MENTAL HEALTH SERVICES ACT
ANNUAL UPDATE
FISCAL YEAR 2019-20

Los Angeles County - Department of Mental Health

Jonathan E. Sherin, M.D., Ph.D., Director

Los Angeles County Board of Supervisors
Adopted on _____

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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 I: Integrated Clinic Model, Integrated Services Management Model, Integrated Mobile Health Team Model and Integrated Peer-Run Model	February 2, 2010
Capital Facilities (CF) Plan	April 19, 2010
Innovation 2: Developing Trauma Resilient Communities through Community Capacity Building	May 28, 2015
Innovation 3: Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions	October 26, 2017
Innovation 4: Transcranial Magnetic Stimulation	April 26, 2018
Innovation 5: Peer Operated Full Service Partnership	April 26, 2018
Innovation 7: Therapeutic Transportation	September 26, 2018
Innovation 8: Early Psychosis Learning Health Care Network	December 16, 2018
Innovation 9: Recovery Supports for Conservatees	September 26, 2018

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

Introduction

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.

While this Annual Update has Service Area maps, you may want to consult the following link for more information http://gis.lacounty.gov/districtlocator/

Any questions or comment should be directed to:

Debbie Innes-Gomberg, Ph.D.
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Los Angeles County Department of Mental Health
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Community Planning Process

Each Service Area Advisory Committees (SAAC) was presented with service area specific MHSA data/information at their SAAC meeting in order to discuss the unmet needs in their respective service areas. Their comments/suggestions are documented in the pages 4-11 . The Service Area specific reports are located in the appendix of this annual update.

Service Area 2 – San Fernando Valley
Meeting: October 11, 2018
Presenter: Robin Ramirez

The following unmet needs were identified as a priority for Service Area 2 prior to the SAAC meeting held on October 11th. The notes included below are written as provided:

Mental Health Services	
Possible Solutions Discussed	• Have providers share information about their service • Work closely with Health, Veterans and Community Colleges • Could use more money on campus to provide PEI services on site and expanding definitions of PEI services. • Increase Integrated Health and MH programs such as College of the Canyons; co – located service providers, DPSS, DHS etc., Collaboration with COC and UCC • Addressing limitations (especially geographic challenges of Access and the need for transportation esp. in unincorporated areas) • Better coordination with hospital discharge planning
Housing/Homelessness	
Possible Solutions Discussed	• Updates information on SA 2 Housing Situation. • Educating community on homelessness. Everyone in campaign - Lori - Hope of the Valley can provide contact. • Panel to discuss 6 Strategies for homeless outreach and coordination • Increased focus on homeless, especially TAY homeless.
Children and Families	
Possible Solutions Discussed	• Increased focus on children panel on what we are doing and gaps in services. • Early Childhood MH – training teachers, parents, consultation for early identification resources early upstream. • DMH needs to provide support for family members: groups etc. (Not just NAMI) Using PEI funds for this purpose.
Outreach Efforts	
Possible Solutions Discussed	• Social events (evenings/weekends) game nights, non-related directly to MH for 30+, focus to decrease isolation and etc. Masonic lodges as possible venues. • Increased materials outreach to Armenian and Farsi speaking communities. • Increased outreach to Latino community. • Karla Wheeler at West Valley MH Clinic talked about “Ideas from clients to Outreach Older Adults” • Monthly Forum – Speakers “We” can relate to with a positive message. • Information about Senior Housing / Supportive Housing. • Arrange (tickets?) for theatre / Concerts / Cultural Events. • NAMI peer-to-peer classes in English / Spanish / Farsi seminars. • Offsite Classes, Increased Activities, Creative Artist, Poetry, Skills. • Gardening Club, Game Night. • Social Club with Music from 70’s, 80’s, 90’s. • Chances / Opportunities to Socialize.

Service Area 2 – San Fernando Valley (continued)

Resources	
Possible Solutions Discussed	• Public speaking trainings for consumers NAMI – "In our own voice" Talk to Zee about scheduling • Increase voting (Richard is putting together voter info guide) they are always available at homeless connect events. • Sponsor a Service Area II summit: Psychiatrist, Judges, Hospitals etc. to draw people in for a larger service area event. • Develop a SA2 Resource Guide ◦ Richard – is gathering information to develop Resource Guide for SA 2. Will be contacting you to set up appointments.
Co-occurring Services	
Possible Solutions Discussed	• Provide more trainings to providers proving co-occurring (substance abuse and mental health services) as they seem ill equipped to do so. • More programs like River Community and Sobering Centers is needed because many of the sober livings are not safe places.

Service Area 3 – San Gabriel Valley
Meeting: October 11, 2018
Presenter: Debbie Innes-Gomberg, Ph.D.

Mental Health Services	

Unmet Need/Problem	• Recovery Resilience and Reintegration
	  ◦ What is the optimal case load?
	  ◦ How do we optimally provide these services?
	  ◦ How do we measure capacity?
	• How is it impacted by the capacity of the Full Service Partnership (FSP) program?
	• More mental health services provided in other languages.
	• More capacity to support those with co-occurring disorders.
	• Specialized mental health services for those 21 and over.
	• The ability to support consumers in their journey through specialized services.
	• The ability to support older adults in FSP, can the Department handle capacity?
	• Is the County capable of keeping up with the age groups and they grow and shift?

Possible Solutions Discussed	• Replicating the Promotores program in other languages. Can this same model be replicated? • Recruitment of staff who speak the languages of the clients served in Service Area 3.

Community Planning Process

Service Area 4 – Metro
Meeting: October 18, 2018
Presenter: Debbie Innes-Gomberg, Ph.D. and Robin Ramirez

Resources	
Unmet Need/Problem	• Lack of childcare resources in the Service Area • Lack of foster homes in the Service Area resulting in children being sent to the Antelope Valley • How can the SAAC provide resources in real time, ex: undocumented clients. • The Housing resource list needs to be shared on broader level and current. • Pest control cleaning is needed for bed bugs: There is a bed bug issue in SA 4 resulting in home services being delayed until the home is professionally cleared. • Lack of housing.
Recommendation(s)	• A SAAC member referenced San Francisco's Peer Networking to the Homeless in the Parks and its successes as a possible solution to the housing crisis.
Community Partners	
Unmet Need/Problem	• Law Enforcement should be educated and trained to gain a better understanding of the mentally ill. • More collaborations • How does the SAAC get invited to participate in the meeting hosted by Diversion and Re-entry? • Better communication across the county: What commissions exist? How do we know they exist? • Los Angeles Unified School District (LAUSD) needs to work in tandem with DMH: Accessing child and families during school days, is very difficult. A formalized MOU is needed to provide mental health services on school grounds. • DMH needs to remember to include Spanish media when they invite other news media outlets to attend events.
Lesbian, Gay Bisexual, Transgender, and Questioning (LGBTQ)	
Unmet Need/Problem	• There is a need for more culturally appropriate services, specifically LGBTQ culturally relevant services. • Housing • More drop-in centers with features that include basketball courts, creative space and art studios • Including LGBTQ as part of collecting demographic information
SAAC 4	
Unmet Need/Problem	• How do we best organize ourselves given we no longer have age groups and now Discipline Chiefs? How do we best convey our needs? • More people involved in outreach efforts. More involvement and outreach efforts to get more people to attend the SAAC meetings. Chances / Opportunities to Socialize. • What can the SAAC do to better support Dr. Debbie Innes-Gomberg, Deputy Director?

Service Area 4 – Metro (continued)

Comments/ General Recommendations
• Mental Health Accountability report will be released soon. It can be found on the Mental Health Accountability website. • Clean environment • With the new DMH building, will there be a new clinic? • DMH belongs to all ethnicities not just Blacks, Whites, and Asians • What population will the new DMH site house? • What does the acronym WDACS stand for? Workforce Development, Aging and Community Services • Any discussion on the Right Balance for triple R?

Service Area 5 – West
Meeting: November 27, 2018
Presenter: Debbie Innes-Gomberg, Ph.D. and Robin Ramirez

Mental Health Services	

Unmet Need/Problem	• In-home care for ages 0-5
	• Recovery Resilience and Reintegration
	  ◦ How do we optimally provide these services?
	  ◦ More money is needed to provide a lower level of care from FSP
	• More mental health services provided in other languages. There are barriers to using the translation line.
	• More child providers in the Service Area.
	• FSP
	  ◦ More slots are needed.
	  ◦ How do we streamline the FSP referrals?
	  ◦ Better documentation of the client's needs in order for clients to be enrolled into the FSP program.
	• Provide more training for child care centers.
	• Low-barrier drop in centers
	• More funding is needed for the 0-5 population, Spanish speaking and undocumented clients

Housing	
Unmet Need/Problem	• Service Area is in need of shelters, people have to leave the Service Area to get housing. • A need for different levels of housing.
Comments/Suggestions	

	• Information about mental health services should be more accessible
	  ◦ It was suggested a user friendly website be available for parents/consumers seeking services for Board and Cares, IMDs, etc.
	  ◦ Users/family members should have the ability to review and rate the mental health facilities.
	  ◦ The Department should explore ways to improve the way in which information is disseminated to family members about what mental health services are available

Community Planning Process

Service Area 6 – South
Meeting: October 18, 2018
Presenter: Kara Taguchi, Psy.D. and Robin Ramirez

Parolees, specifically those inmates who did not receive mental health treatment while incarcerated	
Unmet Need/Problem	• Parolees are not able to utilize the mental health services funded by MHSA. • Parolees who did not receive mental health treatment while incarcerated are released without any linkage to a community mental health agency.
Other Information	Mandatory referrals are made to a Parole Outpatient Clinic (POC) for a mental health assessment for those inmates who are in a mental health treatment program at the time of the prerelease case referral. To provide continuity of care, a POC referral appointment shall occur as soon as possible but not more than 30 days after release to parole.
Possible Solutions Discussed	• Parolees are able to utilize non-MHSA funded programs in the County • Change legislation: create advocacy
Lesbian, Gay Bisexual, Transgender, and Questioning (LGBTQ) Transition Age Youth (TAY)	
Unmet Need/Problem	• There is a need for more culturally appropriate services, specifically LGBTQ culturally relevant services. • Housing • More drop-in centers with features that include basketball courts, creative space and art studios
Questions	• How can DMH/SAAC support the caregivers and community that work with LGBTQ youth receiving mental health services?
Peer Advocates	
Unmet Need/Problem	People in recovery need the proper training as to what is culturally and socially acceptable behavior
Questions	"What may be normal in the hood, isn't normal in the "real" world."
Education about mental health services	
Unmet Need/Problem	• Training should be available to teachers to educate them on the importance of school-based services • Frontline staff such as clerks need more Customer Service and possibly Peer trainings as to how to treat the clients. They give off a feeling as if it is "them vs. the Clients" the SAAC would like it to feel like a community and togetherness.
Staff delivering mental health services	
Unmet Need/Problem	• Not providing enough individual therapy • The need to provide cultural competent services • High caseloads • Retention of staff in Service Area 6 • Those staff that recently graduated are in need of training, some are not ready to provide the services in Service Area 6.
Questions/Comments/ Recommendations	• Cultural competent services in Lynwood are not available. The PET team was called and they were not available. The person was told to call the police for a mental health emergency, 9 black and white police cars arrived which can cause more trauma. • DMH needs to incentivize or make working in SA 6 appealing to staff. SA 6 feels that staff are reluctant to work in the Compton and surrounding areas, thus contributing to the lack of culturally appropriate and competent staff problem in the SA. • The stipend program should be re-evaluated. Stipend recipients are ready to deliver services but the hiring process is taking too long.

Service Area 6 – South (continued)

Mental Health Services	
Unmet Need/Problem	• Mental Health needs to be personalized. • Accountability for the directly-operated clinics: We need to take a look at the standards of the contract agencies. Are the contract agencies being held to the same standards as the directly operated? • Services needed for the sex traffic population. • How do we enhance what we already know? • The SAAC would like services tailored to the "hood" not to the what the outside world thinks the services should look like. They want services from the inside perspective and not the outside in.
Questions/Comments/ Recommendations	There has been a lot of progress in SA 6 since 1951. It was worse in the 1970s and progress is happening.
Service Area 6 Community	
Unmet Need/Problem	• Process of healing ourselves • No monolingual Spanish speakers present at the SAAC meetings, more outreach efforts, possibly changing location of meetings. • When do we start seeing results? • Building communities to help deter from utilizing services

Comments/ General Recommendations

- Due to the lack of access to computers by the homeless population, DMH needs to focus on advertisement on the radio (KJLH), TV, and billboards. Social media is not enough.
- Invite Carlotta Childs-Seagle, Deputy Director, to the SAAC 6 meeting
- The SAAC would like to collaborate with Department of Public Health and Innovation 2, Health Neighborhoods.
- The data and numbers mean nothing to them. The percentage of African American are not accurate due to so many uncounted numbers.
- A SAAC member was upset that this discussion is just now happening. A once a year discussion about the SA unmet needs is unacceptable.
- Your DMH is a possible solution to raise the voice regarding the lack of services.
- The SAAC should contact elected officials and State Legislators to discuss prevention and support.
- A request for Pre-Prevention "Sit at the table" with DMH administration and collaborate. Let the SAAC/community be a part of the change for the future that will impact the services 100 years from now.
- A client at West Central had to wait 6 weeks for an intake appointment. When she finally got her appointment it was for a meet and great and not an intake. The client was then given an appointment for a month out, which was then cancelled and replaced with a Help and Wellness support group appt. The client in crisis was told that the clinic is no longer accepting walk-in clients until the new year. Per West Central supervisor the clinic is back logged 3-4 months and only have 3 therapists on staff, with one on leave. The client is now advocating for all the clients and fears that with the holidays approaching the need for therapy will rise.
- There is a need for Peer respite homes where people who need to get away can go.

Community Planning Process

Service Area 7 – East
Meeting: October 12, 2018
Presenter: Kara Taguchi, Psy.D. and Robin Ramirez

Mental Health Services	
Unmet Need/Problem	• More mental health services provided in other languages. • A need for post hospital release program. • In home services for consumers with difficulties leaving their home. • More integrated care. • A need for an urgent care center, none exist in SA 7. • More Wellness Centers. • Access to care regardless of documented status. • Too long of a wait time for mental health services.
Questions/Comments/ Recommendations	• How are some families more successful at obtaining services than others? • Spotlight success stories
Resources	
Unmet Need/Problem	• Lack of housing for families. • Lack of shelters in SA7, the one currently located in SA 7 is for Countywide use. • Transportation needed to retrieve documents from other agencies in order to apply for services. • Resource Service Centers distributed equally throughout the SA 7. • Money for birth certificates
Collaborations	
Unmet Need/Problem	Commissioners should be regular attendees at the SAAC meetings. More partnerships are needed within the Service Area.
Recommendation (s)	Host a town hall meeting for SA 7.
Staff delivering mental health services	
Unmet Need/ Problem	• Not providing enough individual therapy • The need to provide cultural competent services • High caseloads • Retention of staff in Service Area 7 • More education for intake staff in regards to helping the undocumented receiving services. • More outreach and engagement efforts for those consumers that are hard to reach.
Lesbian, Gay Bisexual, Transgender, and Questioning (LGBTQ)	
Unmet Need/Problem	• There is a need for more culturally appropriate services, specifically LGBTQ culturally relevant services. • Housing • More drop-in centers with features that include basketball courts, creative space and art studios • Including LGBTQ as part of collecting demographic information • Currently, only one TAY Drop-in Center in the Service Area.

Service Area 8 – South Bay
Meeting: October 5, 2018
Presenter: Kara Taguchi, Psy.D. and Robin Ramirez

Mental Health Services	
Unmet Need/Problem	• Better coordination and more partnerships • between mental health, law enforcement, and homeless services • between other municipalities and non-County entities • Services needed at more public locations • Equal distribution of services throughout Service Area 8 • Better communication about the various services within DMH • Better hospital discharge planning • Lack of clinicians and space to provide mental health services to the underserved • Access to children during school hours at the schools.
Questions/Comments/ Recommendations	• Provide services at parks • Create a one-stop location where clients can receive mental health and social services • Mobile service treatment (a recreational vehicle (RV) with showers) • Provide mental health workers at train stations to help avoid arrests • Gender Dysphoria training for clinical staff • Provide transportation to and from mental health services appointment
Housing	
Unmet Need/Problem	• Lack of shelters in Service Area 8

UCC Leadership Meeting
Meeting: October 24, 2018
Presenter: Debbie Innes-Gomberg, Ph.D. and Robin Ramirez

Lesbian, Gay Bisexual, Transgender, and Questioning (LGBTQ)	
Unmet Need/Problem	• Find a way to collect data that is a better representative of the LGBTQ • Better representation in Sacramento for LGBTQ advocacy • Better data collection methods for transgender community • How do we better document the need? • Incorporate data collection for LGBTQ into our electronic health record.
Native Americans	
Unmet Need/Problem	• Find a way to collect data on the tribes. It's not enough to just identify the number of Native Americans served.

MHSA County Compliance Certification

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MHSA County Fiscal Accountability Certification

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Mental Health Commission Approval Letter

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Los Angeles County Board of Supervisors Adopted Letter

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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

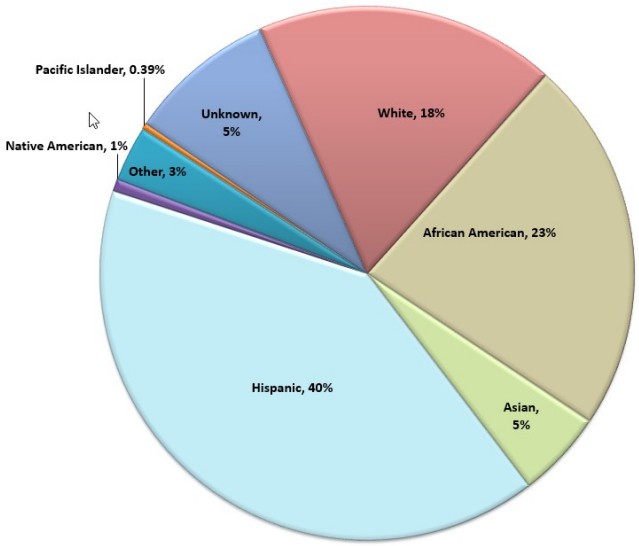
Full Service Partnership - Recovery Resilience & Reintegration - Alternative Crisis Services - Linkage - Housing - Planning Outreach & Engagement

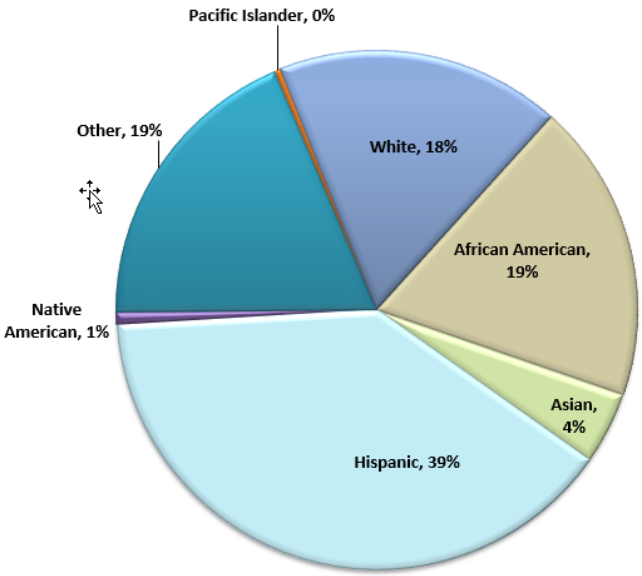
CLIENTS

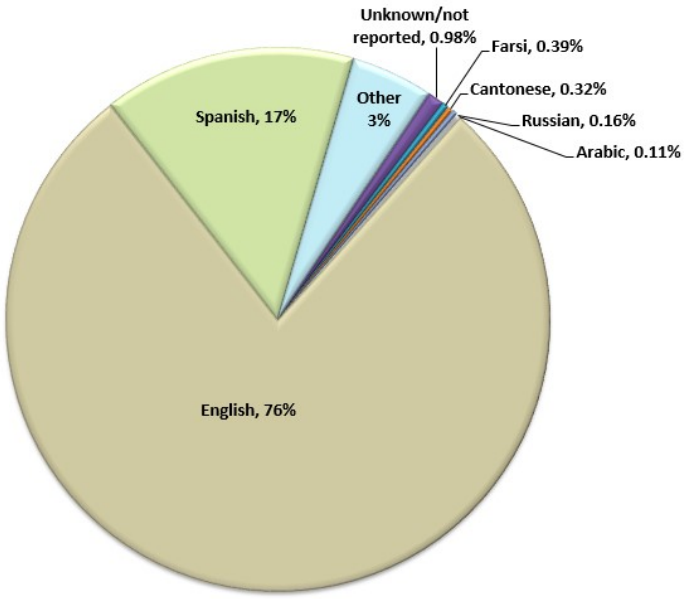
- 132,397 clients received a direct mental health service
- 40% of the clients are Hispanic
- 23% of the clients are African American
- 18% of the clients are White
- 5% of the clients are Asian
- 78% have a primary language of English
- 15% have a primary language of Spanish

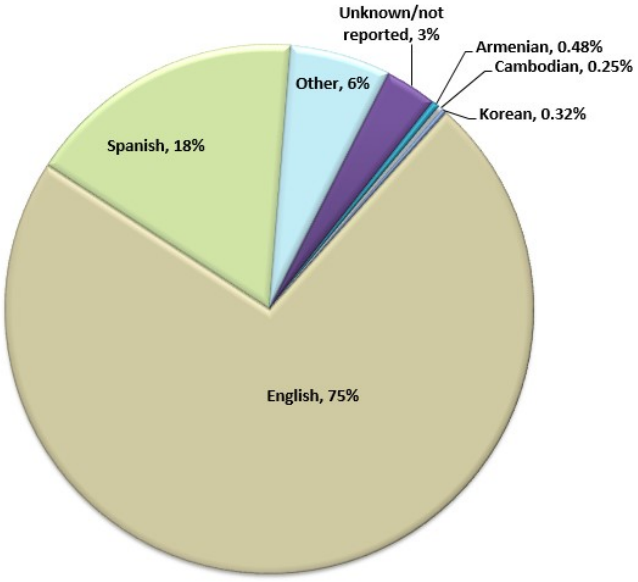
NEW CLIENTS

- 61,985 new clients receiving CSS services Countywide with no previous MHSA service
- 39% of the new clients are Hispanic
- 19% of the new clients are African American
- 18% of the new clients are White
- 75% have a primary language of English
- 18% have a primary language of Spanish

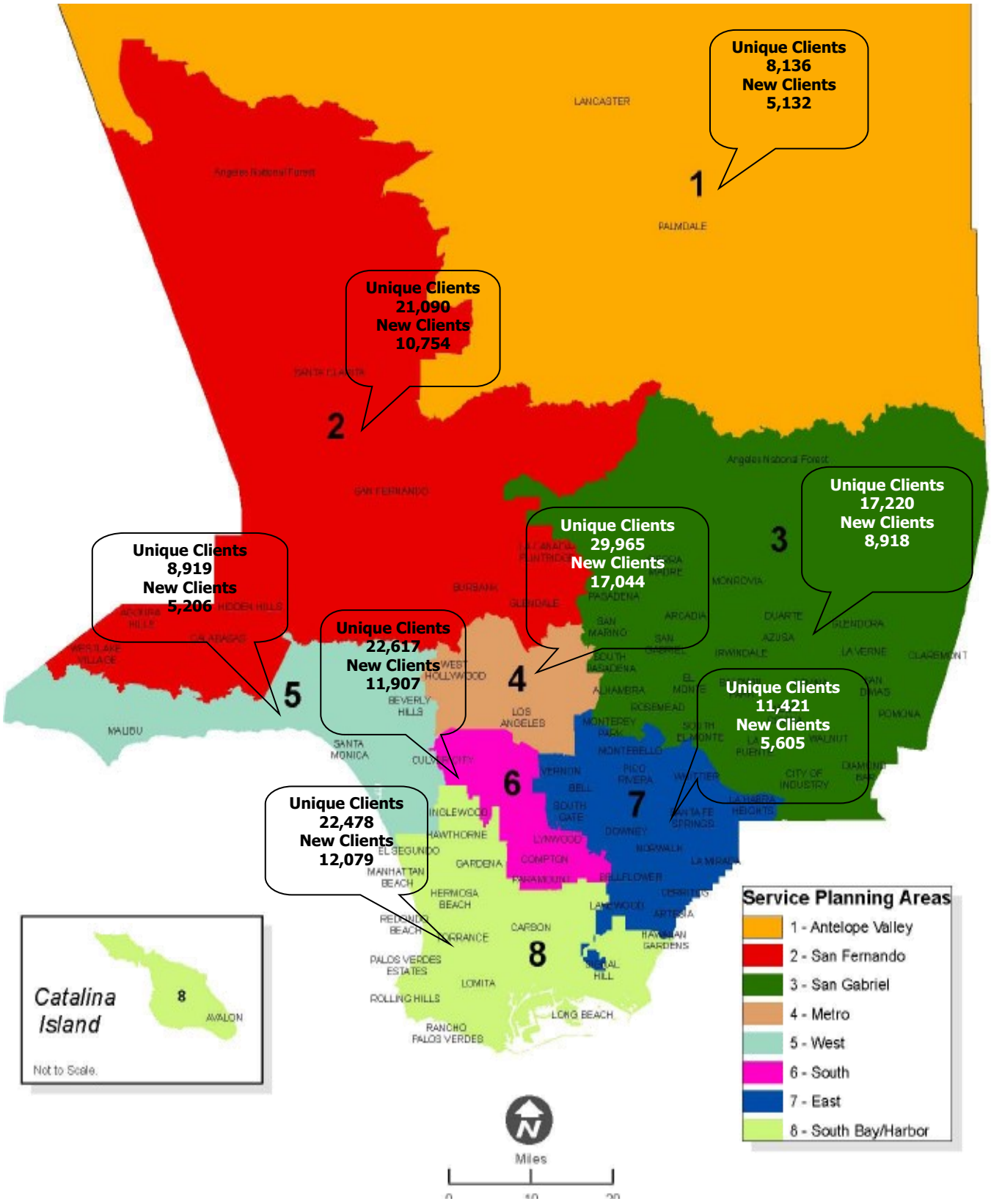




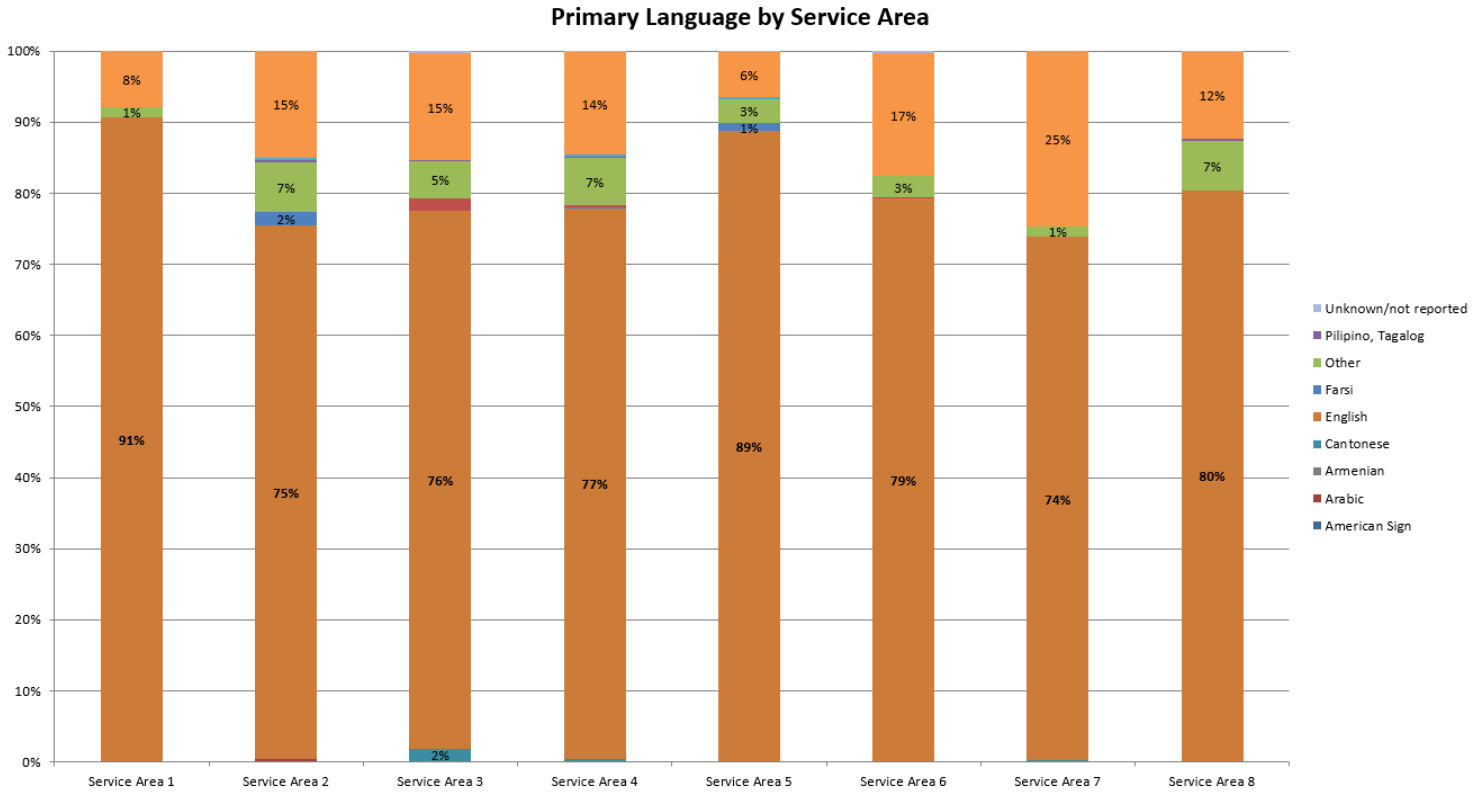


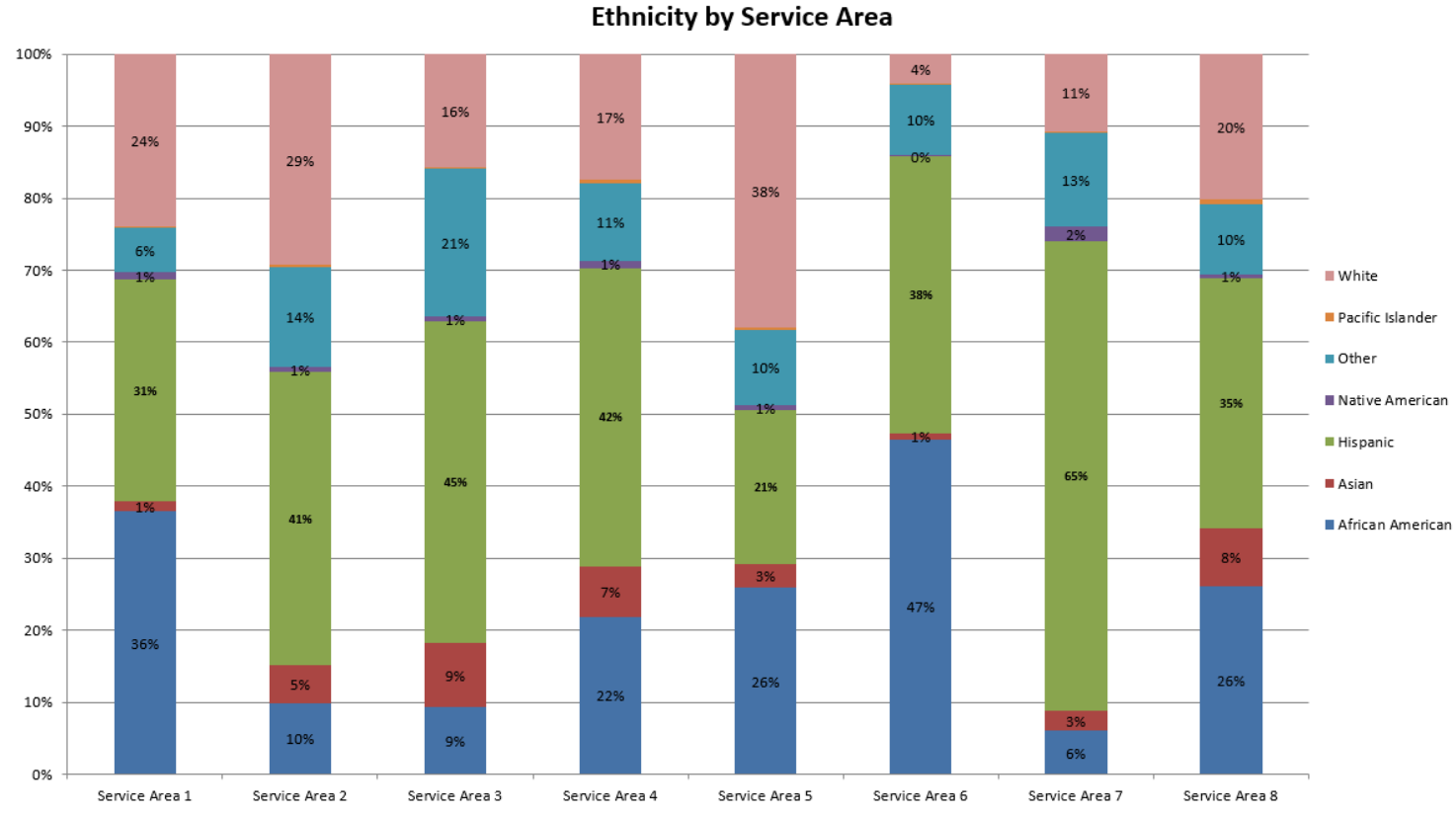


Los Angeles County Clients Served Through CSS by Service Areas Fiscal Year 2017-18



Los Angeles County Clients Served Through CSS by Service Areas Fiscal Year 2017-18





FULL SERVICE PARTNERSHIP

CHILDREN , TRANSITION AGE YOUTH , ADULT , AND OLDER ADULT

PROGRAMS & SLOTS

PROGRAM	SLOTS[1]
Child	2,070
Wraparound Child	523
Intensive Field Capable Clinical Services	765
TAY	1,395
Wraparound TAY	226
Adult	6,524
Integrated Mobile Health Team	300
Assisted Outpatient Treatment	300
Forensic	970
Homeless	1,630
Housing[6]	999
Older Adult	885

UNIQUE CLIENTS SERVED
Children[3] - 4,081
TAY[4] - 2,619
Adult[5] - 6,007
Older Adult - 1,566

AVERAGE COST PER CLIENT[2]
Children - $16,647
TAY - $12,306
Adult - $11,995
Older Adult - $8,900

[1] Slot allocation for FY 2018-19.
[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 & TAY FSP programs.
[4] TAY: unique clients served inclusive of TAY.
[5] Adult: unique clients served inclusive of Adult, Assisted Outpatient Treatment (AOT), Integrated Mobile Health Team (IMHT), Homeless, and Forensic FSP programs.
6 Homeless: Services implemented FY 2018-19.

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:

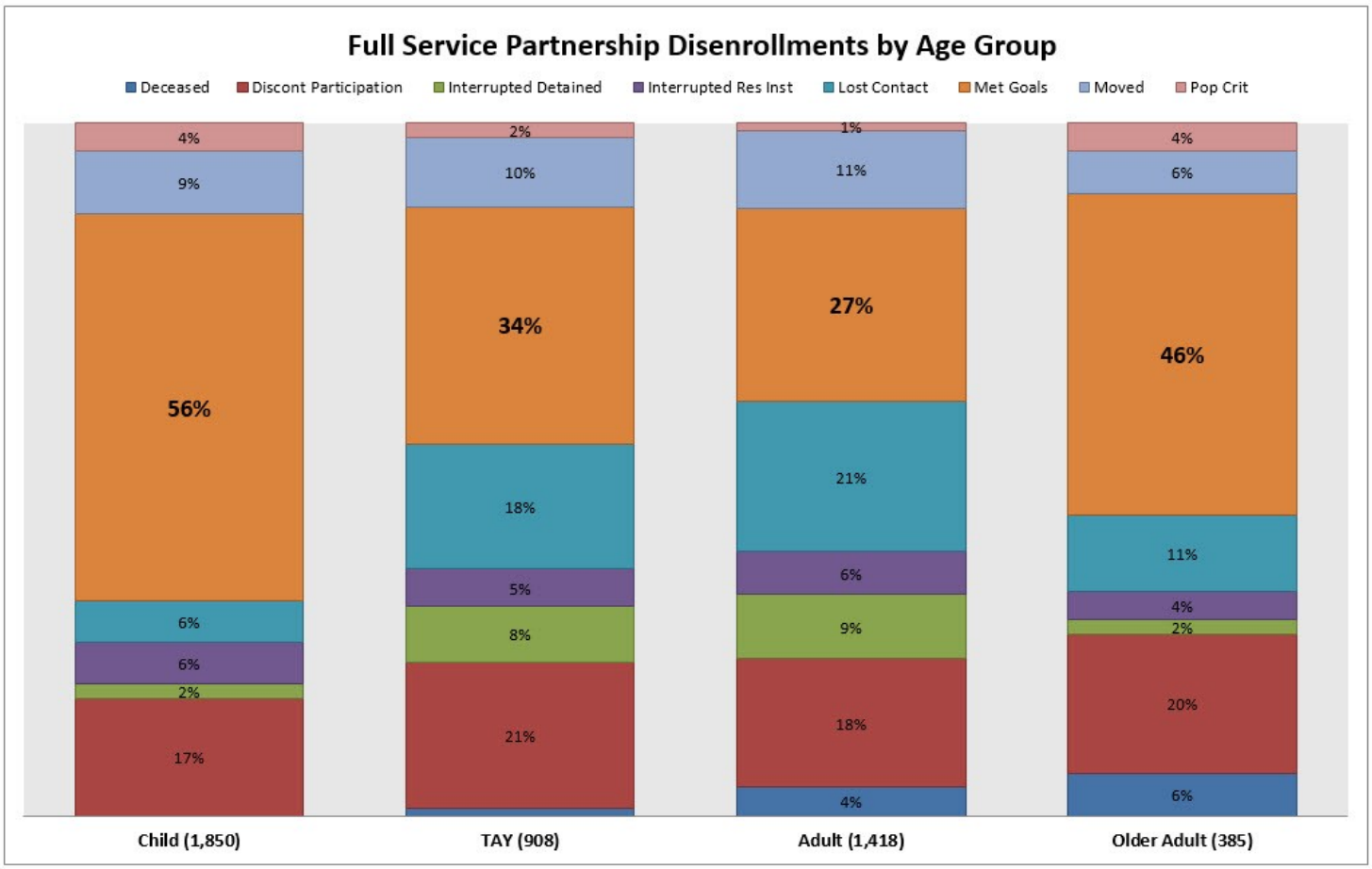
- homeless or at imminent risk of homelessness;
- hospitalizations; jail or at risk of going to jail;
- imminent risk for placement in a skilled nursing facility (SNF) or nursing home or being released from SNF/nursing home;
- presence of a co-occurring disorder;
- serious risk of suicide or recurrent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

FULL SERVICE PARTNERSHIP

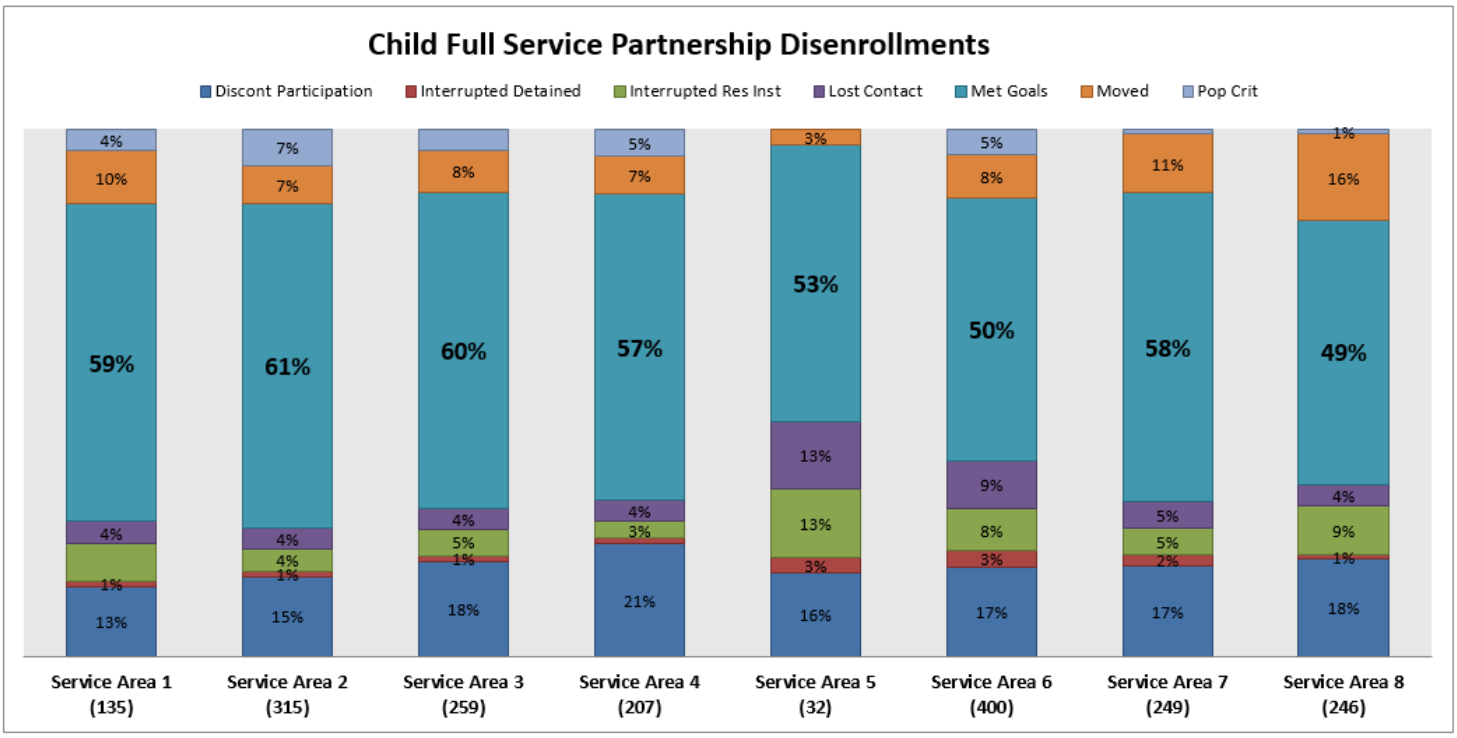
DISENROLLMENTS FY 2017-18

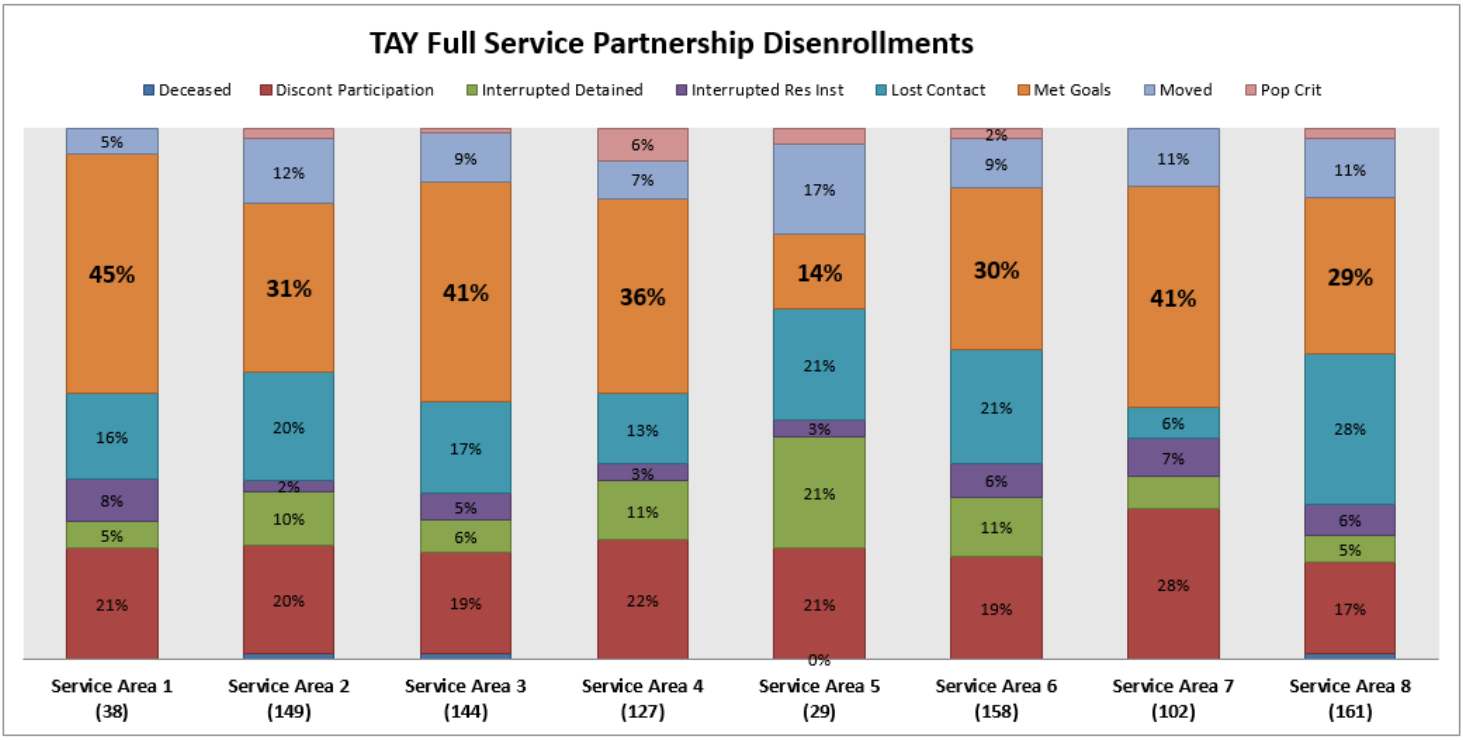
Disenrollment can apply to either an interruption or a discontinuation of service. An interruption of service is defined as a temporary situation in which the client is expected to return to services within twelve (12) months or less from the date of last contact. A discontinuation of service is defined 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.

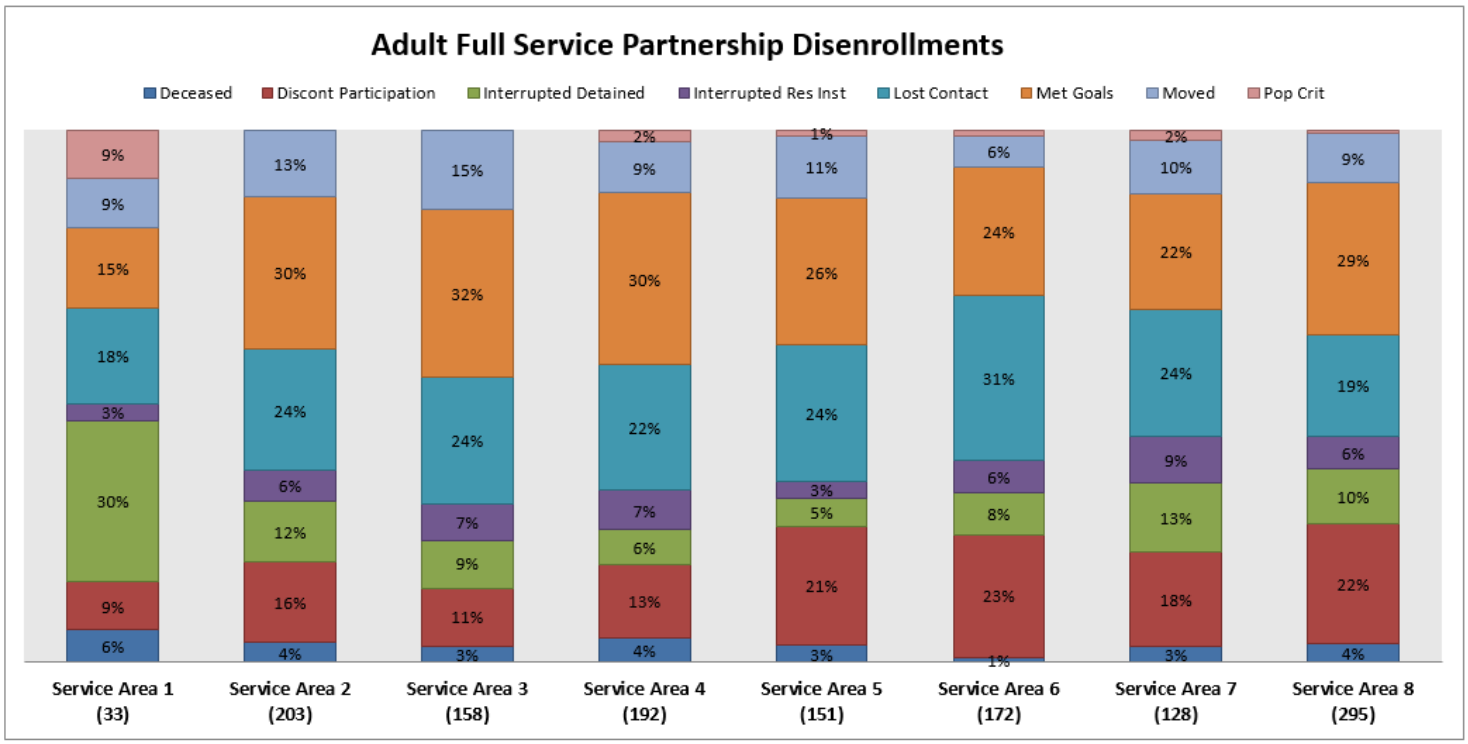


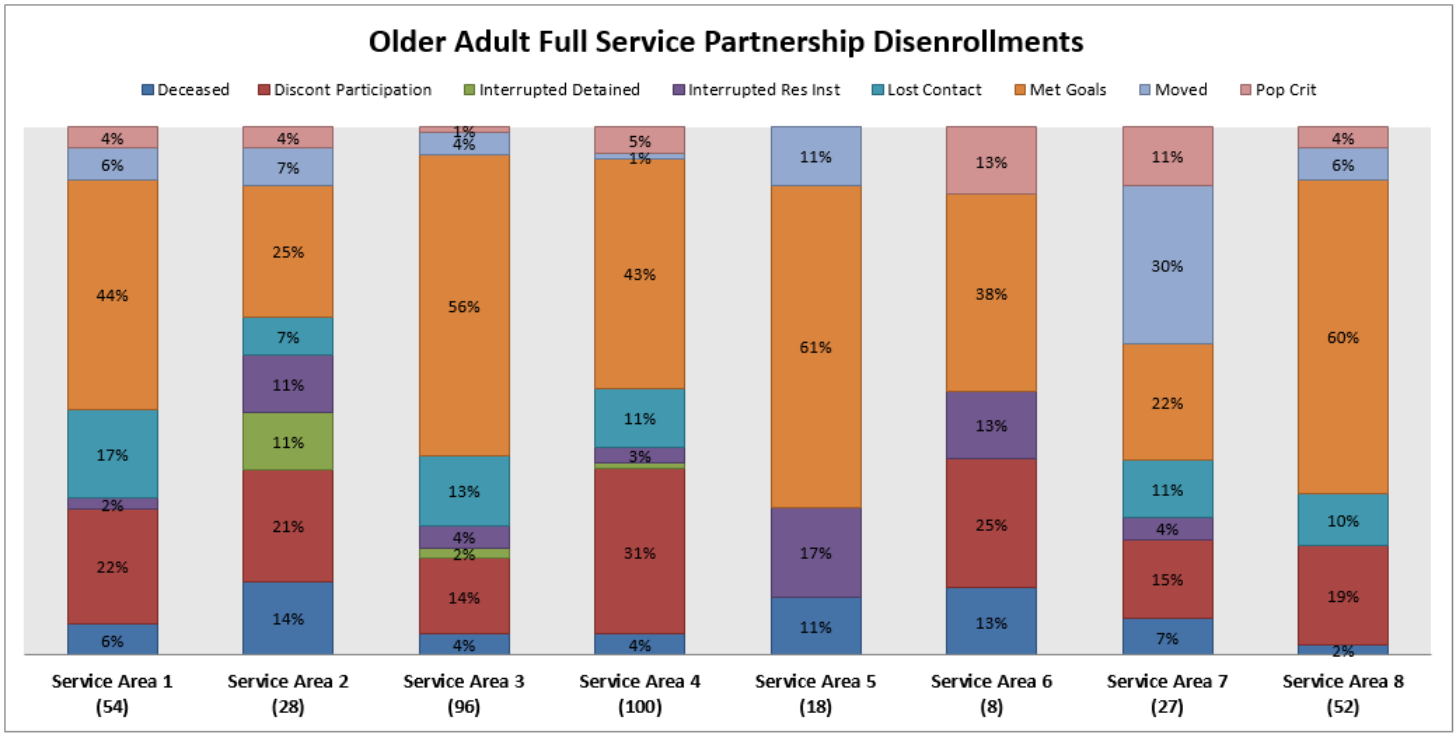
DISENROLLMENTS CONTINUED





DISENROLLMENTS CONTINUED





RESIDENTIAL OUTCOMES

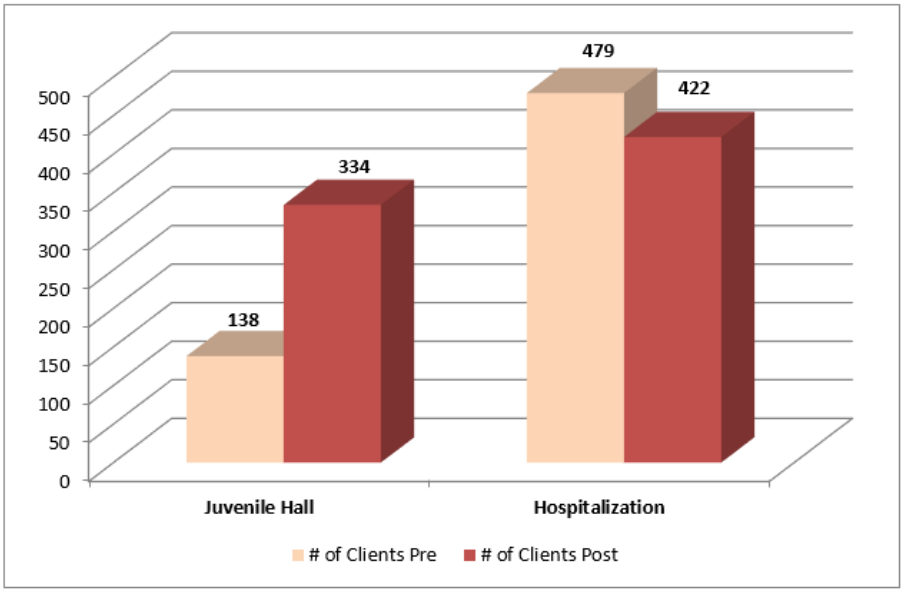
Comparison of residential data for 12 months immediately prior to receiving FSP services (pre-partnership) and for 12 months of residential status while receiving FSP services (post-partnership) for client's outcomes entered through June 30, 2018. Data is adjusted (annualized) by a percentage based on 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.

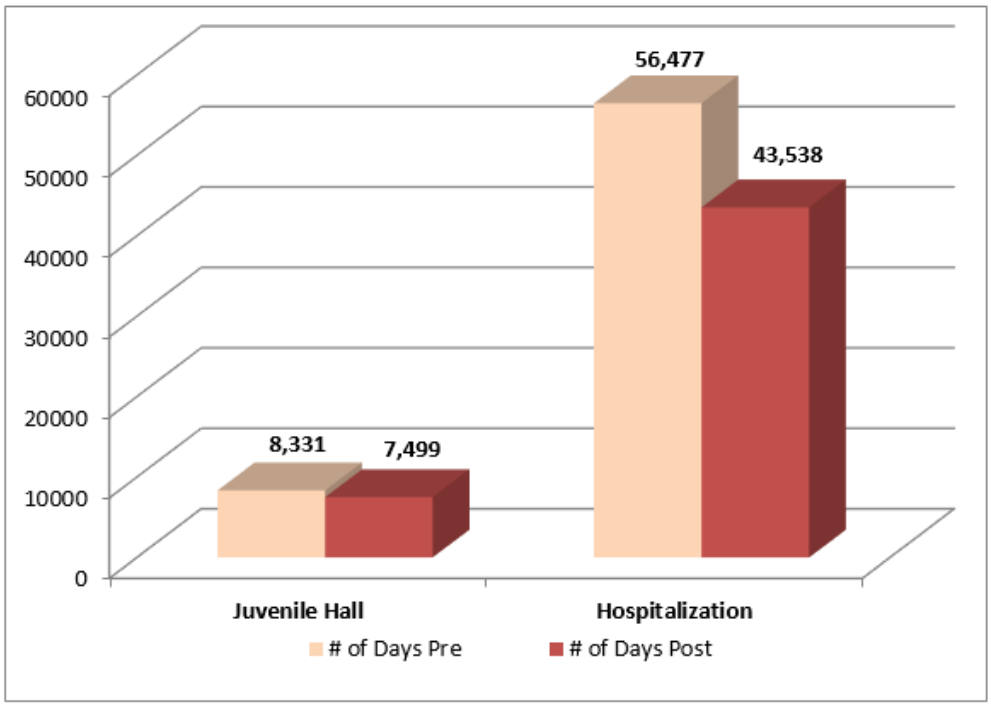
CHILD FSP

NUMBER OF BASELINES: 9,504
NUMBER OF CLIENTS: 9,234

- 23% reduction in days hospitalized
- 10% reduction in days in juvenile hall
- 12% reduction in the number of clients hospitalized
- 142% increase in the number of clients in juvenile hall*

* There was a 142% increase in the number of clients in juvenile hall post-partnership. Data indicates 138 children (approximately 1.5% of the baselines included) reported being in juvenile hall 365 days prior to partnership and 334 children (approximately 3.5% of the baselines included) after partnership was established.

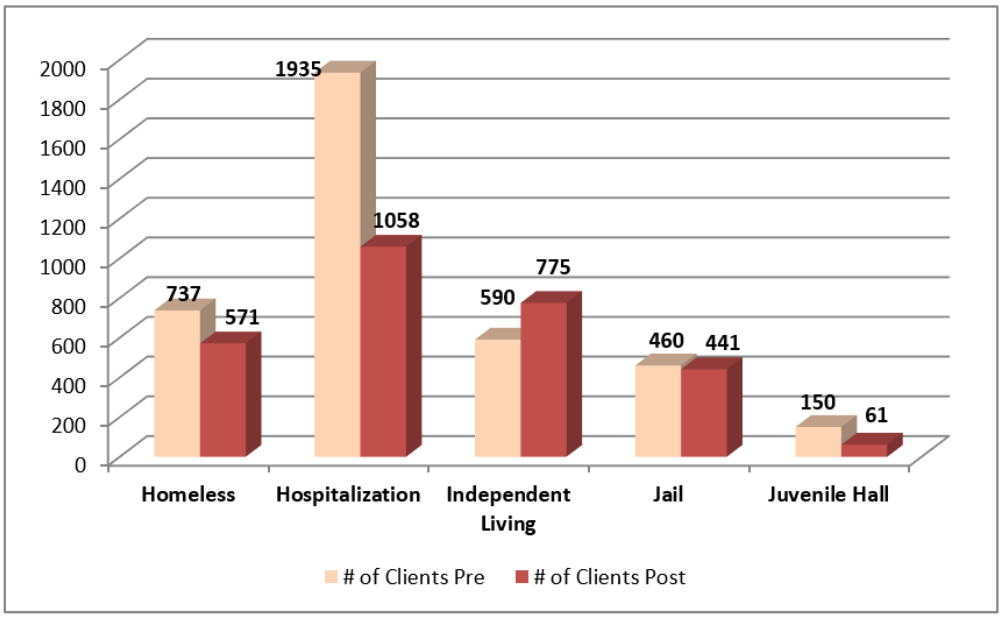


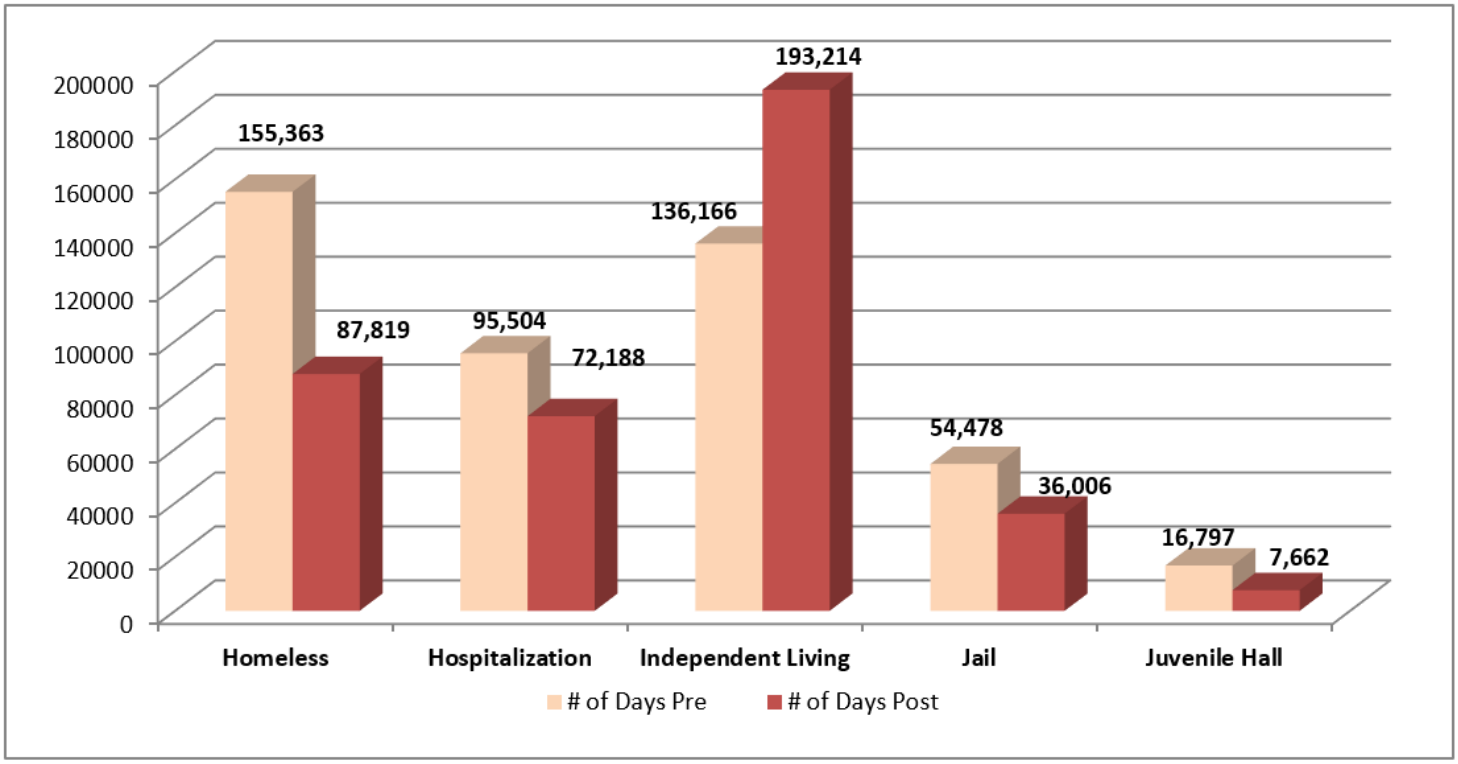


RESIDENTIAL OUTCOMES
CONTINUED

TAY FSP
NUMBER OF BASELINES: 4,907
NUMBER OF CLIENTS: 4,762

- 43% reduction in days homeless
- 24% reduction in days hospitalized
- 34% reduction in days in jail
- 41% increase in days living independently
- 54% reduction in days in juvenile hall
- 23% reduction in clients homeless
- 45% reduction in clients hospitalized
- 4% reduction in clients in jail
- 60% reduction in clients in juvenile hall
- 31% increase in clients living independently

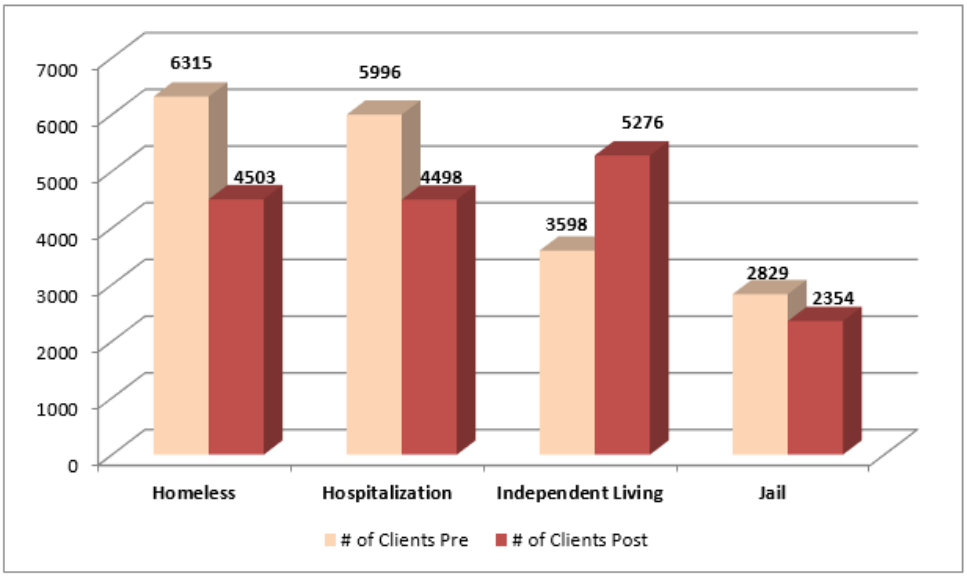


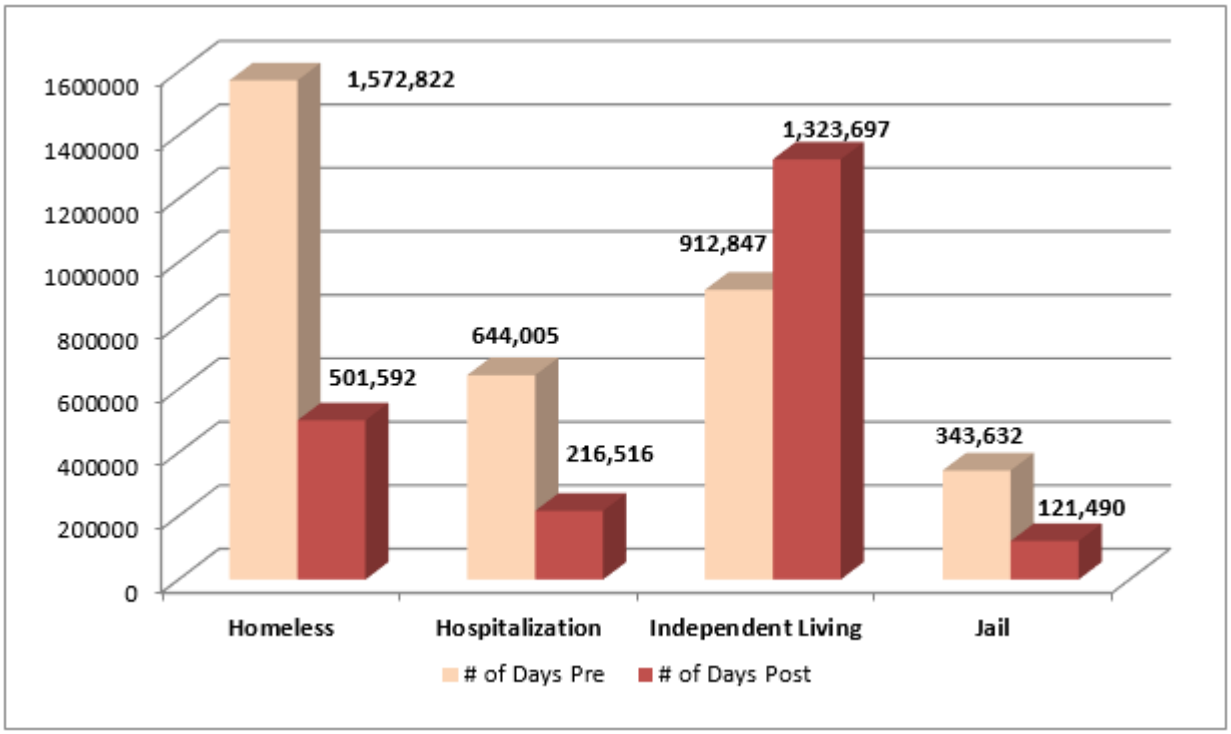


RESIDENTIAL OUTCOMES
CONTINUED

ADULT FSP
NUMBER OF BASELINES: 14,503
NUMBER OF CLIENTS: 13,713

- 68% reduction in days homeless
- 66% reduction in days hospitalized
- 65% reduction in days in jail
- 45% increase in days living independently
- 29% reduction in clients homeless
- 25% reduction in clients hospitalized
- 17% reduction in clients in jail
- 47% increase in clients living independently

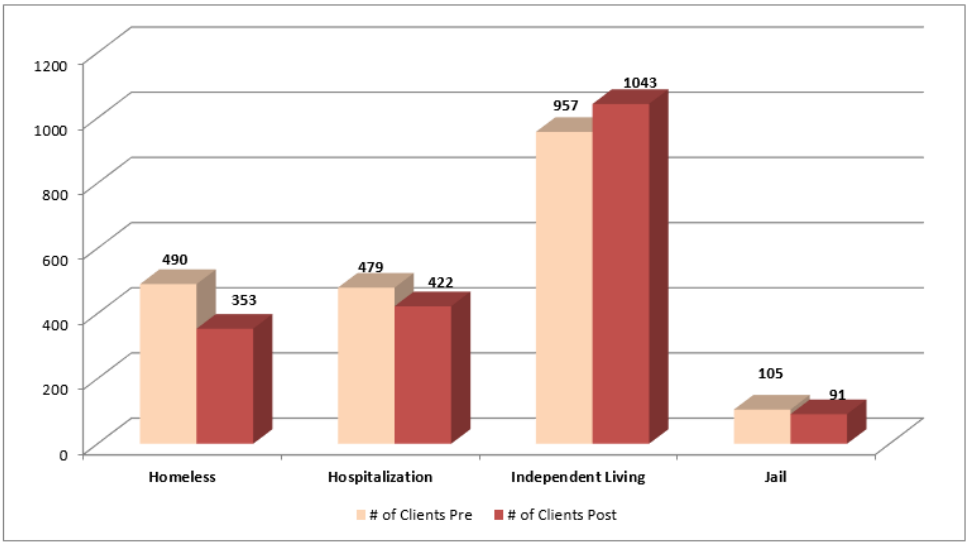


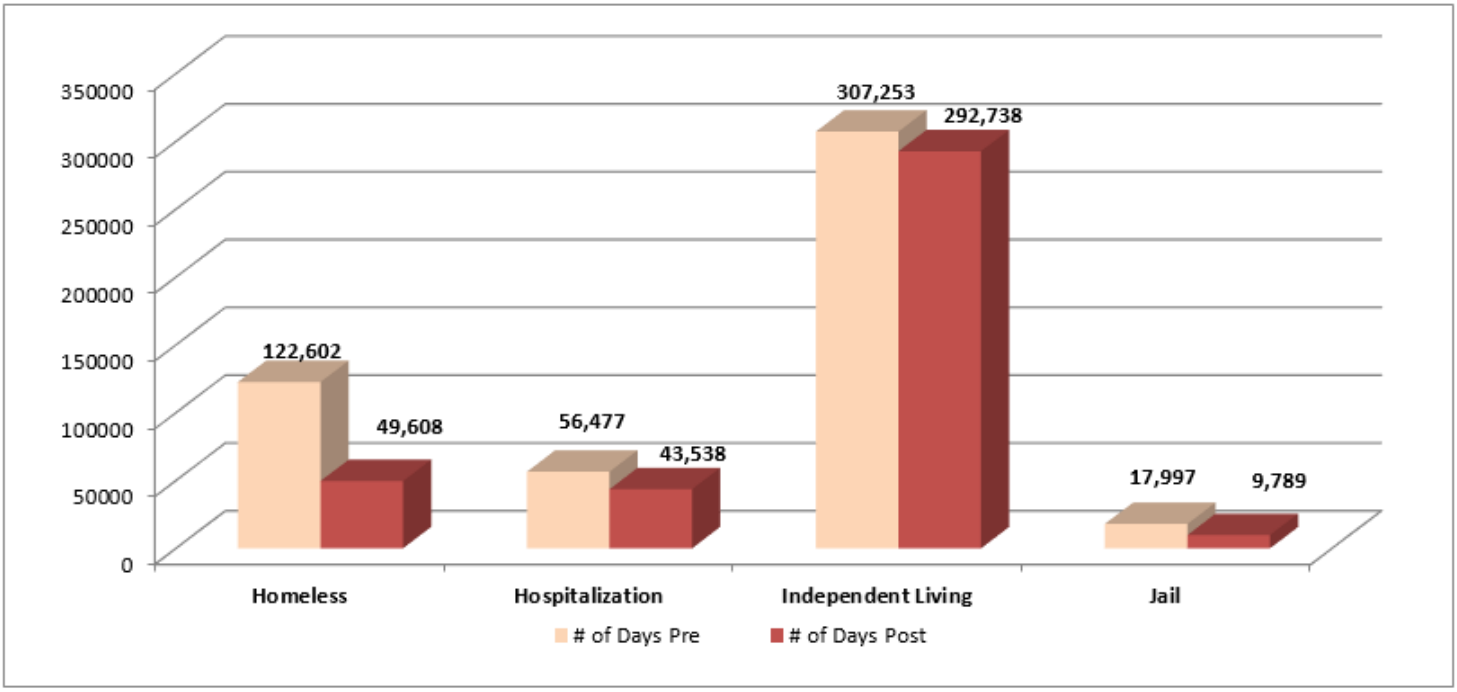


RESIDENTIAL OUTCOMES
CONTINUED

OLDER ADULT FSP
NUMBER OF BASELINES: 1,643
NUMBER OF CLIENTS: 1,606

- 60% reduction in days homeless
- 23% reduction in days hospitalized
- 5% reduction in days living independently
- 46% reduction in days in jail
- 28% reduction in clients homeless
- 12% reduction in clients hospitalized
- 8% increase in clients living independently
- 13% reduction in clients in jail

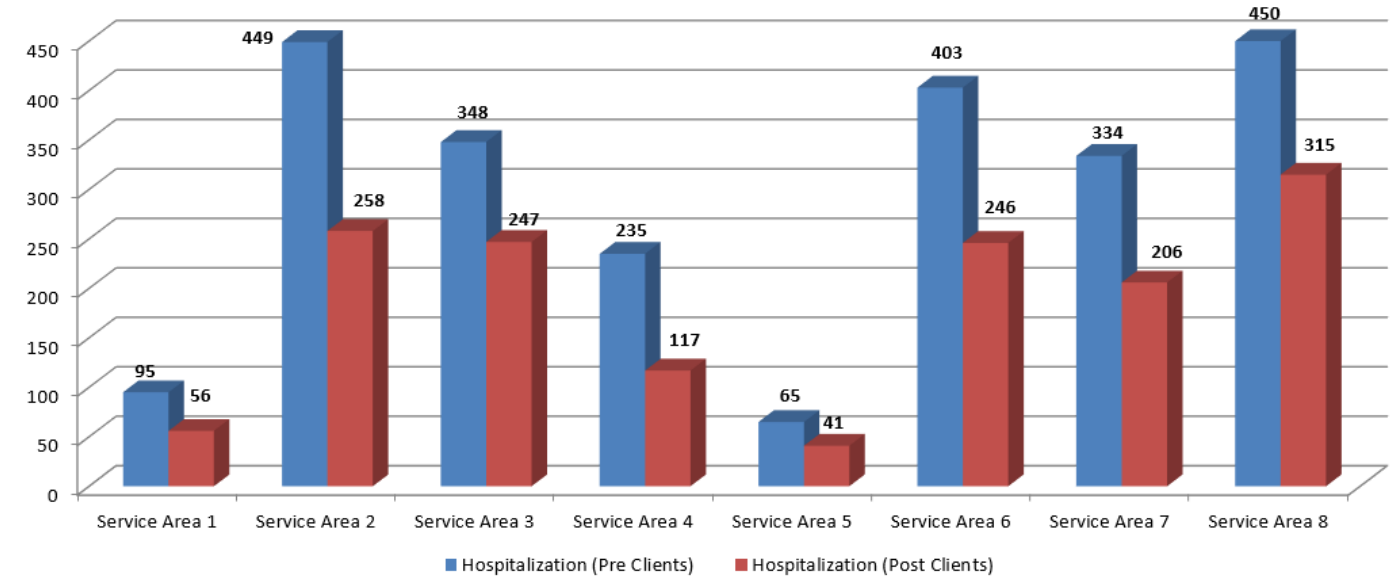


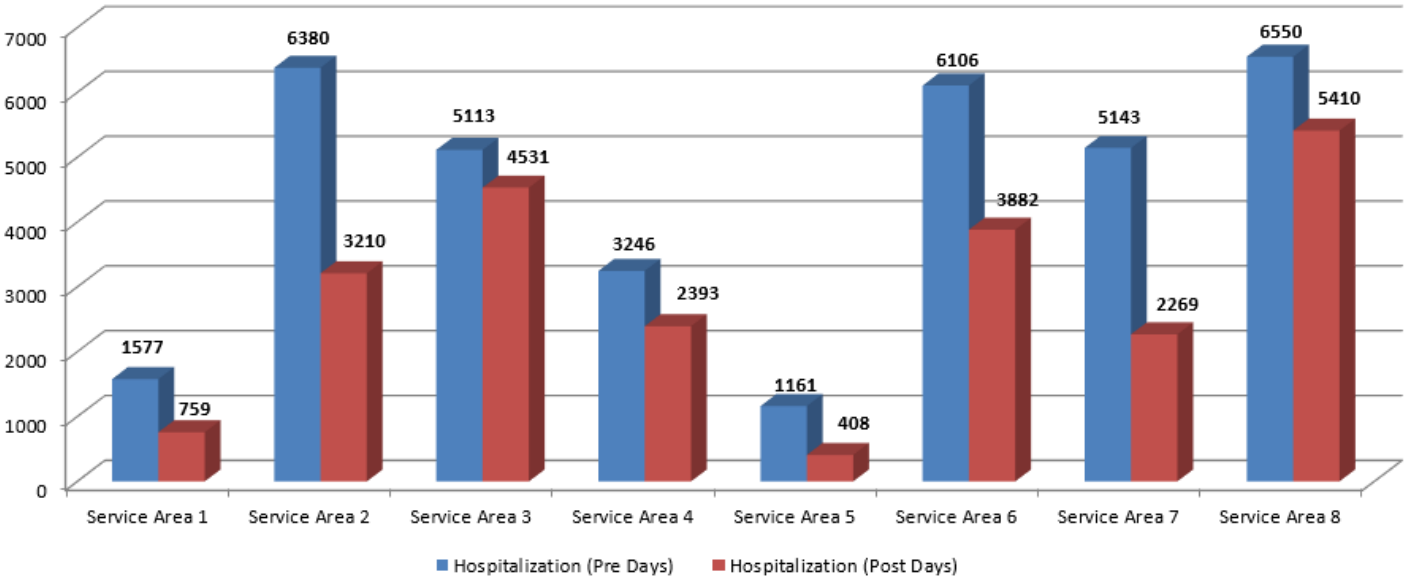


RESIDENTIAL OUTCOMES BY SERVICE AREA

CHILD HOSPITALIZATIONS

- ◊ All Service Areas report a reduction in clients and days hospitalized post-partnership
- ◊ Service Area 4 has the highest percent (50%) reduction in clients hospitalized post-partnership
- ◊ Service Area 5 has the highest percent reduction (65%) in hospital days post-partnership

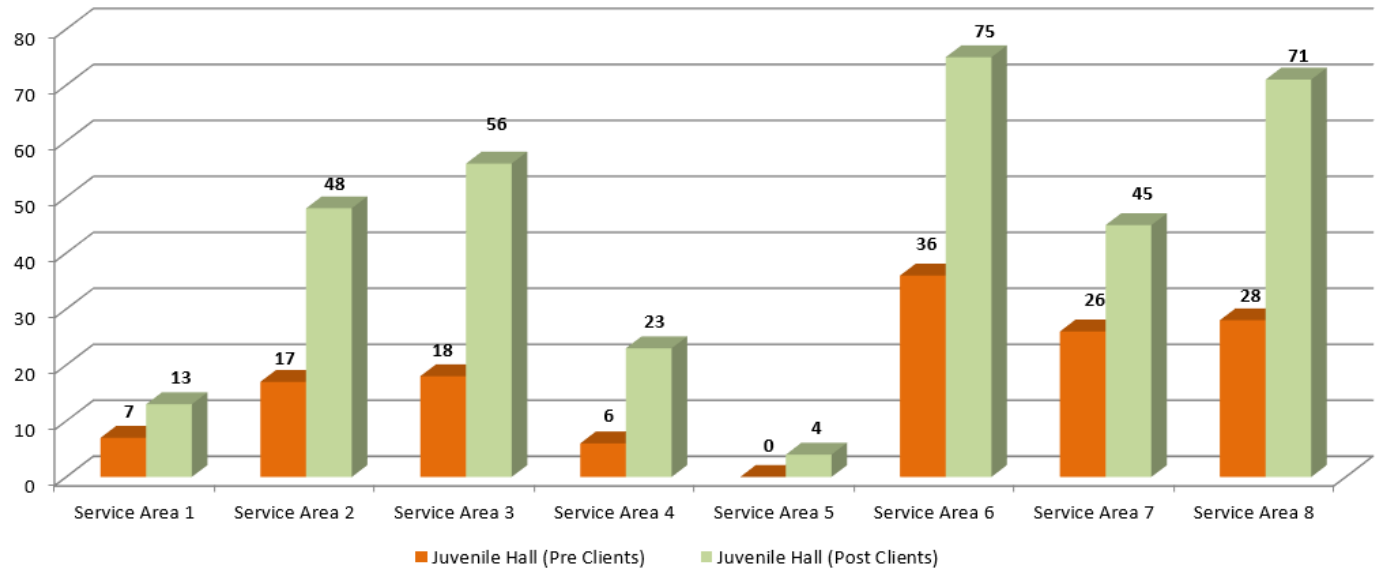


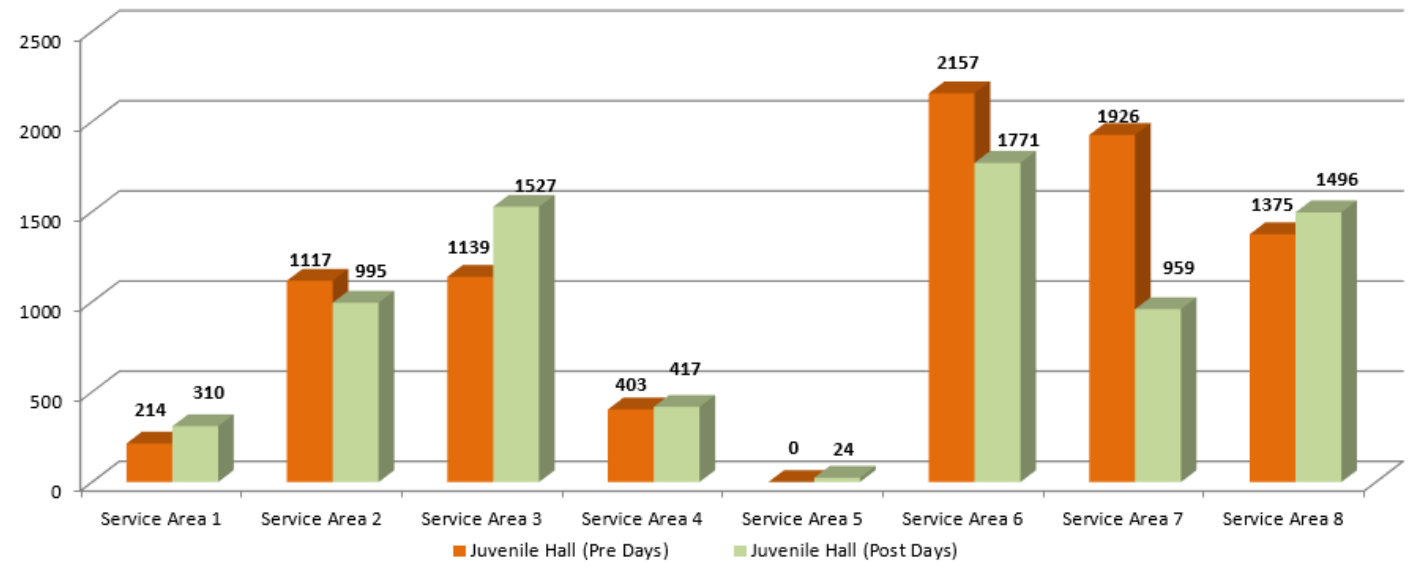


RESIDENTIAL OUTCOMES BY SERVICE AREA

CHILD JUVENILE HALL

- Service Area 8 has the most increase in the number of clients in juvenile hall from pre to post.
- Service Area 7 has the most reduction (50%) in the number of days in juvenile hall from pre to post.

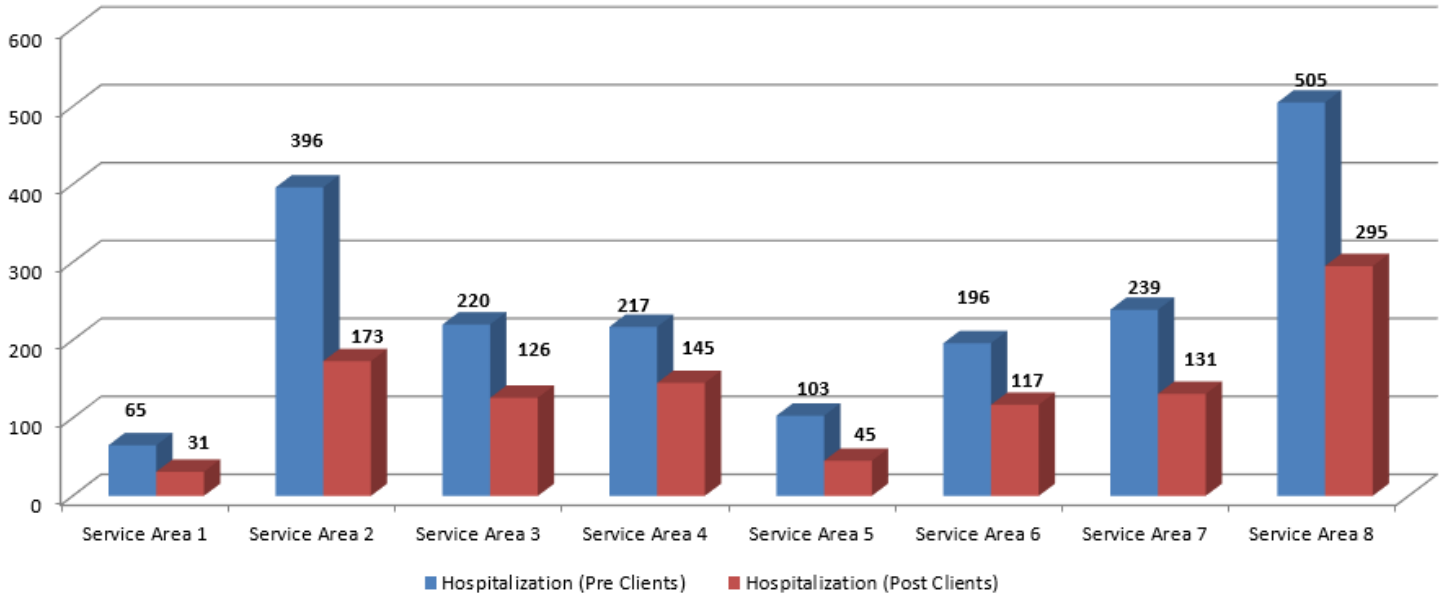


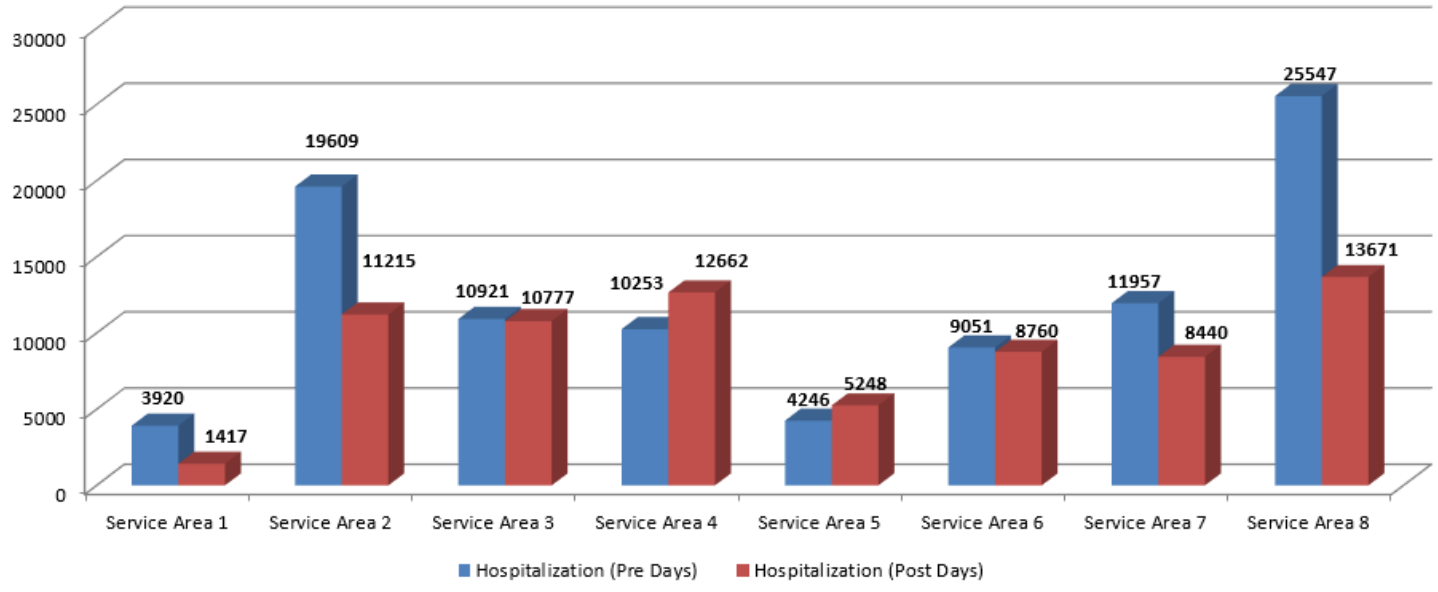


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY HOSPITALIZATIONS

- ◊ All Service Areas report a reduction in clients hospitalized post-partnership
- ◊ Service Areas 2 and 5 have the highest percent (56%) reduction in clients hospitalized post-partnership
- ◊ Service Area 8 has the most clients hospitalized pre-partnership (505) and post-partnership (295) with a 22% percent reduction
- ◊ Service Area 1 has the highest percent reduction (62%) in hospital days post-partnership
- ◊ Service Area 8 has the most days spent in hospitalized pre-partnership (25,547) and post-partnership (13,671) with a 46% percent reduction.

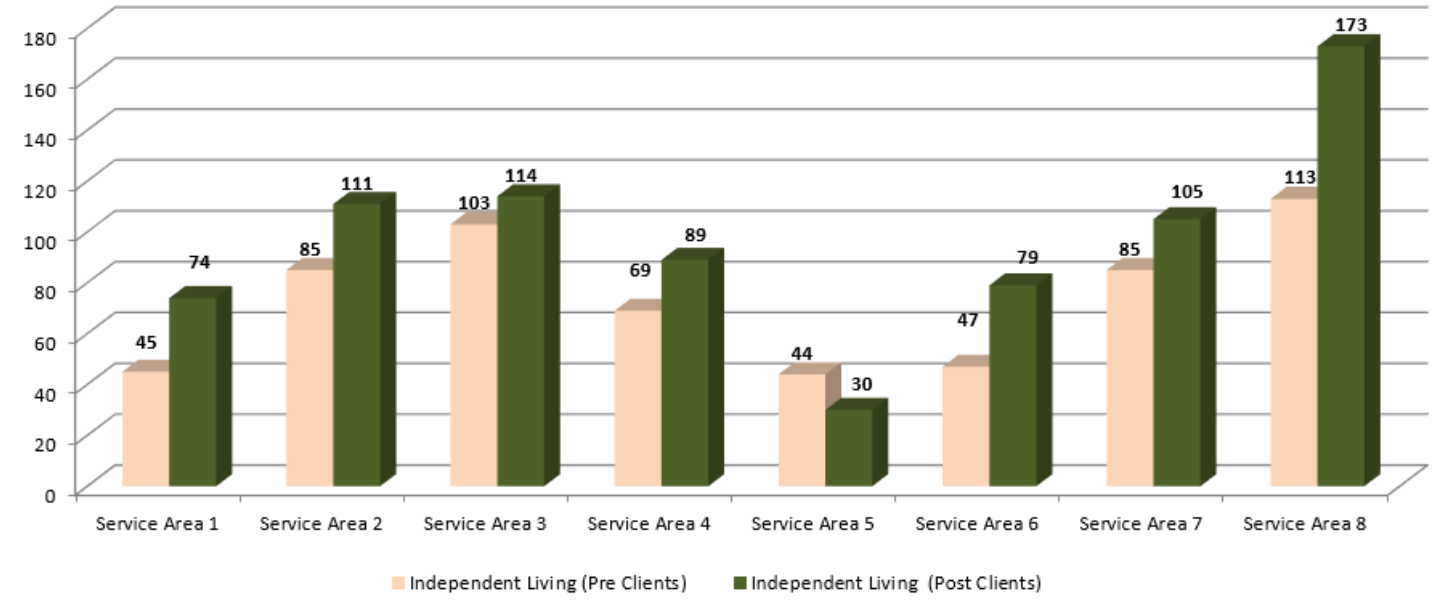


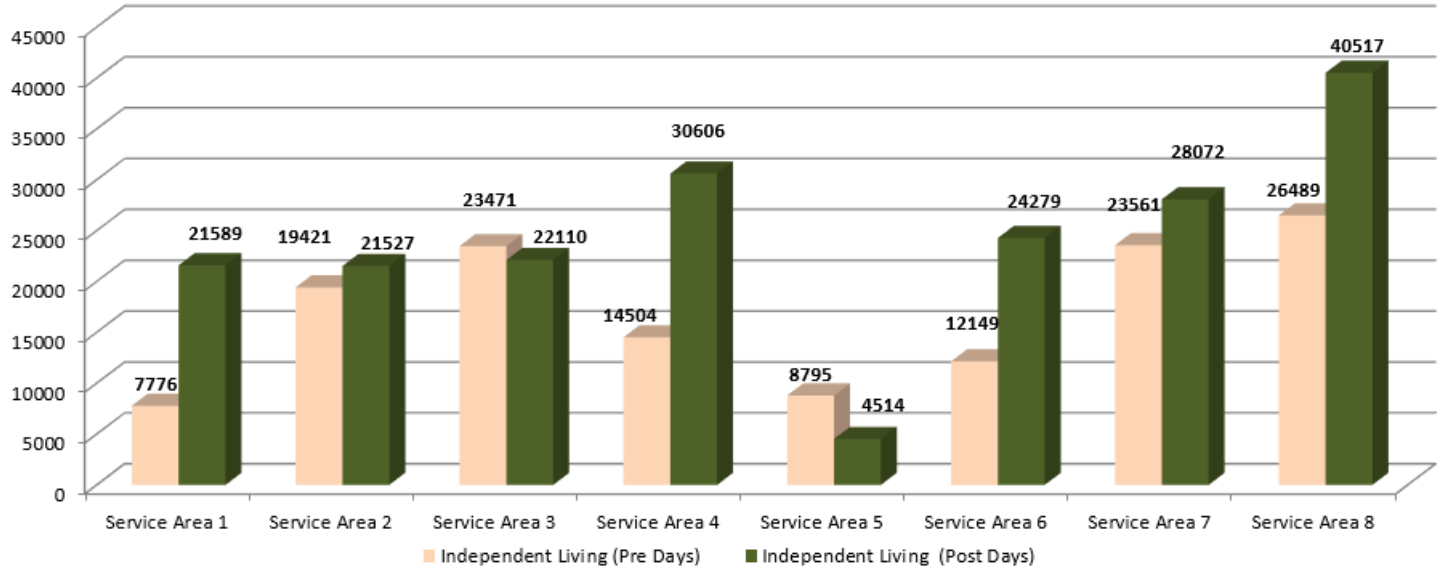


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY INDEPENDENT LIVING

- Service Area 8 has the highest number of clients living independently post partnership, 173
- Service Area 6 has the most percent increase in clients (68%) living independently post-partnership
- Service Area 1 has the most percent increase in days living independently, 178%

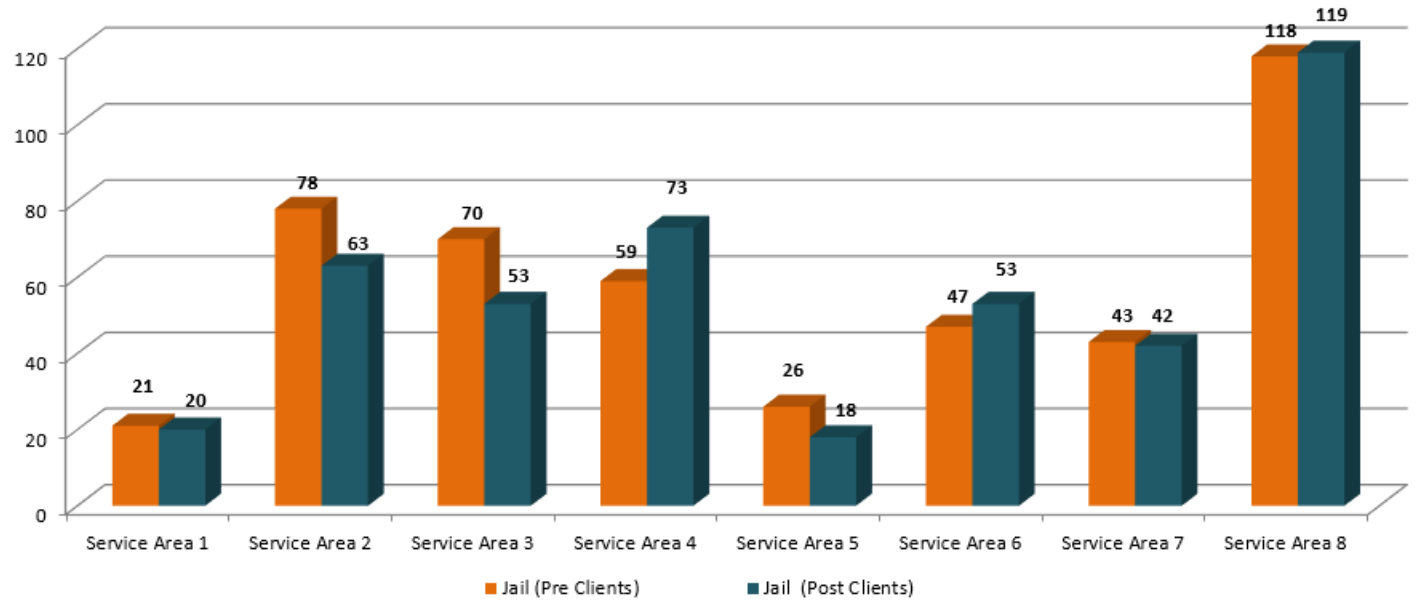


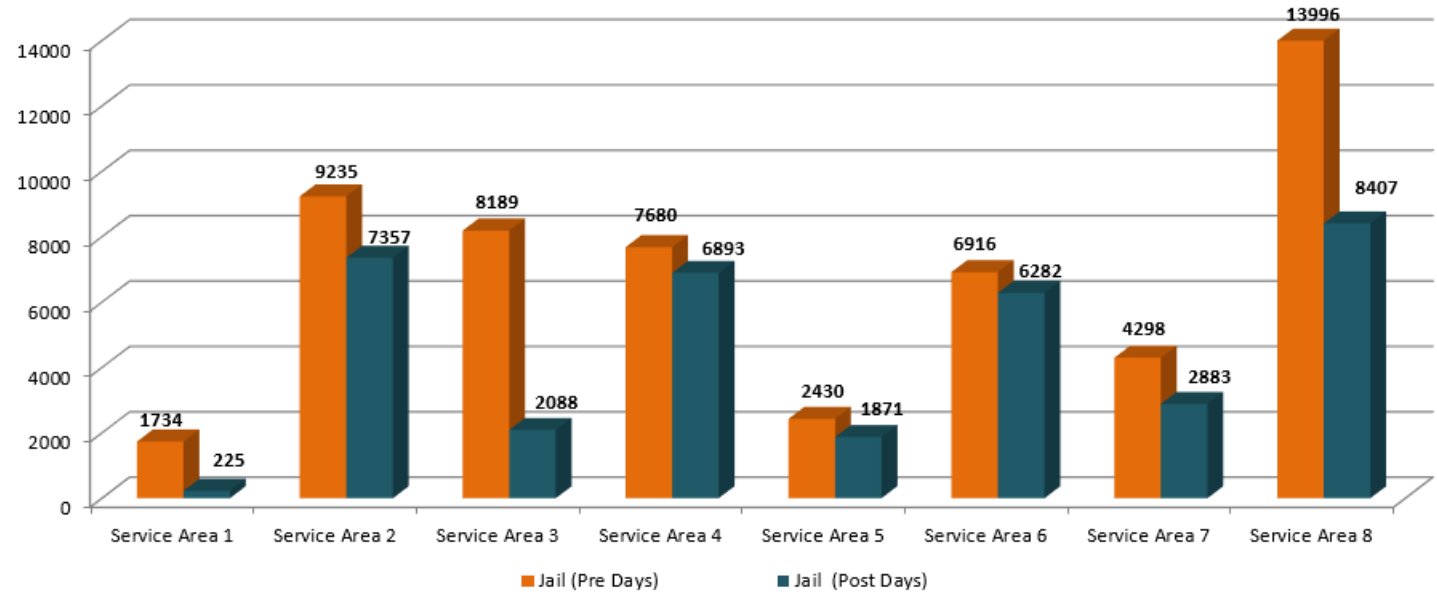


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY JAIL

- Service Area 5 has the highest percent (31%) reduction of clients in jail post-partnership
- Service Area 1 has the highest percent (87%) reduction of days spent in jail post-partnership

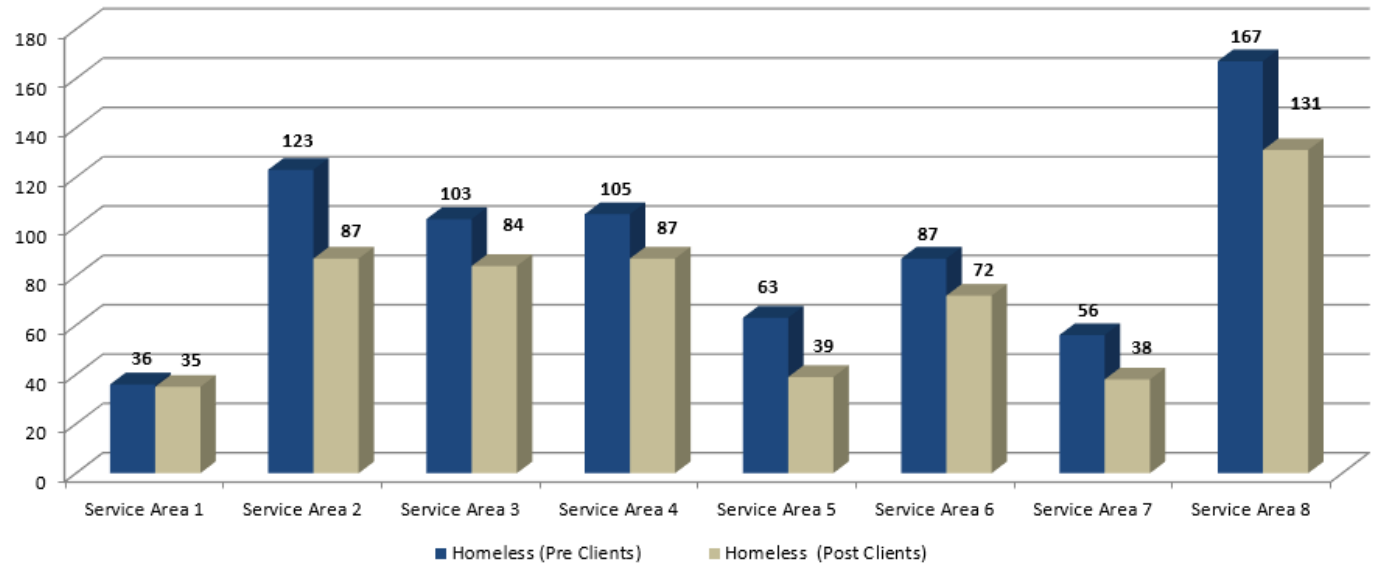


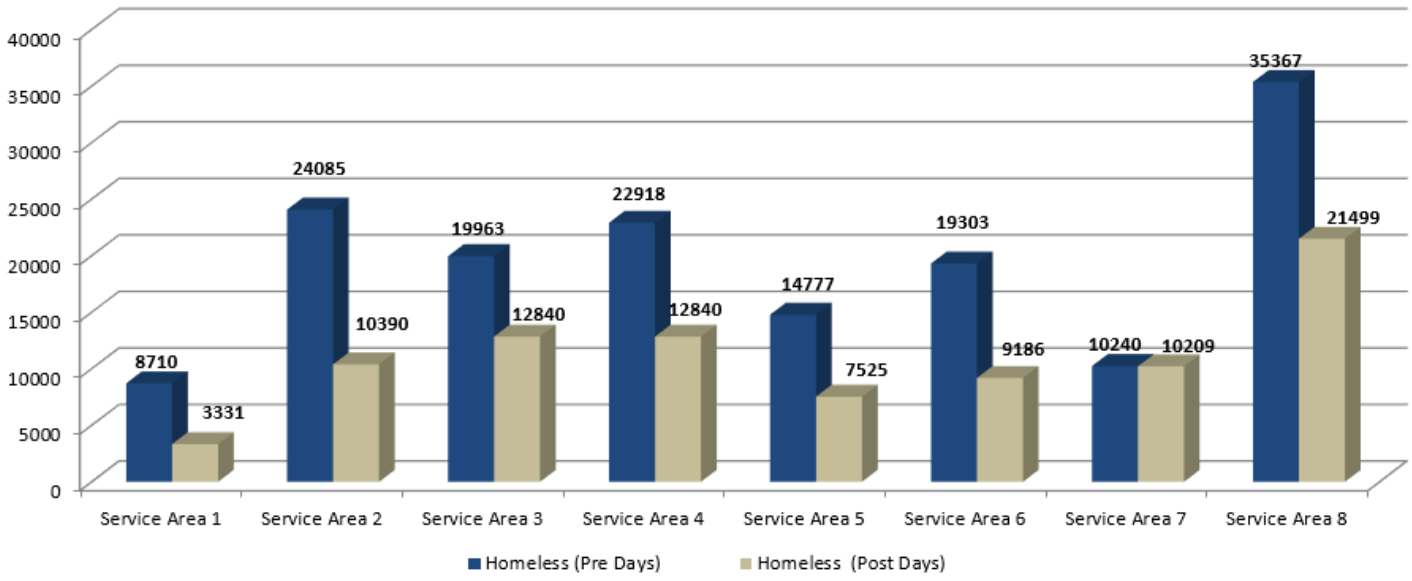


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY HOMELESS

- ◊ Service Area 5 has the highest percent (38%) reduction in clients homeless post-partnership
- ◊ Service Area 1 has the highest percent (62%) reduction in days homeless post-partnership
- ◊ Service Area 8 has the most clients homeless pre-partnership (167) and post-partnership (131) with a 22% percent reduction
- ◊ Service Area 8 has the most days spent homeless pre-partnership (35,367) and post-partnership (21,499) with a 39% percent reduction

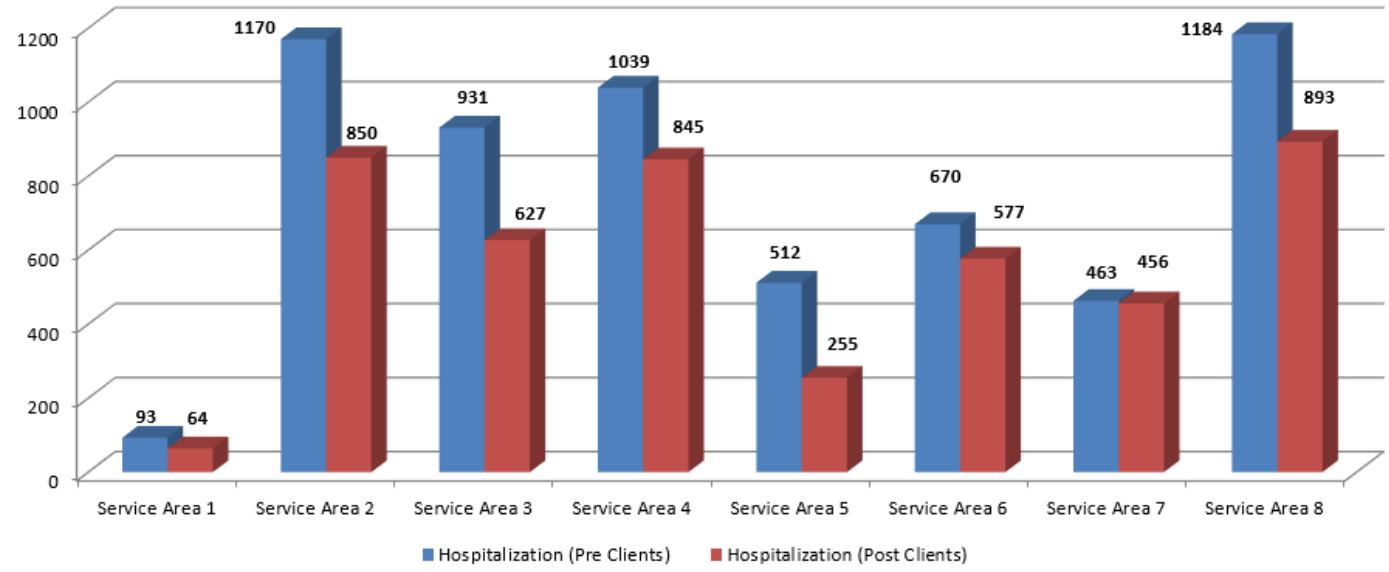


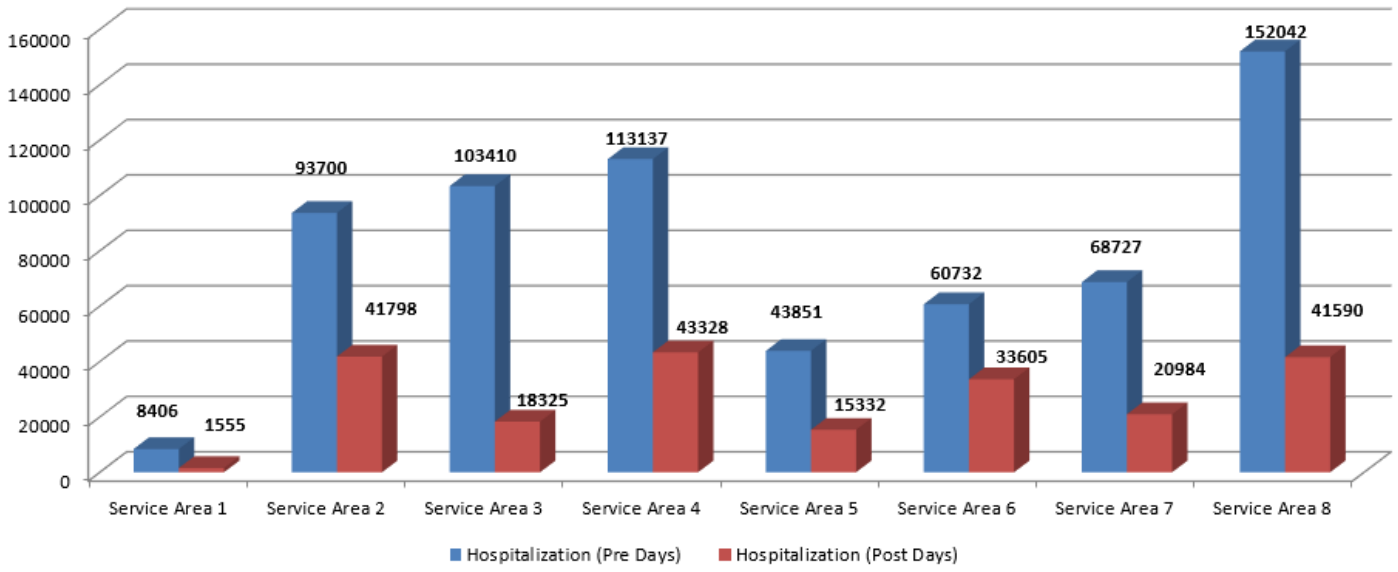


RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT HOSPITALIZATIONS

- ◊ All Service Areas report a reduction in clients and days hospitalized post-partnership
- ◊ Service Area 5 has the highest percent (50%) reduction in clients hospitalized post-partnership
- ◊ Service Areas 1 and 3 have the highest percent reduction (82%) in hospital days post-partnership

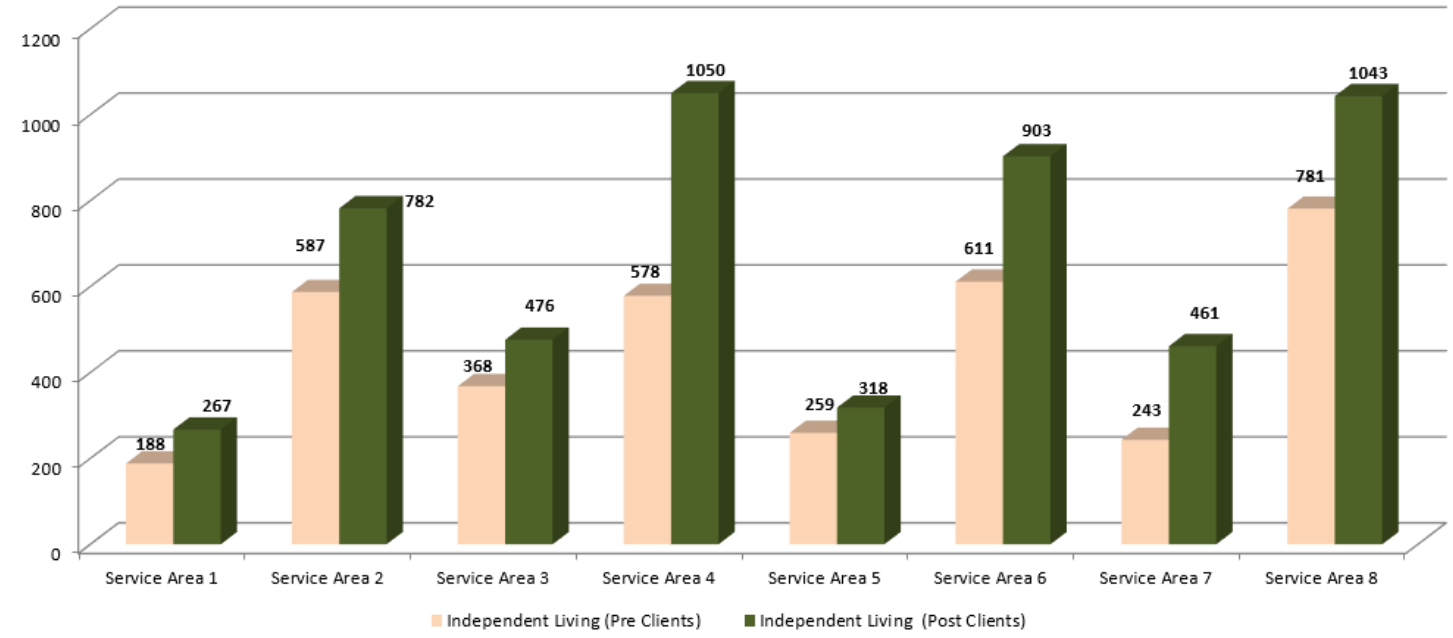


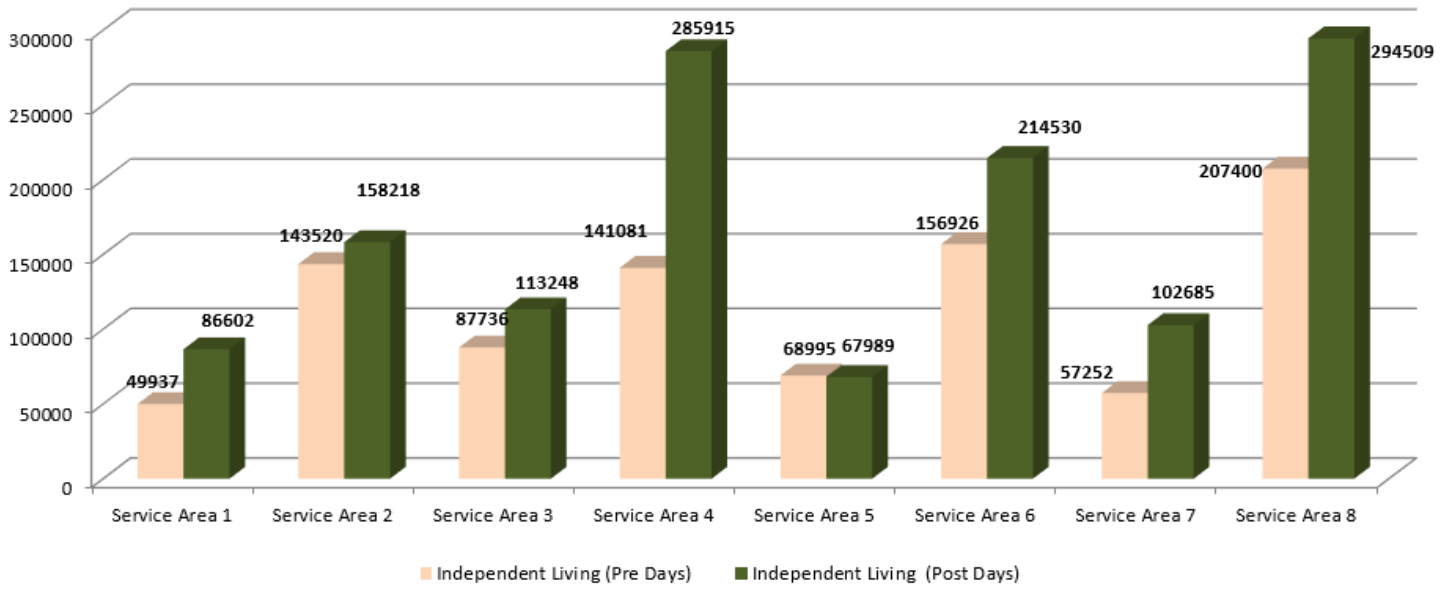


RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT INDEPENDENT LIVING

- All Service Areas report an increase in clients and days living independently post-partnership
- Service Area 4 has the highest number of clients living independently post partnership, 1,050, and Service Area 7 has the most percent increase in clients living independently, 90%
- Service Area 4 has the most percent increase in days living independently, 125%

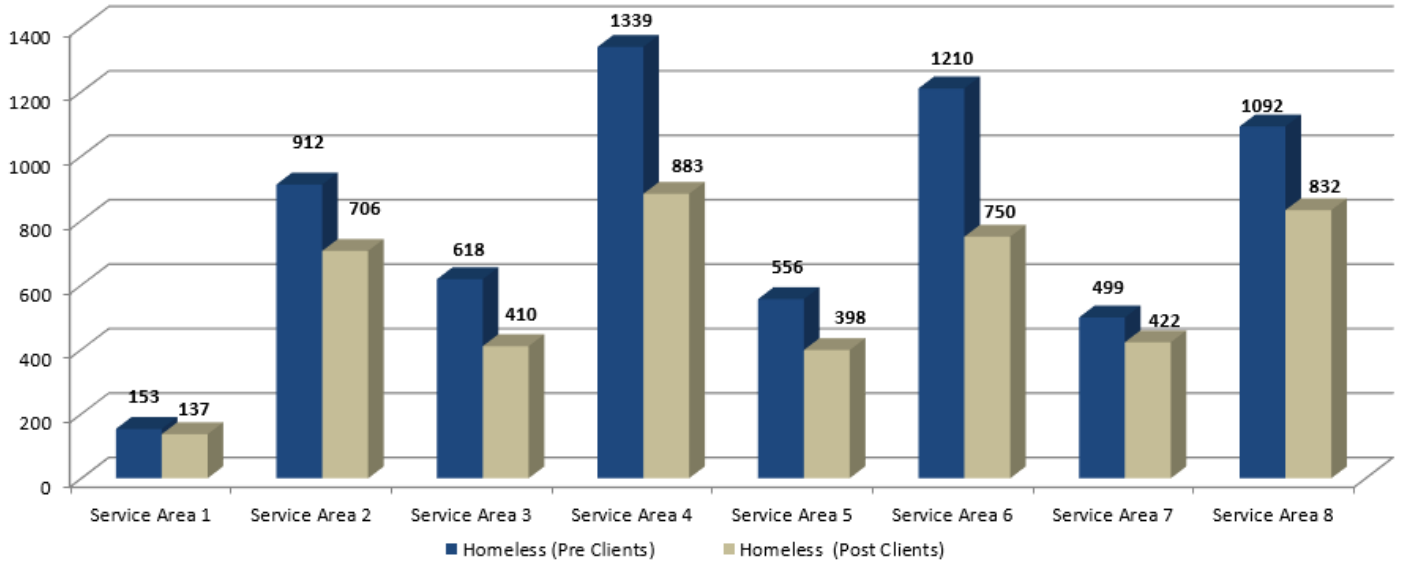


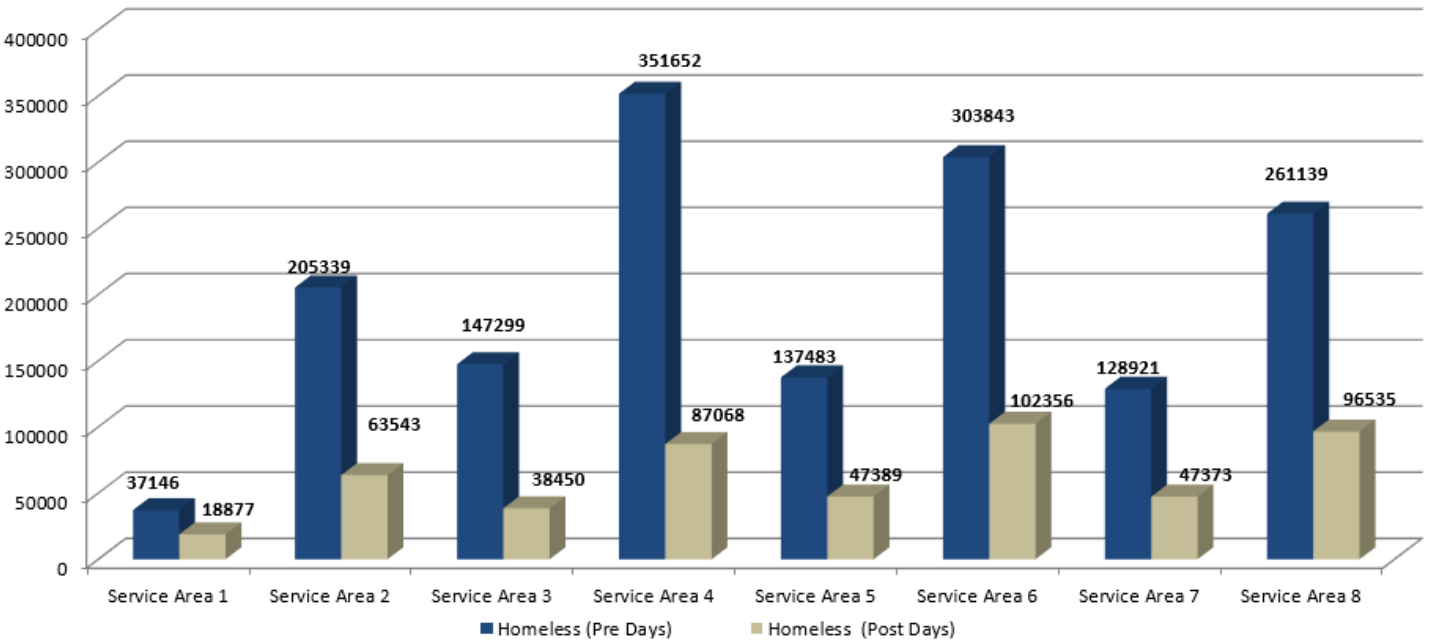


RESIDENTIAL OUTCOMES BY SERVICE AREA

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 (75%) reduction in days homeless post-partnership

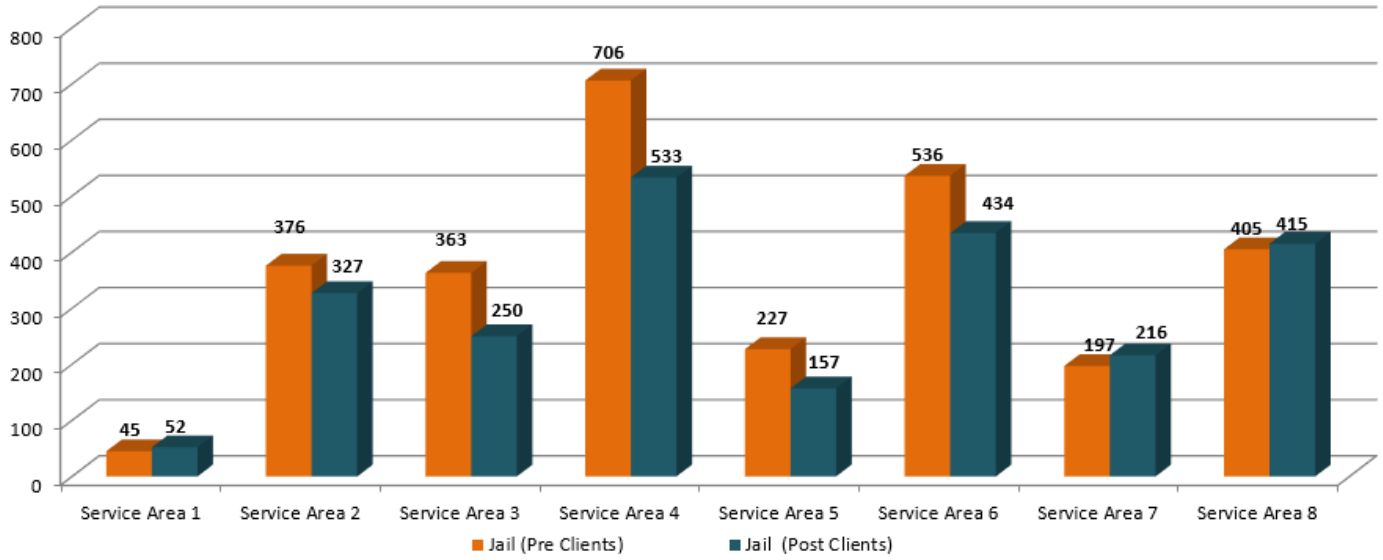


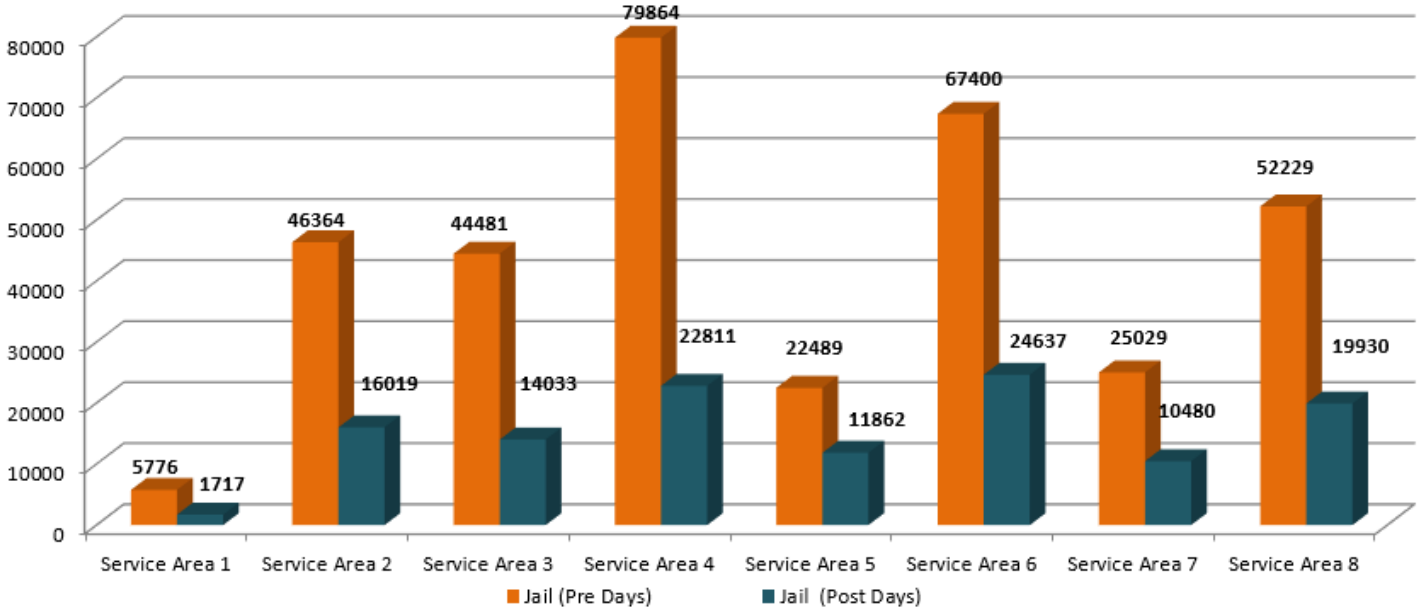


RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT JAIL

- ◊ All Service Areas report a reduction of days spent in jail post-partnership
- ◊ Service Areas 3 and 5 have the highest percent (31%) reduction of clients in jail post-partnership
- ◊ Service Area 4 has the highest percent (71%) reduction of days spent in jail post-partnership

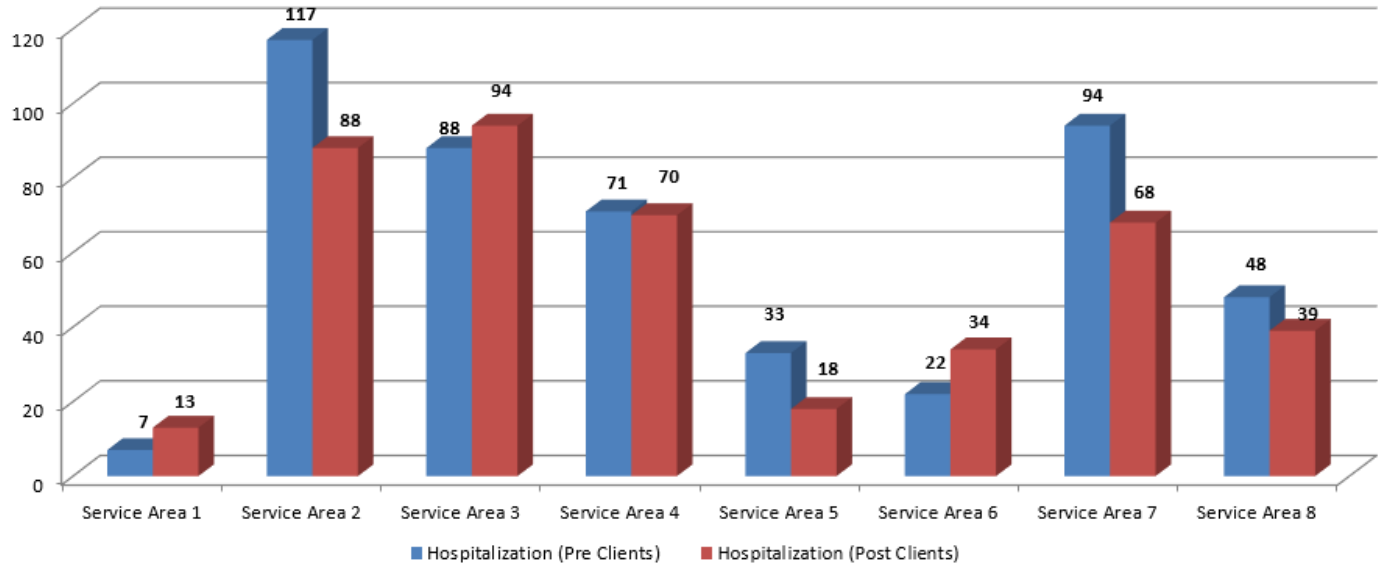


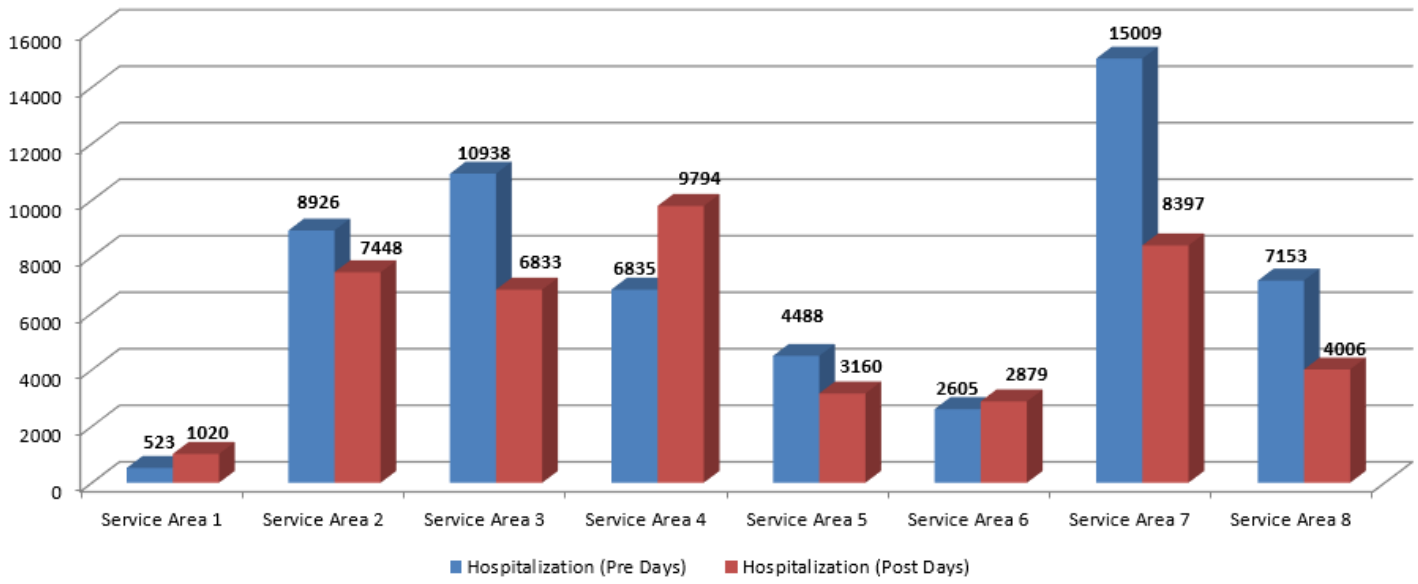


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT HOSPITALIZATION

- ◊ Service Area 5 has the highest percent (45%) reduction in clients hospitalized post-partnership
- ◊ Service Areas 7 and 8 have the highest percent reduction (44%) in hospital days post-partnership

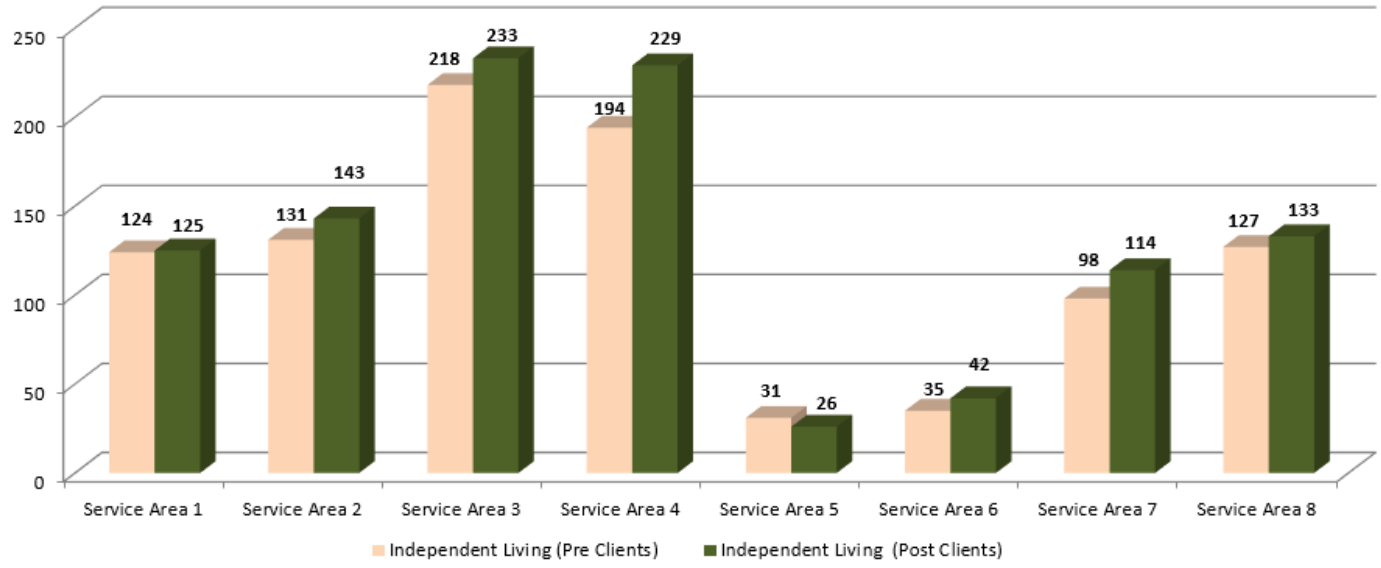


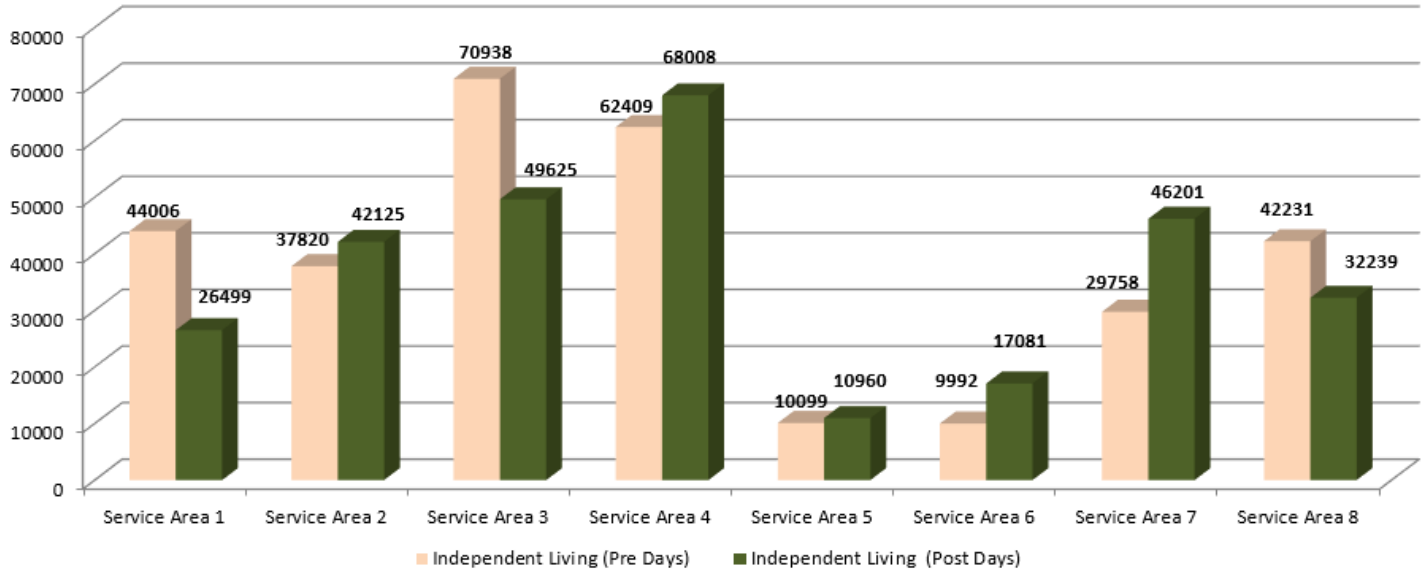


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT INDEPENDENT LIVING

- Service Area 3 has the highest number of clients living independently post partnership, 233
- Service Area 6 has the most percent increase in days (71%)and clients (20%) living independently

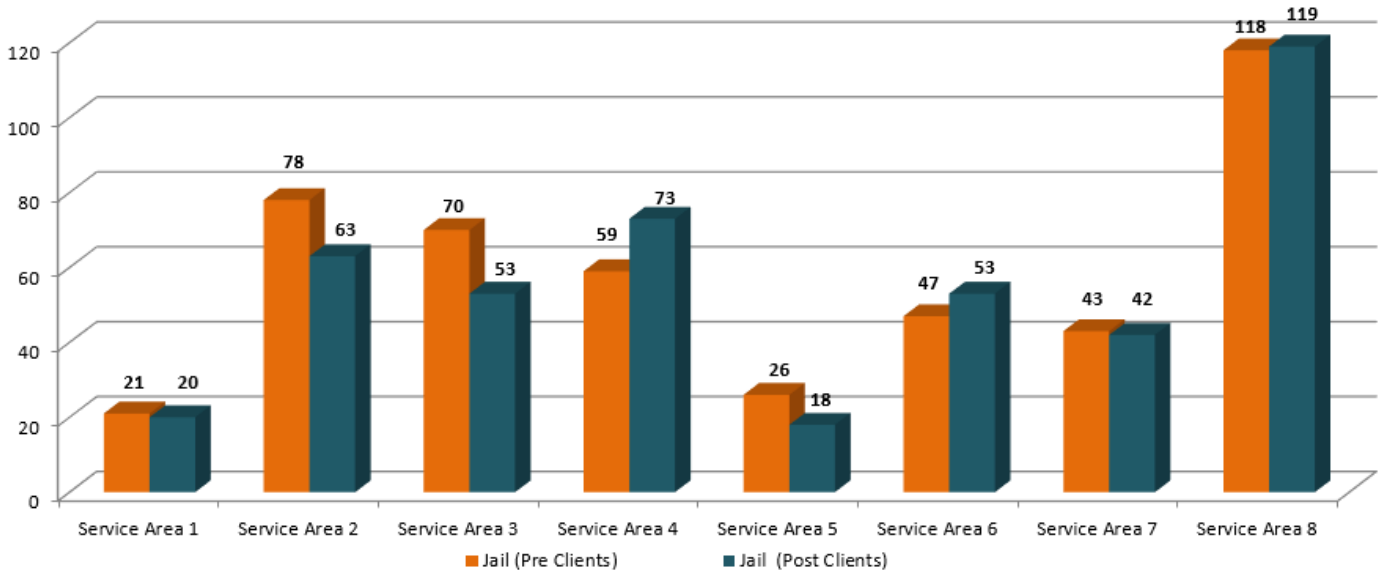


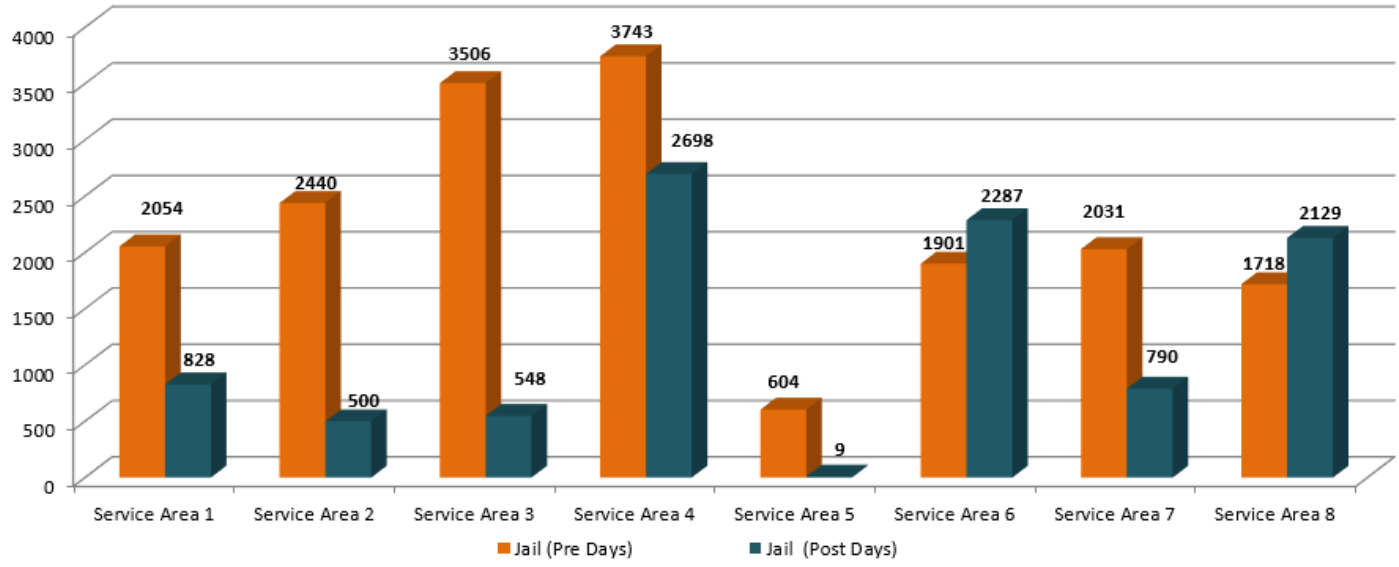


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT JAIL

◊ Service Area 5 has the highest percent (80%) reduction of clients in jail and highest percent (98%) reduction of days spent in jail post-partnership

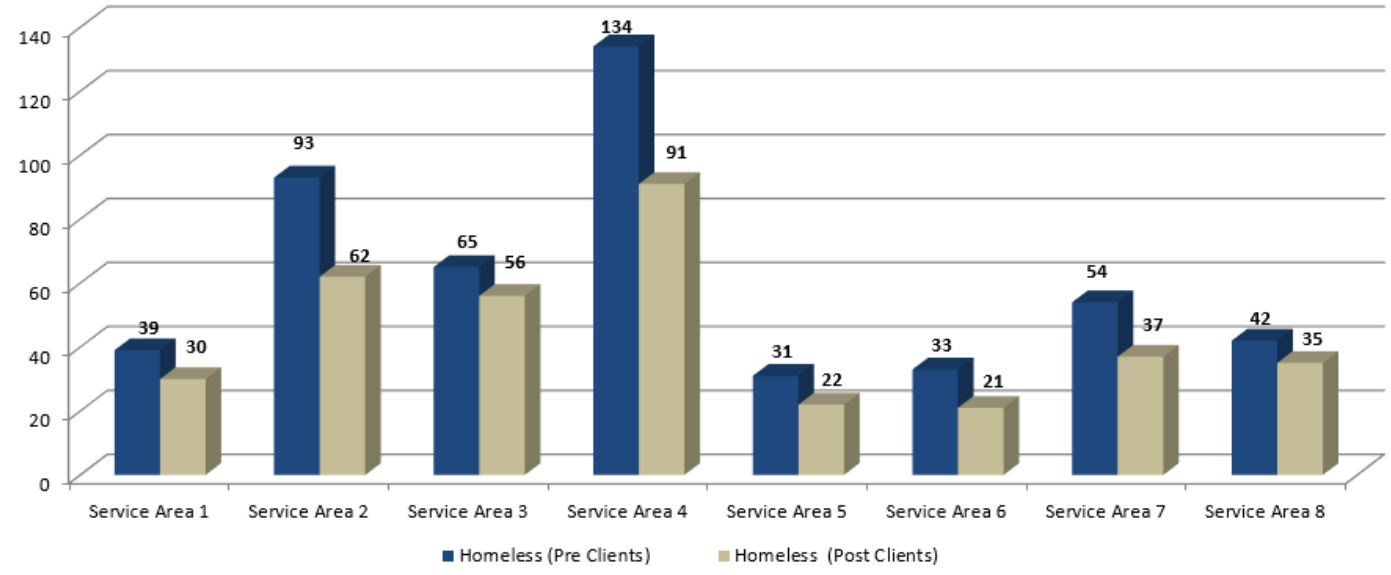


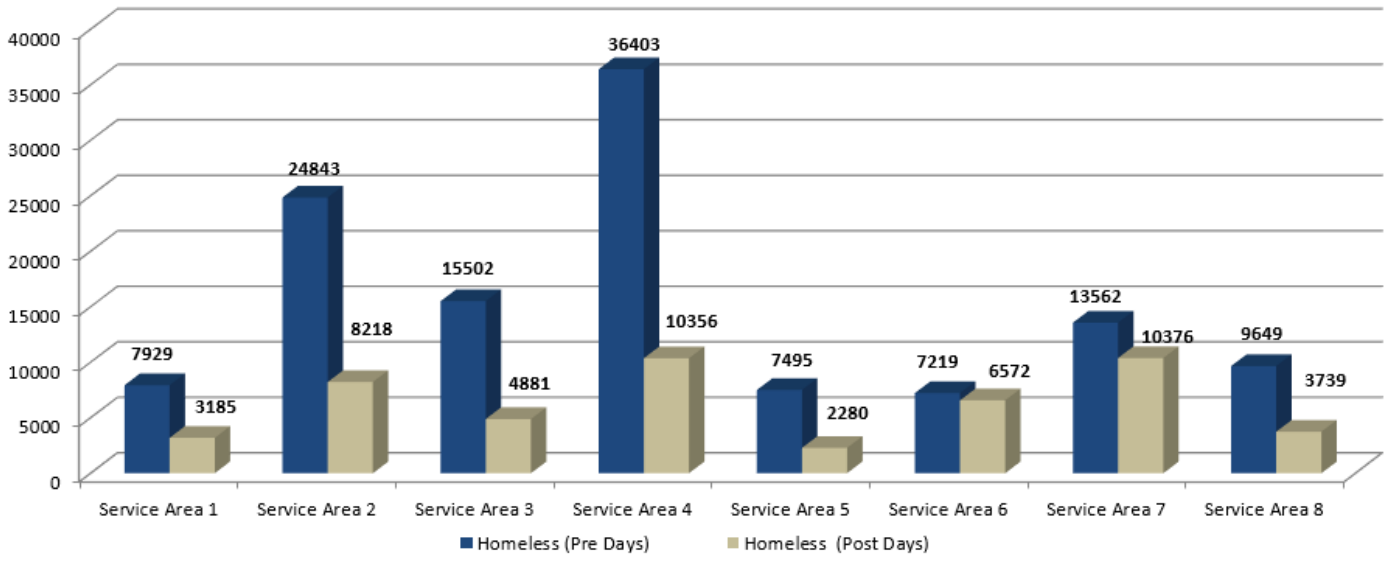


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT HOMELESS

- ◊ Service Area 6 has the highest percent (36%) reduction in clients homeless post-partnership
- ◊ Service Area 4 has the highest percent (72%) reduction in days homeless post-partnership and has the most days spent homeless pre-partnership (36,403)
- ◊ Service Area 4 has the most clients homeless pre-partnership (134) and post-partnership (91) with a 32% percent reduction





RECOVERY, RESILIENCE AND REINTEGRATION

UNIQUE CLIENTS SERVED

Children - 23,538
TAY - 15,195
Adult - 54,701
Older Adult - 13,236

AVERAGE COST PER CLIENT

Children - $5,740
TAY - $3,885
Adult - $2,879
Older Adult - $3,222

TARGET POPULATION

Infants, Children and Adolescents ages 0-18, who have a Serious Emotional Disturbance or Young Adults, Adults and Older Adults ages 18 and up, who have a Serious Mental Illness.

RRR provides a continuum of care so that clients can receive the care they need, when they need it and in the most appropriate setting to meet their needs.

RRR services are designed to meet the mental health needs of individuals in different stages of recovery. There are three Core Service Components including Community-Based Services, Clinic-Based Services and Wellbeing Services. Each program will provide each client with a combination of one or more of the core components to meet the client's individual needs. Within this continuum are Focused Service Models for specific populations, that were originally piloted through the MHSA Innovations work plan and includes the Peer Run Centers (PRC), Peer Run Respite Care Homes (PRRCH), Integrated Service Management (ISM) model and Integrated Clinic Model (ICM). Focused Service Models address the unique needs of their target population through more prescribed service approaches.

RRR services meet the needs of all age ranges from child to transitional age youth (TAY) to adults and older adults. While there may be some minor differences in the specific services provided to each population, there is more commonality across age groups than differences. All age groups will have access to assessments, traditional mental health services, crisis intervention, case management and medication support. The intensity, location (community/field or office/clinic) and duration of the service(s) will depend on the individualized need of each client and will likely change over time. While most clients will hopefully move from more intensive to less intensive services, some clients may need more intensive services for periods of time due to a variety of factors, which include, but are not limited to, the emergence or exacerbation of a severe mental illness, non-adherence to treatment recommendations, a substance use disorder, exposure to trauma or violence or external psychosocial stressors, such as housing, employment, relationship or legal problems.

Core Service Components

Focused Service Models

1. Peer Run Centers
2. Peer Respite Care Homes
3. Integrated Service Management Model
4. Integrated Clinic Model

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.

Achievements and Highlights fro Fiscal Year 2017-18:

- 393 guest were served with an average length of stay of 10 days.
- 133 of these guest where homeless. (The thought of the PRRCH staff is that even those guest who disclose the housing status as homeless can benefit from respite, and with proper support could serve to assist the guest in managing their symptoms before they escalate and there was a need for hospitalization.
- Of the 133 only 63 remained homeless. This is due to some guests not disclosing their true housing nature until the day of departure, leaving the staff with no time to assist in linking to serves in the community. All guests are given resources when the depart.)
- 78% of guest reported making progress towards a personal goal and working towards it during their stay.
- 78% reported having family or friend involvement in their mental health treatment; 18% when things were serious, 18% when things started to go badly, 45% much of the time, with 16% reporting that family involvement helped.
- 88% of guests are involved in consumer run services, peer support groups, Alcoholics Anonymous; drop in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs.
- 49% of guest spend at least 3-6 hours per week in a meaningful role in their community (ex., working, volunteering, school, etc…); 13% spend at least 16-30 hour per week.

Even though the PRRCH is not to be used as shelter and the staff work diligently to with the guests who disclose they are homeless upon arrival to the PRRCH and connect them to housing services.)

TAY PROBATION CAMPS (T-04)

PROBATION CAMPS:

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

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

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.

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	1230 Pine Avenue Long Beach, CA 90813

INTEGRATED CARE PROGRAM

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

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

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

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). 11-28-2018 and 1-28-2018
Medical Legal Pre-Elective	The purpose of this training is to educate participants on cognitive screening test, elements of decision-making capacity and legal report in the context of geriatric patients who requires evaluation for conservatorship, testamentary capacity, undue influence, and other relevant issues that involve the overlap between geriatrics and the law 11-2-2017.
Social Emotional Arts Part 2: Movement and Writing.	This 2-day curriculum also offers general guidelines on the use of each art form in therapeutic contexts, communication techniques for creating rapport and preventing resistance, and containment strategies for managing stress responses. Day 2 will focus on movement and writing. 3-29-2018.

Training	Description
Supervising Peer Providers in the Behavioral Health Workforce	The purpose of this training is to provide essential information and resources to supervisors overseeing peer providers 11-30-2017.
17th 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. 12-14-2017
The Use of Cognitive Screening Measures: The Montreal Cognitive Assessment	The purpose of this training is to provide an overview of The Montreal Cognitive Assessment (MoCA) a cognitive screening tool. 12-21-2016
Milestones of Recovery Scale and Determinants of Care:	The goal of this training is to provide participants with a comprehensive understanding of the Milestones of Recovery Scale (MORS) and the Determinants of Care. 11-14-2017, 11-16-2017, 6-6-2018.
The Use of Cognitive Screening Measures: The Montreal Cognitive Assessment.	The purpose of this training is to provide an overview of The Montreal Cognitive Assessment (MoCA) a cognitive screening tool. 12-7-2017.
Medical/Legal Aspects of Older Adults: Capacity, Undue Influence and Abuse:	This 2 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. 1-4 & 1-8, 2018.
Introduction to Motivational Interviewing	This training will highlight Motivational Interviewing (MI) to promote change in individuals. This training will provide participants advanced understanding of MI and techniques for promoting behavioral change 2-28-2018.
Hoarding Disorder 102: Practical Intervention for your Consumers.	The training will address Hoarding Disorder diagnosis and provide mental health clinicians with strategies for assessment and intervention for willing consumers and harm reduction techniques for resistant consumers 3-8-2018.
Social Emotional Arts Part 1: Music and Art.	In this practical 2-day training program, participants will experience activities in art, movement, Day 1 will focus on music and art; Day 2 will focus on movement and writing music, and writing developed by UCLArts & Healing and its team of creative arts therapists 3-22-2018.
Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Older Adult Clients	This training provides a brief overview of the prevalence of substance use in older adults, criteria for risky use, and the effects of substance use on mental health 3-14-2018.
Older Adult Sexual Assault	The training will discuss the following topics: prevalence of sexual assault in the US, including factors that contribute to older adults heightened risk of sexual assault; victim impact, including common presentations; the influence of rape culture and intersectionality on issues of sexual violence; how to support a survivor; RTC services and how to refer to RTC 3-12-2018.
Hoarding Disorder 101: Introduction to Symptoms, Assessment and Treatment	The training will focus on diagnostic assessment including history, research, etiologies, and age of onset, prevalence, demographics, comorbidities, risk factors, hazards, treatments, and consequences of this disorder 2-28-2018.

ALTERNATIVE CRISIS SERVICES

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.

The following is a status on the development of five Urgent Care Centers. The UCCs will be located in the following areas:

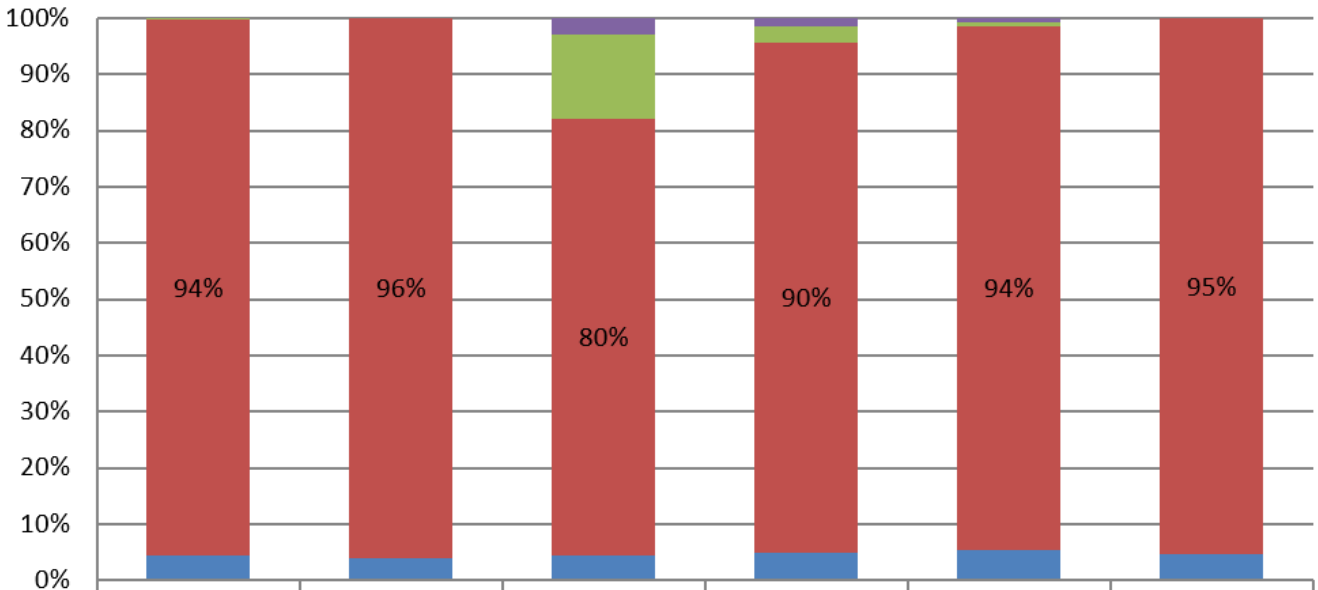
- Antelope Valley: Stars Behavioral Health Group (Stars) has been awarded a service contract to operate a UCC in the Antelope Valley. DMH and Stars are currently working collaboratively with the Supervisorial District to find an appropriate site to house the UCC.
- San Gabriel UCC: Stars was awarded 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 April of 2019.
- Long Beach UCC: Stars Long Beach Urgent Care Center. The UCC became operational on July 31, 2018.
- Long Beach UCC: Providence Little Company of Mary was awarded a service contract to operate a UCC in Long Beach. This UCC became operational in June 2018.
- Harbor-UCLA Medical Center UCC: Exodus Recovery, Inc. has developed a 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 became operational June 12, 2018.

ALTERNATIVE CRISIS SERVICES

The following is a status on the development of 21 new Crisis Residential Treatment Programs (CRTP) that will increase capacity by 336 beds Countywide:

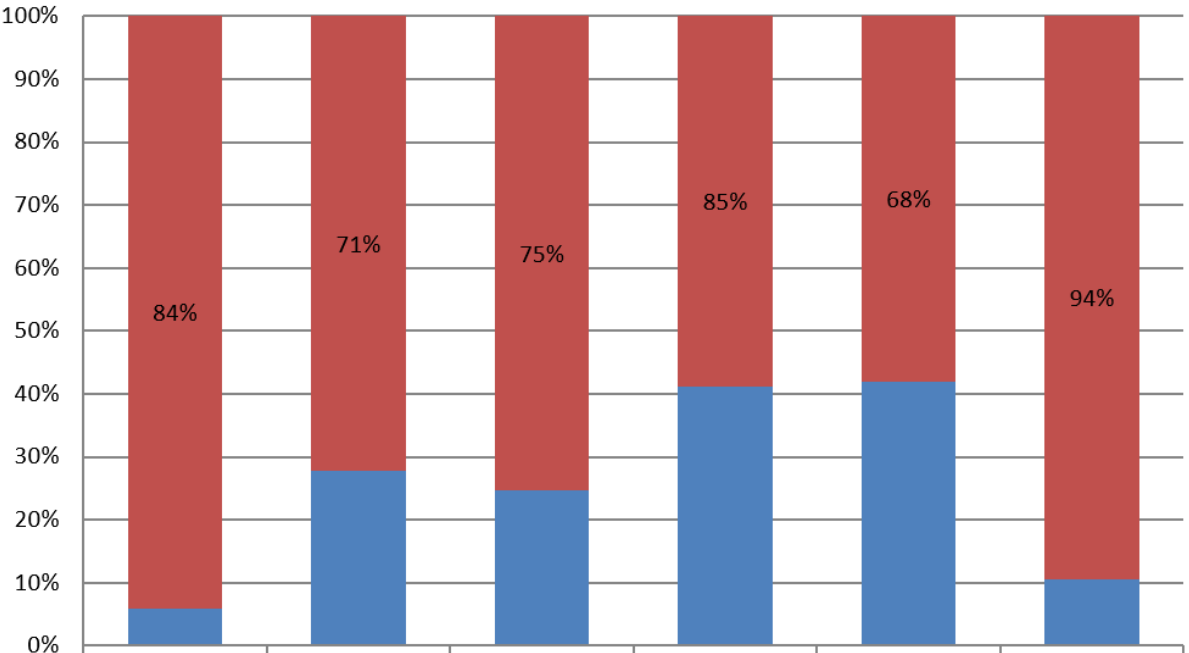
- DMH has implemented two (2) CRTPs. Exodus opened on December 20, 2017 and operates in Service Area 5. They have a total of twelve (12) beds. Gateways became operational on April 12, 2018. Currently, they have a total of sixteen (16) beds. Individuals are referred from hospitals, UCCs, and community programs.
- DMH has opened a CRTP this FY in Santa Monica and will be implementing 3 additional CRTPs in the San Fernando Valley, south central Los Angeles and east Los Angeles. In addition, DMH intends to develop fifteen (15) unique CRTPs for a total of 240 beds on the grounds of four 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 in the near future. 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



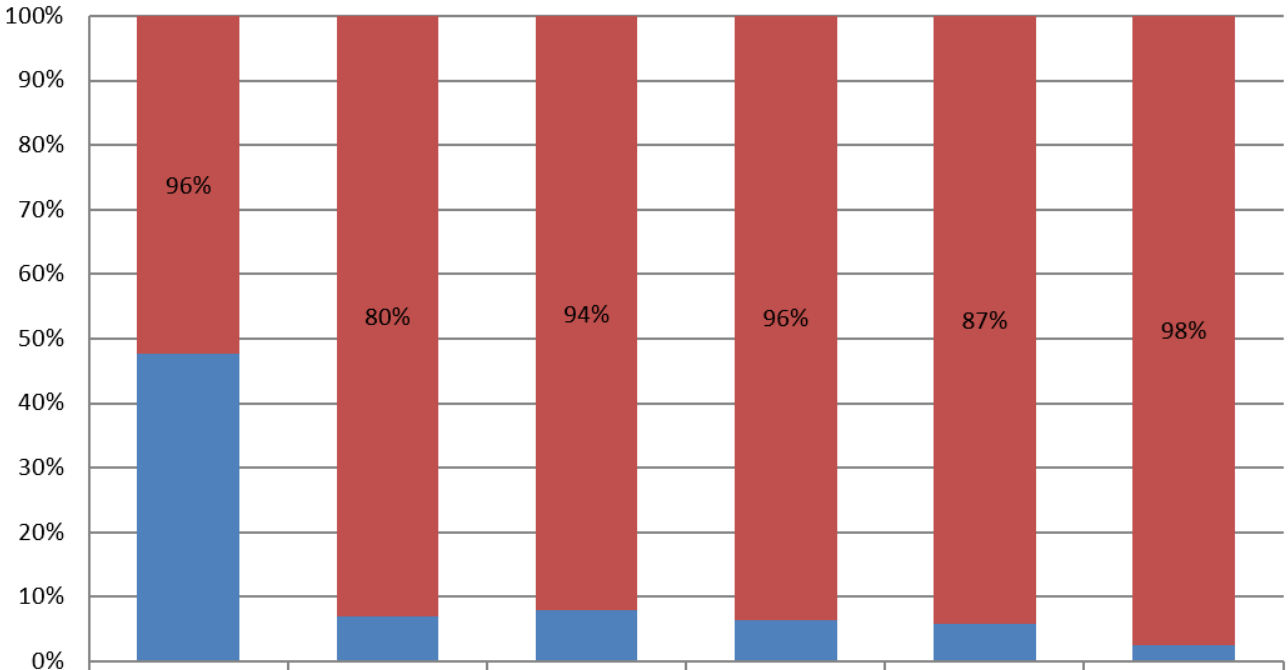
	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
Child	2	0	371	203	32	0
TAY	16	0	1863	445	35	0
Adult	4862	1479	9786	13629	4584	2173
Older Adult	224	61	541	739	269	109

NEW ADMISSIONS AT UCCS WHO WERE HOMELESS UPON ADMISSION



	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
No	4802	1125	9447	8839	2853	2042
Yes	302	432	3087	6177	2067	240

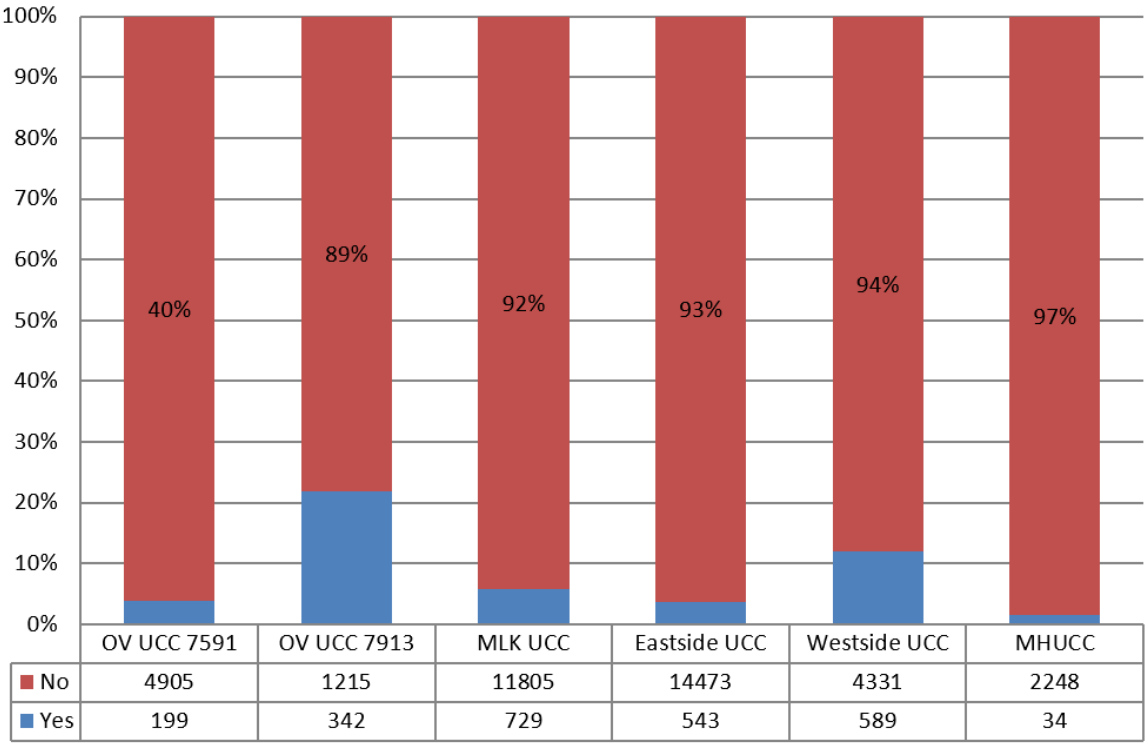
PERCENT OF THOSE WITH AN ASSESSMENT AT A PSYCHIATRIC EMERGENCY ROOM WITHIN 30 DAYS OF A UCC ASSESSMENT



	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
No	2667	1449	11542	14058	4634	2225
Yes	2437	108	992	958	286	57

ALTERNATIVE CRISIS SERVICES

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	4905	1215	11805	14473	4331	2248
Yes	199	342	729	543	589	34

ENRICHED RESIDENTIAL SERVICES

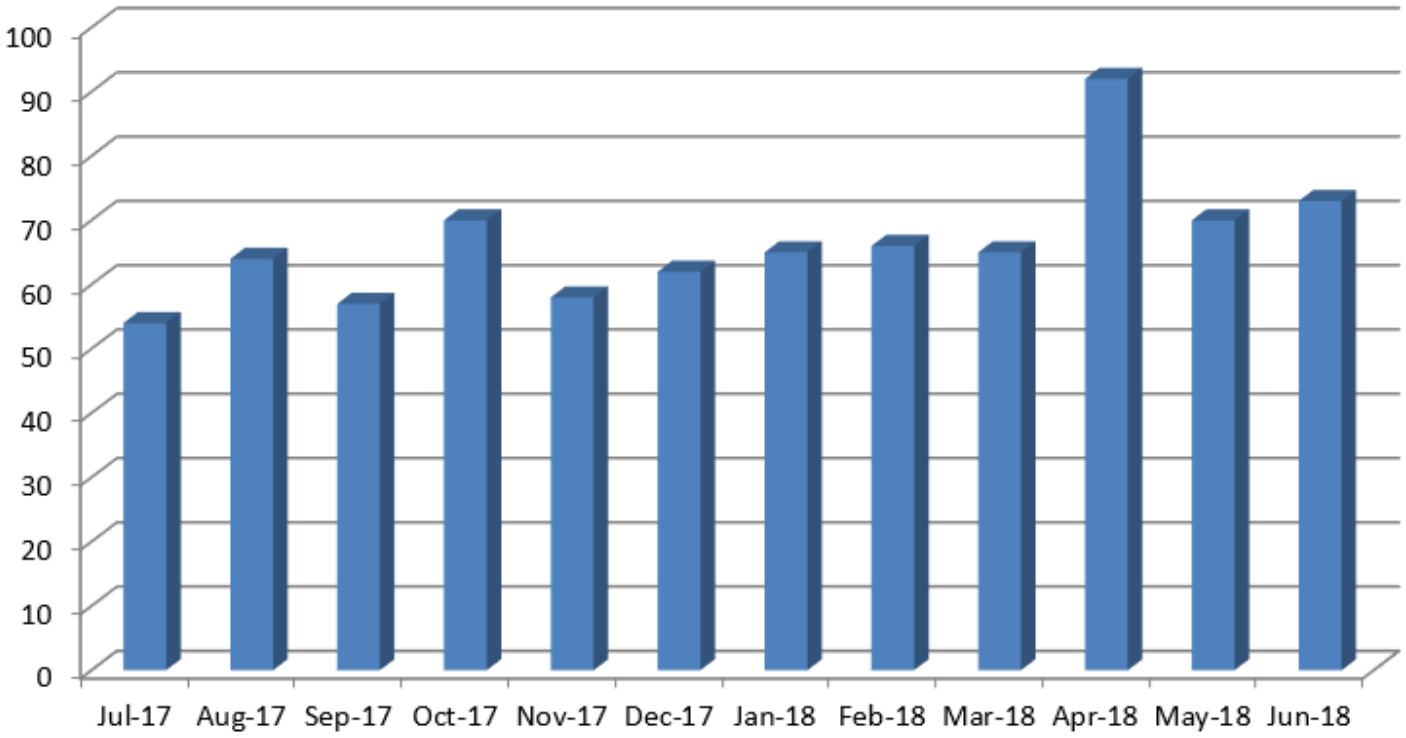
Enriched Residential Services are designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities (ARF), and in some instances, assisted living, congregate housing or other independent living situations. The program also assists clients transitioning from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

ENRICHED RESIDENTIAL SERVICES ADMISSION SOURCES FY 2017-18

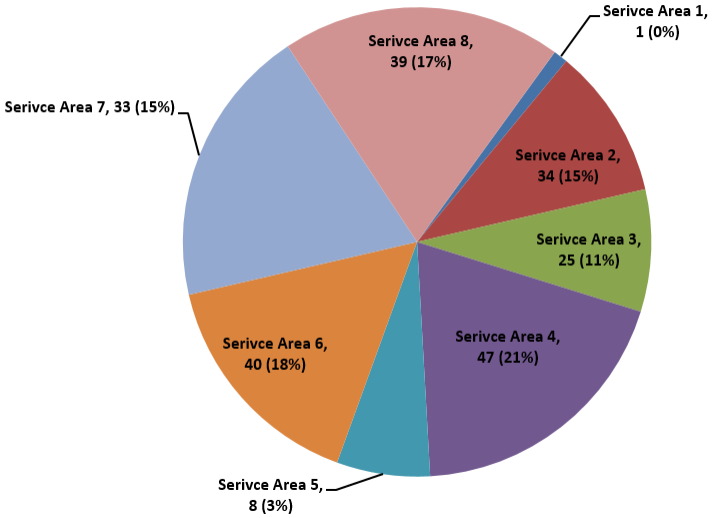
Source	# of Clients	%
State Hospital	9	1%
IMDs	222	22%
County Hospitals	106	13%
Fee for Service Hospitals	223	26%
Psychiatric Health Facilities/Skilled Nursing Facilities	11	1%
DMH Jail/Outpatient Programs	138	16%
Urgent Care Centers	20	2%
Mental Health Outpatient Providers	6	1%
Lateral Transfers/Rollover/Re-admits	80	10%
Emergency Outreach Bureau	16	2%
Crisis Residential Treatment Program	20	2%
Total	**851**	**100%**

ALTERNATIVE CRISIS SERVICES

ENRICHED RESIDENTIAL SERVICES DISCHARGES FY 2017-18



FSP REFERRALS FROM ENRICHED RESIDENTIAL SERVICES BY SERVICE AREA, FY 2017-18 N=202



⇒ Service Area 6 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.

ALTERNATIVE CRISIS SERVICES

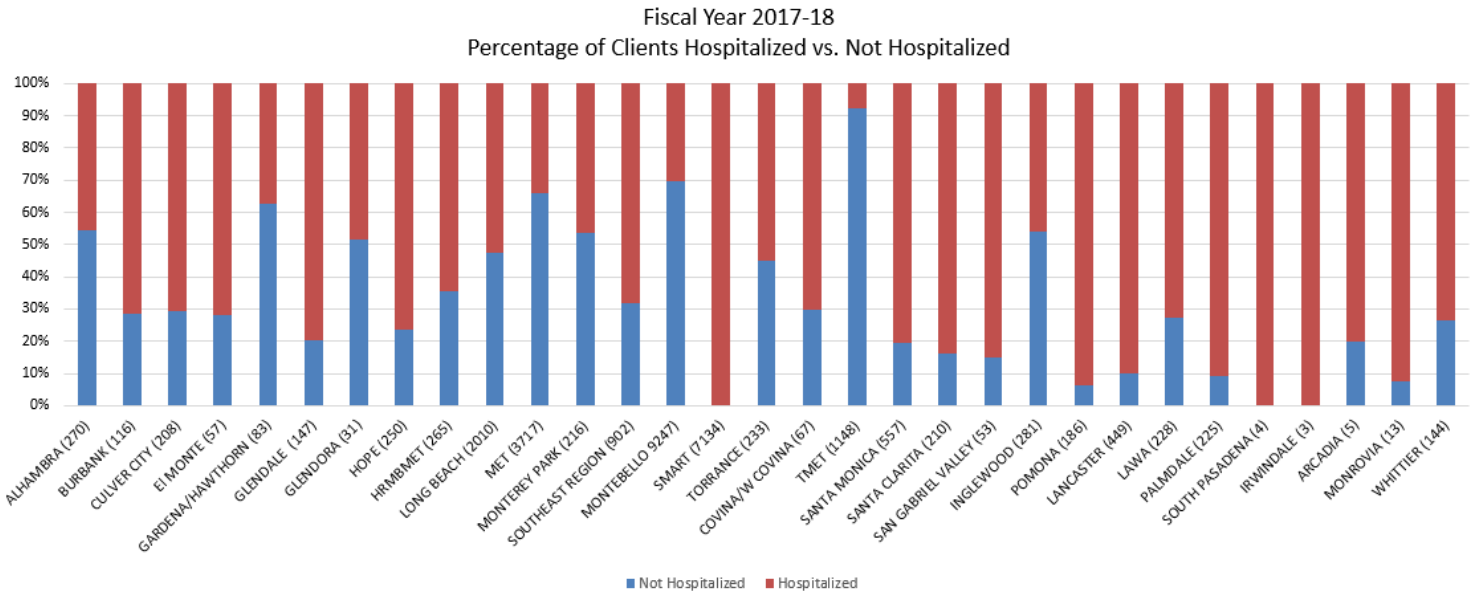
LAW ENFORCEMENT TEAMS (LET) FISCAL YEAR 2017-18

The Countywide police and mental health co-responder teams consist of DMH staff working collaboratively with local police departments in Los Angeles County. The primary mission of LET is to assist patrol officers when responding to 911 calls involving persons with a mental illness. These crisis intervention services are aimed to reduce incarcerations, mitigate police use of force, and allow patrol officers to return quickly to patrol duties.

TOTAL NUMBER OF CALLS: 19,728

OF CLIENTS HOSPITALIZED: 13,404
OF ARRESTS: 347
OF CLIENTS HOMELESS: 9,708

The number of calls increased from FY 2016-17, 14,115 to FY 2017-18, 19,728 by 40%



SMART continues to take the lead in linkage to psychiatric hospitals (7128) , followed by MET (1270), Long Beach MET (1059), Southeast Region (616), Santa Monica (448), Lancaster (404), and remaining providers ranged from 3 to 191

HOUSING SERVICES

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.

As of June 30, 2018, Los Angeles County Department of Mental Health has 36 MHSA funded developments that are occupied with a total of 812 units. During FY 2017-2018, the Department also invested an additional $63,480,000 for 21 additional MHSA developments totaling 366 units. The housing developments target various age groups (TAY, Adults, Older Olders and Families).

UNITS OPENED DURING FY 2017-18

Sponsor Name	Development Name	Development Address	Location		Target Population	# of MHSA	Certificate of Occupancy
Century Villages at Cabrillo	Anchor Place	2001 River Street, Long Beach, 90810	Service Area: 8	Supervisorial District: 4	Single Adults 18+, Families	18	9/28/2017

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.

SERVICE AREA OUTREACH & ENGAGEMENT HIGHLIGHTS

Outreach and Activities As Reported by the Service Areas

SERVICE AREA 1
ANTELOPE VALLEY

Attended multiple joined and planned activities with over 4,000 attendees. The population consisted of African American, Latino, White, Families, Children, Consumers and individuals with various disabilities.

1. **The Desperately Seeking Attachment: Understanding How Trauma & Neglect Disrupt Attachment** - Participants were provided with an overview of identifying attachment theory, understanding types of attachment patterns and how a crisis in the attachment relationship is an opportunity for change and healing. Skills and tools to effectively engage the child who has experienced trauma. As a result of this training, parents and professionals should have an increased understanding with attachment-based interventions and how attachment therapy empowers the family system to become the healing mechanism for the child. Participating agencies and attendees were Parents, DCFS, Penny Lane Centers, Children's Bureau, LAC DMH, Antelope Valley Partners for Health, Grace Resources and Equip Day Care.
2. **Suicide Prevention Campaign** School-based Mental Health providers put together a campaign focused on suicide prevention in May of 2018. Over 1000 flyers were distributed throughout the community at large The goal was to provide information to the public regarding resources related to suicide prevention. Five billboards were also placed around the Antelope Valley.
3. **H.O.P.E. (Homeless, Outreach, Partnership, Event)** The 3rd annual H.O.P.E (Homeless Outreach Partnership Event) consisted of various services provided to the homeless population such as vaccinations, dental examinations, vision screenings, application for reduced bus fees, identification cards, information and advocacy about how to navigate the social security system, assistance with medi-cal enrollment, haircuts and tangible items such as clothing, food, hygiene kits, and blankets. The following service providers participated and provided resources at the event, Mental Health America, Bartz-Altadonna, Antelope Valley Community Clinic, Lancaster School District-Welcome Center, Operation Blankets of Love, Department of Motor Vehicles, San Joaquin College, Various Faith-Based organizations/ministries, Social Security, Department of Health Services, Department of Public Social Services, Department of Public Health.
4. **Implicit Bias Forum** the Antelope Valley Health Neighborhood held its first Implicit Bias Forum. The training included a module on implicit bias as well as cultural competency. This training introduced resources and an individualized development plan to help learners mitigate implicit biases and improve cultural competence. The forum was attended by 85 individuals representing 25 agencies and programs as well as community members from all over the Antelope Valley.

SERVICE AREA 2
SAN FERNANDO VALLEY

Attended multiple joined and planned activities with 7,956 attendees. The population consisted of Latino, African American, Armenian, and White, Asian Pacific Islanders, Russian, Arabic, Iranian and etc.

1. **1st Annual Armenian Genocide Event** focused on Transgenerational Effects on Trauma and Healing. Engaging with the Armenian community, collaborating with professionals from the Glendale Police Department, Glendale Public Library, Glendale Unified School District, Private Armenian Schools, Armenian Clergy and Faith organizations, agencies that provide mental health services to the Armenian population to start conversations about the effects of trauma and how to heal.

SERVICE AREA 2
SAN FERNANDO VALLEY

continued

2. **1st NAMI Armenian Support Group** started in May 2018. The Support Group is held at Didi Hirsch in Glendale on a monthly basis
3. **Clergy Breakfasts/Roundtable/Faith Based Advocacy Council Meetings** Outreach and Engagement teams engaging with health professionals and clergy and faith organizations. Clergy leaders and mental health professionals meet to provide information, updates on their organizations and collaborate with each other to help mutual consumers and congregants.
4. **May is Mental Health "Reaching Out" Private Screening Event** The team assisted outreach, engagement, coordination and promotion of the event
5. The team helped, organized and attended an array of Community Resource Fairs:
    - NAMI Pathway Annual Recovery Fair
    - School/Head Start Resource Fairs
    - Annual Government Day Event
    - LGBTQI
    - Homeless Connect Day Event
    - Summer Fest Health Fair/Child 306
    - EXP Earth Day
    - DCFS Resource Fair

The team also delivered educational presentations in Spanish and English to unserved and underserved ethnic populations, parents, foster parents, and caregivers of children who are at risk of experiencing depression and anxiety.

SERVICE AREA 3
SAN GABRIEL VALLEY

Attended multiple joined and planned activities with over 2,000 attendees. The population consisted of Latino, Asian, Pacific Islanders, Veterans and the community at large.

1. **Peer Support Subcommittee** which serves a planning group for the larger body (SAAC 3). The recruitment of consumers required extensive community grassroots outreach to local mental health clinics and consumer groups.
2. **May is Mental Awareness Poster Campaign** an all consumer band named the River Band provided the entertainment and volunteers served the food and refreshments. T-shirts and posters were designed by the peers and were disseminated into the local neighborhoods in the San Gabriel Valley.
3. Participated in multiple events in the community by providing resource booths with information on Mental Health at:

    - Los Angeles County Veterans and Resource Expo 2017
    - Parks After Dark
    - East San Gabriel Valley Mental Health Clinic Open House
    - Supervisor Hilda L. Solis 1st Anniversary East San Gabriel Valley District Office
    - Los Angeles County Fair
    - Salvation Army Homeless Connect Day
    - The 2nd Annual Disability and Aging Resource Fair
    - Miles Conference
    - Asian American Mental Health Conference
    - Mental Health Conference: Pornography Addiction
    - Adelante Young Men Conference 2017
    - La Fentre Center Annual Health and Information Fair
    - Mountain View High School Community Resource Fair/Open House
    - 17th Annual Conference on Mental Health & Spirituality
    - 21st Annual Tribute Veterans Military Families Resources Fair
    - Boys & Girls Clubs Wellness Fair

SERVICE AREA 4
METRO

Attended multiple joined and planned activities with 5,863 attendees. The population consisted of Latino, African American, Homeless Population, LGBTQ, and the community at large.

1. Mexican, Salvadorian and Guatemalan Consulates Service area 4 provides weekly information booths at each consulate disseminating mental health informational material
2. Interfaith Roundtable/Health Neighborhood/SAAC Meetings consist of local police presentations, Department of Mental professionals providing educational information on mental health, linkage and how to access services. Attendees are able to participate in case vignettes and discussion. These meeting bring a variety of individuals, consumers and the community at large together to collaborate and discuss Mental Health Programs, activities and future goals.
3. Participated in multiple events in the community by providing information on Mental Health at:
    - Various LAUSD Schools Parents/Family Resource Fairs
    - The Wellness 4th Anniversary
    - Pico-Union Resource Fair
    - Archdiocesan Catholic Center
    - Frank D. Lanterman Regional Center Resource Fair
    - USC School of Social Work Immigration Conference
    - Cal State LA 2nd Annual Mental Health & Behavioral Health Conference

SERVICE AREA 5
WEST

Attended multiple joined and planned activities with over 2,000 attendees. The population consisted of the community at large from underserved cultural communities.

1. The Winter Celebration the focus of this event was Self Help. A panel of speakers and representatives from Recovery International, Depression Bipolar Support Association, NAMI Peer Support, Support Groups in Spanish Project and Share. Discussed the importance of Self Help, how to celebrate and encourage opportunities that promote well-being, as well as sharing of success stories.
2. The Summer Celebration the focus was celebrating Health Neighborhoods. This event provided hands on activities to explore what neighborhoods can do to increase well-being within their neighborhood.
3. Participated in multiple events in the community by providing information on Mental Health at:
    - Quarterly Breakfast at churches in Service Area 5
    - City Libraries in Service Area 5
    - Community Resource Fairs
    - Garifuna International Indigenous Film Festival and Mental Health Awareness
    - Women Infant and Children Office (WIC)
    - Winter Shelter

SERVICE AREA 6
SOUTH

Attended multiple joined and planned activities with 5,904 attendees. The population consisted of Latino, African American, White, and the community at large.

1. **17th Annual Conference on Mental Health and Spirituality** the conference theme was "Connected You Are Not Alone"
2. **Dealing with Teen Depression Presentation** focused on a variety of subtopics such as signs and symptoms of depression in adolescent males and females.
3. **The Impact of Domestic Violence Exposure on Children Presentation** focused the emotional toll Domestic Violence has on children, the link between poor academic performance and the PTSD aspect.
4. **Nutrition and Mental Health Presentation** focused on the importance of ingesting a variety of foods that have a positive effect on one's emotional well-being.
5. **Mental Health and Spirituality Presentation** focused on raising awareness on conscious living, increasing inspiration, meaning and purpose to help decrease depression, anxiety, and stress.
6. **Anti-Bullying Presentation** focused on different types of bullying. The attendees were educated on topics such as cyber bullying and how they can help the person being bullied.
7. **Mental Health and Drugs Presentation** attendees were given description of what is considered a drug, how drugs can induce emotional instability and a discussion on physical and emotional changes .
8. Participated in multiple events in the community by providing resource booths with information on Mental Health at:
    - Parks After Dark
    - Victory Baptist Church Resource Fair
    - Compton Unity Festival
    - LAPD National Night Out
    - Family and Back to School Resource Fair
    - Transitional Age Youth Resource Fair
    - Back to School Night and Resource Fair
    - Job and Resource Fair
    - Hands Around Locke Resource Fair
    - FAME Church 2nd Chance Fair
    - Teen Young Parent Holiday Event Health and Resource Fair
    - Foster Young Resource Fair
    - Celebrating Fatherhood Father's Day Event
    - Each Mind Matters Wellness Fair

SERVICE AREA 7
EAST

Attended multiple joined and planned activities with 3,117 attendees. The population consisted of the community at large from underserved cultural communities.

1. **May is Mental Health 2nd annual health fair "Spring Fling"** co-led by Service Area 7, Child 306 and Best Five LA. Hundreds of participants enjoyed entertainment, food, information and education about health, mental health, substance abuse, free dental and vision screenings.
2. **We Rise Event** Service Area 7 provided both clinicians and case managers to man a resource table at the event, Rio Hondo Mental Health Clinic transported clients and volunteers to the event.
3. **American Indian Counseling Center Resource Fair** The event included traditional dance, singing, music, including drumming, and speeches by both clients and members of DMH. A free, hot lunch was served to all participants. There were booths with culturally appropriate arts and crafts activities, and Wellness themes such as Reiki massage, and the use of bells and sound to heal.
4. **Clergy Breakfasts** These meetings allow networking between our Mental health directly operated programs and Providers, with members of local churches, synagogues, temples and mosques, who are often the first to encounter community members experiencing mental health difficulties. Each meeting included a presenter on a mental health topic relevant to the clergy, such as: Spirituality and Psychotropic Medication, Understanding the Needs of Older Adults and the Benefits of Faith, Homelessness on our Doorstep: Mental Health and Harm Reduction; and Rituals in Healing: A Native American Perspective.
5. **Youth Mental Health First Aid training:** Provided by clinician Kelly Brignoni, offered to Rio Hondo College Kinder Care program and twice to the SA 7 Interfaith Coalition. Teaches parents, family members, teachers caregivers, health and human service workers how to help an adolescent who is experiencing mental health or addictions crisis.
6. **Case Management Symposium** Co-sponsored by PIH, SA 7 Health Action Lab and the Southeast Los Angeles Health Neighborhood, this was a four-hour symposium to build skills, create connections and strengthen the community. Panel discussion facilitated by Kelly Brignoni, included speakers from One Degree, 211, Enki, and Whittier First Day, with a keynote address by the Director of Social Work for Whittier College.
7. Participated in multiple events in the community by providing resource booths with information on Mental Health at:
    - Law Enforcement Resource Fair
    - Parks After Dark
    - Ribbon Cutting Ceremony for Supervisor Hilda Solis's Health Center
    - Annual Stepping In Conference with Law Enforcement
    - Annual Spirituality Conference
    - Annual Resource Fair at Rio Hondo Mental Health Clinic "Nuestra Salud"
    - Probation Department's resource fair
    - CORE Resource Fair
    - Senior Centers
    - Rio Hondo College Fair: Suicide Prevention booth with Power 106 FM Radio

SERVICE AREA 8
HARBOR

Attended multiple joined and planned activities with over 4,000 attendees. The population consisted of the community at large from underserved cultural communities.

1. The Long Beach Career, Community & Wellness Fair Expo 2018
2. The coalition was awarded the grant from Cal MHSA. The purpose of the community partnerships is to improve conditions physically, mentally, spirituality, and economically, in the North Long Beach Community. With support from Senator Kamala Harris Office, they recruited several employers, to offer career opportunities to those attending. There were 30 tables for vendors staffed with workers, a DJ and Photographer to document this event also providing information on Community resources including mental health topics, physical wellness topics, as well as government resources.
3. **Client Turkey Basket & Gift Cards for the Holidays event** SA 8 and community churches delivered gift cards, food boxes and wish list gifts to consumers.
4. **San Pedro Mental Health** hosted its annual May is Mental Health Awareness Month Community Health and Resource Fair There where volunteers from Women in Non-Traditional Employment Roles (WINTER), not including consumers, volunteers and staff. Service providers such as Providence Club conducted blood glucose and pressure screenings, Lions Club conducted hearing and vision testing independence Scan conducted carotid artery screenings for strokes assessments, DMV and DPSS and Cal Fresh process applicants.
5. **San Pedro Mental Health hosted a Primeros Auxillos Para Salud Mental (Mental Health First Aid training in Spanish)** Facilitating educational workshops promotes inclusion and reduces stigma associated to mental health in the community. Continuously disseminating information also assists clients to successfully reintegrate in to their community.
6. **San Pedro Mental Health hosted a Suicide Prevention Awareness Workshop Facilitating** educational workshops promoting inclusion and reduces stigma associated to mental health in the community. Continuously disseminating information to the community at large also assists clients to successfully reintegrate into their community.
7. Participated in multiple events in the community by providing resource booths with information on Mental Health at:
    - San Pedro Mental Health participated in the Wilmington Housing and Health Fair
    - Tri-Cities League of Woman Voters Mental Health Form
    - First Ladies Health Initiative

LINKAGE SERVICES

JAIL LINKAGE & TRANSITION AND SERVICE AREA NAVIGATION

JAIL LINKAGE & TRANSITION

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.

Report on Jail Linkage Program services conducted by MHSA-funded staff:

The table below shows clients served per quarter by self-reported race/ethnicity. The final column shows the annual number of unduplicated clients for Fiscal Year 2017-2018.

Ethnicity	Q1 July-Sept 2017	Q2 Oct-Dec 2017	Q3 Jan-Mar 2018	Q4 Apr-June 2018	Unduplicated Client Total FY 2017-2018
African American	96	50	62	84	254
Latino	81	78	46	72	223
Asian Pacific Islander	2	1	1	11	12
Native American/ American Indian	0	0	0	0	0
Caucasian	52	39	31	48	134
Middle Eastern/ Eastern European	2	0	0	0	2
Unknown	9	5	1	1	14
Total	**242**	**173**	**141**	**216**	**639**

Mental Health Outpatient Treatment - Linkage Outcomes

From the unduplicated client count of 639, we created a sample of clients with referrals to mental health outpatient services. Clients were excluded who declined linkage services, were released after July 1, 2018, were transferred to state prisons, state hospitals or other county jails, or were referred to inpatient treatment programs, residential bridging services, Enriched Residential Services (ERS), IMDs, IMD step downs, FSPs and residential SUD treatment programs.

We randomly selected 20% of the remaining individuals, resulting in a sample of 73 clients who received referrals to community mental health outpatient treatment. We searched the financial records section of IBHIS for documentation of billing from outpatient MH clinics in the period following clients' release from jail, to capture "showed up" or successful linkages where the client received treatment services.

In our sample of 73 individuals, 33 (43.4%) had documented visits after release at community MH outpatient providers, including both DMH-contracted agencies and DMH directly operated clinics throughout LA County. Among these 33 individuals, 21 (28.8% of the 73 sampled) received outpatient MH services within 2 months of release.

Outpatient Referral Sample	73
Post-release MH outpatient visit (per billing shown in IBHIS)	33 (43.4%)
MH outpatient visit within 2 months of release (per billing shown in IBHIS)	21 (28.8 %)

MENTAL HEALTH COURT PROGRAM

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

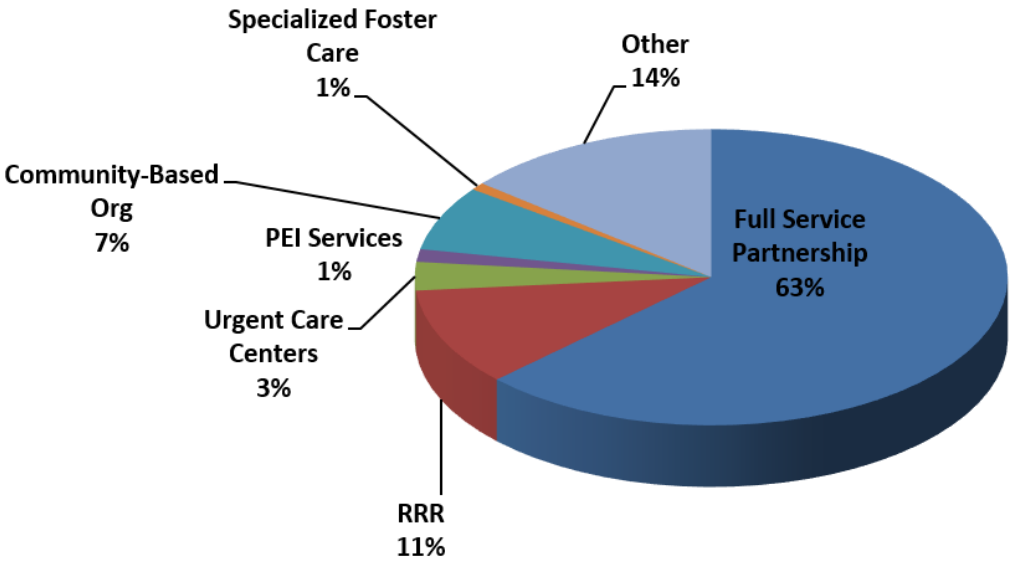
1) The Court Liaison Program is a problem-solving collaboration between the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County Superior Court. It is staffed by a team of mental health clinicians who are co-located at courts countywide. This recovery based program serves adults 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

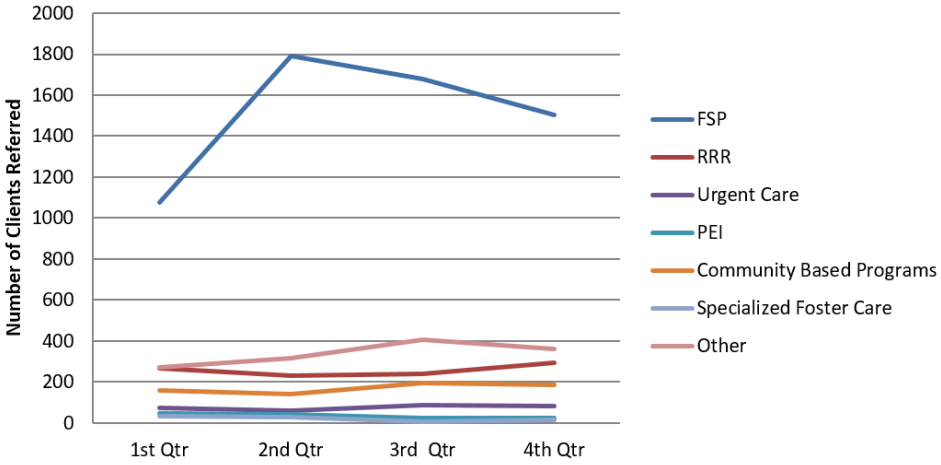
Service Area Navigator Teams assist individuals and families in accessing mental health and other supportive services and network with community-based organizations in order to strengthen the array of services available to clients of the mental health system. Such networking creates portals of entry 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 2017-18
N=12,273

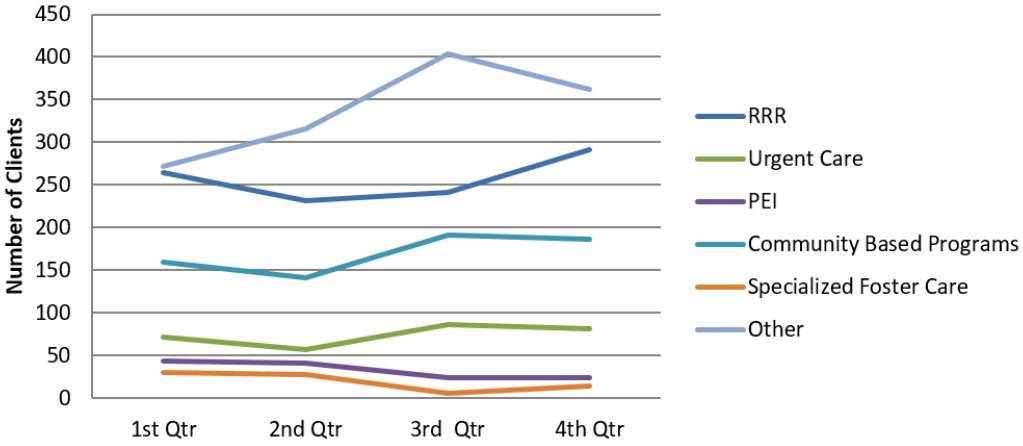


Clients Referred to Services in FY 17-18



Referrals to the Full Service Partnership program steadily decreased at the start of the 2nd quarter.

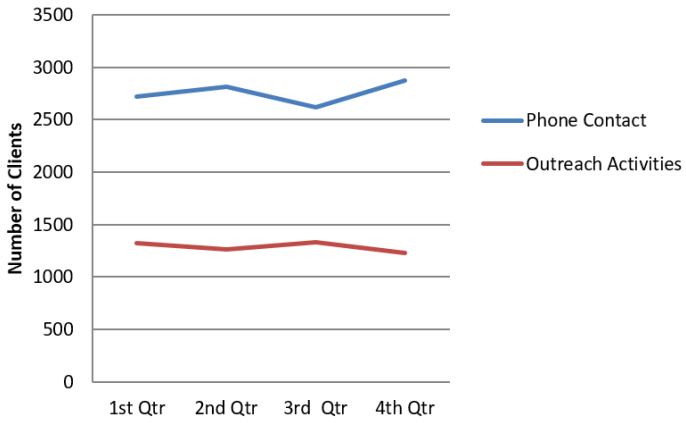
Clients Referred to Services other than FSP in FY 17-18



Referrals to RRR Services decreased 2nd quarter but gradually increased over the 3rd and 4th quarter.

Phone contacts and outreach activities remained constant through the fiscal year.

Phone Contacts and Outreach Activities in FY 17-18



Prevention and Early Intervention

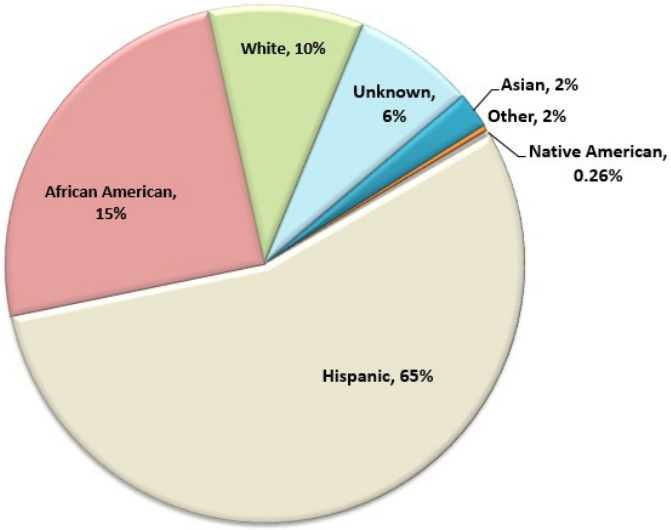
Prevention - Early Intervention - Stigma & Discrimination - Suicide Prevention

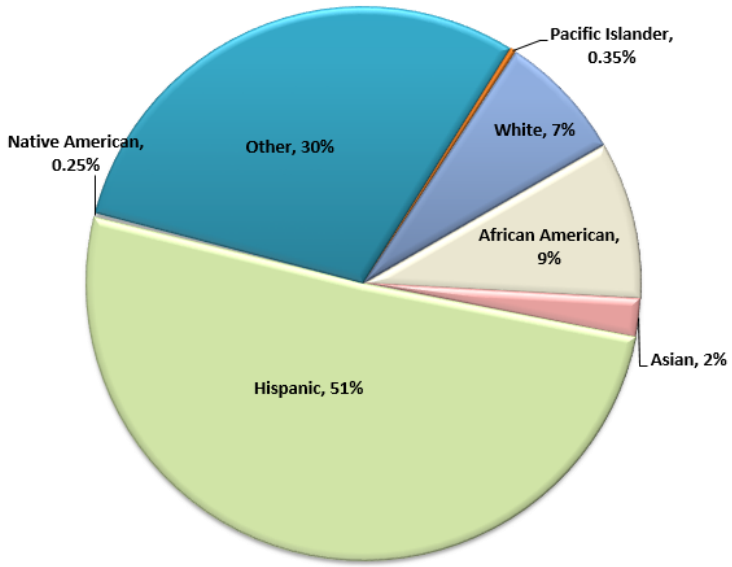
CLIENTS

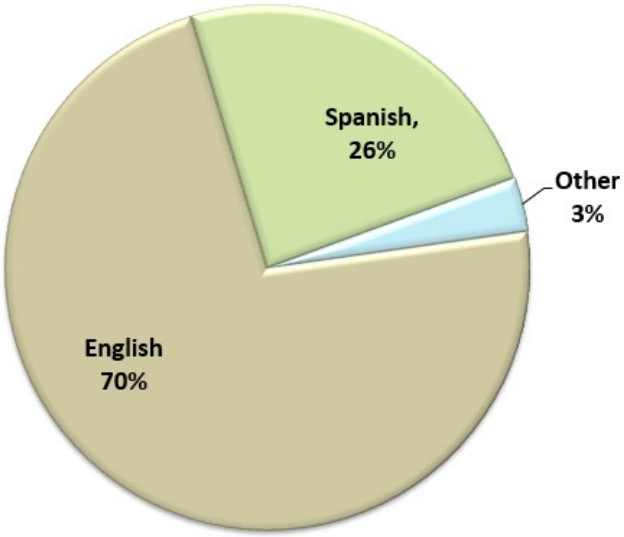
- 44,212 clients received a direct mental health service
- 69% of the clients are children
- 19% of the clients are TAY
- 10% of the clients are Adult
- 2% of the clients are Older Adult
- 55% are Hispanic
- 73% have a primary language of English

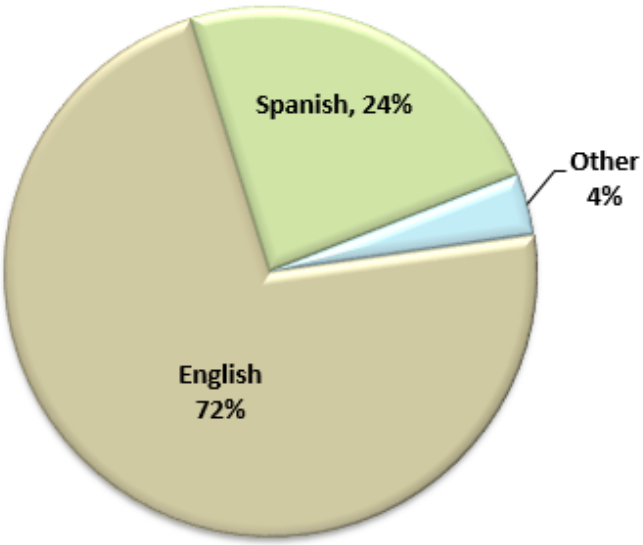
NEW CLIENTS

- 27,341 new clients receiving PEI services Countywide with no previous MHSA service
- 51% are Hispanic
- 72% have a primary language of English

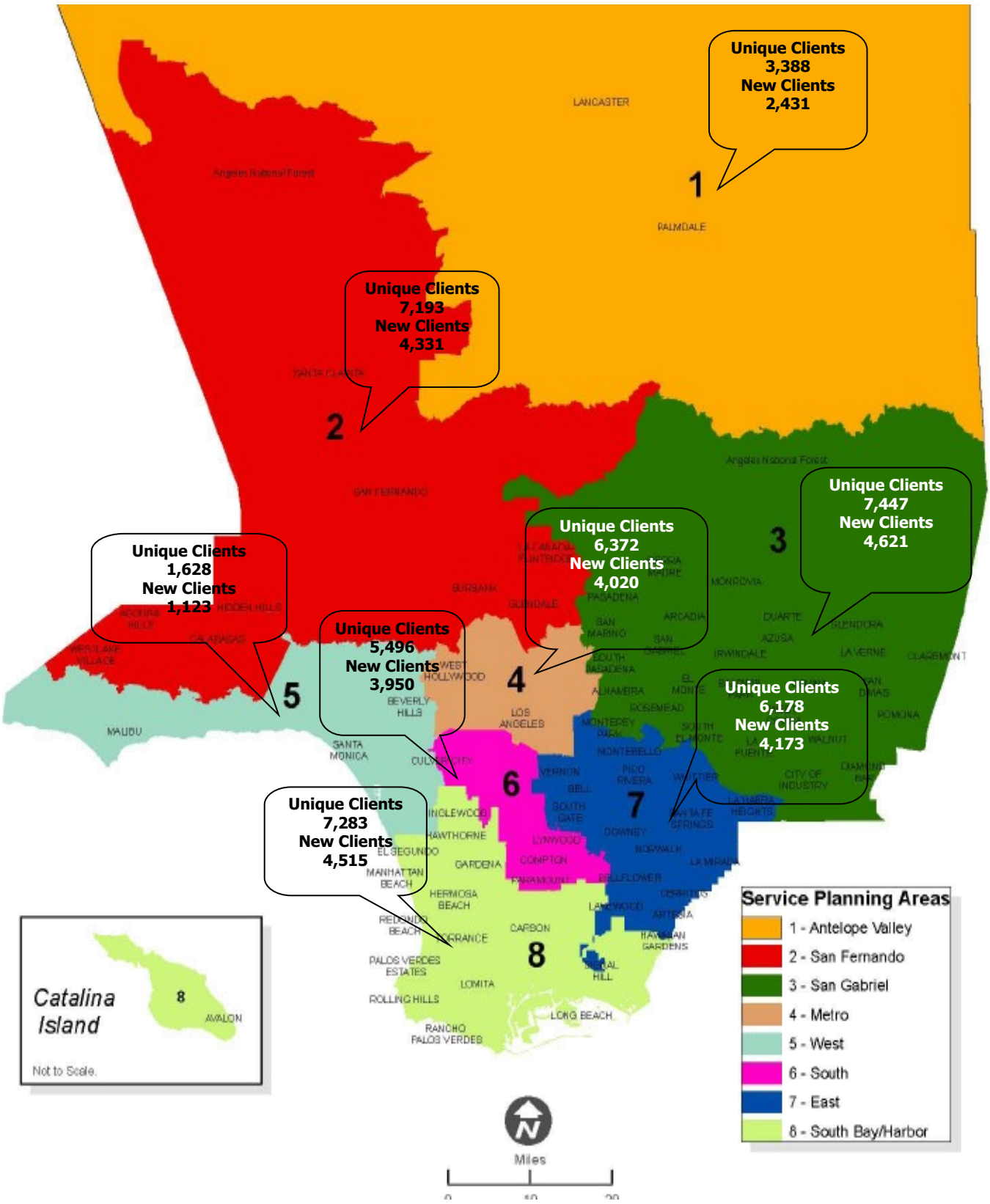






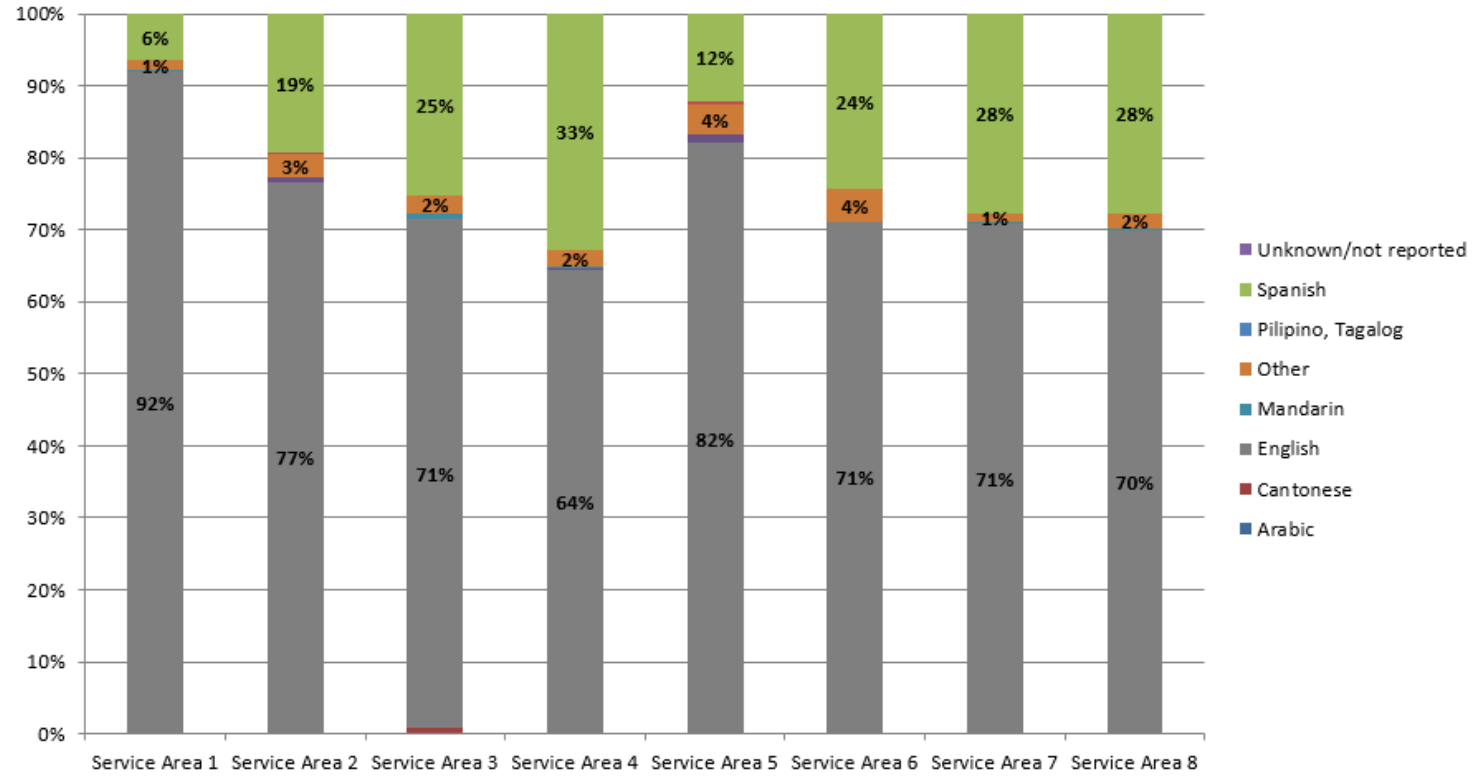


Los Angeles County Clients Served Through PEI by Service Areas Fiscal Year 2017-18

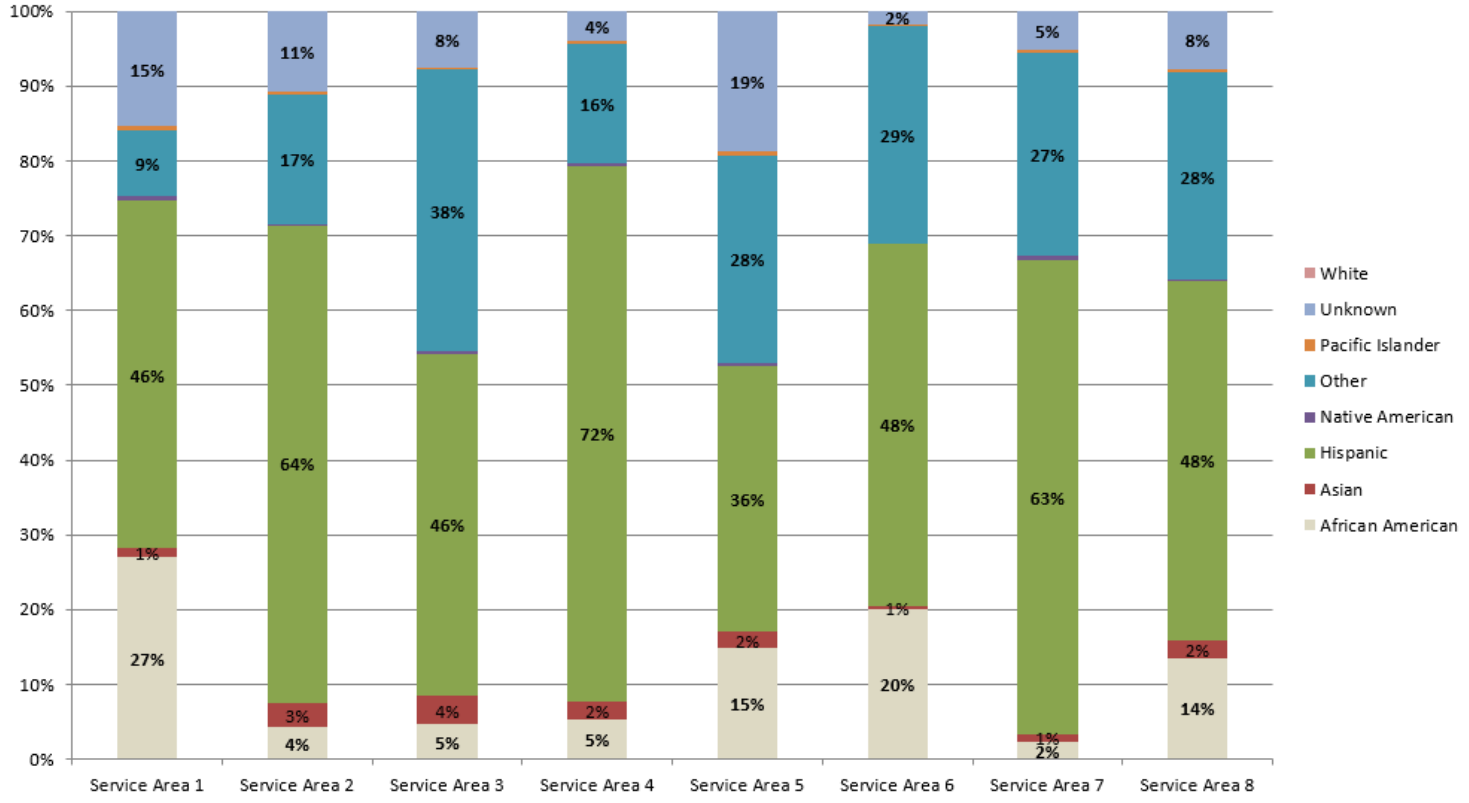


Los Angeles County Clients Served Through PEI by Service Areas Fiscal Year 2017-18

Primary Language by Service Area



Ethnicity by Service Area

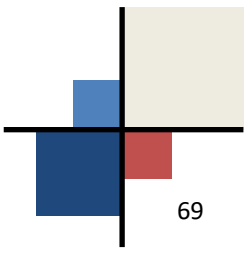


EARLY INTERVENTION

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 Program Development & 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*

Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)

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

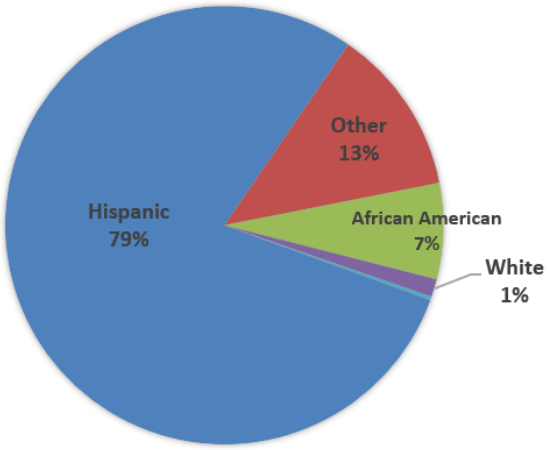
AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive 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

* 1,332 Treatment Cycles
* 49% reported completing the EBP
* 50% Improvement in mental health functioning
* 53% Reduction in symptoms related to posttraumatic stress

ETHNICITY & GENDER

N=381
Male: 60%
Female: 40%



Asian American Family Enrichment Network (AAFEN)

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

The AAFEN Program serves Asian immigrant parents and primary caregivers with inadequate parenting skills to effectively control and nurture their teenage children, who experience reduced family attachment, social functioning, as well as increased family conflict. The AAFEN Program aims at increasing the emotional and behavioral self-efficacy of the Asian parents/caregivers and enhancing the safety and healthy development of Asian immigrant youths. In particular, the AAFEN Program is designed to promote such protective factors as the stability of the Asian immigrant families, the confidence and competence of the Asian immigrant parents and/or primary caregivers in carrying out responsive and effective bicultural parenting and family management skills, and positive family bonding and relationship.

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.

*Data as of 4/4/2018. Outcomes entered July 2011 through April 2018. 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.

Brief Strategic Family Therapy (BSFT)

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

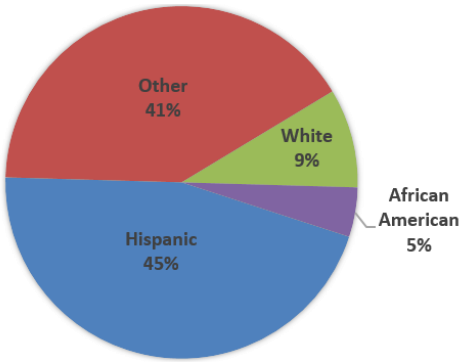
BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed 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

* 185 Treatment Cycles
* 66% reported completing the EBP
* 50% Improvement in mental health functioning
* 50% Reduction in behavioral problems

ETHNICITY & GENDER

N=22
Male: 50%
Female: 50%



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

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

Family Connections

Children (ages 0-17), TAY (ages 16-17)

The goal of FC is to help families meet the basic needs of their children and prevent child maltreatment. Nine practice principles guide FC interventions: community outreach individualized family assessment, tailored interventions, helping alliance; empowerment approaches, strengths perspective, cultural competence, developmental appropriateness, and outcome-driven service plans. Individualized family intervention is geared to increase protective factors, decrease risk factors, and target child safety, well-being, and permanency outcomes.

Incredible Years (IY)

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

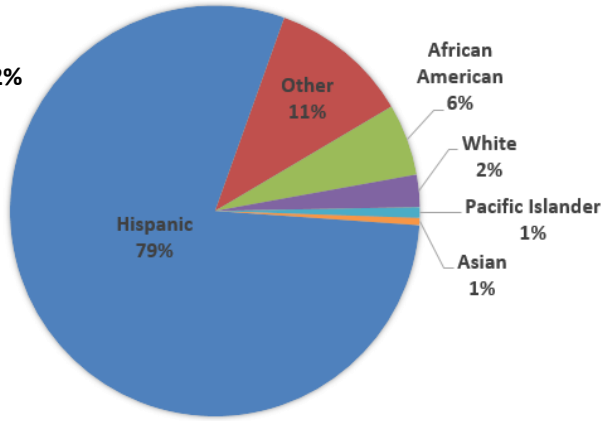
IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child 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

* 2,477 Treatment Cycles
* 64% reported completing the EBP
* 27% Improvement in mental health functioning
* 35% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=354
Male: 68%
Female: 32%



Loving Intervention Family Enrichment Program (LIFE)

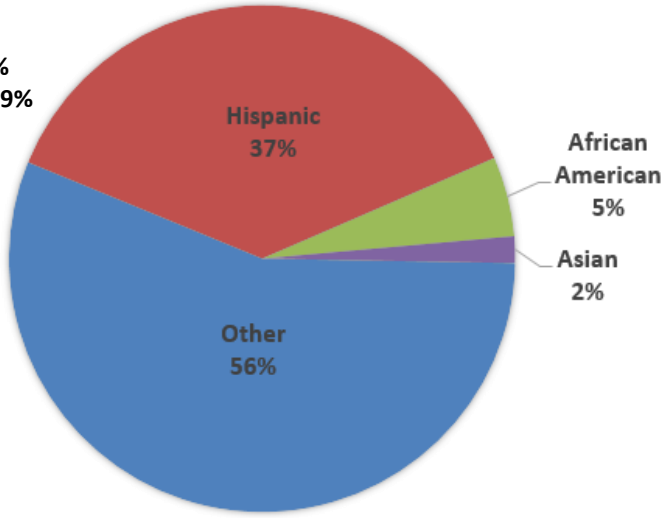
Children (ages 0-8)

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

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

N=59
Male: 61%
Female: 39%



Parent-Child Interaction Therapy (PCIT)

Young Children (2-7)

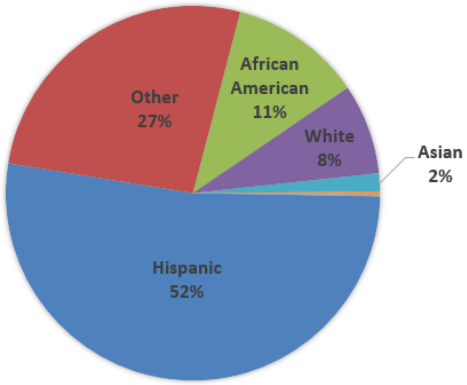
PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/ caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.

OUTCOMES

* 2,947 Treatment Cycles
* 41% reported completing the EBP
* 57% Improvement in mental health functioning
* 63% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=1,410
Male: 66%
Female: 34%



Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle

Children (ages 3-8)

This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational wellbeing. The EBP includes traditional aspects of healing with American Indians and Alaskan Natives from their world view.

Reflective Parenting Program (RPP)

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

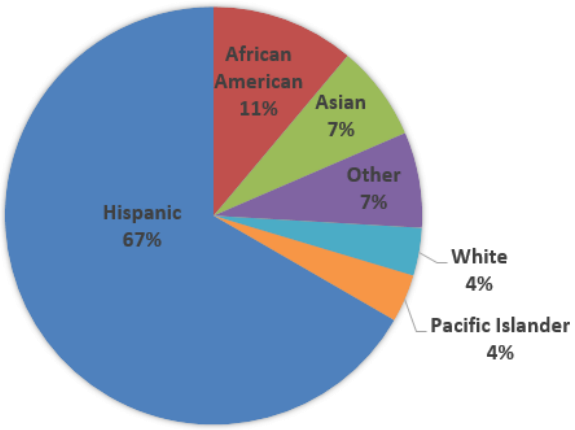
RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents / caregivers enhance their reflective functioning and build strong, healthy bonds with their children.

OUTCOMES

* 222 Treatment Cycles
* 74% reported completing the EBP
* 11% Improvement in mental health functioning
* 15% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=27
Male: 56%
Female: 44%



Triple P Positive Parenting Program (Triple P)

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

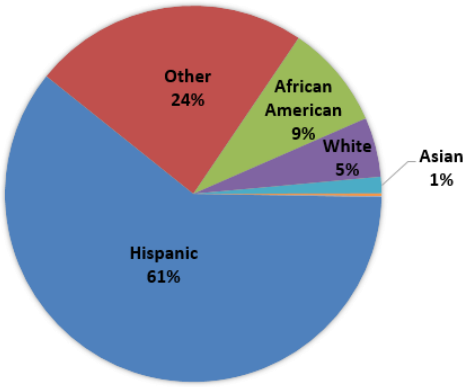
Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being 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

* 5,410 Treatment Cycles
* 59% reported completing the EBP
* 41% Improvement in mental health functioning
* 50% Reduction in disruptive behaviors

ETHNICITY & GENDER

N= 1,270
Male: 68%
Female: 32%



UCLA Ties Transition Model (UCLA TTM)

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

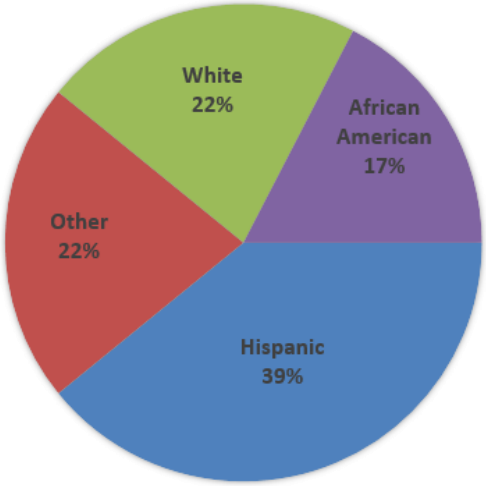
UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho-educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation).

OUTCOMES

* 184 Treatment Cycles
* 50% reported completing the EBP

ETHNICITY & GENDER

N=23
Male: 61%
Female: 39%



Child-Parent Psychotherapy (CPP)

Young Children (ages 0-6)

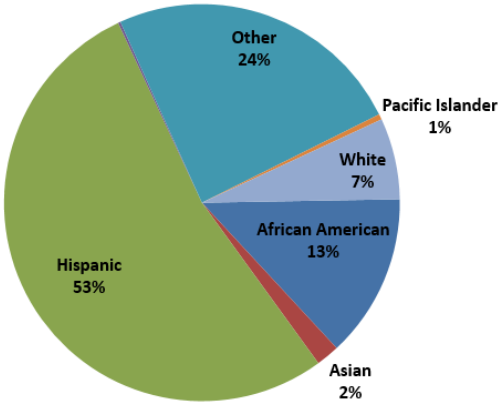
CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive -behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged 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

* 5,039 Treatment Cycles
* 48% Reported completing the EBP
* 55% Improvement in mental health functioning
* 19% Reduction in child's mental health functioning following a traumatic event

ETHNICITY & GENDER

N= 1,572
Male: 52%
Female: 48%



Cognitive Behavioral Intervention for Trauma in School (CBITS)

Children (ages 10-15), TAY

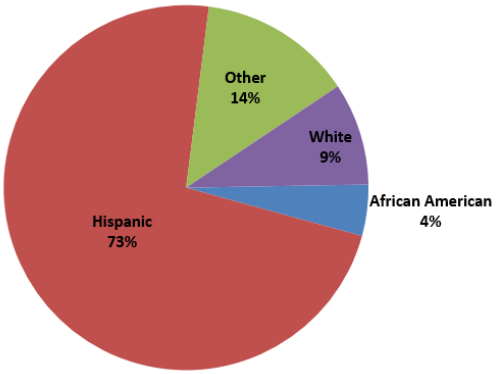
CBITS is an early intervention for children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of Posttraumatic Stress Disorder (PTSD), depression, or anxiety. To improve access to mental health care, services are delivered within the school 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

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

ETHNICITY & GENDER

N=22
Male: 32%
Female: 68%



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

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

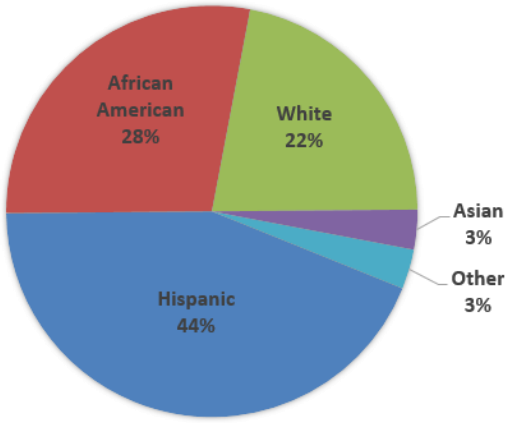
PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.

OUTCOMES

* 66 Treatment Cycles
* 52% reported completing the EBP

ETHNICITY & GENDER

N= 32
Male: 66%
Female: 34%



Seeking Safety (SS)

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

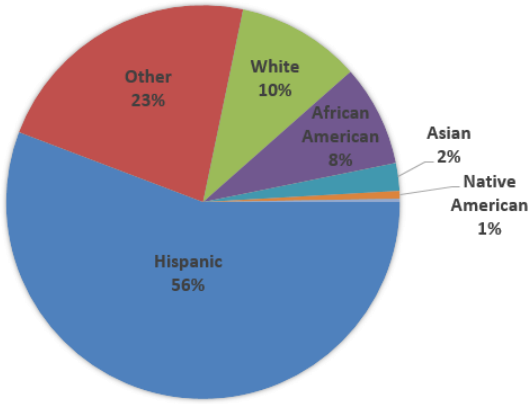
SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.

OUTCOMES

* 18,075 Treatment Cycles
* 40% reported completing the EBP
* 36% Improvement in mental health functioning
* 31% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N= 3,290
Male: 39%
Female: 61%



Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

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

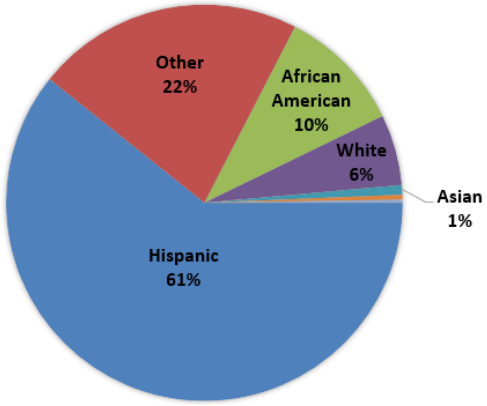
An early intervention for children who may be at risk for symptoms of depression and psychological trauma, subsequent to any number of traumatic experiences, particularly those individuals who are not currently receiving mental health services. Services are specialized mental health services delivered 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

* 18,440 Treatment Cycles
* 55% reported completing the EBP
* 47% Improvement in mental health functioning
* 51% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N= 5,781
Male: 44%
Female: 56%



EARLY INTERVENTION

PEI 05 - INDIVIDUALS AND FAMILIES UNDER STRESS

The purpose of the Individuals and Families Under Stress 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 prevention 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 individual, parental, family, and caregiver skill-building through a variety of training, education, individual, group parent, and family interaction methods.

Crisis Oriented Recovery Services (CORS)

Children , TAY, Adults,, Older Adults

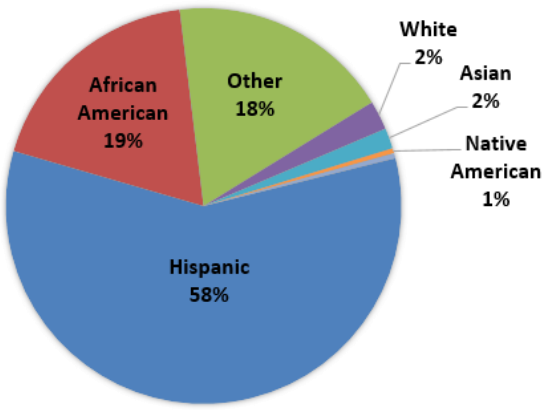
CORS is a short-term intervention designed to provide immediate crisis intervention, address identified case management needs, and assure hard linkage to ongoing services. The primary objective is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress 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

* 3,898 Treatment Cycles
* 59% reported completing the EBP
* 28% Improvement in mental health functioning

ETHNICITY & GENDER

N=716
Male: 50%
Female: 50%



Group Individual Psychotherapy (Group IPT)

Ages 15+

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.

Depression Treatment Quality Improvement (DTQI)

Children , TAY , Adults , Older Adults

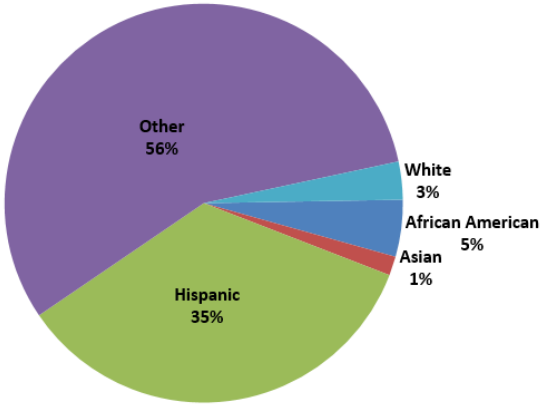
DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed 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

* 1,118 Treatment Cycles
* 62% reported completing the EBP
* 47% Improvement in mental health functioning
* 62% Reduction in symptoms related to depression

ETHNICITY & GENDER

N=100
Male: 41%
Female: 59%



Dialectical Behavior Therapy (DBT)

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

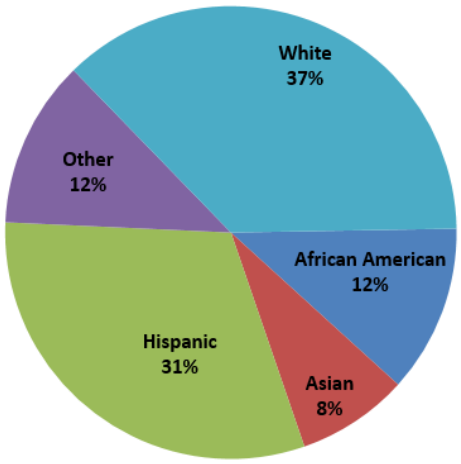
DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, 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

* 109 Treatment Cycles
* 47% reported completing the EBP

ETHNICITY & GENDER

N=100
Male: 29%
Female: 70%



Families Over Coming Under Stress (FOCUS)

Children , TAY , Adults

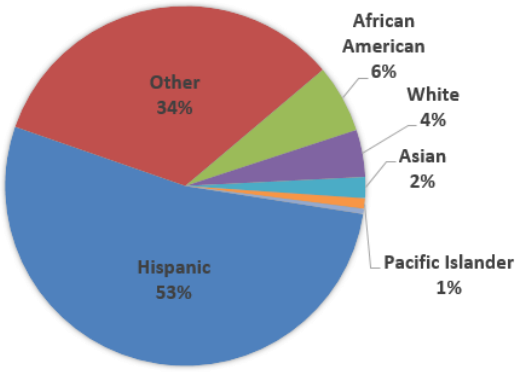
Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. 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

* 414 Treatment Cycles
* 71% reported completing the EBP
* 43% Improvement in mental health functioning
* 50% Improvement in family functioning

ETHNICITY & GENDER

N=212
Male: 53%
Female: 47%



Group Cognitive Behavioral Therapy for Major Depression (Group CBT)

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

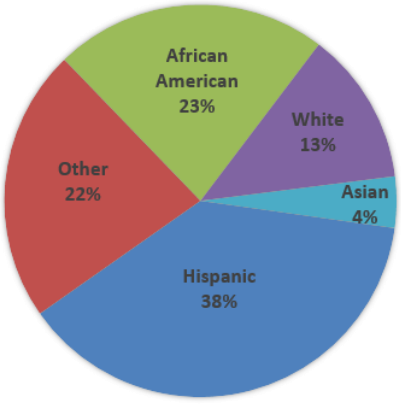
Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is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

* 1,086 Treatment Cycles
* 44% reported completing the EBP
* 21% Improvement in mental health functioning
* 42% Reduction in symptoms related to depression

ETHNICITY & GENDER

N=71
Male: 35%
Female: 65%



Interpersonal Psychotherapy for Depression (IPT)

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

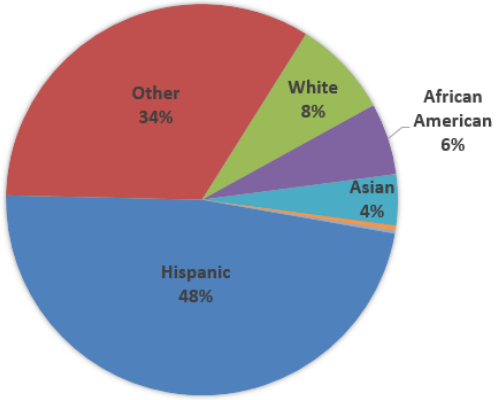
IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.

OUTCOMES

* 5,443 Treatment Cycles
* 52% reported completing the EBP
* 31% Improvement in mental health functioning
* 54% Reduction in symptoms related to depression

ETHNICITY & GENDER

N= 2,110
Male: 33%
Female: 67%



Managing and Adapting Practice (MAP)

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

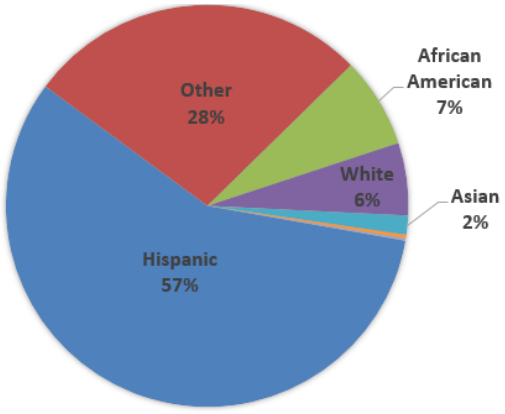
MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the 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

* 42,654 Treatment Cycles
* 54% reported completing the EBP
* 43% Improvement in mental health functioning
* 43% Reduction in disruptive behaviors
* 55% Reduction in symptoms related to depression
* 41% Reduction in symptoms related to anxiety
* 53% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N= 19,129
Male: 54%
Female: 46%



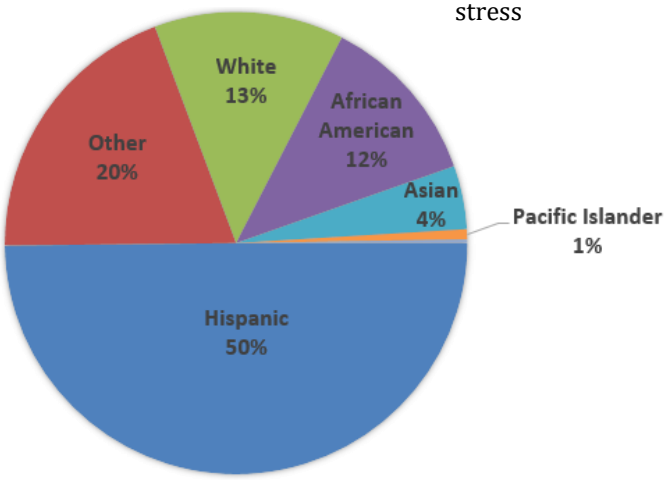
Individual Cognitive Behavioral Therapy (Ind. CBT)

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.

ETHNICITY & GENDER

N=3,962
Male: 32%
Female: 68%



OUTCOMES

Anxiety:
* 1,902 Treatment Cycles
* 43% reported completing the EBP
* 37% Improvement in mental health functioning
* 54% Reduction in symptoms related to anxiety

Depression:
* 4,687Treatment Cycles
* 42% reported completing the EBP
* 35% Improvement in mental health functioning
* 53% Reduction in symptoms related to depression

Trauma:
* 583Treatment Cycles
* 48% reported completing the EBP
* 42% Improvement in mental health functioning
* 59% Reduction in symptoms related to posttraumatic stress

The Mothers and Babies Course, Mamas y Bebes

Ages 13+

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.

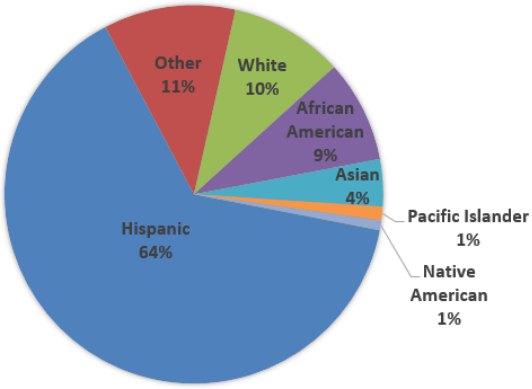
Mental Health Integration Program (MHIP) formerly known as IMPACT

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.

ETHNICITY & GENDER

N= 595
Male: 28%
Female: 72%



OUTCOMES

MHIP-Anxiety
* 1,803 Treatment Cycles
* 39% reported completing the EBP
* 58% Reduction in symptoms related to anxiety

MHIP-Depression
* 5,275 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

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

* 745 Treatment Cycles
* 34% reported completing the EBP
* 37% Improvement in mental health functioning
* 33% Reduction in disruptive behaviors

Problem Solving Therapy (PST)

Older Adults

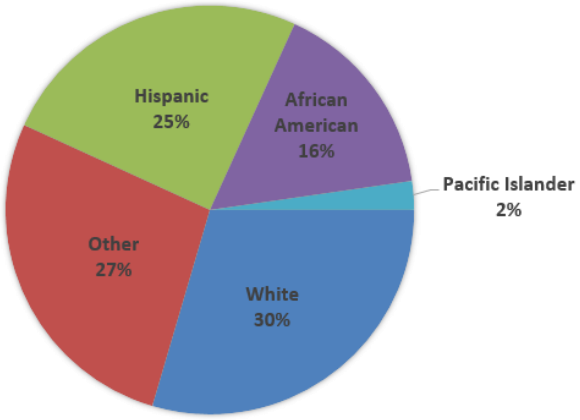
PST has been a primary strategy in IMPACT/ MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting 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

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

ETHNICITY & GENDER

N= 44
Male: 36%
Female: 64%



Program to Encourage Active Rewarding Lives for Seniors (PEARLS)

Older Adults

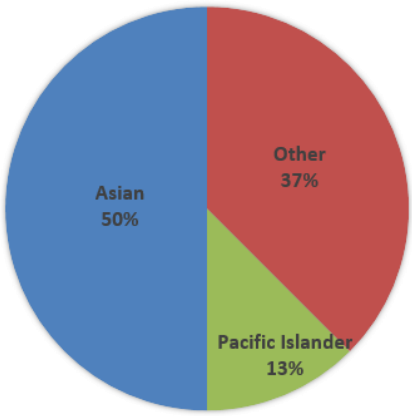
PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.

OUTCOMES

* 162 Treatment Cycles
* 50% reported completing the EBP
* 26% Improvement in mental health functioning
* 45% Reduction in symptoms related to depression

ETHNICITY & GENDER

N= 8
Male: 38%
Female: 63%



EARLY INTERVENTION

AGRESSION REPLACEMENT TRAINING (ART)

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

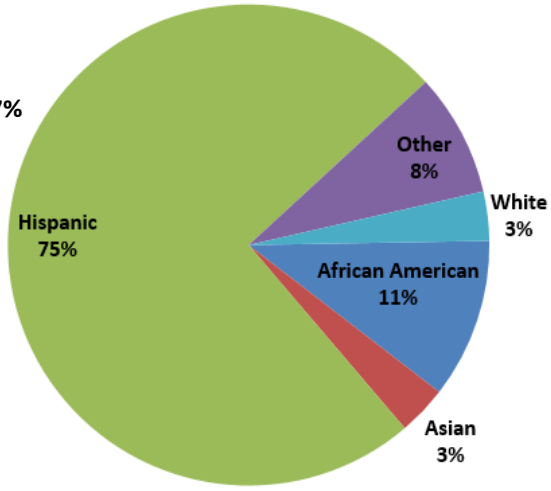
ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control 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

* 3,375 Treatment Cycles
* 42% reported completing the EBP
* 25% Improvement in mental health functioning
* 21% Reduction in disruptive behaviors

ETHNICITY & GENDER

N= 121
Male: 63%
Female: 37%



Functional Family Therapy (FFT)

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

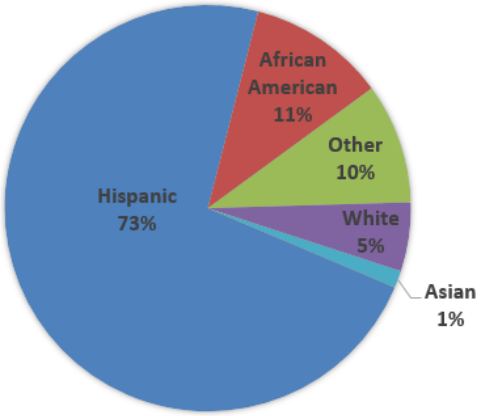
FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.

OUTCOMES

* 1,637 Treatment Cycles
* 65% reported completing the EBP
* 31% Improvement in mental health functioning

ETHNICITY & GENDER

N=73
Male: 55%
Female: 45%



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

TAY

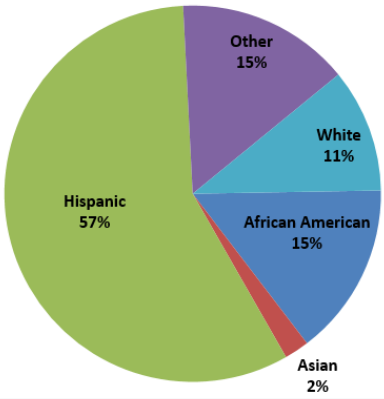
The focus of CAPPS is to conduct outreach and engagement specifically to those youth who are experiencing their first-break psychosis and early onset of serious mental illnesses with psychotic features. In order to mitigate mental health challenges and reduce the progression of these challenges into 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

* 189 Treatment Cycles
* 44% reported completing the EBP
* 31% Improvement in mental health functioning
* 60% Reduction in prodromal symptoms

ETHNICITY & GENDER

N=
Male: 60%
Female: 40%



Coordinated Specialty Care Model for Early Psychosis (CSC-EP)

Children (ages 12-15) & TAY (ages 16-25)

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.

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.

Multidimensional Family Therapy (MDFT)

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

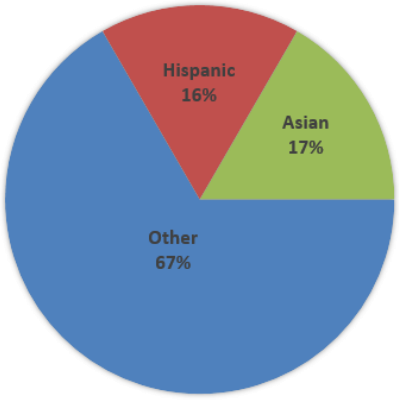
MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are 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

N= 6
Male: 67%
Female: 33%



Multisystemic Therapy (MST)

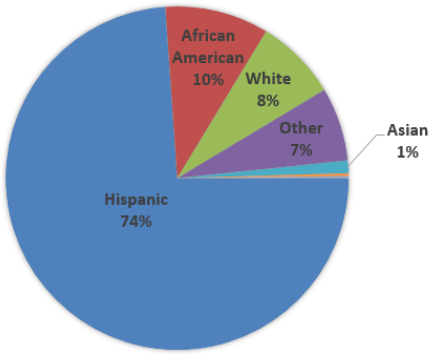
Children (ages 12-15) TAY (ages 16-17)

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

N= 1,513
Male: 67%
Female: 33%



STIGMA AND DISCRIMINATION REDUCTION

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.

Family-focused Strategies to Reduce Mental Health Stigma and Discrimination

During Fiscal Year 2017-2018, Program Development and Outcomes Division (PDOD), formerly Adult System of Care, Stigma and Discrimination Reduction (SDR) team participated in 45 events in 6 out of 8 service areas in Los Angeles County (LAC). Over 1500 LAC community members including families and caregivers 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 addressing stigma. The SDR team also collaborated with various agencies and programs throughout the County such as Department of Probation, Department of Public Health, Department of Social Services, Long Beach City College, East LA Library, and Shiloh Ministries to name a few. In addition, the PDOD SDR team also provides stigma related education to newly hired DMH staff during New Employee Orientation, which is unique to this particular team.

Older Adults Mental Wellness

For the majority of FY 2017-18, the Older Adult Anti-Stigma and Discrimination Team (OA ASD) was comprised of a Community Services Counselor, a Community Worker, and a Service Extender. Other Outpatient Services staff routinely 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 272 events during the FY 2017-18, outreaching to 3,792 Los Angeles County residents. These events include countywide educational presentations, community events such as Resource fairs, community meetings and collaboration with various agencies.

Highlights of OA ASD's accomplishments include:

- Outreached to 3792 individuals in Los Angeles County
- Provided 264 presentations for seniors throughout the county
- Participated in 8 Resource Health Fairs throughout the county
- Increased the number of workshops in Service Areas 1, 2, 5 and 8
- Developed a new presentation "Elder Financial Exploitation: Impact on Emotional Wellbeing" for addition to the menu of topics for our Mental Wellness Series.

Strengths

OA ASD provides prevention services primarily by increasing awareness of Mental Wellness for older adults throughout Los Angeles County, particularly among underserved and under-represented communities. We continue to develop new presentation topics for seniors. OA ASD Team collaborates and coordinates with Los Angeles County Department of Mental Health contracted agencies to provide clinical back-up and coordination of translation services as needed.

GEOGRAPHICAL AREA

Table 1

Service Area	Area	Number of Presentations
1	Antelope Valley	7
2	San Fernando Valley	80
3	San Gabriel Valley	26
4	LA Metro Area	48
5	West LA Area	21
6	South LA Area	16
7	East LA Area	43
8	South Bay Area	31
Grand Total		**272**

Table 1. Demonstrates the distribution of presentations offered throughout Los Angeles County. In comparison to when ASD initially began providing presentations for older adults which required intensive outreach efforts to housing managers in senior housing and staff in senior centers, the ASD team is now contacted directly to request presentations daily.

TYPE OF FACILITY

Table 2

Facility	
Community Center	14
Senior Centers	69
Senior Housing	178
Other (Library, Church, City Hall)	11

Table 2. Illustrates the type of facilities where presentations were provided. In the past, most of our efforts focused on settings where large audiences of older adults congregate, such as senior centers. Due to an increase in awareness of our presentations, the number of senior housing complexes increased to 178 from last year's 165.

ATTENDANCE

Table 3

Number of people who attended	
Community Center	340
Senior Centers	1427
Senior Housing	1909
Other (Library, Church, City Hall)	116
Total	3792

Table 3. Displays the number in attendance at the various facilities. It is noteworthy that 25% of the team's visits were to Senior Centers where they presented to 38% of the total attendants. This compares to 72% of the team's visits being to Senior Housing sites, where they presented to 50% of the total attendants. This illustrates that for FY 17/18, the team's efforts in outreaching in senior centers was a very productive use of their time.

TOPICS

Table 4

Type of Presentation	
Bullying	14
Depression and Anxiety	19
Good Sleep	13
Grief and Loss	10
Health, Wellness, and Wholeness	22
Healthy Aging Bingo	27
Hoarding	30
Holiday Blues	43
Isolation	11
Life-Life Transitions	14
Medication Management	18
Preserving your Memory	25
Resiliency	13
Elder Financial Exploitation: (Scams)	1
Substance Use	3
Other (Resource Fairs, Community meeting)	9

Table 4. Lists the number of topics requested from our Mental Wellness Series. The "Holiday Blues" and "Hoarding" presentations are most frequently requested and scheduled by the activity coordinators at various agencies. "Hoarding" provides helpful information on the difference between hoarding, collecting and cluttering. It helps seniors understand the illness and how to get or help others. The "Holiday Blues" presentation addresses challenges faced by seniors who have experienced losses or feel alone during the holidays and provides some strategies to combat feelings of sadness.

"Grief & Loss" is a relatively new presentation that grew out of requests for assistance when a senior, or close family member of a senior, passes away. This could be in a senior housing site or within a senior center where the deceased was well-known to others. A clinician from our Outpatient Services team provides this presentation due to its sensitive nature and engages in supportive and empathic dialogue with the participants.

LANGUAGES
Table 5

Type of Presentation	
English	205
Spanish	79
Korean	15
Farsi	5
Chinese	4
Russian	3

Table 5. Details presentations provided in the following languages: English, Spanish, Korean, Farsi, Russian and Chinese. Request for Spanish has increased during the FY 17/18 due to senior housing complexes sharing information on the Wellness series.

Recommendations

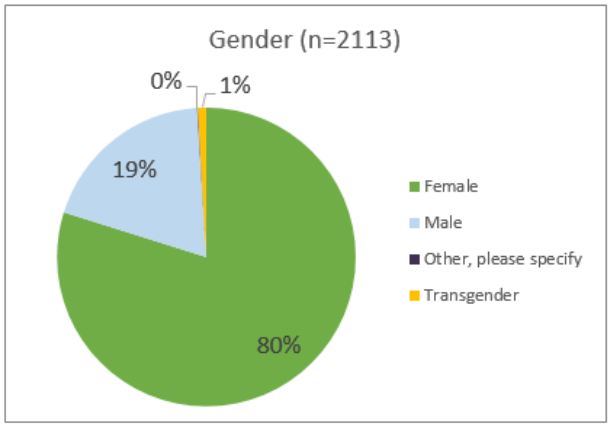
OA ASD's goals for FY 18/19 include: Continue to make efforts to outreach in SA's 1 and 6, Continue to Increase presentations at Senior Centers and train and prepare Service Extenders to offer presentations.

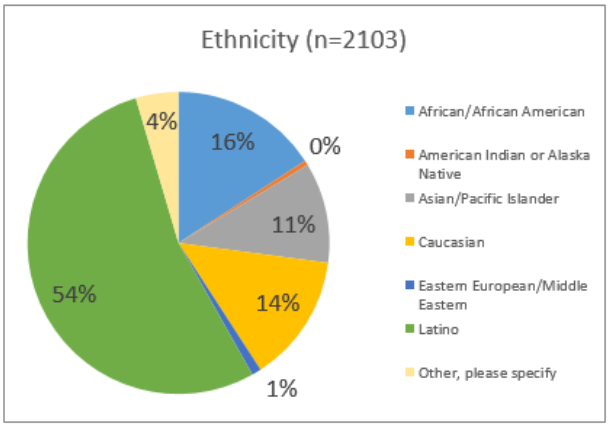
OUTCOMES -ANTI-STIGMA DISCRIMINATION

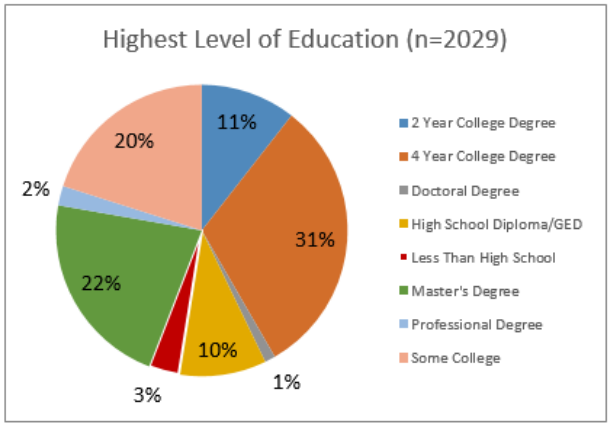
Through training and education, the Los Angeles County Department of Mental Health has shown positive results in increasing knowledge and reducing stigma and discrimination related to mental illness. Stigma and Discrimination Reduction (SDR) Training Outcomes Surveys were administered at the beginning 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.

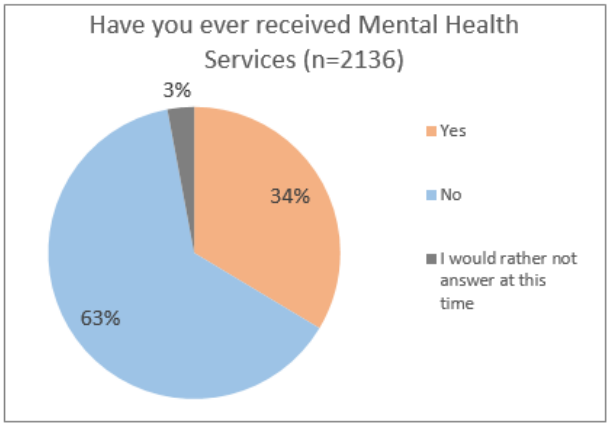
The following are results from the 2,268 surveys received for FY 2017-18:

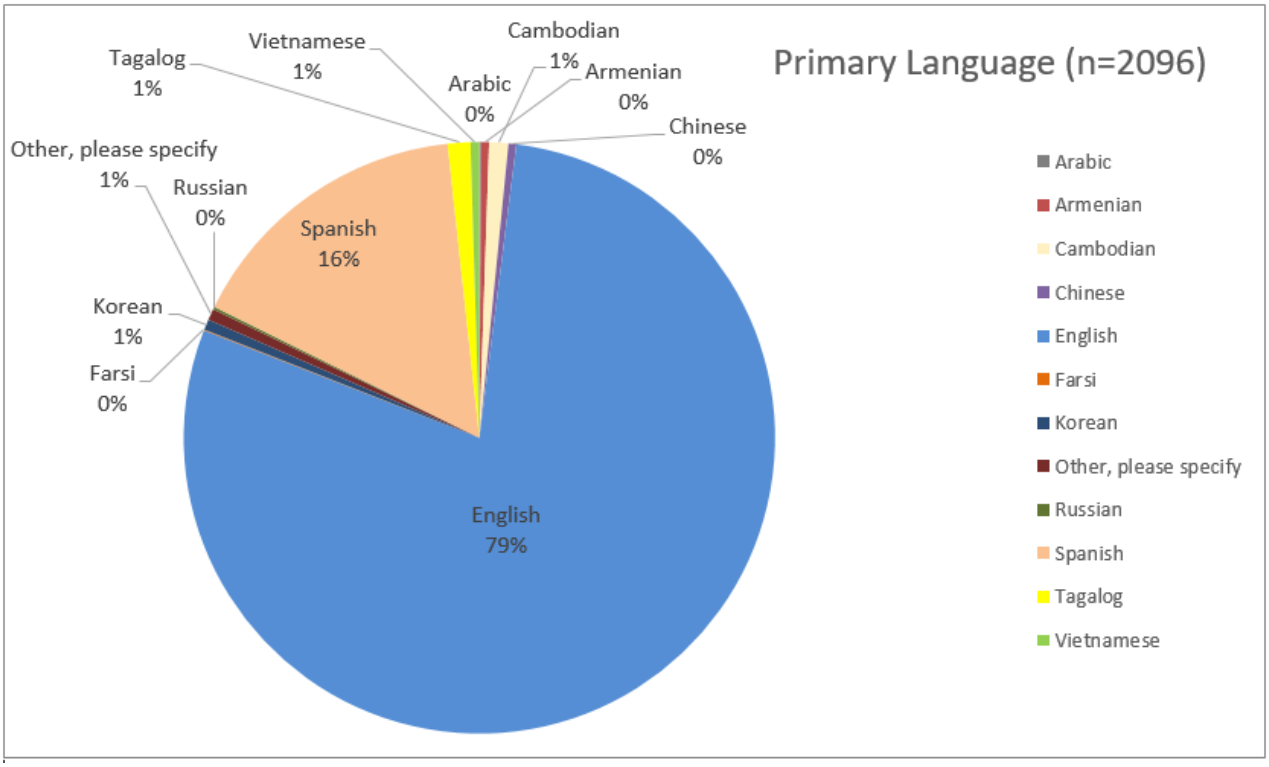
The number of surveys received in FY 2017-18 increased by 31% from the previous fiscal year (1729) and by 51% from FY 2015-16 (1502). The are two possible causes for the increase: 1) increase in survey collection rates from year-to-year and/or 2) increase in the number of people receiving SDR programs from year-to year.

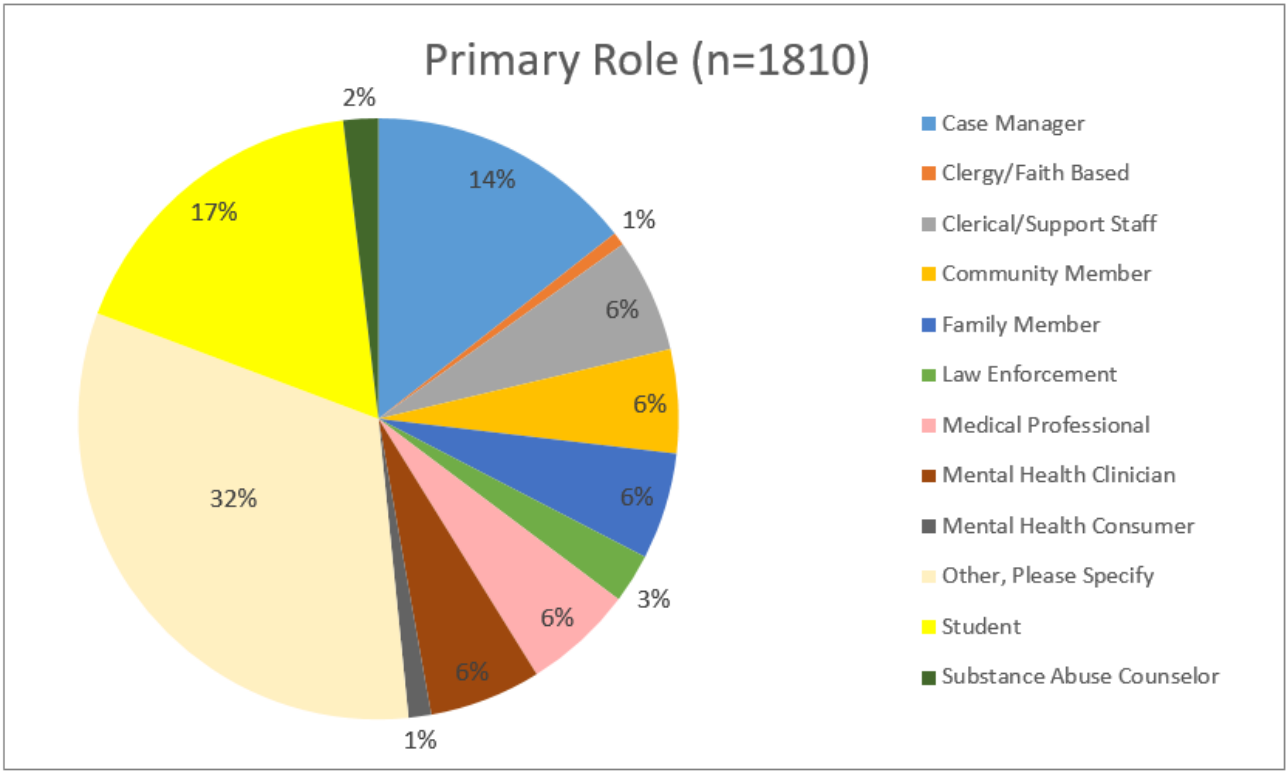


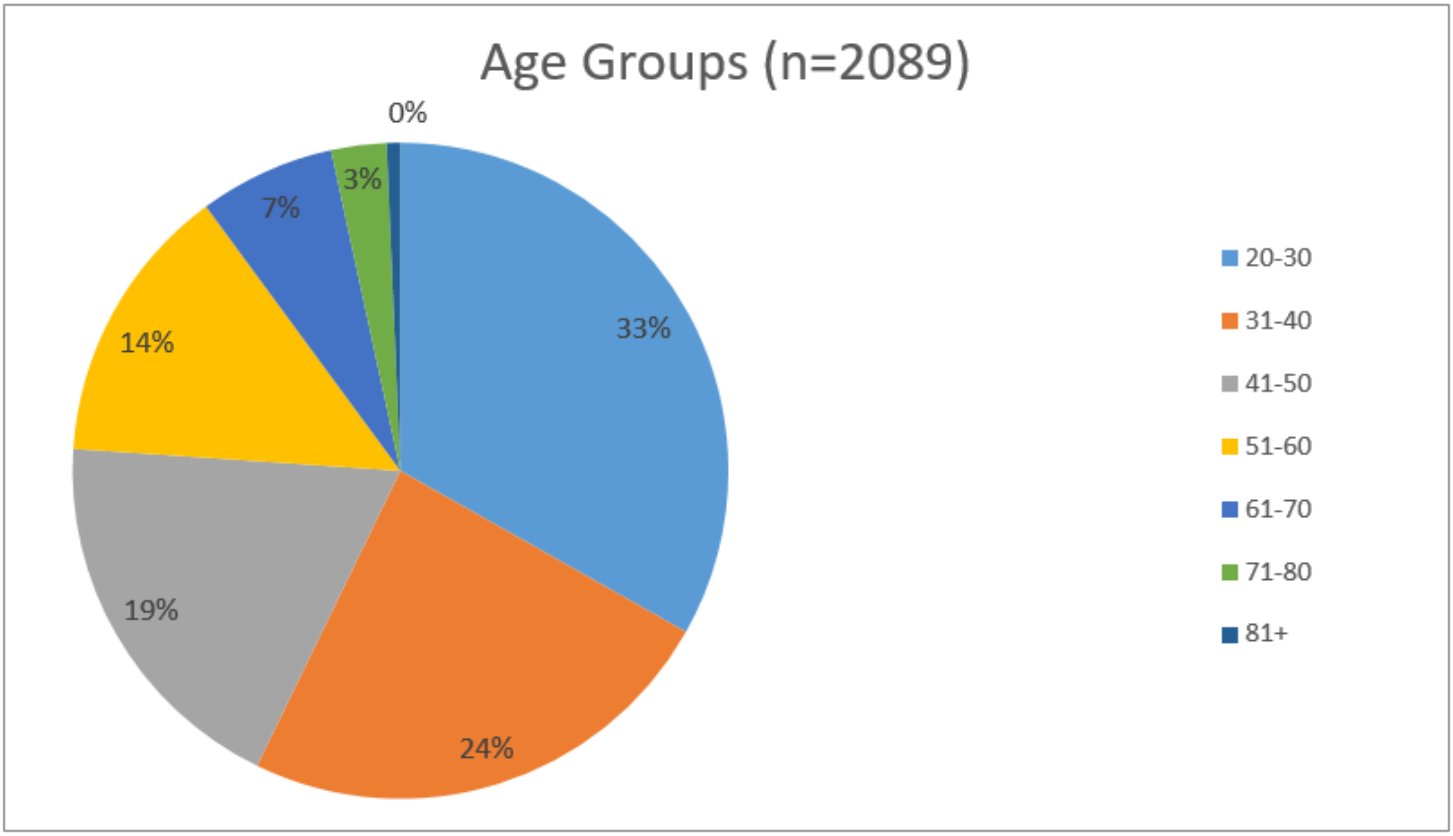







Primary Language (n=2096)
Tagalog 1%
Vietnamese 1%
Cambodian 1%
Arabic 0%
Armenian 0%
Chinese 0%
Other, please specify 1%
Russian 0%
Spanish 16%
Korean 1%
Farsi 0%
English 79%
Arabic
Armenian
Cambodian
Chinese
English
Farsi
Korean
Other, please specify
Russian
Spanish
Tagalog
Vietnamese


Primary Role (n=1810)
14%
1%
6%
6%
6%
3%
6%
6%
1%
32%
17%
2%
Case Manager
Clergy/Faith Based
Clerical/Support Staff
Community Member
Family Member
Law Enforcement
Medical Professional
Mental Health Clinician
Mental Health Consumer
Other, Please Specify
Student
Substance Abuse Counselor



Note: The mean age of trainees who submitted a survey was 40 (age range 18-99).

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 has 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 of whether the person completing it tends to have negative or positive perceptions of persons with mental illness. The Attitudes 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, following the training:

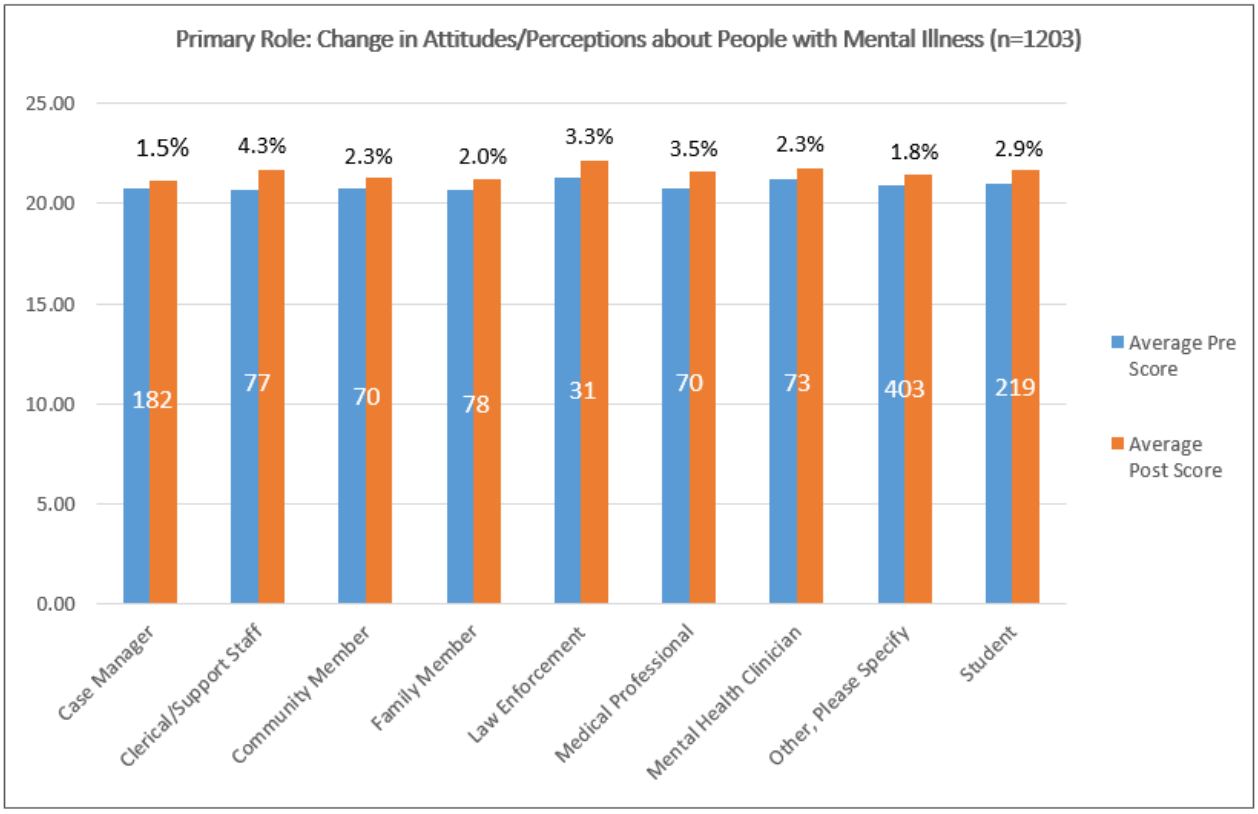
- The mean average Attitudes score improved by (3%) from "pre" to "post"
- Prior to the training, the average total score was in the Very Positive range; at "post" training, the average total score was still in the Very Positive range.
- Prior to the training, 99% of participants' total scores were in either the Positive range (609) or Very Positive range (937). At "post" training, 99% of participants were still in either the Positive range (454) or Very Positive range (1095). These results are identical to the results from FY 16-17. In that year, 99% of participants had "pre" scores in either the Positive or Very Positive range and 99% had "post" scores in either the Positive or Very Positive range.
- Prior to training, 60% of participants' (937) scored in the Very Positive range. At "post", 70% of participants' scored in the Very Positive (1095), an increase of 10%.
- Prior to the training, 12 participants scores were in either the Negative or Very Negative Attitudes Range. Seventy-five percent (75%) of those participants' scores fell in either the Positive (8) or Very Positive (1) range 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.

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:

- The mean average knowledge score improved by (27%) from "pre" to "post"
- Ninety-eight percent (98%) of participants (1526) either increased their knowledge about mental illness or showed no change because they were already knowledgeable on the subject matter.
- Prior to the training, 67% of participants selected Moderately, Very, or Extremely Knowledgeable. "Post" training, 95% of participants selected Moderately, Very, or Extremely Knowledgeable, an increase of 28%.
- Prior to the training, 697 participants selected the response, Moderately Knowledgeable. Fifty-seven percent (57%) of these participants selected either Very Knowledgeable (349) or Extremely Knowledgeable (50), at "post" training.
- Prior to the training, 513 participants selected either the response, Not at all Knowledgeable or Somewhat Knowledgeable. Eighty-seven percent (87%) of these participants selected either Moderately Knowledgeable (277), Very Knowledgeable (141) or Extremely Knowledgeable (26), at "post" training.

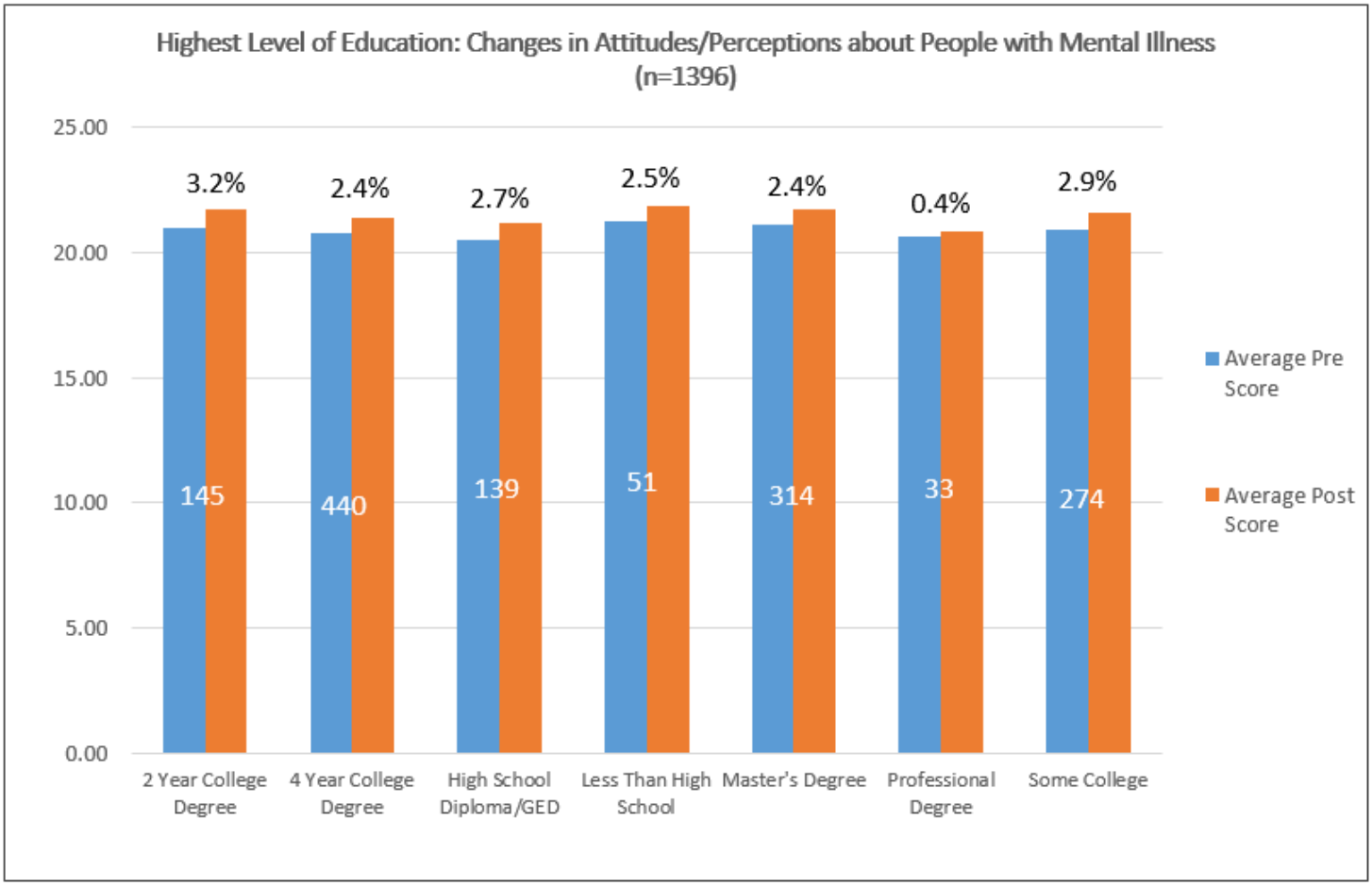
Demographic comparison charts are included when the average percent change in score from "pre" to "post", for at least one group within the category is at least double the percent change of another group. For example, in the Primary Role category, the average percent change in Perception/Attitudes score for the groups, Clerical/Support Staff (4.3%), Law Enforcement (3.3%), and Medical Professional (3.5%) are more than twice as large as the of the average percent change for the group, Case Manager (1.5%). Two sets of results met the percent change condition: 1) Primary Role: Changes in Attitudes/Perceptions about People with Mental Illness 2) Highest Level of Education: Changes in Attitudes/Perceptions about People with Mental Illness.



Note: Results for primary roles that had fewer than 30 matched "pre" and "post" SDR surveys (Clergy/Faith based, Mental Health Consumer) are not included in the chart.

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

- Participants who selected the primary role, Case Manager, had the lowest average percent change (1.5%), from "pre" to "post"; participants who selected Clerical/Support Staff had the highest (4.3%).
- Participants who selected the primary role, Law Enforcement, had the highest average "pre" (21.3) and "post" (22.2) scores; participants who selected Clerical/Support Staff had the lowest average "pre" (20.7) score and participants who selected Case Manager had the lowest average "post" (21.2) score



Note: Results for highest level of education that had fewer than 30 matched "pre" and "post" SDR surveys (Doctoral Degree) is not included in the chart.

Attitudes/Perceptions of people who have mental illness, Highest level of education

- Participants who selected the highest level of education, Professional Degree, had the lowest average percent change (0.4%), from "pre" to "post"; participants who selected 2-year College Degree had the highest (3.2%).
- Participants who selected the highest level of education, Less than High School, had the highest average "pre" (21.3) and "post" (21.9) scores; participants who selected High School Diploma/GED had the lowest average "pre" (20.5) score and participants who selected Professional Degree had the lowest average "post" (20.9) score.
- The low average change in score among participants in the category, Professional Degree, compared with other groups, may be an anomaly resulting from having a small n (33) and/or some characteristic of the group's participants. Deeper review of results for this group showed that 52% of the participants (17) attended the same training and 76% of those at the same training (13) reported working in the legal field, either as an attorney, supervisor, or paralegal. Among those 17 participants, the average "pre" score was (20.8), average "post" was (20.4), and average percent change was (-2.5%).

WhyWeRise Campaign

Taken from www.rand.org. Released Wednesday, November 14, 2018
Youth-Oriented Mental Health Campaign Shows Evidence of Success

A community engagement campaign launched by Los Angeles County Department of Mental Health to address mental health barriers had an impressive reach with the younger audience it targeted and showed signs of changing attitudes, according to a new RAND Corporation evaluation. The county's WhyWeRise campaign targeted people aged 14 to 24 to encourage them to engage with mental health issues and create a movement to lower barriers to mental health access. RAND investigators found that people who were exposed to the campaign were more likely to express support toward people with mental illness. In addition, a countywide survey of youth found that people who were exposed to a campaign event in person or online were more likely to feel empowered and mobilized toward mental health activism. "The campaign was intended to elevate mental health as a civil rights issue and leverage youth enthusiasm for activism as a way to create social change," said Rebecca L. Collins, the study's lead author and a senior behavioral scientist at RAND, a nonprofit research organization. "Our findings show that they reached an impressive proportion of the target audience and seem to have influenced people's attitudes toward mental health."

In May of this year, the Los Angeles Angeles County Department of Mental Health launched a campaign intended to promote community engagement with mental health issues and create a movement to advocate for well-being and address barriers to quality treatment for mental health problems. The centerpiece of the campaign was the WeRise event that ran for three weeks in downtown Los Angeles where visitors could experience an immersive art gallery, rally, performances, panel discussions and workshops about mental health issues.

The effort was part of the the county's prevention and early intervention efforts supported by the Mental Health Services Act, which was passed by voters in 2004 and created a special tax on high income residents to support mental health services and education. Funds support treatment for individuals with mental illness, but a portion is set aside for prevention and early intervention. "Most people who face mental health problems either do not seek treatment or delay seeking help," Collins said. "It's important that we address the reasons why most young people with mental health problems don't get appropriate diagnosis and treatment so that we can change that pattern."

RAND evaluated the campaign by interviewing people who took part in the event, conducting an online survey of more than 1,000 youth from throughout Los Angeles County and analyzing Twitter data from Los Angeles users on the topic of mental health before and the during the campaign. The online survey found that as many as one in five young people in the targeted age group were aware of WeRise or WhyWeRise within just a few weeks after the campaign was launched. In addition, discussion of WeRise was frequent within a Twitter community that discussed common mental health topics. The survey also found that youth who reported exposure to the campaign were more aware of the challenges faced by people with mental illness and more likely to know how to get help with mental health challenges.

While the RAND study suggests the campaign had early successes, researchers say the effort could do more to engage men, younger audiences and people who do not already have a connection to mental health. Leaders of WhyWeRise also could build stronger online connections with other social justice-oriented communities that are also on social media, and sustain the campaign for a longer period of time because public attitudes tend to change slowly. "The WhyWeRise campaign is one of many efforts that are ongoing across California to increase awareness of mental health issues and ease barriers to getting treatment," Collins said. "These efforts are most likely to make lasting changes if they are sustained over time."

The report, "Evaluation of Los Angeles County's Mental Health Community Engagement Campaign," is available at www.rand.org. Other authors of the report are Nicole K. Eberhart, William Marcellino, Lauren Davis and Elizabeth Roth.
RAND Health Care promotes healthier societies by improving health care systems in the United States and other countries.

EVALUATION –MENTAL HEALTH COMMUNITY ENGAGEMENT CAMPAIGN

To evaluate how well the campaign met its goals, RAND conducted an in-person survey of WeRise attendees; a social media analysis of Twitter conversations related to WeRise/WhyWeRise, mental health, mental illness, and well-being; and a web-based survey of a broader population of Los Angeles youth in the age range targeted by WeRise/WhyWeRise.

Overall, the evaluation found evidence that the WeRise/WhyWeRise mental health campaign had impressive reach into the Los Angeles community, with one in five young people exposed to the campaign in some way during the brief period examined. There is early evidence that the campaign might be associated with positive outcomes, such as increased supportive and understanding attitudes toward people with mental illness, awareness of the challenges people with mental illness face, knowledge of how to get help for mental health challenges, and, importantly, empowerment and mobilization toward activism around mental health issues.

Research Questions

1. **Who was reached by the campaign?**
2. **What impact did contact with the campaign have?**

RECOMMENDATIONS

- The campaign should consider using approaches aimed to reduce negative stereotypes and increase mental illness–related knowledge.
- Future events could focus on engaging men, younger audiences, and those who do not already have a connection to mental health.
- The campaign could work toward building stronger social media connections between "mainstream" and social justice–oriented online communities.
- Public attitudes tend to be slow to change, so the campaign should keep doing what it is doing.

Key Findings

The campaign attracted a large number of people

- As many as one in five young people were aware of WeRise or WhyWeRise.
- WeRise was successful in engaging racial and ethnic minorities, especially black and Latino teens.
- The WeRise/WhyWeRise campaign was associated with a moderate increase in Twitter discussion of mental health and well-being.

Those who were exposed to WeRise or WhyWeRise might have benefited from the campaign

- The in-person survey at the event found that those who were present for longer were more likely to express supportive and understanding attitudes toward people with mental illness.
- The large, countywide survey of youth found that those exposed to WeRise or WhyWeRise (either in person or online) were more likely to report feeling empowered and mobilized toward mental health activism — a key goal of the campaign.
- Those exposed to the campaign also had greater awareness of the challenges people with mental illness face, from stigma to treatment-access issues. They were also more likely to know how to get help for their own mental health challenges, consistent with one of the campaign's goals of connecting people to resources.

The WeRise event predominately attracted people who were already interested in and knowledgeable about mental health

- The campaign successfully attracted people for whom mental health was personally relevant, who can readily apply the knowledge and empowerment they get from the campaign to their own life situations.

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 2017-18, the program provided services to 100 individuals, who ranged in age from four (4) to thirty (30) years. An equal number of females (N=50) and males (N=50) participated in the program. With regard to ethnicity, the majority of program participants were Latino (77%); fifteen percent of participants did not specify their race or ethnicity; Caucasians comprised 5%, followed by Asian/Pacific Islander individuals (2%) and Native Americans (1%).

OUTCOMES FOR LATINA YOUTH PROGRAM

(SEE APPENDIX FOR FULL REPORT)

A number of high risk symptoms and behaviors are tracked to measure their severity pre and post intervention. These are based on an ongoing review of literature on death caused by suicide in youth, and include: presence of substance use or abuse, suicidal ideation, past suicidal self directed violence (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. These were initially targeted for identification and treatment based on research findings which correlated them with high risk for suicidality. In subsequent years "issues related to sexual identity" was included as a factor in the list of issues representing high risk for suicidality. 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 measured.

Based on research literature and LYP experience working with children and adolescents dealing with suicidal self-directed violence (suicidality), a total of 13 risk factors were evaluated by program clinicians at intake (Time 1) and at Current or Close of Case (Time 2) for their presence in program participants. These measures were studied for 35 of the program participants. Unfortunately, of the 35 randomly selected cases, only 29 had complete and usable data. The remaining six, either had not been in treatment long enough (three months or more) or the data submitted was incomplete. With regard to specific risk factors, the tables below list incidence rate and intensity at which the factors were endorsed, as well as the difference between pre and post intervention.

RISK FACTORS: INCIDENCE			
NAME	INCIDENCE TIME 1	INCIDENCE TIME 2	CHANGE
Substance Use/Abuse	6	6	0
Suicide Ideation	11	3	-8
Suicide Attempt	1	0	-1
Run Away Behavior	1	0	-1
Communication Problem	26	23	-3
Poor school Functioning	22	19	-3
Difficulty Regulating Emotions	27	25	-2
Legal/Juvenile Justice Involvement	2	3	-1
Sexual Orientation-Gender Identity Distress	4	4	0
Bullying	9	6	-3
Violence (home/community)	6	3	-3
Family High Distress	24	20	-4
Self or Family at Risk of Deportation	4	2	-2
AVERAGE	11	8.8	2.2

OUTCOMES FOR LATINA YOUTH PROGRAM CONTINUED

(SEE APPENDIX FOR FULL REPORT)

RISK FACTORS: INTENSITY			
NAME	Average INTENSITY TIME 1	Average INTENSITY TIME2	CHANGE
Substance Use/Abuse	4.7	3.8	-0.9
Suicide Ideation	6.6	3	-3.6
Suicide Attempt	1	0	-1
Run Away Behavior	5	0	-5
Communication Problem	7.7	5.5	-2.2
Poor school Functioning	7.2	4.2	-3
Difficulty Regulating Emotions	7.6	5.0	-2.6
Legal/Juvenile Justice Involvement	5.5	4.7	-0.8
Sexual Orientation-Gender Identity Distress	5.5	6	+0.5
Bullying	7.4	4.7	-2.7
Violence (home/community)	6.2	6.3	+0.1
Family High Distress	7.0	5.0	-2
Self or Family at Risk of Deportation	6.5	3.5	-3
AVERAGE	6	4	2

Briefly, the range of incidence of risk factors was found to be anywhere from 1 to 27 in the 29 program participants studied. For example, Suicide Attempt and Run Away Behavior were the risk factors less likely to be identified as problematic. They were found to be present only in one each of the program participants at Time One, and were completely absent when measured at Time Two. The risk factors with the highest incidence rates were Difficulty Regulating Emotions, Communication Problems, Family High Distress and Poor School Functioning. Their incidence at Time One was 27, 26, 24 and 22 respectively, and decreased to 25, 23, 20 and 19 at Time Two. On average, the incidence of any one risk factor was 11 at Time 1. Post intervention (Time 2) the range of incidence of any of the risk factors was 0 to 25 with an average of 9. This is a reduction in incidence of 2, suggesting that less program participants were experiencing difficulty with those factors whose incidence decreased. Most importantly the “Suicide Ideation” risk factor went from being endorse by 11 to only 3 participants from Time 1 to Time 2, this reflects 8 participants who no longer are experiencing suicidal thoughts.

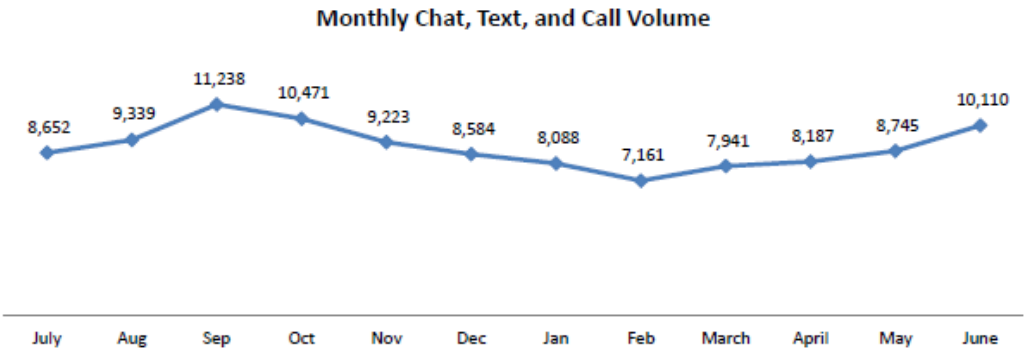
With regard to intensity of experience, clinicians rated program participants’ difficulty with the risk factors on a scale from 0-10, with 0 being “not a problem at all,” to 10 being “extremely problematic.” In this regard, the intensity was on average a 6 at Time One and a 4 at Time Two, reflecting a 2-point decrease in how problematic the risk factors were for the participants. Two risk factors were found to increase in intensity. Sexual Orientation-Gender Identity Distress increased 0.5 and problems due to Bullying increased 0.1. These negligent increases may suggest a greater willingness for clients to identify problems with these issues as time in services progresses, or an increased awareness of these as issues present in and impacting their lives, as clients develop greater insight. Conversely, the intensity at which other risk factors were experienced as problematic decreased on average by 2 points. The greatest decrease in intensity was found in the risk factor Run Away behavior, with a 5 point reduction and Suicidal Ideation, with a 3.6 point decrease. As discussed earlier, risk factors occur in clusters. Program participants were found to have difficulty with anywhere from two to eleven risk factors at Time One and this range went down to 0 to 7 at Time 2. These results suggest that the programs’ interventions are having the desired outcomes on the target population.

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.

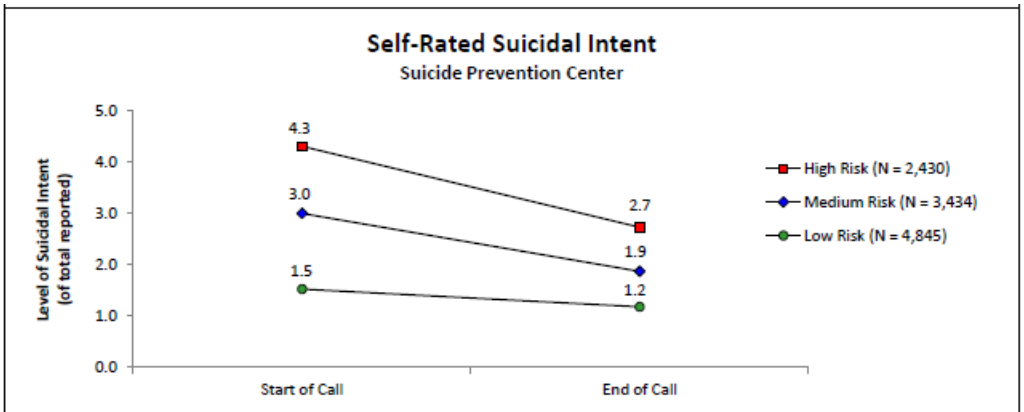
OUTCOMES FOR 24/7 CRISIS HOTLINE

(SEE APPENDIX FOR FULL REPORT)



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

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.

- Callers who rated their suicidal intent as high or imminent risk at the start of the call showed a 59% 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 showed a 58% reduction in their intent by the end 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 133 suicide prevention events during Fiscal Year (FY) 2017-2018, outreaching to more than 2,051 Los Angeles County residents. These events included countywide educational trainings, participation in suicide prevention community events, the 7th Annual Suicide Prevention Summit, and collaboration with various agencies and partners. PSP's accomplishments included:

- The PSP team provided three ASIST (Applied Suicide Intervention Skills Training) trainings throughout the County to 63 participants and continued its collaboration with adjunct ASIST trainers from outside of DMH which increased its training capacity countywide, particularly in service areas further from metro Los Angeles.
- Provided 39 QPR (Question, Persuade and Refer) gatekeeper trainings throughout the County, totaling 1,116 community members trained in QPR by the PSP team during FY 2017-18.
- Provided 28 MHFA (Mental Health First Aid) trainings which is designed to teach members of the community to recognize the symptoms of mental health concerns, offer and provide initial help, and guide the individual to professional help if appropriate. Additionally 3 YMHFA (Youth Mental Health First Aid) trainings were held, with 65 community members trained to recognize symptoms of mental health concerns in youth ages 12-18.
- Four AMSR (Assessing & Managing Suicide Risk) trainings were completed this fiscal year, with a total of 114 clinicians, case managers, and nurses in both directly-operated programs and contracted providers being trained. AMSR trains on the 24 core competencies related to suicide risk assessment and reviews safety planning.
- Provided one Recognizing and Responding to Suicide Risk (RRSR) trainings to 25 participants. 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: 9/28/17, 12/7/17, 3/16/18, and 6/8/18.
- Partners in Suicide Prevention participated in Parks After Dark for the 7th year in a row. PAD was launched in 2010, at three County Parks, as the prevention component of the County's Gang Violence Reduction Initiative. PAD has successfully expanded to 33 parks Countywide and evolved into a key prevention and intervention strategy that utilizes cross-sector collaborations to promote health, safety, family cohesion, community well-being and equity in our underserved communities. This year PSP participated in 8 Parks After Dark events.

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

- 7th Annual Suicide Prevention Summit "The Suicide Contagion Effect: Why Does it Happen, What We Know, & What We Can Do": held on Thursday, September 7, 2017 at the California Endowment and featured April C. Foreman, Ph.D. as keynote speaker. The theme for this year's Summit stemmed from criticism around the program "13 Reasons Why" and its depiction of suicide among high school students. Topics addressed included suicide contagion in schools, the impact (positive and negative) of social media, school response in the event of a suicide, and a discussion of a model suicide prevention program in a local school district. Additionally, there was a 'special session' geared towards clinicians that addressed professional anxieties around the use of social media. Approximately 165 attendees from mental health, education, law enforcement, and community-based organizations took part in this event which was organized and implemented by DMH and partners such as Teen Line, Didi Hirsch, and Santa Monica College.
- Throughout FY 16/17, the Older Adult System of Care outreached to community-based as well as faith-based organizations throughout the County to identify approximately 150 community members to be trained as QPR instructors in an effort to broaden the capacity of this suicide prevention gatekeeper model. The members were trained during the latter portion of FY 16/17 and began their trainings in the community during FY 17/18. Throughout this FY, 26 of these instructors remained active, training 817 of their fellow community members in this suicide prevention gatekeeper model. To strengthen the reach of this project, QPR materials were translated into Chinese, Amharic, and Korean, along with the already-existing Spanish. Instructors who spoke these languages were specifically identified to provide QPR to their respective communities.
- In an effort to increase capacity to provide RRSR, eight (8) DMH staff, most from outside of PSP, were trained in February 2018 by the American Association of Suicidology to become RRSR trainers. A RRSR Training of Trainers has not been held at DMH since approximately 2012, so a new cohort of RRSR trainers has been essential to PSP and DMH's suicide prevention efforts.

OUTCOMES FOR PARTNERS IN SUICIDE

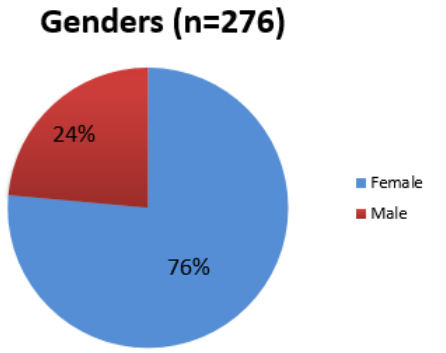
Survey Results

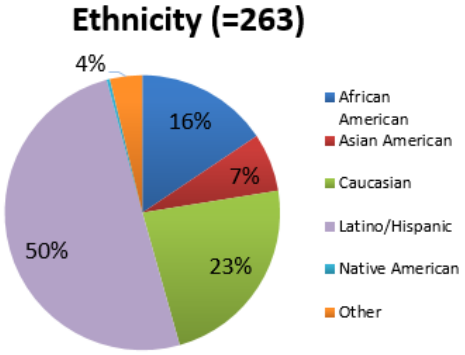
Surveys: 363

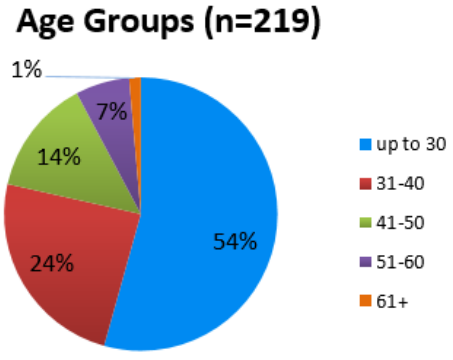
Los Angeles County Department of Mental Health has chosen to implement a suicide prevention program in the form of training and education that has shown to be effective in changing attitudes, knowledge, and/or behavior regarding suicide. Participants in these trainings include but are not limited to first responders, teachers, community members, parents, students, and clinicians. For trainings conducted in FY 2017-18, 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.

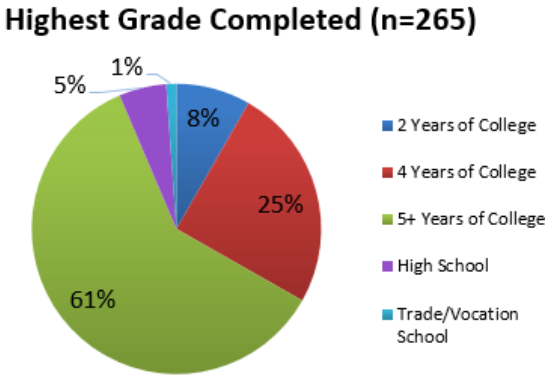
The number of surveys received in FY 2017-18 decreased by 70% from the previous fiscal year (1,197).

The are two possible causes for the decrease: 1) decrease from last year to this year in survey collection rates and/or 2) decrease from last year to this year in the number of people receiving SDR programs.









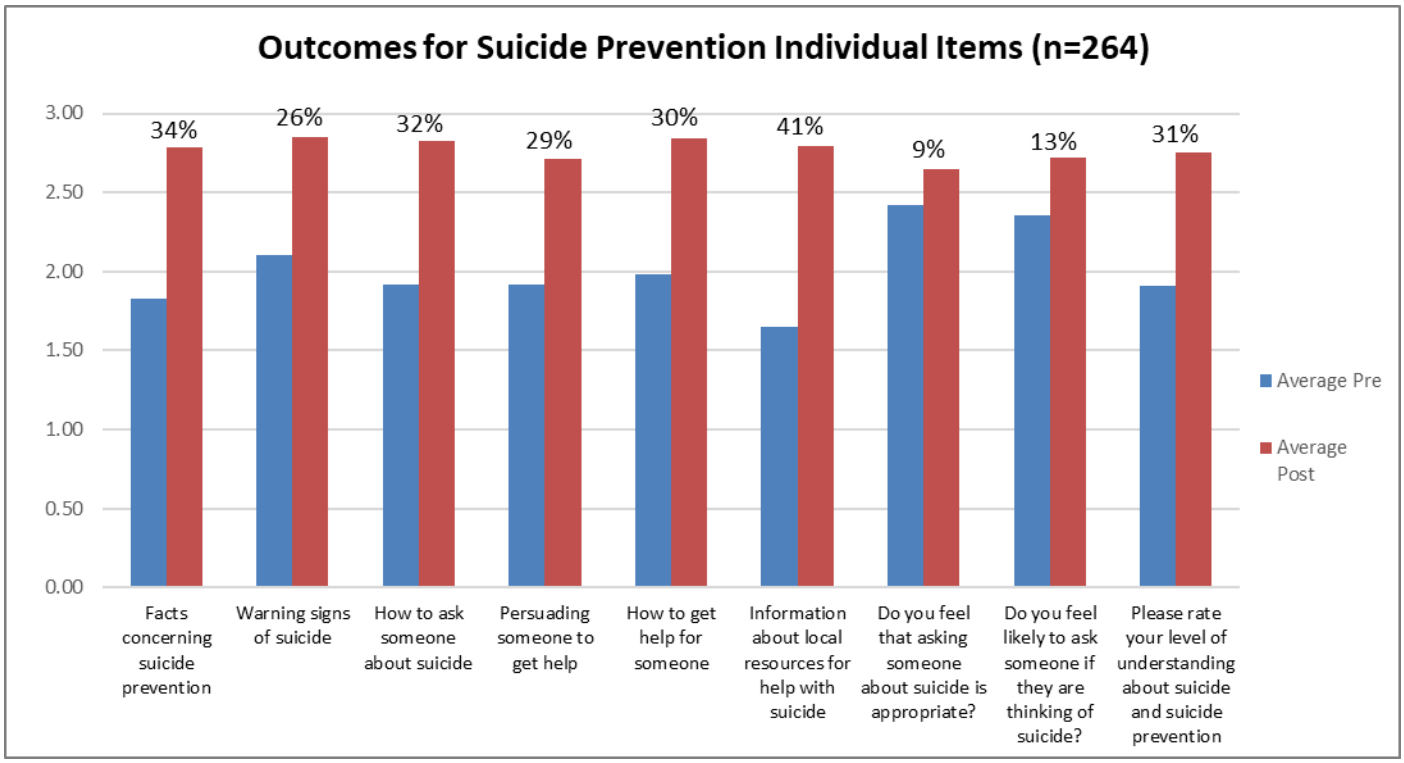
SUICIDE PREVENTION

The SP survey has 9 items. Scores from the 9 items are added together to create a total Knowledge score. The total score can fall into one of three ranges: Low Knowledge, Medium Knowledge, or High Knowledge. An increase in the total scores from "pre" to "post" suggests having more information about suicide. Survey results for FY 17-18 suggest participants' knowledge about suicide and suicide prevention increased through training and education:

- The average score increased by 27% from "pre" to "post" (243).
- The average "pre" score fell in the Medium Knowledge range and the average "post" score fell in the High Knowledge range.
- Prior to training, 21% of participants' (52) scores fell in the High Knowledge range. Post training, 91% of participants' (222) scores fell in the High Knowledge range, an increase of 80%
- Prior to training, 24% of participants' (59) scores fell in the Low Knowledge Range. "Post" training, all of these 59 participants' scores fell in the Moderate Knowledge Range (12%) or High Knowledge Range (84%).

Suicide prevention trainings have shown positive outcomes since inception in FY 2013-14. In FY 2013-14 and 2014-15 combined, participants showed an average 30% increase, in FY 2015-16 an average 25% increase, and in FY 2016-17 an average 24% increase.

Below, is chart showing the average percent change in score from "pre" to "post" training for each of the nine suicide prevention survey items in FY 2017-18, as well as few statements about the results.



- Items 1 and 6 showed the greatest improvement in score from "pre" to "post", increasing by 34% and 41%, respectively.
- Items 7 and 8 showed the least improvement in score from "pre" to "post", increasing by 9% and 13%, 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 because there was less room for improvement 2) items 1-6 and 9 measure changes in knowledge while items 7 and 8 measure changes in behavior. Typically, for instructive interventions like Suicide Prevention, measures of knowledge show greater change from "pre" to "post" treatment than measures of behavior.

SCHOOL THREAT ASSESSMENT RESPONSE TEAM (START)

The START 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 2017-18, the School Threat Assessment Response Team (START) provided 1820 services to 305 individuals at potential or real threat to harm self and/or others on campus: 86 open cases and 219 potential cases. The law enforcement and schools continued to be the two main referral sources. After years of services delivered in the Los Angeles County, START has become one of the major violence crisis management resources in addition to the law enforcement.

START's challenge centered on a decline in the number of staff and increased in demand for services in Fiscal Year 2017-18. Nearly half the number of staff was to be filled. The number of referrals increased from 216 in Fiscal Year 2016-17 to 259 in Fiscal Year 2017-18. Note that it surged from 6 cases in July, 2017 to 53 in February, 2018 following the school shooting in Parkland, Florida. In addition to MOSAIC and Columbia-Suicide Severity Rating Scale (C-SSRS), two new violent threat assessments were being implemented: Structured Assessment of Violence Risk in Youth (SAVRY) and Workplace Assessment of Violence Risk-21 (WAVR-21). These two tools were chosen by the START clinicians. They do not quantitatively calculate the total scores (the risk levels), but present the risk factors. The presence of same risk factors may be weighted differently by various users, and which results in different risk levels. Therefore, the reported outcomes for Fiscal Year 2017-18 will be based on a combination of assessment tools, collateral information, clinical observation, and other reliable sources.

Of the 86 open cases, male and female were 74.42% and 25.58% (Table 1). 39.54% aged between 0 and 15, while 46.51% aged between 16-25, and 13.95% older than 25 years. Note that the 0-15 age group declined from 51.18% in Fiscal Year 2016-17 to 39.54% in Fiscal Year 2017-18, while the 16-25 age group increased from 31.50% to 46.51%. English continued to be the most spoken language: 87.21% (Table 3). Hispanic clients made up of 48.84% of the 86 clients (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 3 was the most served area (19.77%) replacing SA 2 in prior fiscal year, followed by SA 8 (16.28%), SA's 2, 4, and 6 (15.12%), SA 7 (11.63%), SA 5 (4.65%), and SA 1 (2.31%).

SUICIDE PREVENTION

A. Demographics

Table 1 Gender

Gender	Client Count	%
Male	64	74%
Female	22	26%
Total	86	100%

Table 2 Age

Age Group	Client Count	%
0-15	34	40%
16-25	40	47%
26-59	12	14%
Total	86	100%

Table 3 Spoken Language

Language	Client Count	%
English	75	87%
Spanish	9	10%
Farsi	2	2%
Total	86	100%

Table 4 Ethnicity

Ethnicity	Client Count	%
Hispanic	42	49%
White	17	20%
African American	9	10%
Chinese	3	4%
Other	15	17%
Total	86	100%

Table 5 Service Area

Ethnicity	Client Count	%
SA1-Antelope Valley	2	2%
SA2- San Fernando	13	15%
SA3- San Gabriel	17	20%
SA4- Metro	13	15%
SA5- West	4	5%
SA6- South	13	15%
SA7- East	10	12%
SA8- South Bay/Harbor	14	16%
Total	86	100%

B. Primary Diagnosis

The most common primary diagnosis was Mood Disorder (36.05%), followed by Major Depressive Disorder (27.91%), Adjustment Disorder and Schizophrenia Spectrum and Other Psychotic Disorder (8.14), Bipolar and related Disorder and Disruptive, Impulse-control and Conduct Disorder (5.81%) and Anxiety Disorder (4.65%).

Table 6: Primary Diagnosis

Primary Diagnosis	Client Count	%
Mood Disorder	31	36%
Major Depressive Disorder	24	28%
Adjustment Disorder	7	8%
Schizophrenia Spectrum & Other Psychotic Disorder	7	8%
Bipolar and related Disorder	5	6%
Disruptive, Impulse-Control, and Conduct Disorder	5	6%
Anxiety Disorder	4	5%
Encounter for observation for other suspected disease and conditions ruled out	1	1%
Obsessive-compulsive & related Disorder	1	1%
Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence	1	1%
Grand Total	86	100%

C. Services Rendered

Of the 86 open cases, 38 (44.19%) clients were admitted within the same day of the referrals received, 5 (5.81%) within two days, 8 (9.30%) within a week, and 35 (40.70%) exceeded one weeks partially due to difficulty in reaching the clients. In Fiscal Year 2017 -18, START admitted 45 (52.33%) cases and discharged 56 (65.12%) clients of the 56, 20 (23.26%) were admitted and discharged in the same fiscal year.

In addition to the 86 active clients, 219 refer-in cases were outreached to determine their eligibility for the START Program services. If follow-up was required to engage those potential cases, the clinicians extended their services beyond one visit.

1820 services were rendered: 757 (41.59%) to the 86 open cases, 825 (45.33%) to those 219 individuals whose cases were not activated because they were reluctant or ineligible for START Program services, and 238 (13.08%) to the community in general.

D. Changes in Violent and Suicidal Risk Level

In Fiscal Year 2017-18, 56 clients were closed with 10 dropped out early and 46 completed treatment cycles. Below table outlines the change in suicidal and violent risk levels between initial and final contacts. 30 clients posed low suicidal risk throughout the treatment cycles, 10 from medium to low, and 7 from high to low. As for the violent risk levels, 29 cases improved from medium to low violent risk levels, 9 remained low throughout the treatment cycles, 7 from high to low, 1 from high to medium, and 1 medium to medium.

Table 7: Change of Suicidal and Violent Risk Levels between Initial and Final Contacts

Outcome	Change in Suicidal Risk Level	%	Change in Violence Risk Level	%
H to H	0	0.00%	0	0.00%
H to M	0	0.00%	1	1.79%
H to L	7	12.50%	7	12.50%
M to M	0	0.00%	1	1.79%
M to L	10	17.86%	29	51.79%
L to M	0	0.00%	0	0.00%
L to L	30	53.57%	9	16.07%
Early drop out	9	16.07%	9	16.07%
Total	56	100.00%	56	100.00%

E. Trainings

In FY 2017-18, START provided 42 trainings to 1518 attendees in the four subject matters: bullying, targeted school violence, orientation to START services, and suicide prevention.

Table 8: Trainings

Training	Bullying		Targeted School Violence		START		Suicide Prevention	
	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees
12th Grade or below	0	0	0	0	1	30	0	0
College Students	0	0	0	0	11	537	2	50
Professional	1	67	7	212	15	422	3	90
Parent / Other	0	0	0	0	0	0	2	110
Total	1	67	7	212	27	989	7	250

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

Appendix

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SCHOOL BASED SERVICES

FOR

LATINA YOUTH PROGRAM (LYP)

Evaluation Report

CONTRACT YEAR 2017-2018

Pacific Clinics
ADVANCING BEHAVIORAL HEALTHCARE

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 the Latina Youth Program (LYP), for the contract year 2017-2018 (FY 17 - 18). This report contains the results of ongoing literature review updates, which inform program objectives, goals and outcome measures; client demographic information; and documentation on program services and outcomes. Data for this evaluation was gathered through various sources. Current literature was reviewed. Information was also gathered from the U.S. Center for Disease Control (CDC) on youth suicidal self-directed violence and death by suicide in general and in Latina youth in particular. Client data has been gathered from computer generated reports used to monitor program activities. Program staff completed assessment questionnaires regarding risk factor incidence and intensity in program participants. The report is designed to give an overview of program participants, the mental health issues they deal with, suicide behavior, program performance, and outcomes.

SUMMARY

Suicidal Self-directed Violence (suicide) is the second-leading cause of death for children, teens and young people ages 5 to 24 years, according to the U.S. Center for Disease Control and Prevention (June, 2018). In California suicide rates in general have risen 14.8 percent from where they were in 1999. Mental illness is the leading risk factor for suicide. More than 90 percent of people who die by self-directed violence (suicide), suffer from depression and other mental disorders, often exacerbated by substance-abuse disorders. Females with a mental health condition are about twice as likely to commit suicide than their female counter parts without a known mental health condition. This same risk factor is not true for males (CDC, June 2018).

Implemented in 2001 as a demonstration project focusing on Latina adolescent suicide prevention, the Pacific Clinics Latina Youth Program (LYP) is now in its 18th year of services. During the 2017 - 2018 contract year (FY 17-18), the program provided services to 100 individuals, who ranged in age from four to thirty years. The greatest majority of clients were within the 13 to 19 years of age range. An equal number of females (N=50) and males (N=50) participated in the program. With regard to ethnicity, the majority of program participants were Latinix (77%); fifteen percent of participants did not specify their race or ethnicity; Caucasians comprised 5%, followed by Asian/Pacific Islander individuals (2%) and Native Americans (1%). The program is designed to decrease physical barriers to services by going out into the community. Pacific Clinics has collaborative agreements to provide services in 35 schools and services are provided in 10 different cities. Program participants originate from 35 different cities throughout Los Angeles County.

In terms of length of services, client participation in the program ranged from 1 to 12 months, with an average of 4.7 months. The program provided a total of about 1,913 hours of services during this contract year. The average cost per client during contract

year was $3,713.78. The majority of program participants were diagnosed with some type of depressive disorder (56%). An additional 23% were assessed to be suffering from an anxiety related disorder and another 21% were diagnosed with other disorders such as those related to attention deficit and other behavioral problems.

A total of 13 risk factors were evaluated by program clinicians at intake and at either current or close of case for their incidence and level of intensity in program participants. These risk factors include: Substance Use/Abuse; Suicide Ideation; Suicide Attempt; Run Away Behavior; Communication Problems; Poor School Functioning; Difficulty Regulating Emotions; Legal/Juvenile Justice Involvement; Sexual Orientation-Gender Identity Distress; Bullying; Violence (home/community); Family High Distress; and, added most currently due to the political climate and its impact on children and families, Self or Family at Risk of Deportation. The risk factors with the highest incidence rates were Difficulty Regulating Emotions, Communication Problems, Family High Distress and Poor School Functioning. The Suicide Ideation risk factor had the most significant decrease in incidence.

With regard to intensity of experience of the risk factors, clinicians rated program participants' difficulty with the risk factors on a scale from 0-10, with 0 being "not a problem at all," to 10 being "extremely problematic." A 2-point decrease in how problematic the risk factors were for the participants was found on average. The greatest decrease in intensity was found in the risk factors Run Away Behavior and Suicidal Ideation. These results suggest that the programs' interventions are having the desired outcomes on the target population.

BACKGROUND

Suicidal Self-directed Violence (suicide) is the second-leading cause of death for children, teens and young people ages 5 to 24 years. It is surpassed only by accidents, primarily motor vehicle fatalities, according to the U.S. Center for Disease Control and Prevention (June, 2018). Suicidal ideation, suicide attempts and death by suicide are on the rise for those aged 10 to 19 years. One in five teenagers in the U.S. seriously considers suicide annually; 8 percent of adolescents attempt suicide, representing approximately 1 million individuals. Of these, nearly 300,000 receive medical attention for the attempt; and approximately 1,700 teenagers die by suicide each year. Additionally, suicide rates have continued to rise in every state of the U.S., and suicide is one of just three of the leading causes of death that are on the rise while the rate of other causes of death decreases in this age group. In California suicide rates in general have risen 14.8 percent from where they were in 1999. Over the past 15 years, suicide rates in the general population have risen by 30 percent. It is estimated that 69 billion dollars are spent annually due to deaths as a result of suicidal self-directed violence, in direct, medical and lost productivity costs.

Mental illness is the leading risk factor for suicide. More than 90 percent of people who die by self-directed violence (suicide), suffer from depression and other mental disorders, often exacerbated by substance-abuse disorders. Among younger children, suicide

attempts are often impulsive. They may be associated with feelings of sadness, confusion, anger, or problems with attention and hyperactivity. A number of external circumstances seem to overwhelm at-risk teens who are unable to cope with the challenges of adolescence. Examples of stressors are disciplinary and legal problems, interpersonal losses, family and community violence, sexual orientation confusion, physical and sexual abuse, run away behavior, and being the victim of bullying. Risk behaviors associated with suicide in children and young people are likely to occur in clusters e.g., various risk factors present in one individual at the same time, rather than any one risk factor on its own. Trends indicate that adolescent risk behavior may become increasingly problematic in the future, as the initiation of risky behaviors is occurring at progressively younger ages. Finally, other factors associated with increased risk for suicidality include poverty, lack of insurance coverage which affects access to preventative and early health and mental health care, and the experience of systemic oppression i.e., racism, sexism, homophobia, threat of deportation, etc.

LYP (Latina Youth Program)

A lengthy description of the program was provided in the 2016-2017 evaluation report. Here, a brief recount is given: Implemented in 2001 as a demonstration project focusing on Latina adolescent suicide prevention, the Pacific Clinics Latina Youth Program (LYP) is now in its 18th year of services. The 1999 COSSMHO report found that Latina youth were subject to the most serious risk and threat of pregnancy, substance abuse, depression, delinquency and high rates of dropping out of school. These are risk factors often associated with increased risk for suicidality. Not surprisingly the Los Angeles County suicide data at that time, reflected that 80% of suicides in the group of individuals between 10 and 17 years old, were committed by Hispanics. This represented a 33% increase from 1997. As stated above, the picture for death by self-directed violence (suicide) continues to be alarming. Rates of death by suicide, and by implication attempts are on a steady upward tick. Forty-five thousand people die as a result of suicide each year, that is equivalent to one life lost every 12 minutes. Further, approximately one million people attempted suicide in the past year, according to the CDC. Mental disorders continue to play a major role. The CDC reports that of those individuals who die by suicides: in individuals with known mental health conditions, 31% are female and 69% are male; of those individuals who do not have a known mental health condition, 16% are female and 84% are male. Thus, females with a mental health condition are about twice as likely to commit suicide as their female counter parts without a known mental health condition. This same risk factor is not true for males (CDC, June 2018).

Based on the long standing experience of Pacific Clinics and the research literature a school-based program was determined to have the greatest chance of reaching and connecting with those children and adolescents most in need of the program's services. Additionally, locating the program within the schools has allowed Pacific Clinics to impact families, the school staff and the greater community in a more effective way, with regard to enlisting their collaboration in addressing the needs of "at-risk" youth, with regard to suicide prevention. LYP is designed as a collaborative, school based, education, early

intervention, and intensive services program. Pacific Clinics has coordinated the collaboration of many diverse agencies in support of this program. These agencies include community-based organizations, service providers, schools, churches, and local, county, state and federal government representatives.

The primary goals of the Program continue to be: To promote 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; 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 early intervention and health promotion; and to enhance awareness and education among school staff and community members regarding substance abuse and depression.

A number of high risk symptoms and behaviors are tracked to measure their severity pre and post intervention. These are based on an ongoing review of literature on death caused by suicide in youth, and include: presence of substance use or abuse, suicidal ideation, past suicidal self directed violence (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. These were initially targeted for identification and treatment based on research findings which correlated them with high risk for suicidality. In subsequent years "issues related to sexual identity" was included as a factor in the list of issues representing high risk for suicidality. 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 measured.

2017 – 2018 CONTRACT YEAR LYP PERFORMANCE

CLIENT DEMOGRAPHICS

During the 2017 - 2018 contract year, the program provided services to 100 individuals, who ranged in age from four to thirty years. The greatest majority of clients were within the 13 to 19 years of age range. An equal number of females (N=50) and males (N=50) participated in the program. With regard to ethnicity, the majority of program participants were Latinix (77%); fifteen percent of participants did not specify their race or ethnicity; Caucasians comprised 5%, followed by Asian/Pacific Islander individuals (2%) and Native Americans (1%). The tables below summarize this information.

GENDER	
	Number
Male	50
Female	50
ETHNICITY- RACE	
	Number
American Indian	1
Black/African	
Latino/Hispanic/Latinx	77
Asian	2
White/Caucasian	5
Other Not Specified	15

AGE	
Age	Total
4	1
6	1
7	3
8	2
9	2
11	2
12	4
13	8
14	8
15	8
16	12
17	15
18	15
19	10
20	4
21	1
22	1
23	1
24	1
30	1
Total	100

SERVICES

Client participation in the program ranged from 1 to 12 months. On average, clients received services for 4.7 months, for an average of about 20 contacts. This represents an average of 1,248 minutes of contact time. The program provided a total of about 1,913 hours of services during this contract year. The average cost per client during this contract year was $3,713.78, compared to the average County cost for the same period of $3,171.79. This $541.99 difference may reflect the higher needs clients seen by a program that focusses on suicide-related prevention and treatment have, versus those clients seen by other types of prevention programs.

The majority of program participants were diagnosed with some type of depressive disorder (56%). An additional 23% were assessed to be suffering from an anxiety related disorder and another 21% were diagnosed with other disorders such as those related to attention deficit and other behavioral problems. The tables below list the diagnoses, the number of unduplicated clients within each diagnosis and the number of contacts received by those clients. On average clients with a depression related diagnosis received approximately 16 contacts, while those diagnosed with an anxiety related disorder received about 24 contacts, and clients under other categories of diagnoses received about 21 contacts. As stated above, overall participants in the LYP received on average 20 contacts. The client with Panic Disorder without Agoraphobia required the most services, followed by those with a diagnosis of Post Traumatic Stress Disorder and Attention-deficit Hyperactivity disorder, predominantly hyperactive type.

DEPRESSIVE DISORDERS		
DIAGNOSIS	N	CONTACTS
Dysthymic disorder	21	264
Major depressive disorder, single episode, moderate	9	95
Major depressive disorder, recurrent, moderate	8	142
Major depressive disorder, single episode, unspecified	5	95
Major depressive disorder, recurrent severe w/o psych features	5	77
Major depressive disorder, single episode, severe w/o psych features	4	81
Major depressive disorder, recurrent, mild	2	32
Major depressive disorder, recurrent, in partial remission	1	19
Major depressive disorder, single episode, mild	1	97
	56	X = 16

ANXIETY RELATED DISORDERS		
DIAGNOSIS	**N**	**CONTACTS**
Generalized anxiety disorder	12	284
Post-traumatic stress disorder, unspecified	3	100
Adjustment disorder with anxiety	2	45
Anxiety disorder, unspecified	2	10
Post-traumatic stress disorder, chronic	2	23
Panic disorder without agoraphobia	1	56
Post-traumatic stress disorder, acute	1	40
	23	X = 24

OTHERS		
DIAGNOSIS	**N**	**CONTACTS**
Oppositional defiant disorder	6	120
Attention-deficit hyperactivity disorder, combined type	4	99
Adjustment disorder w mixed disturbance of emotions and conduct	2	32
Adjustment disorder with mixed anxiety and depressed mood	2	32
Attention-deficit hyperactivity disorder, predominantly hyperactive type	2	82
Attention-deficit hyperactivity disorder, predominantly inattentive type	2	30
Unspecified mood [affective] disorder	2	35
Adjustment disorder, unspecified	1	10
	21	X = 21

LOCATIONS

The program is designed, among other things, to decrease physical barriers to services by going out into the community. Pacific Clinics has collaborative agreements to provide services in 35 schools. Of these, 14 are elementary, 12 are middle and 9 are senior high schools. The program provides services in 10 different cities. The tables below reflect the types of schools with which Pacific Clinics collaborates and the cities in which programs are located. Program participants originate from 35 different cities, throughout Los Angeles County.

SCHOOL TYPE	
Elementary Schools	14
Middle Schools	12
High Schools	9
TOTAL	35

LOCATINOS	
CITY	NUMBER OF PROGRAMS
El Monte	2
La Mirada	2
La Puente	2
Montebello	3
Monrovia	2
Norwalk	3
Pasadena	2
Pico Rivera	2
Santa Fe Springs	3
Whittier	14
TOTAL	35

RISK FACTORS

As stated previously, based on research literature and LYP experience working with children and adolescents dealing with suicidal self-directed violence (suicidality), a total of 13 risk factors were evaluated by program clinicians at intake (Time 1) and at Current or Close of Case (Time 2) for their presence in program participants. These measures were studied for 35 of the program participants. Unfortunately, of the 35 randomly selected cases, only 29 had complete and usable data. The remaining six, either had not been in treatment long enough (three months or more) or the data submitted was incomplete. With regard to specific risk factors, the tables below list incidence rate and intensity at which the factors were endorsed, as well as the difference between pre and post intervention.

RISK FACTORS: INCIDENCE			
NAME	INCIDENCE TIME 1	INCIDENCE TIME 2	CHANGE
Substance Use/Abuse	6	6	0
Suicide Ideation	11	3	-8
Suicide Attempt	1	0	-1
Run Away Behavior	1	0	-1
Communication Problem	26	23	-3
Poor school Functioning	22	19	-3
Difficulty Regulating Emotions	27	25	-2
Legal/Juvenile Justice Involvement	2	3	-1
Sexual Orientation-Gender Identity Distress	4	4	0
Bullying	9	6	-3
Violence (home/community)	6	3	-3
Family High Distress	24	20	-4
Self or Family at Risk of Deportation	4	2	-2
AVERAGE	11	8.8	2.2

RISK FACTORS: INTENSITY			
NAME	Average INTENSITY TIME 1	Average INTENSITY TIME2	CHANGE
Substance Use/Abuse	4.7	3.8	-0.9
Suicide Ideation	6.6	3	-3.6
Suicide Attempt	1	0	-1
Run Away Behavior	5	0	-5
Communication Problem	7.7	5.5	-2.2
Poor school Functioning	7.2	4.2	-3
Difficulty Regulating Emotions	7.6	5.0	-2.6
Legal/Juvenile Justice Involvement	5.5	4.7	-0.8
Sexual Orientation-Gender Identity Distress	5.5	6	+0.5
Bullying	7.4	4.7	-2.7
Violence (home/community)	6.2	6.3	+0.1
Family High Distress	7.0	5.0	-2
Self or Family at Risk of Deportation	6.5	3.5	-3
AVERAGE	6	4	2

Briefly, the range of incidence of risk factors was found to be anywhere from 1 to 27 in the 29 program participants studied. For example, Suicide Attempt and Run Away Behavior were the risk factors less likely to be identified as problematic. They were found to be present only in one each of the program participants at Time One, and were completely absent when measured at Time Two. The risk factors with the highest

incidence rates were Difficulty Regulating Emotions, Communication Problems, Family High Distress and Poor School Functioning. Their incidence at Time One was 27, 26, 24 and 22 respectively, and decreased to 25, 23, 20 and 19 at Time Two. On average, the incidence of any one risk factor was 11 at Time 1. Post intervention (Time 2) the range of incidence of any of the risk factors was 0 to 25 with an average of 9. This is a reduction in incidence of 2, suggesting that less program participants were experiencing difficulty with those factors whose incidence decreased. Most importantly the "Suicide Ideation" risk factor went from being endorse by 11 to only 3 participants from Time 1 to Time 2, this reflects 8 participants who no longer are experiencing suicidal thoughts.

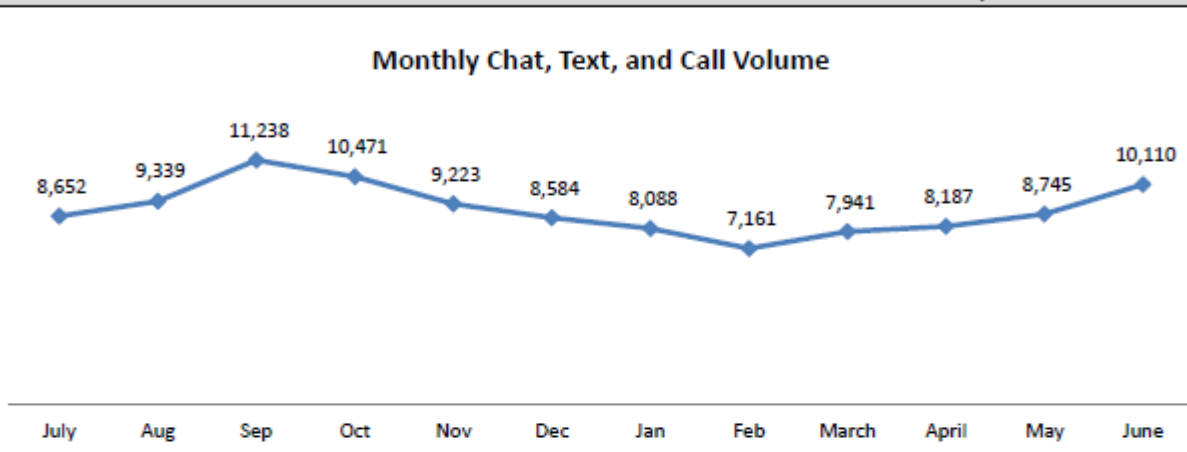
With regard to intensity of experience, clinicians rated program participants' difficulty with the risk factors on a scale from 0-10, with 0 being "not a problem at all," to 10 being "extremely problematic." In this regard, the intensity was on average a 6 at Time One and a 4 at Time Two, reflecting a 2-point decrease in how problematic the risk factors were for the participants. Two risk factors were found to increase in intensity. Sexual Orientation-Gender Identity Distress increased 0.5 and problems due to Bullying increased 0.1. These negligent increases may suggest a greater willingness for clients to identify problems with these issues as time in services progresses, or an increased awareness of these as issues present in and impacting their lives, as clients develop greater insight. Conversely, the intensity at which other risk factors were experienced as problematic decreased on average by 2 points. The greatest decrease in intensity was found in the risk factor Run Away behavior, with a 5 point reduction and Suicidal Ideation, with a 3.6 point decrease. As discussed earlier, risk factors occur in clusters. Program participants were found to have difficulty with anywhere from two to eleven risk factors at Time One and this range went down to 0 to 7 at Time 2. These results suggest that the programs' interventions are having the desired outcomes on the target population.

Pacific Clinics

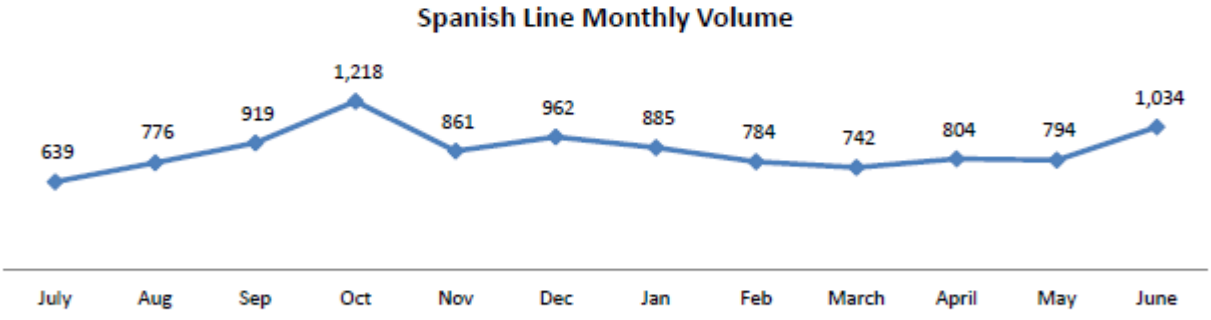
ADVANCING BEHAVIORAL HEALTHCARE

SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

CALL ANALYSIS FOR FISCAL YEAR 2017-2018	
	Fiscal Year 17-18
TOTAL CALLS	99,574
TOTAL CHATS	8,079
TOTAL TEXTS	86
GRAND TOTALS	107,739



Total Calls by Language	
	Fiscal Year 17-18
Korean	24
Spanish	10,418
Vietnamese	6



Total Calls, Chats, and Texts for the Top Counties in California		
County	Fiscal Year 17-18	Percentage of State
Los Angeles	37,361	43%
Orange	11,608	13%
San Bernardino	5,675	7%
Riverside	5,029	6%
Santa Clara	2,829	3%
Ventura	2,190	3%

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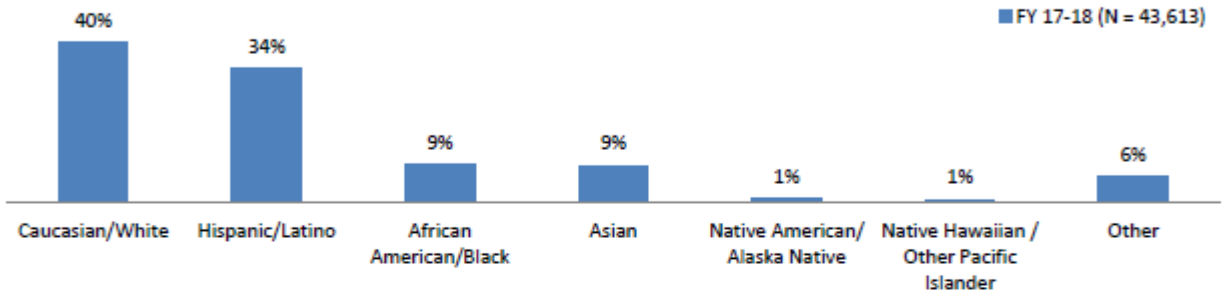
SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

Didi Hirsch MENTAL HEALTH SERVICES

2017-2018 DEMOGRAPHICS
Gender

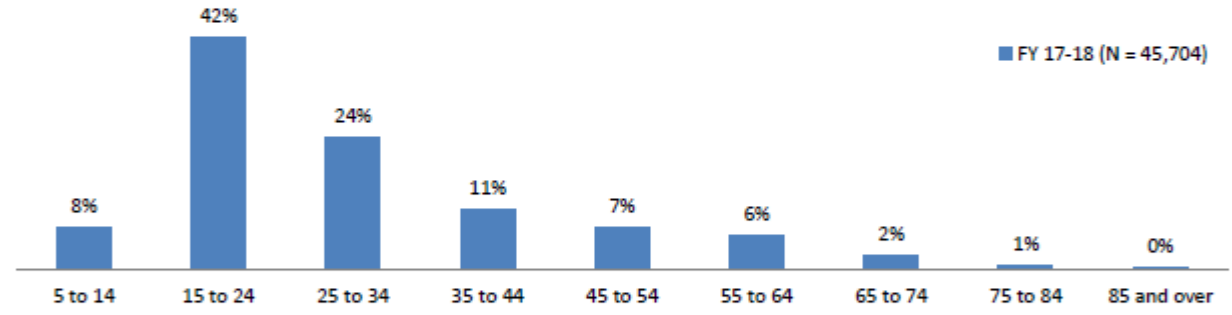
	Fiscal Year 17-18
Female	35,925
Male	30,150

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 17-18	Percentage
Suicidal Desire	27,828	48%
Relationship/ Family Issues	20,480	35%
Depression	18,531	32%
Past Suicidal Ideation/Attempt	16,357	28%
Anxiety/Stress	16,314	28%

*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.

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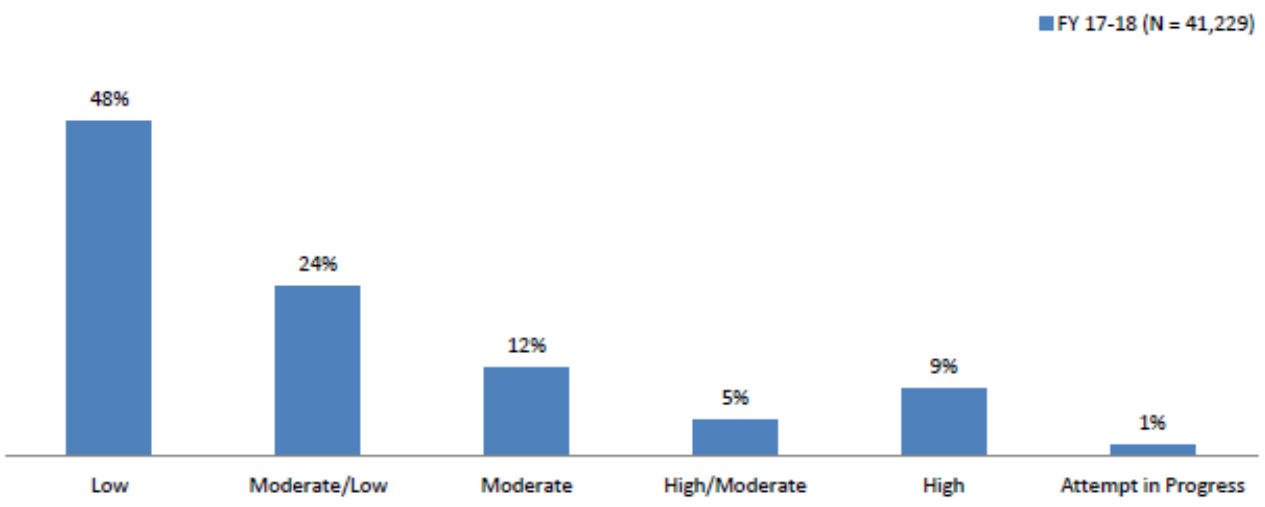
SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

SUICIDE RISK ASSESSMENT		
Rates of Suicide Risk Factors among Callers (callers may identify more than one)		
	Fiscal Year 17-18	**Percentage**
History of Psychiatric Diagnosis	14,836	30%
Prior Suicide Attempt	13,876	28%
Substance Abuse - Current or Prior	8,543	17%
Suicide Survivor	4,988	10%
Access to Gun	1,751	3%

**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.

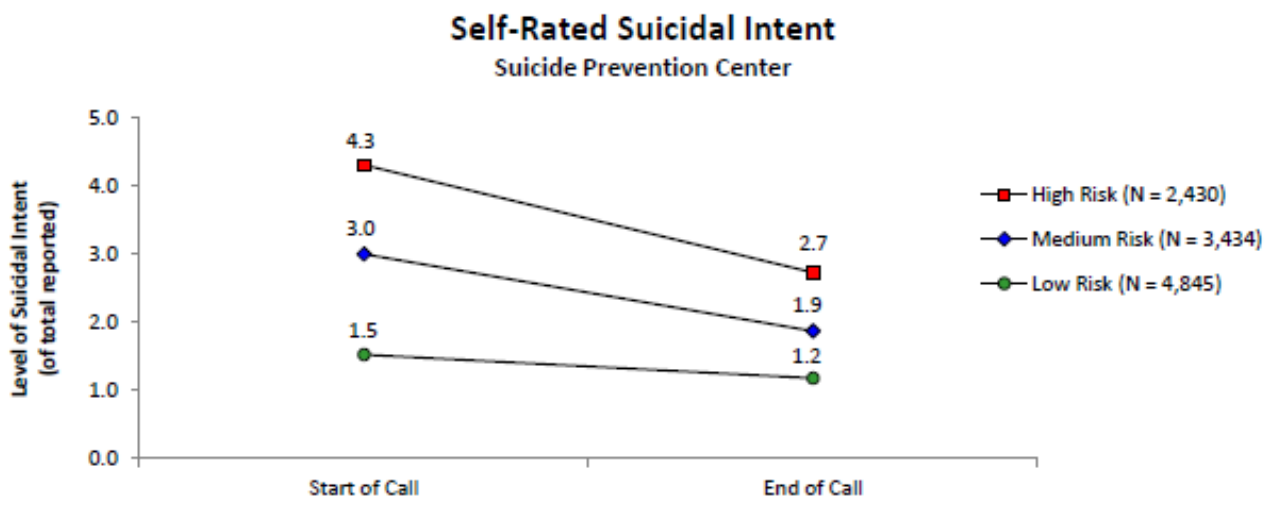
Risk assessment is based on the four core principles of suicide risk: Suicidal Desire, Suicidal Capability, Suicidal Intent, and Buffers/Connectedness (Joiner et al., 2007). A caller's risk level is determined by the combination of core principles present. Fore example, a caller who reports having only 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 17-18	Percentage
Third Party Rescue	2,057	49%
Self-Rescue	980	23%
SPC Initiated Rescue - Voluntary	214	5%
SPC Initiated Rescue - Involuntary	169	4%
Mandated Report	770	18%

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	90	60	25	30
Standard	656	459	224	197
Extended	185	117	77	68
Grand Total	**931**	**636**	**326**	**295**

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 17-18**
LA	5,606
Orange	2,607
Total	**8,213**

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
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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

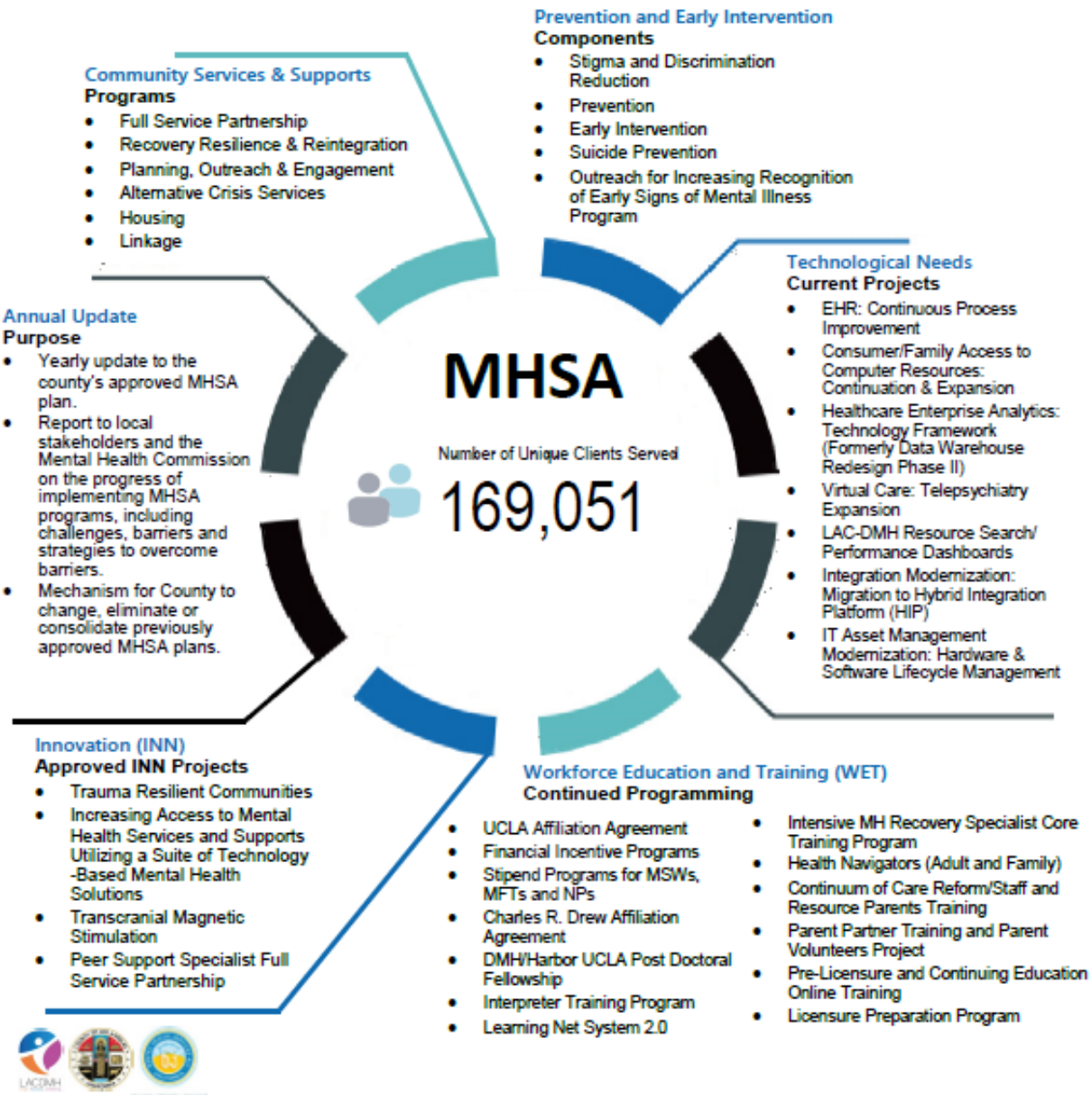
* Providers started collecting outcomes for TF-CBT in December 2010 (MHSA Implementation Memo, dated 12/14/2010).
** Providers started collecting outcomes for MAP-Anxiety and Avoidance, MAP-Traumatic Stress, and MAP-Depression and Withdrawal in February 2011 (MHSA Implementation Memo, dated 2/22/2011).
*** 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.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH SERVICES ACT INFORMATION FISCAL YEAR 2019-2020

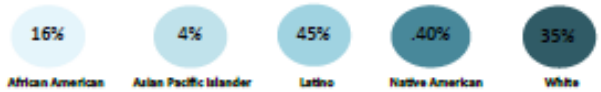
The County of Los Angeles is organized into eight (8) Service Areas (SAs), each with its own characteristics and diverse ethnic make-up. Services within the Los Angeles County - Department of Mental Health (LAC-DMH) are organized on a geographic basis to facilitate greater ease of access. However, clients are free to request services in any geographic area within the system, and may secure referrals to any mental health program, whether directly-operated or contracted with the Local Mental Health Plan (LMHP). The population of LA County is 10,192,376, 48.4% Latino, 28.3% White, 8.5% African American, 14.4% Asian, 0.2% Pacific Islander and 0.2% American Indian.

Mental Health Services Act (MHSA) refers to Proposition 63 which was passed in November 2004 and became state law on January 1, 2005. The Act is funded by a 1 percent tax on personal income above $1 million dollars to expand mental health services and programs serving all ages.



Service Area 1 - Antelope Valley

SA 1 is the largest service area geographically, yet it has the smallest population with approximately **396,357** inhabitants. Spanish is a prominent language. SA1 has a younger population than the other service areas, with a reported 31% of the population between the ages of 1-15.



0-18	19-20	21-25	26-59	60-64	65+
113,478	14,524	36,641	172,652	19,754	39,308
29%	4%	9%	44%	5%	10%

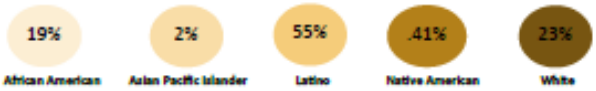
The highest % of Native Americans was in SA 1.

Female 50.3% (199,307)

Male 49.7% (197,050)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=112,355



Age Group N=115,014

0-18	19-20	21-25	26-59	60-64	65+
45,539	4,271	10,549	43,085	4,042	7,528
40%	4%	9%	38%	4%	7%

Female 51.6% (59,393)

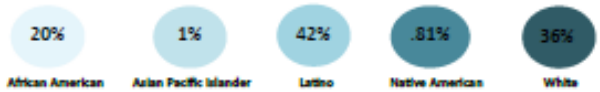
Male 48.4% (55,621)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
589	472	16	351	61,506	111	121	61	36,666	485	295
0.6%	0.5%	0.0%	0.3%	61.1%	0.1%	0.1%	0.1%	36.4%	0.5%	0.3%

Service Area 1 reported 2 threshold languages as their primary languages: English, and Spanish.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=28,609



Age Group N=23,594

0-18	19-20	21-25	26-59	60-64	65+
10,712	600	1,852	8,767	790	873
45%	3%	8%	37%	3%	4%

Female 68.7% (18,143)

Male 31.3% (8,266)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=13,695

Age Group N=15,546

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
5,716	3,551	5,648	631
37%	23%	36%	4%

Female 48.5% (7,528)

Male 51.5% (7,998)

Primary Language of Consumers Served, N=10,977

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
3	0	1	9,936	5	1	9	0	0	1,015	5	2
0.02%	0.0%	0.01%	74.6%	0.04%	0.01%	0.07%	0.00%	0.0%	7.6%	0.04%	0.02%

Spanish is the non-English threshold language reported for consumers in outpatient programs by Service Area I.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

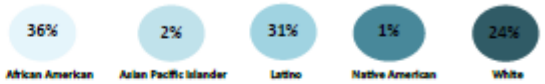
Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports

Number of Unique Clients Served

8,136

CHILD	TAY	ADULT	OLDER ADULT
1,570	1,341	4,678	729



English	Spanish	Other	Unknown/not reported
7,367 91%	638 8%	129 2%	2 .02%

Full Service Partnership

Number of Unique Clients Served

830

CHILD	TAY	ADULT	OLDER ADULT
324	121	272	129

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

7,461

CHILD	TAY	ADULT	OLDER ADULT
1,310	1,239	4,440	635

Service Area I FSP Capacity as of 10/1/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	160	116	73%
Transitional Age Youth	64	66	103%
Adult	486	232	48%
Older Adult	86	98	114%

Countywide FSP Capacity as of 10/1/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	462	60.4%
AOT	300	262	81.9%
IMHT	300	297	99%

Clients can be seen in more than one age group in a year.

Prevention and Early Intervention

The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

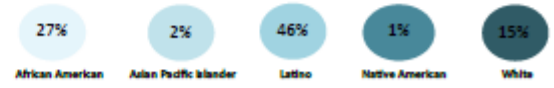
PEI

Number of Unique Clients Served

3,388

CHILD	TAY	ADULT	OLDER ADULT
2,629	437	341	18

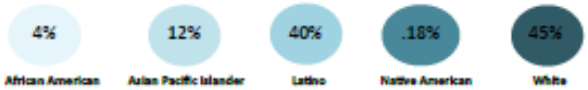
Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.



English	Spanish	Other
3,119 92%	220 6%	49 1%

Service Area II - San Fernando Valley

SA 2 is the most populous service area in Los Angeles County with a population of approximately 2,173,732. English and Spanish are the predominant languages. Although the number of children is within the county average, due to the overall population, there are more children in SA 2 than in any other service area.

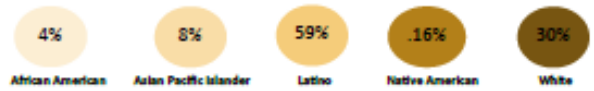


0-18	19-20	21-25	26-59	60-64	65+
518,831	62,652	161,505	1,071,750	125,891	288,192
23%	3%	7%	48%	6%	13%

Female 50.5% (1,125,035)
Male 49.5% (1,103,786)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=488,022



Age Group N=497,831

0-18	19-20	21-25	26-59	60-64	65+
161,324	14,448	39,791	218,836	19,963	43,469
32%	3%	8%	44%	4%	9%

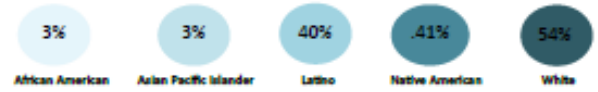
Female 50.7% (252,413)
Male 49.3% (245,418)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
5,158	42,129	252	4,236	136,133	7,094	5,740	6,034	230,798	6,699	2,748
1.2%	9.4%	0.1%	0.9%	30.5%	1.6%	1.3%	1.3%	51.6%	1.5%	0.6%

Service Area II reported 8 threshold languages as their primary languages: Armenian, English, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=128,540



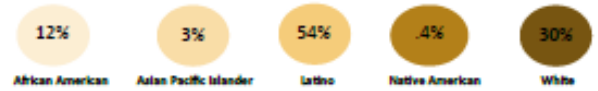
Age Group N=96,207

0-18	19-20	21-25	26-59	60-64	65+
35,779	2,074	6,695	39,754	4,589	7,315
37%	2%	7%	41%	5%	8%

Female 68.7% (76,731)
Male 31.3% (34,980)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=30,078



Age Group N=35,601

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
11,455	7,061	14,382	2,703
32%	20%	40%	8%

Female 49.4% (17,595)
Male 50.6% (17,992)

Primary Language of Consumers Served, N=27,437

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
1,001	19	10	20,370	326	60	13	16	81	5,408	92	41
3.1%	0.1%	0.03%	63.9%	1.0%	0.19%	0.04%	0.05%	0.3%	17.0%	0.29%	0.1%

Armenian, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese are the non-English threshold language reported for consumers in outpatient programs by Service Area II.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

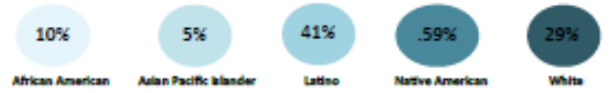
Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports

Number of Unique Clients Served

21,090

CHILD	TAY	ADULT	OLDER ADULT
3,664	3,675	11,522	2,765



English	Spanish	Farsi	Russian	Arabic	Other	Unknown/not reported
15,855 75%	3,153 15%	374 2%	90 .43%	67 .32%	1,544 7%	7 .03%

Full Service Partnership

Number of Unique Clients Served

1,882

CHILD	TAY	ADULT	OLDER ADULT
670	424	713	146

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

16,823

CHILD	TAY	ADULT	OLDER ADULT
3,066	2,663	9,042	2,500

Service Area II FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	430	370	86%
Transitional Age Youth	168	165	98%
Adult	1,115	515	46%
Older Adult	128	111	87%

Countywide FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	452	59%
AOT	300	261	87%
IMHT	300	295	98%

Clients can be seen in more than one age group in a year. Child slots include Wraparound Child and Wraparound TAY. Adult slots include Forensics and Homeless.

Prevention and Early Intervention

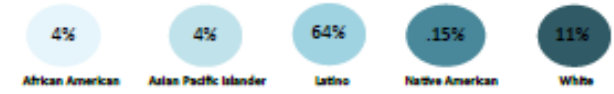
The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

PEI

Number of Unique Clients Served

7,193

CHILD	TAY	ADULT	OLDER ADULT
5,317	1,418	461	130

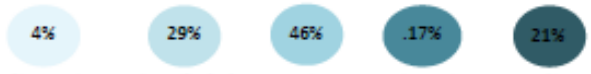


English	Spanish	Other	Farsi	Unknown/not reported
5,504 77%	1,386 19%	250 4%	51 .71%	2 .03%

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.

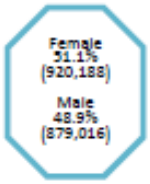
Service Area III - San Gabriel Valley

The total population in the San Gabriel Valley is approximately 1,777,760 with Latinos being the largest ethnic group in the area, followed by Asians.



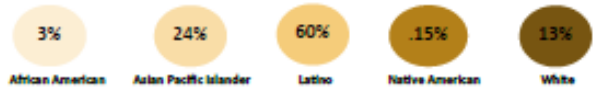
0-18	19-20	21-25	26-59	60-64	65+
417,958	56,940	137,653	823,464	105,994	257,195
23%	3%	8%	46%	6%	14%

The highest % of 60-64 year olds was in SA 3.



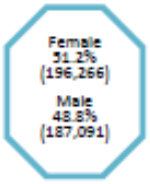
Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=378,717



Age Group N=383,357

0-18	19-20	21-25	26-59	60-64	65+
125,484	11,900	31,049	158,882	16,470	39,572
33%	3%	8%	41%	4%	10%

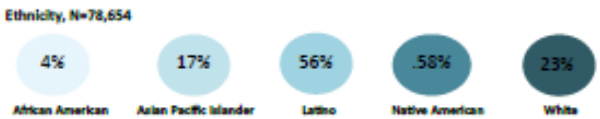


Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
2,264	1,935	1,156	26,632	110,456	634	4,254	274	175,412	4,015	14,059
0.7%	0.6%	0.3%	7.8%	32.4%	0.2%	1.2%	0.1%	51.4%	1.2%	4.1%

Service Area III reported 4 threshold languages as their primary languages: English, Korean, Spanish, and Vietnamese.

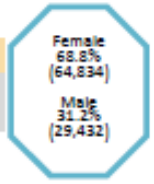
Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=78,654



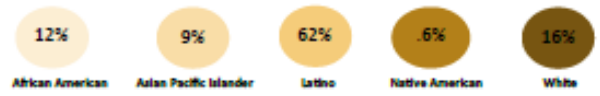
Age Group N=81,052

0-18	19-20	21-25	26-59	60-64	65+
31,256	1,913	5,872	31,915	3,786	6,310
39%	2%	7%	39%	5%	8%



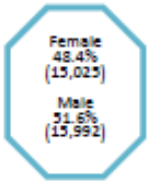
Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=26,157



Age Group N=31,021

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
13,693	5,663	9,912	1,753
44%	18%	32%	6%



Primary Language of Consumers Served, N=22,158

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
65	19	413	16,937	5	26	290	82	2	4,076	30	213
0.2%	0.1%	0.20%	61.2%	0.02%	0.09%	1.10%	0.30%	0.01%	14.7%	0.11%	0.4%

Cantonese, Korean, Mandarin, Spanish, Other Chinese, Spanish, and Vietnamese are the non-English threshold language reported for consumers in outpatient programs by Service Area III.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

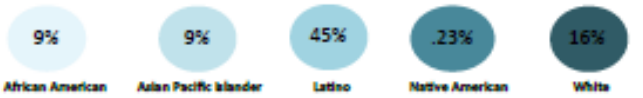
Community Services and Supports

Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports
Number of Unique Clients Served

17,220

CHILD	TAY	ADULT	OLDER ADULT
5,522	3,212	7,380	1,506



English	Spanish	Other	Cantonese	Mandarin	Arabic	Unknown/not reported
13,024 76%	2,583 15%	926 5%	308 2%	300 2%	17 0.10%	62 .36%

Full Service Partnership
Number of Unique Clients Served

1,905

CHILD	TAY	ADULT	OLDER ADULT
565	383	727	307

Recovery, Resilience, and Reintegration
Number of Unique Clients Served

13,745

CHILD	TAY	ADULT	OLDER ADULT
4,852	2,450	5,675	1,085

Service Area III FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	378	343	91%
Transitional Age Youth	188	164	87%
Adult	875	483	55%
Older Adult	203	186	92%

Countywide FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	452	59%
AOT	300	261	87%
IMHT	300	295	98%

Clients can be seen in more than one age group in a year. Child slots include Wraparound Child and Wraparound TAY. Adult slots include Forensics and Homeless.

Prevention and Early Intervention

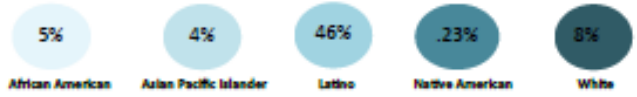
The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

PEI
Number of Unique Clients Served

7,447

CHILD	TAY	ADULT	OLDER ADULT
5,265	1,576	611	180

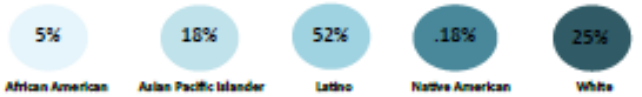
Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.



English	Spanish	Other	Cantonese	Mandarin
5,263 71%	1,872 25%	191 3%	65 .87%	56 .75%

Service Area IV - Metro

Service Area 4 has a population of 1,140,742. It has the highest number of homeless persons within its boundaries. The Metro area has the second highest poverty rate in the county.



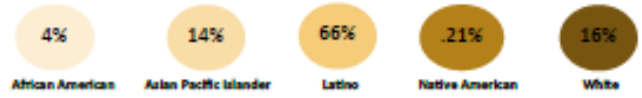
0-18	19-20	21-25	26-59	60-64	65+
244,509	27,602	77,241	623,088	56,535	138,311
21%	2%	7%	53%	5%	12%

Female 48.7% (568,280)

Male 51.3% (599,006)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=402,750



Age Group N=408,609

0-18	19-20	21-25	26-59	60-64	65+
123,761	10,121	30,218	191,665	15,372	37,472
30%	3%	7%	47%	4%	9%

Female 49.6% (202,652)

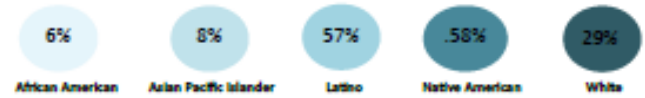
Male 50.4% (205,957)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
1,256	6,278	854	7,947	87,546	1,248	23,751	4,836	230,863	5,612	2,208
0.3%	1.7%	0.2%	2.1%	23.5%	0.3%	6.4%	1.3%	62.0%	1.5%	0.6%

Service Area IV reported 6 threshold languages as their primary languages: Armenian, English, Korean, Russian, Spanish, and Tagalog.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=66,531



Age Group N=60,654

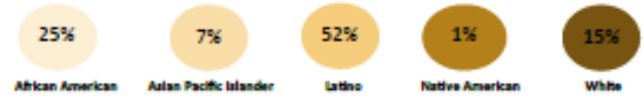
0-18	19-20	21-25	26-59	60-64	65+
20,686	1,220	4,175	26,509	3,020	5,045
34%	2%	7%	44%	5%	8%

Female 67.9% (47,973)

Male 32.1% (22,658)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=40,569



Age Group N=44,049

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
14,584	7,874	17,572	4,019
33%	18%	40%	9%

Female 46.5% (20,444)

Male 53.5% (23,557)

Primary Language of Consumers Served, N=33,292

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
205	123	137	24,033	93	686	120	35	85	7,544	99	132
0.5%	0.3%	0.34%	60.1%	0.2%	1.71%	0.30%	0.09%	0.2%	18.9%	0.25%	0.3%

Armenian, Cantonese, Korean, Russian , Spanish, and Tagalog are the non-English threshold languages reported for consumers in outpatient programs by Service Area IV.

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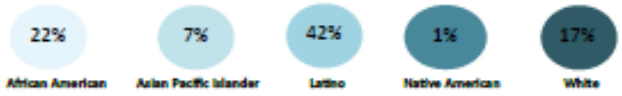
Community Services & Supports

Number of Unique Clients Served

29,965

CHILD	TAY	ADULT	OLDER ADULT
4,422	5,014	17,249	3,811



English	Spanish	Other	Cantonese	Mandarin	Russian	Unknown/not reported
23,222	4,303	2,117	97	75	88	63
78%	15%	7%	.32%	.25%	.29%	.21%

Full Service Partnership

Number of Unique Clients Served

2,407

CHILD	TAY	ADULT	OLDER ADULT
497	434	1,154	391

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

16,949

CHILD	TAY	ADULT	OLDER ADULT
3,522	2,040	9,002	2,807

Service Area IV FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	408	341	84%
Transitional Age Youth	229	192	84%
Adult	1,794	680	38%
Older Adult	148	167	112%

Countywide FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	452	59%
AOT	300	261	87%
IMHT	300	295	98%

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Prevention and Early Intervention

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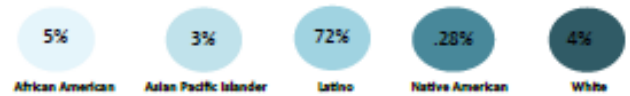
PEI

Number of Unique Clients Served

6,372

CHILD	TAY	ADULT	OLDER ADULT
4,285	1,431	630	133

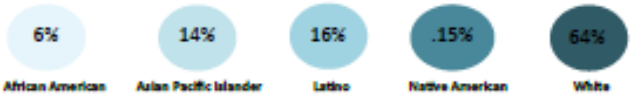
Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.



English	Spanish	Other	Farsi	Unknown/not reported
4,105 64%	2,089 33%	163 3%	14 .22%	1 .02%

Service Area V - West

SA 5 has a population of 646,531. It has the largest number of individuals reporting to speak English as their primary language. Approximately 18% of its population is older adults, compared to 13% countywide. Its median household income is $61,000 compared to $48,000 countywide.



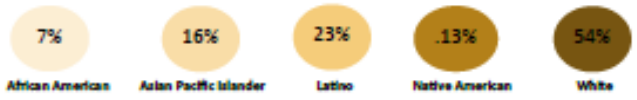
0-18	19-20	21-25	26-59	60-64	65+
117,073	22,635	42,942	337,341	38,044	102,046
18%	3%	7%	51%	6%	16%

Female 51.5% (340,001)
Male 48.5% (320,080)

The highest percentage of Whites and 65+ year olds was is in SA 5.

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=103,437



Age Group N=107,126

0-18	19-20	21-25	26-59	60-64	65+
17,946	3,879	13,819	55,936	4,495	11,051
17%	4%	13%	52%	4%	10%

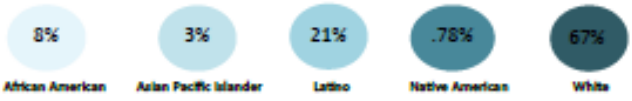
Female 51.7% (55,422)
Male 48.3% (51,704)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
1,423	440	107	3,409	56,116	5,521	1,743	1,210	19,382	523	706
1.6%	0.5%	0.1%	3.8%	62.0%	6.1%	1.9%	1.3%	21.4%	0.6%	0.8%

Service Area V reported 3 threshold languages as their primary languages: English, Farsi, and Spanish.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=19,348



Age Group N=13,423

0-18	19-20	21-25	26-59	60-64	65+
3,692	226	870	6,683	737	1,216
28%	2%	7%	50%	6%	9%

Female 67.4% (10,624)
Male 32.6% (5,129)

The highest prevalence of SED and SMI among Males and the Medi-Cal enrolled population was in SA 5.

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=8,715

Age Group N=10,152

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
2,316	1,423	5,200	1,213
23%	14%	51%	12%

Female 49.4% (5,014)
Male 50.6% (5,134)

Primary Language of Consumers Served, N=7,706

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
5	0	2	6,921	64	7	4	2	14	682	5	0
0.1%	0.0%	0.02%	76.3%	0.7%	0.08%	0.78%	0.02%	0.2%	7.5%	0.06%	0.00%

Farsi, and Spanish are the non-English threshold languages reported for consumers in outpatient programs by Service Area V.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

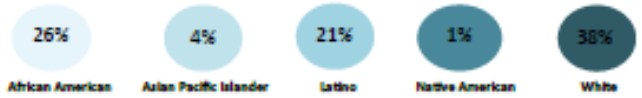
Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports

Number of Unique Clients Served

8,919

CHILD	TAY	ADULT	OLDER ADULT
641	1,259	5,877	1,292



English	Spanish	Other	Farsi	Russian	Arabic	Unknown/not reported
7,897 89%	554 6%	309 3%	102 1%	32 .36%	9 .10%	16 .18%

Full Service Partnership

Number of Unique Clients Served

797

CHILD	TAY	ADULT	OLDER ADULT
80	133	515	93

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

5,413

CHILD	TAY	ADULT	OLDER ADULT
539	586	3,341	1,067

Service Area V FSP Capacity as of 11/14/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	62	46	74%
Transitional Age Youth	73	66	90%
Adult	723	396	55%
Older Adult	29	32	110%

Countywide FSP Capacity as of 11/14/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	468	61%
AOT	300	258	86%
IMHT	300	286	95%

Clients can be seen in more than one age group in a year. Child slots include Wraparound Child and Wraparound TAY. Adult slots include Forensics and Homeless.

Prevention and Early Intervention

The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

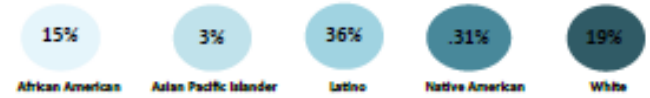
PEI

Number of Unique Clients Served

1,628

CHILD	TAY	ADULT	OLDER ADULT
891	287	351	119

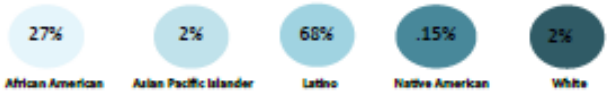
Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.



English	Spanish	Other	Farsi	Russian
1,332 82%	196 12%	71 4%	21 1%	8 .49%

Service Area VI - South

The population is approximately 1,030,078; however, 48% of its population is 25 years of age or less. It has the highest poverty rate in the county – 61% of its population lives below the 200% federal poverty level (FPL). Two ethnic groups account for 94% of the population--African American and Hispanic.



0-18	19-20	21-25	26-59	60-64	65+
321,073 31%	40,721 4%	96,899 9%	460,516 44%	41,781 4%	87,744 8%

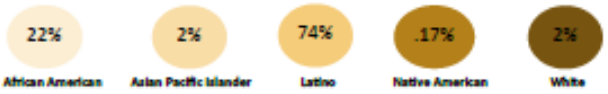
Female 51.2% (537,259)

Male 48.8% (511,475)

The highest percentage of African Americans, Females, 0-18, and 19-20 year olds were in SA 6.

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=510,298



Age Group N=515,778

0-18	19-20	21-25	26-59	60-64	65+
216,622 42%	18,032 4%	46,794 9%	192,637 37%	15,344 3%	26,349 5%

Female 51.3% (264,375)

Male 48.7% (251,403)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
509 0.1%	99 0.02%	207 0.04%	2,487 0.5%	126,532 26.3%	318 0.1%	1,960 0.4%	78 0.02%	348,008 72.4%	303 0.1%	307 0.1%

Service Area 6 reported 2 threshold languages as their primary languages: English, and Spanish.

The highest % of 0-18 year olds estimated to be living at or below the 138% FPL was in SA 6.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=79,833

Age Group N=81,445

0-18	19-20	21-25	26-59	60-64	65+
36,548 45%	1,949 2%	6,188 8%	30,437 37%	2,920 4%	3,403 4%

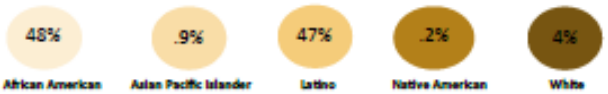
Female 69.1% (63,443)

Male 30.9% (28,309)

The highest prevalence of SED and SMI among the African American ethnic group was in SA 6.

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=32,754



Age Group N=35,815

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
13,434 38%	5,184 15%	14,970 42%	2,227 6%

Female 50.5% (18,084)

Male 49.5% (17,719)

Primary Language of Consumers Served, N=28,600

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
1 0.00%	2 0.01%	11 0.03%	22,224 69.4%	6 0.02%	37 0.12%	16 0.05%	3 0.01%	3 0.01%	6,280 19.6%	7 0.02%	10 0.03%

Spanish is the non-English threshold languages reported for consumers in outpatient programs by Service Area VI.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports

Number of Unique Clients Served

22,617

CHILD	TAY	ADULT	OLDER ADULT
5,416	3,563	11,940	2,212

English	Spanish	Other	Russian	Arabic	Mandarin	Unknown/not reported
17,931	3,903	688	5	5	9	76
79%	17%	3%	.02%	.02%	.04%	.34%

Full Service Partnership

Number of Unique Clients Served

2,312

CHILD	TAY	ADULT	OLDER ADULT
985	423	891	90

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

18,282

CHILD	TAY	ADULT	OLDER ADULT
4,283	2,660	9,720	2,042

Service Area VI FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	594	534	90%
Transitional Age Youth	268	205	77%
Adult	1,298	773	60%
Older Adult	43	39	90%

Countywide FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	452	59%
AOT	300	261	87%
IMHT	300	295	98%

Clients can be seen in more than one age group in a year.

Prevention and Early Intervention

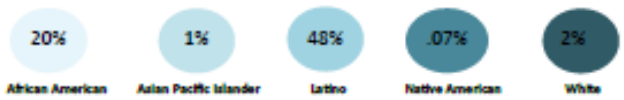
The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

PEI

Number of Unique Clients Served

5,496

CHILD	TAY	ADULT	OLDER ADULT
3,940	956	579	108

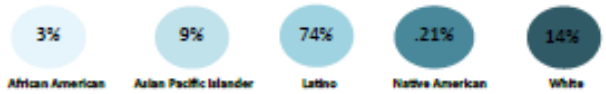


English	Spanish	Other	Unknown/not reported
3,910	1,339	246	1

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.

Service Area VII - East

The population within the boundaries of SA 7 is approximately 1,309,383. It also has a young population with 43% under the age of 26. It is reported that 70% of the population is Latino with Spanish being spoken in 54% of the households.



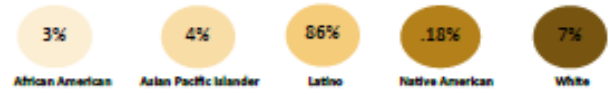
0-18	19-20	21-25	26-59	60-64	65+
358,354 27%	44,130 3%	110,066 8%	593,512 45%	63,643 5%	153,238 12%

Female 50.8% (672,404)

Male 49.2% (650,539)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=354,931



Age Group N=357,167

0-18	19-20	21-25	26-59	60-64	65+
141,912 40%	11,302 3%	28,478 8%	136,683 38%	12,242 3%	26,550 7%

Female 51.0% (182,148)

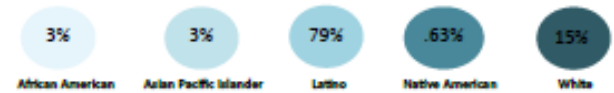
Male 49.0% (175,019)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
1,521 0.4%	767 0.2%	536 0.2%	2,429 0.7%	68,517 20.2%	141 0.04%	3,470 1.0%	147 0.04%	258,174 76.3%	1,991 0.6%	872 0.3%

Service Area VII reported 3 threshold languages as their primary languages: English, Korean, and Spanish.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=68,802



Age Group N=68,150

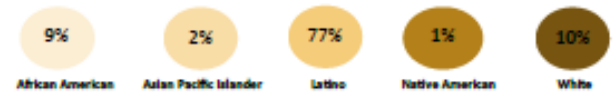
0-18	19-20	21-25	26-59	60-64	65+
29,899 44%	1,666 2%	5,148 8%	24,822 36%	2,640 4%	3,976 6%

Female 69.5% (54,248)

Male 30.5% (23,805)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=23,574



Age Group N=26,848

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
11,537 43%	5,811 22%	8,093 30%	1,407 5%

Female 48.8% (13,091)

Male 51.2% (13,730)

Primary Language of Consumers Served, N=19,557

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
9 0.04%	41 0.2%	8 0.03%	14,219 59.3%	2 0.01%	50 0.21%	38 0.16%	3 0.01%	1 0.0%	5,151 21.5%	29 0.12%	6 1.0%

Korean and Spanish are the non-English threshold language reported for consumers in outpatient programs by Service Area VII.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

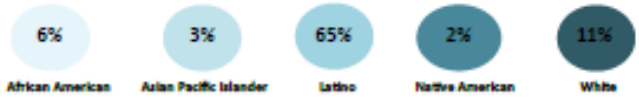
Community Services and Supports

Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports
Number of Unique Clients Served

11,421

CHILD	TAY	ADULT	OLDER ADULT
3,344	2,009	5,340	1,065



English	Spanish	Other	Arabic	Mandarin	Unknown/not reported
8,410 74%	2,809 25%	176 2%	10 .09%	12 .11%	4 .04%

Full Service Partnership
Number of Unique Clients Served

1,646

CHILD	TAY	ADULT	OLDER ADULT
567	310	613	212

Recovery, Resilience, and Reintegration
Number of Unique Clients Served

9,823

CHILD	TAY	ADULT	OLDER ADULT
2,846	1,705	4,694	857

Service Area VII FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	363	308	85%
Transitional Age Youth	173	143	83%
Adult	920	520	57%
Older Adult	99	120	121%

Countywide FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	452	59%
AOT	300	261	87%
IMHT	300	295	98%

Clients can be seen in more than one age group in a year. Child slots include Wraparound Child and Wraparound TAY. Adult slots include Forensics and Homeless.

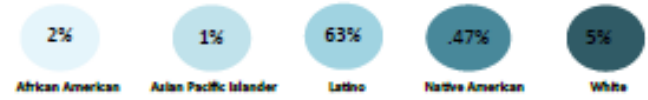
Prevention and Early Intervention

The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

PEI
Number of Unique Clients Served

6,178

CHILD	TAY	ADULT	OLDER ADULT
4,039	1,289	799	178



English	Spanish	Other
4,383 71%	1,709 28%	86 1%

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.

Service Area VIII - South Bay

The population of SA 8 is 1,550,198. It has a household income slightly higher than the county average, and the number of individuals who graduate from college is slightly higher than the county average.

African American	Asian Pacific Islander	Latino	Native American	White
15%	16%	40%	.23%	28%

0-18	19-20	21-25	26-59	60-64	65+
386,870 25%	45,372 3%	114,285 7%	737,620 47%	84,153 5%	200,650 13%

Female 51.1% (800,958)

Male 48.9% (767,992)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=396,580

African American	Asian Pacific Islander	Latino	Native American	White
18%	10%	60%	.24%	12%

Age Group N=404,580

0-18	19-20	21-25	26-59	60-64	65+
147,403 36%	12,783 3%	33,240 8%	167,525 41%	14,667 4%	28,962 7%

Female 48.6% (196,430)

Male 51.4% (208,150)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
1,952 0.5%	278 0.1%	6,009 2%	3,294 0.9%	145,789 40%	689 0.2%	4005 1%	404 0.1%	193,921 53%	4,160 1%	2,903 0.8%

Service Area VIII reported 5 threshold languages as their primary languages: Cambodian, English, Korean, Spanish and Vietnamese.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=69,559

African American	Asian Pacific Islander	Latino	Native American	White
18%	6%	50%	.8%	25%

Age Group N=67,708

0-18	19-20	21-25	26-59	60-64	65+
27,555 41%	1,551 2%	5,079 8%	26,851 40%	2,882 4%	3,790 6%

Female 69.1% (33,481)

Male 30.9% (23,934)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=32,288

African American	Asian Pacific Islander	Latino	Native American	White
30%	5%	46%	.5%	19%

Age Group N=37,767

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
12,734 34%	5,555 15%	16,588 44%	2,890 8%

Female 49.2% (18,561)

Male 50.8% (19,187)

Primary Language of Consumers Served, N=27,764

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
7 0.02%	691 0.02%	7 .01%	21,267 75%	6 .04%	94 .01%	26 .08%	15 .05%	1 .00%	5,385 16.2%	89 .27%	176 .5%

Spanish, Cambodian, Korean and Vietnamese are the non-English threshold language reported for consumers in outpatient programs by Service Area VIII

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports

Number of Unique Clients Served

22,478

CHILD	TAY	ADULT	OLDER ADULT
4,245	3,218	12,670	2,866

English	Spanish	Other	Tagalog	Arabic	Mandarin	Unknown/not reported
18,014 80%	2,748 12%	1,606 7%	65 .29%	18 .08%	14 0.07%	13 0.06%

Full Service Partnership

Number of Unique Clients Served

2,567

CHILD	TAY	ADULT	OLDER ADULT
611	507	1,249	285

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

18,049

CHILD	TAY	ADULT	OLDER ADULT
3,659	2,361	10,018	2,442

Service Area VIII FSP Capacity as of 9/17/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	160	116	72.5%
Transitional Age Youth	64	66	103.1%
Adult	486	230	47%
Older Adult	86	98	114.0%

Countywide FSP Capacity as of 9/17/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	462	60.4%
AOT	300	262	81.9%
IMHT	300	297	99%

Clients can be seen in more than one age group in a year.

Prevention and Early Intervention

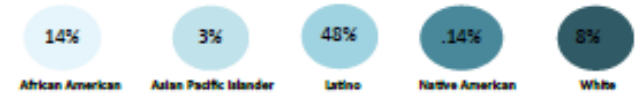
The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

PEI

Number of Unique Clients Served

7,283

CHILD	TAY	ADULT	OLDER ADULT
5,052	1,195	965	201



English	Spanish	Other	Arabic	Unknown/not reported
5,096 70%	2,013 28%	166 2%	5 .07%	3 .04%

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.

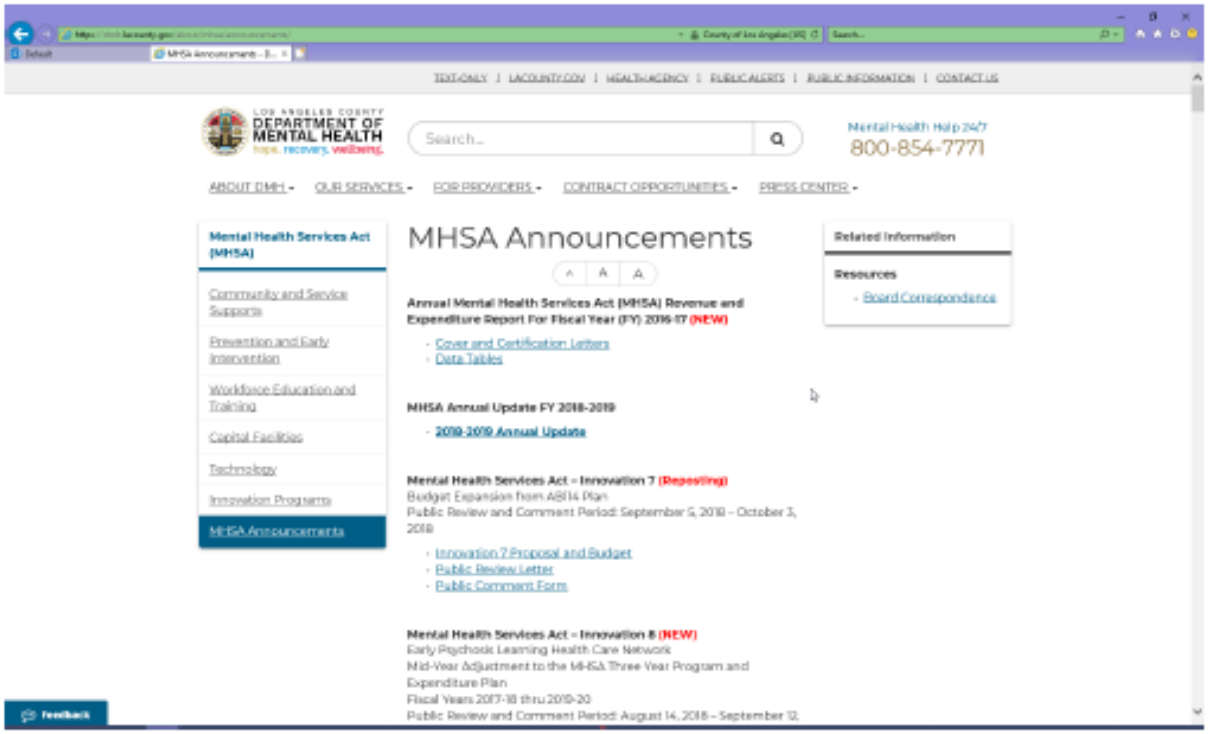
COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH
PROGRAM DEVELOPMENT & OUTCOMES DIVISION

QUESTIONS TO GUIDE DISCUSSION

- What are your unmet needs of the Service Area?
- How do you propose we address the unmet needs?
- How do we improve transitions between levels of care to ensure successful flow?

MHSA ANNUAL UPDATES

Electronic copies of the MHSA Annual Updates and the MHSA Three Year Program and Expenditure Plans are located at the following web address: https://dmh.lacounty.gov/about/mhsa/announcements/



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