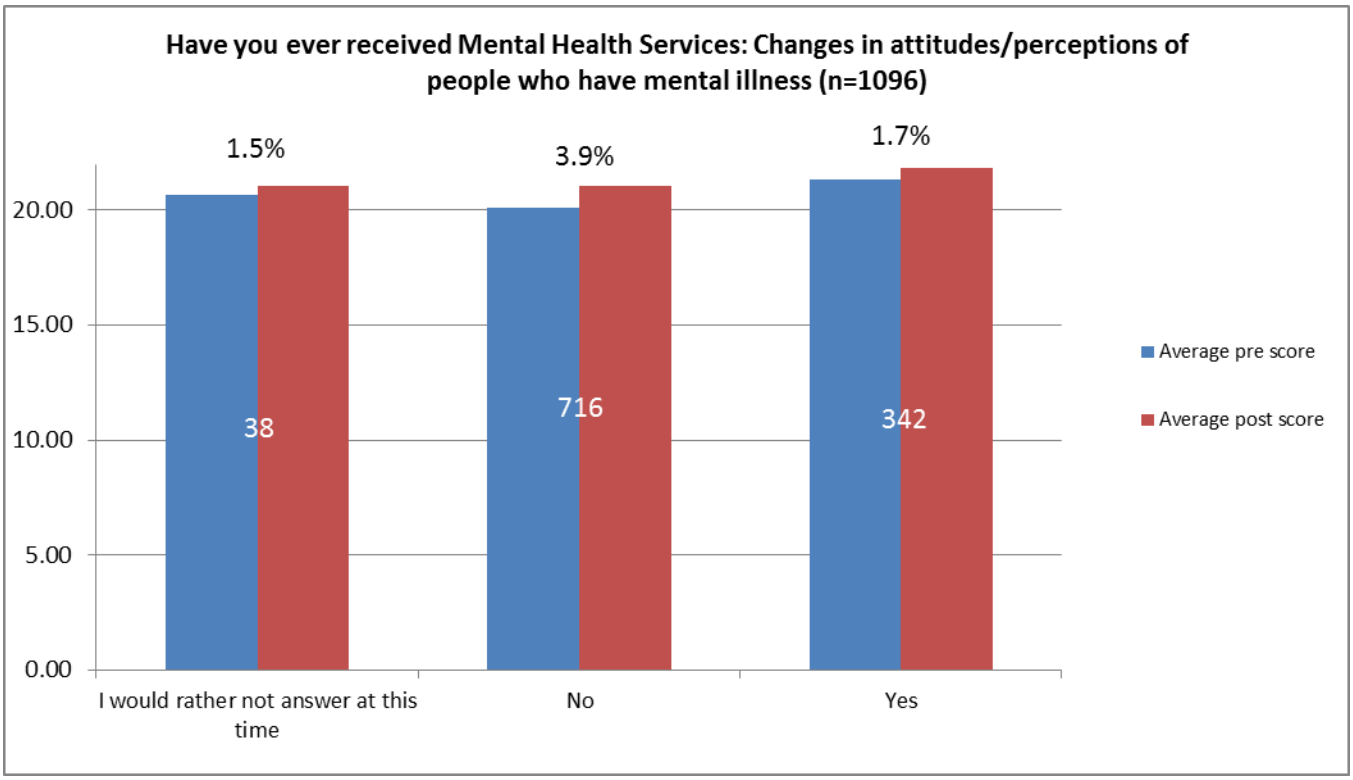


Note: Results for primary roles that had fewer than 20 matched "pre" and "post" SDR surveys (Law Enforcement, Mental Health Consumer, Substance Abuse Counselor, Clergy-Faith Based) are not included in the chart.

Attitudes/perceptions of people who have mental illness, Primary role

- Participants who selected the primary role, Family Member, had the lowest average percent increase (0.9%) in positive perceptions about people who have mental illness, from "pre" to "post"; participants who selected Student, Please Specify Program had the highest (5.3%).

- Participants who selected the primary role, Community Member, had the lowest average "pre" (20.19) score and those who selected Family Member had the lowest average "post" (20.66) score; participants who selected Mental Health Clinician had the highest average "pre" (21.33) score and participants who selected Student, Please Specify Program had the highest average "post" (21.94) score.



Attitudes/perceptions of people who have mental illness, Have you ever received mental health services (MHS)

- Participants who selected the response, No, had the lowest average "pre" (20.14) score and "post" (21.04) score; participants who selected the response, Yes, had the highest average "pre" (21.35) score and "post" (21.86) score.

- Participants who selected the response, I would rather not answer at this time, had the lowest average percent increase (1.5%) in positive perceptions about people who have mental illness, from "pre" to "post"; participants who selected the response, No, had the highest (3.9%). Participants who selected the, No, response also had the highest percent increase (25%) in Knowledge about Mental Illness score. These results suggest, for people who were "naïve" to mental health, SDR trainings were especially effective in reducing stigma against people who have mental illness and increasing knowledge.

SUICIDE PREVENTION

The 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.

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 agency's coordination of collaborative relationships with schools, private and public agencies, as well as other community-based organizations continue to allow it to successfully leverage many services and resources for the benefit of program participants. One of the most important aspects of the collaborative effort is the reduction of barriers and increase in access to mental health services by the community in general and children and adolescents in particular. One way in which this has been achieved is by locating the program at school sites and providing services at locations and times convenient to the program participants and their families. The services are provided at no cost to the participants and that they are provided by staff that is both culturally and linguistically competent further enhances the participants' accessibility to treatment.

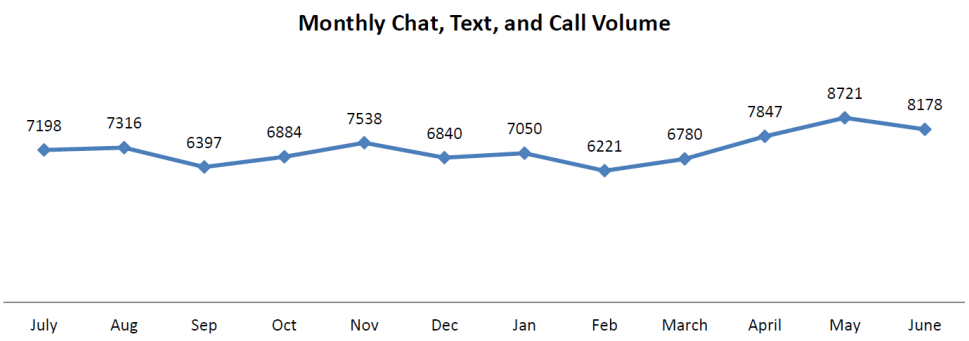
For FY 2016-17, the program provided services to 143 children and TAY and their families, of which 77 cases were opened. With regard to gender, 54% were female and 46% were male. The program’s staff provided over 874 hours of crisis and urgent services as well as preventive activities such as outreach and education to 671 individuals . contacts. (See Appendix for full report)

24/7 CRISIS HOTLINE

The 24/7 Suicide Prevention Crisis Line responded to a total of 86,970 calls, chats, and texts originating from Los Angeles County, including Spanish-language crisis hotline services to 5,900 callers. Korean and Vietnamese language services are also available on the Crisis Hotline. Additionally, various outreach events were conducted in LA and Orange County. Types of outreach events include Adolescent, Adult, Adult Clinical, ASIST, Clinical College, College Clinical, First Responders, and lecture, medical, and safeTALK presentations.

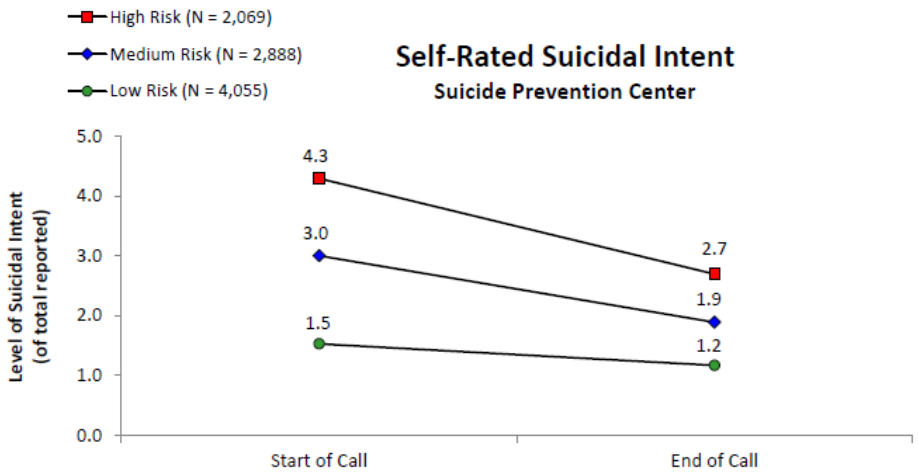
OUTCOMES FOR 24/7 CRISIS HOTLINE

(SEE APPENDIX FOR FULL REPORT)



May received the most amount of chats, texts and calls with February receiving the least

Callers are asked to answer the question: "Ona 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.)



- Callers who rated their suicidal intent as high or imminent risk at the start of the call showed a 37% reduction in their intent by the end of the call.
- Callers who rated their suicidal intent as medium risk at the start of the call also showed a 37% reduction in their intent by the end of the call.

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.

SUICIDE PREVENTION

PARTNERS IN SUICIDE (PSP) TEAM FOR CHILDREN, TAY, ADULTS & OLDER ADULTS

The Partners in Suicide Prevention (PSP) Team for Children, Transition Age Youth (TAY), Adults, and Older Adults (OA) is an innovative program offered by the Los Angeles County Department of Mental Health (DMH) is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The PSP Team offers community education and provides best-practice training models in suicide prevention, and provides linkage and referrals to age appropriate services.

PSP is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The team is comprised of eight staff representing each of the four age groups, and includes six 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 258 suicide prevention events during FY 2016-2017, outreaching to more than 5,168 Los Angeles County residents. These events included countywide educational trainings, participation in suicide prevention community events, and collaboration with various agencies and partners.

Highlights include:

- With the addition of five new adjunct trainers, the PSP team provided nine ASIST (Applied Suicide Intervention Skills Training) trainings throughout the County to 205 participants. This is almost double the amount of ASIST trainings held in prior FY 2015-2016.
- Two PSP members provided two trainings in Suicide to Hope, our newest training. There were 28 clinicians and case managers trained in this workshop which provides tools for them to work with clients who may be persons with experiences of suicide work together to develop achievable recovery and growth goals.
- PSP continued its collaboration with two adjunct ASIST trainers from outside of DMH which increased its training capacity countywide, particularly in service areas further from metro Los Angeles.
- Provided 81 QPR (Question, Persuade and Refer) gatekeeper trainings throughout the County, totaling 2,190 community members trained in QPR by the PSP team during FY 2016-17.
- Provided 68 MHFA (Mental Health First Aid) trainings which is designed to teach members of the community to recognize the symptoms of mental health problems, offer and provide initial help, and guide the individual to professional help if appropriate. Additionally 11 YMHFA (Youth Mental Health First Aid) trainings were held, with 178 community members trained to recognize symptoms of mental health problems in youth ages 12-18.
- Three AMSR (Assessing & Managing Suicide Risk) trainers from PSP provided 13 AMSR trainings this fiscal year training 220 clinicians, case managers, and nurses in both directly-operated programs and contracted providers. AMSR trains on the 24 core competencies related to suicide risk assessment and reviews safety planning.
- Provided two Recognizing and Responding to Suicide Risk (RRSR) trainings to 58 participants, both of which were held at our directly-operated clinics. Five staff members are qualified as RRSR trainers. RRSR trains on the 24 core competencies as well as safety planning, and provides time for highly interactive discussions and role play for attendees.
- Participated in the Inter-Agency Council on Child Abuse and Neglect (ICAN)/Department of Children and Family Services (DCFS) Child Suicide Review Team at the Los Angeles County Coroner's Office.
- Coordinated and hosted the Los Angeles County Suicide Prevention Network (SPN) which has recruited over fifty members from a wide variety of organizations and conducts quarterly meetings to increase collaboration and coordination of suicide prevention activities. Quarterly Suicide Prevention Network meetings occurred on the following dates: 9/30/2016, 12/9/2016, 3/17/207, and 6/9/2017.
- In an effort to increase capacity for the intensive ASIST training, six DMH staff from outside of PSP were trained by LivingWorks to become ASIST trainers, five of whom are now serving as adjunct ASIST trainers working with the PSP team. The goal is for all five of these trainers to complete their certification process during FY 2017-2018.
- Sixth Annual Suicide Prevention Summit "Men & Suicide: Asking for Directions": This Summit took place on September 8, 2016 at the California Endowment and was attended by approximately 265 people, including clinicians, school personnel, first responders, and veterans. Workshops included topics related to men in terms of ethnic culture, high-risk professions, veterans, first responders, LGBTQ, and TAY.

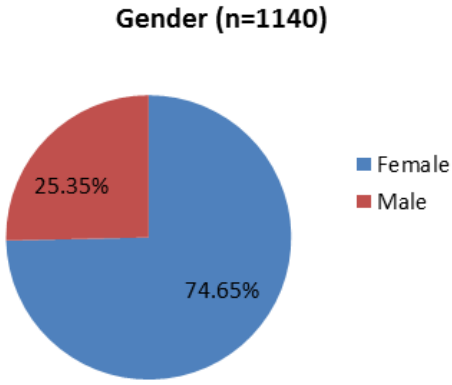
OUTCOMES FOR PARTNERS IN SUICIDE

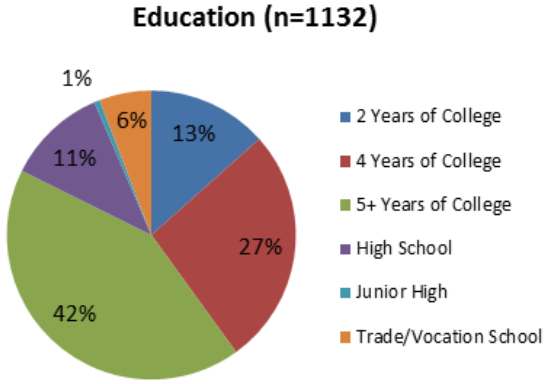
Los Angeles County Department of Mental Health has chosen to implement a suicide prevention program in the form of training and education that has shown to be effective in changing attitudes, knowledge, and/or behavior regarding suicide. Participants in these trainings include but are not limited to first responders, teachers, community members, parents, students, and clinicians. For trainings conducted in FY 16-17, changes in knowledge about suicide were measured using the Suicide Prevention (SP) survey. Participants complete the "pre" survey, just prior to the training to assess their baseline level knowledge about suicide prevention and then complete the "post" survey shortly after completing the training. Increases in participants' survey scores from "pre" to "post" suggest knowledge about suicide prevention has been improved.

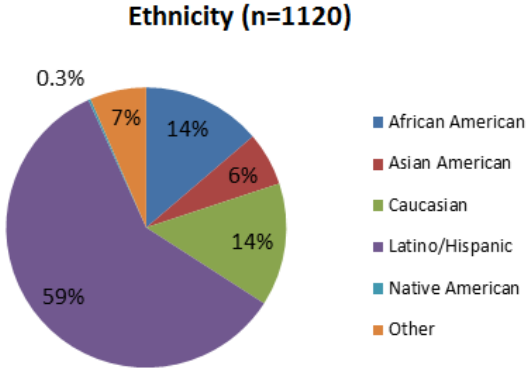
Survey Results

Surveys: 1,197

Los Angeles County Department of Mental Health has chosen to implement a suicide prevention program in the form of training and education that has shown to be effective in changing attitudes, knowledge, and/or behavior regarding suicide. Participants in these trainings include but are not limited to first responders, teachers, community members, parents, students, and clinicians. For trainings conducted in FY 16-17, changes in knowledge about suicide were measured using the Suicide Prevention (SP) survey. Participants complete the "pre" survey, just prior to the training to assess their baseline level knowledge about suicide prevention and then complete the "post" survey shortly after completing the training. Increases in participants' survey scores from "pre" to "post" suggest knowledge about suicide prevention has been improved.



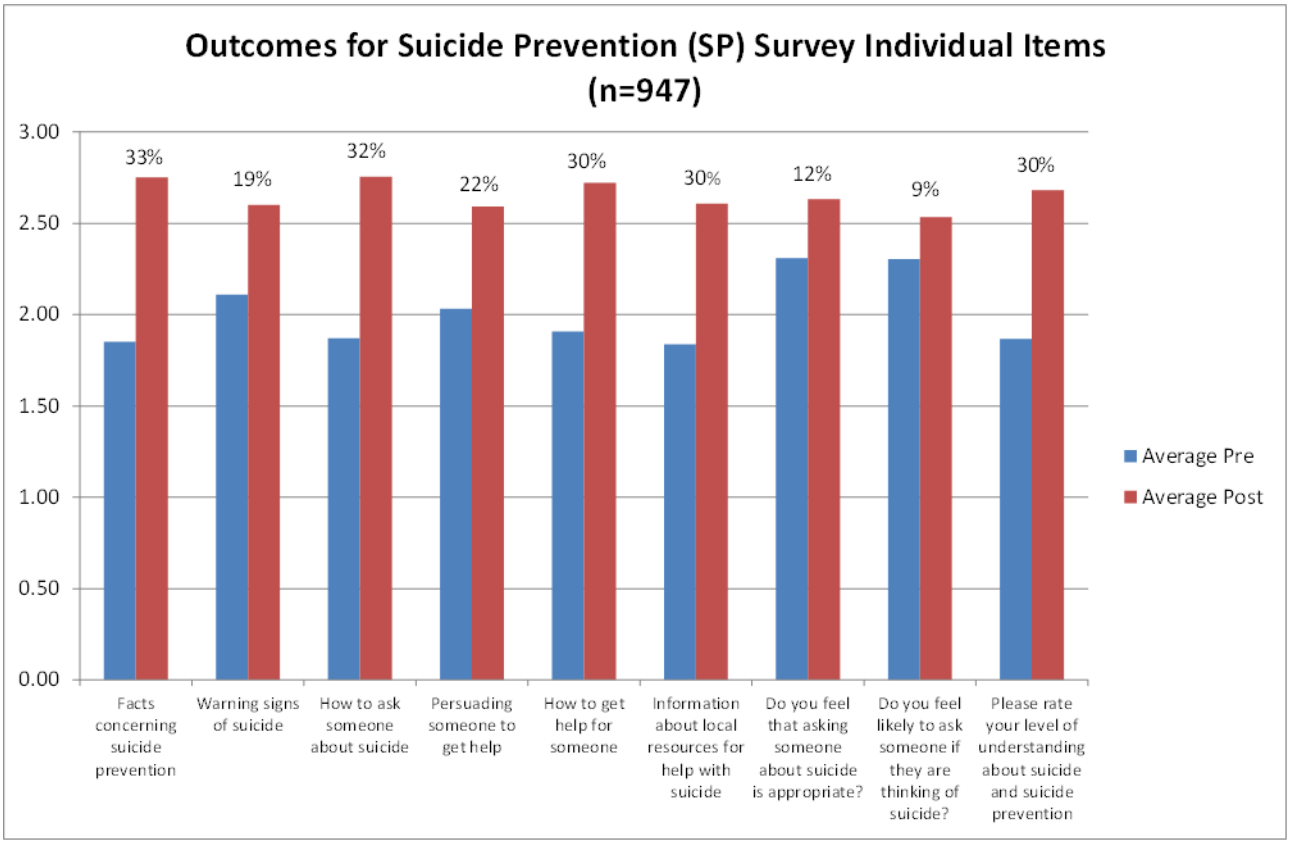




SUICIDE PREVENTION

SP survey results for FY 16-17 suggest participants' knowledge about suicide increased through training and education, with average total score increases from "pre" to "post" of 24% (947). Suicide prevention trainings have shown positive outcomes since inception in FY 13-14. In FY 13-14 and 14-15 combined, participants showed an average 30% increase in knowledge about suicide prevention, and in FY 15-16 participants showed an average 25% increase in knowledge about suicide prevention, as measured by the SP survey.

Below, is chart showing the average percent change in score from "pre" to "post" training for each of the nine suicide prevention survey items, as well as few statements about the results.



- Items 1 and 3 showed the greatest improvement in score from "pre" to "post", increasing by 33% and 32%, respectively.
- Items 7 and 8 showed the least improvement in score from "pre" to "post", increasing by 12% and 9%, respectively. These items likely changed the less than the others' because: 1) their average "pre"-scores were higher than the other items', which created a "ceiling effect," i.e. scores on items 7 and 8 could not improve from "pre" to "post" as much as scores on the other items 2) items 1-6 and 9 measure changes in knowledge while items 7 and 8 measure changes in behavior and typically, for instructive interventions like Suicide Prevention, measures of knowledge show greater change from "pre" to "post" treatment than measures of behavior.

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.

In Fiscal Year 2016-17, the School Threat Assessment Response Team (START) continued to play an integral part in the prevention and early intervention of the campus-related violence. Their timely response and initiative in collaboration with school faculty members, law enforcement, and other professionals established the unyielding foundation of the safety network on campus. The efficiency of START's services was evidenced by the reduction of violent and/or suicidal risk scores measured respectively by the MOSAIC and the Columbia-Suicide Severity rating Scale (C-SSRS). This accomplishment was achieved by START's dedicated management and clinical staff who put the safety and well-being of our community at large as their top priority.

START administered pre- and/or follow-up MOSAIC and C-SSRS assessments periodically to report the risk levels of the127 clients whose cases remained open in Fiscal Year 2016-17. Additionally, 87 clients were provided time-limited outreach and triage services given their repeated absence and/or ineligibility for START services.

A. Demographic Characteristics

Of the 127 cases, male and female were 80.31% and 19.69% (Table 1). 51.18% aged between 0 and 15, while 31.50% aged between 16-25, and 17.32% older than 25 years old. 84.25% of the 127 cases identified English as their spoken language (Table 3). Hispanic clients made up of 51.18% of the service group (Table 4). To meet the clients' cultural need, three fourths of the START clinicians are Spanish-speaking and proficient in the Hispanic culture. In Table 5: Service Area, SA 2 was the most served area (23.62%), followed by SA's 4 and 8 (16.54%), SA 3 (15.75%), SA 7 (11.02%), SA 6 (10.24%), SA 5 (4.72%), and SA 1 (1.57%).

Table 1: Gender

Gender	Client Count	%
Male	102	80%
Female	25	20%
Total	127	100%

Table 2: Age

Age Group	Client Count	%
0-15	65	51%
16-25	40	32%
26-59	22	17%
Total	127	100%

Table 3: Spoken Language

Language	Client Count	%
English	107	84%
Spanish	18	14%
Farsi	1	0.79%
Armenian	1	0.79%
Total	127	100%

Table 4: Ethnicity

Ethnicity	Client Count	%
Hispanic	65	51%
White	21	17%
Black	19	15%
Chinese	4	3%
Other White	4	3%
Filipino	3	2%
Korean	3	2%
American Indian or Alaska Native	1	1%
Asian Indian	1	1%
Cambodian	1	1%
Other	5	4%
Total	127	100%

Table 5: Service Area

Service Area	Client Count	%
SA1:Antelope Valley	2	2%
SA2:San Fernando	30	24%
SA3: San Gabriel	20	16%
SA4: Metro	21	17%
SA5: West	6	5%
SA6: South	13	10
SA7: East	14	11%
SA8: South Bay/Harbor	21	17%
Total	127	100%

B. Primary Diagnosis

The four most common primary diagnoses were Major Depressive Disorder (20.47%), followed by Mood Disorder (21.26%), Schizophrenia Spectrum and Other Psychotic Disorder (18.90%), and Disruptive, Impulse-control and Conduct Disorder (9.45%).

Table 6: Primary Diagnosis

Primary Diagnosis	Client Count	%
Major Depressive Disorder	26	20%
Mood Disorder	27	21%
Schizophrenia Spectrum & Other Psychotic Disorder	24	19%
Disruptive, Impulse-control, and Conduct D/O's	12	9%
Adjustment Disorder	10	8%
Post-traumatic Stress Disorder	9	7%
Anxiety Disorder	6	5%
Attention Deficit Hyperactivity Disorder	5	4%
Bipolar Disorder	4	3%
Neurodevelopment Disorder	2	2%
Obsessive-compulsive & Related Disorder	1	1%
Substance Related and Addictive D/O	1	1%
Total	127	100%

C. Services Rendered

The three most utilized service types were plan development (56.53%), followed by psychiatric diagnostic interview (14.67%), target case management (14.80%). On the average, each client received 11.81 services in FY 16-17: 1500 services by 127 clients.

Table 7: Types of Services

Procedure Code	Total	%
Plan Development	848	57%
Psychiatric Diagnostic Interview	220	15%
Target Case Management	222	15%
Non Billable to Medi-cal crisis intervention due to lack of medical necessity or a lockout but are billable to other available payer	75	5%
Individual Rehabilitation	53	4%
Collateral Contact	46	3%
Non Billable to Medi-cal MHS due to lack of medical necessity or a lockout but are billable to other available payer	15	1%
Crisis Intervention	11	0.73%
Non Billable to Medi Cal TCM due to lack of medical necessity or a lockout but are billable to other available payer	8	0.53%
Outcome Measurement	2	0.13%
Total	1500	100%

D. Change in Violent and Suicidal Risk Level

(a) MOSAIC : The MOSAIC is a computer-assisted assessment rating tool which quantifies threats of violence on a 1-to10 scale with the reliability indicator of IQ score: (1). MOSAIC 1-4 = Low, 5-7 = Medium, 8-10=High, IO = or >125; and (2). The IQ score less than 125 indicates insufficient number of answers as a result of improvement made by clients or lack of information collected. A minus in the MOSAIC score means a reduction in the violent risk.

Table 8: MOSAIC Baseline

Initial Mosaic Score	Client Count	%
2	1	1%
3	7	6%
4	27	21%
5	43	34%
6	34	27%
7	14	11%
8	1	1%
Total	127	100%

At the time of admission clients presented:

- 27.56% low violent threat risk
- 71.65% medium risk
- 0.79% high risk

Table 9: Reduction in MOSAIC Violent Risk Score

Most Recent MOSAIC - Initial MOSAIC	Client Count	%
-4	1	1%
-3	3	2%
-2	25	20%
-1	24	19%
0	64	50%
1	7	6%
2	2	2%
4	1	1%
Total	127	100%

Most recent MOSAIC:

- 42% showed a decrease in the violent threat level
- 50% remained with the same score
- 8% increased in violent threat level

(b) Columbia-Suicide Severity rating Scale (C-SSRS): C-SSRS Suicidal Ideation Subscale consists of a five-point scale designed to assess the level of suicidal ideation. 1 point-wish to be dead,; 2 points-non-specific active suicidal thoughts; 3 points-active suicidal ideation with any methods (not plan) without intent to act; 4-points-active suicidal ideation with some intent to act without specific plan; 5 points-active suicidal ideation with specific plan and intent.

Table 10: C-SSRS Baseline Using Lifetime Score

Suicidal Ideation Lifetime	Client Count	%
0	63	50%
1	10	8%
2	11	9%
3	9	7%
4	10	8%
5	24	19%
Total	127	100%

- 26.77% of the 127 clients presented critical suicidal risk in their entire life-time at baseline

Table 11: C-SSRS Baseline Using Past One Month Prior to the Initial Assessment

Suicidal Ideation Past One Month	Client Count	%
0	80	63%
1	8	6%
2	9	7%
3	6	5%
4	7	6%
5	17	13%
Total	127	100%

Table 12: Reduction in C-SSRS Suicidal Risk Score

Suicidal Ideation Since Last Visit - Past One Month Prior to Admission	Client Count	%
-5	12	10%
-4	6	5%
-3	8	6%
-2	10	8%
-1	9	7%
0	72	57%
1	2	2%
2	2	2%
3	1	1%
5	1	1%
No Follow-up Test Scores	4	3%
Total	127	100%

Of the 127 clients who completed pre- and follow-up measurements (Table 13):

- 43% reduced their suicidal ideation
- 57% remained the same scores for suicidal ideation

Table 13: Referrals and Cases Opened in the HEAT Team from January to June, 2017

South Team	North Team	Total
16	12	28

F. Trainings

In FY 2016-17, START provided 41 trainings to 1580 attendees in the four subject matters: bullying, targeted school violence, orientation to START services, and field safety.

Table 14: Trainings

Training	Bullying		Targeted School Violence		START		FIELD SAFETY	
	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees
12th Grade or below	1	30	0	0	0	0	0	0
College Students	0	0	1	41	5	363	0	0
Professional	1	9	10	416	15	377	3	116
Parent/ Other	1	17	2	86	2	125	0	0
Total	3	56	13	543	22	865	3	116

PREVENTION

The following Prevention programs were identified for implementation through the development of the PEI Three-Year Plan for Fiscal Years 2017-18 to 2019-20 and are currently in the stages of development:

BOYS AND GIRLS CLUB PROJECT LEARN

Age Group: Children (7-15), TAY (16-18) **Target Population:** At-risk Youth

This program involves enhancing the educational performance and well-being of low income youth who are at-risk of school failure and involvement with the juvenile justice system. After school program services are offered at Boys and Girls Clubs through teams of local BGCA staff, school staff, parents, and students. In addition to assistance with academic problems, activities focusing on conflict resolution, social and behavioral skills, anxiety and coping skills will be available.

DOMESTIC VIOLENCE AND INTIMATE PARTNER VIOLENCE SERVICES)

Age Group: TAY (16-25), & Adult (26-59) **Target Population:** Vulnerable Communities

This is a community-based outreach and engagement, educational prevention program to reduce and/or eliminate domestic abuse, spousal abuse, battering, family violence, and intimate partner violence, patterns and behavior which involves the abuse by one partner against another in an intimate relationship such as marriage, cohabitation, dating or within the family. Educational awareness for at risk individuals, group and peer support meetings, and educational training for service providers working with victims will be initiated.

HEATHY IDEAS (IDENTIFYING DEPRESSION, EMPOWERING ACTIVITIES FOR SENIORS)

Age Group: Older Adults (60+) **Target Population:** Individuals & Family Under Stress

This is a community depression program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. The program incorporates four evidence-based components into the ongoing service delivery of care/case management or social service programs serving older individuals in the home environment over several months. *Program components include screening and assessment of depressive symptoms, education about depression and self-care for clients and family caregivers, referral and linkage to health and mental health professionals, and behavioral activation. Behavioral activation is a brief, structured approach to help clients reduce depressive symptoms through increased involvement in meaningful activities, which are pleasurable or reduce stress.

MINDFUL SCHOOLS

Age Group: Children (0-15), TAY (16-25), Adult (26-59) **Target Population:** Individuals & Family Under Stress

This is a school-based pilot project that will provide mindfulness training and technical assistance for students, school staff and parents in school settings ranging from Headstart programs, preschools and K to 12 schools. The program results include improved attention, emotional regulation, less reactivity, improved behavior in schools, social skills, stress reduction, reduced anxiety, improved well-being, and better behavior in schools. For teachers the program focuses on reduced stress and burnout.

OLWEUS BULLYING PREVENTION PROGRAM

Age Group: Children (5-15), TAY (16-18) **Target Population:** At-risk Youth

The Olweus Bullying Prevention Program is designed to improve peer relations and make schools safer, more positive places for students to learn and develop. Goals of the program include: reducing existing bullying problems among students, achieving better peer relations at school, and preventing the development of new bullying problems. 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.

PEI SUPPORTIVE HOUSING SERVICES

Age Group: All Ages **Target Population:** Vulnerable Communities

The goal of this model is to provide PEI services to the residents of Permanent Supportive Housing (PSH) that targets the risk factors with the goal of increasing the protective factors. The model includes a PEI Lead that will coordinate the services along with a team of clinical staff in each Service Area (SA). The SA PEI team will assess the needs for PEI interventions and supportive services in each of the PSH developments based on the population living there, identify appropriate PEI strategies and providers and/or provide the PEI services directly. Services will be provided onsite whenever possible, including mentoring/coaching, school help, life skills, and renting skills.

POSITIVE ACTION

Age Group: Children (12-15) & TAY (16-18) **Target Population:** At-risk Youth

Positive Action is an integrated and comprehensive curriculum-based program that is designed to improve academic achievement, school attendance, and problem behaviors such as substance use, violence, suspensions, disruptive behaviors, dropping out, and sexual behavior. It is also designed to improve parent–child bonding, family cohesion, and family conflict. Cheaper for schools to sustain and materials are free online.

PROJECT FATHERHOOD

Age Group: Children (0-15), Parents/Caregivers & TAY (16-18) **Target Population:** Strengthening Family Functioning

This program that provides comprehensive parenting skills to men in caregiving roles using an innovative support group model. The program was developed to give urban, culturally diverse caregivers an opportunity to connect with their children and paly a meaningful role in their lives. The program continues to be recognized nationally for effectively addressing the problem of absentee fathers. Through therapy, support, parenting education and other services, fathers learns to be more loving, responsible parents and active participants in their children's lives. Project Fatherhood helps fathers to be better parents through: Individual and family counseling; Group support; Significant others group; Therapeutic activities for children; Preventing child abuse and neglect; and Helping fathers to make healthier decisions in relationships. At the heart of the program is the Men in Relationships Group (MIRG), which provides comprehensive support at no cost for culturally diverse fathers.

SAFE SCHOOLS AMBASSADORS

Age Group: Children (5-15), TAY (16-18) **Target Population:** At-risk Youth

The Safe School Ambassadors (SSA) program is a bystander education program that aims to reduce emotional and physical bullying and enhance school climate in elementary, middle, and high schools. The program recruits and trains socially influential student leaders from diverse cliques and interest groups within a school to act as "Ambassadors" against bullying. A Train-the Trainer program facilitates sustainability of the program in schools.

SENIOR REACH

Age Group: Older Adults (60+) **Target Population:** Vulnerable Communities

Senior Reach is an innovative evidence-based program that provides behavioral health, case management, and wellness services to older adults age 60+ and older, who are isolated, frail and in need of support. Senior Reach focuses on identifying and engaging this high-risk target population via a population-based health intervention model. The program provides counseling and wellness services and trains individuals in the community to identify and refer seniors in need. Services will be provided by community and faith-based organizations, non-traditional mental health providers, and the County Community and Senior Services.

VETERANS COMMUNITY COLLEGES OUTREACH AND CASE MANAGEMENT SERVICES

Age Group: TAY (16-25) & Adults (26-59) **Target Population:** Vulnerable Communities

Services will be provided by veterans to veterans attending Community Colleges in Los Angeles. The overall goals of the program are to: 1) increase access, coordinate care, and enhance the capacity of multiple organizations to work together in order to achieve better outcomes for military personnel and their families; 2) provide a newly trained cadre of case managers and faculty capable of helping military personnel and their families manage the pressures of combat-related stressors and post-war adjustments; and 3) develop peer support and training/employment opportunities for veterans. The collaboration with the colleges will focus on intensive case management as well as access to employment, housing and mental health resources to veterans who are suffering from PTSD and other emotional issues resulting from combat duty.

VETERANS MENTAL HEALTH SERVICES

Age Group: TAY (16-25), Adults (26-59) & Older Adults (60+) **Target Population:** Vulnerable Communities

A range of services to Veterans countywide will be expanded and initiated, including services emphasizing peer support, female veterans services, and suicide prevention, and retreats. Collaboration with and coordination of services public and private existing veterans service organizations both in the development and implementation of services will occur, with grants with community-based and faith-based organizations working with veterans. Supportive housing services for Veterans, their partners,

VETERANS SERVICE NAVIGATORS

Age Group: TAY (16-25), Adults (26-59) & Older Adults (60+) **Target Population:** Vulnerable Communities

In collaboration with the County Department of Military and Veterans Affairs, this program utilizes military veterans to engage veterans and their families in order to identify currently available services, including supports and services tailored to the particular cultural, ethnic, age and gender identity of those seeking assistance. Staff follow up with the veterans and their families to ensure that they have successfully linked up and received the help they need. The Navigators engage in joint planning efforts with community partners, including veterans groups, veterans administration, 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 veterans within and outside the mental health system. Staff assists the veterans and their families by promoting awareness of mental health issues and work towards de-stigmatizing seeking help.

WHY TRY PROGRAM

Age Group: Children (7-15), TAY (16-18) **Target Population:** Vulnerable Communities

The Why Try Program is a resilience education curriculum designed for dropout prevention, violence prevention, truancy reduction, and increased academic success. It is intended to serve low income, minority students at risk of school failure, dropping out of school, substance use/abuse, and/or juvenile justice involvement. Why Try includes solution-focused brief therapy, social and emotional intelligence, and multisensory learning. It utilizes a series of ten visual analogies that teach important life skills (e.g., decisions have consequences; dealing with peer pressure; obeying laws and rules; plugging in to support systems).

Workforce Education and Training

The Los Angeles County 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 Los Angeles County, personnel shortages remain a constant concern; however, the needs far out weigh the positions available. In particular the 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, Older Adults, Homeless, and Justice involved.

HIGHLIGHTS

1. **12 participants completed the Homeless Outreach Peer Enhancement Training:** This program is intended to train peers and family members who volunteer in a shelter setting assist consumers identify their recovery goals related to mental health, physical health, substance abuse and stability.
2. **Licensure Examination Preparation:** During FY 2016/2017, 492 MSWs, MFT Interns, and Psychologists were registered in the Licensure Examination Preparation Program.
3. **102 individuals completed a Health Navigator Skill Development Training Program:** Of these, 39 completed Adult Navigation, 10 completed Family Health Navigation, 26 completed Housing Specialist Navigation, and 27 completed the TAY Navigation Training programs.
4. **43 individuals received career advisement to further their careers in the public mental health system:** All 43 participants in this program are currently employed in the public mental health system.
5. **2,047 Mental Health Promoter presentations delivered:** 18,624 community members attended presentations held in local communities of Service Areas 4, 7, and 8.
6. **All 8 Service Areas operated a Faith-Based Roundtable group:** These faith-based roundtables support clergy from various religions collaborate with mental health professionals (and vis a versa) address issues and concerns of congregants and mental health consumers mutually served.
7. **165 staff members participated in the interpreter training program:** Bilingual non clinical and clinical staff are trained to effectively interpret and/or use interpreters, respectively. (Not unique number as some individuals participated in more than one training component.)
8. **60 participants completed Intensive Mental Health Recovery Specialist Training Program:** These participants were trained to work in the public mental health system as mental health rehabilitation specialists.
9. **100 online slots for Pre-Licensure Training were secured for employees of the public mental health system:** Slots provided staff pre-licensure training to fulfill State Board mandates for licensure examinations.
10. **144 Stipends were awarded to 2nd Year MSW and MFT Student:** These stipends were 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.

WORKFORCE EDUCATION AND TRAINING (WET)

1-WET COORDINATION

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

2-LOS ANGELES COUNTY WET OVERSIGHT COMMITTEE

The Los Angeles County WET Oversight Committee assisted and continues to provide recommendations to the LACDMH. The Committee is composed of various subject matter experts, representing many underserved ethnicities in our County.

3-TRANSFORMATION ACADEMY WITHOUT WALLS

This program funds licensure preparation study materials and workshops for unlicensed social workers, marriage and family therapy interns, and psychologists. All participants must be employed in the public mental health system and eligible to take the mandatory Part I, and thereafter Part II of the respective licensure board examinations. Licensure Preparation Program (LPP) – The Licensure Preparation Program will continue with no changes for FY 2017-2018.

The number of participants for each specific exam during FY 2016-17 is as follows:

	DMH	*DMH Contracted*	*Total*	*Bilingual Clinician*	*Pass Rate*
MSW Law & Ethics	91	85	176	69%	28%
MSW Clinical Exam	83	34	117	65%	41%
MFT Law & Ethics	7	90	97	57%	30%
MFT Clinical Exam	15	58	73	67%	29%
EPPP for Psychologists	11	12	23	43%	26%
CPLEE for Psychologists	2	4	6	83%	33%
Total	**209**	**283**	**492**	**64%**	**31%**

Mental Health Promoters
Community members are trained as mental health promoters. With continued support these individuals have become community champions and liaisons educating their respective communities on available mental health services and promoting anti-stigma campaigns. Presently, 89 promoters are trained. During FY 16-17, these individuals presented to 18,624 community members, thru 2,047 communities based presentations.

TRAINING COURSE	TRAINED
Adult Navigators	39
Family Navigators	10
Peer Housing Navigators	26
TAY Navigators	27
TOTAL	**102**

Health Navigator Skill Development Program
This program trains individuals and supervisors on knowledge and skills needed to assist consumers navigate and likewise advocate for themselves in both the public health and mental health systems. During FY 2016/2017, 102 participants completed navigation training.

Online Pre-Licensure Training
Online pre-licensure trainings were available to unlicensed clinical staff. A total of 100 slots were secured (50 for Child Abuse Assessment and Reporting [7 hours]; and 50 for Aging, Long Term Care and Elder/Dependent Adult Abuse [10 Hours]). All 100 slots were utilized by staff and completed.

6-INTERPRETER TRAINING PROGRAM

The Interpreter Training Program (ITP) offers trainings for bilingual staff that currently performs or interested in performing interpreter services and to monolingual 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.

FY 2016/2017 Outcomes:

Training Title	Total
Interpreter Training in Mental Health Setting (21 Hours)	54
Advance Training (7 hours)	6
Increasing Spanish MH Clinical Terminology (7 Hours)	105
Total	**165**

7-TRAINING FOR COMMUNITY PARTNERS

Faith Based Roundtable Project

This project continues to bring together clergy and mental health staff 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. As of FY 2016/2017, all eight service areas continue to participate in these Roundtable sessions. The program funds a consultant to assist in facilitating the roundtables and provide consultation services when needed.

There will be no significant change to the program model during FY 2017/18.

8 - INTENSIVE MENTAL HEALTH RECOVERY SPECIALIST TRAINING PROGRAM

Intensive Mental Health Recovery Specialist Training Program prepares 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 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 2016/2017, 60 individuals interested in employment in the public mental health system completed the training. Of these participants, 85% represented individuals from un- or under- served populations, and 72% spoke a second language, other than English.

No changes are planned for FY 2017/2018.

9 - EXPANDED EMPLOYMENT AND PROFESSIONAL ADVANCEMENT OPPORTUNITIES FOR CONSUMERS IN THE PUBLIC MENTAL HEALTH SYSTEM

Homeless Outreach Peer Enhancement (HOPE)
This program is intended to train mental health peers and family peers who volunteer in a shelter setting to assist consumers identify their recovery goals related to mental health, physical health, substance abuse and stability. During the pilot project in FY 16-17, 12 individuals received this training. The HOPE program is scheduled to be repeated during FY 17-18.

Macro Peer Advocacy Program
This program is targeted to peers, family advocates and members to effectively promote and empower the consumer voice and advocate for continued support of MHSA recovery, resilience, and wellness tenets. Components include the legislative process, communication strategies for both written and in person presentation with county and state constituents, and development of successful political collaborative/relationship approaches. During FY 16-17, 130 peers participated in this training.

Social Rehabilitation Curriculum Building Consultation
Focus groups, consisting of social rehabilitation staff and supervisors across the public mental health system, were conducted to identify competencies necessary for delivery of social rehabilitation specialist services. Six focus group sessions were held, with a total of 45 individuals participating in these focus groups. Based on the Focus Groups' recommendations, competency based trainings are to be developed and implemented. This was a one-time research effort and will not be repeated during FY 17-18.

Working With Psychosis in Community Mental Health
The training will provide participants with awareness about the experiences individuals hearing voices endure and how these experiences impact their lives and recovery process. During FY 2016/2017, 37 individuals participated in this training.

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 solicited with training anticipated to begin FY 2017/2018.

11 - EXPANDED EMPLOYMENT AND PROFESSIONAL ADVANCEMENT OPPORTUNITIES FOR FAMILY MEMBERS IN THE PUBLIC MENTAL HEALTH SYSTEM

These trainings prepare family members of consumers to develop or augment skills related to community outreach, advocacy and leadership and decrease barriers to employment. These trainings include such topics as public speaking, navigating systems, and resource supports for consumers and families. This program is funded with the intent to target/outreach family members about mental health services in the community meeting the objective of the program outlined in the MHSA-WET Plan.

Training Component	Train-The-Trainer Participants	New Speakers Trained	Presentation Participants
Adult Consumers Advocacy Speakers			158
Family Advocacy Speakers			26
Family Support and Advocacy Training	4	50	574
Family Support and Advocacy Training In Spanish		20	160
Family Advocacy Lobby Outreach Program		12	120
Parent/Caregiver Advocate Provider Training Program			150
Parent/Caregiver Advocate Wellness and Recovery Training Program			500
Child/Adolescent Consumer Advocacy Speakers Bureau		40	34
Parent Advocacy Speakers' Bureau		20	30
Parent Support and Advocacy Training Bureau	4	21	85
Parent Support and Advocacy Training Bureau in Spanish		8	65
Parent and Teachers Joint Advocacy Program		22	350
TOTALS	**8**	**193**	**2,252**

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 include: the provision of ongoing career advisement, coordination and development of career goals, linkage to job training resources, mentoring, and information sharing and advocacy. The Mental Health Career Advisors function as a one-stop shop for upward career mobility. A pilot program began services September 2014.

During FY 2016-17, 43 individuals received an aggregate total of 101 career advisement sessions.

18 – SEEKING SAFETY FOR INTERNS

In the effort to better prepare interns for potential employment in the public mental health system, 47 interns were offered training in the evidenced-based-practice known as Seeking Safety.

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 3 different type of awards, as follows:

Tuition Reimbursement Program
Tuition reimbursement will be available for staff pursuing coursework leading to career advancement opportunities in the LA County public mental health system. Tuition will be reimbursed to staff enrolled in a Certificate, Associate's, Bachelor's, Master's, or Doctorate program(s). Reimbursable courses must fulfill requirements defined in the Los Angeles County Human Resources Management System Policies, Procedures, and Guidelines Manual under Section 123, for "Accredited College Education." Awardees will receive up to $15,000 in exchange for a one year commitment to work in the public mental health system

Loan Forgiveness Program
Loan repayment assistance will be available to staff employed in the public mental health system of LA County in exchange for continuous employment in a hard-to-fill/retain mental health program. Direct service providers or supervisors of direct service providers are eligible to apply. Two distinct repayment programs are available: clinical/ direct service (non-MD) staff and Mental Health Psychiatrists.

UsCC Recruitment Pilot
Individuals from underserved communities both culturally and/or linguistically competent to service their respective communities are eligible to apply. This program offers 2 options for awarded individuals. Option 1 includes a 1 year paid "internship" in the public mental health system, with 2 years of Master's Degree Stipend award. Option 2 includes the 2 years of Master's Degree Stipend award only.

21 - STIPEND PROGRAM FOR PSYCHOLOGISTS, MSWS, MFTS, PSYCHIATRIC NURSE

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 2016/2017 this program was available to 70 MFT, 74 MSW students. During this award cycle, all stipends were awarded. 76% of all recipients identified from populations recognized as un- or under- served. During the same cycle, 69% spoke a threshold language.

In addition to the stipends, 6 post-doctoral fellows were also funded.

No significant change is expected for this program during FY 2017/2018.

Innovation

During Fiscal Year 2016-17, there were no active Innovation projects. The following projects are beginning implementation or in development.

INNOVATION 2: TRAUMA RESILIENT COMMUNITIES: COMMUNITY CAPACITY BUILDING

The solicitation was issued in July, 2017. The Department anticipates the selection of lead agencies and the Board's approval to move forward by April, 2018, followed by a 2 day kick-off meeting with lead agencies and their partners. The evaluation of Innovation 2 will be through a solicitation process. The Department anticipates the solicitation being released in mid-February, 2018.

INNOVATION 3: TECHNOLOGY SUITE

Los Angeles, in conjunction with several California counties, is part of a technology collaborative to improve access to mental health care and detect mental health symptoms earlier.

Technology is being used regularly as a tool to assist people with parking their cars, paying their bills, detecting physical activity, and measuring sleep-quality, among numerous other examples. At the same time, recent research demonstrates that technology can be used to impact health and mental health service delivery, thereby influencing various important metrics such as decreasing hospital and emergency department utilization. The Department of Mental Health (DMH) received approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to use Innovation Funds to implement a technology-based project in October, 2017. The project, led by LA County with a number of other California counties now in tow, will bring technology to the public mental health system through a highly innovative set or "suite" of applications designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional/behavioral destabilization, connect individuals seeking help in real time, and increase user access to mental health services when needed.

Components of the Technology Suite

Accessible from a computer, cell phone and tablet utilizing customized applications for:

1. Digital detection of emotional, thought and behavioral disturbances through passively collected data and sophisticated analyses that sense changes in the user interface known to correlate with social isolation, depression, mania, the early psychotic (prodromal) syndrome, and other indicators of either the onset of new mental illness or the recurrence of a chronic condition. As concerning signals are detected, communication to the user is generated through texts, emails, peer (see below) or clinician outreach to prompt care.

INNOVATION 3: TECHNOLOGY SUITE (CONTINUED)

2. A web-based network of trained and certified peers on call to chat 24/7 with individuals experiencing worsening symptoms of mental illness as well as family members and caregivers. A link to this network available through the reengineered DMH website and other forms of social media will be used to widely disseminate the service across Los Angeles County. It will be branded as both a support and a triage tool for anyone experiencing problems at any time, especially those unfamiliar with self-management techniques, confused or unclear about the resources available for help, or reluctant to walk into a mental health clinic.
3. Virtual, evidence-based on-line treatment protocols that use avatars to deliver clinical care. By their nature as virtual tools, this client-provider interface is available 24/7 and can be accessed in the convenience of home environments, clinical settings, and even on smart phones.

Goals

1. Detect mental illness earlier, including depression, suicidal feelings and psychosis
2. Intervene earlier to prevent mental illness and relapse and improve client outcomes
3. Provide alternate modes of engagement, support and intervention.

Target Population

The target population or intended beneficiaries or users of technology-based mental health solutions:

- Individuals with sub-clinical mental health symptom presentations, including those early in the course of a mental health condition who may not recognize that they are experiencing symptoms, including college students.
- Individuals identified as at risk for developing mental health symptoms or who are at risk for relapsing back into mental illness
- Socially isolated individuals, including older adults at risk of depression
- High utilizers of inpatient psychiatric facilities
- Existing mental health clients seeking additional sources of support
- Family members with either children or adults suffering from mental illness who are seeking support
- Individuals at increased risk or in the early stages of a psychotic disorder

Each county participating in the Technology Suite will transfer associated funding to the California Mental Health Services Authority (CalMHSA), a Joint Powers Authority created to support statewide mental health projects. DMH anticipates that Los Angeles County Board of Supervisors will adopt a Board Letter authorizing the transfer of funding for this project to CalMHSA on February 20, 2018.

INNOVATION 4: MOBILE TRANSCRANIAL MAGNETIC STIMULATION

Los Angeles County Department of Mental Health (LACDMH) proposes to implement Transcranial Magnetic Stimulation (TMS) as a treatment for psychiatric disorders. TMS is a non-invasive treatment that can enhance or suppress the activity of neurons in targeted areas of the brain through the use of electromagnetic stimulation. Currently, TMS is F.D.A. approved for the treatment of depression and, according to the American Psychiatric Association best practice guidelines for the treatment of major depressive disorder, TMS is now a first-line treatment for depression that has not responded to one antidepressant medication (APA 2010) as well as being effective for treatment-resistant depression. In addition, recent clinical studies suggest that TMS can be an effective treatment for a number of other psychiatric disorders, including substance use disorders, schizophrenia, obsessive-compulsive disorder, and post-traumatic stress disorder. TMS uses precisely targeted magnetic pulses similar to those used in Magnetic Resonance Imaging (MRI) to stimulate key areas of the brain that are underactive in patients with depression. The patient reclines comfortably in the treatment chair and is awake and alert during treatment. An electromagnetic coil is then placed directly to the target area of the brain where the device generates magnetic fields that alter the electrical activity of neurons. The enhancing or suppressing of neuron activity depends upon a number of variables including the frequency of the TMS pulses. During treatment, the patient hears a clicking sound and feels a tapping sensation on the head. The patient can go back to their normal activities immediately after treatment. Treatment can last between 10-45 minutes and is administered once per day for 5 consecutive days per week for 4-8 weeks. LACDMH proposes to implement a mobile TMS program for individuals residing in Board and Care (B&C) facilities that suffer from treatment-resistant depression that is not responsive to antidepressant medication or therapy. DMH estimates serving 384 clients a year across approximately 8 Board and Care facilities.

TMS program would both bring a novel, effective treatment to this population and also overcome a major barrier to treatment adherence because the treatment would be brought directly to their place of residence. The Department plans to purchase and retrofit a large sprinter van that will contain the TMS device, coil holder, coil cooling system, and a TMS chair. It will be equipped with a generator that can power the TMS system as well as an internet link for charting, medical records and telepsychiatry.

TMS has become a standard treatment in private practice and in academic centers across the country. However, this treatment has been unavailable to clients in the Specialty Public Mental Health system. Therefore, we propose the development of an innovative mobile TMS treatment network that directly brings this treatment to individuals with chronic mental disorders.

The goals of this project include:

- Provide access to new and effective treatment to clients with chronic and severe mental illness
- Increase adherence to treatment by bringing the treatment to the client
- Reduce use of other resources (i.e., psychiatric hospitalization, Emergency Room visits, intensive supportive services, etc.)
- Improve social and occupational functioning that would lead to successful community reintegration
- Collect and analyze data to support treatment efficacy for treatment-resistant depression and other psychiatric conditions in this population

The project would be a 3 year demonstration project.

INNOVATION 4: MOBILE TRANSCRANIAL MAGNETIC STIMULATION (CONTINUED)

Target Population

The target population includes individuals residing in board and care facilities that have a depression as a major part of their psychiatric symptoms and one or more of the following:

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to at least two psychopharmacologic agents in the current depressive episode; or
- Inability to tolerate psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from two different agent classes; or
- History of response to TMS in a previous depressive episode; or
- A history of response to ECT in a previous or current episode or an inability to tolerate ECT, or is a candidate for, but has declined ECT and TMS is considered a less invasive treatment option.

However, because of the nature of the TMS treatment, we would exclude individuals with a history of seizure disorder and those with metal implants in the head or upper torso (e.g., cardiac pacemakers).

The components of this Innovation project are as follows:

1. Purchase TMS device and accessories including modified van that will transport the treatment to contracted board and care facilities in Los Angeles County.
2. A lead psychiatrist will oversee initial TMS treatment sessions and track progress by collecting symptoms and functional outcomes that can, in turn, be used to judge the efficacy of this program.
3. Hire and train staff (Nurse, Psychiatric Technician) to operate equipment.
4. Identify Board and Care facilities with higher numbers of clients who meet criteria listed in Target Population above and engage and educate facility operators.
5. Engage clients at facilities. Once clients have been identified and agree to treatment, they will be seen 1 times per day for 5 consecutive days per week for 4-8 weeks.
6. As clients begin treatment, client satisfaction and reactions will guide use of TMS within each facility.
7. Administer outcome measures at the beginning and end of each week of treatment. Outcome measures may include the following: Quick Inventory of Depressive Symptoms (QIDS-16, patient rated), the Hamilton Depression Rating Scale (HDRS, clinician rated), and a measure for adaptive daily living and quality of life. Additional rating scales may be used to track comorbid symptoms as appropriate. These assessment tools will enable clinicians to track improvements in depressive symptoms and functional outcomes that can, in turn, be used to judge the efficacy of this program.

DMH will seek approval for this project from the MHSOAC on February 22, 2018.

Capital Facilities

The table below is the spending plan for the remaining dollars to be spent on Capital Projects for the Department of Mental Health.

Project	Supervisorial Dist.	Cost	Project Description
Downtown Mental Health Center	2	$15,900,000.00	The purchasing of a 25,000 sq. ft. building for $3.5 Million was completed. The building was refurbished , retro fitted and opened for business in December 2015. Building houses 70 staff and services approximately 220 clients per day providing direct services to clients in the surrounding vicinity. This was project was completed with a cost savings of $1.9m
Arcadia Mental Health Center	5	$13,500,000.00	The new building was finished September 2015. The building is 12,000 sq. ft. and was build on the parking lot of the old clinic. 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. This was completed with a cost savings of $2.7m
Downtown Parking Lot	2	$2,800,000.00	Parking lot for sale that services the Downtown FSP, Men's Reintegration, PEI and other outpatient programs. If the parking lot is not purchased by DMH, staff will have nowhere to park.

Technological Needs

INTEGRATED BEHAVIORAL HEALTH INFORMATION SYSTEM

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.

STATUS

- DMH has completed its implementation and rollout of the vendor's COTS Electronic Health Record (EHR) across its Directly Operated (DO) Programs, 148 sites in total use the EHR. New programs are on-boarded on a regular basis in accordance with established operational support processes. DMH employees at the Juvenile Justice Halls and Camps will be migrated to IBHIS by December 31, 2017. This will allow DMH staff to maintain care coordination between both departments until a viable electronic data exchange solution has been identified and implemented.
- DMH has completed transitioning seventy-four (74) Contract Providers ((seventy (70) Legal Entities (LEs) and four (4) Fee for Service (FFS) providers) to IBHIS as of March 31, 2017. The LEs are not direct users or IBHIS; they submit their data electronically.
- About 55% of DO providers are at or above their pre-IBHIS claiming levels.
- County has deferred interfaces to its Credentialing and eCAPS (County finance) systems because it simply isn't practical as long as DMH uses both the IS and IBHIS. The expectation is that these interfaces will be revisited at a later date if deemed necessary.

ACCOMPLISHMENTS

- Completed the migration of one hundred and forty-eight (148) Directly Operated programs into IBHIS.
- Completed the transition of Seventy four (74) Contract Providers ((seventy (70) Legal Entities (LEs) and four (4) Fee For Service (FFS) providers) to IBHIS.
- Completed twenty (20) system modifications required to improve the efficiency of the claiming process in IBHIS in order to bring LE's onboard at volume.
- Completed Final System Acceptance.
- Transitioned IBHIS implementation activities into documented Support, Operations and System Maintenance processes.

SCHEDULED ACTIVITIES DURING THE NEXT REPORTING PERIOD:

- Continue with the LE and FFS on-boarding activities as scheduled.
- Continue Support and Operations processes, e.g., manage software change requests, manage system updates, enhancements and requests, test system updates, fixes, and modifications.
- Continue ongoing DO end-user training, site preparation and user readiness activities for new programs, and training and support for existing clinical and administrative IBHIS users at DO programs.

CONTRACT PROVIDER TECHNOLOGY NEEDS PROJECT

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.

STATUS

- 120 Contract Providers completed the project proposal review and approval process and prepared Technological Needs Funding Agreements (TNFA) for each Contract Provider that has at least one approved project
- 138 projects approved
- 120 TNFA(s) have been fully executed

ACCOMPLISHMENTS

- Completed review of three IT Project Proposal submissions from Legal Entity Contract Providers
- CPTT Workgroup Meetings: 01/19/2016, 05/26/2016, and 06/02/2016
- Assisted Legal Entity Contract Providers with IBHIS go-live readiness education and assist in communication with DMH with regard to the IBHIS provisioning and Web Services and EDI certification processes
- A total of 52 Legal Entity Contract Providers have gone live with IBHIS
- A total of 54 Legal Entity Contract Providers have fully expended their project dollars and completed their MHSA IT project

SCHEDULED ACTIVITIES DURING THE NEXT REPORTING PERIOD:

- Continue to assist Legal Entity Contract Providers with IBHIS go-live readiness education and assist in communication with DMH with regard to the IBHIS provisioning and Web Services and EDI certification processes
- Continue CPTT Workgroup Meetings on an as needed basis at least until all Legal Entity IBHIS Rollouts have been completed
- Ongoing project maintenance activities which includes contract management of existing Legal Entity Providers.
- Execute new TNFA with one legal entity that was not part of the original group identified for MHSA funding – Los Angeles Free Clinic (LE #01142).

Budget
FY 2018-19 through 2020-21 Three Year MHSA Expenditure Plan Funding

Summary

	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 2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	456,468,046	201,447,999	54,644,679			
2. Estimated New FY2018/19 Funding	417,953,154	104,488,288	27,499,924			
3. Transfer in FY2018/19[a/]	(12,654,023)			7,097,800	5,556,223	
4. Access Local Prudent Reserve in FY2018/19						0
5. Estimated Available Funding for FY2018/19	861,767,177	305,936,287	82,144,603	7,097,800	5,556,223	
B. Estimated FY2018/19 MHSA Expenditures	557,605,408	177,202,263	37,175,387	7,097,800	5,556,223	
C. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	304,161,769	128,734,024	44,969,216	0	0	
2. Estimated New FY2019/20 Funding	423,521,674	105,887,558	27,871,159			
3. Transfer in FY2019/20[a/]	(9,805,088)			7,097,800	2,707,288	
4. Access Local Prudent Reserve in FY2019/20						0
5. Estimated Available Funding for FY2019/20	717,878,355	234,621,582	72,840,375	7,097,800	2,707,288	
D. Estimated FY2019/20 Expenditures	542,310,490	165,317,200	29,175,387	7,097,800	2,707,288	
E. Estimated FY2020/21 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	175,567,865	69,304,382	43,664,988	0	0	
2. Estimated New FY2020/21 Funding	423,521,674	105,887,558	27,871,159			
3. Transfer in FY2020/21[a/]	(8,656,540)			7,097,800	1,558,740	
4. Access Local Prudent Reserve in FY2020/21						0
5. Estimated Available Funding for FY2020/21	590,432,999	175,191,940	71,536,147	7,097,800	1,558,740	
F. Estimated FY2020/21 Expenditures	542,310,490	165,317,200	28,135,387	7,097,800	1,558,740	
G. Estimated FY2020/21 Unspent Fund Balance	48,122,509	9,874,740	43,400,760	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	160,725,402
2. Contributions to the Local Prudent Reserve in FY 2018/19	0
3. Distributions from the Local Prudent Reserve in FY 2018/19	0
4. Estimated Local Prudent Reserve Balance on June 30, 2019	160,725,402
5. Contributions to the Local Prudent Reserve in FY 2019/20	0
6. Distributions from the Local Prudent Reserve in FY 2019/20	0
7. Estimated Local Prudent Reserve Balance on June 30, 2020	160,725,402
8. Contributions to the Local Prudent Reserve in FY 2020/21	0
9. Distributions from the Local Prudent Reserve in FY 2020/21	0
10. Estimated Local Prudent Reserve Balance on June 30, 2021	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.

BUDGET

Community Services & Supports

	Fiscal Year 2018/19					
	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. Full Service Partnerships	219,103,641	114,100,761	73,576,366		26,271,847	5,154,667
2. Recovery, Resilience & Reintegration	197,452,253	86,666,046	77,520,558		31,612,752	1,652,897
3. Alternative Crisis Services	59,131,811	37,577,252	18,138,064		1,418,565	1,997,930
4. Planning Outreach & Engagement	7,242,510	7,188,520	53,990		0	0
5. Linkage Services	12,891,903	12,692,101	136,150		11,575	52,077
6. Housing	75,681,119	75,681,119	0		0	0
Non-FSP Programs						
1. Recovery, Resilience & Reintegration	284,138,606	124,714,553	111,553,974		45,491,520	2,378,559
2. Alternative Crisis Services	64,059,464	40,708,691	19,649,570		1,536,779	2,164,424
3. Planning Outreach & Engagement	8,851,957	8,785,969	65,988		0	0
4. Linkage Services	6,941,793	6,834,208	73,311		6,232	28,042
5. Housing	1,544,513	1,544,513				
CSS Administration	42,190,408	41,111,675	1,078,733			
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	979,229,978	557,605,408	301,846,704	0	106,349,270	13,428,596
FSP Programs as Percent of Total	61%					

	Fiscal Year 2019/20					
	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. Full Service Partnerships	219,103,641	114,100,761	73,576,366		26,271,847	5,154,667
2. Recovery, Resilience & Reintegration	198,838,053	88,051,846	77,520,558		31,612,752	1,652,897
3. Alternative Crisis Services	58,459,811	36,905,252	18,138,064		1,418,565	1,997,930
4. Planning Outreach & Engagement	7,242,510	7,188,520	53,990		0	0
5. Linkage Services	12,891,903	12,692,101	136,150		11,575	52,077
6. Housing	60,402,919	60,402,919	0		0	0
Non-FSP Programs						
1. Recovery, Resilience & Reintegration	286,132,806	126,708,753	111,553,974		45,491,520	2,378,559
2. Alternative Crisis Services	63,331,464	39,980,691	19,649,570		1,536,779	2,164,424
3. Planning Outreach & Engagement	8,851,957	8,785,969	65,988		0	0
4. Linkage Services	6,941,793	6,834,208	73,311		6,232	28,042
5. Housing	1,232,713	1,232,713				
CSS Administration	40,505,490	39,426,757	1,078,733			
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	963,935,060	542,310,490	301,846,704	0	106,349,270	13,428,596
FSP Programs as Percent of Total	60%					

Community Services & Supports

	Fiscal Year 2020/21					
	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. Full Service Partnerships	219,103,641	114,100,761	73,576,366		26,271,847	5,154,667
2. Recovery, Resilience & Reintegration	198,838,053	88,051,846	77,520,558		31,612,752	1,652,897
3. Alternative Crisis Services	58,459,811	36,905,252	18,138,064		1,418,565	1,997,930
4. Planning Outreach & Engagement	7,242,510	7,188,520	53,990		0	0
5. Linkage Services	12,891,903	12,692,101	136,150		11,575	52,077
6. Housing	60,402,919	60,402,919	0		0	0
Non-FSP Programs						
1. Recovery, Resilience & Reintegration	286,132,806	126,708,753	111,553,974		45,491,520	2,378,559
2. Alternative Crisis Services	63,331,464	39,980,691	19,649,570		1,536,779	2,164,424
3. Planning Outreach & Engagement	8,851,957	8,785,969	65,988		0	0
4. Linkage Services	6,941,793	6,834,208	73,311		6,232	28,042
5. Housing	1,232,713	1,232,713				
CSS Administration	40,505,490	39,426,757	1,078,733			
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	963,935,060	542,310,490	301,846,704	0	106,349,270	13,428,596
FSP Programs as Percent of Total	60%					

BUDGET

Prevention & Early Intervention

	Fiscal Year 2018/19					
	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						
PEI-01 SUICIDE PREVENTION	9,826,570	9,826,570				
PEI-02 STIGMA DISCRIMINATION REDUCTION PROGRAM	7,558,900	7,558,900				
PEI-03 PREVENTION	41,977,800	41,977,800				
PEI-04 EARLY INTERVENTION	284,806,198	100,647,186	110,988,270		72,665,810	504,932
PEI Administration	17,191,807	17,191,807				
Total PEI Program Estimated Expenditures	361,361,275	177,202,263	110,988,270	0	72,665,810	504,932

	Fiscal Year 2019/20					
	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						
PEI-01 SUICIDE PREVENTION	9,826,570	9,826,570				
PEI-02 STIGMA DISCRIMINATION REDUCTION PROGRAM	7,558,900	7,558,900				
PEI-03 PREVENTION	41,856,800	41,856,800				
PEI-04 EARLY INTERVENTION	273,406,198	89,247,186	110,988,270		72,665,810	504,932
PEI Administration	16,827,744	16,827,744				
Total PEI Program Estimated Expenditures	349,476,212	165,317,200	110,988,270	0	72,665,810	504,932

	Fiscal Year 2020/21					
	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						
PEI-01 SUICIDE PREVENTION	9,826,570	9,826,570				
PEI-02 STIGMA DISCRIMINATION REDUCTION PROGRAM	7,558,900	7,558,900				
PEI-03 PREVENTION	41,856,800	41,856,800				
PEI-04 EARLY INTERVENTION	273,406,198	89,247,186	110,988,270		72,665,810	504,932
PEI Administration	16,827,744	16,827,744				
Total PEI Program Estimated Expenditures	349,476,212	165,317,200	110,988,270	0	72,665,810	504,932

BUDGET

Innovation

	Fiscal Year 2018/19					
	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. Inn #2 Community Capacity Building	21,000,000	21,000,000				
2. INN # 3 Technology Suite	11,500,000	11,500,000				
3. Inn # 4 Transcranial Magnetic Stimulation Center	540,000	540,000				
4. Inn #5 Peer Full Services Partnership	2,085,160	2,085,160				
INN Administration	2,050,227	2,050,227				
Total INN Program Estimated Expenditures	37,175,387	37,175,387	0	0	0	0

	Fiscal Year 2019/20					
	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. Inn #2 Community Capacity Building	21,000,000	21,000,000				
2. INN # 3 Technology Suite	3,500,000	3,500,000				
3. Inn # 4 Transcranial Magnetic Stimulation Center	540,000	540,000				
4. Inn #5 Peer Full Services Partnership	2,085,160	2,085,160				
INN Administration	2,050,227	2,050,227				
Total INN Program Estimated Expenditures	29,175,387	29,175,387	0	0	0	0

	Fiscal Year 2020/21					
	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. Inn #2 Community Capacity Building	21,000,000	21,000,000				
2. INN # 3 Technology Suite	3,000,000	3,000,000				
3. Inn # 4 Transcranial Magnetic Stimulation Center	0	0				
4. Inn #5 Peer Full Services Partnership	2,085,160	2,085,160				
INN Administration	2,050,227	2,050,227				
Total INN Program Estimated Expenditures	28,135,387	28,135,387	0	0	0	0

Workforce, Education and Training

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	720,000	720,000				
2. Mental Health Career Pathway	1,578,400	1,578,400				
3. Financial Incentive	3,873,600	3,873,600				
WET Administration	925,800	925,800				
Total WET Program Estimated Expenditures	7,097,800	7,097,800	0	0	0	0

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	720,000	720,000				
2. Mental Health Career Pathway	1,578,400	1,578,400				
3. Financial Incentive	3,873,600	3,873,600				
WET Administration	925,800	925,800				
Total WET Program Estimated Expenditures	7,097,800	7,097,800	0	0	0	0

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	720,000	720,000				
2. Mental Health Career Pathway	1,578,400	1,578,400				
3. Financial Incentive	3,873,600	3,873,600				
WET Administration	925,800	925,800				
Total WET Program Estimated Expenditures	7,097,800	7,097,800	0	0	0	0

Capital Facilities/Technological Needs

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
CFTN Programs - Technological Needs Projects						
4. EHR Strategy: IBHIS	1,341,223	1,341,223				
5. Consumer/Family Access to Computing Resources (paid to Library - OC 3606)	263,000	263,000				
6. Consumer/Family Access to Computing Resources (other direct costs - OC 3971)	177,000	177,000				
7. Healthcare Enterprise Analytics (Data Warehouse Redesign)	500,000	500,000				
8. Virtual Care (Telepsychiatry Expansion)	200,000	200,000				
9. DMH Resource Search/Performance Dashboards	1,300,000	1,300,000				
10. Hybrid Integration Platform	500,000	500,000				
11. Digital Workplace: Wifi at Clinics	1,275,000	1,275,000				
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	5,556,223	5,556,223	0	0	0	0

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0	0				
2.	0	0				
3.	0					
CFTN Programs - Technological Needs Projects						
4. EHR Strategy: IBHIS	1,377,288	1,377,288				
5. Consumer/Family Access to Computing Resources (paid to Library - OC 3606)	270,000	270,000				
6. Consumer/Family Access to Computing Resources (other direct costs - OC 3971)	160,000	160,000				
7. Healthcare Enterprise Analytics (Data Warehouse Redesign)	0	0				
8. Virtual Care (Telepsychiatry Expansion)	200,000	200,000				
9. DMH Resource Search/Performance Dashboards	700,000	700,000				
10. Hybrid Integration Platform	0	0				
11. Digital Workplace: Wifi at Clinics	0	0				
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	2,707,288	2,707,288	0	0	0	0

Capital Facilities/Technological Needs (continued)

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
CFTN Programs - Technological Needs Projects						
4. EHR Strategy: IBHIS	928,740	928,740				
5. Consumer/Family Access to Computing Resources (paid to Library - OC 3606)	277,000	277,000				
6. Consumer/Family Access to Computing Resources (other direct costs - OC 3971)	153,000	153,000				
7. Healthcare Enterprise Analytics (Data Warehouse Redesign)	0	0				
8. Virtual Care (Telepsychiatry Expansion)	200,000	200,000				
9. DMH Resource Search/Performance Dashboards	0	0				
10. Hybrid Integration Platform	0	0				
11. Digital Workplace: Wifi at Clinics	0	0				
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	1,558,740	1,558,740	0	0	0	0

Appendix

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SCHOOL BASED SERVICES

FOR

LATINA YOUTH PROGRAM

Evaluation Report

CONTRACT YEAR 2016-2017

INTRODUCTION

The purpose of this report is to summarize progress with regard to ongoing operations and outcome trends of Pacific Clinics' School Based Services for Latina Youth Program (LYP), for the contract year 2016-2017 (FY 16 -17). This report includes an update on the literature upon which program objectives and goals are based; documentation on program direct services, education and outreach activities as well as prevention activities is provided.

Data for this evaluation was gathered through various sources. Current literature (2012-2017) on youth suicide in general and Latina youth and suicide in particular was reviewed. Client data has been gathered from computer generated reports used to monitor program activities. Program evaluation reports from previous years were reviewed and information from those reports was included as appropriate. The report is designed to give an overview of the client participants and program performance. Sections addressing client demographics; program goals and performance on objectives; program outcomes; and lessons learned, are included.

SUMMARY

LYP provided services to a total of 143 child and Transitional Age Youth (TAY) participants and their families, who had open cases, during FY 16-17. Additionally, the program's staff provided crisis and urgent services as well as over 874 hours of preventive activities such as outreach and education to 671 individuals through their Community Client Services and Mental Health Promotion activities/contacts. With regard to cost, Pacific Clinics' average cost per consumer with an open case in the Latina Youth Program was $3,744.63. LYP participants ranged in age from two to 21 years of age, with the greatest number of participants being between 12 and 19 years of age. This represents a movement toward working with more TAY, than in previous years when participants tended to be younger. With regard to gender, 77 participants with open cases, or 54% were female and 66 participants, or 46% were male. The consumers were distributed among grades 2 through 12, and at the community college undergraduate level. With regard to language, a majority of the participants speak English as their primary language at home (43%). This percentage has ranged from 34% to 53% in past evaluation periods. A minority of participants speak Spanish as their primary language at home (23%). This number has ranged from 5% to 47% in past evaluation periods. In 34% of participating families, the children prefer English while the parents prefer Spanish as their primary language at home. In past evaluation periods, this percentage has ranged from 19% to 42%.

The greatest majority of program participants were those of Latino ethnic background, at 87%. This is a decrease from an all-time high of 100% during the

early years of the program's implementation, but an increase from FY15-16 when Latino participants made up 80% of those with open cases. It also represents a two-year trend of increased Latino participation as the figure for FY 14-15 was 74%. Caucasian participants made up 3% of the program population. The percentage of Caucasian participants has ranged from 2% to 13% in past program years. In FY 15-16 it was 4%. Native American and Filipino individuals made up 1% each, of the program population. Finally, there were no African-American program participants this year, and 8% of the remaining individuals identified as "Other."

The majority of program participants were diagnosed with a depressive disorder (58%), including Major Depression, Dysthymia and Schizoaffective Disorder with Depression. Another 15% were diagnosed with anxiety, including Separation Anxiety. Nine percent of program participants were diagnosed with Oppositional Disorder; 7% suffer from Attention Deficit Disorder; 6% met criteria for Adjustment Disorder with mixed disturbance of affect and behavior; 3% received a Post-Traumatic Stress Disorder diagnosis; and one percent each received either a Conduct Disorder or Bipolar diagnosis. With regard to outcomes, review of past interviews with participants and program data revealed that consumers perceived a significant reduction in symptom severity, and improvement in functioning and communication. As in past years the program was successful at preventing suicide among participants. Parents interviewed in past years credit program staff with helping turn their child's life around by providing students with the skills necessary to manage difficult situations at school, and develop a greater sense of control over their behavior both at school and home. Student participants report feeling more hopeful about their future in general, school functioning, as well as social and family relationships. Additionally, they report decreased symptoms and substance use.

Pacific Clinics' LYP continues to leverage many resources and services benefiting program participants and their families by coordinating collaborative relationships with schools, private and public agencies, as well as other community-based organizations. A hallmark of the program continues to be the reduction of barriers to accessing treatment faced by the community in general and children and adolescents in particular. Services are provided at school sites as well as other locations, and at times which are convenient to the program participants and their families. Additionally, services are provided at no cost to the participants, by staff that is both culturally and linguistically competent. The program staff continues to receive training and supervision in Evidence Based Practices.

Due to its consistent and reliable presence for the past 16 years in the community, the program enjoys the trust of community partners and residents. The program has consistently received acknowledgements and accolades from community organizations, city, county, state and federal government representatives for their services and contributions to the community's well-

being. Pacific Clinic's Latina Youth Program provides services in seven cities, including: La Mirada, La Puente, Montebello, Pico Rivera, Norwalk, Santa Fe Springs and Whittier. Its network of schools is spread over 28 schools within these seven cities. These include 12 elementary level, nine middle and seven high schools. School administrators have made room in their already overcrowded facilities to house the program. School staff, who move from one school to another, are able to provide information about the program to schools that may have been unaware of, or hesitant to collaborate in the past, and bring program services with them to new populations. As more students, parents, school staff, community residents and media outlets have experience with program staff and services, the program is seen as not only an important asset in the community, but also as a resource for consulting with experts. School teachers, administrators and other staff frequently consult program staff on issues impacting students and their families. Services provided by the program include response to crises and urgent requests; education regarding mental health, anti-stigma, anti-bullying and other social issues; ongoing therapy and support groups, including parenting education for families, anger management, conflict resolution, anti-bullying and social skills are needed spaces where students and parents can debrief on the current political climate and their fear associated with the increased attacks against minority status communities. As always, the main focus of the program remains on providing direct psychotherapeutic services to children, TAY, and their families in an effort to reduce risk factors associated with suicidality.

PROGRAM	M	F	Ethnicity	Total	Age	Total
7495 SFS	3	2	American Indian	1	6	0
	T	5	Black/African	0	7	0
			Filipino	1	8	0
			Latino/Hispanic	3	9	1
			Laotian	0	10	0
			Samoan	0	11	0
			White/Caucasian	0	12	0
			Other	0	13	0
			TOTAL	5	14	0
					15	1
					16	0
					17	1
					18	1
					19	1
					20	0
					22	0
					T	5

PROGRAM	M	F	Ethnicity	Total	Age	Total
7896 SB Whittier	29	38	American Indian	0	6	0
	T	67	Black/African	0	7	2
			Filipino	0	8	2
			Latino/Hispanic	62	9	1
			Laotian	0	10	0
			Samoan	0	11	2
			White/Caucasian	1	12	9
			Other	4	13	4
			TOTAL	67	14	8
					15	10
					16	12
					17	12
					18	4
					19	1
					20	0
					21	0
					T	67

PROGRAM	M	F	Ethnicity	Total	Age	Total
7902 SFS	7	5	American Indian	0	2	1
	T	12	Black/African	0	7	0
			Filipino	0	8	0
			Latino/Hispanic	10	9	1
			Laotian	0	10	1
			Samoan	0	11	0
			White/Caucasian	0	12	0
			Other	2	13	1
			TOTAL	12	14	0
					17	1
					18	1
					19	1
					20	3
					21	2
					23	0
					25	0
					TOTAL	12

PROGRAM	M	F	Ethnicity	Total	Age	Total
95A Monrovia	10	12	American Indian	0	6	0
	T	22	Black/African	0	7	1
			Filipino	1	8	1
			Latino/Hispanic	14	9	0
			Laotian	0	10	1
			Samoan	0	11	1
			White/Caucasian	2	12	1
			Other	5	13	0
			TOTAL	22	14	0
					15	5
					16	8
					17	2
					18	1
					19	1
					20	
					21	
					T	22

PROGRAM	Male	Female	Ethnicity	Total	Age	Total
95A	17	20	American Indian	0	6	0
Pasadena	Total	37	Black/African	0	7	1
SEA			Filipino	0	8	0
			Latino/Hispanic	35	9	0
			Laotian	0	10	0
			Samoan	0	11	0
			White/Caucasian	1	12	2
			Other	1	13	0
			TOTAL	37	14	1
					15	4
					16	8
					17	7
					18	6
					19	8
					20	0
					21	0
					TOTAL	37

SUMMARY CLIENT DEMOGRAPHICS

GENDER		
	N	**PERCENTAGE**
MALE	66	46%
FEMALE	77	54%
TOTAL	**143**	

ETHNICITY - RACE		
	N	**PERCENTAGE**
AMERICA INDIAN	1	1%
BLACK/AFRICAN AMERICAN	0	0%
FILIPINO	2	1%
LATINO/HISPANIC	124	87%
WHITE/CAUCASIAN	4	3%
OTHER	12	8%
TOTAL	**143**	

AGE		
	N	**PERCENTAGE**
2	1	1%
6	0	0%
7	4	3%
8	3	2%
9	3	2%
10	2	1%
11	3	2%
12	12	8%
13	5	4%
14	9	7%
15	20	14%
16	28	20%
17	23	16%
18	13	9%
19	12	8%
20	3	2%
21	2	1%
TOTAL	**143**	

SUMMARY OF CLIENT DIAGNOSES

PRIMARY DIAGNOSIS		
	N	**PERCENTAGE**
DEPRESSION: Including Major Depression, Dysthymia, Unspecified Depressive Disorder and Schizoaffective Disorder with Depression	83	58%
ANXIETY: Including Generalized Anxiety Disorder and Separation Anxiety	22	15%
OPPOSITIONAL DEFIANT DISORDER	13	9%
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER	10	7%
ADJUSTMENT DISORDER WITH MIXED DISTURBANCE OF AFFECT AND BEHAVIOR	9	6%
POST TRAUMATIC STRESS DISORDER	4	3%
CONDUCT DISORDER	1	1%
BIPOLAR I DISORDER	1	1%
TOTAL	**143**	

SUMMARY OF PROGRAM LOCATIONS

LOCATIONS	
CITY	NUMBER OF PROGRAMS
La Mirada	3
La Puente	2
Montebello	2
Norwalk	2
Pico Rivera	2
Santa Fe Springs	3
Whittier	14
TOTAL	28

SCHOOL TYPE	
Elementary Schools	12
Middle Schools	9
High School	7
TOTAL	28

LYP CUMULATIVE DATA									
Year	2001-2002	2002-2003	2003-2004	2005-2006	2008-2009	2010-2011 & 2011-2012 Extension	2014-2015	2015-2016	2016-2017
Open Cases	105	126	253	259	202	116	214	193	143
Gender									
Female	100%	67.5%	64.1%	46.7%	48.5%	48%	54%	56%	54%
Male		32.5%	35.9%	53.3%	51.5%	52%	46%	44%	46%
Age Range (in years)	11 - 18	4 - 18	4 -17	3 - 18	6 - 18	3 - 25	6 - 21	6 - 23	2 - 21
Grade	6th – 12th	Pre-K – 12th	Pre-K- 12th	Pre-K -12th	1st – 12th	Pre-K - College	1st - College	1st – 12th	2nd - College
Primary Language at Home									
English	34%	49%	41.7%	48.6%	43%	53%	45%	49%	43%
Spanish	47%	21%	18%	19%	20%	5%	19%	17%	23%
Both	19%	30%	41.3%	32.4%	37%	42%	36%	34%	34%
Ethnicity									
Latin@	100%	100%	92.4%	84.2%	92.5%	88%	74%	80%	87%
Caucasian			5.3%	9.5%	4%	8%	13%	4%	3%
African-American			2.3%	2%	1.5%	1%	1%	.005%	
API					1.5%	2%	1%	1%	1%
Native American							1%	1%	1%
Other				4.3%	0.5%	1%	10%	13%	8%

Substance Abuse	26%	19%	11.4%	8.5%	16%	19%	17%	21%	20%
Past Suicide Attempt	24%	10%	5%	5%	13%	8%	11%	14%	11%
Suicide Ideation	55%	26%	27%	21%	29%	25%	30%	34%	31%
Health Insurance Coverage									
None	23%	27%	88.6%	18.6%	28%	68%	45%	48%	39%
MediCal	32%	42%							
EPSDT				75.2%	71%	21%	52%	49%	54%
Healthy Families			3%						
Other	45%	31%	8.4%	6.2%	1%	11%	3%	2%	7%

UPDATED LITERATURE REVIEW

A review of current literature (2012-2017) was conducted in order to ensure the program's goals and assumptions are still in line with current thinking in the field regarding adolescents and suicide. Results from the National Comorbidity Survey (2013) confirm that suicide is the third leading cause of death among US adolescents. In face-to-face interviews with 6483 adolescents 13 to 18 years old and their parents, the lifetime prevalence of suicide ideation was estimated at 12.1%; lifetime prevalence of suicide plans was estimated at 4.0% and suicide attempt prevalence was estimated at 4.1%. Additionally, the study found that the majority of adolescents with suicidal ideation, plans or attempts, meet criteria for at least one DSM-IV mental disorder. While an approximate 80% of these teens receive some form of mental health treatment, and although treatment starts before the onset of suicidal behaviors, for an approximate 55% it fails to prevent the behaviors associated with suicide attempts from occurring. Thus, of those adolescents with suicidal ideation, about 55% transition to suicidal behaviors within the first year after onset of the ideation. This points to the importance of monitoring adolescents with suicidal ideations and plans, particularly for the first year after onset of ideation.

A 2017 survey by the Williams Institute of UCLA looked at LGBTQ Youth in California's public schools. Using the California Student Survey and the California Healthy Kids Survey, they found that overall, 10.3% of the students identified as LGBTQ. Despite the existence of state-level laws intended to protect LGBTQ youth from the disparities observed in national studies (e.g., discrimination based on sexual orientation and gender identity within schools and foster homes; inclusion of LGBT cultural and historical education and within the sex and health education curricula; and enumeration of these social statuses within anti-bullying statutes), these youth reported having less meaningful school participation, lower expectations from adults, fewer caring adult relationships at school, and a lower level of school connection than non-LGBTQ youth. They reported higher rates of experiencing victimization and feeling less safe at school. LGBTQ youth also reported more frequent use of cigarettes, marijuana and alcohol than their non-LGBTQ counterparts. Additional findings from the CDC suggest that of the LGBTQ youth population: 10% were threatened or injured with a weapon on school property; 34% were bullied on school property; 28% were bullied electronically; 23% of LGBTQ students who had dated or went out with someone during the 12 months before the survey had experienced sexual dating violence; 18% of LGBTQ students had experienced physical dating violence; and 18% of LGBTQ students had been forced to have sexual intercourse at some point in their lives. Nearly one-third (29%) of LGBTQ youth have attempted suicide at least once in the prior year compared to 6% of heterosexual youth. The rates are higher for youth who identify as Transgender. These findings are significant given the high correlation between these high risk

factors and suicidal ideation and behavior, and more specifically given the higher rates of completed suicide among this population.

Specifically with regard to Latino youth, Cordova, et. al. (2014) studied 746 adolescents and their parents. They reported that high levels of discrepancy between parent and child in reports of family functioning, correlated with high alcohol and drug use, as well as earlier sexual activity initiation. Family functioning was defined as positive upbringing; parent participation; family cohesion; parental control over friends; and child-parent communication. Although this study focused on risk behaviors for HIV infection in adolescent Latinos, the risk factors identified, have also been shown to impact suicidal behavior. Thus, when adolescents and parents report more accordance regarding family functioning, risk behaviors decrease. The impact of discrepancy in reporting is mitigated by levels of acculturation and adolescent gender, in this study. Vidot, et. al. (2016) looked at crossover effects of participation in Familias Unidas groups on suicidal behaviors among Latino adolescents. They found that improved communication among parents and adolescents reduced suicide attempts in the past year. The effect was found despite the fact that the Familias Unidas groups in this study did not directly address suicide. Romero, et al. (2013) approached depression and suicide among Latina adolescents from an ecodevelopmental perspective. They studied Latinas within the context of U.S. of negative stereotypes and strict immigration enforcement policies which may increase discrimination and family separation. Given the current political climate, this study is very timely. Their findings suggest that families are central to Latina adolescents' world views. When families are confronted with significant distress or conflict, it can lead young Latinas to extreme actions such as suicide ideations and behaviors. Additionally, other factors, including bullying, dating violence, as well as alcohol and substance use contribute to suicidal ideation. Finally, Gulbas and Zayas (2014) conducted qualitative interviews with a small group of Latina adolescents who attempted suicide (n=10) and their parents, and adolescents with no reported history of self-harm (n=10) and their parents. Their focus was the relationship among culture, family, and attempted suicide by Latina adolescents. Those young Latinas who had attempted suicide lacked resources to build and maintain meaningful social ties, while those who had no history of suicidal ideation or behavior were able to create and maintain supportive relationships which mitigated experiences of acculturative tension and oppression.

Initially, the program's governing objectives and goals were to reduce those risk factors which the literature, at that time, had identified as most important. These included the following: Substance use and abuse; previous attempts at suicide; runaway behavior; communication problems; poor school performance; involvement with legal and juvenile systems; and negative peer influences. This most current review adds the following risk factors: Meet criteria for DSM mental disorder; bullying (both in person and electronic); physical and sexual violence; family experience of high distress or conflict; and an inability to build and

maintain meaningful social ties. Additionally, findings in this literature review highlight the fact that LGBTQ adolescents attempt suicide at a rate of 29%, compared to 6% for their heterosexual peers. Finally, this updated literature review highlighted the importance of monitoring adolescents with suicidal ideation for one year post the onset of the ideation, as this is the time frame within which suicidal behaviors emerge. The LYP continues to evolve and to be responsive to new findings in the literature. In recent years the program has provided ongoing training to address the disparity within LGBTQ adolescents, with regard to suicide. Clinicians also receive ongoing training on current issues such as cyber and in-person bullying. The program has always had a strong anti-violence and trauma informed approach to its services. It will now be important, given this new data to formalize the program's ability to monitor children and TAY for at least one year, following the onset of suicidal ideation.

PROGRAM DESIGN

The program's design incorporates key components which directly address the community's needs. These components are Outreach, Educational and Support Groups, and Comprehensive Mental Health Services including Case Management. The program's goals and objectives are directly addressed by these components.

Outreach efforts target various levels of the community and reflect the cultural value of "collectivismo". Colectivismo extends the value placed on positive working relationships out into the community. The school community, including teachers and other guidance staff are engaged through educational workshops and by having program staff at the school sites be available for consultation on a very accessible basis. Youth outreach efforts include presentations by program staff at school assemblies and classroom lectures. These activities have resulted in a high number of self-referrals and referrals of friends by word of mouth to the program. Parent outreach takes place via formal presentation to parent organizations, sending information home with students and parent-to-parent word of mouth. Outreach to community agencies is achieved via formal program presentations, as well as networking by program staff. These activities have resulted in a number of formal and informal collaborative relationships. Community members are engaged through presentations at local community organizations and through word of mouth. Additionally, efforts which expand the program's reach beyond the local community, include trainings to students at the university level and training to professionals through conferences, as well as media presentations.

Educational and support groups are offered to youth, parents, school staff, and community members. These provide an opportunity to address prevention and to identify needs for services. Education groups focus on specific topics related to high risk behavior and suicide. They are offered in various formats to allow for reaching a large number of community members as well as provide an

opportunity for more in depth discussion in smaller groups. Peer support groups for students and parenting groups for parents help connect program participants to others with similar issues and concerns.

Comprehensive Evidence Based Mental Health Services are offered to consumers and their families in a flexible manner. The focus here is not only on best practices, but also on accessibility. Thus, services are offered at the school sites, in the home, at the program offices, and in other places in the community that are most convenient to consumers and their families. The program mental health services include Comprehensive Individual and Family Assessment; Case Management; Support and Advocacy; Mental health Counseling; Medication Support; Substance Abuse Prevention and Services; and Crisis Intervention. Program staff are trained in Evidence Based Intervention Models to provide the most appropriate interventions to program participants.

PROGRAM GOALS AND PERFORMANCE ON OBJECTIVES

The primary goals of the Program are stated as follows:

- To promote prevention and early intervention for youth to decrease substance use and depressive symptoms which are major risk factors for suicide.
- To increase youth awareness of high-risk behaviors and provide immediate assessment and treatment services.
- To increase access to services while decreasing barriers and stigma among youth in accepting mental health services.
- To increase family awareness about high-risk behaviors and empower families through education about the benefits of prevention and early intervention and health promotion.
- To enhance awareness and education among school staff and community members regarding substance abuse and depression.

Progress on these goals is measured by the following objectives:

1. Partner with the program's core schools in the program service area to develop and conduct parents' workshops to raise family and community awareness about youth high-risk behaviors, cultural variance, stigma around mental illness, and communication strategies.

2. Based on evidence-based and best practice models of care, program staff will provide individual and family treatment interventions to consumers to improve their level of functioning and reduce risky behaviors.

3. Based on best practice models, the program will organize and conduct parenting classes in English and in Spanish.

4. Train new program staff in evidence-based or best practice models, as well as integrate mental health and substance abuse treatment.

5. Provide education sessions for local school staff on youth high-risk behaviors, mental health stigma, and youth communication strategies for staff at each of the schools in the program service area, where services are co-located.

6. Organize and conduct peer groups to provide support and education for participants on issues of youth violence, substance abuse, family conflict, anger management, healthy relationships, peer pressure, safe sex practices, and effective interpersonal communication.

OUTCOMES

As stated previously, a number of risk factors have been associated with higher risk for suicidality in adolescents. At its inception LYP identified nine risk factors, which were targeted for treatment in addition to diagnosed mental illness. 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, and negative peer relations. In subsequent years a tenth factor was added. This factor addresses issues related to sexual identity, which research suggests plays a significant role in predicting suicide if children and adolescents are rejected for expressing a sexual orientation or gender identity (SOGI) not consistent with parental expectations. Reflective of the program's responsiveness to issues identified by program participants or emerging research, most recently the program has included bullying-behavior as an additional factor which may present suicide risk for young people. Finally, the most current literature update has identified the need to monitor program participants for at least one year following initiation of suicidal ideation. LYP will need to develop a system for implementing this function.

LESSONS LEARNED

The Latina Youth Program was implemented by Pacific Clinics in 2001 as a demonstration program focusing on adolescent suicide prevention, particularly among Latina Youth. It was originally funded by SAMHSA. This was a time when suicides were increasing at an alarming rate among this population even as the number of suicides were decreasing in other groups. High risk symptoms and behaviors including 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, and negative peer relations were initially targeted for identification and treatment based on research findings which correlated these with high risk for suicidality. In subsequent years "issues related to sexual identity" was included as a factor in the list of factors representing high risk for suicidality as identified in research. Most currently, the need to monitor program participants for suicidal behavior for one year post initiation of suicidal ideation, has been identified as an important component to be added. Since its inception the program has worked with a participant population that matches or exceeds national statistics with regard to reported substance use, past suicide attempts, and suicidal ideation. As the program progressed, there has been a trend toward increased symptom severity and complexity of problems confronting program participants. Given the current political climate of verbal and physical aggression targeted at minority status communities and individuals who may be perceived as immigrants, stress on individuals, families and communities is at an all-time high. This complicates treatment as so many of the factors involved in the increasing challenges facing families, are not ones that can be easily addressed, and require a great deal of case management activity. The program staff are being called upon to do more crisis intervention; provide services for a longer period of time or allow clients to "come and go" as needed; as well as provide more advocacy activities. There has been a trend toward increase in suicide attempts, which have led to hospitalizations. And, in May of 2014, the program experienced its first completed suicide among its participants. The low incidence of completed suicides, along with increased functioning of program participants, as measured by ratings on symptom severity in the past, and parent report, support the assertion that the program is having the desired effect of reducing risk for suicidality within the targeted communities.

Based on sound findings in the literature and a great deal of practical experience working within this underserved community, the program set out to address many of the barriers to services faced by Latinos. Included among these are issues related to social stigma regarding mental health services, the cost of services and the fragmented nature in organization of services. The program works on reducing the stigma associated with going into a mental health facility by placing service providers within the school setting and meeting participants in their home, place of work, an alternative community setting, or at a shelter, as needed. Program participants, when interviewed in the past, have reported that they "recommend the program's services to any friend who seems to need them." Additionally, the increased visibility of program locations within the school, by being moved to more prominent locations within the campuses, allows students and families to discard any misgivings about the acceptability of participation in mental health services. In the past, a parent stated "If the school feels these services are important enough to have them here, then it must mean that they want us to use them." Issues regarding basic physical access are also addressed by providing services in alternative settings; by providing transportation when needed; and scheduling appointments at times that make sense for program participants. The program staff is proactive when participants do not show up for

scheduled appointments. The program staff call participants and offer alternative schedules for appointments, transportation to the program office, a home visit, etc.

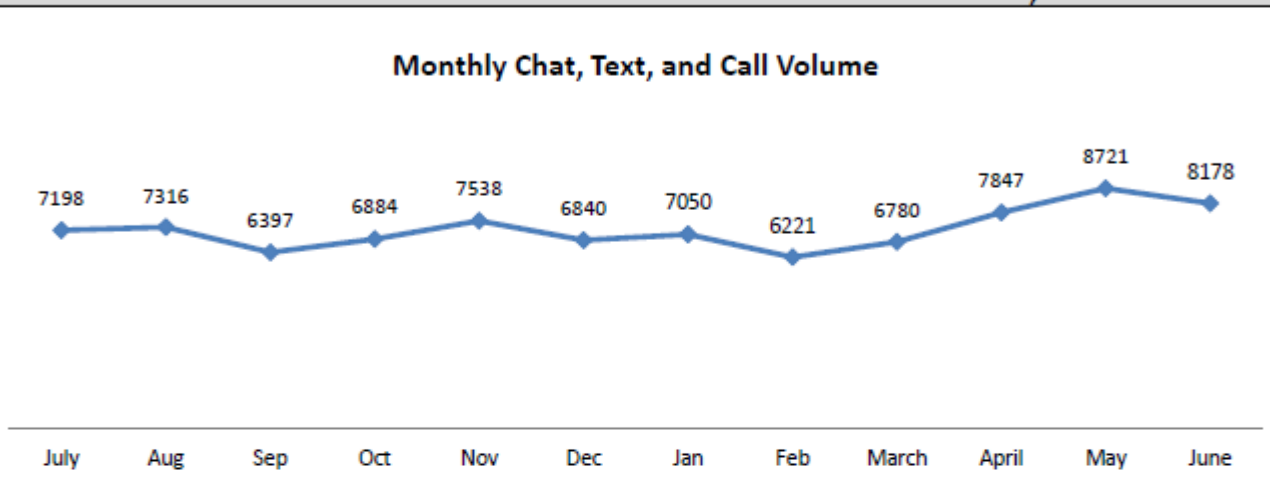
The social stigma associated with mental health issues is also decreased by providing educational presentations in the schools, out in the community and through various media outlets. This kind of visibility works on several levels. The staff provide workshops wherein community residents are able to ask questions, and learn new information. This approach helps community residents get answers to questions that they might not otherwise even consider. Hearing other individuals that they identify with, discuss these topics and perhaps even disclose personal experience with some of the symptoms being addressed, helps community members decrease the sense of stigma experienced when considering accessing mental health services. Feedback from client interviews conducted in past years, reveals that attending these workshops in places other than mental health centers, helps individuals feel more comfortable about engaging in these conversations. Collaborative relations with other mental health organizations, as well as with non-traditional partners (churches, city government, etc.) have proved very useful in helping program staff address participants' needs in a more holistic approach, thus addressing the problem of a fragmented service delivery model. Participants don't have to navigate a number of different agencies all at once in order to address important coexisting needs. The program not only makes accessing mental health counseling and medication support easier, it also provides other resources through the case management component. These might include education and skill development in various areas of social functioning, advocacy with other basic needs, as well as other supportive services. These activities earn the participants' trust and help them identify tangible outcomes. When the psychological benefits of program participation are not readily evident, participants can value these other outcomes.

With regard to cost, funding from Los Angeles County Department of Mental Health (LACDMH) has helped the program leverage in-kind contributions from schools, such as space; and discretionary funding from private foundations, local vendors and businesses for other program activities, which while not directly related to mental health treatment, have significant impact on the wellbeing of participants and their families. Clinically, the program continues to experience an influx of referrals whenever staff provide educational workshops. This means the program must be prepared to provide services to anyone who self identifies as needing them. This is an ethical as well as practical consideration. When community residents learn that there is an explanation for how they are feeling, as well as a possible way to ameliorate their discomfort and pain, they are quick to seek help. This provides a brief window of opportunity and if individuals are placed on long waiting lists or made to go through complicated administrative processes before they can actually receive help, the chance of losing their trust is increased. Program outreach workers need to constantly update their knowledge of resources in the community in order to provide useful information and

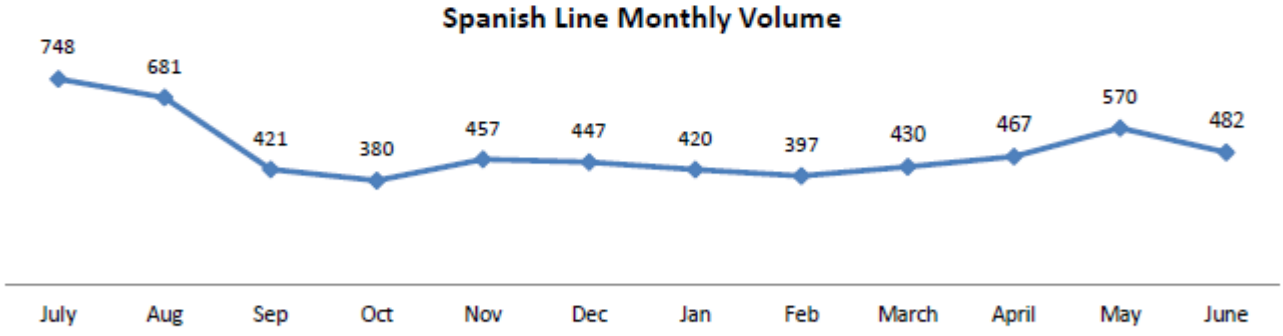
advocacy to community members. And, when community members decide that they are ready for services the program must respond in an expeditious manner. Before a full intake is carried out, the program staff focuses on engaging the family. This process described in greater detail elsewhere in the FY14-15 report to LACDMH, includes using jargon-free language to assess what the participants identify as the problem, and what possible solutions they have considered. Additionally, families are engaged in the process of recognizing what strengths they already possess in order to address the current challenges and how they may have been successful in the past in managing similar problems. When families come into the program office they are made to feel welcomed. Their level of comfort or discomfort is directly addressed by everyone from the front office staff to the clinicians. Staff has found that paying attention to small details in the beginning of the relationship, as well as providing clear information and education about what the participants may expect to gain by participating in the program, goes a long way to preventing consumers from dropping out of services.

SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

CALL ANALYSIS FOR FISCAL YEAR 2016-2017	
	Fiscal Year 16-17
TOTAL CALLS	77,412
TOTAL CHATS	9,529
TOTAL TEXTS	29
GRAND TOTALS	**86,970**



Total Calls by Language	
	Fiscal Year 16-17
Korean	8
Spanish	5,900
Vietnamese	8



Total Calls, Chats, and Texts for the Top Counties in California		
County	**Fiscal Year 16-17**	**Percentage of State**
Los Angeles	29,177	43%
Orange	8,475	12%
San Bernardino	4,153	6%
Riverside	3,747	5%
Santa Clara	3,173	5%
Ventura	1,735	3%

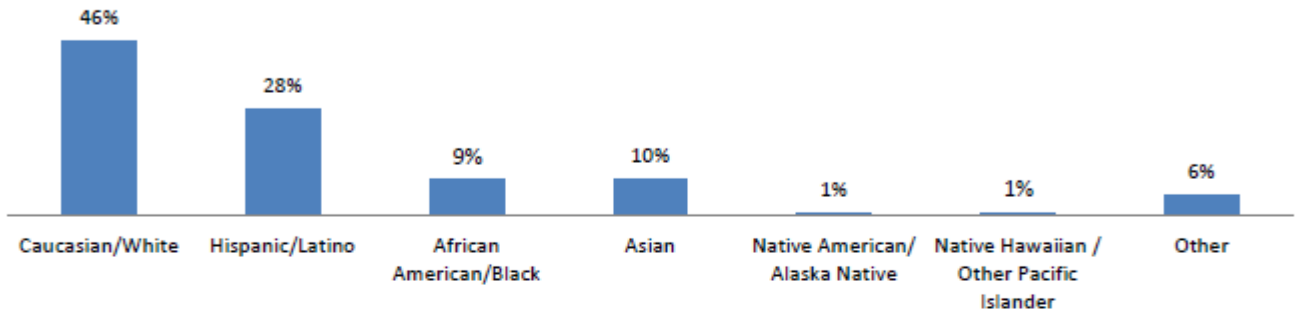
SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

Didi Hirsch MENTAL HEALTH SERVICES

2016-2017 DEMOGRAPHICS
Gender

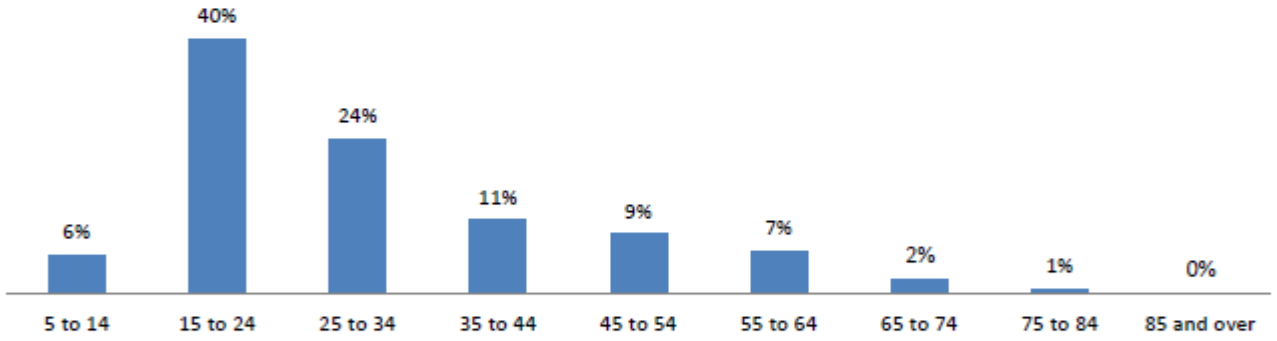
	Fiscal Year 16-17
Female	28,353
Male	22,732

Ethnicity



*Percentages are calculated out of the total number of callers with reported ethnicity.

Age Groups



*Percentages are calculated out of the total number of callers with reported age.

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.

TOP CONCERNS DISCUSSED BY CALLERS (CALLER MAY IDENTIFY MORE THAN ONE)

Caller Concern	Fiscal Year 16-17	Percentage
Suicidal Desire	20,309	48%
Relationship/ Family Issues	15,683	37%
Depression	15,065	36%
Past Suicidal Ideation/Attempt	13,632	32%
Anxiety/Stress	12,480	30%

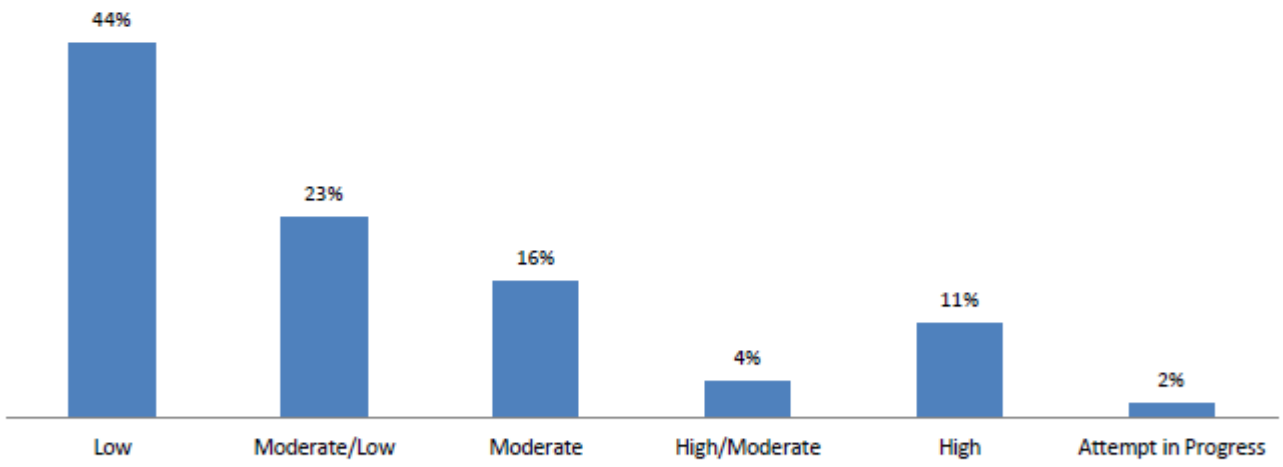
*Counselors listen for the reasons callers contacted the hotline, as well as other issues discussed by callers, and choose one or more categories to fit these issues.

SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

SUICIDE RISK ASSESSMENT		
Rates of Suicide Risk Factors among Callers (callers may identify more than one)		
	Fiscal Year 16-17	**Percentage**
History of Psychiatric Diagnosis	13,346	38%
Prior Suicide Attempt	10,791	31%
Substance Abuse - Current or Prior	7,194	20%
Suicide Survivor	3,485	10%
Access to Gun	1,361	4%

**Presence of the above factors significantly increases an individual's risk for suicide attempts; thus, all callers presenting with crisis or suicide-related issues are assessed for these risk factors. Percentages are calculated out of the total number of calls in which suicide or crisis content was present.

SUICIDE RISK STATUS



*Percentages are calculated out of the total number of callers with reported risk levels.

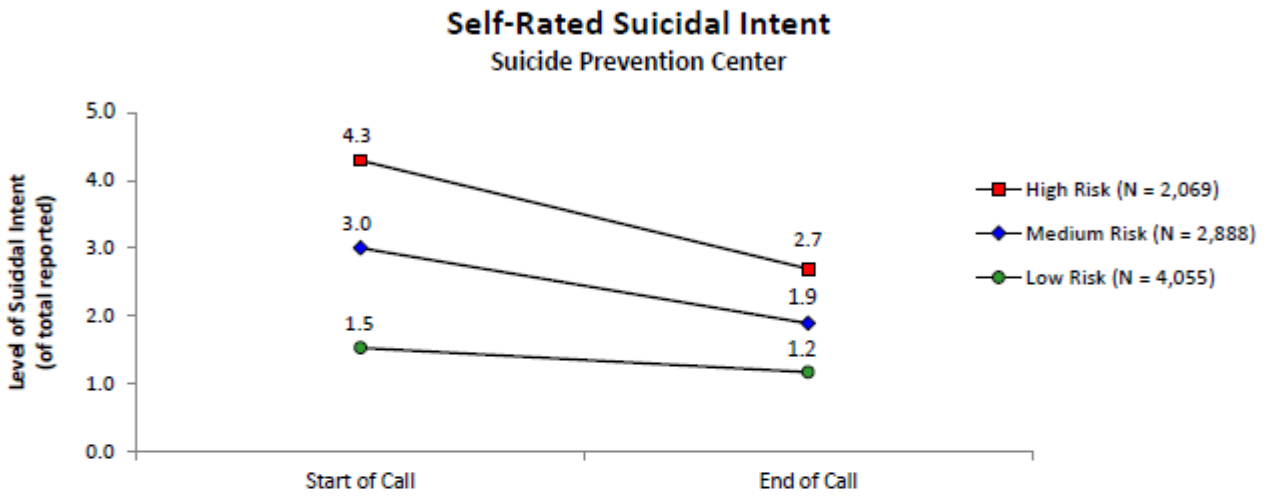
Risk assessment is based on the four core principles of suicide risk: Suicidal Desire, Suicidal Capability, Suicidal Intent, and Buffers/Connectedness (Joiner et al., 2007). A caller's risk level is determined by the combination of core principles present. Fore example, a caller who reports having only suicidal desire, as well as buffers, would be rated as Low Risk. A caller with suicidal desire, capability, and intent present would be rated as High Risk, regardless of the presence of buffers.

SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

INTERVENTION OUTCOMES

Self-rated Suicidal Intent

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.

EMERGENCY RESCUES

Emergency Rescue Type	Fiscal Year 16-17	Percentage
Third Party Rescue	1,554	49%
Self-Rescue	797	25%
SPC Initiated Rescue - Voluntary	214	7%
SPC Initiated Rescue - Involuntary	151	5%
Mandated Report	480	15%

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.

SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

FOLLOW UP PROGRAMS				
Please note: There have been changes to our iCarol system and these numbers represent a best estimate since training is still underway on the additional follow up fields.				
	Total YTD	**Contacted**	**Linked**	**No Contact**
Short-Term	71	52	21	19
Standard	802	611	276	191
Extended	107	72	42	35
Grand Total	**980**	**735**	**339**	**245**

DEFINITIONS
Short-Term Follow-Up: Offered to callers at imminent risk who do not meet criteria for emergency rescue. The follow-up call or calls are made within 24 hours after the initial call.
Standard Follow-Up: Offered to moderate - high risk callers. The follow-up call or calls are made 1-7 days after the initial call.
Extended Follow-Up: Offered to callers who received standard follow-up and need continued assistance (e.g., developing a safety plan and/or connecting to resources). The follow up call or calls are made 1-8 weeks after the initial call.

OUTREACH AND EDUCATION
Various outreach events were conducted in LA and Orange County. Types of outreach events include Adolescent, Adult, Adult Clinical, ASIST, Clinical College, College Clinical, First Responders, Lecture, Medical, and safeTALK presentations. Figures do not include attendance at Info Tables

Individuals reached through these efforts:	
County	**Fiscal Year 16-17**
LA	5,622
Orange	2,006
Total	**7,628**

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

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
ANXIETY	Managing and Adapting Practice (MAP) - Anxiety & Avoidance**	2 - 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 - Parent (RCADS-P) Revised Child Anxiety and Depression Scales (RCADS)	6 - 18	**RCADS-P**: English, Korean, Spanish **RCADS**: Chinese, English, Korean, Spanish
	Individual Cognitive Behavioral Therapy - Anxiety (CBT-Anxiety)	16+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire 45.2	16 - 17 16 - 18 19+	Generalized Anxiety Disorder - 7 (GAD-7)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog
	Mental Health Integration Program (MHIP) - Anxiety	18+	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	Armenian, Chinese, English, Korean, Spanish
	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-RI-5 – Parent*** UCLA PTSD-RI-5 – Child/Adolescent***	7 - 18 7 - 18	**PTSD-RI 5 Child/ Adolescent:** English, 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	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	UCLA PTSD-RI-5 – Parent*** UCLA PTSD-RI-5 – Child/Adolescent***	7 - 18 7 - 18	**PTSD-RI-5 Parent:** English, Spanish
	Seeking Safety (SS)	13+	Outcome Questionnaire - 45.2	19+	PTSD Checklist-5 (PCL-5)***	19+	**PCL-5:** Available in all threshold languages
	Individual Cognitive Behavioral Therapy - Trauma (CBT-Trauma)	16+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	16 - 17 16 - 18 19+	UCLA PTSD-RI-5 – Parent*** UCLA PTSD-RI-5 – Child/Adolescent*** PTSD Checklist-5 (PCL-5)***	16 - 18 16 - 18 19+	
	Prolonged Exposure for PTSD (PE)	18 - 70	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	PTSD Checklist-5 (PCL-5)****	18+	Available in all threshold languages
	Mental Health Integration Program (MHIP)- Trauma	18+	No general measure is required		PTSD Checklist-Civilian (PCL-C)	18+	Chinese, English, Spanish

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

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
CRISIS	Crisis Oriented Recovery Services (CORS)	3+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	No specific measure is required		
FIRST BREAK / TAY	Center for the Assessment and Prevention of Prodromal States (CAPPS)	16 - 25	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	16 - 17 16 - 18 19+	Scale of Prodromal Symptoms (SOPS)	16 - 35	English, Spanish
DEPRESSION	Interpersonal Psychotherapy for Depression (IPT)	12+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	8 - 17 12 - 18 19+	Patient Health Questionnaire - 9 (PHQ-9)	12+	Available in all threshold languages
	Depression Treatment Quality Improvement (DTQI)	12 - 20					
	Managing and Adapting Practice (MAP) - Depression and Withdrawal**	8 - 23					
	Group Cognitive Behavioral Therapy for Major Depression (Group CBT for Major Depression)	18+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	16 - 17 16 - 18 19+	Patient Health Questionnaire - 9 (PHQ-9)	16+	Available in all threshold languages
	Individual Cognitive Behavioral Therapy - Depression (CBT-Depression)	16+					
	Problem Solving Therapy (PST)	60+	Outcome Questionnaire - 45.2	19+			
	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	60+					
	Mental Health Integration Program (MHIP) - Depression	18+	No general measure is required				
EMOTIONAL DYSREGULATION DIFFICULTIES	Dialectical Behavioral Therapy (DBT) DIRECTLY OPERATED CLINICS	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Difficulties in Emotional Regulation Scale (DERS)	18+	English

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

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
DISRUPTIVE BEHAVIOR DISORDERS	Aggression Replacement Training (ART)	12 - 17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory - Revised (SESBI-R) [If parent is unavailable]	2 - 16	**ECBI**: Arabic, Armenian, Cambodian, Chinese, English, Japanese, Korean, Russian, Spanish, Tagalog, Vietnamese **SESBI-R**: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Aggression Replacement Training - Skillstreaming (ART)	5 - 12					
	Promoting Alternative THinking Strategies (PATHS)	3 - 12					
	Managing and Adapting Practice (MAP) - Disruptive Behavior**	0 - 21	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+			
SEVERE BEHAVIORS/ CONDUCT DISORDERS	Brief Strategic Family Therapy (BSFT)	10 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Revised Behavior Problem Checklist - Parent (RBPC) Revised Behavior Problem Checklist - Teacher (RBPC) [If parent is unavailable]	5 - 18	Armenian, Cambodian, English, Spanish
	Multidimensional Family Therapy (MDFT)	11 - 18					
	Strengthening Families Program (SFP)	3 - 16					
	Functional Family Therapy (FFT)	10 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	10 - 17 12 - 18	Developer Required: Clinical Services System: • Counseling Process Questionnaire • Client Outcome Measure • Therapist Outcome Measure • YOQ/YOQ-SR/OQ	10 - 18	English
	Multisystemic Therapy (MST)	11 - 17			Developer Required: Therapist Adherence Measure Supervisor Adherence Measure	11 - 17	English
PARENTING AND FAMILY DIFFICULTIES	Triple P Positive Parenting Program (Triple P)	0 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [If parent is unavailable]	2 - 16	**ECBI**: Arabic, Armenian, Cambodian, Chinese, English, Japanese, Korean, Russian, Spanish, Tagalog, Vietnamese **SESBI-R**: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Incredible Years (IY)	0 - 12					
	Parent – Child Interaction Therapy (PCIT)	2 - 7					
	Family Connections (FC)	0 - 18					
	UCLA TIES Transition Model (UCLA TIES) CDE	0 - 9					
	Caring For Our Families (CFOF) CDE as of 12/1/12	5 - 11					
	Loving Intervention Family Enrichment (LIFE) CDE as of 12/1/12	10 - 17					
	Reflective Parenting Program (RPP) CDE	0 - 12					
	Mindful Parenting Groups (MPG) CDE	0 - 3	No general measure is required		Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T)	1m - 36m	English, Spanish

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

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
PARENTING AND FAMILY DIFFICULTIES	Caring For Our Families (CFOF) CDE prior to 12/1/12	5 - 11	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	As of 12/1/12, the Eyberg Child Behavior Inventory (ECBI) and Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [If parent is unavailable] are being used for all new clients instead of the Child Behavior Checklist for Ages 1 ½ - 5 (CBCL 1.5-5) Child Behavior Checklist (CBCL) Caregiver-Teacher Report Form for Ages 1 ½ - 5 (C-TRF) Teacher Report Form (TRF) Youth Self-Report (YSR)	2 - 16	**ECBI**: Arabic, Armenian, Cambodian, Chinese, English, Japanese, Korean, Russian, Spanish, Tagalog, Vietnamese **SESBI-R**: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Loving Intervention Family Enrichment (LIFE) CDE prior to 12/1/12	10 - 17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	10 - 17 12 - 18			
	Families OverComing Under Stress (FOCUS)	5+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	McMaster Family Assessment Device (FAD)	12+	English

* Providers started collecting outcomes for TF-CBT in December 2010 (MHSA Implementation Memo, dated 12/14/2010).
** Providers started collecting outcomes for MAP-Anxiety and Avoidance, MAP-Traumatic Stress, and MAP-Depression and Withdrawal in February 2011 (MHSA Implementation Memo, dated 2/22/2011).
*** For treatment cycles beginning before November 1, 2015 the DSM-IV UCLA PTSD-RI Child/Adolescent, Parent, and Adult Short Form will be required.
**** For treatment cycles beginning before October 1, 2017 the Posttraumatic Stress Diagnostic Scale (PDS) will be required.
PEI EBP's that are not entered into PEI OMA are shaded.
1. Youth Outcome Questionnaire - 2.01 (Parent); Youth Outcome Questionnaire-Self-Report - 2.0; Outcome Questionnaire - 45.2 are available in all threshold languages/scripts: English, Arabic, Armenian, Cambodian, Chinese (Modern), Chinese (Traditional), Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese, as well as Japanese.
2. Patient Health Questionnaire-9 (PHQ-9) and Posttraumatic Stress Disorder Checklist-5 (PCL-5) are available in all threshold languages/scripts: English, Arabic, Armenian, Cambodian, Chinese (Modern), Chinese (Traditional), Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese.

PUBLIC ANNOUNCEMENT

PUBLIC HEARING OF THE MHSA ANNUAL UPDATE FISCAL YEAR 2018-19

LOS ANGELES COUNTY MENTAL HEALTH COMMISSION
Lawrence J. Lue, Acting Chairperson, Presiding

Thursday, March 22, 2018
11:00 AM – 2:00 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 programs.

Agenda

11:00 – 11:30AM	Reception (Lunch provided)
11:30 – 11:40AM	Opening Session (Welcome & Introductions) – Lawrence J. Lue
11:40 – 11:45AM	Overview of Public Hearing Process
11:45 – 1:15PM	MHSA Annual Update - Dr. Innes-Gomberg
1:15 – 1:50PM	Close Public Comments Period – Lawrence J. Lue
1:50 – 2:00PM	*__Next Steps__ – April 26, 2018 Full Commission Meeting

- Spanish & Korean translation services will be available
- For American Sign Language and other translation services contact: Krystal Wilson at (213) 351-7200 by Thursday, March 1, 2018
- 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 April 26, 2018. 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
JONATHAN E. SHERIN, M.D., Ph.D.
DIRECTOR

MHSA FISCAL YEAR (FY) 2018/2019 ANNUAL UPDATE
AVAILABLE FOR PUBLIC REVIEW

February 20, 2018

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 2018/2019 Annual Update. The Public Review and Comment period will begin February 20, 2018 and expires March 21, 2018. 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 March 22, 2018 and the reception is scheduled to begin at 11:00 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 Program Development and Outcomes Bureau, 550 South Vermont Avenue, 3rd Floor, Los Angeles, CA 90020. Any member of the public may request a hard copy of the document by contacting Debbie Innes-Gomberg, Ph.D. at (213) 738-2756.

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
Program Development and Outcomes Bureau
Attention: MHSA Annual Update FY 2018/2019
550 S. Vermont Avenue, 3rd Floor
Los Angeles, CA 90020
Fax#: (213) 351-2762

550 S. VERMONT AVENUE, LOS ANGELES, CA 90020 | HTTP://DMH.LACOUNTY.GOV
Email: Director@dmh.lacounty.gov | Phone: (213) 738-4601

Mental Health Services Act (MHSA) Annual Update Fiscal Year (FY) 2018-19

1

DEBBIE INNES-GOMBERG, PH.D.
MARCH 22, 2018

WELLNESS • RECOVERY • RESILIENCE

LACDMH
hope. recovery. wellbeing.

Purpose and Facts

2

- 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 certification as to 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- 2016-17

Key Dates

3

Date	Item
January 17, 2018	Presentation of the Annual Update to the System Leadership Team
January 25, 2018	Presentation of the Annual Update to Mental Health Commission
February 19 – March 21, 2018	Public Posting of Plan for 30 days
March 22, 2018	Public Hearing convened by the Mental Health Commission
April 26, 2018	Mental Health Commission deliberation on approval of the MHSA Annual Update
May – July 2018	Board letter submission and adoption, posting of final Annual Update on website and submission to the Mental Health Services Oversight and Accountability Commission

Fiscal Year 2016-17
Community Services & Supports (CSS)

4

FULL SERVICE PARTNERSHIP

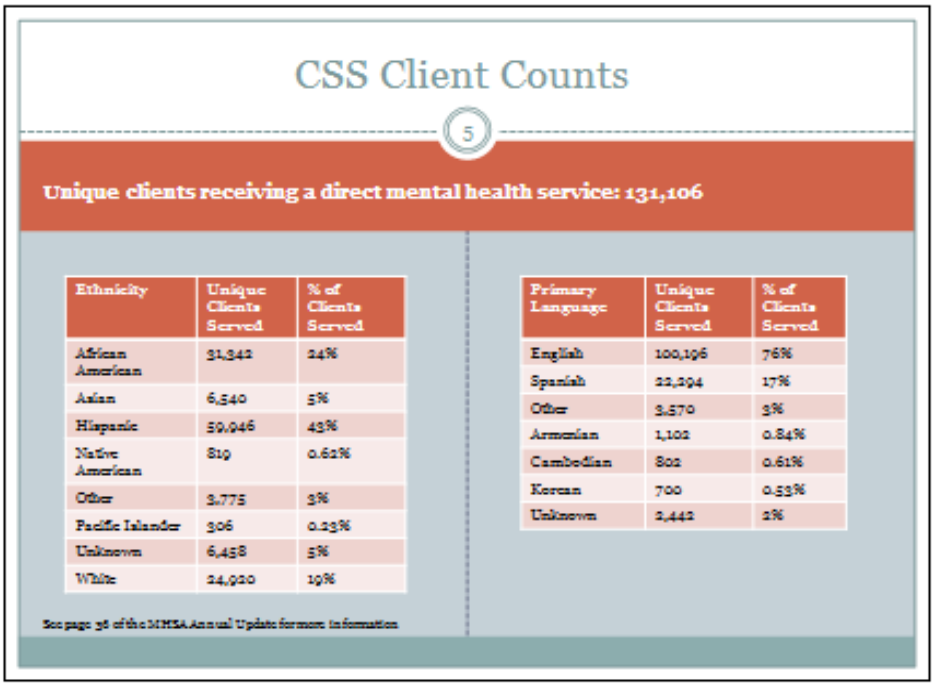
RECOVERY, RESILIENCE & REINTEGRATION

ALTERNATIVE CRISIS SERVICES

PLANNING, OUTREACH & ENGAGEMENT

LINKAGE

HOUSING



CSS Client Counts

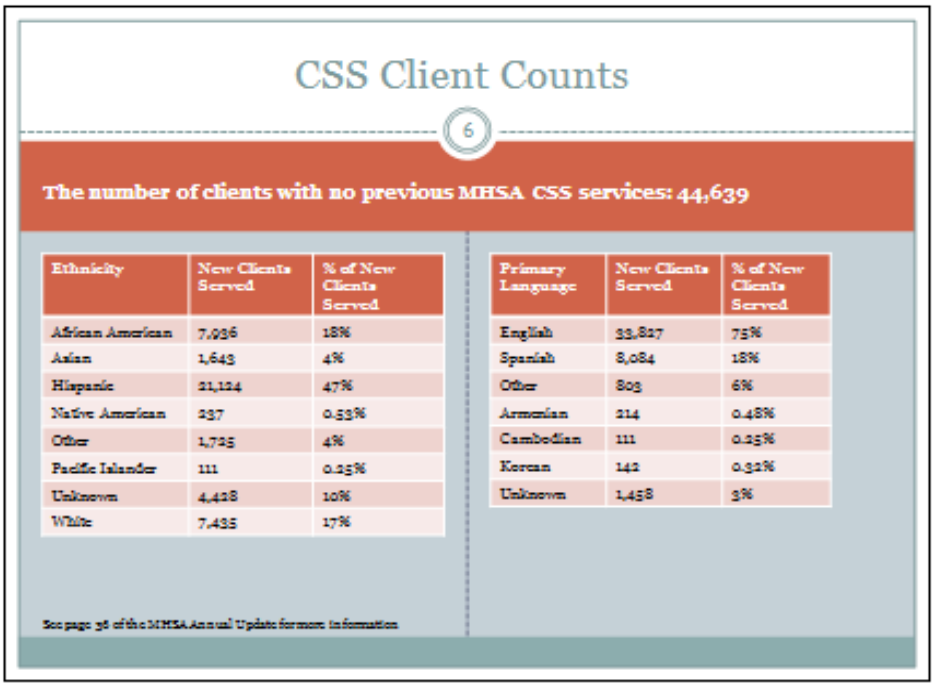
5

Unique clients receiving a direct mental health service: 131,106

Ethnicity	Unique Clients Served	% of Clients Served
African American	31,342	24%
Asian	6,540	5%
Hispanic	59,046	43%
Native American	819	0.62%
Other	3,775	3%
Pacific Islander	306	0.23%
Unknown	6,458	5%
White	24,920	19%

Primary Language	Unique Clients Served	% of Clients Served
English	100,196	76%
Spanish	22,294	17%
Other	3,570	3%
Armenian	1,102	0.84%
Cambodian	802	0.61%
Korean	700	0.53%
Unknown	2,442	2%

See page 36 of the MHSA Annual Update for more information



CSS Client Counts

6

The number of clients with no previous MHSA CSS services: 44,639

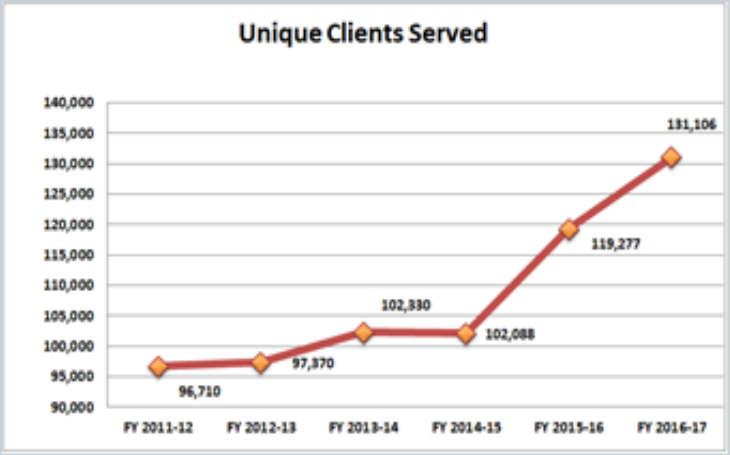
Ethnicity	New Clients Served	% of New Clients Served
African American	7,936	18%
Asian	1,643	4%
Hispanic	21,124	47%
Native American	237	0.53%
Other	1,725	4%
Pacific Islander	111	0.25%
Unknown	4,428	10%
White	7,435	17%

Primary Language	New Clients Served	% of New Clients Served
English	33,827	75%
Spanish	8,084	18%
Other	803	6%
Armenian	214	0.48%
Cambodian	111	0.25%
Korean	142	0.32%
Unknown	1,458	3%

See page 36 of the MHSA Annual Update for more information

Unique Clients Served by Fiscal Year

7



Clients Served by Service Area

8

Service Area	Unique Clients Served	New Clients Served
1	8,051	3,235
2	20,700	7,832
3	15,344	6,413
4	27,953	11,344
5	9,316	4,432
6	25,545	11,273
7	11,018	4,555
8	22,787	8,061

See page 37 of the MHSA Annual Update for more information

Full Service Partnership (FSP) FY 2016-17

9

Age Group	Unique Clients Served in FY 2016-17	Average Cost Per Client[1]	Slots Allocated[2]
Child[3]	2,235	$14,417	2,295
TAY[4]	1,873	$12,000	1,541
Adult[5]	6,019	$11,469	5,705
Older Adult	1,322	$8,725	869

1 Cost is based on Medi-Cal services, not inclusive of community outreach services or client supportive services expenditures.
2 Slot allocation for FY 2016-17.
3 Child: unique clients served inclusive of Child and Wraparound Child FSP programs.
4 TAY: unique clients served inclusive of TAY and Wraparound TAY FSP programs.
5 Adult: unique clients served inclusive of Adult, Assisted Outpatient Treatment (AOT), and Integrated Mobile Health Team (IMHT)

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FSP Slot Allocation for FY 2017-18

10

Age Group	Slot Allocation FY 2017-18	Number of Slots Increased from FY 2016-17
Child	3,371	1,076
TAY	1,621	80
Adult	11,441	5,736
Older Adult	885	16
Total Slots	17,238	6,828

Page 37 of the MHSA Annual Update

FSP: What did we learn?

11

- Most experience the greatest benefit the first year in partnership.
- Older adults experience most improvement in acute hospitalizations over 3 years.
- Adult, TAY and older adults experience the most improvement in employment over two years.
- Child and TAY all improve their grade distribution over two years in partnership but experience the most change during the first year in partnership.
- Possibly explore outcomes within service areas against the background of tenure length and population characteristics.
- In all programs that have enough data to make observations, client meeting goals for treatment becomes the dominate reason for disenrollment during the first (full) year in partnership. Client having met goals seems to mirror actual success in outcomes.
- Moderate relationships exist between client having lost contact and homelessness. Data suggests a moderate relationship between field based work and a client not losing contact.

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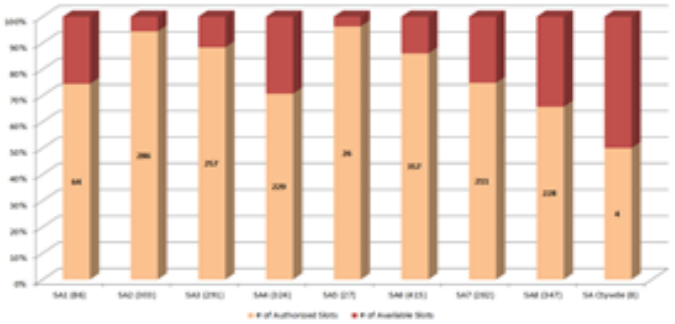
Child FSP Slot Capacity

December 14, 2017

80% of child slots are authorized for services

- Service Area (SA) 5 has the largest percent authorized at 97% but has the smallest number of total slots
- SA8 has the lowest percent authorized at 66%
- SA6 has the largest number of slots, 415 and is at 86% capacity



Child FSP Focal Population

13

- 38% of the 1,662 authorized child FSP clients reported experiencing truancy or sporadic attendance, suspension or expulsion and/or failing classes at school as one of the reasons for referral
- SA 8 reported the largest percentage, 45%
- Child FSP clients experiencing truancy or sporadic attendance, suspension or expulsion and/or failing classes at school as one of the reasons for referral makes up the largest reason for referral for all Service Areas, with the exception of SA3 and SA6

TAY FSP Focal Population

14

- 46% of the 1,105 authorized TAY FSP clients reported homeless as one of the reasons for referral
- 33% of the authorized clients reported substance abuse as one of the reasons for referral
- 30% of the authorized clients reported aging out of the child mental health system, child welfare system or juvenile justice system as one of the reasons for referral
- SA1 has the largest percentage, 60%, of authorized clients reporting homeless as one of the reasons for referral

Adult FSP Focal Population

15

- 51% of the 2,224 authorized adult FSP clients reported homeless as one of the reasons for referral
- SA1 has the largest percentage, 62%, of authorized clients reporting homeless as one of the reasons for referral
- Homeless makes up the largest reason for referral for all Service Areas, with the exception of SA2
- SA8 has the largest number of authorized clients reporting homeless, 496, as one of the reasons for referral

Older Adult FSP Focal Population

16

- 29% of the 963 authorized older adult FSP clients reported homeless as one of the reasons for referral
- 28% of the authorized older adult FSP clients reported being hospitalized one or more days in the last 12 months as one of the reasons for referral
- Older Adult risk factors (45%) makes up for the largest reason for referral for all Service Areas, with the exception of SA1
- SA2 has the largest percentage, 44%, of authorized clients reporting homeless as one of the reasons for referral

FSP Residential Outcomes

17

- Comparison of residential data for 12 months immediately prior to receiving FSP services (pre-partnership) and for 12 months of residential status while receiving FSP services (post-partnership) for client's outcomes entered through June 30, 2017
- Data is adjusted (annualized) by a percentage based on average length of stay in the FSP program
- Data must meet data quality standards to be included in the analysis

Pages 47-61 of the MHSA Annual Update

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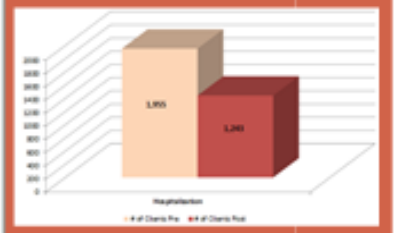
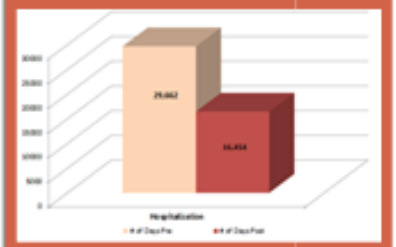
FSP Child's Hospitalization Outcomes





- 45% reduction in days hospitalized
- 36% reduction in the number of clients hospitalized

Number of Clients Included: 8,690
Number of Baselines Included: 8,920

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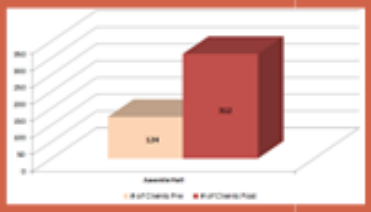
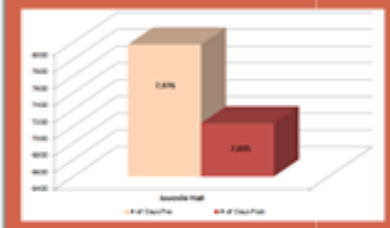
FSP Child's Juvenile Hall Outcomes





- 152% increase in the number of clients in juvenile hall post-partnership
- Data indicates 124 children reported being in juvenile hall 365 days prior to partnership and 312 children after partnership was established.
- This is approximately 1% and 3% respectively of the 8,920 baselines included.
- On average, children spent 64 days in Juvenile Hall prior to partnership and 22 days post partnership. A decrease of 42 days.
- Although there was an increase of 188 clients residing in Juvenile Hall after partnership we see a significant decrease in the number of days spent in Juvenile Hall.
- One thing to keep in mind is that, for children, behaviors that violate social norms (i.e., delinquent or aggressive behaviors) tend to be slower to change because the child's environment may not support positive change.

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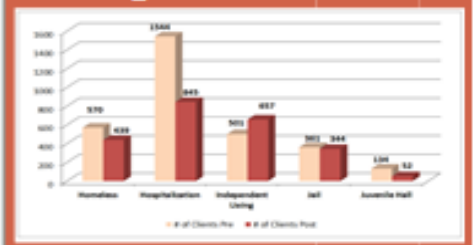
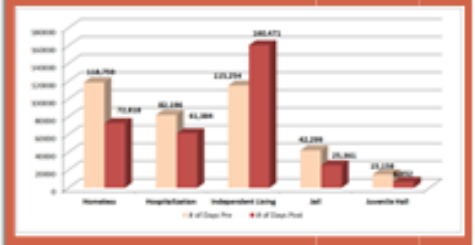
FSP TAY Living Arrangement Outcomes





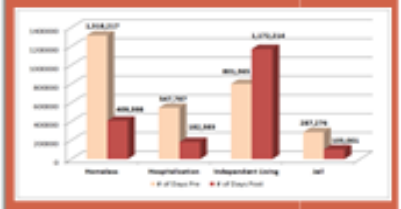
- 39% reduction in days homeless
- 25% reduction in days hospitalized
- 40% reduction in days in jail
- 39% increase in days living independently
- 56% reduction in days in juvenile hall
- 23% reduction in clients homeless
- 45% reduction in clients hospitalized
- 5% reduction in clients in jail
- 31% increase in clients living independently

Number of Clients Included: 4,454
Number of Baselines Included: 4584

Pages 49-52 of the MHSA Annual Update

21

FSP Adult Living Arrangement Outcomes



- 69% reduction in days homeless
- 67% reduction in days hospitalized
- 63% reduction in days in jail
- 46% increase in days living independently
- 30% reduction in clients homeless
- 25% reduction in clients hospitalized
- 17% reduction in clients in jail
- 47% increase in clients living independently

Number of Clients Included: 12,807
Number of Baselines Included: 13481

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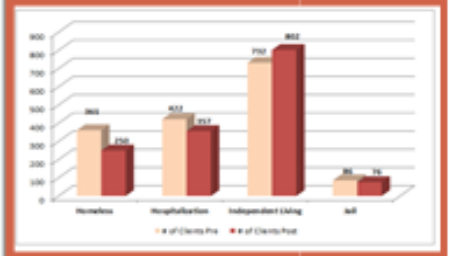
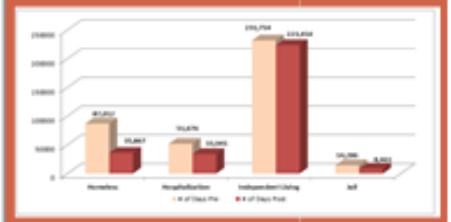
22

FSP Older Adult Living Arrangement Outcomes





- 59% reduction in days homeless
- 34% reduction in days hospitalized
- 4% increase in days living independently
- 41% reduction in days in jail
- 31% reduction in clients homeless
- 15% reduction in clients hospitalized
- 10% increase in clients living independently
- 12% reduction in clients in jail

Number of Clients Included: 1,606
Number of Baselines Included: 1,643

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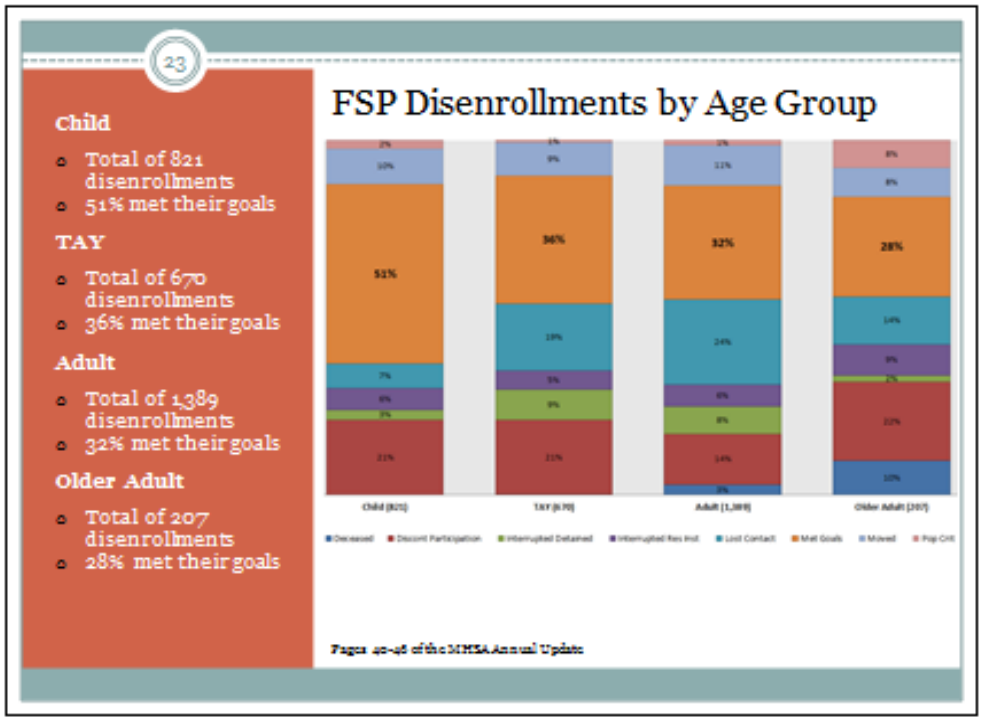
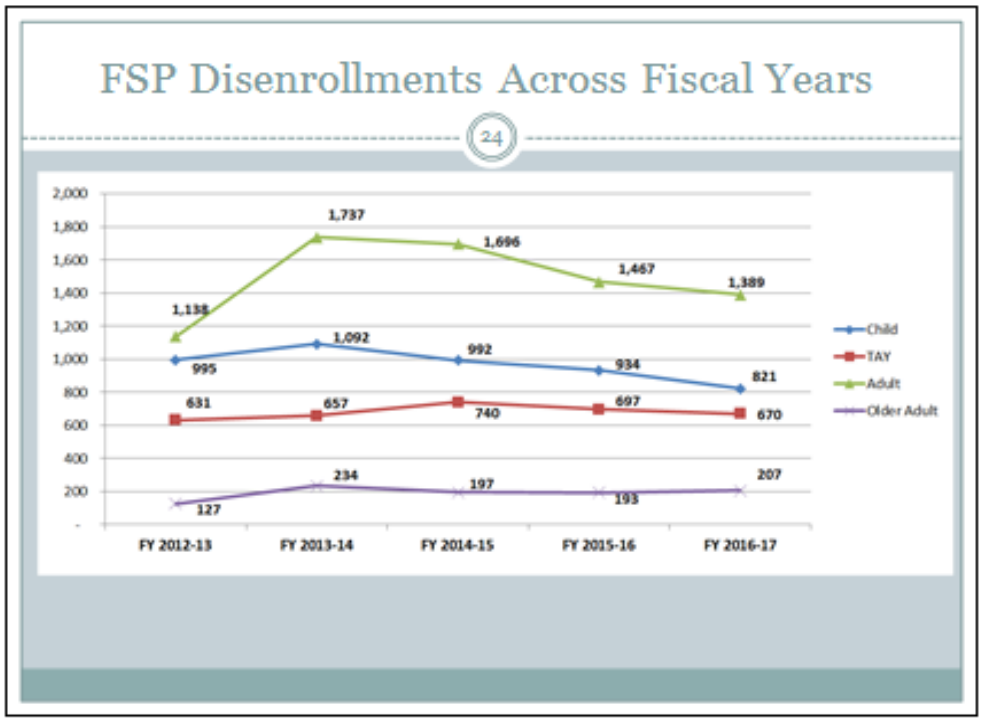
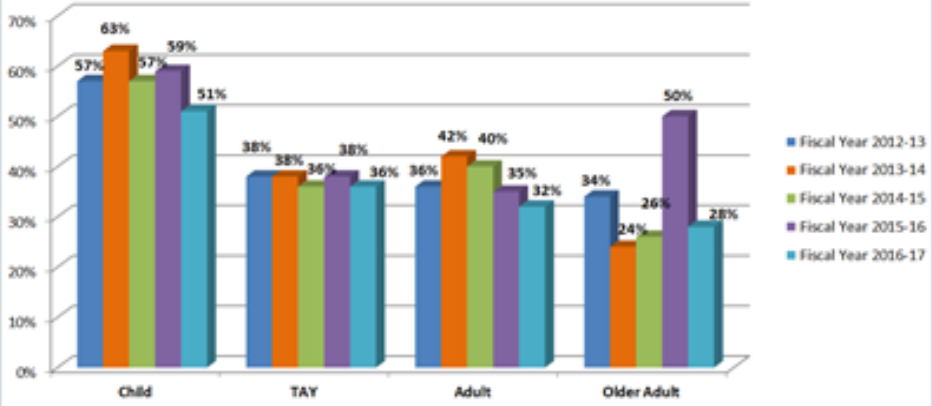

23
Child
Total of 821 disenrollments
51% met their goals
TAY
Total of 670 disenrollments
36% met their goals
Adult
Total of 1,389 disenrollments
32% met their goals
Older Adult
Total of 207 disenrollments
28% met their goals
FSP Disenrollments by Age Group
Pages 40-46 of the MHSA Annual Update


FSP Disenrollments Across Fiscal Years
24
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
-
1,737
1,696
1,467
1,389
1,138
1,092
992
934
821
995
631
657
740
697
670
234
197
193
207
127
FY 2012-13
FY 2013-14
FY 2014-15
FY 2015-16
FY 2016-17
Child
TAY
Adult
Older Adult

FSP Disenrollments with Met Goals

25



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Child FSP Disenrollment Reasons by Number of Years Enrolled

26

Child FSP Disenrollment Reason	Years Enrolled			
	< 1 year (n=4003)	1 Year (n=3317)	2 Years (n=1248)	3+ Years (n=358)
Met Goals	32%	64%	74%	73%
Pop Not Met	2%	1%	2%	1%
Ptnr Discontinued	30%	14%	9%	10%
Moved	14%	8%	6%	4%
Lost Contact	9%	5%	3%	3%
Need Residential	9%	4%	4%	7%
Detained or Jail	4%	3%	2%	2%
Deceased	0%	0%	0%	0%
Total	100%	100%	100%	100%

- Met goals is the top disenrollment reason provided for those leaving the partnership within less than 1 year
- Met goals is the top disenrollment reason provided for those enrolled 1, 2 and 3 years

The disenrollment data was gathered from the FSP Referral Tracking Database as of 9/11/2017.

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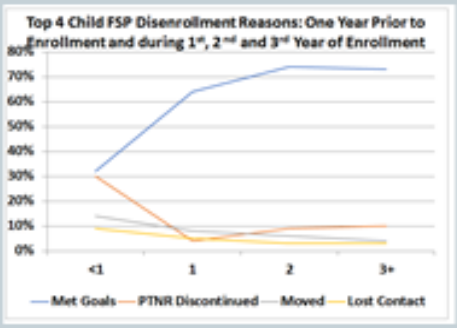
Child FSP Disenrollment Reasons by Number of Years Enrolled

27



- Percentage of met goals becomes the predominate reason for disenrollment during the first year of partnership. With less than 1 year in partnership, disenrollment is seemingly a "toss-up" between goals met and partner discontinued.
- Since so many benefits are associated with at least one year of treatment, finding a way to keep clients in Child FSP for at least one year and, perhaps longer, is essential to maximize the help experienced by clients.

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TAY FSP Disenrollment Reasons by Number of Years Enrolled

28

TAY FSP Disenrollment Reason	Years Enrolled			
	< 1 year (n=2736)	1 Year (n=1925)	2 Years (n=879)	3+ Years (n=566)
Met Goals	14%	41%	58%	60%
Pop Not Met	2%	2%	2%	1%
Ptnr Discontinued	31%	21%	15%	13%
Moved	15%	9%	6%	7%
Lost Contact	21%	16%	11%	8%
Need Residential	7%	5%	5%	4%
Detained or Jail	8%	6%	3%	7%
Deceased	1%	1%	0%	0%
Total	100%	100%	100%	100%

- Lost Contact is the top disenrollment reason provided for those leaving the partnership within less than 1 year
- Met Goals is the top disenrollment reason provided for those enrolled 1, 2 and 3 years

The disenrollment data was gathered from the FSP Referral Tracking Database as of 9/11/2017.

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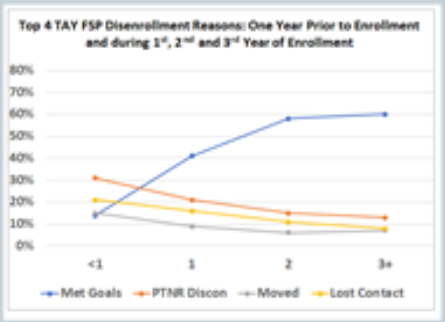
TAY FSP Disenrollment Reasons by Number of Years Enrolled

29



- Percentage of met goals predominates as a reason for disenrollment during the first year of partnership. Even PTNR discontinued and Lost contact fall well below met goals by year one.
- Since so many benefits are associated with at least one year of treatment, finding way to keep clients in TAY FSP for at least one year and, perhaps longer, may be essential to help maximize the help experienced.

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Adult FSP Disenrollment Reasons by Number of Years Enrolled

30

Adult FSP Disenrollment Reason	Years Enrolled			
	< 1 year (n=5003)	1 Year (n=3096)	2 Years (n=1895)	3+ Years (n=2609)
Met Goals	13%	29%	42%	54%
Pop Not Met	5%	1%	2%	2%
Ptnr Discontinued	21%	17%	15%	9%
Moved	13%	13%	12%	10%
Lost Contact	26%	20%	12%	9%
Need Residential	10%	8%	7%	6%
Detained or Jail	10%	8%	6%	4%
Deceased	2%	3%	4%	5%
Total	100%	100%	100%	100%

- Lost Contact is the top disenrollment reason provided for those leaving the partnership within less than 1 year
- Met Goals is the top disenrollment reason provided for those enrolled 1, 2 and 3 years

The disenrollment data was gathered from the FSP Referral Tracking Database as of 9/11/2017.

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Adult FSP Disenrollment Reasons by Number of Years Enrolled

31

- Percentage of Met Goals becomes the predominate reason for disenrollment and not other reasons, two of which could be associated with treatment failure.
- Since so many benefits are associated with at least one year of treatment, finding ways to keep clients in Adult FSP for at least one year and, perhaps longer, is essential to maximize the help experienced by clients.

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Older Adult FSP Disenrollment Reasons by Number of Years Enrolled

32

Older Adult FSP Disenrollment Reason	Years Enrolled			
	< 1 year (n=655)	1 Year (n=347)	2 Years (n=207)	3+ Years (n=226)
Met Goals	17%	30%	45%	49%
Pop Not Met	5%	2%	5%	5%
Ptnr Discontinued	26%	19%	9%	12%
Moved	7%	7%	7%	6%
Lost Contact	20%	13%	8%	7%
Need Residential	14%	17%	11%	6%
Detained or Jail	2%	1%	0%	1%
Deceased	9%	10%	15%	14%
Total	100%	100%	100%	100%

- Lost Contact is the top disenrollment reason provided for those leaving the partnership within less than 1 year
- Met Goals is the top disenrollment reason provided for those enrolled 1, 2 and 3 years

The disenrollment data was gathered from the FSP Referral Tracking Database as of 9/11/2017.

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Older Adult FSP Disenrollment Reasons by Number of Years Enrolled

33

- With less than one year in partnership, disenrollment is more likely to be because of PTNR discontinued or losing contact with the client. Percentage of Met Goals becomes the predominate reason for disenrollment during the first year in partnership.
- Since so many benefits are associated with at least one year of treatment, finding way to keep Older Adults in FSP for at least one year and, likely longer, is essential.

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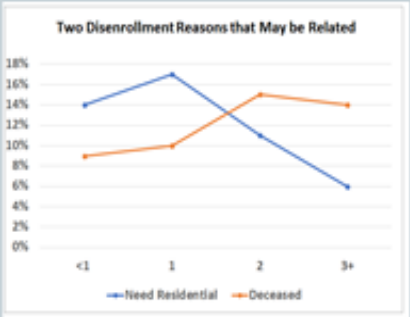
Older Adult FSP Disenrollment Reasons by Number of Years Enrolled

34



- These two disenrollment reasons seem to share a relationship that, if true, is concerning.
- It would be unfortunate if the unmet need for residential care among some of the older adult FSP population is such that death outlasts the need's fulfillment. Or, it could be that those who most need this type of housing cannot tolerate the delay. Additional research is warranted.
- Older adults in FSP may share many of the same needs for housing and more than those expressed by Adult FSP clients.

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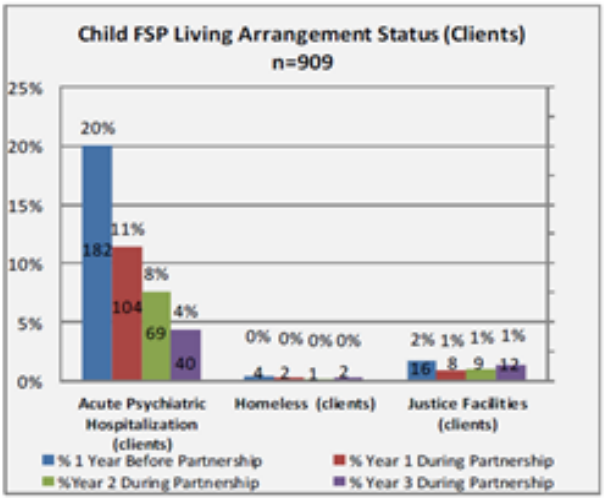
Child FSP Living Arrangement Outcomes

Child FSP has been found to be effective in decreasing the number of clients residing in Acute Psychiatric facilities. There is very little data about homeless or justice facility living arrangements. This may change over time.

Child FSP Outcomes Report– One Year Data September 2017



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Child FSP Outcomes

36

Child FSP Psychiatric Hospitalization

Year to Year Percent Reduction in Psychiatric Hospitalizations	
Year before partnership to 1st Year	43%
During 1st year of partnership to 2nd year	34%
During 2nd year of partnership to 3rd+ year	42%
Year before partnership to year 3	78%

- The biggest drop in psychiatric hospitalizations occurred during the first and third year of partnership

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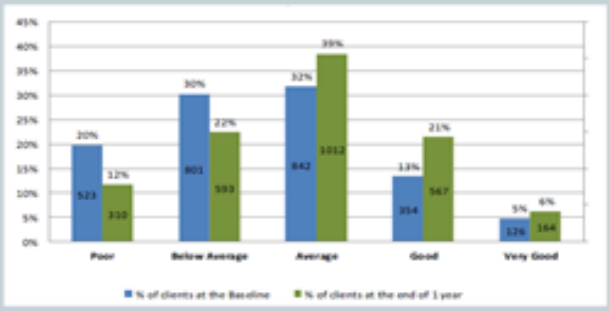
Child FSP Outcomes

37

Child FSP Distribution of Grades at the Baseline and at the End of the 1st Year (n=2,646)

- Each grade category is shown to be moving in the correct direction (e.g. Poor grades are less frequent while average, good and very good grades appear more often)



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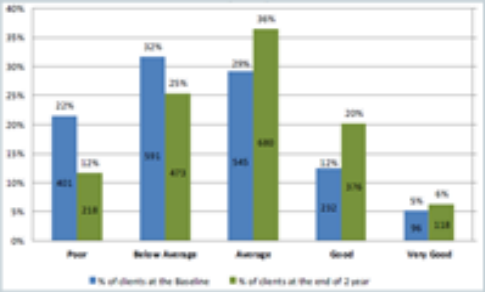
Child FSP Outcomes

38

Child FSP Distribution of Grades at the Baseline and through the End of 2nd Year (n=1,865)

- All grade categories are shown to continue to be moving in the hoped-for direction (e.g. Poor and below average grades are less frequent while average, good and very good grades appear more often).
- Poor grade performance is down over 45% compared to baseline.
- Average grades are up by over 24% compared to 22% during the 1st year in partnership.
- Good grade performance is up over 67% compared to 62% improvement in the first year of partnership



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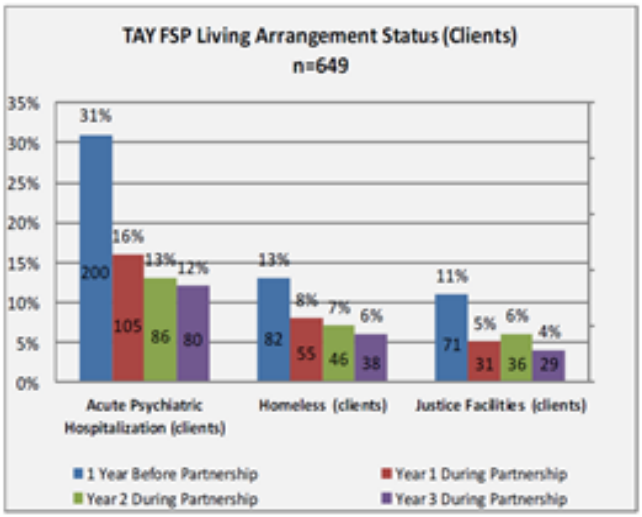
TAY FSP Living Arrangement Outcomes

TAY FSP has been found to be effective in decreasing the number of clients residing in acute psychiatric facilities, reduced the percentage of clients reported to be homeless and the percentage of those residing in justice facilities.

TAY FSP Outcomes Report– One Year Data September 2017



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TAY FSP Outcomes

40

TAY FSP Psychiatric Hospitalization

Year to Year Percent Reduction in Psychiatric Hospitalizations	
Year before partnership to 1st Year	48%
During 1st year of partnership to 2nd year	18%
During 2nd year of partnership to 3rd+ year	7%
Year before partnership to year 3	60%

- The biggest drop occurred in the first year of the partnership.

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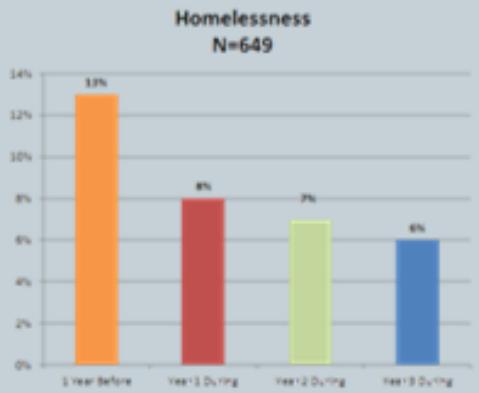
TAY FSP Outcomes

41

TAY FSP Homelessness



Year to Year Percent Reduction in Homelessness	
Year before partnership to 1st Year	33%
During 1st year of partnership to 2nd year	16%
During 2nd year of partnership to 3rd+ year	17%
Year before partnership to year 3	54%

- The biggest drop occurred in the first year of the partnership.

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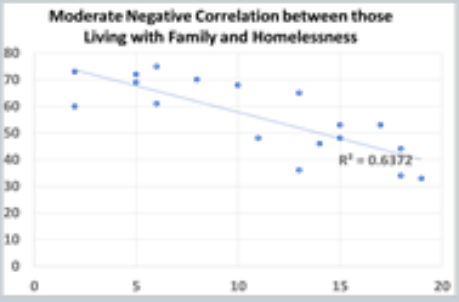
TAY FSP Outcomes

42

Homelessness – Explorative analysis of the relationship between several factors in 18 TAY FSP programs with at least 18 disenrollments over the past 12 months.

- There is a moderate negative correlation between homelessness and clients living with their families.
- This moderate correlation suggests that homelessness may be partly addressed by seeking family reunification through adding family education, family treatment and support and helping to bridge the gap between client and family if possible.



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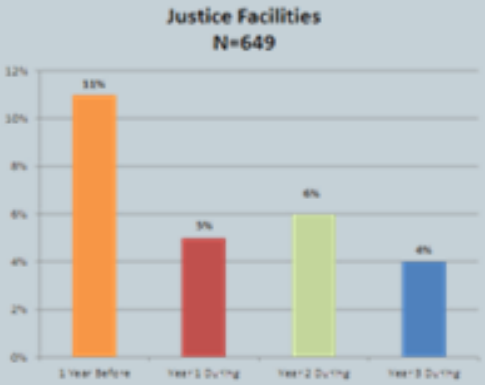
TAY FSP Outcomes

43

TAY FSP Justice Facilities



Year to Year Percent Reduction in Justice Facilities	
Year before partnership to 1st Year	56%
During 1st year of partnership to 2nd year	+20%
During 2nd year of partnership to 3rd+ year	19%
Year before partnership to year 3	59%

- The biggest drop occurred in the first year of partnership and remained low during years 2 and 3

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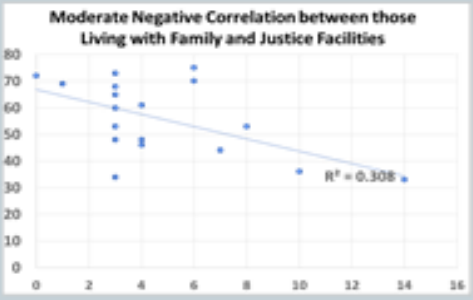
TAY FSP Outcomes

44

Justice Facilities – Explorative analysis of the relationship between several factors in 18 TAY FSP programs with at least 18 disenrollments over the past 12 months.

- A moderate negative correlation exits living with family and living in a justice facility.
- This moderate correlation suggests that justice vulnerability may be partly addressed by seeking family reunification through adding family education, family treatment and support and helping to bridge the gap between client and family if possible.



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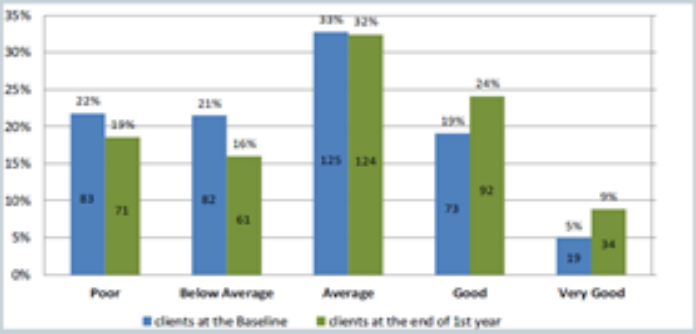
TAY FSP Outcomes

45

TAY FSP Distribution of Grades at the Baseline and at the End of 1st Year (n=371)

- Each grade category is shown to be moving in the correct direction (e.g. Poor grades are less frequent while average to very good grades appear more often)



46

Adult FSP Living Arrangement Outcomes

Adult FSP has been found to be effective in decreasing the number of homeless, the number of those residing in acute psychiatric facilities and in criminal justice facilities in LA County

Adult FSP Outcomes Report– One Year Data September 2017

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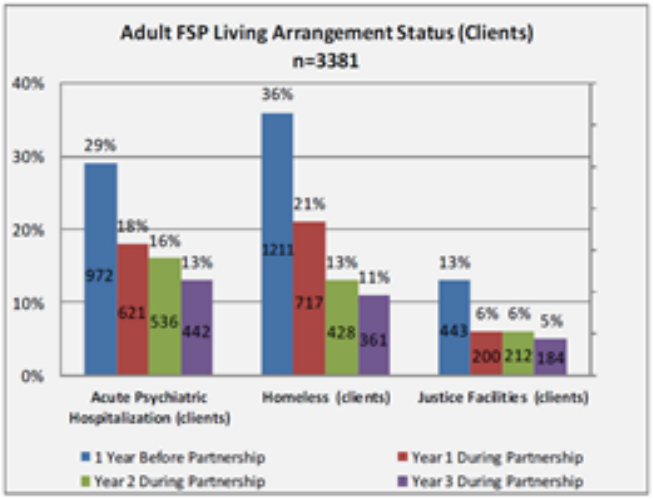
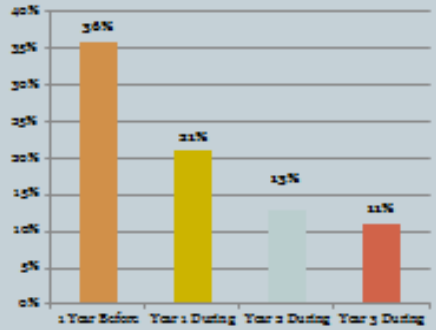


Adult FSP Outcomes

47

Adult FSP Homelessness



Year to Year Percent Reduction in Homelessness	
Year before partnership to 1st Year	41%
During 1st year of partnership to 2nd year	40%
During 2nd year of partnership to 3rd+ year	16%
Year before partnership to year 3	70%

- The biggest drop in homelessness occurred during the first and second year of the partnership.

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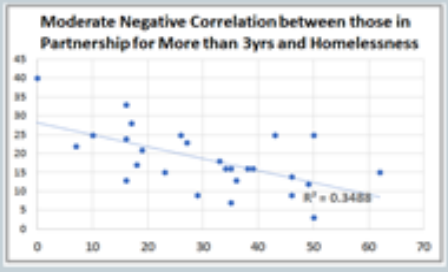
Adult FSP Outcomes

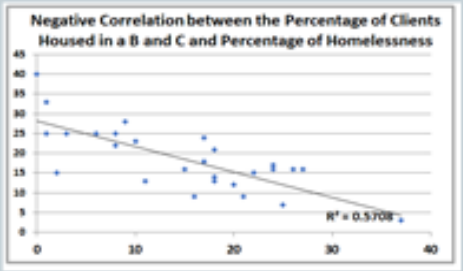
48

Homelessness – Explorative analysis of the relationship between several factors in 27 Adult FSP programs with at least 18 disenrollments over the past 12 months.

- While the biggest year-to-year drop in homelessness occurs between baseline and the 1st year in partnership, many will require additional time to transition



- Having available options for housing (B & C for example) seems to be strongly associated with a reduction in homelessness and may indicate the kind of emphasis that is needed countywide



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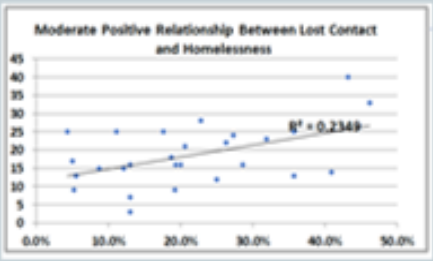
Adult FSP Outcomes

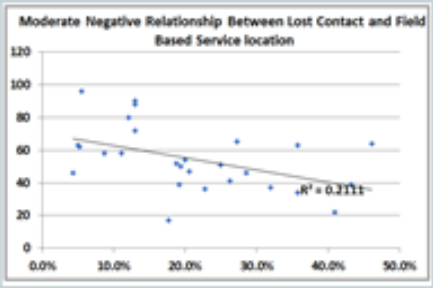
49

Homelessness – Explorative analysis of the relationship between several factors in 27 Adult FSP programs with at least 18 disenrollments over the past 12 months.

- The moderate positive relationship between lost contact as a disenrollment reason and homelessness suggests that the failure to maintain relationship increases the risk of not having, not maintaining or not securing housing.



- The moderate negative relationship between lost contact and field based service location suggests that investing in treatment outside the clinic may play a role in helping to moderate the tendency for clients to go missing.



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Adult FSP Outcomes

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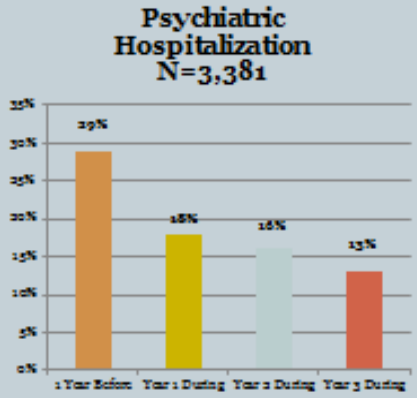
Adult FSP Psychiatric Hospitalization



Year to Year Percent Reduction in Psychiatric Hospitalizations	
Year before partnership to 1st Year	36%
During 1st year of partnership to 2nd year	14%
During 2nd year of partnership to 3rd+ year	18%
Year before partnership to year 3	55%

- The biggest drop occurred in the first year of the partnership.

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Adult FSP Outcomes

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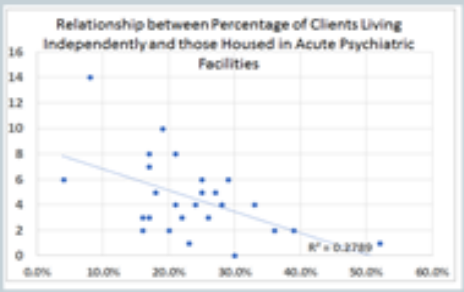
Psychiatric Hospitalization – Explorative analysis of the relationship between several factors in 27 Adult FSP programs with at least 18 disenrollments over the past 12 months.

- There is a moderate relationship between the percentage of clients living independently and those housed in acute psychiatric facilities.
- Living independently maybe the most viable option to being housed in a psychiatric facility provided the client is afforded the necessary skills to succeed.



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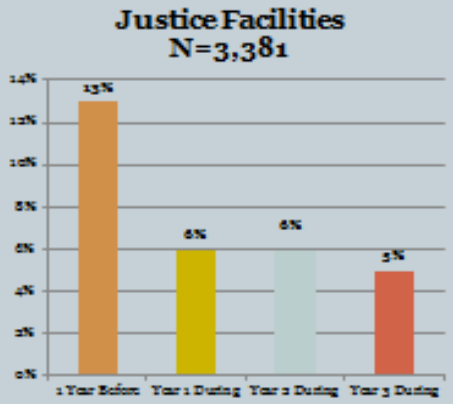
Adult FSP Outcomes

52

Adult FSP Justice Facilities



Year to Year Percent Reduction in Justice Facilities	
Year before partnership to 1st Year	55%
During 1st year of partnership to 2nd year	+6%
During 2nd year of partnership to 3rd+ year	13%
Year before partnership to year 3	58%

- The biggest drop occurred in the first year of the partnership.

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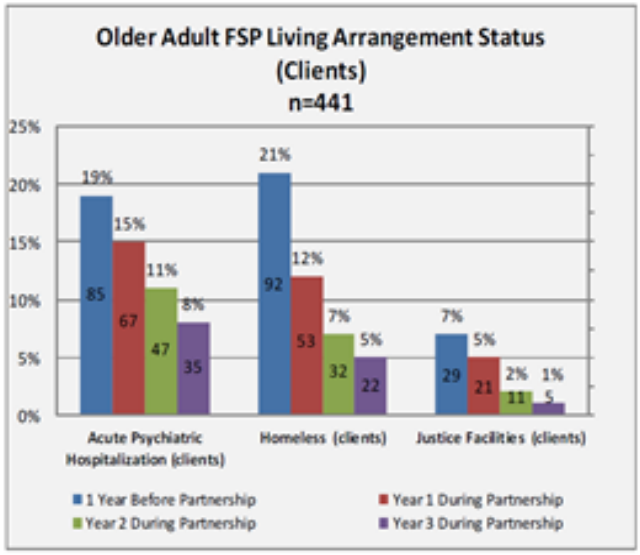
Older Adult FSP Living Arrangement Outcomes

Older Adult FSP has been found to be effective in decreasing the number of clients residing in Acute Psychiatric facilities, reduced the percentage of clients reported to be homeless and the percentage of those residing in justice facilities.

Older Adult FSP Outcomes Region 9- One Year Data September 2017



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Older Adult FSP Outcomes

54

Older Adult FSP Psychiatric Hospitalization

Year to Year Percent Reduction in Psychiatric Hospitalizations	
Year before partnership to 1st Year	21%
During 1st year of partnership to 2nd year	50%
During 2nd year of partnership to 3rd+ year	26%
Year before partnership to year 3	59%

- The biggest drop occurred during the second and third year of the partnership although progress in reducing psychiatric hospitalization seems to be fairly consistent over three years.

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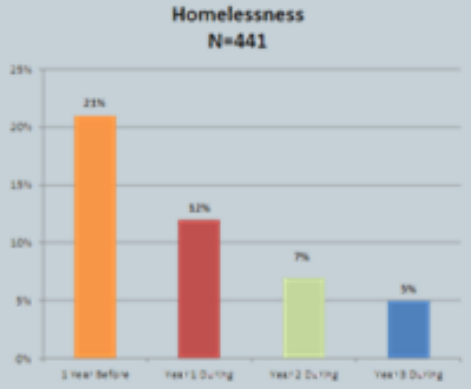
Older Adult FSP Outcomes

55

Older Adult FSP Homelessness



Year to Year Percent Reduction in Homelessness	
Year before partnership to 1st Year	42%
During 1st year of partnership to 2nd year	40%
During 2nd year of partnership to 3rd+ year	31%
Year before partnership to year 3	76%

- The biggest drop in homelessness occurred during the first and second year of the partnership.

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Fiscal Year 2016-17
Prevention and Early Intervention (PEI)

56

STIGMA AND DISCRIMINATION REDUCTION

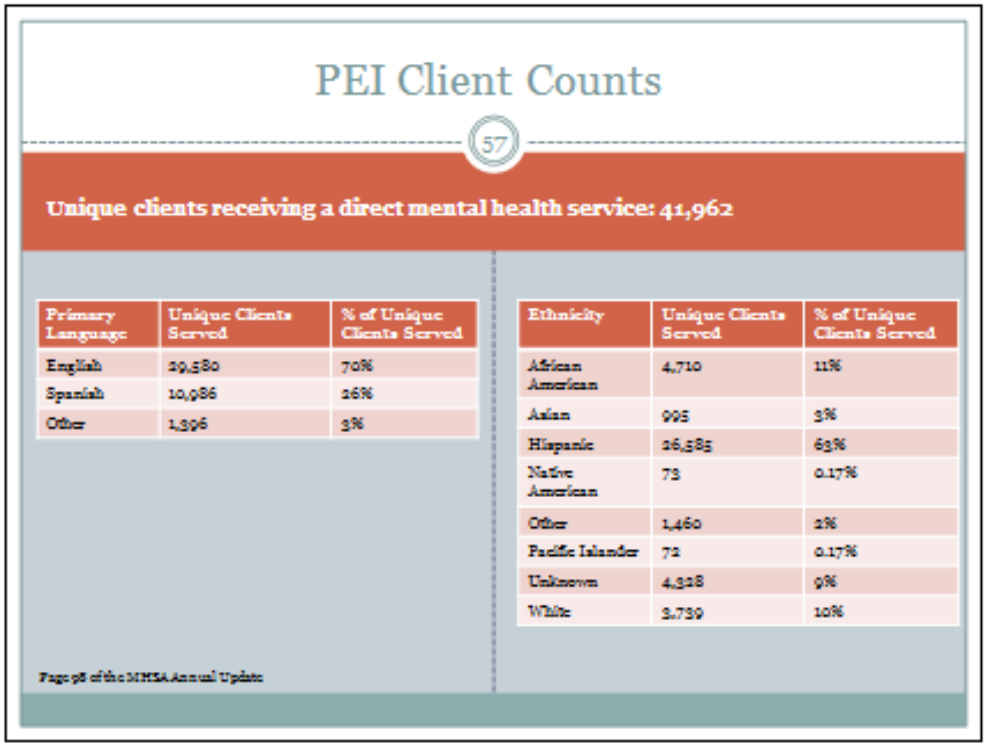
SUICIDE PREVENTION

EARLY INTERVENTION

PREVENTION

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

ACCESS AND LINKAGE TO TREATMENT FOR INDIVIDUALS WHO ARE ALREADY ILL BUT SEEKING SERVICES THROUGH PEI



PEI Client Counts

57

Unique clients receiving a direct mental health service: 41,962

Primary Language	Unique Clients Served	% of Unique Clients Served
English	29,580	70%
Spanish	10,986	26%
Other	1,396	3%

Ethnicity	Unique Clients Served	% of Unique Clients Served
African American	4,710	11%
Asian	995	3%
Hispanic	26,585	63%
Native American	73	0.17%
Other	1,460	2%
Pacific Islander	72	0.17%
Unknown	4,328	9%
White	3,739	10%

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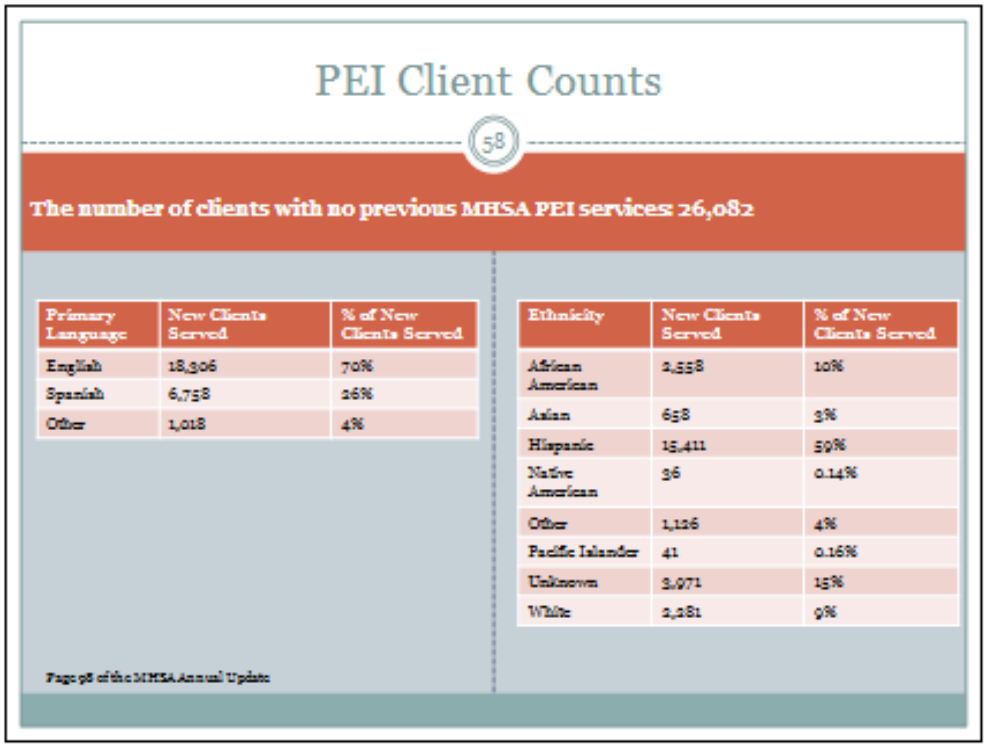

PEI Client Counts

58

The number of clients with no previous MHSA PEI services: 26,082

Primary Language	New Clients Served	% of New Clients Served
English	18,306	70%
Spanish	6,758	26%
Other	1,018	4%

Ethnicity	New Clients Served	% of New Clients Served
African American	2,558	10%
Asian	658	3%
Hispanic	15,411	59%
Native American	36	0.14%
Other	1,126	4%
Pacific Islander	41	0.16%
Unknown	3,971	15%
White	2,281	9%

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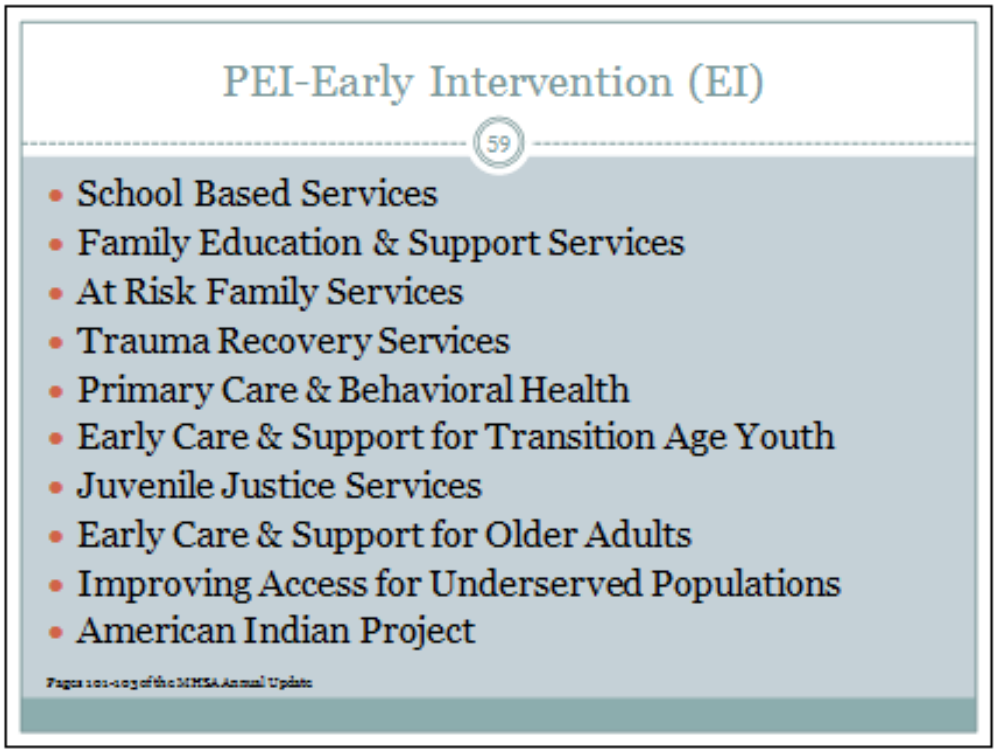
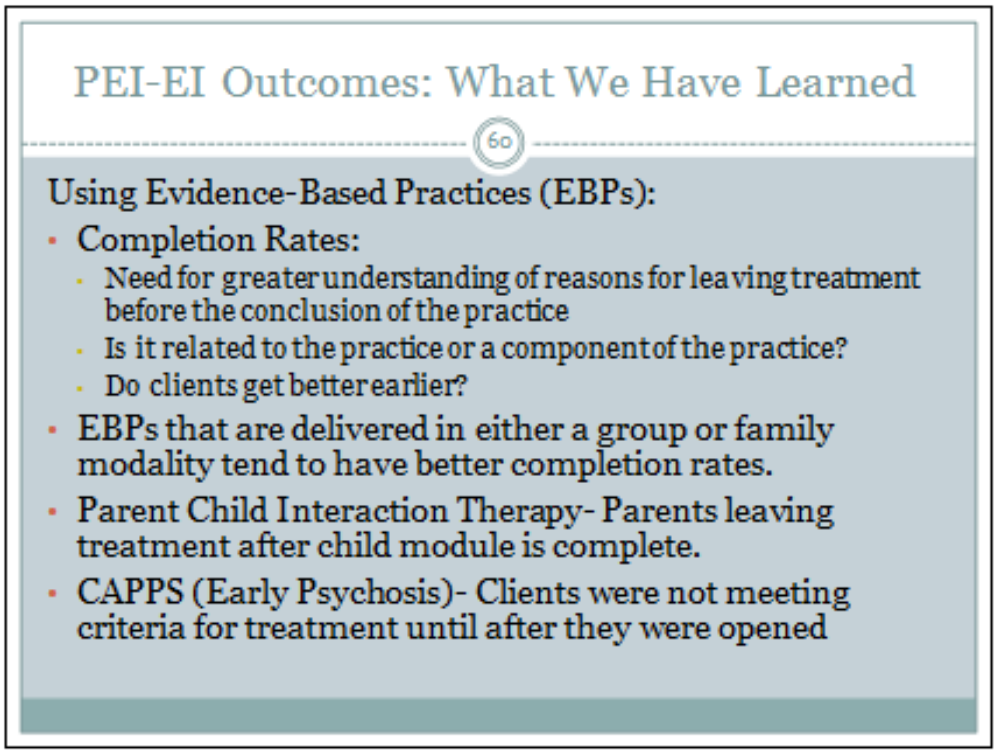

PEI-Early Intervention (EI)
59
School Based Services
Family Education & Support Services
At Risk Family Services
Trauma Recovery Services
Primary Care & Behavioral Health
Early Care & Support for Transition Age Youth
Juvenile Justice Services
Early Care & Support for Older Adults
Improving Access for Underserved Populations
American Indian Project
Pages 101-103 of the MHSA Annual Update


PEI-EI Outcomes: What We Have Learned
60
Using Evidence-Based Practices (EBPs):
Completion Rates:
Need for greater understanding of reasons for leaving treatment before the conclusion of the practice
Is it related to the practice or a component of the practice?
Do clients get better earlier?
EBPs that are delivered in either a group or family modality tend to have better completion rates.
Parent Child Interaction Therapy- Parents leaving treatment after child module is complete.
CAPPS (Early Psychosis)- Clients were not meeting criteria for treatment until after they were opened

61

PEI Outcomes: Assessing pre treatment and post treatment data: Matched Pairs

Matched pairs percentage for the questionnaire was determined by # of matched pairs divided by # of treatment cycles eligible for the questionnaire. The formula is the following:

$$\frac{\text{\# of matched pairs for questionnaire}}{\text{((\# of treatment cycles completed EBP yes) – (\# of clients outside of age range for questionnaire))}}$$

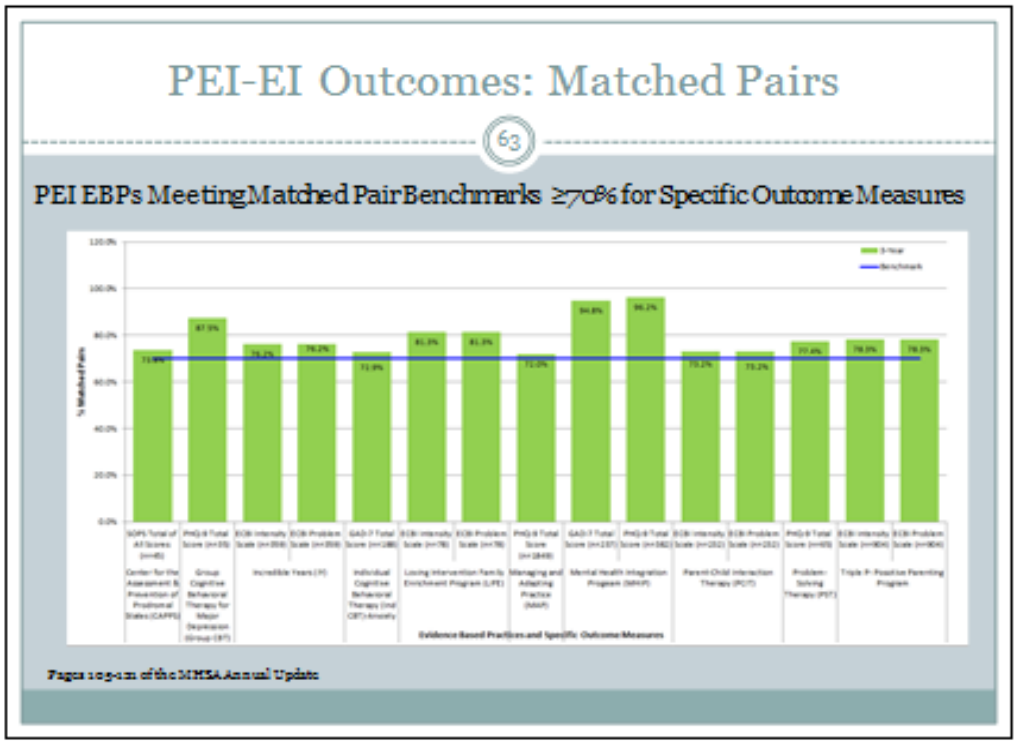
- Creating a benchmark to guide the analyze of the efficacy of PEI practices implemented in Los Angeles County.
- Each practice will have a matched pairs percentage represented for each questionnaire in play with 20 or more matched pairs countywide, or 5 or more matched pairs at the provider level. The benchmark being recommended is ≥ **70% matched pairs** when the client has completed the EBP as indicated by the clinical team.

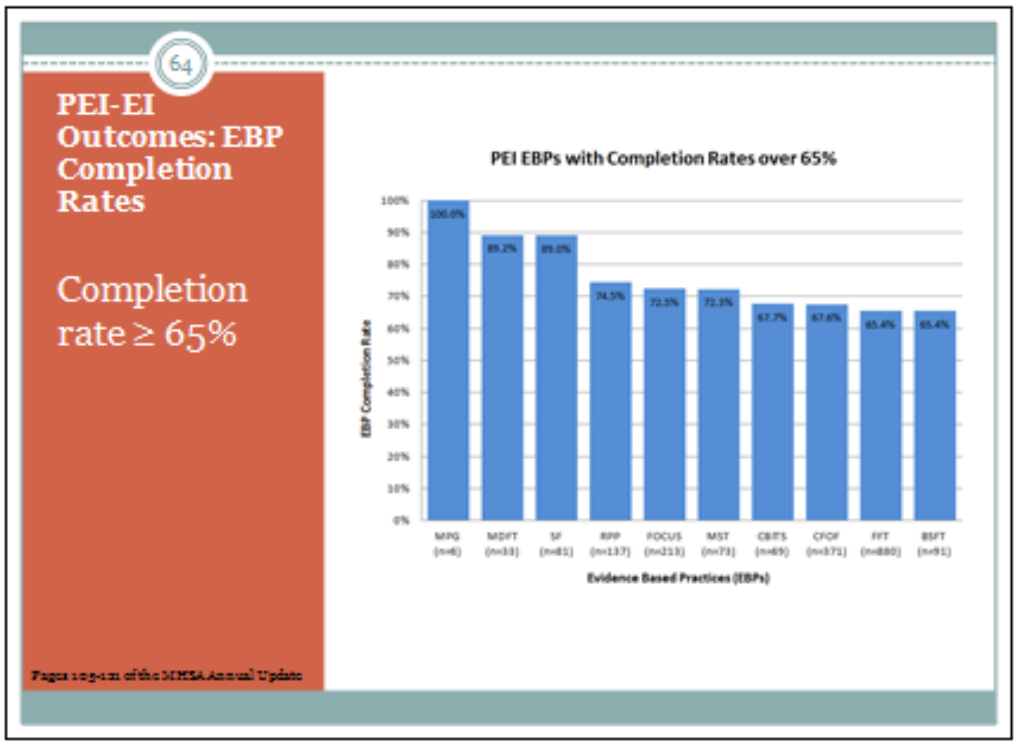
PEI-EI Outcomes: Matched Pairs

62

PEI EBPs Meeting Matched Pair Benchmarks ≥70% for General Outcome Measures

Pages 103-111 of the MHSA Annual Update

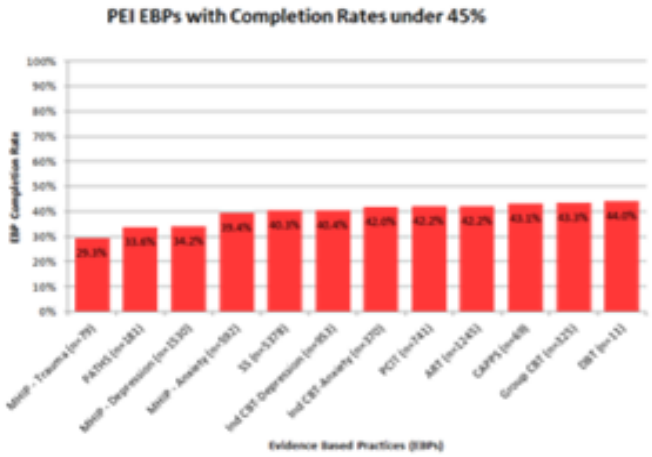

PEI-EI Outcomes: Matched Pairs
63
PEI EBPs Meeting Matched Pair Benchmarks ≥70% for Specific Outcome Measures
Pages 109-111 of the MHSA Annual Update


64
PEI-EI Outcomes: EBP Completion Rates
Completion rate ≥ 65%
PEI EBPs with Completion Rates over 65%
EBP Completion Rate
Evidence Based Practices (EBPs)
Pages 109-111 of the MHSA Annual Update

65

PEI Outcomes: EBP Completion Rates

Completion rate <45%

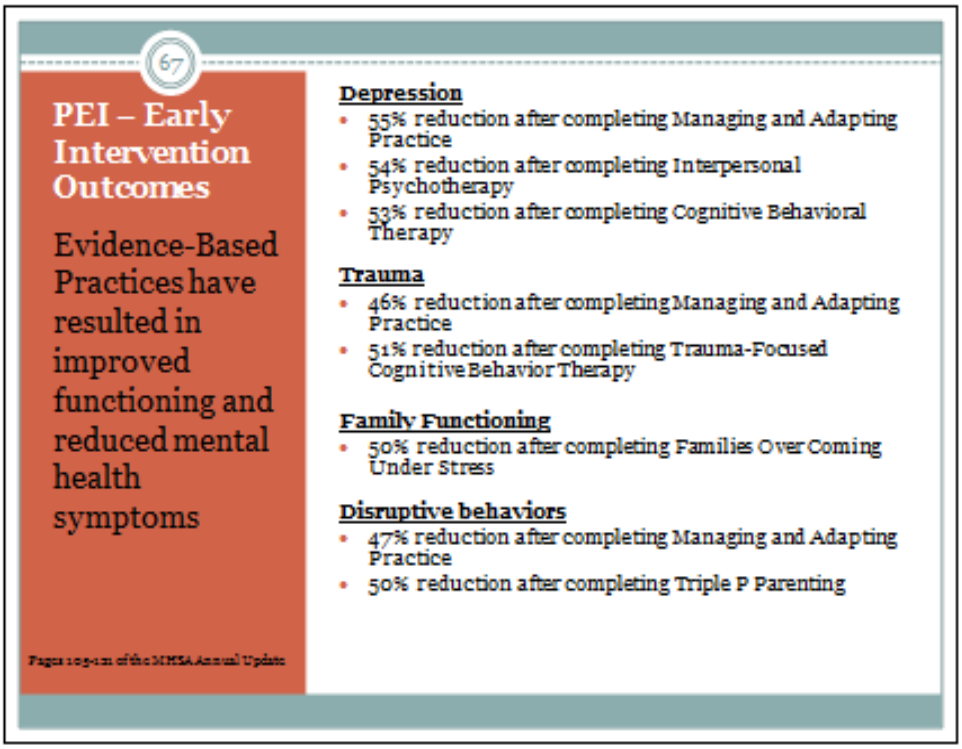


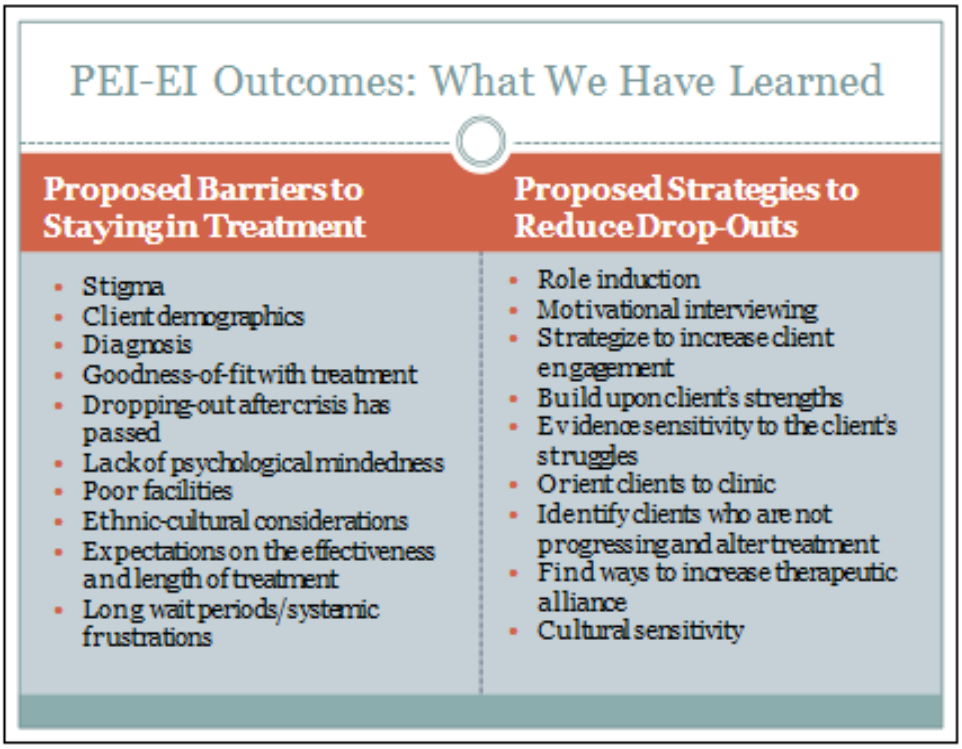
Pages 109-111 of the MHSA Annual Update

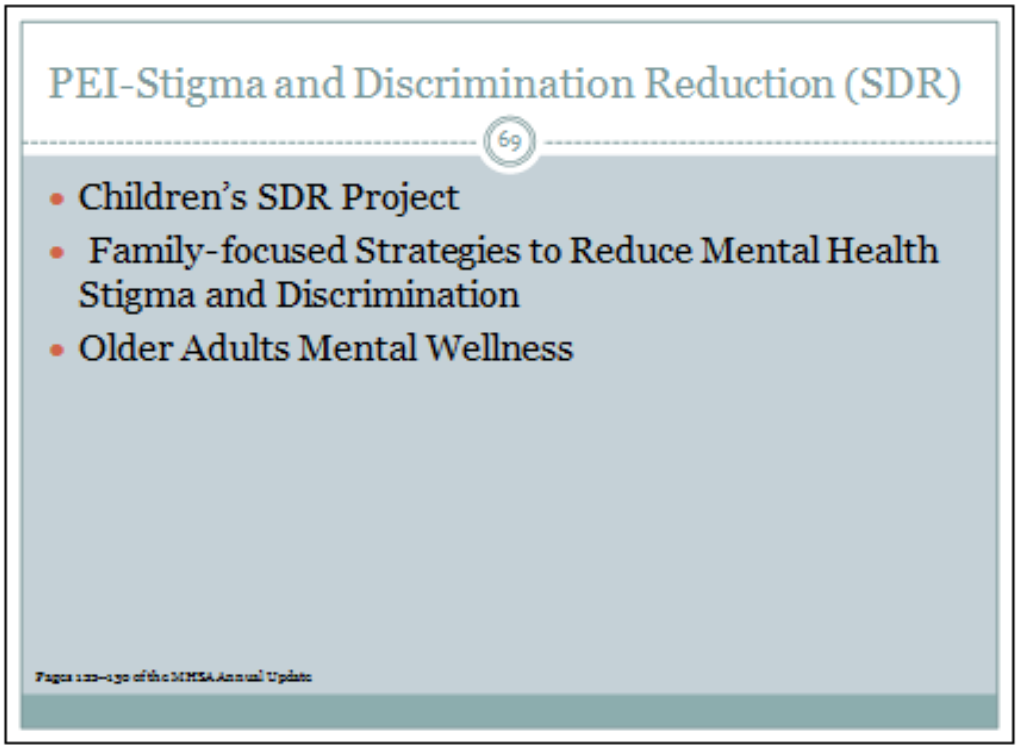
PEI-EI Outcomes: Drop Out Rates

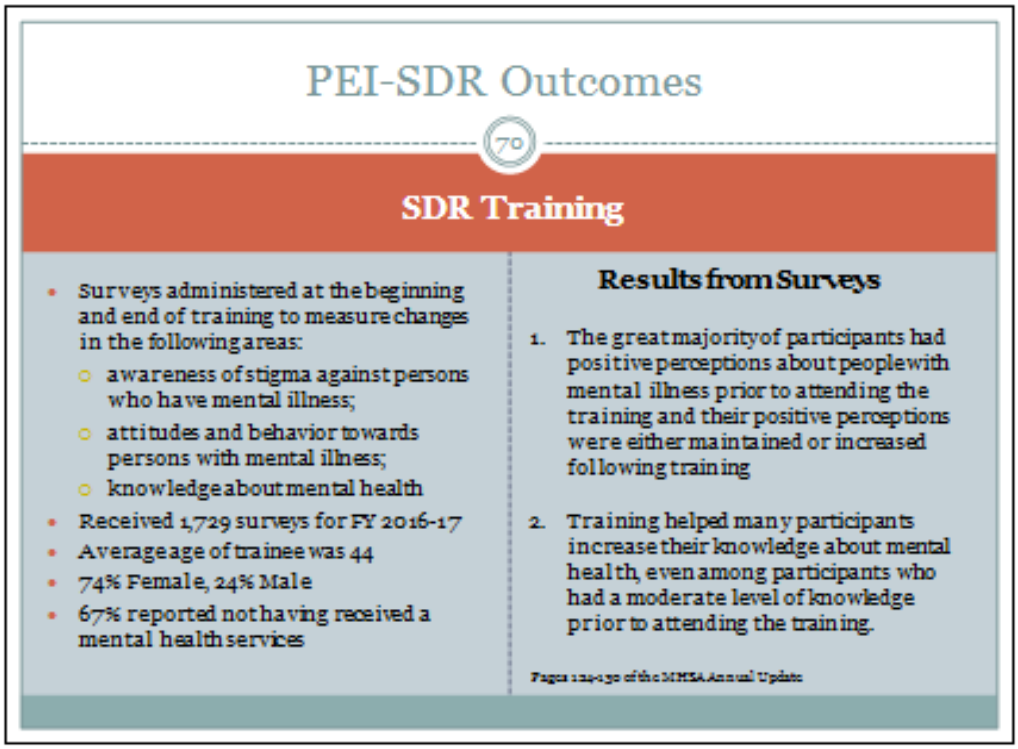
66

- What is "normally expected"?
- Some estimate percent dropping-out can range from 20% to 57% after the first session
- Another suggested up to 65% of clients drop-out before the 10th session
- One author noted that the high drop-out rate was troubling because (in general) 11-13 sessions are needed for half of clients to be considered recovered
- Methodological Issues: What constitutes a "Drop-Out"?


67
PEI – Early Intervention Outcomes
Evidence-Based Practices have resulted in improved functioning and reduced mental health symptoms
Depression
55% reduction after completing Managing and Adapting Practice
54% reduction after completing Interpersonal Psychotherapy
53% reduction after completing Cognitive Behavioral Therapy
Trauma
46% reduction after completing Managing and Adapting Practice
51% reduction after completing Trauma-Focused Cognitive Behavior Therapy
Family Functioning
50% reduction after completing Families Over Coming Under Stress
Disruptive behaviors
47% reduction after completing Managing and Adapting Practice
50% reduction after completing Triple P Parenting


PEI-EI Outcomes: What We Have Learned
Proposed Barriers to Staying in Treatment
Stigma
Client demographics
Diagnosis
Goodness-of-fit with treatment
Dropping-out after crisis has passed
Lack of psychological mindedness
Poor facilities
Ethnic-cultural considerations
Expectations on the effectiveness and length of treatment
Long wait periods/systemic frustrations
Proposed Strategies to Reduce Drop-Outs
Role induction
Motivational interviewing
Strategize to increase client engagement
Build upon client's strengths
Evidence sensitivity to the client's struggles
Orient clients to clinic
Identify clients who are not progressing and alter treatment
Find ways to increase therapeutic alliance
Cultural sensitivity


PEI-Stigma and Discrimination Reduction (SDR)
69
Children's SDR Project
Family-focused Strategies to Reduce Mental Health Stigma and Discrimination
Older Adults Mental Wellness
Pages 122–130 of the MHSA Annual Update


PEI-SDR Outcomes
70
SDR Training
Surveys administered at the beginning and end of training to measure changes in the following areas:
awareness of stigma against persons who have mental illness;
attitudes and behavior towards persons with mental illness;
knowledge about mental health
Received 1,729 surveys for FY 2016-17
Average age of trainee was 44
74% Female, 24% Male
67% reported not having received a mental health services
Results from Surveys
1. The great majority of participants had positive perceptions about people with mental illness prior to attending the training and their positive perceptions were either maintained or increased following training
2. Training helped many participants increase their knowledge about mental health, even among participants who had a moderate level of knowledge prior to attending the training.
Pages 124-130 of the MHSA Annual Update

PEI-Suicide Prevention

71

- Latina Youth Program
- 24/7 Crisis Hotline
- Partners in Suicide Team for Children, TAY, Adults and Older Adults
- School Mental Health Initiative

Pages 131-140 of the MHSA Annual Update

72

PEI-Suicide Prevention Outcomes

Outcomes for Partners in Suicide

Suicide Prevention survey results for FY 2016-17 suggest participants' knowledge about suicide increased through training and education, with a verage total score increases from "pre" to "post" of 24% (947).

Pages 134-135 of the MHSA Annual Update

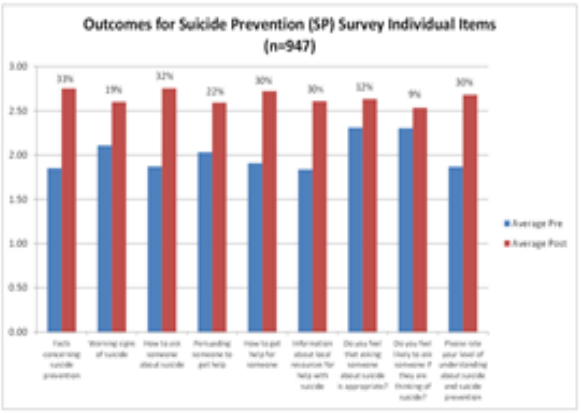


Chart shows the average percent change in score from "pre" to "post" training for each of the nine suicide prevention survey items, as well as few statements about the results.

73

PEI-Suicide Prevention Outcomes

Outcomes for School Mental Health Initiative

The efficiency of School Threat Assessment Response Team's (START) services was evidenced by the reduction of violent and/or suicidal risk scores measured respectively by the MOSAIC and the Columbia-Suicide Severity rating Scale.

Pages 138-140 of the MHSA Annual Update

Of the 127 clients who completed pre- and follow-up measurements:

- 43% reduced their suicidal ideation
- 42% showed a decrease in the violent threat level

START provided 41 trainings to 1,580 attendees:

- 3 trainings on bullying to participants in 12th grade or below, parents/others and professionals
- 13 trainings on targeted school violence to professionals, parents/others and college students
- 22 trainings on START services to professionals, parents/others and college students
- 3 trainings on field safety to professionals

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PEI-Suicide Prevention Outcomes

Outcomes for 24/7 Suicide Prevention Crisis Line

The 24/7 Suicide Prevention Crisis Line responded to a total of 86,970 calls, chats, and texts originating from Los Angeles County, including Spanish-language crisis hotline services to 5,900 callers.

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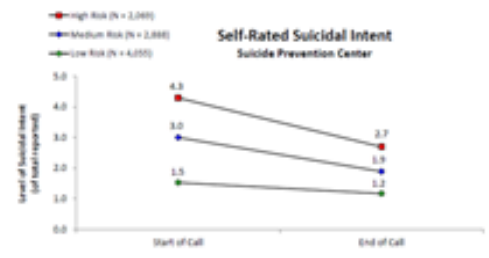
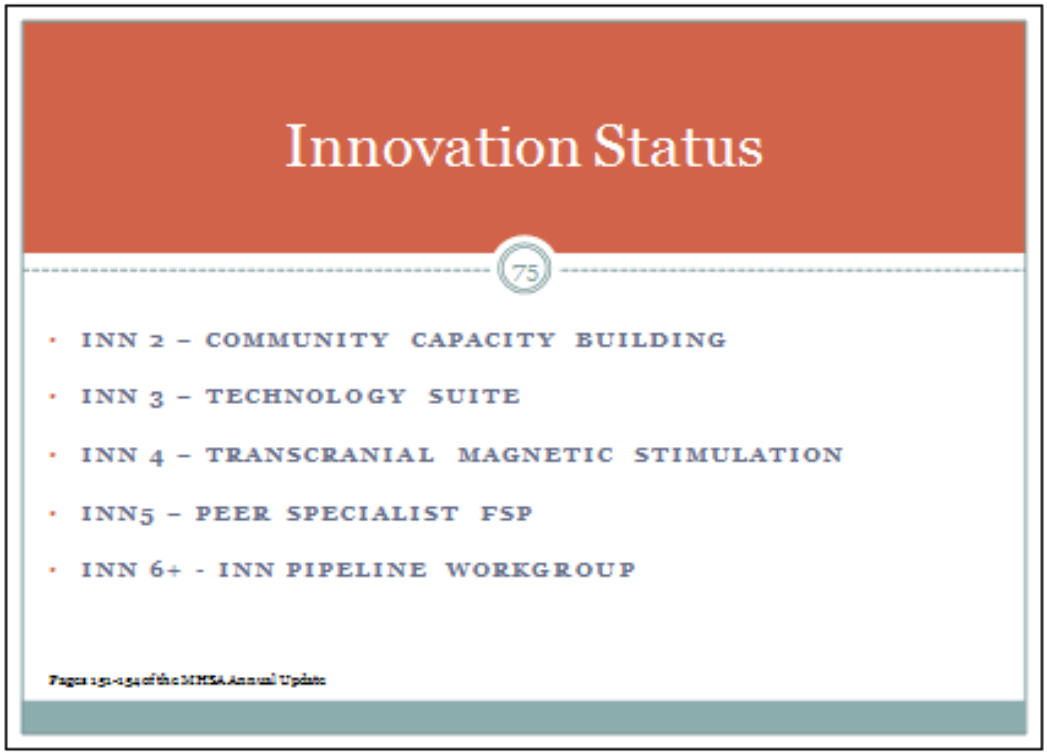
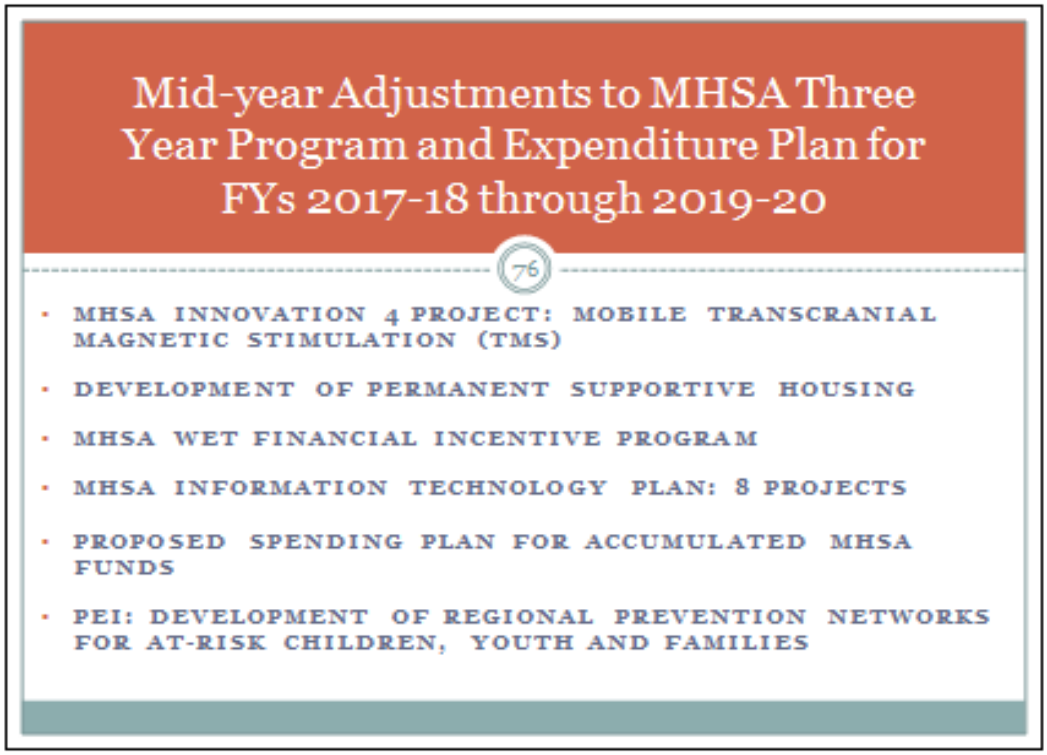
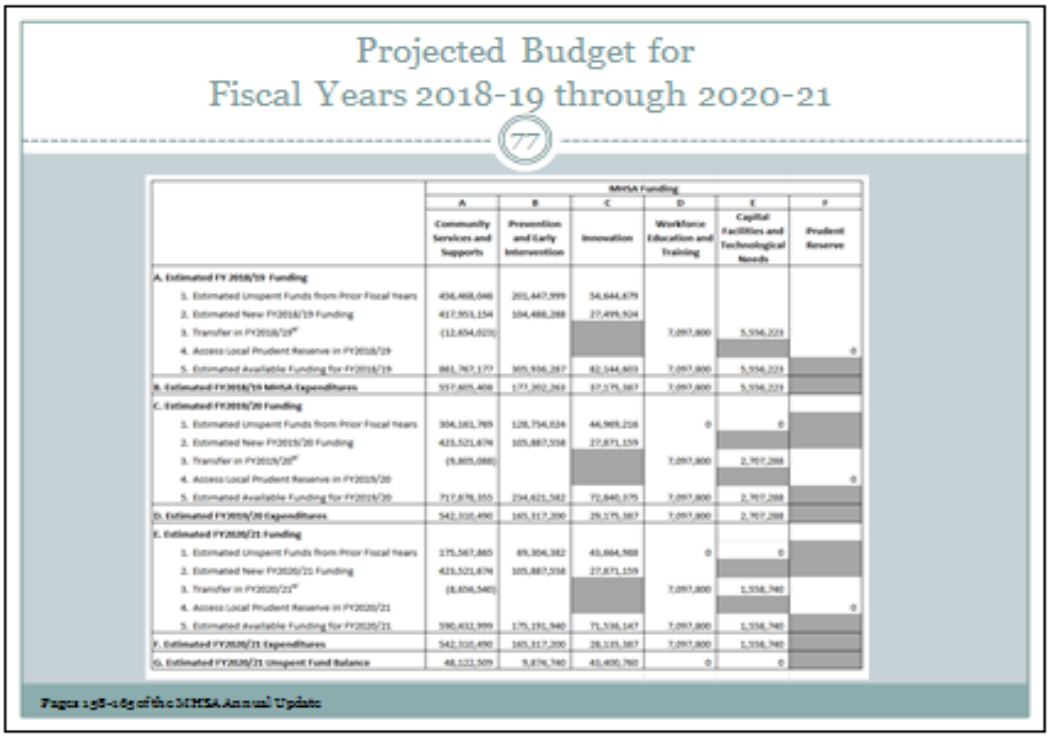


High or Imminent Risk	Refers to callers who rated their Suicidal Intent at 4 or 5 at the beginning of the call.
Medium Risk	Refers to callers who rated their Suicidal Intent at 3 at the beginning of the call.
Low Risk	Refers to callers who rated their Suicidal Intent at 1 or 2 at the beginning of the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

- Callers who rated their suicidal intent as high or imminent risk at the start of the call showed a 37% reduction in their intent by the end of the call.
- Callers who rated their suicidal intent as medium risk at the start of the call also showed a 37% reduction in their intent by the end of the call.


Innovation Status
75
INN 2 – COMMUNITY CAPACITY BUILDING
INN 3 – TECHNOLOGY SUITE
INN 4 – TRANSCRANIAL MAGNETIC STIMULATION
INN5 – PEER SPECIALIST FSP
INN 6+ - INN PIPELINE WORKGROUP
Pages 151-154 of the MHSA Annual Update


Mid-year Adjustments to MHSA Three Year Program and Expenditure Plan for FYs 2017-18 through 2019-20
76
MHSA INNOVATION 4 PROJECT: MOBILE TRANSCRANIAL MAGNETIC STIMULATION (TMS)
DEVELOPMENT OF PERMANENT SUPPORTIVE HOUSING
MHSA WET FINANCIAL INCENTIVE PROGRAM
MHSA INFORMATION TECHNOLOGY PLAN: 8 PROJECTS
PROPOSED SPENDING PLAN FOR ACCUMULATED MHSA FUNDS
PEI: DEVELOPMENT OF REGIONAL PREVENTION NETWORKS FOR AT-RISK CHILDREN, YOUTH AND FAMILIES

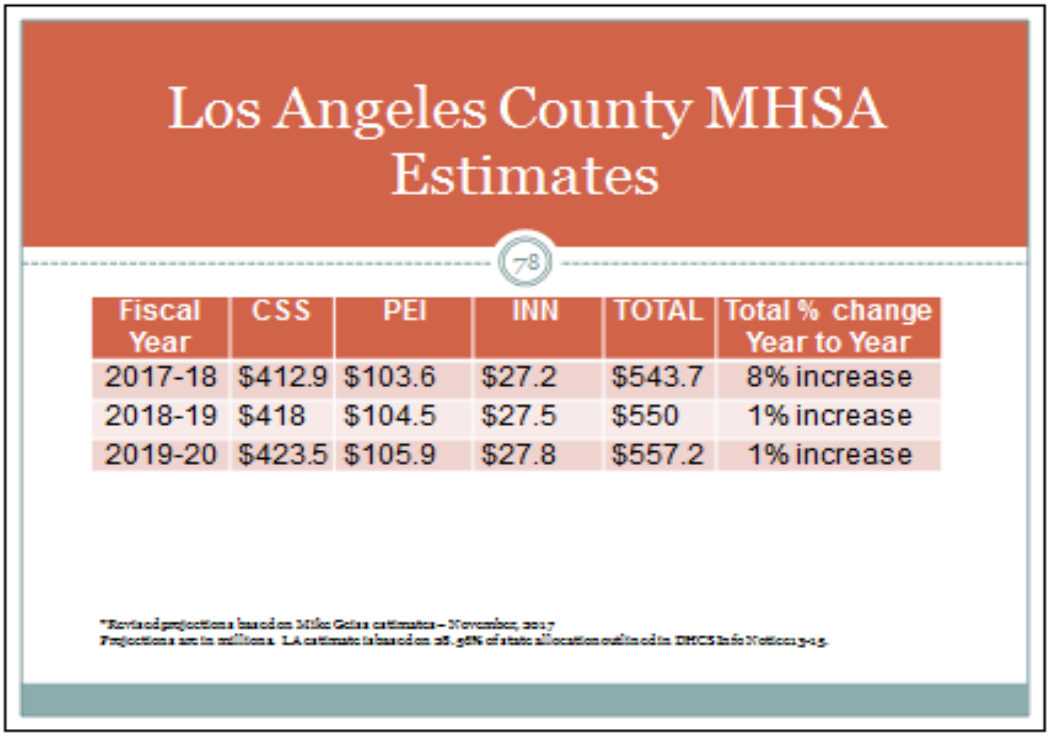


Projected Budget for Fiscal Years 2018-19 through 2020-21

77

	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 2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	456,468,046	201,447,999	54,644,679			
2. Estimated New FY2018/19 Funding	417,953,154	104,488,288	27,499,504			
3. Transfer in FY2018/19[a]	(12,654,023)			7,097,800	5,556,223	
4. Access Local Prudent Reserve in FY2018/19						0
5. Estimated Available Funding for FY2018/19	861,767,177	305,936,287	82,144,183	7,097,800	5,556,223	
B. Estimated FY2018/19 MHSA Expenditures	557,805,408	177,302,263	37,175,387	7,097,800	5,556,223	
C. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	304,161,769	128,754,024	44,969,216	0	0	
2. Estimated New FY2019/20 Funding	423,521,674	105,887,558	27,871,159			
3. Transfer in FY2019/20[a]	(9,805,088)			7,097,800	2,707,288	
4. Access Local Prudent Reserve in FY2019/20						0
5. Estimated Available Funding for FY2019/20	717,878,355	234,421,582	72,840,375	7,097,800	2,707,288	
D. Estimated FY2019/20 Expenditures	542,310,490	165,317,200	29,175,387	7,097,800	2,707,288	
E. Estimated FY2020/21 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	175,567,865	69,104,382	43,664,988	0	0	
2. Estimated New FY2020/21 Funding	423,521,674	105,887,558	27,871,159			
3. Transfer in FY2020/21[a]	(8,656,540)			7,097,800	1,558,740	
4. Access Local Prudent Reserve in FY2020/21						0
5. Estimated Available Funding for FY2020/21	590,432,999	175,191,940	71,536,147	7,097,800	1,558,740	
F. Estimated FY2020/21 Expenditures	542,310,490	165,317,200	28,135,387	7,097,800	1,558,740	
G. Estimated FY2020/21 Unspent Fund Balance	48,122,509	9,874,740	43,400,760	0	0	

Pages 158-165 of the MHSA Annual Update



Los Angeles County MHSA Estimates

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Fiscal Year	CSS	PEI	INN	TOTAL	Total % change Year to Year
2017-18	$412.9	$103.6	$27.2	$543.7	8% increase
2018-19	$418	$104.5	$27.5	$550	1% increase
2019-20	$423.5	$105.9	$27.8	$557.2	1% increase

*Revised projections based on Mike Gelas estimates – November, 2017
Projections are in millions. LA estimate is based on 28.36% of state allocation outlined in DMCS Info Notice 3-15.

Los Angeles County Mental Health Commission
Lawrence J. Lue, Acting Chairperson Presiding.
Thursday, March 22nd, 2018
St. Anne's Auditorium
155 N. Occidental Blvd.
Los Angeles, CA 90026

Captioned by Total Recall Captioning Inc.
Www.yourcaptioner.com

(Close public comments period)

DR. DEBBIE INNES-GOMBERG: We have two microphones. One on each end.

AUDIENCE MEMBER: What's the process?

DR. DEBBIE INNES-GOMBERG: There's a public comment form in your packet and you hand it to one of people here and you state your question or comment.

AUDIENCE MEMBER: Hi, good job as always.

Well, why people disengaged well you say not their cup of tea whatever, how about doing a way of looking into that, questionnaire or something or just interact with the person before they leave and trying to tabulate as to the reason so that can be a way of improving the way you engage. And then as far as, my experience with my son in terms of being engaged FSP, one of the things over the years is turned him is the assessment process. Because if somebody has got pain about their past and assessed that, it can trigger them to be more symptomatic and not wanting to engage ever again. So if there's another way doing assessment that can be more motivational interview and maybe over a period of couple of times.

No. Three, sometimes it takes a month to get someone enrolled in FSP because of the different protocols and you can lose people like that.

No. Four, you mentioned individual therapy. Well, there's never the different service areas my son has been in opportunity for individual therapy. He's a service area four. They don't have individual therapy.

No. Five, in service area four, telecare. In terms of Co-occuring disorders. There's only one group a week. One group therapy session a week and being that 60 percent of people have that disorders, it's an ongoing training and I'm wondering why in the budget there isn't more money for the things that we can do for people with that disorder. Inpatient and outpatient? That's it for now. Thanks.

DR. DEBBIE INNES-GOMBERG: Thank you very much.

AUDIENCE MEMBER: Hi, I had a question about the budget. On the budget pages in the binder, it mentions total mental health available. Please explain how it connects to the FSP dollars.

DR. DEBBIE INNES-GOMBERG: Form like this?

AUDIENCE MEMBER: Next page in. I don't have the book.

AUDIENCE MEMBER: If you go to page 159.

DR. DEBBIE INNES-GOMBERG: Thank you. Let's look at this.

AUDIENCE MEMBER: And the top of the column A, it says estimated mental health expenditures and connections to the other parts of the funding.

DR. DEBBIE INNES-GOMBERG: Page 158 outlines the components and page 159—165 contain the details for each of those components. Are you asking how did -- do those six numbers add up to the expenditure?

AUDIENCE MEMBER: They don't. That's the total -- is there any dollar -- funding for that?

DR. DEBBIE INNES-GOMBERG: I'm going to get back to you on this. Because -- it should be on 159A through F, should sum up exactly plus non-FSP to the 18/19 expenditures on the other page. I'll check that out. Thank you.

Response: Estimated expenditures (Rows B, D and F on page 158 correspond with Column B estimated CSS expenditures on pages 159 and 160).

AUDIENCE MEMBER: Hi, okay. One thing I have a question on the security pipeline -- university college. PEI and CSS. What about the school pipeline for the African-American community? Is there anything about that?

DR. DEBBIE INNES-GOMBERG: Prison to school, do you mean? In other words, people coming out of prison going to school? Going to school and then -- oh, I see, while they are in prison.

AUDIENCE MEMBER: I hear from school to prison pipeline. Too many people end -- is that correct, sir?

DR. DEBBIE INNES-GOMBERG: Thank you. We will take that into account as we start to work more closely with our college and universities. That's important. Thank you.

AUDIENCE MEMBER: Carrie, I'm a community worker and SEIU, local 721. My question is in regards to west central mental health. Their FSP has lots slots but their slots are used in other age groups instead of being used for the TAY clients.

DR. DEBBIE INNES-GOMBERG: West central. Okay. We will look into that.

AUDIENCE MEMBER: Also they are working with the skeleton crew.

You mentioned about additional positions?

AUDIENCE MEMBER: What will that be? More clinical staff, additional positions, or as far as, like, peers, as myself or more substance abuse counselors, or does that include only pertaining to more clinical?

DR. DEBBIE INNES-GOMBERG: In the annual update there's two areas referencing expansion. 250 slots. Those teams are generally comprised of case managers of various levels, psychiatrist, peers, clerical staff and so there's that piece of that. And the other area is accumulated funds spending fund which represents a large expansion of different types of staff. Depends on what the different program is. A lot of investments going county operations.

AUDIENCE MEMBER: Okay. I'm still just -- I heard lot pertaining to the clinical --

DR. DEBBIE INNES-GOMBERG: It's a mix. Mix of clinical, clerical support.

AUDIENCE MEMBER: Okay. Thank you.

DR. DEBBIE INNES-GOMBERG: Thank you.

AUDIENCE MEMBER: Hello. My name is John, I'm a family caregiver times 3, 2 children and a spouse. I have my own diagnosis and medication I take. Activist locally and nationally with different organizations, I have a quite of number of concerns, I'm going to try not duplicate too much what I wrote in here.

One that came up today was the disengagement issue and there has been a long history of mental health program. Funds are supposed to be only for the most seriously ill that's what people voted for in passing proposition 63 and sold to them. I think that needs to be looked at more closely. People who are difficult engaged with are probably the most ill. That's all I got to say about this. I would like to see some reactions on that.

No. Two, my search scholarly article, I did admit is incomplete, and looking at reports by other activists and so forth is that there's no such thing as prevention of serious mental health. So when you talk about early prevention, prevention, no. In early interventions, there's a skepticism about these things. When you see procedures and programs, turn to literatures and people do reviews, they find lots of problems and cannot condone anything that works. This might work but the study was too faulty or no limitation of bias -- so I really have a question -- I know this is I said in my column. It looks too much like funding is predetermined and then you are finding programs to fill the slots rather than looking at who has mental illness and what do they need.

FSP, my son as autism among other diagnoses. When we try to transition through TAY services they demand that he give up therapist. And maybe we would continue to see them privately and ones from DMH. I'm not going to jump through hoops. There's no way we can convince him to do that. So my suggestion is that there should be flexibility, there should be whole gamut and a la cart because one size does not fit all.

DR. DEBBIE INNES-GOMBERG: With you agree with you.

AUDIENCE MEMBER: I asked someone at DMH today and they say no. One size fits all.

DR. DEBBIE INNES-GOMBERG: I will connect you with somebody on that.

AUDIENCE MEMBER: Okay. And again autism, another point, our experience up until November, DMH, regional center and vice versa. And finally partially because of the change in the DMS definitions, which then took years to get my son to go back to regional center. He got accepted by November but he still haven't received receives but approved services.

And MHSA has to address case management. If you are in the DMH program you will have case manager more than likely for that program. My son have wrap around services, case manager for that only. Residential, case manager for only that. Came out -- I'm sorry. Family, then residential and each was different case manager, and no one communicated with anyone and no one dealt with his autism because it wasn't funded.

And among autism people, I have seen there's a high incident of mental illness with autism. And there has to be some bridge and there isn't one. And MHSA should

be funding that.

And again, people for insurance. MHSA should stand up for those, because not only the public on that it's everyone on mental illness. That's another gap MHSA I can find.

Another concern that I have in reading the budget that was put out, I didn't get the big book until someone handed me a copy. The clear on MHSA A funds from other streams.

DR. DEBBIE INNES-GOMBERG: Other what?

AUDIENCE MEMBER: Funding streams. Two issues: One is it seems some program serve a wide spectrum of people with mental illnesses. But only the ones with serious mental illness or who are -- who should be funded. So it doesn't seem to happen. If it's a good program, it gets money. No. It should be allocated serving on the 4% with most serious mental illness.

You know, building parking lot, only people dealing with mental illness park there only or everybody else? So why should it only come out of MHSA fund.

And workforce, it's not clear who is being funded by MHSA.

FSP slots was another thing that came up. When my son didn't get services, the other reason we backed up because in our region our TAY slots were filled up and you have to move to Long Beach. Slots should be allocated countywide and distributed to regions as needed. I know there's issues with that. Because you need to have physical locations with these things. That was totally absurd.

Lastly I spent the last month give myself a crash course on MHSA. You need to train people on MHSA. It was tough.

Last thought, fill the gaps. Treat the most seriously ill. And if you have education program that helps someone reduce their trauma, let education funds do that. Right? It can't all be funded by MHSA and everybody is grabbing from a piece of pie. I saw what I read over in what was provided.

You don't even track who everyone is in the county with serious mental illness. I don't know if you survey private providers or hospitals. It's got to be done.

Last thought, I forgot this one, I didn't see anything for auditing. Use of funds or auditing who served. I don't know if that's done with other money. I didn't see anywhere in the budget.

DR. DEBBIE INNES-GOMBERG: I want to first of all thank you. I got your letter and I want to thank you for coming here today. And my heart -- when I read your letters my heart really went out to you because I know you've struggled and our system haven't met your needs.

I want to respond to couple of things you said. I want to link you up with Dennis who is standing in the corner who will help you out with some of the things you talked about. The act was written so that 80% of a county's allocation goes to the community services and support plan. It's meant to fund a full continuum of services who are already ill and the gaps that you are talking about. There is 20% for prevention and early intervention that you cannot move anywhere else. We can move CSS funds but not the reverse.

Over the last year, DMH has begun to focus much more on prevention. For

myself, I was very compelled when I originally read the adverse childhood experience study that Kaiser did. It articulated that adverse childhood experiences, if left untreated, result in mental health and physical health conditions, including substance use and eating disorders. And I appreciate your comment and Dennis will help you. Thank you very much.

AUDIENCE MEMBER: We will be talking I'm sure. Thank you.

AUDIENCE MEMBER: Representing 92 hospitals in Los Angeles County. I appreciated your presentation and overview. And I have general comments to your presentation.

First of all the PEI for treatment already ill, I think we are missing a huge opportunity to engage those individuals who are non-LPS Designated facilities, sitting in the emergency room waiting for linkage to services. They can sit there for days waiting to get someone in the department to help them. I would strongly encourage the department doing outreach or linkage to those facilities. Because I need to be clear, they are not receiving treatment in the non-LPS facility. They are in a hospital but they are not being treated because they are not licensed to provide psychiatric services.

Two. PEI -- I agree with Brittany's comment. There's a barrier and I would say hospitals, that's where you list the areas you could benefit, but hospitals are not listed in there. I would say, there, again, you can if you are looking at engaging more people, the non-LPS designated facilities would be the opportunity.

There is a lack of response from -- underline, some, FSP providers. That they will not respond to facilities when it comes to case managing those individuals and what happens those individuals recycled back to the facility within days. So I encourage that there's accountability that is placed -- department losing contract with providers that they look seriously at addressing the issue of accountability.

And finally you talked about the county wanted to be fiscally prudent. By being overly prudent, there's a segment of population that's not being served. And right now, I appreciate the focus on homelessness this morning. There are people who are not homeless -- and I would encourage the department spending the surplus dollars provide access to people who are not being served. You are only capturing one segment of the population while the other is being missed.

AUDIENCE MEMBER: I'm back again, this is passionate time. Speaking of hospitals I really think that since the most, you know, seriously mentally ill people cycle in and out of hospitals people like my son. When they are there for a short period, they need to have treatment for what their disorders are. Co-occurring disorders, the psychiatrist say it's chemical dependency. [And segue off that and not understanding what the disorders makes the whole spectrum so much more complicated and dangerous when -- and death, highest death is bye polar and substance depend -- so I'm wondering not amount of money go into psychiatrist.] They forced me to take him out and rehab. And they -- which is kind of blackmail. The psychiatrist said mostly chemical dependency. I e-mailed the -- why can't we get all the psychiatrists up and running about understanding this because they don't and it's really crazy because they are the ones who are prescribing medication and the social worker if there's a treatment team that talks to each other and get on the same page so they can give

client or the patient a congruent message even if they are there for 2 or 3 days or longer. Why the SLT meeting not a big budget for the Co-occurring disorders.

DR. DEBBIE INNES-GOMBERG: Co-occurring disorders treatment is a strategy within the program that targets individuals, in this case, have substance abuse and mental health condition. The Department will develop standards for this.

AUDIENCE MEMBER: We have to know what to train them about and do the research and get the best practices of training that actually show good results. There needs to be a whole Department of Mental health doing this. Because you are missing 60% of your people. In telecare there's only one on this disorder and probably most of the people FSP 60% have this disorder. So we need money not just -- because everybody's different. Every contribution of order is different. You cannot say we will treat this person this way. There has been unique approach depending on the disorder and how they interact with each other and not to say, oh, you go here for substance abuse -- they are not getting better. They are going in and out of jail.

DR. DEBBIE INNES-GOMBERG: And this is not well defined at this point. But the organized deliver system Drug Medi-Cal waiver is another opportunity --

AUDIENCE MEMBER: Why isn't DMH working --

DR. DEBBIE INNES-GOMBERG: We are at a level that's higher than that.

AUDIENCE MEMBER: Where is the concrete ideas and implementation possible sooner rather than later because people's lives are really at stake.

DR. DEBBIE INNES-GOMBERG: Thank you.

AUDIENCE MEMBER: Hello again, I'm back again. In regards to mental health. We mental health and we as employees, peers, volunteers, all of that, that we provide services to all. The thing is that those who are homeless, we are not able to provide any viable services to them as well as -- I don't know if you know this, but not only do you have homeless out there but you have people that are employed through the county that work for DMH as well as other departments that are homeless too. And it's hardening when I got off the phone with coworker at another facility that's homeless. They can't get support, and nothing. They get write up and shit, excuse my language, but it's messed up. Because they can't get any support. They have to go to work on a daily basis -- excuse me -- it hurts -- they get write up for just any old thing for nothing. But they are also dealing with -- I need this job, I need to figure out where I'm going to leave my stuff tonight or where to get my next meal. And at the same time, these people are staying strong and help these people who need services. We, mental health, it's not the same within as far as having a heart and as far as just being there for people. Because you don't know what people are dealing with within, working. Thank you.

DR. DEBBIE INNES-GOMBERG: Thank you.

AUDIENCE MEMBER: Hi, I'm California pal -- we work to improve the health of all Californian advocacy lines. I had a couple of questions about the data, part of our work is improve data, aggregation, to improve the community.

First question, within the entire overview, is there additional breakdown of other populations served by these programs including pregnant woman, uninsured adults, adults with special need. That information captured somewhere. And related to that, is

there additional information here about insurance type, given the current administration, we heard about the immigrant partner. I think it's useful to get additional information on the number of adults who don't have access to Medi-Cal and being served by these programs.

DR. DEBBIE INNES-GOMBERG: Thank you for that. It may not be an annual update but we do track, as a department, whether a client is covered by Medi-Cal or other insurance or indigent. We don't report it in the annual update because there's never been a request to do that. In terms of pregnancy status, that's not a data element that we've ever captured in terms of reporting. And there was a third?

AUDIENCE MEMBER: I think that was more or less it. I mentioned some examples those who are pregnant and indigent but there are other populations that I'm sure people would be interested in learning about how they are being served in the program. So the request is to have more detail about that.

AUDIENCE MEMBER: I'm -- sexual assault prevention. I came today to see if we qualify for the mental health. I have met at -- we sat down this week. We try to find evidence for sexual assault treatment and prevention in the Department of Justice has been talking to them and starting in your community and in your state. So I was looking for you to mention something about that. Do we classify under the mental health?

DR. DEBBIE INNES-GOMBERG: It's one of those things -- as far as I'm aware, we don't track individuals at that level. We certainly serve them either in prevention or early intervention or in community services and supports programs if they meet criteria for Specialty Mental Health Services. We are not able to report how many of our clients fall into that category.

AUDIENCE MEMBER: In my meeting with Mr. Brown he made it clear that they are classified as PTSD. And that develops over time without treatment. I'm looking for demographic and policies and actual sexual assault violence.

DR. DEBBIE INNES-GOMBERG: I'm missing the request. Our focus of our treatment has to be on mental health. Recognizing trauma brain injury can be mental health. And the conditions in which that happen. So we treat those types of individuals. They might present as depressed and traumatized.

AUDIENCE MEMBER: Yes. They said that.

DR. DEBBIE INNES-GOMBERG: Or substance abuse. So we generally do treat those people. But was that the question?

AUDIENCE MEMBER: Under alternative crisis services, I thought maybe they would come up under that category but is that not the case?

DR. DEBBIE INNES-GOMBERG: Alternative crisis are services such as urgent care centers. Along with our law enforcement mental health team -- what you are talking about is a population and then what I just said was a set of services. That population is likely embedded within the service structure.

AUDIENCE MEMBER: That's not what I got from my conversation with Mr. Brown. Only if they developed into PTSD -- So you are saying they are part of the whole population for mental health?

DR. DEBBIE INNES-GOMBERG: When somebody comes to us, they come

because they are suffering to some degree and there's diagnostic consideration for specialty mental health services. I don't have any statistics on how many of those people are receiving services.

AUDIENCE MEMBER: It's a lot. Sexual assault is a lot.

DR. DEBBIE INNES-GOMBERG: We don't track sexual assault status.

AUDIENCE MEMBER: The point is are you open to working together with our organization to see if it's possible where the hospital -- we do have 13 free sessions for sexual assault but not enough. That's why we can do to fill that gap.

DR. DEBBIE INNES-GOMBERG: At the end of this, I'll give you my card and we will schedule a time. Thank you.

AUDIENCE MEMBER: Where we have had almost no services forever and now we have MET team actually in our area in Santa Clarita there's a huge deal. It's making a difference for those people who are aware, there's a bill pending to in Sacramento about having psychiatric people go out on 5150 calls instead of having law enforcement or law enforcement as backup. I may not have all the verbiage, but anyway that is pending. If anyone care to look it up and write a letter.

Second, the business of graduating. I have an IEP that I will be attending again on the same student 16, almost 17. This young man was in the FSP program at child and family center, whatever it's called. And just at the time that he was going to start cohabitating with the father that he didn't really know except as a weekend dad, not live with his mother who had poor boundaries. At that point the FSP determined that he was doing so well that they would close the case and they did. And he went steadily downhill and the school said oh, well he's still doing well at school so we can't get involved with his domestic situation that's going downhill. And now to a point this kid does not go to school and he will not re-engage with staff. Now we put him in residential facility. He's had couple of suicide attempts. He won't take meds or go to school. I just want to put out a plea for considering something called continuity of care where people maintain a relationship with the same treatment staff or at least the same agency so the case doesn't get closed and they just go bye-bye, and they don't have to retell their story from the beginning over and over and over again. I don't know who said it when someone get into a program they get a new case manage and new this and once they leave that hospital or that program, when that door slam shut, they don't know -- they start all over again. And then what happens is that the family becomes the long-term case manager. They are very ill equipped to do that function.

So one of the things that I would like to propose is not a new idea but maybe it can be called a new idea would be that we would start to have an overarching clinical case manager case within the Department of Mental health so when someone goes into jail, and they service good. But they have a clinician that may be peer or whoever in the community, but you have this one person on this team of people that knows this family ideas and out. Knows their religious beliefs so that people don't have to start from the beginning every single time they engage with the Department of Mental health. It's overwhelming. Exhausting. And when people starting to get better, they don't want to remember the bad old days. Because today looks pretty good. But within the definition of chronic illness, you have peace and valleys. Why doesn't clinical

staff recognize that. So we always have somebody we can call -- I have clients that call me, such and such is going on, what should I do?

We are expecting family members to decide what is or is not a 9-1-1 call.

Do you think this is something we can wait for Monday? Do we do it now. The fact that they can talk to somebody oftentimes settles everybody down. But that link of knowing continuity is critical.

One more thing about housing. As you all know I'm passionate about life supporting care homes but I want us to understand that we do have our license homes, sober homes, and different homes and we don't even know where they are all. We need to know. Who are they, what do they charge and their services? We have people getting kicked out 2:00 a.m. with no resources. That's cruel but that's a fact of life. So until we engage and recognize that there's a whole world out there that is affecting people's mental health, we are missing a big chunk of it. So I'm not only talking about the facility that are set to close if they don't get help by July 1st.

One last thing, we need to remember part of the problem with homelessness occurs because of the federal government cutting back every year on hub funding. So we do have people that have been housed long-term, successfully in an apartment with mental illness. No payment or behavior problems but they are falling out and consistently because of the lack of funding from the housing office, whichever one is involved, City of Burbank or City of Glendale or City of Los Angeles so those people become homeless. We need to be care that this whole homeless thing is really, really so much bigger than what anybody thinks it is. And it is -- for those think that prevention doesn't make a difference. We had a government who thought that. When those preventive services cut, we saw immediate rise in homelessness.

DR. DEBBIE INNES-GOMBERG: Thank you very much.

>> 211 L.A. and I would like to second everything that barb just said. We want to see how even with great programs, there's a silo effect how people repeating their story and not getting the variety of services. Particularly when there are multiple needs and crisis can trigger.

One comment is we are talking with DMH how to get people better instead of calling 9-1-1 and getting the outreach team instead of police officer. I'm hoping we will have a good partnership on that and get more preventive services in another option.

I also want to ask a question about the plan. Can you clarify what the process is for spending the available or accumulated funds? Are they allocated to specific projects? Will they be proposal format?

DR. DEBBIE INNES-GOMBERG: We've had two presentations around those different components of the plans. We are still taking input. Depending on the different component of the plan would dictate contracted or whether it would be county operated that sort of thing. Most of the descriptions of the projects are fairly specific.

I would encourage you to continue to come to the leadership meetings, some of the gaps that people talking about we can fill. So thank you very much.

AUDIENCE MEMBER: I request that the DMH department need to build new bathrooms. Because we need to go -- instead of second floor, build in the department -- no bathroom. Everybody need to special order that. Just use the money

for the bathroom's basic needs.

DR. DEBBIE INNES-GOMBERG: Thank you. I think there was an issue around siting and things like that.

AUDIENCE MEMBER: I work for Asia American -- we are not mental health services providers but we have partnerships that serve API populations and we hear a lot of stories from them. I appreciate your presentation and time for public comments. I noticed the general lack of mentioning of cultural competency. If you look at the enrollment or utilization of Asians it's ridiculous low. I just wonder what are the strategy that you set up across these programs to meet that -- to bridge that gap. For instance, even if you look at the primary language, API language spoken in our diverse population. That's one thing I immediately notice.

The second thing -- I appreciate and I also come from a science background, the whole emphasis on Evidence-Based Practices. But as far as I know for our population, practices that are culturally relevant and work for our population in terms of engaging patients even attracting them to the programs or not exactly evidence based, community driven and grounded in cultural background. Besides on data and studies have shown those lab produced results how do we also capture the practices that's shown to work for these populations.

The lack of capturing of groups who are in need that are not based on age but even for the age groups older adults, what are some of the measures to meet their needs because they do have specific needs compared to just none older adults but it doesn't seem to be that there are, exist enough. And API older adults they have more complicated double layer of needs in terms of barrier, discriminations and sigma they face.

DR. DEBBIE INNES-GOMBERG: Please e-mail me. I want to give you some information about that. We noted -- you are right. We need to add in a section around how cultural competency throughout. It's not there. So thank you.

>> We do have one. But we modified the data. So it wasn't reported in this year's annual update but it will next year.

>> I'm the end user of Los Angeles County health agency. And I too want to thank you for the presentation and I'm excited about being here today. Little disappointed that not a lot of our peers. One of the speakers acknowledged that how are we providing people the information that we need in order to actually come here and participate in this very important moment.

I also want to acknowledge Jane Garcia and what he said. But also Carrie who moved me in speaking about staff who are employed at the Department of Mental health and is currently while employed experiencing homelessness. And that's disconcerting for me because I wonder, how healthy and whole are they. So I think the commission should really take a look at what it is D what you can do. I sure going to do something. It's disturbing. If you are not healthy and whole, how are you providing services to others?

I noticed that in the slide No. Eight the client service area, those are very, very high numbers. And what are we doing to make some adjustments and changes around it and improving folks in those service area lives in order for the number to decrease.

The FSP slots, they are extremely high. So what are we going to do different?

Slide 11, I feel like we need to continue relationships and because what if one falls if they are -- they leave out of FSP. The space of sort of door needs to always be there and one should know even they walk away on a high if you are falling, you know, the door's open.

Slide 38. Is this really the first time data on this item -- and I don't have it in front of me.

Slide 60. Why haven't this always been done.

And 68, now that's the one I want to pull to because it's talking about information in which you gathered -- 68 -- with PEI outcomes. You talk about what you've learned. I kind of sat there and I'm sad that you did not already -- why did it take you so long to learn this information here. So I would like to add to that list is one, is to convene those of us who are utilizing the services to get a better idea of what that's like. And two, transportation, there's a heavy police in our clinic and it's important to know that when we are walking through those doors depending on who you are and the days you are walking in, and the heavy sight of police officer is truly unfair. Especially when they are congregating the restroom that you have to past to get there. And that can deter someone.

Cancel appointment. You would be amazed how oftentimes that the staff has cancel appointments or didn't come into work and no one notified us prior to arriving there to find out. Can you imagine what that feels like? Because it's totally unfair. It's caused our time, transmission and also allow us to feel that we are not important and disrespected. So what's going on in the lobbies while we are waiting for our appointments? And if -- it's usually shoot them up bang-bang or judge do you do.

And Department of Mental health spend a lot of money -- and so there are so much that we can do different. In reference to what we are experiencing while we wait. We could be learning more about the stories of our peers perhaps we don't have to know them. But it becomes helpful. Perhaps we can learn about what's the next step as we arrive there for the first time. We can talk about depression, anxiety and stress and the different diagnoses, we can talk about stigma and discriminations. And the SLT and other things that are happening that are important that we may not ever know about unless it's provided by the department. So I lot that I'm going to submit to you but I also want to say thank you for this opportunity but we still have a long way to go. But I almost want to say shame on us. But thank you.

LAWRENCE J. LUE: Thank you, Debbie. I would like to ask -- give our hands to Debbie and the staff. Personally I think the report this year has definitely improved. I give Debbie and the staff credit. Because every year they sought to improve and responsive but, of course, that makes us wanted to demand more.

We look forward to public comment to see what was shared in this room and hopefully get more a sense of what is the response and how is it being incorporated and addressed. If not right away, how will it be addressed in the future.

Another round of applause for them. Thank you.

So we are ready to adjourn the meeting. I do have one announcement. For those of you may have experienced this earlier. Problem with parking. We had talked

to the management here to clarify the miscommunication.

The announcement is to be reimbursed for parking. If you were asked to pay for parking, please see Carlos to receive reimbursement if you paid for parking.

Thank you.

Excuse me, next step. We will be reviewing all the public comment that when we heard today. We will incorporate that into our discussion and at our next meeting April 26th, we will make the recommendation, motion to approve and make that decision at that time after we reviewed it and the department's response.

(Adjourned 2:00 P.M.)

MHSA ANNUAL UPUDATE FISCAL YEAR 2018-19
PUBLIC HEARING PUBLIC COMMENTS AND DMH RESPONSE

Summary Comments	DMH Response
Suggestion to understand better why individual clients disengage/drop out of treatment	In FY 18-19 DMH (Program Development and Outcomes) will expand its current approach to outcomes to include sampling to examine qualitatively and quantitatively client quality of life after completion of a service and reason for service discontinuation.
Lack of consistent integrated mental health services for clients with co-morbid mental health and substance use conditions.	DMH will develop evidence-based service expectations for clients with co-occurring conditions and develop training modules for providers.
Concern that West Central Mental Health's TAY FSP program is not serving TAY-aged clients.	DMH pulled ages of clients being served and found the TAY FSP program is serving TAY-aged clients.
Family member concern about fragmentation of services for someone with conditions that are the responsibility of different systems (regional center, DMH, etc.). Concern expressed about funding only services for those most in need.	Family member linked to a DMH staff to assist with treatment concerns.
Concern from Hospital Association of Southern California about mental health clients in non-LPS designated facilities and what DMH is doing about that.	This concern is being relayed to appropriate managers within DMH to better understand issues. It should be noted that MHSA cannot fund hospital-based services.
Concern expressed about addressing DMH staff who may be homeless and in need of assistance.	Where this is occurring DMH supervisors and management will do what it can to assist and support staff.
Request for reporting on individuals meeting criteria for certain sorts of conditions such as pregnant women and sexual assault survivors.	DMH does not track these sorts of client statuses.
Request for increased continuity of care across service settings and levels of care (after disenrollment/graduation from FSP, when client goes to jail, etc.)	DMH agrees and will review its practices in this area.
API population remains under-served	DMH is addressing this currently.

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year (FY) 2018/19
30-day Public Review and Comment Period
February 20, 2018 – March 21, 2018

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Sawako Nitao
Agency/ Organization: Asian Coalition
E-mail address: SSnitao@outlook.com
Mailing Address:

Comments

I request that At DMH peer department, to build the new Bathroom for 1st floor
wd At DMH. Because everyone need to go special ed adult, and employments of peer specialist and Securities.

Any member of the public may submit written comments on or before March 21, 2018. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

County of Los Angeles - Department of Mental Health
Program Development and Outcomes Bureau
Attention: Debbie Innes-Gomberg
550 S. Vermont Ave, 3rd Floor
Los Angeles, CA 90020
Fax # (213) 351-2762

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year (FY) 2018/19
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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Mihaeljung
Agency/ Organization: cpehn
E-mail address: mjung@cpehn.org
Mailing Address:

Comments

① What are your plans to Help & elevate community-defined/cultured strategies to close the gap for populations such as the API population? (and funding them to be Evidenced-Based)

~~② What are the opportunities for~~

Any member of the public may submit written comments on or before March 21, 2018. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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Los Angeles, CA 90020
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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Carolina Valle
Agency/ Organization: CA Pan-Ethnic Health ~~Network~~
E-mail address: cvalle@cpehn.org
Mailing Address:

Comments

Thank you for the great presentation. We are very appreciative of the annual update. I have a question about additional information captured in the data.

1) Is there a breakdown of more specific sub-populations served by programs, including pregnant women, LGTBQ, uninsured adults, etc.?

2) ~~Second, those who only have emergency - me:~~ Is there any data on coverage type ~~for~~ of the clients served i.e. the number of immigrants served who ~~do not~~ only have access to emergency medi-cal? Is that data captured anywhere?

Any member of the public may submit written comments on or before March 21, 2018. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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PUBLIC REVIEW

Personal Information (OPTIONAL)

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E-mail address: john.hallowell@gmail.com
Mailing Address: 10739 Sharon Avenue

Comments

Yes, please!
1 0-5 engagement the most ill.
2 PEI [Prevention is not supported by scholarly literature.]
3 Partial Service Partnerships
4 DMH vs. Regional Center
5 Case managing for all (one) ~~yesterday~~ Private vs Public

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County of Los Angeles - Department of Mental Health
Program Development and Outcomes Bureau
Attention: Debbie Innes-Gomberg
550 S. Vermont Ave, 3rd Floor
Los Angeles, CA 90020
Fax # (213) 351-2762

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year (FY) 2018/19
30-day Public Review and Comment Period
February 20, 2018 – March 21, 2018

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Alana Hitchcock
Agency/ Organization: 211 LA
E-mail address: ahitchcock@211la.org
Mailing Address:

Comments

Can you clarify ~~what~~ what the plan or process is for spending available or accumulated MHSA funds? Can you talk about whether these funds are already allocated to specific projects, whether there will be RFSQs put out or proposals accepted?

For background, 211 LA has successful linkage, peer support, and case management pilot projects we would like to propose expanding, in particular for underrepresented population and potentially in partnership with NAMI or other community

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: WILLIAM LECERE
Agency/ Organization: BUREC
E-mail address: MR.WLECERE@GMAIL.COM
Mailing Address: 5046 OLSCHEMER STREET, BALDWIN PARK, CA 91706-1705

Comments

WHAT ABOUT THE SCHOOL-TO-PRISON PIPELINE IN THE AFRICAN-AMERICAN COMMUNITY?

Too many people going from school to prison as working.

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Barbara B Wilson
Agency/ Organization: Mental health Hookup
E-mail address: bathp@hotmail.com
Mailing Address: 23638 hyons Ave #214 Newhall 91321

Comments

① Focus on the most seriously ill — We are serving very ill people — Transportation is a real problem Kudos to Whole Person Program

② Graduation of FSP clients Lack of continuing care → elapsed, refusal to re-engage TAY

③ Need to support & create various housing styles. License ALL facilities

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Jaime Garcia
Agency/ Organization: HASC
E-mail address: jgarcia@hasc.org
Mailing Address: 515 So. Figueroa St LA 90071

Comments

- Being fiscally conservative in spending is denying access to new clients who are waiting in a non-LPS Hospital.
- Access & linkage to treatment needs to be expanded to outreach @ non-LPS hospitals + this is a barrier to providing access

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PUBLIC REVIEW

Personal Information (OPTIONAL)	
Name: Carey Grier	
Agency/ Organization: DMH SEIU Local 721	E-mail address: cgrier@dmh.lacounty.gov
Mailing Address:	

Comments

RE: West Central MH - TAY FSP have lots of clients but there Tay slots are being used in other age groups instead of being used for TAY clients. Also there working with a skeleton crew. You mentioned about additional positions? What would these positions look like? clinical Peer, CW, 5! 5100 CM, CM, clerical staff, [illegible] lots of Different

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PUBLIC REVIEW

Personal Information (OPTIONAL)	
Name: PATRICIA RUSSELL	
Agency/ Organization: SAAC 2 Co-chair: NAMI	E-mail address: MOVIESWITHHEART @ gmail .com
Mailing Address: 4465 KATHERINE AVE SHERMAN Oaks	

Comments

1) Find out why people Disengage To ~~[illegible]~~ improve Services - Tabulate
2) Assessment cause pain - turns people away
3) FSP - clients need individual therapy
4) Group therapy for clients with Co-occurring Disorders
5) Why no money in MSHA Budget for Co-occurring Disorders — TREATMENT + TRAINING for Providers

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TO OBTAIN ADDITIONAL INFORMATION CONTACT:

DEBBIE INNES-GOMBERG, PH.D.

DIGOMBERG@DMH.LACOUNTY.GOV

PHONE: (213) 738-2756