



**DEPARTMENT OF MENTAL HEALTH**  
hope. recovery. wellbeing.

**LISA H. WONG, Psy.D.**  
Director

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

**ADOPTED**

**Connie D. Draxler, M.P.A.**  
Acting Chief Deputy Director

June 06, 2023

BOARD OF SUPERVISORS  
COUNTY OF LOS ANGELES

70 June 6, 2023

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

CELIA ZAVALA  
EXECUTIVE OFFICER

Dear Supervisors:

**ADOPT THE DEPARTMENT OF MENTAL HEALTH'S  
MENTAL HEALTH SERVICES ACT ANNUAL UPDATE  
FOR FISCAL YEAR 2023-24  
(ALL SUPERVISORIAL DISTRICTS)  
(3 VOTES)**

**SUBJECT**

Request adoption of the Department of Mental Health's Mental Health Services Act Annual Update for Fiscal Year 2023-24.

**IT IS RECOMMENDED THAT THE BOARD:**

Adopt the Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2023-24 as attached. The MHSA Annual Update has been certified by the Director of Mental Health (Director), or designee, and the Auditor-Controller (A-C) to meet specified MHSA requirements in accordance with Welfare and Institutions Code (WIC) Section 5847.

**PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION**

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

Update is required by law and necessary for DMH to submit the Annual Update for FY 2023-24 to the Mental Health Services Oversight and Accountability Commission (Commission) and Department of Health Care Services (DHCS). Additionally, WIC Section 5848 requires the following: 1) the MHSAs Three-Year Program and Expenditure Plan and the Annual Updates be certified by the Director, or designee, and the A-C attesting that the County has complied with all fiscal accountability requirements as directed by the State DHCS, and that all expenditures are consistent with the MHSAs requirements; 2) a draft MHSAs Three-Year Program and Expenditure Plan and Annual Updates be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans; and 3) the Los Angeles County Mental Health (LACMH) Commission conducts a Public Hearing on the draft MHSAs Three-Year Program and Expenditure Plan and the Annual Updates at the close of the 30-day comment period.

In accordance with these requirements, DMH, on March 24, 2023, posted the MHSAs Annual Update on its website for 30 days for public comment. The LACMH Commission also convened a Public Hearing on April 27, 2023, where DMH presented the Annual Update, addressed public questions, and the LACMH Commission voted to recommend the MHSAs Annual Update for FY 2023-24.

### **Implementation of Strategic Plan Goals**

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

### **FISCAL IMPACT/FINANCING**

DMH utilizes the budget process to appropriate the MHSAs funds for use during the respective fiscal year. Sufficient funding will be included in DMH's Final Annual Adopted Budget for FY 2023-24 for this action.

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

### **FACTS AND PROVISIONS/LEGAL REQUIREMENTS**

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

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

The public hearing notice requirements referenced in WIC Section 5848 (a) and (b), have been satisfied and are recorded in the MHSA Annual Update for FY 2023-24. Additionally, DMH has complied with the certification requirements referenced in WIC Section 5847(b)(8) and (9). Compliance has been recorded in the MHSA Annual Update for FY 2023-24 via a signed MHSA Fiscal Accountability Certification Form.

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

- Expanding the number of sites and areas of availability for the Crisis Residential Treatment Program (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.
- Expanding the number of full-time positions to the Homeless Outreach and Mobile Engagement Teams (HOME). 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).
- Expanding the number of sites for the Transition Age Youth (TAY) Enhanced Emergency Shelter Program (EESP). EESP serves the urgent housing needs of the TAY population, ages 18-25, who are unhoused or at immediate risk of becoming unhoused 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.
- Expanding the number of sites and areas of availability for the Portland Identification and Early Referral Program (PIER). PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25, who are either at clinical high risk for psychosis or have had their first psychotic episode. Currently, referrals from East Los Angeles College Screening and Treatment for Anxiety and Depression, National Alliance Mental Illness Urban Los Angeles, schools, and various outpatient programs are exceeding the capacity of the current service level.
- Proposing an Innovation project that seeks to create new regional, field-based, multidisciplinary teams dedicated to serving people experiencing homelessness 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 assigned to support interim housing sites.
- Continued expansion of opportunities for capacity building and increased partnerships with grass roots organizations to serve at risk communities, including ethnic and other vulnerable communities that are unserved or underserved.

### **IMPACT ON CURRENT SERVICES (OR PROJECTS)**

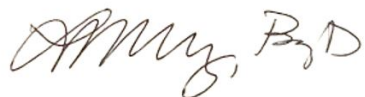
Board adoption of the MHSA Annual Update for FY 2023-24 will ensure compliance with the MHSA, as amended by AB 1467, and allow for uninterrupted access to vital mental health services.

The Honorable Board of Supervisors

6/6/2023

Page 4

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Lisa H. Wong, Psy.D.", written in a cursive style.

LISA H. WONG, Psy.D.

Director

LHW:CDD:DKHSK:ZW:atm

Enclosures

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



# MHSA ANNUAL UPDATE

Fiscal Year 2023-24

WELLNESS • RECOVERY • RESILIENCE

## LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH



Posted for Public Review  
March 24, 2023

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## TABLE OF CONTENTS

I.	<u>INTRODUCTION</u> .....	3
II.	<u>DIRECTOR’S MESSAGE</u> .....	4
III.	<u>EXECUTIVE SUMMARY</u> .....	5
IV.	<u>MHSA OVERVIEW</u> .....	6
V.	<u>DEVELOPMENT OF ANNUAL UPDATE</u>	
	MHSA Requirements.....	7
	County Demographics.....	7
	Community Planning	
	Partnership with Stakeholders.....	13
	MHSA Planning Activities.....	15
	Stakeholder Feedback.....	17
	Corrections Made after Posting.....	20
VI.	<u>ACTIONS SINCE LAST ANNUAL UPDATE</u> .....	23
VII.	<u>EXISTING PROGRAMS AND SERVICES (BY COMPONENT)</u>	
	Community Services and Supports (CSS).....	29
	Full Service Partnership.....	30
	Outpatient Care Services.....	34
	Alternative Crisis Services.....	39
	Housing.....	47
	Linkage.....	54
	Planning, Outreach and Engagement.....	53
	Prevention and Early Intervention (PEI).....	66
	Early Intervention.....	68
	Prevention.....	76
	Stigma and Discrimination Reduction.....	97
	Suicide Prevention.....	102
	Workforce Education and Training (WET).....	109
	Innovation (INN).....	120
	Capital Facilities and Technological Needs (CFTN).....	164
VIII.	<u>PROPOSED CHANGES/EXPANSIONS FOR FISCAL YEAR 2023-24</u> .....	165
IX.	<u>EXHIBITS</u>	
	Exhibit A – Budget Summary.....	169
	Exhibit B – MHSA County Fiscal Accountability Certification.....	171
	Exhibit C – Mental Health Commission (MHC) Letter.....	172
	Exhibit D – LACDMH Response to MHC Letter.....	178
X.	<u>APPENDICES</u>	
	Appendix A – Interim Housing Multidisciplinary Assessment & Treatment Teams.....	186
	Appendix B – Stakeholder/Provider Training – MHSA 101.....	209
	Appendix C – Stakeholder Meeting Participation.....	228
	Appendix D – Public Hearing Agenda, Presentation and Transcripts.....	233
	Appendix E – Acronyms.....	314

## 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

## DIRECTOR'S MESSAGE



## DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.  
Director

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

Connie D. Draxler, M.P.A.  
Acting Chief Deputy Director

Dear L.A. County,

It is an honor for me to serve as the new Director of L.A. County Department of Mental Health (LACDMH). Having been an LACDMH employee for more than 30 years, beginning as a student caring for the most vulnerable individuals on Skid Row, I have seen firsthand the unique challenges that have faced our mental health care delivery system. I have also experienced the unbridled fulfillment in helping to improve people's mental well-being and quality of lives. Without a doubt, the passage of the Mental Health Services Act (MHSA) was an extraordinary turning point in the way that LACDMH could serve and engage with our diverse communities to partner in developing impactful strategies and plans for providing mental health services to anyone who needs it most.

With a nationwide mental health crisis facing our youth and communities, increasing needs of people experiencing homelessness, and the unprecedented shortage of public mental health workforce members, LACDMH has never been more committed to our partnership with stakeholders and community to overcome these challenges and thrive. At LACDMH, we have worked to enhance our stakeholder process to include more and more diverse partners representative of the people we serve. We have expanded participation opportunities this year and are building a foundation to ensure continued, robust involvement in the next year and in years to come.

The results of successful partnerships with our stakeholders and LACDMH strategic planning include:

- Exploring creative incentives, bonuses and recruitment efforts to continue to build the LACDMH workforce and retain dedicated and passionate employees;
- Addressing the homelessness state of emergency by expanding our homeless outreach and mobile engagement (HOME) program to care for and house our most vulnerable clients on the street;
- Continued transformation of the Full-Service Partnership program so that we can best support our highest acuity outpatient clients on the path to recovery in the community and at the same time activating the grass roots through our Community Ambassador Network which empowers individuals through employment opportunities, access to available resources, increased awareness of mental illness, and reduction of stigma; and
- Enhancing our mobile response teams as part of the 9-8-8 crisis line implementation and optimizing the available mental health field responses as an alternative to law enforcement.

I look forward to working with stakeholders, partners and the dedicated LACDMH workforce to ensuring that our MHSA resources help those most in need live healthy, independent, meaningful lives.

Sincerely,

A handwritten signature in black ink that reads "Lisa H. Wong, Psy.D.".

Lisa H. Wong



## 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.

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### 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).

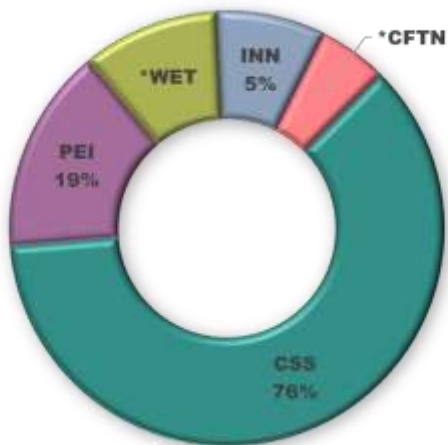
The information within this report is structured in the following sections:

- *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.

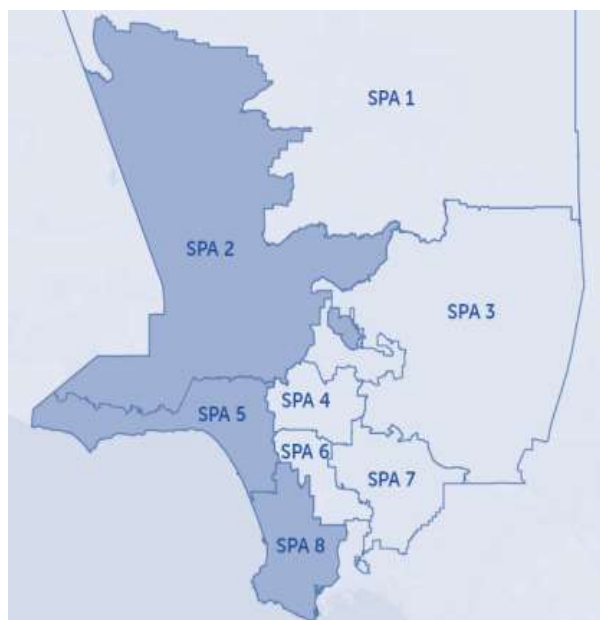
MHSOAC is mandated to oversee MHSA-funded programs and services through these documents, and evaluate how MHSA funding has been used, what outcomes have resulted, and how to improve services and programs.

### 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.

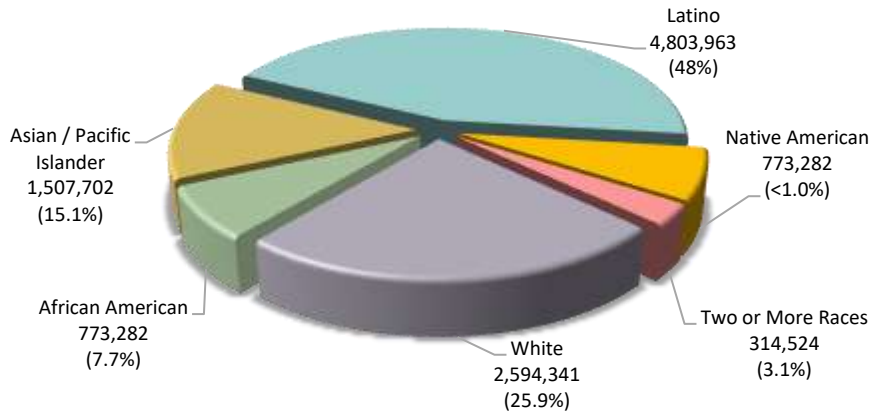
County residents represent one of the most diverse populations. This diverse racial and ethnic makeup are spread across approximately 4,000 miles that the County serves based on eight County defined Service Area (SA) boundaries.

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	<b>1,471</b>	103,725	15,273	418,046
Percent	14.9%	4.0%	52.3%	<b>0.35%</b>	24.8%	3.7%	100.0%
SA 2	79,672	260,898	867,861	3,504	<b>918,778</b>	77,926	2,208,639
Percent	3.6%	11.8%	39.3%	0.16%	<b>41.6%</b>	3.5%	100.0%
SA 3	54,476	<b>546,511</b>	802,885	2,877	304,911	41,922	1,753,582
Percent	3.1%	<b>31.2%</b>	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	<b>105,216</b>	<b>952</b>	395,198	<b>38,168</b>	664,790
Percent	5.0%	13.8%	<b>15.8%</b>	<b>0.14%</b>	59.4%	<b>5.7%</b>	100.0%
SA 6	<b>235,154</b>	<b>24,396</b>	703,549	1,513	<b>32,713</b>	18,944	1,016,269
Percent	<b>23.1%</b>	<b>2.4%</b>	69.2%	0.15%	<b>3.2%</b>	1.9%	100.0%
SA 7	<b>38,727</b>	128,944	<b>950,243</b>	2,800	140,197	<b>20,138</b>	1,281,049
Percent	<b>3.0%</b>	10.1%	<b>74.2%</b>	0.22%	10.9%	<b>1.6%</b>	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%
<b>Total</b>	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

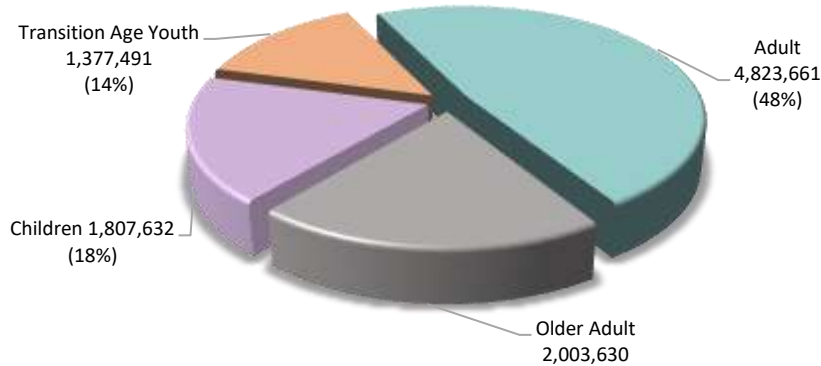


Table 3. Population by age group and Service Area

SA	0-15 years	16-25 years	26-59 years	60+ years	Total
SA 1	98,058	<b>69,473</b>	<b>181,543</b>	<b>68,972</b>	418,046
Percent	23.5%	<b>16.6%</b>	<b>43.4%</b>	<b>16.5%</b>	100.0%
SA 2	<b>389,938</b>	<b>285,219</b>	<b>1,063,968</b>	<b>469,514</b>	2,208,639
Percent	<b>17.7%</b>	<b>12.9%</b>	<b>48.2%</b>	<b>21.3%</b>	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	<b>85,539</b>	86,954	339,179	153,118	664,790
Percent	<b>12.9%</b>	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%
<b>Total</b>	<b>1,807,632</b>	<b>1,377,491</b>	<b>4,823,661</b>	<b>2,003,630</b>	<b>10,012,414</b>
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

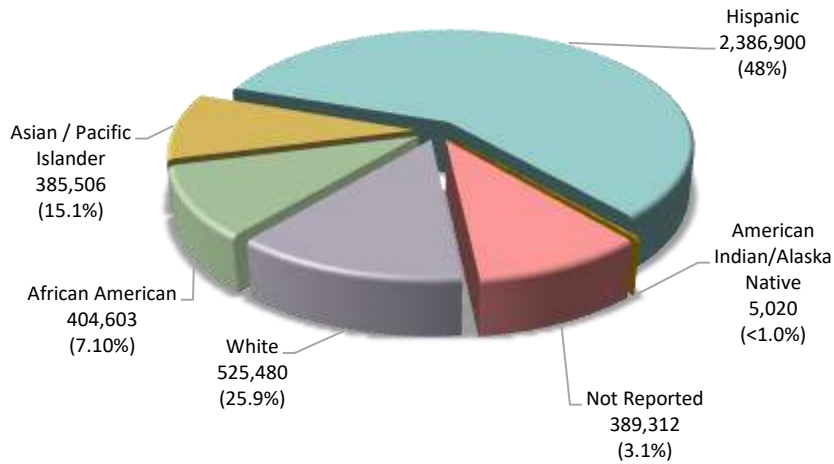
  

SA 1 – Antelope Valley
SA 2 – San Fernando Valley
SA 3 – San Gabriel Valley
SA 4 – Metro
SA 5 – West
SA 6 – South
SA 7 – East
SA 8 – South Bay

### 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

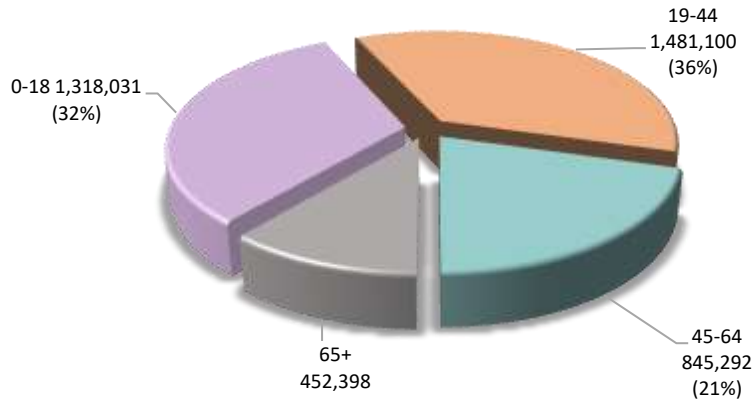


Figure 6. Countywide Poverty Estimates by Primary Language, Calendar Year 2020

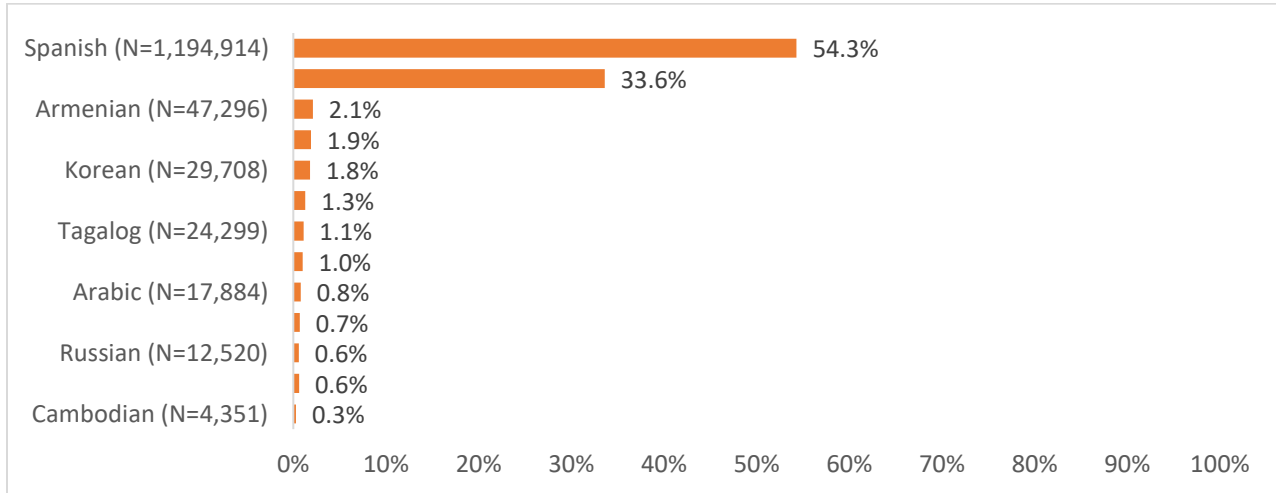
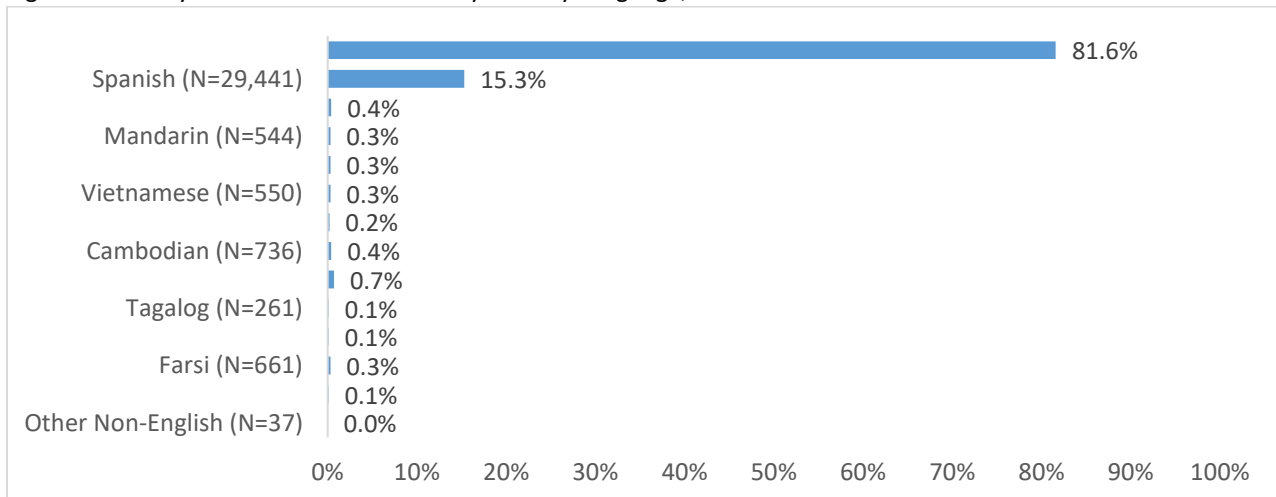


Figure 7. Countywide Consumers Served by Primary Language, FY 2019-20



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	<b>0.6%</b>
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	<b>5</b>	55	60	1.0%
Russian	10	40	50	0.8%
Spanish	<b>544</b>	<b>4,594</b>	<b>5,138</b>	<b>84.2%</b>
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 LACDMH 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 LACDMH 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 (LGBTQI2-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)

#### C. **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. See Appendix C for a breakdown of the Stakeholders attending the events listed below.

## **September 2022**

### **Number of Stakeholder Attendees: 113**

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 MHPA.

## **November 2022**

### **Number of Stakeholder Attendees: 46**

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 MHPA funding requests for the Mid-Year Adjustment, the upcoming FY 2023-24 MHPA Annual Plan update and the MHPA Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26.

## **December 2022**

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

## **January 2023**

### **Number of Stakeholder Attendees: 378**

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

LACDMH conducted an annual MHPA foundational training (1/2/23) to LACDMH staff, provider network staff, and community stakeholders on MHPA policies, the Department's MHPA funding request procedure, the MHPA Three Year Program and Expenditure and Annual Update development and submission process and timeline, and the client resolution process. (See Appendix for training)

LACDMH conducted two community stakeholder meetings (1/23/23, 1/31/23) focused on educating participants on MHPA funding components, requirements, and spending regulations. Participants were also presented with a stakeholder planning calendar and a review of the formal process for requesting MHPA 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 MHPA 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**

**Number of Stakeholder Attendees: 645**

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**

**Number of Stakeholder Attendees: 155**

LACDMH delivered a Provider MHSA 101 Training (3/23/23) (See Appendix for training).

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.

### **April 2023**

LACDMH completed the 30-day public posting and comment period and collection of submitted feedback for inclusion in the draft Annual Update.

The public hearing meeting occurred on April 27, 2023 with Spanish and Korean translation. The agenda, presentations and transcripts are included in Appendix D. Stakeholders were notified about the event via Instagram, email and the DMH website.

## **D. Stakeholder Feedback**

A survey was posted in conjunction with the MHSA Annual Update to collect feedback in both English and Spanish during the public posting and comment period. The Department collected the following:

- 12 Survey responses were received, 12 in English and 0 in Spanish. There were 9 survey questions administered. Not all respondents answered all the questions.

- Various written and email correspondences were received and reflected in the stakeholder feedback toward review of the Plan.

### **Stakeholder Feedback, Themes, Questions and Responses:**

The Commission and Stakeholders requested reporting on overall system budget, recruitment, and hiring status.

- DMH Finance provides and will continue to provide a quarterly update on the overall budget for the entire Department, including all funding streams.
  - The last update was provided at the Stakeholder community planning meeting on 01/23/23
- The Department will continue to explore strategies to provide budget expenditure by service area and supervisorial district and strategies for allocating funding based on an equity lens and unmet needs
- Funding for all MHSA components was also reported on 01/23/23.
- The DMH Director provides and will continue to provide a quarterly update on recruitment and hiring efforts to address the workforce shortage and collaboration with labor unions.

The Commission requested regular reporting, and side by side comparison of budget allocations, service utilization and trends, and funding utilization prior to, during and following the COVID pandemic. The comparison was requested to be reflected by geographic area, ethnic populations, and age group.

- DMH has currently developed a data dashboard that provides service utilization data collected by fiscal year, geographic area, ethnic population and age groups. This data, along with budget allocation information will be used to create the side by side assessment for the pre, during and post COVID fiscal years. This data will be shared and incorporated into a community needs assessment to support the Community Planning Process with the Commission and stakeholders for the development of the upcoming Two-Year Program and Expenditure Plan.

The Commission and Stakeholders requested updates on data and outcomes reporting:

- DMH has developed a data dashboard that provides service utilization data collected by fiscal year, geographic area, ethnic population and age groups. It will be used to review services to specific target populations, including unserved and underserved ethnic populations, primary language, and gender to address service gaps and recommend service priorities for the upcoming Two-Year Plan Community Planning Process, as requested. This dashboard will also provide a more detailed breakout of race/ethnicity data to ensure representation for unserved or underserved cultural communities.
- DMH convened a Data Disparities Workgroup with the goal of focusing on underserved and unserved ethnic population data. Using the Anti-Racism Diversity and Inclusion (ARDI) equity mapping tool and service utilization data, this workgroup will be tasked with monitoring service equity metrics to inform program planning and monitoring for program improvements.
- Specific to the draft Annual Update, the client count data by ethnicity on slide 7 does not balance. The reason for this is the report only reflects client counts for the top 5 ethnicities. In addition, due to client choice or intake circumstances, the ethnicity for

a large group of clients is not reported either . DMH is taking steps to improve reporting of ethnicity data.

- DMH reports on program outcomes and performance in the draft Annual Update. Program outcomes will be discussed as part of the upcoming Community Planning Process.

The Commission and Stakeholders requested specific responses to items reflected in the draft Annual Update

- Program expansions are reflected in the Update.
- In response to the inquiry on the expansion of Portland Identification and Early Referral (PIER) Program: The expansion adds new funding for PIER services in Service Areas 1 and 8 and increases the presence of PIER services in Service Area 6.
- In response to the inquiry of when Innovation proposals will be reviewed and considered for Board and State approval: Submitted Innovation proposals will undergo the review process during the upcoming Two-Year Plan Planning Process, pending available Innovations funding.

The Commission and Stakeholders requested responses to other questions/concerns

- In response to the Commission's inquiry, when will the summary/overview outlining the shift of the May Mental Health Month campaign from We Rise to Take Action be provided: The summary/overview of the shift will be reflected in the upcoming Two-Year Plan.
- The MHSA Annual Update did not incorporate treatment plans/programs for clients with a co-occurring disorder. Requested more information on what the Department is doing with harm reduction and how is the Department engaging the community.

The Commission and Stakeholders requested updates on the Community Planning Process going forward:

- The upcoming Community Planning Process will involve an expansion of stakeholder involvement to ensure greater participation of a more diverse group of stakeholders across LA County communities that is representative of peers and family members, ethnic/cultural populations, geographic areas, community based organizations, other county departments and stakeholders at large. The Community Planning Process will begin late May/early June 2023 and will begin with MHSA 101 training, stakeholder foundational training and a data and community needs assessment toward development of the Three-Year Plan.
- In response to the inquiry will the Mental Health Commission be considered a stakeholder group and be included earlier in the Community Planning Process and the MHSA Funding Request/Proposal submission and stakeholder process on behalf of the Board of Supervisors: Yes. The Mental Health Commission will be notified of the Community Planning Process and timelines for comment, feedback and for submission of MHSA Funding Proposal on behalf of the Board offices. The Mental Health Commission has a unique formal role as part of the Community Planning Process and holds the responsibility to ensure stakeholder voices are included in the process, while providing input in the process on behalf of the Board of Supervisors. DMH shared information with the Mental Health Commission during

the Community Planning Process for the draft Annual Update in Fall 2022 in preparation for stakeholder engagement meetings. DMH will continue to share the process going forward.

#### The Commission and Stakeholders requested updates and clarification on the MHSA Funding Request/Proposal Process

Responses to inquiries regarding the MHSA Funding Request/Proposal Process are listed below:

- How do stakeholders and community members submit proposals?
  - Requests/Proposal can be submitted 24 hours a day/7 days per week through the MHSA Funding Request Portal using online electronic forms. CSS, PEI, WET funding requests should be submitted using the form located at: <https://forms.office.com/g/hFe6wc9LA2>. Innovation funding requests should be submitted using the form found at <https://forms.office.com/g/77BRkSWzUe>. Both portals will be available to receive new proposals for the upcoming Two-Year Planning process from mid May 2023 through January 15, 2024.
- How are proposers notified of the review, approval or rejection status of their submissions?
  - Proposers are informed of the status of their submission via a phone call or through an email.
- Can the source of proposals be shared/released?
  - Yes. The source of proposals (e.g. CBOs, County Entities, or Community Stakeholders) can be made available upon request and are also posted publicly on the DMH MHSAs page.

#### The Commission and Stakeholders requested updates and clarification on the MHSAs Funding Request/Proposal Process

- Can the amount requested by proposers be shared?
  - Yes. The amount requested for proposals was shared with stakeholders during the Community Planning Process. This information is also available upon request. Amounts requested are estimated amounts and may change upon approval and during implementation based on actual confirmed costs and funded activities included in the proposal.
- Can the information on proposed target populations and geographic areas to be served be shared?
  - Yes. This information was shared with stakeholders during Community Planning Process. Upon Board approval and prior to actual implementation, the MHSAs Administration Unit will consult with proposer to confirm proposed target populations and geographic areas. An analysis of each approved proposal will be conducted to ensure equity concerns and considerations are addressed and funding allocations support unmet needs for communities countywide.

#### E. Corrections Made After Posting

The following are changes made to the MHSAs Annual Update based on substantive recommendations received during the 30-day public comment period:

- Portland Identification and Early Referral Program (PIER)



- The spelling for the PIER program was corrected.
- This program will expand the number of sites and areas of availability of the program to Service Areas 1 and 8 and expand services in Services Area 6. PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25 who are either at Clinical High Risk for psychosis or have had their first psychotic episode. Currently, referrals from ELAC STAND (UCLA), NAMI Urban LA, schools and various outpatient programs are exceeding the capacity of the current service level.
- Funding is Prevention and Early Intervention: Early Intervention.
- Full report of the Innovation proposal: Interim Housing Multidisciplinary Assessment & Treatment Teams was added to Appendix A.
- Psychiatric Mobile Response Teams (PMRT) description was added to the Alternative Crisis Service Program.
- Enriched Residential Care Program (ERC)
  - This program should be reflected as a change in Capital Facilities and Technological Needs (CFTN) as it involves a shift of funds from Community Services and Supports to CFTN.
  - The funding request is for \$11.2 million for Fiscal Year 2023/24.
  - DMH has received approval from the Los Angeles County Board of Supervisors to accept \$55.5 million in Community Care Expansion (CCE) Preservation Program 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, less DMH administrative costs, will be combined with the \$11.2 million in one-time MHSA funding designated for licensed residential facility capital improvements, and transferred to the Los Angeles County Development Authority (LACDA), who will serve as the funding administrator as also approved by the Board. An additional \$41.9 million in CCE Preservation Program funding will also be received by DMH and will be used to provide licensed residential facilities with operating subsidy payments through DMH's Enriched Residential Care (ERC) Program to help support operation costs and further prevent closures. This will allow the DMH ERC Program, in partnership with the Department of Health Services (DHS) and their fiscal intermediary, to support 475 clients each year over five years.
- Community Planning dates were incorrectly stated and have been corrected.
- The following programs are existing MHSA programs previously approved by Stakeholders set to expand in Fiscal Year 2023-24:
  - Homeless Outreach and Mobile Engagement (HOME)
    - Funding is CSS: Linkage
    - The expansion will include a total of 107 full time positions, (6 new multidisciplinary teams and 1 Service Area Navigation team) will be added between FY 2022-23 and FY 2023-24. The expansion will bring a total number of 16 multidisciplinary teams Countywide and 1 Service Navigation team.
  - Crisis Residential Treatment Programs (CRTP)
    - Funding is CSS: Alternative Crisis Services
    - Services will be delivered with by a new legal entity – Bel Aire Health Services to provide services in Downey and Sylmar.
  - TAY Drop-In Centers
    - Funding is PEI: Prevention and CSS: Outpatient Care Services

- A total of 10 new sites will be added Countywide. Service Areas 2, 3, 4, 5, 7 and 8 will each receive one new site. Service Areas 1 and 6 will each receive two.
- TAY Enhanced Emergency Shelter Program
  - Funding is CSS: Housing
  - Additional funding will be added to sites.
- Full Service Partnership (FSP)
  - Funding is CSS: FSP
  - The expansion will add additional staff to FSP directly operated programs and create two new half teams. Additional staff will help to form FSP teams at Santa Clarita Mental Health, Antelope Valley Mental Health, and Arcadia Mental Health.

## **ACTIONS SINCE THE LAST ANNUAL UPDATE**

### **A. MID-YEAR ADJUSTMENT**

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. It was adopted by the Board on May 2, 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-trial, 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 necessary administrative and operational actions:

**PEI Funding Realignment : \$7.8M**

Realign existing PEI funding as follows:

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

\*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.

## **B. PROPOSED INNOVATION PROGRAMS**

The following Innovation programs were posted for a 30-day public review and comment period, January 20, 2023 through February 20, 2023.

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 proposed new INN programs:

### **Kedren Restorative Care Village (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.  
See Appendix A for complete Innovation proposal.

### **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 individual's right to due process, the right to have a supporter and must be the least restrictive program to meet the individual's 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 or 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 rapport 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 MHSAs 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.



## EXISTING PROGRAMS AND SERVICES BY COMPONENT

This section provides FY 2021-22 outcome data for existing MHPA 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 MHPA 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: <ul style="list-style-type: none"> <li>- 36% of the clients are Hispanic</li> <li>- 20% of the clients are African American</li> <li>- 17% of the clients are White</li> <li>- 4% of the clients are Asian</li> <li>- 1% of the clients are Native American</li> <li>- 80% have a primary language of English</li> <li>- 13% have a primary language of Spanish</li> </ul>	42,616 new clients receiving CSS services countywide with no previous MHPA service <ul style="list-style-type: none"> <li>- 37% of the new clients are Hispanic</li> <li>- 15% of the new clients are African American</li> <li>- 15% of the new clients are White</li> <li>- 3% of the clients are Asian</li> <li>- 0.38% of the clients are Native American</li> <li>- 77% have a primary language of English</li> <li>- 12% have a primary language of Spanish</li> </ul>

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)

<b>Status</b>	<input checked="" type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input checked="" type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>Priority Population</b>	<input checked="" type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$163,545,000	\$115,915,000		\$95,397,000	
<b>Program Description</b>				
<p>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.</p> <p>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.</p> <p><b>Intended Outcomes</b> Reduce serious mental health systems, homelessness, incarceration, and hospitalization Increase independent living and overall quality of life</p> <p><b>Key Activities</b></p> <ul style="list-style-type: none"> <li>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)</li> <li>Nonclinical services (peer and parent support services; self-help and family support groups; wellness centers; respite care)</li> </ul>				

### 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 <sup>1</sup>	Total Number to be served in FY 2023-24 <sup>2</sup>
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

<sup>1</sup>Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.

<sup>2</sup>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
<b>Homeless</b>		
TAY	19% reduction	44% reduction
Adult	30% reduction	66% reduction
Older Adult	27% reduction	58% reduction
<b>Justice Involvement</b>		
TAY	1% reduction	34% reduction
Adult	23% reduction	66% reduction
Older Adult	21% reduction	48% reduction
<b>Psychiatric Hospitalization</b>		
Child	41% reduction	11% increase
TAY	45% reduction	24% reduction
Adult	25% reduction	64% reduction
Older Adult	6% reduction	24% reduction
<b>Independent Living</b>		
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.

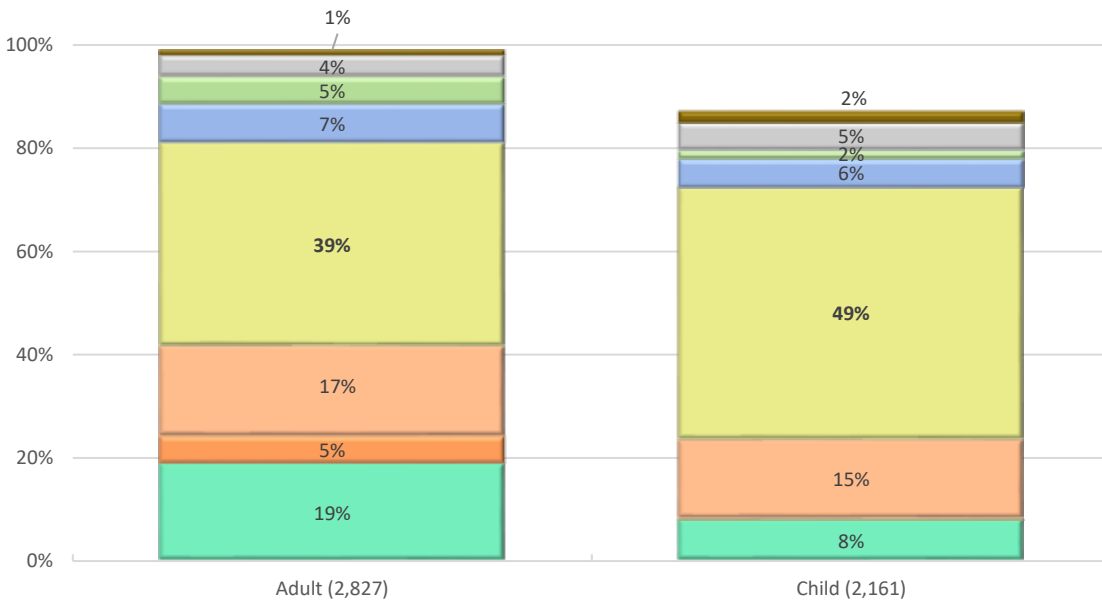
Children (n=13,905)  
 TAY (n=8,386)  
 Adult (n=19,337)  
 Older Adult (n=3,250)  
 Figures represent cumulative changes, inclusive of all clients through June 30, 2022

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



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

## B. Outpatient Care Services

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>Priority Population</b>	<input checked="" type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$234,019,000	\$192,090,000		\$182,950,000	
<b>Program Description</b>				
<p>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.</p> <p>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.</p> <p><b>Intended Outcomes</b></p> <p>Our aim is to help our clients and families to</p> <ul style="list-style-type: none"> <li>• Have a safe place to live</li> <li>• Have healthy relationships</li> <li>• Have access to public assistance when necessary</li> <li>• Weather crises successfully</li> </ul> <p><b>Key Activities</b></p> <ul style="list-style-type: none"> <li>• 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)</li> <li>• Non-clinical services (peer support; family education and support; co-occurring disorder services; linkage to primary care; housing services; vocational and pre-vocational services)</li> </ul>				

### 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 Trials:** 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

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>Priority Population</b>	<input type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$132,177,000	\$138,993,000		\$132,069,000	
<b>Program Description</b>				
<p>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.</p> <p>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.</p> <p>LACDMH MHSa ACS programs:</p> <ul style="list-style-type: none"> <li>• Residential and Bridging Care (RBC) Program</li> <li>• Psychiatric Urgent Care Centers</li> <li>• Enriched Residential Services (ERS)</li> <li>• Crisis Residential Treatment Programs (CRTP)</li> <li>• Law Enforcement Teams (LET)</li> <li>• Restorative Care Villages</li> <li>• Psychiatric Mobile Response Teams (PMRT)</li> </ul> <p><b>Intended Outcomes</b></p> <ul style="list-style-type: none"> <li>• Reduce utilization of psychiatric emergency rooms and inpatient acute psychiatry</li> <li>• Reduce incarceration of persons with severe and persistent mental illness</li> </ul> <p><b>Key Activities</b></p> <ul style="list-style-type: none"> <li>• Divert clients as appropriate to mental health urgent cares</li> <li>• Divert clients as appropriate to Crisis Residential Treatment Programs</li> <li>• Utilize mental health clinician teams in the fields as alternatives to crisis response</li> </ul>				

### 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 <sup>2</sup>	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 <sup>1</sup> MHUCC <sup>2</sup> )	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

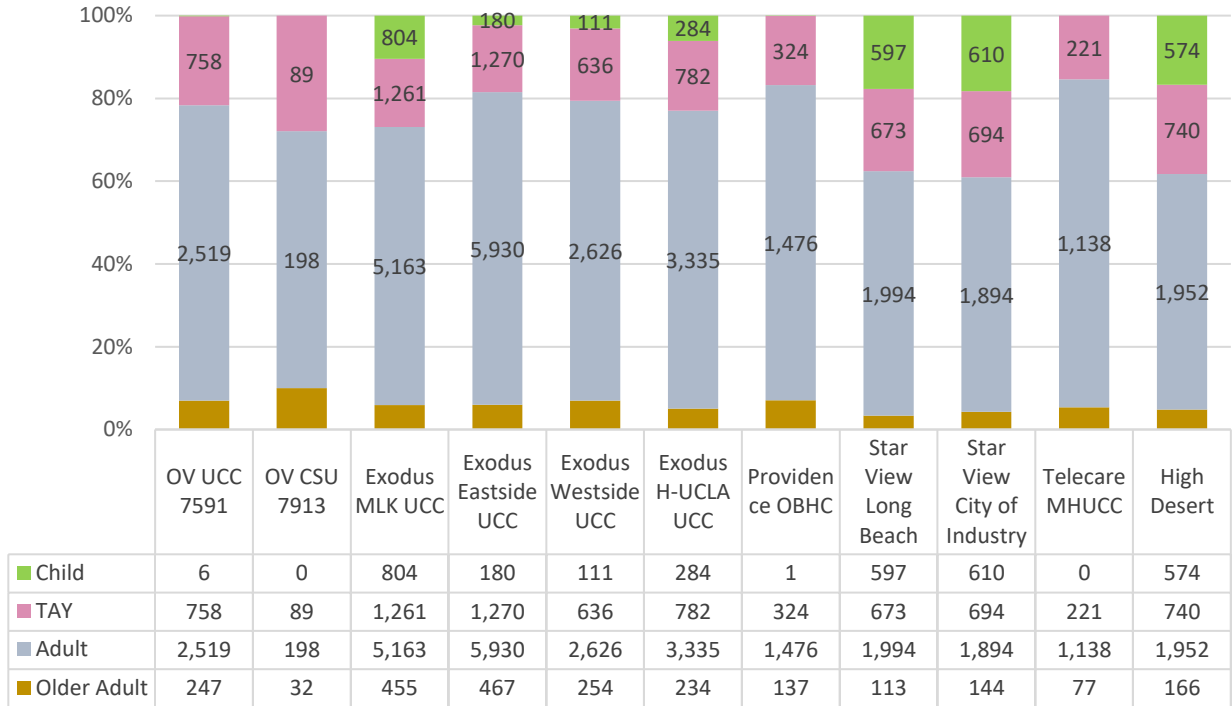


Figure 10. Clients with a psychiatric emergency assessment within 30 days of a UCC assessment

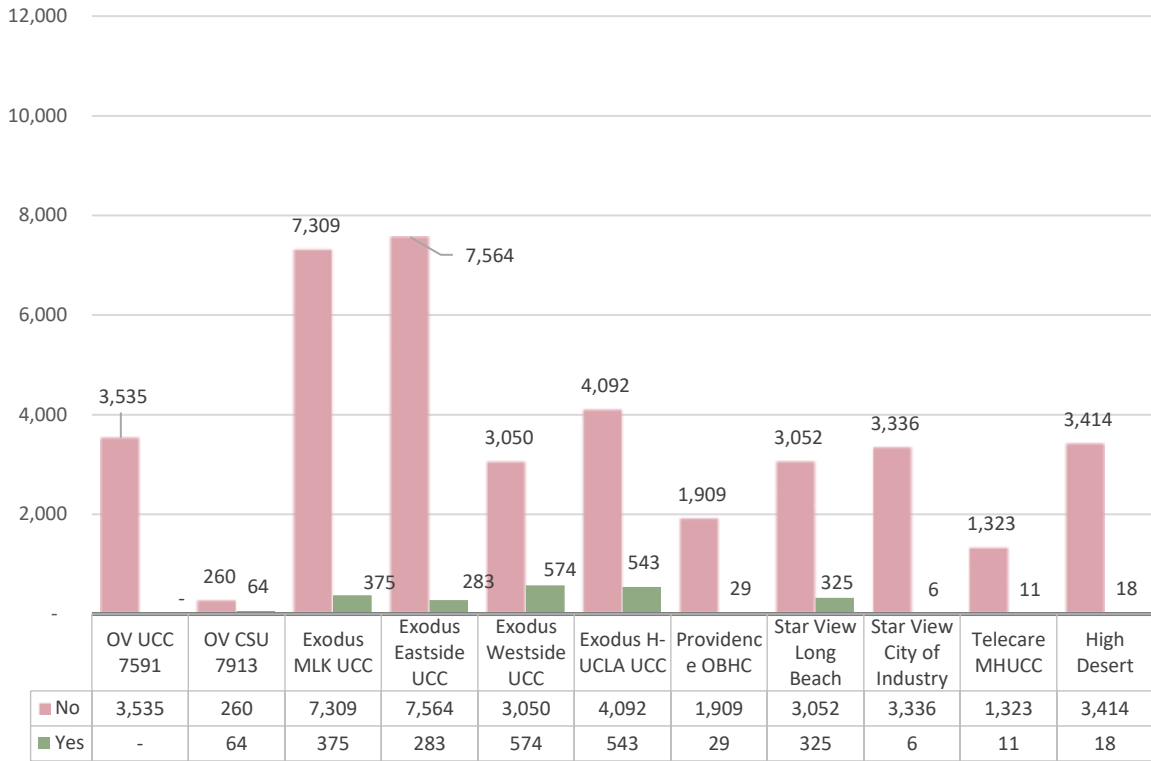


Figure 11. Clients returning to UCC within 30 days of prior UCC visit

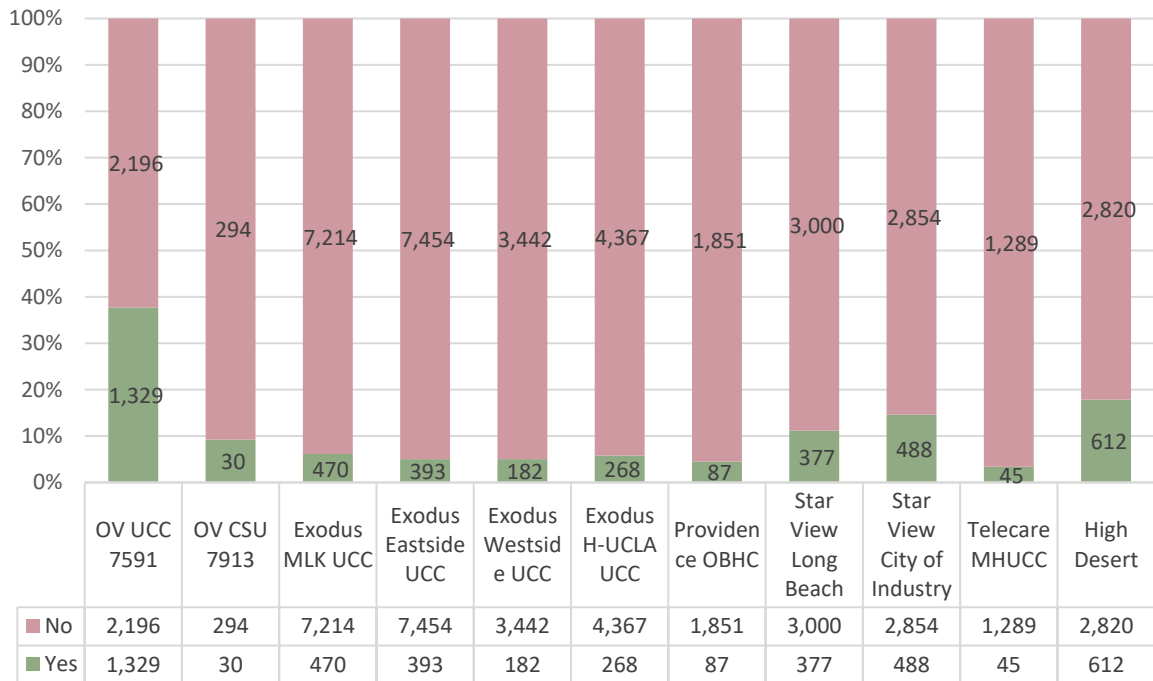
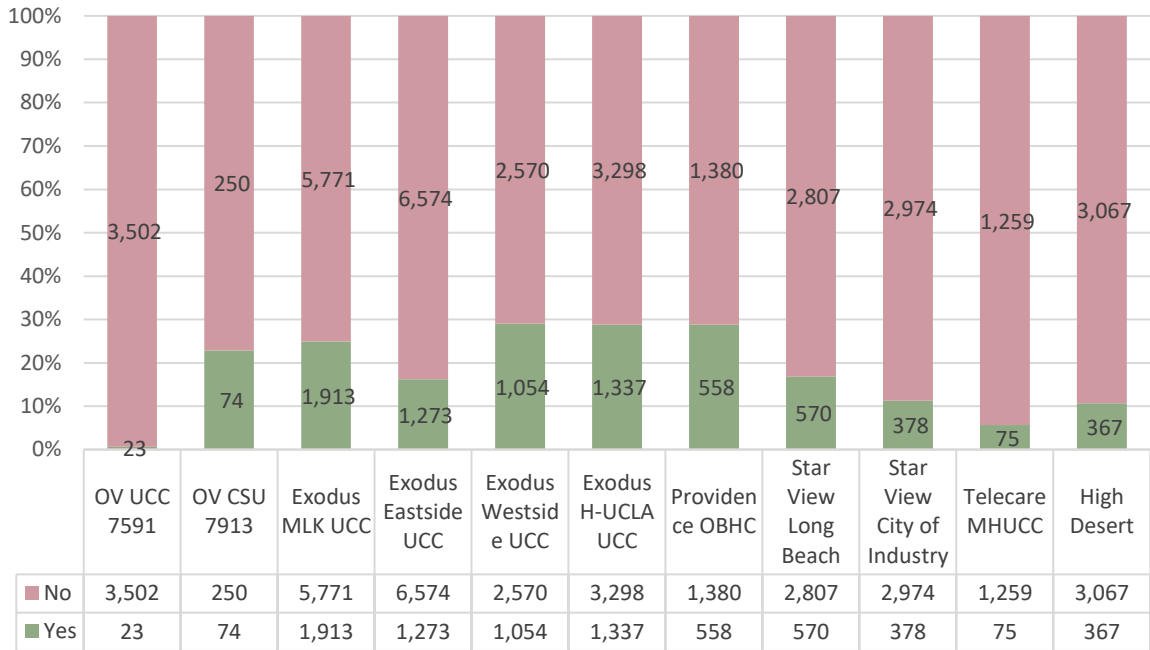


Figure 12. Clients who were homeless upon admission to UCCs



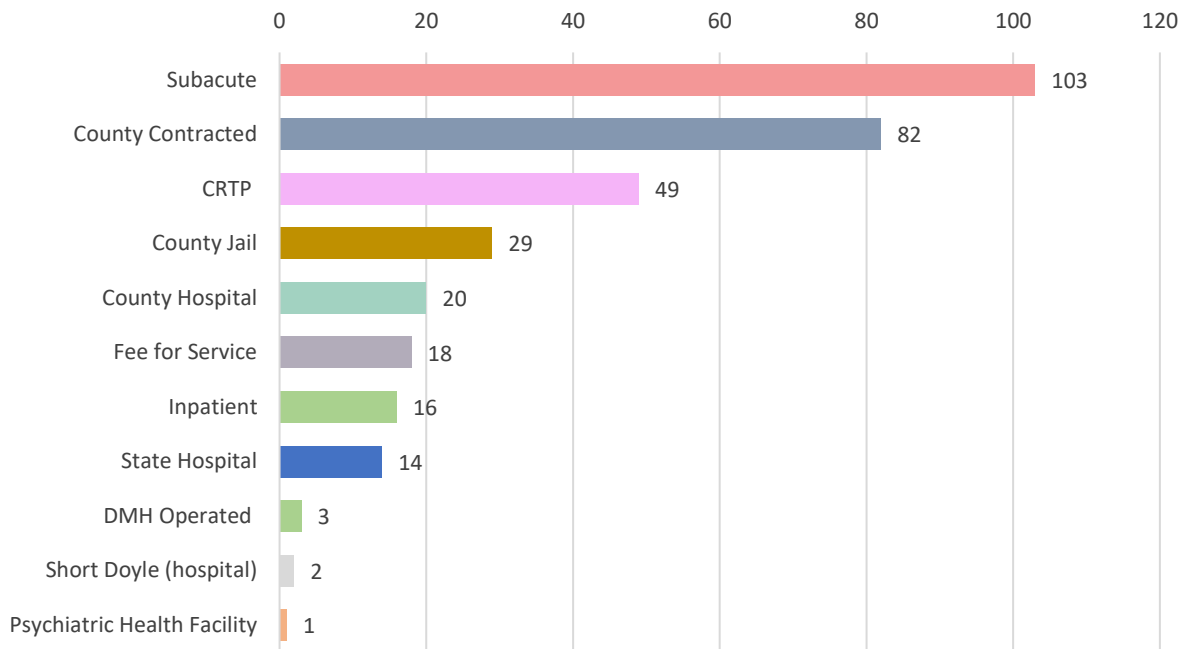
**C3. Enriched Residential Services (ERS)**

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)**

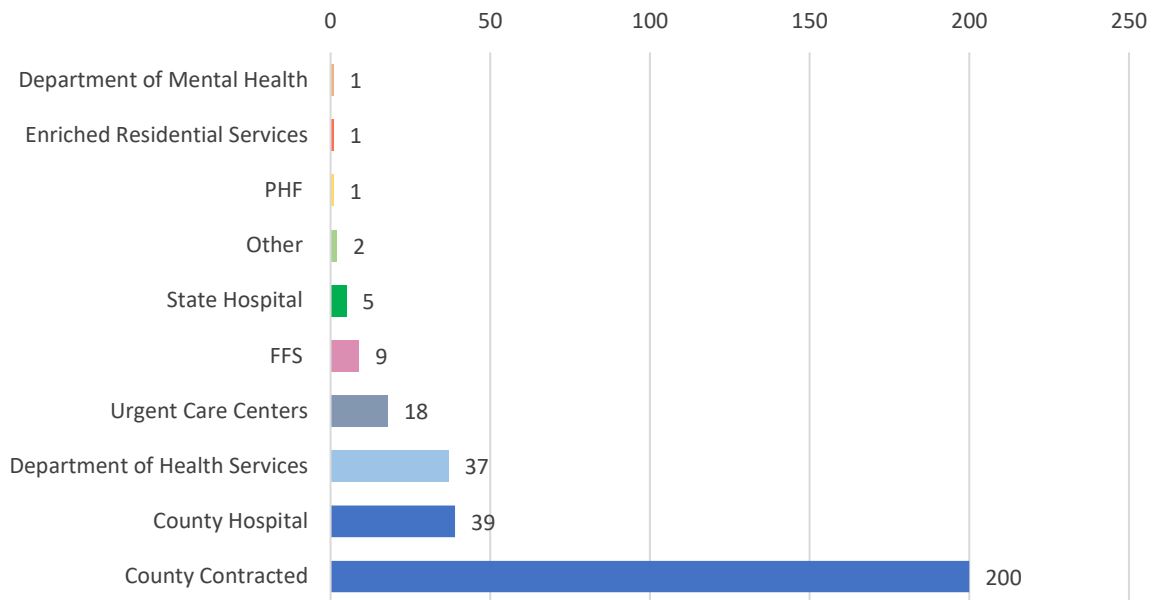
CRTPs are designed to provide short-term, intensive, and supportive services in a home-like environment through an active social rehabilitation program that is certified by the California Department of Health Services and licensed by the California Department of Social Services, Community Care Licensing 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.

**C6. Psychiatric Mobile Response Teams (PMRT)**

PMRT provides non-law enforcement-based mobile crisis response for clients experiencing a psychiatric emergency in the community. PMRT consists of LACDMH clinicians designated to perform evaluations for involuntary detention of individuals determined to be at risk of harming themselves or others, or who are unable to provide food, clothing, or shelter for themselves. PMRT enables successful triage of each situation involving mentally ill, violent or high-risk individuals. PMRT provides caring, deescalating and less traumatizing approaches to crisis intervention—and whenever possible avoids outcomes that involve hospitalization, incarceration, or additional injury. PMRTs’ tactics support clients and their families through trust and attention, and ultimately contribute to reducing stigma surrounding

mental health and accessing help.

PMRTs also receive community calls that do not rise to the level of direct services; in these situations, staff provide information, referrals, and other kinds of alternative support. More than 23 entities send referrals to PMRT, making it a critical source of care and response across LA County.

#### ■ **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

## F. Housing

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>Priority Population</b>	<input type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$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%
<b>Total</b>	<b>\$ 76,166,394</b>	<b>\$ 46,054,920</b>	<b>60%</b>

### 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

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

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

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

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 MHSAs 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 subsidies 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
<b>TOTAL</b>	<b>490</b>	<b>104</b>	<b>92*</b>

\* 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 MHSAs 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

HAP SERVICE TYPE	NUMBER OF HOUSEHOLDS SERVED
Permanent Rental Subsidies	53
Eviction Prevention	1
Directly-Operated TAY FSP Housing Supports	5
Directly-Operated Adult FSP Housing CSS Supports	51
<b>TOTAL</b>	<b>946</b>

**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	%
<b>ERC FUNDING NEEDED</b>						
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%
<b>TOTAL</b>	<b>995</b>	<b>100%</b>	<b>499</b>	<b>100%</b>	<b>401</b>	<b>100%</b>

**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:

- 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



## ■ HOUSING Continued Work

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

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>Priority Population</b>	<input type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$50,878,000	\$44,479,000		\$34,545,000	
<b>Program Description</b>				
<p>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:</p> <ul style="list-style-type: none"> <li>• Jail Transition and Linkage Services</li> <li>• Mental Health Court Linkage</li> <li>• Service Area Navigation</li> <li>• Homeless Outreach and Mobile Engagement (HOME)</li> </ul> <p><b>Intended Outcomes</b></p> <ul style="list-style-type: none"> <li>• 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:</li> <li>• Increase access to mental health services and strengthen the network of services available to clients in the mental health system</li> <li>• Promote awareness of mental health issues and the commitment to recovery, wellness and self-help</li> <li>• 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</li> </ul> <p><b>Key Activities</b></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Assist a multi-disciplinary team in considering candidates’ eligibility and suitability for pre-trial rapid diversion and linkage to treatment services</li> <li>• Develop alternate sentencing, mental health diversion and post-release plans that consider best fit treatment alternatives and Court stipulations</li> </ul>				

### 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

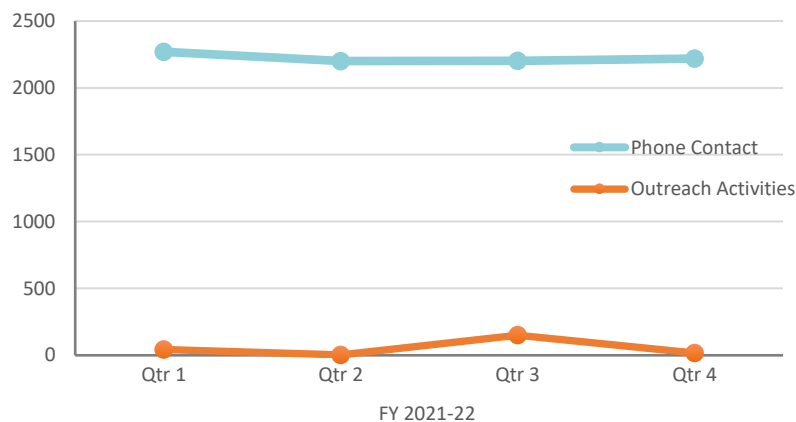


Figure 16. Number of clients referred to FSP services

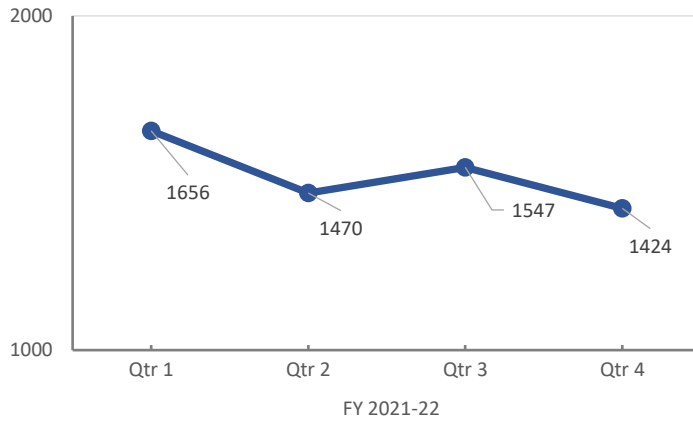
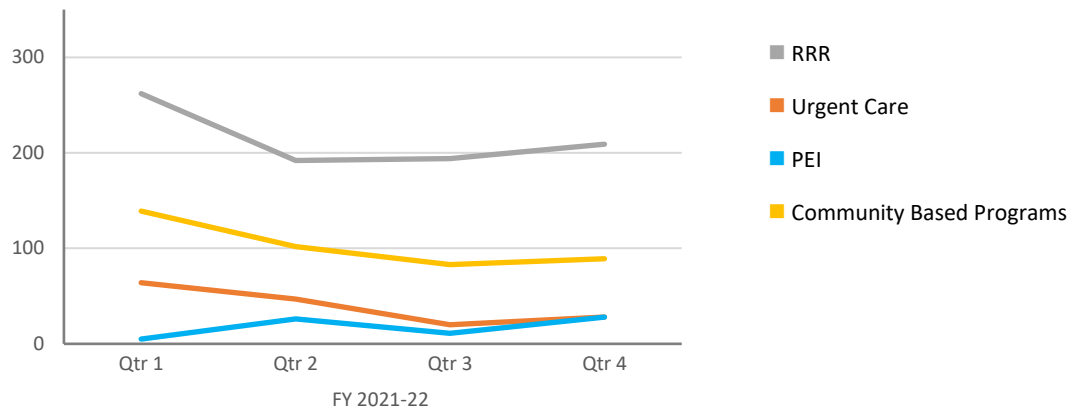


Figure 17. Number of clients referred to Non-FSP services



**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

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>Priority Population</b>	<input type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$16,970,000	\$4,458,000		\$6,178,000	
<b>Program Description</b>				
<p>POE programs:</p> <ul style="list-style-type: none"> <li>• Service Area Liaisons</li> <li>• Underserved Cultural Communities Unit (UsCC)</li> <li>• Stipend for Community Volunteers, examples include Wellness Outreach Workers (WOW) and the Countywide Client Activity Fund (CCAF)</li> </ul> <p><b>Intended Outcomes</b></p> <ul style="list-style-type: none"> <li>• Increase mental health awareness to all communities within the County</li> <li>• Identify and address disparities amongst target populations</li> <li>• Reduce stigma discrimination by educating and empowering communities to understand the importance of mental health care</li> <li>• Increase access to care for mental health services provided by LACDMH and contract providers</li> </ul> <p><b>Key Activities</b></p> <ul style="list-style-type: none"> <li>• Outreach communities throughout the County by conducting conferences and special events</li> <li>• Communities and education community members using various media and print media, as well as grassroots level community mental health presentations.</li> <li>• Communicate and educate community members using various media and print media, as well as and grassroots level community mental health presentations</li> <li>• Conduct surveys to gather results for data analysis to continue planning, outreach and engagement activities</li> <li>• Enlist the help of community members to collaborate in outreach and engagement activities</li> </ul>				

### FY 2021-22 ■ PLANNING, OUTREACH AND ENGAGEMENT 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 ethnic 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
<p><b>Domestic Violence Task Force Workshops</b></p> <p>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.</p>
<p><b>Disability Mental Wellness Round Table for the Deaf, Hard of Hearing, Blind, and Physically Disabled Community</b></p> <p>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</p>

Project
<p>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 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.</p>
<p><b>Podcast and YouTube Series Project</b></p> <p>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).</p>

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

Project
<p><b>American Indian/Alaska Native Mending the Hoop Project</b></p> <p>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.</p>
<p><b>American Indian/Alaska Native Mental Health Community Engagement Campaign</b></p> <p>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.</p>
<p><b>American Indian/Alaska Native Traditional Wellness Gathering Project</b></p> <p>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</p>



Project
<p>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, songs, and food to build connections and reclaim these traditions to improve overall health outcomes.</p>
<p><b>American Indian/Alaska Native Youth Academy Project</b></p> <p>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.</p>

**C. ASIAN PACIFIC ISLANDER (API) UsCC SUBCOMMITTEE**

Project
<p><b>1000 Cranes - Healing Through Arts and Culture Project</b></p> <p>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.</p>
<p><b>Cambodian Americans Oral History Project</b></p> <p>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.</p>

Project
<p><b>Promoting MH Wellness in South Asian Americans</b></p> <p>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.</p>

**D. LATINO UsCC SUBCOMMITTEE**

Project
<p><b>Empowering Latino Youth Mental Health Advocates Project</b></p> <p>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.</p>
<p><b>La Cultura Cura: Engaging the Traditional Arts in Healing Project</b></p> <p>The goal of the project is to provide engagement and mental health education through a partnership with the Mental Health Promoters 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 Promoters 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</p>

Project
<p>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 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.</p>
<p><b>Healing Grief and Loss Through Community Project</b></p> <p>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.</p>

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

Project
<p><b>Black LGBTQ+ Community Engagement Initiative Project</b></p> <p>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.</p>

**Project**

**LGBTQIA2-S Griot 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: <ul style="list-style-type: none"> <li>- 63% of the clients are children</li> <li>- 21% of the clients are TAY</li> <li>- 13% of the clients are adult</li> <li>- 2% of the clients are older adult</li> <li>- 47% of the clients are Hispanic</li> <li>- 8% of the clients are African American</li> <li>- 9% of the clients are White</li> <li>- 1% of the clients are Asian/Pacific Islander</li> <li>- 0.29% of the clients are Native American</li> <li>- 2% of the clients are Multiple Races</li> <li>- 76% have a primary language of English</li> <li>- 21% have a primary language of Spanish</li> </ul>	17,084 new clients receiving PEI services countywide:           with no previous MHSA service <ul style="list-style-type: none"> <li>- 42% of the new clients are Hispanic</li> <li>- 8% of the new clients are African American</li> <li>- 9% of the new clients are White</li> <li>- 1% of the new clients are Asian/Pacific Islander</li> <li>- 4% of the new clients are Multiple Races</li> <li>- 0.73% of the new clients are Native American</li> <li>- 75% have a primary language of English</li> <li>- 21% have a primary language of Spanish</li> </ul>

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

<b>SB 1004 PRIORITY CATEGORIES</b>	<b>% OF FUNDING ALLOCATED BY PRIORITY</b>
Childhood Trauma Prevention and Early Intervention	94%
Early Psychosis and Mood Disorder Detection and Intervention	55%
Youth outreach and engagement strategies that target secondary school and transition age youth	92%
Culturally competent and linguistically appropriate prevention and intervention	95%
Strategies targeting the mental health needs of Older adults	28%
Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis	95%

## A. EARLY INTERVENTION

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>Priority Population</b>	<input checked="" type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>Total Number to be Served for FY 2023-24</b>				
Child: 25,384	TAY: 8,481	Adult: 6,089	Older Adult: 1,007	
<b>Average Cost per Client:</b>	\$4,018			
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$106,479,000	\$34,218,000		\$28,379,000	
<b>Program Description</b>				
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
<p><b>Aggression Replacement Training (ART)</b> Children (ages 5-12) Skill Streaming Only Children (ages 12-15) TAY (ages 16-17)</p> <p><u>Unique Clients Served:</u> 34 <u>Gender:</u> 59% Male, 41% Female <u>Ethnicity:</u> 29% Hispanic, 18% White, 6% African American, 47% Unreported</p>	<p>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.</p>
<p><b>Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)</b> Children (ages 4-15) TAY (ages 16-17)</p> <p><u>Unique Clients Served:</u> 74 <u>Gender:</u> 51% Male, 49% Female <u>Ethnicity:</u> 74% Hispanic, 7% African American, 1% Asian, 5% White, 11% Unreported, 1% Multiple Races</p>	<p>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.</p>
<p><b>Brief Strategic Family Therapy (BSFT)</b> Children (ages 10-15) TAY (ages 16-18)</p> <p><u>Unique Clients Served:</u> 1 <u>Gender:</u> 100% Male <u>Ethnicity:</u> 100% Hispanic</p>	<p>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.</p>
<p><b>Center for the Assessment and Prevention of Prodromal States (CAPPS)</b> TAY</p>	<p>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</p>



Early Intervention EBP	Description
<p><u>Unique Clients Served:</u> 24  <u>Gender:</u> 71% Male, 29% Female  <u>Ethnicity:</u> 63% Hispanic, 17% Unreported, 13% White ,  8% Multiple Races</p>	<p>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.</p>
<p><b>Child-Parent Psychotherapy (CPP)</b>  Young Children (ages 0-6)</p> <p><u>Unique Clients Served:</u> 1,217  <u>Gender:</u> 53% Male, 47% Female  <u>Ethnicity:</u> 47% Hispanic, 13% African American,  1% Asian, 10% White, 24% Unreported  4% Multiple Races, 0.33% Native Hawaiian/Pacific Islander, 1% Other</p>	<p>CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive -behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma.</p>
<p><b>Crisis Oriented Recovery Services (CORS)</b>  Children  TAY  Adults  Older Adults</p> <p><u>Unique Clients Served:</u> 71  <u>Gender:</u> 20% Male, 80% Female  <u>Ethnicity:</u> 17% Hispanic, 8% African American,  1% Asian, 3% White, 61% Unreported,  4% Multiple Races, 6% Other</p>	<p>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.</p>
<p><b>Depression Treatment Quality Improvement (DTQI)</b>  Children  TAY  Adults  Older Adults</p> <p><u>Unique Clients Served:</u> 14  <u>Gender:</u> 57% Male, 43% Female  <u>Ethnicity:</u> 29% Hispanic, 64% Unreported, 7% Other</p>	<p>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.</p>
<p><b>Dialectical Behavioral Therapy (DBT)</b>  Children (ages 12-15)  TAY (ages 16-20)</p> <p><u>Unique Clients Served:</u> 182  <u>Gender:</u> 20% Male, 79% Female, 1% Female to Male  <u>Ethnicity:</u> 38% Hispanic, 9% African American,  4% Asian, 14% White, 26% Unreported,  2% Native Hawaiian/Pacific Islander,  5% Multiple Races, 2% Other</p>	<p>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.</p>
<p><b>Families Over Coming Under Stress (FOCUS)</b>  Children  TAY  Adults</p> <p><u>Unique Clients Served:</u> 70  <u>Gender:</u> 53% Male, 47% Female  <u>Ethnicity:</u> 16% Hispanic, 1% African American, 1% White,  1% Asian, 73% Unreported, 1% Native  Hawaiian/ Pacific Islander, 6% Multiple Races</p>	<p>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.</p>

Early Intervention EBP	Description
<p><b>Functional Family Therapy (FFT)</b>            Children (ages 11-15)            TAY (ages 16-18)</p> <p><u>Unique Clients Served:</u> 14  <u>Gender:</u> 57% Male, 43% Female  <u>Ethnicity:</u> 7% White, 64% Hispanic, 21% Unreported, 7% African American</p>	<p>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.</p>
<p><b>Group Cognitive Behavioral Therapy for Major Depression (Group CBT)</b>            TAY (ages 18-25)            Adults            Older Adults</p> <p><u>Unique Clients Served:</u> 4  <u>Gender:</u> 25% Male, 75% Female  <u>Ethnicity:</u> 25% Asian, 75% Hispanic</p>	<p>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.</p>
<p><b>Incredible Years (IY)</b>            Young Children (ages 2-5)            Children (ages 6-12)</p> <p><u>Unique Clients Served:</u> 102  <u>Gender:</u> 71% Male, 29% Female  <u>Ethnicity:</u> 69% Hispanic, 4% African American, 2% Asian, 14% White, 8% Unreported, 3% Multiple Races, 1% Other</p>	<p>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.</p>
<p><b>Individual Cognitive Behavioral Therapy (Ind. CBT)</b>            TAY (ages 18-25)            Adults            Older Adults            Directly Operated Clinics only</p> <p><u>Unique Clients Served:</u> 8,394  <u>Gender:</u> 26% Male, 74% Female  <u>Ethnicity:</u> 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</p>	<p>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.</p>
<p><b>Interpersonal Psychotherapy for Depression (IPT)</b>            Children (ages 9-15)            TAY            Adults            Older Adults</p> <p><u>Unique Clients Served:</u> 1,048  <u>Gender:</u> 26% Male, 74% Female  <u>Ethnicity:</u> 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</p>	<p>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.</p>

Early Intervention EBP	Description
<p><b>Loving Intervention Family Enrichment Program (LIFE)</b> Children (ages 0-8)</p> <p><u>Unique Clients Served:</u> 1 <u>Gender:</u> 100% Female <u>Ethnicity:</u> 100% Hispanic</p>	<p>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.</p>
<p><b>Managing and Adapting Practice (MAP)</b> Young Children Children TAY (ages 16-21)</p> <p><u>Unique Clients Served:</u> 11,333 <u>Gender:</u> 45% Male, 55% Female <u>Ethnicity:</u> 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</p>	<p>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.</p>
<p><b>Mental Health Integration Program (MHIP)</b> <b>Formerly known as IMPACT</b> Adults</p> <p><u>Unique Clients Served:</u> 986 <u>Gender:</u> 27% Male, 73% Female <u>Ethnicity:</u> 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</p>	<p>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.</p>
<p><b>Multidimensional Family Therapy (MDFT)</b> Children (ages 12-15) TAY (ages 16-18)</p>	<p>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.</p>
<p><b>Multisystemic Therapy (MST)</b> Children (ages 12-15) TAY (ages 16-17)</p> <p><u>Unique Clients Served:</u> 1,277 <u>Gender:</u> 41% Male, 59% Female <u>Ethnicity:</u> 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</p>	<p>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).</p>
<p><b>Parent-Child Interaction Therapy (PCIT)</b> Young Children (2-7)</p> <p><u>Unique Clients Served:</u> 616 <u>Gender:</u> 65% Male, 35% Female <u>Ethnicity:</u> 48% Hispanic, 12% African American, 27% Unreported, 6% White, 5% Multiple Races, 0.32% Native American, 2% Other</p>	<p>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.</p>

Early Intervention EBP	Description
<p><b>Portland Identification and Early Referral (PIER)</b>  Children (ages 12-15)  TAY (ages 16-25)</p>	<p>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.</p>
<p><b>Problem Solving Therapy (PST)</b>  Older Adults</p> <p><u>Unique Clients Served:</u> 10  <u>Gender:</u> 30% Male, 60% Female, 10% Male to Female  <u>Ethnicity:</u> 50% Hispanic, 10% African American, 10% White, 30% Unreported,</p>	<p>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.</p>
<p><b>Program to Encourage Active Rewarding Lives for Seniors (PEARLS)</b>  Older Adults</p> <p><u>Unique Clients Served:</u> 12  <u>Gender:</u> 25% Male, 75% Female  <u>Ethnicity:</u> 25% Asian, 8% White, 17% African American, 50% Unreported</p>	<p>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.</p>
<p><b>Prolonged Exposure - Post Traumatic Stress Disorder (PE-PTSD)</b>  TAY (ages 18-25)  Adults  Older Adults  Directly Operated Clinics Only</p> <p><u>Unique Clients Served:</u> 7  <u>Gender:</u> 29% Male, 71% Female  <u>Ethnicity:</u> 43% Hispanic, 14% African American, 43% Unreported,</p>	<p>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.</p>
<p><b>Reflective Parenting Program (RPP)</b>  Young Children (ages 2-5)  Children (ages 6-12)</p> <p><u>Unique Clients Served:</u> 3  <u>Gender:</u> 33% Male, 67% Female  <u>Ethnicity:</u> 67% African American, 33% White</p>	<p>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.</p>
<p><b>Seeking Safety (SS)</b>  Children (13-15)  TAY  Adults  Older Adults</p> <p><u>Unique Clients Served:</u> 1,198  <u>Gender:</u> 31% Male, 69% Female  <u>Ethnicity:</u> 44% Hispanic, 7% African American, 2% Asian, 9% White, 33% Unreported, 4% Multiple Races, 0.75% Native American, 1% Other</p>	<p>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.</p>

Early Intervention EBP	Description
<p><b>Stepped Care (SC)</b>            Children            TAY            Adults            Older Adults</p> <p><u>Unique Clients Served:</u> 11,758  <u>Gender:</u> 42% Male, 58% Female  <u>Ethnicity:</u> 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</p>	<p>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.</p>
<p><b>Strengthening Families (SF)</b>            Children (ages 3-15)            TAY (ages 16-18)</p>	<p>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.</p>
<p><b>Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle</b>            Children (ages 3-8)</p> <p><u>Unique Clients Served:</u> 2,551  <u>Gender:</u> 36% Male, 64% Female  <u>Ethnicity:</u> 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</p>	<p>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.</p>
<p><b>Triple P Positive Parenting Program (Triple P)</b>            Young Children (ages 0-5)            Children (ages 6-15)            TAY (age 16)</p> <p><u>Unique Clients Served:</u> 270  <u>Gender:</u> 65% Male, 35% Female  <u>Ethnicity:</u> 33% Hispanic, 4% African American, 9% Asian, 7% White, 3% Multiple Races, 42% Unreported, 0.37% Native Hawaiian/Pacific Islander, 1% Other</p>	<p>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.</p>
<p><b>UCLA Ties Transition Model (UCLA TTM)</b>            Young Children (ages 0-5)            Children (ages 6-12)</p> <p><u>Unique Clients Served:</u>  <u>Gender:</u> 50% Male, 50% Female  <u>Ethnicity:</u> 25% Hispanic, 50% White, 25% Unreported</p>	<p>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).</p>

Table 29. EBP Outcomes since 2009 through June 2022

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
<b>ART</b>	3,432	43%	<ul style="list-style-type: none"> <li>- 21% Improvement in disruptive behaviors (as reported by parents and children)</li> <li>- 10% Reduction in the severity of problem behaviors (as reported by parents and children)</li> <li>- 14% Improvement in disruptive behaviors (as reported by teachers)</li> <li>- 6% Reduction in the severity of problem behaviors (as reported by teachers)</li> </ul>
<b>ART Skillstreaming</b>	328	54%	<ul style="list-style-type: none"> <li>- 21% Reduction in disruptive behaviors</li> <li>- 19% Reduction in the severity of problem behaviors</li> </ul>
<b>AF-CBT</b>	1,729	52%	<ul style="list-style-type: none"> <li>- 58% Reduction in trauma related symptoms</li> </ul>
<b>BFST</b>	203	63%	<ul style="list-style-type: none"> <li>- 50% Reduction in behavioral problems</li> <li>- 66% Reduction in anxiety symptoms</li> <li>- 60% Reduction in attention problems</li> <li>- 100% Reduction in psychotic behaviors</li> <li>- 50% Reduction in aggressive behaviors</li> </ul>
<b>CFOF</b>	733	67%	<ul style="list-style-type: none"> <li>- 30% Improvement in disruptive behaviors</li> <li>- 20% Reduction in the severity of problem behaviors</li> </ul>
<b>CAPPS</b>	211	42%	<ul style="list-style-type: none"> <li>- 60% Reduction in prodromal symptoms</li> </ul>
<b>CPP</b>	211	47%	<ul style="list-style-type: none"> <li>- 17% Improvement in mental health functioning following a traumatic event</li> </ul>
<b>CBITS</b>	131	71%	<ul style="list-style-type: none"> <li>- No Data to Report (n=12)</li> </ul>
<b>CORS</b>	4,177	60%	<ul style="list-style-type: none"> <li>- 19% Improvement in mental health functioning</li> </ul>
<b>DBT</b>	303	54%	<ul style="list-style-type: none"> <li>- 8% Improvement in emotional regulation</li> </ul>
<b>DTQI</b>	1,354	65%	<ul style="list-style-type: none"> <li>- 55% Reduction in symptoms related to depression</li> </ul>
<b>FOCUS</b>	754	71%	<ul style="list-style-type: none"> <li>- 50% Improvement in direct communication</li> </ul>
<b>FC</b>	24	44%	<ul style="list-style-type: none"> <li>- No Data to Report (n=1)</li> </ul>
<b>FFT</b>	1,725	66%	<ul style="list-style-type: none"> <li>- 31% Improvement in mental health functioning</li> </ul>
<b>Group CBT</b>	1,143	42%	<ul style="list-style-type: none"> <li>- 42% Reduction in symptoms related to depression</li> </ul>
<b>IY</b>	2,864	64%	<ul style="list-style-type: none"> <li>- 35% Reduction in disruptive behaviors</li> <li>- 18% Reduction in the severity of problem behaviors</li> </ul>
<b>Ind. CBT</b>	Anxiety 3,972 Depression 7,946 Trauma 1,154	Anxiety 46% Depression 45% Trauma 48%	<ul style="list-style-type: none"> <li>- 63% Reduction in symptoms related to anxiety</li> <li>- 58% Reduction in symptoms related to depression</li> <li>- 60% Reduction in trauma related symptoms</li> </ul>
<b>IPT</b>	8,604	49%	<ul style="list-style-type: none"> <li>- 54% Reduction in symptoms related to depression</li> </ul>
<b>LIFE</b>	433	65%	<ul style="list-style-type: none"> <li>- 50% Reduction in disruptive behaviors</li> <li>- 23% Reduction in the severity of problem behaviors</li> </ul>
<b>MAP</b>	69,118	50%	<ul style="list-style-type: none"> <li>- 43% Reduction in disruptive behaviors</li> <li>- 25% Reduction in the severity of problem behaviors</li> <li>- 55% Reduction in symptoms related to depression</li> <li>- 44% Reduction in symptoms related to anxiety</li> <li>- 48% Reduction in trauma related symptoms</li> </ul>
<b>MHIP</b>	Anxiety 2,995 Depression 6,933 Trauma 302	Anxiety 38% Depression 33% Trauma 29%	<ul style="list-style-type: none"> <li>- 54% Reduction in symptoms related to anxiety</li> <li>- 57% Reduction in symptoms related to depression</li> <li>- 24% Reduction in trauma related symptoms</li> </ul>
<b>MPG</b>	16	86%	<ul style="list-style-type: none"> <li>- No Data to Report (n=1)</li> </ul>
<b>MDFT</b>	77	89%	<ul style="list-style-type: none"> <li>- No Data to Report (n=6)</li> </ul>
<b>MST</b>	126	72%	<ul style="list-style-type: none"> <li>- No Data to Report (n=0)</li> <li>- Pediatric Symptom Checklist 35 is used for this practice</li> </ul>
<b>NPP</b>	N/A	N/A	<ul style="list-style-type: none"> <li>- No Data to Report (n=0)</li> </ul>
<b>PCIT</b>	4,868	40%	<ul style="list-style-type: none"> <li>- 61% Reduction in disruptive behaviors</li> <li>- 36% Reduction in the severity of problem behaviors</li> </ul>
<b>PIER</b>	75	18%	<ul style="list-style-type: none"> <li>- No Data to Report</li> </ul>

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

## B. Prevention

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>Priority Population</b>	<input type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$132,105,000	\$85,010,000		\$63,021,000	
<b>Program Description</b>				
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.				
Prevention services are also administered by the California Mental Health Services Authority (CalMHSA). CalMHSA is a Joint Powers of Authority (JPA) providing administrative and fiscal services in support of the Department of Mental Health.				

### 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 grassroots 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 Questionnaire-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 MHLA uses 60+.

\*\*Ethnicity and race were collected as one category by DHS.

▪ **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
▪ Sexual Orientation		Other	13
Gay or Lesbian	3	More than one ethnicity	18
Heterosexual or Straight	676	Declined to answer/Missing/Unknown	356
Bisexual	14	▪ Race	
Questioning or Unsure	3	American Indian or Alaska Native	56
Queer	3	Asian	31
Another Sexual Orientation	23	Black or African-American	116
Declined to answer/Missing/Unknown	352	Native Hawaiian or Pacific Islander	1
▪ Disability		White	132
No	402	More than one race	26
Yes	219	Other	310
Mental domain	51	Declined to answer/Missing/Unknown	377
Physical/mobility domain	30	▪ Age	
Chronic health condition	93	16-25	46
Difficulty seeing	17	26-59	459
Difficulty hearing	10	60+	16
Another type of disability	18	Declined to answer/Missing/Unknown	528
Declined to answer/Missing/Unknown	428	▪ Veteran Status	
		Yes	10
		No	700
		Declined to answer/Missing/Unknown	339

▪ **Prevent Homelessness Promote Health (PH<sup>2</sup>)**

Prevent Homelessness Promote Health (PH<sup>2</sup>) 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<sup>2</sup> 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<sup>2</sup> 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<sup>2</sup> 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<sup>2</sup> 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<sup>2</sup> 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<sup>2</sup> 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<sup>2</sup> Activity Log in IBHIS tracks Peak Eviction Risk Level during the participant's engagement in PH<sup>2</sup>. 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<sup>2</sup> 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<sup>2</sup> were to mental health services, followed by primary care physicians, DHS, and housing and supportive services (Table 9).

Table 39. FY 2021-22 Demographics – PH<sup>2</sup>

	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

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<sup>2</sup> 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.

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	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
▪ Sexual Orientation		More than one ethnicity	2
Heterosexual or Straight	53	Declined to answer/Missing/Unknown	63
Gay or Lesbian	7	▪ Race	
Undecided/Unknown	112	American Indian	1
▪ Age		Asian	4
16-25	1	Black or African-American	39
26-59	118	White	25
60+	52	More than one race	2
▪ Disability		Other*	37
No	20	Declined to answer/Missing/Unknown	63
Yes	62	▪ Veteran Status	
Another communication disability	1	Yes	5
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 programming 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.
- SEED School of Los Angeles (SEED LA)  
SEED LA is the County’s first public, charter, college-preparatory, tuition-free boarding high school for at-risk youth. The curriculum, grounded in science, technology, engineering, and mathematics (STEM), will prepare youth for career and college pathways in the transportation and infrastructure industry. The school provides on-site support, wellness services and socio-emotional counseling for students.

**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
<b>Active Parenting</b> 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.
<b>Arise</b> 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.
<b>Asian American Family Enrichment Network (AAFEN)</b> 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.
<b>Childhelp Speak Up and Be Safe</b> 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.

Prevention Program	Description
<p><b>Coping with Stress</b> Child (13-15) TAY (16-18)</p>	<p>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.</p>
<p><b>Erika’s Lighthouse: A Beacon of Hope for Adolescent Depression</b> Children (12-14)</p>	<p>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."</p>
<p><b>Guiding Good Choices</b> Parents of Children (9-14)</p>	<p>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.</p>
<p><b>Healthy Ideas (Identifying Depression, Empowering Activities for Seniors)</b> Older Adults (60+)</p>	<p>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.</p>
<p><b>Incredible Years (Attentive Parenting)</b> Parents</p>	<p>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.</p>
<p><b>Life Skills Training (LST)</b> Children (8-15) TAY (16-18)</p>	<p>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.</p>
<p><b>Love Notes</b> Children (15) TAY (16-24)</p>	<p>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.</p>
<p><b>Making Parenting a Pleasure (MPAP)</b> Parents of children (0-8)</p>	<p>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.</p>

Prevention Program	Description
<p><b>More than Sad</b> Parents/Teachers/Children (14-15) TAY (16-18)</p>	<p>This is a curriculum for teens, parents and educators to teach how to recognize the signs of depression. The program for teens teaches how to recognize signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process. The program for parents teaches parents how to recognize signs of depression and other mental health problems, initiate a conversation about mental health with their child, and get help. The program for teachers teaches educators to recognize signs of mental health distress in students and refer them for help. The program complies with the requirements for teacher education suicide prevention training in many states.</p>
<p><b>Nurturing Parenting</b> Parents of children (0-18)</p>	<p>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.</p>
<p><b>Peacebuilders</b> Children (0-15)</p>	<p>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.</p>
<p><b>Prevention of Depression (PODS) - Coping with Stress</b> (2nd Generation) Child (13-15) TAY (16-18)</p>	<p>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.</p>
<p><b>Positive Parenting Program (TRIPLE P) Levels 2 and 3</b> Parents/Caregivers of Children (0-12)</p>	<p>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.</p>
<p><b>Project Fatherhood</b> Male Parents/Caregivers of Children (0-15) TAY (16-18)</p>	<p>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.</p>
<p><b>Psychological First Aid (PFA)</b> All Ages</p>	<p>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.</p>
<p><b>School, Community and Law Enforcement (SCALE)</b> Children (12-15) TAY (16-18)</p>	<p>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).</p>
<p><b>Second Step</b> Children (4-14)</p>	<p>A classroom-based program, this practice teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The</p>

Prevention Program	Description
	<p>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.</p>
<p><b>Shifting Boundaries</b> Children (10-15)</p>	<p>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.</p>
<p><b>Teaching Kids to Cope</b> Children (15) TAY (16-22)</p>	<p>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.</p>
<p><b>Why Try</b> Children (7-15) TAY (16-18)</p>	<p>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.</p>

## C. STIGMA AND DISCRIMINATION REDUCTION (SDR)

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>Priority Population</b>	<input checked="" type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$81,836,000	\$21,301,000		\$6,940,000	
<b>Program Description</b>				
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.

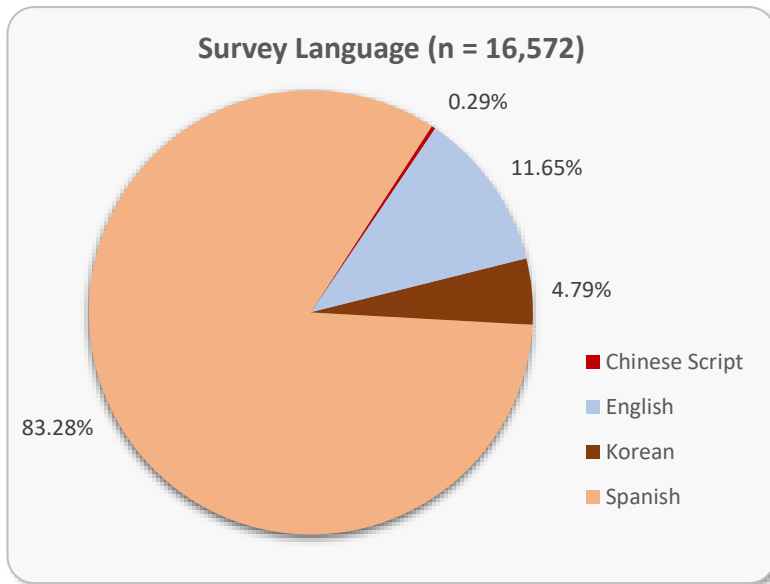
#### C4. SDR Outcomes

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%,

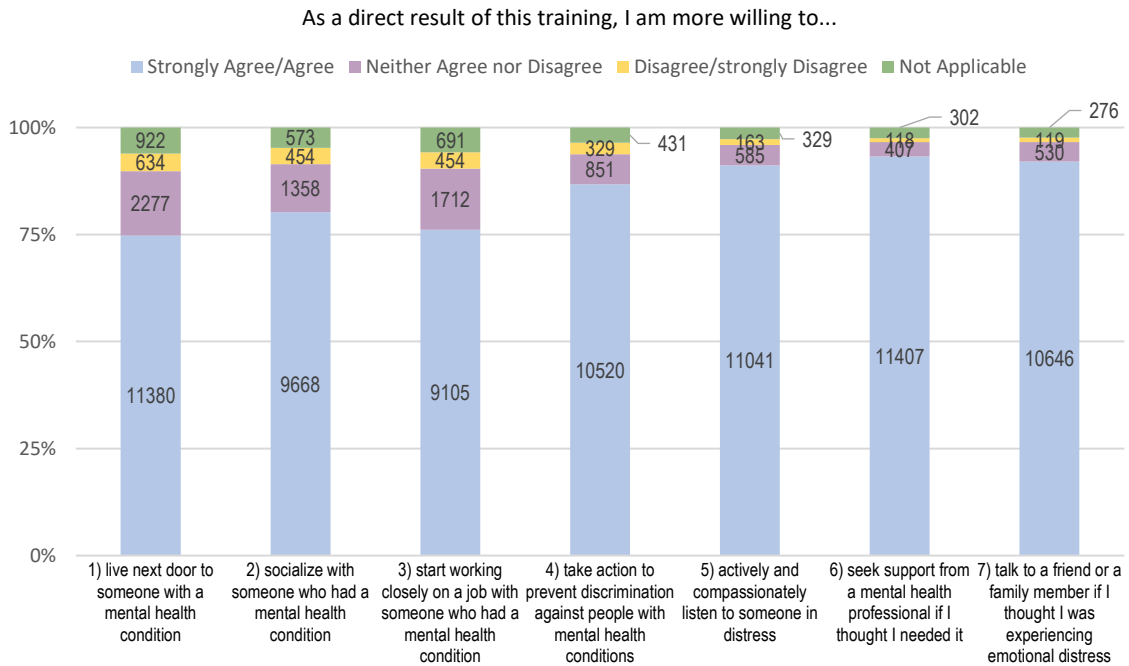
Figure 18. Survey languages



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."

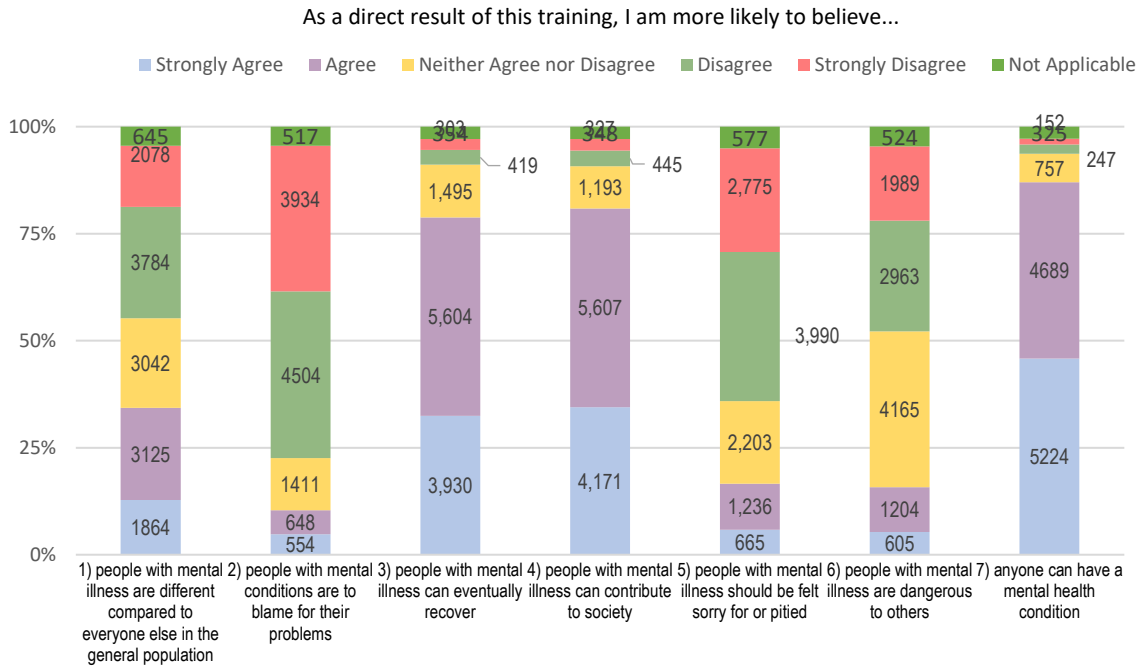
Figure 19. Changes in behavior



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 item 14, "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

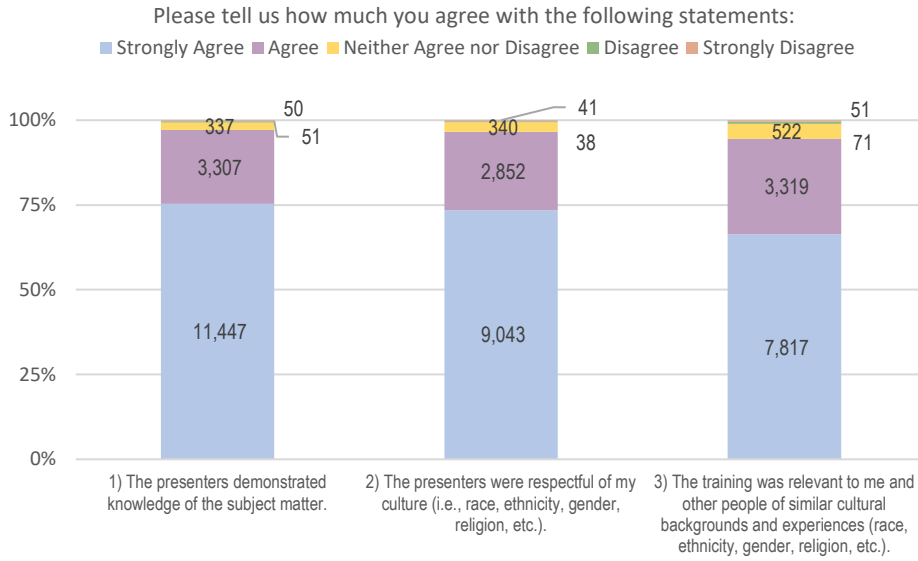


Table 44. Survey demographics (n = 16,572)

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

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>Priority Population</b>	<input checked="" type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$6,146,000	\$5,682,000		\$5,638,000	
<b>Program Description</b>				
<p>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.</p> <p>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.</p> <p>Some of the key elements to suicide prevention are:</p> <ul style="list-style-type: none"> <li>• Focus on fostering prevention and well-being through connections, education, outreach, advocacy and stigma reduction;</li> <li>• 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;</li> <li>• 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</li> <li>• Implement a system of short- and long-term support for individuals, families, schools and communities following a suicide attempt or death.</li> </ul>				

### 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

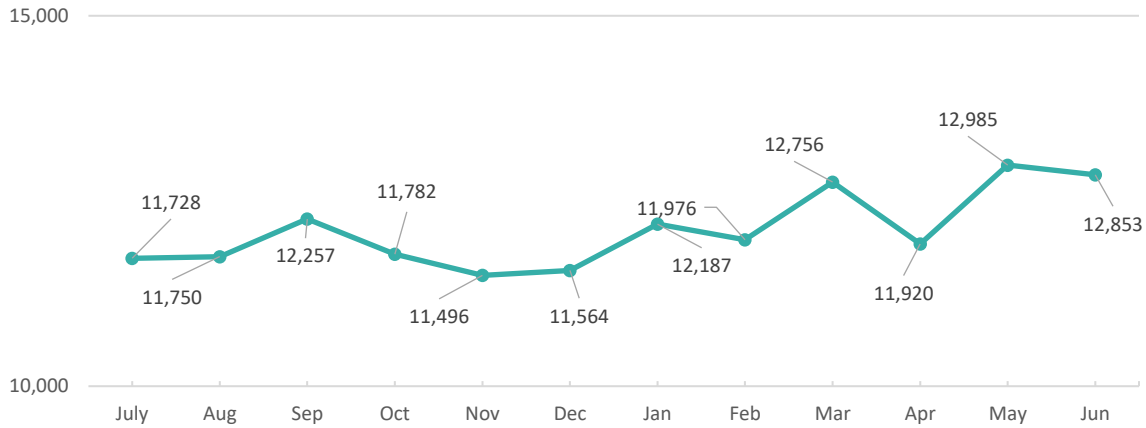


Table 47. Calls and chats by ethnicity

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%

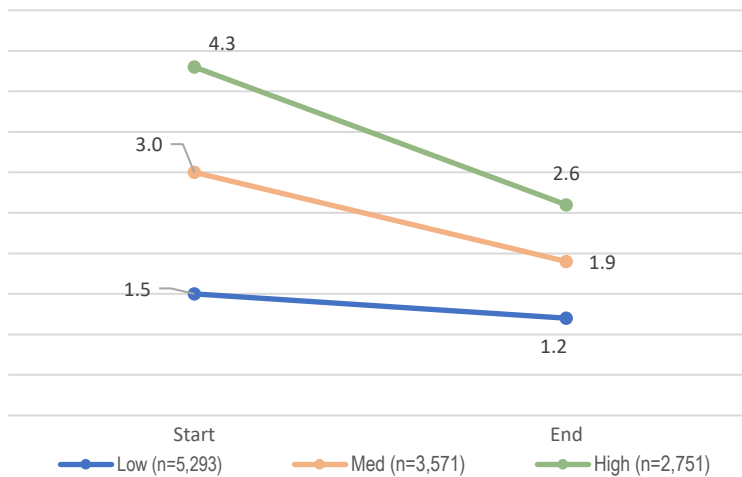
Percentages are calculated based on the total number of callers with reported risk levels.

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

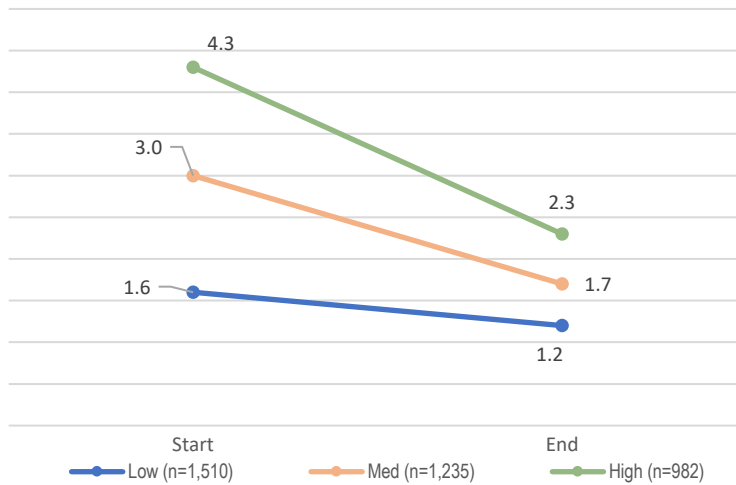
Callers are asked to answer the question: "On a scale of 1 to 5, how likely are you to act upon your suicidal thoughts and feelings at this time, where 1 represents not likely and 5 represents extremely likely?" Callers rate their intent both at the start and end of the call. Note: This data is on calls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

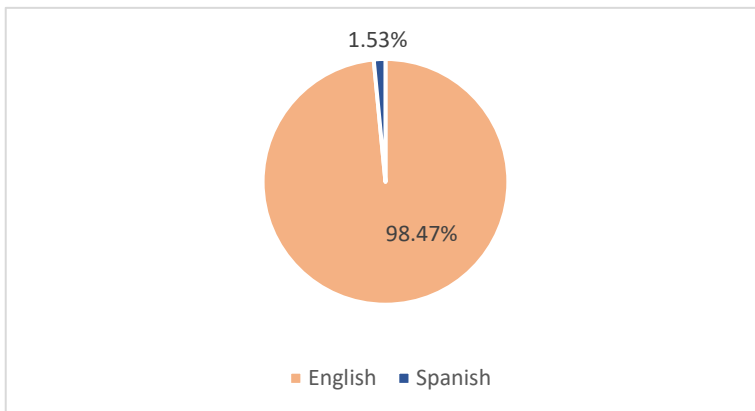


**D3. Suicide Prevention Outcomes**

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 the 1309 questionnaires received for SP trainings conducted during the 2021-2022 Fiscal Year (FY).

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

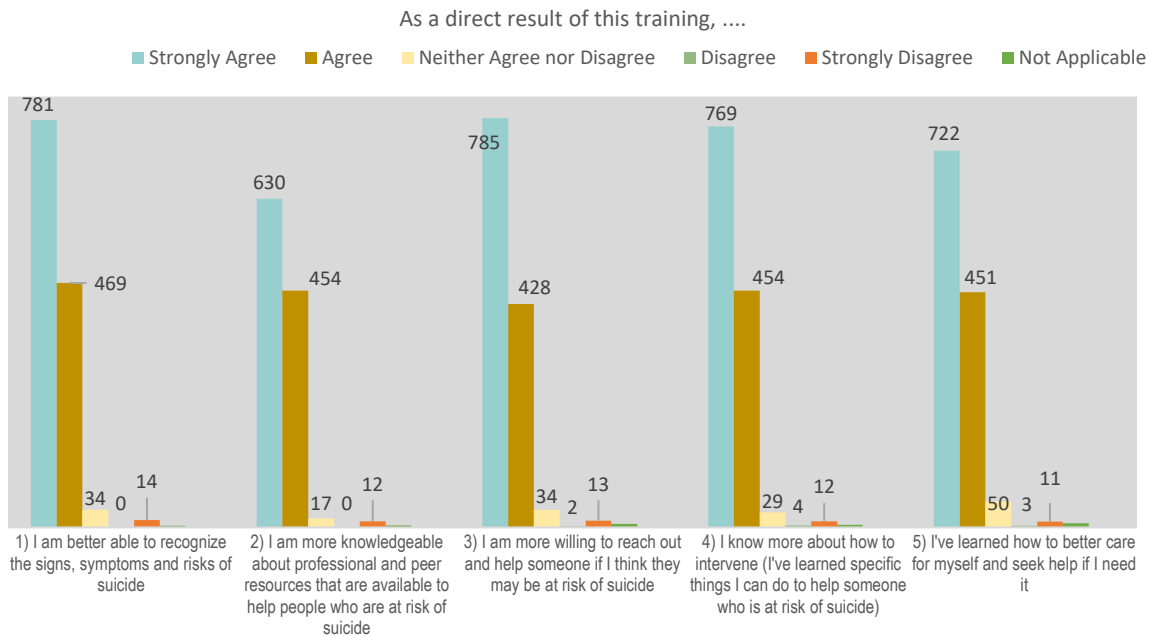


## Changes in Attitudes, Knowledge, and Behavior

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

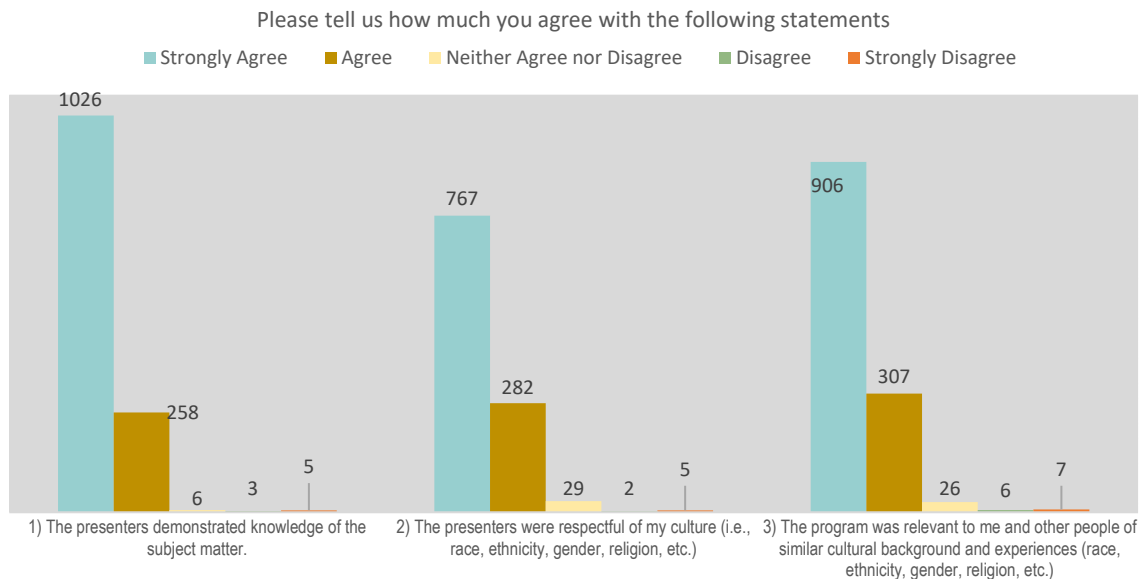


Table 51. FY 2020-21 Survey demographics

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	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> 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	
<b>Program Description</b>				
The Los Angeles County MHA – 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 MHA. 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
<b>TOTAL:</b>	<b>387</b>	<b>819.5</b>	<b>13,026</b>

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 completed 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)

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 an 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	<ul style="list-style-type: none"> <li>• 1 month of university onboarding is done at CDU</li> <li>• Veterans Administration (VA) Long Beach (Inpatient Psychiatry): 4 months</li> <li>• Rancho Los Amigos (Inpatient Medicine): 2 months</li> <li>• Rancho Los Amigos (Neurology): 2 months</li> <li>• Kedren (Outpatient Medicine): 2 months</li> <li>• Harbor-UCLA (Emergency Psychiatry): 1 month</li> </ul>
Year 2 Post Graduates	6	<ul style="list-style-type: none"> <li>• VA Long Beach (Inpatient Psychiatry): 3 months</li> <li>• VA Long Beach (Consultation and Liaison): 2 months</li> <li>• VA Long Beach (Emergency Psychiatry): 1 month</li> <li>• VA Long Beach (Substance Abuse): 2 months</li> <li>• VA Long Beach (Geriatric Psychiatry): 1 month</li> <li>• Kedren (Inpatient Psychiatry): 1 month</li> <li>• Resnick Neuropsych Hospital UCLA (Child and Adolescent Psychiatry): 2 months</li> </ul> <p>*The above PGY 2 rotation times represent averages. Individual resident rotations vary in their second year depending on areas of focus.</p>
Year 3 Post Graduates	6	<p>Rotations in DMH Directly Operated Clinics and Programs:</p> <ul style="list-style-type: none"> <li>• Augustus F. Hawkins MHC</li> <li>• West Central MHC</li> <li>• Compton MHC Child &amp; Adolescent Psychiatry</li> <li>• Women’s Community &amp; Reintegration Center</li> <li>• Harbor UCLA Medical Center HIV Clinic</li> </ul>
Year 4 Post Graduates	6	<p>Rotations in DMH Directly Operated Clinics and Programs:</p> <ul style="list-style-type: none"> <li>• Augustus F. Hawkins MHC</li> <li>• West Central MHC</li> <li>• Street Psychiatry/HOME Team and Disaster Service</li> <li>• Collaborative Care/Telepsychiatry</li> <li>• CDU Didactics Training</li> </ul>

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 Medical Education (GME): UCLA Public Partnership for Wellbeing Agreement

Psychiatry Residency and Fellowships Professional Trainees – Public Psychiatry Professional trainees of the UCLA Graduate Medical Education program at the Jane and Terry Semel Institute for Neuroscience and Human Behavior consisted of adult residents and fellows specializing in child and adolescent, geriatric, and forensic psychiatry. During the reporting period, the 12 trainees provided a total of 7,073 patient visits during their public psychiatry rotations.

Table 55. Outcomes for FY 2021-22

<b>NCSP/GME</b>	<b># Fellows/Residents</b>	<b>Estimated # of Patient Visits</b>
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
<b>Total</b>	<b>12</b>	<b>7,073</b>

## 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. 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.

4. 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 trainings:

a. 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.

b. 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.

- c. 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.
  
- d. 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.

## INNOVATION (INN)

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input checked="" type="checkbox"/> Discontinued
<b>Priority Population</b>	<input checked="" type="checkbox"/> Children Ages 0 - 17	<input checked="" type="checkbox"/> Transition Age Youth (TAY) Ages 16 - 24	<input checked="" type="checkbox"/> Adult Ages 24 - 59	<input checked="" type="checkbox"/> Older Adult Ages 60+
<b>FY 23-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$33,007,000	\$15,600,000		\$36,189,000	
<b>Programs for FY 2021-22</b>				
<ul style="list-style-type: none"> <li>• INN2: Community Capacity Building to Prevent and Address Trauma</li> <li>• INN4: Transcranial Magnetic Stimulation (TMS)</li> <li>• INN7: Therapeutic Transportation (TT)</li> <li>• INN8: Early Psychosis Learning Healthcare Network</li> </ul>				

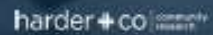
### FY 2021-22 ■ INNOVATION Data and Outcomes

#### 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 MHA 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. (CI) 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. (CI) 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)

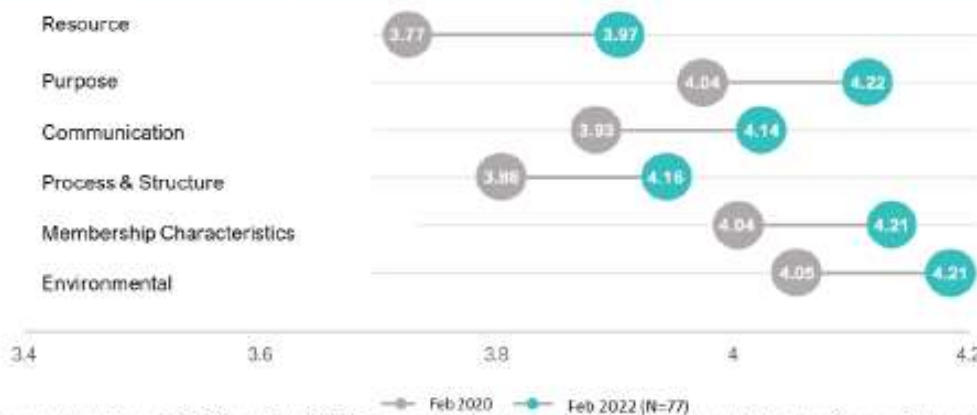
- The Wilder Collaboration Factors Inventory is an assessment tool used by the evaluation to measure changes in six characteristics of successful collaboration and capacity building within partnerships.
  - During the first year, partnerships grew, as agencies formed new relationships with partners and 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.



\* 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 Promotores 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.

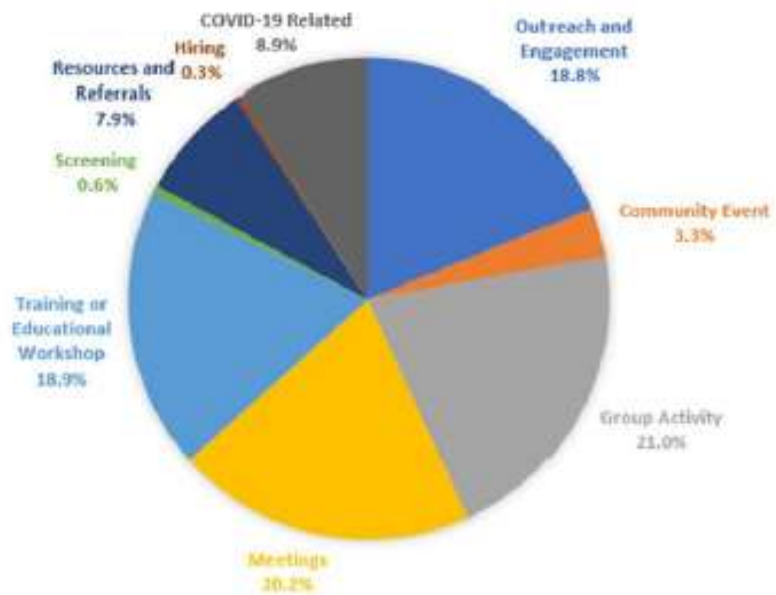
Rank	Type of Event	Event Category	Total # of Events
1	Community Outreach	Outreach & Engagement	1,334
2	Training in the Community	Training or Educational Workshop	450
3	Group Activity	Group Activity	439
4	Partnership Meeting	Meetings	387
5	Community Event	Community Event	358
6	Training for Partners/INN2 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	2,909
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

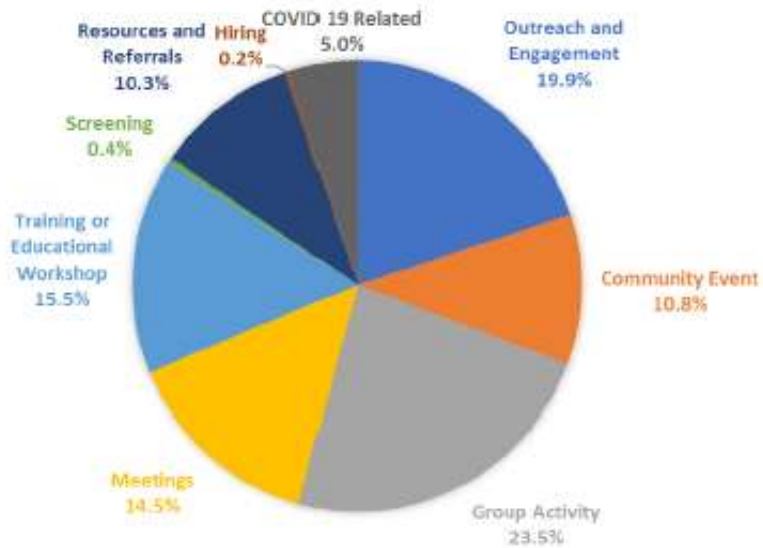
Data recorded in the Event Tracker (IHOMS system) between 5/1/2020 and 4/30/2021.



## 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

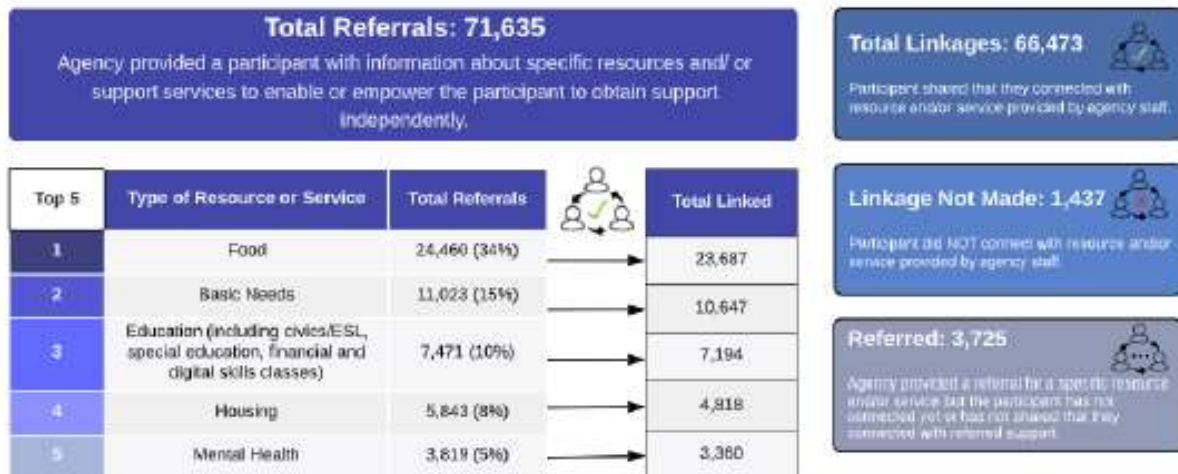
Data recorded in the Event Tracker (IHOMS system) between 5/1/2021 and 4/14/2022.

## Connecting INN 2 Participants with Resources and Supports

### Supporting the Community

Individuals who are reached through 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.



- 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

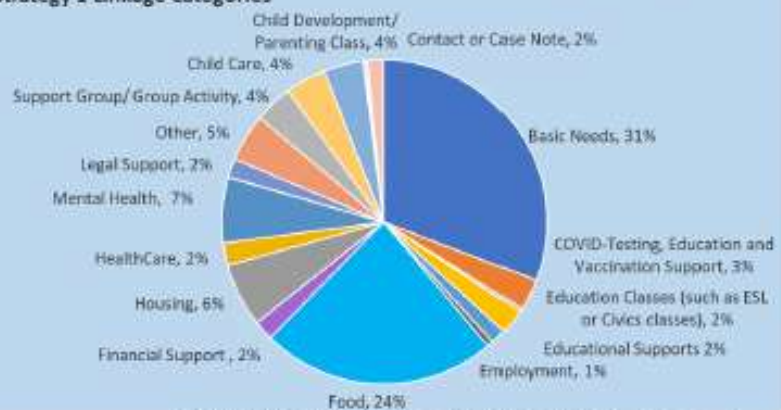
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support young children and their families. It is evident from the types of events recorded in iHOMS that partnerships focused on creating safe spaces for families 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 health 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

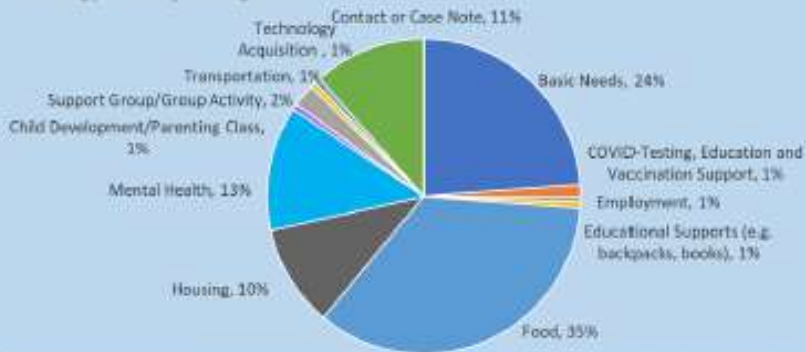
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support children and educators. It is evident from the types of events recorded in iHOMS that partnerships focused on creating safe spaces for educators to connect 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



MHSA INN 2 | Evaluation of INN 2 Executive Summary 8

## 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

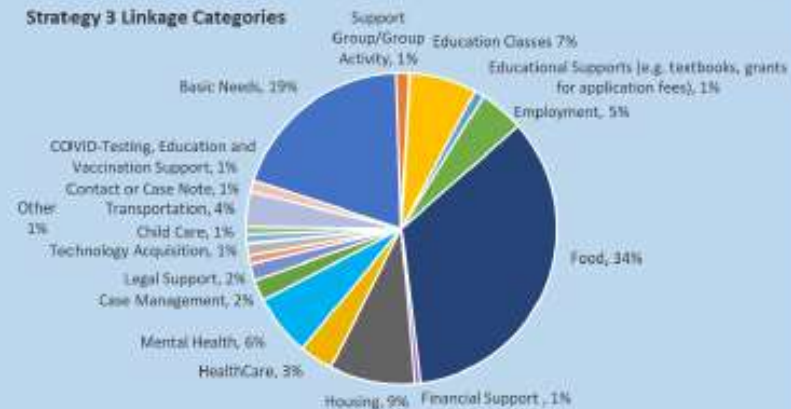
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support TAY. Examples of core programming for Strategy 3 TAY include housing, behavioral health, job skills and career development, and youth advocacy. It is 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 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

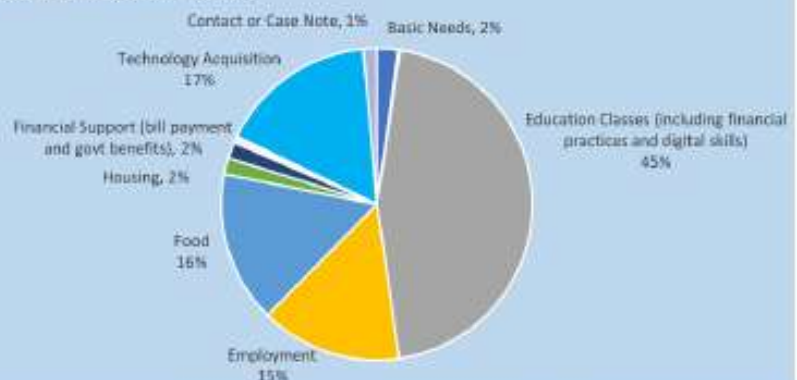
Outreach, community activities and group and linkages with supports were unique to each partnership and community's needs and were tailored to support participants' employment and education goals. It is evident from the types of events recorded in iHOMS that the partnership focused on supporting community 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



MHSA INN 2 | Evaluation of INN 2 Executive Summary 10

## 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

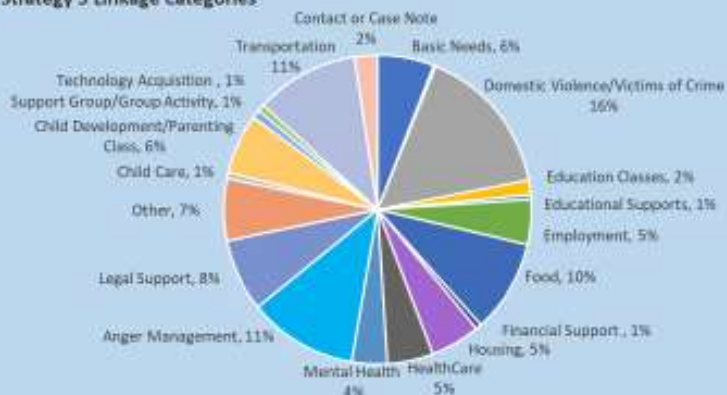
Outreach, community activities and groups, and linkages with supports were unique to each partnership and community's needs and were tailored to support community members with recent incarcerations or involvement with the justice system. It is evident from the types of events recorded in iHOMS that the 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

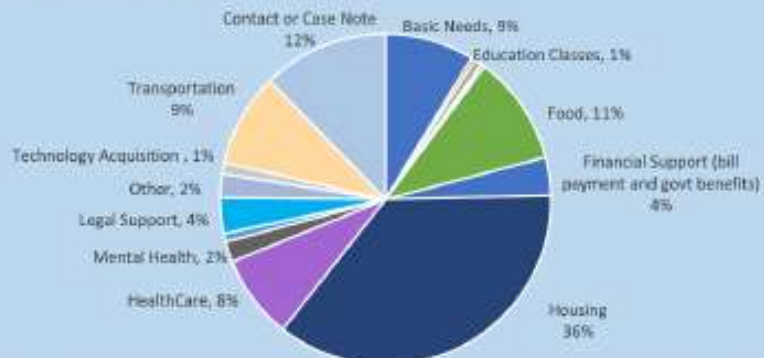
Outreach, community activities and groups, and linkages with supports were unique to each partnership and community's needs and were tailored to support older adults, 60 and over, who are at risk of or experiencing homelessness. It is evident from the types of events recorded in iHOMS that the partnership 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 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

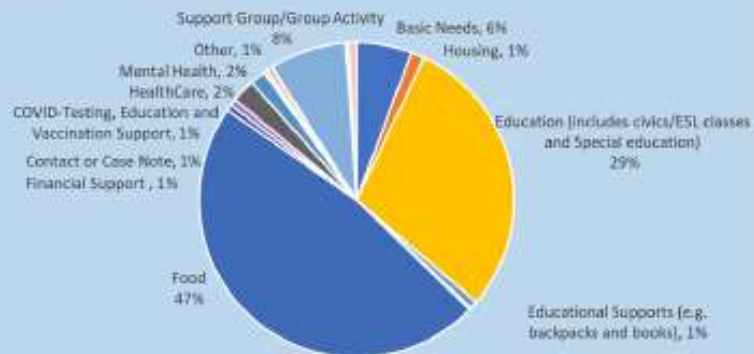
Outreach, community activities and groups, and linkages with supports were unique to each partnership and community's needs and were tailored to support multigenerational families through culturally competent programming. It is evident from the types of events recorded in iHOMS that partnerships focused 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 COVID-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 (HAM-D-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.

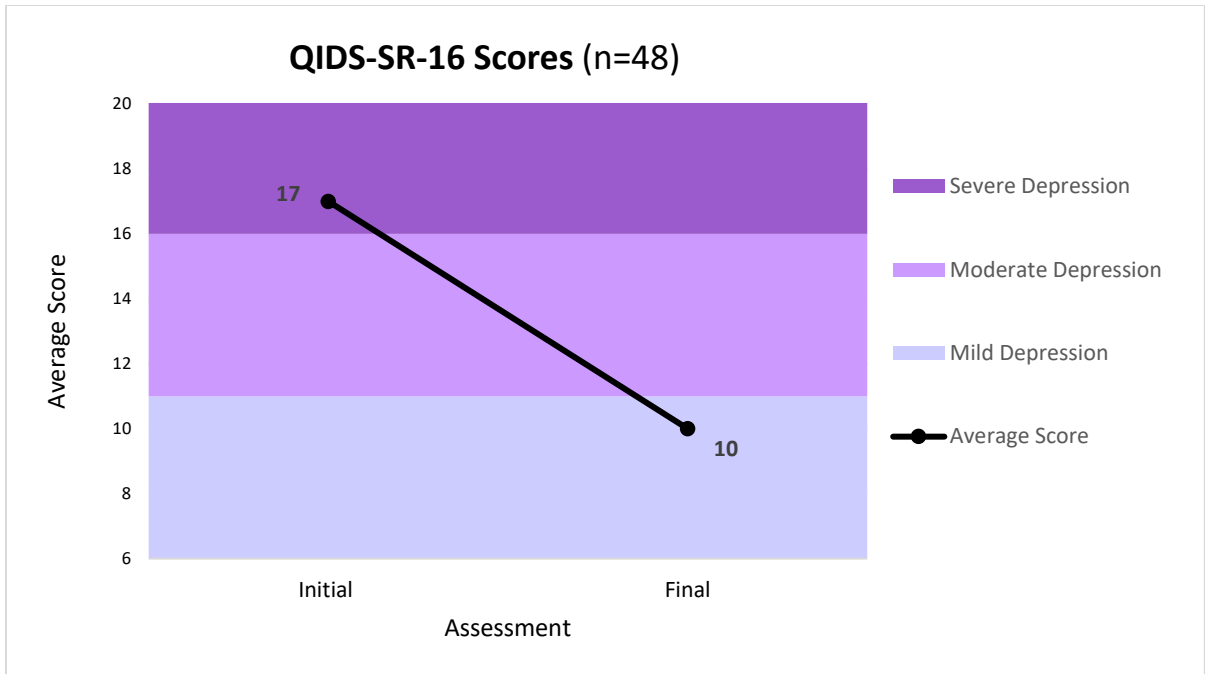
Below are the average initial scores and final scores for each of the three depression measures (QIDS-SR-16, PHQ-9, and HAMD-17) for clients who completed a full TMS treatment course between May 1, 2019, and June 30, 2022. Data included is for clients who received at least two treatments of TMS and completed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



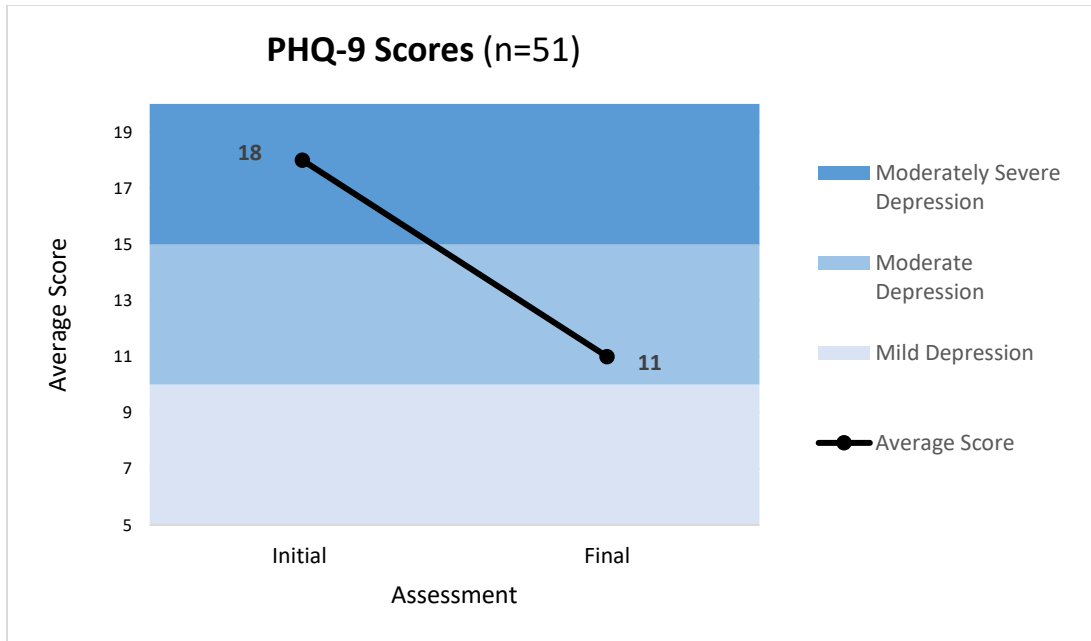
**Graph 1.** Summary of Average QIDS-SR-16 Scores for Mobile TMS clients.

### **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.



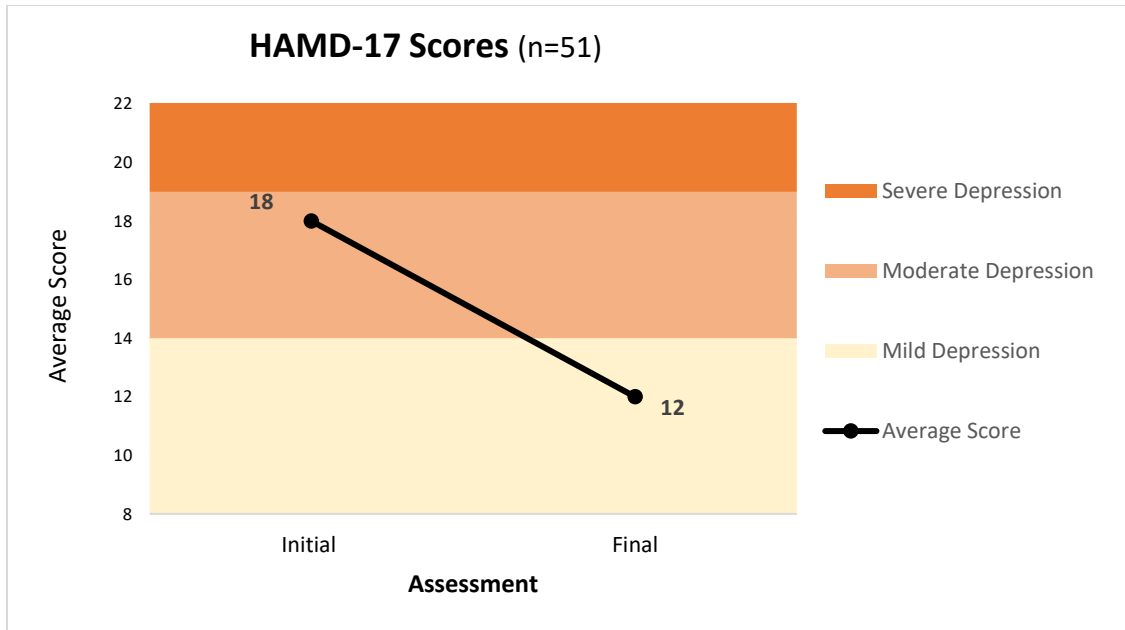
Graph 2. Summary of Average PHQ-9 Scores for Mobile TMS clients.

### 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.



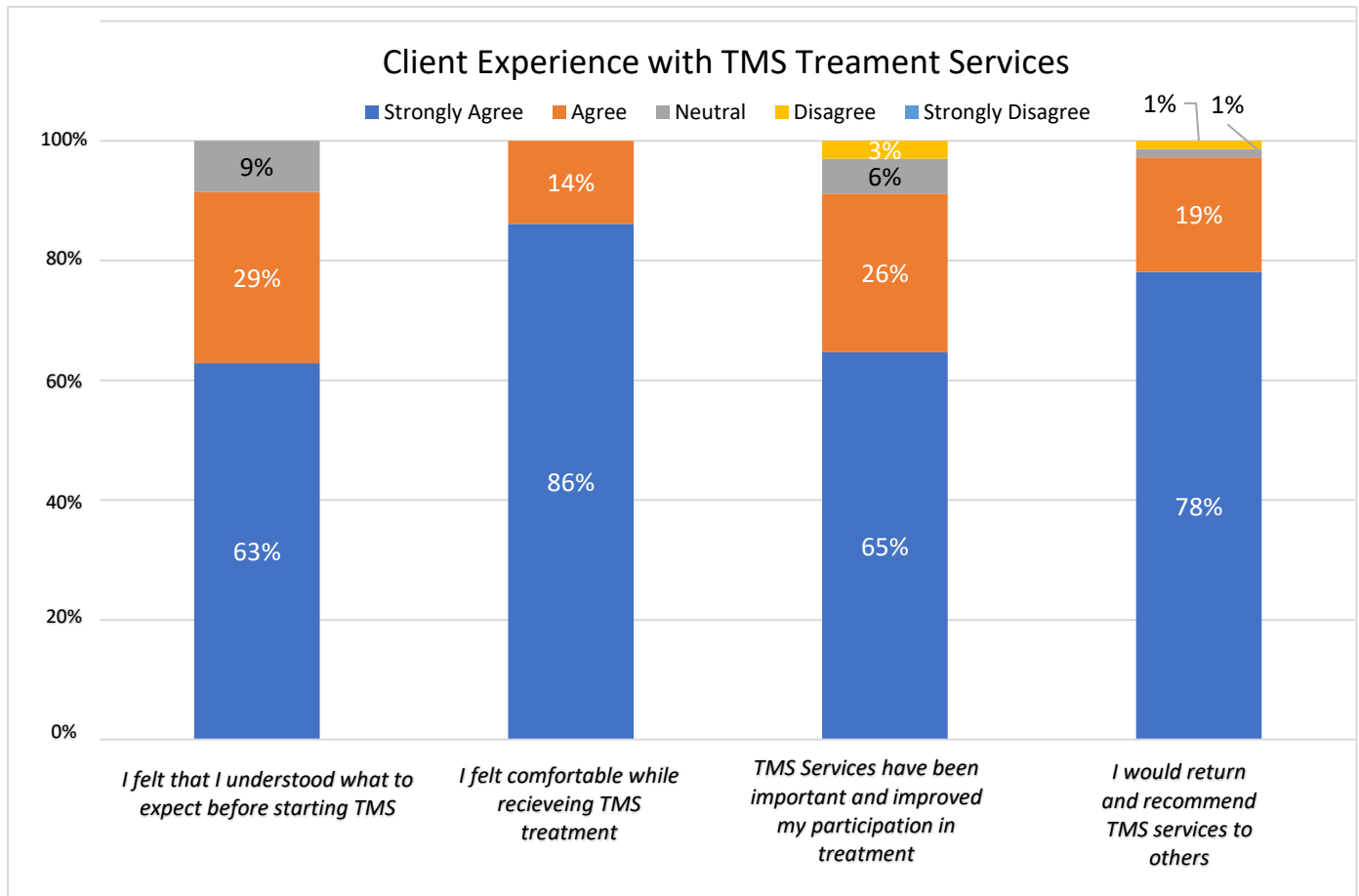


Chart 1. Overall Client Satisfaction with Mobile TMS services

### 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.

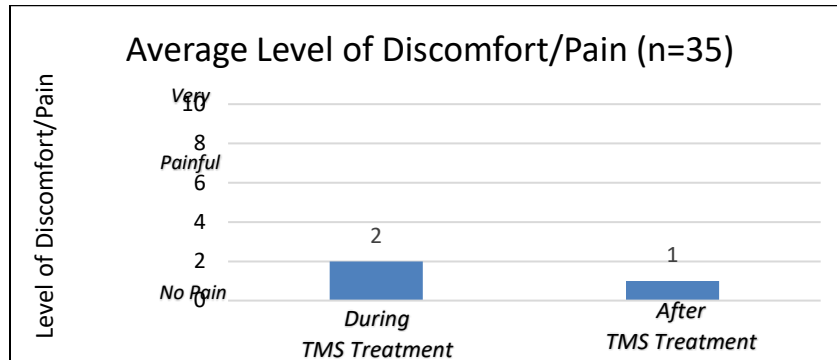


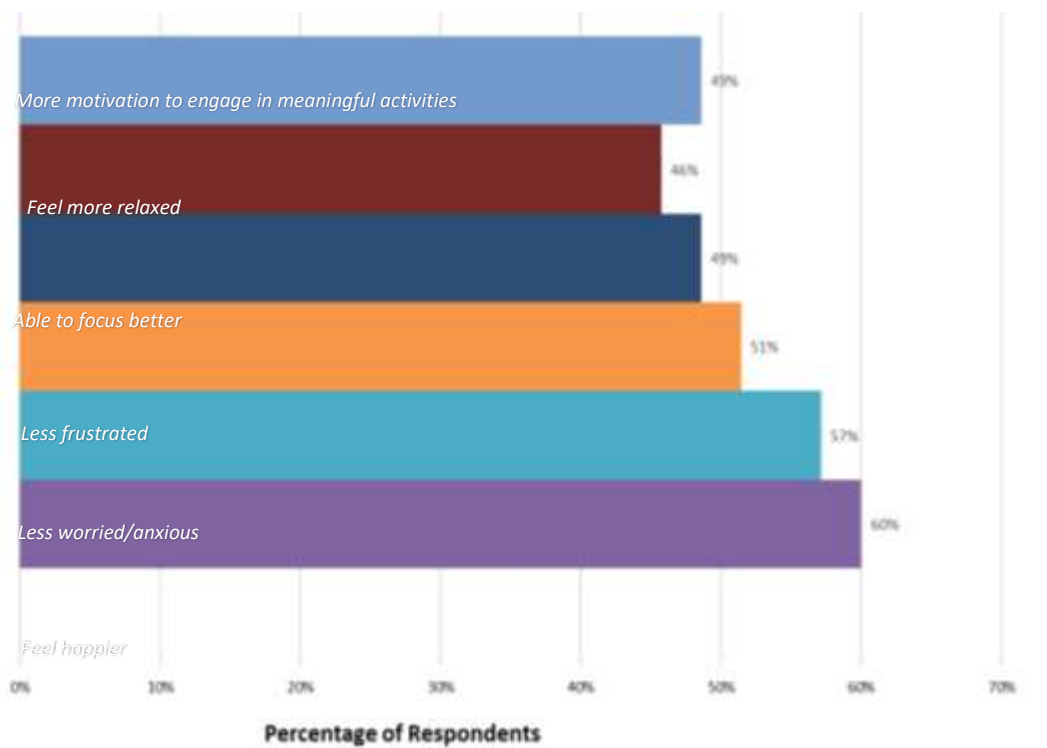
Chart 3. Average Level of Discomfort/Pain During and After Mobile TMS Treatments

### Perceived 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 ability 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.

## How did you benefit from participating in TMS services?



**Chart 4.** Most Common Perceived 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 provided 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 functioning, 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]**.

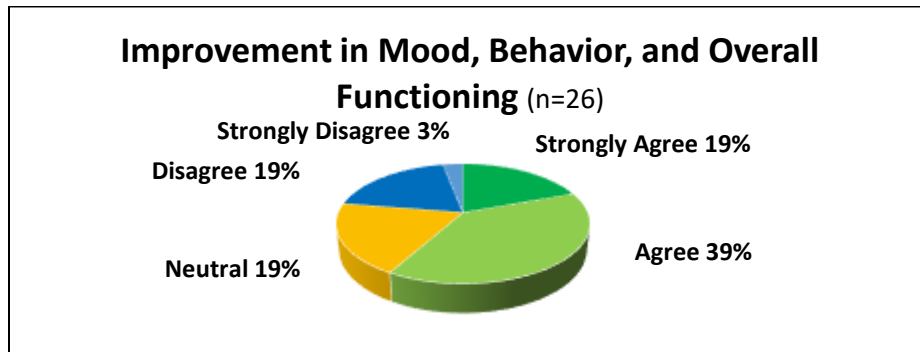


Chart 5. Provider Perception on the Impact of TMS Services on Client's Mood, Behavior, and Overall Functioning

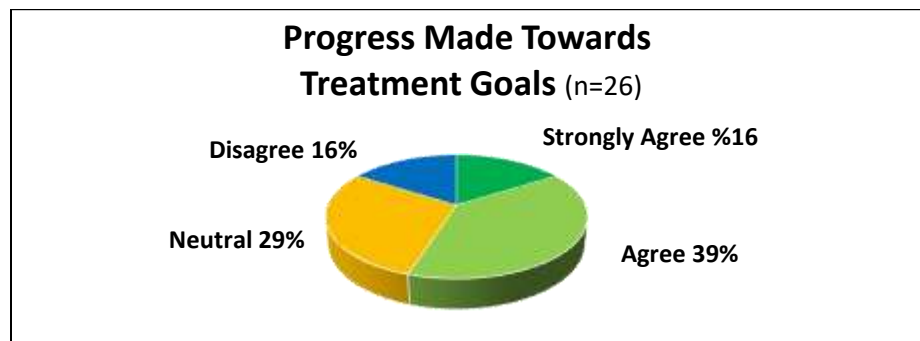
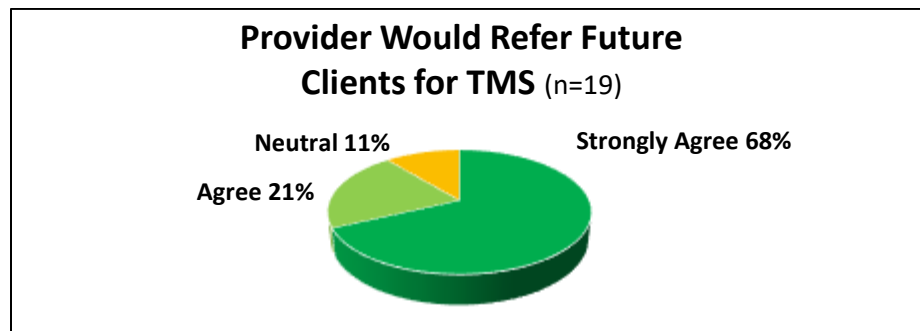


Chart 6. Provider Perception on the Impact of TMS Services on Client's Progress Toward Treatment Goals



**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 suicidal [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 dissipated [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 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	IMPLEMENTATION 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
	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
<b>Station 4</b>	404	250	386	2	4	44	<b>1,090</b>
<b>Station 40</b>	8	3	14	0	0	10	<b>35</b>
<b>Station 59</b>	67	63	107	2	0	7	<b>246</b>
<b>Station 77</b>	40	17	62	2	1	5	<b>127</b>
<b>Station 94</b>	79	27	67	0	0	9	<b>182</b>
<b>Total</b>	<b>598</b>	<b>360</b>	<b>636</b>	<b>6</b>	<b>5</b>	<b>75</b>	<b>1,680</b>
<b>Percentage</b>	<b>36%</b>	<b>21%</b>	<b>38%</b>	<b>0%</b>	<b>0%</b>	<b>4%</b>	<b>100%</b>

**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
<b>Station 4</b>	43	55	235	26	320	411	<b>1,090</b>
<b>Station 40</b>	5	2	5	1	8	14	<b>35</b>
<b>Station 59</b>	18	14	47	13	30	124	<b>246</b>
<b>Station 77</b>	8	28	6	4	14	67	<b>127</b>
<b>Station 94</b>	24	8	17	0	41	92	<b>182</b>
<b>Total</b>	<b>98</b>	<b>107</b>	<b>310</b>	<b>44</b>	<b>413</b>	<b>708</b>	<b>1,680</b>
<b>Percentage</b>	<b>10%</b>	<b>11%</b>	<b>32%</b>	<b>5%</b>	<b>43%</b>		

**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 as 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 30<sup>th</sup>, 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

<b>Program</b>	<b>Pre-Training</b>	<b>Training 1</b>	<b>Intake Workflow</b>	<b>Training 2</b>	<b>Training 3</b>
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/3E8hiEklvSQ>. 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.

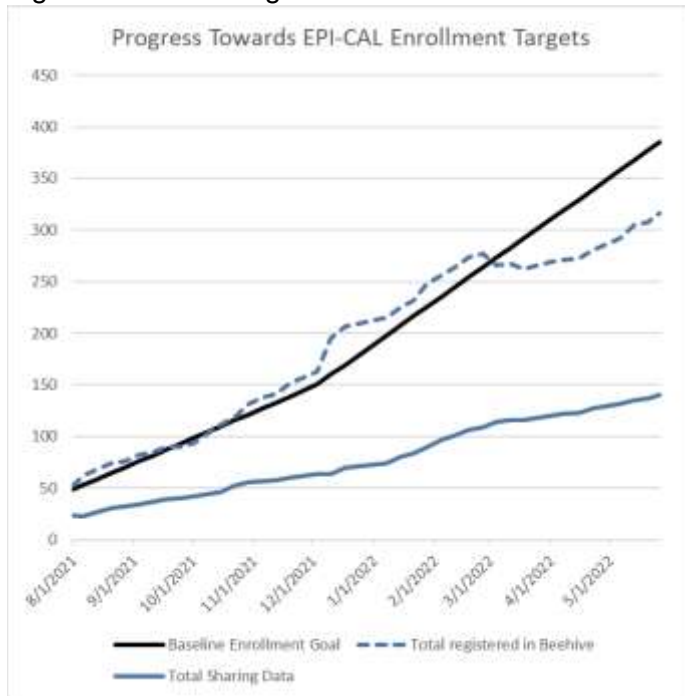
While reviewing these figures each week, the EPI-CAL team discusses observed barriers for sites which are enrolling at a rate below the average LHCN enrollment rate. The team will also discuss solutions or interventions to address barriers. Even when barriers are outside the scope of EPI-CAL project, (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

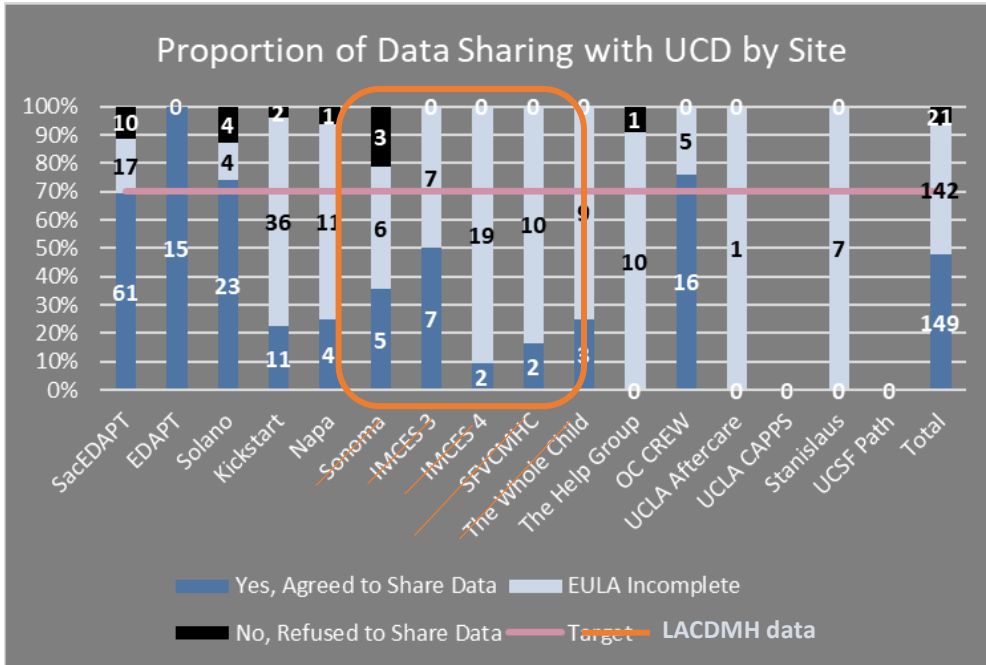
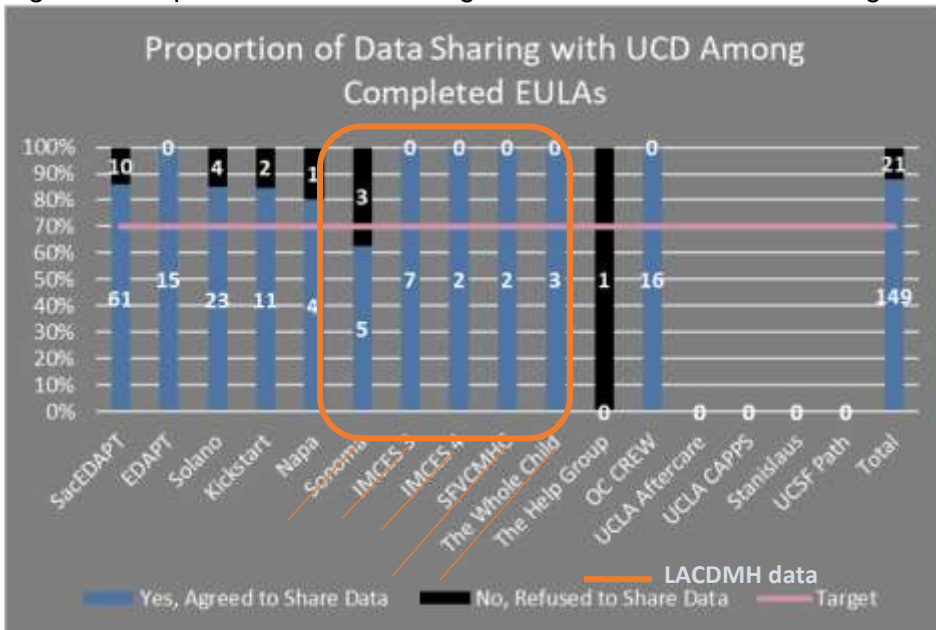


Figure 5 shows the proportion of data sharing choices made by those consumers who have completed their EULA in Beehive. The goal is that 70% of active consumers at each site agree to use Beehive and share their data for research purposes. When considering all consumers known to EPI-CAL, only a few sites 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.

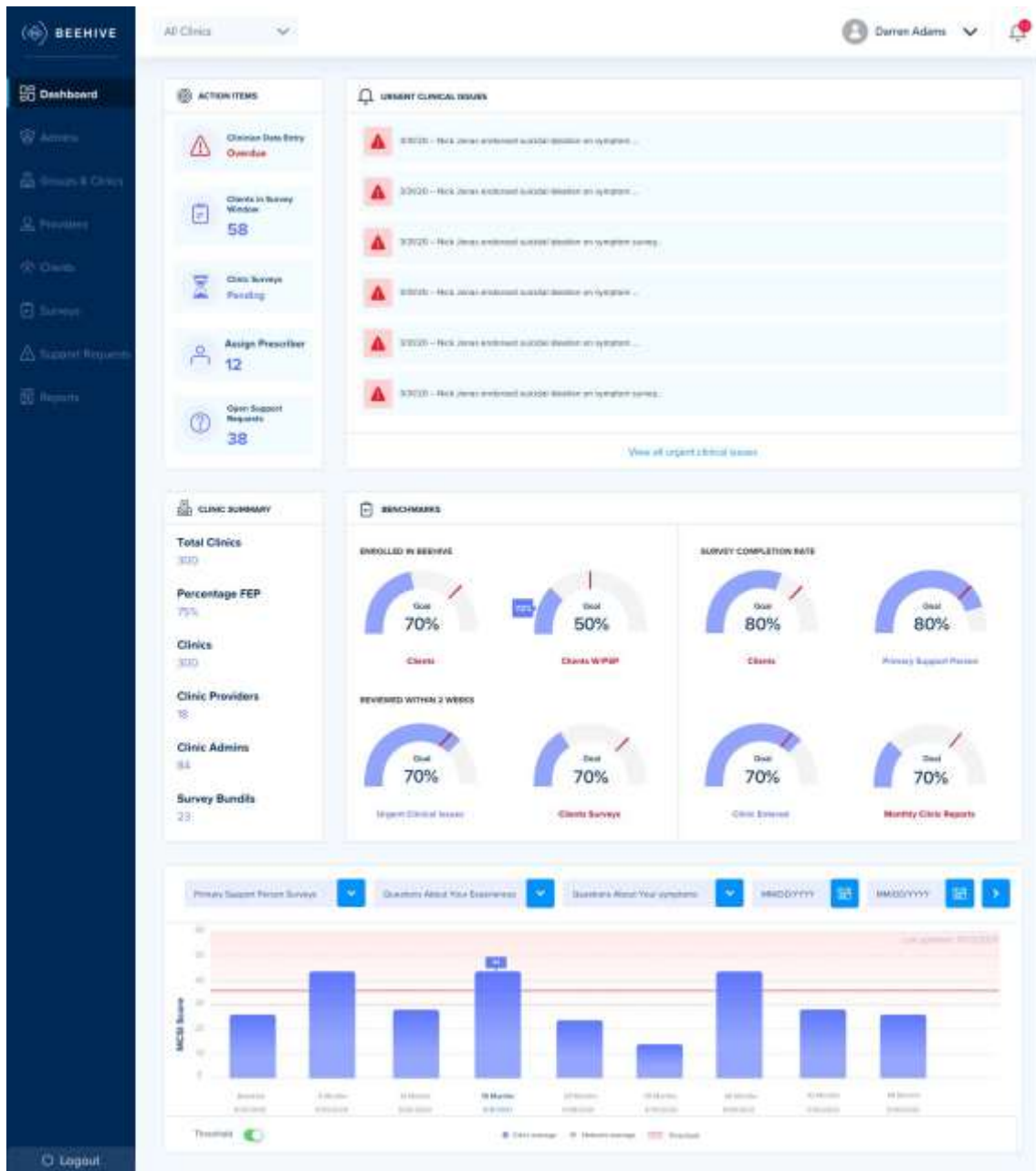
Notably, pentesting was conducted by Azacus.io Cybersecurity on the Beehive application as a security requirement for several programs, including Los Angeles County. Penetration testing, or pentesting, is a simulated hack to test the security of a system. Azacus.io conducted pentesting on both the web 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 be 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%).

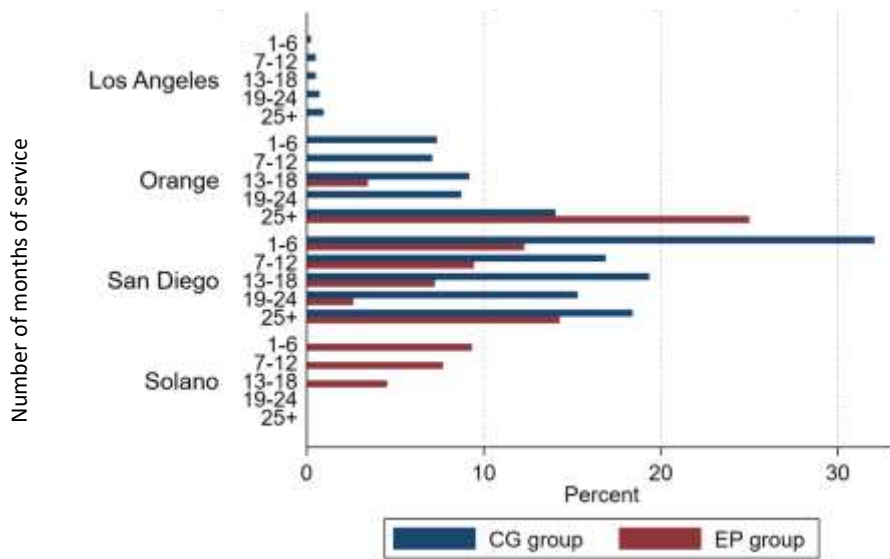
On average, individuals receiving treatment in both groups tended to remain in treatment for roughly one year (EP group: 11.1 months, CG group: 12.2 months), but average duration of treatment was significantly higher for CG individuals ( $p < .05$ ). A roughly equal proportion of EP and CG individuals 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.

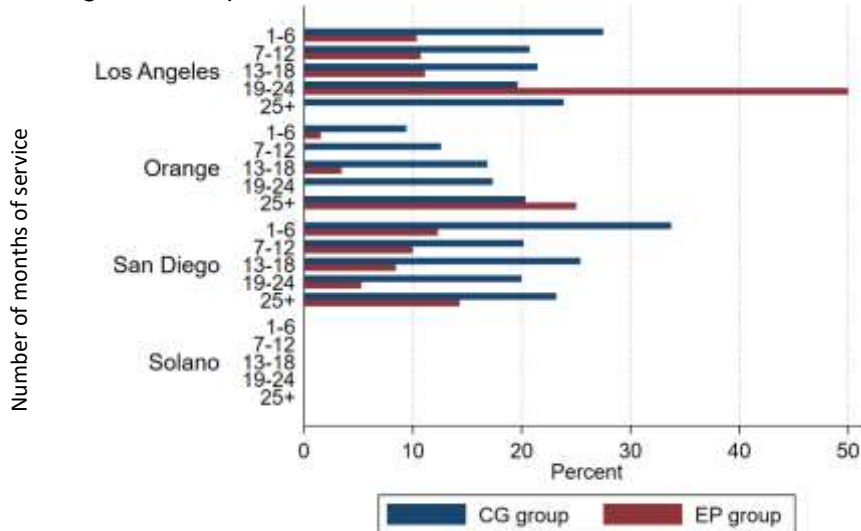
The use of day services was rare for both groups, as only 2.0% of EP and 4.7% of CG individuals received these services while enrolled in EP or general outpatient treatment (see Appendix V – Table 22). Calculated as the proportion of individuals with one or more visits, use of day services was greater 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)

<b>Status</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing	<input type="checkbox"/> Modified	<input type="checkbox"/> Discontinued
<b>FY 2023-24 Estimated Gross Expenditures</b>	<b>FY 2022-23 Estimated Gross Expenditures</b>		<b>FY 2021-22 Total Gross Expenditures</b>	
\$70,400,000	\$22,800,000		\$27,639,000	
<b>Program Description</b>				
<ul style="list-style-type: none"> <li>• LAC + USC Crisis Residential Treatment Programs (CRTPs)</li> <li>• Rancho Los Amigos Crisis Residential Treatment Programs (CRTPs)</li> <li>• Olive View Crisis Residential Treatment Programs (CRTPs)</li> <li>• Olive View Medi-UCC</li> <li>• Olive View Mental Health Wellness Center</li> <li>• MLK Child and Family Center</li> </ul>				

### 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
<b>Component: Prevention and Early Intervention</b>	
<b>Community Family Resource Center (CFRC)</b> 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
<b>Community Schools Initiative (CSI)</b> 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
<b>United Mental Health Promoters Network</b> 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
<b>Friends of the Children (FOTC) - Los Angeles</b> 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
<b>Medical Legal Services</b> 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
<b>Home Visitation: Deepening Connections and Enhancing Services</b> 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
<b>New Parent Engagement-Welcome to the Library and the World</b> 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 through a virtual program every quarter.	New Parents and Caregivers
<b>Our SPOT Teen Program: Social Places and Opportunities for Teens After-School Program</b> 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.	
<p><b>We Rise Parks at Sunset</b> 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.</p>	24 years old and below - Families
<p><b>Parks after Dark Parks at Sunset</b> 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.</p>	24 years old and below - Families
<p><b>DPR Safe Passages: Community Engagement and Safe Passages for Youth and Communities</b> 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.</p>	Children and youth under 18
<p><b>Triple P Parent/Caregiver Engagement</b> 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.</p>	Parents and caregivers
<p><b>Patient Health Navigation Services</b> 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.</p>	All Age Groups
<p><b>School Readiness</b> 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.</p>	2 to 4 Year Old (Toddlers to Preschoolers)
<p><b>Creative Wellbeing: Arts, Schools, and Resilience</b> 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.</p>	24 years and below and Caregivers
<p><b>Abundant Birth Project</b> 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.</p>	Pregnant People and Parents with Children 0-18 Months Old
<p><b>Credible Messenger Mentoring Model</b> 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.</p>	Transition Age Youth 18-25
<p><b>Youth Development Regions</b> 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</p>	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.	
<b>A Local Approach to Preventing Homelessness</b> 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
<b>Laugh Therapy &amp; Gratitude</b> 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
<b>Older Latino Adults &amp; Caregivers</b> 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
<b>Search to Involve Pilipino Americans (SIPA)</b> 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
<b>K-Mental Health Awareness &amp; K-Hotline</b> 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
<b>FosterALL WPW ReParenting Program</b> 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
<b>Cultural Reflections Newsletter</b> Provide opportunities for peer produced mental health related content to be developed and shared throughout the County.	LACDMH Consumers
<b>Hope &amp; Healing: Mental Health Wellness Support to Victim Families &amp; Relatives</b> 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
<b>TransPower Project</b> 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
<b>Open Arms Community Health &amp; Service Center</b> 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
<b>Consumer Empowerment Network</b> 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
<b>INN 2/ PEI</b> 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
<b>Mental Health Services for the Deaf &amp; Hard of Hearing</b> 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
<b>Steven A. Cohen Military Family Clinic at VVSD, Los Angeles</b> 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
<b>Component: Workforce Education and Training</b>	
<b>DBT Expansion</b> 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

## PROGRAM EXPANSIONS FOR FISCAL YEAR 2023-24

Programs below are existing MHSa programs previously approved by Stakeholders set to expand in Fiscal Year 2023-24.

MHSa Component	Program Name	Action
PEI: Early Intervention	Portland Identification and Early Referral Program (PIER)	This program will expand the number of sites and areas of availability of the program to Service Areas 1 and 8, and expand services in Services Area 6. PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25 who are either at Clinical High Risk for psychosis or have had their first psychotic episode. Currently, referrals from ELAC STAND (UCLA) , NAMI Urban LA, schools and various outpatient programs are exceeding the capacity of the current service level.
CSS: Linkage	Homeless Outreach and Mobile Engagement (HOME)	The expansion will include a total of 107 full time positions, (6 new multidisciplinary teams and 1 Service Area Navigation team) will be added between FY 2022-23 and FY 2023-24. The expansion will bring a total number of 16 multidisciplinary teams Countywide and 1 Service Navigation team.
CSS: Alternative Crisis Services	Crisis Residential Treatment Programs (CRTP)	Services will be delivered with by a new legal entity – Bel Aire Health Services to provide services in Downey and Sylmar.
CSS: Outpatient Care Services PEI: Prevention	TAY Drop-In Centers	A total of 10 new sites will be added Countywide. Service Areas 2, 3, 4, 5, 7 and 8 will each receive one new site. Service Areas 1 and 6 will each receive two.
CSS: Housing	TAY Enhanced Emergency Shelter Program	Additional funding will be added to sites.
CSS: Full Service Partnership	Full Service Partnership	The expansion will add additional staff to FSP directly operated programs and create two new half teams. Additional staff will help to form FSP teams at Santa Clarita Mental Health, Antelope Valley Mental Health, and Arcadia Mental Health.

**EXHIBITS**

**EXHIBIT A – BUDGET SUMMARY**

County: Los Angeles

Date: 4/25/23

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Training	Capital Needs	Prudent Reserve
<b>A. Estimated FY 2023/24 Funding</b>						
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 FY2023/24 Funding	688,500,000	175,000,000	48,000,000	100,000	500,000	
3. Transfer in FY2023/24 a/ (89,000,000)				25,000,000	64,000,000	
4. Access Local Prudent Reserve in FY 2023/24						
5. Estimated Available Funding for FY2023/24	1,311,100,000	472,700,000	259,000,000	34,000,000	78,900,000	116,483,541
<b>B. Estimated FY2023/24 MHSA Expenditures</b>	668,785,660	326,824,278	33,006,963	28,996,983	70,400,000	
<b>G. Estimated FY2023/24 Unspent Fund Balance</b>	642,314,340	145,875,722	225,993,037	5,003,017	8,500,000	116,483,541

	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
<b>CSS Programs</b>						
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	66,140,935	66,140,935				
<b>CSS Administration</b>	48,749,803	48,749,803				0
<b>CSS MHSA Housing Program Assigned Funds</b>						
<b>Total CSS Program Estimated Expenditures</b>	1,268,359,315	668,785,660	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
<b>PEI Programs</b>						
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 SERVICE)	125,397,244	124,396,549	844,532		156,163	
4. EARLY INTERVENTION	276,227,068	100,522,973	106,797,935		69,955,744	950,416
<b>PEI Administration</b>	19,056,371	19,056,371				
<b>Total PEI Program Estimated Expenditures</b>	505,608,354	326,824,278	107,707,497	0	70,126,163	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
<b>WET Programs</b>						
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				
<b>WET Administration</b>	1,581,781	1,581,781				
<b>Total WET Program Estimated Expenditures</b>	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
<b>CFTN Programs - Capital Facilities Projects</b>						
1. Capital Project -Tenant Improvement/New Facilities	6,000,000	6,000,000				
2. Exodus	25,000,000	25,000,000				
<b>CFTN Programs - Technological Needs Projects</b>						
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				
<b>CFTN Administration</b>	6,400,000	6,400,000				
<b>Total CFTN Program Estimated Expenditures</b>	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
<b>INN Programs</b>						
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	
<b>INN Administration</b>	3,000,000	3,000,000				
<b>Total INN Program Estimated Expenditures</b>	38,705,892	33,006,963	5,164,334	-	341,380	193,215

**EXHIBIT B – MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION**

**MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION<sup>1</sup>**

County: Los Angeles

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

<p style="text-align: center;"><b>Local Mental Health Director</b></p> <p>Name: Lisa H. Wong, Psy D.</p> <p>Telephone Number: (213) 974-8670</p> <p>E-mail: LWong@dmh.lacounty.gov</p>	<p style="text-align: center;"><b>Interim County Auditor-Controller</b></p> <p>Name: Oscar Valdez</p> <p>Telephone Number: (213) 974-0729</p> <p>E-mail: OValdez@auditor.lacounty.gov</p>
<p>Local Mental Health Mailing Address:</p> <p>County of Los Angeles - Department of Mental Health                      510 S. Vermont Avenue, 22<sup>nd</sup> floor                      Los Angeles, CA 90020</p>	

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

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

Lisa H. Wong, Psy D.  
Local Mental Health Director

 4/12/2023  
Signature Date

I hereby certify that for the fiscal year ended June 30, 2022, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892 (f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/19/22 for the fiscal year ended June 30, 2022. I further certify that for the fiscal year ended June 30, 2022, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891 (a), in that local MSHA funds may not be loaned to a county general fund or any other county fund.

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

Oscar Valdez  
County Auditor Controller (PRINT)

 4/21/23  
Signature Date

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

**EXHIBIT C – MENTAL HEALTH COMMISSION LETTER**



**Los Angeles County  
Mental Health Commission**

*“Advocacy, Accountability and Oversight in Action”*

<b>First District</b> Susan Friedman Imelda Padilla-Frausto Bennett W. Root, Jr.	<b>Second District</b> Kathleen Austria Jack Barbour Reba Stevens	<b>Third District</b> Teresa Banko Stacy Dagleish Vacant	<b>Fourth District</b> Michael Molina Marilyn Sanabria Vacant	<b>Fifth District</b> Judy Cooperberg Lawrence Schallert Brittney Weissman
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Kyla Coates, BOS Representative, Fourth District

May 05, 2023

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

Lisa H. Wong, Psy.D.  
Director, Department of Mental Health  
510 S. Vermont Ave  
Los Angeles, California 90020

Dear Supervisors and Director:

**MENTAL HEALTH SERVICES ACT PUBLIC HEARING  
FISCAL YEAR 2023-2024 ANNUAL UPDATE**

On April 27, 2023, the Chair, and a quorum of the Los Angeles County Mental Health Commission (Commission) hosted the FY 2023-2024 Mental Health Services Act Annual Update (Annual Update) Public Hearing. The Department of Mental Health’s submission of the Annual Update was for a 30-day Comment Period, on March 24, 2023, through April 22, 2023. The Commission, established under Section 5604, conducted a public hearing of the draft Annual Update at the close of the 30-day comment period. In accordance with Section 5848, the adopted Annual Update shall summarize and analyze the Commission’s recommended revisions.

We commend the Department of Mental Health for its continued efforts to strengthen its engagement with community stakeholders through the geographic Service Area Leadership Teams (SALTs), Unserved/Underserved Cultural Communities (UsCCs), and Community Leadership Team (CLT) in the ongoing planning and implementation of the Mental Health Services Act and on the outcomes being achieved.

It is with pleasure that the Los Angeles County Mental Health Commission submits these recommendations for your review and consideration. While our recommendations represent the consensus of the Commission and public comment received during the MHSA Public Hearing, we urge you and the Board of Supervisors (Board) to review all stakeholder testimony



Each Supervisor  
Director  
May 03, 2023  
Page 2

received during the entire public comment period when rendering your final decisions on the Annual Update. Our recommendations center around five broad themes

1. Budget and Accountability
2. Criminal Justice
3. Housing/Homelessness
4. Inequities/Disparities
5. Workforce, Education, and Training (WET)

#### **Budget and Accountability**

The Commission recommends and expects that the Department will include conducting a quantitative and qualitative needs assessment of public mental health needs to inform the next Fiscal Year MHSA Three Year Plan. Furthermore, the Commission expects accountability for unspent funds as this is critical to understanding unmet community needs.

#### **Criminal Justice**

The Commission acknowledges that a significant number of the jail's population have Serious Mental Illness and commends the progress made by the County's Department of Health Services Office of Diversion and Re-Entry (DHS-ODR) in moving forward the Board's Care First, Jail Last Initiative as a strategy within.

#### **Housing & Homelessness**

The Commission acknowledges the dedicated efforts made by the Department to expand services and increase mental health beds and services. As public comment about the need for these services and better access for children and older adults continues, the Commission recommends continued funding and efforts to increase access for this population. In addition, we recommend allocation of MHSA funds for additional workforce. Specifically, the Commission recommends the Department to consider creating and funding peer support specialist positions to support and create linkage to services for persons suffering from mental health disorders and experiencing homelessness.

The Commission recommends providing day services, including direct onsite mental health services, for individuals experiencing homelessness throughout the County which are low barrier services that help link people to housing and mental health services (e.g., the Bridge to Home Shelter Services in Santa Clarita). Additionally, collaboration between Street Medicine, HOME, LAHOP, FSP, DMH Navigators, ODR, Veterans Homeless Outreach programs, Adult Mental Health Clinics, AOT and local shelters and homeless programs should be seamless, especially considering limited funding and the urgency of recently declared states of emergency and the coming Care Court System.

#### **Inequities and Disparities**

State law, Welfare Institutions Code (WIC) Section 5812.5(d), 5868(b), 5878.1(a); and 9 California Code of Regulations (CCR) Section 3200.100 requires a county's MHSA Three Year Plan to address disparities, and cultural and linguistic competency by incorporating and working

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Each Supervisor  
Director  
May 03, 2023  
Page 3

to achieve stated goals in all aspects of policymaking, program design, administration, and service delivery. To accomplish this, the Commission urges action in the following areas:

#### Cultural Humility and Linguistic Competency

The Commission acknowledges recent efforts by the Department to enhance the Department's language capacity with respect to all programming, external relations, and treatments. However, more efforts are needed to prioritize effective communication and delivery of mental health information. The Commission recommends that the Department work with community members, leaders, and population-specific experts in the development of communication strategies and written materials to ensure these are written in plain language and high-quality translations. In addition, the Commission encourages the department to practice cultural humility in its implantation of projects and partnerships to better address mental health inequities and disparities.

#### Data

The Commission acknowledges the Department's inclusion of data metrics in this year's Annual Update and its efforts to improve data collection. However, the Commission recommends additional efforts in providing data that report out by Service Planning Area (SPA), Supervisorial District (SD), and by clinics (e.g., non-profit or for profit, directly operated clinics, physician status reports) to identify inequities and identify data sources that can be used to help with clarifying unmet needs. In addition, we recommend data collection about met and unmet needs and data that identifies services for people with development disabilities.

The Commission recognizes the benefits of the new MHSa data dashboard and thanks the Department for its efforts to address recommendations made in the MHSa Annual Update FY 2022-23 recommendation letter. With the prospect of having this new tool, the Commission recommends and will support any efforts by the Department, as this tool goes live for public use, to increase stakeholder/community-based organizations/providers/consumer confidence in using this important tool by hosting live training sessions, creating recorded trainings, proving a written guide, and having this accessible in multiple languages.

The Commission recommends data collection of all stakeholder hearings include the number of attendees. The Commission also requests these data of attendees be categorized (e.g., staff, providers, and stakeholders).

#### Demographics

The Department should be sensitive to and accountable for resolving inequities around: race and ethnicity, immigration status, geographic location, age (with an option for clients to elect their choice of programs from TAY, Adult or Older Adult categories) and physical and mental health condition. Special attention should be paid toward inequities in populations with physical disabilities and others who qualify under Americans with Disabilities Act status. The Commission also recommends special attention on increasing the access and resources for

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Each Supervisor  
Director  
May 03, 2023  
Page 4

specific populations like the Asian Pacific Islander American (APIA), American Indian, American Native, Black Indigenous People of Color (BIPOC), and Lesbian Gay Bisexual Transgender Questioning (LGBTQ) +.

We continue to urge you to correct for disparities in funding across underserved and unserved populations, including ethnic populations in all service areas. This includes expanding funding for additional TAY drop-in centers to take advantage of full continuum of health, mental health, and supportive services, including areas that are geographically isolated such as Antelope and Santa Clarita Valley.

#### MHSA Proposal Process

The Commission recognizes and offers commendations to DMH's MHSA Administration team for the improvement in efforts to streamline an efficient Request for Proposals (RFP) process. The Commission recommends the Department implement an RFP process that includes providing enough details (e.g., define the scope and boundaries of the project in detail) that can allow applicants to accurately assess their capacity to commit to the project. Furthermore, increasing accessibility to the RFP process by implementing start-up sessions in multiple languages and platforms will give all potential applicants an opportunity to ask questions and to ensure that they understand requirements and technical support.

#### School-Based Mental Health Services

The Commission acknowledges DMH's efforts to increase access for students and their families through robust collaboration with both Los Angeles Unified School District (LAUSD) and Los Angeles County Office of Education (LACOE). The Commission recommends continuing to increase efforts to expand school-based mental health services by identifying additional school districts beyond LAUSD that lie outside of the city of Los Angeles boundaries (e.g., William S Hart, Sulphur Springs, Newhall, Castaic, Saugus, Burbank, Glendale and/or La Canada School Districts).

#### Stakeholder Engagement

While the Commission acknowledges the efforts of the Department to increase community input and participation in the Community Planning Process, the Commission recommends additional efforts to expand stakeholder engagement by increasing the number of meetings, meeting locations, and time of day. In addition, the Commission requests that the Department increase its outreach efforts to the general community, other LA County Agencies and Commissions (e.g., HIV, Public Health, Hospital and Care Delivery, Peer Advisory Council, and Alliance for Health Integration). Efforts to increase stakeholder engagement must include creating dedicated spaces for the community to engage. The Commission recommends the Department consider building Peer Centers in each SPA and requests that the proposal from SALT 8 for a Peer Center be prioritized.

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Each Supervisor  
Director  
May 03, 2023  
Page 5

#### Workforce, Education, and Training (WET)

Utilize MHSa category, Workforce, Education and Training (WET) to fund an enhanced recruitment and retention of DMH employees/Legal Entity (LE) agreements, especially as DMH/LE faces high vacancy rates and heavy turnover while trying to expand our programs and services. One objective to fund such an effort is to incentivize mental health clinicians to join DMH and make sure that those presently employed do not “get burnt out and leave.”

#### Additional Recommendations:

- Alternative Crisis Services: Maintain or expand funding for Alternative Crisis Services.
- Evaluate the composition of stakeholder groups to increase collaboration and representation across all communities/populations.
- Mental Health Urgent Services: The Commission recommends further funding and support of Mental Health Urgent Cares (e.g., an EmPath Center in collaboration with Henry Mayo Hospital in Santa Clarita) that will serve adolescents and adults that can bill Medi-Cal as well as private insurance.
- Behavioral Health Unit (BHU): Plan and implement the decades long requested Behavioral Health Unit (BHU) for adolescents and children in the Santa Clarita and/or San Fernando Valley Areas. Identify if the concept/model can be funded by MHSa for some or part of the model.
- Consider innovative strategies to reduce paperwork for line working clinical staff to increase efficiency, improve morale, staff retention, recruitment, and satisfaction, decrease burnout, increase caseloads, and improve clinical quality.
- Maximize scope of service/practice for Occupational Therapists, Recreation Therapists, and Psychiatric Technicians to alleviate staffing shortages.

#### Acknowledgments:

- The Commission acknowledges the outstanding efforts to fund, expand and improve ODR services; to stand up Restorative Care Villages, and Programs.
- The Commission acknowledges the outstanding progress the department has made with Alternative Crisis Services as part of its Community Services and Support (CSS) efforts and coordination. To this effort, the Commission recommends maintaining and supporting expansion of Alternative Crisis Services countywide rather than a decrease in funding to this program. Furthermore, the Commission recommends the expansion of DMH’s staffing to support work and collaboration in programs like the LA County Sheriff’s Mental Health Evaluation Team (MET) and Los Angeles Police Department’s Systemwide Mental Health Assessment Team (S.M.A.R.T).

The Commission recognizes that the above recommendations should remain in direct relation to the MHSa Annual Update FY 2023-24. However, we cannot adequately provide the above recommendations without also mentioning broader aspects that also impact budget and accountability. We would like to include the following as an additional recommendation or comment related to California Advancing and Innovating Medi-Cal (CalAIM) and indirectly

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Each Supervisor  
Director  
May 03, 2023  
Page 6

related to the overall MHSA budget. The Commission asks the Department to measure the effects of CalAIM on equity, evaluate fairness with the new reimbursement guidelines related to intensive services (e.g., FSP), and report if there will be any increases to services for individuals and families.

Sincerely,

*Kathleen Austria*

Kathleen Austria  
Chair, Mental Health Commission

KA: KF

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## EXHIBIT D – LACDMH RESPONSE TO THE MENTAL HEALTH COMMISSION



### DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.  
Director

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

Connie D. Draxler, M.P.A.  
Acting Chief Deputy Director

May 11, 2023

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

Kathleen Austria  
Chair, Mental Health Commission  
510 South Vermont Avenue  
Los Angeles, CA 90020

#### RESPONSE TO MENTAL HEALTH COMMISSION INQUIRIES ON THE PUBLIC HEARING FOR THE MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2023-2024

On Friday, May 5, 2023, the Los Angeles County Mental Health Commission (Commission) submitted a letter reflecting their comments and inquiries to the Los Angeles County Board of Supervisors (Board) and the Department of Mental Health (DMH) pertaining to the April 27, 2023, public hearing on the Fiscal Year (FY) 2023-24 Mental Health Services Act (MHSA) Annual Update (Annual Update).

In the Commission's letter, DMH was commended for its continued efforts to strengthen the community engagement process related to the Annual Update development and its partnership with key stakeholder groups to ensure the Annual Update represented and addressed the expressed needs of each community with special attention to those communities most at risk and those disproportionately impacted by disparities. The Commission submitted several recommendations for the review, centering around five broad themes:

1. Budget and Accountability
2. Criminal Justice
3. Housing/Homelessness
4. Inequities/Disparities
5. Workforce, Education, and Training (WET)

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Each Supervisor  
Chair, Commission  
May 11, 2023  
Page 2

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

### **Budget and Accountability**

The Commission recommended the Department include a quantitative and qualitative needs assessment of public mental health needs to inform the next FY MHSA Three Year Plan. Furthermore, the Commission stated their expectation of accountability for unspent funds as this is critical to understanding unmet community needs.

The Needs Assessment is a critical component Community Planning process to determine priorities and gaps in services. DMH has begun the process of planning for the Needs Assessment and Community Planning Process (CPP) with Stakeholders. Department leads for this process have engaged Commission members familiar with data as well as stakeholder groups to identify key data sets to be presented as part of the CPP. The MHSA Administration will engage the Mental Health Commission with updates and solicit input throughout the process.

### **Criminal Justice**

The Commission acknowledged that a significant number of the jail's population have Serious Mental Illness and commended the progress made by the County's Department of Health Services Office of Diversion and Re-Entry (DHS-ODR) in moving forward the Board's Care First, Jail Last Initiative as a strategy within.

### **Housing & Homelessness**

The Commission acknowledged the dedicated efforts made by the Department to expand services and increase mental health beds and services. As public comment about the need for these services and better access for children and older adults continues, the Commission recommended continued funding and efforts to increase access for this population. In addition, the Commission recommended allocation of MHSA funds for additional workforce. Specifically, the Commission recommended the Department to consider creating and funding peer support specialist positions to support and create linkage to services for persons suffering from mental health disorders and experiencing homelessness.

The Commission recommended providing day services, including direct onsite mental health services, for individuals experiencing homelessness throughout the County which are low barrier services that help link people to housing and mental health services (e.g., the Bridge to Home Shelter Services in Santa Clarita). Additionally, collaboration between Street Medicine, Homeless Outreach and Mobile Engagement (HOME), Los Angeles Homeless Outreach Program LA-HOP), Full Service Partnership (FSP), DMH Navigators, Office of Diversion and Re-Entry (ODR), Veterans Homeless Outreach programs, Adult Mental Health Clinics, Assisted Outpatient Treatment (AOT) and local shelters and homeless programs should be seamless, especially considering limited

funding and the urgency of recently declared states of emergency and the coming Care Court System.

DMH acknowledges these recommendations. Implementation of new services, and expansion of existing services to meet the needs of the unhoused is a priority both for DMH and for Los Angeles County to ensure access to care and success in permanent housing. In response to this crisis, DMH has committed to the following:

- Development of the Innovations Interim Housing Multidisciplinary Assessment and Treatment teams to serve individuals onsite in all interim housing settings across Los Angeles County, and which includes both 55 Peer positions (titled Community Health Workers) and 11 Supervising Peer positions (Titled Supervising Community Health workers). This proposal has been submitted to the Oversight and Accountability Commission for hearing but has not yet been approved.
- Significant program expansions for FSP and HOME, two programs that target services to persons who are unhoused, include Peer positions.
- The launch of Hollywood 2.0, an Innovations funded program, focused on serving the needs of the unhoused with mental illness in the Hollywood area.
- DMH has developed a recruitment campaign focused on recruitment of Community Health Workers and Clinicians to staff new programs and program expansions.
- To ensure continuity, the newly proposed program will fall under the leadership of the Countywide Engagement Division which also oversees Home, ODR, Veterans, and AOT. This will support program development that is integrated with access to intensive care services.

#### **Inequities and Disparities**

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

#### Cultural Humility and Linguistic Competency

The Commission acknowledged recent efforts by the Department to enhance the Department's language capacity with respect to all programming, external relations, and treatments. The Commission recommended improved communication and delivery of mental health information. The Commission recommended the Department work with community members, leaders, and population-specific experts in the development of communication strategies and written materials to ensure these are written in plain language and high-quality translations. In addition, the Commission encouraged the



Department to practice cultural humility in its implantation of projects and partnerships to better address mental health inequities and disparities.

#### Data

The Commission acknowledged the Department's inclusion of data metrics in this year's Annual Update and its efforts to improve data collection. However, the Commission recommended additional efforts in providing data that report out by Service Planning Area (SPA), Supervisorial District (SD), and by clinics (e.g., non-profit or for profit, directly operated clinics, physician status reports) to identify inequities and identify data sources that can be used to help with clarifying unmet needs. Data collection about met and unmet needs and data that identifies services for people with development disabilities was also recommended.

The Commission recognized the benefits of the new MHSa data dashboard and thanked the Department for its efforts to address recommendations made in the MHSa Annual Update FY 2022-23 recommendation letter. With the prospect of having this new tool, the Commission recommended and will support any efforts by the Department, as this tool goes live for public use, to increase stakeholder/community-based organizations/providers/consumer confidence in using this important tool by hosting live training sessions, creating recorded trainings, proving a written guide, and having this accessible in multiple languages.

The Commission recommended data collection of all stakeholder hearings include the number of attendees. The Commission also requested this data of attendees be categorized (e.g., staff, providers, and stakeholders).

#### Demographics

The Commission recommended the Department be sensitive to and accountable for resolving inequities around: race and ethnicity, immigration status, geographic location, age (with an option for clients to elect their choice of programs from TAY, Adult or Older Adult categories) and physical and mental health condition. Special attention should be paid toward inequities in populations with physical disabilities and others who qualify under Americans with Disabilities Act status. The Commission also recommended special attention on increasing the access and resources for specific populations like the Asian Pacific Islander American (APIA), American Indian, American Native, Black Indigenous People of Color (BIPOC), and Lesbian Gay Bisexual Transgender Questioning (LGBTQ+).

The Commission urged the Department to correct for disparities in funding across underserved and unserved populations, including ethnic populations in all service areas. This includes expanding funding for additional TAY drop-in centers to take advantage of full continuum of health, mental health, and supportive services, including areas that are geographically isolated such as Antelope and Santa Clarita Valley.

Each Supervisor  
Chair, Commission  
May 11, 2023  
Page 5

#### MHSA Proposal Process

The Commission recognized and offered commendations to DMH's MHSA Administration team for the improvement in efforts to streamline an efficient Request for Proposals (RFP) process. The Commission recommended the Department implement an RFP process that includes providing enough details (e.g., define the scope and boundaries of the project in detail) that can allow applicants to accurately assess their capacity to commit to the project. The Commission recommended increasing accessibility to the RFP process by implementing start-up sessions in multiple languages and platforms to give all potential applicants an opportunity to ask questions and to ensure that they understand requirements and technical support.

#### School-Based Mental Health Services

The Commission acknowledged DMH's efforts to increase access for students and their families through robust collaboration with both Los Angeles Unified School District (LAUSD) and Los Angeles County Office of Education (LACOE). The Commission recommended continuing to increase efforts to expand school-based mental health services by identifying additional school districts beyond LAUSD that lie outside of the City of Los Angeles boundaries (e.g., William S Hart, Sulphur Springs, Newhall, Castaic, Saugus, Burbank, Glendale and/or La Canada School Districts).

#### Stakeholder Engagement

The Commission acknowledged the efforts of the Department to increase community input and participation in the Community Planning Process and recommended additional efforts to expand stakeholder engagement by increasing the number of meetings, meeting locations, and time of day. In addition, the Commission requested that the Department increase its outreach efforts to the general community, other Los Angeles County Agencies and Commissions (e.g., HIV, Public Health, Hospital and Care Delivery, Peer Advisory Council, and Alliance for Health Integration). The Commission encouraged the Department to increase stakeholder engagement by creating dedicated spaces for the community to engage. The Commission recommended the Department consider building Peer Centers in each SPA and requests that the proposal from SALT 8 for a Peer Center be prioritized.

DMH is committed to identifying and addressing disparities in services among our population served as well as in the community through Prevention efforts. Examples of these efforts include:

- Enhancing our commitment to the Anti-Racism and Diversity Initiative (ARDI) through the appointment of a dedicated manager and team to addressing Race and Disparity in the workforce, in communities, and in services.
- Development and public posting of the DMH Demographics dashboard as well as the development of the MHSA dashboard. These dashboards, available to the

public, reflect services delivered by Ethnicity, Language, Age, Diagnosis, each of which can be viewed by Supervisorial District and Service Area.

- DMH has significantly expanded the United Mental Health Promoters program to enhance engagement in all regionals and underserved cultural communities in Los Angeles County.
- DMH has developed a Disparities Review Committee to identify metrics for review throughout the year which may reflect progress in addressing disparities.
- DMH is committed to using the CEO Equity Explorer Tool, a heat map which identifies areas of need by a variety of metrics, to identify communities in need for new services and service expansion.
- DMH acknowledges the need to improve reporting on services to individuals with disabilities and better identify their service needs.
- DMH providers offer prevention and early intervention services in 79 of the 81 districts in Los Angeles County. DMH provides school-based services. In addition, the Community Schools initiative is currently serving 17 school Districts in addition to the Los Angeles Unified School District.

DMH will continue its efforts to expand and improve the stakeholder process through:

- Expanding the stakeholder body to include representation by other Los Angeles County Agencies and Commissions and as identified in the MHSA regulations, including but not limited to representation from Health, Public Health, Substance Use, Schools, Veterans Groups. The MHSA Administration will engage the Commission for feedback during the expansion process.
- Work to support and improve recruitment and advocacy among our Service Area Leadership Teams by providing support, advocacy training, and support for development of standards and responsibilities among SALT groups.
- Ensuring materials offered in stakeholder settings as part of the CPP are available in multiple languages, and access needs are met for each meeting (interpretation, sign language, and CART services).
- DMH will develop materials and provide training on the MHSA proposal process.

#### **Workforce, Education, and Training (WET)**

The Commission recommended DMH utilize MHSA category, Workforce, Education and Training (WET) to fund an enhanced recruitment and retention of DMH employees/Legal Entity (LE) agreements, especially as DMH/LE faces high vacancy rates and heavy turnover while trying to expand our programs and services. One objective to fund such an effort is to incentivize mental health clinicians to join DMH and make sure that those presently employed do not "get burnt out and leave".

DMH recognizes the significant impacts of the staffing shortage on service access and has made significant strides in the past year to increase the size and quality of the workforce. DMH has and will continue to focus on recruitment and hiring efforts, while addressing culture change within the Department to maintain the workforce. Incentive programs have included:

- Stipends programs for Marriage and Family Therapists, Nurse Practitioners, Masters in Social Work, and Psychology (PsyD. /PhD) students for entry into the public mental health system.
- DMH Loan Repayment Program, available to both DMH and DMH Contract providers.
- DMH Psychiatrist Incentive Programs.
- DMH is planning a partnership to fund tuition for Psychiatric Technicians in the coming Fiscal Year.
- DMH has developed a recruitment campaign “do worthwhile work” and is currently working with a media company to disseminate this campaign with a focus on Community Health Workers/Peers and Clinicians.

**Additional Recommendations:**

- Alternative Crisis Services: Maintain or expand funding for Alternative Crisis Services.
- Evaluate the composition of stakeholder groups to increase collaboration and representation across all communities/populations.
- Mental Health Urgent Services: The Commission recommends further funding and support of Mental Health Urgent Cares (e.g., an EmPath Center in collaboration with Henry Mayo Hospital in Santa Clarita) that will serve adolescents and adults that can bill Medi-Cal as well as private insurance.
- Behavioral Health Unit (BHU): Plan and implement the decades long requested BHU for adolescents and children in the Santa Clarita and/or San Fernando Valley Areas. Identify if the concept/model can be funded by MHSA for some or part of the model.
- Consider innovative strategies to reduce paperwork for line working clinical staff to increase efficiency, improve morale, staff retention, recruitment, and satisfaction, decrease burnout, increase caseloads, and improve clinical quality.
- Maximize scope of service/practice for Occupational Therapists, Recreation Therapists, and Psychiatric Technicians to alleviate staffing shortages.

In response to the additional recommendations, DMH is expanding Alternative Crisis Services. This includes expansions to Psychiatric Mobile Response Teams (PMRT) and expansions to crisis residential services.

To address paperwork reduction, DMH has updated documentation guidelines according to the new California Advancing and Innovating Medi-Cal (CalAIM) standards, with a focus on reducing burden on staff and incentivizing up-front engagement with new clients.

Each Supervisor  
Chair, Commission  
May 11, 2023  
Page 8

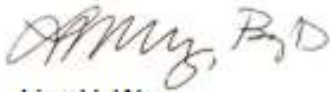
I'd like to thank the Commission for its collaboration during this transition period and thoughtful approach to ensuring the stakeholder voices are valued in the planning process.

Recommendations listed by the Commission will be explored by DMH and vetted with stakeholders. DMH MHSA Administration leadership will be available to provide ongoing updates to these recommendations and priorities identified by stakeholders.

I look forward to working with stakeholders, partners, and the Commission to ensure our MHSA resources help those most in-need live health, independent, meaningful lives.

If there are any questions you can contact me at (213) 947-6670, or staff can contact Kalene Gilbert, MHSA Services Coordinator, at [Kgilbert@dmh.lacounty.gov](mailto:Kgilbert@dmh.lacounty.gov).

Sincerely,

Handwritten signature of Lisa H. Wong in black ink, with the initials 'LHW' and 'BSD' written to the right of the signature.

Lisa H. Wong  
Director

LHW:CDD:KG:lm

## APPENDICES

### Appendix A - Interim Housing Multidisciplinary Assessment & Treatment Teams

<u>County Name:</u>	Los Angeles County
<u>Date submitted:</u>	March 7, 2023
<u>Project Title:</u>	Interim Housing Multidisciplinary Assessment and Treatment Teams
<u>Total Amount Requested:</u>	\$155,927,580 INN
<u>Duration of project:</u>	5 Years

#### Section 1: Innovations Regulations Requirements Categories

##### CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

##### CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- Increases access to mental health services to underserved groups
- Increases the quality of mental health services, including measured outcomes
- Promotes interagency and community collaboration related to mental health services or supports or outcomes
- Increase access to mental health services, including but not limited to services provided through permanent supportive housing

##### Primary Purpose

The purpose of this program is to create new regional, field-based, multidisciplinary teams dedicated to serving people experiencing homelessness (PEH) who are living in interim housing to learn if this multidisciplinary/multi-agency, on-site site service approach will result in:

- Increased access to mental health services and co-occurring substance use disorder (SUD) services,
- Increased exits to permanent housing,
- Decreased exits to homelessness,
- Increase in housing provider staff increasing their knowledge and skills when serving individuals with severe mental illness,
- Reduce incidence of overdose related fatalities.

#### Section 2: Project Overview

## Primary Problem

According to the 2022 Greater Los Angeles Point-In-Time Homeless Count conducted by the Los Angeles Homeless Services Authority (LAHSA), there are 69,144 PEH in Los Angeles County. Of this number, 48,548 are unsheltered on any given night, marking Los Angeles County with the unfortunate distinction of having the largest unsheltered homeless population in the nation. Further examination of the Homeless Count notes that 39.5% of individuals experiencing homelessness in Los Angeles County have mental health and/or substance use disorders<sup>1</sup>.

Although significant efforts and resources have been allocated to the development of permanent affordable housing solutions, including Permanent Supportive Housing (PSH), there is no question that interim housing continues to play a significant role in addressing the immediate and future needs of unsheltered PEH. To this end, there has been a significant investment in interim housing by Los Angeles County and many partnering cities over the last five years including interim housing developed in response to the COVID-19 pandemic such as the State-funded Project Roomkey sites. Amongst the 8 service planning areas (SPA) in Los Angeles County the current interim housing inventory totals approximately 220 sites and 14,376 beds. Another 11 interim housing sites are in the pipeline which will make available an additional 1,037 beds to support PEH. Further, in fiscal year 23-24 the Los Angeles County Homeless Initiative has budgeted 182.2 million (30% of the total budget) for interim housing.

<b>Los Angeles County - Estimated Interim Housing Inventory by SPA*</b>						
	Existing Sites	Existing Beds	Pipeline Sites	Pipeline Beds	Total Sites	Total Beds
SPA 1	9	278	1	38	10	316
SPA 2	35	2,787	1	148	36	2,935
SPA 3	11	487	2	132	13	619
SPA 4	64	5,013	3	239	67	5,252
SPA 5	19	525	-	-	19	525
SPA 6	43	3,211	3	400	46	3,611
SPA 7	15	932	1	80	16	1,012
SPA 8	24	1,143	-	-	24	1,143
<b>Total</b>	<b>220</b>	<b>14,376</b>	<b>11</b>	<b>1,037</b>	<b>231</b>	<b>15,413</b>

\* Estimate based on excluding the following interim housing sites: Department of Public Health – Substance Abuse Prevention and Control (DPH-SAPC) sites, Department of Health Services – Office of Diversion and Re-entry (DHS-ODR) sites, DHS – Housing for Health (DHS-HFH) Safe Landing, LACDMH Care First Community Investment (CFI) sites, Veterans Affairs (VA) sites and Project Homekey sites being converted to PSH.

While interim housing sites in Los Angeles County are funded by a collection of public and private dollars (including but not limited to Measure H, Los Angeles Homeless Service Authority (LAHSA), Departments of Health, Mental Health and Public Health) and available to any person experiencing homelessness, the reality is that PEH often have a variety of complex needs that limit their ability to successfully access and/or maintain stability in these settings despite their desperate need for shelter. For example, interim housing sites are traditionally staffed by homeless service providers who are ill-equipped to serve individuals with more complex medical needs (e.g., colostomy bags, wound care), mental health conditions (e.g., psychotic spectrum disorders, bipolar

<sup>1</sup> Health & disability indicators are not mutually exclusive; a single person may report more than one condition and thus be represented among more than one health & disability subpopulation.

disorders) and/or substance use disorders (e.g., alcohol, methamphetamine or opioid addiction) as well as individuals who need support with activities of daily living (ADLs) such as bathing, eating and dressing and/or independent activities of daily living (IADLs) such as managing medication and finances. This was highlighted in the 2020 preliminary report conducted by LAHSA entitled *Higher Level of Care Needs Among People Experiencing Homelessness at Los Angeles County Project Roomkey Sites*. The report found that a subset of individuals that had complex health and/or mental health conditions which significantly impaired their ability to engage in ADLs/IADLs were recommended for a higher level of care by site operators and LAHSA site coordinators.

The housing service agencies charged with operating the Project Roomkey sites did not have adequate funding or staff trained to provide the needed supports resulting in an increased risk of returning to homelessness for the identified subset. Our experience has also found that individuals who experience behavioral impairments as a result of their mental illness and/or substance use disorders are at high-risk of being exited from interim housing, which often results in them returning to the streets without proper care.

Accordingly, as part of the system of care in Los Angeles County, Department of Mental Health (LACDMH), Department of Health Services (DHS) and Department of Public Health have been intentional about designing, implementing and partnering in programs that can address the wide range of needs that PEH may experience. This included providing specialized psychiatric street outreach through the LACDMH Homeless Outreach & Mobile Engagement (HOME) teams as well as providing integrated specialized supportive services once someone is in permanent housing through the LACDMH Housing Supportive Services Program, DHS Intensive Case Management Services Program (ICMS) and DPH-Substance Abuse Prevention and Control (SAPC) Client Engagement and Navigation Services Program. However, the County currently lacks the dedicated resources needed to be able to respond to requests for field-based, on-demand and proactive health, mental health and substance use services in interim housing settings for individuals living with symptoms and functional impairments associated with severe mental illness, chronic health conditions and/or substance addiction. In fact, the need for these types of augmented services in interim housing was also identified during the community and stakeholder engagement process for Los Angeles County's Measure H funding recommendations and by the Board of Supervisors in a December 20, 2022 Board Motion for the County to support the City of Los Angeles in their State of Emergency on Homelessness.

Given the prevalence of health, mental health and substance use disorders among PEH, there is no doubt that providing interim housing residents with on-site access to health, mental health and substance use services and supports would fill an important gap in the homeless services system and offer assistance that is imperative to supporting a successful interim housing stay and transition to permanent housing and preventing individuals from returning to homelessness by providing critical skills and supports.

## Proposed Project

### Overview

Through the proposed Innovation project, LACDMH seeks to create new regional, field-based, multidisciplinary teams that are specifically dedicated to serving people experiencing homelessness (PEH) who are living in interim housing. The project is designed to address current gaps in behavioral health, including substance use, 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 LACDMH, DPH-SAPC and DHS-



Housing For Health (HFH) in an effort to ensure the full spectrum of client needs can be addressed. LACDMH Innovations funding will be used to support the mental health component of this effort including the provision of on-site specialty mental health and co-occurring SUD care and supports.

Mental health services will include crisis response, outreach, triage, screening/assessment, individual and/or group rehabilitation and therapy, medication evaluation/administration, including medications for addiction treatment (MAT) and ambulatory withdrawal management; crisis intervention including non-MHSA funded psychiatric hospitalization when deemed clinically appropriate, linkage to longitudinal care and consultation DPH-SAPC will provide substance use outreach, engagement, screening and referrals to SUD services including linkage to DPH-SAPC treatment providers who offer MAT in situations where the client's need for MAT and/or ambulatory withdrawal management is not met by an existing mental health service provider.

In addition, DPH-SAPC will provide educational sessions (individual and group) at the interim housing locations that will offer individuals an overview of SUDs and the treatment system as well as a more specific curriculum targeting those at risk of SUDs that is focused on overdose and relapse prevention; recognizing the health consequences of substance use and the connection to mental health; and harm reduction services including naloxone and fentanyl test strip distribution to interim housing residents and providers. For interim housing residents who may need traditional SUD treatment but are reluctant or unable to participate at a SUD treatment site, outpatient treatment services can be provided to residents onsite via DPH-SAPC's network of Field-Based Service treatment providers, including connections to MAT. DPH-SAPC will also coordinate referrals and linkage to appropriate harm reduction services, such as syringe services programs (contracted by DPH and/or DHS), for individuals who continue to use substances.

DPH-SAPC's network consists of 72 residential service (American Society for Addiction Medicine-ASAM) treatment level 3.1, 3.3, and 3.5) providers. Of the 72 residential providers, 16 providers identify as serving the Co-Occurring Disorder (COD) population, consisting of 31 sites. DPH-SAPC proposes a total of 10 residential beds to be dedicated to the COD population residing in interim housing sites, with the proposed INN funds supporting the non-Drug Medi-Cal cost, including room and board. When an interim housing resident needs residential substance use disorder treatment the IH teams will prioritize placement in a treatment location closest in proximity to the IH site whenever possible. INN Funding will also support 16 psychiatric social workers embedded in approximately 31 DPH-SAPC contracted residential treatment sites for the purpose of co-occurring disorder crisis de-escalation, assessment, treatment planning, and care coordination for the provision of integrated mental health and SUD care for patients receiving residential SUD treatment. Psychiatric social workers would be positioned to provide care coordination that links patients with co-occurring disorders to any necessary continuity mental health services, that aren't otherwise accessible from the residential provider directly, in parallel with their SUD treatment.

DHS-HFH will also contribute nursing and other staff to the teams who will be able to provide short-term, physical health care services to residents including but not limited to wound care, medication administration and ADL/IADL support until a dedicated In-Home Supportive Services (IHSS) provider can be established. To fund the physical health component, DHS has received Housing and Homelessness Incentive Program (HHIP) funding from managed care organizations (e.g., L.A. Care, Health Net, etc.).

## **Program Development & Implementation**

**a) Identify which of the three project general requirements specified above [per CRR, Title 9, Sect. 3910(a)] the project will implement**

This project proposal will make a change to an existing practice in the field of mental health, including but not limited to, application to a different population. Outreach and engagement and field-based service delivery are standards of care. Most often, individual participants are enrolled in one of many community-based mental health programs. While LACDMH has street teams who do community outreach for individuals, none are assigned to settings such as an Interim housing site. In addition, multi-agency partnership and supports, including funding from managed care partners, is a new approach for Los Angeles County.

The project proposal supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite. Interim housing is often a necessary first step in the journey to permanent housing for people experiencing homelessness. For many individuals these settings serve as a stabilizing resource allowing one to gather the skills, resources and service connections they need to move to permanent housing. The sites are generally staffed by paraprofessional and security staff who lack training and clinical skills to manage complex behavioral health, health and substance addiction needs of the residents. The result is that individuals with such complex needs are frequently deemed inappropriate for admission or prematurely exited from interim housing due to the provider's limited capacity to manage their needs. The proposed project will fill this service gap by providing critical mental health, health, and addiction treatment onsite, harnessing the collective expertise of three public entities to stabilize their living situation and support a successful transition to permanent housing.

**b) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.**

The proposed Innovation project will not only adapt critical lessons learned from the interim housing efforts implemented during the height of the pandemic (e.g., Project Roomkey) but expand the scope and availability of the services to the entirety of the interim housing portfolio in Los Angeles County. Instead of the current model which requires PEH to connect to specialty care independently, the project will use a multi-Department and multidisciplinary support model to provide tailored mental health, physical health, and substance use services onsite at interim housing facilities.

The teams providing these services will be the first of their kind in Los Angeles County to target residents in interim housing, allowing PEH with complex mental health, health and/or substance use disorders to be provided, for the first time, with augmented care in interim housing settings that will not only support their access to, and stay in interim housing, but also assist residents with obtaining the necessary services and care needed to transition to appropriate permanent housing and prevent a return to homelessness.

Additionally, the partnership with the managed care organizations to use HHIP funding for physical health services would be an innovative way to leverage private resources to provide nursing and other staff onsite at interim housing facilities to complete assessments and provide ADL/IADL supports while working to successfully connect the individuals to longitudinal care such as CalAIM Community Supports-funded caregiving services. HHIP funding will also support those individuals for whom a licensed residential care program would be more appropriate. Overall, we anticipate that this innovative approach to supporting PEH

in interim housing will increase positive health outcomes for those served and, ultimately, reduce health care costs.

**c) Estimate the number of individuals expected to be served annually and how you arrived at this number.**

According to the Los Angeles County Point-In Time Homeless Count 25% of individuals experiencing homelessness self-report having a diagnosis of a serious mental illness and 26% self-report having a substance use disorder<sup>2</sup>. The current inventory of interim housing beds in Los Angeles County (14,376) combined with those in the pipeline (1037) is 15,413 beds. Using the 2022 homeless count self-report percentages LACDMH anticipates serving 4000 individuals in interim housing sites annually, 20,000 over the life of the Innovations project.

**d) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate.)**

The target population for this Innovation project are individuals 18 and older who are homeless and residing in interim housing in Los Angeles County. These individuals will also have mental health, health and/or substance use disorders and can benefit from augmented supports to successfully access and maintain their interim housing, transition to appropriate permanent housing and prevent a return to homelessness. Services and supports will be provided in interim housing settings serving single adults and families. When working with families mental health treatment for children will be coordinated with LACDMH Children’s System of Care.

According to data gathered for the Los Angeles Homeless Services Authority (LAHSA) the current demographic breakdown for their interim housing portfolio is as follows:

**Ethnicity**

- Hispanic/Latino -4 0%
- Black/African American – 43%
- White – 21%
- Mixed or Multi Race – 2.5%
- Asian - .9%
- American Indian 2%
- Native Hawaiian/ Pacific Islander - .2%

**Age**

- Under 18 – 28%
- 18-54 - 55%
- 55 and Older – 17%

**Gender**

- Male - 51%
- Female – 48%
- Non-Binary – .003%
- Questioning – 1 %
- Transgender – .004%

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<sup>2</sup> Health & disability indicators are not mutually exclusive; a single person may report more than one condition and thus be represented among more than one health & disability subpopulation.

## Research on INN Component

### A. What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The proposed INN project aligns with the Governor's proposal for mental health reform by: 1. Focusing on the intersection of mental illness and homelessness. 2. Building out the entire continuum of care as it relates to mental health services in community; 3. Building regional centers of care and support for people experiencing homelessness, mental illness and co-occurring substance use disorders and 4. Leveraging broader strategies related to Medicaid reform. Additionally, the project aligns with LACDMH's strategic plan as it touches our three domains of care 1. Re-Entry Initiatives, Crisis Care and Community Services. Our Re-Entry Initiatives are comprised of programs designed to deploy specialty mental health treatment to help clients who have fallen out of community into the "open-air" asylum of homelessness, "closed-air" asylum of the jail, and the "personal asylum" of deep isolation (i.e. Regional IH Teams) Crisis Care includes the intensive care resources deployed to help individuals in crisis who are falling out of community (e.g. Psychiatric Mobile Response Teams, law enforcement and other first responders); and our North Star, Community Services where the clients we serve are at the center of community, connected not only to treatment but also stable housing, purpose in their lives (e.g. employment, school volunteer opportunities) and meaningful supportive relationships. The entirety of the proposal is focused on moving individuals from the Re-Entry level of care, eliminating the need for Crisis Care, and increasing connections to Community Services.

While some aspects of the proposed project are remotely similar to services/linkages provided by Full Service Partnership and other programs in Humboldt, Santa Barbara and even Los Angeles County, none provide comprehensive services with two key elements that make this project truly innovative:

- 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 psychiatric 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.

The most widely recognized and revered wrap-around treatment protocol for individuals with severe mental illness (SMI) in Los Angeles County are Full-Service Partnership (FSP) programs. These programs offer comprehensive intensive mental health treatment (including wrap around support) to individuals with severe and persistent mental illness. Without question FSP is effective in treating individuals with SMI however the program has eligibility requirements and is enrollment based, thereby limiting services to those with prior treatment failures and those fortunate enough to be connected to a provider. The proposed regional interim housing teams differ from FSP in several ways. First, no eligibility or enrollment criteria is required for an IH resident to receive services. Second, services are provided in the interim housing setting thus increasing access to care and likely, participation rates. Third, services extend beyond specialty mental health to include treatment for substance use and complex medical conditions, and support with ADLs/IADLs and, as clinically indicated, connection to managed care behavioral health resources and other Medicaid reform resources (e.g. Enhanced Care Management). Finally, consistent with the Governor's focus the modernization of the Mental Health Services Act, the interim housing teams described in this proposal are focused on the twin epidemics in the state of California, homelessness and behavioral health. The primary goals of the team's interventions are to increase access to housing resources for individuals with complex, behavioral health, substance use, and/or health needs; prevent

unnecessary return to homelessness due to behavioral health, medical or substance use concerns; and support successful transition to permanent housing.

Humboldt County's Resident Engagement and Support Team (REST) program seeks to improve housing stability in transitional housing via the assignment of case workers and peer staff in the outpatient setting. The primary focus is to help individuals create daily structure and routines, linkage, care management, and providing supportive/problem solving interventions with landlords. REST is different than the proposed project in that services are provided in the outpatient setting and are predominantly aimed at linkage and care and coordination. The services to be provided by the proposed project are 100% on site and entirely dedicated to the interim housing portfolio in Los Angeles County. The multi-disciplinary teams are able to provide interventions on-site in real time through face-to-face intervention and/or telemedicine (including 24/7 crisis response) in addition to being able to connect individuals to longitudinal mental health, health and substance abuse treatment as they transition to permanent housing.

Santa Barbara County currently has a Housing Retention Team facilitated by Good Samaritan Shelters and is funded by a grant from the Santa Barbara County Department of Housing and Community Development. It provides intensive wraparound services including a 24-hour help line for recipients of Emergency Housing Vouchers (EHV) in Santa Barbara County, of which they have approximately 230 EHV recipients. The distinction between Santa Barbara's Housing Retention Team and the project proposed herein is the focus on interim housing residents; comprehensive support which includes assistance with ADL/IADLs, substance abuse prevention, harm reduction and treatment (including medication assisted treatment); and multi-county department collaboration in partnership with managed care plans.

In general, while some homeless service providers in Los Angeles County e.g., LA Family Housing, People Assisting The Homeless (PATH), employ Masters level Social Workers as part of their shelter leadership structure, the services they provide are primarily in the domain of linkage and referral rather than on-site structured treatment and/or crisis response. When residents demonstrate significant behavioral, substance use or physical health needs paraprofessional and paraprofessional staff in these settings rely on the various LACDMH (directly operated and contracted), DPH-SAPC and DHS access points to link and obtain services for the clients serve. Due to the myriad of specialized programs and referral process within these bureaucracies finding the appropriate level of care or specialized resource for an interim housing resident can be a daunting and time consuming endeavor.

An example of more dedicated support in IH settings in Los Angeles County is the recently established interim housing model operated by Special Services for Groups (SSG), the Community First Community Investment (CFCI) model. SSG is a LACDMH legal entity and also manages the IH location. Services to these residents are provided via enrollment in the SSG Full Service Partnership Program. The CFCI model is limited in terms of its target population in that all referrals originate from Twin Towers Correctional Facility and are Misdemeanor Incompetent to Stand Trial (MIST). This approach essentially ties enrollment based intensive mental health supports to IH residents including 24/7 crisis response as part of their service array. The project is dissimilar to the proposed project in multiple ways: residents must be released from correctional institution, be MIST and meet criteria for FSP services; While specialty mental health services are provided, interventions for complex health and substance use treatment needs are not; partnership between County entities and managed care organizations is absent.

Prevent Homelessness Promote Health (PH)<sup>2</sup> is a joint program between the L.A. County Departments of Mental Health and Health Services Housing for Health that focuses on housing

stabilization. (PH)<sup>2</sup> works with adults and families countywide to address risk factors and build skills that support the maintenance of permanent and stable housing. Services consist of brief interventions and other appropriate treatment modalities which are provided by an integrated team of mental health clinicians and physical health care staff and providers. Individuals are referred to (PH)<sup>2</sup> by case managers in permanent supportive housing sites when a tenant is deemed at risk for eviction. Though the program does offer collaboration between County departments it is fundamentally different than the proposed project in that interventions take place in permanent supportive housing settings with the intention of preventing eviction. Conversely, the IH multidisciplinary teams will provide treatment interventions and supportive services while individuals are in transitional housing thereby reducing premature exits from interim housing and increasing the likelihood of successful transition to, and maintenance of, permanent housing. Further, IH multidisciplinary teams have the added layer of interventions related not only to physical health with the Department of Health Services but also substance use via onsite harm reduction interventions (e.g., distribution of naloxone and fentanyl test strips), group treatment and immediate access to dedicated inpatient substance use treatment beds for IH residents.

In response to the COVID-19 pandemic, multiple types of interim housing sites were established in 2020 to serve PEH deemed to be at high risk for adverse health outcomes if infected with the virus. Project Roomkey, for example, used hotels and motels to provide PEH with non-congregate shelter and managed to significantly increase the interim housing bed capacity in Los Angeles County almost overnight. In addition, there were congregate interim housing sites that were temporarily established at recreation centers operated by the City of Los Angeles Department of Recreation and Parks as well as Quarantine & Isolation interim housing sites that were set up at hotels and recuperative care sites for those testing positive or exposed to COVID-19.

Disaster Service Workers (DSWs) from across County Departments were deployed to these interim housing sites to respond to a wide variety of individual needs. LACDMH DSWs, for example, were called upon to provide mental health support, triage, assessment, treatment and crisis intervention to individuals who were experiencing symptoms associated with severe mental illness and/or psychiatric crisis. In fact, throughout the course of the pandemic, in excess of 10,000 individuals from these interim housing sites were served (10,435 as of January 2022) with over 46% of them (or approximately 4,800) having a diagnosis of severe mental illness. Similarly, DSWs from DHS, DPH and the Department of Public Social Services also provided support to residents of these same interim housing sites including on-site medical care for chronic health conditions, assessment and linkage to substance abuse treatment services and connection to in-home supportive services to aid individuals with ADLs/IADLs.

The resulting collaboration between County Departments served as a lifeline to support the interim housing providers and the individuals staying in the interim housing sites and allowed for coordinated and ongoing care across the various County systems for those individuals with more complex needs and co-occurring disorders. Unfortunately, the practice of using DSWs was short term and did not extend to the hundreds of other interim housing locations throughout Los Angeles County that had been established prior to the pandemic.

**B. Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.**

In developing the proposed project in interim housing settings, we investigated local models of service delivered by interim housing providers in Los Angeles County, including models established during the COVID pandemic. Additionally, we reviewed literature focused on the provision of services in interim housing/shelter settings. Search terms in EBSCOhost and Google Scholar were as follows:

- Services in interim housing settings
- Services in homeless shelters
- Mental health treatment in homeless shelters
- Multidisciplinary treatment in homeless shelters

A review of literature was conducted to assess research related to integrated service delivery in interim housing/shelter settings. There are clear gaps in literature focused on the integration of services in adult settings. Though little research on this specific topic was available as a whole, most proximal research on the topic pertains to interventions made for women and families, more specifically, child and family traumatic stress interventions in emergency family shelters (Snyder 2002) and the use of trauma focused cognitive behavioral therapy for children in shelters (Spiegel et al 2022).

In studies focused on adult populations, the research questions pertained to shelter resident's access (or lack thereof) to social services in traditional settings. Stenius-Ayoade, A (2017) for example, examined the degree to which residents of homeless shelters accessed mainstream social service resources such as primary care and emergency room visits based on a diagnosis of mental illness, substance use disorders of co-occurring mental illness and substance use. Fokuo, J et al (2020) explored the feasibility of implementing a screening, testing and treatment protocol for treat hepatitis C in homeless shelters as a means of reducing hepatitis C infections amongst people experiencing homelessness. In study on the establishment of behavioral services in homeless shelters (Kalahasthi, R. et al 2022) held small similarities to the mental health treatment aspect to be implemented in the proposed innovations project, however the sample size was substantively smaller than the target population for this project (n=98).

The analysis illustrated that focusing on shelter residents' distress at the time of intake in homeless shelter settings significantly reduced mental health stress levels. Further, residents who at intake reported negative experiences with outside mental health agencies and where thereby reluctant to engage in treatment, indicated they were willing to engage in mental health services within the shelter setting. The implications from this study while promising for the proposed interventions of the multidisciplinary teams do not reflect the scale and scope of the proposed project wherein the focus is on multiple vulnerabilities (i.e., psychiatric and physical illness, and substance use) that impact health and wellbeing and potentially limit one's ability to access interim housing successfully and/or transition to and maintain permanent housing. Further, the study did not expressly provide interventions catered to those with severe mental illness and lacked the multiagency (public and private), complex vulnerability focus outlined in the proposed project.

Finally, in a study to understand the health care experiences of people experiencing homeless in non-traditional settings (Ramirez, J et al 2022) concluded to achieve optimal health care outcomes for PEH clinical interventions should: (1) utilize shared-decision making during the visit, (2) foster a sense of trust, compassion, and acceptance, (3) emphasize continuity of care, including consistent providers and staff, and (4) integrate social services into Health Care for the Homeless sites. The proposed project addresses all four of the objectives via provision of comprehensive integrated services in a manner that creates maximum accessibility for interim housing residents and

collaborative care coordination between mental health, health and substance use treatment providers. It should be noted that no research articles contained the comprehensive integrated approach outlined in the LACLACDMH multidisciplinary approach to interim housing services proposal.

Citations:

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Los Angeles County Homeless Initiative FY 2023-24 Budget (2023) <https://homeless.lacounty.gov/fy-2023-24-budget/>

Los Angeles Homeless Services Authority (2022) LA County HC22 Data Summary <https://www.lahsa.org/documents?id=6515-lacounty-hc22-data-summary>

Stenius-Ayoade, A., Haaramo, P., Erkkilä, E. *et al.* (2017). Mental disorders and the use of primary health care services among homeless shelter users in the Helsinki metropolitan area, Finland. *BMC Health Serv Res* **17**, 428  
<https://doi.org/10.1186/s12913-017-2372-3>

Snyder, Sean (2022) Meeting them where they are at': A practice note on implementation of the child and family traumatic stress intervention in an emergency family homeless shelter. *Child & Family Social Work* August 8, 2022 <https://onlinelibrary.wiley.com/doi/abs/10.1111/cfs.12962>

Spiegel, Jamie A. (2022) Addressing Mental Health and Trauma-Related Needs of Sheltered Children and Families with Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) *Administration & Policy in Mental Health & Mental Health Services Research*. Sep2022, Vol. 49 Issue 5, p881-898. 18p.  
<https://link.springer.com/article/10.1007/s10488-022-01207-0>

Fokuo, J. Konadu et al (2020) Recommendations for Implementing Hepatitis C Virus Care in Homeless Shelters: The Stakeholder Perspective  
<https://aasldpubs.onlinelibrary.wiley.com/doi/full/10.1002/hep4.1492>

Kalahasthi, Rupa et al (2022) Establishing behavioral health services in homeless shelters and using telehealth digital tools: best practices and guidelines. *Advances in Dual Diagnosis*; November 2022, Vol. 15 Issue: Number 4 p208-226, 19p  
<https://www.emerald.com/insight/content/doi/10.1108/ADD-07-2022-0019/full/html>

Ramirez, Jahanett et al (2022) Understanding the primary health care experiences of individuals who are homeless in non-traditional clinic settings *BMC Primary Care* 23, Article number: 338  
<https://link.springer.com/article/10.1186/s12875-022-01932-3>

### Learning Goals & Objectives

- A. What is it that you want to learn or better understand over the course of the INN project, and why have you prioritized these goals?
- B. How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project.



By implementing the proposed Innovation project, LACDMH's goal is to determine if this approach is a best practice for addressing the needs of the PEH population and supporting their transition to permanent housing. Specifically, LACDMH is interested in answering the questions below.

Does having dedicated field-based, culturally responsive, multidisciplinary, multi-agency teams serving interim housing sites result in the following:

- Increased access and linkages to specialty mental health, health and co-occurring SUD services by interim housing residents?
- Increase and streamline access to non-specialty mental health care provided by managed care plans for interim housing residents.
- Increased linkages to SUD outpatient residential treatment services?
- Increased exits to permanent housing?
- Decreased exits to homelessness?

Decreased use of crisis/emergency services?

- Interim housing provider staff increasing their knowledge and skills when serving individuals with severe mental illness, complex health and substance use disorders and feeling more confident in being able to serve this population in their interim housing sites?
- Increase interim housing providers' ability to discern their capacity to stabilize a interim housing resident's mental health, health and/or substance use disorder in-house versus the necessity to request crisis services or specialty assessment?
- Improve care coordination amongst county departments and managed care organizations?
- Improve our ability to link interim housing to the appropriate level of care/permanent housing resource
- Improve the quality of care in interim housing settings?
- Improve interim housing resident experience and sense of well-being?

Information gained from this Innovation project will inform the way LACDMH and its homeless services system partners design and implement interim housing projects across the County. It will also provide a clearer understanding of the services and supports needed for individuals with severe mental illness and other complex health and substance use conditions who are in interim housing to successfully transition to and maintain permanent housing.

Additionally, we anticipate that the supports offered through this project will enhance accessibility to interim housing for those who otherwise would be regarded as needing a higher level of care due to the complexity and severity of their mental illness and, thereby, help facilitate an opportunity for these individuals to be safely indoors and to have a clear path to permanent housing and recovery in the least restrictive setting.

### **Evaluation or Learning Plan**

LACLACDMH intends to contract the evaluation portion of this project to an external, independent vendor.

### **Section 3: Additional Information for Regulatory Requirements**

#### **Contracting**

LACDMH intends to provide the mental health support and mental health promotion and education services using directly operated providers and contracted providers if needed.

-LACDMH will fund services provided by Department of Public Health-Substance Abuse Prevention and Control. DPH-SAPC will expand the capacity of its existing network of providers to provide substance use prevention, harm-reduction and treatment services. Health Services will be provided by DHS. Finally, the managed care partners will fund their own service delivery and work in collaboration with the LACDMH/DPH-SAPC/DHS teams.

## **Community Program Planning**

### Los Angeles County Homeless Initiative Planning

The recommendation for this plan was developed as part of the community stakeholder process for the Homeless Initiative. This process engaged community members, local government, persons with lived experience with homelessness, and the Spanish speaking Community.

August-October 2022

18 virtual Listening Sessions that drew more than 750 attendees

- Eight Service Planning Area (SPA) Sessions, one in each SPA
- Seven City/Councils of Government (COG) Sessions, one in each COG area
- Two Sessions with People with Lived Expertise
- One Countywide Session in Spanish

August –October 2022

10 Stakeholder Planning Meetings

- One Homeless Service Provider (Executive Director) Meeting
- Five Homeless Rehousing System Lead Agency planning meetings
- Four Homeless Strategy Lead Department Agency Meetings

Recommendations released November 8, 2022

Public Comment period from November 8-22, 2022

January 31, 2023

- Presentation to LACDMH stakeholders including Underserved Community Leads and the Service Area Leadership Team. Materials were available in Spanish translation and live interpretation was offered in Spanish, Korean and ASL.

February 23, 2023

- Presentation to Los Angeles County Mental Health Commissioners materials were available in Spanish translation and live interpretation was offered in Spanish, Korean and ASL.

This concept was also recommended by the Housing and Homeless Incentive Program stakeholder process implemented by the Housing and Homeless Incentive Program. This process also resulted in a recommendation for an Activities of Daily Living Expansion strategy which will provide funding for:

- DHS's physical health nurses that are part of the multidisciplinary teams
- Caregiving services in interim housing for people with ADL needs
- Enhanced services funding to support health plan members in Adult Residential Facilities and/or Residential Care Facilities for the Elderly

## **MHSA General Standard Community Collaboration**

### **A. Cultural Competency**

LACDMH is committed to the provision of services that are delivered in a culturally and linguistically responsive, accessible manner. Our Cultural Competency Unit (CCU) ensures that cultural responsiveness is central in the delivery of all services. The CCU promotes a collective sense of shared responsibility for the delivery of services that address health inequities and meets the needs of Los Angeles County's cultural diversity inclusive of racial, ethnic, linguistic, age, gender identity, sexual orientation, socioeconomic status, degree of physical and cognitive ability and disability, spirituality and religious beliefs, and lifestyle choices among others.

The CCU is housed within the departmental Anti-Racism, Diversity and Inclusion (ARDI) Division and has reporting responsibilities to LACDMH's executive management, the California Department of Health Care Services (DHCS), and the Los Angeles County Board of Supervisors (BOS). The ARDI Division provides cultural competency training and technical assistance to LACDMH staff and programs. Additionally, LACDMH's Human Resources Division seeks to align its recruitment efforts with diversity needs of LA County residents. All aspects of program delivery will be provided by a culturally competent work force. Further, recruitment strategies will include intentionality to employ staff with lived experience at all levels, thereby optimizing the degree of empathy and impact in supporting the recovery journey of IH residents.

### **B. Consumer-Driven:**

LACDMH is committed to Recovery based treatment in which there is shared decision making and the client is at the center of the treatment planning process. The County's directly operated system of care currently has over 500 designated peer positions within its workforce in addition to a large number of peers and family members in leadership roles throughout the Department. The project has a considerable peer lead component. Each regional planning area has at least one (more in densely populated areas) peer team which will drive treatment planning, service connection and support for interim housing residents.

### **C. Family-Driven: Youth and Families?**

The services provided in the proposed project will be dedicated to the portfolio of interim housing sites throughout Los Angeles County including family shelters. In all instances wherein a IH resident has family and/or significant other whom they wish to involve in their recovery journey, project staff will actively engage them in the planning and treatment plan implementation process. Additionally, family members are represented in the Service Area Leadership Team stakeholder groups which have informed the development of this Innovations project and will be involved in its ongoing updates and evaluations.

### **D. Wellness, Recovery and Resilience-Focused:**

Wellness, Recovery and Resilience are at the heart of the proposed project. The goal of all interventions provided in this project is to support residents interim housing who have severe mental illness and other complex needs (e.g., co-occurring substance use or health disorders) successfully transition to, and maintain permanent housing.

### **E. Integrated Service Experience for Clients and Family:**

Integrated services, health, mental health and substance use, are a core feature of this project. The teams will be made up of multi-agency staff, providing access to all three critical services. Additionally, services will be integrated into the interim housing service system, allowing residents to easily access the supports/ treatment they need without delays and/or barriers (e.g., transportation, accessibility limitations).

### **Cultural Competence and Stakeholder Involvement in Evaluation**

Presentations will be made semi-annually to LACDMH Stakeholder body, LA County Board Homeless and Mental Health Deputies, and LAHSA Interim Housing Service Providers to solicit input on program effectiveness and quality improvement. Additionally, the aforementioned entities as well as the LACDMH Underserved Cultural Communities and Service Area Leadership Team advisory groups will be invited to participate in the academic evaluation of the program.

### **Innovation Project Sustainability and Continuity of Care.**

#### **Communication and Dissemination Plan**

**A. How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?**

Updates will be provided to stakeholders on a semi-annual basis via stakeholder meetings which will be offered in person and virtually. The sharing of updates with the community at large (including other counties) will be achieved via posting of the Annual Update and Final Report on for the Innovation project on the County website MHSA webpage. LACDMH will leverage the Service Area leadership Team (SALT) and the Underserved Cultural Communities (UCC) convenings to provide updates, receive community feedback to inform opportunities for quality improvement. Updates on progress will also be provided in the Annual Update and Three-Year plan reports. Annual updates and the final report for the Innovations project will be posted on the County website.

Should the project prove successful LACDMH will assess the level of need, adjust the program accordingly, and continue the provision of specialty mental health treatment by the regional IH teams through the use of MHSA Community Services & Supports paired with Medi-Cal drawdown and consider other local, state and/or federal funding streams (e.g. Measure H, Substance Abuse and Mental Health Service Administration - SAMHSA). DHS and DPH will explore the use of Measure H, Medi-Cal and Drug Medi-Cal to fund ongoing services. Regardless of outcome, LACDMH, DHS and DPH-SAPC will ensure all IH residents in care are connected to ongoing services.

**B. KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.**

Shelter, Interim Housing, In Home Supportive Services, Services in Shelter Settings

#### **Timeline**

**Specify the expected start date and end date of your INN Project**

**A. Specify the total timeframe (duration) of the INN Project**

- B. Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Quarter	Activities
1 YEAR One Q3	<p>LACDMH: 1. Submit Board Letter to request delegated authority to accept Innovations funding and delegated authority to hire            2. Develop Statement of work to identify independent evaluator            3. Release solicitation for independent evaluator            4. Identify and secure office space for regional teams in collaboration with DHS and DPH-SAPC            4. Establish a workgroup with LACDMH, DHS and DPH-SAPC and Managed Care Plans to develop protocols, policies &amp; procedures, and workflows            DPH-SAPC: 1. Amend provider contracts                      2. Modify EHR to capture project data                      3. Develop/amend internal policies for this project                      4. Begin training contracted agency staff                      5. Initiate SUD services at identified IH locations            5. Establish relevant memorandums of understanding and data sharing agreements between respective county departments and managed care organizations.</p>
2 YEAR One Q4	<ol style="list-style-type: none"> <li>1. Recruit, hire and onboard staff 50% of staff</li> <li>2. Identify training needs for staff</li> <li>3. Select independent evaluator</li> <li>4.</li> <li>5. Develop and implement curriculum to address training needs</li> <li>6. Establish quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>7. Finalize regional interim housing locations to be served</li> <li>8. Establish team assignment/rotations</li> <li>9. Begin orientation sessions for service staff and interim housing providers</li> <li>10. Establish forum for quarterly updates for LACDMH stakeholder groups</li> </ol>
3 YEAR Two Q1	<ol style="list-style-type: none"> <li>1. Recruit, hire and onboard remaining staff</li> <li>2. Orient and train remaining staff</li> <li>3. Establish baseline measures for quantitative learning objectives</li> <li>4. Build out project qualitative goals</li> <li>5. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>6. In collaboration with county partners, managed care plans and LACDMH stakeholders develop program evaluation metrics and protocols</li> <li>7. Develop quarterly report dashboard</li> </ol>
4 YEAR Two Q2	<ol style="list-style-type: none"> <li>1. Roll out regional teams to provide specialty mental health, health and substance abuse treatment for interim housing residents.</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>

Quarter	Activities
5 YEAR Two Q3	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
6 YEAR Two Q4	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
7 YEAR Three Q1	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
8 YEAR Three Q2	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
9 YEAR Three Q3	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
10 YEAR Three Q4	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
11 YEAR Four Q1	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
12 YEAR Four Q2	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
13 YEAR Four	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> </ol>

Quarter	Activities
Q3	<ol style="list-style-type: none"> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
14 YEAR Four Q4	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
15 YEAR Five Q1	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
16 YEAR Five Q2	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> </ol>
17 YEAR Five Q3	<ol style="list-style-type: none"> <li>1. Providers continue to provide specialty mental health, health and substance abuse treatment for interim housing residents</li> <li>2. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>3. Develop and release quarterly report</li> <li>4. Quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>5. Develop and release quarterly report</li> </ol>
18 YEAR Five Q 4	<ol style="list-style-type: none"> <li>1. Final quarterly convenings with County Depts, Managed Care organizations and interim housing providers</li> <li>2. Develop final project report</li> </ol>

#### **Section 4: INN Project Budget and Source of Expenditures**

##### **Budget Narrative**

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "\$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total \$15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time..."). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

LACDMH seeks to create new regional, field-based, multidisciplinary teams that are specifically 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 LACDMH, DPH-SAPC and DHS-HFH to ensure the full spectrum of client needs can be addressed. LACDMH Innovations funding will be used to support the mental health component of this effort including the provision of on-site specialty mental health and co-occurring SUD care and supports. Mental health services will include crisis response, outreach, triage, screening/assessment, medication evaluation/administration, crisis intervention (including psychiatric hospitalization when deemed clinically appropriate), linkage to longitudinal care and consultation.

The estimated MHPM cost of the proposed Innovation project will be approximately \$156 million. This will support the implementation and administration of 24 teams countywide comprised of multidisciplinary staff providing on-site specialty mental health and co-occurring SUD care and supports including psychiatrists, clinicians, medical case workers, community health workers, licensed vocational nurses, substance abuse counselors and clerical support. This does not include the physical health services provided by DHS-HFH, which is anticipated to be funded using HHIP dollars from the managed care organizations.

MHPM funds are used to support the following INN Program positions and administrative costs.

#### DIVISION ADMINISTRATIVE TEAM:

1. One (1) Mental Health Program Manager III @ 1.0 Total FTE (Amount = \$153,262). This position provides program planning, implementation, and evaluation of program services. The MHPM III will have an active role in directing and participating in the design of this project. The MHPM III has primary responsibility for clinical and administrative oversight, and coordination involving different programs in the service continuum.
2. One (1) Health Program Analyst II @ 1.0 FTE (Amount = \$102,231). This position provides administrative oversight and management of INN funding including monitoring data, budgetary oversight, compiling and submission of quarterly and annual reports communication with state etc.
3. One (1) Senior Information Systems Analyst @ 1.0 FTE (Amount = \$132,305). This position prepares detailed specifications, addressing scope and boundaries of the system, data requirements, algorithms, user functions, forms and reports, work continuity requirements. Creates data reports and works with the Program to formulate the data elements to report outcomes based on Department and State requirements.
4. One (1) Senior Secretary III @ 1.0 FTE (Amount = \$65,437). This position provides support to the Mental Health Program Manager III to manage the clinical and administrative operations of the INN Project more effectively.
5. One (1) Staff Assistant II @ 1.0 FTE (Amount = \$66,408). This position provides administrative support to the MH Program Manager III. The Staff Assistant II ensure staff adhere to County policies, procedures, and guidelines; and manages the administrative and office operations at the direction of the Program Manager III.



6. One (1) Senior Typist Clerk @ 1.0 FTE (Amount = \$57,787). This position provides administrative and clerical support to the team with data entry into eHR; data tracking and reporting; procurement of services and supplies; managing program assets and facility operations.

#### PROGRAM ADMINISTRATIVE TEAM:

7. Two (2) Mental Health Program Manager II @ 2.0 Total FTE (Amount = \$277,616). This position provides program implementation, management, training, and leadership for the team. The MHPM II has primary responsibility for clinical and administrative oversight.

8. Two (2) Health Program Analyst I @ 2.0 FTE (Amount = \$183,448). This position provides administrative oversight and management including monitoring data, budgetary oversight, compiling and submission of reports etc.

9. Two (2) Staff Assistant I @ 2.0 FTE (Amount = \$109,853). This position provides administrative support to the MH Program Manager II. The Staff Assistant I ensure staff adhere to County policies, procedures, and guidelines; and manages the administrative and office operations at the direction of the Program Manager II.

10. Two (2) Secretary III @ 2.0 FTE (Amount = \$107,716). This position provides support to the Mental Health Program Manager II to manage the clinical and administrative operations of the INN Project more effectively.

11. Two (2) Senior Typist Clerk @ 2.0 FTE (Amount = \$97,117). This position provides administrative and clerical support to the team with data entry into eHR; data tracking and reporting; procurement of services and supplies; managing program assets and facility operations.

#### SERVICE TEAMS:

12. Twelve (12) Mental Health Clinical Supervisor @ 12.0 Total FTE (Amount = \$1,112,704). This position Supervises a multi-disciplinary clinical team including assignment and review of work, conducts orientation, trains, and evaluates work performance. Provides clinical consultation to full time staff, prepares daily work schedules, responds to field calls, monitors monthly productivity reports, and reviews reports on a regular basis.

13. Twenty-four (24) Psychiatric Social Worker II @ 24.0 Total FTE (Amount = \$1,991,693). This position provides outreach and engagement, screenings and assessments, crisis intervention, case management including referrals, mental health and substance use treatment, habilitation, legal advocacy, and housing services to clients.

14. Twenty-Four (24) Medical Case Worker IIs @ 24.0 Total FTE (Amount = \$1,536,017). This position provides outreach and engagement, screenings, crisis intervention, case management services including referrals, habilitation, and housing services to clients.

15. Twelve (12) Licensed Vocational Nurse I @ 12.0 Total FTE (Amount = \$629,436). This position provides medical services such as injections, labs, and blood work.

16. Eleven (11) Supervising Community Health Workers @ 11.0 Total FTE (Amount = \$608,699). This position provides Supervision to a team of Community Health Workers and/or MH Advocates.

17. Fifty-five (55) Community Health Workers @ 55.0 Total FTE (Amount = \$2,504,709). This position provides peer support, outreach and engagement, crisis intervention, case management and housing services to clients.

18. Twelve (12) Intermediate Typist Clerk @ 12.0 FTE (Amount = \$516,316). This position provides general clerical support, including data entry and filing, and assists with producing data reports.

#### SERVICE NAVIGATION & DISPATCH TEAM:

19. One (1) Senior Mental Health Counselor RN @ 1.0 Total FTE (Amount = \$133,568). This position Supervises a multi-disciplinary clinical team including assignment and review of work, conducts orientation, trains, and evaluates work performance. Provides clinical consultation to full time staff, prepares daily work schedules, responds to field calls, monitors monthly productivity reports, and reviews reports on a regular basis. This position also provides clinical supervision and consultation to nursing staff.

20. One (1) Mental Health Clinical Supervisor @ 1.0 Total FTE (Amount = \$92,725). This position Supervises a multi-disciplinary clinical team including assignment and review of work, conducts orientation, trains, and evaluates work performance. Provides clinical consultation to full time staff, prepares daily work schedules, responds to field calls, monitors monthly productivity reports, and reviews reports on a regular basis.

21. Two (2) Mental Health Counselor RN @ 2.0 Total FTE (Amount = \$299,652). This position performs mental and physical clinical assessments and medication management duties. Conducts interviews to assess a client's mental status, developmental status, substance abuse problems as well as needs in the areas of both mental and physical health. As part of this team triages referrals and directs the flow to appropriate level of care.

22. Four (4) Psychiatric Social Worker II @ 4.0 Total FTE (Amount = \$331,949). This position provides outreach and engagement, screenings and assessments, crisis intervention, case management including referrals, mental health and substance use treatment. As part of this team triages referrals and directs the flow to appropriate level of care.

23. Four (4) Patient Financial Services Worker @ 4.0 FTE (Amount = \$216,496). This position assists the program on determining patients' financial eligibility to reimburse the County for healthcare services; interviews and refers patients for benefits; verifies information and explains County policies; may secure payments and arrange payment plans on behalf of the program.

24. Two (1) Senior Typist Clerk @ 2.0 FTE (Amount = \$97,117). This position provides administrative and clerical support to the team with data entry into eHR; data tracking and reporting; procurement of services and supplies; managing program assets and facility operations.

#### PSYCHIATRIC TEAM:

25. One (1) Supervising MH Psychiatric @ 1.0 Total FTE (Amount = \$303,556). This position provides clinical and administrative supervision to psychiatrists and medical prescribers including directing patient care with a caseload of more complex clients.

26. Eight (8) Mental Health Psychiatrists @ 8.0 Total FTE (Amount = \$2,081,943). This position allows LACDMH to evaluate and determine client needs for psychotropic medications; prescribe and administer medications as necessary; and monitor the client's response to medication. The

Psychiatrist writes 72-hour holds for assessment of involuntary treatment and provides strong and credible advocacy for continued in-patient care.

27. Fringe Benefits are the sum of Variable Employee Benefits @ 43% of salaries (Amount = \$10,270,000). This includes such employee benefits as medical, dental, vision, short and long-term disability, and retirement.

28. Services and Supply costs (Amount = \$3,853,800). These costs are for staff supplies and equipment to conduct business related to the INN program including telephone, telecommunication (Cell Phone), Office Supplies, Personal Computer Software, Computers

Printer/Peripherals (Scanner), Space, Training, Mileage, Travel, Utilities and Uniforms. Equipment will be used for data entry, prepare documentation and related reports as part of the outreach and engagement, screenings, crisis intervention, case management services including referrals, habilitation and housing services to clients.

29. Client Services and Supplies costs consist of client support services such as personal supplies including but not limited to food, water, toiletries, clothing, shoes, etc. that may be provided to clients during the outreach and engagement process (Amount = \$140,000) and CAL-cards costs (Amount = \$560,000).

30. Other Charges include Direct Service Order to LAC Department of Public Health to provide 28 CENS staff, 10 Residential Treatment beds, and harm reduction kits (Amount = \$8,977,060.00)

31. Other Expenses include capital assets for the purchase of county vehicles. Capital asset costs for the purchase of fifty (50) vehicles to transport clients to access services and supports such as housing providers, medical services, DPSS, and related community supports to provide linkage and access to care (Amount = \$1,406,760).

32. County Indirect Administrative Costs (MHSA Amount = \$3,894,055). LACDMH does not have a negotiated indirect cost rate agreement and has elected to claim the 10 percent de minimis indirect rate, although our actual rates exceed this amount. LACDMH's indirect costs are comprised of various administrative cost pools, which include but are not limited to Financial Services, Human Resources, Information Technology, Procurement and Contracts.

<b>5 Year Budget</b>	<b>FY 23/24</b>	<b>FY 24/25</b>	<b>FY 25/26</b>	<b>FY 26/27</b>	<b>FY 27/28</b>	<b>TOTAL</b>
Personnel	\$24,019,433	\$24,019,433	\$24,019,433	\$24,019,433	\$24,019,433	\$120,097,163
Operating Costs	\$13,530,860	\$13,530,860	\$13,530,860	\$13,530,860	\$13,530,860	\$67,654,300
Non-recurring costs	\$1,406,760	\$	\$-	\$-	\$-	\$1,406,760
Evaluation	\$750,000	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	\$4,750,000
Indirect Costs	\$3,895,705	\$3,755,029	\$3,755,029	\$3,755,029	\$3,755,029	\$18,915,822
<b>Total</b>	<b>\$43,602,758</b>	<b>\$42,305,322</b>	<b>\$42,305,322</b>	<b>\$42,305,322</b>	<b>\$42,305,322</b>	<b>\$212,824,045</b>

<b>Funding Source</b>	<b>FY 22/23</b>	<b>FY 23/24</b>	<b>FY 24/25</b>	<b>FY 25/26</b>	<b>FY 26/27</b>	<b>TOTAL</b>
Innovation Funds	\$32,173,465	\$30,876,029	\$30,876,029	\$30,876,029	\$30,876,029	\$155,927,580
Medi-Cal Funding	\$11,429,293	\$11,429,293	\$11,429,293	\$11,429,293	\$11,429,293	\$57,146,465
<b>Total</b>	<b>\$43,602,758</b>	<b>\$42,305,322</b>	<b>\$42,305,322</b>	<b>\$42,305,322</b>	<b>\$42,305,322</b>	<b>\$212,824,045</b>

## Appendix B – Mental Health Services Act Trainings



# Mental Health Services Act: MHSA 101



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

## Mental Health Services Act (MHSA) Mission

Optimize the hope, wellbeing and the life trajectory of Los Angeles County's most vulnerable residents through increased access to care and resources that promote independence and personal recovery as well as community connectedness and community reintegration.

# MHSA Vision

The MHSA pledges to look beyond “business as usual” to build a community mental health system where access to care is easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists.

## Presentation Overview

Prevalence of Mental Health Disorders

Lack of Access and Impact

Proposition 63: Legislation to Address Mental Health Need

MHSA: What it is and how it works

Core Principles

Focus

Stakeholders Engagement is Essential

The Five MHSA Program Components

MHSA Key Findings

MHSA Oversight

Additional Resources

MHSA Proposal Process

MHSA Resolution Process

## Prevalence of Mental Health Disorders

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Mental illnesses are among the most common health conditions in the United States

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Mental disorders are common in the United States, with 1 in 5 adults, 52.9 million people, having a mental disorder in any one year

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More than half of Americans report that COVID-19 has had a negative impact on their mental health

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In California, 1,243,000 adults have a serious mental illness

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396,000 Californians age 12–17 have depression

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## Lack of Access and Impact

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- More than half of people with a mental health condition in the U.S. did not receive any treatment in the last year
- Of the 1,562,000 adults in California who did not receive needed mental health care, 35.3% did not because of cost
- In February 2021, 46.1% of adults in California reported symptoms of anxiety or depression. 21.9% were unable to get needed counseling or therapy
- It should be noted that cultural, racial, and ethnic populations have been disproportionately affected as they access mental health services at a lower rates

# Proposition 63: Legislation to Address Mental Health Needs

On November 2, 2004, California voters passed Proposition 63 by majority.

Prop 63, also known as the millionaires' tax, became effective as a statute, the Mental Health Services Act (MHSA) on January 1, 2005.

MHSA seeks to expand and improve mental health services across the state by providing additional funding and oversight and accountability.

Prior to MHSA funding for mental health services was deficient, for example Los Angeles County authorities estimated providing services to only half of those needing public mental health services.

Thirty years ago, the State of California cut back on its services in state hospitals for people with severe mental illnesses, without providing adequate funding for mental health services in the community many people became homeless.

## What is MHSA?

A 1% tax on personal income above \$1 million dollars to fund MHSA programs and projects to greatly improve the delivery of community-based mental health services and treatment across California.

Welfare and Institutions Code (WIC) 5891 states that MHSA revenues may only fund mental health services, MHSA programs and activities and prohibits these funds from supplementing other existing County funds.

Since the State of California decentralized its behavioral health system, most MHSA funding is administered by each California counties.



## How does MHSa work?

Funds programs and services that seek to reduce the long-term adverse impact of untreated mental illness

Transforms the public mental health system from “fail first,” often resulting in treatment delivery through the criminal justice system, the courts, and emergency rooms to “help first,” with a commitment to service, support, and assistance through community based intensive and preventative treatments and interventions on individual need.

MHSa addresses a broad continuum of county mental health services for all populations: children, transitional age youth, adults, older adults, families, unserved and underserved.

## MHSa Core Principles

Client/Family  
Driven Services

Cultural  
Competence

Community  
Collaboration

Service Integration

Focus on Recovery,  
Wellness, and  
Resilience

- Increased and targeted access to services for un-served and underserved populations
- Prioritizing individuals' recovery and wellness goals
- Implementation of effective and sustainable programs and services
- Administration and oversight of cost-effective expenditures
- Engaging stakeholder in meaningful involvement in the ongoing development and implementation of programs and services based on their individual community needs

## Focus of MHSA

## Stakeholder Engagement is Essential

- Title 9 CCR 3300 requires CA Counties to provide a Community Program Planning Process (CPPP) for developing MHSA 3-YR Plans and Annual Updates and to ensure stakeholders have the opportunity to participate in the CPPP (referred to as CPP)
- Stakeholders must represent all populations across all 8 service areas in LAC and must represent unserved and underserved populations and their families, cultural communities reflecting their demographics and geographic locations.
- In addition to the CPP, stakeholders provide DMH with feedback on nonMHSA funded programs and services to ensure community feedback on all programs and services across the system

## Meaningful Stakeholder Involvement is Essential

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“Meaningful” stakeholder involvement should be reflected in mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocation.”

## Stakeholder Engagement is Essential

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MHSA funded initiatives should engage:

- Families of Children, Adults, and Seniors with serious mental illness or severe emotional disturbance
- Providers of Mental Health Services
- Law Enforcement agencies
- Education and Social Services agencies
- Veterans and representatives from Veterans organizations
- Providers of alcohol and drug services
- Health Care organizations
- Other important interests

## Stakeholder Bill of Rights

**Transformation:** We have the right to a Public Mental Health System (PMHS) that embraces the Recovery Model of Care and is fully committed to all General Standards for programs and services set forth by the MHSA

**Information:** We have the right to full transparency in our PMHS

**Education:** We have the right to fully understand the meaning and implications of facts and data relevant to our PMHS

**Representation:** We have the right to competent and adequate representation when important decisions are made in our PMHS

**Participation:** We have the right to shape policy and meaningfully participate in all important programming and funding decisions in our PMHS

**Consideration:** We have the right to submit grievances to our PMHS, to have our grievances acknowledged, and to receive thorough and timely responses to our grievances

## MHSA Components

### CSS Community Services and Supports (CSS)

Direct mental health services and supports for children and youth, transition age youth, adults, and older adults. The largest of the 5 components.

Permanent supportive housing for clients with serious mental illness

### WET Workforce, Education and Training

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

### PEI Prevention and Early Intervention

Services to engage individuals before the development of serious mental illness or at the earliest signs of mental health struggles. The second largest of the 5 components

Statewide projects: Suicide Prevention, Student Mental Health Initiative, Stigma and Discrimination Reduction

### CFTN Capital Facilities and Technological Needs

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

### INN Innovation

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

# Community Services and Supports

**Full Service Partnership (FSP):** Community collaboration and a “whatever it takes” approach to ensure full spectrum community-based mental health service delivery to individuals from identified focal populations

**General Service Development (GSD):** Services that include programs to improve mental health services and supports for all consumers

**Planning Outreach and Engagement (POE):** Activities aimed at engaging the unserved, underserved, and inappropriately served populations

**Housing:** Partnership with the California Housing Finance Agency, CSS provides funding for permanent supportive, affordable housing for individuals with mental illnesses and their families, especially those who are homeless



# CSS Funded Programs

- **Outpatient Care Services (OCS)**
  - Transition Age Youth (TAY) Probation Camps
  - TAY Drop-In Centers
  - Integrated Care Program (ICP)
  - Service Extenders
  - Older Adult Training
- **Alternative Crisis Services (ACS)**
  - Residential and Bridging Program
  - Psychiatric Urgent Care Centers
  - Enriched Residential Services
  - Crisis Residential Treatment Programs
  - Law Enforcement Teams
- **Full Service Partnership (FSP)**
  - Adult (Integrated Mobile Health Team (IMHT), Assisted Outpatient Treatment (AOT), Homeless, and General)
  - Children (General, Wraparound and Intensive Field Capable Clinical Services (IFCCS))
- **Housing Services**
  - Interim Housing Program
  - Enriched Residential Care (ERC) Program
  - Housing Assistance Program (HAP)
  - Housing for Mental Health
  - Federal Housing Subsidies Program
- **Linkage to County-Operated Functions/Programs (Linkage)**
  - Mental Health Court Linkage Program
  - Jail Transition and Linkage Services
  - Service Area Navigation
- **Planning, Outreach, and Engagement Services (POE).**
  - Underserved Cultural Communities Unit (UsCC)
  - Service Area Outreach Teams

# Prevention and Early Intervention

**Prevention:** Proactive approach that targets those with risk factors or increases protection factors

**Stigma and Discrimination Reduction (SDR):** Training, campaigns and activities to reduce and eliminate barriers that prevent people from accessing mental health services. Services feature anti-stigma education specifically targeting underrepresented communities through outreach utilizing culturally sensitive tools; connecting and linking resources to schools, families, and community agencies; and educating and empowering clients and families

**Suicide Prevention:** Services and training to strengthen the capacity of existing community resources and creating new collaborative and comprehensive efforts at the individual, family, and community level. Services include: community outreach and education to identify suicide risks and protective factors; linking services, including access to trained suicide hotline agents, to individuals contemplating, threatening, or attempting suicide

**Early Intervention:** Of individuals and families for whom a short, relatively low-intensity intervention is appropriate to resolve or improve mental health issues and avoid the need for higher levels of care



## PEI Funded Programs

- Library Child, Family and Community Prevention Programs
- My Health LA Behavioral Health Expansion Program
- Prevent Homelessness Promote Health (PH2)
- SEEDS Trauma-Informed Care for Infants & Toddlers
- Veterans Peer Access Network (VPAN)
- Mental Health First Aid (MHFA)
- Mental Health Promoters
- Latina Youth Program
- 24/7 Crisis Hotline
- School Threat Assessment Response Team (START)
- Youth Diversion and Development (YDD)

## Innovation (INN)

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Up to 5 percent of MHSAs funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

An Innovation project must have one of the following primary purposes:

- Increase access to mental health services to underserved groups
- Increase the quality of mental health services, including measurable outcomes
- Promote interagency and community collaboration related to mental health services or supports or outcomes
- Increase access to mental health services

## Workforce Education and Training (WET)

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WET supports programs designed to address the fundamental concepts of creating and supporting a workforce (present and future) that is culturally competent, provides consumer/family centered mental health services and adheres to the principles of wellness, recovery, and resilience.

This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

## WET Funded Programs

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- UCLA and Charles Drew Affiliation
- Training and Technical Assistance
- Navigator Skill Development Program
- Licensure Preparation Program
- Intensive Mental Health Core Training Program
- Peer Specialist/ Parent Partner Training
- Financial Incentive Programs
- Stipend Program for Psychologists, MSWs, MFTs, and NPs

## Capital Facilities and Technological Needs

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CFTN's objective is to increase and improve existing capital facilities infrastructure and support technology projects to accommodate the implementation of MHSA plans.

This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.



## Capital Facilities Needs Projects

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- Funding is used for land and building acquisitions
- Construction of mental health service facilities and administrative space
- Renovation and expansion of existing County-owned facilities which require modernization and transformation to provide an environment for clients and families

## Technological Needs Projects

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- IBHS
- Contract Provider Technology Projects
- Consumer/Family Access to Computer Resources
- Personal Health Record Awareness and Education
- Data Warehouse Re-design
- Virtual Care: Tele-Psychiatry

## MHSA Key Findings

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- ✓ The Los Angeles County Department of Mental Health has used funding from California’s Mental Health Services Act to offer mental health and support services to at-risk populations.
- ✓ The mental health programs evaluated provided services to vulnerable and diverse individuals across the county.
- ✓ Prevention and Early Intervention programs for youth were associated with staying well and improvement in mental health outcomes.
- ✓ Full-Service Partnership programs, which focus on doing “whatever it takes” to improve the lives of those with serious mental illness, were associated with improvements in life circumstances and health

## MHSA Reporting

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### THREE YEAR PROGRAM AND EXPENDITURE PLAN AND THE ANNUAL UPDATE

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.

## MHSA Oversight

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### State Department of Mental Health

- The former SDMH was responsible for planning the sequential phases of development for the five MHSA components and overseeing county implementation of MHSA

### State Department of Health Care Services (DHCS)

- DHCS is primarily responsible for overseeing local mental health agencies' spending of MHSA funds.
- DHCS contracts with each county for the following components: PEI programs; Children's services; and Adult services

### Mental Health Services Oversight and Accountability Commission (OAC)

- The OAC oversees MHSA implementation; develops strategies to overcome stigma; reviews and approves innovation's projects; and provides technical assistance and training to counties, providers, and stakeholders.

## Additional Resources

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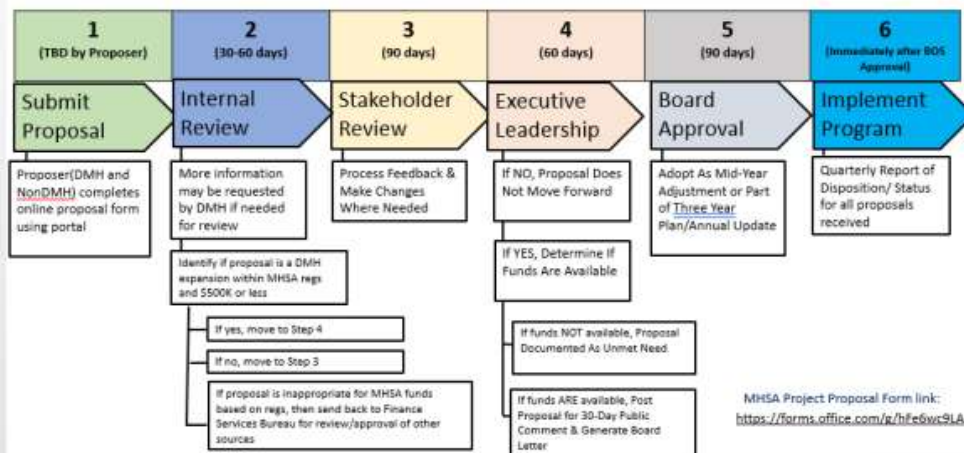
- [MHSA Announcements - Department of Mental Health \(lacounty.gov\)](https://www.lacounty.gov/mhsa)
- [Mental Health Services Act \(MHSA\) \(ca.gov\)](https://www.ca.gov/legislation/act.aspx?act=11300)
- [MHSA Publication and Resources](#)

# Proposing New or Expansion of Existing MHSA Programs and Services

- Stakeholders, DMH directly operated and contracted services providers can propose new programs or services or expansion of existing programs and services;
- Proposals must be submitted electronically at <https://forms.office.com/g/hFe6wc9LA2>
- Proposals will be reviewed based on the Proposal Review Process and associated timeline
- A quarterly report will be published to confirm the status of proposals submitted.

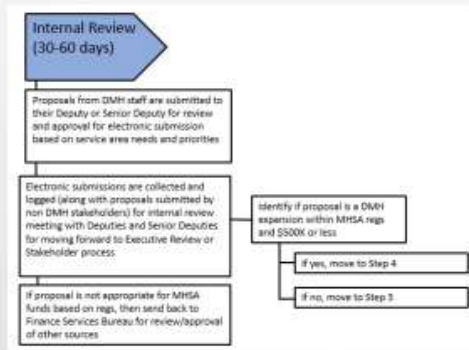
## Process for Proposing MHSA Projects

Step 1

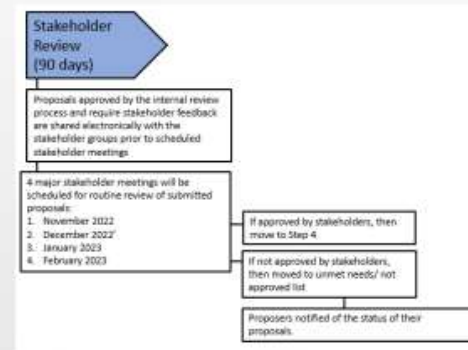


# Process for Proposing MHSA Projects

## STEP 2



## STEP 3



# MHSA Issue Resolution Process

The Los Angeles County Department of Mental Health is committed to resolving issues related to the implementation and ongoing operations of its programs. The resolution of issues associated with MHSA-funded programs is part of the Department's overall issue resolution process.

We strive to address and resolve issues as quickly as possible, with an emphasis on increasing service quality. If an MHSA planning, implementation, or operations issue cannot be resolved by the MHSA Issue Resolution & Oversight Division, it will be reviewed by the Department's appointed Community Leadership Team (CLT).

# MHSA Issue Resolution Process

## TYPES OF MHSA ISSUES THAT MAY BE RESOLVED THROUGH THIS PROCESS:

- Concerns about access or quality of MHSA programs and services
- Inconsistencies between the approved MHSA Plan and implementation
- County MHSA Planning Process

## WHAT TO EXPECT WHEN FILING AN ISSUE

1. The MHSA Administration & Oversight Division will investigate the issue and try to resolve it.
2. If the issue is resolved, the Issue Filer will receive a notification of resolution in writing.
3. If the issue cannot be resolved by the MHSA Administration & Oversight Division, the issue will be referred to the CLT for further review.
4. If the issue was resolved by the CLT, the Issue Filer will receive a notification of resolution in writing.
5. If the CLT did not resolve the issue, the Issue Filer will receive a notification of resolution in writing and he/she may appeal to the State.

# MHSA Issue Resolution Process

## To file an issue using the MHSA Issue Resolution process, you can:

- **File electronically by clicking on the link:** [MHSA Issue Resolution Form](#)
- **Type in the URL:**  
<https://forms.office.com/pages/responsepage.aspx?id=SHJZBzjqG0WKvqY47dusgV9p7rKgDu5CmdNEEMqM9uVURDdJSzdESTA3QkRWTE00MFU3NjkzWUFDNi4u&web=1&wdLOR=c2D85291E-11A5-492D-BDF2-60EE147D560B>
- **File in-person:** 510 South Vermont Avenue, 1<sup>st</sup> Floor, Los Angeles, CA 90020
- **For clients receiving mental health services including Medi-Cal Beneficiaries:** Contact the Patients' Rights Office with the Los Angeles County Department of Mental Health at the following (213) 738-4888 or [dmh.lacounty.gov/our-services/patients-rights](http://dmh.lacounty.gov/our-services/patients-rights)

For more info, contact Darlesh Horn, DPA, Division Chief, at [Dhorn@dmh.lacounty.gov](mailto:Dhorn@dmh.lacounty.gov) or at (213) 943-8475

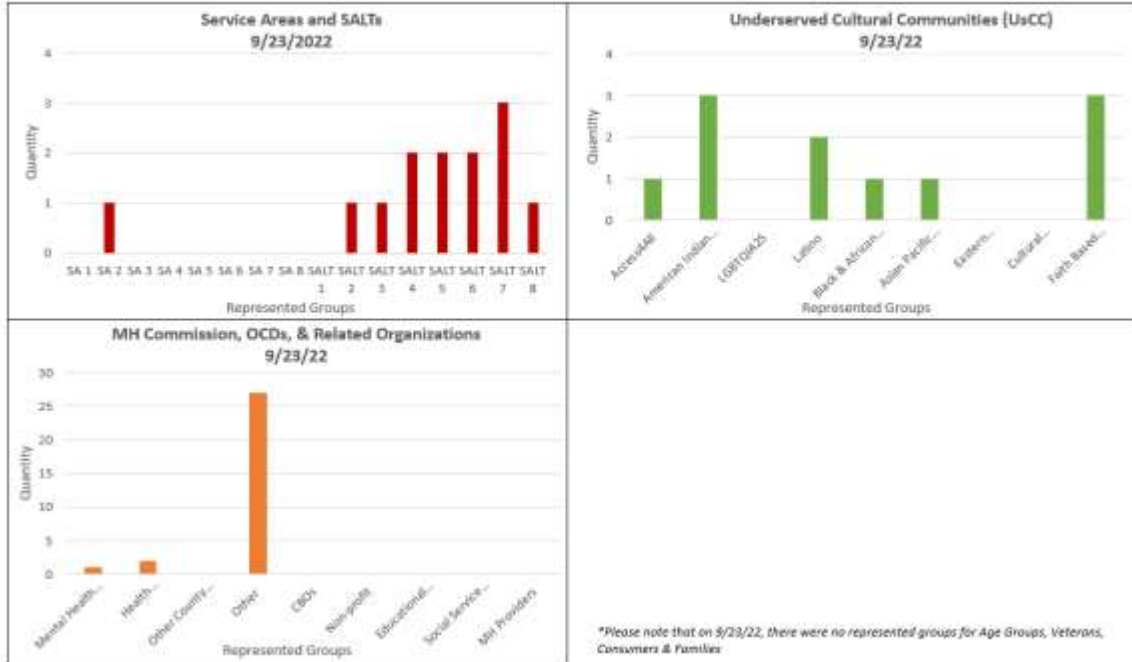
# MHSA 101

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## Questions

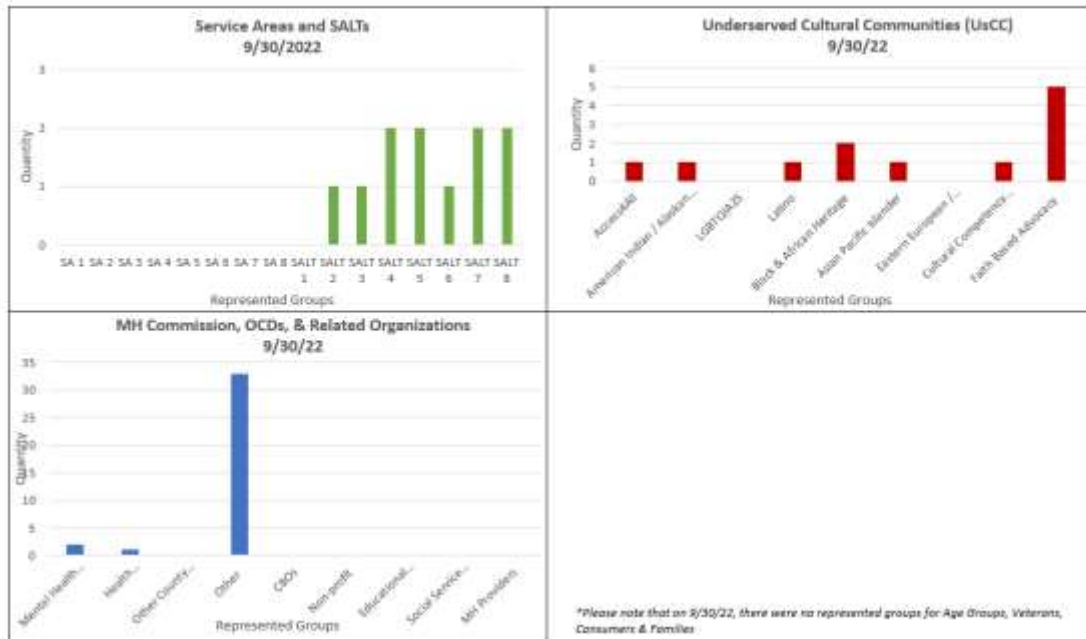
**Appendix C – Stakeholder Meeting Participation by Date: September 2022 through March 2023**

**MHSA STAKEHOLDER EVENT DEMOGRAPHICS – September 23, 2022**

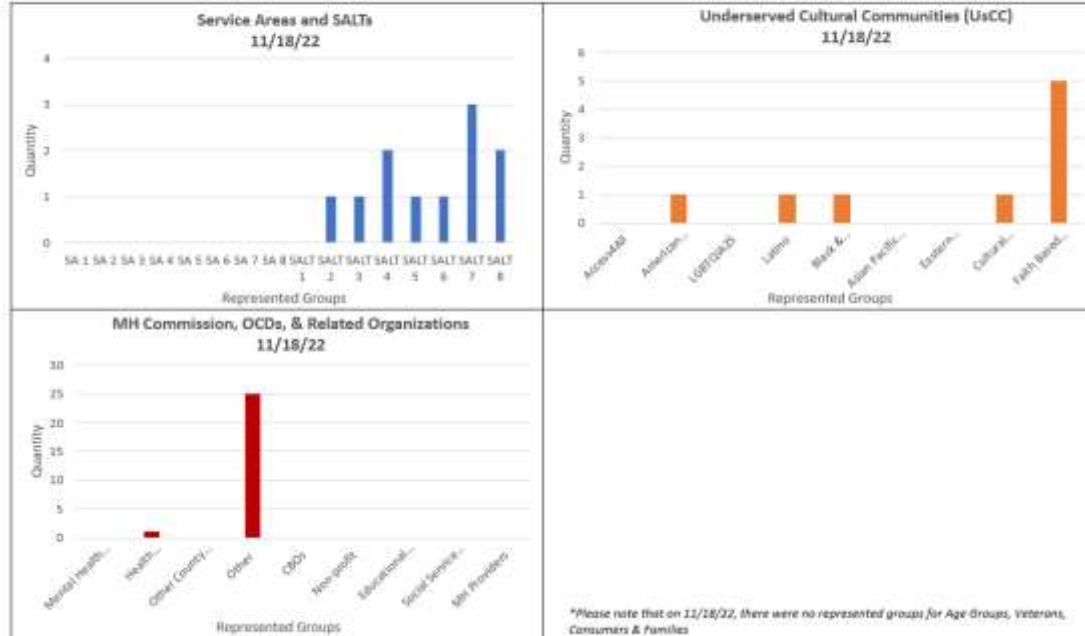




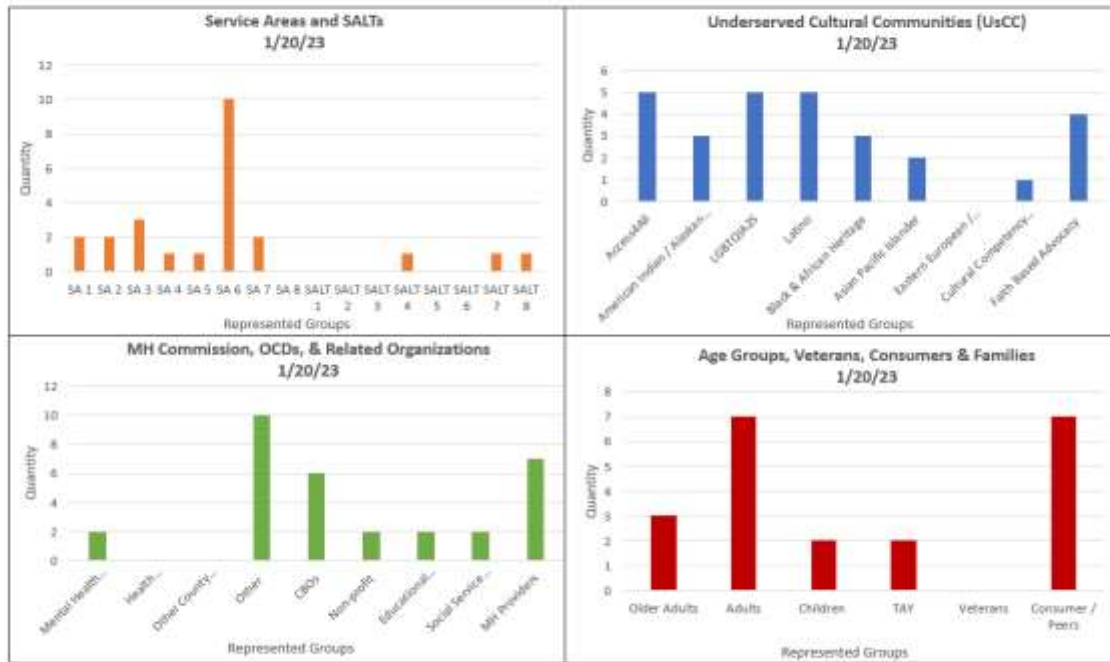
## MHSA STAKEHOLDER EVENT DEMOGRAPHICS – September 30, 2022



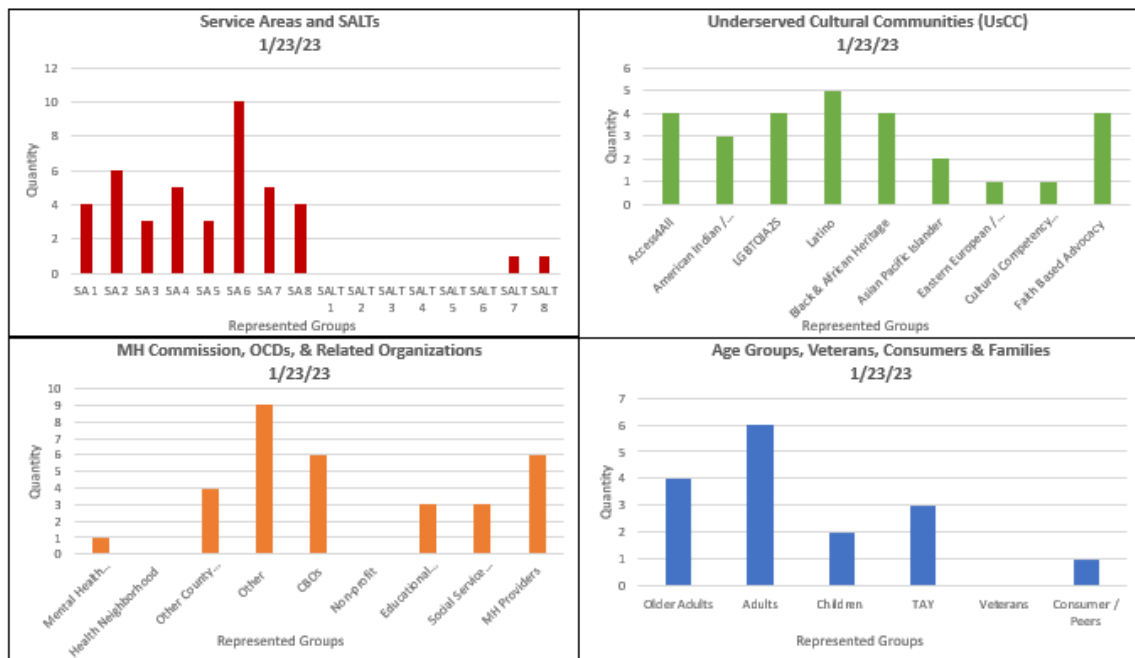
## MHSA STAKEHOLDER EVENT DEMOGRAPHICS – November 18, 2022



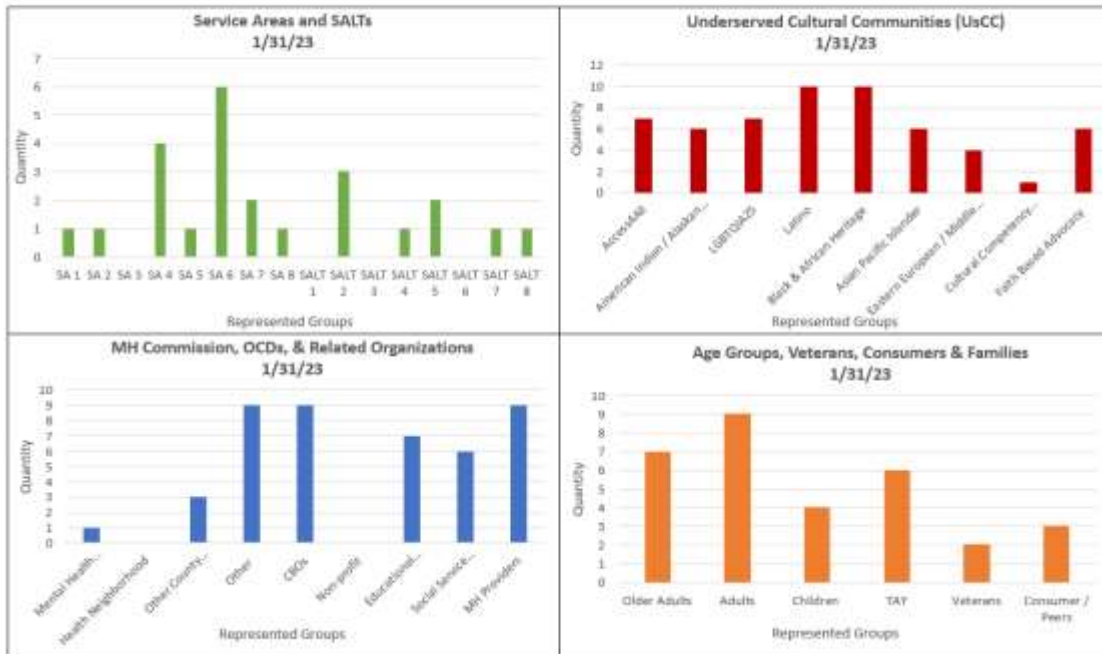
## MHSA STAKEHOLDER EVENT DEMOGRAPHICS – JANUARY 20, 2023



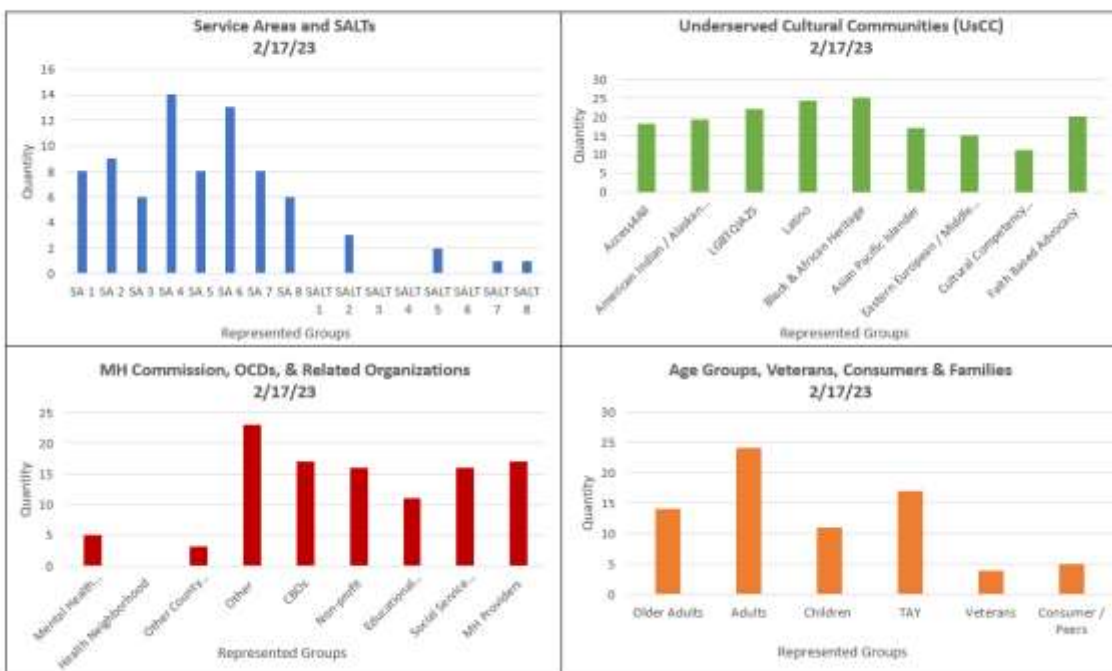
## MHSA STAKEHOLDER EVENT DEMOGRAPHICS – JANUARY 23, 2023



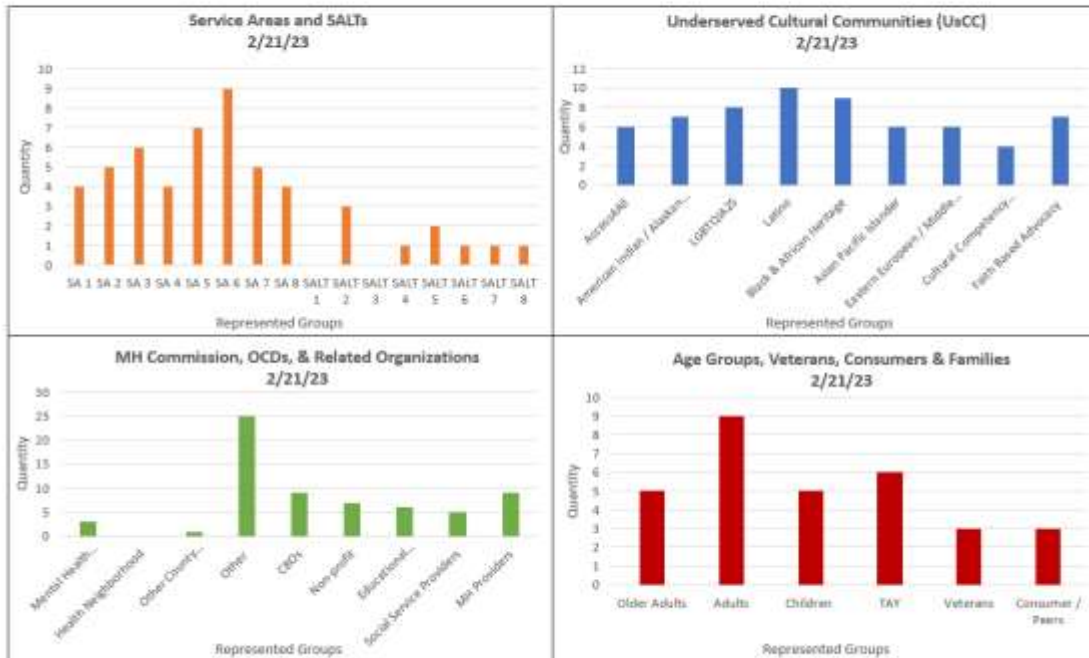
## MHSA STAKEHOLDER EVENT DEMOGRAPHICS – JANUARY 31, 2023



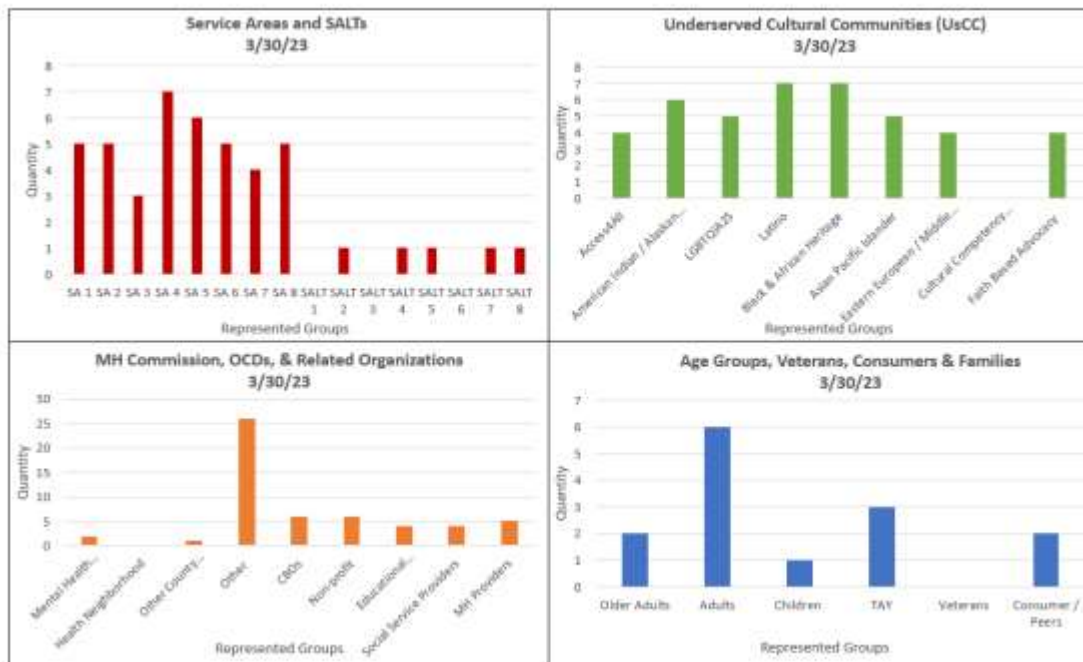
## MHSA STAKEHOLDER EVENT DEMOGRAPHICS – February 17, 2023



## MHSA STAKEHOLDER EVENT DEMOGRAPHICS – February 21, 2023



## MHSA STAKEHOLDER EVENT DEMOGRAPHICS – March 30, 2023



**Appendix D – Public Hearing Presentation and Transcripts, April 27, 2013  
Public Hearing Agenda (English)**

**MENTAL HEALTH COMMISSION (MHC) REGULAR MEETING  
COUNTY OF LOS ANGELES, CALIFORNIA  
"Advocacy, Accountability and Oversight in Action"  
Thursday, April 27, 2023, @ 10:30 a.m.**

**IMPORTANT PUBLIC NOTICE**

Hybrid Meeting

Members of the public can attend the MHC meetings in multiple ways:

Attend virtually: [MS Teams Link](#)  
or scan the QR Code below



Or join the MHC in-person (Voluntary registration requested for in-person attendance, click [HERE](#) to register): 510 South Vermont Ave., 9<sup>th</sup> floor (T) Level Conference Room, Los Angeles 90020.

Free validated parking is available at:  
[523 Shatto Place, Los Angeles, CA 90020](#). When entering structure, take a parking ticket and bring it with you to the meeting. Security will validate your ticket.

Other access options:

To listen only via telephone in Spanish	To listen only via telephone in Korean	For Live Closed Captioning (CART)	For American Sign Language (ASL)
Please call 1-888-204-5987 enter access code when prompted: Participant Access Code 9639884	한국어로 전화로만 들으려면 전화하여 메시지가 표시되면 엑세스 코드를 입력합니다. 참가자 액세스 코드 6699393	Click <a href="#">HERE</a>	Click <a href="#">HERE</a>

Members of the public can address the MHC during the live meeting by attending in-person (see location above), by phone, by email, or by regular mail.

**Instructions:**

1. **Telephonic Public Comment Instructions:**  
During the live event, the Commission Chair will make the announcement for public comment, at that time, please call (844) 291-6362 and enter Participant Code: 4972277. Press 1 and then 0 to address the Commission. Do not repeat. Repeating removes you from the queue. You may provide your name to the moderator, but you are not required to do so. Public comment is limited to 2 minutes per caller.
2. **Electronic Mail (Email) Written Public Comment:** Email public comment may be submitted to the Commission via email at [mhccommission@dmh.lacounty.gov](mailto:mhccommission@dmh.lacounty.gov) prior to or by the date of the meeting.
3. **Regular Mail Written Public Comment:** Regular mail public comment may be submitted to the Commission by regular mail by prior to or by the date of the meeting to the following address:  
Attention: Los Angeles County Mental Health Commission, Vermont Corridor Headquarters, 510 S. Vermont Avenue, (22-111), Los Angeles, CA 90020.

Address: 510 South Vermont Avenue, Los Angeles, CA 90020

E-mail: [MHCCommission@dmh.lacounty.gov](mailto:MHCCommission@dmh.lacounty.gov) Website: <http://dmh.lacounty.gov/about/mental-health-commission/>

If you need accommodations beyond what is listed above, please contact the MHC support staff at (213) 947-6487 or (213) 947-6628 at least 3 days before the meeting to request additional accommodations. You can also submit this request by email to [mhcommission@dmh.lacounty.gov](mailto:mhcommission@dmh.lacounty.gov).

AGENDA POSTED: April 20, 2023

**(AGENDA ON PAGE 3)**

Address: 510 South Vermont Avenue, Los Angeles, CA 90020  
E-mail: [MHCcommission@dmh.lacounty.gov](mailto:MHCcommission@dmh.lacounty.gov) Website: <http://dmh.lacounty.gov/about/mental-health-commission/>



Agenda published April 20, 2023, at  
<https://dmh.lacounty.gov/event/mhc-full-commission-meeting-apr-27-2023/>

**MENTAL HEALTH COMMISSION (MHC) REGULAR MEETING**  
 "Advocacy, Accountability and Oversight in Action"  
**Thursday, April 27, 2023, @ 10:30 a.m.**  
**Public Access:**  
**In-person Location (Voluntary registration requested):** 510 South Vermont Avenue, 9<sup>th</sup> Floor (T) Level Conference Room, Los Angeles, CA 90020.  
**Attend virtually:** [MS Teams Link](#)  
*Kathleen Austria, Chair, Second District*

**Commissioners by District**

**First District**  
 Susan Friedman  
 Imelda Padilla-Frausto  
 Bennett W. Root, Jr.

**Second District**  
 Kathleen Austria  
 Jack Barbour  
 Reba Stevens

**Third District**  
 Teresa Banko  
 Stacy Dagleish  
 Vacant

**Fourth District**  
 Michael Molina  
 Marilyn Sanabria  
 Vacant

**Fifth District**  
 Judy Cooperberg  
 Lawrence Schallert  
 Brittney Weissman

Kyla Coates,  
 BOS Representative, Fourth  
 District

**1. Welcome & Call to Order– Chair Austria**

**2. Roll Call – Commission Staff**

**NOTE:** To allow sufficient time for the MHSA Annual Updates Plan Public Hearing, all committee/ad hoc group proposals/updates, commission updates, stakeholder group reports, and standing items have been deferred to the May 11, 2023, Executive Committee meeting for consideration for the May 25, 2023, MHC regular meeting.

**3. Updates/Action Items**

- a. **Administrative**
  - i. Approval of Minutes - February 23, 2023
  - ii. Approval of Minutes - March 23, 2023
- b. **Election of Executive Committee Officers Update**

**4. Presentations/Reports:**

- a. **MHSA Annual Updates Plan**

To review/download the entire MHSA Annual Update, please click on the links below:

- MHSA Annual Update FY 2023-2024 [English](#) / [Spanish](#)

**5. MHSA Public Hearing:**

- a. **Telephonic Public Comment:** Please call the Public Comment Line at 1-844-291-6362, enter conference code 9271524. (2 min per caller).
- b. **In-Person:** Please form a line and wait to be called upon to speak and address the MHC and MHSA group.

**Adjourn**

Address: 510 South Vermont Avenue, Los Angeles, CA 90020

E-mail: [MHCCommission@dmh.lacounty.gov](mailto:MHCCommission@dmh.lacounty.gov) Website: <http://dmh.lacounty.gov/about/mental-health-commission/>

## Public Hearing Agenda (Spanish)

**REUNION ORDINARIA DE LA COMISION DE SALUD MENTAL (MHC)  
CONDADO DE LOS ANGELES, CALIFORNIA  
"Promoción, rendición de cuentas y supervisión en acción"  
Jueves 27 de abril de 2023, @ 10:30 am**

### AVISO PÚBLICO IMPORTANTE

Reunión híbrida

Los miembros del público pueden asistir a las reuniones del MHC de múltiples maneras:

Asistir virtualmente: [MS Teams Link](#)  
o escanee el código QR a continuación



O únase al MHC en persona (Se solicita inscripción voluntaria para asistencia en persona, haga clic [AQUI](#) para registrarse): 510 South Vermont Ave., 9<sup>th</sup> floor (T) Level Conference Room, Los Angeles 90020.

Hay estacionamiento gratuito disponible en:  
[523 Shatto Place, Los Angeles, CA 90020](#). Al ingresar a la estructura, tome un boleto de estacionamiento y tráigalo con usted a la reunión. La seguridad validará su boleto.

#### Otras opciones de acceso:

Escuchar solo por teléfono en español	Escuchar solo por teléfono en coreano	Para subtítulos en vivo (CART)	Para el lenguaje de señas americano (ASL)
Llame al 1-888-204-5987 e ingrese el código de acceso cuando se le solicite: Código de acceso del participante 9639884	한국어로 전화로만 들으려면 1-888-204-5987 866-434-5269로 전화하여 메시지가 표시되면 액세스 코드를 입력합니다. 참가자 액세스 코드 6699393	Haga clic <a href="#">AQUI</a>	Haga clic <a href="#">AQUI</a>

Los miembros del público pueden dirigirse al MHC durante la reunión en vivo asistiendo en persona (ver ubicación arriba), por teléfono, por correo electrónico o por correo postal.

#### Instrucciones:

1. **Instrucciones telefónicas para comentarios públicos:** Durante el evento en vivo, el Presidente de la Comisión hará el anuncio para comentarios públicos, en ese momento, llame al (844) 291-6362 e ingrese el Código del participante: 4972277. Pulse 1 y, a continuación, 0 para dirigirse a la Comisión. No repetir. La repetición le quita de la cola. Puede proporcionar su nombre al moderador, pero no está obligado a hacerlo. Los comentarios públicos están limitados a 2 minutos por persona que llama.
2. **Comentario público escrito por correo electrónico:** El comentario público por correo electrónico puede enviarse a la Comisión por correo electrónico a [mhcommission@dmh.lacounty.gov](mailto:mhcommission@dmh.lacounty.gov) antes o antes de la fecha de la reunión.
3. **Comentario público escrito por correo regular:** Los comentarios públicos por correo regular pueden enviarse a la Comisión por correo regular antes o antes de la fecha de la reunión a la siguiente dirección: Atención: Comisión de Salud Mental del Condado de Los Angeles, sede del corredor de Vermont, 510 S. Vermont Avenue, (22-111), Los Angeles, CA 90020.

Dirección: 510 South Vermont Avenue, Los Angeles, CA 90020

Correo electrónico: [MHCCommission@dmh.lacounty.gov](mailto:MHCCommission@dmh.lacounty.gov) Sitio web: <http://dmh.lacounty.gov/about/mental-Salud-comision/>



Si necesita adaptaciones más allá de lo mencionado anteriormente, comuníquese con el personal de apoyo de MHC al (213) 947-6487 o al (213) 947-6628 al menos 3 días antes de la reunión para solicitar adaptaciones adicionales. También puede enviar esta solicitud por correo electrónico a [mhcommission@dmh.lacounty.gov](mailto:mhcommission@dmh.lacounty.gov).

AGENDA PUBLICADA: Abril 20, 2023

**(ORDEN DEL DÍA EN LA PÁGINA 3)**

Dirección: 510 South Vermont Avenue, Los Angeles, CA 90020

Correo electrónico: [MHCCommission@dmh.lacounty.gov](mailto:MHCCommission@dmh.lacounty.gov) Sitio web: <http://dmh.lacounty.gov/about/mental-Salud-comisión/>



Agenda publicada el 20 de abril de 2023, a las  
<https://dmh.lacounty.gov/event/mhc-full-commission-meeting-apr-27-2023/>

**REUNIÓN ORDINARIA DE LA COMISIÓN DE SALUD MENTAL (MHC)**

"Promoción, rendición de cuentas y supervisión en acción"

Jueves 27 de abril de 2023, @ 10:30 am

Acceso público:

Ubicación en persona (se solicita inscripción voluntaria): 510 South Vermont Avenue, 9<sup>th</sup> Floor (T) Level Conference Room, Los Angeles, CA 90020.

Asistir virtualmente: [MS Teams Link](#)

*Kathleen Austria, Presidenta, Segundo Distrito*

**Comisionados por distrito**

**Primer Distrito**  
 Susan Friedman  
 Imelda Padilla-Frausto  
 Bennett W. Root, Jr.

**Segundo Distrito**  
 Kathleen Austria  
 Jack Barbour  
 Reba Stevens

**Tercer Distrito**  
 Banco Teresa  
 Stacy Dagleish  
 Vacante

**Cuarto Distrito**  
 Michael Molina  
 Marilyn Sanabria  
 Vacante

**Quinto Distrito**  
 Judy Cooperberg  
 Lawrence Schallert  
 Brittney Weissman

Kyla Coates,  
 Representante de BOS, Cuarto Distrito

**1. Bienvenido y llamada al orden – Presidente Austria**

**2. Pase de lista – Personal de la Comisión**

NOTA: Para dar tiempo suficiente a la Audiencia Pública del Plan de Actualizaciones Anuales de MHSA, todas las propuestas/actualizaciones del comité / grupo ad hoc, las actualizaciones de la comisión, los informes del grupo de partes interesadas y los puntos permanentes se han aplazado hasta la reunión del Comité Ejecutivo del 11 de mayo de 2023 para su consideración para la reunión ordinaria del MHC del 25 de mayo de 2023.

**3. Actualizaciones/Elementos de acción**

**a. Administrativo**

- i. Aprobación del Acta - 23 de febrero de 2023
- ii. Aprobación del Acta - 23 de marzo de 2023

**b. Actualización de la elección de la Mesa del Comité Ejecutivo**

**4. Presentaciones/Informes:**

**a. Plan de actualizaciones anuales de MHSA**

Para revisar/descargar la actualización anual completa de MHSA, haga clic en los siguientes enlaces:

- Actualización anual de MHSA FY 2023-2024 [Inglés](#) / [Español](#)

**5. Audiencia pública de MHSA:**

**a. Comentario público telefónico: Llame a la Línea de comentarios públicos, 1-844-291-6362, escriba el código de conferencia 9271524. (2 min por persona que llama).**

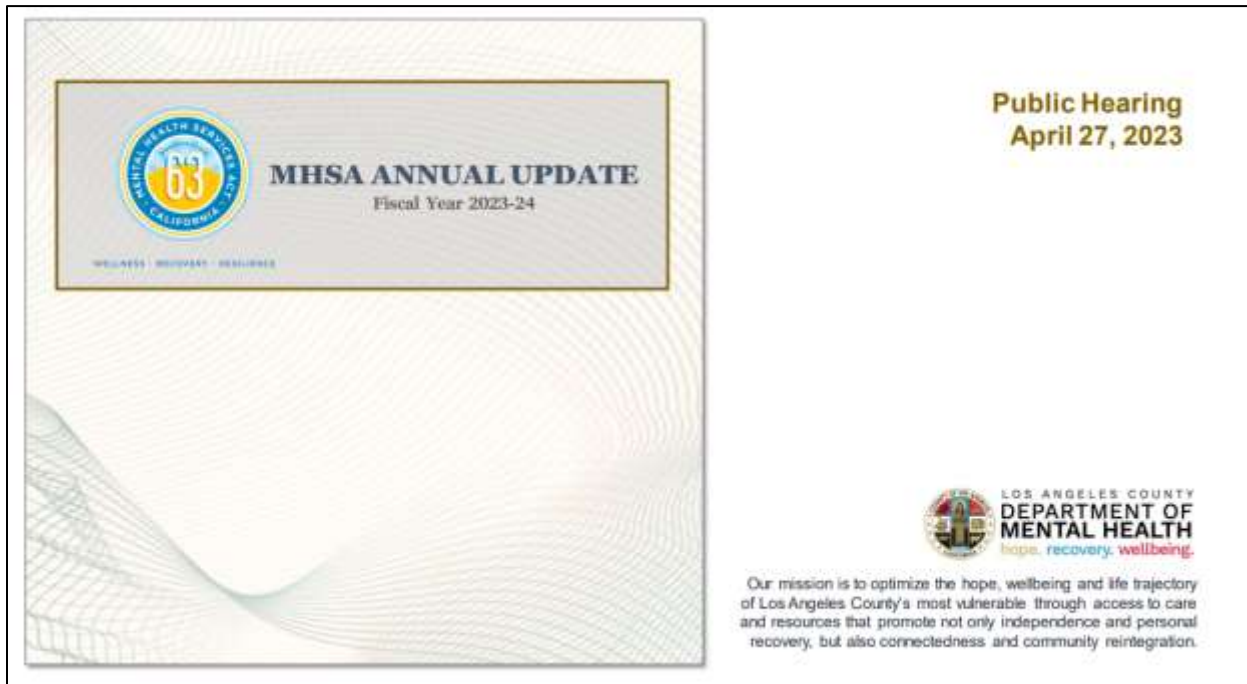
**b. En persona: Por favor, forme una fila y espere a que lo llamen para hablar y dirigirse al grupo MHC y MHSA.**

Aplazar

Dirección: 510 South Vermont Avenue, Los Angeles, CA 90020

Correo electrónico: [MHCCommission@dmh.lacounty.gov](mailto:MHCCommission@dmh.lacounty.gov) Sitio web: <http://dmh.lacounty.gov/about/mental-Salud-comisión/>

## Public Hearing PowerPoint Presentation (English)



**Public Hearing**  
**April 27, 2023**

**MHSa ANNUAL UPDATE**  
Fiscal Year 2023-24

WELLNESS | HOPEFUL | RESILIENT

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

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

### MHSa Annual Update Presentation Overview

- Purpose of the Annual Update
- Overview of MHSa Components
- MHSa Client Counts and Expenditures
- Community Planning Process
- MHSa Proposal Process
- Proposed Changes
- Next Steps and Timeline

1

## MENTAL HEALTH SERVICES ACT AND THE PURPOSE OF THE ANNUAL UPDATE



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

3

## FY 2021-22 Final Adopted Budget \$3.034 Billion Funding Sources

### Primary Funding Sources:

- 45% State and Federal Medi-Cal (\$1.36 Billion)  
Mandated specialty mental health services for eligible clients who meet medical necessity criteria for Medi-Cal
- 26% MHSA (\$801.6 Million)  
Outreach, engagement, prevention, outpatient services, housing, capital, technology, workforce enrichment, and projects for mental health innovations
- 20% Sales Tax Realignment (\$599.5 Million)  
Treatment services mainly in institutional settings, including Probation halls/camps; Short Term Residential Treatment Programs and Community Treatment Facilities for youth and locked mental health treatment beds for adults; and inpatient beds, specialty mental health services to uninsured clients and administration

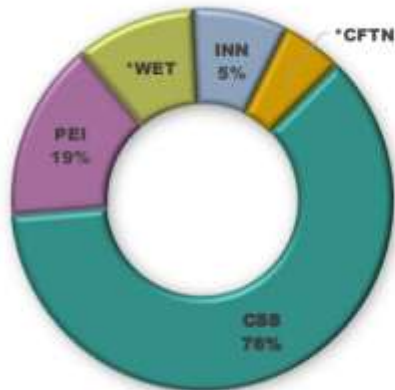


4

## MHSA OVERVIEW BY COMPONENTS



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



5

MHSA  
FY 2022-23  
BUDGET  
(millions)



6

# MHSA CLIENT COUNTS FISCAL YEAR 2021-22

## Community Service and Supports (CSS)



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

### CSS PROGRAMS:

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

### UNIQUE CLIENTS SERVED

147,143 unique clients received a direct service.

#### Ethnicity

- 36% Hispanic
- 20% African American
- 17% White
- 4% Asian/Pacific Islander
- 1% Native American

#### Primary Language

- 80% English
- 13% Spanish

### NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE

42,616 new clients were served with no previous MHSA service.

#### Ethnicity

- 37% Hispanic
- 15% African American
- 15% White
- 3% Asian/Pacific Islander
- 0.38% Native American

#### Primary Language

- 77% English
- 12% Spanish

### CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	10,969	2,852
SA2 – San Fernando Valley	21,809	5,574
SA3 – San Gabriel Valley	20,681	6,945
SA4 – Metro	29,471	8,331
SA5 – West	9,699	2,818
SA6 – South	26,269	6,159
SA7 – East	13,027	2,994
SA8 – South Bay	30,117	8,664

7

# MHSA EXPENDITURES & ESTIMATES – APRIL 2023

## Community Services and Supports (CSS)

Program	FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
Full Service Partnership	\$163,545,000	\$115,915,000	\$95,397,000
Outpatient Care Services	\$234,019,000	\$192,090,000	\$182,950,000
Alternative Crisis Services	\$132,177,000	\$138,993,000	\$132,069,000
Housing	\$69,147,000	\$45,289,000	\$40,593,000
Linkage	\$50,878,000	\$44,479,000	\$34,545,000
Planning, Outreach, and Engagement	\$16,970,000	\$4,485,000	\$6,178,000
<b>Grand Total</b>	<b>\$666,736,000</b>	<b>\$541,224,000</b>	<b>\$491,732,000</b>

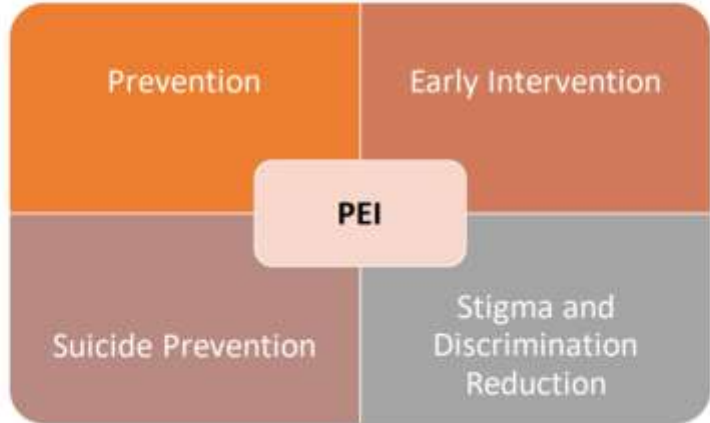
8

# PREVENTION AND EARLY INTERVENTION (PEI)

## Components



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



# PREVENTION AND EARLY INTERVENTION PROGRAMS

## Prevention Services



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.

### FISCAL YEAR 2021-22 PREVENTION SERVICES:

Community Partnership Programs	Number of Clients Surveyed
Antelope Valley Community Family Resource Centers (AV-CFRC)	83
Friends of the Children LA (FOTC-LA)	48
Incubation Academy	13,836
Los Angeles Unified School District (LAUSD)	32,841
My Health LA Behavioral Health Expansion Program	28,593
Nurse Family Partnership	149
Prevention and Aftercare	1,049
Prevent Homelessness Promote Health (PH <sup>2</sup> )	171
Veterans Peer Access Network (VPAN)	15,824
Strategies for Enhancing Early Developmental Success (SEEDS) Trauma-Informed Care for Infants & Toddlers	317

# PREVENTION AND EARLY INTERVENTION PROGRAMS

## Early Intervention Services



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.

### MHSA DIRECT SERVICE CLIENT COUNTS, FISCAL YEAR 2021-22:

UNIQUE CLIENTS SERVED	NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE	CLIENT DATA BY SERVICE AREA																											
<p><b>38,330</b> unique clients received a direct service.</p> <p><b>Ethnicity</b></p> <ul style="list-style-type: none"> <li>• 47% Hispanic</li> <li>• 8% African American</li> <li>• 9% White</li> <li>• 1% Asian/Pacific Islander</li> <li>• 0.29% Native American</li> </ul> <p><b>Primary Language</b></p> <ul style="list-style-type: none"> <li>• 76% English</li> <li>• 21% Spanish</li> </ul>	<p><b>17,084</b> new clients were served with no previous MHSA service</p> <p><b>Ethnicity</b></p> <ul style="list-style-type: none"> <li>• 42% Hispanic</li> <li>• 8% African American</li> <li>• 9% White</li> <li>• 2% Asian/Pacific Islander</li> <li>• 0.64% Native American</li> </ul> <p><b>Primary Language</b></p> <ul style="list-style-type: none"> <li>• 75% English</li> <li>• 21% Spanish</li> </ul>	<table border="1"> <thead> <tr> <th>Service Area</th> <th>Number of Clients Served</th> <th>Number of New Clients</th> </tr> </thead> <tbody> <tr> <td>SA1 – Antelope Valley</td> <td>2,006</td> <td>1,203</td> </tr> <tr> <td>SA2 – San Fernando Valley</td> <td>5,565</td> <td>2,465</td> </tr> <tr> <td>SA3 – San Gabriel Valley</td> <td>5,968</td> <td>3,225</td> </tr> <tr> <td>SA4 – Metro</td> <td>5,399</td> <td>2,997</td> </tr> <tr> <td>SA5 – West</td> <td>1,280</td> <td>739</td> </tr> <tr> <td>SA6 – South</td> <td>3,668</td> <td>1,964</td> </tr> <tr> <td>SA7 – East</td> <td>4,501</td> <td>2,303</td> </tr> <tr> <td>SA8 – South Bay</td> <td>6,202</td> <td>3,078</td> </tr> </tbody> </table>	Service Area	Number of Clients Served	Number of New Clients	SA1 – Antelope Valley	2,006	1,203	SA2 – San Fernando Valley	5,565	2,465	SA3 – San Gabriel Valley	5,968	3,225	SA4 – Metro	5,399	2,997	SA5 – West	1,280	739	SA6 – South	3,668	1,964	SA7 – East	4,501	2,303	SA8 – South Bay	6,202	3,078
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11

# PREVENTION AND EARLY INTERVENTION PROGRAMS

## Suicide Prevention



The Suicide Prevention program provides 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.

### FISCAL YEAR 2021-22 SUICIDE PREVENTION DATA AND OUTCOMES:

- 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**.
- Los Angeles County received **1,309 surveys** from its Suicide Prevention training and education services.

12



## PREVENTION AND EARLY INTERVENTION PROGRAMS Stigma and Discrimination Reduction (SDR)



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. Los Angeles County's Department of Mental Health has implemented Stigma Discrimination Reduction (SDR) programs in the form of training and education.

### FISCAL YEAR 2021-22 SDR DATA AND OUTCOMES: 16,572 SURVEYS COLLECTED

- The majority of participants agreed the training had a positive influence, with a high of 93% agreeing/strongly agreeing with the statement: "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."
- Results showed the trainings had a positive influence, with a high of 87% agreeing/strongly agreeing with the statement: "anyone can have a mental health condition"
- A high of 97% agreed/strongly agreed with the statement: "The presenters demonstrated knowledge of the subject matter."
- A high of 97% agreed/strongly agreeing with the statement: "The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.)."

13

## MHSA EXPENDITURES & ESTIMATES – APRIL 2023 Prevention and Early *Intervention* (PEI)

Program	FY 2023-24 Estimated Gross Expenditures	FY 2022-23 Estimated Gross Expenditures	FY 2021-22 Total Gross Expenditures
Early Intervention	\$106,479,000	\$34,218,000	\$28,379,000
Prevention	\$132,105,000	\$85,010,000	\$63,021,000
Stigma and Discrimination	\$81,836,000	\$21,301,000	\$6,940,000
Suicide Prevention	\$6,146,000	\$5,682,000	\$5,638,000
<b>Grand Total</b>	<b>\$326,566,000</b>	<b>\$146,211,000</b>	<b>\$103,978,000</b>

14

## COMMUNITY PLANNING PROCESS

### Stakeholder Process

#### 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 MHSAs.

#### 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 MHSAs funding requests for the Mid-Year Adjustment, the upcoming FY 2023-24 MHSAs Annual Plan update and the MHSAs Two Year Program and Expenditure Plan for FYs 2024-25 through 2025-26.

15

## COMMUNITY PLANNING PROCESS

### Stakeholder Process

#### December 2022

- LACDMH met with community stakeholders (12/22/22) and presented proposed timelines and processes for meaningful engagement and input on the review of MHSAs funding requests for the Mid-Year Adjustment

#### January 2023

- LACDMH conducted an annual MHSAs foundational training (1/2/23) to LACDMH staff, provider network staff, and community stakeholders on MHSAs policies, the Department's MHSAs funding request procedure, the MHSAs Three Year Program and Expenditure and Annual Update development and submission process and timeline, and the client resolution process.
- LACDMH conducted two community stakeholder meetings (1/23/23, 1/31/23) focused on education participants on MHSAs funding components, requirements and spending regulations.

#### 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 MHSAs Annual Update and building consensus on which proposals presented in January and February meetings would receive final stakeholder recommendation for inclusion in the Plan.

16

# COMMUNITY PLANNING PROCESS

## Stakeholder Process

### March 2023

- LACDMH delivered a Provider MHSA 101 Training (3/23/23).
- LACDMH initiated a 30-day public review and comment period for its FY 2023-24 MHSA Annual Update(3/24/23).
- LACDMH conducted a community stakeholder meeting (3/30/23)with the objective of reviewing the draft FY 2023-24 MHSA Annual Update. Stakeholders received a presentation about all items included in the Update.

### April 2023

- LACDMH 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 (Today)-The Mental Health Commission will hold a public hearing to provide feedback and recommendations for revisions, if any.

17

# COMMUNITY PLANNING PROCESS

## Stakeholder Process



### STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES:

1. **The Commission and Stakeholders requested reporting on overall system budget, recruitment, and hiring status.**
  - DMH Finance provides and will continue to provide a quarterly update on the overall budget for the entire Department, including all funding streams.  
*The last update was provided at the Stakeholder community planning meeting on 01/23/23 (see overall DMH budget on Slide 17).*
  - The Department will continue to explore strategies to provide budget expenditure by service area and supervisorial district and strategies for allocating funding based on an equity lens and unmet needs
  - Funding for all MHSA components was also reported on 01/23/23 and is reflected on Slide 18.
  - The DMH Director provides and will continue to provide a quarterly update on recruitment and hiring efforts to address the workforce shortage and collaboration with labor unions.

18

## COMMUNITY PLANNING PROCESS

### Stakeholder Process



#### STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

2. The Commission requested regular reporting, and side by side comparison of budget allocations, service utilization and trends, and funding utilization prior to, during and following the COVID pandemic. The comparison was requested to be reflected by geographic area, ethnic populations, and age group.
  - DMH has currently developed a data dashboard that provides service utilization data collected by fiscal year, geographic area, ethnic population and age groups. This data, along with budget allocation information will be used to create the side by side assessment for the pre, during and post COVID fiscal years. This data will be shared and incorporated into a community needs assessment to support the Community Planning Process with the Commission and stakeholders for the development of the upcoming Two-Year Program and Expenditure Plan.

19

## COMMUNITY PLANNING PROCESS

### Stakeholder Process



#### STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

3. The Commission and Stakeholders requested updates on data and outcomes reporting:
  - DMH has developed a data dashboard that provides service utilization data collected by fiscal year, geographic area, ethnic population and age groups. It will be used to review services to specific target populations, including unserved and underserved ethnic populations, primary language, and gender to address service gaps and recommend service priorities for the upcoming Two-Year Plan Community Planning Process, as requested. This dashboard will also provide a more detailed breakout of race/ethnicity data to ensure representation for unserved or underserved cultural communities.
  - DMH convened a Data Disparities Workgroup with the goal of focusing on underserved and unserved ethnic population data. Using the Anti-Racism Diversity and Inclusion (ARDI) equity mapping tool and service utilization data, this workgroup will be tasked with monitoring service equity metrics to inform program planning and monitoring for program improvements.
  - Specific to the draft Annual Update, the client count data by ethnicity on slide 7 does not balance. The reason for this is the report only reflects client counts for the top 5 ethnicities. In addition, due to client choice or intake circumstances, the ethnicity for a large group of clients is not reported either. DMH is taking steps to improve reporting of ethnicity data.
  - DMH reports on program outcomes and performance in the draft Annual Update. Program outcomes will be discussed as part of the upcoming Community Planning Process.

20

## COMMUNITY PLANNING PROCESS

### Stakeholder Process



#### STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

##### 4. The Commission and Stakeholders requested specific responses to items reflected in the draft Annual Update

- *DMH will add information on program expansion in the finalized draft of the Annual Update prior to Board review and hearing. Program expansions to be reflected in the Update are listed in this presentation. (Slides 39-40)*
- *Slide 11 on the draft Annual Update PowerPoint was reported as incorrect in the presentation to Mental Health Commission Executive Committee. The dates reflected in the slide were in fact accurate and will be reviewed during today's public hearing (4/27/23).*
- *In response to the inquiry on the expansion of Portland Identification and Early Referral (PIER) Program: The expansion adds new funding for PIER services in Service Areas 1 and 8 and increases the presence of PIER services in Service Area 6.*
- *In response to the inquiry of when Innovations proposals will be reviewed and considered for Board and State approval: Submitted Innovations proposals will undergo the review process during the upcoming Two-Year Plan Planning Process, pending available Innovations funding.*

21

## COMMUNITY PLANNING PROCESS

### Stakeholder Process



#### STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

##### 5. The Commission and Stakeholders requested responses to other questions/concerns:

- *In response to the Commission's inquiry, when will the summary/overview outlining the shift of the May Mental Health Month campaign from We Rise to Take Action be provided: The summary/overview of the shift will be reflected in the upcoming Two-Year Plan.*

22

## COMMUNITY PLANNING PROCESS

### Stakeholder Process



#### STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

##### 6. The Commission and Stakeholders requested updates on the Community Planning Process going forward:

- *The upcoming Community Planning Process will involve an expansion of stakeholder involvement to ensure greater participation of a more diverse group of stakeholders across LA County communities that is representative of peers and family members, ethnic/cultural populations, geographic areas, community based organizations, other county departments and stakeholders at large. The Community Planning Process will begin late May/early June 2023 and will begin with MHSA 101 training, stakeholder foundational training and a data and community needs assessment toward development of the Three-Year Plan.*
- *In response to the inquiry will the Mental Health Commission be considered a stakeholder group and be included earlier in the Community Planning Process and the MHSA Funding Request/Proposal submission and stakeholder process on behalf of the Board of Supervisors: Yes. The Mental Health Commission will be notified of the Community Planning Process and timelines for comment, feedback and for submission of MHSA Funding Proposal on behalf of the Board offices. The Mental Health Commission has a unique formal role as part of the Community Planning Process and holds the responsibility to ensure stakeholder voices are included in the process, while providing input in the process on behalf of the Board of Supervisors. DMH shared information with the Mental Health Commission during the Community Planning Process for the draft Annual Update in Fall 2022 in preparation for stakeholder engagement meetings. DMH will continue to share the process going forward.*

23

## COMMUNITY PLANNING PROCESS

### Stakeholder Process



#### STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

##### 7. The Commission and Stakeholders requested updates and clarification on the MHSA Funding Request/Proposal Process

Responses to inquiries regarding the MHSA Funding Request/Proposal Process are listed below:

How do stakeholders and community members submit proposals?

- *Requests/Proposal can be submitted 24 hours a day/7 days per week through the MHSA Funding Request Portal using online electronic forms. CSS, PEI, WET funding requests should be submitted using the form located at: <https://forms.office.com/q/hFe6wc9LA2>. Innovation funding requests should be submitted using the form found at <https://forms.office.com/q/77BRk5WzUe>. Both portals will be available to receive new proposals for the upcoming Two-Year Planning process from mid May 2023 through January 15, 2024.*

How are proposers notified of the review, approval or rejection status of their submissions?

- *Proposers are informed of the status of their submission via a phone call or through an email.*

Can the source of proposals be shared/released?

- *Yes. The source of proposals (e.g. CBOs, County Entities, or Community Stakeholders) can be made available upon request and are also posted publicly on the DMH MHSA page.*

24

# COMMUNITY PLANNING PROCESS

## Stakeholder Process



### STAKEHOLDER FEEDBACK THEMES, QUESTIONS AND RESPONSES (cont.):

#### 8. The Commission and Stakeholders requested updates and clarification on the MHSA Funding Request/Proposal Process

Can the amount requested by proposers be shared?

- *Yes. The amount requested for proposals was shared with stakeholders during the Community Planning Process. This information is also available upon request. Amounts requested are estimated amounts and may change upon approval and during implementation based on actual confirmed costs and funded activities included in the proposal.*

Can the information on proposed target populations and geographic areas to be served be shared?

- *Yes. This information was shared with stakeholders during Community Planning Process. Upon Board approval and prior to actual implementation, the MHSA Administration Unit will consult with proposer to confirm proposed target populations and geographic areas. An analysis of each approved proposal will be conducted to ensure equity concerns and considerations are addressed and funding allocations support unmet needs for communities countywide.*

25

## FORMAL PROCESS FOR REQUESTING MHSA FUNDING

1 MHSA Funding Request Submission	2 MHSA Admin Review (7-60 days)	3 Stakeholder Review & Recommendation (90 days)	4 DMH Executive Review & Approval (60 days)	5 Public Comment, Posting, & Hearing (30 days)	5 Board and OAC Approval (90 days)
<p>All requests for MHSA funding are submitted through the DMH portal.</p> <p>Submissions are categorized into the following three types:</p> <ul style="list-style-type: none"> <li>• A new mental health program</li> <li>• A change/expansion to an existing MHSA mental health program</li> <li>• Request for additional funding for a legal entity</li> </ul>	<p>Submissions are initially reviewed by MHSA Administration to ensure MHSA regulation compliance and to verify all critical information pertaining to target populations, outcomes, etc. has been included.</p> <p>Submissions meeting MHSA regs are queued for Stakeholder Review and those that don't are forwarded to Financial Services Bureau to determine other potential funding sources.</p>	<p>MHSA Administration approved submissions are presented to Stakeholders to collect feedback.</p> <p>Feedback is reviewed and any changes deemed necessary are made to the proposal.</p>	<p>Approved, funded submissions are included in a 30 day Public Comment Posting.</p> <p>Submissions that are approved but not funding is available for are documented as an Unmet Need</p>	<p>All DMH approved submissions are included in a draft Three Year Plan, Annual Update or Mid Year Adjustment which is posted on the MHSA public facing website for 30 days for public viewing and comment.</p> <p>Upon completion of 30 day posting, any changes based on feedback are made, and a Mental Health Commission Public Hearing is held.</p>	<p>Final draft of the Three Year Plan and Annual Update is submitted to LA County Board of Supervisors for approval.</p> <p>Upon Board approval, Three Year Plan and Annual Update is submitted to the MHSA Oversight and Accountability Commission.</p>

MHSA Project Proposal Form link:  
<https://forms.office.com/g/hf66wcRA2>  
<https://forms.office.com/g/77BRk3VzU6>

26

# PROPOSED CHANGES

## FISCAL YEAR 2023-24



Projects/concepts below were 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.

### Community Family Resource Center (CFRC)

Target Population: All Age Groups and Populations - Families

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.

### Community Schools Initiative (CSI)

Target Population: Middle school and high school youth

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.

### United Mental Health Promoters Network

Target Population: Underserved Cultural Populations

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.

27

# PROPOSED CHANGES (continued)

## FISCAL YEAR 2023-24



Projects/concepts below were 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.

### Friends of the Children (FOFC) - Los Angeles

Target Population: Children and youth under 18, starting at 4-6 years old

FOFC 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. FOFC 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.

### Medical Legal Services

Target Population: All Age Groups

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.

### Home Visitation: Deepening Connections and Enhancing Services

Target Population: Parents and Caregivers with Children 0-to-5 Years Old

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.

28



## PROPOSED CHANGES (continued)

### FISCAL YEAR 2023-24



Projects/concepts below were 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.

#### New Parent Engagement: Welcome to the Library and the World

Target Population: New Parents and Caregivers

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 through a virtual program every quarter.

#### Our SPOT Teen Program: Social Places & Opportunities for Teens After-School Program

Target Population: Children and Youth under 18

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, life-skills and positive experiences that will empower them to create bright futures for themselves.

#### We Rise Parks at Sunset

Target Population: 24 years old and below - Families

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 resources and information on mental health support including free mental well-being workshops.

29

## PROPOSED CHANGES (continued)

### FISCAL YEAR 2023-24



Projects/concepts below were 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.

#### Parks after Dark Parks at Sunset

Target Population: 24 years old and below - Families

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.

#### DPR Safe Passages: Community Engagement and Safe Passages for Youth and Communities

Target Population: Children and Youth under 18

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.

#### Triple P Parent/Caregiver Engagement

Target Population: Parents and Caregivers

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.

30

## PROPOSED CHANGES (continued)

### FISCAL YEAR 2023-24



Projects/concepts below were 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.

#### Patient Health Navigation Services

Target Population: All Age Groups

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.

#### School Readiness

Target Population: 2 to 4 Year Old (Toddlers to Preschoolers)

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.

#### Creative Wellbeing: Arts, Schools, and Resilience

Target Population: 24 years old and Caregivers

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.

31

## PROPOSED CHANGES (continued)

### FISCAL YEAR 2023-24



Projects/concepts below were 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.

#### Abundant Birth Project

Target Population: Pregnant People and Parents with Children 0-18 Months Old

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.

#### Credible Messenger Mentoring Model

Target Population: Transition Age Youth 18-25

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 mentors, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral and resource linkage.

#### Youth Development Regions

Target Population: Transition Age Youth 18-25

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 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.

32

## PROPOSED CHANGES (continued)

### FISCAL YEAR 2023-24



Projects/concepts below were 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.

#### A Local Approach to Preventing Homelessness

Target Population: Young adults exiting foster care and at risk for 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.

#### Laugh Therapy & Gratitude

Target Population: Older Adults - Latino

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 Latino Adults & Caregivers

Target Population: Older Adults - Latino

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.

33

## PROPOSED CHANGES (continued)

### FISCAL YEAR 2023-24



Projects/concepts below were 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.

#### Search to Involve Pilipino Americans (SIPA)

Target Population: Youth

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

#### K-Mental Health Awareness & K-Hotline

Target Population: All Ager Groups - Korean

Seeks to normalize mental illness and treatment in the Korean community so individuals will seek therapy and services without shame or hesitation.

#### FosterALL WPW ReParenting Program

Target Population: Adults and Children Involved with Foster Care System

FosterAll's Wisdom Path 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.

34

## PROPOSED CHANGES (continued)

### FISCAL YEAR 2023-24



Projects/concepts below were 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.

#### Cultural Reflections Newsletter

Target Population: LACDMH Consumers

Provide opportunities for peer produced mental health related content to be developed and shared throughout the County.

#### Hope & Healing: Mental Health Wellness Support to Victim Families & Relatives

Target Population: African American families who have suffered loss due to violence

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.

#### TransPower Project

Target Population: Youth Trans\* Population

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.

35

## PROPOSED CHANGES (continued)

### FISCAL YEAR 2023-24



Projects/concepts below were 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.

#### Open Arms Community Health & Service Center

Target Population: All Age Groups

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.

#### Consumer Empowerment Network

Target Population: LACDMH Consumers

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.

#### Innovation 2/Prevention and Early Intervention

Target Population: Transition Age Youth within Deaf, BIPOC, Disabled, LGBTQIA2S and Asian Pacific Islander communities

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

36

## PROPOSED CHANGES (continued)

### FISCAL YEAR 2023-24



Projects/concepts below were 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.

#### Mental Health Services for the Deaf & Hard of Hearing

Target Population: All Age Groups - 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.

#### Steven A. Cohen Military Family Clinic at VVSD, Los Angeles

Target Population: Veterans and Their Families

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.

#### DBT Expansion

Target Population: Targets Workforce for All LACDMH Consumers

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.

37

## EXPANSION

### FISCAL YEAR 2023-24



Programs below are existing MHSa programs previously approved by Stakeholders set to expand in Fiscal Year 2023-24.

#### Portland Identification and Early Referral Program (PIER)

PEI: Early Intervention

This will expand the number of sites and areas of availability of the program to SA 1 and 8, and expand services in SA 6. PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25 who are either at Clinical High Risk for psychosis or have had their first psychotic episode. Currently, referrals from ELAC STAND (UCLA), NAMI Urban LA, schools and various outpatient programs are exceeding the capacity of the current service level.

#### Homeless Outreach and Mobile Engagement (HOME)

CSS: Planning Outreach and Engagement

The HOME program provides field-based outreach, engagement, support, and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness.

The expansion will include a total of 94 full time positions, (6 new multidisciplinary teams and 1 Service Area Navigation team) will be added between FY 2022-23 and FY 2023-24. The expansion will bring a total number of 16 multidisciplinary teams Countywide and 1 Service Navigation team.

#### Crisis Residential Treatment Programs (CRTP)

CSS: Alternative Crisis Services

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.

Awarded a new legal entity contract to Bel Aire Health Services to provide services at 2 locations: Downey and Sylmar.

38

## EXPANSION (continued)

### FISCAL YEAR 2023-24



Programs below are existing MHSA programs previously approved by Stakeholders set to expand in Fiscal Year 2023-24.

#### TAY Drop-In Centers

PEI: Prevention  
CSS: Outpatient Care Services

TAY Drop-In Centers are intended as entry points to the mental health system for homeless youth or youth in unstable living situations. A total of 10 new sites will be added Countywide. Service Areas 2, 3, 4, 5, 7 and 8 will each receive one new site. Service Areas 1 and 6 will each receive two.

#### TAY Enhanced Emergency Shelter Program

CSS: Housing

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.

Additional funding was added to 5 sites.

#### Full Service Partnership (FSP)

CSS: Full Service Partnership

The expansion will add a total of 66 additional staff to FSP directly operated programs. Some of these additional items will staff two new half teams at Edelman Child and Youth and Valley Coordinated Child Services. Additional staff will help to form FSP teams at Santa Clarita Mental Health, Antelope Valley Mental Health and Arcadia Mental Health. Six FSP teams will also receive additional staff.

39

## NEXT STEPS/TIMELINE



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

### May 2023

- LACDMH will receive the Public Hearing 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 (5/15/23).
- 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.


### 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. (6/6/23)
- 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. (6/30/23)

40



## Public Hearing PowerPoint Presentation (Spanish)



**ACTUALIZACIÓN ANUAL  
DE LA MHS**  
Año Fiscal 2023-24

**Audiencia pública  
27 de abril de 2023**

LOS ANGELES COUNTY  
**DEPARTMENT OF  
MENTAL HEALTH**  
happy. recovery. wellbeing.

Nuestra misión es optimizar la esperanza, el bienestar y la trayectoria de vida de los más vulnerables en el condado de Los Angeles, permitiendo el acceso a la atención y los recursos que promueven no solo la independencia y la recuperación personal, sino también la posibilidad de lograr conectividad y una reintegración en la comunidad.

### Actualización anual de la MHS

#### Resumen de la presentación

- Objetivo de la actualización anual
- Resumen de los componentes de la MHS
- Gastos y cifras de clientes de la MHS
- Proceso de planificación comunitaria
- Proceso de la propuesta de la MHS
- Cambios propuestos
- Próximos pasos y cronograma

2



## LEY DE SERVICIOS DE SALUD MENTAL Y EL OBJETIVO DE LA ACTUALIZACIÓN ANUAL



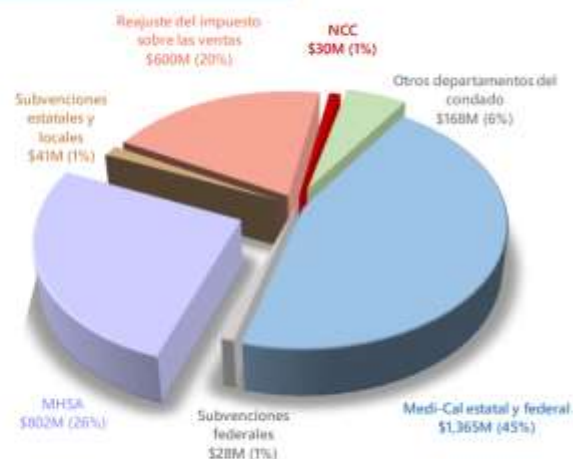
- En noviembre de 2004, los votantes de California apoyaron la Proposición 63 y aprobaron la Ley de Servicios de Salud Mental (MHSA), que impone un impuesto del 1% sobre la renta respecto de los ingresos personales mayores a \$1 millón.
- La Ley brinda una importante financiación que permite expandir, mejorar y transformar los sistemas públicos de salud mental para aumentar la calidad de vida de las personas que sufren una enfermedad mental.
- El artículo 5847 del Código Asistencial e Institucional (WIC, sus siglas en inglés) establece que los programas de salud mental del condado deben preparar y presentar un Plan de Programa de 3 Años y Gastos, seguido de Actualizaciones anuales del plan en el caso de los programas y gastos de la MHSA.
- El Plan brinda la posibilidad de que los condados:
  - Revisen los actuales programas y servicios de la MHSA para evaluar su eficacia.
  - Propongan e incorporen nuevos programas, además de los descritos en el Plan de Programa de 3 Años y Gastos de la MHSA.
- A través de este Proceso de Planificación Comunitaria se reúnen importantes comentarios de las partes interesadas.
- El 22 de junio de 2021, el Consejo de Supervisores del condado adoptó el Plan de 3 Años para el Año Fiscal 2021-2024 de la MHSA.

3

## Presupuesto final aprobado para el AF 2021-22 \$3.034 mil millones en fuentes de financiación

### Principales fuentes de financiación:

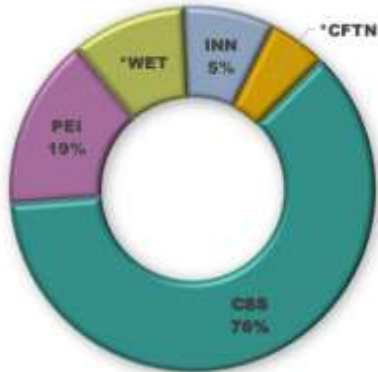
- 45% de Medi-Cal estatal y federal (\$1.36 mil millones)**  
Servicios especializados de salud mental obligatorios para los clientes que cumplan los criterios de necesidad médica de Medi-Cal.
- 26% de MHSA (\$801.6 millones)**  
Alcance, compromiso, prevención, servicios ambulatorios, vivienda, capital, tecnología, enriquecimiento de la fuerza laboral y proyectos para innovaciones en salud mental.
- Reajuste del 20% del impuesto sobre las ventas (\$599.5 millones)**  
Servicios de tratamiento principalmente en entornos institucionales, incluyendo centros y campos de libertad condicional, programas de tratamiento residencial temporal e instalaciones de tratamiento comunitario para jóvenes y camas de tratamiento de salud mental cerradas para adultos y camas de hospitalización, servicios especializados de salud mental para clientes no asegurados y administración.



4

## RESUMEN DE LA MHTA POR COMPONENTES

- A continuación se muestra el porcentaje total de adjudicaciones anuales de MHTA a los CSS, la PEI y la INN.
- \*Las adjudicaciones de la WET y las CFTN son financiadas por transferencias desde los CSS.



5

PRESUPUESTO DE LA MHTA PARA EL AF 2022-23 (en millones)



6

## CIFRAS DE CLIENTES DE LA MHSA - AÑO FISCAL 2021-22

### Servicios y Apoyos Comunitarios (CSS)



- Mayor componente de la MHSA: 76 % de las adjudicaciones de la MHSA.
- Para clientes que sufren una enfermedad mental grave diagnosticada.

#### PROGRAMAS DE CSS:

- Asociación de Servicio Completo
- Servicios de Atención Ambulatoria
- Servicios Alternativos en casos de Crisis
- Vivienda
- Vinculación
- Planificación, Alcance y Compromiso

CLIENTES ÚNICOS ATENDIDOS	NUEVOS CLIENTES SIN SERVICIO DE MHSA PREVIO	DATOS DE CLIENTES POR ÁREA DE SERVICIOS																											
<p>147,143 clientes únicos recibieron un servicio directo.</p> <p><b>Etnia</b></p> <ul style="list-style-type: none"> <li>• 36 % hispanos</li> <li>• 20 % afroamericanos</li> <li>• 17 % blancos</li> <li>• 4 % asiáticos e isleños del Pacífico</li> <li>• 1 % nativos americanos</li> </ul> <p><b>Lengua principal</b></p> <ul style="list-style-type: none"> <li>• 80 % inglés</li> <li>• 13 % español</li> </ul>	<p>42,616 nuevos clientes atendidos sin servicio de la MHSA previo.</p> <p><b>Etnia</b></p> <ul style="list-style-type: none"> <li>• 37 % hispanos</li> <li>• 15 % afroamericanos</li> <li>• 15 % blancos</li> <li>• 3 % asiáticos e isleños del Pacífico</li> <li>• 0.38% nativos americanos</li> </ul> <p><b>Lengua principal</b></p> <ul style="list-style-type: none"> <li>• 77 % inglés</li> <li>• 12 % español</li> </ul>	<table border="1"> <thead> <tr> <th>Área de servicios</th> <th>Cant. clientes atendidos</th> <th>Cant. nuevos clientes</th> </tr> </thead> <tbody> <tr> <td>SA1 – Antelope Valley</td> <td>10,969</td> <td>2,852</td> </tr> <tr> <td>SA2 – San Fernando Valley</td> <td>21,809</td> <td>5,574</td> </tr> <tr> <td>SA3 – San Gabriel Valley</td> <td>20,681</td> <td>6,945</td> </tr> <tr> <td>SA4 – Metro</td> <td>29,471</td> <td>8,331</td> </tr> <tr> <td>SA5 – West</td> <td>9,699</td> <td>2,818</td> </tr> <tr> <td>SA6 – South</td> <td>26,269</td> <td>6,159</td> </tr> <tr> <td>SA7 – East</td> <td>13,027</td> <td>2,994</td> </tr> <tr> <td>SA8 – South Bay</td> <td>30,117</td> <td>8,664</td> </tr> </tbody> </table>	Área de servicios	Cant. clientes atendidos	Cant. nuevos clientes	SA1 – Antelope Valley	10,969	2,852	SA2 – San Fernando Valley	21,809	5,574	SA3 – San Gabriel Valley	20,681	6,945	SA4 – Metro	29,471	8,331	SA5 – West	9,699	2,818	SA6 – South	26,269	6,159	SA7 – East	13,027	2,994	SA8 – South Bay	30,117	8,664
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7

## GASTOS Y ESTIMADOS DE LA MHSA – ABRIL DE 2023

### Servicios y Apoyos Comunitarios (CSS)

Programa	Gastos brutos estimados – AF 2023-24	Gastos brutos estimados – AF 2022-23	Gastos brutos totales – AF 2021-22
Asociación de Servicio Completo	\$163,545,000	\$115,915,000	\$95,397,000
Servicios de Atención Ambulatoria	\$234,019,000	\$192,090,000	\$182,950,000
Servicios Alternativos en casos de Crisis	\$132,177,000	\$138,993,000	\$132,069,000
Vivienda	\$69,147,000	\$45,289,000	\$40,593,000
Vinculación	\$50,878,000	\$44,479,000	\$34,545,000
Planificación, Alcance y Compromiso	\$16,970,000	\$4,485,000	\$6,178,000
<b>Total general</b>	<b>\$666,736,000</b>	<b>\$541,224,000</b>	<b>\$491,732,000</b>

8

# PREVENCIÓN E INTERVENCIÓN TEMPRANA (PEI)

## Componentes



- Segundo componente más importante de la MHSA, con el 19% de la asignación total de la MHSA.
- Se basa en proporcionar estrategias preventivas y de intervención temprana, educación, apoyo y llegada a las personas en riesgo de desarrollar enfermedades mentales o que experimentan síntomas en una fase temprana.



9

# PROGRAMAS DE PREVENCIÓN E INTERVENCIÓN TEMPRANA

## Servicios de prevención



Las actividades y servicios de prevención están orientados a abordar, a través de la concienciación, la educación, la formación, la divulgación y la orientación, los factores de riesgo asociados con la aparición de enfermedades mentales o trastornos emocionales, haciendo especial énfasis en la mejora de los factores de protección, como la conexión social y el apoyo.

### SERVICIOS DE PREVENCIÓN PARA EL AÑO FISCAL 2021-22:

Programas de asociación comunitaria	Cantidad de clientes encuestados
Antelope Valley Community Family Resource Centers (AV-CFRC)	83
Friends of the Children LA (FOTC-LA)	48
Incubation Academy	13,836
Los Angeles Unified School District (LAUSD)	32,841
Programa de extensión de salud conductual My Health LA	28,593
Asociación enfermero-familiar	149
Prevención y cuidados posteriores	1,049
Prevent Homelessness Promote Health (PH2)	171
Veterans Peer Access Network (VPAN)	15,824
Strategies for Enhancing Early Development Success (SEEDS)	317
Atención basada en el trauma para lactantes y niños en edades tempranas	

10

## PROGRAMAS DE PREVENCIÓN E INTERVENCIÓN TEMPRANA

### Servicios de Intervención Temprana



Dirigido a personas y familias que necesitan una intervención a corto plazo (menos de 1 año) y de relativamente baja intensidad para mejorar considerablemente sus problemas de salud mental, evitando así la necesidad de un tratamiento de salud mental más extenso.

#### CIFRAS DE CLIENTES DE SERVICIOS DIRECTOS DE LA MSHA – AÑO FISCAL 2021-22



11

## PROGRAMAS DE PREVENCIÓN E INTERVENCIÓN TEMPRANA

### Prevención del Suicidio



El programa de Prevención del Suicidio brinda servicios a través de múltiples estrategias mediante el fortalecimiento de la capacidad de los recursos comunitarios existentes y la creación de nuevos esfuerzos de colaboración e integrales a nivel individual, familiar y comunitario.

#### DATOS Y RESULTADOS DE LA PREVENCIÓN DEL SUICIDIO PARA EL AÑO FISCAL 2021-22:

- La Línea de Crisis 24/7 para la Prevención del Suicidio respondió un total de **145,254 llamadas, chats y mensajes de texto** procedentes del condado de Los Angeles, incluyendo línea directa de asistencia en crisis en español a **13,087 personas**.
- El condado de Los Angeles recibió **1,309 encuestas** sobre sus servicios de formación y educación para la prevención del suicidio.

12

## PROGRAMAS DE PREVENCIÓN E INTERVENCIÓN TEMPRANA

### Reducción del estigma y la discriminación (SDR)



El propósito de la SDR es reducir y eliminar las barreras que impiden que las personas utilicen los servicios de salud mental priorizando la información y el conocimiento sobre los primeros signos y síntomas de las enfermedades mentales a través de estrategias centradas en el cliente, de apoyo y educación familiar y de defensa de la comunidad. El Departamento de Salud Mental del condado de Los Ángeles ha puesto en marcha programas de Reducción del Estigma y la Discriminación (SDR) a través de la formación y la educación.

#### DATOS Y RESULTADOS DE LA SDR PARA EL AÑO FISCAL 2021-22: 16,572 ENCUESTAS REALIZADAS

- La mayoría de los participantes estuvieron de acuerdo en que la formación tuvo una influencia positiva, con un 93% de acuerdo o muy de acuerdo con la afirmación: "como resultado directo de esta formación, estoy más dispuesto a buscar el apoyo de un profesional de la salud mental si creo que lo necesito".
- Los resultados mostraron que la formación tuvo una influencia positiva, con un 87% de acuerdo o muy de acuerdo con la afirmación: "cualquiera puede tener un problema de salud mental".
- El 97% estaba de acuerdo o muy de acuerdo con la afirmación: "los presentadores demostraron conocimiento del tema".
- Un 97% estuvo de acuerdo o muy de acuerdo con la afirmación: "los presentadores fueron respetuosos con mi cultura (es decir, raza, etnia, género, religión, etc.)".

13

## GASTOS Y ESTIMADOS DE LA MHSA – ABRIL DE 2023

### Prevención e Intervención Temprana (PEI)

Programa	Gastos brutos estimados – AF 2023-24	Gastos brutos estimados – AF 2022-23	Gastos brutos totales – AF 2021-22
Intervención Temprana	\$106,479,000	\$34,218,000	\$28,379,000
Prevención	\$132,105,000	\$85,010,000	\$63,021,000
Estigma y Discriminación	\$81,836,000	\$21,301,000	\$6,940,000
Prevención del Suicidio	\$6,146,000	\$5,682,000	\$5,638,000
<b>Total general</b>	<b>\$326,566,000</b>	<b>\$146,211,000</b>	<b>\$103,978,000</b>

14

## PROCESO DE PLANIFICACIÓN COMUNITARIA

### Proceso de las partes interesadas

#### Septiembre de 2022

- El LACDMH realizó un retiro de 2 días (9/23/22 y 9/30/22) para revitalizar el Proceso de planificación comunitaria y fortalecer las relaciones de colaboración con sus partes interesadas de las poblaciones más vulnerables, desatendidas, marginadas y subrepresentadas de todo el condado.
- Los asistentes tuvieron la oportunidad de examinar los anteriores procesos de compromiso y resultados de partes interesadas y reconocer qué funcionó, qué no e identificar lo que se necesita a futuro para crear y sostener una fuerte relación de colaboración para que el LACDMH ofrezca programas y servicios culturalmente pertinentes en virtud de la MHSA.

#### Noviembre de 2022

- El LACDMH se reunió con las partes interesadas (11/1/22, 11/17/22, 11/18/22) y presentó una propuesta de tiempos y procesos para lograr un compromiso y aporte importantes en la revisión de los pedidos de financiación de la MHSA para el Ajuste de mitad de año, la Actualización del Plan anual de la MHSA para el AF 2023-24 y el Plan de Programa de 2 Años y Gastos de la MHSA para los AF 2024-25 y 2025-26.

15

## PROCESO DE PLANIFICACIÓN COMUNITARIA

### Proceso de las partes interesadas

#### Diciembre de 2022

- El LACDMH se reunió con las partes interesadas de la comunidad (12/22/22) y presentó los plazos y procesos propuestos para una participación y aporte significativos en la revisión de las solicitudes de financiación de MHSA para el Ajuste de mitad de año.

#### Enero de 2023

- El LACDMH llevó a cabo una capacitación fundacional anual de la MHSA (1/2/23) para el personal de LACDMH, el personal de la red de proveedores y las partes interesadas de la comunidad sobre las políticas de la MHSA, el procedimiento de solicitud de fondos de la MHSA del Departamento, el proceso y el cronograma de desarrollo y presentación del Programa de tres años y Gastos y Actualización anual de la MHSA y el proceso de resolución de clientes.
- El LACDMH llevó a cabo dos reuniones con las partes interesadas de la comunidad (1/23/23, 1/31/23) enfocadas en la educación de los participantes sobre los requisitos, las regulaciones de gastos y los componentes de financiamiento de la MHSA.

#### Febrero de 2023

- El LACDMH llevó a cabo dos reuniones con las partes interesadas de la comunidad (2/17/23, 2/21/23) enfocadas en la revisión de las propuestas del DMH y de las partes interesadas que se considerarán para su inclusión en la Actualización anual de la MHSA del año fiscal 2023-24 y la creación de un consenso sobre qué propuestas presentadas en las reuniones de enero y febrero recibirían la recomendación final de las partes interesadas para su inclusión en el Plan.

16

## PROCESO DE PLANIFICACIÓN COMUNITARIA

### Proceso de las partes interesadas

#### Marzo de 2023

- El LACDMH realizó un Entrenamiento para proveedores de la MHSA 101 (3/23/23).
- El LACDMH dio inicio a un período de 30 días de revisión pública y comentarios para la Actualización anual de la MHSA para el AF 2023-24 (3/24/23).
- El LACDMH realizó una reunión de partes interesadas de la comunidad (3/30/23) con el objetivo de revisar el borrador de la Actualización anual de la MHSA para el AF 2023-24. Las partes interesadas recibieron una presentación sobre todos los elementos incluidos en la Actualización.

#### Abril de 2023

- El LACDMH para el 4/24/23: completar el periodo de publicación y comentarios públicos de 30 días y recopilar los comentarios enviados para incluirlos en el borrador de la Actualización anual.
- 4/27/23 (Hoy): la Comisión de Salud Mental llevará a cabo una audiencia pública para proporcionar comentarios y recomendaciones para las revisiones, si las hubiere.

17

## PROCESO DE PLANIFICACIÓN COMUNITARIA

### Proceso de las partes interesadas



#### TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS:

1. **La Comisión y las partes interesadas pidieron que se informara sobre el presupuesto global del sistema, el reclutamiento y el estado de las contrataciones.**
  - DMH Finance proporciona y continuará proporcionando una actualización trimestral del presupuesto general para todo el Departamento, incluyendo todas las fuentes de financiación.  
*La última actualización se proporcionó en la reunión de planificación comunitaria de las partes interesadas celebrada el 01/23/23 (véase el presupuesto general del DMH en la diapositiva 17).*
  - El Departamento continuará explorando estrategias para proporcionar el gasto presupuestario por área de servicios y distrito de supervisión y estrategias para asignar la financiación en base a una perspectiva de equidad y necesidades insatisfechas.
  - La financiación de todos los componentes de la MHSA también se comunicó el 01/23/23 y se refleja en la diapositiva 18.
  - El Director del DMH brinda y seguirá brindando una actualización trimestral sobre los esfuerzos de reclutamiento y contratación para abordar la escasez de mano de obra y la colaboración con los sindicatos.

18



## PROCESO DE PLANIFICACIÓN COMUNITARIA

### Proceso de las partes interesadas



#### TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

2. La Comisión solicitó la presentación de informes periódicos y la comparación directa de las asignaciones presupuestarias, la utilización y las tendencias de los servicios y la utilización de los fondos antes, durante y después de la pandemia por COVID. Se solicitó que la comparación se reflejara por zonas geográficas, poblaciones étnicas y grupos etarios.
  - El DMH ha desarrollado actualmente un panel de datos que brinda datos de utilización de servicios recopilados por año fiscal, área geográfica, población étnica y grupos etarios. Estos datos, junto con la información de asignación presupuestaria, se utilizarán para crear la evaluación directa para los años fiscales anteriores, durante y posteriores al COVID. Estos datos serán compartidos e incorporados a una evaluación de las necesidades de la comunidad para apoyar el Proceso de planificación comunitaria con la Comisión y las partes interesadas para el desarrollo del próximo Plan de Programa de 2 años y Gastos.

19

## PROCESO DE PLANIFICACIÓN COMUNITARIA

### Proceso de las partes interesadas



#### TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

3. La Comisión y las partes interesadas solicitaron información actualizada sobre datos y resultados:
  - El DMH ha desarrollado un panel de datos que proporciona datos de utilización de servicios recopilados por año fiscal, área geográfica, población étnica y grupos etarios. Se utilizará para revisar los servicios a poblaciones de interés específicas, incluyendo las poblaciones étnicas desatendidas y subatendidas, el idioma primario y el género para abordar las grietas en los servicios y recomendar prioridades de servicio para el próximo Proceso de planificación comunitaria del Plan de 2 años, según se solicite. Este tablero también proporcionará un desglose más detallado de los datos de raza /etnia para garantizar la representación de las comunidades culturales desatendidas o subatendidas.
  - El DMH convocó un Grupo de Trabajo sobre Disparidades de Datos con el objetivo de centrarse en los datos de la población étnica desatendida y subatendida. Utilizando la herramienta de mapeo de equidad Anti-Racismo, Diversidad e Inclusión (ARDI) y los datos de utilización de servicios, este grupo de trabajo tendrá la tarea de supervisar las métricas de equidad de servicios para informar la planificación de programas y la supervisión de las mejoras del programa.
  - Específicamente para el borrador de la Actualización anual, los datos de cifras de clientes por etnia en la diapositiva 7 no están equilibrados. Esto se debe a que el informe solo refleja el recuento de clientes de las 5 etnias principales. Además, debido a la elección del cliente o a las circunstancias de admisión, tampoco se informa el origen étnico de un grupo grande de clientes. El DMH está implementando medidas para mejorar la presentación de los datos étnicos.
  - El DMH informa sobre los resultados y el rendimiento del programa en el borrador de la Actualización anual. Los resultados del programa se abordarán como parte del próximo Proceso de planificación comunitaria.

20

## PROCESO DE PLANIFICACIÓN COMUNITARIA

### Proceso de las partes interesadas



#### TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

4. La Comisión y las partes interesadas solicitaron respuestas específicas a los puntos reflejados en el proyecto de actualización anual:

- *El DMH agregará información sobre la expansión del programa en el borrador finalizado de la Actualización anual antes de la revisión y audiencia del Consejo. Las expansiones de programas que se reflejarán en la Actualización se detallan en esta presentación (Diapositivas 39-40).*
- *La diapositiva 11 del borrador del PowerPoint de Actualización anual se informó como incorrecta en la presentación al Comité Ejecutivo de la Comisión de Salud Mental. Las fechas reflejadas en la diapositiva eran correctas y se revisarán durante la audiencia pública de hoy (4/27/23).*
- *En respuesta a la consulta sobre la ampliación del Programa de Identificación y Derivación Temprana de Portland (PIER): la ampliación añade nueva financiación para los servicios PIER en las Áreas de servicios 1 y 8 y aumenta la presencia de los servicios PIER en el Área de servicios 6.*
- *En respuesta a la pregunta sobre cuándo se revisarán y considerarán las propuestas de Innovaciones para su aprobación por parte del Consejo y el estado: las propuestas de Innovación presentadas se someterán al proceso de revisión durante el próximo Proceso de planificación del plan de 2 años, en función de la financiación disponible para Innovaciones.*

21

## PROCESO DE PLANIFICACIÓN COMUNITARIA

### Proceso de las partes interesadas



#### TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

5. La Comisión y las partes interesadas solicitaron respuestas a otras preguntas y preocupaciones:

- *En respuesta a la pregunta de la Comisión sobre cuándo se facilitará el resumen general que describe el cambio de la campaña del Mes de la Salud Mental de mayo de We Rise a Take Action: el resumen del cambio se reflejará en el próximo Plan de 2 años.*

22

## PROCESO DE PLANIFICACIÓN COMUNITARIA

### Proceso de las partes interesadas



#### TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

##### 6. La Comisión y las partes interesadas solicitaron información actualizada sobre el futuro Proceso de planificación comunitaria:

- *El próximo Proceso de planificación comunitaria implicará una expansión de la participación de las partes interesadas para garantizar una mayor participación de un grupo más diverso de partes interesadas de las comunidades del condado de Los Angeles que sea representativo de los pares, los familiares, las poblaciones étnicas/culturales, las áreas geográficas, las organizaciones comunitarias, otros departamentos del condado y las partes interesadas en general. El Proceso de planificación comunitaria comenzará entre fines de mayo y principios de junio de 2023 y empezará con la capacitación en MHSa 101, la capacitación básica de las partes interesadas y una evaluación de las necesidades de la comunidad y los datos para el desarrollo del Plan de 3 años.*
- *En respuesta a la pregunta: ¿se tomará en consideración a la Comisión de Salud Mental como grupo interesado y se la incluirá antes en el Proceso de planificación comunitaria y en el proceso de presentación de Solicitudes y Propuestas de Financiación de la MHSa y de grupos interesados en nombre del Consejo de Supervisores? Sí. Se notificará a la Comisión de Salud Mental sobre el Proceso de planificación comunitaria y los plazos para dejar comentarios, opiniones y para presentar una Propuesta de Financiamiento de la MHSa en nombre de las oficinas del Consejo. La Comisión de Salud Mental tiene un papel formal único como parte del Proceso de planificación comunitaria y tiene la responsabilidad de garantizar que las voces de las partes interesadas se incluyan en el proceso, mientras que brinda información en el proceso en nombre del Consejo de Supervisores. El DMH compartió información con la Comisión de Salud Mental durante el Proceso de planificación comunitaria para el borrador de la Actualización anual en el otoño de 2022, como preparación para las reuniones de participación de las partes interesadas. El DMH continuará compartiendo el proceso en el futuro.*

23

## PROCESO DE PLANIFICACIÓN COMUNITARIA

### Proceso de las partes interesadas



#### TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

##### 7. La Comisión y las partes interesadas solicitaron actualizaciones y aclaraciones sobre el Proceso de solicitud y propuestas de financiación de la MHSa.

Se incluyen las respuestas a las preguntas sobre el Proceso de solicitud/propuestas de financiación de la MHSa:

¿Cómo presentan las propuestas las partes interesadas y los miembros de la comunidad?

- *Las solicitudes/propuestas pueden presentarse 24 horas al día/7 días a la semana a través del Portal de solicitud de financiación de la MHSa utilizando los formularios electrónicos en línea. Las solicitudes de financiación de CSS, PEI y WET deben presentarse mediante el formulario que se encuentra en: <https://forms.office.com/g/hFe6wc9LA2>. Las solicitudes de financiación de Innovación deben presentarse utilizando el formulario que se encuentra en: <https://forms.office.com/g/778Rk5WzUe>. Ambos portales estarán disponibles para recibir nuevas propuestas para el próximo proceso de Planificación de 2 años desde mediados de mayo de 2023 hasta el 15 de enero de 2024.*

¿Cómo se notifica a los proponentes el estado de revisión, aprobación o rechazo de sus propuestas?

- *Se informará a los proponentes el estado de su presentación mediante una llamada telefónica o un correo electrónico.*

¿Puede compartirse o divulgarse la fuente de las propuestas?

- *Sí. La fuente de las propuestas (por ejemplo, OBC, entidades del condado o partes interesadas de la comunidad) puede facilitarse previa solicitud y también se publican en la página del DMH MHSa.*

24

# PROCESO DE PLANIFICACIÓN COMUNITARIA

## Proceso de las partes interesadas



### TEMAS, PREGUNTAS Y RESPUESTAS DE LAS PARTES INTERESADAS (continuación):

8. La Comisión y las partes interesadas solicitaron actualizaciones y aclaraciones sobre el proceso de solicitud y propuestas de financiación de la MHSA.

¿Puede compartirse el importe solicitado por los proponentes?

- *Sí. La cantidad solicitada para las propuestas se compartió con las partes interesadas durante el Proceso de planificación comunitaria. Esta información también está disponible previa solicitud. Los importes solicitados son estimados y pueden variar tras la aprobación y durante la ejecución en función de los costos reales confirmados y de las actividades financiadas que figuren en la propuesta.*

¿Puede compartirse la información sobre las poblaciones de interés propuestas y las zonas geográficas a las que se prestará servicio?

- *Sí. Esta información se compartió con las partes interesadas durante el Proceso de planificación comunitaria. Tras la aprobación del Consejo y antes de la implementación real, la Unidad de Administración de la MHSA consultará con el proponente para confirmar las poblaciones de interés y las áreas geográficas propuestas. Se realizará un análisis de cada propuesta aprobada para garantizar que se aborden las preocupaciones y consideraciones de equidad y que las asignaciones de fondos respalden las necesidades insatisfechas de las comunidades de todo el condado.*

25

## PROCESO FORMAL DE SOLICITUD DE FINANCIACIÓN DE LA MHSA

1 Presentación de solicitud de financiación de la MHSA	2 Revisión administrativa de la MHSA (7-60 días)	3 Revisión y recomendación de partes interesadas (90 días)	4 Revisión y aprobación ejecutiva del DMH (60 días)	5 Comentarios del público, publicación y audiencia (30 días)	6 Aprobación del Consejo y de la OAC (90 días)
<p>Todas las solicitudes de financiación de la MHSA se presentan a través del portal del DMH.</p> <p>Las solicitudes se clasifican en los siguientes tres tipos:</p> <ul style="list-style-type: none"> <li>• Un nuevo programa de salud mental.</li> <li>• Un cambio o ampliación de un programa actual de salud mental de la MHSA.</li> <li>• Solicitud de financiación adicional para una entidad jurídica.</li> </ul>	<p>Las presentaciones son revisadas inicialmente por la Administración de la MHSA para garantizar el cumplimiento de la normativa de la MHSA y verificar que se haya incluido toda la información crítica relativa a las poblaciones de interés, los resultados, etc.</p> <p>Las propuestas que cumplen las normas de la MHSA se someten a revisión de las partes interesadas y las que no lo hacen se remiten a la Oficina de Servicios Financieros para determinar otras posibles fuentes de financiación.</p>	<p>Las propuestas aprobadas por la Administración de la MHSA se presentan a las partes interesadas para brindar sus comentarios.</p> <p>Se revisan los comentarios y se introducen en la propuesta los cambios que se consideren necesarios.</p>	<p>Las propuestas aprobadas y financiadas se incluyen en un anuncio público de 30 días.</p> <p>Las propuestas aprobadas, pero para las que no se dispone de financiación se documentan como una Necesidad insatisfecha.</p>	<p>Todas las presentaciones aprobadas por el DMH se incluyen en un borrador del Plan de 3 años, la Actualización anual o el Ajuste de mitad de año que se publica en el sitio web público de la MHSA durante 30 días para que el público lo vea y haga comentarios.</p> <p>Una vez transcurridos los 30 días de publicación, se realizan los cambios necesarios en función de los comentarios recibidos y se celebra una Audiencia pública de la Comisión de Salud Mental.</p>	<p>El borrador final del Plan de 3 años y la Actualización anual se presenta al Consejo de Supervisores del condado de Los Angeles para su aprobación.</p> <p>Tras la aprobación del Consejo, el Plan de 3 años y la Actualización anual se presentan a la Comisión de Supervisión y Rendición de Cuentas de la MHSA.</p>

Enlace al formulario de propuesta de proyecto de la MHSA:

<https://forms.office.com/g/hFe6c3LA2>

<https://forms.office.com/g/7788a5Wx1e>

26

## CAMBIOS PROPUESTOS AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

### Centro de Recursos Familiares de la Comunidad (CFRC)

Población de interés: todos los grupos etarios y poblaciones - Familias

El CFRC está diseñado para crear un espacio coordinado, motivado y propio de la comunidad donde familias y personas puedan acceder fácilmente a los servicios que necesitan para mejorar su bienestar. Los CFRC crearán sociedades con redes de atención, líderes individuales y organizaciones comunitarias y entidades públicas y privadas de confianza para aprovechar las fortalezas y capacidades de cada uno para atender mejor las necesidades de las personas y familias de su comunidad.

### Iniciativa de Escuelas de la Comunidad (CSI)

Población de interés: jóvenes de la escuela secundaria y preparatoria

La CSI atiende a 15 escuelas preparatorias que sirven como centros para una variedad de servicios de apoyo para estudiantes, familias y personal escolar. El programa asigna a cada sitio un Especialista de Escuelas Comunitario para asistir con los servicios de coordinación y un Trabajador Comunitario Educativo para ayudar en el compromiso de los padres. Los servicios se enfocan en la prevención, ayudando a los cuidadores y a los estudiantes a acceder a una variedad de servicios para prevenir el estrés y posibles enfermedades mentales.

### Red de Promotores de la Salud Mental Unidos

Población de interés: poblaciones culturalmente marginadas

El proyecto de la Red de Promotores de la Salud Mental constituye un esfuerzo de alcance comunitario que sirve para fortalecer a las comunidades y ofrecer orientación laboral a aquellos miembros de la comunidad que funcionan bajo el auspicio de los Promotores de la Salud Mental.

27

## CAMBIOS PROPUESTOS (continuación) AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

### Amigos de los Niños (FOTC) - Los Angeles

Población de interés: niños y jóvenes menores de 18, a partir de 4-6 años

FOTC tiene como objetivo evitar el ingreso en hogares de acogida y mejorar la estabilidad y bienestar de las familias identificadas por el DCFS con mayor riesgo de ingresar en el sistema de acogida. FOTC ofrece tutorías individuales profesionales para niños a partir de los 12 años, comenzando desde los 4 a 6 años. Los mentores son entrenados para apoyar a los cuidadores, fomentar la autodefensa y crear oportunidades para lograr conexiones de pares y con la comunidad culturalmente receptivas.

### Servicios legales médicos

Población de interés: todos los grupos etarios

Aborda los problemas legales de los clientes y aumenta la conciencia respecto de sus derechos, reduciendo el exceso de estrés y empoderándolos por medio de la información. Estos servicios legales pueden eliminar los obstáculos para mantener un ingreso estable a través del empleo.

### Visitas domiciliarias: profundizar conexiones y mejorar servicios

Población de interés: padres y cuidadores de niños de 0 a 5 años

Healthy Families America (HFA) y Parents as Teachers (PAT) son programas nacionales de visitas domiciliarias basados en la investigación y la evidencia que reúnen información familiar para diseñar los servicios para toda la familia. Estos programas ofrecen visitas al hogar cada 1 o 2 semanas para fomentar relaciones positivas entre padres e hijos y un vínculo saludable. Además, darán prioridad a las áreas en donde los datos indican que hay un mayor número de familias con servicios de protección de niños.

28

## CAMBIOS PROPUESTOS (continuación)

### AÑO FISCAL 2023-24



Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

#### Nuevo compromiso de padres: bienvenidos a la biblioteca y al mundo

Población de interés: padres y cuidadores nuevos

Las bibliotecas públicas y Salud de la Mujer del DHS ofrecerán un kit Bienvenidos a la biblioteca y al mundo con información sobre los programas y servicios Smart Start Early Literacy. El programa será ofrecido en 45 sitios dos veces al año y a través de un programa virtual trimestral.

#### Programa para jóvenes SPOT: Oportunidades para Jóvenes luego de la Escuela

Población de interés: niños y jóvenes de menos de 18

Nuestro SPOT: se trata de un programa extenso para después de la escuela que tiene como objetivo involucrarse con los jóvenes de la comunidad y brindarles apoyo, habilidades para vivir y experiencias positivas que los empoderen para forjarse un futuro brillante.

#### We Rise Parques al Atardecer

Población de interés: más o menos de 24 años de edad - familias

We Rise es un programa de prevención que brinda acceso a una programación de autocuidado en 58 parques del condado de LA y se ofrece durante el mes de conciencia sobre la salud mental. Incluye oportunidades constantes para acceder a recursos e información sobre el cuidado de la salud mental, incluyendo talleres gratuitos sobre bienestar mental.

29

## CAMBIOS PROPUESTOS (continuación)

### AÑO FISCAL 2023-24



Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

#### Parques a la Noche Parques al Atardecer

Población de interés: más o menos de 24 años de edad - familias

Diseñado para familias y adultos con el fin de participar en talleres y clases que promueven el autocuidado y la sanación 3 noches a la semana durante 8 semanas. Las actividades incluyen deportes, entrenamiento personal, arte y cultura, películas y conciertos, entre otros.

#### Pasos seguros DPR: compromiso comunitario y pasos seguros para jóvenes y comunidades

Población de interés: niños y jóvenes menores de 18 años

La iniciativa Pasos seguros DPR utiliza interventores y embajadores de bandas entrenados para implementar el mantenimiento de la paz entre los vecindarios de bandas con el fin de asegurar la seguridad a/desde los parques y durante las actividades en los parques y brindar servicios de intervención en casos de crisis en los parques.

#### Compromiso de padres/cuidadores Triple P

Población de interés: padres y cuidadores

Triple P es una práctica eficaz basada en la evidencia que brinda a los padres y cuidadores estrategias simples y prácticas para ayudarlos a construir relaciones fuertes y saludables, manejar con confianza los comportamientos de los niños y evitar el desarrollo de problemas.

30

## CAMBIOS PROPUESTOS (continuación)

### AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

#### Servicios de Navegación de Salud del Paciente

Población de interés: todos los grupos etarios

La propuesta aumentará los actuales Servicios de Navegación de Salud del Paciente sumando servicios enfocados en la prevención de la salud mental, que incluye evaluación, derivación y vinculación a apoyos comunitarios y a educación para aumentar los factores de protección para las personas con riesgo de sufrir una enfermedad mental.

#### Preparación para la Escuela

Población de interés: de 2 a 4 años (niños pequeños y en edad pre-escolar)

Un programa de alfabetización temprana diseñado para niños pequeños y en edad pre-escolar para ayudar a los padres y tutores a apoyar las necesidades de educación de sus niños. A través de libros, canciones, rimas y diversión, los niños construyen habilidades de educación temprana, de matemáticas básicas y sociales, además de otras capacidades esenciales de preparación para la escuela.

#### Bienestar creativo: arte, escuelas y resiliencia

Población de interés: 24 años y cuidadores

Un enfoque no tradicional basado en el arte y la cultura que promueve la salud mental en gente joven y cuidadores. El modelo ofrece estrategias no tradicionales para fomentar la salud mental y el bienestar e incluye talleres artísticos culturalmente adecuados y sanadores para gente joven, además de brindar apoyo para el desarrollo profesional, entrenamientos de vida y apoyo emocional para los adultos que trabajan con ellos. Las actividades incluidas apoyan el desarrollo positivo cognitivo, social y emocional y fomentan un estado de bienestar.

31

## CAMBIOS PROPUESTOS (continuación)

### AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

#### Proyecto de nacimiento abundante

Población de interés: personas embarazadas y padres de niños de 0 a 18 meses

Este programa es una asociación pública-privada que busca brindar apoyo como mínimo a 400 personas embarazadas en el condado de LA de poblaciones marginadas, que tienen mayor probabilidad de sufrir el peor resultado durante el nacimiento con una variedad de apoyos durante 18 meses (salud mental, ayuda financiera, apoyos de bienestar, asistencia en vivienda, educación, etc.). Se trata de un estudio de control para evaluar los efectos de este tipo de asistencia.

#### Modelo de mentoría de mensajeros creíble

Población de interés: jóvenes en edad de transición de 18 a 25

Este programa involucra un entrenamiento de jóvenes pares para aumentar el acceso a recursos y servicios para los jóvenes de color desfavorecidos por los sistemas y servicios tradicionales. Los servicios están dirigidos a jóvenes entre 18 y 25 años e incluyen entrenamiento de pares mensajeros, evaluación de necesidades de los mentores, orientación por jóvenes con experiencia de vida, actividades grupales, intervención en crisis, participación familiar, derivación y vinculación de recursos.

#### Regiones de desarrollo para la juventud

Población de interés: jóvenes en edad de transición de 18 a 25

Este programa brinda apoyo/derivación a una serie de servicios de desarrollo para jóvenes, tras una evaluación de fortalezas, intereses y necesidades de cada uno. Dirigido a jóvenes de 18 a 25 y diseñado para ayudar a cerca de 6,500 por año. Los servicios se ofrecen por medio de organizaciones comunitarias contratadas, derivación y vinculación. Incluye recursos para participación escolar, entrenamiento en solución de conflictos, apoyo de mentores/pares, apoyo escolar, servicios de empleo/laborales, expresión artística/creativa y bienestar social / emocional.

32

## CAMBIOS PROPUESTOS (continuación)

### AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

#### Enfoque local para evitar la falta de techo

Población de interés: adultos jóvenes que salen de hogares de acogida y en riesgo de no tener techo

El Departamento de Servicios de Salud y Sociales de Long Beach convocará a socios locales para identificar brechas en los servicios de prevención de la falta de techo y desarrollar estrategias de intervención para abordar la vivienda a corto plazo, los servicios móviles y en clínica y los programas de apoyo para jóvenes adultos que salen del sistema de hogares de acogida.

#### Terapia de la risa y la gratitud

Población de interés: adultos mayores latinos

Ilustrar al público sobre alternativas terapéuticas que no necesariamente involucran la utilización de medicamentos para mejorar el estado de ánimo y sobre la importancia de aceptar las emociones en lugar de ocultarlas.

#### Adultos mayores latinos y cuidadores

Población de interés: adultos mayores latinos

Crear oportunidades para los inmigrantes mayores latinos para que prosperen y sean más independientes enseñándoles a no temerle a la tecnología sino a utilizarla como una herramienta para estar conectados con los seres queridos, aprender cosas nuevas, encontrar entretenimiento y que se convierta en una herramienta útil para la superación personal.

33

## CAMBIOS PROPUESTOS (continuación)

### AÑO FISCAL 2023-24

Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

#### Búsqueda para Involucrar a los Americanos Pilipino (SIPA)

Población de interés: jóvenes

Brindar servicios de apoyo de la salud mental basados en la fortaleza y dirigidos a la juventud y a las personas marginadas en SPA 4, con especial énfasis en las áreas de Historic Filipinotown y alrededores.

#### Conciencia de la salud mental y línea de ayuda para coreanos

Población de interés: todos los grupos etarios coreanos

Busca normalizar las enfermedades mentales y su tratamiento dentro de la comunidad coreana, para que las personas busquen ayuda y servicios sin vergüenza ni duda.

#### Programa de revinculación WPW de FosterALL

Población de interés: adultos y niños dentro del sistema de hogares de acogida

El Programa Wisdom Path Way de FosterALL se ocupa de niños y adultos en hogares de acogida y brinda resultados positivos para evitar traumas, estrés y enfermedades mentales adicionales, tanto para los niños como para los adultos.

34



## CAMBIOS PROPUESTOS (continuación)

### AÑO FISCAL 2023-24



Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

#### Boletín informativo: Cultural Reflections

Población de interés: consumidores del LACDMH

Brindar oportunidades para que los pares generen contenido relacionado con la salud mental con el fin de ser desarrollado y distribuido en todo el condado.

#### Esperanza y curación: apoyo del bienestar de la salud mental para familias y familiares de víctimas

Población de interés: familias afroamericanas que han sufrido pérdidas por la violencia

Aportar esperanza y bienestar mental para normalizar la conversación y la conciencia para que las familias acudan a los servicios de salud mental y se eliminen los estigmas comunes relacionados que evitan que muchas personas traumatizadas reciban la ayuda que necesitan.

#### Proyecto TransPower

Población de interés: población de jóvenes Trans\*

Aumentar el acceso y eliminar los obstáculos relacionados con el tratamiento, tales como la falta de recursos, las necesidades de transporte y las cuestiones de privacidad, ofreciendo servicios positivos y especializados en la salud mental sin costo.

35

## CAMBIOS PROPUESTOS (continuación)

### AÑO FISCAL 2023-24



Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

#### Centro de Servicios y de Salud Comunitarios *Open Arms*

Población de interés: todos los grupos etarios

Brinda atención a la salud de calidad, apoyo de la salud mental, vivienda, manejo de casos, referencias laborales y servicios de respaldo, tales como comida, vestimenta, kits de aseo personal, transporte, manejo de la ira, uso de sustancias, tráfico sexual y clases para padres.

#### Red de empoderamiento del consumidor

Población de interés: consumidores del LACDMH

Educar a los consumidores del LACDMH sobre la historia de la MHSA, el rol de los consumidores del LACDMH y de todo el estado, los componentes y procesos necesarios, los eventos de las partes interesadas a nivel estatal y del condado, las oportunidades para hacer comentarios y recomendaciones públicas y el proceso legislativo.

#### Innovación 2 / Prevención e Intervención Temprana

Población de interés: jóvenes en edad de transición dentro de comunidades de sordos, BIPOC, discapacitados, LGBTQIA2S y asiáticos e isleños del Pacífico.

Ayudar a construir comunidades informadas sobre el trauma y familias resilientes a través de Especialistas en Recursos Comunitarios (CRS) que trabajen con las familias en sus hogares, para asegurarse de que las crisis de alimentos, médicas o de vivienda no las desestabilicen.

36

# CAMBIOS PROPUESTOS (continuación)

## AÑO FISCAL 2023-24



Los proyectos/conceptos que siguen fueron propuestos por partes interesadas y otros Departamentos del condado durante el proceso de partes interesadas desde octubre de 2022 hasta el 23 de febrero de 2023. El LACDMH asumió el compromiso de trabajar con los proponentes para ultimar los detalles y el presupuesto del proyecto y la capacidad para implementar el programa.

### Servicios de salud mental para sordos e hipoacúsicos

Población de interés: todos los grupos etarios de sordos e hipoacúsicos

Ofrecer intérpretes del Lenguaje Americano de Señas (ASL, en inglés) que puedan traducir eficazmente y con precisión términos y conceptos de salud mental a personas sordas e hipoacúsicas.

### Clínica de familia militar Steven A. Cohen en VVSD, Los Angeles

Población de interés: veteranos y sus familias

La Clínica Cohen ofrece atención de salud mental personalizada y basada en la evidencia junto con alcance y acceso a apoyos para el manejo de casos integrales y derivaciones para abordar la intervención temprana y la prevención del suicidio, el desempleo, las finanzas, la vivienda y cuestiones legales a tiempo.

### Expansión de DBT

Población de interés: fuerza laboral para los consumidores del LACDMH

Este proyecto ofrecerá apoyo al programa DBT de la clínica, brindando financiación específica para el personal médico, de servicios de terapia directa, de trabajadores / apoyo de pares y de gerencia/supervisión para que reciban un entrenamiento pago con el fin de obtener certificación, prácticas e implementación de DBT.

37

# EXPANSIÓN

## AÑO FISCAL 2023-24



Los que siguen son programas actuales de la MHSA aprobados previamente por las partes interesadas para su expansión en el Año Fiscal 2023-24.

### Identificación de Portland y Remisión temprana (PIER)

PEI: Prevención

Actualmente, el DMH tiene 5 sitios de programas PIER prácticamente llenos. Esto aumentará la cantidad de sitios y áreas disponibles para el programa. PIER es un programa de Atención Especializada Coordinada para adolescentes y adultos jóvenes, de 12 a 25 que estén en Alto Riesgo Clínico de sufrir psicosis o hayan tenido su primer episodio psicótico. Actualmente, las derivaciones desde ELAC STAND (UCLA), NAMI Urban LA, escuelas y varios programas ambulatorios exceden la capacidad del actual nivel de servicio.

### Extensión y Participación Móvil para Personas sin Techo (HOME)

CSS: Alcance y compromiso de planificación

El programa HOME brinda alcance, compromiso, apoyo y tratamiento de campo para personas con enfermedades mentales graves y recurrentes que sufren la falta de techo sin refugio.

La expansión permitirá un total de 94 puestos a tiempo completo (6 nuevos equipos multidisciplinarios y 1 equipo de Navegación de Área de Servicios) que serán agregados entre los AF 2022-23 y 2023-24. La expansión aportará un total de 16 equipos multidisciplinarios en el condado y 1 equipo de Navegación de Servicios.

### Programa de Tratamiento Residencial de Crisis (CRTP)

CSS: Servicios de crisis alternativos

Los CRTP están diseñados para brindar servicios a corto plazo intensos y de apoyo en un ambiente hogareño a través de un programa de rehabilitación social activo certificado por el Departamento de Servicios de Salud de California y licenciado por la División de Licencias de Cuidado Comunitario del Departamento de Servicios Sociales de California.

Recibió un nuevo contrato de entidad jurídica para Bel Aire Health Services con el fin de brindar servicios en 2 lugares: Downey y Sylmar.

38

## EXPANSIÓN (continuación)

### AÑO FISCAL 2023-24



Los que siguen son programas actuales de la MHSA aprobados previamente por las partes interesadas para su expansión en el Año Fiscal 2023-24.

#### Centros de atención inmediata para TAY

PEI: Prevención  
CSS: Servicios de Atención Ambulatoria

Los Centros de atención inmediata para TAY sirven como puertos de entrada al sistema de salud mental para jóvenes sin techo o con una situación de vivienda inestable. Se agregarán 10 sitios en total en el condado. Las Áreas de Servicios 2, 3, 4, 5, 7 y 8 recibirán un nuevo sitio cada una y las 1 y 6 recibirán 2 cada una.

#### Programa de Refugio de Emergencia Mejorado para TAY

CSS: Vivienda

El Programa de Refugio de Emergencia Mejorado (EESP) atiende las necesidades urgentes de vivienda de la población TAY de 18 a 25 años que no tiene techo, está en riesgo de perderlo y no tiene otro lugar, tampoco tiene recursos ni ingresos importantes para pagar un refugio, está teniendo complicaciones con la salud mental y está dispuesta a aceptar el tratamiento que le ofrecemos.

Se sumó financiación adicional a 5 sitios.

#### Asociación de Servicio Completo (FSP)

CSS: Asociación de Servicio Completo

La expansión sumará un total de 66 empleados a programas de FSP operados directamente. Algunas de estas adiciones amaran 2 nuevos equipos por la mitad en Edelman Child and Youth y Valley Coordinated Child Services. El resto del personal ayudará a formar los equipos de FSP en Santa Clarita Mental Health, Antelope Valley Mental Health y Arcadia Mental Health. 6 equipos de FSP también recibirán más personal.

39

## PRÓXIMOS PASOS/CRONOGRAMA



El siguiente cronograma incluye los pasos que se darán para la adopción de la Actualización anual del AF 2023-24 de la MHSA por parte del Consejo.

### Mayo de 2023

- El LACDMH recibirá comentarios y recomendaciones de la Audiencia Pública sobre la Actualización anual del AF 2023-24 para su incorporación en el borrador final que será analizado y adoptado por el Consejo de Supervisores (5/15/23).
- El LACDMH comenzará un proceso de Evaluación y Recomendación de Necesidades de la Comunidad para informar el Proceso de planificación comunitaria para el próximo Plan de Programa de 2 años y Gastos de la MHSA para los AF 2024-25 y 2025-26.

### Junio de 2023

- El LACDMH presentará el borrador de la Actualización anual de la MHSA para el AF 2023-24, que incluye todas las opiniones y respuestas de las partes interesadas y de la Comisión de Salud Mental, al Consejo de Supervisores para su revisión, análisis y adopción (6/6/23).
- La Actualización anual de la MHSA para el AF 2023-24 será presentada a la Comisión de Supervisión y Responsabilidad de los Servicios de Salud Mental para su aprobación y ejecución final con el fin de seguir operando o comenzar la implementación de programas y servicios incluidos en la Actualización (6/30/23).

40



## Public Hearing Transcripts

**LOS ANGELES COUNTY**  
**DEPARTMENT OF MENTAL HEALTH**  
**MENTAL HEALTH COMMISSION FULL MEETING**  
**THURSDAY, APRIL 27, 2023**  
**10:30 AM**

>> KENIA FUENTES: Good morning, LA County. Welcome to LA County Mental Health Commission. My name is Kenia, and I am the executive assistant. Today is April 27, 2023. Before I hand it over to Canetana for roll call and

then to our Chair Austria for our official meeting, just a few items. Please make sure that your phone devices are silent. If you are in-person, our restrooms are directly outside of the store, quickly through the hallway to your right. For those who are intending to have attendance verification, please make sure you sign in if you're in person. For those online, a link will be shared so that you can sign in online. Thank you so much.

>> AT&T OPERATOR: Hi, this is Don with AT&T.

>> JULIO MIRANDA: Hi, Don. Thank you so much. My name is Julio. I'll be the tech running online today. And at a later time, we will ask you to provide instructions for queuing up. However, at this time, please just open the line for the public to listen. Thank you so much.

>> AT&T OPERATOR: Okay. Thank you.

#### **[Roll call]**

>> KENIA FUENTES: Thank you. And I will do a roll call.

>> COMMISSIONER FRIEDMAN: [Absent]

>> COMMISSIONER PADILLA-FRAUSTO: [Absent]

>> COMMISSIONER ROOT: Present.

>> CHAIR AUSTRIA: Here.

>> COMMISSIONER BARBOUR: Present.

>> COMMISSIONER STEVENS: Present.

>> COMMISSIONER DALGLEISH: Present.

>> COMMISSIONER MOLINA: Present.

>> COMMISSIONER SANABRIA: [Absent]

>> COMMISSIONER COOPERBERG: Here.

>> COMMISSIONER SCHALLERT: Present.

>> COMMISSIONER WEISSMAN: Here.

>> KENIA FUENTES: Okay. Chair Austria, you have the floor.

>> KENIA FUENTES:

>> CHAIR AUSTRIA: Good morning, everyone. Thank you for being here.

#### **[Approval of meeting minutes]**

>> CHAIR AUSTRIA: Our first item is our approval of minutes for both February and March. We'll start with the approval of the minutes for February. Any comments or questions from the commission?

>> COMMISSIONER DALGLEISH: Do you have a microphone or is it loud enough? Can people hear me?

>> JULIO MIRANDA: Yes. Yes, they can.

>> CHAIR AUSTRIA: And they can hear me.

>> KENIA FUENTES: Can you hear from this?

>> CHAIR AUSTRIA: Okay. Is there a motion to approve --

>> COMMISSIONER MOLINA: I move for approval for February and March.

>> COMMISSIONER DALGLEISH: Second.

>> CHAIR AUSTRIA: It's been seconded, our motion. So all those in favor say "aye."

[Ayes]

>> CHAIR AUSTRIA: Opposed?

[No response]

>> CHAIR AUSTRIA: Thank you. And the next one, approval of the minutes for March 23rd. Again, questions or comments?

>> COMMISSIONER MOLINA: Molina moves approval.

>> COMMISSIONER DALGLEISH: Second.

>> CHAIR AUSTRIA: It's been moved and seconded to approve the March minutes. All those in favor say "aye."

[Ayes]

>> KENIA FUENTES: Can I know who seconded?

>> CHAIR AUSTRIA: Stacy.

>> KENIA FUENTES: Thank you.

>> CHAIR AUSTRIA: Mike Molina and Stacy Dagleish for both motions.

#### **[Elections]**

>> CHAIR AUSTRIA: The next item really is elections. So we need to have an election exercise for the board Executive Committee. Right now we have one person who is a volunteer to be on the elections committee. That's Reba Stevens. Thank you, Reba. We need one more person to volunteer. If we don't have a volunteer, then what I will do is have the staff distribute the paperwork that we need to submit to run. And at that point we will have the election -- Stacy.

>> COMMISSIONER DALGLEISH: Is it still the case according to whichever bylaws we're operating from that you are not to be on the nomination committee if you are planning to run for an office? Because that would exclude me, but --

>> CHAIR AUSTRIA: Yes.

>> COMMISSIONER DALGLEISH: Okay. All right. Thank you.

>> CHAIR AUSTRIA: Yes. Reba.

>> COMMISSIONER STEVENS: I would like to nominate Judy Cooperberg to join me again and be on the committee.

>> COMMISSIONER COOPERBERG: I thought you didn't like me.

[Overlapping Speakers]

[Laughing]

>> COMMISSIONER STEVENS: Well, as you can see, I love you.

[Laughing]

>> COMMISSIONER COOPERBERG: Okay, I'll second.

>> COMMISSIONER STEVENS: So she and I are -- commissioner Cooperberg and I are --

>> CHAIR AUSTRIA: So for the record, Judy Cooperberg and Reba Stevens will be our nominating committee. So if you're interested in running for a position, please contact them, copy Canetana so we can get you the proper paperwork and then we'll help that next. I just want to personally thank you both.

#### [Annual reports]

>> CHAIR AUSTRIA: Okay. So then we're going to the presentation reports or let me just say annual report. And following that, we will have a public hearing at -- for the public comment on the MHSA Update plan. And our main goal here is for the commission to listen to the community and get feedback on the plan. And we may also have some comments of our own at the end. Thank you. Kalene.

#### [MHSA Annual Update report]

>> KALENE GILBERT: Going to start. Can folks hear me okay from here?

>> JULIO MIRANDA: Yes.

>> KALENE GILBERT: Great. Thank you. So good morning, commissioners, and -- good morning, commissioners, and good morning to all of our stakeholders who've also joined us today. I do want to say a big thank you to all of our stakeholders that have taken the time to come to these meetings, sometimes at a great distance to participate in this process. So I'm really pleased to be able to present our Annual Update. Julio, could you please bring up my slides?

>> JULIO MIRANDA: They should be up.

>> KALENE GILBERT: Okay. And can I -- and can I also ask if you can or if you don't mind, could you please add the link to the Annual Update itself into the chat box for anybody online who'd like to access it? There's one in -- a link for both English and Spanish.

>> JULIO MIRANDA: Both those links are posted as an announcement at this time.

>> KALENE GILBERT: You like more space to see? Yeah. Okay. Is it possible, and I apologize, Julio, one more. Is it possible to make it just a little bit bigger? Nope.

>> JULIO MIRANDA: That would be what Kenia said. She's showing her screen. Kenia, can you maximize your viewable window or click on the presentation if you swapped views.

>> KENIA FUENTES: So if I do that, I take out CART and it's an access issue, I apologize for that.

>> COMMISSIONER WEISSMAN: Or it can't be smaller to the right, you can't minimize that -- smaller? Are you expecting them to read that?

>> KENIA FUENTES: Yes. They're reading, so okay. Okay.

>> KALENE GILBERT: All right. So with that, I'll go ahead and get started. This is our Annual Update for fiscal years '22 -- I'm sorry, '23-'24. I'm going to go into a little detail on MHSA and the Annual Update, but just so folks know, before I dive in, the Annual Update tends to cover outcomes and data and budget for the prior fiscal year,

which in this case would be '21-'22. It covers the stakeholder process for this year and some of the planning for next year and the budget for this year. And it also covers our planned updates for next year and the budget for next year. So it kind of covers three fiscal years. So you'll notice we might kind of go back and forth on the dates when I'm talking about budget. And that's because that's what's included in the Annual Update. So if you go to the next slide, please.

So today I will spend some time talking about the purpose of the Annual Update. I'm going to go over the overview of the MHSA components. I'm going to talk a little bit about client counts and expenditures for some of the major components. I'll talk a little bit about the Community Planning Process and some community feedback that we've received to date from online and from commissioners. We'll talk about the proposal process, the proposed changes, and the next steps in the timeline. So next slide, please.

So for those that aren't familiar, the Mental Health Services Act, which we refer to as MHSA, was passed in November of 2004. Prop 63, it was a voter initiative. And it imposed a 1 percent income tax on income in excess of a million. So any of our millionaires here in the state of California, every dollar over a million with 1 percent of that went to fund our public mental health system.

And it was intended to provide significant funding to expand, improve, and transform the system. It really was intended to fill that gap, that promise from when, you know, for our community mental health, that once we move folks out of inpatient settings and into the community, I think the vision for inpatient outpatient care and community care was big. And I think we could all agree it was never quite fulfilled. So MHSA was really meant to expand that system. And it's been commented that MHSA is kind of the mortar, right, that holds a lot of our program together. But I would argue at this point in time, it really is the steel frame of our mental health system.

Regulations require that the mental health programs, which is us, prepare and submit a three-year program and expenditure plan, followed by an annual plan update for MHSA. So every three years in June, we need to submit to the public and to the state our plan for mental health services. It's our roadmap. So this plan should reflect all of our services for the mental health service, all of our MHSA services. And anything that we want to do has to be there. So we have to go through this process to ensure that any programming is included.

Our plan provides us an opportunity to review existing HSA programs and services and to evaluate effectiveness. This is the outcome I was referring to, and to propose any new programs from what was described in our 3-Year Plan. It's through the Community Planning Process that this feedback is gathered. So this is part of that process here today, and this is why we want to make sure that we have opportunities, too, for the public to make a comment. And the 3-Year Plan that we're working off of this is an Annual Update year. The 3-Year Plan that we're working off of was for fiscal years, '21 through '24 and was submitted to the board in June of 2021.

I'm going to make a quick note because we're going to be starting our new planning process. This is the last Annual Update. Next year, we are going to start our new three-year planning process. I do want to make folks aware that it will actually be a two-year plan. And the reason for this is because during COVID we received one additional year. They gave us kind of a delay in reporting up. And the state would like us to get back on track. So throughout this presentation, there are times where I do refer to a two-year plan. I don't want to confuse folks, but I want to make sure that you're aware of that. I'm talking about the same planning process. Can you go to the next?

So I want to start, and this was a request, too, from our commissioners, from the Executive Committee to start with helping folks see where MHSA fits in our broader system. MHSA is about 26 percent of our full budget for the department. At the last fiscal year, it was at 802 million. And just a note for folks who aren't aware, LA County is about a third of the population of the state. So our allocation is a third of that state funding. We have the largest share by far. And another note, too, for folks who are served, this is just how the funding is broken out, but individuals, most individuals served by MHSA are also served by medical health. That's blended. So these aren't separate populations served. Next slide.

So the MHSA components, they include the Community Services and Supports Plan. This is our largest, and there is a -- we have a mandated allocation for each of these components. So from our full allocation, for example, last year of \$802 million, 76 percent of that goes to the Community Services Supports or the CSS plan. This covers Full Service Partnerships. It covers our outpatient services; it covers our urgent care services. We're going to do a little bit of a deeper dive, but I want you to give you -- this is our broad outpatient system.

Secondly, we have Prevention & Early Intervention. That mandated allocation is 19 percent. And that is for our prevention, which is all the community-based work. We do partnerships with parks and libraries, the CBOs we work with, working with families and youth. It also includes early intervention, which are clinic-based services, suicide prevention, and anti-stigma discrimination.



And then 5 percent goes to Innovations. That's our opportunity to try something new. We are always mandated to put away 5 percent for Innovations. And we kind of do, we can do one to five year kind of experiments, so to speak, where we try some sort of new intervention that hasn't been done anywhere else. And then look at those outcomes for sharing and learning and integration into our services if we wish.

We finally have the Workforce Education and Training component and the capital facilities component. There's no mandatory allocation for those. However, if we want to fund those things, it comes out of our CSS pot. So these are two really important areas because it's our infrastructure, right? It's our technology. And right now, workforce and education is particularly important for workforce development. So it's a place where we're looking at some significant -- we've seen some significant increases in funding more recently, but we always have to make that choice to take it out of what services and supports piece to fund those. Next slide.

So our budget for '22, '23, we received an allocation of 879 million. So of that 610 million goes to CSS, 233 to PEI. The Innovations pot was at 10 million. WET, as I noted, is 20 million. And as I noted, that has been an increase for prior years. And CFTN for this year was at 4.1. So next slide.

So let's talk a little bit about the Community Service and Supports component in Fiscal Year '21-'22.. We served under CSS, which includes Full Service Partnership, our outpatient system, Alternative Crisis Services. And that includes urgent care, crisis, residential. It also includes housing. So our housing supports shelter beds. It includes linkage, like, navigation. It includes planning, outreach, and engagement. And that's the funding, for example, that we use with our UsCCs. To work with our stakeholders in that year, we served approximately 147,143 unique clients, 42,000 of which were new. And ethnicity breakout was 30 -- forgive me, I think that's 36 percent Hispanic, 20 percent African American, 17 percent white, 4 percent Asian Pacific Islander, 1 percent Native American with a language breakout of 80 percent English and 13 percent Spanish. These are just the top ones. So of course, there are additional ethnicities and languages. We just wanted to show the major breakouts.

I also want to reflect here that there has been an ask for a further breakout of ethnicity. And that is something that we are offering on our public dashboard. So we understand and recognize the need to break out our API populations, our Latino populations, our Middle Eastern population. So this is a summary. We kind of need to go through this very quickly, but our public dashboard, and we have one up right now that is for all services. Julio, if you don't mind pulling that into the chat box as well if folks want to take a look, and pretty soon, in a couple of weeks, we'll have one for MHSa for folks. But I just want to know that that information will be available.

>> JULIO MIRANDA: It has been posted.

>> KALENE GILBERT: Thank you very much. And thank you, Kenia. So next slide, please.

Here's a breakout of our expenditures and our estimates. What you'll see is a steady increase in funding for nearly all of our programs. And this really has to do -- there's a couple of factors here: one, of course, is we're coming out of COVID. We're coming out of some staffing shortages. But the other thing that we know is happening is our MHSa allocations is increasing, right? So folks are making more money. And when folks make more money, our revenues go up. And so the same thing can happen right as it goes down, those revenues can go back down.

So that is -- those are the maybe, I think, would say the two major factors here. But you can see an intention to really push on outpatient services, particularly Full Service Partnership. We are planning some major expansions and we expect we will need to do those related to the care coordinator and servicing focus. So go ahead. Next slide, please.

So for the Prevention & Early Intervention component or PEI, as I noted, this covers prevention, early intervention, suicide prevention, and stigma and discrimination reduction. It is the second largest component. Let's go ahead and get into some of the details here. Next slide.

So first, we wanted to just give a sampling of prevention services. So prevention services broadly are not like in clinic, claimable services. These are the community-based services that we offer. Here are just some examples of it that include like Nurse Family Partnership, which is a home visiting program, Prevention & Aftercare, which is a partnership, I believe it came from with DCFS to serve at-risk youth and families. VPAN, it was the Peer Access Network for veterans. So what you'll see here, if you go into the Annual Update, you'll see outcomes for these programs. And prevention services, in general, are meant to increase protective factors and reduce risk factors. Those are the primary outcomes that we're looking at with the prevention program. So what we're showing here is just the number of folks served by these programs. So you get a sense of the size, the details, and the outcomes for each of them. Because different tools were used, it's hard to just put a summary up here are available in the Annual Update.

>> COMMISSIONER COOPERBERG: So they're not the number of clients surveyed. It's the number of clients served.

>> KALENE GILBERT: Number of clients surveyed. Thank you. That's correct.

>> COMMISSIONER COOPERBERG: What do you mean by "surveyed"?

>> KALENE GILBERT: So those are the number of clients who participated in the program that responded to a survey.

>> COMMISSIONER COOPERBERG: Oh, okay.

>> KALENE GILBERT: Yes.

>> COMMISSIONER STEVENS: So I have one question. Could you -- could you help me understand why seeds, that number is so low?

>> KALENE GILBERT: So else that is something I'll have to ask and get back to you. You talk to the lead for the program.

>> CHAIR AUSTRIA: Okay. Last question and then we want to proceed with the presentation. Susan?

>> COMMISSIONER FRIEDMAN: Yes. [Inaudible]

>> KALENE GILBERT: So the question is: if I hear you correctly, that the governor wants to change Prevention & Early Intervention. So his proposal actually doesn't say that specifically, but folks anticipate that it will impact Prevention & Early Intervention. If I may, I will be glad to talk a little bit more about that. Do you -- I don't know if you want me to speak on that now?

>> CHAIR AUSTRIA: Finish your presentation, please. And we'll hold questions till the end.

>> KALENE GILBERT: Yeah, it's a much, much -- yeah. It's a large conversation. Can we go to the next slide, please?

So early intervention services, these are clinic-based early intervention services. They are predominantly utilized by children and youth. They're meant to avoid the need for additional mental health services. Treatment is short term, 18 months. This year, we served 35,330 clients. And then of which 17,000 were new. Again, we had a -- this is where if you hear about the evidence-based practices we offer here throughout our services in PEI, this is where the EBPs are. Once again, these are outlined in our Annual Update with outcomes for each of them. So we can go into the next slide.

Another example in PEI services is suicide prevention. I think our biggest examples of our suicide prevention services include the 24/7 suicide prevention crisis line, which this year responded to 145,254 calls on our -- and that was calls, chats, and texts. Our Spanish language crisis hotline responded to 13,000 callers. In addition, we have teams that do suicide prevention training in the community. So not just for providers, but also for community groups, other kinds of service providers and community groups in general. And we had, of all the folks that participated, we received 1,309 surveys for those who completed them as part of the training. We also do an annual conference on suicide prevention. Next slide.

And then finally we have stigma discrimination and reduction. I think our biggest example of this has been the promotores where we have, you know, this is community educating, raising awareness with the community, and providing support and linkage back to services. So for, just for a couple of the samples, the surveys that we do with folks, once they've received kind of whatever training or in-service that they had received or engaged with, one of our promotores, we found that 93 percent agreed that as a direct result of the training, they're more willing to seek support for a mental health professional if needed. And also that 87 percent agreed strongly that anyone can have a mental health condition. So kind of broadening, understanding mental health. These services were often delivered in languages other than English. So I think, again, a breakout of that we can make available. Next slide.

And then, so you have a good idea, too, of our expenditures for last fiscal year, estimated for this fiscal year and moving into next year. You'll see that -- and, again, we anticipate some significant increases in our spending. We do know that I think historically we've seen that low spending. So we have plans now to implement new prevention programming, for example, and expand our services. So, excellent.

So now I'll talk a little bit about our community stakeholder process. I want to acknowledge that there's a lot of text on here. This becomes a public document that we share, so we want it to be referenced. But I'm not going to read them directly, but I will talk through them. So this has been the work of Dr. Darlesh Horn has really taken initiative to revitalize our stakeholder process. And we started with a kickoff in September to re-engage our stakeholders for the past number of years. Under the last administration, our formal stakeholder body has been the community leadership team or CLT, and that's made up of the SALTs, Service Area Leadership co-chairs. So there's broad service area representation, and our UsCC chairs. So we held a two-day retreat in September to kick off the process to hear from folks on what's worked, what hasn't worked, what do I want to see going forward.

In November, we met again with the groups to talk about the timelines and processes, not only for the planning of this year's Annual Update that I'm speaking to now but also what we plan to do for the next year because

we had a short period of time. I think some of you have heard me say, we really took 10 months of planning and put it into four months. So this was a really heavy, tedious process, particularly for those stakeholders. I just -- I can't say how grateful I am to folks that really showed up and participated.

>> COMMISSIONER STEVENS: I have a question. I'm sorry. So I just want to be clear about that particular process. Is it fair to say that it was only the chairs and co-chairs of the community stakeholder groups and not the broader community, or the community at large?

>> KALENE GILBERT: Yeah. For the formal body, CLT, yes. However, I'd like to add that when we got to our stakeholder meetings, the community at large were able to attend. And we also solicited feedback from the community at large as well. So it was not closed after we got through this initial planning process. Once we met in November, I think there was an agreement to maintain the CLT process because we know we have work to do, and we want to do it thoughtfully when we think about that expansion of the stakeholder body. So we would finish out this year with the CLT and then come spring, which is now, our next steps are to kick off a process to expand that route. Next slide.

In December, we met with community stakeholders again to talk a little more about the proposed process and also go through our mid-year adjustment, which is something I've shared here previously. In January is when we kicked off the broader stakeholder planning process. And this was available both to CLT our formal stakeholder body and community. It took us a meeting or two, but we were really proud to be able to pull off some of the first successful fully accessible meetings, hybrid meetings. So we did hold these meetings in-person, but we recognize that, you know, there's an access issue and we now have better tools to allow people to participate. And so we were able to invite folks virtually and still offer sign language and CART services and language translation even within our breakout groups. So some work was that. I say again, a thank you to Julio here, too, because he was a big help in making that happen.

So in January, we spent some time talking about unspent dollars; what's available -- what, you know, what folks had, what the interests were, what were priorities. We talked about some of the proposals that had come forward or had been kind of on the table for a while that we needed to move forward. In February, we talked more about these proposals and we got feedback from folks. We got more specific feedback on comfort level and interest with those proposals. So that information on both scoring not only from our formal stakeholder body, but also from our broader community stakeholders at large is available and was shared. And even I think we'll be including in the final version of our Annual Update the data on the attendance for those meetings. Next slide.

In March 2023, we did an MHSA 101 training. I skipped that part. We also did that with our stakeholders. That is a mandatory piece. We will be doing MHSA 101 training annually. It's kind of like a little bit of what I did earlier here, is just explain to folks about different components and helping educate folks on the services available with MHSA because we want, certainly we want our stakeholders to be educated so they get available to participate in the process.

We also initiated our 30-day public posting which ended on April 24th. And we did solicit some online feedback there, which we'll be sharing a little bit today. And then we conducted a community stakeholder meeting on the 30th with giving folks feedback on what we were moving forward with and what the, what the plan was going forward. So now we are here in April. We've completed that 30-day posting and I'm here today on the 27th with our public hearing. And today is really, again, about more opportunities for the public to provide their feedback. That feedback will be included in the final posting. We do include transcripts and I think for major themes and questions, we'll respond to those as well. Next slide.

Let's see. So stakeholder themes and responses. You'll forgive me now. I think I do need to go to my handout here. So the first one up was commission and stakeholders requested a report on overall system budget recruitment and hiring status. Again, I'm not -- these are kind of here for reference for the future. I'm going to talk through them, not read them off to you our response. But generally, we want to share that. I think when it comes to the overall system budget, we did make the change of adding in the slide and information on where MHSA fits in the budget. We know that that's really, you're asking for a whole lot more than that when we are looking at the broader system. And that is something executive management is aware of and is working on how to respond to that request.

In addition, let's see, the department will -- yeah, we'll look on how we continue to provide budget expenditure reporting. And then finally, when it comes to hiring and recruitment, this is something else that is reported out by our executive management on a regular basis. So they're committed to continuing to provide reports not only here, but also to the board next in our kind of report on accomplishments. But I can note by the way, with hiring, we have seen some significant -- some significant hiring in the past six to nine months, thanks to our leadership. And, you know, I think MHSA has played a role in that with our Workforce Education Training. I noted

that's our opportunity to implement things like stipends, loan repayments offer even additional training to move folks out in the workforce. So that has been a really big contributor to expanding our workforce as intended.

So then the commission requested regular reporting side-by-side comparison of the budget allocations, service utilization and trends, and funding utilization prior to, during, and following the COVID Pandemic. The comparison was requested to be reflected by geographic area.

>> I'm sorry, don't. [Audio fades]

>> KALENE GILBERT: Oh, thank you. The commission requested regular reporting and side-by-side comparison of budget allocations, service utilization and trends, and funding utilization prior to, during, and following the COVID Pandemic. The comparison was requested to be reflected by geographic area, ethnic populations and age group. So this was a request that came from the executive meeting two weeks ago. And it is something we weren't able to turn around so quickly, but we do see this as a valuable report to look at as part of our Community Planning Process going forward. We do recognize really we are coming out of kind of the COVID era of services. So it would be helpful to look at those trends. So we are committed to putting this together, but we'll bring it to our Community Planning Process and certainly can bring it back here. Next slide.

Commission and stakeholders requested updates on data and outcomes reporting. Excuse me while I pull this up on my smaller bike. So I wanted to share with folks that I've already mentioned our countywide public-facing dashboard that will show or reflect clients served. And you can break it out by service area, by Sup district, by ethnicity, age, gender, and even by diagnosis. We are working on an MHSA version of that dashboard. And, again, as I noted, the ethnicities are broken down to sub-communities as well. So we do have that level of detail.

My hope was to have that ready for today, but it's going to be my understanding is another week or two. But as soon as that dashboard is available, it will be up and accessible by anyone 24/7. And we will make sure to share that link for folks. For those that are here, and we can -- I can share this handout with Kenia to send out to those who are online. We did print out a sample of a breakout by Sup district for FSP and for PEI for the last two years since it's not public, but I was able to get the data team to just prepare that for me. So folks got a sense of what we're going to be able to do. This will be available to you.

We're also looking at we have data disparities work group. We're looking forward to working with ARDI to look at and track using the equity mapping pool developed by the CEO and our own internal data to look at disparities and gaps and services.

Let's see, reports and outcomes performance program outcomes. Oh, so we were asked for outcomes and once again, outcomes for programming is available in detail in the Annual Update, or it should be for all of our PEI programs and for FSP. The commission and stakeholders. Next slide.

>> COMMISSIONER STEVENS: I have so many questions.

>> CHAIR AUSTRIA: Okay. Hold them, though, please.

[Laughing]

>> KALENE GILBERT: The commission and stakeholders requested specific responses to items reflected in the draft Annual Update. Let's see. I think we were asked about expansions for programs, which we included in the Annual Update. We did not reflect expansions there. They will be added in the final version and they are discussed here in this presentation.

I think when I spoke here two weeks ago, I paused on a slide and reported it as inaccurate. It was in fact accurate. It was because we were, it was a presentation to our providers on the MHSA 101. I'm looking at the dates that threw me off. But it is accurate and it is definitely accurate in this presentation.

There's a response to the expansion of the Courtland Identification and Early Referral program. This is an early break program. It's one of the proposed expansions. It's a really important program for young folks with first-break psychosis and for families. And the expansion is going to ensure services are available in Service Areas 1, 8, and 6. Right now they're already available in 2, 3, 4, 5, and 7. So we want to make sure that all service areas have access to those services.

And then there was also a question about Innovations proposals and when they'll be reviewed as part of our overall stakeholder process. One thing I noticed, the first thing we're going to start with is an expansion of our stakeholder review. The Innovations proposals are going to fit into that timeline. So we will first bring our new stakeholders. We're hoping to have a new stakeholder group sitting by July 1, or the expanded group sitting by July 1. And then we go through a needs assessment. We look at data, we look at programs data, we look at existing programs we look at, then we're able to look at our priorities and identify gaps. And this is where Innovations and all of the proposals should fit. We should be looking at those proposals through the context of needs identified by the

community once we've had that opportunity to look at both data around services and gaps. So it will be part of our planning process in the coming year. Next slide.

The commission and stakeholders requested responses to when will we be reporting out on the shift from We Rise, which was our campaign last year to take action, which is our May is Mental Health Month campaign. This year, as I noted, the Annual Update reports on outcomes from -- and happenings from the last year. So you'll see a more thorough report on that in next year's program, because that was a shift that happened this year. What you'll see in this Annual Update that has been posted is a report out on We Rise. And if Folks -- We Rise. Thank you.

And for folks who don't know -- sorry, this is one link I did not get -- Julio, take action. We have over 200 events occurring throughout Los Angeles County. Many are funded through CBOs who have proposed to do community events for May is Mental Health Month in our clinics and department as well. There is an online website that shares all of those events and their location. So I want to make sure that everybody will have that and I'll provide that to Kenia to share broadly. It's really exciting. We have a lot going on for me. Very exciting. Next slide.

Let's see. So commission stakeholders requested updates on the Community Planning Process going forward. As I noted, we need to look at expansions. We have our standing stakeholder group, which, of course, stays core to what we're planning to do next, but the regulations do require that we look at broader representation and that includes other community groups. It includes providers, it includes representatives of different systems like schools and fire. So we need to make sure that we have that representation, all the while ensuring we have geographic representation and ensuring we have equity among ethnicity and cultural groups. And then we want to, as in my team, MHSA unit, and the department want to make sure that we maintain that voice and equity, that voice of our consumers and family members. They should always have the spotlight and the core of our feedback. So as we expand -- sorry -- so as we expand, we want to we will be in -- as we expand, we will want to make sure that we have avenues and equity for our consumers and family members, because we have heard that as a concern from our stakeholders. Next slide.

And then there was a request for information on the funding request and proposal process. We have talked about the portal here before. And so the portal will continue to be our method by which we take in new proposals at this very moment. We have learned so much from this last process. We are revamping that form to make sure that we're asking the questions that we need to ask upfront.

[Laughing]

So we're taking what we've learned and we're making some changes. So it is down at this very moment, but hold on to those proposals for folks that have them. It is coming back up in a couple of weeks and we'll continue to be open 24/7 for feedback and entry.

And how are folks notified? We do get back to submitters via phone call or email, depending on how they share their contact information. And can the source of proposals be released? Yeah, where we at least let folks know where proposals are from a CBO, Community-Based Organization, a county entity or a community stakeholder. One thing we do want to make clear is, you know, we do have kind of a fair process here in the county. So just because somebody is the proposer does not necessarily mean they're going to be the funded provider. So we're mindful of that when we think about whose information we're sharing. So next slide.

Can the amount requested by proposers be shared? We did share the proposed amounts in our stakeholder meetings. Those it's available in our handouts online. However, once again, with all of the proposals, and I will talk about each one, there was a proposed budget that was included with them, but that does not necessarily mean it is the final budget, right? Some folks absolutely know how to budget a program. Some are, you know, kind of making an estimate. So we want to work with them. And especially where -- and this gets to the next question, where it's going to be served. Some proposers have talked about the communities that they specifically want to serve. For the more general ones we will be using, like, our geographic data, our demographic data, the equity tool to make sure we're applying those services where they're needed most. So we will -- we are committed, and I think we're responsible for reporting that out on a regular basis. I've talked with my team about a dashboard so that we can regularly report progress on each of these programs and those details as we develop them. Next slide.

This is the formal process for requesting MHSA funding. We've presented this here a few times. This has to do with starts. It always starts with a submission to our portal. I mentioned before this kind of this continuum as part of the stakeholder, the CPP planning process of taking some time to look at data, do the needs assessment, identify priorities, identify gaps, looking at existing -- quite looking at existing programming. So again, this proposal review should fit within that process, right? Thus, when we start to look at what proposals we want to bring forth to review with stakeholders, it should be in the context of the priorities that have been identified by the stakeholders. Next slide.

So proposed changes going forward. Again, there's a lot of detail in these boxes, so I'm just going to read the top: the name of the program and the target population. This is a list of all the proposals that we did receive in time by the January 15th cutoff date. And that cutoff date had to do with this whole process, right? That was the latest that we could take something in and still have time to present it and take it through all of these steps. And so some -- most of them are moving forward. I think anything that's not in here, and I'll explain it's because we have - we're addressing it in another way.

So starting with the Community Family Resource, this is an expansion. The target population here is for all age groups, especially families. Community Schools Initiative. This is another expansion. And it's looking at middle school and high school. So it's inserted, I think, already when they identify which high schools that they look at a number of risk factors and data presented by vulnerability and then -- excuse me, vulnerability index. So this is about, again, supporting schools.

United Mental Health Promoters Network. This is for underserved cultural populations. This is expanding. This is our promotores, this is our former CANS. We're pulling that all together under one program. We are ensuring that there are multiple cultural languages available. So the Prevention Unit is working on that now. Next slide. One.

Okay. Friends of the Children. This is a mentorship program. Target population is children and youth under 18, starting at four to six years old. Medical Legal Services. This supports for folks to address kind some of the trauma of legal issues that are out there when trying to access services. And it's for all age groups. Home Visitation, which always has to do with supporting new moms. So this is for parents and caregivers with children, zero to five years old. Next slide.

The New Parent Engagement. Welcome to the library and the world. This is for new parents and caregivers. Also, our SPOT Teen Program: Social Places and Opportunities for Teens After School Program. This is another library program for children and youth under 18. We Rise, Parks at Sunset. It's a partnership with the parks and recreation. And We Rise not to be confused with our We Rise but it is for folks who are 24 years old or below. And for families it's about creating safe spaces for families. Next slide.

And then there's a second Parks after Dark at Sunset. I believe this is maybe an eight-week summer program that's more specific. Also, for 24 years and below for families. DPR Safe Passages: Community Engagement and Safe Passages for Youth and Communities for children and youth under 18. Triple P Parent/Caregiver Engagement, this is support and training for new parents. Offered through, again, our library settings. Patient Health Navigation Services. This is available to all age groups. School Readiness; here in the target population is toddlers, two-to-four years old. Creative Wellbeing: Arts Schools and Resilience. Target population here is 24-year-olds and caregivers. The Abundant Birth Project. Next slide.

Oh my goodness. I'm sorry. I need -- let's go back. Yeah. The Abundant Birth Project. Let's see. Slide 32. Okay. So the Abundant Birth Project is adjunct services and supports a stipend program that is offered by another community. We're not offering the stipends; we're just offering the additional support for pregnant people and parents with children 0 to 18 months old. There's the Credible Messenger Mentoring Model for transitional age youth ages 18 to 25, and then Youth Development Regions. And that is for, again, transition age youth, ages 18 to 25. Next slide, please.

A Local Approach to Preventing Homelessness. This is from the City of Long Beach, who also declared a state of emergency around homelessness. They want to focus on young adults exiting foster care and who are at risk for homelessness. There's Laugh Therapy & Gratitude, which is focused on older adults who are Latino. And then there's the older Latino Adults & Caregivers Program, again, focused on older adults for Latino. Next slide, please.

There is the Search to involve Pilipino Americans, SIPA. Target population there is youth. There's the K-Mental Health Awareness and K-hotline. Target population is all age groups for Korean culture. Foster All WPW ReParenting program. This is for children and adults involved with the foster care system. Next slide.

Here's the Cultural Reflections Newsletter. I'm particularly excited about this one. I think this is one where we're looking to create communication among all of our stakeholder groups. I think there's a real need to make sure everybody is up-to-date. The idea here is that it is developed by peers, for peers. There is Hope & Healing: Mental Health Wellness and Support to Victims and Families and Relatives. And the target population here is African-American families who have suffered loss due to violence. We have the TransPower Project and the target population here is the youth trans population. We're almost there, I promise. Next slide.

There's the Open Arms Community Health & Service Center. Target population here is all age groups. Consumer Empowerment Network. The idea here, again, is to educate, create awareness for our stakeholders and consumers to help them become better advocates and help them learn how to navigate and advocate within the system. Innovation 2/Prevention & Early Intervention. I think this is a request that was related to the CANS

program, which is going to be solicited out very shortly. Which is the Former Innovations Program. Sorry, Innovation/CAN. Next slide, please.

Mental Health Services for Deaf and Hard of Hearing. Think this was an ask for a program for ASL. I think one thing that we're starting with as a department is we are bringing on our own ASL interpreter to be broadly available. There's the Stephen Cohen Military Family Clinic at VVSD Los Angeles. The target population here is veterans and their families.

>> What's VVSD?

>> KALENE GILBERT I don't know, but I can actually get that for you.

>> I think it is --

>> KALENE GILBERT: Sorry, the question was: what is VVSD? I need to get that acronym for you. I don't know it off the top of my head. There's also the DBT expansion. DBT stands for Dialectical Behavioral Therapy. This is a very effective treatment model. It is available at a number of our clinics. The request for us for DBT services at one of our clinics. And this is one where we are already addressing. We have regular trainings on this. We just began a new cohort. We see this as a really valuable intervention and we want to see this more broadly available. Next slide.

>> VVSD is Veterans Village San Diego.

>> KALENE GILBERT: Thank you. Huh. But in Los Angeles. Thank you very much. So if folks didn't hear, it's Veterans Village San Diego. Yeah, thank you. Let's see. Next.

Okay, so now we're going to start to talk about expansion. These are programs that have already been approved by stakeholders. They've been in our plan for quite some time. This is the expansion that we're planning in the next year. Many of them are a response to needs in the community. So I want to talk about where that work is happening because we've had lots of wonderful opportunities with prevention programs, but we know there are some there's a lot happening that we need to be addressing.

So let's start with the Portland Identification and Early Referral Program. I've mentioned this one already. This is that first break program. We recognized a need for services in service areas 1, 6, and 8. So it's an expansion to those service areas. There's the Homeless Outreach and Mobile Engagement expansion. This right now is so critical. I think we were adjusting the state of emergency here. This is an expansion of our street outreach teams. These are the folks who serve the hardest to reach, hardest to engage. Like where you've seen our LA Times articles in our wonderful street teams in street medicine, this is HOME. So we are expanding this program by 94 full-time physicians so that we have 16 teams countywide. And they will be placed where they are needed most, but they will be -- they are available in every single service area. Crisis Residential Treatment Programs, this is additional beds then for folks who are in crisis. They are not necessarily lock settings. So this is just another level of care that we can help folks stay out of the hospital and stay independent. So we're expanding some services and putting them in Downey and Sylmar. Next slide, please.

TAY Drop-in Centers. Another expansion of our TAY Drop-in centers. We recognize, again, this is a high risk population. So we are looking at a total of 10 new sites that will be added countywide service areas 2, 3, 4, 5, 7, and 8. Service areas 1 and 6 will each receive two new sites. TAY Enhanced Emergency Shelter program. This is additional shelter beds. Also for TAY, we're looking at an additional five sites. And I recognize, I think there will probably be an ask where those are. And that is something I can follow up with.

>> Yep.

>> KALENE GILBERT: And then Full Service Partnership. Then we are, of course, looking at an expansion. I've already talked about this, a Full Service Partnership and starting with some of our directly operated where we're adding 66 additional staff to FSP, but expect to see more FSP expansion in the future. Next slide.

Almost there. May. So in terms of next steps and timeline so right now I've noted already, I think we're here in April, right? So the next thing is, I think, we're looking at processing and moving the Annual Update forward so that we can then move on to planning for next year. The end of this month, we're looking at kicking off our process to expand our stakeholder groups. And in May you can anticipate we will continue to work with our stakeholders for that part of that extension. We want that to be a co-created process. In addition, we will be incorporating the feedback that we hear in today's hearing into the Annual Update into the final version that will go forward, will be posted online and will be shared with the board. In June of 2023, we have a reserved board date of June 6th for hearing and approval by the Board of Supervisors, which is required for us to move forward with the plan. And after that, we send it off to the state so that we're able to start services in July. So that is, I believe, we'll go to the next slide.

I believe that is the end of this presentation.

>> CHAIR AUSTRIA: Thank you very much. We appreciate all the hard work that's gone into this and all the meetings with the stakeholders. And we know that you're new to this position and that you're trying to improve it. So we thank you for that. I also have a -- I want to state that we're going to move into the public hearing first and then we'll get feedback from the commissioners because I expect the community stakeholders that are here will inform our thinking and then, you know, ask and improve our questions. I see one quick hand. Brittney?

>> COMMISSIONER WEISSMAN: Yeah, I just want to add to your thanks because I'm not sure that all the commissioners and the public are aware of the process that we've taken to get to today. So I just want to compliment you on, first, the presentation. It was really well organized and all of the questions that you see in the back that you just covered were questions that were raised by the Executive Committee last time we met in person here. And so to see full responses to all the questions written is really helpful. And I just want to commend your overall presentation, give you a chance to catch your breath before we move we move into questions and say thank you for being responsive to what we've desired so far. I think this bodes well for everything ahead here.

>> COMMISSIONER STEVENS: Here. Here.

>> CHAIR AUSTRIA: I have a personal complaint.

[Laughing]

Which does, and I don't want, it's not directed at Kalene, it's directed at DMH executive staff overall. We were -- the commission was asked to sign off on the draft today, you know, before we even hear, we're going to hear a public hearing when they want to sign off. And I just think that there's a point process that is not correct. We need to hear from the community so we can incorporate their comments into our board letter. So I just want to state that. I doubt that we're going to be signing off today, and that will be up to the commission.

The other thing I noted was that it's on the board agenda for this week. And so when I looked at the board agenda last night, I was a little surprised to see that, you know, it ought to be approved this coming Tuesday. So I would, you know, it's there. It's on the agenda. So, you know, I'm going to ask our commissioners to please ask you, you know, board members to please hold until the commission has a chance to incorporate the public comments that, you know, are going to be made today. And also, you know that. So again, and I also know none of the executive staff are in the room today. But thank you, Kalene. Again, this is not directed at you.

>> KALENE GILBERT: May I offer a correction? What is going to be heard on May 2nd is the mid-year adjustment. This Annual Update is on the board agenda for June 6th.

>> CHAIR AUSTRIA: But it's also, if you go look at the agenda, it's there.

[Laughing]

So it has the whole presentation you just made. It's on the board agenda. Okay. So thank you. We'll, and I may follow when seeing things last night when I look at tomorrow's agenda. But I am concerned about that.

>> KALENE GILBERT: Thank you. We'll follow up. Thank you.

>> CHAIR AUSTRIA: So I want to move to the public. I'd like to have the public and just to know we're going to go first -- the person in the room and the person online. And we'll go back and forth to make sure everyone's heard. I want to end public comment at 1:10 so that the commission itself has a chance to ask questions to, you know, internalize what the public has said. And then I have questions because I know they brought up questions. Thank you. And I'm going to turn it over to Kenia Fuentes, our executive assistant, to explain the process. Thank you all. Thank you again, Kalene.

>> KALENE GILBERT: Thank you.

>> KENIA FUENTES: Yeah. So for our online folks, we have AT&T who will handle that. And for our in-person folks, we will need to walk up to where you see Daniel. And we need to speak into the podium so that everyone can hear you and you don't have to project your voice, and it'll be clear to everyone. And so we'll do one person from our hybrid system and then we'll do one person in-person. Okay. So, Julio, we can get at AT&T start with our first caller.

>> DANIEL: Anyone here, who would like to make a public comment, if you'd like to line up on my left-hand side to make a possible comment, you're welcome to come up.

#### [Public comments]

>> JULIO MIRANDA: I'm sorry, I missed that second part, Kenia, and somebody else spoke.

>> KALENE GILBERT: Oh, it was Daniel giving instructions to me.

>> JULIO MIRANDA: Got it. Don, are you on?

>> AT&T MODERATOR: Yes, I am.



>> JULIO MIRANDA: Thank you, Don. Can you instruct the members who are listening in, if they would like to speak in public comment to queue up with your queuing up instructions?

>> AT&T MODERATOR: Absolutely. Ladies and gentlemen, remember if you want to ask a question, please press "1" then "0" on your telephone keypad. You may withdraw your question at any time by repeating the "1," "0" command.

>> JULIO MIRANDA: Thank you, Don, is there anyone in the queue?

>> AT&T MODERATOR: We do have one in the queue at the moment. Oh, we have a few now. Would you like to begin?

>> JULIO MIRANDA: Yes, please.

>> AT&T MODERATOR: Okay. First we're going to line number 8. Please go ahead.

>> HECTOR RAMIREZ: Hello, can you hear me?

>> JULIO MIRANDA: Yes, you can.

>> HECTOR RAMIREZ: Hello. Good afternoon, commissioners. My name is Hector Ramirez. I am Apache and Mexican, and I am a consumer with the Department of Mental Health at West Valley Mental Health Clinic in Chatsworth, Supervisorial District 3. Supervisor Harvard is my representative. Thank you for this report. I speak here wearing multiple hats but primarily as a consumer. I'm also one of the co-chairs for Access For All. And I call volunteer, which is a state advocacy program funded by MHSA.

And I really want to thank the department for this report. You know, it really, it's absolutely a plus that we've never had as a department. I've been engaged as a consumer since the passage of MHSA. And, you know, we have a lot of first ever first time actually having a stakeholder recommendation. The department has served over 250,000 people in Los Angeles County, and yet one of the things that this report has to highlight is that of all the people that participated, only one consumer submitted proposals. And that was myself.

And the reason for that is multiple reasons. This process out of all the years that I've participated was really inaccessible, particularly because the facilitator and some of the processes and the lack of accommodations that we got were not necessarily the process of good practices, but just constant fighting. It was very difficult, particularly for our Hispanic, Latino communities who really lacked to have access to the same information as anybody else, you know, when they were showing up.

And then, you know, as a consumer, the other thing was very difficult to attend these processes and having to be in competition with DMH staff and, you know, CBOs that were really there, you know, oftentimes replacing us and, you know, making recommendations and shutting us down, and sometimes even retaliating --

>> JULIO MIRANDA: 30 seconds.

>> HECTOR RAMIREZ: -- against us, and he was really, really abusive. And the fact that we have such limited opportunity to really ask for feedback, you know, really highlights the fact that, you know, the disparities, none of that is included in this report. So I really feel gaslighted and it's part of the trauma that this system kind of perpetuates over and over. You know, so I appreciate all the great things but, you know, as well for accountability and, you know, equity and really highlight the struggles that we had. We had people get COVID trying to attend these meetings. We've had people that died while participating in, you know, none of that is really kind of reflected.

>> CHAIR AUSTRIA: Thank you.

>> JULIO MIRANDA: Next caller, please.

>> AT&T MODERATOR: Next, we'll go to line number 11. Please go ahead.

>> KENIA FUENTES: Julio, please go for someone from in person.

>> JULIO MIRANDA: Oh, I'm so sorry. Don, if you can hold that line just for one second longer. We need to have somebody from in-person speak now. Okay. Can you go ahead?

>> KENIA FUENTES: Thank you. And then before we go off to that, Chair Austria, I do want to acknowledge that we do have a representative from our DMH executive team. We have Kimberly Nall with us.

>> KIMBERLY NALL: Hi. Hello. Good to see you.

>> Good to see you, too.

>> KENIA FUENTES: Go ahead.

>> BARBARA WILSON: Yes. Good morning, everyone. This is Barbara Wilson. I'm also from the same service area that Hector is from Service Area 2. I'm here in person and am glad to be able to be heard. I didn't have a lot of love with the technology.

Just wanted to comment. Our favorite -- my favorite passion is about licensed adult residential facilities. We are still losing them. And the concern, of course, is that as we lose licensed facilities, that necessarily means that people, that families that are looking for a placement, when a hospital calls and says, "Come get your loved one over.

We're going to send them to Skid Row." This strikes terror in the hearts of parents and family members. And what we are finding is increasingly facilities are being notified or advised that they should dump the residents that they have currently because they only can pay SSI rates and take in new people because they'll come with a batch or they'll come with an LW on some of these other funding mechanisms.

And so I just need to make you aware of the critical, critical situation that we have for families that don't know how to work the system. They just know that they have a loved one that needs a safe place to be absent of drugs and drug paraphernalia and able to give them medications and meals and an SSI rate. Thank you.

>> CHAIR AUSTRIA: We don't normally have questions, but we do have a question.

>> COMMISSIONER DALGLEISH: I have a follow-up question. Do you have an idea of, you know, a general idea of how many beds have been lost over the last, say, five years and actual facilities that have closed?

>> BARBARA WILSON I don't have that information, but I know people.

>> COMMISSIONER DALGLEISH: Okay. Great.

>> BARBARA WILSON: I can give an estimate.

>> COMMISSIONER DALGLEISH: Thank you. Thank you.

>> CHAIR AUSTRIA: Next comment.

>> JULIO MIRANDA: Don, do we have another caller, please?

>> AT&T MODERATOR: Yep. And we can go on back to line number 11. Please go ahead. 11 took themselves out of the queue. So we're going to line number --

>> MARK KARMATZ: 11.

>> AT&T MODERATOR: Okay. 11, you're on now. Go ahead.

>> MARK KARMATZ: This is Mark Karmatz and I have a -- the consumers have a major, major concern. There's a building for the state legislature having to deal with group disability. And what the bill does is changes the definition and kind of loosens it up in order to get people on involuntary holds. And the person can be detained, conserved, and can -- and unless I have a personal care Medicare provider who can be allowed, taken into custody, usually by police are held in a locked facility for six -- for periods of time. The state would then appoint a conservatorship, which other states called guardians, they can be placed at a locked facility. Significant loss of rights. There would be a -- the bill was passed yesterday at -- not yesterday, it was Tuesday -- it's now either the judiciary committee. It's going to the appropriations.

>> JULIO MIRANDA: 30 seconds.

>> MARK KARMATZ: And so that's very concerning for consumers. So that's basically what my comment is right now.

>> CHAIR AUSTRIA: Thank you.

>> KENIA FUENTES: Thank you. We'll go to in-person attendants.

>> MARK KARMATZ: What was the question?

>> JULIO MIRANDA: Oh, Mark --

>> CHAIR AUSTRIA: Thank you for your comment.

>> MARK KARMATZ: Thank you. We need to take a position on that.

>> CHAIR AUSTRIA: Thank you.

>> JULIO MIRANDA: We're now moving over to an in-room comment. Thank you.

>> JOHN WARDEN: Thank you. My name is John Warden. I'm here today to talk about Life Score: a simple, easy-to-use peer support, full health improvement platform with unique privacy and security to reduce or eliminate stigma, and can build capacity while connecting users to communities and the right resources to the right person at the right time. We have the support of Dr. John Sherin, former LA County Mental Health director, who writes, "I've seen numerous technology tools come and go. I'm hopeful that Life Score gets an opportunity to demonstrate its full potential efficacy and impact, which I believe to be substantial. It's the combination of ongoing self-monitoring to drive self-care objective assessments that prompt external interventions when indicated access to curated resource directories that match evolving patient needs, and the realtime connections with the personal support network set it apart from technology solutions that I've previously seen and tested. I believe that Life score is very worthy of support as a longtime leader of efforts that improve the mental health and wellbeing of individuals and populations suffering from a wide range of illnesses and traumas. I would recommend investing in Life Score and thereby the needs of community by funding a pilot program which will empower technology to scale." Thank you.

>> CHAIR AUSTRIA: Thank you. Next.

>> JULIO MIRANDA: And, AT&T operator, one more on the conference line, please.

>> AT&T MODERATOR: And once again, if you'd like to ask a question or make a comment, may please press "1" then "0". And we are going to line number 3. Please go ahead.

>> OSBEE SANGSTER: Good day. My name is Osbee Sangster, speaking on behalf of the black Los Angeles County Client Coalition, Inc. Today's public comment serves as the counterpoint to the neoliberal apologist who rule in dismissing or denying the reality of the SALT 3 virtual meeting minutes for the months of January and February. And let us take a moment to recapitulate the Black Los Angeles County Client Coalition's public comment delivered on April 13th. The mirrors of truth. SALT 3 minutes edits were demeaning, distorted, broken English, duped, and published. Reflecting rules confined by class in our color, like an unrestrained and deadly virus.

If Dr. King were alive today, he still unflinchingly used his visionary telling voice to declare a deficiency of will to do what's right. In the spirit of Dr. King, we wish to enlist your help as we attempt to unnerve the powers that deny and downplay the rights of people in this county. The month of April is --

>> JULIO MIRANDA: 30 seconds.

>> OSBEE SANGSTER: Los Angeles County Client Coalition's anniversary date, 17 years serving. We take great pride in the needy giveaway, HP Chromebook computers. I ask once again the Mental Health Commission Chair, Kathleen Austria, And the Mental Health Commissioners to please schedule a meeting to discuss and heed this call to care and for the concern ourselves with the plight of this matter. Thank you.

>> CHAIR AUSTRIA: Thank you. Next caller or person.

>> KENIA FUENTES: It'll be a person in person.

>> JULIO MIRANDA: In person. Thank you.

>> PASTOR NAH: Hello, everyone. I am just so glad to meet all of you and the stakeholders and commissioners. And also in particular, I would like to express my gratitude to DMH employees and staff members. I've encountered a lot of all of you during the last 13 meetings or so. I would like to express my gratitude as well. I've learned a great deal through CLT meetings, including what the blind spots are and where they're located. And through the CLT gatherings, I found that we have commonalities and the passions that we share. And then with the passions that we have, I feel that we can do a great deal of work. And through the MHSA Annual Update meetings, I realized that we can do a lot to help the communities after this Pandemic and people who have suffered during the Pandemic.

Okay, so one thing I would like to share with all of you is that there is no such a thing as a perfect way or perfect path. But I feel that things are never going to be perfect, but we do have the choice of going and walking the right path and we can walk that path. Thank you.

>> JULIO MIRANDA: Thank you.

>> CHAIR AUSTRIA: Thank you.

>> JULIO MIRANDA: And do we have an online caller?

>> AT&T MODERATOR: Yes, we do. And once again, if you're making comments, please press "1" then "0".

Next, we're going to line number 12. Please go ahead. Hi, can you hear me?

>> JULIO MIRANDA: Yes, we can.

>> CHAIR AUSTRIA: Yes.

>> PAMELA INABA: Yes. Hi, this is Pamela Inaba. I'm an Access ambassador with Access California Cal Voices. I'm in the LA County Client Coalition Inc. The community leadership with the coalition -- I'm in the Community Leadership Team with three UsCCs and the Cultural Competency Committee. I also -- I want to applaud and congratulate the department and the MHSA coordination team for organizing and doing the training and meetings for the CLT. And for other stakeholders of the MHSA, talking about the MHSA process and enhancing the access with creating virtual access. And in addition to the in-person orientations of the MHSA planning process and the proposal review training and meetings. I'm happy that DMH has made a considered effort to explain and show the DMH budget to stakeholders and urge another venue, the Endowment Center for better access to more stakeholders.

I will continue to work with the SALTs and UsCCs and collaborating with consumer-run organizations to increase the stakeholder voice and choice in the Community Planning Process and increase the number of proposals so that programs --

>> JULIO MIRANDA: 30 seconds.

>> PAMELA INABA: -- are more culturally competent with an emphasis on the BIPOC, and especially the AAPI, LGBTQ+, older adults, and the physical disabilities communities as target populations and offer more language access and more recreational opportunities for Fiscal Year '23-'24. One of my jobs as Access ambassador in LA County is to help DMH follow the MHSA guidelines. And I have been proud to be part of --

>> JULIO MIRANDA: Time.

>> PAMELA INABA: -- the planning process and appreciate all the work that the staff and administration has done to work with us, and I really want us to discontinue to do more. Thank you very much.

>> CHAIR AUSTRIA: Thank you. Next person.

>> JULIO MIRANDA: In-person, please.

>> JEAN HARRIS: Good morning. This is Jean Harris. I'm co-chair of the SALT in Service Area 1. I want to address the MHSA presentation on page 41 of Ms. Gilbert's PowerPoint. There is, in June, the adopted final MHSA Annual Update will be presented to the MHSA-OAC for final execution. I believe we have an opportunity to have public comment at the Mental Health Services Oversight and Accountability Commission as well on this final plan. And I'd like to ask -- make sure that that's correct and share that with the community the Innovations process.

Another question: When we were having the January and February meetings, which I did drive down from Antelope Valley and attend all of those in-person, that we were presented with several other Innovations proposals, and I wonder what happened to the Neurofeedback proposal? How does that Innovations process work? I support Neurofeedback and I was pretty excited to see it. I've been telling everybody who listens and now I don't see it anymore.

I would like to address the prudent reserve versus unspent funds. The prudent reserve has apparently been decided to be increased dramatically, and I'd like to have a conversation about that and allow stakeholders to comment on that as well.

On page 165, in the full MHSA report, there is Innovations 3: Hollywood Mental Health co-op \$26 million. Is that from one year, the '23-'24? And on page 35, 36 of the urgent care clinics across the county, there are some age levels, and I talked to Ms. Gilbert about this already. But the children in the High Desert Clinic affects Service Area 1, but the clinic there, the urgent care doesn't accept children 13 and under. They also do not accept older adults that are above age 65. And so that also needs to be documented in the statistics. Is there a possibility of requesting a hard copy to review before the final presentation? Because looking at it online, my eyes can't go over almost 200 pages.

>> CHAIR AUSTRIA: Thank you.

>> PAMELA INABA: -- and analyze.

>> CHAIR AUSTRIA: What we'll do is maybe you can Kalene can stay after and we have your questions. They've been documented and so hopefully we can get back to you and feel free to contact me.

>> PAMELA INABA: That's all I have.

>> CHAIR AUSTRIA: Thank you.

>> KALENE GILBERT: Is there anyone online?

>> AT&T MODERATOR: There are no new callers in queue, but line 11 is back; is that okay?

>> KENIA FUENTES: We'll give a person on the floor come in and then Chair Austria wants to give a second two minutes.

>> JULIO MIRANDA: Just to clarify, we are holding for in-person, for everyone to cycle through, and if there is room, Chair Austria will allow time for a repeat caller. Thank you.

>> CHAIR AUSTRIA: Yes.

>> RICHARD KIM: Good afternoon, Madam Chair, Commissioners. It's been a long time. Just want to address the new innovation projects, the Interim Housing Multidisciplinary assessment and training teams and the new IN proposed for this year 2023, 2024 does not address and does not include the number of positions for on-house peer support specialists on this team. This is in February 2022, where I became a participant of the State of California's Project Homekey. After four years of chronic street homelessness as a PHK stakeholder, I've seen many of my peers cycle into a transitional housing setting for the first time in years and cycling back out to the streets.

And unhoused peer support specialists sharing lived experiences that are invaluable to assisting linkages in mental health services and co-occurring SUD services by interim housing residents that can help decrease homelessness. California Mental Health Services Authority is accepting proposals for their peer support specialist training curriculum and certification program for justice-involved training, crisis specialization training, and unhoused peer specialization training, each one due by May 12, 2023, 5:00 PM Pacific Daylight Time.

My question is: why is the new innovation program, Interim Housing and Multidisciplinary Assessment and treatment teams not including peer positions on the team with a five-year proposed budget of \$190 Million? Does the Multidisciplinary Assessment also include the role of peers in interim housing who are violent to housing retention, linkages to mental health, co-occurring substance use services and support for recovering wellness of Project Homekey interim housing residents? Moreover, to better serve Project Homekey stakeholders, we must consider creating a peer-driven and led advisory committee that will advise new and existing interim housing policies

in Project Homekey that address the needs of PHK stakeholders and advocate the former current, new, and future PHK stakeholders to the mayor's office, Los Angeles City Council, Los Angeles County Board of Supervisors, the Los Angeles County Department Mental Health, Mental Health Commission, and any oversight commissions of Los Angeles County Departments of Public Health --

>> CHAIR AUSTRIA: Thank you.

>> RICHARD KIM: -- and health services. And if the commission so chooses also the quasi organization called "LAHSA" maybe. Thank you.

>> CHAIR AUSTRIA: Thank you.

>> JULIO MIRANDA: And online, has anyone else joined the conference line?

>> AT&T MODERATOR: Yes, sir. We're going to line number 13, please go ahead.

>> DR. STEPHEN MOUTON: Oh, great. Hi, this is Dr. Stephen Mouton. I'm a psychologist and policy lead liaison for the Seven LA County Regional Centers for Developmental Disabilities. And what I would like to see is the identification of services for people with developmental disabilities, more in the requests for proposals that are done, and then also when services are provided. They're usually broken down by different populations, by different ethnic groups, by different languages.

But you don't often see that a service is available for a person, let's say an intellectual disability or autism, severe or low functioning autism and a variety of those types of services. So I just think it'd be easier for parents and clients of the Regional Center to find mental health services when they have a co-occurring mental health and developmental disability, to be able to look at services and see some kind of identifying code that this service provider would be able to provide services because many times they're not able to get services that they say they do not provide services to people with developmental disabilities, even when they have mental health difficulties. That's it. Thank you.

>> CHAIR AUSTRIA: Thank you.

>> JULIO MIRANDA: Anyone in the room?

>> Yes.

>> LISETTE MARTINEZ: Good morning. My name is Lisette Martinez, and I'm on behalf of the Commission on HIV. So really I come today just to ask for potential collaboration with the Mental Health Commission. Our commission has been reaching out to other commissions to see how we can potentially collaborate to reach our most vulnerable population. So welcome the opportunity to collaborate soon.

>> CHAIR AUSTRIA: Thank you.

>> KENIA FUENTES: And that's all we have for in-person. Julio, is there anyone else online?

>> JULIO MIRANDA: Don, would you be willing to let -- thank you.

>> AT&T MODERATOR: Yes. I'll be going back to line number 11. Please go ahead.

>> MARK KARMATZ: What was I going to say?

>> AT&T MODERATOR: Okay. Line 11, please just speak, don't press the button.

>> MARK KARMATZ: Thank you. This is Mark Karmatz. And I was listening to the -- I'm sorry, to the meeting with the legislature yesterday with regards to the -- I forgot what committee it was. But anyway, they were talking about Senate Bill 403, which has to do with the -- has to do with the caste systems and so that we don't have the same thing going on that they had in India, basically. And it reminded me that we need to have this into the Mental Health Services Act. And having it -- this could be a cultural competency issue with him. So I think we need to -- and we think we need to get that introduced into the Mental Health Services Act meetings here in Los Angeles County. So thank you.

>> CHAIR AUSTRIA: Thank you. Is there any other public comment?

>> KENIA FUENTES: That's all we have in person. I imagine there's no one else behind.

>> CHAIR AUSTRIA: Yes. Go ahead, Jean.

>> JEAN HARRIS: Sorry I ran out of time before.

>> CHAIR AUSTRIA: That's okay.

>> JEAN HARRIS: I'd also like to address the fact that when we're going over these Annual Updates that I'd love to see those budget figures in the service areas getting these proposed services. How are their monies being spent across the county per service area? I see that we were provided with a data sheet as an example of supervisory districts, and that's wonderful. I can't wait to see the statistics.

I also want to commend on the difference from past years with MHSA only being addressed when it's time for the 3-Year Plan. And I am really welcoming DMH's commitment to getting that stakeholder involvement. I would love to see stakeholder meetings in every service area rather than requiring people to travel long distances to attend

in-person meetings. Online is a very much different experience and I want to get all of our communities all across the county involved. Thank you so much for all the effort and all the hard work.

>> CHAIR AUSTRIA: Thank you. I think what I would like to do is maybe, Kalene, you could -- if you can address some of the questions that came up on our public commenters and then we'll go to commission. So I know Jean has some questions and a few others, and I don't know that you can answer them all. Stacy.

>> KALENE GILBERT: So first, first of all, I just -- I want to thank folks for their feedback. I feel like there was a lot of, like, not only positive feedback, but like a lot of helpful feedback that helps us think about how we do not only things in the future, but actually how we communicate in the future. So that was very, very helpful for us.

Just a couple of things that I could say. Well, I think where we saw some, had some direct questions. I do want to start again with the board date. Quite frankly, Ms. Nall shared with me that what is going on to the board calendar on the second is called the Revised Annual Update.

So I had referred to it as the mid-year adjustment, but it's an adjustment to the Annual Update from last fiscal year. So it went onto the board calendar as the revised Annual Update. So it is for fiscal years '22-'23 for this fiscal year. So that helps. Actually, I didn't even recognize it when you had shared it with me, so I appreciate that. So I wanted to make that clarification. It is indeed the mid-year adjustment. It's just referred to as the updated update. So I wanted to share that with folks.

I did hear the ask for the Innovations Neurofeedback. I want to let you know that that is still in progress. Innovations, I kind of see it's on its own timeline.

So one of the things I have shared with stakeholders is that we have two big priority projects with the interim housing and with the CARE Court piece. We're mandated to do CARE Court, and we absolutely insist that we have peers as part of that team and its supporters. But Neurofeedback is next in the queue, so it has not gone away. And, in fact, I'm working with the team now so that we can do the full 30-day post. So that's coming, but it's on its own timeline. I think we just need to get through the big commission meetings, the process with these two first.

>> CHAIR AUSTRIA: And let me just ask a quick question. So on the process then, because we were also asked to sign off on this today, and that we need time to digest the public comment, as well as our own feedback from our, you know, board members. What is the drop-dead date? We can submit a letter to you because we need a little bit of time, at least a week.

>> KALENE GILBERT: I think we need this, and I apologize, I'm going to look to my team. Yeah.

>> Tuesday.

>> CHAIR AUSTRIA: This Tuesday?

>> KALENE GILBERT: Yeah, that's it. It has to do with when we have to submit it to the board so they can go through their process for hearing it by case.

>> CHAIR AUSTRIA: And I -- just, again, in the process, we can't do that and get together. This is difficult to get us all together. We come from all ends of the county. We couldn't talk online, but to actually generate an appropriate letter with appropriate feedback, we need some more time. So we need you to take that back and get back to us.

>> KALENE GILBERT: Yes, absolutely.

>> CHAIR AUSTRIA: Thank you. All right. If you have any other questions that you can respond to from the community? I just want to make sure we're on point in the process. And also, if anybody comes on -- [Clears throat] excuse me, online, Julio, can you let us know and then we'll break and let people comment because I don't want to cut off the hearing too soon.

>> AT&T MODERATOR: We do have -- we do have another person, another repeat if you'd like to open that line now.

>> CHAIR AUSTRIA: Okay.

>> AT&T MODERATOR: Okay. Going back to line number 8. Please go ahead.

> HECTOR RAMIREZ: Can you hear me? Can you hear me? Does anybody hear me?

>> CHAIR AUSTRIA: Yes, we can.

>> JULIO MIRANDA: Yes, we can hear you.

> HECTOR RAMIREZ: Thank you. So I'm Hector Ramirez. So in addition to what I wanted to add, one of the things that I really wanted to recommend, and we have been asking for this over and over is for the department -- the Department of Mental Health MHSU Unit to have additional resources. This is the largest county in the state, and it is nowhere nearly supported or funded to really have the stakeholder process that, you know, we intended and that we need to do this. And so we're kind of functioning at a smaller county-level capacity. We're not even like an

Orange County level but we have great staff, but they're being worked so hard, and that's why we are having all these kinds of big fumbles happening.

You know, and in addition to the lack of Spanish access for our Latino Hispanic population, the other thing that we have been really struggling with is getting information in plain language. And this is a disability accommodation request that we did and request way back in September. And so it's a disability accommodation, and we ask over and over. It makes it very difficult to print, you know, the big over 100-page document and process it. You know, sometimes I have support staff that helps me go through it, but my peers don't. You know, the community does it. And so it really puts our community sometimes, unfortunately, at a disadvantage. If you're not a paid community person or a lobbying person for home, you know, board and care, you really don't have this type of infrastructure to support you.

And so as a result, you know, our both needed partners research, our consumers and our family members are being really oftentimes, you know, supplemented or replaced. And we don't necessarily have that opportunity. And I think our possible solution for that is definitely the stakeholder process suggestions, which I really appreciate and hope that they get funded properly. But then also to have the infrastructure for the department to be able to do this, because right now they don't. And that's why these big, big mistakes are happening --

>> JULIO MIRANDA: Time.

>> HECTOR RAMIREZ: -- and it's not fair for employees that are really trying really hard, not fair for the community. And it's not -- it's something that we -- I would really like to fix.

>> CHAIR AUSTRIA: Thank you

>> COMMISSIONER MOLINA: Thank you for the point of order. Can I just offer a recommendation, then? He's reflecting on Chair Austria's concern and I see frustration a little on the timeline of getting this letter sent to the board office on a timely basis to make your June 6th deadline with the Board of Supervisors. Can we work today to draft the letter so that it reflects the comments and the questions and maybe the concerns of the commission and some of the points that are made in the public hearing today, so that the letter that is drafted really be thoughtful in the discussion that we're having today.

And then if that draft letter could be submitted to us for consideration and for the chair's signature, eventually. I think the point is well made that while the schedule and even the process probably ends up being quick at the very end, as long as that letter reflects some of our comments and some of our thoughts today, I think that may solve a concern that the chair has, that today's meeting somehow is reflected the most comments.

>> COMMISSIONER DALGLEISH: I just would like to agree with that. I think it also provides an opportunity for us to be transparent in our deliberation. So thank you for bringing that out.

>> CHAIR AUSTRIA: Okay. Do you have a last something, a few comments to make and then I want to move to the commission?

>> KALENE GILBERT: Sure. I did want to respond to one other -- actually, two other comments now to the gentleman that asked about the Innovations Project and peers on the team. I do, I think, again, this comes back to how we post and communicate things. There are absolutely -- sorry, there are absolutely peers as part of that program. We would not do outreach novel services without that. We recognize that as so important for engagement, but I also recognize that we didn't share that as part of the details. So that's very helpful feedback for us. But I wanted to assure you that that is most certainly part of the programming there, and I thank you for raising that. So we can share that more publicly.

And then I just, again, I wanted to thank Hector for his final comments, too, on just the infrastructure and support. We are a new unit. It's taken some time, but we are growing very soon. [Laughing] So the team has really worked extraordinarily hard. And I think I've tried to do the work of several people at once. I really want to acknowledge Dr. Horn, who has really worked hard to make sure that these stakeholder processes have gone well. And I think we anticipate seeing that next year. So thank you again for just the acknowledgement of the support.

>> CHAIR AUSTRIA: And we appreciate, again, all of the work and we recognize the changes. Actually, I would like to have the names of your team so we could appropriately thank them.

>> KALENE GILBERT: Absolutely.

>> CHAIR AUSTRIA: And I want to go ahead and move to the commissioner's questions. So yeah, let's go around. We'll start with and just go around. I think that's the easiest. I won't ask.

[Overlapping speakers]

Reba Stevens.

>> COMMISSIONER STEVENS: So my first question is I was curious because through the plan, I didn't find PMRT. So is it included in the plan?

>> KALENE GILBERT: So I believe that right now, PMRT and this is to confirm this, I want to confirm the funding source for PMRT last year versus this year.

>> COMMISSIONER STEVENS: Okay. Got it.

>> KALENE GILBERT: So that's a confirmation I need to make.

>> COMMISSIONER STEVENS: Say that again?

>> KALENE GILBERT: I need to confirm the funding source for PMRT last year versus this year.

>> COMMISSIONER STEVENS: So it's not.

>> KALENE GILBERT: I'm sorry. Let me -- Kim.

>> KIMBERLY NALL: The source of funds is ACS, Alternative Crisis Services, and it is included in the annual. It didn't change. So there was no change to.

>> COMMISSIONER STEVENS: So I'm not going to spend a lot of time, so I'm going to ask for someone to send an email to write me there. And the other question that I have is, you know, and you don't have to answer it now, perhaps you'll send it an email. I'd like to know clearly what is DMH's equity tool and clearly what it is. What is DMH's equity tool?

And then I'll ask just one more question. But I also want to take you to the slide. I believe it's a slide -- I think it's 40.

>> COMMISSIONER FRIEDMAN: Reba, speak up a little bit.

>> COMMISSIONER STEVENS: Really? We never had asked that.

[Laughter]

So slide 40.

>> KENIA FUENTES: So I think what I like to do is, if I interrupt, can I have you go to the podium?

[Overlapping speakers]

>> COMMISSIONER STEVENS: So I'm going to stand up.

>> KENIA FUENTES: Yeah, because it's hard. They also want to hear your beautiful voice.

>> COMMISSIONER STEVENS: So I would like to thank you and everyone who made public comments. I'm going to stand right here. And the question I have on page 40 or slide 40 is you mentioned the TAY drop-in sentence. And it excludes SPA six, but it includes it because then you mentioned that SPA 1 and 6 will receive two, but it's not clear as to where they are and what they look like. And so I would like more information on the SPA 6 needs.

And then the very last thing that I'll say is around Prevention & Early Intervention and suicide prevention. It was mentioned today and reminded us about co-occurring disorders. As we all know, people are dying, literally dying on our streets as a result of fentanyl and other substances. So I would like to know more about what the Department of Mental Health is doing with harm reduction, and what exactly does harm reduction look like in engaging in our community. And I just want to remind us that any of us who are using street drugs have a mental health challenge, because there is something wrong with street substances. And I'll end there for now.

>> CHAIR AUSTRIA: Thank you.

>> KALENE GILBERT: Can I respond?

>> CHAIR AUSTRIA: Yeah, go ahead and respond.

>> KALENE GILBERT: So on the TAY drop-in centers, that is something, the information I can talk with the unit that is rolling those out and get the details for you. Regarding harm reduction, I can tell you that is absolutely the approach of the department. And, in fact, we have also been working really hard to expand not only access to Narcan among all of our teams but also MAT, medication-assisted therapies to make that more broadly accessible. What that looks like, and I think more specifically approach, I would talk to the SMEs, the specialty, the folks who do the programming to give you more information on that. But I can tell you harm reduction is the approach. But what that looks like off the streets and how that's rolled out, I would like to give the program to speak more to that. Yes.

>> CHAIR AUSTRIA: Thank you. I'm going to go to Brittney, and after Brittney, I'm going to go to Imelda, who's online. Go ahead, Brittney.

>> COMMISSIONER WEISSMAN: Thank you. I did -- this is Brittney Weissman. I did represent my questions at the last time we met as an Executive Committee, so they've been mostly addressed. I'll just point out again, in front of, you know, the public hearing that the numbers for PEI just seemed so low in terms of service collective people reached, and I realized that it was a COVID year. And so I'm just hoping for a little bit more context around that because how could LA County possibly serve so few people in PEI.

>> I'm sorry, repeat that.

>> COMMISSIONER WEISSMAN: Possibly serve so few people in PEI over the course of an entire, you know, fiscal year. And then I would say my next point is if you are developing this dashboard for data and it's ready in two



weeks, hallelujah. That is so much work in such a short amount of time. For you and the department to work out something that is public facing that quickly just, I wanted to call out and say congratulations and thank you.

>> KALENE GILBERT: That is a project that has been worked on since I came on board. So there's definitely been, I think we've heard the request long ago. The team has worked very diligently on it. It is done.

>> COMMISSIONER WEISSMAN: I think it's a matter of just final basics. So I'm really excited to share it. So thank you for that. And would we welcome you to do, like, a beta focus group test with us anytime?

>> KALENE GILBERT: Absolutely. We did this with -- actually, I should mention, we did do a preview for our Cultural Competency Committee and got a lot of wonderful feedback. So glad to do that here as well.

>> CHAIR AUSTRIA: Absolutely. Thank you. I want to go to Ms. Frausto, please.

>> COMMISSIONER PADILLA-FRAUSTO: Hi. Thank you. Can everyone hear me?

>> CHAIR AUSTRIA: Yes.

>> JULIO MIRANDA: Yes.

>> COMMISSIONER PADILLA-FRAUSTO: Okay. Thank you. First, I just want to apologize for not being there in person. Many of the issues that we are discussing today have happened in real life or my family. We lost my son-in-law to a fentanyl overdose at the beginning of March. My daughter and my granddaughter have been reeling in devastation from that and has triggered manic and psychotic episodes for my daughter this past month. So we are living this live as we speak. But I do want to say I am here because our mental health system really needs to change. I am living this live in person and it is frustrating. But to this MHSA update in particular, thank you, thank you, thank you so much for all this wonderful information and putting this all together. I'm so happy to hear that there is a dashboard coming together.

I just want to ask a clarifying question. Are these numbers that you presented on slide seven of the client served, is this client served just through MHSA funding, or is it client served through all of DMH? And if you could answer that before I move on to my next question.

>> KALENE GILBERT: Sure. So on slide 7, if folks remember, this is our Community Services and Supports plan slide. This is specific to the Community Services and Supports component. So it's just one part of MHSA, not all of MHSA. So it includes the children, youth, adults, older adults. It's directly operated and contracted services. But once again, it is specific to the programs you see there, which are Full Service Partnership, outpatient care, Alternative Crisis Services, housing linkage, and planning outreach.

>> COMMISSIONER PADILLA-FRAUSTO: Okay. Thank you for that clarification. The second question, and I guess the point that I want to make, and this has come up multiple times because I brought it up, is the need to have the number of people in need. Not just the number of people served, because we, these numbers look great and all, but if we don't know what the need is out in the communities, we don't know if we're actually reaching the people that we need to be serving. And so I did a quick little analysis here based off of the data you provided on slide seven. And these are Community Services and Supports for all ages. And what I did is I compared that to the numbers the estimates of adults in need. It's only adults? No, it's SMI and STD. So it does include kids, my apologies. It includes both.

So I took that number from the Cultural Competency Plan, which is on DMH's website. There, it was from their Table 8. And so I -- they use CHES Data and American Community Survey to provide estimates of mental health need by SPA. They also break it down by race ethnicity, but for now, I just did by SPA and took that number of what, you know, this document identifies as need by SPA and looked at the number of clients served in CSS, which does make sense using CHES Data because data from CHES is a household survey. So these are people who are living in the community, so it doesn't include anybody that's homeless unhoused or institutionalized. And then I used that number of need and subtracted the number of clients served. It kind of overlaps at the same time period. The time periods may be off a little bit and I can adjust that.

But what I'm seeing here is that 75 percent of people in need of all ages in LA County are not getting the services that they need, 75 percent. And this ranges from 66 percent of unmet need in SPA 7, down to 34 percent in SPA 5. And all the other SPAs fall in between there. SPA 7, 2, and 6 and 3 all have more than 50 percent of unmet need. I would highly, highly encourage us to include these numbers in these updates in the dashboard so that we can really start seeing where we need to move the needle, where we really need to start allocating resources and really reaching the people that we really need to reach. Because 75 percent of unmet needs in LA County is not great for us. And I would like for this commission to really work hard with DMH to move that needle so that we are reaching more people.

So to Commissioner Weissman's point about PEI, we should be touching every one of these people who are in need, who are identified as having need, and we're not doing that. So we have worked ahead of us and I am

happy to work with anybody on data to really to really help us address this and really help us start moving this needle and getting people's needs met asap.

>> CHAIR AUSTRIA: Thank you. Can you send your data? And then, Kalene, maybe you could connect personally and have a discussion?

>> KALENE GILBERT: Absolutely. Can I speak to some of the points I want to make?

>> CHAIR AUSTRIA: Sure. Commissioner Frausto, I don't want to interrupt you.

>> COMMISSIONER PADILLA-FRAUSTO: Yeah, no, I'm done. Thank you so much.

>> CHAIR AUSTRIA: Thank you.

>> KALENE GILBERT: So, and then Commissioner Frausto, thank you so much. Just one of the first, what you're really talking about here is doing a proper community needs assessment and really trying to assess what the need is in the community and then how well we're meeting that. I would caution on just using the CSS numbers for a couple of things. I want to -- I would caution against using just the CSS numbers and perhaps the current public facing dashboard that is for all DMH services might give you a better idea of how many people are served across the board. Because it's much larger than here. This is just a subset of MHSa.

A comment. I came -- prior to here, I came from Quality Improvement. So we did look really closely. We do work with them, and it is one of the California Health Information Survey that's done by USC. It's one of the only tools we really have to try to assess what the need is in the community. I think we've struggled a little bit with their questioning. So I would very much love to sit down and talk about how we use it and how we can apply it because, I think, the questions are very general. So I appreciate that, appreciate the attention to detail and I'm really glad to follow up with that. And this -- oh, sorry. Go ahead, please.

>> COMMISSIONER PADILLA-FRAUSTO: Oh, no, I'm just saying that I'm happy to help you with that because the data comes from UCLA. It is housed at the center where I work and we're another house as a researcher. So, you know, please feel free to pick my brain. Let's get this data, let's get it out there. Let's be informed so we know how best to move forward.

>> KALENE GILBERT: Thank you so much. This will be a big part of that community's need. And I also want to speak to the other side of where we apply that data and what population we're applying it to because really what was kind of trying to tell us is the rate of need and, you know, are we applying that to LA County at large? Are we applying into the Medi-Cal population, which is more the population we're serving? Are we applying it to the population of 138 percent poverty, right? Trying to capture folks who maybe don't have Medi-Cal.

So there's a lot of -- I'm so grateful that give -- you're a numbers person, I'd love to work with you. But I think that's one of the things we need to be really clear about, too, when we share statistics is what they really mean and what we use to build those numbers.

I also appreciate the corrections. I think I said USB. I'm a bruin, so that was a huge foe fa. I didn't give credit to the right school. But thank you very much.

>> I will not write you out.

[Laughter]

>> COMMISSIONER PADILLA-FRAUSTO: Thank you. May I just ask to reflect that it's not Brittney Weismann who's continuing to speak. This is Imelda.

>> CHAIR AUSTRIA: Yes, thank you.

>> COMMISSIONER PADILLA-FRAUSTO: Okay, thank you.

>> CHAIR AUSTRIA: Okay. All right. We're -- as we're going to continue to go around I want to move to Larry Schallert. Thank you, Imelda. Going around. Thank you. Go ahead, Larry.

>> COMMISSIONER SCHALLERT: Oh, sorry. Thank you very much, Kalene, for this great report. It's really -- I really appreciate the detail and the amazing thing everyone's doing. Just one issue, I'm kind of taking up on someone else's -- I can't remember who said it -- on the alternative crisis care. Two things. One, the importance of being able to treat, to see adolescence is really crucial. Let alone children under 13. So those two areas are really lacking. And I noticed in the funding, it's actually going down for alternative crisis care, which seems really counterintuitive. Which slide was it? I had it for a second. Yeah, it's slide 8. Do I have that right? That our price Alternative Crisis Services funding is actually decreased at a time when we -- it's been proven how important that services across the board, whether it's a net team or it's an empath center or subversion care we're, obviously, trying to get those in our areas. So can you comment on that? What happened with that?

>> KALENE GILBERT: The change in the funding, I would want to take a closer look before I share that. So I really would like to get back to you with that. I think the other thing that we can do, though, is share all the work that has been done with the alternative crisis because we have seen a significant expansion and I don't know how

publicly we talked about that. And I do appreciate the comment about the age ranges. So this is something, let me, if I can, get more thorough, I want to make sure I'm accurate to that.

>> COMMISSIONER SCHALLERT: Great. And I'm not complaining about everything that's been done because just bringing it all into one department has been amazing. People that are running it's amazing. I mean, everything's great, but we're not -- we're not burying this. Thank you.

>> KALENE GILBERT: And yeah, the trend, and I won't try to explain that. It's a good question.

>> CHAIR AUSTRIA: Judy.

>> COMMISSIONER FRIEDMAN: Susan. I was just going around. Susan?

[Overlapping Speakers]

You're going to defer to Susan, we'll come back. Susan?

>> COMMISSIONER FRIEDMAN: I have two questions. Thank you, Kalene. I'm saying, so I'll just say it up. First of all, if you could tell us more because I do know that the governor has been talking about eliminating Prevention & Early Intervention. The second thing I wanted to ask was about the suicide because are you talking about the 988 line or are you talking about the Didi Hirsch? I was under the impression that DMH is going to use the Didi Hirsch suicide center as that's going to be where the calls; is that correct? So the Didi Hirsch, yes, that is correct with the suicide hotline numbers are specific to a suicide pipeline. Those are the calls that came in last year. Okay. The ones that we reported out on today. But in terms of, are those two points blended together in the future? That's a question I need to ask, but [Speaking away from the mic] is always under the impression that DMH suicide prevention.

>> KALENE GILBERT: Yeah, Didi Hirsch's always been our suicide hotline provider. In terms of the 988, I think I'm wanting to clarify your question, but let me -- again, this is another thing that I want to bring back the folks who are at top to the folks who are doing 988 because again, I want to make sure you have the right answer.

>> COMMISSIONER FRIEDMAN: Can you tell us anything at all?

>> KALENE GILBERT: Sure. And I'll try to write this brief because I do know it is a much, much larger conversation. But just to make sure that if the information out there is correct, and you can go onto the state website and I share that information, too, with Kenia. There will be opportunities for stakeholders to speak. The proposal, as it stands, specifically looks to change those components that I talked about today of CSS, PEI, when from that allocation make up to 30 percent housing and housing services, 35 percent FSP, and 35 percent everything else. And then everything else could be PEI, could be outpatient, right? It doesn't really speak to you. It's like the other things that we prioritize. So that's the proposal as it stands. It also includes services to folks who have substance use disorders and no mental health needs.

Some other things I want to make clear, it is a proposal to put something on the ballot in November of 2024. It'll go back to the voters. So this is not something that's just going to get a railroad, right? There's a lot of conversation that's going to be happening between now and then. We will expect that proposal to morph, but it is something that will be coming to the voters. So at no time did he say we're eliminating PEI but he's proposing that we change those buckets. And if we want to bring that conversation back here, there's a lot we don't know yet. So I want to be very careful about making sure there's accurate information. Does that help?

>> COMMISSIONER FRIEDMAN: Thank you.

>> CHAIR AUSTRIA: Judy.

>> COMMISSIONER COOPERBERG: Yeah. First, I really want to say that I appreciate you including the stakeholder feedback, themes, questions, and responses. This, that's the first time we've ever seen this. And I'm the old lady of the commission, so I know I've never seen this before. So thank you for that. Part of it was the commission's request for data budget allocations, service utilization. I want to encourage that we stay away from any data on Sup districts because there's a big difference between Sup districts. I can't say the whole word.

[Laughter]

Yeah. What he said. And service areas. Service Area 1 goes from Antelope Valley, Santa Clarita Valley, San Fernando Valley, San Gabriel Valley. So they really have nothing to do with one another. And so if you do that one picture in a Sup district, it's way out there in space. So if you stick with the service areas, it really gives you a better picture.

Addressing the current services, that's great. You have the client data by service area, but what is the population of each of those service areas? Because we don't know between ourselves what service areas have what population. And that gives you a better indication of where people aren't being served, where the unmet needs can be focused on. And so if you could include the populations, that would be really helpful. And like what Imelda said, and we brought this up at the Executive Committee meeting, is that we know that this is the MHSA report, but in

terms of us really having a grasp of the department, we need all the funding, all the services, all the data to really be on top of what's actually going on in our county.

>> KALENE GILBERT: If I can, I'll try to start -- and thank you for those comments, Commissioner Cooperberg. I want to start by thanking you for acknowledging the work on responding to those comments. I want to acknowledge your team member, Dr. Horn, again, who spent time to really go through and come over with those attendees and make sure that we do get that information back. So I'm glad that that was helpful. For the data, what I had shared today by Sup district is part of the dashboard. And the dashboard will allow you to cut by district or service area. So that when it comes to our reporting out to the community, we usually broadly go by service area since it's more specific. But we also want to make sure, especially us commissioners and representatives of board members and their constituents can cut either way you need. But we'll continue in that direction.

And then for the total population, there is actually a second report that is available on the department's webpage. And I can share this with Kenia that flyers to the whole department. That's our -- it's our annual needs assessment whereby we do go through, it is by service area, but we do look at not only all the population statistics and demographics, but then we do a cut by, as I was mentioning earlier, we do a cut by Medi-Cal. We do a cut by 138 percent poverty. So I don't want you to have to look at these side by side. So I want to say, I hear the comment that you'd like to see this past. If there's something you're interested in seeing now, it's available. Sure.

>> COMMISSIONER COOPERBERG: It would be helpful to see it side by side.

>> CHAIR AUSTRIA: Right.

>> KALENE GILBERT: Did I miss a question? I just want to make sure I got everything.

>> CHAIR AUSTRIA: No. Thank you. Dr. Barbour.

>> COMMISSIONER BARBOUR: Thank you so much for this comprehensive report. Really quite a lot of detail and I'm looking forward to the dashboard. And I understand that it's a lot of work, but I look forward to seeing how it can be sliced and diced in the way you just described. I think that's going to be very helpful to our community. I just have a few questions and things that I just want to wonder about. And one of them was PMRT. I heard Kimberly said they're seed funded, but in that report there's very little about PMRT. Unless I just missed it going through it. I may have missed it, but maybe I just didn't see it. However, in the LA Times on April 13th, there was quite a lot about PMRT and they gave quite a lot of statistics about PMRT and what's not happening in communities.

And so I'm very concerned about the crisis system and how it can be fortified because I've been a part of it. I'm part of something that's sunseting and I take great, great risk in talking about that. But I do feel like I have to speak about it because the PMRT is not here. But there are groups, enormous statistics that were in the LA Times, and I just wonder if there's something that we're missing. Is there a problem here? And how it's going to be -- is it always funded by ARC or is it moving to ARC? Is that something new? Is there a lot of flux going on in that area? Because crisis services to people who are experiencing suicidal thoughts, who are experiencing overdoses, who are experiencing domestic violence challenges or who just need access, and we're talking about access to care is really important. And so I just have to bring that up.

I also see what there is a mention in here about FSP wanting to increase it to 51 percent. And I'm really glad that UCLA has been a partner with FSP. It's mentioned in the report what they have done in terms of training, but I'm wondering if there's any training that UCLA or anybody in the department can do that has to do with the sustainability of FSP under CalAIM. We've not talked about CalAIM in this forum as long as I've been, and it's, of course, not in this report because it's retrospective mostly, but it goes a little prospective as well. And I think the absence of that conversation around some of the intensive programs is really kind of noticeable.

I want -- I also want to -- I was very encouraged to see the UsCC recommendations in those meetings. And the LGBTQ+ recommendations serving the Black community, there were at least three and they were well elaborated. I wasn't sure who was implementing it. And I think that would be great because many would like to enjoin that effort to be able to implement. And so those, because these are among the most marginalized people in our community and we experience it in SPA 6 and how can we help that, but we need a little more information and perhaps I can do a little outreach to the UsCC to see where they are so that it's just not words on the paper.

>> CHAIR AUSTRIA: Thank you. Kimberly, can you respond?

>> KALENE GILBERT: Yes. I would like to first respond about -- do you want me to stand up?

>> COMMISSIONER STEVENS: I think before she responds, can I just ask one question that she could maybe include in that in reference to CalAIM? And my question would be: how will wraparound services be impacted by CalAIM?

>> KIMBERLY NALL: You would give me a challenging one, right?

[Laughter]

>> COMMISSIONER STEVENS: Of course.

>> KIMBERLY NALL: So first I would like to speak about PMRT. So this PowerPoint is basically focused on what's changing for next fiscal year. And so that's why you do not see a slide or anything specific on PMRT. So on those pages, you will see that it basically says proposed changes for '23-'24. And so PMRT is already budgeted. It is already in the plan. And I think that what I would like to do is have us come back and share with you more information and details about PMRT and ACR. ACR stands for Alternative Crisis Response, and it involves more than PMRT. And we can give a very wide, you know, range report out on, you know, what that means.

>> COMMISSIONER BARBOUR: I just didn't see it in the updates in the document.

>> KIMBERLY NALL: It's -- right. So basically this update is focused on what is changing. So that's why you didn't see it. It is part of the existing and so we focused on the new stuff that was going in that you guys may not be aware of. Does that make sense?

>> CHAIR AUSTRIA: And we understand that this is just a slice and we just -- it's a big slice, but it's not the whole pie.

>> KIMBERLY NALL: Right.

>> CHAIR AUSTRIA: And we understand that there are many funding streams that come to DMH, which are very complicated.

>> KIMBERLY NALL: Sure.

>> CHAIR AUSTRIA: And so it's sometimes when we're just saying this, of course, it's hard for us to see, it looks like there's gaps when maybe there isn't a gap. So we need to understand that, and that's why we'd ask you in the past to, you know, come and present to us so we stay up on budget, what's coming and all that. So thank you for that. And we would need a report on that, I think.

>> KIMBERLY NALL: Yes.

>> CHAIR AUSTRIA: Okay. Let me go round. Reba. Stacy? Is it something related? Go ahead, Reba.

>> COMMISSIONER STEVENS: Well, actually, you know, it was something that was said, and I believe that it was Commissioner Schallert that had raised a concern around her young people. And so while Kim Nall is still at the podium --

[Laughter]

-- to address something that, you know, I had been watching for quite some time. So in 2018, DMH entered into a grant agreement with the Mental Health Oversight and Accountability Commission. And the grants are ending. So the question is: what is the plan to continue with the services for our --

>> KIMBERLY NALL: The OTTCOTT program?

>> COMMISSIONER STEVENS: The OTTCOTT I think we need to make sure that people understand that OTTCOTT is the outreach triage team --

>> KIMBERLY NALL: And for adults.

>> COMMISSIONER STEVENS: For adults. And that COT is for our Child Outreach Triage chain. So it's important for us to understand these services provided immediate intervention for our TAY to avoid hospitalization. So could you help us to understand, and if you need some support, I have.

>> KIMBERLY NALL: Oh, no. I don't need any support. I got it. So OTTCOTT was a program that we received state funding for, for three years. The OTTCOTT funding source was for personnel only. And we developed a program with outreach teams that took referrals from PMRT if they did not have to put a client on 5150 holds. So basically they had a call, they stabilized the client, right? And the client did not need to go to the hospital. Those referrals were given to the OTTCOTT team. OTTCOTT teams were basically to work with the clients to link them to services. They were not supposed to open cases and do long-term care, but basically to link them, to triage them basically back into mental health services. And so the funding is ending. We have reached out to the state and asked them if they could extend the funding because we have not spent it all, and the state was not able to do so. So the funding will end. We have suspended the referrals to the OTTCOTT teams and our PMRT teams, which we have expanded, and our MCOT teams are picking up these referrals. So I know, you know, it's a lot of PMRT and MCOT. So, you know, PMRT is our --

>> CHAIR AUSTRIA: Right. So I'm going to interrupt. So what happens to the unspent funds?

>> KIMBERLY NALL: Oh, it goes back to the state. So the state has not paid us. We just didn't maximize those funds. So let me explain why. Okay. So I previously stated that the state gave us a personnel grant. It only paid for salaries. That's it. So DMH had to cover the other expenses associated with the OTTCOTT program, which we did because we know that when we put together a program, it's not only for staff.

>> CHAIR AUSTRIA: How much money is going back?

>> KIMBERLY NALL: Oh, I will get that amount for you.

>> CHAIR AUSTRIA: I think that's our concern. If we didn't maximize the funding, we know that it got started two years after the grant. So...

>> KIMBERLY NALL: It was extended. So we did get a full three years to implement the program.

>> COMMISSIONER STEVENS: You know, I really -- I oftentimes wonder about connections, relationships, partnerships.

>> KIMBERLY NALL: Mm-hmm.

>> COMMISSIONER STEVENS: Because, you know, I like, and I can't speak for all of us, but I think we're all advocates. And I would like to be used in a positive light to be able to advocate. But I can't do that if I don't know that these are the challenges in which the department is facing that monies are not being able to be spent for whatever given reason or going back, or the state is not, you know, I want to say cooperating with the department. This is where we could, you know, this would be something new for this body, but we could suit up and show up and support the department because other than that, it's like being a checkbox. And I just need to say that at this moment because I don't like the way that makes me feel when I'm learning that something has been happening and I had no knowledge of it, and now it's too late to help.

>> KIMBERLY NALL: Sure.

>> COMMISSIONER STEVENS: So I'll end. Thank you.

>> KIMBERLY NALL: Okay. You're welcome.

>> CHAIR AUSTRIA: We'd like to know how much money is being returned.

>> KIMBERLY NALL: Sure.

>> CHAIR AUSTRIA: Stacy.

>> COMMISSIONER DALGLEISH: Stacy. Yes. Stacy Dalglish. So thank you very much. I think that goes without saying, I really appreciate it. I agree that this is the best version of this that I've seen in the time that I've been on the commission, and I appreciate your addition of all stakeholders, consumer's concerns, and advisory capacity for this update. I'd like to start with just a clarification on page 14 of the, you know, Annual Update under Full Mental Health Commission and the qualifications and requirements.

Last year, there was an additional requirement that there be a member of the military on our commissions. Now, if this is just for the previous -- oh, I need to raise my voice. Okay. Sorry. If it's just for the previous year, then I understand. But going forward that is a new requirement and in the legislature right now it looks like they're going to add a youth member, too, so we'll keep our eye on that.

When I was up in Sacramento last month something that kept coming up was the lack of services for older adults and being one. Now I started going through this highlighting all of the issues about older adults and I was really there are places where the numbers aren't there. I don't know if that's just a formatting error, but if we could get those specific numbers, I'm happy to give you the pages where those are located. Also, let me see here. The Incubation Academy, I was really surprised with the number that was on the surveys because I had no idea that there were that many people. I know that there, you mentioned 29 projects but I would love to have more detail on that survey. I know that it appears that that's been a really positive innovation and if we can get more information about it and what we're looking at moving forward I would love to see that in the future. Let me just see here.

In the statistics on -- you have the total numbers served and there's one number that's for, you know, that says you have unique clients served, and then another that is on new. And I'm wondering if those numbers are then combined. Are the new combined in the unique or are those two separate numbers that are then added for a total? So that was something that I was interested in.

And on page 28, reasons for dis-enrollments. There's a category here that I don't see the color combination for. And it looks like it is, it would be a dark orange. And so I'm curious about what that might have been. And if we could see that would be great. I also was curious about getting more information about our investment in faith-based communities because that's something that I really had never thought about, but I see it coming up often in the SALT meetings that I attend and a lot of dollars are being spent in SALT funds in faith-based communities. So I'm curious to know the numbers around that for the department that might be separate from what is being spent in the SALTs. And then I guess we would want to see equity in that, too.

So I'm not going to go over all of the places where I found the issues for older adults. I can provide that separately. I was concerned on 35 and 36 where Starview is missing on 6 36. I don't see Starview or let me just see, unless it's High Desert. Sorry. It is. I apologize. I'm wrong on that one. So I -- and I will not ask the question about UCLA because I could be wrong about that one, too. So on 114, it is an item under the WET or workforce training -- education and training, I believe. There is a comment that says the following training, and I didn't see anything about

what that was referencing. It says "expanded employment," right? And then it says, "The department delivered the following training." And then it says you'll -- the department will continue with new offerings. So I kind of expected that there might be a colon after that to the following, and then it goes straight into Innovations on the next page. So I'd love to know what, you know, more detail on that.

And I do want to thank you for all of your work and for taking into consideration our Underserved Cultural Communities. I see that there's an oral history project for our Cambodian community. I'd love to see that for all of our Underserved Cultural Communities, being able to have, you know, an oral history so that it's not lost. Thank you. And thank you again, and thank you for your time.

>> CHAIR AUSTRIA: Thank you.

>> KALENE GILBERT: So there's a couple things I think I can try to address here, and certainly some things that I'll get back to for you. I do want to comment for older adults. I think you probably are already aware, at least within FSP, I think we eliminated that specific category, but we should still be reporting out where we're serving older adults. We do still have a few practices, so we can do some work to try to highlight that a little bit better.

>> CHAIR AUSTRIA: And I think, I just want to say, I think that was, it was in public comment out there, the planning council. And that was one of the concerns was that once older adults got moved into adults, but, you know, they were different. They were up to, I don't know, 59 or something. So thank you.

>> KALENE GILBERT: The good news is that the providers that have that expertise continue to provide services. So we do continue to have specialty knowledge on serving this conservation. But we can look to see, I think, where we need to do more of a breakout. For the Incubation Academy, the providers, the 29 providers that participate, have funding to deliver their services to the community. So those surveys, right, are connected with the services that are delivered to the community by those participants.

Just for a little more clarification for the faith-based, I don't feel like they have a regular budget. I can tell you one of the big things we invested in this year is a faith-based conference. And we've been working with that committee to roll that conference out. It's going to be May 31st. And, again, Kenia, I can give her some details so that we can email, we've got support to really build bridges, and there is a goal, there's an awareness that there's not equity among the groups. I think we have to do other groups, right? Our SALTs, our UsCC, they all represent different parts of the population in LA County. So we want to do some work to ensure they've got support that's in line with their representation, what they're doing. And so we'll go ahead and look -- take a look at those.

>> COMMISSIONER DALGLEISH: Thank you. Thank you. I do want to mention one other thing. The conversation keeps coming up with combining SUD and mental health.

>> CAPTIONER: Sorry, I can't hear you.

>> COMMISSIONER DALGLEISH: Oh, I'm sorry. The conversation about combining substance use disorder with mental health disorders keeps coming up. I'm always worried when people start looking at the MHSA budget that was specifically for services. And now because there are such needs for housing that potentially can start taking away a lot of money. [Applause] And it's mentioned that it's not just, in some circles it's mentioned that it's not just for people with severe and persistent mental illness, which is referring back to the original intent of MHSA, concerns me. I know it's a big pot of money and everybody wants some of it because there's not enough money in other places. But I feel very protective of that MHSA money. And I think that -- so thank you.

>> CHAIR AUSTRIA: Commissioner Root.

>> COMMISSIONER ROOT: I'd like to thank you for the detailed report. This is much more we've seen before. That's very helpful. As the loss in the details and seeing a lot of trees in this forest. And I think several commissioners have hit on, we seem to have money allocated to various budgets driven by seeds revenues, not needs. And as was pointed out, what's noted here are gaps. And because we can't seek gaps, you can't see priorities or how monies are allocated. Page 8, I think, of the slides are very helpful. Thank you.

I can see that increases year-over-year vary from 50 percent in FSP but 3 percent down in crisis services. Some of the many priorities are here based on something. But this report doesn't require any of that. So we can't give feedback. The community can't give feedback on how priorities are being set and what needs are being addressed. Great step forward, don't misunderstand me, but we can do a better job now of fine tuning details that we have, getting them getting spots where they belong. And I would like to see the supplement of the good work done today with the needs analysis, gap analysis, and how priorities to be set among the various things.

>> CHAIR AUSTRIA: Thank you.

>> KALENE GILBERT: Thank you. I want to start by just acknowledging that need. We've talked about the process that as we see it next year, should absolutely include not only the needs assessment and that data, the gap

analysis, but looking at what we have and what those priorities are. So that should be part of the process every year. And that's the work we're doing to establish. So I appreciate the comment. That is good.

>> COMMISSIONER ROOT: I have to step out early, I apologize.

>> CHAIR AUSTRIA: Thank you. Thank you.

>> COMMISSIONER ROOT: Thank you for letting me give in.

>> COMMISSIONER STEVENS: But before Commissioner Root, and being that there has been discussion -- and thank you, Commissioner Stacy, for raising concern around substance use disorder and then around substance use disorder, but also homelessness under MHSA. So here's the deal: I don't care where money comes from. I'm going to say it again, I don't care where the money comes from.

If we really think about Prevention & Early Intervention, and we can go back maybe 10 or 15 years ago, what could have happened then perhaps would have addressed a lot of where we are today. And today, people are dying unhoused on our streets. People are dying in record numbers. We talk about the county of Los Angeles and MHSA. But the question -- the bigger question for me is: how are we working together with, you know, across the county, partnering with our cities to address the immediate needs in the community?

So the question is also: have you read or are you aware of the state of Black Los Angeles? That's a yes or no?

>> Yes.

>> COMMISSIONER STEVENS: That's a yes or no. Yes or no? Yes or no. It's a no. And here's the thing: because what's happening is the silence. And I think that it's really important for us to even address. And once again, I don't care where the money comes from, the needs of the people that are on our streets, who are dying or either using substances and walking around talking to themselves and not being cared for. We as many people are outside in our community and not only can really speak for Service Area 6, I don't see anyone. Where are the people who are caring for the people who are outreaching to the people to save the people? And the other thing is, how many people did we house this year?

So I think that we need to be understanding what those numbers are. And then you mentioned harm reduction. I want to hear how many people are in treatment? Inside treatment. Where are our treatment facilities? How are we working with the alcohol and other drug commission? We have HIV that came right on up in here and asked, huh, for partnership, right? And we have someone who actually has a seat at that table. So we're going to -- I'm hoping that we will even make better use of you and what you have to offer and bring in connection to what's going on.

So I just -- I want to know how many people were housed. And then I also want to -- there's something else that I have, and I'll be quiet, Madam Chair. In your -- in this document, this handout that you gave today, I found this fascinating. So it says that, "Through the FSP program, the Second District," as I am representing, "those who were served," we almost had, we had over 45, right? But then when you turn over and you look at Prevention & Early Intervention, the numbers is less, which says to me that something is wrong with these numbers.

Something is wrong with where we are actually investing money and how we are addressing, first and foremost, this high need in the Second District to begin with. Then it turns around and it becomes for Prevention & Early Intervention and a whole nother district. And, I mean, I'm okay with everybody getting helped and served, but something is wrong here, Kim Nall. Something is wrong here with this data and these numbers in reference to how dollars or resources are being positioned in our communities that clearly show this is your data, not mine. A need. So I've been hoping that either, not necessarily about addressing it, but fixing it.

>> CHAIR AUSTRIA: Thank you.

>> COMMISSIONER WEISSMAN: I just want to point out that to Kim's point, or there's an aspect here, that these numbers are short three months for the current. They're likely under captive.

>> COMMISSIONER WEISSMAN: She loves you.

[Laughter]

[Overlapping speakers]

>> KIMBERLY NALL: I had the same question, but there must be an under if there's three much shy of data in this.

[Overlapping speakers]

>> CHAIR AUSTRIA: Mike Molina, give him an opportunity.

>> COMMISSIONER MOLINA: Thank you. I just wanted to say to Kalene and to your staff that this is completely your fault. So five years, I've been on this commission, you finally received a quality document. And when we get a quality document, you get an engaged commission. This is the best commission meeting I've been in for five years.



You see passion, engagement, interaction, dialogue, something we've been asking for years, this document is turned. So thank you very much. Thank you for the level of detail. Thank you for responding to a lot of our concerns in previous years. Fantastic document. Now, here's how it can be even better.

[Laughter]

I was happy to come two weeks ago at the invitation of the chair to the Executive Committee to look at this document early on. A lot of us were there. I love the level of detail that begins on page 160 of all these added programs. But I said that day is the same. Same thing. I'm just going to say today, what's missing in those little blue boxes and those little yellow boxes is, and we've heard about this over and over again, and that is, how are these services affecting us by geography? I'm singing out of the Judy Cooperberg and Kim Nall, she wrote the song. We have to look at ways that we can effectively, as Reba said, advocate for these changes among our communities. When we go back to the SALT meetings and they run up and say, "What did we get out of MHSA this year?" I don't know, we got a bunch of green boxes, but I can't tell you what's going to SALT 8 or to SALT 7 or SALT 1. I can't tell you.

So what's missing in these excellent boxes is more description of how this affects our, you know -- we're all rep, we're all here because supervisors appointed. Our supervisors are looking at countywide policies, but they also have their own districts. So we need to be able to respond to our constituents by saying, "Here's the monies that are coming in. Here are the changes that are happening that affect each and every one of our districts," as Judy said, our service areas, which is even better.

So hopefully we can receive, ideally, an appendix to these boxes that give us a chance to advocate among our constituents of where the monies are going, where these projects are best effective. So thank you for that, Kalene.

Just very quickly, I think the stakeholder process description and process itself is far improved. It just looks phenomenal. What I would like to see with the myriad meetings that have taken place is not just the date of the meeting, but how many people attend. I would love to be able to see, "Wow, 300 people showed up to this meeting," or three people showed up to that meeting. So I think it helps me to gauge the effectiveness of the stakeholder process if we know exactly how many people were in attendance at those meetings so that we can see whether or not they were effective processes. That's it.

The last thing is, and maybe this is something for a future meeting, we heard in public comment, and I'm curious on the selection of these programs, the changes: what is the RFP process? How do organizations know there are processes in place that they can apply to programs? I would just love a little 101 on RFPs for the MHSA. So if there's a January 15th deadline, okay, when does it begin? How do people know about it? How is it advertised? We heard that from a couple of our public comments that, you know, there may have been programs that were not fully better, whatever. Let's give us a chance to learn a little bit more so we could advocate among our contacts, among our communities in knowing how that proposal process takes place. And for this year, I'd love to know the total number of proposals that we were funding compared to previous years. Was this a banner year or was this consistent with previous years the number of proposals. So I think those are my major issues for today. Thank you.

>> CHAIR AUSTRIA: Thank you. Thank you. Susan, do you have a last comment?

>> COMMISSIONER FRIEDMAN: I don't have a last comment. I think Mike covered everything.

[Laughter]

>> CHAIR AUSTRIA: Ditto. Stacy had a comment and then I'll --

>> COMMISSIONER DALGLEISH: Yes. Regarding what you were just speaking about, Michael. One, I'd like to see attendance broken down in categories. And I'm thinking of three: one would be staff, one would be providers, and the other one would be people who I would consider to be a real stakeholder. Hang on one, just one second.

And then in terms of the RFP process, one of the U SCCs I was at this week mentioned that these proposals and please tell me what the situation is on the reporting back that they're sent out to those providers who have signed up in a particular category as opposed to a broader distribution to, you know, so that everybody's included in. So thank you.

>> CHAIR AUSTRIA: I want to make a comment first, please, Reba. Thank you. So I do -- I know there's so much work that you and the team have done and I commend you for, cause obviously people have been here longer than I been made a difference. And I thank you for that. I also appreciate all the people that came today, both online and in person and all the previous meetings to make comments. My comments go, when I need this data by district, I need it by SPA. I need it actually by the clinics, whether it's a nonprofit or for profit. We need, like, a position status report because people implement programs and we know that we've made progress in human resources and hiring people, but we don't know about the nonprofit's ability to hire people. And if we don't have the people to

implement, even though we have all these wonderful programs, they, I'm wondering about the implementation of all these programs, right?

>> CHAIR AUSTRIA: Mm-hmm., are they partially implemented? I know that trans transportation was, they couldn't get staff for it. So they're trying to relax the standards. So we've written these things and I think some of the undercounting is not that's for sure, but it's because we don't have, we lack the staff to provide services. It's, so I am requesting from the department, and this goes beyond to say, this goes for the whole department and I want to position a status report. So I know by facility who's got empty, empty has, you know, vacant positions. And then they need to find some way to work with the nonprofits to find out what kind of vacancies they have. And so I'm just very concerned about program implementation and I'm concerned about equity.

So some of these places I know like SALT 6 or SPA 6, where you can see there's a high need for service. We were the last to get transportation. I'm not even sure if we filled it. So they weren't any transportation, which means our patients in that area still had to go by ambulance or police car to, you know, a place where they can be treated. So those are some of my questions. Also capital projects in each district. I know those need to be equitable. And I want to address housing. In the beginning of MHSA, they had a housing fund, which was separate from the rest of the MHSA, which was, I believe spent. But I know I spent a lot of time at that committee making sure that, you know, funds were being spent. Because I will say a couple of districts actually at that time rejected the funding because they didn't want homeless housing built in their district.

>> Sorry, they didn't want what?

>> CHAIR AUSTRIA: They didn't want homeless housing built in their districts. Which, you know, were moved beyond that. But I'm saying there we need to maybe advocate for a housing fund, you know, in addition to that. So that goes beyond MHSA at this point. So those are some of my things. And I also had, in the community stakeholder process, I wanted to see a few -- a whole list of community stakeholders so that we could identify the gaps. I know, like, the police should be at the table. We need other community members. The developmental community disability brought up something. HIV is here. Who is missing from our table that we need to hear from and how do we hear it? Because we are -- there's over 10 million residents in LA County and high needs. So how do we make sure we're being represented? In a previous process on the System Leadership Team, it was identified and we made sure slots were billed so that people, everybody was at the table. And I think that's missing at this point. And so that's my comments.

Again, on the OTT and COTT, again, I'm moving beyond and talking beyond MHSA and looking at the whole budget. You know, we might have a spoken here like PMRT that's, you know, being filled, but we don't know, because right now we're only looking at this piece. So we want to have, you know, unsilo ourselves and make sure that we're looking and programs side-by-side so we can see the whole funding. And, again, whole funding that by district, by SPA, and by location, you know, specific locations to make sure that we're being equitable. And then Reba and then Brittney and then Stacy.

>> COMMISSIONER STEVENS: She can go.

>> COMMISSIONER WEISSMAN: I'm just noticing time and the value of the quality of the comments are sounding to me very similar and aligned. And it feels to me like we might be ready to start crafting whatever the letter you had in mind for the draft discussion conversation if you'd like to get that started. I just thought I would prompt that.

>> CHAIR AUSTRIA: Thank you. Reba.

>> COMMISSIONER WEISSMAN: Whatever you have in mind for that process.

>> COMMISSIONER STEVENS: So I'll just make it real quick based on what is being said and because all of this is deeply associated with MHSA, and that is our stakeholder process, right? And so my question, and I wrote a few things down, is about, you know, composition. So for those of you who remember we had the Systems Leadership Team that no longer exists and as a result of, I don't know, perhaps the department realized that, "Uh-oh," and so what was created was the Service Area Leadership Teams; however, does it have the composition in which you were talking about, Chair Austria? And how do we know that? How are we holding ourselves accountable in all of our service area groups accountable to ensure that we are actually in compliance with MHSA, which is critically important.

And then throughout the stakeholder process, without being if we're not in compliance. And that says that we're really not hearing from the people that we should be hearing, the stakeholders that we should be hearing from prior to this being even approved. I'm just saying we need to really take a look at that. Yeah. So that's all we got.

>> CHAIR AUSTRIA: Thank you. Stacy.

>> COMMISSIONER DALGLEISH: Yeah. Well, just capping off what Commissioner Stevens said, I think this could be in the letter as one of the issues of filling slots on the commission, at least, is the supervisor's court. And we really don't have, I mean, much input to that. We don't even have input to the director's choice. Oh, I'm sorry. I just thought that since we're writing a letter to the Board of Supervisors, we could have this, something about the composition in that because they are the only ones who can make appointments, at least at the commission level. And so if we're -- and in terms of disregarding the commission, as a side note, we weren't included even though it's in the WIC code, in the selection of the director.

>> CHAIR AUSTRIA: Thank you. Thank you. So yeah, I do think a committee, we need a small committee to write this letter. What I would request from the whole commission is if you have something you want included in the letter, if you could, I know that again, short timeline, if you could have it to us, say, by -- today's Thursday -- by Monday, which means you're, I'm spoiling a weekend perhaps [Laughing]. But if you can get that to us, then we can start getting a letter together. And I can't commit to Tuesday.

>> COMMISSIONER DALGLEISH: Are we not going to start now?

We can start now, but I'd like to make sure that people because I know I need to sit down at the computer to write my thoughts.

>> COMMISSIONER FRIEDMAN: How are we doing this?

>> COMMISSIONER STEVENS: We'll just start. Well, I thought there was a small committee that would craft the letter.

>> CHAIR AUSTRIA: Mr. Molina, what was your position?

>> COMMISSIONER MOLINA: Well, my thought would be that it's the staff that would begin drafting the letter and that we would react to something rather than us actually composing the letter. Now, I think we've had a long and engaging discussion today and that this, including the public comment and that the draft of a letter would reflect some of the major issues that have been discussed today. Staff can put that together, send it to us for our review, and then we can make comments from there. I think that's probably a logical way to approach it rather than us getting together with the laptop. Sorry to write something there. There's a template already there. So use the template, let the staff include within that template the major issues that have been discussed today, and then send that letter to us at the beginning of next week for our consideration. That's how I would see it done.

>> CHAIR AUSTRIA: Stacy.

>> COMMISSIONER DALGLEISH: Yes, I would like to add, having written this and Commissioner Weissman also has written one that that is the way it works. The staff writes the letter, and then it comes back. And the important part is that we don't rubber stamp the staff letter, but we make sure that the community and our --

>> COMMISSIONER MOLINA: I agree. I think that, and this whole process is my last comment, this whole process for five years, I've always felt at this moment, all we're here to do is put a check mark, right? You know, and it's been the frustrating part. This is the last -- this is the first year I don't feel as frustrating. I feel like there's some kind of a path and a lot of that is a staff driven improvement in the process. So if the letter -- if the draft truly is not a template and truly is a reflection of today's discussion. I am much, much more comfortable with furthering the letter to the Board of Supervisors.

>> CHAIR AUSTRIA: Mm-hmm. Okay. I do believe, Kenia, you included a draft of last year's letter.

>> KENIA FUENTES: [inaudible]

>> CHAIR AUSTRIA: So everybody has a copy. So I'm going to request that and I will work with you. We can take some of the comments. We need to get the comments for today, download it quickly, and we can start a draft. And actually, I'm babysitting tomorrow all day.  
[Laughing]

But I will make myself available, you know, to work on that. And if everybody can get their comments, I think they've been made, and they've been put into the written draft. So unless you have something different, we can work off of that. And if that's okay with the commission.

>> KENIA FUENTES: Yes. I think I'll share the --

>> COMMISSIONER WEISSMAN: And, Kenia, I don't know if you have it, but the letter that went out in 2021 was the really 3-Year Plan, but that's the year that got flummoxed for two years now.

>> CHAIR AUSTRIA: Right. Is that a contract?

>> KENIA FUENTES: I'm happy to send that as an example as well, as long as it's bucketed in themes.

>> COMMISSIONER MOLINA: I remember that.

>> KENIA FUENTES: Okay. Yeah, that was a good line.

>> CHAIR AUSTRIA: No, we had, I think the last couple of times the commission has put more into it and we are taking our role seriously and we want the board and the community to understand that we take our role seriously, that we need to take the community input and feedback to the Board of Supervisors. So we need a little bit more time for DMH to do that. And a comment from the floor. Jean.

>> JEAN HARRIS: Thank you chair. I just wanted to add that since attending the January, beginning of the stakeholder meetings on the MHSA mid-year adjustment and now the annual adjustment that I've been asking repeatedly every chance I get for the geographical information. And so that has actually been months in requesting some information that is apparently unavailable. And I know we're moving into the 3-Year Plan after this. And so I hope that our concerns are addressed. I know the commission itself has asked so many times for different information that is never forthcoming. And so I do not want to have our questions and our comments and concerns ignored.

>> CHAIR AUSTRIA: And we do take them seriously and I did ask for that -- the status report so that we know where, you know, where there's gaps.

>> COMMISSIONER STEVENS: And when is the timeline on receiving that status report?

>> CHAIR AUSTRIA: Again, I would -- Kim, because I know it takes a lot. So we need to be in that process because I know that people will be unhappy with me for asking for that report because I've asked for it in the past.

>> COMMISSIONER STEVENS: But she's going to ask --

>> CHAIR AUSTRIA: Let me finish. So I know it's difficult, but we need it, you know, pretty quickly.

>> KIMBERLY NALL: So may I ask that I work with somebody on this data. So we have a lot of data and we need to be able to provide you exactly what you want or let you know what we have that gives you that or let you know what we have.

>> CHAIR AUSTRIA: And I'm going to refer you back to employee relations because employee relations has been asked for this data in the past by unions.

>> KIMBERLY NALL: Oh, for vacancies you mean?

>> CHAIR AUSTRIA: Yeah. Vacancy.

>> KIMBERLY NALL: Oh, sorry. I thought you meant something else.

>> CHAIR AUSTRIA: Well, both. I want to know -- we want to know, like, how things are budgeted by the facility.

>> KIMBERLY NALL: Yeah. So you want vacancies?

>> CHAIR AUSTRIA: Vacancies by location, not just by SPA. But I would like to know by facility because I know some facilities -- I know traditionally in my past experiences for asking for this, District 5 and District 2 had the most difficulty recruiting and fillings things, one, because again, geographic issues and also because people don't want to work in certain areas or in certain locations like the jail and they have to do certain things to recruit people. So we need that data and we can sit down and, like, really drill down. And I want it quicker than when I asked for the commission data on just for our budget, it took months. So I need that position quicker than it did just to get our commission. So I'm sorry if I'm being harsh.

>> KIMBERLY NALL: Oh, no. It's okay.

>> CHAIR AUSTRIA: Again, I'm very passionate about this too.

>> KIMBERLY NALL: Sure. So if you want vacancies for directly operated --

>> CHAIR AUSTRIA: And nonprofit.

>> KIMBERLY NALL: -- facilities. Okay. So we can give you. Okay. So for our directly operated clinics, that is DMH staff, we have that data. We have it by you. So it is very easy for us to pull up that data. Do you want a specific time period? So I think that that is where --

>> CHAIR AUSTRIA: Well, a present would be nice.

[Laughing]

>> KIMBERLY NALL: As of March 30th.

>> CHAIR AUSTRIA: March 30. That's fine.

>> KIMBERLY NALL: So now for the nonprofits, DMH does not have the data. We will have to reach out to all of our legal entity providers and request that information from them. Yes. Jack Barbour.

>> COMMISSIONER BARBOUR: CMMD reached out to us and asked us about that data. CMMD reached out to us.

>> CHAIR AUSTRIA: What is CMMD?

>> COMMISSIONER BARBOUR: Contracts Management and Monitoring. They reached out to us to ask for that data.

>> KIMBERLY NALL: Sure. A survey.  
>> COMMISSIONER BARBOUR: A survey.  
>> KIMBERLY NALL: But not to all providers. And we do have that, but it is a subset. So if you want that subset, we do have it available. If you want all the items, we will have to do a broader reach and we can --  
>> CHAIR AUSTRIA: Start short-term and long-term.  
>> KIMBERLY NALL: Okay.  
>> CHAIR AUSTRIA: Okay. I think Brittney and then Stacy, and then we need to move.  
>> COMMISSIONER WEISSMAN: I just suggest moving at this point. I think that this conversation is really important, but it's not the purpose of today's meeting. It's in addition to today's meeting. And so I think let us do the good work of closing out what we started off as really rigorous, robust conversation on the MHSA plan and the next steps. And thank you, Brittney. Stacy, and then we'll close it.  
>> COMMISSIONER DALGLEISH: We're going against what Commissioner Weissman said.

[Laughing]

I've been asking for two to three months for the additional breakout of people who are out on leave because that is a vacancy. It may be funded, it may even be filled, but if nobody's there, it doesn't help people that we're trying to reach. So that subset is what I'd like. And I'm happy with just directly operated clinics and the department or however that works.

>> KIMBERLY NALL: And so would you like that also by facility?

>> COMMISSIONER DALGLEISH: I meant, you know, eventually that's great. But I have just been asking for it for the department to date.

>> KIMBERLY NALL: Thank you.

>> CHAIR AUSTRIA: All right. I want to conclude the meeting. I want to especially thank the commission for our really valuable input. I want to thank the community again, both online and all the way over here. I want to thank Kalene and her staff and for doing such an excellent group.

[Applause]

[Overlapping speakers]

I want to thank the DMH staff, our Executive Assistant, Kenia, Canetana and Dan -- Kenia, Canetana Daniel and Robert because we are transitioning back to in-person. You know, we're still doing hybrid, but for the commission we do have to come in-person. So thank you for that. I'm going to ask Kenia to stay after so we can talk about the letter and anyone else who wants from the commission, who wants to have a small meeting to talk about the letter, additional input. This concludes our public hearing. And, again, thank you all.

>> Thank you.

>> JULIO MIRANDA: The live event has ended. Thank you, Operator. Can you please close the line?

**[End of the meeting]**

## Appendix E – Acronyms

ACS:	Alternative Crisis Services	EBP(s)	Evidence Based Practice(s)
ACT:	Assertive Community Treatment	ECBI:	Eyeberg Child Behavioral Inventory
ADLS:	Assisted Daily Living Skills	EESP:	Emergency Shelter Program
AF-CBT	Alternatives for Families – Cognitive Behavioral Therapy	EPSDT:	Early Periodic Screening, Diagnosis and Treatment
AI:	Aging Initiative	ER:	Emergency Room
AILSP:	American Indian Life Skills Program	FFP:	Federal Financial Participation
APF:	American Psychiatric Foundation	FFT:	Functional Family Therapy
ARF:	Adult Residential Facility	FOCUS:	Families Overcoming Under Stress
ART:	Aggression Replacement Training	FSP(s):	Full Service Partnership(s)
ASD:	Anti-Stigma and Discrimination	FSS:	Family Support Services
ASIST:	Applied Suicide Intervention Skills Training	FY:	Fiscal Year
ASL:	American Sign Language	Group CBT:	Group Cognitive Behavioral Therapy
BSFT:	Brief Strategic Family Therapy	GROW:	General Relief Opportunities for Work
CalSWEC:	CA Social Work Education Center	GVRI:	Gang Violence Reduction Initiative
CAPPS:	Center for the Assessment and Prevention of Prodromal States	HIPAA:	Health Insurance Portability and Accountability Act
CBITS:	Cognitive Behavioral Intervention for Trauma in Schools	HOME:	Homeless Outreach and Mobile Engagement
CBO:	Community-Based Organizations	HSRC:	Harder-Company Community Research
CBT:	Cognitive Behavioral Therapy	HWLA:	Healthy Way Los Angeles
CDE:	Community Defined Evidence	IBHIS:	Integrated Behavioral Health System
CDOL:	Center for Distance and Online Learning	ICC:	Intensive Care Coordination
CEO:	Chief Executive Office	ICM:	Integrated Clinic Model
CF:	Capital Facilities	IEP(s):	Individualized Education Program
CFOF:	Caring for our Families	IFCCS:	Intensive Field Capable Clinical Services
CI MH:	California Institute for Behavioral Health	IHBS:	Intensive Home Base Services
CMHDA:	California Mental Health Directors' Association	ILP:	Independent Living Program
CORS:	Crisis Oriented Recovery Services	IMD:	Institution for Mental Disease
COTS:	Commercial-Off-The-Shelf	Ind CBT:	Individual Cognitive Behavioral Therapy
CPP:	Child Parent Psychotherapy	IMHT:	Integrated Mobile Health Team
CSS:	Community Services & Supports	IMPACT:	Improving Mood-Promoting Access to Collaborative Treatment
C-SSRS:	Columbia-Suicide Severity Rating Scale	IMR:	Illness Management Recovery
CTF:	Community Treatment Facility	INN:	Innovation
CW:	Countywide	IPT:	Interpersonal Psychotherapy for Depression
DBT:	Dialectical Behavioral Therapy	IS:	Integrated System
DCES:	Diabetes Camping and Educational Services	ISM:	Integrated Service Management model
DCFS:	Department of Children and Family Services	ITP:	Interpreter Training Program
DHS:	Department of Health Services	IY:	Incredible Years
DPH:	Department of Public Health	KEC:	Key Event Change
DTQI:	Depression Treatment Quality Improvement		

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.