WELLNESS • RECOVERY • RESILIENCE

MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN

Fiscal Years 2021-22 through 2023-24

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

Adopted by the
Los Angeles County Board of Supervisors
On June 22, 2021

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INTRODUCTION

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

LACDMH 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) as shown below:

MHSA Component	Approval Dates
Community Services and Support (CSS) Plan	February 14, 2006
Workforce Education and Training (WET) Plan	April 8, 2009
Technological Needs (TN) Plan	May 8, 2009
Prevention and Early Intervention (PEI) Plan	September 27, 2009
Innovation 1 - 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 (Renamed to Help@Hand)	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
True Recovery Innovation Embraces Systems that Empower (TRIESTE)	May 23, 2019

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

DIRECTOR'S MESSAGE

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
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Gregory C. Polk, M.P.A.
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Chief Medical Officer

Lisa H. Wong, Psy.D.
Senior Deputy Director

Dear LA County,

Since its passage, the Mental Health Services Act (MHSA) has provided the County Mental Health Departments of California and the communities they serve with an unprecedented opportunity to partner in developing and tailoring local delivery systems. Building on a decade plus of stakeholder engagement successes, Los Angeles County (LA County) has stepped up its investment of money and time significantly in recent years to build out more robust, inclusive and coordinated community planning through a process we call "YourDMH."

Though we still have a long way to go in order to optimize YourDMH as a stakeholder engagement process, it represents a clear commitment to create a platform for planning that is driven by transparent and collective partnership focused on action. With that in mind, I extend my deepest appreciation to all who have been involved directly and/or indirectly in navigating the journey together thus far. The energy and commitment of key guiding bodies in the community, including the Mental Health Commission, Service Area Leadership Teams and Underserved Communities as well as myriad advocates and activists make it possible to engineer a deeper, wider and more genuine stakeholder engagement process.

In the Three-Year Plan, you will find numerous service expansions and program innovations that are under way in LA County, as well as efforts to sustain programs that have proven effective and upon which so many depend each day. In pushing to reform our mental health system, it is my hope that MHSA resources will continue to help those in most need lead independent and connected lives with an abundance of opportunity for purpose each day.

The plan herein represents an immense amount of iterative work based upon ongoing discourse across LA County and relentless efforts by staff to organize and operationalize plans. While the department has had to pivot dramatically in response to the COVID-19 crisis, we have continued to engage stakeholders so we can understand and best adapt to the realities of our communities. Such engagement will not relent and instead uptick as we move from COVID-19 responses to community reopening and recovery strategies.

We are committed to relying heavily upon our community relationships to help guide the deployment of MHSA funds to offer hope, facilitate recovery and promote well-being.

Heart Forward,

EXECUTIVE SUMMARY

PREFACE

In November 2004, California voters supported Proposition 63 and passed the Mental Health Services Act (MHSA) that imposes a 1% income tax on personal income in excess of $1 million. The Act provides the significant funding to expand, improve and transform public mental health systems to improve the quality of life for individuals living with a mental illness. MHSA funds an array of services that starts with prevention and integrates it into a comprehensive system of care to treat the whole person, with focus on wellness, recovery and resilience so that we may keep him/her out of hospitals, off the streets, and out of the jails.

Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan ("Three-Year Plan" or "Plan") followed by Annual Plan Updates for MHSA programs and expenditures. The Plan provides an opportunity for the Los Angeles County (County) - Department of Mental Health (LACDMH) to review its existing MHSA programs and services to evaluate their effectiveness. The Plan also allows LACDMH to propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available. It is through this Community Planning Process that LACDMH will obtain important feedback from a broad array of stakeholders. Any changes made to any MHSA program must comply with MHSA regulations, as well as relevant State requirements.

PLAN LAYOUT

This Plan describes the programs that are funded by MHSA and is organized by the five MHSA components (Community Services and Supports; Prevention and Early Intervention; Innovation; Workforce Education and Training; and Capital Facilities and Technological Needs).

The information within this report is structured in the following three sections:

- *Actions Since the Last Annual Update*
  This purpose of this section is to capture any all posted Mid-Year Adjustments that occurred after the adoption of the FY 2019-20 Annual Update. The Adjustments are included in this Plan.

- *Proposed Plan Changes for FYs 2021-2024*
  The Plan details significant changes that are either being proposed or will be explored within the next three-year period, as highlighted below. For the latter, LACDMH will incorporate changes into a Mid-Year Adjustment or an upcoming Annual Update depending upon the timeline of the proposal.

- *Existing Programs and Services by MHSA Component*
  The Plan provides relevant program outcomes specific to FY 2019-20 for programs previously reflected in the prior Three-Year Plan for FYs 2017-18 through 2019-20 and associated Annual Updates, as well as any Mid-Year Adjustments. This prior Three-Year Plan was ultimately extended to FY 2020-21 due to the COVID-19 pandemic.

PLAN CHANGES FOR FYs 2021-22 THROUGH 2023-24

It is important to start out this section of the Plan by acknowledging that the world found itself in unprecedented times when the global lockdown occurred virtually overnight in early 2020 as a result of the COVID-19 pandemic. The ongoing COVID-19 pandemic has reshaped almost everything imaginable on a global level.

Financial impact of COVID-19

The pandemic will continue to have an ever-lasting effect as economic and health care systems navigate financial and operational challenges while rapidly addressing the needs of their customers to the extent that they can. LACDMH's approximately $3.0 billion budget is funded by three main sources: 45% State and federal Medi-Cal, 27% MHSA and 19% Sales Tax Realignment. The impact is anticipated to occur in the next few years as the State allocation for MHSA is projected to decrease in FY 2021-22 and further in FY 2022-23, based on projections from the California Behavioral Health Directors Association. LACDMH will reduce one-time commitments, as appropriate, and rely on the one-time fund balance to maintain service levels during these fiscal years. Sales Tax Realignment will also continue to decline but hopefully the economy will regain momentum as the State goes through the reopening process for local businesses, stores and restaurants.

Funding Opportunities

While there are funding concerns, LACDMH hopes there might be some light at the end of the tunnel as funding opportunities may be available. New revenue streams will provide additional financial support to sustain current operations and allow for expansions to further County initiatives. The following highlights funding opportunities:

- The County has received CARES Act funding and LACDMH has been providing services under the CARES Act for specialized services and activities.
- During the November 2020 election, Los Angeles County voters approved Measure J that diverts more County funding to social services and jail diversion programs. LACDMH is a participant on the Alternatives to Incarcerations (ATI) workgroup led by the County Chief Executive Office and recently submitted funding proposals consistent with fundamental recommendations that advance the County's vision of "care first." Proposals were submitted for various MHSA programs, such as Mental Health Treatment Beds and Housing.
- LACDMH is realigning programs funded by Substance Abuse and Mental Health Services Administration (SAMHSA) revenue to readily address LACDMH priorities consistent with its Strategic Plan, as well as funding needs.

Overview of Three-Year Plan Changes

LACDMH proposes two changes to the current Plan: Full Service Partnership Redesign and the 24/7 ACCESS Call Center Modernization Project. The change to extend the life of certain Innovation Projects is more administrative in nature.

The final item – Mental Health Treatment Beds and Housing Capacity – is being highlighted in this Plan as not only a County initiative but also a LACDMH Strategic Plan goal that focuses on prevention and diversion of clients to the more appropriate, lower levels of care.

- **Full Service Partnership Redesign**
  FSP programs and services were developed to provide comprehensive mental health services by a multi-disciplinary team to clients requiring intensive treatment based on a specific number of client slots and may include, but are not limited to, 24/7 crisis response; ongoing intensive mental health treatment; housing services; employment services; and co-occurring mental illness and substance use treatment services. FSP was designed to enable people to create their own plans for recovery with support from professionals and peers, recreational or other therapeutic, and 24/7 support to make their plan a reality.

  To meet the ever-changing needs of vulnerable children and adults in Los Angeles County, a redesign of the existing slot-based programming model and restructuring of provider contracts to include new program parameters, such as utilizing a multi-disciplinary team/population approach rather than slots; centralizing authorization, enrollment and disenrollment processes; and restructuring provider contracts that will reflect performance-based criteria, incentives and standardized salary rates comparable to their County counterparts in the clinics.

- **Mental Health Treatment Beds and Housing Capacity**
  Prior to the COVID-19 pandemic, there was already an extreme shortage of mental health hospital beds in the County that created longstanding service gaps in its mental health system of care and hampered efficient management of these beds. This results in a host of issues, such as overcrowded psychiatric emergency rooms; homeless individuals cycling in and out of hospitals and on and off the streets with no sustainable path to recovery; incarcerated individuals unable to receive needed care in a treatment facility; and long waitlists to transition patients from costly acute treatment settings to the appropriate level of care. In 2019, LACDMH recommended a two-year pilot to expand bed capacity up to 500 beds to the extent that the $25 million in Sales Tax Realignment set aside could fund in support of a County initiative on this matter. The partial implementation of the bed pilot has already exhausted these funds.

  There is now a far greater need to increase mental health treatment bed capacity since COVID-19 to decompress County hospital beds. While this Plan does not reflect a proposed change to MHSA Community Services and Supports - Alternative Crisis Services and Housing associated with any expansion of mental health treatment bed capacity, this matter is being highlighted to stress that the flexibility to invest MHSA resources in the near future is likely to occur, as it is critical to furthering this County initiative. In the meantime, LACDMH is seeking other funding opportunities, such as Measure J and SAMHSA.

- **24/7 ACCESS Call Center Modernization Project**
  LACDMH seeks to engage a consultant to design and implement the technical and business goals of this project at a proposed total cost of $3.5 million. There is existing funding for this project within the Technological Needs Plan.

  LACDMH's current system is antiquated with disparate systems, as well as different applications, and is therefore, in critical need of a major overhaul. The goal is to modernize business processes, workflows and technology that allows for a more streamlined process between the call agent and caller for end-to-end assistance. The modernized Call Center is to serve as the "hub" of entry points to access of care; thereby improving client care delivery.

- **Innovation (INN) Projects Timeline**
  This component of MHSA provides 5% funding for time-sensitive projects that introduce new or improved practices or approaches to the delivery of mental health services. The Plan maintains funding that aligns with the various stages of all INN projects. LACDMH is in the process of evaluating all INN projects for effectiveness and consideration of continued funding. This Plan reflects continuation of certain INN projects to the maximum of five years.

COMMUNITY PLANNING PROCESS

LACDMH embarked on a streamlined community planning process to ensure the opportunity for stakeholder input in this Plan. The engagement and presentations were done entirely on a virtual platform using Microsoft Teams due to State and County Safer at Home Orders and social distancing directives that prohibited large gatherings. The initial engagement started in October 2020 with two important networks of stakeholders: Service Area Leadership Teams (SALT) and Underserved Cultural Communities (UsCC). MHSA data specific to geographical areas was presented to each group and a needs assessment was conducted by way of a survey over the course of two months. There are eight SALT groups and seven UsCC subcommittees. Cultural competency data focused on a breakdown of services countywide by ethnic populations, languages spoken, sexual orientation and gender identity was also provided to the UsCC.

LACDMH also engages with the Community Leadership Team (CLT) comprised of Co-Chairs from SALT and UsCC who all work together to discuss and consolidate stakeholder priorities. LACDMH reached out to CLT members and on March 5, 2021, a presentation that identified and addressed disparities was provided to this specific group.

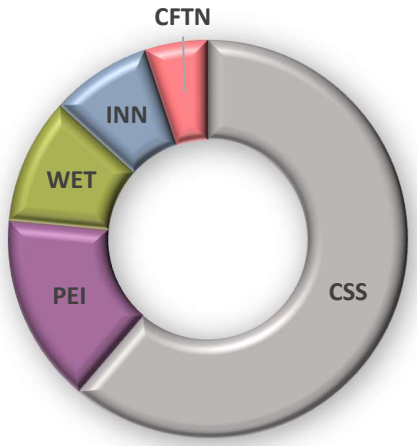
In addition, LACDMH presented a high-level Plan overview to the Executive Committee members of the Mental Health Commission (MHC) on February 11, 2021. A follow-up presentation that focused on disparities and MHSA budget information was presented to the Full MHC on March 25, 2021.

A draft version of the Plan was posted on the LACDMH website on March 19, 2021 with a 30-day public comment period of March 19 through April 18. A Spanish version was also posted. The virtual Public Hearing occurred on April 22, 2021 and both Spanish and Korean translation was provided.

MHSA OVERVIEW

The Mental Health Services Act (MHSA) was enacted in January 2005 following the passage of Proposition 63 in late 2004. The Act imposes a 1% income tax on personal income in excess of $1.0 million to provide resources that will greatly improve the delivery of community-based mental health services and treatment across the State.

WIC Section 5891 states that MHSA revenues may only fund mental health services, and MHSA programs and activities. MHSA addresses a broad continuum of county mental health services for all populations: children, transition-age youth, adults, older adults, families, and underserved. MHSA specifies five required components that support county mental health systems.



Community Services and Supports (CSS)

- Direct mental health services and supports for children and youth, transition age youth, adults, and older adults
- Permanent supportive housing for clients with serious mental illness
- Accounts of 76% of the total MHSA allocation

Prevention and Early Intervention (PEI)

- Services to engage individuals before the development of serious mental illness or at the earliest signs of mental health struggles
- Accounts of 19% of the total MHSA allocation

Workforce and Education Training (WET)*

- Enhancement of the mental health workforce through continuous education and training programs

Innovation (INN)

- Opportunities to design and test time-limited new or changing mental health practices that have not yet been demonstrated as effective, and to fuse such practices into the mental health system, thereby increasing access to underserved communities, promotion of interagency collaboration, and the overall quality of mental health services
- Accounts for 5% of the total MHSA allocation

Capital Facilities and Technological Needs (CFTN)*

- Building projects and improvements of mental health services delivery systems using the latest technology

**Transfers of CSS funds to WET and/or CFTN are permitted in accordance with MHSA guidelines*

DEVELOPMENT OF THE THREE-YEAR PLAN

MHSA Requirements

WIC Section 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan and Annual Updates for MHSA programs and expenditures. Counties must also submit Annual Updates reflecting the status of their programs and services, as well as any changes.

Plans and Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after Board of Supervisor adoption.

WIC Section 5848 states the mental health board shall conduct a public hearing on the draft Three-Year Program and Expenditure Plan at the close of the 30-day comment period.

MHSOAC is mandated to:

- oversee MHSA-funded programs and services through these documents, and
- evaluate how MHSA funding has been used, what outcomes have resulted, and how to improve services and programs.

LACDMH STRATEGIC PLAN 2020-30:
TRANSFORMING THE LOS ANGELES COUNTY MENTAL HEALTH SYSTEM

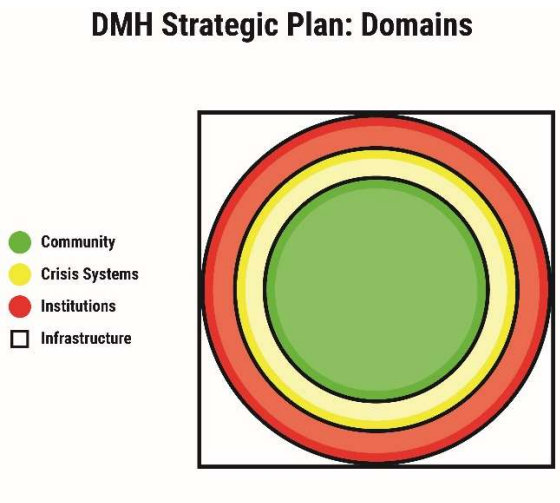
Vision
We envision an LA County unified by shared intention and cross-sector collaboration that helps those suffering from serious mental illness heal, grow and flourish by providing easy access to the right services and the right opportunities at the right time in the right place from the right people.

Mission
Our mission is to optimize the hope, well-being and life trajectory of Los Angeles County's most vulnerable through access to care and opportunities that promote not only independence and personal recovery but also connectedness and community reintegration.

Values and Principles
The LACDMH Strategic Plan is based on a core set of fundamental values and principles that will guide us on how best to implement change. To succeed, the plan must embody the following values and principles:

- **Client driven** – where we engage consumers, families, communities and all of our grassroots stakeholders as full collaborators in transformation, from care delivery to systems redesign.
- **Community focused** – where the needs and preferences of the communities are recognized and where resources are specially designed and aggressively deployed to meet them.
- **Equitable and culturally competent** – where consumers, family members and communities are cared for equitably and where services are delivered with cultural respect.
- **Accessible and hospitable** – where all services and opportunities are readily available, easy to find, timely and welcoming to everyone.
- **Dedicated to customer service** – where our core calling is to provide premier services to all of our customers, from consumers and families to DMH staff and the vast network of contractors.
- **A heart-forward culture** – where we hold sacred the humanity, dignity and autonomy of those we serve because everyone has the right to flourish and to live a healthy, free and fulfilling life.
- **Collaborative** – where we recognize that we cannot go it alone and that we need the expertise, dedication and teamwork of many other departments and the full range of community partners.
- **Continuous improvement** – where care is focused on meeting the needs of those we serve through best practices, where decisions are tailored and informed by outcomes and where ongoing efforts to increase our impact are built into our work at every level, every day.

The LACDMH Strategic Plan focuses on the change we need to drive across the system, a system we break down into the three key domains where we interface with clients.



The **Community**, reflected in the green circle, signifies our North Star where we will always prefer and strive to provide services and opportunities; half of the Strategic Plan focuses on community and ways in which proactive and therapeutic resources can be built up across the County. Our work in the community domain will eventually interlock to construct a fully heart-forward, recovery-based system of care. In time, we aspire to have enriched, welcoming and inclusive communities where human needs are met in a responsive and effective manner across the County and where falling out of community due to mental illness is neither common nor acceptable. Achieving this goal will require more prevention services, resources to address social determinants and outpatient mental health care.

The second domain, the **Crisis** System, reflected in the yellow ring, is defined by our interactions with clients experiencing crises and includes the intensive care resources (real time services as well as facility-based treatment for rapid stabilization) needed to help individuals in crisis who are falling out of community. With a strong crisis system in place, numerous bouts of homelessness and episodes of incarceration (the institutions of our day) can be avoided. Proper function in this domain will require the addition of new staffing capacity, including emergency outreach and triage division reinforcements, and a significant expansion of urgent care, crisis residential (including Short-Term Residential Treatment Program - STRTP), sub-acute and acute treatment beds that together create an impenetrable guardrail around communities to keep our most vulnerable clients out of harm's way. In short, this portion of the LACDMH Strategic Plan focuses on intensive treatment.

The third domain, **Institutions**, is represented by the red ring, where our broad portfolio of re-entry resources (including compelled treatment) is deployed to help clients who have fallen out of community into the "open-air" asylum of the street, the "closed-air" asylum of the jail, and the personal asylum of deep isolation none of which is an acceptable place for engagement and care, let alone habitation. Given the epidemics of homelessness and incarceration in our County, we must be sure that we have in place a robust portfolio of re-entry initiatives designed to care for individuals languishing and subsisting in the institutions and that we provide clear, resourced pathways back to community. For children, "Institution" refers to prolonged or repeated child welfare involvement and juvenile probation. This portion of the LACDMH Strategic Plan focuses on re-entry initiatives.

Our **Infrastructure**, reflected by the square and circular lines, is where we ensure LACDMH is firmly anchored in the best people and processes to carry out our work. It is ever-present across all three domains and provides a foundation for everything we do. Here is where we prioritize the efficiency and effectiveness needed to achieve the best possible outcomes on behalf of our communities. This part of the LACDMH Strategic Plan focuses on organizational support.

As LACDMH advances its mission, it is entirely committed to playing a key role as partner and contributor to the County's broader vision for addressing critical challenges and helping communities thrive. To this end, LACDMH has aligned the goals of its own Strategic Plan with the 2016-2021 County Strategic Plan (https://lacounty.gov/strategic-plan-and-goals/) to ensure a cohesive response.

Los Angeles County Strategic Plan

GOAL I	GOAL II	GOAL III
Make Investments That Transform Lives	Foster Vibrant and Resilient Communities	Realize Tomorrow's Government Today

MISSION: Establish superior services through inter-Departmental and cross-sector collaboration that measurably improves the quality of life for the people and communities of Los Angeles County

VISION: A value driven culture, characterized by extraordinary employee commitment to enrich lives through effective and caring service, and empower people through knowledge and information

COUNTY DEMOGRAPHICS

The Los Angeles County (County) Department of Mental Health (LACDMH) is the largest county-operated mental health system in the United States. Serving as the local mental health plan in an area with over 10 million residents, LACDMH ensures access to quality mental health care through its provider network composed of directly operated clinic sites, contracted clinic sites, and co-located sites. These sites provide an array of programs and services to County residents within and beyond the physical clinic facilities in more than 85 cities within its boundaries.

County residents represent one of the most diverse populations. This diverse racial and ethnic makeup are spread across approximately 4,000 miles that the County serves based on eight County defined Service Area (SA) boundaries. The next two tables provide the breakdown by race/ethnicity based on the SAs. Bold values shown in blue and brown represent the highest and lowest percentages, respectively, within each racial/ethnic group (Table 1) and across all SAs (Table 2).

Figure 1. Total population by race/ethnicity

SA 1 – Antelope Valley
SA 2 – San Fernando Valley
SA 3 – San Gabriel Valley
SA 4 – Metro Los Angeles
SA 5 – West Los Angeles
SA 6 – South Los Angeles
SA 7 – East Los Angeles County
SA 8 – South Bay

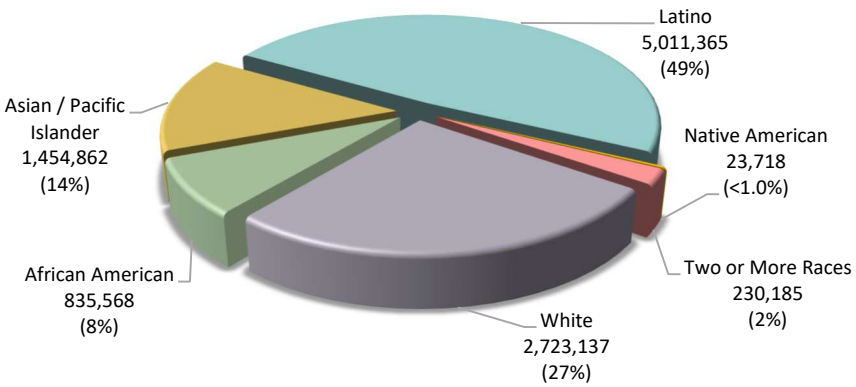


Table 1. Population by race/ethnicity and Service Area

Service Area (SA)	African American	Asian / Pacific Islander	Latino	Native American	White	Two + Races	Total
SA 1	60,592	15,412	182,426	**1,912**	125,919	11,322	**397,583**
Percent	15.24%	3.88%	45.88%	**0.48%**	31.67%	2.85%	100%
SA 2	76,738	255,524	916,400	4,751	949,722	59,141	**2,262,276**
Percent	3.39%	11.29%	40.51%	0.21%	41.98%	2.61%	100%
SA 3	63,526	**505,293**	843,458	3,716	357,632	34,638	**1,808,263**
Percent	3.51%	**27.94%**	46.64%	0.21%	19.78%	1.92%	100%
SA 4	58,698	204,655	617,033	2,599	281,580	21,229	**1,185,794**
Percent	4.95%	17.26%	52.04%	0.22%	23.75%	1.79%	100%
SA 5	37,280	91,290	**110,426**	1,198	**399,221**	**28,448**	**667,863**
Percent	5.58%	13.67%	**16.53%**	0.18%	**59.78%**	**4.26%**	100%
SA 6	**276,877**	**19,331**	722,715	**1,812**	**25,529**	**11,431**	**1,057,695**
Percent	**26.18%**	**1.83%**	68.33%	**0.17%**	**2.41%**	**1.08%**	100%
SA 7	**38,961**	118,547	**975,913**	3,329	169,183	15,372	**1,321,305**
Percent	**2.95%**	8.97%	**73.86%**	0.25%	12.80%	1.16%	100%
SA 8	222,896	244,810	642,994	4,401	414,351	48,604	**1,578,056**
Percent	14.12%	15.51%	40.75%	0.28%	26.26%	3.08%	100%
Total	**835,568**	**1,454,862**	**5,011,365**	**23,718**	**2,723,137**	**230,185**	**10,278,835**
Percent	8.13%	14.15%	48.75%	0.23%	26.49%	2.24%	100%

Data source: ACS, US Census Bureau and Hedderson Demographic Services, 2019
Some totals and percentages reflect rounding

Table 2. Population by race/ethnicity and Service Area

Ethnic Group	Highest	Lowest
African-American	SA 6 (26.2%)	SA 7 (2.9%)
Asian/Pacific Islander	SA 3 (27.9%)	SA 6 (1.8%)
Latino	SA 7 (73.9%)	SA 5 (16.5%)
Native American	SA 1 (0.48%)	SA 6 (0.17%)
White	SA 5 (59.8%)	SA 6 (2.4%)
Two or More Races	SA 5 (4.3%)	SA 6 (1.1%)

SA 1 – Antelope Valley
SA 2 – San Fernando Valley
SA 3 – San Gabriel Valley
SA 4 – Metro Los Angeles
SA 5 – West Los Angeles
SA 6 – South Los Angeles
SA 7 – East Los Angeles County
SA 8 – South Bay

In addition to the racial and ethnic diversity, LACDMH also serves residents across their lifespan. Figure 2 and Tables 3 and 4 below provide a snapshot of the population breakdown by age group based on the SAs. Bold values shown in blue and brown in represent the highest and lowest percentages, respectively, within each age group (Table 3) and across all SAs (Table 4).

Figure 2. Total population by age group

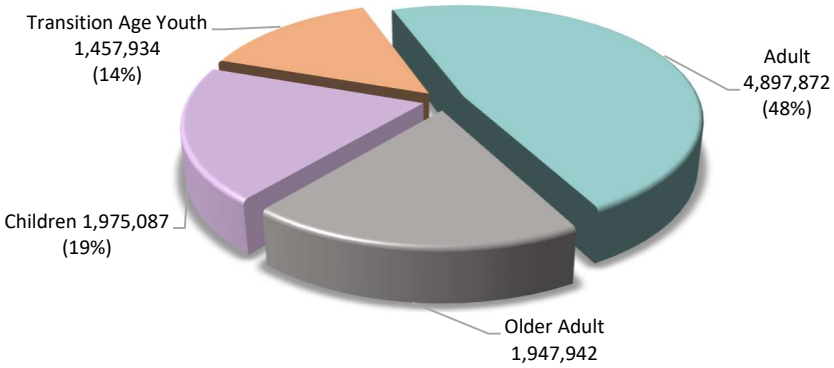


Table 3. Population by age group and Service Area

Service Area	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	106,815	13,746	**35,085**	**175,578**	23,206	43,153	**397,583**
Percent	26.87%	3.46%	**8.82%**	**44.16%**	5.84%	10.85%	100%
SA 2	499,201	61,811	155,507	1,091,975	143,160	310,623	**2,262,277**
Percent	22.07%	2.73%	6.87%	48.27%	6.33%	13.73%	100%
SA 3	397,955	54,967	133,761	831,319	**116,518**	273,743	**1,808,263**
Percent	22.01%	3.04%	7.40%	45.97%	**6.44%**	15.14%	100%
SA 4	241,723	**26,490**	**70,982**	**637,635**	62,497	146,467	**1,185,794**
Percent	20.38%	**2.23%**	**5.99%**	**53.77%**	5.27%	12.35%	100%
SA 5	**119,703**	23,198	41,669	335,949	40,961	**106,383**	**667,863**
Percent	**17.92%**	3.47%	6.24%	50.30%	6.13%	**15.93%**	100%
SA 6	**307,162**	**38,831**	**93,469**	476,370	**48,518**	**93,344**	**1,057,694**
Percent	**29.04%**	**3.67%**	**8.84%**	45.04%	**4.59%**	**8.83%**	100%
SA 7	337,324	41,472	105,306	605,575	70,813	160,814	**1,321,304**
Percent	25.53%	3.14%	7.97%	45.83%	5.36%	12.17%	100%
SA 8	370,643	44,234	111,967	743,471	95,325	212,417	**1,578,057**
Percent	23.49%	2.80%	7.10%	47.11%	6.04%	13.46%	100%
Total	**2,380,526**	**304,749**	**747,746**	**4,897,872**	**600,998**	**1,346,944**	**10,278,835**
Percent	23.16%	2.96%	7.27%	47.65%	5.85%	13.10%	100%

Data source: ACS, US Census Bureau and Hedderson Demographic Services, 2019
Some totals and percentages reflect rounding

Table 4. Population by age group and Service Area

Age Group	Highest (in blue)	Lowest (in brown)
0-18	SA 6 (29.0%)	SA 5 (17.9%)
19-20	SA 6 (3.7%)	SA 4 (2.2%)
21-25	SA 6 & 7 (8.8%)	SA (6.0%)
26-59	SA 4 (53.8%)	SA 1 (44.2%)
60-64	SA 3 (6.4%)	SA 6 (4.7%)
65+	SA 5 (15.9%)	SA 6 (8.8%)

SA 1 – Antelope Valley
SA 2 – San Fernando Valley
SA 3 – San Gabriel Valley
SA 4 – Metro
SA 5 – West
SA 6 – South
SA 7 – East
SA 8 – South Bay

COMMUNITY PLANNING

The goal of the Community Planning Process is to ensure community stakeholders take an active role in advising the County on service needs across all Los Angeles County communities. LACDMH takes a collaborative and inclusive approach to understanding community priorities through a community-driven partnership that engages the large, multicultural, and diverse community stakeholder group within the County.

A. Partnership with Stakeholders: YourDMH

The purpose of this collaborative and inclusive approach is to develop shared goals of hope, recovery, and well-being. This approach, known as YourDMH, is engaged to produce community-driven stakeholder priorities that provide feedback and guidance to LACDMH in the development of LACDMH action plans for countywide service provision across the system. It forms planning and development for large system efforts, including the MHSA Three-Year Plan. Partners in YourDMH play an active role in setting the priorities of funding allocations for services funded by MHSA and provide feedback on priority populations and service models to be implemented.

The active partnership includes these diverse groups of stakeholders:

- Service Area Leadership Teams (SALT)
- Underserved Cultural Communities (UsCC)
- Community Leadership Team (CLT)
- Mental Health Commission

Service Area Leadership Teams (SALT)

For the purposes of planning and operation, Los Angeles County is divided into eight Service Areas (SA) as shown in the table below. Each SA has a SALT - formerly known as Service Area Advisory Committee (SAAC). Each SALT functions as a local forum of consumers, families, service providers and community representatives to provide LACDMH with information, advice, and recommendations regarding the:

- Functioning of local service systems;
- Mental health service needs of their geographic area;
- Most effective/efficient use of available resources; and
- Maintenance of two-way communication between LACDMH and various groups and geographic communities.

Table 5. County Service Areas

SA 1 – Antelope Valley	SA 5 – West Los Angeles
SA 2 – San Fernando Valley	SA 6 – South Los Angeles
SA 3 – San Gabriel Valley	SA 7 – East Los Angeles County
SA 4 – Metro Los Angeles	SA 8 – South Bay

Underserved Cultural Communities (UsCC)

One of the cornerstones of MHSA is to empower underrepresented ethnic/cultural groups and to give them a voice in the stakeholder process. The term refers to communities historically unserved, underserved and inappropriately served, in terms of mental health services. As a result of MHSA, UsCC subcommittees were developed by LACDMH to address the needs of targeted ethnic/cultural communities and reduce cultural and ethnic disparities in access to care and service delivery. There are seven UsCC subcommittees.

Table 6. UsCC subcommittees

African/African American	Eastern European/Middle Eastern
American Indian/Alaska Native	Latino
Asian Pacific Islander	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Two-Spirit (LBGTQI2-S)
Deaf, Hard of Hearing, Blind, and Physical Disabilities	

The UsCC subcommittees are an important part of the YourDMH community stakeholder engagement process. The UsCC subcommittees work closely with community partners and consumers to increase the capacity of the public mental health system and to develop culturally competent recovery-oriented policies and services specific to the UsCC communities. As a part of the YourDMH community stakeholder engagement process, the UsCC subcommittees have been allotted funding to develop capacity building projects that provide a unique opportunity to draw on the collective wisdom and experience of community members to determine the greatest needs and priorities related to mental health in their communities.

The goals of the UsCC capacity building projects include increasing knowledge about mental illness, increasing access to mental health resources, and decreasing stigma related to mental illness in the targeted UsCC community. These projects are not intended for the delivery of mental health services but to increase access to care by unserved, underserved, and inappropriately served populations who are uninsured/uninsurable and across age groups (children, transitional aged youth, adult, and older adult) consistent with the language and cultural needs and demographics of those communities. The projects should be community-based and include culturally effective outreach, engagement, and education and respond to historical and geographic disparities and barriers to services.

Community Leadership Team (CLT)

CLT is made up of Co-Chairs from two important networks of stakeholders: SALT and UsCC. CLT participants work together to discuss and consolidate stakeholder priorities. All stakeholder priorities that are officially endorsed by SALT and the UsCC and any other convening groups, are then included on the stakeholder priority list. The purpose of combining similar stakeholder priorities is to indicate which priorities have the support of multiple stakeholders and therefore must be relayed to LACDMH through the CLT. This group meets quarterly.

This inclusive and ongoing community planning process allows the LACDMH to gather input about experiences with MHSA programs and the current mental health system; to gauge the overall impact and effectiveness of such programs; to record recommendations for improvement of programs and processes; and to acknowledge feedback regarding future and/or unmet needs pursuant to WIC Section 5848(a).

Mental Health Commission (MHC)

In adherence to WIC Section 5604 that sets very specific membership requirements, the MHC is made up of 16 members. Each member represents a Supervisorial District. The role of the MHC is to review and evaluate the community's mental health needs, services, facilities and special programs.

B. MHSA Planning Activities

LACDMH initiated the community planning process late 2020 as LACDMH engaged members of SALT, UsCC and CLT in virtual meetings to encourage stakeholder engagement. This inclusive and on-going community planning process allows LACDMH to gather input about experiences with MHSA programs and the current mental health system; to gauge the overall impact and effectiveness of such programs; record recommendations for improvement of programs and processes; and acknowledge feedback regarding future and/or unmet needs pursuant to WIC Section 5848(a). Details for the process and timeline are shown below. All agendas and presentation documents, if any, for these stakeholder meetings are attached as Appendix A.

Figure 3. Community planning process and timeline

Quarterly CLT Meeting: October 12, 2020

During this meeting, CLT members were presented with a timeline of all the community planning process efforts that would take place within the SALT and UsCC meetings during FY 2020-21 and offered an opportunity to provide feedback on that process timeline.

SALT Presentations: October/November 2020

LACDMH conducted multiple meetings to present SA specific MHSA information including demographics, services provided and consumer needs to each SALT. This data is attached as Appendix B. Data presentation and survey were drafted specifically for each SA and then presented at the monthly SALT meetings for stakeholder input and feedback. The needs assessment was conducted to solicit input based on the survey questions below. The same survey was also made available online.

- What are some of the unmet needs of the SA you represent?
- How has the COVID-19 pandemic further impacted unmet needs of the SA you represent?
- How do you propose LACDMH address the unmet needs?
- How can MHSA programs throughout LACDMH address issues of social equity?
- What can LACDMH do to improve transitions between levels of care to ensure successful flow of clients through needed levels of care?
- What are the strengths and weaknesses of LACDMH?

UsCC Presentations: October/November 2020
Alongside geographic data presentation, cultural competency data was presented at each of the seven UsCC monthly meetings during the months of October and November 2020. Cultural competency data presentations focused on a breakdown of services countywide by ethnic populations, languages spoken, sexual orientation and gender identity. Throughout these monthly engagements with the SALTs and UsCCs, each group of stakeholders were able to provide input and feedback to the presentations in real-time and via the same needs assessment survey.

Quarterly CLT Meeting: January 20, 2021
During this meeting, CLT members were presented with an analysis of the feedback obtained throughout the various engagement opportunities that took place October through December 2020. Feedback and input were organized and filtered by categories, i.e., housing, service delivery, resources, etc. Stakeholders were given additional opportunity to further provide feedback on the process.

Mental Health Commission (MHC) Executive Committee: February 11, 2021
A high-level overview of the Plan was presented to Executive Committee members to receive input and feedback. The agenda and presentation are attached as Appendix C.

CLT Presentation: March 5, 2021
LACDMH presented an overview of MHSA and highlighted the continued work that will be accomplished by program under the current Three-Year Plan. CLT was also provided disparities data and how LACDMH intends to reduce these disparities in the different MHSA plans over the course of the next three years under the new Plan. LACDMH also brought forward proposed changes that will be in the new Plan. The agenda and presentation are attached as Appendix C.

Posting of Draft Three-Year Plan: March 19, 2021
The full version of the draft Plan was posted to the LACDMH website on this date followed by a 30-day public comment period. A Spanish version was later posted. Public comments received during this period are attached as Appendix D.

MHC Presentation: March 25, 2021
LACDMH will focus this presentation on stakeholder input and LACDMH responses to that feedback, along with disparities information. A budget overview of MHSA annual allocation by the State and carryover funding will also presented. The agenda and presentation are attached as Appendix C.

Public Hearing: April 22, 2021
The virtual Public Hearing meeting occurred on this date with Spanish and Korean translation. The agenda, presentation and transcripts are attached as Appendix E.

C. Response to Stakeholder Feedback

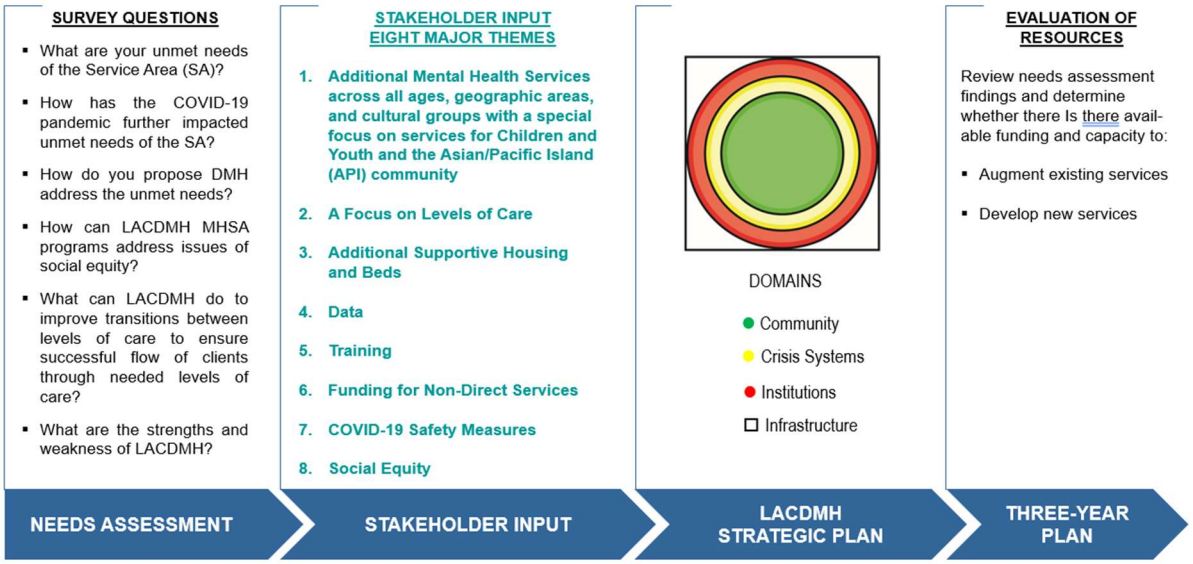
The next section provides an overview of LACDMH responses to stakeholder feedback. It captures feedback provided by UsCC, SALT, CLT, as well as the MHC.

During the community planning process in late 2020, a needs assessment was conducted to allow stakeholder participation. A survey was provided during each of the meetings and was available online for the public as well. The survey questions are captured in the next figure.

The input received from the survey questions are categorized in eight major themes. It was important for LACDMH to assess the identified needs and gaps within each theme to ensure that they align with the Strategic Plan and then evaluate available funding and capacity to address those needs and gaps to the extent possible.

1. Additional mental health services across all ages, geographic areas, and cultural groups with a special focus on services for Children and Youth and the Asian/Pacific Islander (API) community
2. A focus on levels of care
3. Additional supportive housing and beds
4. Data
5. Training
6. Funding for non-direct services
7. COVID-19 safety measures
8. Social equity

Figure 4. Process to synthesize stakeholder input community needs assessment



Below are summaries of the feedback received from stakeholders through the community needs assessment and categorized by the eight individual themes. The feedback is either linked to existing or planned programs or identified as an area for future opportunity. Following each summary are brief narratives on the existing, pending or future opportunities that are identified to address the stakeholders' feedback. For some areas, the "other" column is checked that means 1) feedback did not provide enough information or context to appropriately assess the need or 2) resources to address that specific feedback are beyond the scope of LACDMH but can be identified through other County departments and/or outside public and/or private entities.

1) Identified Need: Mental Health Services	Existing	Pending	Future	Other
Provide psychiatric mental health services at all levels of care for children and youth. Focus on 0-5, childhood trauma and sexual abuse and LGBTQ youth	X	X		

1) Identified Need: Mental Health Services	Existing	Pending	Future	Other
Increase culturally appropriate services, including language capacity that destigmatize services for all cultural groups, including API populations, African-American/Black, African immigrant, and Latino Communities across all SAs	X	X	X	
Increase directly operated FSP program services, Increase quality and oversight measures for FSPs and outpatient clinics	X	X	X	
Increase long term residential treatment options		X	X	X
Increase services for individuals with developmental disabilities, particularly residential treatment options for TAYs with significant mental health challenges.	X		X	
Support infrastructure and capacity building through subcontracting smaller organizations			X	
Increase number and hours of mental health crisis response teams so that law enforcement is not the only response. Increase PMRT services through additional funding so PMRT staff can assist with holds when programs do not have enough staff to go out in the field and write hold		X	X	
Increase the number of peer specialists across SAs			X	
Fund and integrate drug and alcohol services to better serve clients with co-occurring mental health and substance abuse service needs		X		

There is an array of mental health services, at various levels of care, provided by existing MHSA funded programs and services. For children and youth, LACDMH has already had specialized training to increase the number of clinical staff able to provide intensive services for children ages 0-5, resulting in an increase in the number of children served. To further augment services to children and youth, LACDMH will add additional funding for Child FSP services to enable the provision of ICC/IHBS services to all eligible EPSDT children/youth. This augmentation does not require children/youth to have involvement with the child welfare system, which was previously the requirement to receive ICC/IHBS services. Services to this population will also be expanded to include additional urgent care center services through the new configuration of the Olive View UCC that will include a child/adolescent unit.

To provide increased culturally appropriate services, LACDMH has increased the number of peer specialists across SAs through the expansion of Promotores/Promoters to serve all cultural groups and the development of the Community Ambassador Network (CAN) with specific emphasis on African Americans, API and American Indian populations. LADMH is also focusing on additional services focused on the API community through various efforts including adding slots to FSP teams in SA 3 to provide increased targeted mental health services for the API community, opening a new Koreatown clinic later in the year, and having regular meetings with A3PCON leadership and leaders from other API organizations. LACDMH will also implement a Peer Run Center at Northeast Mental Health Center next year with a focus on the Spanish speaking population. Larger efforts to address service capacity for cultural communities include supporting smaller, grass roots CBOs in building service capacity to provide services to their communities through subcontracting opportunities through Incubation Academy, and through the development of a disparities workgroup.

To provide an increase in LACDMH's capacity to provide mental health crisis services, LACDMH is entering into an agreement with Los Angeles Fire Department (LAFD) to implement the Therapeutic Transportation Pilot Program. The goals of this Innovation 7 Project are to optimize access to and the quality of mental health services to underserved populations; reduce the use of LAFD and Los Angeles Police Department (LAPD) resources for mental health emergency responses; and to leverage partnerships to develop a community-driven approach toward improving outcomes for individuals experiencing a mental health emergency. Throughout the 12-month pilot program, the benefits of utilizing LACDMH's therapeutic transport response as an accompaniment to LAFD's operations will be evaluated for possible Program refinements or expansion Citywide or Countywide as an alternate or augmented asset for dispatching to emergency calls. This program will operate 24/7. LACDMH is also looking into the current crisis teams and exploring the possibilities to have services 24/7 instead of 20 hours a day.

2) Identified Need: Levels of Care	Existing	Pending	Future	Other
Increase partnerships within systems for mental health and health care to ensure access to appropriate levels of care and to bridge services for clients	X			
Increase integrated services through technology	X		X	
Increase the number of navigation staff to help clients successfully transition from one level of care to another. Make the referral process less extensive and faster.	X	X	X	
Create an acuity level point system to inform levels of care	X	X		
Prioritize clients that need to be transitioned between levels of care within an agency	X	X		
Eliminate age range programs for child and TAY consumers to facilitate movement between programs. Create better system/protocol for transitioning clients when they age out of a previous system. Age range programs inhibits service provision.	X			
Assign clients to a care liaison to assist a caseload of 25-30 clients with accessing the appropriate levels of care			X	
Have a seamless system for communication and warm handoffs	X	X	X	
Decrease wait time while waiting for a higher level of service.		X		
More case management. whether it be via email, phone call or even a text	X	X		
Assign ONE patient advocate that follows the patient through all necessary levels of care... WHEREVER THEY GO			X	
Create service policies and procedures that require staff to leave client cases open until a successful transition into a new program. Staff cannot close client until they are opened in the new program	X			
Fund additional FSP and OCS system wide			X	

To ensure clients are receiving the most appropriate level of care, it is important that the navigation, referral and linkage processes between levels of care and service providers are collaborative and seamless. There are currently several existing collaborations and co-locations of services between LACDMH and Los County Department of Health Services (DHS) to provide an array of MHSA funded programs and services. Training for staff and navigators across both systems are done regularly on referral and linkage services and how to conduct effective outreach and engagements, and transitions. Additional technical supports were added for FSP programs to provide needed client supports in the soon to be transformed FSP program. In addition, LACDMH uses LANES which shares data with other partners. LACDMH consistently explores additional ways to integrate data to support seamless service provision. LACDMH has instituted additional case reviews and clinical team meetings to discuss possible client transitions to other levels of care and implemented many provider type webinars to increase communication and ensure all providers are working on the same goals as it relates to access to care and streamlining referral and linkage processes.

LACDMH is closely monitoring access to care across programs in order to ensure decreasing wait times; streamlining processes and increased capacity as part of the call center modernization project and has taken additional measures to make necessary levels of care decisions for individual clients, including using Intergual in the LACDMH Intensive Care Division to inform level of care decisions. This tool is being explored for use in FSP programs and in Outpatient Care Services. LACDMH has updated reports to track/monitor clients, reworked outcomes, and are implementing processes to better monitor progress and provide support in FSP and Outpatient Care Services and is also considering implementing pre-appointment appointments for case managers to meet with clients before every appointment with their psychiatrist.

3) Identified Need: Housing	Existing	Pending	Future	Other
Provide greater independently living housing opportunities for consumers other than shelters like Project Room Key, fund more affordable permanent housing for homeless clients with wrap around services. Increase support services and links to housing for people living on the streets. Provide appropriate housing for SPMI	X			
Fund youth residential treatment centers, at this time this is limited to Tarzana	X		X	
Fund additional beds for youth in SA 2			X	
Fund additional long-term residential care and Board and Care	X			
Fund more case management, support services and onsite treatment services in housing, numerous calls to LAHSA and HOPICs go unanswered	X			
Fund more housing in the Mar Vista area (SA 5) to address increase in homeless encampments, aggressive homeless with mental illness, that commit crime, drug use, encampments next to 405 freeway and at Grand View Bl and Venice Blvd	X			

3) Identified Need: Housing	Existing	Pending	Future	Other
Fund more field services to the homeless. More crisis teams with 1 hour response time to get all off the street. Add more mental health and substance abuse services for homeless	X			
Provide additional funding for shelters to include WiFi access/hotspot distribution and transportation to shelter locations where families can access Wi-Fi or Wi-Fi hotspot distribution, working with LAUSD to distribute laptops		X		
Fund refuge clean up near and around homeless encampments				X
Team mental health workers with police to deal with those out on the streets using drugs or other addictions	X		X	
Provide a list of providers that offer housing services, does LACDMH have a list of DHS and LAHSA agencies so that we may more easily refer clients to housing services		X		
Develop opportunities for value, meaning, occupational and job assistance in long term residential care and supportive housing for clients-it's not a lock down	X			
Managed care as part of services in a few centralized FEMA type transitional housing village sites. If sick people have a hard time traveling to a clinic or doctor offering on site would facilitate the levels of care they need. The closer they are to the services and follow-ups the better. But, to save cost, time and travel expenses the homeless services must be placed in a centralized location so services are not spread out all over the place costing more than it should to provide. One or two large centralized regulated camps for homeless where they can stay for the long haul with clean facilities and services next to them	X			
More field workers for encampments across Los Angeles County. There should be emergency teams throughout the region and a hotline so people can call you when a mental health crisis is occurring in their neighborhood, so people don't have to call the police.			X	
Mandate transitional housing for the unsheltered				X
Increased security is needed in homeless encampments. Countless encounters with mentally unstable, drug addicted homeless has left residents feeling at risk from violent threats and bodily harm. homeless are in danger of being assaulted near encampments that harbor drug abusers and others that have abnormal mental issues				X

LACDMH provides opportunities for independent living through the Housing Division, which provides services to people experiencing homelessness through its network of Homeless FSP programs which outreach to people experiencing homelessness and assist them with obtaining housing. Housing FSP coupled with Intensive Case Management Services (ICMS) are provided to consumers matched to LACDMH's housing resources. Once in permanent supportive housing, clients are supported by ICMS and Housing FSP providers with their recovery goals, including employment goals. LACDMH also assists homeless clients in

securing temporary housing through Project Room Key (PRK) resources. The clients are also assisted with transitioning to other housing in the community. LAHSA provides funding to assist all people in PRK to secure permanent housing. LACDMH also continues to expand its permanent housing resources by providing investments in the capital development of housing (dedicated to LACDMH clients), flexible housing subsidy pool, Enriched Residential Care Program (ERC) and contracts with the Housing Authorities for subsidies through Section 8 and Shelter Plus Care. Through the ERC program, LACDMH can subsidize the rent for clients with no income living in Board and Care homes. LACDMH is also able to pay an enhanced rate to the Board and Care operators. Also, the County is developing an interactive map that will including interim and permanent housing sites. LACDMH is also implementing MHRLN that will have a public facing interactive map of the ERC facilities. LACDMH has intentionally worked to develop housing opportunities both interim and permanent in each Service Area to ensure accessibility for clients. Due to several factors such as community acceptance and opportunity, some areas do have more housing than others but LACDMH will continue to look for opportunities for geographic disbursement of housing in all parts of the County.

Street outreach and services for homeless encampments are provided by the LACDMH HOME Teams. Many areas experiencing public health and safety challenges caused by growing encampments such as in SA 5 receive regular outreach and engagement efforts conducted by the HOME Team. While encampment clean-up is managed in large part by LA City Unified Homeless Response Center in coordination with other relevant City and County departments (e.g., animal services, public works, etc.), the HOME conducts outreach in collaboration with DHS funded multidisciplinary teams and LAHSA Homeless Engagement Teams to identify, refer and link clients to integrated services as appropriated. Services through the Law Enforcement Teams Co-response model is used to respond to 911 calls in and near encampments to assist individual who come to the attention of law enforcement but need mental health services. As clients are linked to services, LACDMH continues to explore suitable housing opportunities and resources across SAs using the Housing First Model. Across Los Angeles County housing costs vary, which in some cases may also result in some areas have more available housing resources than others.

Access to technology and the internet is important given the multiple resources that are available to clients on-line. LACDMH is surveying its current Interim Housing providers to determine which sites have WiFi access for the clients and will explore how to get all of them to provide this service. Some of the housing providers are on LACDMH's website under Housing Resources. LACDMH embraces client choice and Housing First. Not sure how the "security" need would be addressed by LACDMH. HOME does conduct outreach to encampments as part of the larger countywide coordinated outreach strategy.

4) Identified Need: Data	Existing	Pending	Future	Other
Provide data for those with physical disabilities, LGBTQ				X
Provide data for indigent population (not clear if it is already counted under Latino Population or Native American) preferably to have their own category				X
Provide data on ethnicity breakdown for FSP Child	X			
Provide data specific to identifying Native Americans (example: Native American or identify primarily or identify culturally as Native American), Native American needs assessment	X			X

4) Identified Need: Data	Existing	Pending	Future	Other
Provide ethnic breakdown within the age category (same for PEI Data)	X			
Provide data on Korean speaking populations	X			X
Provide data to safely document or track the needs of undocumented population, distinguish data for insured vs. uninsured				X
Provide data of the population that are served by health plans				X
Provide data for Black populations, e.g., African Americans other Black Americans or cultures	X		X	
Provide data for managed care (Medi-Cal/Medi-Care) to be more accurate for funding				X
Provide all data in percentages and not just raw numbers	X			
Provide data report cards on updates (e.g., are programs getting better, meeting goals, quality of care, are clients accessing services, why or why not, did they fall out of service)			X	
Centralize data collection and make this centralized unit resolve issues as needed	X			
Collect data on the increase in services for the AIAN population as UsCC groups want to see if activities (e.g., conferences, outreach, PSAs are successful)	X			
Need to incorporate data for those with physical disabilities and those who are deaf and communicate with sign language. The lack of ADA compliant services and agencies providing services for those who are deaf and hard of hearing is problematic			X	

During the initial phase of engagement, LACDMH provided disparity data by SA and ethnic population for unique clients serviced across MHSA programs and services, including prominent languages across SAs. In addition to the data provided, LACDMH can report on penetration rates for Medi-Cal beneficiaries. LACDMH is working towards developing an ongoing dashboard to make data informed decisions about service provision and programming. This includes collecting data and/or identifying service resources for those who require. LACDMH will need to place greater emphasis on collecting data and/or identifying service resources for those who require ADA compliant services and/or services for the deaf and hard of hearing populations.

5) Identified Need: Funding for Non-Direct Mental Health Services	Existing	Pending	Future	Other
Increase WET funding with a focus on technology to increase workforce for therapists and to purchase technology for CBOs that will be used to buy equipment clients can borrow to access tele health/mental health services	X		X	

5) Identified Need: Funding for Non-Direct Mental Health Services	Existing	Pending	Future	Other
Spend the budget that has been allocated to build community, show that all volunteers are appreciated through stipend payments	X			
Start paying advocates that are independent of LACDMH to help. Especially those who have been trained by Project Return Peer Support Network. And offer hourly wage to work with people they can support until they get to the right service provider.	X			
Fund an advocate to the state of CA that will lobby for MHSA funds be used to treat/house/intervene for seriously mentally ill. Assist the SMI community with interventions asap			X	

LACDMH enhanced their telehealth abilities within the existing workforce and as new employees are hired, the workforce increases and continues to explore telehealth activities and programs currently being offered through CBO's and will consider additional needs to expand this capacity. LACDMH appreciates and values, the support and expertise of volunteers. Examples of current stipend volunteer programs include the Wellness Outreach Workers (WOW) and Service Extender (SE), volunteer programs. These programs support client well-being, while also providing an opportunity for volunteers to leverage their experience and skills, to partner with those who may be isolated or vulnerable. In addition, LACDMH has implemented a robust Promoters Program that will enable the hiring of advocates with and without lived experience as County employees to provide linkage services, training, and outreach and engagement to the community. LACDMH also has stipend volunteer programs that support client well-being while also providing an opportunity for volunteers to leverage their experience and skills to partner with those who may be seeking the right service provider.

6) Identified Need: Training	Existing	Pending	Future	Other
Provide training for under-represented groups to learn how to use Teams/Zoom	X		X	
Provide training for children providers on testing to distinguish between learning disabilities and SED diagnosis				X
Provide additional training for service providers in SA 2 on providing appropriate services for older adults			X	
Provide additional training for staff on co-occurring disorders		X		
Provide training to staff on providing services for ID/DD individuals rather than labeling them as an unserved population and not offering this population services		X		
Provide Basic training for clients on how to use electronics and how to register or even send an email.		X		

LACDMH consistently explores how to support the training needs of the system that can be appropriately supported with MHSA funding and resources. As a result of the COVID-19 pandemic, many in-person platforms switched to virtual settings. By utilizing Microsoft Teams, LACDMH was able to enhance existing infrastructure to maintain operations, such as community meetings, while also creating an opportunity to reach a wider audience. Other trainings that LACDMH continues to explore to support with MHSA funding include training for serving older adults and additional skill building for clinicians to service clients with co-occurring disorders.

7) Identified Need: Safety/COVID-19 Impacts	Existing	Pending	Future	Other
Increasing need for mental health services resulting from stress of COVID changes, losses, stresses, and decrease in access to needed services, food insufficiency, social isolation, family needs, unemployment, childcare needs, family loss and grief	X			
Provide COVID-19 testing sites that cater to our SMI clients				X
Ensure PPE is available for clients when they are provided face-to-face services	X			
COVID-19 has made case management services limited due to the closure of many public offices. COVID-19 has only made the lack of services even more apparent - Exasperated the unmet needs in this area, magnifying the needs and equity in under-served communities-Highlighted inequalities with technology access, health resources (unable to access medical telehealth if there are technology access or MD offices delayed or rescheduled appointments), and housing -Outreach is a lot more difficult. Homeless people may not have the technology to do appointments by zoom.			X	X
What is being done to address the threat of contagion the homeless population does not as a rule wear masks or obeying any of the CDC guidelines for social distancing so clearly COVID-19 only amplifies the health risks posed by homelessness. Many more do not abide by health codes and have no qualms about defecating next to private property. That in itself is a high-risk contagion situation that residents such as myself are REPEATEDLY exposed to! Homeless must live with safety issues and health threats just by defecation and used needle waste. With COVID-19 things just got a little bit beyond the tolerance level of health risks posed to residents immediately next to the 405 encampments.	X			
More homeless men and women walking the streets more now than ever you see patients being released from jail that need emergency mental health needs.	X			X
Increase in substance use and isolation giving rise to severe mental health issues and relationship issues.	X			X
Harsher restrictions on service providers for safety protocols; example: not allowed to drive clients to appointments, clients forced to use more public transportation and are at greater risk/exposure	X			

7) Identified Need: Safety/COVID-19 Impacts	Existing	Pending	Future	Other
There is a virtual halt to admissions at acute psych and long-term psych facilities	X			
"Stay-at home" has exacerbated mental health challenges for many, not the least of which are those who experience developmental or cognitive delays/impairments. It remains unfair that these are the individuals who continue to be barred from access to appropriate and much needed services.	X			
There needs to be a focus on outreach and programs that focus on basic needs of community members to reduce risk factors and stressors leading to full mental health services. The webpage can have an easier way of viewing by community members to get the information needed.	X			
Target communities of color experiencing disparities related to COVID-19 and provide short-term services to cope with stressors, conduct assessments, offer education and outreach, link community members to important resources	X			X
Need greater access to mental health services/peer support, transportation to services during COVID-19	X			

LACDMH has taken a number of measures to provide additional services and supports to individuals and communities in need during the recent COVID-19 pandemic to support the well-being of our County residents and communities. The loss or the potential loss of physical/mental health and wellness, loved ones and friends, economic/housing secure and the constant news and updates about COVID-19 triggered widespread anxiety, panic, frustration, and depression—even when an individual's risk of getting sick was low. During this time of disease outbreak, LACDMH provided supports to assist individuals and communities in taking care of their physical and mental health and took extra steps to reach out to those that needed to be connected or re-connected with services through in-person socially distanced visits, phone calls, and virtual means.

In addition, LACDMH provided equipment and other resources to assist individuals and communities in maintaining safety and wellness during the pandemic. Supports provided by DMH included: offering personal protective equipment (PPE) to all clinics and clinicians on a routine bi-weekly basis to use and offer clients when providing in-person services. For clients not coming into traditional mental health clinics or accessing online/phone supports or services through the LACDMH telephone help line, LACDMH, through its street outreach teams routinely distributed PPE during outreach. Teams also provide COVID-19 education of symptoms, isolation and quarantine sites. LACDMH also provided staff to be disaster service workers to sites across the County in collaboration with public health and the CEO to assist with coordination of countywide efforts to address individual and community needs. LACDMH also provided education, resource and contact information for additional services and supports appropriate for individuals of all Los Angeles communities and age ranges at its public facing website at https://dmh.lacounty.gov/covid-19-information. To address racial disparities, LACDMH engaged in the Advancement Project, in which 30 cities that were really impacted by the pandemic were identified in which racial inequities were already an underlying issue. LACDMH is working closely with these cities through MHSA Innovations 2 supports and the newly developed Community Ambassador Network (CAN).

8) Identified Need: Social Equity	Existing	Pending	Future	Other
Address the intersections of race, gender and class that led to many of these individuals being the streets.	X		X	X
Provide integrated care, education to black and brown communities.	X		X	
Make the services available to everyone regardless of finances. Make it more widely known that these services are available so that there is no denying they exist to help people in need.	X			
LACDMH employees need training in the area of Trauma, because the employees supporting LACDMH are those traumatizing others by their own actions, therefore creating hostility to those who volunteer and give of themselves, thus creating a lack of trust and partnership	X		X	
Development social equity team and share info with community about outcome of needs assessment, resources that will be brought in, training that will be delivered to community and LACDMH, and strategic goals and plan to address equity issues	X		X	
Make sure staff is diverse and speak different languages.	X			
The programs can ensure that there is scheduling flexibility for working people, a clearer cancellation policy due to many people requiring to be available for gig work and on call positions (people cannot follow a typical once a week every week same day/time schedule given economic uncertainty. There needs to be more outreach to understand each neighborhood's needs and to adapt funding to those needs. Everything is not one size fits all. They can promote a whole person care modality so that no one ignores economic, racial and other oppressive systems which is impacting a person's care (wellness includes mental and emotional not just physical, but we all have to work collaboratively to support our community members), Discussions on the effects of racism and impacts on wellness, discussion of things that reduce trust when entering a program associated with a "system".	X			
By examining and addressing "social determinants" of need such as various stressors that disproportionately affect BIPOC community members. Review, improve and change, where needed, its readiness, practices, personnel to match the needs of these communities. Address the slow turn-around from data collection to policy change(s)	X			
Give more grants for grass roots	X			
Through education and outreach activities would aid in lowering the stigma associated with seeking mental health services and increase the individuals reaching out for services	X			
If we make efforts and can be the voice for the people who do not have a voice, we will be able to make the difference to have social equity.	X		X	

8) Identified Need: Social Equity	Existing	Pending	Future	Other
Assess the needs of all community members insured/uninsured or documented/undocumented. Programs can develop safe ways to share this information with the county to ensure the overall community needs are met and not just the needs of some.	X		X	
Explicit recognition of the physical and mental health harms of inequality	X			
More dissemination of info and Provide a safe space to discuss issues	X			
Outreach engagement and education for all cultures	X			
On-going training. Mandate all staff (managers, clinical supervisors, line staff) attend.	X		X	

LACDMH has continued and augmented its efforts to address issues of social equity. While LACDMH serves all clients that are in need regardless of their ability to pay, it has had to make some very intentional efforts to address disparities related to social equity or lack thereof. To address issues of racial equity in service division, LACDMH continues to try and ensure services are in the preferred language of the client and there are staff can provide mental health care with an understanding of the cultural and language competencies needed by the client. In addition to continued improvements in cultural competencies and appropriateness, LACDMH is working in collaboration with other County departments, most notably the Chief Executive Office in developing and implementing workgroups and strategies around social justice. LACDMH is an active participant in the Los Angeles County Anti-Racism, Diversity, and Inclusion (ARDI) Initiative which is an effort committed to fighting racism in all its dimensions, especially racism that systemically and systematically effects Black residents in the County. LACDMH also held Action Learning Communities (ALC) which identified various actions needed to address issues that create equity issues for Black, Indigenous, and People of Color (BIPOC) communities. Grass roots organizations that can provide culturally congruent services to their communities were also supported through MHSA PEI funding to build capacity and develop service infrastructure towards the goal of becoming a part of the LACDMH Provider Network.

LACDMH conducted two presentation and information sessions for the CLT in which feedback was collected. On March 5, 2021 a summary of the Plan was presented. Some general comments and sentiments shared by this group included the direct quotes below:

- "*This is a wonderful opportunity to collaborate and learn together*." Wendy C.
- "*Yes, so really focusing on disparities and also aligning with the criterion of DMH cultural competency plan, so training, having a diverse workforce, language, there are a lot of great ingredients there*…." Andrew P.
- "*Excellent. Very educational and good follow-up*." Rick P.
- "*This was a great dialogue*." Claudia
- "*Feeling informed*." La Vonda

D. Disparities

When comparing the racial and ethnic distributions of Los Angeles County Medi-Cal enrollees with the racial and ethnic distributions of those who receive direct mental health services within Los Angeles County, trends emerge that need to be addressed. Specifically, both the Latino and Asian/Pacific Islander (API) groups have proportionately received fewer mental health services than their representation as Medi-Cal enrollees would suggest. See table below.

Table 7. Medi-Cal enrollees and beneficiaries served in calendar year (CY) 2018 by race/ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	Percent Enrollees	Unduplicated Annual County Beneficiaries Served	Percent Served
White	514,888	13.0%	32,635	15.5%
Latino/Hispanic	2,320,000	58.6%	108,093	51.4%
African-American	390,371	9.9%	37,455	17.8%
Asian/Pacific Islander (API)	377,714	9.5%	9,422	4.5%
Native American	5,042	0.1%	522	0.2%
Other	356,845	9.0%	22,210	10.6%
Total	3,960,000	100%	210,337	100%

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it.
The averages are calculated independently. Data represents entire Los Angeles County and is not specific to MHSA

When comparing External Quality Review Organization (EQRO) calendar year 2015 through 2019 Medi-Cal claims data, both Latino and API populations in Los Angeles County consistently are under-served relative to their percentage as Medi-Cal enrollees. The next table illustrates this trend.

Table 8. Percent of enrolled Latino and API receiving service

Race Ethnicity	CY 2015		CY 2016		CY 2017		CY 2018		CY 2019	
	Enrollees	Percent Served	Enrollees	Served	Enrollees	Served	Enrollees	Served	Enrollees	Served
Latino	60.2%	45.7%	57.5%	46.9%	58.2%	46.4%	58.6%	51.4%	59.1%	53.1%
API	8.5%	4.3%	9.7%	4.6%	9.5%	4.1%	9.5%	4.5%	9.6%	4.3%

This trend extends beyond Los Angeles County, statewide. CY 2018 EQRO Behavioral Health Concepts data indicates that while the percent of Medi-Cal enrollees Statewide for the API and Latino populations respectively are 9.91% and 50.28%, only 4.78% of API and 40.73% of Latino beneficiaries received one or more direct mental health services (California EQRO MHP Annual Report Presentation FY 2019-20, March 5, 2021).

Finally, a report issued by the California Healthcare Foundation, found that in FY 2017-18, the API and Latino populations served by County Mental Health Plans, when compared to other racial and ethnic populations, had the lowest continued engagement rates, as defined by receiving 5 or more mental health services in a year (Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal, November 2020, California Healthcare Foundation).

Proposed Actions to Address Racial/Ethnic Mental Health Care Disparities

Based on feedback from UsCC groups, LACDMH will review the data it collects to attempt to comprehensively capture racial, ethnic, cultural and disability status to more accurately identify who we are providing mental health services to. LACDMH has committed to participating in a multi-county learning collaborative, informed by the outstanding work of

Solano County and comprised of training from the University of California, Davis (UC Davis) Center for Reducing Disparities on applying the Culturally and Linguistically Appropriate Standards (CLAS) to populations that we specify and to utilize quality improvement approaches to reduce disparities. Our participation is contingent upon the MHSOAC approving the work with UC Davis. LACDMH views this opportunity as a vehicle for the disparities reduction efforts to be initiated.

In the meantime, there are both current and planned efforts within individual MHSA programs and services to address disparities.

- ***Full Service Partnership***
  - Provide trainings and support for working with diverse populations, with a particular focus on the API community
  - Work with University of California, Los Angeles (UCLA) and subject matter expects from the API and other communities to develop best practices
  - Add additional API FSP teams in Service Areas (SA) 3, 4, and 8
  - Increase the use of disparities data across the LACDMH system, as well as at the local SA level, to inform and shape FSP services for diverse populations

- ***Outpatient Care Services***
  - Establish a new clinic in Koreatown
  - Develop telehealth network across SA to provide language capacity and cultural competency, beginning with an API pilot

- ***Housing Programs and Services***

  LACDMH manages various housing resources that are dedicated to individuals who are homeless and have a serious mental illness (SMI). The table below represents individuals living in units that are included in LACDMH's Permanent Supportive Housing (PSH) portfolio and compares their race and ethnicity to the 2020 Greater Los Angeles Homeless Count and the overall Los Angeles County population. The data seems to suggest that there is an overrepresentation of the Black/African American and White populations and an underrepresentation of the Hispanic/Latino population. However, there are nuances to the data that are unknown such as the percentage of individuals within a racial or ethnic group who have SMI and the vulnerability levels of those in each group which would impact who is matched to PSH.

  LACDMH is participating in system-wide work to research and address disparities in homeless services and housing to:
  - Respond to the recommendations of the Los Angeles Homeless Services Authority (LAHSA) Ad Hoc Committee on Black People Experiencing Homelessness;
  - Collaborate with the California Policy Lab to evaluate differences in service histories and housing outcomes among different racial and ethnic groups; and
  - Focus on identifying and addressing biases of the Coordinated Entry System (CES) Vulnerability Tool used to determine vulnerability and match those individuals who are homeless and have high vulnerability to available housing resources.

Table 9. Ethnicity groups currently housed in LACDMH PSH units as of December 31, 2020

Race/Ethnicity	Total	Percent of DMH PSH Portfolio	Percent of Greater LA Homeless Count	Percent of Overall Los Angeles County Population
American Indian	59	1.6%	1.1%	0.2%
Asian	57	1.5%	1.2%	14.4%
Black or African American	1,832	48.9%	33.7%	7.9%
Hispanic or Latino	394	10.5%	36.1%	48.5%
Native Hawaiian or Other Pacific Islander	14	0.4%	0.3%	0.2%
White	1,124	30.0%	25.5%	26.3%
Multi-Racial/Other	54	1.4%	2.1%	2.5%
Unknown	211	5.6%	0.0%	0.0%
Grand Total	3,745	100.0%	100.0%	100.0%

- ***Prevention and Early Intervention***
  - COVID-19 Priority Places Map

    The pandemic has taken a particularly brutal toll on communities of color, with black, indigenous and people of color (BIPOC) people composing a disproportionate share of infections, hospitalizations, and deaths in the County. BIPOC communities have also borne the brunt of the economic downtown caused by the pandemic. To better tailor our COVID-19 response to those communities hardest hit by the pandemic, LACDMH worked with the LACDMH+UCLA Public Partnership for Well-Being (PPfW) to create a COVID-19 Priority Places Map.

    Using data and the index developed from the Advancement Project, which focuses on the intersection of highest week-over-week averages in COVID-19 cases and communities with vulnerable and high-risk populations (defined as individuals living 200% under the federal poverty level and racial composition), 30 communities across Los Angeles County were identified at the greatest risk for adverse outcomes from COVID-19. Using that information, LACDMH focused the development of the new Community Ambassador Network to hire people from and provide resources in those communities. LACDMH will continue to use the COVID-19 Priority Places Map and other sources to inform our COVID-19 recovery strategy.

  - Community Ambassador Network (CAN)

    Community Ambassadors are trusted members of the community who are trained and hired as lay Mental Health workers. The Ambassadors help nurture healthy and racially equitable communities by empowering others, raising awareness and mobilizing change while infusing much needed funding and jobs into our most disenfranchised populations.

    CAN focuses on those communities which have been disproportionately impacted by the pandemic, systemic racism, police violence and the resulting civil unrest, or that are otherwise marginalized. LACDMH launched CAN by leveraging the existing network of trusted community-based organizations currently implementing the Innovation 2 Project - Developing Trauma Resilient Communities through Community Capacity Building project (INN 2). By repurposing unspent INN 2 funds, existing providers were able to create 197 Community Ambassador positions.

E. Public Hearing and Approval by the Board of Supervisors

The Three-Year Plan for FYs 2021-22 through 2023-24 was completed and posted to the LACDMH website on March 19, 2021 for a 30-day review by the public. A Spanish version was later posted. Public comments and survey responses captured during this period are attached as Appendix D. LACDMH hosted the virtual Public Hearing on April 22, 2021 and provided translation in both Spanish and Korean.

At the Public Hearing, LACDMH provided information on disparities in mental health care and proposed actions to address these disparities from all aspects - FSP, outpatient care, housing, and PEI. LACDMH also provided an overview of the community planning and stakeholder engagement process. LACDMH presented the proposed changes within this Plan that align with County initiatives and the LACDMH Strategic Plan. At the close of the presentation, members of the public called in to provide comments followed by questions and comments from the Mental Health Commission MHC) led by the Chair of the MHC. The MHC Recommendations Letter and LACDMH Response are attached as Exhibits E and F, respectively. The Public Hearing presentation and transcripts are attached as Appendix E.

During all the presentations leading up to and including the Public Hearing, there were many comments regarding the need for more mental health services especially where there are disparities concerns. LACDMH stressed the fact that MHSA alone cannot address these concerns, as there are also competing Countywide initiatives and priorities, as well as the economic impact of COVID-19 on the various funding streams. Addressing disparities in mental health care requires considerable work with other County departments to address barriers to seeking treatment that include the composition and competencies of the workforce, addressing the barriers associated with the social determinants of health, culturally relevant engagement and education and understanding the link between the disproportionate representation of specific cultures in the key focal populations we serve. LACDMH intends to bring these efforts together and learn how to bring governance and leadership together with linguistically appropriate communication, engagement, and continuous improvement to reduce disparities in mental health treatment and recovery.

LACDMH has responded to all substantive public comments to finalize and submit the Plan to the Board of Supervisors for approval at the regularly scheduled meeting on June 22, 2021. The adopted letter and minutes are attached as Exhibit G. The approved FYs 2021-23 through FY 2023-24 Plan were submitted to the MHSOAC as the final step for implementation effective July 1, 2021.

COVID-19 IMPACT ON THE COUNTY MENTAL HEALTH SYSTEM

The demand for critical mental health services is far greater now a year since the COVID-19 outbreak. In the last 12 months, people have been facing increased levels of stress and struggling to cope with all aspects of the pandemic - isolation and limited human interaction due to restrictions on social gatherings; loss of income or home; fear of contracting the virus; and losing loved ones to the virus. While COVID-19 resulted in major disruptions to in-person services, it was critical for LACDMH to adapt quickly to overcome these challenges, such as deploying the use of telepsychiatry on a far greater scale to maintain essential mental health services.

The significant economic impact of the pandemic was highlighted at the beginning of this Plan, so this section captures the impact on mental health programs and services, as well as access to care. It has been an increasingly challenging time for our LACDMH programs as staff, client and community concerns about COVID-19 have escalated with each passing day. Responding to the changing needs of our system of care, the LACDMH community came together to reach out to, and support, one another – staff, clients, and communities. Together, we have been able to rise to the challenges of doing our best to care for the most vulnerable, the communities in which they reside, and the staff who have provided care throughout this pandemic. We have learned through this experience that we have more capacity to be flexible and responsive than we may have previously thought possible and remain hopeful that we can emerge from this crisis a stronger community of care.

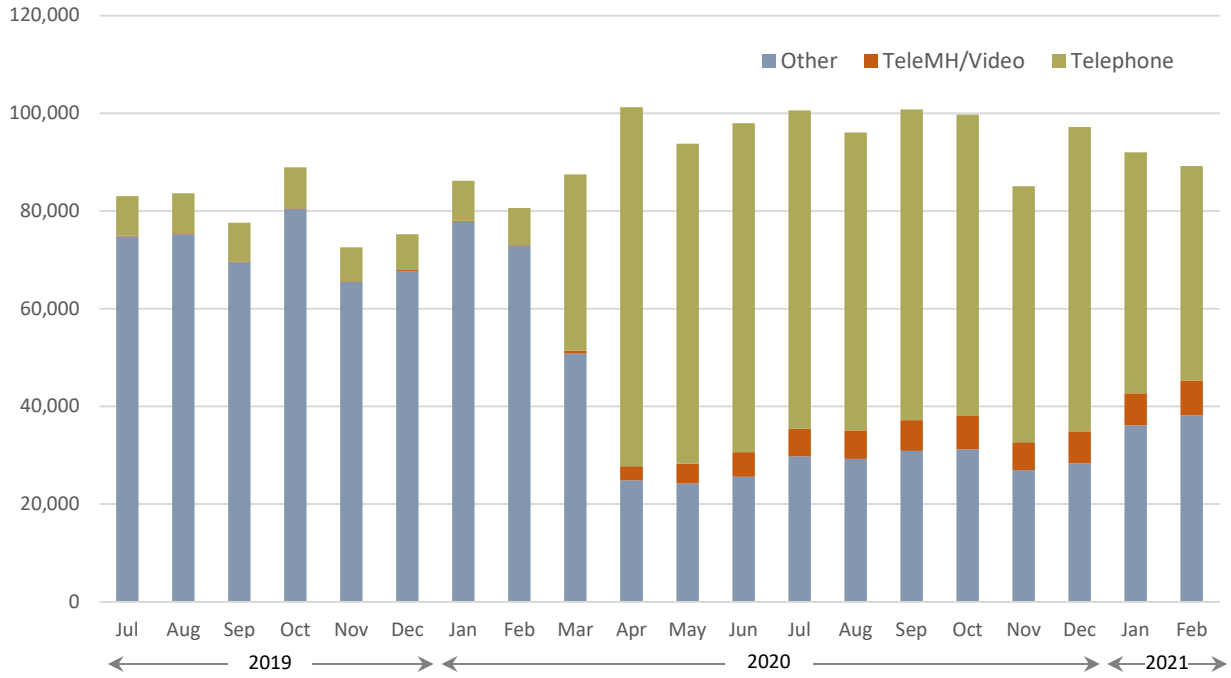
As we move forward – even in light of experience gained, and progress on the COVID-19 front – challenges remain: limited funding capacity paired with increasing demand for mental health services; maintaining a workforce in the face of illnesses, childcare issues, and meeting the demands of emergency deployments; dealing with increasingly limited community resources, and effectively collaborating with community resources in the virtual realm; and meeting the technology needs of clients to be able to increase telehealth capacity.

Outpatient Care Services

In response to the COVID-19 pandemic, LACDMH made immediate modifications to standard clinical operations in order to reduce risk, support our staff, and maintain the health and safety of our clients, staff, and communities. To reduce risk, one of the first steps taken was to reduce our footprint in LACDMH programs. We transitioned the bulk of our staff to telework, and provided most services via telehealth. We maintained in-person services for essential/urgent/emergent needs (e.g., vulnerable populations, crises, FSP clients, 5150 evaluations, clients without access to technology), and developed ways to adapt and monitor clinical practice in the context of telework. Additionally, we identified the technology solutions our workforce needed to provide care consistent with the modifications made to our clinical practice during the pandemic. Clients and staff had to adjust to a largely virtual world, and training was needed to prepare both clients and staff. To prevent any gaps in service, LACDMH quickly mobilized resources, including: the distribution of personal protective equipment; creating psychiatry hubs that could reach across the County from any location; the capacity for clinical pharmacy refills that could be done without in-person contact; and providing needed vehicles, laptops, and phones. These are examples of clinic services during the pandemic:

- A clinic's peer volunteers started a warm line for the clients of the clinic who were having a difficult time
- Virtual groups implemented to help clients stay connected with one another and the clinic
- Virtual celebrations to boost client and staff morale
- Video clinical team meetings, case conferencing, and clinical supervision to ensure best clinical practice and team cohesion
- Checking in with every client on the entire case load of each clinic

Figure 5. Mental health session types since July 2019



Full Service Partnership (FSP) - Assisted Outpatient Program (AOT)

At the beginning of the pandemic, the team outreached by phone as LACDMH employees were teleworking. Most clients were not comfortable to talk over the phone, so contact was maintained only with those with collaterals. LACDMH staff did go out to try to house homeless clients when that request was made. Fortunately, AOT teams were back in the field by the end of April; however, AOT faces challenges trying to place clients in different types of facilities due to COVID-19 restrictions. In addition, visits to clients while they are hospitalized or incarcerated have been greatly curtailed for the same reasons. Several FSP AOT initially greatly reduced their field response and since this population does not do so well with telepsychiatry, many clients were not progressing as they should. Some of these FSPs have returned to full field base responses while some have limited field responses. There was a greater number of referrals from regular FSP because, "*they are not responding in the field,*" so the client needs a higher level of care.

AOT Court closed from the end of March to the end of May. Once reopened, most of the hearings and progress reports are done through Web Ex and not in person in the courtroom. Although the Judge, Public Defender, AOT Psychologist and AOT Program Manager are in the courtroom, everyone else participates via telephone or teleconference. This has a very different impact on the client. In addition, often those clients that require hospitalization are not being ordered due to the overburdened hospital situation and the increased risk of COVID-19 in hospital congregate settings like psychiatric units.

Homeless Outreach and Mobile Engagement (HOME)

HOME was severely impacted as they were initially tasked with the monumental task of assisting with mitigating the risk of spread of COVID-19 amongst and by people experiencing homelessness (PEH). HOME was tasked with mobilizing the effort to identify, enroll, and transport PEH into Project Room Key (PRK) which is a collaborative effort by the State, County and the Los Angeles Homeless Services Authority (LAHSA) to secure hotel and motel rooms for vulnerable people experiencing homelessness to protect the capacity of hospitals and the healthcare system. The

follow-up to this effort as PRK began to demobilize was the extensive task of matching individuals to housing subsidies, and ongoing supportive services and benefits. HOME was involved with the City of Los Angeles and County COVID-19 testing teams that have now transitioned into supporting vaccination of PEH over the age of 65. Last summer HOME worked collaboratively with DHS and LAHSA to deliver over one million lunches to PEH and help people shelter in place.

Prevent Homelessness Promote Health (PH^2)
PH^2 was severely impacted as all staff were on rotation for deployment as County Disaster Service Workers to assist in shelters, community centers, and isolation quarantine sites countywide, and support PRK.

Veteran Peer Access Network (VPAN)
VPAN has been minimally impacted by COVID-19. Staff adjusted from working out of the office to working out of their homes while continuing to deploy to the field as necessary. As a result of the opportunity afforded by the pandemic, VPAN was able to provide a support line available 7 days a week to drastically increase access to our target population. VPAN staff has been participating in regular street outreach in multiple SAs working closely with HOME, VA, E-6, and other outreach providers.

Whole Person Care (WPC) Intensive Service Recipient and Kin through Peer (ISR/KTP)
This program was drastically affected by COVID-19 as the program relies on relationships with hospitals and the ability to first engage and enroll participants during a hospitalization. Over the last 12 months, very few hospitals allowed WPC staff to enter the facility to engage and enroll individuals. Some staff continued to outreach to in-person and the program continued to receive referrals from many hospitals. Staff observed that it was much less effective and often the staff was unable to contact individuals after they were released from the hospital.

Women's ReEntry and Well-Being Center
The staff of Women's ReEntry were challenged transitioning from face-to-face contact in the field to online platforms to engage a target population that is high needs and often homeless. Initially, the program struggled to consistently engage clients online despite the outreach efforts. In part, numerous new hires started 6 months or less before COVID-19. LACDMH program orientation of new staff was delayed as training commonly took place in the field. Additionally, access to electronic case documentation trainings for new staff was also delayed. Eventually, many staff who felt safe were able to resume field work to locate, engage and train clients to use and access the online platform for telepsychiatry via cell phones. However, many employees were infected with COVID-19 and their absence had a significant impact on the program. Overall, these field base services involving highly vulnerable clients was challenging which led to an initial dip in the provision of mental health services.

Interim Housing Program (IHP)
IHP provides safe and clean shelter, 24-hour general oversight, three meals a day, clean linens, clothing, hygiene products and case management services to adults with mental illness and their minor children who are homeless. LACDMH has worked closely with DHS and the County Public Health (DPH) to support the health and safety of clients that have been in interim housing during the COVID-19 pandemic. As recommended by DHS' COVID-19 Response Teams (CRTs), the number of clients served by IHP was reduced from 565 to 429 to address safe occupancy. Of the 20 sites that provide IHP services, approximately 8-15 of them have been placed on quarantine by DPH at any given time and no new clients can be admitted to the sites during quarantine. The length of the quarantine time has varied between 3-12 weeks. DHS CRTs provided COVID-19 testing to both staff and clients, and they have begun providing vaccinations at the sites in accordance with DPH vaccination prioritization categories.

Enriched Residential Care (ERC) Program

ERC provides funding to house high-acuity clients with SMI in Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs). These facilities provide a home to some of LACDMH's most vulnerable clients who struggle to maintain independent housing and many of whom without this resource would be homeless or require higher levels of care in inpatient settings. Prior to the COVID-19 pandemic, LACDMH had been working on initiatives to better capacitate these facilities and mitigate numerous closures occurring across the County related to underfunding. Since the emergence of the COVID-19 pandemic, LACDMH has shifted the focus of this work toward providing support and guidance to these facilities around COVID-19. This work has included collaboration with various partners including DHS, Veteran's Administration (VA), Long Term Care Ombudsman (LTCO) and California State Community Care Licensing Division (CCLD), with a special focus on capacitating facilities that serve residents that have Social Security Income, which are especially vulnerable due to underfunding.

Through the COVID-19 response system implemented, a collaborative partner lead was assigned to each ARF/RCFE and tasked with targeted follow up. Through this collaboration, a survey is e-mailed out on a weekly basis to about 350 facilities that serve LACDMH or DHS clients or that meet specific vulnerability criteria. This survey asks basic information regarding a facility's recent experiences with COVID-19 including whether in the past week any residents have tested positive for COVID-19. For those facilities reporting new positive cases, the collaborative partner lead follows up with a longer questionnaire, which allows for a better understanding of the ways a facility is managing the outbreak and how best to target guidance to strengthen the outbreak response. This follow-up guidance is provided mainly by phone and includes information on how to report an outbreak to DPH and CCLD, how to access and use appropriate personal protective equipment and how to link to community testing resources for ongoing outbreak and surveillance testing for staff and residents, as well as information and assistance in coordinating on-site COVID-19 vaccination resources through the Federal Pharmacy Partnership Program. As of February 22, 2021, over 93 percent of the facilities that LACDMH works with have received at least the first dose of the vaccination.

Starting in November 2020, LACDMH has also been able to leverage DHS CRTs, which include a Registered Nurse and Licensed Vocational Nurse, to provide a subset of especially high-risk facilities with on-site infection control site assessments, guidance on responding to instances where residents test positive for COVID-19, emergency outbreak testing and influenza vaccinations. This onsite work has been especially valuable in light of the most recent surge, which caused a drastic increase in the number of facilities experiencing outbreaks.

The impact of the COVID-19 pandemic has significantly lowered the referral count due to closing of the schools, community colleges and universities since March of 2020. LACDMH to implement the Safe at Home Act, and have staff render telepsychiatry services from homes. To meet the emergency service demand, some START clinicians provided disaster services in the shelters, Psychiatric Mobile Response Teams (PMRT) services in the field, and warm-line phone services. Furthermore, the START conducted numerous trainings to address threat prevention via applications, such as Skype and Teams. In FY 2019-20, START served 809 clients with 5,102 services. The impact on the START program will be substantial for FY 2020-21 due to the continued closure of schools and academic institutions.

Mental Health Treatment Beds

LACDMH was able to decompress DHS hospital acute inpatient psychiatry to make space for patients with acute COVID-19 medical symptomatology. This included a shift from acute inpatient psychiatry to subacute institutions for mental disease (IMD), from subacute IMD to enriched residential services, and from enriched residential services to enriched residential care and Full Service Partnership and outpatient services. In other words, patients were assessed for safety and decanted to one level lower. This effort reduced the number of patients waiting for subacute beds on DHS acute inpatient units by 32% from April to October 2020. In addition, LACDMH opened acute inpatient psychiatric beds to accommodate patients on involuntary psychiatry holds (Lanterman Petris Short) at Pacifica Hospital (16 beds) in Sun Valley, as well as an open level of care to accommodate patients that needed quarantine and isolation along with assistance with medication support at the Sherman Hotel (13 beds) in Sherman Oaks.

ACTIONS SINCE LAST UPDATE

The following MHSA Midyear Adjustments posted after the adoption of the FY 2019-20 Annual Update adopted on June 4, 2019 by the Board of Supervisors. The postings are listed in chronological order based on the dates of the 30-day public review and comment period, starting with the most recent.

August 18, 2020 to September 16, 2020
Use of approximately $30.9 million of MHSA Prevention and Early Intervention (PEI) funding to develop and/or expand four community-based prevention platforms over the next fiscal year, including Patient Navigation Services; Media and Prevention Supports; Veterans Peer Access Network; and Peer, Family, and Community Approaches and Supports

July 23, 2020 to August 21, 2020
Use of the $13.7 million MHSA State Workforce Education and Training (WET) Regional Partnership Grant to fund a Loan Repayment Program similar to the State's Mental Health Loan Assumption Program (MHLAP)

July 23, 2020 to August 21, 2020
Suspension of the $3.1 million MHSA WET Stipend Program for FY 2020-21

July 22, 2020 to August 20, 2020
Suspension of the $3.3 million MHSA WET Project: The Financial Incentive Program for Psychiatry for FY 2020-21

September 5, 2019 to October 5, 2019
Use of approximately $5.7 million of MHSA PEI funding for the enhanced My Health LA Program to provide mental health services, namely prevention services that will reduce risk factors for developing potentially SMI, as well as help build protective factors

June 11, 2019 to July 10, 2019
Transfer $1.7 million of funding from Community Services and Supports (CSS) Plan to the WET Plan for the development of a collaborative agreement between LACDMH and the University of California, Los Angeles (UCLA) to accomplish the shared goals of transferring state-of-the-art treatment strategies from academia to the community and a training environment for clinical staff

May 31, 2019 to June 29, 2019
Transfer $35.0 million of CSS funding to Capital Facilities Technological Needs Plan (CFTN) for the capital development of a network of restorative care services for individuals with a mental illness who are being discharged from County psychiatric emergency services, psychiatric inpatient units and jails

May 8, 2019 to June 6, 2019
Transfer of $10.5 million in CSS funding to CFTN allows for the High Desert Mental Health Urgent Care Center project (a new building, a parking lot, an ambulance drive and landscaping improvements)

April 26, 2019 to May 25, 2019
Transfer of $4.0 million in CSS funding to CFTN allows for the capital facilities partial purchase of a parking lot located at 636 Maple Avenue for the use of Downtown Mental Health Center

November 29, 2018 to December 28, 2018
Transfer of $10.0 million in CSS funding to CFTN for the capital development of the Olive View Mental Health Wellness Center to provide an array of outpatient mental health and supportive services for clients who live with serious mental illness

PROPOSED CHANGES FOR THREE-YEAR PLAN

This section provides detailed information for proposed changes that are incorporated into this Plan for FYs 2021-22 through 2023-24, in addition to highlighting a critical need that may ultimately result in LACDMH proposing a change in the near future through an Annual Update.

- **FSP REDESIGN**

  As part of the previous Three-Year Plan, FSP programs and services were developed to provide comprehensive mental health services to clients requiring intensive treatment. Services are provided by a multi-disciplinary team based on a specific number of client slots. Services provided to clients enrolled in FSP may include, but are not limited to, 24/7 crisis response (in-person when needed); ongoing intensive mental health treatment; housing services; employment services; and co-occurring mental illness and substance use treatment services. All services are focused on reducing institutional service utilization and increasing recovery rates. FSP was designed to enable people to create their own plans for recovery with support from professionals and peers, recreational or other therapeutic, and 24/7 support to make their plan a reality. Existing FSP programs serve children between the ages of 0-15; transition age youth (16-25), adults (26-59), and older adults (60+).

  To meet the ever-changing needs of vulnerable children and adults in Los Angeles County requiring FSP level supports, LACDMH has determined that the current FSP Program requires programmatic redesign utilizing existing resources that include several program enhancements. The FSP redesign seeks to address the current need for better-defined programmatic requirements and performance measures to ensure services meet the needs of children and adults requiring the most intensive care and result in better mental health outcomes while addressing disparities.

  The information below is intended to provide an overview of the FSP redesign.

  What are we doing*?*

  LACDMH is transforming the FSP program so that we can best support our highest acuity outpatient consumers on the path to recovery and well-being. This effort includes:

  - Changes to the eligibility criteria to be more focused on those most in need of FSP care;
  - Changes to the FSP service model to utilize a multidisciplinary team/population approach, rather than individual caseloads and "slots;"
  - Integrating all current specialty FSP into one FSP model (exception is Housing FSP will go under housing support);
  - Lowering client to staff ratios;
  - Additional staffing to enable Child FSP programs to provide Intensive Care Coordination (ICC) & Intensive Home Based Services (IHBS);
  - Providing enhanced training and technical assistance to support FSP providers in achieving desired outcomes;
  - Enhancing services and supports to ensure successful transitions between levels of care;
  - Centralizing the authorization, enrollment, and disenrollment processes for FSP to ensure that those highest needs clients are able to access the FSP services;
  - Standardizing rates to bring contracted provider staff salaries closer to parity with their counterparts in the LACDMH clinics, as a part of LACDMH's broader rate-setting exercise; and
  - Changes to the FSP contracts to add incentives for providers to help their clients achieve critical life outcomes, moving our system towards performance-based contracting; and
  - Using data, and consumer & provider feedback to drive continuous improvement.

How will this work?
These changes will be incorporated into the Service Exhibits within the contracts, which will be included in the new Legal Entity agreements.

- Focal Population: The redesigned FSP program will prioritize FSP services for those with severe and persistent mental illness (SPMI) who also meet as least one of the FSP focal population criteria: homeless, justice-involved, or high utilizers of emergency or high acuity mental health services. This represents a critical refocusing of the program on those consumers most in need of the "whatever it takes" intensive outpatient services at the core of FSP and eliminates an earlier LACDMH expansion of FSP eligibility to those classified "at-risk" for meeting the focal population criteria. In our experience, the inclusion of "at-risk" as an option for enrollment in FSP has resulted in a disproportionate share of FSP services going to those who may be successfully treated in a lower level of care. The only exception to this will be court-ordered Assisted Outpatient Treatment (AOT) FSP clients.

  Another important element of the FSP transformation is integrating the current Adult FSP specialty models into one FSP model and raising the level of service provided within the transformed FSP program to meet the needs of all who were previously served by the specialty FSP programs. This includes the integration of the core features of the Integrated Mobile Health Team (IMHT) FSP, Homeless FSP, AOT FSP, and Forensic FSP models into the new Adult FSP model. LACDMH made this shift because we realized that many of the consumers in need of FSP services and being served by our existing Adult FSP program are also eligible for, and would benefit from, the enhanced services being provided by the Specialty FSP models, whether that be significant physical health issues or a history of homelessness or justice involvement.

- Age Groups: The new Adult FSP program will now serve clients ages 21 and up, including older adults. The Child FSP program will serve children and youth up to age 21.

- Priority Outcomes & Incentives: Under the new FSP model, FSP providers will focus on a set of priority outcomes and metrics related to best serving the FSP focal population clients in their programs and providing services and supports that help their clients achieve important life outcomes. LACDMH will work with providers to collect, monitor and learn from their data related to these outcomes and metrics and will provide bonus incentives payments for those providers that hit specified performance targets.

For example, Adult FSP providers will be eligible for incentives for retaining those hardest to reach FSP clients for a period of at least six months. These include individuals with a history of experiencing chronic street homelessness, acute mental health needs, prior justice system involvement, or a history of high utilization of psychiatric emergency departments. Providers will also be incentivized for helping clients improve their housing stability, reduce their utilization of psychiatric emergency departments, and reduce involvement with the criminal justice system.

Why are we doing this?
LACDMH undertook this transformation with the intention to improve life outcomes for those we serve who are at highest risk and empower contract providers to deliver the best care possible. We believe that doing so requires increased flexibility, support, and accountability, and better use of data to drive decision-making.

When will this happen?
The transformed FSP program is tentatively scheduled to launch in July 2021. Because this program redesign will be new for both LACDMH and contract providers, we plan to work with existing FSP providers to pilot this new model over the next 3 years. Lessons learned from this pilot will inform the rebid of FSP contracts for FY 2024-25.

What is the fiscal impact?
The transformed FSP program is tentatively scheduled to launch in July 2021. It is estimated that the incentives will require $3.5 million in FY 2021-22 and $7.0 million annually for FY 2022-23 and FY 2023-24.

- **MENTAL HEALTH TREATMENT BED AND HOUSING CAPACITY**

In early 2019, the Board of Supervisors approved a motion that focused on the critical shortage of mental health hospital beds in the County and highlighted the need to remedy the longstanding service gaps in its mental health system of care, with particular attention to LACDMH's treatment bed capacity. In short, our inventory of treatment beds needs to increase dramatically and LACDMH needs to be able to optimize the management of these beds to deliver enough high-quality facility-based treatment to avoid:

- Overcrowded psychiatric emergency rooms with long wait-times for acute psychiatric beds;
- Cycling homeless individuals with mental illness and often co-occurring substance use disorder in and out of hospitals and on and off the streets with no sustainable path to recovery;
- Incarcerating individuals with mental illness and often co-occurring substance use disorder in lieu of receiving needed care in a treatment (rather than a custody) facility; high hospital readmission rates; and
- Long waitlists to transition patients from costly acute treatment settings to the appropriate level of care.

LACDMH 500-Bed Pilot
Later that year, LACDMH recommended a two-year pilot, along with strategies to expand and improve mental health bed capacity and service quality throughout the system, to procure up to 500 mental health treatment beds of varying types based on available funding. To date, 156 beds have been contracted and fully funded by the $25 million in Sales Tax Realignment revenues set aside in the FY 2019-20 Final Adopted Budget. This bed pilot was implemented in the context of the COVID-19 pandemic and as such, it was executed in combination with the County Continuity of Operations: Surge Plan.

Opportunities to Further the County Initiative for Bed Expansion

LACDMH has identified the remaining beds at various levels of care to further make improvements in client flow throughout the network. This includes beds in addition to those that are currently funded through MHSA Community Services and Supports (CSS) - Alternative Crisis Services (ACS) for Enriched Residential Services, Crisis Residential Care, and Urgent Care and MHSA CSS - Housing for Enriched Residential Care. In addition, LACDMH has dedicated substantial Sales Tax Realignment funding towards beds, such as the $25 million set-aside for partial implementation of the 500-bed pilot, cost-of-living adjustments to providers, and the realignment of funding levels commensurate with utilization rates.

While this Plan does not reflect a proposed change to MHSA CSS - ACS and Housing associated with any expansion of mental health treatment bed capacity, it is important to stress that the flexibility to invest MHSA resources is critical to furthering this County initiative. This need may be sooner than later, and if likely to occur, will be incorporated into an Annual Update.

In the meantime, LACDMH recently submitted Measure J funding proposals specific to the Alternatives to Incarceration (ATI) recommendation that highlights the need for more acute inpatient, subacute, residential, and congregate care beds to allow more individuals with SMI be diverted out to the jails. Another funding proposal was submitted for expansion of crisis residential treatment programs that serve as locations for law enforcement to quickly drop an individual in crisis and avoid incarceration, as well as provide diversion from emergency rooms. This proposal addresses the ATI recommendation that stresses the importance of facilities to enable "care first" crisis care throughout the County.

- **ACCESS CALL CENTER MODERNIZATION PROJECT**

A new IT project is incorporated in the Technological Needs Plan to engage a consultant to design and implement the technical and business goals of the 24/7 ACCESS Call Center Modernization Project at a proposed total cost of $3.5 million. There is existing funding within the Technological Needs Plan. LACDMH's current system is antiquated with disparate systems, as well as different applications, and is therefore, in critical need of a major overhaul. The goal is to modernize business processes, workflows and technology that allows for a more streamlined process between the call agent and the caller for end-to-end assistance with the intention to:

- Improve client care delivery and enhance the call agent experience by simplifying call workflows and case documentation;
- Reduce time-to-care by centralizing scheduling and crisis response dispatch processes;
- Drive a reduction in call hold times by streamlining call agent tasks allowing agents to answer calls quicker; and
- Automate ACCESS call analytics to ensure the needs of callers are met.

The focus at this juncture is the redesign of workflows and an overhaul of the infrastructure utilized by call agents. LACDMH will evaluate the need for staff resources as this project evolves and incorporate proposals for changes in future Annual Updates or Midyear Adjustments.

Current System

Below are diagrams that show the infrastructure as it exists today, and the complexity of the process as it captures the cumbersome service flow starting from the initiation of a call to the Helpline to work with Call Center agents to schedule separate appointments for intake/assessment and treatment. The current process for people seeking help across our system is complex, time consuming and confusing. This may potentially cause additional emotional distress especially if the process for LACDMH staff to resolve these issues is equally complex.

The current Helpline was built quickly, and new elements were added over time with neither user input nor strategic alignment. Call agents may have to utilize as many as 11 different applications, forms, or services to assist a single call. Existing applications can be difficult to use and call agents have a limited view to provide crisis response team availability. While the Helpline is not modernized or optimized, it is currently functioning with no known major issues. Calls are being answered and people are being helped. However, there are certainly areas in which it can definitely be optimized for both staff and people seeking services to create a more efficient and user-friendly experience.

Figure 6. Existing Call Center infrastructure that includes different Helplines

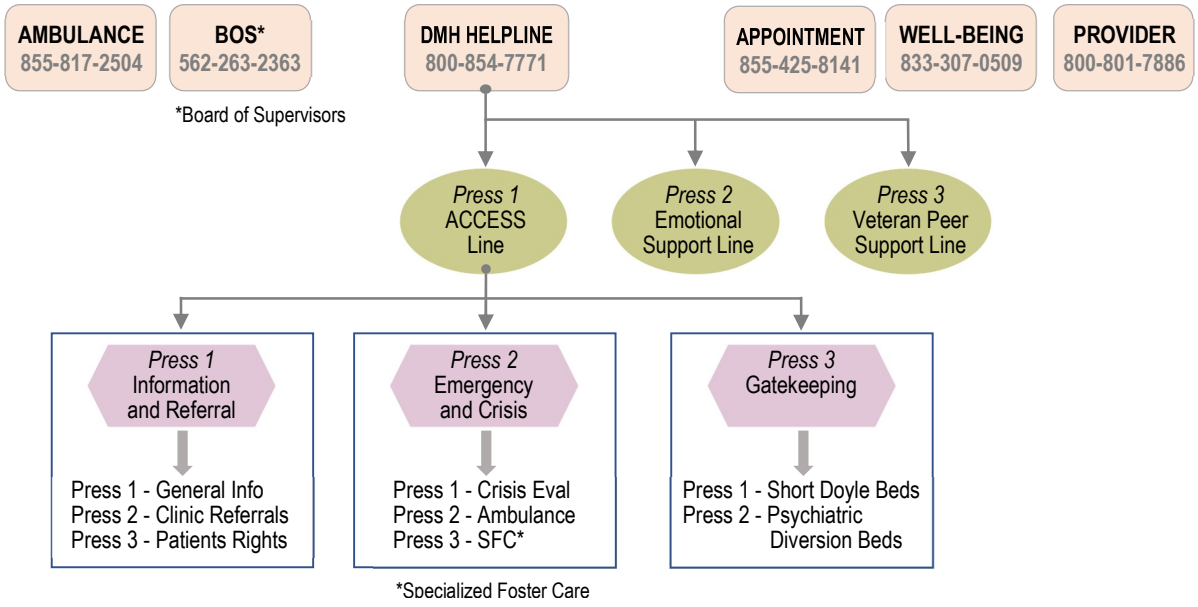
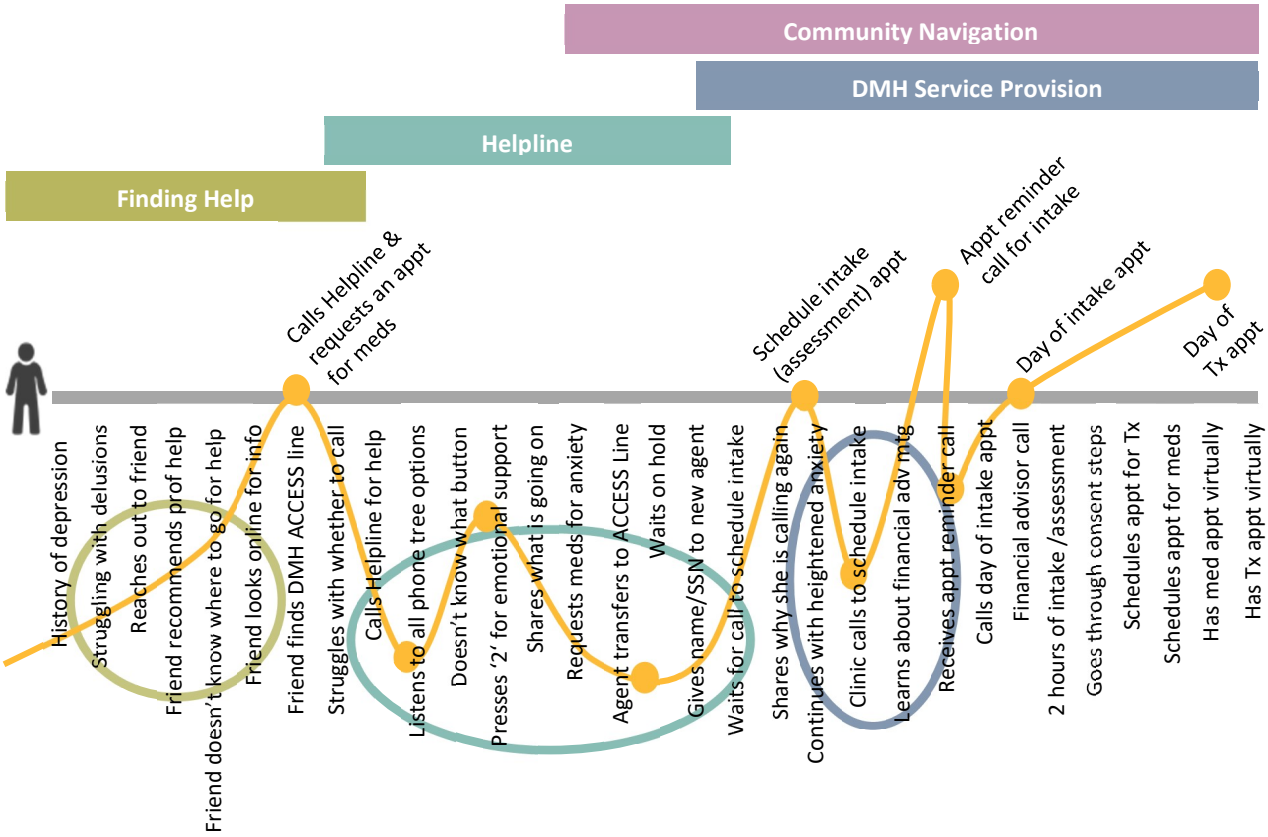


Figure 7. A typical call to the DMH HelpLine

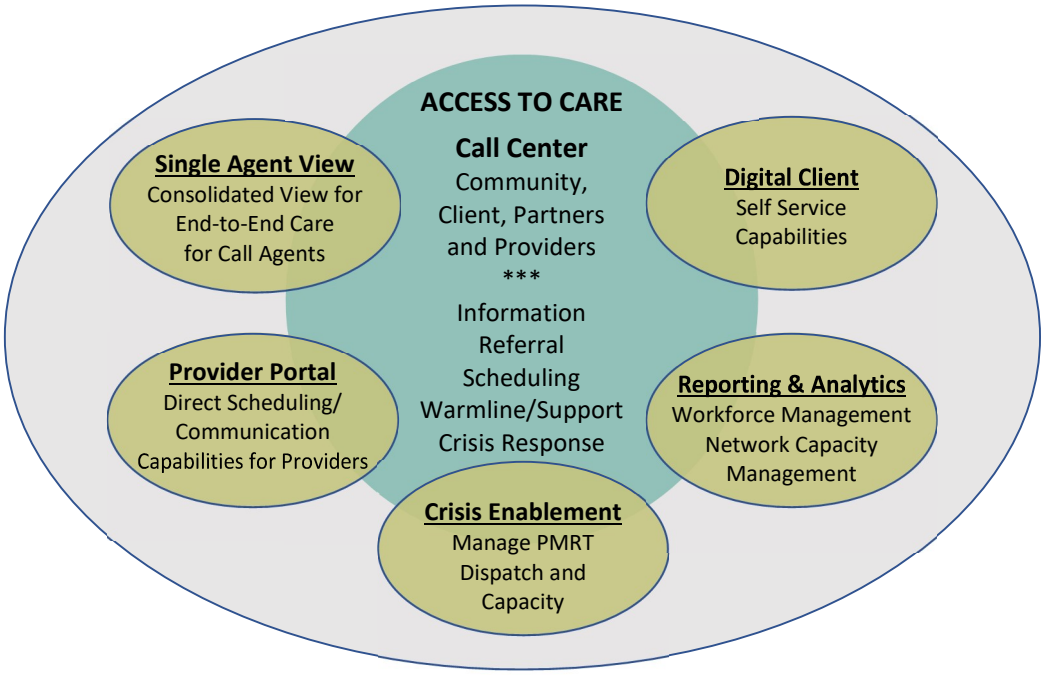


Modernized Call Center System

The 24/7 ACCESS Call Center should serve as a "hub" for LACDMH with call agents having a complete view into capacity and availability within the LACDMH network of providers. In addition, call agents should have a single view of information available about the caller, to best meet his/her needs. This entry point will be designed to improve access to care and the overall experience when calling the ACCESS Call Center.

The technology and workflow enhancements to the Call Center will provide end-to-end assistance in an efficient and user-centered manner, streamline the agent experience and develop self-service functions for clients and extend capabilities to providers throughout LACDMH. The overall user experience can be improved by focusing on how the Helpline fits into the entire access to care experience and creating an efficient and streamlined user experience.

Figure 8. The vision of the modernized 24/7 ACCESS Call Center



- **TIMELINE OF EXISTING INN PROJECTS**

LACDMH is in the process of evaluating all INN projects for effectiveness and consideration of continued funding and alignment to the LACDMH Strategic Plan. This Plan, however, reflects the following projects that require extensions to the original project timeline due to delayed implementation. The timelines will adjust to the five-year maximum. LACDMH will also notify MHSOAC under separate cover.

Table 10. INN Project extensions

Project	Additional Years
INN 2 – Community Capacity Building to Prevent Trauma	1 year
INN 3 – Help@Hand (formerly Technology Suite)	2 years
INN 4 – Transcranial Magnetic Stimulation	2 years
INN 7 – Therapeutic Transport	2 years

EXISTING PROGRAMS AND SERVICES BY COMPONENT

This section provides FY 2019-20 outcome data for existing MHSA programs and is organized by component. It also provides financial information for two prior FYs 2018-19 and 2019-20, as well as the proposed annual budget for FY 2021-22 and the total proposed budget for the three FYs of this Plan. Costs are reported at gross and does not include program administration.

COMMUNITY SERVICES AND SUPPORTS (CSS)

As the largest component with 76% of the total MHSA allocation, CSS was designed with service categories that shape the integrated system of care for clients diagnosed with SMI. In FY 2019-20, approximately 148,000 unique clients received a direct mental health service through CSS. The two tables below provide additional detail.

The CSS component of the Plan includes the following programs:

- Full Service Partnership (FSP)
- Outpatient Care Services* (OCS)
- Alternative Crisis Services (ACS)
- Housing Services
- Linkage to County-Operated Functions/Programs (Linkage)
- Planning, Outreach, and Engagement Services (POE).

**formerly known as Recovery, Resilience and Reintegration (RRR)*

Table 11. Clients served through CSS in FY 2019-20

Clients Served	New Clients Served
147,766 clients received a direct mental health service: - 35% of the clients are Hispanic - 20% of the clients are African American - 17% of the clients are White - 3% of the clients are Asian - 79% have a primary language of English - 14% have a primary language of Spanish	50,502 new clients receiving CSS services countywide with no previous MHSA service - 38% of the new clients are Hispanic - 15% of the new clients are African American - 16% of the new clients are White - 78% have a primary language of English - 14% have a primary language of Spanish

Table 12. CSS clients served by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	8,786	4,800
SA 2 – San Fernando Valley	21,926	10,345
SA 3 – San Gabriel Valley	19,602	11,721
SA 4 – Metro Los Angeles	31,318	16,743
SA 5 – West Los Angeles	10,236	5,698
SA 6 – South Los Angeles	28,413	15,796
SA 7 – East Los Angeles County	12,662	7,406
SA 8 – South Bay	30,675	17,317

The next few pages provide a summary of information for each CSS program. The summary will include a follow-up on the last approved Three-Year Plan (FYs 2017-20) that was also extended through FY 2020-21, as well as outcome data for the specific program.

A. FULL SERVICE PARTNERSHIP (FSP)

Status	☐ New	☐ Continuing	☒ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

FSP programs provide a wide array of services and supports, guided by a commitment by providers to do "whatever it takes" within the resources available to help the highest acuity clients within defined populations make progress on their paths to recovery and wellness.

FSP services are provided by multi-disciplinary teams of professional and paraprofessional and volunteer providers who have received specialized training preparing them to work effectively with children and their families; FSP teams provide 24/7 crisis services and develop plans with families to do whatever it takes within the resources available and the recovery plan agreed between the client and the FSP provider team to help clients meet individualized recovery, resiliency, and development and/or recovery goals or treatment plan; and FSP teams are responsive and appropriate to the cultural and linguistic needs of the child and their family.

Intended Outcomes

- Reduce serious mental health systems, homelessness, incarceration and hospitalization
- Increase independent living and overall quality of life

Key Activities

- Clinical services (24/7 assessment and crisis services; counseling and psychotherapy; field-based services; integrated treatment for co-occurring mental health and substance abuse disorder; case management to provide linkages to services to employment, education, housing and physical health care)
- Nonclinical services (peer and parent support services; self-help and family support groups; wellness centers; respite care)

FY 2019-20 ■ FULL SERVICE PARTNERSHIP Data and Outcomes

As of June 30, 2020, LACDMH had 16,865 FSP slots as shown in the next table.

Table 13. FSP summary: age group, slots, average cost per client, and unique clients served

Age Group	Number of Slots	Average Cost per Client	Number of Unique Clients Served
Children (includes Wraparound Child, Intensive Field Capable Clinical Services, and Wraparound TAY)	3,584	$18,102	3,994
TAY, Ages 16-25	1,410	$13,940	2,950
Adult, Ages 26-59 (includes Integrated Mobile Health Team, Assisted Outpatient Treatment, Forensic, Homeless, Measure H and Housing)	10,986	$13,678	7,715
Older Adult, Ages 60+	885	$11,192	1,897

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

We assessed the impact of FSP enrollment on client outcomes by measuring changes in the proportions of clients and in the numbers of days spent with homelessness, justice involvement, psychiatric hospitalization, or independent living.

Comparing a client's life before and after, FSP enrollment shows that the program
- Reduces homelessness;
- Reduces justice involvement;
- Reduces psychiatric hospitalization; and
- Increases independent living.

Table 14. Impact of FSP on post-partnership residential outcomes

FSP Program	Percentage by Clients	Percentage by Days
Homeless		
TAY	21% reduction	43% reduction
Adult	30% reduction	64% reduction
Older Adult	27% reduction	58% reduction
Justice Involvement		
TAY	16% reduction	37% reduction
Adult	27% reduction	64% reduction
Older Adult	21% reduction	48% reduction
Psychiatric Hospitalization		
Child	39% reduction	% reduction
TAY	46% reduction	19% reduction
Adult	26% reduction	62% reduction
Older Adult	12% reduction	20% reduction
Independent Living		
TAY	31% increase	41% increase
Adult	41% increase	41% increase

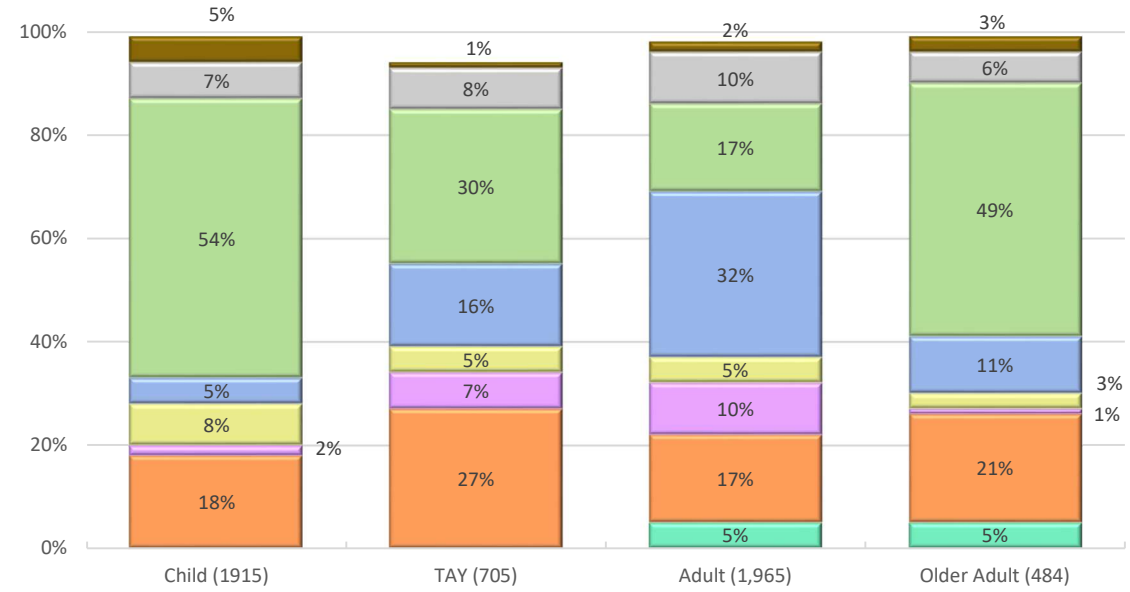
Comparison of residential data for 12 months immediately prior to receiving FSP services (pre-partnership) and for 12 months of residential status while receiving FSP services (post-partnership) for client's outcomes entered through June 30, 2019. Data is adjusted (annualized) by a percentage based on average length of stay in the FSP program. Data must meet data quality standards to be included in the analysis.

Children (n =17,490)
TAY (n = 6,623)
Adults (n = 16,842)
Older adults (n = 2,678)
Figures represent cumulative changes, inclusive of all clients through June 30, 2020

FSP 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 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 12 months from the date of last contact.

The reasons for disenrollment are as follows:
- Target population criteria not met;
- Client decided to discontinue FSP participation after partnership was established;
- Client moved to another county/service area;
- Client cannot be located after attempts to contact client;
- Community services/program interrupted - client will be detained or incarcerated in the juvenile or adult system for over 90 days;
- Community services/program interrupted - client will require residential/institutional mental health services - Institutions for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC) or State Hospital
- Client has successfully met his/her goals such that discontinuation of FSP is appropriate; or
- Client is deceased.

Figure 9. Reasons for FY 2019-20 FSP disenrollments



FYs 2021-24 ■ FULL SERVICE PARTNERSHIP Proposed Change
The transformed FSP program is tentatively scheduled to launch in July 2021. Because this program redesign will be new for both LACDMH and contract providers, the plan is to work with existing FSP providers to pilot this new model over the next 3 years. Lessons learned from this pilot will inform the rebid of FSP contracts for FY 2024-25.

■ FULL SERVICE PARTNERSHIP			
Prior FY 2019-20		Prior FY 2018-19	
15,955 Total Number Served[1]	$269.6 million Total Gross Expenditures	15,517 Total Number Served	$241.9 million Total Gross Expenditures
FY 2021-22		Three-Year Plan FYs 2021-24	
15,736 Total Number Served[2]	$290.8 million Estimated Gross Expenditures	$910.2 million Estimated Gross Expenditures	

Notes

1 Prior Year Total Number Served: Number of unduplicated clients receiving Mode 15 Direct Services, not inclusive of community outreach services or client support services

2 FY 2021-22 Total Number Served: Reflects average of two prior years

B. OUTPATIENT CARE SERVICES

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ TAY Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

Outpatient Care Services, formerly known as Recovery, Resilience and Reintegration (RRR), provides a broad array of integrated community-based, clinic-based and well-being services and a recovery-focused supportive system of care services to all age groups. A continuum of care is critical so clients can receive the care they need when they need it and in the most appropriate setting to meet their needs.

The goal is for clients to achieve their recovery goals to reintegrate successfully into the community. An array of services designed to meet the mental health needs of individuals in different stages of recovery. Each program will provide each client with a combination of one or more of the core components to meet the client's individual needs. These services meet the needs of all age ranges from child to 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. These factors 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.

Intended Outcomes

Our aim is to help our clients and families to

- Have a safe place to live
- Have healthy relationships
- Have access to public assistance when necessary
- Weather crises successfully
- Use their time in a meaningful way
- Have the best possible physical health

Key Activities

- Clinical services (individual, group and family therapy; crisis resolution/intervention; evidence-based treatments; medication management and support; outreach and engagement screenings and assessments to determine the level of functioning and impairment; case management)
- Non-clinical services (peer support; family education and support; linkage to primary care; housing services; vocational and pre-vocational services)

FY 2019-20 ■ OUTPATIENT CARE SERVICES Data and Outcomes

Table 15. FY 2019-20 Data for clients served through various outpatient programs

Age Group	Number of Unique Clients Served	Average Cost per Client
Children, Ages 0-15	25,549	$5,603
TAY, Ages 16-25	17,971	$4,313
Adult, Ages 26-59	57,620	$3,249
Older Adult, Ages 60+	14,934	$3,344

B1. TAY Probation Camps

LACDMH staff provides MHSA-funded services to youth in camps operated by the Los Angeles County Probation Department, including youth with SED/SMI. LACDMH staff and contract providers are co-located in these camps along with Probation, DHS Juvenile Court Health Services (JCHS), and Los Angeles County Office of Education (LACOE). This inter-departmental team provides coordinated care to the youth housed at the camps.

Youth housed in the camps receive an array of mental health services, including assessments; individual group, and family therapy; medication support; and aftercare and transition services. These services are individually tailored to meet the needs of each youth, including co-occurring disorders and trauma. Interventions include evidence-based practices such as Aggression Replacement Training, Adapted Dialectical Behavior Therapy and Seeking Safety. MHSA funding has made it possible for youth to be housed in a broader array of camps and still receive psychotropic medications.

B2. 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. They 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. However, MHSA funding allows for expanded hours of operation during the evenings and weekends when access to these centers is even more crucial.

Table 16. Drop-in Center locations

Service Area	Agency	Address
SA 1	Penny Lane Centers Yellow Submarine	43520 Division Street Lancaster, CA 93535
SA 2	The Village Family Services TVFS TAY Drop-In Center	6801 Coldwater Canyon Blvd North Hollywood, CA 91606
SA 3	Pacific Clinics Hope Drop-In Center	13001 Ramona Blvd Irwindale, CA 91706
SA 4	Los Angeles LGBT Center Youth Center on Highland	1220 N. Highland Ave Los Angeles, CA 90038
SA 5	Daniel's Place Step-Up on Second Street, Inc.	1619 Santa Monica Blvd Santa Monica, CA 90405
SA 6	Good Seed Church of God in Christ, Inc. Good Seed Youth Drop-in Center	2814 W. MLK Jr., Blvd Los Angeles, CA 90008
SA 7	Penny Lane Centers With A Little Help from My Friends	5628 E. Slauson Ave Commerce, CA 90040
SA 8	Good Seed Church of God in Christ, Inc. Good Seed on Pine Youth Drop-In Center	1230 Pine Ave Long Beach, CA 90813

B3. Integrated Care Program (ICP)

ICP is 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 and uninsured. ICP promotes 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 SMI or SED who 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.

B4. 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 utilizes performance-based contracting measures to promote program services.

This team is comprised of two health program analyst positions. The goal of the team is to ensure that our older adult consumers receive appropriate and timely mental health services from our provider agencies, and they do this by providing data and analytic support to their Program Manager and the Client Supportive Services 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.

B5. Service Extenders

Service Extenders are volunteers and part of the Older Adult RRR 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.

B6. 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, gero-psychiatry fellowship, service extenders and evidence based practices.

The following are achievements/highlights for FY 2019-20

- *Older Adult Consultation Medical Doctor's (OACT-MD) Series*
  This was 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 and Re-Entry Program for Seniors (CDRP): Training and Consultation Series*
  This training and consultation series, as part of the Older Adult Training & Consultation Team, was offered to mental health staff with professional expertise in geriatric medicine, gero-psychiatry, case management/community resources, substance use, and other resources. The ongoing training and 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*
  As part of ongoing multi-disciplinary Older Adult Consultation team trainings, the following was provided: training and Elder Law consultation, curriculum training development and coordination on Elder Law for LACDMH and LACDMH-contracted clinical and non-clinical staff on best practices for working with Older Adult populations.
- *Public Speaking Club Graduate Curriculum*
  Speaker Club graduate programs were provided 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 once a month.
- *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.
- *Recognizing and Responding to Suicide Risk (RRSR)*
  This is an interactive training for mental health clinicians who want to acquire competency-based skills for working with consumers who are at risk for suicide. The RRSR training model is based on a set of 24 core clinical competencies developed by a task force of clinical experts collaborating with the American Association of Suicidology (AAS) and the Suicide Prevention Resource Center.
- *Seeking Safety Training*
  This training provides an overview of Seeking Safety, an evidenced-based treatment for trauma and/or substance abuse. Covered in the training are the following topics: (a) background on trauma and substance abuse (rates, presentation, models and stages of treatment, clinical challenges); and (b) implementation of Seeking Safety (overview, evidence base). Assessment tools and community resources are also

addressed. Finally, the training will allow participants to be able to implement Seeking Safety in their setting.

- *18th Annual Collaboration in Geriatric Mental Health Care*
  Technology & Mental Health Care of Older Adults: In collaboration with LA Care Health Plan, LACDMH hosted the 18th Annual Collaboration in Geriatric Psychiatry breakfast. The new name reflects the focus on collaboration among multiple agencies and among multiple disciplines working together for the mental health care of older individuals. With the advent of national, state, and local directives to integrate health and mental healthcare, and especially with the establishment of the Medi-Cal managed health and mental health plans, this year's training will highlight how technology can improve social isolation and morbidity of individuals and how technology can be effectively used by providers.
- *Medical Legal Pre-Elective Part I*
  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.
- *Medical Legal Elective Part II Direct and Cross Examination*
  The following training will educate mental health participants on strategies for expert witness court testimony specific to older adults with cognitive impairments. This training will prepare medical doctors and psychologists on ethnically diverse older adult cases with practiced simulated direct and cross examination situations.
- *Medical Legal Elective Part III Simulated Trails*
  The following training will educate mental health participants on strategies for expert witness court testimony specific to older adults with cognitive impairments. The training will describe the evolution of mock trials and be involved in a simulated actual case, including practicing attorneys, and an experienced judge in a condensed version of a trial.
- *Problem Solving Treatment (PST)*
  PST is a brief intervention and will offer experiential activities to enhance clinical skills thereby supporting the model's effectiveness.
- *The Use of Cognitive Screening Measures: The Mini Mental State Exam (MMSE)*
  The purpose of this training is to provide an overview of a cognitive screening tool as well as hands on-experience using MMSE.
- *Older Adult Sexual Assault*
  The Rape Treatment Center (RTC) at the UCLA Medical Center in Santa Monica provided a training on sexual assault and rape, with a specific focus on the older adult population. The training will discuss the following topics: prevalence of sexual assault in the U.S., 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.
- *Advanced Issues in Grief and Loss*
  This training will address areas related to grief and loss in children and adults, such as issues faced by adults exiting the criminal justice system, homeless adults, and immigrants facing unresolved grief over the loss of loved ones and their homes, among other factors. Cultural factors impacting the grief and loss process will be addressed throughout this training, since culture plays a critical role in dealing with grief and loss. Finally, the training also focuses on ways to effectively work with adults across the life span facing complicated grief and loss.

FYs 2021-24 ■ OUTPATIENT CARE SERVICES Continued Work
In the next three years, the coming enhancements to improve service delivery will be the modernized Call Center to assist in access to services and the most appropriate level of care. LACDMH will also be building up and supporting capacity to ensure successful transitions from higher levels of care.

■ OUTPATIENT CARE SERVICES			
Prior FY 2019-20		**Prior FY 2018-19**	
15,955 Total Number Served[1]	$478.2 million Total Gross Expenditures	15,517 Total Number Served	$456.6 million Total Gross Expenditures
FY 2021-22		**Three-Year Plan FYs 2021-24**	
15,736 Total Number Served[2]	$614.2 million Estimated Gross Expenditures	$1.919 billion Estimated Gross Expenditures	

Notes

1 Prior Year Total Number Served: Number of unduplicated clients receiving Mode 15 Direct Services, not inclusive of community outreach services or client support services

2 FY 2021-22 Total Number Served: Reflects average of two prior years

C. ALTERNATIVE CRISIS SERVICES

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ TAY Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

Alternative 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., FSP and Assertive Community Treatment programs, 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.

In 2019, Countywide Resource Management integrated with the Managed Care Division and changed its name to the Intensive Care Division. It remains responsible for overall administrative, clinical, integrative, and fiscal aspects of programs that serve the most severely ill individuals with mental illness. This includes planning, developing, and implementing urgent care centers and enriched residential programs for these specialized populations. Also, it coordinates functions to maximize the flow of clients between various levels of care and community-based mental health services and supports.

LACDMH MHSA ACS programs:

- Residential and Bridging Care (RBC) Program
- Psychiatric Urgent Care Centers
- Enriched Residential Services (ERS)
- Crisis Residential Treatment Programs (CRTP)
- Law Enforcement Teams (LET)

Intended Outcomes

- Reduce utilization of psychiatric emergency rooms and inpatient acute psychiatry
- Reduce incarceration of persons with severe and persistent mental illness

Key Activities

- Divert clients as appropriate to mental health urgent cares
- Divert clients as appropriate to Crisis Residential Treatment Programs
- Utilize mental health clinician teams in the field as Alternatives to Crisis Response

FY 2019-20 ■ ALTERNATIVE CRISIS SERVICES Data and Outcomes

During FY 2019-20, LACDMH continued its investment in the development of PSH for homeless or chronically homeless individuals and families who are living with SMI or serious emotional disturbances (SED).

C1. Residential and Bridging Program (RBC)

RBC 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, FSP, residential providers, self-help groups, and other community providers. Peer advocates provide support to individuals in subacute settings, Enriched Residential Services (ERS) facilities, and intensive residential programs to successfully transition to community living.

The County Hospital Adult Linkage Program is part of the RBC program. Its mission is to assist in the coordination of psychiatric services for LACDMH clients at County hospitals operated by DHS to ensure clients are discharged to the appropriate level of care and that they are provided relevant mental health, residential, substance abuse, or other specialized programs. This program promotes the expectation that clients are successfully reintegrated into their communities upon discharge and that all care providers participate in client transitions.

C2. Psychiatric Urgent Care Centers (UCC)

Psychiatric UCCs are Medi-Cal certified and Lanterman Petris Short (LPS) designated free-standing crisis stabilization units that provide rapid access to mental health evaluation and assessment, crisis intervention and medication support 24-hours per day, 7 days per week. UCCs also provide case management for individuals experiencing psychological distress and/or psychiatric crisis. UCC services, including integrated services for co-occurring disorders, are focused on stabilization and linkage to recovery-oriented community-based resources. Clients are permitted to stay in the UCC chair 23 hours and 59 minutes that are licensed by the California Department of Health Care Services.

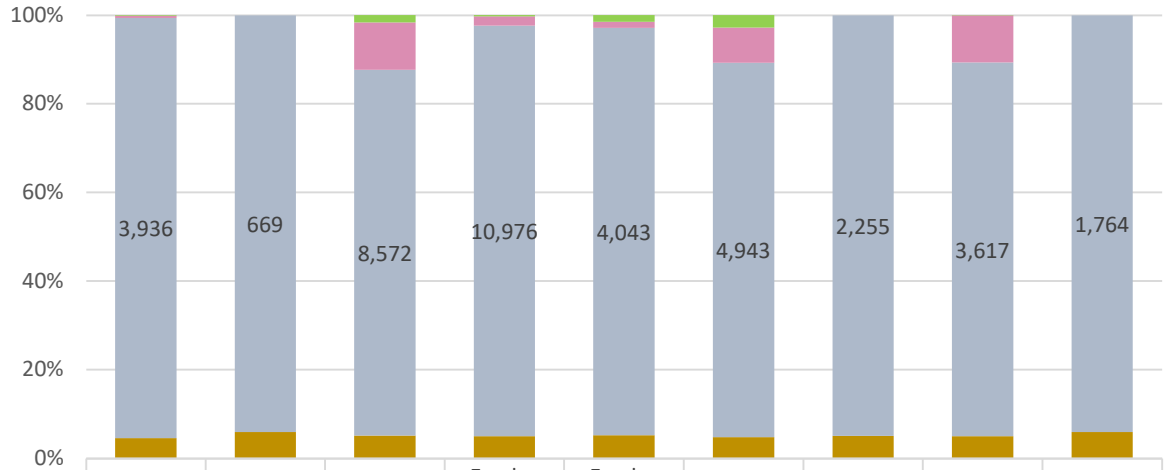
Table 17. Bed capacity and location of the current UCCs

Urgent Care Center	Service Area	Location	Open	Beds (Age 18+)	Beds (17 & under)
Exodus (Eastside UCC)	SA 4	Downtown Los Angeles	Yes	22	
Exodus (Harbor UCC)	SA 8	Harbor-UCLA/Torrance	Yes	14	4
Exodus (MLK UCC)	SA 6	MLK/Los Angeles	Yes	16	8
Exodus (Westside UCC)	SA 5	Culver City	Yes	12	
Olive View Community Care Services (OV UCC)	SA 2	Sylmar	Yes	8	
Providence Little Company of Mary OBHC[2]	SA 8	San Pedro	Yes	20	
Star View BHUCC	SA 8	Long Beach	Yes	12	6
Star View BHUCC	SA 3	San Gabriel Valley	Yes	12	6
Telecare (La Casa[1] MHUCC[2])	SA 8	Long Beach	Yes	Varies	

1 La Casa is an exception; it is not open 24-hours per day, 7 days a week. It is LPS-designated.
2 MHUCC = Mental Health UCC; OBHC = Outpatient Behavioral Health Center

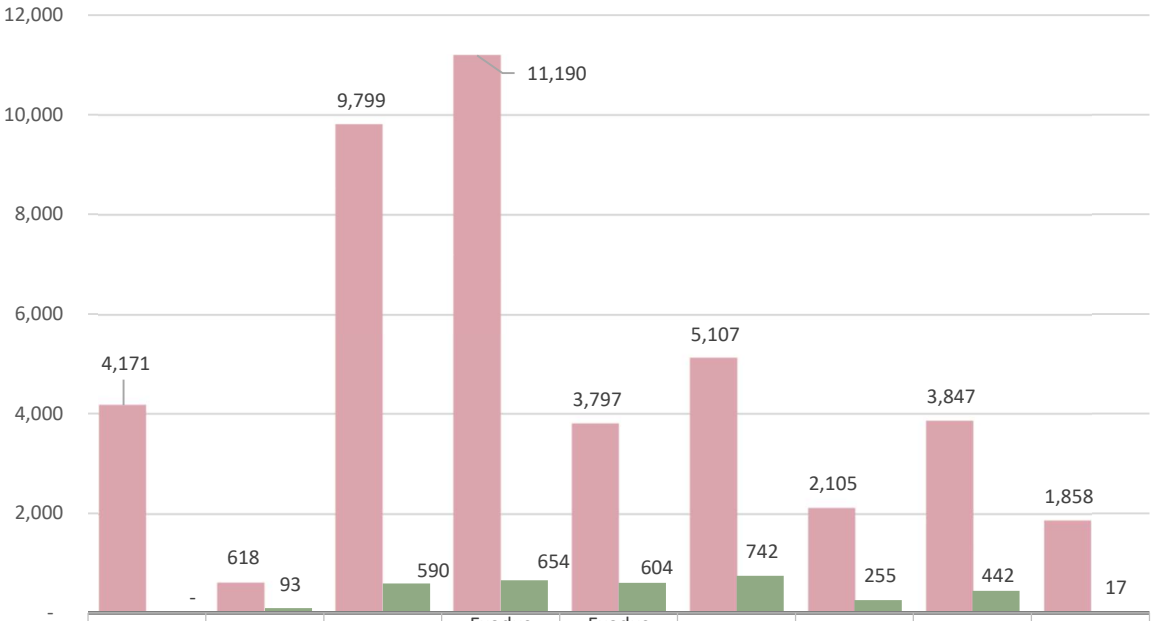
The following graphs provide an overview of FY 2019-20 outcomes of the eight UCCs. Olive View UCC has two components: Crisis Stabilization Unit (CSU) - 7913 and Outpatient UCC - 7591 that does not operate 24/7.

Figure 10. FY 2019-20 UCC New admissions by age group



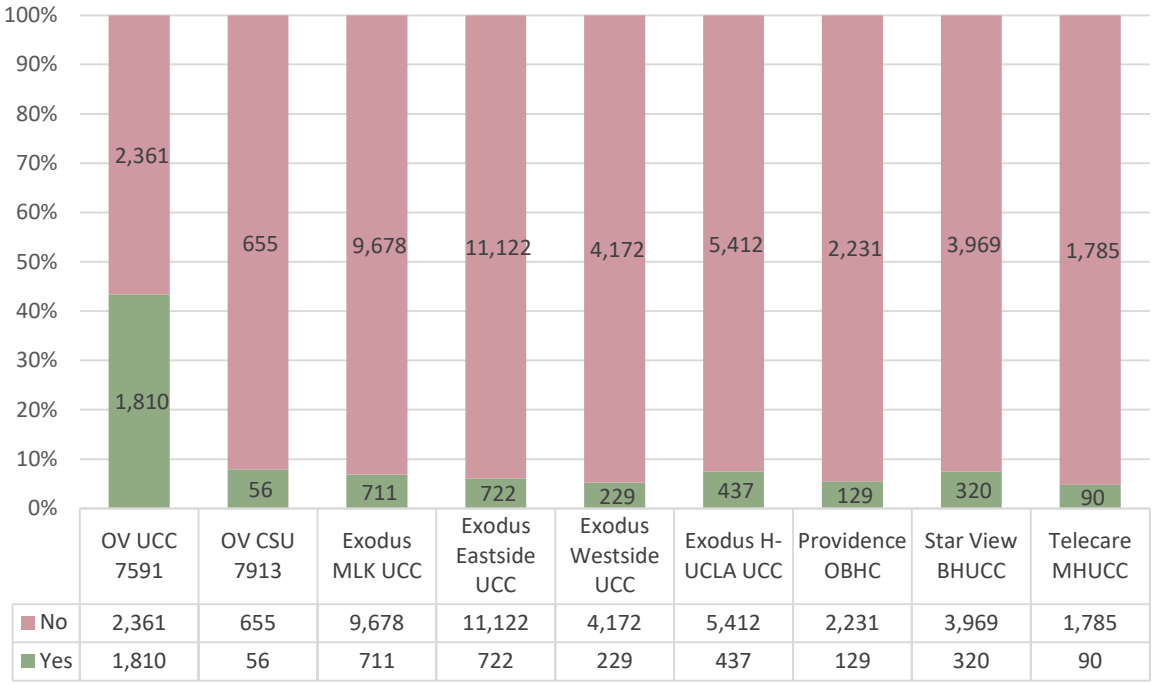
	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View BHUCC	Telecare MHUCC
Child	5	0	172	35	67	162	0	1	0
TAY	20	0	1,112	245	60	466	0	458	0
Adult	3,936	669	8,572	10,976	4,043	4,943	2,255	3,617	1,764
Older Adult	191	42	533	588	231	278	120	213	111

Figure 11. Clients with a psychiatric emergency assessment within 30 days of an UCC assessment



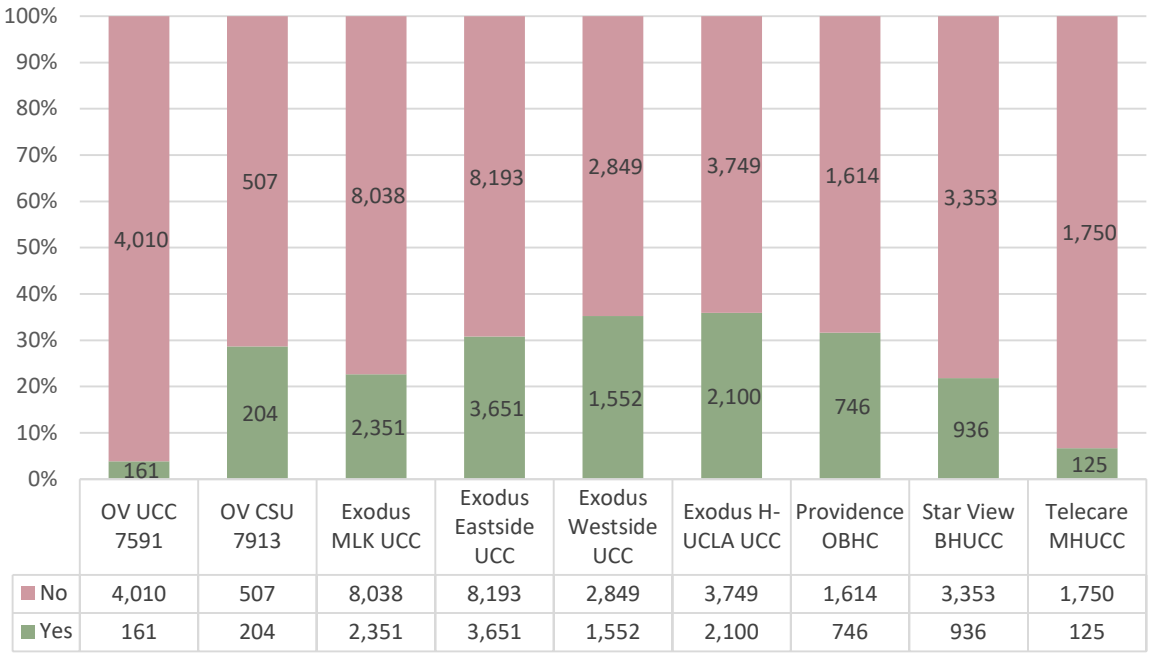
	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View BHUCC	Telecare MHUCC
No	4,171	618	9,799	11,190	3,797	5,107	2,105	3,847	1,858
Yes	-	93	590	654	604	742	255	442	17

Figure 12. Clients returning to UCC within 30 days of prior UCC visit



	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View BHUCC	Telecare MHUCC
No	2,361	655	9,678	11,122	4,172	5,412	2,231	3,969	1,785
Yes	1,810	56	711	722	229	437	129	320	90

Figure 13. Clients who were homeless upon admission to UCCs



	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View BHUCC	Telecare MHUCC
No	4,010	507	8,038	8,193	2,849	3,749	1,614	3,353	1,750
Yes	161	204	2,351	3,651	1,552	2,100	746	936	125

C3. Enriched Residential Services (ERS)

ERS is designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities, 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. The following graphs provide an overview of FY 2019-20 outcomes of the nine ERS facilities.

Figure 14. Source of client referrals for ERS admissions (n = 988)

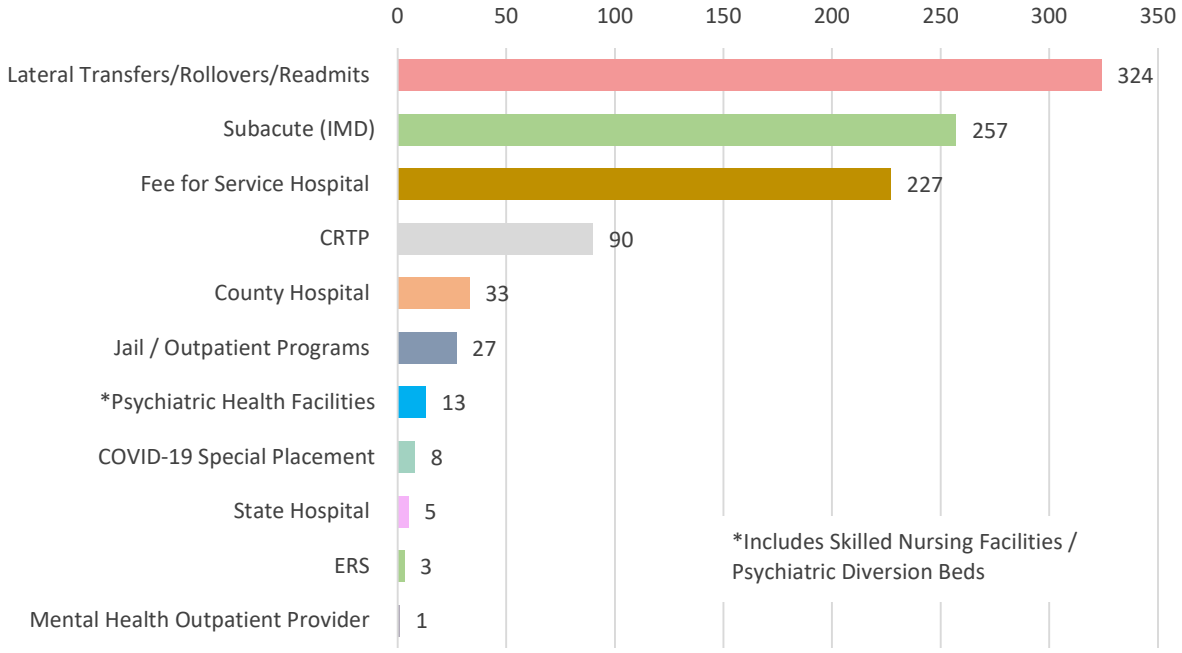
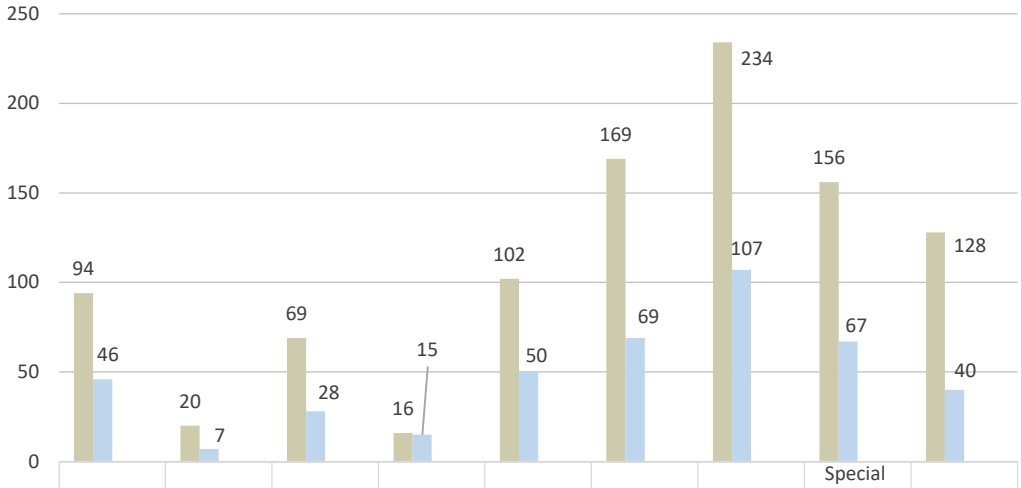
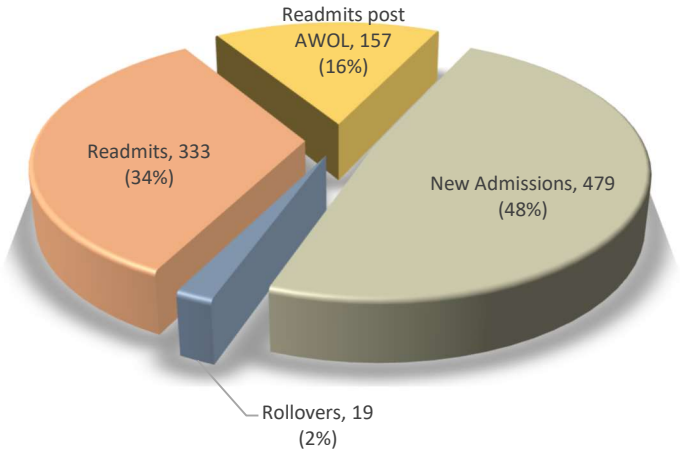


Figure 15. Client admission and discharge rates to ERS facilities (admission n = 988; discharge n = 429)



	Anne Sippi Clinic	Bridges	Cedar Street Homes	Gateways Satellite	Normandie Village	Percy Village	Special Services for Groups	Special Services for Groups - Special Needs	Telecare 7
Admissions	94	20	69	16	102	169	234	156	128
Discharges	46	7	28	15	50	69	107	67	40
Discharged	49%	35%	41%	94%	49%	41%	46%	43%	31%
Average Length of Stay	53	134	67	175	115	72	76	77	79

Figure 16. Client admission types to ERC facilities (n = 988)



Admission types include clients who newly admit into a facility for the current fiscal year (New Admissions); readmit into the same facility as result of an absence (Readmits or Readmits post AWOL); (3) transfer internally to a higher or lower level of care (Lateral Transfers); and (4) change bed type, such as from indigent to Medi-Cal (Rollovers).

C4. Crisis Residential Treatment Programs (CRTP)

CRTPs are designed to provide short-term, intensive, and supportive services in a home-like environment through an active social rehabilitation program that is certified by the California Department of Health Services and licensed by the California Department of Social Services, Community Care Licensing Division. They are designed to improve the lives and adaptive functioning of those they serve. Those admitted to a CRTP can be expected to receive an array of services including self-help skills, peer support, individual and group interventions, social skills, community re-integration, medication support, co-occurring services, pre-vocational / educational support, and discharge planning.

Table 18. Overview of current and future CRTPs

CRTP	Bed Count	Open
Hillview (includes 3 AB109 slots)	15	Yes
Excelsior House	14	Yes
Jump Street	10	Yes
Exodus	12	Yes
Gateways	16	Yes
CLARE Foundation	16	Yes
Teen Project	16	Yes
Lacada	16	July 2021
Special Services for Groups (SSG)	16	July 2021
Martin Luther King, Jr.	16	Fall 2021

Figure 17. Source of Client Referrals for Crisis Residential Facility Admissions (n = 1,374)

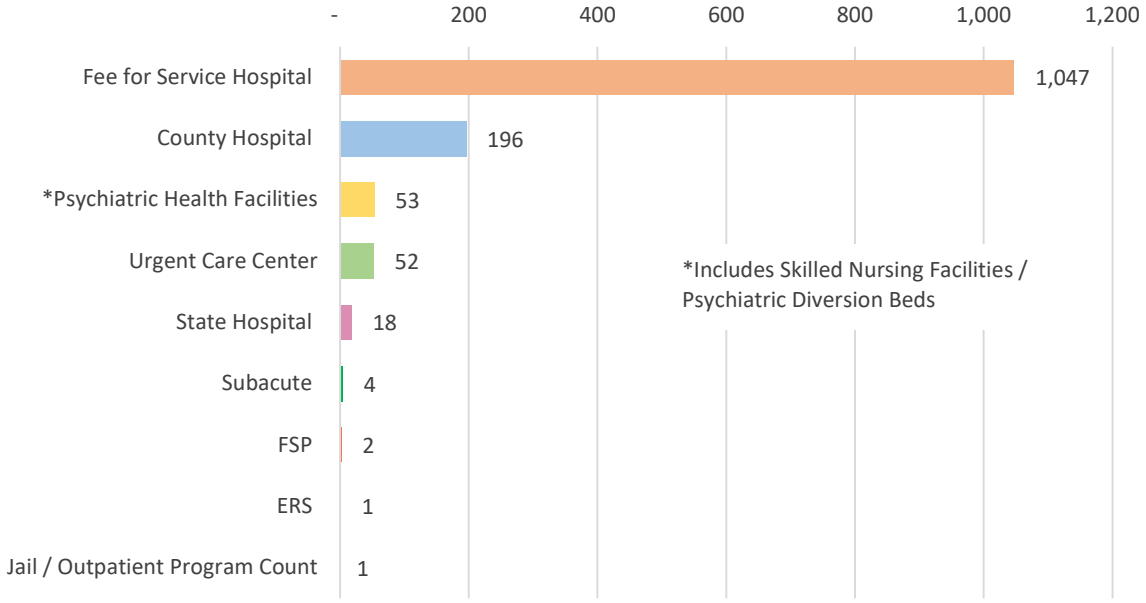
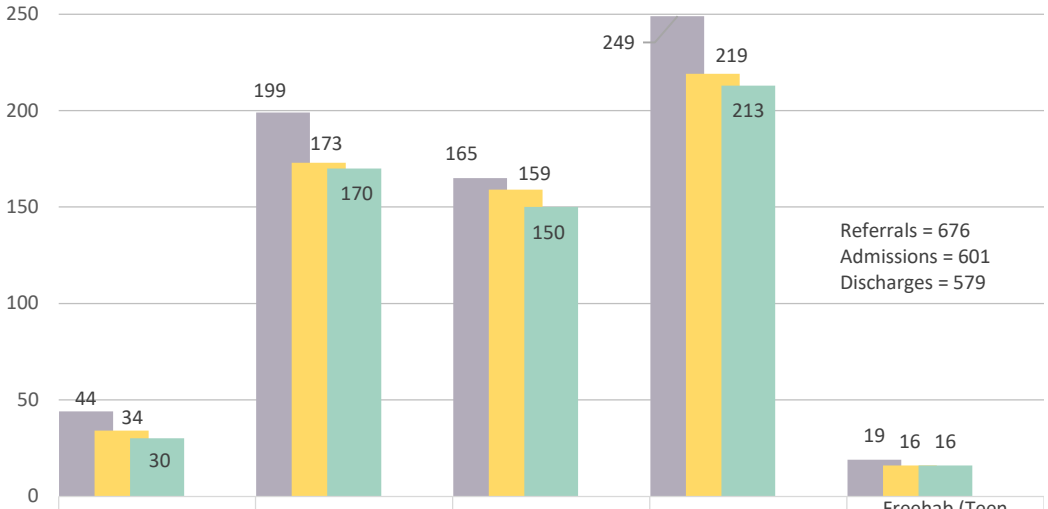


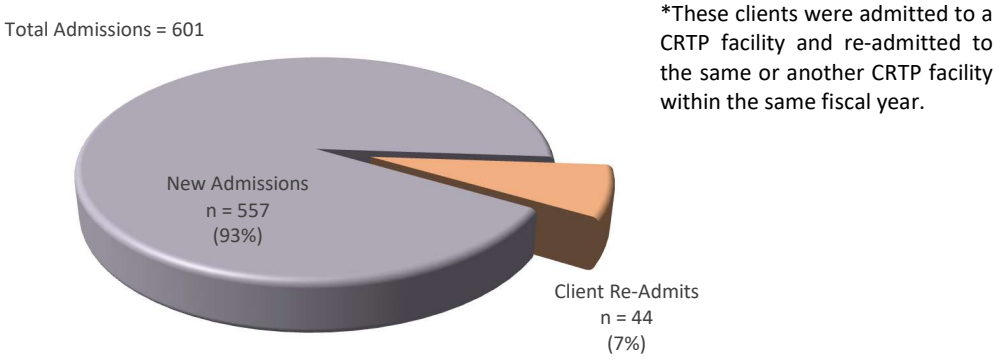
Figure 18. Client referrals, admissions and discharge rates CRTP admissions



	Hillview	CLARE Foundation	Gateways SRP	Exodus	Freehab (Teen Project)
Total Referrals*	44	199	165	249	19
Total Admissions	34	173	159	219	16
Total Discharges	30	170	150	213	16
Discharged	88%	98%	94%	97%	100%
Average Length of Stay	76	28	26	23	26

Not all CRTP referrals result in an admission. For FY 2019-20, there were 1,392 CRTP referrals, of those 790 clients 'were no longer referred'. Clients are no longer referred for the following reasons: (1) client discharged from the hospital prior to admission; (2) client declined the CRTP; (3) client discharged to CRTP but decided to no-show; (4) client admitted to another CRTP. Freehab (Teen Project) opened in November 2019.

Figure 19. Client admission types to CRTP facilities (n = 601)



C5. Law Enforcement Teams (LET)

The countywide police and mental health co-responder teams consist of LACDMH 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.

The County's diverse population requires compassionate and equitable intervention methods across the spectrum of care. LACDMH serves those most vulnerable and at-risk in our community through expanded personalized programs and collaboration with other County departments.

LET co-response teams consist of a law enforcement officer and a LACDMH mental health clinician who respond to 911 calls involving mental health crises. These teams ensure that the individuals in crisis receive appropriate, specialized care and safe transportation to the treatment facilities. LET and LACDMH's Psychiatric Mobile Response Teams (PMRT) support one another as resources permit. Mental health clinicians have already been assigned to work with 40 of the 46 police departments throughout the County.

During FY 2019-20, there were 14,472 calls, of which 31% involved homeless individuals; 3% resulted in arrests; and 61% required hospitalizations.

FYs 2021-24 ■ ALTERNATIVE CRISIS SERVICES Continued Work

For FYs 2021-24, LACDMH will continue to look for opportunities to enhance MHSA ACS funded program leveraging other potential funding sources to while ensuring existing resources meet the varied needs of those served. Recent activities and future plans include:

- Focus on prevention and diversion to subacute and open residential treatment beds, as well as crisis residential beds that will help decompress County hospital beds
- Secure Measure J funding to expand treatment beds (UCCs, sobering centers, CRTPs, peer respite); acute, subacute, board and care, and congregate housing; and LET by an additional 50 teams to service different parts of the County
- Increase placement options at various levels of care to help fill current gaps/lack of availability of "back-end" referral resources for diversion and linkage

■ ALTERNATIVE CRISIS SERVICES			
Prior FY 2019-20		**Prior FY 2018-19**	
33,458 Total Number Served[1]	$119.4 million Total Gross Expenditures	25,449 Total Number Served	$117.3 million Total Gross Expenditures
FY 2021-22		**Three-Year Plan FYs 2021-24**	
29,453 Total Number Served[2]	$133.5 million Estimated Gross Expenditures	$419.8 million Estimated Gross Expenditures	

Notes

1 Prior Year Total Number Served: Number of unduplicated clients receiving Mode 15 Direct Services, not inclusive of community outreach services or client support services

2 FY 2021-22 Total Number Served: Reflects average of two prior years

D. HOUSING

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ TAY Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

The Housing program develops and manages housing resources and mental health programs for individuals who are homeless and have a SMI or SED; and provides employment and education programs; training technical assistance; and advocacy on housing, employment, and education.

LACDMH Housing and Housing Supportive Services programs:

- Enriched Residential Care (ERC) Program
- Federal Housing Subsidies Program
- Housing Assistance Program (HAP)
- Housing for Mental Health (HFMH)
- Intensive Case Management Services (ICMS) Program
- Interim Housing Program (IHP)
- Mental Health Housing Program
- MHSA Housing and Special Needs Housing Program
- No Place Like Home

Intended Outcomes

- Assist LACDMH clients who are homeless to obtain interim housing and permanent housing
- Assist LACDMH clients living in permanent housing to retain housing
- Increase the overall number of interim and permanent supportive housing (PSH) units and rental subsidies targeting LACDMH clients

Key Activities

- Provide immediate interim housing and supportive services to LACDMH clients who are homeless to get them off the streets
- Provide financial assistance to help LACDMH clients transition from homelessness to permanent housing (e.g., rental subsidies, security deposits, utility assistance, furniture, household goods, etc.)
- Provide mental health, case management and housing retention services to LACDMH clients who are formerly homeless and living in permanent housing
- Invest in the capital development of PSH for individuals who are homeless and have a SMI/SED in partnership with the Los Angeles County Development Authority (LACDA) and through the use of No Place Like Home funding and managing the current portfolio of PSH to ensure the intended population is targeted

FY 2019-20 ■ HOUSING Data and Outcomes

During FY 2019-20, LACDMH continued its investment in the development of PSH for homeless or chronically homeless individuals and families who are living with SMI or severe emotional disorder.

Table 19. Number of new developments by target population in FY 2019-20

Target Population	Number of Developments	Number of Units
TAY	7	168
Adults	33	1,158
Older Adults	11	338
Families	3	83
Veterans	3	127
Total	57	1,854

Through the No Place Like Home Program which is funded by MHSA and in collaboration with the Los Angeles County Development Authority, $390 million was committed for the development of 57 new MHSA housing developments that will add 1,854 MHSA units to the county's overall total unit count. These newly funded housing developments target various age groups as indicated in this table.

Table 20. Number of developments by target population in FY 2019-20

Target Population	Number of Developments	Number of Units
TAY	20	335
Adults	73	1,978*
Older Adults	23	588
Families	18	513**
Veterans	6	194
Total	140	3,608

Since 2008, LACDMH has invested $670 million overall in the development of PSH across Los Angeles County providing capital funding for 140 housing developments and capitalized operating subsidies for 13 of them. As of June 30, 2020, 43 of the 140 MHSA funded housing developments had finished construction and 953 units including studios and/or 1 to 4 bedroom apartments were occupied. One-hundred and thirty-two (132) of the units were newly leased up during the fiscal year.

*24 of 1,978 units are targeting non-health care eligible veterans.
**12 of 513 units are targeting non-health care eligible veterans.

With new move-ins and exits during FY 2019-20, LACDMH provided housing to a total of 996 clients along with 584 additional adult family members and 284 minor children. While 905 of these clients were still in their units at the end of the fiscal year, 91 clients had exited housing reflecting a 91% retention rate.

D1. Federal Housing Subsidies Program

In addition to the MHSA PSH units, LACDMH grew its number of tenant-based PSH units to 2,399 in FY 2019-20 through 18 contracts with the City and County of Los Angeles Housing Authorities. These contracts provide LACDMH clients that are homeless with access to federal tenant-based PSH subsidies such as Shelter Plus Care, Tenant Based Supportive Housing, Mainstream Vouchers and Section 8. Federal subsidies make units affordable by allowing clients to pay a limited percentage of their income as rent, with the balance paid to the property owner by the Housing Authority. LACDMH MHSA funded services are leveraged through the Federal Housing Subsidies program and are used as the required federal match for Shelter Plus Care. LACDMH clinicians and case managers assist their homeless clients with accessing these housing resources by supporting them through the application, interview and housing location process and then by providing the supportive services necessary to maintain their housing.

With new move-ins and exits during the fiscal year, LACDMH provided housing to 2,045 clients along with 96 additional adult family members and 691 minor children. Three hundred and twenty-four clients newly leased up during the fiscal year while 89 households exited housing reflecting a retention rate of 96%.

D2. Housing for Mental Health (HFMH)

In FY 2019-20, $10 million in MHSA funding was set aside to launch HFMH that provides for ongoing rental subsidies, as well as funding for security deposits, utility assistance and household goods. This program targets highly vulnerable individuals with SMI who are enrolled in a FSP Program and are homeless and/or have criminal justice involvement. Twenty percent of housing subsidies are reserved for FSP clients referred by DHS Office of Diversion and Reentry (ODR).

The HFMH Program also works in close collaboration with DHS' Intensive Case Services (ICMS) teams who work alongside the FSP teams to assist clients with the housing process and with Brilliant Corners who serves as the administrator of the HFMH subsidies.

Using this $10 million, LACDMH has been able to allocate 413 HFMH housing subsidy vouchers across 17 FSP and ODR programs. The FSP and ODR programs, in turn, refer clients to these HFMH vouchers.

Table 21. Number of referrals by permanent housing type

Permanent Housing	New Referrals	New Move-ins
Tenant-Based Housing	224	113
Project-Based Housing	90	59
Licensed Residential Facility	16	10
Shared Housing	1	1
Total	331	183

As of June 30, 2020, 331 individuals had been referred for HFMH vouchers and 183 had moved into permanent housing. Recognizing that the housing needs of referred clients may vary, HFMH vouchers can be used for various types of PSH including tenant-based housing, project-based housing at one of eight partnering housing developments, housing at licensed residential facilities and shared housing. The table details the types of PSH to which clients were referred and moved into in FY 2019-20. LACDMH looks forward to these numbers continuing to grow in FY 2020-21 as the HFMH Program enters its second year.

D3. Housing Assistance Program (HAP)

HAP uses a variety of funding sources including MHSA to assist homeless consumers of mental health services who have limited or no income with the move-in costs needed to transition from homelessness into permanent housing. The program provides assistance in seven areas including Security Deposits, Utility Deposits, Household Goods, One-Time Rental Assistance, Ongoing Rental Assistance, Eviction Prevention and Permanent Rental Subsidies through the Flexible Housing Subsidy Pool (FHSP).

Table 22. Number of clients served by program components

Services Provided	Number of Clients	Expenditure
Security Deposits	151	$208,879
Utility Deposits	38	$8,846
Household Goods	672	$667,433
One-Time Rental Assistance	6	$7,447
Ongoing Rental Assistance	131	$779,332
Eviction Prevention	29	$24,169
FHSP Rental Subsidies	55	$788,476
TOTAL	1,082	$2,484,581

As of June 30, 2020, HAP provided financial assistance to 1,082 individuals/households totaling $2.48 million. This table reflects the services that were funded through MHSA and other funds and the number of individuals served.

In addition to the HAP services described above, LACDMH also provided some age-specific funding. In FY 2019-20, 20 TAY clients participating in directly-operated programs received housing assistance including ongoing rental assistance and move-in costs totaling $45,000. In addition, directly-operated Adult FSP Client Supportive Services funds were used for the purchase of goods and/or services that support an individual's ability to remain in the community and live independently. To this end, 66 mental health consumers were assisted during FY 2019-20 with expenditures totaling $80,000.

D4. Enriched Residential Care (ERC) Program

ERC provides housing subsidies for LACDMH clients with SMI who need the care and supervision supports provided by an Adult Residential Facility (ARF) or Residential Care Facility for the Elderly (RCFE) to live successfully in the community. These unlocked State-licensed facilities provide residents with 24-hour care and supervision, medication management, three meals per day and assistance with activities of daily living. MHSA funds are used to pay for the client's rent at the facility and personal and incidental (P&I) expenses should the client not have adequate income to pay for these items. MHSA funds are also used to provide the facility with an enhanced rate as needed to help cover the costs of enhanced services that a client with high acuity and complex needs may require due to their mental illness.

Those clients receiving only enhanced rate funding are clients who receive Supplemental Security Income (SSI) or have access to other funding that can cover the rent and P&I costs. It is a program requirement that all clients who are eligible for SSI receive assistance to apply for SSI.

Table 23. Number of new move-ins

Funding Type	Total New Move-Ins	Final Census (as of 6/30/20)
Rent, P&I and Enhanced Rate	161	161
Enhanced Rate Only	95	411
Total	256	572

As of June 30, 2020, the ERC Program was serving a total of 572 clients. The total number of new clients who moved into an ARF or RCFE with ERC support in FY 2019-20 was 256.

D5. Interim Housing Program (IHP)

IHP is intended to provide short-term shelter services for adults with mental illness and their minor children who are homeless and do not have adequate income to pay for temporary housing. Serving as a bridge to permanent housing, IHP sites provide clients with safe and clean shelter, 24-hour general oversight, three meals per day, linens, clothing and toiletries.

Table 24. Number served and contracted beds/units

Funding Type	Total New Move-Ins	Final Census (as of 6/30/20)
Individuals	430	1,129
Families	74	153
Total	504	1,282

MHSA funds enabled the IHP to contract for 504 beds across 19 sites. This included 430 beds for individuals and 74 family units. Utilizing these resources, the IHP was able to serve a total of 1,129 individuals and 153 families in FY 2019-20.

In terms of client outcome data for those that exited the program, 36 percent transitioned to permanent housing including subsidized housing through such voucher programs as Section 8, Shelter Plus Care, Rapid Rehousing and the Flexible Housing Subsidy Pool; sober living homes; shared/collaborative housing; non-subsidized apartments; ARFs/RCFEs and living with friends or family. Thirteen percent transitioned to transitional

or interim housing while 10 percent returned to homelessness and six percent entered hospitals or jails. An additional 35 percent transitioned to an unknown destination.

FYs 2021-24 ■ HOUSING Continued Work

For FYs 2021-24, LACDMH will continue the indicated Key Activities to help clients who are homeless to obtain and retain interim and permanent housing. At the same time, LACDMH continues to look for opportunities to grow its housing resources and ensure its existing resources meet the varied needs of those served. Recent activities and future plans include:

- Redesign the Housing FSP program to enhance the program design and service model. The new Housing Supportive Services Program (HSSP) will go into effect July 1, 2021 and continue to provide services to LACDMH clients who are formerly homeless and now living in PSH
- Secure Measure J funding for Housing expansion that aligns with Alternatives to Incarceration (ATI) "Care First" model
- Submit a $6.0 million request to the Substance Abuse and Mental Health Services Administration (SAMHSA) to increase funding for the ERC Program. If approved, LACDMH estimates to help fund licensed residential facility placements for 283 new clients
- Use $11.7 million in existing one-time MHSA funding to help enhance the licensed residential facility system of care in the County that serves Supplemental Security Income (SSI) recipients, including many LACDMH clients and initiate a:
  - ✓ Membership Association for facility operators that will facilitate collaboration around best practices, training, client care and advocacy
  - ✓ Capital improvements grant program to address deferred maintenance issues (repairs, technology, etc.) that could threaten facility operations. Additional funding from philanthropic partners will also be leveraged to fund capital needs assessments and research that will analyze the operational and ownership structures of these facilities
  - ✓ Bed tracking system that will allow facilities to share information more easily on available beds with mental health providers and community members
- Utilize $0.5 million in funding from the Conrad N. Hilton Foundation towards the short-term housing needs of individuals released from prison who are linked into and receiving mental health services from LACDMH service providers
- Continue to allocate the remaining No Place Like Home funding, of which $100.0 million has been set aside to develop PSH at Restorative Care Village sites on County healthcare campuses
- Propose the implementation of the Trieste INN project by partnering with the First Presbyterian Church of Hollywood (FPCH) to develop and implement a two-phase project that will transition and provide services to individuals in that area who are experiencing homelessness and have a SMI to innovative, no-barrier housing model envisioned to be a Pop-Up Village. A formal agreement with FPCH would be subject to Board approval.

■ HOUSING	
Prior FY 2019-20	**Prior FY 2018-19**
$22.4 million Total Gross Expenditures	$76.2 million Total Gross Expenditures
FY 2021-22	**Three-Year Plan FYs 2021-24**
$35.4 million Estimated Gross Expenditures	$105.6 million Estimated Gross Expenditures

Currently, unique client count is only for MHSA programs with Mode 15 Direct Services (FSP, Outpatient Services, and Alternative Crisis Services). LACDMH is working to strengthen its data collection methods to better capture exit data.

All dollar amounts in this table are reported at gross costs and does not include any program administration costs.

E. LINKAGE

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☐ TAY Ages 16 - 24	☒ Adult Ages 24 - 59	☐ Older Adult Ages 60+

Program Description

Linkage provides programming that works with those in the community to connect them to essential services that include treatment, housing and other mental health service programs throughout the County.

Linkage Programs:

- Jail Transition and Linkage Services
- Mental Health Court Linkage
- Service Area Navigation

Intended Outcomes

Linkage programming engages in joint planning efforts to ensure that an active locally-based support network comprised of community partners, including community-based organizations, other County departments, intradepartmental staff, schools, health service programs, faith-based organizations, and self-help and advocacy groups:

- Increase access to mental health services and strengthen the network of services available to clients in the mental health system
- Promote awareness of mental health issues and the commitment to recovery, wellness and self-help
- Engage with people and families to quickly identify currently available services, including supports and services tailored to a client's cultural, ethnic, age and gender identity

Key Activities

- Assist the judicial system with individual service needs assessments of defendants, link defendants to treatment programs, and provide support and assistance to defendants and families
- Assist a multi-disciplinary team in considering candidates' eligibility and suitability for pre-trial rapid diversion and linkage to treatment services
- Develop alternate sentencing, mental health diversion and post-release plans that consider best fit treatment alternatives and Court stipulations

FY 2019-20 ■ LINKAGE Data and Outcomes

E1. Jail Transition and Linkage Services

Client Contacts: 2,555

This 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. 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 is to successfully link individuals to community-based services upon discharge to prevent

releasing them to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services.

E2. Mental Health Court Linkage Program

Client Contacts: 5,300

This program has two sub-programs funded by MHSA:

- The Court Liaison Program is a problem-solving collaboration between LACDMH 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 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 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. Also, this 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.

E3. Service Area Navigation

Client Contacts: 22,544

Service Area Navigator Teams assist individuals and families in accessing mental health and other supportive services and network with community-based organizations 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 long-standing goal of “no wrong door” achievable.

The following charts reflect FY 2019-20 data reported by the Service Area Navigators.

Figure 20. Number of phone contacts and outreach activities

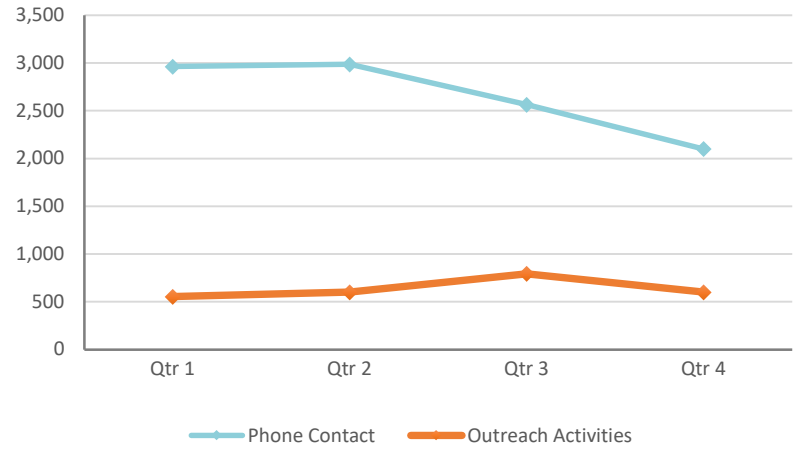


Figure 21. Number of clients referred to FSP services

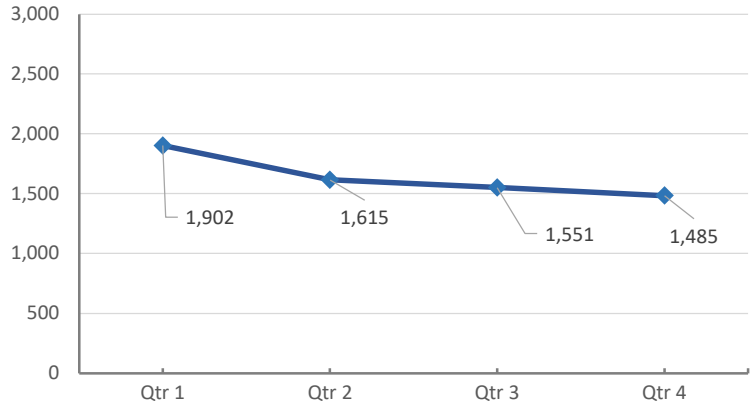
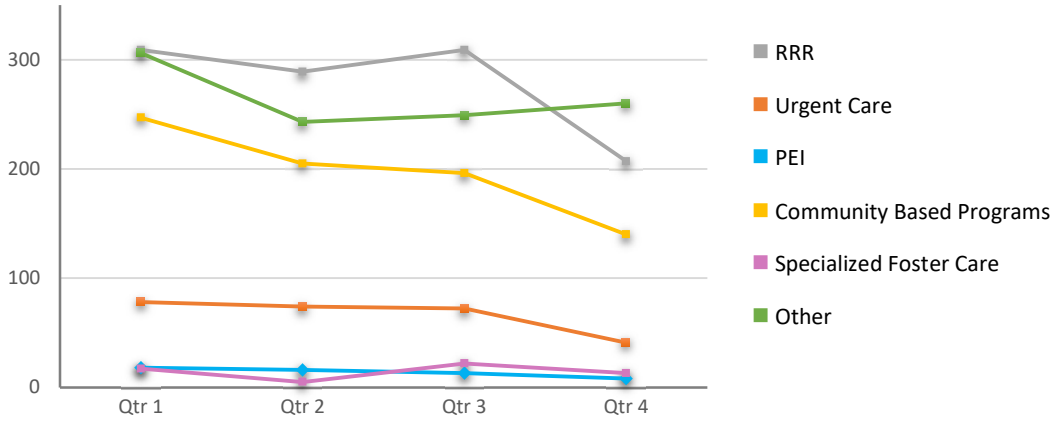


Figure 22. Number of clients referred to Non-FSP services



FYs 2021-24 ■ LINKAGE Continued Work

For FYs 2021-24, LACDMH will continue the indicated Key Activities by the following:

- Secure Measure J funding to expand Court Linkage to additional courthouses
- Expand rapid diversion programs to additional courthouses to better service the significant needs of the County
- Expand and enhance videoconferencing capabilities and capacity in courthouse, lock-up, and jail facilities to more efficiently and rapidly provide diversion and linkage services to a greater number of clients, including leveraging flexible resource pools and economies of sale factors
- Create direct communication and coordination channels/pathways between the judicial system and diversion and linkage referral resources, including LACDMH directly-operated and contracted service programs

LINKAGE	
Prior FY 2019-20	**Prior FY 2018-19**
$18.5 million Total Gross Expenditures	$16.6 million Total Gross Expenditures
FY 2021-22	**Three-Year Plan FYs 2021-24**
$27.1 million Estimated Gross Expenditures	$85.0 million Estimated Gross Expenditures

Currently, unique client count is only for MHSA programs with Mode 15 Direct Services (FSP, Outpatient Services, and Alternative Crisis Services).

All dollar amounts in this table are reported at gross costs and does not include any program administration costs.

F. PLANNING, OUTREACH AND ENGAGEMENT

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ TAY Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

One of the cornerstones of MHSA is to empower underrepresented ethnic populations. In June 2007, LACDMH established the Underserved Cultural Communities Unit (UsCC) to develop a stakeholder platform to historically underserved ethic and cultural communities in Los Angeles County. Subcommittees were established to work closely with the various underrepresented / underserved ethnic and cultural populations in order to address their individual needs.

UsCC Subcommittees:

- African/African American
- American Indian/Alaska Native
- Asian Pacific Islander
- Deaf, Hard-of-Hearing, Blind, and Physical Disabilities
- Eastern European/Middle Eastern
- Latino
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, and Two-Spirit (LGBTQIA2-S)

Each UsCC subcommittee is allotted one-time funding totaling $200,000 per fiscal year to focus on CSS-based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. Project proposals are created and submitted via a participatory and consensus-based approach.

Intended Outcomes

- Increase mental health awareness to all communities within the County
- Identify and address disparities amongst target populations
- Reduce stigma discrimination by educating and empowering communities to understand the importance of mental health care
- Increase access to care for mental health services provided by LACDMH and contract providers

Key Activities

- Outreach communities throughout the County by conducting conferences and special events
- Communicate and educate community members using various media and print media, as well as and grassroot level community mental health presentations
- Conduct surveys to gather results for data analysis to continue planning, outreach and engagement activities
- Enlist the help of community members to collaborate in outreach and engagement activities

FY 2019-20 ■ PLANNING, OUTREACH AND ENGAGEMENT Data and Outcomes

In FY 2019-20, Service Area outreach staff attended multiple events with 58,375 participants. The population consisted of the community at large from UsCCs. Staff disseminated mental health information at job fairs, Veteran events, colleges, libraries, community events and activities at local senior centers.

Table 25. Event participants by Service Area

Service Area	Number of Participants
SA1 – Antelope Valley	13,170
SA2 – San Fernando Valley	7,216
SA3 – San Gabriel Valley	5,893
SA4 – Metro Los Angeles	3,370
SA5 – West Los Angeles	5,998
SA6 – South Los Angeles	9,206
SA7 – East Los Angeles County	8,224
SA8 – South Bay	5,298

An overview of the projects that were approved for FY 2019-20 for each of the seven UsCC Subcommittees is provided below. In observance of social distancing measures, the implementation of some of the UsCC capacity building projects was conducted using a variety of different virtual platforms.

A. BLACK AND AFRICAN HERITAGE UsCC SUBCOMMITTEE

Project	Project Outcomes
Community Agents of Change Network Project The purpose of the project is to spread mental health awareness, education, and community resources to African American community members who reside in SA 6 - South Bay and SA 8 - South Bay. This project aims to educate and empower the African American community about the importance of mental health care to build awareness and community connections by training community members to become Community Agents of Change Educators (CACE). Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project involved two components: 1) the facilitation of community stakeholder focus groups that will help with the development of a culturally responsive outreach and engagement curriculum; the recruitment of community members and volunteers; and the training of community members who reside in SAs 6 and 8 to become CACE; and 2) CACEs to conduct grassroots level community mental health presentations and/or 1 to 1 outreach and engagement supportive activities.	▪ Twelve (12) CACEs were trained to deliver community mental health presentations. ▪ Twenty-two (22) community mental health presentations were successfully completed. ▪ To date, 408 community members have been educated about basic mental health education and accessibility to services in Los Angeles County. ▪ Eight (8) additional community presentations are scheduled for the month of February 2021. ▪ This project is scheduled to be completed on February 28, 2021.

Project	Project Outcomes
African American Youth Community Ambassador Network Project The purpose of the project is to educate and empower Black youth about the importance of mental health care to build awareness and community connections. This project will increase mental health awareness through educational workshops, the arts (dance, music, drama, poetry, etc.), and other outreach and engagement activities that are culturally sensitive to this community. This project targeted SA1 African American youth ages 12-25. This project involved two components.: 1) the facilitation of community stakeholder focus groups that helped with the development of a culturally responsive outreach and engagement curriculum targeting African American youth ages 12 and older, as well as the recruitment of Black youth ages 18-25 years, who will be trained to conduct the outreach and engagement activities; and 2) the trained African American presenters to conduct grassroots level community mental health presentations through educational workshops, the arts and or other cultural relevant activities.	▪ Seven (7) Black youth were recruited and trained to conduct virtual community mental health presentations. ▪ To date, twenty (20) community mental health presentation have been conducted by the youth. ▪ To date, 273 Black youth ages 12-25 have participated in the virtual community mental health presentations. ▪ This project is scheduled to be completed by February 28, 2021.

B. AMERICAN INDIAN/ALASKA NATIVE (AI/AN) UsCC SUBCOMMITTEE

Project	Project Outcomes
AI/AN Community Symposiums Project The purpose of the Community Symposiums project was to engage, empower, and enlist the AI/AN community into conversations about mental health and traditional forms of healing. Attendees of the Community Symposiums were given the opportunity to learn more about some of the unique mental health needs of the AI/AN community and the traditional forms of healing that are practiced by community members. In total, five symposiums were held on the following dates: 2019 – Sept 28, Oct 12, Nov 9 2020 – Jan 11, Feb 8 Symposium topics included traditional ways of healing, indigenize education, art and music as medicine, suicide prevention and harm reduction, and historical trauma to intergenerational resilience.	▪ A total of 339 participants attended the Community Symposiums. ▪ Two hundred (200) pre/posts tests were collected. ▪ Overall, participants reported an increase in knowledge from the pre-test to the post-test regarding the mental health challenges experienced by the AI/AN community (15.75% increase) as well as traditional forms of healing for this population (10% increase). ▪ This project was completed on April 30, 2020.
AI/AN Educational Public Service Announcement (PSA) Project A media consultant was contracted to produce five 60-second PSAs. The production consisted of pre-production (creative development, concepts, ideas, script development/approval, development meetings, breakdowns, casting), production/filming, and post-production (editing, voice-over, and delivery).	▪ A total of five PSAs were developed. ▪ The consultant conducted focus groups with AI/AN community members to determine the subject matter of the PSAs. ▪ The five PSAs covered the following topics: AI/AN UsCC subcommittee (75-seconds); American Indian Counseling Center (30-seconds); The Dark Cave (75-seconds); Trust Umbrella (60-seconds); and The Invisible Man (105-seconds). ▪ All five PSAs were uploaded to the LACDMH website and YouTube pages and are being used as a tool to promote

Project	Project Outcomes
	mental health education and services accessibility targeting the AI/AN community. ▪ This project was completed on May 31, 2020.
AI/AN Video Showcase Project A media consultant was contracted to produce a Video Showcase project that included two videos. The first video was a 12-minute video highlighting the American Indian Counseling Center (AICC), a LACDMH directly-operated clinic providing services to the AI/AN community. This video was developed with the intent to be played in the clinic and to provide viewers with information on how to access services, what the process of accessing services may involve, and what services can be provided including intake, case management, medication management, substance abuse counseling, housing resources, etc. The second video was a five-minute video highlighting AICC, as well as other providers serving the AI/AN community. This video was developed with the intent to be played on social media platforms. The production consisted of pre-production (creative development, concepts, ideas, script development/approval, development meetings, breakdowns, casting), production/filming, and post-production (editing, voice-over, and delivery).	▪ The consultant partnered with AI/AN community members to develop the concepts for the two videos and attended AI/AN gatherings to capture additional footage. ▪ Upon completion, both videos were uploaded to the LACDMH website and YouTube pages and is being used as a tool to promote mental health education and services accessibility targeting the AI/AN community. ▪ This project was completed on February 28, 2020.
AI/AN Mental Health Conference One of the recommendations of the AI/AN UsCC subcommittee was to plan and coordinate the 2019 AI/AN Native Mental Health Conference: "Native Health & Resilience." The conference took place on November 12, 2019. The goals of the conference were to inform participants of mental health issues unique to the AI/AN community; improve participants' ability to recognize when to refer an AI/AN community member for mental health services; provide participants with useful information on available mental health resources for AI/AN community members; and improve participants' ability to provide culturally appropriate mental health treatment to AI/AN consumers. A survey was handed out to all participants at the start of the conference. A total of 97 completed surveys were received from the 207 individuals who attended the conference.	A total of 97 completed surveys were received from the 207 individuals who attended the conference. The feedback revealed: - 96% agreed or strongly agreed that the conference made them more aware about the mental health issues unique to the AI/AN community - 78% agreed or strongly agreed that the conference improved their ability to recognize when to refer an AI/AN community member for mental health services - 92% agreed or strongly agreed that they received useful information on mental health resources for AI/AN community members - 85% agreed or strongly agreed that the conference improved their ability to provide culturally-appropriate mental health treatment to AI/AN consumers

C. ASIAN PACIFIC ISLANDER (API) UsCC SUBCOMMITTEE

Project	Project Outcomes
API Wellness Summit 2019 This API Wellness Summit 2019 took place on April 11, 2019 and it aimed to raise awareness of how culturally competent interventions and providers are vital for prevention, early intervention, and recovery for the API community and featured personal testimonies of API consumers and their family members on their recovery journeys. The theme for this inaugural conference was "Sharing Our Stories of Resilience". Workshops focused on Self-Care and Stress Management for API Peers; The Self-Care and Nutrition in Mental Health from a Traditional Asian Medicine Perspective; Addressing Mental Health in the Older Adult API Community: Building Awareness and Providing Access to Help; Substance Abuse and Addiction in the API Community, Tai Chai for Mental and Physical Wellness; and Asian / Pacific Islander Resilience, Healing, and Empowerment.	▪ A total of 219 participants took part in the conference which included: 78 consumers; 57 community members; 34 LACDMH staff; 19 family members; 14 Peer Advocates; 13 Other (not specified); 2 Family Advocates; and 2 Mental Health Promotors. ▪ Services for language interpretations were provided in six (6) different languages which included: Korean, Cambodian, Cantonese, Mandarin, Thai, and Vietnamese. ▪ Fifty-seven (57) participants utilized the interpretation services. ▪ Ninety-nine (99) Post Summit Surveys were collected from the participants. The survey assessed the impact of the event on the participants' awareness and knowledge of mental illness. Results indicated the following: - 66% strongly agree or agree that they had a better understanding of the experience of recovery for API consumers - 92% strongly agree or agree that they have a better understanding of the experience of recovery for API family members - 93% strongly agree or agree that they learned how to better support and advocate for API consumers and family members - 98% strongly agree or agree that they learned that people with mental illness can recover from their condition - 96% strongly agree or agree that they received useful information on mental health resources for mental health treatment and support for API community members - 91% strongly agree or agree reported that their ability to provide culturally appropriate mental health treatment to API consumers improved (for clinicians only)
API Families – Supporting through Recovery This project aims to increase awareness about mental health related struggles that API consumers and family members experience to decrease mental health related stigma and encourage early access of services. The overarching goal of this project is to develop a Mental Health Informational Booklet specifically designed for API family members and friends to understand the scope of mental illness, address their fears and questions, and offer suggestions on how to care for and assist their loved ones. To develop the booklet, key Informant interviews and focus groups with API family members, API support groups and mental health providers that serve the API community were conducted. The goal is to better understand the challenges and identify effective strategies to help support and guide API family members in their efforts to support themselves and their loved one who is suffering from mental illness. Once developed, the booklet will be translated into five API languages (specifically Khmer, Simplified Chinese, Korean, Tagalog, and Vietnamese) and distributed to clinics and	▪ Eleven (11) focus groups were conducted to gather qualitative and quantitative data to develop the API Mental Health Informational Booklet. ▪ Eighty-three (83) community members participated in the focus groups; Participants consisted of family members and providers who spoke different API languages and represented different API groups. ▪ Due to social distance guidelines, the completion of this project is delayed. This project is scheduled to be completed by February 28, 2021. ▪ The completed API Mental Health Informational Booklet will be released by spring 2021. Copies of the booklet will be printed and distributed among community members and it will be made available digitally to all community non-profit organizations countywide that serve the API community.

Project	Project Outcomes
community-based agencies that serve API consumers and family members.	
API – Sharing Tea, Sharing Hope This project aims to increase awareness about mental health to decrease mental health related stigma and encourage early access of services within the API community. The focus of this project is conduct mental health outreach to the API community using a mobile teacart service, and/or online virtual tea salons via Zoom. Bilingual API individuals were recruited and trained as "Community Listeners" to engage API community members at various outreach events with the goal of engaging them in discussions about mental health and providing information on mental health issues and services. Through sharing of tea, the goal is to create a space to provide education about signs and symptoms of mental illness, mental health resources to reduce mental illness related stigma and gaps in mental health service delivery in the various API communities. The following API communities are targeted for this project: Cambodian (Khmer), Chinese (Mandarin or Cantonese), Filipino (Tagalog), Vietnamese, and Korean. The outreach events will focus on areas across the County where there are large concentrations of API community members.	▪ Five (5) community members were trained to become "Community Listeners". Once trained, the Community Listener were required to conduct the community mental health presentations targeting five different API groups ▪ To date, ten (10) community mental health presentations have been completed; 8 out of 10 presentations were conducted using a virtual platform due to the COVID-19 social distance guidelines ▪ This project is still in process and outcomes will be shared once completed

D. DEAF, HARD OF HEARING, BLIND, AND PHYSICAL DISABILITIES UsCC SUBCOMMITTEE

Project	Project Outcomes
Deaf, Hard of Hearing, Blind, and Physical Disabilities PSA Development Project This project consisted of collaborating with a media consultant to develop the concept and produce a 30-second PSA targeting the Deaf, Hard of Hearing, Blind, Physically Disabled communities throughout the County. The goal of the PSA is to promote mental health services, increase awareness, reduce stigma, and increase the capacity of our public mental health system.	▪ The 30-second PSA was developed in collaboration with community members, cultural brokers, and individuals with lived-experience. ▪ Members of the Deaf, Hard of Hearing, Blind, and Physically Disabled communities were showcased in the PSA to increase mental health awareness. ▪ For FY 2021-22, the PSA will be utilized to launch a media campaign that aims to reduce mental health disparities and increasing mental health access for the disabled community in the County.
Deaf, Hard of Hearing, Blind, and Physical Disabilities Peer-to-Peer Network The Peer-to-Peer Network Project aims to engage, empower, and enlist the Deaf, Hard of Hearing, Blind, and Physically Disabled community members into advocacy and activism around mental health issues that are affecting their community. Community members with lived-experience were trained to become Community Advocates and Activists around issues related to mental health. In addition, they were given the responsibility to conduct community presentations regarding mental health and mental health resources.	▪ Twenty-six (26) community members were trained to become Mental Health Advocates and Activist. Due to the pandemic, 23 members dropped out of the project and only three were available for the virtually community presentations. As a result, the trainer and one community member facilitated the presentation. ▪ To date, eleven (11) virtual community presentations have been conducted. Due to social distance guidelines and issues related to accessibility to internet services and devices, only twenty-eight (28) community members participated. ▪ This project is still in process and outcomes will be shared once completed.

Deaf, Hard of Hearing, Blind, and Physical Disabilities Clinical Mental Health Training A mental health training specifically addressing the mental health needs and treatment modalities pertaining to the Deaf, Hard of Hearing, Blind, and Physically disabled community was made available for licensed clinical staff at LACDMH directly-operated clinics and contracted providers. This project aims to provide mental health clinicians with an opportunity to be trained on identifying and treating the unique mental health needs and challenges faced by this community. The consultant was responsible for developing the training curriculum and facilitating the one-day clinical trainings that were conducted using a virtual platform due to social distance guidelines.	▪ Focus groups were conducted to develop the curriculum for the Clinical Mental Health training. ▪ To date, seven (7) Clinical Mental Health trainings have been conducted; two (2) trainings were done in-person and five (5) were conducted using a virtual platform due to social distance guidelines. ▪ This project is still in process and outcomes will be shared once completed.

E. EASTERN EUROPEAN/MIDDLE EASTERN UsCC SUBCOMMITTEE

Project	Project Outcomes
Parenting Seminars for the Arabic Speaking Community Project The project was designed to increase knowledge about effective parenting practices and accessibility to mental health services for Arabic speaking community members. The parenting seminar was conducted 12 times at different locations countywide. The goal of the project was to conduct the parenting seminars, and to provide mental health linkage and referral information pertaining to the services offered by LACDMH.	▪ Twelve (12) parenting seminars were conducted countywide. ▪ One hundred eighty-one (181) community members participated in the parenting seminars. ▪ The pre and post survey indicated that among those who participated in the Parenting seminars, 90% gained a greater understanding of the signs and symptoms of mental illnesses and 95% gained a solid understanding of how to seek mental health services from LACDMH. ▪ Qualitative feedback received from participants suggests success in the intended program outcomes. It was clear that these services made a tangible difference at many locations, evidenced by the desire of the community to sustain services not previously offered or sustained and to expand them with other psychoeducational opportunities and classes. ▪ Utilizing and implementing culturally competent promotion/prevention and treatment/intervention education through a diverse lens including the diversity of locations where the seminars were held, such as mosques, Muslim Community Organizations, universities, etc. Community members, who did not share their personal challenges previously, now participate in both community wellness programs (promotion/prevention) and client counseling services (treatment/intervention).
The Armenian Mental Health Show Project The Armenian Mental Health Television Show was developed to help increase knowledge and awareness about mental health issues and treatment modalities and services available for the Armenian community. The local Armenian-Russian Television Network (ARTN) was contracted to produce, direct, host and broadcast this weekly mental health show in the Armenian language.	▪ Thirty-four (34) half-hour (1/2 Hour) episodes presenting various mental health topics were produced and aired on ARTN from June - September in 2019. ▪ There are more than 200,000 Armenians who reside in Southern California who was given the opportunity to learn about mental illness and how it affects their community from the comfort of their own home. ▪ The show focused on educating the Armenian community about various mental health conditions, therapeutic modalities, and services accessibility in the County. ▪ Based on the TV ratings, the mental health show had great success within the Armenian community. ▪ Based on the feedback provided by viewers, Armenian community members felt that the show was engaging,

Project	Project Outcomes
	culturally relevant, and overall, it increased their knowledge about mental health issues, available resources, and helped to decrease mental health stigma. ▪ The qualitative data demonstrated that there is an increase in community awareness and education pertaining to mental illness and services that are offered by LACDMH.
The Russian and Farsi Speaking Mental Health Theatrical Performances Project This project was developed for the purpose of increasing mental health access and reducing disparities for the Russian and Farsi speaking communities. A local non-profit organization specializing in serving the Farsi and Russian community was contracted to develop and implement a theatrical play with an emphasis on mental health. The goal of this project was to increase mental health awareness and education among the targeted cultural groups. In addition, it aimed to promote mental health services that are offered by the LACDMH.	▪ A Table Read and a Virtual Play replaced the live theatrical performances as a result of the pandemic. It was conducted a total of 8 times using a virtual platform. ▪ It aired in the English, Farsi, and Russian languages. ▪ Over 100 community members participated. ▪ The pre and post surveys demonstrated that there was a significant shift in the participants' beliefs and knowledge about mental health issues. ▪ The qualitative feedback demonstrated that community members' perception about mental health changed and were more open to talk about this "highly stigmatized" topic.

F. LATINO UsCC SUBCOMMITTEE

Project	Project Outcomes
The Latino Comic Book Project – Cómics Que Curan (Comics that Heal) The Latino Comic Book project was developed to engage Latino Transitional Aged-Youth in a dialogue about mental health awareness and education. Latino Transitional Age Youth (TAY), ages 16-25 were recruited countywide to participate in creating their own 2-page comic about their mental health struggles and experiences. At the start of the project, they were provided with education about mental health issues and resources and were introduced to the art of comic book writing. The youth were provided with training and technical assistance during the writing-process and once completed; the comics were then complied into an anthology featuring the 2-page comics of each participating youth. The overarching goal of this project was to display stories written by Latino Youth in a Comic book. The comic book will be used as an outreach tool to educate the community about the mental health issues that Latino youth are experiencing and initiate a community dialogue about their mental health needs and the services that they need. Due to social distance guidelines, a virtual community culmination event was conducted, which included using Eventbrite as the digital registration platform for event attendees, and Google Meet as the web-based platform for individuals to view the unveiling of the artwork installation on the two aforementioned bus shelters, the display of all published comics featured in both "Comics que Curan" anthology (Volume 1), and a Q&A session with all of the "Cómics que Curan" workshop participants.	▪ Twelve (12) Latino TAY participated in this project. ▪ Eleven (11) short stories were featured in the Comic Book. ▪ Forty (40) community members participated in the virtual culmination/award ceremony. The community event was done virtually, which affected the number of community members who participated. ▪ Seventeen (17) pre and post surveys were submitted, and the feedback demonstrated the following: - The majority of the participants recommended the implementation of similar programs/projects to be continually offered for underserved communities. - The majority of the Latino TAY Youth who participated in the project reported that the workshop series allowed them to be open and speak up about their mental health struggles and that it would also help adults around them better understand their experience of mental illness and struggles without feeling ashamed. - All survey respondents reported having a better understanding of mental illness affecting Latino youth and mental health in general.

Project	Project Outcomes
The Latino Mental Health Stigma Reduction Community Theatre Project - "De Sabios & Locos Todos Tenemos Un Poco" This project was developed to increase awareness and education about mental health issues in the Latino community. Through this theatrical play, the community will gain an inside look into the world of those who suffer from a mental health condition. In addition, the Latino community will be educated on how to access mental health services and understand some of the cultural biases associated with suffering from a mental health condition. The play was conducted in the Spanish language.	▪ To date, sixteen (16) theatrical presentations were conducted in all Services Areas countywide. ▪ Three (3) presentations were delivered in-person at local churches and parks. However, the vendor transitioned the remaining 13 in-person theatrical plays into virtual platform. ▪ At the end of each theatrical presentation, there was a 30-minute live Q&A segment led by Dr. Ana Nogales, who is a well-known Spanish speaking Clinical Psychologist in the Los Angeles area. On the average, 20 community members engaged in the Q&A segment, which creates an opportunity to educate the community and decrease mental health stigma. ▪ To date, more than 280 community members have attended either the in-person or virtual theatrical play. ▪ This project is scheduled to be completed by February 28, 2021.

G. LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, QUESTIONING, INTERSEX, ASEXUAL, TWO-SPIRIT (LGBTQIA2-S) UsCC SUBCOMMITTEE

Project	Project Outcomes
LGBTQIA2-S Story Collective Project The purpose of this project was to engage, empower, and enlist LGBTQIA2-S community members into advocacy and activism around mental health all while building capacity of this marginalized population using their own passions and skills. The consultant recruited LGBTQIA2-S community members to participate in the Story Collective Training Program. The participants attended three sessions in total. The first session was attended by all participants and was focused on mental health stigma reduction. Participants were then allowed to choose two art-focused sessions: sculpting, photography, poetry, or painting. After completion of the Training Program, the consultant and participants held a virtual Community Art Exhibit to display their work during the Training Programanthology (Volume 1), and a Q&A session with all the "Cómics que Curan" workshop participants.	▪ In total, 26 LGBTQIA2-S community members participated in the Story Collective Training Program and all participants completed a pre and post-test that revealed: - 100% strongly agreed or agreed that they know what to do and who to talk to if they have a mental health concern or problem - 88% strongly agreed or agreed they felt comfortable seeking mental health assistance when needed regardless of their sexual orientation or gender identity ▪ The Story Collective Community Art Exhibit was held virtually via Zoom on October 6, 2020 and was attended by 60 individuals and was also shared via YouTube and Facebook. ▪ Of the 60 attendees, feedback was received from surveys completed by 33 attendees: - 94% of attendees rated the Art Exhibit as excellent or very good - 94% strongly agreed or agreed that these types of events contribute to stigma reduction
LGBTQIA2-S Indigenous Pride LA Project The purpose of the Indigenous Pride LA: Voices to Faces project is to spread cultural awareness and education of healing practices that positively affect mental health among the Two-Spirit community. The project aims to destigmatize mental health issues among Two-Spirit people by highlighting the diversity of the population and the need for culturally sensitive resources. The consultant recruited six Two-Spirit community members into a Community Collaborative to discuss mental health and identify the specific needs of the Two-Spirit community. Following the Community Collaborative, the consultant developed a curriculum to be utilized during five Health and Wellness Workshops.	▪ The consultant transitioned the Community Collaborative meetings to a virtual platform and conducted six meetings of the Community Collaborative via Zoom during June and July 2020. ▪ This project is still in process and outcomes will be shared once completed. ▪ The curriculum was finalized, and the Health and Wellness Workshops are scheduled for January 30, 2021 and February 6, 2021.

Project	Project Outcomes
LGBTQIA2-S Black LGBTQ+ Network Project The purpose of the Black LGBTQ+ Network Project is to identify the needs of Black LGBTQ+ individuals, while educating and empowering this community about the importance of mental health care to build awareness and connection. This project aims to destigmatize mental health issues among Black LGBTQ+ people by highlighting the diversity of the population and the need for culturally sensitive resources. The consultant recruited 12 community members into a Community Collaborative to develop a survey to be administered to Black LGBTQ+ people to identify the specific mental health concerns experienced by this underserved community and any gaps in service delivery, as well as learn how to best serve this community in a culturally sensitive way. Survey results will be compiled to produce a White Paper to address the mental health needs of the Black LGBTQ+ community and provide recommendations as to how LACDMH can engage this population as part of the MHSA stakeholder process, as well as incorporate services to target this population.	▪ The consultant transitioned the Community Collaborative meetings to a virtual platform and conducted eight meetings of the Community Collaborative as of December 31, 2020. ▪ In total, 150 surveys have been collected with the goal of 250 surveys. ▪ This project is still in process and outcomes will be shared once completed.
LGBTQIA2-S Mental Health Conference One of the recommendations of the LGBTQIA2-S UsCC subcommittee was to plan and coordinate the 2019 LGBTQIA2-S Mental Health Conference: "Reclaiming & Restoring – Telling Our Stories." The conference took place on June 12, 2019. The goals of the conference were to inform participants of mental health issues unique to the LGBTQIA2-S community; improve participants' ability to recognize when to refer an LGBTQIA2-S community member for mental health services; provide participants with useful information on available mental health resources for community members; and improve participants' ability to provide culturally appropriate mental health treatment to consumers. A survey was handed out to all participants at the start of the conference.	In total, 334 individuals attended the conference and of those, feedback received from 166 completed surveys indicate: - 94% agreed or strongly agreed that the conference made them more aware about the mental health issues unique to the LGBTQIA2-S community - 85% agreed or strongly agreed that the conference improved their ability to recognize when to refer an LGBTQIA2-S community member for mental health services - 90% agreed or strongly agreed that they received useful information on mental health resources for LGBTQIA2-S community members - 89% agreed or strongly agreed that the conference improved their ability to provide culturally appropriate mental health treatment to LGBTQIA2-S consumers

FYs 2021-24 ■ PLANNING, OUTREACH AND ENGAGEMENT Continued Work

For FYs 2021-24, LACDMH will continue outreach and engagement activities.

■ PLANNING, OUTREACH AND ENGAGEMENT	
Prior FY 2019-20	**Prior FY 2018-19**
$6.3 million Total Gross Expenditures	$9.2 million Total Gross Expenditures
FY 2021-22	**Three-Year Plan FYs 2021-24**
$6.8 million Estimated Gross Expenditures	$21.3 million Estimated Gross Expenditures

Currently, unique client count is only for MHSA programs with Mode 15 Direct Services (FSP, Outpatient Services, and Alternative Crisis Services).

All dollar amounts in this table are reported at gross costs.

PREVENTION AND EARLY INTERVENTION (PEI)

This section outlines the services and activities associated with the various components of PEI. Over the last year, LACDMH has moved toward a more robust and upstream approach to PEI services. While the focus of early intervention continues to be evidence-based practices (EBP), promising practices and community-defined evidence practices, LACDMH is in the process of implementing prevention strategies in settings such as schools and libraries where access platforms are being established. By identifying individuals with specific risk factors, particularly for trauma, and through the promotion of protective factors, such as social connectedness and engagement, a prevention service platform is being developed that:

- Raises awareness of the importance of mental and emotional well-being and health, the impact of trauma and the promotion of resilience strategies on systems and communities;
- Builds organizational and community capacity to promote well-being and resiliency and to recognize and respond to trauma and mental health needs; and
- Builds bridges to mental health care when it is requested.

The prevention strategies involve, at a minimum, a combination of training, resource infusion at the site of the access platform, partnership development and consultation to educators.

PEI includes the following services:

- Prevention
- Early Intervention
- Stigma and Discrimination
- Suicide Prevention

Table 26. FY 2019-20 Clients served through PEI

Clients Served	New Clients Served
47,602 clients received a direct mental health service: - 65% of the clients are children - 19% of the clients are TAY - 45% of the clients are Hispanic - 9% of the clients are African American - 8% of the clients are White - 2% of the clients are Asian - 74% have a primary language of English - 22% have a primary language of Spanish	26,381 new clients receiving PEI services countywide: with no previous MHSA service - 44% of the new clients are Hispanic - 8% of the new clients are African American - 8% of the new clients are White - 74% have a primary language of English - 22% have a primary language of Spanish

Table 27. FY 2019-20 Clients served through PEI by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	3,410	2,990
SA 2 – San Fernando Valley	7,596	5,840
SA 3 – San Gabriel Valley	8,494	6,414
SA 4 – Metro Los Angeles	6,329	5,388
SA 5 – West Los Angeles	1,828	1,685
SA 6 – South Los Angeles	6,049	5,163
SA 7 – East Los Angeles County	6,720	5,892
SA 8 – South Bay	7,923	6,846

A. EARLY INTERVENTION

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ TAY Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

Early Intervention is directed toward individuals and families for whom a short (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems and avoid the need for more extensive mental health treatment.

FY 2019-20 ■ EARLY INTERVENTION Data and Outcomes

Table 28. FY 2019-20 EBPs

Note: Some age groups show the specific age(s) of clients served

Early Intervention EBP	Description
Aggression Replacement Training (ART) Children (ages 5-12) Skill Streaming Only Children (ages 12-15) TAY (ages 16-17) Unique Clients Served: 37 Gender: 62% Male, 38% Female Ethnicity: 38% Hispanic, 14% African American, 43% Unreported, 5% Multiple Races	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.
Alternatives for Families Cognitive Behavioral Therapy (AF-CBT) Children (ages 4-15) TAY (ages 16-17) Unique Clients Served: 231 Gender: 57% Male, 43% Female Ethnicity: 64% Hispanic, 9% African American, 1% Asian, 1% White, 23% Unreported, 1% Native Hawaiian/Pacific Islander, 1% Multiple Races	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.
Brief Strategic Family Therapy (BFST) Children (ages 10-15) TAY (ages 16-18) Unique Clients Served: 5 Gender: 60% Male, 40% Female Ethnicity: 40% Hispanic, 40% Unreported, 20% White	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.
Center for the Assessment and Prevention of Prodromal States (CAPPS) TAY Unique Clients Served: 38 Gender: 68% Male, 32% Female Ethnicity: 55% Hispanic, 21% Unreported, 11% White 5% Asian, 3% Multiple Races 5%Native Hawaiian/Pacific Islander	The focus of CAPPS is to conduct outreach and engagement specifically to those youths 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.

Early Intervention EBP	Description
Child-Parent Psychotherapy (CPP) Young Children (ages 0-6) Unique Clients Served: 1,579 Gender: 53% Male, 47% Female Ethnicity: 45% Hispanic, 12% African American, 1% Asian, 9% White, 28% Unreported 5% Multiple Races	CPP is a psychotherapy model that integrates psycho-dynamic, 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.
Crisis Oriented Recovery Services (CORS) Children TAY Adults Older Adults Unique Clients Served: 134 Gender: 37% Male, 63% Female Ethnicity: 43% Hispanic, 4% African American, 3% Asian, 8% White, 33% Unreported, 9% Multiple Races	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.
Depression Treatment Quality Improvement (DTQI) Children TAY Adults Older Adults Unique Clients Served: 120 Gender: 33% Male, 66% Female, 1% Female to Male Ethnicity: 32% Hispanic, 2% African American, 62% Unreported, 2% White, 2% Multiple Races	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.
Dialectical Behavior Therapy (DBT) Children (ages 12-15) TAY (ages 16-20) Unique Clients Served: 153 Gender: 26% Male, 73% Female, 1% Female to Male Ethnicity: 30% Hispanic, 11% African American, 3% Asian, 32% White, 14% Unreported, 2% Native Hawaiian/Pacific Islander, 8% Multiple Races	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.
Families Over Coming Under Stress (FOCUS) Children TAY Adults Unique Clients Served: 127 Gender: 53% Male, 47% Female Ethnicity: 27% Hispanic, 1% African American, 1% Asian, 7% White, 60% Unreported, 1% Native Hawaiian/Pacific Islander, 3% Multiple Races	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 by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.

Early Intervention EBP	Description
Functional Family Therapy (FFT) Children (ages 11-15) TAY (ages 16-18) Unique Clients Served: 58 Gender: 60% Male, 40% Female Ethnicity: 60% Hispanic, 9% African American, 7% White, 12% Multiple Races, 2% Native Hawaiian/Pacific Islander, 10% Unreported	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.
Group Cognitive Behavioral Therapy for Major Depression (Group CBT) TAY (ages 18-25) Adults Older Adults Unique Clients Served: 23 Gender: 22% Male, 78% Female Ethnicity: 44% Hispanic, 13% African American, 4% Asian, 18% White, 17% Unreported, 4% Native Hawaiian/Pacific Islander	Group CBT focuses on changing an individual's thoughts (cognitive patterns) 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.
Incredible Years (IY) Young Children (ages 2-5) Children (ages 6-12) Unique Clients Served: 153 Gender: 73% Male, 27% Female Ethnicity: 74% Hispanic, 2% African American, 1% Asian, 4% White, 16% Unreported, 3% Multiple Races	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.
Individual Cognitive Behavioral Therapy (Ind. CBT) TAY (ages 18-25) Adults Older Adults Directly Operated Clinics only Unique Clients Served: 9,906 Gender: 31% Male, 69% Female Ethnicity: 48% Hispanic, 7% African American, 2% Asian, 16% White, 21% Unreported, 1% Native Hawaiian/Pacific Islander, 5% Multiple Races	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 psycho-education, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.
Interpersonal Psychotherapy for Depression (IPT) Children (ages 9-15) TAY Adults Older Adults Unique Clients Served: 1,703 Gender: 31% Male, 69% Female Ethnicity: 40% Hispanic, 5% African American, 3% Asian, 5% White, 43% Unreported, 1% Native Hawaiian/Pacific Islander, 3% Multiple Races	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.

Early Intervention EBP	Description
Loving Intervention Family Enrichment Program (LIFE) Children (ages 0-8) Unique Clients Served: 21 Gender: 62% Male, 38% Female Ethnicity: 62% Hispanic, 9% African American, 29% Unreported	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.
Managing and Adapting Practice (MAP) Young Children Children TAY (ages 16-21) Unique Clients Served: 16,099 Gender: 52% Male, 48% Female Ethnicity: 47% Hispanic, 7% African American, 1% Asian, 6% White, 36% Unreported, 3% Multiple Races	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 the County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.
Mental Health Integration Program (MHIP) **Formerly known as IMPACT** Adults Unique Clients Served: 629 Gender: 28% Male, 72% Female Ethnicity: 66% Hispanic, 9% African American, 2% Asian, 10% White, 7% Unreported, 2% Native Hawaiian/Pacific Islander, 4% Multiple Races	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.
Multidimensional Family Therapy (MDFT) Children (ages 12-15) TAY (ages 16-18) Unique Clients Served: 4 Gender: 100% Male Ethnicity: 100% Unreported	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.
Multisystemic Therapy (MST) Children (ages 12-15) TAY (ages 16-17) Unique Clients Served: 1,661 Gender: 48% Male, 52% Female Ethnicity: 62% Hispanic, 12% African American, 1% Asian, 9% White, 7% Unreported, 1% Native Hawaiian/Pacific Islander, 8% Multiple Races	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).
Parent-Child Interaction Therapy (PCIT) Young Children (2-7) Unique Clients Served: 1,377 Gender: 65% Male, 35% Female Ethnicity: 45% Hispanic, 9% African American, 32% Unreported, 8% White, 6% Multiple Races	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.

Early Intervention EBP	Description
Problem Solving Therapy (PST) Older Adults Unique Clients Served: 24 Gender: 25% Male, 75% Female Ethnicity: 63% Hispanic, 4% African American, 21% White, 4% Multiple Races, 8% Unreported	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.
Program to Encourage Active Rewarding Lives for Seniors (PEARLS) Older Adults Unique Clients Served: 8 Gender: 100% Female Ethnicity: 13% Hispanic, 37% Asian, 12% White, 25% African American, 13% Unreported	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.
Prolonged Exposure - Post Traumatic Stress Disorder (PE-PTSD) TAY (ages 18-25) Adults Older Adults Directly Operated Clinics Only Unique Clients Served: 23 Gender: 22% Male, 78% Female Ethnicity: 48% Hispanic, 13% African American, 13% Unreported, 13% White, 9% Native Hawaiian/Pacific Islander, 4% Multiple Races	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.
Reflective Parenting Program (RPP) Young Children (ages 2-5) Children (ages 6-12) Unique Clients Served: 9 Gender: 44% Male, 56% Female Ethnicity: 45% Hispanic, 22% African American, 11% White, 22% Multiple Races	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.
Seeking Safety (SS) Children (13-15) TAY Adults Older Adults Unique Clients Served: 2,108 Gender: 36% Male, 64% Female Ethnicity: 47% Hispanic, 6% African American, 3% Asian, 11% White, 29% Unreported, 1% Native Hawaiian/Pacific Islander 3% Multiple Races	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.

Early Intervention EBP	Description
Strengthening Families (SF) Children (ages 3-15) TAY (ages 16-18) Unique Clients Served: 18 Gender: 56% Male, 44% Female Ethnicity: 39% Hispanic, 11% White 50% Unreported	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.
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle Children (ages 3-8) Unique Clients Served: 4,517 Gender: 41% Male, 59% Female Ethnicity: 50% Hispanic, 8% African American, 6% White, 30% Unreported, 1% Native Hawaiian/Pacific Islander, 5% Multiple Races	This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational well-being. The EBP includes traditional aspects of healing with American Indians and Alaskan Natives from their world view.
Triple P Positive Parenting Program (Triple P) Young Children (ages 0-5) Children (ages 6-15) TAY (age 16) Unique Clients Served: 475 Gender: 67% Male, 33% Female Ethnicity: 49% Hispanic, 4% African American, 3% Asian, 6% White, 5% Multiple Races, 33% Unreported	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 LACDMH directly operated and contract agencies.
UCLA Ties Transition Model (UCLA TTM) Young Children (ages 0-5) Children (ages 6-12) Unique Clients Served: 23 Gender: 57% Male, 43% Female Ethnicity: 17% Hispanic, 17% African American, 9% Asian, 35% White	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).

Table 29. EBP Outcomes since 2009 through June 2020

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
ART	3,432	42%	- 24% Improvement in mental health functioning
AF-CBT	1,618	52%	- 50% Improvement in mental health functioning - 53% Reduction in symptoms related to posttraumatic stress
BFST	203	63%	- 48% Improvement in mental health functioning - 50% Reduction in behavioral problems
Caring for our Families	733	67%	- 23% Improvement in mental health functioning - 30 % Reduction in disruptive behaviors
CAPPS	202	43%	- 30% Improvement in mental health functioning - 60% Reduction in prodromal symptoms
CPP	6,695	47%	- 53% Improvement in mental health functioning - 19% Reduction in child's mental health functioning following a traumatic event

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
CBITS	130	71%	- 30% Improvement in mental health functioning - 28% Reduction in symptoms related to posttraumatic stress
CORS	4,125	60%	- 27 % Improvement in mental health functioning
DBT	219	66%	- 28 % Improvement in mental health functioning
DTQI	1,210	65%	- 48% Improvement in mental health functioning - 55% Reduction in symptoms related to depression
FOCUS	640	70%	- 40% Improvement in mental health functioning - 50% Improvement in family functioning
FFT	1,713	66%	- 29% Improvement in mental health functioning
Group CBT	1,139	42%	- 20% Improvement in mental health functioning - 42% Reduction in symptoms related to depression
IY	2,843	64%	- 27% Improvement in mental health functioning - 35% Reduction in disruptive behaviors
Ind. CBT	Anxiety 3,099 Depression 6,807 Trauma 936	Anxiety 45% Depression 44% Trauma 47%	▪ Anxiety - 37% Improvement in mental health functioning - 63% Reduction in symptoms related to anxiety ▪ Depression - 35% Improvement in mental health functioning - 50% Reduction in symptoms related to depression ▪ Trauma - 44% Improvement in mental health functioning - 61% Reduction in symptoms related to posttraumatic stress
IPT	7,576	50%	- 31% Improvement in mental health functioning - 50% Reduction in symptoms related to depression
LIFE	431	65%	- 36% Improvement in mental health functioning - 50% Reduction in disruptive behaviors
MAP	63,003	54%	- 46% Improvement in mental health functioning - 43% Reduction in disruptive behaviors - 55% Reduction in symptoms related to depression - 44% Reduction in symptoms related to anxiety - 50% Reducing symptoms related to posttraumatic stress
MHIP	Anxiety 2,280 Depression 5,981 Trauma 297	Anxiety 38% Depression 34% Trauma 29%	▪ Anxiety - 58% Reduction in symptoms related to anxiety ▪ Depression - 60% Reduction in symptoms related to depression ▪ Trauma - 24% Reduction in symptoms associated with exposure to trauma
MDFT	77	89%	- 25% Improvement in mental health functioning
MST	126	73%	- 46% Improvement in mental health functioning
PCIT	4,364	40%	- 58% Improvement in mental health functioning - 53% Reduction in disruptive behaviors
PST	395	62%	- 28% Improvement in mental health functioning - 45% Reduction in symptoms related to depression
PEARLS	165	48%	- 26% Improvement in mental health functioning - 45% Reduction in symptoms related to depression
PATHS	747	33%	- 37% Improvement in mental health functioning - 33% Reduction in disruptive behaviors
RPP	247	71%	- 9% Improvement in mental health functioning - 15% Reduction in disruptive behaviors
SS	20,546	40%	- 36% Improvement in mental health functioning - 31% Reducing symptoms related to posttraumatic stress
TF-CBT	24,532	54%	- 48% Improvement in mental health functioning - 51% Reducing symptoms related to posttraumatic stress
Triple P	6,280	60%	- 42% Improvement in mental health functioning - 47% Reduction in disruptive behaviors

EARLY INTERVENTION			
Prior FY 2019-20		**Prior FY 2018-19**	
47,602 Total Number Served[1]	$192.1 million Total Gross Expenditures	50,865 Total Number Served	$188.4 million Total Gross Expenditures
FY 2021-22		**Three-Year Plan FYs 2021-24**	
49,233 Total Number Served[2]	$194.5 million Estimated Gross Expenditures	$602.4 million Estimated Gross Expenditures	

Notes

1 Prior Year Total Number Served: Number of unduplicated clients receiving Mode 15 Direct Services, not inclusive of community outreach services or client support services

2 FY 2021-22 Total Number Served: Reflects average of two prior years

B. PREVENTION

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ TAY Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

The following prevention activities and services are geared toward addressing, through awareness, education, training, outreach and/or navigation, the risk factors associated with the onset of mental illness or emotional disturbances, including a focus on enhancing protective factors such as social connectedness and support.

The COVID-19 pandemic impacted service delivery of prevention services. Some programs were able to adapt by providing services virtually while others were not able to continue providing services under social distancing and other safety guidelines. As a result, this report reflects both decreased service delivery and outcomes data collection.

FY 2019-20 ■ PREVENTION Data and Outcomes

B1. Community Partnerships

LACDMH partners with several county and city agencies, such as the Los Angeles County Departments of Parks and Recreation, Children and Family Services (DCFS), DPH, Sheriff's Department, and Public Library; and the Los Angeles Unified School District (LAUSD) to deliver mental health prevention and promotion programming to populations served by those agencies. Programs with the Public Library and Parks and Recreation are the largest with over 400,000 public contacts in FY 2019-20. Other partner programs served about 50,000 people combined in FY 2019-20.

- *Children's Health Outreach, Enrollment, Utilization, and Retention (CHOEUR)*
  DPH's Children's Health Outreach Initiatives (CHOI) program administers the CHOEUR services to uninsured children, families, and individuals in the County who may be eligible for Medi-Cal, Covered California, My Health LA, and other low-cost health coverage programs. CHOEUR contractors utilize various techniques for outreach and enrollment for health coverage, provide individual assessments of health coverage eligibility, utilize various techniques to reduce barriers to health coverage enrollment and utilization of benefits, and implement strategies to support health coverage retention. CHOEUR services contractors incorporate an additional screening for mental health, while providing comprehensive and coordinated health coverage outreach, enrollment, utilization, and retention services to children and families. CHOUER staff outreached to 41,667 people in FY 2019-20. Of those, they helped 14,342 with applications for benefits, and verified enrollment and provided troubleshooting to over 25,000 people.

Table 30. CHOEUR client demographics (n = 20,838)

▪ Primary Language			▪ Ethnicity	
Arabic	18		Hispanic or Latino as follows:	14,522
Armenian	12		Caribbean	22
Cambodian	67		Central American	2,946
English	6,694		Mexican/Mexican American/Chicano	8,711

Farsi	9		Puerto Rican	26
Korean	5		South American	220
Other Chinese	469		Other	2,590
Russian	25		Non-Hispanic or Non-Latino as follows:	6,316
Spanish	10,518		African	312
Tagalog	77		Asian Indian/South Asian	260
Vietnamese	253		Cambodian	105
Other	996		Chinese	484
Declined to answer	1,695		Eastern European	34
▪ Age			European	44
0-15	3,822		Filipino	392
16-25	3,669		Japanese	81
26-59	10,776		Korean	30
Older than 60	2,012		Middle Eastern	86
Declined to answer	559		Vietnamese	288
▪ Gender Assigned at Birth			Other	1,178
Male	7,499		More than one ethnicity	150
Female	11,235		Declined to answer	2,872
Declined to answer	2,104		▪ Race	
▪ Current Gender Identity			American Indian	17
Male	5,825		Asian	2,147
Female	9,550		Black or African-American	396
Transgender	19		Native Hawaiian or Other Pacific Islander	29
Genderqueer	19		White	7,491
Questioning or unsure	16		More than one race	133
Another gender identity	14		Declined to answer	10,625
Declined to answer	5,488		▪ Sexual Orientation	
▪ Disability			Gay or Lesbian	74
No	14,779		Heterosexual or Straight	14,044
Yes	11,105		Queer	6
Difficulty seeing	53		Questioning or Unsure	2
Difficulty hearing	34		Declined to Answer	6,712
Mental domain	95			
Physical/mobility domain	147		▪ Veteran Status	
Chronic health condition	569		Yes	114
Other	379		No	14,206
Declined to answer	5,046		Declined to answer	6,518

- *Home Visitation Program (HVP)*

  HVP includes three home visiting programs: Healthy Families America (HFA), Parents as Teachers (PAT), and Nurse Family Partnership (NFP) that target high-risk, low-income, pregnant women, or parents/caregivers with children between the ages of 0 and 5 years old. Screenings for mental health and protective factors were integrated into existing services in an effort to decrease risk factors and provide support and services. The skills of HVP home visitors were also enhanced through trainings so that they can recognize mental health risk factors and refer for mental health treatment when deemed necessary.

The HVP uses the following as indicators to measure outcomes: social connections, parental/caregiver knowledge of child development, self-sufficiency, risky behaviors, birth outcomes, child development inclusive of kindergarten readiness, and parental and familial resiliency. In addition, to determine a correlation between services and improvement in screening scores, NFP created a cohort of mothers whose progress was tracked during FY 2019-20. The scores for women in this group decreased during the 12 months in services, showing a decrease in anxiety and depressive symptoms.

Table 31. HVP client demographics (n = 2,015)

▪ Primary Language			▪ Ethnicity	
Armenian	1		Hispanic or Latino as follows:	1,471
Cambodian	11		Caribbean	8
Cantonese	11		Central American	271
English	1,269		Mexican/Mexican American/Chicano	977
Spanish	676		Puerto Rican	11
Tagalog	2		South American	20
Vietnamese	1		Other	179
Declined to answer	44		Non-Hispanic or Non-Latino as follows:	622
▪ Age			African	67
0-15	17		Asian Indian/South Asian	14
16-25	979		Cambodian	11
26-59	1,008		Chinese	12
Declined to answer	11		Eastern European	7
▪ Gender Assigned at Birth			European	15
Male	24		Filipino	23
Female	1,343		Japanese	2
Declined to answer	648		Korean	5
▪ Current Gender Identity			Middle Eastern	14
Male	24		Vietnamese	2
Female	1,343		Other	178
Transgender	10		More than one ethnicity	44
Genderqueer	3		Declined to answer	233
Questioning or unsure	1		▪ Race	
Another gender identity	21		American Indian	12
Declined to answer	613		Asian	81
▪ Disability			Black or African-American	260
No	1,507		Native Hawaiian or Other Pacific Islander	5
Yes	449		White	766
Difficulty seeing	2		More than one race	54
Difficulty hearing	4		Other	834
Mental domain	83		Declined to answer	3
Physical/mobility domain	3		▪ Veteran Status	
Chronic health condition	202		Yes	31
Other	247		No	1919
Declined to answer	59		Declined to answer	65

- *Integrated Correctional Health Training Services (ICHS)*
  The trainings provided through this project were designed to educate jail mental health staff to better identify, respond, and intervene with men and women identified as having mental health needs while incarcerated in County jails. The correctional health support staff and medical providers perform needs assessments, and conduct on-going workshops on Compassionate Care in Mental Health Inmates/Patients, Trauma Informed Care, Suicide Prevention, Clinical Work in Forensics, Mental Health for Nurses in Correction Health, Suicide Risk Assessment for Correctional Health Nurses, DSM Diagnosis, and other trainings. LACDMH administered its training evaluation form to the participants at the end of each training. Participants were asked about their satisfaction with meeting the learning objectives. The majority of participants rated the trainings as "Excellent" or "Very Good". Demographic data was not obtained for the 689 participants in these trainings, which were conducted in English.

- *Library Child, Family and Community Prevention Programs*
  This program is intended to increase protective factors, thereby mitigating the impact of risk factors associated with serious psychiatric illness and negative outcomes. It is also intended to serve four primary target populations residing in underserved communities experiencing adversity: 1) young children and their parents/caregivers, 2) school-aged children, 3) TAY, and 4) older adults.

  Library staff were trained to deliver several mental health promotion programs encompassing the deliverables below.

Table 32. Library programs deliverables

Library Program	Deliverable
School Readiness Smarty Pants Storytime	37,000 children and adult caregiver contacts
Triple P	8,358 consultations
Afterschool Programs	45,169 youth attended
Summer Discovery Program	18,853 child and parent attended
STEAM/MākMō	nearly 30,000 attended

Table 33. Library client demographics (n = 3,293)

▪ Primary Language	
Arabic	20
Armenian	25
Cambodian	3
Chinese (Cantonese & Mandarin)	256
English	2,873
Farsi	15
Korean	53
Russian	11
Spanish	997
Tagalog	13
Vietnamese	13
Other	86
Declined to answer	13
▪ Age	
0-15	400

16-25	243
26-59	2,729
60+	350
Declined to answer	31

- *Los Angeles Unified School District (LAUSD)*
  LAUSD conducts an assortment of mental health promotion interventions with students and their parents, including More Than Sad, Erika's Lighthouse, FOCUS Resilience Curriculum, FOCUS on Parenting, and Triple P. In FY 2019-20, these programs served more than over 14,000 students and parents.

Figure 23. Self-Efficacy Outcomes

Percentage reporting statement is Very/Pretty Much True
(n = 14,069)

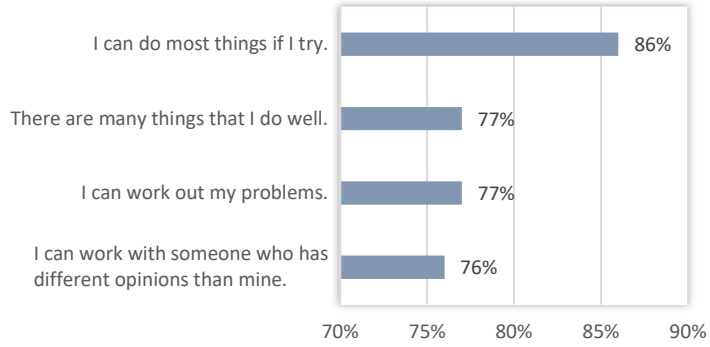


Figure 24. Student Connectedness Outcomes

Percentage of students in grades 4-8 who report statement is true Most/All Of The Time when asked the following questions: "Do the teachers and other grown-ups at school…"
(n = 6,535)

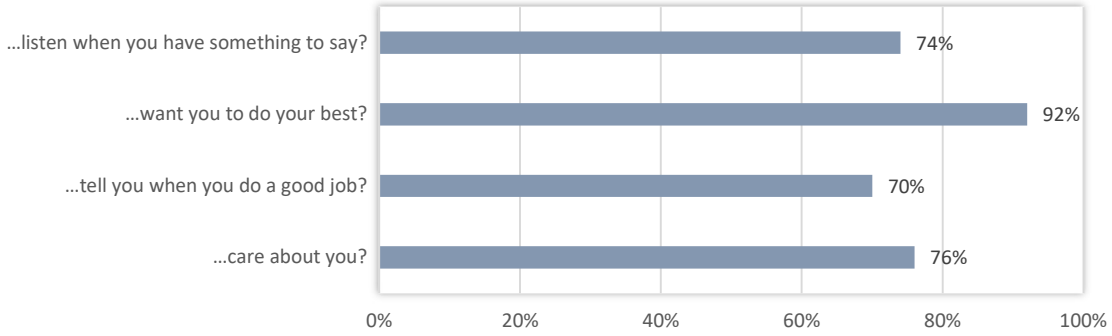


Table 34. LAUSD client demographics (n = 11,281)

▪ Primary Language		▪ Ethnicity	
Arabic	20	Hispanic or Latino	9,787
Armenian	55	Non-Hispanic or Non-Latino follows:	
Cambodian	5	African	604
Cantonese	40	Asian Indian/South Asian	157
English	3,042	Cambodian	11
Farsi	1	Chinese	20
Korean	9	European	358
Mandarin	6	Filipino	205
Russian	16	Japanese	2
Spanish	7,762	Korean	10
Tagalog	172	Vietnamese	7
Vietnamese	12	Other Non-Hispanic or Non-Latino	41
Other	141	More than one ethnicity	69
▪ Gender		Decline to answer	10
Male	5,712	▪ Race	
Female	5,569	American Indian or Alaska Native	35
▪ Disability		Asian	462
Yes	1,249	Black or African-American	682
Chronic health condition	1	Native Hawaiian or Other Pacific Islander	38
Mental domain	122	White	371
Physical/mobility domain	15	Other*	9,448
Difficulty seeing	1	Declined to answer	245
Difficulty hearing	36	▪ Age	
Other	1,074	0-15	8,676
Declined to Answer	10,032	16-25	2,605

*Ethnicity and race were collected as one category by LAUSD. Therefore, some students identified as Hispanic or Latino were coded as "Other" race. Hispanic and Latino and Filipino were the only ethnicities coded separately from race.

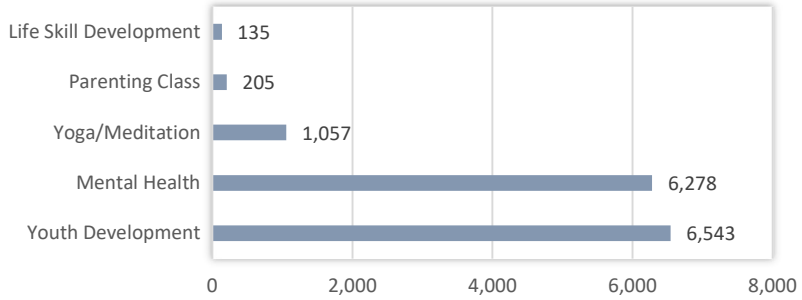
- *Parks after Dark (PAD) Program*

PAD is a program featuring extended park hours and activities for youth and families to increase physical activity, reduce violence, and enhance health and social well-being among community residents of all ages. By providing PEI services through mental health education, outreach, and early identification (prior to diagnosis), LACDMH can mitigate costly negative long-term outcomes for mental health consumers and their families. PAD is intended to reduce risk factors and increase protective factors which is in support of the MHSA PEI regulations.

The Department of Parks and Recreation possess great potential to address service gaps by serving as community hubs where mental health and other organizations can provide education and outreach to vulnerable populations, and participants of all ages can easily access a diverse array of important services and resources in a fun and welcoming setting that is less stigmatized than a government building or mental health clinic. With the goal to increase access to free recreational programming and health and

social services, total attendance was reported to be more than 270,000 in FY 2019-20. Of those who completed PAD surveys, 69% were Hispanic/Latino. Those who were age 15 years or younger comprised about one quarter of the participants surveyed, while those ages 16 through 25 comprised about 13% of the participants surveyed. About two-thirds of the participants surveyed were female.

Figure 25. Number of PAD participants by type of mental health-related activity



Note that the majority of participants attended activities involving Entertainment, Sports, Exercise, and Food.

- *Permanency Partners Program (P3), Upfront Family Finding (UFF)*

  The P3 program can improve outcomes for children and youth by providing specific focus on engagement of family and Non-Related Extended Family Members to increase placement stability and provide opportunities for social connectedness. Meanwhile, UFF was created to reduce risk of negative outcomes for children and youth due to lack of family support and meaningful social connections as well as resources. The goal of UFF is provide family finding efforts to children and youth as close to the time of detention as possible, for a period of 90 days. Data is collected regarding the type of placement for each child or youth served. Of the 667 children served in FY 2019-20, 178 maintained placement in the home of a relative and 319 maintained placement in a foster family home. These interventions reduce rates of involvement with law enforcement, use of public assistance, reduction in multiple placements, and family isolation.

Table 35. P3/UFF client demographics (n = 667)

▪ Primary Language			▪ Age	
Cambodian	2		0-15	609
English	478		16-25	58
Spanish	134		▪ Ethnicity	
Decline to Answer	53		Hispanic or Latino as follows:	109
▪ Gender assigned at birth:			Central American	12
Male	230		Mexican/Mexican-American/Chicano	97
Female	356		Non-Hispanic or Non-Latino follows:	66
Declined to Answer	81		African	594
▪ Current gender identity			Cambodian	70
Male	197		European	1
Female	313		Other Non-Hispanic or Non-Latino	20
Transgender	2		Decline to answer	492
Another gender identity	1		▪ Race	
Decline to answer	154		American Indian or Alaska Native	6

▪ Disability			Asian	7
No	536		Black or African-American	125
Yes	46		Native Hawaiian or Other Pacific Islander	3
Chronic health condition	23		White	155
Mental domain	17		Other	262
Physical/mobility domain	3		More than one race	30
Difficulty seeing	1		Declined to answer	79
Difficulty hearing	2			
Declined to Answer	85			

- *Prevent Homelessness Promote Health (PH [2])*

  In collaboration with DHS Housing for Health, this program provides services to residents of Interim Housing Licensed Residential Facilities, Permanent Supportive Housing residents and other residents at risk of returning to homelessness. Services consist of time-limited EBPs and appropriate treatment modalities and interventions provided by an integrated team of LACDMH and DHS staff. This program began in 2020 and will report on outcomes in the next report.

- *Prevention and Aftercare (P&A)*

  This program is for children residing in Los Angeles County who are at risk of entering the DCFS system, involved with DCFS, or have exited the child welfare system. All children and families receive services specifically tailored to meet their needs and include one or more of the following:

  - community activities, events, and workshops that outreach and engage the family, increase financial literacy, raise awareness of concrete supports that meet basic needs, and/or increase access and utilization of resources, supports and services;
  - case navigation: case management services that assess participant needs, provide coaching and empowerment, provide direct linkage and referrals, help participants set goals, allow for skill building, and/or provide economic development.

  The P&A agencies administered the Protective Factors Survey (PFS) at enrollment and termination. During FY 2019-20, P&A agencies surveyed 3,157 participants. Not all cases were assessed at termination due to attrition. The table below reflects the average scores for the PFS at enrollment and termination, as well as the percent change. Families demonstrated an increase in protective factors including parental resilience, social connections, knowledge of parenting and child development, social and emotional competence of children, concrete support in times of need, family economic opportunity, and social/emotional competence of adults. Note that the average for every protective factor increased from baseline to termination by at least 8%.

Table 36. P&A Protective Factors at enrollment and termination

Protective Factor Assessed	Average Initial Score	Average Final Score	Pre-Post Percent Change
Parental Resilience	5.33	5.74	8%
Social Connections	5.32	5.81	9%
Concrete Support in Times of Need	3.61	4.43	23%
Knowledge of Parenting and Child Development	4.10	4.33	6%
Social and Emotional Competence of Children	6.24	6.37	2%
Family Economic Opportunity/Development	4.99	5.35	7%
Social and Emotional Competence of Adults	5.90	6.19	5%
Overall PFS Average	5.07	5.46	8%

During FY 2019-20, P&A agencies held a total of 436 one-time events, with an estimated total attendance of over 12,000. These events ranged from one-time workshops to larger community events. A total of 4,492 one-time event surveys were collected. Of those surveyed, about 90% reported being able to connect with others, 80% reported learning something new about themselves or their family, 88% reported learning about resources that would be useful to themselves or their family, and 86% reported learning tips, tools, resources to strengthen their own or their family's well-being.

Table 37. P&A client demographics (n = 3,157)

▪ Primary Language		▪ Age	
Arabic	6	0-15	4
Armenian	1	16-25	320
Cambodian	2	26-59	2,452
Chinese (including Cantonese and Mandarin)	19	60 or older	91
English	1,476	Declined to answer	290
Korean	107	▪ Ethnicity	
Spanish	1,479	Hispanic or Latino as follows:	
Tagalog	7	Caribbean	19
Vietnamese	1	Central American	393
Other	20	Mexican/Mexican-American/Chicano	1,516
Declined to answer	39	Puerto Rican	16
▪ Gender Assigned at Birth		South American	73
Male	607	Non-Hispanic or Non-Latino as follows:	
Female	2,504	African	205
Declined to answer	46	Asian Indian/South Asian	11
▪ Current Gender Identity		Cambodian	2
Male	623	Chinese	19
Female	2,463	Eastern European	8
Trans	1	European	33
Genderqueer	3	Filipino	19
Questioning or unsure of gender identity	1	Japanese	1
Another gender identity	2	Korean	110
Declined to answer	64	Middle Eastern	6

▪ Disability			Vietnamese	3
No	2,020		Other	137
Yes	890		More than one ethnicity	46
Difficulty seeing	76		Declined to answer	279
Difficulty hearing	38		▪ Race	
Mental domain	236		American Indian	118
Physical/mobility domain	123		Asian	168
Chronic health condition	343		Black or African-American	496
Other	77		Native Hawaiian or Other Pacific Islander	8
Declined to answer	247		White	837
▪ Veteran Status			Other	1,196
Yes	43		More than one race	43
No	2,995		Declined to answer	291
Declined to answer	119			

- *School-Based Healing-Informed Arts Education*

  The Los Angeles County Office of Child Protection's Education Coordinating Council (ECC), Los Angeles County Department of Arts and Culture (Arts and Culture) and the Arts for Incarcerated Youth Network (AIYN) have partnered with LACDMH to foster communities of wellness within selected public schools centering arts as a healing and community-building strategy. This model is designed to support school personnel to incorporate healing-informed arts strategies in classroom and campus activities. This project will establish school cultures grounded in the practices of healing-informed care by providing arts-based student instruction, professional development and community building activities. This work constitutes a systems change effort in which healing-informed school campuses serve as models within their school districts.

  Through virtual pivots between March and June 2020, we successfully reached 301 young people and youth-serving adults, including 155 educators and caregivers and 146 youth in congregate care sites. a formative evaluation, and our initial data suggests that the creative well-being activities had numerous positive effects on educators' ability to take a healing-informed, arts-based approach to student mental health and well-being and to incorporate this approach into existing curriculums and campus activities.

- *Substance Use Disorder: Trauma-Informed Parent Support (SUD-TIPS)*

  This program provides education, screening, and linkage to substance use treatment, mental health services, and other social support services to adult parents identified by DCFS as substance using. During FY 2019-20, 940 people were screened. During the initial screening, questions were asked to gauge concrete supports, parental resilience, and social connection. Of those screened, over two-thirds reported that they have others who will listen when they need to talk about problems or if there is a crisis. Over one quarter reported that they would not know where to go for help if they had trouble making ends meet, or that they would not know where to go for help if they needed help finding a job. LACDMH and the DPH Health are collaboratively working to determine tools to evaluate the program's effectiveness and intended outcomes.

Table 38. SUD-TIPS client demographics (n = 940)

▪ Primary Language			▪ Ethnicity	
Armenian	3		Hispanic or Latino as follows:	
English	760		Central American	47
Russian	3		Mexican/Mexican-American/Chicano	482
Spanish	156		Puerto Rican	4
Other	2		South American	16
Declined to answer	16		Non-Hispanic or Non-Latino as follows:	
▪ Age			African	42
15-25	191		Asian Indian/South Asian	4
26-35	435		Eastern European	9
36 or older	314		European	28
Declined to Answer	16		Filipino	3
▪ Gender Assigned at Birth			Middle Eastern	6
Male	340		Other	216
Female	578		More than one ethnicity	35
Declined to answer	22		Declined to answer	48
▪ Current Gender Identity			▪ Race	
Male	577		American Indian or Alaska Native	5
Female	342		Asian	5
Genderqueer	1		Black or African-American	101
Another gender identity	2		Native Hawaiian or other Pacific Islander	9
Declined to answer	18		White	394
▪ Veteran Status			Other	331
No	940		More than one race	52
▪ Disability			Declined to answer	43
No	940			

- *Technology Enhanced Arts Learning – Social Emotional Learning (TEAL-SEL)* Developed and implemented in partnership with the LA County Office of Education (LACOE) Center for Distance and Online Learning (CDOL) and LACDMH, TEAL-SEL is a professional development program that offers current and pre-service TK-6 educators a series of online resources and in-person trainings focused on integrating the arts (i.e. dance, media arts, music, theatre, visual arts), social emotional learning, and trauma-informed practices into teaching in other core subjects (e.g. language arts, math, science, social studies).

  At each TEAL professional development, an exit survey evaluated three primary protective factor outcomes and the results demonstrate:
  - Average of 96% reported an increase in their capacity to foster social connectedness among students
  - Average of 96% reported an increase in their knowledge of child development
  - Average of 97% reported an increase in social and emotional competency

- *Veterans Peer Access Network (VPAN)*
  The mission of VPAN is to provide a high quality, coordinated network of care that is easily accessible for Los Angeles County service members, veterans and their families through an enduring, world-class VPAN that will deploy trained Veteran and Military Family Peers throughout Los Angeles County to connect veterans and their families to critical resources including housing, mental health care, substance abuse treatment, job placement and legal services. VPAN started in early 2020 and engaged 340 veteran clients from March to June 2020. This program is expected to engage many more veterans in 2021.

- *Veterans Service Navigators*
  This Veterans Mental Health Services program will utilize military veterans to engage veterans and their families to identify currently available services, including supports and services tailored to the particular cultural, ethnic, age and gender identity of those seeking assistance. Staff follow with the veterans and their families to ensure that they have successfully linked and received the help they need. The Navigators engage in joint planning efforts with community partners, including veteran's groups, veteran's administration, community-based organizations, other County departments, intradepartmental staff, schools, health service programs, faith based organizations, self-help and advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services available to veterans within and outside the mental health system. Staff assists the veterans and their families by promoting awareness of mental health issues and work towards de-stigmatizing seeking help.

  In FY 2019-20, Military and Veterans Affairs Navigators participated in 43 community outreach events providing benefits information to include healthcare and mental health referrals to Department of Veterans Affairs (VA) Clinics, Veterans Centers, West Los Angeles, and Long Beach VA. All Veteran Service Navigators (including but not limited to LACDMH sponsored) assisted 14,476 veterans with making nearly 31,500 claims, including almost 300 for mental health treatment. There were 394 indigent referrals, 1,025 female veterans, 292 homeless veterans, and 48 incarcerated veterans served by the program.

- *Youth Diversion and Development (YDD)*

The YDD Program is comprised of three components:

- The Annual YDD Summit is a conference designed to provide law enforcement, community-based agencies, other youth-serving agencies, and key stakeholders with training and capacity building. The YDD Summit did not occur this year due to COVID-19.
- Youth Development Services (YDS) is intensive case management provided to youth identified and referred through law enforcement through contracted community-based partners. Another aspect of YDS is My Brother's Keeper (MBK), a trauma responsive school-based mentorship and youth development program focused on improving high school completion and reducing justice system involvement. In FY 2019-20, the YDS MBK providers expanded from 10 to 24 school sites, serving 381 students. The demographics of these students is indicated below.
- The third aspect, YDD Training and Technical Assistance, involves the education, training, and technical assistance necessary to provide Y-Intensive Case Management Services and ensure the success of the YDD Program.

Table 39. YDS MBK client demographics (n = 381)

▪ Primary Language			▪ Ethnicity	
English	182		Hispanic or Latino as follows:	
Spanish	19		Central American	8
Declined to answer	180		Mexican/Mexican-American/Chicano	86
▪ Age			South American	5
0-15	218		Other Hispanic	10
16-25	160		Non-Hispanic or Non-Latino as follows:	
Declined to Answer	3		African	13
▪ Current Gender Identity			Asian Indian/South Asian	2
Male	150		Middle Eastern	1
Female	62		Other Non-Hispanic	35
Genderqueer	1		Declined to answer	221
Declined to answer	168		▪ Race	
▪ Disability			American Indian or Alaska Native	2
No	149		Black or African-American	89
Yes	34		Native Hawaiian or other Pacific Islander	3
Difficulty Seeing	3		White	16
Difficulty Hearing	1		Other	169
Mental Disability	14		More than one race	7
Chronic Health Condition	12		Declined to answer	95
Another Type of Disability	4		▪ Sexual Orientation	
Declined to Answer	198		Gay or Lesbian	3
			Heterosexual or Straight	178
			Bisexual	11
			Another Sexual Orientation	1
			Declined to Answer	220

B2. Prevention: Community Outreach

LACDMH has expanded its PEI Community Outreach Services (COS) in order to achieve the following:

- Increase the number of individuals receiving prevention and early intervention services;
- Outreach to underserved communities through culturally appropriate mental health promotion and education services; and
- Provide mental health education and reduce stigma on mental health issues in our communities.

COS affords an avenue for the LACDMH PEI network to provide services such as education and information to individuals who are not formal clients of the mental health system and providers who are outside the county mental health system. Often individuals, as well as their parents, family, caregivers, and other support system, who need or would benefit from prevention and early intervention mental health services do not seek traditional clinic-based services due to a multitude of factors. Community outreach is a key component in initiating and providing effective mental health supportive services to these individuals. Most programs are not evidence-based practices, but nonetheless have significant data and research indicating the effectiveness of their services.

COS Outcomes

In previous years, LACDMH in collaboration with RAND, developed questionnaires that asked individuals to report on general wellness and risk and protective factors for our COS programs. For each different population (adult, parent, youth), surveys were administered to clients at the start of a prevention activity and follow-up surveys were administered to clients after they participated in the prevention activity.

In FY 2019-20, LACDMH suspended the use of the instrument created by the RAND Corporation to collect outcomes for COS programs. LACDMH is making changes to the data collection protocol for Prevention programs funded under PEI. These changes were proposed after consulting with subject matter experts based on input from our stakeholders to reduce the burden of collecting additional measures while still ensuring data satisfies PEI evaluation regulations.

Table 40. COS Prevention services provided

Agency	Program(s)	Number Served
Alcott Center	Not reported	148
Alma Family Services	Not reported	Not reported
Child & Family Center	Not reported	Not reported
Child & Family Guidance Center	Not reported	Not reported
Childnet Youth & Family Services	Not reported	8,040
Childrens Center of the Antelope Valley	PCIT	695
Children's Hospital of LA	Incredible Years	Not reported
Children's Institute	Not reported	Not reported
Community Family Guidance Center	Triple P Level 2	18
Counseling4Kids	Not reported	Not reported
Didi Hirsch	Not reported	Not reported
Dignity Health	Not reported	Not reported
El Centro de Amistad	Not reported	Not reported
Emotional Health Association SHARE	Self-help support group referral service	2,355
Enki Health & Research Systems	More than Sad; MPAP	Not reported
Exceptional Childrens Foundation	Not reported	Not reported
Foothill Family Services	Not reported	50
Hamburger Home	Not reported	Not reported

Agency	Program(s)	Number Served
Hathaway Sycamores Child & Family	Not reported	Not reported
Healthright 360	Not reported	Not reported
Helpline Youth Counseling	Not reported	Not reported
Heritage Clinic & CAPS	Not reported	Not reported
Hillsides	Not reported	405
Hillview Mental Health Center	Not reported	Not reported
IMCES	Not reported	Not reported
Jewish Family Services of LA	Not reported	Not reported
Korean American Family Service Center	Not reported	91
Los Angeles Unified School District	Not reported	Not reported
One in Long Beach	Not reported	Not reported
Pacific Asian Counseling Service	Not reported	Not reported
Pacific Clinics	Not reported	Not reported
Para Los Ninos	Not reported	Not reported
Penny Lane Centers	Triple P Level 2	Not reported
Project Return Peer Support Network	Not reported	Not reported
San Fernando Valley Community MH	Not reported	50
San Gabriel Childrens Center	Not reported	Not reported
Shields for Families	Not reported	Not reported
Social Model Recovery Systems	Not reported	80
Special Services for Groups	Asian & Pacific Islander Community Empowerment	Not reported
St Anne's Maternity Home	Not reported	Not reported
St Francis Medical Center	Not reported	Not reported
St. Joseph Center	Not reported	Not reported
Star View Behavioral Health	Not reported	Not reported
Stirling Academy	Not reported	115
Tarzana Treatment Centers	Not reported	Not reported
Telecare	Not reported	Not reported
Tessie Cleveland Comm Service	Outreach & Engagement	1,339
The Help Group	Not reported	Not reported
The Village Family Services	Not reported	291
The Whole Child	Not reported	Not reported
Tobinworld	Not reported	Not reported
Uplift Family Services	Not reported	Not reported
Victor Treatment Centers	Not reported	Not reported
VIP Community MH Center	Not reported	Not reported

Table 41. Programs approved for billing PEI COS

Prevention Program	Description
Active Parenting Parents of children (3-17)	Active Parenting provides evidence-based, video-based, group parenting classes that cover topics including parenting skills training, step-parenting, managing divorce, school success, and character education. Active Parenting classes can be delivered in 1, 3, 4, or 6 group sessions. Curriculum addresses: child development, appropriate discipline, communication skills, decision-making and prevention of risk behaviors.
Arise Children (4-15) TAY (16-25) Adult (26-59) Older Adult (60-64)	Arise provides evidence-based life skills group based curricula and staff training programs. Programs are geared towards at-risk youth; however, the program is adaptable for adults as well. Program content focuses on violence reduction, goal setting, anger management, drug and alcohol avoidance and other life management skills.
Asian American Family Enrichment Network (AAFEN) Parents of Children (12-15) TAY (16-18)	AAFEN is for Asian immigrant parents and/or primary caregivers with inadequate parenting skills to effectively discipline and nurture their teenage children. Because of the cultural and linguistic barriers experienced by many of these immigrant parents, they often feel overwhelmed and incompetent in terms of effectively managing their family lives. Moreover, their children experience reduced family

Prevention Program	Description
	attachment and social functioning, as well as increased family conflict. The children are thus at high risk for emotional and behavioral problems. Their immigrant parents and/or primary caregivers are at high risk for depressive disorders and for being reported to DCFS to corporal punishment.
Childhelp Speak Up and Be Safe Children (3-15) TAY (16-19)	This is a child-focused, school-based curriculum designed to build safety skills within the child while addressing today's societal risks, such as bullying and Internet safety. The program helps children and teens learn the skills to prevent or interrupt cycles of neglect, bullying, and child abuse. The program focuses on enhancing the child's overall sense of confidence regarding safety and promotes respect for self and peers that can be applied to general as well as potentially harmful situations. In addition to increasing children's ability to recognize unsafe situations or abusive behaviors and building resistance skills, lessons focus on helping children build a responsive safety network with peers and adults that the child identifies as safe.
Coping with Stress Child (13-15) TAY (16-18)	This course consists of 15 one-hour sessions, which can be offered at a pace of 2 to 4 times per week, depending on site capabilities and needs. The first few sessions provide an overview of depression, its relationship to stressful situations, and an introduction to other group members. Subsequent sessions focus on cognitive-restructuring skills and techniques for modifying irrational or negative self-statements and thoughts which are hypothesized to contribute to the development and maintenance of depressive disorders.
Erika's Lighthouse: A Beacon of Hope for Adolescent Depression Children (12-14)	Erika's Lighthouse is an introductory depression awareness and mental health empowerment program for early adolescence. The program educates school communities about teen depression, reduces the stigma associated with mental illness, and empowers teens to take charge of their mental health. "The Real Teenagers Talking about Adolescent Depression: A Video Based Study Guide" is a depression and mental health school program designed for middle and high school classrooms and is listed in the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention "Best Practices Registry for Suicide Prevention."
Guiding Good Choices Parents of Children (9-14)	Guiding Good Choices is a five-session parent involvement program that teaches parents of children ages 9-14 how to reduce the risk that their children will develop drug problems. The goal of the program is to prevent substance abuse among teens by teaching parents the skills they need to improve family communication and family bonding. Participants learn specific strategies to help their children avoid drug use and other adolescent problem behaviors and develop into healthy adults. They also learn to set clear family guidelines on drugs, as well as learn and practice skills to strengthen family bonds, help their children develop healthy behaviors, and increase children's involvement in the family.
Healthy Ideas (Identifying Depression, Empowering Activities for Seniors) Older Adults (60+)	This is a community program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. The program incorporates four evidence-based components into the ongoing service delivery of care/case management or social service programs serving older individuals in the home environment over several months. Program components include screening and assessment of depressive symptoms, education about depression and self-care for clients and family caregivers, referral and linkage to health and mental health professionals, and behavioral activation.
Incredible Years (Attentive Parenting) Parents	The Attentive Parenting program is a 6-8 session group-based "universal" parenting program. It can be offered to ALL parents to promote their children's emotional regulation, social competence, problem solving, reading, and school readiness.
Life Skills Training (LST) Children (8-15) TAY (16-18)	LST is a group-based substance abuse prevention program developed to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This comprehensive program utilizes collaborative learning strategies taught through lecture, discussion, coaching, and practice to enhance youth's self-esteem, self-confidence, decision-making ability and ability to resist peer and media pressure. LST provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations.

Prevention Program	Description
Love Notes Children (15) TAY (16-24)	Love Notes consists of 13 lessons for high risk youth and TAY in which they discover, often for the first time, how to make wise choices about partners, sex, relationships, pregnancy, and more. Love Notes appeals to the aspirations and builds assets in disconnected youth.
Making Parenting a Pleasure (MPAP) Parents of children (0-8)	MPAP is a 13-week, group-based, parent training program designed for parent educators of parents and/or caregivers of children from birth to eight years of age. The program is designed to address the stress, isolation, and lack of adequate parenting information and social support that many parents experience. The curriculum focuses first on the need for self -care and personal empowerment and moves from an adult focus to a parent/child/family emphasis. Its content is adaptable and flexible to fit a wide range of parent education programs and has broad appeal to families from a wide spectrum of socioeconomic, educational, cultural and geographical background.
More than Sad Parents/Teachers/Children (14-15) TAY (16-18)	This is a curriculum for teens, parents and educators to teach how to recognize the signs of depression. The program for teens teaches how to recognize signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process. The program for parents teaches parents how to recognize signs of depression and other mental health problems, initiate a conversation about mental health with their child, and get help. The program for teachers teaches educators to recognize signs of mental health distress in students and refer them for help. The program complies with the requirements for teacher education suicide prevention training in many states.
Nurturing Parenting Parents of children (0-18)	These are family-based programs utilized for the treatment and prevention of child abuse and neglect. Program sessions are offered in group-based and home-based formats ranging from 5-58 sessions. Programs are designed for parents with young children birth to 5 years old, school-aged children 5-11 years old, and teens 12-18 years old. Developed from the known behaviors that contribute to the maltreatment of children, the goals of the curriculum are: (1) to teach age-appropriate expectations and neurological development of children; (2) to develop empathy and self-worth in parents and children; (3) to utilize nurturing, non-violent strategies and techniques in establishing family discipline; (4) to empower parents and children to utilize their personal power to make healthy choices; and (5) to increase awareness of self and others in developing positive patterns of communication while establishing healthy, caring relationships.
Peacebuilders Children (0-15)	PeaceBuilders is a violence prevention curriculum and professional development program for grades pre-K to 12. Its essence is a common language - six principles, taught, modeled and practiced.
Prevention of Depression (PODS) - Coping with Stress (2nd Generation) Child (13-15) TAY (16-18)	This is the second-generation version of the Coping with Stress program. PODS is an eight-session curriculum developed for the prevention of unipolar depression in adolescents with increased risk. It is not meant to be a treatment for active episodes of depression. It is designed to be offered either in a healthcare setting or in schools.
Positive Parenting Program (TRIPLE P) Levels 2 and 3 Parents/Caregivers of Children (0-12)	Triple P is intended for the prevention of social, emotional, and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Selected Triple P (Levels 2 and 3) is a "light touch" parenting information presentation to a large group of parents (20 to 200) who are generally coping well but have one or two concerns. There are three seminar topics with each taking around 60 minutes to present, plus 30 minutes for question time.
Project Fatherhood Male Parents/Caregivers of Children (0-15) TAY (16-18)	Project Fatherhood program provides comprehensive parenting skills to men in caregiving roles using an innovative support group model. The program was developed to give urban, culturally diverse caregivers an opportunity to connect with their children and play a meaningful role in their lives. The program continues to be recognized nationally for effectively addressing the problem of absentee fathers. Through therapy, support, parenting education and other services, fathers learn to be more loving, responsible parents and active participants in their children's lives.

Prevention Program	Description
Psychological First Aid (PFA) All Ages	PFA is an evidence-informed approach for assisting children, adolescents, adults, and families in the aftermath of disaster and terrorism. The practice is a partnership between the National Child Traumatic Stress Network and the National Center for PTSD. The Core Actions of PFA include Contact and Engagement; Safety and Comfort; Stabilization; Information Gathering: Current Needs and Concerns; Practical Assistance; Connection with Social Supports; Information on Coping; and Linkage with Collaborative Services.
School, Community and Law Enforcement (SCALE) Children (12-15) TAY (16-18)	SCALE Program is for Asian immigrant youths who are at high risk for, or are exhibiting the beginning signs of, delinquent behavioral problems. These behavioral problems include, but are not limited to, school truancy, academic failure, association with gang members, and early stages of law enforcement encounter and detention (such as by police or probation officers).
Second Step Children (4-14)	A classroom-based program, this practice teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research, and social information-processing theories. The program consists of in- school curricula, parent training, and skill development. Second Step teaches children to identify and understand their own and others' emotions, reduce impulsiveness and choose positive goals, and manage their emotional reactions and decision-making process when emotionally aroused in developmentally and age-appropriate ways.
Shifting Boundaries Children (10-15)	Shifting Boundaries is a six session, group based, dating violence prevention program that focuses on peer sexual harassment. The intervention consists of classroom-based curricula designed to reduce the incidence and prevalence of dating violence and sexual harassment among middle school students. The program aims to: Increase knowledge and awareness of sexual abuse and harassment; Promote pro-social attitudes and a negative view of dating violence and sexual harassment; Promote nonviolent behavioral intentions in bystanders; Reduce the occurrence of dating and peer violence; and Reduce the occurrence of sexual harassment.
Teaching Kids to Cope Children (15) TAY (16-22)	This 10-session group intervention is designed to reduce depression and stress by enhancing coping skills. Program components include group discussions, interactive scenes, videos, group projects, and homework assignments. Group discussions include a variety of topics, such as family life situations, typical teen stressors, self-perception issues, and interactions with others.
Why Try Children (7-15) TAY (16-18)	Why Try is a resilience education curriculum designed for dropout prevention, violence prevention, truancy reduction, and increased academic success. It is intended to serve low income, minority students at risk of school failure, dropping out of school, substance use/abuse, and/or juvenile justice involvement. Why Try includes solution-focused brief therapy, social and emotional intelligence, and multisensory learning.

■ PREVENTION	
Prior FY 2019-20	**Prior FY 2018-19**
$65.3 million Total Gross Expenditures	$52.0 million Total Gross Expenditures
FY 2021-22	**Three-Year Plan FYs 2021-24**
$63.3 million Estimated Gross Expenditures	$162.8 million Estimated Gross Expenditures

Currently, unique client count is only for MHSA programs with Mode 15 Direct Services (Prevention).

All dollar amounts in this table are reported at gross costs and does not include program administration costs.

C. STIGMA AND DISCRIMINATION REDUCTION (SDR)

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ TAY Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

The purpose of SDR 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.

FY 2019-20 ■ STIGMA AND DISCRIMINATION REDUCTION Data and Outcomes

C1. Mental Health First Aid (MHFA)

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 enhances 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.

C2. Mental Health Promoters/Promotores

Many underserved communities have been shown to have high rates of mental health related stigma as well as cultural/linguistic barriers that limit their access to mental health services and mental health resources available. Often these barriers limit/prevent the utilization of mental health services until symptoms are chronic and severe. Underserved communities, such as the API and Latino communities in Los Angeles County show high levels of ongoing disparities in their access and use of public mental health services. The Promotores program represents a promising approach to mental illness & disease prevention as it increases knowledge about mental illness, increases awareness about available mental health services and promotes early use of mental health services. The criteria will be to decrease mental health and stigma.

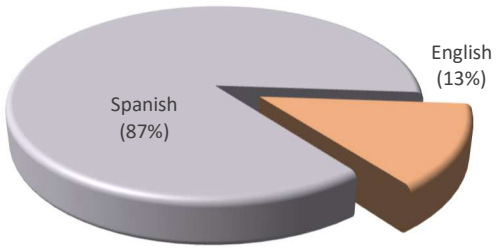
C3. SDR Outcomes

SDR trainings are intended to decrease stigma and discrimination against people who have a mental illness and increase knowledge about the topic of mental health. To determine the effectiveness of its SDR trainings, Los Angeles County uses a post-training survey that assesses the impact of trainings on participants' knowledge about stigma towards persons with mental illness as well as their attitudes and behavior toward persons with mental illness. In addition, the survey measures training quality and demographics.

The following write-up discusses the results of data analyses performed on the 5,968 SDR surveys administered to assess SDR trainings that were conducted during the FY 2019-20, from July 2019 through March 2020.

The SDR survey is available in each of the County's 13 threshold languages as well as Hmong, though only Spanish (5,166) and English (781) language surveys were received from training participants. The high percentage of Spanish surveys received is noteworthy as it suggests SDR trainings are successfully reaching the monolingual Spanish speaking people that the County has historically struggled to serve. This success is due primarily to the Promotores de Salud, a LACDMH program that primarily serves monolingual Spanish speaking individuals.

Figure 26. Survey languages (n = 5,968)

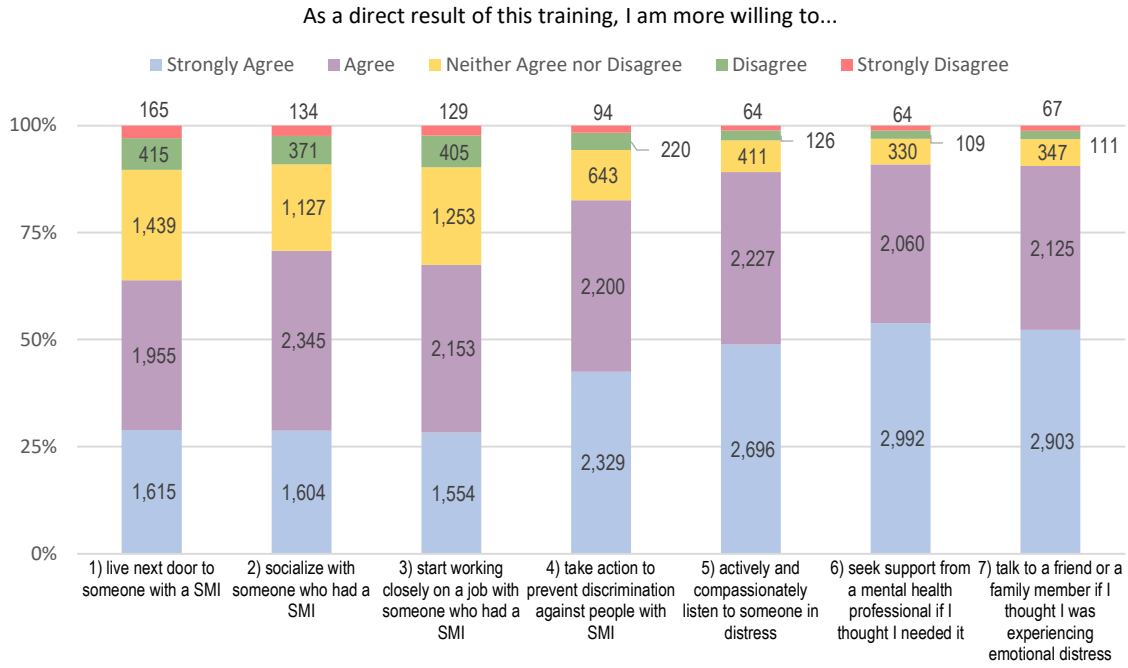


The following chart assesses the impact of SDR trainings on participants' willingness to engage in behaviors that support persons with mental illness. Item ratings are: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Agreeing suggests the participant believes the training positively influenced their future behavior (e.g. willingness to advocate for a person who has a mental illness). Results suggest participants believed the trainings: 1) decreased the likelihood of discriminating against persons with mental illness; 2) increased the likelihood of acting in support of individuals who have a mental illness; and 3) and greatly increased the likelihood of seeking support for themselves in times of need.

Across all items, at least 64% of participants agreed the training had a positive influence, with:

- Item 6: A high of 91% agreeing (37%) or strongly agreeing (54%) the training increased willingness to "*seek support from a mental health professional if I thought I needed it*"
- Item 7: A high of 91% agreeing (38%) or strongly agreeing (52%) the training increased willingness to "*talk to a friend or a family member if I thought I was experiencing emotional distress*"

Figure 27. Changes in behavior

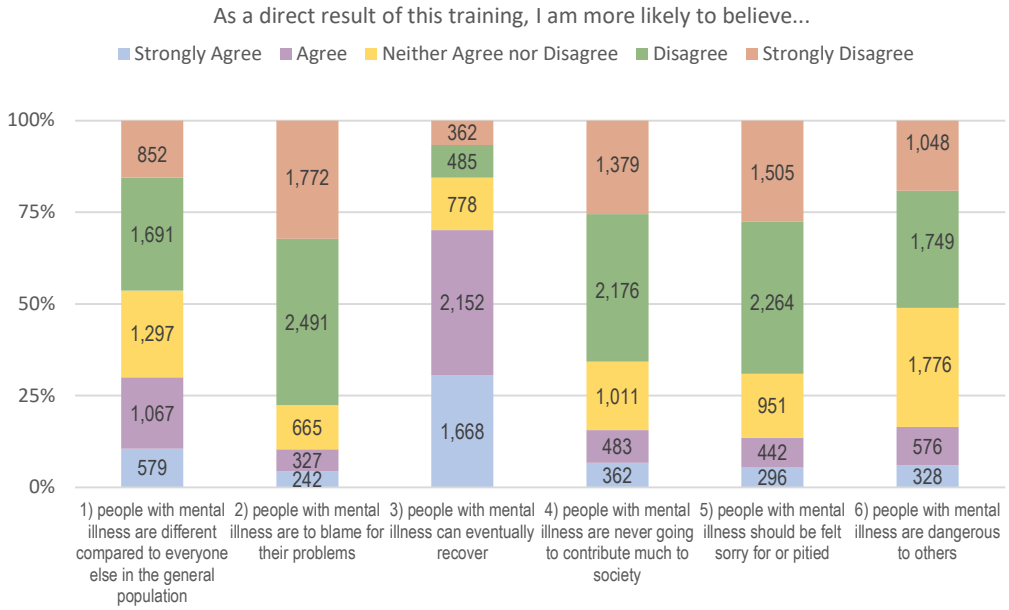


The following chart assesses change resulting from attending an SDR training in knowledge about mental illness and beliefs about mentally ill people. Items may be rated: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Disagreeing suggests the participant believes training had a positive influence (e.g., decreasing with the belief mentally ill people are dangerous) and agreeing suggests the opposite, for all but the third item (see previous figure in the *Changes in Behavior* ratings). Survey results suggest trainings tended to positively influence participants' knowledge about the topic of mental illness and beliefs about people who have a mental illness.

Across all items, the majority of participants agreed the trainings had a positive influence, with:

- Item 1: A low of 52% disagreeing (34%) or strongly disagreeing (18%) the training increased the likelihood of believing, "*people with mental illness are different compared to everyone else in the general population"*
- Item 2: A high of 79% disagreeing (47%) or strongly disagreeing (32%) the training increased the likelihood of believing, "*people with mental illness are to blame for their problems*"

Figure 28. Changes in knowledge and beliefs



The next figure assesses the quality of SDR trainings. Items may be rated: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Agreeing suggests the participant had positive perceptions about the training quality and disagreeing suggests the opposite. Participants tended to have extremely positive perceptions of the trainings' quality, particularly in their perceptions of presenters

- A high of 91% agreed (22%) or strongly agreed (69%) the trainers "*demonstrated knowledge of the subject matter*" while only 1% disagreed
- A low of 88% agreed (23%) or strongly agreed (65%) agreed "*the training was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.)"*

Figure 29. Training Quality

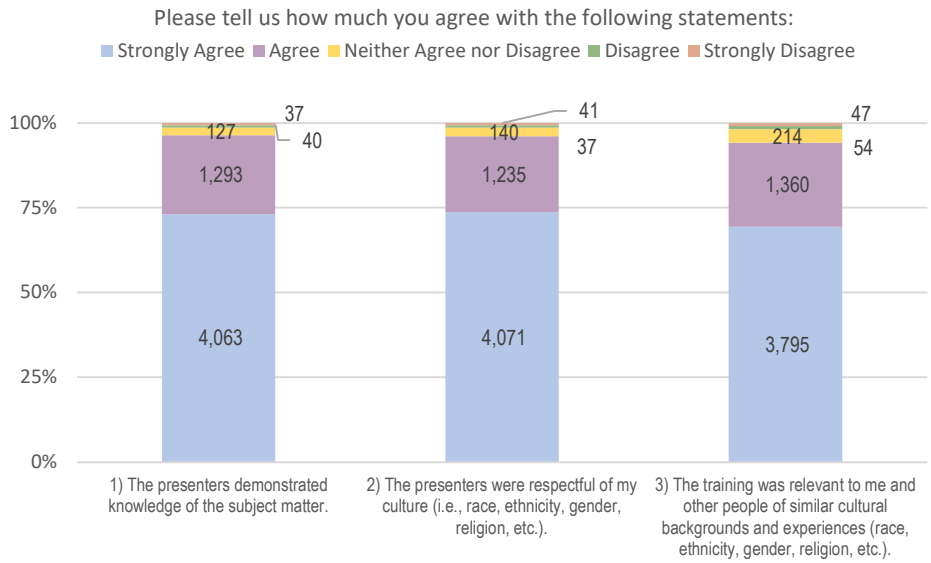


Table 42. Survey demographics (n = 5,968)

Sex at Birth	Female - 72% Male - 11%	Declined to answer - 17%
Gender Identity	Female - 72% Male - 11%	Declined to answer - 16%
Sexual Orientation	Heterosexual or straight - 61% Another sexual orientation - 1%	Declined to answer - 36%
Ethnicity	Mexican/Mexican-American/Chicano - 55% Central American - 12% European - 2%	Other - 11% Declined to answer - 19%
Veteran Status	Yes - 1% No - 75%	Declined to answer - 24%
Age Groups	Children (0-15) - 1% TAY (16-25) - 7% Adult (26-59) - 64%	Older Adult (60+) - 9% Declined to answer - 19%
Disability	Yes - 6% No - 71%	Declined to answer - 23%
Primary Language	English - 11% Spanish - 64%	Other - 4% Declined to answer - 21%
Race	White - 37% Black or African American - 2% Asian - 2%	More than one race - 2% Other - 31% Declined to answer - 26%

■ STIGMA AND DISCRIMINATION REDUCTION	
Prior FY 2019-20	**Prior FY 2018-19**
$2.7 million Total Gross Expenditures	$2.1 million Total Gross Expenditures
FY 2021-22	**Three-Year Plan FYs 2021-24**
$0.4 million Estimated Gross Expenditures	$1.1 million Estimated Gross Expenditures

Currently, unique client count is only for MHSA programs with Mode 15 Direct Services (Prevention).

All dollar amounts in this table are reported at gross costs and does not include program administration costs.

D. SUICIDE PREVENTION

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ TAY Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

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.

In response to the needs in our community, the Los Angeles County Suicide Prevention Network, with support from LACDMH, has developed a strategic plan for suicide prevention to guide our efforts towards the goal of zero suicides in the County.

Some of the key elements to suicide prevention are:

- Focus on fostering prevention and well-being through connections, education, outreach, advocacy and stigma reduction;
- Promote early help seeking where people know the warning signs and resources and are confident to intervene with someone they care about or get help for themselves;
- Ensure a safe and compassionate response during and in response to crises by focusing on stabilization and linkages to services in the least restrictive setting; and
- Implement a system of short- and long-term support for individuals, families, schools and communities following a suicide attempt or death.

FY 2019-20 ■ SUICIDE PREVENTION Data and Outcomes

D1. Latina Youth Program (LYP)

The primary goals of LYP 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.

During FY 2019-20, LYP provided direct clinical services, outreach, and education to 40 unduplicated clients and their families with funding through the LACDMH contract. These clients are those who have no other coverage for mental health services. They represent

four percent of the total LYP program population (n = 1010). The outcomes focus on this subgroup. A range of clinical presentations were noted in this group. While the majority of clients continue to present with either a depressive or anxiety related disorder, neurodevelopmental, trauma related, and substance use disorders were also common diagnoses. Although one suicide attempt and 24 psychiatric hospitalizations were reported during FY 2019-20, only 12 of the hospitalizations and the one attempted suicide occurred within this LACDMH funded subgroup. Fortunately, and as in other program years, there were no completed suicides. Outreach, education and clinical services were provided at 27 schools, and throughout the community. Program staff are trained in eight different EBPs. Administrative staff focused much of their feedback on the program's pivot to COVID-19 related activities, as well as lessons learned over the program's long history. They are proud of the passage in the U.S. House of Representative of H.R. 1109, the Mental Health Services for Students Act which is based on LYP's program design. The bill is authored by Representative Grace F. Napolitano, a strong supporter of Pacific Clinic's LYP since its inception.

D2. 24/7 Crisis Hotline

During FY 2019-20, the 24/7 Suicide Prevention Crisis Line responded to a total of 133,837 calls, chats, and texts originating from Los Angeles County, including Spanish-language crisis hotline services to 12,588 callers. Korean and Vietnamese language services are also available on the crisis hotline. Additionally, various outreach events were conducted in Los Angeles and Orange County.

Table 43. Call analysis

Total calls	112,878
Total chats	20,949
Total texts	10
Total*	133,837

*Calls from Lifeline, Lifeline Spanish, SPC Local Line, Teenline, and Disaster/Distress.

Table 44. Total calls by language

Korean	85
Spanish	12,588
English	100,205
Total	112,878

Figure 30. Call, chat and text volume by month

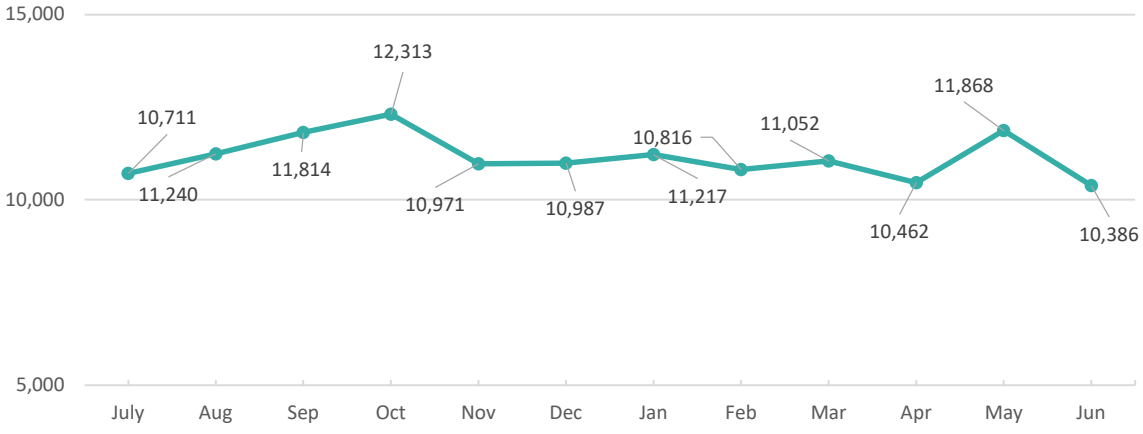


Table 45. Calls and chats by ethnicity

Ethnicity	Call (n = 46,850)	Chat (n = 19,339)
White	37%	59%
Hispanic	35%	13%
Black	10%	11%
Asian	9%	7%
Native American	1%	1%
Pacific Islander	1%	0%
Other Race	8%	0%

Table 46. Calls and chats by age groups

Age Groups	Call (n = 57,690)	Chat (n = 20,437)
5 to 14	6%	18%
15 to 24	37%	52%
25 to 34	26%	19%
35 to 44	12%	6%
45 to 54	8%	3%
55 to 64	7%	1%
65 to 74	3%	1%
75 to 84	1%	0%
85 and up	0%	0%

Table 47. Calls and chats by suicide risk assessment

Suicide Risk Assessment	Calls	Chats
History of psychiatric diagnosis	42%	37%
Prior suicide attempt	26%	28%
Substance abuse - current or prior	16%	6%
Suicide survivor	8%	4%
Access to gun	3%	4%

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

Table 48. Suicide risk status

Suicide Risk Status	Calls (n = 40,712)	Chats (n = 5,750)
Low Risk	49%	49%
Low-Moderate Risk	25%	21%
Moderate Risk	13%	15%
High-Moderate Risk	5%	6%
High Risk	8%	8%
Attempt in Progress	1%	0%

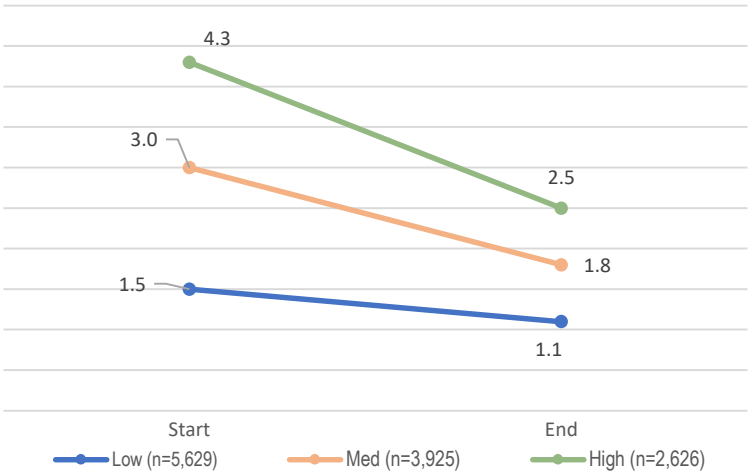
Percentages are calculated based on the total number of callers with reported risk levels.

Risk assessment is based on the four core principles of suicide risk: suicidal desire, suicidal capability, suicidal intent, and buffers/connectedness. A caller's risk level is determined by the combination of core principles present. For 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.

Intervention Outcomes: Self-rated Intent

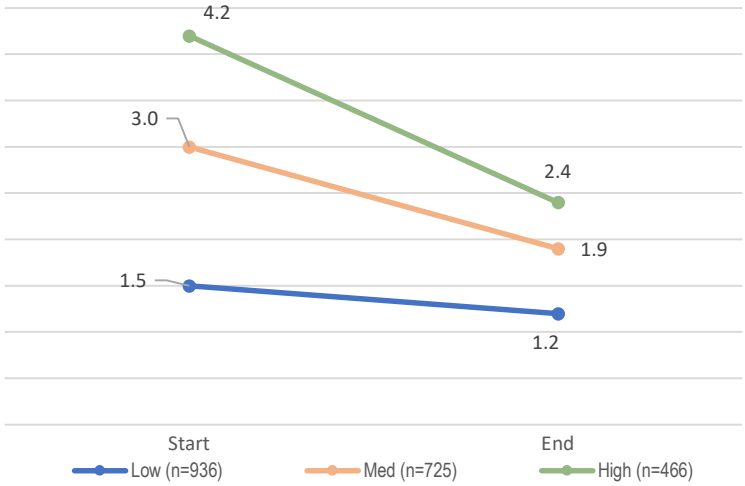
Callers are asked to answer the question: "*On a scale of 1 to 5, how likely are you to act upon your suicidal thoughts and feelings at this time, where 1 represents not likely and 5 represents extremely likely?*" Callers rate their intent both at the start and end of the call. Note: This data is on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

Figure 31. Self-rated suicidal intent calls



Callers rating of suicidal intent at the beginning of the call:
4 or 5 = high or imminent risk
3 = medium risk
1-2 = low risk

Figure 32. Self-rated suicidal intent chats



D3. Suicide Prevention Outcomes

LACDMH has chosen to implement a suicide prevention program in the form of training and education that has shown effectiveness 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.

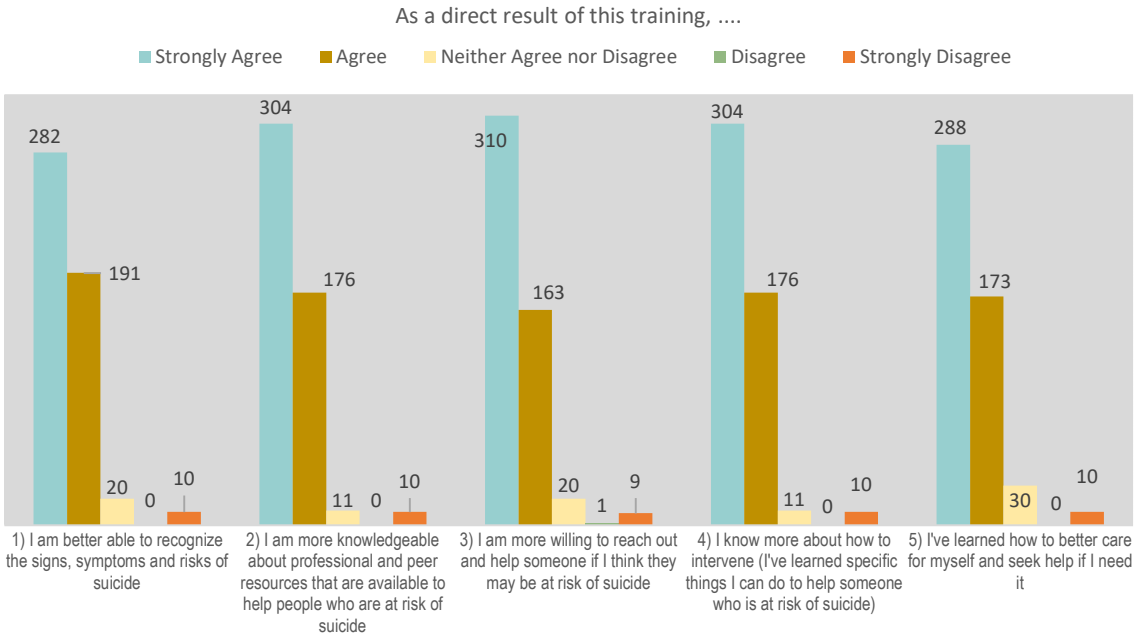
To determine the effectiveness of its Suicide Prevention trainings, the County utilized the California Institute of Behavioral Health Services' Suicide Prevention Program participant questionnaire, which assesses the impact of trainings on participants' attitudes, knowledge, and behaviors related to suicide. In addition, the questionnaire measures training quality and participant demographics. This write-up discusses the results of data analyses performed on the 541 questionnaires received for these trainings conducted during the FY2019-20. The questionnaire is available in each of the County's 13 threshold languages, as well as Hmong. All questionnaires received were in in English.

The three primary goals of the Suicide Prevention program interventions are to: 1) increase knowledge about suicide and ways to help someone who may be at risk of suicide; 2) increase willingness to help someone who may be at risk of suicide; and 3) increase the likelihood the participants seeking support for themselves in times of need. The questionnaire includes five items that assess the success of these trainings in meeting program goals. Items may be rated: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Agreeing with an item suggests the training met a program goal(s), disagreeing suggests the opposite.

Data analyses of questionnaire results in the following figure found that at least 92% of participants agreed or strongly agreed with all 5 items, suggesting that, overall, the Suicide Prevention programs had great success in meeting their program goals. Here are few highlights from the data analyses:

- Highest percent of agreement with the item 2: 96% agreed (35%) or strongly agreed (67%) that, "*as a direct result of this training, I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide*,"
- Lowest percent of agreement with the item 5: (92%) agreed (35%) or strongly agreed (57%) that, "*as a direct result of this training, I've learned how to better care for myself and seek help if I need it*."
- Majority of participants strongly agreed with all 5 items, from a low of 56% strongly agreeing with the item 1 to a high of 62% strongly agreeing with item 3.

Figure 33. Responses to suicide prevention training



The questionnaire includes three items in the following figure that assesses the quality of Suicide Prevention trainings. Items may be rated: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Agreeing suggests the participant had positive perceptions about the training quality and disagreeing suggests the opposite. Participants tended to have extremely positive views of the trainings' quality, particularly with presenters:

- a high of 97% agreed (20%) or strongly agreed (77%) with item 1, "*the presenters demonstrated knowledge of the subject matter,"*
- the second highest rating…96% agreed (20%) or strongly agreed (76%) with item 2, "*the presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.).*

Figure 34. Responses to suicide prevention training

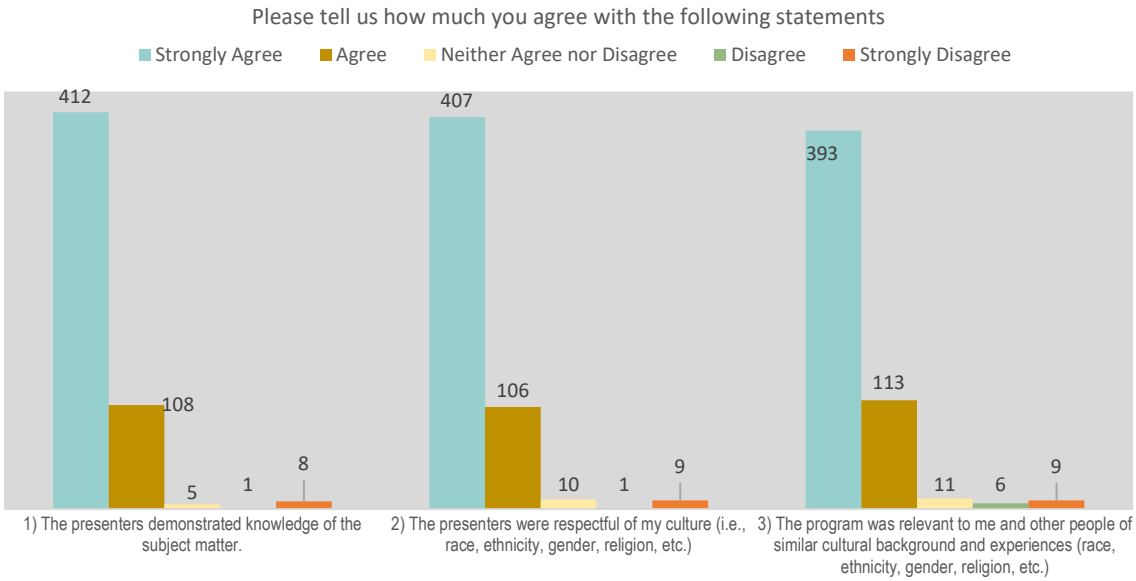


Table 49. FY 2019-20 Survey demographics

Gender Identity	Female - 75% Male - 21%	Declined to answer - 4%
Age Groups	TAY (16-25) - 17% Adult (26-59) - 73%	Declined to answer - 4% Older Adult (60+) - 6%
Race	White - 22% African American - 15% Asian - 7%	Other - 33% Declined to answer - 14% More than one race - 8%
Sexual Orientation	Heterosexual - 82% Gay/Lesbian - 3% Bisexual - 4%	Queer - 1% Declined to answer - 9%
Ethnicity	Central American - 11% European - 5% More than one ethnicity - 9% Filipino - 2% Mexican/Mexican-American/Chicano - 36%	Other - 15% Declined to answer - 22% African - 3% Middle Eastern - 2%
Veteran Status	Yes - 5% No - 93% Declined to answer - 2%	
Disability	Yes - 10% No - 82% Declined to answer - 8%	
Primary Language	English - 74% Spanish - 10% Armenian - 1%	Other - 7% Declined to answer - 8%

D4. School Threat Assessment Response Team (START)

In FY 2019-20, START provided 5,102 services to 809 individuals at either suicidal or homicidal risk: 168 open cases. Law enforcement agencies and schools continue to be the two main referral sources. After years of services delivered in the County, START has become one of the major violence crisis management resources in addition to the law enforcement.

Clinicians triaged and determined their active status: consultation only, limited follow-up for cases either posed no threat, received services from other mental health providers, or declined START services, and active follow-up identifying as open cases.

In FY 2019-20, 147 male cases and 21 female cases were opened, and 101 of those were between the ages of 0-15; 55 were between the ages of 16-25; 12 were between the ages of 25-59. English was the language spoken by most clients (148) followed by Spanish (17). Close to half of the open cases were identified as Hispanic at 46%. The clients identified as white (23%) was the second largest ethnic group and African Americans/blacks were third at 15%. To meet the clients' cultural need, one third of START clinicians are Spanish-speaking.

The reported outcomes for FY 2019-20 were based on a combination of assessment tools, collateral information, clinical observation, and other reliable sources. The three assessment tools consist of Columbia-Suicide Severity Rating Scale (C-SSRS), Structured Assessment of Violence Risk in Youth (SAVRY) and Workplace Assessment of Violence Risk-21 (WAVR-21). These three tools do not quantitatively calculate the risk levels but present the risk factors. Clinicians subjectively weigh on each risk factor to determine the total risk levels on each tool and then conclude the final risk levels after reviewing the information collected from all sources mentioned above.

Both high suicidal risk and moderate suicidal risk groups showed a decline in the client counts with the provision of START interventions. 17 clients (10.12%) were referred to the START Program with high suicidal risk and dropped to 1 client (0.60%) as the START services progressed. 20 clients (11.90%) presented moderate suicidal risk in the initial contacts and decreased to 15 clients (8.93%) with the START interventions. As for the low suicidal risk level group, 131 clients (77.98%) increased to 152 (90.47%) after they continued to receive interventions from the START program.

Table 50. Change of suicidal risk levels between initial and most recent contacts

Risk Level	Initial Suicidal Risk Level	Most Recent Suicidal Risk Level
High	17 (10.12%)	1 (0.60%)
Moderate	20 (11.90%)	15 (8.93%)
Low	131 (77.98%)	152 (90.47%)
Early Dropout	0 (0.00%)	0 (0.00%)
Total	168	168

In FY 2019-20, the client counts also dropped in both high and moderate violent risk groups with the START interventions:

- Twelve (12) clients (7.14%) were rated as high violent risk in the beginning of the service period and decreased to 3 clients (1.79%) throughout the service cycles.
- Seventy (70) clients (41.67%) presented moderate violent risk in the initial contacts and declined to 24 clients (14.29%) as the services continued.
- As for the low violent risk group, 86 clients (51.19%) increased to 135 (80.35%) after they remained in the START Program.
- No most recent (or last reported) violent risk levels were reported for 6 (3.57%) clients due to early dropout.

Table 51. Change of violent risk levels between initial and most recent contacts

Risk Level	Initial Violent Risk Level	Most Recent Violent Risk Level
High	12 (7.14%)	3 (1.79%)
Moderate	70 (41.67%)	24 (14.29%)
Low	86 (51.19%)	135 (80.35%)
Early Drop Out	0 (0.00%)	6 (3.57%)
Total	168 (100%)	168 (100%)

Clinician cannot reach the client but is actively following on this case through contacts with other professionals.

START provided 68 trainings to 3,823 attendees. The training topics include bullying, de-escalation of violent behaviors, targeted school violence, orientation to START services, suicide prevention, mental health awareness, and outreach.

START has years of partnership with various threat management teams in the Los Angeles Community College District (LACCD), the largest community college system in the nation. Through its partnership with the Los Angeles County Sheriff's Department and the LACCD, START has established protocol for managing threats in educational settings. The services include, but are not limited to, faculty consultation on threat management; close monitoring of potentially violent individuals; development of threat management plans and interventions specific to individuals; trainings extended to students and their families; and linkage to a wide range of community resources. Additionally, START participates in LAUSD's Threat Assessment Response Partners (TARP) collaborative, and the higher education Threat Assessment Regional Group Evaluation Team (TARGET) to provide on-going consultations and trainings on threat cases. START will continue with its mission to be the driving force in establishing a safe, healthy school environment in the County.

■ SUICIDE PREVENTION	
Prior FY 2019-20	**Prior FY 2018-19**
$20.0 million Total Gross Expenditures	$18.7 million Total Gross Expenditures
FY 2021-22	**Three-Year Plan FYs 2021-24**
$23.3 million Estimated Gross Expenditures	$50.9 million Estimated Gross Expenditures

Currently, unique client count is only for MHSA programs with Mode 15 Direct Services (Prevention).

All dollar amounts in this table are reported at gross costs and does not include program administration costs.

WORKFORCE EDUCATION AND TRAINING (WET)

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued

Program Description

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

FY 2019-20 ■ WORKFORCE EDUCATION AND TRAINING Data and Outcomes

A. Training and Technical Assistance: Public Mental Health Partnership (PMHP)

The mission of the University of California, Los Angeles (UCLA)-LACDMH PMHP is to implement exemplary training and technical assistance activities focused on vulnerable populations with SMI in ways that build excellence in public mental health care across the County; and to do so in the context of a transparent, trusting partnership with LACDMH that generates benefits for both UCLA and public health communities. The PMHP is comprised of two sections focused on SMI - the Initiative for Community Psychiatry (ICP) and the FSP Training and Implementation Program.

Table 52. Public Mental Health Partnership

Training	Service Provided
Initiative for Community Psychiatry	
Core curricular training workshops (HOME)	• 10 day long workshops within each Service Area. • Creation of a HOME Manual
Consultation with Homeless outreach leaders, clinicians, and agencies.	As needed training and consultation
Quality Assurance	• Created brief and final case dossier templates • Development of a HOME client screener
FSP Training and Implementation	
In person/Zoom training and coaching	• Planning and development • 100 FSP Training & Consultation sessions • FSP Team Shadows • FSP Site visits • FSP Supervisors Training • FSP Conference • FSP Training Collaborative
Quality assurance	• Developed FSP Training Champions Proposal • Finalized Conservatorship FAQs • Outcome Measures Dev. • Fidelity Measure Dev. • 3 FSP Adult Focus Groups
Innovating for performance improvement	• Prepare and disseminate team newsletters • Occupational Therapy Report • FSP Team Guide on "Maintaining engagement with substance using clients." • Develop an online library for FSP • Create a Psychiatry listserv

Training	Service Provided
UCLA Extension Course	• Develop curriculum for Role and Functions of Substance Use Disorder Counselors in s multi-disciplinary team. • 14 (3 hour) courses delivered
AOT Evaluation	• Quarterly Report (2) • HSRC Review • Final Report

BASIC T Pipeline	• Recruit and onboard:
	  ○ Postdoctoral Fellows (1)
	  ○ Early Entry Neuropsychologists (2)
	  ○ Social Workers (2)
	  ○ Training Plans for Post Doc Fellows
	• Staff above provide training to in-house staff across disciplines.
	• Respond to LACDMH referrals for a Comprehensive Neuropsychological Assessment (CNAs) for clients.
	• Performed CNAs for 10 children in Palmdale
	• 4 trainings to 100 LACDMH Psychologists

Training & Consultation for Older Adults	
OACT MD Journal Club	6 sessions
Didactic Training	10 sessions
Curriculum Training Development	30 hours
Continuing Education	• Curriculum Development • Peer Consultation and on call consultation • Developed assessment skills (one-on-one peer consultation) • Developed COVID-19 specific curriculum for Promotores De Salud Mental • Trained Promotores and Community Based and Faith Based organizations on COVID-19.

B. Navigator Skill Development Program

- Health Navigation Certification Training
  This program trains individuals employed as community workers, medical case workers, substance abuse counselors, peer specialists, and their supervisors on knowledge and skills needed to assist consumers navigate and advocate in both the public health and mental health systems. Due to COVID-19, recruitment and delivery of this training has been delayed and potentially pushed back to FY 2020-21.

- Family Health Navigation Certification Training
  This program trains staff working with family members of children served in the public mental health system to navigate and advocate medical concerns on behalf of their children's needs in both the public health and mental health systems. Due to COVID-19, recruitment and delivery of this training has been delayed and potentially pushed back to FY 2020-21.

- Interpreter Training Program (ITP)
  ITP offers trainings for bilingual staff currently performing or interested in performing interpreter services and monolingual English speaking mental health providers. The use of linguistically and culturally competent interpreters is important to bridging the language and cultural gap in the delivery of services in public mental health. Due to COVID-19, additionally scheduled interpreting training was not delivered.

Table 53. ITP Outcomes for FY 2019-20

Training	Number of Attendees
Increasing Mandarin Mental Health Clinical Terminology	18
Increasing Spanish Mental Health Clinical Terminology	83
Introduction to Interpreting in Mental Health Settings	24
Totals	125

C. Learning Net System

LACDMH is developing an online registration system that manages both registration and payment for trainings and conferences coordinated by LACDMH. This system is being developed in multiple phases and projected to be completed FY 2020-21.

D. Charles R. Drew Affiliation Agreement - Pathways to Health Academy Program

This academic and internship program is for high school students in SA 6 interested in behavioral health careers including mental health. During FY 2019-20, 36 students participated, with 94% representing un- or underserved communities. Of these students, 66% spoke a second language.

E. Charles R. Drew Affiliation Agreement – Psychiatric Residency Program

Charles Drew University (CDU) was contracted to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and LACDMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County.

The first class started in Academic Year 2018-19 and at the program's capacity, there will be 24 trainees ranging from Post Graduate Year Is to IVs. The first class will graduate in June 2022.

Table 54. Outcomes for FY 2019-20

Post Graduates	Number of Psychiatric Residents	Rotations
Year 1 Post Graduates	6	• 1 month of university onboarding is done at CDU • Veterans Administration (VA) Long Beach (Inpatient Psychiatry): 4 months • Rancho Los Amigos (Inpatient Medicine): 2 months • Rancho Los Amigos (Neurology): 2 months • Kedren (Outpatient Medicine): 2 months • Harbor-UCLA (Emergency Psychiatry): 1 month
Year 2 Post Graduates	6	• VA Long Beach (Inpatient Psychiatry): 3 months • VA Long Beach (Consultation and Liaison): 2 months • VA Long Beach (Emergency Psychiatry): 1 month • VA Long Beach (Substance Abuse): 2 months • VA Long Beach (Geriatric Psychiatry): 1 month • Kedren (Inpatient Psychiatry): 1 month • Resnick Neuropsych Hospital UCLA (Child and Adolescent Psychiatry): 2 months

The above Post Graduate Year 2 rotation times represents averages. Individual resident rotations vary in their second year depending on areas of focus.

F. Intensive Mental Health Recovery Specialist Training Program

This program prepares individual, mental health consumers and family members, with a minimum of 2 years of college credit, to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This program is delivered in partnership with a mental health contractor and local community college. Successful completion of this program ensures that participants are qualified to apply for case management level career opportunities in the public mental health system. Due to COVID-19, only one cohort was able to complete this training.

During FY 2019-20, 21 individuals completed the training of which 81% represented individuals from un- or underserved populations, and 57% spoke a second language, other than English.

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

- Parent Partners Training Program
  This training program promotes knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children. It enhances resilience and wellness understandings increasing the availability of a workforce oriented to self-help, personal wellness and resilience grounded in parent advocate/parent partner empowerment. Lastly, the training program supports employment of parents and caregivers of children and youth consumers. During FY 2019-20, 96 parents were trained. Due to COVID-19, this program experienced a reduction in delivered training.

- Parent Partner Training Symposium
  The three-day symposium was held twice during the fiscal year and was attended by approximately 164 parent partners, each symposium. These training opportunities covered a wide range of topics including integrating care/co-occurring disorders; criminal justice issues; crisis intervention and support strategies; education; employment; homelessness; housing; inpatient/hospitalizations; LGBTQI issues; older adults; residential and group homes; suicide prevention, etc. Due to COVID-19, this program experienced a reduction in delivered training.

- Honest, Open, Proud Program
  Through the Illinois Institute of Technology, LACDMH offered technical assistance to participants who had completed the training during FY 2018-19. Due to COVID-19, only one participant was able to take advantage of this technical assistance offer during FY 2019-20. Additional components of this training are planned for subsequent fiscal years.

- Community Inclusion and Peer Support Program
  Through this training effort, the County has secured a trainer to develop and offer training and technical assistance to assist the health system in the implementation of practices and tools to promote and advance community participation for people in recovery through the intentional skills of Peer Supporters. During FY 2019-20, 74 individuals completed this training. Additional components of this training are planned for subsequent fiscal years.

- Wellness Recovery Action Plan (WRAP)
  This WRAP program will train participants through the process of identifying their personal wellness resources and how to use those resources as a guide for daily living, dealing with triggers, early warning signs of symptoms, indicators that things are

breaking down, and developing advance directive and post- crisis plans. Due to COVID-19, no training components were delivered during FY 2019-20. It is projected that delivery of this training will begin in subsequent fiscal years.

- Continuum of Care Reform (CCR)
  Assembly Bill (AB) 403, also known CCR, provides comprehensive transformation of the foster care system with the intent of achieving permanency planning for foster youth and their families. This legislation brings forth significant changes for group homes and respective providers that necessitate training for legislative compliance and provider readiness. To that end, LACDMH offered the following trainings and include topics subjects such as introduction to mental health, diagnosis/assessment and self-care:

Table 55. CCR training

Training	Service Provided
CCR: Child and Family Team Process Overview (CFT) FY 2019-20: 20 participants	This training will provide an overview of how the CFT process is utilized in the CCR. In CCR, the CFT process is the decision- making vehicle for case planning and service delivery. This training will review the elements involved in the CFT process, team members, and their roles. This training identifies the Integrated Core Practice Model elements embedded in the CFT process, and its role in providing collaborative services. Participants will learn engagement strategies and the importance of keeping the child and family's voice and choice at the center. Participants will learn strategies for effective teaming with children and families, and formal and informal supports. This training will review how teaming can promote positive permanency outcomes and assist with meeting the underlying needs of children. This training utilizes both didactic and experiential learning strategies to support the transfer of learning.
CCR: Integrated Core Practice Model Overview (ICPM) FY 2019-20: 292 participants	This training provides an overview of the CCR, ICPM practice standards. It highlights expansion of the California's Core Practice Model, including the core values, principles, and elements; additional discussion incorporates the model's practice wheel components and practice behaviors. Participants will learn to utilize interagency teaming strategies while providing services to children and families involved in the child welfare system. The child and family's voice and choice are of primary importance and supported utilizing a strength-based and trauma-informed approach. A review of safety, permanency, and well-being promote the tenets of the model throughout the training. Lastly, both didactic and experiential learning strategies serve to enhance application of understanding and knowledge.
Crafting Underlying Needs Statements and Services (UNDERLYING NEEDS) FY 2019-20: 25 participants	This training provides information on Underlying Needs and its application in the CCR process. It prepares providers to identify the relationship between underlying needs and youth's behavior as well as highlight the importance of engaging youth and families and empowering their voice and choice. Participants will learn approaches for effective teaming and collaboration with children and families and their formal and informal supports. Incorporation of the family's culture and functional strengths inform the needs based statement and support development of individualized services for youth and families in the child welfare system. Both didactic and experiential learning activities serve to enhance understanding, knowledge, skills and implementation of training strategies.
Engaging Probation Youth (PROBATION) FY 2019-20: 397 participants	This training will provide the audience with knowledge to recognize and understand trauma when observed in youth on probation through a trauma informed lens. The impact of trauma and its effects on the brain, attachment, physiology, and social relationships are examined. The overview includes discussion of the trauma informed approach, cultural sensitivity, and underlying needs. Strategies for engagement as well as staff's awareness of their countertransference are explored. Group activities are incorporated to enhance application of learning and address challenging behaviors. Lastly, the training covers self-care, and participants will develop self-care strategies for themselves.

Training	Service Provided
Everything You Have Wanted to Know About Psycho-Pharmacology: Medication Side Effects (MEDICATION) FY 2019-20: 397 participants	This workshop provides an introduction to common side effects that may be experienced by youth being prescribed psychotropic medications. Basic neurobiology and the role of neurotransmitters in psychiatric illness/medication response will be reviewed along with an update on the desired effects, duration of action, and side effect profiles of antidepressants, stimulants, anti-anxiety agents and anti-psychotic medications. The differences between an allergic response and a side effect will be reviewed and illustrated. The role of the Food and Drug Administration (FDA) will be reviewed to understand how medications come to market and side effects monitored. Cultural differences (based on population genetics) will be illustrated to demonstrate why certain illnesses/syndromes are more common in some groups, while medication side effects may occur more frequently in some populations and not others.
LGBTQ+ Youth in Placement: Strategies and Interventions (LGBTQ) FY 2019-20: 241 participants	This training seeks to provide the audience with a better understanding of trauma and barriers specific to LGBTQ+ youth in the child welfare and probation systems. A trauma informed lens will be utilized to increase participants' awareness of specific challenges that affect this vulnerable population. Using a culturally sensitive approach, trainers will highlight appropriate LGBTQ+ terminology as well as explore the impact of stigma and trauma, particularly as it relates to LGBTQ+ youth of color. This training discusses how community impacts LGBTQ+ youth and suggests strategies to support positive connections. Participants will learn about the Helm's Identity Development Model to conceptualize the coming out process and how to employ healthy approaches in their daily interactions with these youth. Trainers will provide practical applications to address bullying, LGBTQ+ challenges, the coming out process, and the CFT model. Group activities will enhance learning and increase one's self-awareness as it relates to this population.
Permanency Values and Skills for Child Welfare, Probation, and Mental Health Professionals (PERMANENCY) FY 2019-20: 110 participants	Every child needs a "no matter what" family for a lifetime. This includes children with special needs, sibling groups, older adolescents and children across all backgrounds and cultures. Adolescents need lifetime families, skills for successful adulthood and resources to support their safety and well-being. One of the core values of the CCR is permanency. This training supports the goal of permanency for children and youth involved in the child welfare system. Training discussions include understanding the value of taking a "both/and" approach when working with children and youth as well as learning skills and strategies that support achieving a "no matter what" family for every child. Case-based practice interventions are embedded to enhance the application of trauma-responsive, team-based 5-step approach. The training will also provide tools for addressing and working with youth who say "no" to permanency. Lastly, participants are provided strategies to support the achievement of permanency for child welfare involved children and youth including those stepping down from residential settings.
Prevent the Eruption: Trauma Informed De-Escalation Strategies (DE-ESCALATION) FY 2019-20: 634 participants	This training seeks to provide LACDMH, DCFS, Probation and Contract Provider staff with knowledge to recognize and better understand trauma when observed in children and youth; address the impact of trauma on the brain; and provide trauma informed care strategies using a developmentally appropriate and culturally relevant approach. This training will review the ascent of escalation phases, de-escalation phase clues and offer trauma informed interventions for each phase including specifics regarding the debriefing process and strategies for prevention of self-injurious behavior. Finally, the importance of self-care is discussed, and the participants will develop self-care strategies for their use.

Training	Service Provided
Engaging Runaway Youth in Placement: Overview and Strategies for Response (RUNAWAY) FY 2019-20: 30 participants	Most runaway youths struggle with substance abuse and mental health issues, are at high risk for being a victim of sex trafficking and have higher rates of involvement with the juvenile justice system. This training shall increase participants' understanding of the characteristics of youth who run and the impact of traumatic experiences and development on running behavior. It will provide strategies to reduce the risk of running, including recommended policy, practice, training, and direct engagement with youth. The curriculum will take a case based approach to designing implementable strategies to reduce risk to run. Following the introduction of core content, attendees will review case information using a multidisciplinary and collaborative lens to assist them in identifying effective strategies for engaging youth and reducing run risk. Teams will learn to develop safety plans that encompass run behavior prevention and intervention.
Self-Care for Providers (SELF-CARE) FY 2019-20: 21 participants	This training prepares CCR providers to identify the relationship between compassion fatigue and self-care strategies. Self-care and general well-being are essential components to prevent compassion fatigue and support quality services. Discussion will include risks factors, signs, and impact associated with compassion fatigue. Participants will learn the relationship between culture and self-care. Also reviewed are prevention approaches important for mitigating compassion fatigue risk and increasing self-care and resilience. Identification and integration of self- care strategies into daily practice are addressed. Lastly, this training incorporates both didactic and experiential learning to support transfer of understanding, knowledge, and integration of training objectives.
Supervision of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families (STIC) FY 2019-20: 78 participants	This six-hour training will review the use of competency-based supervision and essential components of trauma-informed care for implementation and monitoring purposes. Trauma-informed supervision is known for its protective factor attributes and in conjunction with trauma-informed self-care support are critical to supporting personnel. (Please Note: Trauma-informed supervision refers to security, respect, and trust within the supervisory relationship.) Knowledge, skills, and understandings regarding trauma-informed care, secondary trauma, the role of supervision within those, and positive self-care practices will be explored. This training will be highly experiential, focused on skills and enhancing understanding using vignettes and role-play by the trainer and the participants.
Supervision of Vicarious Trauma of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families (SVT) FY 2019-20: 98 participants	It specifically addresses the impact of vicarious traumatization on clinicians as well as supervisors of clinicians who work with the complexity traumatized. Included in the discussion is the role of effective competency-based supervision as a protective factor for clinicians and its facilitative factor impact on client efficacy treatment. This training will have both didactic and experiential components and incorporate current competency-based supervision strategies applicable to working in trauma-informed care. Vignettes serve to enhance the understanding and implementation of content to the supervisory role. The experiential component of the training addresses both supervisor and supervisee psychological resilience promoting their health and well-being within the context of trauma work.
Trauma-Informed Practice for Child Welfare Involved Children and Families (TIC) FY 2019-20: 370 participants	This foundational trauma-informed care training supports the CCR requirement that services provided to child welfare children and families are trauma-informed. This training introduces key and essential trauma recovery skills that staff and programs can use to provide a safety-oriented, trauma-informed framework for youth and families. Participants will be provided with an overview of developmental trauma implications on the brain and behavior. Participants will learn tools to recognize trauma related behaviors and respond in ways that foster resilience. This training will review practice strategies to effectively engage foster youth who have experienced trauma. As a result of this training, participants will gain knowledge and skills to deliver services through a trauma-informed lens.

Training	Service Provided
Youth Mental Health First Aid Course (YMHFA) FY 2019-20: 35 participants	Mental Health First Aid teaches a 5-step action plan to offer initial help to people with the signs and symptoms of a mental illness or in a crisis, and connect them with the appropriate professional, peer, social, or self-help care. Anyone can take the 8-hour Mental Health First Aid course - first responders, students, teachers, leaders of faith communities, human resources professionals, and caring community members.
Youth with Developmental Disabilities and Mental Illness: Overview and Interventions (MHDD) FY 2019-20: 22 participants	The Co-occurring Development Disabilities (CDD) Program trains mental health clinicians to assess and treat mental health issues that consumers with CDD are at high risk of developing. The curriculum will provide participants with tools to differentiate the mental health issue from the intellectual/developmental disability and to treat the mental health issue in context of the CDD as well. During the training, the participants will learn to apply the Diagnostic Manual-Intellectual Disability (DM-ID-2): A Textbook of Diagnosis of Mental Disorders in Person with Intellectual mental health problem(s). Knowledge and expertise related to these diagnostic tools are increasingly valued as a complement to the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM V).

H. Financial Incentive Programs

- Mental Health Psychiatrist (MHP) Student Loan Repayment Incentive
  LACDMH offers a financial incentive towards the outstanding balance of student loans for full-time MHP and Supervising MHP who have completed one-year of continuous service at LACDMH and have active, unpaid, graduate, or medical, student loans. Eligible psychiatrists who have not participated in or have received funds from the MHP Recruitment Incentive program, will receive a maximum annual amount of up to $50,000 for a period of five years which equates to a lifetime total of $250,000. During FY 2019-20, 17 mental health psychiatrists where awarded. Of these awardees, 13 (76%) identified as representing ethnic minorities and seven (41%) spoke a second language.

- MHP Recruitment Incentive Program
  This program targets recruitment of potential Mental Health Psychiatrist for employment in the public mental health system. For eligible full-time MHP and Supervising MHP who have completed one year of continuous service in LACDMH and who have not participated in or received funds from the Student Loan Repayment Incentive program, a one-time award of $50,000 will be granted consisting of $25,000 upon completion of the first year of continuous service at LACDMH, and an additional payment of $25,000 upon completion of the second year of continuous service. During FY 2019-20, two individuals were recruited and awarded.

- MHP Relocation Expense Reimbursement
  Available to full-time, newly hired MHP or Supervising MHP who have been recruited by LACDMH. The maximum reimbursement amount for eligible relocation expenses is $15,000. If the employee leaves LACDMH within one-year from employment start date, the full reimbursement amount must be repaid. During FY 2019-20, one individual was awarded.

- Stipend Program for MSWs, MFTs, and Psychiatric Nurse
  LACDMH provides 2nd year students with education stipends in the amount of $18,500 in exchange for a contractual obligation to secure employment in a hard-to-fill area of the county for a minimum of 1 year. This program targets students who are linguistically and/or culturally able to service the traditionally unserved and underserved populations. During FY 2019-20 this program awarded stipends to 4 Nurse Practitioner, 70 MFT and 70 MSW students. During this award cycle, all stipends were awarded. Of all awardees,

81% of recipients identified from populations recognized as un- or under- served. Likewise, 78% spoke a threshold language.

WORKFORCE EDUCATION AND TRAINING	
Prior FY 2019-20	**Prior FY 2018-19**
$14.8 million Total Gross Expenditures	$15.9 million Total Gross Expenditures
FY 2021-22	**Three-Year Plan FYs 2021-24**
$19.0 million Estimated Gross Expenditures	$57.1 million Estimated Gross Expenditures

Does not include program administration costs

INNOVATION (INN)

FY 2019-20 ■ INNOVATION Data and Outcomes

A. INN 2: Community Capacity Building to Prevent and Address Trauma

This project centers on building the capacity of the community to identify and support community members at risk of trauma or experiencing trauma. The project aims to utilize the assets of the community to test strategies that allow local communities to work together in ways that will ultimately lead to better mental health and reductions in trauma, through the building of shared community values, leadership development and community member empowerment.

Ten lead agencies were approved, two in each Supervisorial District, to establish community partnerships in geographically-defined communities. The identified communities are those with a concentration of inequalities, including disproportionate levels of poverty, high concentrations of unserved and underserved individuals and poor health and well-being outcomes, including educational and unemployment inequities. Lead agencies were selected through a solicitation process. Each proposing organization and their community partners select specific strategies from the menu below, based on their community's interests. Beyond the implementation of selected strategies, each community partnership is responsible for building the capacity of the specific communities to work collectively toward supporting community identification and reduction of trauma, as outlined in the solicitation.

Strategies

- Community Ambassador Network (CAN) the newest strategy added to the project extends across all providers, which streamlines all peers into this network of community ambassadors to educate and empower the communities, primarily at this time, around COVID-19. The CAN will emphasize and expand upon the community capacity building already central to the INN 2 project.
- Building Trauma Resilient Families targeting children ages birth to five and their caregivers who have experienced trauma and/or are at risk for trauma. Activities include assessing and educating families and young children for exposure to Adverse Childhood Experiences (ACES).
- Trauma-Informed Psycho-education and Support for School Communities Training/workshops on recognizing behaviors and symptoms of stress and trauma in children provided to early care/education and school personnel and community mentors who work with children ages 0-15. The workshops would teach simple trauma-informed coping techniques that can be implemented within EC/E and school settings to reduce stress experienced by children.
- Outreach and engagement to TAY and TAY peer support groups to outreach and engage TAY who are at risk of or experiencing trauma as a result of homelessness.
- Coordinated Employment within a community. Through a standardized employment assessment tool, a network of businesses within a specific community will be created that will provide coordinated job opportunities to individuals who are mentally ill and homeless/formally homeless. Job opportunities will be sought out in the competitive employment market and through the development of social enterprises within the neighborhood.
- Community Integration for individuals with a mental illness with recent incarcerations or who were diverted from the criminal justice system. A community response involving the creation of a consortium of law enforcement, the courts and community agencies designed to reduce re-incarcerations.

- Geriatric Empowerment Model designed to outreach, engage and house homeless older adults.
- Culturally competent non-traditional self-help activities for families with multiple generations experiencing trauma, including engagement, intergenerational story- telling and intergenerational mentorship programs.

Currently, Innovation 2 is halfway through the third year of this four year project. Since the implementation of the INN 2 project, there have been a two-day kick off and eight (8) learning sessions, attended by INN 2 lead agencies, community partners, community members, and each session filled with informative experts sharing their knowledge on various keynote subject matter, in addition to INN 2 partner presentations. The INN 2 team has called in, attended in-person/virtually and reviewed the minutes from over 500 community partner, provider and TAY network meetings.

Since the inception of this project, nine (9) lead agencies and their community partners/subcontractors have implemented one or more of seven identified key strategies for capacity building focused on targeted outreach and community empowerment. All partnerships and participants have been tasked with registering in Innovation Outcomes Management System (iHOMS) in order to track outcomes, data and observe various learning curves related to the strategies of this project, including major pivots affecting lead agency work during the pandemic. Lead agencies that have implemented more than one capacity building strategy have higher INN 2 participant enrollment in general, and the data collection system is accurate although at times may under-report actual participation and community engagement by a particular agency when participants disappear from returning for further engagement. The INN 2 COVID-19 pivots have included the addition of the CAN and specified data collection for both the CAN and COVID-19 specific activities and outreach and engagement.

During the first two and a half years of the INN 2 project (2018-2020), lead agencies have committed themselves and their partnerships to serving their communities in trauma-informed ways, and while the goals for this project are innovative in that they are not delivering traditional direct mental health services, the community capacity vision of a non-traditional approach has been serving all communities very well, based on the data collection.

Learning Sessions are held quarterly (January, April, July and October) and have been designed intentionally to be dynamic and support real-time learning for partners and LACDMH Staff. As such, Learning sessions included expert training, peer learning and discussions. Activities conducted within each Learning Session have strengthened community capacity building tools and skills, built trust and deeper relationships among partners' and have used evaluation data for expansive learning. To-date, Innovation 2 has conducted 8 full Learning Sessions.

During this unprecedented time of COVID-19, which has impacted INN 2 communities and beyond, the work of the lead agencies and their partners has been unwavering. By leveraging existing relationships and partnerships, each lead agency was able to identify available resources and connect with community members with needed supports (i.e., housing, food, mobile shower units, hot meals, rental assistance and a multitude of linkages) while expanding various social media platforms and creating a higher visibility for providing these resources and services. Virtual agency and partnership meetings have moved to Zoom and other teleconferencing platforms, allowing every individual to continue on with important, life-changing work and remain connected. It should also be noted that a COVID-related category

has been implemented on the iHOMS database, allowing for the tracking of all lead agency COVID-related data.

Many lead agencies have used social determinants of mental health to identify at-risk and vulnerable populations within their communities. Using social media to educate their communities with accurate virus information, reopening, available concrete supports, outreach and engagement, education, training and census participation and voting information during the 2020 election, this project has slowly transitioned to a platform that has identified deeper community needs and the plan to incorporate CAN moving forward for the next two years.

Cultural Humility Workgroups have designed a framework and associated goals in conjunction with the assistance of the evaluation team for INN 2. This workgroup initially convened in December 2019, composed of agency representatives. Over the course of several meetings, the workgroup has discussed the intersection of cultural competence and trauma-informed care, with the goals remaining aligned with community capacity building strategies.

Sustainability planning has been implemented during this past year. Template guides were dispersed to each lead agency along with thought-provoking brainstorms during monthly partnership meetings for project expansion and future funding planning projected for after the fourth year conclusion of joint lead agency-LACDMH collaboration. The anticipated keys for sustainability that have been discussed included the "Three C's": connectedness, collective agency (combined personal agency of all community members) and community capacity building.

Outcome Measures

Learning from both qualitative and quantitative sources is necessary to document how strategies are successful at increasing community awareness of trauma and partnerships' ability to support community members who have experienced trauma or are at risk of experiencing trauma. The quantitative measurement approach focuses on implementing tools and outcome measures that support continuous learning. This approach focuses at two levels of the project.

At the close of 2020, nearly 4,000 participants have been registered in iHOMS. The iHOMS system was launched in February 2019 to support completion of two partnership measures, the Wilder Collaboration Factors Inventory and the Social Network Survey. The system has since evolved in parallel with INN 2, and now supports tracking outreach and engagement activities and linkages with resources and supports, as well as outcome measurement for INN 2 participants. Programmers are currently continuing to expand the reporting and data sharing capabilities. To-date, the majority of the data collected is from INN 2 participants who are families with young children between the ages of 0-5 (> 32%), TAY (> 25%) and individuals who were recently incarcerations or diverted from the justice system (> 17%).

- Measurement of the partnerships, using the Wilder Collaboration Factors Inventory, Social Network Survey and Trauma-Informed Partnership (TIP) Self-Assessment, to document partnership development and coalition building.
- The impact of capacity building strategies on INN 2 participants is measured using the Conner-Davidson Resilience Scale (CD-RISC-10), COPE Inventory (Brief Version) and Inclusion of Community in Self (ICS) Scale.

The following are a brief overview of outcome measurement tools used:

- The ICS Scale is a pictorial measure designed to understand one's perception of connectedness with the community.
- The CD-RISK-10 is a 10-item self-report measure of an individual's level of resilience. Resilience may be viewed as a measure of successful stress-coping ability, which varies with time and context.
- The COPE Inventory is a multidimensional self-report measure to assess the different ways in which people respond to stress. The 28-item Brief COPE items assess a broad range of coping responses, such as positive reframing, active coping, self-distraction, denials acceptance, substance use, and venting.
- The Wilder Collaboration Factors Inventory is a 44-item research-based assessment tool designed to measure twenty-two factors that influence the success of collaboration.
- The Social Network Survey is a 2-item survey designed for INN 2 to visualize partnership structure and changes in communication within partnerships over the course of INN 2.
- The TIP Self-Assessment is based on the Trauma-Informed Organizational Toolkit. The 36-item assessment is intended as a tool to help organizations assess their knowledge of trauma-informed culture within their partnership.

Additional Qualitative Breakdown of the Analysis Approach for This Project To-Date:

- The average score for INN 2 participants on the ICS Scale at baseline was > 3.63 with more than 36% of participants in the 3 to 4 range (a scale used to gauge the relationship between participant and their community), demonstrating some sense of interconnectedness within the community on average. The overall data suggests that individuals may feel higher levels of connectedness through participation in Innovation 2. (Connectedness)

- The average CD-RISC-10 score for INN 2 participants at baseline was greater than 28 out of scoring higher than 40, with higher scores indicating greater resiliency. This measurement tool uses a scale to gauge between "sometimes true" and "often true" for participants who have experienced resilience in the aftermath of trauma. The average CD-RISC score for participant assessments was around 30.5+, which is a statically significant increase compared to baseline. This data suggests that some individuals may feel more resilient through participation in Innovation 2. (Resilience)

- Brief Cope scores are presented for two overarching coping styles, avoidant coping and approach coping. Avoidant coping can be linked with poorer physical health and is shown to be less effective at managing anxiety. Approach coping is associated with more helpful responses to adversity, including adaptive practical adjustment, better physical health outcome, and more stable emotional responding. Emotional avoidance is a common reaction to trauma. The average approach coping score for INN 2 participants at baseline was greater than 36 and the average avoidance coping scores at baseline was more than 23 out of 48+. This data suggests that INN 2 participants perceive that they use more coping skills than avoidant when they confront difficult or stressful events. During a review of annual assessment inventory, fewer participants felt that they were "learning to live with it" and were "doing things to think about it less" when it came to their trauma. (Coping Skills)

- Progress for the Wilder has evolved over the past year, as most agencies have moved past previous challenges related to forming their partnerships. The progress achieved as a result of this year-long evolution was likely facilitated by relationship building, using partnership data to identify areas for growth. This data also helped frame Learning Session agendas, and agencies collaborating to develop the vision and implementation

plans moving further along for INN 2 throughout year 2. Annual review of data evaluates relationship building, partnership growth and progress, which helped frame Learning Session agendas, agencies collaborating and fine-tuning their vision for INN 2 plans. (Partnerships and capacity building data collection tool)

- Social network analysis (SNA) is a science to understand structure, interactions, and relationships among individuals in a group. SNA illustrates communication patterns and information flow among individuals who are connected to each other. From the SNA, we hope to better understand who communicates with who within partnerships and how these communication patterns evolve as partnerships develop. The SNA will always be able to identify each network's most influential people, then analyze create or amend the network maps around centralized key players. INN 2 data suggests a consistently favorable political and social environment and a history of community leadership which has included a statistically significant increase in new relationships, with over 58% of partners completing this measure. Over 20% partnership increase in participation of the SNA survey, and networks averaging around 60+ partners at an increase of over double from the previous year (2019).

- The TIP Self-Assessment is based on the Trauma-Informed Organizational Toolkit and is intended as a tool to help organizations assess their trauma-informed knowledge and culture within a partnership. It is not a measure of what individuals know about trauma, but rather the opportunities for education and training with an organization/partnership. the TIP includes three areas of focus: CRM, Emotional CPR/Mental Health First Aid and LACDMH's Becoming Trauma-Informed/general care trainings approaches.

  The core objective for TIP data collection is to understand each partnerships' readiness to implement trauma-informed approaches and identify core knowledge components of trauma needed to teach others. A bi-annual review (every six months) of the 2020 data has shown over 77% of partners reported participating in a trauma-informed care training as part of their role for Innovation 2. The most common trainings included "Community Resilience Model (CRM)", "Emotional CPR"/"Mental Health First Aid", and LACDMH's "Becoming Trauma-Informed" among other general Trauma-Informed Care trainings. Over 88% of INN 2 partners felt there were education and training opportunities on the definition of traumatic stress, what the relationship between trauma and mental health is and how traumatic stress affects the brain and body.

  Seventy nine percent of INN 2 partners learned about how trauma affects a child's development through this project's training and education. Over 75% have identified opportunities about how working with trauma survivors impacts the general community as a whole.

Summary

Overall, training and education for all partners is crucial to becoming trauma-informed as the data has suggested. Having shared knowledge about these specific topics ensures that partners have the same level of uniform understanding and can consistently provide similar types of trauma-sensitive responses. All CAN are currently being trained in both the COVID-19 LACDMH/DPH/DHS collaborative training and the Community Resiliency Model (CRM), and in turn will deliver both these trainings to their surrounding communities.

B. INN 3: Help@Hand (formerly Technology Suite)

Help@Hand (previously known as the Innovation Technology Suite) is a multi-county and city collaborative project, with potential to reach over half of the California population, that aims to use a menu of innovative digital mental health solutions, to increase access to care and well-being. Based on initial learnings from the first year of the project, LACDMH focused its local target populations and aims to:

- Focus on engaging college, graduate, and vocational students with a set of technology applications that aim to meet their mental health and well-being needs and/or assist in linking them to appropriate levels of care and supports;
- Improve mental health and well-being of *County employees* by increasing access and engagement to digital technologies supporting mental health and well-being;
- Improve mental health and well-being of *County residents* by increasing access and engagement to digital technologies supporting mental health and well-being; and
- Improve engagement among individuals receiving services at LACDMH through digital mental health and well-being tools.

After receiving approval from the MHSOAC on October 26, 2017, LACDMH entered into an agreement with the California Mental Health Services Authority (CalMHSA), a Joint Powers Authority utilized by counties, to facilitate the administrative functions such as fiscal, contract, and project management, of this multi-county and city project. The participation agreement was approved by Board of Supervisors in February 2018. Participating county mental health departments aim to bring technology-based mental health solutions into the public mental health system with objectives to:

- Increase access to the appropriate level of care;
- Reduce stigma associated with mental illness by promoting mental wellness;
- Detect and acknowledge mental health symptoms sooner;
- Increase purpose, belonging, and social connectedness of individuals served; and
- Analyze and collect data to improve mental health needs assessment and service delivery.

Los Angeles, Kern and Mono counties participated in vendor selection for technologies in February 2018 and selected 7 Cups and Mindstrong as initial vendors. In April 2018, Orange and Modoc counties were approved to join the Technology Suite and, in September 2018, 10 additional counties were approved, for a total of 15 counties and cities. During the early summer of 2018, RSE was selected as an outreach, engagement and marketing firm and the University of California, Irvine as the evaluator of the project.

Significant learning was accomplished in the initial phase of the project with the piloting of the first two applications. LACDMH is piloting the Mindstrong care application at Harbor-UCLA's outpatient Dialectical Behavioral Therapy (DBT) program as a strategy to promote early detection of emotional dysregulation. LACDMH also piloted 7Cups as a digital tool (application and web-based) to increase social connectedness through chat and well-being through growth paths and educational, self-help content.

Status of implementation as of December 1, 2020: Project is on hold

C. INN 4: Transcranial Magnetic Stimulation (TMS)

LACDMH implemented Mobile Transcranial Magnetic Stimulation (TMS) as the Innovation 4 project. TMS is FDA approved for the treatment of depression and is a non-invasive treatment that can enhance or suppress the activity of neurons in targeted areas of the brain through the use of electromagnetic stimulation. According to the American Psychiatric Association best practice guidelines for the treatment of major depressive disorder, TMS is now a first-line treatment for depression that has not responded to one antidepressant medication (APA 2010) as well as being effective for treatment-resistant depression.

TMS uses precisely targeted magnetic pulses similar to those used in Magnetic Resonance Imaging (MRI) to stimulate key areas of the brain that are underactive in clients with depression. The client reclines comfortably in the treatment chair and is awake and alert during treatment. An electromagnetic coil is then placed on the skull directly to the target area of the brain where the device generates magnetic fields that alter the electrical activity of neurons. The enhancing or suppressing of neuron activity depends upon a number of variables including the frequency of the TMS pulses. During treatment, the client hears a clicking sound and feels a tapping sensation on the head. The client can go back to their normal activities immediately after treatment. Treatment can last between 3-45 minutes and is administered once per day for 5 consecutive days per week for 4-8 weeks.

In April 2018, LACDMH was approved to implement a Mobile TMS program via in a mobile van outfitted with the technology, delivered to fully consenting clients receiving services in adult outpatient programs. The target population includes individuals receiving outpatient services that have a depression as a major part of their psychiatric symptoms and one or more of the following:

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

Given the nature of the TMS treatment, individuals with a history of seizure disorder and those with metal implants in the head or upper torso (e.g., cardiac pacemakers) are excluded. The goals of The INN 4 Mobile TMS Project include:

- Provide access to new and effective treatment to clients with chronic and severe mental illness
- Increase adherence to treatment by bringing the treatment to the client
- Reduce use of other resources (i.e., psychiatric hospitalization, Emergency Room visits, intensive supportive services, etc.)
- Improve social and occupational functioning that would lead to successful community reintegration
- Increase the quality of life of clients with histories of poorly treated depression.
- Overall, the primary purpose of this Innovation project is to improve the quality of mental health services and achieve greater outcomes by providing new and effective treatment to clients with chronic and severe mental illness. This project seeks to introduce a new approach or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.

Status of implementation as of December 1, 2020

Provision of service for this project began on May 30, 2019 after obtaining a mobile TMS unit. The mobile TMS unit consists of a customized van with modifications that allow a small treatment team to deliver TMS treatments within it. Clients of directly operated clinics are referred to the TMS program by their outpatient providers (psychiatrists or clinicians). After receiving referrals, clients have an in-person consultation with the TMS program director (Marc Heiser, MD, PhD) during which their symptoms, treatment history, and medical history are reviewed, and a safety screening form and initial symptom rating scales are completed. The treatment is explained and demonstrated for the clients and clients have the opportunity to ask any questions. If they are interested and the treatment is appropriate, an informed consent form is completed and they are scheduled for their initial treatment.

Until March 13, 2020, clients were being referred and receiving daily (Monday- Friday) treatments within the mobile TMS unit at one location, the Harbor UCLA Outpatient Psychiatry Clinic. While the TMS unit has been at one location, the program has received referrals and treated clients from six LACDMH clinics located throughout LA County (including SAs 2, 3, 5 and 8).

Mobile TMS services were put on hold as of March 14, 2020, due to COVID-19. Due to the intensive treatment schedule that TMS services require (5 days per week for approximately 4-6 weeks), in general, clients sometimes have difficulty adjusting to the change and experience a sudden worsening of depressive symptoms. Therefore, TMS staff completed phone check-ins with TMS clients as soon as possible to assess how they were coping with the transition and continued to conduct phone check-ins 1-2 times per week while they were not receiving TMS services, to the extent possible. PHQ-9 scores were also completed over the phone weekly with each client while they were not receiving TMS services in order to track depressive symptomology. This information is used to monitor clients and determine the need for a client to return for TMS treatments with a decreased frequency (provided 1-2 times per week) until TMS services are back up to scale in FY 2020-21.

Number of clients served:

As of March 13, 2020, the program had received 47 referrals. Between May 1, 2019 and March 13, 2020, 40 consultations were completed and 29 clients have received TMS treatments. 16 of these clients completed a full TMS treatment course.

Three clients did not complete a full treatment course, but only one out of the three was due to difficulty tolerating the treatment. One of the others could not complete the treatment course due to entry into a residential substance use program. The other client who did not complete a full course of TMS had an exacerbation of unrelated medical problems that made it too difficult to attend daily treatments. A number of clients had treatment interrupted by the COVID-19 pandemic and have now restarted treatments.

Below is a summary of the demographic information on the 16 clients who completed a full treatment course of TMS as of March 13, 2020:

- The majority were adults (ages 26-59) 75%, while 25% were older adults (60+ years)
- The majority identified as male (69%) versus female (31%)
- The majority identified as Non-Hispanic/Latino (75%). 19% identified as Hispanic/Latino and for 6% of the clients, the ethnicity was unknown.
- Half identified as White (50%) followed by Mexican (13%). Other races included Asian Native (6%), Black/African American (6%), Cambodian 6%), and Korean (6%). The race of 13% of clients was unknown.

- The majority of clients stated that their primary language was English (81%). Other primary languages included Spanish (13%), and Cambodian (6%).

Outcome data being collected and any analysis of impact to date:
The Overarching Learning Questions for this project include the following:
- Will these individuals be adherent with a mobile TMS treatment program?
- Is TMS an effective treatment for this population?
- Does TMS for depression lead to improvement in comorbid symptoms (i.e., substance use, psychotic symptoms, etc.)?
- If TMS is an effective treatment for this population, should the program be expanded to treat a larger part of the population?

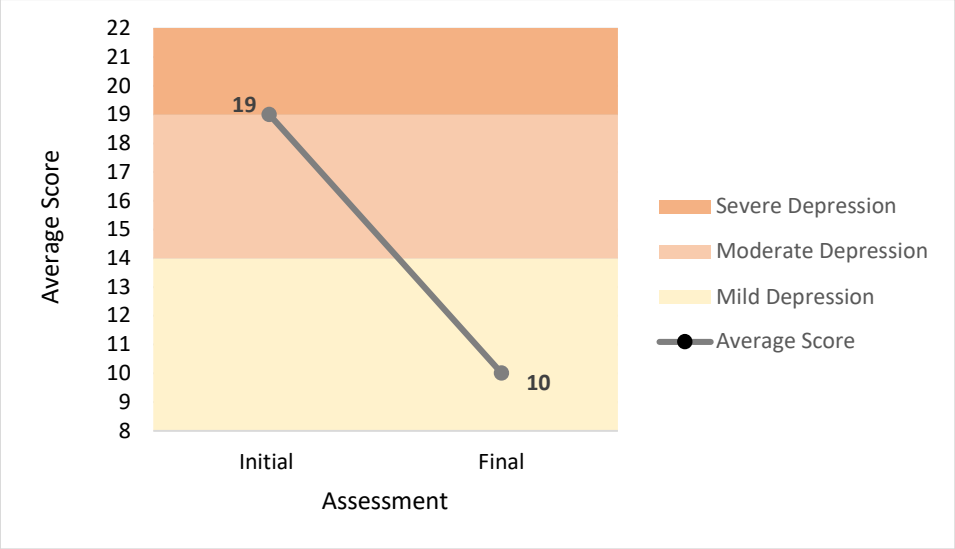
To assess the impact of TMS, depression outcome measures are administered at the beginning of treatment and weekly throughout the course of treatment. Measures include the following: Quick Inventory of Depressive Symptoms (QIDS-SR-16, client rated), the Hamilton Depression Rating Scale (HAM-D, clinician rated), and the Patient Health Questionnaire (PHQ-9, client rated). Client satisfaction with TMS is also assessed at the end of each session, utilizing a verbal check in, and using a Client Satisfaction Survey at the end of treatment. These assessment tools enable clinicians to track improvements in depressive symptoms and functional outcomes that can, in turn, will be used to judge the efficacy of this program.

Below is a summary of the data gathered for clients who completed a full treatment course between May 1, 2019 and March 13, 2020. Data included is for clients who received at least two treatments of TMS and completed the respective measure at least twice.

Hamilton Depression Rating Scale (HAMD-17)
The HAMD-17 is one of the longest standing, most widely used measures of depression in research and clinical practice. The HAMD-17 is a clinician completed measure that includes 17-items. Total scores of 0-7 indicate no depression; scores of 8-13 indicate mild depression, scores of 14-18 indicate moderate depression, scores of 19-22 indicate severe depression, and scores 23-50 indicate very severe depression.

For the clients who received TMS treatment during this period, the average starting HAMD-17 score was 19 which indicates severe depression. At the end of treatment, the average score was 10, which indicates mild depression. *There was an average change in score from the beginning to end of treatment of 9 points (47% decrease), which indicates that there was an overall improvement in depressive symptoms at the end of the course of TMS treatment.*

Figure 35. Summary of Average HAMD-17 Scores for Mobile TMS clients (n = 16)

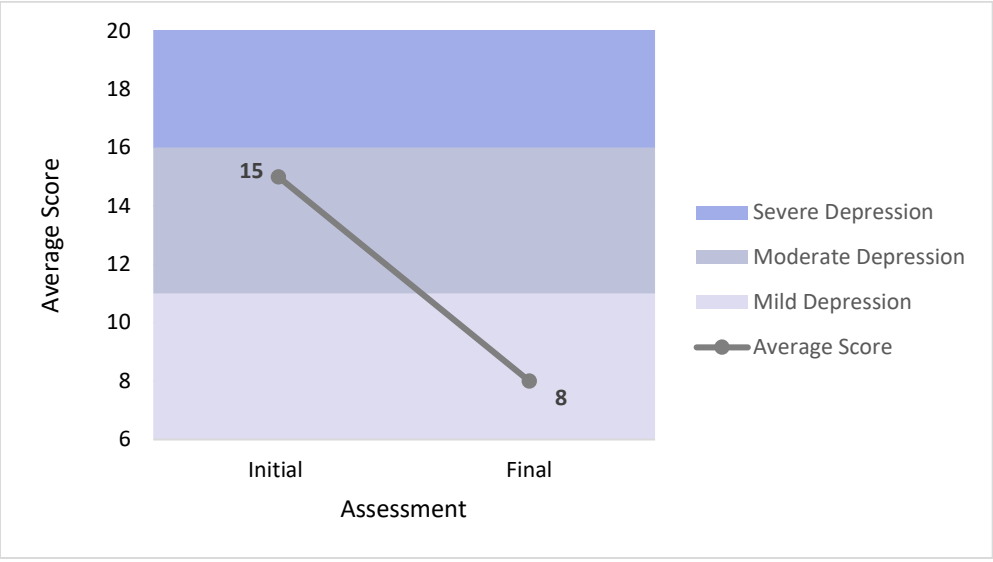


Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR-16)

The QIDS-SR-16 is a 16-item self-report measure of depressive symptom severity derived from the 30-item Inventory of Depressive Symptomatology (IDS). There are nine depression symptoms measured across the 16 items (sleep, mood, appetite/weight, concentration, view of self, suicidal ideation, interest, fatigue, and psychomotor). Scores 1-5 indicate no depression; scores of 6-10 indicate mild depression; scores of 11-15 indicate moderate depression; scores of 16-20 indicate severe depression; scores 21-27 indicate very severe depression.

For the clients who received TMS treatment during this period, the average starting QIDS-SR-16 score was 15, which indicates moderate depression. At the end of treatment, the average score was 8, which indicates mild depression. *There was an average change in score from the beginning to end of treatment of 7 points (47% decrease), which indicates that there was an overall improvement in depressive symptoms at the end of the course of TMS treatment.*

Figure 36. Summary of Average QIDS-SR-16 Scores for Mobile TMS clients (n = 13)

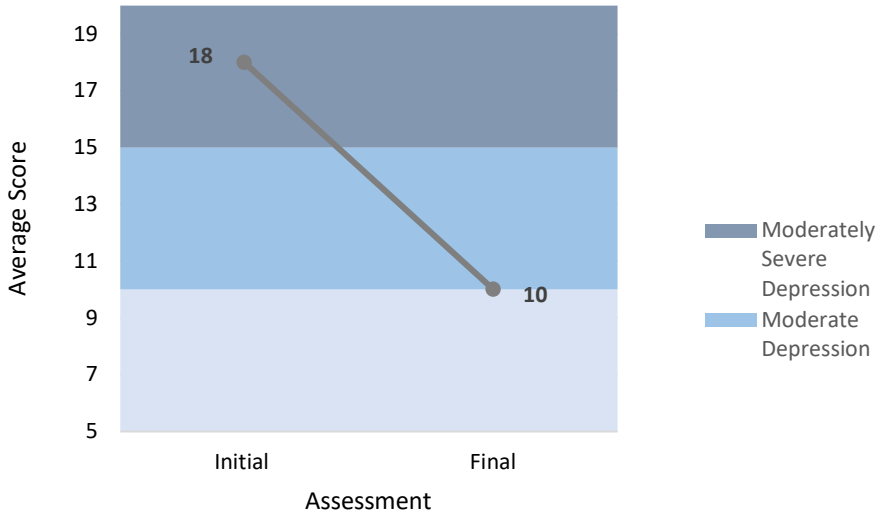


Patient Health Questionnaire (PHQ-9)

The PHQ-9 is a concise, self-administered screening tool for assessing depression. It incorporates DSM-IV depression criteria with other leading major depressive symptoms into a brief self-report instrument that is commonly used for screening and diagnosis, as well as selecting and monitoring treatment. Scores of 0-4 indicate minimal depression; scores of 5-9 indicate mild depression; scores of 10-14 indicate moderate depression; scores of 15-19 indicate moderately severe depression; and scores 20-27 indicate severe depression.

For the clients who received TMS treatment during this period, the average starting PHQ-9 score was 18, which indicates moderately severe depression. At the end of treatment, the average score was 10, which indicates moderate depression. *There was an average change in score from the beginning to end of treatment of 8 points (44% decrease), which indicates that there was an improvement in depressive symptoms at the end of the course of TMS treatment.*

Figure 37. Summary of Average PHQ-9 Scores for Mobile TMS clients (n = 16)



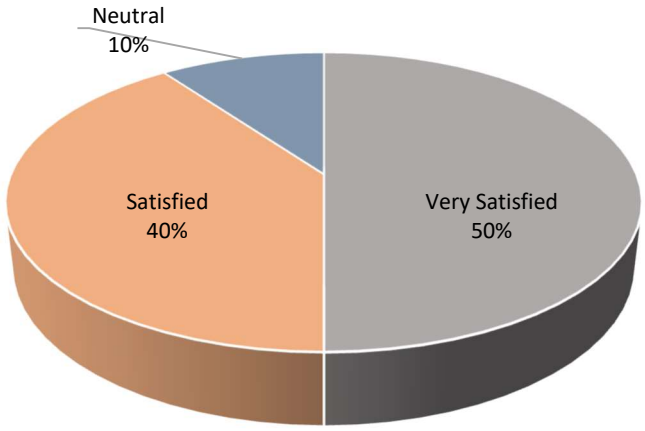
TMS Client Satisfaction Survey

The TMS Client Satisfaction Survey was developed by LACDMH and was completed by clients who completed a full course of TMS treatment. The Client Satisfaction Survey includes 11 items that assess satisfaction with various aspects of TMS treatment and the impact of TMS on the client's overall well-being and functioning.

Overall Satisfaction [Chart 1]:

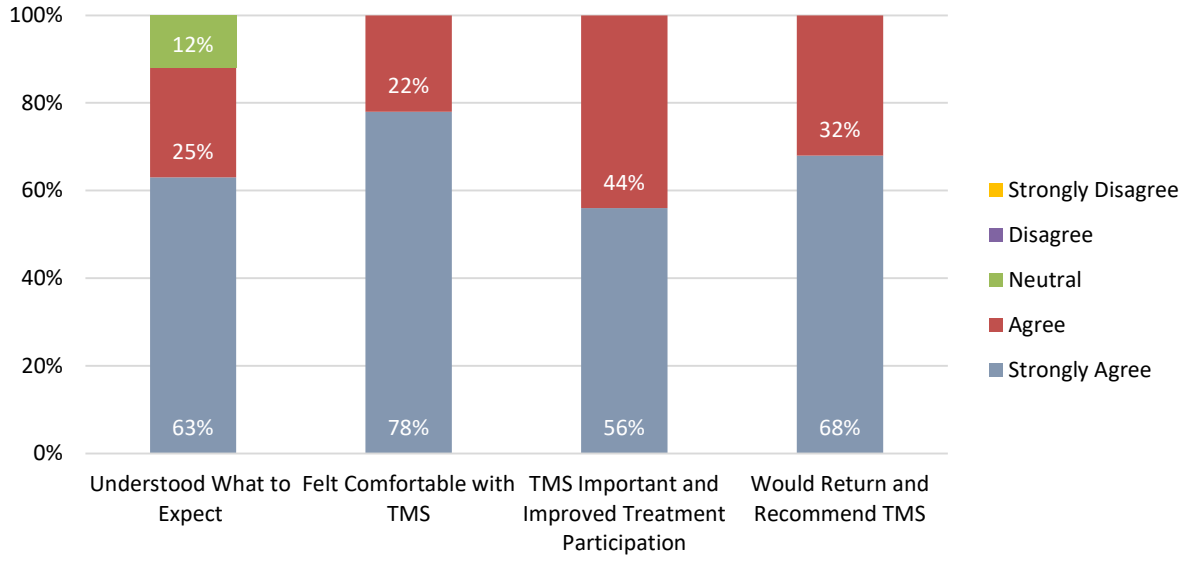
Overall, a majority (90%) of respondents were "Very Satisfied" or "Satisfied" with their TMS experience, which is 17% increase since December 1, 2019. None of the clients were dissatisfied with their TMS experience.

Figure 38. Overall Satisfaction with Mobile TMS services (n = 10)



TMS Treatment Experience [Chart 2]:
A majority of respondents (88%) "Strongly Agreed" or "Agreed" that they understood what to expect before starting TMS treatment. All respondents (100%) "Strongly Agreed" or "Agreed" that they felt comfortable while receiving TMS services. As well, all respondents (100%) "Strongly Agreed" or "Agreed" that TMS services have been an important part of their treatment and that TMS services have improved their participation in their treatment. Finally, all respondents (100%) "Strongly Agreed" or "Agreed" that they would return for more TMS treatments in the future if recommended by their clinician and would recommend TMS to others if they are experiencing depression.

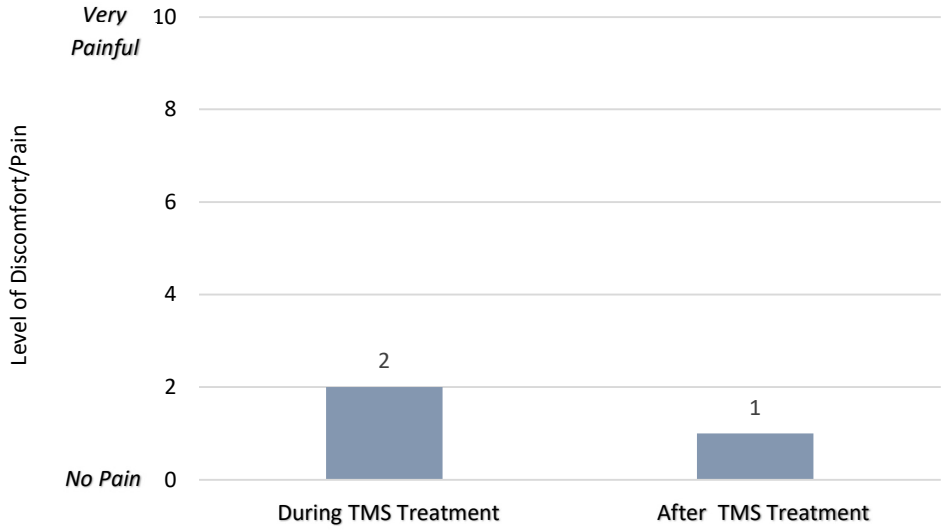
Figure 39. Feedback on Mobile TMS Experience (n = 10)



Level of Discomfort/Pain during and after TMS Treatment [Chart 3]:
Clients were asked to rate their discomfort/pain during TMS treatments and after TMS treatments on a scale of 1-10, with 1 corresponding to "No Pain" and a score of 10 corresponding to "Very Painful". On average, respondents felt mild discomfort/pain during TMS treatments (*2 out of 10*) and less mild discomfort/pain after TMS treatments (*1 out of 10*). Clients most often described

discomfort/pain as “annoying” and the the discomfort usually decreased over the course of treatment and resolved after treatment.

Figure 40. Average Level of Discomfort/Pain During and After Mobile TMS Treatments (n = 8)



Perceived Benefits of TMS Services:
Clients (n = 8) were asked how they felt they benefitted from participating in TMS services. As a result of TMS services:

- 60% of respondents stated that they that they feel happier.
- 50% of respondents stated that they feel less worried/anxious.
- 30% of respondents stated that they are sleeping better, feel less frustrated, have more contact with family/friends, have more motivation to engage in meaningful activities, and that they have an increased abilty to do the things that they want to do.
- 20% of respondents stated that they are able to focus better, feel more relaxed, have more energy, and have more self-confidence.
- 10% of respondents stated that, as a result of TMS services, they are eating better, feel less body pain, and are getting along better with family/friends.

Treatment Team Survey

A survey was provided to each of the client’s treatment team of providers. The providers were asked to rate their perception of their client’s improvement in mood, behavior, overall functioning, and progress made toward treatment goals as a result of TMS services. A total of 15 of surveys (for 13 clients) were completed by treatment team staff (11 Psychiatrists, 3 Case Managers, and 1 Registered Nurse).

- A majority (60%) of providers “Strongly Agreed” or “Agreed” that their client demonstrated improvements in mood, behavior, and overall functioning (family, community, occupational) as a result of TMS services [Chart 4].
- A majority of providers (53%) “Strongly Agreed” or “Agreed” that their client made progress towards his/her treatment goals as a result of TMS Services [Chart 5].

Figure 41. Provider Perception on the Impact of TMS - Services on Client's Mood, Behavior, and Overall Functioning (n = 15)

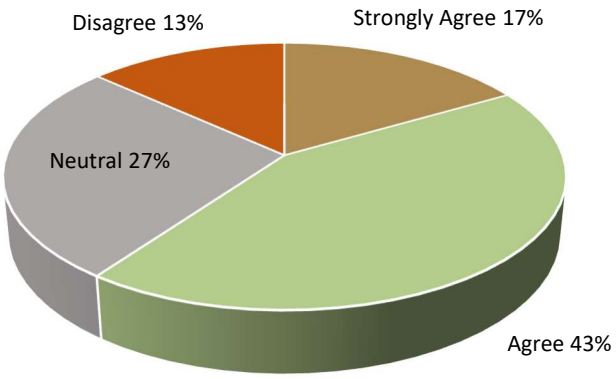
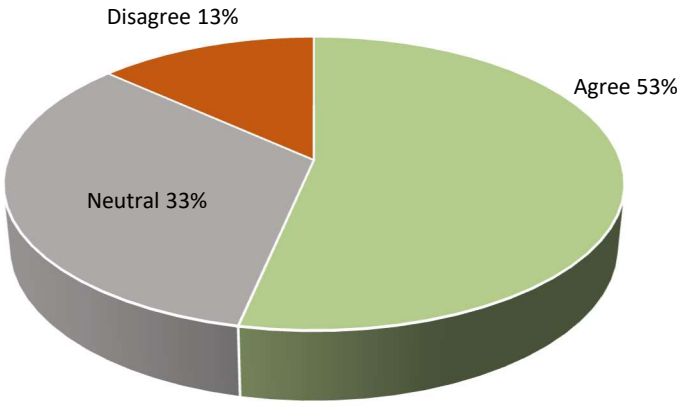


Figure 42. Provider Perception on the Impact of TMS - Services on Client's Progress Toward Treatment Goals (n = 15)



D. INN 5: Peer Support Specialist Full Service Partnership

LACDMH received approval from the MHSOAC on April 26, 2018 to implement 2 teams comprised mostly of peer support specialists to provide FSP level services. PeerSS FIRST will utilize a team primarily staffed by individuals with lived experience as mental health consumers or family members, supported by clinical staff, to provide intensive field-based services to individuals with multiple challenges including justice involvement. Two contracted PeerSS FIRSTs will each serve a caseload of 50 individuals. Each PeerSS FIRST will provide a full array of mental health services ranging from peer support to medication management as well as 24-hour on-call coverage.

Successful implementation of PeerSS FIRST will expand the role of peers from an adjunct or supportive service provider to a leading member of the treatment team and the primary contact for every service recipient. PeerSS FIRST will prove the effectiveness of peer staff and peer-based services.

Status of implementation as of December 1, 2020
Due to COVID-19, implementation of the program has been delayed.

E. INN 7: Therapeutic Transportation (TT)

The overall goals of the Pilot Therapeutic Transportation Project - INN 7 are to: (1) increase access and enhance the quality of mental health services to individual callers in crisis; (2) decompress EDs; (3) reduce the use of Los Angeles Fire Department (LAFD) resources for mental health responses; and (4) leverage partnerships to develop a community-driven approach toward improving outcomes for individuals experiencing a mental health crisis.

LACDMH has developed a collaborative with Los Angeles City (City) LAFD to implement INN 7. The City estimates tens of thousands of emergency calls per year to its police and fire dispatch centers that involve people suffering from a mental health crisis. LAFD Emergency Medical Technicians (EMTs)/paramedics do not have the training or experience to deal with mental health crises and in turn, need the support of LACDMH to provide a mental health field response operation.

Currently, LACDMH triages mental health crises through its ACCESS hotline and deploys the Psychiatric Mobile Emergency Response Team (PMRT). PMRT is staffed with licensed clinicians, who have legal authority per Welfare and Institutions Code Sections 5150 and 5585, to initiate applications for evaluation of involuntary detention of individuals determined to be at risk of harming themselves or others due to a mental health disorder. If transportation is necessary for an individual, PMRT staff utilize the ACCESS hotline to request an ambulance to transport the individual.

However, for City mental health emergency dispatch calls, PMRT is not called to provide on-site mental health crisis services or to arrange an ambulance for individuals since PMRT only responds to community calls. To expand PMRT's role to assist with the City's mental health emergency calls, INN 7 will allow PMRT to work in conjunction with LAFD to assess and treat individuals with mental health crises through LAFD's Tiered Dispatch System and the placement of LACDMH Teams/PMRT staff at five select fire stations. The fire stations were identified based on their mental health emergency call load, proximity to a mental health urgent care facility, and inclusion within County Supervisorial Districts. Each LACDMH Team is staffed with three employees: Peer Support Specialist, Licensed Psychiatric Technician, and Clinical Driver.

F. INN 8: EARLY PSYCHOSIS LEARNING HEALTHCARE NETWORK

LACDMH received approval from the MHSOAC for this multi-county 5-year project on December 17, 2018. The Early Psychosis Learning Healthcare Network (LHCN) will allow counties who use a variety of coordinated specialty care models to treat early psychosis to collect common outcome data, be able to use it to inform treatment, and engage in cross-county learning informed by outcome data. The goals of the Statewide Early Psychosis Evaluation and LHCN are to increase the quality of mental health services including measurable outcomes, and to introduce a mental health practice or approach that is new to the overall mental health system.

One of LACDMH's early psychosis coordinated specialty care models is the Portland Identification and Early Intervention (PIER) program to identify and comprehensively treat individuals ages 12-25 who are at clinical high risk for psychosis (prodromal) or have experienced their first psychotic episode. Five contractor teams have been trained in the PIER Model as of December 2019 and began community outreach and direct service in January 2020. As of November 11, 2020, there are 35 clients enrolled at five clinics across Los Angeles County.

Status of Implementation as of December 1, 2020
LACDMH entered a contract with UC Davis to execute this project as of July 1, 2020. Since then, deliverables in the following areas have been completed.

Human Subjects Research Committee Approval
LACDMH Human Subjects Research Committee (HSRC) approved the LHCN project on April 23, 2020. LACDMH requires a review of an application, consent documents, recruitment materials, evidence of principle investigator qualifications, documents from the Institutional Review Board of record (UC Davis, in this case) including application and approval letter, and oath of confidentiality agreements with LACDMH. HSRC review also includes review by LACDMH Data Security and Privacy Officers. An amendment to the study protocol was approved on July 16, 2020 due to the need to complete Focus Groups remotely in response to COVID-19, to update consent forms to reflect this change and to update research personnel.

Establishing Advisory Committee and Multi-county Quarterly Meetings
Advisory Committee meetings were attended by a county representative from each participating county, a representative of each participating EP program, and up to 5 peer and 5 family advocates who are associated with the participating programs. This Committee is co-led by Bonnie Hotz, family advocate from Sacramento County. The first Advisory Committee meeting was held on May 8, 2020 with a follow up meeting on July 7, 2020. The committee was updated on progress on the Qualitative data and County data components. Recruitment of additional client members for the next Advisory Committee scheduled for December 11, 2020 is ongoing.

Multi-county Quarterly meetings were developed to discuss LHCN-related topics as a group and to encourage cross-county learning during the project period. The first meeting was held on August 31, 2020. This meeting was held with county leadership to discuss LHCN project-related items. The second meeting also included program staff and was held on November 16, 2020. The results of the pre-implementation questionnaires were discussed (see below).

Focus Groups – Outcome Domain and Outcome Measure Selection
Remote focus groups including LACDMH stakeholders were held on 8/26/2020 (provider), 8/26/20 (one-on-one client) and 8/31/20 (family) in order to determine which early psychosis

outcome measures should be incorporated into the web and tablet application dashboard. Outcomes are discussed in the Outcomes Data section below.

Focus Groups – Application Wireframe
UC Davis executed a subcontract with Quorum Technologies to modify UC Davis' existing MOBI software to develop the LHCN platform and application. This application will be used to collect client outcome data which in turn can be used by clinicians with clients to access client-level outcomes. Quorum Technologies has developed two applications for research purposes for UC Davis and they specialize in health care application development.

Remote focus groups including LACDMH stakeholders were held on August 25, 2020 (provider) and August 28, 2020 (client and family). Participants were presented with various aspects of the application storyboard, which allows participants a visualization of the look, feel and functionality of the application prior to development. Presentations were tailored to the roles of the focus group members such as client, providers, clinic admin and family members. Participants provided feedback on the look and feel of the application, how it would integrate into clinic workflow and ease of use. The feedback was relayed to the application developers and were integrated while balancing client and family needs with provider and staff needs.

County stakeholders were also asked for feedback about how to adapt both the data collection and data visualization components of the application for use with telehealth. Multiple staff participants agreed that a remote data collection option which would allow clients to complete surveys from home would be ideal. Client and family stakeholders agreed and were split between their preference for a mobile application or a personalized link that could be emailed or texted to them from their provider. Client and family stakeholders said they would prefer to look at their data with their provider and would not necessarily want individual access to look at their results from home.

Application Development – Alpha Testing
An Alpha version of the both the web and tablet applications were released from Quorum to UC Davis on September 18, 2020. Alpha testing targeted specific features and did not include all planned features of the application. Features such as registration of users, login or check-in or different types of user, creation of groups and clinics, creation of surveys and survey bundles, visualization of survey responses and client-facing pages, and completion of surveys. The goal of alpha testing was to identify errors and areas that may require additional training before application rollout. Testing was conducted by seven EPI-CAL staff members, including researchers from UC Davis and UC San Diego. While staff was able to test the tablet application on personal devices, a delay in having the application available in Apple's "App Store Connect" delayed testing on UC Davis Health System devices. Next steps include testing the application in a clinic setting. Clients and providers at SacEDAPT and EDAPT clinics will enter test data once the application is added to devices. Feedback from clients and providers that have entered test data will be incorporated as developers create the beta version of the application.

Pre-Implementation Questionnaires with Providers
Across all participating counties, 140 participants including program leadership, treatment and non-treatment staff/providers who consented for research completed baseline pre-implementation questionnaires. Of those participants, another 110 participants completed surveys specific to leadership, treatment providers and non-treatment staff. Questionnaires measured organizational readiness for change, attitudes and beliefs about technology, staff characteristics regarding attitudes towards recovery and stigma, evidenced-based practices, approach to client care and new information, and assessment of burnout and compassion

fatigue. During the Multi-county Quarterly meeting in November 2020, it was decided that individual county results would be reviewed with county and clinic leadership first during December 2020 and January 2021 in order to make appropriate plans to present to staff.

Number of clients served for FY 2019-20 (where applicable)**:**
N/A – No clients were served during FY 2019-20 as the contract with UC Davis did not begin until July 1, 2020.

Outcome data being collected and any analysis of impact to date
Qualitative data - Outcome Domain and Outcome Measure Selection
Focus Groups were asked to select which domains would be most important to focus on when measuring outcomes in clients being treated for early psychosis. Participants were asked to select which domains they felt were important pre-discussion and post-discussion. Figures 43 and 44 show the agreement in responses for all focus group members divided by role. Figures 45 and 46 include a more detailed breakdown of clients and family members. All figures include data from all counties and clinics including Los Angeles County and were prepared by UC Davis staff.

Focus groups from other counties and university programs favored measuring outcomes regarding functioning, quality of life/well-being, recovery, and psychiatric symptoms. The usefulness and applicability of various measures were discussed. Also, appropriate wording and for Family Impact (versus Family Burden) was discussed along with a general preference of self-report items in many domains and the inclusion of social cognition in cognitive measures. LACDMH focus groups were also given a chance to vote on the outcome domains that felt were most important and most data was aligned with the previous focus groups (Figures 43 and 44). The researchers asked LACDMH contract providers and staff to focus their discussion instead on issues around hospitalization, incarceration/recidivism, and homelessness to provide deeper information on these outcome domains.

Providers and staff saw hospitalization data to measure onset of illness and the absence of hospitalization as an indicator of a positive outcome. Self-report of hospitalization was seen as an accurate way of collecting this data with clinicians exploring additional clinical details if needed. In terms of incarceration, sometimes legal contact became a pathway to care, while in other instances, it could be a stressor that leads to worsening symptoms. Providers agreed that capturing legal contact versus arrests/probation would be more useful as predictors of future legal contact and were more common in the early psychosis population. Also, measuring contact with school police that is often unrecorded as well as recording truancy that could lead to legal action would be important areas to measure. When discussing homelessness, specific examples versus general questions about homelessness were preferred. Homelessness was not seen as a very prevalent concern to participants, but participants felt specific questions were still important as inadequate housing may cause additional stress.

LACDMH consumer who participated in an individual interview voted and discussed outcomes in a manner consistent with prior groups. They also emphasized the importance of shared decision making and increased contact with the clinic. The consumer also discussed incarceration but felt it was more of a global issue than one that the early psychosis population faces, though it can worsen well-being in this population. The consumer shared that a risk factor for homelessness can also be related to “thoughts of running away” that are the result of symptoms.

In family focus groups, participants found that tracking legal interactions as well as the types of interactions were important but felt that the consumer may need a family member or clinician to help fill out these questions. Family participants felt homelessness was an important issue, especially when families struggle to manage issues such as aggression in the home (Figures 45 and 46).

Figure 43. Pre-discussion voting priorities by role

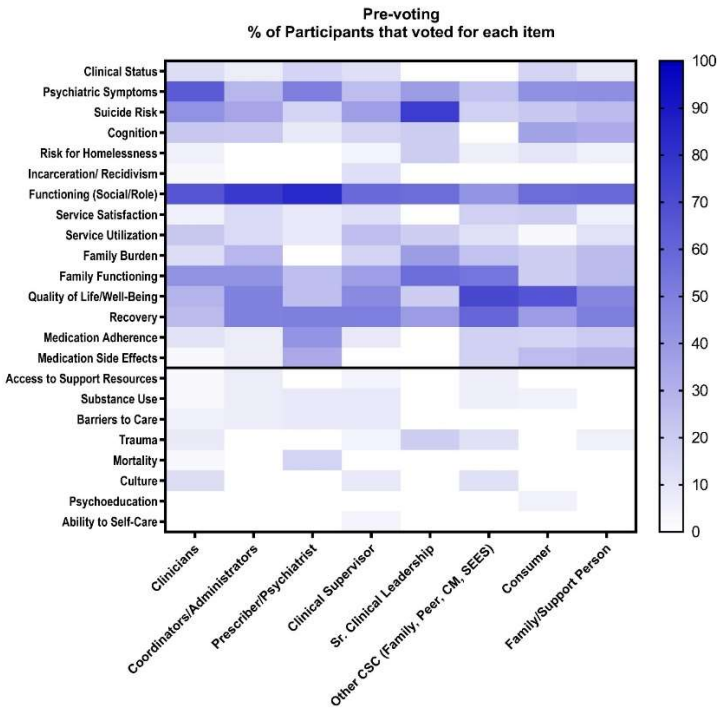


Figure 44. Post-discussion voting priorities by role

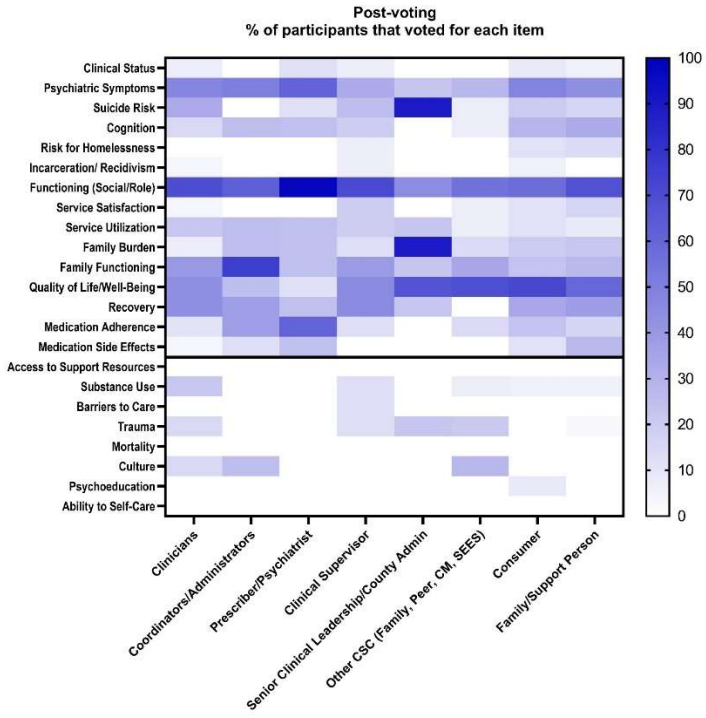


Figure 45. Family and consumers pre-voting

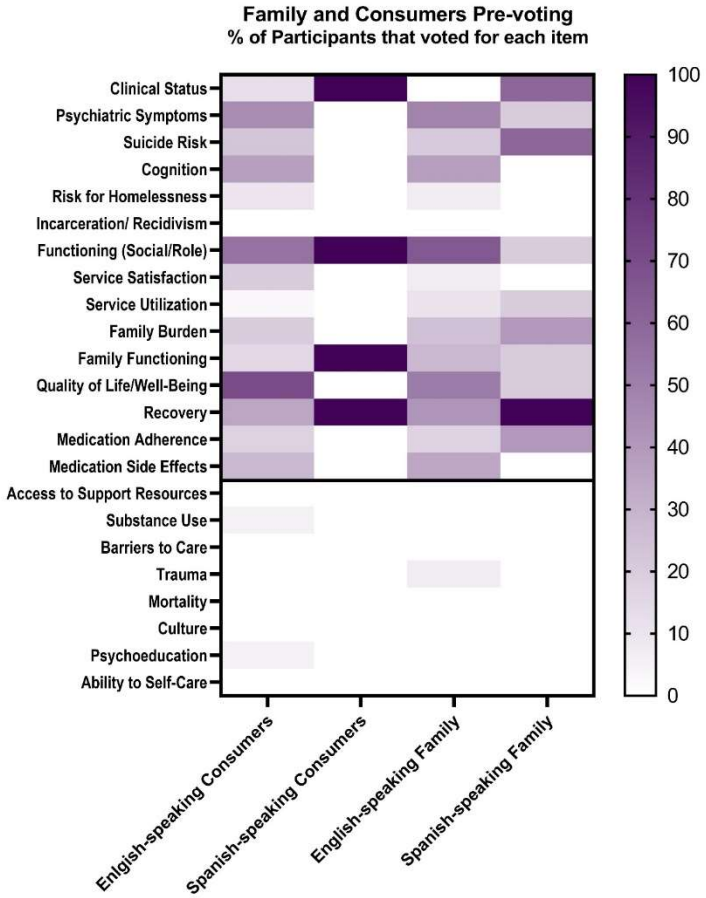
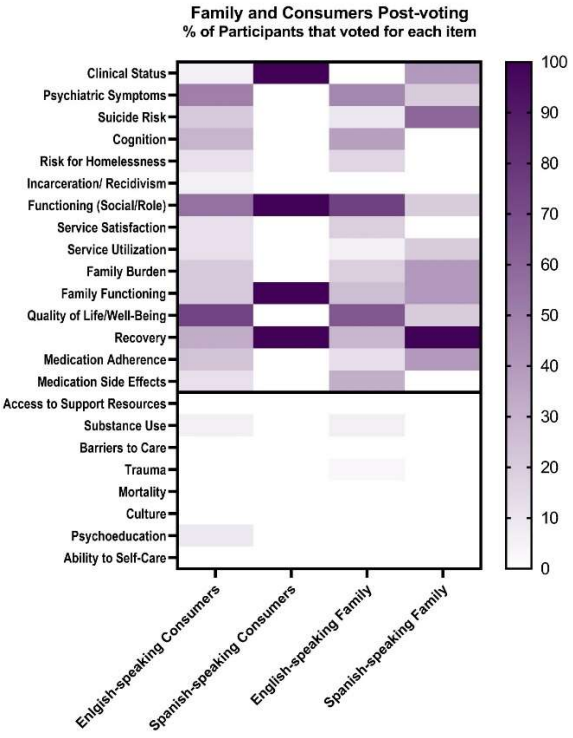


Figure 46. Family and consumers post-voting



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INNOVATION	
Prior FY 2019-20	**Prior FY 2018-19**
$21.3 million Total Gross Expenditures	$14.7 million Total Gross Expenditures
FY 2021-22	**Three-Year Plan FYs 2021-24**
$33.3 million Estimated Gross Expenditures	$70.5 million Estimated Gross Expenditures

Does not include program administration costs

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

A. CAPITAL FACILITIES

- ***Olive View Mental Health Wellness Center***
  LACDMH will provide an array of outpatient mental health and supportive services for clients who live with serious mental illness at the Mental Health Wellness Center. This Center will be complete and operational in the summer of 2021.

- ***The Sheila Kuehl Family Wellness Center***
  LACDMH will co-locate with the DPH in this new Wellness Center for the collaboration of services, such as substance abuse, mental health, health and teen pregnancy. This Center was opened January 2019.

- ***High Desert Mental Health Urgent Care Center (UCC)***
  UCCs provide 24/7 rapid access to mental health evaluation and assessment, intervention, and medication support. They also support the County's efforts to decompress psychiatric emergency services, reduce unnecessary hospitalizations, thereby improving access to mental health treatment and services.

- ***LAC+USC, Olive View and Rancho Crisis Residential Treatment Programs (CRTPs)***
  CRTPs provide a short-term alternative to hospitalization to address mental health needs. The services are designed to resolve the immediate needs and improve the level of functionality of the individuals so that they can return to a less intensive treatment environment via care coordination and discharge planning. Residents participate in the development of recovery-oriented, individualized plans that promote the goal of becoming self-sufficient and going into permanent supportive housing. The CRTPs are scheduled to open in the summer of 2021.

- ***Downtown Mental Health Parking Lot***
  LACDMH purchased a parking lot located at 636 Maple Avenue for the use of Downtown Mental Health Center. The parking lot will provide additional parking for clients and departmental personnel. The parking lot was purchased December 2019.

B. TECHNOLOGICAL NEEDS

There are no MHSA funded IT projects in FY 2019-20 to report.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS	
Prior FY 2019-20	**Prior FY 2018-19**
$17.0 million Total Gross Expenditures	$0.4 million Total Gross Expenditures
FY 2021-22	**Three-Year Plan FYs 2021-24**
$30.7 million Estimated Gross Expenditures	$30.7 million Estimated Gross Expenditures

Does not include program administration costs

EXHIBITS

EXHIBIT A - FUNDING SUMMARY

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Los Angeles Date: 3/18/21

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	304,239,767	193,176,692	167,000,000	13,500,000	17,278,597	116,483,541
2. Estimated New FY2021/22 Funding	427,920,280	107,005,070	28,152,480			
3. Transfer in FY2021/22 a/	(33,935,958)			20,431,958	13,504,000	
4. Access Local Prudent Reserve in FY 2021/22						-
5. Estimated Available Funding for FY2021/22	698,224,090	300,181,762	195,152,480	33,931,958	30,782,597	
B. Estimated FY2021/22 MHSA Expenditures	445,147,396	139,863,897	37,990,702	20,431,958	30,653,597	
C. Estimated FY2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	253,076,694	160,317,865	157,161,778	13,500,000	129,000	
2. Estimated New FY2022/23 Funding	346,920,790	86,698,140	22,814,620			
3. Transfer in FY2022/23 a/	(20,431,958)			20,431,958		
4. Access Local Prudent Reserve in FY2022/23						0
5. Estimated Available Funding for FY 2022/23	579,565,526	247,016,005	179,976,398	33,931,958	129,000	
D. Estimated FY2022/23 Expenditures	461,472,261	125,349,381	30,147,274	20,431,958	0	
E. Estimated FY2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	118,093,265	121,666,624	149,829,124	13,500,000	129,000	
2. Estimated New FY2023/24 Funding	387,400,000	96,900,000	25,500,000			
3. Transfer in FY2023/24 a/	(20,431,958)			20,431,958		
4. Access Local Prudent Reserve in FY2023/24						0
5. Estimated Available Funding for FY2023/24	485,061,308	218,566,624	175,329,124	33,931,958	129,000	
F. Estimated FY2023/24 Expenditures	480,751,247	103,530,954	13,655,165	20,431,958	0	
G. Estimated FY2023/24 Unspent Fund Balance	4,310,061	115,035,670	161,673,959	13,500,000	129,000	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2021	116,483,541
2. Contributions to the Local Prudent Reserve in FY 2021/22	0
3. Distributions from the Local Prudent Reserve in FY 2021/22	0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	116,483,541
5. Contributions to the Local Prudent Reserve in FY 2022/23	0
6. Distributions from the Local Prudent Reserve in FY 2022/23	0
7. Estimated Local Prudent Reserve Balance on June 30, 2023	116,483,541
8. Contributions to the Local Prudent Reserve in FY 2023/24	0
9. Distributions from the Local Prudent Reserve in FY 2023/24	0
10. Estimated Local Prudent Reserve Balance on June 30, 2024	116,483,541

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

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Los Angeles Date: 3/18/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CSS Programs						
1. Full Service Partnerships	290,807,563	90,100,560	152,256,387		41,901,508	6,549,108
2. Outpatient Care Services	614,163,329	157,929,082	346,732,686		85,329,724	24,171,837
3. Alternative Crisis Services	133,478,652	95,486,564	34,240,856		1,454,987	2,296,246
4. Planning Outreach & Engagement	6,826,874	6,686,818	133,668		0	6,388
5. Linkage Services	27,062,740	21,707,756	4,935,466		34,499	385,018
6. Housing	35,431,191	35,431,191	0		0	0
CSS Administration	37,805,425	37,805,425	0		0	
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,145,575,774	445,147,396	538,299,063	0	128,720,718	33,408,597

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CSS Programs						
1. Full Service Partnerships	302,391,232	92,139,133	159,322,013		44,053,524	6,876,563
2. Outpatient Care Services	636,564,407	165,362,448	356,282,260		89,539,270	25,380,429
3. Alternative Crisis Services	139,819,715	100,281,570	35,599,350		1,527,736	2,411,058
4. Planning Outreach & Engagement	7,108,451	6,965,109	136,634		0	6,707
5. Linkage Services	28,322,985	22,785,324	5,097,168		36,224	404,269
6. Housing	35,073,361	35,073,361	0		0	0
CSS Administration	38,865,316	38,865,316	0		0	
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,188,145,468	461,472,261	556,437,426	0	135,156,754	35,079,027

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CSS Programs						
1. Full Service Partnerships	317,007,103	96,242,399	167,288,113		46,256,200	7,220,391
2. Outpatient Care Services	668,132,522	173,370,465	374,096,373		94,016,234	26,649,451
3. Alternative Crisis Services	146,477,830	104,962,778	37,379,318		1,604,123	2,531,611
4. Planning Outreach & Engagement	7,404,107	7,253,598	143,466		0	7,043
5. Linkage Services	29,646,244	23,831,700	5,352,027		38,035	424,482
6. Housing	35,133,304	35,133,304	0		0	0
CSS Administration	39,957,003	39,957,003	0		0	
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,243,758,114	480,751,247	584,259,297	0	141,914,592	36,832,978

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Los Angeles Date: 3/18/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs						
1. SUICIDE PREVENTION	23,302,998	23,302,998				
2. STIGMA DISCRIMINATION REDUCTION PROGRAM	366,250	366,250				
3. PREVENTION	63,313,868	63,313,868				
4 EARLY INTERVENTION	194,496,387	39,279,868	98,639,744		52,947,818	3,628,958
PEI Administration	13,600,914	13,600,914				
Total PEI Program Estimated Expenditures	295,080,417	139,863,897	98,639,744	0	52,947,818	3,628,958

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs						
1. SUICIDE PREVENTION	22,302,998	22,302,998				
2. STIGMA DISCRIMINATION REDUCTION PROGRAM	366,250	366,250				
3. PREVENTION	51,933,815	51,933,815				
4 EARLY INTERVENTION	198,997,562	36,402,740	103,189,208		55,595,209	3,810,405
PEI Administration	14,343,578	14,343,578				
Total PEI Program Estimated Expenditures	287,944,203	125,349,381	103,189,208	0	55,595,209	3,810,405

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs						
1. SUICIDE PREVENTION	5,302,998	5,302,998				
2. STIGMA DISCRIMINATION REDUCTION PROGRAM	366,250	366,250				
3. PREVENTION	47,626,940	47,626,940				
4 EARLY INTERVENTION	208,882,751	38,158,188	108,348,668		58,374,969	4,000,926
PEI Administration	12,076,578	12,076,578				
Total PEI Program Estimated Expenditures	274,255,517	103,530,954	108,348,668	0	58,374,969	4,000,926

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Los Angeles Date: 3/18/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	7,915,501	7,915,501				
2. Mental Health Career Pathway	1,260,000	1,260,000				
3. Financial Incentive	6,936,684	6,936,684				
4. Residency	2,907,394	2,907,394				
WET Administration	1,412,379	1,412,379				
Total WET Program Estimated Expenditures	20,431,958	20,431,958	0	0	0	0

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	7,915,501	7,915,501				
2. Mental Health Career Pathway	1,260,000	1,260,000				
3. Financial Incentive	6,936,684	6,936,684				
4. Residency	2,907,394	2,907,394				
WET Administration	1,412,379	1,412,379				
Total WET Program Estimated Expenditures	20,431,958	20,431,958	0	0	0	0

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	7,915,501	7,915,501				
2. Mental Health Career Pathway	1,260,000	1,260,000				
3. Financial Incentive	6,936,684	6,936,684				
4. Residency	2,907,394	2,907,394				
WET Administration	1,412,379	1,412,379				
Total WET Program Estimated Expenditures	20,431,958	20,431,958	0	0	0	0

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Los Angeles Date: 3/18/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Inn # 2 Community Capacity Building	21,700,000	21,700,000				
2. INN # 3 Technology Suite	6,321,028	6,321,028				
3. Inn # 4 Transcranial Magnetic Stimulation Center	1,146,889	1,070,122	71,540			5,227
4. Inn # 7 Therapeutic Transportation	3,387,415	3,387,415				
5. Inn # 8 Early Psychosis Learning Health Care Network	775,137	775,137				
INN Administration	4,737,000	4,737,000				
Total INN Program Estimated Expenditures	38,067,469	37,990,702	71,540	-	-	5,227

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Inn # 2 Community Capacity Building	14,700,000	14,700,000				
2. INN # 3 Technology Suite	6,321,028	6,321,028				
3. Inn # 4 Transcranial Magnetic Stimulation Center	1,150,727	1,070,122	75,117			5,488
4. Inn # 7 Therapeutic Transportation	3,387,415	3,387,415				
5. Inn # 8 Early Psychosis Learning Health Care Network	492,709	492,709				
INN Administration	4,176,000	4,176,000				
Total INN Program Estimated Expenditures	30,227,879	30,147,274	75,117	0	0	5,488

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Inn # 2 Community Capacity Building	-	-				
2. INN # 3 Technology Suite	6,321,028	6,321,028				
3. Inn # 4 Transcranial Magnetic Stimulation Center	1,154,757	1,070,122	78,872			5,763
4. Inn # 7 Therapeutic Transportation	3,387,415	3,387,415				
5. Inn # 8 Early Psychosis Learning Health Care Network	252,600	252,600				
INN Administration	2,624,000	2,624,000				
Total INN Program Estimated Expenditures	13,739,800	13,655,165	78,872	0	0	5,763

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Los Angeles Date: 3/18/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Olive View Medi-Cal Center Wellness Ctr	3,393,000	3,393,000				
2. Olive View Medi-UCC	3,224,000	3,224,000				
3. MLK Child and Family Center	715,000	715,000				
4. LAC+USC CRTP	5,747,000	5,747,000				
5. Rancho Los Amigos CRTP	6,546,000	6,546,000				
6. Olive View CRTP	7,178,597	7,178,597				
CFTN Programs - Technological Needs Projects						
7. Modern Call Center	3,500,000	3,500,000				
8.	0					
CFTN Administration	350,000	350,000				
Total CFTN Program Estimated Expenditures	30,653,597	30,653,597	0	0	0	0

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0	0				
2.	0	0				
CFTN Programs - Technological Needs Projects						
3.	0					
4.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
CFTN Programs - Technological Needs Projects						
3.	0					
4.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

EXHIBIT B - PRUDENT RESERVE

WIC Section 5847 requires counties to establish and maintain a Prudent Reserve (PR) to ensure MHSA programs will continue to serve children, adults and seniors during years in which tax revenues are below recent averages. It is essentially the MHSA "Rainy Day Fund."

Access to the PR will be determined on a statewide level, as the State will calculate the access threshold and release the information prior to the start of the upcoming fiscal year. Funding level requirements will be suspended during the period access to the PR is in effect.

The Los Angeles County PR totaled $116 million as of June 30, 2020. The previous PR level was at $160 million as shown below, but new regulation set a maximum of 33% of the average amount of CSS allocation and therefore, $44 million in excess PR funding was transferred to CSS ($35 million) and PEI ($9 million) during FY 2019-20.

Table X. PR levels since 2007-08

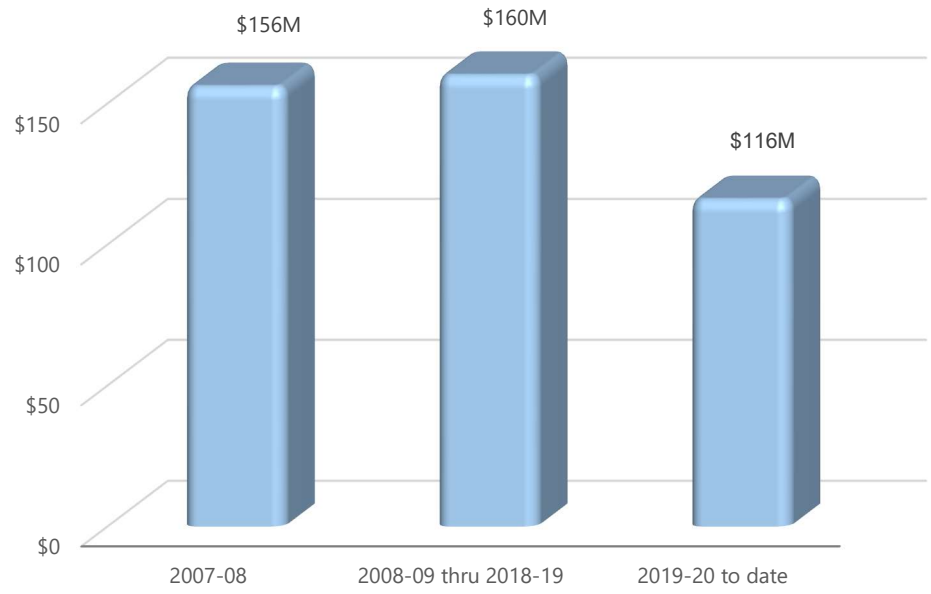

EXHIBIT C - MHSA COUNTY COMPLIANCE CERTIFICATION

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Los Angeles

■ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director	Program Lead
Name: Jonathan E. Sherin, M.D., Ph.D.	Name: Gregory C. Polk
Telephone Number: (213) 738-4108	Telephone Number: (213) 738-4926
Email: JSherin@dmh.lacounty.gov	Email: gpolk@dmh.lacounty.gov

Local Mental Health Mailing Address:

County of Los Angeles - Department of Mental Health
550 S. Vermont Avenue, 12th Floor
Los Angeles, CA 90020

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

This Three-Year Program and Expenditure Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The Three-Year Program and Expenditure Plan, attached hereto, was adopted by the County Board of Supervisors on June 22, 2021.

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

All documents in the attached Three-Year Program and Expenditure Plan are true and correct.

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

Signature

6/23/21
Date

EXHIBIT D - MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County: Los Angeles

- [x] Three-Year Program and Expenditure Plan
- [ ] Annual Update
- [ ] Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller
Name: Jonathan E. Sherin, M.D., Ph.D.	Name: Arlene Barrera
Telephone Number: (213) 738-4601	Telephone Number: (213) 974-8302
E-mail: JSherin@dmh.lacounty.gov	E-mail: ABarrera@auditor.lacounty.gov

Local Mental Health Mailing Address:

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

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

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

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

Signature — Date: 4/22/21

I hereby certify that for the fiscal year ended June 30, 2020, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892 (f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/11/20 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891 (a), in that local MSHA funds may not be loaned to a county general fund or any other county fund.

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

Arlene Barrera
County Auditor Controller (PRINT)

Arlene Barrera — Signature — Date: 4/30/21

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

EXHIBIT E - MENTAL HEALTH COMMISSION RECOMMENDATIONS LETTER

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

First District	Second District	Third District	Fourth District	Fifth District
Hilda L. Solis	**Holly J. Mitchell**	**Sheila Kuehl**	**Janice Hahn**	**Kathryn Barger**
Susan Friedman	Harold Turner	Stacy Dalgleish	Patrick Ogawa	Brittney Weissman, MPP
Imelda Padilla-Frausto	Reba Stevens	Rev. Kathy Cooper Ledesma	Kevin Acebo	Judy Cooperberg, MS, CPRP
		Tess Banko	Mike Molina	

May 3, 2021

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

Jonathan E. Sherin, M.D., PH.D.,
Director, Department of Mental Health
550 S. Vermont Ave
Los Angeles, California 90020

Dear Supervisors and Director:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING FISCAL YEAR 2021-2022 to 2023-2024 THREE YEAR PLAN

On April 22, 2021 the Chair and a quorum of the Los Angeles County Mental Health Commission (Commission) hosted the FY 2021-2022 to 2023-2024 Mental Health Services Act Three Year Plan Public Hearing. The Department of Mental Health's submission of the Mental Health Services Act FY 2021-2022 to 2023-2024 was posted for 30-day Comment Period on March 18, 2021 through April 18, 2021. The Commission, established under Section 5604, conducted a public hearing of the draft Three Year program and expenditure plan at the close of the 30-day comment period. In accordance with Section 5604, the adopted three-year program and expenditure plan shall summarize and analyze the Commission's recommended revisions.

We commend the Department of Mental Health for strengthening its engagement with community stakeholders through the geographic Service Area Leadership Teams (SALTs) and Unserved/Underserved Cultural Communities (UsCCs) and combined Community Leadership Team (CLT) throughout the months of October through January of FY 2020-2021 in the ongoing planning and implementation of the Mental Health Services Act and on the outcomes you are achieving. The Commission looks forward to your continued progress improving the lives of clients receiving services in the public mental health system and continuing our partnership.

It is with pleasure that the Los Angeles County Mental Health Commission submits these recommendations for your review and consideration. While our recommendations represent the

consensus of the Commission, we urge you and the Board of Supervisors to review all stakeholder testimony received during the public comment period when rendering your final recommendation on the Three Year Plan. Our recommendations center around six broad themes:

1. Inequities/Disparities
2. Treatments and Services
3. Family Inclusion
4. Housing and homelessness
5. Criminal Justice, and
6. Impact of COVID-19

Inequities and Disparities

State law, Welfare Institutions Code (WIC) Section 5812.5(d), 5868(b), 5878.1(a); and, 9 California Code of Regulations (CCR) Section 3200.100 requires a county's MHSA Three Year Plan to address disparities, and cultural and linguistic competency by incorporating and working to achieve stated goals in all aspects of policymaking, program design, administration and service delivery. To accomplish this, the Commission urges action in the following areas.

Data

The Commission urges our County to improve data collection to identify inequities and identify data sources that can be used to help with clarifying unmet needs. We also see the development of data analysis and sharing tools to allow to track how well recommendations are being implemented as an area for broad improvement. We believe that enhanced technology driven tools and services are the future and deserve investment.

Cultural and Linguistic Competency

The Department and Board of Supervisors should consider the recommendations from the cultural competency ad hoc workgroup established by Commissioner Patrick Ogawa. Likewise, the Commission formally recognizes and uplifts the report and recommendations from the ad hoc committee on undocumented immigrants. Understanding the perspectives, needs, and recommendations from both groups will be critical to the Department's success at improving inequities. We heard loud and clear the critical need to enhance the Department's language capacity with respect to all programming, external relations, and treatments. Information for people with mental illness and their families should be always made available in multiple languages – specifically those included in the 13 thresholds in Los Angeles County.

Demographics

The Department should be sensitive to and accountable for resolving inequities around: race and ethnicity, immigration status, geographic location, perinatal and maternal status, age (with an option for clients to elect their choice of programs from TAY, Adult or Older Adult categories)

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and physical and mental health condition. Special attention should be paid toward inequities in populations with physical disabilities and others who qualify under Americans with Disabilities Act status. We urge you to correct for disparities in funding across underserved and unserved populations, including ethnic populations in all service areas.

Treatments and Services and utilization and penetration by underrepresented communities

Plentiful public comment reminded the Commission that only three hospitals provide psychiatric emergency service, which makes our recommendation to expand service obvious. Steps should be taken to better integrate the care provided, and provider contracts should incentivize or punish contractor ability to provide improved health outcomes for patients. With regard to contracting, the Commission supports the Departments preference for outcomes-based contracts that highlight improved health outcomes over fees for specific services. However, we stress the need for increased oversight and accountability for these and all services. In addition, MHSA expenditures should be allocated to provide access to transport for adults with serious mental illness who live in Board and Cares and in private homes to access day programming. Please also reconsider any and all funding cuts to the home visitation program. Likewise, we advise the Department to support and continue allocating funding and resources for culturally specific programs – arts, spiritual, etc. – as part of the Prevention and Early Intervention portfolio.

Outreach to Families

Nearly every public comment period of Commission meetings highlights the critical need to improve education and resources for families experiencing the first mental health crisis of their loved one. The Department must do more to create and enhance education channels to families and create resources to families specific to their needs. Families who will help their loved one cope with the lifelong impacts of mental illness need to be supported – immediately and effectively. They need navigation services provided in a culturally supportive manner, as well as reliable, warm hand offs between providers and other levels of care.

These materials should be part of leave behind materials for all Mobile Crisis Response and future Alternative Crisis Response efforts. To further this aim, the Commission suggests that family engagement be made an explicit outcome within all Provider contracts. As we well know, one size does not fit all and interventions and supports must be individualized for every family's unique needs. Therefore, we recommend that all communications materials be co-developed with affected community members who will no doubt have many positive contributions to the final outreach and engagement tools and products.

Housing & Homelessness

The Department should advance the countywide goals of preventing people with mental illness from falling into homelessness, supporting people with mental illness to remain housed, and establish long-term housing with wraparound essential services. To facilitate this, the

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Department should create useful education materials on prevention, resources and a physical location for individuals to seek input and navigation. We urge the Department to redouble its efforts to ensure those who are housed remain in good contact with mental health supports and treatments. We need to build community and community resilience to broadly support this and should employ the Service Area Leadership Teams to strengthen department-driven efforts. At all levels, we suggest improved oversight and accountability – and increased transparency – by way of more public data and reporting out. In addition, the Commission formally acknowledges the report on Black People Experiencing Homelessness Report and supports instituting the recommendations from that report.

Criminal Justice

The Commission acknowledges the overrepresentation of Black people who are incarcerated, with no place to go and the impact of that on Black communities and society at large.

With regard to mental health and substance use and/or abuse, the Department must identify sustainable funds to support mental health clients and leverage all sources of funding to vulnerable incarcerated individuals, which entails collaborating with other County Departments such as Substance Abuse Prevention Control at Department of Public Health and Office of Diversion and Reentry and Department of Health Services. Please consider and apply MHSA funds with matching funds programs available. The Commission supports adding funding to the following areas: data collection, sobering centers, MET or co-response teams, diversion, Law Enforcement Assisted Diversion, court liaison programs, juvenile adult collaborative courts, alternative sentencing options, mental health beds, mobile crisis response teams. Implementing a true integrated system of care, leveraging appropriate matching funds, and a formal public review of cost savings and improved outcomes will demonstrate the value of our criminal justice reforms to the county.

Impact of COVID-19

The Commission notes the profound short- and long-term impacts of the COVID-19 global health crisis on school-aged children, their families and particularly on women and women who work outside the home. The pandemic and Safer-At-Home public health orders exacerbated already strident racial and ethnic inequities and social economic inequities that lead to more mental health issues among these populations and require additional interventions that are adequately tailored to these populations. The pandemic's mental health crisis is here.

In closing, the Commission urges the Board of Supervisors to consider inequity during its review of the Department's MHSA Three Year Plan and budget to develop funding recommendations to correct for them. The Commission finds persistent inequities within race and culture, treatments and services and utilization and penetration by underrepresented communities, family inclusion, housing and homelessness, criminal justice, and the impact of COVID.

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

Sincerely yours,

Brittney Weissman, MPP
Chair, Mental Health Commission

BW:PM

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DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

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

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

Lisa H. Wong, Psy.D.
Senior Deputy Director

June 16, 2021

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

VIA EMAIL

Brittney Weissman, MPP
Chair, Mental Health Commission
550 South Vermont Avenue
Los Angeles, California 90020

RESPONSE TO MENTAL HEALTH COMMISSION INQUIRIES ON THE PUBLIC HEARING FOR THE MENTAL HEALTH SERVICES ACT THREE YEAR PLAN FOR FISCAL YEARS 2021-2022 TO 2023-2024

On May 3, 2021, the Los Angeles County Mental Health Commission (Commission) submitted a letter reflecting their comments and inquiries to the Los Angeles County Board of Supervisors (Board) and the Department of Mental Health (DMH) pertaining to the April 22, 2021, public hearing on the Fiscal Years (FYs) 2021-2022 to 2023-2024 Mental Health Services Act (MHSA) Three Year Plan (Plan).

In the Commission's letter, DMH was commended for its community engagement process related to the Plan development and its partnership with key stakeholder groups to ensure a Plan that represents and addresses the expressed needs of each community (with special attention to those communities disproportionately impacted by disparities and the COVID-19 Pandemic). The Commission submitted several recommendations for the review and consideration of your Board and DMH centering around six broad themes:

1. Inequities/Disparities;
2. Treatments and Services;
3. Family Inclusion;
4. Housing and Homelessness;
5. Criminal Justice; and
6. Impact of COVID-19.

The following are DMH's responses to the Commission's recommendations, which overlap the Commission's six broad themes.

Inequities and Disparities
The Commission identified State law, Welfare and Institutions Code (WIC) Section 5812.5(d), 5868(b), 5878.1(a), and Title 9, California Code of Regulations (CCR), Section 3200.100 requiring a county's MHSA Three Year Plan to address disparities, and cultural and linguistic competency by incorporating and working to achieve stated goals in all aspects of policymaking, program design, administration, and service delivery. To accomplish this, the Commission urged DMH to:

- Improve data collection to identify inequities;
- Identify data sources that can be used to help with clarifying unmet needs;
- Develop data analysis and sharing tools to allow to track how well recommendations are being implemented as an area for broad improvement;
- Invest in enhanced technology driven tools and services;
- Correct for disparities in funding across underserved and unserved populations, including ethnic populations in all service areas; and
- Make information available for people with mental illness and their families in multiple languages – specifically those included in the 13 thresholds in Los Angeles County.

In response to these recommendations, DMH notes its key role, along with other County departments and city governments, to reduce disparities in access to high quality health and mental health care. DMH is working in line with the County's efforts to address barriers to seeking treatment that include the composition and competencies of the workforce, addressing the barriers associated with the social determinants of health, culturally relevant engagement and education, and understanding the link between the disproportionate representation of specific cultures in the key focal populations we serve. The Department intends to bring multiple efforts together and learn how to bring governance and leadership together with linguistically appropriate communication, engagement, and continuous improvement to reduce disparities in mental health treatment and recovery.

In an effort to address ethnic and racial disparities and their negative impacts on the overall health and wellbeing of Los Angeles County's marginalized populations, DMH has initiated a number of actions, including:

- Reviewing and analyzing the Department's service and demographic data in an attempt to more comprehensively capture racial, ethnic, cultural, and disability status to more accurately identify to whom we are providing mental health services, including reporting at a more granular level;

- Developing a plan for a public-facing dashboard that will include key demographic data on the clients DMH serves in order to assess the impact of the Department's efforts to reach and serve clients from various ethnic and racial communities; and
- Participating in a multi-county learning collaborative, informed by the outstanding work of Solano County and comprised of training from the University of California, Davis (UC Davis) Center for Reducing Disparities on applying the Culturally and Linguistically Appropriate Standards (CLAS) to populations that we specify and to utilize quality improvement approaches to reduce disparities. DMH's participation is contingent upon the Mental Health Services Oversight and Accountability Commission (MHSOAC) approving the work with UC Davis. DMH views this opportunity as a vehicle to initiate efforts to reduce disparities.

While these new efforts seek to better address disparities going forward, DMH has also identified current and planned efforts within individual MHSA programs and services to address disparities, including:

- ***Full Service Partnership (FSP)***
  - Provide trainings and support for working with diverse populations, with a particular focus on the API community;
  - Work with University of California, Los Angeles (UCLA) and subject matter experts from the API and other communities to develop best practices;
  - Add additional API FSP teams in Service Areas (SAs) 3, 4, and 8; and
  - Increase the use of disparities data across the DMH system, as well as at the local SA level, to inform and shape FSP services for diverse populations.
- ***Outpatient Care Services (OCS)***
  - Establish a new clinic in Koreatown; and
  - Develop a telehealth network across SA to provide language capacity and cultural competency, beginning with an API pilot.
- ***Housing Programs and Services***

  DMH manages various housing resources that are dedicated to individuals who are homeless and have a serious mental illness (SMI). The table below represents individuals living in units that are included in DMH's Permanent Supportive Housing (PSH) portfolio and compares their race and ethnicity to the 2020 Greater Los Angeles Homeless Count and the overall Los Angeles County population. The data seems to suggest that there is an overrepresentation of the Black/African American and White populations and an underrepresentation of the Hispanic/Latino population. However, there are nuances to the data that are unknown, such as the percentage of individuals within a racial or ethnic group who have SMI and the vulnerability levels of those in each group which would impact who is matched to PSH. DMH is participating in system-wide work to research and address disparities in homeless services and housing to:
  - Respond to the recommendations of the Los Angeles Homeless Services Authority (LAHSA) Ad Hoc Committee on Black People Experiencing Homelessness;
  - Collaborate with the California Policy Lab to evaluate differences in service histories and housing outcomes among different racial and ethnic groups; and
  - Focus on identifying and addressing biases of the Coordinated Entry System (CES) Vulnerability Tool used to determine vulnerability and match those

individuals who are homeless and have high vulnerability to available housing resources.

Ethnicity groups currently housed in LACDMH PSH units as of December 31, 2020

Race/Ethnicity	Total	Percent of DMH PSH Portfolio	Percent of Greater LA Homeless Count	Percent of Overall Los Angeles County Population
American Indian	59	1.6%	1.1%	0.2%
Asian	57	1.5%	1.2%	14.4%
Black or African American	1,832	48.9%	33.7%	7.9%
Hispanic or Latino	394	10.5%	36.1%	48.5%
Native Hawaiian or Other Pacific Islander	14	0.4%	0.3%	0.2%
White	1,124	30.0%	25.5%	26.3%
Multi-Racial/Other	54	1.4%	2.1%	2.5%
Unknown	211	5.6%	0.0%	0.0%
Grand Total	3,745	100.0%	100.0%	100.0%

- ***Prevention and Early Intervention***
  The COVID-19 Pandemic has taken a particularly brutal toll on communities of color, with black, indigenous, and people of color (BIPOC) people composing a disproportionate share of infections, hospitalizations, and deaths in the County. BIPOC communities have also borne the brunt of the economic downturn caused by the Pandemic. To better tailor our COVID-19 response to those communities hardest hit by the pandemic, DMH worked with UCLA through its LACDMH+UCLA Public Partnership for Wellbeing (PPfW) to create a COVID-19 Priority Places Map.
  - The COVID-19 Priority Places Map uses data and the index developed from the Advancement Project, which focuses on the intersection of highest week-over-week averages in COVID-19 cases and communities with vulnerable and high-risk populations (defined as individuals living 200% under the federal poverty level and racial composition). Thirty communities across Los Angeles County were identified at the greatest risk for adverse outcomes from COVID-19. Using that information, DMH focused the development of the new Community Ambassador Network (CAN) to hire people from and provide resources in those communities. DMH will continue to use the COVID-19 Priority Places Map and other sources to inform our COVID-19 recovery strategy.
  - The Community Ambassadors are trusted members of the community who are trained and hired as lay mental health workers. The Community Ambassadors help nurture healthy and racially equitable communities by empowering others, raising awareness and mobilizing change, while infusing much needed funding and jobs into our most disenfranchised populations. CAN focuses on those communities which have been disproportionately impacted by the pandemic, systemic racism, police violence and the resulting civil unrest, or that are otherwise marginalized.

DMH launched CAN by leveraging the existing network of trusted community-based organizations currently implementing the Innovation 2 Project - Developing Trauma Resilient Communities through Community Capacity Building project (INN 2). By repurposing unspent INN 2 funds, existing providers were able to create 197 Community Ambassador positions.

Treatments and Services and Utilization and Penetration by Underrepresented Communities

The Commission noted that there were only three (3) hospitals providing psychiatric emergency services, and therefore recommended expansion of this service. In addition, the Commission recommended that an investment should be made to increase access to transport for adults with serious mental illness who live in board and care facilities and in private homes to access day programming.

DMH recognizes the ongoing need for additional psychiatric emergency services (PES). DMH continues to explore ways in which to secure additional funding and/or bed capacity to address the unmet need. In the interim, DMH works closely with our existing PES resources, which include 49 LPS-designated facilities available to place patients in crisis on an involuntary hold, including over 25 General Acute Care Hospitals, nine (9) Acute Psychiatric Hospitals, and eight (8) Mental Health Urgent Care Centers that operate 24/7. DMH also has enriched board and care facilities that have vans which transport patients to and from mental health appointments, medical appointments, and other appointments, such as Social Security.

The Commission recommended steps be taken to better integrate care by incorporating performance-based contract incentives and/or performance improvement plans/consequences and that family engagement be made an explicit outcome within all provider contracts.

During the last two years DMH has embarked on a process and implemented steps to improve the performance of its vast Legal Entity contract provider network, and to ensure that services delivered to clients and families meet standards consistent with federal, State, and local requirements/expectations and perform in alignment with mandates and our strategic plan. Specifically, DMH now has a Contract Management and Monitoring Division (CMMD) with committed staff and resources solely focused on monitoring contract provider performance and service delivery accountability. DMH has developed and implemented several policies and procedures designed to monitor provider performance including: Service Delivery Plans, monthly meetings with agency executive leadership, utilization data, risk management assessment tools, tracking Access to Care metrics, outcomes, etc. DMH uses this information to help inform programmatic and fiscal decision-making.

In addition, DMH currently has a plan to pilot incentivizing provider performance through the FSP redesign.

Outreach Materials
The Commission noted several areas in which outreach materials were needed. They recommended education and resource materials be made available for **outreach to families** to assist families in helping their loved one cope with the lifelong impacts of mental illness and need to be supported - immediately and effectively, and also materials on **homeless prevention** and **housing resources** and a physical location for individuals to seek input and navigation. The Commission recommended these materials should be part of leave behind materials for all Mobile Crisis Response and future Alternative Crisis Response efforts.

DMH acknowledges the need for more educational materials and distribution of these materials through mobile response teams. The DMH Mobile Crisis Teams will prepare materials and/or collaborate with other programs throughout the Department to offer resource information to individuals and families as a part of their response efforts. DMH is also currently working on the Alternative Crisis Response (motion) that includes expansion of Mobile Crisis Teams/PMRT and Mental Evaluation Teams (MET), and the implementation of the 988 National Crisis Line.

Criminal Justice
The Commission recommended adding funding to the following areas: data collection, sobering centers, MET or co-response teams, diversion, Law Enforcement Assisted Diversion, court liaison programs, juvenile adult collaborative courts, alternative sentencing options, mental health beds, mobile crisis response teams.

Upon funding availability, DMH will explore expanding programs and services in the areas recommended by the Commission. As part of a broader effort, DMH continues to partner with the Los Angeles County Chief Executive Office (CEO) Alternatives to Incarceration (ATI) Initiative. DMH is currently exploring expansion of court linkage functions to additional courthouses throughout LA County, either via DMH staff or through contracted agencies. Most of this expansion would be in the Rapid Diversion Program, which was started at the Criminal Courts Building in June 2019, and was expanded to other courthouses in late 2020 and early 2021. Early statistics on diversion outcomes are promising, and DMH is working closely with the ATI Division of the CEO, as well as our other justice partners, in this endeavor.

In the interim, DMH has existing programs and services to support individuals suffering from mental illness that are involved in the criminal justice system, including:

- Jail Transition and Linkage services 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 and to prevent release to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services.

- Mental Health Court Program, a collaboration between DMH and the Los Angeles County Superior Court. 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 provides ongoing support to families and education for court staff and the community at large regarding the specific needs of individuals with mental illness. 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.
- 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 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. Also, this 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.

DMH looks forward to continued collaboration with Your Board and the Commission on the continued progress and implementation of this Plan over the next three years and in our joint mission and ongoing pursuit of improving the lives of individuals, families and communities receiving services and supports from the public mental health system in Los Angeles County.

Sincerely,

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

JES:GP:tld

EXHIBIT G - COUNTY BOARD OF SUPERVISORS ADOPTED LETTER AND MINUTES

DEPARTMENT OF MENTAL HEALTH
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JONATHAN E. SHERIN, M.D., Ph.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer
Clinical Operations

Gregory C. Polk, M.P.A.
Chief Deputy Director
Administrative Operations

June 22, 2021

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES
46 June 22, 2021
CELIA ZAVALA
EXECUTIVE OFFICER

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

Dear Supervisors:

ADOPTION OF THE DEPARTMENT OF MENTAL HEALTH'S MENTAL HEALTH SERVICES ACT THREE-YEAR PROGRAM AND EXPENDITURE PLAN

(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Three-Year Program and Expenditure Plan for Fiscal Years 2021-22, 2022-23, and 2023-24.

IT IS RECOMMENDED THAT THE BOARD:

1. Adopt the Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years (FYs) 2021-22, 2022-23, and 2023-24 (Attachment I). The MHSA Three-Year Program and Expenditure Plan has been certified by the County's Mental Health Director and the Auditor-Controller (A-C) to meet specified MHSA requirements in accordance with Welfare and Institutions Code (WIC) Section 5847.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

In accordance to WIC Section 5847, DMH shall prepare and submit the MHSA Three-Year Program and Expenditure Plan to the County Board of Supervisors for adoption. Board approval of the recommended action will allow DMH to submit the MHSA Three-Year Program and Expenditure Plan to the State of California's Mental Health Services Oversight and Accountability Commission per WIC Section 5847.

Additionally, WIC Section 5848 requires the County's DMH to post the draft MHSA Three-Year Program and Expenditure Plan, for at least 30 days, for the stakeholders and public to review and provide comments. As such, DMH posted the draft MHSA Three-Year Program and Expenditure Plan on its website on March 19, 2021. At the close of the 30-day public review period, DMH and the Mental Health Commission convened a virtual Public Hearing on April 22, 2021 where DMH presented the Plan to stakeholders and the public. At the conclusion of the Public Hearing event, the Mental Health Commission voted to approve the MHSA Three-Year Program and Expenditure Plan.

The MHSA Three-Year Program and Expenditure Plan has been certified by the County's Mental Health Director and the A-C attesting that the County has complied with all fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the MHSA requirements.

Implementation of Strategic Plan Goals

The recommended actions are consistent with the County's Strategic Plan Goal I, Make Investments that Transform Lives, specifically Strategy I.1 — Increase Our Focus on Prevention Initiatives, and Strategy I.2 — Enhance Our Delivery of Comprehensive Interventions.

FISCAL IMPACT/FINANCING

There is no fiscal impact/financing associated with this action.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Assembly Bill (AB) 1467, chaptered into law on June 27, 2012, implemented changes to the MHSA law. AB 1467 requires each county mental health program to prepare the MHSA Three-Year Program and Expenditure Plan and have it adopted by the County's Board of Supervisors prior to the submission to the Mental Health Services Oversight and Accountability Commission. Accordingly, DMH is seeking your Board's approval of its MHSA Three-Year Program and Expenditure Plan in order to comply with these requirements.

The updated MHSA Three-Year Program and Expenditure Plan was originally set to be certified at the beginning of FY 2020-21. However, due to the Covid-19 pandemic the State of California allowed counties to extend the timeline.

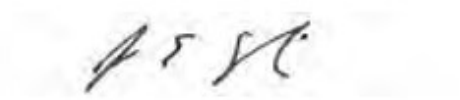
The public hearing notice requirements referenced in WIC Section 5848, subdivisions (a) and (b) have been fulfilled and are recorded in MHSA Three-Year Program and Expenditure Plan.

The MHSA Three-Year Program and Expenditure Plan for FYs 2021-22, 2022-23, and 2023-24 contains a summary of MHSA programs for FY 2019-20, including clients served by MHSA programs and Service Area as well as program outcomes.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Three-Year Program and Expenditure Plan for FYs 2021-22, 2022-23, and 2023-24 will ensure compliance with AB 1467 requirements and ensure that DMH clients continue to have access to the appropriate services.

Respectfully submitted,



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

JES:GCP:SK
MP:atm

Enclosures

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

STATEMENT OF PROCEEDINGS FOR THE

REGULAR MEETING OF THE BOARD OF SUPERVISORS

OF THE COUNTY OF LOS ANGELES HELD VIRTUALLY IN

ROOM 381B OF THE KENNETH HAHN HALL OF ADMINISTRATION

500 WEST TEMPLE STREET, LOS ANGELES, CALIFORNIA 90012

Tuesday, June 22, 2021

9:30 AM

Present: Supervisor Mitchell, Supervisor Kuehl, Supervisor Hahn, Supervisor Barger and Supervisor Solis

Video Link for the Entire Virtual Meeting (03-1075)

Attachments: Video Transcript

46. Mental Health Services Act Three-Year Program and Expenditure Plan

Recommendation: Adopt the Department of Mental Health's Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years 2021-22, 2022-23 and 2023-24, which has been certified by the Director of Mental Health and the Auditor-Controller to meet specified MHSA requirements in accordance with Welfare and Institutions Code Section 5847. **(Department of Mental Health)** (21-2494)

Interested person(s) submitted written testimony.

On motion of Supervisor Kuehl, seconded by Supervisor Hahn, this item was duly carried by the following vote:

Ayes: 5 - Supervisor Mitchell, Supervisor Kuehl, Supervisor Hahn, Supervisor Barger and Supervisor Solis

Attachments: Board Letter
Revised Board Letter
Public Comment/Correspondence

http://file.lacounty.gov/SDSInter/bos/supdocs/159434.pdf

APPENDICES

APPENDIX A - COMMUNITY PLANNING

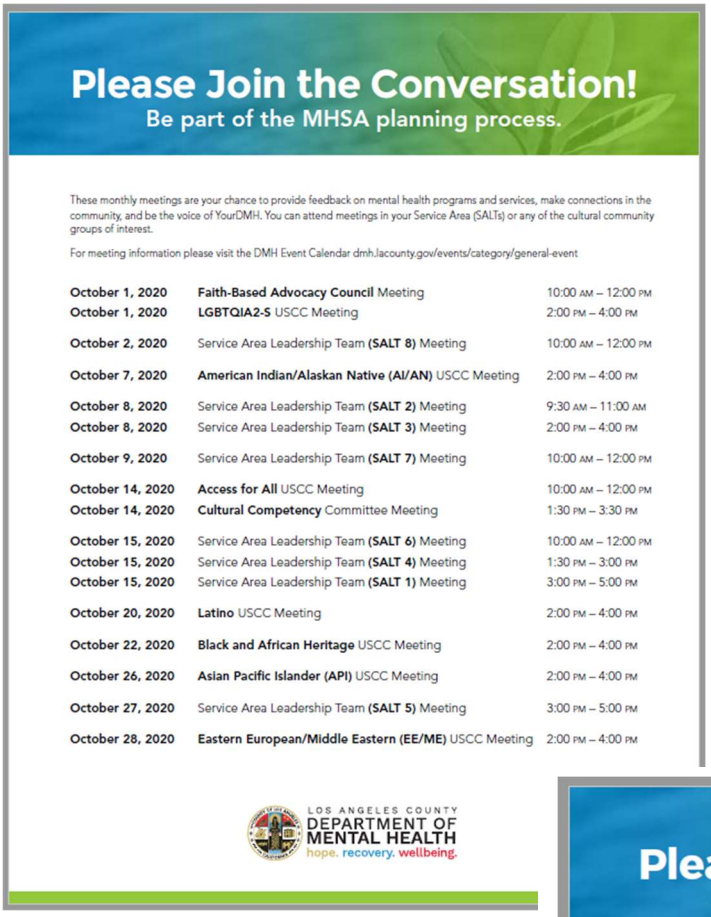
[A1] STAKEHOLDER PRESENTATION TO SALT AND USCC (OCT – NOV 2021) CALENDAR OF MEETINGS AND SURVEY INFORMATION (PLEASE SEE SERVICE AREA DATA IN APPENDIX B)

The trauma of racial injustice and the continued presence of the COVID-19 affect each person's mental well-being in different ways. As the Department stands to support racial equity across all our programs and services, the community's feedback was solicited. Survey questions also highlight the feedback necessary to drive our pivots in light of the pandemic. Input was welcomed through this survey in English & Spanish and if additional language needs for completing the survey were needed, they could contact PIO@dmh.lacounty.gov.

In late 2020, LACDMH presented its MHSA information for FY 2018-19, including demographics, services provided and consumer needs specific to each County Service Area (see Appendix B). The information provided is available using the following link: https://dmh.lacounty.gov/about/mhsa/announcements.

The needs assessment was conducted during these meetings. Stakeholders were asked to answer the following survey questions:

- What are some of the unmet needs of the Service Area (SA) you represent?
- How has the COVID 19 pandemic further impacted unmet needs of the SA you represent?
- How do you propose LACDMH address the unmet needs?
- How can MHSA programs throughout the Department address issues of social equity?
- What can LACDMH do to improve transitions between levels of care to ensure successful flow of clients through needed levels of care?
- What are the strengths and weaknesses of LACDMH?



Please Join the Conversation!

Be part of the MHSA planning process.

These monthly meetings are your chance to provide feedback on mental health programs and services, make connections in the community, and be the voice of YourDMH. You can attend meetings in your Service Area (SALTs) or any of the cultural community groups of interest.

For meeting information please visit the DMH Event Calendar dmh.lacounty.gov/events/category/general-event

October 1, 2020	**Faith-Based Advocacy Council** Meeting	10:00 AM – 12:00 PM
October 1, 2020	**LGBTQIA2-S** USCC Meeting	2:00 PM – 4:00 PM
October 2, 2020	Service Area Leadership Team **(SALT 8)** Meeting	10:00 AM – 12:00 PM
October 7, 2020	**American Indian/Alaskan Native (AI/AN)** USCC Meeting	2:00 PM – 4:00 PM
October 8, 2020	Service Area Leadership Team **(SALT 2)** Meeting	9:30 AM – 11:00 AM
October 8, 2020	Service Area Leadership Team **(SALT 3)** Meeting	2:00 PM – 4:00 PM
October 9, 2020	Service Area Leadership Team **(SALT 7)** Meeting	10:00 AM – 12:00 PM
October 14, 2020	**Access for All** USCC Meeting	10:00 AM – 12:00 PM
October 14, 2020	**Cultural Competency** Committee Meeting	1:30 PM – 3:30 PM
October 15, 2020	Service Area Leadership Team **(SALT 6)** Meeting	10:00 AM – 12:00 PM
October 15, 2020	Service Area Leadership Team **(SALT 4)** Meeting	1:30 PM – 3:00 PM
October 15, 2020	Service Area Leadership Team **(SALT 1)** Meeting	3:00 PM – 5:00 PM
October 20, 2020	**Latino** USCC Meeting	2:00 PM – 4:00 PM
October 22, 2020	**Black and African Heritage** USCC Meeting	2:00 PM – 4:00 PM
October 26, 2020	**Asian Pacific Islander (API)** USCC Meeting	2:00 PM – 4:00 PM
October 27, 2020	Service Area Leadership Team **(SALT 5)** Meeting	3:00 PM – 5:00 PM
October 28, 2020	**Eastern European/Middle Eastern (EE/ME)** USCC Meeting	2:00 PM – 4:00 PM

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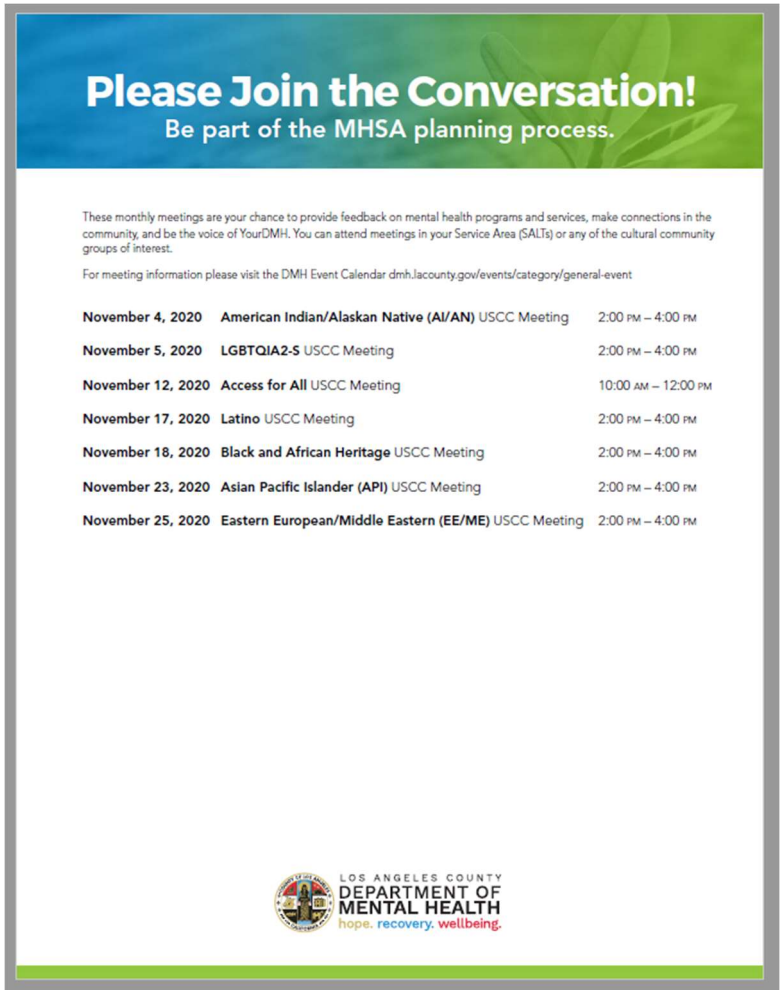

Please Join the Conversation!

Be part of the MHSA planning process.

These monthly meetings are your chance to provide feedback on mental health programs and services, make connections in the community, and be the voice of YourDMH. You can attend meetings in your Service Area (SALTs) or any of the cultural community groups of interest.

For meeting information please visit the DMH Event Calendar dmh.lacounty.gov/events/category/general-event

November 4, 2020	**American Indian/Alaskan Native (AI/AN)** USCC Meeting	2:00 PM – 4:00 PM
November 5, 2020	**LGBTQIA2-S** USCC Meeting	2:00 PM – 4:00 PM
November 12, 2020	**Access for All** USCC Meeting	10:00 AM – 12:00 PM
November 17, 2020	**Latino** USCC Meeting	2:00 PM – 4:00 PM
November 18, 2020	**Black and African Heritage** USCC Meeting	2:00 PM – 4:00 PM
November 23, 2020	**Asian Pacific Islander (API)** USCC Meeting	2:00 PM – 4:00 PM
November 25, 2020	**Eastern European/Middle Eastern (EE/ME)** USCC Meeting	2:00 PM – 4:00 PM

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[A2] CLT QUARTERLY MEETING AGENDA - OCT 12, 2020

Los Angeles County Department of Mental Health (DMH)
Community Leadership Team – Quarterly Meeting
Wednesday, October 12, 2020
1:00 – 3:00 PM

Purpose

To strengthen the collaborative relationship between the Community Leadership Team (CLT) and the DMH Director and key staff to achieve a shared vision.

Objectives

1. Present a milestone calendar that describes key points in the year when DMH gathers information, sets priorities, and establishes a budget.
2. Discuss how DMH can support CLT Co-Chairs so that Service Area Leadership Teams (SALTs), Underserved Cultural Communities (UsCCs), and the Cultural Competency Committee (CCC) can provide timely and relevant information to shape DMH's priorities and budgeting.
3. Share a general update on CARES Act Funds and DMH's Ambassadors/Promotoras Program.

Agenda

Time	Item	Outcome – Ideally, participants will…
1:00 (20 min)	**1. Meeting Opening** a. Welcome & Introductions (15 min) b. Review Agenda (3 min) c. Ground Rules (2 min)	• Know who is present, understand the agenda, and agree to meeting ground rules.
1:20 (40 min)	**2. DMH Milestone Calendar** a. Presentation (15 min) b. Discussion (25 min)	• Identify key points in the year when DMH gathers information, sets priorities, and creates a budget. • Recognize when CLT information is most relevant and timely to inform DMH priorities and budget.
2:00 (30 min)	**3. Co-Chair Support and IT Infrastructure** a. Presentation (15 min) b. Discussion (15 min)	• Share key Co-Chairs' needs and the critical importance of an IT infrastructure to support community access and participation.
2:40 (20 min)	**4. CARES Act Funds and DMH** a. Presentation (10 min) b. Discussion (10 min)	• Recognize how CARES Act will be used by DMH and how to access these resources.
2:50 (10 min)	**5. Closing Reflections** a. Next Steps & Next CLT Meeting b. Brief Closing Reflection	• Concretize next steps, including the date for the next CLT meeting. • Share a one-word statement about their meeting experience.
3:00	**6. Adjourn**	

[A3] CLT QUARTERLY MEETING AGENDA - JAN 20, 2021

Los Angeles County Department of Mental Health (DMH)
Community Leadership Team – Quarterly Meeting
Wednesday, January 20, 2021
12:00 – 3:00 PM

Purpose

To strengthen the collaborative relationship between the Community Leadership Team (CLT) and the DMH Director and key staff to achieve a shared vision.

Objectives

1. Present an organizational framework that describes roles, expectations, and best practices for Co-Chairs and DMH staff, obtain feedback, and articulate next steps.
2. Describe the last stage of the MHSA Three-Year Plan planning process and the remaining opportunities for community input.
3. Share a general update from the perspective of the DMH Director, Dr. Jonathan Sherin.

Agenda

Time	Item
12:00 (20 min)	**1. Meeting Opening** a. Welcome & Introductions (15 min) b. Review Agenda (3 min) c. Ground Rules (2 min)
12:20 (75 min)	**2. Organizational Framework** a. Overview (15 min) b. Small Group Dialogue (45 min) c. Large Group Discussion (30 min)
1:35 (10 min)	**3. Break**
1:45 (30 min)	**4. MHSA 3-Year Plan - Planning Process** a. Presentation (10 min) b. Discussion (20 min)
2:15 (40 min)	**5. DMH Director Update and Dialogue** a. Presentation (15 min) b. Dialogue (25 min)
2:55 (5 min)	**6. Closing Reflections** a. Next Steps & Next CLT Meeting b. Brief Closing Reflection
3:00	**7. Adjourn**

[A4] THREE-YEAR PLAN PRESENTATION TO CLT (MAR 5, 2021) AGENDA AND POWERPOINT PRESENTATION

This presentation of the FYs 2021-2024 Three-Year Plan to the CLT members focused on identifying and reducing disparities.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
MHSA Three-Year Plan Program and Expenditure Plan, FY 2021-2024
Community Leadership Team Feedback Session
Friday, March 5, 2021 / 10am-2pm

OBJECTIVES

1. **Provide** a big-picture view of DMH's approach to reducing mental health disparities in Los Angeles County through multiple strategies and resources.
2. **Describe** the Community Planning Process (CPP) and **present** the draft *MHSA Plan* components (i.e., *CSS Plan, PEI Plan, INN Plan, WET Plan, and CF/TN Plan*).
3. **Obtain** the Community Leadership Team's feedback regarding the draft *MHSA 3-Year Plan.*

AGENDA

Item		Time
I.	**Meeting Opening**	
	A. Purpose, Objectives, Meeting Principles	10:00-10:20
	B. Introductions	
II.	**Big-Picture View: DMH's Approach to Mental Health Disparities**	
	A. Presentation	10:20-11:00
	B. Discussion	
III.	**MHSA Plan Presentation, Part 1**	
	A. CPP	11:00-11:35
	B. CSS Plan	
IV.	**Break**	11:35-11:45
V.	**MHSA Plan Presentation, Part 2**	
	A. PEI Plan	
	B. INN Plan	11:45-12:15
	C. WET Plan	
	D. CF/TN Plan	
VI.	**Transition**	12:15-12:20
VII.	**Small Group Discussion**	
	A. Group A: *CSS Plan*	12:25-1:00
	B. Group B: *PEI Plan, INN Plan, WET Plan, and CF/TN Plan*	
VIII.	**Transition/Break**	1:00-1:10
IX.	**Small Group Discussion**	
	A. Group A: *PEI Plan, INN Plan, WET Plan, and CF/TN Plan*	1:10-1:45
	B. Group B: *CSS Plan*	
X.	**Transition**	1:45-1:50
XI.	**Closing Reflections**	1:50-2:00
XII.	**Adjourn**	2:00


MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2021-22 through 2023-24
WELLNESS • RECOVERY • RESILIENCE
Presentation to the
Community Leadership Team (CLT)
March 5, 2021
LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.
Our mission is to optimize the hope, wellbeing and life trajectory of Los Angeles County's most vulnerable through access to care and resources that promote not only independence and personal recovery, but also connectedness and community reintegration.

1


MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN PRESENTATION LAYOUT
01 INTRO AND FOCUS ON DISPARITIES
• Mental Health Services Act and Purpose of Three-Year Plan
• Funding Concerns and Opportunities
• FY 2019-20 MHSA Direct Services Cost by Ethnicity and Plan
• FY 2019-20 CAL-EQRO Performance Measures
• Percent Change in Consumers Served in Outpatient Programs by Race over a Four-Year Period
• Proposed Actions to Address Racial/Ethnic Mental Health Care Disparities
02 COMMUNITY PLANNING
• Community Planning Process
- Activities and Meeting Dates
- Upcoming Important Dates
- Stakeholder Engagement
03 EXISTING MHSA PROGRAMS AND PROPOSED CHANGES
• Review of Existing Programs and Services by MHSA Component
• Proposed Changes
- Full Service Partnership Redesign
- Mental Health Treatment Bed Capacity
- Modernization of 24/7 ACCESS Call Center
04 SMALL GROUP DISCUSSIONS
• What did you like? What questions do you have?
• What suggestions do you have?
SLIDE • 2

2

MENTAL HEALTH SERVICES ACT AND THE PURPOSE OF THE THREE-YEAR PLAN

- In November 2004, California voters supported Proposition 63 and passed the Mental Health Services Act (MHSA) that imposes a 1% income tax on personal income in excess of $1 million.
- The Act provides the significant funding to expand, improve and transform public mental health systems to improve the quality of life for individuals living with a mental illness.
- Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Plan Updates for MHSA programs and expenditures.
- The Plan provides an opportunity for counties to
  - Review its existing MHSA programs and services to evaluate their effectiveness; and
  - Propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available.
- It is through this Community Planning Process that important feedback is gathered from stakeholders.

SLIDE - 3

3

FUNDING CONCERNS AND OPPORTUNITIES

- Anticipated reductions in MHSA, Sales Tax Realignment, County NCC funding
  - Economic Impact of COVID-19
  - Competing Countywide Initiatives, such as
    - Alternatives to Incarceration
    - Justice Reform
    - Homelessness
    - Affordable Housing
    - Healthcare Integration (Restorative Care Villages)
- Potential Funding Opportunities
  - Measure J
  - CARES Act
  - Substance Abuse and Mental Health Services Administration (SAMHSA)
- Challenges
  - Implementation Delays
  - DMH Infrastructure
  - Statutory and Contractual Limitations

Measure J Funding Proposals
Crisis Facility Care
Mental Health Treatment Beds (Acute, Subacute, Residential and Congregate Care)
Housing for Mental Health
Psychiatric Mobile Response Teams (PMRT)
Therapeutic Transportation
Mental Health Court Linkage
Co-Response Teams
Mental Health Conservatorship
Assisted Outpatient Treatment (AOT)
Outpatient & Community Services – Peer Workforce
Crisis Information Exchange
Individualized Placement and Support (IPS)

SLIDE - 4

4

FOCUS ON DISPARITIES

MHSA Direct Services Costs by Ethnicity and Plan

FY 2019-20 MHSA DIRECT SERVICES COSTS BY ETHNICITY AND PLAN

MHSA Plan (in millions)	Asian/ Pacific Islander	Black/ African American	Hispanic	Multiple Races	Native American	Other	White	Total
Full Service Partnership (FSP)	$8.9 [4%]	$61.8 [26%]	$78.1 [33%]	$8.2 [3%]	$2.2 [1%]	$37.4 [16%]	$43.6 [18%]	**$240.2**
Alternative Crisis Services (ACS)	$3.1 [3%]	$17.4 [24%]	$20.0 [28%]	$3.0 [4%]	$0.3 [<1%]	$10.5 [15%]	$17.5 [24%]	**$71.8**
Outpatient Care Services (OCS)	$23.6 [5%]	$76.3 [17%]	$174.2 [38%]	$19.1 [4%]	$3.5 [1%]	$92.5 [20%]	$68.7 [15%]	**$457.9**
Prevention and Early Intervention (PEI)	$2.8 [5%]	$5.8 [10%]	$24.2 [43%]	$3.4 [6%]	$0.4 [1%]	$14.0 [25%]	$6.1 [11%]	**$56.7**
Total	**$38.4**	**$161.3**	**$296.5**	**$33.7**	**$6.4**	**$154.4**	**$135.9**	**$826.6**

SLIDE = 5

5

FOCUS ON DISPARITIES

California External Quality Review Organization (CAL-EQRO) FY 2019-20 Performance Measures

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018, by Race/Ethnicity Los Angeles MHP

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	514,888	13.0%	32,635	15.5%
Latino/Hispanic	2,320,000	58.6%	108,093	51.4%
African-American	390,371	9.9%	37,455	17.8%
Asian/Pacific Islander	377,714	9.5%	9,422	4.5%
Native American	5,042	0.1%	522	0.2%
Other	356,845	9.0%	22,210	10.6%
Total	**3,960,000**	**100%**	**210,337**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it.
The averages are calculated independently.

Data represents entire Los Angeles County and is not MHSA specific

Data Source: The Mental Health Services Division at DHCS contracts with Behavioral Health Concepts, Inc. (BHC) to provide EQRO services for California's MHPs. Information on Medi-Cal beneficiaries served and penetration rates represent two of the seven performance measures summarized in their annual BHC-CalEQRO Validation of Performance Measures (PM) Reports.

SLIDE = 6

6

FOCUS ON DISPARITIES

Percent Change in Consumers Served in Outpatient Programs by Race/Ethnicity (Four-Year Period)

Percent change by ethnicity group served in outpatient programs between FY 2016-17 and FY 2017-18:

- Latinos - ⇩ *decreased* by 8.2 percentage points (PP) from 57.2% to 49.0%
- Asian/Pacific Islanders - ⇧ *increased* by 1.8% PP from 4.0% to 5.8%
- Native Americans - ⇧ *increased* by 0.2 PP from 0.6% to 0.8%

Includes all funding sources, not only MHSA

Ethnicity	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Latino	51.8%	53.8%	57.2%	49.0%
African American	25.2%	23.7%	21.6%	25.0%
White	16.5%	17.2%	16.5%	19.5%
Asian/Pacific Islander	6.0%	4.7%	4.0%	5.8%
Native American	0.4%	0.5%	0.6%	0.8%

Figure shows the change in race/ethnicity that has occurred within consumers served in Los Angeles County mental health outpatient settings over four fiscal years.
Data Source: DMH, IS-IBHIS, September 2019

SLIDE = 7

7

FOCUS ON DISPARITIES

Proposed Actions to Address Racial/Ethnic Mental Health Care Disparities

MULTI-COUNTY LEARNING COLLABORATIVE

Participate in a multi-county learning collaborative with UC Davis' Center for Reducing Disparities. Los Angeles County will apply the learning related to the Culturally and Linguistically Appropriate Services (CLAS) Standards to the populations we have identified and utilize quality improvement strategies to work toward disparities reduction and culturally relevant treatment approaches.

CULTURAL AND LINGUISTIC COMPETENT MENTAL HEALTH SERVICES

Increase the availability of culturally and linguistically competent mental and behavioral health services accessible to racial and ethnic minorities and cultures.

SLIDE = 8

8

COMMUNITY PLANNING PROCESS (CPP)

CPP Activities and Meeting Dates

[Oct 21, 2020]
DMH presented a timeline of scheduled CPP efforts CLT, made up of Co-Chairs from 2 stakeholder networks: the Service Area Leadership Teams (SALTs) and Underserved Community Groups (UsCC).

[Oct – Nov 2020]
Multiple meetings with SALTs and UsCCs to:
- present demographic and consumer needs info specific to each Service Area; and
- conduct a Needs Assessment (online survey was also available).

[Feb 11, 2021]
A Summary of the Plan was presented to the Executive Committee of the Mental Health Commission for input and feedback.

[March 5, 2021]
A Summary of the Plan, including Stakeholder Feedback and a Focus on Disparities, is being presented today to the CLT for input and feedback.

Upcoming Important Dates

[Mar 19, 2021]
The full version of the draft FYs 2021-22 through 2023-24 Three-Year Plan will be posted on the DMH website to allow for the 30-day public review and comment period.

[Apr 22, 2021]
The draft Three-Year Plan will be presented to the full Mental Health Commission at this Public Hearing date.

[May – June 2021]
Final Three-Year Plan will be presented to the Board of Supervisors for approval.

SLIDE = 9

9

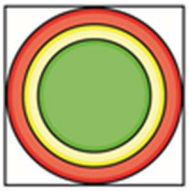
STAKEHOLDER ENGAGEMENT

SURVEY QUESTIONS

- What are your unmet needs of the Service Area (SA)?
- How has the COVID-19 pandemic further impacted unmet needs of the SA?
- How do you propose DMH address the unmet needs?
- What can DMH do to improve transitions between levels of care to ensure successful flow of clients through needed levels of care?

STAKEHOLDER FEEDBACK EIGHT MAJOR THEMES

1. Additional Mental Health Services across all ages, geographic areas, and cultural groups with a special focus on services for Children and Youth and the Asian/Pacific Island (API) community
2. A Focus on Levels of Care
3. Additional Supportive Housing and Beds
4. Data
5. Training
6. Funding for Non-Direct Services
7. Covid-19 Safety Measures
8. Social Equity



EVALUATION OF RESOURCES

Is there available funding and capacity to:

- Augment existing services; and
- Develop new services?

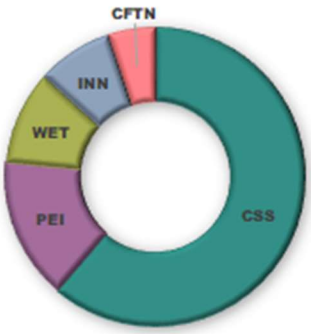
NEEDS ASSESSMENT → STAKEHOLDER INPUT → DMH STRATEGIC PLAN → THREE-YEAR PLAN

SLIDE = 10

10

MHSA OVERVIEW BY COMPONENTS

The next few slides will provide information on the existing programs by MHSA Component



- COMMUNITY SERVICES AND SUPPORTS (CSS)
- PREVENTION AND EARLY INTERVENTION (PEI)
- WORKFORCE EDUCATION AND TRAINING (WET)
- INNOVATIONS (INN)
- CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

SLIDE = 11

11

CSS OVERVIEW

- Largest MHSA component with 76% of the total MHSA allocation
- For clients with a diagnosed serious mental illness

CSS PROGRAMS:

- Full Service Partnership (FSP)
- Outpatient Care Services (OCS)
- Alternative Services Crisis (ACS)
- Housing
- Linkage
- Planning, Outreach and Engagement (POE)

UNIQUE CLIENTS SERVED

In FY 2019-20, 147,766 unique clients received a direct service.

Ethnicity
- 35% Hispanic
- 20% African American
- 17% White
- 5% Asian/Pacific Islander
- 1% Native American

Primary Language
- 79% English
- 14% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE

50,502 new clients were served with no previous MHSA service.

Ethnicity
- 38% Hispanic
- 15% African American
- 16% White
- 3% Asian/Pacific Islander
- 0.51% Native American

Primary Language
- 78% English
- 14% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	8,786	4,800
SA2 – San Fernando Valley	21,926	10,345
SA3 – San Gabriel Valley	19,602	11,721
SA4 – Metro	31,318	16,743
SA5 – West	10,236	5,698
SA6 – South	28,413	15,796
SA7 – East	12,662	7,406
SA8 – South Bay	30,675	17,317

SLIDE = 12

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CSS – FULL SERVICE PARTNERSHIP OVERVIEW

- Provides 24/7 intensive outpatient services for DMH's highest acuity clients who fall within State focal population guidelines
- Intended Outcomes
  - Reduces serious mental health systems, homelessness, incarceration and hospitalization
  - Increases independent living

FSP SLOTS AND CLIENTS SERVED BY AGE GROUP
(FY 2019-20)

Age Group	Slots	Number of Clients Served
Child	3,584	3,944
Transitional Age Youth	1,410	2,950
Adult	10,986	7,715
Older Adults	885	1,897

Proposed Changes in New Three-Year Plan

FSP Transformation - Launches July 1, 2021, with existing FSP providers to pilot this new model over the next three years. Lessons learned from this pilot will inform the rebid of FSP contracts in FY 2024-25.

- Eligibility criteria more focused on those most in need of FSP care
- Multidisciplinary team/population approach rather than individual caseloads and "slots"
- Integrating all current specialty FSP into one FSP model (exception is Housing FSP will go under housing support)
- Lower client-to-staff ratios
- Additional staffing to enable Child FSP to provide Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)
- Enhanced training and technical assistance to support FSP providers in achieving outcomes
- Enhanced services and supports to ensure successful transitions from levels of care
- Centralized authorization, enrollment and disenrollment processes
- Standardized rates to bring contracted provider staff salaries closer to parity with counterparts in DMH clinics
- Changes to FSP contract to add incentives to help clients achieve critical life outcomes
- Using data, and consumer/provider feedback to drive continuous improvement

SLIDE = 13

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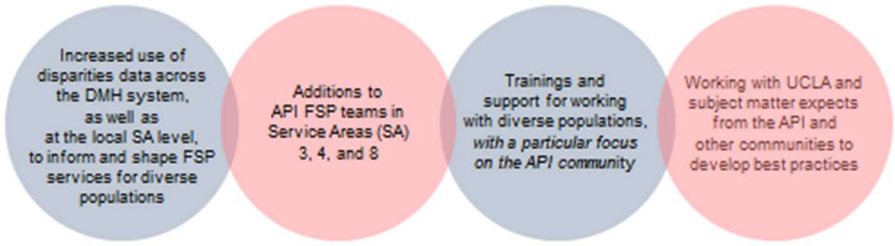
CSS – ADDRESSING FSP DISPARITIES



SLIDE = 14

14

CSS – OUTPATIENT CARE SERVICES OVERVIEW

- Provides community-based, clinic-based, and well-being services, including
  - Individual, group & family therapy
  - Evidence-based treatments
  - Peer support
  - Medication
  - Case management
  - Crisis resolution/crisis intervention
  - Linkage to primary care
  - Assistance with benefits establishment, housing and other social determinants of health
  - Vocational & pre-vocational services
- Our aim is to help our clients and families to:
  - Achieve their recovery goals
  - Have a safe place to live
  - Use their time in a meaningful way
  - Have healthy relationships
  - Access public assistance when necessary
  - Weather crises successfully
  - Have the best possible physical health

CLIENTS SERVED BY AGE GROUP (FY 2019-20)

Age Group	Number of Clients Served
Child	24,549
Transitional Age Youth	17,971
Adult	57,620
Older Adults	14,934

Continued Work based on Current Three-Year Plan

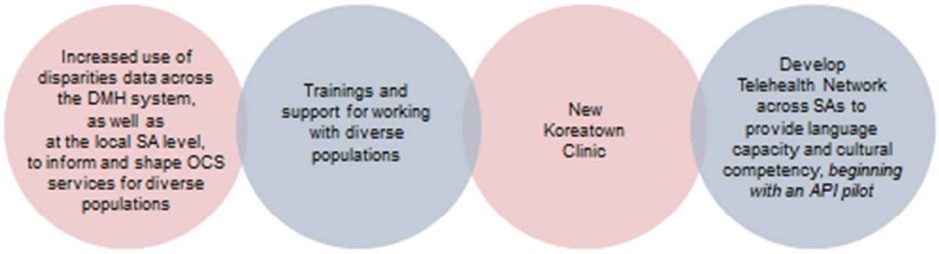
Coming enhancements:

- Modernized Call Center to assist in access to services and the most appropriate level of care
- Building up and supporting capacity to ensure successful transitions from higher levels of care

SLIDE = 15

15

CSS – ADDRESSING OCS DISPARITIES



SLIDE = 16

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CSS – HOUSING OVERVIEW

- Provides housing resources; mental health programs for individuals with Serious Mental Illness (SMI) or Serious Emotional Disorder.
- Provides training technical assistance; and advocacy on housing, employment and education.
- Intended Outcomes
  - Assist homeless clients to obtain interim housing and permanent housing;
  - Assist clients living in permanent housing to retain housing;
  - Increase the overall number of interim and permanent supportive housing (PSH) units and rental subsidies targeting DMH clients.

HOUSING DATA (FY 2019-20)

- $390M in housing capital investments through No Place Like Home (NPLH) with additional $50M to be awarded
- 2,399 tenant-based PSH units
- $10M in ongoing rental subsidies for 413 FSP clients who are homeless with high acuity
- $2.4M in move-in costs to transition 1,082 households from homelessness to housing
- Expanded Enriched Residential Care Program to provide funding for licensed residential facility to serve a final census of 572 clients at fiscal year end
- 504 interim housing beds to provide 1,129 individuals and 153 families with short-term shelter and case management services

MULTI-YEAR HOUSING INVESTMENTS SINCE 2008

- $670M for 140 PSH developments and funding 3,608 units for individuals with SMI
- Operating subsidies for 13 of 140 housing developments
- Housing FSP services at 92 housing sites

SLIDE = 17

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CSS – HOUSING OVERVIEW

Continued Work based on Current Three-Year Plan

- Continue investments in the capital development PSH through NPLH including allocating at least $100M to develop PSH at Restorative Care Village sites on health care campuses
- Redesign the Housing FSP program to enhance the service model and continue to expand supportive services to those who are living in PSH as new developments open and lease up
- Continue investing in efforts to strengthen Licensed Residential Facilities, including increasing the budget by $6M with SAMHSA* funds to subsidize more DMH clients living in Board and Care Homes; seeding a membership association; administering a capital improvements grant program; and implementing a bed tracking system
- Partner with the County Department of Health Services (DHS) and California Policy Lab to implement the new Homeless Prevention Unit, which identifies those who are most at risk of homelessness through predictive analytics and provides them with housing retention services
- Utilize $500,000 in funding from the Conrad N. Hilton Foundation to pay for the short-term housing needs of individuals released from prison that are linked to DMH services

*Substance Abuse and Mental Health Services Administration

SLIDE = 18

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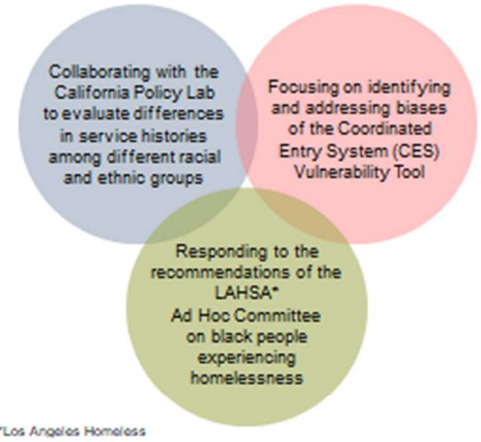
CSS – ADDRESSING HOUSING DISPARITIES

DMH is participating in systemwide work to research and address racial disparities in homeless services and housing, including



*Los Angeles Homeless Services Authority

Race/Ethnicity of Housed Clients in DMH PSH as of 12/31/2020

Race	DMH PSH Total	DMH PSH %	Homeless Count %	L.A. County%
American Indian	59	1.6%	1.1%	0.2%
Asian	57	1.5%	1.2%	14.4%
Black or African American	1832	48.9%	33.7%	7.9%
Hispanic or Latino	394	10.5%	36.1%	48.5%
Native Hawaiian or Other Pacific Islander	14	0.4%	0.3%	0.2%
White	1124	30.0%	25.5%	26.3%
Multi-Racial / Other	54	1.4%	2.1%	2.5%
Unknown	211	5.6%	0.0%	0.0%
Grand Total	**3,745**	**100.0%**	**100.0%**	**100.0%**

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CSS – ALTERNATIVE CRISIS SERVICES OVERVIEW

- Provides a comprehensive range of services and supports for mentally-ill individuals that are designed to
  - Offer alternatives to emergency room care, acute inpatient hospitalization and institutional care
  - Reduce homelessness
  - Prevent incarceration
- MHSA ACS programs include:
  - Residential and Bridging Care (RBC) Program
  - Psychiatric Urgent Care Centers (UCC)
  - Enriched Residential Services (ERS)
  - Crisis Residential Treatment Programs (CRTP)
  - Law Enforcement Teams (LET)

FY 2019-20

ERS

388 Admissions

CRTP

7 Centers and 99 Beds
(280 additional beds planned)

UCC

8 UCCs
- Service Areas 2, 3, 4, 5, 6 and 8
- New UCCs - High Desert (SA1) & Olive View (Part of Restorative Care Village)
- Approximately 126 Beds
- 49,518 Client Contacts

LET

14,472 Calls
- 31% Homeless individuals
- 3% Arrests
- 61% Required Hospitalization

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CSS – ACS OVERVIEW

Proposed Changes in New Three-Year Plan

- No proposed changes.
- However, continued work over the next three fiscal years to implement County initiative to expand mental health bed capacity and improve service quality, pending funding commitments:
  - Two-year bed pilot program to procure various types of beds
  - COVID-19 resulted in greater need for beds to focus on prevention, as well as open residential treatment and crisis residential beds; and decompress County hospital beds
  - Strategize to invest resources based on funding availability (potential sources: County NCC funding, Measure J, CARES Act, MHSA, SAMHSA)

FY 2020-21 Budget

Cost	Beds
$209M	Acute Psychiatric Hospitals
$194M	Subacute (includes IMD, Medical SNF, State Hospitals, and State Hospital Alternatives)
$38M	Open Residential (includes ERS, Crisis Residential Care, ERC, and Congregate Care)
$49M	Urgent Care Center Chairs

= $490M Total Budgeted in Gross Cost

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PEI OVERVIEW

- Second largest MHSA component with 19% of the total MHSA allocation
- Focus on providing preventative and early intervention strategies, education, support and outreach to those at risk of developing mental illness or experiencing early symptoms.

PEI PROGRAMS:
- Prevention
- Early Intervention
- Suicide Prevention
- Stigma and Discrimination Reduction

UNIQUE CLIENTS SERVED

In FY 2019-20, 47,602 unique clients received a direct service.

Ethnicity
- 45% Hispanic
- 9% African American
- 8% White
- 2% Asian/Pacific Islander
- 1% Native American

Primary Language
- 74% English
- 22% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA

26,381 new clients were served with no previous MHSA service

Ethnicity
- 44% Hispanic
- 8% African American
- 8% White
- 3% Asian/Pacific Islander
- 0.48% Native American

Primary Language
- 74% English
- 22% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	3,410	2,990
SA2 – San Fernando Valley	7,596	5,840
SA3 – San Gabriel Valley	8,494	6,414
SA4 – Metro	6,329	5,388
SA5 – West	1,828	1,685
SA6 – South	6,049	5,163
SA7 – East	6,720	5,892
SA8 – South Bay	7,923	6,846

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PEI OVERVIEW

- Prevention programs and services promote positive cognitive, social and emotional development that serves to reduce or prevent mental illness from occurring while providing supportive services to individuals, families and communities outside of traditional clinic settings with the goal of avoiding adverse system involvement.

- *Continued Work based on Current Three-Year Plan*
  DMH continues to provide an array of Prevention Programs and Projects to significantly reduce risk factors or stressors, build protective factors and skills, and increase supports where at-risk individuals live, work, worship and gather. Some of these efforts include:
  - School Based Community Access Platforms
  - Youth Diversion and Development
  - Transforming LA (formally known as Incubation Academy)

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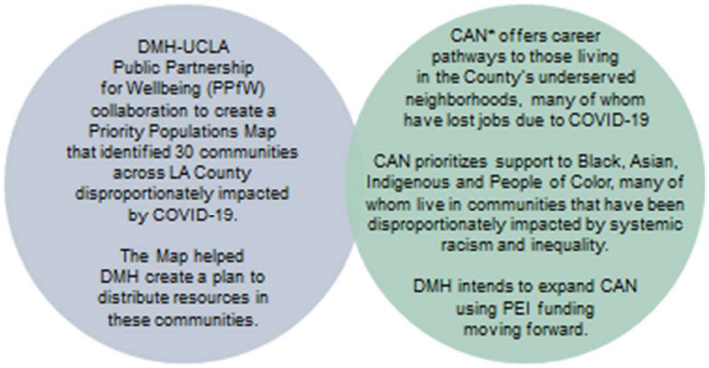
PEI – ADDRESSING DISPARITIES

Prevention efforts are addressing racial disparities and helping improve the overall mental health and wellbeing of our entire County. These efforts include:



*Community Ambassador Network

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INN OVERVIEW

Provides 5% funding for time-sensitive projects that introduce new or improved practices or approaches to the delivery of mental health services.

INN PROJECTS

INN 2 - Community Capacity Building to Prevent Trauma
INN 3 - Technology Suites
INN 4 - Transcranial Magnetic Stimulation "TMS"
INN 5 - Peer Operated FSP
INN 7 - Therapeutic Transport
INN 8 - Early Psychosis Learning Network
INN 9 - Conservatee Support
TRIESTE (→ Hollywood Pilot)

- Priority Projects
  - INN 7 Therapeutic Transport
  - INN 8 Early Psychosis Learning Network
  - TRIESTE (→ Hollywood Pilot)
    Partnership with the First Presbyterian Church of Hollywood to develop and implement a two-phase project that will transition individuals outreached by the HOME Team and living in the Hollywood area who are experiencing homelessness and have a SMI to innovative no barriers housing model
- DMH is reevaluating remaining INN projects to determine whether they align with Strategic Plan.

Proposed Changes in New Three-Year Plan

INN TIMELINE EXTENSIONS - The following projects will require extensions to the original project timeline due to delayed implementation. The timelines will adjust to the 5-year maximum.
INN 2 - Community Capacity Building to Prevent Trauma
INN 3 - Technology Suites
INN 4 - Transcranial Magnetic Stimulation "TMS"
INN 5 - Peer Operated FSP
INN 7 - Therapeutic Transport

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WET OVERVIEW

Focused on creating and supporting a workforce that is culturally competent, consumer/family driven and promotes the transformation of mental health services to a strength-based approach that is inclusive of recovery, resilience and wellness

WET PROGRAMS

Navigator Skill Development Program
Charles Drew Affiliation Agreements - Pathways to Health Academy Program - Psychiatric Residency Program
Intensive Mental Health Recovery Specialist Training Program
Interpreter Training Program
DMH+UCLA Public Partnership for Wellbeing
Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System
WET Regional Partnership
Licensure Preparation Programs (MSW, MFT, PSY)

Continued Work based on Current Three-Year Plan

The following Midyear Adjustments were posted during FY 2020-21 and therefore, implementation was completed.

- Use of the MHSA State WET Regional Partnership Grant to fund a Loan Repayment Program similar to the State's Mental Health Loan Assumption Program (MHLAP)
- Suspension of MHSA WET Stipend Program for FY2020-21 due to the economic impact of COVID-19 resulting in curtailments across County departments. Curtailments impact recruitment of students who will likely not have the ability to be hired and would be placed at risk of having to repay the stipends.

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CFTN – CAPITAL FACILITIES OVERVIEW

- Transfers from CSS to Capital Facilities to fund capital improvements
- *Continued Work based on Current Three-Year Plan*
  Midyear Adjustments were posted during FY 2018-19, such as the Restorative Care Villages

  - Part of the County's strategic plan to enhance delivery of comprehensive interventions by integrating direct care services for individuals who require physical health, mental health, substance abuse treatment, and housing-related services and supports

  - Envisioned to be the country's first mental health and well-being campuses that will provide a full continuum of programming and services

  - Located on these County hospital campuses: High Desert; LAC+USC; MLK; Olive View+UCLA; and Rancho Los Amigos

LAC+USC RESTORATIVE CARE VILLAGE RENDERINGS

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CFTN – CAPITAL FACILITIES OVERVIEW

MRT BEHAVIORAL HEALTH CENTER

OLIVE VIEW RESTORATIVE CARE VILLAGE RENDERINGS

RANCHO LOS AMIGOS RESTORATIVE CARE VILLAGE RENDERINGS

HIGH DESERT RESTORATIVE CARE VILLAGE RENDERINGS

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CFTN – TECHNOLOGICAL NEEDS OVERVIEW

- Transfers from CSS to Technological Needs to fund technology needs/projects to advance overarching MHSA goals
  - Increase consumer and family empowerment towards providing the tools for secure consumer and family access to health information; and
  - Modernize clinical and administrative information systems to ensure quality of care, parity, operational efficiencies and effectiveness.
- Currently, there is no MHSA-funded IT projects. However, DMH continues to forge ahead to build for tomorrow, today. Examples of current innovations include, but not limited to:
  - Virtual Mental Healthy Delivery System: Modernize its Virtual Mental Health technology and expand its network to connect with clients in jails, probation camps, shelters and other programs using various platforms as appropriate (e.g. VSEE)
  - MHRLN: Extend/enhance features to track mental health resources (beds, etc.) tracking and provide case management functionality to DMH staff by making it accessible to Contract Providers.
  - Mobile/smartphone solutions for DMH clients and practitioners: Initial delivery will be to implement and extend the mindLAMP smartphone solution that allows clients to participate in treatment by completing daily diary cards to share with their practitioners during sessions, thus enhancing the quality and usefulness of clinical encounters.
  - iPaaS-DPH/DMH Interoperability Collaboration:
    - Project stands up the Azure platform and develops Fast Healthcare Interoperability Resources (FHIR) compliant messages/services such as client services and EDI claims that are currently exchanged with our contracted providers (via BizTalk).
    - Project provides a common platform for DMH and Department of Public Health to exchange data with mutual contract providers.

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CFTN – TECHNOLOGICAL NEEDS OVERVIEW

Proposed Changes in New Three-Year Plan

Modernization of 24/7 ACCESS Call Center – A funding shift will be necessary to engage with a consultant to modernize the existing antiquated Call Center into the hub in accessing services with the DMH system of care.

The Call Center will provide end-to-end assistance in an efficient and client-focused manner utilizing an agent and client centered design. Project goals are as follows:

- Reduce the number of software applications used by agents by developing a single view with end-to-end care visibility in order to best meet the needs of the caller
- Allow for integration with other systems (e.g. law enforcement) for receiving, assessing, triaging and mounting non-law enforcement responses to crises across our communities
- Provide integration technology between the Call Center and service providers (including crisis response) in order to reduce time-to-care, maximize service capacity and improve coordination of services
- Develop self-service capabilities and alternative access-points designed by feedback from the community
- Automate call and client analytics to ensure the Call Center is meeting the needs of the community and responding in a timely manner

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APPENDIX B - MHSA DATA BY SERVICE AREA

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT INFORMATION
Service Area 1 – Antelope Valley
Fiscal Year 2018-19

In Fiscal Year 2018-19, 181,135 unique clients received a direct Mental Health Services Act (MHSA) mental health service in Los Angeles County. 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.

Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan ("Three-Year Plan" or "Plan") followed by Annual Plan Updates for MHSA programs and expenditures. The Plan provides an opportunity for the Los Angeles County - Department of Mental Health (LACDMH) to review its existing MHSA programs and services to evaluate their effectiveness. The Plan also allows LACDMH to propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available. It is through this Community Planning Process that LACDMH will obtain important feedback from a broad array of stakeholders. Any changes made to any MHSA program must comply with MHSA regulations, as well as relevant State requirements.

MHSA is made up of five components: Community Services & Support; Prevention & Early Intervention; Innovation; Capital Facilities & Technological Needs and Workforce Education & Training.

Community Services & Support

Community Services & Support (CSS) is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component. Services include:

- Full Service Partnership
- Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration Services RRR);
- Alternative Crisis Services (ACS);
- Housing Services;
- Linkage to County-Operated Functions/Programs (Linkage); and
- Planning, Outreach, and Engagement Services (POE).

Prevention & Early Intervention

The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs. The components are as follows:

- Early Intervention
- Prevention
- Stigma and Discrimination
- Suicide Prevention

Innovation

The MHSOAC controls funding approval for the Innovation (INN) component of the MHSA. The goal of Innovation is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed Innovation plan. The programs are as follows:

- INN 2: Community Capacity Building to Prevent and Address Trauma
- INN 3: Help@Hand (formerly Technology Suite)
- INN 4: Transcranial Magnetic Stimulation (TMS)
- INN 5: Peer Support Specialist Full Service Partnership
- INN 7: Therapeutic Transportation (TT)
- INN 8: Early Psychosis Learning Healthcare Network
- TRIESTE

Workforce Education & Training

The goal of the Workforce Education & Training (WET) component is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

Service Area 1 – Antelope Valley
Demographics

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).

SA 1 has a population of 397,583. It has the largest percentages of Native Americans.

Population by race/ethnicity

Figure 1. Los Angeles County (n = 10,278,834)

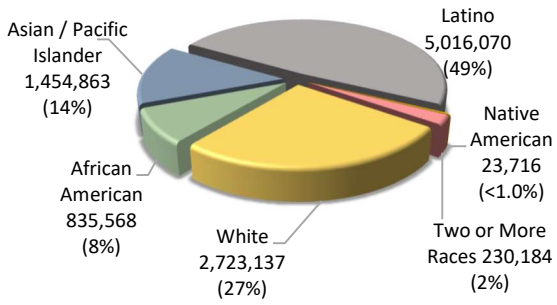
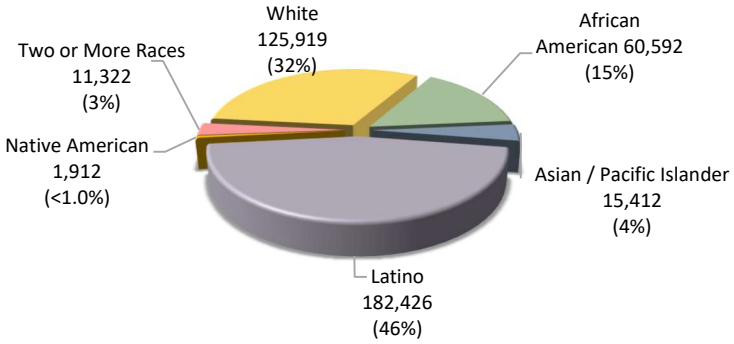


Figure 2. Service Area 1 (n = 397,583)



Population by age group

Figure 3. Los Angeles County (n = 10,278,834)

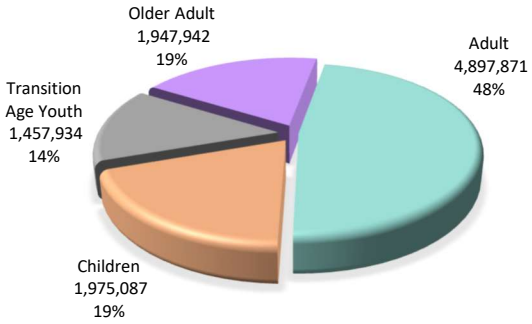
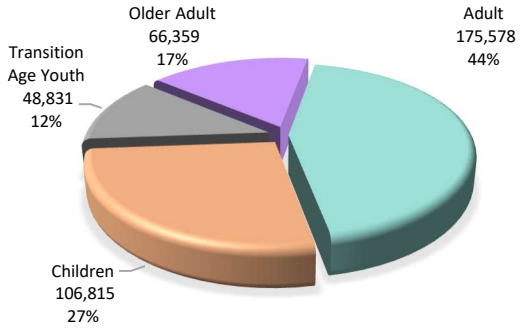


Figure 4. Service Area 1 (n = 397,583)



Medi-Cal Enrolled Population in Service Area 1 by Ethnicity and Age Group

Figure 5. Service Area 1 Ethnicity (n = 171,569)

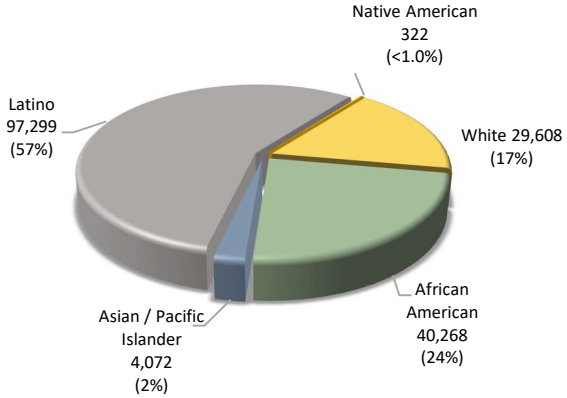
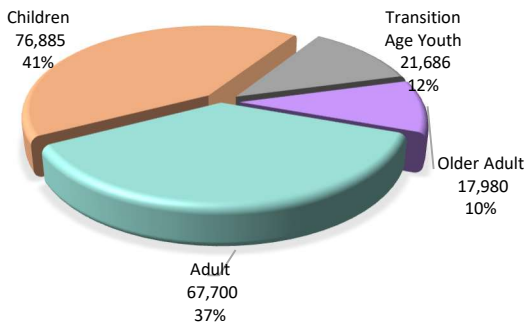


Figure 6. Service Area 1 Age Group (n = 184,251)



Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population in Service Area 1 by Ethnicity and Age Group

Figure 7. Service Area 1 Ethnicity (n = 23,280)

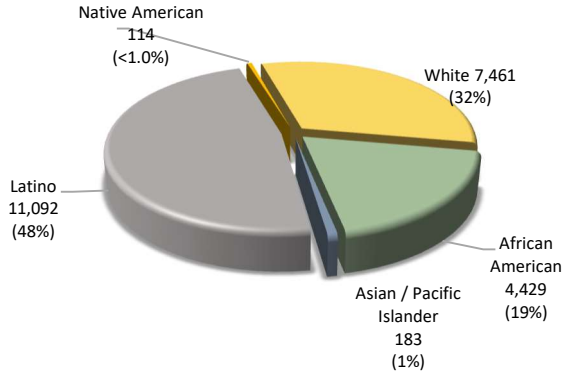
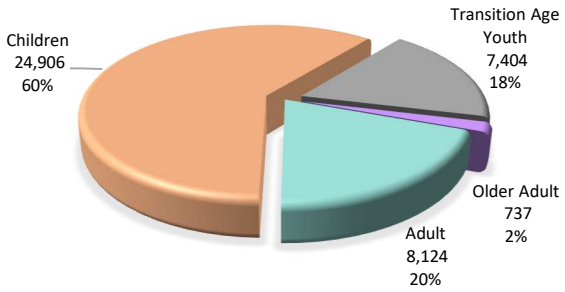


Figure 8. Service Area 1 Age Group (n = 41,171)



Among the population enrolled in Medi-Cal, Service Area 1 has two threshold languages: English (74.3%) and Spanish (25.1%).

Consumers Served in Los Angeles County Department of Mental Health Service Area 1 Outpatient Programs

Figure 9. Service Area 1 Ethnicity (n = 11,585)

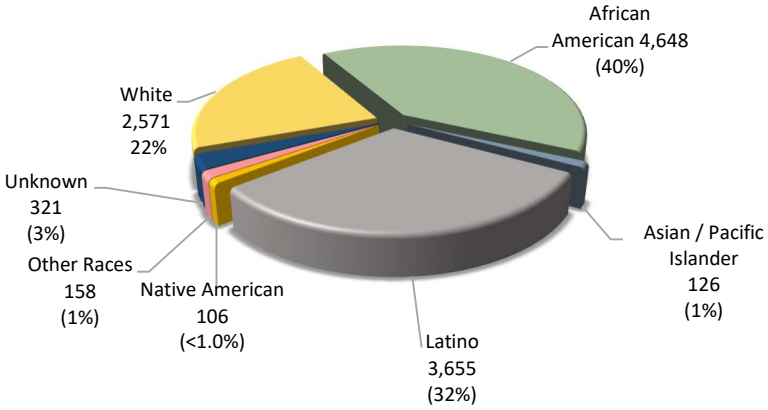
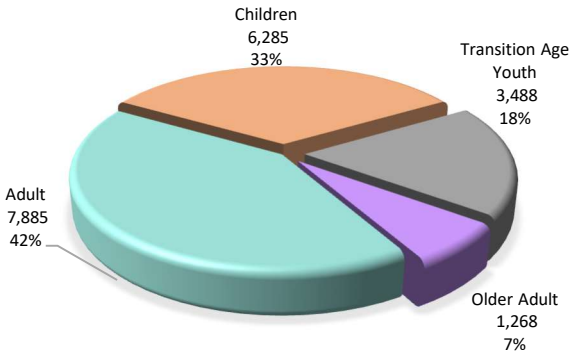


Figure 10. Service Area 1 Age Group (n = 18,926)



Spanish is the non-English threshold languages reported for consumers in outpatient programs by Service Area 1.

Needs Assessment of Medi-Cal Enrolled Population in Service Area 1

A negative number indicates that the estimated need for mental health services has not been met. Zero indicates “no disparity”. A “+” number in parentheses indicates the number of individuals receiving services beyond the estimated need of services.

Table 1. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Ethnicity

Ethnicity	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
African American	4,429	4,300	-129
Asian/Pacific Islander	183	121	-62
Latino	11,092	3,345	-7,747
Native American	114	95	-19
White	7,461	2,324	-5,137

Table 2. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Age Group

Age Group	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
Children (0-15)	24,906	5,763	-19,143
Transition Age Youth (16-25)	7,404	3,173	-4,231
Adult (26-59)	8,124	7,383	-741
Older Adult (60+)	737	1,206	(+)469

Mental Health Services Act Services

Community Services and Supports

Number of Unique Clients Served: 8,547 Number of New Clients Served: 2,840

Table 3. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	1,650	1,403	4,836	861
MHSA Cost	$13,431,049	$5,906,633	$12,669,998	$2,346,621

Table 4. Number of unique clients served by Ethnicity

Ethnicity	White	African American	Latino	Asian Pacific Islander	Native American	Other
Number of Clients Served	2063	3,050	2,710	129	80	515
Percentage	24.14%	35.69%	31.71%	1.51%	0.94%	6.03%

Table 5. Number of unique clients served by Primary Language

Primary Language	English	Spanish	Farsi	Russian	Arabic	Mandarin	American Sign Language	Pilipino, Tagalog	Other
Number of Clients Served	7,829	597	6	2	3	2	2	3	103
Percentage	91.60%	6.98%	0.07%	0.02%	0.04%	0.02%	0.02%	0.04%	1%

Full Service Partnership (FSP)

Table 6. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	366	145	416	157
MHSA Cost	$6,095,098	$1,997,714	$4,044,860	$921,527

Table 7. Service Area 1 Full Service Partnership Capacity as of 8/15/20

Service Area 1 FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Children (includes Wraparound Child, and Wraparound TAY)	160	125	78%
Transition Age Youth, Ages 16-25	64	57	89%
Adult, Ages 26-59 (includes Forensic, Homeless, Measure H and Housing)	479	411	86%
Older Adult, Ages 60+	86	68	79%

Table 8. Countywide Full Service Partnership Capacity as of 8/15/20

Countywide FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Intensive Field Capable Clinical Services (IFCCS)	765	504	66%
Assisted Outpatient Program (AOT)	385	289	75%
Integrated Mental Health Team (IMHT)	300	278	93%

Clients can be seen in more than one FSP program in a year.

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Table 9. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	1,354	1,282	4,487	749
MHSA Cost	$7,329,723	$3,895,842	$8,322,465	$1,356,491

Prevention and Early Intervention

Number of Unique Clients Served: 4,072 Number of New Clients Served: 2,680

Table 10. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	2,716	581	764	59
MHSA Cost	$8,998,693	$1,553,531	$1,453,425	$109,004

Table 11. Number of unique clients served by Ethnicity

Ethnicity	Latino	White	African American	Asian Pacific Islander	Native American	Other
Number of Clients Served	1,759	718	1,080	53	22	440
Percentage	43%	18%	27%	1%	0.54%	11%

Table 12. Number of unique clients served by primary language

Primary Language	English	Spanish	Other
Number of Clients Served	3,657	341	74
Percentage	90%	8%	2%

If you have any questions about this report, please contact Robin Ramirez, rramirez@dmh.lacounty.gov.

Data Source for Figures 1-10 and Tables 1-2: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019. Data Source for Tables 3-12: Direct service claiming as of 8/31/2020. Cost is based on Mode 15 services and not inclusive of community outreach services, client supportive services or invoiced services.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT INFORMATION
Service Area 2 – San Fernando Valley
Fiscal Year 2018-19

In Fiscal Year 2018-19, 181,135 unique clients received a direct Mental Health Services Act (MHSA) mental health service in Los Angeles County. 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.

Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan ("Three-Year Plan" or "Plan") followed by Annual Plan Updates for MHSA programs and expenditures. The Plan provides an opportunity for the Los Angeles County - Department of Mental Health (LACDMH) to review its existing MHSA programs and services to evaluate their effectiveness. The Plan also allows LACDMH to propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available. It is through this Community Planning Process that LACDMH will obtain important feedback from a broad array of stakeholders. Any changes made to any MHSA program must comply with MHSA regulations, as well as relevant State requirements.

MHSA is made up of five components: Community Services & Support; Prevention & Early Intervention; Innovation; Capital Facilities & Technological Needs and Workforce Education & Training.

Community Services & Support

Community Services & Support (CSS) is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component. Services include:

- Full Service Partnership
- Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration Services RRR);
- Alternative Crisis Services (ACS);
- Housing Services;
- Linkage to County-Operated Functions/Programs (Linkage); and
- Planning, Outreach, and Engagement Services (POE).

Prevention & Early Intervention

The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs. The components are as follows:

- Early Intervention
- Prevention
- Stigma and Discrimination
- Suicide Prevention

Innovation

The MHSOAC controls funding approval for the Innovation (INN) component of the MHSA. The goal of Innovation is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed Innovation plan. The programs are as follows:

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- INN 3: Help@Hand (formerly Technology Suite)
- INN 4: Transcranial Magnetic Stimulation (TMS)
- INN 5: Peer Support Specialist Full Service Partnership
- INN 7: Therapeutic Transportation (TT)
- INN 8: Early Psychosis Learning Healthcare Network
- TRIESTE

Workforce Education & Training

The goal of the Workforce Education & Training (WET) component is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

Service Area 2 – San Fernando Valley
Demographics

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).

SA 2 has a population of 2,262,277.

Population by race/ethnicity

Figure 1. Los Angeles County (n = 10,278,834)

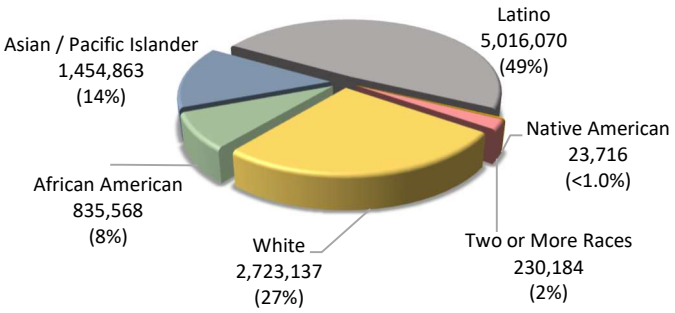
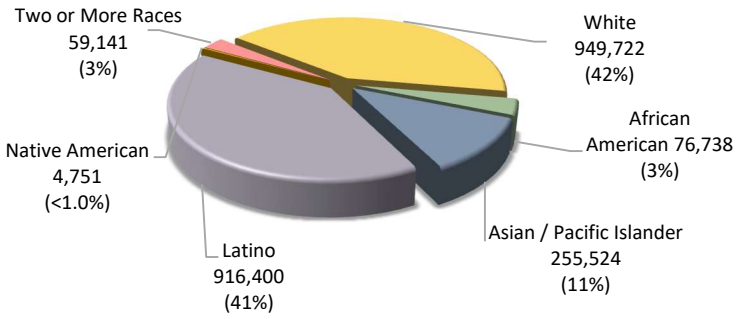


Figure 2. Service Area 2 (n = 2,262,277)



Population by age group

Figure 3. Los Angeles County (n = 10,278,834)

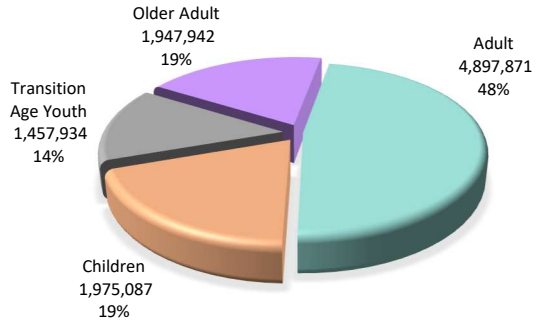
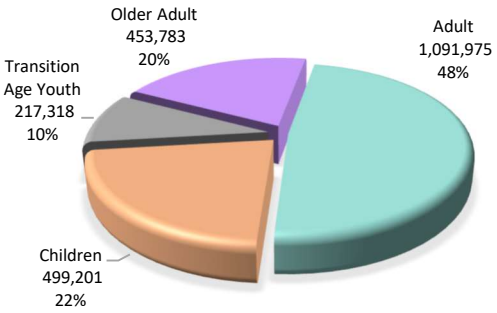


Figure 4. Service Area 2 (n = 2,262,277)



Medi-Cal Enrolled Population in Service Area 2 by Ethnicity and Age Group

Figure 5. Service Area 2 Ethnicity (n = 662,292)

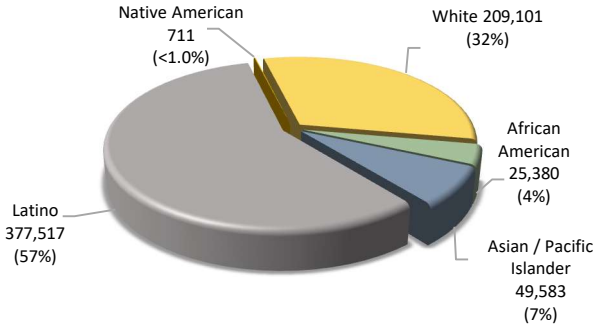
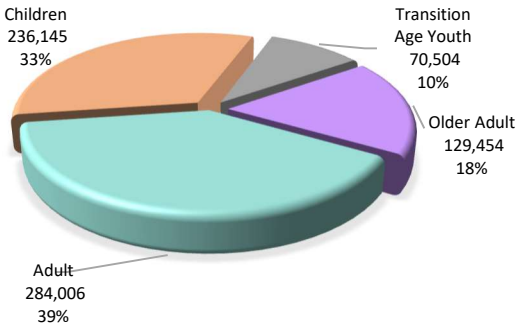


Figure 6. Service Area 2 Age Group (n = 720,109)



Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population in Service Area 2 by Ethnicity and Age Group

Figure 7. Service Area 2 Ethnicity (n = 101,004)

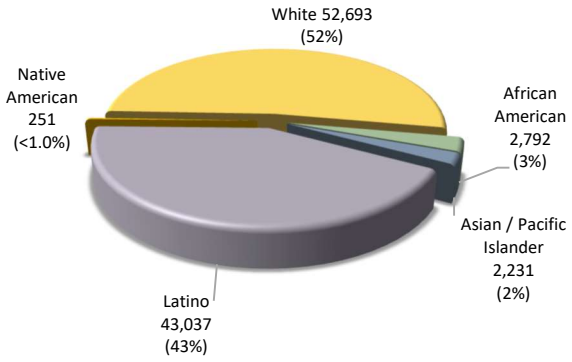
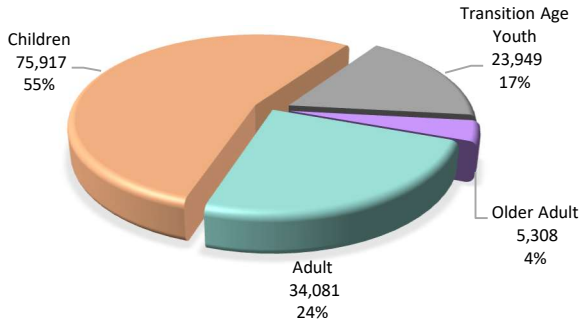


Figure 8. Service Area 2 Age Group (n = 139,255)



Among the population enrolled in Medi-Cal, Service Area 2 has eight threshold languages: Armenian (9.1%), English (52.2%), Farsi (1.4%), Korean (0.7%), Russian (0.9%), Spanish (34.3%), Tagalog (0.4%) and Vietnamese (0.5%).

Consumers Served in Los Angeles County Department of Mental Health Service Area 2 Outpatient Programs

Figure 9. Service Area 2 Ethnicity (n = 24,439)

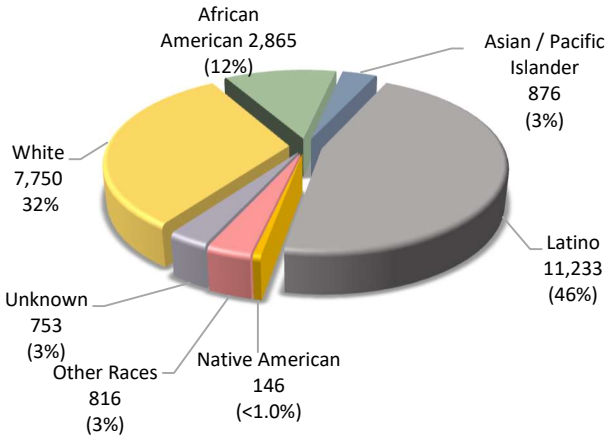
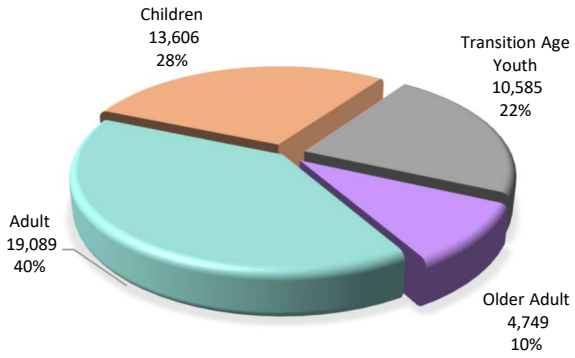


Figure 10. Service Area 2 Age Group (n = 48,029)



Armenian, Farsi, Russian, Spanish, Tagalog and Vietnamese are the non-English threshold languages reported for consumers in outpatient programs by Service Area 2.

Needs Assessment of Medi-Cal Enrolled Population in Service Area 2

A negative number indicates that the estimated need for mental health services has not been met. Zero indicates “no disparity”. A “+” number in parentheses indicates the number of individuals receiving services beyond the estimated need of services.

Table 1. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Ethnicity

Ethnicity	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
African American	2,792	2,520	-272
Asian/Pacific Islander	2,231	747	-1,484
Latino	43,037	9,632	-33,405
Native American	251	131	-120
White	52,693	6,430	-46.263

Table 2. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Age Group

Age Group	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
Children (0-15)	75,917	12,120	-63,797
Transition Age Youth (16-25)	23,949	9,159	-14,790
Adult (26-59)	34,081	16,590	-17,491
Older Adult (60+)	5,308	4,177	-1,131

Mental Health Services Act Services

Community Services and Supports

Number of Unique Clients Served: 21,778 Number of New Clients Served: 8,095

Table 3. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	3,699	3,828	11,903	2,961
MHSA Cost	$35,191,034	$20,249,207	$47,099,080	$11,310,823

Table 4. Number of unique clients served by Ethnicity

Ethnicity	White	African American	Latino	Asian Pacific Islander	Native American	Other
Number of Clients Served	6,368	2,050	8,857	1,258	110	3,135
Percentage	29.24%	9.41%	40.67%	5.78%	0.51%	14.4%

Table 5. Number of unique clients served by Primary Language

Primary Language	English	Spanish	Farsi	Russian	Arabic	Mandarin	Pilipino, Tagalog	Other
Number of Clients Served	16,555	3,143	395	90	62	7	54	1,472
Percentage	76.02%	14.43%	1.81%	0.41%	0.28%	0.03%	0.25%	7%

Full Service Partnership (FSP)

Table 6. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	616	441	836	156
MHSA Cost	$11,293,952	$5,339,396	$10,771,247	$2,018,079

Table 7. Service Area 2 Full Service Partnership Capacity as of 8/15/20

Service Area 2 FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Children (includes Wraparound Child, and Wraparound TAY)	455	397	87%
Transition Age Youth, Ages 16-25	168	157	93.5%
Adult, Ages 26-59 (includes Forensic, Homeless, Measure H and Housing)	1130	772	68%
Older Adult, Ages 60+	128	101	78.9%

Table 8. Countywide Full Service Partnership Capacity as of 8/15/20

Countywide FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Intensive Field Capable Clinical Services (IFCCS)	765	504	66%
Assisted Outpatient Program (AOT)	385	289	75%
Integrated Mental Health Team (IMHT)	300	278	93%

Clients can be seen in more than one FSP program in a year.

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Table 9. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	3,175	2,963	9,674	2,725
MHSA Cost	$23,801,632	$13,672,220	$32,469,916	$9,071,499

Prevention and Early Intervention

Number of Unique Clients Served: 7,926 Number of New Clients Served: 4,886

Table 10. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	5,710	1,606	645	137
MHSA Cost	$24,285,248	$6,200,161	$1,816,061	$271,373

Table 11. Number of unique clients served by ethnicity

Ethnicity	Latino	White	African American	Asian Pacific Islander	Native American	Other
Number of Clients Served	4,874	895	327	299	10	1521
Percentage	61%	11%	4%	4%	0.13%	19%

Table 12. Number of unique clients served by primary language

Primary Language	English	Spanish	Farsi	Russian	Other
Number of Clients Served	6,218	1,422	42	11	233
Percentage	78%	18%	1%	0.14%	3%

If you have any questions about this report, please contact Robin Ramirez, rramirez@dmh.lacounty.gov.

Data Source for Figures 1-10 and Tables 1-2: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019. Data Source for Tables 3-12: Direct service claiming as of 8/31/2020. Cost is based on Mode 15 services and not inclusive of community outreach services, client supportive services or invoiced services.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT INFORMATION
Service Area 3 – San Gabriel Valley
Fiscal Year 2018-19

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MHSA is made up of five components: Community Services & Support; Prevention & Early Intervention; Innovation; Capital Facilities & Technological Needs and Workforce Education & Training.

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Community Services & Support (CSS) is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component. Services include:

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Service Area 3 – San Gabriel Valley
Demographics

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SA 3 has a population of 1,808,263. It has the highest percentage of Asian/Pacific Islanders in the County.

Population by race/ethnicity

Figure 1. Los Angeles County (n = 10,278,834)

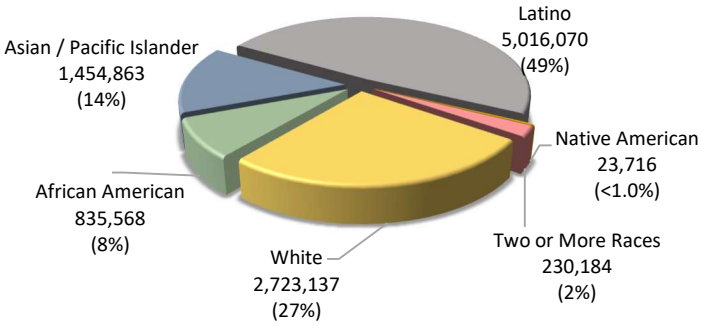
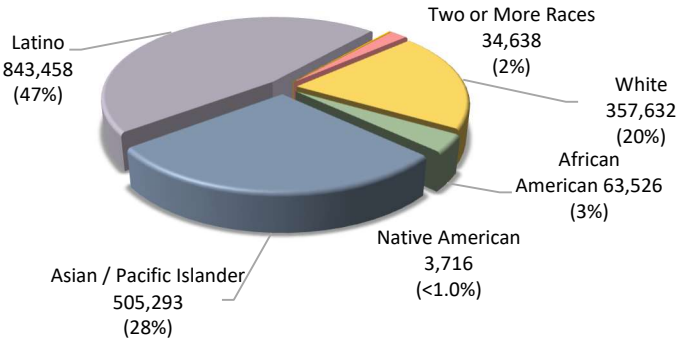
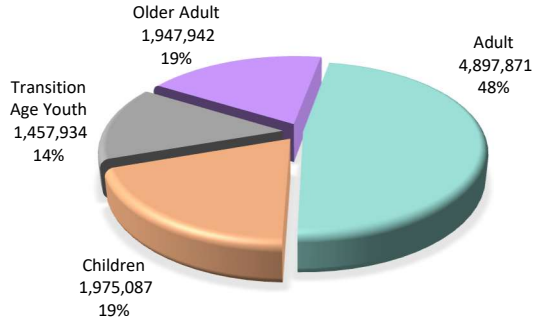


Figure 2. Service Area 3 (n = 1,808,263)



Population by age group

Figure 3. Los Angeles County (n = 10,278,834)



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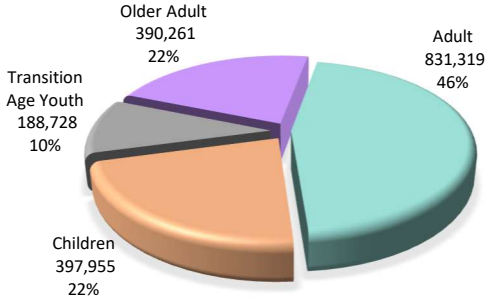


Medi-Cal Enrolled Population in Service Area 3 by Ethnicity and Age Group

Figure 5. Service Area 3 Ethnicity (n = 544,879)

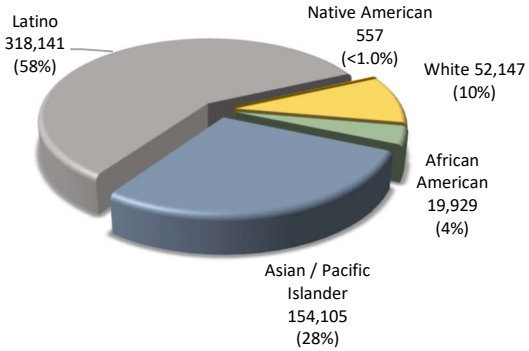
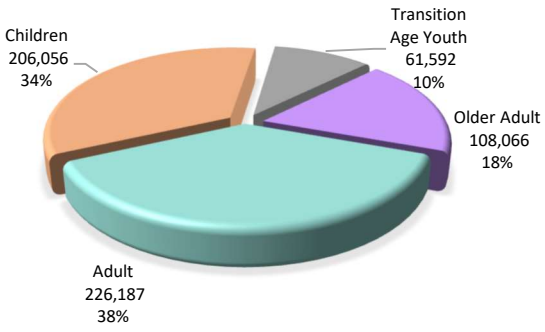


Figure 6. Service Area 3 Age Group (n = 601,901)



Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population in Service Area 3 by Ethnicity and Age Group

Figure 7. Service Area 3 Ethnicity (n = 58,733)

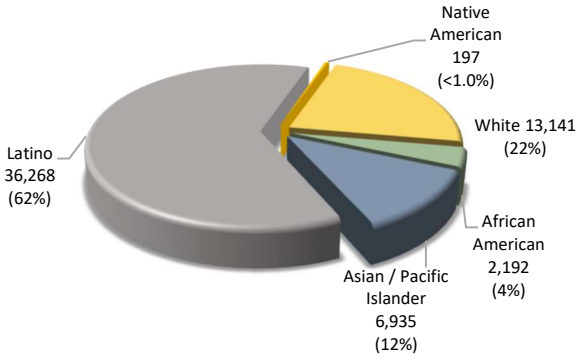
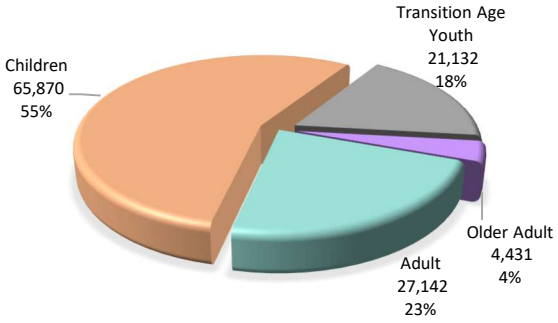


Figure 8. Service Area 3 Age Group (n = 118,575)



Among the population enrolled in Medi-Cal, Service Area 3 has seven threshold languages: Cantonese (5.8%), English (54.3%), Korean (0.5%), Mandarin (7.4%), Other Chinese (0.6%), Spanish (26.7%) and Vietnamese (3.5%).

Consumers Served in Los Angeles County Department of Mental Health Service Area 3 Outpatient Programs

Figure 9. Service Area 3 Ethnicity (n = 20,825)

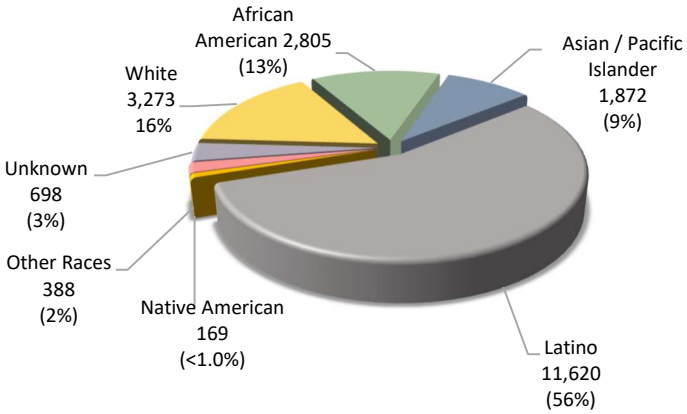
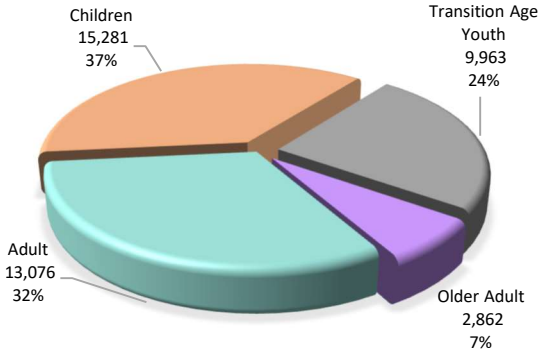


Figure 10. Service Area 3 Age Group (n = 41,182)



Cantonese, Korean, Mandarin, Spanish, and Vietnamese are the non-English threshold languages reported for consumers in outpatient programs by Service Area 3.

Needs Assessment of Medi-Cal Enrolled Population in Service Area 3

A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services.

Table 1. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Ethnicity

Ethnicity	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
African American	2,192	2,456	(+)264
Asian/Pacific Islander	6,935	1,472	-5,463
Latino	36,268	9,296	-26,972
Native American	197	133	-64
White	13,141	2,483	-10,658

Table 2. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Age Group

Age Group	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
Children (0-15)	65,870	12,733	-53,137
Transition Age Youth (16-25)	21,132	8,200	-12,932
Adult (26-59)	27,142	10,796	-16,346
Older Adult (60+)	4,431	2,362	-2,069

Mental Health Services Act Services

Community Services and Supports

Number of Unique Clients Served: 18,262 Number of New Clients Served: 8,095

Table 3. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	5,484	3,453	8,102	1,670
MHSA Cost	$39,423,790	20,182,347	35,401,636	7,108,436

Table 4. Number of unique clients served by Ethnicity

Ethnicity	White	African American	Latino	Asian Pacific Islander	Native American	Other
Number of Clients Served	2,928	1,706	7,609	1,642	111	4,266
Percentage	16%	9%	42%	1%	1%	23%

Table 5. Number of unique clients served by Primary Language

Primary Language	English	Spanish	Farsi	Arabic	Mandarin	Cantonese	Pilipino, Tagalog	Other
Number of Clients Served	13,724	2,759	4	18	312	302	10	1,131
Percentage	75%	15%	0.02%	0.01%	1.71%	1.65%	0.05%	7%

Full Service Partnership (FSP)

Table 6. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	502	380	801	353
MHSA Cost	$8,869,975	$5,413,847	$9,654,102	$2,293,975

Table 7. Service Area 3 Full Service Partnership Capacity as of 8/15/20

Service Area 3 FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Children (includes Wraparound Child, and Wraparound TAY)	379	248	65%
Transition Age Youth, Ages 16-25	188	134	71%
Adult, Ages 26-59 (includes Forensic, Homeless, Measure H and Housing)	839	652	78%
Older Adult, Ages 60+	203	169	83%

Table 8. Countywide Full Service Partnership Capacity as of 8/15/20

Countywide FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Intensive Field Capable Clinical Services (IFCCS)	765	504	66%
Assisted Outpatient Program (AOT)	385	289	75%
Integrated Mental Health Team (IMHT)	300	278	93%

Clients can be seen in more than one FSP program in a year.

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Table 9. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	4,748	2,530	5,839	1,126
MHSA Cost	$29,770,194	$12,942,615	20,968,214	$4,257,227

Prevention and Early Intervention

Number of Unique Clients Served: 8,996
Number of New Clients Served: 5,639

Table 10. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	6,383	1,757	826	185
MHSA Cost	$22,931,763	$6,033,942	$2,079,525	$647,398

Table 11. Number of unique clients served by Ethnicity

Ethnicity	Latino	White	African American	Asian Pacific Islander	Native American	Other
Number of Clients Served	3574	653	426	333	30	3980
Percentage	40%	7%	5%	3.7%	0.33%	44%

Table 12. Number of unique clients served by primary language

Primary Language	English	Spanish	Mandarin	Cantonese	Other
Number of Clients Served	6,383	2,195	71	83	264
Percentage	71%	24%	1%	1%	3%

If you have any questions about this report, please contact Robin Ramirez, rramirez@dmh.lacounty.gov.

Data Source for Figures 1-10 and Tables 1-2: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019. Data Source for Tables 3-12: Direct service claiming as of 8/31/2020. Cost is based on Mode 15 services and not inclusive of community outreach services, client supportive services or invoiced services.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT INFORMATION
Service Area 4 – Metro Los Angeles
Fiscal Year 2018-19

In Fiscal Year 2018-19, 181,135 unique clients received a direct Mental Health Services Act (MHSA) mental health service in Los Angeles County. 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.

Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan ("Three-Year Plan" or "Plan") followed by Annual Plan Updates for MHSA programs and expenditures. The Plan provides an opportunity for the Los Angeles County - Department of Mental Health (LACDMH) to review its existing MHSA programs and services to evaluate their effectiveness. The Plan also allows LACDMH to propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available. It is through this Community Planning Process that LACDMH will obtain important feedback from a broad array of stakeholders. Any changes made to any MHSA program must comply with MHSA regulations, as well as relevant State requirements.

MHSA is made up of five components: Community Services & Support; Prevention & Early Intervention; Innovation; Capital Facilities & Technological Needs and Workforce Education & Training.

Community Services & Support

Community Services & Support (CSS) is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component. Services include:

- Full Service Partnership
- Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration Services RRR);
- Alternative Crisis Services (ACS);
- Housing Services;
- Linkage to County-Operated Functions/Programs (Linkage); and
- Planning, Outreach, and Engagement Services (POE).

Prevention & Early Intervention

The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs. The components are as follows:

- Early Intervention
- Prevention
- Stigma and Discrimination
- Suicide Prevention

Innovation

The MHSOAC controls funding approval for the Innovation (INN) component of the MHSA. The goal of Innovation is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed Innovation plan. The programs are as follows:

- INN 2: Community Capacity Building to Prevent and Address Trauma
- INN 3: Help@Hand (formerly Technology Suite)
- INN 4: Transcranial Magnetic Stimulation (TMS)
- INN 5: Peer Support Specialist Full Service Partnership
- INN 7: Therapeutic Transportation (TT)
- INN 8: Early Psychosis Learning Healthcare Network
- TRIESTE

Workforce Education & Training

The goal of the Workforce Education & Training (WET) component is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

Service Area 4 – Metro Los Angeles
Demographics

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).

SA 4 has a population of 1,185,794.

Population by race/ethnicity

Figure 1. Los Angeles County (n = 10,278,834)

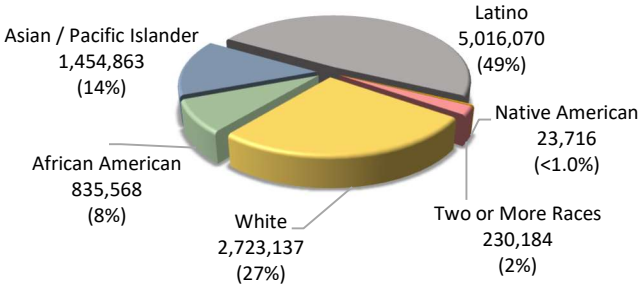
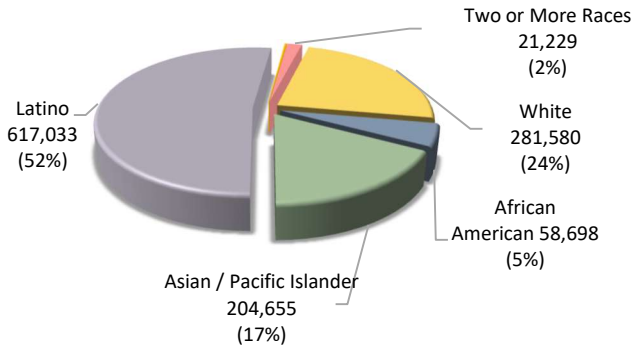


Figure 2. Service Area 4 (n = 1,185,794)



Population by age group

Figure 3. Los Angeles County (n = 10,278,834)

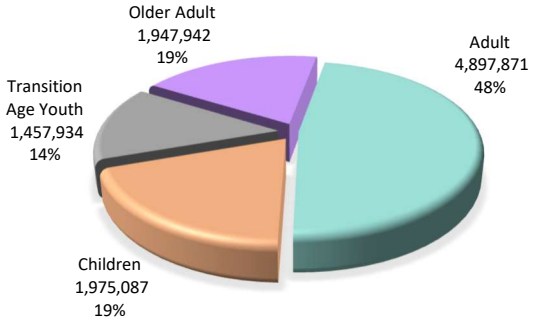
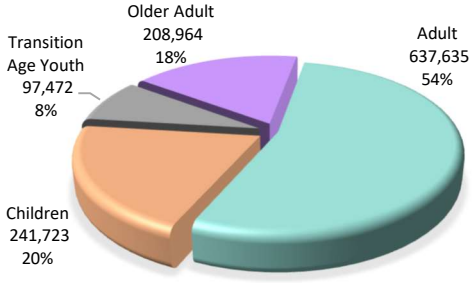


Figure 4. Service Area 4 (n = 1,185,794)



Medi-Cal Enrolled Population in Service Area 4 by Ethnicity and Age Group

Figure 5. Service Area 4 Ethnicity (n = 423,460)

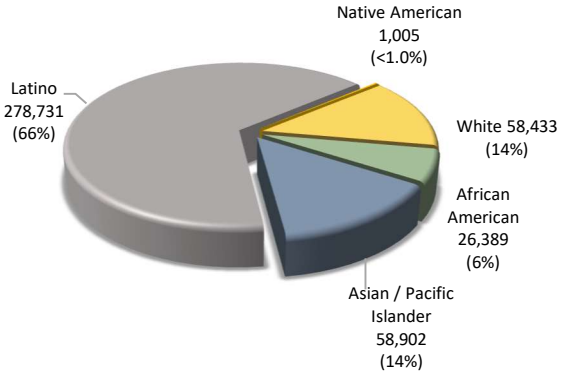
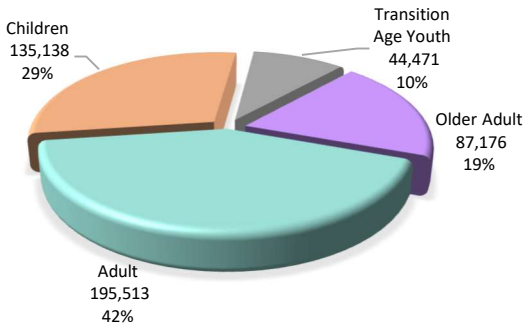


Figure 6. Service Area 4 Age Group (n = 462,298)



Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population in Service Area 4 by Ethnicity and Age Group

Figure 7. Service Area 4 Ethnicity (n = 52,409)

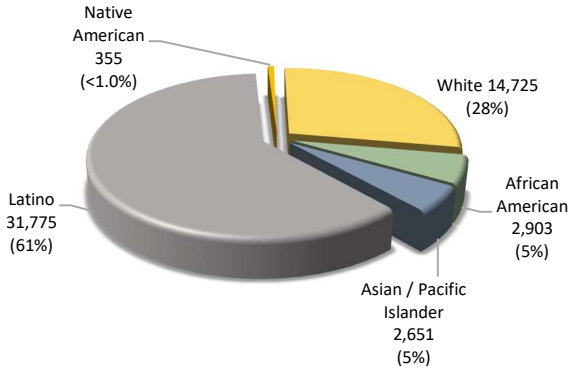
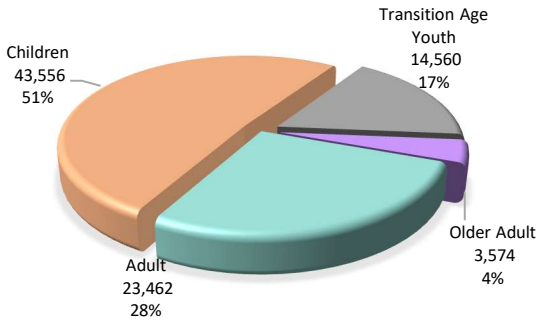


Figure 8. Service Area 4 Age Group (n = 85,152)



Among the population enrolled in Medi-Cal, Service Area 4 has six threshold languages: Armenian (1.4%), Cantonese (1.7%), English (47.0%), Korean (4.1%), Russian (1.1%) and Spanish (43.0%).

Consumers Served in Los Angeles County Department of Mental Health Service Area 4 Outpatient Programs

Figure 9. Service Area 4 Ethnicity (n = 22,995)

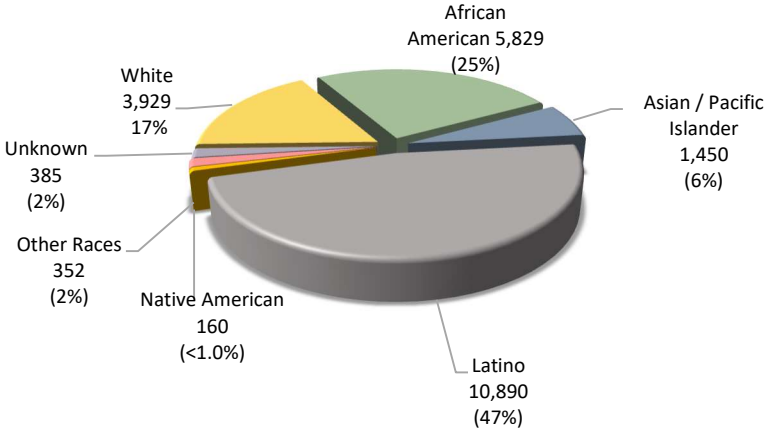
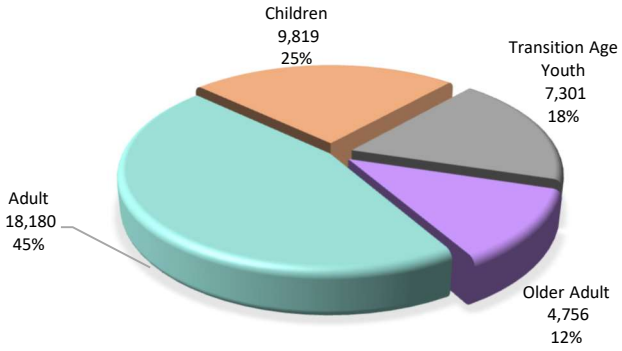


Figure 10. Service Area 4 Age Group (n = 40,056)



Armenian, Cantonese, Korean, Mandarin, Other Chinese, Russian, Spanish, and Tagalog are the non-English threshold languages reported for consumers in outpatient programs by Service Area 4.

Needs Assessment of Medi-Cal Enrolled Population in Service Area 4

A negative number indicates that the estimated need for mental health services has not been met. Zero indicates “no disparity”. A “+” number in parentheses indicates the number of individuals receiving services beyond the estimated need of services.

Table 1. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Ethnicity

Ethnicity	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
African American	2,903	4,951	(+)2,048
Asian/Pacific Islander	2,651	1,079	-1,572
Latino	31,775	8,171	-23,604
Native American	355	118	-237
White	14,725	2,857	-11,868

Table 2. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Age Group

Age Group	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
Children (0-15)	43,556	7,860	-35,696
Transition Age Youth (16-25)	14,560	5,697	-8,863
Adult (26-59)	23,462	14,307	-9,155
Older Adult (60+)	3,574	3,751	(+)177

Mental Health Services Act Services

Community Services and Supports

Number of Unique Clients Served: 30,065 Number of New Clients Served: 12,730

Table 3. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	4,200	5,017	17,319	4,070
MHSA Cost	$29,160,830	$23,868,088	$66,405,449	$19,628,653

Table 4. Number of unique clients served by Ethnicity

Ethnicity	White	African American	Latino	Asian Pacific Islander	Native American	Other
Number of Clients Served	5,075	6,691	12,446	2,201	298	3,354
Percentage	17%	22%	41%	4%	1%	11%

Table 5. Number of unique clients served by Primary Language

Primary Language	English	Spanish	Russian	Mandarin	Cantonese	Pilipino, Tagalog	Other
Number of Clients Served	23,574	4,135	77	68	97	35	2,041
Percentage	78%	14%	0.26%	0.23%	0.32%	0.12%	7%

Full Service Partnership (FSP)

Table 6. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	480	510	1,546	455
MHSA Cost	$8,402,138	$7,994,275	$20,097,732	$4,936,327

Table 7. Service Area 4 Full Service Partnership Capacity as of 8/15/20

Service Area 4 FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Children (includes Wraparound Child, and Wraparound TAY)	419	311	74%
Transition Age Youth, Ages 16-25	229	195	85%
Adult, Ages 26-59 (includes Forensic, Homeless, Measure H and Housing)	2,398	1,422	59%
Older Adult, Ages 60+	148	133	90%

Table 8. Countywide Full Service Partnership Capacity as of 8/15/20

Countywide FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Intensive Field Capable Clinical Services (IFCCS)	765	504	66%
Assisted Outpatient Program (AOT)	385	289	75%
Integrated Mental Health Team (IMHT)	300	278	93%

Clients can be seen in more than one FSP program in a year.

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Table 9. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	3,335	2,332	9,590	3,049
MHSA Cost	$19,687,635	$9,664,826	$30,006,270	$13,065,379

Prevention and Early Intervention

Number of Unique Clients Served: 6,797 Number of New Clients Served: 4,330

Table 10. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	4,663	1,381	722	185
MHSA Cost	$17,900,515	$5,178,099	$2,342,433	$813,931

Table 11. Number of unique clients served by Ethnicity

Ethnicity	Latino	White	African American	Asian Pacific Islander	Native American	Other
Number of Clients Served	4,429	256	366	328	32	1386
Percentage	65%	4%	5%	5%	0.47%	20%

Table 12. Number of unique clients served by primary language

Primary Language	English	Spanish	Mandarin	Cantonese	Other
Number of Clients Served	4,636	1,907	19	11	221
Percentage	68%	28%	0.28%	0.16%	3%

If you have any questions about this report, please contact Robin Ramirez, rramirez@dmh.lacounty.gov.

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COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT INFORMATION
Service Area 5 – West Los Angeles
Fiscal Year 2018-19

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Prevention & Early Intervention

The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs. The components are as follows:

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The goal of the Workforce Education & Training (WET) component is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

Service Area 5 – West Los Angeles
Demographics

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SA 5 has a population of 667,863. It has the largest number of individuals reporting to speak English as their primary language.

Population by race/ethnicity

Figure 1. Los Angeles County (n = 10,278,834)

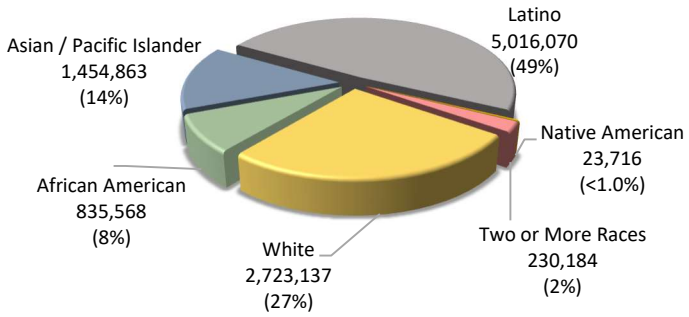
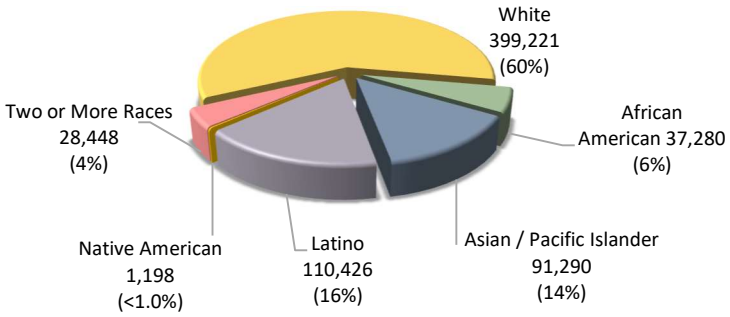


Figure 2. Service Area 5 (n = 667,863)



Population by age group

Figure 3. Los Angeles County (n = 10,278,834)

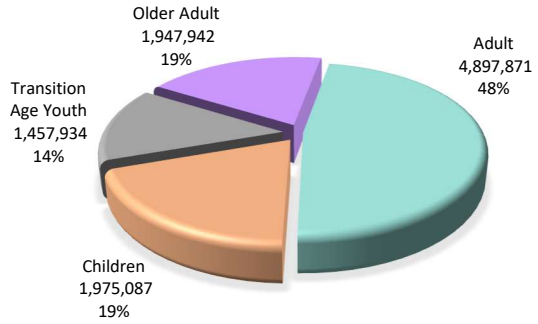
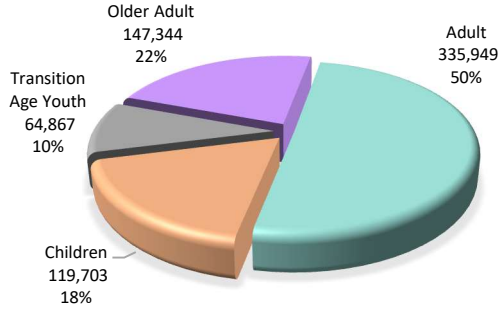


Figure 4. Service Area 5 (n = 667,863)



Medi-Cal Enrolled Population in Service Area 5 by Ethnicity and Age Group

Figure 5. Service Area 5 Ethnicity (n = 83,111)

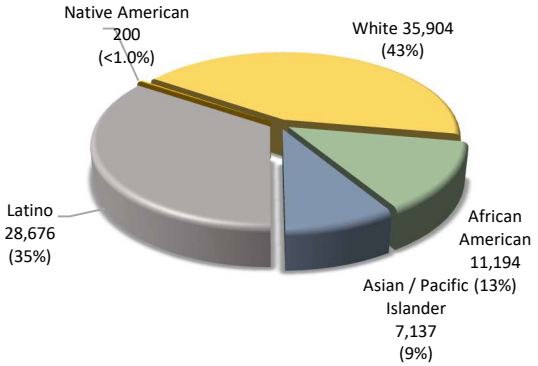
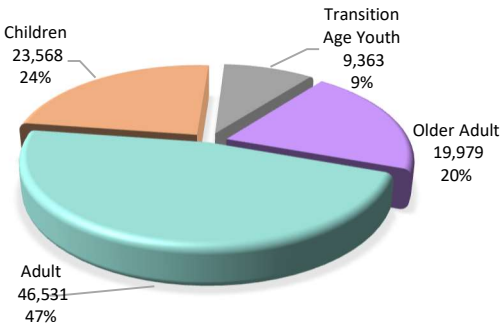


Figure 6. Service Area 5 Age Group (n = 99,441)



Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population in Service Area 5 by Ethnicity and Age Group

Figure 7. Service Area 5 Ethnicity (n = 13,940)

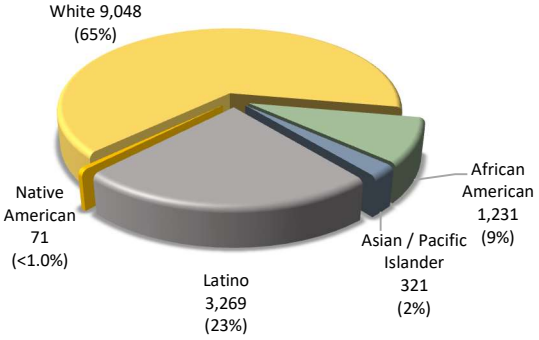
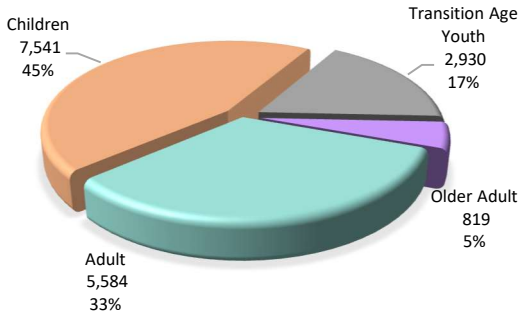


Figure 8. Service Area 5 Age Group (n = 16,874)



Among the population enrolled in Medi-Cal, Service Area 5 has three threshold languages: English (75.5%), Farsi (4.0%) and Spanish (17.3%).

Consumers Served in Los Angeles County Department of Mental Health Service Area 5 Outpatient Programs

Figure 9. Service Area 5 Ethnicity (n = 5,909)

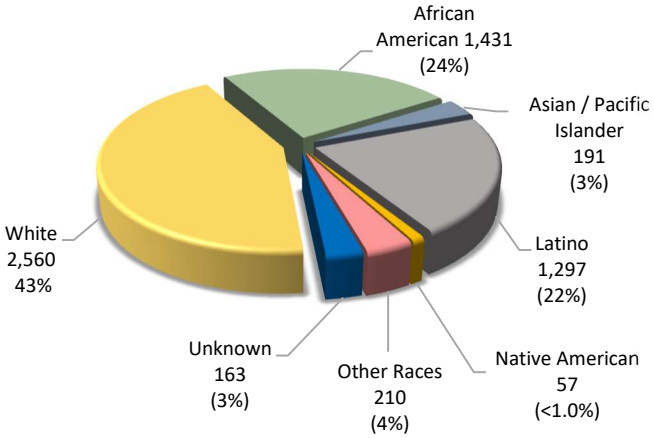
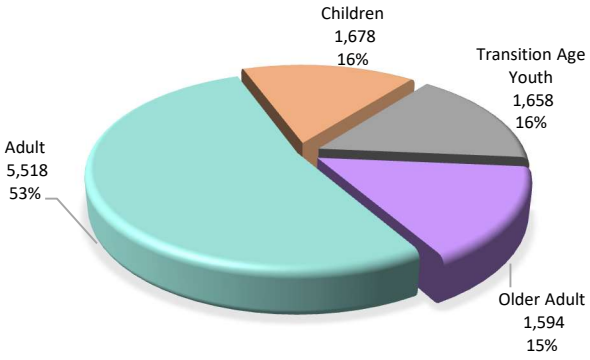


Figure 10. Service Area 5 Age Group (n = 10,448)



Farsi and Spanish are the non-English threshold languages reported for consumers in outpatient programs by Service Area 5.

Needs Assessment of Medi-Cal Enrolled Population in Service Area 5

A negative number indicates that the estimated need for mental health services has not been met. Zero indicates “no disparity”. A “+” number in parentheses indicates the number of individuals receiving services beyond the estimated need of services.

Table 1. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Ethnicity

Ethnicity	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
African American	1,231	1,201	-30
Asian/Pacific Islander	321	130	-191
Latino	3,269	946	-2,323
Native American	71	43	-28
White	9,048	1,774	-7,274

Table 2. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Age Group

Age Group	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
Children (0-15)	7,541	1,308	-6233
Transition Age Youth (16-25)	2,930	1,271	-1659
Adult (26-59)	5,584	4,203	-1381
Older Adult (60+)	819	1,193	+374

Mental Health Services Act Services

Community Services and Supports

Number of Unique Clients Served: 9,458 Number of New Clients Served: 4,267

Table 3. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	812	1,385	6,021	1,397
MHSA Cost	$4,231,543	$5,095,170	$24,906,465	$6,975,823

Table 4. Number of unique clients served by Ethnicity

Ethnicity	White	African American	Latino	Asian Pacific Islander	Native American	Other
Number of Clients Served	3,382	2,381	2,101	367	76	1,151
Percentage	36%	25%	22%	4%	1%	12%

Table 5. Number of unique clients served by Primary Language

Primary Language	English	Spanish	Farsi	Russian	Arabic	Mandarin	Cantonese	American Sign Language	Pilipino, Tagalog	Other	Unknown
Number of Clients Served	8,332	608	105	32	13	6	3	2	1	351	5
Percentage	88%	6%	1%	0.34%	0.14%	0.06%	0.03%	0.02%	0.01%	4%	0.05%

Full Service Partnership (FSP)

Table 6. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	78	146	669	136
MHSA Cost	$1,164,926	$1,385,728	$7,921,502	$1,514,032

Table 7. Service Area 5 Full Service Partnership Capacity as of 8/15/20

Service Area 5 FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Children (includes Wraparound Child, and Wraparound TAY)	61	42	69%
Transition Age Youth, Ages 16-25	73	56	77%
Adult, Ages 26-59 (includes Forensic, Homeless, Measure H and Housing)	760	554	73%
Older Adult, Ages 60+	29	26	90%

Table 8. Countywide Full Service Partnership Capacity as of 8/15/20

Countywide FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Intensive Field Capable Clinical Services (IFCCS)	765	504	66%
Assisted Outpatient Program (AOT)	385	289	75%
Integrated Mental Health Team (IMHT)	300	278	93%

Clients can be seen in more than one FSP program in a year.

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Table 9. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	709	733	3,497	1,097
MHSA Cost	$3,014,752	$2,473,234	$11,437,140	$4,929,687

Prevention and Early Intervention

Number of Unique Clients Served: 1,725 Number of New Clients Served: 1,178

Table 10. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	928	323	395	107
MHSA Cost	$3,616,995	$1,032,627	$1,296,341	$496,795

Table 11. Number of unique clients served by Ethnicity

Ethnicity	Latino	White	African American	Asian Pacific Islander	Native American	Other
Number of Clients Served	548	369	272	52	6	478
Percentage	32%	21%	16%	3%	0.35%	28%

Table 12. Number of unique clients served by primary language

Primary Language	English	Spanish	Farsi	Russian	Other
Number of Clients Served	1,473	165	24	6	57
Percentage	85%	10%	1%	0.35%	3%

If you have any questions about this report, please contact Robin Ramirez, rramirez@dmh.lacounty.gov.

Data Source for Figures 1-10 and Tables 1-2: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019.
Data Source for Tables 3-12: Direct service claiming as of 8/31/2020. Cost is based on Mode 15 services and not inclusive of community outreach services, client supportive services or invoiced services.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT INFORMATION
Service Area 6 – South Los Angeles
Fiscal Year 2018-19

In Fiscal Year 2018-19, 181,135 unique clients received a direct Mental Health Services Act (MHSA) mental health service in Los Angeles County. 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.

Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan ("Three-Year Plan" or "Plan") followed by Annual Plan Updates for MHSA programs and expenditures. The Plan provides an opportunity for the Los Angeles County - Department of Mental Health (LACDMH) to review its existing MHSA programs and services to evaluate their effectiveness. The Plan also allows LACDMH to propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available. It is through this Community Planning Process that LACDMH will obtain important feedback from a broad array of stakeholders. Any changes made to any MHSA program must comply with MHSA regulations, as well as relevant State requirements.

MHSA is made up of five components: Community Services & Support; Prevention & Early Intervention; Innovation; Capital Facilities & Technological Needs and Workforce Education & Training.

Community Services & Support

Community Services & Support (CSS) is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component. Services include:

- Full Service Partnership
- Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration Services RRR);
- Alternative Crisis Services (ACS);
- Housing Services;
- Linkage to County-Operated Functions/Programs (Linkage); and
- Planning, Outreach, and Engagement Services (POE).

Prevention & Early Intervention

The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs. The components are as follows:

- Early Intervention
- Prevention
- Stigma and Discrimination
- Suicide Prevention

Innovation

The MHSOAC controls funding approval for the Innovation (INN) component of the MHSA. The goal of Innovation is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed Innovation plan. The programs are as follows:

- INN 2: Community Capacity Building to Prevent and Address Trauma
- INN 3: Help@Hand (formerly Technology Suite)
- INN 4: Transcranial Magnetic Stimulation (TMS)
- INN 5: Peer Support Specialist Full Service Partnership
- INN 7: Therapeutic Transportation (TT)
- INN 8: Early Psychosis Learning Healthcare Network
- TRIESTE

Workforce Education & Training

The goal of the Workforce Education & Training (WET) component is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

Service Area 6 – South Los Angeles
Demographics

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).

SA 6 has a population of 1,057,694. It has the highest percentage of African Americans in the County.

Population by race/ethnicity

Figure 1. Los Angeles County (n = 10,278,834)

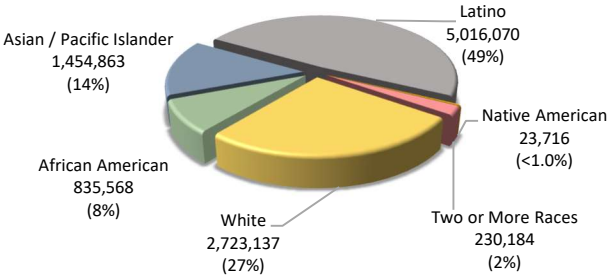
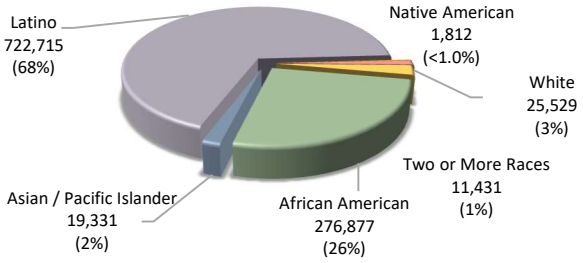


Figure 2. Service Area 6 (n = 1,057,694)



Population by age group

Figure 3. Los Angeles County (n = 10,278,834)

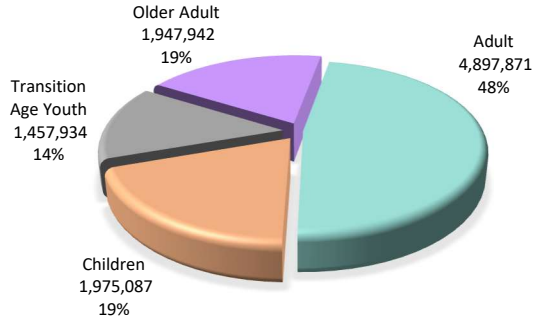
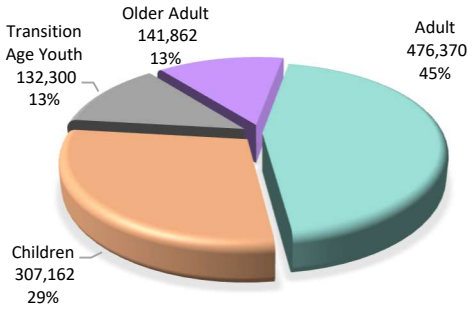


Figure 4. Service Area 6 (n = 1,057,694)



Medi-Cal Enrolled Population in Service Area 6 by Ethnicity and Age Group

Figure 5. Service Area 6 Ethnicity (n = 574,574)

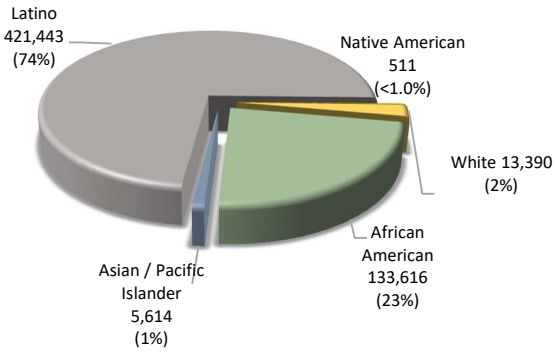
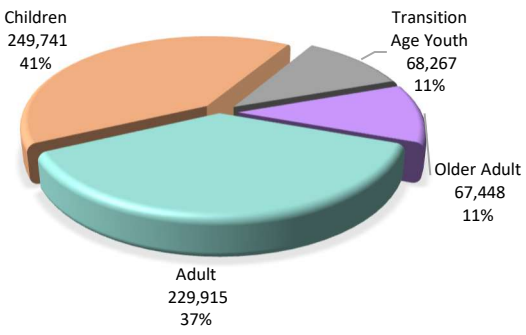


Figure 6. Service Area 6 Age Group (n = 615,371)



Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population in Service Area 6 by Ethnicity and Age Group

Figure 7. Service Area 6 Ethnicity (n = 66,550)

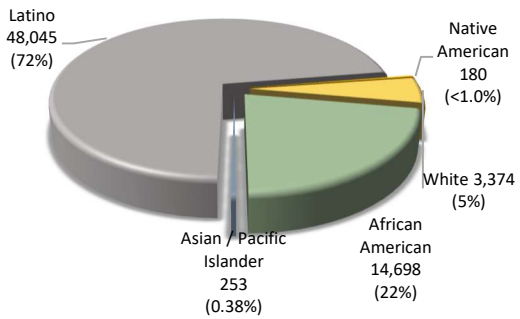
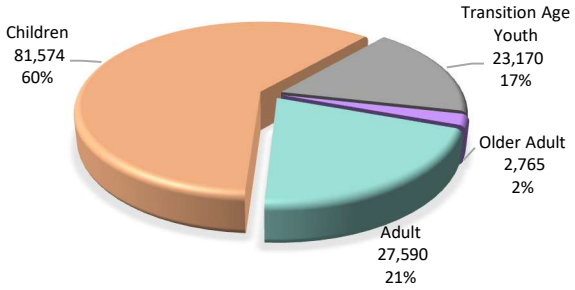


Figure 8. Service Area 6 Age Group (n = 135,099)



Among the population enrolled in Medi-Cal, Service Area 6 has two threshold languages: English (51%) and Spanish (49%).

Consumers Served in Los Angeles County Department of Mental Health Service Area 6 Outpatient Programs

Figure 9. Service Area 6 Ethnicity (n = 31,556)

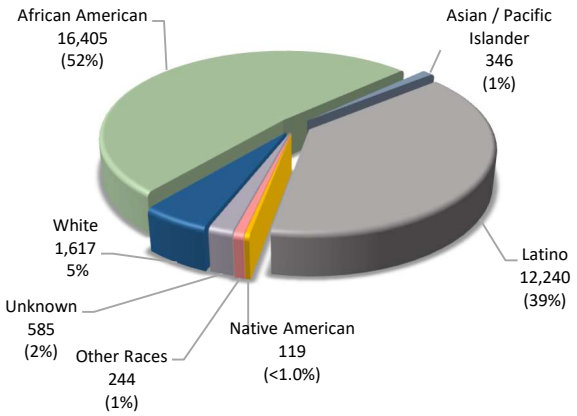
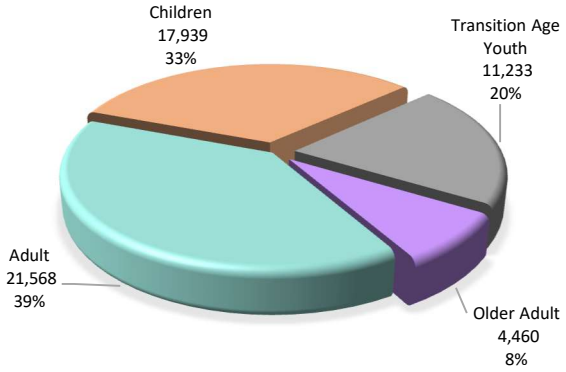


Figure 10. Service Area 6 Age Group (n = 55,200)



Spanish is the non-English threshold languages reported for consumers in outpatient programs by Service Area 6.

Needs Assessment of Medi-Cal Enrolled Population in Service Area 6

A negative number indicates that the estimated need for mental health services has not been met. Zero indicates “no disparity”. A “+” number in parentheses indicates the number of individuals receiving services beyond the estimated need of services.

Table 1. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Ethnicity

Ethnicity	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
African American	14,698	12,705	-1,993
Asian/Pacific Islander	253	228	-25
Latino	48,045	8,491	-39,554
Native American	180	95	-85
White	3,374	1,110	-2,264

Table 2. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Age Group

Age Group	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
Children (0-15)	81,574	13,648	-67,926
Transition Age Youth (16-25)	23,170	8,434	-14,736
Adult (26-59)	27,590	16,103	-11,487
Older Adult (60+)	2,765	3,301	(+)536

Mental Health Services Act Services

Community Services and Supports

Number of Unique Clients Served: 22,840 Number of New Clients Served: 8,258

Table 3. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	5,554	3,634	11,725	2,479
MHSA Cost	$38,898,694	$17,974,221	$47,816,490	$7,588,867

Table 4. Number of unique clients served by Ethnicity

Ethnicity	White	African American	Latino	Asian Pacific Islander	Native American	Other
Number of Clients Served	737	10,501	9,073	185	48	2,296
Percentage	3%	46%	40%	1%	0.21%	10%

Table 5. Number of unique clients served by Primary Language

Primary Language	English	Spanish	Farsi	Russian	Arabic	Mandarin	American Sign Language	Other
Number of Clients Served	18,099	4,040	3	3	3	5	3	682
Percentage	79%	18%	.01%	.01%	.01%	.02%	.01%	3%

Full Service Partnership (FSP)

Table 6. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	993	462	1,162	138
MHSA Cost	$17,819,835	$6,310,427	$16,270,267	$1,302,973

Table 7. Service Area 6 Full Service Partnership Capacity as of 8/15/20

Service Area 6 FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Children (includes Wraparound Child, and Wraparound TAY)	548	428	78%
Transition Age Youth, Ages 16-25	268	160	60%
Adult, Ages 26-59 (includes Forensic, Homeless, Measure H and Housing)	1,596	1,184	74%
Older Adult, Ages 60+	43	29	67%

Table 8. Countywide Full Service Partnership Capacity as of 8/15/20

Countywide FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Intensive Field Capable Clinical Services (IFCCS)	765	504	66%
Assisted Outpatient Program (AOT)	385	289	75%
Integrated Mental Health Team (IMHT)	300	278	93%

Clients can be seen in more than one FSP program in a year.

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Table 9. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	4,722	3,239	10,524	2,350
MHSA Cost	$20,163,782	$10,096,081	$26,763,310	$5,883,526

Prevention and Early Intervention

Number of Unique Clients Served: 6,816 Number of New Clients Served: 4,424

Table 10. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	5,052	1,111	669	110
MHSA Cost	$16,339,659	$3,420,305	$1,548,779	$267,049

Table 11. Number of unique clients served by Ethnicity

Ethnicity	Latino	White	African American	Asian Pacific Islander	Native American	Other
Number of Clients Served	3,348	102	1,345	43	7	1,971
Percentage	49%	1%	20%	1%	.10%	29%

Table 12. Number of unique clients served by primary language

Primary Language	English	Spanish	Arabic	Other
Number of Clients Served	4,716	1,855	4	241
Percentage	69%	27%	.06%	4%

If you have any questions about this report, please contact Robin Ramirez, rramirez@dmh.lacounty.gov.

Data Source for Figures 1-8 and Tables 1-2: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019.
Data Source for Tables 3-12: Direct service claiming as of 8/31/2020. Cost is based on Mode 15 services and not inclusive of community outreach services, client supportive services or invoiced services.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT INFORMATION
Service Area 7 – East Los Angeles County
Fiscal Year 2018-19

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MHSA is made up of five components: Community Services & Support; Prevention & Early Intervention; Innovation; Capital Facilities & Technological Needs and Workforce Education & Training.

Community Services & Support

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- Full Service Partnership
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- Alternative Crisis Services (ACS);
- Housing Services;
- Linkage to County-Operated Functions/Programs (Linkage); and
- Planning, Outreach, and Engagement Services (POE).

Prevention & Early Intervention

The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs. The components are as follows:

- Early Intervention
- Prevention
- Stigma and Discrimination
- Suicide Prevention

Innovation

The MHSOAC controls funding approval for the Innovation (INN) component of the MHSA. The goal of Innovation is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed Innovation plan. The programs are as follows:

- INN 2: Community Capacity Building to Prevent and Address Trauma
- INN 3: Help@Hand (formerly Technology Suite)
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- INN 5: Peer Support Specialist Full Service Partnership
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- INN 8: Early Psychosis Learning Healthcare Network
- TRIESTE

Workforce Education & Training

The goal of the Workforce Education & Training (WET) component is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

Service Area 7 – East Los Angeles County
Demographics

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).

SA 7 has a population of 1,321,304. It has the highest percentage of Latinos in the County.

Population by race/ethnicity

Figure 1. Los Angeles County (n = 10,278,834)

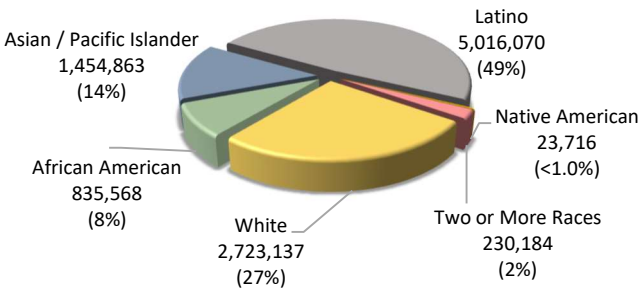
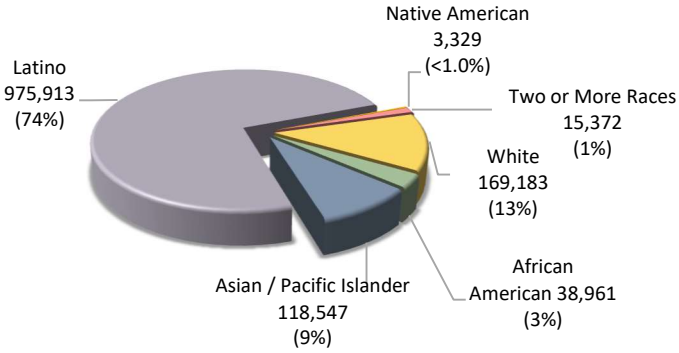


Figure 2. Service Area 7 (n = 1,321,304)



Population by age group

Figure 3. Los Angeles County (n = 10,278,834)

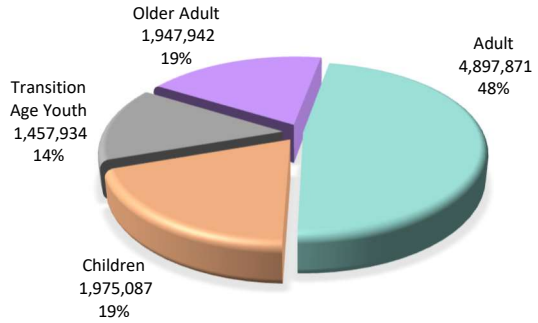
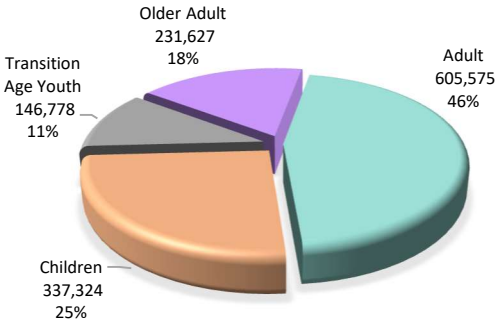


Figure 4. Service Area 7 (n = 1,321,304)



Medi-Cal Enrolled Population in Service Area 7 by Ethnicity and Age Group

Figure 5. Service Area 7 Ethnicity (n = 465,835)

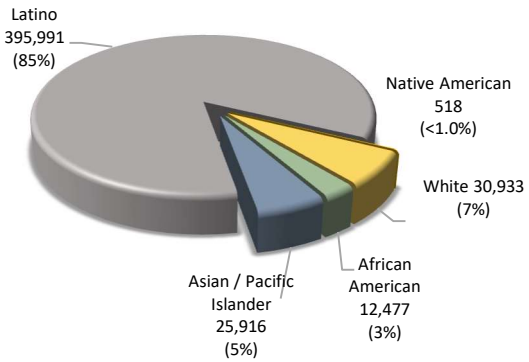
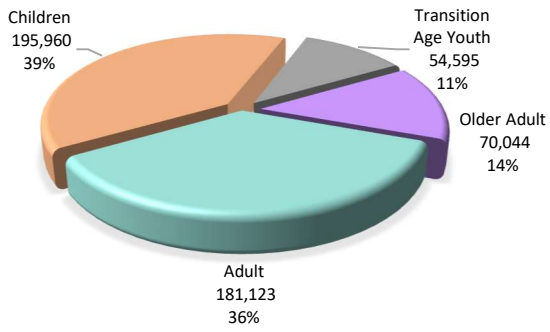


Figure 6. Service Area 7 Age Group (n = 501,722)



Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population in Service Area 7 by Ethnicity and Age Group

Figure 7. Service Area 7 Ethnicity (n = 55,660)

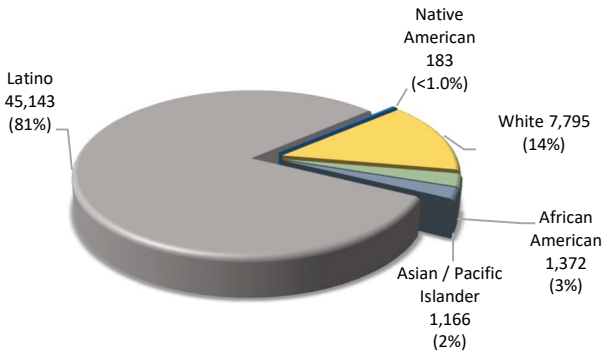
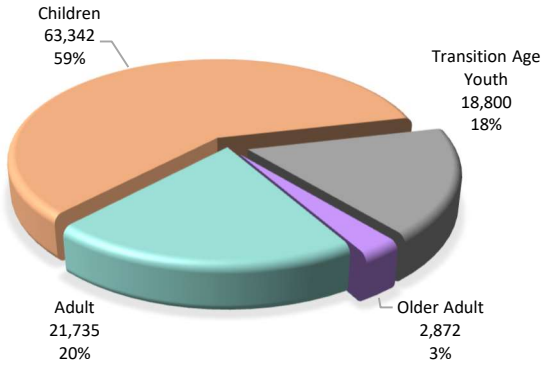


Figure 8. Service Area 7 Age Group (n = 106,749)



Among the population enrolled in Medi-Cal, Service Area 7 has three threshold languages: English (753.1%), Korean (0.6%) and Spanish (44.8%).

Consumers Served in Los Angeles County Department of Mental Health Service Area 7 Outpatient Programs

Figure 9. Service Area 7 Ethnicity (n = 18,372)

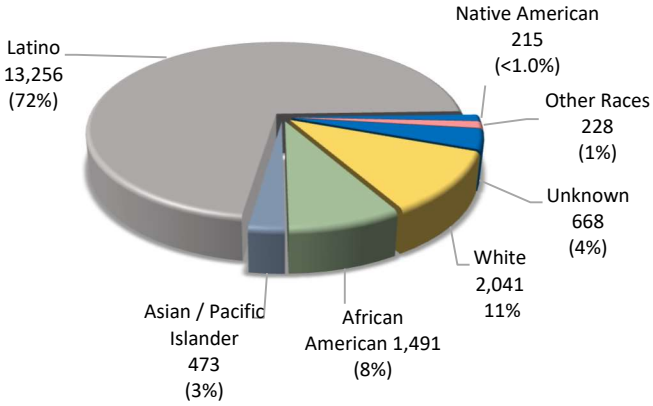
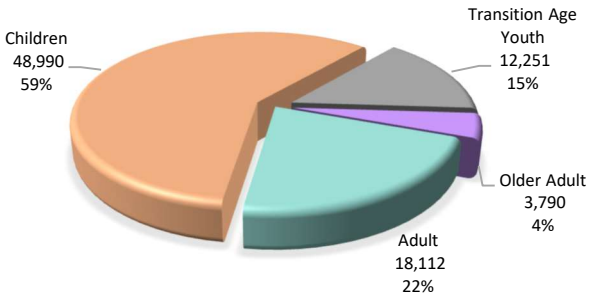


Figure 10. Service Area 7 Age Group (n = 36,930)



Korean and Spanish are the non-English threshold languages reported for consumers in outpatient programs by Service Area 7.

Needs Assessment of Medi-Cal Enrolled Population in Service Area 7

A negative number indicates that the estimated need for mental health services has not been met. Zero indicates “no disparity”. A “+” number in parentheses indicates the number of individuals receiving services beyond the estimated need of services.

Table 1. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Ethnicity

Ethnicity	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
African American	1,372	1,103	-269
Asian/Pacific Islander	1,166	307	-859
Latino	45,143	8,759	-36,384
Native American	183	159	-24
White	7,795	1,327	-6,468

Table 2. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Age Group

Age Group	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
Children (0-15)	63,342	9,962	-53,380
Transition Age Youth (16-25)	18,800	5,967	-12,833
Adult (26-59)	21,735	8,433	-13,302
Older Adult (60+)	2,872	1,737	-1,135

Mental Health Services Act Services

Community Services and Supports

Number of Unique Clients Served: 12,886 Number of New Clients Served: 5,236

Table 3. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	3,619	2,285	6,039	1,283
MHSA Cost	$20,030,058	$10,478,236	$25,960,019	$5,545,856

Table 4. Number of unique clients served by Ethnicity

Ethnicity	White	African American	Latino	Asian Pacific Islander	Native American	Other
Number of Clients Served	1,353	822	7,893	380	224	2,214
Percentage	10.50%	6.38%	61.25%	2.94%	1.74%	17.18%

Table 5. Number of unique clients served by Primary Language

Primary Language	English	Spanish	Farsi	Arabic	Mandarin	American Sign Language	Pilipino, Tagalog	Other
Number of Clients Served	9,551	3,093	4	12	14	6	5	201
Percentage	74.12%	24%	0.03%	0.09%	0.11%	0.05%	0.04%	2%

Full Service Partnership (FSP)

Table 6. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	618	378	683	228
MHSA Cost	$9,650,326	$4,346,670	$8,168,879	$2,367,889

Table 7. Service Area 7 Full Service Partnership Capacity as of 8/15/20

Service Area 7 FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Children (includes Wraparound Child, and Wraparound TAY)	372	304	82%
Transition Age Youth, Ages 16-25	173	141	82%
Adult, Ages 26-59 (includes Forensic, Homeless, Measure H and Housing)	866	640	74%
Older Adult, Ages 60+	99	77	78%

Table 8. Countywide Full Service Partnership Capacity as of 8/15/20

Countywide FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Intensive Field Capable Clinical Services (IFCCS)	765	504	66%
Assisted Outpatient Program (AOT)	385	289	75%
Integrated Mental Health Team (IMHT)	300	278	93%

Clients can be seen in more than one FSP program in a year.

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Table 9. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	3,102	1,915	5,243	1,041
MHSA Cost	$13,318,808	$5,886,930	$16,722,862	$3,101,849

Prevention and Early Intervention

Number of Unique Clients Served: 7,362 Number of New Clients Served: 4,797

Table 10. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	4,714	1,504	1,096	197
MHSA Cost	$15,407,388	$4,741,386	$2,271,326	$644,946

Table 11. Number of unique clients served by Ethnicity

Ethnicity	Latino	White	African American	Asian Pacific Islander	Native American	Other
Number of Clients Served	4,427	355	197	107	34	2,242
Percentage	60%	5%	3%	1%	0.46%	30%

Table 12. Number of unique clients served by primary language

Primary Language	English	Spanish	Cantonese	Mandarin	Other
Number of Clients Served	5,385	1,836	2	2	137
Percentage	73%	25%	0.03%	0.03%	2%

If you have any questions about this report, please contact Robin Ramirez, rramirez@dmh.lacounty.gov.

Data Source for Figures 1-10 and Tables 1-2: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019.
Data Source for Tables 3-12: Direct service claiming as of 8/31/2020. Cost is based on Mode 15 services and not inclusive of community outreach services, client supportive services or invoiced services.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT INFORMATION
Service Area 8 – South Bay
Fiscal Year 2018-19

In Fiscal Year 2018-19, 181,135 unique clients received a direct Mental Health Services Act (MHSA) mental health service in Los Angeles County. 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.

Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan ("Three-Year Plan" or "Plan") followed by Annual Plan Updates for MHSA programs and expenditures. The Plan provides an opportunity for the Los Angeles County - Department of Mental Health (LACDMH) to review its existing MHSA programs and services to evaluate their effectiveness. The Plan also allows LACDMH to propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available. It is through this Community Planning Process that LACDMH will obtain important feedback from a broad array of stakeholders. Any changes made to any MHSA program must comply with MHSA regulations, as well as relevant State requirements.

MHSA is made up of five components: Community Services & Support; Prevention & Early Intervention; Innovation; Capital Facilities & Technological Needs and Workforce Education & Training.

Community Services & Support

Community Services & Support (CSS) is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component. Services include:

- Full Service Partnership
- Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration Services RRR);
- Alternative Crisis Services (ACS);
- Housing Services;
- Linkage to County-Operated Functions/Programs (Linkage); and
- Planning, Outreach, and Engagement Services (POE).

Prevention & Early Intervention

The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs. The components are as follows:

- Early Intervention
- Prevention
- Stigma and Discrimination
- Suicide Prevention

Innovation

The MHSOAC controls funding approval for the Innovation (INN) component of the MHSA. The goal of Innovation is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed Innovation plan. The programs are as follows:

- INN 2: Community Capacity Building to Prevent and Address Trauma
- INN 3: Help@Hand (formerly Technology Suite)
- INN 4: Transcranial Magnetic Stimulation (TMS)
- INN 5: Peer Support Specialist Full Service Partnership
- INN 7: Therapeutic Transportation (TT)
- INN 8: Early Psychosis Learning Healthcare Network
- TRIESTE

Workforce Education & Training

The goal of the Workforce Education & Training (WET) component is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

Service Area 8 – South Bay
Demographics

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).

SA 8 has a population of 1,578,056.

Population by race/ethnicity

Figure 1. Los Angeles County (n = 10,278,834)

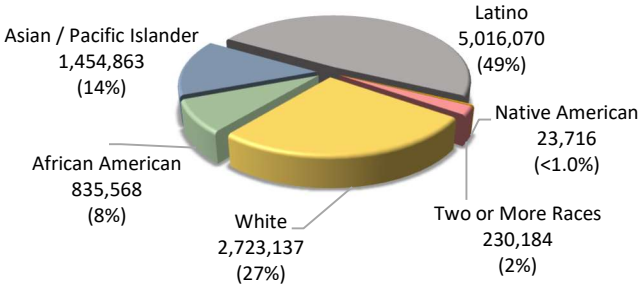
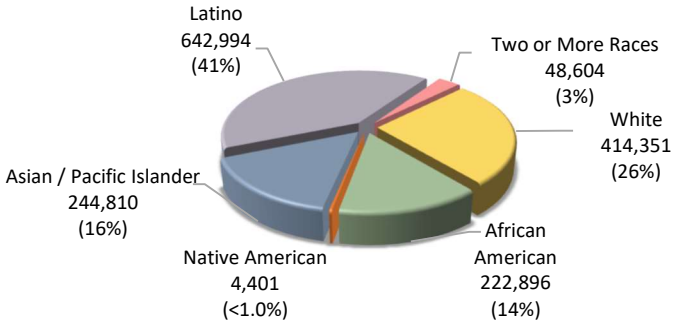


Figure 2. Service Area 8 (n = 1,578,056)



Population by age group

Figure 3. Los Angeles County (n = 10,278,834)

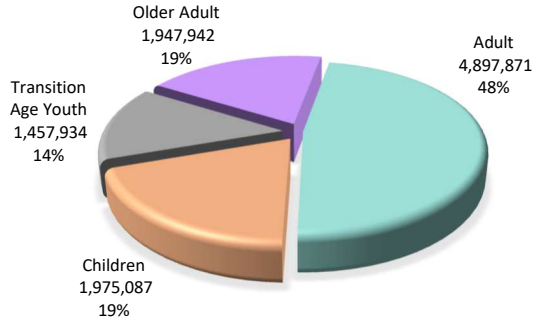
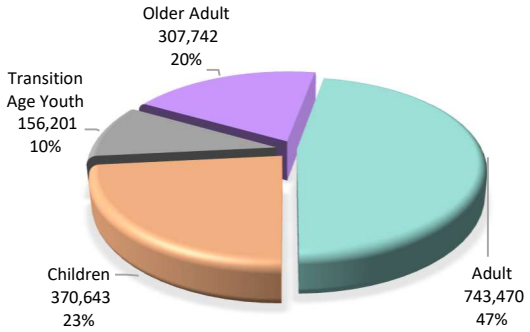


Figure 4. Service Area 8 (n = 1,578,056)



Medi-Cal Enrolled Population in Service Area 8 by Ethnicity and Age Group

Figure 5. Service Area 8 Ethnicity (n = 451,839)

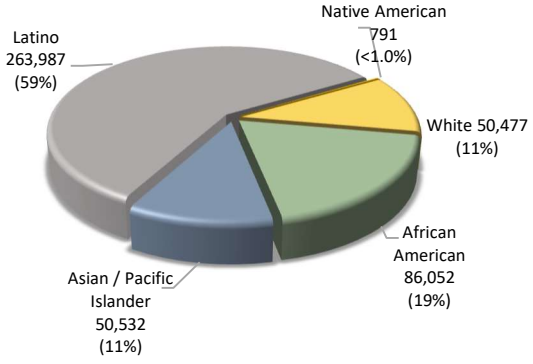
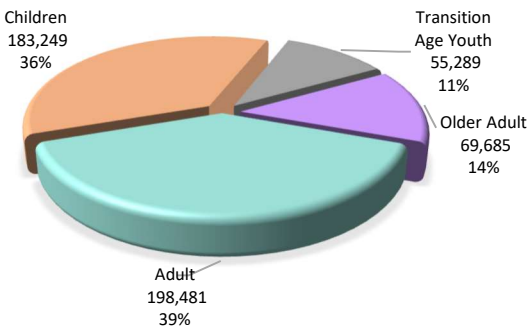


Figure 6. Service Area 8 Age Group (n = 506,704)



Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population in Service Area 8 by Ethnicity and Age Group

Figure 7. Service Area 8 Ethnicity (n = 54,834)

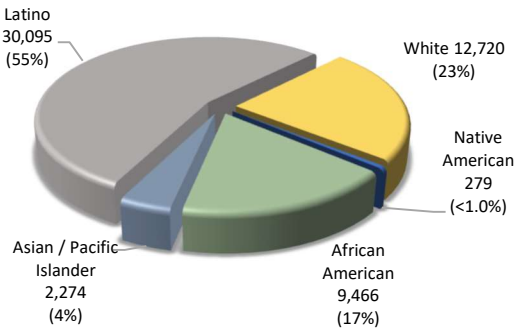
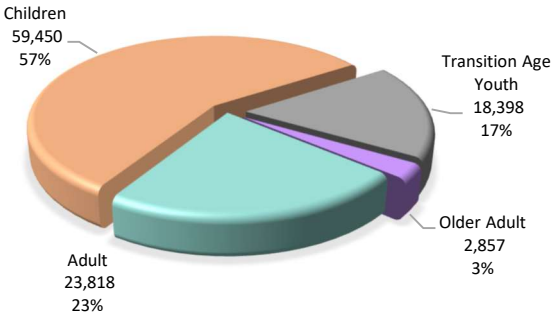


Figure 8. Service Area 8 Age Group (n = 104,523)



Among the population enrolled in Medi-Cal, Service Area 8 has five threshold languages: English (65.0%), Cambodian (1.1%), Korean (0.7%), Vietnamese (0.6%), and Spanish (31.6%).

Consumers Served in Los Angeles County Department of Mental Health Service Area 8 Outpatient Programs

Figure 9. Service Area 8 Ethnicity (n = 25,000)

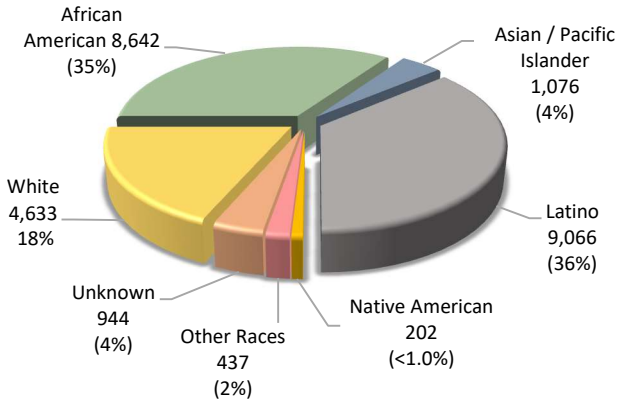
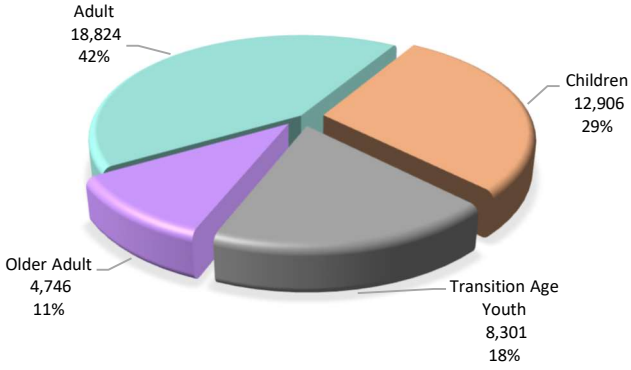


Figure 10. Service Area 8 Age Group (n = 44,777)



Cambodian, Korean, Spanish, and Vietnamese are the non-English threshold languages reported for consumers in outpatient programs by Service Area 8.

Needs Assessment of Medi-Cal Enrolled Population in Service Area 8

A negative number indicates that the estimated need for mental health services has not been met. Zero indicates “no disparity”. A “+” number in parentheses indicates the number of individuals receiving services beyond the estimated need of services.

Table 1. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Ethnicity

Ethnicity	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
African American	9,466	6,084	-3,382
Asian/Pacific Islander	2,274	678	-1,596
Latino	30,095	5,485	-24,610
Native American	279	146	-133
White	12,720	2,901	-9,819

Table 2. Needs Assessment of Medi-Cal Enrolled Population with SED and SMI by Age Group

Age Group	Medi-Cal Enrolled Population Estimated with SED and SMI	Outpatient Consumers Served	Service Area Disparity
Children (0-15)	59,450	8,971	-50,479
Transition Age Youth (16-25)	18,398	5,580	-12,818
Adult (26-59)	23,818	12,604	-11,214
Older Adult (60+)	2,857	3,154	(+)297

Mental Health Services Act Services

Community Services and Supports

Number of Unique Clients Served: 27,409 Number of New Clients Served: 12,028

Table 3. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	4,976	4,524	15,195	3,276
MHSA Cost	$34,127,247	$19,382,792	$58,993,684	$14,002,283

Table 4. Number of unique clients served by Ethnicity

Ethnicity	White	African American	Latino	Asian Pacific Islander	Native American	Other
Number of Clients Served	5,406	6,949	9,912	2,119	138	2,885
Percentage	20%	25%	36%	8%	1%	11%

Table 5. Number of unique clients served by Primary Language

Primary Language	English	Spanish	Farsi	Russian	Arabic	Mandarin	Cantonese	American Sign Language	Pilipino, Tagalog	Other
Number of Clients Served	22,600	3,137	12	7	12	17	10	6	55	1,553
Percentage	82.45%	11.45%	0.04%	0.03%	0.04%	0.06%	0.04%	0.02%	0.20%	5.66%

Full Service Partnership (FSP)

Table 6. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	710	516	1,350	326
MHSA Cost	$10,230,161	$5,929,032	$16,304,340	$3,474,194

Table 7. Service Area 8 Full Service Partnership Capacity as of 8/15/20

Service Area 8 FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Children (includes Wraparound Child, and Wraparound TAY)	417	247	59%
Transition Age Youth, Ages 16-25	238	228	96%
Adult, Ages 26-59 (includes Forensic, Homeless, Measure H and Housing)	1,637	1,144	70%
Older Adult, Ages 60+	149	143	96%

Table 8. Countywide Full Service Partnership Capacity as of 8/15/20

Countywide FSP Program	Number of Slots	Number of Authorized Slots	Percent of Target Met
Intensive Field Capable Clinical Services (IFCCS)	765	504	66%
Assisted Outpatient Program (AOT)	385	289	75%
Integrated Mental Health Team (IMHT)	300	278	93%

Clients can be seen in more than one FSP program in a year.

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Table 9. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	4,031	2,793	10,237	2,670
MHSA Cost	$23,242,972	$11,182,547	$35,073,609	$9,910,474

Prevention and Early Intervention

Number of Unique Clients Served: 8,175 Number of New Clients Served: 4,936

Table 10. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	5,416	1,470	1,204	237
MHSA Cost	$20,153,096	$4,972,404	$3,439,052	$710,796

Table 11. Number of unique clients served by Ethnicity

Ethnicity	Latino	White	African American	Asian Pacific Islander	Native American	Other
Number of Clients Served	3,609	677	1,091	257	12	2,529
Percentage	44%	8%	13%	4%	0.15%	31%

Table 12. Number of unique clients served by primary language

Primary Language	English	Spanish	Arabic	Other
Number of Clients Served	5,825	2,154	4	192
Percentage	71%	26%	0.05%	2%

If you have any questions about this report, please contact Robin Ramirez, rramirez@dmh.lacounty.gov.

Data Source for Figures 1-8 and Tables 1-2: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019.
Data Source for Tables 3-12: Direct service claiming as of 8/31/2020. Cost is based on Mode 15 services and not inclusive of community outreach services, client supportive services or invoiced services.

APPENDIX C - MENTAL HEALTH COMMISSION (MHC) PRESENTATIONS

[C1] PRESENTATION TO THE MHC EXECUTIVE COMMITTEE - FEB 11, 2021 AGENDA AND POWERPOINT PRESENTATION

A high-level Plan overview was presented to the Executive Committee members.

Los Angeles County

Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

First District	Second District	Third District	Fourth District	Fifth District
Hilda L. Solis	**Holly J. Mitchell**	**Sheila Kuehl**	**Janice Hahn**	**Kathryn Barger**
D. Imelda Padilla-Frausto	Harold Turner	Stacy Dalgleish	Patrick Ogawa	Brittney Weissman, MPP
Susan Friedman	Reba Stevens	Rev. Kathy Cooper Ledesma	Kevin Acebo	Judy Cooperberg, MS, CPRP
Luis R. Orozco	Vacant	Teresa Banko	Michael Molina	Vacant

EXECUTIVE COMMITTEE MEETING

1st Vice Chair	2nd Vice Chair	Chair	Members-at-Large	
Imelda Padilla-Frausto	Kevin Acebo	Brittney Weissman	Harold Turner	Patrick Ogawa

Thursday, February 11, 2021 / *Jueves 11 de febrero de 2021*
12:00 pm
(Please note the change in regular meeting time)

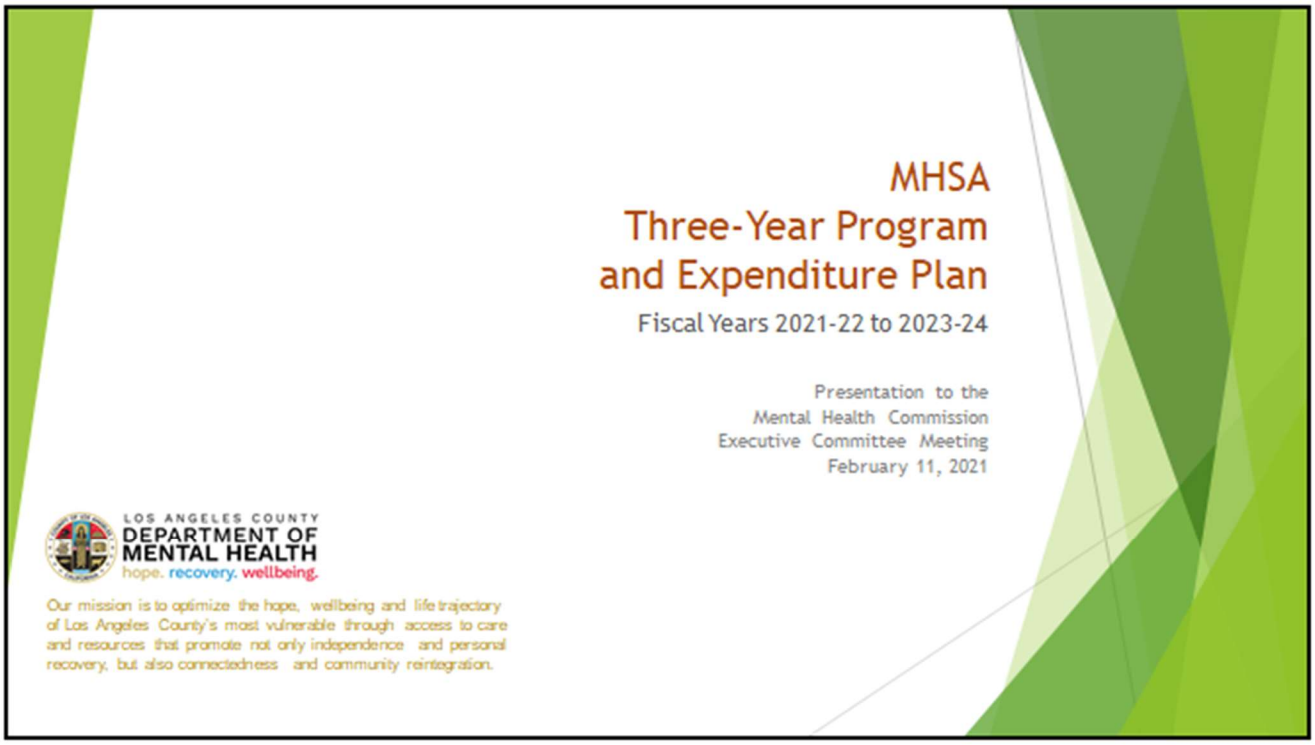
Watch Online (Virtual)	Public Comment Line	Únase por teléfono	CART Link
Click to Join	Toll-Free: 844-291-5490 Access Code: 1840647	Español: (888) 204-5987 ID de conferencia: 9639884#	CART Link

Agenda

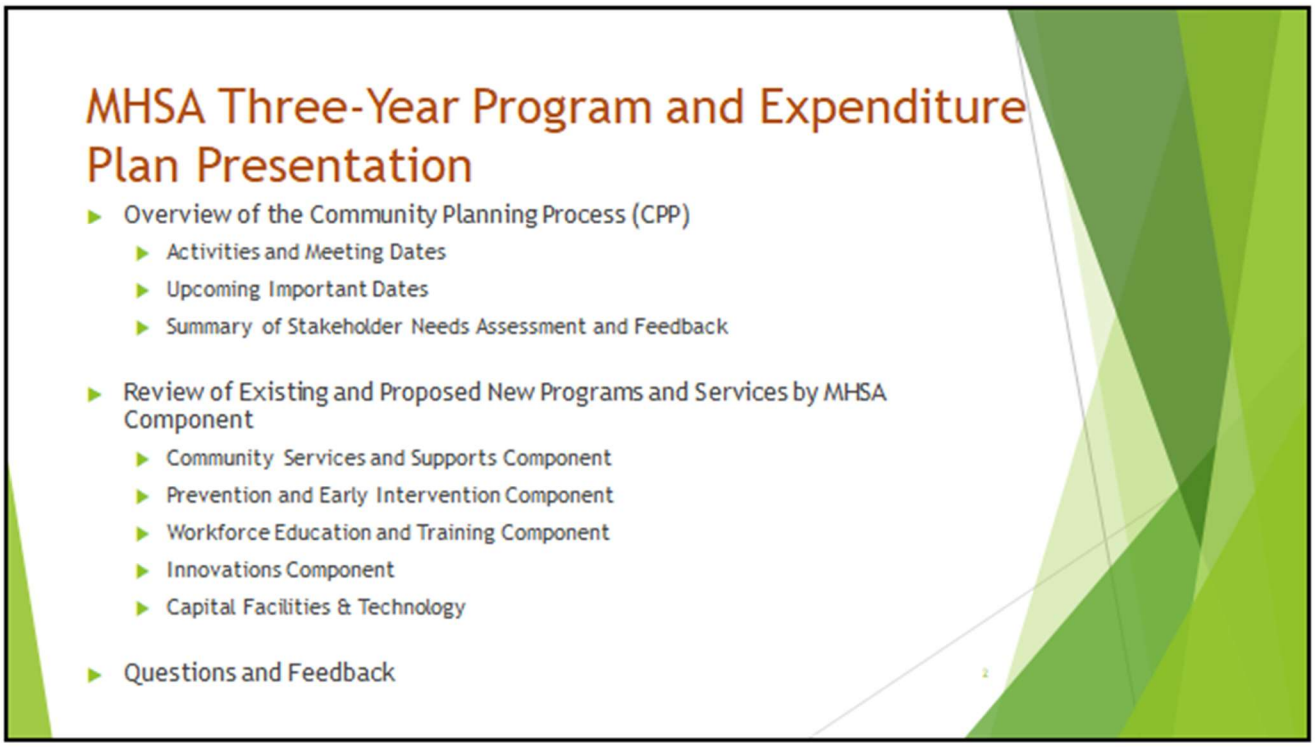
I. **Call to Order** / *Llamada al orden*
   a. **Action Item:** *Approve January Minutes / Aprobar actas de enero*
II. **Department Update** / *Actualización del Departamento de salud mental*
   a. **MHSA 3-Year Plan Overview** / *Descripción general del plan de 3 años de la MHSA*
III. **Non-Agenda Public Comments** / *Comentarios públicos no pertenecientes a la agenda*
IV. **Commission Business** / *Actualización de Commission*
   a. **February Full Agenda** / *Agenda de febrero*
   b. **Public Comment** / *Comentarios públicos*
V. **Adjourn** / *Aplazado*

NOTICE: Notice is hereby given that the order of consideration of matters on this agenda may be changed without prior notice. All items may be heard in a different order than listed on the agenda. / *Se hace notar que el orden de consideración de los asuntos en este orden del día puede cambiarse sin previo aviso. Todos los puntos pueden ser escuchados en un orden diferente al que figura en el orden del día.*

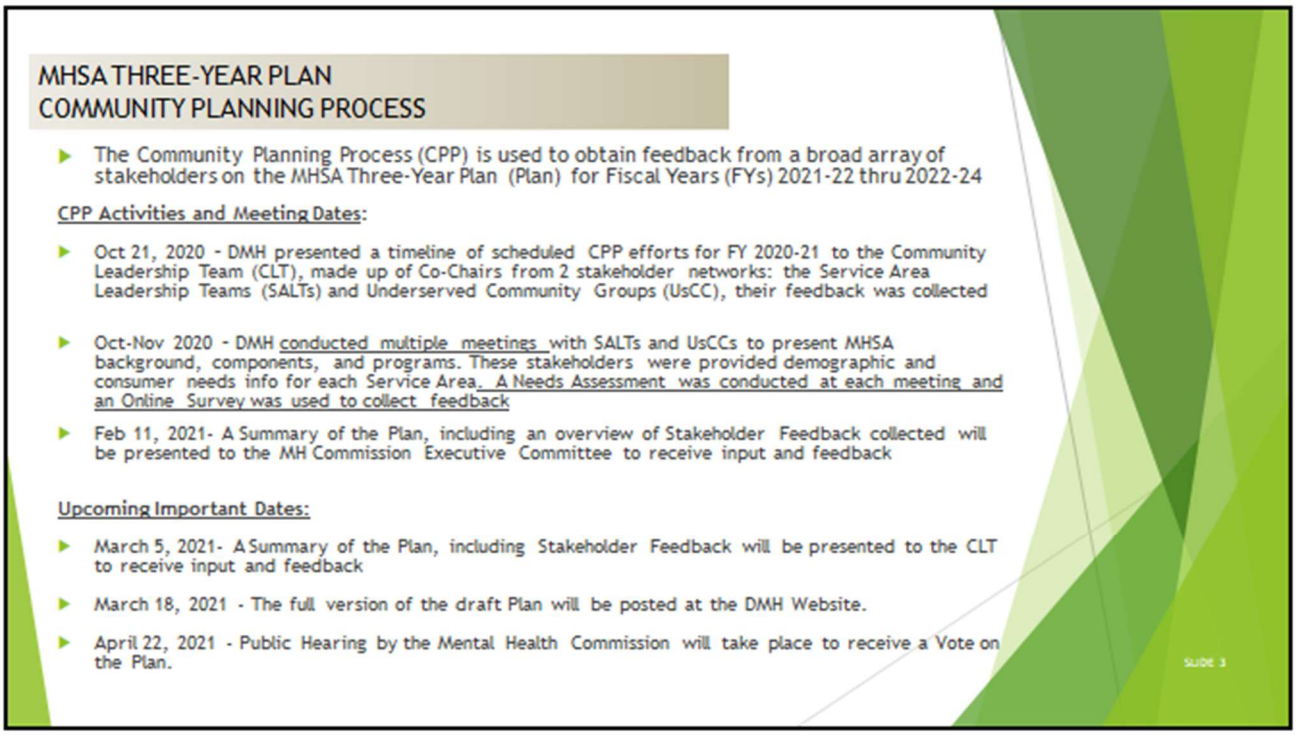
Address: 550 South Vermont. 12th Fl. Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov Website: http://dmh.lacounty.gov/about/mental-health-commission/


MHSA
Three-Year Program
and Expenditure Plan
Fiscal Years 2021-22 to 2023-24
Presentation to the
Mental Health Commission
Executive Committee Meeting
February 11, 2021
LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.
Our mission is to optimize the hope, wellbeing and life trajectory of Los Angeles County's most vulnerable through access to care and resources that promote not only independence and personal recovery, but also connectedness and community reintegration.

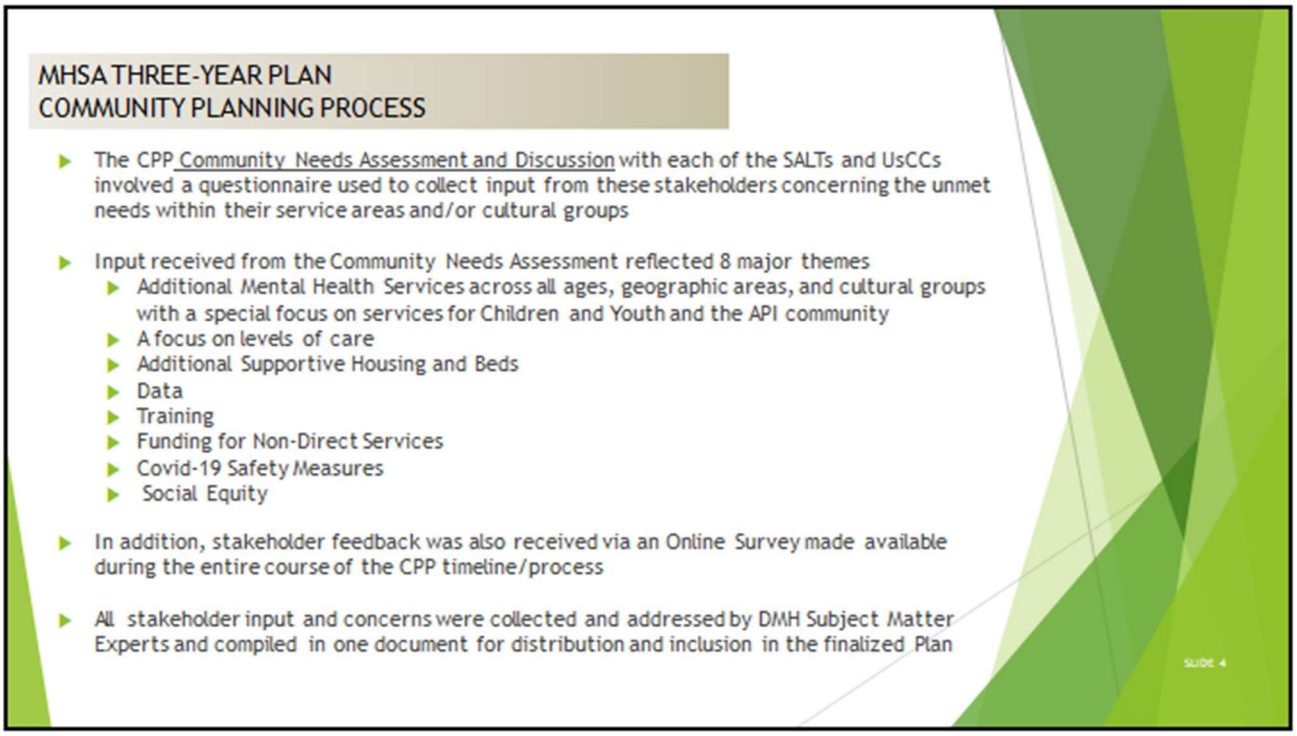
1


MHSA Three-Year Program and Expenditure Plan Presentation
Overview of the Community Planning Process (CPP)
Activities and Meeting Dates
Upcoming Important Dates
Summary of Stakeholder Needs Assessment and Feedback
Review of Existing and Proposed New Programs and Services by MHSA Component
Community Services and Supports Component
Prevention and Early Intervention Component
Workforce Education and Training Component
Innovations Component
Capital Facilities & Technology
Questions and Feedback
2

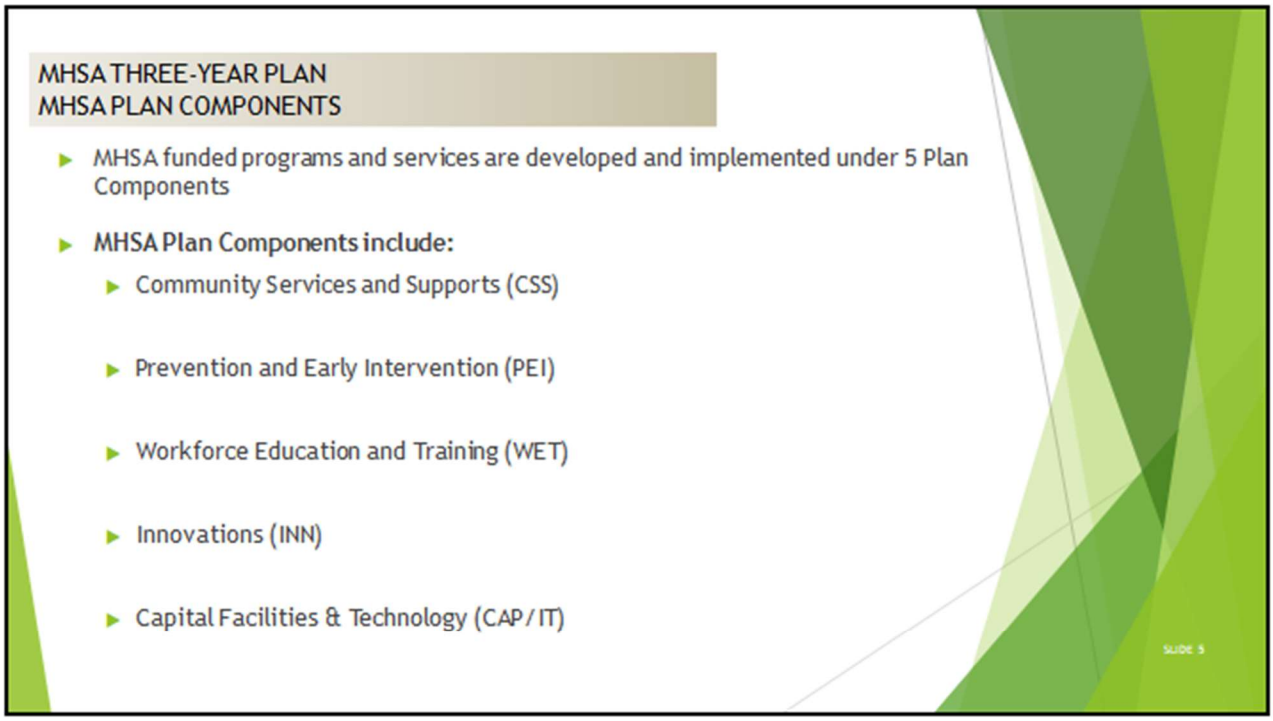
2


MHSA THREE-YEAR PLAN
COMMUNITY PLANNING PROCESS
The Community Planning Process (CPP) is used to obtain feedback from a broad array of stakeholders on the MHSA Three-Year Plan (Plan) for Fiscal Years (FYs) 2021-22 thru 2022-24
CPP Activities and Meeting Dates:
Oct 21, 2020 - DMH presented a timeline of scheduled CPP efforts for FY 2020-21 to the Community Leadership Team (CLT), made up of Co-Chairs from 2 stakeholder networks: the Service Area Leadership Teams (SALTs) and Underserved Community Groups (UsCC), their feedback was collected
Oct-Nov 2020 - DMH conducted multiple meetings with SALTs and UsCCs to present MHSA background, components, and programs. These stakeholders were provided demographic and consumer needs info for each Service Area. A Needs Assessment was conducted at each meeting and an Online Survey was used to collect feedback
Feb 11, 2021- A Summary of the Plan, including an overview of Stakeholder Feedback collected will be presented to the MH Commission Executive Committee to receive input and feedback
Upcoming Important Dates:
March 5, 2021- A Summary of the Plan, including Stakeholder Feedback will be presented to the CLT to receive input and feedback
March 18, 2021 - The full version of the draft Plan will be posted at the DMH Website.
April 22, 2021 - Public Hearing by the Mental Health Commission will take place to receive a Vote on the Plan.
SLIDE 3

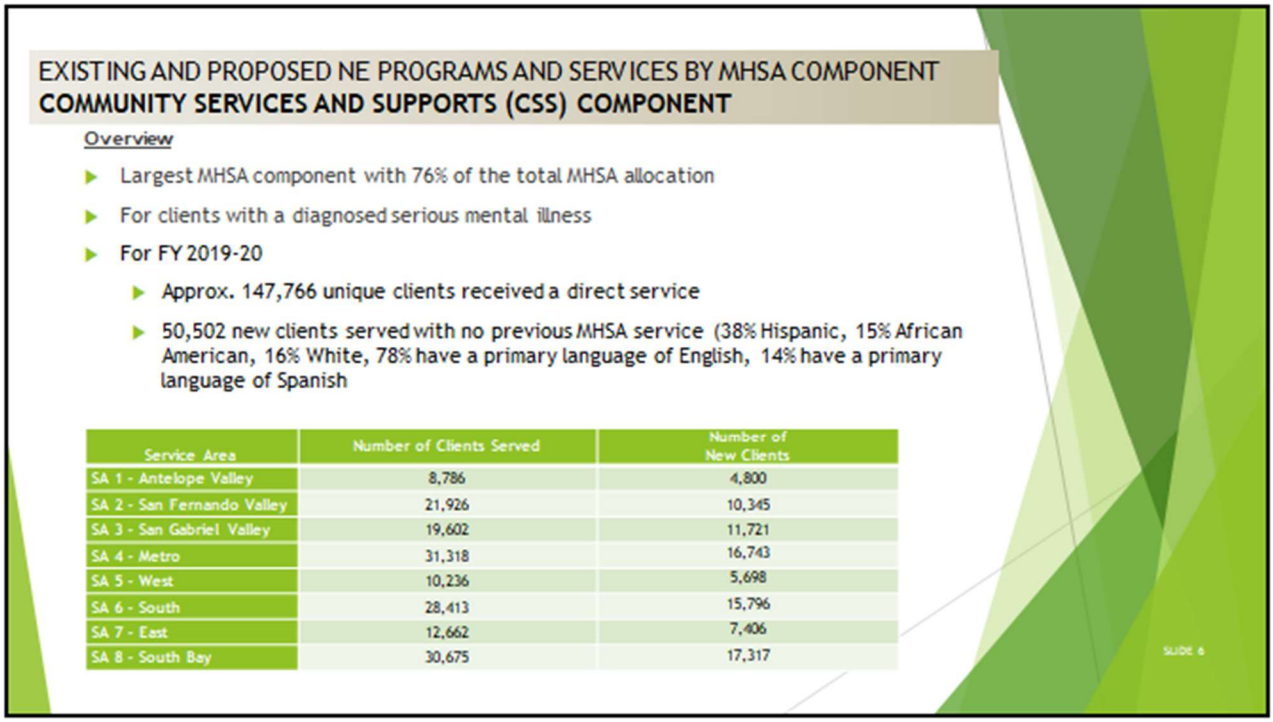
3


MHSA THREE-YEAR PLAN
COMMUNITY PLANNING PROCESS
The CPP Community Needs Assessment and Discussion with each of the SALTs and UsCCs involved a questionnaire used to collect input from these stakeholders concerning the unmet needs within their service areas and/or cultural groups
Input received from the Community Needs Assessment reflected 8 major themes
Additional Mental Health Services across all ages, geographic areas, and cultural groups with a special focus on services for Children and Youth and the API community
A focus on levels of care
Additional Supportive Housing and Beds
Data
Training
Funding for Non-Direct Services
Covid-19 Safety Measures
Social Equity
In addition, stakeholder feedback was also received via an Online Survey made available during the entire course of the CPP timeline/process
All stakeholder input and concerns were collected and addressed by DMH Subject Matter Experts and compiled in one document for distribution and inclusion in the finalized Plan
SLIDE 4

4


MHSA THREE-YEAR PLAN
MHSA PLAN COMPONENTS
MHSA funded programs and services are developed and implemented under 5 Plan Components
MHSA Plan Components include:
Community Services and Supports (CSS)
Prevention and Early Intervention (PEI)
Workforce Education and Training (WET)
Innovations (INN)
Capital Facilities & Technology (CAP/IT)
SLIDE 5

5


EXISTING AND PROPOSED NE PROGRAMS AND SERVICES BY MHSA COMPONENT
COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT
Overview
Largest MHSA component with 76% of the total MHSA allocation
For clients with a diagnosed serious mental illness
For FY 2019-20
Approx. 147,766 unique clients received a direct service
50,502 new clients served with no previous MHSA service (38% Hispanic, 15% African American, 16% White, 78% have a primary language of English, 14% have a primary language of Spanish
Service Area | Number of Clients Served | Number of New Clients
SA 1 - Antelope Valley | 8,786 | 4,800
SA 2 - San Fernando Valley | 21,926 | 10,345
SA 3 - San Gabriel Valley | 19,602 | 11,721
SA 4 - Metro | 31,318 | 16,743
SA 5 - West | 10,236 | 5,698
SA 6 - South | 28,413 | 15,796
SA 7 - East | 12,662 | 7,406
SA 8 - South Bay | 30,675 | 17,317
SLIDE 6

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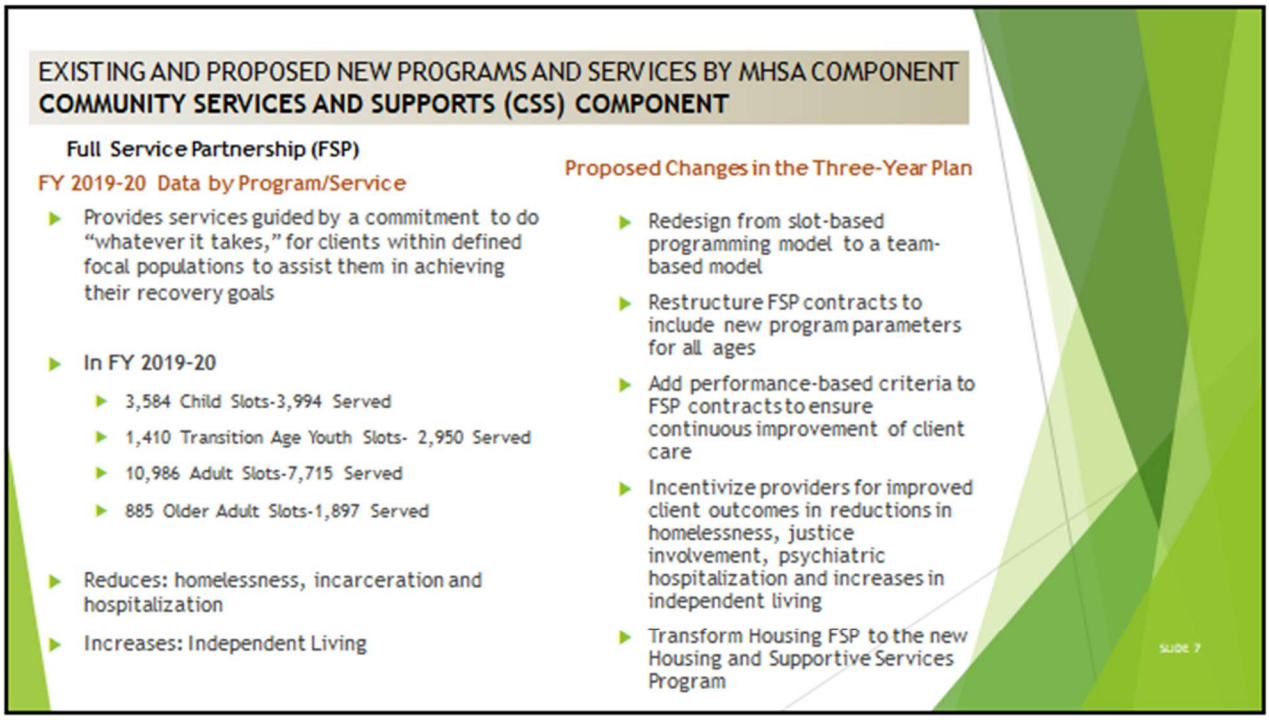
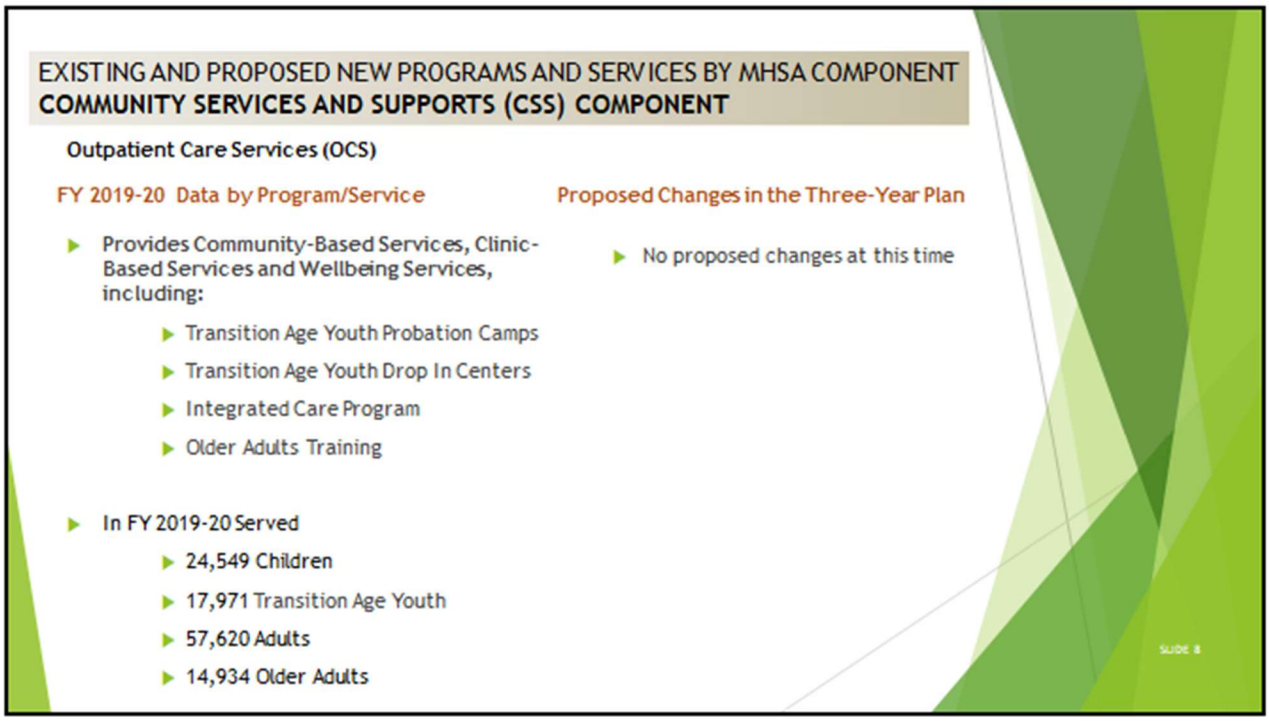

EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT
Full Service Partnership (FSP)
FY 2019-20 Data by Program/Service
Provides services guided by a commitment to do "whatever it takes," for clients within defined focal populations to assist them in achieving their recovery goals
In FY 2019-20
3,584 Child Slots-3,994 Served
1,410 Transition Age Youth Slots- 2,950 Served
10,986 Adult Slots-7,715 Served
885 Older Adult Slots-1,897 Served
Reduces: homelessness, incarceration and hospitalization
Increases: Independent Living
Proposed Changes in the Three-Year Plan
Redesign from slot-based programming model to a team-based model
Restructure FSP contracts to include new program parameters for all ages
Add performance-based criteria to FSP contracts to ensure continuous improvement of client care
Incentivize providers for improved client outcomes in reductions in homelessness, justice involvement, psychiatric hospitalization and increases in independent living
Transform Housing FSP to the new Housing and Supportive Services Program
SLIDE 7

7


EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT
Outpatient Care Services (OCS)
FY 2019-20 Data by Program/Service
Provides Community-Based Services, Clinic-Based Services and Wellbeing Services, including:
Transition Age Youth Probation Camps
Transition Age Youth Drop In Centers
Integrated Care Program
Older Adults Training
In FY 2019-20 Served
24,549 Children
17,971 Transition Age Youth
57,620 Adults
14,934 Older Adults
Proposed Changes in the Three-Year Plan
No proposed changes at this time
SLIDE 8

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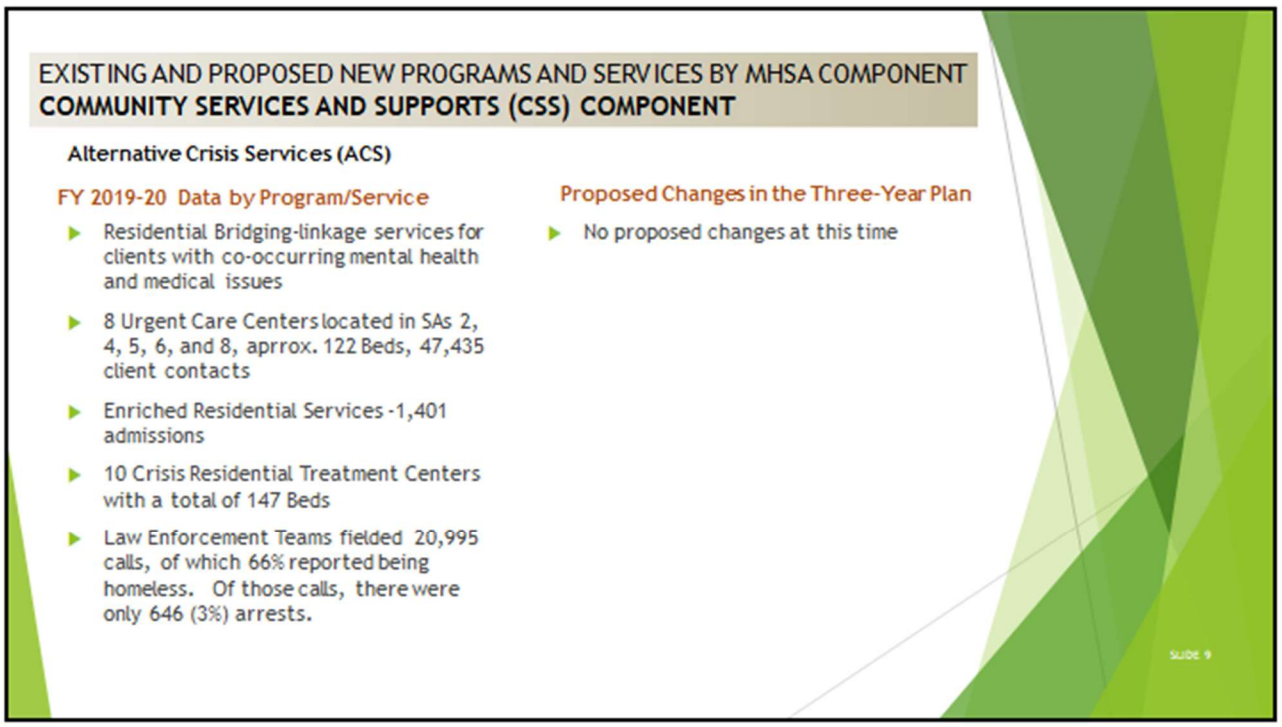
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT
Alternative Crisis Services (ACS)
FY 2019-20 Data by Program/Service
Residential Bridging-linkage services for clients with co-occurring mental health and medical issues
8 Urgent Care Centers located in SAs 2, 4, 5, 6, and 8, aprrox. 122 Beds, 47,435 client contacts
Enriched Residential Services -1,401 admissions
10 Crisis Residential Treatment Centers with a total of 147 Beds
Law Enforcement Teams fielded 20,995 calls, of which 66% reported being homeless. Of those calls, there were only 646 (3%) arrests.
Proposed Changes in the Three-Year Plan
No proposed changes at this time
SLIDE 9

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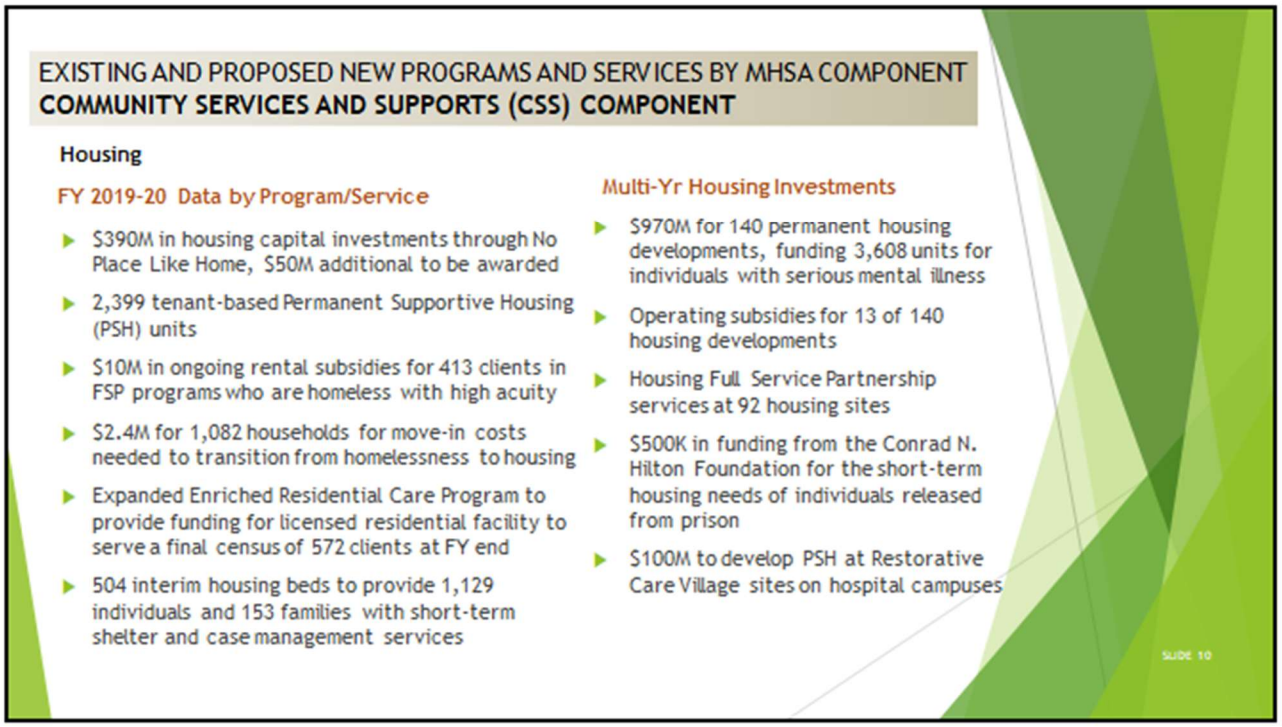
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT
Housing
FY 2019-20 Data by Program/Service
$390M in housing capital investments through No Place Like Home, $50M additional to be awarded
2,399 tenant-based Permanent Supportive Housing (PSH) units
$10M in ongoing rental subsidies for 413 clients in FSP programs who are homeless with high acuity
$2.4M for 1,082 households for move-in costs needed to transition from homelessness to housing
Expanded Enriched Residential Care Program to provide funding for licensed residential facility to serve a final census of 572 clients at FY end
504 interim housing beds to provide 1,129 individuals and 153 families with short-term shelter and case management services
Multi-Yr Housing Investments
$970M for 140 permanent housing developments, funding 3,608 units for individuals with serious mental illness
Operating subsidies for 13 of 140 housing developments
Housing Full Service Partnership services at 92 housing sites
$500K in funding from the Conrad N. Hilton Foundation for the short-term housing needs of individuals released from prison
$100M to develop PSH at Restorative Care Village sites on hospital campuses
SLIDE 10

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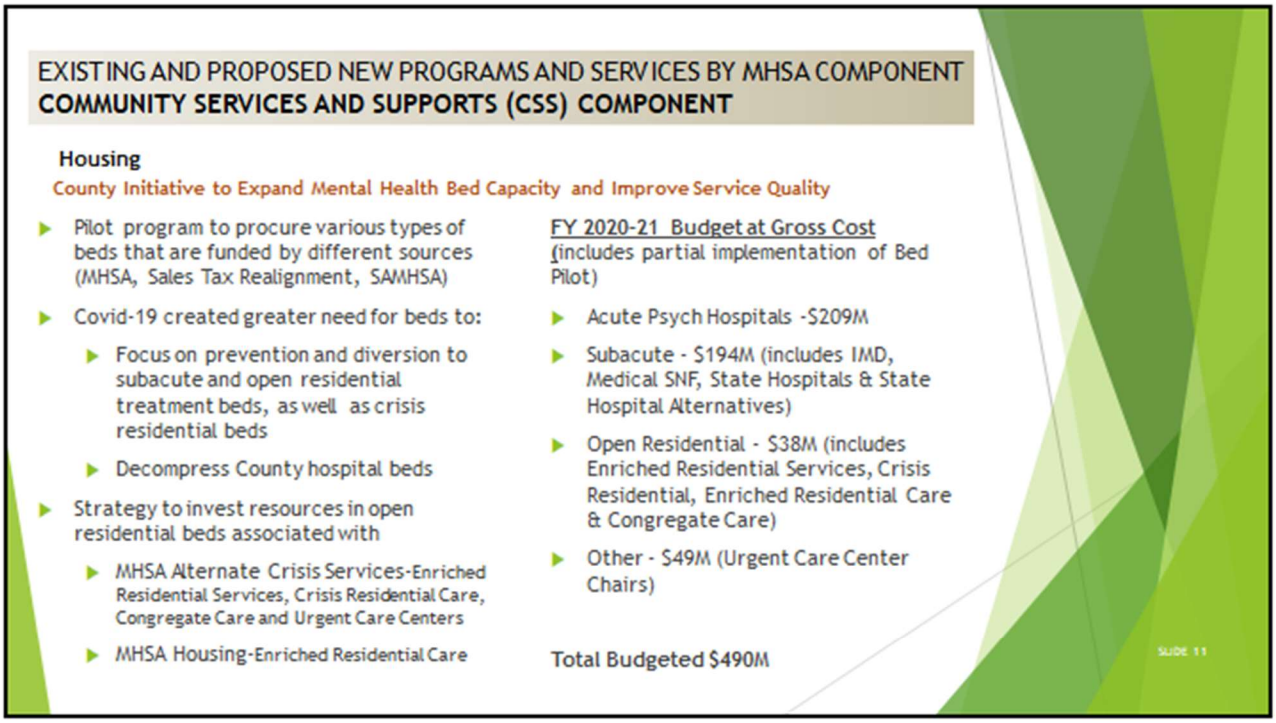
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT
Housing
County Initiative to Expand Mental Health Bed Capacity and Improve Service Quality
Pilot program to procure various types of beds that are funded by different sources (MHSA, Sales Tax Realignment, SAMHSA)
Covid-19 created greater need for beds to:
Focus on prevention and diversion to subacute and open residential treatment beds, as well as crisis residential beds
Decompress County hospital beds
Strategy to invest resources in open residential beds associated with
MHSA Alternate Crisis Services-Enriched Residential Services, Crisis Residential Care, Congregate Care and Urgent Care Centers
MHSA Housing-Enriched Residential Care
FY 2020-21 Budget at Gross Cost (includes partial implementation of Bed Pilot)
Acute Psych Hospitals -$209M
Subacute - $194M (includes IMD, Medical SNF, State Hospitals & State Hospital Alternatives)
Open Residential - $38M (includes Enriched Residential Services, Crisis Residential, Enriched Residential Care & Congregate Care)
Other - $49M (Urgent Care Center Chairs)
Total Budgeted $490M
SLIDE 11

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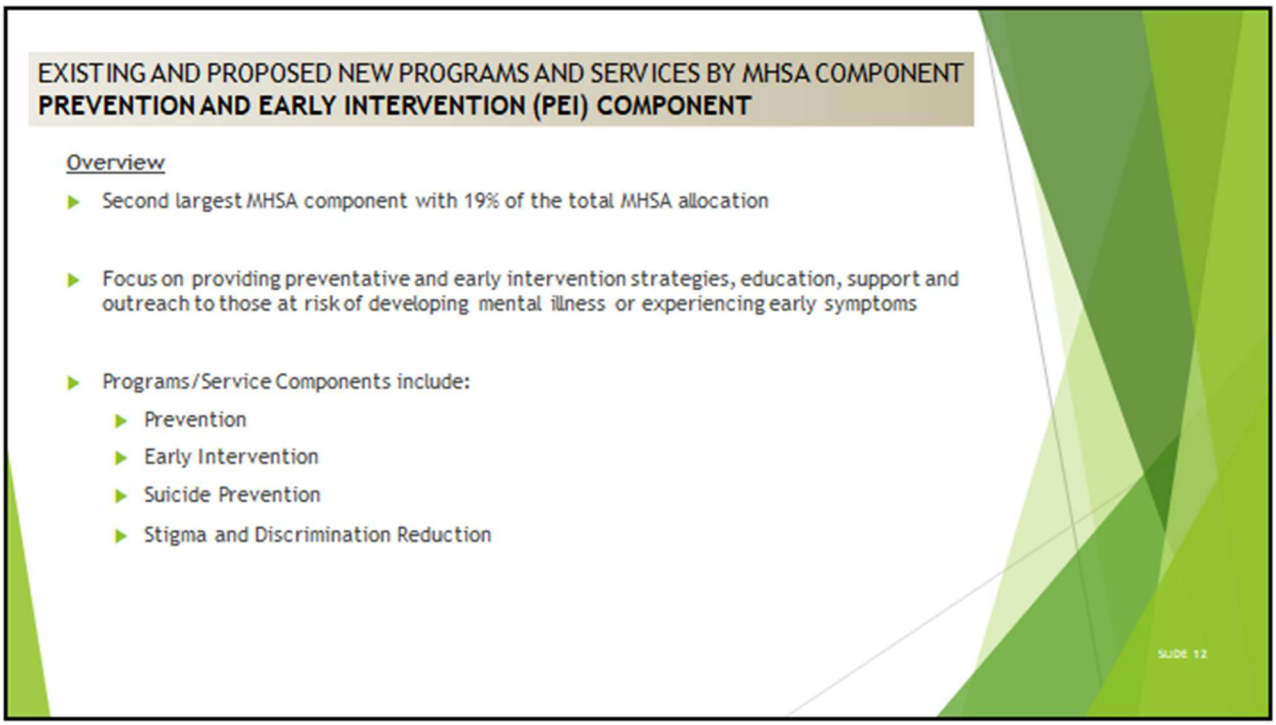
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
PREVENTION AND EARLY INTERVENTION (PEI) COMPONENT
Overview
Second largest MHSA component with 19% of the total MHSA allocation
Focus on providing preventative and early intervention strategies, education, support and outreach to those at risk of developing mental illness or experiencing early symptoms
Programs/Service Components include:
Prevention
Early Intervention
Suicide Prevention
Stigma and Discrimination Reduction
SLIDE 12

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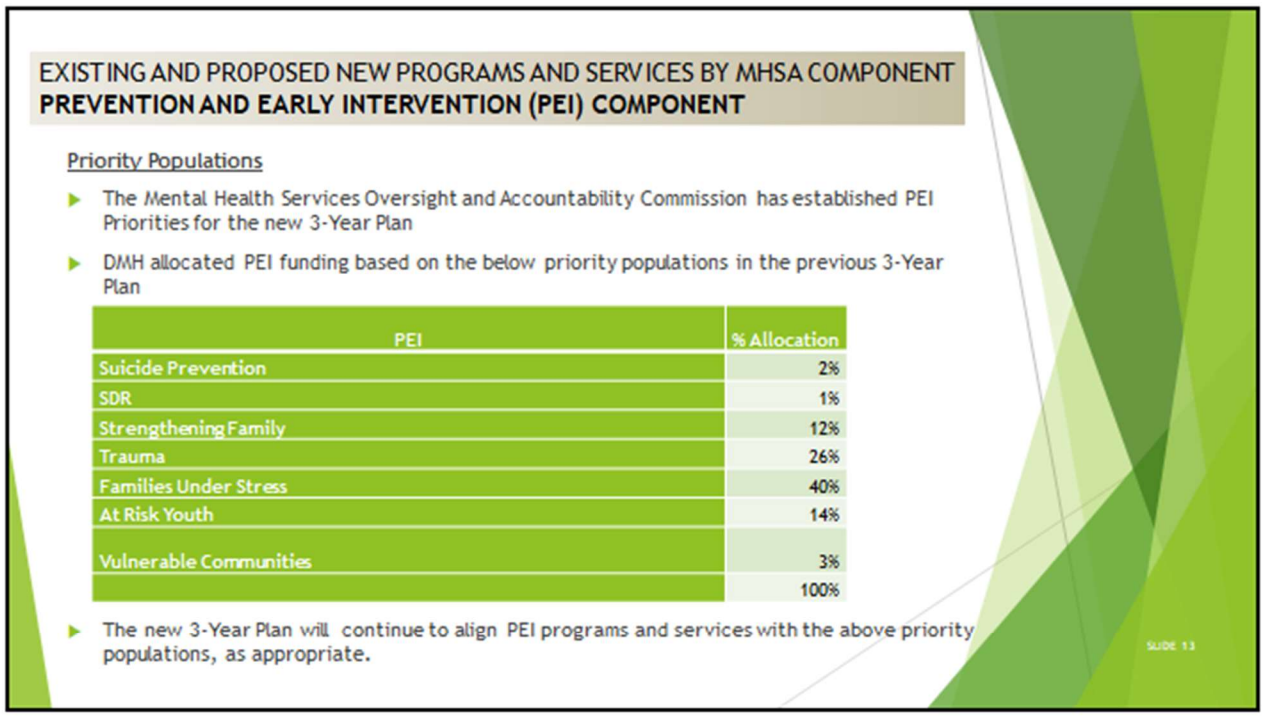
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
PREVENTION AND EARLY INTERVENTION (PEI) COMPONENT
Priority Populations
The Mental Health Services Oversight and Accountability Commission has established PEI Priorities for the new 3-Year Plan
DMH allocated PEI funding based on the below priority populations in the previous 3-Year Plan
PEI
% Allocation
Suicide Prevention
2%
SDR
1%
Strengthening Family
12%
Trauma
26%
Families Under Stress
40%
At Risk Youth
14%
Vulnerable Communities
3%
100%
The new 3-Year Plan will continue to align PEI programs and services with the above priority populations, as appropriate.
SLIDE 13

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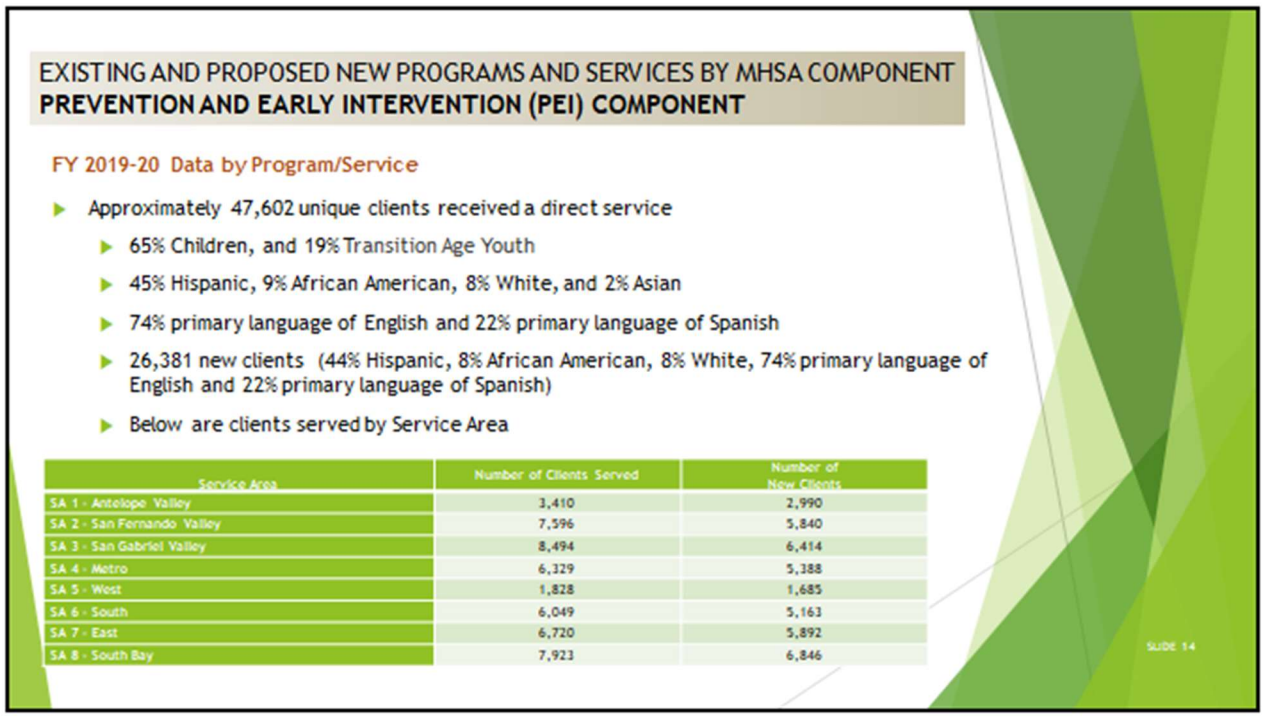
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
PREVENTION AND EARLY INTERVENTION (PEI) COMPONENT
FY 2019-20 Data by Program/Service
Approximately 47,602 unique clients received a direct service
65% Children, and 19% Transition Age Youth
45% Hispanic, 9% African American, 8% White, and 2% Asian
74% primary language of English and 22% primary language of Spanish
26,381 new clients (44% Hispanic, 8% African American, 8% White, 74% primary language of English and 22% primary language of Spanish)
Below are clients served by Service Area
Service Area
Number of Clients Served
Number of New Clients
SA 1 - Antelope Valley
3,410
2,990
SA 2 - San Fernando Valley
7,596
5,840
SA 3 - San Gabriel Valley
8,494
6,414
SA 4 - Metro
6,329
5,388
SA 5 - West
1,828
1,685
SA 6 - South
6,049
5,163
SA 7 - East
6,720
5,892
SA 8 - South Bay
7,923
6,846
SLIDE 14

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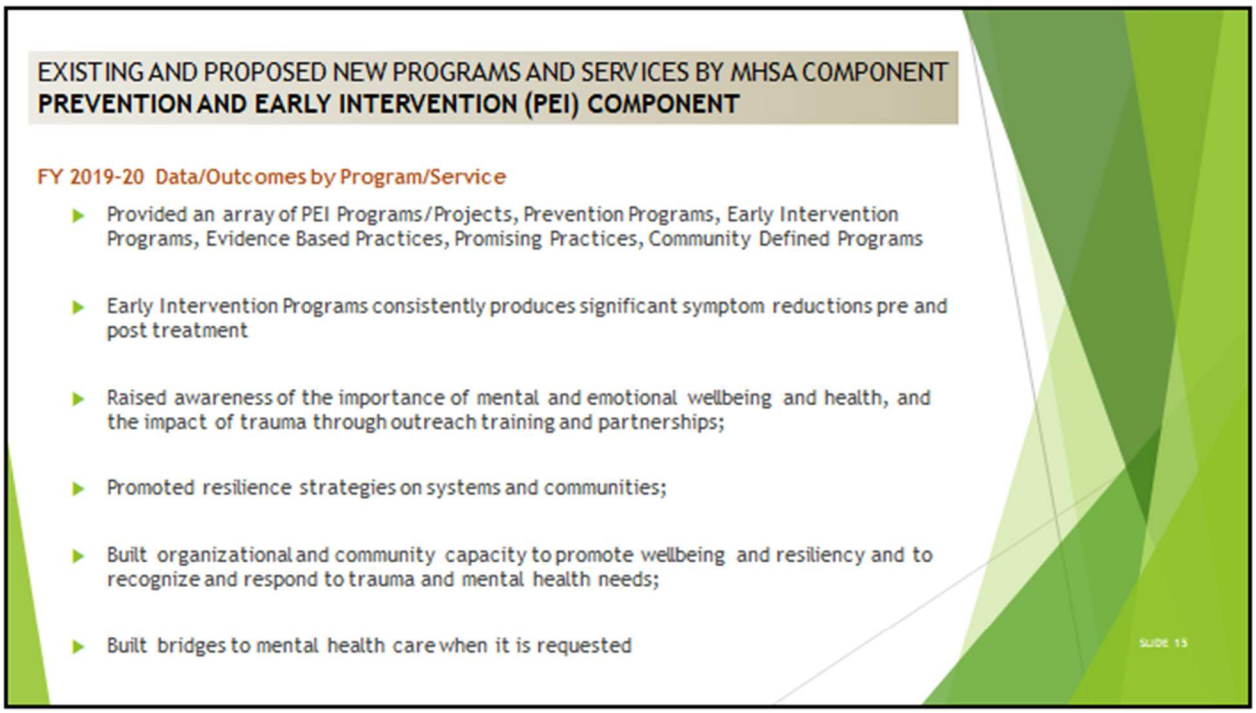
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
PREVENTION AND EARLY INTERVENTION (PEI) COMPONENT
FY 2019-20 Data/Outcomes by Program/Service
Provided an array of PEI Programs/Projects, Prevention Programs, Early Intervention Programs, Evidence Based Practices, Promising Practices, Community Defined Programs
Early Intervention Programs consistently produces significant symptom reductions pre and post treatment
Raised awareness of the importance of mental and emotional wellbeing and health, and the impact of trauma through outreach training and partnerships;
Promoted resilience strategies on systems and communities;
Built organizational and community capacity to promote wellbeing and resiliency and to recognize and respond to trauma and mental health needs;
Built bridges to mental health care when it is requested
SLIDE 15

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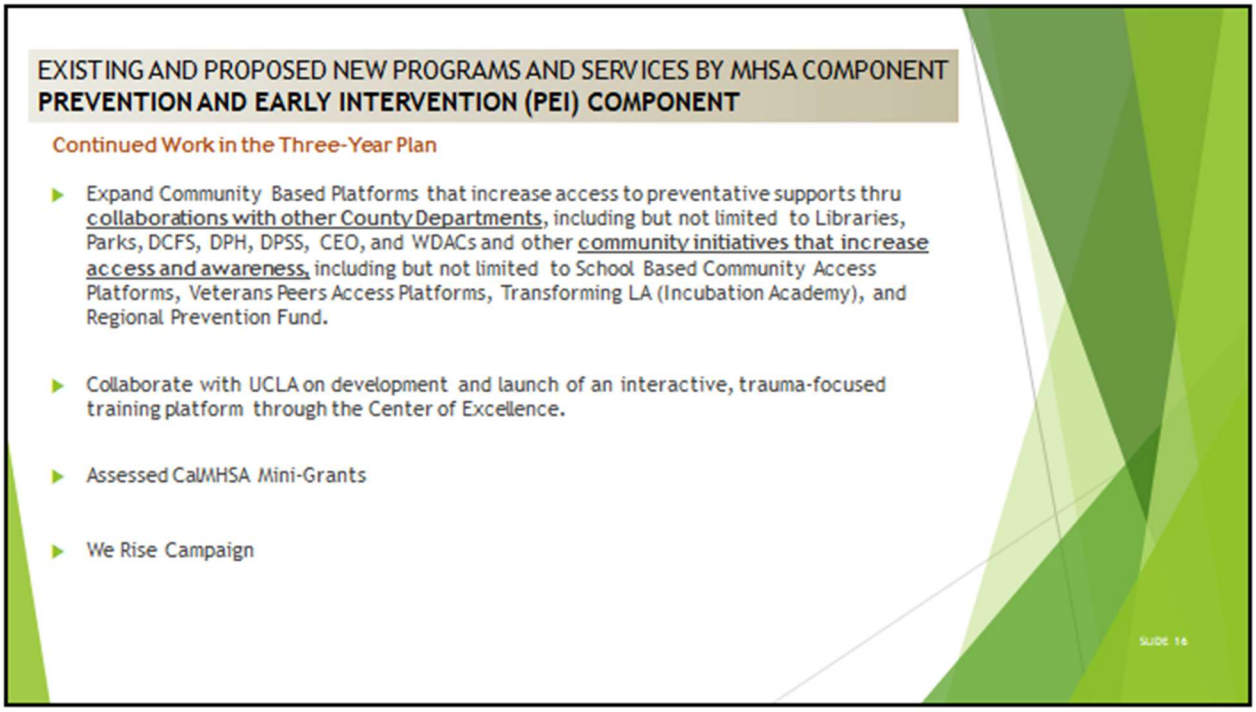
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
PREVENTION AND EARLY INTERVENTION (PEI) COMPONENT
Continued Work in the Three-Year Plan
Expand Community Based Platforms that increase access to preventative supports thru collaborations with other County Departments, including but not limited to Libraries, Parks, DCFS, DPH, DPSS, CEO, and WDACs and other community initiatives that increase access and awareness, including but not limited to School Based Community Access Platforms, Veterans Peers Access Platforms, Transforming LA (Incubation Academy), and Regional Prevention Fund.
Collaborate with UCLA on development and launch of an interactive, trauma-focused training platform through the Center of Excellence.
Assessed CalMHSA Mini-Grants
We Rise Campaign
SLIDE 16

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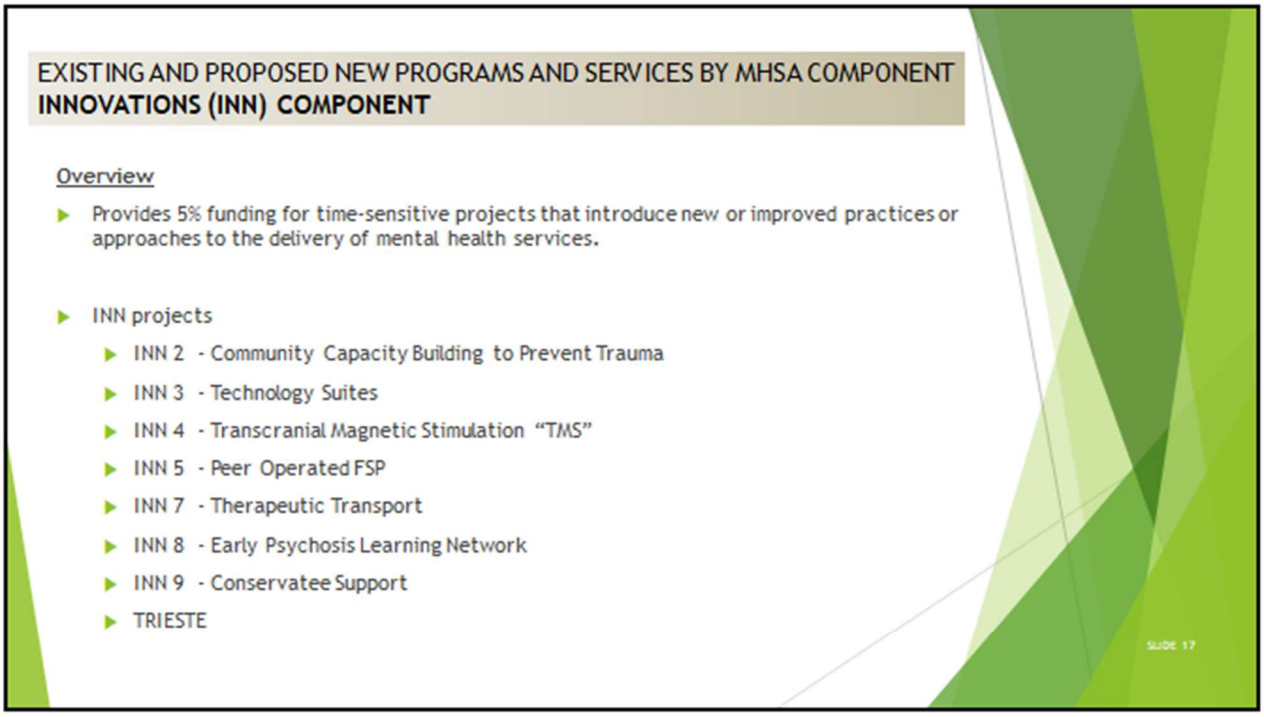
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
INNOVATIONS (INN) COMPONENT
Overview
Provides 5% funding for time-sensitive projects that introduce new or improved practices or approaches to the delivery of mental health services.
INN projects
INN 2 - Community Capacity Building to Prevent Trauma
INN 3 - Technology Suites
INN 4 - Transcranial Magnetic Stimulation "TMS"
INN 5 - Peer Operated FSP
INN 7 - Therapeutic Transport
INN 8 - Early Psychosis Learning Network
INN 9 - Conservatee Support
TRIESTE
SLIDE 17

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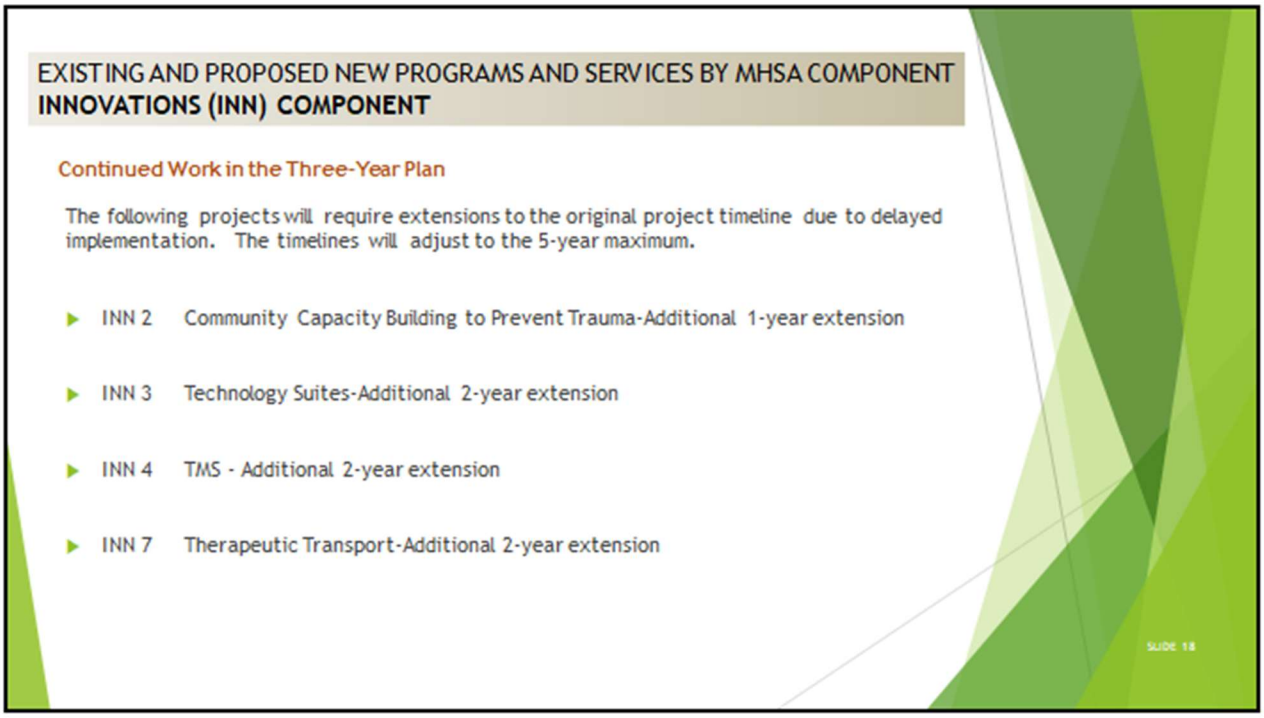
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
INNOVATIONS (INN) COMPONENT
Continued Work in the Three-Year Plan
The following projects will require extensions to the original project timeline due to delayed implementation. The timelines will adjust to the 5-year maximum.
INN 2 Community Capacity Building to Prevent Trauma-Additional 1-year extension
INN 3 Technology Suites-Additional 2-year extension
INN 4 TMS - Additional 2-year extension
INN 7 Therapeutic Transport-Additional 2-year extension
SLIDE 18

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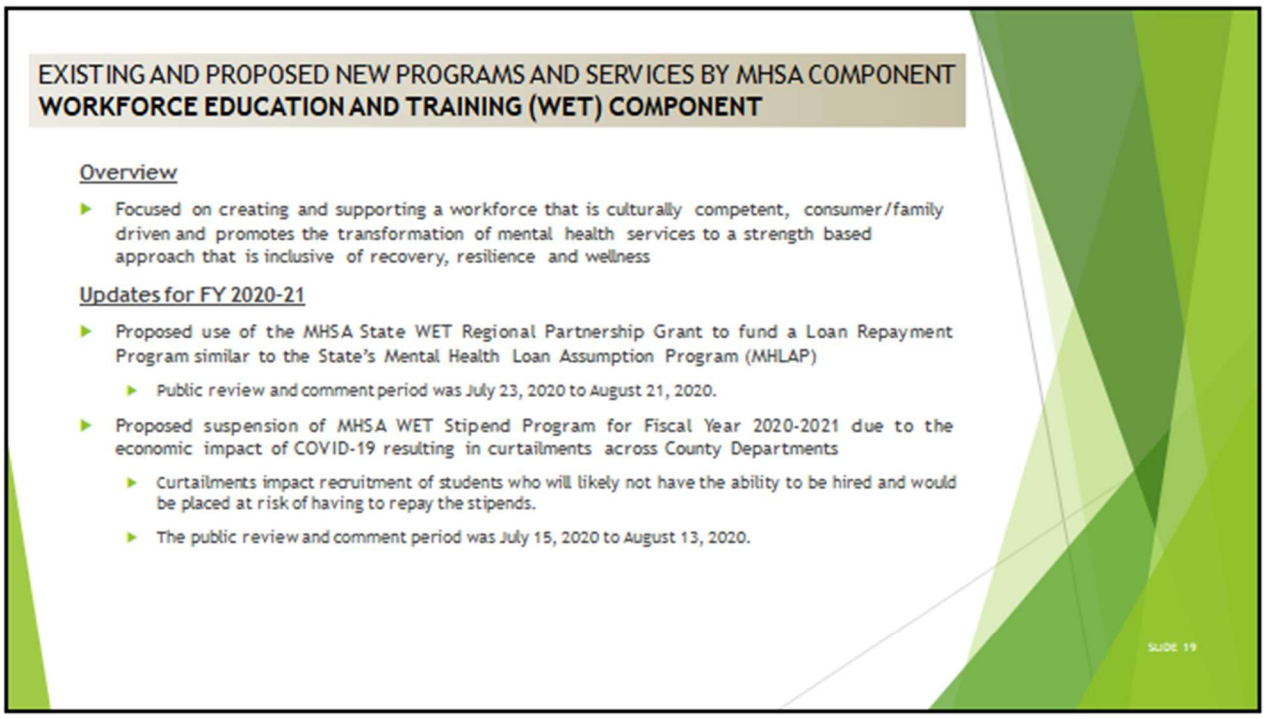
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
WORKFORCE EDUCATION AND TRAINING (WET) COMPONENT
Overview
Focused on creating and supporting a workforce that is culturally competent, consumer/family driven and promotes the transformation of mental health services to a strength based approach that is inclusive of recovery, resilience and wellness
Updates for FY 2020-21
Proposed use of the MHSA State WET Regional Partnership Grant to fund a Loan Repayment Program similar to the State's Mental Health Loan Assumption Program (MHLAP)
Public review and comment period was July 23, 2020 to August 21, 2020.
Proposed suspension of MHSA WET Stipend Program for Fiscal Year 2020-2021 due to the economic impact of COVID-19 resulting in curtailments across County Departments
Curtailments impact recruitment of students who will likely not have the ability to be hired and would be placed at risk of having to repay the stipends.
The public review and comment period was July 15, 2020 to August 13, 2020.
SLIDE 19

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EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
WORKFORCE EDUCATION AND TRAINING (WET) COMPONENT
Continued Work in the Three-Year Plan
Training and Technical Assistance: Public Mental Health Partnership
Navigator Skill Development Program
Learning Net System/EventsHub
Charles R. Drew Affiliation Agreement - Pathways to Health Academy Program
Charles R. Drew Affiliation Agreement - Psychiatric Residency Program
Intensive Mental Health Recovery Specialist Training Program
Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System
Financial Incentive Programs
Interpreter Training Program
DMH+UCLA Public Partnership for Wellbeing
DMH/Harbor-UCLA Post Doctoral Fellowship
Peer Focused Training
Licensure Preparation Program (MSW, MFT, PSY)
WET Regional Partnership
Continuum of Care Reform (CCR)
SLIDE 20

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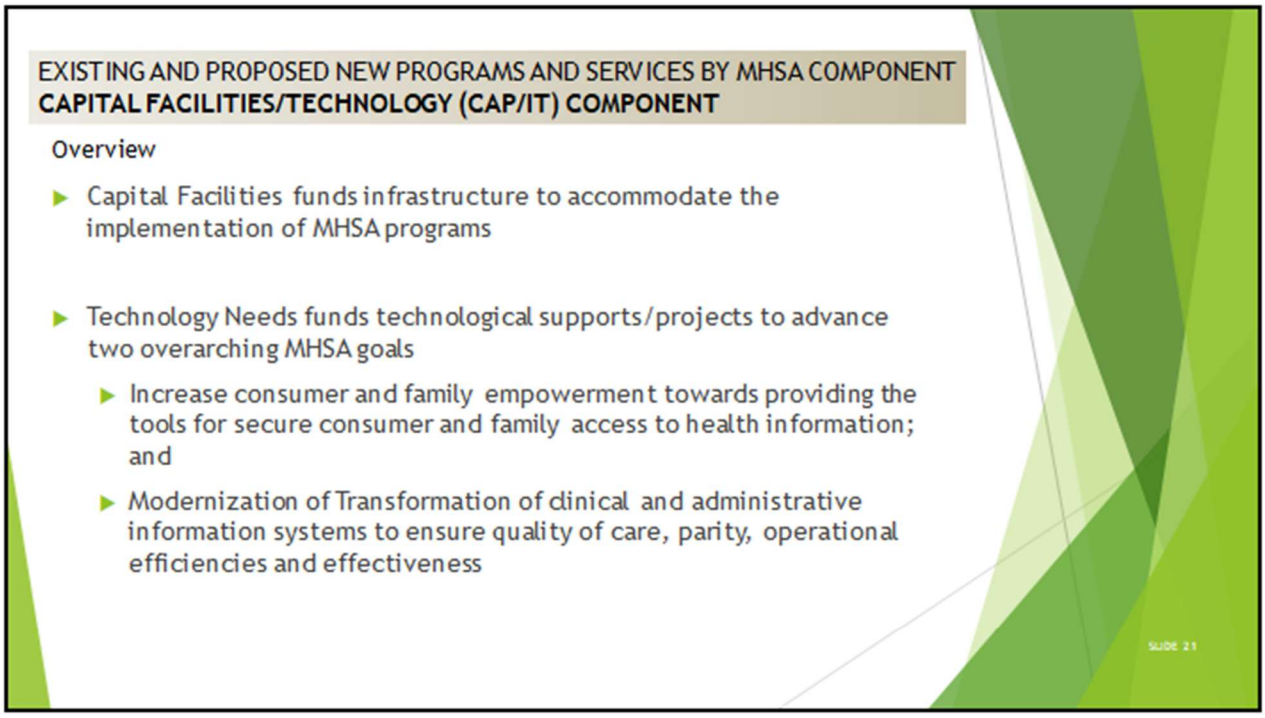
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
CAPITAL FACILITIES/TECHNOLOGY (CAP/IT) COMPONENT
Overview
Capital Facilities funds infrastructure to accommodate the implementation of MHSA programs
Technology Needs funds technological supports/projects to advance two overarching MHSA goals
Increase consumer and family empowerment towards providing the tools for secure consumer and family access to health information; and
Modernization of Transformation of clinical and administrative information systems to ensure quality of care, parity, operational efficiencies and effectiveness
SLIDE 21

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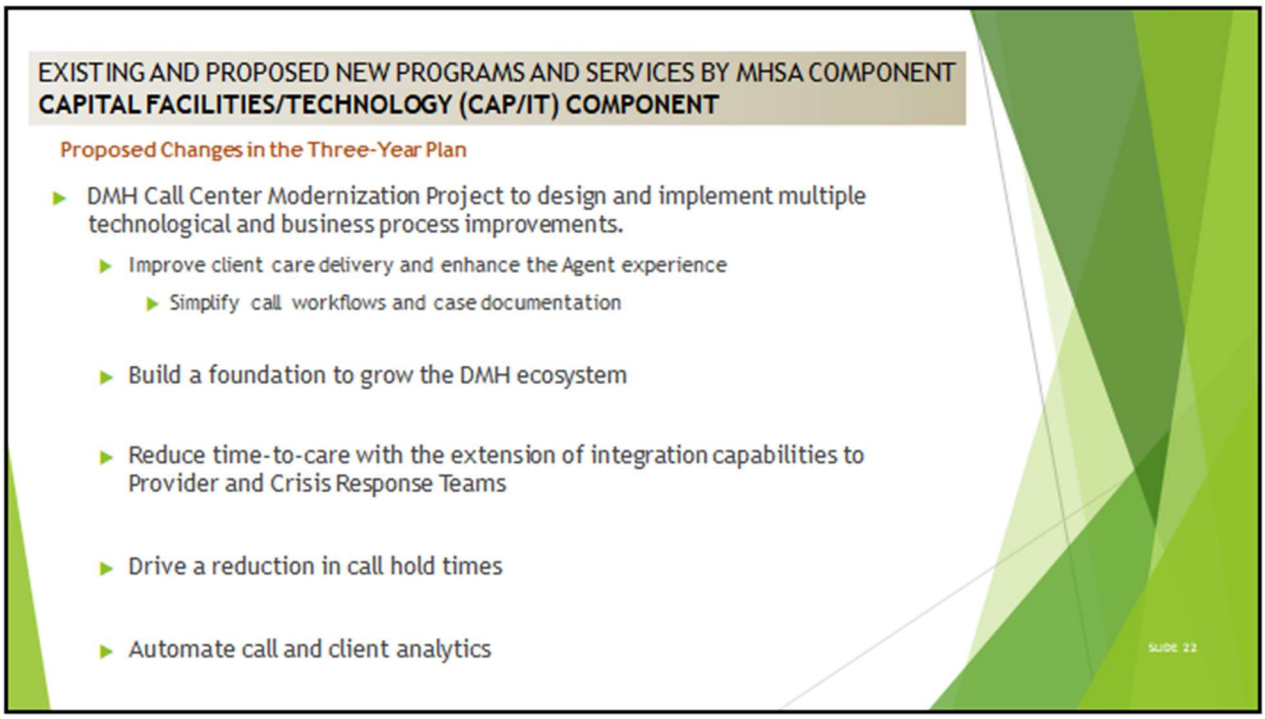
EXISTING AND PROPOSED NEW PROGRAMS AND SERVICES BY MHSA COMPONENT
CAPITAL FACILITIES/TECHNOLOGY (CAP/IT) COMPONENT
Proposed Changes in the Three-Year Plan
DMH Call Center Modernization Project to design and implement multiple technological and business process improvements.
Improve client care delivery and enhance the Agent experience
Simplify call workflows and case documentation
Build a foundation to grow the DMH ecosystem
Reduce time-to-care with the extension of integration capabilities to Provider and Crisis Response Teams
Drive a reduction in call hold times
Automate call and client analytics
SLIDE 22

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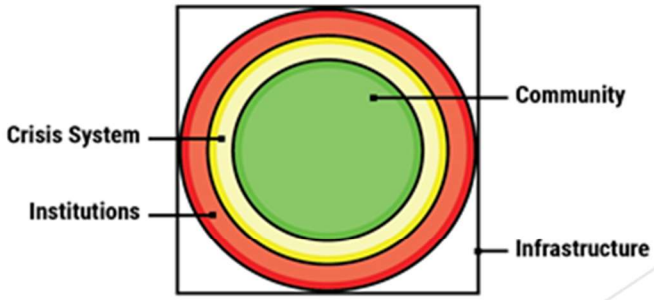
MHSA Three-Year Program and Expenditure Plan FYs 2021-22 to 2023-24 and the DMH Strategic Plan

- DMH will align programs and services in the 3-Year plan with the Department's Strategic Plan which is focused on 4 major Domains: Community, Crisis System, Institutions and Infrastructure
- The Plan will identify how programs and services fit within each domain and the expected outcomes to achieve the goals of the Strategic Plan

DOMAINS FOR OUR STRATEGY



SLIDE 23

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MHSA Three-Year Program and Expenditure Plan FYs 2021-22 to 2023-24

Questions and Feedback

SLIDE 24

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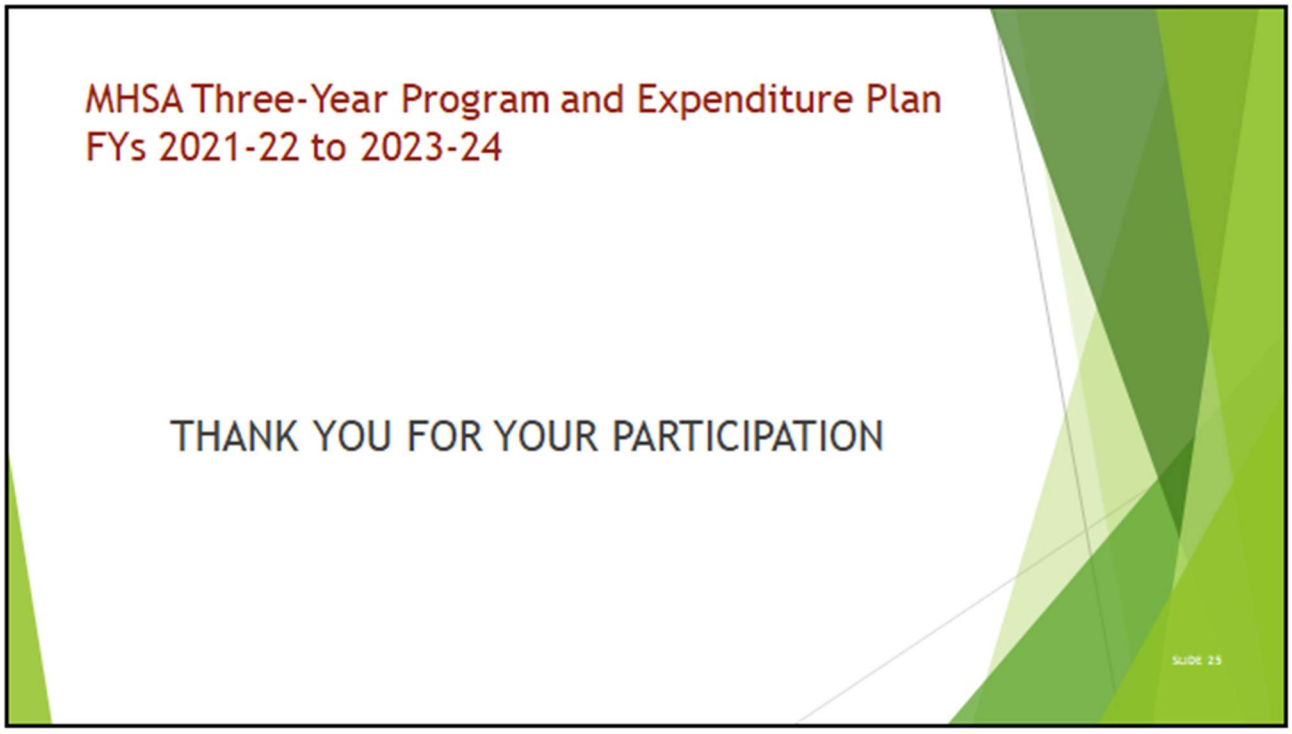
MHSA Three-Year Program and Expenditure Plan
FYs 2021-22 to 2023-24
THANK YOU FOR YOUR PARTICIPATION
SLIDE 25

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[C2] PRESENTATION TO THE MHC FULL COMMISSION - MARCH 25, 2021 AGENDA AND POWERPOINT PRESENTATION

A follow-up presentation was provided to the MHC Full Commission members that focused on stakeholder input and disparities. A budget overview of MHSA allocation and carryover funding was also presented.

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

First District	Second District	Third District	Fourth District	Fifth District
Hilda L. Solis	**Holly J Mitchell**	**Sheila Kuehl**	**Janice Hahn**	**Kathryn Barger**
Imelda Padilla-Frausto	Harold Turner	Stacy Dalgleish	Patrick Ogawa	Brittney Weissman, MPP
Susan Friedman	Reba Stevens	Rev. Kathy Cooper Ledesma	Kevin Acebo	Judy Cooperberg, MS, CPRP
Luis Orozco	Vacant	Teresa Banko	Michael Molina	Vacant

MENTAL HEALTH COMMISSION
FULL COMMISSION MEETING
THURSDAY, MARCH 25, 2021
11:00AM

MS Teams (Online Virtual)*	AT&T Line for Public Comments	Únase por teléfono	Closed Captioning
Click here to join the meeting Or call in (audio only) +1 323-776-6996 ID: 279 556 014#	877-336-4436 Access Code: 6946369	Español: (888) 204-5987 ID de conferencia: 9639884#	Click for CART

Agenda Posted: March 22, 2021

Telephonic Public Comment: You may address the Commission during the live meeting by calling the phone line provided above. A live AT&T moderator will be on the call to place you into a que to give public comment. Only one (1) public comment per telephonic caller. Comments will be limited in time as arranged by the Chair at the beginning at the meeting.

Written Public Comment: Written public comment may be submitted to the Commission via e-mail at MHCommission@dmh.lacounty.gov.

In-Person Public Comment: In person public comments can be submitted via a public comment form at the Los Angeles County Department of Mental Health Headquarters located at 550 South Vermont Ave. Los Angeles, CA 990020. Please enter the main lobby located on Vermont Avenue and request a 'Mental Health Commission Public Comment Form' from the front desk. Please complete and submit the comment form on-site.

Address: 550 South Vermont Ave. 12th Fl, Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov **Website**: https://dmh.lacounty.gov/about/mental-health-commission/

Los Angeles County

Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

AGENDA

Brittney Weissman, Chair, Presiding

I. Call to order

a. Roll Call – *Canetana Hurd, Commission Staff*

b. Approve Meeting Minutes (February)

II. Non-Agenda Public Comments (1 min) – *Members of the public*: to make a live public comment, please call the **Join via Phone** line above. When the AT&T moderator asks for public comment, they will put you into the que to provide public comment.

III. Department of Mental Health Presentation

a. MHSA & Budget Presented by *Greg Polk, Chief Deputy Director, Operations*

IV. Reports from SALT & UsCC Co-Chairs – *Co-Chairs*: to provide the MHC with a verbal report, please call the **Join via Phone** line above. Your name will be called at the time of SALT & UsCC Reports.

V. Commission Business

a. **Chair Updates**

b. **Priorities/Ad Hoc Report Status** – *Executive Committee Leads*

i. Housing/Homeless

ii. Integrated Care Services/Cultural Competency

iii. Budget & Accountability

iv. Covid19/Disparities

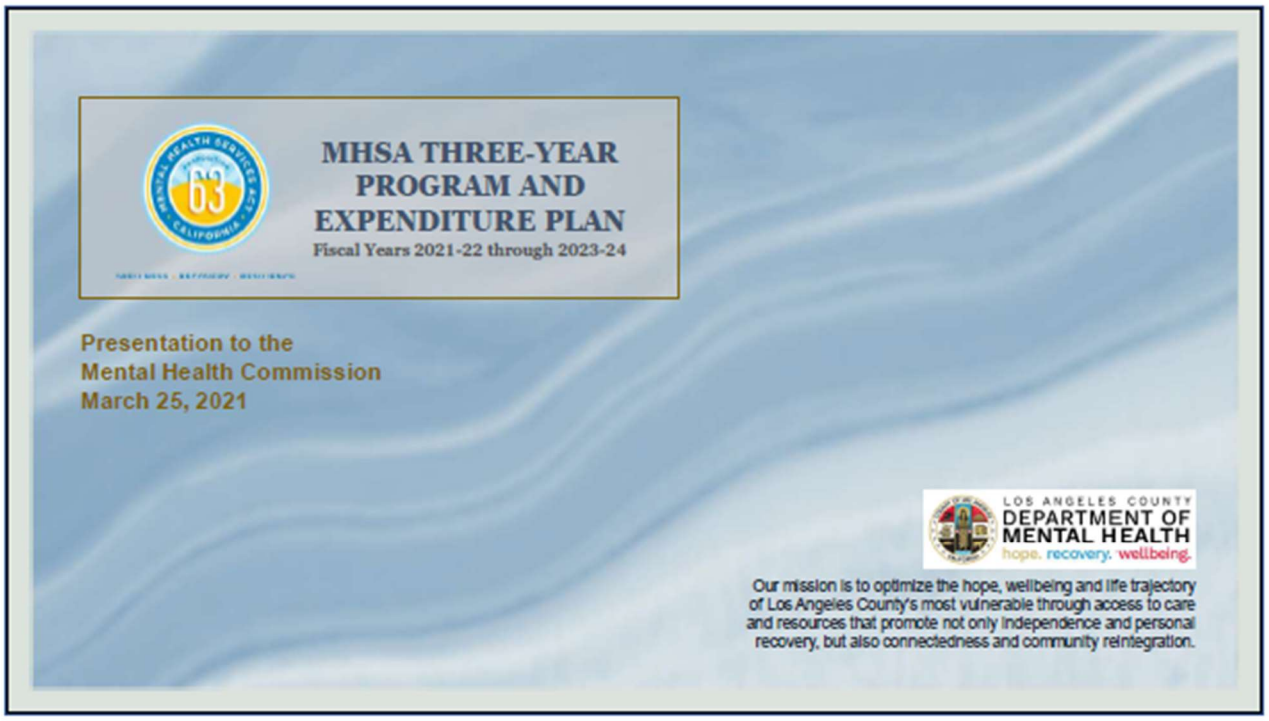
v. Criminal Justice

c. **FY 2021-2022 Election Next Steps**

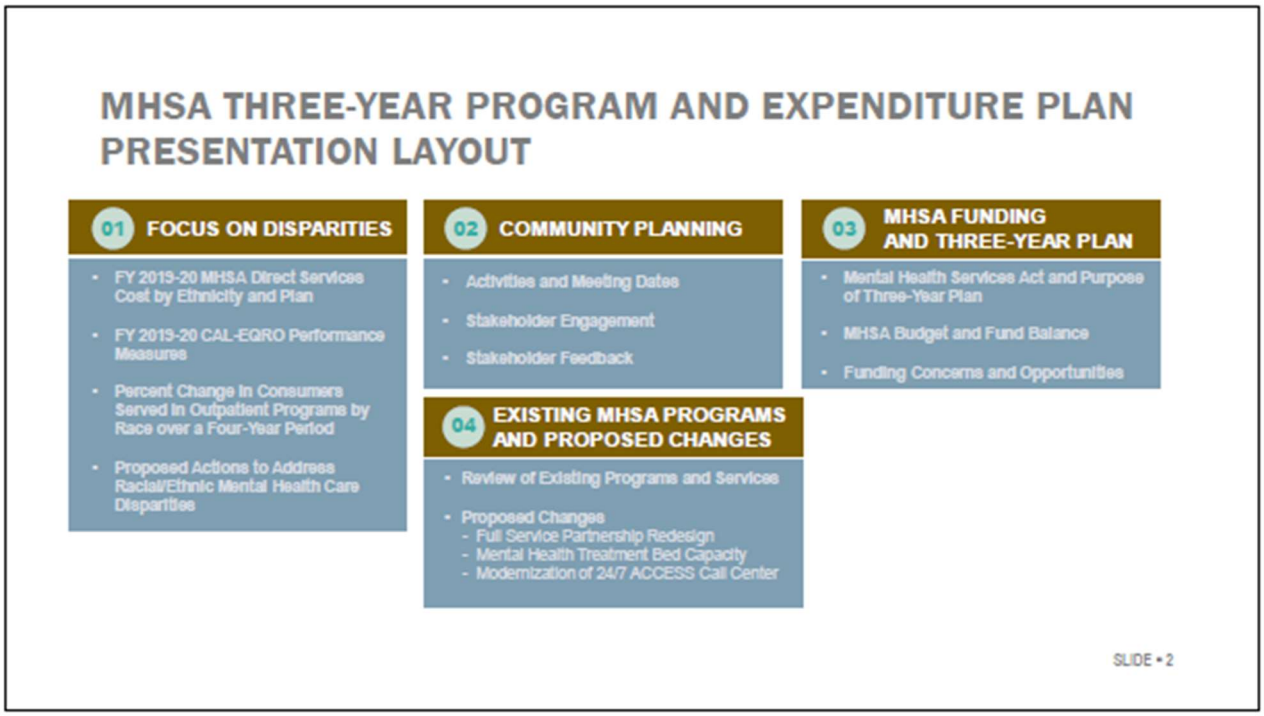
d. **Public Comments (1 min)** – *Members of the public*: to make a live public comment, please call the **Join via Phone** line above. When the AT&T moderator asks for public comment, they will put you into the que to provide public comment.

VI. Adjourn

NOTICE: Notice is hereby given that the order of consideration of matters on this agenda may be changed without prior notice. All items may be heard in a different order than listed on the agenda.


MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2021-22 through 2023-24
Presentation to the
Mental Health Commission
March 25, 2021
LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.
Our mission is to optimize the hope, wellbeing and life trajectory of Los Angeles County's most vulnerable through access to care and resources that promote not only independence and personal recovery, but also connectedness and community reintegration.

1


MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN PRESENTATION LAYOUT
01 FOCUS ON DISPARITIES
FY 2019-20 MHSA Direct Services Cost by Ethnicity and Plan
FY 2019-20 CAL-EQRO Performance Measures
Percent Change in Consumers Served in Outpatient Programs by Race over a Four-Year Period
Proposed Actions to Address Racial/Ethnic Mental Health Care Disparities
02 COMMUNITY PLANNING
Activities and Meeting Dates
Stakeholder Engagement
Stakeholder Feedback
03 MHSA FUNDING AND THREE-YEAR PLAN
Mental Health Services Act and Purpose of Three-Year Plan
MHSA Budget and Fund Balance
Funding Concerns and Opportunities
04 EXISTING MHSA PROGRAMS AND PROPOSED CHANGES
Review of Existing Programs and Services
Proposed Changes
- Full Service Partnership Redesign
- Mental Health Treatment Bed Capacity
- Modernization of 24/7 ACCESS Call Center
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FOCUS ON DISPARITIES

MHSA Direct Services Costs by Ethnicity and Plan

FY 2019-20 MHSA DIRECT SERVICES COSTS BY ETHNICITY AND PLAN

MHSA Plan (*in millions*)	Asian/ Pacific Islander	Black/ African American	Hispanic	Multiple Races	Native American	Other	White	Total
Full Service Partnership (FSP)	$8.9 [4%]	$61.8 [26%]	$78.1 [33%]	$8.2 [3%]	$2.2 [1%]	$37.4 [16%]	$43.6 [18%]	$240.2
Alternative Crisis Services (ACS)	$3.1 [3%]	$17.4 [24%]	$20.0 [28%]	$3.0 [4%]	$0.3 [<1%]	$10.5 [15%]	$17.5 [24%]	$71.8
Outpatient Care Services (OCS)	$23.6 [5%]	$76.3 [17%]	$174.2 [38%]	$19.1 [4%]	$3.5 [1%]	$92.5 [20%]	$68.7 [15%]	$457.9
Prevention and Early Intervention (PEI)	$2.8 [5%]	$5.8 [10%]	$24.2 [43%]	$3.4 [6%]	$0.4 [1%]	$14.0 [25%]	$6.1 [11%]	$56.7
Total	$38.4	$161.3	$296.5	$33.7	$6.4	$154.4	$135.9	$826.6

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3

FOCUS ON DISPARITIES

California External Quality Review Organization (CAL-EQRO) FY 2019-20 Performance Measures

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018, by Race/Ethnicity Los Angeles MHP

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	514,888	13.0%	32,635	15.5%
Latino/Hispanic	2,320,000	58.6%	108,093	51.4%
African-American	390,371	9.9%	37,455	17.8%
Asian/Pacific Islander	377,714	9.5%	9,422	4.5%
Native American	5,042	0.1%	522	0.2%
Other	356,845	9.0%	22,210	10.6%
Total	**3,960,000**	**100%**	**210,337**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

Data represents entire Los Angeles County and is not MHSA specific

Data Source: The Mental Health Services Division at DHCS contracts with Behavioral Health Concepts, Inc. (BHC) to provide EQRO services for California's MHPs. Information on Medi-Cal beneficiaries served and penetration rates represent two of the seven performance measures summarized in their annual BHC-CalEQRO Validation of Performance Measures (PM) Reports.

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FOCUS ON DISPARITIES

Percent Change in Consumers Served in Outpatient Programs by Race/Ethnicity (Four-Year Period)

Percent change by ethnicity group served in outpatient programs between FY 2016-17 and FY 2017-18:

- Latinos - ⇩ *decreased* by 8.2 percentage points (PP) from 57.2% to 49.0%
- Asian/Pacific Islanders - ⇧ *increased* by 1.8% PP from 4.0% to 5.8%
- Native Americans - ⇧ *increased* by 0.2 PP from 0.6% to 0.8%

Includes all funding sources, not only MHSA

Ethnicity	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Latino	51.8%	53.8%	57.2%	49.0%
African American	25.2%	23.7%	21.6%	25.0%
White	16.5%	17.2%	16.5%	19.5%
Asian/Pacific Islander	6.0%	4.7%	4.0%	5.8%
Native American	0.4%	0.5%	0.6%	0.8%

Figure shows the change in race/ethnicity that has occurred within consumers served in Los Angeles County mental health outpatient settings over four fiscal years.
Data Source: DMH, IS-IBHIS, September 2019

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FOCUS ON DISPARITIES

Proposed Actions to Address Racial/Ethnic Mental Health Care Disparities

MULTI-COUNTY LEARNING COLLABORATIVE

Participate in a multi-county learning collaborative with UC Davis' Center for Reducing Disparities. Los Angeles County will apply the learning related to the Culturally and Linguistically Appropriate Services (CLAS) Standards to the populations we have identified and utilize quality improvement strategies to work toward disparities reduction and culturally relevant treatment approaches.

CULTURAL AND LINGUISTICALLY COMPETENT MENTAL HEALTH SERVICES

Increase the availability of culturally and linguistically competent mental and behavioral health services accessible to racial and ethnic minorities and cultures.

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COMMUNITY PLANNING PROCESS (CPP)

CPP Activities and Meeting Dates

[Oct 21, 2020]
DMH presented a timeline of scheduled CPP efforts to CLT, made up of Co-Chairs from 2 stakeholder networks: the Service Area Leadership Teams (SALTs) and Underserved Community Groups (UsCC).

[Oct – Nov 2020]
Multiple meetings with SALTs and UsCCs to:
- present demographic and consumer needs info specific to each Service Area; and
- conduct a Needs Assessment (online survey was also available).

[Feb 11, 2021]
A Summary of the Plan was presented to the Executive Committee of the Mental Health Commission (MHC) for input and feedback.

[March 5, 2021]
A Summary of the Plan, including Stakeholder Feedback and a Focus on Disparities was presented to the CLT for input and feedback.

[Mar 19, 2021]
The full version of the draft FYs 2021-22 through 2023-24 Three-Year Plan was posted on the DMH website to allow for the 30-day public review and comment period.

[Mar 25, 2021]
Today is the follow-up presentation for the full MHC.

Upcoming Important Dates

[Apr 22, 2021]
The draft Three-Year Plan will be presented to the full Mental Health Commission at this Public Hearing date.

[May – June 2021]
Final Three-Year Plan will be presented to the Board of Supervisors for approval.

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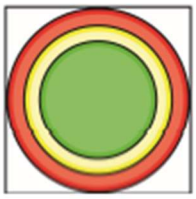
STAKEHOLDER ENGAGEMENT

SURVEY QUESTIONS

- What are your unmet needs of the Service Area (SA)?
- How has the COVID-19 pandemic further impacted unmet needs of the SA?
- How do you propose DMH address the unmet needs?
- What can DMH do to improve transitions between levels of care to ensure successful flow of clients through needed levels of care?

STAKEHOLDER FEEDBACK EIGHT MAJOR THEMES

1. Additional Mental Health Services across all ages, geographic areas, and cultural groups with a special focus on services for Children and Youth and the Asian/Pacific Island (API) community
2. A Focus on Levels of Care
3. Additional Supportive Housing and Beds
4. Data
5. Training
6. Funding for Non-Direct Services
7. COVID-19 Safety Measures
8. Social Equity



EVALUATION OF RESOURCES

Is there available funding and capacity to:

- Augment existing services; and
- Develop new services?

NEEDS ASSESSMENT → STAKEHOLDER INPUT → DMH STRATEGIC PLAN → THREE-YEAR PLAN

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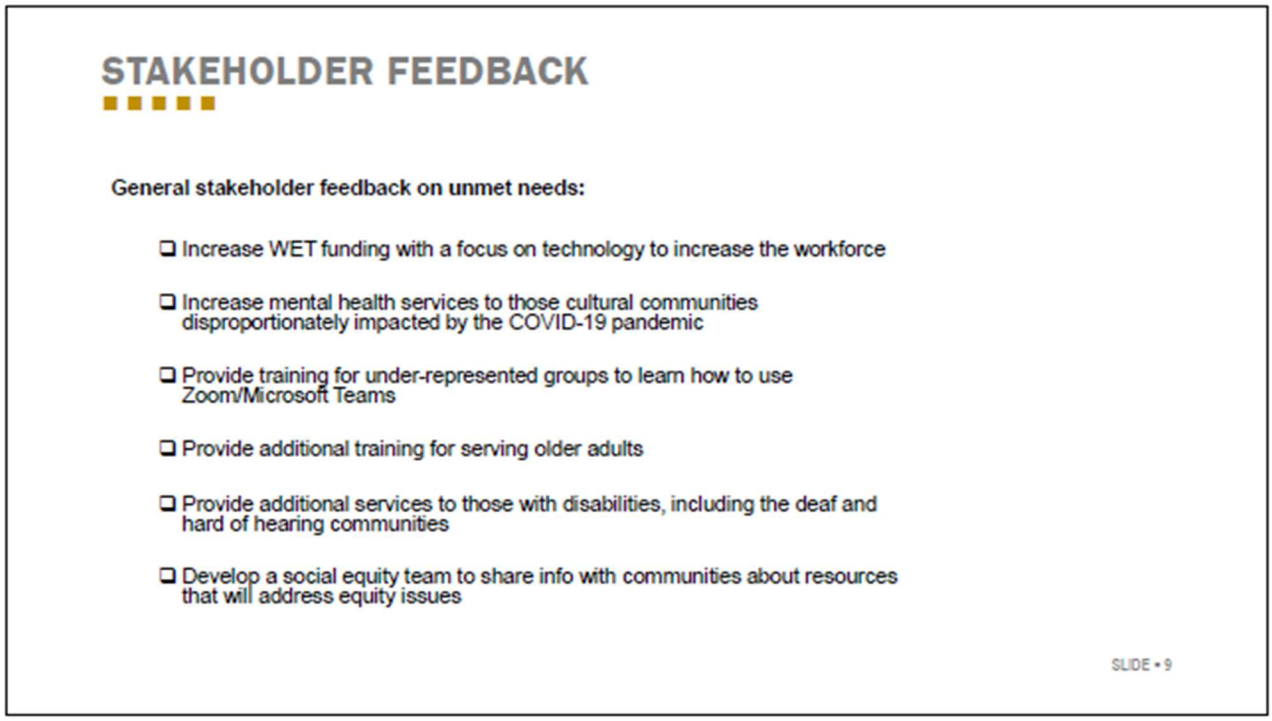
STAKEHOLDER FEEDBACK
General stakeholder feedback on unmet needs:
Increase WET funding with a focus on technology to increase the workforce
Increase mental health services to those cultural communities disproportionately impacted by the COVID-19 pandemic
Provide training for under-represented groups to learn how to use Zoom/Microsoft Teams
Provide additional training for serving older adults
Provide additional services to those with disabilities, including the deaf and hard of hearing communities
Develop a social equity team to share info with communities about resources that will address equity issues
SLIDE • 9

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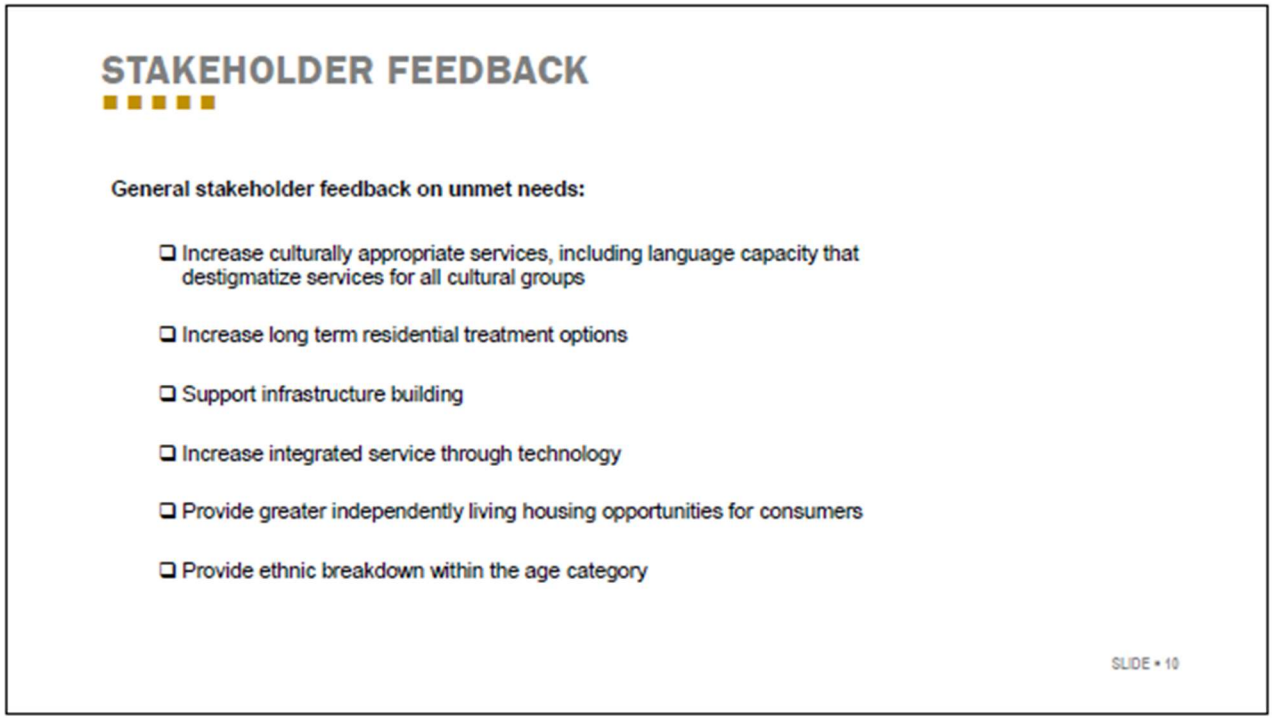
STAKEHOLDER FEEDBACK
General stakeholder feedback on unmet needs:
Increase culturally appropriate services, including language capacity that destigmatize services for all cultural groups
Increase long term residential treatment options
Support infrastructure building
Increase integrated service through technology
Provide greater independently living housing opportunities for consumers
Provide ethnic breakdown within the age category
SLIDE • 10

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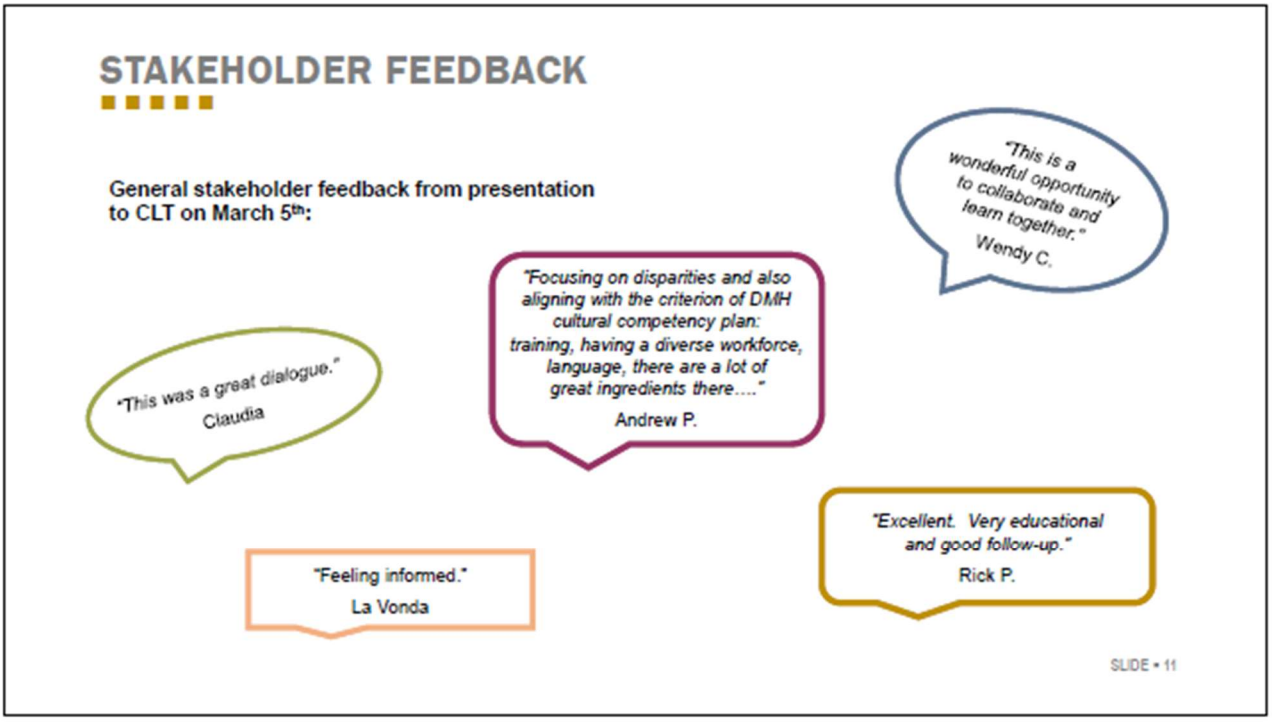
STAKEHOLDER FEEDBACK
General stakeholder feedback from presentation to CLT on March 5th:
"This is a wonderful opportunity to collaborate and learn together."
Wendy C.
"Focusing on disparities and also aligning with the criterion of DMH cultural competency plan: training, having a diverse workforce, language, there are a lot of great ingredients there...."
Andrew P.
"This was a great dialogue."
Claudia
"Excellent. Very educational and good follow-up."
Rick P.
"Feeling informed."
La Vonda
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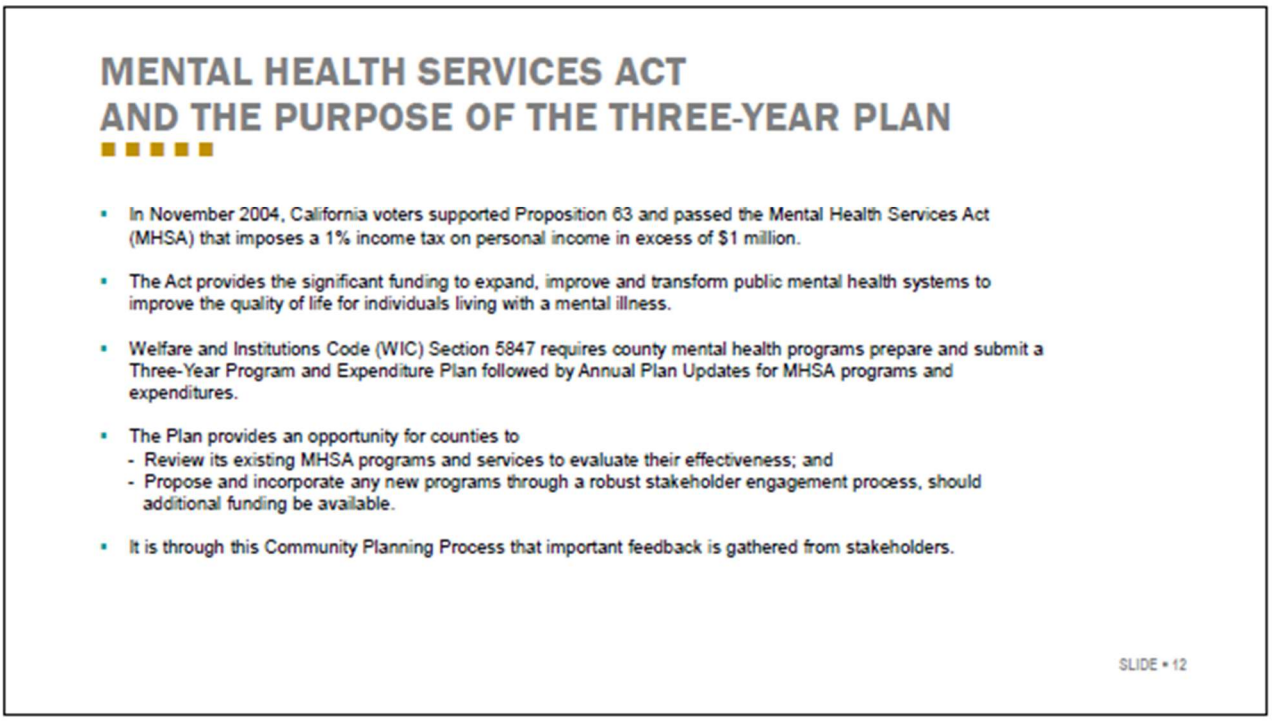
MENTAL HEALTH SERVICES ACT
AND THE PURPOSE OF THE THREE-YEAR PLAN
In November 2004, California voters supported Proposition 63 and passed the Mental Health Services Act (MHSA) that imposes a 1% income tax on personal income in excess of $1 million.
The Act provides the significant funding to expand, improve and transform public mental health systems to improve the quality of life for individuals living with a mental illness.
Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Plan Updates for MHSA programs and expenditures.
The Plan provides an opportunity for counties to
- Review its existing MHSA programs and services to evaluate their effectiveness; and
- Propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available.
It is through this Community Planning Process that important feedback is gathered from stakeholders.
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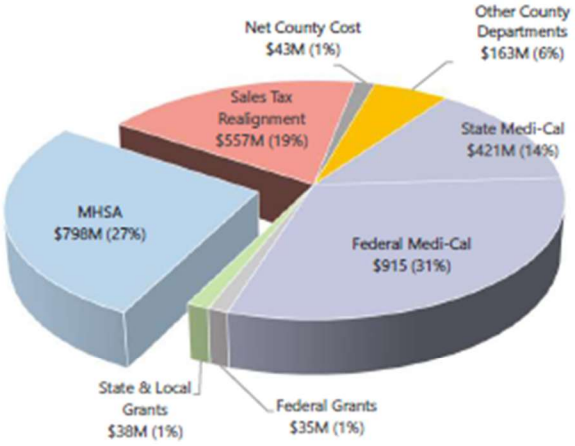
DMH FY 2021-22 Recommended Budget Request
$2.970 Billion Funding Sources

Primary Funding Sources:

- 45% State and Federal Medi-Cal ($1.3 Billion)
  Mandated mental health services for eligible clients who meet medical necessity criteria for Medi-Cal
- 27% MHSA ($798 Million)
  Outreach, engagement, prevention, outpatient services, housing, capital, technology, workforce enrichment, and projects to mental health innovations
- 19% Sales Tax Realignment ($557 Million)
  Treatment services in institutional settings, including Probation halls/camps, STRTPs and CTFs for youth and locked mental health treatment beds for adults



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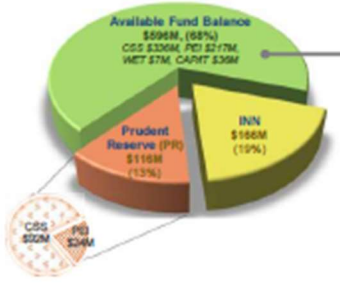
MHSA FUND BALANCE

MHSA Expenditures

(millions)	2018-19	2019-20	2020-21est
CSS	$471	$392	$457
PEI	$147	$148	$147
WET	$16	$15	$13
INN	$25	$21	$35
CAPIT	$7	$17	$32
Current Year Total	$666	$591	$684
Prior Year RER Adjust	$43	$5	$(7)
Total	$709*	$596	$677

*2018-19 includes $95M transfer to CDC

FY 2020-21
MHSA Total Fund Balance
$878.9 Million
As of July 1, 2020



FIFO methodology to cover expenditures

Current FY - New Money
Reverts June 30, 2023
*Includes one-time increase of $111M due to State reconciliation of tax payments

Next FY 2021-22 Estimated Total Fund Balance $825.0 Million

- $547M C/O FB
- + $162M INN
- + $116M PR
- = $825M
- $54M from FY 2020-21

This presentation is consistent with the 2020-21 MHSA Quarterly Forecast as of December 30, 2020

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FUNDING CONCERNS AND OPPORTUNITIES

- Anticipated reductions in MHSA, Sales Tax Realignment, County NCC funding
  - Economic Impact of COVID-19
  - Competing Countywide Initiatives, such as
    - Alternatives to Incarceration
    - Justice Reform
    - Homelessness
    - Affordable Housing
    - Healthcare Integration (Restorative Care Villages)
- Potential Funding Opportunities
  - Measure J
  - CARES Act
  - Substance Abuse and Mental Health Services Administration (SAMHSA)
- Challenges
  - Implementation Delays
  - DMH Infrastructure
  - Statutory and Contractual Limitations

Measure J Funding Proposals
Crisis Facility Care
Mental Health Treatment Beds (Acute, Subacute, Residential and Congregate Care)
Housing for Mental Health
Psychiatric Mobile Response Teams (PMRT)
Therapeutic Transportation
Mental Health Court Linkage
Co-Response Teams
Mental Health Conservatorship
Assisted Outpatient Treatment (AOT)
Outpatient & Community Services – Peer Workforce
Crisis Information Exchange
Individualized Placement and Support (IPS)

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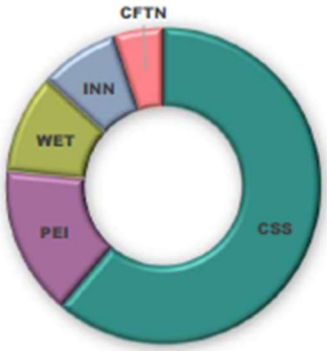
MHSA OVERVIEW BY COMPONENTS

The next few slides will provide information on the existing programs by MHSA Component



COMMUNITY SERVICES AND SUPPORTS (CSS)

PREVENTION AND EARLY INTERVENTION (PEI)

WORKFORCE EDUCATION AND TRAINING (WET)

INNOVATIONS (INN)

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

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CSS OVERVIEW

- Largest MHSA component with 76% of the total MHSA allocation
- For clients with a diagnosed serious mental illness

CSS PROGRAMS:

- Full Service Partnership (FSP)
- Outpatient Care Services (OCS)
- Alternative Services Crisis (ACS)
- Housing
- Linkage
- Planning, Outreach and Engagement (POE)

UNIQUE CLIENTS SERVED

In FY 2019-20, 147,766 unique clients received a direct service.

Ethnicity
- 35% Hispanic
- 20% African American
- 17% White
- 5% Asian/Pacific Islander
- 1% Native American

Primary Language
- 79% English
- 14% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE

50,502 new clients were served with no previous MHSA service.

Ethnicity
- 38% Hispanic
- 15% African American
- 16% White
- 3% Asian/Pacific Islander
- 0.51% Native American

Primary Language
- 78% English
- 14% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	8,786	4,800
SA2 – San Fernando Valley	21,926	10,345
SA3 – San Gabriel Valley	19,602	11,721
SA4 – Metro	31,318	16,743
SA5 – West	10,236	5,698
SA6 – South	28,413	15,796
SA7 – East	12,662	7,406
SA8 – South Bay	30,675	17,317

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CSS – FULL SERVICE PARTNERSHIP OVERVIEW

- Provides 24/7 intensive outpatient services for DMH's highest acuity clients who fall within State focal population guidelines
- Intended Outcomes
  - Reduces serious mental health systems, homelessness, incarceration and hospitalization
  - Increases independent living

FSP SLOTS AND CLIENTS SERVED BY AGE GROUP (FY 2019-20)

Age Group	Slots	Number of Clients Served
Child	3,584	3,944
Transitional Age Youth	1,410	2,950
Adult	10,986	7,715
Older Adults	885	1,897

Proposed Changes in New Three-Year Plan

FSP Transformation - Launches July 1, 2021, with existing FSP providers to pilot this new model over the next three years. Lessons learned from this pilot will inform the rebid of FSP contracts in FY 2024-25.

- Eligibility criteria more focused on those most in need of FSP care
- Multidisciplinary team/population approach rather than individual caseloads and "slots"
- Integrating all current specialty FSP into one FSP model (exception is Housing FSP will go under housing support)
- Lower client-to-staff ratios
- Additional staffing to enable Child FSP to provide Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)
- Enhanced training and technical assistance to support FSP providers in achieving outcomes
- Enhanced services and supports to ensure successful transitions from levels of care
- Centralized authorization, enrollment and disenrollment processes
- Standardized rates to bring contracted provider staff salaries closer to parity with counterparts in DMH clinics
- Changes to FSP contract to add incentives to help clients achieve critical life outcomes
- Using data, and consumer/provider feedback to drive continuous improvement

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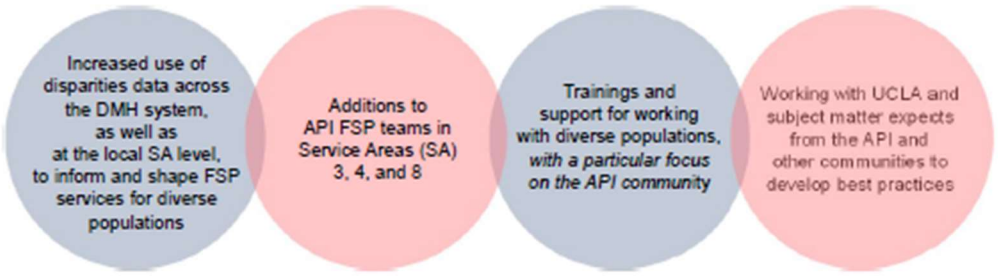
CSS – ADDRESSING FSP DISPARITIES



SLIDE • 19

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CSS – OUTPATIENT CARE SERVICES OVERVIEW

- Provides community-based, clinic-based, and well-being services, including
  - Individual, group & family therapy
  - Evidence-based treatments
  - Peer support
  - Medication
  - Case management
  - Crisis resolution/crisis intervention
  - Linkage to primary care
  - Assistance with benefits establishment, housing and other social determinants of health
  - Vocational & pre-vocational services
- Our aim is to help our clients and families to:
  - Achieve their recovery goals
  - Have a safe place to live
  - Use their time in a meaningful way
  - Have healthy relationships
  - Access public assistance when necessary
  - Weather crises successfully
  - Have the best possible physical health

CLIENTS SERVED BY AGE GROUP (FY 2019-20)

Age Group	Number of Clients Served
Child	24,549
Transitional Age Youth	17,971
Adult	57,620
Older Adults	14,934

Continued Work based on Current Three-Year Plan

Coming enhancements:

- Modernized Call Center to assist in access to services and the most appropriate level of care
- Building up and supporting capacity to ensure successful transitions from higher levels of care

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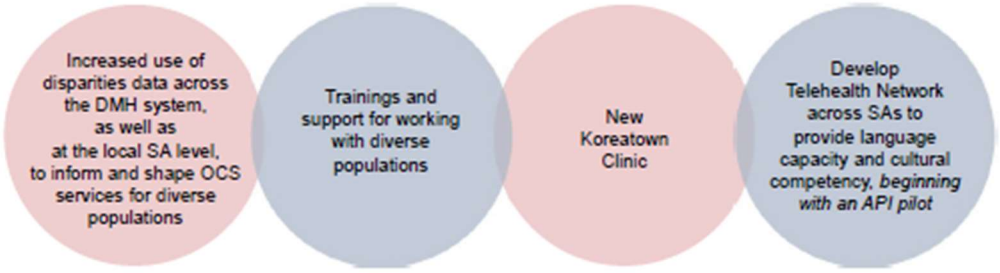
CSS – ADDRESSING OCS DISPARITIES



SLIDE • 21

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CSS – HOUSING OVERVIEW

- Provides housing resources; mental health programs for individuals with Serious Mental Illness (SMI) or Serious Emotional Disorder.
- Provides training technical assistance; and advocacy on housing, employment and education.
- Intended Outcomes
  - Assist homeless clients to obtain interim housing and permanent housing;
  - Assist clients living in permanent housing to retain housing;
  - Increase the overall number of interim and permanent supportive housing (PSH) units and rental subsidies targeting DMH clients.

HOUSING DATA (FY 2019-20)

- $390M in housing capital investments through No Place Like Home (NPLH) with additional $50M to be awarded
- 2,399 tenant-based PSH units
- $10M in ongoing rental subsidies for 413 FSP clients who are homeless with high acuity
- $2.4M in move-in costs to transition 1,082 households from homelessness to housing
- Expanded Enriched Residential Care Program to provide funding for licensed residential facility to serve a final census of 572 clients at fiscal year end
- 504 interim housing beds to provide 1,129 individuals and 153 families with short-term shelter and case management services

MULTI-YEAR HOUSING INVESTMENTS SINCE 2008

- $670M for 140 PSH developments and funding 3,608 units for individuals with SMI
- Operating subsidies for 13 of 140 housing developments
- Housing FSP services at 92 housing sites

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CSS – HOUSING OVERVIEW

Continued Work based on Current Three-Year Plan

- Continue investments in the capital development PSH through NPLH including allocating at least $100M to develop PSH at Restorative Care Village sites on health care campuses
- Redesign the Housing FSP program to enhance the service model and continue to expand supportive services to those who are living in PSH as new developments open and lease up
- Continue investing in efforts to strengthen Licensed Residential Facilities, including increasing the budget by $6M with SAMHSA* funds to subsidize more DMH clients living in Board and Care Homes; seeding a membership association; administering a capital improvements grant program; and implementing a bed tracking system
- Partner with the County Department of Health Services (DHS) and California Policy Lab to implement the new Homeless Prevention Unit, which identifies those who are most at risk of homelessness through predictive analytics and provides them with housing retention services
- Utilize $500,000 in funding from the Conrad N. Hilton Foundation to pay for the short-term housing needs of individuals released from prison that are linked to DMH services

*Substance Abuse and Mental Health Services Administration

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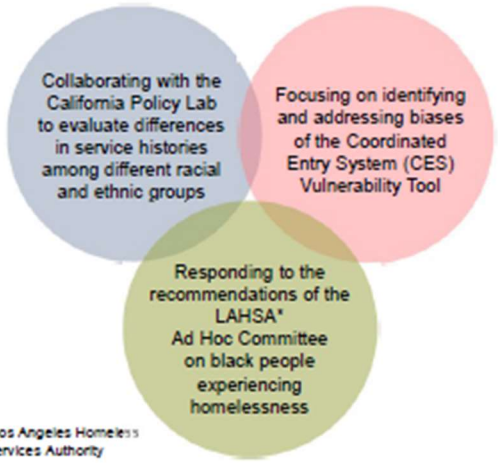
CSS – ADDRESSING HOUSING DISPARITIES

DMH is participating in systemwide work to research and address racial disparities in homeless services and housing, including



*Los Angeles Homeless Services Authority

Ethnicity groups currently housed in LACDMH PSH units as of December 31, 2020

Race/Ethnicity	Total	Percent of DMH PSH Portfolio	Percent of Greater LA Homeless Count	Percent of Overall LA County Population
American Indian	59	1.6%	1.1%	0.2%
Asian	57	1.5%	1.2%	14.4%
Black or African American	1,832	48.9%	33.7%	7.9%
Hispanic or Latino	394	10.5%	36.1%	48.5%
Native Hawaiian or Other Pacific Islander	14	0.4%	0.3%	0.2%
White	1,124	30.0%	25.5%	26.3%
Multi-Racial/Other	54	1.4%	2.1%	2.5%
Unknown	211	5.6%	0.0%	0.0%
Grand Total	3,745	100.0%	100.0%	100.0%

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CSS – ALTERNATIVE CRISIS SERVICES OVERVIEW

- Provides a comprehensive range of services and supports for mentally-ill individuals that are designed to
  - Offer alternatives to emergency room care, acute inpatient hospitalization and institutional care
  - Reduce homelessness
  - Prevent incarceration
- MHSA ACS programs include:
  - Residential and Bridging Care (RBC) Program
  - Psychiatric Urgent Care Centers (UCC)
  - Enriched Residential Services (ERS)
  - Crisis Residential Treatment Programs (CRTP)
  - Law Enforcement Teams (LET)

FY 2019-20

ERS	CRTP
988 Admissions	7 Centers and 99 Beds (280 additional beds planned)

UCC	LET
8 UCCs • Service Areas 2, 3, 4, 5, 6 and 8 • New UCCs - High Desert (SA1) & Olive View (Part of Restorative Care Village) • Approximately 126 Beds • 49,518 Client Contacts	14,472 Calls • 31% Homeless Individuals • 3% Arrests • 61% Required Hospitalization

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CSS – ACS OVERVIEW

Proposed Changes in New Three-Year Plan

- No proposed changes.
- However, continued work over the next three fiscal years to implement County initiative to expand mental health bed capacity and improve service quality, pending funding commitments:
  - Two-year bed pilot program to procure various types of beds
  - COVID-19 resulted in greater need for beds to focus on prevention, as well as open residential treatment and crisis residential beds; and decompress County hospital beds
  - Strategize to invest resources based on funding availability (potential sources: County NCC funding, Measure J, CARES Act, MHSA, SAMHSA)

FY 2020-21 Budget

Cost	Beds
$209M	Acute Psychiatric Hospitals
$194M	Subacute (includes IMD, Medical SNF, State Hospitals, and State Hospital Alternatives)
$38M	Open Residential (includes ERS, Crisis Residential Care, ERC, and Congregate Care)
$49M	Urgent Care Center Chairs

= $490M Total Budgeted in Gross Cost

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PEI OVERVIEW

- Second largest MHSA component with 19% of the total MHSA allocation
- Focus on providing preventative and early intervention strategies, education, support and outreach to those at risk of developing mental illness or experiencing early symptoms.

PEI PROGRAMS:
- Prevention
- Early Intervention
- Suicide Prevention
- Stigma and Discrimination Reduction

UNIQUE CLIENTS SERVED

In FY 2019-20, 47,602 unique clients received a direct service.

Ethnicity
- 45% Hispanic
- 9% African American
- 8% White
- 2% Asian/Pacific Islander
- 1% Native American

Primary Language
- 74% English
- 22% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA

26,381 new clients were served with no previous MHSA service

Ethnicity
- 44% Hispanic
- 8% African American
- 8% White
- 3% Asian/Pacific Islander
- 0.48% Native American

Primary Language
- 74% English
- 22% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	3,410	2,990
SA2 – San Fernando Valley	7,596	5,840
SA3 – San Gabriel Valley	8,494	6,414
SA4 – Metro	6,329	5,388
SA5 – West	1,828	1,685
SA6 – South	6,049	5,163
SA7 – East	6,720	5,892
SA8 – South Bay	7,923	6,846

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PEI OVERVIEW

- Prevention programs and services promote positive cognitive, social and emotional development that serves to reduce or prevent mental illness from occurring while providing supportive services to individuals, families and communities outside of traditional clinic settings with the goal of avoiding adverse system involvement.

- *Continued Work based on Current Three-Year Plan*
  DMH continues to provide an array of Prevention Programs and Projects to significantly reduce risk factors or stressors, build protective factors and skills, and increase supports where at-risk individuals live, work, worship and gather. Some of these efforts include:
  - School Based Community Access Platforms
  - Youth Diversion and Development
  - Transforming LA (formally known as Incubation Academy)

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PEI – ADDRESSING DISPARITIES

Prevention efforts are addressing racial disparities and helping improve the overall mental health and wellbeing of our entire County. These efforts include:

DMH-UCLA Public Partnership for Wellbeing (PPfW) collaboration to create a Priority Populations Map that identified 30 communities across LA County disproportionately impacted by COVID-19.

The Map helped DMH create a plan to distribute resources in these communities.

CAN* offers career pathways to those living in the County's underserved neighborhoods, many of whom have lost jobs due to COVID-19

CAN prioritizes support to Black, Asian, Indigenous and People of Color, many of whom live in communities that have been disproportionately impacted by systemic racism and inequality.

DMH intends to expand CAN using PEI funding moving forward.

*Community Ambassador Network

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INN OVERVIEW

Provides 5% funding for time-sensitive projects that introduce new or improved practices or approaches to the delivery of mental health services.

INN PROJECTS
INN 2 - Community Capacity Building to Prevent Trauma
INN 3 - Technology Suites
INN 4 - Transcranial Magnetic Stimulation "TMS"
INN 5 - Peer Operated FSP
INN 7 - Therapeutic Transport
INN 8 - Early Psychosis Learning Network
INN 9 - Conservatee Support
TRIESTE (→ Hollywood Pilot)

- Priority Projects
  - INN 7 Therapeutic Transport
  - INN 8 Early Psychosis Learning Network
  - TRIESTE (→ Hollywood Pilot)
    Partnership with the First Presbyterian Church of Hollywood to develop and implement a two-phase project that will transition individuals outreached by the HOME Team and living in the Hollywood area who are experiencing homelessness and have a SMI to innovative no barriers housing model
- DMH is reevaluating remaining INN projects to determine whether they align with Strategic Plan.

Proposed Changes in New Three-Year Plan

INN TIMELINE EXTENSIONS - The following projects will require extensions to the original project timeline due to delayed implementation. The timelines will adjust to the 5-year maximum.
INN 2 - Community Capacity Building to Prevent Trauma
INN 3 - Technology Suites
INN 4 - Transcranial Magnetic Stimulation "TMS"
INN 5 - Peer Operated FSP
INN 7 - Therapeutic Transport

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WET OVERVIEW

Focused on creating and supporting a workforce that is culturally competent, consumer/family driven and promotes the transformation of mental health services to a strength-based approach that is inclusive of recovery, resilience and wellness

WET PROGRAMS
Navigator Skill Development Program
Charles Drew Affiliation Agreements - Pathways to Health Academy Program - Psychiatric Residency Program
Intensive Mental Health Recovery Specialist Training Program
Interpreter Training Program
DMH+UCLA Public Partnership for Wellbeing
Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System
WET Regional Partnership
Licensure Preparation Programs (MSW, MFT, PSY)

Continued Work based on Current Three-Year Plan

The following Midyear Adjustments were posted during FY 2020-21 and therefore, implementation was completed.

- Use of the MHSA State WET Regional Partnership Grant to fund a Loan Repayment Program similar to the State's Mental Health Loan Assumption Program (MHLAP)
- Suspension of MHSA WET Stipend Program for FY2020-21 due to the economic impact of COVID-19 resulting in curtailments across County departments. Curtailments impact recruitment of students who will likely not have the ability to be hired and would be placed at risk of having to repay the stipends.

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CFTN – CAPITAL FACILITIES OVERVIEW

- Transfers from CSS to Capital Facilities to fund capital improvements
- *Continued Work based on Current Three-Year Plan*
  Midyear Adjustments were posted during FY 2018-19, such as the Restorative Care Villages

  - Part of the County's strategic plan to enhance delivery of comprehensive interventions by integrating direct care services for individuals who require physical health, mental health, substance abuse treatment, and housing-related services and supports

  - Envisioned to be the country's first mental health and well-being campuses that will provide a full continuum of programming and services

  - Located on these County hospital campuses: High Desert; LAC+USC; MLK; Olive View+UCLA; and Rancho Los Amigos

LAC+USC RESTORATIVE CARE VILLAGE RENDERINGS

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CFTN – CAPITAL FACILITIES OVERVIEW

MRT BEHAVIORAL HEALTH CENTER

OLIVE VIEW RESTORATIVE CARE VILLAGE RENDERINGS

RANCHO LOS AMIGOS RESTORATIVE CARE VILLAGE RENDERINGS

HIGH DESERT RESTORATIVE CARE VILLAGE RENDERINGS

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CFTN – TECHNOLOGICAL NEEDS OVERVIEW

- Transfers from CSS to Technological Needs to fund technology needs/projects to advance overarching MHSA goals
  - Increase consumer and family empowerment towards providing the tools for secure consumer and family access to health information; and
  - Modernize clinical and administrative information systems to ensure quality of care, parity, operational efficiencies and effectiveness.

- Currently, there is no MHSA-funded IT projects. However, DMH continues to forge ahead to build for tomorrow, today. Examples of current innovations include, but not limited to:
  - Virtual Mental Healthy Delivery System: Modernize its Virtual Mental Health technology and expand its network to connect with clients in jails, probation camps, shelters and other programs using various platforms as appropriate (e.g. VSEE)
  - MHRLN: Extend/enhance features to track mental health resources (beds, etc.) tracking and provide case management functionality to DMH staff by making it accessible to Contract Providers.
  - Mobile/smartphone solutions for DMH clients and practitioners: Initial delivery will be to implement and extend the mindLAMP smartphone solution that allows clients to participate in treatment by completing daily diary cards to share with their practitioners during sessions, thus enhancing the quality and usefulness of clinical encounters.
  - iPaaS-DPH/DMH Interoperability Collaboration:
    - Project stands up the Azure platform and develops Fast Healthcare Interoperability Resources (FHIR) compliant messages/services such as client services and EDI claims that are currently exchanged with our contracted providers (via BizTalk).
    - Project provides a common platform for DMH and Department of Public Health to exchange data with mutual contract providers.

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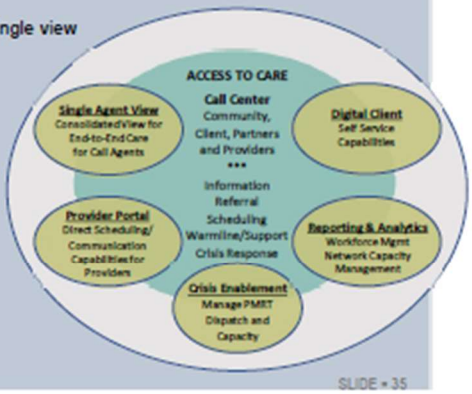
CFTN – TECHNOLOGICAL NEEDS OVERVIEW

Proposed Changes in New Three-Year Plan

Modernization of 24/7 ACCESS Call Center – A funding shift will be necessary to engage with a consultant to modernize the existing antiquated Call Center into the hub in accessing services with the DMH system of care.

The Call Center will provide end-to-end assistance in an efficient and client-focused manner utilizing an agent and client centered design. Project goals are as follows:

- Reduce the number of software applications used by agents by developing a single view with end-to-end care visibility in order to best meet the needs of the caller
- Allow for integration with other systems (e.g., law enforcement) for receiving, assessing, triaging and mounting non-law enforcement responses to crises across our communities
- Provide integration technology between the Call Center and service providers (including crisis response) in order to reduce time-to-care, maximize service capacity and improve coordination of services
- Develop self-service capabilities and alternative access-points designed by feedback from the community
- Automate call and client analytics to ensure the Call Center is meeting the needs of the community and responding in a timely manner



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THANK YOU

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APPENDIX D - PUBLIC REVIEW OF DRAFT THREE-YEAR PLAN AND COMMENT PERIOD: MARCH 19 THROUGH APRIL 18, 2021
PUBLIC COMMENTS AND SURVEY RESPONSES RECEIVED

What do you see as strengths to the FY 2021-22 through 2023-24 Three Year Plan?

- Tele health is a strength
- Changes to FSP plan, Mental Health Treatment Beds and increased Housing Capacity.
- Innovation campaign, WET, PEI, and Tech
- Great help, also need of information updated .
- The Peer Support plan which is vital to recovery and the WET Components.
- It has at its disposal a significant stakeholder population that is able and willing to engage LACDMH MHSA CPP to improve the lives of people in Los Angeles County.
- The National Service Office of Nurse-Family Partnership and Child First appreciates LA DMH's highlighting as an outcome of MHSA Prevention and Early Intervention funding during FY19-20 a reduction in anxiety and depressive symptoms among expectant and new mothers served by the Nurse-Family Partnership (NFP) evidence-based maternal infant and early childhood home visiting program delivered by the L.A. Department of Public Health through an investment from L.A. DMH. NFP is a national, evidence-based, maternal-infant home visiting program delivered by specially trained nurses to high-risk expectant mothers and their infants. Nurses are paired with expectant mothers as early in their pregnancy as possible, and support their clients with intensive, 1:1 visits in the home or other location of the mother's choosing, on a weekly to biweekly basis, until the child's second birthday. Typically delivered to first-time expectant mothers, Los Angeles County has received a special allowance to offer NFP services to multiparous mothers who already have had a live birth – one of only 31 sites authorized in 12 states to do so as part of a formative study to learn how best to deliver NFP to multiparous mothers. In addition to highlighting the reduction in anxiety and depressive symptoms among NFP clients supported by DMH funding, DMH reports that NFP and the Healthy Families America and Parents as Teachers home visiting programs successfully leveraged DMH investment during the previous three-year period to increase integration of screenings for mental health and protective factors into the scope of activities and services delivered in the home by nurses, social workers, parent educators and other specially trained paraprofessionals to high-risk, low-income pregnant people, parents, and caretakers of children aged 0-5. Yet due to a projected discontinuation of funding from L.A. DMH in FY21-22, more than half of the 1,110 families that could receive NFP in L.A. County in a given year are projected to lose services as of July. In fact, cuts to the NFP and HFA programs administered through L.A. DPH are projected to result in a combined loss of services to 900 vulnerable families in the County.
- SEIU Local 721 acknowledges many strengths in the draft FY 2021-2024 MHSA Three-Year Plan. However, there are a few areas of initial concern that we highlight in the following weaknesses section.
- Focus on expanding field-based services for people experiencing homelessness - especially w/ MH and co-occurring substance use disorders (SUD).
- Increasing access to service for children 0-5 (removing requirement for involvement with child welfare system). New child/adolescent unit at Olive View
- "a. Graphics used to explain concepts and money flow were helpful throughout the plan. b. The past successes of components funded in previous years demonstrate DMH's commitment to the community and to transparency. "
- Happy to hear the proposed changes in the FSP program to reduce caseloads and allow the person to remain with their team with whom they have a trust relationship vs being forced to "graduate" and to begin with all new people. Even a hybrid would be better than all new people or closing the case as has happened with some teens. (transferred to school treatment person)
- Nothing
- I like the peer support plan which is vital to recovery and the (WET) Workforce Education and Training component
- Too big to read.
- Easy access to resources

- It is LITERALLY the same old dog and pony show. WHAT has been done to streamline service delivery? Hold staff accountable? Provide better comprehensive services?
- I like that a lot of the three-year plan focused on homeless health. Homelessness is identified as a big priority and there is a lot of emphasis on creating more affordable housing for them.
- Their efforts to recruit more people (students) to work for DMH. It is important to have people that know the community and look/speak like the people seeking services.
- Use of evidence-based practices and data to support them
- Find me stable housing
- More funding and more treatment at lower levels
- Let's get real. Strengths would be to address the stress from this Pandemic with stress busters, like safe virtual social encounters, exercise in Nature and the Arts outside or virtual.
- None
- Help needed, Be positive
- Hopefully a better outline to what's already in place. Make sure we get our stimulus checks
- focus on most in need, most vulnerable

What do you see as weaknesses to the FY 2021-22 through 2023-24 Three Year Plan?

- 1- There was no Outreach for Families to participate in meetings to evaluate the 3-year-plan in October. Families were not reached. Therefore these meetings had small attendance and very poor representation of stakeholders. How much % of families attended? How much % of families of the SMI? Why it is up to families to check the DMH website? SALTs are clueless. They don't even know how many families there are in their region that have a loved one with mental illness and they have no clue on reaching out to families. Even I, the only family who participated in Salt-5 meetings for 2 years, was not sent announcements when they merged to online meetings in 2020. I had to reach out to them and by then the October meeting for the 3-year plan was over. It is important to remember that families are running after housing and treatment for their loved ones, the last thing they will do is look at the DMH calendar of events! 2- The report made sure there was "cultural and racial " demographics in every section - but forget the most important demographics which is by "diagnosis" ! The lack of this focus on the report shows that who is writing it DOES NOT TALK WITH FAMILIES otherwise would know that Diagnosis is crucial, because mental illness hits every race and culture equally! What is the % of who is getting these services? How many people with mild anxiety versus how many people with SMI? You can't determine what kind of area needs more funds until you get an accurate demographics of diagnosis. 3) Long term housing needs to be THERAPEUTIC. This term is missing in the 3 Year Plan. This means that it does not work to give just 4 walls to the SMI. There must be an on-site structured program and treatment. It is not sufficient to offer a mobile team on-demand through FSP. Check the Report our Group of Mothers produced on real incidents and performance of FSP services and other services. 4) Where in the budget is OVERSIGHT and ACCOUNTABILITY? Contractors are receiving $ 210,000 p/patient and are they providing more than 4 walls? This is enough money to provide one live-in mental health trained staff (not a building maintenance person) for medication management and provide a full on-site day program with Therapists, Phys Ed and Recreation Staff. Our group of mothers have been researching programs that work, and the cost is $ 150,000 per person with live-in staff bringing excelthis lent results. So, why are contractors getting more money just to build the same square meter without in-home therapeutic staff? 5) There is need for TRANSPORTATION FOR OUTINGS FOR THE SMI who reside in IMD's. Access only transports for medical reasons. People with SMI have been 5, 10 years without being able to have a recreational outing because providers do not have a van or staff for this purpose. Providers only allow the use of their van for trips to the court, for emergency and outings for residents who reach the discharge level. A fleet of 50 vans is needed, with 3 trained staff per van to make the rounds in all contracted IMD facilities, so that each resident can have an outing at least every 15 days to parks, beaches, hiking and exercise in open air nature which is both therapeutic and helps the immune system. funds Can this request be included in INNOVATIONS? 6) There needs to be in TECHNOLOGY or INNOVATIONS funds allocated to building a WEBSITE listing with all the contracted DMH facilities for public reviews. This is the best way for families to inform DMH about how these contracted facilities are being run, what services are being promised but not really offered, the real program features and failures, the performance of psychiatrists and staff, the conditions of the buildings, including lack of space for exercise and fresh air, the criteria for admission

and discharge, the quality of meals and nutrition, etc...This is crucial for the improvement and oversight of these contracted facilities. Families don't fill up formal complaints, as it is too time-consuming and also families fear retaliation or getting their loved ones discharged. Transparency of these contracted services will improve their quality. I hope the Commissioners and Board of Supervisor reads the Failures and Solutions report from our group of Mothers, as you would understand what areas need improvement and funding! https://www.noahsschizophrenia.com/wp-content/uploads/2021/03/Official-Report-from-the-Mother-Advocates-for-the-SMI-LAC.pdf

- Not assisting me as a homeless client. I need an apartment and the workers just wanted to refer me to a shelter.
- Oversight Community have no Forensic Recreational Therapist health professionals on board. Majority of programs have 80% psycho social and psycho educational programming daily facilitated by Forensic Recreational Therapists... Full Service Partnership Programs should continue implementating onsite recovery and resiliency day programming to improve continuity of care and access to high utilizing consumers. These professionals should have clinical and admin oversight by seasoned Forensics Recreational Therapist along with evakuative1 and accountability processes to ensure best practices across the county.
- None.
- A clearer breakdown is needed of the specific programs that will see reduced funding or will be completely cut. For example, the home visiting program funding listed does not include additional information about funding going forward. We would like to see home visiting listed explicitly as a prevention and early intervention strategy in the proposal. The proposed increase in CalWORKs Home Visiting Program slots will not benefit parenting foster youth, as they are ineligible for CalWORKs benefits. Further, CalWORKs remains a public charge, excluding many families within the various immigrant communities of Los Angeles County. As highlighted in California Surgeon General Dr. Nadine Burke Harris's December 2020 report, home visiting buffers the effect of adverse childhood experiences (ACEs) and intergenerational transmission of ACEs. We urge DMH to include and expand home visiting in the FY 2021-22 through 2023-24 Three Year Plan.
- Not enough utilization of resources for the homeless, especially beds/slots left unused for FSP.
- It does not reflect, reference, or address LACDMH stakeholder recommendations, needs, and values. The data collection process that was utilized to make the informed recommendations in this plan not only do not reflect an accurate representation of the populations and barriers that LACDMH consumers/beneficiaries have reported and or attempted to report on numerous occasions at SALT meetings in the San Fernando Valley, Los Angeles County Mental Health Commission meetings, Cultural Competence Committee, and UsCC's. For example, QMRP data for the last 2 years is significantly at odds with the major behavioral equity issues for Latino, Native American, Disabled, LGBTQIA2S+, Black, and systems impacted individuals who had been significantly impacted by the COVID-19 pandemic, digital divide, lack of federally mandated disability accommodations and/or services, homeless epidemic, social unrest, police violence, and the significant increase of directed violence towards historically marginalized and oppressed communities. The plan also expands on MHSA funded services that are not only not accessible to people with disabilities, but many of these services occur in settings that are not welcoming and or safe for these marginalized communities that many leave feeling worse about themselves when trying to access the MHSA funded services, in many occasion folks never come back after their initial visit. Such experiences contribute to the stigma that prevents people, families, and communities from getting help when they seek it on their own and or when they are accompanied by a friend or family member. This plan also does not address or justify how its funding recommendations will address the behavioral health needs of the community while also addressing the trauma and stigma that people experience when trying to get help from LACDMH. The continuation of funding for innovation projects like the Tech suit and the Triste pilot has been requested by stakeholders to stop. In part because of the high need for funding of actual services that are accessible to people during the pandemic, and also because the development and implementation of such proposals did not fall in line with LACDMH promise to engage its Latino, Native American, Black, Disabled, LGBTQIA2S+, and other diverse consumer stakeholders as it initially and continually proposed. LACDMH stakeholders who have voiced concerns for these projects and proposals experience intimidation and retaliation from members of the LACDMH leadership team and other members of the LACDMH executive management team. The use of Microsoft Teams as the mandate platform for all LACDMH stakeholder process created significant barriers and limitation that further exacerbated inequities for Latino, Native American, Black,

Disabled, older adults, children, TAY, LGBTQIA2S+, API, Middle Eastern, systems impacted, immigrant, and unhoused individuals in the Los Angeles County. Such barriers were further entranced with the mental health commission which also further limited stakeholder participation by giving LACDMH consumers only 1 minute to speak in meetings that had a limited amount of stakeholder comments while focusing primarily on the chairs CBO's goals and priorities (increasing conservatorship services, and AOT) During the COVID-19 pandemic, many LACDMH stakeholders tried to comment about barriers, limitations, and challenges accessing not only MHSA funded services but all LACDMH services. Many of these stakeholders presented and or tried to become inhouse or were unhoused before the pandemic. Many had lost their jobs. Some had loved ones who had contracted COVID19, some contracted the virus themselves. We also had LACDMH consumers who tried to inform the LACDMH and the mental health commission about what they were experiencing and what they needed but have now died from COVID-19. The weakness of this plan is that it failed to listen to the people who use and need these MHSA services. This plan instead advanced priorities and initiatives that have not only furthered mental health stigma but also fails to equitably fund services in proportion to the most impacted, vulnerable, and in need communities of Los Angeles County.

- FSPs: SEIU 721's position is that FSPs should be directly operated unless the contracted entity has demonstrated expertise with the FSP population being served - justice-involved, foster youth, LGBTQ+, AB109, etc. While we understand the need to retain staff and ensure continuity of care for clients in contracted FSPs, the Department should ensure that accountability measures are in place to demonstrate that any contracted rates are directed only to salary and employee benefit expenditures for those contracted staff who are assigned to the FSPs. For example, in order to continue accessing increased rates, contracted employers must submit wage, salary, and benefit increases by position title, annual turnover rates, impact on caseload ratios, and the allocation methodology used to distribute the funding for salaries, wages, and benefits. Further, in order to demonstrate elevated outcomes, contracted entities could provide data on linkages to medical providers, as well as decreased preventable rehospitalizations or inappropriate utilization of the acute hospital emergency departments. 721 is also generally supportive of the caseload reduction proposal, but it is imperative that FSPs be balanced in terms of client acuity. We recommend considering (with stakeholders) whether a triage tool to assign FSP clients might be developed to ensure that balance. CSS - Outpatient Care Services - Modernized Call Center: 721 is generally supportive of a coordinated, county-operated system but in light of proposed state-level policy changes that correlate to the call center redesign and new initiatives (therapeutic transportation pilot program, etc.), there needs to be a centralized stakeholder engagement process to provide input (including triage protocols) and clarity. Prevention - Community Outreach: The plan mentions that the use of a previously distributed RAND questionnaire was suspended in FY 2019-20 and a corresponding Table 40 "COS Prevention services provided" outlines the data submitted from contracted providers. However, the majority of the fields in the table indicate that data was not reported. Is this a discrepancy created by the discontinuation of the RAND questionnaire or did other factors prevent or dissuade contractors from providing the data? More clarity on this issue would be appreciated. Workforce Educating & Training (WET): SEIU 721 understands the value of recruiting and retaining workers with lived experience. As peers are brought into county employment on community healthcare worker items, they also would benefit from career-path opportunities and specific workforce development initiatives.
- I am concerned about some elements of the proposed Full Service Partnership (FSP) redesign. The elimination of the transition age youth (TAY) age group may result in significantly different services available to "children" 19-20 yrs old vs. "adults" 21-22 years old. Additionally, the elimination of speciality FSP teams (Homeless FSP, IMHT, AOT and Forensic FSP) may result in a loss of the specialization and unique training/expertise of programs accustomed to serving clients experiencing homelessness. Under the new redesign, vulnerable clients - especially those experiencing homelessness or with co-occurring medical/SUD issues or justice-system involvement - may be referred to programs without the nuanced expertise serving this complex population.
- Regarding changes to FSP - with elimination of TAY program, attention will need to be paid to thoughtfully support the transition of clients from "child" at age 20 to "adult" at age 21.
- "a. The plan does not break down funding for each program funded under each category (i.e. Prevention and Early Intervention). The totals provide a good overall summary but do not address individual programs to be funded. The funding under PEI totals $162.8 M. What is the specific

breakdown for each program? b.New programs are outlined under the “Proposed Changes” section, but programs that will no longer be funded as a result of these new proposed investments are highlighted in the section. Which programs will be cut? c.The section on past FY components summarizes ways past funding was implemented. There is no indication in the report as to whether these programs will be continued to be funding and at what amount. For example, the home visiting program funding listed does not include additional information about funding going forward. d.We would like to see home visiting listed explicitly as a prevention and early intervention strategy. The proposed increase in CalWORKs Home Visiting Program slots will not benefit parenting foster youth, as they are ineligible for CalWORKs benefits. Further, CalWORKs remains a public charge, excluding many families within the various immigrant communities of Los Angeles County. e.The plan inaccurately captures the history of mental health screenings conducted by home visitors. Mental health screenings were already a part of home visitation’s scope of work, prior to any funding allocated by DMH. f.As highlighted in California Surgeon General Dr. Nadine Burke Harris’s December 2020 report, home visiting buffers the effect of adverse childhood experiences (ACEs) and intergenerational transmission of ACEs. We urge DMH leadership to consider the inclusion of home visiting in the FY 2021-22 through 2023-24 Three Year Plan"

- Inadequate funding to truly meet the needs of the SMI clients.
- Nothing
- There is not enough utilization of resources for the homeless especially the beds/slots left unused for (FSP) Full Service Partnership.
- Consumers who can't read or understand it.
- Please house mentally unstable for longer period of time at medical/mandated long-term facilities. The constant in and out of a facility is incredibly damaging to a community for safety and health reasons.
- not enough peer support to go out in pairs daily to outreach there entire supervisorial district
- The document mentions challenges in delivery care, e.g. whole person care (WPC) Intensive Service Recipient and Kin through Peer (ISR/KTP). What steps have been taken to actively resolve and overcome these challenges? Gaps of care exist because the doctors are not talking to each other. Bad integration and collaboration with DHS, DPH and FQHCs.
- Lack of focus on serious mental illness. Complete lack of focus on getting enough treatment beds
- Not enough prevention funding. Suggested further funding for Family and community partnerships unit as well as Suicide Prevention Network.
- I would like to see more emphasis on older adult mental health because they're a neglected and underserved population and addressing their mental health is important too.
- 1. First and most critical is that DMH has gone backwards in stakeholder involvement. I don't see outreach and engagement happening for the variety of groups respresented in our community mainly Peer Run Agencies. There are three in LA County yet no stakeholder involvement. This should be easy since you all continue to say that this is important to you. 2. Second is equally important is that DMH has shifted to an expansion effort of county operated clinics instead of utilizing community based agencies. It appears that you are now seeing yourselves as the provider of choice at the exclusion of non-profits. 3. There isn't anything about expanding Warm Line resources but there is a focus on 24/7 access call center. 4. There isn't anyting in the plan about adding peer respites. Right now there only two in LA county and they stay full and serve as alternative to other crisis housing. 5. Under section 3: Housing - it would be appailing to pair mental health workers in outreach just because someone is using drugs. 6. Adding treatment beds/hospitalization beds isn't a viable solution because many people use these resources because the system has failed them. I would prefer to see an increase in alternative housing/employment/outreach etc. Overall you have been stressing the importance of peer specailist but it isn't reflected in this report other than you planning to expand your services. It leads me to belive that peer run agencies weren't involved this plan at all.
- I did not read anything about what’s the plan for telehealth or remote services after Covid.
- Wasting money on expensive not very effective strategies when cheaper more effective strategies are available. For example, we now know that 12-Step programs are more effective at stopping substance abuse than professional treatment programs yet we are expanding professional treatment programs and not investing in successfully referring people to self-help support groups. (Kelly JF, Humphreys K, Ferri M. (2020) Alcoholics Anonymous and other 12-step programs for alcohol use disorder. Cochrane Database of Systematic Reviews 2020, Issue 3. Art. No.: CD012880. DOI: 10.1002/14651858.CD012880.pub2.) Shared Recovery Housing is a SAMHSA evidence-based best

practice as it costs a fraction of the cost of traditional Permanent Supportive Housing yet we only referred one person to it in FY2019-20 (see page 72 of the 3-year plan) and have no plan to expand it. We are also paying more than $210,000 per unit of PSH (page 71) when in past years DMH had agreed to a cap of $100,000 per unit. By sticking to the cap of $100,000 we could house more than twice as many people for the same investment. Evidence-based Peer Services are not fully implemented in the Plan although they greatly improve outcomes and increase the number of people who can be served with the same amount of money. All clients should have access to evidence-based Peer Services and self-help support groups, particularly in OCS (page 55) as they reduce hospitalizations by 50%, incarcerations by 67% and the amount of clinician time needed to treat people with SMI. Peer Respites should be added to Alternative Crisis Services (page 61) as they help people get thru crises at a fraction of the cost of other options. The reasons people leave FSP need to be independently evaluated as stories abound about people terminated without their permission. My two foster children were terminated from services because the clinician could not figure out how to engage with them during the Covid pandemic. There is no reason on the list which matches this (page 53). The entire plan seems to be moving towards more of a medical model than a recovery model. The return to calling services in the community "Outpatient Services" is but one example of this. This tiny box makes providing feedback very difficult as one cannot see what one has written before.

- Employees that don’t have social work degrees and just have sociology degrees. Not the same thing
- Have not got my section 8 yet
- lot of red tape need to be taken away when the family is involved to help a person who is mentally ill he don't have to tell you that he has suicidal thought to get him help family know better you should consider their opinion it's important especially when the history of patient and back ground was good with help he can back to society I wish you guy need to consider to make changes in your present profile syed razvi 6264942039
- Uncertainty of funding resources after Covid
- Please see the above comment.
- There is no specific as to how to recruit maintain and sustain consumer participation in varied capacities inclusive of decision making
- Not having it
- We need more medical for our people.And that we get our stimulus checks.
  seems like the department is all over the place

After reviewing the FY 2021-22 through 2023-24 Three Year Plan, please rate your understanding of the following:

Overall ease and clarity of the information presented (n=36)

- 14% reported Excellent
- 25% reported Very Good
- 25% reported Good
- 28% reported Fair
- 8% reported Poor

How MHSA programs are being implemented (n=36)

- 8% reported Excellent
- 19% reported Very Good
- 22% reported Good
- 33% reported Fair
- 17% reported Poor

How MHSA funding is being spent (n=35)

- 11% reported Excellent
- 17% reported Very Good
- 29% reported Good
- 11% reported Fair
- 31% reported Poor

Ideas on how to improve the presentation and content of future MHSA reports and updates?

- It is not about the presentation! What you need to improve is listening to families with loved ones with mental illness, specially the ones with severe mental illness! Listen to what they have to say about the facilities and services they use, and you will understand better where the financing needs to go, what areas need improvement. A professional needs to be hired to REACH OUT to families, to enroll families who use services into a mailing that provides them with all the dates and meetings they need to attend - and make these meetings happen at hours that the families can attend! Or record the meeting and send out the recording for people to see when they can. And have an open direct and organized channel of communication to receive the COMPLAINTS, the SUGGESTIONS, the SOLUTIONS that family have to offer. The content needs to focus on DIAGNOSIS demographics.
- Start with explaining changes from previous 3 year plan.
- Great information review, updated and written, to read and clearly be understanding.
- List all programs that will be funded under each component, a breakdown of proposed funding under each category, estimate of population/residents that will be impacted by the program/funding, and race/ethnicity of population/residents that will be impacted by program/funding. Additionally, the Department should include it's reasoning for reducing and eliminating funding for specific programs (e.g. community driven, dept. decision based on XX reasons, etc.)
- Give more time to review the plan by doing the presentations sooner. Sending the plan out 1 month earlier than this time would help. Clients need more time to read and to give feedback. Also offering more forums to stakeholders so that they can discuss feedback with other stakeholders.
- Follow MHSA standards. Have LACDMH peers lead the CPP. Utilize community participatory budgeting's. Utilize the facilitators that the LA County used for the Measure J. Its more trauma informed, culturally proficient, and stakeholder friendly that what LACDMH has been utilizing these past months. Also don't use the Cultural Competence department for this, staff actually interfere and prevented the equitable participation of Spanish monolingual stakeholders and LACDMH consumers with disabilities who requested disability accommodations
- The National Service Office of Nurse-Family Partnership and Child First is gravely concerned that despite the outcomes for the Home Visiting Program supported by DMH MHSA funding during the preceding three years, the Department has decided to discontinue funding these evidence-based programs that are delivered to high-risk, pregnant and new parents/caretakers of children aged 0-5. Given the well-documented increase in mental health needs during the pandemic, now is not the time for DMH's Prevention and Early Intervention strategy to cease support for delivery of evidence-based home visiting services to pregnant people and parents/caretakers of children aged 0-5. We respectfully urge the Department to include evidence-based home visiting services as an Early Intervention strategy for fiscal years 2021-2022 through 2023-2024 and to prioritize maternal mental health in the FY22-24 plan. Perinatal mood and anxiety disorders are the most common medical complication affecting women during pregnancy and after childbirth. They include prenatal and postpartum depression and/or anxiety, and in extreme cases, postpartum psychosis. Women who suffer from maternal depression, anxiety or other mental health issues during pregnancy are at risk of not receiving the health care they need to support a healthy pregnancy and birth and may also be more susceptible to misusing drugs and using alcohol as a method to manage their symptoms – which can be harmful to the unborn child. Moreover, women who suffer from depression, anxiety or both following the birth of the child are at higher risk of not attaching/bonding to their child, not providing the child with the physical care and interaction needed for healthy growth and development, and as with pregnancy, misusing drugs and alcohol as coping mechanism that may lead to the neglect or abuse of the child. Further, poverty increases the risk of mental health conditions and can be both a causal factor and a consequence of mental health disorders. Mental health is shaped by the wide-ranging characteristics (including inequalities) of the social, economic, and physical environments in which people live. Pregnancy is a time of increased vulnerability for the development of anxiety and depression. Yet home visiting can be a critical tool to mitigate the effects of perinatal mood and anxiety disorder. In fact, the December 2020 "Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health" released by the Office of the Surgeon General of California and the California Department of Health Care Services notes that home visiting programs can mitigate the risk of adverse childhood experiences attributable to untreated parental mental illness: "Another common risk factor for [Adverse Childhood

Experiences] is untreated parental mental illness, which can also be alleviated to a certain extent by home visiting programs. One study found that depressed mothers experienced improved symptoms by 8.8%, were 12.7% more likely to be screened for depression, and had 23.9% higher usage of evidence-based services following a positive screen" (p. 178). The L.A. DPH NFP program focuses on low-income mothers—a vulnerable population who experience poverty, economic hardship, systemic racism, substance use disorders, pregnancy complications, homelessness, intimate partner violence, and lack of socioeconomic and educational opportunity. During FY19-20, 61% of the NFP clients supported by L.A. Department of Public Health through LA DMH funding were transition-age youth (TAY) between ages 16-25 at enrollment. A majority (51%) had a median household income equal to or less than $12,000, and an additional 24% were dependent on a parent or guardian. Moreover, 22% reported having a history of mental health diagnoses at intake, with depression, anxiety, bipolar disorder, and addiction among the most frequently reported diagnoses. Because of the trusted relationship that NFP nurses establish when they enroll clients prenatally and develop through weekly to biweekly visits in the home, our nurses are uniquely positioned to screen and assess their clients' mental and behavioral health needs and connect them to appropriate resources. In fact, standard NFP nursing practice uses clinically validated mental health screening and assessment tools to identify anxiety and depression prenatally upon program enrollment, at 36 weeks' gestation, and at three intervals after delivery. When combined with screenings and assessments for social determinants of health and adverse community and childhood experiences, the results of these assessments inform NFP nurses' development, implementation and refinement of individualized care plans that includes nurse-delivered model of integrated mental health within their scope of practice and linkage to appropriate behavioral and mental health services. Although some of the families who receive home visiting services previously funded by L.A. DMH are now eligible for their home visits to be delivered through L.A. Department of Social Services' CalWORKs Home Visiting Program, that is not the case for all families. With the sunsetting of DMH funding for home visiting, upwards of 900 families are at risk of losing NFP and HFA services – in part because those families do not qualify for, or choose not to enroll in, CalWORKs. Further, in August 2020, L.A. DPH, in consultation with DMH, First 5 L.A., and the departments of Health Services and Children and Family Services, reported to the Board of Supervisors on unmet need for home visiting services in the County. In its response, the departments estimated an unmet need of more than 14,000 mothers - with the possibility of introducing new models to the County's suite of home visiting programs as an option to serve women in the mental health system. Among the new models identified for exploration is Child First. Child First is an intensive, early childhood home visiting intervention that works with the most vulnerable young children and their families to help them heal from the damaging effects of stress and trauma. The Child First model uses a team-based approach to support families, with a master's level mental health/developmental clinician and care coordinator delivering the psychotherapeutic, two-generation intervention; care coordination; and facilitation of executive functioning. The home-based intervention increases emotional health and learning success and prevents child abuse and neglect. We are concerned the failure to explicitly identify home visiting as a Prevention and Early Intervention strategy in the County's MHSA plan for FY2021-22 through 2023-24 will result in a loss of critical services that can identify early onset of behavioral and mental health needs, including substance misuse, among expectant and new parents/caretakers – and connect them to appropriate services before those needs become more acute. For these reasons, we respectfully encourage L.A. DMH to prioritize evidence-based home visiting services in its MHSA strategy over the next three years.

- "a. List all programs that will be funded under each component. b. Provide a breakdown of proposed funding under each category."
- There needs to be an ability to provide Psych Testing for high-functioning SSI claimants with SMI as some of these cases are being lost.
- I'd like clarity on what the spending actually accomplishes as well as the specific monetary amounts.
- Break it down into a very simple language. Bullet points. Those at the top spend the funding the way they want. Stop funding cbo's based on name. Consumer oversight should be used and considered!
- Have stakeholder meetings/interactive presentations.
- 1. Transparency/accountability 2. Allow families providers and users of services to provide comment 3. Decrease fractured services. No one seems to know how to get things done.. 4. Streamline service delivery 5. Streamline provider reimbursement

- Write at an easier level so that the information is understandable for everyone.
- Involve the three peer run agencies in the development and expand services though contracts with peer run agencies.
- I think you guys did a great job. No changes needed.
- Hire Peers!
- Over site over lazy employees. Cheryl Lopez Galam
- Help homeless people out more
- I do not know what can be done to make more people aware of and more compassionate about mental health issues and remove the stigma attached.
- Don't just involve psychologists.
- Ensure that all stakeholders are made aware in a timely manner inclusive of new stakeholders there must be better engagement and enforcement of efforts to build capacity for American Descendants of slavery in efforts to address equity. There must be a intentional specific well defined plan that provides metrics and benchmarks and these must be monitored and enforced to implement
- Resend sometimes don't get info
- People with disabilities should be looked out as first in line.And that we get our stimulus checks
- It's just a lot of information!

What is your affiliation? (The respondents can choose more than one category)

- 35% of the respondents are clients/consumers
- 22% of the respondents are peers
- 38% of the respondents are advocates
- 30% of the respondents are family members of a client/consumer
- 8% of the respondents are other government employees
- 5% of the respondents are LACDMH staff/employees
- 14% of the respondents are mental health service provider

What is your age? (n=35)

- 3% reported Under 20 years old
- 6% reported 20 to 29 years old
- 27% reported 30 to 39 years old
- 21% reported 40 to 49 years old
- 15% reported 50 to 59 years old
- 18% reported 60 to 69 years old
- 9% reported 70 years old or over

What ethnic groups do you identify with? (n=37)

- 5% reported African
- 8% reported Asian
- 29% reported Caucasian
- 24% reported Latin/Latina/Latinx
- 5% reported Mixed/multi-ethnic
- 8% reported Native American / American Indian / Alaskan Native
- 3% reported Hawaiian or Pacific Islander
- 18% reported Other

APPENDIX E - PUBLIC HEARING PRESENTATION AND TRANSCRIPTS

[E1] PUBLIC HEARING AGENDA

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

First District	Second District	Third District	Fourth District	Fifth District
Hilda L. Solis	**Holly J Mitchell**	**Sheila Kuehl**	**Janice Hahn**	**Kathryn Barger**
Imelda Padilla-Frausto	Harold Turner	Stacy Dalgleish	Patrick Ogawa	Brittney Weissman, MPP
Susan Friedman	Reba Stevens	Rev. Kathy Cooper Ledesma	Kevin Acebo	Judy Cooperberg, MS, CPRP
Luis Orozco	Vacant	Teresa Banko	Michael Molina	Vacant

MENTAL HEALTH COMMISSION
FULL COMMISSION MEETING
THURSDAY, APRIL 22, 2021
11:00AM

MS Teams (Online Virtual)*	AT&T Line for Public Comments	Únase por teléfono	Closed Captioning
Click to Join	877-336-4436 Access Code: 6946369	Español: (888) 204-5987 ID de conferencia: 9639884#	Click for CART

Agenda Posted: April 19, 2021

Telephonic Public Comment: You may address the Commission during the live meeting by calling the phone line provided above. A live AT&T moderator will be on the call to place you into a que to give public comment. Only one (1) public comment per telephonic caller. Comments will be limited in time as arranged by the Chair at the beginning at the meeting.

Written Public Comment: Written public comment may be submitted to the Commission via e-mail at MHCommission@dmh.lacounty.gov.

In-Person Public Comment: In person public comments can be submitted via a public comment form at the Los Angeles County Department of Mental Health Headquarters located at 550 South Vermont Ave. Los Angeles, CA 90020. Please enter the main lobby located on Vermont Avenue and request a 'Mental Health Commission Public Comment Form' from the front desk. Please complete and submit the comment form on-site.

Address: 550 South Vermont Ave. 12th Fl, Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov **Website**: https://dmh.lacounty.gov/about/mental-health-commission/

Los Angeles County

Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

AGENDA

Brittney Weissman, Chair, Presiding

I. Call to order

a. Roll Call – *Canetana Hurd, Commission Staff*

b. Approve Meeting Minutes (March)

II. Mental Health Services Act (MHSA) 3 Year Plan Public Hearing*

Greg Polk, Chief Deputy Director, Operations, Department of Mental Health

III. Public Comments (1 min) – ***Members of the public***: to make a live public comment, please call the **Join via Phone** line above. When the AT&T moderator asks for public comment, they will put you into the que to provide public comment.

IV. Commission Discussion/Next Steps

a. **Chair Updates**

b. **FY 2021-2022 Election Next Steps**

V. Adjourn

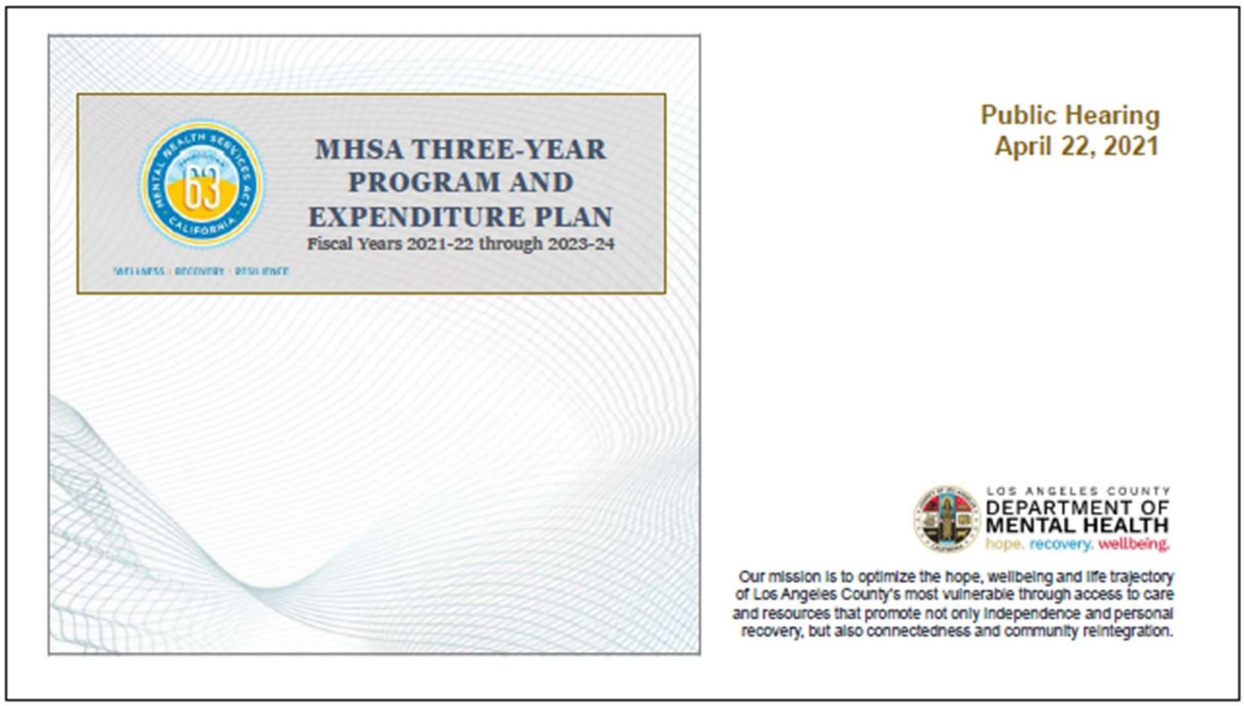
NOTICE: Notice is hereby given that the order of consideration of matters on this agenda may be changed without prior notice. All items may be heard in a different order than listed on the agenda.

* WIC 5848(b): The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations (see (f) below) for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the local mental health agency or local behavioral health agency, as applicable, for revisions.

(f) For purposes of this section "Substantive recommendations made by the local mental health board" means any recommendation that is brought before the board and approved by a majority vote of the membership present at a public hearing of the local mental health board that has established its quorum. (WIC 5848 updated 10/19)

Address: 550 South Vermont Ave. 12th Fl, Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov **Website**: https://dmh.lacounty.gov/about/mental-health-commission/

[E2] PUBLIC HEARING POWERPOINT PRESENTATION



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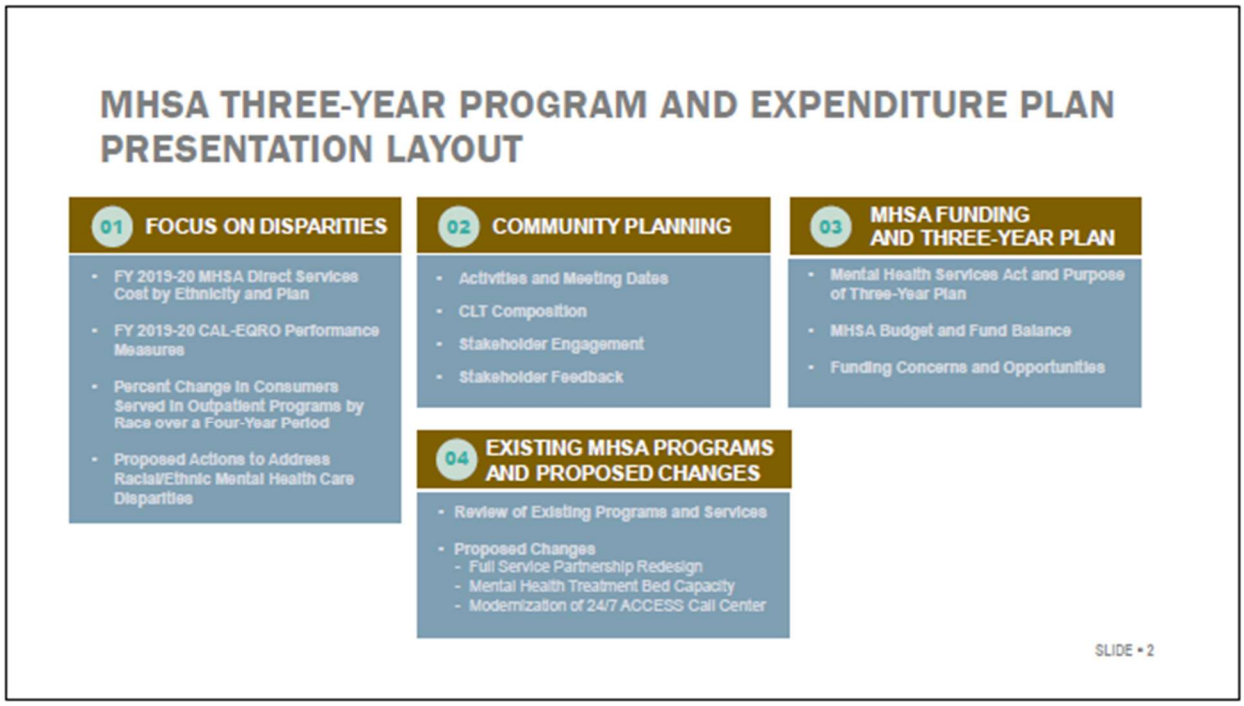

2

FOCUS ON DISPARITIES

MHSA Direct Services Costs by Ethnicity and Plan

FY 2019-20 MHSA DIRECT SERVICES COSTS BY ETHNICITY AND PLAN

MHSA Plan (*in millions*)	Asian/ Pacific Islander	Black/ African American	Hispanic	Multiple Races	Native American	Other	White	Total
Full Service Partnership (FSP)	$8.9 [4%]	$61.8 [26%]	$78.1 [33%]	$8.2 [3%]	$2.2 [1%]	$37.4 [16%]	$43.6 [18%]	$240.2
Alternative Crisis Services (ACS)	$3.1 [3%]	$17.4 [24%]	$20.0 [28%]	$3.0 [4%]	$0.3 [<1%]	$10.5 [15%]	$17.5 [24%]	$71.8
Outpatient Care Services (OCS)	$23.6 [5%]	$76.3 [17%]	$174.2 [38%]	$19.1 [4%]	$3.5 [1%]	$92.5 [20%]	$68.7 [15%]	$457.9
Prevention and Early Intervention (PEI)	$2.8 [5%]	$5.8 [10%]	$24.2 [43%]	$3.4 [6%]	$0.4 [1%]	$14.0 [25%]	$6.1 [11%]	$56.7
Total	**$38.4**	**$161.3**	**$296.5**	**$33.7**	**$6.4**	**$154.4**	**$135.9**	**$826.6**

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FOCUS ON DISPARITIES

California External Quality Review Organization (CAL-EQRO) FY 2019-20 Performance Measures

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018, by Race/Ethnicity Los Angeles MHP

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	514,888	13.0%	32,635	15.5%
Latino/Hispanic	2,320,000	58.6%	108,093	51.4%
African-American	390,371	9.9%	37,455	17.8%
Asian/Pacific Islander	377,714	9.5%	9,422	4.5%
Native American	5,042	0.1%	522	0.2%
Other	356,845	9.0%	22,210	10.6%
Total	**3,960,000**	**100%**	**210,337**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

Data represents entire Los Angeles County and is not MHSA specific

Data Source: The Mental Health Services Division at DHCS contracts with Behavioral Health Concepts, Inc. (BHC) to provide EQRO services for California's MHPs. Information on Medi-Cal beneficiaries served and penetration rates represent two of the seven performance measures summarized in their annual BHC-CalEQRO Validation of Performance Measures (PM) Reports.

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FOCUS ON DISPARITIES

Percent Change in Consumers Served in Outpatient Programs by Race/Ethnicity (Four-Year Period)

Includes all funding sources, not only MHSA

Ethnicity	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Latino	37.8%	33.9%	34.8%	37.6%
African American	20.5%	19.1%	17.9%	17.4%
White	15.7%	14.4%	14.3%	14.4%
Asian/Pacific Islander	3.9%	3.8%	4.0%	4.0%
Native American	0.5%	0.5%	0.5%	0.6%
Multi	1.2%	1.5%	1.9%	2.4%
Unreported	20.3%	26.8%	26.6%	23.6%

Figure shows the change in race/ethnicity that has occurred within consumers served in Los Angeles County mental health outpatient settings over four fiscal years.
Data Source: DMH, IS-IBHIS, September 2019

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FOCUS ON DISPARITIES

Proposed Actions to Address Racial/Ethnic Mental Health Care Disparities

MULTI-COUNTY LEARNING COLLABORATIVE

Participate in a multi-county learning collaborative with UC Davis' Center for Reducing Disparities. Los Angeles County will apply the learning related to the Culturally and Linguistically Appropriate Services (CLAS) Standards to the populations we have identified and utilize quality improvement strategies to work toward disparities reduction and culturally relevant treatment approaches.

CULTURAL AND LINGUISTICALLY COMPETENT MENTAL HEALTH SERVICES

Increase the availability of culturally and linguistically competent mental and behavioral health services accessible to racial and ethnic minorities and cultures.

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6

COMMUNITY PLANNING PROCESS (CPP)

CPP Activities and Meeting Dates

[Oct 21, 2020]
DMH presented a timeline of scheduled CPP efforts to CLT, made up of Co-Chairs from 2 stakeholder networks: the Service Area Leadership Teams (SALTs) and Underserved Community Groups (UsCC).

[Oct – Nov 2020]
Multiple meetings with SALTs and UsCCs to:
- present demographic and consumer needs info specific to each Service Area; and
- conduct a Needs Assessment (online survey was also available).

[Feb 11, 2021]
A Summary of the Plan was presented to the Executive Committee of the Mental Health Commission (MHC) for input and feedback.

[March 5, 2021]
A Summary of the Plan, including Stakeholder Feedback and a Focus on Disparities was presented to the CLT for input and feedback.

[Mar 19, 2021]
The full version of the draft FYs 2021-22 through 2023-24 Three-Year Plan was posted on the DMH website to allow for the 30-day public review and comment period.

[Mar 25, 2021]
Follow-up presentation for the full MHC.

Upcoming Important Dates

[Apr 22, 2021]
The draft Three-Year Plan is presented to the full Mental Health Commission today at the Public Hearing.

[May – June 2021]
Final Three-Year Plan will be presented to the Board of Supervisors for approval.

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COMMUNITY LEADERSHIP TEAM (CLT) COMPOSITION

Community Co-chair / Organization	Representation
Jean Harris, Jill Blanks, Pam Griffin	Representing Antelope Valley/SA1
Leticia Muniz & Marcus Halley	Representing San Fernando Valley/SA2
Andrew Preston & LaVon Robinson	Representing San Gabriel Valley/SA3
Carmen Perez, Esiquio Reyes, Pastor Nah	Representing Metro LA/SA4
Yolanda B. Jones, Martel Okonji, Penny Mehra	Representing West LA/SA5
Dorthy Bank	Representing South LA/SA6
Rick Pulido & Erika Corral	Representing East LA/SA7
Paul Stansbury & Lianette Morgan	Representing South Bay/SA8
Roque Bucton & Cody Hanable	Representing unserved/underserved communities with physical disabilities
Sylvia Gonzales Youngblood & Shannon Rivers	Representing unserved/underserved communities of the American Indian/Alaska Native population
Richer Sam & Leo Huang	Representing unserved/underserved communities of the Asian Pacific Islander population
Nakeya Fields & Wendy Cabil	Representing unserved/underserved communities of the Black & African Heritage population
Sarkis Simonian & Dr. Heather Laird	Representing unserved/underserved communities of the Eastern European/Middle Eastern population
Nicole Kristal & Greg Wilson	Representing unserved/underserved communities of LGBBTQIA2-S population
Bianca Gallegos & Hector Ramirez	Representing unserved/underserved communities of the Latinx population
Sunnie Wipple & Bernice Mascher	Representing the Cultural Competence Committee
Peer Action 4 Change/SHARE!/DPH Youth Council	**Representing Peers/Peer organizations & Youth**

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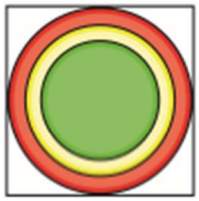
STAKEHOLDER ENGAGEMENT

SURVEY QUESTIONS

- What are your unmet needs of the Service Area (SA)?
- How has the COVID-19 pandemic further impacted unmet needs of the SA?
- How do you propose DMH address the unmet needs?
- What can DMH do to improve transitions between levels of care to ensure successful flow of clients through needed levels of care?

STAKEHOLDER FEEDBACK
EIGHT MAJOR THEMES

1. Additional Mental Health Services across all ages, geographic areas, and cultural groups with a special focus on services for Children and Youth and the Asian/Pacific Island (API) community
2. A Focus on Levels of Care
3. Additional Supportive Housing and Beds
4. Data
5. Training
6. Funding for Non-Direct Services
7. COVID-19 Safety Measures
8. Social Equity



DOMAINS
Community
Institutions
Crisis Systems
Infrastructure

EVALUATION OF RESOURCES

Is there available funding and capacity to:

- Augment existing services; and
- Develop new services?

NEEDS ASSESSMENT → STAKEHOLDER INPUT → DMH STRATEGIC PLAN → THREE-YEAR PLAN

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STAKEHOLDER FEEDBACK

General stakeholder feedback on unmet needs:

- ❑ Increase WET funding with a focus on technology to increase the workforce
- ❑ Increase mental health services to those cultural communities disproportionately impacted by the COVID-19 pandemic
- ❑ Provide training for under-represented groups to learn how to use Zoom/Microsoft Teams
- ❑ Provide additional training for serving older adults
- ❑ Provide additional services to those with disabilities, including the deaf and hard of hearing communities
- ❑ Develop a social equity team to share info with communities about resources that will address equity issues

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STAKEHOLDER FEEDBACK

General stakeholder feedback on unmet needs:

- ❑ Increase culturally appropriate services, including language capacity that destigmatize services for all cultural groups
- ❑ Increase long term residential treatment options
- ❑ Support infrastructure building
- ❑ Increase integrated service through technology
- ❑ Provide greater independently living housing opportunities for consumers
- ❑ Provide ethnic breakdown within the age category

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STAKEHOLDER FEEDBACK

General stakeholder feedback from presentation to CLT on March 5th:

"This is a wonderful opportunity to collaborate and learn together."
Wendy C.

"Focusing on disparities and also aligning with the criterion of DMH cultural competency plan: training, having a diverse workforce, language, there are a lot of great ingredients there…."
Andrew P.

"This was a great dialogue."
Claudia

"Excellent. Very educational and good follow-up."
Rick P.

"Feeling informed."
La Vonda

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MENTAL HEALTH SERVICES ACT AND THE PURPOSE OF THE THREE-YEAR PLAN

- In November 2004, California voters supported Proposition 63 and passed the Mental Health Services Act (MHSA) that imposes a 1% income tax on personal income in excess of $1 million.
- The Act provides the significant funding to expand, improve and transform public mental health systems to improve the quality of life for individuals living with a mental illness.
- Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Plan Updates for MHSA programs and expenditures.
- The Plan provides an opportunity for counties to
  - Review its existing MHSA programs and services to evaluate their effectiveness; and
  - Propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available.
- It is through this Community Planning Process that important feedback is gathered from stakeholders.

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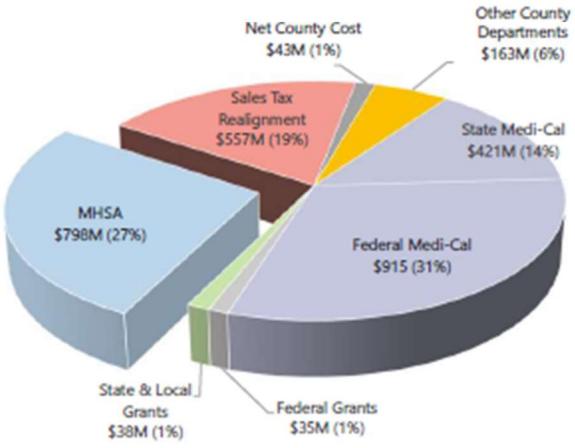
DMH FY 2021-22 Recommended Budget Request $2.970 Billion Funding Sources

Primary Funding Sources:

- **45% State and Federal Medi-Cal ($1.3 Billion)**
  Mandated mental health services for eligible clients who meet medical necessity criteria for Medi-Cal
- **27% MHSA ($798 Million)**
  Outreach, engagement, prevention, outpatient services, housing, capital, technology, workforce enrichment, and projects to mental health innovations
- **19% Sales Tax Realignment ($557 Million)**
  Treatment services in institutional settings, including Probation halls/camps, STRTPs and CTFs for youth and locked mental health treatment beds for adults



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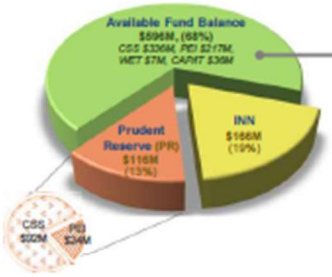
MHSA FUND BALANCE

FY 2020-21
MHSA Total Fund Balance
$878.9 Million
As of July 1, 2020



MHSA Expenditures

(millions)	2018-19	2019-20	2020-21est
CSS	$471	$392	$457
PEI	$147	$148	$147
WET	$16	$15	$13
INN	$25	$21	$35
CAPMT	$7	$17	$32
Current Year Total	$666	$591	$684
Prior Year RER Adjust	$43	$5	$(7)
Total	$709*	$596	$677

*2018-19 includes $9M transfer to CDC

FIFO methodology to cover expenditures

Current FY - New Money
Reverts June 30, 2023
*Includes one-time increase of $111M due to State reconciliation of tax payments

Next FY 2021-22
Estimated
Total Fund Balance
$825.0 Million

$547M C/O FB
+ $162M INN
+ $116M PR
= $825M
$54M from FY 2020-21

This presentation is consistent with the 2020-21 MHSA Quarterly Forecast as of December 30, 2020

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FUNDING CONCERNS AND OPPORTUNITIES

- Anticipated reductions in MHSA, Sales Tax Realignment, County NCC funding
  - Economic Impact of COVID-19
  - Competing Countywide Initiatives, such as
    - Alternatives to Incarceration
    - Justice Reform
    - Homelessness
    - Affordable Housing
    - Healthcare Integration (Restorative Care Villages)
- Potential Funding Opportunities
  - Measure J
  - CARES Act
  - Substance Abuse and Mental Health Services Administration (SAMHSA)
- Challenges
  - Implementation Delays
  - DMH Infrastructure
  - Statutory and Contractual Limitations

Measure J Funding Proposals
Crisis Facility Care
Mental Health Treatment Beds (Acute, Subacute, Residential and Congregate Care)
Housing for Mental Health
Psychiatric Mobile Response Teams (PMRT)
Therapeutic Transportation
Mental Health Court Linkage
Co-Response Teams
Mental Health Conservatorship
Assisted Outpatient Treatment (AOT)
Outpatient & Community Services – Peer Workforce
Crisis Information Exchange
Individualized Placement and Support (IPS)

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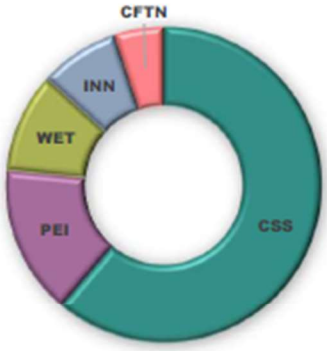
MHSA OVERVIEW BY COMPONENTS

The next few slides will provide information on the existing programs by MHSA Component



- COMMUNITY SERVICES AND SUPPORTS (CSS)
- PREVENTION AND EARLY INTERVENTION (PEI)
- WORKFORCE EDUCATION AND TRAINING (WET)
- INNOVATIONS (INN)
- CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

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CSS OVERVIEW

- Largest MHSA component with 76% of the total MHSA allocation
- For clients with a diagnosed serious mental illness

CSS PROGRAMS:

- Full Service Partnership (FSP)
- Outpatient Care Services (OCS)
- Alternative Services Crisis (ACS)
- Housing
- Linkage
- Planning, Outreach and Engagement (POE)

UNIQUE CLIENTS SERVED

In FY 2019-20, 147,766 unique clients received a direct service.

Ethnicity
- 35% Hispanic
- 20% African American
- 17% White
- 5% Asian/Pacific Islander
- 1% Native American

Primary Language
- 79% English
- 14% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE

50,502 new clients were served with no previous MHSA service.

Ethnicity
- 38% Hispanic
- 15% African American
- 16% White
- 3% Asian/Pacific Islander
- 0.51% Native American

Primary Language
- 78% English
- 14% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	8,786	4,800
SA2 – San Fernando Valley	21,926	10,345
SA3 – San Gabriel Valley	19,602	11,721
SA4 – Metro	31,318	16,743
SA5 – West	10,236	5,698
SA6 – South	28,413	15,796
SA7 – East	12,662	7,406
SA8 – South Bay	30,675	17,317

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CSS – FULL SERVICE PARTNERSHIP OVERVIEW

- Provides 24/7 intensive outpatient services for DMH's highest acuity clients who fall within State focal population guidelines
- Intended Outcomes
  - Reduces serious mental health systems, homelessness, incarceration & hospitalization
  - Increases independent living & community integration

FSP SLOTS AND CLIENTS SERVED BY AGE GROUP (FY 2019-20)

Age Group	Slots	Number of Clients Served
Child	3,584	3,944
Transitional Age Youth	1,410	2,950
Adult	10,986	7,715
Older Adults	885	1,897

Proposed Changes in New Three-Year Plan

FSP Transformation - Launches July 1, 2021, with existing FSP providers to pilot this new model over the next three years. Lessons learned from this pilot will inform the rebid of FSP contracts in FY 2024-25.

- Eligibility criteria more focused on those most in need of FSP care
- Multidisciplinary team/population approach rather than individual caseloads and "slots"
- Integrating all current specialty FSP into one FSP model (exception is Housing FSP will go under housing support)
- Lower client-to-staff ratios
- Additional staffing to enable Child FSP to provide Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)
- Enhanced training and technical assistance to support FSP providers in achieving outcomes
- Enhanced services and supports to ensure successful transitions from levels of care
- Centralized authorization, enrollment and disenrollment processes
- Standardized rates to bring contracted provider staff salaries closer to parity with counterparts in DMH clinics
- Addition of incentives to FSP contract to help clients achieve critical life outcomes
- Using data, and consumer/provider feedback to drive continuous improvement

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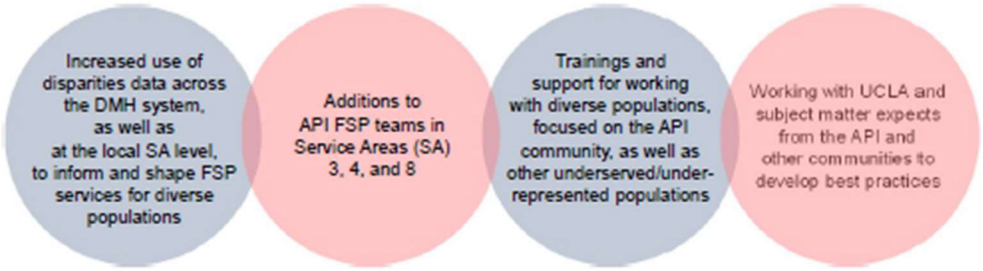
CSS – ADDRESSING FSP DISPARITIES



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CSS – OUTPATIENT CARE SERVICES OVERVIEW

- Provides community-based, clinic-based, and well-being services, including
  - Individual, group & family therapy
  - Evidence-based treatments
  - Peer support
  - Medication
  - Case management
  - Crisis resolution/crisis intervention
  - Linkage to primary care
  - Assistance with benefits establishment, housing and other social determinants of health
  - Vocational & pre-vocational services
- Our aim is to help our clients and families to:
  - Achieve their recovery goals
  - Have a safe place to live
  - Use their time in a meaningful way
  - Have healthy relationships
  - Access public assistance when necessary
  - Weather crises successfully
  - Have the best possible physical health

CLIENTS SERVED BY AGE GROUP (FY 2019-20)

Age Group	Number of Clients Served
Child	24,549
Transitional Age Youth	17,971
Adult	57,620
Older Adults	14,934

Continued Work based on Current Three-Year Plan

Coming enhancements:

- Modernized Call Center to assist in access to services and the most appropriate level of care
- Building up and supporting capacity to ensure successful transitions from higher levels of care

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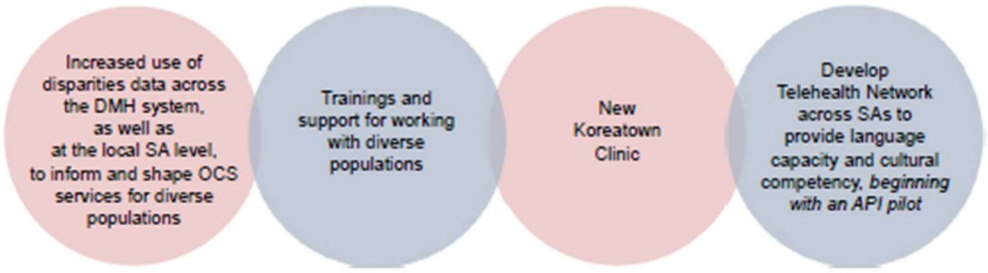
CSS – ADDRESSING OCS DISPARITIES



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API UPDATES

- LACDMH Directly Operated clinics implemented an outreach protocol since the beginning of the pandemic. Clinics provide regular check ins with a clinic's entire caseload Clients receive outreach from clinics via phone, video, or written communication based on the client's preference. For those clients who can't be reached via any of these means, the clinic keeps a list and attempts to reach out to them when they attend their MD appointments.
- LACDMH client check in are focused on mental health & health status, housing & food security, and any other needs the client may have. The entire clinic's caseload receives outreach every 1-2 months. A new protocol was added checking in specifically with AAPI clients re: whether clients have experienced any type of anti-Asian hate crime, or are feeling distressed by seeing it go on around them. This has allowed clinics to have a broader conversation around any racism, bias, or trauma that any of our clients have experienced.
- LACDMH will begin to have discussion with LEs and CMMD around implementing a similar check in for their clients.
- LACDMH has extended services at Long Beach API clinic countywide to add cultural responsiveness & language capacity.
- LACDMH is adding to the FSP capacity of both Long Beach API and Coastal API.
- LACDMH is developing a small resource guide (where and how to report anti-Asian hate crimes, advocacy orgs, bystander training, and mental health resources).

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API UPDATES

- Cultural Competency Committee hosted a panel discussion regarding Anti-Asian hate crimes. Panelists included API LACDMH staff, consumers, and contractors.
- LACDMH shared the ACCESS and LACDMH Warm Line contact information during various client meetings/interviews related to the mental health impact of anti-Asian hate crimes.
- Activities focused on API wellbeing will take place in May 2021, which is Mental Health Month and API Heritage month. Activities designed to show support for API clients and staff and for DMH to support a strong response to these API hate crimes and show LACDMH's commitment to the API communities served.

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CSS – HOUSING OVERVIEW

DMH's Housing and Job Development Division:

- Manages housing resources including interim housing, project and tenant based Permanent Supportive Housing (PSH), Enriched Residential Care Program, security deposits/household goods and mental health programs for individuals who are homeless and have Serious Mental Illness (SMI) or Serious Emotional Disorder.
- Provides training and technical assistance; and advocacy on housing, employment and education.
- Intended Outcomes
  - Assist homeless clients to obtain interim housing and permanent housing;
  - Assist clients living in permanent housing to retain housing;
  - Increase the overall number of interim and PSH units and rental subsidies targeting DMH clients.

HOUSING DATA (FY 2019-20)

- $390M in housing capital investments through No Place Like Home (NPLH) with additional $50M to be awarded soon
- 2,399 tenant-based PSH units
- $10M in ongoing rental subsidies for 413 FSP clients who are homeless with high acuity
- $2.4M in move-in costs to transition 1,082 households from homelessness to housing
- Expanded Enriched Residential Care Program to provide funding for licensed residential facility to serve a final census of 572 clients at fiscal year end
- 504 interim housing beds to provide 1,129 individuals and 153 families with short-term shelter and case management services

MULTI-YEAR HOUSING INVESTMENTS SINCE 2008

- DMH has allocated $670M which leverages other funding for the capital development of 140 PSH developments with 3,608 units for individuals who are homeless and have SMI
- DMH provides operating subsidies for 13 of the 140 housing developments
- Housing FSP services provided at 92 housing sites

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CSS – HOUSING OVERVIEW

Continued Work based on Current Three-Year Plan

- Continue investments in the capital development of PSH through NPLH including allocating at least $100M to develop PSH at Restorative Care Village sites on health care campuses
- Redesign the Housing FSP program to enhance the service model and continue to expand supportive services to those who are living in PSH as new developments open and lease up
- Continue investing in efforts to strengthen Licensed Residential Facilities including:
  - Increasing the Enriched Residential Care budget by $6M with SAMHSA* funds to subsidize more LACDMH clients living in Board and Care Homes;
  - Seeding a membership association;
  - Administering a capital improvements grant program; and
  - Implementing a bed tracking system.
- Partner with the County Department of Health Services (DHS) and California Policy Lab to implement the new Homelessness Prevention Unit, which identifies those who are most at risk of homelessness through predictive analytics and provides them with housing retention services including financial resources
- Utilize $500,000 in funding from the Conrad N. Hilton Foundation to pay for the short-term housing needs of individuals released from prison that are linked to DMH services

*Substance Abuse and Mental Health Services Administration

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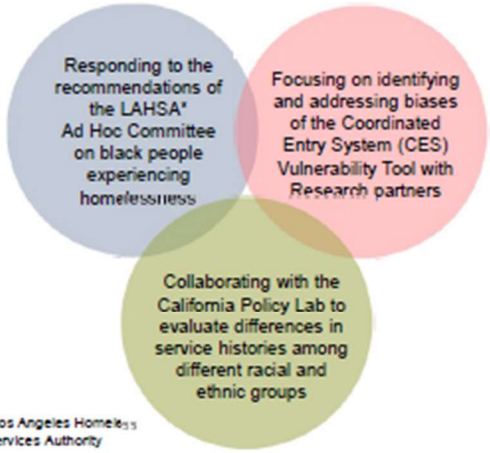
CSS – ADDRESSING HOUSING DISPARITIES

DMH is participating in systemwide work to research and address racial disparities in homeless services and housing by:



*Los Angeles Homeless Services Authority

Race/Ethnicity of residents currently living in LACDMH PSH units as of December 31, 2020

Race/Ethnicity	Total	Percent of DMH PSH Portfolio	Percent of Greater LA Homeless Count	Percent of Overall LA County Population
American Indian	59	1.6%	1.1%	0.2%
Asian	57	1.5%	1.2%	14.4%
Black or African American	1,832	48.9%	33.7%	7.9%
Hispanic or Latino	394	10.5%	36.1%	48.5%
Native Hawaiian or Other Pacific Islander	14	0.4%	0.3%	0.2%
White	1,124	30.0%	25.5%	26.3%
Multi-Racial/Other	54	1.4%	2.1%	2.5%
Unknown	211	5.6%	0.0%	0.0%
Grand Total	3,745	100.0%	100.0%	100.0%

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CSS – ALTERNATIVE CRISIS SERVICES OVERVIEW

- Provides a comprehensive range of services and supports for mentally-ill individuals that are designed to
  - Offer alternatives to emergency room care, acute inpatient hospitalization and institutional care
  - Reduce homelessness
  - Prevent incarceration
- MHSA ACS programs include:
  - Residential and Bridging Care (RBC) Program
  - Psychiatric Urgent Care Centers (UCC)
  - Enriched Residential Services (ERS)
  - Crisis Residential Treatment Programs (CRTP)
  - Law Enforcement Teams (LET)

FY 2019-20

ERS

988 Admissions

CRTP

7 Centers and 99 Beds
(280 additional beds planned)

UCC

8 UCCs
- Service Areas 2, 3, 4, 5, 6 and 8
- New UCCs - High Desert (SA1) & Olive View (Part of Restorative Care Village)
- Approximately 126 Beds
- 49,518 Client Contacts

LET

14,472 Calls
- 31% Homeless Individuals
- 3% Arrests
- 61% Required Hospitalization

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CSS – ACS OVERVIEW

Proposed Changes in New Three-Year Plan

- No proposed changes.
- However, continued work over the next three fiscal years to implement County initiative to expand mental health bed capacity and improve service quality, pending funding commitments:
  - Two-year bed pilot program to procure various types of beds
  - COVID-19 resulted in greater need for beds to focus on prevention, as well as open residential treatment and crisis residential beds; and decompress County hospital beds
  - Strategize to invest resources based on funding availability (potential sources: County NCC funding, Measure J, CARES Act, MHSA, SAMHSA)

FY 2020-21 Budget

Cost	Beds
$209M	Acute Psychiatric Hospitals
$194M	Subacute (includes IMD, Medical SNF, State Hospitals, and State Hospital Alternatives)
$38M	Open Residential (includes ERS, Crisis Residential Care, ERC, and Congregate Care)
$49M	Urgent Care Center Chairs

= $490M Total Budgeted in Gross Cost

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PEI OVERVIEW

- Second largest MHSA component with 19% of the total MHSA allocation
- Focus on providing preventative and early intervention strategies, education, support and outreach to those at risk of developing mental illness or experiencing early symptoms.

PEI PROGRAMS:
- Prevention
- Early Intervention
- Suicide Prevention
- Stigma and Discrimination Reduction

UNIQUE CLIENTS SERVED

In FY 2019-20, 47,602 unique clients received a direct service.

Ethnicity
- 45% Hispanic
- 9% African American
- 8% White
- 2% Asian/Pacific Islander
- 1% Native American

Primary Language
- 74% English
- 22% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA

26,381 new clients were served with no previous MHSA service

Ethnicity
- 44% Hispanic
- 8% African American
- 8% White
- 3% Asian/Pacific Islander
- 0.48% Native American

Primary Language
- 74% English
- 22% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	3,410	2,990
SA2 – San Fernando Valley	7,596	5,840
SA3 – San Gabriel Valley	8,494	6,414
SA4 – Metro	6,329	5,388
SA5 – West	1,828	1,685
SA6 – South	6,049	5,163
SA7 – East	6,720	5,892
SA8 – South Bay	7,923	6,846

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PEI OVERVIEW

- Prevention programs and services promote positive cognitive, social and emotional development that serves to reduce or prevent mental illness from occurring while providing supportive services to individuals, families and communities outside of traditional clinic settings with the goal of avoiding adverse system involvement.

- ***Continued Work based on Current Three-Year Plan***
  DMH continues to provide an array of Prevention Programs and Projects to significantly reduce risk factors or stressors, build protective factors and skills, and increase supports where at-risk individuals live, work, worship and gather. Some of these efforts include:
  - School Based Community Access Platforms
  - Youth Diversion and Development
  - Transforming LA (formally known as Incubation Academy)

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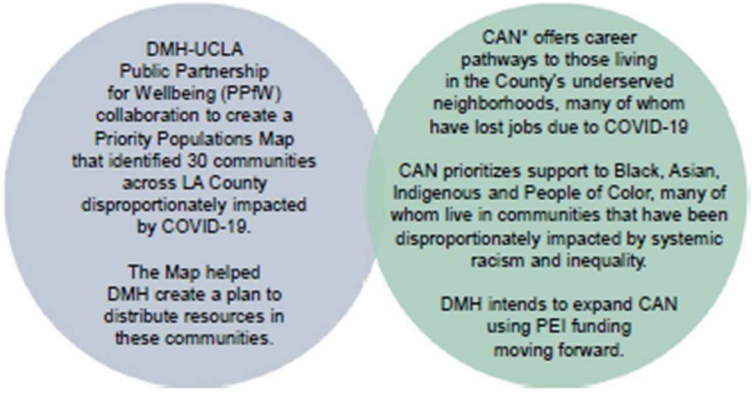
PEI – ADDRESSING DISPARITIES

Prevention efforts are addressing racial disparities and helping improve the overall mental health and wellbeing of our entire County. These efforts include:



*Community Ambassador Network

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PEI – School Based Platforms Updates

LACDMH plans to utilize the following School Based Community Access Platforms to provide prevention services to children, youth and families.

- **Three new initiatives**: (1) the Community Schools Initiative with Los Angeles County Office of Education (LACOE); (2) Trauma and Resilience-Informed Early Enrichment (TRiEE) with Los Angeles Unified School District (LAUSD), and (3) Partnerships with Department of Public (DPH) Student Well-Being Centers.

  - LACOE Community Schools Initiative focuses on both academic and out-of-school factors that impact a student's life for middle and high school children. LACOE CSI target students at 15 LACOE School Districts.

  - Trauma and Resilience-Informed Early Enrichment (TRiEE) with LAUSD focuses on promoting social-emotional wellbeing and resilience for children birth to eight years of age. LAUSD prevention programming targets children at five early education centers and one feeder elementary schools.

  - DPH Wellbeing Centers are school-based centers that provide education on sexual and reproductive health, and promote social/emotional wellbeing for students. These will be located at 50 high school campuses across the County and are operated through a partnership that includes LACDMH, LAUSD, DPH and Planned Parenthood Los Angeles.

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PEI – School Based Platforms Updates

DMH is developing a **School Reopening Plan**

- The 80 school districts in Los Angeles County are in the process of devising plans to safely reopen schools amidst the pandemic. LACDMH is aware that schools will need increased support to address the school community's mental health and wellbeing needs. To aid in the transition back to in-person instruction, DMH has prepared a tiered plan of support for students, their families, and school staff which include Universal, Early Intervention, and Intensive Services and Supports.

- Some supports undergoing planning and possible implementation to be included in this plan include:
  a. Headspace: Online meditation and mindfulness resources to reduce stress, free access for LA County Residents.
  b. National Alliance on Mental Illness (NAMI) – provides peer and family approaches for mental health awareness, skill training, emotional support, advocacy, and education. NAMI supports are provided by individuals with live;
  c. The continued use of the UCLA Public Partnership for Wellbeing (PPFW) which provides supports to teachers, school staff and administrators via the LA County Wellbeing Line & Chat and the DMH+UCLA Wellbeing for LA Learning Center
  d. DMH Regional Team: Provides trainings to equip school staff with skills to identify students who may need a referral to a higher level of mental health services and can assist with creating a map of school based Legal Entity provider network based on school site and school district.
  e. Prevail Health: iPrevail platform increases access to mental health care and support and promote early detection of mental health symptoms that predict the onset of mental illness for ages 13+ utilizing virtual mental health care platforms and technology-based mental health solutions accessed through multi-factor devices.
  f. Community Ambassador Network (CAN): High school students and parents trained to serve as lay mental health agents, navigators, and mobilizers within their school community conducting a needs assessment to help determine and develop school-wide content, increase awareness, advocacy and engagement.
  g. DMH School Mental Health Triage and Referral services to assist with linkage, warm handoff, and follow-up to appropriate mental health services and programs to promote timely and equitable access to mental health supports.

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INN OVERVIEW

Provides 5% funding for time-sensitive projects that introduce new or improved practices or approaches to the delivery of mental health services.

INN PROJECTS

INN 2 - Community Capacity Building to Prevent Trauma
INN 3 - Technology Suites
INN 4 - Transcranial Magnetic Stimulation "TMS"
INN 5 - Peer Operated FSP
INN 7 - Therapeutic Transport
INN 8 - Early Psychosis Learning Network
INN 9 - Conservatee Support
TRIESTE (→ Hollywood Pilot)

- Priority Projects
  - INN 7 Therapeutic Transport
  - INN 8 Early Psychosis Learning Network
  - TRIESTE (→ Hollywood Pilot)
    Partnership with the First Presbyterian Church of Hollywood to develop and implement a two-phase project that will transition individuals outreached by the HOME Team and living in the Hollywood area who are experiencing homelessness and have a SMI to innovative no barriers housing model
- DMH is reevaluating remaining INN projects to determine whether they align with Strategic Plan.

Proposed Changes in New Three-Year Plan

INN TIMELINE EXTENSIONS - The following projects will require extensions to the original project timeline due to delayed implementation. The timelines will adjust to the 5-year maximum.
INN 2 - Community Capacity Building to Prevent Trauma
INN 3 - Technology Suites
INN 4 - Transcranial Magnetic Stimulation "TMS"
INN 5 - Peer Operated FSP
INN 7 - Therapeutic Transport

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WET OVERVIEW

Focused on creating and supporting a workforce that is culturally competent, consumer/family driven and promotes the transformation of mental health services to a strength-based approach that is inclusive of recovery, resilience and wellness

WET PROGRAMS

Navigator Skill Development Program
Charles Drew Affiliation Agreements - Pathways to Health Academy Program - Psychiatric Residency Program
Intensive Mental Health Recovery Specialist Training Program
Interpreter Training Program
DMH+UCLA Public Partnership for Wellbeing
Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System
WET Regional Partnership
Licensure Preparation Programs (MSW, MFT, PSY)

Continued Work based on Current Three-Year Plan

The following Midyear Adjustments were posted during FY 2020-21 and therefore, implementation was completed.

- Use of the MHSA State WET Regional Partnership Grant to fund a Loan Repayment Program similar to the State's Mental Health Loan Assumption Program (MHLAP)
- Suspension of MHSA WET Stipend Program for FY2020-21 due to the economic impact of COVID-19 resulting in curtailments across County departments. Curtailments impact recruitment of students who will likely not have the ability to be hired and would be placed at risk of having to repay the stipends.

SLIDE • 36

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CFTN – CAPITAL FACILITIES OVERVIEW

- Transfers from CSS to Capital Facilities to fund capital improvements
- *Continued Work based on Current Three-Year Plan*
  Midyear Adjustments were posted during FY 2018-19, such as the Restorative Care Villages

  - Part of the County's strategic plan to enhance delivery of comprehensive interventions by integrating direct care services for individuals who require physical health, mental health, substance abuse treatment, and housing-related services and supports

  - Envisioned to be the country's first mental health and well-being campuses that will provide a full continuum of programming and services

  - Located on these County hospital campuses: High Desert; LAC+USC; MLK; Olive View+UCLA; and Rancho Los Amigos

LAC+USC RESTORATIVE CARE VILLAGE RENDERINGS

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CFTN – CAPITAL FACILITIES OVERVIEW

MRT BEHAVIORAL HEALTH CENTER

OLIVE VIEW RESTORATIVE CARE VILLAGE RENDERINGS

RANCHO LOS AMIGOS RESTORATIVE CARE VILLAGE RENDERINGS

HIGH DESERT RESTORATIVE CARE VILLAGE RENDERINGS

SLIDE • 38

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CFTN – TECHNOLOGICAL NEEDS OVERVIEW

- Transfers from CSS to Technological Needs to fund technology needs/projects to advance overarching MHSA goals
  - Increase consumer and family empowerment towards providing the tools for secure consumer and family access to health information; and
  - Modernize clinical and administrative information systems to ensure quality of care, parity, operational efficiencies and effectiveness.

- Currently, there is no MHSA-funded IT projects. However, DMH continues to forge ahead to build for tomorrow, today. Examples of current innovations include, but not limited to:
  - Virtual Mental Healthy Delivery System: Modernize its Virtual Mental Health technology and expand its network to connect with clients in jails, probation camps, shelters and other programs using various platforms as appropriate (e.g. VSEE)
  - MHRLN: Extend/enhance features to track mental health resources (beds, etc.) tracking and provide case management functionality to DMH staff by making it accessible to Contract Providers.
  - Mobile/smartphone solutions for DMH clients and practitioners: Initial delivery will be to implement and extend the mindLAMP smartphone solution that allows clients to participate in treatment by completing daily diary cards to share with their practitioners during sessions, thus enhancing the quality and usefulness of clinical encounters.
  - iPaaS-DPH/DMH Interoperability Collaboration:
    - Project stands up the Azure platform and develops Fast Healthcare Interoperability Resources (FHIR) compliant messages/services such as client services and EDI claims that are currently exchanged with our contracted providers (via BizTalk).
    - Project provides a common platform for DMH and Department of Public Health to exchange data with mutual contract providers.

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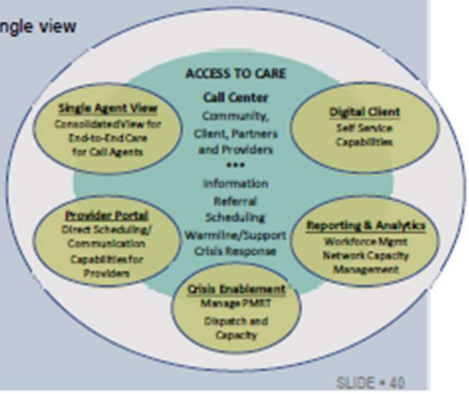
CFTN – TECHNOLOGICAL NEEDS OVERVIEW

Proposed Changes in New Three-Year Plan

Modernization of 24/7 ACCESS Call Center – A funding shift will be necessary to engage with a consultant to modernize the existing antiquated Call Center into the hub in accessing services with the DMH system of care.

The Call Center will provide end-to-end assistance in an efficient and client-focused manner utilizing an agent and client centered design. Project goals are as follows:

- Reduce the number of software applications used by agents by developing a single view with end-to-end care visibility in order to best meet the needs of the caller
- Allow for integration with other systems (e.g., law enforcement) for receiving, assessing, triaging and mounting non-law enforcement responses to crises across our communities
- Provide integration technology between the Call Center and service providers (including crisis response) in order to reduce time-to-care, maximize service capacity and improve coordination of services
- Develop self-service capabilities and alternative access-points designed by feedback from the community
- Automate call and client analytics to ensure the Call Center is meeting the needs of the community and responding in a timely manner



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[E3] PUBLIC HEARING TRANSCRIPTS

APRIL 22, 2021.
MHC.
MHSA Public Hearing.
11:00 a.m.

Good morning, everyone. Welcome. My name is Brittney Weissman. I'm the chair of the Los Angeles County Mental Health Commission. Today is our public hearing for the Mental Health Services Act 3-Year Plan. Very glad to have everybody with us today. We have a lot of services attached to our meeting. We have CART closed captioning. We have Korean and Spanish interpretations happening at the same time. We have our regular Office of Consumer and Family Affairs staff online, a whole slew of department staff, ready to present on the MHSA 3-Year Plan for L.A. County and all of our commissioners, the commission, staff, and the IT field crew who kind of troubleshoot everything and anything as it arises in real-time. And I want to extend my thanks to everybody and also the members of the public who are attending here with us today. Our agenda is specific to the MHSA 3-Year Plan. The commission is not reviewing any other agenda items today. And in terms of how we're going to process through the meeting, what we'll do is I'll make some remarks about how the commission relates to the MHSA 3-Year Plan, and then we will turn it over to Greg Polk to run through the 3-Year Plan itself. We'll move straight into public comment. And I'll ask the AT&T moderator to recite the instructions for calling in to public comment. After that, the commission will address questions and answers with the DMH staff on the plan and consider everything we've heard to date, all of the meetings, and iterative reports that we've received on the plan. And then the commission will conduct its business and its conversation to make sense of what we've heard, integrate and synthesize some recommendations, and hopefully begin to draft them or even approve them by the end of today's meeting. So you can imagine it will be a lengthy meeting. Please feel free to stretch, get up and use the restroom if you need to, grab another cup of coffee if you need to. We appreciate you being here with us. And to get started, I'm going to call the meeting to order officially and ask our commission staff, Canetana Hurd, if you would please call for a roll.

>> CANETANA HURD: Imelda Padilla-Frausto.
>> COMMISSIONER PADILLA-FRAUSTO: Present.
>> CANETANA HURD: Susan Friedman.
>> COMMISSIONER FRIEDMAN: Here.
>> CANETANA HURD: Harold Turner
>> COMMISSIONER TURNER: Here.
>> CANETANA HURD: Stacy Dalgleish.
>> COMMISSIONER DALGLEISH: Here.
>> CANETANA HURD: Kathy-Cooper-Ledesma.
>> COMMISSIONER COOPER-LEDESMA: Here.
>> CANETANA HURD: Teresa Banko
>> COMMISSIONER BANKO: [Absent].
>> CANETANA HURD: Patrick Ogawa.
>> COMMISSIONER OGAWA: Present.
>> CANETANA HURD: Kevin Acebo.
>> COMMISSIONER ACEBO: [Absent, excused].
>> CANETANA HURD: Michael Molina.
>> COMMISSIONER MOLINA: Present.
>> CANETANA HURD: Brittney Weissman.
>> CHAIR WEISSMAN: Present.

>> CANETANA HURD: Judy Cooperberg.
>> COMMISSIONER COOPERBERG: Present.
>> CANETANA HURD: Madam Chair, you have a quorum.
>> CHAIR WEISSMAN: Wonderful. Thank you, Canetana. And also happy Earth Day to everybody on our call. I hope you get to breathe in some fresh air and remark about the world that has supported us being here today. So thank you for Earth Day. Before I call up Greg Holt to speak, I wanted to ask the AT&T moderator, Roxanne, to just give us the instructions for calling in. We will not be taking public comment for quite a while, but I'd like the instructions to be recited from time to time. So Roxanne, if you could just let people know if and when it is time to call in and make a comment, how they would do that.
>> AT&T MODERATOR: Thank you. So if you have any comments at any time, please press 1, then 0. Again, press 1, then 0. Your line will be accessed at that time.
>> CHAIR WEISSMAN: Thank you. And the call-in numbers are on our agendas that have been posted to the DMH website on the MHSA Plan. They're on the DMH calendar. They're also on the splash screen with you now. Let us move to the next slide that talks about the commission role.
Yes. Thank you. So as you may or may not know, all of the commissioners are appointed by a supervisor in L.A. County. There are five supervisors, each of which elects -- appoints three commissioners, and most of us are here today, we have a quorum. And one of our responsibilities is around the Mental Health Services Act 3-Year Plan. And what we aim to do today is simply provide a platform for the public hearing. We host the public hearing so that we can have a presentation by department staff on the updates to the plan. And then we consider those updates. We consider our own thoughts. We consider public comments that have come in over the course of the public comment period, which has been at this point over 30 days. And then at the end of our meeting, what we'll do is we'll, like I said, review our thoughts and create some recommendations if we have some thoughts that we'd like to address to the report or the plan. What we do as a commission is, we ensure that there is a robust stakeholder involvement. And as Greg Polk will outline in his presentation, he'll discuss all of the ways the department has reached out to the various constituencies and stakeholders of DMH to make this plan a really great one. Next slide, please.
And this just outlines, you know, the WIC code that allows the commission for L.A. County to review and ensure that citizen and professional involvement has been involved in all of the stages of the planning process around MHSA. And I hope that gives an overview and some insight as to what we're doing here as commissioners hosting the public hearing. And I think without much further ado, let us call Greg Polk on to begin the 3-Year Plan update.
>> GREG POLK: Thank you, Madam chair, members of the commission, also members of the public. Thank you guys for being a part of this process. I think it's important that we have you guys as a part of this process and to give us some advisement and kind of lead us into what you feel is required for the requirement to do. Just kind of the first slide. Next slide, please.
First, I just want to kind of go over the areas and kind of the present presentation layout. We're going to focus on disparities, huge conversation around disparities. We're going to talk about the community planning process, which is an important process. We are going to talk about MHSA funding and a 3-Year Plan, the funding for the 3-Year Plan.

And also we're going to talk about existing MHSA programs and propose changes to those programs. And just to move forward on our first focus area, I'll turn it over to Dr. Debbie Innes-Gomberg to talk about disparities.
>> DEBBIE INNES-GOMBERG: Hi. Good morning
[echo].
I'm hearing some feedback, so maybe people can mute themselves. Okay. Thank you.
What I'm going to be presenting are three slides with different types of data and as many of you know, I love data. So I'm going to be presenting slides on data related to disparities in mental health care in Los Angeles County. And what you'll note -- what you'll find and when you look broader at the data across the state, is that the trends we see in L.A. County are actually similar to trends we see statewide. And if we could go to the next slide, that would be great. Thank you so much.
So this first slide is Mental Health Services Act direct service costs by ethnicity and by MHSA Plan. And what you see here is in the first column, you've got different programs, so full service partnerships, alternative crisis service, which really helps keep people out of jail; and in the emergency department, outpatient care services, which are really either a step down from FSP or a lower level of service from FSP; and then prevention and early intervention. And we have the percent of the expenditures in Fiscal Year 19/20 by ethnicity here. And one of the things that you're going to notice is that some focal or target populations tend to be disproportionately represented here in terms of being African-American or Latino. And as an example of that full service partnership programs, 26% of clients -- of expenditures in Fiscal Year 19/20 went -- were for African-Americans, 33% for Latinos, and part -- that's in part because the types of clients that FSP programs enroll people that have histories of homelessness, incarcerations, and are in and out of the psychiatric hospitals. And when you look down at alternative crisis services, it changes a little bit. And so while you have a decent proportion, 24 and 28% of expenditures for African-Americans and Latinos, you also have 24% of expenditures for the White category. And this year, that's inclusive of Middle Eastern/Eastern European clients as well.
And then with outpatient care services and prevention and earlier intervention, it changes towards having more clients or more expenditures for which, you know, adds 38% for outpatient care services and 43% for early intervention and PEI. So that just gives you a bit of a sense of expenditures. And then we can go to the next slide.
And this slide is, really helps to, I think, establish context, and it compares the ethnic distribution of L.A. County Medi-Cal enrollees to their distribution related to them receiving mental health services. And this is, this represents 2018 data. It's an EQRO slide, actually. And the areas to focus on in this particular slide, the first column are race or ethnicity. And then the third and fifth column are the ones to really to take a look at. And as an example, Latinos represent about 59% of Medi-Cal enrollees in L.A. County, and they represent 51% of clients who received a mental health service in the calendar year 2018. Similarly, Asian Pacific Islanders represented about 9.5% of Medi-Cal enrollees, and they were only served at 4.5%. So that is kind of the key thing I wanted you to take away from this slide. And you can see the other ethnicities as well. And you will go on to the next slide. Thank you so much.
This is a person changing consumer served in outpatient programs by race and ethnicity over a four year period. And one thing to notice here is

that for some ethnicities, there isn't much change over four years. And I think when you look at Latinos, they dropped a couple of years, went back up to 37% in Fiscal Year 17/18, Asian and Pacific Islanders virtually no change there. One of the things that we are doing now is we're looking at multi-race. And so -- and so this will be a challenge in terms of reporting. One of the things we're working out right now is, do you count clients that endorse multi-race as just multi-race or also as the races they represent? And this is something that, you know, that we're taking a look at, but people are endorsing multi-race more frequently as the Fiscal Years have gone on, and we've got some work to do in this area. I think we're going to report at a more granular level, including desegregating Middle Eastern and Eastern European from a "White" category. And we're also going to be reporting on disparity, excuse me, disability status and sexual orientation and gender identity. And so we're working with folks and Mirian Avalos in particular and her team to be able to do that. So in the future, you're going to see a much more granular reporting.

Finally, the final thing I want to report on this slide is that you'll see unreported at the bottom. And it -- the number, the percentage of clients who do not have ethnicity reported is anywhere from 20 to 23%, and that's problematic. And so one of the things that CIO is going to do is make that field mandatory. Right now it's mandatory in the directly operated system, but in the future, it'll be mandatory as well in our legal entities system as well. So you won't be able to complete an intake or a financial if that -- if you don't have an ethnicity recorded. And we'll go onto the next slide, please.

So this is really about, and we're going to hear a lot more about what we're going to -- what we're doing about these disparities, but a couple of things I wanted to point out. And the first one is an opportunity we have to participate in a multi-county learning collaborative. Solano County recently reached out to us about participating in a multi-county learning collaborative with UC Davis Center for Reducing Disparities. And what they would be doing is training us in how to apply the class standards, which are culturally and linguistically appropriate service standards to specific populations that we would choose in L.A. County. And we would be part of a multi-county collaborative to really focus on using quality improvement strategies and the class standards to reduce disparities and treatment. Really looking forward to moving forward with that. The Oversight and Accountability Commission relevant subcommittees have approved this learning collaborative and they're just working out the, I think the contract in details with UC Davis, and then we'll go ahead and be able to get started in that work, which I think will be very relevant.

And then, finally, we're, and you're going to hear about this from other presenters, we really want to increase the availability of culturally and linguistically competent mental health services to various racial and ethnic minorities and cultures. And again, you're going to hear more from other speakers, so thank you very much.

>> JOHN FLYNN: Mr. Polk, if you're speaking, you are muted.

>> GREG POLK: I'm sorry. Yeah, just to kind of piggyback on what Debbie was saying. Dr. Sherin has been pretty clear about, you know, his intent to want us to make sure we focus on disparity and try to resolve the disparities as we can. But I think it's important to know too, MHSA alone is not going to solve disparities. I think it's important that this is a collective effort, state, federal, I mean, as disparities throughout this nation from even vaccinations. You know, disparities exist and are real, and I think it takes a group effort to address this issue. And so I

don't want to leave this meeting with people thinking MHSA can resolve this issue, because it can't do it on its own. We're trying to do what we can do at the department to address it. But it's a huge issue that needs to be a collective effort nationwide. Just wanted to add that piece.
Moving right along, I think the next focus area that we're going to discuss is, it's the community planning process, a huge effort around community planning. We feel this is really important. We feel stakeholder processes are mandatory and a must. I think that's where we get kind of feedback on what we're trying to achieve and what we're trying to do. And today we have Rigoberto to kind of talk about this focus area.
>> RIGO RODRIGUEZ: Thank you, Chief Deputy Greg Polk, for introducing me. Good morning, everyone. I'm Dr. Rigo Rodriguez and I am a community planning facilitator with over 25 years of community planning experience. And today, I'm going to describe the community planning process that has been used to obtain input, feedback, and recommendations from community stakeholders. This slide that you are seeing contains some of the key dates for this process, going back to October of last year, all the way to today. On the left-hand side, you'll see that there were some dated October, November, and then again, February and March of this year that were used to collect a lot of this input and process this input. And that I'll describe in a second in more detail in the upcoming slides. On the right-hand side you'll notice March 19th. And that's when the full version was uploaded to the website for the whole public to see. And then the remainder are really the dates that we're in right now. Let's go to the next slide.
So over the course of the past seven months, DMH has deliberately engaged the Community Leadership Team for input, feedback, and recommendations. For members of the public, the CLT as we know it, abbreviation for Community Leadership Team, has essentially replaced the System Leadership Team as the primary community stakeholder body that provides input feedback recommendations to DMH, especially on this MHSA 3-Year Plan. The CLT consists of co-chairs from the Service Area Leadership Teams, the Service Area Leadership Teams or what we call the SALTs, and the SALTs represent eight regions across L.A. County. So the SALTs are the committees that really make sure that services and communication and needs are articulated regionally, geographically.
And then there are the Underserved Cultural Communities groups that range from folks who experienced physical -- folks who have physical disabilities, to ethnic and racial groups, to LGBTQIA two-spirited population, as well as the Cultural Competency Committee, peers, and then youth. So it's a wide range of groups that really speak to the needs of cultural groups that have been underserved historically and today.
Let's go on to the next slide.
So in relationship to this body that has representation and links to different geographies and cultural communities, the input stage, you'll see it on the left hand side under needs assessment, that input stage started in October, November, where the SALT and the UsCCs were provided with data largely around disparities, and each of these bodies provided input into unmet needs and services needed. From there, in December all the way through January, the Department of Mental Health -- oh, I should've mentioned that the collection of this data also included a survey as well, not just visiting the committees, but also through surveys. And in December, January, this subject matter experts from DMH reviewed, analyzed the data, and organized this input into the eight major categories that you see listed in the second column. The input revolved around additional mental health services that were requested

across age, geography, cultural groups and so on, children, youth, Asian Pacific Islander communities, that's kind of theme one. But in addition to that, an interest in focus on the different levels of care, housing, data, training, funding for non-direct services, COVID-19 was pretty prominent, and then social equity. So those were the eight categories. And in relationship to those eight categories, the subject matter experts then processed that information through the broader framework of the department, because the department has a strategic plan and there's other resources as well, and from there, asked themselves the question about, how do we nest these services into the 3-Year MHSA Plan? Are folks asking for an augmentation of services? Are they asking for new services? Or are some of the services that people are asking for outside of the domain of DMH? Again, this speaks to what Mr. Greg Polk just brought up that, alone, DMH cannot solve the deeper social determinants of inequity, but rather it does require a broader collaborative strategy across the county. And so with that in mind, if you go to the next slide.

Here are some of the general areas. I'm not going to go through each of these, but, and these aren't exhaustive -- this isn't an exhaustive list. I'm just going to highlight some things. But generally speaking, the requests came around the need for more trainings around cultural competency and just additional training for different groups to build skills, education, learning supports, of course, also for more services of different types, capacity building. If you go to the next slide as well, sort of integration of services, data. You'll notice also technology and infrastructure.

And so if you look at that last bullet point, provide ethnic breakdown within the age category, there were a number of requests just around data, because as you'll see in the next slide that, or as I close, that the -- there is an interest around what we do moving forward in terms of monitoring accountability. Let's go to the next slide.

So in -- as I mentioned, December, January, that subject matter experts put together a proposal, a first proposal for the MHSA 3-Year Plan. And then on March 5th, we reconvened the CLT on March 5th for about four hours where all this information was reviewed again, and they had a chance to provide additional input and feedback on the 3-Year MHSA Plan.

So to close, and so here you see some comments, it was a pretty well-received session. And so to close, if you go to the next slide. Let's see. Oh, no, that was my last. So if you -- actually go back one slide, just let me close on this stuff. So again, the session was positively received, but I do want to signal two areas of concern. One is moving forward as we continue to engage communities. We just need to be that much more deliberate about how we track input and how that gets coated onto services. I would be happy to talk about that more if you'd like.

And then lastly, again, this concern about making sure that data on disparities are provided to the SALT or the UsCCs, and that moving forward, we're able to track how the services and the strategies that are funded in the MHSA 3-Year Plan, along with other resources from the Department of Mental Health and the county, how do we track that those strategies are actually achieving the outcomes that we are intending? And so I just want to stress that I'm in the midst of a capacity building project with the CLT, and we'll continue to work on those areas. So thank you so much. This concludes my part.

>> GREG POLK: Thank you, Dr. Rodriguez. I think it's important to know that for those who don't know, Dr. Rodriguez is not a part of DMH. You know, we brought Dr. Rodriguez on and make sure he held us accountable when we talk about the stakeholder process. I think it's

important to let the record reflect also that Dr. Sherin is a huge advocate of stakeholder engagement. I think it's key that we involve stakeholders in the process. So, like I said earlier, Dr. Rodriguez is an anomaly. He's a great facilitator, and I think he's done a great job around the stakeholder process. Next slide, please.
Just here, just kind of talking about the purpose of the 3-Year Plan, it's pretty straightforward and dialed in for Prop 63 was passes, also called Mental Health Services Act, 1% of personal income over one million dollars went to fund the MHSA Prop 63 is -- the whole purpose is to expand, improve, transform mental health systems, I mean, to improve the quality of individuals living with mental illness. Obviously with Code 5847 kind of lays that out. The plan has an opportunity to provide the county with, you know, to review its existing MHSA programs and services, also to propose and incorporate any new stakeholder feedback. And I think that's why that feedback and that stakeholder engagement process is so important. Next slide.
It kind of lays out the DMH 2021-22, but I think it's important to kind of put MHSA in context of the whole department's budget. When you look at 21-22 recommended budget approved by the board, plus 795 million or 27% of net budget was MHSA. The biggest piece of our budget is 1.3 billion in federal and state Medi-Cal. In a sales tax realignment is about 557. I think it's important to show this just to put in context what chunk does MHSA plan a whole overview about the budget. Next slide.
And what we tried to do here, we took that MHSA piece, that funding that we talked about, that big chunk, and we kind of broke it down what's available, right? When you talk about the $878 million and fund balance that we have, available is about $596 million, available of that. And when you look at this, there's a prudent reserve required by the MHSA Act where you have to set aside, I think, a certain amount of money in prudent reserve. And also we have an innovation component of it that kind of comprise the whole mental health fund balance of 879 million. And that was as of July 1, 2020. Then when you look to the box to the right, it talks about what's actually allocated in a 2021 budget for 624 million. And having the components of it is to the right of that. Next slide. Next slide, please.
Funding concerns. A lot of funding concerns around, you know, MHSA Dollars in the apartment in general. You know, we anticipated reductions in MHSA sales tax to the extent that, you know, businesses are closed, you don't generate sales tax. Huge piece of our as you saw on the -- on a couple of slides, right? Huge piece realignment is what we call sales tax, huge piece of funding for this department, net county cost, real slight piece of the pie. 1% of our three billion dollar budget is net county cost. And, you know, there's some huge things going on. I mean, the impact of COVID-19 obviously really get our sales tax and also tax from MHSA that is computing initiatives, you have Alternatives to Incarceration, you have Justice Reform, you have homelessness, which is -- which is all, you know, really requiring a lot of our funding from the county. You know, we're trying to do this healthcare integration around restorative care and villages and just the whole conversation about affordable housing. I don't know if you guys are familiar with what's been going on recently with Judge Carter rulings around trying to get homes or housing for all people on Skid Row and homeless individuals - huge, huge, huge issue for this department. And we're going to try to be a piece of that pie, but we'll see where that goes, but, you know, a lot of hands out for mental health money to sort of speak. And we talk about potential funding issues. Measure J and that we submitted a budget request to see if we can get Measure J dollars. There's no money in his budget that's from Measure J

fund, no program funded by Measure J in our budget right now. We did submit proposals trying to get Measure J funding and Care X, finding all ways to looking at Care X dollars. You know, we've been tapping into SAMHSA dollars and trying to see if we can get more revenue there. You know, a lot of challenges too. You're talking about implementation delays, DMH infrastructure. Do we have the infrastructure to do a lot of this stuff? Do we have a staffing motto appropriate to carry out some of these requirements and requests? Do we have the space to even do it? Is there housing available to house these people? I mean, there's a lot of conversations about infrastructure and just facts, rhetoric and contractual limitations. You know, I think a lot of people would see fun bounces on MHSA and say, oh, why did you bother me if it's dirty? A lot of guard rails around spending in MHSA dollars, especially PEI dollars. A lot of guard rails and we're trying to -- no, I think Dr. Sherin is very huge advocate at the state and federal level, trying to break down from those barriers or some of those guard rails around MHSA to kind of allow us to be kind of a more free flowing in explaining those dollars. Next slide, please.
Just MHSA overview by component, you know, just a kind of liaison, you got to CSS, Community Services and Support. You have PEI, Prevention and Early Intervention, and the rest kind of speaks for themselves. Next slide.
Just kind of a CSS overview. Just kind of talk about some of the things that CSS does. Unique clients served is about 147,000 in Fiscal Year 19/20/21. And you can see the ethnicity and the primary language breakdown pretty consistent. When you look at the new clients with no previous MHSA experience, about 50,000 there, then we lay out, you know, client data by service area kind of speaks to it, speaks for it. So I want to kind of turn it over to Dr. Lisa Wong to kind of lead us around our CSS full service partners here overview.
>> LISA WONG: Great. Thank you very much, Mr. Polk. Next slide, please.
Okay. So first we're going to talk a bit about the full service partnership, which is our specialty program that provides 24/7 intensive outpatient services for our highest acuity clients who fall within our state focal population guidelines. So really what this program we're trying to do is reduce serious mental health symptoms, reduce homelessness, incarceration, hospitalization, and we want to increase independent living and community integration. You can take a look at the table on this slide to see the slots that we have and the age groups served for Fiscal Year 19/20. What's most exciting about our full service partnership this year is our FSP transformation that we'll be launching on July 1st. We're going to be working with existing FSP providers to pilot this new model over the next three years. And then we're going to take lessons learned to inform a rebid in about a few years later.
So here's a list of some of the changes. I know that all of you have probably heard a lot of these, so I won't go through them, but you can kind of look at it on the slide. Some of the really big ones are that we are really focused on those most in need of FSP care and getting rid of, sort of that at-risk category, really focusing on those focal populations. And then we're emphasizing multidisciplinary team population approach rather than individual caseloads. Next slide please.
Hey. I'm sorry, I'm having a little problem with my officials. Okay, so one of our big goals in FSP is focusing on addressing disparities. We're trying to increase the use of disparity states across the DMH system, as well as at the local service area level to inform and shape FSP services for diverse populations. We are adding to an API FSP team, for example, in service areas 3, 4, and 8, and we are having trainings and

support for working with diverse populations, focus on the API community, as well as other underserved and underrepresented populations. And very important, we're working with UCLA and subject matter experts from the API and other communities to develop best practices for all of our FSP providers. Okay. Next slide please.
Next, we're going to talk a little bit about our outpatient care services. This is probably the biggest component of our outpatient system. And really this is the -- these are the programs that provide community-based, clinic-based, and wellbeing services, and they include things like all our individual and group and family therapies, our evidence-based treatments, peer support, medication, case management, crisis resolution, linkages to primary care, substance use disorder, and also assistance with, you know, real world needs like benefits establishment, housing, and other social determinants of health. We are also anticipating a real focus on vocational and pre vocational services this coming Fiscal Year. Our aim is to help our clients and families to achieve their recovery goals, have safe places to live, use their time in meaningful ways, have healthy relationships, access public assistance when necessary, get through crises successfully, and have the best possible physical health. And you'll see on the table for this slide the clients served by age group in Fiscal Year 2019 to 2020.
So some of the coming enhancements for our outpatient care services are we are developing a modernized call center to assist in access to services and the most appropriate levels of care, and also we're building up and supporting capacity to ensure that they're successful transitions from higher levels of care. So when somebody comes out of the hospital or somebody is transitioning from our full service partnership, we want to make sure that we have an adequate place for them to land, where they will be supported and their recovery journey will continue. Next slide, please.
So as with our FSP programs in outpatient care services, we are really trying to have a focus on disparities. We want to increase our use, again, of disparities data across our system, as well as at the local service area level, because we want to be able to inform and shape our outpatient care services for diverse populations, you know, where it counts in the communities. As we know, the picture may look one way across all of the county, but when we look at individual communities, you know, they're very different pictures from community-community, from service area to service area. We are also having trainings and support for working with diverse populations. We have a new Koreatown clinic coming up along with a small attached FSP and we are developing our telehealth network across service areas so we can provide language capacity and cultural competency. And we're starting this with an API pilot. Next slide, please.
So as an example of some of the things that we're doing to address disparities and diversity issues, I'll talk a little bit about some API updates that we have. So DMH directly operated clinics implemented an outreach protocol since the beginning of the pandemic where clinics provide regular check-ins with everybody on a clinics caseload. Clients receive outreach from clinics via phone, video, written communication, based on whatever the client's preference is or availability. And for those clients who can't be reached via any of these means, the clinic keeps a list and attempts to reach out to them when they attend their empty appointments. So the client check-ins are focused on mental health and health status, housing and food security, and any other needs the clients may have. So the entire clinic's caseload receives outreach every one to two months. And new protocol has been added now, checking in specifically with AAPI clients regarding whether clients have experienced

any type of anti-Asian hate crime or feeling distressed by seeing it go on around them. This has allowed clinics to have a broader conversation around any racism, bias, or trauma that any of our clients have experienced. And I'm really happy that we will have this intentional focus now because as we know, so many of our clients are exposed to various traumas and stressors. So DMH will also begin to have a discussion with our legal entities and our contracting division around implementing a similar check-in for the legal entity clients. We've extended services at Long Beach API Clinic county-wide to add cultural responsiveness and language capacity, and we're adding to the FSP capacity of both Long Beach API and Coastal API, as well as one of our legal entity API FSP teams, and DMH is developing a small resource guide where and how to report anti-Asian hate crimes, advocacy organizations, bystander training, and mental health resources. Next slide, please.
Okay. The Cultural Competency Committee has hosted a panel discussion regarding anti-Asian hate crimes and the panelists have included API DMH staff, consumers and contract providers, and the department issued the Access and L.A. County DMH Warmline contact information during various client meetings, media interviews related to the mental health impact of anti-Asian hate crimes. So activities focused on API wellbeing will take place in May, 2021 during our May Is Mental Health Month and API Heritage Month. Activities are designed to show support for our API clients and staff, and for DMH to support a strong response to the API hate crimes and show our commitment to the communities served. Okay. Thank you.
>> Can we ask questions?
>> GREG POLK: Thank you, Dr. Wong. And I think now we want to move into housing. And I think Dr. Maria Funk is kind of here to go through housing.
>> Greg, can the Commissioners ask questions?
>> CHAIR WEISSMAN: This is Brittney, I'm the chair, and I would like to hold all questions until actually we turn -- we finish the DMH report, we take public comment, and then the commission will ask questions of the DMH staff. So if you do have questions, commissioners, please write them down and we'll get back to them later in the agenda.
>> COMMISSIONER COOPERBERG: Okay. Thank you.
>> GREG POLK: Hi, Dr. Funk.
>> MARIA FUNK: Hi, good afternoon. Or good morning, I guess it's still morning. So as Mr. Polk said we [Clears throat], excuse me, we know that DMH really plays a critical part as it relates to combating homelessness here in Los Angeles County. According to the last count, there were over 66,000 people who are homeless in Los Angeles County, and an estimated 20 to 25% have mental illness. We definitely have been working for years and continue to work with our partners at Los Angeles Homeless Services Authority. DHS is housing for health program. The chief executive office's homeless initiative and other departments and agencies in combating homelessness. For years now, I can say being part of the work that has been done on behalf of the department. We have heard from stakeholders that, you know, you're very concerned about people who are homeless and having mental illness and that you want to know and want to see us continue to increase our resources for people who are homeless. So DMH does have that housing and job development division, which I oversee. We oversee various resources for people who are homeless, including interim housing. We have large investments in the capital of development and permanent supportive housing. We also have funding and other resources for subsidies to make housing affordable for our

clients. So I'm going to talk a little bit about those resources. Ultimately, our goal is to assist our clients who are homeless to move into permanent housing, to help them maintain the housing that they're living in, and then of course, to increase the number of resources that we have for our clients, so we can continue to help them.
So just quickly, some of the data from 19/20. In 1920, we allocated $390 million for the capital development of housing through the No Place Like Home Program, which I'm sure people are familiar with through proposition two. There's another 50 million that will be awarded soon. We have contracts with the two housing authorities, the county and the city, and over 2,000 -- about 2,400 subsidies through the Housing Authority contracts. We also allocated $10 million of MHSA funding for local subsidy through our housing permanent health program that will serve clients in FSPs, the homeless FSP, and also clients referred from the office of Diversion and Reentry. We -- in that year, we had $2.4 million that we used to assist clients that were moving into housing that needed security deposits, and also needed funds to pay for household goods, such as furniture. Through our enriched residential care program, we served 572 people who are living in licensed residential facilities, also known as boarding care homes. And then through our interim housing program, we served 504 people, both individuals and families. Also since 2008, we have invested, as I said, a lot of money in the capital development of permanent housing, $670 million. We have funds in 140 different projects that are providing affordable housing for people with serious mental illness. We also have housing FSP program that provides services to support people living in permanent housing in 92 different sites. Next slide please.
In the next three years, our plan includes that we are going to continue to allocate the No Place Like Home funding. $100 million has been set aside to provide housing in restorative care villages. You'll hear more about those later in the presentation. We're also in the process of redesigning our housing FSP program. We will continue to provide services for people living in permanent housing. We're going to refine the model and it will be called housing and supportive services starting next year. We also continue our efforts in strengthening the licensed residential facilities. We increased our budget by six million dollars using SAMHSA federal funding.We're also seeking a membership association for the board and care operators. We hope to have a contract in place by July 1st. We are administrating a capital improvements program in collaboration with Cedars-Sinai, which has allocated five billion dollars to support this effort with us. And we're implementing a bed tracking system. We hope to -- we have a launch of that on June 10th for the boarding care part of that system. We're also partnering with the Department of Health Services and California Policy Lab to implement a new homelessness prevention unit which is identifying people who are at risk of homelessness. And so we are just implementing that now. And then, finally, we also got a grant through the Hilton Foundation that was provided to Brilliant Corners $500,000 to assist people leaving prison with housing. Next slide.
We're also looking at disparities as it relates to housing. And you can study this chart here. I think what's important to note is that we're looking at the percent of people in the PS8 portfolio that we manage at DMH and comparing it to the percentages of people, the different demographics of people who are homeless, which we know is very different than the overall general population. So, for example, Black and African-American people in the general population are about 8% and the homeless population is about -- there about 34%, greatly over-represented in

DMH's portfolio of housing, there are about 49%, and we are working with other county departments and the County Anti-racism and Diversity and Inclusion Initiative to respond to the ad hoc committee on Black people experiencing homelessness, again, looking at disparities, also looking at the coordinated entry system and the tools that are used and looking at revising them if there -- if they find disparities and there are studies being done to look into that. So I'll end there. Thank you.
>> I think that's where we want to be --
>> GREG POLK: I'm sorry. Moving on to Dr. Amanda Ruiz to talk about Alternative Crisis Services.
>> DR. AMANDA RUIZ: So Alternative Crisis Services are a range of different services and support for the mentally ill and they provide alternatives to emergency room care and acute inpatient hospitalization so they can reduce homelessness and prevent incarceration. We have a range of different services, including enriched residential services, which are board and care services that provide treatment onsite and offsite. We have urgent care services, which are mental health urgent cares. And we're looking to provide a new urgent care in Service Area 1 and another new urgent care as part of the restorative care village. And in Service Area 3, we have approximately 126 tags and almost 15,000 client contacts. And we also have Crisis Residential Treatment Programs. Those treatment programs have an average length of stay of between 14 days and 30 days. We're looking to add approximately 280 additional beds, which will be primarily once again in the restorative care villages, which are on the county campuses. And we have the law enforcement teams, which are COVID response teams made up of a clinician and an officer. We have approximately 39 teams out of the 46 different police departments throughout Los Angeles County. 31% of those calls involved homeless individuals, 3% resulted in arrests, and 61% required hospitalizations. Those made up approximately 14,500 calls. Next slide.
So for Alternative Crisis Services, we don't have any huge changes coming in the coming year, but we're always looking for additional funding in order to drive the bed pilot. As we know, in October of 2019, we had a bed report that stated that we needed additional beds to add to our network. COVID-19 resulted in a need to move patients from the inpatient system to our community-based network. So we'd like to strategize to invest resources and we're looking through potential sources, including Measure J, the Cares Act, MHSA, and SAMHSA. We'd like to add beds, so 209 million are for acute psychiatric hospitals, 194 million for our subacutes, which house and provide treatment for our patients that are conserved. Those are typically locked beds, a state hospital and state hospital alternatives. Our open residential beds are unlocked beds once again, providing treatment for offsite and onsite, it'd be 38 million and approximately 50 million for our urgent care center chairs. So the total is approximately 490 million. So I'll wrap it up here in the interest of time. Thank you very much, everyone. Thank you, Mr. Polk.
>> GREG POLK: Let's move on now to the second largest component, which is PEI. Just kind of an overview of PEI. You know, it's -- you had about 47,000 in 2019/20 unique clients there and about 26,000 new clients certainly. You can see kind of the data breakdown by service area. I move it over to Darlesh so she can give us kind of an overview of PEI.
>> DARLESH HORN: Thank you, Mr. Polk. And thank you, everyone, for joining us for this presentation. Again, as Mr. Polk mentioned, PEI is the second largest plan of the MHSA component. It's about 90% of the total

allocation, and you can see the number of unique clients served by ethnicity and primary language in the data that's presented there. And you can also see the number of clients served by geographic area. I do want to point out that PEI has four different program components: prevention, early intervention, suicide prevention and stigma and discrimination reduction. The data that you see on this slide really points to our early intervention services, which provides evidence-based practice or practices or short-term treatment modalities to clients that are in need. And really the goal is to reduce mental illness or the exacerbation of mental illness. So this data really points to those evidence-based practices that are provided. Next slide.

For our new plan and what we've been doing over the course of the last few years is really focusing on our prevention programs. So prevention programs really are designed to be served in the communities where people live and work and worship. They're not designed to be really a part of our traditional clinic settings. And so we really want to get out into communities and reach people where they are. These provincial programs really promote social wellbeing and emotional development so that people can thrive in their daily lives. We're continuing work in some of our programs that we've been working on for the past couple of years. One, we've done huge efforts around our school-based community access platforms, really working with our teachers and administrators in our school districts and providing services to students in their families so that children thrive both educationally, but of course, you know, in wellbeing. We also have the diversion and development programs that we are continuing to provide throughout communities. And we're also just focusing on disparities as many of the previous presenters have mentioned, really working with our grassroots organizations and bringing them on into our network and serving their communities because they know their communities best. And one of our efforts has been our transforming LA effort, which some may know as the Incubation Academy, where we really reach out and train grassroots organizations on how to provide their services through a prevention, mental health prevention lens in order to support their communities. Next slide, please.

Again, the focus is being for PEI as well as the other MHSA components and addressing disparities. We've had two major efforts that have gone forth and we'll continue to go forth in our upcoming 3-Year Plan and one is around, is a collaboration with UCLA, our public partnership for wellbeing, and that collaboration has produced what we know as a heat map. So many of the other presenters before me have mentioned how certain communities were disproportionately impacted by the COVID-19 pandemic. And so these heat maps really identify the 30 communities that were most impacted and we were able to identify their needs and where they would need more support and really work towards developing programs and services that are specific to their needs. The second effort that we have going forward to address disparities that's supported by PEI is our Community Ambassador Network. That network really provides career opportunities to these disproportionately impacted communities due to COVID and really creating jobs and other resources for those communities. Next slide, please.

So now that we are in an area of, I won't say post-COVID, but we are regaining some sense of normalness, the schools, as you all may know, are coming back online. Many of the students and families have been at home for over a year. And so there's this huge effort within a department using PEI resources to support school reopenings. And so we are piggybacking on some of the work that we've done with our three initiatives in our school-based platforms. So one of those initiatives that

went forth early on is a collaboration with LACOE and working with the LACOE school districts. That collaboration really focused on middle school and high school students and providing them with support, teaching students about wellbeing and how to really address certain issues that they may have, issues extenuating circumstances within their families. And so we've trained teachers, we've trained administrators in those areas.
Our next initiative was our Trauma & Resilience Informed Early Enrichment Program or TRiEE. That collaboration is with LAUSD in our early education centers, really focuses on children from birth to eight years old and promoting social and emotional wellbeing and working with their parents and teachers and supporting them. And then finally, one of our last initiatives that we've already put into place working with Planned Parenthood and our Department of Public Health and working in wellbeing centers that are across a number of different high schools and teaching about education and sexual and reproductive health. Next slide, please.
So going forward again, where we're still consistently working with school districts around school reopenings, we have a number of initiatives that we're working on and continue to working on. Some of them you've already heard of. One of the initiatives is Headspace. It's an online meditation platform that really focuses on mindfulness and stress reduction. We continue to work with NAMI around educating and providing peer and family support, emotional support across various communities in L.A. County. I've already mentioned our collaboration with UCLA. We will continue to support that effort. And also our Community Ambassador Network. I mentioned that earlier ,we will continue to do that. We have another online platform, the I Prevail, which really works to identify symptoms. If a particular teenager, 13 and and older, really engages this platform to identify if they're experiencing symptoms or need support, that's our I Prevail platform. And then lastly, we're looking at a mental health triage and referral services, and really bolstering those efforts. We currently already have triage and linkage efforts, but really bolstering those efforts so that we identify people very early on, which is the cornerstone of prevention, and we get them into the services that they need. And so with that, that concludes my presentation.
>> GREG POLK: Thank you.
[Echo].]
I'm getting a little feedback from someone. Next area we're going to talk about is innovation. You know, there's a separate innovation project that actually Dr. Sherin and I are looking at our innovation projects and trying to decide, are we going to move forward with all innovations that actually exist? Or do we see, because of COVID, because of how funding is, are there other things that we can be a little more integrated about? So we'll be looking at those, but one that I kind of want to talk about is the Hollywood Pilot Project, and I have Dr. Funk to kind of give us a brief overview of what we're doing in Hollywood right now.
>> DR. MARIA FUNK: Sure. So I think people are aware one of our innovation projects was the TRIESTE Project in the Hollywood Area, but, you know, really due to the pandemic, that project has been delayed. So we're pivoting to work with a church in Hollywood to do some innovative housing there for people who really have the most serious mental illnesses. The project that we're doing has two different phases. One is working with them on opening a spring refuge, again, for people who have very serious mental illness, but perhaps grave disability in the Hollywood Area. That's actually open already. It opened, I think, about a

week ago and they're working with our home team, our homeless outreach team, to identify clients in the Hollywood Area to move in there, and clients have already moved in.
The second phase is looking at using a parking lot that they have to develop a pop-up village, which would have innovative housing. Again, that would have the same tenants as TRIESTE and creating community and having different types of housing that would meet the needs of different people. So that is still a work in progress, and we will keep people updated as it moves along.
>> GREG POLK: Thank you, Dr. Funk. Next slide, please. This is kind of work through the WET program, which is the Workforce Investment and Technology fund. I'm going to have Debbie, Dr. Debbie Innes-Gomberg to give kind of an overview of this.
>> DEBBIE INNES-GOMBERG: Thanks, Polk. Of course, education and training is really a key infrastructure component of the Mental Health Services Act. And I just wanted to highlight one particular program, and that's the use of MHSA WET Regional Partnership Funds. We put in three million dollars to get $10 million from the state to be able to do in loan repayment program which had historically been very well received and very much appreciated by people that work for the department or our contractors who could really benefit from loan repayment. So I'll kind of stop at that one. I think you know the WET programs, we've had these for many years, so I'll defer to the next presenter.
>> GREG POLK: Thank you, Debbie. And the last two components that we're going to talk about is our capital facilities and our IT. So I'm bringing Jo Ann to talk about the capital facilities.
>> JO ANN PINEDO: Thank you, Mr. Polk. Good afternoon, everyone. Wanted to go over a very briefly a high level overview about the restorative care village programs. In 2017, the Board of Supervisors approved the concept of the restorative care villages to provide a continuum of care on county healthcare campuses. And in an effort to make this vision a reality, we are currently in processes of building these facilities on the LAC USC campus, the [Indiscernible] Campus, Rancho Los Amigos, and High Desert, as well as the MLK Campus. So at LAC USC, we're going to have 64 Crisis Residential Treatment Program beds as Dr. Ruiz had mentioned earlier. At the [Indiscernible] campus, we'll have 80 Crisis Residential Treatment Program beds, as well as a new outpatient center and an urgent care center that will be relocated from its current location about two city blocks away onto the hospital campus. At Rancho Los Amigos, we'll have 80 Crisis Residential Treatment Program beds on the High Desert Campus. We will have very shortly a mental health urgent care center for both adults and adolescents. And last but not least, on the MLK Campus, we have repurposed the Old King Luther Hospital and transformed it into a behavioral health center and that will have 16 Crisis Residential Treatment Program beds, 32 puff beds, 16 for adults, 16 for adolescents, 48 MHRC beds, 32 will be dedicated to justice and all clients editable and it also has an outpatient center that will be relocated from the Hopkins Building. And the urgent care center will be relocated from the Ted Watkins Building, as well as a Peer Research Center. And I will turn it over to the next presenter. Thank you.
>> MIRIAN AVALOS: Okay. Good afternoon, everyone. This is Mirian Avalos and I'm going to just quickly go over a couple of the initiatives that we have in DMH for IT. We currently do not have any MHSA funded IT projects, but there are a couple that are very important to the delivery of services. One of them, obviously, as a result of COVID, we pivoted to develop a comprehensive virtual mental health delivery system. And so the technology has been in play for about a year and it has helped with

providing services in close facilities, such as cares, probation camps, and shelters. And so it also -- one of the things, one of the benefits of this program is that it has been key and instrumental in helping some of the disparities that we have across the network, especially making sure that we're able to provide language services across L.A. County.
So the second initiative that is -- that I'm going to be highlighting is the iPaaS, and that's an integration platform, its a service, and that's moving, as a result of the federal final rule legislation ,we're moving towards a different platform that's going to enable us to be -- to have interoperability and capture data. And that's critical so that we're able to present data in a much more granular level as Doctor Cooperberg and Dr. Funk talked about in some of the initiatives that we have. So being able to provide demographic data in a much more granular level and for all our communities is critical.
And finally, one of the key initiatives that the next percentage is going to be talking about is the access to center modernization project. And that's something that IT is supporting the programs on.
>> JENNIFER HALLMAN: Thank you, Mirian. I'm Jan Hallman and I want to present on the call center modernization, which Dr. Wong mentioned earlier. We're asking to shift funding which would be necessary to engage with a consultant to assist us in modernizing our antiquated call center. The goal would be that the call center becomes really the hub of accessing care throughout L.A. County. They would have the ability to provide information, make referrals, schedule appointments directly, and also provide warmline and crisis response services. With this technology, it would assist call agents by being able to provide efficient services and reducing the number of software applications that the agents have to use in order to provide the best care to the caller. The call center modernization technology would also allow for integration with other systems outside of our system, such as law enforcement, so that we can better assess triage and screen crises across the community. And then it would also integrate that technology with our direct service providers so that we can reduce time to care and maximize service capacity and improve coordination of services across our mental health system. And then lastly, I just want to point out that the technology will also be used to develop self-service capabilities and alternative access points designed from feedback from the community in order to meet the needs of the community. And with that, thank you. And I'll pass it back to Mr. Polk.
>> GREG POLK: Thank you, guys. Madam chair, that kind of wraps up our presentation. I'd just like to say thank you to all the DMH staff that's been involved in this whole process. It's been a tough process, but a favorable process and a good process. And I just want to say thanks to all my staff and all the DMH staff that's been involved.
>> CHAIR WEISSMAN: Thank you. Thank you very much, Greg, and DMH staff leads. I have to say that this is probably the fourth time that commissioners have been able to engage with the MHSA Plan. So we've seen it in various iterations as it made its way towards this more perfect document, and it's gotten better every time. And I really appreciate all of the work that you've done throughout the process. Each of your staff leads to be responsive to commission feedback, to stakeholder feedback that comes in online, but also through the Community Leadership Team and the SALTs and the UsCCs. Thank you for being responsive to all of that. Also, I want to comment that this has been such a pleasurable meeting in a virtual setting compared to some of our past meetings as the commission. So thank you so much to the DMH IT team. John Flynn and Julio, thank you for pulling out all the

stops to make this a really easy breezy experience, at least from my perspective. So I very much appreciate that. I'm glad we have the splash screen up that has the public comment called in line now because it's time now that we shift from the presentation to the public comment period of our agenda. And so you're all welcome to call in and make a one minute public comment. If you're speaking in another language, we'll provide two minutes for extra time for translation, interpretation and the call-in numbers for English are +1 (877) 336-4436. And I just missed that screen somehow.
>> JOHN FLYNN: Apologies. Hang on. I'm playing cards here.
>> CHAIR WEISSMAN: I can, I can not imagine what's on your screen, John Flynn. And the access code for the English line is 6946369. For Spanish, it's (888) 204-5987. And the access code is 9639884. So I will turn it over to our AT&T Moderator, Roxanne, if you would recite the instructions again for people to get in queue, to make a public comment.
>> AT&T MODERATOR: Certainly. Ladies and gentlemen, if you wish to make a public comment, please press 1, then 0 at this time. Again, please press 1, then 0.
>> CHAIR WEISSMAN: And we can go with the first caller.
>> AT&T MODERATOR: And at first caller comes from the line of Osby Sangster. Please go ahead.
>> OSBY SANGSTER: Good day. My name is Orby Sangster, the feedback loop, the Black Los Angeles County Client Coalition Advocacy Efforts. We are extremely concerned with the addition of chronic homelessness and urge inclusion to reestablish the Los Angeles County Mental Health Services Act Housing Trust Fund in the interim to address immediate needs and expansion economically, less cost, rapid housing solutions for the greater Los Angeles County, priority investment in Housing Trust Fund. We must do better to achieve short and long-term goals and to provide the supportive services and operational expenses related to immediate instant housing units, such as building up structure, renovation, restorative rehabilitation sites, conversion, prefabricated, and modular units. How can we better serve and support homelessness for marginalized consumers and families, the need for supportive housing projects for individuals with mental illness --
>> JOHN FLYNN: Time.
>> CHAIR WEISSMAN: Thank you, Osby. I'm more than challenged to fit all I want to say into the one minute public comment period when I call into other meetings and so I know how it feels. If you'd like, you're always welcome to send an email to our commission email address and we'll all get it, all commissioners will get it. The commission email address is at the bottom of the splash screen as well. It's MHcommission@dmh.lacounty.gov. Okay, Roxanne, next caller, please.
>> AT&T MODERATOR: Again, ladies and gentlemen, if you wish to make a public comment, please press 1 then 0. Again, press 1, then 0. And at this time there is no one in queue.
>> CHAIR WEISSMAN: Okay. I think I find that hard to believe. So I'd like to give it a beat and maybe troubleshoot how we might be able to get some callers in. There are only five --
>> AT&T MODERATOR: Excuse me, I'm sorry. We do have one person who cued up, and that's from the line of Anna Anita.
>> ANNA ANITA:Hello, everybody. I am speaking from Skype by the way. And so I'm not on the phone at this moment, very challenging, but I managed. So my question is in regards to the board, there's several things, but one of them -- of the plan is needing to have data on diagnosis. I see that as there was a lot of effort on culture and racial demographics, it's missing the data on diagnosis, like who has anxiety,

who has severe mental wellness. You know, that's very important to put where the budget goes. And the other thing is missing on this budget, I didn't see anything about oversight and accountability. Is there a budget for oversight and accountability of all these funds are being invested? And the last thing I want to say is about technology and innovations to have feedback from the families, with a website where the families can afford reviews -- contracted facility.
>> AT&T MODERATOR: Certainly. And again, ladies and gentlemen, if you wish to make a public comment, please press 1, then 0. Again, please press 1, then 0 to make a public comment.
>> CHAIR WEISSMAN: Thank you, Anna. And Anna, we did also get your email with all of the comments in fuller format. So we have that to sift through. And I encourage folks, if you're interested in joining to make a public comment, you do need to call into our AT&T phone line. The number is on our agenda and it's also on the splash screen. And so I invite Roxanne. If we have other callers, let's go to the next.
>> CHAIR WEISSMAN: And we do have a comment, I believe from our Korean language line, which we would be welcome to hear now as well.
>> PASTOR NAH: Hello, everybody. I have sent something to the commissioners through email. I wonder if you have received that. What I propose in that content is that we establish a dedicated team for each language. One of the examples might be a Korean team in order to provide an integrated approach to prevention to discharge. And what I've been hearing is that it takes as much as two, three hours in order for the PMRT team to connect peers or clients to different beds. And I think in line with what we talked about modernization, I feel that we need to act faster for PMRT to connect clients to beds available. Thank you.
>> CHAIR WEISSMAN: Thank you very much. Thank you for those comments. Is there anyone else calling in on the Korean language line?
>> JOHN FLYNN: Madam chair, I wanted to check in. We're getting comments in the Webcast Q$A, which nobody inside this meeting can see, that people are saying that the AT&T line is locked. They call the number that it says the meeting is locked. I am trying to call. We have double checked the call-in number and it seems to be correct. We've fed the call-in number into the Q&A for our Webcast. So I'm wondering, AT&T is there -- is it possible that somehow the queue is locked?
>> AT&T MODERATOR: I am double checking with our technicians. I don't think so, but we're double checking. It'll be just a moment. All I can do is encourage people to continue to dial into the number.
>> IMELDA: John, this is Imelda. I'm also getting text messages that people cannot get in.
>> JOHN FLYNN: All right. So I think if I know her well and I do, I think Brittney is trying -- is doing a proof of concept here, she's checking to see if she can get in. So let's pause for just one moment.
>> IMELDA: I'm doing the same thing.
>> JOHN FLYNN: Commissioner Dagleish is saying, reporting, it says "locked by commentator." So we've had a couple of people get through, but we're getting reports of at least six or seven people who would like to comment who are not able to get through.
>> CHAIR WEISSMAN: Okay. And for me, it's just on the hold music without any mention of what's going on.
>> JOHN FLYNN: And when you press 1 and 0?
>> CHAIR WEISSMAN: Oh, no, you can't -- I can't get to the part where you would press 1 or 0. It's just the whole music.
>> AT&T MODERATOR: Again, this is the AT&T operator. I do apologize. We are getting operators on the line right now. I'm not sure what happened, but we are getting people on to answer those lines.

That'll be just a few moments.
>> CHAIR WEISSMAN: Okay. No problem. You know, we have quite a bit --
[Overlapping Speakers]
>> JOHN FLYNN: Go ahead.
>> CHAIR WEISSMAN: Business even if we wait to work out the technical difficulty and take public comment in a minute. We have plenty of business to discuss in the meantime. So let me know kind of an ETA for the fix, if you have one.
>> AT&T MODERATOR: Thank you. And in the meantime, I do have someone who has queued up for a question. Can I go ahead and announce that person?
>> CHAIR WEISSMAN: Yes, please.
>> AT&T MODERATOR: Okay. Perfect. One moment. So Hector Ramirez, your line is now open. Please go ahead with your question or your comment.
>> HECTOR RAMIREZ: Thank you. Good morning. This has been a very difficult and burdensome process to engage that -- I've been locked up. So this is true. It was just frustrating. So I want to make my comments. And this particular budget doesn't reflect the interests or the recommendations of the Latino community. So Latino UsCC brings forward, again, some recommendations. One really is to review and implement funding recommendations presented by members of the Latino UsCC, which is represented at the marginal services oversight commission. They have an essential and County Board of Supervisors for all UsCC, Access for All, CLT meetings, mental health committees and a special Spanish MHSA listening session that we have this victim. Number two, ensure that the kind of recommendations follow the equitable distribution of funds for services, training facilities, et cetera, for Latino communities, which have been significantly impacted by COVID-19. And, you know, we do need to increase more oversight funding, particularly we would like to request oversight and accountability of all NAMI LACC, NAMI San Fernando Valley Programs.
>> CHAIR WEISSMAN: Thank you. And Hector, you are so awesome and you were speaking so fast that I'm not sure everybody picked up everything you meant to convey. So I do encourage you to follow up your public comment with an email to our email address, which is MHcommission@dmh.lacounty.gov. And Roxanne, can you tell me just a little bit about what would -- what the time is to resolve the issue, maybe?
>> AT&T MODERATOR: Actually the participants who are waiting are now on. So again, ladies and gentlemen, if you wish to make a public comment, please press 1 then 0 to put your line in queue. Again, press 1, then 0 to make a public comment. And we have our comment from the line of us. Esiquio Reyes, please go ahead.
>> ESIQUIO REYES: Hi. My name is Esiquio Reyes. I was wanting to bring out an issue that I've been on the forefront with, which is helping the homeless. A lot of them in cottage style housing units have been relaying that they're being -- that there's nothing to do. And I'm going to try to see about advocating for internet service for them so that they can get connected, stay connected with family members, with health -- telehealth that they have going and other things like going back to school. There's many different things that can be utilized for them having internet service at these cottage style units. A lot of them, like I said, are people that just need a little bit of help and then that they can get back on their feet and this will help them with that trying. Thank you.
>> CHAIR WEISSMAN: Thank you, Esiquio. And I do have confirmation

from some others that the lines are open now, too. So please dial in to make a public comment in the English line or the Spanish line. We'll also go around and check for Korean language public comments as well. And you have plenty of time to call in. We'll be here for minutes, at least 10 minutes. I'm sure. So don't leave us. Okay. Roxanne, next caller please.
>> AT&T MODERATOR: Yes. And that comes from the line of Kelly O'Connor Kay. Your line is open.
>> KELLY O'CONNOR KAY: Hi, my name is Kelly O'Connor Kay, I'm the executive director of Maternal Mental Health Now. I'm calling to request that the [Indiscernible] prioritize perinatal mental health. In other words, the mental health of a pregnant or postpartum person, that's the child's second birthday. The COVID-19 pandemic has exasperated perinatal and anxiety disorders, and the recent tragic [Indiscernible] demonstrates the catastrophic consequences of these concerns when they go and address. I'd like to make three proposals: end up training and treatment options that are perinatal anxiety disorders for a small cohort of clinicians within each service planning area. So that would be in California Medi-Cal patient who's suffering, we know exactly where to refer them to. Funding specifically for individual and group therapy, targeted case management and supervision and coordination of the program. Linking clients to other services within DMH and other county agencies, such as DHS and substance abuse, and finally funding for intensive perinatal inpatient and outpatient program. Nothing like this exists in the county for the population. And it's very, very challenging to get a new mom --
>> CHAIR WEISSMAN: Thank you, Kelly. Roxanne, next caller, please.
>> AT&T MODERATOR: Our next caller comes from the line of Carmen Perez. Please go ahead. Your line is open.
>> CARMEN PEREZ: Hi, commissioners, this is Carmen Perez, SALT 4 co-chair. And thank you so much for having this public comment. And thank you DMH for representing. For me it's more of a question. I received that budget for the MHSA, and page 162, where there's a summary of the budget. I just had a question in regards to the rollover amount of expenditure -- of funding, I mean, where it's a lot of money being rolled over every year, like hundreds of millions of dollars being roller over every year. And my question is, why so much money being rolled over every year instead of putting that money towards programs and other initiatives? And another question that I have too on page 164 of the proposal is this stigma discrimination reduction program. I believe that budget is very low. It's under the PEI category. And I'm just wondering why that funding is so low, and whether we could probably do more towards stigma reduction. So that's pretty much my question and to the rollover amount.
>> CHAIR WEISSMAN: Thank you, Carmen. Roxanne, next caller.
>> AT&T MODERATOR: Certainly. And again, ladies and gentlemen, if you wish to make a public comment, please press 1, then 0. And our next comment is from the line of William [Indiscernible]. Please go ahead.
>> WILLIAM: [Indiscernible].
>> CHAIR WEISSMAN: Thank you very much, William, for speaking up on that point. AT&T moderator, next caller.
>> AT&T MODERATOR: And that comes from the line of Pete Thompson. Your line is open.
>> PETE THOMPSON: Yes. I think post-traumatic stress disorder and childhood sex abuse is a very common difficulty in mental illness. And it's not like to admit it happened is not like forgiveness is not possible. I think it's -- there can be conflict in families where the person shows underlying --the victim shows underlying symptoms of anger and then

the family is worried whether they're going to grow up and want revenge on them and they need to -- there needs to be calm -- and there needs to be an attempt to show you a peaceful and that you don't want revenge and to wake up. Thank you.
>> CHAIR WEISSMAN: Thank you, Pete. AT&T moderator, next caller, please.
>> AT&T MODERATOR: Certainly. And that comes from the line of Natalie Olsen. Please go ahead. Your line is open.
>> NATALIE: Hello?
>> AT&T MODERATOR: Natalie, your line is open.
>> NATALIE: Okay, I couldn't hear. My turn?
>> AT&T MODERATOR: Yes.
>> NATALIE: Okay. My name is Natalie and I'm a stakeholder.
>> CHAIR WEISSMAN: Go ahead. Natalie, are you there? Natalie?
>> AT&T MODERATOR: And it looks like Natalie just dropped off. So we'll go on to the next presenter, and that will be Paul Stanbury. Please go ahead. Your line is open.
>> PAUL STANBURY: Good afternoon. Thank you for the opportunity to comment. I want to, for the SALT co-chair, appreciate the efforts of the Department of Mental Health and Mental Health Commission to help inform our SALTs on the MHSA process, and I'm hearing all the great work being done. We're very appreciative of that. We have the MHSA funding and we got happened. I'm concerned it's all I recommend or commend Dr. Rodriguez, on terms of the comments, probably concerns is how do the strategies that we're seeing in terms of the SFP transformation, the community-based initiatives, the efforts in terms of addressing the technology address, some of the comments we have, and feedback we have from the SALTs in our SALT. This was a comprehensive county-wide concern. I'm sort of concerned, how do we really see them happening in our service area is more a looking forward type of comment. Also, we know one of the big concerns at our SALT was the --
>> CHAIR WEISSMAN: Paul might've gotten an emergency alert because I just got one too. So let's give him a couple of seconds.
>> PAUL STANBURY: Thank you very much.
>> CHAIR WEISSMAN: Thank you, Paul. And the last few, maybe comments you were making fell off of the line because I think we're all getting an emergency alert on our cell phones. So you're welcome to submit the final thoughts by email to our Mental Health Commission email address. I wonder also if we have any colors on the Korean language line, I wanted to check again.
>> PASTOR NAH: Yes, I do have a comment. I was wondering if we can come up with a manual about addresses 911 information as well as a 72-hour hold and information on getting discharged from hospital and what you do from that point on. And if we have these manuals in different languages, I think that clergy members, as well as caregivers could utilize and people could more readily access DMH mental services. And another thing that I was thinking of is doing a survey for different cultures, cultural groups, and different language groups so that we can find out what the current actual status is among the different cultural groups and language specific groups. I wonder if the MHSA 3-Year Plan can address that. Currently, my understanding is that the most heavily targeted age group is from 26 years old to 45 years old. And I think it be wonderful if we could conduct a survey to find out how they are impacted in that group for Korean language group and what kind of language access difficulties that Korean people or others that we could do about it.

>> CHAIR WEISSMAN: Thank you, Pastor Nah. Thank you very much. And I'd like to go over to the Spanish language line. Are there any callers?
>> ALEX: Good afternoon. Yes, we do have two comments. The first comment that we have is from Moreno from the SALT 2. She said there should be more bilingual clinicians on the clinics operated by the county, because what is happening right now is it's taking about three to four weeks until the psychologists or the psychiatrists see the patients. So she is recommending to put more bilingual clinicians, English and Spanish in the clinic operated by the county. And also there is another comment by Joanna Lozano. Let me ask her about her comment. Give me one moment. Okay. Give me one second.
Okay. Joanna Lozano, she lives in East Los Angeles and why she's requesting is that we should have a copulated data about the different age groups and then we can compare and contrast every year. Because what happened is that when we get the data from the kind of the clinics, the data that we have is just from one to 18 years old, but also in that category, they all show that their case is included. So how can we compare where they are two different age groups? Okay. And also I think that we should have short and long-term goals so we can compare and see if the programs that we implement are working. If they are not working, some then we have to change it because not what happened is we are guests just spending money and we don't know -- and if they're not working, we should go and ask the community what they need or wanted. Okay.
>> CHAIR WEISSMAN: Thank you, Alex. And thank you to the speaker. And I want to let you know that we're also receiving comments into our email address. So I appreciate everybody who's sending in a written comment to our email address. We'll be getting those shortly. Roxanne, are there any other callers on the line?
>> AT&T MODERATOR: Yes, there is actually, and we have one from the line of Rick Pulido. Please go ahead. Your line is open.
>> RICK PULIDO: Good afternoon to all the commissioners and --
>> CHAIR WEISSMAN: Rick, go ahead.
>> JOHN FLYNN: I think actually our AT&T line just got muted. AT&T, could you “*6” and start Rick Pulido again, please. Roxanne, AT&T operator, your line is muted right now. As I mentioned at the top of our dial star 6. And there you go. And I believe Rick Pulido --
>> CHAIR WEISSMAN: Rick Pulido, your line is now open. Please continue.
>> RICK PULIDO: Okay. Hi, can you hear me now?
>> CHAIR WEISSMAN: Yes.
>> RICK PULIDO: Oh, right. Thank you. Good afternoon to everybody here with the honorable commission and also to DMH and to our Board of Supervisors, I hope some of their -- had their secretaries and their staff who are listening. This is a very engaging interaction meeting at this point on public hearing now. I just would like to say a couple of points. One. I agree with Dr. Paul Stansbury on the initiative issues, community based. I'd also like to include that I don't see anything MHSA regarding the, [Clears Throat] excuse me, the holistic treatment approaches. We just had a great doctor [Indiscernible] speak to us the other day in one of general meetings with NAMI. And I think this is the wave of the future. I know Dr. Sherin has talked about it with TRIESTE and with a few of these initiatives, but this has to be put on a top priority, along with DEI - Diversity, Equity, and Inclusion. We showed that throughout this whole county -- SALT should have a DEI initiative going on. Lastly, I did want to say --

>> CHAIR WEISSMAN: I'm sorry, Rick, to cut you off. If you want to add additional points, please do email them in, but we did hear you on the points you made.
[Background Noise]
And for John Flynn and crew, I do think there's somebody maybe in our meeting or their line is open.
>> JOHN FLYNN: You are correct, Madam Chair. There's a 323. We don't know who it is. Excuse me, if you are a member of the public, the comment line goes through AT&T. I've asked our assistant to drop that call. I'm not sure how that number got out there, but apparently several people got the little secret number for AT&T.
>> CHAIR WEISSMAN: No problem. Okay, let's go back to Roxanne. Any further callers?
>> AT&T MODERATOR: Certainly. If you wish to make a public comment, please press 1, then 0. And we do have a comment from the line of Natalie Olsen. Your line is now open.
>> NATALIE: Okay. So my name is Natalie and I'm a stakeholder. I believe we need to set goals and reevaluate if they work. And also it's concerning that one trillion -- let's see, one trillion unspent funds. Let's see. And then we need to set some short and long-term goals and report where the DMH reached it. If it didn't, they must incorporate stakeholders and the community being served on pollution, plus reevaluate short-term and long-term goals. There are over a trillion unspent funds and we've yeah, yeah. Anyway, that's it.
>> CHAIR WEISSMAN: Okay. Thank you. And AT&T moderator, Roxanne, just so you know, it's one public comment per line. So each caller is welcome to make one public comment, but they can't get back in line and continue to make public comments. If they'd like to state more, they're welcome to email us. We can take the next caller, please.
>> AT&T MODERATOR: Again, if there's any public comments, please press 1, then 0. There's nobody in queue at this time.
>> CHAIR WEISSMAN: Great. And can we check the Spanish language line? Alex, is there anyone with you?
>> ALEX: I'm asking. At the present time, no.
>> CHAIR WEISSMAN: Okay. And the Korean language line, anyone else?
[No Response].
Okay, I believe that's the conclusion of our public comment period. I'll give it a beat to make sure that we have no new callers on who are interested in lining up for the first time.
>> AT&T MODERATOR: And you have Barbara Wilson in queue. Do you like to take that one?
>> CHAIR WEISSMAN: Yes, please.
>> AT&T MODERATOR: Barbara, your line is open. Please go ahead.
>> BARBARA WILSON: Thank you. Can you hear me?
>> CHAIR WEISSMAN: Yes.
>> BARBARA WILSON: So I thank you for the opportunity to speak. I just wanted to support the proposed changes for boarding care homes, recognizing the important contributions that they make in helping to prevent homelessness and as a part of the continuum of housing options for people that have serious mental illness. And I also wanted to just support the change -- proposed changes for the FSP programs. Thank you so much.
>> CHAIR WEISSMAN: Thank you, Barbara. Okay. Roxanne, you can stop me if there's anyone else on the line.
>> AT&T MODERATOR: At this time there's no one in queue.
>> CHAIR WEISSMAN: Thank you. Okay. Well, that really does

conclude then the public comment period of the MHSA 3-Year Plan update. Let us now turn to the commission. So if you're a commissioner, please turn your camera on. What we'll do is we're going to be discussing the plan and the public comment, and we'll have a chance to engage now with department staff who presented to us today, if we have questions, et cetera.
And if you recall, John Flynn let you know how to do a large gallery view so you can see all of us who have our cameras on all at the same time, if you're able.
>> JOHN FLYNN: And I will be sharing that view with the audience so they'll be able to see everybody who's got their camera on, including our wonderful ASL interpreters.
>> CHAIR WEISSMAN: Awesome. And John, I mean, really, it's such a different experience today than all of the prior meetings, at least for me, and I am so appreciative.
>> JOHN FLYNN: I'm very happy to hear that.
>> CHAIR WEISSMAN: So let's go. If you don't mind, let's go to the question. So I know, you know, for instance, Commissioner Cooperburg, she had a question during the presentation, but we didn't stop for it. So everyone take out your notes from your pad, paper, and let's go through one by one. And we'll go, again, through the districts like we always do. And let us start with our district, Judy. So go ahead with your questions. [No Response]. And somehow I just lost you, Judy. Are you there? John, is Judy on?
>> JOHN FLYNN: Checking for Commissioner Coopersburg.
>> CHAIR WEISSMAN: Okay. And then I guess we can check Greg Polk. Is he -- is your crew here and with us?
>> GREG POLK: Yes, they should be still here. Yes.
>> CHAIR WEISSMAN: Okay, very good. And we do have Commissioner Stevens on the line. She is joining us by phone only, and she is present.
>> JOHN FLYNN: So I want to instruct my staff, please do not reject the 323 number. I think that might be Commissioner Stevens. You were getting a lot of background noise from that.
>> CHAIR WEISSMAN: Oh, gotcha. Okay. Well, why don't we start at the other end of the spectrum. We'll go with the first district and we'll take questions from the first district and then work back to five. So Padilla-Frausto and Friedman, those Commissioners, if you have any questions for Greg Polk and team.
>> COMMISSIONER PADILLA-FRAUSTO: Yes, I do. So at first, I just want to say thank you to all the staff who worked on this 3-Year Plan. It's a beast. I know, and I know working on revisions can be a nightmare and I just want to applaud you all for pulling this piece together in a very wonderful and inclusive way. So that's the first thing. And I did want to say a huge thanks to Debbie for the data on disparities and inequities. I'm also a data geek, so definitely appreciate that data. And there was one thing that -- there's a few things that I wanted to just clarify on some of the data on disparities. And that's I think drawing out the -- in the text maybe of like what you presented in the presentation, I thought that was very helpful, Debbie, to really highlight what is it that we're looking at and what's the important pieces. For example, in the homelessness disparities chart there was text in the 3-Year Plan that kind of grouped the over-representation and under-representation together for several groups. And I think there's two different things going on in that graph. One is that there is an over-representation of homelessness among Black African Americans. So that's like the first piece, like we really need to highlight that, and that there needs to be efforts to address and

prevent this over-representation. The second piece of that was showing the proportion, the percentage of those who were homeless and percentage who are receiving services. And what you see there is that the Latinos are actually under-represented in the amount of services that we receive. So I think there needs to be explicit -- that needs to be the word explicitly, that that needs to do that services for the homeless Latino population needs to be addressed and insurance has increased. So just trying to tease apart some of those things that we're seeing in those graphs, I think would be really, really helpful and then tying it to, you know, what is, you know, what will the Department of Mental Health do to address those things? So I'm really happy to see that. And let's see.

Some of the other things that I was really happy to see was the inclusion of discussion around social determinant and social inequities. And, you know, I wholeheartedly agree with you all in your statement about this can't just fall solely on the Department of Mental Health, because that would be impossible. But I'm wondering, are there plans to work with other departments to address the social determinants and social inequities? You know, this does have to be a statewide federal effort. But I'm just wondering, is there -- are there plans?

>> GREG POLK: Yes. Yeah, this is correct. Well, I can answer that. There's plans to engage other departments within L.A. County, but also in other jurisdictions as well, connect the federal and state level also.

>> COMMISSIONER PADILLA-FRAUSTO: Okay. I would like to just see that in the 3-Year Plan of just what those plans are, even if you don't know exactly what they are right now, but just, you know, what are you envisioning? And then the third piece is, again, thank you, Debbie, for identifying the racial and ethnic disparities among the API and the LatinX communities. And I really appreciated tying, you know, that data with, you know, what you're going to do for the API community. What I didn't see is how are the disparities through the LatinX community going to be addressed? So I would like to see more in the 3-Year Plan around those efforts as well. I know the LatinX UsCC submitted some recommendations in particular for immigrant populations and undocumented. So as much as you can, I don't know if DMH collects this kind of data on immigration status or citizenship status, but I think if you do, it'd be great to see that data. And if not, it would be great to start including that data collection. I'm also really, really happy to see the repurposing of the constant INN funds for the prevention and early intervention Community Ambassador Network, really happy to see that there is another 197 positions. And the MHSA 3-Year Plan, it talks about them providing resources. And I'm just wondering what type of resources will they be providing, and will they be addressing some of the social determinants? And --

>> GREG POLK: Just answer that question, I would say, yes, that's the intent.

>> COMMISSIONER PADILLA-FRAUSTO: Okay, great. I'm really happy to see that because it does help. I work on promotoras project that actually train them as mental health practitioners and they worked with the clinicians and they worked on the social determinant side, while the clinician worked on the medical and therapy side and it was -- it was a really big program.

The last piece that I want to talk about is with all of these great programs and great things that you guys are doing, I'm just wondering, are there plans to collect data? I think several of our public commentators have talked about, you know, short-term and long-term goals, what's the evaluation piece behind these programs and services, will you be

evaluating them? Will they bring, I'm sure you guys do quality assurance, are there more efforts, you know, to gather more evaluation data and patient satisfaction data and trying to train about that so that, you know, you're seeing what those outcomes are, or our efforts towards these programs really improving outcomes? If not, how do we switch it up so that we continue moving that forward?
>> GREG POLK: Debbie, do you want to respond to that?
>> DEBBIE INNES-GOMBERG: Absolutely. Yeah. You know, one of the things we haven't done that you raised that we will do in the future is incorporate our twice a year consumer satisfaction survey results into the, either the annual update of the 3-Year Plan. And it makes perfect sense to do that. And I just went over the results of the most recent survey, and even in 2020 is, as bad as 2020 was, we actually got -- we got an equivalent amount of clients responding to this survey which was mostly electronic and not in person on paper. And the results were actually better. People were more satisfied with services. They were more connected with family. They were more connected with clinicians and it was -- that was very gratifying to see.
The second thing is and we haven't talked much about this, but we now have a contract with a Gallup Company to administer the Gallup Wellbeing Finder for sampling of consumers, adult consumers, across our system of care. And this will actually be the first time that we will have one measure, at least for adults, that measures a client that's in FSP or in PEI or any of the, you know, work plans. Anybody who's receiving a direct mental health service will have an opportunity to be able to the answer the Gallup Wellbeing Finder, and then we'll be able to report out on that. And I think that will also track progress over time for a consumer. So I hope that's helpful.
>> CHAIR WEISSMAN: Okay. And I know we have Commissioner Friedman who would like to make a question or comment, and just in terms of laying out the rest of the meeting here, we're discussing Q&A with the department staff, but then the real output of our meeting should be -- let's or recommendations or starting place for recommendations that would need to go from us to the board. So that's really where I'd like to make sure we have some time. I also want to note that we lose Commissioner Molina at 1:30. So after I asked Commissioner Friedman for her comments, we'll move over to the fourth district for Q&A. Susan, go ahead.
>> COMMISSIONER FRIEDMAN: Hi, I have one question. There were several mentions by several people about the new call center. So I'd like to know when the new call center will be in operation. You talked about people being able to schedule appointments. You spoke about something about technology, and I'm wondering is the call center going to require that people have certain technology and just what is the status of this call center? Because it is the heartbeat of what's going to happen in the future.
>> GREG POLK: Do you guys want to respond to that?
>> JENNIFER HALLMAN: I can respond. So there will be no additional technology requirements on people who call, I believe it's still going to be all done by phone. Although we are looking at other technology that if somebody wanted to turn it to chat in or to request services, we're looking at those alternative capabilities for somebody who would want to use those. And then we're also looking at capabilities that if you call and you get an appointment asking a communication preference, so we could send you a notification in whatever form that you may like, such as email or text message. But we're trying to make it as available as possible to callers.

>> COMMISSIONER FRIEDMAN: Okay. But when will the new call center be operable?
>> JENNIFER HALLMAN: So we are looking and hoping for it within the end of this calendar year, but we're working. Part of this is to bring on a consultant who's going to help build out all of that technology. So we won't have a definitive timeline until we bring them on.
>> COMMISSIONER FRIEDMAN: So for the moment now, what do we have?
>> JENNIFER HALLMAN: At the moment, it is still, if you call, then we will make a referral and get you connected to a clinic where they will contact you and provide an appointment. We are also actually implementing a -- we have a pilot going on right now in Service Area 3 where for hospital discharges, the hospitals can call and directly get an appointment. So we're kind of testing it out in a small pilot right now.
>> COMMISSIONER FRIEDMAN: Okay. And how many people do we have? Like, for example, suppose somebody calls and it's an urgency thing, how many people do we have available to go out when it's an urgent situation?
>> JENNIFER HALLMAN: Dr. Ruiz is on and she can talk about PMRT because I think you're asking about PMRT dispatch capability.
>> COMMISSIONER FRIEDMAN: We did talk before about having these van, but I don't know if they ever got on the road or if they're still parked someplace.
>> DR. RUIZ: The therapeutic transportation vans, we are still waiting for the MOU to be signed. We're anticipating that that program will be starting soon..
>> COMMISSIONER FRIEDMAN: Okay. Thank you.
>> CHAIR WEISSMAN: Okay. Thank you, Commissioner Friedman. Let us go to now Supervisor Hahn's appointees, Patrick Ogawa and Mike Molina.
>> COMMISSIONER MOLINA: Hello, this is Mike Molina. Hi, everybody. I just, very quickly, relative to the plan itself, I have no questions. I'm commending you, Greg and your staff, you are doing a terrific job in the presentation. All my questions were answered through your side, so thank you. As well as to you Madam Chair, you're doing a terrific job navigating all of us. But relative to the plan itself, I have no questions.
>> CHAIR WEISSMAN: Wonderful to hear. Thank you so much. Commissioner Ogawa.
>> COMMISSIONER OGAWA: Thank you, Greg. I appreciate everything you did and putting into the plan. Very well done. I want to thank also Debbie for the data that you brought forward. I'm glad to hear that in the future, you're going to be looking at addressing the multi-ethnicity and the unreported issues. Those are going to be critical data pieces as we move along. The only thing I do ask Greg is maybe on the campus facilities, is there any possibilities of stating in there something about how flexible are the dollars in being able to access that? I know you mentioned county facilities and some of that stuff, but I'm just wondering, can the monies be used for other types of capital improvements? And what I'm aware of with this is expansion of beds.
>> GREG POLK: I think a lot of these dollars here that's funding some of the federal projects that we talked about is grant from like CHAFA, you know, from the state, there's a lot of state grant money here, but that money is obviously guardrail and specific for projects. I mean, there are projects, there are some funding that we allocate out of to MHSA, but it's really not for bids, right? We try to stay -- we try to get beds. And in other forms, in fact, I mean, that's been a lot of conversation with the CEO's office around CARE Act Funding around to fund their drive because, you

know, to be assessed required by report that we wanted particularly 1,200 to 1500, whatever it was, subacute beds. DMH will never be able to fund that. We just don't have a funding mechanism for that. So we're seeking all opportunities to provide that money, including so we can allocate MHSA dollars. We do.
>> COMMISSIONER OGAWA: But I would welcome your expertise on the mental health side to really look at an integrated model in terms of how we can provide more active services for the core population, not just for mental health, but those that have also healthcare problems as well. So that's kind of what we're going to be looking for, particularly within the criminal justice area I know. The other planning sites bring out a set. I'm very pleased with the updates on the API groups. I appreciate that. I know that many of them are listening now and APCON members are also aggressively coming up with some recommendations for us as we move forward. So thank you for that information. And it helps a whole lot in terms of moving forward.
>> GREG POLK: Thank you.
>> COMMISSIONER OGAWA: That's it for me.
>> CHAIR WEISSMAN: Thank you, Commissioner Ogawa. Let's return to Commissioner Cooperberg who has rejoined.
>> COMMISSIONER COOPERBERG: Yeah, I publicly criticized spectrum for their internet service and so they got back at me by taking me off.
I have two questions which I did. I was babbling to myself earlier, not knowing that I had lost contact. And I was brilliant before. So hopefully I can catch up to myself. Two questions and one comment. So someone in public comment has stated something and there's been a question over time during -- at the commission. So I just want to briefly make a statement about it. When Commissioner Molina and I met with some of the DMH financial staff a month or so ago, we had this epiphany with the disclosure of information about dollars being rolled over from one year to another and what was explained to us and Greg, I hope I get this correctly. What was explained to us was that some funding for programs are funded from anywhere from three to five years and so those dollars roll over to the next year to continue that funding. So that was an amazing thing for us to hear.
>> GREG POLK: Yes. That's correct. Right.
>> COMMISSIONER COOPERBERG: Okay. Okay, so I hope that answers that question for that individual who brought that up and also other commissioners who have brought that up before. So that was very comforting to hear that.
My two questions. In the changes in FSP, I'm sure a lot of agencies are very happy about the equitable salaries being proposed and lowering the staff to client ratios. However, lowering the staff to client ratios without any change in the funding source means that less people will be served by those programs. And so my question is, how is that going to be mitigated, especially when we have people waiting and clamoring to get into the FSP programs?
The other question I have is, with the change of the age groups for child FSP, 16 to 21, right now the adult programs are serving transition age youth 18 to 25. What happens to those individuals who may be 18, 19, 20, who are already in adult programs, receiving services? Are they going to have a choice in continuing with the agency if they're satisfied, or do they have to go back to a children's provider?
>> GREG POLK: Lisa Wong, can you respond to those?
>> LISA WONG: Yes, definitely. So let me respond to the age group question first, and that is for those individuals who are in FSTs already,

who are in that 18 to 21 category, they will not have to change. We really want to assure continuity of care. And even after this transition, if there is a clinical reason for somebody to stay in the program or to, you know, change once they turn 18, we will be working with the providers to do that. So we want to maintain flexibility, and we really wanted to have the capacity to look specifically at what each individual's needs were and not just give like these like super concrete categories.
Now, the other question was around capacity. So when we were kind of launching into this transformation exercise, one of the things we wanted to look at was the utilization patterns across, you know, all of our age groups. And what we found was, you know, there are two different things. There's utilization in terms of dollars, but there's utilization in terms of what we used to call slots or, you know, number of openings per program. So a provider would be allocated a number of slots let's say, but because of vacancies or other, you know, circumstances, they would never get to that capacity. So they would serve just a finite number of people with the staffing they had. But also what we noticed too, was a lot of our clients required a lot more hours and a lot more services than were anticipated when we came up with that 15 to one ratio. So those are kind of the two reasons why we decided to get rid of -- absolutely get rid of, but reduce the overall number of slots without reducing the capacity of the clients we're actually seeing and then reducing the caseload so it could better match the amount of service time actually required with each client.
So let's say like if we had 10 slots allocated to somebody, but they never used more than six, what happens is we use the funding budgeted in those four slots that they never used to add to reduce the case loads. So theoretically the number of slots are less, but there's no reduction in the number of people served.
>> COMMISSIONER COOPERBERG: Okay. So are all the agencies maximizing the old slots or --
>> GREG POLK: No.
>> LISA WONG: No. Almost none of them.
>> COMMISSIONER COOPERBERG: Oh, okay.
>> LISA WONG: And that's probably why you saw in like the yearly reports, you would see like 76% utilization for adult FSP. Well, it wasn't truly 76% utilization. It was 76% of the allocated slots.
>> COMMISSIONER COOPERBERG: Okay. Thank you.
>> LISA WONG: You're welcome.
>> CHAIR WEISSMAN: Commissioner Cooperberg, any others? Thank you. Let's move to Holly Mitchell's appointees, Carol Turner and Reba Stevens. And Reba, you're welcome to text me if there's something you'd like me to address for you. Otherwise, let's go to Harold.
>> COMMISSIONER TURNER: Okay. This is Harold. And, again, I want to thank Greg and his team. They did a wonderful job for presenting the data. I know a lot of work went into that. You know, we have, you know, work groups on the commission ourselves and we're working on in particular on disparities trying to understand, you know, what the effects of these COVID-19 and various other things in terms of disparities were. So there's a lot of data to plow through. So I really appreciate the work that you guys have put into it. I thank you very much for that. And I didn't really have many questions around that, but some things did occur to me during the presentation. I think across all the work groups we had on the commission and other places, our reliance on data. And I think that's the only going to increase. And I'm thinking how nice that would be if that -- if some training went into the SALTs and the UsCCs about how to get this data, and more importantly, creating some sort of dashboards to

track community health outcomes, you know, with real times sorts of data. You know, I saw, you know, UCLA is one of your partners in the work they're doing with what's called the California Health Information Survey, and the different ways that can be query. But I think it would be worth giving some thought to how we can put that capability, you know, into the SALTs and the UsCCs to come up with a finite set of queries maybe, you know, geared to tracking the areas that they deem to be important, you know, in their particular area. And we can do that real time and we wouldn't have to wait, you know, for this, you know, the report to come out every time to know where we are, but to have that, and maybe have somebody from one of our partners help develop these queries and create these dashboards for the community and have access to that information, you know, more real time and at least more regularly.
>> GREG POLK: Yeah, Commissioner Turner, that's definitely a great recommendation. It's something that we can take a look at. And like you say, we do work with UCLA and other universities to try to take advantage of some of the expertise that they have. That's something that we can take a look at, along with Debbie's shot.
>> COMMISSIONER TURNER: Yeah. Thank you. I just think there could be customizable from service area to service area because there are differences between communities sometimes in the things that we want to track and see how successful they're being or not being in and to know on more of a real-time basis when certain areas need to receive some attention.
>> GREG POLK: Fair enough.
>> COMMISSIONER TURNER: Yeah. And just wanted, again, thank you for a very comprehensive report. Good job to everyone involved. Thank you.
>> GREG POLK: Thank you.
>> CHAIR WEISSMAN: Thank you.
>> MARK KARMATZ: This is Mark Karm --
>> CHAIR WEISSMAN: Mark, I'm sorry. You're on the wrong line somehow. And I'm sorry, that's our fault that something you called in the wrong light, but this is not an open line for members of the public. This is simply for commissioner discussion. So we'll see you at the next meeting. And then I also want the commissioners to know that Reba Stevens is [Indiscernible] and she's thanking Greg and Debbie and their entire team for the good works. She also supports all of the comments of her fellow commissioners on this line. And John, if I got it wrong and that's not Mark Karmatz and if it's somebody else, please let me know.
>> JOHN FLYNN: I believe you were correct. And if you weren't, it's my fault.
>> CHAIR WEISSMAN: Okay. Okay. Thank you very much. All right, let us go. And Reba, you got a thank you very much back to you from Debbie Innes-Gomberg. Let us go to the third district. We have Stacy Dalgleish and Kathy Cooper-Ledesma if there are any questions or concerns for DMH staff.
>> COMMISSIONER COOPER-LEDESMA: I had one.
>> CHAIR WEISSMAN: Go ahead, Cooper.
>> COMMISSIONER COOPER-LEDESMA: Hi, I want to thank you too Greg and the entire team for a really thorough presentation. I just have one point of clarification. In the innovation section, I noticed that the presentation said -- I'm really excited about the innovation project at Hollywood Press that began last week, their spring refuge, and then the other village is going to come as a part of this. But I want to clarify that while this is a wonderful project, it is not the TRIESTE project. I want to

be really clear about that. I want to make sure I understand that.
>> GREG POLK: That's correct. That's correct. I mean, there's a pilot project that, you know, to the extent it's successful, we're looking to kind of now move it elsewhere, but that's not the true TRIESTE project in of itself.
>> COMMISSIONER COOPER-LEDESMA: And TRIESTE project is still to be post COVID. I just want to make sure that that's --
>> GREG POLK: I mean, we're having discussions about what to do with TRIESTE because of COVID, right? You know, and getting what's going on in Hollywood. So, you know, we haven't put that on the back burner, but there's a lot of discussion around how we move forward with the board offices around a TRIESTE project.
>> COMMISSIONER COOPER-LEDESMA: Right. Okay. Thank you very much.
>> CHAIR WEISSMAN: Commissioner Dalgleish.
>> COMMISSIONER DALGLEISH: Yes. Hi. Can you hear me?
>> CHAIR WEISSMAN: Yes.
>> COMMISSIONER DALGLEISH: All right. Good. I'm glad that Kathy brought that up because on, I think, it's slide 30 under the innovation projects. It has, in the Innovation 10 slot,TRIESTE, but with an arrow going to the Hollywood pilot. And I do think that there's been a lot of so much positive energy around the idea of the restorative villages that I think all of us want to make sure that we don't lose that.
But continuing with the innovations, Innovation 3 is something that has been discussed over the last several years. And I remember there was a discussion initially about how it would address, for example, SALTs being able to be present at meetings by innovation locations in the county and not having to drive down to our meetings. And so I want to be sure that we continue to think about how we can use Innovation 3 to reach more people.
And along with that, when I think about how well telehealth has come in to be an excellent service during COVID, and something that we want to be able to continue for people, we are only able to reach people through telehealth who have the capability of using that technology. And I'm unclear about how many of our friends and families who are unsheltered are part of receiving services from DMH, but I'm sure that it serves as a barrier if they don't have the technology to be able to take advantage of telehealth for their needs. And it's something that has been brought up before, but, you know, during COVID suddenly we lost the libraries which were providing internet capability to people who are unsheltered, and then we also lost the ability for people to even power those devices. So if we can think when we're looking at Innovation 3 and/or even in the other areas, I mean, I think that it also fits into prevention, for example, ways that we can make sure that we're getting that technology into areas where we have hot spots, where we have data that are able to utilize the telehealth and charging capabilities too such as solar chargers. I think it's something that we need to be thinking about for that group of our clients and our potential clients.
>> GREG POLK: It's funny that you mentioned that, you know, Dr. Sherin and I we've had a lot of conversations around that exactly right. How do we -- how do we get access to care to those people that don't have -- clients that don't have that ability to, you know, get on telehealth? You know, you look at the technology of the telephones, right. You know, mostly everybody they don't have anything else, they have a telephone, right? It's like, how do we tap into, you know, providing services, maybe through a telephone, through a watch, like Apple watches down. You know, we're thinking about innovation project strictly around that and

trying to see if we can put something together and do an integration project on it. So we've already kind of identified that as something that we want to attack.
>> LISA WONG: And Greg, can I speak too on what we've already been doing in the outpatient clinics, because it's really been a concern of ours too. And I'm not sure if you remember, I had mentioned that one of our strategies with our outpatient clinics is that we're trying to get through the entire caseload of every clinic, like the Keegan. So we make sure people don't fall through the cracks, but then we have a significant number who don't have the technology to be reached. So we're keeping a running list of those so that we can get in touch with them every time they come into the clinic, they're tagged for that. What we've developed is we have kiosks at our clinics so that, you know, in the absence of libraries or in the absence of technology, clients can actually come in and have a private space at our clinic and do telehealth from there if they like. But also the libraries are going to be coming back online soon as well. So, but, you know, I think the bigger thing is what Greg and Dr. Sherin have been working on in terms of seeing what else we can tap into for funding to have innovative technological solutions.
>> COMMISSIONER DALGLEISH: Right. I mean, when you think about what was able to happen in the schools where students who didn't have that capability were provided with hotspots and tablets, it was really remarkable that the school district was able to provide for that. And given, I don't know what the number is when we talk about the number of people who are served in a particular group versus the need in a particular group. I don't know what that particular need number is for people who are either in shelters or living on the street, who are dealing with a severe mental illness.
>> GREG POLK: Yeah. And one of the things that we run into and maybe our CIO could speak to it is just whole protective -- being protective about the information, right? You don't have to make sure that you have an ability to protect because HIPAA rules protect the information on these devices. And that's always been a challenge too, when you start putting devices out into the community, how do you protect the data around the people, especially around mental illness. Right. And so that's always a challenge as well.
>> COMMISSIONER DALGLEISH: Of course. Thank you.
>> CHAIR WEISSMAN: Thank you. Commissioner Dalgleish. And I skipped over Commissioner Banko. So Tes, please go ahead.
>> COMMISISONER BANKO: Hi, thank you so much for all the hard work that's gone into creating this plan. I know how tremendously challenging and important it is to work among different sections and different, you know, the cautions of the plan is particularly with addressing disparities especially, you know, right now I think it's coming to sharp focus the disparities, especially in mental health the access engagement piece of it, which is tremendously important. And by the way, congratulations on your new communications director there at DMH. I think that's going to figure prominently because I heard the question, the public question about, you know, the outcomes in that information. So it's not just about collecting data. So determining what the important data is, collecting it, creating a strategy for that, but then also getting it out to the public so that they know and can see in very clear and succinct ways. This is, you know, what we've captured. So I admit to, you know, being a relative, you know, relatively new commissioner, newbie to the MHSA. But I did look and see the implementation and outcomes division, which is helpful for me. So I just wanted to mention that it's on the DMH website in case any of the

commenters or public want to talk about that, but being is tremendously important. So not only do you have to implement but then make the staffing plan to be able to support the different pieces as you well know. So just congratulations. Very, very tremendous work. I did want to ask the question coming from a veteran background and being privy to the things that are happening in the veterans community. I know that the Board of Supervisors had enacted the Veteran Peer Access Network, which was part of DMH, and that funding runs for three years. And I'm just wondering if there's been any conversation about possibly ruling the succession and the continuation of VPAN services into the MHSA. I know it's a little bit early to talk about since, you know, every year you all look at this, but that portion of it, including the call line, which has been a lifeline to the veterans community, which some may not know, but it's the highest population of veterans and families in the country here in Los Angeles County and also a very large population of homeless veterans. So there's that piece of it. And then also just, again, thanks. I'm the mother of a young child, seven. She's seven and I saw firsthand the effects of Safer at Home and just was very, very happy to see that, you know, those are being addressed within the plan as well.
>> COMMISSIONER BANKO: Thank you.
>> GREG POLK: Thank you. I mean, I can just respond to the question about, you know, the veteran piece. You know, we always do our priority setting and I can say this, that that's definitely a high priority for Dr. Sherin. So I think that to the extent we can find and do what we can do around that veteran's trays, what would be best.
>> CHAIR WEISSMAN: Okay. Thank you. And I believe that concludes the Commissioner Q&A with the department staff. And I have a question --
>> COMMISSIONER TURNER: I did have something I wanted to add, Brittney, I'm sorry.
>> CHAIR WEISSMAN: That's okay. Go ahead.
>> COMMISSIONER TURNER: And it just goes back to the, you know, the IT capability and how important that is and how that's taught through, you know. We need to look at, you know, these homes as communications hubs that really connect with resources, job opportunities, vaccine appointment, whatever it is, requires some connectivity. So that needs to be thought through. You know, I know we ran into that, you know, at NAMI urban Los Angeles, we're now offering Chromebooks and hotspots for clients to participate in our programs who don't have that through a grant from, you know, from L.A. CARE. And we see the importance of that now. And of course the devil is always in the details, you know, how do you reclaim clean, redistribute this, I think it's a lot, you know, going into it. And so -- but I think that we should think, you know, from the Department of Mental Health standpoint, at least from the people on our client list, ensuring they have that connectivity and, you know, the support behind that, you know, there's ongoing fees associated with that connectivity, you know, how will those be managed and paid for? And so just something to, I want to be sure we think about as we go on, because I do believe in that. And but we have to think through that piece of it as well, you know, every month there's going to be a bill coming through from your internet service provider and, you know, your cable service about, you know, what costs you've incurred.
>> GREG POLK: You know, we have a little experience and that as we went through COVID and our employees started working from home, I think Mary Avalos and her staff did a wonderful job, a tremendous job around making sure that we still have connectivity, right? So we had to get our laptops. We have to get our connectivity opportunities, we had to

get out of hotspots. And it's a challenge, and then a bigger challenge is updating it. The second challenge is how do you protect the information? But, you know, we got a little experiences and I think we had, you know, there were lessons learned from that. And I think moving forward, we'll have an opportunity to see how we can move that same program for like our clients.
>> MIRIAN AVALOS: And I think Greg, if I may, the county as a whole is taking a look at it. DMH is part of the larger CIO -- County CIO, County CEO driven initiative that's taking a really deep look into the digital divide and really asking itself who is not on the internet. And obviously when we dig into the data, we start taking a look at, you know, the overlays between our clients and our client demographics and who is not on the internet, who does not have access to the internet. And so those things are important as far as penetration of devices. So we're definitely taking a look, you know, obviously as a business function, we're taking a look at the devices and how they operate, and then also taking a look at the technology and how to make it as easy as possible to get on with as limited as bandwidth as some folks that are unhoused have.
>> GREG POLK: Great.
>> CHAIR WEISSMAN: Thank you. Okay. I have a question in terms of process for our commission. So now we're at the time in the agenda where we've heard public comment, we've asked questions of the department and that's concluded, but we have some emails in from public comment as well that we have not yet been able to read because they came in during our meeting. So I know we want to be sure to consider them. And then after that we consider them, we would then develop recommendations, feedback. You know, I would help draft a letter that gets attached to this report. But given that we want to review those emails, we have a couple of options in my mind. One is we adjourn the meeting, you know, at the end of this little talk that I'm giving and we reconvene next week. And that gives us between today and next week to read the emails. And we come back next week together for a brief time to work on just the recommendations or letter that gets attached to the plan. So that's an option.
Another option is we can take a brief recess now of 10 minutes maybe, and you can look through your emails, review the emails that have come in from the public, and then we can come back as a team now in 10 minutes after and we can work on our recommendations for another, say half an hour, 40 minutes after that. So it really depends on the longevity of your attention spans and the rest of your day and also the rest of next week. What do you think makes the most sense?
>> COMMISSIONER PADILLA-FRAUSTO: I'm going to chime in and I'm going to say I'm like mentally saturated. So I vote for taking a week and get through this and reconvening next week. That's my preference.
>> COMMISSIONER TURNER: Second. [laughing]
>> COMMISSIONER FRIEDMAN: Third.
>> COMMISSIONER OGAWA: Fourth.
>> COMMISSIONER BANKO: [Thumbs up].
>> CHAIR WEISSMAN: Okay. Okay, I got some thumbs up, some yeses. Sounds like we'll be coming back together next week. I did suggest a time for Thursday afternoon, but I'll have to work that out with the DMH IT team and our Mental Health Commission team. We will need a quorum for next week in order for us to make a decision about our recommendations. We will not need DMH staff present at that meeting. It is simply to talk amongst ourselves and develop our letter. It does look like we have confirmation from the IT team and the Mental Health Commission team now I'm getting word. So it looks like we are good for

1:30 to 3:00 p.m. Ish next week. Hopefully it takes less time. And we'll reconvene again by Teams. And what we'll do at that point is we'll double check that we all read the emails that came in through Pinki while we were at this meeting and then develop our recommendations. That gives time for other commissioners who couldn't make it today to join us possibly. I think that covers it. Is there anything I'm leaving out?
>> GREG POLK: I just have one comment, Brittney. First of all, thank you, Madam chair for leading this effort. I want to thank all the commissioners for being professional. I think it's been, there's always a great, great, great opportunity to collaborate with the commissioners. And I think that makes it a lot easier when everybody's opinion is respected, right. And I just want a nod to the commission, I really appreciate all you guys' positive feedback, even if it was negative feedback, if they can feedback and impact what we needed to do it was, it was less than flattering for us. And I just want to say thank you to all you guys.
>> MARK KARMATZ: This is Mark --
>> CHAIR WEISSMAN: We would reflect that back to you. I believe Mark Karmatz is back on our line, John. But we reflect that back to you, Greg, and all of your staff. I mean, I'm going to name some folks. I think it was on the phone we had Lisa Wong and Maria funk, Amanda Ruiz, Darlesh Horn, Debbie Innes-Gomberg, Jo Ann Pinedo, and Jennifer Hallman. And I'm sorry if I missed somebody else --
>> GREG POLK: There's a couple of people behind the scenes, which is Cynthia Duang and we have Robin Ramirez who play key roles in making this a success. So I want to thank them as well.
>> CHAIR WEISSMAN: Thank you. And I think so many lessons learned over the past year, really, about how to interact with each other online. Again, my heart goes out -- my thanks go out to John and Julio for making this very seamless. We'll look forward to more seamless meetings in the future. To all of the people who are, you know, members of the public paying attention and keeping us accountable and keeping our ears, you know, to the ground, thank you so much because you'll see next week how we conclude this kind of public comment period and make some recommendations that attach to this plan, I would also just announce that the public comment period for MHSA is now closed. So the commission will be receiving and reviewing everything received to date, but nothing further. And we have that already in our emails. So just stay tuned for the next announcement about our meeting next week. Thank you, everybody, again for a pleasurable and productive meeting. I hope you stay well and enjoy Earth Day.
>> GREG POLK: Thank You.
>> CHAIR WEISSMAN: Okay.
>> Bye-bye.
>> Bye-bye.
>> Thank You.
>> Bye.
[End of Meeting].
1:44 P.M.

APPENDIX F - ACRONYMS

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:	Department of Children and Family Services
DHS:	Department of Health Services
DPH:	Department of Public Health
DTQI:	Depression Treatment Quality Improvement
EBP(s)	Evidence Based Practice(s)
ECBI:	Eyeberg Child Behavioral Inventory
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)
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

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