MHSA ANNUAL UPDATE

Fiscal Year 2023-24

WELLNESS • RECOVERY • RESILIENCE

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

Posted for Public Review
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INTRODUCTION

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

LACDMH engaged in individual community planning processes for each component of the MHSA as guidelines were issued by the California Department of Mental Health. Implementation of each component began after plan approval by either the California Department of Mental Health or the Mental Health Services Oversight and Accountability Commission (MHSOAC) as shown below:

MHSA Component	Approval Dates
Community Services and Support (CSS) Plan	February 14, 2006
Workforce Education and Training (WET) Plan	April 8, 2009
Technological Needs (TN) Plan	May 8, 2009
Prevention and Early Intervention (PEI) Plan	September 27, 2009
Innovation 1 - Integrated Clinic Model, Integrated Services Management Model, Integrated Mobile Health Team Model and Integrated Peer-Run Model	February 2, 2010
Capital Facilities (CF) Plan	April 19, 2010
Innovation 2 - Developing Trauma Resilient Communities through Community Capacity Building	May 28, 2015
Innovation 3 - Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions (Renamed to Help@Hand)	October 26, 2017
Innovation 4 - Transcranial Magnetic Stimulation	April 26, 2018
Innovation 5 - Peer Operated Full Service Partnership	April 26, 2018
Innovation 7 - Therapeutic Transportation	September 26, 2018
Innovation 8 - Early Psychosis Learning Health Care Network	December 16, 2018
Innovation 9 - Recovery Supports for Conservatees	September 26, 2018
True Recovery Innovation Embraces Systems that Empower (TRIESTE) *Revised as Hollywood 2.0	May 23, 2019 May 27, 2021

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 individuals 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).

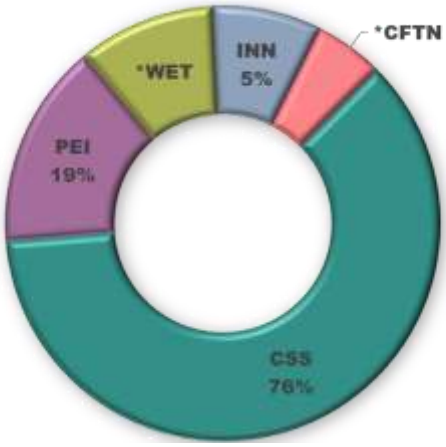
The information within this report is structured in the following sections:

- *MHSA Overview*
- *Development of the Annual Update*
- *Actions Since the Last Annual Update*
  The purpose of this section is to capture any posted Mid-Year Adjustments that occurred after the adoption of the FY 2022-23 Annual Update.
- *Existing Programs and Services by MHSA Component*
  The Plan provides relevant program outcomes specific to FY 2021-22 for programs previously approved.
- *Proposed Plan Changes*
  The Plan details significant changes that are either being proposed or will be explored within the next fiscal year.

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 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.

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.

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 of Board of Supervisor adoption.

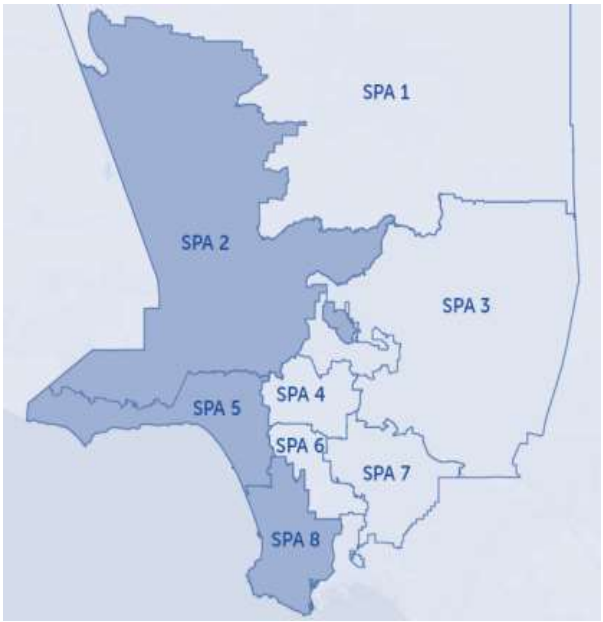
MHSOAC is mandated to oversee MHSA-funded programs and services through these documents, and evaluate how MHSA funding has been used, what outcomes have resulted, and how to improve services and programs.

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.

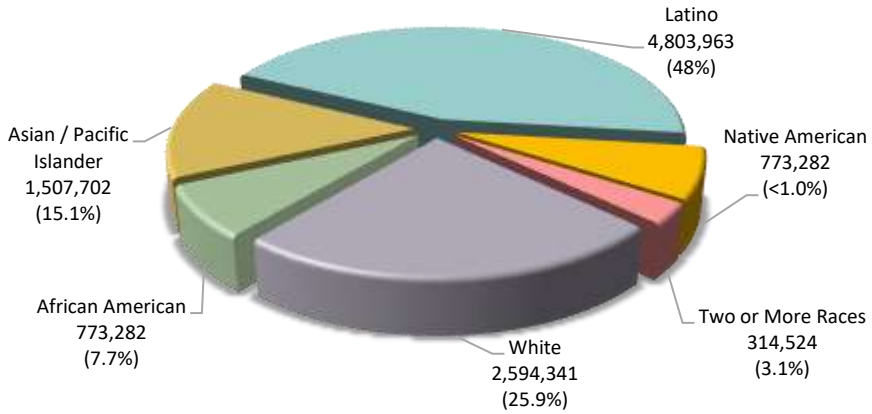
County residents represent one of the most diverse populations. This diverse racial and ethnic makeup are spread across approximately 4,000 miles that the County serves based on eight County defined Service Area (SA) boundaries.

Figure 1. Map of Los Angeles County Service Planning Areas



The Antelope Valley area, or SA 1, consists of two legal cities, or 3.9% of all cities in Los Angeles County. SA 1 is the largest geographical but the least densely populated. SA 2, the San Fernando area, consists of 11 legal cities, or 22% of all cities. SA 2 is the most densely populated. The San Gabriel Valley area, or SA 3, consists of 30 legal cities, or 17.6% of all cities. SA 4 is the county's Metro area and consists of two legal cities, or 11.5% of all cities. SA 4 has the highest number of individuals experiencing homelessness within its boundaries. SA 5 represents the West and comprises five legal cities or 6.5% of all. The South, or SA 6, consists of five legal cities, or 10.3% of all cities. It has the highest poverty rate in the county. The East, or SA 7, consists of 21 legal cities, or 12.9% of all cities. SA 8 is the South Bay area and consists of 20 legal cities, or 15.4% of all cities in Los Angeles County.

Figure 2. Total population by race/ethnicity



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).

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	62,383	16,691	218,503	**1,471**	103,725	15,273	418,046
Percent	14.9%	4.0%	52.3%	**0.35%**	24.8%	3.7%	100.0%
SA 2	79,672	260,898	867,861	3,504	**918,778**	77,926	2,208,639
Percent	3.6%	11.8%	39.3%	0.16%	**41.6%**	3.5%	100.0%
SA 3	54,476	**546,511**	802,885	2,877	304,911	41,922	1,753,582
Percent	3.1%	**31.2%**	45.8%	0.16%	17.4%	2.4%	100.0%
SA 4	62,046	191,774	520,983	2,300	306,752	36,686	1,120,541
Percent	5.5%	17.1%	46.5%	0.21%	27.4%	3.3%	100.0%
SA 5	33,383	91,873	**105,216**	**952**	395,198	**38,168**	664,790
Percent	5.0%	13.8%	**15.8%**	**0.14%**	59.4%	**5.7%**	100.0%
SA 6	**235,154**	**24,396**	703,549	1,513	**32,713**	18,944	1,016,269
Percent	**23.1%**	**2.4%**	69.2%	0.15%	**3.2%**	1.9%	100.0%
SA 7	**38,727**	128,944	**950,243**	2,800	140,197	**20,138**	1,281,049
Percent	**3.0%**	10.1%	**74.2%**	0.22%	10.9%	**1.6%**	100.0%
SA 8	207,441	246,615	634,723	3,185	392,067	65,467	1,549,498
Percent	13.4%	15.9%	41.0%	0.21%	25.3%	4.2%	100.0%
Total	773,282	1,507,702	4,803,963	18,602	2,594,341	314,524	10,012,414
Percent	7.7%	15.1%	48.0%	0.19%	25.9%	3.1%	100.0%

Data source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH Chief Information Office Bureau (CIOB) in May 2022. Some totals and percentages reflect rounding

Table 2. Population by race/ethnicity and Service Area

Ethnic Group	Highest (in blue)	Lowest (in orange)
African-American	SA 6	SA 7
Asian/Pacific Islander	SA 3	SA 6
Latino	SA 7	SA 5
Native American	SA 1	SA 5
White	SA 2	SA 6
Two or More Races	SA 5	SA 7

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 3. Total population by age group

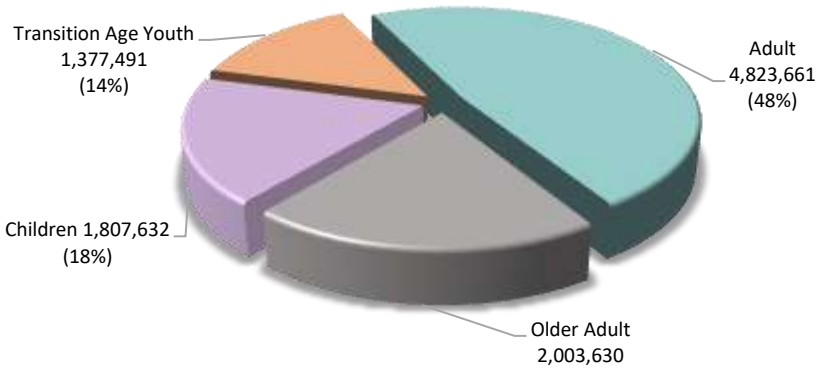


Table 3. Population by age group and Service Area

SA	0-15 years	16-25 years	26-59 years	60+ years	Total
SA 1	98,058	**69,473**	**181,543**	**68,972**	418,046
Percent	23.5%	**16.6%**	**43.4%**	**16.5%**	100.0%
SA 2	**389,938**	**285,219**	**1,063,968**	**469,514**	2,208,639
Percent	**17.7%**	**12.9%**	**48.2%**	**21.3%**	100.0%
SA 3	303,349	243,208	811,066	395,959	1,753,582
Percent	17.3%	13.9%	46.3%	22.6%	100.0%
SA 4	157,283	117,989	628,240	217,029	1,120,541
Percent	14.0%	10.5%	56.1%	19.4%	100.0%
SA 5	**85,539**	86,954	339,179	153,118	664,790
Percent	**12.9%**	13.1%	51.0%	23.0%	100.0%
SA 6	231,070	172,510	469,180	143,509	1,016,269
Percent	22.7%	17.0%	46.2%	14.1%	100.0%
SA 7	257,060	193,466	596,356	234,167	1,281,049
Percent	20.1%	15.1%	46.6%	18.3%	100.0%

SA	0-15 years	16-25 years	26-59 years	60+ years	Total
SA 8	285,335	208,672	734,129	321,362	1,549,498
Percent	18.4%	13.5%	47.4%	20.7%	100.0%
Total	1,807,632	1,377,491	4,823,661	2,003,630	10,012,414
Percent	18.1%	13.8%	48.2%	20.0%	100.0%

Data source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH Chief Information Office Bureau (CIOB) in May 2022. Some totals and percentages reflect rounding

Table 4. Population by age group and Service Area

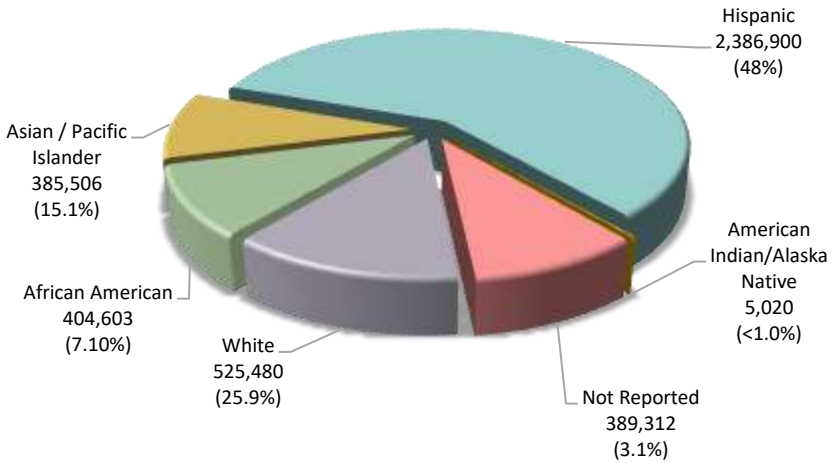
Age Group	Highest (in blue)	Lowest (in orange)
0-15	SA 2	SA 5
16-25	SA 2	SA 1
26-59	SA 2	SA 1
60+	SA 2	SA 1

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

MEDI-CAL ELIGIBLES

Approximately 40% of the Los Angeles County population makes up the Medi-cal Eligible population.

Figure 4. Distribution of Race/Ethnicity among Los Angeles County's Medi-Cal Eligibles



Data source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, downloaded on December 28, 2021. Due to rounding, some estimated totals and percentages may not total 100%.

Figure 5. Age Group Distribution among Medi-Cal Eligibles

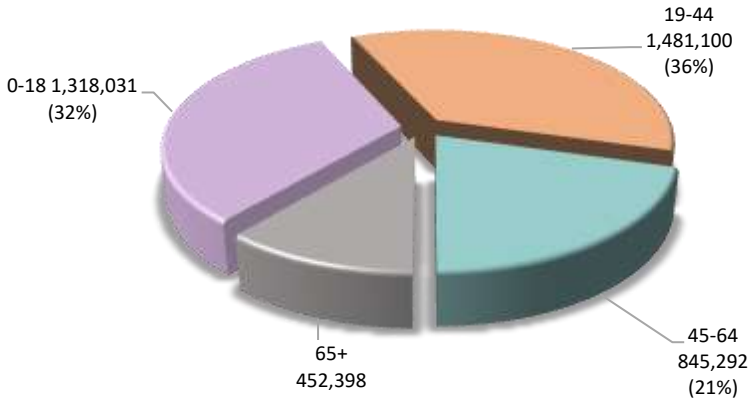


Figure 6. Countywide Poverty Estimates by Primary Language, Calendar Year 2020

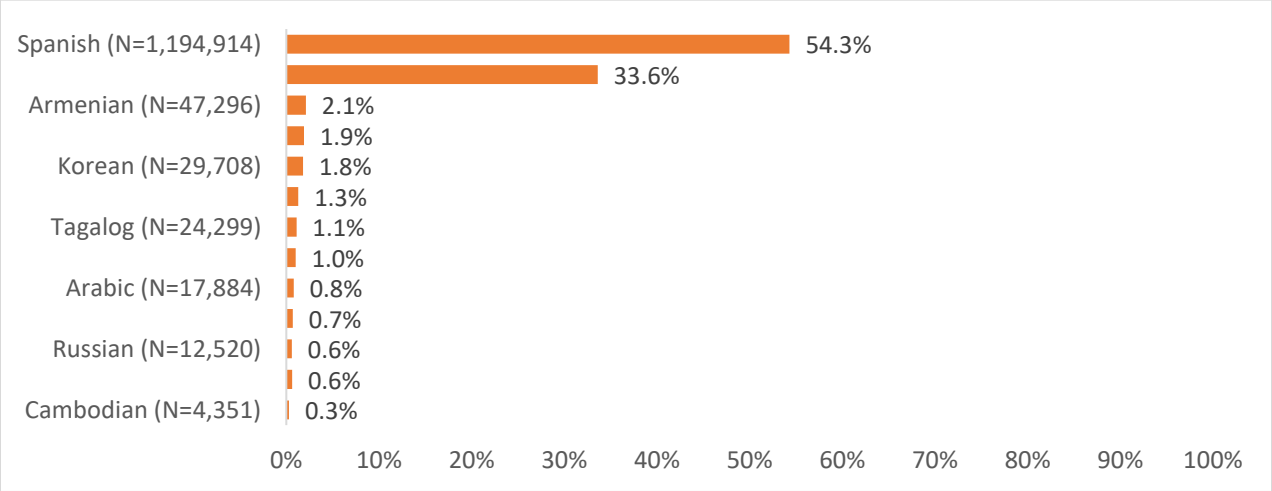
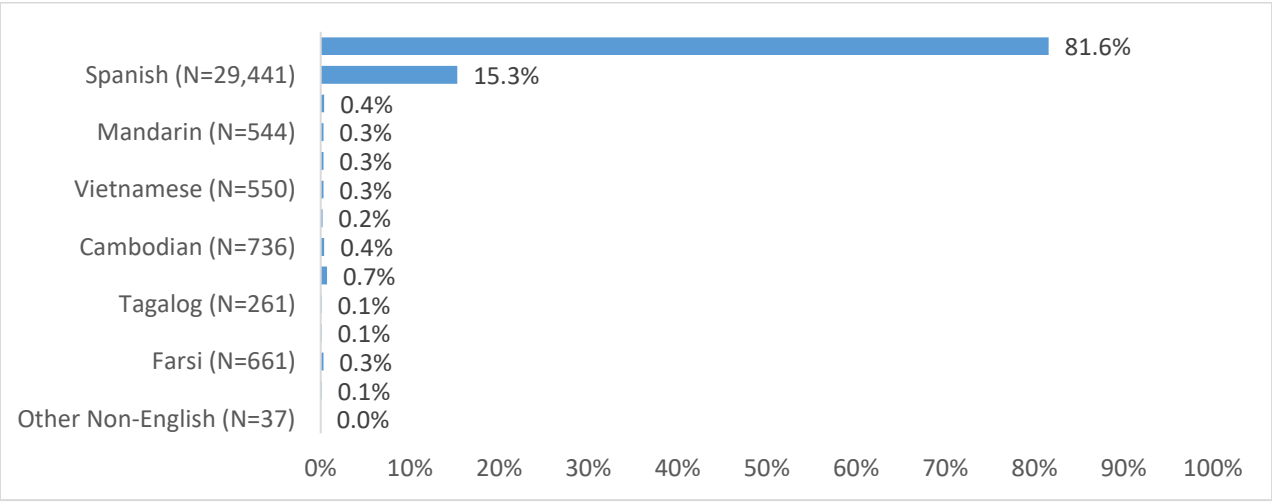


Figure 7. Countywide Consumers Served by Primary Language, FY 2019-20



Data source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH Chief Information Office Bureau (CIOB) in May 2022. Note: Numbers and percentages may not total to 100% due to rounding.

Practitioners speaking a non-English threshold language most commonly spoke Spanish (84.2%), followed by Korean (3.0%), Mandarin (2.1%), Armenian (1.9%), Tagalog (1.9%), and Farsi (1.4%). Spanish, Korean, Mandarin, Armenian, and Farsi were the primary languages most frequently spoken by clients in CY 2021 other than English.

Table 5. Practitioners Fluent and Certified in Non-English Threshold Languages, May 2022

Language	Number of Certified Practitioners	Number of Fluent Practitioners	Total	Percent
Arabic	9	26	35	**0.6%**
Armenian	29	89	118	1.9%
Cambodian	7	40	47	0.8%
Cantonese	8	62	70	1.1%
Farsi	10	75	85	1.4%
Korean	20	161	181	3.0%
Mandarin	17	109	126	2.1%
Other Chinese	**5**	55	60	1.0%
Russian	10	40	50	0.8%
Spanish	**544**	**4,594**	**5,138**	**84.2%**
Tagalog	18	96	114	1.9%
Vietnamese	8	50	58	1.0%

Note: Bolded numbers represent the highest and lowest values for that column.

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

YourLACDMH is a collaborative and inclusive approach to engaging stakeholders across LA County. The purpose of this collaborative is to develop shared goals of hope, recovery, and well-being. This approach ensures identification of stakeholder priorities and the collection of feedback and guidance to LACLACDMH in the development of comprehensive plans for countywide service provision across the system. It is the foundation for planning and development for large system efforts, including the MHSA Three-Year Plan. Partners in YourLACDMH play an active role in setting the priorities for funding allocations for services funded by MHSA and provide feedback on priority populations and service models to be implemented.

The YourLACDMH partnership includes four diverse groups:

1. Service Area Leadership Teams (SALT)
2. Underserved Cultural Communities (UsCC)
3. Community Leadership Team (CLT)
4. Mental Health Commission

The following provides a brief description of each group:

1. 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.

Table 6. 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

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 LACLACDMH and various groups and geographic communities.

2. Underrepresented Ethnic/Cultural Communities Subcommittees (UsCCs)

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 LACLACDMH to address the specific needs of ethnic/cultural communities and

reduce cultural and ethnic disparities in access to care and service delivery. There are seven UsCC subcommittees.

Table 7. 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, & Physical Disabilities	

The UsCC subcommittees are essential to the YourLACDMH 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 YourLACDMH community stakeholder engagement process, the UsCC subcommittees have been allocated annual 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 for unserved, underserved, and inappropriately served populations who may be uninsured/uninsurable.

These projects aim to reach ethnic populations across age groups (children, transitional aged youth, adult, and older adult) and seek to provide outreach and engage activities consistent with the language and cultural needs and demographics of those communities. The projects are driven by community needs and include culturally effective outreach, engagement, and education strategies and respond to historical and geographic disparities and barriers to services.

3. Community Leadership Team (CLT)

The CLT meets quarterly and is made up of Co-Chairs from two important networks of stakeholders: SALTs and UsCCs. CLT participants work together to discuss and consolidate stakeholder priorities. All stakeholder priorities that are officially endorsed by SALTs and the UsCCs 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 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).

4. Mental Health Commission (Commission)

The role of the MHC is to review and evaluate the community's mental health needs, services, facilities, and special programs. The Commission consists of 16 members based on very specific requirements in adherence to WIC Section 5604. Membership requirements of the Commission include:

- Commission membership must consist of 50% consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services.
- Consumers must constitute at least 20% of the total Commission membership.
- Families of consumers must constitute at least 20% of the membership
- One member of the Commission must be a member of the Board of Supervisors

The law also establishes special requirements on ethnic diversity and conflict of interest. To the extent feasible, Commission membership should reflect the Los Angeles County's ethnically diverse.

The Mental Health Commission provides input and recommendations to LACDMH regarding its developed plan for MHSA funded programs and services based on evaluated community needs.

B. Partnership with Stakeholders At Large:

To ensure opportunities for the broadest, most inclusive community planning process, LACLACDMH also engages Stakeholders At Large, in addition to the YourLACDMH framework. These stakeholders are community members, network providers and other groups that are impacted by programs and services planned by LACLACDMH. Stakeholders at Large may be impacted as they live, work or provide services to LA County residents that may be impacted by mental health related issues. These stakeholders are included in community planning meetings and provide feedback and recommendations to LACLACDMH on developed plans. Stakeholders at Large include, but are not limited to, the following groups:

- Community residents
- Other LAC Departments
- Community Based Network Service Providers
- City officials/representatives within LA County boundaries
- Business owners/workers within LA County boundaries
- Quazi-governmental partner agencies, such as LA Homeless Services Authority (LAHSA)

MHSA Planning Activities

LACDMH engaged in an array of activities, training and several planning meetings to execute its current Community Planning Process towards the development of the FY 2022-23 Mid-Year Adjustment, the upcoming FY 2023-24 MHSA Annual Plan Update and the MHSA Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26.

September 2022

LACDMH held a two-day retreat (9/23/22 and 9/30/22) to revitalize its Community Planning Process and strengthen its collaborative relationships with stakeholders from the most vulnerable unserved, underserved, and under-represented populations across the County. Participants had an opportunity to examine the past stakeholder engagement processes and outcomes and acknowledge what worked well, what has not worked and identify what is needed in the future to create and sustain a strong collaborative relationship necessary for LACDMH to deliver effective and culturally congruent programs and services under MHSA.

November 2022

LACDMH met with community stakeholders (11/1/22, 11/17/22, 11/18/22) and presented proposed timelines and processes for meaningful engagement and input on the review of MHSA funding requests for the Mid-Year Adjustment, the upcoming FY 2023-24 MHSA Annual Plan update and the MHSA Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26.

December 2022

LACDMH conducted an annual MHSA foundational training (12/22/22) to LACDMH staff, provider network staff, and community stakeholders on MHSA policies, the Department's MHSA funding request procedure, the MHSA Three Year Program and Expenditure and Annual Update development and submission process and timeline, and the client resolution process.

January 2023

LACDMH designed and developed a MHSA proposal submission and review process to efficiently present and consider a large volume of MHSA program and service proposals to its stakeholders through an equitable community engagement and planning process.

LACDMH conducted three community stakeholder meetings (1/20/23, 1/23/23, 1/31/23) focused on educating participants on MHSA funding components, requirements and spending regulations. Participants were also presented with a stakeholder planning calendar and a review of the formal process for requesting MHSA funding and asked to identify key gaps in the process. Stakeholders were presented with LACDMH and stakeholder proposals to be considered for inclusion in the FY 2023-24 MHSA Annual Update. LACDMH gathered feedback, recommendations and questions regarding these proposals.

LACDMH initiated a 30-day public review and comment period (1/20/23) for its Mid-Year Adjustment to the Los Angeles County FY 2022-23 MHSA Annual Update. The posting outlined proposed programs, expansion of existing programs and administrative changes ranging from new CSS, PEI and INN programs to

administrative and operational actions programs. On January 31, 2023, the Mid-Year Adjustment was presented to stakeholders and feedback/recommendations were collected. Participants were encouraged to share this information with the communities they represent and offer their communities an opportunity to submit written feedback and written comment during the 30-day public review and comment period.

February 2023

LACDMH conducted two community stakeholder meetings (2/17/23, 2/21/23) focused on reviewing DMH and stakeholder proposals to be considered for inclusion in the FY 2023-24 MHSA Annual Update and building consensus on which proposals presented in January and February meetings would receive final stakeholder recommendation for inclusion in the Plan. LACDMH gathered feedback, recommendations from participants and responded to questions regarding the proposals presented.

LACDMH completed the 30-day public posting, review and comment period (2/20/23) for its FY 2022-23 Mid-Year Adjustment.

March 2023

LACDMH initiated a 30-day public review and comment period for its FY 2023-24 MHSA Annual Update (3/24/23).
LACDMH will conduct a community stakeholder meeting (3/30/23) with the objective of reviewing the draft FY 2023-24 MHSA Annual Update. Stakeholders will receive a presentation about all items included in the Update. LACDMH will collect their feedback and recommendations. Participants will be encouraged to share the information with the communities they represent and offer their communities an opportunity to submit written feedback during the 30-day public review and comment period.

Stakeholder Feedback

The complete summary of stakeholder feedback will be available for inclusion in the final draft of the Annual Update which will be presented to the LAC Board of Supervisors for review, revision and adoption upon the completion of the 30-day public review and comment period (4/24/23) and Mental Health Commission Public Hearing.

Next Steps and Timeline

The following timeline outlines next steps to Board adoption of the FY 2023-24 Annual Update.

April 2023

LACDMH will initiate and/or complete administrative steps towards adoption of the FY 2023-24 MHSA Annual Update, including:

- 4/24/23-Completion of the 30-day public posting and comment period and collection of submitted feedback for inclusion in the draft Annual Update
- 4/27/23-The Mental Health Commission will hold a public hearing to provide feedback and recommendations for revisions, if any.

LAC will initiate targeted stakeholder meetings for the development of the MHSA Three Year Program and Expenditure Plan for FYs 2024-25 through 2026-27.

May 2023

LACDMH will receive the Mental Health Commission's feedback and recommendation on the FY 2023-24 Annual Update for inclusion in the final draft to be heard and adopted by the Board of Supervisors (5/15/24).

LACDMH will initiate a Community Needs Assessment and Recommendation process to inform the Community Planning Process for the upcoming MHSA Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26. Stakeholder groups will be presented with existing data on client services utilization, access to care and other population data by service area and ethnic group and age group. Data presented to stakeholders will provide information on existing programs and services for communities across LA County in order to set a foundation for stakeholder groups to identify service gaps. Stakeholders will be surveyed on recommended programs and services to meet identified gaps and to recommend priorities for funding to address unmet needs for the communities they represent.

June 2023

LACDMH will present the draft FY 2023-24 MHSA Annual Update, including all stakeholder and Mental Health Commission's feedback and responses to the Board of Supervisors review, hearing, and adoption. (6/6/24)

Adopted FY 2023-24 MHSA Annual Update will be presented to the Mental Health Oversight and Accountability Commission for approval and final execution to continue existing or begin implementation of programs and services within the Update. (6/30/24)

ACTIONS SINCE THE LAST ANNUAL UPDATE

The following MHSA Mid-year Adjustment posted after the Fiscal Year 2022-23 MHSA Annual Update adopted on June 28, 2022 by the Board of Supervisors. The 30 day public review and comment period was: January 20, 2023 through February 20, 2023.

The following are the proposed new Community Services and Supports (CSS) programs:

Office of Diversion & Reentry (ODR) – Expansion: $25M

This project will equitably reduce the number of people incarcerated in LA County with serious mental illness or other complex health needs, and reduce homelessness, emergency services use, and healthcare cost for this population.

Key ODR expansion activities include:

- Receiving referrals from justice partners and target the jail mental health population to identify, screen, and recommend clients for diversion.
- Facilitating clients' diversion through pre-trail, and post-conviction mechanisms via LA County Superior Court.
- Establishing clinically supported interim housing to clients exiting custody
- Coordinating jail release and transportation
- Coordinating client care with Probation Department and LA Superior Court
- Providing ongoing clinical support to support client's mental health stability and general health needs.
- Partnering with Community Based Organizations to develop permanent supportive housing units and ensure access to affordable housing.

The program will serve 395 clients.

Project Impact – OCS: $.2M

In addition to providing PEI services and consistent with the MHSA Outpatient Care Service (OCS) Plan, Project IMPACT will also provide a continuum of care, ranging from children to transitional age youth/young adults as well as their parents/caregivers. All age groups will have access to outreach and engagement, assessments, culturally responsive mental health services, crisis intervention, case management, and medication support.

Project Impact will serve approximately 168 OCS clients.

The following is the proposed new PEI programs:

Project Impact – PEI:$.6M

The intent of Project Impact's PEI program is to serve children and young adults who have experienced or have been exposed to traumatic events such as child sexual abuse, violence, traumatic loss and/or experiencing difficulty related to symptoms of Post-Traumatic Stress Disorder (PTSD), depression, anxiety, or additional co-occurring

disorders; and to provide early intervention mental health services to reduce the impact of the identified symptoms and problems.

Project Impact will serve approximately 672 PEI clients

The following are the proposed new INN programs:

Kedren Restorative Care Villlage (RCV): $109M

The Kedren Restorative Care Village will promote interagency and community collaboration related to mental health services, supports and outcomes by building a continuum of care for children and their families in a single location. The levels of care include:

- Family Housing (24 units)
- Children and youth Crisis Residential (16 beds)
- Crisis and Stabilization Unit
- Outpatient Services including:
  - Rehabilitation services
  - Partial hospitalization
- Inpatient services will be available on site, but will not be funded with MHSA funds

The goals of this project include:

- Increasing step down care resources including a crisis stabilization unit (urgent care center) and crisis residential treatment program
- Increasing access to housing resources for families whose children are in Kedren RCV program, including 24 units of on-site housing children and families.
- Ensuring appropriate level of care is provided (i.e., decreasing number of emergency room visits, reduce number of inpatient bed days, etc.).

The existing 17 beds serve 316 children annually. By increasing the total capacity to 30 beds, a projection based on average monthly census shows that 480 children can be served annually. It is projected that the Crisis Residential Treatment Program (CRTP) will serve approximately 300 children annually and the Crisis Stabilization Unit (CSU) will serve a minimum of 3,000 clients. The innovation is providing a full continuum of care for children and their families on a single campus to ensure the right level of care. The learning will be focused on improved outcomes for children and families as a result of access to this continuum of services.

The proposed budget will cover 5 years of programming.

Interim Housing Multidisciplinary Assessment & Treatment Teams:$190M

This proposed Innovation project seeks to create new regional, field-based, multidisciplinary teams dedicated to serving people experiencing homelessness (PEH) who are living in interim housing. The project is designed to address current gaps in behavioral health and physical health services, support interim housing stability, facilitate transition to permanent housing and prevent a return to homelessness.

The Interim Housing Multidisciplinary Assessment and Treatment Teams will serve all eight Service Areas in Los Angeles County and will be comprised of staff from DMH, DPH-SAPC and DHS-HFH in an effort to ensure the full spectrum of client needs can be addressed. Teams will be assigned to support interim housing sites.

The current interim housing inventory in Los Angeles County is approximately 220 sites and 14,376 beds. The additional 11 interim housing sites in the pipeline provide an additional 1,037 beds to support PEH.

The key elements that make this project innovative are:

- The implementation of dedicated field-based multidisciplinary teams that are specifically outreaching, engaging and providing direct mental health, physical health and substance use services to clients in interim housing at their interim housing location, which is an entirely new service setting. This includes 24/7 crisis response.
- The partnership with the managed care organizations that will allow the County to leverage private resources from local health plans to support interim housing client needs.

By implementing this innovative project, LACDMH intends to learn if having dedicated field-based, multidisciplinary teams serving interim housing sites result in the following:

- Increased access to mental health services and co-occurring SUD services by interim housing residents?
- Increased exits to permanent housing?
- Decreased exits to homelessness?
- Interim housing provider staff increasing their knowledge and skills when serving individuals with severe mental illness and feeling more confident in being able to serve this population in their interim housing sites?

The proposed budget will cover 5 years of programming.

Care Court Peer Support : $12.7M

The implementation of SB1338—the Community Assistance, Recovery, and Empowerment (CARE) Court Program in Los Angeles County allows the Department of Mental Health to lead the county in working with individuals who are struggling to care for themselves and advocate with insight for their own care.

DMH was ordered by legislation/law to implement the CARE Act/Court. In January 2023, Governor Newsom, the County Board of Supervisors, the County CEO, and the Presiding Judge of the Los Angeles County Superior Court issued a press release indicating LA County would begin implementation of Care Court in December 2023—a year earlier than mandated by law.

The process and options of CARE Court are set by legislation.

- CARE Court is a civil court process that gives clients many offers and opportunities to accept voluntary treatment.
- Once the client agrees and enrolls in a voluntary treatment program, the court may monitor progress or the case can be dismissed.

- CARE Court supports an individuals right to due process, the right to have a supporter and must be the least restrictive program to meet the individuals mental health needs.
- Care Court does not change LPS Criteria for WIC 5150

LA County anticipates approximately 6,000+ clients may be eligible for the CARE court program out of a 10,000,000 county population.

The LA County DMH implementation of Care Court will integrate elements of court based clinical services with field-based engagement operations to support care and treatment in field based community settings. While the final version of the law did not include the mandatory role of a "supporter" person——to work with the client during the court process and treatment planning process and help the CARE Court respondent in supportive decision making - this was an important part of the program which LA County DMH wanted to make sure was included in our implementation. DMH will incorporate peers o support individuals from the time a petition is filed to the point of case dismissal, graduation, or in the process failure when other services could then be explored.

It is DMH's goal to have Care Court support individuals and their voluntary participation in mental health services within their own communities to stabilize, heal, and thrive ultimately without the necessity of court updates.

As an MHSA Innovation Project, DMH is proposing multiple peer supporters with lived experience to help develop the teams which engage clients at the beginning, middle, and end of the Care Court process. The purpose of the innovation project is for the Care Court process to utilize our peer supporters to develop and operate a client centered multipurpose mental health team to support clients through the entire Care Court process and assist with supported decision making skills. Peer supporters are a powerful voice speaking from their lived experience and have strong positive rapports and relationships often with individuals who are struggling with their risk of homelessness, institutionalization, incarceration, out-of home placement, or other serious health consequences due to long periods without proper care. An advocate with lived experience can provide a powerful example of Recovery, Wellbeing, and Hope.

DMH Peer Supporter Team members will be imbedded within the Care Court multidisciplinary mobile teams (stationed at the courthouse and in the community) to:

- Support prospective care court clients during their court appearances, court related appointments, and other meetings
- Provide transportation and attend appointments with individuals including their health and social appointments, court hearings, or other quality of life activities
- Participate in community outreach and engagement teams to other stakeholder groups sharing about Care Court programs
- Engage individuals recently released from jail and/or prison in coordination with other DMH field based programs to encourage participation in various voluntary services (to avoid Care Court)
- Provide individualized referrals and resources from culturally competent providers for those identifying as members of underserved communities, with

military affiliations, and/or conditions which need support to have full and equal access to all services and facilities to meet their needs
- Provide specialized case management for those who have other acute medical concerns and other complex case needs
- Provide supported decision making and if appropriate assist the CARE Court respondent in completing a Psychiatric Advance Directive

The CARE court legislation is new. LACDMH's goal is to be highly successful in the number of individuals who will seek, obtain, and utilize the voluntary mental health services offered by DMH and successfully exit the Care Court process. The MHSA Innovation, having peer supporters be active advocates in the planning, implementation, and ongoing treatment teams during Care Court, is what we believe to be the reason we will see success as measured in defined outcomes/results. We expect through peer supporter participation that:

- the client rates of voluntary participation with mental health treatment programs will be achieved with less outreach activities and time frames
- the notable increase in one's level of overall health, functioning, and wellbeing will be achieved in a shorter time frame
- the longevity of the average length of outpatient treatment will be higher than other non-peer dominant outreach, engagement, and voluntary treatment interventions compared with other clinical settings

We humbly submit this innovation idea for your review, feedback, and welcome an opportunity soon to have an open dialogue and discuss ways to help clients receive treatment in their community full of hope, in recovery, and with wellbeing.

The proposed budget will cover 5 years of programming.

Note: *Proposed INN programs will still go through further review processes including presentation to the Los Angeles County Mental Health Commission and Mental Health Services Oversight and Accountability Commission before final approval*

The following are necessary administrative and operational actions:

PEI Funding Realignment : $7.8M

Realign existing PEI funding as follows:

Work Plans	Description	Planned Realignment & Increase
Prevention	NAMI- Prevention Services for Peer & Family Support Services	($ 2,000,000)
	Mental Health Promoters/Promotors ; the services include Fiscal Intermediary to pay to promotors	(16,720,000)
	Community Ambassador Network (CAN) Project	29,550,000
	Prevention Sub-Total	**10,830,000**
Community Outreach	Community Ambassador Network (CAN) Project	(21,735,000)
	OC Sub-Total	**(21,735,000)**
Stigma & Discriminati on Reduction	Mental Health Promoters/Promotors ; the services include Fiscal Intermediary to pay to promotors	16,720,000
	Why We Rise Mental Health Campaign- A Sole Source Participation Agreement with CalMHSA to fund Mental Health Prevention Program*	17,000,000
	NAMI- Prevention Services for Peer & Family Support Services	2,000,000
	SDR Sub-Total	**35,720,000**
Suicide Prevention	Why We Rise Mental Health Campaign- A Sole Source Participation Agreement with CalMHSA to fund Mental Health Prevention Program	(17,000,000)
	SP Sub-Total	**(17,000,000)**
	Grand Total	**$ 7,815,000**

*The Why We Rise Mental Health Campaign will be called Take Action.

51% FSP Funding Requirement: $76.1M

Revise the CSS Budget to reflect the services that would correctly be attributed to the 51% FSP threshold

Capital Facilities Project: $6M

Transfer funds from CSS funding to Capital Funds and Technology Needs (CFTN) for anticipated capital facilities projects/tenant improvements including but not limited to:

a. Olive View Urgent Care Center
b. Children's medical HUB
c. Central administration expenditures
d. General County Funds pool dollars

Call Center Modernization: $2.8M

In FY 21-22, $3.5 M was allocated for Phase 1 of the project. In 2022-23, an additional $3.5M was allocated for Phase 2. However, an additional $2.8M is needed to fully fund this project.

End of Year Legal Entity Contract Amendments: $31M

Additional funding is needed to ensure continuation of services through end of the Fiscal Year.

TAY Supported Employment Shift

TAY Supported Employment to be funded by PEI instead of CSS.

EXISTING PROGRAMS AND SERVICES BY COMPONENT

This section provides FY 2021-22 outcome data for existing MHSA programs and is organized by component: Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities and Technological Needs and Innovation.

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 2021-22, approximately 147,143 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 8. Clients served through CSS in FY 2021-22

Clients Served	New Clients Served
147,143 clients received a direct mental health service: - 36% of the clients are Hispanic - 20% of the clients are African American - 17% of the clients are White - 4% of the clients are Asian - 1% of the clients are Native American - 80% have a primary language of English - 13% have a primary language of Spanish	42,616 new clients receiving CSS services countywide with no previous MHSA service - 37% of the new clients are Hispanic - 15% of the new clients are African American - 15% of the new clients are White - 3% of the clients are Asian - 0.38% of the clients are Native American - 77% have a primary language of English - 12% have a primary language of Spanish

Table 9. CSS clients served by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	10,969	2,852
SA 2 – San Fernando Valley	21,809	5,574
SA 3 – San Gabriel Valley	20,681	6,945
SA 4 – Metro Los Angeles	29,471	8,331
SA 5 – West Los Angeles	9,699	2,818
SA 6 – South Los Angeles	26,269	6,159
SA 7 – East Los Angeles County	13,027	2,994
SA 8 – South Bay	30,117	8,664

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+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$163,545,000	$115,915,000	$95,397,000

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 2021-22 ■ 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+.

As of July 1, 2021, LACDMH began to transform 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:

- Changing the eligibility criteria to be more focused on those most in need of FSP care;

- Changing the FSP service model to utilize a multidisciplinary team/population approach, rather than individual caseloads;
- Began the integration of all specialty FSP programs into one FSP model (with the exception of Housing FSP which transitioned to housing support);
- Lowering staff to client ratios;
- Adding funding for additional staffing to enable Child FSP programs to provide Intensive Care Coordination (ICC) & Intensive Home Based Services (IHBS);
- Providing enhanced training and technical assistance to support FSP providers in achieving desired outcomes;
- Enhancing services and supports to ensure successful transitions between levels of care;
- Centralizing the authorization, enrollment, and disenrollment processes for FSP to ensure that those highest needs clients are able to access the FSP services;
- Standardizing rates to bring contracted provider staff salaries closer to parity with their counterparts in the LACDMH clinics, as a part of LACDMH's broader rate-setting exercise; and
- Changing 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 transformation of the FSP program began 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 2021-22 ■ FULL SERVICE PARTNERSHIP Data and Outcomes

As of June 30, 2022, LACDMH had 12,788 FSP slots as shown in the next table.

Table 10. FSP Slots summary: age group, slots, average cost per client, and unique clients served

Age Group	Number of Slots
Children (includes Wraparound and Intensive Field Capable Clinical Services)	3,683
Adult (includes Integrated Mobile Health Team, Assisted Outpatient Treatment, and Homeless)	9,105

Table 11. FSP summary: age group, average cost per client, unique clients served and total number to be served

Age Group	Average Cost per Client	Number of Unique Clients Served[1]	Total Number to be served in FY 2023-24[2]
Children	$19,428.14	3,267	3,544
TAY	$14,625	2,504	2,710
Adult	$15,146	6,672	7,145
Older Adult	$12,830	1,782	1,888

[1]Cost is based on Mode 15 services, not inclusive of community outreach ser-vices or client supportive services expenditures.

[2]FY 2023-24 Total Number to be served: Reflects average of two prior years

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 12. Impact of FSP on post-partnership residential outcomes

FSP Program	Percentage by Clients	Percentage by Days
Homeless		
TAY	19% reduction	44% reduction
Adult	30% reduction	66% reduction
Older Adult	27% reduction	58% reduction
Justice Involvement		
TAY	1% reduction	34% reduction
Adult	23% reduction	66% reduction
Older Adult	21% reduction	48% reduction
Psychiatric Hospitalization		
Child	41% reduction	11% increase
TAY	45% reduction	24% reduction
Adult	25% reduction	64% reduction
Older Adult	6% reduction	24% reduction
Independent Living		
TAY	31% increase	34% increase
Adult	45% increase	42% 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, 2022. 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.

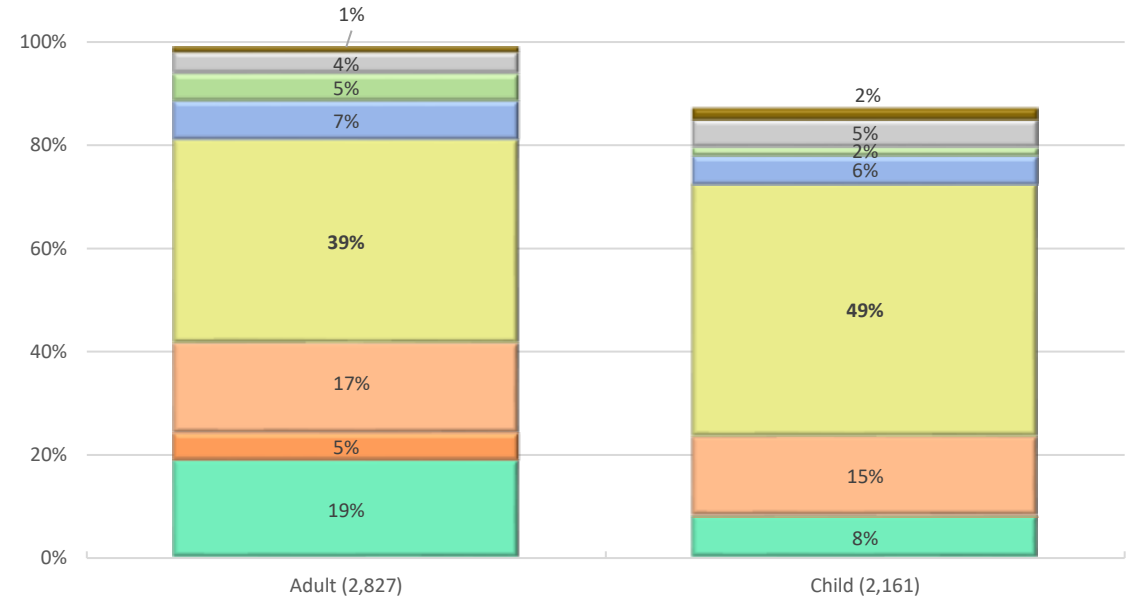
Children (n=13,905)
TAY (n=8,386)
Adult (n=19,337)
Older Adult (n=3,250)
Figures represent cumulative changes, inclusive of all clients through June 30, 2022

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 8. Reasons for FY 2021-22 FSP disenrollments



B. OUTPATIENT CARE SERVICES

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+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$234,019,000	$192,090,000	$182,950,000

Program Description

Outpatient Care Services (OCS) provides a broad array of integrated community-based, clinic and/or field-based services in a recovery-focused supportive system of care. This system of care provides a full continuum of services to all age groups. As part of this continuum clients can receive mental health services and supports in a timely manner in the most appropriate setting to meet their needs. OCS is inclusive and strives to provide culturally sensitive and linguistically appropriate services to meet the needs of the diverse communities of Los Angeles County.

The aim is for clients to move toward and achieve self-determined meaningful goals that promote connectedness, mental and physical wellbeing, and meaningful use of time. All age groups will have access to core components of mental health services such as assessments, individual and/or group therapy, crisis intervention, case management, peer support, co-occurring disorders treatment, medication support services (MSS) and Medication Assisted Treatment (MAT). 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 generally 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; and exposure to trauma, violence, or external psychosocial stressors such as housing, employment, relationship, or legal problems. These services meet the needs of all age ranges from child to TAY to adults and older adults.

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

Key Activities

- Clinical services (individual, group, and family therapy; crisis resolution/intervention; evidence-based treatments; MSS, including MAT; 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; co-occurring disorder services; linkage to primary care; housing services; vocational and pre-vocational services)

FY 2021-22 ■ OUTPATIENT CARE SERVICES Data and Outcomes

Table 13. FY 2021-22 Data for clients by Age Group served through various outpatient programs

Age Group	Number of Unique Clients Served
Children, Ages 0-15	19,699
TAY, Ages 16-25	19,166
Adult, Ages 26-59	60,473
Older Adult, Ages 60+	16,740

Table 14. FY 2021-22 Data for unique clients served through various outpatient programs and average cost per client

Unique Clients Served	Average Cost per Client
111,361	$4,278

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 15. 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 (OA)Trainings via Outpatient Service Division were impacted as a result of COVID-19, LA County restrictions. Below are the OA trainings which addresses the training needs of existing mental health professionals and community partners by providing the following training topics: medical/legal aspects, elder abuse, older adult consultation training, older adult law/abuse training, sleep impairments, co-occurring disorders, Medication in older adults, geriatric psychiatry, cognitive impairments, screening measures, Chronic Pain, Family Caregiving & Alzheimer's and evidence-based practices.

The following are achievements/highlights for FY 2021-22:

- **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.
    - **Neuropsychiatric Manifestations of COVID-19:** The Training provided a brief overview of societal effects of the COVID-19 pandemic on mental health. The presentation will serve to increase the familiarity with short-term and long-term neuropsychiatric complications of COVID-19 including depression, anxiety, stroke, delirium, dementia and PTSD. Lastly, the presentation provided a discussion for future investigation into neuropsychiatric sequelae of COVID-19.

- **Sleep: An Overview, Select Disorders in Older Populations and Treatment:** The training focused on sleep disorders, which disproportionately affect older populations and relevant information for clinicians and non-clinicians working with older adults. Discussion included primary insomnia and sleep disorders in dementia. Both pharmacologic and non-pharmacologic treatments were also discussed.
- **Psilocybin As Treatment for Existential Anxiety and Demoralization in Terminal Illness:** The training consisted of a discussion on the history of psychedelic use in general, for medicinal and spiritual purposes around the world. The presentation discussed its recent resurgence as a means of treatment for a variety of psychiatric conditions, and specifically for advanced cancer, focused on potential palliative effects in end of life settings associated with existential anxiety, distress, and demoralization.
- **Chronic Pain in Older Adults: A Neuroscience-Based Psychological Assessment and Treatment Approach:** The following training examined relationships between stress, emotions, the brain, and subtypes of chronic pain. In addition, the trainer identified disparities in care for treatment of patients with chronic pain. The training also provided a brief, integrative assessment to elicit evidence of pain centralization. Finally, the training discussed the use of basic principles from Pain Reprocessing Therapy (PRT) and Emotional Awareness and Expression Therapy (EAET) to address centralized chronic pain in older adults.

- **Medications for Serious Mental Illness: What Non-Prescribers Need to Know:**
  This training discussed the barriers to medication adherence. The training included discussions on cultural considerations, to approaching conversations about medications. It provided participants knowledge in developing an understanding of the positive outcomes that derive from medication adherence, and potential solutions for clients that are struggling with medication non-adherence.
- **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.

- **Medical Legal Elective Part II Direct and Cross Examination:** The following training will educate mental health participants on strategies for expert witness court testimony specific to older adults with cognitive impairments. This training will prepare medical doctors and psychologists on ethnically diverse older adult cases with practiced simulated direct and cross examination situations.
- **Medical Legal Elective Part III Simulated Trails:** The following training will educate mental health participants on strategies for expert witness court testimony specific to older adults with cognitive impairments. The training will describe the evolution of mock trials and be involved in a simulated actual case, including practicing attorneys, and an experienced judge in a condensed version of a trial.
- **Effective Techniques in Working with Individuals with Mild to Moderate Cognitive Impairment:** A training request from LA County Board of Supervisor. The training outlined 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.
- **Family Caregiving and Alzheimer's Disease:** The training provided a working definition of dementia, identify possible symptoms, and discuss techniques to help address problematic behaviors. Discussion will include identifying signs of potential abuse, enhancing communication, examining healthy coping strategies and identifying new treatments and policies that give families hope for the future. Finally, the training provided valuable information regarding the challenges of family caregiving who attend to individuals suffering from Alzheimer's Disease.
- **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.
- **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).

FY 2023-24 ■ 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.

C. ALTERNATIVE CRISIS SERVICES

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+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$132,177,000	$138,993,000	$132,069,000

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)
- Restorative Care Villages

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 fields as alternatives to crisis response

FY 2021-22 ■ ALTERNATIVE CRISIS SERVICES Data and Outcomes

During FY 21-22, 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.

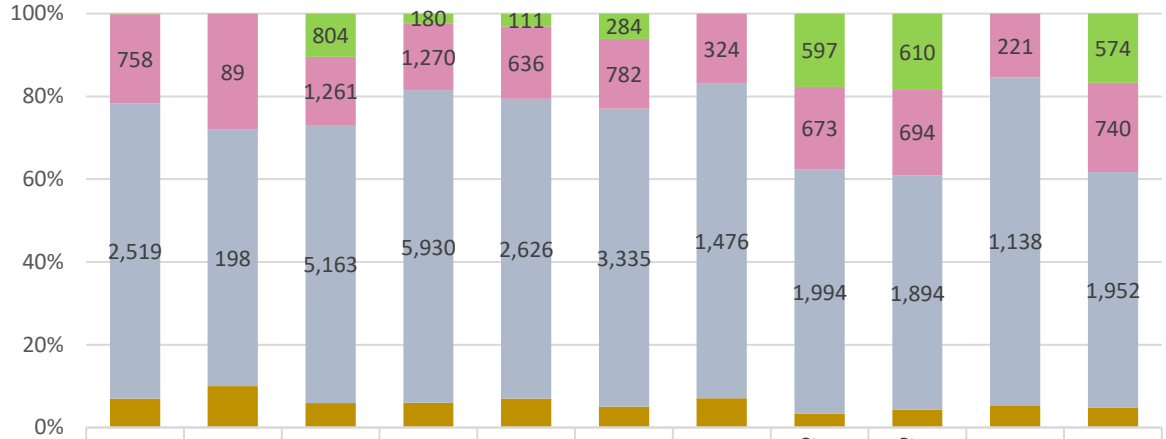
Table 16. Location of the current UCCs

Urgent Care Center	Service Area	Location	Address	Phone
Starview High Desert	1	Lancaster	415 East Avenue I Lancaster, CA 93535	Ph: (661) 522-6770 Fax: (661) 723-9079
Behavioral Health UCC	2	San Fernando Valley	14228 Saranac Lane Sylmar, CA 91342	Ph: (747) 315-6108 Office: (747) 315-6100
Olive View Community Care Services (OV UCC)	2	San Fernando Valley	14445 Olive View Drive Sylmar, CA 91342	(747) 210-3127
Star View BHUCC	3	East – City of Industry/East San Gabriel	18501 Gale Ave. Ste. 100 City of Industry, CA 91748	Ph: (626) 626-4997
Exodus (Eastside UCC)	4	Downtown Los Angeles	1920 Marengo Street Los Angeles, CA 90033	Ph: (323) 276-6400 Fax: (323) 276-6498
Exodus (Westside UCC)	5	West Los Angeles	11444 W. Washington Blvd., Ste D. Los Angeles, CA 90066	Ph: (310) 253-9494 Fax: (310) 253-9495
Exodus (MLK UCC)	6	South Los Angeles	12021 S. Wilmington Ave., Los Angeles, CA 90059	Ph: (562) 295-4617
Exodus (Harbor UCC)	8	Harbor-UCLA/Torrance	1000 W Carson Street, Bldg. 2 South Torrance, CA 90502	Ph: (424) 405-5888
Providence Little Company of Mary OBHC[2]	8	San Pedro	1300 W. 7th Street San Pedro, CA 90732	Ph: (310) 832-3311
Star View BHUCC	8	Long Beach	3210 Long Beach Blvd. Long Beach, CA 90807	Ph: (562) 548-6565
Telecare (La Casa[1] MHUCC[2])	SA 8	Long Beach	6060 Paramount Blvd. Long Beach, CA 90805	Ph: (562) 790-1860 Fax: (562) 529-2463

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

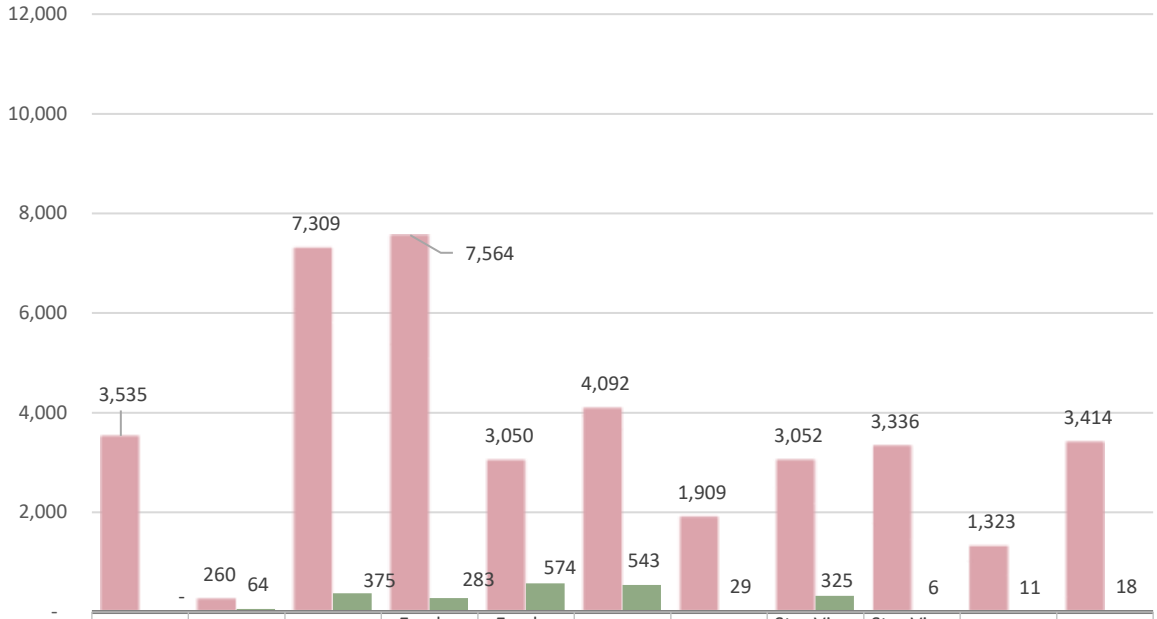
The following graphs provide an overview of FY 2021-22 outcomes of the UCCs. Olive View UCC has two components: Crisis Stabilization Unit (CSU) - 7913 and Outpatient UCC - 7591 that does not operate 24/7.

Figure 9. FY 2021-22 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	High Desert
Child	6	0	804	180	111	284	1	597	610	0	574
TAY	758	89	1,261	1,270	636	782	324	673	694	221	740
Adult	2,519	198	5,163	5,930	2,626	3,335	1,476	1,994	1,894	1,138	1,952
Older Adult	247	32	455	467	254	234	137	113	144	77	166

Figure 10. Clients with a psychiatric emergency assessment within 30 days of a UCC assessment

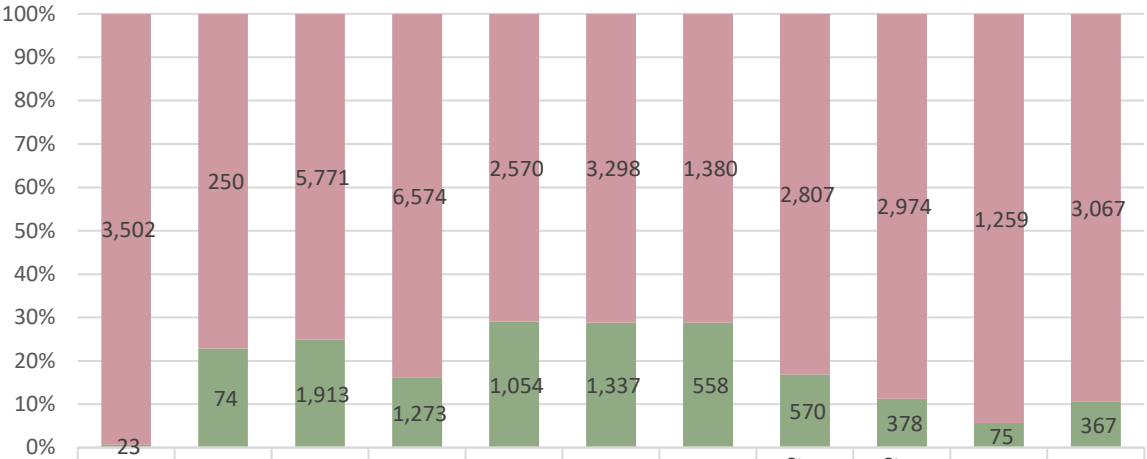


	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View Long Beach	Star View City of Industry	Telecare MHUCC	High Desert
No	3,535	260	7,309	7,564	3,050	4,092	1,909	3,052	3,336	1,323	3,414
Yes	-	64	375	283	574	543	29	325	6	11	18

Figure 11. 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	High Desert
No	2,196	294	7,214	7,454	3,442	4,367	1,851	3,000	2,854	1,289	2,820
Yes	1,329	30	470	393	182	268	87	377	488	45	612

Figure 12. 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	High Desert
No	3,502	250	5,771	6,574	2,570	3,298	1,380	2,807	2,974	1,259	3,067
Yes	23	74	1,913	1,273	1,054	1,337	558	570	378	75	367

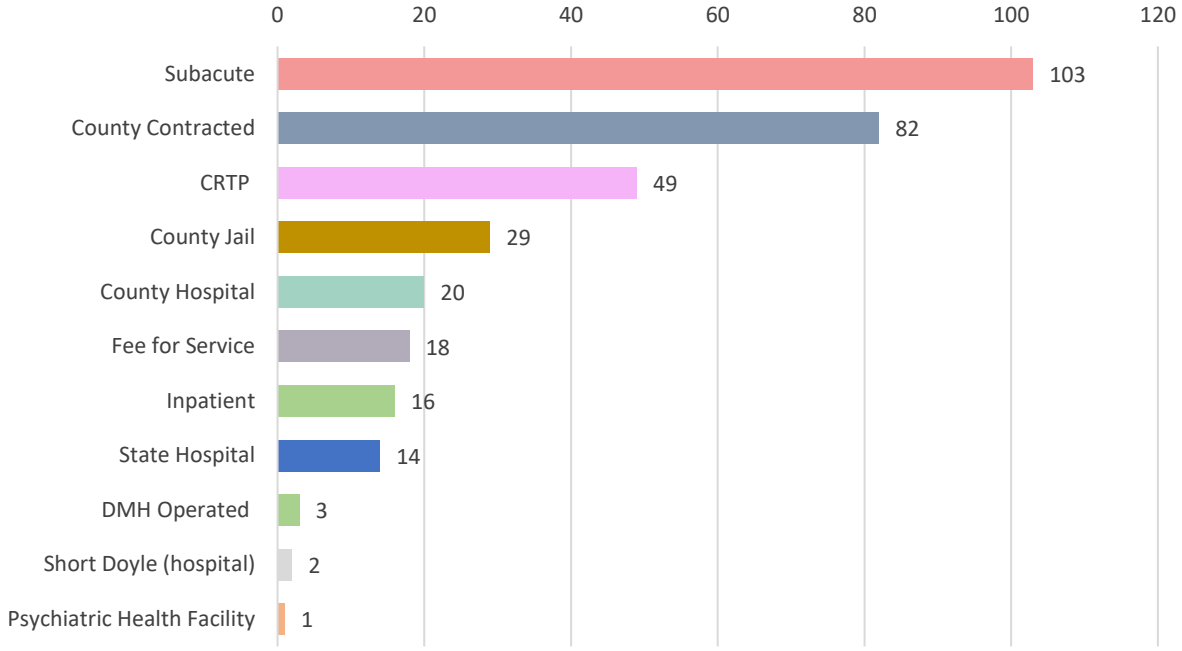
C3. Enriched Residential Services (ERS)

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.

Table 17. Enriched Residential Services Facilities

Anne Sippi Clinic 5335 Craner Ave. North Hollywood, CA 91601 Ph: (818) 927-4045 Fax: (818) 927-4016	Bridges – Casitas Esperanza 11927 Elliott Ave. El Monte, CA 91732-3740 Ph: (626) 350-5304	Cedar Street Homes 11401 Bloomfield St. Bldg. 305 Norwalk, CA 90650 Ph: (562) 207-9660 Fax: (562) 207-9680	Percy Village 4063 Whittier Blvd., Suite #202 Los Angeles, CA 90023 (323) 268-2100 ext. 234 Fax (323) 263-3393 eFax 323-983-7530
Telecare 7 4335 Atlantic Blvd. Long Beach, CA 90807 Ph: (562) 216-4900 Fax: (562) 484-3039	Normandie Village East– 1338 S. Grand Ave Los Angeles, CA 90015 Ph: (213) 389-5820 Fax: (213) 389-5802	Special Services for Groups (SSG) 11100 Artesia Blvd. Ste. A Cerritos, CA 9070 Ph: (562) 865-1733 Fax: (213) 389-7993	

Figure 13. Source of client referrals for ERS admissions (n =339)



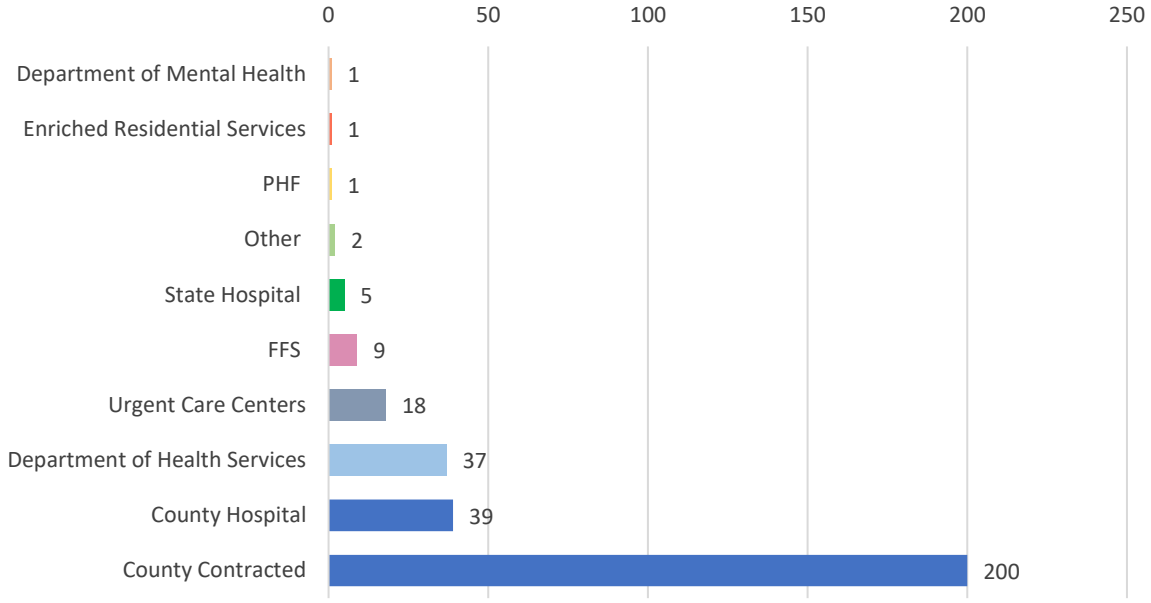
C4. Crisis Residential Treatment Programs (CRTP)

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

Table 18. List of current CRTPs

Hillview Crisis Residential 12408 Van Nuys Blvd., Bldg. C Pacoima, CA 91331 Ph: (818) 896-1161 x 401	Didi Hirsch Excelsior House DiDi Hirsch Comm. MH 1007 Myrtle Ave. Inglewood, CA 90301 Ph: (310) 412-4191 Fax: (310) 412-3942	Didi Hirsch Jump Street CRTP DiDi Hirsch Comm. MH 1233 S. La Cienega Blvd. Los Angeles, CA 90035 Ph: (310) 895-2343 Fax: (310) 855-0138
Exodus CRTP 3754-3756 Overland Avenue Los Angeles, CA 90034 Ph: (424) 384-6130 Fax: (213) 265-3290	Freehab (Teen Project) CRTP 8142 Sunland Blvd., Sun Valley, CA 91352 Phone: (818) 582-8832 Fax: (818) 582-8836	Gateways CRTP 423 N. Hoover Street Los Angeles, CA 90004 Ph: (323) 300-1830 Fax: (323) 664-0064
Safe Haven CRTP – 12580 Lakeland Rd. Santa Fe Springs, CA 90670 Phone: (562) 210-5751	SSG Florence House CRTP 8627 Juniper Street Los Angeles, CA 90002 Phone: (323) 537-8979	Valley Star MLK CRTP 12021 Wilmington Ave. Los Angeles, CA 90059 Phone: (213) 222-1681
Telecare Olive House CRTP 14149 Bucher Ave. Sylmar, CA 91342 Phone: (747) 999-4232	Telecare Citrus House CRTP 7725 Leeds Street Bldg. D Downey, CA 90242 Phone: (562) 445-3001	Telecare Magnolia House CRTP 1774 Zonal Ave RTP, Bldg. D Los Angeles, CA 90033 Phone: (323) 992-4323
Central Star Rancho Los Amigos 7745 Leeds St. Downey, Ca 90242 Phone: (562) 719-2866		

Figure 14. Source of Client Referrals for Crisis Residential Facility Admissions (n =465)



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 2021-22, there were 12,446 incidents, of which 29% involved homeless individuals; 6% resulted in arrests; and 59% 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

C. HOUSING

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+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$69,147,000	$45,289,000	$40,593,000

Program Description

The Department of Mental Health (DMH) provides a wide variety of housing resources and services for individuals who have a serious mental illness and are homeless or at risk of homelessness. In FY 2021-22, the Housing Services budget for the DMH Housing and Job Development Division (HJDD) and related programs totaled $76.1 million, of which $46 million was funded with Mental Health Services Act (MHSA) dollars. This report provides updates on the housing programs funded with MHSA support, with budget details specific for each program included in the chart below.

DMH HOUSING SERVICES BUDGET, FY 2021-22

Program Name	Budgeted Amount	MHSA Amount	MHSA %
Housing Supportive Services Program	$ 23,090,184	$ 3,410,706	15%
Intensive Case Management Services Program	$ 6,200,000	$ 6,200,000	100%
Housing for Mental Health	$ 10,000,000	$ 10,000,000	100%
Housing Assistance Program	$ 2,408,566	$ 1,169,115	49%
Enriched Residential Care Program	$ 17,841,612	$ 9,122,067	51%
Interim Housing Program - Adults	$ 13,987,179	$ 13,824,179	99%
Enhanced Emergency Shelter Program - TAY*	$ 2,638,853	$ 2,328,853	88%
Total	**$ 76,166,394**	**$ 46,054,920**	**60%**

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

D1. Capital Investments Program

Since 2008, DMH has invested over $1 billion in MHSA funding toward the development of project-based 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. The below chart details these one-time capital investments and the corresponding amounts.

Table 19. One-Time Capital Investments

DMH ONE-TIME CAPITAL INVESTMENTS (2008 – Present)		
Program Name	**MHSA Amount**	
No Place Like Home	$	744,903,877
Special Needs Housing Program/MHSA Housing Program	$	155,000,000
Mental Health Housing Program	$	103,300,000
Total	**$**	**1,003,203,877**

To date, $778.2 million of this $1.003 billion in MHSA funding has been committed toward the implementation and administration of capital efforts including providing capital funding for 154 PSH developments and 3,912 PSH units as well as providing capitalized operating subsidies for 13 of these developments to help make the units affordable for individuals with limited income. These PSH developments and units are intended to serve a wide range of DMH clients. Their target populations are further detailed in the chart below.

Table 20. MHSA Project-Based Permanent Supportive Housing Developments

TARGET POPULATION	NUMBER OF MHSA PROJECT-BASED PSH DEVELOPMENTS	NUMBER OF MHSA PROJECT-BASED PSH UNITS
Adults	87	2,427
Families	10	270
Older Adults	26	619
TAY	19	344
Veterans	12	252
TOTAL	**154**	**3,912**

By the end of FY 2021-22, 60 of the 154 PSH developments had finished construction, resulting in 1,479 units available for occupancy. PSH units ranged in size from studio to four-bedroom apartments and, throughout the fiscal year, provided housing for a total of 1,882 adult clients and adult family members along with 162 minor children. Specifically, during FY 2021-22, 15 PSH developments comprising 327 units began leasing up and 316 of those units were occupied by June 30, 2022. The other two developments will complete their lease up in the next fiscal year. Overall, the housing retention rate for the Capital Investments Program was 95%.

Included as part of DMH's $744 million No Place Like Home (NPLH) capital investment is $100 million that has been set aside to develop PSH on each of the County's five medical

center campuses. This housing will be part of the Restorative Care Villages initiative, which will provide a continuum of clinical care and supportive services such as recuperative and respite care, psychiatric urgent care and Crisis Residential Treatment Program beds in addition to PSH. On October 19, 2021, the Los Angeles County Development Authority (LACDA), in partnership with DMH, released a Request for Proposals (RFP) to select a PSH developer for the first of the five Restorative Care Village sites, LAC+USC. Century Housing was recommended to receive the funding and is proposing a 300-unit project with 150 units targeting individuals who are homeless and who have a serious mental illness. DMH will continue to work with LACDA on developing RFPs for the other Restorative Care Village sites.

D2. Federal Housing Subsidies Unit

In addition to supporting project-based PSH, DMH maintained its 19 contracts with the City and County of Los Angeles Housing Authorities that provide DMH clients who are homeless with access to federal tenant-based PSH subsidies through such programs as Continuum of Care, Tenant Based Supportive Housing, Mainstream Voucher and Section 8. These subsidies make units affordable by allowing clients to pay 30% of their income as rent, with the balance paid to the property owner by the Housing Authority. DMH leverages MHSA-funded specialty mental health services, which are provided to DMH clients who access these tenant-based subsidies, to meet the match requirement for the Continuum of Care program. Leveraged services include the full range of specialty mental health services provided by DMH clinicians and case managers including housing supports such as assisting clients with the application, interview and housing location process as well as supporting clients in maintaining their housing once they move in.

During FY 2021-22, DMH Housing Authority contracts supported 2,778 tenant-based PSH units. These units helped to provide housing to 3,085 individuals, which included 1,821 single adults and 518 adults who had family members living with them including 746 minor children. New units that were leased up during the fiscal year totaled 315. The housing retention rate for DMH clients residing in these tenant-based PSH units was 94%.

D3. Supportive Services for Individuals in PSH

During FY 2021-22, Los Angeles County continued to use an integrated multi-Department service model to provide individuals living in PSH with the supportive services needed to promote housing stability and retention and to meet their recovery goals. Through this model, PSH residents were able to access specialty mental health services through the DMH Housing Supportive Services Program (HSSP), case management services through the Department of Health Services (DHS) Intensive Case Management Services (ICMS) program and substance use services through the Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) Client Engagement and Navigation Services (CENS) program.

MHSA and County Measure H funding were used to provide 1,356 individuals with HSSP services throughout the course of the fiscal year including such services as individual and group therapy, crisis intervention and medication management. MHSA dollars were also used to fund ICMS for 1,183 individuals living in MHSA-funded PSH units and other PSH units targeting individuals with mental illness. Many of those in PSH received both HSSP and ICMS services.

D4. Housing for Mental Health

The Housing for Mental Health (HFMH) program uses MHSA funds to provide 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 FSP Program and are homeless. Twenty percent of HFMH rental subsidies are for individuals who were referred to FSP by the DHS Office of Diversion and Reentry and have criminal justice involvement. The HFMH program also collaborates closely with DHS ICMS teams who work alongside FSP staff to assist clients with obtaining and retaining housing.

As of June 30, 2022, a total of 490 DMH clients were in permanent housing supported by the HFMH program. Throughout the fiscal year, 104 individuals were newly referred to the program and 92 individuals newly moved into 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 PSH, project-based PSH at one of eight partnering housing developments and licensed residential facilities. The chart below details the types of permanent housing to which clients were referred as well as where they moved in. The housing retention rate for the HFMH program was 92%.

Table 21. Housing for Mental Health Program Client Referrals

HFMH HOUSING TYPE	TOTAL IN HOUSING	NEW REFERRALS	NEW MOVE-INS
Tenant-Based PSH	282	33	37
Project-Based PSH	186	63	49
Licensed Residential Facility	22	8	6
TOTAL	**490**	**104**	**92***

* Clients included in this total may have been referred to HFMH in FY 2020-21.

D5. Housing Assistance Program

The Housing Assistance Program (HAP) uses MHSA and other funding to assist DMH clients including directly-operated Full Service Partnership (FSP) clients who are homeless or at-risk of homelessness and who have limited or no income with security deposits, utility deposits, household goods, one-time rental assistance, time-limited rental assistance, permanent rental subsidies, eviction prevention assistance and client supportive services (CSS). In FY 2021-22, HAP provided financial assistance to 946 households. The chart below provides details on the number of clients receiving each type of HAP service.

Table 22. Housing Assistance Program Households Served

HAP SERVICE TYPE	NUMBER OF HOUSEHOLDS SERVED
Security Deposits	330
Utility Deposits	19
Household Goods	374
One-Time Rental Assistance	3
Time-Limited Rental Assistance	110
Permanent Rental Subsidies	53
Eviction Prevention	1

HAP SERVICE TYPE	NUMBER OF HOUSEHOLDS SERVED
Directly-Operated TAY FSP Housing Supports	5
Directly-Operated Adult FSP Housing CSS Supports	51
TOTAL	**946**

D6. Enriched Residential Care 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 the additional supports provided by these facilities is needed to live successfully in the community. ARFs and RCFEs are unlocked residential facilities that are licensed by the State and 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 client rent at the ARFs and RCFEs 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. DMH has partnered with DHS' Countywide Benefits Entitlement Services Team (CBEST) program to assist ERC clients without income to apply for benefits for which they are eligible such as SSI. MHSA and other funds are also used to provide ARFs and RCFEs with an enhanced rate for the DMH clients they serve to help cover the costs of enhanced services that clients may require due to their higher acuity and complex needs.

As of June 30, 2022, the ERC program was serving a total of 995 clients. Throughout the fiscal year, 499 clients were newly referred to the program and 401 clients moved into an ARF or RCFE with ERC financial support. See chart below for further details on the types of financial support that were needed by those referred and served. Overall, the ERC program housing retention rate was 82%.

Table 23. ERC Program Housing Served

	TOTAL SERVED		NEW REFERRALS		NEW MOVE-INS	
	Number Served	%	Number Referred	%	Number Moved-In	%
ERC FUNDING NEEDED						
Rent and P&I Only	1	0.1%	0	0%	0	0%
Rent, P&I and Enhanced Rate	213	21.4%	358	71.7%	298	74.3%
Enhanced Rate Only	781	78.5%	141	28.3%	103	25.7%
TOTAL	**995**	**100%**	**499**	**100%**	**401**	**100%**

D7. Interim Housing

Interim Housing Program – Adults

The Interim Housing Program (IHP) is intended to provide short-term shelter services for adults with serious mental illness and their minor children who are homeless and do not have adequate income to pay for temporary housing. Serving as a bridge to permanent housing, IHP provides clients with safe and clean shelter, 24-hour general oversight, three

meals per day, linens, clothing, toiletries and case management services.

MHSA funds enabled DMH to contract for 570 IHP beds across 20 sites. This included 501 beds for individuals and 69 family units. However, during FY 2021-22, the capacity at some IHP sites was reduced to allow for safer occupancy in accordance with DPH COVID-19 guidelines. As a result, IHP served a total of 838 individuals and 89 families throughout the fiscal year. Hotel and motel rooms secured through Project Homekey were also made accessible to individuals who were homeless and served by DMH.

Enhanced Emergency Shelter Program – TAY

The Enhanced Emergency Shelter Program (EESP) serves the urgent housing needs of the TAY population, ages 18-25, who are unhoused or at immediate risk with no alternative place to stay, no significant resources or income to pay for shelter, are experiencing mental health concerns, and are willing to accept the treatment we offer. The EESP offers a warm, clean and safe place to sleep, hygiene facilities, hot meals (breakfast, lunch, dinner) and case management services. TAY are provided shelter in the EESP for up to 60 nights while working with the TAY Navigation Team to identify longer-term and more permanent housing resources to help ensure longer-term stability as well as linkage to needed mental health and other supportive services.

Using MHSA and other funds, there were approximately 82-84 beds contracted to serve TAY in six EESP shelters within the geographic area of Service Areas 4 and 6 throughout FY 2021-22. The total number of TAY served in the EESP during that time period was approximately 561. COVID restrictions, as well as closures due to COVID illness, created fluctuations throughout the fiscal year that led to reduced numbers of clients served overall, including clients staying in beds longer than the designated 60 nights.

■ **HOUSING Continued Work**

The Department of Mental Health (DMH) Housing and Job Development Division (HJDD) continues to look for opportunities to grow and enhance its housing and employment services and resources for those who are homeless or at risk of homelessness. Other recent activities and future plans include:

- DMH has received approval from the Los Angeles County Board of Supervisors to accept $53 million in Community Care Expansion (CCE) Preservation funding from the State to help licensed residential facilities complete the capital repairs and improvements needed to remain in operation and serve as a housing resource for DMH clients. This funding, combined with the $11.2 million in one-time MHSA funding designated for licensed residential facility capital improvements, will be transferred to the Los Angeles County Development Authority (LACDA), who will serve as the funding administrator as also approved by the Board. An additional $39.5 million in CCE Preservation funding will also be received by DMH and will be used to provide licensed residential facilities with operating subsidy payments to help support operation costs and further prevent closures. This will allow DMH, in partnership with the Department of Health Services (DHS) and their fiscal intermediary, to support approximately 450 additional clients per year for five years through the Enriched Residential Care program.
- As part of the Hollywood 2.0 initiative, HJDD is working in collaboration with community stakeholders, including Hollywood 4WRD, and other DMH Hollywood 2.0 leads to implement the Housing and Employment Strategies recommended by stakeholder groups. This includes growing the number of interim housing, licensed residential care facility and permanent supportive housing resources that are available to serve Hollywood 2.0 clients that are in the Hollywood region as well as taking the lead on the solicitation process to implement a clubhouse that will utilize the Clubhouse International standards for adults living, working and/or receiving mental health treatment in the Hollywood area who have a serious mental illness – many of whom may be unhoused or at risk of homelessness.
- To enhance our ability to critically analyze program effectiveness and racial and gender equity in terms of those served by DMH's housing resources and to make enhancements and improvements where needed, DMH has

applied and been approved for a grant from the LA Care and Health Net health plans. This grant, which is funded with Housing and Homelessness Incentive Program (HHIP) dollars, will be used by the DMH Chief Information Office to secure the services of consultants who will assist with implementing long-needed technical infrastructure that will greatly enhance the Department's ability to capture, analyze and report out on housing data including data for DMH MHSA housing programs such as demographics.

- DMH is actively working on a proposal for MHSA Innovations funding that would allow DMH to implement new regional, field-based, multidisciplinary teams dedicated to serving people experiencing homelessness who are living in interim housing. These Interim Housing Multidisciplinary Assessment and Treatment Teams would serve all eight County Service Areas and be comprised of staff from DMH, DHS Housing for Health and Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) to help ensure the full spectrum of client needs can be addressed. MHSA Innovations funding would specifically support the mental health component of this effort including the provision of on-site specialty mental health and co-occurring substance use disorder care and supports. This effort would also be a partnership with the L.A. Care and Health Net health plans, who would provide HHIP dollars for DHS to fund Assistance with Daily Living staff that would be a part of the interim housing multidisciplinary teams and help assess the activities of daily living (ADL) needs of interim housing clients and provide caregiving services as well as to fund Enriched Residential Care subsidies for those individuals who need to transition from interim housing to a licensed residential care facility.
- DMH is continuing its efforts to allocate the remaining No Place Like Home funding toward capital investments. In particular, a solicitation for $50 million is planned to be released in the Spring of 2023 to fund the development of additional permanent supportive housing Countywide that is dedicated to individuals with serious mental illness who are also homeless.

E. LINKAGE

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+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$50,878,000	$44,479,000	$34,545,000

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 include:

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

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 2021-22 ■ LINKAGE Data and Outcomes

E1. Jail Transition and Linkage Services

Client Contacts: 3,033

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: 4,377

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: 18,163

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 2021-22 data reported by the Service Area Navigators.

Figure 15. Number of phone contacts and outreach activities

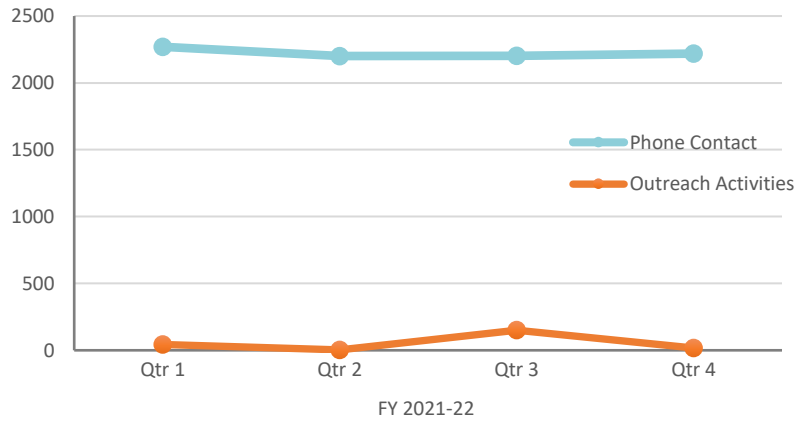


Figure 16. Number of clients referred to FSP services

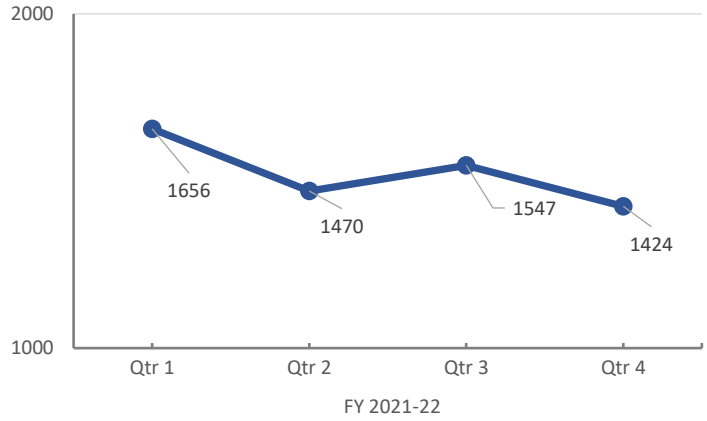
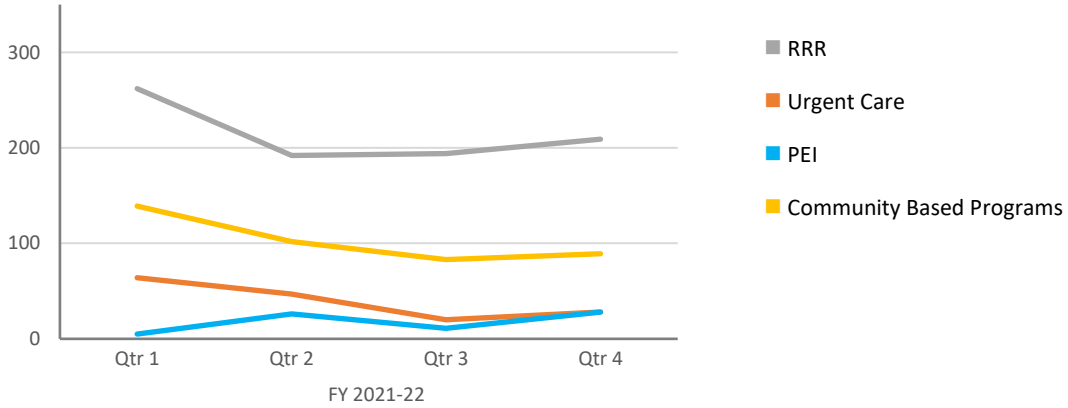


Figure 17. Number of clients referred to Non-FSP services



E4. Homeless Outreach and Mobile Engagement (HOME)

The Homeless Outreach & Mobile Engagement (HOME) program provides field-based outreach, engagement, support, and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness. Services are provided by addressing basic needs; conducting clinical assessments; providing street psychiatry; and providing linkage to appropriate services (including mental health services substance abuse treatment and shelter).

HOME serves individuals 18 and over who are experiencing chronic unsheltered homelessness and who have profound mental health needs and associated impairments. These vulnerable and disengaged individuals struggle with securing appropriate food, clothing, and shelter due to their mental illness. In addition, they may have critical deficits in hygiene and communication, and are generally highly avoidant of services. They are unable to live safely in the community and require specialized mental health services to secure and sustain housing.

Most referrals are submitted by generalist homeless outreach providers who identify individuals with severe impairment that require specialized and intensive support and engagement.

FYs 2023-24 ■ LINKAGE Continued Work
• For FYs 2023-24, 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 scale 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

F. PLANNING, OUTREACH AND ENGAGEMENT

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+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$16,970,000	$4,458,000	$6,178,000

Program Description

POE programs:

- Service Area Liaisons
- Underserved Cultural Communities Unit (UsCC)
- Stipend for Community Volunteers, examples include Wellness Outreach Workers (WOW) and the Countywide Client Activity Fund (CCAF)

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
- Communities and education community members using various media and print media, as well as grassroot level community mental health presentations.
- 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 2021-22 ■ PLANNING, OUTREACH AND ENGAGEMNT Data and Outcomes

F1. Service Area Liaisons

In FY 2021-22, Service Area outreach staff attended multiple events with 63,135 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 24. Event participants by Service Area

Service Area	Number of Participants
SA1 – Antelope Valley	10,679
SA2 – San Fernando Valley	967
SA3 – San Gabriel Valley	4,377
SA4 – Metro Los Angeles	891
SA5 – West Los Angeles	32,410
SA6 – South Los Angeles	6,210
SA7 – East Los Angeles County	7,048
SA8 – South Bay	553

F2. Underserved Cultural Communities

- 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:
  - American Indian/Alaska Native
  - Asian Pacific Islander
  - Deaf, Hard-of-Hearing, Blind, and Physical Disabilities
  - 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.

An overview of the FY 2021-2022 projects that were approved for each of the UsCC Subcommittees is provided below. Most projects in this cycle are currently being implemented and therefore outcomes will not be available to report until after June of 2023. For the Black & African Heritage (BAH) and Eastern European/Middle Eastern (EE/ME) UsCC subcommittees, the FY 2021-2022 projects were rolled over into FY 2022-2023.

A. ACCESS FOR ALL (DEAF, HARD OF HEARING, BLIND, AND PHYSICAL DISABILITIES) UsCC SUBCOMMITTEE

Project
Domestic Violence Task Force Workshops The goal of this project is to engage, empower, and enlist the Deaf, Hard of Hearing, Blind, and Physically Disabled community as well as their family members and caretakers into advocacy and activism around mental health. It aims to educate the participants on how to identify the signs of people who are victims of domestic violence and be able to provide the resources and access to appropriate help. The Facilitator is a clinician who specializes in domestic violence and providing mental health services to the Deaf, Hard of Hearing, Blind, and Physically Disabled populations. This project is designed to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County. It 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.
Disability Mental Wellness Round Table for the Deaf, Hard of Hearing, Blind, and Physically Disabled Community The goal of this project is to reduce mental health access barriers for this community by engaging the population into conversations about mental health where they can freely share their experiences with peers. 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

Project
community member engagement in the LACDMH stakeholder process. Peers will be individuals aged 18+ who are members of the Deaf, Hard of Hearing, Blind, and Physically Disabled community with some experience with LACDMH mental health services, either directly or indirectly. This project will also include the testimony of at least three (3) Deaf/Hard of Hearing, three (3) Blind, and three (3) Physically Disabled community members with lived experience.
Podcast and YouTube Series Project The goal of this project is to provide better accommodation and accessibility to the targeted communities. This Consultant will deliver a total of 12 Podcast and YouTube sessions with different topics related to mental health and disabilities. Additionally, the Consultant will be responsible for recruiting panelists for each session including host/s, guests/participants, speakers, and presenters as well as the production and airing of all the shows. The objective of the project is to outreach and engage people from the deaf, hard of hearing, blind, and physically disabled populations into a virtual discussion regarding the mental health needs of these communities in a culturally appropriate and non-intrusive way 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 and create a safe space with mental health resources available to those that utilize American Sign Language (ASL).

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

Project
American Indian/Alaska Native Mending the Hoop Project The goal of this project is to promote mental health services for AI/AN community members, 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 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. The objectives of this project will include engaging this population into conversations about mental health and creating healing spaces for community members to come together to improve overall health outcomes.
American Indian/Alaska Native Mental Health Community Engagement Campaign The goal of this project is to reinforce that LACDMH is here to support AI/AN community members. The project should be tailored to resonate with the AI/AN community, reaching members using video-based content with culturally appropriate messages, distributed in the places where they already seek information and using visuals/design that complement LACDMH's current public outreach efforts. The Campaign includes production and distribution of five videos 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.
American Indian/Alaska Native Traditional Wellness Gathering Project The goal of the project to reduce mental health access barriers for AI/AN community members by engaging this population into conversations about the role of cultural traditions and language in mental health and 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. 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. Additionally, this project aims to utilize traditional methods of healing such as language, prayer, spirituality, history,

Project
songs, and food to build connections and reclaim these traditions to improve overall health outcomes.
American Indian/Alaska Native Youth Academy Project The goal of the project is to identify mental health access barriers for AI/AN Transition Age Youth (TAY) (aged 16-24) by engaging this population in advocacy and activism around mental health all while building capacity using traditional forms of healing. 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. The Facilitator will recruit twenty (20) AI/AN Transition Age Youth (TAY) (aged 16-24) to participate in the Youth Academy. Of those, at least ten (10) should identify as having lived experience either personally or as a family member/caregiver for someone with mental health conditions and will have some experience utilizing public mental health services. The Youth Academy should include a mental health stigma reduction program, art breakouts focused on traditional forms of healing, and athletic workshops. At the end of the Youth Academy, the youth and Facilitator will host a Community Forum to showcase their work.

C. ASIAN PACIFIC ISLANDER (API) UsCC SUBCOMMITTEE

Project
1000 Cranes - Healing Through Arts and Culture Project This project will target the API community County-wide, with a specific emphasis on the Japanese community throughout Los Angeles County by having API community members unite to fold 1000 origami cranes as symbol for wishing someone's emotional healing. The Japanese, red-crowned crane is an iconic bird that symbolizes many contexts such as resilience, recovery, and longevity giving the 1000 origami cranes a spiritual approach to encourage wellness in mental health. API communities continue to experience systemic inequities in mental health services and resources. In addition, over 30% of API Americans are not fluent in English. There is a significant gap in accessing treatment due to the lack of bilingual and bicultural mental health care providers. Cultural stigma and lack of understanding mental illness can lead to neglect and denial of mental health treatment particularly among the 1st generation API communities. In API's country of origin, often stigma, shame, and "losing face" will affect the whole family and result in being shunned by society. Families will go to great lengths to protect their reputation including isolation or suicide. This project aims to address the stigma, lack of knowledge, and cultural barriers that prevent many API community members from accessing quality mental health services in a timely manner.
Cambodian Americans Oral History Project A Consultant will be hired for the purpose of implementing a project to develop oral histories on the mental health impact of trauma on Cambodian American adults living in Los Angeles County who were children during the Khmer genocide. It would yield information on their mental health status and help reduce stigma in first generation Cambodian Americans. The goal is to fill a gap in knowledge and understanding as to the mental health impact of the historical trauma as a result of genocide of a Cambodian Americans who arrived as children. The culturally unresponsive mental health services and deeply embedded stigma prevents them from seeking or receiving mental health services resulting in mental health disparities that continue to persist. Culturally unresponsive services have also resulted in misunderstandings between therapist and patient, and barriers to successful access and engagement in treatment.

Project
Promoting MH Wellness in South Asian Americans This project proposes to enhance mental health and wellness of South Asian immigrant families. According to literature, South Asian families are collectivistic and hence engagement efforts are most effective if these efforts take a multi-generational and holistic approach rather than individual-focused. A bilingual (Hindi or Punjabi)/English consultant with extensive experience working with the South Asian community in Los Angeles County will be hired for the purpose of developing and implementing Promoting Mental Health Wellness in South Asian Americans Project. South Asian immigrants often want to protect and preserve their culture and pass cultural practices and traditions to their children. For South Asian families, this may create tension and stress as they struggle to adjust to changes in their cultural identity as a result of acculturation. Cultural identity represents a person's cultural practices, values, and identification. South Asian families may experience difficulties between preservation and adaptation of two very different cultures. A first-generation South Asian person may experience a range of emotions while they learn to adjust to the new culture, many times with minimal or no family support. First and Second-generation family members living in the same household may experience the acculturation process very differently, resulting in different degrees of acculturation. This may cause conflicts as children may not be comfortable confiding about their socio-emotional struggles or difficulties with their parents. This may put them at risk of developing mental health issues such as depression and anxiety and in some cases may even put them at risk of suicidal ideation or developing personality disorders.

D. LATINO UsCC SUBCOMMITTEE

Project
Empowering Latino Youth Mental Health Advocates Project The goal of this project is to reduce barriers to accessing mental health services for underserved members of the Latino community by providing education to empower young people to be mental health advocates for their communities throughout Los Angeles County. Youth will incorporate the media arts utilizing age and culturally appropriate practices to provide outreach, engagement, and education to reduce stigma in their communities. The primary objectives of this project are to empower Latino youth as the experts in developing innovative strategies using media arts to reach other Latino youth throughout Los Angeles County, provide education about the importance of mental health care, destigmatize mental health issues amongst Latino youth, develop culturally sensitive resources/tools, and to increase Latino youth engagement in the LACDMH stakeholder process.
La Cultura Cura: Engaging the Traditional Arts in Healing Project The goal of the project is to provide engagement and mental health education through a partnership with the Mental Health Promotors and/or people with community outreach experience. The Consultant will integrate the traditional arts and cultural/ancestral knowledge into community education about mental health in the Latino community. The Consultant will partner with Mental Health Promotors from three different Service Areas of Los Angeles County to present a mental health workshop series that integrates cultural knowledge and healthy coping when facing emotional and mental distress. This project will target the Latino community County-wide focused on individual adults and youth. As documented by a Surgeon General report, only about 20% of the Latino community with mental health challenges speak to their doctor about their mental health. Negative cultural attitudes contribute to Latino communities living in the U.S. perceiving a lower need for mental health care despite common mental health conditions increasing among the Latino population. Stigma, language barriers, and inequities in mental health care continue to be key barriers to the Latino community receiving culturally responsive mental health services. Research

Project
has shown that engagement in cultural practices enhances physical and mental health, positive self-perception, desire to grow and learn, self-actualization, community involvement, and increased clarity of future goals. In addition, studies also indicate that engagement with art activities outside of traditional health care settings can help community members voice their mental health needs and explore the multiple facets of their wellbeing issues, including seeking mental health services when needed.
Healing Grief and Loss Through Community Project The goal of this project is to outreach, educate, and increase knowledge pertaining to grief/loss and trauma as well as mental health services by utilizing a non-stigmatizing and empowering approach to help the community begin the healing process. A consultant will be hired for the purpose of developing and implementing the Healing Grief and Loss Through Community Project. This project will target the Latino community at-large. Latinos are over-represented in occupations that require wage earners to leave their homes and interact with co-workers and clients, such as farm workers and grocery store clerks. Many of these workers are predominantly first-generation Latino immigrants. Since March of 2020, Latinos have held many of the essential jobs that have kept Los Angeles County and California well-fed and functioning. Unfortunately, this has resulted in Latinos having the highest rate of infections and deaths in California and 2.3x more times compared to White, non-Latinos/Hispanics. The disproportionally high number of deaths and infections resulting from COVID-19 has resulted in many Latinos experiencing unprocessed grief and loss while mental health education and service utilization remains significantly low. This project aims to address the stigma, lack of knowledge, and language barriers that have prevented many Latinos from accessing quality mental health services.

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

Project
Black LGBTQ+ Community Engagement Initiative Project The goal of the project is to accomplish four specific goals relative to meeting the mental health needs of Black LGBTQ+ people living in Los Angeles County. The first is to increase the level of buy-in from community stakeholders through community outreach and engagement. The second goal is to develop and implement a targeted needs assessment of the Black LGBTQ+ community living in Los Angeles County. The third is to develop and implement non-traditional and Black centered innovation support systems that address the specific needs of the Black LGBTQ+ community. The fourth goal is to develop a detailed and comprehensive report including recommendations for long-term systemic change within LACDMH to meet the needs of Black LGBTQ+ people living in Los Angeles County. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project will involve four components. The first will include multi-stakeholder engagement that involves leading and managing a collaboration with multiple Black LGBTQ+ stakeholders that jointly addresses Black LGBTQ+ community priorities. The second component involves Black LGBTQ+ community education and empowerment involving closed biweekly meetings with community members that focus on specific issues of individual segments of the Black LGBTQ+ community. The third component involves Black LGBTQ+ community outreach and engagement. This will include planning a minimum of 2 community outreach events to hold discussions on Black LGBTQ+ community needs, share pertinent information with community stakeholders, and obtain input from community members. The fourth component consists of a community needs assessment and gap analysis.
LGBTQIA2-S Griot Project

Project
The goal of the project is to bring together an intergenerational group of Black and African-American LGBTQIA2-S community members to share and record stories of Black and African-American LGBTQIA2-S elders. The project will help to bridge the disconnect between Black elders and younger generations in order to improve mental health outcomes. It will provide an opportunity for younger generations to explore the past lives of Black elders from the LGBTQIA2-S community through active listening and dialoguing about elder experiences. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project looks to strengthen intergenerational ties in the Black and African American LGBTQIA2-S community. Through the exploration of Black LGBTQIA2-S cultural history, participants will gain a greater sense of self, build self-esteem and confidence, grow their ability for compassion, and embrace self-expression. Participants will bring newly minted skills and an improved sense of self to their communities and beyond. This project will involve two components. The first will include outreach and engagement of a minimum of twenty-five (25) Black and African-American LGBTQIA2-S elders and youngers (elders aged 50 and older and youngers aged 25 and younger) into a cohort. Of those, at least ten (10) should identify as having lived experience either personally or as a family member/caregiver for someone with mental health conditions and will have some experience utilizing public mental health services. Cohort members will meet a minimum of eight (8) times to create a narrative videos/interviews of the elders' histories. The second component will involve conducting a community forum to present the finalized narrative videos/interviews.
LGBTQIA2-S Panthera Project The goal of the project is to provide an actionable and supportive environment for Black transmasculine community members navigating their mental health within the employment landscape. This project will provide insight and guidance on how strategy, education, and self-advocacy can be used to improve mental health outcomes for Black transmasculine community members. Tools will be developed to provide Black transmaculine community members the knowledge and capacity to secure their mental health while navigating employment with confidence and eliminate the stigma of coming out at work. Adverse experiences in workplace environments can lead to declining mental health and social standing as Black men, which can lead to other negative health outcomes. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project will involve two components. The first component will include outreach and engagement of 25 Black transmasculine community members into a Cohort. Cohort members will meet a minimum of 10 times. The purpose of the meetings will be to provide education on workplace rights as it relates to harassment in the workplace and accessing mental health during and after encounters with harmful workplace environments and educating community members on how to navigate toxic workplace environments while safeguarding their mental health. Additionally, the meetings will address the root causes of financial inequality that threaten self-sustainability amongst Black transmasculine community members. The meetings should also provide attendees with resources in the pursuit of affirming gainful employment and financial literacy in order to improve mental health outcomes. The second component will involve Facilitator and Cohort members designing a survey specific to Black transmasculine community members to identify the specific mental health concerns experienced by this underserved community and any gaps in service delivery, as well as learn how to best serve this community in a culturally sensitive way. This survey should also gather data relative to the employment needs amongst this community and the impact on mental health when facing toxic work environments. The goal will be for a minimum of 100 Black transmasculine community members in Los Angeles County to complete the survey.
LGBTQIA2-S What We Think Project

Project
The goal of the project is to identify the needs of Black Gay Male Elders, while educating and empowering this community about the importance of mental health care in an effort to build awareness and connection. This project aims to address the social isolation, trauma, and mental health issues experienced by Black Gay Male Elders by highlighting the diversity of the population and the need for culturally sensitive resources. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project will involve two components. The first will include outreach and engagement of a minimum of twenty-five (25) Black Gay Male Elders (aged 50+) into a cohort. Cohort members will meet a minimum of ten (10) times to support one another and to develop a survey to be disseminated to Black Gay Male Elder community members throughout Los Angeles County. The goal of the survey will be to identify the specific mental health concerns experienced by this underserved community and any gaps in service delivery, as well as learn how to best serve this community in a culturally sensitive and holistic way. The second component will involve conducting two (2) community town halls focused on the broader issues of aging, and in particular amongst the Black Gay Male Elder population.

FYs 2023-24 ■ PLANNING, OUTREACH AND ENGAGEMENT Continued Work
• LACDMH will continue outreach and engagement activities.

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 25. FY 2021-22 Clients served through PEI

Clients Served	New Clients Served
35,330 clients received a direct mental health service: - 63% of the clients are children - 21% of the clients are TAY - 13% of the clients are adult - 2% of the clients are older adult - 47% of the clients are Hispanic - 8% of the clients are African American - 9% of the clients are White - 1% of the clients are Asian/Pacific Islander - 0.29% of the clients are Native American - 2% of the clients are Multiple Races - 76% have a primary language of English - 21% have a primary language of Spanish	17,084 new clients receiving PEI services countywide: with no previous MHSA service - 42% of the new clients are Hispanic - 8% of the new clients are African American - 9% of the new clients are White - 1% of the new clients are Asian/Pacific Islander - 4% of the new clients are Multiple Races - 0.73% of the new clients are Native American - 75% have a primary language of English - 21% have a primary language of Spanish

Table 26. FY 2021-22 Clients served through PEI by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	2,006	1,203
SA 2 – San Fernando Valley	5,565	2,465
SA 3 – San Gabriel Valley	5,968	3,225
SA 4 – Metro Los Angeles	5,399	2,997
SA 5 – West Los Angeles	1,280	739
SA 6 – South Los Angeles	3,668	1,964
SA 7 – East Los Angeles County	4,501	2,303
SA 8 – South Bay	6,202	3,078

SB 1004 PEI PROGRAM PRIORITY AREAS

All PEI programs are required to comply with WIC Section 5840.7 enacted by Senate Bill 1004 which requires counties to specify how they are incorporating the following six Commission-identified priorities in the FY20-23 MHSA plan:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs;
2. Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan;
3. Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs;
4. Culturally competent and linguistically appropriate prevention and intervention;
5. Strategies targeting the mental health needs of older adults;
6. Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis

Each of these priorities outlined in WIC Section 5840.7/SB 1004 are integrated into our plan and aligned with our previously outlined strategies which are consistent with our community planning process.

Per WIC Section 5840.7/SB 1004, counties are also required to provide an estimate of the share of PEI funding allocated to each priority. The following table provides these estimates:

Table 27. PEI Priority Percentages by SB 1004 Priority Categories

SB 1004 PRIORITY CATEGORIES	% OF FUNDING ALLOCATED BY PRIORITY
Childhood Trauma Prevention and Early Intervention	94%
Early Psychosis and Mood Disorder Detection and Intervention	85%
Youth outreach and engagement strategies that target secondary school and transition age youth	91%
Culturally competent and linguistically appropriate prevention and intervention	95%
Strategies targeting the mental health needs of Older adults	88%
Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis	95%

A. EARLY INTERVENTION

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+
Total Number to be Served for FY 2023-24				
Child: 25,384	TAY: 8,481	Adult: 6,089	Older Adult: 1,007	
Average Cost per Client:	$4,018			
FY 2023-24 Estimated Gross Expenditures	**FY 2022-23 Estimated Gross Expenditures**	**FY 2021-22 Total Gross Expenditures**		
$106,479,000	$34,218,000	$28,379,000		
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 2021-22 ■ EARLY INTERVENTION Data and Outcomes

Table 28. FY 2021-22 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: 34 Gender: 59% Male, 41% Female Ethnicity: 29% Hispanic, 18% White, 6% African American, 47% Unreported	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: 74 Gender: 51% Male, 49% Female Ethnicity: 74% Hispanic, 7% African American, 1% Asian, 5% White, 11% Unreported, 1% Multiple Races	AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.
Brief Strategic Family Therapy (BFST) Children (ages 10-15) TAY (ages 16-18) Unique Clients Served: 1 Gender: 100% Male Ethnicity: 100% Hispanic	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	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

Early Intervention EBP	Description
Unique Clients Served: 24 Gender: 71% Male, 29% Female Ethnicity: 63% Hispanic, 17% Unreported, 13% White , 8% Multiple Races	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: 1,217 Gender: 53% Male, 47% Female Ethnicity: 47% Hispanic, 13% African American, 1% Asian, 10% White, 24% Unreported 4% Multiple Races, 0.33% Native Hawaiian/Pacific Islander, 1% Other	CPP is a psychotherapy model that integrates psycho-dynamic, attachment, trauma, cognitive -behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma.
Crisis Oriented Recovery Services (CORS) Children TAY Adults Older Adults Unique Clients Served: 71 Gender: 20% Male, 80% Female Ethnicity: 17% Hispanic, 8% African American, 1% Asian, 3% White, 61% Unreported, 4% Multiple Races, 6% Other	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: 14 Gender: 57% Male, 43% Female Ethnicity: 29% Hispanic, 64% Unreported, 7% Other	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 Behavioral Therapy (DBT) Children (ages 12-15) TAY (ages 16-20) Unique Clients Served: 182 Gender: 20% Male, 79% Female, 1% Female to Male Ethnicity: 38% Hispanic, 9% African American, 4% Asian, 14% White, 26% Unreported, 2% Native Hawaiian/Pacific Islander, 5% Multiple Races, 2% Other	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: 70 Gender: 53% Male, 47% Female Ethnicity: 16% Hispanic, 1% African American, 1% White, 1% Asian, 73% Unreported, 1% Native Hawaiian/ Pacific Islander, 6% Multiple Races	Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.

Early Intervention EBP	Description
Functional Family Therapy (FFT) Children (ages 11-15) TAY (ages 16-18) Unique Clients Served: 14 Gender: 57% Male, 43% Female Ethnicity: 7% White, 64% Hispanic, 21% Unreported, 7% African American	FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.
Group Cognitive Behavioral Therapy for Major Depression (Group CBT) TAY (ages 18-25) Adults Older Adults Unique Clients Served: 4 Gender: 25% Male, 75% 6emale Ethnicity: 25% Asian, 75% Hispanic	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: 102 Gender: 71% Male, 29% Female Ethnicity: 69% Hispanic, 4% African American, 2% Asian, 14% White, 8% Unreported, 3% Multiple Races, 1% Other	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: 8,394 Gender: 26% Male, 74% Female Ethnicity: 47% Hispanic, 7% African American, 3% Asian, 11% White, 24% Unreported, 1% Native Hawaiian/Pacific Islander, 4% Multiple Races, 0.29% Native American, 2% Other	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: 1,048 Gender: 26% Male, 74% Female Ethnicity: 26% Hispanic, 5% African American, 3% Asian, 8% White, 40% Unreported, 0.38% Native American, 15% Multiple Races, 1% Native Hawaiian/Pacific Islander, 1% Other	IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.

Early Intervention EBP	Description
Loving Intervention Family Enrichment Program (LIFE) Children (ages 0-8) Unique Clients Served: 1 Gender: 100% Female Ethnicity: 100% Hispanic	An adaptation of Parent Project, LIFE is a 22- week skills-based curriculum implemented with parenting classes/ support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/ or school failure.
Managing and Adapting Practice (MAP) Young Children Children TAY (ages 16-21) Unique Clients Served: 11,333 Gender: 45% Male, 55% Female Ethnicity: 44% Hispanic, 6% African American, 1% Asian, 9% White, 34% Unreported, 0.07% Native American, 4% Multiple Races 2% Native Hawaiian/Pacific Islander, 1% Other	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: 986 Gender: 27% Male, 73% Female Ethnicity: 56% Hispanic, 11% African American, 2% Asian, 12% White, 12% Unreported, 3% Multiple Races, 2% Native Hawaiian/Pacific Islander, 0.20% Native American, 1% Other	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: 1,277 Gender: 41% Male, 59% Female Ethnicity: 53% Hispanic, 12% African American, 1% Asian, 16% White, 11% Unreported, 4% Multiple Races, 1% Native Hawaiian/Pacific Islander, 0.08% Native American, 2% Other	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: 616 Gender: 65% Male, 35% Female Ethnicity: 48% Hispanic, 12% African American, 27% Unreported, 6% White, 5% Multiple Races 0.32% Native American, 2% Other	PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/ caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/ caregiver-child patterns.

Early Intervention EBP	Description
Powerful Initiatives for Early Recovery (PIER) Children (ages 12-15) TAY (ages 16-25)	PIER provides early treatment for youth who pose a clinical-high-risk of developing severe mental illness, such as schizophrenia and psychosis. By detecting and treating patients at the onset of psychosis, the negative impact of psychosis may be mitigated. The PIER program assists youth and families to increase performance in all areas of life by building coping skills, reducing stress, and implementing problem-solving techniques.
Problem Solving Therapy (PST) Older Adults Unique Clients Served: 10 Gender: 30% Male, 60% Female, 10% Male to Female Ethnicity: 50% Hispanic, 10% African American, 10% White, 30% 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: 12 Gender: 25% Male, 75% Female Ethnicity: 25% Asian, 8% White, 17% African American, 50% 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: 7 Gender: 29% Male, 71% Female Ethnicity: 43% Hispanic, 14% African American, 43% Unreported,	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: 3 Gender: 33% Male, 67% Female Ethnicity: 67% African American, 33% White	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: 1,198 Gender: 31% Male, 69% Female Ethnicity: 44% Hispanic, 7% African American, 2% Asian, 9% White, 33% Unreported, 4% Multiple Races, 0.75% Native American, 1% Other	SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.

Early Intervention EBP	Description
Stepped Care (SC) Children TAY Adults Older Adults Unique Clients Served: 11,758 Gender: 42% Male, 58% Female Ethnicity: 42% Hispanic, 8% African American, 3% Asian, 9% White, 33% Unreported, 3% Multiple Races, 1% Native Hawaiian/Pacific Islander, 0.25% Native American, 1% Other	This service delivery option intends to improve access to services for clients and families who are experiencing early signs and symptoms of mental illness, require engagement into the mental health system, and are not ready to participate in evidence-based early intervention services. Client level of care received is determined by the initial and ongoing assessment.
Strengthening Families (SF) Children (ages 3-15) TAY (ages 16-18)	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: 2,551 Gender: 36% Male, 64% Female Ethnicity: 41% Hispanic, 8% African American, 7% White, 33% Unreported, 1% Asian 0.31% Native Hawaiian/Pacific Islander, 0.24% Native American, 7% Multiple Races, 2% Other	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: 270 Gender: 65% Male, 35% Female Ethnicity: 33% Hispanic, 4% African American, 9% Asian, 7% White, 3% Multiple Races, 42% Unreported, 0.37% Native Hawaiian/Pacific Islander, 1% Other	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: Gender: 50% Male, 50% Female Ethnicity: 25% Hispanic, 50% White, 25% Unreported	UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho- educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption- specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation).

Table 29. EBP Outcomes since 2009 through June 2022

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
ART	3,432	43%	- 21% Improvement in disruptive behaviors (as reported by parents and children) - 10% Reduction in the severity of problem behaviors (as reported by parents and children) - 14% Improvement in disruptive behaviors (as reported by teachers) - 6% 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	1,729	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 - 100% Reduction in psychotic behaviors - 50% Reduction in aggressive behaviors
CFOF	733	67%	- 30% Improvement in disruptive behaviors - 20% Reduction in the severity of problem behaviors
CAPPS	211	42%	- 60% Reduction in prodromal symptoms
CPP	211	47%	- 17% Improvement in mental health functioning following a traumatic event
CBITS	131	71%	- No Data to Report (n=12)
CORS	4,177	60%	- 19% Improvement in mental health functioning
DBT	303	54%	- 8% Improvement in emotional regulation
DTQI	1,354	65%	- 55% Reduction in symptoms related to depression
FOCUS	754	71%	- 50% Improvement in direct communication
FC	24	44%	- No Data to Report (n=1)
FFT	1,725	66%	- 31% Improvement in mental health functioning
Group CBT	1,143	42%	- 42% Reduction in symptoms related to depression
IY	2,864	64%	- 35% Reduction in disruptive behaviors - 18% Reduction in the severity of problem behaviors
Ind. CBT	Anxiety 3,972 Depression 7,946 Trauma 1,154	Anxiety 46% Depression 45% Trauma 48%	- 63% Reduction in symptoms related to anxiety - 58% Reduction in symptoms related to depression - 60% Reduction in trauma related symptoms
IPT	8,604	49%	- 54% Reduction in symptoms related to depression
LIFE	433	65%	- 50% Reduction in disruptive behaviors - 23% Reduction in the severity of problem behaviors
MAP	69,118	50%	- 43% Reduction in disruptive behaviors - 25% Reduction in the severity of problem behaviors - 55% Reduction in symptoms related to depression - 44% Reduction in symptoms related to anxiety - 48% Reduction in trauma related symptoms
MHIP	Anxiety 2,995 Depression 6,933 Trauma 302	Anxiety 38% Depression 33% Trauma 29%	- 54% 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	4,868	40%	- 61% Reduction in disruptive behaviors - 36% Reduction in the severity of problem behaviors
PIER	75	18%	- No Data to Report

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
PST	412	63%	- 45% Reduction in symptoms related to depression
PEARLS	173	49%	- 45% Reduction in symptoms related to depression
PE-PTSD	99	57%	- No Data to Report (n=14)
PATHS	747	33%	- 33% Reduction in disruptive behaviors - 19% Reduction in the severity of problem behaviors
RPP	252	71%	- 15% Reduction in disruptive behaviors - 6% Reduction in the severity of problem behaviors
SS	21,273	40%	- 51% Reduction in trauma related symptoms (Adults) - 44% Reduction in trauma related symptoms (Children)
SC	10,559	100%	- 24% Improvement in mental health functioning
SF	237	89%	- No Data to Report (n=15)
TF-CBT	26,904	54%	- 51% Reduction in trauma related symptoms
Triple P	6,545	60%	- 50% Reduction in disruptive behaviors - 27% Reduction in the severity of problem behaviors
UCLA TTM	196	50%	- No Data to Report (N=11)

B. PREVENTION

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+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$132,105,000	$85,010,000	$63,021,000

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.

FY 2021-22 ■ PREVENTION Data and Outcomes

B1. Community Partnerships

- Antelope Valley Community Family Resource Centers (AV-CFRC)

  The Antelope Valley Community Family Resource Centers are intended to reimagine service delivery, create career pathways, reduce stigma related to mental health while also reducing risk factors, improving protective factors and to embrace children, families and communities as change agents. The AV CFRC is designed to create a coordinated (public/private) community owned and driven space, or network of spaces, where families and individuals in the AV can easily access the services they need to enhance their wellbeing. The CFRCs will be using Community Outreach Services to support, create and share tools and resources that help residents and partner agencies take actions that build upon the resilience of the community to respond to the major stressors that impact individual, child and family wellbeing. Part of the AV-CFRC support is to get true community buy in and support by using Community Ambassadors and co-located partners (such as Antelope Valley Partners for Health (AVPH), Foundation Christian Ministries, and the Wilsona School district) to provide such resources and linkages to address social, housing, food, clothing, employment and any other resource that could mitigate mental health issues.

  The number of surveys collected for the Community Outreach Services (COS) under the Antelope Valley Community Family Resource Center (AV-CFRC) came to a total of 83 surveys, while the number of people served in this program exceeded 500 individuals. Unfortunately, there was a gap between service delivery and survey administration, and only a percentage of the individuals served elected to respond to the surveys. That said, there was a significant positive response to the single event services provided as evidenced by verbal testimonials and via the one-time event surveys, as they demonstrated that the over 70% of those who completed one-time event surveys reported strong in social connectedness/sense of belonging, knowledge of human behavior/development, family functioning/resiliency, nurturing/attachment, concrete supports, hopefulness. Additionally, over 75% reported that they would return for future events/activities and recommend others.

Table 29. FY 2021-22 Demographics – AV-CFRC

Demographics	FY 21-22 (n = 83)		Demographics	FY 21-22 (n = 83)
▪ Primary Language			▪ Ethnicity	
English	65		Hispanic or Latino	
Spanish	14		Central American	3
Declined to Answer	4		Mexican/Mexican-American	30
▪ Sex Assigned at Birth			South American	2
Male	8		Other Hispanic	2
Female	72		Non-Hispanic or Non-Latino follows:	
Declined to Answer/Missing/Unknown	3		Other Non-Hispanic or Non-Latino	14
▪ Current Gender Identity			More than one ethnicity	5
Male/Man	9		Declined to Answer/Missing/Unknown	27
Female/Woman	72		▪ Race	
Another Gender Identity	2		American Indian or Alaska Native	1
Declined to Answer/Missing/Unknown	2		Black or African-American	29
▪ Sexual Orientation			White	23
Gay or Lesbian	2		More than one race	7
Heterosexual or Straight	60		Other	15
Bisexual	1		Declined to Answer/Missing/Unknown	8
Declined to Answer/Missing/Unknown	20		▪ Age	
▪ Disability			16-25	7
No	55		26-59	68
Yes	19		60+	7
Mental disability	7		Declined to Answer/Missing/Unknown	1
Physical/mobility disability	6		▪ Veteran Status	
Chronic health condition	9		Yes	2
Difficulty seeing	1		No	79
Difficulty hearing	2		Declined to Answer/Missing/Unknown	2
Another type of disability	3			
Declined to Answer/Missing/Unknown	9			

- Friends of the Children LA (FOTC-LA)

FOTC-LA ("Friends") aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at high risk of entering foster care, and who are facing challenges like intergenerational poverty and multiple Adverse Childhood Experiences. The program currently focuses on children residing in the Antelope Valley, where professional "friends" support a child and their family for 12+ years. The focus is on developing parental resilience, social connections, knowledge of parenting and child development, concrete supports, and social and emotional competence of children.

Twenty-nine parents or caregivers were surveyed (some have multiple children enrolled in FOTC-LA) about their participation in the program.

- 92% said Friends connected them to concrete supports that enrich and stabilize their family
- 88% said their child's behavior had improved, making their home a more positive place
- 91% said Friends helped them support their child's school success
- 86% said Friends supported them to better understand their child's needs and strengths

Table 30. FY 2021-22 Demographics – FOTC-LA

Demographics	Count (n = 48)		Demographics	Count (n = 48)
▪ Primary Language			▪ Ethnicity	
English	44		Hispanic or Latino as follows:	
Spanish	4		Other/Unknown Hispanic	22
▪ Age			Non-Hispanic or Non-Latino as follows:	
<16	48		African	23
▪ Sex Assigned at Birth			Declined to Answer	3
Male	32		▪ Race	
Female	16		Black or African-American	23
▪ Disability			White	25
No	48			

- Incubation Academy

  The Incubation Academy is a capacity-building project in collaboration with Community Partners. The project provides mentorship, training, technical support and financial resources for 29 small and mid-sized grassroot organizations that are providing prevention-related mental health activities within their communities. The organizations vary in their programming and target population as the goal is to prepare such organizations to compete for future contracting with DMH.

Table 31. FY 2021-22 Demographics – Incubation Academy

Demographics	Count (n = 13,836)	Demographics	Count (n = 13,836)
▪ Primary Language		▪ Ethnicity	
Arabic	3	Hispanic or Latino as follows:	
Armenian	1	Caribbean	10
Cantonese	1	Central American	115
English	2,094	Mexican/Mexican American/Chicano	665
Farsi	4	Puerto Rican	7
Korean	3	South American	18
Mandarin	1	Other Hispanic/Latino	122
Spanish	406	Non-Hispanic or Non-Latino as follows:	
Tagalog	4	African	144
American Sign Language	1	Asian Indian/South Asian	6
Other	16	Cambodian	1
Declined to answer/Missing/Unknown	11,286	Chinese	3
▪ Sex Assigned at Birth		Eastern European	32
Male	790	European	393
Female	1,388	Filipino	14
Declined to answer/Missing/Unknown	11,658	Japanese	3
▪ Current Gender Identity		Korean	3
Male/Man	841	Middle Eastern	12
Female/Woman	1,331	Vietnamese	1
Transgender	6	Other	63
Genderqueer/Non-Binary	19	More than one ethnicity	70
Another Gender Identity	2	Declined to answer/Missing/Unknown	12,154
Declined to answer/Missing/Not sure what question means	11,328	▪ Race	
▪ Sexual Orientation		American Indian or Alaska Native	70
Gay or Lesbian	106	Asian	52
Heterosexual or Straight	1,040	Black or African-American	489
Bisexual	32	Native Hawaiian or Pacific Islander	14
Questioning or Unsure	16	White	883
Queer	20	More than one race	105
Another Sexual Orientation	2	Other	487
Declined to answer/Missing/Unknown	12,314	Declined to answer/Missing/Unknown	11,736
▪ Disability		▪ Age	
No	1,423	<16	724
Yes	250	16-25	568
Mental domain	106	26-59	1,158
Physical/mobility domain	58	60+	309
Chronic health condition	52	Declined to answer/Missing/Unknown	11,077
Difficulty seeing	34	▪ Veteran Status	
Difficulty hearing	19	Yes	96
Another type of disability	8	No	1,684
Declined to answer/Missing/Unknown	12,163	Declined to answer/Missing/Unknown	11,750

- Los Angeles Unified School District (LAUSD)

LAUSD conducts a variety of mental health promotion and risk prevention activities with students and their parents. In FY 2021-22, some of the programs provided included Bounce Back, CBITS, Erika's Lighthouse, FOCUS Resilience Curriculum, Second Step, and Seeking Safety. In FY 2020-21, these programs served over 32,000 students and parents.

Table 32. FY 2021-22 Demographics - LAUSD

Demographics	Count (n = 32,841)		Demographics	Count (n = 32,841)
▪ Primary Language			▪ Ethnicity**	
English	14,982		Hispanic or Latino as follows:	
Arabic	52		Mexican/Mexican-American/Chicano	5
Armenian	148		Other/Unknown Hispanic	24,933
Farsi	75		Non-Hispanic or Non-Latino as follows:	
Cambodian	7		Cambodian	15
Cantonese	37		Chinese	62
Korean	68		Filipino	394
Mandarin	17		Japanese	27
Russian	69		Korean	95
Spanish	16,499		Vietnamese	45
Vietnamese	26		Other Non-Hispanic	454
Other	527		More than one ethnicity	672
Declined to answer/missing	334		Declined to answer/missing	6,139
▪ Age			▪ Race**	
<16	23,974		Asian	645
16-25	8,867		Black or African-American	4,277
▪ Disability*			Native Hawaiian or other Pacific Islander	574
No	27,645		White	23,395
Yes	5,196		Other	778
Mental disability	250		Declined to answer/missing	3,172
Physical/mobility disability	36		▪ Gender	
Difficulty seeing	7		Male	14,715
Difficulty hearing	1,287		Female	18,126
Another type of disability	3,616			

*Disability is not collected by LAUSD. In the past, students enrolled in Special Education were coded as "Yes" while those not enrolled in Special Education were coded as "Declined to answer/missing" while this year they were coded as "No".

**Ethnicity and race were collected as one category by LAUSD. In the past, students identified as Hispanic or Latino were re-coded as "Other" race while this year they were re-coded as "White" race.

- 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. On November 20, 2018, the Board of Supervisors approved numerous changes to the MHLA agreement with Community Partner Clinics (CPs). A workgroup was formed to understand gaps in behavioral healthcare access and how to address those gaps. The group identified as a priority the need to better support CPs who provide mental health care services to MHLA participants in a primary care setting. It was determined 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 CPs through a Prevention Program. As of September 2019, approximately 142,000 individuals were enrolled in the program.

  In this second year of this piloted program of integrating MHPS into CPs, a primary objective was to address any implementation challenges that surfaced in year one, and where feasible, make the necessary program modifications to further the original mission and objectives established in year one. As in year one of this piloted program, the ongoing Covid-19 Pandemic continued to impact each of the participating CPs' workforce. These community-based health care clinics remained on the front line in their respective communities for handling Covid-19 education and information dissemination, treatment, testing, and vaccinations. The CP staff had again been pulled in multiple directions to help their community manage the Pandemic while continuing with their implementation efforts of this MHPS Program. Some new program implementation challenges from year one, such as staffing logistics (new hires), revisions to business workflows (claiming and billing processes) and clinical workflows (referrals to and from MHPS), etc. remained as second year challenges as well.

  Despite the challenges outlined above, in this second year of the piloted program, MHPS outcome metrics [Patient Health Questionnairre-9 (PHQ-9) as the required measure in the MHPS screening, and the Generalized Anxiety Disorder-7 (GAD-7) as the optional second measure] were able to be collected, aggregated, data mined and reported. The number of unique MHLA patients receiving at least one MHPS for the period of July 1, 2021 through and including April 30, 2022 was 28,593*.

  Table 33. FY 2021-22 Outcomes - MHPS

Name of Outcome Measure	Total Number of Reported Cases with both a Pre and Post Score	Average Pre-Score	Average Post Score	Average Percentage Score Change	Average Number of Sessions
Anxiety (GAD-7)	114	7.51	4.25	43.34%	6.8
Depression (PHQ-9)	336	7.92	4.32	45.40%	7.2

  Among those who were assessed at both the beginning of the program and end of the program, the average GAD-7 score decreased by more than 43%, while the average PHQ-9 score decreased by more than 45%, indicating there was an overall decline in both self-reported anxiety and depression symptoms through the course of programming (Table 5).

  *At the time this information was generated, data for the months of May and June were not yet available. Additionally, the number of MHLA enrollees fluctuated in a downward trend with the final number of enrollees for FY21-22 at 94,892. Much of the final decline

in the number of MHLA enrollees was attributed to the new California law which gave full scope Medi-Cal to adults 50 years of age and older, regardless to immigration status.

Table 34. FY 2021-22 Demographics – MHPS

Demographics	Count (n = 28,593)		Demographics	Count (n = 28,593)
▪ Primary Language			▪ Ethnicity**	
English	1,746		Hispanic or Latino as follows:	
Arabic	1		Other/Unknown Hispanic	26,907
Armenian	89		Non-Hispanic or Non-Latino as follows:	
Farsi	2		Asian Indian/South Asian	9
Khmer/Cambodian	6		Cambodian	6
Korean	11		Chinese	5
Chinese (multiple dialects)	20		Filipino	340
Hindi	5		Japanese	1
Russian	17		Korean	18
Spanish	26,459		Vietnamese	4
Tagalog	23		Other Non-Hispanic	1
Thai	129		▪ Race**	
Vietnamese	4		Asian	365
Other	16		Black or African-American	44
Declined to answer/missing	65		Native Hawaiian or other Pacific Islander	5
▪ Age			White	161
26-64	25,881		Other/mixed	63
65+*	2,712		Declined to answer/missing	664
▪ Gender				
Male	10,038			
Female	18,548			
Other	7			

*DHS uses 65+ to indicate elderly whereas MHSA uses 60+.
**Ethnicity and race were collected as one category by DHS.
Table 35. Library programs deliverable

- Nurse Family Partnership (NFP)

The Nurse Family Partnership (NFP) is a program implemented by the Department of Public Health which targets high-risk, low-income, pregnant women, or parents/caregivers with children between the ages of 0 and 5 years old. A woman can receive services through the child's second birthday. As a result of the pandemic, the majority of services were delivered via telehealth and a small portion were delivered in person. 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 NFP home visitors were also enhanced through trainings so that they can recognize mental health risk factors and refer for mental health treatment when deemed necessary.

Nurse Family Partnership (NFP) targets child abuse and neglect, preterm births, risky health behaviors, reliance on public assistance, and crime. Home visitors target potential negative outcomes by working with parents/caregivers in the following areas: personal health; parental role; child health and development; reproductive health practices; and case management including referral and linkage to concrete supports. NFP interventions target the improvement of the following protective factors: parental resilience, social connections, concrete support, knowledge of parenting and child development, and social and emotional competence of children.

NFP uses the Parents' Assessment of Protective Factors (PAPF) to determine outcomes. However due to the limited number of home visits because of the pandemic, results were not conclusive. NFP served 267 parents/caregivers in FY 2021-22. Demographics are provided for those who were newly enrolled in FY 2021-22.

Table 35. FY 2021-22 Demographics - NFP

Demographics	Count (n = 149)	Demographics	Count (n = 149)
▪ Primary Language		▪ Ethnicity	
English	91	Hispanic or Latino as follows:	
Spanish	53	Central American	17
Other	1	Mexican/Mexican American/Chicano	69
Declined to answer	4	Puerto Rican	3
▪ Age		South American	5
0-15	2	Other Hispanic	43
16-25	76	Non-Hispanic or Non-Latino as follows:	
26-59	61	African	4
Declined to answer	10	Filipino	3
▪ Gender Assigned at Birth		More than one ethnicity	2
Female	140	Declined to answer	3
Declined to answer	9	▪ Race	
▪ Current Gender Identity		American Indian	4
Female/Woman	140	Asian	6
Declined to answer	9	Black or African-American	3
▪ Sexual Orientation		White	131
Heterosexual or Straight	129	More than one race	2
Declined to answer	20	Declined to answer	3
▪ Disability		▪ Veteran Status	
No	42	No	126
Yes	93	Declined to answer	23
Mental domain	33		
Chronic health condition	1		
Other	8		
Declined to answer	14		

- Prevention & Aftercare (P&A)

Prevention and Aftercare (P&A) is a DCFS-monitored program of ten leading community agencies proving a variety of services to the community to empower, advocate, educated, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of Adverse Childhood Experiences (ACEs) and social determinants of health. Program services are delivered in-person and virtually and can be from one time to a year or ongoing.

Prevention and Aftercare program services are to be offered and rendered to all families Countywide, who meet one or more of the following criteria:

1. Children and families at-risk of child maltreatment and/or DCFS involvement self-referred or referred by community stakeholders such as DMH Specialized Foster Care (SFC) offices, schools, hospitals, and law-enforcement agencies.
2. Children and families with unfounded, closed child abuse DCFS referrals.
3. Children and families with evaluated out DCFS child abuse and/or neglect referrals.
4. DCFS referred clients, who are receiving Family Reunification services.

5. DCFS referred children and families who have exited the public child welfare system and are in need of services to prevent subsequent child maltreatment and/or DCFS involvement.

Negative outcomes identified by MHSA and which participants of P&A may be risk of that may result from untreated, undertreated or inappropriately treated mental illnesses are: 1) suicide, 2) incarceration, 3) school failure or dropout, 4) unemployment, 5) prolonged suffering, 6) homelessness, and 7) removal of children from their homes.

It was estimated that 8,464 people attended P&A single events. With only one person per family completing a survey, there were 2,290 surveys collected. On average over 85% of families surveyed reported that they felt that because of the one-time event they were able to:

- Connect with others
- Learn something new about themselves
- Learn about community programs and/or resources that can be useful and increase access
- Learned something new and will be doing something different with their family

The following findings are based on 1,049 Protective Factors Surveys administered at baseline and after completion of multi-session P&A case navigation services. There was a general increase in protective factors from families from baseline to end of services. The most notable increases were in:

- Parent/caregiver resilience: score increased from 2.8 to 3.1
- Social connections: score increased from 2.7 to 3.0
- Knowledge of parenting and child development: score increased from 2.7 to 3.0
- Social and emotional competence of children: 4.0 to 4.2
- Social and emotional competence of adults: 4.0 to 4.1
- Caregiver/Practitioner Relationship: 3.0 to 3.2

Table 36. FY 2021-22 Demographics – P&A

Demographics	Count (n = 1,049)	Demographics	Count (n = 1,049)
▪ Primary Language		▪ Ethnicity	
Cambodian	1	Hispanic or Latino as follows:	
Cantonese	1	Caribbean	3
English	487	Central American	91
Farsi	1	Mexican/Mexican American/Chicano	367
Korean	7	Puerto Rican	6
Spanish	233	South American	11
Declined to answer/Missing/Unknown	319	Other Hispanic/Latino	70
▪ Sex Assigned at Birth		Non-Hispanic or Non-Latino as follows:	
Male	141	African	63
Female	601	Asian Indian/South Asian	6
Declined to answer/Missing/Unknown	307	Cambodian	4
▪ Current Gender Identity		Chinese	7
Male/Man	138	European	10
Female/Woman	597	Filipino	11
Genderqueer/Non-Binary	1	Japanese	1
Another Gender Identity	1	Korean	7
Declined to answer/Missing/Not sure what question means	312	Middle Eastern	5
		Other	13
▪ Sexual Orientation		More than one ethnicity	18
Gay or Lesbian	3	Declined to answer/Missing/Unknown	356
Heterosexual or Straight	676	▪ Race	
Bisexual	14	American Indian or Alaska Native	56
Questioning or Unsure	3	Asian	31
Queer	3	Black or African-American	116
Another Sexual Orientation	23	Native Hawaiian or Pacific Islander	1
Declined to answer/Missing/Unknown	352	White	132
▪ Disability		More than one race	26
No	402	Other	310
Yes	219	Declined to answer/Missing/Unknown	377
Mental domain	51	▪ Age	
Physical/mobility domain	30	16-25	46
Chronic health condition	93	26-59	459
Difficulty seeing	17	60+	16
Difficulty hearing	10	Declined to answer/Missing/Unknown	528
Another type of disability	18	▪ Veteran Status	
Declined to answer/Missing/Unknown	428	Yes	10
		No	700
		Declined to answer/Missing/Unknown	339

- Prevent Homelessness Promote Health (PH^2)

Prevent Homelessness Promote Health (PH^2) is a collaboration between Los Angeles County Department of Health Services (DHS): 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 - PH^2 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 PH^2 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 PH^2 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 cumulative number of new individuals served during this reporting period is 172. This is not inclusive of 21 unique individuals that carried over from last reporting period that continued to be provided service. Total individuals served during this reporting period is 213.

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 PH^2 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 PH^2 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 PH^2 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 PH^2 Activity Log in IBHIS tracks Peak Eviction Risk Level during the participant's engagement in PH^2. 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 37. FY 2021-22 PH[2] Linkages to Each Resource

Mental Health Services	257
Primary Care Physician	45
Department of Health Services	41
Housing and Supportive Services	29
Food Bank	22
Emergency Services	14
Transportation	12
Adult FSP	10
CBEST	6
Calfresh	4
Social Security	3
General Relief	3
Other (ICMS, IHSS, IHCG, groceries, clothing, utility assistance, etc.)	100

Note: Referrals can have multiple linkages

The most common linkages provided by PH[2] were to mental health services, followed by primary care physicians, DHS, and housing and supportive services (Table 9).

Of the 156 closed cases, 74 clients had an eviction prevented. 68 clients were linked to appropriate mental health services. For only seven closed cases was eviction not prevented (Table 10).

Table 38. FY 2021-22 PH[2] Disposition of Closed Cases

	Count (n = 156)
Eviction Prevented	74
Linked to Appropriate MHS	68
No Current Risk of Eviction	19
Eviction not Prevented	7
Could not Locate	29
Declined Services	45
Unknown/Other	19

Note: clients can have more than one closure reason.

Table 39. FY 2021-22 Demographics – PH[2]

	Count (n = 171)
▪ Primary Language	
English	146
Spanish	7
Declined to answer/Missing/Unknown	18
▪ Sex Assigned at Birth	
Male	99
Female	72
▪ Current Gender Identity	
Male/Man	91
Female/Woman	67
Transgender man/Transmasculine	2
Undecided/unknown	8
Declined to answer/ask or Missing or Not sure what question means	3
▪ Sexual Orientation	
Heterosexual or Straight	53
Gay or Lesbian	7
Undecided/Unknown	112
▪ Age	
16-25	1
26-59	118
60+	52
▪ Disability	
No	20
Yes	62
Mental domain	43
Physical/mobility domain	28
Chronic health condition	14
Difficulty seeing	2
Difficulty hearing	1

	Count (n = 171)
▪ Ethnicity	
Hispanic or Latino as follows:	
Caribbean	1
Central American	2
Mexican/Mexican American/Chicano	20
Puerto Rican	1
Other Hispanic/Latino	7
Non-Hispanic or Non-Latino as follows:	
Asian Indian/South Asian	2
European	1
Korean	3
Middle Eastern	1
Other	68
More than one ethnicity	2
Declined to answer/Missing/Unknown	63
▪ Race	
American Indian	1
Asian	4
Black or African-American	39
White	25
More than one race	2
Other*	37
Declined to answer/Missing/Unknown	63
▪ Veteran Status	
Yes	5
No	74
Declined to answer/ask or Missing or Unknown	92

	Count (n = 171)			Count (n = 171)
▪ Primary Language			▪ Ethnicity	
English	146		Hispanic or Latino as follows:	
Spanish	7		Caribbean	1
Declined to answer/Missing/Unknown	18		Central American	2
▪ Sex Assigned at Birth			Mexican/Mexican American/Chicano	20
Male	99		Puerto Rican	1
Female	72		Other Hispanic/Latino	7
▪ Current Gender Identity			Non-Hispanic or Non-Latino as follows:	
Male/Man	91		Asian Indian/South Asian	2
Female/Woman	67		European	1
Transgender man/Transmasculine	2		Korean	3
Undecided/unknown	8		Middle Eastern	1
Declined to answer/ask or Missing or Not sure what question means	3		Other	68
			More than one ethnicity	2
▪ Sexual Orientation			Declined to answer/Missing/Unknown	63
Heterosexual or Straight	53		▪ Race	
Gay or Lesbian	7		American Indian	1
Undecided/Unknown	112		Asian	4
▪ Age			Black or African-American	39
16-25	1		White	25
26-59	118		More than one race	2
60+	52		Other*	37
▪ Disability			Declined to answer/Missing/Unknown	63
No	20		▪ Veteran Status	
Yes	62		Yes	5
Another communication disability	1			
Another type of disability	2			
Declined to answer/ask or Missing or Unknown	89			

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

- Strategies for Enhancing Early Developmental Success (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 12 cohorts of this training series with 317 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)

On an item measuring global satisfaction with the series (rated on a 10-point scale, with 1 = extremely unsatisfied and 10 = extremely satisfied), participants' mean rating was 9.38, suggesting a high level of satisfaction overall with the training series.

In addition, 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 6.1, whereas at the post-training assessment they had a mean score of 8.5, indicating a mean improvement of 2.4.

Table 40. FY 2021-22 Outcomes - SEEDS

Knowledge/Skill Domain	Pre-training % correct	Post-training % correct	Change from pre- to post-
1. Trauma-informed approach/using observation with infants	100%	100%	0%
2. Co-regulating using sensory inputs	23%	75%	+52%
3. Self-regulation in infants and toddlers	77%	75%	-2%
4. Trauma-informed approach: using observation with toddlers	54%	100%	+46%
5. Trauma-informed approach: what types of questions to ask ourselves before intervening	69%	75%	+6%
6. Goal for adult caregivers is not to prevent the child's dysregulation, but to attempt co-regulation to strengthen relationship	39%	88%	+49%
7. Relationships as crucial for infants' and toddlers' development	62%	88%	+26%
8. Responding in hot moments	69%	100%	+31%
9. Child-led play, skills of duplicate and elaborate	54%	63%	+9%
10. Hot and cool moments	62%	88%	+26%

The percentage of participants that answered correctly improved dramatically in several domains (by about 50% each), including the skills *co-regulating using sensory inputs* and *trauma-informed approach of using observation with* toddlers, and the knowledge domain *goal for adult caregivers is not to prevent the child's dysregulation, but to attempt co-regulation to strengthen relationship* (Table 12).

- 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.

1. Under VPAN, DMH and SoCal 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.

Peer services are provided from 8:00am-6:00pm, five days per week, Monday through Friday. Community events may be held on weekends. The program is delivered based on the client's needs in-person, by phone, or virtually. In FY 2021-22, 3,324 veterans and military family members were served through VPAN CBOs.

2. 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.

In FY 2021-22, the Veteran Support Line received a total of 10,546 calls, of which 162 were assigned to VPAN field staff for follow-up. Due to the nature of the support line, a referral is generated, and demographics collected only when the caller is requesting services and/or benefits.

3. In addition, under the VPAN Veteran System Navigators program, the Department of Military and Veterans Affairs (DMVA) provides benefits establishment, reducing potential 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. The DMVA County Veterans Service Office has secured more than $ 27 million dollars in benefits for veterans, their dependents, and survivors. Veterans Systems Navigators lead the way in ensuring veterans in the community apply for and secure benefits they have earned, relieving financial stress during transition periods, preventing homelessness by assisting with housing resources, and enrolling veterans into Department of Veterans Affairs Healthcare/Mental Health to include Veterans Centers so veterans can receive the care they need and deserve.

DMVA served a total of 812 clients in FY 2021-22.

The different VPAN programs have different data collection procedures, with variable questions and response options, such that in many cases entire categories are missing. It is also possible that some participants are represented in multiple datasets. That said, the following is available demographic data on VPAN participants.

Table 41. FY 2021-22 Demographics – VPAN

	Count (n=15,824)			Count (n=15,824)
▪ Age			▪ Ethnicity	
0-15	3		Hispanic or Latino as follows:	
16-25	320		Mexican/Mexican-American/Chicano	192
26-59	2,903		Other Hispanic	861
60+	2,046		Non-Hispanic or Non-Latino as follows:	
Declined to Answer/Missing/Unknown	10,552		Other Non-Hispanic	1,962
▪ Sex Assigned at Birth			Declined to Answer/Missing/Unknown	12,809
Male	4,017		▪ Race	
Female	1,024		American Indian or Alaska Native	50
Declined to Answer/Missing/Unknown	10,783		Asian	200
▪ Current Gender Identity			Black or African-American	1,047
Male / Man	4,017		Native Hawaiian or other Pacific Islander	55
Female / Woman	1,024		White	1,570
Genderqueer / Non-Binary	7		Other	811
Another Gender Identity	4		More than one race	152
Declined to Answer/Missing/Unknown	10,772		Declined to Answer/Missing/Unknown	11,939
▪ Sexual Orientation			▪ Primary Language	
Heterosexual or Straight	812		English	4,136
Declined to Answer/Missing/Unknown	15,012		Declined to Answer/Missing/Unknown	11,688
▪ Disability			▪ Veteran	
No	978		No	519
Yes	1,992		Yes	4,656
Mental Disability	112		Declined to Answer/Missing/Unknown	10,649
Physical/Mobility Disability	92			
Chronic Health Condition	617			
Difficulty Seeing	20			
Difficulty Hearing	83			
Declined to Answer/Missing/Unknown	12,854			

- Youth-Community Ambassador Network (CAN-Youth)

  The Los Angeles Trust for Children's Health (The L.A. Trust) was contracted by California Mental Health Services Authority (CalMHSA) to support the Los Angeles County Department of Mental Health (LACDMH) by developing the Youth Community Ambassador Program. The aim is to co-create a Youth Peer Ambassador Program in partnership with students and LAUSD school mental health staff focused on prevention and navigation to care. The L.A. Trust provides oversight of the activities, training, staffing, and student stipend distribution, for the Community Ambassador Network-Youth (CAN Youth) program within the Los Angeles Unified School District (LAUSD). High school students within selected LAUSD school sites are recruited and vetted to serve on the Student Advisory Boards as trained Youth Community Ambassadors and serve as mental health access agents, navigators, and mobilizers within their school communities. Youth Community Ambassadors leverage their peer relationships to support mental health, driving a collective self-help model to promote healing, recovery, and youth empowerment.

  In FY 2021-22, 16,792 youth were served through CAN Youth. A survey was developed by the UCLA evaluators. However, the requirements for approval from LAUSD and parental consent delayed data collection such that surveys were only completed by 11 respondents.

Table 42. FY 2021-22 Demographics – CAN Youth

	Count (n = 11)			Count (n = 11)
▪ Primary Language			▪ Ethnicity	
English	11		Hispanic or Latino as follows:	
▪ Age			Central American	1
16-25	11		Mexican/Mexican-American/Chicano	5
▪ Current Gender Identity			Other Hispanic	1
Declined to answer/Missing	11		Non-Hispanic or Non-Latino as follows:	
▪ Sex Assigned at Birth			Asian	3
Male	1		Other Non-Hispanic	1
Female	10		▪ Race	
▪ Sexual Orientation			Black or African-American	2
Heterosexual or Straight	8		White	1
Bisexual	1		Other	2
Questioning or Unsure	1		More than one race	1
Declined to Answer/Missing	1		Declined to answer	5
▪ Veteran			▪ Disability	
No	11		No	10
			Declined to Answer/Missing	1

- Center for Strategic Partnership
  Joint collaboration to support philanthropic engagement and strategic consultation on various complex countywide Board directed initiatives and priorities.

- Los Angeles County Office of Education
  LACOE CS focus on both academic and out-of-school factors that impact high school students' lives. LACOE CS targets high school students from 15 school districts. Currently each of the 15 districts has one identified high school site. The LACOE CS model supports schools in becoming centralized hubs for students and their families to receive greater access to a continuum of services that range from concrete supports, school resources, staff support, mental health prevention services and referrals/linkages to community resources.

B2. Prevention: Community Outreach

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

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

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

COS Outcomes

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

In FY 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 2022-23.

Table 43. Programs approved for billing PEI COS

Prevention Program	Description
Active Parenting Parents of children (3-17)	Active Parenting provides evidence-based, video-based, group parenting classes that cover topics including parenting skills training, step-parenting, managing divorce, school success, and character education. Active Parenting classes can be delivered in 1, 3, 4, or 6 group sessions. Curriculum addresses: child development, appropriate discipline, communication skills, decision-making and prevention of risk behaviors.
Arise Children (4-15) TAY (16-25) Adult (26-59) Older Adult (60-64)	Arise provides evidence-based life skills group based curricula and staff training programs. Programs are geared towards at-risk youth; however, the program is adaptable for adults as well. Program content focuses on violence reduction, goal setting, anger management, drug and alcohol avoidance and other life management skills.
Asian American Family Enrichment Network (AAFEN) Parents of Children (12-15) TAY (16-18)	AAFEN is for Asian immigrant parents and/or primary caregivers with inadequate parenting skills to effectively discipline and nurture their teenage children. Because of the cultural and linguistic barriers experienced by many of these immigrant parents, they often feel overwhelmed and incompetent in terms of effectively managing their family lives. Moreover, their children experience reduced family attachment and social functioning, as well as increased family conflict. The children are thus at high risk for emotional and behavioral problems. Their immigrant parents and/or primary caregivers are at high risk for depressive disorders and for being reported to DCFS to corporal punishment.
Childhelp Speak Up and Be Safe Children (3-15) TAY (16-19)	This is a child-focused, school-based curriculum designed to build safety skills within the child while addressing today's societal risks, such as bullying and Internet safety. The program helps children and teens learn the skills to prevent or interrupt cycles of neglect, bullying, and child abuse. The program focuses on enhancing the child's overall sense of confidence regarding safety and promotes respect for self and peers that can be applied to general as well as potentially harmful situations. In addition to increasing children's ability to recognize unsafe situations or abusive behaviors and building resistance skills, lessons focus on helping children build a responsive safety network with peers and adults that the child identifies as safe.
Coping with Stress Child (13-15) TAY (16-18)	This course consists of 15 one-hour sessions, which can be offered at a pace of 2 to 4 times per week, depending on site capabilities and needs. The first few sessions provide an overview of depression, its relationship to stressful situations, and an introduction to other group members. Subsequent sessions focus on cognitive-restructuring skills and techniques for modifying irrational or negative self-statements and thoughts which are hypothesized to contribute to the development and maintenance of depressive disorders.

Prevention Program	Description
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.
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

Prevention Program	Description
	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.
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.

Prevention Program	Description
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.

C. STIGMA AND DISCRIMINATION REDUCTION (SDR)

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+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$81,836,000	$21,301,000	$6,940,000

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 2021-22 ■ 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.

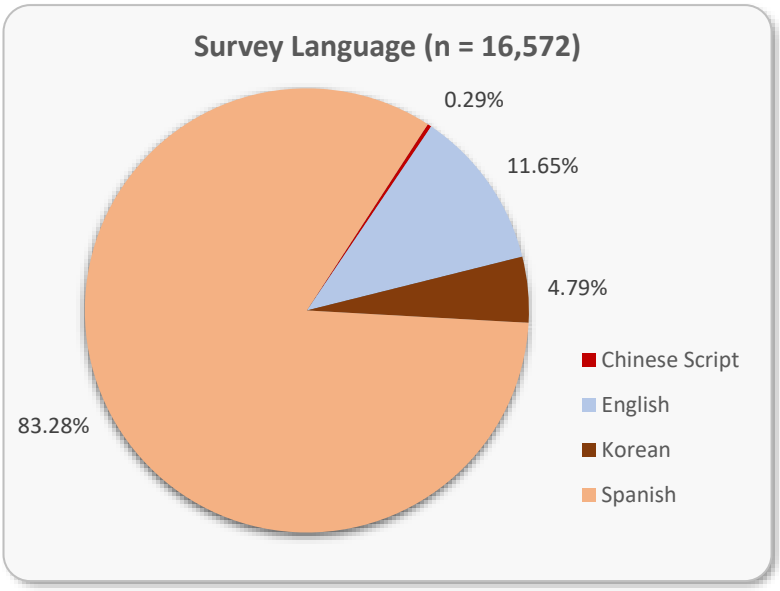
C4. SDR Outcomes

Los Angeles County's Department of Mental Health has implemented Stigma Discrimination Reduction (SDR) programs in the form of training and education. Trainings have the goals of decreasing 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 used the California Institute of Behavioral Health Services' (CiBHS) SDR Program Participant Questionnaire, a brief measure that assesses the impact of trainings on participants': 1) attitudes and behavior toward persons with mental illness 2) knowledge about stigma towards persons with mental illness 3) awareness of ways to support persons who may need mental health resources. In addition, the questionnaire measures training quality and participant demographics.

This write-up discusses the results of data analyses performed on the SDR questionnaires administered to assess SDR trainings that were conducted during the 2021-2022 Fiscal Year (FY), from July 2021 through June 2022. The number of surveys collected in FY 21-22 (16,572) increased dramatically from the previous FY (109). Collection in FY 2020-21 was atypically low due to the County not having electronic SDR surveys translations available when SDR trainings switched from in person to online due to the COVID-19 pandemic.

Seven electronic translations were introduced during FY 2021-22. Most critical was the addition of the Spanish translation. The majority of SDR trainings are delivered in Spanish to participants who report Spanish (69%) as their primary language; the Spanish translation comprised the majority of surveys submitted (83%, see Survey Language graph). The County introduced six other electronic translations during the fiscal year (Arabic, Armenian, Cambodian, Chinese (Traditional), Korean, Vietnamese). The translations comprise 88% of all surveys submitted in the FY (Spanish 83%, Korean 5%, Chinese 0.3%)

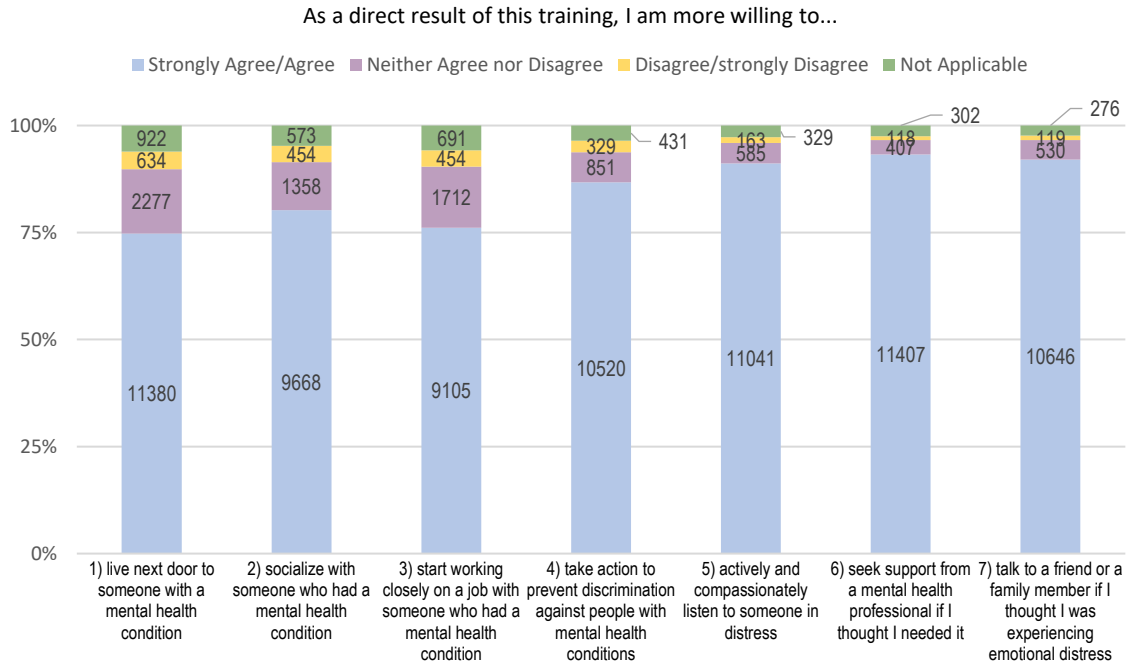
Figure 18. Survey languages



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:

- On all 7 items, the majority of participants agreed the training had a positive influence, with a high of 93% agreeing (37%) or strongly agreeing (56%) with item 6: "As a direct result of this training I am more willing to seek support from a mental health professional if I thought I needed it."

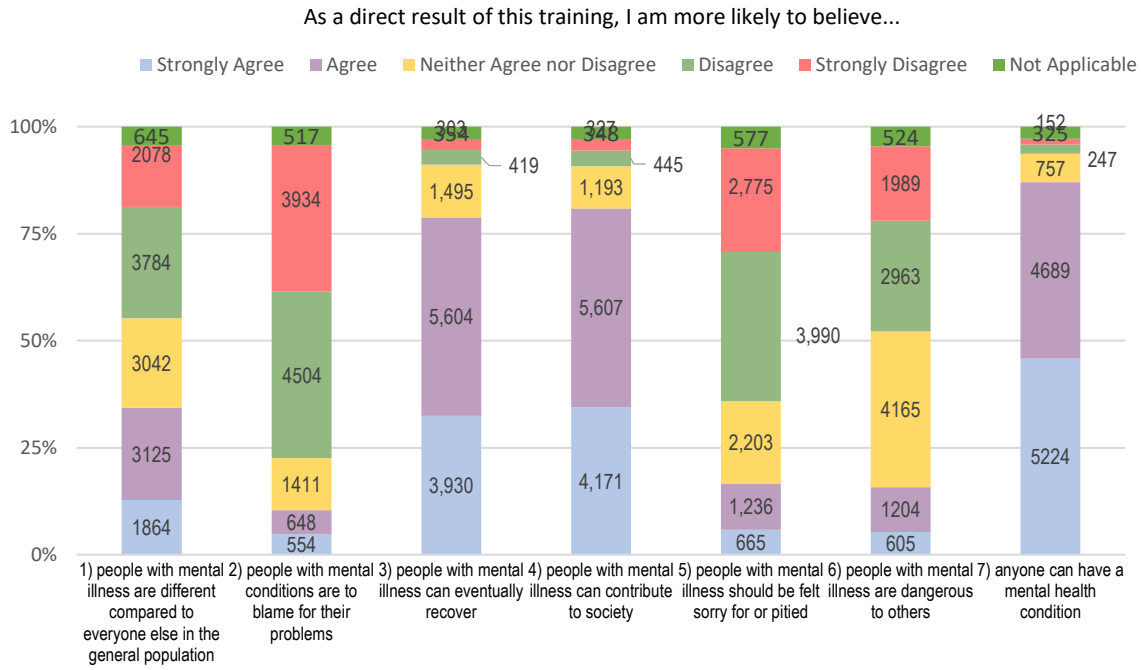
Figure 19. Changes in behavior



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.

- On five of 7 items, results showed the trainings had a positive influence, with a high of 87% agreeing (41%) or strongly agreeing (46%) with item14, "anyone can have a mental health condition"

Figure 20. 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 95% of participants agreed or strongly agreed with every item:

- a high of 97% agreed (39%) or strongly agreed (59%) with item 15, "The presenters demonstrated knowledge of the subject matter."
- a high of 97% agreed (39%) or strongly agreed (59%) with item 16, "The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.)."

Figure 21. Training Quality

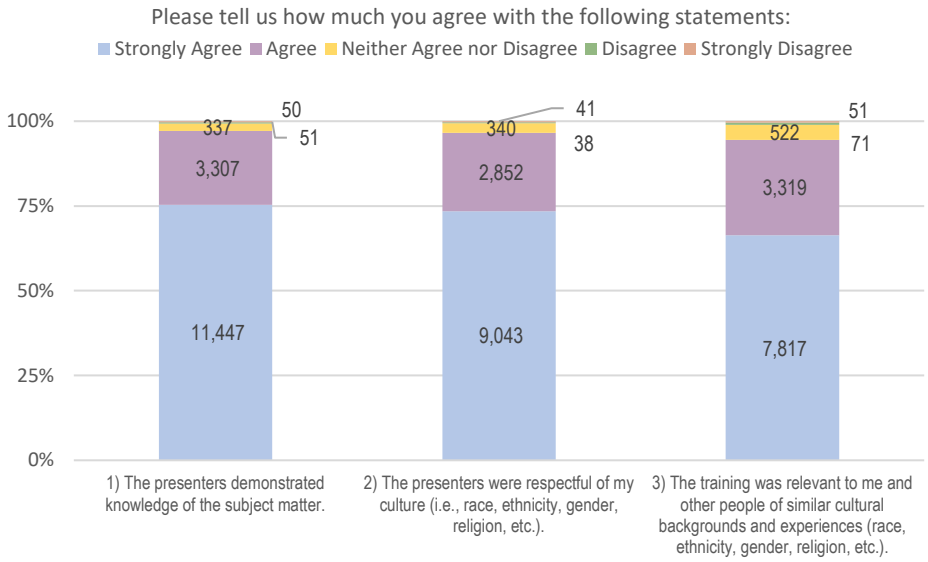


Table 44. Survey demographics (n = 16,572)

Sex at Birth	Female - 75% Male - 12%	Declined to answer - 13%
Sexual Orientation	Heterosexual or straight - 61% Gay or lesbian - 1% Questioning or unsure of sexual orientation – 0.17% Queer – 0.17%	Declined to answer - 35% Bisexual – 2% Another sexual orientation – 0.39%
Ethnicity	Mexican/Mexican-American/Chicano - 48% Central American - 14% South American - 4% More than one ethnicity - 1%	Other - 18% Declined to answer - 15%
Veteran Status	Yes - 1% No - 84%	Declined to answer - 15%
Age Groups	Children (0-15) – 0.26% TAY (16-25) – 3.41% Adult (26-59) - 72%	Older Adult (60+) - 12% Declined to answer - 13%
Disability	Yes -6% No - 78%	Declined to answer - 17%
Primary Language	English - 13% Spanish - 69% Korean – 5%	Other – 1% Declined to answer - 12%
Race	White - 39% Black or African American – 1.5% Asian - 6%	More than one race - 3% Other - 18% Declined to answer - 32%

D. SUICIDE PREVENTION

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+

FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$6,146,000	$5,682,000	$5,638,000

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 2021-22 ■ 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 2021-22, the 24/7 Suicide Prevention Crisis Line responded to a total of 145,254 calls, chats, and texts originating from Los Angeles County, including Spanish-language crisis hotline services to 13,087 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 45. Call analysis

Total calls	126,833
Total chats	15,265
Total texts	3,153
Total*	145,254

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

Table 46. Total calls by language

Korean	43
Spanish	13,087
English	113,703
Total	126,833

Figure 22. Call, chat and text volume by month

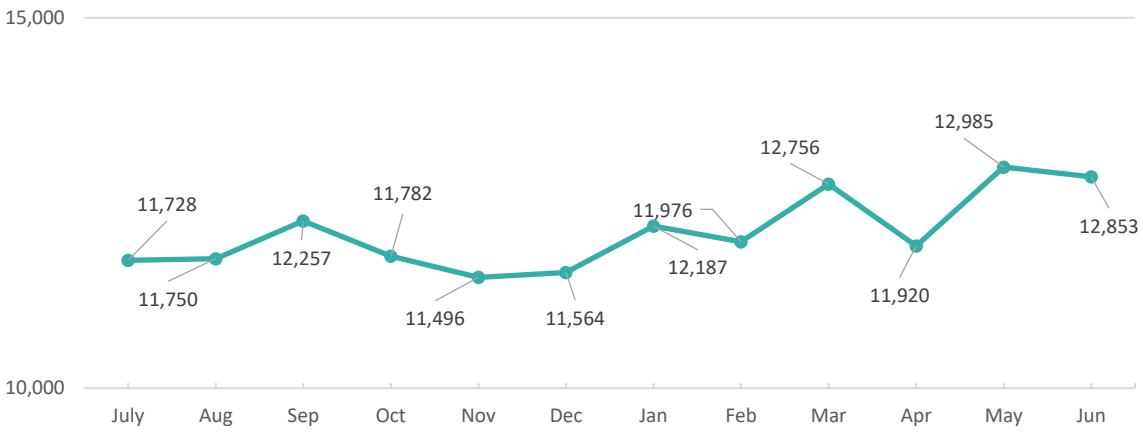


Table 47. Calls and chats by ethnicity

Ethnicity	Call (n = 63,403)	Chat/Text (n = 3,186)
White	36%	58%
Hispanic	35%	12%
Black	12%	13%
Asian	8%	5%
Native American	1%	1%
Pacific Islander	0%	0%
Other Race	8%	0%

Table 48. Calls and chats by age groups

Age Groups	Call (n = 66,941)	Chat (n = 15,741)
5 to 14	5%	23%
15 to 24	35%	46%
25 to 34	28%	19%
35 to 44	13%	7%
45 to 54	7%	3%
55 to 64	6%	1%
65 to 74	4%	1%
75 to 84	1%	0%
85 and up	0%	0%

Table 49. Calls and chats by suicide risk assessment

Suicide Risk Assessment	Calls	Chats
History of psychiatric diagnosis	43%	0%
Prior suicide attempt	24%	6%
Substance abuse - current or prior	15%	0%
Suicide survivor	8%	1%
Access to gun	3%	3%

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

Table 50. Suicide risk status

Suicide Risk Status	Calls (n = 50,865)	Chats (n = 2,008)
Low Risk	52%	29%
Low-Moderate Risk	23%	23%
Moderate Risk	14%	17%
High-Moderate Risk	3%	8%
High Risk	7%	17%
Attempt in Progress	1%	0%

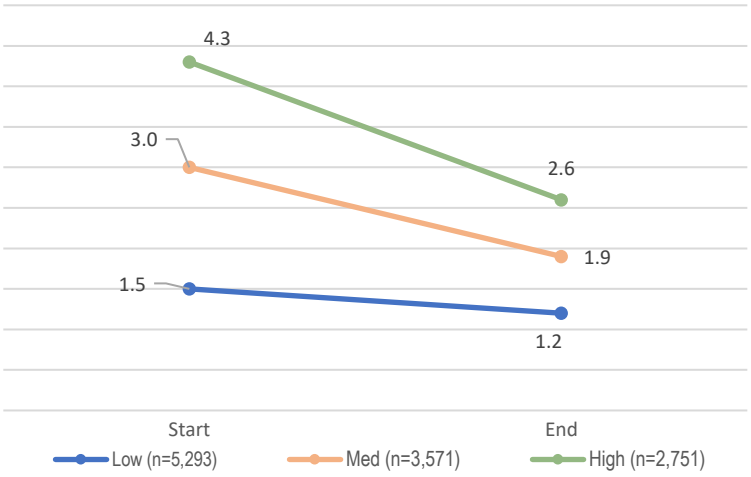
Percentages are calculated based on the total number of callers with reported risk levels.

Risk assessment is based on the four core principles of suicide risk: suicidal desire, suicidal capability, suicidal intent, and buffers/connectedness. A caller's risk level is determined by the combination of core principles present. For example, a caller who reports having only suicidal desire, as well as buffers, would be rated as low risk. A caller with suicidal desire, capability, and intent present would be rated as high risk, regardless of the presence of buffers.

Intervention Outcomes: Self-rated Intent

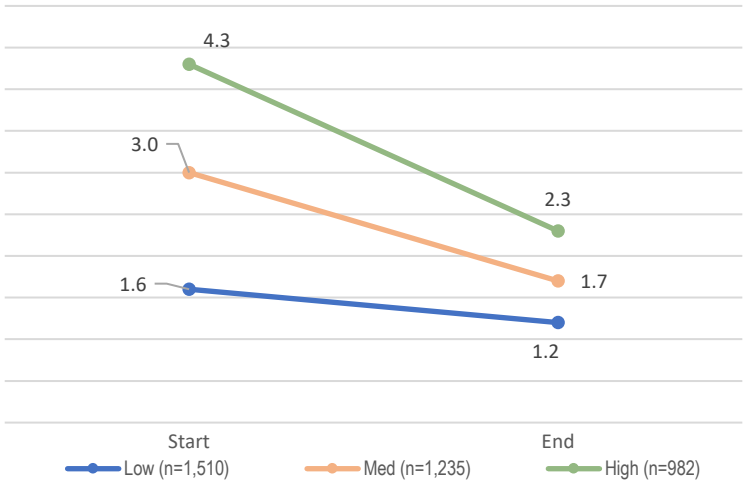
Callers are asked to answer the question: "*On a scale of 1 to 5, how likely are you to act upon your suicidal thoughts and feelings at this time, where 1 represents not likely and 5 represents extremely likely?*" Callers rate their intent both at the start and end of the call. Note: This data is on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

Figure 23. 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 24. Self-rated suicidal intent chats

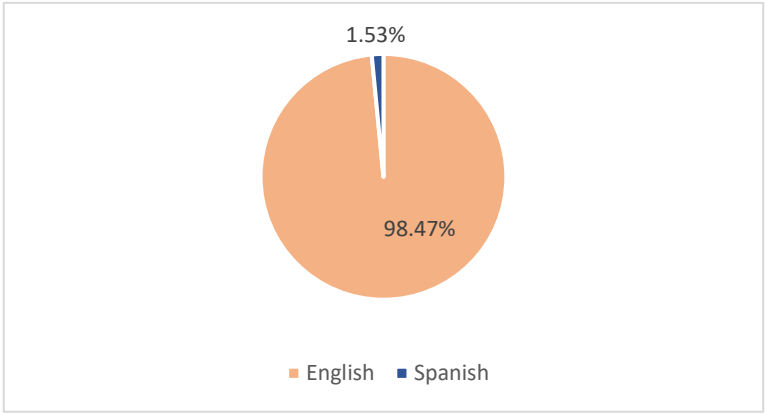


D3. Suicide Prevention Outcomes

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 SP trainings, Los Angeles County utilized the California Institute of Behavioral Health Services' (CiBHS) SP Program Participant Questionnaire, which assessed the impact of trainings on participants' attitudes, knowledge, and behaviors related to suicide. In addition, the questionnaire measured training quality and participant demographics. This write-up discusses the results of a data analyses performed on the1309 questionnaires received for SP trainings conducted during the 2021-2022 Fiscal Year (FY).

Figure 25. Survey Language (n-1,309)

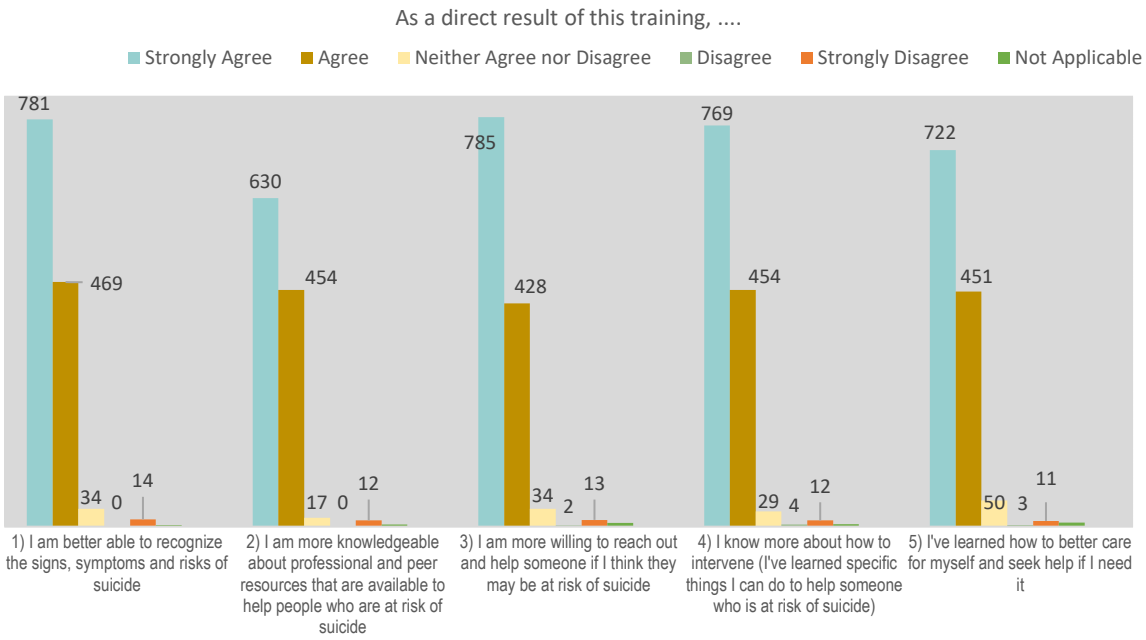


Changes in Attitudes, Knowledge, and Behavior

The three primary goals of the SP program are: 1) increasing knowledge about suicide and ways to help someone who may be at risk of suicide 2) increasing willingness to help someone who may be at risk of suicide 3) increasing the likelihood participants will seek support for themselves in times of need. The questionnaire includes five items (see Results Graph 1 for items and results) assessing the success of SP trainings in meeting program goals. Items may be rated: Strongly Agree, Agree, Neither Agree or 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 found that at least 94% of participants agreed or strongly agreed with all 5 items, suggesting that, overall, the SP programs were tremendously successful in meeting their program goals

- Participants had the highest percentage of agreement with the 2nd item; 97% agreed (41%) or strongly agreed (56%) 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 26. Responses to suicide prevention training



Training Quality

The questionnaire includes three items (see Results Graph 2 for items and results) assessing the quality of SP 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 at least 97% agreed or strongly agreed with all 3 items.

- A high of 99% of participants agreed (20%) or strongly agreed (80%) with item 6: "The presenters demonstrated knowledge of the subject matter."

Figure 27. Responses to suicide prevention training

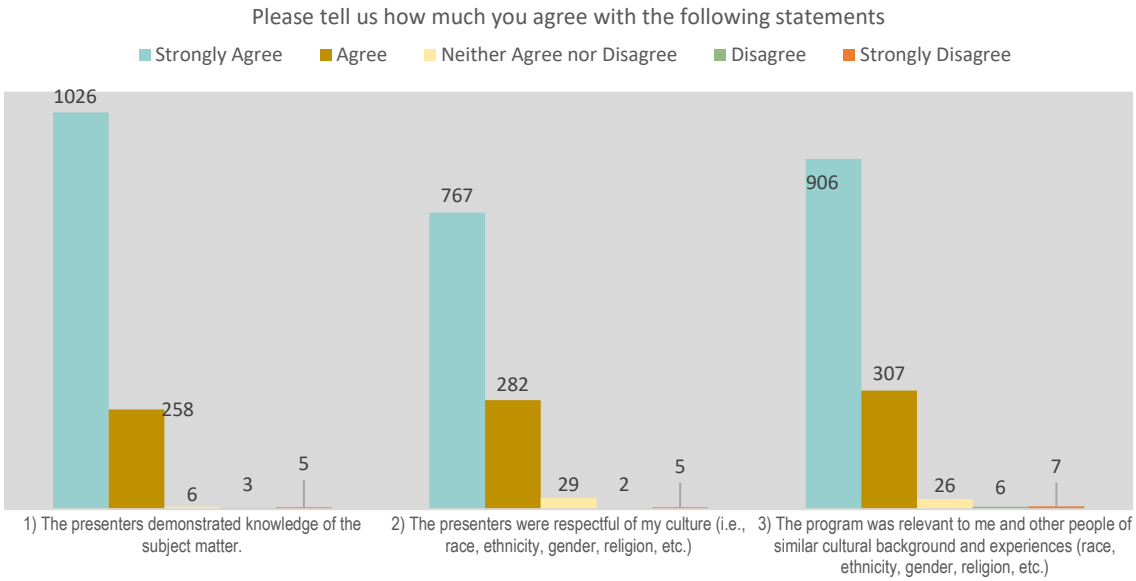


Table 51. FY 2020-21 Survey demographics

Gender Identity	Female – 81% Male – 15%	Declined to answer – 4%
Age Groups	TAY (16-25) – 5% Adult (26-59) – 84%	Declined to answer – 5% Older Adult (60+) – 6%
Race	White – 29% African American – 13% Asian – 1% American Indian – 1%	Other – 28% Declined to answer – 21% More than one race – 7%
Sexual Orientation	Heterosexual – 82% Gay/Lesbian – 3% Bisexual – 2%	Queer – 2% Declined to answer – 9%
Ethnicity	Central American – 9% European – 7% More than one ethnicity – 7% Other – 23% Mexican/Mexican-American/Chicano – 35%	Declined to answer – 14% African – 5%
Veteran Status	Yes – 1% No – 79% Declined to answer – 20%	
Disability	Yes – 6% No – 86% Declined to answer – 8%	
Primary Language	English – 74% Spanish – 16% Armenian – 2%	Other – 4% Declined to answer – 4%

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.

E. Outreach for Increasing Recognition of Early Signs of Mental Illness

The Department funds this function through CSS, specifically through Planning, Outreach and Engagement and through the work of Promotores/Promoter Community Mental Health Workers.

F. Access and Linkage to Treatment for Individuals with Serious Mental Illness/Serious Emotional Disturbance Seeking Services through PEI

The Department's provider network provides a full continuum of services and generally do not have PEI services in stand-alone buildings. Individuals presenting for services are assessed and referred according to need. Consequently, this PEI component does not apply to the Los Angeles County and cannot be reported on.

WORKFORCE EDUCATION AND TRAINING (WET)

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
FY 2023-24 Estimated Gross Expenditures	**FY 2022-23 Estimated Gross Expenditures**	**FY 2021-22 Total Gross Expenditures**		
$28,997,000	$17,200,000	$63,021,000		
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 2021-22 ■ WORKFORCE EDUCATION AND TRAINING Data and Outcomes

A. Training and Technical Assistance:

1. Public Mental Health Partnership

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 2021-22, UCLA provided the following trainings services:

During the reporting period, the PMHP delivered 111 live trainings and 387 anytime trainings with over 819.5 training hours, with an attendance of 13,026 participants. The training team provided trainings on a wide variety of topics including Person Centeredness, Cultural Humility, and Psychiatric Disorders and Symptoms. The training topics delivered to the most participants include “Crisis & Safety Intervention” (1,598 participants) and “Continuous Quality Improvement” (1591 participants)

Table 52. Public Mental Health Partnership Trainings

Topic Name	Number of Trainings	Training Hours	Number of Participants
Cultural Humility	26	76	1,774
Crisis & Safety Intervention	28	85	1,598
Continuous Quality Improvement	78	81	1,591
Ethical Issues	9	22.5	1,417
Manualized Evidence-Based Practices	31	65.5	1,150
Psychiatric Disorders & Symptoms	16	60.5	943
Co-Occurring Disorders	19	70.25	781
Service Delivery Skills	16	17	579
Team-Based Clinical Services	46	71.5	541
Provider Wellbeing	35	51.5	457
Trauma	10	40	439
Manualized Evidence-Based Practices (HR)	19	46	395
Person Centeredness	13	47	383
Everyday Functioning	14	16	244

Topic Name	Number of Trainings	Training Hours	Number of Participants
Manualized Evidence-Based Practices (ROC)	13	20.75	244
Persistent & Committed Engagement	4	6	190
Manualized Evidence-Based Practices (TIC)	2	3	177
Whole Person Care	8	40	143
TOTAL:	**387**	**819.5**	**13,026**

2. Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T):

BASIC T: The Hispanic Neuroscience Center of Excellence (HNCE) had two broad focus: 1) work with Promotores de Salud and 2) build relationships with faith- and community-based organizations (FBO/CBO). For both groups, the Center provided training on psychological first aid and recovery to help reduce stigma around mental health topics and care. In the final quarter of the fiscal year, BASIC-T focused on completing the training of its postdoctoral fellows in neuropsychology as part of the Pipeline Program and adapting a series of prior live-interactive trainings developed for LACDMH to be produced as videos in both English and Spanish to facilitate broader dissemination of culturally and linguistically responsive content for the Latina/x community.

During the 4th quarter, BASIC-T continued to make progress in training neuropsychology fellows as part of its Pipeline program. It also worked to adapt and transition previously developed live and interactive training content to a format that could be digitized to facilitate additional asynchronous learning opportunities. This included the production of a total of 32 videos: 24 (12 in English, 12 in Spanish) focused on the United Mental Health Promoter Curriculum, and 8 videos (4 in English, 4 in Spanish) focused on the theme of FBOs and CBO Mental Health Ministries. BASIC-T also continued to migrate a large cache of previously recorded interviews and informational PSAs on various mental health topics within Spanish language media that were produced as part of its FBO and CBO engagement strategy during the COVID-19 pandemic.

During the reporting period, the HNCE delivered 56 trainings with 101 training hours, with an attendance of 986 participants. With guidance from the HNCE, the Promotores program was strengthened going from 120 to almost 300 Promotores and 47 clinicians, expansion of the Spanish language arm of the program, and the opportunity to offer services in other languages. The team has created resources and worked to support mental health ministries with local faith-based organizations including the Los Angeles Diocese, to help reach communities that were previously unreachable and raise awareness of mental wellbeing outside of clinics. 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 that were delivered to the most participants in FY 2021/2022 included Culturally Competent COVID-19 and Creating Mental Health Ministries (including Psychological First Aid & Skills for Psychological Recovery) for Faith Based Organizations and Churches (159 participants) and Culturally Competent COVID-19 Mental Health Intervention with Community Based Organizations (431 participants).

Table 53. BASIC-T Outcomes for FY 2021-22

Topic Name	Number of Trainings	Training Hours	Number of Participants
Culturally Competent COVID-19 and Creating Mental Health Ministries (including Psychological First Aid & Skills for Psychological Recovery) for Faith Based Organizations and Churches	20	39.5	826
Culturally Competent COVID-19 Mental Health Intervention with Community Based Organizations	30	36	431
Culturally Competent COVID-19 Skills for Psychological Recovery for Faith Based Organizations and Churches	6	8.5	191
Virtual Support Groups for Isolated Older Adults during COVID-19 (Genesis)	10	22	163
An introduction to creating a Mental Health Ministry	60	120	233
Child Abuse Prevention During COVID-19	45	45	118
COVID-19 and Impact of Childhood Disorders-Other Bipolar, PTSD, ODD, Conduct Disorders	16	24.5	244
Drug and Alcohol Use and Prevention During COVID-19	5	12	87
Family Violence Prevention During COVID-19	3	6	74
Depression and Anxiety - Separation anxiety, generalized anxiety, panic disorder, severe depression, persistent depression—English Pediatrics	3	6	71
Neurodevelopmental Disorders - Learning disabilities, intellectual disability, autism, ADHD—English Pediatrics	2	4	38
Grief, Loss and Resilience—Spanish Lifespan	2	4	33
Impact of COVID-19 on Anxiety Disorders with Adults—English Lifespan	4	8	183
Impact of COVID-19 on Anxiety Disorders with Adults—Spanish Lifespan	1	2	20
Suicide Prevention During COVID-19—Spanish Lifespan	4	10	153

Topic Name	Number of Trainings	Training Hours	Number of Participants
Cultural and linguistic considerations when assessing Latina/o patients	6	12	311
Culturally Competent COVID-19 Psychological First Aid for Faith Based Organizations and Churches	3	6	159
Totals:	56	101	986

The HNCE has developed a strong relationship with Spanish media and Catholic radio and TV to get information out on a weekly basis to communities, filling a void where Spanish language information on mental health had not existed before.

3. Navigator Skill Development Program

The Health Navigation Certification Training targets 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. During FY 2021/2022, 23 individuals completed this model, with all representing an un- or under- served community.

The Peer Housing Navigation Specialists Training targets peer to prepare them to assist consumers with housing insecurities to work towards establishing and meeting steps to a goal of housing permanency. During FY 2021/2022, 22 individuals competed the training, of these 60% spoke a threshold language (other than English), and all represented un- or under- served communities.

4. Interpreter Training Program (ITP)b

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. FY 2021/2022 Outcomes:

Table 54. ITP Outcomes for FY 2021-22

Training	# of Attendees
Increasing Armenian Mental Health Clinical Terminology	7
Increasing Mandarin Mental Health Clinical Terminology	17
Increasing Spanish Mental Health Clinical Terminology	88
Introduction To Interpreting in Mental Health Settings	22
Therapeutic Cross-Cultural Communication	11
TOTAL	145

5. 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 2023-24.

6. Licensure Preparation Program (MSW, MFT, PSY)

In an effort to increase the pool of licensed mental health professionals, the Department offers subsidized study preparation material for Part 1 and Part 2 licensure examination for Social Workers, Marriage and Family Therapists, Licensed Professional Clinical Counselors and Psychologists. During FY 2021/2022, the Department subsidized 58 individuals across these professions, with 55% self-identifying from a un- or under-served community, and 48% speaking a threshold language in addition to English.

7. Academy of Cognitive Therapy

Effective FY 2022-23, MHSA WET will initiate funding a multi-year effort to increase the number of staff utilizing this clinical approach. Individual Cognitive Behavioral Therapy (Ind CBT) is one of the most frequently utilized evidence-based practice (EBP), with considerable research supporting its effectiveness and adaptability in clinical practice. Ind CBT integrates the rationale and techniques from both cognitive therapy and behavioral therapy, thereby challenging automatic negative thoughts with more direct methods of behavioral therapy. Ind CBT helps individuals deal with their difficulties by changing their thinking patterns, behaviors, and emotional responses. Treatment focuses on identifying more positive reinforcing thoughts to elicit a more desired behavior. The Ind CBT program shall target its services to consumers age 16 years and older throughout the Los Angeles County (LAC). Specifically, the EBP will treat transition-age youth dealing with early onset of mental illness; adults facing traumatic experiences which lead to depression, anxiety, or post-traumatic stress disorder; and older adults to prevent or alleviate depressive symptomology. The treatment is intended for consumers seeking services to address depression, anxiety, or trauma in an individual or group setting consisting of 18 to 56 weeks of sessions.

8. Staff Development Training

Historically, public mental health systems across the county have experienced ongoing staffing shortages. Unfortunately, in recent years Covid-19 has exasperated this shortage. The Department will fund a new program targeting further professional skill development of its existing workforce alongside am increase recruitment effort.

B. Residency and Internship

1. Charles R. Drew Affiliation Agreement: Psychiatric Residency Program

The County Board of Supervisors formed the Los Angeles County Health Agency in 2015 to better integrate the Departments of Health Services, Mental Health and Public Health. The Health Agency contracted with Charles Drew University to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and DMH 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 2018-2019 and at the program's capacity, we will have 24 trainees raging from Post Graduate Year Is to IVs. The first class graduated in June 2022.

Table 54. Outcomes for FY 2021-22

Post Graduates	Number of Psychiatric Residents	Rotations
Year 1 Post Graduates	6	• 1 month of university onboarding is done at CDU • Veterans Administration (VA) Long Beach (Inpatient Psychiatry): 4 months • Rancho Los Amigos (Inpatient Medicine): 2 months • Rancho Los Amigos (Neurology): 2 months • Kedren (Outpatient Medicine): 2 months • Harbor-UCLA (Emergency Psychiatry): 1 month
Year 2 Post Graduates	6	• VA Long Beach (Inpatient Psychiatry): 3 months • VA Long Beach (Consultation and Liaison): 2 months • VA Long Beach (Emergency Psychiatry): 1 month • VA Long Beach (Substance Abuse): 2 months • VA Long Beach (Geriatric Psychiatry): 1 month • Kedren (Inpatient Psychiatry): 1 month • Resnick Neuropsych Hospital UCLA (Child and Adolescent Psychiatry): 2 months *The above PGY 2 rotation times represent averages. Individual resident rotations vary in their second year depending on areas of focus.
Year 3 Post Graduates	6	Rotations in DMH Directly Operated Clinics and Programs: • Augustus F. Hawkins MHC • West Central MHC • Compton MHC Child & Adolescent Psychiatry • Women's Community & Reintegration Center • Harbor UCLA Medical Center HIV Clinic
Year 4 Post Graduates	6	Rotations in DMH Directly Operated Clinics and Programs: • Augustus F. Hawkins MHC • West Central MHC • Street Psychiatry/HOME Team and Disaster Service • Collaborative Care/Telepsychiatry • CDU Didactics Training

2. LACDMH + Semel Institute National Clinician Scholars Program (NCSP) Professional Trainees (UCLA Public Partnership for Wellbeing Agreement)

Public Psychiatry Professional trainees of the LACDMH + Semel Institute position for National Clinician Scholars Program consisted of 1 Adult Psychiatrist/Researcher who provided 114 patient visits.

NCSP serves to advance and promote the work of clinician leaders (physicians, nurses) who address health equity over the course of their career, through postdoctoral training as part of the National Clinician Scholars Program, with DMH as their sponsor. The National Clinician Scholars Program is a multi-site program for all physician specialties and nurses with a PhD. The program provides training in partnered research, quality improvement, health services and policy research and leadership. Scholars are selected within a competitive process with applicants from across the country.

DMH funds one fellowship slot at a time (new fellows eligible every two years). Scholars Program activities include:

- Participating in coursework, the equivalent of a master's program or auditing as an option.
- Conducting up to 20% clinical work with DMH and participate in leadership activities.
- Conducting 1-4 projects, at least 1 of which is in partnership with DMH.
- Participating in a policy elective their second year when possible.
- Attending annual NCSP meetings and other local and national meetings.
- Access to research funds and a mentorship team

For Fiscal Year 2023-24:

- The Department may begin developing a curriculum for a new Child Psychiatry Fellowship class that will start in FY 2024-25 under the Charles Drew university Agreement.
- The Department will also have a three early care Neuropsychologist providing services at DMH directly operated sites as part of the BASIC T SOW under the UCLA Agreement.

3. DMH + UCLA General Medial 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 12 trainees provided a total of 7,073 patient visits during their public psychiatry rotations.

Table 55. Outcomes for FY 2021-22

NCSP/GME	# Fellows/Residents	Estimated # of Patient Visits
Adult Psychiatrist/Researcher	1	862
Adult Psychiatry Residency	3	1,124
Child Psychiatry Fellowship	4	1,672
Geriatric Psychiatry Fellowship	1	1,098
Forensic Psychiatry Fellowship	3	2,317
Total	**12**	**7,073**

C. Financial Incentive

1. Mental Health Psychiatrist (MHP) Student Loan Repayment Incentive

DMH 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 2021/2022, 2 mental health psychiatrists participated in this program. This program is expected to increase awards during the following Fiscal Years.

2. MHSA 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 2021/2022, no individuals were awarded. This program is expected to increase awards during the following Fiscal Years.

3. 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 2021/2022, 1 individual was recruited and awarded. This program is expected to increase awards during the following Fiscal Years.

4. Stipend Program for MSWs, MFTs and Psychiatric Nurses

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 2021/2022, 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 impacted reinstatement of the program.

Stipend awards will resume during FY 2022/2023. Program will include Psychologists, in addition to MSWs, MFTs, LPCC, PNP and Psychiatric Techs. The Department is ready to disburse over 100 awards.

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.

5. MHSA WET Regional Partnership Match

Pending the availability of additional MHSA WET Regional Partnership funding from the State, the Department may be required to provide a 33% local match to accept and implement and recruitment or retention efforts mandated in future Fiscal Years.

D. Mental Health Career Pathway

1. Intensive Mental Health Recovery Specialist Training Program

Intensive Mental Health Recovery Specialist Training Program prepares individual, mental health consumers and family members to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This program is delivered in partnership with a mental health contractor. Successful completion of this program ensures that participants are qualified to apply for case management level career opportunities in the public mental health system. Two cohorts were delivered this training. Of the 39 individuals that began this training, 37 completed the training with 77% identifying from an un- or under- served community, 47% speaking a second language and 90% indicating lived experience as peers or family members. Of those that completed the training, 38% have secured employment, with all but one working in the mental health field. No changes are expected through 2023-24.

2. 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 2021/2022, 2,387 individuals receiving this training through 26 training events.

3. Intentional Peer Support Advanced Training
   It's an innovative practice that has been developed by and for people with shared mental health experiences that focuses on building and growing connected mutual relationships. In this interactive training, participants learn the principles of IPS, examine and challenge assumptions about how we have come to know what we know, and explore ways to create relationships in which power is negotiated, co-learning is possible, and support goes beyond traditional notions of "service." This innovative curriculum details the difference between peer support and other helping practices, and has been widely used as foundational training for people working in both traditional and alternative mental health settings. In FY 2021/2022, 15 people completed the IPS Core training.

4. Online Wellness Recovery Action Plan (WRAP)
   This training is an introduction to WRAP® and how to use it to increase personal wellness and improve quality of life. The training is highly interactive and encourages participation and sharing from all present. It also lays a broad foundation for building and supporting a skilled peer workforce. Participants will learn to apply the Key Concepts of Recovery and use tools and skills to address encountered thoughts, feelings, and behaviors for improved states of wellness. The history, foundation, and structures of WRAP® will be discussed. Successful completion of this training fulfills the prerequisites for the WRAP® Facilitator Training. During FY 2021/2022, we provided two online WRAP Seminars I. A total of 24 participants have completed this training.

5. Online Wellness Recovery Action Plan Facilitator Refresher Training
   The WRAP® Refresher Training is an interactive training to sharpen and expand facilitation skills of trained facilitators to further engage groups they facilitate in the implementation of their Wellness Recovery Action Plan®. Participants in this training will be expected to interact in learning activities and demonstrate their own experience with WRAP®. This training is for the current WRAP facilitators who will lead WRAP® groups, work with others to develop their own WRAP® and give presentations on mental health recovery-related issues to groups or organizations. Participants are expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how WRAP® can work. A total of 6 people have been recertified to facilitate the WRAP groups for the department.

6. Wellness Recovery Action Plan (WRAP) Facilitator Training:
   This training equips participants to facilitate WRAP® classes in the community and within their organizations. The WRAP® Facilitator training provides an experiential learning environment based on mutuality and self-determination. Participants are expected to join in interactive learning activities and demonstrate their own experience with WRAP®. Upon completion of this training, participants will be able to lead WRAP® groups, work with others to develop their own WRAP® and give presentations on mental health recovery-related issues to groups or organizations. Lastly, participants are expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how WRAP® can work. One WRAP Facilitator Training has been provided in FY 2021/2022 and 7 people have successfully completed the training. They are now able to facilitate the WRAP groups for the department programs.

7. Continuum of Care Reform
   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, in the prior year the Department utilized MHSA WET to deliver training to these populations. Such training included topics such as introduction to mental health, diagnosis/assessment, and self-care. During FY 2021/2022, these mandated trainings were funded by other MHSA WET allocations.

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

   The Department continues to develop new, innovative training opportunities to prepare peers, parent advocates, child advocates and caregivers for employment in the public mental health system. During FY 2021-2022 the Department delivered the following training. For the upcoming Fiscal Years, the Department will continue to develop new training offerings for these populations.

INNOVATION (INN)

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+

FY 23-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
$33,007,000	$15,600,000	$36,189,000

Programs for FY 2021-22

- INN2: Community Capacity Building to Prevent and Address Trauma
- INN4: Transcranial Magnetic Stimulation (TMS)
- INN7: Therapeutic Transportation (TT)
- INN8: Early Psychosis Learning Healthcare Network

FY 2021-22 ■ 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.

See report on next page.

Evaluation of MHSA Innovation (INN) 2 Trauma Resilient Communities: Executive Summary

The **Innovation 2 (INN 2)** initiative centers on the creation and implementation of place-based community partnerships within geographically-defined communities to foster the collective will to support and develop trauma-resilient communities. This objective is accomplished using asset-based community capacity building approaches within communities to identify, educate and support members of the community who are at risk of or experiencing trauma and resulting mental illness.

- A **community capacity building approach** identifies and builds on the assets and skill sets that currently exist within a community. The community's capacity is strengthened by collaborating with community members to identify their needs and strengths, and utilizing strategies that embody shared community values, leadership development, and community member empowerment.

Over the past four years of the initiative, the Los Angeles County Department of Mental Health (LACDMH) has supported **nine** lead agencies and their community partners as they have implemented community-driven capacity building strategies to address the trauma and challenges within specific target populations within communities (see chart below for a list of each strategy). These strategies target the needs and experiences of specific populations, such as parents of young children, transition-age youth, older adults, and multigenerational families, through innovative outreach and education, providing needed resources and supports and facilitating connection and community spaces.

Building Trauma-Resilient Families (Caregivers with children who are 0-5 years old)	Alma Family Services (Alma) Children's Institute, Inc. (CII) Para los Niños The Children's Clinic (TCC) Westside Infant-Family Network (WIN)
Trauma-Informed Psycho-Education and Support for School Communities	Alma Family Services (Alma) Children's Institute, Inc. (CII) Para los Niños Westside Infant-Family Network (WIN)
Transitional Age Youth (TAY) Support Network (16-25-year-old TAY)	Alma Family Service (Alma) Children's Clinic of Antelope Valley (CCAV) Mental Health America of Los Angeles (MHALA) Pasadena Public Health (PPH) Safe Places for Youth (SPY)
Coordinated Employment within a Community	Mental Health America of Los Angeles (MHALA)
Community Integration for Individuals with Recent Incarcerations or Diverted from the Justice System	Children's Clinic of Antelope Valley (CCAV)
Geriatric Empowerment Model (GEM) for Older Adults (60+) who are experiencing Homelessness	Pasadena Public Health (PPH)
Culturally Competent Activities for Multigenerational Families	Alma Family Services (Alma) The Children's Clinic (TCC)

Purpose of this Executive Summary

With an emphasis on collective learning, this executive summary seeks to describe the impacts of outreach and engagement activities and benefits of community capacity building on strengthening communities who have experienced trauma. This report includes various data sources collected between **September 17, 2018 – April 14, 2022**, including surveys completed by INN 2 participants and partners, observation notes, interviews, and events and linkage tracking input into the Innovation 2 Health Outcomes Management System (iHOMS), a secure data collection and reporting database, to highlight the objectives and achievements of the INN 2 initiative.

The comprehensive evaluation of INN 2, including reporting of outcomes data, best practices and learnings that have emerged during the initiative, will be delivered at the end of the current fiscal year (June 2022).

Capacity Building within Partnerships

Collaboration within Partnerships during the Early Phase of the Initiative (February 2019 – February 2020)

- The Wilder Collaboration Factors Inventory is an assessment tool used by the evaluation to measure changes in six characteristics of successful collaboration and capacity building within partnerships.
  - During the first year, partnerships grew, as agencies formed new relationships with partners and hired new staff to do the INN 2 work. To put the baseline data into context, the Wilder was completed during a period when several partnerships were still experiencing challenges related to forming their partnerships.
- Compared to ratings on the first assessment (completed February 2019), Environmental, Membership Characteristics, Process & Structure, Communication, and Purpose category scores increased significantly during the first year of the initiative.
  - This progress observed at the end of the first year was likely facilitated by relationship building, using partnership data to identify areas for growth, which helped frame Learning Session agendas, and agencies collaborating to develop the vision and implementation plans for INN 2.

Scores of 4.0 to 5.0 - strengths to leverage

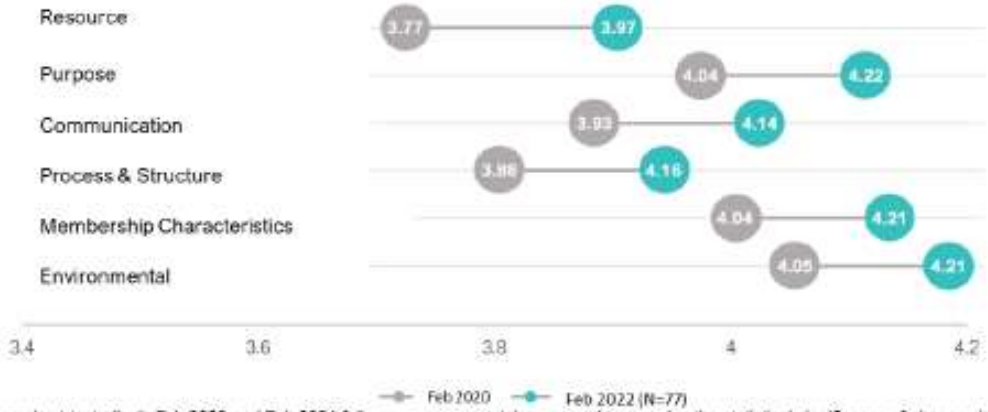
Scores of 3.0 to 3.9 - opportunity for growth & deserves discussion

Scores of 2.9 or lower - concern that should be addressed

* Paired samples t-tests (both baseline and Feb 2020 follow-up assessments) were used to examine the statistical significance of changes in scores on the measures over time. Average Wilder scores range from 1 to 5 with 5. Displayed values of graph axis have been changed to provide easier viewing of changes of scores.

Collaboration within Partnerships during the Pandemic (February 2020- February 2022)

- Partnerships grew by 13% as INN 2 partnerships expanded to include new organizations and community members during the pandemic.
  - Having an available network to leverage resources and collaboration with the community to test new ideas likely contributed to INN 2's ability to successfully pivot and incorporate the community ambassador network while supporting communities during this pandemic.
- Compared to ratings completed in February 2020, all Wilder category scores increased significantly, suggesting a strengthening of capacity within the partnerships.



* Paired samples t-tests (both Feb 2020 and Feb 2021 follow-up assessments) were used to examine the statistical significance of changes in scores on the measures over time. Average Wilder scores range from 1 to 5 with 5. Displayed values of graph axis have been changed to provide easier viewing of changes of scores.

Community Outreach and the Community Ambassador Network (CAN)

Community Ambassador Network

In June 2020, LACDMH proposed the use of Coronavirus Aid, Relief, & Economic Security (CARES) Act and rollover INN 2 funding to integrate community mental health workers (community ambassadors) to support INN 2 agencies in COVID-19 support, education and community outreach. The CAN program expanded in July 2021 to incorporate CAN Interns through collaboration between LACDMH, CalWorks and DPSS.

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.

- As of April 14, 2021, 334 individuals have been a part of the Community Ambassador Network. This includes 41 CAN interns, 80 community members hired in 2021 or 2022, 84 community members hired through the CARES ACT, as well as 129 INN 2 peers, navigators, parent partners and Promatores who are now part of the CAN.
- **Two hundred and nine (209) individuals are active Community Ambassadors.**
- The most prevalent language spoken by CAN (aside from English) is Spanish (50%), and 7% of CAN speak Khmer.
- The majority of CAN (45.5%) identify as Latino/Latina/ Latinx, Hispanic or Mexican. Fifteen percent (15.3%) of CAN identified as Black and/or African American, 9.6% Asian, Cambodian, Filipino, Korean, East Indian, or Tongan (Asian and Pacific Islander), 5.1% as Multiracial and 3.8% as White.

Connecting with the Community

An objective of INN 2 focuses on the importance of building awareness and knowledge, social connectedness, and coping skills to foster resiliency and, ultimately, lead to better mental health and wellness for community members. Many people have recognized that direct delivery of mental health services is not always the optimal entry point for community members. Part of the community capacity vision of INN 2 has been to test non-traditional outreach methods and pathways to connect with community services and social supports. The Event Tracker is intended to capture the larger outreach and engagement efforts, as well as community member participation in programs and activities. During the past two years, it has also been widely used to capture COVID-19 relief and recovery efforts within the communities. The following sections provide a summary of the types of events INN 2 agencies have provided throughout the initiative.

Outreach and Engagement Activities during the Early Phase of the Initiative (2018-2020)

- During the early implementation phase of the initiative (Sept 2017-March 2020), agencies invested time building relationships with their partners and the community and creating awareness about INN 2 through targeted community outreach and community events.
    - We heard during the interviews with agency leads that taking the time to get to know people in the community and involving the communities' preferences and needs into programming and group activities was essential for building trust, which in turn is a precursor for people to open up about their individual needs.

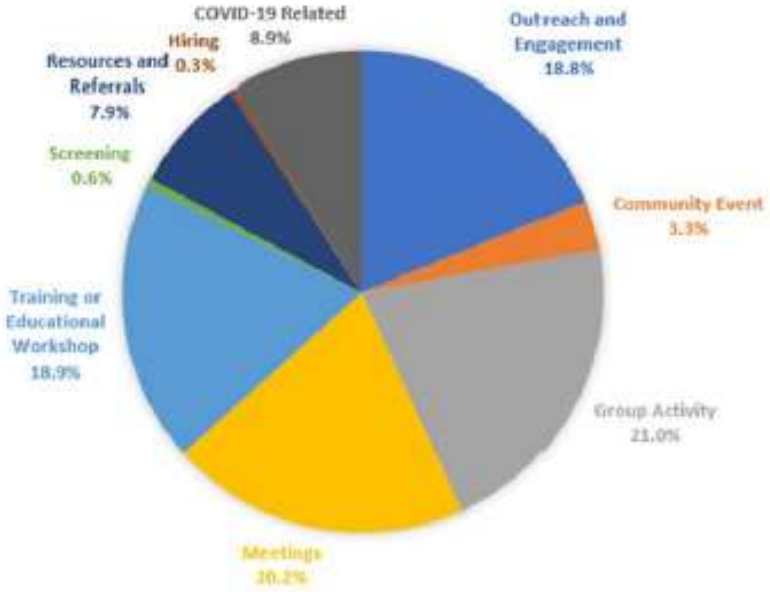
Rank	Type of Event	Event Category	Total # of Events
1	Community Outreach	Outreach & Engagement	1,334
2	Training in the Community	Training or Educational Workshop	450
3	Group Activity	Group Activity	439
4	Partnership Meeting	Meetings	387
5	Community Event	Community Event	358
6	Training for Partners/INN2 Staff	Training or Educational Workshop	349

Data recorded in the Event Tracker (IHOMS system) between 9/18/2017 and 4/30/2020. This table provides information on the top six event categories across all INN 2 programs. There may be variability in how agencies determine the number of attendees during community outreach and events.

Impact and Reach of INN 2

Outreach and Engagement Activities during the Early Pandemic (2020-2021)

- Non-traditional approaches to "meet people where they are at" and the flexibility afforded by the learning approach of the initiative were critical to partnerships' responsiveness to the COVID-19 crisis and social unrest during the first year of the COVID-19 pandemic.
- As evident by the **pie chart**, the pandemic may have changed the way INN 2 partners connected with each other and the community, but agencies were still able to move the work forward while worked together to meet the challenges and unknowns facing communities because of the COVID-19 pandemic and civil unrest.
  - Programming and capacity building approaches were adapted, and partnerships leveraged their existing relationships and developed new partnerships to support the community.
  - Creating awareness and outreach through Community events decreased because of COVID-related closures and social distancing safety guidelines.
- Significant effort was placed on COVID-19 education and relief efforts.
- Group activities have been used as an integral part of programming among agencies to provide community specific engagement and provide meaningful and innovative support to their participants.
  - These group activities included family and parent support groups, play sessions, storytelling workshops, Zumba classes, and self-care and mindfulness sessions, along with many other innovative activities.



The pie chart above summarizes the percentages of overall outreach and engagement categories recorded in iHOMS. The table below summarizes the top six event types and their corresponding category across all INN 2 programs.

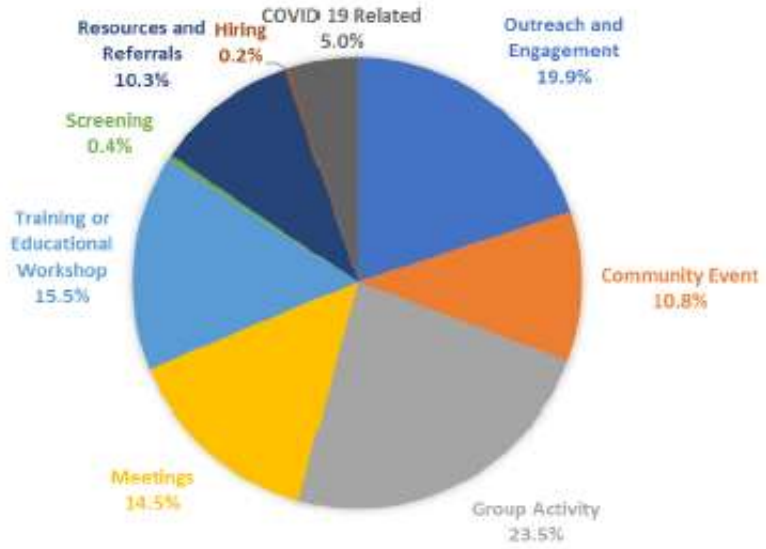
Rank	Type of Event	Event Category	Total # of Events
1	Group Activity	Group Activity	2,989
2	Partnership & Other Meetings	Meetings	2,698
3	Community Outreach	Outreach & Engagement	1,964
4	Training in the Community	Training or Educational Workshop	1,646
5	COVID-19 Education Efforts	COVID-19 Related	1,078
6	Training for Partners/INN2 Staff	Training or Educational Workshop	1,044

Data recorded in the Event Tracker (iHOMS system) between 5/1/2020 and 4/30/2021.

Impact and Reach of INN 2

Outreach and Engagement Activities during the Past Year of the Pandemic (2021-2022)

- INN 2 providers recorded a total of **13,841 outreach and engagement events** the past year.
- Through these innovative events, partnerships have reached hundreds of thousands of community members.
- INN 2 providers have consistently supported a high number of annual outreach and engagement events over the past two years of the project.
- General community outreach, meetings, trainings, and community events represent the other top outreach and engagement activities.
- As pandemic related restrictions have lifted over the past year, it is notable to see that community events have increased substantially. Agencies have been able to host larger community-wide events such as community cookouts, mental health fairs, and cultural festivals.
- While there was significant effort placed on COVID-19 education and relief efforts last year, programs have slightly decreased direct COVID-19 related outreach efforts this year as they focus on building back pre-COVID in-person activities.
- It is promising to see that programs have continued to make trainings a priority throughout the initiative. Trainings in the community have remained consistently high and have been an integral way for partnerships to help build capacity within their communities.
- As expected with partnerships in the sustainability phase of the project, there were less trainings for partners and staff over the past year as compared to previous years.



The pie chart above summarizes the percentages of overall outreach and engagement categories recorded in iHOMS. The table below summarizes the top six event types and their corresponding category across all INN 2 programs.

Rank	Type of Event	Event Category	Total # of Events
1	Group Activity	Group Activity	3,247
2	Community Outreach	Outreach & Engagement	2,200
3	Partnership & Other Meetings	Meetings	1,890
4	Training in the Community	Training or Educational Workshop	1,576
5	Community Event	Community Event	1,440
6	Training for Partners/INN2 Staff	Training or Educational Workshop	573

Data recorded in the Event Tracker (iHOMS system) between 5/1/2021 and 4/14/2022.

Connecting INN 2 Participants with Resources and Supports

Supporting the Community

Individuals who are reached though community outreach and events may later become an INN 2 participant. INN 2 participants are community members who participate in ongoing INN 2 group activities, educational classes or programs, which vary by capacity building strategy and partnership. These activities may include parenting classes or play groups, knitting groups, trauma-informed trainings, gardening groups, or case management services for older adults who are experiencing homelessness. Through participation in classes and groups, INN 2 staff can develop relationships based on trust and learn more about their individual or family needs and strengths. This approach allows staff to tailor support and linkages with resources or services to meet an individuals' goals and needs. As of 4/14/2022, **12,316 participants have been registered in iHOMS.**

The following table summarizes the top five types of referrals made for resources and supports during INN 2.

Total Referrals: 71,635

Agency provided a participant with information about specific resources and/ or support services to enable or empower the participant to obtain support independently.

Total Linkages: 66,473

Participant shared that they connected with resource and/or service provided by agency staff.

Linkage Not Made: 1,437

Participant did NOT connect with resource and/or service provided by agency staff.

Referred: 3,725

Agency provided a referral for a specific resource and/or service but the participant has not connected yet or has not shared that they connected with referred support.

Top 5	Type of Resource or Service	Total Referrals	Total Linked
1	Food	24,460 (34%)	23,687
2	Basic Needs	11,023 (15%)	10,647
3	Education (including civics/ESL, special education, financial and digital skills classes)	7,471 (10%)	7,194
4	Housing	5,843 (8%)	4,818
5	Mental Health	3,819 (5%)	3,360

- INN 2 providers made a total of **71,635 referrals** to community resources and supports **for 8,901 participants** during the initiative.
  - Ninety-three (93%) percent of referrals were noted as successful linkages, meaning that agency staff provided a warm handoff or followed up with the participant to confirm that they had connected with the referred support or resource.
  - Because of the community trust and capacity building infrastructure built through relationships and collaboration with organizations and community leaders during the first two years of INN 2, providers were able to continue to provide much needed support and resources during the past two years of the pandemic.
- The most common referrals during the initiative were for basic needs, including food and housing, education and mental health services and supports.
  - Linkages with food included vouchers or gift cards for local markets, support applying for Cal-Fresh, and distribution of food boxes or groceries through curbside pick-up or delivery services. Prior to the pandemic, food only accounted for 5% of the referrals made, which highlights how the pandemic exacerbated the already pressing issue of food insecurity for many individuals within Los Angeles County.
  - Referrals for basic needs includes linkages with backpacks and sleeping bags for TAY, clothes, diapers and wipes for families, and hygiene and household cleaning products.

To illustrate how INN 2 partnerships tailored their approaches to build capacity and meet the needs of the target populations and communities they support, outreach and linkages with supports are reported for each capacity building strategy. The following linkage and events reporting does not include participants registered to more than one strategy, or those enrolled under Strategy 8, which is used to denote COVID-19 related recovery efforts associated with CARES ACT. Reporting of resiliency, coping and community connectedness outcomes will be included in the final evaluation report delivered in June 2022.

Strategy 1: Building Trauma-Resilient Families

Strategy Description and Objectives

Strategy 1's approach to build capacity within the community targets children ages 0-5 and their caregivers who have experienced trauma and/or are at risk of complex childhood trauma (i.e., children exposed to domestic violence, abuse, neglect, traumatic grief and other traumas and adverse childhood experiences).

Activities were tailored for each community and designed to enhance parent/caregiver knowledge of child development, common reactions children might experience after a traumatic event, socio-emotional skills, promote positive social skills in children, and facilitate access to needed natural social support networks and resources.

Strategy 1 has been implemented by five lead agencies (Alma Family Services, Children's Institute, Inc., Para los Niños, The Children's Clinic, and Westside Infant-Family Network) and their community partners.

As of April 14, 2022, **3,020** participants have been registered in iHOMS under Strategy 1 or Strategies 1 and 8.

Intended Outcomes

- Increase positive coping strategies to reduce impact of trauma among at-risk children and their families.
- Social isolation reported by parents or caregivers and children will decrease.
- At-risk children with trauma symptoms who have been underserved will receive referrals to mental health treatment/systems when necessary.

NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people reached is not de-duplicated.

Events and Activities

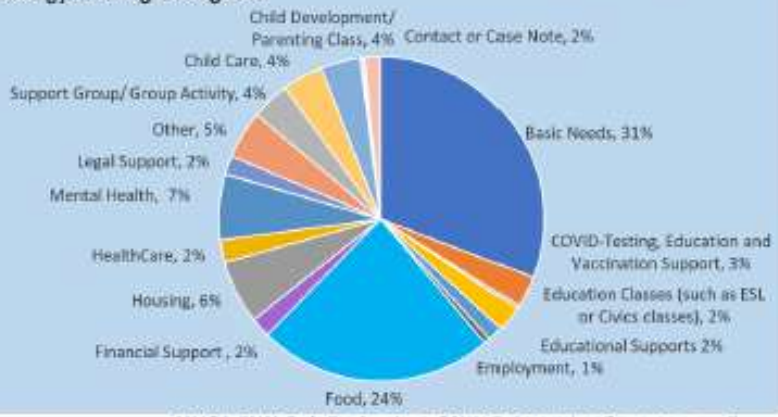
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support young children and their families. It is evident from the types of events recorded in iHOMS that partnerships focused on creating safe spaces for families to connect, strengthen their knowledge of child development and attachment as well as self-care and wellness and create awareness within the community for resources and supports.

- Agencies recorded more than **6,000 events** in iHOMS, reaching hundreds of thousands of families and their young children through their Strategy 1 outreach and events.
- Strategy 1 programming focused on providing group activities, making up nearly **40%** of all their event-related activities. These group activities included family and parent support groups, play sessions for children, art and music classes, wellness activities, and many other innovative activities.
- All Strategy 1 programs were able to adapt these group activities to a virtual format using Zoom or via live streaming when the pandemic restricted in-person groups and remained connected with their families.
  - **51,882 community members** were reached through a total of **2,201** community events and outreach, group activities and posts on social media between June 1, 2020, and December 6, 2021.
- Part of outreach efforts has included creating awareness about resources, trauma-informed care, wellness, and COVID-19 to educate the community and partners.
  - Staff provided **68 trainings to 1,790 partners and community members**, and **278 COVID-19 testing and education events for 29,770 community members.**

Linkages for Strategy 1 Participants

- Referrals and resources recorded in iHOMS focus on supporting the diverse needs the community.
  - Overall, there were **7,775** referrals for resources and services provided to 63% (1,907) of Strategy 1 participants during the initiative.
  - Eighty eight percent **(88%)** of referrals were reported as successful linkages.
  - Food, basic needs (such as diapers and wipes), mental heath and housing were the most frequent linkages for Strategy 1 participants.

Strategy 1 Linkage Categories



Strategy 2: Trauma-Informed Psycho-education and Support for School Communities

Strategy Description and Objectives

Strategy 2's approach to build capacity within the community targets school administrators' teachers, and after-school staff. Trainings/workshops center on recognizing behaviors and symptoms of stress and trauma in children in early care/education (EC/E), school personnel and community mentors who work with children ages 3-15. Teachers and care providers learn to recognize behaviors associated with trauma; how family trauma, historic trauma and poverty contribute to further instability within families and their school/care environments; and how to support children dealing with complex trauma through relationship-building, providing scaffolding and effective, positive discipline. Another component of the strategy focuses on addressing burn-out, stress, and vicarious trauma amongst teachers by teaching them mindfulness and other self-care practices.

Strategy 2 has been implemented by four lead agencies (Alma Family Services, Children's Institute, Inc., Para los Niños, and Westside Infant-Family Network) and their community partners.

As of April 14, 2022, **504** participants have been registered in iHOMS.

Intended Outcomes

- Increase knowledge about trauma among educators and staff.
- Reduce stress amongst educators and at-risk students.
- At-risk students with trauma symptoms who have been underserved will receive referrals to mental health treatment/systems when necessary.

NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people

Events and Activities

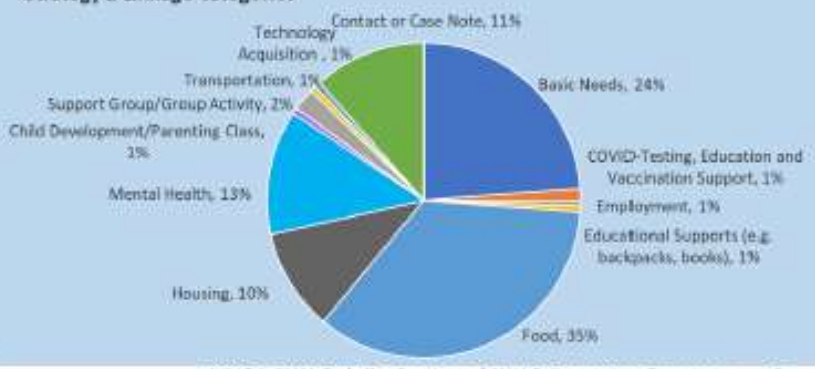
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support children and educators. It is evident from the types of events recorded in iHOMS that partnerships focused on creating safe spaces for educators to connect and strengthen their knowledge of trauma and using a trauma-informed lenses to reframe children's 'challenging behaviors'.

- Agencies recorded more than **1,854 events** in iHOMS, connecting with school staff and providing classroom-based education and supports through Strategy 2.
- Strategy 2 programming focused on providing **trainings** to school staff and educators, making up over **60%** of all their event-related activities. These trainings provided specialized consultation and education on trauma-informed psycho-education support.
- The pandemic greatly impacted the efforts of Strategy 2 due to school closures and the shift to virtual learning. In-person trainings shifted to online training forums and curriculums were adapted to address the needs of educators, incorporating topics such as grief, mindfulness, and self-care.
    - However, there has been a significant increase in Strategy 2 activities, with over 90% of events occurring after January 1, 2021.
- To meet each community's needs during the pandemic, outreach and education extended beyond the original scope of the strategy to include schoolwide and parent/student focused support groups to address the challenges of access and learning new technologies and coping with stress and isolation.

Linkages for Strategy 2 Participants

- Given the strategy's focus on trainings and education, resources and linkages are not generally provided like other strategies.
    - Overall, there were **172** referrals for resources and services provided to 28 Strategy 2 participants during the initiative.
    - Ninety two percent **(92%)** of referrals were reported as successful linkages.
    - Referrals focused on basic needs, such as food, family supports and housing, and referrals for mental health services. This reflects the shift towards including families who attended the partnering schools as a response to the needs of the community during the pandemic.
    - INN 2 staff used the linkage tracker to document check-ins with teachers (contact notes) and sharing informational or event flyers.

Strategy 2 Linkage Categories



Strategy 3: Transition Age Youth (TAY) Support Network

Strategy Description and Objectives

Strategy 3's approach to build capacity within the community targets TAY (ages 13-25) who are currently or formerly experiencing homelessness and who are emotionally and physically vulnerable. Certain populations of TAY are at higher risk of experiencing homelessness and social isolation due to the identities they hold, including LGBTQ TAY, TAY who have experienced racism, and TAY who have been victims of abuse or crime.

Strategy 3 was designed as a peer-to-peer model that meets TAY where they are at through trauma informed programs and integrating social media into their outreach strategies to build awareness and educate TAY on trauma, stress and wellness, COVID-19, self-care and mindfulness practices. Within Strategy 3, partners facilitate safe spaces and opportunities for TAY to develop the protective factors of social connectedness within Support Networks, and support their housing, employment or education goals through case management.

Strategy 3 has been implemented by five lead agencies (Alma Family Services, Children's Clinic of Antelope Valley, MHALA, Safe Places for Youth, and Pasadena Public Health and their community partners.

As of April 14, 2022, **2,944** participants have been registered in iHOMS under Strategy 3 or Strategies 3 and 8.

Intended Outcomes

- Increase positive coping strategies to reduce impact of trauma.
- Decrease social isolation/withdrawal and negative social connections among youth.
- Maintain and/or secure housing

Events and Activities

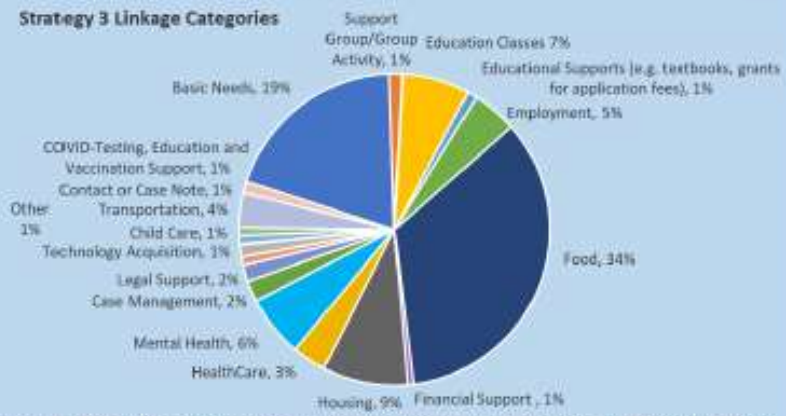
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support TAY. Examples of core programing for Strategy 3 TAY include housing, behavioral health, job skills and career development, and youth advocacy. It is evident from the types of events recorded in iHOMS that partnerships focused on creating safe spaces for TAY to connect, strengthen their self-autonomy and create awareness within the community for resources and supports.

- Agencies recorded more than **5,000 events** in iHOMS, reaching TAY through extensive outreach and engagement efforts in the community and providing their TAY participants with necessary resources and referrals.
- Strategy 3 provided the widest variety of event types of any of the strategies.
  - Almost half of Strategy 3 activities are split between **outreach and engagement (23.0%)** and **resources and referrals (23.1%)**.
- Strategy 3 implemented innovative outreach methods to reach the TAY population in their communities, including outreach at the boardwalks and skate parks, via social media live streaming and virtual "hang-outs", free haircut and laundry events, and presentations at the community colleges.

Linkages for Strategy 3 Participants

- Referrals and resources recorded in iHOMS focus on supporting the diverse needs the community.
  - Overall, there were **33,948** referrals for resources and services provided to 83% (2,454) of Strategy 3 participants during the initiative.
  - Ninety six percent **(96%)** of referrals were reported as successful linkages.
  - Food, basic needs (such as clothing, backpacks and sleeping bags), housing and education/skills classes were the most frequent linkages for Strategy 3 participants.
    - Agencies provided shelter, rent and motel support, and linkages to a multitude of housing programs. Some housing linkages have been innovative, utilizing relationships with the community to temporarily house individuals in motels during the early COVID shelter in place closures and with their bridge housing partner.

Strategy 3 Linkage Categories



NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people reached is not de-duplicated.

Strategy 4: Coordinated Employment within a Community

Strategy Description and Objectives

Strategy 4's approach is to build capacity to assist individuals who were previously homeless, currently homeless and at risk of or experiencing symptoms of mental illness related to trauma to advance their educational, vocational and employment goals. Strategy 4 partners approach employment as a protective factor for individuals living with severe and persistent mental illness. They intentionally put in the practice the belief that employment can be a strong tool for recovery.

During 2020, the department approved a pivot to the strategy to address a challenge within the community intensified by the pandemic and shelter in place restrictions (the need to bridge the digital divide to improve employment opportunities and reduce economic exclusion). The objective of the pivot, called *Project Opportunity*, is to inform and empower individuals through education and skills development while at the same time expanding the economic opportunities and community connections available to the target population.

MHALA (and their community partners) is the only agency to implement Strategy 4.

As of April 14, 2022, **98** participants have been registered in iHOMS under Strategy 4 or Strategies 4 and 8.

Intended Outcomes of *Project Opportunity*

- Improvement in financial wellbeing.
- Increase social connectedness.
- Participants will make progress towards educational/vocational goals.
- Increase access to technology

NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people

Events and Activities

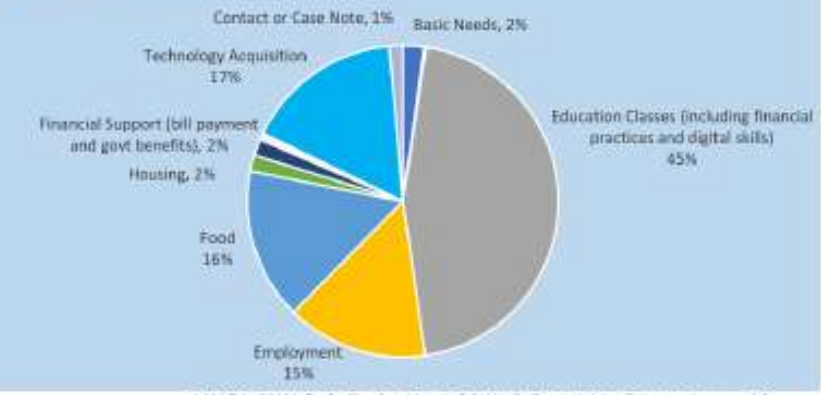
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support participants' employment and education goals. It is evident from the types of events recorded in iHOMS that the partnership focused on supporting community members to advance their educational, employment and financial goals through trainings and skill development opportunities.

- **718 events** were recorded in iHOMS for Strategy 4, supporting individuals entering the workforce with trainings and resources.
- During the pandemic, strategy 4's approach towards outreach and education pivoted to focus on financial literacy and technology acquisition/skills as a way to address economic exclusion because of the digital divide.
  - **Trainings** to their partnering agencies and their participants on digital skills and financial practices to support individuals in the workforce, made up **over 40% of their event-related activities.**
  - These included hosting a digital skills training series, money management workshops, and employment and education webinars.
- In addition to trainings, 33.4% of their events were strategy development meetings including Project Opportunity team meetings and curriculum development meetings for their digital and financial tools.

Linkages for Strategy 4 Participants

- Referrals and resources recorded in iHOMS focus on supporting the diverse needs the community.
  - Overall, there were **591** referrals for resources and services provided to 88% (86) of Strategy 4 participants during the initiative.
  - Eighty one percent **(81%)** of referrals were reported as successful linkages, while twelve percentage of referrals are documented as in progress.
  - The top linkages reported in iHOMS align with the strategy pivot. *Project Opportunity* provides most resources and supports for participants to obtain laptops and WIFI and enroll in education and skills training. *Project Opportunity* also provided linkages to support volunteer opportunities, education, and employment goals.
    - Financial Wellness focuses on highly individualized interventions including, financial education and coaching, credit and debt management, tax filing assistance and savings programs.

Strategy 4 Linkage Categories



Strategy 5: Community Integration for Individuals with a Mental Illness with Recent Incarcerations or Who Were Diverted from the Justice System

Strategy Description and Objectives

The purpose of Strategy 5 was to provide programming to reduce the impact of trauma associated with incarceration and mental illness. Individuals with a mental illness and histories of incarcerations often have extensive histories of trauma that are re-activated after release from jail by lack of pro-social community supports, high risk housing and substance use. Strategy 5 focuses on empowering individual's who are often discriminated against or have little voice to make demands on the larger community for increased resources or equal treatment. In order to ensure community members are accessing the resources they need, Strategy 5 partners focus on providing "warm handoff" referrals and bringing resources out into the community via mobile services. Engagement in the community and foot in the door outreach is crucial for this strategy, so strategy 5 partners focus on providing concrete supports (showers, food, clothing, haircuts, etc.) to build trust within the community.

The Children's Clinic of Antelope Valley (and their community partners) is the only agency to implement Strategy 5.

As of April 14, 2022, **1,321** participants have been registered in iHOMS.

Intended Outcomes

- Secure housing for individuals with recent incarcerations.
- Reduce re-incarcerations.
- Increase connection with the community.
- Increase access to care within the community.

NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people reached is not de-duplicated.

Events and Activities

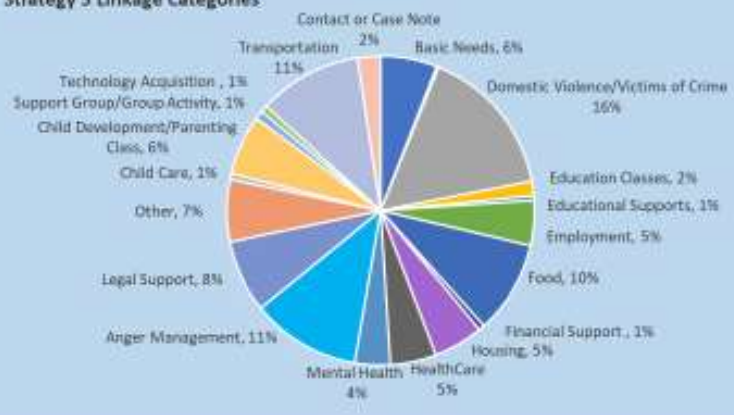
Outreach, community activities and groups, and linkages with supports were unique to each partnership and community's needs and were tailored to support community members with recent incarcerations or involvement with the justice system. It is evident from the types of events recorded in iHOMS that the partnership focused on creating safe spaces for justice involved individuals and their families to receive the help and support they need and assist in successful re-integration.

- **Over 3,500 events** were recorded in iHOMS for Strategy 5, providing trainings and support to community members with recent incarcerations or involvement with the justice system.
- Strategy 5 focused on providing **trainings** to their participants, making up over **75%** of all their event-related activities.
  - These trainings included domestic violence classes, anger management classes, legal and justice system educational trainings.
  - These trainings are often provided for individuals with court mandated requirements to assist them in meeting their requirement and to promote successful re-integration for those recently incarcerated.

Linkages for Strategy 5 Participants

- Referrals and resources recorded in iHOMS focus on supporting the needs of the target population of previously justice-involved individuals reconnect with the community.
  - Overall, there were **4,527** referrals for resources and services provided to 93% (1,235) of Strategy 5 participants during the initiative.
  - Ninety two percent **(92%)** of referrals were reported as successful linkages.
  - Resources for domestic violence/victims of crime and anger management classes were the most frequent linkages for Strategy 5 participants, which aligns with the objectives of the strategy.
  - Transportation, such as linking participants with free bus pass programs, and legal support services, were also common supports provided.

Strategy 5 Linkage Categories



Strategy 6: Geriatric Empowerment Model (GEM)

Strategy Description and Objectives

The purpose of Strategy 6 was to provide programming to reduce the impact of trauma associated with homelessness for Older Adults. Older Adults experiencing the trauma of homelessness are living with a multitude of losses, including isolation and stigma within the larger community, and represent one of the most vulnerable populations at risk for harm. There is a compelling need for a safe environment for older adults, which would include a place for them to visit on a daily basis to rest and shower, eat a meal, wash their clothes, receive screenings to identify immediate health, substance abuse and mental health needs and receive housing support. Homeless shelters are not the optimal setting for older adults who are homeless because they often do not address the unique needs of this population as services and programs in these locations generally have an emphasis on the needs of younger individuals and/or families who are homeless.

Partners who are part of the GEM Program work with the community to develop effective strategies for interacting with older adults who are homeless, establish a homeless senior center for seniors to access during the day, and provide case management and supportive services to meet the complex psychiatric and social needs of older adults.

As of April 14, 2022, **296** participants have been registered in iHOMS.

Intended Outcomes

- Decrease homelessness among seniors
- Increase access to care
- Improve knowledge of and linkages to community resources

Events and Activities

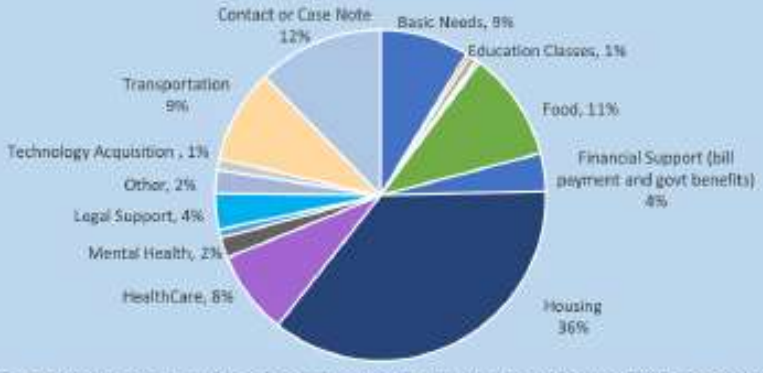
Outreach, community activities and groups, and linkages with supports were unique to each partnership and community's needs and were tailored to support older adults, 60 and over, who are at risk of or experiencing homelessness. It is evident from the types of events recorded in iHOMS that the partnership focused on creating safe spaces to empower older adults experiencing homelessness to receive the care and resources they need as they work towards permanent housing.

- **737 events** were recorded in iHOMS for Strategy 6, focusing on outreach and engagement to older adults at risk of or experiencing homelessness.
- **Community outreach** made up over **90%** of all Strategy 6 events.
  - This included general outreach and community canvassing as well as outreach and engagement efforts through providing community members with free meals, showers, and laundry services.

Linkages for Strategy 6 Participants

- Referrals and resources recorded in iHOMS focus on supporting the unique needs the older adults.
  - Overall, there were **5,080** referrals for resources and services provided to 93% (275) of Strategy 6 participants during the initiative.
  - Seventy three percent **(73%)** of referrals were reported as successful linkages, while sixteen percentage of referrals are documented as in progress.
  - The top linkages reported during the initiative highlights a focus on supporting basic needs. Strategy 6 programs provided most resources and supports for GEM participants in the way of housing assistance, food, and transportation. The INN 2 staff also provided many linkages for healthcare services.
    - Linkages with housing during the pandemic has been innovative. GEM staff partnered with a local motel to assist in temporarily housing their older adult participants experiencing homelessness who were at a higher risk for severe illness or death from COVID-19 in motels that were not being booked during the early months of the pandemic and with their community housing partner. GEM staff were able to help participants establish more permanent housing

Strategy 6 Linkage Categories



NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people reached is not de-duplicated.

Strategy 7: Culturally Competent Activities for Multigenerational Families Experiencing Trauma

Strategy Description and Objectives

The purpose of Strategy 7 is to provide programming to reduce the impact of community or societally-induced trauma experienced by intergenerational families. Working with intergenerational families means that partners need to be responsive to the multi-faceted needs of a family. Within Strategy 7, partners focus on implementing culturally appropriate outreach, education and engagement (OEE), culturally appropriate intergenerational family wellness screenings, and intergenerational family healing activities.

Examples of topics that have been discussed during family activities include working together with area schools, healthy lifestyles, community resources, and family wellness. These programs promote healing and reconnection by identifying and accessing inherent strengths within intergenerational families and communities. Partners within Strategy 7 also works to bring specific cultural activities that are representative of the communities and families.

Strategy 7 has been implemented by two lead agencies (Alma Family Services and The Children's Clinic) and their community partners.

As of April 14, 2022, **2,823** participants have been registered in iHOMS.

Intended Outcomes

- Increase sense of social connectedness among multigenerational families
- Increase positive coping strategies
- Reduce shame and stigma related to trauma/mental illness
- Increase access to care

Events and Activities

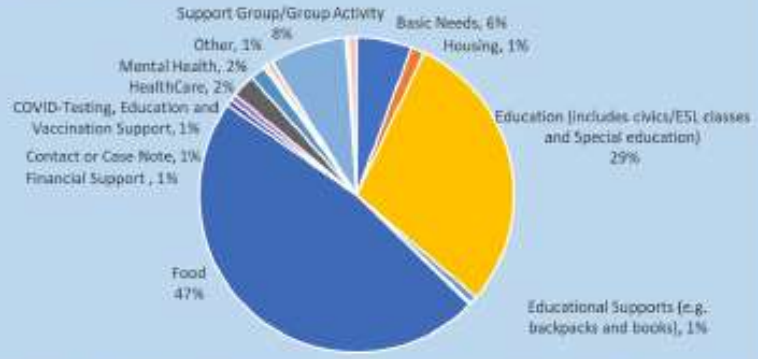
Outreach, community activities and groups, and linkages with supports were unique to each partnership and community's needs and were tailored to support multigenerational families through culturally competent programming. It is evident from the types of events recorded in iHOMS that partnerships focused on creating safe spaces for families to connect, share their culture, break down mental health stigmas and barriers, and create awareness within the community for resources and supports.

- Agencies recorded more than **4,000 events** in iHOMS, providing culturally competent activities to thousands of families through their Strategy 7 outreach and events.
- Strategy 7 programming focused on providing innovative and culturally appropriate group activities for families to participate in together, making up over **60%** of all their event-related activities.
    - These group activities included story telling groups, language specific parenting groups (i.e. hosted in Spanish or Khmer), spiritual activities, ESL classes, along with many other innovative activities.
- Strategy 7 programs were also able to adapt many of these group activities to a virtual format and hold them online when the pandemic restricted in-person groups and remained connected with their families.

Linkages for Strategy 7 Participants

- Referrals and resources recorded in iHOMS focus on supporting the diverse needs the community.
    - Overall, there were **15,688** referrals for resources and services provided to 75% (2,115) of Strategy 7 participants during the initiative.
    - Ninety five percent **(95%)** of referrals were reported as successful linkages.
    - Food and basic needs (such as diapers and wipes) were linkages for Strategy 7 participants.
    - Strategy 7 providers also reported linking participants with needed classes, support groups and group activities. Most notably, strategy seven providers linked participants to Civics and ESL classes to assist them as they prepared for the immigration process.

Strategy 7 Linkage Categories



NOTE: The total number of referrals does not reflect the total number of people served. INN 2 participants may have more than one linkage or referral. Events and the total number of people reached is not de-duplicated.

B. INN 4: Transcranial Magnetic Stimulation (TMS)

Los Angeles County Department of Mental Health (LACDMH) implemented Mobile Transcranial Magnetic Stimulation (TMS) as the Innovation 4 project as of May 2019. 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 sessions can last between 3-45 minutes and services are typically 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 in a van outfitted with the technology, delivered to fully consenting clients receiving treatment in adult outpatient programs. The target population includes individuals receiving outpatient services that have depression as a major part of their psychiatric symptoms and *one or more of the following*:

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

Because of 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 an approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.

Status of Implementation as of June 30, 2022:

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 services within it. Clients of directly operated LACDMH 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 are given the opportunity to ask any questions. If they are interested and the treatment is deemed 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 Service Areas 2, 3, 5 and 8).

INN 4 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), in general, clients sometimes have difficulty adjusting to the change and experience a sudden worsening of depressive symptoms. Therefore, TMS staff completed phone check-ins with TMS clients as soon as was possible to assess how clients were coping with the transition and continued to conduct phone check-ins 1-2 times per week while clients 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 was 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 were 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. As of December 2022, TMS services continue to be administered 5 days a week and take place inside a designated office space.

Number of clients served:

As of **June 30, 2022,** the program had received **135** referrals. Between May 1, 2019, and June 30, 2022, **110** client consultations/initial evaluations were completed. A total of **51** 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 perceived lack of efficacy.

Below is a summary of the demographic information on the **51** clients who completed a full treatment course of TMS as of **June 30, 2022**:

- The majority were adults (ages 26-59) 82%, while 14% were older adults (60 years or older) and 4% were transitional age youth (ages 15-25). In this sample, the two transitional age youth were both 23 years old.
- The majority identified as male (53%) and 47% identified as female.
- The majority identified as Non-Hispanic/Latino (49%), while 29% identified as Hispanic/Latino and for 11% of the clients, the ethnicity was unknown.
- 22% of clients identified their race as White and 12% identified as Mexican. Other races included Asian Native (2%), Black/African American (4%), Cambodian (2%), Central/South American (6%), Korean (2%), and Vietnamese (2%). 14% of clients were of another race and the race of 35% of clients was unknown.
- The majority of clients stated that their preferred language was English (75%). Other preferred languages included Spanish (15%), Cambodian (4%), Farsi (4%), Vietnamese (4%).

Outcome data being collected and analysis of impact:

The Overarching Learning Questions for this project include the following:

1. Will these individuals be adherent with a mobile TMS treatment program?
2. Is TMS an effective treatment for this population?
3. Does TMS for depression lead to improvement in comorbid symptoms (i.e., substance use, psychotic symptoms, etc.)?
4. If TMS is an effective treatment for this population, should the program be expanded to treat a larger part of the population?

In order 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 (HAMD-17, clinician rated), and the Patient Health Questionnaire (PHQ-9, client rated). Client satisfaction with TMS services 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. Additionally, the providers in the client's treatment team are asked to complete a brief survey to assess their impression on the impact of TMS services in the clients overall recovery and functioning at the end of treatment. These assessment tools enable clinicians to track improvements in depressive symptoms and functional outcomes that, in turn, are used to judge the efficacy of this program.

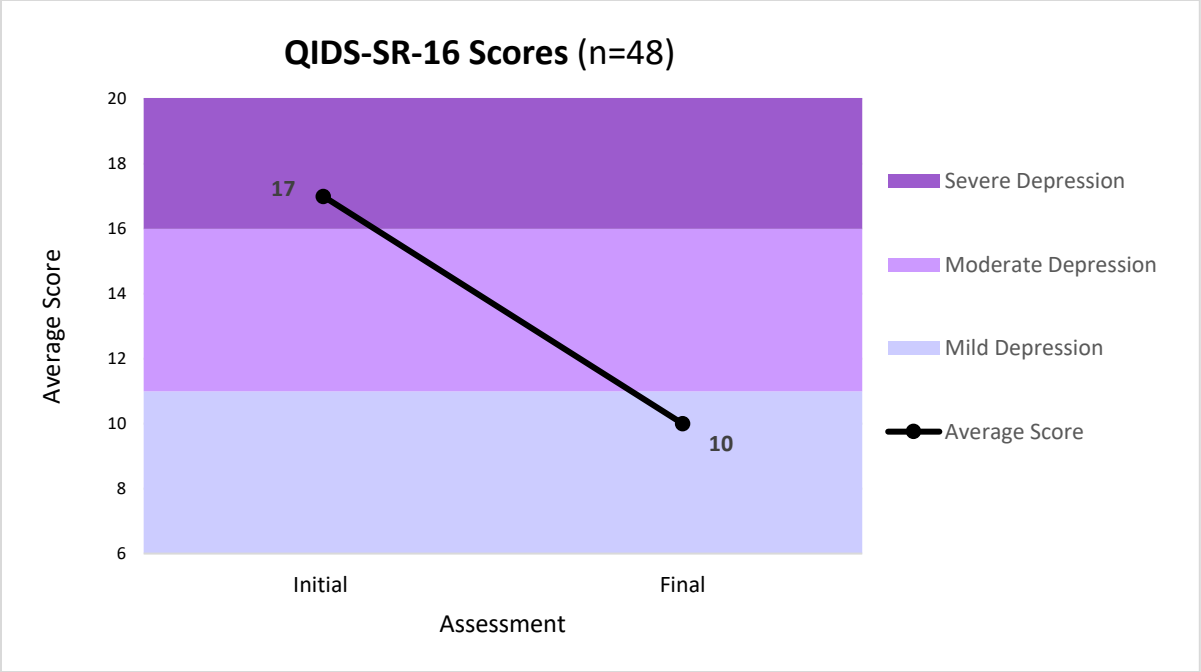
Below are the average initial scores and final scores for each of the three depression measures (QIDS-SR-16, PHQ-9, and HAMD-17) for clients who completed a full TMS treatment course between May 1, 2019, and June 30, 2022. Data included is for clients who received at least two treatments of TMS and completed the respective measure at least twice.

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 10, which indicates mild depression. **There was an average change in score of 7 points (41% 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, 12 clients (**25%**) of clients met criteria for remission (no depressive symptoms) at the end of treatment.
- 14 clients had an initial score that indicated very severe depression (score of 21 or more). Depressive symptoms improved for **64%** of these clients (scores of 20 or less) at the end of the course of TMS treatment.



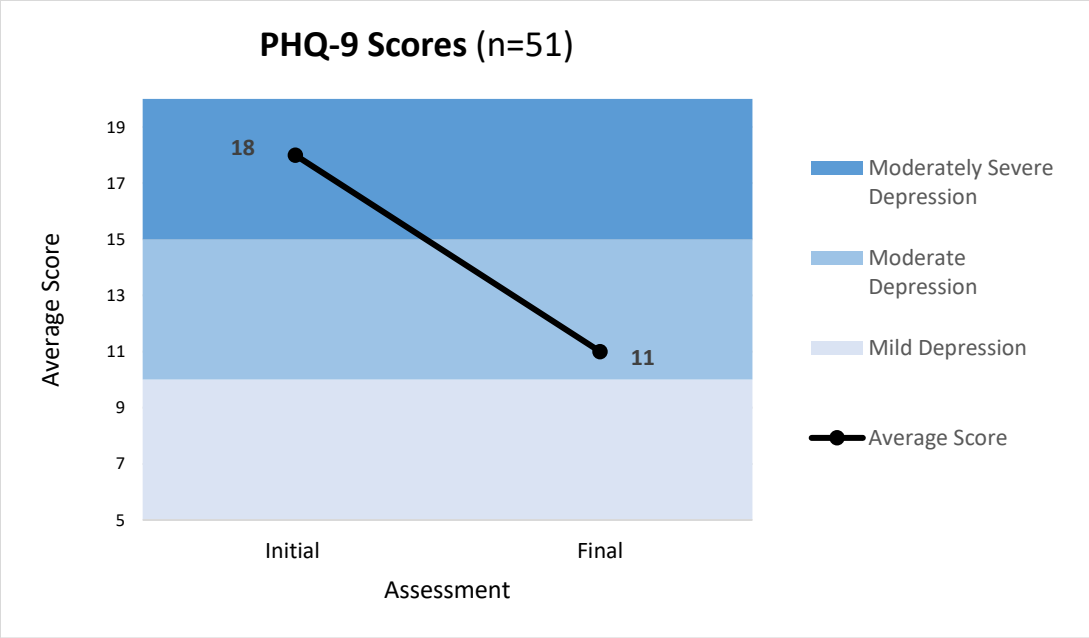
Graph 1. Summary of Average QIDS-SR-16 Scores for Mobile TMS clients.

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 11, which indicates moderate depression. **There was an average change in score of 7 points (39% 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, 11 clients (**22%**) of clients met criteria for remission (no depressive symptoms) at the end of treatment.
- 25 clients had an initial score that indicated severe depression (score of 20 or above). Depressive symptoms improved for **60%** of these clients (scores less than 20) at the end of the course of TMS treatment.



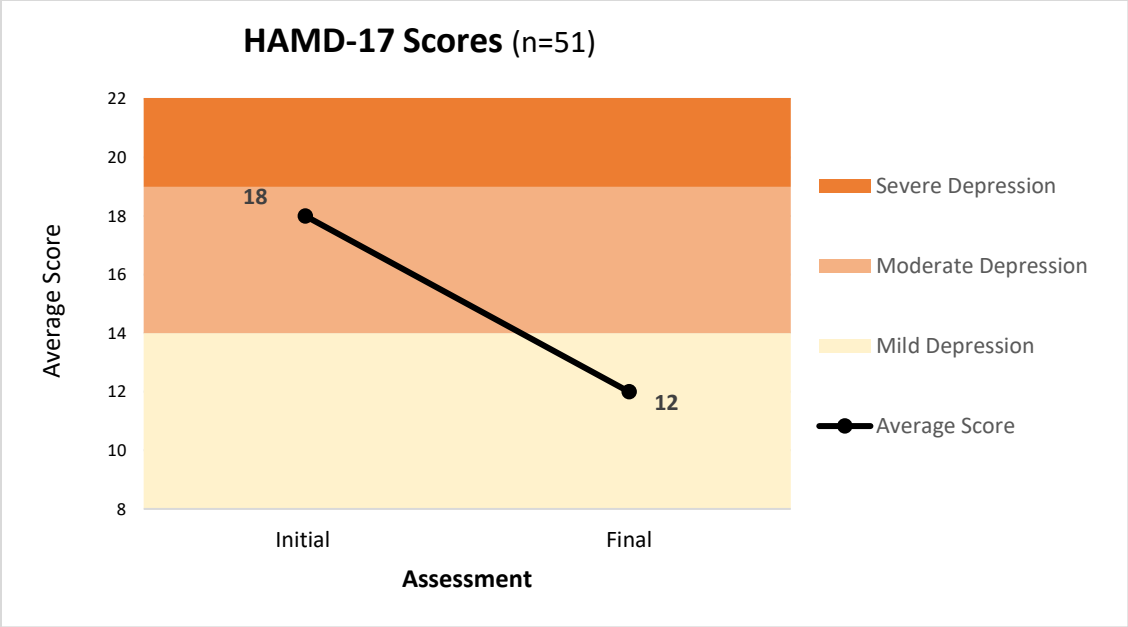
Graph 2. Summary of Average PHQ-9 Scores for Mobile TMS clients.

Hamilton Depression Rating Scale (HAMD-17)

The HAMD-17 is one of the longest standing and 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 12, which indicates mild depression. **There was an average change in score of 6 points (33% 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 (**18%** of clients) met criteria for remission (no depressive symptoms) at the end of treatment.
- 3 clients had an initial score that indicated severe depression (scores of 25 and above). Depressive symptoms improved for **33%** of these clients (final scores of 24 and below) at the end of the course of TMS treatment.



Graph 3. Summary of Average HAMD-17 Scores for Mobile TMS clients.

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 the client's satisfaction with various aspects of TMS treatment and the client's perceived impact of TMS services on the client's overall well-being and functioning.

Overall Satisfaction [Chart 1]:

- Overall, a majority (**95%**) of clients who completed a CSS were "Very Satisfied" or "Satisfied" with their TMS experience, which is a **22% increase since December 1, 2019.**
- None of the clients were dissatisfied with their TMS experience.

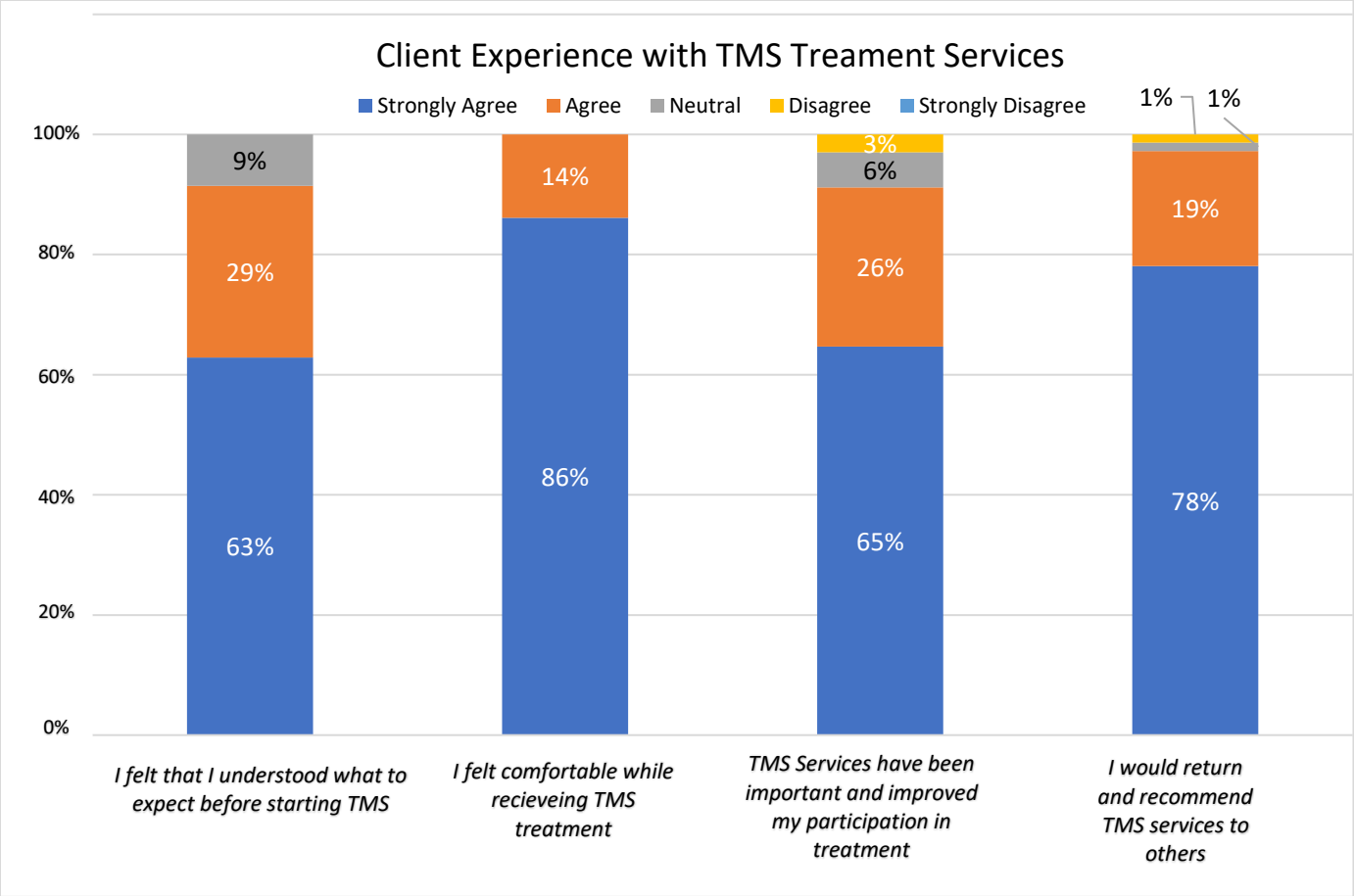


Chart 1. Overall Client Satisfaction with Mobile TMS services

TMS Treatment Experience [Chart 2]:

- A majority of clients who completed a CSS (**94%**) "Strongly Agreed" or "Agreed" that they understood what to expect before starting TMS treatment.
- All clients (**100%**) "Strongly Agreed" or "Agreed" that they felt comfortable while receiving TMS services.
- A majority of clients (**91%**) "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, a majority of clients (**97%**) "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.

Level of Discomfort/Pain during and after TMS Treatment [Chart 3]:

Clients were asked to rate their discomfort/pain during TMS treatments and after TMS treatments on a scale of 1-10, with 1 corresponding to "No Pain" and a score of 10 corresponding to "Very Painful".

- On average, respondents felt mild discomfort/pain during TMS treatments (*2 out of 10*) and less mild discomfort/pain after TMS treatments (*1 out of 10*).
- Clients most often described discomfort/pain as “annoying” and the the discomfort usually decreased over the course of treatment and resolved after treatment.

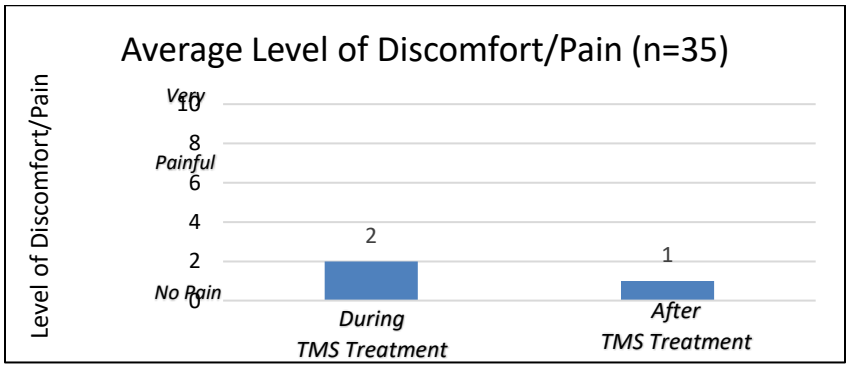


Chart 3. Average Level of Discomfort/Pain During and After Mobile TMS Treatments

Percieved Benefits of TMS Services [Chart 4]:

Clients were asked how they felt they benefitted from participating in TMS services. All answers are listed below and the most endorsed benefits are shown in Chart 4.

- **60%** of clients stated that they that they feel happier.
- **57%** of clients stated that they feel less worried/anxious.
- **51%** of clients stated that they are less frustrated.
- **49%** of clients stated that they have more motivation to engage in meaningful activities and that that they are able to focus better.
- **46%** of clients stated that they feel more relaxed.
- **40%** of clients stated that they have more energy and an increased abilty to do the things that they want to do.
- **34%** of clients stated that they have more contact with family/friends.
- **31%** of clients stated that they are sleeping better.
- **29%** of clients stated that they have more self-confidence and that they are getting along better with family/friends.
- **17%** of clients stated that they are eating better.
- **14%** of clients stated that they feel less body pain.

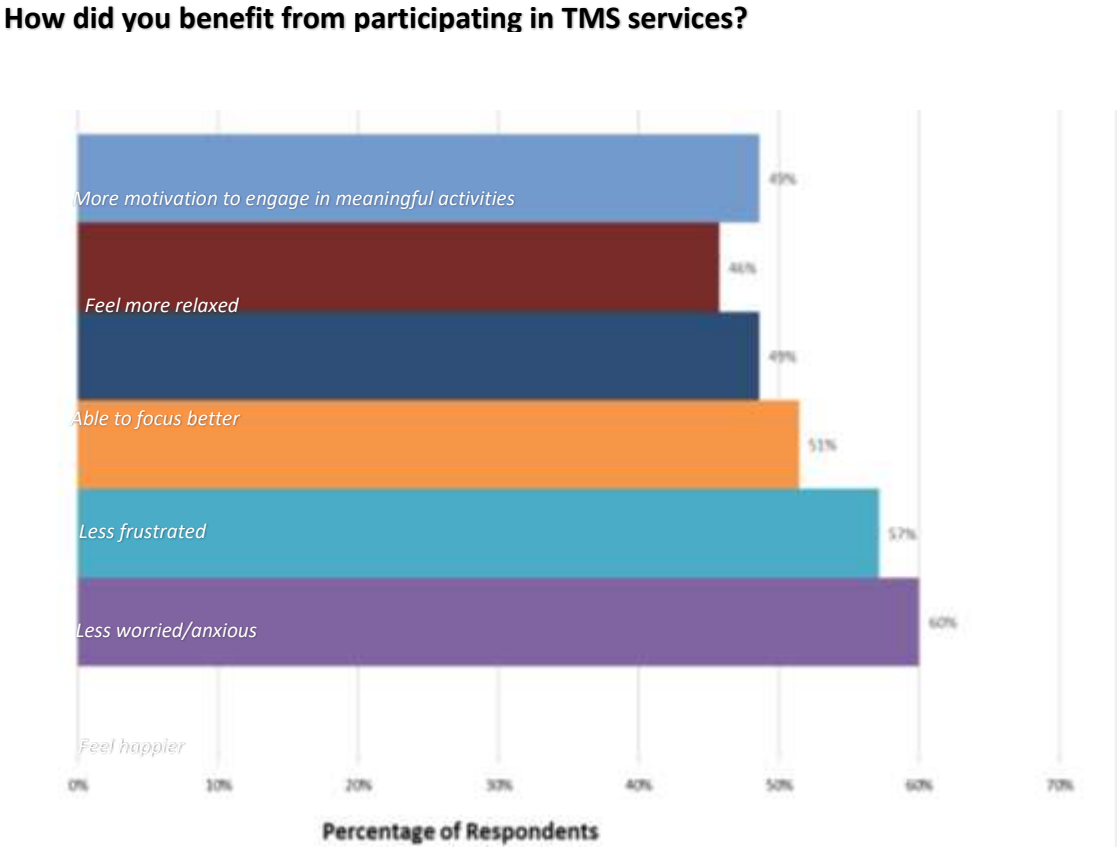


Chart 4. Most Common Percieved Benefits of TMS Services by Clients After Mobile TMS Treatment.

Additional Client Feedback:

Upon treatment completion, clients were asked to share any additional feedback that they may have regarding their experience with TMS services through client exit interviews and on the Client Satisfaction Survey. Some of their feedback is listed below:

- "…the overall process was friendly and calm."
- "I think that TMS helps to reduce my headache. My brain is more clearer than before. My mood is more happier because of reducing headache."
- "[I] finally feel hope."
- "Slightly more conversational. A bit more improvement with depression."
- "The staff was very nice and helpful."
- "TMS has been extremely beneficial. My depression has at least been cut in half and all the benefits from the above list. Thank you so much."
- "[I] have better clarity and less feelings of shame guilt."
- "No longer crying and suicidal"
- "A lot less depressed. Feel more ok."

Treatment Team Survey

A survey was provdied to each of the client's treatment team of providers at the end of treatment. The providers were asked to rate their client's improvement in mood, behavior, overall funcitoning, and progress made toward treatment goals as a result of TMS services. A total of **32** surveys (for **26** clients) were completed by treatment team staff (16 Psychiatrists/Medical Doctors, 5 Therapists, 3 Case Managers, and 1 Registered Nurse).

- A majority (**58%**) of providers "Strongly Agreed" or "Agreed" that their client demonstrated improvements in mood, behavior, and overall functioning (family, community, occupational) as a result of TMS services **[Chart 5].**
- A majority of providers (**55%**) "Strongly Agreed" or "Agreed" that their client made progress towards her/his treatment goals as a result of TMS Services **[Chart 6].**
- A majority (**89%**) of providers "Strongly Agreed" or "Agreed" that they would refer future clients for TMS services **[Chart 7].**

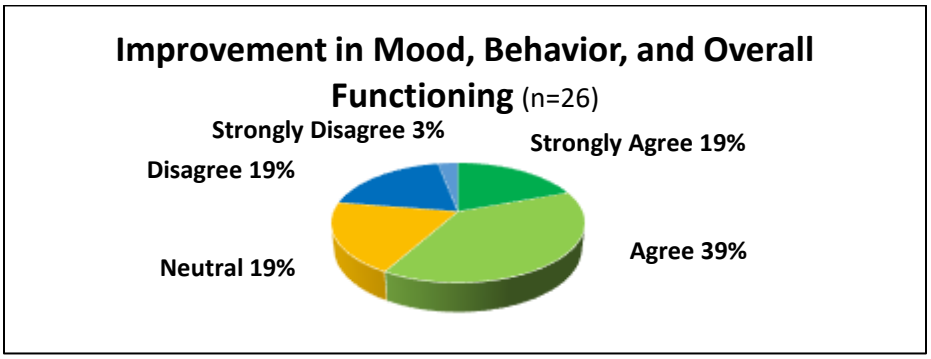


Chart 5. Provider Perception on the Impact of TMS Services on Client's Mood, Behavior, and Overall Functioning

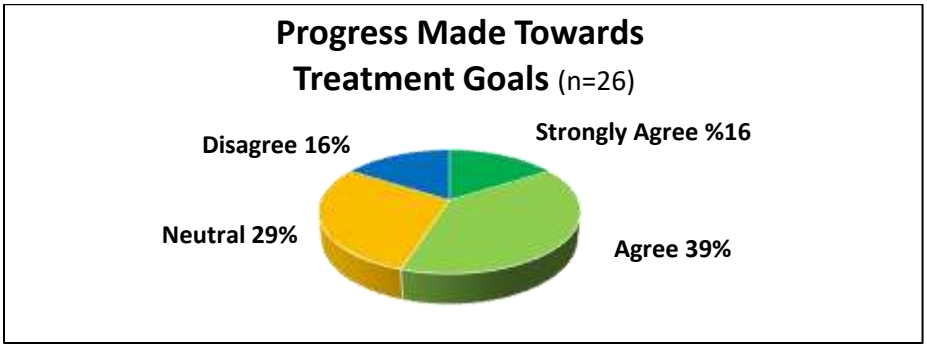


Chart 6. Provider Perception on the Impact of TMS Services on Client's Progress Toward Treatment Goals

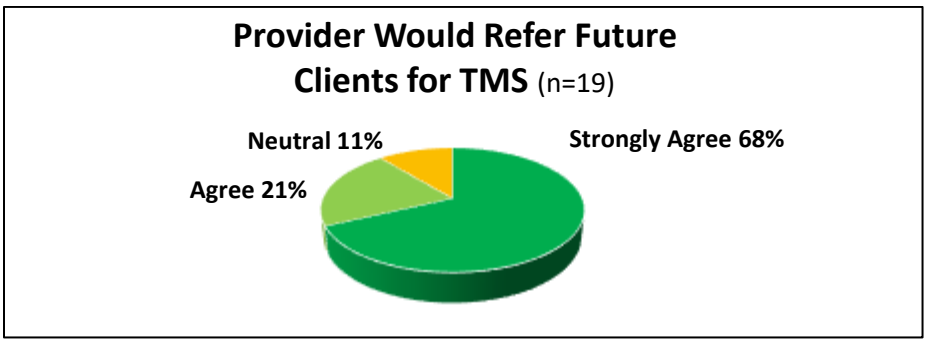


Chart 7. Likelihood of Provider Referral to TMS Services for Future Clients

Provider staff were also asked to share any additional feedback, which is listed below:

- "Patient was appreciative of the opportunity and enjoyed the experience..." (Psychiatrist)
- "[The client] was able to make it to TMS every day and that was the biggest progress." (Case Manager)
- "Client appeared more engaged at his last appointment and...he noted overall improvement with mood and focus." (Nurse)
- "The notable change that seems to have remained since TMS treatment is that the client is more socially engaged and involved with community activities." (Case Manager)
- "Client comes to dance group and MD's appointments regularly. He is noticed to be more interactive and sociable." (Case Manager)
- "His headaches and sleep improved significantly." (Psychiatrist)
- "The client had improvement in ability to function despite pain and chronic headaches." (Psychiatrist)
- "Eliminated suicidal ideation. Reduced negative thinking/rumination. Increased hope." (Therapist)
- "Client was more open to the therapeutic process after receiving services. Client reported that services were very helpful in being able to lift the feelings of severe depression." (Therapist)
- "Patient reports that it was beneficial for her mood! That's a big deal for her, as medications have not been particularly helpful for her. The only issue was transportation/location." (Psychiatrist)
- "There has been a significant change in her symptoms (particularly her suicidal thought and mood)..." (Psychiatrist)
- "Anger reduced" (Psychiatrist)
- "The supportive structure and daily visits helped this client through some incredibly stressful times that likely would have resulted in more crises without the daily interventions." (Therapist)
- "[The client] …was also proud of accomplishment of going to TMS, it was behavioral activation, and it was motivating for her." (Psychiatrist)
- "Client reported improved mood that she has not experienced in a while." (Case Manager)

Client Testimonials:

"For over a year I have benefitted from Transcranial Magnetic Therapy at Harbor-UCLA. I suffer from Major Depressive Disorder and have been a county mental health patient for years. Medications have worked intermittently but I have not had a sustained recovery where I can manage my mood consistently. TMS has made things better. Since starting treatment I have not had completely immobilizing depression. I have been depressed but I bounce back sooner. I have a more confident outlook. I feel that I have an underlying sense of support. For me, this is big progress. I was fearful of the treatment at first because I was unfamiliar it and it initially hurt. This quickly changed because Dr. Heiser and his team helped me feel calm and safe. Despite the unusual treatment in a van, they made me feel comfortable and I even once fell

asleep once during treatment. The opportunity to get this treatment from the county facility was a surprise. I had thought it was only available to wealthy patients. In this way the TMS program works to mitigate health disparities. I hope it can expand."

"I have been undergoing TMS for several months. It's been a Godsend me. I had been going through constant suicidel [sic] thoughts for years, if not for the TMS I would have most likely followed through with them. Thanks to the TMS, Dr. Heiser and his team, I am still alive. It has given me hope to keep going. Hopefully this treatment can help other peopol [sic]. To me it is the rock of my treatment. Thank you 😊 "

"I have had years of therapy and I have tried different medications for depression and they did not work like TMS did. I wish the whole world could get TMS. We would be better to each other if we could. Thank you, Violet, Desta, Desiree, and Dr. Heiser & Thank you to the TMS machine."

"Before I started I was so depressed to the point of daily suicidal ideation. Felt helpless, worthless, undeserving, and didn't understand why I even existed. It was daily torture to the extreme of suicide attempts and multiple hospitalizations. Now, on this day of leaving final treatment, I feel ALIVE! I feel like living. I'm very seldom depressed and haven't had a suicidal thought in 4 months. That is so new for me. This TMS has helped me more than words can say. Thank you 😊"

"I am extremely thankful for being informed of considered for and accepted as a patient whom can benefit from TMS treatments. I consider myself blessed by the kindness, acceptance, professionalism, care, attention and support that I have received from your wonderful DMH staff."

"I notice that even when I feel down I am still able to function at a higher level as far as getting tasks done. The initial wave of happiness I felt the first few weeks of treatment has dissipatted [sic] but I still feel it has had a positive effect for the entire treatment."

"I am truly grateful to have been able to have this treatment. While I still have issues with depression, anxiety and pain, the TMS treatment has made a treatment has made a tremendous difference. The physicians and all of the clinicians involved in treatment have been wonderful. Thank you all very much."

C. 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.

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.

Therapeutic Transportation January – December 2022

IMPLEMENTATION DATES

STATION #	SD	IMPLENTATION DATE	HOURS OF OPERATION	COMMENTS
4	1	01/30/22	24/7	
59	3	03/06/22	24/7	LPT resigned on 2/15/23 – 12/7 since January 2023
77	5	05/16/22	12/7	Difficulties hiring LPTs for noc shift
94	2	08/08/22	12/7	Difficulties hiring LPTs for noc shift
40	4	09/26/22	12/7	Difficulties hiring LPTs for noc shift

TOTAL NUMBER OF CALLS

During the months of January through December 2022, Therapeutic Transportation Teams received **1,680** calls. Station 4 received **65%** (N=1,090) of the calls while station 59 received **15%** (N=246) followed by Station 94 which received **11%** (N=182)

Months	Station 4	Station 40	Station 59	Station 77	Station 94	Total
Jan*	3					**3**
Feb	129					**129**
Mar*	88		20			**108**
Apr	120		30			**150**
May*	94		23	1		**118**

Months	Station 4	Station 40	Station 59	Station 77	Station 94	Total
Jun	93		11	15		**119**
Jul	108		32	19		**159**
Aug*	102		30	28	4	**164**
Sep*	96		39	21	44	**200**
Oct	105	16	31	19	50	**221**
Nov	82	15	16	17	42	**172**
Dec	70	4	14	7	42	**137**
Total	**1,090**	**35**	**246**	**127**	**182**	**1,680**
Percentage	**65%**	**2%**	**15%**	**8%**	**11%**	**100%**

*Month Station open

TRANSPORTED

57% of calls were transported by Therapeutic Transportation Teams. The table below illustrates the number and percentage of transported calls by station and month.

Station	Station 4		Station 40		Station 59		Station 77		Station 94		Transport	No Transport
Transported	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
Jan*	2	1									**2**	**1**
Feb	79	50									**79**	**50**
Mar*	68	20			10	10					**78**	**30**
Apr	83	37			16	14					**99**	**51**
May*	66	28			15	8		1			**81**	**37**
Jun	51	42			7	4	7	8			**65**	**54**
Jul	64	44			23	9	6	13			**93**	**66**
Aug*	60	42			13	17	15	13	2	2	**90**	**74**
Sep*	59	37			18	21	9	12	22	22	**108**	**92**
Oct	52	53	9	7	13	18	9	10	29	21	**112**	**109**
Nov	42	40	9	6	10	6	5	12	20	22	**86**	**86**
Dec	37	33	3	1	3	11	5	2	17	25	**65**	**72**
Total	**663**	**427**	**21**	**14**	**128**	**118**	**56**	**71**	**90**	**92**	**958**	**722**
Percentage Transported	**61%**		**60%**		**52%**		**44%**		**49%**		**57%**	

OUTCOMES

36% (N=598) of calls during this period we placed on an involuntary hold, **21%** (N=360) of calls during this period were evaluated, did not meet criteria, or transported for services (6000), **4%** (N=75) were evaluated and accepted voluntarily accepted services while **38 %** (N=636) of calls were cancelled due to various reasons. The table below illustrates the various dispositions by station during this reporting period.

Station #	5150	6000	Cancelled	Refer	Refused	Voluntary	Total
Station 4	404	250	386	2	4	44	**1,090**
Station 40	8	3	14	0	0	10	**35**
Station 59	67	63	107	2	0	7	**246**
Station 77	40	17	62	2	1	5	**127**
Station 94	79	27	67	0	0	9	**182**
Total	**598**	**360**	**636**	**6**	**5**	**75**	**1,680**
Percentage	**36%**	**21%**	**38%**	**0%**	**0%**	**4%**	**100%**

DESTINATION

57% of TT calls were transported to a facility. Majority of transported calls, **43%** (N=413) were transported to UCC, followed by **32%** (N=310) were transported to a hospital. **11%** (N=107) were transported to the emergency room and **10%** (N=98) were transported to a clinic.

Station #	CLINIC	ER	Hospital	Other Facility	UCC	No Transport	Total
Station 4	43	55	235	26	320	411	**1,090**
Station 40	5	2	5	1	8	14	**35**
Station 59	18	14	47	13	30	124	**246**
Station 77	8	28	6	4	14	67	**127**
Station 94	24	8	17	0	41	92	**182**
Total	**98**	**107**	**310**	**44**	**413**	**708**	**1,680**
Percentage	**10%**	**11%**	**32%**	**5%**	**43%**		

D. INN 8: EARLY PSYCHOSIS LEARNING HEALTHCARE NETWORK

The Department received approval from the Mental Health Services Oversight and Accountability Commission (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 after initial approval by the Human Subjects Research Committee on April 23, 2020. The Early Psychosis Learning Healthcare Network (LHCN) allows counties who use a variety of Coordinated Specialty Care models to treat early psychosis to collect common outcome data. They can then use this outcome data to inform treatment and engage in cross-county learning.

Participation in this learning collaborative connects California counties with a national effort to promote evidence-based Coordinated Specialty Care models to effectively treat first episode psychosis and to collect common outcome data. It is a very unique California effort to join a national movement to reduce the duration of untreated psychosis and improve the outcomes and lives of individuals experiencing a first psychotic break. Los Angeles County has expanded its population to also include those who are identified as at clinical high risk for experiencing a first psychotic episode.

Beehive is a tablet- and web-based application developed by the UC Davis-led Learning Healthcare Network that is being 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.

Additional funding by the National Institutes of Health (NIH) obtained by UC Davis has allowed the project to further expand to add additional sites across the State. 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).

The Department's early psychosis coordinated specialty care model 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 30, 2022, there are 105 clients enrolled at five (5) clinics across Los Angeles County.

Status of Implementation as of June 30, 2022:

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 consumers and family members who have been, or are being served, by EP programs. Attendees receive updates and provide feedback on project elements biannually. Advisory Committee meetings during this reporting period were held on December 15, 2021, and June 10, 2022.

The December 15, 2021 meeting focused on updates on expansion of the LHCN committee to include Napa and Stanislaus Counties along with acknowledgment of the collection of initial services data from participating counties, including Los Angeles County. The Beehive training progress and barrier were discussed as well as changes implemented in Beehive from user feedback as well an update on Spanish language Beehive services. The June 10, 2022 meeting further discussed the expansion of training and the barriers to providers integrating Beehive into their workflow. Following this, breakout rooms focused on Incorporating Beehive in Care, Consumer Engagement and Training and Beehive Learning Curve to come up with collaborative solutions to barriers.

EP Program Fidelity Assessments

Each early psychosis clinic undergoes a fidelity assessment using the First Episode Psychosis Services Fidelity Scale (FEPS-FS). The FEPS-FS represents a standardized measure of fidelity to EP program best practice and was recently revised to meet the agreed upon standards of EP care in the US and allow large-scale fidelity evaluation. However, most programs within EPI-CAL, including Los Angeles County, also provide services to individuals with the clinical high-risk syndrome (CHR), for whom evidence-based best practice differs from FEP care in several respects. To provide a program assessment that most accurately

represents the care delivered, alongside the FEP-FS, research team will be piloting a new scale under development designed to assess the components of care delivered to individuals with the diagnosis of CHR, known as the CHRP-FS.

Each EP program will participate in an assessment of EP program components using the revised FEPS-FS/CHRPS-FS, which will be completed via web-based teleconference. The fidelity assessment will be used to identify program strengths and possible areas for improvement, which can serve an important driver to improving early psychosis care delivered in EP programs in the LHCN. Assessments are completed by trained clinical staff with expertise in early psychosis care and supported by evaluation administrative and research staff. As of June 30th, 2022, Los Angeles County was scheduled to be reviewed in July-September 2022. However, because of site scheduling issues and staff availability, fidelity reviews are scheduled to be completed by the end of December 2022.

Training and implementation of outcomes measurement on app

The Epi-Cal team provided core training on the Beehive application to non-pilot EP programs, including Los Angeles County. Due to the COVID-19 pandemic, trainings were provided remotely. The core trainings begin with a pre-training meeting with leadership and IT staff from each program 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 and IT systems. Next, the team conducted a training series consisting of a pre-training meeting with program leadership to introduce the training plan, three training sessions to introduce Beehive to each program (Part 1, Part 2, and Part 3), and an intake-workflow meeting with key clinic staff to understand clinic workflow and brainstorm how to best implement Beehive within their program context. Note that booster trainings (for entire program or for individuals at the program) have also been conducted in addition to the core trainings and are not included on the table below.

Figure 1: EPI-CAL Program Training Completion

Program	Pre-Training	Training 1	Intake Workflow	Training 2	Training 3
LAC- IMCES 3	5/10/2021	6/21/2021	8/11/2021	11/10/2021	12/8/2021
LAC - IMCES 4	5/10/2021	6/21/2021	8/11/2021	11/10/2021	12/8/2021
LAC - SFVCMHC	5/11/2021	6/18/2021	7/19/2021	11/18/2021	12/9/2021
LAC- The Whole Child	5/13/2021	6/17/2021	7/21/2021	11/23/2021	1/25/2022
LAC- The Help Group	5/14/2021	6/14/2021	8/10/2021	11/29/2021	1/5/2022

The End User License Agreement (EULA) video was also reviewed with staff to streamline the registration process for staff during the training and to orient them to what consumers and families also see when they first access the Beehive system. The EULA video in English can be accessed here: https://youtu.be/3E8hiEkIvSQ. The Spanish EULA video is available here: https://youtu.be/UgY7ZUhe-Fk. The EULA video was developed through focus groups with EPI-CAL community partners (consumers, family members and providers) to ensure that core aspects of Beehive (e.g., purpose, security, consent and data sharing) were clear to users. Every new user of Beehive was presented with the EULA video before making their data sharing choices.

After training, each program has an EPI-CAL staff point person to provide regular check-ins to provide training and implementation support. Additionally, point persons may also

provide booster trainings to individuals at the program or to groups of program staff. These may be conducted remotely via web conferencing. More recently the EPI-CAL team has begun to visit sites in-person as initially proposed and planned prior to COVID-19 in-person meeting restrictions. The site visit for Los Angeles County is tentatively planned for January 25-27, 2023.

Preliminary results on program-level data from 3 pilot EP programs

A pilot study was conducted by UC Davis to understand barriers and facilitators to Beehive app implementation, including interviews with pilot EP programs. After initial Beehive trainings, EDAPT/SacEDAPT in Sacramento County, Solano SOAR Aldea programs and Kickstart in San Diego County began enrolling consumers into Beehive in March 2021. LACDMH was not part of this pilot, however a similar Beehive enrollment process below was implemented by the County after the pilot period.

Basic demographic information is entered into Beehive by clinic staff when initially registering a consumer and their support persons. Consumers are then invited by clinic staff to join Beehive via email link or in person using an electronic tablet. All consumers complete the EULA before being presented with outcome surveys. Their choices are explained in the EULA video. When consumers complete the EULA, they indicate whether they want to share their data with UC Davis and/or the NIH for research purposes beyond using Beehive for the purpose of their clinical care. Consumers then complete their registration and can complete surveys.

The goal is to have 70% of consumers agree to share their data with UC Davis and NIH.
For this annual report, data collected in those three pilot programs was through December 3rd, 2021 for those who agreed to share their data with UC Davis. One hundred and twenty-five consumers were registered in Beehive across the three pilot clinics, and of those, 66 completed their EULA indicating their data sharing permissions. Of those who completed their EULA, 55 consumers agreed to share their data with UC Davis (83%).

The majority of these 55 consumers were ages 18-23 (49%) with the next largest group being ages 12-17 (33%). Fifty-three percent (53%) of consumers selected male as their sex at birth and 49% identified their gender as male. The largest consumer group by race was Hispanic/Latinx only (25%) followed by African/African American/Black and White/Caucasian (24% each). Most consumers were diagnosed with First Episode Psychosis diagnoses. It is important to note that 25 consumers were missing a diagnosis at the time of data collection.

After registration is complete, the EPI-CAL Enrollment Life Questions are made available for the consumer to complete. If a consumer is in a survey window (e.g., at intake or six months), Beehive makes available 15 additional surveys that assess various community partner-chosen outcomes including family functioning, education, social relationships, demographics and background, medications, and symptoms (see Figure 2). These surveys are presented in different bundles that are grouped based on subject matter and/or timing of the surveys (i.e., whether they receive the survey just at enrollment, or at enrollment and every six months thereafter). The pilot data only tracked EPI-CAL enrollment and required bundles, and 80% off consumers completed all three Enrollment surveys.

Figure 2: 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	
	Social Relationships	
	Employment and Related Activities	
	Education	

Enrollment and follow up completion rates for LHCN app in all EP programs

After the pilot, EPI-CAL staff monitor enrollment progress and symptom survey completion for LHCN across all EP programs in LHCN on a weekly basis. The following metrics are monitored and visualized: Beehive registrations, Beehive enrollments (i.e., consumers with a completed EULA), opt-ins for data sharing with UCD and/or NIH for research purposes, and completion of the Modified Colorado Symptom Index (MCSI) at Baseline, 12 months, and 24 months.

While reviewing these figures each week, the EPI-CAL team discusses observed barriers for sites which are enrolling at a rate below the average LHCN enrollment rate. The team will also discuss solutions or interventions to address barriers. Even when barriers are outside the scope of EPI-CAL project, (e.g., program turnover, dedication of program staff efforts), the EPI-CAL team will still attempt to understand how to can accommodate the program given their needs at that moment. The EPI-CAL team also discusses the facilitators for sites which are enrolling above the average LHCN enrollment rate. EPI-CAL staff develop strategies to disseminate facilitators among all LHCN sites.

LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs

Figure 3 shows the LHCN Progress towards EPI-CAL Enrollment targets as of June 10, 2022. Consumers are considered enrolled if they have completed the Beehive EULA and agreed to share their data with UC Davis for use in research. If consumers do not allow their data for use in research but agree to use Beehive as part of clinical care, their data may be used for quality management or quality assurance purposes only. The goal at this point in the project was to have 405 individuals enrolled (endpoint of black line in figure below). The observed rate of enrollment across the LHCN is 145 consumers (solid blue line in figure below). There

are an additional 142 consumers who have been registered by the clinic in Beehive (dashed blue line in figure below), but who have not engaged with Beehive by completing the EULA or starting their surveys. The number of registered individuals is monitored because it serves as a proxy for program census (though most clinics do not yet have all active consumers registered) and allows the EPI-CAL team to see what possible enrollment across the network could be.

Figure 3: LHCN Progress Towards EPI-CAL Enrollment Targets

Figures 4-5 show a site-by-site breakdown of the proportion of individuals who agreed to data sharing with UC Davis for research purposes as of June 10, 2022. Figure 4 shows all registered consumers, regardless of EULA completion status. For Los Angeles County, 26% of consumers had completed their EULA status. EPI-CAL Team members met with County project leadership to discuss barriers to EULA completion and to create a plan of action to improve completion. Significant barriers noted were staff turnover at sites, difficulties with consumers accessing the web-based Beehive app while receiving telehealth services, and challenges with program staff integration of Beehive into their workflow. Individual meetings between EP Programs and County staff were scheduled in the weeks after, the results of which improved EULA and registration completion, in the next fiscal year.

Figure 4: Proportion of Data Sharing with UCD for Research by Site

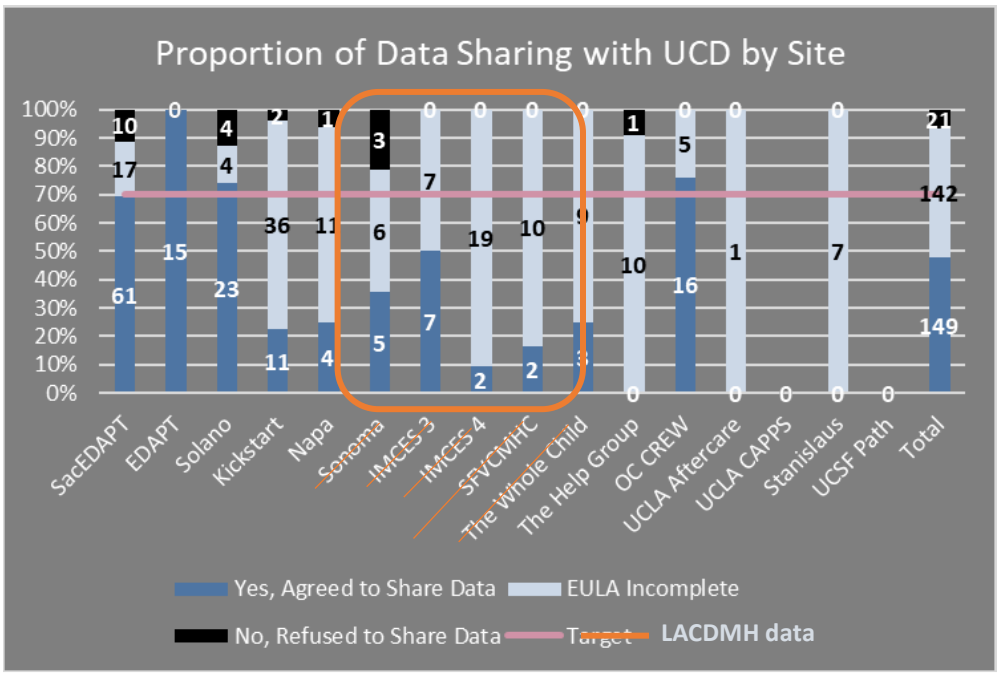
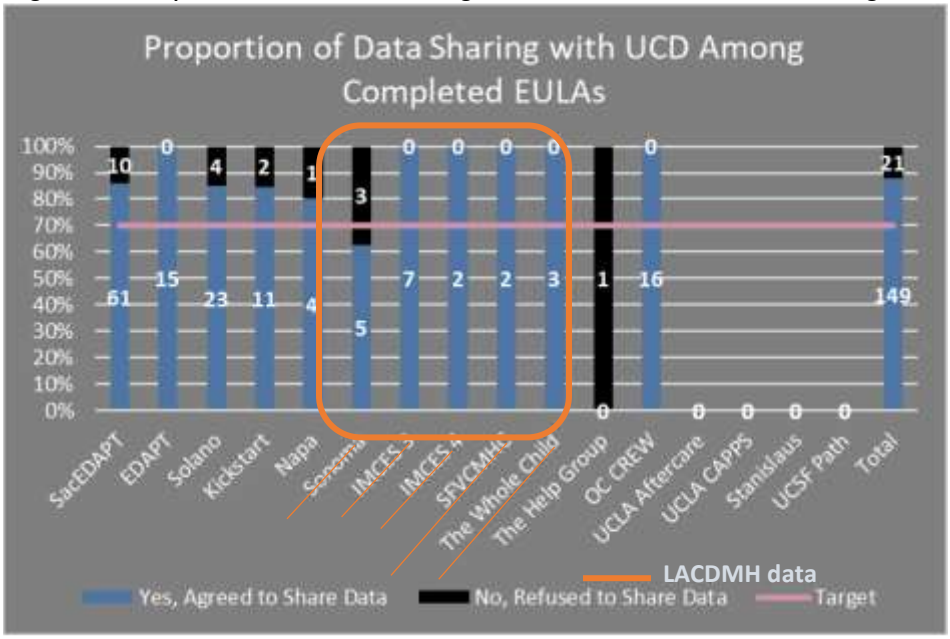


Figure 5 shows the proportion of data sharing choices made by those consumers who have completed their EULA in Beehive. The goal is that 70% of active consumers at each site agree to use Beehive and share their data for research purposes. When considering all consumers known to EPI-CAL, only a few sites are meeting this metric. However, among those individuals who have engaged with Beehive and completed the EULA, the target was exceeded across the network. For Los Angeles County, 93% of clients who completed the EULA agreed to data sharing.

Figure 5: Proportion of Data Sharing with UCD for Research among Completed EULAs



As of May 26, 2022, 76% of all enrolled consumers (n=107) have completed at least one enrollment survey. As of May 19, 2022, 92% of enrolled Los Angeles County consumers (n=13) have completed at least one enrollment survey. Note that all consumers can complete enrollment surveys regardless of when in their treatment they are enrolled. Consumers are not able to complete some survey windows (e.g., baseline) if they are enrolled later in treatment. Some consumers have completed surveys at more than one time point.

Subcontractor to revise dashboard to include feedback from programs and community partners

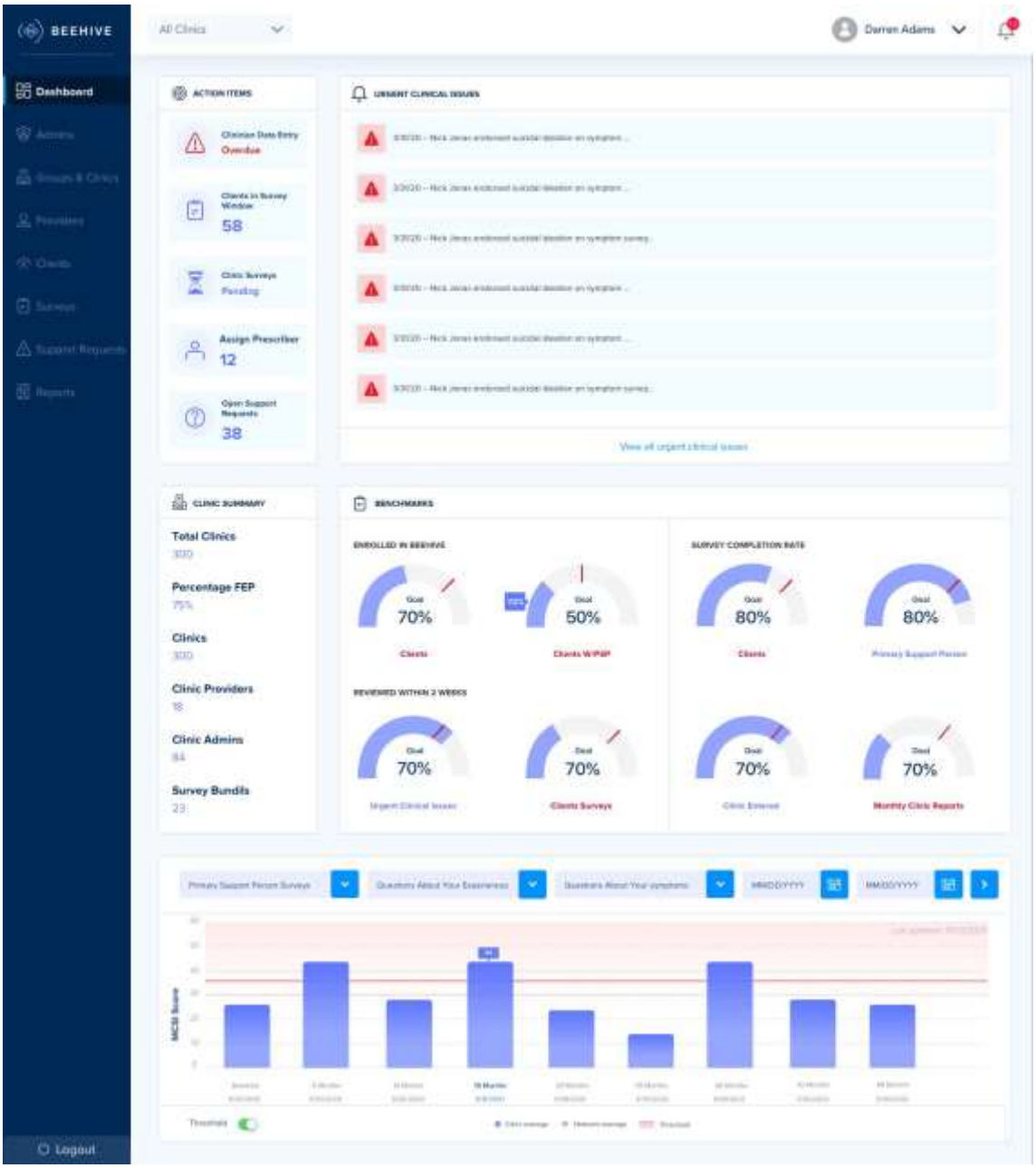
As Beehive has been designed for EP Programs, the needs and preferences of EP programs and the institutions of which they are a part have driven the design of Beehive. Security requirements of counties and institutions have led to increases in the security of Beehive. Feedback from users at EP Programs has identified several aspects of the application that could be improved to increase compatibility with their existing workflows and facilitate implementation of this novel technology.

Notably, pentesting was conducted by Azacus.io Cybersecurity on the Beehive application as a security requirement for several programs, including Los Angeles County. Penetration testing, or pentesting, is a simulated hack to test the security of a system. Azacus.io conducted pentesting on both the web and iOS applications between June 21, 2021 and July 3, 2021. Azacus.io delivered the results of pentesting to the EPI-CAL team on July 12, 2021. All issues of vulnerability that were identified in the testing were addressed by the developers. On September 10, 2021, Azacus.io completed a retest of the application that proved all identified vulnerabilities had been fixed. Annual pentesting will be completed per Los Angeles County request.

User feedback has also contributed to the development of Beehive. Updates to the Survey Status Screen, including a New Data Icon for unreviewed consumer data, and bolding of newly answered consumer surveys in bold in dropdown menus.

The Beehive dashboard was also redesigned with input from programs. The goal of the dashboard is to provide users with the information that is of the highest priority for them when using Beehive. However, feedback from beta users indicated that they weren't sure what was most important, and the dashboard seemed busy. With this in mind, the dashboard was redesigned with input from community partners across all EP programs.

Figure 6: Updated Beehive Dashboard



To prioritize community partner preferences and needs, the EPI-CAL team has implemented a system of formally gathering user feedback before planning each sprint series with the developers. A survey was sent out to all beta sites to solicit their feedback to prioritize the issues and ideas they had reported over the beta testing period.

Feedback from interviews with EP community partners about experience in EP treatment programs.

Interviews were conducted with EP community partners about the barriers and facilitators to implementing a Learning Health Care Network into EP treatment programs.

The interview guide was developed by the qualitative lead, with input from the rest of the research team, the LHCN advisory group and community partner feedback. The interview guide is structured to explore provider experiences related to each component of Beehive

implementation, including enrolling consumers into the application, consenting and other steps prior to consumers inputting data, the data inputting process itself, and then incorporating Beehive and the data in care. Finally, provider experiences of training and ongoing support were explored.

Four clinics with the highest engagement with the Beehive platform (Solano, EDAPT, SacEDAPT, and OC CREW) were interviewed. Preliminary findings centered on five prominent domains: training, enrollment workflow, clinical utility, the learning curve to understanding Beehive, and consumer engagement in surveys. More interviews with staff at additional clinics as well as consumer interviews are needed to fully understand the barriers and facilitators to implementing a LHCN into EP programs.

Finalize statistical methods and identify county-level available data for multi-county-integrated evaluation of costs and utilization data

The proposed data analysis is based on pilot work conducted in Sacramento County, scaled to multiple counties (Niendam et al., 2016). It focuses on consumer-level data related to program service utilization, other outpatient services utilization, crisis/ED utilization, and psychiatric hospitalization and costs associated with these utilization domains during two time periods: 1) the three years prior to implementation of project tablet in the Early Psychosis (EP) programs (e.g., Jan 2017 – Dec 2019), to harmonize data across counties and account for potential historical trends, and 2) for the 2.5 year period contemporaneous with the prospective EP program level data collection via the tablet (Jan 2020 - June 2022). Data will de-identified and be shared through an encrypted and password protected SFTP server, which is housed on UCD secure servers.

Early Psychosis (EP) sample

First, all individuals entering the EP programs January 1, 2017 – December 31, 2019 will be identified using County Electronic Health Record (EHR) data. Because LACDMH did not begin enrolling consumers into the PIER program until January 2020, Los Angeles County identified 91 consumers who received EP services under the Center for Assessment and Prevention of Prodromal States (CAPPS) Program during the study period at three legal entity providers (Special Services Group – Occupational Therapy Training Program, The Help Group and San Fernando Valley Community Mental Health Inc.). Programs identified those individuals who received treatment versus only eligibility assessment and referral to another service. Comparison was restricted to individuals diagnosed with first-episode psychosis (FEP), and not include those at Clinical High-Risk (CHR) for psychosis, due to an inability to reliably identify individuals with CHR in the comparator group.

Comparator Group (CG) sample

The EPI-CAL team will compare the utilization and costs of the FEP participants in EP programs to utilization and cost among a group of FEP individuals with similar demographic and clinical characteristics who do not receive care in the EP program during the same timeframe in the same County. FEP individuals meeting the same eligibility criteria for the EP program (e.g., FEP diagnoses, within the same age group) who enter standard care outpatient programs in the County during that same period will be identified as part of the comparator group (CG). Los Angeles County identified 19,956 consumers in the initial comparator group.

Service Utilization

Next, data will be requested from the County EHR on all services received by individuals in both groups including 1) any non-EP outpatient services; 2) inpatient services and 3)

crisis/ED services. LACDMH identified over 2.6 million relevant inpatient and outpatient service claims.

Costs
LACDMH was able to identify cost data on each service and worked with the EPI-CAL team to provide information on service contracts, cost reports and published rates to determine additional cost data. The EPI-CAL team will determine whether to apply a single cost across all services (by type of service) or to apply costs that are county or provider specific. We will include billable and non-billable services. Outcomes will be calculated per month to account for varying lengths of time receiving services during the active study period.

The data will be harmonized on demographics, diagnoses, and service types across Los Angeles, San Diego, Orange, Napa, Stanislaus, and Solano counties for EP and CG groups, then merged into a single dataset for our primary analyses. The EPI-CAL team will identify an EP group consisting of individuals served by the EP program, and a CG group, consisting of individuals with EP diagnoses, within the same age group, who enter standard care outpatient programs during that same time period. For each county, the EPI-CAL team held meetings with the EP program managers and the LACDMH data analysts to determine service delivery, program characteristics, staffing, billing and funding sources for the CAPPS and PIER programs. The information from LACDMH was combined with other counties into a multi-county data table.

Cost and utilization data from preliminary multi-county integrated evaluation, identification of problems and solutions for county-level data analysis
Preliminary analysis comparing the EP and CG groups in San Diego County on service utilization and related costs data was provided in the EPI-CAL team's final report to the MHSOAC. Due to the challenges outlined at the end of this section, the EPI-CAL team was not yet able to integrate or analyze cost data from Solano County, Orange County, and Los Angeles County. The team is confident that the cost comparison analysis, along with a finalized comparison analysis of service utilization, will be completed for the next deliverable, due December 2022.

Following the preliminary analysis of San Diego County data, a preliminary multi-county comparison of the service utilization was completed. Service utilization of individuals with FEP treated at the participating EP programs was compared to service utilization of a similar group served between January 1, 2017- December 31, 2019. Consumers were ages 12-25. The eligible diagnoses were based on the psychotic disorder diagnoses accepted by the EP programs, standardized across counties, and included psychotic disorders and when no psychotic disorder was present, a mood disorder with psychotic features. Clients excluded from the comparable group included those with intellectual disabilities, those with a psychotic disorder more than 2 years prior to the index service date during the study period, or if the first outpatient service was a Full-Service Partnership (FSP) OR the consumer received FSP services in the two years prior to the study period. The data set included outpatient, day/crisis stabilization and 24-hour services such as psychiatric inpatient hospitalization or residential treatment.

Demographic categories of age, sex and race/ethnicity were harmonized across counties. Only EP consumers who were publicly insured (e.g., Medi-Cal) were included. Duration of EP treatment was focused on the first 24 months of service as most programs had a maximum

treatment period of about two years. To account for variation in intensity of services and attrition over time, the team defined service periods as index service date to 6 months, 7-12 months, 13-18 months, 19-24 months and 25 months+ (until last service date). The final cohort includes a sample of 506 individuals served by EP programs and 17,092 individuals from the CG group.

The EP sample had an average age of 17.0 years, 59% of whom identified as male. Of those receiving treatment in the CG group, the mean age was 20.1, and 61% of them identified as male. The average age of CG individuals was significantly older than the average age of EP individuals in this sample ($p<.001$). No statistical difference in the distribution of sex was found. The EP group included a significantly higher number of individuals who identified as Hispanic/Latino (56%) compared to the proportion of individuals from the CG clinics (44%, $p<.001$). In addition, a higher percentage of EP individuals identified as Caucasian (27%) compared to CG individuals (17%). However, a majority of CG individuals reported Unknown race (54%).

A higher proportion of individuals in the EP group had a Psychosis Spectrum disorder as the primary index diagnostic category compared to the CG group (EP Group: 80%; CG Group: 61%, $p<.001$). For both groups, Mood Spectrum disorders represented a smaller proportion of the primary diagnoses (EP Group: 6%; CG Group: 21%).

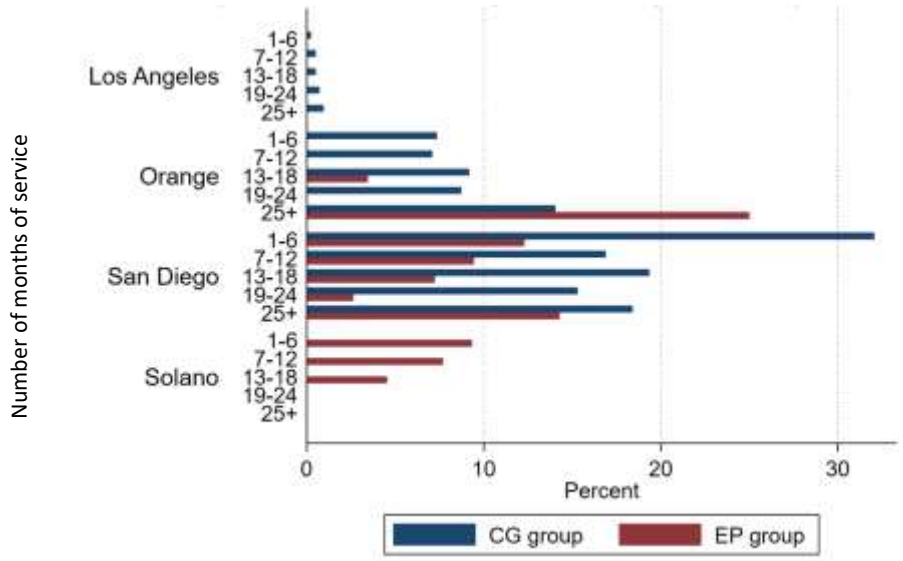
On average, individuals receiving treatment in both groups tended to remain in treatment for roughly one year (EP group: 11.1 months, CG group: 12.2 months), but average duration of treatment was significantly higher for CG individuals ($p<.05$). A roughly equal proportion of EP and CG individuals ended treatment within the first 6 months (43% and 44%, respectively). A greater proportion of EP individuals ended treatment between 7 and 12 months compared to CG consumers (28% vs. 13%, respectively). However, compared to EP individuals, a larger proportion of CG individuals ended treatment after they had received over 25 months of services (5% vs. 24%, respectively).

The EP and CG clinics offered similar types of outpatient services, including assessment, case management, collateral, crisis intervention, group therapy, individual therapy, medication support, plan development, and rehabilitation.

In examining the total minutes of outpatient services provided to individuals per month, those served in the EP group received significantly more minutes of service across all time points compared to the CG group. When specific services are examined individually, the greatest difference is observed between groups in minutes of collateral, per person, per month (EP group: 140 minutes; CG group: 66 minutes) and individual therapy (EP group: 239 minutes; CG group: 188 minutes) per person.

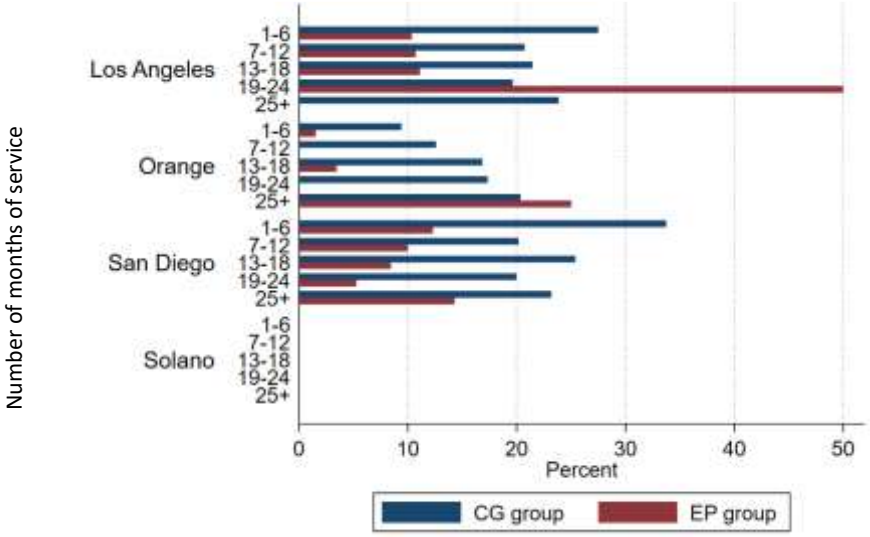
The use of day services was rare for both groups, as only 2.0% of EP and 4.7% of CG individuals received these services while enrolled in EP or general outpatient treatment (see Appendix V – Table 22). Calculated as the proportion of individuals with one or more visits, use of day services was greater in the CG group across all time points ($p<.001$). Further, the rate of day service visits was the highest among individuals that had been enrolled in treatment for 25 months or more (EP group: 3.3%; CG group: 5.7%, see Figure 7).

Figure 7: Proportion of consumers with at least one day service visit by time period by county



A significantly greater proportion of CG individuals experienced at least one 24-hour service or inpatient hospitalization during their enrollment compared to EP individuals (22.4% vs. 8.9%, *p*<.001). As shown in Figure 12, 24-hour services occurred most frequently during the first 6 months of treatment (EP group: 9.4%; CG group: 24.8%) and after 25 months of treatment (EP group: 17.0%; CG group: 23.7%), although we did not test these differences statistically. This data was unavailable for Solano County.

Figure 8: Proportion of consumers with at least one 24-hour service by time period by county



The cost comparison analysis goal was not met due to the complexity of the data required to be harmonized across counties and the variety of data sources. Nearly all programs and counties, as well as the EPI-CAL central team, have been impacted by staff shortages due to unfilled positions and redeployment of staff during the COVID-19 pandemic, which has delayed project coordination and data extraction. The team continues to meet with counties including LACDMH to clarify questions about received cost and utilization data, and to troubleshoot issues related to incomplete or unclear data elements.

Limitations in the preliminary analysis of service utilization data have attempted to be addressed by the EPI-CAL team. The County Data evaluation team is reviewing CG and EP group data to identify ways to improve the harmonization of data across the counties in the evaluation. In addition to methodological improvements, the county data evaluation team is working with county staff to extract additional data required for the analytic methods. The team requested historical data for consumers in our county EP groups to be used in the weighting methodology described above. LACDMH staff were able to identify previously unavailable service data for 24-hour service categories for all consumers.

Summary
Across all time periods, the total minutes of outpatient services per month was higher among EP individuals compared to CG individuals. However, the proportion of individuals in the EP group with one or more day services and/or 24-hour services/ inpatient hospitalizations was lower compared to the CG group.

Interpretations
Regarding duration of enrollment in treatment, the EP and CG groups are generally similar, with more EP consumers receiving 7-12 months of service, and the CG group having a substantial proportion of consumers who received longer-term treatment (25+ months), past the standard end-point of EP treatment at 24 months. In both groups, nearly half of the consumers received services for less than 6 months, which may represent challenges in engagement with this population, as well as the mobility of TAY youth, who may also have received services elsewhere.

The groups were both predominantly male, as is often typical in early psychosis clinical samples. There was a slightly older average age in the CG group, and more Hispanic/Latino consumers and Caucasian consumers in the EP group. This may reflect the focus of programs on outreach and staffing availability predominantly in English and Spanish. They identified as predominantly heterosexual across both groups. The results of this preliminary analysis are consistent with the intent of EP programs- to offer more intensive and evidence-based outpatient services to reduce the need for higher levels of care and to promote recovery. This is evident in the higher overall outpatient minutes for the EP group. Greater time spent in individual therapy likely reflects the treatment models of the EP programs, which focus on CBT for psychosis or other similar forms of therapy. EP programs make a concerted effort to involve families of these transition age youth, reflected in the results of more collateral services than the CG group.

Similarly, the significantly greater proportion of CG individuals who had inpatient hospitalizations during the study period may demonstrate the effectiveness of early intervention in reducing hospitalization rates. Day services were so rare in both groups that we only analyzed the proportion of individuals with at least one service. Overall, these group differences are quite promising, although at this time, we cannot rule out differences in severity and needs between the EP and CG groups at baseline that could partly or fully explain the service utilization differences. As noted previously, access to hospitalization data may have been limited (e.g., by treatment outside county); however, these issues should have affected the EP and CG groups in a county similarly.

Next Steps

In the next project period, the EPI-CAL team will continue to conduct fidelity assessments with EPI-CAL programs and meet with county and program leadership to provide detailed feedback on fidelity results. The team will also continue and complete training of EP programs from both the LHCN and larger EPI-CAL network, especially as new programs join. As implementation of Beehive continues, the team will elicit feedback from EP programs how to improve both the training process and Beehive itself via feedback surveys, regular check-ins from point people, and qualitative interviews. The goal is to continue to improve Beehive in an iterative process and to incorporate community partner feedback so that Beehive be a useful data collection and visualization tool for the programs using it. We are also working with sites to understand why enrollments are not matching the original projections and to support them to increase the degree to which they are integrating Beehive into their standard practice.

In addition, for all counties participating in the county data component of the LHCN, meetings will be scheduled over the next several months with each county to review the details of the EP and CG retrospective data pulls, the cost data, and to problem-solve any issues that arise. We will then conduct the statistical analyses for individual counties and across the integrated dataset. In anticipation of the prospective data analysis, we have met with each county to discuss the timeline for obtaining their data and details of what will be included in the data pull. We will submit the formal data extraction requests in writing in July 2022, after we complete meetings with all relevant parties.

Another major goal of the next project period is to develop the final analysis plan for all LHCN data, with a particular focus on the consumer outcomes data collected via Beehive. This will integrate results from the fidelity assessments.

Niendam et al., 2022. *Annual Innovation Report: Summary Report of the Activities of the LHCN Fiscal Year 2021-2022.* Pending final submission. Prepared by UC Davis, San Francisco and San Diego.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
FY 2023-24 Estimated Gross Expenditures		**FY 2022-23 Estimated Gross Expenditures**		**FY 2021-22 Total Gross Expenditures**
$70,400,000		$22,800,000		$27,639,000
Program Description				
• LAC + USC Crisis Residential Treatment Programs (CRTPs) • Rancho Los Amigos Crisis Residential Treatment Programs (CRTPs) • Olive View Crisis Residential Treatment Programs (CRTPs) • Olive View Medi-UCC • Olive View Mental Health Wellness Center • MLK Child and Family Center				

CAPITAL FACILITIES

Crisis Residential Treatment Programs (CRTPS)

- LAC + USC Crisis Residential Treatment Programs: Construction was comprised of four approximately 9,400 square foot, three-story buildings, each with 16-beds. Full certificate of occupancy was issued on April 7, 2022.
- Rancho Los Amigos Crisis Residential Treatment Programs: Construction was comprised of five approximately 9,400 square foot, two-story buildings, each with 16-beds. Full certificate of occupancy was issued on July 16, 2021.
- Olive View Crisis Residential Treatment Programs: Construction was comprised of five approximately 9,500 square foot, two-story buildings, each with 16-beds. Full certificate of occupancy was issued on November 4, 2021.

Olive View Medi-UCC (Olive View Mental Health Urgent Care Center): Construction was comprised of one approximately 9,900 square foot, one-story building. The facility has 16 adult chairs and eight adolescent chairs. Full certificate of occupancy was issued on July 1, 2021.

Olive View Mental Health Wellness Center: Construction was comprised of one approximately 9,900 square foot, one-story building. Full certificate of occupancy was issued on July 1, 2021.

MLK Child and Family Center (now called the Jacqueline Avant Child and Family Center per a motion introduced by SD2): DMH has space on the first floor and the entire third floor of this 55,000 square foot, three-story facility. Construction was delayed due to the builder of record not completing its scope of work by the substantial completion date of December 14, 2021. Construction of the first floor space was completed in November 2022. Construction of the third floor, which will house a crisis stabilization unit and children's outpatient program, is anticipated to be completed by November 2023.

PROPOSED PLAN CHANGES FOR FISCAL YEAR 2023-24

These are the projects/concepts in the table below proposed by Stakeholders and other County Departments during the Stakeholder process from October 2022 through February 23, 2023. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the program.

Table 56. Program Proposals for FY 2023-24

Program	Target Population
Component: Prevention and Early Intervention	
Community Family Resource Center (CFRC) The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and families in the community it serves.	All Age Groups and Populations - Families
Community Schools Initiative (CSI) CSI serves 15 high schools that serve as hubs for a range of support services for students, families, and school staff. The program provides each site with a Community Schools Specialist to assist with coordinating services and Educational Community Worker to support parent engagement. Services focus on prevention, helping caregivers and students access a variety of services to prevent stress and possible mental health concerns.	Middle school and high school youth
United Mental Health Promoters Network The Mental Health Promoters Network project is a community outreach effort, serving to strengthen communities and create career paths for those community members functioning under the umbrella of Mental Health Promoters.	Underserved Cultural Populations
Friends of the Children (FOTC) - Los Angeles FOTC aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at highest risk of entering foster care. FOTC provides professional 1:1 mentorship to children for 12+ years; starting around the age of 4-6 years old. Mentors are trained to support caregivers, promote self-advocacy and created opportunities for culturally responsive community and peer-to-peer connections.	Children and youth under 18, starting at 4-6 years old
Medical Legal Services Addresses clients' legal problems and increases awareness of their rights to which lessens undue stress and empowers them with the information. These legal services can eliminate barriers to sustaining stable income through employment	All Age Groups
Home Visitation: Deepening Connections and Enhancing Services Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. The programs offer home visits delivered weekly or every two weeks to promote positive parent– child relationships and healthy attachment. This Home Visiting Program will prioritize areas where data indicates there is a high number of families involved with child protective services.	Parents and Caregivers with Children 0-to-5 Years Old
New Parent Engagement-Welcome to the Library and the World Public Libraries and DHS Women's Health will offer a Welcome to the Library and the World kit which will include information on the library Smart Start Early Literacy programs and services. The program will be offered at 45 locations twice a year, and though a a virtual program every quarter.	New Parents and Caregivers
Our SPOT Teen Program: Social Places and Opportunities for Teens After-School Program Our SPOT: Social Places and Opportunities for Teens is a comprehensive after-school teen program aimed at engaging and providing community youth with the support,	Children and youth under 18

Program	Target Population
life-skills and positive experiences that will empower them to create bright futures for themselves.	
We Rise Parks at Sunset We Rise a prevention program which creates access to self-care programming in 58 LA County parks and is offered during mental health awareness month. It provides repeated opportunities to access esources and information on mental health support including free mental well-being workshops.	24 years old and below - Families
Parks after Dark Parks at Sunset Designed for families and adults to participate in workshops and classes promoting self-care and healing, three evenings a week over 8-weeks. Activities include sports, fitness, arts and culture, movies and concerts and more.	24 years old and below - Families
DPR Safe Passages: Community Engagement and Safe Passages for Youth and Communities DPR Safe Passages Initiative utilizes trained gang interventionists and ambassadors to implement peace maintenance among gang neighborhoods to ensure safety to and from parks, and during park activities and provide crisis intervention services at the parks.	Children and youth under 18
Triple P Parent/Caregiver Engagement Triple P is an effective evidence-based practice that gives parents and caregivers with simple and practical strategies to help them build strong, healthy relationships, confidently manage their children's behavior and prevent problems developing.	Parents and caregivers
Patient Health Navigation Services This proposal will augment existing Patient Health Navigation Services by adding mental health prevention focused services, including assessment, referral and linkage to community supports and education that increase protective factors for individuals at-risk of a mental illness.	All Age Groups
School Readiness An early literacy program designed for toddlers and preschoolers to help empower parents and guardians in supporting the education needs of their children. While enjoying books, songs, rhymes and fun, kids build early literacy skills, basic math skills, and social skills, and other essential school readiness competencies.	2 to 4 Year Old (Toddlers to Preschoolers)
Creative Wellbeing: Arts, Schools, and Resilience A non-traditional, arts and culture–based approach for promoting mental health in young people and caregivers. . The model offers non-traditional strategies for promoting mental health and wellness that include culturally relevant, healing-centered, arts-based workshops for youth, as well as professional development, coaching, and emotional support for the adults who work with them. Project activities support positive cognitive, social, and emotional development, and encourage a state of wellbeing.	24 years and below and Caregivers
Abundant Birth Project This program is a private-public partnership that seeks to provide support to a minimum of 400 pregnant people in LA County from marginalized populations most likely to experience the worst birth outcomes with a variety of supports for 18 months (i.e. mental health, financial coaching, wellness supports, housing assistance, education, etc. This would be a randomized control study to evaluate the effects of this type of support.	Pregnant People and Parents with Children 0-18 Months Old
Credible Messenger Mentoring Model This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services. Services are targeted to Youth 18-25 and include training of messenger peers, needs assessment of youth to paired mentors, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral and resource linkage.	Transition Age Youth 18-25
Youth Development Regions This program will support youth by providing and/or referring to a range of youth development services based on an assessment of individual strengths, interests, and needs. The target population is youth 18-25 and is projected to serve approximately	Transition Age Youth 18-25

Program	Target Population
6,500 youths annually. Services are provided through contracted CBOs and referral and linkage and will include school engagement, conflict resolution training, mentoring/peer support, educational support, employment/career services, arts/creative expression and social/emotional wellbeing resources.	
A Local Approach to Preventing Homelessness The Long Beach Department of Health and Human Services will convene local partners to identify gaps in homeless prevention services and develop interventions strategies addressing short term housing, mobile and clinic services and supportive transition programs for young adults exiting the foster care system.	Young adults exiting foster care and at risk for homelessness
Laugh Therapy & Gratitude Enlighten the public on therapeutic alternatives that don't necessarily require the use of drugs to improve one's state of mind and the importance of embracing emotions rather than masking them.	Older Adults - Latino
Older Latino Adults & Caregivers Create opportunities for elderly Latino immigrants to prosper and grow independent by teaching them not fear technology but rather, use it as a helpful tool to stay connected to loved ones, learn new things, find entertainment, and use it as a tool for self improvement.	Older Adults - Latino
Search to Involve Pilipino Americans (SIPA) Provide strength based, youth-centered mental health support services to youth and underserved individuals in SPA 4, with a focus on Historic Filipinotown and adjacent areas	Youth
K-Mental Health Awareness & K-Hotline Seeks to normalize mental illness and treatment in the Korean community so individuals will seek therapy and services without shame or hesitation.	All Age Groups - Korean
FosterALL WPW ReParenting Program FosterAll's WisdomPath Way Program addresses both the adults and children in foster care and provides positive outcomes to prevent additional trauma, stress and mental illness for both adults and children	Adults and Children Involved with Foster Care System
Cultural Reflections Newsletter Provide opportunities for peer produced mental health related content to be developed and shared throughout the County.	LACDMH Consumers
Hope & Healing: **Mental Health Wellness Support to Victim Families & Relatives** Bring Faith and Mental Wellness together to normalize the conversation and consciousness of families to seek mental health services and eliminate common stigmas preventing many traumatized persons from getting the help they need.	African American families who have suffered loss due to violence
TransPower Project Increase access and remove treatment barriers such as lack of resources, transportation needs and privacy concerns by offering specialized affirmative mental health services at no cost.	Youth Trans* Population
Open Arms Community Health & Service Center Provide quality health care, mental health support, housing, case management, employment referrals and supportive services such as food, clothing, hygiene kits, transportation anger management, substance use, sex trafficking, and parenting classes.	All Age Groups
Consumer Empowerment Network Educate LACDMH consumers on the history of MHSA, the role of LACDMH consumers and consumers from through the state, components and required processes, county, and state stakeholder events and opportunities to make public comments, recommendations, and legislative process.	LACDMH Consumers
INN 2 / PEI To help build trauma-informed communities and resilient families through Community Resource Specialists (CRSs) who work in-home with families to ensure that food, medical or housing crises don't destabilize families.	Transition Age Youth within Deaf, BIPOC, Disabled, LGBTQIA2S and Asian Pacific Islander communities

Program	Target Population
Mental Health Services for the Deaf & Hard of Hearing Provide American Sign Language (ASL) interpreters who can translate mental health terms and concepts accurately and effectively to deaf and hard of hearing people.	All Age Groups - Deaf & Hard of Hearing
Steven A. Cohen Military Family Clinic at VVSD, Los Angeles The Cohen Clinic offers personalized, evidence-based mental health care along with outreach and timely access to comprehensive case management support and referrals to address early intervention and suicide prevention, unemployment, finances, housing, and legal issues.	Veterans and Their Families
Component: Workforce Education and Training	
DBT Expansion This project would provide support for the clinic's DBT program by providing dedicated funding for medical staff, direct therapy services staff, peer workers/support staff, and management/supervision staff to have paid time to be trained on DBT certification, practices, and implementation.	Targets Workforce for All LACDMH Consumers

EXHIBITS

EXHIBIT A - FUNDING

	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 2023/24 Funding						
1. Estimated Unspent Funds	711,600,000	297,700,000	211,000,000	8,900,000	14,400,000	116,483,541
2. Estimated New FY 2023/24 Funding	688,500,000	175,000,000	48,000,000	100,000	500,000	
3. Transfer in FY 2023/24	(89,000,000)			25,000,000	64,000,000	
4. Access Local Prudent Reserve in FY 2023/24						-
5. Estimated Available Funding for FY 2023/24	1,311,100,000	472,700,000	259,000,000	34,000,000	78,900,000	116,483,541
B. Estimated FY 2023/24 MHSA Expenditures	666,735,660	326,566,778	33,006,963	28,996,983	70,400,000	
G. Estimated FY 2023/24 Unspent Fund Balance	644,364,340	146,133,222	225,993,037	5,003,017	8,500,000	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 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	360,780,442	151,587,276	153,415,852		55,470,571	306,743
2. Outpatient Care Services	522,765,877	216,907,729	215,900,212		88,905,835	1,052,101
3. Alternative Crisis Services	200,176,455	122,512,681	70,045,377		7,608,286	10,111
4. Planning Outreach & Engagement	15,859,159	15,728,743	130,416			
5. Linkage Services	53,886,644	47,158,493	4,280,817		369,848	2,077,486
6. Housing	64,090,935	64,090,935				
CSS Administration	48,749,803	48,749,803				0
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,266,309,315	666,735,660	443,772,674	0	152,354,540	3,446,441

	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	5,866,764	5,787,478	65,030		14,256	
2. STIGMA DISCRIMINATION REDUCTION PROGRAM	77,060,907	77,060,907				
3. PREVENTION (with Outreach & Navigation Services)	125,397,244	124,396,549	844,532		156,163	
4. EARLY INTERVENTION	276,727,068	100,265,473	106,125,435		69,385,744	950,416
PEI Administration	19,056,371	19,056,371				
Total PEI Program Estimated Expenditures	504,108,354	326,566,778	107,034,997	0	69,556,163	950,416

	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. TTA	8,071,305	8,071,305				
2. MHCPATHWAY	2,818,573	2,818,573				
3. Residency	6,284,554	6,284,554				
4. Financial Incentive	10,240,770	10,240,770				
WET Administration	1,581,781	1,581,781				
Total WET Program Estimated Expenditures	28,996,983	28,996,983	0	0	0	0

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Capital Project -Tenant Improvement/New Facilities	6,000,000	6,000,000				
2. Exodus	25,000,000	25,000,000				
CFTN Programs - Technological Needs Projects						
3. IBHIS -Netsmart	11,000,000	11,000,000				
4. IBHIS - Microsoft Agreement	2,000,000	2,000,000				
5. Technology Improvements	20,000,000	20,000,000				
CFTN Administration	6,400,000	6,400,000				
Total CFTN Program Estimated Expenditures	70,400,000	70,400,000	0	0	0	0

	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. Innovation 7 - Therapeutic Transportation	7,097,195	6,653,266	217,045		33,669	193,215
2. Innovation 8 - Early Psychosis Learning Health Care Network	252,600	252,600				
3. Hollywood Mental Health Cooperative (formally known Hollywood 2.0 project)	28,356,097	23,101,097	4,947,289		307,711	
INN Administration	3,000,000	3,000,000				
Total INN Program Estimated Expenditures	38,705,892	33,006,963	5,164,334	-	341,380	193,215

APPENDICES

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
FFP:	Federal Financial Participation
FFT:	Functional Family Therapy
FOCUS:	Families Overcoming Under Stress
FSP(s):	Full Service Partnership(s)
FSS:	Family Support Services
FY:	Fiscal Year
Group CBT:	Group Cognitive Behavioral Therapy
GROW:	General Relief Opportunities for Work
GVRI:	Gang Violence Reduction Initiative
HIPAA:	Health Insurance Portability and Accountability Act
HOME:	Homeless Outreach and Mobile Engagement
HSRC:	Harder-Company Community Research
HWLA:	Healthy Way Los Angeles
IBHIS:	Integrated Behavioral Health System
ICC:	Intensive Care Coordination
ICM:	Integrated Clinic Model
IEP(s):	Individualized Education Program
IFCCS:	Intensive Field Capable Clinical Services
IHBS:	Intensive Home Base Services
ILP:	Independent Living Program
IMD:	Institution for Mental Disease
Ind CBT:	Individual Cognitive Behavioral Therapy
IMHT:	Integrated Mobile Health Team
IMPACT:	Improving Mood-Promoting Access to Collaborative Treatment
IMR:	Illness Management Recovery
INN:	Innovation
IPT:	Interpersonal Psychotherapy for Depression
IS:	Integrated System
ISM:	Integrated Service Management model
ITP:	Interpreter Training Program
IY:	Incredible Years
KEC:	Key Event Change

LGBTQ:	Lesbian/Gay/Bisexual/Transgender/Questioning	PEMR(s):	Probation Electronic Medical Records
LIFE:	Loving Intervention Family Enrichment	PE-PTSD:	Prolonged Exposure therapy for Post-Traumatic Stress Disorder
LIHP:	Low Income Health Plan	PMHS:	Public Mental Health System
LPP:	Licensure Preparation Program	PMRT:	Psychiatric Mobile Response Team
MAP:	Managing and Adapting Practice	PRISM:	Peer-Run Integrated Services Management
MAST:	Mosaic for Assessment of Student Threats	PRRCH:	Peer-Run Respite Care Homes
MDFT:	Multidimensional Family Therapy	PSH:	Permanent Supportive Housing
MDT:	Multidisciplinary Team	PSP:	Partners in Suicide Prevention
MFT:	Masters in Family and Therapy	PST:	Problem Solving Therapy
MH:	Mental Health	PTSD:	Post-Traumatic Stress Disorder
MHC:	Mental Health Commission	PTSD-RI:	Post-Traumatic Stress Disorder – Reaction Index
MHCLP:	Mental Health Court Linkage Program	QPR:	Question, Persuade and Refer
MHFA:	Mental Health First Aide	RFS:	Request For Services
MHIP:	Mental Health Integration Program	RFSQ:	Request for Statement of Qualifications
MHRC:	Mental Health Rehabilitation Center	ROSTCP:	Recovery Oriented Supervision Training and Consultation Program
MHSA:	Mental Health Services Act	RPP:	Reflective Parenting Program
MHSOAC:	Mental Health Services Oversight and Accountability Commission	RRSR:	Recognizing and Responding to Suicide Risk
MMSE:	Mini-Mental State Examination	SA:	Service Area
MORS:	Milestones of Recovery Scale	SAAC:	Service Area Advisory Committee
MOU:	Memorandum of Understanding	SAPC:	Substance Abuse Prevention and Control
MP:	Mindful Parenting	SED:	Severely Emotionally Disturbed
MPAP:	Make Parenting a Pleasure	SF:	Strengthening Families Program
MPG:	Mindful Parenting Groups	SH:	State Hospital
MST:	Multisystemic Therapy	SLT:	System Leadership Team
NACo:	National Association of Counties	SNF:	Skilled Nursing Facility
NFP:	Nurse Family Partnerships	SPC:	Suicide Prevention Center
OA:	Older Adult	SPMI:	Severe and Persistently Mentally Ill
OACT:	Older Adult Care Teams	SS:	Seeking Safety
OASCOC:	Older Adult System of Care	START:	School Threat Assessment and Response Team
OBPP:	Olweus Bullying Prevention Program	TAY:	Transitional Age Youth
OEF:	Operation Enduring Freedom	TF-CBT:	Trauma Focused-Cognitive Behavioral Therapy
OEP:	Outreach and Education Pilot	TN:	Technological Needs
OMA:	Outcome Measures Application	Triple P:	Triple P Positive Parenting Program
OND:	Operation New Dawn	TSV:	Targeted School Violence
OQ:	Outcome Questionnaire	UC:	Usual Care
PATHS:	Providing Alternative Thinking Strategies	UCC(s):	Urgent Care Center(s)
PCIT:	Parent-Child Interaction Therapy	UCLA:	University of California, Los Angeles
PDAT:	Public Defender Advocacy Team	UCLA TTM:	UCLA Ties Transition Model
PE:	Prolonged Exposure	VALOR:	Veterans' and Loved Ones Recovery
PEARLS:	Program to Encourage Active, Rewarding Lives for Seniors	VPAN:	Veteran’s Peer Network

PEI:	Prevention and Early Intervention	WCRSEC:	Women's Community Reintegration Service and Education Centers
WET:	Workforce Education and Training		
YOQ:	Youth Outcome Questionnaire		
YOQ-SR:	Youth Outcome Questionnaire – Status Report		
YTD:	Year to Date		

Adult Age Group: Age range is 26 to 59 years old.
Child Age Group: Age range is 0 to 15 years old.
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.