DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

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

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

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

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

June 28, 2022

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

43 June 28, 2022

CELIA ZAVALA
EXECUTIVE OFFICER

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

Dear Supervisors:

ADOPT THE DEPARTMENT OF MENTAL HEALTH'S MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2022-23
(All Supervisorial Districts)
(3 Votes)

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Annual Update for Fiscal Year 2022-23.

IT IS RECOMMENDED THAT THE BOARD:

Adopt the Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2022-23 as attached. The MHSA Annual Update has been certified by the Director of Mental Health (Director), or designee, and the Auditor-Controller (A-C) to meet specified MHSA requirements in accordance with Welfare and Institutions Code (WIC) Section 5847.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

The MHSA Annual Update for FY 2022-23 builds upon the DMH-approved MHSA Three-Year Program and Expenditure Plan for each MHSA component. It contains a summary of MHSA programs for FY 2021-22, including clients served by MHSA programs, and Service Area and program outcomes. Additionally, the Annual Update describes DMH's ongoing Community Program Planning (CPP) and progress towards continued implementation of existing programs and/or program expansions and proposed new programs to be incorporated into the Three-Year Program and Expenditure Plan for FYs 2021-22 through 2023-24. Board adoption of the MHSA Annual Update is required by law and necessary for DMH to submit the Annual Update for FY 2022-23 to

the Mental Health Services Oversight and Accountability Commission (Commission). Additionally, WIC Section 5848 requires the following: 1) the MHSA Three-Year Program and Expenditure Plan and the Annual Updates be certified by the Director, or designee, and the A-C attesting that the County has complied with all fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the MHSA requirements; 2) a draft MHSA Three-Year Program and Expenditure Plan and Annual Updates be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans; and 3) the Los Angeles County Mental Health (LACMH) Commission conducts a Public Hearing on the draft MHSA Three-Year Program and Expenditure Plan and the Annual Updates at the close of the 30-day comment period.

In accordance with these requirements, DMH, on March 4, 2022, posted the MHSA Annual Update on its website for 30 days for public comment. DMH, upon stakeholder request, allowed for an extended public comment period through 45 days. The LACMH Commission also convened a Public Hearing on April 28, 2022, where DMH presented the Annual Update and addressed public questions. The LACMH Commission voted to approve the MHSA Annual Update for FY 2022-23 at its meeting on May 4, 2022.

Implementation of Strategic Plan Goals

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

FISCAL IMPACT/FINANCING

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

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Assembly Bill (AB) 1467, chaptered into law on June 27, 2012, implemented changes to the MHSA law. More specifically, AB 1467 amended WIC and requires that each county mental health program prepare a MHSA Three-Year Program and Expenditure Plan and Annual Updates, which were to be adopted by the County Board of Supervisors and submitted to the Commission. AB 1467 also amended WIC requiring that the MHSA Three-Year Program and Expenditure Plan and Annual Updates be certified by the Director and the A-C. This requirement includes the Director's certification as to the requisite stakeholder participation and compliance with MHSA non-supplantation provisions. Additionally, the statute was amended to require that the MHSA Three-Year Program and Expenditure Plan and Annual Updates be circulated for public review and comment and that a public hearing be conducted at the close of the comment period.

The Commission provided direction to all California counties to complete MHSA Annual Updates through a memo dated April 24, 2015, and distributed the MHSA Fiscal Accountability Certification Form to be completed by the Director and A-C.

The public hearing notice requirements referenced in WIC Section 5848 (a) and (b), have been satisfied and are recorded in the MHSA Annual Update for
FY 2022-23. Additionally, DMH has complied with the certification requirements referenced in WIC Section 5847(b)(8) and (9). Compliance has been recorded in the MHSA Annual Update for FY 2022-23 via a signed MHSA Fiscal Accountability Certification Form.

Additionally, with this update, there are many service expansions underway in Los Angeles County, some of which depend almost exclusively on funding from MHSA, including:

- Continuing Innovation 2 programming which was originally implemented in June 2020. Innovation 2 will be continued using Prevention and Early Intervention funding to ensure Community Health Workers (Community Ambassadors) will continue to provide services throughout the County. Community Ambassadors build the capacity of communities to identify and support community members at risk of trauma or who are experiencing trauma, while building shared community values, leadership development and community member empowerment;

- Implementation of Hollywood 2.0, a new comprehensive approach to serve individuals in the Hollywood area that are suffering with Serious and Persistent Mental Illness, including those experiencing homelessness, with or without a substance use disorder. The key program components include Full Service Partnership, Homeless Outreach and Mobile Engagement (HOME) Teams, Team Based Intensive Outpatient Services, Peer Resource Centers/Clubhouses, Alternative Crisis Response Services, and various housing options, including: Interim, Permanent Supportive, Congregate and Enriched Residential Care Program (Board and care);

- Planning for implementation of future capital improvements using the Capital Facilities component funds to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded MHSA programs. Improvements will address the current and anticipated needs of both public mental health service facilities and administrative space as space utilization at all facilities is currently at maximum capacity. To the extent possible, DMH will 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; and

- Continued expansion of opportunities for capacity building and increased partnerships with grass-roots organizations to serve at-risk communities, including ethnic and other vulnerable communities that are unserved or underserved.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Annual Update for FY 2022-23 will ensure compliance with the MHSA, as amended by AB 1467, and allow for uninterrupted access to vital mental health services.

Respectfully submitted,

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

JES:GCP:DKH:SKRLR:ZW:atm

Enclosures

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

MHSA ANNUAL UPDATE

Fiscal Year 2022-23

WELLNESS • RECOVERY • RESILIENCE

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

TABLE OF CONTENTS

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.

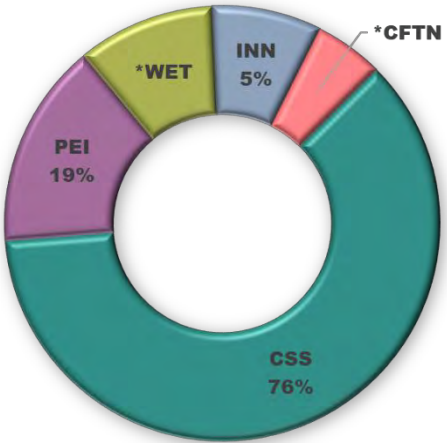
Additional funding for capital facilities will help to expand the opportunities for accessible community based services for clients and their families, promoting the reduction in disparities in underserved groups.

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

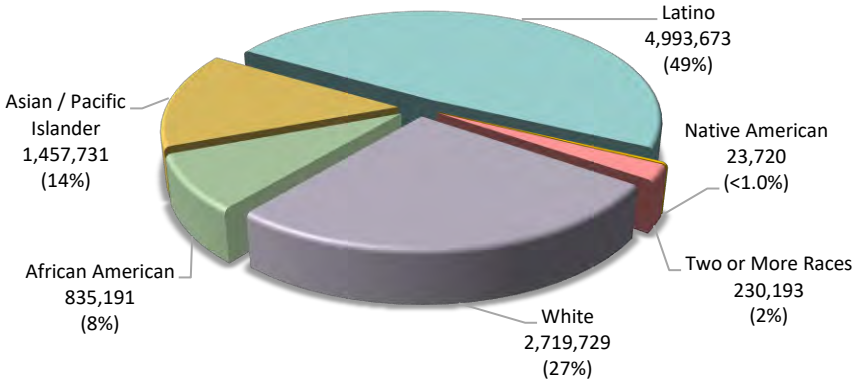


Table 1. Population by race/ethnicity and Service Area

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

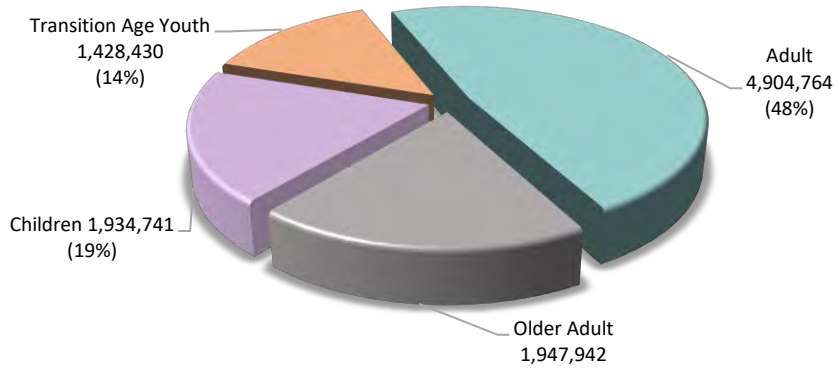


Table 3. Population by age group and Service Area

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. A Spanish version as posted on March 10, 2022. See Appendix A.

Stakeholder Meeting: March 9, 2022

A high-level overview of the Update was presented at the full Mental Health Commission meeting attended by CLT, UsCCs and SALTs to receive input and feedback. LACDMH also brought forward proposed changes included in the Plan. The presentation is attached as Appendix B.

Mental Health Commission (MHC) Executive Committee: March 10, 2022

A high-level overview of the Update was presented to Executive Committee members to receive input and feedback. A budget overview, the impact of COVID, proposed changes and updates on previously approved programs was presented. The agenda and presentation are attached as Appendix C.

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 45-day public comment period. A Spanish version was later posted. Public comments received during this period are attached as Appendix D.

Public Hearing: April 28, 2022

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

C. Stakeholder Feedback

Surveys in both English and Spanish were available to provide feedback during the public posting and comment period. Through this feedback process, the Department collected the following:

- 66 Survey responses were received, 65 in English and 1 in Spanish. There were 9 survey questions administered. Not all respondents answered all the questions.
- Various written and email correspondences were received that were recorded and reflect in the stakeholder feedback toward review of the Plan

The input collected from the surveys represents input from individuals representing various (self-reported) stakeholder categories including:

- 21% of the respondents are clients/consumers
- 7% of the respondents are peers
- 13% of the respondents are advocates
- 14% of the respondents are family members of a client/consumer
- 5% of the respondents are other government employees
- 6% of the respondents are LACDMH staff/employees
- 17% of the respondents are mental health service provider
- 16% of the respondents indicated Other

Among these categories, the following ethnic populations were represented:

- 14% reported African American
- 8% reported Asian
- 24% reported Caucasian
- 26% reported Latin/Latina/Latinx
- 4% reported Mixed/multi-ethnic
- 10% reported Native American / American Indian/ Alaskan Native
- 14% reported Other

Summary of Feedback Received

The comments received about the Plan, included:

- Plan written so that it is easily understandable to stakeholders and the general public
- Access to services to communities in need expanded through regular phone calls with clients and family members
- Focuses on objectives to expand mental health services to ethnic and underserved communities
- Very data driven
- Continuation of FSP
- Additional information on budget and spending provided to stakeholders

Input received on opportunities to improve the plan/process included:

- Provide additional focus on Individuals with serious mental illness/gravely disabled, dually diagnosed/those suffering from opioid crisis
- Finding more treatment beds or facilities.
- Increase advocacy, family support or engagement

- Continue support for CANs program seems to be the bridge in making sure the community members have access to the needed resources.
- Open grant opportunities and open bid solicitations with limited restrictions directly targeting innovative approaches expanding direct mental health services.
- Better identify treatment services for mental health disorders like Rape Trauma Syndrome (PTSD), Intermittent Explosive Disorder in Children and Teens, Adjustment Disorder, Autism with Behavioral Disorders.
- Increase time for sharing plan information and making follow up contact information available
- Make the plan more LGBTQ1AS5 friendly by ensuring more direct hiring of individuals that identify as LGBTQ1AS5, especially LGBTQ1AS5 of color, youth and older adults
- Create more peer specialist roles for LGBTQ1AS5 and integrate them in both directly operated and contracted programs
- Make pronouns universal across all programs
- Allocate FSP slots for patients discharged from DHS hospitals
- Provide more DMH psychiatry to support DHS Collaborative Care Model for Depression in the Primary Care Medical Homes
- Create innovation that will create a technological application that provides record sharing across entities, including court evaluators, to speed up the competency evaluation process;
- Expand diversion related services by funding the Los Angeles County Department of Health Services' Office of Diversion and Re-entry (ODR) to expand diversion services beyond its 2,200-bed capacity based on ODRs demonstrated success in reducing the number of incarcerated mentally ill individuals
- Improve layout and format of the Plan documents by increasing size of font for presentation slide content

Strategies for Bolstering the CPPP and Stakeholder Involvement for Future Plans and Updates:

- Continue to expand outreach efforts through multiple outlets (e.g. media, public posting, email blasts, etc.) to ensure the public and stakeholder groups are aware of MHSA programs and activities and how to participate in CPPP
- Increase use of tables and summaries similar to current Annual Update presentation to ensure streamlined, user-friendly information is provided to stakeholders to receive feedback. Information will be distributed through monthly meetings with CLTs, UsCCs, SALTs and the MH Commission.
- Provide monthly MHSA 101 trainings to identified stakeholder groups, including SALTs, CLTs, UsCCs, Mental Health Commission, and contracted and partner/grassroots CBOs. DMH will also provide bi-annual training for Mental Health Providers, County Departments' staff, and DMH employees and staff
- Continue NAMI contract for 3 additional years to provide expanded training for family members across the County
- Update communication follow up process including the resolution process and have a MHSA mailbox to receive input and communication year-around

D. Disparities

When comparing the racial and ethnic distributions of Los Angeles County Medi-Cal enrollees with the racial and ethnic distributions of those who receive direct mental health services within Los Angeles County, trends 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 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.

▪ 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 housing vouchers provided to mental health clients for rent.

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
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.
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

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
				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.

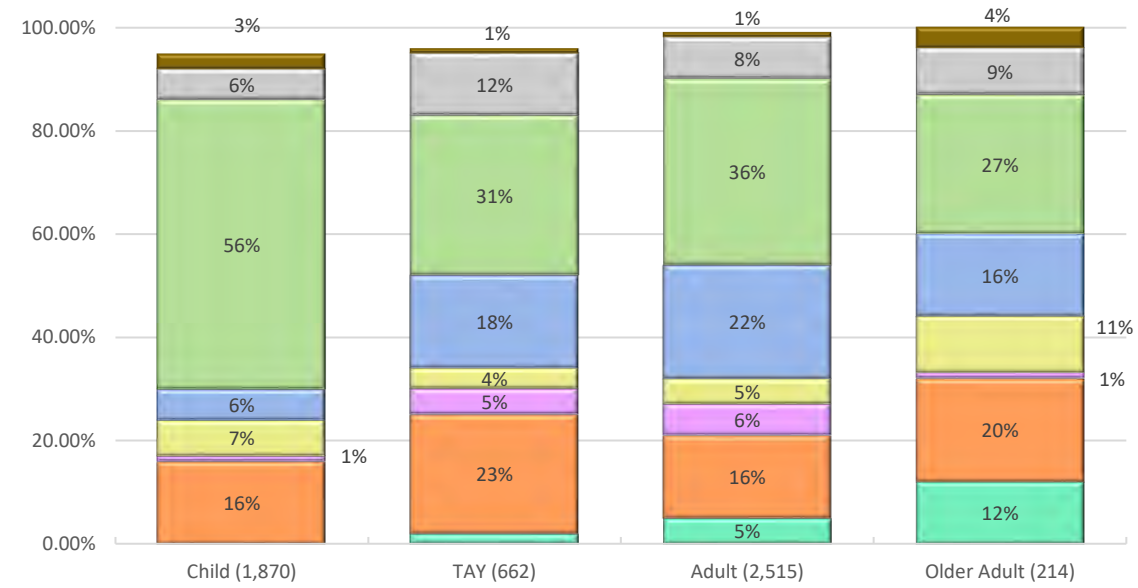
Children (n=12,254)
TAY (n = 6,870)
Adults (n =19,886)
Older adults (n = 2,763)
Figures represent cumulative changes, inclusive of all clients through June 30, 2021

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.

FY 20-21 ■ ALTERNATIVE CRISIS SERVICES Data and Outcomes

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.

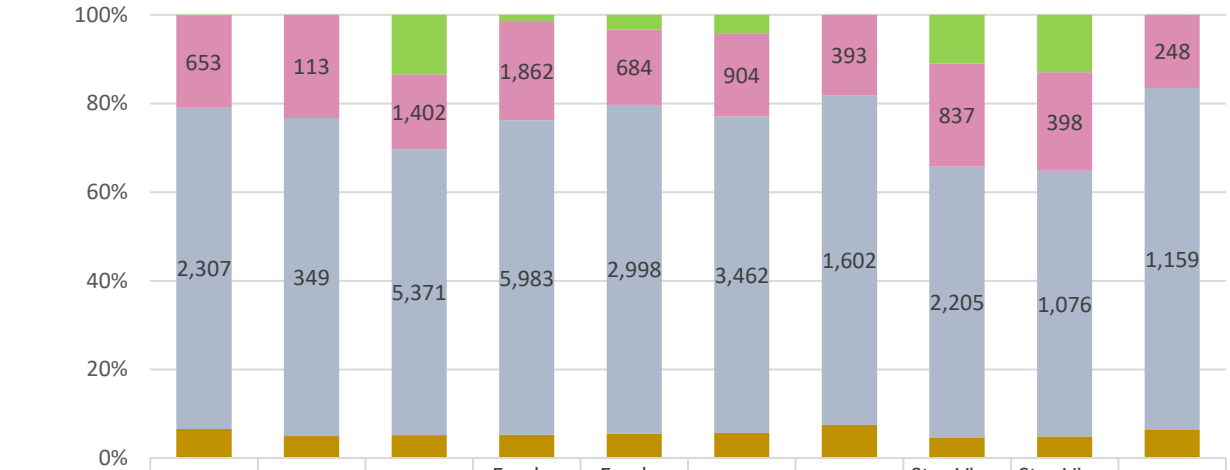
Table 23. Bed capacity and location of the current UCCs

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

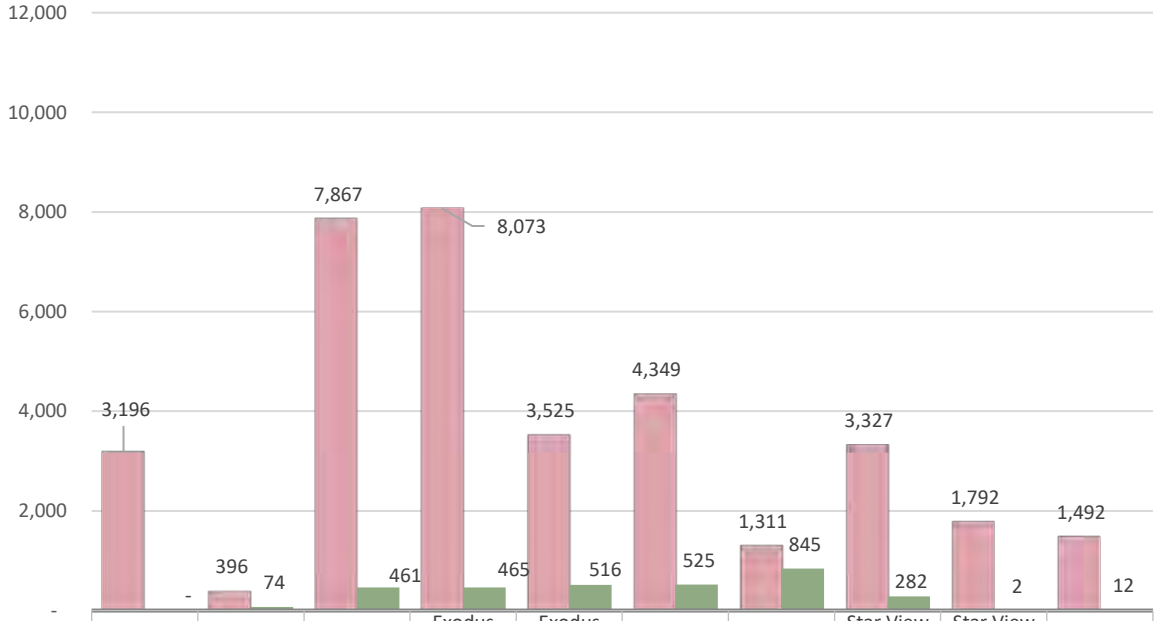
The following graphs provide an overview of FY 2020-21 outcomes of the nine UCCs. Olive View UCC has two components: Crisis Stabilization Unit (CSU) - 7913 and Outpatient UCC - 7591 that does not operate 24/7.

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

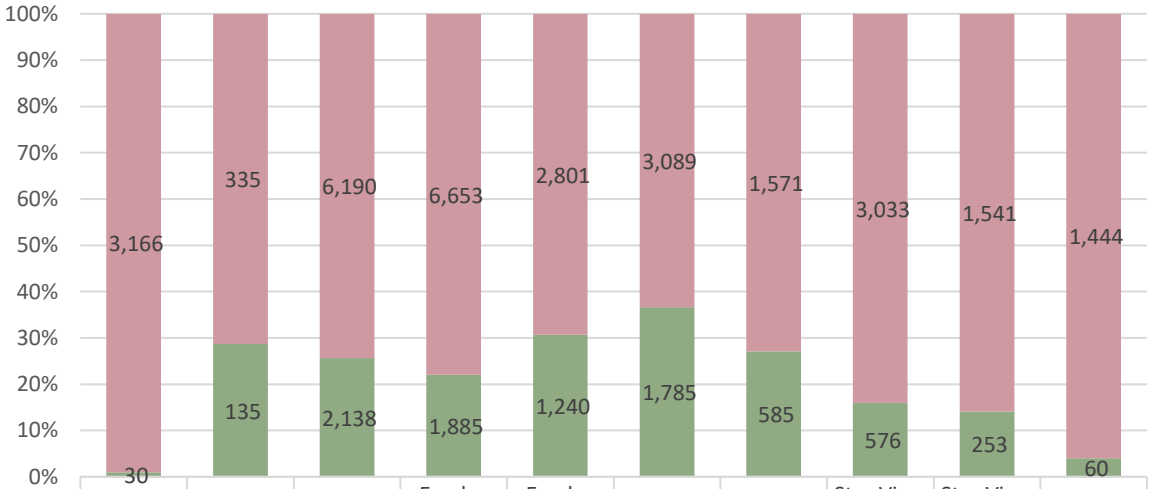


	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View Long Beach	Star View City of Industry	Telecare MHUCC
No	3,196	396	7,867	8,073	3,525	4,349	1,311	3,327	1,792	1,492
Yes	-	74	461	465	516	525	845	282	2	12

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)

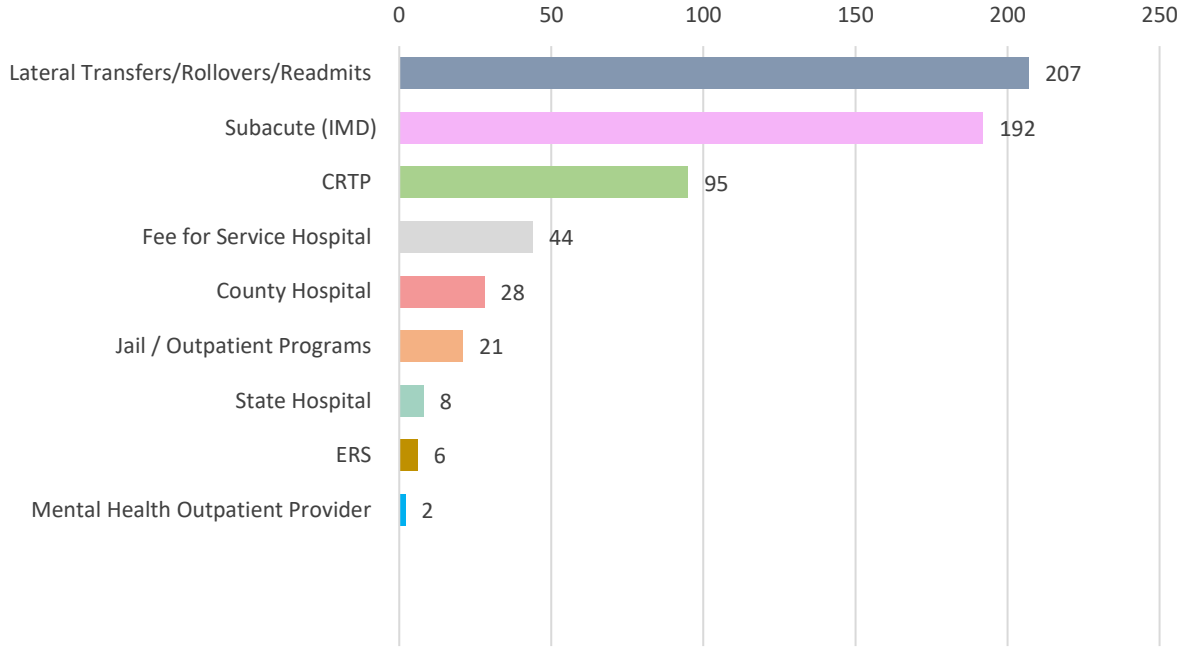
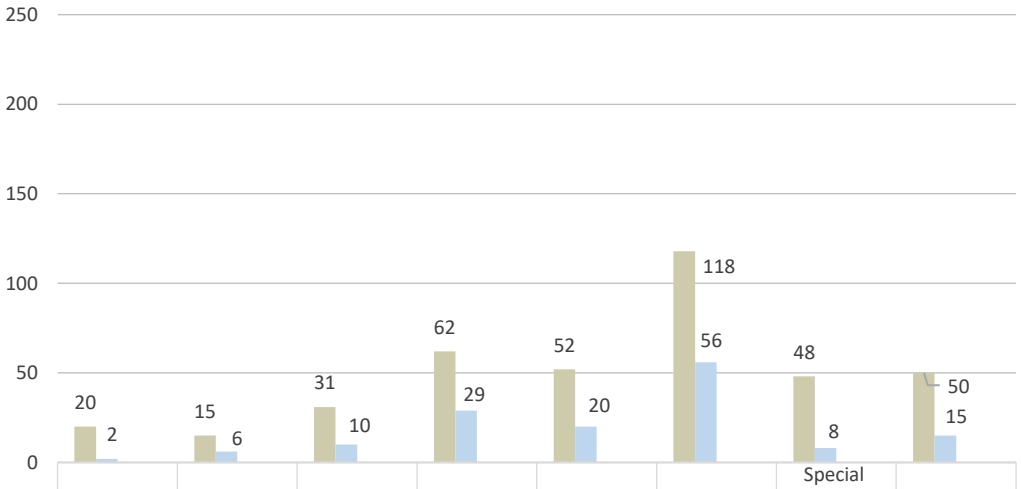
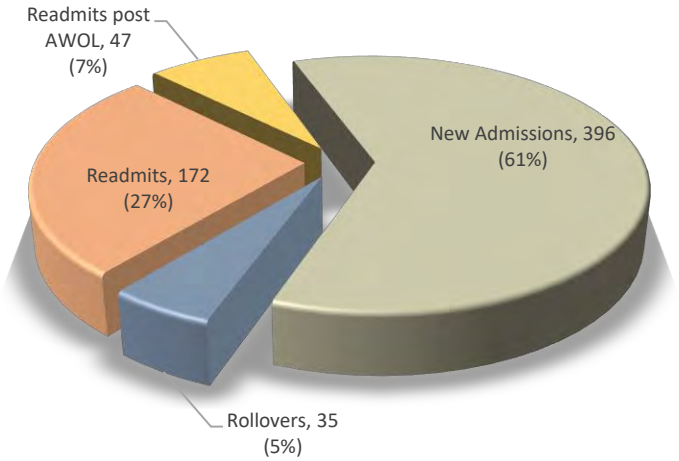


Figure 9. Client admission and discharge rates to ERS facilities (admission n = 396; discharge n = 146)



	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)

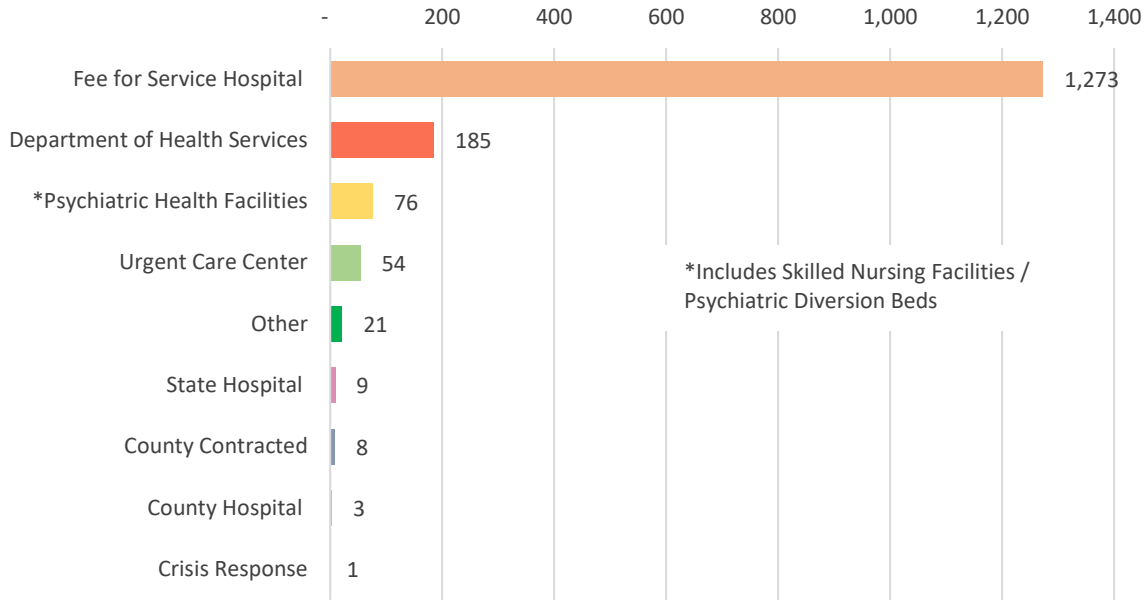
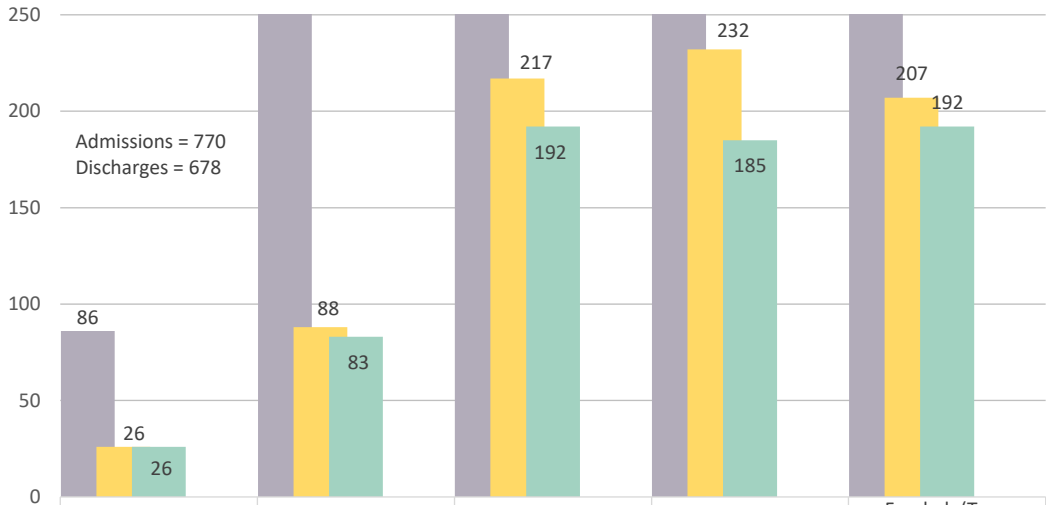


Figure 12. Client referrals, admissions and discharge rates CRTP admissions



	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 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

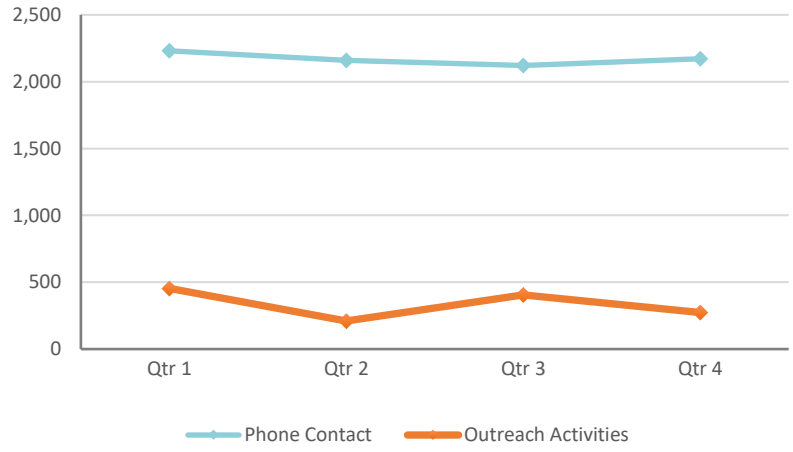


Figure 14. Number of clients referred to FSP services

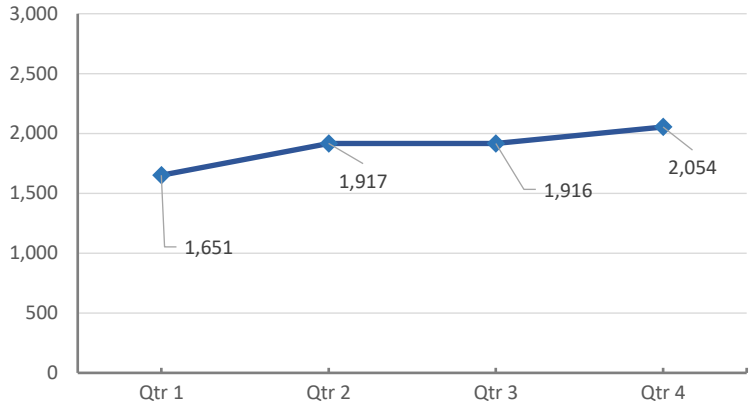
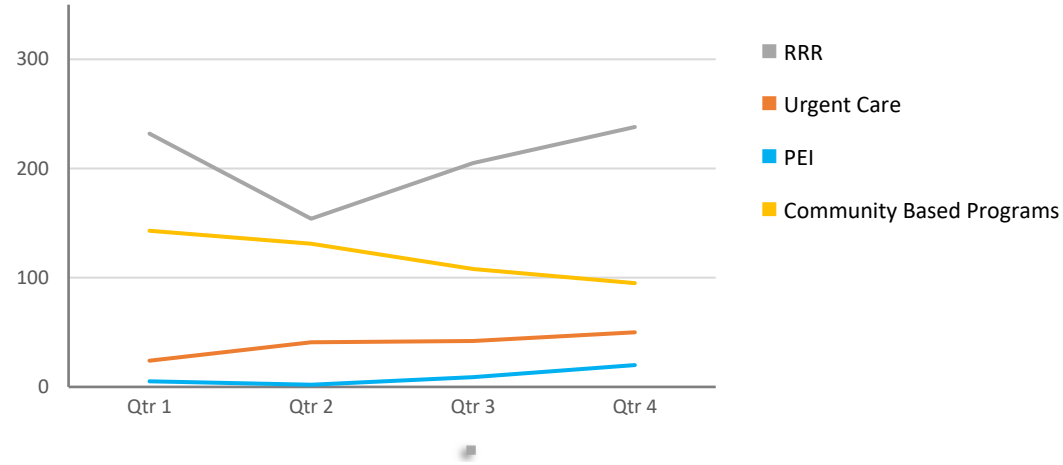


Figure 15. Number of clients referred to Non-FSP services



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.

Project
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 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. ●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
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.
Child-Parent Psychotherapy (CPP) Young Children (ages 0-6) Unique Clients Served: 1,526	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

Early Intervention EBP	Description
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	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.
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.

Early Intervention EBP	Description
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.
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.

Early Intervention EBP	Description
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.
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.

Early Intervention EBP	Description
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.
Stepped Care (SC) Children TAY Adults Older Adults Unique Clients Served: 12,203 Gender: 43% Male, 57% Female Ethnicity: 42% Hispanic, 8% African American,	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.

Early Intervention EBP	Description
3% Asian, 8% White, 5% Multiple Races, 1% Native Hawaiian/Pacific Islander	
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)
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

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
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

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

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

Prevention Program	Description
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.

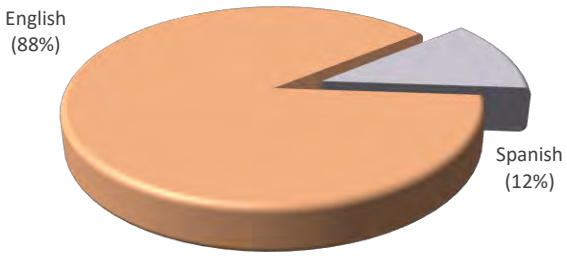
In summary, there is evidence that both elements of the LACDMH WhyWeRise campaign successfully reached a racially, culturally, and economically diverse group of Los Angeles County residents, fostered a feeling of support among those exposed, boosted awareness of county mental health resources, and conveyed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

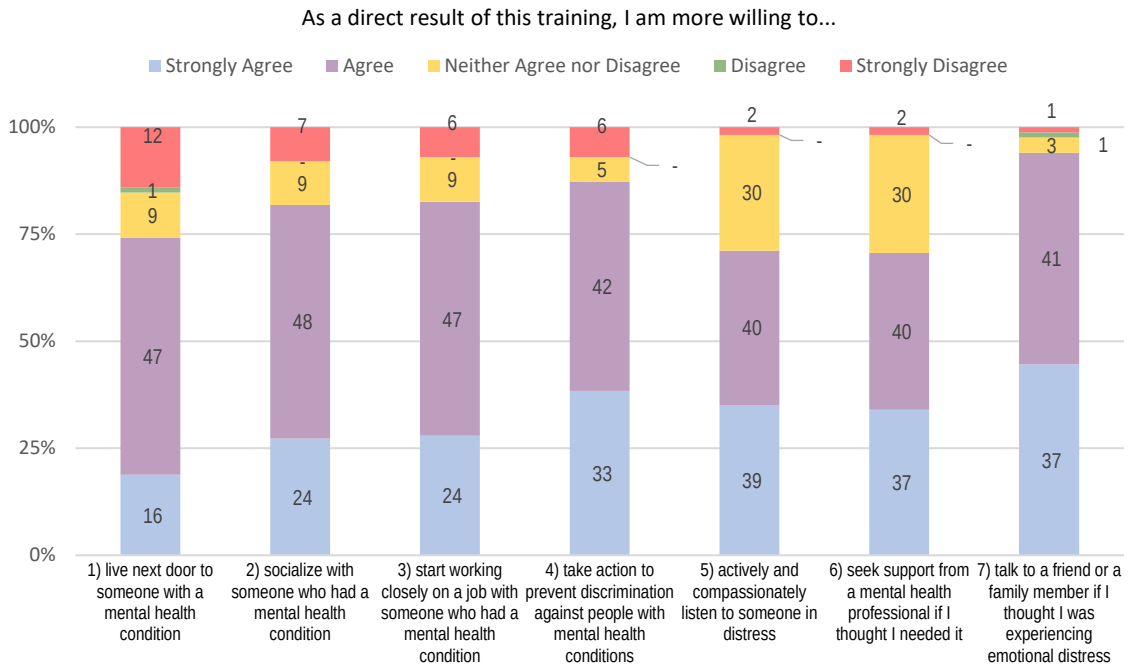
Figure 16. Survey languages (n = 109)



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

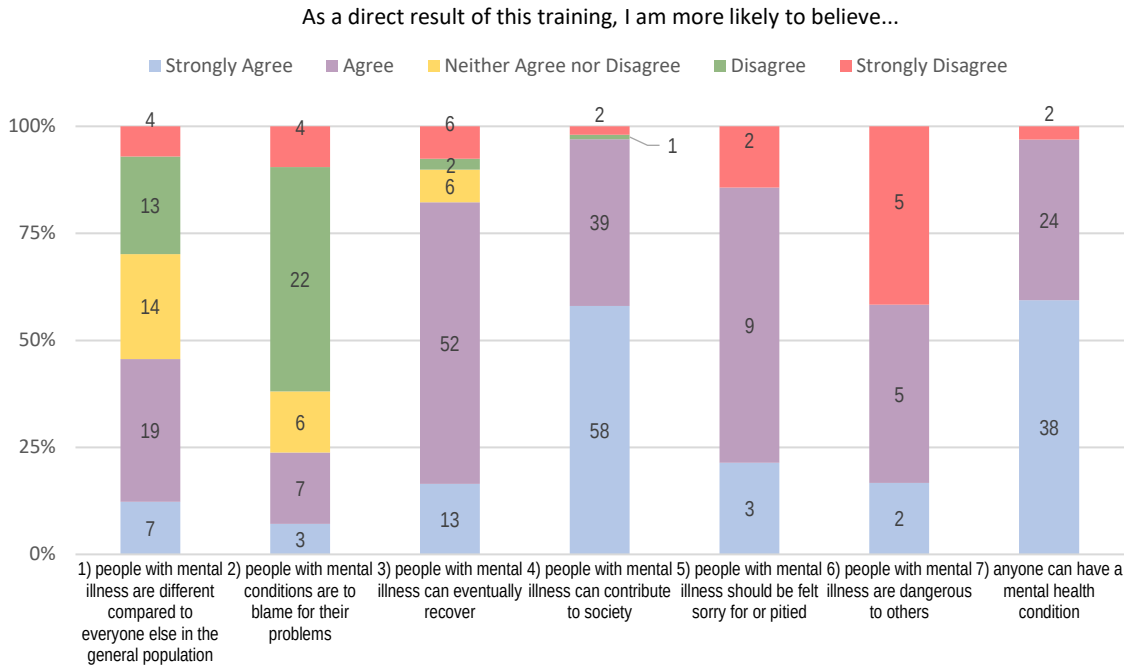


The following chart assesses change resulting from attending an SDR training in knowledge about mental illness and beliefs about mentally ill people. Items may be rated: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Disagreeing suggests the participant believes 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

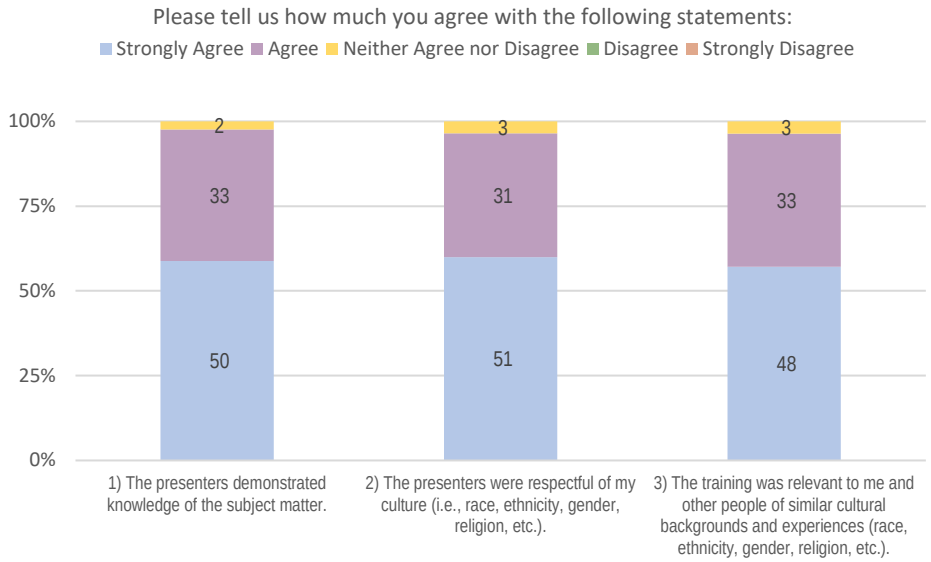


Table 49. Survey demographics (n = 109)

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

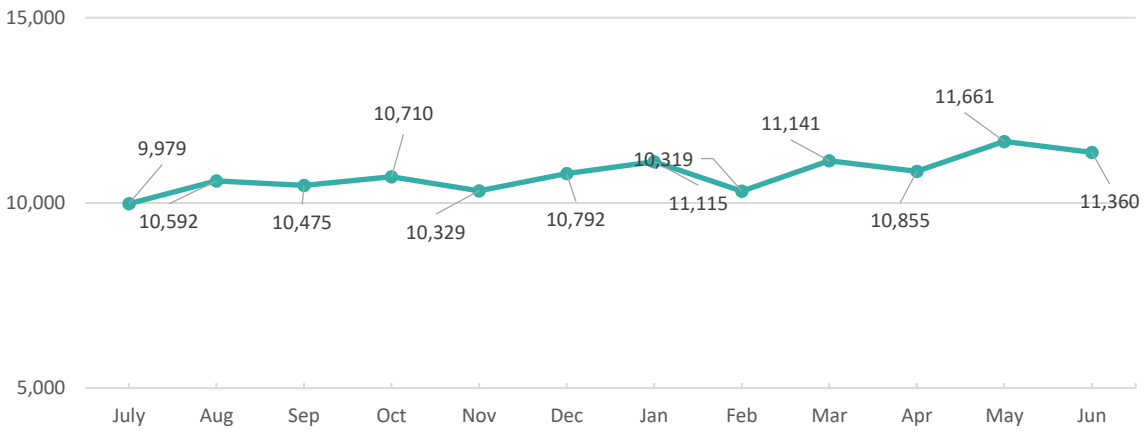


Table 52. Calls and chats by ethnicity

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%
Moderate Risk	14%	16%
High-Moderate Risk	3%	4%

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

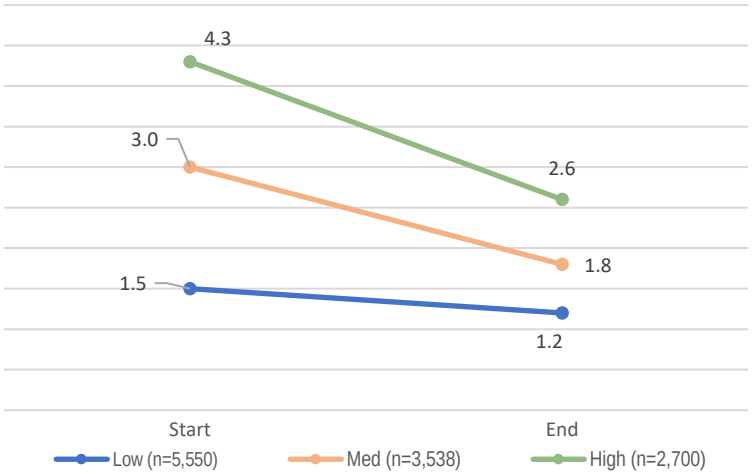
High Risk	8%	12%
Attempt in Progress	1%	0%

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

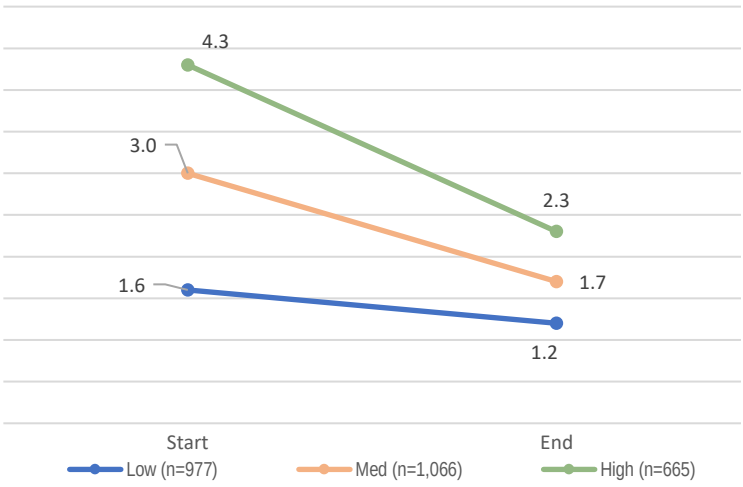
Callers are asked to answer the question: "*On a scale of 1 to 5, how likely are you to act upon your suicidal thoughts and feelings at this time, where 1 represents not likely and 5 represents extremely likely?*" Callers rate their intent both at the start and end of the call. Note: This data is on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

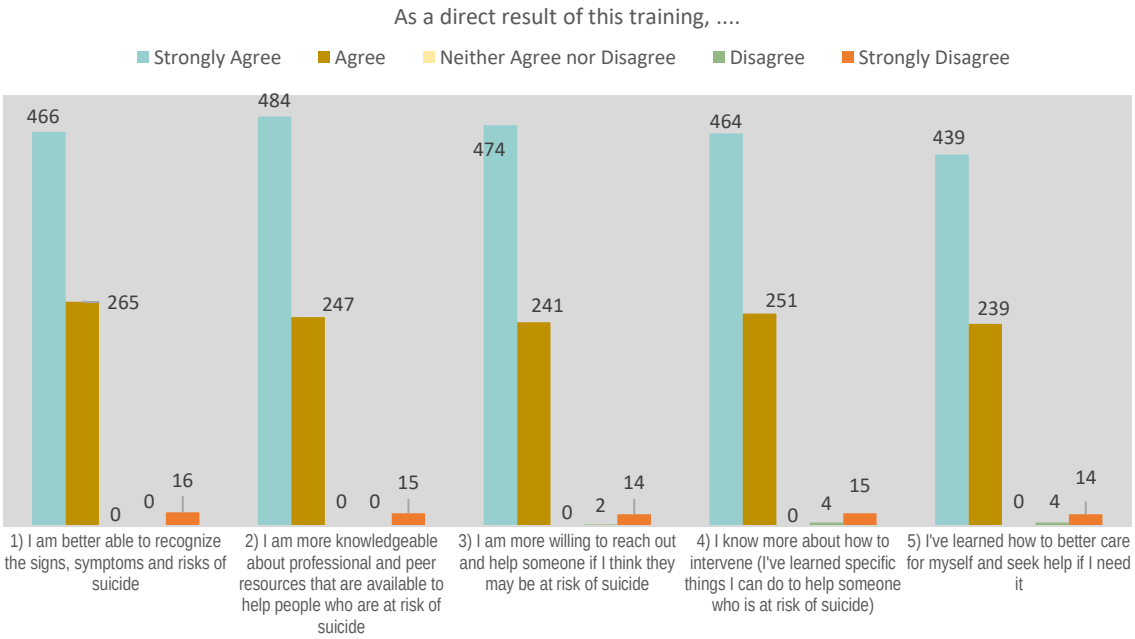
LACDMH has chosen to implement a suicide prevention program in the form of training and education that has shown effectiveness in changing attitudes, knowledge, and/or behavior regarding suicide. Participants in these trainings include, but are not limited to, first responders, teachers, community members, 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

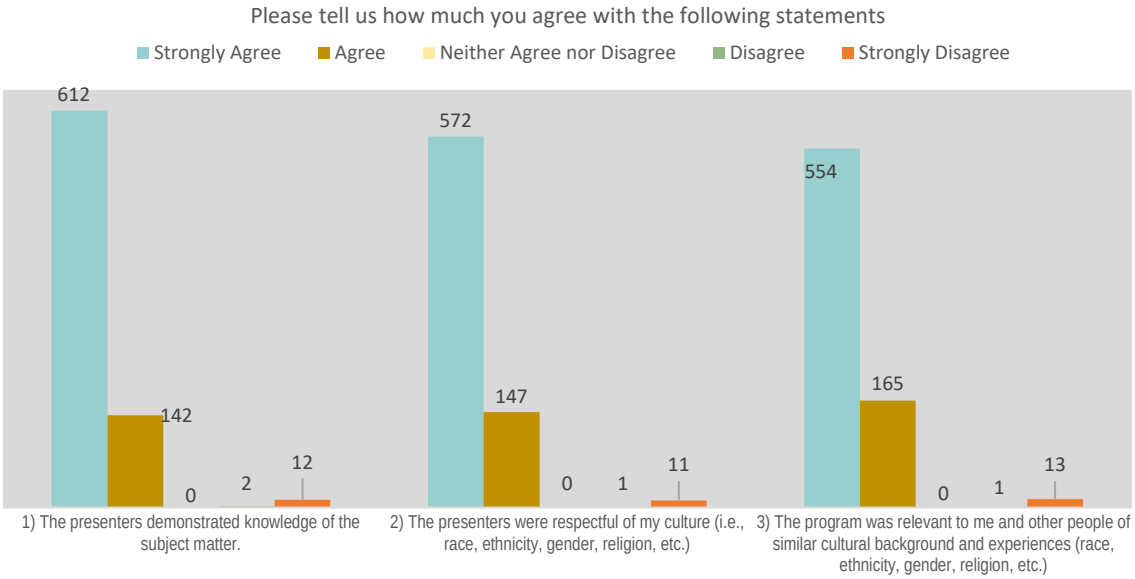


Table 56. FY 2020-21 Survey demographics

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
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	20	20	61

Topic Name	Number of Trainings	Training Hours	Number of Participants
Neurodevelopment Disabilities during COVID-19			
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 • 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

Post Graduates	Number of Psychiatric Residents	Rotations
		• 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 FY 2020-21: 143 participants	This training provides an overview of the CCR, ICPM practice standards. It highlights expansion of the California's Core Practice Model, including the core values, principles, and elements; additional discussion incorporates the model's practice wheel components and practice behaviors. Participants will learn to utilize interagency teaming strategies while providing services to children and families involved in the child welfare system. The child and family's voice and choice are of primary importance and supported utilizing a strength-based and trauma-informed approach. A review of safety, permanency, and well-being promote the tenets of the model throughout the training. Lastly, both didactic and experiential learning strategies serve to enhance application of understanding and knowledge.
Crafting Underlying Needs Statements and Services (UNDERLYING NEEDS) 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:	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

Training	Service Provided
70 participants	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 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

Training	Service Provided
	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

INNOVATION (INN)

FY 2020-21 ■ INNOVATION Data and Outcomes

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

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

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.

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

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.

<u>Number of clients served:</u>
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%).

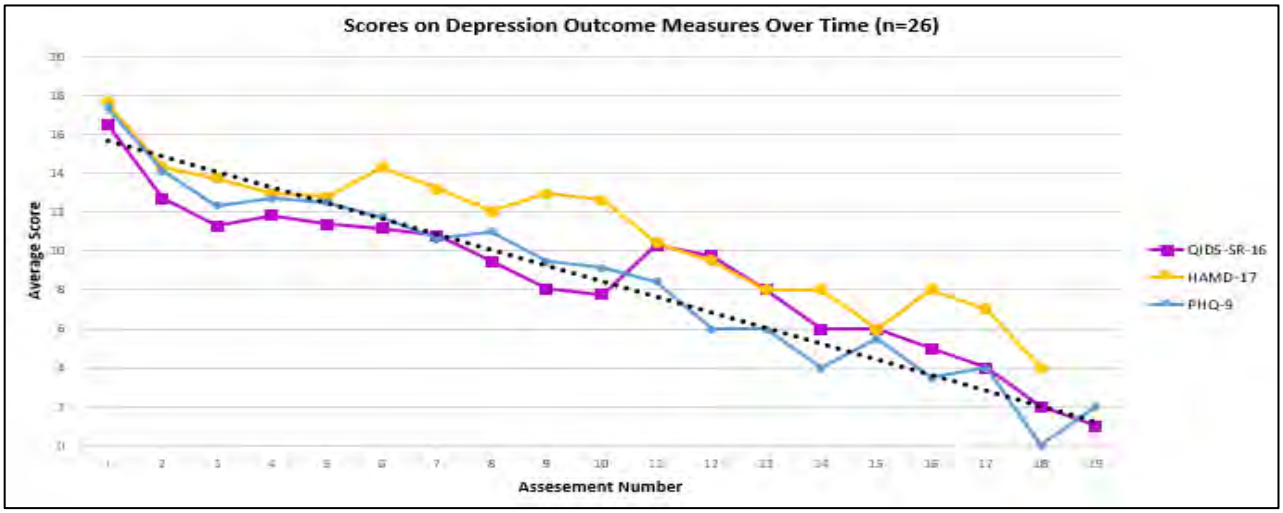
Outcome data being collected and any analysis of impact to date:

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.



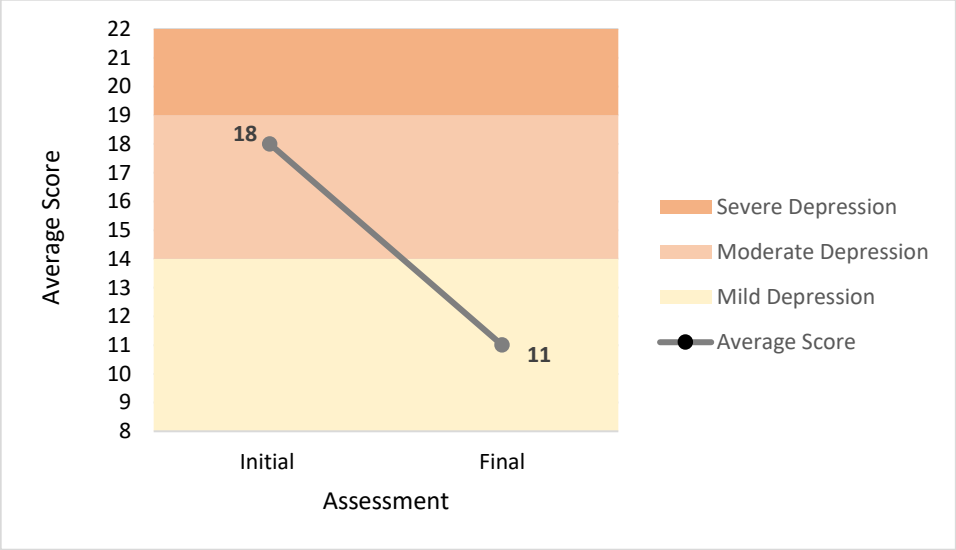
Hamilton Depression Rating Scale (HAMD-17)

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)

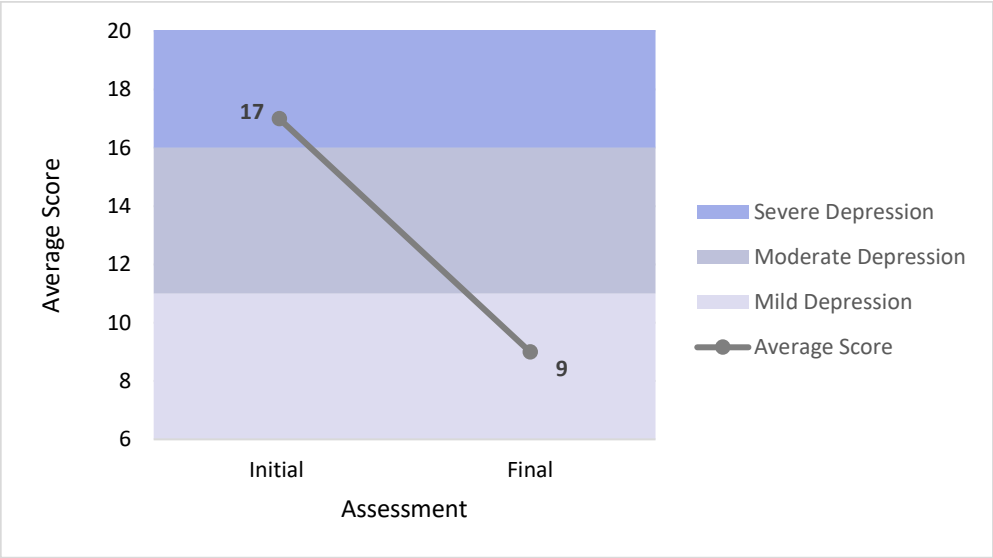


Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR-16)

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)

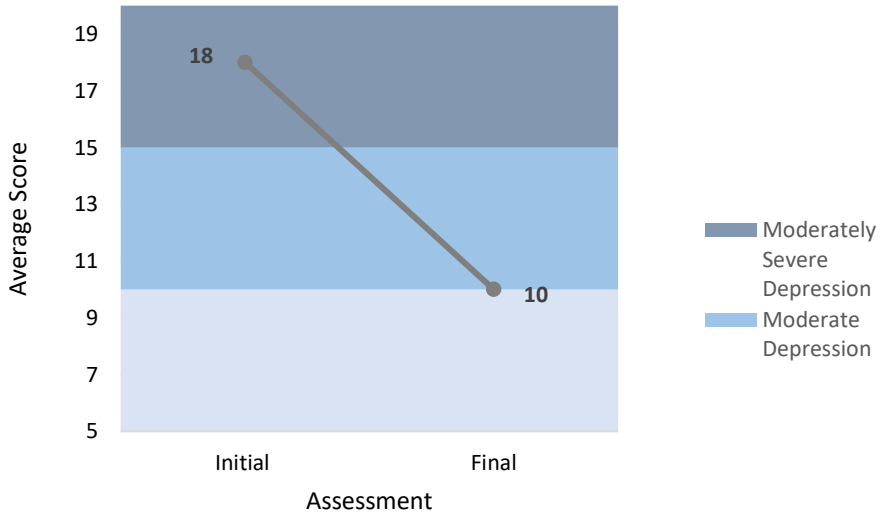


Patient Health Questionnaire (PHQ-9)

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)



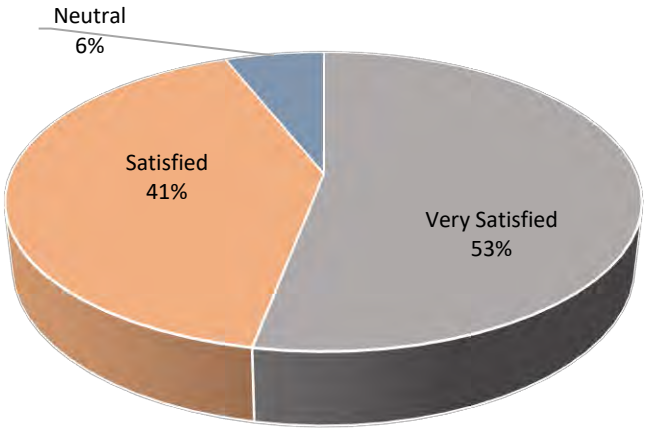
TMS Client Satisfaction Survey

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.

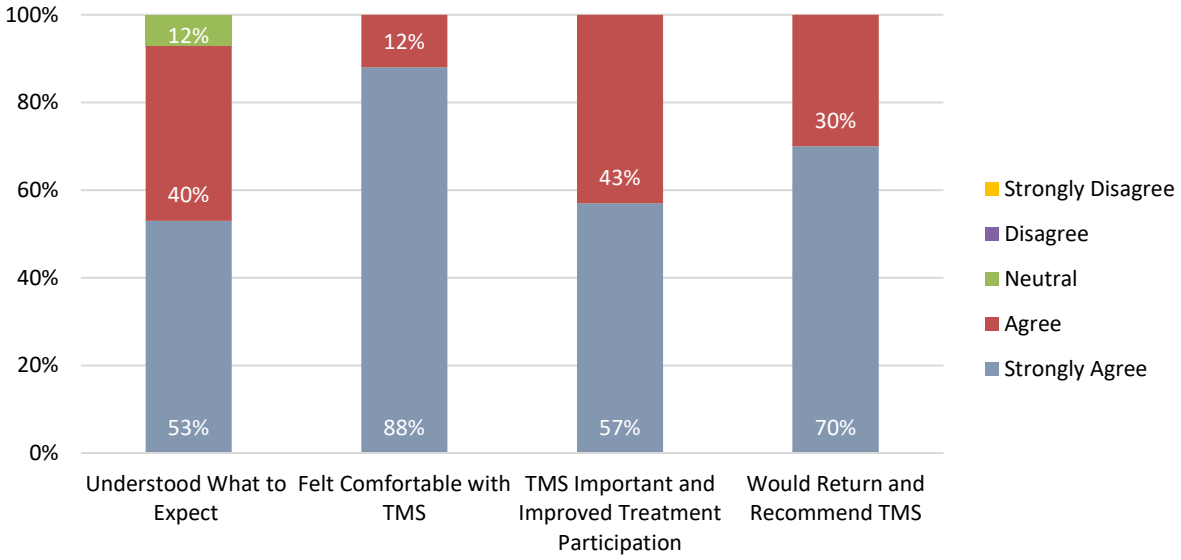
Figure 28. Overall Satisfaction with Mobile TMS services (n = 17)



TMS Treatment Experience [Figure 29]:

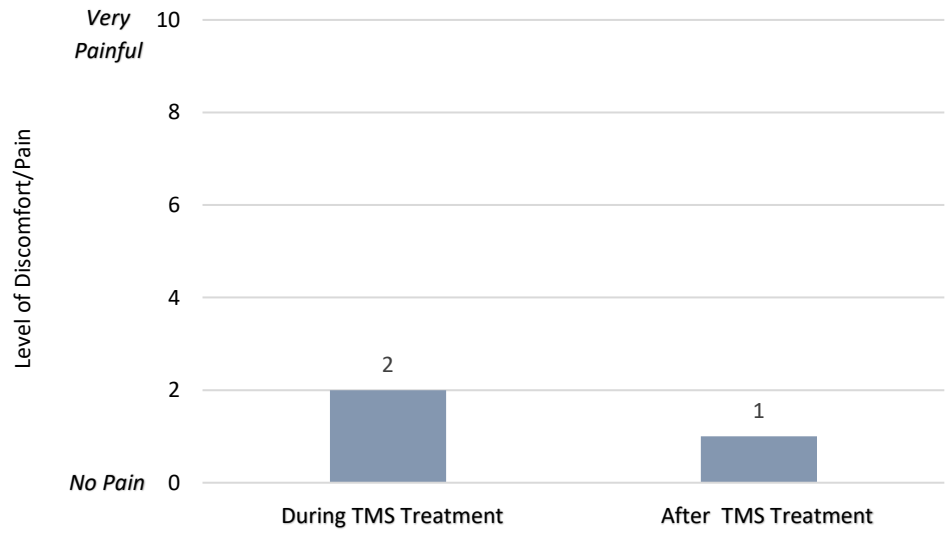
A majority of respondents (93%) "Strongly Agreed" or "Agreed" that they understood what to expect before starting TMS treatment. All respondents (100%) "Strongly Agreed" or "Agreed" that they felt comfortable while receiving TMS services. As well, all respondents (100%) "Strongly Agreed" or "Agreed" 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)

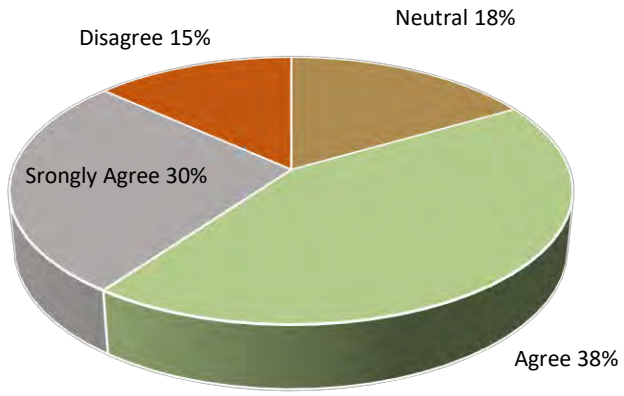
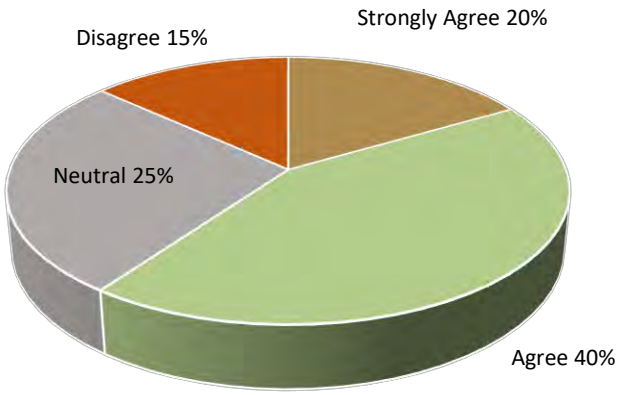


Figure 32. Provider Perception on the Impact of TMS - Services on Client's Progress Toward Treatment Goals (n = 20)



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.

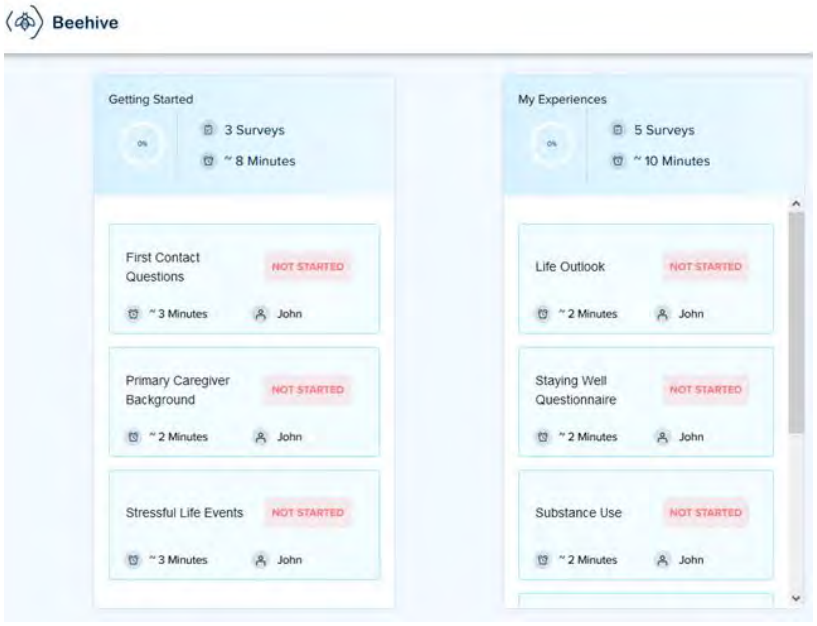
Table 62: EPI-CAL Enrollment and Required Survey Bundles

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

Bundle Name	Survey Name	Bundle Timing
	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.

<u>County-level Historical Data Analysis</u>
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.

<u>Number of clients served for FY 2020-21 (where applicable)</u>**:**
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

ATTACHMENT I

	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

EXHIBIT B - MHSA COUNTY COMPLIANCE CERTIFICATION

[Document inserted after the Board of Supervisors adopts the plan. This document is signed by the Director of Mental Health]

Page intentionally left blank

EXHIBIT C - MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Los Angeles

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

Local Mental Health Director	County Auditor-Controller
Name: Jonathan E. Sherin, M.D., Ph.D.	Name: Arlene Barrera
Telephone Number: (213) 739-4601	Telephone Number: (213) 974-8302
E-mail: JSherin@dmh.lacounty.gov	E-mail:ABarrera@auditor.lacounty.gov

Local Mental Health Mailing Address:

County of Los Angeles - Department of Mental Health
MHSA Administration and Oversight Division
510 S. Vermont Avenue, 22nd Floor
Los Angeles, CA 90020

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

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

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

Gregory C. Polk 4-8-21
Signature Date

I hereby certify that for the fiscal year ended June 30, 2021, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892 (f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/15/21 for the fiscal year ended June 30, 2021. I further certify that for the fiscal year ended June 30, 2021, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891 (a), in that local MSHA funds may not be loaned to a county general fund or any other county fund.

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

Arlene Barrera
County Auditor Controller

Arlene Barrera 4-29-21
Signature Date

[1] Welfare and Institutions Code Sections 5847 (b)(9) and 5899 (a)

EXHIBIT D - MENTAL HEALTH COMMISSION LETTER

Los Angeles County

Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

May 4, 2022

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

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

Dear Supervisors and Director:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING
FISCAL YEAR 2022-2023 ANNUAL UPDATE

On April 28, 2022, the Chair and a quorum of the Los Angeles County Mental Health Commission (Commission) hosted the FY 2022-2023 Mental Health Services Act Annual Update (Annual Update) Public Hearing. The Department of Mental Health's submission of the Annual Update posted for a 45-day Comment Period, exceeding the 30-day requirement, on March 8, 2022, through April 19, 2022. The Commission, established under Section 5604, conducted a public hearing of the draft Annual Update at the close of the 45-day comment period. In accordance with Section 5848, the adopted Annual Update shall summarize and analyze the Commission's recommended revisions.

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

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

consensus of the Commission, we urge you and the Board of Supervisors (Board) to review all stakeholder testimony received during the public comment period when rendering your final decisions on the Annual Update. Our recommendations center around four broad themes:

1. Inequities/Disparities
2. Housing and Homelessness
3. Budget and Accountability
4. Criminal Justice

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

Data
The Commission acknowledges the Department's inclusion of data metrics in this year's Annual Update, but continues to urge our County to improve data collection, and report out by Service Planning Area (SPA) and Supervisorial District (SD), to identify inequities and identify data sources that can be used to help with clarifying unmet needs.

Demographics
The Department should be sensitive to and accountable for resolving inequities around: race and ethnicity, immigration status, geographic location, age (with an option for clients to elect their choice of programs from TAY, Adult or Older Adult categories) and physical and mental health condition. Special attention should be paid toward inequities in populations with physical disabilities and others who qualify under Americans with Disabilities Act status. The Commission also recommends special attention on increasing the access and resources for the Asian Pacific Islander American (APIA) population due to ongoing negative experiences from the communities as a reaction due to the COVID-19 Pandemic.

We continue to urge you to correct for disparities in funding across underserved and unserved populations, including ethnic populations in all service areas.

Outreach to Families
While the Commission acknowledges the efforts of the Department to increase access for students and their families through robust collaboration with both Los Angeles Unified School District (LAUSD) and Los Angeles County Office of Education (LACOE), we recommend continuing to increase efforts to expand school based mental health services.

Housing & Homelessness
Over this past year, the County has established, and is in the process of opening, several Restorative Care Villages (RCV) Countywide thanks, in large part, to the advocacy, efforts and funding of the Department. The Commission acknowledges these efforts and recommends expanding the RCV model to additional campuses and to include youth and children mental health beds and services in the model in each service area.

Budget and Accountability
Currently, the MHSA Fund Balance is in excess of $1 billion, with the anticipation of increased funds coming from the State. It is imperative that the Department drive this funding into the community, by continuing to build up access to services, increasing funding to the stakeholder engagement groups, increasing the Countywide Activity Fund (CAF) and other programs that will benefit our mental health stakeholders and individuals with severe and persistent mental illness.

The Commission would also recommend the creation of dashboards for reporting both program and budget data per SPA/SD.

Criminal Justice
The Commission acknowledges that a significant number of the jail's population have Serious Mental Illness and feels it is essential to do what it reasonably can to care for this vulnerable population. The Commission also acknowledges the positive work of the County's Department of Health Services Office of Diversion and Re-Entry (DHS-ODR) in moving forward the Board's Care First Jail Last initiative. On April 28, 2022, the Commission voted to strongly recommend the DMH allocate $25 million a year ongoing MHSA funds to support the DHS-ODR services to MHSA eligible clients (Motion/Amendments) and requested to receive additional outcome data from the DHS-ODR program.

Additional Recommendations

- Workforce and Peer Certification Training & Employment;
- Addressing workforce shortages;
- Increase funding for Peer Services/ Peer Certification, for example, continuing funding for Careers for a Cause at Southwest College;
- A mentorship program in South Los Angeles for young boys and girls of color, similar to the MHSA funded program in the Antelope Valley;
- Fund additional transition aged youth centers to take advantage of full continuum of health, mental health and supportive services already on that campus, for example on the Martin Luther King Jr. (MLK) campus;
- Increase funding money for ODR annually (Motion/Amendments);
- Increase funding for care coordination services that foster integration of physical and behavioral health, working alongside health providers in primary care (Department of Health Services (DHS) sites, Federally Qualified Health Centers);

- Increased capacity of the Wraparound Services for Children and Youth in underserved areas, for example, South Los Angeles;
- Maximized scope of service/practice for Occupational Therapists, Recreation Therapists, and Psychiatric Technicians to alleviate staffing shortages;
- Strong recommendation, that the MH Commission has requested previously on several occasions, to conduct a needs assessment survey in the Service Areas/Supervisorial Districts. This would allow for the Supervisors to call on and get input from experts and interested parties, stakeholders and community members. Additionally, inviting the Department of Public Health- Substance Abuse Prevention and Control, DHS-ODR and Chief Executive Office-Homeless Initiative directors;
- Collect the *unmet need data* in our communities using the Social Determinants of Health in South Los Angeles and across the County. ("Addressing the Social Determinants of Mental Health—or Perhaps Not - Mad In America" by Phillip Hickey, PhD.);
- Specify a plan for replacing West Central Mental Health clinic that continues to meet the needs of that community;
- Utilize the MHSA category, Prevention and Early Intervention (PEI), to expand the Alternative Crisis Response services (i.e., PMRT) consistent with the Board's motions;
- Utilize MHSA category, Workforce, Education and Training (WET) to fund an enhanced recruitment and retention of DMH employees, especially as DMH faces high vacancy rates and heavy turnover while trying to expand our programs and services. One objective to fund such an effort is to incentivize mental health clinicians to join DMH and also make sure that the ones presently employed do not "get burnt out and leave";
- Consider the White Memorial Community Based Integrated Model for funding under the MHSA Innovation category (FY2021 MHC Annual Report);
- Consider funding APIA community based mental health services to address the disparities and DMH provide the information to the Board and the Commission as outlined in the 2020 Board Motion and the 2020 recommendation from the Commission's Integrated Services and Cultural Competency subcommittee;
- Funding and support for some version of a Mental Health Urgent Care (e.g., an EmPath Center in collaboration with Henry Mayo Hospital in Santa Clarita) that will serve adolescents and adults that can bill Medi-Cal as well as private insurance;
- A Behavioral Health Unit (BHU) for adolescents and children continues to be critical need in the Santa Clarita and San Fernando Valley Areas; while this may not be a MHSA funded program, MHSA funded programs (e.g., Full-Service Partnerships) desperately need the resource; and
- Day services for individuals experiencing homelessness throughout the County which are low barrier services that help link people to housing and mental health.

The Commissioners will work on gathering additional specific requests from their respective districts to provide as recommendations to the Department throughout the year.

In closing, the Commission urges the Board of Supervisors to approve the FY2022-2023 MHSA Annual Update and to encourage the Department of Mental Health to continue to improve upon

stakeholder and community engagement in preparing future Annual Updates and MHSA 3-year plans.

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

Sincerely yours,

Stacy Dalgleish
Chair, Mental Health Commission

SD:CK

Attachments

EXHIBIT E –MHC COMMISSION LETTERS OF SUPPORT

Partnership: Adventist Health White Memorial, Family Care Specialist Medical Group/Altais & Wellnest

The purpose of the partnership between Adventist Health White Memorial (AHWM), Family Care Specialist Medical Group (FCSMG), and Wellnest is to integrate health care and mental health services for mild to moderate patients at the clinic level and SMI services at the hospital setting. This model of care will help reduce ED visits, improve community well-being and care coordination, and create better systems of care. With this project our goal is to show how patients can be better cared when communication is streamlined, services are closely located, bilingual/ bicultural care is provided, and there is an infrastructure to facilitate this process. This is a community based/focused model of integrated care.

1. **Family Care Specialists Medical Group Clinics:**
   Family Care Specialist clinics are community-based and Latinx-led. FCS Medical Group/Altais comprise four privately-owned medical clinics that focus on different payer types: Medi-Medi, Medi-Cal, Medicare, and commercial plans serving about 30,000 patients.
   Clinic:

   a. AHWM campus clinic 402: has case management services through Blue Shield. In addition, MSW interns will work in this clinic as part of workforce development pipeline pilot. This will be in partnership with local colleges and universities.
   b. AHWM campus clinic 230: has a Family Residency Program, a psychologist to work with residents, and care manager services.
   c. Montebello clinic
   d. Highland Park clinic

2. **Wellnest:**
   Partnership with Wellnest provides mild to moderate services to all patients who need mental health services and have a medical condition. Referral process is in place, and patients are currently being referred. Wellnest's office is located above clinic 402, in Suite 532. This is an Integrated Services Management (ISM) program with focus on the Latinx community. Bilingual/bicultural services provided in Boyle Heights:
   Services:

   a. Therapist
   b. Psychiatry (psychiatric medicine management)
   c. Case management
   d. Peer support
   e. Non-traditional providers/services
   f. Outreach and engagement

3. **"Café con Pan: Talks and Activities"** are group-style sessions that provide information to participants on a variety of topics such as meditation and breathing techniques. The purpose of the talks is to help introduce participants to different approaches to well-being, destigmatize mental health, and enroll participants in Wellnest's services. This is a collaboration between AHWM, FSCMG, and Wellnest.

The classes take place in Adventist Health White Memorial Hospital's community garden and allows for participants to listen and openly discuss their feelings. Maximum capacity is 20 people, and all are welcome. Classes are free and snacks, coffee, tea, and water are provided during sessions. Sessions are held in Spanish and English.

Presenters:

1. DMH Promotoras
2. Wellnest staff
3. Doctors from AHWM and Residents from family medicine program
4. Chase Community Outreach — Benny Sanchez, Community Manager

4. Mental Health Trainings:

Mental health trainings for all staff at FCS clinics will be targeted at two groups: clinicians (doctors, nurses, PAs, and NPs) and support/admin staff. The trainings will happen quarterly, and the objectives are to understand mental health, destigmatize, help better diagnose patients, improve medication management, promote awareness, and provide more inclusive care for LGBTQ+ patients. We will work with psychologist Dr. Geny Zapata, Psy.D. to implement and add to her trainings.

Trainers:

a. DMH Speaker's Bureau
b. DMH Promotoras
c. Wellnest
d. Dr. Geny Zapata

5. Adventist Health White Memorial Hospital:

AHWM provides SMI services through the Behavioral Health (BH) unit funded through LACDMH. The Continuum of Care Department (CCD) provides social work services to the different hospital units but needs mild to moderate mental health services for the patients who are discharged from hospital. The plan is to work with BH unit and CCD to help streamline services between mild to moderate and SMI. Also, one of the objectives of this project is to improve communication with patients' primary care physician (PCP) on plan of care for mental health services.

Departments:

a. Continuum of Care Dept./Social Work Dept.
b. Behavioral Health Unit
c. Community Resource Center

6. Adventist Health Community Clinic (FQHC)

Wellnest
EMOTIONAL HEALTH & WELLNESS

Adventist Health
White Memorial

Café con Pan: Talks & Activities

Join us and learn new skills for living a healthier and stress-free life.

Where: **AHWM Community Garden**
1718 Bridge St.
Los Angeles, CA 90033

When: **Every Tuesday @ 8:30am-10:00am**

CLASSES ARE FREE

To register, please call us at:

(323) 545-3522

Our Upcoming Class Schedule:

3/29/22 - Stretching with Amber Alonso
4/5/22 - Medicinal Herbs and Spices with Dr. Hazly
4/12/22 - Aromatherapy and Massage Therapy with Dr. Hazly
4/19/22 - Art for healing with Martha Navarro
4/26/22 - Women's Health with Dr. Hazly
5/3/22 - Benefits of Stretching with Dr. Hazly
5/10/22 - Arts and Crafts for healing with Martha Navarro
5/17/22 - Zumba with Amber Alonso
5/24/22 - Cafecito with Benny

Limited spaces available, register today!

ATTACHMENT I

DHCS
BRADLEY P. GILBERT, MD, MPP
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

GAVIN NEWSOM
GOVERNOR

March 23, 2020

FACT SHEET

How Can MHSA Be Used To Support Homeless Individuals?

MHSA statute acknowledges that a system of care for individuals with severe mental illness is vital for successful management of mental health. It requires a comprehensive and coordinated system of care that includes criminal justice, employment, housing, public welfare, health, and mental health to address mental illness and deliver cost-effective programs.[1]

Like any program funded through MHSA, the program must be set forth in the 3-year expenditure plan and annual update pursuant to W&I Code § 5847 and be vetted through a local stakeholder process.

MHSA funded services and assistance are available to persons who are homeless or at risk of being homeless, who are also suffering from serious mental illness.[2]

Counties are authorized to fund services to the homeless and housing assistance through the **Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), and Capital Facilities and Technological Needs (CF/TN) components** of MHSA.

CSS Programs

CSS is the largest MHSA component at 76% of county MHSA funding.[3] CSS funds may be used to serve the homeless population through the following services and programs.

Full Service Partnership (FSP)
Counties are required to direct a majority of their CSS funds to FSPs.[4] Individuals eligible for an FSP include those who are unserved or underserved and may be homeless or at risk of becoming homeless.[5] FSPs

[1] Welfare & Institutions (W&I) Code § 5802.
[2] W&I Code §§ 5600.3(b)(4)(A) and 5600.4(j).
[3] California Code of Regulations (CCR) § 3420; W&I Code § 5892(a)(5)).
[4] CCR § 3620(c).
[5] CCR § 3620.05(b)(c)(d).

Behavioral Health
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
Phone (916) 440-7800 Fax (916) 319-8219
Internet Address: http://www.DHCS.ca.gov

provide wrap-around or "whatever it takes" services to clients. FSP mental health services and supports[6] include:

- Mental Health Treatment
- Supportive Services to Assist the Individual in Obtaining and Maintaining Employment, Housing and/or Education
- Peer Support
- Wellness Centers
- Personal Service Coordination/Case Management
- Needs Assessment
- Individual Services and Supports Plan (ISSP) Development
- Crisis Intervention/Stabilization Services
- Family Education and Reunification Services

FSP non-mental health services and supports[7] include:

- Food
- Clothing
- Housing, including, but not limited to:
  - Rent Subsidies
  - Housing Vouchers
  - House Payments
  - Residence in a Drug/Alcohol Rehabilitation Program
  - Transitional and Temporary Housing
- Cost of Health Care Treatment
- Cost of Treatment of Co-Occurring Conditions, such as Substance Abuse
- Respite Care

General System Development (GSD) Programs

CSS funds can also be used to fund GSD programs, which may include mental health treatment, peer support, and personal service coordination. Such programs could include assistance in accessing housing and crisis intervention/stabilization services.[8] Examples of such programs include:

- Countywide housing specialist teams that provide housing placement services.
- Crisis teams that provide linkage to county mental health programs.

Additionally, under GSD, a county may transfer funds to their local government housing entity for a specific Project-Based Housing Program.[5] Examples of Project Based Housing include:

- Rehabilitation of a hotel for short-term housing.
- Purchase of a house for transitional housing.
- Construction of a building for master leasing of units.

---

[5] CCR § 3620(a)(1)(A).
[7] CCR § 3620(a)(1)(A).
[5] CCR § 3630(b).
[8] CCR § 3630.05(a).

Outreach and Engagement (O&E)
CSS can be used to fund outreach activities/programs that are intended to identify unserved individuals who meet certain criteria[10], in order to engage them in the mental health system so that they receive the appropriate services.[11]

- O&E funds may pay for food, clothing, and shelter, *but only when* the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system. Examples:
  - Multi-Disciplinary Teams that Engage Homeless
  - Peer Services
  - TAY Targeted Teams
  - Navigators
- O&E activities include:
  - Outreach to entities such as schools, tribal communities, public places such as streets and trails, jails and hospitals.
  - Outreach to individuals who are homeless and those who are incarcerated in county facilities.

Housing Assistance
CSS funds may be used for "housing assistance"[12] which includes:

- Rental assistance or capitalized operating subsidies.
- Security deposits, utility deposits, or other move-in cost assistance.
- Utility payments.
- Moving cost assistance.
- Capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless.[13]
- Housing may include short-term housing (ex. hotel), transitional and permanent supportive housing.

No Place Like Home (NPLH) MHSA-Funded Supportive Services
NPLH funding is a separate funding source from MHSA, but to get the funding through NPLH, an applicant county has to commit to providing the NPLH tenant population mental health supportive services for at least 20 years. They can use multiple funding sources to provide the supportive services including MHSA funding. The NPLH program is dedicated to the development of permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. Under this program, counties can use the money awarded them to fund housing, and subsidize extremely low rent levels. If a county is awarded NPLH funding, then the program requires

[10] W&I Code § 5600.3 (criteria).
[11] CCR § 3640(a).
[12] W&I Code § 5892(a)(5).
[13] W&I Code § 5892.5.

the following mandatory supportive services (which can be funded through MHSA) to be provided to NPLH tenants[14]:

- Case management.
- Peer support activities.
- Mental health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups.
- Substance use disorder services, such as treatment, relapse prevention, and peer support groups.
- Support in linking to physical health care, including access to routine and preventive health and dental care, medication management, and wellness services.
- Benefits counseling and advocacy, including assistance in accessing SSI/SSP, and enrolling in Medi-Cal.
- Basic housing retention skills (such as unit maintenance and upkeep, cooking, laundry, and money management).

And the following services to be made available and encouraged[15]:

- Services for persons with co-occurring mental and physical disabilities or co-occurring mental health and substance use disorders not listed above.
- Recreational and social activities.
- Educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process.
- Employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work.
- Obtaining access to other needed services, such as civil legal services, or access to food and clothing.

MHSA Housing Program

This program provided funding for the capital costs and operating subsidies to develop permanent supportive housing for individuals with serious mental illness who are homeless, or at risk of homelessness. In 2016 the MHSA Housing Program was replaced with the Local Government Special Needs Housing Program (SNHP), which was intended to be a bridge between the MHSA Housing Program and NPLH. Effective January 3, 2020, the California Housing and Finance Agency (CalHFA) discontinued SNHP. While no longer in effect, this program:

- Created over 2,500 supportive housing units dedicated to individuals with serious mental illness.
- Used MHSA funds to leverage public, local, state, and federal funding to develop over 10,000 affordable housing units.

[14] NPLH Program Guidelines, pp 24-25.
[15] NPLH Program Guidelines, pp 25.

- For each dollar that MHSA provided, the federal government provided $4.50, private banks and non-profit organizations provided $3.50, locals provided $1.50, and the Housing and Community Development agency provided $1.

PEI Programs

PEI is the second largest component at 20% of a county's MHSA funding.[16] PEI programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness, including, but not limited to, prolonged suffering and homelessness.[17] Some examples of PEI programs offering support to the homeless or at risk of being homeless are:

- **Landlord Outreach and Recruitment**
  These programs may prevent homelessness and build relationships that may lead to the availability of additional housing units. The county/provider acts as an intermediary by providing support to the tenant and conflict resolution assistance with the landlord.

- **Emancipating, Emancipated, and Homeless TAY Targeted Projects**
  These projects identify, support, treat, and minimize the impact for youth who may be in the early stages of a serious mental illness.

- **Wellness Centers**
  These centers provide recovery/supportive services for people with co-occurring conditions (mental, substance use or physical health conditions). This may include linkage to housing.

INN Projects

INN projects are funded with 5% of the total of CSS and PEI funds.[18] An INN project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, permanent supportive housing development.[19] A primary purpose of an INN project may be to:

- Increase access to underserved groups, which may include providing access through the provision of permanent supportive housing.[20]
- Support innovative approaches by participating in a housing program designed to stabilize a person's living situation while also providing supportive services on site.[21]

---

[16] W&I Code § 5892(a)(3).
[17] W&I Code § 5840(d).
[18] W&I Code § 5892(a)(6).
[19] W&I Code § 5830(c)(9).
[20] W&I Code § 5830(b)(1)(A).
[21] W&I Code § 5830(b)(2)(D).

CF/TN Projects

A county may transfer CSS funds to the CF/TN component provided the transfer does not exceed 20 percent of the average amount of funds allocated to the county for the previous five fiscal years.[22] CF/TN projects are meant enhance the infrastructure needed to support implementation of MHSA, which includes improving or replacing existing technology systems and/or developing capital facilities to meet increased needs of the local mental health system. All plans for proposed facilities with restrictive settings must demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing.[23] Examples include homeless shelters and navigation centers.

MHSA funding can be versatile in its application to assist individuals with mental health issues at risk for homelessness or experiencing homelessness. It is important to remember that if a county is interested in using MHSA funding for such programs, every program must be reflected in the Three-Year Program and Expenditure Plan and annual update, and counties are required to partner with constituents and stakeholders throughout the planning and development process. The next county plan is due to the Mental Health Services Oversight & Accountability Commission (MHOAC) and the Department of Health Care Services (DHCS) in FY 2020 and will cover FY 2020-2023.

[22] W&I Code §5892(b).
[23] W&I Code § 5847(b)(5).

Asian Pacific Policy & Planning Council's Proposal for Expansion of DMH Services

PROPOSAL SUMMARY

The Asian Pacific Policy & Planning Council (A3PCON) is a coalition of community-based organizations that advocates for the rights and needs of the Asian and Pacific Islander American (APIA) Community in the greater Los Angeles area, with a particular focus on low income, immigrant, refugee and other disadvantaged sectors of the population. To accomplish this mission, A3PCON strives to:

- Serve as a vehicle for promoting the needs, interests and concerns of the APIA Community to policy makers and the public.
- Promote collaboration, planning and collective action amongst its members to support common advocacy/policy, organizational development and capacity-building goals.
- Activate the APIA electorate and promote public accountability to the APIA Community through non-partisan political and electoral participation.

The A3PCON Mental Health Provider Network is comprised of 12 culturally competent community based agencies whose multidisciplinary staff provide services in 12 Asian languages. They provide these services in over 20 locations and in every service area of the county.

Collectively, the following members of the A3PCON Mental Health Provider Network are requesting expansion in the following categories to expand service to the API Community:

Cambodian Advocacy Collaborative
Center for Pacific Asian Families
Chinatown Service Center
Little Tokyo Service Center
Pacific Asian Alcohol and Drug Program
Federation of Filipino American Associations
Samoan National Nurses Association
Search to Involve Filipino Americans
South Asian Network
Special Service for Groups, Inc.

PROPOSAL TO EXPAND API FSP SERVICES

Overview:

- *Access to care:* Increase utilization of programs and strategies that target Underserved Cultural Communities and the use of non-traditional practices to engage these specific communities
- *Reducing Disparities:* Increase the number of API FPS slots to match the reflected increase of the API population as service utilization rates have remained stagnant as the population has continued to grow but only accounts for 4% of all clients in mental health programs
- *Cultural Competence:* Demonstrate cultural competence in serving API consumers as a condition to receiving funding. Targeted, culturally and linguistically competent programs and providers show significant success over mainstream programs.

Requested FSP Funding

Goal: Expands the FSP slots allocated to the existing API provider network as well as develop the capability of additional API community based providers. DMH funds are imperative for development and capacity building for successful engagement of API high needs consumers.

	Current	Year 1 Increase		Year 2 Increase		Year 3 Increase		Total at year 3
Older Adult	**45**	41	$1,615,000	40	**$2,185,000**	40	**$2,755,000**	**166** **330**
Adult	**121**	69	$3,610,000	70	**$4,750,000**	70	**$5,890,000**	**270**
TAY	**30**	75	$1,995,000	80	**$3,515,000**	85	**$4,465,000**	**275**
Child	**83**	57	$2,717,000	65	**$3,952,000**	70	**$5,130,000**	

PROPOSAL TO EXPAND API WELLNESS ACTIVITIES AND RRR SERVICES

In order to provide an adequate continuum of care in LA County for API consumers in all age groups under the FSP, ISM, FCCS, and other contracts, **the current lack of funding for wellness activities and RRR services for APIs must be addressed.** Since the inception of the API FSP collaborative, FCCS funding was not allocated under the countywide contracts.

With three proposals in the pipeline to DMH that address disparity for APIs, it is critical that funding for recovery based and wellness-focused services for API clients and family members be given priority.

Proposed Funding:

Request for RRR (Formerly FCCS) Funding: We propose that $12,500 be allocated for each FSP client to provide wellness activities and RRR services plus an additional Wellness amount for Older Adults. Details in chart below.

FSP Expansion: Year 1 – total 500 API FSP slots countywide

Year 2 – total 725 API FSP slots countywide

Year 3 – total 950 API FSP slots countywide

Goal: Expands the continuum of care for high need API consumers initially served through FSP, allows FSP consumers to step down, and provides access for those not qualified for FSP due to acuity (i.e. mild to moderate). RRR can be instrumental in preventing individuals from needing a higher level of care and promote recovery.

	Requested*		**Year 1 Increase**		**Year 2 Increase**		**Year 3 Increase**	
Older Adult	44	**$550,000**	75	**$937,500**	105	**$1,312,500**	135	**$1,687,500**
			Wellness	**$50,000**	Wellness	**$100,000**	Wellness	**$150,000**
Adult	121	**$1,512,500**	180	**$2,250,000**	240	**$3,000,000**	300	**$3,750,000**
TAY	30	**$375,000**	105	**$1,312,500**	180	**$2,250,000**	255	**$3,187,500**
Child	83	**$1,037,500**	140	**$1,750,000**	200	**$2,500,000**	260	**$3,250,000**

*Requested RRR amount based on current FSP slots. Amount calculated based on $12,500 annually including service delivery costs and flex dollars

RRR Costs for API FSP clients:

Year 1 = $6,300,000

Year 2 = $15,462,500

Year 3 - $27,487,000

Community Partner Empowerment Project: $285,000 per year (see proposal for details)

Expansion of API ISMs: 3 ISMs x 50 enrollees x $5000 pp $750,000 per year

TOTAL RRR Costs for FSP, Community Partner Empowerment and ISM proposals:

Total for Year One: $7,335,000

Total for Year Two: $23,832,000

Total for Year Three: $28,522,000

This proposal would address Gap #7 regarding the lack of recovery based and wellness-focused services for API clients from the DMH Disparities Report.

Consumers during the input process felt strongly that funding should be included for family members, too. They feel that for APIs the support and involvement of the family is a key element in the recovery of the client. Services that assist family members in this process should be part of the wellness process.

Proposed Implementation:

We highly recommend that the strategies and interventions developed under the Innovation Plan One API ISMs be used as a model of care for recovery based and wellness focused services and RRR funding allow for the billing of these activities. This would be in addition to the DMH list of RRR activities and goals (See Addendum B below). Each API community or ethnic group must have individualized approaches that are culturally sensitive and relevant, but there are commonalities that can be used as a blueprint for success:

1. Hire staff at all levels who are bilingual and culturally knowledgeable about their community, the country of origin, the cultural norms and traditions, and even the politics of the place of origin as well as the community in LA County. Recruitment of community members for staff positions is important.
    a. Hire staff who understand how that community operates, the hierarchy of power, etc.
    b. Hire staff who will be respected by the community.
    c. Hire staff who are committed to supporting clients towards recovery.
2. Emphasize employment opportunities for clients so they have more meaningful roles and jobs. This includes hiring FT employment specialists for the RRR level clients who assist the consumer to determine their job goal as well as actively outreach to employers for positions, following the CalWORKs EBP of Individual Placement and Support Supported Employment (IPS-SE). The employment specialist would follow-up with the consumer to troubleshoot communication and life skill issues, monitor progress, and ensure client satisfaction with their employment.
3. Utilize the Support Specialists, peer and family advocates more fully at each agency with the goal of attaining full time employment. Agencies should provide them with frequent training opportunities that expand their skills and improve their changes for promotions within the system. Clinical staff should receive training on how a peer strengthens the clinical team and what their role in treatment will be for a client and family members.
4. Understand the role of spirituality or religion within that community and incorporate them into the treatment plan.
5. Use practices such as meditation, dance, gardening, cooking, etc. as part of whole person approach to health.
6. Use a trauma focused approach to care for the client and the family.
7. Encourage a whole person approach to care that includes physical health, substance abuse and emotional well-being.
8. Utilize strategies that encourage clients and family members to meet one another to decrease isolation, share information and support one another.
    a. Developing groups with a concrete purpose such as artwork, sewing, handicrafts where participants are encouraged to interact.

b. Encourage clients to participate in community activities with staff support such as community fairs, cultural events, etc. so they become comfortable going back to the community.
c. Use of rehab specialist or navigators so clients can learn needed skills such as how to use the bus, financial skills, applying for benefits, etc.
d. Encourage family members to use supplementary services such as respite care for themselves.

PROPOSAL TO EXPAND API ISMs

Given the diversity of the API communities in LA County that includes 40 plus ethnicities and over 30 languages, we propose the expansion of the 3 current RRR-ISM models and the formation of 3 new API ISMs. All of these API ISMs should be flexible enough to allow for either regional populations or single ethnic-specific programs depending on the needs and resources of that community.

Double the size and budget of the three current API ISMs. We propose **doubling** the existing ISMs to allow for the following:

1. Korean ISM (KISM) – Double the size of the KISM agencies. The demand for services in the Korean community continues to surpass the available services, particularly for the Adult and Older Adult populations. The KISM has increased annual client slots by 50% from 54 to 81 over the past 5 years and it continues to enroll more clients than it can serve in the Adult and Older Adult categories. The number of days that clients have to wait before enrollment has steadily increased by 20 days.[1]
2. Cambodian ISM (INC Program) –Expand the INC Program to include other Southeast Asian populations, such as Thai, Hmong and/or Laotian and increase the service area to the entire county. These populations have many similarities in their culture, customs and traditions but are also uniquely individual. The Hmong and Laotian communities tend to cluster in the Long Beach area where PACS already has infrastructure capacity in its INC Program. In FY2017-18, PACS has already subcontracted with Thai CDC under its PEI COS contract to conduct community outreach services to Thais, primarily in SA2 and SA4. There is a definitive number of Thais in the Long Beach (SA8) area as well.
    a. See Addendum A for Cambodian client feedback on this proposal below.
3. Chinese ISM (CISM) – Double the size and expand the CISM program to include the Vietnamese population. Asian Pacific Family Center, which provides the mental health services under the Chinese ISM, states that approximately 20% of the agency's clients (500) identify as Vietnamese and another 25% (625) as Chinese-Vietnamese, who immigrated from Vietnam but are originally of Chinese ancestry. Although the Chinese-Vietnamese clients could be served under the Chinese ISM because they can speak some Chinese and have Chinese ancestry, about 1 in 3 would prefer to receive services in Vietnamese, which is their stronger language.

[1] To accommodate the need in the Korean community, the existing KISM led by KYCC could be expanded and a second Korean ISM could be established led by another agency.

We recommend adding three additional API ISMs. At this time, we envision THREE entirely new API ISMs to reach populations that are of sufficient size in LA County but still largely underserved:

1. Filipino ISM – This is the second largest API ethnic group in LA County after the Chinese, but it is severely underserved for mental health services. The population is dispersed throughout LA County and there is a lack of culturally specific programs and services tailored to this community's needs.
2. South Asian ISM – The Asian Indian, Pakistani, and Bangladeshi populations are of a significant size in LA County yet there have been few culturally specific mental health services dedicated to this population. The depth of need in its many communities as well as the many languages of the diverse population have made it difficult to select just one population.
3. Pacific Islander ISM – Pacific Islanders have some of the poorest health outcomes of any racial or ethnic group in the County, yet they are severely underserved and often overlooked amongst the API communities. Some of the suggested populations would include Samoan, Native Hawaiian, Tongan, and/or Guamanian.

Proposed Funding: $3,600,000

Approximately $600,000 added to each of the existing ISMs plus $600,000 for each of the new ISMs. 6 ISMs (3 expanded + 3 new) x $600,000

Each of these regional groupings may include several different nationalities, ethnicities, languages and religious beliefs. Each is unique, but several may share some commonalities. Our recommendation is based:

A. On the knowledge that for most of the new or expanded ISMs, their numbers are not large enough to sustain the needed outreach and client enrollments to be a stand-alone ISM.
B. Many of these communities do not have a CBO large enough to handle the requirements to become a legal entity under DMH at this time.
C. Existing API ISMs have the knowledge, experience and infrastructure to expand services to their additional communities in a shorter amount of time. They can serve as a rich resource to mentor the new ISMs.
D. If the API communities must wait until these two conditions are met - sufficient numbers and meet the requirements to become a DMH legal entity – they will continue to be underserved for many years despite a documented need for mental health services now.

This proposal would **address two gaps** identified in the DMH Disparities Report:

Gap #1: Underutilization of public mental health services by APIs. This proposal would expand the current network of providers, implement strategies that address the unique needs of API subpopulations, increase awareness of mental illness through culturally relevant outreach activities through partnerships and collaborations with established community networks and increase the number of API consumers.

Gap #2: Recognize that API sub-populations are unique, culturally diverse and are separated by many challenges such as language, religion and cultural beliefs. This proposal would address this at the sub-population level while involving many community stakeholders and relevant organizations.

Proposed Implementation:

Each lead agency must commit to have individualized activities, strategies and programs for each of their ethnic communities. This is especially important when it comes to non-traditional practices. Community specific workers and peers need to be hired to develop trust with each community.

Each lead agency would subcontract out OEE to the smaller CBOs that are already working with that population. The goal would be to mentor these CBOs to become independent providers over time. If there are no CBOs as is probably the case with the Hmong and Laotians, the lead agency would use in-house staffing to provide direct services and recruit community workers for OEE.

Some of the enrollment requirements such as having an FQHC for each ethnic community may need modification. For example, the lead agency will commit to find medical care for enrollees if their FQHC is not available due to location or linguistic barriers. If the ACA continues, many of these potential clients may already have medical care through a local physician whom they may wish to continue with.

Allowing for regional ISMs provides an opportunity for each collaborative to grow and evolve based on the community's needs. For example, based on the opportunities and challenges described above, the South Asian ISM might want to start with the Bangladeshi and Indian communities but later expand to encompass another South Asian community. As the mental health needs of an underserved, emerging population are identified, the regional ISMs should be allowed to include them.

The implementation of these collaborative ISMs will be challenging. This proposal recognizes that it is an enormous undertaking for the lead agencies to be community specific, culturally humble to each group and innovative enough to do effective OEE. There are probably new implementation strategies that will need to be tested and refined for these communities. Flexibility must be built into the implementation process so changes can be made as needed. However without such an expansion, many of the smaller and/or emerging API communities will never be adequately served.

Cambodian ISM Expansion (move to Cambodian narrative?)

In December 2017, nine Cambodian clients from the INC Program and two peer advocates met to discuss the feasibility of expanding the Cambodian ISM. This is a summary of their discussion. Overall they had a positive response to the proposal as well as identifying some of the challenges.

1. How do you feel about having other Southeast Asians (SEA – such as Thai, Lao and Hmong) join the INC Program?
    a. Happy to:
        i. Share experiences, cultures and language differences
        ii. Beneficial to have more SEA people access the services of an ISM
        iii. Promotes openness and acceptance of other cultural differences
        iv. Promotes a feeling of being united as Asian Americans
2. How about the addition of non-traditional services?

a. They would like to see the addition of traditional Khmer Blessing dance as well as classical, folk and social dances.
b. Add traditional New Year games
c. Add groups that teach arts and crafts. They see this as way to empowerment as they would like to sell these.
d. Add groups for traditional music classes.

3. What are the challenges/barriers to grouping SEA into the INC Program?
    a. Currently there is no language specific materials for the other countries. This would need to be developed.
    b. There is the challenge of hiring staff with language capacity.
    c. There are some differences in each community's non-traditional practices.
        i. There is a history of political conflicts. These cannot be ignored but they need to be addressed in a culturally sensitive manner.
        ii. There may be unresolved feelings of animosity or resentment. The remembrance of these conflicts may re-trigger symptoms due to past trauma.

Cambodian Multigenerational Expanded Services

The Cambodian population experiences significant physical health, mental health, socioeconomic, and educational disparities which the effects of span across generations. In human developmental terms, Cambodian immigrants and refugees are among the most traumatized populations in the United States. Cambodian refugees faced the "Killing Fields" genocide firsthand from 1975-1979 and were, virtually without exception, left traumatized by their experience and its aftermath, the indeterminacy of flight, camp life and resettlement in poor, high-crime neighborhoods in America. The cognitive impact of torture and the refugee experience often results in traumatic emotional distress, depression, memory loss, concentration problems, learning difficulties. Although decades have passed since the war and genocide in Cambodia, a study by RAND involving Long Beach Cambodians found "shockingly high" rates of post-traumatic stress disorder (PTSD) among this population; 62% met the DMS-IV diagnosis criteria for PTSD and 51% met diagnostic criteria for major depression[2]. Over time, experiences of extreme untreated and unresolved trauma can result in patterns of emotional distress, poor sleep, unhealthy diet, physical inactivity, and other health-compromising behaviors, which if left unaddressed, result in severe mental illness and chronic disease.

The Cambodian Advocacy Collaborative recognizes that Cambodians have been suffering from the disproportionate mental health disparities and challenges that have become multigenerational, extending past the first generation of refugees to the youth who are American-born citizens. In a study by Khmer Girl in Action (KGA) of youth engaged in their program, 50% of Cambodian youth surveyed reported depressive symptoms[3]. Sixty-four percent of Cambodians have five or more chronic health conditions that include co-morbid PTSD and depression[4]. A most recent Community Needs Assessment

[2] Marshall, G.N. et al. Mental Health of Cambodian Refugees 2 Decades After Resettlement in the United States. Journal of the American Medical Association, 2005 294(5), 571-579.
[3] Khmer Girl in Action (KGA), Step Into Long Beach, Exposing How Cambodian American Youth are Under Resourced, Over Policed and Fighting Back for /their Wellness. A participatory action research project funded by the UCLA Center for Community Partnership, the Women's Foundation of California, the Third Wave Foundation, Asian American/Pacific Islander in Philanthropy's National Gender and Equity Campaign, the Dwight Stuart Youth Foundation, and the California Endowment. November 2011.
[4] Berthold, S.M. et al. Comorbid Mental and Physical Health and Health Access in Cambodian Refugees in the U.S. Journal of Community Health, 2014. http://www.ncbi.nlm.nih.gov/pubmed/24651944.

conducted by the California State University Long Beach and the CAC partners in 2017 indicates that one out of two Cambodians in Long Beach have depressive symptoms, 25.4% have either attempted suicide or knew someone who attempted suicide[5]. Furthermore, the majority of Cambodians have incomes below the poverty level. Overall, these factors result in Cambodians be between ages 45-64 get sick and die an average of 10-15 years younger than their counterparts in other ethnic groups[6].

The proposed expansion of services under Full Service Partnership (FSP) and Recovery, Resilience & Reintegration (RRR) services will reduce the mental health disparities and risk factors for very severe mental illness and increase protective factors among the Cambodian community and will in turn help to reduce mental health disparities for the overall API community.

Overall expected outcomes are

- Access to care: Increase access to appropriate mental services to the severely underserved Cambodian community including low-income, aging Cambodians who are at risk of severe mental illness and Younger Cambodians, including transition-age youth (TAY) at-risk of severe mental illness
- Reducing Disparities: Reduce the mental health disparities and the risk factors for very severe mental illness and increases protective factors among Cambodians
- Cultural Competence: Demonstrate cultural competence in serving API/Cambodian consumers with targeted, culturally and linguistically competent programs and providers to increase access to community resources, promote discussion of mental health needs earlier, and reduce mental health stigma in the community

Filipino Expanded Services

The Search to Involve Pilipino Americans, Pacific Asian Alcohol and Drug Program, and the Federation of Filipino Associations

A3PCON MENTAL HEALTH COMMUNITY PARTNER PROFILES

Cambodian Association of America

The Cambodian Association of America (CAA), incorporated as a nonprofit organization in 1975, is the oldest and largest Cambodian organization in the United States. The organization has been instrumental in establishing the Cambodian community across the United States, especially in Long Beach, and promoting small businesses along the Anaheim and Atlantic corridors, an area known to

[5] CSULB & Cambodian Advocacy Collaborative, Community Needs Assessment. A participatory action research project funded by the California Endowment Building Healthy Community, 2017.
[6] National Cambodian American Health Initiative, in partnership with the University of Connecticut School of Pharmacy, Funded by Centers for Disease Control & Prevention Grant#558DP000988
Wong, Eunice C., et al. RAND Corporation. Santa Monica, CA. The Unusually Poor Physical Health Status of Cambodian Refugees Two Decades After Resettlement. *Journal of Immigrant Minority Health*, 13, 876-882.

many as “Cambodia Town.” The mission of the early founders was to assist Cambodian refugees in acculturating and assimilating to life in America, while preserving the Cambodian culture, customs, and values. *CAA’s current mission is to improve the quality of life of low-income children and families by providing linguistically and culturally appropriate social, health, mental health, outreach education and employment services.*

Since 2000, CAA has expanded services to serve non-Asian groups, including Hispanics, African Americans, Caucasians, and others. CAA’s current programs include counseling and advocacy programs, such as the Community Family Preservation Program, the Domestic Violence Program, the Substance Abuse Outpatient Counseling Program, the Child Abuse, Neglect Prevention and Intervention, and the Cambodian Senior Services. CAA has over 10 years of experience in providing mental health services. CAA’s other programs include: Substance Abuse Community Prevention Services, Healthy Marriage Education Services, Career Enhancement and Job Placement Services, Lifeline Outreach Education services, Citizenship Network and Legal Assistance, the Cambodian Art Preservation Program, and Cambodian Radio Broadcast (106.3 FM). Each year, over 4,500 people receive direct services from CAA, and our outreach education programs reach over 35,000 people annually.

Cambodian Advocacy Collaborative

The Cambodian Advocacy Collaborative (CAC) made up of five nonprofit agencies dedicated to health, mental health, and social service provision in the greater Long Beach Area. The CAC is made up of Cambodian Association of America (CAA) mentioned above, the United Cambodian Community (UCC), Khmer Parents Association (KPA), Families in Good Health (FiGH), and The Khmer Girl in Action (KGA).

- **Families in Good Health (FiGH)** developed and implemented its original perinatal health education program in 1987 and has built on this model over the years (with the indigenous Community Health Worker as the crux of this home visitation model). Based on the model of the indigenous community facilitator (as used to reach low-literate communities in rural areas of developing countries), the Community Health Worker (CHW) serves as the essential bridge between the Southeast Asian family and the Western health care system. FiGH (CHW) provide the cultural linkage to the Southeast Asian community that they serve and enable Families in Good Health to build strong reputations with families, local Buddhist temples, agencies and other community partners. These CHWs facilitate needed cultural access for our clients and families through services like linguistic translation, cultural interpretation, health and nutrition education, development of culturally appropriate educational materials and cultural sensitivity training for health and social service professionals. In 1989, FiGH implemented a home visitation model for seniors (known as the Older Southeast Asian Health Project), an approach synonymous with practices currently recognized as “aging in place.” FiGH adapted its bilingual, bicultural Health Navigator model so as to train CHWs as Community Health Navigators – These Navigators are equipped to navigate community members to services, while providing culturally and linguistically appropriate support.

- **Khmer Parent Association's (KPA)** mission is to produce tomorrow’s leaders of today's Khmer youth through higher education by providing tutoring, leadership development, scholarships,

and health education to youth, women and families. Khmer Parent Association is a nonprofit focused on afterschool tutoring for grades 1 thru 12, annual scholarships for Southeast Asian High School Graduates, medical interpretation and patient navigation, health education, and free health screenings for the Cambodian community with an Annual Khmer Health Forum.

- **United Cambodian Community (UCC)** has provided culturally competent services to the Cambodian community in Long Beach. UCC's mission is to promote and advocate for the well-being and advancement of the Cambodian community. Beginning as a self-help group in the 1970's for Cambodian refugees, UCC has developed into a comprehensive social service provider. UCC provides culturally competent health, youth development, and community engagement programs. UCC's health programs include health education, chronic disease management, health insurance enrollment, mental health outreach and education, wellness activities, social support groups, and case management. Through its youth development program, UCC empowers youth to success through college readiness, recreation activities, leadership development, and work readiness programs.

- **Khmer Girls in Action (KGA)** is a community-based organization whose mission is to build a progressive and sustainable Long Beach community that works for gender, racial and economic justice led by Southeast Asian young women. KGA believes in the leadership of Southeast Asian youth to create social change. Our programming invests in and empowers Southeast Asian youth to become leaders in their community and their lives. KGA take a comprehensive approach to working with our members to ensure their holistic development. KGA's areas of programming are infused with an analysis of gender, class, race, sexuality and culture.

Center for the Pacific Asian Families

CPAF has been a pioneer in providing services API survivors of sexual assault, domestic violence and child abuse, with nearly 40 years of experience. As mentioned below, last fiscal year, CPAF responded to 3,861crisis calls from callers speaking 25 different languages in LA County, enabling them to be the first responders to these individuals and provide the necessary crisis support and linkage to needed services, including mental health. CPAF provides a continuum of comprehensive services for survivors, including emergency shelter, transitional shelter, counseling, and case management. They also engage in frequent community outreach, capacity building and training to various government and community-based organizations, who seek and benefit from CPAF's expertise in sexual assault, domestic violence and child abuse prevention and intervention services. SSG has subcontracted with CPAF on DCFS programs targeting child abuse prevention and treatment, and have collaborated for 20 years in serving mutual clients, families and our communities.

CPAF has been a pioneer in creating and providing services for underserved and marginalized Asian and Pacific Islander (API) immigrants since 1978, when it established the first multilingual hotline assisting API survivors of sexual assault, domestic violence and child abuse in the United States. In 1981 CPAF opened the first multilingual and multicultural emergency shelter in the US to specialize in serving API survivors of sexual assault and domestic violence. In 1998, CPAF

opened the first multilingual and multicultural transitional shelter in the nation, focusing on the needs of the API survivors who seek to establish independent and violence-free lives. Today, CPAF continues to provide multilingual and multicultural, comprehensive and free services in Los Angeles targeting API community. Last fiscal year, CPAF responded to 3,861 crisis calls from callers speaking 25 different languages; provided intervention services to 238 survivors through its community-based case management and counseling program, and provided shelter to 132 sexual and domestic violence survivors and children.

Chinatown Service Center

The Chinatown Service Center (CSC) is the largest private, non-profit, community-based Chinese American health and human services organization in Southern California, serving immigrant s, refugees, and others in need of assistance. CSC promotes community collaboration and partnerships to assist underserved populations in achieving their American dream. CSC's mission is "to provide outstanding services and advocacy that promote a better quality of life and equal opportunity for immigrants and other communities so we can fulfill our vision of thriving lives in empowered communities." CSC provides services in English and a variety of Chinese dialects: Cantonese, Mandarin, Toisan, Chiu Chow and other languages including Vietnamese, Spanish, and Khmer (Cambodian).

Search to Involve Pilipino Americans

SIPA enriches and empowers generations of Pilipino Americans and others by providing health and human services, community economic development, and a place where all people of all backgrounds can come together to strengthen community.

Founded in 1972, the mission of Search to Involve Pilipino Americans (SIPA) is to enhance the quality of life in Los Angeles' Historic Filipino town and for Pilipino Americans throughout Los Angeles County. As such, SIPA provides a wide range of health and human services and community economic development programs aimed at improving economic self-sufficiency, educational attainment, cultural awareness and civic engagement. Youth and family services (counseling and case management, afterschool programs, etc.) are the core of SIPA's programs, but in the 1990's housing, small business and consumer assistance and civic engagement and advocacy were added to more comprehensively address the needs of our clients. Additionally, SIPA has expanded its capacity to serve a diverse population and currently provides services in English, Tagalog (Filipino), Spanish and Armenian.

Pacific Asian Alcohol & Drug Program (PAADP)

The mission of the Pacific Asian Alcohol and Drug Program (PAADP) is to enhance and enrich the quality of life of Los Angeles County residents by: providing alcohol and drug prevention, treatment and recovery services; supporting youth leadership and development; providing child and family services, housing referrals; and participation in collaborative activities with other health and human service providers and institutions. Dr. Leo Pandac is a long-time community leader and gatekeeper for the Filipino community.

Federation of Filipino American Associations (FFAA)

The FFAA led by long-time leader Paul Blanco is a leadership, civic engagement and advocacy organization based in Long Beach. One of their many focus areas is immigration issues relating to civil rights as well as health and wellness.

Asian Pacific AIDS Intervention Team (APAIT)

APAIT is a thirty-year-old HIV/AIDS service and behavioral health program of SSG, Inc. aimed at advocating, educating, and achieving optimal health and well-being for the LGBTQ community of Los Angeles and Orange Counties. Behavioral health programming will include:

1. *outreach and engagement activities in non-traditional settings frequented by the LGBTQ community including but not limited to night clubs, bars, health fairs, school-based settings, public sex environments such as a sex clubs and bathhouses, street and alley outreach, and psychosocial groups;*
2. *peer-driven support groups including but not limited to populations such as pre-and-post gender reassignment surgery (GRS} for transgender and gender non-binary, trauma-informed anti-bullying programs for LGBTQ;*
3. *evidence based intervention therapy, case management, and rehabilitation services including but not limited to LGBTQ affirmative cognitive behavioral therapy, Seeking Safety, and Interpersonal therapy (IPT}; and provision of LGBTQ cultural competency and sensitivity training as well as mental health first aid training.*

Little Tokyo Service Center

Little Tokyo Service Center, a Community Development Corporation (LTSC CDC}, was established in 1979 by representatives of various Japanese American groups who wanted to form a multipurpose social service center. Little Tokyo Service Center aimed to provide linguistically and culturally sensitive social services to the Little Tokyo community and the broader Japanese American community in the Southland.

LTSC CDC is a nonprofit charitable organization serving Asian and Pacific Islanders throughout Los Angeles County who are in need, especially those facing language or cultural gaps, financial need, or physical disabilities.

Currently, LTSC CDC sponsors over a dozen different community and social service programs, with over 100 paid staff persons and hundreds of volunteers to provide competent and compassionate services in many languages. Services include individual and family mental health counseling, child abuse prevention, case management, support groups, senior services, childcare, preschool, after- school youth programs, and domestic violence programs.

LTSC conducts outreach and education to increase awareness mental health services by Japanese and Japanese American families and individuals when they are needed. A part of that work involves overcoming social stigma and developing an awareness of tools and resources for

counseling, support groups and educational workshops. Our counselors provide culturally sensitive and linguistically appropriate services to the Japanese American community throughout Southern California and uses a variety of therapies that cut through cultural barriers to understanding.

Samoan National Nurses Association

SNNA was established in 1996. The mission of SNNA is to assist the Samoan community to better health . SNNA works to improve and expand the community's opportunities through quality health education, prevention screenings and primary health services, local and national policy advocacy, community organizing, community-based research and developing resources and linkages with government and community healthcare agencies.

Given that Pacific Islanders are by nature and their culture a religious people, SNNA's primary collaboration has been with faith-based organizations. SNNA works together with pastors and their congregations to utilize their capacity to adequately share and disseminate health information by holding youth and adult community forums, focus groups and workshops where information/ findings will be shared through the church affecting all generations and promoting community .

South Asian Network

South Asian Network was founded in 1990 to provide an open forum for people of South Asian origin to gather and discuss social, economic, and political issues affecting the community, with the goal of raising awareness, engagement and advocacy among community members leading to empowerment. As the South Asian American community continues to grow, SAN is committed to challenging systems of oppression and inequality, building solidarities with other communities, and achieving economic, political, and human right s for all. South Asian Network is a community-based organization advancing the health, well-being, and civil rights of South Asians in Southern California.

Special Service for Groups

Special Service for Groups (SSG) is a private, non-profit agency incorporated in 1952. SSG is a unique 'umbrella' organization, and currently operates over 25 major social service programs, located throughout Los Angeles and Orange Counties. SSG is renowned for effective fiscal and program management, in particular strong administration of public grants (Federal, State, County, City and regional).

SSG is a well-established and respected provider of comprehensive behavioral health services. SSG is a long-time contractor in excellent standing with the Los Angeles County Department of Mental Health (DMH). We are well known for our comprehensive and innovative program design and support to minority, Limited English Proficient (LEP) and other disenfranchised groups of all ages in need of services throughout the entire LA County. SSG currently operates twenty five (25) mental health outpatient project locations funded wholly or in part with DMH funds and in addition provides housing (directly operated and via community partnerships), vocational rehabilitation services, other employment services, Independent Living Skills training, and much more.

SSG is a leader in providing culturally competent community based behavioral health services. SSG is also noted for strategic community partnerships that include support and empowerment for grass roots associations, neighborhood groups, social enterprise start-up entities and more. SSG has also excelled in developing and leading multi-group collaborative efforts as a lead agency with the recognized fiscal and program management skills necessary for such efforts. SSG is highly diverse with more than 85% of the staff and board members representing minority communities. People with disabilities, people living with HIV/AIDS, and people of color make up over 80% leadership positions within SSG programs. SSG maintains local and national accreditation status -- being both State Medi-Cal certified as well as certification by the Commission on Accreditation of Rehabilitation Facilities (CARF). SSG is also one of the few nonprofit organizations nationwide with an accredited Institutional Review Board (IRB) under the direction of the SSG Research & Evaluation unit.

Attachment: Asian and Pacific Islander (API) Disparities

Executive Summary

From 2020-21 the Mental Health Commission's (MHC) Integrated Services and Cultural Competency subcommittee made a review and provided a recommendation regarding disparities of services to the Asian and Pacific Islander American (APIA Community in Los Angeles County and how it can be addressed within the Mental Health Services Act (MHSA).

The subcommittee made the following observations to the Commission the following:

The disparities of mental health services and attention to communities of color is especially acute in the APIA community. The disparity is apparent over a multiple years and admitted by the becoming Department of Mental Health (DMH) numerous times in testimony and MHSA-related documents. This has become a condition of "benign neglect."

The APIA disparity is not addressed in a meaningful way in the recent 3-year MHSA plan despite the data establishing the fact it is a multi-year the disparity exists while ; this Census the APIA population has increased to 15% in Los Angeles County.

The latest FSP data re: serving APIA community hovers around 5%. The APIA mental health community since 2019 supported by a Board of Supervisors motion and subsequent DMH memos accentuates the APIA admits disparity in Los Angeles County.

The alarming glaring disparity that exists is that APIA services and funding is NOT being addressed by DMH.

There is a need to identify and addressing the APIA disparity and other issues contained in the Board 2019 motion with clear service and funding related recommendations.

RECOMMENDATION: *The Mental Health Commission recommends the Board of Supervisor consider funding APIA community based mental health services to address disparities and the DMH provide the gap analysis information to the Board and MHC as outlined in the 2019 Board Motion. In addition, the testimony to the MHC of Dr. Herb Hatanaka regarding the APIA mental health service disparities and how they can be addressed via MHSA be reviewed.*

---

1. Background

Per State law - Welfare Institutions Code (WIC)Section 5812.5(d), 5868(b), 5878.1(a); and, 9 California Code of Regulations (CCR) Section 3200.100 — requires a county's' MHSA 3 Year Plan to address disparities, cultural and linguistic competency by incorporating and working to achieve the following goals listed below into all aspects of policy-making, program design, administration and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocoled procedure are developed as necessary to achieve the following goals:

- *Equal access to services of equal quality is provided, without disparities among racial/ethnic, cultural and linguistic populations or communities.*
- *Treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.*
- *Disparities in services are identified and measured, strategies and programs area developed and implemented , and adjustments are made to existing programs to eliminate these disparities.*
- *An understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups is incorporated into policy, program planning, and service delivery.*
- *An understanding of the impact historical bias, racism, and other forms of discrimination have upon each racial/ethnic, cultural, and linguistic population or community is incorporated into policy, program planning, and service delivery.*
- *An understanding of the impact bias, racism, and other forms of discrimination have on the mental health of each individual served is incorporated into service delivery.*
- *Services and supports utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community they serve.*
- *Staff, contractors, and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and/or linguistic population or community they serve.*
- *Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involve din service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community.*

The Board of Supervisors in 2017 directed the DMH Director to develop strategies to reduce disparities in the delivery of mental health services to underrepresented ethnic and cultural communities, focusing on the Asian and Pacific Islander community, in part, how are these addressed in the DMH MHSA Three Year Plan. The motion also instructs DMH to report back to the Board of Supervisors on a gap analysis of disparities and areas that are underrepresented and how to address those issues throughout Los Angeles County.

Specifically, the 2017 motion unanimously passed by the Board of Supervisors:

a) Directed the Director of Mental Health to include in the Mental Health Services Act Three Year Plan recommendations on outreach strategies to address the need of the API community for mental health services to the Countywide population over the next five years. A recommendation should address appropriate allocations for CSS funding for individuals with serious mental illness and MHSA Prevention and Early Intervention funding in all age groups:

b) Required the Department of Mental Health to conduct an evaluation to determine specific areas of geographic and programmatic disparities in order to develop a targeted outreach strategy for addressing the needs of the API population;

c) Required the Director of Mental Health or his staff to collaborate with groups that provide mental health services to the API population to enhance existing successful outreach approaches and identify new strategies for decreasing disparities in mental health care among this population including the options of expanding the service network; and

d) Instructed the Director of Mental health to report back to the Board a gap analysis on disparities and areas that are underrepresented, how to address those issues, and disparities in funding throughout the County.

These cultural and linguistic disparities are particularly prevalent within the Los Angeles County Asian Pacific Islander populations, and like others, deserves great deal of attention within the DMH MHSA 3 Yr Plan. Additionally, it is unclear how and adequately these disparities are addressed in the Plan.

2. Data

A report published by Mental Health America highlights that more than 10 million adults in the U.S have an unmet need for mental health treatment.

(see link: https://mhanational.org/issues/state-mental-health-america)

The National Council for Behavioral Health (NCBH) also reports that:

"Mental health services in the US are insufficient despite more than half of Americans (56%) seeking help."

"Limited options and long waits are the norm, but some bright spots with 76% of Americans now seeing mental health as important as physical health."

The National Council for Behavioral Health makes reference to three big issues: high cost and insufficient insurance coverage; lack of awareness; and stigma. Below are excerpts from the NCBH.

High Cost and Insufficient Insurance Coverage*: Forty-two percent of the population saw cost and poor insurance coverage as the top barriers for accessing mental health care. One in four (25%) Americans reported having to choose between getting mental health treatment and paying for daily necessities.*

Limited Options and Long Waits*: Access to face-to-face services is a higher priority for Americans seeking mental health treatment than access to medication. Ninety-six million Americans, or 38%, have had to wait longer than one week for mental health treatments. And*

nearly half of Americans, or 46%, have had to or know someone who has had to drive more than an hour roundtrip to seek treatment.

Social Stigma: *Nearly one-third of Americans, or 31%, have worried about others judging them when they told them they have sought mental health services, and over a fifth of the population, or 21%, have even lied to avoid telling people they were seeking mental health services. This stigma is particularly true for younger Americans, who are more likely to have worried about others judging them when they say they have sought mental health services (i.e., 49% Gen Z vs. 40% Millennials vs. 30% Gen X vs. 20% Boomers).*

The following provides a glaring picture of regarding unmet needs for mental health services among California and Los Angeles County Adults:

In a recent UCLA Health Policy Brief, co-authored by Los Angeles County's Mental Health Commissioner Imelda Padilla-Frausto, "Based on data from the 2018 California Health Interview Survey (CHIS), approximately 11 million California adults were MHSA eligible due to their insurance status. Over one-quarter of these (3 million) reported psychological distress, with the majority (1.8 million) reporting unmet needs for services. Policies that could reduce this unmet need include expanding the breadth and reach of PEI programs and increasing efforts to develop a robust, culturally and linguistically competent workforce across all MHSA services."

Commission Padilla-Frausto also provided the MHC a supplemental document based on this policy brief that has LA County specific data:

" In 2018, over one-quarter or 700,000 of Los Angeles County MHSA-eligible adults reported symptoms indicating a need for public mental health services (Exhibit 1).

"• 15.1% or 500,000 MHSA-eligible adults reported symptoms associated with serious psychological distress, an estimate of adults with serious diagnosable mental health disorders that warrant mental health treatment.[1]

"• 12.0% or 400,000 MHSA-eligible adults reported symptoms associated with moderate psychological distress, an estimate of adults with mental distress that are clinically relevant and warrants mental health intervention.[2] "

The "LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH OFFICE OF ADMINISTRATIVE OPERATIONS - CULTURAL COMPETENCY UNIT - CULTURAL COMPETENCE PLAN UPDATE – FY 2019," pages 90-100, analyzes and assesses the unmet need for mental health services in the County, specifically:

***Disparity by Race/Ethnicity (African American, Asian/Pacific Islander Population, Latino, Native American, White) Within Service Areas 1-8;*

*** Disparity by Language;*

***Disparity by Age (0-15, 16-25, 26-59, 60+) Within Service Areas 1-8; and,*

***Disparity by Gender Within Service Provider Areas.*

(see link: http://file.lacounty.gov/SDSInter/dmh/1061452_2019CCPlanCR1-8FINAL.pdf)

These findings show those who have the greatest need for services include Latino and Asian American adults, adults who are noncitizen, and adults with no to low English proficiency, and in pronounced in specific Service Areas of the County. It also reinforces the Board's motion of 2017 and other related motions such as: Improving and Expanding the Mental Health Delivery Service for Underserved Latino Communities throughout Los Angeles County,

(see link: http://file.lacounty.gov/SDSInter/bos/supdocs/146649.pdf)

In 2017, the Board of Supervisors unanimously passed a motion that:

a) Directed the Director of Mental Health to include in the Mental Health Services Act Three Year Plan recommendations on outreach strategies to address the need of the API community for mental health services to the Countywide population over the next five years. A recommendation should address appropriate allocations for CSS funding for individuals with serious mental illness and MHSA Prevention and Early Intervention funding in all age groups:

b) Required the Department of Mental Health to conduct an evaluation to determine specific areas of geographic and programmatic disparities in order to develop a targeted outreach strategy for addressing the needs of the API population;

c) Required the Director of Mental Health or his staff to collaborate with groups that provide mental health services to the API population to enhance existing successful outreach approaches and identify new strategies for decreasing disparities in mental health care among this population including the options of expanding the service network; and

d) Instructed the Director of Mental health to report back to the Board a gap analysis on disparities and areas that are underrepresented, how to address those issues, and disparities in funding throughout the County.

These cultural and linguistic disparities are particularly prevalent within the Los Angeles County Asian Pacific Islander populations, and like others, deserves great deal of attention within the DMH MHSA 3 Yr Plan. Additionally, it is unclear how and adequately these disparities are addressed in the Plan.

Issues & Data

The Mental Health Services Act funding is intended to address access to care disparities for all communities of color and underserved populations unfortunately the data points to a historic and continued lack of progress in this for the API communities of Los Angeles County.

In an August 17, 2016, DMH document entitled, "Mental Health Service Act (MHSA) 3 Year Program & Expenditure Plan, Fiscal Years 2017-18 through 2019-20 Planning Process," the API total population was 14.6%. Yet, API populations represent 5.35% of the CSS clients served and 2.64% of the PEI clients served. The document pointed out that regarding PEI Programs"[t]he numbers suggest that Asian/Pacific Islanders and Whites may the ethnic groups in most need of services."

("Mental Health Service Act (MHSA) 3 Year Program & Expenditure Plan, Fiscal Years 2017-18 through 2019-20 Planning Process," pp. 19-22, 24-25, 27-28)

Today, per the Untied State Census, the Asian, Native Hawaiian and Pacific Islander population in Los Angeles County is 15.8%. (see link: https://www.census.gov/quickfacts/losangelescountycalifornia) However, within the MHSA 3-year plan brought before the Board of Supervisors, API populations continue to represent 5% of all CSS clients and 3% f all PEI clients served by DMH. (see pages 32 and 65 respectively of the DMH MHSA 3 Yr Plan)

In a LAC/DMH memo to the L.A. County Board of Supervisors dated May 30, 2017 and titled "Strategies To Reduce Disparities to Mental health Services in Underrepresented Ethnic and Cultural Communities (Item No. 8, Agenda of February 21, 2017)" [hereafter called "DMH Memo"], the fact that "API, as a group, do not utilize public mental health services in proportion to either their relative percentage of the County's population or estimated mental health prevalence rate" is recognized.

(LAC/DMH memo to the L.A. County Board of Supervisors dated May 30, 2017 and titled "Strategies To Reduce Disparities to Mental health Services in Underrepresented Ethnic and Cultural Communities)

Dr. Herbert K. Hatanaka, DSW, is the Co-Chair of the Asian Pacific Planning Council's (A3PCON) Mental Health Committee, an established coalition of community-based organizations that advocates for the rights and needs of Asian and Pacific Islander American Community in the greater Los Angeles area, with a particularly focus on low income, immigrant, refugee and other disadvantaged sectors of population since 1976. Dr. Hatanaka in written testimony to the MHC regarding the DMH MHSA 3 Yr Plan noted the following:

"As a network of providers A3PCON continues to be concerned about the lack of targeted effort by the Department of Mental Health to address the longstanding disparities in mental health service access for Asian Pacific Islanders communities in this county. ***We do not see any significant targeted commitment to address disparities and cultural competence in the three year MHSA Plan submitted by DMH for your review and approval.*** *API's continue to represent less than 4% of all clients served by DMH while representing 16% of the County's total population. While the Mental Health Services Act funding is intended to address access to care disparities for all communities of color and underserved populations we unfortunately have seen no progress in reducing this disparity of access to care for the API communities of this county.*

Furthermore as the UCLA Center for Health Policy Research points out in their review of MHSA and unmet mental health need, the level of unmet need (both serious and moderate) is highest for Latino and Asian Pacific Islander communities relative to the other racial groups.

"Since Supervisor Hahn s original Board motion in February 2017 to direct DMH to develop a plan to address API disparities and the subsequent DMH plan submitted to the Board on May 30, 2017, A3PCON has provided recommendations and expansion proposals to DMH for FSP, PEI and Innovations over a three year period. We are attaching summaries of these proposals for your review. " (see Asian Pacific Policy & Planning Council s Proposal for Addressing Unmet Mental Health Need of the Asian Pacific Islander Community: Written Testimony to the Los Angeles County Mental Health Commission)

Asian Pacific Policy & Planning Council's Proposal for Addressing Unmet Mental Health Need of the Asian Pacific Islander Community:

Written Testimony to the Los Angeles County

Mental Health Commission

Dr. Herbert K. Hatanaka, DSW

Co-Chair, Mental Health Committee

July 2, 2020

Dear Commissioners Acebo, Ogawa and the Mental Health Commission,

I am Dr. Herbert K. Hatanaka, Executive Director of Special Service for Groups (SSG) and the Co-Chair of the Mental Committee of the Asian Pacific Policy and Planning Council (A3PCON). The committee is composed of 12 culturally competent community based mental health agencies serving the Asian Pacific Islander communities in Los Angeles County including two directly operated DMH clinics. This network of API provider agencies are fully staffed with multi-disciplinary staffing providing services in 12 API languages in every Supervisorial District and annually serves over 10,000 clients. This network of API provider agencies represents the foundation in the DMH system for the provision of culturally competent mental health care in the County of Los Angeles.

As a network of providers A3PCON continues to be concerned about the lack of targeted effort by the Department of Mental Health to address the longstanding disparities in mental health service access for Asian Pacific Islanders communities in this county. **We do not see any significant targeted commitment to address disparities and cultural competence in the three year MHSA Plan submitted by DMH for your review and approval.** API's continue to represent less than 4% of all clients served by DMH while representing 16% of the County's total population. While the Mental Health Services Act funding is intended to address access to care disparities for all communities of color and underserved populations we unfortunately have seen no progress in reducing this disparity of access to care for the API communities of this county. Furthermore as the UCLA Center for Health Policy Research points out in their review of MHSA and unmet mental health need, the level of unmet need (both serious and moderate) is highest for Latino and Asian Pacific Islander communities relative to the other racial groups.

Since Supervisor Hahn's original Board motion in February 2017 to direct DMH to develop a plan to address API disparities and the subsequent DMH plan submitted to the Board on May 30, 2017, A3PCON has provided recommendations and expansion proposals to DMH for FSP, PEI and Innovations over a three year period. We are attaching summaries of these proposals for your review.

We fully understand the importance of mental health related issues facing this County such the continued rises in the mentally ill among the homeless and justice involved populations and of course the life threatening COVID-19 pandemic that all of us face. However we respectfully like to point out that in regards to COVID-19 that communities of color including APIs are disproportionately represented in the highest rates of infection and death and this is attributed to the historic lack of access to health and mental health care.

We would respectfully appreciate your response and support for an amendment to the County's MHSA 3 year plan to address the mental health services disparity of culturally competent services for our Asian Pacific Islander communities. Please feel free to contact me for any questions or clarification of our proposals that we have previously submitted to the department.

Sincerely,

Herbert Hatanaka, A3PCON MH Committee, Co-chair

ASIAN PACIFIC POLICY AND PLANNING COUNCIL (A3PCON)

Recommendations to LAC/DMH on Prevention & Early Intervention (PEI) Services for Asian and Pacific Islander (API) Communities

INTRODUCTION & ISSUE

In the LAC/DMH memo to the L.A. County Board of Supervisors dated May 30, 2017 and titled "Strategies To Reduce Disparities to Mental health Services in Underrepresented Ethnic and Cultural Communities (Item No. 8, Agenda of February 21, 2017)" [hereafter called "DMH Memo"], the fact that "API, as a group, do not utilize public mental health services in proportion to either their relative percentage of the County's population or estimated mental health prevalence rate" is recognized. Such underutilization is particularly glaring when it comes to PEI services. For example, in the "Mental Health Services Act Annual Update, Fiscal Year 2018-19" document prepared by LAC/DMH, APIs constituted only about 2.5% of all those who received PEI services in Los Angeles County in Fiscal Year 2016-17.

In response to the recommendations contained in the "Summary of Gaps and Recommendations to Reduce Mental Health Disparities Among API Communities" Table of this DMH Memo [hereafter called "Summary Table"], a PEI Workgroup [hereafter called the "Workgroup"] was formed by A3PCON Mental Health Committee to:

1. Review the status of current Prevention and Early Intervention (PEI) services in the Asian and Pacific Islander (API) communities in Los Angeles County;
2. Identify PEI service gaps and needs; and
3. Develop culturally responsive recommendations to address the identified service gaps and needs.

The Workgroup meetings have been attended by a total of over 30 service consumers and family members, service providers, and other community stakeholders. The Workgroup met on: 5/30/18, 6/20/18, 6/27/18, 7/25/18, 9/26/18, 10/24/18 and 11/28/18. Data collection and proposal preparation was conducted during the first four months of 2019. The current proposal was reviewed and approved by A3PCON Mental Health Committee and A3PCON Board on 5/22/19 and _____ respectively.

SUMMARY OF RECOMMENDATIONS

1. Approve as allowable activities and services under PEI Expansion funding all "Community-Defined Programs and Strategies" in the "California Reducing Disparities Project API Population Report." (http://crdp.pacificclinics.org/files/resource/2013/04/Report.pdf)
2. Approve $3,360,000 of new PEI Expansion funding to address the identified PEI service gaps in the API communities immediately and approve an increase of 50% for each of the following two years.

3. Approve API community-based agencies currently not having service contracts with LAC/DMH to provide PEI Expansion services.

RECOMMENDATIONS AND REATIONALE

Recommendation #1

Approve as allowable activities and services under PEI Expansion funding all "Community-Defined Programs and Strategies" in the "California Reducing Disparities Project API Population Report"
(http://crdp.pacificclinics.org/files/resource/2013/04/Report.pdf)

[This Recommendation addresses #2, #3 and #5 of the "Recommended Solutions/Priority Service Areas/Pop" under #1 of the "System Level Strategies," as well as #1 and #3 of the "Recommended Solutions/Priority Service Areas/Pop" under #2 of the "System Level Strategies" in the Summary Table of the DMH Memo.]

The compendium document of the "California Reducing Disparities Project APA Population Report" titled "Appendices: Community-Defined Promising Practices" includes summary information on 56 "Community-Defined Programs and Strategies" that have been developed by diverse API community behavioral and mental health service programs in California. These programs and strategies have all met the review criteria for inclusion in the document through a process and a format that parallel those used by LAC/DMH to create its list of "PEI Community Defined Evidence (CDE) Programs."

These 56 evidence-based programs and strategies all have a high level of community relevance and varying degree of program evaluation outcome data support. In addition, they not only cover the Asian American, Pacific Islander, South Asian, and Southeast Asian populations but also 24 distinctive ethnic groups within them. These API ethnic groups include Afghani, Bhutanese, Burmese, Cambodian, Chamorro, Chinese, Filipino, Hmong, Indian, Iranian, Iraqi, Iu-Mien, Japanese, Korean, Lao, Mongolian, Native Hawaiian, Nepali, Punjabi, Samoan, Thai, Tibetan, Tongan, and Vietnamese.

Given the very limited number of PEI CDE programs and strategies in the LAC/DMH list that are culturally appropriate and relevant with the API populations, these 56 evidence-based programs and strategies will greatly increase the availability of culturally competent PEI services to the API communities in Los Angeles County. It is therefore recommended that all the 56 evidence-based programs and strategies contained in the "California Reducing Disparities Project API Population Report" be approved as allowable activities and services under PEI Expansion funding. Such *en mass* approval of programs and strategies has a precedent in the recent approval by LAC/DMH of all DCFS Prevention and Aftercare (PnA) services and approaches as allowable ones for PEI Expansion funding.

Recommendation #2

Approve $3,360,000 of new PEI Expansion funding to address the identified PEI service gaps in the API communities immediately and approve an increase of 50% for each of the following two years.

[This Recommendation addresses #2, #3 #5 and #6 of the "Recommended Solutions/Priority Service Areas/Pop" under #1 of the "System Level Strategies," #1 and #3 of the "Recommended Solutions/Priority Service Areas/Pop" under #2 of the "System Level Strategies," as well as #1 of the "Recommended Solutions/Priority Service Areas/Pop" under #1 of the "Program Level Strategies" in the Summary Table of the DMH Memo.]

In addition to identifying the current LAC/DMH funded PEI services that are specific for the API populations, the Workgroup conducted a survey with diverse API community service programs and agencies in Los Angeles County. The survey asked about both the PEI service needs in their respective communities and their capacity to provide the needed services to their constituents using the LAC/DMH list of PEI CDE programs and/or some of the 56 evidence-based programs and strategies included in the "California Reducing Disparities Project API Population Report." Snowball technique was used to broaden the outreach to as many of the API programs and agencies in Los Angeles County as possible when the Workgroup conducted this survey. The "Expanded PEI Needs, Gaps & Proposed PEI Intervention Matrix" (hereafter called the "Gaps and Needs Matrix") in Appendix 1 of this document is a summary of those PEI service gaps and those API community programs and agencies that have current organizational capacity to provide PEI Expansion services to meet those needs if funding is made available to them.

To begin the process of meeting the glaring gaps in, and urgent needs for, PEI services in the API communities, it is recommended that LAC/DMH approves $3,360,000 of new PEI Expansion funding *immediately* to address the identified needs in the "Gaps and Needs Matrix" in Appendix 1. Such funding will help ensure that culturally competent evidence-based PEI programs and strategies will be more available to these grossly underserved API ethnic communities. Specifically, it will provide PEI services to an additional 2,100 API consumers and family members.

In the Summary Table of the DMH Memo, #6 of the "Recommended Solutions/Priority Service Areas/Pop" under #1 of the "System Level Strategies" calls for an increase of 20% each year in the number of API consumers served and the community contacts as the overall goal. By approving the PEI-Expansion funding level proposed here, this overall goal can be met (and, in fact, exceeded) for PEI services.

Even with the approval of this recommended PEI Expansion funding and the increase in the number of APIs served by these additional PEI services, APIs will still be underserved. This is the case because their service utilization rate still will not have caught up with their percentage of the County population. It is thus further recommended that the initial PEI Expansion funding proposed above (i.e. $3,360,000) be increased by 50% each year in Year 2 and Year 3. By doing so, it will further increase the availability of the very much needed PEI services to the diverse API ethnic populations in Los Angeles County.

Recommendation #3

Approve API community-based agencies currently not having service contracts with LAC/DMH to provide PEI Expansion services.

[This Recommendation addresses #1 and #2 of the "Recommended Solutions/Priority Service Areas/Pop" under #1 of the "System Level Strategies," #1 and #3 of the "Recommended Solutions/Priority Service Areas/Pop" under #2 of the "System Level Strategies," #1 and #3 of the "Recommended Solutions/Priority Service Areas/Pop" under #1 of the "Program Level Strategies," as well as #1 of the "Recommended Solutions/Priority Service Areas/Pop" under #2 of the "Program Level Strategies" in the Summary Table of the DMH Memo.]

It is clear from the "Gaps and Needs Matrix" in Appendix 1 of this document that the API community mental and behavioral health agencies and programs that are currently funded to provide PEI and PEI Expansion services are vital but insufficient to meet the service gaps and needs identified. Such is the case because the PEI service needs of the diverse API ethnic communities in Los Angeles County are far greater than the capacity of these limited number of current LAC/DMH contract agencies to address them. In addition to augmenting the funding of these current LAC/DMH contract agencies to provide additional PEI Expansion services, it is therefore recommended that new API community-based agencies that currently do not have service contracts with LAC/DMH be added to this PEI service delivery network. Those API community-based agencies and programs identified in the "Gaps and Needs Matrix" in Appendix 1 that currently do not have LAC/DMH service contracts are particularly recommended to be approved as LAC/DMH contract agencies so that they can provide culturally competent PEI Expansion service to the diverse API ethnic communities in Los Angeles County.

Appendix A

Expanded PEI Needs, Gaps & Proposed PEI Expansion Matrix

A3PCON MH Committee

Expanded PEI Needs, Gaps & Proposed PEI Interventions Matrix

Agency Name	If currently funded, list the DMH CDE Program or CRDP-API Wkgrp Promising Practices Used	Current API Ethnic Group(s) Served	Current PEI Funding	Current PEI-COS Funding	If Expanded PEI (Non-MediCal) Funding were available, what could your agency accommodate in Year 1?	# of API Clients that could be served with additional PEI funding	Proposed PEI Inteventions to be Used with Expanded PEI Funding & Target Populations that Will Be Served (in brackets)
Children's Hospital Los Angeles	Incredible Years - Baby, Attentive, School Years (Basic & Advanced)	Filipino (English- and Tagalog-speaking)	$ 97,396.00	$ -	$ 250,000.00	200	Incredible years - All Ages (Basic & Advanced)[1] [Filipino - English- and Tagalog-speaking]
Asian Pacific Family Center (APFC), Pacific Clinics	TF-CBT, MAP, Seeking Safety, IPT, PST,ART, PPP, AAFEN, SCALE	Chinese, Vietnamese, Korean, Cambodian	$ 767,000.00	$ 100,000.00	$ 300,000.00	160	AAFEN[3] and SCALE[4] [Chinese, Korean, & Vietnamese]
KFAM	Seeking Safety	Korean Primarily, but not exclusive	$ 65,950.00	$ 3,000.00	$ 220,000.00	75	PREP[3] [Korean]
SSG - Alliance	Mental Health First Aid, Seeking Safety	Filipino, Samoan, South Asian, Japanese, Cambodian	$ 10,000.00	$ 250,000.00	$ 300,000.00	200	Seeking Safety[1] and Mental Health First Aid[3] [Japanese, Korean, Mandarin, Cantonese, Vietnamese, Tagalog, Urdu, Hindi]
Pacific Asian Counseling Services (PACS)	Seeking Safety, Family Connections, TF-CBT, MAP	Cambodian, Korean, Chinese, Japanese, Vietnamese	$ 694,000.00	$ 184,000.00	$ 150,000.00	175	Parent-Child Psychotherapy[2], Active Parenting[3], and Mental health First Aid[3] [Cambodian, Korean, Chinese, Japanese, Samoan, Vietnamese, Thai, Filipino]
LTSC	CBT, CORS, Family Connections, IPT, PEARLS, PST, Seeking Safety, Mental Health First Aid	Japanese, Korean, Chinese	$ 100,000.00	$ 25,000.00	$ 150,000.00	75	API Connections[2], SITIF[2], In-Home Mental Health Support[2], Outreach Groups (UCI)[2], AAFEN[2], SCALE[2], Nikkei Tomodachi Program[2] [Japanese, Korean, Chinese]
SSG-APCTC	Seeking Safety, MAP, Family Connection, IPT, CORS, PST, MHIP, PEARLS, ICBT	Chinese, Korean, Japanese, Tagalog, Vietnamese, Laotian, Thai, Khmer	$ 916,802.00	$ 20,000.00	$ 200,000.00	75	Seeking Safety[2], PEARLS[1], CORS[1] and Family Connections[1] [Cambodian, Chinese, Filipino, Japanese, Korean, Laotian, Thai, Vietnamese]
Cambodian Assn of America	PEARLS, Seeking Safety, CORS, IPT	Cambodian, Vietnamese, Thai, Laotian, Hmong	$ -	$ 100,000.00	$ 200,000.00	100	Southeast Asian Consumer Advocacy Program[2], Outreach Groups[2], Southeast Asian Support Group[2] [Cambodian, Laotian/Hmong, Thai, Vietnamese]
South Asian Network	PEARLS, Seeking Safety, CORS	South Asian	$ 30,000.00	$ 108,000.00	$ 90,000.00	40	SITIF[2], Elder Multicultural Access & Support Services Program (EMASS)[2], IMPACT[2] [South Asian]

Korean Youth & Community Center (KYCC)	Triple P, MAP, ICBP, CORS, Seeking Safety	Korean Primarily, but not exclusive	$ 123,524.00	$ 18,699.00	$ 400,000.00	400	Lotus Blossom [parent-child play group][3], Incredible Years - BASIC Pre-school Program (with cultural adaptation)[3], AAFEN[3], SITIF[3], Health Navigation[3], Outreach Groups (UCI)[3] [Korean]
NAPAFASA		Chinese, Multi-ethnic	$ -	$ -	$ 200,000.00	200	"Problem Gambling Prevention Project" intervention[2] [Chinese, Multi-ethnic]
AP Healthcare Venture		API multi-ethnic populations	$ -	$ -	$ 200,000.00	50	Asian Primary Care Integration[2] [Chinese, Vietnamese, Korean, Multi-ethnic]
Asian Youth Center		Chinese/Multi-ethnic	$ -	$ -	$ 200,000.00	100	MPG (Mindful Parenting Groups)[1], PATHS (Promoting Alternative Thinking Strategies)[1] [Mandarin, Cantonese, and Vietnamese speaking immigrant parents and Asian American Youth]
API Equality - LA		API Multi-ethnic populations	$ -	$ -	$ 200,000.00	100	FMHI [Filipino Mental Health Initiative - adapted for API LGBT][3] [Multi-ethnic]
Family in Good Health		Cambodian	$ -	$ -	$ 100,000.00	50	Change Together[3], Outreach Groups[3], Southeast Asian Support Group[3] [Cambodian]
Khmer Girls in Action		Cambodian	$ -	$ -	$ 100,000.00	50	Inspire and Mobilize People to Achieve Change Together[3], Outreach Groups[3], Southeast Asian Support Group[3] [Cambodian]
United Cambodian Community		Southeast Asian, Cambodian, Vietnamese, Thai, Laotian, Hmong	$ -	$ -	$ 100,000.00	50	Meta (Mercy Health)[3], Outreach Groups[3], Southeast Asian Support Group[3] [Cambodian]
		TOTAL	$2,804,672	$ 808,699.00	$3,360,000.00	2100	

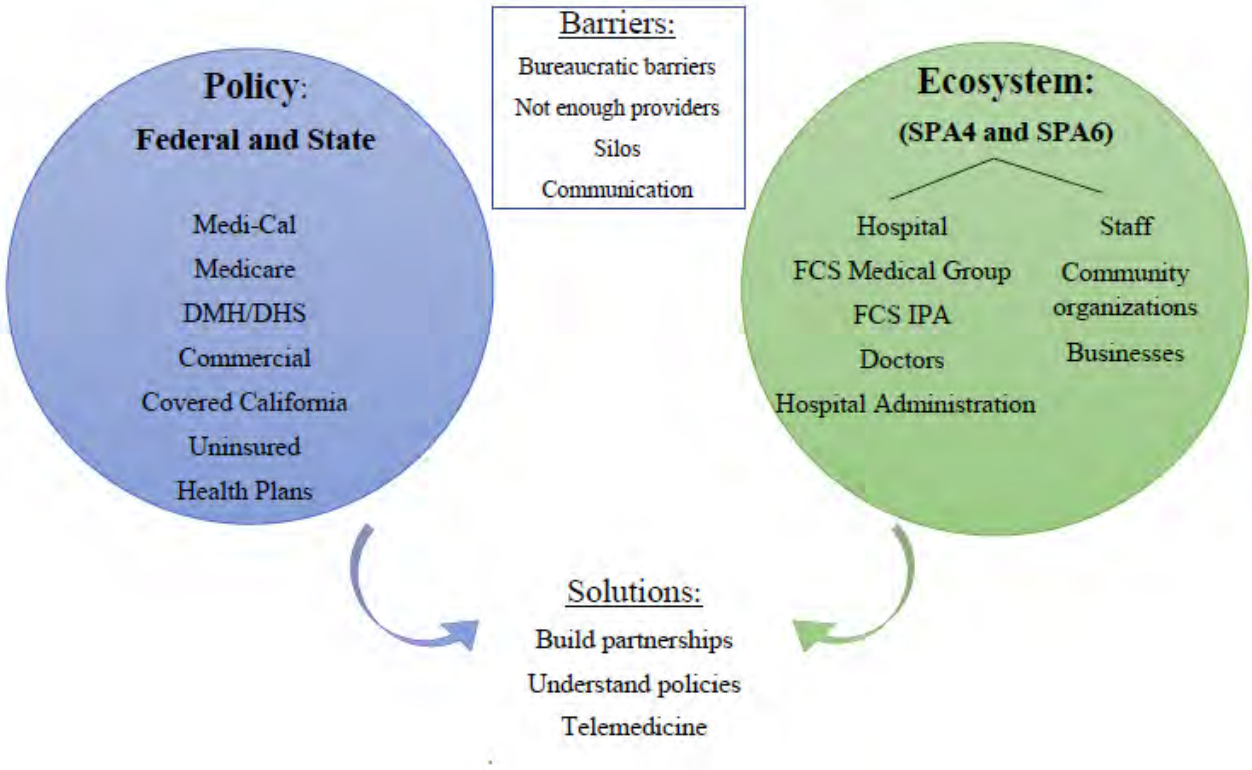
Black - Existing DMH Contract or Subcontract Agencies; Red - Currently Non DMH Contract Agencies

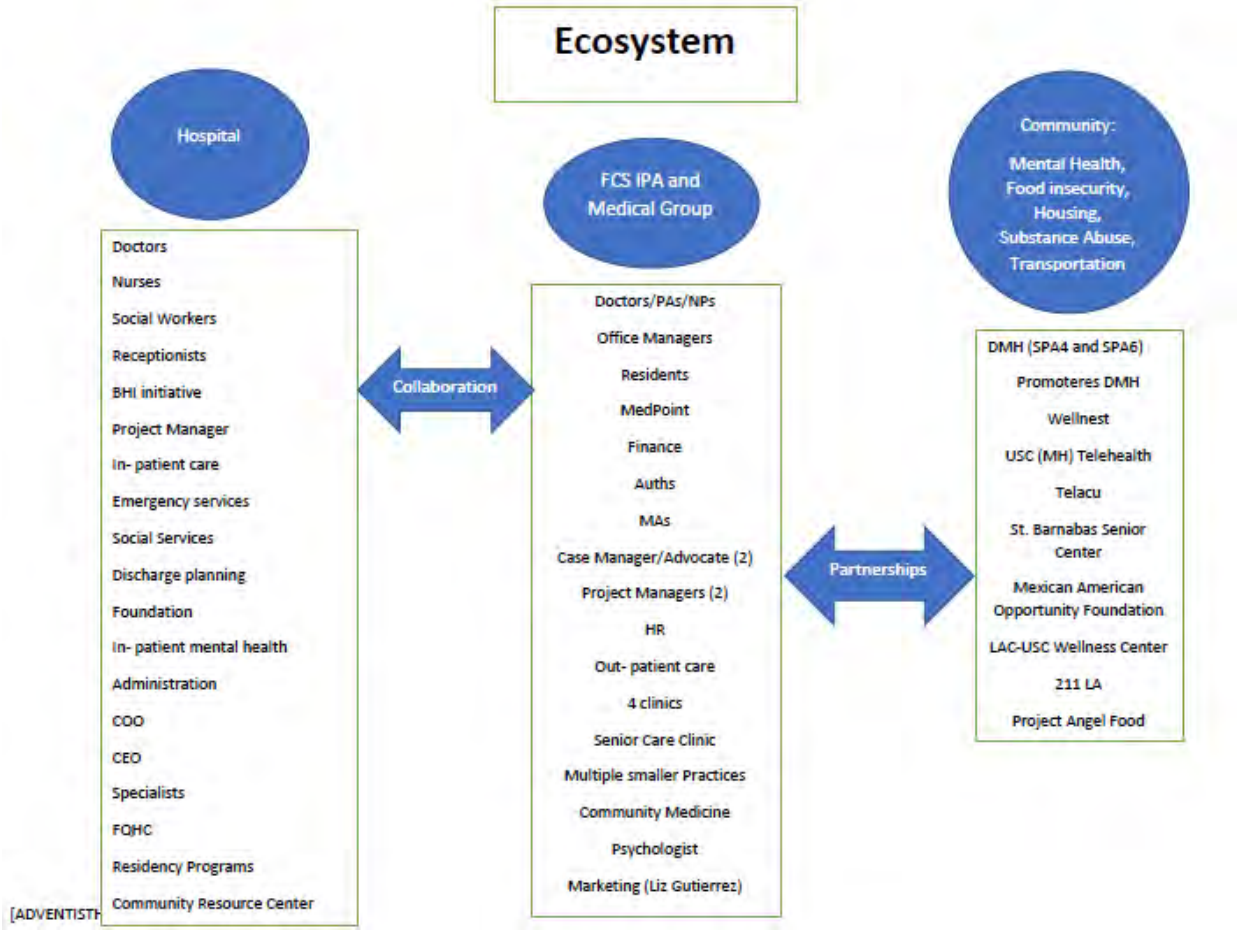
[1]LAC/DMH PEI Resource Guide 2.0

[2]CRDP-API Workgroup Promising Programs & Strategies

[3]Federal SAMHSA NREP

Game Plan for Integration




Ecosystem
Hospital
Doctors
Nurses
Social Workers
Receptionists
BHI initiative
Project Manager
In- patient care
Emergency services
Social Services
Discharge planning
Foundation
In- patient mental health
Administration
COO
CEO
Specialists
FQHC
Residency Programs
Community Resource Center
[ADVENTIST
Collaboration
FCS IPA and Medical Group
Doctors/PAs/NPs
Office Managers
Residents
MedPoint
Finance
Auths
MAs
Case Manager/Advocate (2)
Project Managers (2)
HR
Out- patient care
4 clinics
Senior Care Clinic
Multiple smaller Practices
Community Medicine
Psychologist
Marketing (Liz Gutierrez)
Partnerships
Community:
Mental Health, Food insecurity, Housing, Substance Abuse, Transportation
DMH (SPA4 and SPA6)
Promoteres DMH
Wellnest
USC (MH) Telehealth
Telacu
St. Barnabas Senior Center
Mexican American Opportunity Foundation
LAC-USC Wellness Center
211 LA
Project Angel Food

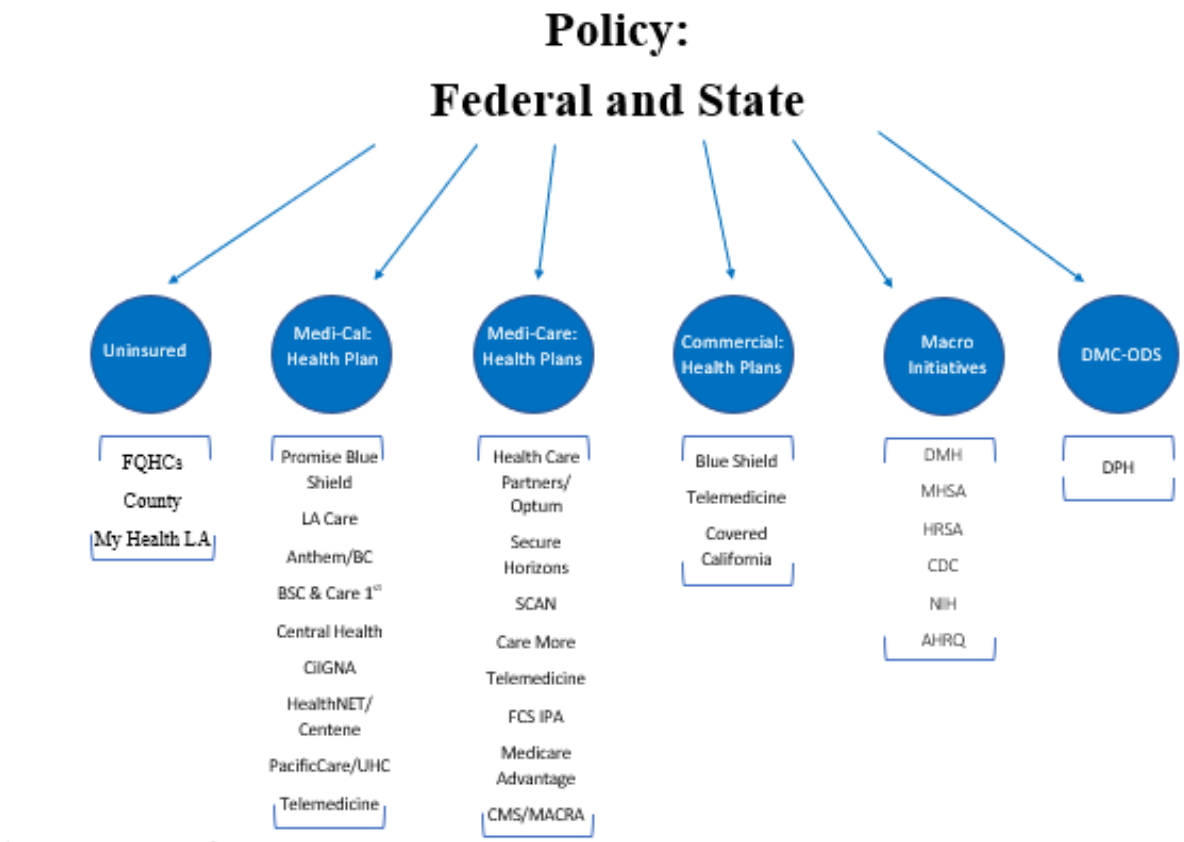


EXHIBIT F – LACDMH RESPONSE TO MHC

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

May 27, 2022

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 W. Temple Street
Los Angeles, CA 90012

Stacy Dalgleish
Chair, Mental Health Commission
510 S. Vermont Avenue
Los Angeles, CA 90020

RESPONSE TO MENTAL HEALTH COMMISSION INQUIRIES ON THE PUBLIC HEARING FOR THE MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2022-2023

On May 4, 2022, the Los Angeles County Mental Health Commission (Commission) submitted a letter reflecting their comments and inquiries to the Los Angeles County Board of Supervisors (Board) and the Department of Mental Health (DMH) pertaining to the April 28, 2022, public hearing on the Fiscal Year (FY) 2022-23 Mental Health Services Act (MHSA) Annual Update (Annual Update). In the Commission's letter, DMH was commended for its continued efforts to strengthen the community engagement process related to the Annual Update development and its partnership with key stakeholder groups to ensure the Annual Update represented and addressed the expressed needs of each community (with special attention to those communities most at risk and those disproportionately impacted by disparities). The Commission submitted several recommendations for the review and consideration of your Board and DMH centering around four broad themes:

1. Inequities/Disparities
2. Housing and Homelessness
3. Budget and Accountability
4. Criminal Justice

The following are DMH's responses to the Commission's recommendations:

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

- Data: The Commission acknowledged DMH's inclusion of data metrics in this year's Annual Update, and requested improvements continue to be made in the areas of data collection, report out by Service Area (SA) and Supervisorial District (SD), and identifying inequities and data sources that can be used to help with clarifying unmet needs.

- Demographics: The Commission noted that DMH should be sensitive to and accountable for resolving inequities around: race and ethnicity, immigration status, geographic location, age (with an option for clients to elect their choice of programs from Transitional Age Youth (TAY), Adult or Older Adult categories), and physical and mental health condition. Special attention should be paid toward inequities in populations with physical disabilities and others who qualify under Americans with Disabilities Act status. The Commission also recommended special attention on increasing the access and resources for the Asian Pacific Islander American (APIA) population due to ongoing negative experiences from the communities as a reaction due to the COVID-19 Pandemic. In addition, it was noted that DMH should continue efforts to correct for disparities in funding across underserved and unserved populations, including ethnic populations in all SAs.

- Outreach to Families: The Commission acknowledged DMH's efforts to increase access for students and their families through robust collaboration with both Los Angeles Unified School District (LAUSD) and Los Angeles County Office of Education (LACOE). The Commission recommended continuing to increase efforts to expand school based mental health services.

In response to these recommendations and consistent with DMH's response to the Commission's recommendations to our Three-Year Plan/Annual Update, DMH notes its key role, along with other County departments and city governments; to reduce inequities around race, ethnicity immigration status, geographic locations, age and physical and mental health condition and in access to high quality health and mental health care.

DMH is working in line with the County's efforts to address barriers to seek treatment that include the composition and competencies of the workforce; addressing the barriers associated with the social determinants of health, culturally relevant engagement and education; and understanding the link between the disproportionate representation of specific cultures in the key focal populations we serve. DMH intends to bring multiple efforts together and merge governance and leadership together with linguistically appropriate communication, engagement, and continuous improvement to reduce disparities in mental health treatment and recovery.

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

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

- Posting on the DMH website a public-facing dashboard that will include key demographic data on the clients DMH serve in order to assess the impact of the Department's efforts to reach and serve clients from various ethnic and racial communities;

- Participate in the 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. The Department's Underserved Cultural Community (UsCC) groups and stakeholders, along with service and prevalence data, will help inform the populations of focus for this learning collaborative;

- Initiating ongoing learning on best practices for serving mental health clients with physical disabilities through the development of regular training, support and peer consultation; and

- Implementing 711 as a more effective and user-friendly solution for the deaf and hard of hearing population to contact the DMH Help Line.

Housing & Homelessness
The Commission noted that over the past year the County has established, and is in the process of opening, several Restorative Care Villages (RCV) Countywide thanks, in large part, to the advocacy, efforts and funding of DMH. The Commission acknowledged these efforts and recommended expanding the RCV model to additional campuses and to include children and youth mental health beds and services in the model in each SA.

In response to this recommendation, DMH is committed to investing MHSA funds to expand facilities for children and youth services on Harbor-University of California Los Angeles (UCLA), Martin Luther King Jr. (MLK) and Olive View, campuses, as well as the Antelpe Valley High Desert (High Desert). Below is a list of the facilities.

- Harbor-UCLA Children and Youth Outpatient Center
- MLK Children and Youth Outpatient Center
- Olive View Hub for Department of Children and Family Services (DCFS) Involved Children and Youth
- High Desert Children and Youth Outpatient Center
- High Desert Hub for DCFS Involved Children and Youth

Budget and Accountability
The Commission noted the current MHSA Fund Balance which is in excess of $1.0 billion, with the anticipation of increased funds coming from the State. The Commission commented that it is imperative that DMH drive this funding into the community by continuing to build up access to services, increasing funding to the stakeholder engagement groups, increasing the Countywide Activity Fund (CAF) and to other programs that will benefit Los Angeles County's mental health stakeholders and individuals with severe and persistent mental illness. The Commission also recommended the creation of dashboards for reporting both program and budget data per SA/SD.

In response to this recommendation, DMH will seek stakeholder engagement to obtain the needs of the community to determine how to spend-down the portion of the $1.0 billion one-time funds that is available for use, to a reasonable amount that will allow sufficient time to ramp down services in the event of an economic downturn in revenue, as applicable. DMH is finalizing the process to be used for this recommended action. The process will be provided by the beginning of FY 2022-23.

DMH is also working on dashboards for reporting both program and budget data by SA/SD. Reports will be published by July 1, 2022.

In addition, DMH committed to increasing the annual allocation for each of the UsCC groups to $350,000.00; and the stipend allotment for the Service Area Leadership Team (SALT), Community Leadership Team (CLT) and Cultural Competency Committee (CCC) Co-Chairs to $150.00 per month; both effective July 1, 2022. Also, the County Activity Fund (CAF) Program is currently under review, based on the restructuring of our Community Planning Process. The request for an increase in the CAF allocation will be decided by July 1, 2022.

Criminal Justice

The Commission acknowledged that a significant number of the jail's population have serious mental illness and commented that it was essential for DMH to do what it reasonably can to care for this vulnerable population. The Commission also acknowledged the positive work of the County's Department of Health Services Office of Diversion and Re-Entry (DHS-ODR) in moving forward the Board's Care First Jail Last initiative. The Commission voted to strongly recommend DMH to allocate $25 million a year, ongoing MHSA funds to support the DHS-ODR services to MHSA eligible clients and requested to receive additional outcome data from the DHS-ODR program.

In response to this recommendation, DMH Program and Finance staff members committed to working with DHS-ODR to finalize the spending plan and vet the completed proposal, with its details, internally with DMH Management. Upon approval, the proposal with be vetted with DMH stakeholders with the goal of supporting ODR services for MHSA eligible clients. Funding is contingent upon stakeholder engagement of the services to be provided under this program. The next steps will be provided to the Commission as they are dependent upon the outcome of the detailed proposal. If approved,per State DMH will require outcome data for these DHS-ODR services.

Additional Recommendations

In addition to the above recommendations, the Commission recommended the following for further exploration by DMH:

- Create a Workforce and Peer Certification Training & Employment program and provide adequate funding/increased funding for programs such as Careers for a Cause at Southwest College;
- Address workforce shortages;
- Develop a mentorship program in South Los Angeles for young boys and girls of color, similar to the MHSA funded program in the Antelope Valley;

- Fund additional TAY centers to take advantage of full continuum of health, mental health and supportive services, similar to those available at the MLK campus;

- Increase funding for care coordination services that foster integration of physical and behavioral health, working alongside health providers in primary care (Department of Health Services (DHS) sites, Federally Qualified Health Centers);

- Increase capacity of the Wraparound Services for Children and Youth in underserved areas, such as South Los Angeles;

- Maximize the scope of service/practice for Occupational Therapists, Recreation Therapists, and Psychiatric Technicians to alleviate staffing shortages;

- Conduct a needs assessment survey in the SAs/SDs to allow for the Supervisors to call on and get input from experts and interested parties, stakeholders and community members. Additionally, invite the Department of Public Health - Substance Abuse Prevention and Control, DHS-ODR and Chief Executive Office-Homeless Initiative directors to receive their input;

- Collect the unmet needs data in our communities using the Social Determinants of Health in South Los Angeles and across the County;

- Specify a plan for replacing West Central Mental Health clinic to continue to meet the needs of that community;

- Identify the appropriate MHSA category to expand Alternative Crisis Response services (i.e., PMRT) consistent with the Board's motions;

- Utilize MHSA Plan Component, Workforce, Education and Training (WET), to fund an enhanced recruitment and retention program for DMH employees; especially as DMH faces high vacancy rates and heavy turnover while trying to expand our programs and services. One objective to fund such an effort is to incentivize mental health clinicians to join DMH and also make sure that the ones presently employed do not experience burn out and leave the Department;

- Consider the White Memorial Community Based Integrated Model for funding under the MHSA Innovation category (refer to FY 2021 MHC Annual Report);

- Consider funding APIA community based mental health services to address the disparities and provide information to the Board and the Commission as outlined

in the 2020 Board Motion and the 2020 Recommendations from the Commission's Integrated Services and Cultural Competency subcommittee;

- Fund and support Mental Health Urgent Cares (e.g., an EmPath Center in collaboration with Henry Mayo Hospital in Santa Clarita) that will serve adolescents and adults that can bill Medi-Cal as well as private insurance;
- Receive further definition and clarification from the MH Commission on the concept and potential development of a "Behavioral Health Unit (BHU)" for adolescents and children in the Santa Clarita and San Fernando Valley Areas. Identify if the concept/model can be funded by MHSA and if it will need to provide MHSA related services/programs (e.g. Full-Service Partnerships), and
- Provide day services for individuals experiencing homelessness throughout the County which are low barrier services that help link people to housing and mental health.

The additional recommendation listed above will be explored by DMH and vetted with stakeholders for next steps. DMH looks forward to continued collaboration with Your Board and the Commission on the progress and implementation of this Annual Update over the next year and in our joint mission and ongoing pursuit of improving the lives of individuals, families and communities receiving services and supports from the public mental health system in Los Angeles County.

If there are any questions you can contact me, or staff can contact Darlesh Horn, MHSA Administration and Oversight Division Chief at dhorn@dmh.lacounty.gov.

Sincerely,

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

JES:GCP:DKH:mp

EXHIBIT G - COUNTY BOARD OF SUPERVISORS ADOPTED LETTER AND MINUTES

[Letter inserted once plan has been adopted by the Board]

Page intentionally left blank

APPENDICES

APPENDIX A – EXECUTIVE SUMMARY
POSTED TO THE LACDMH WEBSITE ON MARCH 4, 2022. THE EXECUTIVE SUMMARY HIGHLIGHTED THE UPCOMING CHANGES FOR FY 2022-23 AND PROVIDED AN UPDATE ON THE PROGRAMS CHANGED IN THE THREE YEAR PROGRAM AND EXPENDITURE PLAN.

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)

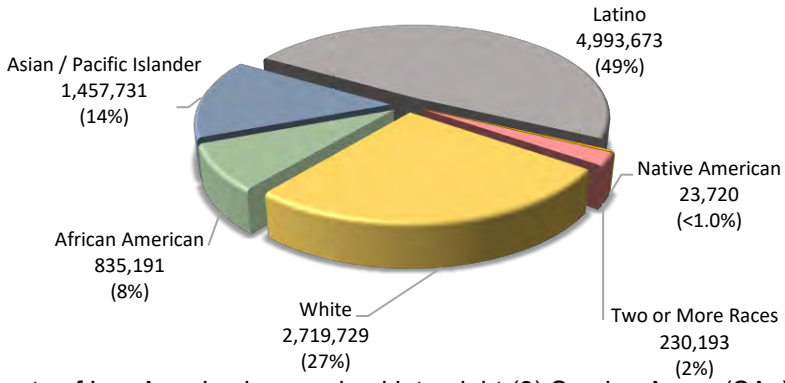
Workforce Education & Training

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

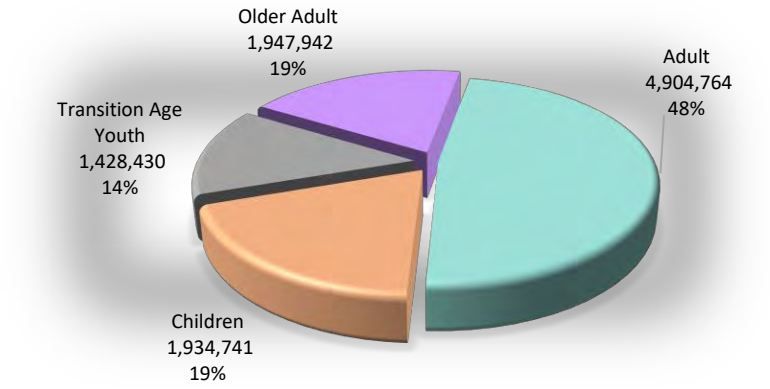


Table 3. Total Population by Age and Service Area, CY 2019

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.

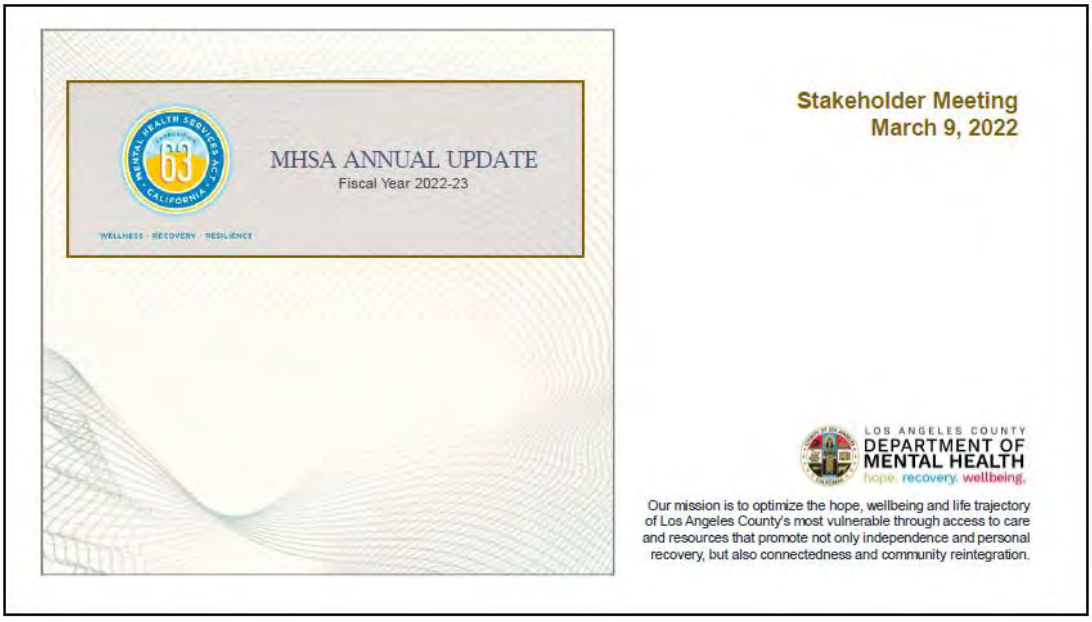
The Hollywood 2.0 pilot represents an opportunity for the County to leverage MHSA Innovation funding, partner with local community leadership, and use existing local assets to build out a rich array of resources that will strengthen clients' ties to the Hollywood community. Such resources include a robust 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.

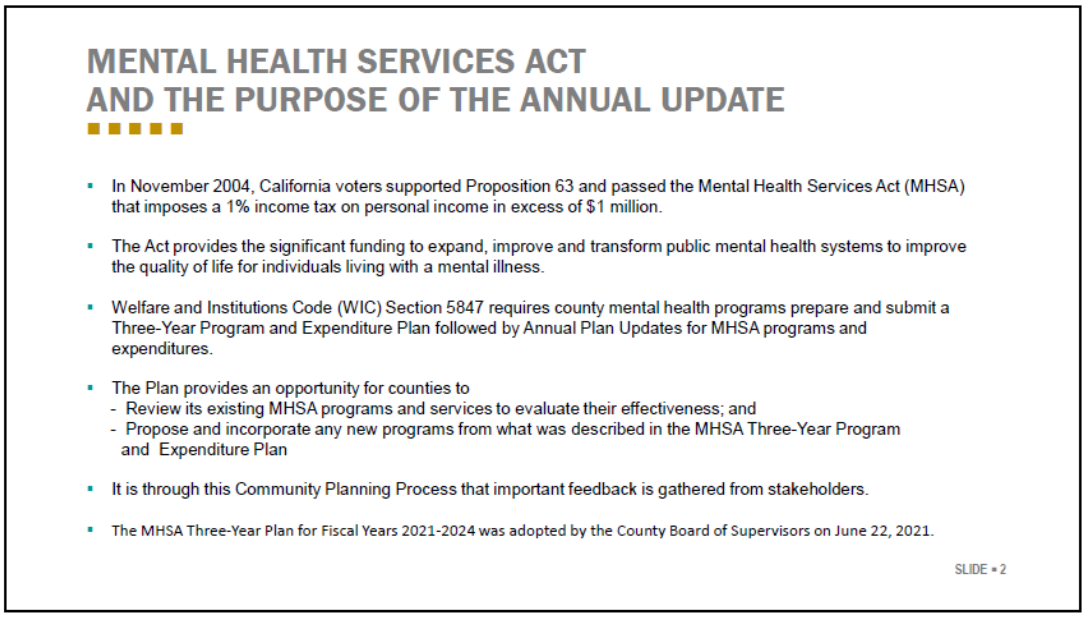
Hollywood 2.0 will allow the Department to develop novel programs and services that willenhance client's abilities to lead fulfilling lives and feel connected to their surroundingneighborhood. New programs such as Supportive Employment and Supportive Education services will provide clients with opportunities 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.

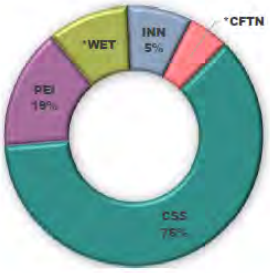
APPENDIX B – STAKEHOLDER PRESENTATION – MARCH 9, 2022
POWERPOINT PRESENTATION TO THE CLT, SLT AND FULL MENTAL HEALTH COMMISSION –





MHSA OVERVIEW BY COMPONENTS

- CSS, PEI and INN percent of total annual MHSA allocations shown below
- *WET and CFTN allocations are funded by transfers from CSS



COMMUNITY SERVICES AND SUPPORTS (CSS)

PREVENTION AND EARLY INTERVENTION (PEI)

WORKFORCE EDUCATION AND TRAINING (WET)

INNOVATIONS (INN)

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

SLIDE • 3

Fiscal Year 2022-23
MHSA Annual Update Presentation Overview

- COVID-19 Impact on Mental Health Services
- Budget
- Focus on Disparities
- MHSA Client Counts
- Actions Previously Approved
- Proposed Changes

SLIDE • 4

COVID-19 IMPACT ON MENTAL HEALTH SERVICES

- LACDMH MHSA 3-Year Plan shed light on the significant impact the COVID-19 outbreak had on County residents and communities:
  - 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
  - Widespread rising COVID infection rates prompting the need for temporary and/or permanent business and clinic closures
- This third year of the pandemic, especially after the Delta and Omicron variants, has shown improvements in the County's ability to control infection rates, hospitalizations, and to provide social services and economic help to those in need

SLIDE • 5

COVID-19 IMPACT ON MENTAL HEALTH SERVICES

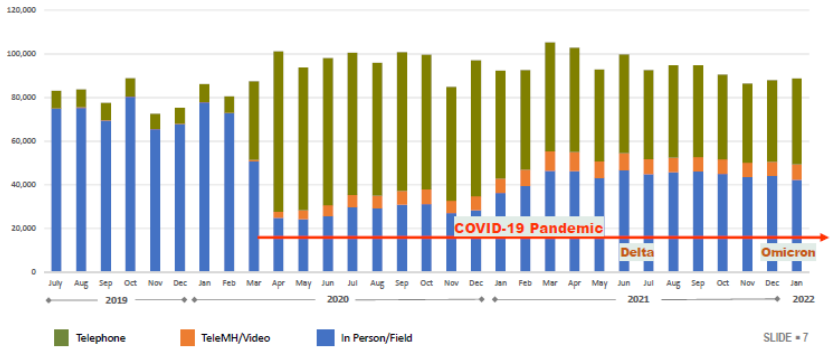
LACDMH has developed and executed several strategies to continue to adapt to the new normal, including:

- Increased use of technology, including telehealth and telepsychiatry, virtual groups and celebrations to ensure clients have access to care
- Regular phone check in 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
- Resuming outreach and engagement teams with increased COVID-19 safety measures

SLIDE • 6

COVID-19 IMPACT ON MENTAL HEALTH SERVICES

Directly Operated Mental Health Sessions by Type
July 2019 to January 2022

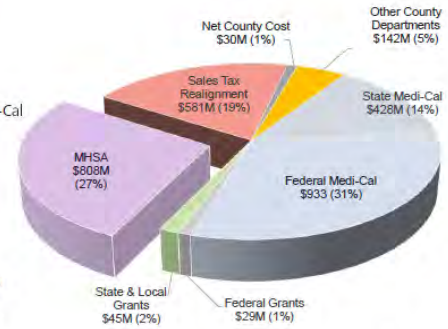


SLIDE • 7

LACDMH FY 2022-23 RECOMMENDED BUDGET REQUEST
$2.996 Billion Funding Sources

Primary Funding Sources:

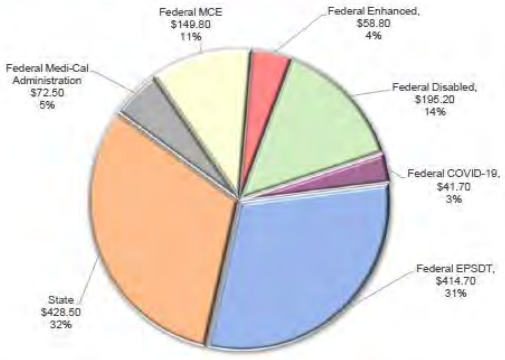
- 45% State and Federal Medi-Cal ($1.3 Billion)
  Mandated mental health services for eligible clients who meet medical necessity criteria for Medi-Cal
- 27% MHSA ($808 Million)
  Outreach, engagement, prevention, outpatient services, housing, capital, technology, workforce enrichment, and projects to mental health innovations
- 19% Sales Tax Realignment ($581 Million)
  Treatment services in institutional settings, including Probation halls/camps, STRTPs and CTFs for youth and locked mental health treatment beds for adults



SLIDE • 8

LACDMH FY 2022-23 RECOMMENDED BUDGET REQUEST
$1.3 Billion State and Federal Medi-Cal

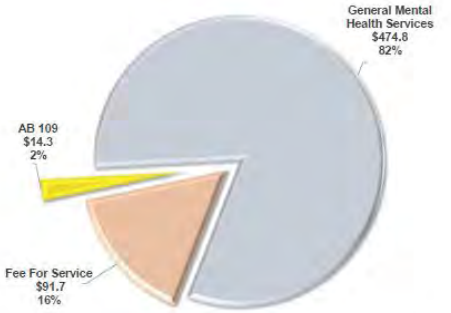
- Funding for mandated mental health services to Medi-Cal eligible clients based on their approved eligibility status.
- State matching funds to Medi-Cal for children and transitional age youth that meet medical necessity criteria
- Funding for the Medi-Cal Expansion (MCE) - Obama Care
- Funding for Medicare eligible services, to administer the Medi-Cal program, and for performing Medi-Cal administrative activities
- Increased Federal Medi-Cal reimbursable percentage for the pandemic period under the Family First Coronavirus Response Act (FFCRA)



SLIDE • 9

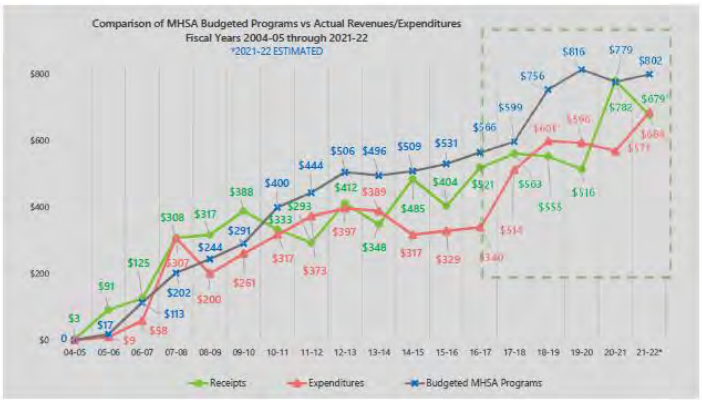
LACDMH FY 2022-23 RECOMMENDED BUDGET REQUEST
$581 Million Sales Tax Realignment

Funding for general mental health services,
- mainly in the Probation Halls/Camps and group homes;
- State Hospital and IMD beds;
- Fee For Service inpatient beds and professional psychiatric services; mental health services to the AB 109 population; and
- administration and general operating costs.



SLIDE • 10

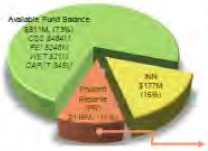
MHSA – A Historical Look



SLIDE • 11

MHSA FUND BALANCE AND REVERSION

FY 2021-22
MHSA Total Fund Balance
$1.104 Billion
As of July 1, 2021



MHSA Expenditures

(millions)	2019-20	2020-21	2021-22est
CSS	$392	$416	$459
PEI	$146	$119	$140
WET	$15	$7	$17
INN	$21	$29	$41
CAP/IT	$17	-	$28
Current Year Total	$591	$571	$684
Prior Year RER Adjust	$5	-	-
Total	$596	$571	$684

Current FY - New Money
As reflected in
Governor's May Revise Budget

Next FY 2022-23
Estimated
Total Fund Balance
$1.099 Billion

$812M C/O FB
+ $171M INN
+ $116M PR
= $1.099B
$9M from
FY 2021-22

In accordance with MHSA regulations, PR is calculated at min 23% and max 33% of the average amount of CSS allocation, with assessments to be made on the max level every five years.

Access to the PR is determined on a statewide level.

The PR is currently at the max level but still not enough to sustain existing DMH services and programs.

Reversion Timeline

Fund Balance	Amount by Component	Reversion Period
2019-20	$36M PEI	June 30, 2022
2020-21	$484M CSS $150M PEI	June 30, 2023

Fund Balance	Amount by Component	Reversion Period
Transfer of CSS Funds	$32M CAP/IT $13M CAP/IT $21M WET	June 30, 2028 June 30, 2030 June 30, 2030

This presentation is consistent with the 2021-22 MHSA Quarterly Forecast as of December 31, 2021

SLIDE • 12

FY 2022-23 BUDGET PROJECTION CHANGES

Summary by Program

MHSA Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change
CSS	$ 1,188,145,468	$ 1,154,359,375	$ (33,786,093)
PEI	$ 287,944,203	$ 315,514,026	$ 27,569,823
INN	$ 30,227,878	$ 14,861,609	$ (15,366,269)
WET	$ 20,431,958	$ 20,201,184	$ (230,774)
CFTN	$ 3,850,000	$ 10,650,000	$ 6,800,000
TOTAL	$ 1,530,599,507	$ 1,515,586,193	$ (15,013,313)

SLIDE • 13

FY 2022-23 BUDGET PROJECTION CHANGES

Community Services and Supports (CSS)

CSS Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Notes
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 and 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)	

SLIDE • 14

FY 2022-23 BUDGET PROJECTION CHANGES

Prevention and Early Intervention (PEI)

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 community promoters to provide outreach and education, as well as the one-time extension of the My Health LA Agreement with the 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 for Increasing Recognition of Early Signs of Mental Illness Program	$ 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**	

SLIDE • 15

FY 2022-23 BUDGET PROJECTION CHANGES

Innovation (INN)

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. LACDMH 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 the Hollywood 2.0 Project (formerly known as the True Recovery Innovation Embraces Systems That Empower - TRIESTE)
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)**	

SLIDE • 16

FY 2022-23 BUDGET PROJECTION CHANGES

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	$ -	

SLIDE • 17

FY 2022-23 BUDGET PROJECTION CHANGES

Workforce Education and Training (WET)

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
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)**	

SLIDE • 18

FY 2022-23 BUDGET PROJECTION CHANGES

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 Angeles 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**	

SLIDE • 19

FOCUS ON DISPARITIES

Proposed Actions to Address Racial/Ethnic Mental Health Care Disparities

MULTI-COUNTY LEARNING COLLABORATIVE

During the first quarter of 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. This opportunity is a vehicle for the disparities reduction efforts and as a way to strengthen community voice.

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.

SLIDE • 20

MHSA CLIENT COUNTS

Community Services and Supports

- Largest MHSA component with 76% of the total MHSA allocation
- For clients with a diagnosed serious mental illness

CSS PROGRAMS:
- Full Service Partnership
- Outpatient Care Services
- Alternative Services Crisis
- Housing
- Linkage
- Planning, Outreach and Engagement

UNIQUE CLIENTS SERVED

In FY 2020-21, 135,232 unique clients received a direct service.

Ethnicity
- 37% Hispanic
- 20% African American
- 18% White
- 5% Asian/Pacific Islander
- 1% Native American

Primary Language
- 79% English
- 14% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE

35,499 new clients were served with no previous MHSA service.

Ethnicity
- 36% Hispanic
- 14% African American
- 16% White
- 3% Asian/Pacific Islander
- 0.48% Native American

Primary Language
- 77% English
- 14% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	9,098	2,410
SA2 – San Fernando Valley	22,613	5,886
SA3 – San Gabriel Valley	19,146	5,952
SA4 – Metro	25,458	6,801
SA5 – West	7,837	1,918
SA6 – South	21,882	4,727
SA7 – East	12,465	2,953
SA8 – South Bay	27,189	6,940

SLIDE • 21

MHSA CLIENT COUNTS

Prevention and Early Intervention

- Second largest MHSA component with 19% of the total MHSA allocation
- Focus on providing preventative and early intervention strategies, education, support and outreach to those at risk of developing mental illness or experiencing early symptoms.

PEI PROGRAMS:
- Prevention
- Early Intervention
- Suicide Prevention
- Stigma and Discrimination Reduction

UNIQUE CLIENTS SERVED

In FY 2019-20, 42,784 unique clients received a direct service.

Ethnicity
- 45% Hispanic
- 9% African American
- 9% White
- 2% Asian/Pacific Islander
- 1% Native American

Primary Language
- 76% English
- 21% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA

23,277 new clients were served with no previous MHSA service

Ethnicity
- 42% Hispanic
- 9% African American
- 9% White
- 2% Asian/Pacific Islander
- 0.64% Native American

Primary Language
- 76% English
- 21% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	3,410	2,990
SA2 – San Fernando Valley	7,596	5,840
SA3 – San Gabriel Valley	8,494	6,414
SA4 – Metro	6,329	5,388
SA5 – West	1,828	1,685
SA6 – South	6,049	5,163
SA7 – East	6,720	5,892
SA8 – South Bay	7,923	6,846

SLIDE • 22

ACTIONS PREVIOUSLY APPROVED

Full Service Partnership Redesign

FSP Transformation – 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.

- 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.

SLIDE • 23

ACTIONS PREVIOUSLY APPROVED

Capital Facilities: Modernization of 24/7 Access Call Center

Modernization of 24/7 ACCESS Call Center – 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

Update: 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.

ACTIONS PREVIOUSLY APPROVED

Alternative Crisis Services

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.

PROPOSED CHANGE

Innovation 2: Community Capacity Building to Prevent and Address Trauma

Innovation 2– Requesting to continue programming using Prevention and Early Intervention funding with an annual budget of $22,489,000.

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.

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.

OUTCOMES

- 8,077 registered participants, with 68% (5,499) of all participants were enrolled in INN 2 during the pandemic.
- 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.
- 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.
- 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.

PROPOSED CHANGE
Innovation: Hollywood 2.0

A new comprehensive approach to serve people with Serious and Persistent Mental Illness, including those experiencing homelessness, with or without a substance abuse disorder.

KEY CHARACTERISTICS:

Holistic | Human Centered | Hospitality-oriented | Care in Community

HOW DOES IT DIFFER FROM TRIESTE?	KEY COMPONENTS	WHY HOLLYWOOD?
• Optimizes funds through the full Federal match • Avoids the use of fiscal/administrative intermediary • Expedites community planning processes by actively exploring available resources through philanthropy • Avoids unnecessary technological/EMR investments	• Full Service Partnership • HOME Team • Intensive Outpatient Services: Team Based • Peer Resource Center/Clubhouse • Alternative Crisis Response • Housing: Interim, Permanent Supportive, Congregate and Enhanced Residential (Board and care)	• Large concentration of unhoused individuals suffering from serious brain illnesses • Strong coalition of local neighborhood business and faith leaders, government and health care providers and law enforcement (i.e. Hollywood 4WRD)

SLIDE ▪ 27

PROPOSED CHANGE
Capital Facilities

Requesting $5 million dollars for future improvement projects.

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.

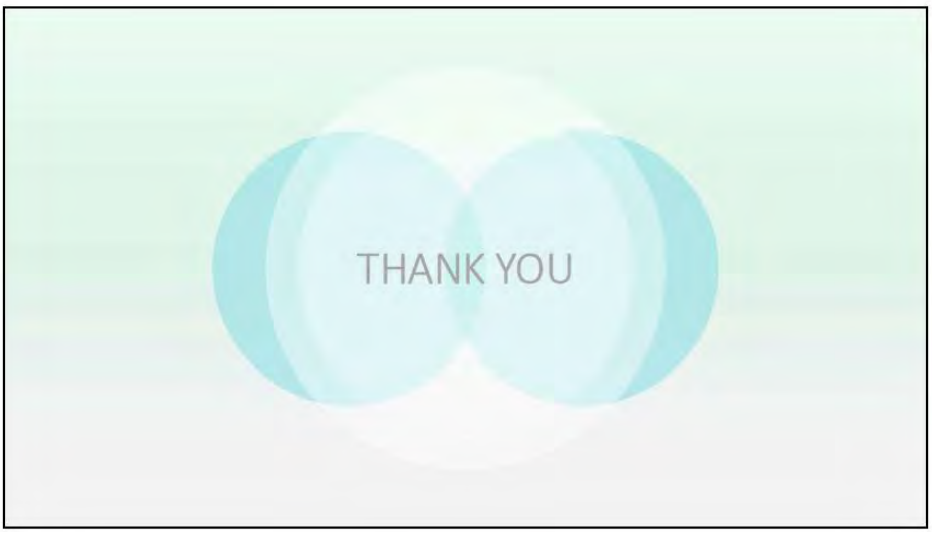
SLIDE ▪ 28

PROPOSED CHANGE
Capital Facilities

CAPITAL FACILITIES: NEW PROJECTS PLANNED FOR CHILDREN AND YOUTH

- Harbor-UCLA Children and Youth Outpatient Center
- High Desert Hub for DCFS Involved Children and Youth
- High Desert Children and Youth Outpatient Center
- MLK Children and Youth Outpatient Center
- Olive View Hub for DCFS Involved Children and Youth

SLIDE ▪ 29


THANK YOU

APPENDIX C – EXECUTIVE COMMITTEE MENTAL HEALTH COMMISSION (MHC) PRESENTATION
PRESENTATION TO THE MHC EXECUTIVE COMMITTEE – MARCH 10, 2022
[C1] AGENDA

Los Angeles County

Mental Health Commission
Executive Committee

Meeting Agenda
March 10, 2022 @12:00 p.m.
Stacy Dalgleish, Chair, Presiding

In response to the State's enactment of **AB361**, the Mental Health Commission will continue to hold all Brown Act meetings virtually via teleconference until further notice.

1. **Call to Order** and **Roll Call**

2. **Acknowledgements**: ASL interpreters, Spanish interpreters, CART captioner, technology and multimedia team, and staff support

Administrative Matters

3. **Approval of the February Executive Committee meeting minutes**

Public Comment

4. **Public Comment: Agenda & Non-Agenda Items**
   Opportunity for members of the public to address the MHC on items of interest that are within the jurisdiction of the Commission. You may submit public comment by email to MHCommission@dmh.lacounty.gov by mail or in person: 510 South Vermont Avenue, Los Angeles, CA 90020.

Presentation

5. **MHSA Annual Update 2022-23 – Gregory C. Polk, M.P.A., Chief Deputy Director, Los Angeles County Department of Mental Health**

MHSA FY 2021-2022 Annual Update Dates:

- **30-Day Comment Period**
  March 7, 2022 through April 6, 2022
- **Community Stakeholder Presentation**
  Wednesday, March 9, 2022, 2-4 p.m.
- **Presentation to the Mental Health Commission**
  Thursday, March 10, 2022 (to take place during March MHC Exec. Mtg*)
- **MHSA Annual Update Public Hearing**
  Thursday, April 14, 2022 (to take place during April MHC Exec. Mtg*)

*Please note, the presentation to the Mental Health Commission (MHC) and the Public Hearing both fall on dates of MHC Executive Meetings due to timeline requirements set by the BOS for review and approval.

Public Comment

6. **Public Comment: Agenda & Non-Agenda Items**
   Opportunity for members of the public to address the MHC on items of interest that are within the jurisdiction of the Commission. You may submit public comment by email to MHCommission@dmh.lacounty.gov by mail or in person: 510 South Vermont Avenue, Los Angeles, CA 90020.

Adjournment

[C2] POWERPOINT PRESENTATION

Mental Health Executive Committee Meeting
March 10, 2022

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

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

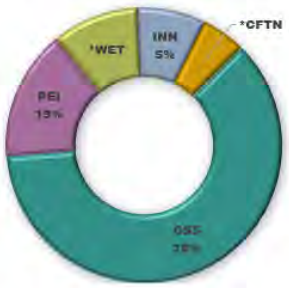
MENTAL HEALTH SERVICES ACT AND THE PURPOSE OF THE ANNUAL UPDATE

- In November 2004, California voters supported Proposition 63 and passed the Mental Health Services Act (MHSA) that imposes a 1% income tax on personal income in excess of $1 million.
- The Act provides the significant funding to expand, improve and transform public mental health systems to improve the quality of life for individuals living with a mental illness.
- Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Plan Updates for MHSA programs and expenditures.
- The Plan provides an opportunity for counties to
  - Review its existing MHSA programs and services to evaluate their effectiveness; and
  - Propose and incorporate any new programs from what was described in the MHSA Three-Year Program and Expenditure Plan
- It is through this Community Planning Process that important feedback is gathered from stakeholders.
- The MHSA Three-Year Plan for Fiscal Years 2021-2024 was adopted by the County Board of Supervisors on June 22, 2021.

SLIDE ▪ 2

MHSA OVERVIEW BY COMPONENTS

- CSS, PEI and INN percent of total annual MHSA allocations shown below
- *WET and CFTN allocations are funded by transfers from CSS



- COMMUNITY SERVICES AND SUPPORTS (CSS)
- PREVENTION AND EARLY INTERVENTION (PEI)
- WORKFORCE EDUCATION AND TRAINING (WET)
- INNOVATIONS (INN)
- CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

SLIDE = 3

Fiscal Year 2022-23
MHSA Annual Update Presentation Overview

- COVID-19 Impact on Mental Health Services
- Budget
- Focus on Disparities
- MHSA Client Counts
- Actions Previously Approved
- Proposed Changes
- MH Commission Inquiries

SLIDE = 4

COVID-19 IMPACT ON MENTAL HEALTH SERVICES

- LACDMH MHSA 3-Year Plan shed light on the significant impact the COVID-19 outbreak had on County residents and communities:
  - 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
  - Widespread rising COVID infection rates prompting the need for temporary and/or permanent business and clinic closures

- This third year of the pandemic, especially after the Delta and Omicron variants, has shown improvements in the County's ability to control infection rates, hospitalizations, and to provide social services and economic help to those in need

SLIDE = 5

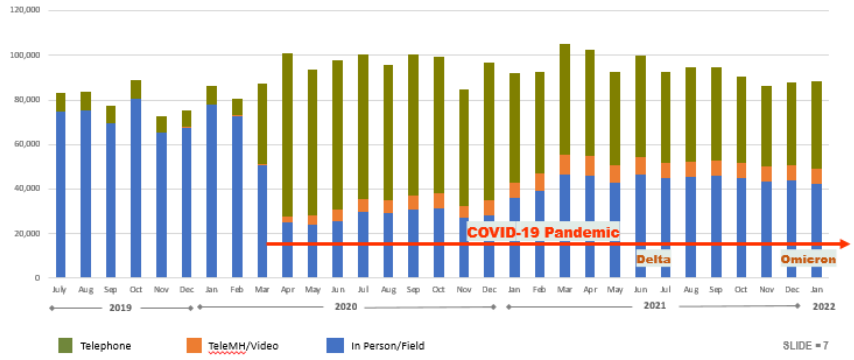
COVID-19 IMPACT ON MENTAL HEALTH SERVICES

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

- Increased use of technology, including telehealth and telepsychiatry, virtual groups and celebrations to ensure clients have access to care
- Regular phone check in 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
- Resuming outreach and engagement teams with increased COVID-19 safety measures

COVID-19 IMPACT ON MENTAL HEALTH SERVICES

Directly Operated Mental Health Sessions by Type
July 2019 to January 2022



SLIDE = 7

LACDMH FY 2022-23 RECOMMENDED BUDGET REQUEST
$2.996 Billion Funding Sources

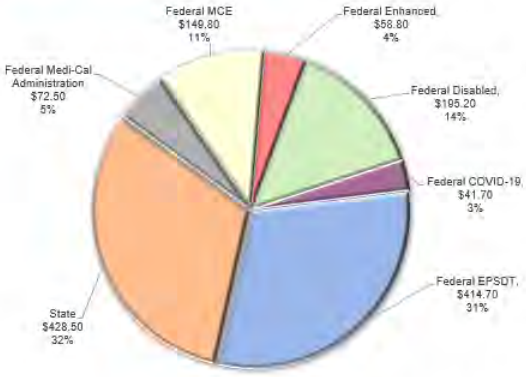
Primary Funding Sources:

- **45% State and Federal Medi-Cal ($1.3 Billion)**
  Mandated mental health services for eligible clients who meet medical necessity criteria for Medi-Cal
- **27% MHSA ($808 Million)**
  Outreach, engagement, prevention, outpatient services, housing, capital, technology, workforce enrichment, and projects to mental health innovations
- **19% Sales Tax Realignment ($581 Million)**
  Treatment services in institutional settings, including Probation halls/camps, STRTPs and CTFs for youth and locked mental health treatment beds for adults

SLIDE = 8

LACDMH FY 2022-23 RECOMMENDED BUDGET REQUEST
$1.3 Billion State and Federal Medi-Cal

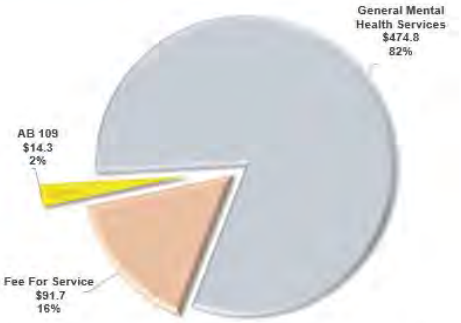
- Funding for mandated mental health services to Medi-Cal eligible clients based on their approved eligibility status.
- State matching funds to Medi-Cal for children and transitional age youth that meet medical necessity criteria
- Funding for the Medi-Cal Expansion (MCE) - Obama Care
- Funding for Medicare eligible services, to administer the Medi-Cal program, and for performing Medi-Cal administrative activities
- Increased Federal Medi-Cal reimbursable percentage for the pandemic period under the Family First Coronavirus Response Act (FFCRA)



SLIDE = 9

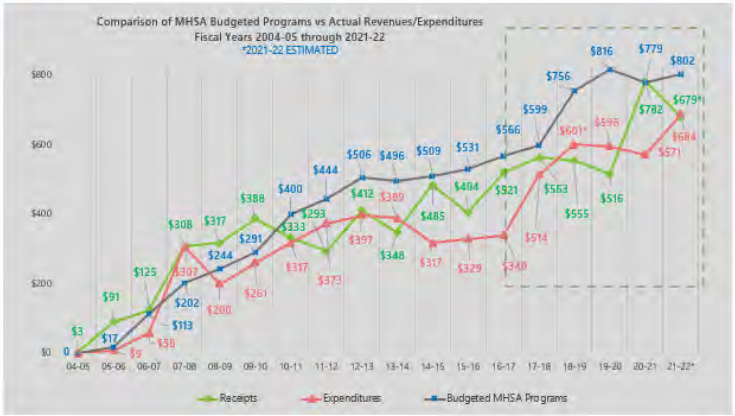
LACDMH FY 2022-23 RECOMMENDED BUDGET REQUEST
$581 Million Sales Tax Realignment

Funding for general mental health services,
- mainly in the Probation Halls/Camps and group homes;
- State Hospital and IMD beds;
- Fee For Service inpatient beds and professional psychiatric services; mental health services to the AB 109 population; and
- administration and general operating costs.



SLIDE = 10

MHSA – A Historical Look



SLIDE = 11

MHSA FUND BALANCE AND REVERSION

FY 2021-22
MHSA Total Fund Balance
$1.104 Billion
As of July 1, 2021

MHSA Expenditures

(millions)	2019-20	2020-21	2021-22est
CSS	$392	$416	$459
PEI	$146	$119	$140
WET	$15	$7	$17
INN	$21	$29	$41
CAPIT	$17	-	$28
Current Year Total	$591	$571	$684
Prior Year RER Adjust	$5	-	-
Total	$596	$571	$684

Next FY 2022-23
Estimated
Total Fund Balance
$1.099 Billion

$812M C/O FB
+ $171M INN
+ $116M PR
= $1.099B

$9M from
FY 2021-22

Current FY - New Money
As reflected in
Governor's May Revise Budget

In accordance with MHSA regulations, PR is calculated at min 23% and max 33% of the average amount of CSS allocation, with assessments to be made on the max level every five years.

Access to the PR is determined on a statewide level.

The PR is currently at the max level but still not enough to sustain existing DMH services and programs.

Reversion Timeline

Fund Balance	Amount by Component	Reversion Period
2019-20	$36M PEI	June 30, 2022
2020-21	$454M CSS $150M PEI	June 30, 2023

Fund Balance	Amount by Component	Reversion Period
Transfer of CSS Funds	$32M CAPIT $13M CAPIT $21M WET	June 30, 2026 June 30, 2030 June 30, 2030

This presentation is consistent with the 2021-22 MHSA Quarterly Forecast as of December 31, 2021

SLIDE = 12

FY 2022-23 BUDGET PROJECTION CHANGES

Summary by Program

MHSA Program	Original Projections as of June 2021 (Amounts approved in Three Year Plan)	Updated Projections as of March 2022 (Amounts reflected in Annual Update)	Change
CSS	$ 1,188,145,468	$ 1,154,359,375	$ (33,786,093)
PEI	$ 287,944,203	$ 315,514,026	$ 27,569,823
INN	$ 30,227,878	$ 14,861,609	$ (15,366,269)
WET	$ 20,431,958	$ 20,201,184	$ (230,774)
CFTN	$ 3,850,000	$ 10,650,000	$ 6,800,000
TOTAL	$ 1,530,599,507	$ 1,515,586,193	$ (15,013,313)

SLIDE = 13

FY 2022-23 BUDGET PROJECTION CHANGES

Community Services and Supports (CSS)

CSS Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Notes
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 and 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)**	

SLIDE = 14

FY 2022-23 BUDGET PROJECTION CHANGES

Prevention and Early Intervention (PEI)

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 community promoters to provide outreach and education, as well as the one-time extension of the My Health LA Agreement with the 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 for Increasing Recognition of Early Signs of Mental Illness Program	$ 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**	

FY 2022-23 BUDGET PROJECTION CHANGES

Innovation (INN)

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. LACDMH 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 the Hollywood 2.0 Project (formerly known as the True Recovery Innovation Embraces Systems That Empower - TRIESTE)
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)**	

FY 2022-23 BUDGET PROJECTION CHANGES

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	$ -	

FY 2022-23 BUDGET PROJECTION CHANGES

Workforce Education and Training (WET)

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
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)**	

SLIDE = 18

FY 2022-23 BUDGET PROJECTION CHANGES

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 Angeles 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**	

SLIDE = 19

FOCUS ON DISPARITIES

Proposed Actions to Address Racial/Ethnic Mental Health Care Disparities

MULTI-COUNTY LEARNING COLLABORATIVE

During the first quarter of 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. This opportunity is a vehicle for the disparities reduction efforts and as a way to strengthen community voice.

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.

SLIDE = 20

MHSA CLIENT COUNTS

Community Services and Supports

- Largest MHSA component with 76% of the total MHSA allocation
- For clients with a diagnosed serious mental illness

CSS PROGRAMS:
- Full Service Partnership
- Outpatient Care Services
- Alternative Services Crisis
- Housing
- Linkage
- Planning, Outreach and Engagement

UNIQUE CLIENTS SERVED

In FY 2020-21, 135,232 unique clients received a direct service.

Ethnicity
- 37% Hispanic
- 20% African American
- 18% White
- 5% Asian/Pacific Islander
- 1% Native American

Primary Language
- 79% English
- 14% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE

35,499 new clients were served with no previous MHSA service.

Ethnicity
- 36% Hispanic
- 14% African American
- 16% White
- 3% Asian/Pacific Islander
- 0.48% Native American

Primary Language
- 77% English
- 14% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	9,098	2,410
SA2 – San Fernando Valley	22,613	5,886
SA3 – San Gabriel Valley	19,146	5,952
SA4 – Metro	25,458	6,801
SA5 – West	7,837	1,918
SA6 – South	21,682	4,727
SA7 – East	12,465	2,953
SA8 – South Bay	27,189	6,940

SLIDE ▪ 21

MHSA CLIENT COUNTS

Prevention and Early Intervention

- Second largest MHSA component with 19% of the total MHSA allocation
- Focus on providing preventative and early intervention strategies, education, support and outreach to those at risk of developing mental illness or experiencing early symptoms.

PEI PROGRAMS:
- Prevention
- Early Intervention
- Suicide Prevention
- Stigma and Discrimination Reduction

UNIQUE CLIENTS SERVED

In FY 2019-20, 42,784 unique clients received a direct service.

Ethnicity
- 45% Hispanic
- 9% African American
- 9% White
- 2% Asian/Pacific Islander
- 1% Native American

Primary Language
- 76% English
- 21% Spanish

NEW CLIENTS WITH NO PREVIOUS MHSA

23,277 new clients were served with no previous MHSA service

Ethnicity
- 42% Hispanic
- 9% African American
- 9% White
- 2% Asian/Pacific Islander
- 0.64% Native American

Primary Language
- 76% English
- 21% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	3,410	2,990
SA2 – San Fernando Valley	7,596	5,840
SA3 – San Gabriel Valley	8,494	6,414
SA4 – Metro	6,329	5,388
SA5 – West	1,828	1,685
SA6 – South	6,049	5,163
SA7 – East	6,720	5,892
SA8 – South Bay	7,923	6,846

SLIDE ▪ 22

ACTIONS PREVIOUSLY APPROVED

Full Service Partnership Redesign

FSP Transformation – 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.

- 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.

SLIDE ▪ 23

ACTIONS PREVIOUSLY APPROVED

Capital Facilities: Modernization of 24/7 Access Call Center

Modernization of 24/7 ACCESS Call Center – 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

Update: 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.

ACTIONS PREVIOUSLY APPROVED

Alternative Crisis Services

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 exceeded the budget by $11.5 million to date utilizing one-time Sales Tax Realignment and will continue to increase.
- 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.

PROPOSED CHANGE

Innovation 2: Community Capacity Building to Prevent and Address Trauma

Innovation 2– Requesting to continue programming using Prevention and Early Intervention funding with an annual budget of $22,489,000.

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.

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.

OUTCOMES

- 8,077 registered participants, with 68% (5,499) of all participants were enrolled in INN 2 during the pandemic.
- 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.
- 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.
- 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.

PROPOSED CHANGE
Innovation: Hollywood 2.0

A new comprehensive approach to serve people with Serious and Persistent Mental Illness, including those experiencing homelessness, with or without a substance abuse disorder.

KEY CHARACTERISTICS:

Holistic | Human Centered | Hospitality-oriented | Care in Community

HOW DOES IT DIFFER FROM TRIESTE?	KEY COMPONENTS	WHY HOLLYWOOD?
• Optimizes funds through the full Federal match • Avoids the use of fiscal/administrative intermediary • Expedites community planning processes by actively exploring available resources through philanthropy • Avoids unnecessary technological/EMR investments	• Full Service Partnership • HOME Team • Intensive Outpatient Services: Team Based • Peer Resource Center/Clubhouse • Alternative Crisis Response • Housing: Interim, Permanent Supportive, Congregate and Enhanced Residential (Board and care)	▪ Large concentration of unhoused individuals suffering from serious brain illnesses ▪ Strong coalition of local neighborhood business and faith leaders, government and health care providers and law enforcement (i.e. Hollywood 4WRD)

PROPOSED CHANGE
Capital Facilities

Requesting $5 million dollars for future improvement projects.

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.

PROPOSED CHANGE
Capital Facilities

CAPITAL FACILITIES: NEW PROJECTS PLANNED FOR CHILDREN AND YOUTH

- Harbor-UCLA Children and Youth Outpatient Center
- High Desert Hub for DCFS Involved Children and Youth
- High Desert Children and Youth Outpatient Center
- MLK Children and Youth Outpatient Center
- Olive View Hub for DCFS Involved Children and Youth

RECENT MH COMMISSION INQUIRIES
DMH Responses

#1 – FY 2022-23 Recommended Budget by Major Category

Program	Description	Amount	Percent
Outpatient Services	An array of services to individuals with severe and persistent mental illness and to severely emotionally disturbed children, adolescents, and their families.	$2.367 B	79.0%
Treatment Beds	Inpatient services to clients that need 24-hour care for grave mental health disabilities.	$290.1 M	9.7%
Public Guardian	Investigates the need for conservatorship and serves as the public conservator for individuals mandated by the courts to be gravely disabled due to a mental disorder, unable to properly care for themselves, and/or unable to manage their finances.	$29.4 M	1.0%
Administration	Support required for the ongoing operational functions of the Department	$309.4 M	10.3%
	Total Budget Appropriation	**$2.996 B**	**100.0%**

RECENT MH COMMISSION INQUIRIES
DMH Responses

#2 – Detailed Report of FY 2022-23 Recommended Budget Changes for Expenditures and Revenues

New/Expanded Program Changes

Program	Description	FTE	Cost
MHSA Approved Plans	Includes, among other miscellaneous changes, - $1.8M for the SEED Foundation School to provide prevention services - $2.0M and 20.0 positions for Therapeutic Transportation - $0.5M and 4.0 positions for field-based services associated with HOME - $1.0M to fund 3.0 clinical leadership positions - Revenue: MHSA and Medi-Cal revenue	27.0	$3.1 M
Emotional Support Line	- Permanent operation of a hotline that was implemented during COVID-19 to provide non-urgent emotional support - Revenue: SAMHSA	18.0	$2.0 M
Intensive Care Services	- Expand concurrent review work on inpatient admissions at various hospitals/facilities - Revenue: 2011 Realignment Fee For Service	8.0	$1.2 M

RECENT MH COMMISSION INQUIRIES
DMH Responses

#2 – Detailed Report of FY 2022-23 Recommended Budget Changes for Expenditures and Revenues

Other Program Changes

Program	Description	FTE	Cost
Inpatient Bed Rates	Reflects a rate increase in the daily bed rate for Fee for Service Inpatient Hospitals that service adolescents and adults. Revenue: 2011 Realignment Fee For Service	-	$8.6 M
Reduction of Funding and Shortfalls from Other County Departments	Reflects reduction of funding from DCFS for the Wraparound Case Rate and the Arts Care services, and termination of the Schedule D-Rate Program. Also reflects the deletion of vacant budgeted positions in response to funding shortfalls from Probation, DPSS and DCFS. Revenue: Reduction of funding from Probation, DPSS and DCFS	(42.0)	$-5.2 M
Deletion of AB109 Funding	Deletion of one-time funding for the expansions of the Suicide Prevention Call Center and Psychiatric Mobile Response Teams, as well as the Family Assistance Program for burial expenses. Revenue: Sales Tax Realignment AB 109	-	$-35.0 M

RECENT MH COMMISSION INQUIRIES
DMH Responses

#3 FY 2021-22 Budgeted Positions/Vacancies

Total Budgeted Positions – 6,407.0 FTEs

Total Vacant Positions – 862.0 FTEs*

* Reflects the Total Vacancies of 1,621.0 FTEs less the FTEs required to remain vacant of 759.0 to meet Salary Savings amount. The DMH budget includes a reduction in salaries, called salary savings, to account for anticipated vacancies, step differentials and hiring delays.

#4 FY 2020-21 Savings due to Vacancies Caused by the Pandemic

DMH estimated savings that could have caused by the pandemic is approximately $15 million. This amount is primarily related to overtime, training, travel, food, less bank card fees, no match for the Savings Plans, and the replacement of vehicles. This savings resulted in the under-realization of revenue by an equal amount.

RECENT MH COMMISSION INQUIRIES
DMH Responses

#5 Increase in County Mobile Emergency Team Programs and Expansion Planned

FY 2022-23 Recommended Budget
- Expansion of 20.0 Therapeutic Transportation Teams with the LA City Fire Department
- 4.0 FTEs for the Home Teams

FY 2022-23 Requests for Future Budget Phases
- Expansion of 16 Directly Operated PMRTs
- Expansion of 4 Therapeutic Transportation Teams with the City of Santa Monica
- Expansion of approximately 60 MCOT – Mobile Crisis Outreach Teams to be provided by Community Based Organizations

RECENT MH COMMISSION INQUIRIES
DMH Responses

#6 MHSA Community Planning Program (CPP)

The DMH is currently claiming all CPP expenditures to Planning, Outreach and Engagement (POE). The DMH is working on identifying the appropriate expenditures to be claimed to CPP for this FY and will record them, accordingly. The DMH will establish protocols for FY 2022-23 and ongoing to ensure the expenditures are reported appropriately between CPP and POE.

#7 Percentage of Outpatient/Inpatient Services Spent on the Unhoused

This information is not readily available. The DMH is reviewing available information to determine if we can provide relevant regarding this matter.

#8 Trust Fund Balances as of July 1, 2021

- MHSA - $1.104 Billion (includes restricted funds $116M Prudent Reserve and $177M Innovation)
- Sales Tax Realignment - $268.5 Million

RECENT MH COMMISSION INQUIRIES
DMH Responses

#9 FY 2022-23 Recommended Budget will be presented to the Board of Supervisors on April 19, 2022, per the Countywide Budget Calendar

#10 Three-Year Comparison of Unmet Needs What has been met and what is still unmet

- Prescribers for laboratory and pharmacy services.
- Directly operated services, including services to the foster care and juvenile justice populations
- Beds
- Housing
- Public Guardian
- Field Based Teams

The Department's Unmet Needs primarily remained constant for the past three fiscal years; however, the following items were partially funded:

FY 2021-22
- Prescribers/Pharmacy positions to address audit findings
- Additional beds to support the 500-Bed Pilot
- Positions to support Court Linkage Services

FY 2022-23
- Additional positions for the HOME Team

RECENT MH COMMISSION INQUIRIES
DMH Responses

#11 Update on peers and services/support for peers

- Trainings: Wellness Action Recovery Plan; Intentional Peer Support; and Social Practice: Foundation House Model
- Hired first Supervising Community Health Worker – Peers supervised by Peers
- Completion of grant-funded survey assessing Peer staff's readiness to complete state certification
- Developing plan to assist Peers with the certification processes
- Presentations in each Service Area and to UsCC and Cultural Competency Subcomittees to provide overview of SB 803
- DMH Parent Partner Training Academy curriculum submitted to CalMHSA for consideration as approved certification and specialized training for peers who are primary caregivers for children and youth involved with Probation, DCFS, Regional Centers and DMH
- Initiated efforts to form a Peer Advisory Council for DMH

#12 State Budget surplus – impact on DMH

RECENT MH COMMISSION INQUIRIES
DMH Responses

#13 Detail of programs included in Outpatient Services

❖ **Mental Health Services Act**

- Full Service Partnerships/Assisted Outpatient Programs
- Outpatient Care Services
- Alternative Crisis Services
  - ➢ Urgent Care Centers
  - ➢ Enriched Residential Centers
  - ➢ Crisis Residential Treatment Programs
  - ➢ Psychiatric Mobile Response Teams
- Linkage - HOME Teams, Men's Reintegration, Veteran's Peer Access Network, MH Court Program
- Housing/Housing Supportive Service
- Planning, Outreach, & Engagement
- Prevention and Early Intervention
  - ➢ Suicide Prevention
  - ➢ Community School Initiatives

RECENT MH COMMISSION INQUIRIES
DMH Responses

#13 Detail of programs included in Outpatient Services
(cont'd)

❖ **Department Of Children and Family Service**
- Family Preservation Program
- Multi-Disciplinary Assess Team (MAT)
- Enhanced Mental Health Services - Katie A
- Treatment Foster Care Services
- Wraparound
- Mental Health Services in the Medical HUBs

❖ **Department of Public Social Services**
- CalWORKs Mental Health Services
- GROW
- Family Stabilization
- Disability Assessment

RECENT MH COMMISSION INQUIRIES
DMH Responses

#13 Detail of programs included in Outpatient Services
(cont'd)

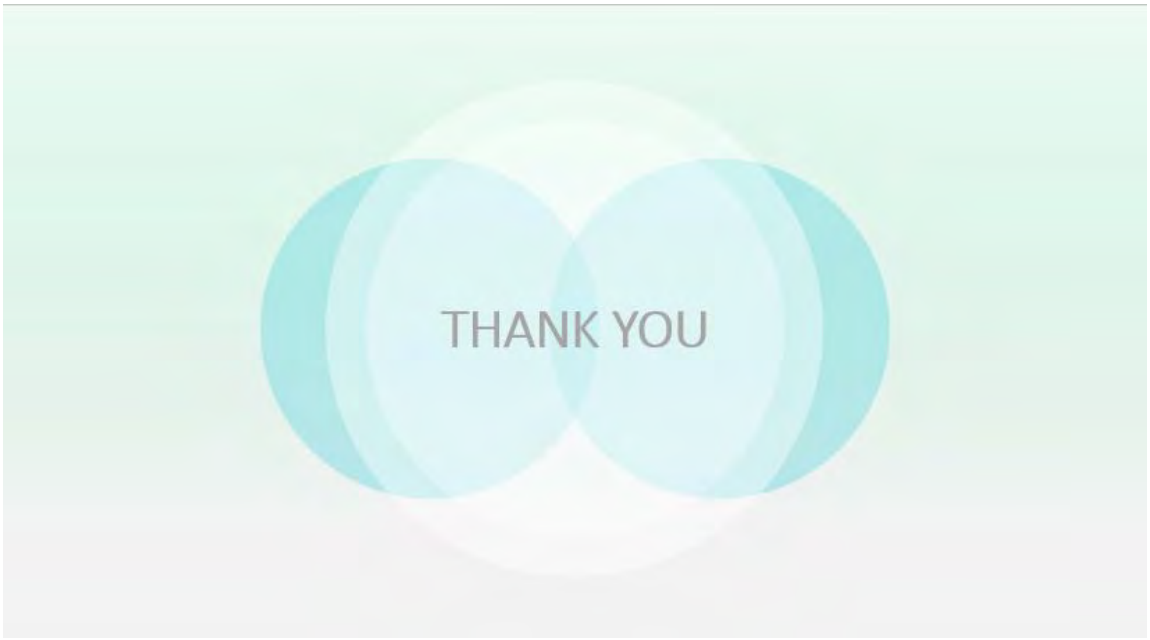
❖ **Probation Department**
- Mental Health Services, Assessment and Training
- Multi-Systematic Training
- New Directions / Hope Center
- Co-Occurring Disorders (COD)
- 16 Hour Pilot Program at Central Juvenile Hall
- Youth Offenders Block Grant

❖ **Whole Person Care**
- Integrated Services Recipient
- Residential and Bridging
- Enhanced Care Coordination
- Kin To Peer

RECENT MH COMMISSION INQUIRIES
DMH Responses

#13 Detail of programs included in Outpatient Services
(cont'd)

❖ **Miscellaneous**
- Law Enforcement Teams, Mental Health Evaluation Teams, START
- Post-Release Community Supervision & Reintegration Program (AB 109)
- Forensic Center Services
- EPIC Program-Outpatient Services at Antelope Valley Residential Center
- Measure H - Housing Supportive Services Program
- Children's Outreach & Triage Team (COTT)
- Outreach & Triage Team (OTT)
- Homeless Outreach Services Teams (Sheriff)


THANK YOU

APPENDIX D - PUBLIC REVIEW OF DRAFT ANNUAL UPDATE AND COMMENT PERIOD: MARCH 8 THROUGH APRIL 13, 2022
PUBLIC COMMENTS AND SURVEY RESPONSES RECEIVED

[D1] SURVEY RESPONSES

66 Survey responses were received, 65 in English and 1 in Spanish.
Not all respondents answered all the questions.

After reviewing the FY 2022/23 MHSA Annual Update, please rate your understanding of the following:

Overall ease and clarity of the information presented (n=60)

- 8% reported Excellent
- 20% reported Very Good
- 22% reported Good
- 32% reported Fair
- 8% reported Poor

How MHSA programs are being implemented (n=60)

- 5% reported Excellent
- 15% reported Very Good
- 22% reported Good
- 33% reported Fair
- 25% reported Poor

How MHSA funding is being spent (n=60)

- 7% reported Excellent
- 17% reported Very Good
- 27% reported Good
- 20% reported Fair
- 30% reported Poor

What is your affiliation? (The respondents can choose more than one category)

- 21% of the respondents are clients/consumers
- 7% of the respondents are peers
- 13% of the respondents are advocates
- 14% of the respondents are family members of a client/consumer
- 5% of the respondents are other government employees
- 6% of the respondents are LACDMH staff/employees
- 17% of the respondents are mental health service provider
- 16% of the respondents indicated Other

What is your age? (n=65)

- 0% reported Under 20 years old
- 6% reported 20 to 29 years old
- 17% reported 30 to 39 years old
- 26% reported 40 to 49 years old
- 25% reported 50 to 59 years old
- 17% reported 60 to 69 years old
- 9% reported 70 years old or over

What ethnic groups do you identify with? (The respondents can choose more than one category)

- 14% reported African
- 8% reported Asian
- 24% reported Caucasian
- 26% reported Latin/Latina/Latinx
- 4% reported Mixed/multi-ethnic
- 10% reported Native American / American Indian / Alaskan Native
- 14% reported Other

SURVEY #1

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- So disconnected. There is no strength to this

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Not enough focus on serious mental illness, not enough focus on finding enough treatment beds or facilities. Not enough advocacy not enough family support or engagement not enough being done for the gravely disabled... Not enough done for the dually diagnosed

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Even the email is confusing.. spread the words to the public that they can provide input as to how the county treats the mentally ill and post about in online, on social media, on the radio and you will vet alot of information

SURVEY #2

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Similar goals with less difficult language that is causative of side talk. Rendering delays

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Very little

SURVEY #3

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- There will be more communication with those in need in terms of having regular phone calls with clients and/or their families.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- If I understood correctly, the CANs program is expected to end. There is a high need for community members trying to access resources, and the CANs program seems to be the bridge in making sure the community members have access to the needed resources.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- It would be helpful to put a brief summary/explanation after each table presented with information/money. It would also have been helpful to talk about the action steps taken to address the impact of COVID-19 on mental health services.

SURVEY #4

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- The objective to expand mental health services to underserve communities

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Failure to open MHSA funds in a grant driven, open bid solicitation unrestrictive bidding directly targeting innovative approaches expanding direct mental health services. Treatment services are not identified for mental health disorders like Rape Trauma Syndrome (PTSD), Intermittent Explosive Disorder in Children and Teens, Adjustment Disorder, Autism with Behavioral Disorders.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Include the number of clients served and evaluation process which reports effectiveness rate of money spent. Innovation Grants: Detailed description on how programs are selected, number of grants released and the recipients receiving the money

SURVEY #5

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Nothing

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Very weak

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Get me a fucking housing for me and my daughter.

SURVEY #6

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Very data driven.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- It was a lot of information in a short amount of time. There was no contact information provided as follow-up. Also, the slides were too small to read the content. First, there is one area of public health that was not called out specifically. That is the devastating acceleration of the opioid crisis since the pandemic. Overdose deaths have increased 45% in 2020. Please help me understand what this year's plans are to address this issue. Second, the pandemic forced a lot of small businesses and non-profits to close while the needs of the community intensified. The contracting process within LA county required 3 years of experience. New businesses (which most are because the old ones closed) do not meet those criteria. I propose a new pathway be created to encourage innovation, adaptability, and agility to respond to the ever changing needs of the community. This will also promote equity and fairness in the application process.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Contact information for follow-up questions in specific areas.

SURVEY #7

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- FSP

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Family Education about Mental Illness and DMH service.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Family Education(like NAMI Family-to-Family)

SURVEY #8

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- The Budget it's ok , I wish the DMH or DPSS AND Children Department DEVELOP PROGRAM TO ERRADICATED BULLING IN THE SCHOOLS

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- The pandemic 😂 still on, and I hope THE CDC DEVELOP VACCINE FOR THE 5 year old

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Print out or hard copy the Document

SURVEY #9

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- There is a plan and action is being taken. The needs of those who struggle with housing are being address especially by DMH.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- The issue of substance use (all substances) and the lack of awareness to substance use being a contributor to a transient lifestyle.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Use client stories to share what services benefited and why type of personality was most helpful to their wellbeing.

SURVEY #10

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- NOTHING. IT'S THE SAME PLAN AS BEFORE, NAMELY: "STAY THE COURSE."

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- IN THE ENTIRE REPORT, I FOUND ONLY 4 INSTANCES MENTIONING AOT, AND THEY WERE ALL IN ONE SHORT PARAGRAPH ON PAGE 16 WITH ONLY 300 SLOTS.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- THE EXECUTIVE SUMMARY SHOULD NOT LOOK LIKE THE APPENDIX. PLEASE REMOVE ALL THE DATA, AND TABLES, AND MAKE IT ONE PAGE STRICTLY HIGHLIGHTING THE BEFORE, THE NOW, AND THE FUTURE IN PLAIN ENGLISH. AOT SHOULD BE EXPANDED. ONLY 300 SLOTS OUT OF 171K?! WE TREAT ANIMALS BETTER THAN WE TREAT PEOPLE. RESCUING A DOG FROM THE LA RIVER WAS BIGGER NEWS THAN 800 PEOPLE WITH MENTAL ILLNESS DYING EVERY YEAR ON THE LA STREETS FROM PREVENTABLE DEATHS! IF ONLY WE HAD A "FOSTER A PERSON WITH MENTAL ILLNESS" PROGRAM TO AT LEAST COME CLOSE TO HOW PEOPLE TAKE PETS IN THEIR HOMES! ANTONOVICH USED TO BRING OUT A PUPPY THAT IS UP FOR ADOPTION AT EVERY BOS MEETING. WHY CAN'T DMH SELECT A BOS SUPERVISOR WHO WILL BE THE MENTAL HEALTH CHAMPION AND FEATURE A PERSON WITH MENTAL HEALTH PROBLEMS AT EVERY MEETING WHO IS IN NEED OF A HOME, CARE, LOVE, COMMUNITY, AND SUPPORT? IF WE CAN GET THE PUBLIC TO LOOK AT PEOPLE WITH MENTAL ILLNESS THE WAY THEY LOOK AT THE RESCUE STORIES FEATURED ON YOUTUBE CHANNEL "THE DODO" (SEE FOR EXAMPLE THE YOUTUBE CHANNEL "LIVING WELL WITH SCHIZOPHRENIA") THEN WE AT LEAST WILL BE HALF WAY THERE. PLEASE EXPAND AOT TO INCLUDE "OPEN HOUSE" (FOR THE LACK OF A BETTER WORD) EVENTS AT SHELTERS, DMH TREATMENT FACILITIES, WHERE PEOPLE WITH MONEY WON'T HAVE TO GO TO FOREIGN COUNTRIES TO LOOK FOR COMPANIONS BUT INSTEAD FIND THEIR COMPANIONS AND THE FAMILIES THEY CAN HELP BY TAKING THEM INTO THEIR MANSIONS DIRECTLY FROM THE LA HOMELESS SHELTERS! THERE ARE MANY RECOVERED PEOPLE WITH MENTAL ILLNESS WHO ARE ON DATING APPS SEARCHING FOR SOMEONE LIKE THEM, WHEREAS THEY COULD BE SEARCHING IN THE WRONG PLACE! THEIR FUTURE MATE COULD BE WAITING FOR THEM AT A HOMELESS SHELTER OR A DMH TREATMENT FACILITY! CREATE A BRIDGE FOR MORE PEOPLE TO CONNECT WITH AKIN PEOPLE RATHER THAN FOR MORE PEOPLE TO CONNECT WITH MORE SHELTERED, ABUSED, HURT, AND DISTRESSED ANIMALS. WHAT MAKES SUCH A BIG DIFFERENCE BETWEEN THESE ANIMALS AND THE PEOPLE WE CAN SAVE?

SURVEY #11

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- The population served was broken down by SPAs with specific numbers for each service area.
- Charts/visual are accessible and easy to follow the data presented
- Measures taken by the agency to address the disabled population being served (Deaf/HOH)
- The inclusion of areas where the agency needs grow and the ability of the agency to self-monitor and design programs as needed.
- The agency's acknowledgement of trauma consequences and potential interventions to address the issue.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Lack of disaggregated API data (Ideally be specific to Filipinos and others served)
- 3 Year Plan is too broad
- Provide links to the proposed programs/plans in order to have a better understanding of the proposed changes and/or services.
- Topic of DMH being a multi-county collaboration with other counties; what is its purpose? What has been done? Who are the counties?
- Capital Facilities – what does this mean? Provide definitions for terms to make it accessible for the public

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Perhaps using hyperlink to access more detail information about programs, projects, data and expenditures (more detailed graphs)

SURVEY #12

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Loaded with information

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- everything is to general

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- send out a survey before putting together the budget, asking people what they would want elaborated on and add depth with how money will be spent on the most voted upon..

SURVEY #13

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- HELP THE HOMELESS MORE

SURVEY #14

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- IS TO FIND WAYS TO HELP IMPROVE EVERY PERSON WITH MENTAL HEALTH AND FINDS WAYS TO CREATE UP MORE VALUE FOR MORE MENTAL HEALTH CLINICS, CORPORATIONS, COMPANIES WITH EXCELLENT PHARMACY SUPPLY GREATMEDICATIONS.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- NOT PROVIDING ENOUGH SUPPORT AND MEDICAL ASSISTANCE FOR PEOPLE DEALING WITH MENTAL HEALTH

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- TO SUPPLY A REALLY GOOD MEDICAL STAFF FOR MENTAL HEALTH.

SURVEY #15

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- USING 4 MEDICAL FACILITIES TO HOUSE OR MANAGE THOSE IN CRISIS.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- The person in crisis must be referred by provider. Some are uninsured and medical records are not available for historical patient data.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Half of the budget is being spent on Hispanics. More neighborhood resources should be made available for this group.

SURVEY #16

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- An over all there could be improvement, where it's programs or planning housing for the homeless, changing rules where there are protecting the clients as well as the staff, over seeing attitudes management?

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Based of communication, with clients and not being knowledgeable of any abuse.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- By making a application, for phone app. So client can view appointment and treatment plans.

SURVEY #17

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Available resources

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Not having a team in place for mental health on emergency they take days to respond

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Having available mental health specialist there to support families in s crisis

SURVEY #18

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- How does this plan help the mentally ill for the long term.?
- Where is the plan to provide them a community of recovery?

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- nothing references LIVED experiences. Where is the input from people experiencing mental illness NOW?
- How does this plan help those for the long term.?

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- People living with mental illness NEED a community of recovery and hope. Build communities with housing where people have a purpose. Those that cannot recover stay and live a decent life. Those that can learn a skill, take their meds and live on their own can leave the community and live a hopeful life.

SURVEY #19

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- THESE REPORTS ON WHO FUNDS ARE USED, BUT IT'S DIFFICULT TO RESULTS AND OUTCOMES. WITH THE WAY THE SOCIETY IS FUNCTIONING I CAN'T VISIBLY OR MENTALLY GET MY MIND AROUND THINGS GETTING BETTER. I HAVEN'T PARTICIPATED IN THE CULTURE FOR OVER 3 YEARS, DUE TO COVID BUT STILL CAN'T INQUIRIES ABOUT ALL TYPE OF SERVICES. IT'S OVERWHELMING. IT'S LIKE A LOGIC MODEL ALL OVER THE PLACE.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- What's hard is interpreting the information effectiveness with the amount of money being spent. The information overload.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Stats that show reduction on the problems and who is being helped to become less dependent on the system. For three years, I tracked two former lifer's journeys after 32 years in prison upon reentry. Tracking, evaluation and support service that successful watched them be productive. I see the tangible.

SURVEY #20

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Very little.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Am so sick and tired of talk and no action. DMH is mostly a dead broken bureaucracy, and no one really even tries to fix it

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Fuck improving your presentation --start fixing problems and make things work.

SURVEY #21

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- NOTHING

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- lot with me in general

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Check my email and stay rite in tell god call on to me.

SURVEY #22

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Not sure

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- I ONLY KNOW YOU ARE NOT SEEING THINGS AS IT REALLY IS. OVER 65 YEAR OLDS NO MATTER WHAT RACE ARE IMPACTED BY PANDEMIC SO BAD THAT MOST OF ALL I KNOW HAVE WITHDRAWN FROM ALL SOCIAL EVENTS AND OUR LIVES HAVE BECOME SO DEPRESSED THAT I'M SURE OUR LIFE HAS LOST 10 YEARS OF EXPECTANCY

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Help people who are not poor or homeless but can't afford help

SURVEY #23

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- THE PROCESS FOR INPUT AND REVIEW.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- FLEXIBILITY IN BETTER UNDERSTANDING THE VARIOUS STAGES ENTITIES/CONTRACTORS ARE IN.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- IT IS ACTUALLY PRETTY GOOD BUT NEEDS BETTER DESIGN AND EASE OF USE.

SURVEY #24

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- NONE

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- NONE

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Open

[SURVEY #25

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- THERE IS A LOT OF GOOD INFORMATION BUT IT'S HARD TO KNOW HOW EVENLY SERVICES ARE BEING COVERED. FOR INSTANCE WHEN THE CATEGORY OF CHILDREN IS LISTED THERE IS NO BREAKDOWN TO KNOW HOW MANY CHILDREN 0-5 ARE BEING COVERED OR HOW MANY TAY ARE BEING SERVED.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- I GUESS I COVERED THAT IN THE FIRST QUESTION. SHOWS HOW MUCH MONEY IS ALLOTTED BUT NOT HOW WELL SERVICES ARE ACTUALLY BEING PROVIDED.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Offer outcomes - perhaps in another document. Breakdown categories such as children into 0-5 and 6 to 14 and TAY

SURVEY #26

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Strong promotion of racial classification and "wastebasket" taxonomies of Linnaeus & various white supremacist psuedoscientists. Strong perpetuation of functional inferiorization of "underserved" Foundational and Indigenous Americans. Excellent masking of corebarrier i.e., irrational invisibility of whiteness, with rationality.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Bolstering white settler meritocracy through reconceptualizing cultural competency as a measure of poor adaptation to white supremacy named "stigma", while 2% of U.S. psychiatrists are non-white. Misappropriation of Adinkara and ancestral African technology in support of advancing status quo. Pathological avoidance of real structural change eg. Redistribution of wealth as a social determinant of well

being and equitable access. Imposing fallacies of a white settler episteme eg. universal psychosocial axiology, "intersectionality", cultural capitalization, trauma integration, mental health as a set rather than component of human health, on Foundational Black American communities. The continuing presentation of white supremacy as rational. Pandering to white settler psychosocial scholarship that only seeks to measure, & profit from, the adaptive failure of stolen fresh water fish, in a toxic salt water environment, without addressing the "health" of the water.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Encourage and support the voices of "real"(i.e. non-nationalistic, unconditioned through white settler meritocracy) FBA & first peoples' advocates who seek to dismantle imperialist, white-supremacist, capitalist, patriarchy and restore space, time, energy, and movement as "health" agency in our communities. Address and face the fragile white-settler fears of the "cost" of a truly equitable Nuestra Señora La Reina de los Angeles de Porciuncula.

SURVEY #27

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Unsure. Received the notice for this survey on April 5th. Comments are due April 6th. This is not adequate notice.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Unsure. Received the notice for this survey on April 5th. Comments are due April 6th. This is not adequate notice.

SURVEY #28

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- not enough skilled and educated clinicians and para professionals to meet the demand in providing the services required. No accountability with the contract providers. We need to see greater outcomes and if there are poor results we must not delay in scraping a program and turn our attention elswhere. Thank-You

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Work ethics implementation for those with higher functioning skills need to be addressed. And entry level job opportunities for those mentally ill clients who would like to work would benefit from a program that could prepare them into the work force and make them independent from other services.

SURVEY #29

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Peers, Community Workers, and Medical Case Workers

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Management and DMH Leadership

SURVEY #30

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- THE MODERNIZATION OF THE CALL CENTER AND HOLLYWOOD 2.0 PROJECT

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- 1. Communication with DMH has become difficult.
- 2. DMH is planning to pilot the Hollywood 2.0 project intead of relying on community partners that are more flexible and nimble.
- 3. Despite the success of Peer Respites DMH still isn't talking to providers about adding more peer respites to our our continum.

SURVEY #31

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- None

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- A) It's not stakeholder driven, and it failed to follow stakeholder recommendations and request to correct the major errors by LACDMH and its consultants in their failed understanding and implementation of state mondated CPP legal requirements.
- B) The process discriminated against LACDMH who are Spanish monolingual by not having equitable opportunities to learn, participate, and develop this 2022/23 Annual Update. This current update does not include, reflect, or represent the interest, comments, and recommendations of Spanish monolingual stakeholders who provided comments to LACDMH about this MHSA update, and or who wanted to participate in the CPP process for the 2022/23 Annual Update that was presented by LACDMH in such a limited manner. The process included discrimination, harrasment, and retaliation of LACDMH consumers who participated in LACDMH MHSA planning and implementation sessions by LACDMH staff, consultants, and service providers.
- Here is a video link to example sited: http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=9758http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=9758

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- We need the CPP because the CPP can only be robust when (LACDMH) stakeholders, staff, and commissioners understand the requirements and is intentions about reaching out to stakeholders, unserved and underserved communities.
- Needs include:
- 1) Staff Training (for local mental/behavioral health agency staff) that includes:
- a. CPP Requirements by law:
- i. Definition
- ii. Participants
- iii. Process
- b. Community Engagement Training - Local agency staff should go out into the community (in-person & remotely) as they work to engage and receive input. Components of community engagement training should include: Individual Meetings with Leadership of Community Organizations (such as Cultural Organizations, Older Adult Groups, Children & Youth Groups, Parent Organizations, Veterans Groups, Advocacy Groups, Peer Groups)
- 1. Create a Relationship
- 2. Understand Cultural Sensitivity/Understanding regarding Mental Health
- 3. Discuss Barriers/Gaps and Successes
- ii. Listening Sessions with small groups
- c. Unconscious Bias Training
- 2) Ensure CPP Requirements are Met - Increased Emphasis in all of Los Angeles County localities, SALT's, UsCCs, LACDMH operated clinics/sites, mental health commission to review and approve the procedures used to ensure LA County residents and LACDMH consumers are involved in all stages of the planning process.
- 3) Identify and Communicate Successful Programs – Stakeholders, unserved and underserved communities as well as agency staff need to know what success looks like. They need to know about effective mental health strategies and programs that meet the needs of individuals with diverse backgrounds and experiences (including ethnic, racial, cultural, older-adult, justice-involved, people with disabilities, children, transitional age youth (TAY), and LGBTQIA2S+). CA's state agencies should work to increase the identification and communication of effective behavioral health programs and practices. Provide ongoing training and discussions about the MHSA, reports, and updates.
- 4) Have a dedicated staff that consumers, stakeholders, and community members can email and get timely responses about questions, concears, recommendations, and information related to LACDMH MHSA reports, updates, and mandated CPP processes.
- 5) Have safe spaces where LACDMH consumers are not attacked, and can be provided support from LACDMH staff when they are attacked, retaliated, harassed, and victimized by LACDMH staff, consultants, and contract providers for attending and participating in these MHSA process.

- We never got an answer about how much money is being allocated to LACDMH CPP , or how much has been spent and on what. Similarly there was no clear answer about the reported $100 million dollars of unspent MHSA money that LACDMH has not spent and is saving.

SURVEY #32

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- EFFORT TO ADDRESS BUDGET AND AVAILABLE FUNDING DIFFERENCES

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Continued token effort to address barriers and lack of services for deaf, hard of hearing, deaf-blind, and physically disabled

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Greater effort to address public concerns across services

SURVEY #33

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- larger scope

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- real time solution.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- That a person with community is more involved into planning etc.. As he / she is able to identify issues.

SURVEY #34

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Robust list of services and options that DMH provides

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Did not get a sense of support specific to my area, SPA 8 Additionally, we would like to see more MHSA investments in mobile mental health crisis response vans. It is our understanding that Orange County utilizes MHSA prevention funding for these services. LA County should provide funding to municipalities or COGs looking to implement mobile mental health crisis response services.

SURVEY #35

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- We get an overall view of the budget and provides information on each part of MHSA.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- The community stakeholder process is not being implemented correctly. The community should be working with DMH on creating the 3 year MHSA budget. There needs to be more transparency and accountability in this process

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Provide more detail about the budget: how are projects/ programs get selected. How can community provide input on money is spent. Be more transparent with the community stakeholder process

SURVEY #36

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- We need to continue to have the opportunity to gather as stakeholders through the Underserved Cultural Communities (UsCC) subcommittees and MHSA.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- More funding for community-based organizations servicing the American Indian/Alaska Native (AI/AN) community and more funding needs to be given to the underserved cultural community (UsCC) subcommittees (an increase in UsCC funding from 200k to 500k). More time needs to be allocated for stakeholders, consumers, and peers to provide feedback on this plan. The presentations did not offer an opportunity for community feedback. Please extend the public comment period beyond 4/6/22. There is a

clause in MHSA that it should go through a collaborative process with community members and that did not occur.

- Increased accessibility options/accommodations.
- Frequent presentations should be provided to stakeholders leading up to the three-year plan including background information regarding MHSA to increase meaningful participation. One option would be to educate community leaders who can then educate their community (train the trainer). This could potentially come out of the Community Planning Process (CPP) funding source.
- There is a need for increased education to the Native American community on navigating the public mental health system and on their rights.
- With regards to Native youth, to practice a similar enforcement process so that the family/caregivers have the necessary information to advocate for their children. Similarly to follow and comply with necessary consultation requirements with IHSS and tribal communities (similar to as mandated by the Katie A Law).
- For AI/AN community members, we would like to see more community-based driven MHSA funded projects that are peer driven. Offer meaningful incentive based/reimbursement based services to facilitate access and participation.
- DMH can develop better programs/services to meet the needs of the AI/AN community by increasing capacity for AI/AN UsCC staff and projects.
- DMH can better evaluate contracts and funds by looking at outcomes that increase access, participation, and continuity of engagement in LACDMH AI/AN services/programs

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- During the recent Community Leadership Team meeting, the promised breakout rooms to have deeper discussions were not provided.

SURVEY #37

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- The briefings gave more clarity on Full Service Partnership team approach, schools initiative and data on numbers served in different service areas. Also, more clarity on Innovations projects especially Innovations 2 as it is evolving to ongoing program and Hollywood 2.0

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Didn't see any metrics for goals/objectives in what was new efforts or difference was going to be made especially in terms of disparities. How is the MHSA filling in the gaps in our system wasn't addressed. Didn't explain why there were increasing or decreases in numers or groups which could be very important with the racisim, economic and COVID issues. Still large amount of unspent funds when need is so great even allowing for prudent reserve and captial funds being set aside for long term projects. Didnt' really address the problems of staffing shortages and need for more mental health professionals. Hard to tell if things are getting better or worse from the report without measures It may be the funds are not sufficient but no explanation if that is a problem. Also, no real information on how effective the system is in serving clients. How long to assistance or referred to and got services. What happens with those who refuse service

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Hard to comment on use of funds without know the overall plans of DMH. How do the MHSA fund plans support, complement the other plans of the DMH.

SURVEY #38

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- More funding for the Mental Health Promoter Program to increase Promoters to full-time (permanent) Positions. More funding for the UsCC's.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- More time for meaningful participation and inclusion of the American Indian, Alaskan Native and Indigenous Community.

SURVEY #39

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Focus is being dealt with Regards to mental health

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Statistically the highest impacted group of people in the United States with mental health issues are Native Americans in yet they are not addressed adequately. Native Americans fall in between the cracks because too often they are identified as other racial groups

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- For those that are unable to attend the meetings that breakdown the report a YouTube video or other form of media breaking down the key points would be good

SURVEY #40

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- No mention or emphasis on services to older adults other than FSP teams. Criteria for these teams do not include most older adults needing mental health services with mobility impairments. Please see attached letter addressed to county Aging Dept.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Include older adults as a specialized population

SURVEY #41

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- They help more the people who are struggling whit mental issues

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- They need more programs to help the people who got more mental issues be usefull in society

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Help the comunity the has mental issue over come there problems

SURVEY #42

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- No layoffs

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Lazy workers taking advantage of teleworking.

SURVEY #43

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- i see the strengths as being involved with people of the community

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- weakness is that you guys dont enough people handling the amount of people that need the help

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- hire more people to help with others that need the help

SURVEY #44

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- I got help but it took the courts for me to get any help , I knew I was in trouble but the medical profession was incapable of sending me to a place where I would get help, yes it was COVID , everything was locked down but my problem started long before COVID,

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- My son needs help , he had a psychotic break at his job , and no one was available to help , he called the police and told them I had been kidnapped, the police talked with and I explained he was in the middle of a psychotic break , don't take him to jail , , that was in December 2021 , I finally got him help , from olive view mental health , but he can't afford the meds , he lost his job , and this has caused us to owe so much in utilities that they will probably shut off our gas and electric, he went down to where he used to work and begged for his job back , he got it back , but as before , the job is only minimum wage and stil only part time , he has no insurance to pay for his meds no money to pay for transportation , and I only get 1060. A month , our rent is 1238. a month so we are stuck , I just got this free phone , but our utilities and WiFi cost us a lot , we will be in the dark soon , I am a senior walk with a cane have vision problems , there is no bus , no sidewalks where

we live except in front of our rental . So I am imprisoned to the house , after we pay rent there is 0 money . So paying for a therapist for my son is out of the question. He does not make enough , and I have nothing after rent is paid

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Follow up on people who get lost in the system , we have been in trouble for years and no one comes to help.

SURVEY #45

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- it was a comprehensive report

SURVEY #46

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Do not know much about it.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Do not know enough about it to judge.

SURVEY #47

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Good

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Okay

SURVEY #48

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- My energy

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Money problem on paying bills on time

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Seek different styles of knowledge for all together

SURVEY #49

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Help the homeless

SURVEY #50

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- Include all mental heath advocates and or primary mental health patient representatives.

SURVEY #51

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Excellent

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- none

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- let us come back to the clinic

SURVEY #52

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- organized approach

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- not addressing underserved communities enough

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- more concise. big bullet points and then more details on each later

[D53] SURVEY #53

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Emphasis on reaching underserved communities

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Too many programs that seem to overlap with one another. Not clear how specific communities are impacted by programs. There is a lot of programs at at Latinx population, but others are not brought into focus.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- There was a lot of information about the WeRise campaign, but I think that the other programs are much more important. Would have wanted more details on those programs.

SURVEY #54

Q1 ¿Cuáles cree que son los puntos fuertes de la actualización anual del año fiscal 2022/23?

- 8

Translation: Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- 8

Q2 ¿Qué ve como debilidades en la actualización anual FY2022/23?

- Anormal

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Abnormal

SURVEY #55

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- This group was not able to name any strengths to the FY 2022/23 Annual Update

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- There was not enough time to get information about this update, ask questions, or make feedback.
- The proposed listening session did not have consistent and reliable ASL services.
- The presented materials were presented were not ADA accessible.
- The printed materials for this update were not ADA accessible.
- There were no Spanish interpreters for the Annual Update presentation.
- The facilitator for this annual update was not adequate in facilitating, organizing, and responding to what is needed for this presentation.

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

- There was a general consensus in this UsCC that LACMH should have a “paid” disability-led task force that can create, guide, and partner with LACDMH in its MHSA process to ensure compliance with Welfare and Institutions Code (WIC), section 5847(b)-(e), 5848(a), 5892(g) required that a draft plan be developed through the Community Program and Planning process (CPP).
- More opportunities for our stakeholders to provide MHSA suggesting ideas. Nothing about us without us.
- Finally, LACDMH needs to have in place a mechanism to immediately address instances of discrimination, harassment, retaliation, and intimidation because of our disability(ies) not only in its MHSA-funded programs, but also in its MHSA CPP process

SURVEY #56

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Better effort to decrease gaps in services

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Bare minimum effort at decreasing gaps in MH resources for deaf and hard of hearing

SURVEY #57

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Very clear and detailed. Easy to understand.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Related to public engagement, please continue to improve the public engagement process with quarterly presentations to Service Area leadership and Under-served Cultural Community groups, and additional language translation.

SURVEY #58

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Peer Support and Employment are very important to the success of RECOVERY, information being put out to the PUBLIC is a complete BREAK-THOUGH, BREAKING THE SIGMA as we chisel away at this BIG ROCK it will have to CLUMBLE, On Line meetings and programs.

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Lack of CHILDRENS BEDS especially in THE SAN FERNANADO VALLEY, creates more of a TRAUMA to children not being able to see parents due to the distance and issues with TRANSPORTATION. (Personal Experience). More respect for THE CONSUMER by FORENSIC personal at entrance at our CLINIC SITES. SLOW RESPONCE BY PMRT TEAMS.Not working closer with Mental Health Commissioners for on SITE inspections or visits.

SURVEY #59

Q1 What do you see as strengths to the FY 2022/23 Annual Update?

- Being a mental health advocate supporting people struggling with mental health

Q2 What do you see as weaknesses to the FY 2022/23 Annual Update?

- Schedule

[D2] EMAILS

Received March 14, 2022, 1:33 PM

Hello,

Thank you for posting this report and your presentation last week. It was very helpful. I have two comments/questions.

First, there is one area of public health that was not called out specifically. That is the devastating acceleration of the opioid crisis since the pandemic. Overdose deaths have increased 45% in 2020. Please help me understand what this year's plans are to address this issue.

Second, the pandemic forced a lot of small businesses and non-profits to close while the needs of the community intensified. The contracting process within LA county required 3 years of experience. New businesses (which most are because the old ones closed) do not meet those criteria. I propose a new pathway be created to encourage innovation, adaptability, and agility to respond to the ever changing needs of the community. This will also promote equity and fairness in the application process.

Received March 10, 2022, 3:12 PM

I have sat on Spa 6 Consumer Advisory Committee since minimally 2014 when Yolanda Whittington was the Administrator. She was recently called upon as an advocate to attempt to resolve a landlord Tenant dispute.

DMH Hollywood involved. Dakota Simms DMH West Central Mental Health. Recently contacted regarding Collaboration. Previously contacted regarding Housing from DMH representative. Women's Reintegration Center contacted multiple times regarding obtaining records. Sandra DMH was supposed to.mail. Apparently all emails and DocUsign and Documents in question even signatures

---

Received March 9, 2022, 2:07 PM

My Name is Terri Jay, community member and member of the LADMH-SubCommittee - LGBTQIA2-S,

This email pertains to questions to present in the reading of DRAFT : LADMH " MHSA Fiscal Year 2022/2023 Annual Update and here are my questions seeking your answers based on what I read and i'm quite confused that needs information.

1. Language not being used correctly for LGBTQIA2-S as most of the term for LGBTQIA2-S where A is left out most of the report and some are used with A (Asexual) for instance for page 11 Table and page 52 Sec F as correct with definition. I do believe in the FISCAL Year report, the report should be consistent to use terms with all acronyms in LGBTQIA2-S throughout the report.

2. Again using the term isa important and what is INCONSISTENCY is in the report is not being consistent using the correct term identifying community as NATIVE AMERICAN / ALASKA NATIVE and throughout the reports is inconsistency using either NATIVE AMERICAN, AMERICAN INDIAN and not using ALASKA NATIVE with NATIVE AMERICAN . such as TABLES 1,2, 6 SEC F Page 52 and page 58 PEI-SEC TABLE 30 , 7, 17. Again throughout the report is the inconsistency in using correct term / language to identify for DEMOGRAPHICS and for Percentages % and for the sole purpose of fiscal allotted revenue for outlets to all community at large or for projects or for outreach engagement reports.

3. On Pgae 89 the Term GENDER IDENTITY if not specific as to what percentages are reported to what? is the report on d=gender identity for TRANSWOMEN and TRANSMEN or GENDER NON-BINARY or QUEERS community or the Gender Identity inclusive for all identifying as MEN and WOMEN, is this is true, there is no clarity of specifications.

Any feedback to help me understand the terms is helpful and the entire FISCAL reports cannot move forward until there is FINAL DRAFT approved until DRAFT is corrected/edited with correct terms/languages as mentioned.

Thank you for your understanding,

Terri Jay
Case manager, Community Member and Member of LADH- SubCommittee LGBTQIA2-S

Received April 6, 2022, 12:36 PM

Hello, on March 21, 2022, as co-chairs of the ACCESS For All UsCC, Cody and I requested our LACDMH UsCC support staff send out a Microsoft teams survey to our membership, similarly to the one that was created and distributed to the members of other UsCC's to gather timely and meaningful feedback from their members, Instead, our disabled community and stakeholders got a word document with only 2 days to offer comments.

I would like to point out that the feedback process that LACDMH and its paid contractor created for stakeholders to participate in the SLT meeting was not guided by stakeholders and did not provide stakeholders an opportunity to participate in the advertised break out group sessions, ASL services were both not consistent or reliable through the presentation, there were no Spanish language interpreters, and the materials presented were not ADA accessible for our communities

The Los Angeles County Department of Mental Health (LACDMH), with a budget of approaching $3 billion, is the largest county-operated mental health department in the United States, directly operating programs in more than 85 sites, and providing services through contract programs and LACDMH staff at approximately 300 sites co-located with other County departments, schools, courts, and various organizations. Each year, the County contracts with close to 1,000 organizations and individual practitioners to provide a variety of mental health-related services. On average, more than 250,000 County residents of all ages are served every year.

A large portion of the funding that LACDMH receives is obtained by the MHSA funds and so we know that LACDMH and its staff are committed to upholding is statutory obligations in order to receive MHS funds and continue providing services to our most impacted and historically marginalized communities.

Given the many barriers, challenges, and missed opportunities our stakeholders have had to deal with we are asking once again for an extension to the public comment period that LACDMH has establishes for the MHSA report, in accordance with Welfare and Institutions Code (WIC), section 5847(b)-(e), 5848(a), 5892(g) required that a draft plan be developed through the Community Program and Planning process (CPP).

In unity,

Héctor Manuel Ramírez

Received April 6, 2022, 10:28 AM

Hello,

I did request a call back in the online survey after the annual update meeting last month and never heard back. Is there someone that I could speak with?

My name is Sarah Anderson and I have started a new non-profit, Vic James Center, to help meet the needs of the community.

Many non-profits closed due to the pandemic which has created a surge in the demand for these healthcare services. The new non-profits built to replace the ones that closed are backed into a corner with lengthy applications and prior service requirement. They are unable to get the funding they need. It is also difficult to to secure a lease for the same reasons.

My ask is that we put in place application processes that encourage innovation, agility, and adaptability to meet the needs of the community we can fill the gap the pandemic has created without sacrificing integrity, quality, or reliability. We also need support from the State and County to establish the resources when roadblocks come up.

Thank you for making it possible to skillfully respond to our communities' everchanging needs.

Sarah Anderson
Founder & CEO
Vic James Center

Received April 6, 2022, 9:47 AM

Feed back Great

Received April 12, 2022, 12:18 PM

Dear LACDMH:
Here is the recommendations on behalf of the LGBTQIA2S+ community.

what we found is that the MHSA 3 YEAR PLAN isnot LGBTQIA2S friendly) and also what we wanted to see in the 3 year plan was hard to do because there were no programs that were directly done from DMH. We thought having no employee lay-offs and hiring more people who identify as LGBTQIA2S of color need to be hired. We want to see data collected that asks sexual identity, gender, and sex assigned at birth, as well as pronouns be universal in all programs. We want to have training for all staff, we also want to see the expenditure for all programs.

1 - I had a direct conversation with the L.A. Census Bureau last week. The Census representative confidently stated they feel there will be an Undercount. The current status of the count is not where they projected it to be at this time. How are you going to factor this into your forecasting of the 3-Year Plan?

2 - For ease of use for multiple readers/interested parties there uld be hyperlinks to each of the sections within the 3-Year Plan originating from the Table of Contents within the document.

3 - Fail to understand why the presentation within the 3-Year Plan for the new 3-Year Plan is at such a low resolution. Was this by design? This is concerning and inexcusable given access to any type of open/online applications that can create a decent PDF. This low resolution is difficult to read for those readers who have vision challenges or is being read by older eyes.

4 - Given a $528 million dollar budget currently serving 140,000 clients that amounts to $3,771.43 per client. How is this dollar value being measured against the success value of services the clients are receiving.

6 - I find it very concerning that given our current world situation there is no call out to address climate change, extreme heat, and mental illness as a direct result of extreme heat. The 3-Year Plan is short-sighted in this area.

7 - The 3-Year Plan mentions the LGBTQIA2-S community. The 3-Year Plan needs specific language to address the LGBTQIA2-S community and its unique mental and social health issues. Most importantly dressing unique needs of LGBTQIA2-S older adults

8 - The 3-Year Plan needs to collect data on sexual orientation gender identity (SOGI) at all times. On May 6, 2020 California State Senator Scott Wiener introduced SB 932- Collecting LGTBQ Data as it relates to COVID-19. The bill mandates that the state collect SOGI data for anyone tested or treated for COVID-19. It is in the best interest of any arm of the County of Los Angeles to collect SOGI in all matters of public health and public mental health, not just COVID-19.

Please share my comments above with the Ad Hoc Committee. Please have someone send me a summary of the Ad Hoc meeting.

We need targeted identification, hiring, training, and professional advancement opportunities for Peer Specialists who identify as LGBTQIA2-S, with specific efforts geared toward Black and American Indian/Alaska Native peers as well as transgender, non-binary, and gender expansive peers. Peer Specialists represent a growing and vitally important segment of providers within DMH, and LGBTQIA2-S-identified Peer Specialists would be incredibly valuable in promoting prevention and wellness for our most marginalized and underserved LGBTQIA2-S community members.

a. LGBTQIA2-S Peer Specialists should represent diverse age groups, especially TAY and Older Adults.

b. LGBTQIA2-S Peer Specialists should be integrated within Directly Operated programs in all Service Areas, as well as within DMH-contracted programs.

Within the scope of Facilities funding, we advocate for an evaluation of all DMH clinics/offices for the presence of at least one all-gender restroom that is ADA-compliant and accessible to consumers and staff. This all-gender restroom should have explicit signage designating it as such, and additional signs should be easily visible throughout the building to provide directions to this restroom. Within facilities that do not already have a designated and accessible all-gender restroom, funding should be allocated to ensure that each clinic/office adds at least one ADA-compliant all-gender restroom onsite.

Given the increasing shift toward delivering care through virtual platforms, DMH should allocate funding to train staff on trauma-informed approaches to telehealth. This is especially relevant for LGBTQIA2-S youth, who may be engaging in mental health services while in an unsafe and/or invalidating environment. DMH should ensure that service providers (including clinicians, outreach specialists, medical case workers, and peer specialists) have the necessary skills and training to recognize and respond to trauma events and posttraumatic stress, including secondary and vicarious trauma, through the lens of service provision via telehealth.

Funding - As Greg Polk mentioned on durning the 6/25/20 Public Hearing, there will be shortage of funds due to the prudent reserve

Programs- There should be programs to address the specific needs of the LGBTQIA2S community. Currently on the 3 MHSA Plan, there are none.

Training- There should be more training for all DMH Staff and partners, the LGBTQIA2S UsCC has offered many training opportunities

Listen- to the LGBTQIA2S UsCC they have been working on many levels on this for a long time. Please listen to their specific needs.

Safety- has been a concern that many people have raised. Being home during COVID19 is not safe for many. Please consider the higher risk a lot of people face due to their identities.

[D3] LETTER FROM THE CULTURAL COMPETENCY COMMITTEE AND THE UNDERSERVED CULTURAL COMMUNITIES

March 21, 2022

Jonathan E. Sherin, M.D., Ph.D.
Director of Los Angeles County Department of Mental Health
550 S Vermont Ave
Los Angeles CA, 90020

Dear Dr. Sherin:

The Cultural Competency Committee (CCC) and the Underserved Cultural Communities (UsCCs) are writing to request an increase of funding to $500,000 for each UsCC to invest

in community based capacity building projects and separate funding for the CCC. By directly funding the CCC and the UsCCs, you will be upholding your commitment to serving the most impacted communities and uplifting the voices of the consumers. This can be achieved by increasing the use of CSS funds for these stakeholder bodies. Additionally, the timeline for stakeholder involvement must restart due to violations to the MHSA general standard of a client driven process and the Welfare and Institutions Code.

INCREASE THE PERCENTAGE OF PLANNING OUTREACH AND ENGAGEMENT IN THE CSS FUNDS

According to the LA County Department MHSA Update for FY 2022-2023, your department is suffering from a lack of and retention of staff (slide 14 from the Community Leadership Team Stakeholder Meeting on March 9, 2022). Therefore, the work culture and service rendered by LACDMH is currently insufficient for staff and clients. It would be wise to place funds towards CSS (Planning Outreach and Engagement) so that the community can provide the services to those in need while LACDMH is hiring and restructuring its infrastructure towards a more equitable and anti-racist institution. There have also been cuts to Prevention and Early Intervention, which is key to living a fulfilled life with a behavioral health condition. The CCC and UsCC leadership agree this is not a wise decision for consumers.

MHSA states that counties can use up to 5% of the CSS budget for Planning Outreach and Engagement (POE). In LA County for FY 2022-2023 that is $57.7 Million dollars that could be spent on Planning Outreach and Engagement to fund programs like UsCC and CCC. However, LACDMH is only spending $6,464,688. There are about $51 Million dollars that are not being used. In fact LACDMH is reducing the initial projection of $7,108,451 by $643,783, due to “Overall reduction in services due to the pandemic and difficulties in retaining staff”. If LACDMH is low on staff, then they should compensate the Community Leader Volunteers who serve in “Your DMH” Committees as stated in the August 19, 2019 UsCC Charter- “Policies, Procedures, and By-laws”. Many promises have been made to community members by LACDMH for participation in the Community Planning Process, but there is no follow-through.

LACDMH CURRENT PLAN FY 2022-2023

PROPOSED CSS MHSA BUDGET FY 2022-2023	PROPOSED CSS BUDGET FOR PROJECT OUTREACH & ENGAGEMENT FY 2022-2023	PERCENTAGE OF PROPOSED CSS BUDGET FOR PROJECT OUTREACH & ENGAGEMENT FY 2022-2023	MHSA LAW PERCENTAGE SUGGESTION (UP TO)
$ 1,154,359,375	$ 6,464,668	0.56%	5%

CCC AND USCC RECOMMENDATION FOR FY 2022-2023

PROPOSED CSS MHSA BUDGET FY 2022-2023	PROPOSED CSS BUDGET FOR PROJECT OUTREACH & ENGAGEMENT FY 2022-2023	PERCENTAGE OF PROPOSED CSS BUDGET FOR PROJECT OUTREACH & ENGAGEMENT FY 2022-2023	MHSA LAW PERCENTAGE SUGGESTION (UP TO)
$ 1,154,359,375	$ 57,717,968.75	5%	5%

VIOLATIONS OF THE MHSA ON STAKEHOLDER ENGAGEMENT

On March 9, 2022 at the CLT meeting, the promised breakout sessions did not occur, thus inhibiting the input of stakeholders. According to the Welfare and Institutions Code (WIC), section 5847(b)-(e), 5848(a), (5892(g) required that a draft plan is developed through the Community Program and Planning process (CPP). As stakeholders, we must be involved in the drafting process by MHSA law, not have a draft given for stakeholders to vote on. The plans must contain a programming component and a budgetary component. There were many barriers for stakeholders in addition to the cancellation of breakouts sessions. These included but are not limited to:

- Lack of space/opportunity to adequately advise and provide feedback on MHSA budget
- Language interpreting availability and quality – above and beyond the bare minimum to begin meeting accessibility standards

We kindly demand that timeline for stakeholder input be restarted due to the violation of the MHSA general standard for the process to be client driven (9 CCR §3200.050) and community collaborative (9 CCR §32.060).

CONCLUSION

Therefore, as leadership of the UsCC and CCCs, we kindly request you increase your investment in the capacity building project that positively and directly impacts our underserved communities. We are requesting $4 million dollars for the UsCC and CCC, or $500,000 per subcommittee. This is an increase of only $2.6 million dollars from the existing budget for the UsCC. Community leaders must be reimbursed for their work, and we need more capacity building projects that affect our most vulnerable and underserved populations who have been the most impacted by the COVID-19 Pandemic. When the community and LACDMH staff collaborate, we can achieve more.

Very respectfully,
CCC and Us

[D4] COMMENTS/QUESTIONS FROM THE DEPARTMENT OF HEALTH SERVICES REGARDING THE EXECUTIVE SUMMARY FOR THE MHSA ANNUAL UPDATE FY 2022-23

FSP Transformation

1. Table 10: How many of these FSP slots were authorized, and connected upon discharged and housed for patients discharged from DHS county hospitals?

2. Table 11: How many slots were utilized for each Countywide FSP Program?

3. Table 11: How many were authorized, accepted, connected upon discharge and housed for patients discharged from DHS County hospitals?

4. Table 18 and 19: Does this mean that less funding was used or less funding is projected and planned for 22-23? Can these buckets of funding be used for designated collaborative care psychiatry support?
   DHS is seeking for greater DMH psychiatry support to assist with DHS Collaborative Care model for Depression in the Primary Care Medical Home.
   Please provide clarification on the changes in eligibility criteria for the FSP Transformation?
   - DMH Response: The focus is on highest acuity, most vulnerable clients who meet focal population criteria.

5. Please provide clarity to the difference in the previous FSP model?
   - DMH Response: There is a long list of program differences. The previous model included "at-risk" populations. Also, there were a number of specialty FSPs that have now all been integrated into 1 general FSP because our clients tend to have overlapping domains of need (not just homeless, not only forensic, etc.). The changes are outlined at the bottom of page 12 & top of 13. Are there specific changes that need clarification?

6. What is the current ratio compared to the previous (FSP)? With current challenges with workforce shortage, does this lowered client to staff ratios affect the service utilization and/or FSP capacity/slots availabilities?
   - DMH Response: Past client to staff ratio was 15:1, now it is 10-12:1. These are not hard and fast ratios; there is flexibility based on clinical need. We lowered the ratio to match the specialty FSPs, recognizing that some clients are at a level of need that requires more resources & staff time. We've had some providers tell us that they are able to adequately serve their current client populations with the 15:1 ratio. The current workforce shortages do make it a challenge to maintain capacity while lowering caseloads. We have given extra technical assistance, support, and consultation to mitigate the impact on capacity as much as possible.

7. Please clarify what are new "enhanced services and supports" are being provided between levels of care and how is this being measured (FSP)?
   - DMH Response: Enhanced services & supports include: technical assistance (from data to clinical issues); specialized trainings focused on working with high acuity populations, homelessness, justice involvement, cultural differences, reducing disparities, clinical issues, involuntary treatment, specialty populations, supportive supervision, self care, trauma, and many other topics; increased availability of flex funds and housing supports; adding to OCS capacity & navigation teams, standards for relentless engagement & assessing appropriate levels of care, and protocols for overlapping services to strengthen transitions between levels of care.

8. What are the changes?
   - DMH Response: Some changes include the addition of incentives for specific outcomes, emphasis of focal population and a multidisciplinary/population approach, easier access to data & an emphasis on data-informed practice, and a rate setting exercise to bring LE provider salaries closer to parity with their DMH counterparts.

9. Are the service exhibits accessible to public?
   - DMH Response: Yes

500 Bed Pilot

10. Please clarify. Does this mean that funding for 239 beds are allocated, however only 160 beds were available and utilized (500 bed pilot)?
    - DMH Response: Yes, as of the time of the writing of the report.

11. What are the reasons for the remaining beds not utilize, particularly during COVID surge when hospital beds were short and lacked capacity?
    - DMH Response: The remaining subacute beds were occupied by other counties.

12. How many of these beds were provided and utilized by DHS county hospital patients?
    - DMH Response: Beds were prioritized and utilized by DHS county patients as they came available. A total of 112 beds were utilized by DHS.

13. What are the level of care for these 239 beds?
    - DMH Response: The 239 beds included acute inpatient beds, subacute beds, and skilled nursing facility beds.

14. Were any of these beds re-purposed? If so, in what way?
    - DMH Response: Not certain what is meant by re-purposed.

15. How many of these beds were authorized for DHS county hospital patients?
    - DMH Response: Beds were prioritized and utilized by DHS county patients as they came available. Because acute inpatient beds and other transitional beds were turned over quickly, the number of beds provided & utilized by DHS outnumbered 239.

[D5] MOTION BY COMMISSIONERS KATHLEEN AUSTRIA AND REBA STEVENS: EXPANDING DIVERSION-RELATED SERVICES

MOTION BY COMMISSIONERS KATHLEEN AUSTRIA AND REBA STEVENS
Expanding Diversion-Related Services April 28, 2022

There are currently 12,859 people in the Los Angeles County jail system. It is essential that the Mental Health Commission do what it reasonably can to care for the forty-three percent of the jail's population who have serious mental health needs -- a 21% increase since 2020. Consistent with national trends, incarcerated women have a particularly high rate of mental health needs. Moreover, there are significant racial disparities in who is incarcerated—with Black Angelenos and Latinx/Hispanics hit the hardest. The RAND Corporation did a study in 2020 which found at least 61% of the individuals with serious mental health needs could safely be served in community-based settings.

Many experts have recommended further expansion of community-based mental health treatment options to increase diversion for people with mental health conditions. The Los Angeles County Department of Health Services' Office of Diversion and Re-entry (ODR) has demonstrated success in addressing this crisis, but it has not been able to expand services beyond its 2,200-bed capacity because of financial constraints.

The Los Angeles County Board of Supervisors created ODR in 2015 to reduce the number of people incarcerated in Los Angeles County jails with mental health and/or substance use disorders who are at risk of homelessness, to reduce recidivism, and to improve the health outcomes of justice-involved populations who have the most serious underlying health needs. Since its creation, the courts have released 7,414 persons from jail and into ODR's care where they receive community-based treatment and various types of supportive housing programs. (See Attachment A). Numerous studies have confirmed that ODR's programming is successful at stabilizing persons with serious mental illness so they can safely live in the community. Another Rand Corporation study of ODR's Supportive Housing Program found 91% of its clients had stable housing after six months; 74% had stable housing after twelve months; and 86% had no new felony convictions after a year. Ninety percent of its clients successfully remained housed after six months, and only 15% had a felony conviction within the next year. 2

Preliminary results of a study by UCLA of 962 ODR clients is showing that their medical and mental health hospitalization and emergency department visit rates dramatically dropped after they enrolled in ODR programs. (See below).

Table 2. Medical Health Utilization Rate (per 100,000 clients) in pre and post 12 Months of Enrollment

Variable	*In pre 12 months*	*In post 12 months*
Number of hospitalizations (per 100,000 clients)	156,128	63,454
Number of ED visits (per 100,000 clients)	313,092	116,896
Number of primary care visits (per 100,000 clients)	92,200	199,249
Number of specialty visits (per 100,000 clients)	59,888	92,490

Table 3. Mental Health Utilization Rate (per 100,000 clients) in pre and post 12 Months of Enrollment

Variable	*In pre 12 months*	*In post 12 months*
Number of hospitalizations (per 100,000 clients)	71,587	20,775
Number of ED visits (per 100,000 clients)	56,546	17,271

Despite the demonstrated efficacy of the ODR model, sufficient funding has not been identified to sustain its current operations, much less scale up diversion efforts to keep pace with the growing need. It is time for the MHSA Commission to confirm its support for this program and the dignity it restores to its persons with serious mental illness.

WE THEREFORE MOVE THAT THE MENTAL HEALTH COMMISSION:

1. Proclaim that Jail-Based Diversion is a strong priority of the Mental Health Services Act Commission.
2. Strongly recommend that the Department of Mental Health allocate $25M a year in ongoing Mental Health Service Act (MHSA) funds, beginning FY 2022-2023, to support the Office of Diversion & Reentry's services to MHSA eligible clients and that the fiscal year MHSA plan be amended to reflect these recommendations.

AMENDMENTS TO THE MOTION

Amendment 1:
The Department of Mental Health reports back to the Commission on Mental Health at its May 2022 meeting with recommendations on how the ODR-DMH MOU "operational pieces" can enhance reimbursements such as Medi-Cal and other state and federal funding.

Amendment 2:
The Department of Mental Health report back to the Commission on Mental Health Commission at its May 2022 with recommendations on enhancing client/mental health outcome data from ODR.

Amendment 3:
The Department of Mental Health report back to the Commission on Mental Health at its May 2022 meeting as to what category the ODR funding will be allocated and what, if any, specific MHSA state requirements need to be addressed regarding the allocation.

Amendment 4:
The recommendation for ODR MHSA funding be subject to 30-day community input hearing.

Amendment 5:
Ensure MHSA funds will not supplant other funds.

Amendment 6:
Add details on a budget; report back on metrics and health outcomes, people that get out of jail due to this funding and data sharing

ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
Southern California

April 27, 2022

Via E-Mail
Honorable Members of the Mental Health Commission
510 South Vermont Avenue
Los Angeles, CA 90020

RE: Support for Motion by Commissioners Austria and Stevens recommending allocation of $25 million of MHSA funding for the Office of Diversion and Reentry (ODR) (agenda item 4, April 28, 2022)

Honorable Members of the Mental Health Commission:

The ACLU of Southern California (ACLU) strongly supports the Motion by Commissioners Austria and Stevens recommending allocation of $25 million of MHSA funding for ODR (agenda item 4, April 28, 2022).

For years the ACLU has critical of the over incarceration of people with mental illness in the criminal legal system and argued for a massive reduction of the population of people with mental illness in the jail through diversion to community-based treatment *See* S. Leibowitz, P Eliasberg, et al, *A Way Forward: Diverting People with Mental Illness from Inhumane and Expensive Jails Into Community Based Treatment that Works*, (Report by ACLU So Cal and Bazelon Center for Mental Health Law, July, 2014).[1] As part of our work, we have advocated for the creation and expansion of ODR, opposed the construction of Mental Health Jail and criticized the failure of the County to move more quickly to implement its stated goals of "Care First, Jails Last" and the closure of Men's Central Jail.

The preamble to the Motion makes clear how successful ODR has been in moving people with mental illness out of jail into community treatment programs that work as measured by recidivism rates, housing stability rates, and reduction in use of medical and mental health hospitalization and emergency services by clients of ODR. By contrast, keeping people with mental illness in jail results in poor mental health outcomes, enormous human suffering, awful recidivism rates, and significantly higher costs compared to community treatment – costs that are not covered by Medical.

Unfortunately, despite the proven success of ODR's programs, the Board of Supervisors has not adequately funded ODR on an ongoing basis. Nor has DMH provided adequate MHSA funds to allow ODR to maintain and expand its work. As a result, ODR's highly successful ODR Housing

[1] Available at MENTAL-HEALTH-JAILS-REPORT.pdf (aclusocal.org)

program has been unable to take on new clients for more than a year. See Elena Dugdale, *This LA Jail Program Is A Huge Success. So Why Can't It Take On More People?* (LAIST, April 27, 2022).[2] The need for ODR to receive substantial ongoing funding is pressing.

While the benefit of passage and implementation of this Motion will be most pronounced for people with mental illness who currently suffer in the jails, and their families, it will have significant additional benefits:

1) Help the County create the community treatment beds necessary to allow for the closure of Men's Central Jail.
2) Enable the County to begin to fix its shameful history of non-compliance with the consent decree between with the United State Department of Justice governing treatment of people with mental illness in the County jails.[3]

Accordingly, the ACLU strongly supports the Motion and urges the Commission to pass it and DMH to abide by its recommendation.

Sincerely,

Peter Eliasberg
Chief Counsel

cc: Dr. Christina Ghaly
Dr. Clemens Hong
Dr. Kristen Ochoa
Mental Health Deputies

[2] Available at https://laist.com/news/criminal-justice/this-la-jail-program-is-a-huge-success-so-why-cant-it-take-on-more-people

[3] We explained in the attached letter dated December 10, 2021 to the Board of Supervisors how the County cannot come into compliance with the consent decree with the Department of Justice without substantially reducing the number of people with mental illness in the jails.

APPENDIX E - PUBLIC HEARING PRESENTATION AND TRANSCRIPTS

[E1] PUBLIC HEARING AGENDA

Los Angeles County

Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

First District	Second District	Third District	Fourth District	Fifth District
Imelda Padilla-Frausto	Reba Stevens	Teresa Banko	Kevin Acebo	Judy Cooperberg
Susan Friedman	Kathleen Austria	Stacy Dalgleish	Michael Molina	Lawrence Schallert
Ben Root	Jack Barbour	Martel Okonji	Vacant	Brittney Weissman

Lily Sofiani, Second District Representative

Mental Health Commission

MHSA Annual Update FY 2022-23 – Public Hearing

Thursday, April 28, 2022
11:00 am – until end of business

Stacy Dalgleish, Chair, Presiding

VIRTUAL MEETING

To Watch Live: Click Live Event

To provide live public comment, call the AT&T Public Comment Line at 844-291-6362 Conference Code 4972277. You may provide your name to the moderator, but you are not required to do so. Public Comment is limited to 2 minutes per speaker.

To listen only via telephone in **Spanish**, call 888-204-5987 Conference Code 9639884#

Live Closed Captioning (**CART**) services are provided on this link: Closed Captioning

American Sign Language (**ASL**) is provided on the Live Meeting link above.

In response to the State's enactment of **AB361**, the Mental Health Commission will continue to hold all Brown Act meetings virtually via teleconference until further notice.

(AGENDA ON NEXT PAGE)

Los Angeles County

Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

Agenda

April 28, 2022
11:00 am - until end of business

Stacy Dalgleish, Chair, Presiding

In response to the State's enactment of **AB361**, the Mental Health Commission will continue to hold all Brown Act meetings virtually via teleconference until further notice.

1. **Call to Order/Roll Call/Acknowledgements**

2. **Announcement: Dr. Jonathan Sherin, Director, Department of Mental Health**

3. **Public Comment: Agenda & Non-Agenda Items (2 min)**
   Opportunity for members of the public to address the MHC on items of interest that are within the jurisdiction of the Commission. You may submit public comment by email to MHCommission@dmh.lacounty.gov, by mail or in person: 510 South Vermont Avenue, Los Angeles, CA 90020.

4. **Motion by Commissioners Stevens and Austria**
   Support Expansion of Diversion Services (attached)

5. **Public Comment: Agenda & Non-Agenda Items (2 min)**
   See instructions above.

6. **Mental Health Services Act (MHSA) Annual Update FY 2022-23 Public Hearing**
   Gregory C. Polk, MPA, Chief Deputy Director, Los Angeles County Department of Mental Health

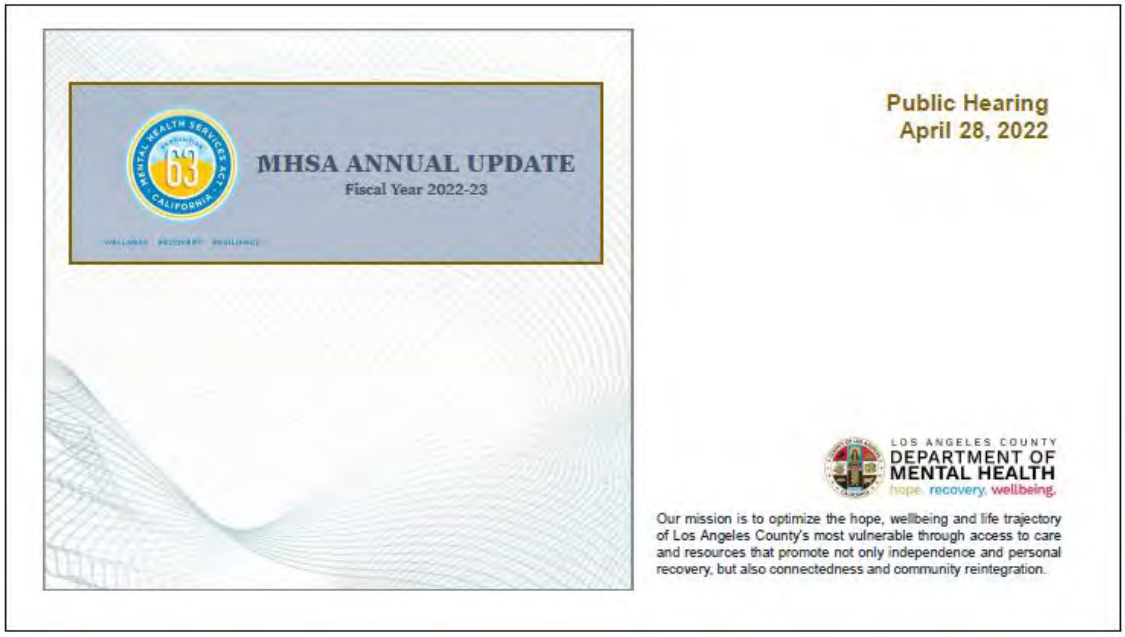
7. **Public Comment: Agenda & Non-Agenda Items (2 min)**
   See instructions above.

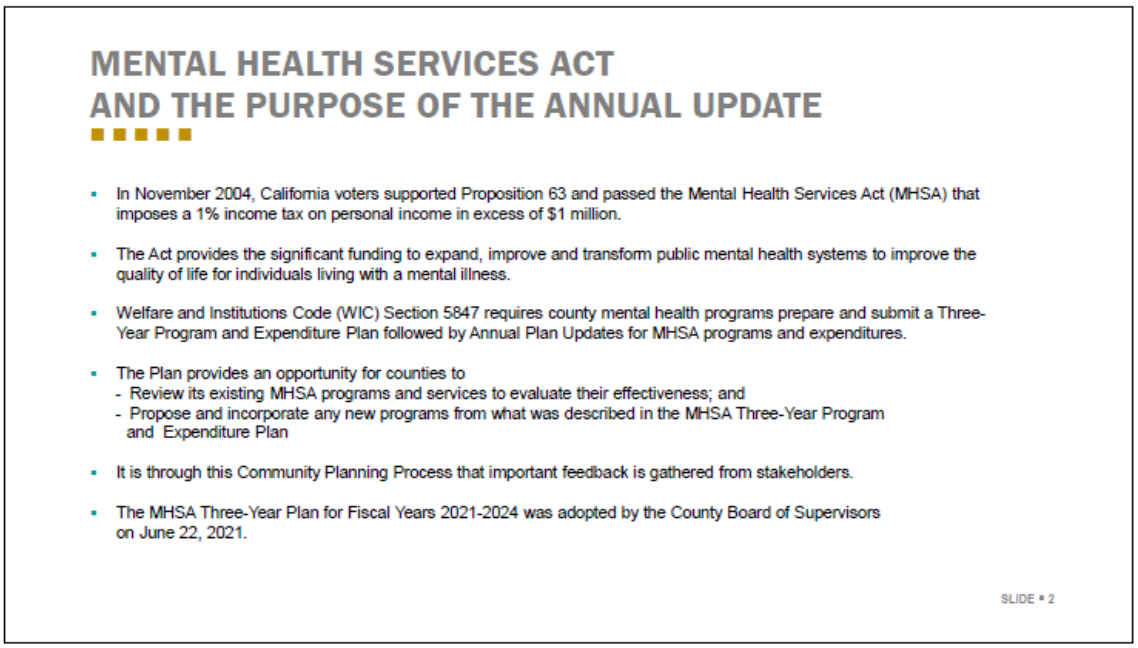
8. **Update: Board of Supervisors, Lily Sofiani, Second District Representative**

9. **Update: Commissioners**

Adjournment

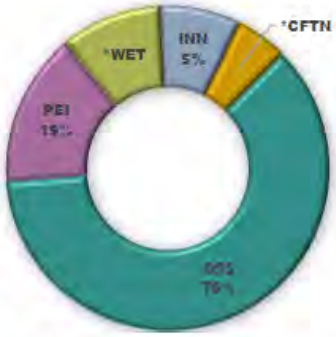
[E2] PUBLIC HEARING POWERPOINT PRESENTATION





MHSA OVERVIEW BY COMPONENTS

- CSS, PEI and INN percent of total annual MHSA allocations shown below
- *WET and CFTN allocations are funded by transfers from CSS



COMMUNITY SERVICES AND SUPPORTS (CSS)

PREVENTION AND EARLY INTERVENTION (PEI)

WORKFORCE EDUCATION AND TRAINING (WET)

INNOVATIONS (INN)

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

SLIDE # 3

Fiscal Year 2022-23
MHSA Annual Update Presentation Overview

- COVID-19 Impact on Mental Health Services
- Focus on Disparities
- MHSA Client Counts
- Proposed Changes
- Community Planning Process
- Community Feedback

SLIDE # 4

COVID-19 IMPACT ON MENTAL HEALTH SERVICES

- LACDMH MHSA 3-Year Plan shed light on the significant impact the COVID-19 outbreak had on County residents and communities:
  - 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
  - Widespread rising COVID infection rates prompting the need for temporary and/or permanent business and clinic closures
- This third year of the pandemic, especially after the Delta and Omicron variants, has shown improvements in the County's ability to control infection rates, hospitalizations, and to provide social services and economic help to those in need

SLIDE # 5

5

COVID-19 IMPACT ON MENTAL HEALTH SERVICES

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

- Increased use of technology, including telehealth and telepsychiatry, virtual groups and celebrations to ensure clients have access to care
- Regular phone check in 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
- Resuming outreach and engagement teams with increased COVID-19 safety measures

SLIDE # 6

6

FOCUS ON DISPARITIES

Proposed Actions to Address Racial/Ethnic Mental Health Care Disparities

MULTI-COUNTY LEARNING COLLABORATIVE

During the first quarter of 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. This opportunity is a vehicle for the disparities reduction efforts and as a way to strengthen community voice.

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.

SLIDE ▪ 7

7

MHSA CLIENT COUNTS

Community Services and Supports

- Largest MHSA component with 76% of the total MHSA allocation
- For clients with a diagnosed serious mental illness

CSS Programs	UNIQUE CLIENTS SERVED	NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE
• Full Service Partnership • Outpatient Care Services • Alternative Crisis Services • Housing • Linkage • Planning, Outreach and Engagement	In FY 2020-21, 135,232 unique clients received a direct service. Ethnicity • 37% Hispanic • 20% African American • 18% White • 5% Asian/Pacific Islander • 1% Native American Primary Language • 79% English • 14% Spanish	35,499 new clients were served with no previous MHSA service. Ethnicity • 36% Hispanic • 14% African American • 16% White • 3% Asian/Pacific Islander • 0.48% Native American Primary Language • 77% English • 14% Spanish

SLIDE ▪ 8

MHSA CLIENT COUNTS

Community Services and Supports

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	9,098	2,410
SA2 – San Fernando Valley	22,613	5,886
SA3 – San Gabriel Valley	19,146	5,952
SA4 – Metro	25,458	6,801
SA5 – West	7,837	1,918
SA6 – South	21,682	4,727
SA7 – East	12,465	2,953
SA8 – South Bay	27,189	6,940

SLIDE # 9

MHSA CLIENT COUNTS

Prevention and Early Intervention

- Second largest MHSA component with 19% of the total MHSA allocation
- Focus on providing preventative and early intervention strategies, education, support and outreach to those at risk of developing mental illness or experiencing early symptoms.

PEI PROGRAMS	UNIQUE CLIENTS SERVED	NEW CLIENTS WITH NO PREVIOUS MHSA
• Prevention • Early Intervention • Suicide Prevention • Stigma and Discrimination Reduction	In FY 2019-20, 42,784 unique clients received a direct service. Ethnicity • 45% Hispanic • 9% African American • 9% White • 2% Asian/Pacific Islander • 1% Native American Primary Language • 76% English • 21% Spanish	23,277 new clients were served with no previous MHSA service Ethnicity • 42% Hispanic • 9% African American • 9% White • 2% Asian/Pacific Islander • 0.64% Native American Primary Language • 76% English • 21% Spanish

SLIDE # 10

MHSA CLIENT COUNTS

Prevention and Early Intervention

CLIENT DATA BY SERVICE AREA		
Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	3,410	2,990
SA2 – San Fernando Valley	7,596	5,840
SA3 – San Gabriel Valley	8,494	6,414
SA4 – Metro	6,329	5,388
SA5 – West	1,828	1,685
SA6 – South	6,049	5,163
SA7 – East	6,720	5,892
SA8 – South Bay	7,923	6,846

SLIDE # 11

11

PROPOSED CHANGE

Innovation 2: Community Capacity Building to Prevent and Address Trauma

Innovation 2– Requesting to continue programming using Prevention and Early Intervention funding with an annual budget of $29,520,000.

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.

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.

OUTCOMES

- 8,077 registered participants, with 68% (5,499) of all participants were enrolled in INN 2 during the pandemic.
- 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.
- 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.
- 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.

SLIDE # 12

PROPOSED CHANGE

Innovation: Hollywood 2.0

A new comprehensive approach to serve people with Serious and Persistent Mental Illness, including those experiencing homelessness, with or without a substance abuse disorder.

KEY CHARACTERISTICS:

Holistic | Human Centered | Hospitality-oriented | Care in Community

HOW DOES IT DIFFER FROM TRIESTE?

- Optimizes funds through the full Federal match
- Avoids the use of fiscal/administrative intermediary
- Expedites community planning processes by actively exploring available resources through philanthropy
- Avoids unnecessary technological/EMR investments

KEY COMPONENTS

- Full Service Partnership
- HOME Team
- Intensive Outpatient Services: Team Based
- Peer Resource Center/Clubhouse
- Alternative Crisis Response
- Housing: Interim, Permanent Supportive, Congregate and Enhanced Residential (Board and care)

WHY HOLLYWOOD?

- Large concentration of unhoused individuals suffering from serious brain illnesses
- Strong coalition of local neighborhood business and faith leaders, government and health care providers and law enforcement (i.e. Hollywood 4WRD)

SLIDE ▪ 13

PROPOSED CHANGE

Capital Facilities

Requesting $5 million dollars for future improvement projects.

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.

SLIDE ▪ 14

RECOMMENDED CHANGE

Expansion of Diversion Related Services

- Recommended motion by Mental Health Commission dated April 28, 2022, to dedicate MHSA funding to expand community-based mental health treatment options for increase jail diversion efforts for individuals with mental health conditions
- Funding will support the Los Angeles County Department of Health Services' Office of Diversion and Re-entry (ODR) to expand diversion services beyond its 2,200-bed capacity based on ODRs demonstrated success in reducing the number of incarcerated mentally ill individuals
- Expanded Diversion services seeks to address racial and ethnic disparities reflected in the jail population in LA County
- Recommended change will allocate $25 million ongoing MHSA funding annually beginning FY July 2022
- Requires a 30-day public posting and comment period (est. May 15-June 15, 2022)

15

FY 2022-23 BUDGET PROJECTION CHANGES

Summary by Program

MHSA Program	Original Projections as of June 2021 (Amounts approved in Three Year Plan)	Updated Projections as of March 2022 (Amounts reflected in Annual Update)	Change
CSS	$ 1,188,145,468	$ 1,154,359,375	$ (33,786,093)
PEI	$ 287,944,203	$ 315,514,026	$ 27,569,823
INN	$ 30,227,878	$ 14,861,609	$ (15,366,269)
WET	$ 20,431,958	$ 20,201,184	$ (230,774)
CFTN	$ 3,850,000	$ 10,650,000	$ 6,800,000
TOTAL	$ 1,530,599,507	$ 1,515,586,193	$ (15,013,313)

SLIDE # 16

FY 2022-23 BUDGET PROJECTION CHANGES

Community Services and Supports (CSS)

CSS Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Notes
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 and 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)**	

FY 2022-23 BUDGET PROJECTION CHANGES

Prevention and Early Intervention (PEI)

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Suicide Prevention	$ 22,302,998	$ 22,302,998	$ -	No Change
Stigma & Discrimination Reduction	$ 366,250	$ 366,250	$ -	No Change
Prevention	$ 43,564,826	$ 50,513,488	$ 6,948,662	Primarily reflects the addition of 311 positions for community promoters to provide outreach and education, as well as the one-time extension of the My Health LA Agreement with the 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 for Increasing Recognition of Early Signs of Mental Illness Program	$ 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**	

FY 2022-23 BUDGET PROJECTION CHANGES

Innovation (INN)

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. LACDMH 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 the Hollywood 2.0 Project (formerly known as the True Recovery Innovation Embraces Systems That Empower – TRIESTE)
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)	

SLIDE # 19

FY 2022-23 BUDGET PROJECTION CHANGES

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	$ -	No Change
Stipend Program for MSWs, MFTs, AND NPs	$ 3,063,600	$ 3,063,600	$ -	No Change
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	$ -	No Change
Interpreter Training Program	$ 80,000	$ 80,000	$ -	No Change
Learning Net System 2.0	$ 250,000	$ 250,000	$ -	No Change

SLIDE # 20

FY 2022-23 BUDGET PROJECTION CHANGES

Workforce Education and Training (WET)

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
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	$ -	No Change
Parent Partner Training and Parent Volunteers Project	$ 320,000	$ 320,000	$ -	No Change
Peer Focused Training	$ -	$ 400,000	$ 400,000	Reflects funding for Peer focused training.
Med. School Affiliation at Harbor	$ 260,000	$ 260,000	$ -	No Change
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	$ -	No Change
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)**	

SLIDE • 21

FY 2022-23 BUDGET PROJECTION CHANGES

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 Angeles 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**	

SLIDE • 22

COMMUNITY PLANNING PROCESS (CPP)

CPP Activities and Meeting Dates for Current Plan and Update

[March 4, 2022]
An Executive Summary of the MHSA Annual Update was posted to the DMH website for review.

[March 8, 2022]
- A Spanish version of the Executive Summary of the MHSA Annual Update was posted to the DMH website for review.
- The full version of the draft MHSA Annual Update was posted on the DMH website to allow for the 30-day public review and comment period.

[March 9, 2022]
A Summary of the Plan, including a Focus on Disparities and proposed changes was presented at the full Mental Health Commission meeting attended by CLT, UsCCs and SALTs for input and feedback

[March 10, 2022]
A Summary of the Plan was presented to the Executive Committee of the Mental Health Commission (MHC) for input and feedback.

[April 26, 2022]
MHSA Annual Update briefing for the Board of Supervisors Health Deputies.

[April 28, 2022]
The draft MHSA Annual Update is presented today at the Public Hearing.

[May – June 2022]
Final MHSA Annual Update will be presented to the Board of Supervisors for approval.

SLIDE • 23

STAKEHOLDER FEEDBACK

Methods for gathering and documenting stakeholder feedback

- 45 day public comment period (required 30 days, extended for an additional 15 days) with Online Survey (Open March 3-April 19, 2022)
  - 66 Survey responses were received, 65 in English and 1 in Spanish.
  - 9 survey questions. Not all respondents answered all the questions.
  - Of those surveyed:

Self Identified Affiliation
- 21% of the respondents are clients/consumers
- 7% of the respondents are peers
- 13% of the respondents are advocates
- 14% of the respondents are family members of a client/consumer
- 5% of the respondents are other government employees
- 6% of the respondents are LACDMH staff/employees
- 17% of the respondents are mental health service provider
- 16% of the respondents indicated Other

Reported Ethnicity
- 14% reported African American
- 8% reported Asian
- 24% reported Caucasian
- 26% reported Latin/Latina/Latinx
- 4% reported Mixed/multi-ethnic
- 10% reported Native American / American Indian/ Alaskan Native
- 14% reported Other

- Transcripts from discussion portion of stakeholder meetings (i.e. CLT, MHC, etc.)
- Emails/correspondences received

SLIDE • 24

STAKEHOLDER FEEDBACK

Summary of Feedback for Survey Questions

Highlights of Current Plan	Opportunities to Improve Plan
• Plan written so that it is easily understandable to stakeholders and the general public • Access to services to communities in need expanded through regular phone calls with clients and family members • Focuses on objectives to expand mental health services to ethnic and underserved communities • Very data driven • Continuation of FSP • Additional information on budget and spending provided to stakeholders	• Provide additional focus on Individuals with serious mental illness/gravely disabled, dually diagnosed/those suffering from opioid crisis • Finding more treatment beds or facilities. • Advocacy, family support or engagement • Continued support for CANs program seems to be the bridge in making sure the community members have access to the needed resources. • Opening grant opportunities and open bid solicitations with limited restrictions directly targeting innovative approaches expanding direct mental health services. • Treatment services are not identified for mental health disorders like Rape Trauma Syndrome (PTSD), Intermittent Explosive Disorder in Children and Teens, Adjustment Disorder, Autism with Behavioral Disorders. • Increase time for sharing plan information and making follow up contact information available • Increase size of font for presentation slide content

SLIDE • 25

STAKEHOLDER FEEDBACK

DMH Strategies for Addressing Feedback Received

Strategies
• DMH will continue to expand outreach efforts through multiple outlets to ensure the general public and specific stakeholder groups are aware of MHSA funded programs and activities and how to participate in CPPP • DMH will continue to streamline docs to provide tables and summaries similar to current annual update presentation. Information will be distributed through monthly meetings with CLTS, UsCCs, SALTs and the MH Commission • Actions to address COVID-19 delays and barriers will continue to be outlined in Annual Updates and 3-year plan presentations • DMH will provide monthly MHSA 101 trainings to identified stakeholder groups, including SALTs, UsCCs, CLTs and the Mental Health Commission. DMH will also provide training for the general public as requested, Mental Health Providers, County Departments staff, and DMH employees and staff • DMH is currently exploring funding opportunities through the Incubation Academy and other grant opportunities for CBOs • DMH has entered into agreement with NAMI for 3 additional years to provide expanded training for family members across the County • DMH will provide hard copies to stakeholder groups and the general public for all 3-Year Plans and Annual Updates • DMH is updating its communication follow up process including its resolution process and having a MHSA mailbox to receive input and communication year-around

SLIDE • 26

NEXT STEPS

1. Complete the Public Hearing: April 28, 2022
2. Receive Mental Health Commission Feedback and Recommendation: May 4, 2022
3. Presentation to Board Deputies: June 8, 2022
4. Estimated Board Hearing Date: June 28, 2022

CONTACT INFORMATION

For questions or more information on the Los Angeles County MHSA Annual Update, email:

mhsaadmin@dmh.lacounty.gov

[E3] PUBLIC HEARING TRANSCRIPTS

>> CHAIR DALGLEISH: Let the games begin. Thank you. >> JOHN FLYNN: Just a second, I want to make sure I've got Mr. Polk's slide deck ready to roll. I only have by the way two documents today, I have the main slide deck and I have Mr. Polk's MHSA annual update. Should I be expecting anything else? That's it, right? >> That's it on our end. > JOHN FLYNN: Thank you, Darlesh. >> CHAIR DALGLEISH:Commissionr Friedman is asking if she's on. She didn't hear miles an hour name mentioned.>> JOHN FLYNN: Commissioner Friedman is here, I also saw Commissioner Acebo, I -- Dr. Weissman. It's a full house today. >> CHAIR DALGLEISH: I know, boy, this is awesome. All right. Good. Thank you. Let's hit it, John. >> JOHN FLYNN: A moment of silence, I'm going to start the live event. And when I raise my –>> CHAIR DALGLEISH: I'm not seeing your picture, I need to see your photo. >> JOHN FLYNN: I'm going to spotlight myself for a moment. You can see me, right? >> CHAIR DALGLEISH: I can't see you. Why don't you just tell me. >> JOHN FLYNN: I'll just say good morning and turn it over to you. >> CHAIR DALGLEISH: Okay. >> JOHN FLYNN: A moment of silence, please. >> JOHN FLYNN: Good morning, and welcome to the Mental Health Commission for April, 2022. And good morning to our Chair, Commissioner Stacy Dalgleish. >> CHAIR DALGLEISH: Thank you for joining us for the April full commission meeting. It's a packed agenda and I understand we have quite a few visitors with us as well. So I want to welcome you too. I want to take this opportunity to thank several people who are joining us today, and helping make this meeting the quality and accessible meeting that it is. Our ASL interpreters, mark Robinson, Johnathan, Spanish interpretation, by Lucy and Alex, we have Korean translation as well today, welcome. Samantha, you and Sumi. And our CART services are by Juline Bajada. I.T. is jf, and Julio Miranda, and our staff, Canetana Hurd will be taking roll call momentarily. I do want to introduce a new commissioner today, (indiscernible) I don't know why there is an echo. Can you fix that, John, or is that coming from me? >> JOHN FLYNN: Got it, Commissioner. We're good. >> CHAIR DALGLEISH: Okay, great. Dr. Jack barber is a new appointee from supervisor Holly Mitchell's office, and I want to welcome him, he's a long-time member of the mental health community, and in contact as well and working with the Department of Mental Health. He's been the director of Kedren as well as other entities, and we're honored to have him, and his expertise joining our commission. If if Dr. Barber is here, I'd like him to speak and introduce himself before we head into the roll call. Dr. Barber? >> COMMISSIONER BARBER: I'm excited to be a part of this commission, and to be able to move things in a care-forward manner. I'm very excited to be able to speak with all of the commissioners very soon,

I'm the CEO of Southern California Health and Rehabilitation Programs in South L.A., our flagship site is on Crenshaw and can be seen from anybody who drives up and down Crenshaw and those that community. This is my first meeting, so I'm learning a bit, but I understand there's a big agenda today, so thank you very much Stacy for introducing me, and I appreciate Supervisor Mitchell the opportunity to serve. >> CHAIR DALGLEISH: Thank you. We also will have Supervisor Mitchell with us today, Supervisor Mitchell serves as the 16th seat on our commission, and a voting member of the commission as well. So I want to welcome her if she is on the line at this time. It's an honor to have you with us, and I hope that you'll join us again in the future. In the meantime, it's also been a pleasure having (indiscernible) with us representing. Let's go ahead and take roll call, please. Canetana Hurd? Thank you. >> COMMISSIONER PADILLA-FRAUSTO: Commissioner Friedman. (no answer). Ben Root? He's trying to get in. >> Susan is here. Sorry. >> CANETANA HURD: Hold on a second, I did something. Commissioner Stevens present. >> Bar 54 here. (roll call). Commissioner Schallert here Commissioner Weissman here. >> CANETANA HURD: We have a big quorum. >> CHAIR DALGLEISH: Thank you very much. Welcome all commissioners. Let's move on then to the next part of our agenda. We have -- is Dr. Sherin on the line? >> DR. SHERIN: I'm here. >> CHAIR DALGLEISH: Great. Welcome, Dr. Sherin. Thank you for joining us today. You have the floor. >> DR. SHERIN: Thanks very much to the commission and to everybody. I guess the first thing on my mind is that I really wish that we were doing this in a big room together, and that I could see you and we could share in the energy of a really important convening. I miss being with people. And especially for at such a juncture for me. The annual update in the three-year plan are really, really important documents that represent an amazing amount of work. An amazing amount of work by the department and by the entire community. And I want to salute everybody that has been working on this in a relentless way, in an ongoing way, and an iterative way throughout the year, and I will say when I started this job about 5½ years ago, I didn't feel that the stakeholder process was one that was really genuinely driven by the grass-roots, by our communities. And I'm not saying we're where we need to be, but we're a long way from where we were when I started. And there was a lot of great work. That had been done before I got here, but we have continued to push for a much more robust, genuine way to distill the voices of our communities so that we understand how to direct our resources. And how our services can be the most impactful. Supply ask demand is key. The program, we call it Your DMH, I think it's a really important one -- it's an important one. It's important not just to update and improve, but to embrace. And to recognize that it's through ongoing efforts on all of our parts that we can get to that place where we realize the vision for your DMH. Another thing which I think is representative of us

trying to really blow the roof off of our process is that we have some new components today. We have a motion by the commission which I wasn't aware it was a process, about very important stuff, and work that our board of supervisors is trying and we're trying as a county to drive. Decarceration, particularly for people who are punished and incarcerated because of their condition. Which is completely unacceptable. And needs to be remedied. I invite that new process, I think it's important, I think it's symbolizes again at least for me that the stakeholder process is continuing to evolve in a very important way. And also, I think we have Supervisor Mitchell in the house today. So I mean, this for me, these are symbols for me -- to me of us breaking open what I think was a smaller process and a more closed process into one that has to be transparent. It has to be the way the department runs, and not just this department, but the whole community. The whole county. To address the needs of our community. I guess the last part -- I have not been doing well on this piece of exchanges in the past few weeks. I don't know, week. I certainly was not expecting the "LA Times" to cover the fact that I am stepping down. Or to have access to the letter I wrote to the staff. But the "LA Times" is a special entity, which I think, you know, helps us communicate about certain things, and I don't want to go into details about my personal scenario, but it's time for me and -- I talk about being art forward, and that's really all I've ever tried to be. And I guess my heart hasn't been able to keep up. I'm going to take time to look out for myself. I haven't done that well, spend more time with my family, which I have not done, because I always push at a high space. I only know one speed, and whoever is running this department in my opinion needs to keep up that pace. And I just, I send a lot of love to everybody, and I'll be watching, and I will reemerge, because this mission is one that's in my DNA, it's in my blood. It was ingrained in me by my mom, and I'll never give it up. I don't know what form, but this is a very special event today. I'm sorry if I took too much time to the commission U. and I know it hasn't always been easy. And nothing is easy when it really, really is important. So let's get on with the affairs and I'm going to be going around and seeing people in the community as much as I can, and I hope that some of the things that I've tried to bring and some of my spirit and heart will continue as a part of this endeavor going forward. Thank you very much. >> CHAIR DALGLEISH: Thank you very much, Dr. Sherin, and thank you for your service. I think I arrived shortly after you did, and so I didn't know the department before, I know that many of the commissioners did, but I want to thank you for your help to me as a commissioner and as chair. Thank you. And we look forward to seeing you around and your continued support for what we're all trying to accomplish for our community. Thank you. Let's move on, then. On our agenda. I believe the next item on our agenda would be public comment. Public comment is two minutes. We are introducing a new feature this time.

Which is that John Flynn will be announcing your 30-minute mark when you have -- 30 -- when you have 30 seconds left in your two minutes, he'll be announcing that so you have some warning about speaking. I also want to remind you that when you are asked, the instructions are to press 1 and then 0, that's a toggle feature, so if you press it again, it will disconnect you. So when you're ready to speak, press 1 and 0. We'll be getting further instructions from our AT&T operator. AT&T operator? >> AT&T OPERATOR: Thank you. As noted, it's 1, then 0 to get into the comment queue. And an operator will provide you with your line number, and you'll be addressed by this line number for your comments. Your time limit will be two minutes. If you have a comment, please press 1, then 0. >> CHAIR DALGLEISH: All right. Thank you. And then I'd like to go to our Spanish interpreters, would you please interpret the instructions at this time? >> INTERPRETER: Absolutely. [speaking Spanish] So far we have none but I have left a message. Thank you. >> CHAIR DALGLEISH: Thank you. Now our Korean interpreter. (speaking Korean). >> CHAIR DALGLEISH: Thank you. Do we have anyone on the line for public comment? AT&T operator? >> AT&T OPERATOR: Yes. >> CHAIR DALGLEISH: Someone is speaking on the line, John, can you handle that? >> JOHN FLYNN: Will do. >> AT&T OPERATOR: All right. Our first -- (speaking Korean). >> JOHN FLYNN: Stand by, make sure our translators are in the right place. Julio, I'm still hearing background noise. I think we're ready to roll, go ahead. >> AT&T OPERATOR: First comment will be from line 16, please go ahead. I'm sorry, line 16, please, hit 1, then 0. Until line 16 returns, we'll move to line five, please go ahead. Line five, your line is open. >> I'm sorry, I wasn't given the number at the beginning. Given -- I guess for Dr. Sherin, for him to be leaving will be like a hole for those that are a part of Salt, given the number of times he's actually taken out of his time to meet with the team. So that will be a great loss, and that will set a bar for the next person that will be taking his spot. Thank you very much. >> AT&T OPERATOR: Thank you. Our next comment will come from line 12. Please go ahead. >> Hello, can you hear me? >> JOHN FLYNN: Yes. >> My name is Trouty Winters, and I'm the executive director of NAMI L.A. County. I'm calling in support of the motion that I believe is going to be heard today, recommending that DMH dedicates 25 million a year in ongoing MHSA funds to support the very successful ODR program. NAMI has been involved many years in supporting ODR and has seen the success of the program. The numbers speak for themselves. Over 7,000 people including those with serious mental illness have been diverted from jail and offered the support they need including various types of supportive housing, community-based treatment, and a better quality of life. Several studies have shown ODR is successful in stabilizing persons with serious mental illness so they can safely live in the community. The recidivism rate of the program is lower for those that are enrolled in the program. It's less expensive to house a person than to

incarcerate them. Additionally, many people with serious mental illness in our jails are currently candidates for diversion. Let's please continue the success of this program and support its long-term sustainability, including housing, funding to support this program. Thank you. >> AT&T OPERATOR: Thank you. Next we go to line 6. Peter? Please go ahead. >> I'm sorry, did you say line six? >> AT&T OPERATOR: Yes, your line is open. >> Hi, this is Peter Elias from the ACLU of Southern California and chief counsel. The ACLU strongly supports the motion to provide ongoing MHSA funding to ODR, and we submitted a letter on this fact. I think the motion does an excellent job of laying out the success of ODR's programs. The reasons why ODR programming is so much better for people with mental health issues who get caught up in the criminal legal system and incarceration, which is brutal and inhumane, leads to terrible mental health outcomes, horrible recidivism rates, and a variety of other negative effects. I want to actually touch on a couple things that maybe members of the commission might not be aware of, make they are. It's essential that the county dramatically lower its population of people with mental illness, the county, for 25 years has been flagrantly out of compliance with both a memorandum of agreement and a consent decree with the United States Department of Justice governing the treatment of people with mental health illness in the jails. It's really shameful that the county has not been able to come into compliance in 25 years. As I explained in a letter that I attached to the letter I submitted to the commission, it will be impossible for the county ever to come into compliance with that consent decree, unless it dramatically lowers the population of people with mental illness in the jails. They simply cannot provide adequate high observation and medium observation housing -- >> JOHN FLYNN: 30 seconding. >> -- in a variety of other ways. You're simply no acceptable reason for the county to be out of compliance, and unless, however, there is enough community treatment of the kind that's provided through ODR, the county can't lower its jail population and will tb ton out of compliance with this decree designed to protect the rights of people with mental illness. So we strongly support this motion. >> AT&T OPERATOR: Thank you. Our next comment will come from mark G, like golf. Please go ahead. >> Can you hear me? Is this me? >> JOHN FLYNN: Yes. >> Okay. I guess it is. My name is Mark, I'm also with NAMI, and I'm our criminal justice chair. I'm also a member of the permanent steering committee of ODR and has been since its early inception. So I've watched everything that ODR has done since really the blueprint for change back in 2015, and the inception of ODR. The success of the program speaks for itself. I call your attention to a report from ODR that was delivered to the public safety realignment team on April 21st with statistics that also speak for themselves. And a world where recidivism rates are 60-70% for people coming out of jail or prison, rearrest rates, since that is the subject of the day, 16%. Mesh program of 20%, the CBR17%,

rearrest rate for DSH diversion, 2%, if did you look at the number of hospitalizations for 100,000 clients, down 60-70%, the number of emergency department visits, the county is saving a tremendous amount of money in crisis resources because ODR has helped so many thousands of people. The number of emergency department visits are down 63%, and people are getting better healthcare because primary care visits are up 161%. And specialty visits up 154%. This program works. And if the county is going to go forth with a mission of care first, jails last, and I read everything that Peter Elias said, and all the good statistics in the motion, but if we're going to say we're care first, jails last, the cap on ODR needs to be lifted, we need to get creative with our funding, we need housing money, we need sustainability, we need accountability, so we have more -- >> JOHN FLYNN: Time. >> -- how well this works. Thank you very much. >> AT&T OPERATOR: Our next question will come from line nine. Please go ahead. >> Hi. This is Tiffany Smith, to Dr. Sherin, I watched him (indiscernible) and tackle the -- supporting me as an advocate and I love you. Also am 100% ODR funding, my matter is tied to it -- my heart is tied to it, I was on the board of directors for the reentry agency that contracts with ODR. My husband is a program manager for (indiscernible) housing there. I know it's working. Again, I'm in 100% support. The reason for my phone call today is to talk to you about a failure. When I hang up I have to pick up a 6'8" Black man and take him to (indiscernible) because he's been in county jail, has a schizophrenia diagnosis, his last long-acting injection was March 3rd, he was released March 10th. No treatment plan. No medication. No nothing. The failure is because (indiscernible) has not been on his 30-month -- his 30-day injection. LAPD shows up, we all know what can happen. How many were released to the streets without medication? Into a home that says yes, he can live there where there's a woman with dementia and an abusive alcoholic man. >> JOHN FLYNN: Time. >> When I ask how he's doing, he said I just need a roof over my head. >> AT&T OPERATOR: Thank you. >> CHAIR DALGLEISH: Excuse me, this is Stacy Dalgleish. Do we have someone available to speak to this caller? A support person? >> JOHN FLYNN: Robert is on. >> CHAIR DALGLEISH: Can you please take care of that transfer? Thank you. >> AT&T OPERATOR: Ready for the next public comment? >> CHAIR DALGLEISH: Yes. >> AT&T OPERATOR: Moving on to line eight, please go ahead. We lost line eight. 13, your line is open. >> Good day. My name is (indiscernible), speaking on behalf of the Black Los Angeles County Client Coalition, I would like to share a recent informational feedback loop regarding concern of community stakeholders about the West Central Family Mental Health Services recent move to the site of Augustus Hawkins Mental Health located at 1720 East 120th Street, Los Angeles. The Augustus Hawkins Center supports services primary for adults and children. Most services are restricted to adults who live in the southeast region in parts of San Antonio health

region, this area includes Compton, South Central Los Angeles. The African American community has asked the Black Los Angeles County Client Coalition about any pending plans in our solicitations pending to replace essential family mental health services, clinical services replacement. Et cetera on the Crenshaw corridor. I'm glad to know that Jack Barbour has joined the commission. I applaud you, Doctor. And our services, located in close proximity nearest - -- >> JOHN FLYNN: 30 seconds. >> Nearest in place, transportation time in relation to the (indiscernible) West central family mental health services, We Beseech the Los Angeles County Mental Health Commission Oversight and Action for Answers to the African American stakeholder inquiry, furthermore, the feedback loop stated the deputy director has transferred to MLK. We'll be in touch in the near future concerning this matter with Commissioner Dalgleish, chair presiding. >> JOHN FLYNN: Time. >> Thank you. >> CHAIR DALGLEISH: How many callers are there on the line? >> AT&T OPERATOR: There are currently -- there's one in the comment queue. >> CHAIR DALGLEISH: All right. And does that include line eight? >> AT&T OPERATOR: It does not. Anyone who was overlooked, line 10 is the last one in the queue at this time. >> CHAIR DALGLEISH: All right. So if there was anyone else who phoned in they should phone in now, and then -- the motion has not been made yet that is being addressed at this time. There will be another comment time as well. But we do have someone who is trying to speak who was on line eight, just to let you know. And then go ahead and we'll continue with the last caller, please. >> AT&T OPERATOR: Very good. Line 10, your line is now open. Go ahead, Mark. >> This is Mark, can you hear me? >> JOHN FLYNN: Yes. >> CHAIR DALGLEISH: Yes, mark. >> Okay. I want to give some answers to something, that is the cowboys did a workshop about incarceration and about a week and a half ago, and I'm going to read some of the suggestions that they have, that they made, and I hope that's okay. They had videos that included peer provider workshops, including engagements. There was several videos, slides that included sequential (indiscernible) and practices for recruiting and data mining and hearing for hiring peer staff. In justice settings. The supports integrating (indiscernible) peer providers, and there's a whole list of stuff that they gave, like -- we can probably call and get that -- get the slides, and there's a bunch of them that were on YouTube. So these are -- those are programs that can be -- we can utilize in order to bring peer support -- >> JOHN FLYNN: 30 seconds. >> -- so that people can be (indiscernible) in peer support while they're incarcerated, and then can be brought out. This was also done sort of at the alternatives conference last year. There was an organization in New York that brought peer supporters into the jails there, and introduced trainings into their system. We can get that. >> AT&T OPERATOR: Thank you. We do have line eight. >> Hello, can you hear me? >> CHAIR DALGLEISH: Yes, we can, thank you. >> Wonderful. Thank you. I want to express to Dr. Sherin how

wonderful it's been to have him on the team, and he definitely will be missed, and I really hope that someone can try to fill his shoes. His heart has always been apparent. I want to address an issue in the antelope valley with SFP service quality, and the ability to receive trauma-informed care through SFP programs. I did write a letter of comment to the commission regarding an individual case which is not the first, probably not the last, but I want to find out how we can audit SFP if people we are dealing with and trying to support are not getting FSP services that they are needing or supposed to get. Peer mentors, peer support specialists desperately needed to fill this role of trying to intervene in families and individuals with the Department of Mental Health that are not able to get through the blockades. I also want to express my sincere support for ODR. So many people, that is the only option. And I'm sick and tired of telling families that maybe their loved one will get help for their mental illness when they get in jail. That is so wrong. And I don't want to ever have to tell families that again. We need to change laws, change requirements for gravely disabled, I know there are bills in the state legislature to do so, but this is imperative to be able to require people to get the help they need and not have to go to jail to access treatment for mental illness. Thank you. >> CHAIR DALGLEISH: Thank you. I have Alex, the Spanish interpreter's hand up. >> INTERPRETER: We are here. Let me give you the -- let me set up the interpretation. [speaking Spanish] >> My name is Mrs. Lozano. I just wanted to thank Dr. Sherin wholeheartedly. I hope that God blesses him and walks with him always. I'm calling to ask that they increase the funds so that the community can help heal the community. And I remember that the commission had said that they were going to send an application at a federal level to request funds and emergency state funds monies for this purpose. Because at this time we do not have enough people to give the services to the community. Speaking of the subcommittees, like the Latino groups and other groups. >> INTERPRETER: That's who she's speaking of. And I'm sorry for. >> I'm. >> INTERPRETER: This is the interpreter. We're going to miss Dr. Sherin very much. I'm sorry for being emotional. Thank you very much. That is the end of her comment. >> CHAIR DALGLEISH: Thank you. All right. Clearly we have a lot of people who want to speak on different issues that are on our agenda right now. I'm going to return right now to our commissioners. Commissioner Friedman. >> COMMISSIONER FRIEDMAN: I apologize. I noticed that Alex's hand is up. Are you aware of that? >> JOHN FLYNN: That was the translation we did. Commissioner Friedman, are you muted at the moment. >> COMMISSIONER FRIEDMAN: I s it my turn? >> CHAIR DALGLEISH: Yes, it is, it's your turn. >> COMMISSIONER FRIEDMAN: I just wanted to say to Dr. Sherin that from the moment you arrived, we felt and the department felt a new energy. You did that. That was a quite extraordinary thing to happen in this department, because finally things were

moving along, and people began feeling like we can finally do the work that needs to be done. We need to get to this work. And we were moving along, and then the pandemic hit. And then a whole new group of problems appeared. And now we have all of those problems and all of those people who are suffering anxiety, depression, whatever. And the school children. We have so many more things to deal with right now, and we will miss you terribly. Really, really miss you. And your energy, and your ideas. And just you, being there. So all I want to say is, I really wish you good health. I hope that your health improves, and I hope that somehow you can get some of your ideas settley back to us so that we can continue to work with them, because they were all quite wonderful. We will miss you terribly. Thank you, thank you, thank you for everything you did. >> CHAIR DALGLEISH: Thank you, Susan. I see that there were many comments in the chat as well. Are there any other commissioners who would like to speak at this time? >> COMMISSIONER BANKO: I would. >> CHAIR DALGLEISH: Go ahead. >> COMMISSIONER BANKO:Than k you. I wanted to thank you, Dr. Sherin, I think it takes a special human being to uphold and undertake a position like yours with the Department of Mental Health, but also to make sense of the bureaucracy, to strive for better, to clear blockages, to enact programs that support people in the best ways possible. So again, just thank you so much. You're a truly special person, and you've left a great legacy behind. >> CHAIR DALGLEISH: Thank you. Commissioner Schallert? >> COMMISSIONER SCHALLERT: Y eah, I would just like to reiterate what everyone is saying. Thank you, Dr. Sherin, for all you've done. We down in the fox holes appreciate all you've done, and kind of what -- we see how difficult the job is, and I thank you for taking it on. It's quite a job. So just wish you the best of luck and appreciate everything you've done. >> CHAIR DALGLEISH: Thank you. Commissioner Weissman. >> COMMISSIONER WEISSMAN: >> JOHN FLYNN: We're not hearing you, commissioner Weissman, and I'm not sure why. It looks like your mic is active. But we're not getting audio. She says come back, as in I think come back to me. >> CHAIR DALGLEISH: All right. Good. We will be coming back as well to this subject. So thank you, everyone. >> COMMISSIONER WEISSMAN: H ow about now? >> JOHN FLYNN: That works. >> COMMISSIONER WEISSMAN: O kay, good. Thank you, sorry for the blip. I just wanted to thank Dr. Sherin and echo what everyone else has said from the commission. But also to note that coming from NAMI and from the mental health client perspective, and peer perspective, how it can still be strong leadership to do self-care first and foremost, and show strong leadership by making a decision that puts yourself first and make sure that you maintain your own well-being. Even with everything else going on. So I gist wanted to recognize that it affirmed decisions that I'd made in my personal life and professional life to do similar kinds of things, and I think it's good for our community to see that as a strong leader as well. So

thank you, Dr. Sherin. >> CHAIR DALGLEISH: Thank you. All right. Let's move on right now, then, to the next part of our agenda. We're going to move to the motion to be made by Commissioners Stevens and Austria. >> COMMISSIONER STEVENS: We put forth a motion regarding expanding the services for ODR that are much needed. I think the statistics do speak for themselves -- >> COMMISSIONER AUSTRIA: I think most of you read them, but there's questions down the line, we'd like to have you ask them. We also have Dr. Ochoa on the line, and also our supervisor, Supervisor Holly Mitchell, who is the actual 16th member, and I really welcome her and maybe Supervisor Mitchell if you'd like to make remarks regarding the motion. >> CHAIR DALGLEISH: Could we start by your reading the motion, please? >> COMMISSIONER AUSTRIA:Su re. It's a little long. So here we go. The motion is by the second district Kathleen Austria, Stevens, and the motion is entitled Expanding Diversion-Related Services. There are currently 12,859 people in the Los Angeles County jail system. It is essential that the commission do what it reasonably can to care for the 43% of the jail population who have serious mental health needs. 21% increase since 2020. Consistent with national trends, incarcerated women of a particularly high rate of mental health needs. Moreover, there are significant racial disparities with Black Angelenos and Latinx Hispanics hit the hardest. The Rand Corporation did a study in 2020 which found at least 61% of the individuals with serious mental health needs could safely be served in the community. Many experts have recommended further expansion of community-based mental health treatment options. We in-- version for people with mental health conditions. The Los Angeles County Department of Health services, office of diversion and reentry, ODR, has demonstrated success in addressing this crisis. But it has not been able to expand services beyond the 2200-bed capacity because of its financial constraints. The Los Angeles County Board of Supervisors created ODR in 2015 to reduce the number of people incarcerated in Los Angeles County jails with mental health and/or substance abuse disorders who are at risk of homelessness. Reduced recidivism and to improve health outcomes of justice involved populations, the most serious underlying health needs. (indiscernible) the courts have released 7,414 persons from jail and into the ODR care where they receive community-based treatment and various types of supportive housing programs. The attachment A. Numerous studies have confirmed that ODR's programming is successful at stabilizing persons with serious mental illness so they can safely live within the community. Another Rand Corporation study of ODR supportive housing program from 91% of its clients had stable housing after six months. 74% have stable housing after 12 months, and 86% have no new felony convictions after a year. 90% of its clients profess (indiscernible) housed after six months, only 15% had a felony conviction within the next year. Preliminary results of a study by UCLA of 962 ODR

clients is showing that their medical and mental health hospitalizations and emergency department visit rates dramatically dropped after they enrolled in ODR programs. See below. Would you care for me to read that, everyone? That piece? It's really critical, actually. The number of hospitalizations per 100,000 clients, in 12 months, 156,128 clients. Post 12 months, (indiscernible). >> CHAIR DALGLEISH:Kathlee n, can we -- the screen we're sharing with the motion on it, is it possible to just maximize that so we can all see? It's very small. >> JOHN FLYNN: Will do. >> COMMISSIONER AUSTRIA:Th ank you. It will give me a chance to drink water. Number of ED visits per 100,000 clients. 313,092, and post 12 months, 116 -- 116,986. Number of primary care visits per hundred00,000 clients, previously 92,200, post, 199,249. Number of specialty visits per 100,000 clients, 59,888, versus post, 92,490. That was an increase. Mental health utilization rate per one huh,000 clients, in pre and post 12 months of enrollment. The number of clients per hundred thousand, pre12 months, 71,587. Post 12 months, 20,775. Number of ED visits per 100,000 clients, 56,546, versus 17,271. Despite the demonstrated efficacy of the ODR model, sufficient funding has not been identified to sustain its current operations, much less scale up diversion efforts to keep pace with the growing need. It is time for Mental Health Commission to confirm its support for this program and the dignity it restores to its persons with serious mental illness. We therefore move that the Mental Health Commission proclaim that jail-based diversion is a strong priority of the Mental Health Commission, we should delete "services act," strongly recommend that the department of mental health allocate 25 million a year in ongoing mental health services to say beginning fiscal year 2022-2023 to support the Office of Diversion and Reentry services to MHSA eligible clients and that the fiscal year MHSA plan to be amended to reflect these recommendations. Thank you for your time on that reading. There's also a graph in the back. Showing the efficacy of the program. And you can read that. Any questions on that slide? >> CHAIR DALGLEISH: I see one hand up. It was up before by Commissioner Root, but we do have a question being raised as to whether the motion was noticed 72 hours in advance. And I've asked the staff to confirm that it was posted to our website along with the agenda 72 hours in advance. >> We did put it in in a timely way. >> CHAIR DALGLEISH: I know you did. I'm questioning the -- I'm asking if it was posted to the website along with the agenda timely. Canetana Hurd, are you there? >> CANETANA HURD: Yes. I'm searching the link to send to you. That it was. I can send you the email where it was confirmed. >> CHAIR DALGLEISH: Thank you. Yes? >> A point of clarification, we have the chair of the board of supervisors on the line now, and we should yield time to her because her time is very valuable. That would be my recommendation to the commission. >> CHAIR DALGLEISH: I agree. And it was -- >> I agree, and it was posted in a timely manner. I would defer also. >> CHAIR

DALGLEISH: All right. Good. Thank you very much. Yes, Supervisor Mitchell, you have the floor. Thank you. >> SUPERVISOR MITCHELL: Thank you very much for that. I'm here to support and answer questions if there are any. I wanted to be here in support of the second district commissioners in bringing forth this motion. And so I didn't intend to make any comments. If questions come up, I'm happy to respond to them. I appreciate the comment, hearing the public's commitment to care first, jails last, hearing very real, emotional testimony about why the public feels ODR beds must be funded and must be made available for all the reasons I completely support. I appreciate you for all your time and commitment and I want to tip my hat to the second district commissioners for doing the hard work of moving this motion forward that I fully support. >> CHAIR DALGLEISH: Thank you very much, Supervisor. We have the motion, we have a second, and we are going to move to discussion at this time. I see we have several hands raised at the moment. Let's move first to Commissioner Root. >> COMMISSIONER ROOT: Thank you. I am strongly in favor of ODR and the work that it's done, and particularly the first portion of this motion. I am not sure whether the second item in the motion is well stated or not. For example, I'm not sure whether $25 million is enough, is a suitable amount to meet our objectives. Secondly, I'm not sure that we should have a motion of this type without having some idea about how money would be used, so that we're sure that it is being used with the most effective way possible. Third, I would like to make sure that our justice deputies, as well as our health deputies, are consulted. This is one of these areas where we have a foot in two camps. Mental health, very important, we're intimately familiar with that and deeply committed to it. I'm not as familiar with some of the justice issues, and I know that there are both sides of this. And fourth, I am -- what I know of ODR's work is, I would like to be able to bottle what they have done and use it in some other areas within the county, particularly over at SAPSI, because the recidivism rates that were noted by several callers and in the motion are astoundingly different in ODR's case, for reasons that I think we can trace, and may relate to homelessness issues so they're very timely. And they touch other substance use and abuse issues with which we need to be concerneds on behavioral health side. So for all of those reasons, I fully support this. I would move to table this motion for 30 days, ask that some of the commissioners form a subset to answer the four questions. Is the amount of money enough, how should it be used, what input if any do the justice deputies have, and how can we export the success that ODR has for other mental health use? And I'd like to ask that the 30 days be used to have a subcommittee study those things, and come back and make a recommendation to the full commission about whether the second part of this motion should be more detailed, perhaps have more time to take a look at those four issues, so that we can pass or at least consider I think

pass, a motion that will be as effective as it can be. I move to table for 30 days with those provisions. >> CHAIR DALGLEISH: Thank you, Commissioner Root. So we have a new motion. I am not operating from my office, so I don't have my Robert's Rules in front of me, however, I do know Commissioner Acebo is adept in this area. May I ask you to step in on this issue right now? Thank you. >> COMMISSIONER ACEBO:Mada m Chair, members, there is a motion to table, which requires a second. >> CHAIR DALGLEISH: Do I hear a second? >> COMMISSIONER FRIEDMAN: D oes tabling take this off the table in terms of the agenda and plan and allocation? What's the implication on timing of tabling? >> CHAIR DALGLEISH:Commiss ioner Acebo? >> COMMISSIONER ACEBO:Ques tion to the author, Mr. Root, can you elaborate? >> COMMISSIONER ROOT: Yes. It's my intention, Brittany, that we not take it off our agenda, but we defer a vote for 30 days, have a report back that would detail and consider -- maybe item two is just perfect the way it's written. I don't know. I'm fully in favor of the item one in this motion. But I -- before we vote on it, and put it away, I'd like to consider is $25 million enough, and what are the other elements here that would best guide this? So I don't want to take it off out of our consideration, I want to get some more information so that we can vote with the maximum impact and I would hope that it could be brought back on our agenda for a final vote next month. >> COMMISSIONER ACEBO:Ther e needs to be a second to the motion, and then we can have more conversation specific to the motion. Is there a second? Having no second to the motion -- >> If the request is a second to the motion, Chief Mitchell will second it. If it's a second to the table motion, I'm not seconding that. If we're seconding the motion in chief I will second it. >> COMMISSIONER ACEBO: No, it's -- Madam Chair, it's regarding specific to the tabling, Madam Chair. >> SUPERVISOR MITCHELL: Thank you. >> COMMISSIONER ACEBO: Go ahead, Ms. Freedman. >> I will second Mr. Root's motion, I'm very much in support of this, but I do want to know what the money is going for. >> COMMISSIONER ACEBO:Ther e is a second to the motion, open to discussion, Madam Chair, you can recognize whoever would like to speak. >> CHAIR DALGLEISH: Thank you. All right. I am looking to see whose hands are raised to speak. And I will start with Commissioner Cooperberg. Thank you. And this is a discussion specifically related to the motion to table. Thank you. >> COMMISSIONER COOPERBERG: T hank you. It actually relates to both. First of all, I am in support of ODR expansion. My question is, and it may be added to Commissioner Root's issues, is looking at MHSA and they do have criteria, exclusions, requirements on what MHSA funds can actually go to, is there anything in the legislation that would preclude using funding for ODR? Thank you. >> CHAIR DALGLEISH: Thank you. Commissioner Stevens. >> COMMISSIONER STEVENS:Th ank you. I'm not certain if county council is on the line, and I also want to acknowledge that in reference to this

motion that's on the table, I also want to acknowledge that there -- that Dr. Ochoa is present, and I believe there's opportunity for a lot of the questions that are being asked of Commissioner Root to be answered. >> CHAIR DALGLEISH: All right. Thank you. We are -- this discussion is related to the motion to table. So if I am -- let me see. Commissioner Schallert, please. >> COMMISSIONER SCHALLERT: T hank you. I'm also totally in favor of the (indiscernible) ODR expansion. I've seen it work amazingly well. Just a quick question to the tabling question, will that affect -- is there a time element here with MHSA, three year, one-year plan? Will a month make a big difference? Because I feel like we're right on the edge of these you MHSA three-year plan being approved. I don't know the answer to that, but that should be answered, I think. >> CHAIR DALGLEISH: Thank you. Commissioner Root, is your hand up related to your motion, or is your hand still up from before? >> COMMISSIONER ROOT: My bad, my hand is still up. I have said my piece and let me take it down if I can figure out how to do that. >> CHAIR DALGLEISH: Thank you. Commissioner Barbour. >> COMMISSIONER BARBOU RU: Yes. As a provider and working in mental health, I've had some exposure to ODR. Working in that setting and I have been impressed with the versatility of the program. How nimble it is. How quickly it is able to stabilize individuals and the intensity of the providers who do this in terms of its -- their residential placement. We talk a lot about bureaucracy and no red tape, and all of these things, and I think the motion and its intent and its purity is to try to eliminate red tape and bureaucracy by being able to directly infuse these funds without a lot of difficulties and barriers. And I worry that programs that are so nimble sometimes don't -- are hung up. And so therefore I do not really support the tabling. It would be nice to have this move ahead. >> CHAIR DALGLEISH: Thank you. Supervisor Mitchell, is your hand up from previously, or is your hand up to speak again to this -- to the motion to table? >> SUPERVISOR MITCHELL: My hand is up to speak to the motion to table. Again, to speak to the motion to table, the 30 days from my understanding is problematic. I think another commissioner raised the point that given the timing on the finalization of the MHSA plan, that we would lose the window of opportunity if we wait the 30 days. So that's concern number one. So again, speaking to the motion, I understand that Dr. Ochoa is on and perhaps can answer some of the questions now that Commissioner Root has. With regard to how the money would be allocated with regard to is it, quote, enough, and so if ODR could answer those questions in real time, I think that would be helpful. Again, speaking to the motion. With regard to the justice deputy's involvement, the justice deputies for the second district work collaboratively with the second district commissioners in developing the motion language. I do not believe that justice deputies for the other offices are aware, I'm going to check with my own justice deputy to see if they've communicated with the justice

deputies from the other supervisorral offices, but ours was directly involved in assisting with the -- and my health deputy, in assisting with the crafting of the motion. But again, to speak to the motion, based on the questions raised, if they could be answered now, Commissioner Root can decide if he wants to continue with his motion or not. But I think we have the opportunity to have those questions answered to the best of Dr. Ochoa's ability right now. So I hope that we would be afford -- he would be afforded the opportunity to do so. >> Point of clarification, Madam Chair. Would it be advisable -- >> COMMISSIONER ACEBO:Woul d it be advisable, to call the question on tabling so we can get to the main motion because those questions will obviously come up as referenced by the chair of the board. So I'm calling the question on the motion to table. >> CHAIR DALGLEISH: The question has been called. Canetana Hurd? >> COMMISSIONER AUSTRIA: I think it's premature without having the first question. We have someone here, so I would say let her speak -- >> COMMISSIONER ACEBO:We'r e going to have -- Madam Chair? Sorry to interrupt. I think these are relevant questions to the main motion. And it's going to come up again and again. So I would rather wait until we get to the main motion, because there are a lot of members who probably have other questions relating to that to the main motion. So really the question, let's disperse with the motion that's on tabling first. So we can get to the main motion and move forward. Because I think that's really what the's the bottom line here. That's my opinion, Commissioner Austria. >> COMMISSIONER AUSTRIA: My opinion is if we don't get the questions answered, how do we vote -- >> COMMISSIONER FRIEDMAN: H ow do we vote on tabling it if we don't get the questions answered? >> COMMISSIONER ACEBO: My suggestion to the commission that this is a procedural motion to table. It is not a substive message to the actual motion. And we can get to those if we get to the tabling motion. I get a sense that maybe the body of the commission may not be favorable to tabling with all respect, Commissioner Root, and I would like to just disperse with that so we can get on with the direct business of the actual motion. But that would be my suggestion to the chair. But I yield to my commissioners and the majority of the commission. >> CHAIR DALGLEISH:Commiss ioner Acebo, I have -- go ahead, but I have a question for -- one moment, please. I have a question for Commissioner Acebo, because I'm using him as my guide right now. Commissioner Acebo, we will -- someone will be able to make another motion to table after we've had the discussion on the motion. Is that correct? >> COMMISSIONER ACEBO: If someone chooses to make another motion to table, they are free to. But if I was an individual looking at how to maybe how the outcome of this first tabling the motion, it would not be my advice that they would do another motion to table. >> COMMISSIONER ROOT: I'm happy to withdraw the motion, hear the discussion, and then if we need to make it again, I'll make

it again. I don't want to have this taken out of our -- >> CHAIR DALGLEISH: Thank you. Are you removing the motion? >> COMMISSIONER ROOT: I'll withdraw the motion. >> CHAIR DALGLEISH: You're withdrawing? All right. >> COMMISSIONER ROOT: Yes, I'll withdraw the motion, let's have the discussion. >> CHAIR DALGLEISH: And we had a second. Commissioner Friedman, are you -- >> COMMISSIONER FRIEDMAN: S econd. Withdraw. >> CHAIR DALGLEISH: Thank you. All right. The motion has been withdrawn, let's proceed with the discussion on the motion, and that is before the commission right now. And I would like to go now to Sharon, who is county council. Go ahead. >> SHARON LIKEMAN: I'm an assistant county council with the office of the county council. I have been with the county since roughly 1991. I am currently stationed at the health department but I have been involved quite extensively with ODR and the mental health department around negotiating the MOU, or as we're calling it the MOA, that sets out how ODR and the Department of Mental Health will move forward cooperatively. If there are questions that I can assist within that regard, I would be very happy to help you. If you're not familiar with the MOA, what it does is it sets out the responsibility of both departments in terms of services and funding. And so we are actually in the process now of building out operational pieces for that MOA, and I think that work is going at a very positive directs and we're moving really well towards establishing, I think, a solid collaborative working relationship. >> CHAIR DALGLEISH: Thank you. I see hands raised. I'm going to move next to Commissioner Molina. >> COMMISSIONER MOLINA:Tha nk you, Madam Chair. Just a very simple question based upon what we were just told. Does an MOA between the department and ODR need to be in place in order for us to utilize MHSA funding for ODR? Yes or no? >> I'm going to give you the attorney answer. What I would say is not necessarily. I apologize. But let me just briefly explain. The MOA is essentially the board's guidebook. The road map for how the departments will allocate services and funding. And so there is the opportunity under the MOA to deal with allocations including those related to MHSA, so that the departments make those decisions in accord with the board's road map. I hope that helps. >> COMMISSIONER MOLINA: It kind of didn'ted. So what's -- what's the purpose or the objective of the MOA? >> SHARON REICHMAN: The purpose is to ensure that ODR is providing mental health services that are consistent with legal requirements in the county code and state law. And so if you'd like me to elaborate a little more on that, what that means -- >> COMMISSIONER MOLINA: One final question and I'll be done. When do you foresee the conclusion or the signing of this MOA? Days, weeks, months? >> SHARON REICHMAN: It's been executed by both directors and the board of supervisors. So that road map as I like to call it, is in place and approved. Now the departments are dealing with operational pieces to ensure that they are acting consistently with the way the MOA is

structured, with regard to mental health services being provided by ODR. And so much of that operational discussion will include pieces about finance. >> COMMISSIONER MOLINA:Tha t's helpful. Thank you very much. >> SHARON REICHMAN: You're welcome. >> CHAIR DALGLEISH:Commiss ioner Acebo. >> COMMISSIONER ACEBO:Than k you, Madam Chair. Members, a question to the county council and also I hope that there is a Department of Mental Health staff person available to answer other questions related to this specific MOA. Question to the county counsel. With respect to operational pieces specifically financing, is it the intent of the board to look at and meet all requirements relating to state and/or federal funding that could be available to ODR for mental health purposes? Services, purposes? >> SHARON REICHMAN: I think -- >> COMMISSIONER ACEBO: Does the 2019 motion, if you remember, states that they cited a number of various state funding options, including MHSA. >> SHARON REICHMAN: I apologize, I'm not familiar with the 2019 motion. >> COMMISSIONER ACEBO: The 2019 motion was the actual motion by sprr Hn that put this in motion to establish this MOA. Sorry, not to put you on the spot, county counsel. >> SHARON REICHMAN: No, no, no. This is one of the side effects of me being stationed away from the hall of administrations. I sometimes miss things like this motion. >> COMMISSIONER ACEBO: Let me try to rephrase the question for you. You had mentioned operational pieces and associated with financing. I assumed that opens the door for many revenue options for ODR to pursue and the board hoping that they would pursue it to provide mental health services. Would you say that is a -- that is correct on my part? >> SHARON REICHMAN: The MOA is specifically structured to allow ODR to access funding for mental health services in a legally complaint way. So that in other words, so that the mental health department and the health department cooperate to ensure that any finances that are structured, any money that is dispersed will be handled appropriately as required by law. >> COMMISSIONER ACEBO: Okay . So MHSA is an appropriate funding alternative, yes? >> SHARON REICHMAN: Yes, I believe so, sir. >> COMMISSIONER ACEBO:Medi um Cal reimbursement is an appropriate funding option as well. >> SHARON REICHMAN: Yes, that is correct. For specialty mental health. >> COMMISSIONER ACEBO: All right. Can I have a member of the Department of Mental Health available to answer a question for me? >> GREG POLK: This is Greg Polk. Welcome, Supervisor, Mitchell. Glad to see you here. >> COMMISSIONER ACEBO:Than k you for being on the call, and members, I appreciate your patience with me. I want to get to this funding issue, Greg. Because under MHSA there are these categories, it wasn't stipulated in the motion which category that the 25 million would come out of. It's not for me to decide, but how is that decided, and if that is decided in terms of a category, what are the state requirements associated with that category of 25 million so the commission is clear what will be

required of ODR relating to this 25 million. >> GREG POARK: I think it depends on the services ODR are providing. The parameters around PEI dollars, prevention and early intervention dollars, parameters around CSS dollars. So it has to fall within the parameters of those categories. So what we would do is take a look at the dollars, of the services being provided by ODR, and see where it fits within the whole MHSA plan, so to speak. So it has to fall with one -- within one of those categories. >> COMMISSIONER ACEBO: Do you know, Greg, if ODR is pursuing med Cal reimbursement since it will be available particularly under the MOA? >> GREG POLK: I would assume so. Maybe Dr. Ochoa can answer that. I would assume they will be. >> COMMISSIONER ACEBO: And I would assume that the practice of any county department is that we always protect net county costs or general fund dollars. And try to get reimbursed from state and federal as much as possible. I would assume would that be a correct assumption on my part? >> GREG POLK: I think that's been a directive of the board. The board always tries to protect net county costs, and to the extent it can be funded by state and federal revenues, that's always our first disability. >> COMMISSIONER ACEBO: I have a question for Dr. Ochoa, Madam Chair, if that's okay. >> CHAIR DALGLEISH: All right. I do want to say I understood that the MOA had been executed also by the director, or directors. And since we have the director of the Department of Mental Health on the line, I would like Dr. Sherin to address this issue if possible. >> DR. SHERIN: I haven't left yet. A couple things. First of all, Greg's points are important. It really depends on the type of program that's being administered in terms of what funding, what bucket of MHSA can be used as many know, going back at least four years, I and others have been trying to simplify the use of those funds, because they're so constrained. There is a little bit of an issue here around timing, because as you all would know, there's a required 30-day posting for new types of programming. Though maybe there's a way we can think about how all of the input that we've collected over the past year supports the programs that would be delivered. And that's something I think we want to figure out. If we are going to go forward. The other thing, I want to make something really clear. Going back to 2018, myself and lawyers at the time, in this department, raised the flag to say, listen, ODR is doing great work, but in order for them to be authorized to deliver treatment, to draw down funds, they need a contract with the Department of Mental Health. So we've been pushing for that. And unfortunately I think it's taken a long time for a variety of reasons, including the fact that when you use money like this, it's constrained. It's constrained when you want to draw down, there's a lot of reporting requirements, et cetera we did sign it, Christina and I signed it as soon as we could get through all the process, and we want to move, and we want to invest in ODR as a contractor for the Department of Mental Health. Big-time. In fact, I'm working and our team is working on innovation

project, because we also have innovation funding, that we want to use to get people out of the jail. You have to realize also that one of the things about MHSA is that it can't be used in any institutional setting. So any of the funding -- any of the services that would be funded would have to occur in the community, which I don't think is a problem. But I want the community to know that the Department of Mental Health is very much behind the work that ODR does, it will be not as flexible, because the money has things tied to it, and it took since at least the beginning of 2018 when we raised the flag to say that we needed an MOA until, I don't know, four or five, six months ago to get that agreement signed. >> CHAIR DALGLEISH: Thank you. >> COMMISSIONER STEVENS:Co uld we invite -- Ochoa to the discussion, please? >> CHAIR DALGLEISH: I think she's still here. Are you asking me to -- >> COMMISSIONER STEVENS:I' m asking for Dr. Ochoa -- >> CHAIR DALGLEISH: Is she not able to get on the line? >> COMMISSIONER STEVENS:I' m asking to welcome her into the discussion. She is present. Thank you. >> CHAIR DALGLEISH: All right. Fine. Yes, thank you. Go ahead. >> COMMISSIONER ACEBO:Mada m Chair, I have a question for Dr. Ochoa before I yield it to Dr. Sherin. Is that still appropriate? >> CHAIR DALGLEISH: Go ahead. I see everyone's hand. >> COMMISSIONER ACEBO: I just want to finish my question to Dr. Ochoa. Or do I need to yield, ma'am? >> CHAIR DALGLEISH: I'm asking you to go ahead, please. >> COMMISSIONER ACEBO:Than k you. Welcome to the Mental Health Commission and thank you for being here. And a very important motion and -- that the second district commissioners have brought forward. I just have a couple questions on sort of your reporting. And I know at least two years ago that under Commissioner Weissman's chairmanship we did a deep dive into ODR, and so we are very knowledgeable of the great work it does. I'm curious about the, your reporting, look be at your website, you report on recidivism and housing retention. And hospitalization visits. Can you tell me, do you do any reporting relating to mental health outcomes? Specific consumer outdismoms by ODR? >> DR. OCHOA: Can you hear me? >> COMMISSIONER ACEBO: Yes, ma'am. >> DR. OCHOA: Thank you. And thank you for -- to everyone who is considering our work and who cares so much about what we do, we really appreciate everything I've been hearing on this call. So we -- right now the health services research that's taken place around our work, and you've seen it in the motion from UCLA, really looks at outask comes in terms of mental health and psychiatric emergency room visits as well as psychiatric and patient hospitalizations. That's what we've reported on thus far. And as you mentioned, rearrests, what the CIO's office calls failure to appear in court, which basically means someone has fallen out of the court's eyes and is not reporting back to court as they are court ordered to do. And then housing retention, whether people stay in our program and stay in housing, we are housing first model, so

those are the primary outcomes. However, we have a very -- I'm a researcher by background, and we have a really robust analytical ability with our own pretty rigorous data and database, and so I'm pretty confident that if there were further requirements under MHSA that we could meet them in terms of reporting outcomes. >> COMMISSIONER ACEBO:Than k you, Madam Chair, I appreciate your patience. >> CHAIR DALGLEISH: Thank you. Dr. Sherin, had you finished? Before I move on to other questions. >> DR. SHERIN: Yes, that's fine. Thanks for giving me a chance. >> CHAIR DALGLEISH: All right. Thank you. I'm moving on now, Commissioner Austria, please. >> COMMISSIONER AUSTRIA:Ye s. I wanted to point out that ODR is a new and innovative program which comes under MHSA. I believe it's up to DHS and DMH to find exact funding piece. But there is a surplus of funds in MHSA, which has been identified but not particularly shared with the commission. So I would ask that -- we're giving a directive as commissioners, we're not asking to be the bureaucrats ourselves. We're asking the commission we make a recommendation to DMH to work with DHS and ODR to move this really critical piece and not delay it. Because if we delay it, the program is already closed. I got a call Tuesday after I went and visited a site, and there's a young man in jail, a graduate of USC, schizophrenic, he's been arrested a couple times. And he was in jail, and he needs a program like this. But he can't be referred at this moment. There's a lot of people sitting here, so I want to remind people that there are individuals that need to be thought of first and let the people who need to work out the bureaucracy. From what I understood of how the money would be spent, it would be spent primarily to increase the project by 500 beds. So I'm asking people to think about that, the departments and the -- how we can get the directive from us and then move this motion. >> CHAIR DALGLEISH: Thank you. You did bring up one point that we will need to circle back to, and that is extra money that has not been revealed to the commission, but we will come back to that because Dr. Galley has just joined us, and Dr. Galley would like to speak to this motion. I would like to give you the opportunity. Thank you. >> DR. GALLEY: This is director of DHS. I apologize, I just joined because of another conflict with my schedule. So I missed the first part of the meeting. But I do want to thank the commissioners for the motion in support of ODR. I understand that the site visit was informative earlier this week, and I hope offered an opportunity to see in action some of the really life-changing services that are provided through ODR. And how those services, by providing a housing first approach, offering stability through housing, through case management services, through medications and therapy, as well as other services, can really change the trajectory of people's lives. The outcomes that ODR has been able to achieve through its various programs are impressive in terms of greater housing stability, reduced recidivism rates, and are frankly much better than anything

else I think that's been seen among a population that is really very, very sick. I'm very supportive of this motion surrounding the use much MHSA funding, it's entirely consistent with MHSA funding principles. It would not be used to supplant any additional revenue sources that ODR receives, either through other county funding sources, whether it's net county cost or other funding. And also would not supplant any Medi-Cal revenue, either nonfederal share or federal share that also ODR would be able to bring in and it's entirely consistent with the MOA that has already been signed, which DHS and ODR are absolutely and fully supportive of. We're still working out all of the operational agreements for how that MOA will be operationalized, but there's absolutely nothing consistent with the use of MHSA funding for the ODR purpose, and that separate MOA. So just want to express my thanks to the entire commission for those who put forward the motion, and for the commission's consideration of it, and to the ODR team for being here. I would be more than happy to answer questions. I'm sure a lot of it has been covered, but more than happy to address any other concerns or questions there might be, and again, just thank you for your time. >> CHAIR DALGLEISH: Thank you very much for joining us. And giving us your time. If there are any questions for Dr. Ghaly at this time, I'm going to go through the hands that are already raised, we have Commissioner Weissman, Commissioner Friedman, and Commissioner Stevens. Commissioner Weissman. >> COMMISSIONER WEISSMAN: T hank you very much for all of the context and in input from all of the doctors and department leaders and Supervisor Mitchell. It's a lot to consider at this point. We've heard lots of different angles a this premise. I would like to just chip in my couple of cents here, which are one, it's pretty frustrating to be dealing with this when it feels like a sense of urgency or emergency, really, that program with ODR has been quiet for some time due to funding concerns. We've known this for some time, so to come to the commission and kind of hail Mary it to get a motion passed to get $25 million infused, it feels very tight. And can I want to voice that, I'm sure I'm not the only commissioner who feels a little behind the eight ball trying to conceive of all this and make sense and integrate. It does feel a little bit like a political football coming to the Mental Health Commission, it seems to me that with the questions that are coming up through the commissioners and the content being provided in response, that more due diligence is maybe needed for us at least to understand a little bit more fully, and I consider myself somewhat on the cusp of being an insider to witness the birth of ODR and the transitions, and the escalation through the years. I don't know if we want to consider talking internally up through the Department of Mental Health to get ideas from DMH leadership on what our motion should look like to get the most out of MHSA dollars for ODR. Because my goal is really to support ODR, and the most -- to make it the biggest, most successful program it can

be in the most sustainable way. And $25 million in an annual installment from MHSA in a kind of a nonscript way, it doesn't seem like it's tied to much, is that the best way to do that for ODR's sustainability, and forever ability in L.A. County, which I hope it can be. And then finally, with the advent of the MOA discussion here, I was just getting confused as to whether or not our motion as a commission supports what's in the MOA, are we informing the MOA, could the MOA inform this motion? And so I think to the extent that any of the experts and knowers on this call can help me make sense of any of that, I'd appreciate it. >> CHAIR DALGLEISH: Thank you. I'm going to continue through the -- at this moment, unless Dr. Ghaly has a response specifically to the last question from Commissioner Weissman. Or if Dr. Sherin has a response to that. >> DR. GHALY: With respect to the MOA, there's really nothing inconsistent with the two pathways. The MOA governs a process where ODR would be able to seek a contract so that it can receive payment in Medi-Cal -- and Medi-Cal reimbursement for the services it provides. It's to date not been able to access Medi-Cal reimbursement because it doesn't have a contract with the plan. So this MOA offers that structure for it to be able to obtain Medi-Cal reimbursement for eligible specialty mental health services. It also offers a framework for how performance contract related funds would be governed. And then leaves the rest of the discretion to ODR and DHS for areas in which DMH is not directly involved as a source of revenue. So in this sense, be where DMH is the designated authority for development of MHSA spending plans, the MOA as signed by both departments is entirely consistent with DMH making an allocation to ODR or to anything that MHSA is able to fund and the MOA is in support of that. It doesn't speak to any of the details about what has to be included in it, or what has to be funded. The MOA doesn't speak to those issues. But it allows for that possibility. So they really run I would say in parallel. I don't know if Commissioner Weissman if that gives you enough information for your question. >> COMMISSIONER WEISSMAN: Y es. It does seem like they can run in parallel. But again, the swirling concerns around -- the integrity of our decision making process and how we're considering things as a Mental Health Commission feels under the gun right now, and I don't know how we're going to come to peace, but I have faith in our chair to help us along, Stacy. >> CHAIR DALGLEISH: Thank you. Commissioner Friedman. >> COMMISSIONER FRIEDMAN: I just want to say that I absolutely agree with every single thing that Brittany said. And I was going to say the exact same thing. But I have one specific question, and that is, what is the urgency? Is the urgency if we pass this today, does that mean that on Tuesday the board of supervisors will have a motion and they will vote on it and the money is immediately available? Or what is the urgency? Could someone answer that? >> CHAIR DALGLEISH: Counsel or commissioner or Dr. Ghaly or someone from DMH, please. >>

COMMISSIONER STEVENS: I want to remind us -- >> CHAIR DALGLEISH: I was going to call you next, Commissioner Stevens. >> DR. GHALY: I don't know whether you can answer questions about timelines or where the board would weigh in or perhaps one of the health deputies has the information to answer that question, or alternatively, our counsel, I believe Sharon may still be on the line. >> DR. SHERIN SLZ I THOUGHT I HAD COMMENTED ON THIS IN MY: Earlier statements. There technically is a 30-day period of comment that's required from the community around the use of MHSA dollars. What I'm saying is, we probably can look at all the input we've gotten that supports the concepts for the program so that we can thereby conclude that there is community support for the program, and that the 30-day period is unnecessary. I'm not a lawyer. I don't pretend to be, but that would certainly be my recommendation is to see if we can do that. And I also just, what I've said earlier, I don't know if you were on, the Department of Mental Health has wanted to have a contract with ODR for some time. And now that we have one in place, we will be able to invest in it as we do with contractors all over L.A. County and leverage the expertise that has been developed and the practices that have been developed. I'm -- one last thing, I'm a little confused about comments related to the department not sharing funding issues with MHSA. We've been struggling to spend mast in two pots. The prevention pot and the innovation pot. And because there are more millionaires as a result of COVID, there's a massive amount of new MHSA money coming down to all of the counties. So we're looking in the department, we've been actively figuring out ways we can invest particularly through other departments to spend the money, because it's really outstripping our ability to hire and to contract ourselves. So this for us is a good thing, it's core to the direction of the board, the direction of the Health and Human Services departments in the county. And we -- so we're very interested, I'm interested on my way out in figuring out how to get this done, now that we have Christina, you ESPY have signed this MOA. >> CHAIR DALGLEISH: Thank you. Commissioner Stevens and then Commissioner Austria. >> COMMISSIONER STEVENS: I want to first thank everyone for the conversation that we're having. Thank you Dr. Christina Ghaly, Dr. Ochoa, county counsel, thank you Dr. Sherin for acknowledging interest. And the work that's already currently -- the direction in which we're going. I want to remind us, because there was a question that was asked about what's the urgency, what's the rush? I think it's important to remind us that there are over 13,000 people right now that are languishing in the county jail system. And in order to provide them with opportunity, we have to have funding and places for them to go. I experienced 12 arrests, untreated mental illness, unhoused, a disaster. A mess. There was no ODR. So I know firsthand the benefits of what ODR offers, and the opportunity for people to live -- you cannot get well in a cell. It's a disgrace. Because

oftentimes even upon release, and I was released all 12 times, with nowhere to go. No opportunity, no new possibilities. So when you talk about a rush, and you talk about why now, I want to remind this commission, I brought this up last year, around this time, the year before, and because of the support and because I had the courage to ask for help to do something different, not only are we having a conversation about a motion, but we're doing something we ain't never done before. And so I think this is a great opportunity for us to wrap ourselves around this new possibility and new opportunity to do something different and grow as a commission, but also think about the people that we are here to serve. Some of them are inside of the jails and under the Department of Health services. But the truth of the matter is, we're talking about people who have severe mental health issues or challenges, and we're also talking about an opportunity to give them an opportunity, and we should not miss that moment. It is before us here today. I have no questions. The only thing that I have -- I have an ask. And I ask that this commission embrace and support, even if we're making amendments, but let's move this forward. Thank you honorable Supervisor Holly Mitchell for being here today and for the support of your staff and this courageous bold move and ask from the second district commission. Thank you. >> CHAIR DALGLEISH: Thank you. Commissioner Austria and then (indiscernible). >> COMMISSIONER AUSTRIA:It 's always hard to follow Reba, she's so passionate. That is passion that is needed for all of us as commissioners. Because I too am from the other end, not as a peer, but an employee in the field, and seeing a need. Firsthand. Getting calls as a board staff prior, and still getting those calls from people who are -- people who are in jail who need help now. And they're not getting it. So this is really critical. I know that in the letter of recommendation from the commission last year, this was put in there, there was a recommendation to make this a priority. And so what we're trying to do is move that recommendation from last year's recommendation to actually move it into a motion and take action. So we are asking for action in the county, and not to be so bureaucratic, still meeting the bureaucratic needs, it fits under MHSA, community-based, and it's needed now. So please support the motion, and we thank all of you, if it feels urgent, I'm sorry, it's been lingering and the program has moved forward and I think this is the time. And if we need to form something so that people are monitoring it, I'm fine with that. I will happily head something up. But what I understand, it's to create 500 more beds, which is a fairly simple act in terms of this is the goal. How we get there, I leave that to Dr. Sherin, Dr. Ghaly, to Dr. Ochoa, and to the authorities that need to do that -- the others that need to do that with us monitoring that. Thank you. >> CHAIR DALGLEISH: Thank you. (indiscernible) and then there's a question in chat from Yolanda Vera, and I will read that after the next person speaks. Thank you. >> Thank you. I also just wanted to echo

Commissioner Stevens' sentiment on the question of urgency. I think we spent decades in meetings like this discussing how we need to move with urgency on the matter of the homelessness and mental health crisis on our streets. And now we found a model that actually works, that is nationally recognized as a best practice. At the same time we find out we have almost a billion dollars of unspent dollars in reserves, that we could move quickly to fund the programs that we know work to reduce incarceration, adverse mental health risks, and homelessness. And so I'm a little confused by the question of what is the urgency here. Because all I ever hear is that we need to move with urgency to act on this. So, yeah. Kathleen, don't think you need to apologize for the urge si here. That's all. >> CHAIR DALGLEISH: Thank you. That is bringing up the question of discovering unused funds. I'm going to wait for that until I read Yolanda's question, if this motion is tabled and the MHSA update goes forward without the funding for ODR, does that mean ODR and diversion services must wait another year until the next plan before any relief is afforded? And I have asked for someone to answer that question. >> GREG POLK: It required a 30-day posting. Once the posting is done it requires a board to go before the vote -- the board to vote, or the supervisors can bring in a green sheet or motion to make that happen. >> CHAIR DALGLEISH: Dr. She rin has also said that there might be a way around that. So I think that might be what is being asked here. Dr. Sherin, are you still with us? >> DR. SHERIN: I am, and I have to peel off for an interview. You're right, I think what Greg is saying, I can't say for sure that we've gotten the kind of public comment about a specific program that technically statutorily we're required to get. On one hand we don't move fast enough, and on the other hand we move too quickly. I can't tell you how many times we get reprimanded and -- about not including people's voices, and then things -- and now we're trying to push something quickly. There's no one that's more restless about all of these things, especially around homelessness, and this department, as well as those who are incarcerated. So we want to move together in partnership, and as I've said, in 2018, I told both departments and everybody in this county that we needed to have a contract with ODR. For them to do the work they wanted to do. And now that we're here, it's great. And let's move. And we're trying to spend the money. We have contractors all over the county who can't spend the money that we give them. Let's let ODR, let's see how much money ODR can spend to go after a board priority, that's fine. We want that. We want great contracts with everybody, including other departments, we want to grow our own department as quickly as possible. That's not the issue. We're not trying to -- the bureaucratic processes are what we fight about, what I fight about all the time. Including the more flexibility for MHSA money so we don't have to have all of these onerous processes and fenced bucketed money. The money that's easy to spend is spent. The money that's difficult to spend is

not. Prevention money. We have a the who of prevention money. You can't use prevention money for this population. It's prevented by statute. So we will do everything in our power to move this as quickly as possible. I would love for it to go in to the plan that we can get signed off on in the process that I think Yolanda is asking about. If we can't, we'll do whatever we can with board support to expedite it. And we'll also make sure that the departments and the operationalizing of the MOA are taken care of. There will be learning curves. ODR has not operated as a part of the plan with all of the requirements around reporting, and programmatic restrictions, and what it takes to draw down money. That's going to be a learning curve for them, and it's not going to be fun, but those are the realities. If it were up to me, we wouldn't have any of that. We would give money and get asked to achieve outcomes for the people we are here to serve. >> CHAIR DALGLEISH: Thank you. Ms. Vera, does that answer your question? >> YOLANDA VERA: Actually, hi some concerns and issues on it, because I don't know whether counsel is still on the line, because my understanding was that the board was always told they could not direct the commission or DMH as to how to spend MHSA dollars. So I don't know to what extend the board could direct it, and that's why it's so critical that the commission recommends it to occur. I've been watching ODR through the years, we've seen so many studies, we've heard eloquently from witnesses about the outcomes. But to date, years have gone by and there still have been no MHSA dollars to support services for MHSA eligible clients. So that's the urgency, that's the push on acting now. Rather than deferring it over to the board of supervisors. Which certainly would want to support the effort and do everything to get the county departments engaged so that they can implement it with Dr. Sherin, Dr. Ghaly, and the ODR staff. But I -- we've always been told, and I have county counsel opinions that no, the board can't direct DMH, if the commission does not do it first. So that's the need for the vote today. >> DR. SHERIN: I just need to say, we're not suggesting the board would tell us, and the board is not thoarsed to do that. The community input, which we incorporate as guidance, is then built into a plan. Right now the commission representative of the community is providing input to the annual update. The thing about the board is that if we are unable to move this as quickly as we would all like to, in terms of this annual update, we would then revise the annual update early a in the -- in the next year, like within a 30-day period, and then once that is done, and there's a 30-day comment period on this particular program, we then would need authority to act upon a modification of the plan. So this -- we're not asking for mandate from the board. And in terms -- I'm going to say this again. This is the third or fourth time I've said it -- in order to use MHSA money, to do things like support ODR, we need a contract with ODR. And we finally have one. So we're now actually technically able to do that.

We had thought -- >> DR. GHALY: MHSA funds can be allocated and a contract can be developed. It is true that an MOA is in place and it's not a barrier, the MOA, though, largely governs Medi-Cal specialty mental health reimbursement. It's not particular to MHSA. There's absolutely no reason why MHSA funding could not have moved to ODR prior to that contract being in place. So I just don't want there to be any misunderstanding that there's some barrier in place either historically or currently. I think -- I'll defer to others as to why there hasn't been an ability to fund ODR with MHSA funds, but the contract is not the primary barrier. We are all glad, I know all of us on this call are glad that an MOA is in place now, we think that's a major step forward. We believe for both organizations, and that there's a lot of good that will come from that in seeking that reimbursement through the various options for Medi-Cal. But it's not, never was, and is not a barrier to MHSA funding being able to move to ODR programs. >> DR. SHERIN: It's unfortunate, especially as I'm exiting this county to air differences on a call like this, but in order for an entity to deliver mental health treatment, it has to be authorized by the mental health plan. And that was not the case prior. So maybe for things other than treatment, what you're saying is true. But inners the of treatment, that's been the crux of the whole matter. >> DR. GHALY: The agreement is in place now. I just don't want people to think there is any sort of relevance of a barrier of the MOA. That's not the case. >> DR. SHERIN: You get the last word. We'll move it. >> CHAIR DALGLEISH: Thank you. >> COMMISSIONER FRIEDMAN: I used the word "urgent" -- >> CHAIR DALGLEISH: Wait. >> COMMISSIONER FRIEDMAN: C an I say this one thing? >> CHAIR DALGLEISH:Commiss ioner Friedman, are you speaking? >> COMMISSIONER FRIEDMAN: I just want to -- >> CHAIR DALGLEISH: You will be next. I'm going next to Commissioner Root, then freedman, then Acebo. Commissioner Root. >> COMMISSIONER ROOT: Thank you. Certainly there's a sense, I gather the commission to move this ahead, and it's a sense that I agree with and support. I also hear Commissioner Weissman's comment that there are a lot of questions about how and we do this, and I still am not sure I understand the difference between doing it today and doing it after we have more direction and some answers to this question. Reba, I certainly hear your passion in this, and I support that. What I'd like to see is if we're going to put 25 million bucks in this T. or some other number, maybe that's not enough, as I said, is it -- yes, that's my point. Is it 500 beds or is it 500 beds and some other things? ODR does some great work, and their model of tying homes and tying back with long-term supervision is what I believe has made this successful. That model doesn't exist in other mental health services. In recovery from addictions and things like that. I'd like to see whether we can -- as long as we're putting the money in this and making a commitment, I'd like to be able to use this success and build on it for some other programs. So I'm going to

support the concept that we do this. Whether the number and the direction is correct, I don't know. And I would like to have a little more time, but I'm going to support this overall, and if somebody says if we don't support it today we're going to lose the opportunity of putting the 25 million bucks or some other number in, I'm going to be in favor of it today. If somebody fails to tell me that, I'm going to come back and say I think we ought to take 30 days and see whether item two needs to be fleshed out a little bit in more detail to make the motion of the commission as impactful as it can be. Don't hear me that I want another four years of playing around with this and not getting anything done. I want to make item two as powerful as it can be. >> CHAIR DALGLEISH: Thank you. Thank you, Commissioner Root. I get a lot of time -- I did allow a lot of time for this motion today. We do have one other item on the agenda. We don't have an ending time. And that's intentional because of this motion and the report that we have as a public hearing which has to happen. So if -- I will proceed with allowing people to speak, please make it brief, because we would like to move forward on this or at least reach some resolution. Thank you. Commissioner Friedman, Acebo, Schallert, Weissman, Stevens, and then that will be the end of our discussion. We need to go to public comment as well. Thank you. >> COMMISSIONER FRIEDMAN: I just wanted to say when I used the word "urgent" that was an incorrect use of the word. What I really meant was what is going to happen if today we approve this, does that mean that on Tuesday the board of supervisors will vote on it, and approve it, and then when does the money flow to ODR? And my second question is, if we do approve it, 25 million does seem like a minuscule amount of money. I wish we could ask for more money. It would make a lot of sense to ask for more money, because I'm not sure how much 25 million can do. But my real question is, what does this mean? Does this mean that after Tuesday ODR gets the money and then things start happening? Can someone answer that for me? >> CHAIR DALGLEISH: I will just say that we can't say what's going to happen at the board of supervisors meeting at this juncture. Even if it's not on the agenda at this time, there is time for it to be noticed. Commissioner Acebo. >> COMMISSIONER ACEBO: I have a question for Mr. Polk if he's still available, please. >> GREG POLK: I'm available. >> COMMISSIONER ACEBO: I just from the fourth district point of view, we support Dr. Sherin's interpretation of the MHSA. And we are the authority on MHSA. I will also say, Dr.-- Mr. Polk that Dr. Sherin seems to say the timing of delaying the vote doesn't mean that we have to wait a year. And I also think it means that we maybe have to wait a month or two because the board still has to decide and budget negotiations for FY22-23. Is that somewhat -- is that accurate on my part, Mr. Polk? >> GREG POLK: One of the things the board has to vote on the whole plan. The adjustments that we make and the commission makes up. There is a need, when you are talking about appropriation, it has

to be appropriation authority given for us to shift money from DHS. All that is once there's an agreement we need to do that. And one of the things I wanted to say too is that, you know, we're clear what the direction is of this department. Of this supervisor Mitchell, we understand what we need to do, and I don't think it's upon mental health to help inform the process. I think we should work with the commission, work with the board officers of how we think these dollars should work, athan who with DHS and Christina and her staff, and should have a conversation about how best to move this forward. Because one of the things that's required here is two outcomes. The one thing about MHSA, there's a lot of data behind it, and data requirements. So we have to talk about the outcomes and how we report those outcomes to the state. And so I don't know if the commission or the department is familiar with how that process works. I think we need to be a part of that to help inform what Supervisor Mitchell is trying to achieve. Like Dr. Sherin said, we've -- we're all in on spending dollars, as much money as we can spend. We're trying to spend MHSA dollars, there's no secret about that. It's just there's a process, there's always a process, and a big piece of it is the stakeholder process. And I think we have to get that part done by statute, and once we do that, I think it's important for us to help inform how we move this toward and get the best outcomes for our clients, and move it forward. >> COMMISSIONER ACEBO:Than k you. And I have one more question K. Madam Chair, for ODR. >> CHAIR DALGLEISH: Go ahead. >> COMMISSIONER ACEBO: Is it true that the CEO just allocated 30 million in net costs to ODR because of its fiscal challenges? >> DR. GHALY: The board of supervisors CEO, the budget is still to be approved, allocated $30 million in net county cost as ongoing funding to maintain the current set of beds for ODR housing, because ODR has a fiscal cliff. So the portal that allows for new clients for new individuals to be diverted, that would be needed to build up additional housing isn't -- that portal is still closed, ODR can't build additional housing. The 30 million you're referring to, sir, is just for the ability to maintain the existing portion, not even all, a portion of the existing ODR housing portfolio. It does not allow for any growth or expansion. >> COMMISSIONER ACEBO:Than k you. Madam Chair, just on my time, I will say that after we get to public comment that I have amendments to the motion. Which I will introduce after all comments. Thank you. >> CHAIR DALGLEISH: Thank you. Commissioner Schallert. >> COMMISSIONER SCHALLERT: T his isn't totally relevant to this, but we did receive a letter very recently from the ACLU pointing out that L.A. county has entered into a dissent decree way back in 2015 after 1997 investigation that said our jails were horrendous. And by May of this year we're still -- the county is supposed to have reasonable plan in place. So I found that I have interesting, that that's something I didn't know about. So I don't know if we really need to take that into account, but it seems like we should since

this is not a new problem. Just a comment. >> CHAIR DALGLEISH: Thank you. Hang on a second, I'm sorry. Commissioner Weissman and then Commissioner Turner, and then we'll go to public comment. Thank you. >> COMMISSIONER WEISSMAN: T hank you. Maybe this speaks to Kevin's idea about amendments, but I was wondering if we could move this forward and approve if we simply added some detail and specifics to that number two, like around budget and report backs and outcomes, and data sharing. Once those elements are on paper it would address a lot of the concerns I've heard, and we'd be able to make a recommendation to DMH and BOS to take this a little further. >> CHAIR DALGLEISH: Thank you. Commissioner Stevens. >> COMMISSIONER STEVENS:Th ank you, Commissioner Weissman, you basically said it. And that was my comment. And then in reference to what Greg Polk had stated about outcomes, I think it's important that -- and I know that Dr. Ochoa and as well as Dr. Ghaly can provide that information as well. Around that. But I just want to end by saying, before the public speaks, that it's important that when folks are exiting that there's opportunity and a place to exit. But more importantly, I think it's important for us to remember that it's important for them to live safely in community-based settings. And have appropriate mental health care as well as case management services. And I hate the word "case management." Because I don't like -- I never want to be case managed. But care managed is what I would love for us to fight to change that. The other is around restoring dignity. And it is really clear, I wanted to make sure that I shared the experience that I had by going to on the tour to two of those sites, and what was most fascinating was -- it was sad but it was fascinating too to see so many Black men, and also men of color that were taken advantage or being providing an opportunity. I think we also need to be calling for data around ethnicity. Because we know that there's an overrepresentation of Black people or Black and brown people who are currently incarcerated. And so the importance to restore dignity to their lives, and especially those who have mental health challenges, because I do know that we can get better. And that we're capable of doing just that. And so that's all that I want to say. But I will end with this -- there was one question that I asked all of the men in this -- in these two facilities and I asked them, what would you like to see different? And you would be amazed at what they said. Nothing. So it says that the good work that's happening currently today, those participants did not find a fault anywhere. And I think that's really important to highlight. So thank you, thank you again, thank you everyone. Thank you for your support. >> CHAIR DALGLEISH: Thank you. We do have a request for a quick break at this time. Could you, AT&T operator, could you tell me how many people are on the line for public comment? >> AT&T OPERATOR: Currently three in the queue for public comment. >> CHAIR DALGLEISH: All right. Then let's go to public comment and

then we'll take a five-minute break. Thank you. >> AT&T OPERATOR: You currently have -- line 30, please go ahead. >> Hi, my name is (indiscernible), I'm an L.A. County commissioners -- consumer and former commission body. I really appreciate that this is being brought up as an issue. It's important DMH begin to tackle it. However, the MHSA has significant stakeholder requirements that everybody here has been aware of. So I'm glad that I don't have to be repeating those issues again. I know this is a significant priority for all of us, but particularly as I hear from the board of supervisors, the priority, the board of supervisors needs to fund it from their other budget. They have a lot more money than they pay for the Department of Mental Health. The Department of Mental Health only gets about 10% from the county's budget. And that needs to change so the priorities like this are equitably funded across our systems. This feels very rushed through our MHSA process, and by no way should that burden or responsibility be put on this commission. Th The county has a responsibility to fund ODR fully, fully and continuously to the partnership and it should not be doing it by reading images of funds. Particularly with this are some of our most, you know, very delivery type of processes, so I really agree. Advice with physicians as well and the discussion that has been had, you know around this issue, but going through it with me She has a funding mechanism really seems very rushed at this point. I actually liked the proposal, but the mechanism doesn't necessarily work, even though there is significant issue with the questions around ODR. And want to remind everybody about those responsibilities. >> Thank you. Line 37 please go ahead. >> Rick P: Hello, this is Rick Pulido. SALT 7, a longtime advocate for parents and for here for and South Bay Area. I have to agree with the first of all I want to say Dr. Sherin. Shara was unable to get on to his public comment on the CLT meeting, but he's a very strong advocate and emotional person And he made some excellent points. You all and the board of supervisors need to take heed because we are we, I'm including myself, are dragging our feet getting this ODR instead of 25 million only I suggest you guys contemplate on asking for 25 million per district so make that more like 125 million. As a starter or even more, because the funds are there like my previous colleagues were saying. This has to be grass roots effort, and need to be connecting because the silos are huge, and more importantly DMH is doing a great job overall, and have to say it's not easy with your hands full right now with the crisis, and wars, and Coronavirus and whatnot but, in closing, I would just like you to please move this forward as soon as possible because of disparity right now for people of color as the commissioner said. Dignity. We need a one stop shop concept, I talked about this for years, a job on the job training for peers peers peers.. Street treatment. Funding for MHSA. And we need to take care of our families and peers now. Thank you, and god bless you. >> Thank you. On the line you are open. Carmen line 39 please go ahead. >>

Carmen Perez: Hello, I'm Carmen Perez. The interim co chair of the Latin X Mental Health policies as well at the LatinaUsCC. I'm calling about workforce in regards to implementing a lot of these programs were already having issues with...And I'm wondering how that department will tap for the lack of workforce specially bilingual, bicultural, and implementing some of these programs we haven't seen a plant from the department about workforce development. And I think that's imperative right now when it comes to implementing a lot of the programs that we're talking about today. So just try to figure out what the department is trying to do around workforce and if you can please show that, thank you very much. >> Thank you, and line 32 please go ahead. >> Good afternoon, Anette director of policy and advocacy of dignity and power now, an organization founded by the advocacy of family members with loved ones as Mental Health needs that were criminalized. I'm also a commissioner on the gender responsive advisory committee, as well as other county commissions,the gender response advisory committee set out recommendations last year, which included not just maintaining significantly extending ODR housing because this is a gender justice issue. Black women are disproportionately impacted by Mental Health needs that are unmet within the criminal legal system. They also serve the longest length of stay inside of LA County Jail, of any population across race, or gender. . By providing the funding for ODR expansion now we're able to meet the needs of our most marginalized folks, and trance folks that K6G which are also disproportionately black and disproportionally held with Mental Health needs that are unmet inside the jail system. . I urge you not to delay this motion any further, or providing funding for ODR any further, really appreciate the comments from Commissioner Stevens. Really grounding us in the reality of urgency. But these are human beings that are languishing in these jails. These are human beings who are our family members who need services and diversion now. It is completely unacceptable that for decades, LA County has been the largest Mental Health care provider -- and I use that term loosely -- in the nation. This is a moment where we need to act with urgency because I need. This was a need that has been long standing. And as pointed out, there is legal imperative to fund ODR. 25 million is just the beginning. I agree with a previous speaker that said we need a lot more money to divert to ODR but that shouldn't stop this commission from voting on this motion. And shouldn't stop the commission from moving on the motion as written. A please don't include any amendments that will create additional partners hurdles. >> Time. >> Thank you, line 33 employees go ahead. >> AMBROSE BROOKS: Hi, this is Ambrose Brooks and the campaign coordinator at dignity and power nowand the coalition coordinator for the justice fell a coalition, I'm calling to express my strong support for this motion as is ODR is currently the county's leader in the CareFirst division. Just last month I was outside of

men's Central Jail, speaking to family members of incarcerated people who have severe mental illness and would be perfect candidates to ODR programming. But due to lack of cap of ODR funding and ODR portal being closed due to lack of funds these individuals could not received the services they're very much qualifieded for. I want to say this motion absolutely should be passed today. And then, more adequate funding should be considered at a later date. But should not be any more delay as thousands of individuals are currently inside of LA county jails in need of ODR services. And I just want to say that ODR, again, is the county's leader in the care first division and the Board of Supervisors has recognized that rhetorically but now also needs to recognize that through budget allocation. >> Thank you. Line 35 employees go ahead. >> Can you all hear me. >> Yes, proceed. >> Megan: Hi my name is Megan and I am the coordinated for the reimagined led coalition, I want to first thank Commissioner for sharing your perspective and uplifting the urgency around this issue. I also want to express my strong support of the motion for trending toward or we are as is right ODR has been proven, and report after report to be highly effective in the sense of that are provided right and also making sure that we're diverting people with the highest needs and needs that would otherwise sit in jail. Or otherwise, otherwise you behind bars in cages right . And any delays with funding toward ODR will only continue to have detrimental effects on those folks with legal health and their families. So I ask you vote for the 25 million without delay. And making sure that we are pushing toward and the county has verbally expressed in supportive for to make that happen now. So again, I strongly support the motion. Thank you. >> Thank you, line 8 please go ahead. >> Jean Harris: I also asked for you to please pass this motion. Today, as a beginning, if we need to extend the MHSA3 year plan for additional time in order to have public comment on this we can not go forward without making this happen. And it is a beginning. It needs a lot more funding which I would ask the board of super visors to consider additional funding. With you the MHSA3 year plan ties into how we care for communities and stop the tragedy-travesty of the individual that are incarcerated. You like that word, tragedy and travisty together. It's got to start somewhere. We need to fund ODR, whatever it takes to make it happen. Thank you. >> CHAIR DALGLEISH:Thank you at&t operator. >> You have 4 currently in the qua. >> CHAIR DALGLEISH: So I'm going to limit the time to 1 minute, thank you. >> Thank you, line 13 you have one minute, please proceed. >> Speaking on behalf of the Black Los Angeles County coalition, like to say thank you commissioners for all your hard work. And once again like to echo the urgency, however public comment is very important to this national recognized model ODR. >> CHAIR DALGLEISH: Thank you,line 10, please go ahead. You have one minute. >> Mark Carmets: >> Operator: Go ahead. >> Mark Carmets: I'm trying to. >> CHAIR DALGLEISH: Mark you have one minute to speak go

ahead. >> Yes, this is Mark Carmets: And I looked up a couple things, last year at the conference, there was two workshops for reentry, and one was called ready for reentry and beyond. And the other was called the justice initiative. Model for activating justice involved peers in your communities. And it had to do with people re-entering from jails into the community. And classes that were taking place in the jails so that they would not repeat what they did before hand. >> Operator: Time. Thank you. >> In other words... >> Thank you, Mark. >> Operator: Line 36 please go ahead. >> Hello, I'm James Nelson, formally incarcerated. 8 year now. I do programs at dignity and power. Now I'm Senior Advocacy I'm calling in support of funding for ODR is like, we know that if some things that need to change in the way of changing things for the better, and really address care before cages, and ODR, the example that ODR has shown. So I think we no longer need to delay that. The longer we delay the more people being harmed and dying inside of these cages, we need to act on this. We get paid to do this. We need to be responsible and put our differences aside, and address the real issue at hand. People are dying in jail. Thank you. >> Thank you. And our last commenter will be line 10. One moment. Your line... line is open. Please go ahead. Mark, please proceed with your comment. >> Mark: This is Mark again. >> CHAIR DALGLEISH: You had your time. >> Mark: That's fine. >> CHAIR DALGLEISH: There will be another opportunity for public consent at the end and thank you very much for calling. Go ahead. >> CHAIR DALGLEISH: If that's the last caller, we're going to take a 5-minute break and come back. Thank you. >> Ladies and gentlemen, we'll take a 5 minute break, and return in 5 minutes, at approximately 1:33. . >> CHAIR DALGLEISH: John, are you there? How is our 5 minutes going >> JOHN FLYNN: We're there. >> CHAIR DALGLEISH: Okay, welcome back. I'm going to go to Judy Cooperberg. >> COMMISSIONER COOPERBERG: Yes, thank you, Madam Chair, at last I would like to call for the question. >> CHAIR DALGLEISH: Thank you. Commission Acebo? >> COMMISSIONER ACEBO: Madam Chair and members, I will put in the chat amendments to the motion. Friendly amendments in terms of report backs. And I would like to second, so I can present it. >> COMMISSIONER MOLINA: Molina seconds. >> COMMISSIONER ACEBO: I speak to amendment. >> Madam Chair, I'm not your parliamentarian but I believe that we do need to at least read those out loud >> >> COMMISSIONER ACEBO: Recommendation and this is an amendment to ODR MSA funding be subject to the following one the Department of Mental Health report back to the Commission on Mental Health had its May 2022. Meeting with recommendation how the ODR DMH. MOU operational pieces can enhance reimbursement such as medical and other state and federal funding to the Department of Mental Health report back to the Commission on Mental Health. Provisional Mental Health, sorry, they got that word as its at its May 22 meeting with a recommendation

on enhancing client slash med Mental Health outcome data from ODR. ODR Number three for department Mental Health report back to the commissioner Mental Health, and it's me May 2022 meeting, as to what category the ODR funding will be allocated. And what if any specific state requirements need to be addressed regarding the allocation . 4: The recommendation for ODR image as a funding be subject to the 30 day community input hearing that is the motion was seconded, >> CHAIR DALGLEISH: Discussion. >> COMMISSIONER ACEBO: The motion really -- after hearing Commissioner Root and Commissioner Weissman and both my commissioner Molina and I have spoken about this prior to the our meeting today. We just think that a little bit more information would enhance the motion, and provide the entire Commission and the public with greater information. And that's the intent of the amendments. Thank you Madam Chair. >> CHAIR DALGLEISH: Thank you. Commissioner Austria? >> COMMISSIONER AUSTRIA: I was looking for them in writing. Because I'm visual. I just want to make sure we're not bogging down. I do believe we should have a 30-day process. Don't want to violate a process. And want to make sure it doesn't get bogged down in layers of bueraucracy to delay implementation, and that's my concern regarding that. >> COMMISSIONER ACEBO: Madam Chair, the amends are in chat, and wanted to mention that to you. So you can read them properly. If so. >> CHAIR DALGLEISH: We have motion and amendments that have been spoken and written, and read into the record. And we have call for the vote. >> COMMISSIONER AUSTRIA: On the amenment. >> CHAIR DALGLEISH: Sorry? >> COMMISSIONER AUSTRIA: I believe we have to address the amendment first and vote that up or down, and then the actual motion. First we have to vote on the amendment. >> CHAIR DALGLEISH: And we're calling for that. Apologize, we're calling for that vote right now. Role call vote. We have motion and second on these amendments. >> Then don't we go to discussion. >> CHAIR DALGLEISH: I thought we just had discussion. Okay, I see a couple new hands up I thought we were finished with those. Apologize. Commissioner Banko. >> COMMISSIONER BANKO: Sorry, I had computer issues, I'm wondering could we say in order to avoid the 30 day causing additional wait time, could we say upon enactment per... instead of requiring that 30-day input period. Apologize if you all already discussed this. Having it before hand, having it after. Is that possible? >> Madam may I take a stab at the amendment. Commissioner Banko the reason I said 30 days and director Sharon and Dr. Sherin confirmed with Greg Polk there is 30 day input hearing, and that's why the 30 days was there to reflect their advice to the Commission. >> Good afternoon, this is Patti -- counsel, sorry to interrupt, but the 30 days is required for the welfare institutions code. >> Point of order Madam Chair. Commissioner Acebo we do not see the language in the chat. You might have to hit the little arrow on the bottom right

corner under your message RNGS and that's why I'm here. >> COMMISSIONER ACEBO: Commissioners I apologize for my technological ininadequacies. >> CHAIR DALGLEISH: Thank you. Thank you, IT. >> Does that answer your question commissioner Banko. >> COMMISSIONER BANKO: It does, I do share the same concern, nobody wants to wait on. >> CHAIR DALGLEISH:... >> >> COMMISSIONER WEISSMAN: I am interested if we're talking about amendments and just adding details to the motion on these few things. A budget, so I don't know what dollar amount but any dollar amount and a budget attach report backs of some regular basis and metrics and outcomes on health outcomespeople that get out of jail because of the infusion of money on an annual basis, and data sharing, and I thought we add those elements to whatever final language there is. >> COMMISSIONER ACEBO: I accept as friendly additions to the amendment. >> CHAIR DALGLEISH: I so no other hands raised. Sorry, I do. Commissioner Stevens. >> COMMISSIONER STEVENS: I just want to be clear if we could still move forward with approving it with the friendly amendments today. And here is the deal -- why not have. >> CHAIR DALGLEISH: I believe the answer is yes. But I will ask for confirmation of that. Just to be clear. I think we're all trying to move forward on this. And I hear... >> COMMISSIONER ACEBO: I can clarify that as maker of the amendments. I think Commissioner Stevens and Austria are correct, that definitely want to move in step with them. And sorry, commissioner Barbra you too. And welcome Jack, did you like the first meeting we planned it that way for you. [Laughter] >> COMMISSIONER ACEBO: And so it is to add to your motion. It's like No. 3 underneath it. All the other parts of your motion remain in tact, Commissioner Stevens, I hope that answers the question. >> CHAIR DALGLEISH: Commissioner Stevens? >> COMMISSIONER ROOT: I understand the commissioner Weissman... >> CHAIR DALGLEISH: Moving and recognizing Commissioner Root and Commissioner Austria. >> COMMISSIONER ROOT: As I understand the friendly amendment at this point, Commissioner Weissman points are added to Commissioner's Acebo points under item 3 of the motion, so we have a budget ready. Can you repeat the four things, they addressed the very issues I want that makes me able to support this. >> COMMISSIONER WEISSMAN: Yes. >> CHAIR DALGLEISH: And also commissioner Weissman please write them into the chat so they're part of the written record as well. >> COMMISSIONER WEISSMAN: Yes, forgive me I'm on the more casual side of the commissioner, so I'll write them nicely and formally in the chatbox so many. They are budget for the requested dollar amount. Report backses to the regular interval to the commission, board, etc. Metrics and outcomes so what we are hoping to achieve in the area of data driven decision making and report backs. And then data sharing, and regular intervals providing report of progress to date, and just as with any grant or funding stream. >> CHAIR DALGLEISH: Thank you, is that clear to all commissioners at this time?

Thank you. Commissioner Austria and then Commissioner Stevens. >> COMMISSIONER AUSTRIA: [Muted]. >> CHAIR DALGLEISH: Commissioner Austria and then Commissioner Stevens. >> COMMISSIONER AUSTRIA: I want to make amendment to make sure the funds -- are not supplanted. (INDISCERNIBLE). To not supplant them. >> COMMISSIONER ACEBO: I accept as friendly addition to the amendments. >> COMMISSIONER AUSTRIA: Thank you, there is a lot of them. >> CHAIR DALGLEISH: Thank you. We could have just started with this. Commissioner Stevens. >> COMMISSIONER STEVENS: I want to apologize, I got distracted reading the amendments and added in the chat and I will say out loud, it seems the first amendment could cause some delay. And want to make certain we're not delaying this. So could you clarify that very first one would not delay us. >> COMMISSIONER ACEBO: Thank you, Commissioner Stevens for the question. Each amendment as you saw as written is consistent with the 30-day. That's why it was made in 22 meeting -- right the next meeting that the information come back. And because of the county council's comments that operational pieces are being worked out. We may be able to expand ODR abilities by going after other funding such as Medi-Cal reimbursement and other state federal funding and that is the intent. >> CHAIR DALGLEISH: Thank you. I do want to say I attended -- I was very pleased to be able to attend two site visits yesterday that were arranged by the commissioners making the motion. And was very impressed by both the facilities, staff and services being offered. And did have the opportunity to interview some of the people living in those two locations. And without exception they spoke very highly of their experience and positive effect it had on them. Commissioner Barber please. >> Commissioner Barbour: Yes, I just want to let people know that I've had direct experience, a few years ago, as being a psychiatrist, a consultant psychiatrists for ODR program. It was one of the most transformative experiences I had in mental health and what was so transformative about it, was the flexibility, and versatility. And lack of red tape. And how urgent the movement of people from jails to a community setting was. And as a Black man, I was really struck by seeing so many Black men receiving treatment and in this type of a setting. And really like nothing I seen before -- in terms of residential setting and terms of beds being available. I think all of us know that beds are a huge priority for the whole county. And there are no beds that are more difficult than people who are justice involved. And have have substance abuse problems. And Mental Health problems, and I'm very concerned that we are going to delay the impact that ODR has. I want to try to move this amendment along. I think much of the community has been made aware of ODR through the department of health services and DMH. Because many DMH programs have had interlocking relationships with ODR. So I just want to suggest that we move this as quickly as possible. >> CHAIR DALGLEISH: Thank you. I have not heard

anything from -- at least directly from any commissioner suggesting there be a delay. In fact I think all of us want to move it as quickly as possible. So we have motion and friendly amendment. So to speak friendly amendment, and we have a call for the vote. Commissioner Stevens. >> COMMISSIONER STEVENS: I want to make sure Brittany Weissman was your hand up, or one of your beautiful flowers. >> CHAIR DALGLEISH: Let me go back and check, I thought I got to everyone with their hands raised. >> COMMISSIONER WEISSMAN: My hand was not raised but I do wonder about the amendment number 1 and the delay item. I don't know if we're going to wait until May to approve this or today with the amendments. I don't understand. >> CHAIR DALGLEISH: Commissioner Acebo my understanding that we would be approving today with the amendments to come back with these items at our full commission meeting in May. Is that correct. >> COMMISSIONER ACEBO: That is correct. To commissioner Weissman comments. Commissioner Weissman it's consistent with the 30-day clock, that community input is needed under MSHA verified by the county counsel. So everything is in alignment to come back, both community input in this information as well, and that's why it was written as such. Does that help commissioner Weissman. >> COMMISSIONER WEISSMAN: I'm afraid nod. That would mean if we're not approving today. If we accept your amendment we are not approving today is that correct, >> COMMISSIONER ACEBO: The language says that, that it's subject to the following, right, but it's subject to a 30 day clock which is already consistent with the community input, okay. Because it can not happen, at least according to county counsel, as spoken that the funding can not be allocated or approved by the board is supervising an amendment, until a 30 day process occurs, and I'm following that process. . >> COMMISSIONER STEVENS: I'm just going to jump in. >> CHAIR DALGLEISH: Go ahead. I see your hand raised. Thank you commissioner Stevens. >> COMMISSIONER STEVENS: I don't know what it is. But I am not embracing the first amendment. I believe it's going to bog us down, and delay things for us. And I'm really concerned about that. Let's a look at it, this very first one. >> COMMISSIONER AUSTRIA: Can I make a suggestion that we bifurcate the amendments, quite a bit on. Also we can pass this motion. >> CHAIR DALGLEISH: We have the amendment and the wording of the motion. Has I just want to go back if I'm wrong, please correct me, my understanding is that we have the motion we have the amendment, and we hadagreement from the makers of the motion to the amendment, is that correct? >> COMMISSIONER ACEBO: Point of clarification Madam Chair. Is there a second to the amendment that is on the floor. >>MIKE MOLINA: Second. No, this is Molina. I made it. >> COMMISSIONER ACEBO: I'm not trying to close comments off. If there is no more comments, everyone should vote as they see fit. And move on to the motion as is. >> COMMISSIONER AUSTRIA: I have procedural comment,

we didn't really accept it, we were discussing it. I would suggest that we bifurcate the pieces. No matter what happens if we pass this motion today they still have to do the 30 day, it doesn't preclude mhsaa process, we must do it. There's no question of that. . >> COMMISSIONER ACEBO: Madam Chair. >> May I try. >> COMMISSIONER MOLINA: There is no delay. No delay. No delay. These are report backs to our next commission meeting on the details relative to this issue. There is no delay for our commission to move on this motion today. Beauty of the report backs, is that there's a 30 day period anyway as designated by statute,so we have to go through the 30-day community period. But our action today there is absolutely no delay. The amendments call for report back at future meeting. We can act on the motion today, and the amendments will in no way delay what the spirit of the motion does. Thank you. >> COMMISSIONER STEVENS: Going back to the very first one, if that's the case, then why is it necessary, why is the language necessary, if we know that by law, we have to do the 30 day period. And I'm just going to be honest with you, I am so unafraid when I am uncertain about something and something doesn't feel right, I don't have a problem saying it. And so I need this to click for me, because as far as what I'm reading here, and we all know, and it was already stated that by law, we have to do the 30-day period. Okay, I'm with that. But the language in the first amendment, why is it necessary? Why aren't we just asking for the report back, we already know they're going to report back to us. >> CHAIR DALGLEISH: Commissioner Acebo. I understand what commissioner Stevens concern is, and so I'm going back to Commissioner Acebo on amendment one. >> COMMISSIONER ACEBO: Madam Chair and members, if you read each amendment they talk about issues that have been raised in the entire hearing. And by commissioners. And I think that it's information, and I think that information does not delay the intent of the motion. Now, if there are commissioners that still feel the amendments are not agreeable, they have the right to vote up or down. >> CHAIR DALGLEISH: So we could be taking each one of these amendment separately. >> COMMISSIONER ACEBO: That's not the intent. I introduced them as whole. They have whole as one amendment, they are not separated. And not bifurcation. >> CHAIR DALGLEISH: All right, that's exactly my question. >> Point of order I did call for the question, people can vote it down if we want to, but should be taking the vote. >> COMMISSIONER ROOT: Point of order the motion was amended by commissioner Weissman amendment. And so the amendment we're voting on is what commissioner Acebo said, and what commissioner Weissman said together. And that's an up or down vote, and then we vote on the whole motion as amended if that passes, or without amendment if it doesn't. >> I requested not to supplant funds as an amendment. >> COMMISSIONER ACEBO: Unaccepted. >> CHAIR DALGLEISH: We have... we have commissioner Cooperberg who has called the question.

We are moving to a role call vote. >> CHAIR DALGLEISH: Would like a restatement at this time. Thank you. >> COMMISSIONER ACEBO: Madam Chair should I try to read it, and that it also includes commissioner Weissman and commissioner Austria's comments. Would you like me to do that Madam Chair. >> CHAIR DALGLEISH: Proceed please commissioner Acebo. >> COMMISSIONER ACEBO: [2:41 p.m.] Kevin M. Acebo (Guest). The recommendation regarding ODR MHSA funding be subject to the following: Amendment #1: The Department of Mental Health report back to the Commission on Mental Health at its May 2022 meeting with recommendations on how the ODR-DMH MOU “operational pieces” can enhance reimbursements such as Medi-CAL and other state and federal funding. Amendment #2: The Department of Mental Health report back to the Commission on Mental Health Commission at its May 2022 with recommendations on enhancing client/mental health outcome data from ODR. Amendment #3: The Department of Mental Health report back to the Commission on Mental Healthat its May 2022 meeting as to what category the ODR funding will be allocated and what, if any, specific MHSA state requirements need to be addressed regarding the allocation. Amendment #4: The recommendation for ODR MHSA funding be subject to 30 day community input hearing. Commissioner Weissman added that the budget amount request would be reported back on regular intervals to the mental health commission, the Board of Supervisors. DMH that metrics and outcomes for the investment be shared and data sharing across departments, with the public. . >> COMMISSIONER ACEBO: And commissioner Austria wanted to make sure any of the funds -- any funds are not supplanting the MHSA25 million. I think that covers. >> CHAIR DALGLEISH: Thank you very much. And in no way is this meant in anyway to delay the implementation. Role call vote. Please proceed with the vote. >> Before we vote are we voting on those amendments together or bifurcating it. >> COMMISSIONER ACEBO: I believe we're voting on the amendments super visor Friedman. That was the motion and seconded with the friendly added. >> CHAIR DALGLEISH: Do you understand Commissioner Friedman. >> COMMISSIONER STEVENS: I'm going back. I'm sorry. This is a learning curve. >> CHAIR DALGLEISH:... to move ahead. >> COMMISSIONER STEVENS: Well... >> CHAIR DALGLEISH: It sounds to me your concern commissioner Stevens is the delay. >> COMMISSIONER STEVENS: I want to go back to Brittany, and her... can you repeat Brittany's. >> COMMISSIONER WEISSMAN: Yeah, I put it in the chatbox. My only request In addition to the original motion is a Budget for requested amount, report backs at regular intervals to MHC, BOS, DMH, metrics and outcomes for the investment, data sharing across Depts and with public. >> CHAIR DALGLEISH: I'm not hearing Commissioner Weissman. >> COMMISSIONER STEVENS: You didn't hear her? >> CHAIR DALGLEISH: I didn't hear her just now. If you can repeat -- I heard you list your

amendments, I didn't hear any comment from you that came after listing those amendments. >> COMMISSIONER WEISSMAN: I didn't make a comment. >> CHAIR DALGLEISH: That explains why I didn't hear you. >> COMMISSIONER STEVENS: I'm still uncomfortable. >> COMMISSIONER ROOT: The question has been moved, we should vote on the amendment, that's where we stand. >> COMMISSIONER STEVENS: Wait a minute, didn't see Supervisor Mitchell. >> She has her hand. >> CHAIR DALGLEISH: I understand that. I haven't herd from you each time we asked about calling, just want to make sure you are there. >> Yes. >> CHAIR DALGLEISH: Supervisor Mitchell. >> Supervisor Mitchell: I respect you call for the question, ignore my hand. I was going to reply to commissioner Weissman, but I'll do it after the vote on the amendment, thank you. >> CHAIR DALGLEISH: Role call vote please. >> Commissioner Friedman: Yes. >> COMMISSIONER ROOT: Aye. >> COMMISSIONER STEVENS: No. >> COMMISSIONER AUSTRIA: No. >> Commissioner Barber: No. >> COMMISSIONER BANKO: No. >> CHAIR DALGLEISH: Yes. >> COMMISSIONER ACEBO: Aye. >> COMMISSIONER MOLINA: Aye. >> COMMISSIONER COOPERBERG: Aye. >> COMMISSIONER SCHALLERT: Aye. >> COMMISSIONER WEISSMAN: Yes. >> CHAIR DALGLEISH: Supervisor Mitchell. >> Supervisor Mitchell: No. The amendment passes with 8 yeses and 5 no's. The amendment carries. >> ROOT: I move the question as to the amended motion. >> COMMISSIONER ACEBO: Second. >> CHAIR DALGLEISH: Root moved the question and who was the second? >> COMMISSIONER ACEBO: Acebo. >> >> Discussion? >> Supervisor Mitchell. >> CHAIR DALGLEISH: Supervisor Mitchell, did you have your hand up about this. I didn't lower it, I know you were going to speak with commissioner Weissman. I lowered it previously, it's my understanding that the commissioner Weissman amendments were not taken in the first set of amendments we just voted on. So I was going to offer if those amendments failed and I did not support them. Then I accept commissioner Weissman amendments, but it's my understanding that commissioner Weissman amendments were not included in the first set of amendments, so since those passed I don't know how you want to do that Madam Chair. >> COMMISSIONER ACEBO: Point of clarification. I accepted Commissioner Wiseman's Amendment additions to the First Amendment well I was, I was looking at the amendments. >> Supervisor Mitchell: Well, I was I was looking at the amendments that were since the amendments were flying kind of fast and loose, let me say that. And so when I was attempting to follow what was submitted in chat I didn't see them, because those amendments I, it's unfortunate that the amendments word bifurcated I would like to support it, some of them, I still don't support the 30 day delay I think it is going to be a problem. I appreciate you not choosing to do so. So I thought I was trying to pick up commissioner Weissman amendments, thank you Madam Chair allowing to get

clarification. >> We did pick up Kathleen's amendment as well about supplementation. >> CHAIR DALGLEISH: Super visor Mitchell, did you hear what commissioner Weissman said. >> Supervisor Mitchell: I was clear about that. And I was clear about that and again my statement was bifurcated I would love to have support at some of those. The reason I was a no vote was because they weren't bifurcated and I don't support the first amendment as it was submitted in the chat. . That's why it was a no vote I appreciate somewhere accepted, but without the bifurcation, I couldn't support the motion >> CHAIR DALGLEISH: I understand. Thank you. All right, I see no other hands up, although I thought I might have seen Yolanda Vera raising her hand physically. All right, moving forward. I see Commissioner Austria agreeing with Supervisor Mitchell. All right. I lost part of my screen so... Let me see here. >> Madam Chair, you don't have any hands up. >> CHAIR DALGLEISH: All right, thank you very much. Moving forward we have a first, second, discussion. Commissioner Acebo. >> COMMISSIONER ACEBO: [Muted]. The question was called -- the motion was moved and seconded, and so that's what is on the floor right now Madam Chair. >> CHAIR DALGLEISH: Yes, and we had discussions so we're moving to a roll call vote. Hurd, please. >> CANETANA HURD: Commissioner Friedman. >> COMMISSIONER FRIEDMAN: Yes. >> CANETANA HURD: Commissioner Root. >> COMMISSIONER ROOT: Aye. >> CANETANA HURD: Commissioner Stevens. >> COMMISSIONER STEVENS: Aye. >> CANETANA HURD: Commissioner Austria. >> Commissioner Austria: Aye. >> CANETANA HURD: Commissioner Barbour. >> Commissioner Barbour: Aye. >> COMMISSIONER BANKO: Aye. >> CHAIR DALGLEISH: Aye. >> COMMISSIONER ACEBO: Aye. >> COMMISSIONER MOLINA: Aye. >> COMMISSIONER COOPERBERG: Aye. >> COMMISSIONER SCHALLERT: Aye. >> COMMISSIONER WEISSMAN: Yes. >> CANETANA HURD: Are these the amendments or motion. >> Supervisor Mitchell: To the motion as amended. Motion as amended passed with unanimous vote. >> CHAIR DALGLEISH: Thank you everyone, I just want to pause and thank you all for your involvement, and thank our commissioners who came forward with the motion from Supervisor Mitchell's office. And want to thank the Supervisor for being with us as well. This is the first time in my history on the commission when we have had our Supervisor with us, thank you for being here, it's an honor to have worked together. Let's move forward now with public comment. >> COMMISSIONER STEVENS: I have my hand up. >> CHAIR DALGLEISH: I'm sorry, just a second. Let me go back here to hands. >> COMMISSIONER STEVENS: I personally want to -- >> CHAIR DALGLEISH: Go ahead. >> COMMISSIONER STEVENS: I want to thank everyone here. All the commissioners. But I want to say something. And I say this as a person with lived experience. One who has been dedicated and committed to systems change, who have been attending on a regular basis, the Mental Health Commission

since 2008. And I never experienced a motion being brought forth: but I think it's important for me to also highlight something I noticed here. There is robust discussion, and amendments made, and votes taken around this particular motion that would truly change many lives. But I ask us to pay attention to ourselves, because as we move forward it is my hope that we will challenge, or that we will address concerns on every level when it comes to what is happening and what the Department of Mental Health is doing even after Dr. Sherin exhibits. I also want to bring to our attention that it's been brought to us about W Mental Health Centre. Which is directly operated clinic that belongs to the Department of Mental Health operates. And yes there has been little ask or little push to ensure the quality of those folks's lives are secured. And I just wanted to highlight that. I truly from my whole heart thank you thank you for us moving forward with this motion. But I hold myself and each and every one of us accountable as we move forward to challenge and to question. Thank you. >> CHAIR DALGLEISH: Thank you, Commissioner Stevens. Thank you. Seeing no other hands raised let's move to public comment, AT&T operator. >> Operator: Thank you, ladies and gentlemen, once again, if you have a public comment, please press 1, 0, to get into the queue. Repeating the 1, 0 demand will remove from you the queue. Please limit your comments. Our first comment will come from Ezekiel Riez. >> Sorry, the time? >> CHAIR DALGLEISH: One minute, please. >> The time, 1 minute or two minutes? >> CHAIR DALGLEISH: How many callers do we have. >> Operator: 3 currently in the queue. >> CHAIR DALGLEISH: 2 minutes each and then we'll move on. Thank you. Mr. Raiz please proceed. >> I sent in a diagram to the Commission. It's a study of little more than 100 people. By asking general questions about food an individual can gain insight into how quick or developing different stages of mental disorders. The diagram shows for questions that intensify emotion felt. Amplifying stress for our homeless, the numbers represent the scenarios played out in an individual's mind simultaneously. The higher the number the more unstable the individual becomes. With the lack of food patterns form, developed form rapidly to adjust. While those that are housed feel that housing is detrimental to a Homeless Person's cognitive stability. Housing is it would be third or fourth on the list. This can be see how many people would rather stay homeless than move in doors, issues higher up on the list is food, water, stereotypes, and then safe place to sleep. As struggles fashion the next steps for those experiencing homelessness in order to adapt when was fine the repetition, and the struggles and the because of the barrage of issues faced. Repetitions formulated comprised of hunger, than need to find clean water, stereotypes, and a safe place to sleep and developing patterns of fear, depression and worry. I know many of you dealing with homelessness as a race against timebut helping our homeless needs to start from the basics. Because the lack of the lack of basic needs,

drives people think, to thinking through their situation hastily causing confusion. Starting late to help the homelessness hinders their opportunity to move on down the line. Thank you. >> CHAIR DALGLEISH: Thank you. >> Operator: Thank you, line 43 please go ahead. >> Charlene Newhouse: Charlie Newhouse My telephone number is 424-370-6948. I've been searching for homeless assistance in the form of like some type of housing in Los Angeles County. Attempted to registerer with the homelessness service provider for several months. Almost a year now, and I have not been successful. And if L is filled to capacity Dr. Sherin can the department of mental health step in to help provide housing for my family and I? >> CHAIR DALGLEISH: Thank you. Dr. Sherin isn't on the line. Do we have someone from the department who can take this call at this time, John? >> JOHN FLYNN: I'm checking to see if Robert is here from OCFS. I do not see him. >> CHAIR DALGLEISH: You took the phone number though. Do you have the phone number. Would you please take care, or another member of staff please take care of connecting this caller to the department. >> JOHN FLYNN: Caller could you please repeat the phone number. >> CHAIR DALGLEISH: Why don't we take her offline, and get the phone number, so it doesn't have to be said again publicly, because of privacy reasons, thank you, caller. And yes, we have one more. And then we have our Spanish interpreters hand it up. Alex is this something you need to say now before we continue? Are you having a problem with interpretation. >> No, just waiting in queue we have one person with a comment. >> CHAIR DALGLEISH: Fine, thank you. Go ahead. ATAT operator first, and then from our Spanish language line, please, thank you. >> Operator: Thank you. Line 37, please go ahead. >> Is that me? >> CHAIR DALGLEISH: Yes. >> Operator: Yes. >> Rick PULIDO: . Rick Pulido here. Grassroots longtime advocate for the families and for our loved ones here from Nami, I just want to say, Namiwe're having our NAMI walks, May 21st. Here at Grant Park at 830 Dris Sherin is going to be there as one of his fair wells. To help stamp out the stigma and to work with NAMI walks in, in being the strongest and the biggest, grassroots Mental Health agency in the world. I'd like to also say thank you to the commissioners for passing the motion today ODR and especially to our honorable Holly Mitchell who's always been the forefront for jails and folks that don't have a voice. And appreciate all her hard work, and all the commissioners and all the supervisors Hilda and Janice, and all the rest, want to say, keep up the great work, and he with have a lot of work to go ahead of us this year. With the pandemic, want to make sure we address, and making sure our peers, we get to their homes, and unhoused this year. And mobile, DMH vans we're doing, and very, very useful. And working harder to make sure our loved ones are taken care of comprehensively, with job opportunities for those in full recuperation. And with outpatient treatment, I believe that's the key right now. >> Operator: 30 seconds. >>

Rick Pulido: And want to say if you can, please commissioners if you can make sure you get out to all the SALT meetings. I know that the term chairperson, a few others always get out, we appreciate your words of wisdom, and we look forward to working closely this up program year. I'm going to be turning out this year so I just want you to know that it's been a pleasure being a co Chairman out here at Salt seven. Being innovators with the podcast, but the peer resource centers, and withthe things we're doing now. Thank you god bless you and see you later. >> CHAIR DALGLEISH: Thank you for your efforts, and commitment Mr. Pulido thank you. Spanish line please. >> LOZANO: I belong to the district that belongs to... and I'm talking about Supervisor Mitchell as well as Commissioner Stevens. They have done a great deal today for our community. I truly hope they continue doing this. Because they themselves have not only the tools, but they are helping to heal our community. And I hope that more Supervisors come forth to the commission meetings because we're doing really good work. I congratulate you all for what you have done today, and for saying "yes". >> CHAIR DALGLEISH: Was that the end. >> Yes, that was the end of her comment. >> CHAIR DALGLEISH: Mucho Gracis. Let's move forward on the agenda. At this time, we're moving to item 8. The mental health services annual update for fiscal year 2020 to 23, public hearing. Thank you. Go ahead, . >> GREG POLK: Thank you. Thank you, Madam. Madam Chair, thank you guys who's participating in 2020 Next slide please. . >> CHAIR DALGLEISH: I'm not seeing the slides. If you are, I'll work it out. Thank you. >> GREG POLK: Yeah, as I was saying the purpose of the annual update, want to lay out what the purpose is. Obviously back in November 2004, prop 63 passed. 1% income tax on personal income in excess of a million dollars. Act provides for significant funding to expand services around the public Mental Health system and improve the quality of individuals living with Mental Health. A code that supports this. WIC code. An 847 which requires county Mental Health programs are submitted three year plan and expenditure plan followed by an annual updates and MSA programs or procedure. This provides a lot of opportunities to review current existing MHSA programs and services and allows us the opportunity to evaluate the effectiveness of the services. To incorporate any new programs, described in the 3 year plan is also part of the requirement. And we gather fee back from stakeholders, and we try to have robust community planning process, and stakeholder process. 3 year plan, that we're speaking of. Is for fiscal years 2021, 24, adopted by the board, June 22, 2021. Next slide, please. And another review of components, there is major components, talking about funding of MSHA. And largest, is CSS community services and supports, and second largest component and prevention and early intervention, referred to as PEI, about 19%. And component of work force and education and training, the WET budget, we have innovation, 5% of the budget, and capital facilities and

technological needs component. Next slide, please. Annual update, and talk about the presentation, overview. And we're going to talk about COVID impact on mental health services. And huge focus on disparities I know in the past with conversations with the commission, a lot of focus on disparities and we want to make sure that we address that. MHSA client accounts. I think there is a lot of interest in client counts, by SPA's, and tried to address that. And overall increase and decrease, and talking about proposed changes year to year. And big piece of the presentation, and community planning process, I know there is a lot of conversation about robust community planning process, and what we done, and make sure we include the stakeholders as required by statute. So we're going to talk about that as well. Community feedback you know, we have some information based on community feedback from some of our plans. Next slide please. Impact on meantal health service, obviously, there was an increase in demand for Mental Health services due to the stress and isolation of the population, as it resulted to COVID-19 increase housing and economic prosperity to communities of color that we found out there is significant capacity shortage for Mental Health services and health safety nets to meet the needs of those vulnerable you will, there's a huge challenge of getting not only for the department but the whole mental health system nationwide. That was a huge impact, and another widespread of COVID infection rates. Temporary and permanent business and clinic closures. Now, we got out of that and hopefully we don't we don't fall back into that. And pandemic, and delta and omicron variants. Hown improvement and accountability to control the infection and hospitalizations, and to provide social services economic help to go to those in need, next slide, please. Focus on disparities, I'll pass this on to the assistant director, Debbie, Gins sburg to talk about this one. >> Debbie Ginsburg: Thank you, Greg. This slide really reflects an update to what we talked about last year. And that was the focus on disparities and the different ways that we're trying to address disparities. And so the first thing I wanted to report on. >> GREG POLK: Can we move to the next slide. >> Debbie: There we go. Awesome. The multicounty learning collaborative is the first thing I wanted to report on in terms of our progress. We are -- as you may remember, Solano county approached us last year about joining a multi county Learning Collaborative, that would focus on specific cultural communities, and reducing disparities within those communities. It took the Oversight and Accountability Commission and Sacramento a little while to approve the contract between UC Davis, and OAC funding this learning collaborative. But I'm happy to say it starts next month, and I think this will be super helpful to us, and very community driven, in fact the communities and under served cultural community groups, will be the ones identify identify the communities we will focus on in Los Angeles County, we'd be very interested in your input as well. The second

thing is sexual orientation and gender identity, and being able to identify clients sexual orientation and gender identity and match of courseto appropriate services for that population, and being able to report on that. We have made significant progress in the last year around this. In part, the California initiative. Cal-Aim has compelled each county, to really adopt federal standards around this and we work with our electronic health record, net smart to be able to input that into our, and then to create what's called a web service for the contractors that have different electronic health records. So we will probably probably by the middle two are closer to the end of this calendar year will be able to report out on the number of clients from different gender identity and is sexual orientations and providing comprehensive training around this as well. Because we know that's super important. And then finally services for clients with disabilities, we focused on two areas here. And the first one is the reporting on clients who, who say that their primary language is American Sign Language. We now are reporting on that in the annual update, and so far, point 03% of clients we have been searching report that as are their primary language, and second thing I wanted to report out on is using technology to be able to improve our services for the Deaf and hard of hearing community, and through our access center, our help line, we're now able to use 711 as opposed to the really antiquated TTyTTD service that we had before. Those are updates to three I think very key areas that we had all talked about last year. I'll pass it back to Greg. >> GREG POLK: Thank you, Debbie. One of the things we want to talk about is the programs and the amount of client that we serve, unique clients we serve as well as new clients served. So this slide depicts, this is community services and supports, which is 76% of our allocation. And some of the programs that false under CSS is the service partnership, referred to as FSP, out patient care services, alternative crisis services. Our housing, linkage, and we call POE, planning out reach and engagement. I think it's important to note in fiscal year 2021 we had about 135,000 new unique clients receive direct service, and what we try to show is ethnicity and primary language break down, and 37% his span,ic, and 20% African American, and 18% white, and 5% Asian pacific islander, and 1% native American. Primary language was English with second with Spanish second of the 135,000 unique clients there was about 35,000 new client service from with no previous images say service. And so when you look at the ethnicity breakdown it's 36% Hispanic 14% African American, and 16% white, and 3API and less than half a percent, native American, and primary language, 77% English, and 14% Spanish. I know when we had other conversations with the commission, we talked about service areas, how does this impact service areas. What are the numbers around each Service Area, so we try to show here that the information that I showed before by Service Area. So if you look at client data by Service Area, number of clients served.

About 25,000 clients served, followed by San Fernando Service Area 2. And of that, 5900 new clients served. And of the 25,000 in Service Area 4 about 6,000 new clients. Next slide please. Second largest piece is prevention and early intervention. 19% of total MHSA allocation. And focus on early intervention, education, suicide prevention, and stigma and discrimination reduction. We talk about unique clients, 42,000 received direct service. When you talk about ethnicity break down, there is a shift we saw from CSS. Hispanic 45%, 9% African American, 9% white, and 2% API and 1% native American, and primary language, 76% English, and 21% Spanish. And again, of that 42,000, it was 23,000 new clients, with no previous MHSA experience, and the train of ethnicity remained the same and primary language consistent as well. Next slide. And again we want to break it down by Service Area. You see here, the largest Service Area was the San Gabriel valley. 835,000. It's quite interesting in that area about 6400 new clients to get the second largest area being against SanFernando 6800 I'm sorry, new client makes like I was saying because you know this is where we want to talk about some of the things that we're changing, and I let Robert Byrd of our staff speak to this, this is around and changes in the proposal. . >> Good afternoon, one of the recommended changes we're proposing is continue the innovations 2 project, but funding it with prevention and early intervention dollars. With a budget of 29, 520,000. The innovations to project really centers around community capacity building with the goal of increasing awareness of an understanding of and then identifying and supporting trauma. And identifying and supporting community members at risk of trauma, or potentially getting experiencing trauma. The project utilized assets within communities to really test strategies that allow local communities to work together in ways to lead to improved mental health and reductions in trauma through building on shared community values, and leadership development, and community membership empowerment. In June of 2020, DMH integrated community mental health workers, or what are... better known as community ambassadors into the innovations 2 project, the concept of the community ambassadors, really leverages existing networks within a trusted community based providers and organizations. So we have the right people in the right place at the right time to provide necessary resources to community members who are in need. The outcomes for this have been pretty strong, and, you know, warrant the continuation of the project. As I said one of the primary role of the community ambassador is to provide out reach education to the community, and particularly during the last two years, some of that around COVID-19 and wellness, and awareness of resources and supports within the community. There were over 10,000 community events. Out reach and social media posts, reaching 560,000 community members. 18,000 meals provided. Nearly 10,000 individuals vaccinated for COVID-19. And PPE was

provided to nearly 14,000 individuals. The community ambassadors themselves demonstrated a stronger understanding of the relationship between trauma, and mental health. Acknowledged significant improvements in their own resilience, and improved ability to cope to stress, and able to share that to the community members they were interacting. In addition, over the past year there were 29,000, almost 30,000 linkages to community resources and support. 93% of those were successful. That means people took the referral or linkage, and followed through with it. Pretty strong statement for the work the community ambassadors are doing, and the trust the community members have in the ambassadors. We can go to the next slide. >> GREG POLK: Just to add what Robert said there, the biggest Chang was the integration tool with an innovation project that ran it's course, and the outcomes were so great, and we decided to recommend funding it using PEI dollars. Next changes around Hollywood 2.0. And we have Dr. Dr. B to give us an update on what we're doing here. >> GREG POLK: I think Dr. B is with us. >> Sorry, I'm not seeing Dr. B on the list. >> GREG POLK: I'll take it. Hollywood 2.0, moving that forward. That's been a huge point of conversation with the third district. Supervisors really helping us move this right along. Some of the things we're talking about, key characteristics we want to speak to. Holistic, human centred, hospitality oriented and it's going to be carrying a community and as a lot of questions How does it differ from Truestay. Some of the reasons why I differ is it optimizes funding through full federal match voice the use of fiscal administrative intermediaries, expedite community planning processes by actively exploring available resources through philanthropic areas. Also avoid unnecessary technological electronic medical record investments key components, FSP. Full service partnership, we have home team one of the out reach teams. We have intensive out patient services team based. There is peer research, and clubhouse component, alternative crisis component here, and also housing, interim and permanent supporter congregate and enhanced residential, which we commonly refer to as boarding care services here. And then we always get the question why Hollywood right a large concentration of unhoused individuals suffering from serious brain, injury there. Also there's a strong coalition of local neighborhood businesses and faith leaders in government health care providers. And law enforcement, i e, the group Hollywood forward, that has a lot of impact and Hollywood and can make a lot of things happen. We talked about possibly Skid Row, but just the problem on skid row with just two challenging at this time and so we decided to move to the Hollywood area. Next slide, please. Cap facilitates. Requesting about $5 million for future and problem improvement projects. So there's a lot of problems with with our facilities and our infrastructure. So some of these dollars want to put a forth addressing improvement in our facilities. Next slide. Expansion and diverse related

services. The board recommended a motion, just a motion we talked about today right here, and wanted to make sure we had something in here to kind of speak to this. So obviously motion by the commission today to dedicate funding for ODR. Obviously there was expansion of beds to expand beyond the 2200 beds capacity based ODR demonstrating success and reducing the number of incarcerated individuals with mental illness, and expand services to radical ethnic disparities reflected in the jail population, and recommended Chang allocate 25 million dollars we spoke of. Annual, July 2022. And this required a 30 day public posting in comment period, so thinking around May 15 or June 15th, that can always be adjusted. And we hadded added this slide so we reference this and the record reflects during the presentation we were aware of this. Next slide. Talking about budget projections here. When we presented in June 2021 we had what I consider an estimated actual. Basically what we thought would be spending at that time, and so wanted with presenting now -- updated numbers, and based on utilization, and this is showning each program, and share from last time, what the major changes, are CSS dropped about 33 million dollars, and PEI up 27. And innovation, and down 15 million. And you see about 68 million in Cap facilities. Next slide. Please. Here we talk about each individual program, and kind of some notes as to why the shift, you look at the full service partnership, decreasing about 2.8 million, the whole purpose of this is mainly due to the pandemic, and difficulties in retaining staff, offset by allocation of flexible housing subsidy pool for housing vouchers, so the main reduction here was related to the pandemic, as you see a lot of them have pandemic impact. Out patient care services dropped about 67 million dollars in projection, due to the pandemic and again, difficulties in restaining staff. ACS. There was increase in ACS, reflects the cost of crisis residential treatment program, and increase there. And pending an out reach engagement and wasn't an opportunity to get out and have engage face to face engagement, pandemic impact there. And linkage services increased due to current utilization, and housing and administrative cost, driven by the amount of money you spend as percentage, as the spending goes down and administrative cost goes down, and all impacted by the pandemic. Next slide, please. Here we talk about prevention and early intervention, when you look at the stigma and discrimination reduction, really no Chang, pretty much on target what we talked about last time. Prevention, you see increase of about 6 million dollars, 6.9 million dollars of the last estimate, again, estimate from June 2021. March is about 9 months, and so... on the prevention side, 6.9. Reflect a lot of community promoters and I think we increased 311 postioonscommunity promoted to provide out reach engagement as well as one time extension to my health la agreement with DHS for Mental Health preventive services privately provided primary and the primary care setting. Early intervention was

increase due to the pandemic again. Our recent increase in recognition of early signs of mental illness, huge increase, primarily because of the continued continuation of funding for the Lego project and LAUSD for community school initiatives, and a transition of innovation community capacity building project so funding to make sure we have impact in schools. And PEI administration had a small increase. Next slide, please. Innovation projects: -- bear with me one second. Innovation projects, innovation 2 of the CANS program. There is no Chang there. Pretty much we had 14 million dollars consider CAN2. And CAN3, 6.3 million dollars. Transcranial magnetic stimulation center this is reflexive content what continuation of that project or 2022 23 at about $1.1 million. . Increase in the therapeutic transportation program. You know, we we expand it to teams and a partnership with LA County, LA City Fire Department so that's under way. So cost there increase. O our call today to increase our early psycho Kosis Learning Health Net Health Care Network kind of keeps the continuation there at a 2020 for 2023. Some expenditures for having a 2.0 we expect to spend about 5.6 million 5.5 million there. Also innovation, administration goes along with expenditures spent. Next slide. Huge investment here. Work force investment and training, sorry, work force education and training, UCLA affiliation agreement we have. Our cost going down just a little bit. One-time services going away. Financial incentive programs, no change there. This is the loan repayment program that relates to loan repayments, and hopefully continue to increase that, and stipendeked program for that we will continue. No change to that for stipends. For MS W's and MFTs and nurse practitioners are child through affiliation agreement, small increase due to services and supplies for increase in services for the drew affiliation. 510,000 for science consultant for postdoc at Harvard UCLA, between your net program, and there's no change to what we anticipated our projections to be for bone health recovery specialist core training program. Interpreter training program, and Learning Net System. Next slide, please. And again here, just more WET programs and projections. And so increase in navigators 200,000 increase there. Resource parents training we see our projections pretty consistent as well as our prayer partner training and parent volunteers project. New one anneding is the peer focus training. 400,000 dedicated to that. Projections as it relates to medical school affiliation with Harvard and UCLA medical school affiliation agreement MSSA there's pretty consistent with our anticipated spend and licensure program for expenditures. Cap facilities. 5 million dollars set aside to meet the goals of the mental health services to have our facilities up to para-and modernize that. And 5 million there. Call centre, 3.5 million of those, and projects still on target, and administration jumped up here, reflect Chang, and increase again, percentage of what we spend, so when we add 5 million there, there is percentage that administration can bill for. Next slide, please. Big conversation about

the community planning process, I know Dr. Sherin has been a huge advocate for robust community planning process, and stakeholder process, and what we wanted to lay out here what we have done as it relates to this process. What our meeting dates and any activities that took place. To make sure and tried to ensure that we met that threshold of stakeholder process -- that robust stakeholder process we're trying to achieve. Key dates here, March 4th executive summery of the annual update posted on the DMH website, and obviously a couple days later, we posted a Spanish version of the executive summery, in the annual update, and posted to the DMH website for review, and March 8th full version of the draft update posted on the website. To allow the 30 day public comment. And March 8, focus on disparity and is propose changes presented in full health commission, meeting attended by the CLT's underserved communities to sought for input and feedback on the 10th of March, a summary of a summary of the plan was presented to the executive committee of the Mental Health Commission for input and feedback. . April 26th, update presented to the health deputies on the 28th which is obviously today.plan presented for public hearing and sometime between May and June, present to the board for approval. Our next slide. Talk about some of the stakeholder feedback, in gathering that feedback and documenting stakeholder feedback, and 45 public comment peer, and obviously we mentioned it requires 30 days, we extended for 15 days, with online surveys open for March 3rd to April 19th and again try to get as much input as we could on this. 66 survey responses and 65 in English and Spanish, and it was 9 question survey, and not all respondents answered the questions, so we're just trying to gather information, and some of the stuff we gathered, self-identified affiliation, respondents being clients or consumers, seven other responders are peers 13% of respondents are advocates. Now the 14 was an unresponsive or family members of clients and consumers. 5% government employees. And 6% of respondents are staff and employees, 17% are mental health service providers. And another 16% responders indicators other. We want to also capture the racial ethnicity breakdown of this feedback. And again, we got about 14% African American eight reported as Asian: 24% Caucasian 20% Latin Latino 4% Mix multi ethnic 10% reported Native American or Indian American and Alaskan Native native and 14% reported other . Transcripts for discussion which portion of the stakeholder meetings were included like the CLTs and Mental Health Commission and excetera and emails and correspondence received. . Next slide, please. Want to lay out some of the responses and highlights of the current plans and we feel are some of the opportunities to improve the plan, some of the stakeholder feedback we got was the plant was finally run in a manner the stakeholder, in the general public can read and easily understand. And thought was positive feedback, and access to services to communities in need, expanded regular phone calls,

client and family members. That was response to feedback, and planned focus on objective to expand mental health services to ethnic and under served community and is thought this plan really reflects that. And the plan was very data-driven. And happy to see the continuation of the full service partnership program. And additional information on budget and spending, and providers and stakeholders were helpful for them to see. Not just on department spend, but what is the full revenue stream, and also got feedback on opportunities to improve. They felt that we need to focus on people SMI, and disable, and dual diagnosed and suffering in the opioid crisis, and obviously always a need for more beds and some of the opportunities for stakeholder feedback, we need to find more treatment beds or facilities, and wanted us to have more advocacy for family support and engagement, and wanted to see programs, to bridge, and show community members have access to the needed resources. So that was an opportunity that we need to take into consideration. A lot of requests for grant opportunities in open-bed solicitation. With restrictions targeting innovation, approach is to expand the direct Mental Health services mainly through CBOs and other areas like that. They felt we need to focus a little more on treatment services that identify for Mental Health disorders like rape trauma syndrome, intermediate Explosive Disorder, or children, children and teens. Autisms and behavior disorders like a lot more increased time for sharing the plan. You know, we try to make this a robust process as you see we increased it by 15 days to kind of address this issue. Here, just increased time for sending a plan and making follow up contact information available. . And one we found interesting, they thought the font was too small, so we need to make the font larger when we print our documents. Next slide. Some of the strategies, that were identified and how to respond to that. Continue to maintain multiple outlets to ensure the general public and stakeholder groups are aware of the mhsaa funded proposal but not only aware, of programs and activities but to engage in the CPPP so we will continue to expand that and make sure that that that being kind of in the forefront of what we do to get us as inclusive as we can be. . We'll continue to streamline document and is provide tables and summaries similar to what we did breaking down a lot of the information by SPA. And past meetings the commission wanted to have a little more deeper dive into how it impacted certain Service Area. And so we'll continue to try to do that. Not only from a client perspective, but as we talk about dollars, and trying to find a way, how to break down our dollars, and how do we allocate in certain areas, and certain spots, and geographic areas. And so, continual challenge for us, but we're going to get there. And access to address COVID, and barriers, and update, it's important to discuss where we struggle, around the impact of COVID-19. Not only on our clinic, but on our hiring, and our ability to gather work force, and retiring work force. I think we'll

continue to report on that. And one of the things we're thinking about doing is providing monthly MHSA one on one training stakeholders, and UsCC and the commission. Anyone interested in the general public, interested in how MHSA is working and provide trainings around mental health providers and department staff. And DMH, to make sure everybody understands the process, the stakeholder process, and feedback process, and we try to incorporate everything for the commission, to inform the commission so they can vote in an informed manner. Incubation academies and other grant opportunities for CBOs. I think that this is one where I think we want to make sure that the And exploring funding opportunities and CBOs have an opportunity to be acquired, other process so you know keep an incubation category kind of training them about the county, processes and how you get a grant how you get a contract with the county, and what's required to be a grantee with the county and continue to work on those. We've entered into an agreement with nominee for three additional years to provide expanding training for family members across the county that's another thing that we're working on. And one of the things, seems small. We want to provide hard copies to stakeholder groups and the general public for all three year plans and annual updates you know it's a Herculean effort to print these documents and when you're talking 1000s of documents of these large plans it's challenging, and providing in different languages, it gets tough, but we're going to try to make an effort to do that. And I think we want to continue to update our communication, and follow a process, as it relates, by having a mailbox, and receive input, and communication year round. And I just through a meeting through the commission, or update period, and year round, if there is input we need to take into consideration. We want to be able to do that. Next slide. Next steps, we complete public hearing April 28th. Which is today. We receive Mental Health Commission feedback and recommendations by May 14 You know there's another presentation to board deputies on June, 8,. And estimate trying to get the plan to board around June 28th. Next slide. Again, any contact information, or questions around the annual update, it can go to the stated email address, MHSA, admin at DMA.LA county.gov. And with that I thank you guys. Madam Chair. >> CHAIR DALGLEISH: Thank you. I have a couple questions, and as I see hands raised I'll go to other commissioners with questions. Thank you very much to you and to your staff. I have a question. Appreciate you giving us the information based on service areas, and demographics. I know that I've been asked about services and expenditures by supervisorial district. And since there's often overlap of service areas, and the numbers you know per service area don't line up the way that the supervisorial districts do where you have about 2 million people per district. I wonder if that's something that is available or can be available in the future. >> GREG POLK: That's something we're working on

when we trying to figure out how to do that. The budget is not set up that way by supervisor district, it's overall county budget, so you have to collect that data in that format. So we're trying to change some of our data collection to make that available. >> CHAIR DALGLEISH: Okay, and you also said you were going to do that in relation to stakeholder engagement and outreach, so assume you are continuing to do that and expect more detailed numbers on that. So we don't have people saying we're not spending money in those areas. >> GREG POLK: Absolutely. >> CHAIR DALGLEISH: When do you think we would be able to see that. >> GREG POLK: We're trending that way. DMH has a lot of priorities, our finance staff and CFO does a good job responding not only the board, but to the commission, and had numerous conversations about that, and hopefully in the next 6 months we can have something that he we can break down. Key is that we budget that way, and challenging to take -- huge, larger than that. Huge budget like this. And try to flip it into the another way of reporting out. And it's a challenge, but I think we can get there. I think we have some ideas on how we could do this. >> CHAIR DALGLEISH: I understand it's a challenge, and also part of MHS mandate, when it says 5%, and people are asking about numbers, and we're not showing numbers that are relative to measure it, it's important that we prioritize that so we can come back to people, and that you can come back to the Commission with those too. So I know that we have been talking about having reports from you on an on going basis. Even an monthly basis, so we'll continue moving toward that. >> GREG POLK: Yep. >> CHAIR DALGLEISH: I also had a question. You were talking about Hollywood 2.0, or Treisa project. And the new formation. I'm wondering about funding for that and how much you are allocated toward it. It's a pretty robust plan, or it was. And I don't know if it's been paired down, or how you are planning on funding it so it's successful. >> GREG POLK: When the project was approved, allocation of 116 million dollars, that allocation hasn't changed. The only thing that changed was Triase to Hollywood 2.0. But the allocation of funding has not changed. >> CHAIR DALGLEISH: How much has expended. >> GREG POLK: I think in the chart, it was 5 million. >>STACY WILLIAMS: You are anticipating. I'm wondering how much has been extended. >> GREG POLK: I don't have that number. We put in the presentation, what we expect to spend this year. >> CHAIR DALGLEISH: If you don't have it right now. >> GREG POLK: We can report back what year to date we spent. >> CHAIR DALGLEISH: I've been sending some questions to staff that I want to have answers to. And one of them relates to the CAF. And how much are we spending on CAF. And how many people are receiving CAF money. And has there been a problem with that? Because, we certainly have seen a drop in attendance to our meetings. I know that in part, some people used to attend, because they were receiving CAF it's important for us to be able to continue to get that stakeholder input, and

anything that can be done to increase that participation is very important to us. From what I understand CAF hasn't been increased over decades. And so I think that's something to be looked at from the perspective of what need is. And so more people know about it and are using it so they're attending our meetings and making public comment. So I would like your commitment to working on that and further discussion about how much it should be. But if you know how much it is right now, that you are spending on CAP or have spent over the last fiscal year, I would like to know that. >> GREG POLK: I don't know that number in my head, a lot of expenditures, we have, but what I can say is that Madam Chair that I understand the commission the Commissioner is requesting us to do and we'll make sure we make the effort to do that and report back. >> CHAIR DALGLEISH: Okay, I'm keep coming back to you on that. Thank you. I appreciate that. And then in regards to FSP. We hear from people who aren't having great experiences with FSP, and I'm just curious what kind of monitoring there is that is done with the FSP providers from the department on quality control or outcome? >> GREG POLK: We have a contract monitoring unit, they're tasked with making sure that not only the numbers are right when you talk about budget, but also quality of care, I think we have robust unit that works on that. And so I would say that, by Terry Boykins and she does a great job, ensuring the programs adhere to what we expect from a quality perspective, and financial perspective. So there are quality controls in place. >> CHAIR DALGLEISH: All right, I'll come back to you on that too so we can be -- I would like to be more clear, so I have answers as well. So I'm going to open it up to other questions right now. Thank you, again. And Commissioner Austria, please. >> COMMISSIONER AUSTRIA: Hi, I just wanted to follow-up on one of Stacy's questions, and that was breaking it down by district. I know I was able to get that in the distant past, prior to, I think Greg coming over to DMH. But we received it by, facility, and added that up. And nonprofit, contracts as well as directly operator, and looked at position status report, and able to come up with a... >> GREG POLK: Yeah, I think we had a conversation about that, you and I, about how did we do that in the past. >> GREG POLK: And one of the things, research back how they did that. And make sure we can align it the same way, based on how we budget now. >> COMMISSIONER AUSTRIA: I know they used to do it by the head of that, like pacific clinics was in the 5th district, and looked like there was more budget over there. But it was actually spread through the county, just making sure it's done properly. >> GREG POLK: I think that's a good example, you take pacific clinics, and they may have clinics all over the county. >> COMMISSIONER AUSTRIA: Break it down by each facilities and staffing, and status report on vacancies and all that good stuff. The other question is MHSAA reserves. Which we haven't really spoken very specifically about. So I'm wondering exactly how much because I've heard like 350

million 200 million. And also, how do we engage with the Commission in developing a plan to spend reserves, this is money there. We know there is. We had a motion today, which in the scheme of things isn't that much money, but a lot of money in some ways. And so, how can we do that. >> GREG POLK: Obviously the commission at any time can request and update on MHSA and discussion about how to ex-spend those dollars, and Dr. Sherin has been pretty clear, about the anticipation and ex-pentations to get rid of fund you know, our fund balance started in July won about close to a billion dollars you know, we bring in about 600 700 million a year. So you know when you think about and I expenditure up to about 700 million a year. So we think about a billion dollar fund balance is not a lot is probably 7,8,9 months in the hole . So any time we downsize, we have to have available funding. We can't take clients on day one. And we see our revenue streams going down and just say hey, guess what, you guys got to leave so we have to have the ability to downsize now, what's the correct amount of fund balances is six months is it a year. Is it less than that or more than that. That's a conversation we have to have as a Commission, as a county. >> COMMISSIONER AUSTRIA: Right, and I think it's prudent to have prudent reserve, and rainy day fund. But we also need to make sure people are getting services and so finding that balance is, I think a discussion we should have just to say a lot of that fund balance. >> GREG POLK: To remind the commission a lot of fun balances one time money. Right. And so when you deal with one time when you need to spend one time money on one time type of activities that you can, you can set yourself up for a structural deficit right. So have to keep that in mind. >> COMMISSIONER AUSTRIA: Yeah, we have to have a deeper conversation with budget as we move along. Not just MHSAA budget, but the DMH budget overall. And again, we know again staffing is another issue that has been a challenge for DMH. And want to know, what are we doing, again, to ensure -- I see the WET program working on it. But what are we doing really specifically to get people hired. And also understand, I'm getting a number of reports from staff in the field about, you know, ability to hire or promotions, they're sitting on desks for weeks at a time, and HR is why hasn't it moved off the desk, because somebody hasn't signed it, and quite a few signatures required, to get somebody hired or promoted. And I'm getting blowback on making sure people are signing off on those in a timely way. >> GREG POLK: It's funny that you mentioned that. Sent out a memo around hiring, first of all to dismiss this notion that the department is not hiring on or a hiring freeze. We're trying to hire as fast as anybody else. There is definitely a shortage of the work force in this department, so making every effort to increase the work force, obviously hiring takes time, talking about live scans, and reference checks, it takes time, we have no control of that, can't control the federal government or State government about live scanning people, it's part of the hiring

process. We sent that to our managers. >> COMMISSIONER AUSTRIA: It's sitting on desks. That's something we can control. When they're waiting for somebody to get it off their desk. HR is calling people, we haven't received it and we know we sent it out. >> GREG POLK: I'm not aware of that, but can follow-up. >> COMMISSIONER AUSTRIA: Yeah, saying get these things off your desk and move it, please. Hard enough, so providing that little extra thing. Thank you, do appreciate everyone's work, we know this is difficult. We know a lot of work has been put in that. And don't want our questions, to be, you know, we're not attacking. We're just asking questions, and appreciate the hard work that goes into this. >> GREG POLK: I'm pretty tough, I can take it. It's fine with me. >> COMMISSIONER AUSTRIA: Being in accounting. >> GREG POLK: Exactly. >> I have a question, what is our budget. Other commissioners are asking what is your budget. >> GREG POLK: I think we need to have a conversation about that. And lay out what is a commission budget. And all depends what the commission wants to do, you guys drive this. And need to have a deeper conversation, so when I talk about meeting more frequently will be helpful to all figure out what we want, as a commission and department, how we want to align, and budget and things we want to do and make sure we're all on the same page. >>CHAIR: So I'll put that on the agenda for the executive committee meeting coming up in May. Great. Do we have a quorum by the way. >> 11 commissioners. >> According to Robert's rule, once you establish a qorum you don't lose a quorum that's my understanding of Roberts rules. >> CHAIR DALGLEISH: Mine is you lose a quorum you lose a quorum . >> Mr. Polk, I know you will be watching very close, and hope that it bears fruit for you, and maybe at the same time you can give the department updates, as it will have significant impact on the budget. I have a question for the chair regarding the MHSAA plan. >> Madam Chair for the last two years or so The commission has worked, you know, focus a lot of plan. And it is my suggestions that you review sort of the Commission's communication to definitely his apartment. He's a board of supervisors, regarding particular unmet needs and programs. I will focus on one of particular interest to the fourth district. Regarding the disparity Asian And Pacific Islander Community. I hope the executive committee would review those communications and review that in your report to the Board. Regarding the annual update. >> CHAIR DALGLEISH: I think it was included last time if I recall. Point noted and make sure that's included this year as well. And from what understand you are saying with follow-up, so we're able to note any change or movement made. Is that part of what you are asking. >> Yeah, and previously before commissioner G left. He said had particular concerns with his working group, associated not only with the disparity within the Asian Pacific Islander Community. But also regarding integrate service and the model they worked on. Relating to community based setting. In the first district would

like Memorial Hospital. Thank you Madam Chair, >> CHAIR DALGLEISH: Anyone else, anytime that you want to have on the record as recommendation. Just to reiterate, we don't approve this budget. We are accepting and listening to the public hearing. But it's not that we as a commission approve the budget per se. Commissioner Austria. I think that's the only hand I see. Go ahead. Commissioner Austria. >> COMMISSIONER AUSTRIA: One of the questions about the trauma-building, capacity building, and I was wondering how many budgeted positions there are and how many filled, and how many yet to be filled. You might not have right at your fingertips, if you can find that out for me I would appreciate it. >> GREG POLK: We have that information. I'll make sure we send that back to you. >> And I don't think sent rat in is your capital project, it doesn't really specify what capital projects are. We want to know where west central falls in capital projects, if it's this budget or other budget, I know they are having difficulty finding that. >> GREG POLK: Just talked about how much we're allocating. I think the cap project lead Pinedo does a great job around what and so we can make available somebody ideas, Her and Damien Parker about what we're going to do and how we're going to fund some of the cap projects of our clinics.. >> COMMISSIONER AUSTRIA: Yeah, we're getting a lot of feedback from our constituents and people are gonna go, go to Hopkins, you know, where are we going to go so you know it's been a long time clinics and that's gonna be a big change. >> GREG POLK: Yep understood. >> CHAIR DALGLEISH: Thank you. I know that several commissioners are going to need to be leaving, I just want to start by thanking all of the commissioners for being on with us for this marathon session. And I know Commissioner Stevens has her hand raised. I want to ask Canetana are you with us. Just to confirm we do not vote to approve this. In the past what has been the action of the Commission after the public hearing. >> CANETANA HURD: From my history, a letter composed and submitted to the MHSA Report. Yeah, addressed to the board and Dr. Sherin on the recommendations. On recommendations. >> CHAIR DALGLEISH: That's my understanding too. Just to clarify, thank you. All right thank you, everyone who is still with us, I am going to ask if there is anyone on the public comment line. Hang on one second. I see commission Stevens hand is raised. >> COMMISSIONER STEVENS: Let me apologize, someone had a crisis, and got my undivided attention. So my question may have been answered, just wondering about ODR. Just want to confirm the actions will be included in the report. The MHSA report. That's one question. And then the other is -- I believe it was Commissioner Austria who asked about West Central Mental Health. And I'm wondering if perhaps may be not today, but very soon we get an update about that. And then asked about the process here and what is the roles and responsibilities of the commission around MHSA. So I would hope -- I'm not sure the second district is still on the line or not. But I would hope that perhaps we could really

get something solid, to really clearly understand what is the role and responsibility around MHSA. Greg, my question to you directly is -- what process was used to collect the unmet needs across the communities? Because I don't recall it going to Service Area 6. Did that process happen? In our Service Area groups, as well as in our under served culture community groups at large or not. >> GREG POLK: From my understanding I believe those are collected at group settings under served cultural communities, if not, several different types of unmet needs, and budget process, unmet needs and data department layout, and capacity, and nature we need as a department, and stakeholder unmet need is a different process, right. And that's captured with our CLT and things like that. And if not, I'll verify where that information is captured. >> COMMISSIONER STEVENS: I'm happy you mentioned CLT. CLT is not community, it's just elected members chairing those groups. But I do recall a time when it happened broadly in the community at the Service Area level during a Service Area meeting group. And I think it's important for us to get back to basics around collecting the communities input as well around the unmet needs in those immediate communities. And so if we shied away from that. Perhaps you don't have the answer right now. But I would like to know why. And then back to collecting that information at every Service Area level. Thank you. >> CHAIR DALGLEISH: Thanks. Thank you. Not thanks, but thank you. All right, I do not see any other hands raised. Do we have anybody on public comment lines? >> Operator: If you would like to register a comment please press 1 then 0 at this time. We'll go to Line 49. >> CHAIR DALGLEISH: How many do we have? >> Hello, can you hear me? >> CHAIR DALGLEISH: Yes, I can hear you. >> Can you hear me. Hi, yes, my name is Hector M. I want to point out the fact, the department of mental health has at least 237,651 people that he provides that you provided services to. And I just want to point out the incredibly low number of consumer responses. In this particular process. With all the money, the millions the department is getting, why was response from consumers from the department of mental health so low. And fact that majority of residents of LA County, and the people receiving services member from Latina community you know, our participation was second highest to people who identify as white, but yet our priorities are nowhere reflected in this particular plan. . So I see a significant disconnect in the stakeholder process, which really is not accessible to consumers. So I want to point out the CAP is inaccessible to our communities because you need to have a computer to access it and get it approved safely the CLT is not a community project, our community process, because it's not led by consumers or chairs of the committee. It's It is completely driven by stuff like this particular last meeting. We didn't even have an agenda. So, those particular spaces can not be ethically stakeholder processes because they're not. From the US they disability USCC community members have access to sign

language. Services for things like FSP our adult services. We don't have adult services, when in ASL for our for our community and here, you know, money's going left and right and you're not even able to take care of your fiduciary need for the people that you already have. I'm an FSP person that hasn't been able to get FSB services, because there's no sign language services. I have to pay for it if I want to use it, and that is super expensive. So you talk about FSP -- it isn't. I really want to point out the fact no response for questions, or input. So this was kind of informative to see and also kind of disappointing. >> CHAIR DALGLEISH: Thank you. >> Operator: We'll go next to line 50. >> All right, that's me. Hello. >> CHAIR DALGLEISH: Hello. >> Can you hear me. >> Operator: Yes. >> Okay, I'm going to speak now. Okay. >> Operator: Go for it. >> CHAIR DALGLEISH: M-hm. >> Okay. Hello. >> CHAIR DALGLEISH: Yes, hello. >> Hello my name... >> CHAIR DALGLEISH: Go ahead. >> Romalez Taylor: And I'm the new cochair for the Black and African heritage UsCC. I want to ask why can't we turn around and expand the contracting services since it's been shut down for the past 2 or 3 years that is culturally relevant and culturally competent in the communities for high needs, South central LA, and east LA and Antelope Valley. Where the people are critically needed we can use the MHSA funds to provide services such as trauma focused cognitive behavioral therapy and other services that many of these culturally appropriate agencies are ready to go, able to meet those needs. When is the department going to expand and do that for all the agencies sitting there ready to go. >> CHAIR DALGLEISH: Excuse me, Mr. Taylor, do you have your phone on also. I'm hearing an echo. >> Yeah, I do. Sorry. >> CHAIR DALGLEISH: All right. So we heard... thank you. >> Operator: We'll go next to line 10. >> MARK: >> Operator: Line 10, your line is open. >> MARK: My comment right now, especially for the people who are coming out of the jails, and for that part of the meeting CRD, you need to bring that up before the mental health services Oversight and Accountability Commission. So they can approve the funding for that. And another -- I was looking on the Oversight Commission Meeting. And there was a program called REST where they have cabins for people who are homelessness. So there is kind of housing for them. That's up in Butte County. And something like that in Germany. And like I said before, look into the -- I got off their site -- look into the stuff from the alternatives conference, regards to people reintegrating from jails, two work shops, thought I kept on the computer but I didn't. >> Operator: 30 seconds. Into the jails, taught taught classes there are people there are whenever working in the community to reduce -- from what I understand reduce disparities. And I should have mentioned -- I know what I was going to do. Hold on a second. I mentioned it before, so... >> Operator: >> MARK: Sorry I didn't do that. Here it is. I spotted it. NYC peers justice initiative. Justice involved, peers in our community, and also the forensic peer mentor connect with them,

so many people who were in jail. Maybe we can provide something Thank you. >> CHAIR DALGLEISH: Thank you. >> MARK: ... >> CHAIR DALGLEISH: Mark? Your time is up. >> I'll let you go. >> CHAIR DALGLEISH: Do we have anyone on the Korean line, or Korean speaking line or Spanish language line. >> ALEX: We don't have anybody on the Spanish line. >> Korean Interpreter: We don't have anybody from the Korean line. >> CHAIR DALGLEISH: Want to thank both of you for our service at today's meeting. So, let me see here. All right, so moving to... Thank you very much again Mr. Polk for your presentation. And we will be preparing a letter based on today's meeting which will be sent, thank you. >> GREG POLK: Thank you. >> CHAIR DALGLEISH: Let's see here. Let's go on to continuing with the agenda. Pull it up here, we have Lily Sofiani are you here? >> Sofiani stepped off. >> CHAIR DALGLEISH: I completely understand. We will ask for a report from her. Maybe she didn't give a written report that we can send out at our next meeting. >> Yolanda is here, I know lily stepped off. She had asked me to provide any updates with regards to board activities. And it's a pleasure meeting all the commissioners. I haven't had a chance to address the commissioners before, the Senior Deputy for health and wellness for supervisor Michel, thus the mask. And in terms of other things coming just generally before the Board of Supervisors. There's a number of topics that we're watching carefully this coming Tuesday there will be a large motion, that was introduced by supervisor Barger and I believe some leaves with regards to the Blue Ribbon Commission on homelessness. It has significant changes, and probably would be great for the commissioners just to become aware of that motion generally. And other things coming before the board, you heard quite a bit today about ODR. And that's part of larger effort the board of supervisors is doing to try and identify funding, of all types for beds, because we have such a shortfall of beds into the community. And will be seen in the coming board meetings more activities related to that. And other things, that I think you will be seeing as well too, is restorative care villages. There are roughly -- every campus, medical campus, in the county has a restorative vary village. Village at Harbor UCLA, which is a 72 acre campus and Carson. In his in his supervisors district. We're doing a feasibility study and putting a restorative care village there as well too. There is one that is opening up the MLK campus , perhaps that would be a great opportunity for the commissioners to come out and do a tour once it's fully opened in the fall I would say. There is effort to create beds at LSEUSC. Campus also has some beds and then Rancho Los Amigos. At Harbor. We are doing a feasibility study to figure out what space might be available to Toomore restorative care village there and that would be the county walking the walk, and creating beds. A full continuum of Mental Health services for both individuals who might beexperiences mental health crisis, and substance abuse crisis. I would be happy to share with you Madam Chair any

motions that come up, and alert of you opportunities to weigh in before the board on all these items. >> CHAIR DALGLEISH: If possible, could you send that in written format to attach to the minutes. >> Absolutely will, happy to do that. >> CHAIR DALGLEISH: Looks to me we reached the end of the meeting. And I'm -- I doubt that we would have any opposition to adjourning at this time? So... the meeting is adjourned. Thank you everyone. And we'll see you next month for May is mental health month. >> Thanks everybody, take care. >> CHAIR DALGLEISH: Thank you. >> COMMISSIONER STEVENS: Enjoy your weekend. >> COMMISSIONER FRIEDMAN: Thanks Stacy. >> CHAIR DALGLEISH: Remember, we're meeting in person next month. Bye.

APPENDIX F – ACRONYMS

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

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