MHSA ANNUAL UPDATE

Fiscal Year 2022-23

WELLNESS • RECOVERY • RESILIENCE

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

TABLE OF CONTENTS

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.
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

Dear L.A. County,

Since its passage, the Mental Health Services Act (MHSA) has provided the Los Angeles County Department of Mental Health (LACDMH) and the myriad communities we serve with an unprecedented opportunity to engage and partner in developing and promoting a shared plan for impact. Building on the successes achieved over years, we have doubled down on our investment in stakeholder engagement through our guiding bodies including the Service Area Leadership Team, the Underserved Cultural Communities, and the Board appointed Mental Health Commission. Known as YourDMH, community leaders come together as a Community Leadership Team (CLT) to help catalyze the processes we need in place to plan properly and transparently.

Many important service expansions and improvements have been informed through YourDMH in alignment with the LACDMH strategic plan including:

- Reinstituting the Psychiatrist Loan Repayment program that incentivizes recruitment of quality, motivated, and dedicated professionals to serve our clients and strengthen our staff;
- Transforming the Full Service Partnership program so that we can best support our highest acuity outpatient clients on the path to recovery in the community and at the same time activating the grass roots through our Community Ambassador Network which empowers individuals through employment opportunities, access to available resources, increased awareness of mental illness, and reduction of stigma;
- Bolstering the Therapeutic Transportation Van program to provide intensive care resources needed to help individuals in crisis who are falling out of community; and
- Expanding our homeless outreach and mobile engagement (HOME) program to care for and house our most vulnerable clients who too often linger in the open-air asylum of the street.

I am steadfast in my commitment to ensuring that our MHSA resources help those most in need to develop and maintain strong personal relationships, live freely in stable and dignified environments of their choice, and engage in meaningful life activities.

Heart Forward,

Jon

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:

- *Proposed Plan Changes*
  The Plan details significant changes that are either being proposed or will be explored within the next fiscal year.

- *Existing Programs and Services by MHSA Component*
  The Plan provides relevant program outcomes specific to FY 2020-21 for programs previously reflected in the Three-Year Plan for FYs 2021-22 through 2023-24.

PLAN CHANGES

LACDMH proposes four (4) changes to the adopted MHSA Three Year Plan for FYs 2021-22 through 2023-24: The continuation of Innovation 2 services, Community Capacity Building to Prevent and Address Trauma, using Prevention funding, the addition of $5 million dollars to the Capital Facilities component, the redesign of the Innovation Project, Trieste and budget projections.

Innovation 2 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.

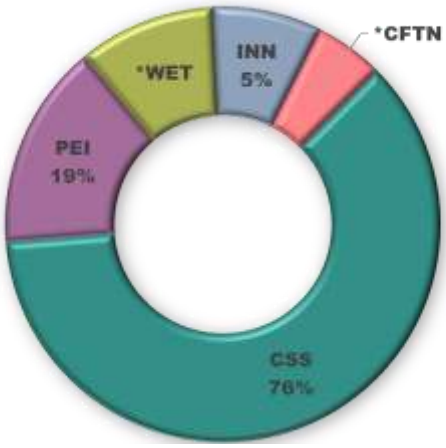
Additional funding for capital facilities will help to expand the opportunities for accessible community based services for clients and their families, promoting the reduction in disparities in underserved groups.

The Hollywood 2.0 Pilot Project is a modification of the MHSA Innovation project (originally Trieste) approved by the MHSOC in May of 2019.

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 75% 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 18% 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 MHSA ANNUAL UPDATE

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.

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

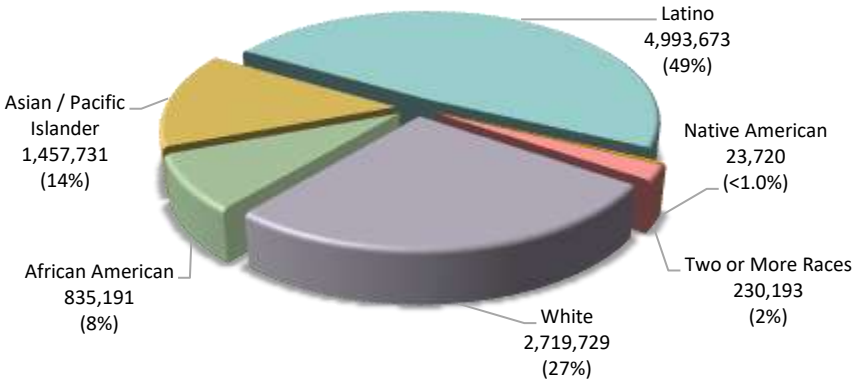


Table 1. Population by race/ethnicity and Service Area

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	61,148	15,464	181,754	1,922	125,684	**11,300**	**397,272**
Percent	15.4%	3.9%	45.8%	0.48%	31.6%	**2.8%**	100%
SA 2	77,002	254,680	909,678	**4,703**	**943,807**	**58,441**	**2,248,311**
Percent	3.4%	11.3%	40.5%	**0.21%**	**42.0%**	**2.6%**	100%
SA 3	63,409	**507,240**	846,574	3,720	358,478	35,040	**1,814,459**
Percent	3.5%	**28.0%**	46.7%	0.21%	19.8%	1.9%	100%
SA 4	59,582	206,948	616,104	2,619	285,102	21,416	**1,191,772**
Percent	5.0%	17.4%	51.7%	0.22%	23.9%	1.8%	100%
SA 5	**37,299**	91,134	**110,277**	**1,184**	398,949	28,378	**667,220**
Percent	**5.6%**	13.7%	**16.5%**	**0.18%**	59.8%	4.3%	100%
SA 6	**275,338**	**19,164**	717,130	1,825	**25,738**	11,503	**1,050,698**
Percent	**26.2%**	**1.8%**	68.3%	0.17%	**2.4%**	1.1%	100%
SA 7	39,210	119,386	**974,630**	3,344	168,786	15,589	**1,320,945**
Percent	3.0%	9.0%	**73.8%**	0.25%	12.8%	1.2%	100%
SA 8	222,204	243,714	637,526	4,403	413,188	48,525	**1,569,560**
Percent	14.2%	15.5%	40.6%	0.28%	26.3%	3.1%	100.0%
Total	**835,191**	**1,457,731**	**4,993,673**	**23,720**	**2,719,729**	**230,193**	**10,260,237**
Percent	8.1%	14.2%	48.7%	0.23%	26.5%	2.2%	100%

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

Table 2. Population by race/ethnicity and Service Area

Ethnic Group	Highest	Lowest
African-American	SA 6 (33%)	SA 5 (4%)
Asian/Pacific Islander	SA 3 (35%)	SA 6 (1%)
Latino	SA 7 (20%)	SA 5 (2%)
Native American	SA 2 (20%)	SA 5 (5%)
White	SA 2 (35%)	SA 6 (1%)
Two or More Races	SA 2 (25%)	SA 1 (5%)

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

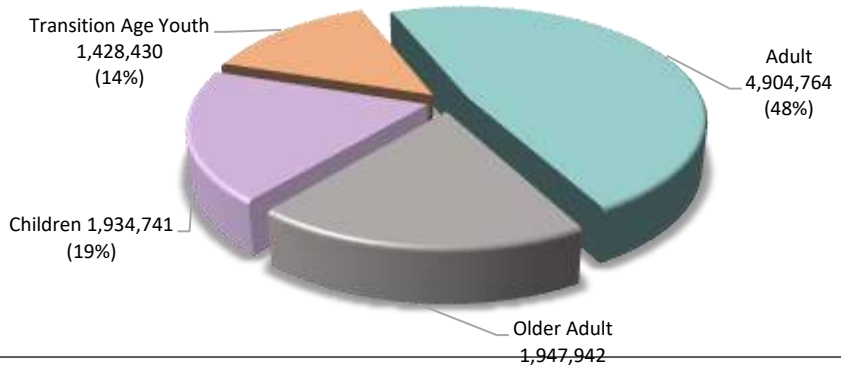


Table 3. Population by age group and Service Area

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	104,022	13,206	34,450	176,405	24,364	44,825	**397,272**
Percent	26.2%	3.3%	8.7%	44.4%	6.1%	11.3%	100%
SA 2	486,825	60,627	152,108	1,085,643	147,042	316,066	**2,248,311**
Percent	21.7%	2.7%	6.8%	48.3%	6.5%	14.1%	100%
SA 3	390,614	54,138	131,937	837,009	119,711	281,050	**1,814,459**
Percent	21.5%	3.0%	7.3%	46.1%	6.6%	15.5%	100%
SA 4	239,083	26,350	69,744	643,006	64,200	149,389	**1,191,772**
Percent	20.1%	2.2%	5.9%	54.0%	5.4%	12.5%	100%
SA 5	119,662	23,038	40,973	334,647	41,382	107,518	**667,220**
Percent	17.9%	3.5%	6.1%	50.2%	6.2%	16.1%	100%
SA 6	298,631	38,452	90,823	477,317	50,349	95,126	**1,050,698**
Percent	28.4%	3.7%	8.6%	45.4%	4.8%	9.1%	100%
SA 7	329,651	40,947	103,494	610,331	72,824	163,698	**1,320,945**
Percent	25.0%	3.1%	7.8%	46.2%	5.5%	12.4%	100%
SA 8	361,487	43,443	109,466	740,406	98,813	215,945	**1,569,560**
Percent	23.0%	2.8%	7.0%	47.2%	6.3%	13.8%	100%
Total	**2,329,975**	**300,201**	**732,995**	**4,904,764**	**618,685**	**1,373,617**	**10,260,237**
Percent	22.7%	2.9%	7.1%	47.8%	6.0%	13.4%	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 2 (21%)	SA 1 (4%)
19-20	SA 2 (20%)	SA 1 (4%)
21-25	SA 2 (21%)	SA 1 (5%)
26-59	SA 2 (22%)	SA 1 (4%)
60-64	SA 2 (24%)	SA 1 (4%)
65+	SA 2 (23%)	SA 1 (3%)

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

Posting of Executive Summary: March 4, 2022
An executive summary highlighting Service Area data, MHSA client counts, updates on actions approved in the MHSA Three Year Program and Expenditure Plan FYs 2021-22 through 2023-24 and proposed changes in the MHSA Annual Update FY 2022-23, was posted to the LACDMH website on this date. See Appendix A.

Stakeholder Meeting: March 9, 2022
A high-level overview of the Update will be presented to Executive Committee members to receive input and feedback.

Mental Health Commission (MHC) Executive Committee: March 10, 2022
A high-level overview of the Update will be presented to Executive Committee members to receive input and feedback.

Posting of Draft MHSA Annual Update: March 8, 2022
The full version of the draft update was posted to the LACDMH website on this date followed by a 30-day public comment period.

Public Hearing: April 14, 2022

C. 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 have continued that need to be addressed. When comparing 2019 to 2020 calendar year data, Medi-Cal beneficiaries receiving Specialty Mental Health Services who report their ethnicities as Latino, African American and White have proportionately increased (1.8% for Latino, .5% for African Americans and .2% for Whites), Latino and Asian/Pacific Islander (API) groups continue to proportionately receive fewer mental health services than their representation as Medi-Cal enrollees would suggest. See table below.

Table 7. County Med-Cal Eligible Population and Beneficiaries Served in Calendar Year 2020, by Race/Ethnicity (From BHC-EQRO Report)

Los Angeles Mental Health Plan				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Beneficiaries	Percentage of Medi-Cal Beneficiaries	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
White	505,892	13.1%	33,290	15.7%
Latino/Hispanic	2,280,000	58.9%	112,962	53.2%
African-American	392,427	10.1%	38,800	18.3%
Asian/Pacific Islander	373,270	9.6%	9,141	4.3%
Native American	4,802	0.1%	530	0.2%
Other	311,841	8.1%	17,549	8.3%
Total	**3,868,232**	**100%**	**212,272**	**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. The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. Data represents entire Los Angeles County and is not specific to MHSA.				

Status of Actions to Address Racial/Ethnic Mental Health Care Disparities

Based on feedback from UsCC groups, LACDMH reviewed the data it collects to more comprehensively capture the racial, ethnic, cultural and disability status of the clients its serves.

Race and Ethnicity:

LACDMH will now be reporting the racial and ethnic status, including primary language spoken, of the clients served at a more granular level and will publish a public-facing dashboard on its website.

Sexual Orientation and Gender Identity (SOGI)

The County has finalized data collection fields for gender identity and sexual orientation. LACDMH has been working to ensure that recent federal requirements are consistent with County reporting prior to modifying its electronic health record and requiring that of contractors. The Department's subject matter expert on SOGI has developed training materials for staff on collecting this information and will finalize once data fields are finalized.

Services for Clients with Disabilities

- The number of clients who report their primary language as American Sign Language (ASL) will now be reported. Current data has clients who report their primary language as ASL is .03% of clients served.
- The ACCESS Center Help Line is in the process of transitioning to 711, the California Relay Service, to assist callers who are deaf or hard of hearing. This will replace the antiquated TTY-TTD system. Informational materials will be disseminated upon adoption of 711.

In the first quarter of calendar year 2022, LACDMH will begin 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. LACDMH views this opportunity as a vehicle for the disparities reduction efforts and as a way to strengthen community voice.

COVID-19 IMPACT ON THE COUNTY MENTAL HEALTH SYSTEM

The recent LACDMH MHSA 3-year Plan shed light on the significant impact the COVID-19 outbreak had on residents and communities within the County. The Plan noted the challenges County residents faced over the last 2-years of the pandemic, highlighting the increased demand for critical mental health services due to increased stress and isolation across populations, increased housing and economic disparities for communities of color, and significant capacity shortages for the mental health and health safety nets to meet the needs of those most vulnerable. Wide spread rising COVID infection rates prompting the need for temporary and/or permanent business and clinic closures resulted in shortages in the workforce available to meet the needs of LA County residents across industries, including social services and the county mental health system. While the entire world has witnessed improvements in this third year of the pandemic in our ability to control infection rates, hospitalizations, and to provide social services and economic help to those in need, many individuals and families are still faced with increased levels of stress while struggling to cope mentally with the emotional and financial aftermath of the last two years. In the 3-year Plan, LACDMH developed several strategies to quickly adapt to challenges faced by our LA County residents that depend on our services. We outlined strategies such as deploying the use of telepsychiatry on a far greater scale to maintain essential mental health services and to address heightened social isolation and limited human interaction due to restrictions on social gatherings caused by the pandemic. We also proposed services that increased focus on heighten mental illness due to fear of loss of income or home; fear of contracting the virus; and losing loved ones to the virus.

The significant economic impact of the pandemic was highlighted at the beginning of the 3-Year Plan, and throughout the plan the impact on mental health programs and services, as well as access to care were captured. We continue to learn throughout this experience that we have found more capacity to be flexible and responsive than we may have previously thought possible and remain hopeful that we can continue to emerge from this crisis a stronger community of care.

As we continue to move forward confronting the ongoing challenges that remain in this third year of the COVID-19 pandemic, we have employed our planned strategies and effectively increased our collaboration with community resources in the physical and virtual realm. We continue to increase our use of technology in order ensure continued access to care for our communities and clients. The following are updates to those strategies identified in the 3-Year Plan to continue address COVID related challenges to service provision to ensure the mental health needs our communities and clients are met.

<u>Outpatient Care Services</u>
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 transition the bulk of our staff from in-person client care to client care through telework, providing 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. 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. Clinic services during the pandemic included:

- A peer/volunteer run warm line for those seeking to reach out by phone to stay connected,
- Virtual group for clients and clinic staff to meet and remain connected, including virtual celebrations,
- Video clinical team meetings, case conferencing, and clinical supervision to ensure best clinical practice and team cohesion, and
- Regular client check in for all clients by clinic staff.

These strategies are still in use and continue to ensure clients stay connected and receive the care that they need while we continue in our joint efforts to keep clients, communities and staff safe and healthy through the pandemic.

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

The AOT Teams outreached by phone to their clients since the beginning of the pandemic and when not possible to reach the client directly, the Team maintained contact with clients' collaterals. When in-person requests were made to attempt to house a homeless client, staff made those in-person contacts. AOT Teams have fully returned to field-based services and continue to experience placement issues for clients due to facility COVID-19 restrictions. While the pandemic also significantly reduced the number visits that could be made to clients in hospitals and in jails the Teams continue their efforts to engage clients through telephone/teleconference or WEBEX court hearings when possible and if the client has capacity to engage in services using these technological mediums.

Homeless Outreach and Mobile Engagement (HOME)

HOME was initially tasked with assisting in the mitigation of 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 secured hotel and motel rooms for vulnerable PEH 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 permanent supportive housing subsidies, and ongoing supportive services and benefits. Over the last year of the pandemic, HOME Teams have transitioned to targeting the most acutely mentally ill individuals experiencing homelessness and providing intensive outreach, treatment and street medicine.

Veteran Peer Access Network (VPAN)

VPAN continues to be 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 continues to provide a support line available 7 days a week to drastically increase access to the program's target population. VPAN staff continues to participate in regular street outreach in multiple SAs working closely with HOME, VA, E-6, and other outreach providers.

Enhanced Care Management (ECM) formerly Whole Person Care (WPC) Intensive Service Recipient and Kin through Peer (ISR/KTP)

The WPC was drastically impacted by COVID-19 as the program relies on relationships with hospitals and the ability to first engage and enroll participants during a hospitalization. Given over the first years of the pandemic few hospitals allowed WPC staff to enter the facility to engage and enroll individuals. Enrollments were critically reduced. Staff continued to outreach and provide in-person services 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. As of January 1, 2022, WPC was transitioned to Enhanced Care Management.

Women's ReEntry and Well-Being Center

Consistent with other DMH programs, the staff of Women's ReEntry and Well-Being Center 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 their many outreach efforts. Numerous efforts were made in the first years of the pandemic including hiring staff and providing staff with access to electronic case documentation trainings. Staff were ultimately able to resume field work to locate, engage and train clients to use and access the online platform for telepsychiatry via cell phones.

Currently the program has established a work structure incorporating field work and online platforms which has helped increase the provisions of mental health services. However, in the past 3 months the program continues to address capacity challenges as numerous staff and clients become infected with Covid variants. This factor has disrupted specific services such as groups, ability to transport, and In-Reach (outreach to new clients in Jail) with CRDF on lock down.

Interim Housing Program (IHP)

The Interim Housing Program (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. DMH has worked closely with the Departments of Health Services (DHS) and Public Health (DPH) to support the health and safety of clients that have been in interim housing during the COVID-19 pandemic. Over the past year the DHS' COVID-19 Response Teams (CRTs) recommended the number of clients served by IHP be reduced from 570 to 475 to address safe occupancy concerns. Of the 20 sites that provided IHP services, all of them were placed on quarantine by DPH at some time during the past years of the pandemic and no new clients could be admitted to the site. The length of the quarantine time varied between one to nine months. The CRTs provided COVID-19 testing and vaccinations to both staff and clients at the sites in accordance with DPH vaccination prioritization categories. A minimum of bi-weekly IHP COVID Learning Collaboratives were offered to the providers, and COVID information update memos were sent to support them during the pandemic.

Enriched Residential Care (ERC) Program

The Enriched Residential Care 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 DMH's most vulnerable clients who struggle to maintain independent housing - many of whom, without this resource, would be homeless or require higher levels of care in inpatient settings. As the pandemic enters its third year, many operators of ARFs and RCFEs have become increasingly equipped and adept at managing COVID-19 cases and outbreaks within their facilities. At the start of the pandemic, it was necessary for DMH to collaborate with partners from various departments and agencies, including the Departments of Health Services (DHS) and Public Health (DPH), Veterans Administration (VA), Community Care Licensing Division (CCLD) and Long-Term Care Ombudsman (LTCO), to provide extensive support and technical assistance to facilities. This included webinars, telephonic outreach and onsite visits to provide facilities with training and guidance around outbreak management, infection control, isolation and quarantine procedures and other topics related to the management of COVID-19 as well as assistance with establishing onsite testing and vaccination capacity. These efforts were supported by the distribution of a weekly COVID-19 related survey by DMH and DHS to all facilities working with ERC clients that captured the number of residents and staff testing positive for COVID-19 as well as any requests for support. Telephonic follow up was

then completed for those facilities whose survey responses indicated a need. As a result, facilities now have the knowledge and tools to be more independent around COVID-19 response.

For this reason and to relieve operators from having to report duplicative information to various entities, DMH and DHS have terminated the weekly distribution of surveys and, instead, facilities are now only required to report COVID-19 cases to DPH and CCLD as they now take the lead on COVID-19 response. Although DMH and DHS are no longer monitoring COVID-19 cases directly, DPH shares access to data so that all agencies remain aware of which facilities are currently experiencing outbreaks. Additionally, when facilities report cases to DPH, DMH and DHS continue to make follow-up phone calls to offer any support needed to manage the outbreak including assistance with facilitating testing. In most cases, facilities are reporting their ability to manage the outbreaks independently without direct assistance from DMH or DHS.

In terms of access to COVID-19 vaccinations, all licensed residential facilities have had the opportunity to provide onsite vaccination clinics through the Federal Pharmacy Partnership Program, which offered residents the initial two COVID-19 vaccines. At this time, most facilities have also been able to work with local pharmacy partners, County agencies or other resources to provide residents with onsite opportunities to receive COVID-19 booster shots. DPH and DHS also have capacity to assist with coordination and distribution of booster shots in cases where facilities are unable to coordinate these services independently. These robust efforts to provide vaccinations to residents and staff at ARFs and RCFEs have led to a drastic reduction in the number and severity of COVID-19 outbreaks within facilities. Though rates of COVID-19 did increase slightly as a result of the recent Omicron surge, outbreak rates and severity of outbreaks within facilities were significantly lower than prior to vaccination efforts.

While facilities are more equipped to manage COVID-19 independently, costs related to the pandemic still impose an increased financial burden on ARFs and RCFEs that serve Supplemental Security Income (SSI) recipients. In an effort to mitigate these cost burdens, the newly formed Licensed Adult Residential Care Association (LARCA) partnered with DMH to provide COVID-19 related resources to facilities through their Emergency Assistance Program (EAP). Through this effort, LARCA secured grant funding for 1,260 rapid antigen tests that were mailed out to member facilities. In addition, LARCA was able to obtain 44,100 KN95 masks and 960 hand sanitizer bottles from the Governor's Office of Emergency Services, which were provided to both member and non-member facilities Countywide through four in-person distribution events organized in collaboration with DMH and DHS. Through these events, LARCA was able to provide resources to over 100 facilities ranging from four to 250 beds.

Although overall COVID-19 response has significantly ramped down, DHS maintains one COVID-19 Response Team that is available to make onsite visits and provide testing and technical assistance in cases where licensed residential facilities need more intensive assistance with outbreak management. Furthermore, facilities are aware of the support available to them through County resources and have not hesitated to reach out for assistance as needed.

PROPOSED CHANGES

This section provides detailed information for proposed changes that are incorporated into the Update.

- **INNOVATION 2: COMMUNITY CAPACITY BUILDING TO PREVENT AND ADDRESS TRAUMA**

  This Innovation project was posted to the LACDMH website on February 27, 2015 and approved by the OAC on May 28, 2015.

  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. In June 2020, LACDMH integrated community mental health workers (community ambassadors) into the INN 2 project.

  The concept of the Community Ambassador Network (CAN) leverages existing networks of trusted community-based providers and organizations to have the right people in the right place at the right time to provide necessary resources to those in need. The development of the Community Ambassador Network (CAN) through Innovations 2 has allowed DMH to expand our behavioral health workforce, in partnership with community based organizations, to hire and train 326 community ambassadors. As of 12/6/2021, 321 individuals have been part of the CAN. The CAN intern project was introduced a year ago as a collaborative project with the Department of Public Social Services (DPSS), the INN 2 team and the California Work Opportunity and Responsibility to Kids (CalWORKs) team. Funded by DPSS, CAN Interns expand the reach and supports available within communities by members of the community.

  The Los Angeles County Board of Supervisors approved nine (9) lead agencies and ten (10) projects, two (2) 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 selected specific strategies based on their community's interests and needs. 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.

  COVID-19 has resulted in a critical need for mental health services, and the 321 individuals that have been part of the CAN have allowed DMH to build capacity, provide trauma-informed targeted outreach and resources to communities at higher risk. In addition, 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 and utility assistance and a multitude of linkages).

  Outcomes

  Specifically, the following process and summative outcomes were achieved by the Innovations 2 program:

- There were 8,077 registered participants, with 68% (5,499) of all participants were enrolled in INN 2 during the pandemic. Most participants in INN 2 are families with young children between the ages of 0-5 (25.2% of participants), intergenerational families (23.2% of participants) and TAY (22.3% of participants).
- Through nearly 10,700 community events, outreach and social media posts, 560,268 community members were reached, 18,000 meals provided, 9,865 individuals vaccinated for COVID-19 and PPE provided to nearly 14,000 individuals.
- The CAN Participants demonstrated a stronger understanding of the relationship between trauma and mental health, significant improvements in resilience, and improved ability to cope with stress.
- Over the past year, 93% of the 29,587 linkages to community resources and supports were successful. Despite the impact of the COVID-19 pandemic, linkages increased substantially from the prior year.
- During FY 2020-2021, there were a total of 14,219 outreach and engagement efforts, representing a substantial increase compared to the prior year of the project.
- Through Learning Sessions, partners learned how to engage a wider net of at risk community members to provide support.
- Participants enrolled in INN 2 during the COVID-19 pandemic, reported feeling significantly more connected with the community, and utilized more approach coping skills after three months of INN 2 activities.
- Participants reported feeling significantly more resilient after 9 months of participation in INN 2.
- Based on data from the Conner-Davidson Resilience Scale (CD-RISC-10) participants who enrolled in INN 2 during the past year of the pandemic, reported no decline in their resilience despite the significant amount of stress communities experienced over the course of the past year.
- In addition, based on the Inclusion of Community in Self (ICS) Scale, INN 2 participants reported a significant increase in their connection to the community, relative to the baseline score.
- Community members engaged with INN 2 and the Community Ambassadors also reported significant improvement in Approach Coping scores, based on The Cope Inventory.
- Partnership rosters within the community increased by 13% as INN 2 partnerships expanded to include new organizations and community members. Specifically, the INN 2 networks averaged 57 partners in February 2021, compared to 51 partners last year (February 2020) and 36 partners in March 2019 (baseline assessment). On key factor responsible for the stronger community partnerships has been the addition of the Community Ambassador Network.

Table 8. Innovation Evaluation Rubric across Programs:

INN 2 Events (Program Level)	Count
Total Outreach and Engagement Events	14,219
Group Activities	2,989
Partnership and Other Meetings	2,698
Community Outreach	1,964
Community Based Trainings	1,646
Covid-19 Education Efforts	1,078
Linkages (Participant Level)	
Successful Linkages	29,587
Number Participants Linked	4,594

Outcome (Participant Level)	Baseline *(M)*	Most Recent *(M)*
Conner-Davidson Resilience Scale (CD-RISC-10)	28.7/40	28.9/40
The Cope Inventory (Approach Coping)	34.8/48	35.7/48
The Cope Inventory (Avoidance Coping)	23.1/48	22.8/48
Inclusion of Community in Self (ICS) Scale	3.47/6	3.62/6

Table 9.

Partnership and Collaboration (Project Level): Wilder Collaborative Factor Inventory						
	Environment	Memberships	Process	Communications	Purpose	Resources
Feb 2020	4.03	4.04	3.88	3.94	4.06	3.78
Aug 2020	4.06	4.05	3.91	3.95	4.08	3.73
Feb 2021	4.13	4.11	4.01	4.02	4.10	3.86

Table 10.

Partnership and Collaboration (Project Level): Social Network Analysis/Partner Roster		
	Network Average Partners (M)	Partnership Roster % Increase
Mar. 2019	36	--
Feb. 2020	51	40%
Feb. 2021	57	13%

It is requested the project be extended using Prevention funding in order to continue the support of the CAN and ongoing assistance to the communities in the recovery from the COVID-19 pandemic. Goal is, within two years, LACDMH will develop and release a solicitation to sustain and expand the community capacity building and community access platform work being accomplished through the Community Ambassador Network (CAN)

- ## CAPITAL FACILITIES

Capital Facilities component funds will be utilized to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded MHSA programs. The additional funds will address the current and anticipated needs of both public mental health service facilities and administrative space. Space utilization at all facilities is currently at maximum capacity. To the extent possible, DMH will utilize these funds to continue to modernize and develop welcoming facilities that will move its mental health system toward the goals of wellness, recovery, and resiliency; and will also help to expand the opportunities for accessible community based services for clients and their families, promoting the reduction in disparities in underserved groups.

- ## INNOVATION – TRIESTE: HOLLYWOOD 2.0

LACDMH was approved to receive MHSA Innovation funding from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to test a new and comprehensive approach to providing services to individuals in the Hollywood area suffering from severe and persistent mental illness, as a result, experiencing chronic homelessness, incarceration and or repeated hospital use. The Hollywood 2.0 Pilot Project is a modification of the MHSA Innovations project Trieste, which was approved by the MHSOC in May of 2019 prior to the pandemic. The project is based on LACDMH's fiscal projections and the anticipated CalAim program. The Hollywood 2.0 pilot aims to provide our most vulnerable residents with relentless engagement and enhanced access to treatment functioning as tools to facilitate individuals with connection to people, place, and purpose in life. Hollywood 4WRD (4 Walls, a Roof and a Door), a grassroots public-private coalition, will serve as the engagement body for the Hollywood 2.0 Pilot Project. The primary purpose of the Hollywood 2.0 Pilot Project is to

establish a variety of recovery-oriented resources that promote an integrated, community-based approach in the delivery of novel programs and services that enhance the client's abilities to lead fulfilling lives in their neighborhood. The project is proposed for 5 years.

The Hollywood 2.0 pilot represents an opportunity for the County to leverage MHSA Innovation funding, partner with local community leadership, and use existing local assets to build out a rich array of resources that will strengthen clients' ties to the Hollywood community. Such resources include a robust infrastructure of facilities and a system of care that offers both services and opportunities to support a highly vulnerable community in new and exciting ways.

Hollywood 2.0 will allow the Department to develop novel programs and services that will enhance client's abilities to lead fulfilling lives and feel connected to their surrounding neighborhood. New programs such as Supportive Employment and Supportive Education services will provide clients with opportunities to learn life skills while simultaneously connecting them to agencies and employers in the Hollywood area. By providing the Pilot's clients with a chance to find purpose in their daily lives and make meaningful connections to others in their community, Hollywood 2.0 embraces the Department's belief in clients' ability to manage their life successfully, which is a key element of recovery.

Staffing for Hollywood 2.0 will be identified for assignment to Full-Service Partnership (FSP) (6-7 staff) and Homeless Outreach Mobile Engagement (HOME) teams dedicated to the project. The proposed annual budget is $100,000.

Hollywood has one of the County's most concentrated populations of unhoused individuals suffering from profound brain illness(es) and languishing in the streets. Aside from putting in place resources needed to address this crisis, the goal of the Hollywood 2.0 project is to leverage the significant momentum and buy-in across the Hollywood community. As part of our plan to expand the current footprint and establish new resources in Hollywood to create service arrays, the pilot will leverage a few key evolving reform efforts, including the Full-Service Partnership (FSP) Redesign, (HOME) Outpatient Conservatorship Pilot (HOME pilot), Peer Resource Center replication (including clubhouse type programming) and Alternative Crisis Response (ACR) initiatives.

FISCAL YEAR 2022-23 BUDGET PROJECTION CHANGES

Tables 11-16 show the difference of what was projected for FY 2022-23 in the Three Year Program and Expenditure Plan, Fiscal Years 2021-22 through 2023-24, and what is now projected in the MHSA Annual Update FY 2022-23.

Table 11. Community Services and Supports

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Full Service Partnership	$302,391,232	$299,567,466	$(2,823,767)	(1) Overall reduction in services due to the pandemic and difficulties to retain staff offset by funds allocated to maintain the Flexible Housing Subsidies Pool for

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
				housing vouchers provided to mental health clients for rent.
Outpatient Care Services	$636,564,407	$569,476,324	$67,088,083)	(2) Overall reduction in services due to the pandemic and difficulties in retaining staff.
Alternative Crisis Services	$139,819,715	$165,520,546	$25,700,832	Reflects the operating cost for the new Crisis Residential Treatment Programs (CRTP) at the Restorative Villages.
Planning Outreach & Engagement	$7,108,451	$6,464,668	$(643,783)	Same as (2) above
Linkage Services	$28,322,985	$34,901,893	$6,578,907	Reflects projection of additional Linkage services based on current utilization.
Housing	$ 35,073,361	$35,144,049	$70,688	Same as (1) above
CSS Administration	$38,865,316	$43,284,429	$4,419,113	Same as (2) above
TOTAL	**$1,188,145,468**	**$1,154,359,375**	**$(33,786,093)**	

Table 12. Prevention and Early Intervention

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Suicide Prevention	$ 22,302,998	$22,302,998	$ -	
Stigma & Discrimination Reduction	$366,250	$366,250	$ -	
Prevention	$43,564,826	$50,513,488	$6,948,662	Primarily reflects the addition of 311 positions for universal promoters which will serve as community promoters to provide outreach and education and the one-time extension of My Health LA (MHLA) Agreement with Department of Health Services (DHS) for mental health prevention services provided in a primary care setting.
Early Intervention	$198,997,562	$188,002,410	$(10,995,152)	Reflects the overall reduction in services due to the pandemic and difficulties in retaining staff.

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Outreach	$8,368,989	$ 38,688,869	$30,319,880	Primarily reflects continuation of funding for the Los Angeles Unified School District (LAUSD) and Los Angeles County Office of Education (LACOE) for Community School Initiatives (CSI) and the transition of the Innovation Community Capacity Building project.
PEI Administration	$14,343,578	$15,640,011	$1,296,433	Reflects the change in administrative costs based on the projected cost of the projects.
TOTAL	**$287,944,203**	**$315,514,026**	**$ 27,569,823**	

Table 13. Innovation

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Inn #2 - Community Capacity Building	$ 14,700,000	$ -	$(14,700,000)	Continuation of CANS programming with PEI funding.
INN # 3 - Technology Suite	$6,321,028	$ -	$(6,321,028)	Reflects the completion of the project. DMH is currently in discussions with the California Mental Health Services Authority (CalMHSA) for additional services that may be provided.
Inn # 4 - Transcranial Magnetic Stimulation Center	$1,150,726	$1,150,726	$ -	Reflects the continuation of this project in FY 2022-23.
Inn #7 - Therapeutic Transportation	$ 3,387,415	$5,467,999	$2,080,584	Reflects the expansion of teams in partnership with Los Angeles City Fire Department.
Inn # 8 - Early Psychosis Learning Health Care Network	$492,709	$492,709	$ -	Reflects the continuation of this project in FY 2022-23.
Hollywood 2.0 Project (formally known Trieste)		$5,439,504	$5,439,504	Reflects the implementation of True Recovery Innovation Embraces Systems That Empower (TRIESTE) / Hollywood 2.0 Project
INN - Administration	$ 4,176,000	$2,310,671	$(1,865,329)	Reflects the change in administrative costs based on the projected cost of the projects
TOTAL	**$ 30,227,878**	**$14,861,609**	**$ (15,366,269)**	

Table 14. Workforce Education and Training (WET)

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
UCLA Affiliation Agreement	$7,135,501	$6,417,864	$(717,637)	Reflects scheduled reduction of one-time services.
Financial Incentive Programs	$3,873,084	$3,873,084	$ -	
Stipend Program for MSWs, MFTs, AND NPs	$3,063,600	$3,063,600	$ -	
Charles R. Drew Affiliation Agreement	$2,011,394	$2,309,058	$297,664	Reflects an increase in the services provided in the residency program.
Funds Assistant Behavioral Sciences Consultants (6 FTEs), for Post-Docs at Harbor-UCLA	$510,000	$ -	$(510,000)	Reflects the elimination of this funding as the fellows being funding with a different funding source, as they provide direct mental health services.
Intensive MH Recovery Specialist Core Training Program	$440,000	$ 440,000	$ -	
Interpreter Training Program	$ 80,000	$80,000	$ -	
Learning Net System 2.0	$250,000	$250,000	$ -	
Navigators (Health and Housing)	$200,000	$ 400,000	$ 200,000	Reflects an expansion in the Health Navigation training program.
Continuum of Care Reform / Staff and Resource Parents Training	$500,000	$500,000	$ -	
Parent Partner Training and Parent Volunteers Project	$320,000	$320,000	$ -	
Peer Focused Training	$ -	$400,000	$400,000	Reflects funding for Peer focused training.
Med. School Affiliation at Harbor	$260,000	$260,000	$ -	
UCLA Medical School Affiliation Agreement (MSAA)	$126,000	$136,000	$10,000	Reflects an increase in cost for services provided by UCLA.
Licensure Preparation Program (MSW, MFT, PSY)	$250,000	$250,000	$ -	
Administrative Overhead	$1,412,379	$1,501,578	$89,199	Reflects the change in administrative costs based on the projected cost of the projects.
TOTAL	**$20,431,958**	**$20,201,184**	**$(230,774)**	

Table 15. Capital Facilities/Technological Needs (CFTN)

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Tenant Improvement / Capital Facilities		$5,000,000	$5,000,000	Reflects funding for new and/or existing facilities to continue to modernize and develop welcoming building to meet the goals of the mental health services delivered in Los Angele County.
Modern Call Center	$3,500,000	$3,500,000	$ -	Reflects the continuation of this project in FY 2022-23.
CFTN - Administration	$350,000	$2,150,000	$1,800,000	Reflects the change in administrative costs based on the projected cost of the projects
TOTAL	**$3,850,000**	**$10,650,000**	**$6,800,000**	

Table 16. Summary by Program

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change
Community Services and Supports (CSS) Plan	$1,188,145,468	$1,154,359,375	$(33,786,093)
Prevention and Early Intervention (PEI) Plan	$287,944,203	$315,514,026	$27,569,823
Innovation	$30,227,878	$14,861,609	$(15,366,269)
Workforce, Education and Training (WET) Plan	$20,431,958	$20,201,184	$(230,774)
Capital Faculties / Technology Needs(CFTN) Plan	$3,850,000	$10,650,000	$6,800,000
TOTAL	**$1,530,599,507**	**$1,515,586,193**	**$(15,013,313)**

EXISTING PROGRAMS AND SERVICES BY COMPONENT

This section provides FY 2020-21 outcome data for existing MHSA programs and is organized by component. It also provides financial information for two prior FYs 2019-20 and 2020-21, as well as the proposed annual budget for FY 2022-23 and the total proposed budget for the three FYs 2021-22 through 2023-24 of the MHSA Three Year Program and Expenditure 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 2020-21, approximately 135,232 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).

Table 17. Clients served through CSS in FY 2020-21

Clients Served	New Clients Served
135,232 clients received a direct mental health service: - 37% of the clients are Hispanic - 20% of the clients are African American - 18% of the clients are White - 5% of the clients are Asian - 1% of the clients are Native American - 79% have a primary language of English - 14% have a primary language of Spanish	35,499 new clients receiving CSS services countywide with no previous MHSA service - 36% of the new clients are Hispanic - 14% of the new clients are African American - 16% of the new clients are White - 3% of the clients are Asian - 0.48% of the clients are Native American - 77% have a primary language of English - 14% have a primary language of Spanish

Table 18. CSS clients served by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	9,098	2,410
SA 2 – San Fernando Valley	22,613	5,886
SA 3 – San Gabriel Valley	19,146	5,952
SA 4 – Metro Los Angeles	25,458	6,801
SA 5 – West Los Angeles	7,837	1,918
SA 6 – South Los Angeles	21,682	4,727
SA 7 – East Los Angeles County	12,465	2,953
SA 8 – South Bay	27,189	6,940

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 2021-24), 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 2020-21 ■ FULL SERVICE PARTNERSHIP Update

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. Adult FSP Services aim to help Clients, those adults enrolled in Adult FSP Services, increase their ability to function at optimal levels, decrease homelessness and incarcerations, and reduce unnecessary medical and psychiatric urgent care and emergency room visits and hospitalizations. For those Clients that are homeless, Adult FSP Services will help them transition from street to home by providing immediate and on-going assistance with securing and maintaining housing. Child/Young Adult (YA) FSP Services include but are not limited to individual and family counseling, 24/7 assessment and crisis services, Intensive Care Coordination (ICC), and Intensive Home Based Services (IHBS). The intent of these services is to help Clients and/or families increase their ability to function at optimal levels. Existing FSP programs serve children and young adults between the ages of 0-20 and adults (21+).

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

- Changed the eligibility criteria to be more focused on those most in need of FSP care;
- Changed the FSP service model to utilize a multidisciplinary team/population approach, rather than individual caseloads and "slots;"
- Began the integration of all specialty FSP programs into one FSP model (with the exception of Housing FSP which transitioned to housing support);
- Lowered client to staff ratios;
- Added funding for additional staffing to enable Child FSP programs to provide Intensive Care Coordination (ICC) & Intensive Home Based Services (IHBS);
- Provided enhanced training and technical assistance to support FSP providers in achieving desired outcomes;
- Enhanced services and supports to ensure successful transitions between levels of care;
- Centralized the authorization, enrollment, and disenrollment processes for FSP to ensure that those highest needs clients are able to access the FSP services;
- Standardized 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.

These changes were incorporated into the Service Exhibits within the contracts, which were included in the new Legal Entity agreements that were executed on July 1, 2021. The transformed FSP program was launched on July 1, 2021. Because this program redesign is 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.

FY 2020-21 ■ FULL SERVICE PARTNERSHIP Data and Outcomes

As of June 30, 2021, LACDMH had 17,298 FSP slots as shown in the next table.

Table 19. 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	$17,954	3,777
TAY, Ages 16-25	1,410	$13,405	2,915
Adult, Ages 26-59 (includes Integrated Mobile Health Team, Assisted Outpatient Treatment, Forensic, Homeless, Measure H and Housing)	11,419	$14,642	7,618
Older Adult, Ages 60+	885	$11,373	1,993

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 20. Impact of FSP on post-partnership residential outcomes

FSP Program	Percentage by Clients	Percentage by Days
Homeless		
TAY	21% reduction	41% reduction
Adult	31% reduction	63% reduction
Older Adult	27% reduction	58% reduction
Justice Involvement		
TAY	3% reduction	34% reduction
Adult	28% reduction	64% reduction
Older Adult	20% reduction	49% reduction
Psychiatric Hospitalization		
Child	40% reduction	40% reduction
TAY	47% reduction	17% reduction
Adult	25% reduction	62% reduction
Older Adult	12% reduction	22% reduction
Independent Living		
TAY	33% increase	41% increase
Adult	42% increase	41% increase

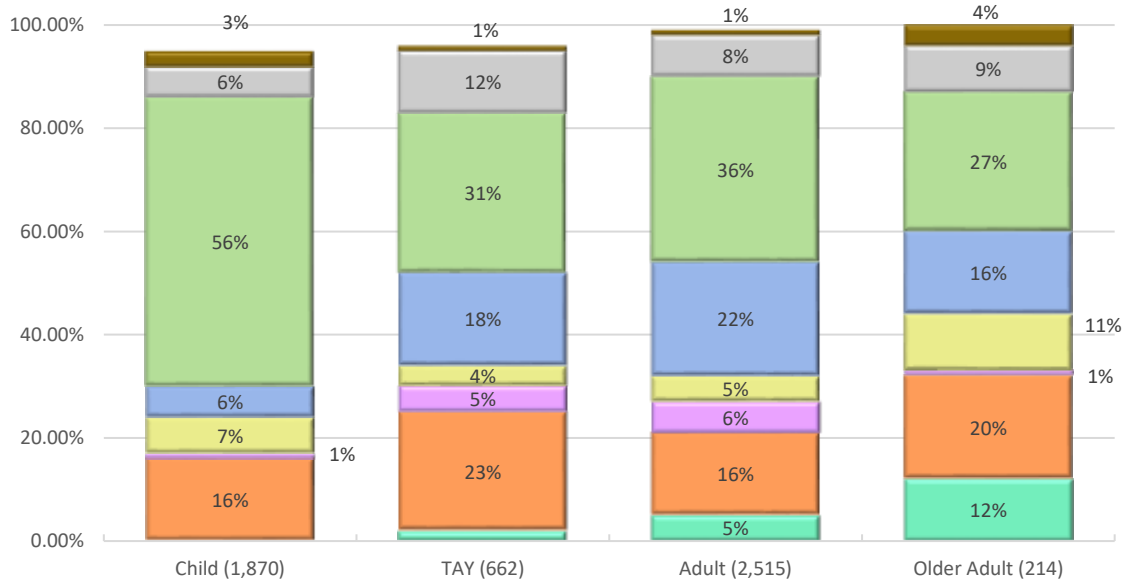
Comparison of residential data for 12 months immediately prior to receiving FSP services (pre-partnership) and for 12 months of residential status while receiving FSP services (post-partnership) for client's outcomes entered through June 30, 2021. Data is adjusted (annualized) by a percentage based on average length of stay in the FSP program. Data must meet data quality standards to be included in the analysis.

Children (n=12,254)
TAY (n = 6,870)
Adults (n =19,886)
Older adults (n = 2,763)
Figures represent cumulative changes, inclusive of all clients through June 30, 2021

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 3. Reasons for FY 2020-21 FSP disenrollments



- Target population criteria not met
- Client moved to another county/service area
- Client has successfully met his/her goals such that discontinuation of FSP is appropriate
- Client cannot be located after attempts to contact client
- Community services/program interrupted - client is in a residential/institutional facility
- Community services/program interrupted - client is detained
- Client decided to discontinue FSP participation after partnership was established
- Client is deceased

FULL SERVICE PARTNERSHIP			
Prior FY 2020-21		**Prior FY 2019-20**	
16,093 Total Number Served[1]	$271.6 million Total Gross Expenditures	15,955 Total Number Served	$268.7 million Total Gross Expenditures
FY 2022-23		**Three-Year Plan FYs 2021-24**	
16,024 Total Number to be Served[2]	$299.6 million Estimated Gross Expenditures	$921.5 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 2022-23 Total Number to be 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 2020-21 ■ OUTPATIENT CARE SERVICES Data and Outcomes

Table 21. FY 2020-21 Data for clients served through various outpatient programs

Age Group	Number of Unique Clients Served	Average Cost per Client
Children, Ages 0-15	21,110	$5,972
TAY, Ages 16-25	18,696	$4,642
Adult, Ages 26-59	60,206	$3,861
Older Adult, Ages 60+	16,175	$3,885

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 22. 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 2020-21

- Older Adult Consultation Medical Doctor's (OACT-MD) Series: Outpatient Services Division conducted this ongoing OACT-MD Series for training and consultation for psychiatrists, nurse practitioners, nurses & mental health clinicians to improve the accessibility and quality of mental health services for Older Adults.
    - Cognitive Screening using the St. Louis University Mental Status Exam, 10-22-20.
    - Polypharmacy Lecture, 01-28-21.
- The Holiday Blues: Training which exams the role holidays, can play on mental health, during the holiday season and its impact on older adults as they may be isolated or the contact with family has decreased, 11-2-20.
- Older Adult Legal Issues/Elder Law Trainings and Consultation: OASOC as part of ongoing multi-disciplinary Older Adult Consultation team trainings, provided training and Elder Law consultation, curriculum training development and coordination on Elder Law for DMH and DMH-contracted clinical and non-clinical staff on best practices for working with Older Adult populations.
- 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, 12-17-20.

- 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, 04-22-21.
- 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, 4-29-21.
- Effective Techniques in Working with Individuals with Mild to Moderate Cognitive Impairment: A training request from LA County Board of Supervisor. The training outline different types of cognitive impairment often observed among older adults, including normal aging, mild cognitive impairment, dementia, and impairments resulting from COVID and/or pandemic conditions, 5-12-21.
- Co-Occurring Disorder Mini-Conference: The Los Angeles County Department of Mental Health (DMH) presents the Co-Occurring Disorders Mini-Conference. The Conference will discuss treatment of Co-Occurring Mental Health and Substance Use Disorders (COD) within the DMH system, 5-26-21.
- Problem Solving Treatment (PST): Problem Solving Treatment (PST) is a brief intervention and will offer experiential activities to enhance clinical skills thereby supporting the model's effectiveness, 5-27-21.
- 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 The Mini Mental State Exam (MMSE), 5-19-21; 6-29-21.
- Problem Solving Treatment (PST): Problem Solving Treatment (PST) is a brief intervention and will offer experiential activities to enhance clinical skills thereby supporting the model's effectiveness, 6-24-21

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 2020-21		Prior FY 2019-20	
113,145 Total Number Served[1]	$584.2 million Total Gross Expenditures	113,003 Total Number Served[1]	$483.4 million Total Gross Expenditures
FY 2022-23		Three-Year Plan FYs 2021-24	
113,074 Total Number to be Served[2]	$569.5 million Estimated Gross Expenditures	$1.794 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 2022-23 Total Number to be 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 20-21 ■ ALTERNATIVE CRISIS SERVICES Update

LACDMH recommended a two-year pilot, long 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. In the last two years, LACDMH arranged for access to up to 239 beds when they became (or will become) available, of which 160 beds were utilized. In implementing the bed pilot, DMH went approximately $9.9 million dollars over budget utilizing one-time Sales Tax Realignment. In order to continue to move patients and allow continuous and efficient system flow, ongoing funding above the $25 million in Sales Tax Realignment revenues set aside in the FY 2019-20 Final Adopted Budget by LACDMH is required. 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.

During FY 20-21, 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.

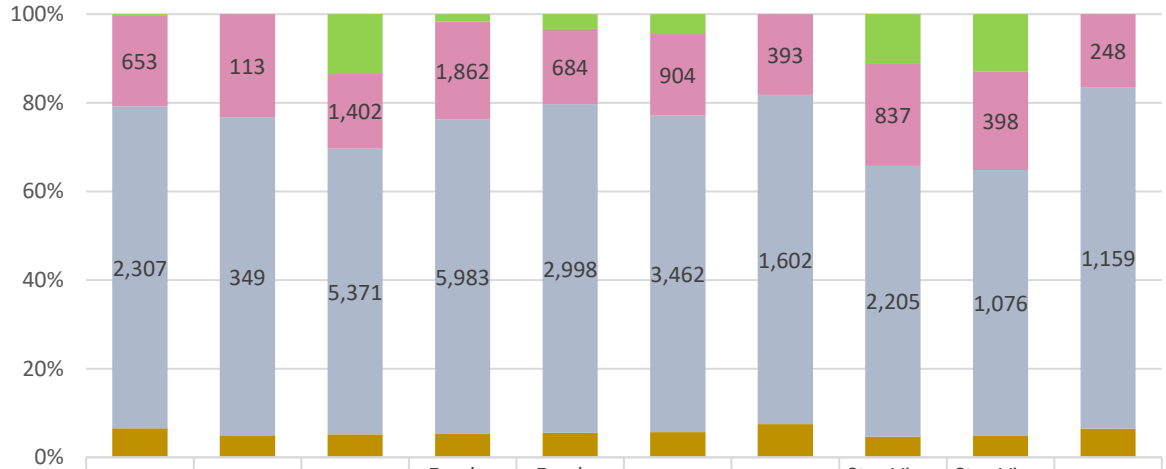
Table 23. Bed capacity and location of the current UCCs

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	15	0
Exodus (MLK UCC)	SA 6	MLK/Los Angeles	Yes	14	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	12	
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

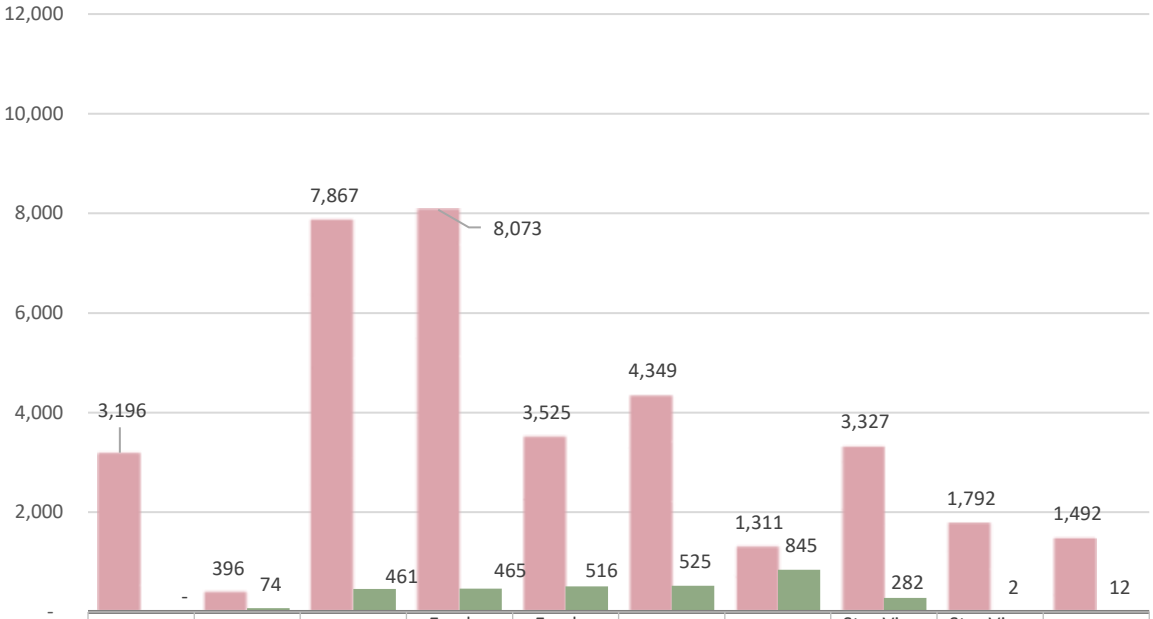
The following graphs provide an overview of FY 2020-21 outcomes of the nine UCCs. Olive View UCC has two components: Crisis Stabilization Unit (CSU) - 7913 and Outpatient UCC - 7591 that does not operate 24/7.

Figure 4. FY 2020-21 UCC New admissions by age group



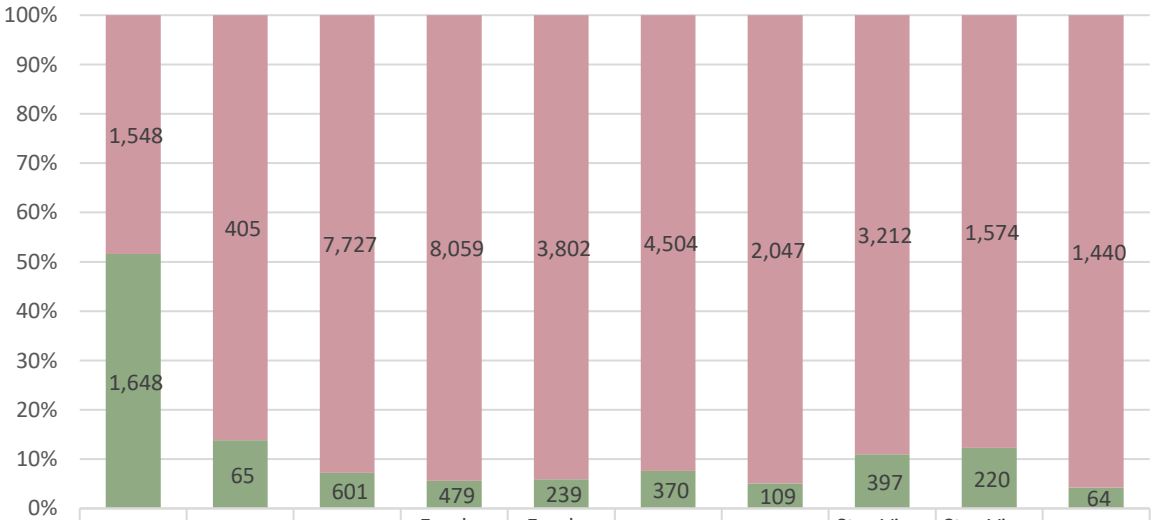
	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View Long Beach	Star View City of Industry	Telecare MHUCC
Child	8	0	1,123	139	136	208	0	398	233	0
TAY	653	113	1,402	1,862	684	904	393	837	398	248
Adult	2,307	349	5,371	5,983	2,998	3,462	1,602	2,205	1,076	1,159
Older Adult	208	24	430	440	223	275	162	169	87	97

Figure 5. Clients with a psychiatric emergency assessment within 30 days of a UCC assessment



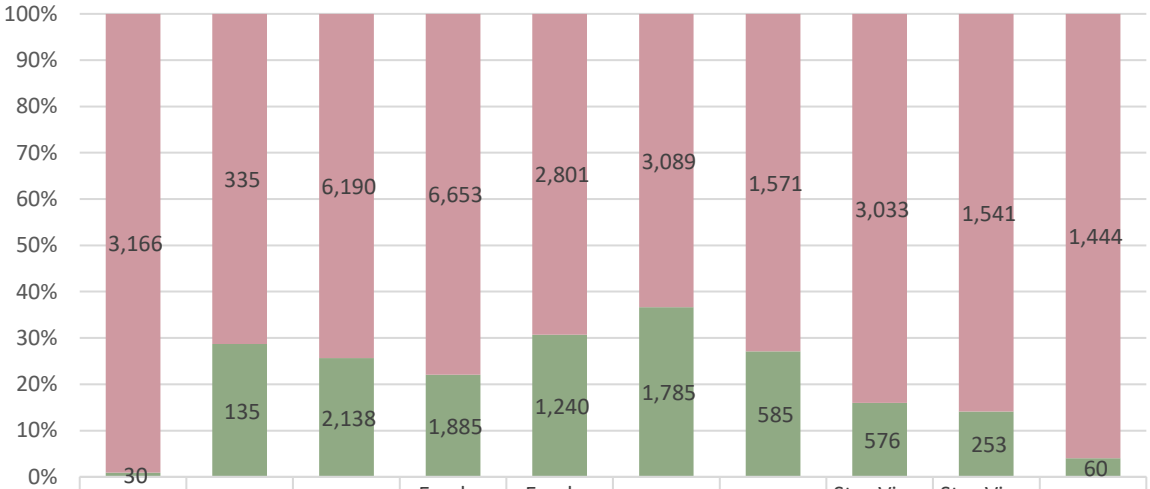
	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View Long Beach	Star View City of Industry	Telecare MHUCC
No	3,196	396	7,867	8,073	3,525	4,349	1,311	3,327	1,792	1,492
Yes	-	74	461	465	516	525	845	282	2	12

Figure 6. 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 Long Beach	Star View City of Industry	Telecare MHUCC
No	1,548	405	7,727	8,059	3,802	4,504	2,047	3,212	1,574	1,440
Yes	1,648	65	601	479	239	370	109	397	220	64

Figure 7. 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 Long Beach	Star View City of Industry	Telecare MHUCC
No	3,166	335	6,190	6,653	2,801	3,089	1,571	3,033	1,541	1,444
Yes	30	135	2,138	1,885	1,240	1,785	585	576	253	60

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 2020-21 outcomes of the nine ERS facilities.

Figure 8. Source of client referrals for ERS admissions (n = 603)

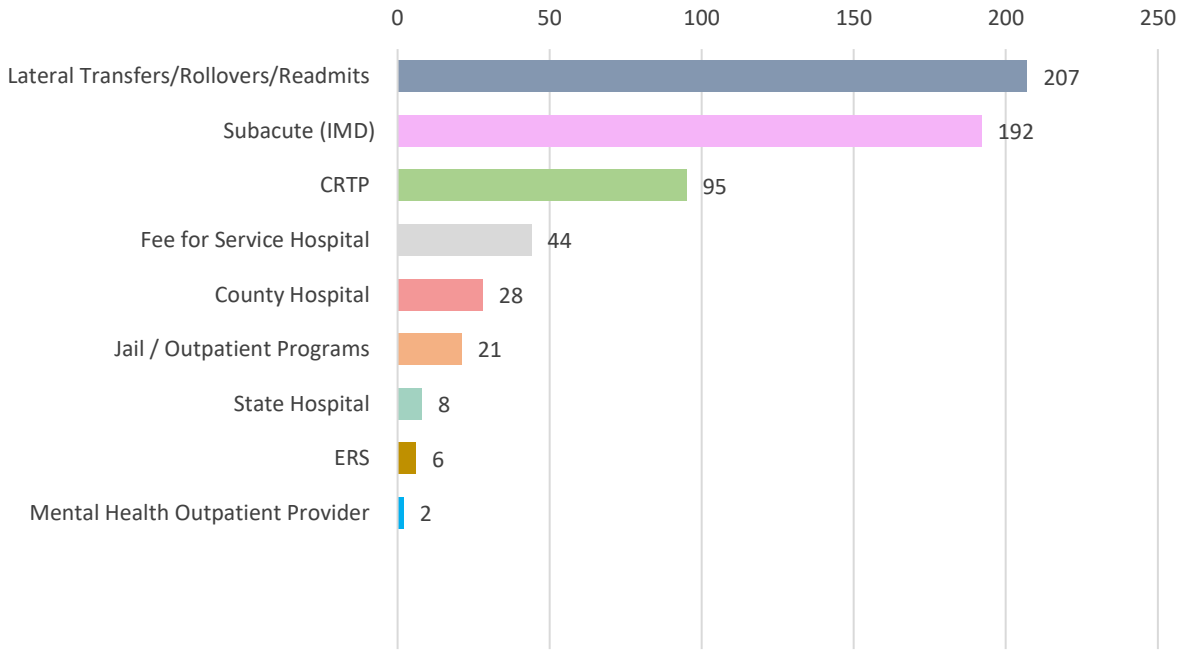
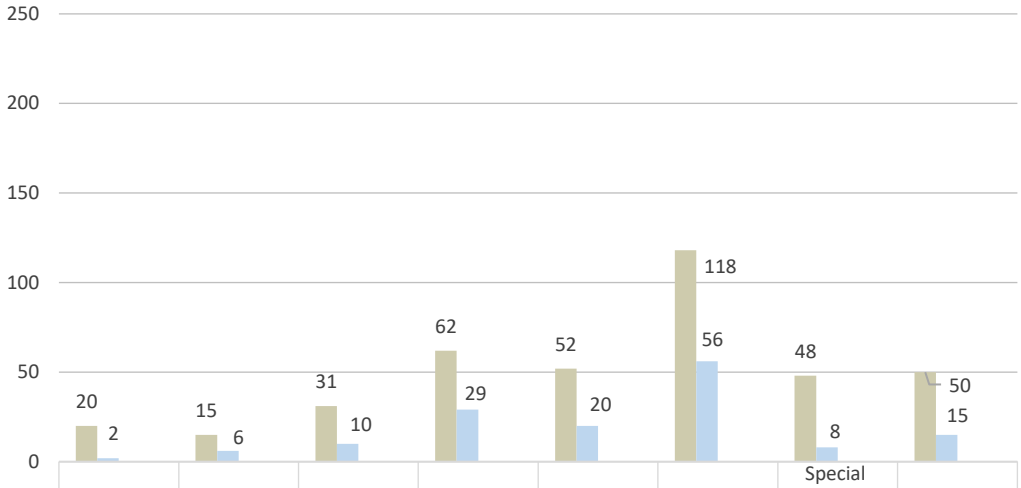
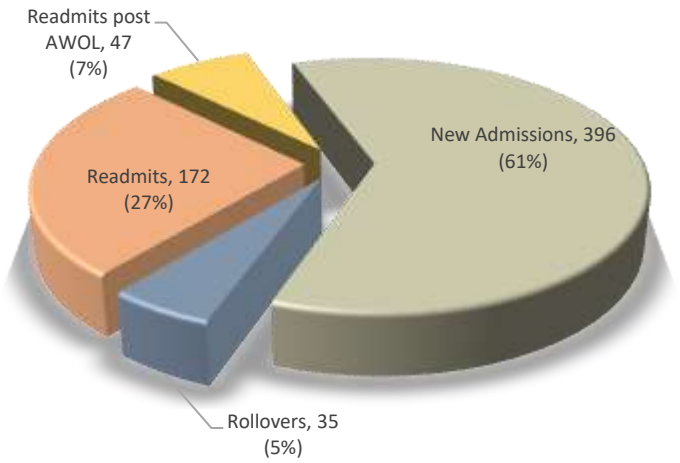


Figure 9. Client admission and discharge rates to ERS facilities (admission n = 396; discharge n = 146)



	Anne Sippi Clinic	Bridges	Cedar Street Homes	Normandie Village	Percy Village	Special Services for Groups	Special Services for Groups - Special Needs	Telecare 7
Admissions	20	15	31	62	52	118	48	50
Discharges	2	6	10	29	20	56	8	15
Discharged	10%	40%	32%	47%	38%	47%	17%	30%
Average Length of Stay	149	175	179	130	106	144	147	124

Figure 10. Client admission types to ERC facilities (n = 603)



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 24. 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	February 2022
Special Services for Groups (SSG)	16	February 2022
Martin Luther King, Jr.	16	February 2022

Figure 11. Source of Client Referrals for Crisis Residential Facility Admissions (n = 1,630)

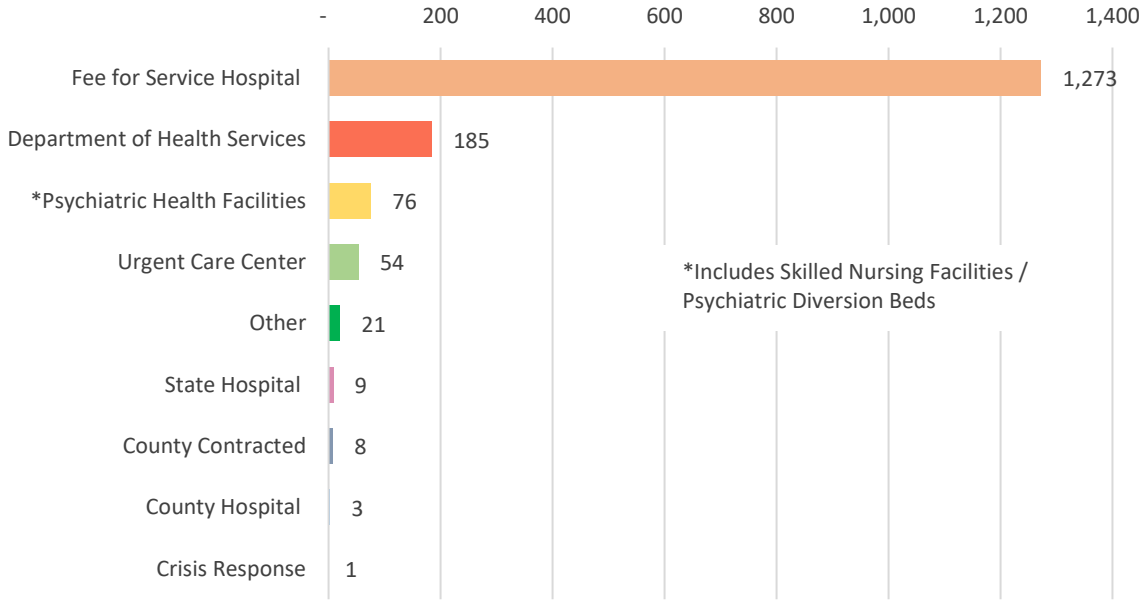
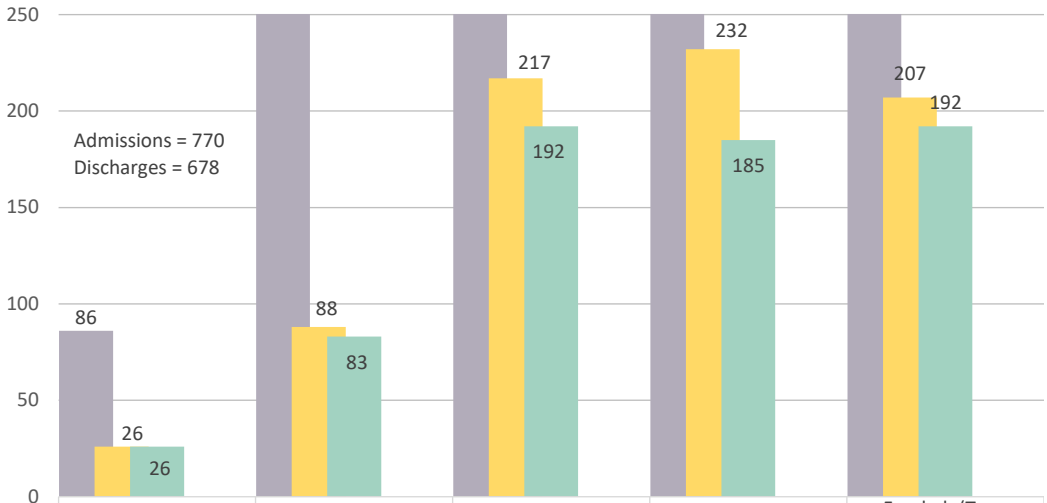


Figure 12. Client referrals, admissions and discharge rates CRTP admissions



	Hillview	CLARE Foundation	Gateways SRP	Exodus	Freehab (Teen Project)
Total Referrals*	86	397	612	643	485
Total Admissions	26	88	217	232	207
Total Discharges	26	83	192	185	192
Discharged	100%	94%	88%	80%	93%
Average Length of Stay	85	32	24	25	20

*Not all CRTP referrals result in an admission. For FY 2020-21, there were 2,223 CRTP referrals, of those 1,452 '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.

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 2020-21, there were 13,871 incidents, of which 31% involved homeless individuals; 4% resulted in arrests; and 60% required hospitalizations.

ALTERNATIVE CRISIS SERVICES Continued Work

LACDMH will continue to look for opportunities to enhance MHSA ACS funded program leveraging other potential funding sources 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 expand LET by an additional 10 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 2020-21		Prior FY 2019-20	
14,423 Total Number Served[1]	$137.3 million Total Gross Expenditures	33,458 Total Number Served	$124.2 million Total Gross Expenditures
FY 2022-23		**Three-Year Plan FYs 2021-24**	
23,940 Total Number to be Served[2]	$165.5 million Estimated Gross Expenditures	$516.3 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 2022-23 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 2020-21 ■ HOUSING Data and Outcomes

During FY 2020-21, 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 25. Number of developments by target population in FY 2020-21

Target Population	Number of Developments	Number of Units
TAY	20	360
Adults	80	2,154*
Older Adults	26	621
Families	14	408
Veterans	8	176*
Total	148	3,719

Since 2008, DMH has invested over $958 million in MHSA funds, of which $664 million has been committed, toward the development of Permanent Supportive Housing (PSH) in Los Angeles County for individuals and families who are homeless and living with a serious mental illness or severe emotional disorder. This has included providing capital funding for 148 PSH developments and 3,719 units as well as capitalized operating subsidies for 13 of these developments. The chart to the left offers further details on the populations being targeted for these development and units as of FY 2020-21.

*Includes both health-care eligible and non-health-care eligible Veterans.

By the end of FY 2020-21, 56 of the 148 PSH developments had finished construction and 1,100 of the 3,719 units were occupied with units ranging in size from studios to 1- to-4 bedroom apartments. Taking into account all move-ins and exits throughout the fiscal year, a total of 1,199 clients were served as well as 491 adult family members and 222 minor children. New lease-ups for the fiscal year totaled 268. The housing retention rate for the program was 95%.

As part of its PSH investment efforts for FY 2020-21, DMH continued to work in collaboration with the Los Angeles County Development Authority (LACDA) on the MHSA-funded No Place Like Home (NPLH) program. In October 2020, LACDA in collaboration with DMH released a Notice of Funding Availability (NOFA), which included $50 million in new NPLH dollars. The NOFA resulted in a commitment of NPLH funds toward 12 new PSH developments and 357 units targeting adults and older adults. These developments and units are included in the chart above.

D1. Federal Housing Subsidies Program

In addition to MHSA project-based PSH units, DMH grew its number of tenant-based PSH units to 2,639 in FY 2020-21 through 19 contracts with the City and County of Los Angeles Housing Authorities including two contracts managed by the Los Angeles County Department of Health Services (DHS). These contracts provide DMH clients who are homeless with access to federal tenant-based PSH subsidies such as Continuum of Care, Tenant Based Supportive Housing, Mainstream Voucher and Section 8 program subsidies. 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. The Federal Housing Subsidies Program leverages MHSA-funded services, which are used to meet the required Federal match for Continuum of Care subsidies. These services include those provided by DMH clinicians and case managers who assist clients who are homeless with accessing federal subsidies such as supporting them through the application, interview and housing location process as well as maintaining their housing once obtained.

With new move-ins and exits during the fiscal year, the Federal Housing Subsidies Program provided housing to 2,185 clients, 117 adult family members and 766 minor children. The number of clients newly leased up during the fiscal year totaled 314. With 122 clients also exiting housing, the retention rate for the program was 94%.

D2. Housing for Mental Health (HFMH)

In FY 2020-21, $10 million in MHSA funding was set aside for the Housing for Mental Health (HFMH) program. This program provides ongoing rental subsidies, as well as funding for security deposits, utility assistance and household goods, for highly vulnerable individuals with a serious mental illness who are enrolled in a Full Service Partnership (FSP) Program and are homeless and/or have criminal justice involvement. Twenty percent of housing subsidies are for FSP clients referred by

the Department of Health Services (DHS) Office of Diversion and Reentry. The HFMH program also works in close collaboration with DHS Intensive Case Management Services (ICMS) teams, who work alongside FSP staff to assist clients with the housing process, and with Brilliant Corners who serves as the administrator of the HFMH subsidies.

Table 26. Number of referrals by permanent housing type

Housing	Referrals	Move-ins
Tenant-Based Housing	95	150
Project-Based Housing	70	90
Licensed Residential Facility	6	8
Total	**171**	**248**

During FY 2020-21, a total of 445 individuals were served by the HFMH program. This included 171 individuals who were newly referred and 248 who newly moved into permanent housing. Recognizing that the housing needs of referred clients vary, HFMH rental subsides can be used for various types of permanent housing including tenant-based housing, project-based housing at one of eight partnering housing developments, and licensed residential facilities. The chart details to which types of permanent housing clients were referred as well as where they moved in. The housing retention rate for the program was 90%.

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 27. Number of clients served by program components

Services Provided	Number of Clients	Expenditure
Security Deposits	195	$301,753
Utility Deposits	26	$4,916
Household Goods	485	$478,558
One-Time Rental Assistance	3	$530
Time-Limited Rental Assistance	121	$424,705
Eviction Prevention	11	$8,699
Permanent Rental Subsidies	53	$1,162,292
TOTAL	**894**	**$2,381,453**

In FY 2020-2021, HAP provided financial assistance to 894 households totaling $2.38 million with amounts by service type detailed in the chart.

In addition to the above, HAP provided financial assistance to other DMH special populations. This included $40,354 to support eight Transition Age Youth (TAY) clients in directly-operated programs with rental assistance and move-in costs and $85,175 to support 28 adult FSP clients in directly-operated programs with Client Supportive Services (CSS) funding.

D4. Enriched Residential Care (ERC) Program

The Enriched Residential Care (ERC) Program assists DMH clients to obtain and maintain housing at an Adult Residential Facility (ARF) or Residential Care Facility for the Elderly (RCFE) when needed to live successfully in the community. Such unlocked facilities, which are licensed by the State, provide residents with 24-hour care and supervision, medication

management, three meals per day and assistance with activities of daily living. MHSA and other funds are used to pay for the client's rent at the facility as well as personal and incidental (P&I) expenses should the client not have Supplemental Security Income (SSI) or other adequate income to pay for these items. (It is a program requirement that all clients who are potentially eligible for SSI receive assistance to apply for SSI.) MHSA and other funds are also used to provide facilities with an enhanced rate to help cover the costs of enhanced services that a client may require due to their higher acuity and complex needs.

As of June 30, 2021, the ERC Program was serving a total of 595 clients. This included 175 clients who were receiving financial assistance for rent, P&I expenses and an enhanced rate as well as 420 clients who were receiving funding for an enhanced rate only.

Table 28. Number of new move-ins

Funding Type	Total New Move-Ins	Final Census (as of 6/30/20)
Rent, P&I and Enhanced Rate	151	119
Enhanced Rate Only	85	65
Total	236	184

Throughout FY 2020-21, 236 clients were newly referred to the ERC Program and 184 of them moved into an ARF or RCFE with ERC support. See chart below for further details on the population served by the ERC program. Overall, the ERC housing retention rate was 85%.

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, the IHP provides clients with safe and clean shelter, 24-hour general oversight, three meals per day, linens, clothing, toiletries and case management services.

Prior to the COVID-19 pandemic, MHSA funds enabled the IHP to contract for 575 beds across 19 sites. This included 506 beds for individuals and 69 family units. However, during FY 2020-21, IHP site capacity was reduced to provide safe occupancy in accordance with Los Angeles County Department of Public Health (DPH) guidelines. As a result, 413 individual beds and 69 family units were available last fiscal year, which served a total of 1,129 individuals and 153 families. Hotel and motel rooms secured through Project Roomkey were also made accessible to individuals in the IHP and new referrals who were COVID vulnerable.

FYs 2021-24 ■ HOUSING Continued Work

For FYs 2022-24, LACDMH continues to look for opportunities to grow its housing resources and ensure its existing resources meet the varied needs of those served. Other recent activities and future plans include:

- Initiating a capital improvements grant program for licensed residential facilities to help them address deferred maintenance issues (repairs, technology, etc.) that could threaten facility operations and impact their ability to provide critical housing and services to DMH clients in need. $11.2M in one-time MHSA funding has already been designated toward this program. To further fund these efforts, the County will also be applying for a portion of the $805M in Community Care Expansion funding that was approved by the State to support licensed residential facilities that serve people who are homeless or at risk of becoming homeless. Additional funding from philanthropic partners is also being leveraged to fund capital needs assessments and research that will analyze the operational and ownership structures of these facilities.
- Increasing Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding for the Enriched Residential Care (ERC) Program from $6M in FY 2021 to $8.7M in FY 2022. These additional dollars will fund new licensed residential care placements for DMH clients in need as well as help ensure the continued payment of client enhanced rates to licensed residential facilities that were previously supported by Whole Person Care funding, which ended in December 2021.
- Partnering with the Los Angeles Homeless Services Authority (LAHSA) on an application to the State for Encampment Resolution Grant funding that would help fund outreach and navigation services and interim and

FYs 2021-24 ■ HOUSING Continued Work
permanent housing for 500 women experiencing homelessness in the Skid Row area of Los Angeles and their associated households. - Exploring opportunities to implement temporary outdoor living environments within Los Angeles County, known as Triage Communities, that would increase the availability of officially endorsed, organized, safe, clean and resource-enriched sites where people experiencing homelessness can sleep, eat, work and socialize as a community while establishing longer-term plans. - Continuing to allocate the remaining No Place Like Home funding, of which $100 million has been set aside to develop PSH at Restorative Care Village sites on County healthcare campuses.

■ HOUSING	
Prior FY 2020-21	**Prior FY 2019-20**
$10.5 million Total Gross Expenditures	$31.2 million Total Gross Expenditures
FY 2022-23	**Three-Year Plan FYs 2021-24**
$35.1 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 2020-21 ■ LINKAGE Data and Outcomes

E1. Jail Transition and Linkage Services

Client Contacts: 2,825

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: 4,489

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: 20,166

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 2020-21 data reported by the Service Area Navigators.

Figure 13. Number of phone contacts and outreach activities

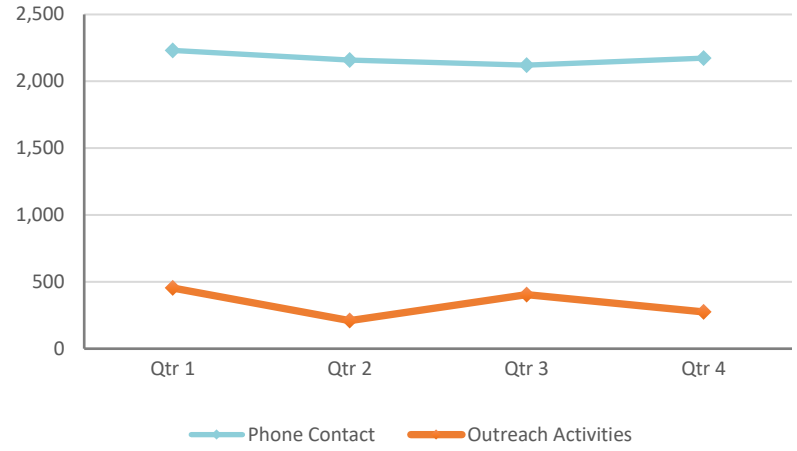


Figure 14. Number of clients referred to FSP services

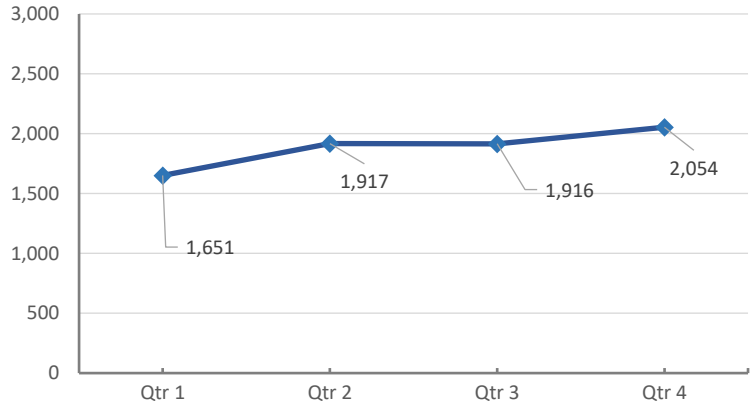
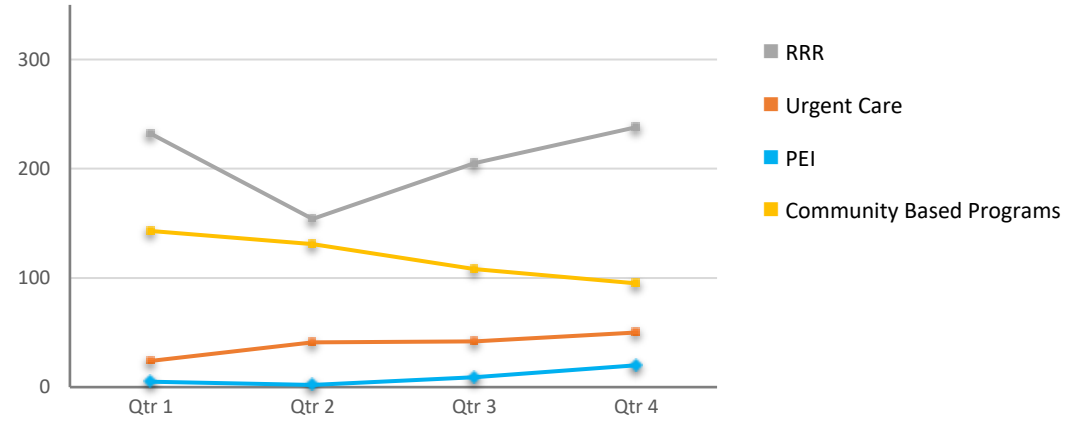


Figure 15. Number of clients referred to Non-FSP services



FYs 2022-24 ■ LINKAGE Continued Work
For FYs 2022-24, 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 2020-21	**Prior FY 2019-20**
$37.7 million Total Gross Expenditures	$17.7 million Total Gross Expenditures
FY 2022-23	**Three-Year Plan FYs 2021-24**
$34.9 million Estimated Gross Expenditures	$109.5 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 2020-21 ■ PLANNING, OUTREACH AND ENGAGEMENT Data and Outcomes

In FY 2020-21, Service Area outreach staff attended multiple events with 24,035 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 29. Event participants by Service Area

Service Area	Number of Participants
SA1 – Antelope Valley	2,874
SA2 – San Fernando Valley	95
SA3 – San Gabriel Valley	1,939
SA4 – Metro Los Angeles	458
SA5 – West Los Angeles	12,301
SA6 – South Los Angeles	2,204
SA7 – East Los Angeles County	4,035
SA8 – South Bay	85

An overview of the projects that were approved for each of the seven UsCC Subcommittees is provided below. Due to COVID-19 precautions, the FY 2019-2020 UsCC projects were rolled into FY 2020-2021. Most projects in this cycle are currently being implemented and therefore outcomes will not be available to report until after June of 2022. For projects in the this cycle that have been completed, a brief statement of the outcomes was provided.

A. AFRICAN/AFRICAN AMERICAN UsCC SUBCOMMITTEE

Project
Black & African-American Village Elders Mental Health Project Black and African-American Village Elders Mental Health Project aims to build a cadre of Community Service Leaders that have the knowledge and capacity to recognize and respond to signs of social isolation and disconnection from community amongst Black and African-American elders and their caregivers. Community Service Leaders will present community seminars specifically to these populations. 1st Component: Include recruitment of Community Service Leaders (CSLs), followed by the facilitation of a forum for the CSLs that focuses on how to work with and assist the Black and African-American elder population, as well as their caregivers, with regards to mental health awareness and signs and symptoms of isolation and depression. 2nd Component: For the CSLs to conduct community mental health seminars to outreach and engage elders and their caregivers.

Project
"Empowering the Black & African-American Family" A Wellness Conversation Series in Service Area 3 The objective of this project is to increase awareness and dialogue surrounding mental health issues, signs, and symptoms, provide multidisciplinary psycho-education on mental health challenges experienced by Black and African American adults and youth and destigmatize the topic of mental health in these communities. The goal is to have a monthly Wellness Conversation to decrease stigma about mental health issues and increase awareness of healthy coping strategies, connect community members to supportive resources and services needed to improve opportunities for healing and wholeness in their lives.

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

Project
American Indian/Alaska Native Community Mental Health Needs Assessment The project is to outreach and engage the AI/AN population into a discussion regarding the needs of their community, as well as reduce stigma associated with mental health services. Additionally, this project aims to increase awareness of the mental health needs of AI/AN individuals, increase connections with mental health providers, and provide opportunities to address concerns about mental health services. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. Phase 1: Outreach to individuals within the AI/AN community Phase 2: Conduct an AI/AN Community Leaders Mental Health Forum made up of leaders and providers who will be brought together into a learning collaborative to discuss the needs of the community.
American Indian/Alaska Native Outreach and Engagement Toolkit This project aims to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County, as well as increase community member engagement in the LACDMH stakeholder process. This project will include the recruitment of AI/AN community members, peers, and family members into a Cohort, the development of an Outreach and Engagement Toolkit including a training video, and the facilitation of a Community Wellness Forum. 1st Component: Outreach and engagement of AI/AN community members, peers, and family members into a Cohort. 2nd Component: Involve Cohort Members hosting a Community Wellness Forum with the purpose of further building community connections and sharing personal testimonials regarding their experiences during the Cohort Meetings, and providing attendees with a copy of the Toolkit.
American Indian/Alaska Native Wellness Forums The project aims to reduce mental health access barriers for AI/AN community members by engaging this population into conversations about mental health and traditional forms of healing. This will enable this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services as well.

C. ASIAN PACIFIC ISLANDER (API) UsCC SUBCOMMITTEE

Project
Korean Mental Health Navigation Services Pilot Project The goal of this project is to develop Korean Mental Health Navigation Services that will primarily target the first generation immigrant Korean community (all ages) in Service Area (SA) 4. It will include information on mental health resources, help connecting to services and faith-based programs, as well as provide mental health awareness workshops for Clergy and community members.
Asian Pacific Islander Families – Our Stories and Our Journey on Mental Health Recovery and Resilience This project aims to compile helpful mental health wellness information, resources, and personal stories of recovery and resilience in audio-visual format to share with various API communities (e.g., Cambodian, Chinese, Filipino, Korean, South Asian, Vietnamese). The audio-visual format, such as narrated Power Point presentations (with audio and video segments), could be shared via social media (such as: YouTube; WeChat) and in waiting rooms of clinics to de-mystify mental health issues

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

Project
Mental Health Needs Assessment for the Blind, Partially Sighted, and Visually Impaired Community The goal of this project is to outreach and engage people who are blind, partially sighted, and visually impaired individuals into a virtual discussion regarding the mental health needs of this community, as well as to reduce the stigma associated with mental health services. Additionally, this project aims to increase connections with mental health providers and provide opportunities to address concerns about mental health services. This project will target blind, partially sighted, and visually impaired community members from eight the (8) service areas across Los Angeles County.
Mental Health Needs Assessment for the Deaf and Hard of Hearing Community The goal of this project is to outreach and engage people who are blind, partially sighted, and visually impaired individuals into a virtual discussion regarding the mental health needs of this community, as well as to reduce the stigma associated with mental health services. Additionally, this project aims to increase connections with mental health providers and provide opportunities to address concerns about mental health services. This project will target blind, partially sighted, and visually impaired community members from eight the (8) service areas across Los Angeles County.
Mental Health Needs Assessment for Physically Disabled Community The goal of this project is to outreach and engage people who are physically disabled individuals into a virtual discussion regarding the mental health needs of this community, as well as to reduce the stigma associated with mental health services. Additionally, this project aims to increase connections with mental health providers and provide opportunities to address concerns about mental health services. This project will target blind, partially sighted, and visually impaired community members from eight the (8) service areas across Los Angeles County.

E. EASTERN EUROPEAN/MIDDLE EASTERN UsCC SUBCOMMITTEE

Project
Armenian Community Symposiums Project This project aims to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County. This will enable this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services as well. In addition, this project will inform the Armenian community members regarding the EE/ME UsCC subcommittee in order to increase community member and consumer interest and participation in the MHSA stakeholder process and engage more consumers and community members to participate in the monthly EE/ME UsCC subcommittee meetings. Project Outcomes: Virtual Armenian Mental Health Symposium #1 was conducted on 12/5/2021. There were around 35 participants. Three different mental health topics were presented, such as Depression, Substance Abuse and Domestic Violence within the Armenian Community. This symposium was conducted in the Armenian language. The presentations were educational and culturally sensitive. Participants provided positive feedback about the presentations, stating that the presentations were informative and interesting.
Mental Health Needs Assessment for the Arabic Speaking Community through Virtual Focus Groups This project aims to develop and implement Mental Health Needs Assessment Project for the Arabic speaking community through conducting 8 virtual focus groups. This t will be completed in two phases: ❶ Conduct Community Leaders Mental Health Forum made up of leaders and providers within the Arabic speaking community who will be brought together virtually (i.e. Zoom, Skype) into a learning collaborative to discuss the needs of the community. ❷ Outreach to the Arabic speaking community and engage them in virtual focus groups to assess the needs of the community, identify gaps in access to mental health services, and identify how to engage community members into mental health services provided by LACDMH
The Farsi Poetry Night Mental Health Virtual Outreach Project This project aims to develop and implement virtual the Poetry Night Mental Health Outreach Project. This project will target Farsi speaking older adults residing in Los Angeles County. This project will consist of virtual Poetry Night events two (2) times a month, for ten (10) consecutive months. Poetry is an important part of the Iranian culture and is traditionally used as a tool to help individuals heal from their mental and emotional problems. The Poetry Night Mental Health Outreach Project

Project
or “Shabeh Sher” will provide a place for Farsi speaking older adults to get together and interact with one another. It will also provide a safe space for them to share their emotional and mental health issues in a culturally appropriate and acceptable manner. Poetry night events will be facilitated by a poetry expert, who will bring in poems to share with the participants and have interactive group discussion. Project Outcomes: Vendor provided schedules for the Poetry Workshops in English and Farsi for all 10 months. Individual flyers include zoom link. Four poetry classes have been conducted already. Vendor reported that overall, the workshops are going very well. The poetry classes are getting good attendance and very positive feedback from community members. Vendor is also planning on doing some advertisements with the local Iranian radio stations for the workshops starting in January.
Russian Mental Health Outreach Campaign The Russian Public Service Announcement Project seeks to increase mental health awareness and education to the Russian community in Los Angeles County, which is significantly underserved by the public mental health system. The Campaign includes production and distribution of PSAs that will serve as the centerpiece of the engagement efforts. The selected Consultant is expected to have experience reaching the intended audiences and expertise in the specific outreach strategies being used to reach them. An initial project proposal must be approved by LACDMH before beginning work. This Campaigns should run for a period of 12 months. A final report and summary of the Campaign’s results is required at the completion of the project/ Project Outcomes: Russian PSAs have been airing on Russian-Armenian Television, ARTN, Network, 4 times a day and Russian Television Network, RTN, 2 times a day. Vendor submitted Airing Logs from RTN for the Russian Media Campaign and is waiting to receive the Airing Logs from ARTN. The project is going well according to the Vendor.

F. LATINO UsCC SUBCOMMITTEE

Project
Older Latino Adults Outreach and Engagement Project This project will target the older Latino adult community at large by promoting mental health literacy, increasing mental health service utilization and education, and reducing mental health stigma. Older Latino adults in Los Angeles County are predominantly Spanish-speaking and first-generation immigrants. Among this group, the rates of untreated anxiety, loneliness, and depression are high while mental health education, service utilization, and health literacy remains significantly low. Health literacy disparities are most likely to affect older ethnic minority adults, particularly first-generation immigrants who are non-native English-speakers. Social stigma, a lack of knowledge, language barriers, and Eurocentric clinical approaches lacking cultural relevance have prevented older Latino adults from receiving mental health services in a timely and culturally appropriate manner.
Latino Garment District Workers Outreach Project This project aims to develop and implement the Latino Garment District Workers Outreach Project. It will target the Latino garment workers in Service Area four (4), Service Area six (6), and Service Area seven (7), but can include other service areas based on need. The project’s main goal is to outreach, educate, and increase knowledge pertaining to mental health services and resources by utilizing a non-stigmatizing and empowering approach. To develop and implement this project

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

Project
Abusua PA The “Abusua Pa” Black LGBTQIA2-S Parents, Caregivers, and Youth Collaborative Project hopes to develop tools, resources, and educational videos to help Black and African American caregivers in working with their LGBTQIA2-S identified youth as well as help providers and clinicians in engaging and working with the Black LGBTQIA2-S community. ● 1st Component: Outreach and engagement of Black and African American parents and caregivers of LGBTQIA2-S identified youth, as well as the youth themselves into a Collaborative. Collaborative members will participate in 2-hour weekly meetings for a minimum period of 8 weeks.

Project
●2nd Component: Collaborative members hosting a Community Wellness Forum with the purpose of further building community connections and sharing personal testimonials regarding their experiences during the Collaborative meetings, and providing attendees with a copy of the Toolkit.
LGBTQIA2-S Youth Mental Health Community Engagement Campaign The LGBTQIA2-S UsCC's aims to create content that will reach and inspire youth to promote mental health services, reduce stigma and barriers to mental health services for LGBTQIA2-S youth. The Campaign includes production and distribution of five videos that will serve as the centerpiece of the engagement efforts
LGBTQIA2-S Youth Innovation Lab & Fellowship Project This project aims to empower youth as the experts to develop their own innovative strategies, educate and empower this community about the importance of mental health care, destigmatize mental health issues amongst LGBTQIA2-S youth, develop culturally sensitive resources/tools. e hired to implement the LGBTQIA2-S Youth Innovation Lab & Fellowship Project. It include outreach and engagement of LGBTQIA2-S Youth Fellows into a Youth Innovation Lab. During the Lab, the Fellows will develop innovative strategies for reducing mental health access barriers for their community, work on building stronger social connections, and develop tools and resources that can be shared with other LGBTQIA2-S youth, as well as clinicians and providers.
LGBTQIA2-S Non-Binary & Intersex Mental Health Survey The objective of the LGBTQIA2-S Non-Binary & Intersex Mental Health Survey is to conduct a community survey, including focus groups, of the non-binary and intersex communities in order to promote mental health services, reduce stigma and barriers to mental health services for the non-binary and intersex communities, and increase the capacity of the public mental health system in Los Angeles County. As non-binary and intersex identities are becoming more visible and understood by the public, there remains very little data and research around mental health and related issues/challenges regarding non-binary and intersex people. Project Outcomes: Two surveys completed: Survey 1 produced 296 usable entries and Survey 2 produced 300 usable entries. Of those, 144 were currently receiving or had received mental health care in the past. The majority of survey participants identified as non-binary. 165 participants reported having encountered barriers to care while trying to access mental health services. Most common barriers included lack of affirming clinicians and too expensive/lack of financial resources. 281 participants reported that telehealth is a beneficial tool to assist in affirming gender identity during medical appointments.

FYs 2022-24 ■ PLANNING, OUTREACH AND ENGAGEMENT Continued Work
For FYs 2022-24, LACDMH will continue outreach and engagement activities.

■ PLANNING, OUTREACH AND ENGAGEMENT	
Prior FY 2020-21	**Prior FY 2019-20**
$8.3 million Total Gross Expenditures	$6.7 million Total Gross Expenditures
FY 2022-23	**Three-Year Plan FYs 2021-24**
$6.5 million Estimated Gross Expenditures	$20.2 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 30. FY 2020-21 Clients served through PEI

Clients Served	New Clients Served
42,784 clients received a direct mental health service: - 62% of the clients are children - 21% of the clients are TAY - 15% of the clients are adult - 2% of the clients are older adult - 45% of the clients are Hispanic - 9% of the clients are African American - 9% of the clients are White - 3% of the clients are Asian/Pacific Islander - 1% of the clients are Native American - 4% of the clients are Multiple Races - 76% have a primary language of English - 21% have a primary language of Spanish	23,277 new clients receiving PEI services countywide: with no previous MHSA service - 42% of the new clients are Hispanic - 9% of the new clients are African American - 9% of the new clients are White - 3% of the new clients are Asian/Pacific Islander - 4% of the new clients are Multiple Races - 0.42% of the new clients are Native American - 76% have a primary language of English - 21% have a primary language of Spanish

Table 31. FY 2020-21 Clients served through PEI by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	43,588	1,560
SA 2 – San Fernando Valley	2,850	3,807
SA 3 – San Gabriel Valley	7,288	4,068
SA 4 – Metro Los Angeles	7,042	3,890
SA 5 – West Los Angeles	6,231	931
SA 6 – South Los Angeles	1,626	3,334
SA 7 – East Los Angeles County	6,185	3,882
SA 8 – South Bay	7,020	3,807

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 2020-21 ■ EARLY INTERVENTION Data and Outcomes

Table 32. FY 2020-21 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: 19 Gender: 68% Male, 32% Female Ethnicity: 53% Hispanic, 5% African American, 37% 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: 161 Gender: 53% Male, 47% Female Ethnicity: 66% Hispanic, 14% African American, 1% Asian, 2% White, 16% 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)	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: 31 Gender: 65% Male, 35% Female Ethnicity: 58% Hispanic, 10% Unreported, 13% White 3% Asian, 10% Multiple Races, 3% African American, 3% 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: 1,526 Gender: 53% Male, 47% Female Ethnicity: 43% Hispanic, 12% African American, 0.46% Asian, 10% White, 28% Unreported 5% Multiple Races, 0.13% Native American, 1% Native Hawaiian/Pacific Islander	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: 78 Gender: 31% Male, 69% Female Ethnicity: 35% Hispanic, 15% African American, 5% Asian, 6% White, 24% Unreported, 13% Multiple Races, 1% Native Hawaiian/Pacific Islander	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: 37% Male, 63% Female Ethnicity: 26% Hispanic, 1% Native American, 68% Unreported, 1% White, 3% 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: 202 Gender: 20% Male, 79% Female, 1% Female to Male Ethnicity: 33% Hispanic, 11% African American, 3% Asian, 21% White, 22% Unreported, 2% Native Hawaiian/Pacific Islander, 5% 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: 97 Gender: 53% Male, 47% Female Ethnicity: 17% Hispanic, 4% African American, 1% White, 77% Unreported, 1% 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: 38 Gender: 55% Male, 45% Female Ethnicity: 11% White, 53% Hispanic, 18% Unreported, 11% African American, 8% Multiple Races,	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: 5 Gender: 40% Male, 60% Female Ethnicity: 20% Asian, 40% Hispanic, 20% African American, 20% Multiple Races	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: 118 Gender: 73% Male, 27% Female Ethnicity: 64% Hispanic, 4% African American, 4% Asian, 13% White, 14% Unreported, 1% 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: 3,239 Gender: 27% Male, 73% Female Ethnicity: 49% Hispanic, 7% African American, 2% Asian, 13% White, 22% Unreported, 1% Native Hawaiian/Pacific Islander, 6% Multiple Races, 0.25% Native American	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: 1,311 Gender: 31% Male, 69% Female Ethnicity: 35% Hispanic, 6% African American, 2% Asian, 7% White, 47% Unreported, 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)	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: 13,761 Gender: 47% Male, 53% Female Ethnicity: 47% Hispanic, 6% African American, 1% Asian, 7% White, 34% Unreported, 4% 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: 907 Gender: 28% Male, 72% Female Ethnicity: 54% Hispanic, 11% African American, 2% Asian, 14% White, 12% 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)	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: 1,733 Gender: 45% Male, 55% Female Ethnicity: 54% Hispanic, 13% African American, 2% Asian, 14% White, 8% Unreported, 1% Native Hawaiian/Pacific Islander, 7% 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: 950 Gender: 62% Male, 38% Female Ethnicity: 45% Hispanic, 9% African American, 31% 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
Powerful Initiatives for Early Recovery (PIER) Children (ages 12-15) TAY (ages 16-25)	PIER provides early treatment for youth who pose a clinical-high-risk of developing severe mental illness, such as schizophrenia and psychosis. By detecting and treating patients at the onset of psychosis, the negative impact of psychosis may be mitigated. The PIER program assists youth and families to increase performance in all areas of life by building coping skills, reducing stress, and implementing problem-solving techniques.
Problem Solving Therapy (PST) Older Adults Unique Clients Served: 15 Gender: 33% Male, 67% Female Ethnicity: 80% Hispanic, 13% White, 7% 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: 9 Gender: 89% Female, 11% Male Ethnicity: 11% Hispanic, 33% Asian, 11% White, 11% African American, 33% 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: 12 Gender: 25% Male, 75% Female Ethnicity: 33% Hispanic, 8% African American, 33% Unreported, 8% White, 8% 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: 16 Gender: 44% Male, 56% Female Ethnicity: 44% Hispanic, 12% African American, 25% Unreported, 13% White, 6% Asian	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: 1,429 Gender: 33% Male, 67% Female Ethnicity: 51% Hispanic, 7% African American, 1% Asian, 10% White, 27% Unreported, 1% Native Hawaiian/Pacific Islander 2% 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
Stepped Care (SC) Children TAY Adults Older Adults Unique Clients Served: 12,203 Gender: 43% Male, 57% Female Ethnicity: 42% Hispanic, 8% African American, 3% Asian, 8% White, 5% Multiple Races, 1% Native Hawaiian/Pacific Islander	This service delivery option intends to improve access to services for clients and families who are experiencing early signs and symptoms of mental illness, require engagement into the mental health system, and are not ready to participate in evidence-based early intervention services. Client level of care received is determined by the initial and ongoing assessment.
Strengthening Families (SF) Children (ages 3-15) TAY (ages 16-18) Unique Clients Served: 4 Gender: 25% Male, 75% Female Ethnicity: 25% Hispanic, 75% 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: 3,432 Gender: 40% Male, 60% Female Ethnicity: 46% Hispanic, 8% African American, 7% White, 32% Unreported, 1% Asian 0.55% 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: 356 Gender: 67% Male, 33% Female Ethnicity: 42% Hispanic, 4% African American, 2% Asian, 11% White, 7% Multiple Races, 35% 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: 7 Gender: 43% Male, 57% Female Ethnicity: 43% Hispanic, 14% African American, 14% Unreported, 14% White, 14% Multiple Races	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 33. EBP Outcomes since 2009 through June 2021

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
ART	3,432	43%	- 10% Improvement in disruptive behaviors (as reported by parents and children) - 21% Reduction in the severity of problem behaviors (as reported by parents and children) - 6% Improvement in disruptive behaviors (as reported by teachers) - 14% Reduction in the severity of problem behaviors (as reported by teachers)
ART Skillstreaming	328	54%	- 21% Reduction in disruptive behaviors - 19% Reduction in the severity of problem behaviors
AF-CBT	1,699	52%	- 58% Reduction in trauma related symptoms
BFST	203	63%	- 50% Reduction in behavioral problems - 66% Reduction in anxiety symptoms - 60% Reduction in attention problems
CFOF	733	67%	- 30% Improvement in disruptive behaviors - 20% Reduction in the severity of problem behaviors
CAPPS	207	42%	- 60% Reduction in prodromal symptoms
CPP	7,313	47%	- 17% Improvement in mental health functioning following a traumatic event
CBITS	131	71%	- No Data to Report (n=12)
CORS	4,163	60%	- 18% Improvement in mental health functioning
DBT	263	59%	- 7% Improvement in emotional regulation
DTQI	1,331	65%	- 55% Reduction in symptoms related to depression
FOCUS	714	70%	- 50% Improvement in direct communication
FC	23	44%	- No Data to Report (n=1)
FFT	1,721	66%	- 31% Improvement in mental health functioning
Group CBT	1,137	42%	- 42% Reduction in symptoms related to depression
IY	2,856	64%	- 35% Reduction in disruptive behaviors - 18% Reduction in the severity of problem behaviors
Ind. CBT	Anxiety 3,561 Depression 7,478 Trauma 1,057	Anxiety 45% Depression 44% Trauma 47%	- 63% Reduction in symptoms related to anxiety - 58% Reduction in symptoms related to depression - 61% Reduction in trauma related symptoms
IPT	8,166	49%	- 50% Reduction in symptoms related to depression
LIFE	433	65%	- 50% Reduction in disruptive behaviors - 23% Reduction in the severity of problem behaviors
MAP	66,271	51%	- 43% Reduction in disruptive behaviors - 26% Reduction in the severity of problem behaviors - 55% Reduction in symptoms related to depression - 44% Reduction in symptoms related to anxiety - 50% Reduction in trauma related symptoms
MHIP	Anxiety 2,670 Depression 6,475 Trauma 302	Anxiety 38% Depression 33% Trauma 29%	- 58% Reduction in symptoms related to anxiety - 57% Reduction in symptoms related to depression - 24% Reduction in trauma related symptoms
MPG	16	86%	- No Data to Report (n=1)
MDFT	77	89%	- No Data to Report (n=6)
MST	126	72%	- No Data to Report (n=0) Pediatric Symptom Checklist 35 is used for this practice
NPP	N/A	N/A	- No Data to Report (n=0)

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
PCIT	4,666	40%	- 63% Reduction in disruptive behaviors - 37% Reduction in the severity of problem behaviors
PIER	N/A	N/A	- No Data to Report
PST	409	63%	- 45% Reduction in symptoms related to depression
PEARLS	168	49%	- 45% Reduction in symptoms related to depression
PE-PTSD	99	58%	- No Data to Report (n=14)
PATHS	747	33%	- 33% Reduction in disruptive behaviors - 19% Reduction in the severity of problem behaviors
RPP	250	72%	- 15% Reduction in disruptive behaviors - 6% Reduction in the severity of problem behaviors
SS	20,954	40%	- 52% Reduction in trauma related symptoms (Adults) - 42% Reduction in trauma related symptoms (Children)
SC	8,767	100%	- 26% Improvement in mental health functioning
SF	237	89%	- No Data to Report (n=15)
TF-CBT	25,721	54%	- 51% Reduction in trauma related symptoms
Triple P	6,423	60%	- 50% Reduction in disruptive behaviors - 27% Reduction in the severity of problem behaviors
UCLA TTM	196	50%	- No Data to Report (N=11)

■ EARLY INTERVENTION			
Prior FY 2020-21		**Prior FY 2019-20**	
42,784 Total Number Served[1]	$188.6 million Total Gross Expenditures	47,602 Total Number Served	$206.5 million Total Gross Expenditures
FY 2022-23		**Three-Year Plan FYs 2021-24**	
45,193 Total Number to be Served[2]	$226.2 million Estimated Gross Expenditures	$667.4 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 2020-21 ■ 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.

- *Home Visitation Program (HVP)*

  The Home Visitation Program (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 could 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.

Table 34. HVP client demographics (n = 911)

▪ Primary Language		▪ Ethnicity	
Arabic	1	Hispanic or Latino as follows:	
Cambodian	12	Central American	142
Cantonese	3	Mexican/Mexican American/Chicano	450
English	541	Puerto Rican	4
Spanish	334	South American	12
Tagalog	2	Other	70
Other	17	Non-Hispanic or Non-Latino as follows:	
Declined to answer	1	African	36
▪ Age		Asian Indian/South Asian	8
0-15	16	Cambodian	14
16-25	419	Chinese	3
26-59	447	Eastern European	5
Declined to answer	29	European	5
▪ Gender Assigned at Birth		Filipino	12
Male	20	Japanese	1
Female	588	Korean	2
Declined to answer	303	Middle Eastern	5
▪ Current Gender Identity		Vietnamese	2
Male	20	Other	46
Female	588	More than one ethnicity	22
Transgender	1	Declined to answer	72
Genderqueer	2	▪ Race	
Questioning or unsure	0	American Indian	5
Another gender identity	6	Asian	52
Declined to answer	347	Black or African-American	92
▪ Disability		Native Hawaiian or Other Pacific Islander	3
No	666	White	
Yes	208	More than one race	52402
Difficulty seeing	1	Other	277
Difficulty hearing	2	Declined to answer	28
Mental domain	110	▪ Veteran Status	
Physical/mobility domain	30	Yes	5
Chronic health condition	99	No	865
Other	20	Declined to answer	41
Declined to answer	37		

- *Library Child, Family and Community Prevention Programs*

The Library initiative is intended to increase protective factors, thereby mitigating the impact of risk factors associated with serious psychiatric illness and negative outcomes. It is intended to serve primary target populations residing in underserved communities experiencing adversity: 1) young children and their parents/caregivers, 2) school-aged children, and 3) Transitional Age Youth (TAY).

With the advent of COVID-19, the Library pivoted to address community need by adapting program service delivery pathways to mediums such as YouTube, Facebook, and WebEx. Specifically, the Library developed on-line programming as an alternative to in-person activities. Library staff scripted, researched, produced, and disseminated

live and recorded programs. Staff reductions due to factors such as deployment, reassignment, retention issues, and leave impacted the program delivery time frame. Other challenges included community technology disparity and access to content for virtual programming. Challenges notwithstanding, the benefit of using virtual platforms to support program continuity during a time of pivot cannot be understated as it provided a necessary conduit for Library programs to be maintained and reach an audience that transcended the conventional Library patronage.

The Library initiative was implemented through five programs delivered by funded staff with the intention of increasing protective factors (e.g. resilience, socio-emotional skill building and social connectedness). The specific programs were:

1. School Readiness - Smarty Pants Storytime introduced parents and children to the variety of skills needed for school success and allowed practice of those skills in a virtual setting.

2. Triple P Positive Parenting Program (Triple P). Librarians, certified in the Triple P model, engaged with participants, and provided parenting assistance. They offered information and educational materials on parenting and child development. Triple P librarians attended select School Readiness Programs, Parent Cafes, Afterschool Programs, and other funded programs that have parents in attendance.

Triple P programming was generally delivered during “brief contacts” under 15 minutes in length. These consultations were informal conversations with parents or caregivers about their parenting concerns. For instance, a Library staff might have provided a Triple P consultation in response to a parent asking for strategies to help their child go to bed on time. Consultations were scheduled upon requests and provided virtually or by phone.

3. Afterschool Program. Programming delivered afterschool activities in a virtual setting targeting youth and families. Programs varied and included self-expression through activities that encompassed art and exploration of STEM subjects.

4. The Summer Discovery Programs are generally interactive and delivered by professionals. Programming introduced aspects of a culture to a family-focused audience. The programs featured a culture prevalent in the community or introduced aspects of a less dominant culture in the area. These programs were offered during the spring and summer seasons.

5. Steam/MākMō programming supported exploration of science, technology, engineering, arts, and mathematics (STEAM) subjects through fun and interactive activities designed for children, teens, and adults.

During FY 2020-21, the Library provided a total of 458 virtual programs. There were 103,755 cumulative views across all programming.

Table 35. Library programs deliverables

Library Program	Number of programs	Number of Views
School Readiness (0-5)	225	76,543
Triple P (parent/caregiver)	71	7,147
Afterschool (youth)	70	10,945
Summer Discovery Programs (youth and families)	42	3,122
STEAM/MākMō (all ages)	50	5,728
TOTAL	458	103,755

In an effort to evaluate the impact of these programs on protective factors, participants were encouraged to complete one of two (depending on age) surveys that were available via link after the virtual program. The surveys were composed of two demographic questions (age and primary language) and 5 self-report items intended to assess perception of protective factors resulting from participation in Library Prevention Programming. Approximately 1% of virtual programs resulted in a participant following the link to a survey. Although this is a small convenience sample, respondents overwhelmingly agreed that the Library Prevention Programs provided helpful information, that it helped them feel like a part of the community, that it was a good use of their time, and that the Library was a safe place. The demographics reported by this sample are as follows:

Table 36. Library client demographics (n = 1,184)

▪ Primary Language	
Arabic	5
Armenian	4
Cambodian	1
Chinese (Other/Unknown dialect)	32
English	986
Farsi	2
Korean	11
Russian	9
Spanish	76
Tagalog	21
Vietnamese	13
Other	13
Declined to answer	11
▪ Age	
0-15	201
16-25	48
26-59	617
60+	291
Declined to answer	27

- *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.

- *My Health LA Behavioral Health Expansion Program*

  On October 1, 2014, DHS formally launched the My Health LA (MHLA) Program with the goal of increasing access to primary health care services for low income, uninsured residents of Los Angeles County. The Board of Supervisors approved numerous changes to the MHLA agreement with Community Partner Clinics (CPs) on November 20, 2018. A workgroup was formed to understand gaps in behavioral healthcare access and how to address those gaps. The group identified the need to better support CPs who provide mental health care services to MHLA participants in the primary care setting as a priority.

  It was determined that DMH would fund and support mental health prevention services and/or activities (MHPS) to reduce/manage risk factors associated with the onset of serious mental illness, as well as to cultivate and support protective factors of MHLA participants at CP clinics through a Prevention Program.

  MHLA participants who live in Los Angeles County, are age 26 or older, low-income and do not have and cannot get health insurance are eligible to receive one or more applicable and clinically appropriate MHPS. The MHPS delivered through MHLA are designed to reduce/manage risk factors, as well as to cultivate and support protective factors.

  These services included (but were not limited to): Initial Engagement and Mental Health Screening, Linkage to non-specialty and specialty mental health services as needed, psychoeducation, wellbeing workshops, individual support services such as social and emotional skill development, healthy coping skills, stress reduction, mitigating the impacts of trauma, and prevention skills for depression and anxiety. All services may be delivered in person, by phone or virtually. Further, these services were offered as individual or group sessions.

  In FY 2020-2021, 27,603 MHLA patients elected to enroll in these Mental Health Prevention Services (MHPS). 10,676 of them received two or more MHPS services.

  The Covid-19 Pandemic impacted program delivery and data collection for a variety of reasons, including the strain put on County staff and resources and each CPs' workforce. As community-based health care clinics, CPs were front line in their respective communities for handling Covid-19 education and information dissemination, treatment, testing, and vaccinations. As such, staff were being pulled in multiple directions to help their community manage this crisis while also trying to implement this new MHPS Program.

  The measures selected to collect outcomes for this Prevention program were the Patient Health Questionnairre-9 (or PHQ-9) as a required measure and the Generalized Anxiety Disorder-7 or (GAD-7) as an optional, but recommended measure, respectively used to self-report on depression and anxiety. However due to the aforementioned factors and others, that data is not available at this time.

Table 37. MHPS client demographics (n = 27,603)

▪ Primary Language			▪ Ethnicity	
English	1,900		Hispanic or Latino as follows:	
Arabic	3		Other/Unknown Hispanic	25,835
Armenian	84		Non-Hispanic or Non-Latino as follows:	
Farsi	3		African	42
Korean	104		Asian Indian/South Asian	13
Chinese (Other/Unknown)	21		Cambodian	4
Russian	8		Chinese	19
Spanish	25,132		Filipino	270
Tagalog	34		Japanese	3
Vietnamese	1		Korean	65
Other	258		Vietnamese	1
Declined to answer/missing	55		Other Non-Hispanic	771
▪ Age			Declined to answer	580
26-64	24,789		▪ Race	
65+*	2,814		Asian	620
▪ Gender			Black or African-American	42
Male	9,614		Native Hawaiian or other Pacific Islander	274
Female	17,972		White	220
Other	17		Other**	25,867
			Declined to answer/missing	580

*DHS uses 65+ to indicate elderly whereas MHSA uses 60+.

**Ethnicity and race were collected as one category by DHS. Therefore, participants identified as Hispanic or Latino were coded as "Other" race.

- *Prevent Homelessness Promote Health (PH^2)*

Prevent Homelessness Promote Health (PH2) is a collaboration between Los Angeles County Department of Health Services: Housing for Health (HFH) and Department of Mental Health (DMH). It is a Countywide program that conducts field-based outreach services to assist previously homeless individuals and families who are experiencing untreated serious and persistent medical and mental illness avoid returning to homelessness due to lease violations.

The DMH Prevent Homelessness Promote Health - PH2 employs an interdisciplinary, multicultural, and bilingual staff, utilizing a collaborative approach through coordination with Department of Health Services (DHS), Housing for Health (HFH) Intensive Case Managers (ICMS), Department of Mental Health (DMH), and community housing agencies. This program provides services within the 8 Service Areas of Los Angeles County. All initial outreach is provided in the community where the individual lives to promote access to care. The PH2 team conducts triage, coordination of services, and brief clinical interventions, as well as incorporating Motivation Interviewing (MI), Harm Reduction, Trauma Informed therapy, Solution Oriented therapy, Cognitive Behavior therapy, and Seeking Safety. Services are delivered primarily in person or can be delivered by phone or virtually.

Individuals are referred with the following identified problems, among others: Aggressive/Violent Behavior, Destruction of Property, Failure to Pay Rent, Fire Safety/Health Hazard, Hoarding, Infestation of Unit, Legal Issues, Relationship Conflicts, and Substance Abuse. The PH2 team meets with individuals weekly, depending on acuity and need. The program may see participants from two weeks to 18 months, with an average of six months.

The effectiveness of the program can be demonstrated by examining three sources of data in the Integrated Behavior Health Information System (IBHIS):

- The first tool is the Service Request Log (SRL). The SRL documents the name of the individual being referred and other pertinent details of the referral.
- The second tool is the PH2 Referral Log. This log contains referring party information (agency), reason for referral, service provider area, type of housing, eviction status, safety issues, referral type (physical or mental health related), type of housing voucher, gender identity, sexual orientation, disability and veteran status.
- The third tool is the PH2 Activity Log. The purpose of this log is to capture what type of services were offered and/or provided that prevented the return to homelessness. The PH2 Activity Log is completed for each corresponding billable note in IBHIS (direct or indirect). The categories include resources offered, linkages obtained, peak eviction risk, eviction prevented, eviction date (if applicable) and closure reason.

Housing insecurity is addressed when an individual's protective factors are increased and/or their risk factors are decreased. The PH2 Activity Log in IBHIS tracks Peak Eviction Risk Level during the participant's engagement in PH2. Meanwhile, linkage to resources like mental health services, medical care, In Home Supportive Services, and food and other basic necessities, indicate progressive housing stabilization. As such, the number of referrals with linkages and the number of evictions prevented serve as good proxies for reduced homelessness and the conditions caused or exacerbated by homelessness.

Table 38. FY 2020-21 Referrals for Each Identified Problem Area

Aggressive/Violent Behavior	80
Destruction of Property	64
Failure to Pay	56
Fire Safety/Health Hazard	59
HMIS Forms	33
Hoarding	43
Infestation	26
Needs MHS Connection	73
Other	139
Relationship Conflicts	89
Substance Abuse	108
Unit Abandonment	3

Note: Referrals can have multiple problem areas.

Of the unique referrals received by PH[2], 49% were successfully linked to mental health services. These linkages and other types of linkages address and reduce isolation, substance use disorders, hoarding, and aggressive/violent behavior, and improve communication, conflict resolution, financial resources, activities of daily living, and other solution-oriented activities.

Table 39. FY 2020-21 Linkages to Each Resource

Mental Health Services	146		Transportation	5
Psychoeducation (not client)	39		Pet Supplies	5
Gift Cards	30		General Relief	5
Housing and Supportive Services	27		In-Home Support Services	4
Clothing	23		Countywide Benefits Enrollment Services Team	3
Personal Protective Equipment	23			
DHS	16		In-Home Care Giver	2
Food Bank	15		Safety Supports (Emer. Res.- not client)	2
Basic Necessities	14		Shelter Placement	2
Shelf Stable Food	12		Board and Care	1
Emergency Services	9		Adult FSP	1
Primary Care Physician	8		Life Line	1
Cal Cards	7		Other (ICMS, groceries, etc.)	206

Note: Referrals can have multiple linkages.

Table 40. FY 2020-21 Disposition of Closed Cases

	Count (n = 57)
Declined Services	10
Eviction Prevented	16
Eviction not Prevented	5
Unknown	26

Among those for whom disposition was known at the end of their PH[2] programming (31 participants), eviction was prevented for more than half (51.6%). About a third (32%) did not engage in services long enough to prevent eviction. 16% were evicted.

Table 41. P3/UFF client demographics (n = 667)

▪ Primary Language			▪ Ethnicity	
Armenian	1		Hispanic or Latino as follows:	
American Sign Language	1		Central American	1
English	228		Mexican/Mexican American/Chicano	15
Farsi	1		Puerto Rican	2
Spanish	17		South American	1
Tagalog	1		Other	12
Vietnamese	1		Non-Hispanic or Non-Latino as follows:	
Other	2		African	66
Declined to answer/Unknown	42		Cambodian	1
▪ Sex Assigned at Birth			Filipino	1
Male	153		Korean	1
Female	126		Middle Eastern	1
Declined to answer/Unknown	15		Other	52
▪ Current Gender Identity			More than one ethnicity	8
Male	151		Declined to answer/Unknown	133
Female	125		▪ Race	
Transgender	4		American Indian	4
Genderqueer/Non-Binary	2		Asian	3
Declined to answer/ask	15		Black or African-American	67
▪ Sexual Orientation			Native Hawaiian or Other Pacific Islander	2
Heterosexual or Straight	32		White	41
Another sexual orientation	1		More than one race	5
Declined to answer/ask	261		Other*	39
▪ Disability			Declined to answer/Unknown	133
No	13		▪ Age	
Yes	62		16-25	4
Difficulty seeing	3		26-59	182
Mental domain	47		60+	93
Physical/mobility domain	20		Declined to answer/Unknown	15
Chronic health condition	17		▪ Veteran Status	
Other	2		Yes	5
Declined to answer/ask	219		No	49
			Declined to answer/ask	240

*Ethnicity and race were collected as one category by IBHIS. Therefore, participants identified as Hispanic or Latino were coded as "Other" race.

- *SEEDS Trauma-Informed Care for Infants & Toddlers*

In fall 2020, SEEDS launched its Trauma-Informed Care for Infants & Toddlers ("SEEDS Infants & Toddlers series"), a four-part trauma-informed, attachment-based virtual training series designed for professionals who work with young children and families. As of the writing of this report, SEEDS has completed seven cohorts of this training series with 188 total participants.

SEEDS Infants & Toddlers series explores how to co-regulate with and promote self-regulation in infants and toddlers, including those who have experienced trauma and other early adversities. Self-regulation skills in young children have been found to be highly predictive of positive educational, social, and mental health outcomes throughout childhood, adolescence, and later in adult life.

In total, the series provides 6 hours of specialized training in trauma-informed care for young children (ages birth to 3 years old), including:

•Part 1: Learning how to recognize the types of cues that infants and toddlers demonstrate,
•Part 2: Practicing how to understand (or seek to understand) the meaning of these cues in light of what we know about early childhood trauma and early adversities,
•Part 3: Preparing to respond to infant and toddler cues in hot moments (that is, when the child and/or the adult is distressed, upset, or dysregulated),
•Part 4: Preparing to respond to infant and toddler cues in cool moments (that is, when the child and the adult are comfortable, calm, and able to play, engage, or have fun together).

Participants completed a 10-item measure (with possible scores ranging for 0 to 10) to assess their knowledge of concepts and skills covered in SEEDS Infants & Toddlers series. At the pre-training assessment, participants had a mean score of 6.17, whereas at the post-training assessment they had a mean score of 7.49, indicating a mean improvement of 1.32.

Table 42. FY 2020-21 Outcomes - SEEDS

Knowledge/Skill Domain	Pre-training % correct	Post-training % correct	Change from pre- to post-
1. Trauma-informed approach/using observation with infants	77%	89%	+12%
2. Co-regulating using sensory inputs	27%	37%	+10%
3. Self-regulation in infants and toddlers	62%	71%	+09%
4. Trauma-informed approach/using observation with toddlers	64%	83%	+19%
5. Trauma-informed approach/What types of questions to ask ourselves before intervening	80%	71%	-09%
6. Goal for adult caregivers is not to prevent the child's dysregulation, but to attempt co-regulation to strengthen relationship	53%	66%	+13%
7. Relationships as crucial for infants' and toddlers' development	77%	80%	+03%
8. Responding in hot moments	70%	83%	+13%
9. Child-led play, skills of duplicate and elaborate	44%	71%	+27%
10. Hot and cool moments	62%	97%	+35%

- *Veterans Peer Access Network (VPAN)*

  Veteran Peer Access Network (VPAN) is a Prevention program which serves Veterans and Military family members in Los Angeles County. The goals are to: 1) increase protective factors such as financial stability, resiliency, socio-emotional skill building, and social connectedness, and 2) reduce risk factors such as suicidality, homelessness, and under/unemployment.

  Under VPAN, DMH and Southern California Grantmakers, as well as other Community-based Organizations (CBOs), provide peer support and linkage to services, reducing mental health services utilization. The goal of prevention services provided through VPAN CBOs is to implement a set of strategies that will augment existing programs. In addition, new preventative and trauma-informed community supports are provided to Veterans and Veteran family members in order to promote protective factors and diminish risk factors for developing a potentially serious mental illness.

  Data collected is based on services provided to clients by the veteran service navigators such as benefits establishment, employment and education assistance and referrals/linkage to mental health services. Out of 748 clients referred to SCG's contract CBO network for the VPAN, 1432 requests for services were made.

  Table 43. FY 2020-21 VPAN CBO Network Requested Services

Requested Service	Count
Total requests	1,432
Housing & Shelter	358
Benefits Navigation	266
Employment	235
Income Support	142
Individual & Family Support	142
Legal	100
Mental/Behavioral Health	36
Food Assistance	29
Physical Health	28
Transportation	28
Education	24
Clothing & Household Goods	18
Substance Use	10
Utilities	5
Money Management	4
Social Enrichment	4
Wellness	2
Entrepreneurship	1

  In addition, under the VPAN Veteran System Navigators program, the Department of Military and Veterans Affairs (DMVA) provides benefits establishment, reducing potential economic negative outcomes like homelessness, food insecurity, and associated stress. Prevention programing serves to increase protective factors which include resilience, socio-emotional skill building in Veterans and Veteran family members, and social connectedness through specialty programming. Veterans and Veteran family members will have access to services delivered by Veteran System Navigators staff who have been trained in the impacts of Question, Persuade, and Refer (QPR) and Mental Health First Aid.

DMVA served a total of 101 clients for FY 2020-21, of which, 93.1% (94) requested assistance with compensation benefits. 92.1% (93) clients claimed mental disability. Additionally, 92.1% (93) were referred for PTSD/anxiety/depression.

The VPAN Support Line is dedicated to assisting active-duty military personnel, veterans, reservists, and guard members. The peers who staff the VPAN Support Line understand the unique sacrifices and emotional needs that come with military life. The VPAN Support Line offers Emotional First Aid related to stressors, referrals to community services, real-time psychoeducation on mental health services, and direct access to field-based teams for additional support and follow-up.

The Veteran Support Line received a total 4,071 calls, of which 94 were assigned to VPAN field staff for follow-up. Due to the nature of the support line, a referral is generated and demographics are collected only when the caller is requesting services and/or benefits.

Table 44. FY 2020-21 Demographics – VPAN (N=2,009)

▪ Primary Language			▪ Ethnicity	
English	213		Hispanic or Latino as follows:	
Spanish	4		Mexican/Mexican-American/Chicano	171
ASL	1		Other Hispanic	38
Declined to answer/missing	1,791		Non-Hispanic or Non-Latino as follows:	
▪ Age			African	18
0-15	3		Asian Indian/South Asian	1
16-25	58		Japanese	1
26-59	661		Other Non-Hispanic	354
60+	371		Declined to answer/missing	1,426
Declined to Answer/missing	916		▪ Race	
▪ Current Gender Identity			American Indian or Alaska Native	7
Male	866		Asian	34
Female	195		Black or African-American	199
Declined to answer/missing	948		Native Hawaiian or other Pacific Islander	7
▪ Disability			White	249
No	261		Other	129
Yes	303		More than one race	1
Difficulty Hearing	1		Declined to answer/missing	1,383
Mental Disability	93		▪ Veteran	
Physical/Mobility Disability	6		No	49
Declined to Answer/missing	1,445		Yes	744
			Declined to Answer/missing	1,216

- *Youth Diversion and Development (YDD)*

The YDD program aims to improve outcomes for youth by redirecting law enforcement contact and addressing underlying needs through systems of care that prioritize equity, advance wellbeing, support accountability, and promote public safety. The YDD program primarily aims to decrease negative outcomes related to incarceration, school failure, unemployment, substance use, social isolation, and family conflict. The YDD program may also decrease the risk of suicide, prolonged suffering, homelessness and removal from their homes.

Youth diversion programs can improve outcomes for youth otherwise at risk for long-term involvement in the justice system and the associated damage to their health and wellbeing. Studies show youth who participate in pre-arrest diversion programs are 2.5

times less likely to re-offend than similar youth who were not diverted. Likewise, youth who participate in post-arrest diversion programs are 1.5 times less likely to re-offend.

YDD serves children and youth 18 years of age and younger. Law enforcement determine whether a child/youth is eligible for diversion services using a universal screening tool. Children/youth enrolled in the YDD program receive intensive case management services. Services this past year were all virtual or over the phone across YDD provider sites. Recently, some providers have made plans for limited, socially distanced in-person services. However, most youth services remain virtual/over the phone.

In FY 2020-21, 259 youth were served through YDD. Those who completed the program indicated improvement in several protective factors.

Table 45. FY 2020-21 Outcomes - YDD

***Protective factor* & Question**	**Enrollment (n = 186)**	**Completion (n = 126)**
Emotional Competence "When feeling anxious, angry, or depressed, I am able to take positive steps to help myself feel better."	67%	91%
Ability to resolve conflicts "I'm pretty good at figuring out how to resolve disagreements."	68%	89%
School Engagement "I feel engaged and supported in school."	70%	80%

Table 46. FY 2020-21 Demographics – YDD

	Count (n = 259)			Count (n = 259)
▪ Primary Language			▪ Ethnicity	
English	149		Hispanic or Latino as follows:	
Spanish	39		Central American	7
Declined to answer/Missing	71		Mexican/Mexican-American/Chicano	104
▪ Age			South American	7
0-15	130		Other Hispanic	4
16-25	127		Non-Hispanic or Non-Latino as follows:	
Declined to Answer/Missing	2		African	19
▪ Current Gender Identity			European	1
Male	142		Filipino	2
Female	59		Middle Eastern	2
Transgender	1		Other Non-Hispanic	26
Genderqueer/Non-Binary	1		Declined to answer/Missing	87
Declined to answer/Missing	56		▪ Race	
▪ Sex Assigned at Birth			American Indian or Alaska Native	1
Male	142		Asian	2
Female	59		Black or African-American	56
Declined to Answer/Missing	58		White	144
▪ Sexual Orientation			Other	1
Gay or Lesbian	4		More than one race	8
Heterosexual or Straight	160		Declined to answer	47
Bisexual	6		▪ Disability	
Questioning or Unsure	2		No	158
Declined to Answer/Missing	87		Yes	15
▪ Veteran			Difficulty Seeing	1
No	259		Another Communication Disability	2
			Mental Disability	5
			Physical/Mobility Disability	1

		Another Type of Disability	6
		Declined to Answer/Missing	86

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.

Table 47. COS Prevention services provided

Agencies	
Alcott Center	Los Angeles Unified School District
Alma Family Services	One in Long Beach
Child & Family Center	Pacific Asian Counseling Service
Child & Family Guidance Center	Pacific Clinics
Childnet Youth & Family Services	Para Los Ninos
Childrens Center of the Antelope Valley	Penny Lane Centers
Children's Hospital of LA	Project Return Peer Support Network
Children's Institute	San Fernando Valley Community MH
Community Family Guidance Center	San Gabriel Childrens Center
Counseling4Kids	Shields for Families
Didi Hirsch	Social Model Recovery Systems
Dignity Health	Special Services for Groups
El Centro de Amistad	St Anne's Maternity Home
Emotional Health Association SHARE	St Francis Medical Center
Enki Health & Research Systems	St. Joseph Center
Exceptional Childrens Foundation	Star View Behavioral Health
Foothill Family Services	Stirling Academy
Hamburger Home	Tarzana Treatment Centers
Hathaway Sycamores Child & Family	Telecare
Healthright 360	Tessie Cleveland Comm Service
Helpline Youth Counseling	The Help Group
Heritage Clinic & CAPS	The Village Family Services
Hillsides	The Whole Child
Hillview Mental Health Center	Tobinworld
IMCES	Uplift Family Services
Jewish Family Services of LA	Victor Treatment Centers
Korean American Family Service Center	VIP Community MH Center

Table 48. 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 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

Prevention Program	Description
	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.
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.

Prevention Program	Description
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.
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.

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 2020-21, LACDMH suspended the use of the instrument created by the RAND corporation to collect outcomes for COS programs. LACDMH recently made changes to the data collection protocol for Prevention programs funded under MHSA Prevention and Early Intervention (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 set forth by the Mental Health Oversight and Accountability Commission (MHSOAC). It is anticipated that these outcomes and demographics will be available starting in FY 2021-22.

■ PREVENTION	
Prior FY 2020-21	**Prior FY 2019-20**
$37.4 million Total Gross Expenditures	$74.3 million Total Gross Expenditures
FY 2022-23	**Three-Year Plan FYs 2021-24**
$50.5 million Estimated Gross Expenditures	$140.2 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 2020-21 ■ 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. WhyWeRise Mental Health Campaign

WhyWeRise is a social marketing campaign conducted by The Los Angeles County Department of Mental Health (LACDMH) that is focused on prevention of, and early intervention for, mental health challenges among county residents. It is intended to promote community engagement with mental health issues along a continuum from self-care to professional treatment services, reduce barriers to care, and increase awareness of how to seek mental health care. While remaining committed to this overarching goal, the campaign has shifted its emphasis over the years since its inception (in May of 2018), responding to shifting community needs and refreshing content to maintain and expand community interest. The primary aim of the fall 2020 campaign was to continue to raise awareness of resources available to support mental health in Los Angeles County, perceptions of support, and feelings of hope and connection.

The spring 2020 WeRise was wholly conducted online due to COVID-19, but in 2021 WeRise used a hybrid model. Online events were a strong focus, together with "pop-up" COVID-safe in-person events in communities throughout the county, Art Rise outdoor art installations in five Los Angeles neighborhoods, Love Letters in Light that projected poetry from residents on the outside of ten public libraries, and Rising with Chalk events where artists and youth created sidewalk art at 55 Los Angeles parks.

To gain insight into the fall 2020 WhyWeRise campaign's reach and impact and that of the 2021 WeRise effort, LACDMH and the California Mental Health Services Authority (CalMHSA) commissioned the RAND Corporation to conduct an evaluation. RAND previously evaluated the 2018 and 2019 WhyWeRise campaigns, as well as the COVID-19 campaign (Collins et al., 2018, 2019, 2021). The current report provides an evaluation of fall 2020 WhyWeRise outdoor ads (e.g., billboards, bus shelters), television and radio outreach, and an evaluation of the online portion of the 2021 WeRise events. RAND researchers conducted online surveys of attendees at the WeRise online events and (separately) a representative sample of Los Angeles County adults; both surveys were limited to those ages 18 and older. The WeRise survey looks at the experiences of those who attended the online WeRise events, while the WhyWeRise countywide survey allows for comparison of those who were exposed to the WhyWeRise campaign to those who were not exposed to the campaign to assess possible effects of exposure.

Event-attendee survey results indicated that the pivot to include online WeRise events in the face of COVID-19 and associated restrictions on social contact was successful. Attendees felt empowered by the events, connected to community, and hopeful about the future. Nine in ten of those attending most of the events said afterward that they know how to find mental health information or resources if needed and felt empowered to care for their own wellbeing.

Countywide survey results indicated that the WhyWeRise campaign reached an impressive percentage of Los Angeles County residents: About half of adults reported exposure to the campaign. The campaign was effective in reaching all major racial/ethnic groups in the county, particularly Spanish-preferring Hispanic residents and those with lower income and education. County residents were exposed to the campaign via the two major forms of outreach: broadcast media (television and radio ads) and outdoor ads. The majority of individuals reached by the campaign found it beneficial, in that it made them feel their mental health was important and provided new information on how to get mental health help. Los Angeles County residents exposed to the campaign were nearly twice as likely to be aware of the information and resources offered by LACDMH and were significantly more likely to say the agency is there for them if they need help. The campaign was also effective in driving those exposed to the LACDMH website and help line, as intended, though overall rates of use for both resources are low.

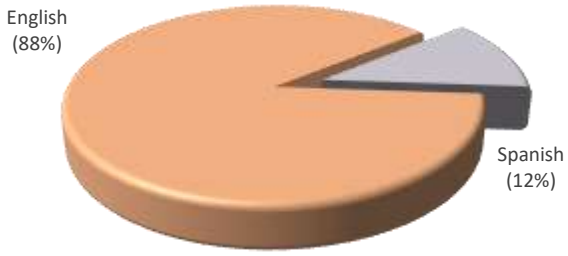
In summary, there is evidence that both elements of the LACDMH WhyWeRise campaign successfully reached a racially, culturally, and economically diverse group of Los Angeles County residents, fostered a feeling of support among those exposed, boosted awareness of county mental health resources, and conveyed how to seek help with mental health issues.

C4. 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 109 SDR surveys administered to assess SDR trainings that were conducted during the FY 2020-21, from July 2020 through June 2021. The number of surveys collected in FY20-21 (109) was far less than in previous years (e.g.; FY19-20 5,968). The decrease is primarily due to LA County not having online Spanish SDR survey when SDR programs unexpectedly changed from in-person to online programing in March 2020, following the global pandemic of Covid-19, as most participants at SDR trainings are monolingual Spanish speakers. The County developed a Spanish language version of the online survey in March 2021.

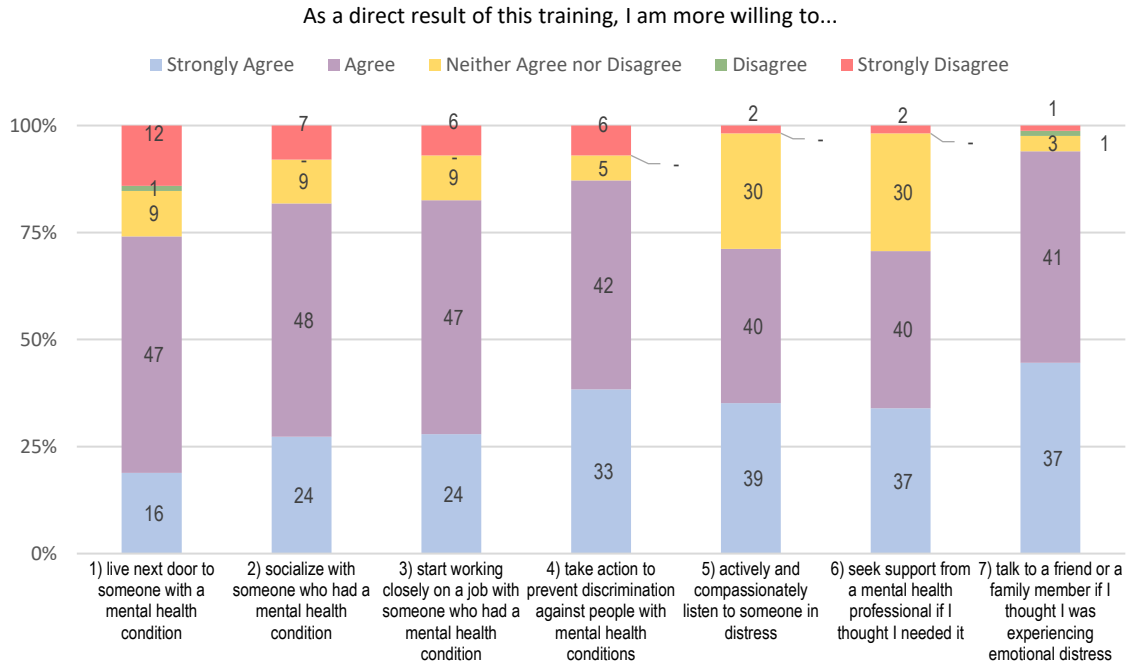
Figure 16. Survey languages (n = 109)



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:

- Item 5: A high of 94% agreeing (46%) or strongly agreeing (48%) the training increased willingness to "actively and compassionately listen to someone in distress"
- Item 6: A high of 94% agreeing (45%) or strongly agreeing (49%) the training increased willingness to "*seek support from a mental health professional if I thought I needed it*"
- Item 7: A high of 94% agreeing (45%) or strongly agreeing (49%) the training increased willingness to "*talk to a friend or a family member if I thought I was experiencing emotional distress*"

Figure 17. Changes in behavior

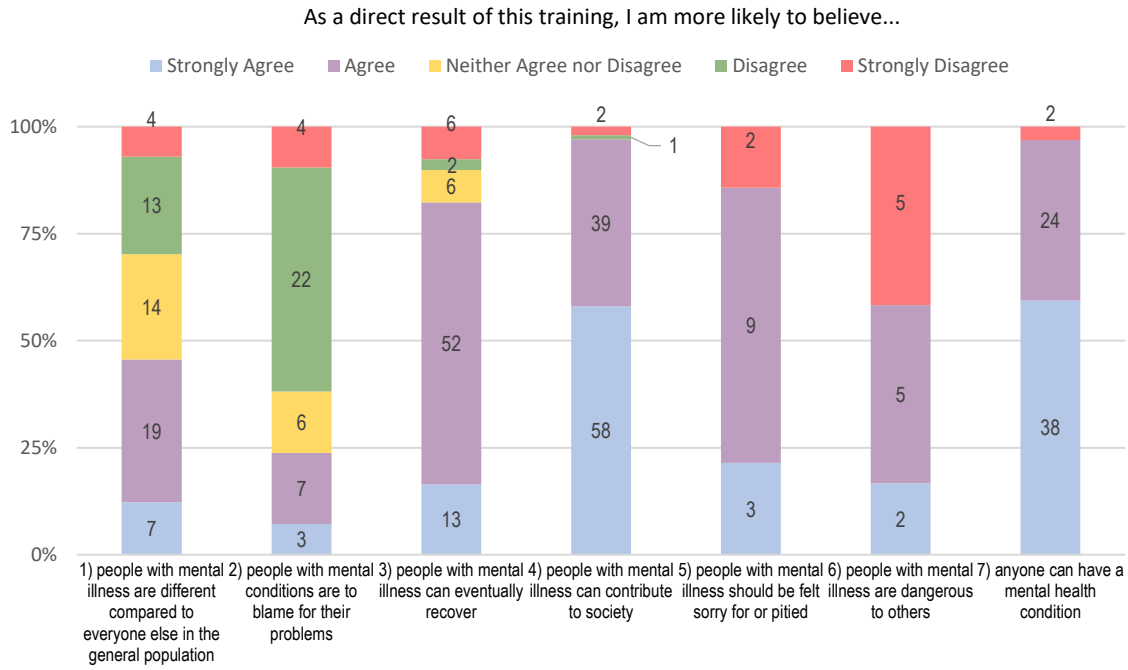


The following chart assesses change resulting from attending an SDR training in knowledge about mental illness and beliefs about mentally ill people. Items may be rated: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Disagreeing suggests the participant believes 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 six of the seven items, the majority of participants agreed the trainings had a positive influence, with the strongest positive influence on items rating beliefs about people who have a mental illness, as the data callouts below suggest:

- Item 4: A high of 97% agreed (39%) or strongly agreed (58%) the training increased the likelihood of believing, "*people with mental health conditions can contribute to society"*
- Item 7: A high of 97% agreed (38%) or strongly agreed (59%) the training increased the likelihood of believing, "*anyone can have a mental health condition*"

Figure 18. 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. At least 96% of participants agreed or strongly agreed with every item, and a high of 98% agreed (39%) or strongly agreed (59%) with item 1, "The presenters demonstrated knowledge of the subject matter."

Figure 19. Training Quality

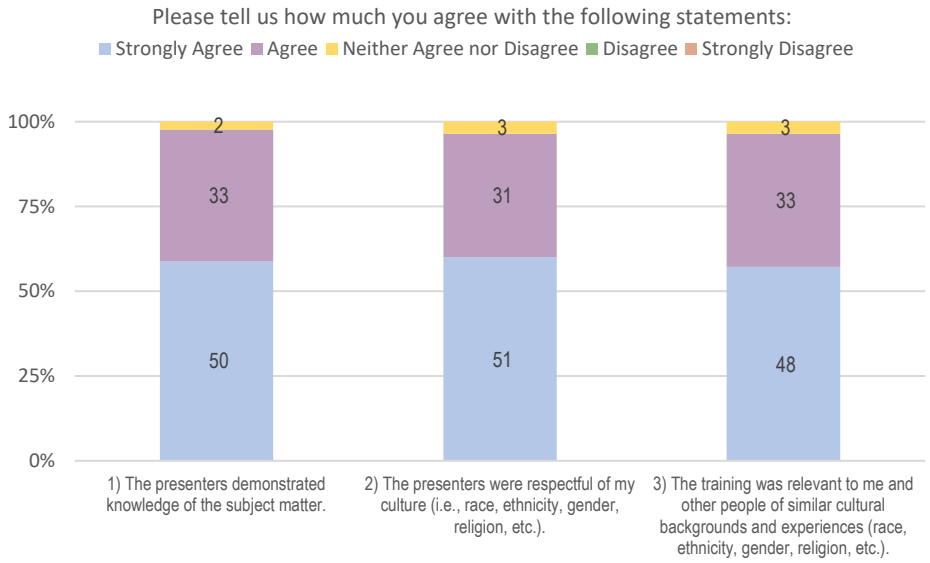


Table 49. Survey demographics (n = 109)

Sex at Birth	Female - 85% Male - 9%	Declined to answer - 6%
Gender Identity	Female - 84% Male - 10%	Declined to answer - 5% Genderqueer/Non-Binary 1%
Sexual Orientation	Heterosexual or straight - 78% Gay or lesbian - 3% Questioning or unsure of sexual orientation – 1% Queer – 4%	Declined to answer - 23% Bisexual – 2%
Ethnicity	Mexican/Mexican-American/Chicano - 46% Central American - 6% European - 6% More than one ethnicity - 7%	Other - 20% Declined to answer - 15%
Veteran Status	Yes - 1% No - 96%	Declined to answer - 3%
Age Groups	Children (0-15) - 1% TAY (16-25) - 14% Adult (26-59) - 67%	Older Adult (60+) - 14% Declined to answer - 5%
Disability	Yes -4% No - 88%	Declined to answer - 8%
Primary Language	English - 65% Spanish - 26%	Other - 7% Declined to answer - 2%
Race	White - 22% Black or African American - 8% Asian - 5%	More than one race - 10% Other - 29% Declined to answer - 26%

■ STIGMA AND DISCRIMINATION REDUCTION	
Prior FY 2020-21	**Prior FY 2019-20**
$2.4 million Total Gross Expenditures	$3.2 million Total Gross Expenditures
FY 2022-23	**Three-Year Plan FYs 2021-24**
$0.4 million Estimated Gross Expenditures	$1.2 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 2020-21 ■ 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.

D2. 24/7 Crisis Hotline

During FY 2020-21, the 24/7 Suicide Prevention Crisis Line responded to a total of 129,328 calls, chats, and texts originating from Los Angeles County, including Spanish-language crisis hotline services to 12,420 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 50. Call analysis

Total calls	115,902
Total chats	7,422
Total texts	6,004
Total*	129,328

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

Table 51. Total calls by language

Korean	49
Spanish	12,420
English	100,205
Total	103,433

Figure 20. Call, chat and text volume by month

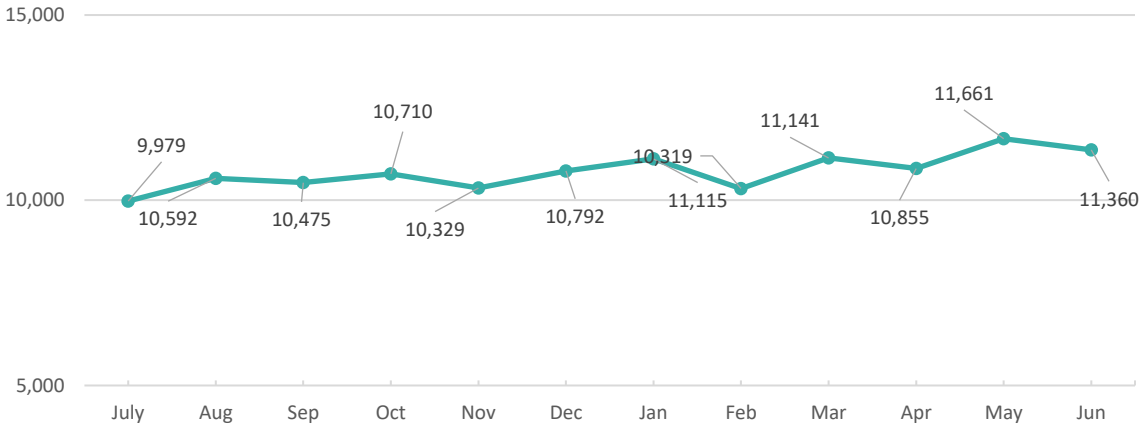


Table 52. Calls and chats by ethnicity

Ethnicity	Call (n = 53,133)	Chat/Text (n = 1,848)
White	36%	50%
Hispanic	36%	16%
Black	12%	15%
Asian	8%	5%
Native American	1%	1%
Pacific Islander	0%	0%
Other Race	8%	0%

Table 53. Calls and chats by age groups

Age Groups	Call (n = 64,468)	Chat (n = 8,964)
5 to 14	6%	29%
15 to 24	37%	44%
25 to 34	26%	16%
35 to 44	11%	5%
45 to 54	8%	2%
55 to 64	7%	1%
65 to 74	4%	1%
75 to 84	1%	0%
85 and up	0%	0%

Table 54. Calls and chats by suicide risk assessment

Suicide Risk Assessment	Calls	Chats
History of psychiatric diagnosis	44%	0%
Prior suicide attempt	24%	6%
Substance abuse - current or prior	18%	0%
Suicide survivor	7%	1%
Access to gun	3%	2%

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 55. Suicide risk status

Suicide Risk Status	Calls (n = 47,208)	Chats (n = 3,951)
Low Risk	51%	44%
Low-Moderate Risk	23%	22%

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

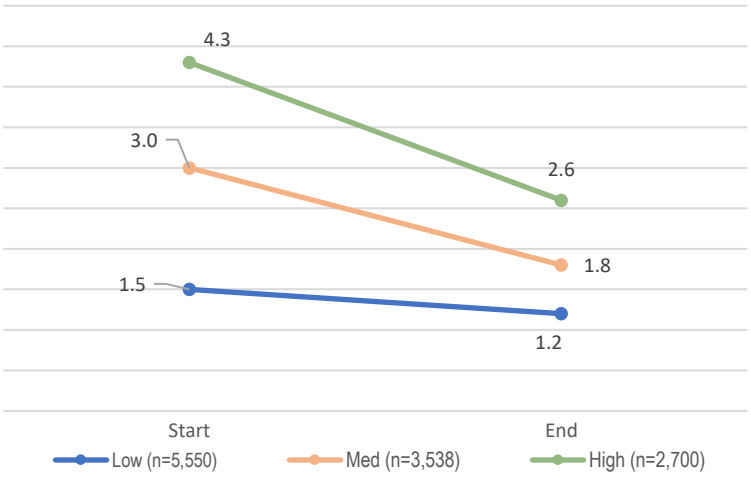
Moderate Risk	14%	16%
High-Moderate Risk	3%	4%
High Risk	8%	12%
Attempt in Progress	1%	0%

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

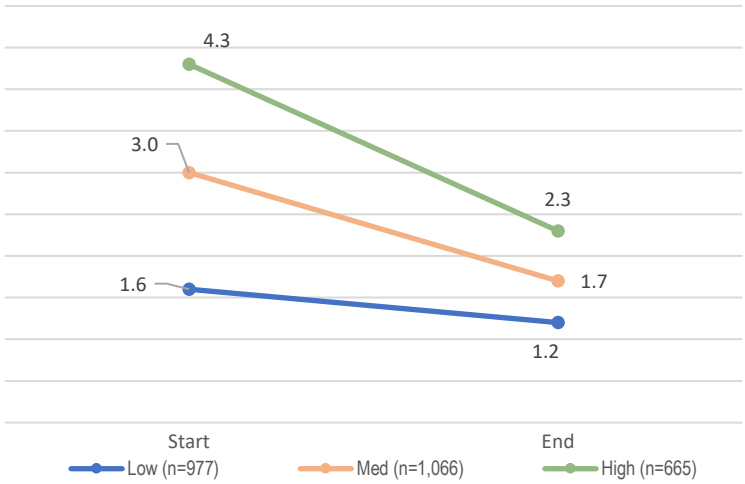
Callers are asked to answer the question: "*On a scale of 1 to 5, how likely are you to act upon your suicidal thoughts and feelings at this time, where 1 represents not likely and 5 represents extremely likely?*" Callers rate their intent both at the start and end of the call. Note: This data is on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

Figure 21. 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 22. Self-rated suicidal intent chats



D3. Suicide Prevention Outcomes

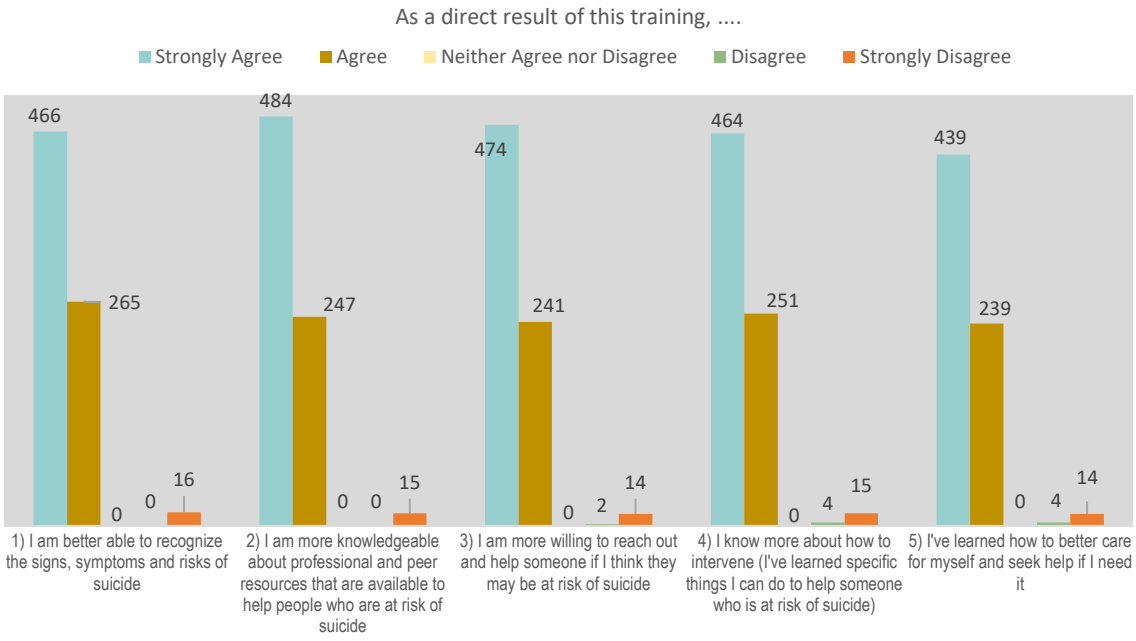
LACDMH has chosen to implement a suicide prevention program in the form of training and education that has shown effectiveness in changing attitudes, knowledge, and/or behavior regarding suicide. Participants in these trainings include, but are not limited to, first responders, teachers, community members, 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 780 questionnaires received for these trainings conducted during the FY 2020-21. The questionnaire is available in each of the County's 13 threshold languages, as well as Hmong.

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 97% 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. Participants had the highest percentage of agreement with the 2nd items; 98% agreed (33%) or strongly agreed (65%) 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".

Figure 23. 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 as 98% agreed or strongly agreed with all 3 items. The majority of participants strongly agreed with all 3 items, with the highest percentage of strong agreement (80%) for item 7, "The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.)."

Figure 24. Responses to suicide prevention training

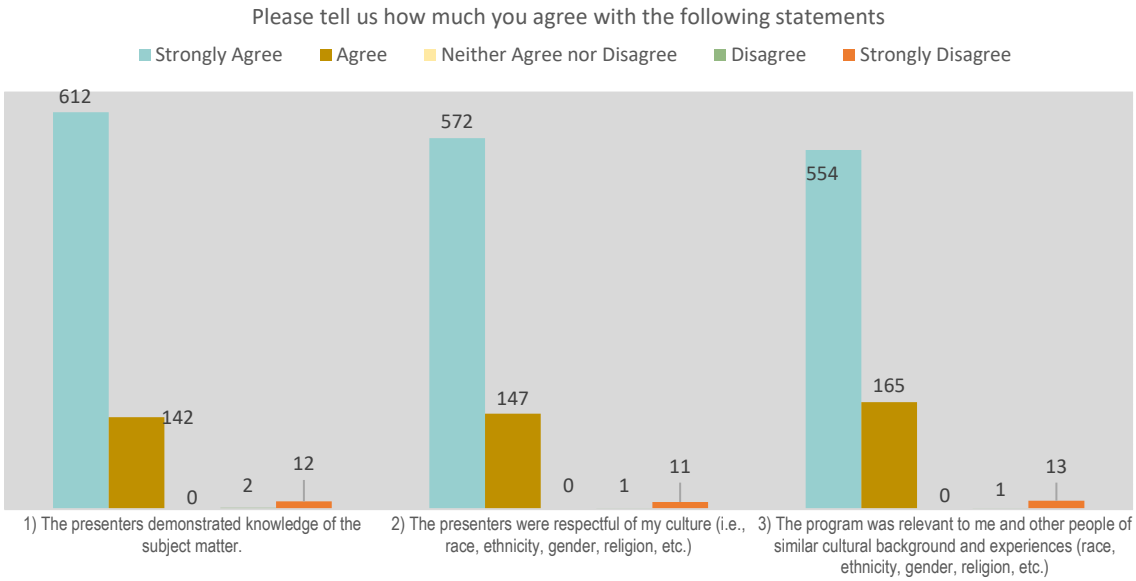


Table 56. FY 2020-21 Survey demographics

Gender Identity	Female - 81% Male - 16%	Declined to answer - 3%
Age Groups	TAY (16-25) - 6% Adult (26-59) - 85%	Declined to answer - 4% Older Adult (60+) - 5%
Race	White - 24% African American - 11% Asian - 11% American Indian – 2%	Other - 23% Declined to answer - 22% More than one race - 7%
Sexual Orientation	Heterosexual - 82% Gay/Lesbian - 4% Bisexual - 2%	Queer - 2% Declined to answer - 11%
Ethnicity	Central American - 9% European - 5% More than one ethnicity - 9% Filipino - 2% Mexican/Mexican-American/Chicano - 35% Chinese – 3%	Other - 14% Declined to answer - 15% African - 6% Middle Eastern - 1%
Veteran Status	Yes - 2% No - 96% Declined to answer - 2%	
Disability	Yes - 5% No - 88% Declined to answer - 7%	
Primary Language	English - 73% Spanish - 15% Armenian - 1%	Other - 9% Declined to answer - 2%

D4. School Threat Assessment Response Team (START)

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 2020-21	**Prior FY 2019-20**
$17.4 million Total Gross Expenditures	$18.0 million Total Gross Expenditures
FY 2022-23	**Three-Year Plan FYs 2021-24**
$22.3 million Estimated Gross Expenditures	$32.9 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 2020-21 ■ WORKFORCE EDUCATION AND TRAINING Data and Outcomes

A. Training and Technical Assistance:

- Public Mental Health Partnership (PMHP)

The mission of the UCLA-DMH Public Mental Health Partnership (PMHP) is to implement exemplary training and technical assistance activities focused on vulnerable populations with serious mental illness in ways that build excellence in public mental health care across Los Angeles County (LAC); and to do so in the context of a transparent, trusting partnership with the Los Angeles County Department of Mental Health (DMH) that generates benefits for both the University and public health communities. The PMHP is comprised of two sections focused on serious mental illness -- the Initiative for Community Psychiatry (ICP) and the Full-Service Partnership (FSP) and HOME Training and Implementation Program. During FY 2020-21, UCLA provided the following trainings services:

During the reporting period, the PMHP delivered 110 trainings over 315.5 hours, with an attendance of 4,683 participants. The training team provided trainings on a wide variety of topics including person centeredness, cultural humility, and psychiatric disorders and symptoms (Table 57). The training topics delivered to the most participants include “Crisis & Safety Intervention” (1,321 participants) and “Continuous Quality Improvement” (776 participants)

Table 57. Public Mental Health Partnership Trainings

Topic Name	Number of Trainings	Training Hours	Number of Participants
Crisis & Safety Intervention	18	59	1321
Continuous Quality Improvement	33	44.5	776
Manualized Evidence-Based Practices	10	43.5	473
Provider Wellbeing	8	15.5	379
Trauma	10	37.5	376
Psychiatric Disorders & Symptoms	6	19.5	355
Cultural Humility	7	27	247
Person Centeredness	5	21	203
Persistent & Committed Engagement	3	5	202
Co-Occurring Disorders	3	15	131
Team-Based Clinical Services	3	15	129
Whole Person Care	2	10	60
Everyday Functioning	1	1	31
Ethical Issues	0	0	0
Service Delivery Skills	1	2	0
TOTAL	**110**	**315.5**	**4,683**

Participants who attended PMHP trainings represented a broad range of roles (Table 57). Clinical social workers comprised the largest group (26.7%), followed by case manager (18.8%) and program directors/supervisors (14.9%). Most participants worked in an FSP setting (44.5%).

- Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T)

BASIC T: Professional trainees within the Hispanic Neuroscience Center of Excellence (HNCE) consist of three (3) early entry neuropsychologists, three (3) postdoctoral fellows, and three (3) clinical social workers who work in multidisciplinary teams. The neuropsychologists are receiving training in the completion of comprehensive neuropsychological assessments across the life span, while the clinical social workers are being trained to provide allied linkage services following comprehensive assessment and psychosocial support that addresses multiple social determinant of health including: economic stability, education access and quality, healthcare access and quality, neighborhood and build environment, social and community context. During the reporting period, HNCE trainees have collectively cared for 258 patients, with a total of 504 since program inception.

During the reporting period, the HNCE delivered 88 trainings over 151 hours, with an attendance of 1,060 participants (Table 58). This was on par with maintaining the initial rapid COVID-19 Pivot made prior to the current reporting (i.e., April to June 2020), during which HNCE delivered 48 trainings over 122 hours, with an attendance of 1,274 participants. The training team provided bilingual trainings in English and Spanish on a wide variety of topics, including mental health stigma among communities of color during COVID-19 and support groups for isolated older adults and parents of children with developmental disabilities during COVID-19. Some of the training topics delivered to the most participants include “Culturally Competent COVID-19 Psychological First Aid for Faith based Organizations and Churches” (260 participants), “Culturally Competent COVID-19 Mental Health Intervention with Community Based Organizations” (140 participants), and “Culturally Competent Recovery & Resilience Intervention during COVID-19” (138 participants). Participants in the HNCE trainings represented all five LA County Supervisorial Districts. In addition to direct participants reached through HNCE trainings, it is important to highlight that the training provided through the HNCE on COVID-19 topics for Health Promoters has already resulted in the Latina/o/x Promotoras reaching an additional 15,705 community members via their own 2,171 trainings over 3,505 hours.

Table 58. BASIC-T Outcomes for FY 2020-21

Topic Name	Number of Trainings	Training Hours	Number of Participants
Culturally Competent COVID-19 Psychological First Aid for Faith Based Organizations and Churches	43		
Culturally Competent COVID-19 Mental Health Intervention with Community Based Organizations	11	22	260
Culturally Competent COVID-19 Mental Health Intervention with Community Based Organizations	6	11	140
Culturally Competent Recovery & Resilience Intervention during COVID-19	3	4	138
COVID-19 & the Brain (Promotoras)	8	16	113

Topic Name	Number of Trainings	Training Hours	Number of Participants
Virtual Support Groups for Isolated Older Adults during COVID-19 (Genesis)	25	50	94
Support Groups for Latino and Spanish-speaking Parents with Children Diagnosed with Neurodevelopment Disabilities during COVID-19	20	20	61
COVID-19: Psychiatric & Cognitive Sequelae	3	5	57
Psychological First Aid Related to COVID-19 & Related Trauma (Promotoras)	3	6	54
Use of Telehealth & Digital Platforms for Psychological Intervention during COVID-19 (Promotoras)	2	4	54
The Community Mental Health Promoters Model: The roles of mental health promoters and popular education during COVID-19	1	2	20
Social Determinants of Health & COVID-19	1	2	20
Mental Health & Stigma Among Communities of Color during COVID-19	1	2	20
Resilience & the Role of Self-Care in the time of COVID19	1	2	20
Culturally Competent Support Groups for Caregivers of Older Adults with Dementia during COVID-19 (Genesis & Others)	3	5	9
Totals:	**88**	**151**	**1,060**

Consultations For the reporting period, HNCE spent 324 hours on consultation providing support to LACDMH clinicians with respect to ongoing needs for psychometric assessment, resilience/ coping/ bereavement, and continued COVID-19 related program development. Additionally, BASIC-T conducted a number of mass media appearances via COVID-19 related PSAs and interviews that reach a large TV, radio, and online viewership within Los Angeles, as well as nationally and internationally in Spanish (e.g., 1.0 to 3.5 million media consumers locally).

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. Training was limited during the Covid-19 pandemic, and training was delivered to one cohort. In this group, 18 individuals completed this model, with 44% spoke a threshold language, and 83 represented an un- or under- served community.

- Interpreter Training Program (ITP)

The Interpreter Training Program (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, this program had limited offerings.

Table 59. ITP Outcomes for FY 2020-21

Training	Number of Attendees
Increasing Spanish Mental Health Clinical Terminology	43
Introduction to Interpreting in Mental Health Settings	11
Totals	54

C. Learning Net System

The Department has developed an online registration system called eventsHub that manages both registration and payment for trainings and conferences coordinated by the Department. eventsHub is fully operational with most if not all clinical training administratively processed by the system inclusive of posting, registration, and other training logistics important for tracking purposes. Enhancement and maintenance of eventsHub continues through FY 2021-22.

D. DMH + UCLA General Medical Education (GME): UCLA Public Partnership for Wellbeing Agreement

Psychiatry Residency and Fellowships Professional Trainees – Public Psychiatry Professional trainees of the UCLA Graduate Medical Education program at the Jane and Terry Semel Institute for Neuroscience and Human Behavior consisted of adult residents and fellows specializing in child and adolescent, geriatric, and forensic psychiatry. During the reporting period, the trainees provided a total of 574 patient visits during their public psychiatry rotations. There was a total of 11 trainees: 4 psychiatric residents, 3 Child Psychiatry Fellows, 1 Geriatric Fellow and 3 Forensic Psychiatry Fellows.

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 60. Outcomes for FY 2020-21

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

Post Graduates	Number of Psychiatric Residents	Rotations
		• Harbor-UCLA (Emergency Psychiatry): 1 month
Year 2 Post Graduates	6	• VA Long Beach (Inpatient Psychiatry): 1 month • 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): 3 months • Resnick Neuropsych Hospital UCLA (Child and Adolescent Psychiatry): 2 months

Year 3 Post Graduates	6	• Rotations in LACDMH Directly Operated Clinics and Programs:
		  • Augustus F. Hawkins MHC
		  • West Central MHC
		  • Compton MHC Child & Adolescent Psychiatry
		  • Women's Community & Reintegration Center
		  • Harbor UCLA Medical Center HIV Clinic
		  • Street Psychiatry/HOME Team and Disaster Service
		  • Collaborative Care/Telepsychiatry

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

Intensive Mental Health Recovery Specialist Training 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. Of the 27 individuals that began this training, 18 completed the training with 76% representing an un- or under- served community and 73% speaking a second language. Of those that completed the training, 50% have secured employment, with all but one working in the mental health field.

During FY 2020-21, a solicitation was released for the training program, one proposal was submitted and reviewed for awarding. A contract agreement was executed to begin training services Fiscal Year 2021-22.

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 2020-21, available training opportunities moved to an online platform, resulting in 1,568 individuals receiving this training through 39 online sessions.

- Honest, Open, Proud Program

During FY 2020-21, one training (4 online sessions) was delivered on 6/8, 6/9, 6/15 and 6/16/2021. A total of 17 DMH Peer staff have successfully completed the training. The training was provided to help the DMH Peer Workforce to identify and overcome the negative impact of the internalized shame and stigma of mental illness. The training demonstrated the necessity and importance of effective self-disclosure in self-empowerment and providing peer support services. It provided strategies on how to effectively disclose their lived-experience for the provision of peer support services as the DMH Peer Workforce. Additional components of this training are planned for subsequent Fiscal Years..

- Intentional Peer Support (IPS) Advanced Training
  During FY 2020-21, one Advanced Intentional Peer Support training (6 online sessions) was provided 04/27,05/04,05/11,05/18,05/25,and 06/01/2021. Sixteen (16) DMH Peer Staff, former graduates of the Core Training, completed this Advanced IPS Training. Advanced level IPS practices were covered and included a review of core principles, application of strategies to real-life scenarios, affirmation of self-reflection understanding and promotion of enhanced mutual connections all relevant to sustaining the practice.

  During FY 20-21, one cohort of IPS Co-reflection training was delivered (6 online sessions were provided) with 7 Peer Staffs from DMH and DMH contracted agencies participating. Staff regularly met to review and discuss issues and concerns associated with implementation of peer services and application of the IPS practice. Topics included peer to peer relationship challenges, unhelpful assumptions, and fidelity of IPS principles to peer service practices.

- Continuum of Care Reform (CCR)
  Assembly Bill (AB) 403, also known as Continuum of Care Reform (CCR) provides comprehensive transformation of the foster care system with the intent of achieving permanency planning for foster youth and their families. In particular, this legislation brings forth significant changes for group homes and respective providers that necessitate training for legislative compliance and provider readiness. To that end, the following table outlines DMH-offered trainings and include topics subjects such as introduction to mental health, diagnosis/assessment and self-care. A total of 1,459 individuals were trained.

Table 61. CCR training

Training	Service Provided
CCR: Child and Family Team Process Overview (CFT) 3 trainings FY 2020-21: 113 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) 5 trainings	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

Training	Service Provided
FY 2020-21: 143 participants	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) 7 trainings FY 2020-21: 177 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) 2 trainings FY 2020-21: 70 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.
LGBTQ+ Youth in Placement: Strategies and Interventions (LGBTQ) 2 trainings FY 2020-21: 35 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.
Prevent the Eruption: Trauma Informed De-Escalation Strategies (DE-ESCALATION) 21 trainings FY 2020-21: 513 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.
LGBTQ+ Youth In Care: Guidelines for Clinical Practice 1 training FY 2020-21: 29 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, particularly as it relates to LGBTQ+ youth of color. Lastly, participants will learn about Eli Coleman's Identity Model as a way to conceptualize the coming out process and the value of acceptance. Group

Training	Service Provided
	activities will be facilitated to enhance application of learning and increase one's self-awareness as it relates to this population.
Engaging Runaway Youth In Placement: Overview and Strategies for Response 5 trainings FY 2020-21: 177 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.
Creative Interventions for System Involved Youth 1 training FY 2020-21: 28 participants	This training prepares Continuum of Care Reform (CCR) providers to explore the transformative and restorative power of creativity for youth. Discover how providers can utilize creative interventions when working with youth who are involved in systems of care including child welfare, mental health and probation. Discussions will include the key components of trauma-informed expressive art therapy, creative art therapy modalities, and adaptable interventions. Participants will build awareness of the benefits of utilizing creative trauma-informed interventions and identify tools to support the implementation of art, dance/movement, music, play, drama, and other expressive modalities in their work with youth. Lastly, this training incorporates both didactic and experiential learning to support transfer of understanding, knowledge and integration of training objectives.
Prevent the Eruption: Interventions Booster (2 hours 3 trainings FY 2020-21: 45 participants	This booster training seeks to provide DMH, DCFS, Probation and Contract Provider staff with information and practice in the following areas: engagement, phases of escalation, strategies to de-escalate youth, and ways to manage trauma triggers and unsafe behaviors. This training builds upon strategies learned in the Prevent the Eruption: Trauma- Informed De-escalation Strategies to further equip providers with developmentally and culturally relevant tools to support the de-escalation process. Participants will be placed in breakout rooms to facilitate the learning process through group work and discussions.
Engaging Youth in Placement: From Admission Through Aftercare 1 training FY 2020-21: 24 participants	This training provides an overview and practical applications for engaging youth in placement throughout the course of treatment from admission to aftercare. Topics covered include trauma, challenges and barriers to engagement, specific strategies to initiate and maintain engagement with youth, interagency collaboration, and aftercare planning. Utilizing a trauma-informed lens, trainers discuss the impact of trauma on youth's overall development, attachment, and relationships. Participants learn a variety of approaches to aftercare planning which they may integrate into their own agencies. Interagency collaboration efforts as well as connecting youth to community resources are considered. The warm hand-off and facilitation of a "good goodbye" with youth and families are highlighted. Group activities enhance learning and provide opportunities to apply a variety of useful strategies to promote engagement.
Youth with Developmental Disabilities and Mental Illness: Overview and Interventions 4 trainings FY 2020-21: 105 participants	This training focuses on youth with developmental disabilities and mental illness. It address how to identify common mental health symptoms for youth with developmental disabilities placed in a STRTP. Differences abide in presentation of mental illness symptoms in this population and such conditions warrant adapting interventions to meet their unique needs. Lastly, additional discussion includes the CFT process, which is a collaboration strategy which can provide practical tools and techniques to support providers who work directly with this population.

H. Financial Incentive Programs

- Mental Health Psychiatrist Student Loan Repayment Incentive
  LACDMH offers a financial incentive towards the outstanding balance of student loans for full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one-year of continuous service at DMH and have active, unpaid, graduate, or medical, student loans. Eligible psychiatrists who have not participated in or have received funds from the MH Psychiatrist 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 2020-21, 37 mental health psychiatrists participated in this program.
- MHP Recruitment Incentive Program
  This program targets recruitment of potential Mental Health Psychiatrists for employment in the public mental health system. For eligible full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one year of continuous service in DMH 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 DMH, and an additional payment of $25,000 upon completion of the second year of continuous service. During FY 2020-21, 10 individuals were recruited and awarded.
- MHP Relocation Expense Reimbursement
  Available to full-time, newly hired Mental Health Psychiatrists or Supervising Mental Health Psychiatrists who have been recruited by DMH. The maximum reimbursement amount for eligible relocation expenses is $15,000. If the employee leaves DMH within one-year from employment start date, the full reimbursement amount must be repaid. During FY 2020-21, 2 individuals were 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 work commitment (a minimum of 1 year) to secure employment in a hard-to-fill/hard to recruit program/area. This program targets students who are linguistically and/or culturally able to service the traditionally unserved and underserved populations of the County.

  During FY 2020-21, due to the Covid-19 pandemic, no stipends were awarded. The contracted fiscal intermediaries provided past stipend recipients job seeking assistance; work commitment extensions were given on a case-by-case basis. Tracking and administrative functions continued throughout the Fiscal Year. Program needs, funding, and hiring freezes have impacted reinstatement of the program. DMH will continue to review workforce needs with potential reinstatement consideration FY 2021-22.

  In addition to the stipends, 9 post-doctoral fellows were also funded as part of the Department's Psychology Post-Doctoral Fellowship Program. Of these fellows, 5 represented un- or under- served communities and 5 individuals spoke a second language, other than English.

■ WORKFORCE EDUCATION AND TRAINING	
Prior FY 2020-21	**Prior FY 2019-20**
$4.1 million Total Gross Expenditures	$14.2 million Total Gross Expenditures
FY 2022-23	**Three-Year Plan FYs 2021-24**
$18.7 million Estimated Gross Expenditures	$56.1 million Estimated Gross Expenditures

Does not include program administration costs

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.

In the past eighteen months the Community Ambassador Network (CAN) was developed and implemented into the INN 2 project. To date, over 265 CAN have been hired and/or rebranded. The CAN was introduced to expand the concept of community capacity building and to address the traumas to communities around the COVID-19 pandemic. The Community Ambassadors (CA) who comprise the CAN, are members of the community who are trusted and are the right people, at the right time, who provide the necessary services and supports to individuals within their identified communities. The CAN intern project was an additional concept that was introduced to the project a year ago as a collaborative project with the Department of Public Social Services (DPSS), the INN 2 team and the CalWORKs team. CAN Interns were introduced to the project, funded by DPSS, and supporting each of the projects and expanding the reach and supports available to those communities most in need. Training and supports have been provided and to date 160 CAN and 36 CAN interns are working across the project.

The Los Angeles County Board of Supervisors approved nine (9) lead agencies and ten (10) projects, 2 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 selected 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 fourth year of this four-year project. Since the implementation of the INN 2 project, there have been a two-day kick off and twelve (12) learning sessions, attended by INN 2 lead agencies, community partners, community members, CAs 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 625 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 iHOMS, an electronic data collection system, 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 COVID-19 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 when data is not input in a timely manner. The INN 2 COVID-19 pivots have included the addition of the Community Ambassador Network (CAN) and specified data collection for both the CAN and COVID-19 specific activities and outreach and engagement.

During the first three and a half years of the INN 2 project (2018-2021), lead agencies have committed themselves and their partnerships to serving their communities in trauma-informed ways. 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 indicated below.
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 DMH 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 12 full Learning Sessions. The CAN Promoting Learning, Networking and Advocacy (PLAN) Meetings were implemented in January of 2021, with the completion of nine (9) meetings to date with an average of approximately 120 CAN/CAN Interns in attendance at each of the meetings.
During this unprecedented time of the novel coronavirus disease-2019 (COVID-19) pandemic 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 and utility assistance and a multitude of linkages) while expanding various social media platforms and creating a higher visibility for providing these resources and services. Agency and partnership meetings have moved to Zoom and other teleconferencing platforms, allowing every individual to continue with important, life-changing work and remain connected. It should also be noted that a COVID-related category has been tracked since these pivots were made and all CAN and CAN Interns have been registered in iHOMS with the ability to track all CAN activities, along with cultural and language capacity.

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 have supported communities around COVID-19 testing, immunization and boosters. This project has slowly transitioned to a platform that has identified deeper community needs and incorporating the CAN and CAN interns has made it possible to reach communities at a deeper and more meaningful level.

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 12 primary meetings in 2020 and 10 meetings in 2021, the workgroup has discussed the intersection of cultural competence and trauma-informed care, with the goals remaining aligned with community capacity building strategies. About 5 ad-hoc meetings and comprehensive one-on-one checks with lead agency participants took place to engage the workgroup in the planning of the July 2020 Learning Session and to determine optimal format and strategy for the workgroup. The latest conversations that have taken place in 2021 were brought to a CAN PLAN meeting for feedback and insight from the boots on the ground and will be more deeply discussed and addressed at the upcoming Learning Session in January 2022.

Sustainability planning has been implemented since the halfway mark of the project. 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-DMH 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. As conversations have progressed this past year the importance of the community and CAN being trained and informed of important practices with regards to trauma informed care, resiliency and community capacity building, has been discussed and will leave long lasting impacts and sustainable knowledge across communities as well.

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.

- Measurement of the partnerships, using the Wilder Collaboration Factors Inventory, Social Network Survey and Trauma-Informed Partnership 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.

At the close of 2021, nearly 8,100 participants have been registered in iHOMS (Innovation Outcomes Management System). 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 and hiring and training tracking of CAN. The system also supports real-time automated reporting of partner and participant outcomes. The evaluation team also made all the partnership and outcome measures available (in English and Spanish) in Qualtrics, an online survey platform which does not require a login and password to access, as a way to enable participants to complete measures from home during the pandemic.

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 (25.2%), TAY (22.3%), intergenerational families (23.2%) and individuals who were recently incarcerations or diverted from the justice system (10.4%).

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

- The Inclusion of Community in Self (ICS) Scale is a pictorial measure designed to understand one's perception of connectedness with the community.
- The Conner-Davidson Resilience Scale (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 Trauma-Informed Partnership (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.

<u>Additional Qualitative Breakdown of the Analysis Approach for This Project To-Date:</u>

The average Inclusion of Community in Self (ICS) Scale score for all INN 2 participants with a pair of assessments (n=1732) at baseline was 3.5 (out of a possible score of 6), with more than 40% of participants in the 3 to 4 range, demonstrating some sense of interconnectedness within the community. The average ICS score for participants at the most recent follow-up assessment was 3.6, which is a statistically significant increase from baseline. More participants (31.8%) rated their relationship with the community in the 5 to 6 range at the most recent follow-up assessment, compared to baseline, which suggests that some individuals may feel higher levels of connectedness through participation in Innovation 2. (Connectedness)

The average Conner-Davidson Resilience Scale (CD-RISC-10) score for INN 2 participants at baseline was 28.7 out of a possible score of 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 participants at the most recent follow-up assessment was 28.9. While there is no significant change in scores, it is notable that there is no loss of stress tolerance during the pandemic, which speaks to the community capacity building efforts. Focusing on participants who enrolled in INN 2 during the past year of the pandemic, there was a statistically significant change in average CD-RISC scores between baseline (28.2) and the 9-month follow-up assessment (29.4). It is possible that participants' resiliency is impacted by longer engagement in INN 2 activities. (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 and stress. Approach coping is associated with more helpful responses to adversity, including adaptive practical adjustment, better physical health outcomes, and more stable emotional responding. Emotional avoidance is a common reaction to trauma. The average Approach Coping sum score for all INN 2 participants with a pair of assessments (n=1383) at baseline was 34.8 out of a possible score of 48. Higher scores indicate more approach coping. The average Approach Coping score for participants at the most recent follow-up assessment was 35.7. This suggests that INN 2 participants perceive that they use more approach coping skills than avoidant coping skills when they confront difficult or stressful events. Focusing on participants who enrolled in INN 2 during the past year of the pandemic, there was a statistically significant change in average Approach Coping sum scores between baseline (34.7) and the 3-month follow-up assessment (35.5), which suggests that some individuals may feel better able to cope with stress through participation in Innovation 2. The average Avoidance Coping sum score for all INN 2 participants with a pair of assessments (n=1391) at baseline was 23.1 out of a possible score of 48. Lower scores indicating less avoidance coping. The average Avoidance Coping score for participants at the most recent follow-up assessment was 22.8. There was no statistically significant change in Avoidance Coping scores. (Coping Skills)

Partnership development, as measured by the Wilder, continued to grow over the past year, as most agencies have moved past previous challenges related to forming their partnerships. Partner's ratings of collaboration within their partnerships is seen as a strength, as most Wilder category scores are close to or greater than 4.0 (On a scale of 1-5). Collaboration among partnerships likely contributed to INN 2's ability to successfully pivot outreach and engagement activities and provide needed linkages and resources to support communities during the past year. Biannual review of the data highlights strengths to leverage and opportunities for partnership growth and progress, and also helps to frame Learning Session agendas and 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. Over the past year, partnership rosters increased by 13% as INN 2 partnerships expanded to include new organizations and community members. The biggest change seen in the network maps is the addition of the CAN. All networks have more connections. Networks averaged 57 partners in February 2021, compared to 51 partners last year (February 2020) and 36 partners in March 2019 (baseline assessment). Organizations, which are part of a network, are able to leverage resources, new ideas and knowledge to build capacity more effectively than those that "go it alone." (Partnerships and capacity building data collection tool)

The Trauma-Informed Partnership (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 core objective for TIP data collection is to understand each partnerships' capacity to implement trauma-informed approaches and identify core knowledge components of trauma needed to educate others. A bi-annual review (every six months) of the 2020 data has shown 93.4% 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 DMH's "Becoming Trauma-Informed" among other general Trauma-Informed Care trainings. Over 86% 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. 79% 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.

Additional Quantitative Breakdown of Outreach and Linkages for This Project To-Date:

One vision of INN 2 is to invest in the community and extend outreach and support to those community members who have been previously unaware of available resources or may not be willing to seek out a mental health organization directly. Non-traditional approaches to "meet people where they are at" has been essential to partnerships' responsiveness to the COVID-19 crisis and social unrest. The pandemic changed the way INN 2 partners are able to connect with each other and the community. It has required agencies to pivot their INN 2 work quickly to be responsive to community needs. Programming and capacity building approaches were adapted to incorporate social media and partnerships continue to leverage their existing relationships and develop new partnerships to support the community.

This past year, INN 2 providers recorded a total of 14,219 outreach and engagement events in iHOMS. This is a substantial increase in events compared to the prior year of the project. Partnerships placed significant effort in hosting group activities over the past year in innovative ways to keep participants engaged and provide meaningful group support virtually (21% of recorded events). General community outreach, meetings, trainings, and COVID-19 education efforts represent the other top outreach and engagement activities, which have reached an estimated 323,641 community members (count is not de-

duplicated). Monthly community partnership meeting engagement grew with the use of virtual platforms, allowing for increased participation across communities. Programs continued to make trainings in the community and for their partners and staff a priority throughout the challenges of the past year, as these trainings are integral to building capacity as programs move more towards sustainability efforts.

INN 2 providers made a total of 29,587 linkages to community resources and supports for 4,594 participants during the past year. This is a substantial increase in linkages compared to the prior year of the project. Linkages were tailored for the target population and varied by capacity building strategy. The most common linkages were for basic needs, including food (32.8%), housing (9.9%), and education (10%). Education includes supports for students, such as backpacks and school supplies, and skill building classes.

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 DMH/DPH/DHS collaborative training and the Community Resiliency Model (CRM), and in turn will deliver both these trainings to their surrounding communities. The aforementioned trainings are in addition to the CAN Landing page developed and supported by UCLA, which offer a plethora of supportive and informative trainings, including motivational interviewing, among many others.

We are requesting the project be extended, in order to continue the support of the CAN and ongoing assistance to the communities in the recovery from the COVID-19 pandemic. It is requested that Prevention funds be used for these efforts to be uninterrupted.

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.

Project has been completed.

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 August 15, 2021

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 the COVID-19 pandemic. Due to the intensive treatment schedule that TMS services require (5 days per week for approximately 4-6 weeks), clients may 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 November 2020, TMS services restarted once weekly treatment for clients who had been receiving treatment prior to COVID-19 and who were struggling with worsening mood symptoms. By February 2021, TMS services were being provided to current clients 5 days per week and the TMS team began treating new clients. TMS services are currently being provided five days per week. In addition, due to the small size of interior space of the Mobile TMS van and concern for client and staff safety during COVID-19 pandemic, the TMS device was moved from the van into an office space in Long Beach in February of 2021 and the plan is to continue administering TMS from this office space.

Number of clients served:
As of August 15, 2021, the program had received 89 referrals. Between May 1, 2019, and August 15, 2021, 70 client consultations/initial evaluations were completed. A total of 26 of these clients completed a full TMS treatment course. Common reasons for not completing a full TMS treatment include a disruption due to COIVD-19, difficulty with transportation, and lack of efficacy.

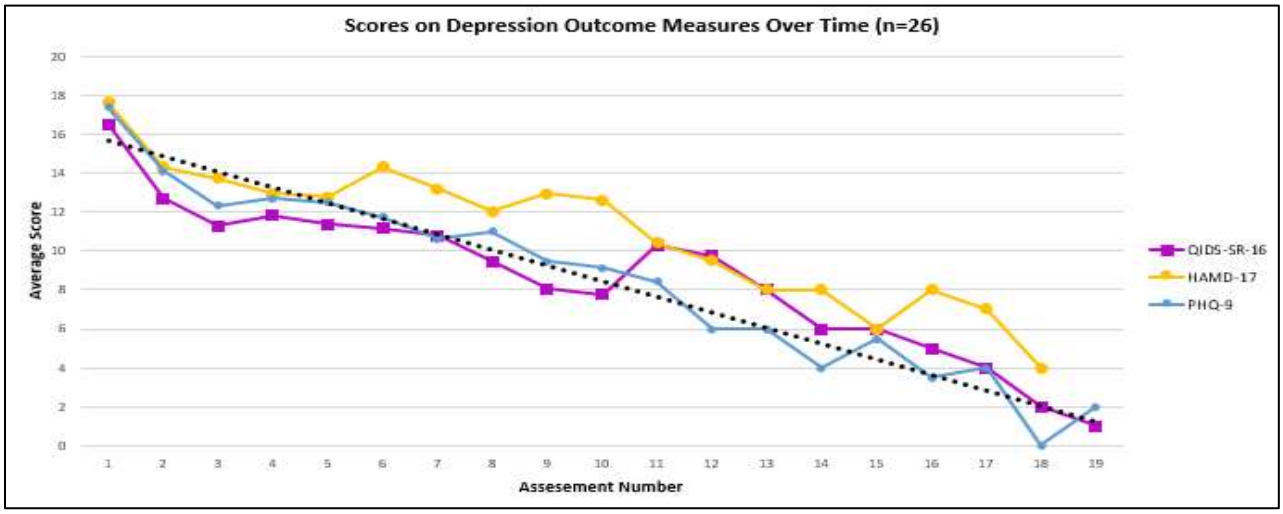
Below is a summary of the demographic information on the 26 clients who completed a full treatment course of TMS as of August 15, 2021:
- The majority were adults (ages 26-59) 88%, while 12% were older adults (60 years or older).
- The majority identified as male (65%) and 35% identified as female.
- The majority identified as Non-Hispanic/Latino (58%), while 31% identified as Hispanic/Latino and for 12% of the clients, the ethnicity was unknown.
- 31% of clients identified their race as White and 12% identified as Mexican. Other races included Asian Native (4%), Black/African American (4%), Cambodian 4%), Central American (4%), Korean (4%), South American (4%), and Vietnamese (4%). 16% of clients were of another race and the race of 19% of clients was unknown.
- The majority of clients stated that their primary language was English (77%). Other primary languages included Spanish (15%), Cambodian (4%), Vietnamese (4%).

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 the average score on each of the three depression measures over the course of treatment for clients who completed a full treatment course of TMS treatment between May 1, 2019, and August 15, 2021. The length of treatment varies for each client, but the trend line (in black) shows that, on average, depressive symptoms decreased in frequency and intensity over time as TMS treatment was provided.

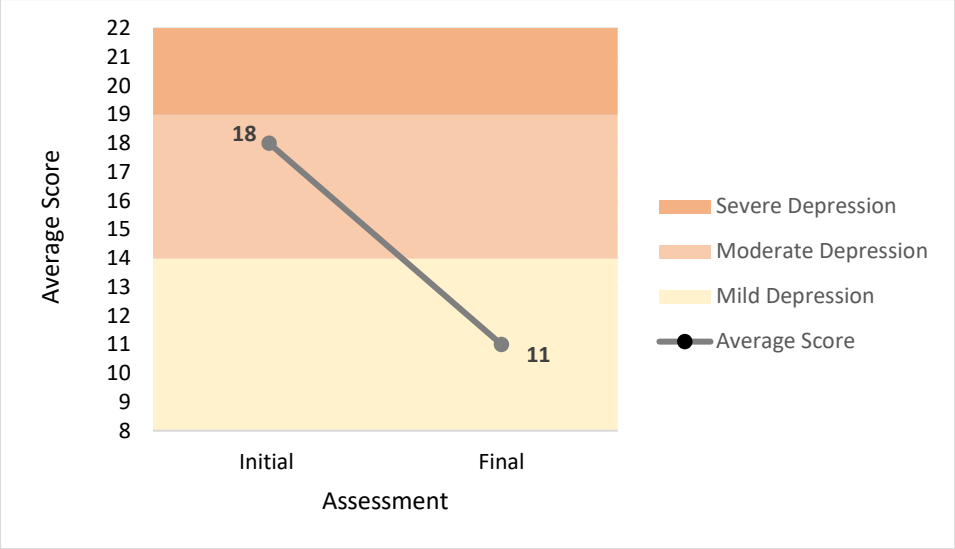


Hamilton Depression Rating Scale (HAMD-17)

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 initial HAMD-17 score was 18 which indicates moderate depression. At the end of treatment, the average final HAMD-17 score was 11, which indicates mild depression. There was an average change in score of 7 points (39% decrease), which indicates that there was an overall improvement in depressive symptoms at the end of the course of TMS treatment. Of those who completed a full course of TMS treatment, 9 clients (35%) of clients met criteria for remission (no depressive symptoms) at the end of treatment.

Figure 25. Summary of Average HAMD-17 Scores for Mobile TMS clients (n = 26)

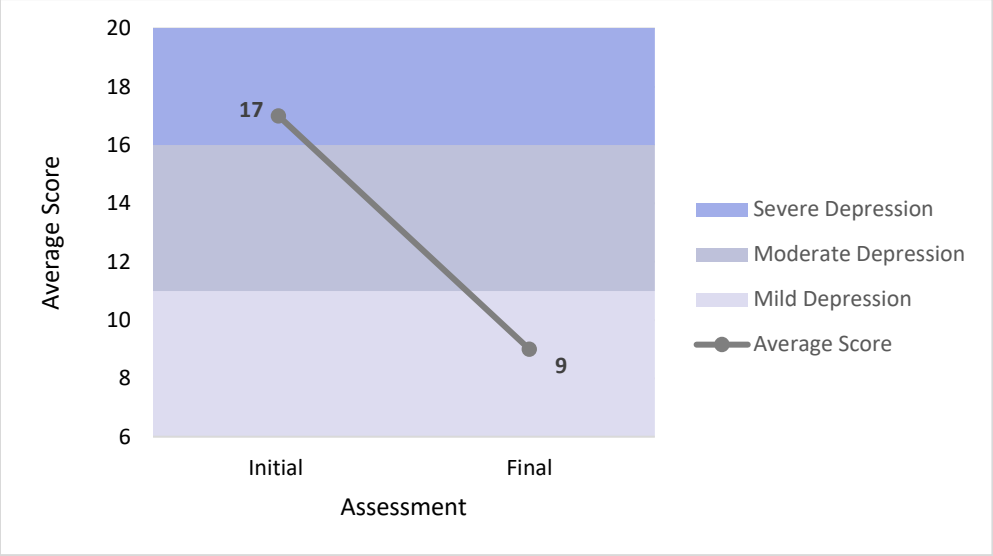


Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR-16)

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 initial QIDS-SR-16 score was 17, which indicates severe depression. At the end of treatment, the average final QIDS-SR-16 score was 9, which indicates mild depression. There was an average change in score of 8 points (47% decrease), which indicates that there was an overall improvement in depressive symptoms at the end of the course of TMS treatment. Of those who completed a full course of TMS treatment, 6 clients (26%) of clients met criteria for remission (no depressive symptoms) at the end of treatment.

Figure 26. Summary of Average QIDS-SR-16 Scores for Mobile TMS clients (n = 23)

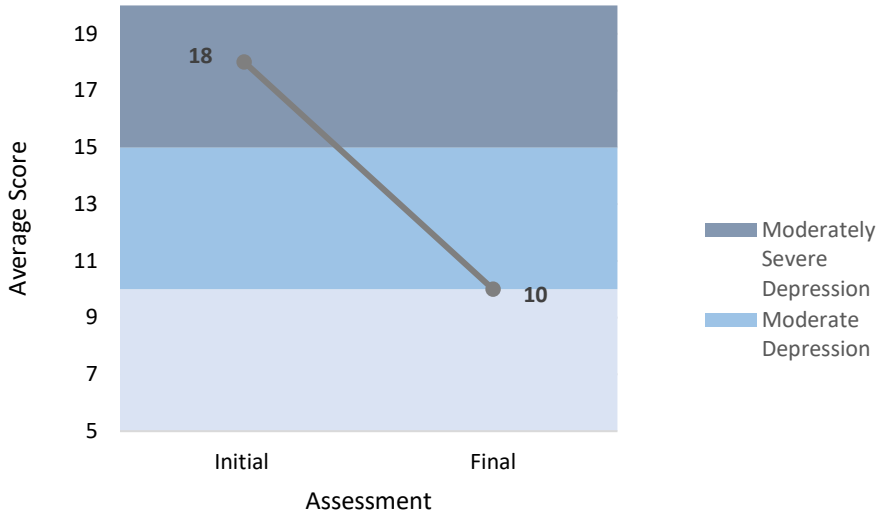


Patient Health Questionnaire (PHQ-9)

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 initial PHQ-9 score was 18, which indicates moderately severe depression. At the end of treatment, the average final PHQ-9 score was 10, which indicates moderate depression. There was an average change in score of 8 points (44% decrease), which indicates that there was an improvement in depressive symptoms at the end of the course of TMS treatment. Of those who completed a full course of TMS treatment, 6 clients (23%) of clients met criteria for remission (no depressive symptoms) at the end of treatment.

Figure 27. Summary of Average PHQ-9 Scores for Mobile TMS clients (n = 26)



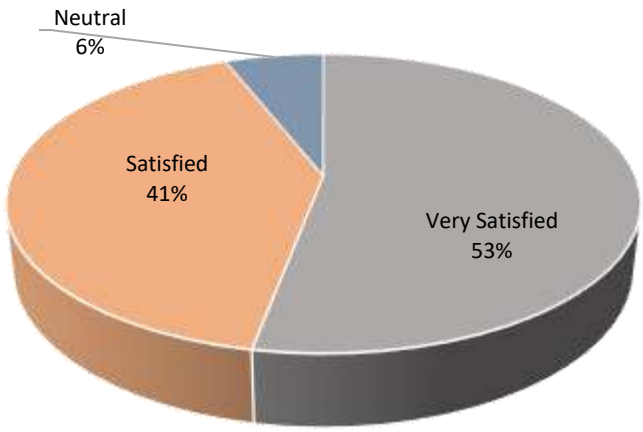
TMS Client Satisfaction Survey

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 [Figure 28]:

Overall, a majority (94%) of respondents were "Very Satisfied" or "Satisfied" with their TMS experience, which is 21% increase since December 1, 2019. None of the clients were dissatisfied with their TMS experience.

Figure 28. Overall Satisfaction with Mobile TMS services (n = 17)

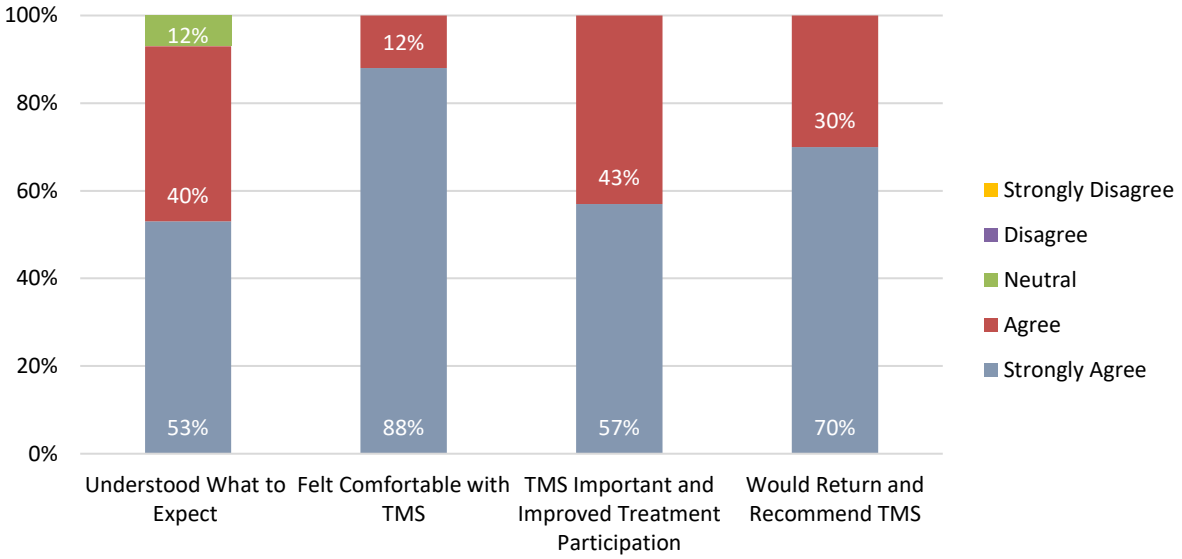


TMS Treatment Experience [Figure 29]:

A majority of respondents (93%) "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

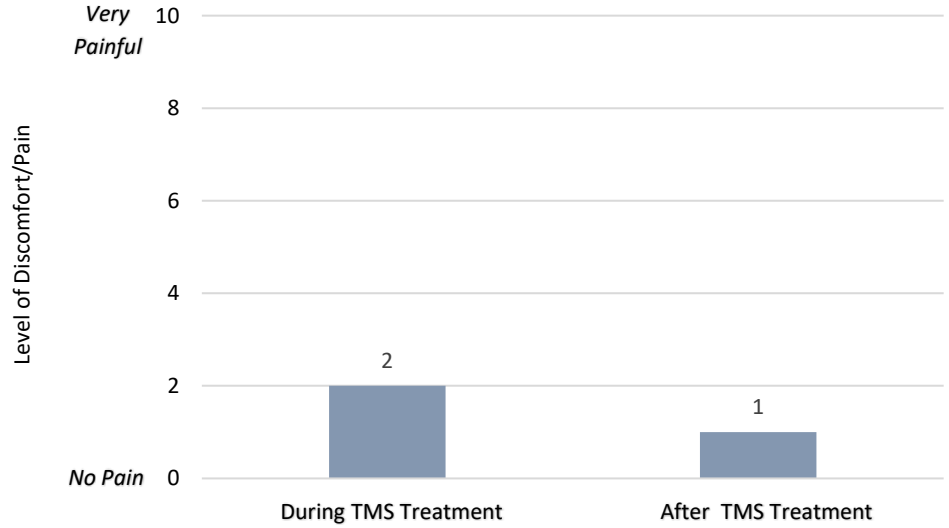
"Agreed" that TMS services have been an important part of their treatment and that TMS services have improved their participation in their treatment. Finally, all respondents (100%) "Strongly Agreed" or "Agreed" that they would return for more TMS treatments in the future if recommended by their clinician and would recommend TMS to others if they are experiencing depression.

Figure 29. Feedback on Mobile TMS Experience (n = 17)



Level of Discomfort/Pain during and after TMS Treatment [Figure 30]:
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 30. Average Level of Discomfort/Pain During and After Mobile TMS Treatments (n = 15)



Perceived Benefits of TMS Services:
Clients (n = 15) were asked how they felt they benefitted from participating in TMS services. As a result of TMS services:

- 73% of clients stated that they that they feel happier.
- 67% of clients stated that they feel less worried/anxious.
- 53% of clients stated that they have more motivation to engage in meaningful activities.
- 47% of clients stated that they are less frustrated, have more contact with family/friends, and have more energy.
- 40% of clients stated that they are able to focus better, feel more relaxed, and that they have an increased abilty to do the things that they want to do.
- 33% of clients stated that they are sleeping better.
- 27% of clients stated that they have more self-confidence.
- 20% of clients stated that they feel less body pain and are getting along better with family/friends.
- 13% of clients stated that they are eating better.

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 20 surveys (for 17 clients) were completed by treatment team staff (13 Psychiatrists, 4 Therapist, 2 Case Managers, and 1 Registered Nurse).

- A majority (68%) 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 [Figure 31].
- A majority of providers (85%) "Strongly Agreed" or "Agreed" that their client made progress towards his/her treatment goals as a result of TMS Services [Figure 31].

Figure 31. Provider Perception on the Impact of TMS -
Services on Client's Mood, Behavior, and Overall Functioning (n = 20)

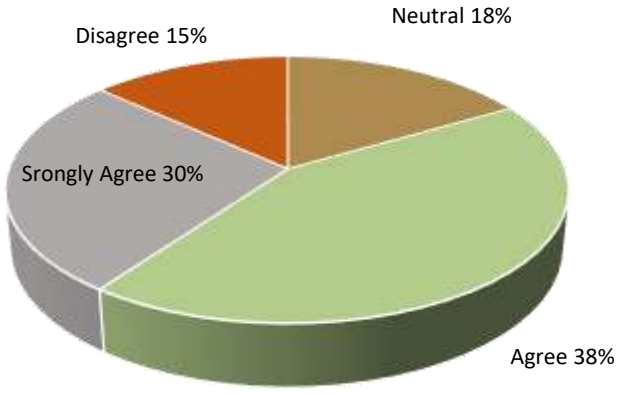
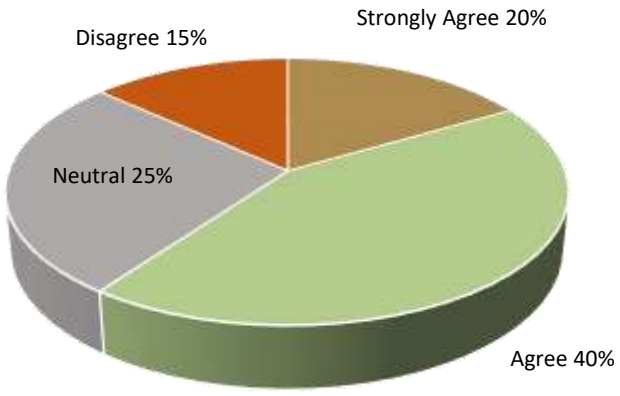


Figure 32. Provider Perception on the Impact of TMS - Services on Client's Progress Toward Treatment Goals (n = 20)



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, 2021
Due to COVID-19, implementation of the program has been delayed.

E. INN 7: Therapeutic Transportation (TT)

TT program was partially implemented on January 30, 2022. Since then, DMH staff have been housed at Los Angeles City Fire Department (LAFD) Station 4 - Downtown area, providing services 24/7. 4 Licensed Psychiatric Technicians, 4 Community Health Workers, and 4 Drivers were trained by LAFD on communications and how to utilize the radios and IPad for deployment purposes. To date, teams have responded to over 100 calls that were generated through the 911 system. The program has provided mental health services and when necessary transported to Urgent Care Centers.

Currently, LAFD is training staff with the goal to expand to Station 59 - West Los Angeles/ Venice Area. The teams will begin to be deployed by LAFD on March 6, 2022 to provide mental health services 24/7.

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 and DMH entered a contract with UC Davis to execute this project as of July 1, 2020. 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. It includes the development of the Beehive tablet and web application. Beehive will be used by programs to collect client and clinician-reported outcome data and help clinicians, clinic management and County administration visualize client outcome data to help inform treatment and track clinic and Countywide program outcomes. 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.

Additional funding by the National Institutes of Health (NIH) obtained by UC Davis has allowed the project to further expand to add additional sites. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now "EPI-CAL." In this and future reports, we will refer to the LHCN only when describing components of the project that are specific to the LHCN evaluation (e.g., county data analysis).

One of the Department's early psychosis coordinated specialty care models is the Portland Identification and Early Referral (PIER) program to identify and comprehensively treat individuals ages 12-25 who are at clinical high risk for psychosis (i.e., prodromal) or have experienced their first psychotic episode. Five (5) 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 15, 2021, there are 77 clients enrolled at five (5) clinics across Los Angeles County.

Status of Implementation as of December 1, 2021

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.

Stakeholder Advisory Committee and Multi-County Quarterly Leadership Meetings

The Advisory Committee for the LHCN is comprised of a county representative from each participating county, a representative from each participating EP program, and up to five (5) consumers and five (5) family members who have been, or are being served, by EP programs. Attendees receive updates and provide feedback on project elements biannually. Recruitment for the Advisory Committee is ongoing, and includes past consumers, family members, clinic staff and providers. Advisory Committee meetings during this reporting period were held on December 8, 2020, June 7, 2021 and November 15, 2021.

Attendees reviewed progress on the development of the Beehive application, including development of questionnaire battery to be included in the application, surveys related to factors that may impact Beehive implementation (e.g., organizational readiness for change, comfort with technology) or consumer-level outcomes (e.g., provider burnout, stigma around mental health, views on recovery) and End User License Agreement (EULA) video used at enrollment in the Beehive application and Beehive training progress with programs. Attendees also were also able to hear feedback from pilot programs about the advantages and challenges of implementing Beehive in their programs.

Beehive Software Application Development, Pilot and Rollout

Over the course of the past year, the EPI-CAL team has conducted extensive qualitative research in order to engage various stakeholders and utilize their valuable feedback to shape the development of the Beehive application. The team received qualitative feedback throughout the development of this custom application in three different types of qualitative focus groups: 1) wireframe focus groups, 2) alpha testing groups, and 3) data-sharing/end user license agreement (EULA) focus groups. They conducted a total of 23 focus groups spanning these three focus group types in order to get detailed feedback and suggestions for the application and dashboard from EP program staff, EP program consumers, and their family members. Feedback was then gathered into a qualitative report summarizing results.

In the wireframe focus groups, stakeholders provided feedback on the wireframe for the tablet and web-based applications developed collaboratively by the EPI-CAL research team and the software development subcontractor, Quorum. When integrating the feedback into application development, the team endeavored to balance consumer and family needs with provider and

staff needs. Overall, stakeholders approved of the look and feel of the application. They provided feedback about color scheme, imagery and visual information.

Stakeholders also provided several suggestions to improve integration of the application into their EP clinic workflow and procedures. Stakeholders emphasized the importance of having an option for clinic staff to pre-register consumers if they gather registration information over the phone prior to the consumer's first visit in the clinic to reduce burden on the consumer and demonstrate that the clinic was well organized and listening to the information consumers and family members had already provided.

Some stakeholders provided feedback specific to their role in the clinic. For instance, based on feedback from participants in a focus group with clinic administrators from various programs, the team subsequently built in data visualizations for race, ethnicity, sex, gender identity, and other metrics which clinics are commonly asked to report. On the other hand, consumers and their family members nearly unanimously agreed about how they wanted to view data visualizations on the web application with their provider. Instead of seeing the results of the symptom survey as the default display, they preferred to see a more recovery-oriented measure, such as the Questionnaire about the Process of Recovery (QPR), when first looking at their survey responses.

During focus groups with Los Angeles County stakeholders in August 2020, the team also asked for feedback about how to adapt both the data collection and data visualization components of the application for use with telehealth. Multiple EP staff participants agreed that a remote data collection option, which would allow consumers to complete surveys from home, would be ideal. Consumer and family stakeholders agreed with providers for the remote option, but were split between their preference for a mobile application or a personalized link that could be emailed or texted from their provider. Consumer 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.

Once an Alpha version of the Beehive application was developed from the wireframes, a focus group was held on October 22, 2020 to elicit feedback from stakeholders on the development of the Beehive application. This feedback was valuable as it was the first opportunity for stakeholders to review the application in a production environment, rather than wireframes or plans. Focus group participants made suggestions to improve the application, including changes to language, look and feel, features, and information presented to consumers.

To develop the End User License Agreement (EULA) and presentation of data-sharing options for Beehive, the EPI-CAL team conducted a series of focus groups to gather stakeholder feedback. Two different phases of groups were conducted: (1) Data-Sharing Preferences Focus Groups, and (2) EULA Focus Groups. The Phase 1 focus groups conducted in August 2020 were to understand stakeholders' views on how their personal health information is and should be used in the EPI-CAL study including a review of definitions of key terms (e.g., privacy, confidentiality), a discussion focused on stakeholders' understanding of and perspective on data sharing, changing sharing options, and sharing different types of data (i.e., identifiable vs. de-identified) at different levels (i.e., individual- and group-levels). Using notes and preliminary analysis of the transcripts from these focus groups as guidance, the EPI-CAL team developed the materials for the EULA focus group.

The Phase 2 Focus Groups were conducted in January 2021 to understand stakeholders' response to how the End User License Agreement (EULA) in Beehive is presented. First, participants were shown an informational video (YouTube link:

https://www.youtube.com/watch?v=jzrVmToiGmo&ab_channel=EPI-CAL) created by the research team presenting the key points of the Beehive EULA. After watching the video, participants were asked their opinions about how the information was presented, what questions they still had after watching the video, and how they felt about this method of presenting a EULA. Participants were then shown a demonstration of how the EULA would be presented in the application, with a specific emphasis on the screen on which users may opt-in to data-sharing outside of their clinic for research purposes. Participants were asked for their perspective on how the information was written and presented.

In general, stakeholders thought that using a video to present the EULA was a creative approach that may help users to understand this information better than if they were simply presented this information in a written format alone. All stakeholder groups commented on how to further clarify the information provided.

Preliminary Results of Beehive Pilot

The first part of beta testing was internal user acceptance testing (UAT) by the EPI-CAL team. UAT began when the developers released the beta version of Beehive to the EPI-CAL team, who created test clinics and users at all levels in order to test various use-scenarios to ensure Beehive was working as expected and report any issues in cases where there were typos, bugs, etc. Any typo or bug that was found was reported in a shared review document and corrected internally, if possible, or sent to the developers if it was not an issue that could be resolved by the team.

After the initial training on Beehive, beta testing began on March 22, 2021 in two pilot programs (EDAPT/SacEDAPT and Solano County SOAR Aldea; LACDMH providers were not pilot programs), providers and staff in each of the pilot programs shared feedback after their initial introduction to the Beehive application via a survey. In addition to feedback surveys, the EPI-CAL team assigned each pilot program an EPI-CAL staff point person. This point person manages any issues that arise as users implement Beehive in their assigned program including utilizing a ticket system that allows Beehive users to create a support request, resolve a request, and escalate a request outside of their clinic or group. This similar model has also been established at LACDMH with two point people assigned from UC San Diego to manage support requests.

Pilot programs were able to begin enrolling consumers into Beehive. After registration is complete, Beehive will then prompt consumers and families to complete registration, review the EULA, and choose data sharing permissions. When consumers finish registration in Beehive, they then have access to Beehive surveys. Beehive makes the EPI-CAL Enrollment Life Questions survey bundle available for completion (see Table 53). If a consumer is in a survey window (e.g., at intake or six months), Beehive makes available 15 additional surveys arranged in bundles that assess various outcomes including family functioning, education, social relationships, demographics and background, medications, and symptoms (see Table 1). EPI-CAL enrollment and required bundles are automatically assigned to every consumer who registers in Beehive. However, each individual clinic also has the option of assigning addition surveys if they choose to do so. The current data only include EPI-CAL enrollment and required bundles.

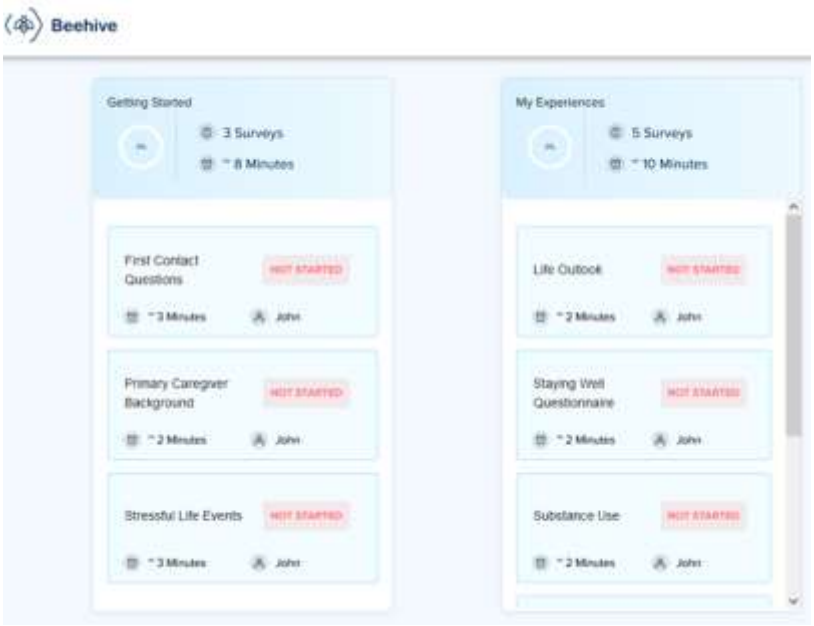
Table 62: EPI-CAL Enrollment and Required Survey Bundles

Bundle Name	Survey Name	Bundle Timing
EPI-CAL Enrollment Life Questions	EPI-CAL Enrollment Life Questions	Enrollment only
	Adverse Childhood Experiences (ACES)	

Bundle Name	Survey Name	Bundle Timing
	Primary Caregiver Background	
EPI-CAL Experiences Bundle	Life Outlook	Every 6 months, including intake
	Questionnaire About the Process of Recovery (QPR)	
	Modified Colorado Symptom Index (MCSI)	
	Substance Use	
	Legal Involvement and Related	
EPI-CAL Treatment bundle	Intent to Attend and Complete Treatment Scale	Every 6 months, including intake
	End of Survey Questions	
	Hospitalizations	
	Shared Decision Making (SDM)	
	Medications	
EPI-CAL Life Bundle	SCORE-15	Every 6 months, including intake
	Demographics and Background	
	Social Relationships	
	Employment and Related Activities	
	Education	

Beehive then shows them the surveys that are available for them to complete within each bundle (see Figure 33 below). Respondents can choose which surveys they wish to complete in the order they wish to complete them.

Figure 33: Surveys Available for Consumer to Complete at Baseline



During the initial phase of Beehive roll out, clinics were asked to enroll consumers and support persons who are already engaged in EP care. When these active consumers are enrolled, Beehive prompts them to complete registration, review the EULA, choose data sharing permissions, and complete enrollment surveys. If they are within the active 6-monthly survey window, they are also able to complete the EPI-CAL required bundles.

At this time, we are reporting the survey completion rate from 17 consumers on the three available enrollment surveys because some consumers were enrolled outside of survey windows and thus were not presented with the remaining 15 surveys. The distribution of survey completion is reported in Figure 8. Survey completion rate ranges from 0-100%, with 47% of individuals completing all three enrollment surveys. The point person at each clinic site will track survey completion and inform clinic staff if there are consumers who are not completing their surveys so that the clinic staff may check in with consumers.

To support the successful integration of the data platform into clinical practice, a series of interviews will be completed with providers, consumers, and family members from participating EPI-CAL clinics. The aims for these interviews will be to determine the acceptability of the platform in this setting, identify potential barriers and solutions to implementation, and explore factors that may facilitate implementation.

Overall, the interview participants interviewed identified several strengths and challenges in the initial implementation of Beehive. Participants elicited some concern that the current intake process takes significantly longer relative to previous protocols. For one participant, the expectation was that some of these challenges could be alleviated by the return of in-person assessments. Other proposals included delaying the completion of the survey to after the initial clinical intake, advocating for functionality changes to allow the Beehive system to send surveys prior to the intake date for earlier completion, and reducing the level of online support afforded to consumers during the completion of the surveys. These challenges highlight the importance of the research team providing significant support during the initial implementation process, and the necessity of the research process being as flexible as possible to help minimize stakeholder burden. In later reports, the success of implementing modifications to the intake process will be explored, with facilitators to efficient intake procedures being distributed across the network to support other programs.

Additionally, after receiving feedback from Beehive beta testing, the EPI-CAL team pushed issues to the application developers to implement in future versions of the application. The types of issues reported were bugs (such as items not displaying as expected), cosmetic issues (such as typos and updating language and display icons), fixes to already implemented features, usability problems (such as expanding input characters permitted) and requested new features.

Training and Rollout of Beehive in Los Angeles County

Los Angeles County consumers and PIER Program staff were asked to complete self-report questionnaires in the pre-implementation period of the project during August and September 2020. Consumers are asked to complete self-report questionnaires about insight into illness, perceived utility of the application, satisfaction with treatment, treatment alliance, and comfort with technology. Unfortunately, no data was collected from Los Angeles County clients before implementation. PIER Program staff from treatment, non-treatment, and leadership roles were also asked to complete pre-implementation questionnaires. The goal was to assess baseline factors thought to impact buy-in and adoption of new technology, like Beehive, in the clinic, and factors thought to impact client outcomes. Thirty-one PIER staff across all 5 clinics completed the pre-implementation surveys. Reports for each clinic were made available to

LACDMH on December 6, 2021, and meetings to discuss outcomes with management from each program are planned for January 2022. Outcomes from surveys will be reported in the next annual report.

In the original LHCN proposal, in-person site visits to conduct the initial training for the Beehive application were proposed, however, due to the COVID-19 pandemic, the training plan was adjusted and the first training "site visits" were conducted remotely. This began with a pre-training meetings during the week of May 10, 2021 with leadership at all five LACDMH contracted program sites to discuss which program staff members would be designated as providers, group analysts, or group and clinic admin in Beehive, as well as to cover topics around integrating Beehive into their current data collection system.
Next, the EPI-CAL team conducted a three-part training series to introduce Beehive to each program (Part 1, Part 2, and Part 3). In June, 2021, the EPI-CAL team began to onboard non-pilot sites, starting with the Los Angeles County PIER programs. All LA County PIER programs completed Part 1 trainings in June 2021, starting with The Help Group on June 14, 2021, The Whole Child on June 17, 2021, San Fernando Valley Community Mental Health Center (SFVCMHC) on June 18, 2021 and Institute for Multicultural Counseling and Education Services (IMCES) Service Area 3 and 4 on June 21, 2021. During these meetings, a re-introduction to the EPI-CAL project was given, including the overarching purpose and goals of data collection via Beehive. There was also a presentation on the value of Beehive and data collection, and finally, the Beehive Application training session was completed.

During pre-training meetings and Part 1 trainings, PIER programs were able to enroll their staff and administrators as providers and administrators in Beehive. As of December 1, the five PIER programs were able to enroll 38 staff that included both direct service providers and administrative staff. Additionally, DMH has enrolled two administrators in Beehive who can access County-level data.
As there was a significant gap between the Part 1 and Part 2 training due to waiting on penetration testing results and DMH information security approval, as well as a new training cohort of 20 PIER staff in September 2021, refresher sessions for the Beehive Part 1 training were offered by Beehive staff on October 28, 2021 and November 3, 2021 in preparation of the Part 2 training.

The second Beehive training focused on how providers can utilize individual level data in care. Next, the training details the types of urgent clinical issues that are currently tracked by Beehive, including "Risk to self", "Risk to others", "Risk of homelessness," and "Plan to stop taking medication." To conclude the training, the trainer introduces the "Data Use in Care" question pop up and its different response options. These data will contribute to a data-driven understanding of Beehive's impact (e.g., whether and how staff use data as part of treatment) on the participating programs of the LHCN.

All LA County PIER programs completed Part 2 trainings in November 2021, starting with SFVCMHC on November 18, 2021, IMCES Service Area 3 and 4 on November 19, 2021, The Whole Child on November 23, 2021 and The Help Group on November 29, 2021. Part 3 trainings for all sites are currently being scheduled for December 2021.
Additionally, each program will undergo a fidelity assessment to determine their adherence to evidence-based practices for first-episode services using a revised version of the First Episode Psychosis Services Fidelity Scale (FEPS-FS). The FEPS-FS represents a standardized measure of fidelity to EP program best practices (Addington et al., 2016; First Episode Psychosis Services Fidelity Scale: (FEPS-FS 1.0), 2015). Fidelity assessments for each of the 5 Los Angeles County PIER programs are scheduled for July, August and September 2022.

County-level Historical Data Analysis

As part of the LHCN evaluation, service utilization and costs are compared between EP and comparator outpatient programs in that county who serve similar consumers with EP diagnoses. These comparator programs are identified by input from county representatives and an evaluation of county level data to identify where first-episode psychosis consumers are typically treated in their county outside of the EP program. Individuals with EP diagnoses, within the same age group, who enter standard care outpatient programs during that same time period, will be identified as part of the comparator group (CG). This analysis focuses on data from Los Angeles, San Diego, Orange, Napa, and Solano Counties only, until other counties join the LHCN and opt in to this part of the project. For this component of the project, the evaluation has two phases: 1) the three years prior to the start of this project (e.g., January 1, 2017 – December 31, 2019) to harmonize data across counties, and 2) for the 3.5-year period contemporaneous with the prospective EP program level data collection to account for potential historical trends during the evaluation period.

LACDMH was able to provide retrospective EP program de-identified datasets for 91 clients from the CAPPS Early Psychosis program through a secure UC Davis web portal on February 18, 2021, and for comparator data for 19,856 clients on November 9, 2021.

Number of clients served for FY 2020-21 (where applicable)**:**

Because Part 1 Trainings for Beehive did not begin until June 2021 and final approval of penetration test results by the LACDMH Information Security Officer occurred on September 13, 2021, the first consumers were not enrolled in Beehive until October 22, 2021. However, as of December 1, 2021, eight existing consumers and nine primary support persons of those consumers were enrolled throughout Los Angeles County. All clients are pending to complete the EULA process and assigned survey bundles in Beehive.

Outcome data being collected and any analysis of impact to date

Qualitative data - Outcome Domain and Outcome Measure Selection

As the focus of this annual year period has been to develop the Beehive application which will be used in data collection, outcomes data is limited. At this time, there is no client outcome data for Los Angeles County as LACDMH did not participate in the pilot.

Once the two pilot EP programs (EDAPT/SacEDAPT and Solano County SOAR Aldea) were trained in March 2021, programs were able to begin enrolling consumers into Beehive. As of May 31, 2021, 41 consumers were registered in Beehive across both pilot clinics and of those, 22 consumers completed their EULA indicating their data sharing permissions and 17 consumers agreed to share their data with UC Davis (77%). The goal was to have 70% of consumers agree to share their data with UC Davis and NIH. It is important to note that clinic staff register consumers and invite them to Beehive; consumers then complete their registration and then have the ability to complete surveys. So, if someone has been registered in Beehive, it does not necessarily mean that they have completed any of the outcomes surveys available in Beehive.

As stated above, Los Angeles County will continue to provide updates on client outcomes once more clients are enrolled in Beehive and begin completing surveys. Additionally, as county-level utilization and cost data are analyzed by UC Davis in the next annual period, a preliminary evaluation for both EP and comparator group programs is expected in subsequent annual reports.

References

Niendam et al., 2021. *FY 2020/21 Annual Innovation Report: Early Psychosis Learning Health Care Network.* Pending submission. Prepared by UC Davis, San Francisco and San Diego.

■ INNOVATION	
Prior FY 2020-21	**Prior FY 2019-20**
$24.0 million Total Gross Expenditures	$26.3 million Total Gross Expenditures
FY 2022-23	**Three-Year Plan FYs 2021-24**
$12.6 million Estimated Gross Expenditures	$34.6 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 spring of 2022.

- ***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. The facility opened in July 2021.

- ***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 spring of 2022.

B. TECHNOLOGICAL NEEDS

- ***ACCESS Call Center Modernization Project***

The approved funding shift allows the Department 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 cross 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.

On September 28, 2021, DMH posted a solicitation to secure the services of a vendor for the ACCESS Call Center Modernization Project. A bidders conference was held on October 5, 2021. As of February 2022, DMH has received multiple bids for this solicitation and is in the evaluation process. This evaluation process is anticipated to be completed no later than spring 2022.

■ CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS	
Prior FY 2020-21	**Prior FY 2019-20**
$3.5 million Total Gross Expenditures	$5.3 million Total Gross Expenditures
FY 2022-23	**Three-Year Plan FYs 2021-24**
$8.5 million Estimated Gross Expenditures	$8.5 million Estimated Gross Expenditures

Does not include program administration costs

EXHIBITS

EXHIBIT A - FUNDING SUMMARY

County: Los Angeles

Date: 3/7/22

	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 2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	539,777,291	237,548,361	170,875,440	3,865,729	30,593,373	116,483,541
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	0	
4. Access Local Prudent Reserve in FY 2022/23						-
5. Estimated Available Funding for FY2022/23	866,266,124	324,246,501	193,690,060	24,297,687	30,593,373	
B. Estimated FY2022/23 MHSA Expenditures	498,199,762	160,898,313	14,781,005	20,201,184	10,650,000	
C. Estimated FY2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	368,066,362	163,348,188	178,909,055	4,096,503	19,943,373	
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 FY 2023/24	735,034,404	260,248,188	204,409,055	24,528,460	19,943,373	
D. Estimated FY2023/24 Expenditures	507,475,505	126,178,604	13,363,762	20,201,184	0	
E. Estimated FY2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	227,558,899	134,069,584	191,045,293	4,327,276	19,943,373	
2. Estimated New FY2024/25 Funding	387,400,000	96,900,000	25,500,000			
3. Transfer in FY2024/25 a/	(20,431,958)			20,431,958		
4. Access Local Prudent Reserve in FY2024/25						0
5. Estimated Available Funding for FY2024/25	594,526,942	230,969,584	216,545,293	24,759,234	19,943,373	
F. Estimated FY2024/25 Expenditures	527,573,230	106,525,061	13,085,902	20,201,184	0	
G. Estimated FY2024/25 Unspent Fund Balance	66,953,711	124,444,523	203,459,391	4,558,050	19,943,373	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2022	116,483,541
2. Contributions to the Local Prudent Reserve in FY 2022/23	0
3. Distributions from the Local Prudent Reserve in FY 2022/23	0
4. Estimated Local Prudent Reserve Balance on June 30, 2023	116,483,541
5. Contributions to the Local Prudent Reserve in FY 2023/24	0
6. Distributions from the Local Prudent Reserve in FY 2023/24	0
7. Estimated Local Prudent Reserve Balance on June 30, 2024	116,483,541
8. Contributions to the Local Prudent Reserve in FY 2024/25	0
9. Distributions from the Local Prudent Reserve in FY 2024/25	0
10. Estimated Local Prudent Reserve Balance on June 30, 2025	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.

	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	299,567,466	98,700,902	155,605,596		40,265,395	4,995,573
2. Outpatient Care Services	569,476,324	162,472,363	324,830,375		68,340,224	13,833,362
3. Alternative Crisis Services	165,520,546	126,698,258	34,987,693		1,575,735	2,258,860
4. Planning Outreach & Engagement	6,464,668	6,249,626	195,225		0	19,817
5. Linkage Services	34,901,893	25,664,968	8,563,190		61,131	612,603
6. Housing	35,144,049	35,129,217	13,349		0	1,483
			0		0	0
CSS Administration	43,284,429	43,284,429				0
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,154,359,375	498,199,762	524,195,428	0	110,242,485	21,721,699

	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	303,598,229	92,688,337	163,385,876		42,278,665	5,245,352
2. Outpatient Care Services	597,380,192	170,026,032	341,071,894		71,757,235	14,525,031
3. Alternative Crisis Services	171,981,222	131,217,819	36,737,078		1,654,522	2,371,803
4. Planning Outreach & Engagement	6,727,687	6,501,893	204,986		0	20,808
5. Linkage Services	36,462,280	26,763,509	8,991,350		64,188	643,233
6. Housing	35,207,526	35,191,952	14,016		0	1,557
			0		0	0
CSS Administration	45,085,962	45,085,962				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,196,443,099	507,475,505	550,405,199	0	115,754,610	22,807,784

	Fiscal Year 2024/25					
	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	318,330,532	96,875,145	171,555,170		44,392,598	5,507,619
2. Outpatient Care Services	626,679,253	177,957,385	358,125,489		75,345,097	15,251,282
3. Alternative Crisis Services	178,764,932	135,963,359	38,573,932		1,737,248	2,490,394
4. Planning Outreach & Engagement	7,003,858	6,766,774	215,235		0	21,848
5. Linkage Services	38,100,687	27,916,977	9,440,917		67,397	675,395
6. Housing	35,274,177	35,257,825	14,717		0	1,635
			0		0	0
CSS Administration	46,835,766	46,835,766				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,250,989,203	527,573,230	577,925,459	0	121,542,340	23,948,173

	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	50,513,488	50,513,488				
4 EARLY INTERVENTION	188,002,409	33,386,697	97,595,422		52,832,093	4,188,197
5 OUTREACH	38,688,869	38,688,869				
PEI Administration	15,640,011	15,640,011				
Total PEI Program Estimated Expenditures	315,514,025	160,898,313	97,595,422	0	52,832,093	4,188,197

	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	5,311,429	5,311,429				
2. STIGMA DISCRIMINATION REDUCTION PROGRAM	366,250	366,250				
3. PREVENTION	44,868,185	44,868,185				
4 EARLY INTERVENTION	197,322,500	34,976,002	102,475,193		55,473,698	4,397,607
5 OUTREACH	28,897,144	28,897,144				
PEI Administration	11,759,594	11,759,594				
Total PEI Program Estimated Expenditures	288,525,103	126,178,604	102,475,193	0	55,473,698	4,397,607

	Fiscal Year 2024/25					
	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	5,311,429	5,311,429				
2. STIGMA DISCRIMINATION REDUCTION PROGRAM	366,250	366,250				
3. PREVENTION	44,868,185	44,868,185				
4 EARLY INTERVENTION	207,108,595	36,644,772	107,598,953		58,247,383	4,617,487
5 OUTREACH	7,401,833	7,401,833				
PEI Administration	11,932,591	11,932,591				
Total PEI Program Estimated Expenditures	276,988,884	106,525,061	107,598,953	0	58,247,383	4,617,487

	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	7,397,864	7,397,864				
2. Mental Health Career Pathway	1,660,000	1,660,000				
3. Financial Incentive	6,936,684	6,936,684				
4. Residency	2,705,058	2,705,058				
WET Administration	1,501,578	1,501,578				
Total WET Program Estimated Expenditures	20,201,184	20,201,184	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	7,397,864	7,397,864				
2. Mental Health Career Pathway	1,660,000	1,660,000				
3. Financial Incentive	6,936,684	6,936,684				
4. Residency	2,705,058	2,705,058				
WET Administration	1,501,578	1,501,578				
Total WET Program Estimated Expenditures	20,201,184	20,201,184	0	0	0	0

	Fiscal Year 2024/25					
	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	7,397,864	7,397,864				
2. Mental Health Career Pathway	1,660,000	1,660,000				
3. Financial Incentive	6,936,684	6,936,684				
4. Residency	2,705,058	2,705,058				
WET Administration	1,501,578	1,501,578				
Total WET Program Estimated Expenditures	20,201,184	20,201,184	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. Capital Project -Tenant Improvement/New Facilities	5,000,000	5,000,000				
CFTN Programs - Technological Needs Projects						
2. Modern Call Center	3,500,000	3,500,000				
CFTN Administration	2,150,000	2,150,000				
Total CFTN Program Estimated Expenditures	10,650,000	10,650,000	0	0	0	0

	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 # 3 Technology Suite	-	-				
2. Inn # 4 Transcranial Magnetic Stimulation Center	1,150,726	1,070,122	75,116			5,488
3. Inn #7 Therapeutic Transportation	5,467,999	5,467,999				
4. Inn # 8 Early Psychosis Learning Health Care Network	492,709	492,709				
5. Hollywood 2.0 Project (formally known Trieste)	5,439,504	5,439,504				
INN Administration	2,310,671	2,310,671				
Total INN Program Estimated Expenditures	14,861,609	14,781,005	75,116	-	-	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 #7 Therapeutic Transportation	5,467,999	5,467,999				
2. Inn # 8 Early Psychosis Learning Health Care Network	252,600	252,600				
3. Hollywood 2.0 Project (formally known Trieste)	5,439,504	5,439,504				
INN Administration	2,203,659	2,203,659				
Total INN Program Estimated Expenditures	13,363,762	13,363,762	0	0	0	0

	Fiscal Year 2024/25					
	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 #7 Therapeutic Transportation	5,467,999	5,467,999				
2. Hollywood 2.0 Project (formally known Trieste)	5,439,504	5,439,504				
INN Administration	2,178,399	2,178,399				
Total INN Program Estimated Expenditures	13,085,902	13,085,902	0	0	0	0

APPENDICES

APPENDIX A – MHSA EXECUTIVE SUMMARY

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL UPDATE FY 2022-23
EXECUTIVE SUMMARY

A. MHSA Background Information

In Fiscal Year (FY) 2020-21, 170,077 unique clients in Los Angeles County received a direct mental health service through programs and services funded by the Mental Health Services Act (MHSA). The MHSA funded by Proposition 63, was passed by the Californian electorate in November 2004 and became state law on January 1, 2005. The Act required a one percent (1%) tax on personal incomes above one million dollars ($1M) to expand mental health services and programs serving all ages.

Once MHSA was written into law, the Welfare and Institutions Code (WIC) Section 5847 required county mental health programs in California to prepare and submit a Three-Year Program and Expenditure Plan ("Three-Year Plan" or "Plan") followed by Annual Plan Updates for all MHSA programs and expenditures. In Los Angeles County, the Plan provides an opportunity for the Department of Mental Health (LACDMH) and its stakeholders to review its existing MHSA programs and services to evaluate their effectiveness. Through the Plan's required Community Planning Process (CPP), LACDMH, engages a broad array of stakeholders that provide feedback and input on existing MHSA programs and services which allows LACDMH an opportunity to propose and incorporate new programs and services that meet the diverse needs of all communities served. Changes made to the Plan, through the CPP 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
- True Recovery Innovation Embraces Systems that Empower (TRIESTE)

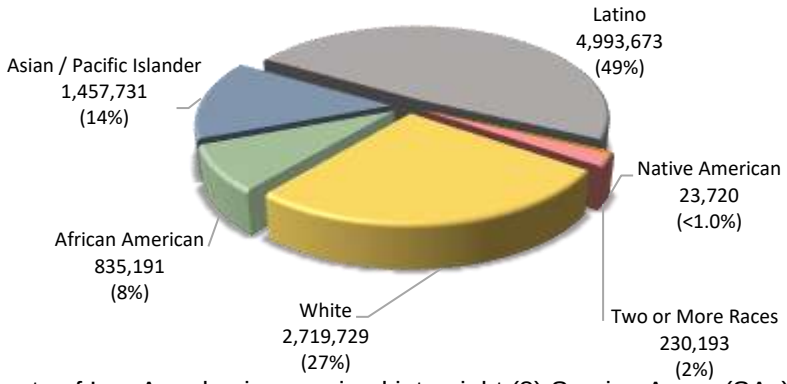
Workforce Education & Training

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.

B. Los Angeles County Demographics

The County of Los Angeles is the most populated in the United States (US), with an estimated 10,260,237 residents in Calendar Year (CY) 2019. According to California's census data, in Los Angeles County, the Latino group is the most represented race/ethnicity, and the Native American group is the smallest.

Figure 1. Los Angeles County (N=10,278,834)



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). At the SA level, White residents (including non-Hispanic, European Americans, and Middle Eastern Americans) are the largest in SA 2 and SA 5. In contrast, Latinos are the largest group in all other SAs.

Table 1. Total Population by Race/Ethnicity and Service Area, CY 2019

SA	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	61,148	15,464	181,754	1,922	125,684	11,300	397,272
Percent	15.4%	3.9%	45.8%	0.48%	31.6%	2.8%	100.0%
SA 2	77,002	254,680	909,678	4,703	943,807	58,441	2,248,311
Percent	3.4%	11.3%	40.5%	0.21%	42.0%	2.6%	100.0%
SA 3	63,409	507,240	846,574	3,720	358,478	35,040	1,814,459
Percent	3.5%	28.0%	46.7%	0.21%	19.8%	1.9%	100.0%
SA 4	59,582	206,948	616,104	2,619	285,102	21,416	1,191,772
Percent	5.0%	17.4%	51.7%	0.22%	23.9%	1.8%	100.0%
SA 5	37,299	91,134	110,277	1,184	398,949	28,378	667,220
Percent	5.6%	13.7%	16.5%	0.18%	59.8%	4.3%	100.0%
SA 6	275,338	19,164	717,130	1,825	25,738	11,503	1,050,698
Percent	26.2%	1.8%	68.3%	0.17%	2.4%	1.1%	100.0%
SA 7	39,210	119,386	974,630	3,344	168,786	15,589	1,320,945
Percent	3.0%	9.0%	73.8%	0.25%	12.8%	1.2%	100.0%
SA 8	222,204	243,714	637,526	4,403	413,188	48,525	1,569,560
Percent	14.2%	15.5%	40.6%	0.28%	26.3%	3.1%	100.0%
Total	835,191	1,457,731	4,993,673	23,720	2,719,729	230,193	10,260,237
Percent	8.1%	14.2%	48.7%	0.23%	26.5%	2.2%	100%

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

Table 2. Population by race/ethnicity and Service Area

Ethnic Group	Highest	Lowest
African-American	SA 6 (33%)	SA 5 (4%)
Asian/Pacific Islander	SA 3 (35%)	SA 6 (1%)
Latino	SA 7 (20%)	SA 5 (2%)
Native American	SA 2 (20%)	SA 5 (5%)
White	SA 2 (35%)	SA 6 (1%)
Two or More Races	SA 2 (25%)	SA 1 (5%)

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 Table 3 below provide a snapshot of the population breakdown by age group based on the SAs.

Figure 2. Total Population by Age Group CY 2019

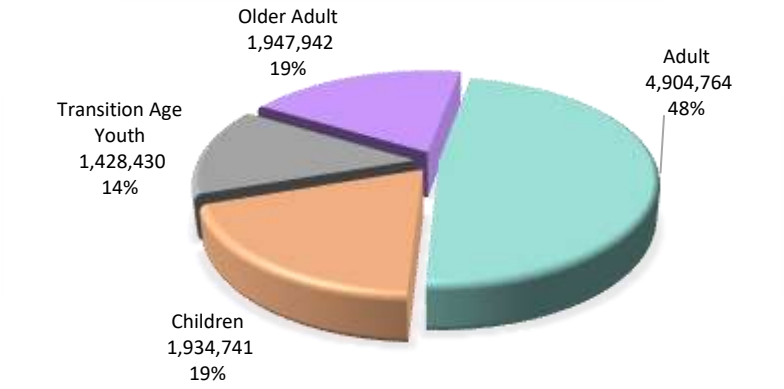


Table 3. Total Population by Age and Service Area, CY 2019

SA	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	104,022	13,206	34,450	176,405	24,364	44,825	397,272
Percent	26.2%	3.3%	8.7%	44.4%	6.1%	11.3%	100.0%
SA 2	486.825	60,627	152,108	1,085,643	147,042	316,066	2,248,311
Percent	21.7%	2.7%	6.8%	48.3%	6.5%	14.1%	100.0%
SA 3	390,614	54,138	131,937	837,009	119,711	281,050	1,814,459
Percent	21.5%	3.0%	7.3%	46.1%	6.6%	15.5%	100.0%
SA 4	239,083	26,350	69,744	643,006	64,200	149,389	1,191,772
Percent	20.1%	2.2%	5.9%	54.0%	5.4%	12.5%	100.0%
SA 5	119,662	23,038	40,973	334,647	41,382	107,518	667,220
Percent	17.9%	3.5%	6.1%	50.2%	6.2%	16.1%	100.0%
SA 6	298,631	38,452	90,823	477,317	50,349	95,126	1,050,698
Percent	28.4%	3.7%	8.6%	45.4%	4.8%	9.1%	100.0%
SA 7	329,651	40,947	103,494	610,331	72,824	163,698	1,320,945
Percent	25.0%	3.1%	7.8%	46.2%	5.5%	12.4%	100.0%
SA 8	361,487	43,443	109,466	740,406	98,813	215,945	1,569,560
Percent	23.0%	2.8%	7.0%	47.2%	6.3%	13.8%	100.0%
Total	2,329,975	300,201	732,995	4,904,764	618,685	1,373,617	10,260,237
Percent	22.7%	2.9%	7.1%	47.8%	6.0%	13.4%	100%

C. MHSA Client Counts, FY 2020-21

COMMUNITY SERVICES AND SUPPORTS

Number of Unique Clients Served: 135,232
Number of New Clients Served: 35,499

Table 4. CSS clients served by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	9,098	2,410
SA 2 – San Fernando Valley	22,613	5,886
SA 3 – San Gabriel Valley	19,146	5,952
SA 4 – Metro Los Angeles	25,458	6,801
SA 5 – West Los Angeles	7,837	1,918
SA 6 – South Los Angeles	21,682	4,727
SA 7 – East Los Angeles	12,465	2,953
SA 8 - South Bay	27,189	6,940

Table 5. Number of unique clients served through CSS by age group and Average MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	24,408	22,917	72,752	18,872
Average MHSA Cost	$195,844,453.30	$135,016,574.60	$381,253,396.18	$90,581,063.20

Table 6. Number of unique clients served through CSS by Ethnicity

Ethnicity	White	African American	Latino	Asian/ Pacific Islander	Native American	Multiple Races
Number of Clients Served	23,998	27,373	49,468	6,831	1,087	1,276
Percentage	18%	20%	37%	5%	1%	1%

Table 7. Number of unique clients served through CSS by ethnicity and Service Area

Service Area	White	African American	Latino	Asian/ Pacific Islander	Native American	Multiple Races
SA 1 (9,098)	2,141	2,890	2,496	127	50	616
Percent	24%	32%	27%	2%	1%	7%
SA 2 (22,613)	6238	1910	7876	826	76	1,338
Percent	28%	8%	35%	8%	0.34%	6%
SA 3 (19,146)	268	1655	6246	1,541	84	815
Percent	14%	9%	33%	8%	0.44%	4%
SA 4 (25,458)	4,301	5,133	9,248	1,589	218	990
Percent	17%	20%	36%	6%	1%	4%
SA 5 (7,837)	2,679	1,668	1,427	222	40	414
Percent	34%	21%	21%	3%	1%	5%
SA 6 (21,682)	969	8,866	7,676	171	212	690
Percent	4%	41%	41%	1%	1%	3%
SA 7 (12,465)	1,372	804	6,189	393	134	669
Percent	11%	6%	6%	3%	1%	5%

Service Area	White	African American	Latino	Asian/ Pacific Islander	Native American	Multiple Races
SA 8 (27,189)	4,622	6,724	8,461	1,794	101	1,475
Percent	17%	25%	31%	7%	0.4%	5%

Table 8. Number of unique clients served through CSS by Primary Language

Primary Language	English	Spanish	Farsi	Vietnamese	Korean	Mandarin	American Sign Language	Pilipino, Tagalog	Other
Number of Clients Served	106,987	18,668	611	406	601	381	58	235	6,573
Percentage	79%	14%	0.45%	0.30%	0.44%	0.28%	0.04%	0.17%	5%

Full Service Partnership (FSP)

Table 9. Number of unique clients served by age group and Average MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	3,777	2,915	7,618	1,993
MHSA Average Cost	$17,954	$13,405	$14,642	$11,373

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

Table 10. Service Area Full Service Partnership Slots as of 2/14/22 (Master Slot Allocation Reports)

Service Area	Number of Children Slots (0-17)	Number of Wraparound Slots	Number of Adult Slots (18+)	Number of Homeless Slots
Service Area 1	103	60	380	70
Service Area 2	386	110	854	100
Service Area 3	360	70	845	70
Service Area 4	451	60	1209	420
Service Area 5	36	0	524	160
Service Area 6	531	120	1045	300
Service Area 7	390	60	705	70
Service Area 8	381	40	1304	170
Countywide	15	0	229	0

Table 11. Countywide Full Service Partnership Slots as of 2/14/21

Countywide FSP Program	Number of Slots
Intensive Field Capable Clinical Services (IFCCS)	510
Assisted Outpatient Program (AOT)	300
Integrated Mental Health Team (IMHT)	300

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Table 12. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	21,110	18,696	60,206	16,175
MHSA Average Cost	$5,972	$4,642	$3,861	$3,885

Prevention and Early Intervention

Number of Unique Clients Served: 42,784
Number of New Clients Served: 23,277

Table 13. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	27,025	9,002	6,609	1,027
MHSA Average Cost	$3,915	$3,794	$3,072	$3,243

Table 14. PEI clients served by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	2,850	1,560
SA 2 – San Fernando Valley	7,288	3,807
SA 3 – San Gabriel Valley	7,042	4,068
SA 4 – Metro Los Angeles	6,231	3,890
SA 5 – West Los Angeles	1,626	931
SA 6 – South Los Angeles	5,249	3,334
SA 7 – East Los Angeles	6,185	3,882
SA 8 - South Bay	7,020	3,807

Table 15. Number of unique clients served by Ethnicity

Ethnicity	Latino	White	African American	Asian Pacific Islander	Native American	Multiple Races
Number of Clients Served	19,181	3,701	3,779	1,058	210	1,760
Percentage	45%	9%	9%	2%	1%	4%

Table 16. Number of unique clients served by ethnicity and Service Area

Service Area	White	African American	Latino	Asian/ Pacific Islander	Native American	Multiple Races
SA 1 (2,850)	484	675	1,040	18	16	213
Percent	17%	24%	36%	1%	1%	7%
SA 2 (7,288)	986	280	4,009	182	11	434
Percent	14%	4%	55%	3%	0.15%	6%
SA 3 (7,042)	474	232	2,250	225	17	147
Percent	7%	3%	32%	4%	0.24%	2%
SA 4 (6,231)	474	335	3,318	300	15	170
Percent	8%	5%	53%	5%	0.24%	3%

Service Area	White	African American	Latino	Asian/ Pacific Islander	Native American	Multiple Races
SA 5 (1,626)	281	225	496	37	4	59
Percent	17%	14%	31%	1.14%	0.25%	4%
SA 6 (5,249)	142	1,069	2,378	30	109	108
Percent	3%	20%	45%	0.29%	2%	2%
SA 7 (6,185)	385	156	3,079	78	32	254
Percent	6%	3%	50%	1%	1%	4%
SA 8 (7,020)	549	887	2,976	201	8	401
Percent	8%	13%	42%	3%	0.11%	6%

Table 17. Number of unique clients served by primary language

Primary Language	English	Spanish	Korean	Unknown/Not Reported	Other
Number of Clients Served	32,413	9,051	119	634	686
Percentage	76%	21%	0.28%	1.48%	1.60%

Data Source for Figures 1-2 and Tables 1-3: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019. Data Source for Tables 4-17: Direct service claiming as of 12/1/2021. Cost is based on Mode 15 services and not inclusive of community outreach services, client supportive services or invoiced services.

D. Covid-19 Impact on Mental Health Services

The LACDMH MHSA Three Year Program and Expenditure Plan, Fiscal Years 2021-22 through 2023-24 sheds light on the significant impact the COVID-19 outbreak had on residents and communities within the County noting:

- increased demand for critical mental health services due to increased stress and isolation across populations
- increased housing and economic disparities for communities of color
- significant capacity/staff shortages for the mental health and health safety nets to meet the needs of those most vulnerable populations
- Widespread rising COVID infection rates prompting the need for temporary and/or permanent business and clinic closures

The third year of the pandemic reflects improvements in the County's ability to control infection rates, hospitalizations, and to provide social services and economic assistance to those in need.

LACDMH has developed and executed several strategies to continue to adapt, including:

- Increased use of technology, including telehealth and telepsychiatry, and virtual groups and celebrations to ensure clients have access to care
- Regular phone check ins with clients and/or their families
- Implementation of a peer/volunteer run warm line for those seeking to reach out by phone to stay connected
- Video clinical team meetings, case conferencing, and clinical supervision to ensure best clinical practice and team cohesion
- WebEx court hearings when possible for clients involved in the justice system
- Continued street outreach to clients experiencing homelessness
- Resumed outreach and engagement teams with increased COVID-19 safety measures

E. Fiscal Year-2022-23 Budget Projection Changes

Tables 18-23 show the difference of what was projected for FY 2022-23 in the Three Year Program and Expenditure Plan, Fiscal Years 2021-22 through 2023-24, and what is now projected in the MHSA Annual Update FY 2022-23.

Table 18. Community Services and Supports

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Full Service Partnership	$302,391,232	$299,567,466	$(2,823,767)	(1) Overall reduction in services due to the pandemic and difficulties to retain staff offset by funds allocated to maintain the Flexible Housing Subsidies Pool for housing vouchers provided to mental health clients for rent.
Outpatient Care Services	$636,564,407	$569,476,324	$67,088,083)	(2) Overall reduction in services due to the pandemic and difficulties in retaining staff.
Alternative Crisis Services	$139,819,715	$165,520,546	$25,700,832	Reflects the operating cost for the new Crisis Residential Treatment Programs (CRTP) at the Restorative Villages.
Planning Outreach & Engagement	$7,108,451	$6,464,668	$(643,783)	Same as (2) above
Linkage Services	$28,322,985	$34,901,893	$6,578,907	Reflects projection of additional Linkage services based on current utilization.
Housing	$ 35,073,361	$35,144,049	$70,688	Same as (1) above
CSS Administration	$38,865,316	$43,284,429	$4,419,113	Same as (2) above
TOTAL	**$1,188,145,468**	**$1,154,359,375**	**$(33,786,093)**	

Table 19. Prevention and Early Intervention

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Suicide Prevention	$ 22,302,998	$22,302,998	$ -	
Stigma & Discrimination Reduction	$366,250	$366,250	$ -	

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Prevention	$43,564,826	$50,513,488	$6,948,662	Primarily reflects the addition of 311 positions for universal promoters which will serve as community promoters to provide outreach and education and the one-time extension of My Health LA (MHLA) Agreement with Department of Health Services (DHS) for mental health prevention services provided in a primary care setting.
Early Intervention	$198,997,562	$188,002,410	$(10,995,152)	Reflects the overall reduction in services due to the pandemic and difficulties in retaining staff.
Outreach	$8,368,989	$ 38,688,869	$30,319,880	Primarily reflects continuation of funding for the Los Angeles Unified School District (LAUSD) and Los Angeles County Office of Education (LACOE) for Community School Initiatives (CSI) and the transition of the Innovation Community Capacity Building project.
PEI Administration	$14,343,578	$15,640,011	$1,296,433	Reflects the change in administrative costs based on the projected cost of the projects.
TOTAL	**$287,944,203**	**$315,514,026**	**$ 27,569,823**	

Table 20. Innovation

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Inn #2 - Community Capacity Building	$ 14,700,000	$ -	$(14,700,000)	Continuation of CANS programming with PEI funding.
INN # 3 - Technology Suite	$6,321,028	$ -	$(6,321,028)	Reflects the completion of the project. DMH is currently in discussions with the California Mental Health Services Authority (CalMHSA) for additional services that may be provided.
Inn # 4 - Transcranial Magnetic Stimulation Center	$1,150,726	$1,150,726	$ -	Reflects the continuation of this project in FY 2022-23.
Inn #7 - Therapeutic Transportation	$ 3,387,415	$5,467,999	$2,080,584	Reflects the expansion of teams in partnership with Los Angeles City Fire Department.
Inn # 8 - Early Psychosis Learning Health Care Network	$492,709	$492,709	$ -	Reflects the continuation of this project in FY 2022-23.
Hollywood 2.0 Project (formally known Trieste)		$5,439,504	$5,439,504	Reflects the implementation of True Recovery Innovation Embraces Systems That Empower (TRIESTE) / Hollywood 2.0 Project
INN - Administration	$ 4,176,000	$2,310,671	$(1,865,329)	Reflects the change in administrative costs based on the projected cost of the projects

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
TOTAL	**$ 30,227,878**	**$14,861,609**	**$ (15,366,269)**	

Table 21. Workforce Education and Training (WET)

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
UCLA Affiliation Agreement	$7,135,501	$6,417,864	$(717,637)	Reflects scheduled reduction of one-time services.
Financial Incentive Programs	$3,873,084	$3,873,084	$ -	
Stipend Program for MSWs, MFTs, AND NPs	$3,063,600	$3,063,600	$ -	
Charles R. Drew Affiliation Agreement	$2,011,394	$2,309,058	$297,664	Reflects an increase in the services provided in the residency program.
Funds Assistant Behavioral Sciences Consultants (6 FTEs), for Post-Docs at Harbor-UCLA	$510,000	$ -	$(510,000)	Reflects the elimination of this funding as the fellows being funding with a different funding source, as they provide direct mental health services.
Intensive MH Recovery Specialist Core Training Program	$440,000	$ 440,000	$ -	
Interpreter Training Program	$ 80,000	$80,000	$ -	
Learning Net System 2.0	$250,000	$250,000	$ -	
Navigators (Health and Housing)	$200,000	$ 400,000	$ 200,000	Reflects an expansion in the Health Navigation training program.
Continuum of Care Reform / Staff and Resource Parents Training	$500,000	$500,000	$ -	
Parent Partner Training and Parent Volunteers Project	$320,000	$320,000	$ -	
Peer Focused Training	$ -	$400,000	$400,000	Reflects funding for Peer focused training.
Med. School Affiliation at Harbor	$260,000	$260,000	$ -	
UCLA Medical School Affiliation Agreement (MSAA)	$126,000	$136,000	$10,000	Reflects an increase in cost for services provided by UCLA.
Licensure Preparation Program (MSW, MFT, PSY)	$250,000	$250,000	$ -	
Administrative Overhead	$1,412,379	$1,501,578	$89,199	Reflects the change in administrative costs based on the projected cost of the projects.

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
TOTAL	**$20,431,958**	**$20,201,184**	**$(230,774)**	

Table 22. Capital Facilities/Technological Needs (CFTN)

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Tenant Improvement / Capital Facilities		$5,000,000	$5,000,000	Reflects funding for new and/or existing facilities to continue to modernize and develop welcoming building to meet the goals of the mental health services delivered in Los Angele County.
Modern Call Center	$3,500,000	$3,500,000	$ -	Reflects the continuation of this project in FY 2022-23.
CFTN - Administration	$350,000	$2,150,000	$1,800,000	Reflects the change in administrative costs based on the projected cost of the projects
TOTAL	**$3,850,000**	**$10,650,000**	**$6,800,000**	

Table 23. Summary by Program

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change
Community Services and Supports (CSS) Plan	$1,188,145,468	$1,154,359,375	$(33,786,093)
Prevention and Early Intervention (PEI) Plan	$287,944,203	$315,514,026	$27,569,823
Innovation	$30,227,878	$14,861,609	$(15,366,269)
Workforce, Education and Training (WET) Plan	$20,431,958	$20,201,184	$(230,774)
Capital Faculties / Technology Needs(CFTN) Plan	$3,850,000	$10,650,000	$6,800,000
TOTAL	**$1,530,599,507**	**$1,515,586,193**	**$(15,013,313)**

F. Disparities

Based on feedback from Underserved Cultural Communities (UsCC) groups, LACDMH reviewed the data it collects to more comprehensively capture the racial, ethnic, cultural and disability status of the clients its serves.

Race and Ethnicity:

LACDMH will now be reporting the racial and ethnic status, including primary language spoken, of the clients served at a more granular level and will publish a public-facing dashboard on its website.

Sexual Orientation and Gender Identity (SOGI)

The County has finalized data collection fields for gender identity and sexual orientation. LACDMH has been working to ensure that recent federal requirements are consistent with County reporting prior to modifying its electronic health record and requiring that of contractors. The Department's subject matter expert on SOGI has developed training materials for staff on collecting this information and will finalize once data fields are finalized.

Services for Clients with Disabilities

- The number of clients who report their primary language as American Sign Language (ASL) will now be reported. Current data has clients who report their primary language as ASL is .03% of clients served.
- The ACCESS Center Help Line is in the process of transitioning to 711, the California Relay Service, to assist callers who are deaf or hard of hearing. This will replace the antiquated TTY-TTD system. Informational materials will be disseminated upon adoption of 711.

In the first quarter of calendar year 2022, LACDMH will begin 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. LACDMH views this opportunity as a vehicle for the disparities reduction efforts and as a way to strengthen community voice.

G. Updates on Actions Approved in the MHSA Three Year Program and Expenditure Plan FYs 2021-22 through 2023-24

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. Adult FSP Services aim to help Clients, those adults enrolled in Adult FSP Services, increase their ability to function at optimal levels, decrease homelessness and incarcerations, and reduce unnecessary medical and psychiatric urgent care and emergency room visits and hospitalizations. For those Clients that are homeless, Adult FSP Services will help them transition from street to home by providing immediate and on-going assistance with securing and maintaining housing. Child/Young Adult (YA) FSP Services include but are not limited to individual and family counseling, 24/7 assessment and crisis services, Intensive Care Coordination (ICC), and Intensive Home Based Services (IHBS). The intent of these services is to help Clients and/or families increase their ability to function at optimal levels. Existing FSP programs serve children and young adults between the ages of 0-20 and adults (21+).

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

- Changed the eligibility criteria to be more focused on those most in need of FSP care;
- Changed the FSP service model to utilize a multidisciplinary team/population approach, rather than individual caseloads and "slots;"

- Began the integration of all specialty FSP programs into one FSP model (with the exception of Housing FSP which transitioned to housing support);
- Lowered client to staff ratios;
- Added funding for additional staffing to enable Child FSP programs to provide Intensive Care Coordination (ICC) & Intensive Home Based Services (IHBS);
- Provided enhanced training and technical assistance to support FSP providers in achieving desired outcomes;
- Enhanced services and supports to ensure successful transitions between levels of care;
- Centralized the authorization, enrollment, and disenrollment processes for FSP to ensure that those highest needs clients are able to access the FSP services;
- Standardized 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.

These changes were incorporated into the Service Exhibits within the contracts, which were included in the new Legal Entity agreements that were executed on July 1, 2021. The transformed FSP program was launched on July 1, 2021. Because this program redesign is 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.

24/7 Access Modernization Project

The approved funding shift allows the Department 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 cross 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.

On September 28, 202, DMH posted a solicitation to secure the services of a vendor for the ACCESS Call Center Modernization Project. A bidders conference was held on October 5, 2021. As of February 2022, DMH has received multiple bids for this solicitation and is in the evaluation process. This evaluation process is anticipated to be completed no later than spring 2022.

Mental Health Treatment Beds and Housing Capacity

LACDMH recommended a two-year pilot, long 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. In the last two years, LACDMH arranged for access to up to 239 beds when they became (or will become) available, of which 160 beds were utilized. In implementing the bed pilot, DMH went approximately $9.9 million dollars over budget utilizing one-time Sales Tax Realignment. In order to continue to move patients and allow continuous and efficient system flow, ongoing funding above the $25 million in Sales Tax Realignment revenues set aside in the FY 2019-20 Final Adopted Budget by LACDMH is required.

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.

G. Proposed Changes in the MHSA Annual Update FY 2022-23

Innovation 2: Community Capacity Building to Prevent and Address Trauma

This Innovation project was posted to the LACDMH website on February 27, 2015 and approved by the OAC on May 28, 2015. Due to the time-limited nature of MHSA-Innovations, this project is scheduled to end on June 30, 2022.

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. In June 2020, LACDMH integrated community mental health workers (community ambassadors) into the INN 2 project.

The concept of the Community Ambassador Network (CAN) leverages existing networks of trusted community-based providers and organizations to have the right people in the right place at the right time to provide necessary resources to those in need. The development of the CAN through Innovations 2 has allowed LACDMH to expand our behavioral health workforce, in partnership with community based organizations, to hire and train 326 community ambassadors. As of 12/6/2021, 321 individuals have been part of the CAN. The CAN intern project was introduced a year ago as a collaborative project with the Department of Public Social Services (DPSS), the INN 2 team and the California Work Opportunity and Responsibility to Kids (CalWORKs) team. Funded by DPSS, CAN Interns expand the reach and supports available within communities by members of the community.

The Los Angeles County Board of Supervisors approved nine (9) lead agencies and ten (10) projects, two (2) 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 selected specific strategies based on their community's interests and needs. 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.

COVID-19 has resulted in a critical need for mental health services, and the 321 individuals that have been part of the CAN have allowed DMH to build capacity, provide trauma-informed targeted outreach and resources to communities at higher risk. In addition, 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 and utility assistance and a multitude of linkages).

Innovation 2: Outcomes

Specifically, the following process and summative outcomes were achieved by the Innovations 2 program:

- There were 8,077 registered participants, with 68% (5,499) of all participants were enrolled in INN 2 during the pandemic. Most participants in INN 2 are families with young children between the ages of 0-5 (25.2% of participants), intergenerational families (23.2% of participants) and TAY (22.3% of participants).

- Through nearly 10,700 community events, outreach and social media posts, 560,268 community members were reached, 18,000 meals provided, 9,865 individuals vaccinated for COVID-19 and PPE provided to nearly 14,000 individuals.
- The CAN Participants demonstrated a stronger understanding of the relationship between trauma and mental health, significant improvements in resilience, and improved ability to cope with stress.
- Over the past year, 93% of the 29,587 linkages to community resources and supports were successful. Despite the impact of the COVID-19 pandemic, linkages increased substantially from the prior year.
- During FY 2020-2021, there were a total of 14,219 outreach and engagement efforts, representing a substantial increase compared to the prior year of the project.
- Through Learning Sessions, partners learned how to engage a wider net of at-risk community members to provide support.
- Participants enrolled in INN 2 during the COVID-19 pandemic, reported feeling significantly more connected with the community, and utilized more approach coping skills after three months of INN 2 activities.
- Participants reported feeling significantly more resilient after 9 months of participation in INN 2.
- Based on data from the Conner-Davidson Resilience Scale (CD-RISC-10) participants who enrolled in INN 2 during the past year of the pandemic, reported no decline in their resilience despite the significant amount of stress communities experienced over the course of the past year.
- In addition, based on the Inclusion of Community in Self (ICS) Scale, INN 2 participants reported a significant increase in their connection to the community, relative to the baseline score.
- Community members engaged with INN 2 and the Community Ambassadors also reported significant improvement in Approach Coping scores, based on The Cope Inventory.
- Partnership rosters within the community increased by 13% as INN 2 partnerships expanded to include new organizations and community members. Specifically, the INN 2 networks averaged 57 partners in February 2021, compared to 51 partners last year (February 2020) and 36 partners in March 2019 (baseline assessment). On key factor responsible for the stronger community partnerships has been the addition of the Community Ambassador Network.

Innovation 2: Proposed Budget
An annual budget of $22,489,000 using Prevention and Early Intervention funding.

Capital Facilities

Capital Facilities component funds will be utilized to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded MHSA programs. The additional funds will address the current and anticipated needs of both public mental health service facilities and administrative space. Space utilization at all facilities is currently at maximum capacity. To the extent possible, DMH will utilize these funds to continue to modernize and develop welcoming facilities that will move its mental health system toward the goals of wellness, recovery, and resiliency; and will also help to expand the opportunities for accessible community based services for clients and their families, promoting the reduction in disparities in underserved groups.

Innovation – Hollywood 2.0 Pilot Project

LACDMH was approved to receive MHSA Innovation funding from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to test a new and comprehensive approach to providing services to individuals in the Hollywood area suffering from severe and persistent mental illness, as a result, experiencing chronic homelessness, incarceration and or repeated hospital use. The Hollywood 2.0 Pilot Project is a

modification of the MHSA Innovations project Trieste, which was approved by the MHSOC in May of 2019 prior to the pandemic. The project is based on LACDMH's fiscal projections and the anticipated CalAim program. The Hollywood 2.0 pilot aims to provide our most vulnerable residents with relentless engagement and enhanced access to treatment functioning as tools to facilitate individuals with connection to people, place, and purpose in life. Hollywood 4WRD (4 Walls, a Roof and a Door), a grassroots public-private coalition, will serve as the engagement body for the Hollywood 2.0 Pilot Project. The primary purpose of the Hollywood 2.0 Pilot Project is to establish a variety of recovery-oriented resources that promote an integrated, community-based approach in the delivery of novel programs and services that enhance the client's abilities to lead fulfilling lives in their neighborhood. The project is proposed for 5 years.

The Hollywood 2.0 pilot represents an opportunity for the County to leverage MHSA Innovation funding, partner with local community leadership, and use existing local assets to build out a rich array of resources that will strengthen clients' ties to the Hollywood community. Such resources include a robust infrastructure of facilities and a system of care that offers both services and opportunities to support a highly vulnerable community in new and exciting ways.

Hollywood 2.0 will allow the Department to develop novel programs and services that willenhance client's abilities to lead fulfilling lives and feel connected to their surroundingneighborhood. New programs such as Supportive Employment and Supportive Education services will provide clients with opportunities to learn life skills while simultaneously connecting them to agencies and employers in the Hollywood area. By providing the Pilot's clients with a chance to find purpose in their daily lives and make meaningful connections to others in their community, Hollywood 2.0 embraces the Department's belief in clients' ability to manage their life successfully, which is a key element of recovery.

Staffing for Hollywood 2.0 will be identified for assignment to Full-Service Partnership (FSP) (6-7 staff) and Homeless Outreach Mobile Engagement (HOME) teams dedicated to the project. The proposed annual budget is $100,000.

Hollywood has one of the County's most concentrated populations of unhoused individuals suffering from profound brain illness(es) and languishing in the streets. Aside from putting in place resources needed to address this crisis, the goal of the Hollywood 2.0 project is to leverage the significant momentum and buy-in across the Hollywood community. As part of our plan to expand the current footprint and establish new resources in Hollywood to create service arrays, the pilot will leverage a few key evolving reform efforts, including the Full-Service Partnership (FSP) Redesign, (HOME) Outpatient Conservatorship Pilot (HOME pilot), Peer Resource Center replication (including clubhouse type programming) and Alternative Crisis Response (ACR) initiatives.

APPENDIX B – ACRONYMS

ACS:	Alternative Crisis Services	EBP(s)	Evidence Based Practice(s)
ACT:	Assertive Community Treatment	ECBI:	Eyeberg Child Behavioral Inventory
ADLS:	Assisted Daily Living Skills	EESP:	Emergency Shelter Program
AF-CBT	Alternatives for Families – Cognitive Behavioral Therapy	EPSDT:	Early Periodic Screening, Diagnosis and Treatment
AI:	Aging Initiative	ER:	Emergency Room
AILSP:	American Indian Life Skills Program	FCCS:	Field Capable Clinical Services
APF:	American Psychiatric Foundation	FFP:	Federal Financial Participation
ARF:	Adult Residential Facility	FFT:	Functional Family Therapy
ART:	Aggression Replacement Training	FOCUS:	Families Overcoming Under Stress
ASD:	Anti-Stigma and Discrimination	FSP(s):	Full Service Partnership(s)
ASIST:	Applied Suicide Intervention Skills Training	FSS:	Family Support Services
ASL:	American Sign Language	FY:	Fiscal Year
BSFT:	Brief Strategic Family Therapy	Group CBT:	Group Cognitive Behavioral Therapy
CalSWEC:	CA Social Work Education Center	GROW:	General Relief Opportunities for Work
CAPPS:	Center for the Assessment and Prevention of Prodromal States	GVRI:	Gang Violence Reduction Initiative
CBITS:	Cognitive Behavioral Intervention for Trauma in Schools	HIPAA:	Health Insurance Portability and Accountability Act
CBO:	Community-Based Organizations	HOME:	Homeless Outreach and Mobile Engagement
CBT:	Cognitive Behavioral Therapy	HSRC:	Harder-Company Community Research
CDE:	Community Defined Evidence	HWLA:	Healthy Way Los Angeles
CDOL:	Center for Distance and Online Learning	IBHIS:	Integrated Behavioral Health System
CEO:	Chief Executive Office	ICC:	Intensive Care Coordination
CF:	Capital Facilities	ICM:	Integrated Clinic Model
CFOF:	Caring for our Families	IEP(s):	Individualized Education Program
CiMH:	California Institute for Behavioral Health	IFCCS:	Intensive Field Capable Clinical Services
CMHDA:	California Mental Health Directors' Association	IHBS:	Intensive Home Base Services
CORS:	Crisis Oriented Recovery Services	ILP:	Independent Living Program
COTS:	Commercial-Off-The-Shelf	IMD:	Institution for Mental Disease
CPP:	Child Parent Psychotherapy	Ind CBT:	Individual Cognitive Behavioral Therapy
CSS:	Community Services & Supports	IMHT:	Integrated Mobile Health Team
C-SSRS:	Columbia-Suicide Severity Rating Scale	IMPACT:	Improving Mood-Promoting Access to Collaborative Treatment
CTF:	Community Treatment Facility	IMR:	Illness Management Recovery
CW:	Countywide	INN:	Innovation
DBT:	Dialectical Behavioral Therapy	IPT:	Interpersonal Psychotherapy for Depression
DCES:	Diabetes Camping and Educational Services	IS:	Integrated System
DCFS:	Department of Children and Family Services	ISM:	Integrated Service Management model
DHS:	Department of Health Services	ITP:	Interpreter Training Program
DPH:	Department of Public Health	IY:	Incredible Years
DTQI:	Depression Treatment Quality Improvement	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.
New Community Services and Supports clients may have received a non-MHSA mental health service.
New Prevention and Early Intervention clients may have received a non-MHSA mental health service.
Older Adult Age Group: Age range is 60+.
Transitional Age Youth Age Group: Age range is 16 to 25 years old.
Total client cost calculation is based on Mode 15 services, inclusive of Federal Financial Participation (FFP) & Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Not inclusive of community outreach services or client supportive services expenditures. Data as of December 2017.
Unique client means a single client claimed in the Integrated Behavioral Health Information System. Data as of December 2017.