Performance Improvement Project Implementation & Submission Tool

PLANNING TEMPLATE

INTRODUCTION & INSTRUCTION

This tool provides a structure for development and submission of Performance Improvement Projects (PIPs). It is based on EQR Protocol 3: Validating Performance Improvement Projects (PIPs), as a mandatory protocol delivered by the Centers for Medicare & Medicaid Services (CMS) in September of 2012.

The use of this format for PIP submission will assure that the MHP addresses all of the required elements of a PIP. If the MHP uses another format, they must ensure that all of the required elements of the PIP are addressed and included in their submission.

- The PIP should target improvement in either a clinical or non-clinical service delivered by the MHP.
- The PIP process is not used to evaluate the effectiveness of a specific program operated by the MHP. If a specific program is experiencing identified problems, changes and interventions can be studied using the PIP process. This can be done to create improvements in the program and should be included in the narrative.
- The narrative should explain how addressing the study issue will also address a broad spectrum of consumer care and services over time. If the PIP addresses a high-impact or high risk condition, it may involve a smaller portion of the MHP consumer population, so the importance of addressing this type of issue must be detailed in the study narrative.
- Each year a PIP is evaluated is separate and specific. Although topic selection and explanation may cover more the one PIP year, every section should be reviewed and updated, as needed, to ensure continued relevance and to address on-going and new interventions or changes to the study.
- If sampling methods are used the documentation presented must include the appropriateness and validity of the sampling method, the type of sampling method used and why, and what statistical subset of the consumer population was used.
- General information about the use of sampling methods and the types of sampling methods to use to obtain valid and reliable information can be found in Appendix II of the EQR Protocols.[1]

[1] EQR Protocol: Appendix II: Sampling Approaches, Sept. 2012, DHHS, Centers for Medicare & Medicaid Services (CMS), OMB Approval No. 0938-0786

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IDENTIFICATION OF PLAN/PROJECT

Plan Name:	**Los Angeles County Department of Mental Health (LACDMH)**		
Project Title:	**Commercial Sexual Exploitation of Children and Youth (CSECY)**	Clinical: X	Non-Clinical: _____
Project Leader:	**Terri Boykins, LCSW**	Title: Deputy Director	Role: CSECY Lead
Initiation Date:	**July 1, 2014**		
Completion :			

SECTION 1: SELECT & DESCRIBE THE STUDY TOPIC

The Commercial and Sexual Exploitation of Children and Youth (CSECY) PIP stakeholders are as follows:

Anna Perne, LCSW	Training Coordinator, TAY System of Care (TAYSOC)
Belen Fuller	Program Head, Juvenile Justice Aftercare Services
Catherine Clay	Client Coalition Member
Christi Acosta	Housing Specialist, TAYSOC
Erica Reynoso, Ph.D., LCSW	Co-Leads CSECY Program, TAYSOC
Gail Blesi, Ph.D.	Supervising Psychologist, Juvenile Hall
Helena Ditko, LCSW	Director, Office of Consumer and Family Affairs (OCFA)
Joaquin Castor	Training Coordinator, TAYSOC
Karen Streich, Ph.D.	Mental Health Clinical District Chief, Juvenile Hall
LyNetta Gore, Psy.D	Clinical Psychologist II, Quality Improvement Division
Makesha Jones-Chambers, Psy.D.	Co-Lead CSECY Program, TAYSOC
Mira Kim	Training Coordinator, WET Division
Myla Lampkin, LCSW	Clinician, Juvenile Hall
Naga Kasarabada, Ph.D.	Mental Health Clinical Program Manager III, Quality Improvement Division
Terri Boykins, LCSW	Deputy Director, TAY Division
Terry Lewis	Executive Assistant, Mental Health Commission
Tonia Jones, RN, Ph.D.	Senior Mental Health Counselor, RN, Quality Improvement Division
Vandana Joshi, Ph.D.	Program Head, QI-Data-GIS Unit, Quality Improvement Division
Clinicians trained on CSECY	All LACDMH CSECY trainees
Countywide Case Management Team	Administrative and Clinical Team

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Stakeholder Roles: Participants of the CSECY steering committee were chosen based on their familiarity, expertise, or interest in the subject matter. Ms. Boykins, Dr. Jones-Chambers, and Dr. Reynoso are key leads in the process of communicating this project's information among the directly-operated and county contracted clinics who have trained clinicians that are currently providing services to the identified and not yet identified CSECY population. As clinicians identifying and treating CSECY clients, Ms. Lampkin and Ms. Acosta demonstrate a greater understanding of the commercially and sexually exploited child and youth populations. As the Director of Consumer and Family Affairs, Ms. Ditko stands in as an advocate for consumers and families. Ms. Perne and Ms. Kim are directly involved in the LACMDH workforce training that pertains to the CSECY project. Drs. Streich and Blesi are able to contribute insight on the CSECY population within the Juvenile Halls and Camps. Drs. Kasarabada, Joshi, Jones, and Gore maintain roles within the LACDMH Quality Improvement Division (QID). Ms. Catherine Clay and Ms. Lewis have contributed their commitment, lived experiences, and first-hand knowledge of the CSECY population's barriers to treatment, to the PIP team's discussions. On November 17, 2015, this Clinical PIP project's name was changed from CSEC to CSEC Youth (CSECY).

Study Topic: Commercial Sexual Exploitation of Children and Youth (CSECY) is a form of human trafficking, affecting our most vulnerable children and youth. This growing problem affects all communities, children and families. On average, early adolescence between ages 11-14 years is the most common time for children to fall victim to commercial sexual exploitation. Traffickers (or "pimps") target vulnerable children and lure them into prostitution and other forms of sexual exploitation, often preying and exploiting the youth's emotional vulnerabilities; their absences of belonging or feeling loved and use a combination of psychological or emotional manipulation.

As identified by the Federal Bureau of Investigations (FBI), three of the nation's 13 high-intensity child prostitution areas are located in California. Among these concentrated hubs is Los Angeles. Research into the number of annual victims has led to widely varying numbers. One study estimated that approximately 100,000 American children are being commercially trafficked each year (www.misssey.org/services.html). The Crimes Against Children Research Center found that each year between 300,000 and 600,000 juveniles have engaged in prostitution in the United States (http://www.unh.edu/ccrc/prostitution/Juvenile_Prostitution_factsheet.pdf). In the past two years, California's nine human trafficking task forces identified 1,277 victims. There has been no accurate data tracking on the approximate number of CSECY victims in the Los Angeles County partly due to the lack of awareness and knowledge about CSECY until more recently. Another problem has been that the identification and definition of CSECY varies across systems. The Mental Health arena operationalizes CSECY very differently from Probation and Child Welfare Services, and there have been no published reports on CSECY numbers for Los Angeles County. There have been serious concerns in the increasing numbers and need for attention from public service agencies.

The CSECY workgroup provided recommendations to the California Child Welfare Council in order to address this epidemic in CA. An epidemic that involves multiple agencies such as Law Enforcement, Probation, Education, Mental Health, Medical Care and Public Health systems as well as non-profit organizations that serve these victims (Kate Walker, California Child Welfare Council, Ending the Commercial Sexual Exploitation of Children: A Call for Multi-System Collaboration in California, 2013). On September 24, 2013, a Board motion introduced by Supervisors Mark Ridley-Thomas and Don Knabe was approved to establish a countywide, multi-agency response model to combat the sex trafficking of children in Los Angeles. The Los Angeles County judicial system developed the Succeeding Through Achievement and Resilience (STAR) Court, a specialty court for CSECY. The STAR court is developing new and effective approaches to meeting the needs of CSECY. The Los Angeles County Probation Department provides a "comprehensive multi-disciplinary program for sexually trafficked females in the Juvenile Justice system. The Probation Department is also committed to training staff and community members. As of 2012, the Department had trained 1,600 people about CSECY.

A study of CSECY (Alexander et al., 2005) showed that 68% of the victims suffered from Posttraumatic Stress Disorder (PTSD) and had an increased risk for both suicide and depression. A study of 113 CSECY victims done by West Coast Children's Clinic found that 35% of the youth in their study had engaged

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in self-injurious behavior to an intensity that required medical attention, 12% had a suicidal gesture, attempt, or plan within 30 days of their initial assessment, 76% suffered from depression, 55% suffered from anxiety, and 58% experienced significant difficulties with anger management. Over a quarter of the youth in their study were still aligned with their pimps, believing that their pimps were acting in their best interest and/or actively defending them against accusations of exploitation. Of their participants, an estimated 14% were pregnant at any given time, and 56% of those pregnant were using drugs or other illicit substances known to cause harm to a fetus. This same study identified the lack of appropriate services for these youth as a key issue that needs to be addressed (http://www.westcoastcc.org/WCC_SEM_Needs-and-Strengths_FINAL.pdf). These studies also demonstrated the serious impact of a CSECY related trauma. The significant risks and adverse outcomes associated with CSECY victims and the need for performance improvement in the area of CSECY assessment and treatment interventions have also been highlighted in research.

Increased training of mental health clinicians in CSECY has been identified by the CSECY workgroup as an area of need. There are limited resources in Los Angeles County where victims can be referred to in order to receive services from clinicians who understand their experience and who can provide treatment accordingly. Most victims are not being identified until they have encountered experts within the juvenile justice system, in spite of their history of treatment and involvement with the Department of Child and Family Services (DCFS). CSECY victims have historically reported alternative forms of abuse; however, it requires a trained clinician who can ask questions and use language that better elicit reports of commercial sexual exploitation. Until they are identified, CSECY victims are being hindered in their ability to work through the trauma of their experiences and facilitate the healing process.

In response to the recommendation made by the CSECY workgroup, the Los Angeles County Department of Mental Health (LACDMH) has implemented this Clinical PIP. The goal of this PIP is to address the training needs of mental health professionals treating CSECY victims; to further provide CSECY specialized services and supports; to use culturally competent and trauma-informed practices; and to thereby improve the quality of services to the CSECY victims and related outcomes.

In order to make significant strides towards changing the perceptions of the CSECY population and to enhance the process of providing effective and applicable interventions, training is essential. A two-pronged approach to training mental health practitioners is suggested: 1) Increase awareness of the psychosocial factors pertaining to CSECY population (or "CSECY 101" training) so that CSECY victims are able to participate in a more comprehensive assessment and subsequently their treatment becomes geared towards addressing the psychosocial factors unique to their traumatic experiences and 2) Provide clinical training on the best practices and trauma-informed mental health care that is specific to sexually exploited children and youth with a goal of improving the quality of services and outcomes for the CSECY identified population. It is hoped that the suggested training series would better equip the mental health practitioner with the tools needed in order to identify, assess, and provide effective treatment services to CSECY.

Approximately 17,941 clients under the age of 21 received trauma related interventions/Evidence Based Practice (EBP) interventions from the Los Angeles County Department of Mental Health (LACDMH) during FY 13-14. These EBPs include Trauma Focused CBT (TF-CBT, N=9958), Seeking Safety (N=6171), and Crisis Oriented Recovery Services (CORS). The goal is to target training to clinicians already trained in one or more of these three EBPs as the CSECY victims would benefit most from receiving trauma related interventions.

Updates for the Current Fiscal Year (FY): During Calendar Year 2015, CSECY trainings were conducted in May, November, and December ***(Attachment 3D.1)***. Clinical and non-clinical staff from directly-operated clinics, outpatient county contracted clinics, juvenile justice camps, and specialized foster care programs participated in the training. Spring 2016 CSECY trainings began on March 23, 2016 ***(Attachment 3D.2)*** and included participants from both directly-operated and county contracted outpatient clinics.

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The PIP team has also highlighted the importance of community stakeholder presence at CSECY PIP meetings. Valuable issues were addressed when Client Coalition and Mental Health Commission members were involved. Client Coalition member, Ms. Clay contributed to discussions surrounding the increased need for CSECY services and resources. It has been determined that there remains to be CSECY involved programs and services that would benefit from the additional training. Specialized Foster Care programs and the Women's Re-integration Center were introduced as mental health treatment providers that may benefit from additional information regarding treatment for CSECY identified individuals; management from both programs were contacted and information for the upcoming 2016 year was provided. The PIP team explored the need for CSECY services among the adult population. Ms. Clay shared that the CSECY trainings may be valuable for clinicians treating Adult clients with self-reported CSECY experiences. The Women's Reintegration Center provides services to the adult population. Ms. Ditko proposed the idea of designing a focus group that would aim to further identify limitations to accessing CSECY services and adequate training within the community. The same or separate focus group would also prove beneficial towards improving the process of collecting CSECY related data and client satisfaction data.

On March 15, 2016, the juvenile justice program began piloting a CSECY screening tool. The Commercial Sexual Exploitation – Identification Tool (CSE-IT) was being validated by the developer in a variety of settings across the State of California. The juvenile justice programs are participating in this validation study and are completing the CSE-IT for all new admissions to Central Juvenile Hall. Data from this pilot will be analyzed by the developer and aggregate data on the profile of youth will be provided back to LA County at a future date.

SECTION 2: DEFINE & INCLUDE THE STUDY QUESTION

1. Will the CSECY training result in an increase in the number of CSECY clients identified?
2. Will the CSECY training result in improved clinical outcomes for sampled CSECY victims receiving treatment from clinicians who completed the CSECY training compared to sampled CSECY victims treated previously by these clinicians prior to completing the CSECY training, as measured by:
   A. The UCLA Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) and the Outcome Questionnaire (OQ) for CSECY clients receiving trauma informed EBP services in outpatient settings
   B. The Brief Symptom Inventory (BSI) for CSECY clients served in Juvenile Halls
   C. Full Service Partnership outcomes on the Outcomes Measures application
3. Will the CSECY training lead to increased clinician awareness of CSECY, increased awareness of mental health issues associated with CSECY and improve clinician confidence regarding ability to effectively identify and treat CSECY victims, as measured by the pre and post CSECY training surveys?

SECTION 3: IDENTIFY STUDY POPULATION

This study targets all beneficiaries, including, Medi-Cal beneficiaries within Child and Transition Age Youth (TAY) services who have been the victims of commercial sexual exploitation. Current data is unavailable regarding the exact number of CSECY victims served by LACDMH, as this information is not currently captured in the electronic health record. The training plan will cast a wide net by including a significant number of providers who are likely to come into contact with such youth should they seek out services through LACDMH. These include providers across the Children's and TAY Systems of Care who have already received training in evidence-based approaches to treating trauma. The department will capture data regarding CSECY victims served by LACDMH by surveying the training participants about the numbers of CSECY victims they serve, both before receiving training and afterward. Trainings offered will increasingly identify CSECY victims.

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Efforts to Gather Data and CSECY Client Related Outcomes: Efforts have been made to identify CSECY clients within the outpatient clinics and Juvenile Halls. In June 2015, Dr. Streich introduced the idea of gathering CSECY information from clients within the Juvenile Justice System. In order to track youth who are identified as CSECY clients, the juvenile justice programs created a secure shared drive between the programs. Identified youth are tracked on this shared drive and this information was used to collect data for the CSECY PIP. The information collected on the youth included the date of the clinician's training, as well as any available Brief Symptom Inventory (BSI) scores for the client, both before and after the clinician's training. Each of the juvenile hall programs periodically updates the information contained on the shared drive as additional clients are identified. The juvenile justice programs have actively participated in the CSECY PIP during this past year. As part of this participation, the juvenile justice staff have been trained both in the identification of CSECY youth and in the clinical interventions which are appropriate for this population. In November 2015, Dr. Streich reported that the BSI questionnaires of CSECY identified clients were being scored and subsequently forwarded to the Quality Improvement Division (QID) for review. The QID received Juvenile Hall data, in February 2016. When queried in the pre-training survey during all trainings conducted between February 2015 and April 2016, trained clinicians from the Juvenile Halls, Field Capable Clinical Services (FCCS)/Full Service Partnership (FSP) outpatient programs and Specialized Foster Care programs self-reported having worked with a total of **1,185** CSECY identified individuals, in the past three months. The process of obtaining the number of CSECY identified individuals participating in treatment with CSECY trained clinicians has been a challenge.

SECTION 4: SELECT & EXPLAIN THE STUDY INDICATORS

Rationale for Selection of Study Measure 1:	Identify the CSECY clients from individuals that received CSECY training and who are actively serving CSECY clients.
Quantifiable Measure 1:	Number of CSECY clients identified
Numerator:	Number of CSECY clients identified
Denominator:	Not Applicable
Rationale for Selection of Study Measures 2 & 3:	Clinical outcomes on EBP-based data for CSECY clients treated by clinicians post-training compared to CSECY clients treated by clinicians pre-training will demonstrate training's effectiveness and improvement in trauma related symptoms and distress.
Quantifiable Measure 2:	Scores on the PTSD-RI (adult or child form, depending on client's age).
Numerator:	**Group 1**: CSECY clients seen by clinicians pre-training: PTSD-RI Scores at Baseline - PTSD-RI Scores at 6 months

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	Group 2: CSECY clients seen by clinicians post-training: PTSDI-RI Scores at Baseline - PTSDI-RI Scores at 6 months
	(EBP Measure: PTSD-RI Score=PTSD Severity Score).
Denominator:	**Group 1**: Baseline Scores on the PTSD-RI for CSECY clients seen by clinicians pre-training
	Group 2: Baseline Scores on the PTSD-RI for CSECY clients seen by clinicians post-training
First measurement period dates:	CSECY Clients seen by clinicians pre-training would have already completed baseline and 6 month outcome measures. CSECY Clients seen by clinicians post-training will receive baseline assessments between March-May and will be re-assessed at the 6-month mark.
Goal:	Clients seen by clinicians post-training will demonstrate statistically significant improvements on outcome measures at the 6-month mark when compared to the outcomes of clients seen by clinicians pre-training at the 6-month mark in their treatment.
Quantifiable Measure 3:	Scores on the YOQ or OQ (depending on client's age).
Numerator:	**Group 1:** CSECY clients seen by clinicians pre-training: YOQ or OQ at Baseline - YOQ or OQ at 6 months
	Group 2: CSECY clients seen by clinicians post-training: YOQ or OQ at Baseline - YOQ or OQ at 6 months

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	(EBP Measure and relevant scales: YOQ Scores=Intrapersonal Distress, Interpersonal Relations, Social Problems, Behavioral Dysfunction, Critical Items; OQ Scores=Symptom Distress, Interpersonal Relations, Critical Items)
Denominator:	Group 1: Baseline Scores on the YOQ or OQ for CSECY clients seen by clinicians pre-training
	Group 2: Baseline Scores on YOQ or OQ for CSECY clients seen by clinicians post-training
First measurement period dates:	CSECY Clients seen by clinicians pre-training would have already completed baseline and 6 month outcome measures. CSECY Clients seen by clinicians post-training will receive baseline assessments between March-May and will be re-assessed at the 6-month mark.
Goal:	Clients seen by clinicians post-training will demonstrate statistically significant improvements on outcome measures at the 6-month mark when compared to the outcomes of clients seen by clinicians pre-training at the 6-month mark in their treatment.

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Rationale for Selection of Study Measure 4:	Clinical outcomes on the Global Severity Index (GSI) of the Brief Symptom Inventory for CSECY clients treated by clinicians in Juvenile Halls post-training compared to CSECY clients treated by clinicians pre-training will demonstrate training's effectiveness and reduction in distress level for CSECY clients.
Quantifiable Measure 4:	Global Severity Index (GSI) on the Brief Symptom Inventory (BSI)
Numerator:	**Group 1**: CSECY clients seen by clinicians pre-training: BSI Measure at Baseline - BSI Measure post within six weeks
	Group 2: CSECY clients seen by clinicians post-training: BSI Measure at Baseline - BSI Measure post within six weeks

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	The Brief Symptom Inventory (BSI) has been administered by Department of Mental Health (DMH) staff in the Juvenile Halls since 2002. The BSI is a supplemental outcome measure for the Los Angeles County Juvenile Justice Crime Prevention Act (JJCPA) which is evaluated annually by the RAND Corporation. The BSI is administered to newly admitted youth who are being opened for mental health treatment. A second BSI is administered at 3 weeks (if the youth is still in custody). The BSI is intended to measure the clinical effectiveness of the assessment and treatment which is provided to youth in the juvenile halls. The BSI is used to measure the subjective distress of the youth. For purposes of the RAND evaluation the Global Severity Index (GSI) is used as the outcome measure. The GSI is a global index of the BSI and is the most sensitive single indicator of the youth's level. A decrease in the score on the GSI indicates a decrease in the distress of the youth.
Denominator:	**Group 1**: Baseline Scores on BSI for CSECY clients seen by clinicians pre-training
	Group 2: Baseline Scores on BSI for CSECY clients seen by clinicians post-training
First measurement period dates:	CSECY Clients seen by clinicians pre-training would have already completed baseline and 3 week outcome measures. CSECY Clients seen by clinicians post-training will receive baseline assessments beginning in May and be re-assessed at the 3 weeks mark.

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Goal:	CSECY Clients seen by clinicians post-training will demonstrate statistically significant improvements on GSI scores of BSI at the 3 week mark when compared to the GSI scores of CSECY clients seen by clinicians pre-training at the 3 week mark in their treatment.
Rationale for Selection of Study Measure 5:	Improved school attendance as measured by the FSP Outcomes Measures Application (OMA) for CSECY clients treated by clinicians post-training compared to CSECY clients treated by clinicians pre-training will demonstrate training's effectiveness.
Quantifiable Measure 5:	FSP Outcome Measures Application (OMA)
Numerator:	**Group 1**: CSECY clients seen by clinicians pre-training: School attendance at 3 months - school attendance at baseline
	Group 2: CSECY clients seen by clinicians post-training: School attendance at 3 months – school attendance at baseline
	Note: School attendance is measured on a 5-point scale (Always attends school, attends school most of the time, sometimes attends school, infrequently attends school, never attends school).
Denominator:	**Group 1**: Baseline attendance
	Group 2: Baseline attendance

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First measurement period dates:	CSECY Clients seen by clinicians pre-training have already completed baseline and 3 month outcome measures. CSECY Clients seen by clinicians post-training will receive baseline assessments beginning in May and be re-assessed at the 3 month mark and at any critical event.
Goal:	CSECY Clients seen by clinicians post-training will demonstrate statistically significant improvement in school attendance at the 3 month mark when compared to the attendance of CSECY clients seen by clinicians pre-training at the 3 month mark in their treatment.
Rationale for Selection of Study Measure 6:	Improved clinician awareness of CSECY, awareness of mental health issues associated with CSECY, and confidence in treating CSECY victims will contribute to improved beneficiary outcomes and satisfaction.
Quantifiable Measure 6:	Clinicians reporting on post-training survey improvement in awareness of CSECY, awareness of mental health issues associated with CSECY, and confidence in treating CSECY victims when compared to their pre-training surveys.
Numerator:	Pre and Post-training difference in ratings for:
	1. Awareness of CSECY
	2. Awareness of mental health issues associated with CSECY
	3. Confidence in treating CSECY victims.

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Denominator:	Pre-Training survey results for :
	1. Awareness of CSECY
	2. Awareness of mental health issues associated with CSECY
	3. Confidence in treating CSECY victims.
First measurement period dates:	In CY 2015, pre-training surveys were administered on 5/6/15, 5/12/15, 11/4/15, 11/10/15, 12/2/15, 12/7/15, and 12/10/15. In CY 2016, pre training surveys were administered on 3/23/16 and 4/6/16. Post training surveys were administered for May 2015 trainings on 8/12/2015, and for November and December 2015 trainings on 2/22/2016.
Goal:	At post-survey, matched pair analysis will show statistically significant increases in awareness of CSECY, awareness of mental health issues associated with CSECY, confidence in treating CSECY victims.

SECTION 5: DEVELOP & DESCRIBE STUDY INTERVENTIONS

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Number of Intervention	List each Specific Intervention	Barriers/Causes Intervention Designed to Target	Corresponding Indicator	Date Applied
1	Day 1 CSECY Awareness Training (Part I)	Lack of knowledge and cultural competency around CSECY. CSECY victims often not identified by clinicians because of this lack of knowledge and cultural competency.	Pre and Post Survey Comparisons	5/6/15 and 5/12/15
2	Day 2 CSECY Interventions (Part II)	Lack of knowledge of appropriate clinical interventions for CSECY is reflected in low clinician confidence in their ability to treat CSECY victims once identified.	EBP outcomes for CSECY victims post-training	5/7/15 and 5/13/15
3	CSECY 101 and CSECY Interventions (One-day)	1. Lack of knowledge and cultural competency around CSECY. CSECY victims often not identified by clinicians because of this lack of knowledge and cultural competency. 2. Lack of knowledge of appropriate clinical interventions for CSECY is reflected in low clinician confidence in their ability to treat CSECY victims once identified.	Pre and Post Survey Comparisons	11/4/15, 11/10/15, 12/2/15, 12/7/15, 12/10/15, 3/23/16 and 4/6/16
4	Strategies for Identification of CSECY clients seen by CSECY trained clinicians	Lack of current systems to track and identify CSECY clients.	Number of CSECY clients identified	July 1, 2015 – April 6, 2016

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SECTION 6: DEVELOP STUDY DESIGN & DATA COLLECTION PROCEDURES

The training efforts of the CSECY PIP team span from increasing the number of trainings available, outreach efforts to CSECY serving clinicians, re-structuring the design and registration of the training, and exploring additional training needs.

A total of 390 individuals received CSECY training between May and December 2015. The spring 2015 CSECY Training Parts I and II occurred **May 6th -7th and May 12th -13th; 166 individuals participated in these trainings and 104 of the trainees were clinicians.** November and December training dates were established for a Winter 2015 cohort. It was determined to condense the two-part CSECY training into a one day curriculum and this format change started with the November 2015 trainings. CSECY trainings conducted on **November 4th, November 10th, December 2nd, December 7th, and December 10th resulted in 224 individuals trained, 100 of the trainings' participants were clinicians.** Trainees were notified through training bulletins that were sent to directly-operated clinics and LACDMH contracted providers. In March 2016, the training schedule for the spring 2016 cohort was established.

Training bulletins have been distributed for the spring 2016 trainings and training registration in in progress. The spring 2016 trainings were scheduled as follows: March 23rd, April 6th, and May 9th of the 2016 year ***(Attachment 3D.3)***. **There were 53 participants in the March 23rd CSECY 101 training; 41 trainees indicated that they were actively serving clients and 12 participants did not specify their professional role. There were 93 participants in the April 6th CSECY 101 training; 64 trainees indicated that they were actively serving clients, 7 participants did not specify their role.** The Clinical PIP team determined that the spring 2016 cohort would remain open to clinical and non-clinical staff. In the future, additional one-day trainings will be offered for those that are interested in grasping a deeper understanding of the specific treatment methodology to utilize while providing services to CSECY identified individuals. Training locations are purposefully chosen to occur within the community and spread out amongst the diverse areas that prospective CSECY clinicians are providing services. In an effort to incorporate feedback that was expressed by previously CSECY trained clinicians, a specialized CSECY training that emphasizes the male CSECY population has been developed. LACDMH clinicians have been invited to "The Commercial Sexual Exploitation of Boys, Young Men, and Transgender Youth" training that is scheduled for May 3, 2016 ***(Attachment 3D.4)***. In Calendar Year (CY) 2015, **a total of 470 clinicians** that are directly serving clients have participated in CSECY training. These clinicians are providing mental health treatment services to Children and Youth within directly-operated and county contracted outpatient clinics, juvenile halls and camps, juvenile court, and specialized foster care programs. **In March and April 2016, 105 clinicians participated in CSECY training and 50 CSECY clients were identified prior to training. For the performance project, a total of 575 clinicians have been trained thus far.** Overall, **675** individuals who hold both administrative and clinical roles have received CSECY training.

Data Collection Procedures and Outcomes: In June of 2015, it was determined that a SharePoint site where directly-operated staff could identify and provide data on CSECY victims would simplify tracking. A SharePoint site is a secure website accessible through LACDMH's intranet. The **SharePoint site was implemented on August 12, 2015** and was

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developed as a means of communicating CSECY related information and gathering data from the CSECY trained clinicians in directly-operated outpatient clinics. County contracted programs have been instructed to send their CSECY client data

lists via a secure email to QI and TAY CSECY leads. An email account has also been created to facilitate data submission and any requests from CSECY trainees for clarification. The email address is as follows: CSECinfo@dmh.lacounty.gov.

The SharePoint webinar was aimed at further familiarizing the webinar's participants with the SharePoint's features as well as the process of entering client information. Information gathered in the tracking file includes: agency name, client name, clinician full name, Practitioner ID, and pre/post CSECY training client ID ***(Attachment 3D.5)***. Changes to the client data spreadsheet were proposed in November 2015. It was suggested that two columns were created in order to distinguish between CSECY clients that were identified during the pre-survey period and those added post training. The "Today's Date" field was also deemed no longer necessary as this spreadsheet is aimed at post training client data. In November of 2015, the client data spreadsheet was revised to include a field for the name of the rendering provider where the client participated in treatment services. The client data spreadsheet was discussed in detail during the SharePoint Webinar.

A **memo explaining the process of creating a CSECY client list and the availability of the SharePoint website webinar was finalized in November 2015 and further disseminated by the TAY Division to all directly-operated clinics *(Attachment 3D.6)*. The first SharePoint webinar, facilitated by QID, was conducted on December 13, 2015.** This webinar served as an introduction and was attended by directly-operated Specialized Foster Care providers and CSECY Administration. **The following SharePoint webinars were conducted on January 13, 2016 and January 27, 2016.** The January 13th webinar included attendees from: San Antonio Family Center, Specialized Foster Care program, Juvenile Hall Challenger, as well as three PIP team members. Dr. Joshi led the webinar and Dr. Reynoso offered support. The participants were provided an overview of the CSECY PIP and why working with multiple divisions in order to better identify CSECY clients was important. The role of the QI team in tracking outcomes, reviewing data, and collaborating on interventions was also discussed. It was highlighted that clinicians are being asked to share information on the SharePoint's secure website in support of tracking whether or not CSECY clients are being identified and concurrently receiving the services that are needed. Participants were shown how to access each of the site's pages via the "All Site Content" link. The process of entering client data was explained as follows: (1) locate the name of your clinic; (2) click on the Excel Sheet; (3) list client(s) IS# as well as their first and last name for those seen prior(pre) to the CSECY training as well as client(s) that were seen after (post); (4) select the option to open the sheet in excel, enter data accordingly, and save the sheet; and (5) reload the workbook onto the SharePoint website. Participants were informed that gaining access to the SharePoint website has granted them access to all of the site's content and features (i.e., creating task, adding client data). Participants were informed that the website was limited to directly-operated clinics with plans towards gathering client data from other clinics in development. Satellite programs were encouraged to enter client data under one of their associated providers; they were informed that the duplicate clients will be cleared up by QID. The webinar conducted on January 27, 2016 maintained a similar process and content review as the December and January webinars. Attendees for the January 27th webinar included Dr. Joshi as the facilitator, PSB-QI Clinical Psychologist II and a single participant from the Dorothy Kirby Center. The webinar participant was encouraged to contact QID with any questions.

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Barriers to Data Collection and Strategies to Address them: The lower than expected webinar attendance and client data were brought to the PIP team's attention. In December 2015, the PIP team introduced their plans to development a separate webinar aimed at reviewing the procedures towards creating a client list on the Share Point Webinar. The PIP team has discussed barriers to the client data collection process on an on-going basis. Due to the consistently low attendance at the webinars, a decision was made by the PIP team for a QID team member to be present during the CSECY trainings. Per **PDSA 1** ***(Attachment 3D.7)*** on March 23, 2016, Dr. Joshi conducted a demonstration of the SharePoint website and collected client lists that were completed pre-CSECY training, in-person. Elements of the SharePoint website and the Pre-CSECY client data spreadsheet has evolved over the course of this year.

There is a relevant need for services and it is the goal of the PIP team to maintain the importance of the CSECY trained clinicians to contribute client list data pre and post training. In an additional effort to address the growing need for CSECY related services among the large and diverse community of Los Angeles County, the PIP team has consistently identified and discussed methods towards enhancing the CSECY training needs.

Dr. Reynoso and Dr. Streich indicated clinician apprehension towards sharing client information. The PIP team also explored the lack of access, by legal entities, to the DMH secure SharePoint site created a barrier. An Enhanced File Transfer (EFT) folder that may be accessed by contract providers is being developed and trained clinicians have been instructed to forward private client data via secure email, to QID staff. In March 2015, the PIP team initiated the process of directly outreaching CSECY trained clinicians and the agencies where they are providing services. It was proposed that one on one outreach may serve to alleviate suspected clinician hesitation. The TAY division and QID staff are working collaboratively with program managers, clinical supervisors, Service Area (SA) Quality Improvement Committee (QIC) chairs, and clinicians in order to offer further technical support and encouragement as needed.

QID gathered a list of all participants in CSECY trainings. The list was then organized by type of clinic or program (i.e., directly-operated, county contracted, specialized foster care, etc.) and further separated across the 8 corresponding SAs. The list was shared with the PIP team members and reviewed for accuracy. Dr. Jones-Chambers removed the names of trainees that held identified administrative or supervisory roles and who are not actively treating CSECY. **An outreach planning call was held on March 15, 2015 and Drs. Gore, Jones-Chambers, Kasarabada, and Reynoso were present on the call.** In an effort to collect client data from the CSECY trained clinicians, the following strategies were successively carried out: (1) Dr. Kasarabada held a meeting with Christina Maeder in order to discuss the barriers to collecting data from clinicians providing services within the Specialized Foster Care – Katie A programs, (2) Dr. Reynoso telephoned and emailed program management and supervisory staff from Juvenile Justice, Katie A, SFC, and Juvenile Court – Mental Health requesting that client data lists are forwarded, and (3) Dr. Kasarabada enlisted the assistance of the SA QIC Chairs during **the March 14th QIC meeting** and encouraged CSECY client data outreach to contract providers that are CSECY trained and providing services within their SA.

The pre and post trainings surveys have undergone changes. A second **PDSA** was developed to address an improvement of the CSECY clients identified ***(Attachment 3D.8).*** This was accomplished in November 2015 with the addition of a note to Question number three of the pre-training survey; specifically requesting that clinicians who endorse greater than "0"

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clients are prompted to create a CSECY client list that includes: Client ID, Last name, and First name. The revised survey was sent online prior to the December 2015 trainings (***Attachment 3D.9)***.

SECTION 7: DATA ANALYSIS & INTERPRETATION OF STUDY RESULTS

For Study Measure 1 Client Identification that is mentioned in Section 4, a total of **296** CSECY clients were identified in different settings – Juvenile Halls, Court Linkage Programs and Outpatient Programs. Of these, **167** clients were identified as receiving services in Juvenile Halls, **56** clients were from Outpatient programs and **73** individuals were reported from Juvenile Court Mental Health Services.

An additional 30 clients were identified by a multi-disciplinary team (MDT) formed to review CSECY cases presented to the CSEC Dependency Start Court. In January 2016, the CSEC Dependency Star Court was created as a result of the amendment to the Welfare & Institutions Code § 300(b)(2) and the availability of state funds. The majority of CSEC victims are now served by the child welfare system, instead of the juvenile delinquency system. Accordingly, a multi-disciplinary team (MDT) was formed to review all CSEC cases presented to this court. The MDT includes representatives from DCFS, DMH, DHS, Children's Law Center, educational representatives and survivor advocates who inform the court on the best interests of the youth. The DCFS-led MDT meets weekly to plan for the youth's placement, safety, and on-going service needs, including mental health services. Through this process, approximately 30 additional CSEC youth have been identified thereby increasing the total number identified thus far to **326.**

Demographic data is reported for **142** unique CSECY clients that matched the LACDMH claims data in CY 2015. Nearly 44% were African American, 42% were Latinos, 9% were White, 1% were Asian Pacific Islanders and remaining 1% were Other and 3% were Unknown. Ninety percent of the clients reported English as their primary language and the remaining 10% Spanish. Majority of the clients were females at 94% and 6% were males. Nearly a quarter or 26% were 16 years of age, 22% were 15 years, 18% were 17 years, 12% were 14 years, 10% were between 11 and 13 years, 9% were between 18 and 27 years and 4% of the birth dates were unreliable.

The primary diagnosis at admission for the 142 unique CSECY clients was as follows:
Bipolar Disorders - 24%, Depressive Disorders – 23%, Disruptive Behavior Disorder NOS – 14%, PTSD – 13%, Adjustment Disorders – 9%, ADHD – 5%, Anxiety Disorders – 4%, Oppositional Defiant Disorder – 4%, Conduct Disorder – 1%, Deferred Diagnosis – 1% and No Diagnosis – 2%.

The highest percentage of clients based on their area of residence were from SA 3 (20%) followed by SA 6 (17%), 11% in SA 7, 9% each in SAs 2, 4 and 8, 4% in SA 1 and 19% had missing data on their area of residence. However, the highest percentage of clients received services in SA 4 (50%), followed by SA 7 (16%), 13% in SA 2, 8% in SA 6, 5% in SA 8, 6% in SA 3 and 1% in SA 1 and the remaining 1% in a CW program.

Majority of these clients (40%) were seen at the Central Juvenile Hall.

The Juvenile Hall TAY Management provided other juvenile justice related data for the Juvenile Hall clients as listed below:

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- CRIMINAL CHARGES
    - INCLUDED PROSTITUTION CHARGES = 44%
    - DID NOT INCLUDE PROSTITUTION CHARGES = 56%
- CONTACT WITH DMH PRIOR TO INCARCERATION = 68%
- IDENTIFIED AS DEVELOPMENTALLY DISABLED = 7%
- HAVE BEEN HOSPITALIZED (From IS) = 36%
    - AVERAGE NUMBER OF HOSPITALIZATIONS = 2

For the 73 individuals reported by the Juvenile Court Mental Health Services between October 2012 and March 2016, **a total of 106 arrests were made for prostitution.** Seventy-three unique clients were provided with a referral or linkages for additional services. The total number of arrests for prostitution and number of unique CSECY clients differ as one CSECY identified victim may have received multiple charges for the same offense, at different times. Each arrest can be examined for the number of charges of prostitution that were received. Of the 106 arrests by the Juvenile Court, 77% were reported as having one charge for prostitution, 27% were reported as having two charges for prostitution, and 15% were reported as having three or more charges for prostitution. The highest number of charges for prostitution reported was observed in one CSECY identified client who had received a total 8 charges in a single arrest. There has been a noticeable increase in the number of youth arrests for prostitution over time. A total of 4% of the 106 arrests occurred in 2013 (October – December), 27% of the arrests were made in 2014, 49% of the arrests were made in 2015, and in early 2016 (January, February, and half of March) 10% of the total arrests were made. A total of 59% of CSECY identified youth were charged and detained following their arrest. Ninety-two percent of the CSECY victims identified by the Juvenile Court Mental Health Services were female. African American (77%), Latino (21%), and White (7%) were among the ethnicities represented and one CSECY identified individual of an unknown race. The type of referral for these youth include: 26% were dependents of Children's court with formal probation through delinquency court pending, 13% were pending both children's court dependency and formal probation through juvenile court, 27% were reassessment for review, 14% were reassessment for a new arrest, and 20% had no information available regarding the type of referral. The disposition types for these youth include: 21% dually supervised by probation and DCFS with suitable placement, 3% dually supervised by probation and DCFS with home placement, 5% received suitable placement or home placement, 16% received informal probation, 9% of the charges for prostitution were dismissed and 7% of the dispositions were reported as other. For **223** clients for whom Client ID information was available, data was analyzed for the Outcomes Measures. This list could be gathered only for clients seen by clinicians post CSECY training.

For Study Measures 2, 3 and 5 data was not available for Group 1 because as mentioned in Study Measure 1, the pre-CSECY client list could not be gathered from clinicians.

Unfortunately, information was not available for Group 1 (pre CSECY Training Outcome Measures) per the Study design that was presented in Section 4. Due to multiple barriers, the Pre-CSECY client list information could not be gathered from the clinicians at the time of training or prior to training, despite several attempts. These barriers included: HIPAA compliance concerns, difficulties with remembering the Client IDs of those served in the past and multiple competing priorities for clinicians that maintain high caseloads.

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For Study Measure 4 related to GSI scores, the following information is hereby reported for Group 2 (Post-CSECY training) for all outcome measures. Out of the **167** clients in the Juvenile Hall, 107 clients had BSI data available. However, only 27 clients had a **Pre Post GSI** data reported.

For 48% (n = 13) of the 27 clients, there was a decline of an average of 11 points in their post GSI score thereby indicating an improvement. The range for pre/baseline score was 33-77 and the range for post was 26-65 for this group. This change in pre and post score was statistically significant at .001 level (t value = 12.91, df = 12).

For three clients the GSI score remained the same.

For the remaining eleven (11) clients there was an increase of an average of 15 points in the post GSI scores compared to the pre indicating an increase in their distress. The range for pre/baseline score was 28-65 and the range for post was 35-80 for this group. This change in pre and post score was statistically significant at .001 level (t value = 14.78, df = 10). (***Attachment 3D.11)***.

The baseline mean score for the remaining 80 clients was 52.5 and the range was 26-80. A GSI score above 50 is indicative of high distress.

Per the TAY Division Juvenile Hall management team, the increase in the post scores could potentially be attributed to an increase in the disclosure of severity symptoms associated with an increase in the development of trust in the CSECY trained clinicians. In other words, the improved assessment and treatment skills of these clinicians following training could potentially be contributing to the development of trust and rapport with clients and potentially long-term positive outcomes.

Of the **223** clients with available Client IDs, 48 showed pre post matched pairs data available for EBP measures, 17 unique clients were receiving services from FSP programs and 22 received services from FCCS. However none of the outcomes data was collected after the CSECY training dates of trained clinicians and hence is not analyzed.

For Study Measure 6, for the **Spring 2015** surveys there were statistically significant pre post differences (p < .001) in the awareness of CSECY, in the awareness of mental health issues associated with CSECY, and the level of confidence in treating CSECY clients (N = 105). **For Study Measure 6**, for the **Fall 2015** surveys there were statistically significant pre post differences (p < .001) in the awareness of CSECY, in the awareness of mental health issues associated with CSECY, and level of confidence in treating CSECY clients (N = 52). The fall and spring 2015 CSECY Matched Pair Evaluation summaries have been added as an attachment ***(Attachment 3D.10)***.

Baseline survey results for the **Spring 2015 cohort (N=260)** showed that **only 44% were Aware or Very Aware of CSECY, 50% were Aware or Very Aware of mental health issues associated with CSECY and only 20% were Confident or Very Confident in treating CSECY clients**. Baseline survey results for the **Fall 2015 cohort (N=123)** showed that **only 39% were Aware or Very Aware of CSECY, only 42% were Aware or Very Aware of mental health issues associated with CSECY and only 20% were Confident or Very Confident in treating CSECY clients** (***Attachment 3D.12)***.

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March and April 2016 baseline data (N = 125) shows (***Attachment 3D.13)*** that **only 40% were Aware or Very Aware of CSECY, only 43% were Aware or Very Aware of mental health issues associated with CSECY and only 25% were Confident or Very Confident in treating CSECY clients**. This demonstrates a continued need for clinicians to be trained in this area.

Performance Indicator	Date of Baseline Measurement	Baseline Measurement (numerator/denominator)	Goal for % Improvement	Intervention Applied & Date	Date of Re-measurement	Results (numerator/denominator	% Improvement Achieved
See Attachment 3D.10 and Attachment 3D.11							

SECTION 8: ASSESS OUTCOMES OF PIP

Real and sustained improvement are the result of a continuous cycle of measuring and analyzing performance, thoroughly analyzing results, and ensuring implementation of appropriate solutions. To analyze the results of the PIP the MPH must document the following steps:

- Describe issues associated with data analysis –
  - Did data cycles clearly identify when measurements occurred? Should monitoring have occurred more frequently?
  - Results of statistical significance testing.
  - What factors influenced comparability of the initial and repeat measures?
  - What, in any, factors threatened the internal or external validity of the outcomes?
- To what extent was the PIP successful and how did the interventions applied contribute to this success?
- Are there plans for follow-up activities?
- Does the data analysis demonstrate an improvement in processes or consumer outcomes?

The data cycles for the administration of post BSI at juvenile halls occurred within 5 weeks from the baseline for only 27 clients. Of the 167 clients, 107 had valid GSI scores available from the BSI administration. Due to the nature of this population, it was difficult to track and administer pre and post administrations when there were unplanned discharges. Monitoring of administration of the surveys can be improved. There were statistically significant differences in pre-post GSI scores in both positive and negative directions. However, due to the low N, more data is needed to make any conclusions about these differences. The BSI is a standardized instrument with high reliability and validity and there are no known factors that affected the outcomes.

On the pre-post survey differences for the clinician surveys for Study Measure 6, there were statistically significant difference in a positive direction in all three areas: awareness of CSECY, awareness of mental health issues in CSECY and confidence in treating CSECY victims thereby indicating a positive impact from the CSECY training on the knowledge and skills for the clinicians who were trained. The baseline survey was administered in person whereas the post survey was online. The differences in methodology of administration may have impacted the response rate but not the comparability of the initial and repeat measures as there were similar results for different training cohorts from February through December 2015.

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Success of the PIP: The CSECY training was the intervention for this PIP and the results reported for Study Measure # 1 indicate that this PIP was successful. Prior to the trainings and tracking of the CSECY clients implemented by this PIP, there were no CSECY clients identified by LACDMH that could be reported. As a result of the trainings offered in CY 2015 and CY 2016, this number increased from N=0 prior to the PIP implementation to a total of **N=326** following the PIP implementation. This is attributable to the improved knowledge and skills in identifying the CSECY clients following participation in these trainings.

However, from the reported numbers on the baseline survey a total of **1,185** clients were estimated as having been seen by some clinicians prior to this training. As mentioned in the "Barriers to data collection" section of this PIP document, there have been barriers (in collecting data with specific client IDs) such as HIPAA compliance concerns, difficulties with remembering the Client IDs of those served in the past and multiple competing priorities for clinicians that maintain high caseloads. It is important that LACDMH addresses these barriers to ensure consistent tracking and reporting of CSECY clients.

Although the Share Point site was created for the county operated program clinicians to enter their CSECY client information, this tool was not used to the full potential. Relying on SA QI liaisons, QID, and TAY leads to gather this information led to some positive results. However, this is not the most efficient way to collect this data. It is important that LACDMH continues to explore using the EHR to track and report CSECY clients as this will create a seamless process and also addresses barriers discussed earlier such as HIPAA concerns about emailing secure information and additional burden in using a different tool than the EHR to enter the CSECY data.

The CSECY trainings made an impact on all three areas assessed pre-post training for the Spring and Fall cohorts and showed statistically significant pre-post differences in the awareness of the CSECY, awareness of mental health issues associated with CSECY and the confidence in treating this population. Although the response rate on the post survey was not high and the matched pair data was for N=157, post survey data for the March, April and May 2016 data will be gathered to ensure the reliability and validity of the findings for the 2015 cohorts. The PIP team intends to continue the data collection process on post surveys for the 2016 cohort. It is important to note that the baseline survey data for all trainings in CY 2015 and CY 2016 consistently showed that **less than 50% of clinicians were Aware or Very Aware of CSECY and mental health issues associated with CSECY and less than 25% were Confident or Very Confident in treating CSECY clients.** This clearly demonstrates a need for on-going training to all clinicians to improve identifying CSECY clients as well as increase their confidence level in treating CSECY clients.

Qualitative Data-Clinicians Impressions: The most frequent feedback, comments and reactions by mental health providers following a CSEC 101/Awareness training include:

- Reflection about *former* cases that the clinician assessed or treated and having a 'sinking' feeling that they 'missed' the signs and risk factors for CSE.
- Reflection upon *current* cases that the clinician currently treats and has 'epiphanies' about their client 'being in the life' (i.e., may be actively a victim of CSE). In this scenario, the clinician is eager to return to his/her clinic to explore further.

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- Enthusiasm and an impetus to contribute to the eradication of CSE.
- Immediate research and exploration of resources in their community
- Involvement in activism and/or sharing the learned knowledge with colleagues and supervisors

This positive feedback from the trained clinicians shows clinicians highly value this training and recognize this as an important area for improving their assessment and treatment skills.

Follow up Activities: There are several follow up activities planned for this PIP as listed below:

1. The TAYSOC CSECY leads have been providing consultation to CSECY trained clinicians to answer questions that arise in clinical practice. The consultation provided by these leads has been valuable and has been useful to even clinicians who have not been trained on CSECY. For example, in March 2016 following the PIP updates at QIC meeting, a SA QI liaison contacted the CSECY leads to seek consultation on a CSECY client being treated in a Wraparound program in this SA by a clinician who was not as yet trained on CSECY. The TAYSOC CSECY leads recognized the need to provide immediate consultation on this client and assisted the clinician as the next training was more than one month away (on April 6th).
   At the April PIP meeting, the PIP team recommended that it would be helpful to formalize the consultation process and have a monthly case consultation meeting or conference call to assist clinicians who have questions on CSECY related issues. TAYSOC will consider implementing this recommendation.
2. TAYSOC CSECY leads will extend the CSECY trainings to faith-based organizations, homeless shelters, drop-in centers, and other agencies that may be in contact with these victims to raise awareness and resources available ***(Attachment 3D.14).*** TAYSOC CSECY leads presented Juvenile Justice related matters including CSECY at the Clergy Breakfast on **April 20th 2016** and this presentation was well received by faith based leaders.
3. TAYSOC CSECY leads will continue to present at collaborative meetings such as what was presented on March 22 2016 ***(Attachment 3D.15)*** at the Regional Center Collaborative meeting**.** Presentations will be focused on the unique needs and circumstances of the CSECY population that will improve the overall treatment outcomes for these youth.
4. Another recommendation provided by the PIP team was to develop an alert system to notify when a CSECY client who is already being currently treated by one provider group in the DMH system of care (Specialized Foster Care, outpatient programs, FSPs, Juvenile Halls shows up in a different program). This alert system to flag the notification to the primary provider will go a long way in improving the continuity of care for this population that is transient in nature.
5. An interdepartmental committee including Probation, Department of Mental Health, Juvenile Court Health Services and the National Center for Youth Law developed and drafted the "Juvenile Hall Interagency Protocol for Commercially Sexually Exploited Children (CSEC)". This document, outlines the goals, guiding principles and Department participation in the protocol. Each Departments' responsibilities are defined during the admission

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process and during the youth's stay in the juvenile hall. The protocol outlines interagency communication for the benefit of youth who are identified as CSEC, including the use of multi-disciplinary teams. This coordinated approach to the identification and treatment of CSEC youth is an important step toward making sure that the youth's medical and mental health needs are met. This protocol is tentatively scheduled to be implemented in August 2016.

6. TAYSOC CSECY leads and QID leads are scheduled to present at the Countywide Case Management meeting on May 10th to provide training to the staff who are involved in linkage of hospital discharges. The goal is to enable them to identify CSECY clients and provide appropriate referrals to the programs who have CSECY trained clinicians.
7. Following the last training for this fiscal year on May 9th, TAYSOC CSECY leads will develop a list of current active CSECY trained clinicians in both directly operated and contract programs. It is critical to generate this referral and resource list for programs that are key contact points for CSECY victims including but not limited to Juvenile Halls, Specialized Foster Care programs, Countywide Case management, and Emergency Outreach Bureau Psychiatric Mobile Response Teams (PMRT) to ensure timely linkage and appropriate trauma focused treatment much needed for the CSECY victims.
8. The validation study on the CSECY screening tool at the Central Juvenile Hall by the developer will provide important information for future expansion of this tool to other juvenile halls and the LACDMH outpatient programs piloted at the Juvenile Justice Program.
9. The CSECY PIP team will continue to administer pre-post surveys and track the outcomes. The tracking and identification of CSECY clients via the Secure CSECY Client list mechanism or Share Point site will be continued to continue to track and identify this population and provide appropriate treatment.

Outcome Measures: The outcome measures data was only available and analyzed for the Juvenile Hall involved CSECY clients and there were significant differences on the GSI scores in the positive direction for 13 of the 27 clients indicating reduction in symptom distress. However, due to the small N for this group compared to the entire cohort from the Juvenile Hall (N=167) no conclusions can be made.

The outcome measures for the EBP related and FSP pre-post data was minimal and not available for these clients post clinician training dates and therefore no meaningful analysis could be done.

Lessons learned from this PIP include the following:

1. Due to the transient nature of this population that is also hard to engage and retain, it is not appropriate to use EBP based outcome measures which are administered at 3 or 6 month intervals to track outcomes. A more appropriate outcome measure would be to track the number of linkages for CSECY victims once identified and referred to programs that have CSECY trained clinicians as discussed earlier in # 7 of the "Follow up Activities" section.
2. Once linked and enrolled into a program, the next outcome measure would be the retention in the program – so # of sessions, or # of claims/services received.

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3. Once enrolled in programs, it may be useful to administer a consumer satisfaction survey to these clients specific to treatment received by the CSECY trained clinician. As suggested by the Director, OCFA a focus group could also be conducted with these clients by the OCFA staff to gather this data in a more conducive environment.
4. As more CSECY clients are tracked, creating support groups will be important for agencies located in high density areas for this population. Tracking the attendance at support groups and resulting benefits from attending will be important to assess the outcomes of this intervention.
5. Selecting an outcome measure specific to this population would result in better data collection.

SECTION 9: PLAN FOR "REAL" IMPROVEMENT

It is essential to determine if the reported change is "real" change, or the result of an environmental or unintended consequence, or random chance. The following questions should be answered in the documentation:

- How did you validate that the same methodology was used when each measurement was repeated?
- Was there documented quantitative improvement in process or outcomes of care?
- Describe the "face validity," or how the improvements appear to be the results of the PIP interventions.
- Describe the statistical evidence supporting that the improvement is true improvement.
- Was the improvement sustained through repeated measurements over comparable time periods? (If this is a new PIP, what is the plan for monitoring and sustaining improvement?)

The trainings provided were by the same trainers and had similar content and so the same methodology was used to assess the impact of the training as measured by Study Measure 6. The GSI scores from the administration of BSI which is a tool with high reliability and validity. The initial and repeat measures were consistent and the scoring was computerized for this measure.

Similar levels of improvement in the confidence level of trained staff as indicated in the in the Spring and Fall 2015 Post training surveys indicates consistent understanding of the study measures by the survey respondents indicating face validity of the survey measures.

As discussed earlier, statistical tests conducted showed significant differences were noted for Study Measure 4 and Study Measure 6. The improvement for Study Measure 4 was based on a small N and no conclusive findings can be made of real improvement. More data has to be gathered to show sustained improvement. Study Measure 6 that was based on a Larger N and across different periods better demonstrates sustained improvement.

The reported change in terms of CSECY clients identified as reported by Study Measure 1 in this PIP from "0" in the last FY to "326" in this FY shows real change and improvement in the identification of this population by CSECY trained DMH clinicians. The goal is to continue these trainings to sustain this change and continued identification and tracking of CSECY victims who require a sensitive and highly structured treatment program delivered by a team of trauma specialists.

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