MENTAL HEALTH SERVICES ACT

School-based Services | Family Education and Support Services | At-risk Family Services | Trauma Recovery Services | Primary Care and Behavioral Health | Early Care and Support for Transition-age Youth | Juvenile Justice Services | Early Care and Support for Older Adults | Improving Access for Underserved Populations | American Indian Project

Prevention and Early Intervention Plan

for Los Angeles County

June 30, 2009
Revised August 17, 2009





COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT | PREVENTION AND EARLY INTERVENTION

COUNTY OF LOS ANGELES

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Reply To: (213) 738-2321
Fax: (213) 351-2026

June 30, 2009

Ms. Bertha MacDonald
California Department of Mental Health
MHSA Plan Review
1600 9th Street, Room 100
Sacramento, CA 95814

Dear Ms. MacDonald:

The Los Angeles County Department of Mental Health (LAC-DMH) hereby submits its request to amend its Mental Health Services Act (MHSA) Agreement to include an increased level of funding for Fiscal Year 2009-2010. The request is for additional Prevention and Early Intervention (PEI) funds to begin PEI Plan Projects consistent with State Department of Mental Health Information Notice No. 07-19 released September 25, 2007 and Notice No. 08-23 released August 7, 2008.

Pursuant to the Welfare and Institutions Code Local Review Process requirements, a 30-day public comment period was completed on June 24, 2009. The public hearing, convened by our Mental Health Commission, was on June 25, 2009 where the PEI Plan was unanimously approved. (Please find a summary of comments/questions included in the Appendix of our submission.)

LAC-DMH and its stakeholders look forward to the State's prompt review and approval of our plan and when approved, the Department will submit the approved plan to our Board of Supervisors for implementation.

If you have any questions or concerns, please contact Lillian Bando at (213) 738-2321.

Sincerely,

Marvin J. Southard, D.S.W.
Director of Mental Health

MJS:RK:DM:LB

Attachments

c: Mental Health Commission

County of Los Angeles Department of Mental Health
MHSA Prevention and Early Intervention Plan

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MENTAL HEALTH SERVICES ACT (MHSA)

PREVENTION AND EARLY INTERVENTION COMPONENT

OF THE THREE-YEAR

PROGRAM AND EXPENDITURE PLAN

Fiscal Year 2009-2010

County Name: **Los Angeles**	Date: **June 30, 2009**

COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	**Project Lead**
Name: **Marvin J. Southard, DSW**	Name: **Lillian Bando**
Telephone Number: (213) 738-4601	Telephone Number: (213) 738-2321
Fax Number: (213) 386-1297	Fax Number: (213) 351-2026
E-mail: MSouthard@dmh.lacounty.gov	E-mail: lbando@dmh.lacounty.gov
Mailing Address: County of Los Angeles Department of Mental Health 550 South Vermont Avenue Los Angeles, CA 90020	

AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that the county has complied with all pertinent regulations, laws and statutes. The county has not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and the administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2009-10 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for "very small counties"), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature  6/30/09

County Mental Health Director — Date

Executed at Los Angeles, California

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

OVERVIEW OF THE PREVENTION AND EARLY INTERVENTION PLAN

1. Overview of Prevention and Early Intervention
2. Advisory Groups' Input
3. Community Program Planning Process
4. Project Guidelines for Los Angeles County
5. PEI Projects and Programs
6. Service Area and Countywide Programs

Encompassing 4,084 square miles, Los Angeles County is one of the nation's largest counties in geographic area and is home to approximately 27% of all Californians. The size and diversity of the county is evidenced by the 88 cities contained within its borders. Additionally, more than 65% of the county is unincorporated area. In 2005 the population estimates for the county reached 9.8 million, the most populous county in the United States, and is exceeded by only eight states. The median age was 33.7 years, which made it one of the most youthful areas in the country. Twenty eight percent (28%) of the population was under 18 years, and 10% was 65 years and older.

The MHSA Prevention and Early Intervention (PEI) plan for Los Angeles County addresses the diversity of nearly 10 million individuals, taking into consideration age, race/ethnicity, language, culture, sexual orientation, immigration history, mental health, economic status, geography, and other key factors distinguishing over 100 unique communities. Following a lengthy, representative, and inclusive planning process, the County of Los Angeles Department of Mental Health submits its PEI plan for $121,661,559 for Fiscal Year 2009-2010.

1. OVERVIEW OF PREVENTION AND EARLY INTERVENTION

The California State Department of Mental Health (SDMH) has responsibility for developing guidelines for the Plans authorized by MHSA and the funding of the statewide and county programs. In February 2006, SDMH approved the Los Angeles County Department of Mental Health's (LACDMH) Community Services and Supports (CSS) Plan, the first of the MHSA Plans to be released. Implementation of the programs funded under the CSS Plan was initiated in 2007. Subsequently, on September 25, 2007 SDMH released the Prevention and Early Intervention (PEI)

guidelines, the second largest component of the MHSA. PEI focuses on evidence-based services, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

A. TRANSFORMATIONAL CONCEPTS

The PEI projects and programs in the Los Angeles county plan align with the transformational concepts adopted by the Mental Health Services Oversight and Accountability Commission (OAC):

1. Community Collaboration
2. Cultural Competence
3. Individual and Family-driven Programs and Interventions, with Specific Attention to Individuals from Underserved Communities
4. Wellness Focus, which Includes the Concepts of Resilience and Recovery
5. Integrated Service Experience for Individuals and their Families
6. Outcomes-based Program Design

B. PEI FRAMEWORK

The framework for PEI programs encompasses both key community mental health needs and priority populations that each county plan must address.

Key Community Mental Health Needs. SDMH identified five categories of community mental health needs critical in developing prevention and early intervention strategies.

1. *Disparities in Access to Mental Health Services* – PEI efforts will reduce disparities in access to early mental health interventions due to stigma, lack of knowledge about mental health services or lack of suitability (i.e., cultural competency) of traditional mainstream services.

2. *Psycho-Social Impact of Trauma* – PEI efforts will reduce the negative psycho-social impact of trauma on all ages.

3. *At-Risk Children, Youth, and Young Adult Populations* – PEI efforts will increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations.

4. *Stigma and Discrimination* - PEI will reduce stigma and discrimination affecting individuals with mental health illness and mental health problems.

5. *Suicide Risk* - PEI will increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.

Priority Populations. In addition to the key community mental health needs, the PEI plan must address six priority populations that are the focus of prevention and early intervention strategies.

1. *Underserved Cultural Populations* – PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from Prevention and Early Intervention programs and interventions.
2. *Individuals Experiencing Onset of Serious Psychiatric Illness* – Those identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.
3. *Children/Youth in Stressed Families* – Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
4. *Trauma-Exposed* – Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.
5. *Children/Youth at Risk for School Failure* – Due to unaddressed emotional and behavioral problems.
6. *Children/Youth at Risk of or Experiencing Juvenile Justice Involvement* – Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports (CSS).

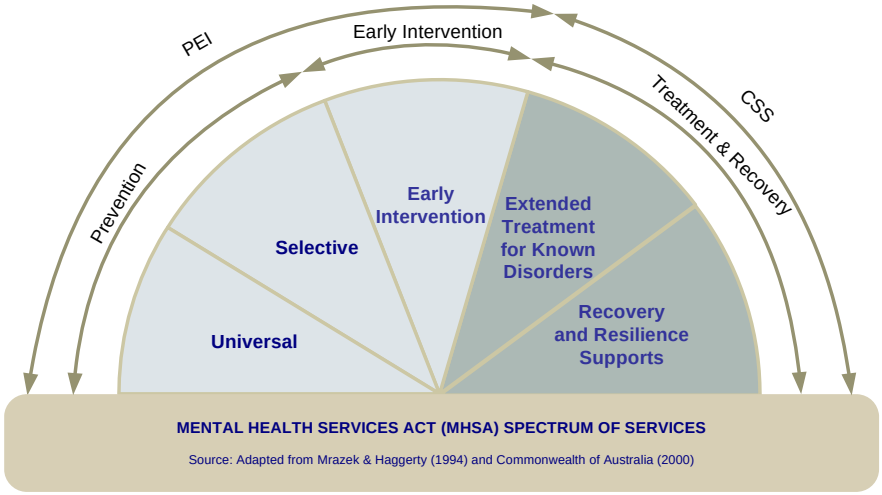
C. PREVENTION AND EARLY INTERVENTION OPERATIONAL DEFINITIONS

SDMH guidelines described operational definitions for prevention and early intervention in order to delineate funding parameters for the PEI plan as distinct from other MHSA components. While prevention and mental health occur across the entire spectrum of mental health, the PEI component occurs at the early end of the spectrum. (See the Mental Health Intervention Spectrum on the following page.)

Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support. Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances. Universal Prevention targets the general public or a whole population

group that has not been identified on the basis of individual risks. Selective Prevention targets individuals or a subgroup whose risk of developing mental illness is significantly higher than average.

Early Intervention is directed toward individuals and families for whom a short duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.



2. ADVISORY GROUPS' INPUT

Formal input into and community review of the PEI plan has been through the LACDMH MHSA Stakeholder Delegates, PEI Ad Hoc Advisory Groups, and Service Area Ad Hoc Steering Committees. All Ad Hoc Advisory Group and Steering Committee recommendations were reviewed and approved by the Stakeholder Delegates group.

A. MHSA STAKEHOLDER DELEGATES

The Los Angeles County MHSA Stakeholder Delegates group was originally formed in 2005 to obtain community input to the MHSA CSS Plan. In 2007 membership was revised and expanded to include broader representation from non-traditional mental health providers as well as the required PEI sectors (individuals with serious mental health illness and/or their families, underserved cultural populations, providers of mental health services, social services, education, health, and law enforcement) and the recommended sectors (community family resource centers, employment, and media).

The Stakeholder Delegates group is currently comprised of over 100 community representatives from the PEI sectors, various L.A. County departments, community organizations, racial/ethnic groups, and special needs populations groups. (See Appendix 1-A for the MHSA Stakeholder Delegates Roster.)

Stakeholder Delegates activities:

- Expanded the Stakeholder Delegates group to include new members from the PEI required and recommended sectors.
- Generated recommendations related to:
  - PEI mission and guidelines for Los Angeles County
  - Distribution of PEI funding by age groups
  - Distribution of PEI funds by provider category
  - Support for leveraging of funds
  - Allocation formula for distribution funding for service areas

B. PEI AD HOC ADVISORY GROUPS

The Department convened three Ad Hoc Advisory Groups to provide guidance at different phases of the broad-based, intensive PEI planning process.

(1) Ad Hoc Plan-to-Plan Advisory Group

The Ad Hoc Plan-to-Plan Advisory Group, formed in August 2007 before the release of the State's final PEI guidelines, met over a period of three months. Its purpose was to advise the Department regarding the strategies and planning process for the County's MHSA PEI Plan. The role of the members was to provide the guidance and necessary expertise to represent the required and recommended sectors for PEI planning. The members also reviewed related documents and provided feedback to LACDMH and its PEI staff to help ensure a successful stakeholder planning process. Membership was drawn from the System Leadership Team (SLT), MHSA Stakeholder Delegates, and other PEI sector representatives. (See Appendix 1-B for the Ad Hoc Plan-to-Plan Advisory Group.)

Ad Hoc Plan-to-Plan Advisory Group activities:

- Convened a 29-member advisory group comprised of representatives from the required and recommended PEI sectors.
- Generated recommendations related to:
  - Structure of the planning process, including clarification of the planning stages and PEI road map
  - Participants in the planning process, including outreach to non-traditional mental health groups
  - Service area-based planning, including the importance of the Service Area Advisory Committees

- Key individuals, including the selection process and interview questions
- Focus groups, including criteria for selection of participants and key topics
- Community forums, including how to organize the forums and maximize participants' input

(2) Ad Hoc Guidelines Advisory Group

The Ad Hoc Guidelines Advisory Group, convened from March to April 2008, developed a set of guidelines on how to develop service area PEI plans in an inclusive, consistent, and effective manner. The SLT determined that membership should consist of MHSA Stakeholder Delegates and Alternates, with additional participants as necessary to cover required sectors for PEI planning, as well as representation from the Service Area Advisory Committee (SAAC) Chairs and District Chiefs. (See Appendix 1-C for the Ad Hoc Guidelines Advisory Group.) On April 25, 2008, representatives from the Advisory Group presented three documents to the MHSA Stakeholder Delegates: (1) Mission Statement and Guiding Principles, (2) Common Expectations for the Service Area Advisory Committee's (SAAC) Role in the PEI Planning Process, and (3) Community Forum Models. After lengthy discussion and some revisions by the Stakeholder Delegates, all three documents were approved.

Ad Hoc Guidelines Advisory Group activities:

- Convened a 28-member advisory group comprised of representatives from the required and recommended PEI sectors
- Generated recommendations related to:
  - The mission statement and guiding principles for the community-based planning process for the L.A. County MHSA PEI Plan
  - Common parameters for service area and countywide PEI planning, and a set of models for PEI Community Forums

(3) Ad Hoc PEI Plan Development Advisory Group

The purpose of the Ad Hoc Plan Development Advisory Group was to provide guidance for the countywide community forum targeted at special populations and to review the Department's PEI resource manual, which included Evidence-Based Practices (EBP), Promising Practices (PP), and Community-Defined Evidence (CDE) practices. Members from the Ad Hoc Guidelines Advisory Group were invited as members, and other individuals were sought to ensure inclusion of the special countywide populations. The Advisory Group met from October 2008 to May 2009. (See Appendix 1-D for the Ad Hoc PEI Plan Development Advisory Group.)

Ad Hoc PEI Plan Development Advisory Group activities:

- Convened a 25-member advisory group comprised of representatives from the required and recommended PEI sectors, as well as the countywide populations

- Recommended the format and procedures for the service area and countywide community forums
- Formed a subcommittee to review the PEI EBP and PPs.
- Formed the Countywide Ad Hoc PEI Steering Committee to review the needs assessment findings and develop recommendations for the countywide populations

(4) Service Area PEI Ad Hoc Steering Committees

The primary focus for developing the PEI Plan for Los Angeles County is at the service area level. The Service Area Advisory Committees (SAACs) are comprised of dedicated and experienced community leaders and have a membership ranging from 50-150 volunteers. These committees have been in existence for over 20 years and have historically played an important role in providing valuable feedback to the LACDMH on programs, service delivery priorities, and budget allocation issues impacting their regions. (See Appendix 2-A for the SAAC Co-Chairs Roster.)

Given their importance, SAAC participation in the community-based planning process has been essential to the development of locally-driven recommendations regarding which community mental health needs and populations are of the highest priority for PEI programs within a given service area. SDMH as well as the MHSOAC have emphasized the importance of building upon the CSS planning process, and using existing organizations, rather than creating new and temporary groups that will be involved in long-term MHSA planning. Each of the SAACs was asked to establish a PEI Ad Hoc Steering Committee (AHSC) and convene regular meetings of the AHSC. The intent of establishing the Steering Committees was to provide the regional leadership and guidance necessary for a successful PEI planning process within the service area. (See Appendix 2-B for the Service Area AHSC Rosters.)

Ad Hoc Steering Committee activities:

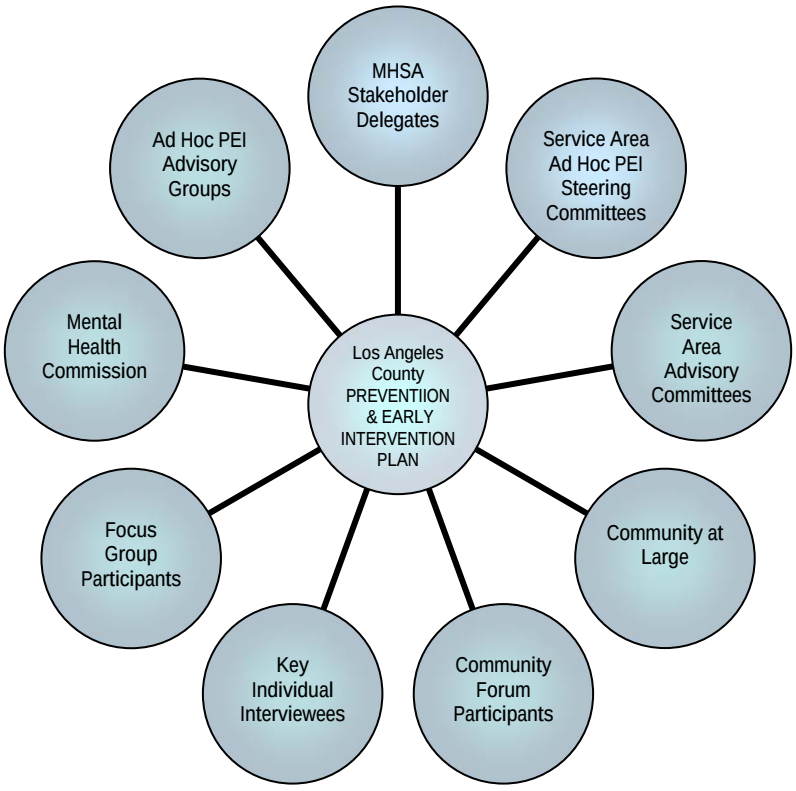
- Collaborated with the SAACs to develop eight service area Ad Hoc PEI Steering Committees comprised of 28-30 members representing the four age groups, underserved communities, required PEI sectors, SAAC Co-Chair, and Service Area District Chief.
- Ranked the importance of each priority population for a service area utilizing an evaluation tool based on findings from the service area data profiles, key individual interviews, focus groups, and community forums.
- Determined the appropriateness of Evidence-Based Practices and Promising Practices for each service area's needs, priority populations and subpopulations.

- Developed recommendations identifying the priority populations to be served, specific subpopulations, and PEI programs to be implemented in the service areas and countywide

3. COMMUNITY PROGRAM PLANNING PROCESS

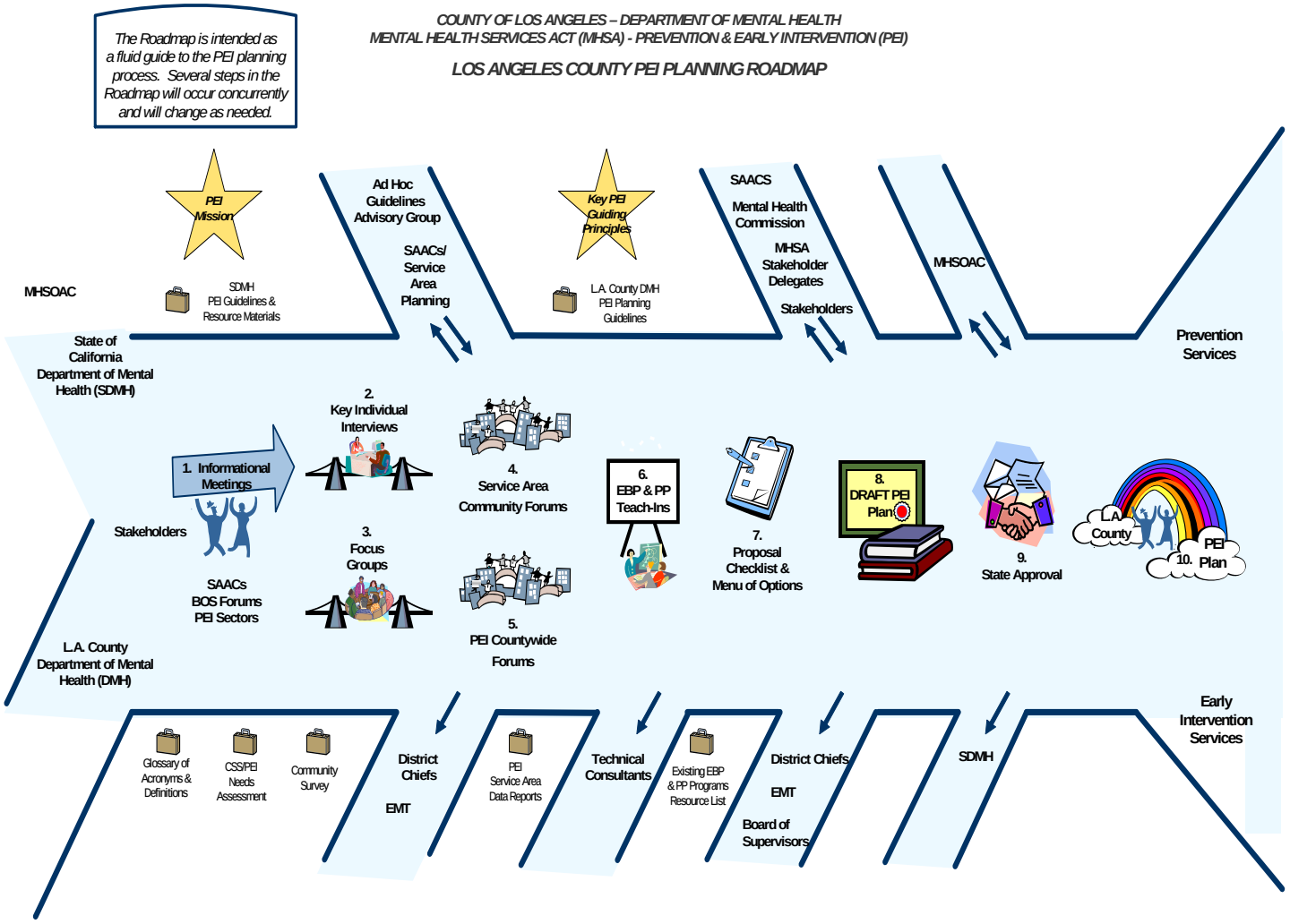
In 2007 LACDMH initiated an intensive, inclusive, and multi-faceted approach to developing the County's MHSA PEI Plan. Community input from a broad and diverse group of stakeholders has been built into the planning process in multiple stages, both formally and informally. In order to capture the concerns of local communities, the focus for developing the PEI Plan occurred predominantly at the Service Area (SA) level, which encompasses eight geographic areas within Los Angeles County. Each of the SAs has distinct and varying demography, geography, resources, and other factors that make it critical for PEI services to be specific to regional and community-based needs.

Los Angeles County Stakeholder Input to the PEI Plan



A. PHASE 1: OUTREACH AND EDUCATION

The community planning process was undertaken in three phases: (1) Outreach and Education, (2) Needs Assessment, and (3) Plan Development. The first phase started in the summer of 2007 with pre-planning activities and continued through winter 2008. Active involvement by community stakeholders – consumers, parents, caregivers, family members, sector members, and other concerned individuals – in the PEI planning process was critical to developing effective, representative, and culturally-appropriate PEI services. The County's road map provides an overview of the planning stages. (See Appendix 3 for a detailed copy of the PEI Road Map.)



(1) Initial Planning

In spring 2007 the Department began initial planning in anticipation of SDMH's release of the PEI guidelines. A core part of the planning involved strategizing to ensure meaningful involvement and engagement of diverse communities and potential individual participants, their families, and other community stakeholders. This initial planning stage resulted in the submission of LACDMH's community program planning request to SDMH. The initial planning activities resulted in the following:

- Developed the Department's request for $7.1 million in PEI planning dollars, which was approved by the MHSOAC and SDMH.
- Conducted a solicitation process for the selection of strategic planning consultants to assist LACDMH with the countywide, community-based PEI planning process.
- Subsequently submitted in January 2009 a planning request for $7.1 in additional Community Program planning funds as authorized by the 2008 SDMH Notice.

(2) Information Campaign

LACDMH developed a multi-media information campaign at the beginning of the PEI planning process to provide information about the PEI guidelines and to solicit community participation in the various planning activities. The information campaign included live presentations by the LACDMH PEI unit as well as outreach workers, printed materials in English and the 12 threshold languages, and PowerPoints. The information campaign resulted in the following:

- Conducted a successful countywide PEI information campaign, which included 133 presentations that reached over 5,300 community members.
- Conducted informational presentations in all eight service areas as well as many sector-related meetings (e.g., education, health, law enforcement, probation, etc.).
- Held mental health community forums sponsored with the Board of Supervisors in each of the five Supervisorial districts.
- Developed a PowerPoint slideshow in both English and Spanish for orienting individuals and organizations about PEI. (See Appendix 4 for a copy of the PowerPoint: Prevention and Early Intervention: The Mental Health Services Act in Los Angeles County.)
- Developed and distributed a tri-fold PEI informational brochure translated in all the L.A. County threshold languages (Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Simplified Chinese, Spanish, Tagalog, and Vietnamese) that provided individuals the opportunity to be added to the LACDMH information distribution list and receive future information on the PEI

plan. (See Appendix 5 for a copy of the English version of the information brochures. Copies of the brochure in other languages can be found on LACDMH's website at *http://dmh.lacounty.info/mhsa/plans/pei.html)*

- Developed and distributed a PEI orientation booklet with detailed information on the PEI planning process. (See Appendix 6 for a copy of the PEI Orientation to Planning Process booklet.)
- Developed and distributed a graphic "road map" of the PEI planning process with a narrative explanation.
- Developed the DMH PEI website, which includes an overview of the Plan, six PEI resource documents, links to PEI information on the State DMH and CiMH websites, and the PEI brochure in all of the threshold languages for L.A. County. The website can be accessed at *http://dmh.lacounty.gov/AboutDMH/MHSA/MHSA_Plans/pei.html)*.
- Developed and distributed a PEI newsletter.
- Developed a PEI distribution database with a current membership of over 6,800 individuals to catalog outreach and engagement activities by sector, agency/organization, priority population, Service Area, and Supervisorial District, which will provide data to demonstrate the county's planning process in the PEI Plan submitted to the state.
- Developed a resource database to facilitate the identification and selection of subject matter experts, key individuals, and focus groups.

(3) Position Papers

The Department received a number of papers from organizations stating their positions on the PEI Plan, including details on the selection of the priority populations, top community mental health needs, allocation of funding, age group emphasis, and preferred programs and/or strategies. In the interest of disseminating this information to stakeholders, LACDMH posed the position papers on its website. The presence of a paper on the website did not indicate LACDMH endorsement in any way, but it allowed for the exchange of views. These planning activities included:

- Reviewed nine position papers on the PEI plan submitted to the LACDMH PEI administration unit.
- Approved and posted four PEI position papers on the LACDMH website.

B. PHASE 2: NEEDS ASSESSMENT

In order to create the best possible MHSA PEI Plan, it was essential that LACDMH compile and generate accurate information from a wide range of sources. To gather this information, the Department employed six different needs assessment strategies: recommendations from CSS planning, community surveys, service area data profiles,

key individual interviews, focus groups, and community forums countywide. Each of these six strategies built on the knowledge gained through earlier strategies. Through each strategy, the questions being asked and answered became more specific and the depth of knowledge increased. Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI.

Decision-making bodies (such as the SAACs, MHSA Stakeholder Delegates, and LACDMH staff) were asked to examine the gathered information collectively so that there emerged a clearer picture of the county's PEI needs. As each needs assessment strategy was completed, the information was summarized and made available to the public though the MHSA PEI website. (See the chart on the next page for the stages in the needs assessment strategies.)

(1) Community Services and Supports Plan Identifying PEI Needs

The Department reviewed the reports from the CSS community planning process to identify recommendations specifically related to prevention and early intervention. This involved a review of the 29 MHSA-CSS countywide work groups and the eight Service Area Advisory Committees' (SAACs) final reports. These reports, and the pertinent PEI recommendations, provided a starting point for a critical analysis and discussion relating to prevention and early intervention needs, strategies, implementation, and outcomes. Although the assessments were conducted in 2004 and the reports generated in 2004-2005, the needs that were identified then still exist, as funding for prevention and early intervention services was not yet available. The development of the MHSA PEI Plan and availability of SDMH funding for Los Angeles County offer opportunities to acknowledge and incorporate the recommendations from these earlier planning processes. The review resulted in the following:

- Developed and distributed the 12-page report, *Recommendations Related to Prevention and Early Intervention from the 2005 Los Angeles County Mental Health Services Act Community Services and Supports Needs Assessment.* (See Appendix 7 for a copy of the CSS Needs Assessment report.)

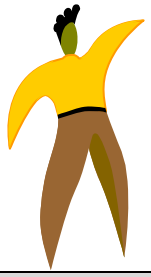
(2) Community Surveys

Beginning in October 2007 the Department distributed a community survey requesting input into planning for PEI programs in the local communities. The survey was used to gather initial feedback regarding planning priorities on three components of PEI planning in Los Angeles County so that an initial planning course could be set: PEI age groups, key PEI community mental health needs, and PEI priority populations. The PEI

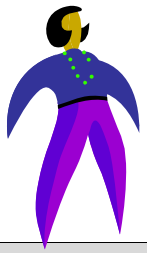
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH (LACDMH)
PREVENTION AND EARLY INTERVENTION (PEI)

NEEDS ASSESSMENT STRATEGIES

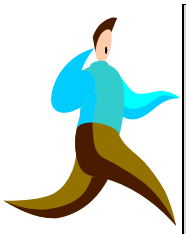
The LACDMH PEI planning process builds on several data-gathering methods to obtain diverse, broad-based community input in order to develop an inclusive and extensive MHSA Prevention and Early Intervention Plan for Los Angeles County.



COMMUNITY FORUMS *Strategies & Priority Populations*	*How should PEI programs be designed to meet mental health needs and overcome barriers?* Purpose: To identify the priority populations in each service area and the key components that must exist in a PEI program. Outcomes: Recommendations for service area or countywide program strategies
FOCUS GROUPS *Barriers & Challenges*	*What barriers & challenges are faced when seeking or delivering services?* Purpose: To obtain information from diverse groups on the barriers and challenges for at-risk populations in each service area Outcomes: List of barriers and challenges specific to the service areas and underserved communities



KEY INDIVIDUAL INTERVIEWS *Problems & Needs*	*What are the key mental health problems and needs in the community?* Purpose: To determine the major mental health needs in the community Outcomes: List of specific mental health problems and needs in the communities in the service areas
SERVICE AREA DATA PROFILES *Risk Factors*	*What does the data say about at-risk populations in each service area?* Purpose: To provide information about at-risk populations in each service area Outcomes: Profiles of the at-risk populations in each service area



COMMUNITY SURVEYS *Priority Groups*	*As a starting point, who do you think should be served by the PEI Plan?* Purpose: To identify which of the MHSA PEI priority populations are important in each service area Outcomes: Preliminary ranking of PEI priority populations and key community mental health needs
COMMUNITY SERVICES & SUPPORTS (CSS) PLANNING *PEI Needs*	*Building on the CSS Planning Process* LACDMH conducted an extensive community planning process for the MHSA CSS Plan in 2004-2005. The PEI planning process builds on the CSS stakeholder groups as well as broadens the diversity and expertise of stakeholders new to MHSA. The PEI-related recommendations from the 29 CSS county work groups and the eight Service Area Advisory Committees were summarized in the report, Recommendations Related to Prevention and Early Intervention from the 2005 Los Angeles County Mental Health Services Act Community Services and Supports Needs Assessment. The CSS process provides a starting point for a critical analysis and discussion relating to prevention and early intervention needs, strategies, implementation, and outcomes.

community survey was administered in English and Spanish to individuals who attended a PEI informational presentation between October 2007 and April 2008. Additional groups were included to insure that the final tally was representative of all PEI planning sectors, service area constituents, and countywide populations. Offered in the two main primary languages of Los Angeles County, English and Spanish, surveys were distributed at over 133 planning meetings. The results indicated that across Los Angeles County children are a clear priority for many individuals; however, more information needs to be gathered to determine which specific PEI priority populations should be targeted. (See Appendix 8 for a copy of the Summary of Community Survey Results.) The outcomes of the community survey process included:

- Distributed surveys at over 133 meetings, resulting in over 1,500 surveys being completed and tabulated.
- Nearly 20% of the Surveys were completed by self-identified consumers, family members and parents.
- Determined that the majority of respondents (57%) ranked children as their most important priority group. Transition-age youth (TAY) were ranked second, followed by adults and older adults.
- Determined that the majority (53%) of respondents ranked as the most important community mental health need "At-risk Children, Youth and Young Adult Populations" as the first priority, followed closely by "Disparities in Access to Mental Health Services" and "Psycho-Social Impact of Trauma". "Suicide Risk" and "Stigma and Discrimination" were ranked as lower priority mental health needs across the County.
- Determined that overall, no priority population was clearly ranked as the top priority, although there was a slight preference for "Children/Youth in Stressed Families," followed by "Children/Youth At-risk for School Failure."

(3) Data Profiles

A key tenet of the MHSA PEI planning process is that decisions should be based on objective available data. The purpose of the data profiles was to provide objective information to planners and stakeholders on the characteristics of Los Angeles County and each of the County's eight services areas. Profiles for each of the eight service areas as well as a countywide report were published. The service area data profiles consolidated demographic data relevant to PEI from a wide variety of sources. Socio-economic demographic data and mental health statistics were included. Key indicators of risk were selected for each of the six PEI priority populations: underserved cultural populations, individuals experiencing onset of serious psychiatric illness, children/youth in stressed families, trauma-exposed, children/youth at risk for school failure, and children/youth at risk of or experiencing juvenile justice involvement. For example, to identify underserved cultural populations, planners might consider information on a community's primary languages and the language capacities of mental health providers in the area.

Key indicators included ethnicity, primary language, linguistic isolation, serious mental illness penetration rate, depression, co-occurring disorders, poverty, unemployment rate, disrupted families, safe place to play, child abuse statistics, elder abuse statistics, posttraumatic stress disorder (PTSD), homelessness, high school graduation rates, English fluency, 3rd grade reading level, school discipline, juvenile felony arrests, youths on probation, language capacity of mental health providers, deaths by suicide, and mental health emergency statistics.

The profiles assisted stakeholders and others interested in prevention and early intervention strategies to identify the high risk factors in their service areas and make decisions for the PEI plan based upon the data. The data profiles made a great deal of information accessible to the diverse group of PEI planners and stakeholders. The information gathered from the data profiles was used to guide the discussions made at the community forums and PEI program development. In addition, specific data profiles were developed for the special populations discussed at the countywide community forum, including the deaf/hard of hearing, veterans, gay/lesbian/bisexual/transgender/ questioning individuals, and countywide health plans. Copies of all these reports are available on the LACDMH website. Outcomes of the data assessment included:

- Collaborated with the County of Los Angeles Departments of Children and Family Services, Community and Senior Services, Internal Services, Probation, Health, Public Health, and Urban Research/GIS in the compilation of data.
- Published a special report for the PEI Roundtable in October 2008, *Vulnerable Communities in Los Angeles County: Special Edition for PEI Roundtable.*
- Published a countywide report, *Vulnerable Communities in Los Angeles County: Key Indicators of Mental Health Fall 2008.* (See Appendix 9 for a copy of the *Vulnerable Communities data r*eport.)
- Published eight reports, *Vulnerable Communities in Los Angeles County: Key Indicators of Mental Health Fall 2008 – Service Area*, specific to each service area.
- Compiled special reports for the Countywide Community forum:
  - *American Indian/Alaskan Native Needs Assessment Selected Findings for Prevention and Early Intervention*
  - *Deaf/Hard of Hearing in Los Angeles County Fact Sheet for Prevention and Early Intervention*
  - *Resources for LA Health Care Plans Administration*
  - *Key Indicators of Health 2007, LAC DPH*
  - *2007 Overview of the Uninsured: Los Angeles County May 2008*
  - *What Health Care System Administrators Need to Know About Racial and Ethnic Disparities in Healthcare, IOM*
  - *Los Angeles County Scorecard, Children NOW*

- *April 2007 Health Insurance Coverage Fact Sheet for Los Angeles County*
- *Children/Youth at Risk of or Experiencing Juvenile Justice Involvement Selected Findings*
- *Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) Populations in Los Angeles County Fact Sheet*
- *Veterans in Los Angeles County Fact Sheet for Prevention and Early Intervention*

(4) Key Individual Interviews

The purpose of the key individual interviews was to conduct in-depth discussions with individuals whose position, education, or experience indicated that they were knowledgeable about a specific community, issue, or problem which can inform mental health prevention and early intervention. Key individuals included, but were not limited to, community leaders, community members, gatekeepers, service providers, consumers, and other individuals who possess noteworthy insight and understanding about an issue, can articulate specific needs, and can assist in program planning. These individuals were also selected based on service area, priority population experience, knowledge of community mental health needs, and age group focus. As the planning process in Los Angeles County was largely driven by its geographical service areas, at least five participants were selected from each service area and 14 other participants were representative of countywide populations.

The intent of conducting key individual interviews was to gather qualitative, in-depth information from a diverse range of individuals about the mental health prevention and early intervention needs of the communities in Los Angeles County. Qualitative analyses were conducted on transcripts of each interview and an aggregated de-identified report was generated and distributed throughout the county to assist planning teams in their deliberations.The information gathered from the key individual interviews and focus groups was used to identify potential strategies for PEI program development and to guide the discussions made at the community forums. (See Appendix 10 for a copy of the Key Individual Interviews report.) Outcomes of the key individual interviews included:

- Conducted a total of 54 interviews, including five in each of the eight service areas and 14 countywide from February to September 2008.
- Interviewed individuals representing all seven PEI required sectors.
- Interviewed racially diverse individuals, including African American, Latino, Native American, Asian/Pacific/islander (Cambodian, Chinese, Japanese, Korean), Middle Eastern/Eastern European (Iranian), and Caucasian. All of the participants spoke English, one-quarter spoke Spanish, and about one-fourth spoke Tagalog. Additional languages spoken by smaller percentages of participants included Armenian, Farsi, Cambodian, and Chinese.

- Interviewed TAY, adults, and older adults.
- Compiled the findings into a report, *Findings from the Key Individual Interviews.*
- Distributed printed copies of the findings to over 2500 individuals and posted the *Findings* on the LACDMH MHSA/PEI website.

(5) Focus Groups

The purpose of the focus groups was to determine the gaps, barriers and challenges to mental health services with community members, especially those that are currently unserved or underserved, in order to identify their concerns, issues, and recommendations for developing PEI strategies. The input from a diverse range of individuals from multiple sectors provided LACDMH with information on the significant obstacles that stand in the way of consumers, parents, family members, and the community accessing critical mental health services as early as possible to prevent and/or mitigate serious mental illness.

Focus groups were composed of 6-10 individuals who explored through a structured discussion a specific priority population or key community mental health need. Focus groups drew individuals from existing groups in the required and recommended sectors. Suggestions from stakeholder groups were solicited for representative agencies to host the focus groups. Groups were chosen by examining the mission of an agency and its constituent population and determining if it was consistent with the intent of the PEI component. Final group selection was conducted to insure that the planning process adequately covered the required planning sectors, priority populations, age groups, and community mental health needs. The focus groups were organized to address issues targeted for a specific priority population or key community mental health need. Although individual participants in focus groups were not identified in any reports, the names of the groups and organizations that participated were listed. (See Appendix 11 for a copy of the *Overall Focus Groups Summary Report.)* Outcomes of the focus groups needs assessment activities included:

- A total of 65 focus groups were held, including six in each of the eight service areas and 17 at the countywide level from April to September 2008.
- Interviewed 572 individuals representing all seven PEI required sectors.
- Interviewed racially diverse individuals, including African American (including African Ethiopian), Hispanic, Native American, Asian/Pacific Islander (Cambodian, Chinese, Japanese, Korean, Pilipino), Middle Eastern/Eastern European (Armenian, Iranian, Polish), and conducted focus groups in Spanish, Cambodian, Korean, Vietnamese, and Mandarin.
- Interviewed TAY, adults, and older adults.
- Compiled the findings into ten reports, including *Findings from the Focus Groups* (eight separate reports for each service area as well as one for the countywide focus groups and a summation, *Overall Summary Report of the*

Focus Groups. Copies of all these reports are available on the LACDMH website.

- Distributed printed copies of the *Findings* to over 2500 individuals and posted the *Findings* reports on the LACDMH MHSA PEI website.

(6) Community Forums

The purpose of the community forums was to identify the priority populations in each service area and the key components that must exist in a PEI program. Broad and diverse community input was sought from consumers, parents, family members, mental health providers, required and recommended PEI sector partners. The community forums were open to the general public, but were especially targeted to individuals that have an interest in mental health strategies related to prevention and early intervention. LACDMH staff collaborated with the SAAC Chairs as well as the SAACs themselves to plan for the community forums and ensure extensive outreach to ensure broad and diverse participation. SAAC community forum planning committees were established in each of the eight service areas. As co-conveners, the SAACs assisted LACDMH in selecting locations, days, times, and outreach strategies that were appropriate for their service area.

The service area community forums were held October-December 2008, and lasted 3-1/2 to 4 hours. Transportation, childcare, and translators will were provided as needed. The plenary session included a general overview about PEI, summary of the community needs assessment activities to date, and desired community input expectations, followed by 6-8 concurrent breakout groups led by trained facilitators. Activities within the breakout sessions included facilitated discussions and the casting of votes in order to prioritize PEI populations and age groups. This resulted in the selection of the top two priority populations paired with a targeted age group. Following this, further discussion specified sub-populations of these defined populations and then, generated possible strategies for prevention and intervention within these sub-groups. Recommendations from each of the breakout sessions were then reported to the general session. Utilizing the same format, a countywide community forum was held in January 2009 that addressed the needs of populations that were identified as needing a countywide service delivery focus. These populations included American Indians, veterans, deaf and hard of hearing, lesbian/gay/bisexual/transgender/questioning, juvenile justice, and countywide health plans.

The community forums resulted in Service Area-specific recommendations for the priority populations that need to be served in the local areas and the types of program strategies required to serve these populations. Summary reports which included vote counts were developed and distributed throughout the County in order to inform ad hoc steering committees who would be making program selection recommendations. (See Appendix 12 for a copy of the *Overall Community Forums Summary Report.)* Outcomes of the community forums included:

- Collaborated with eight service area community forum planning committees to co-convene the community forums.
- Held 15 service area community forums from October to December 2008, including two community forums in each service area, with the exception of Service Area 1, which held only one community forum. More than 1800 individuals attended the service area community forums.
- Held a countywide community forum at the Los Angeles Convention Center in January 2009 that was attended by nearly 300 individuals.
- Provided interpretation services at all community forums, including Spanish, Cambodian, Cantonese, Korean, Mandarin, and Vietnamese languages as well as American Sign Language interpreters.
- Provided on-site childcare services at all service area and countywide community forums.
- Provided transportation services at all service area and countywide community forums.
- Compiled the findings into ten reports, including *Findings from Community Forums* (eight separate reports for each service area and one for countywide) and a summation, *Overall Summary Report of the Community forums.* Copies of all these reports are available on the LACDMH website.
- Distributed printed copies of the *Findings* to over 2500 individuals and posted the *Findings* reports on the LACDMH MHSA PEI website.

C. PHASE 3: PEI PLAN DEVELOPMENT

(1) PEI Roundtable

On October 2, 2008 the Department held the Los Angeles County PEI Roundtable. The purpose of the Roundtable was (1) to provide an introduction to the MHSA and PEI Plan, (2) to summarize "What We've Learned So Far" through results from the needs assessments activities to date; and (3) to enable different sector groups to exchange information about PEI and their priority populations. Presentations included updates on the PEI planning process, an overview of PEI research, and preliminary findings from the PEI key individual interviews and focus groups. Following the plenary session, participants formed breakout groups to discuss their views on the PEI priority populations, network within their planning sectors, and share their agencies' resources. Although the Roundtable preceded the community forums, the emphasis was on getting participants to begin examining the findings from the needs assessment activities and to begin to develop the PEI plan. Outcomes of the Roundtable activities included:

- Convened the Roundtable attended by over 350 individuals

- Developed and distributed copies of the reports *Vulnerable Communities in Los Angeles County – Special Edition for PEI Roundtable* and *Selected Findings from the Key individual Interviews*
- Enabled nine breakout groups organized by sectors and age groups to engage in initial discussion on PEI priority populations
- Posted a video of the Roundtable on the LACDMH website, together with the handouts.
- Posted questions and answers asked at the Roundtable on the LACDMH website.

(2) Teach-Ins

From November to December 2008, the Department co-sponsored, together with the SAACs, a "PEI teach-in" in each service area to provide an introductory training for interested stakeholders regarding EBPs, PPs, emerging practices, and CDEs. The teach-ins were intended to be an introduction to the types of programs that LACDMH would be including in its PEI Plan and that the Steering Committees would be considering in its deliberations. (See Appendix 13 for a copy of the PowerPoint: Understanding Evidence-Based Practices.) Outcomes of the teach-ins included:

- Conducted PEI teach-ins in each of the eight service areas attended by over 190 individuals.
- Developed a PowerPoint: Understanding Evidence-Based Practices presented at all of the teach-ins.
- Distributed educational materials on EBPs, PPs, and EPs to attendees.
- Developed a webcast of the teach-ins posted on the LACDMH website for those unable to attend a live presentation.

(3) Ad Hoc Steering Committee Deliberations

The Service Area PEI Ad Hoc Steering Committees were formed in fall 2008 and began meeting as early as November 2008 through the end of March 2009. A countywide steering committee for the special populations was also formed in early 2009. In order to proceed with project-building, all of the community assessment information was made available to a group of ad hoc steering committees who further refined population, age, and program selections. The stated task for each Steering Committee was to develop a set of service area recommendations identifying (1) the top two priority populations for the children and youth age groups and the top one priority population for adults and older adults that would be served; (2) 3-5 subpopulations for each of the top priority populations selected; and (3) the PEI EBPs and PPs that should be implemented to serve these populations. The final sets of recommendations were summarized in a planning document that was utilized for developing the PEI projects at the service area and countywide levels. (See Appendix 14 for a copy of the Summary of the Service

Area PEI Ad Hoc Steering Committee Recommendations.) Outcomes of the Ad Hoc PEI Steering Committee activities include:

- Provided updates and technical assistance to the Steering Committee meetings as needed.
- Utilized independent consultants to act as facilitators for each of the Steering Committees during the voting process.
- Developed an evaluation tool to determine the rank importance of each priority population for a service area based on findings from the service area data profiles, key individual interviews, focus groups, and community forums; tallied the scores; compiled the results; and identified each Service Area's top priority populations for each age group.
- Developed an evaluation tool to determine ranking of each EBP and PP on a service area's menu of options relative to their identified priority population and subpopulation needs; tallied the scores; compiled the results; and identified each Service Area's top EBP and PP programs.
- Obtained recommendations regarding specific PEI programs to be implemented in the service areas and countywide.

4. PROJECT GUIDELINES FOR LOS ANGELES COUNTY

A. MISSION STATEMENT AND GUIDING PRINCIPLES

In the initial planning stages the stakeholders discussed the direction of the PEI plan for Los Angeles County and determined that a vision for the PEI plan was needed to guide the process. The Ad Hoc Guidelines Advisory Group and the Stakeholder Delegates developed and approved a mission statement and guiding principles for the PEI plan.

Mission Statement: To promote healthy communities in Los Angeles County through education, prevention and early intervention programs that emphasize coordination of services and help people who are at risk for or have experienced the early stages of mental illness feel welcomed and supported.

Guiding Principles: The following principles were selected to inform and guide the community planning process:

PEI Planning will reflect the following principles:

1. Include consumers; their family members, parents and caregivers; community members; and advocates for unserved or hard-to-reach communities of all ages and ethnicities in all levels of the planning process.

2. Have a local planning process that results in the best possible distribution of available resources for the communities to be served.
3. Use facts, statistics and any other important non-traditional information available about the people who live in Los Angeles County to guide the decision-making process.

PEI Programs will reflect the following principles:

4. Uphold MHSA values that services should be consumer/family-driven, culturally competent, and help people stay well by preventing mental illness and promoting recovery.
5. Encourage agencies and organizations to work together to coordinate or blend their services in order to establish prevention and early intervention programs that can serve more people.
6. Serve all age groups and hard-to-reach communities in all service areas, with a minimum of 51% of the total funds going to individuals who are 0-25 years of age.
7. Form lasting partnerships with community-based support systems, including faith-based organizations that show the ability to establish relationships with at-risk populations.
8. Encourage agencies and organizations to share costs and other resources for those prevention and early intervention services and programs that are likely to have positive outcomes and/or save money.
9. Focus on how to successfully provide services to hard-to-reach populations.
10. Develop programs that promote equal access to mental health services for everyone regardless of race, ethnicity, culture, language, gender, age, economic status, deafness or disability.
11. Ensure programs address the unique strengths and challenges in ethnic minority and other diverse communities and use bi-cultural and bi-lingual staff to provide services, as needed.
12. Develop programs that can show positive results from the services they deliver.
13. Ensure programs developed are different from but can be coordinated with other MHSA-funded services and programs.

B. FUNDING GUIDELINES

The California State Department of Mental Health established specific funding parameters for PEI funds. Specifically, the guidelines stated that:

- All ages must be served.
- At least 51% of the county's overall PEI budget must be targeted to individuals age 25 and under.
- Funds cannot be used for services to individuals who have been diagnosed with a serious mental illness or their families. The exception is for early onset of a serious psychiatric illness with psychotic features.
- MHSA funds cannot be used to supplant existing programs.

The Ad Hoc PEI Plan-to-Plan Advisory Group recommended that LACDMH provide guidelines for community planning prior to the community forums, such as how the PEI funds would be distributed in Los Angeles County. On April 25, 2008, the MHSA Delegates approved three funding guidelines that addressed funding by age groups, by provider category, and leveraging considerations. Because the PEI plan is Service Area-driven, it was also necessary to determine the amount of funds available for each Service Area. Each Service Area differs by population size, geographic area, racial/ethnic composition, poverty status, to name a few key variables. On March 25, 2009, the MHSA Stakeholders approved funding guidelines for the Service areas.

(1) Distribution of PEI Funds by Age Group

The spirit and intent of the PEI component is to intervene before a diagnosis of mental illness has developed in order to restore general well-being as soon as possible. Since the onset of mental illness is most often before age 25, the majority of funds should be dedicated to this age group. The overwhelming majority of mental illnesses (75%) can be identified during childhood and young adulthood. Consequently, a proportionate share of the PEI funds will be directed to prevention and early intervention strategies for these age groups. The following guidelines were approved:

- 65% of PEI funds for services to children (ages 0-15), TAY (ages 16-25), and their families.
- 17. 5% of PEI funds for services to adults (ages 26-59).
- 17.5% of PEI funds for services to older adults (ages 60+).

(2) Distribution of PEI Funds by Provider Category

State PEI Guidelines indicate that prevention and early intervention services need to be provided in non-traditional mental health settings. The county Plan must demonstrate links with community agencies, including those that have not traditionally been defined as mental health, and individuals who have established, or show capacity to establish, relationships with at-risk populations. Under these guidelines it was anticipated that some of the PEI providers will be non-mental health organizations that do not currently have a LACDMH contract. LACDMH recognizes that small to mid-size organizations are a potential resource to meet the county's long-term need for mental health services.

The PEI Plan provides another opportunity to expand the pool of mental health providers. LACDMH will utilize a competitive bidding process to select PEI contractors, whether new or current. The following provider guidelines were approved:

- 30% for new contractors
- 40% for current contractor agencies
- 30% for LACDMH directly-operated agencies

(3) Leveraging Funds

The annual allocation for the PEI Plan is insufficient to meet Los Angeles County's needs, so it is critical that leveraging opportunities be sought to increase the funding available for PEI services. The emphasis is on linking PEI funds with additional resources from other entities to increase the total amount of available funds and maximize the impact of PEI services. In order to increase the funds available for PEI services and maximize the impact of PEI programs for as many individuals and families as possible, the County's PEI plan needs to leverage as many resources as possible. Leveraging is not limited to actual cash dollars, but can include other resources. This broad definition allows potential providers to bring a menu of diverse supports to leverage the proposed programs. Community-based organizations and other agencies that are unable to provide leveraging resources can partner with larger entities if necessary. Leveraging will not necessarily exclude agencies; integration and coordination of services are an example of leveraging funds. The following guideline was approved:

- Special consideration will be given to those entities that engage in leveraging PEI funds.

(4) Distribution of Funds by Service Area

The Stakeholder Delegates were asked to determine the allocation formula for distributing funds to each of the county's eight services, which differ in geographic size, population, racial/ethnic composition, and poverty levels. Given the limited PEI funds and the great needs of the county residents, the following guidelines were approved:

- Allocation of PEI funds is based on population and poverty (persons below 200% of the federal poverty level) in each service area, with population constituting 15% and poverty 85%.

The PEI allocations for FY 09-10, together with the data sources for calculating the allocations, were posted on the LACDMH website.

C. EVIDENCE-BASED PRACTICES, PROMISING PRACTICES, AND COMMUNITY-DEFINED EVIDENCE MODELS

As a means of maximizing the MHSA goals of outcomes and accountability as well as to foster a cooperative learning environment among stakeholders and advance the state-of-art in mental health, SDMH developed a set of recommended Evidence-Based practices (EBPs) and Promising Practices (PPs). The foundation for the County's PEI projects is built on evidence-based and promising practices, drawn not only from the list developed by SDMH but others identified during its planning process. In addition, community-defined evidence (CDE) practices, which represent community practices developed and/or implemented in the county, are also included.

(1) Programs in Los Angeles County

An initial starting point for selecting programs for the PEI plan was to identify existing EBPs and PPs in the County. In summer 2008 the Department conducted an electronic survey inquiring about PEI programs that agencies or organizations were already utilizing. The survey identified the EBPs listed in the SDMH resource materials as well as other EBPs not on the list. The survey form requested information about the name of the agency currently using the practice, geographic location where services were being provided, age group served, population, setting, and duration of the program. The results of the survey included:

- A total of 86 EBPs listed in the SDMH resource manual were being used by 441 agencies.
- A total of 54 other EBPs not on the SDMH list were being used by 70 agencies
- A total of 37 PPs, emerging practices, and other community practices were being used by 37 agencies

(2) Evidence-Based Practice and Promising Practice Resource Guide

The Department engaged the California Institute of Mental Health to assist in the development of the PEI *Evidence-Based Practices and Promising Practices Resource Guide.* The Guide was designed to inform the deliberations of the Ad Hoc Steering Committees as they identified priorities to be addressed in the county MHSA PEI Plan. The guide also contained information (e.g., implementation and funding costs) that would help in the development of the plan once the priorities had been identified. (See Appendix 15 for a copy of the Resource Guide.) Two groups gave input about which EBPs and PPs should be included in the manual: (1) A panel of technical consultants with research background and/or practical experience with EBPs and PPs, and (2) a subcommittee of the PEI Ad Hoc PEI Plan Development Advisory Group comprised of community and sector members. The members reviewed and analyzed EBPs and PPs that could be implemented in Los Angeles County.

Based on the priority populations and subpopulations selected by the Steering Committees, LACDMH ad CiMH developed a PEI Menu of Options from which the Steering Committees could select EBPs and PPs they desired implemented in their service areas or for the countywide special populations. The Menu listed appropriate EBPs and PPs for each of the age groups and priority populations selected by a service area. During deliberations, Steering Committee members consulted the Guide as questions arose regarding the suitability of a particular program or practice in relation to the needs of a specific population or geographic area. The Guide served as reference material for the PEI Menu of Options (the service area/countywide lists of possible PEI programs that may be included in the PEI Plan). Steering Committee members were advised to carefully weigh the relative merits of each EBP or PP along with its relative limitations as they made their recommendations. The outcomes from the development and utilization of the Guide included:

- Developed the *PEI Evidence-Based Practices and Promising Practices Resource Guide* that includes 79 EBPs and PPs appropriate to implement in Los Angeles County
- Developed a Menu of Options from which the Steering Committees could select EBPs and PPs that correspond to the priority populations and subpopulations identified by the Committee
- Distributed over 350 copies of the Resource Guide to Steering Committee members and other interested parties, as well as posted an electronic copy on the LACDMH website.

(3) Community Defined Evidence Models

As part of is PEI program planning, in December 2008 LACDMH solicited applications for CDEs for review and possible inclusion in a list of PEI models recommended for inclusion in LACDMH's final PEI plan. CDE practices are a set of practices that communities have been shown to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community. Only CDE models that targeted PEI priority populations and outcomes would be included in the list of PEI practices. To be included on the Department's list of possible PEI interventions, services had to be sufficiently well-articulated to be delivered in a consistent manner and replicated by others, and have some level of demonstrated effectiveness. CDE models are distinguished from national EBPs or PPs by having been developed and used primarily in Los Angeles County and not described in academic or commercial publications. Further, inclusion on the list did not guarantee selection as a program for the County's PEI plan. Due to the wealth of potential and emerging community practices that could be developed or need assistance in developing outcomes and collecting data, LACDMH is planning CDE technical assistance workshops later in 2009. (See Appendix 16 for a copy of the Community Defined Evidence Models Guide.) The outcomes from the CDE solicitation:

- A total of 320 applications were received, many proposing services not yet in existence or for programs already on the County's PEI *Resource Guide*
- A total of 18 practices met the criteria for CDE status. Thirteen CDEs were selected for inclusion in a PEI plan on the basis of stakeholder input and whether or not the practice was non-duplicative in terms of its intended outcomes.
- Developed the *Community Defined Evidence Models Guide* which describes the services qualified as CDE practices and posted a copy on the LACDMH website.

5. PEI PROJECTS AND PROGRAMS

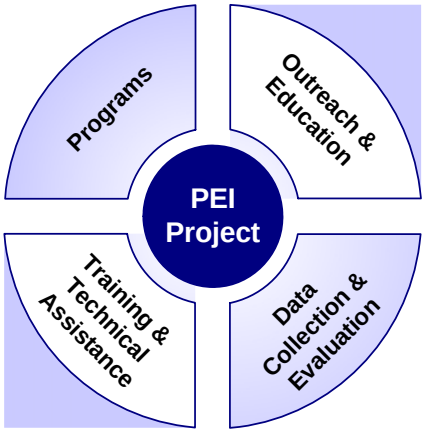
A. PROJECT COMPONENTS

The Los Angeles County plan is the result of a community-driven planning process that extended over 20 months, with input from over 10,000 individuals and 655 agency- and community-based programs. Another input facet of the planning was that it was data-driven, i.e., the most recent L.A. County statistics relevant to risk factors were utilized. New as well as expanded programs emphasizing prevention, early intervention, or a combination of both, comprise the overall approach to the County's PEI plan. Each PEI project is designed to address one or more key community mental health needs and one or more priority populations. The projects are consistent with PEI principles to meet specific PEI individual, family, program, and system outcomes. In line with SDMH requirements, the projects were structured according to two options:

1. *Priority Population-based* – Activities, programs and approaches directed at multiple priority populations are placed into one PEI project based on the most salient of the risk factors. (*Example – Early Care and Support for TAY, Early Care and Support for Older Adults, Trauma Recovery Services, Improving Access for Underserved Populations, and American Indian Project.)*

2. *Program-based* – Two or more priority populations are placed into one PEI project because all the programs are relevant to those priority populations. *(Example – School-based Services, Family Education and Support Services, At-Risk Family Services, Primary Care and Behavioral Health Services, and Juvenile Justice Services.)*

Each PEI project is comprised of the following components:



1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.

2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.

3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures that accurate data is captured on a systematic and ongoing basis so that the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.

4. PEI Programs – Overall, the PEI projects are composed of 35 EBPs and PPs (70%), 13 CDE practices (26%), and two pilot programs (4%), a total of 50 distinct programs that include both prevention and early intervention techniques and strategies.

B. LOS ANGELES COUNTY PEI PROJECTS

Based on community input from stakeholders, LACDMH developed ten projects that address the needs, priority populations, special sub-populations, and PEI programs selected by the stakeholders.

(1) Project Summaries

A summary description of each project is listed on the chart on the next page, followed by a chart with the proposed programs for each project. Note that stakeholders wanted

to place an emphasis on the younger age children, so that programs are identified as serving young children (0-5 years) and children (6-15 years).

PEI PROJECT ALLOCATION	PROJECT SUMMARIES
1. School-based Services Project $8,606,785	The School-Based Services Project will (1) build resiliency and increase protective factors among children, youth and their families; (2) identify as early as possible children and youth who have risk factors for mental illness; and (3) provide on-site services to address non-academic problems that impede successful school progress. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; foster a positive school climate; offer early mental health intervention services on school sites; and provide training in mental health evidence-based programs to school personnel and providers working with youth and children.
2. Family Education and Support Project $11,324,296	The Family Education and Support Project will build competencies, capacity and resiliency in parents, family members and other caregivers in raising their children by teaching a variety of strategies. Services will be offered to a diverse population throughout the county. The project utilizes universal and selective intervention as well as early intervention approaches for children/youth in stressed families. The programs will address the risk factors and protective factors that promote positive mental health, concentrating on parental skill-building through a variety of training, education, individual, group parent, and family interaction methods.
3. At-risk Family Services $10,780,932	The At-Risk Family Services Project will (1) provide training and assistance to families whose children are at risk for placement in foster care, group homes, psychiatric hospitals, and other out of home placements; (2) build skills for families with difficult, out of control or substance abusing children who may face the juvenile justice involvement; and (3) provide support to families whose environment and history renders them vulnerable to forces that lead to destructive behavior and the disintegration of the family.
4. Trauma Recovery Services $26,790,611	The Trauma Recovery Services Project will (1) provide short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event; and (2) provide more intensive services to trauma-exposed youth, adults, and older adults to decrease the negative impact and behaviors resulting from the traumatic events. The programs include outreach and education, psychosocial assessment, individual short-term crisis counseling, family counseling, youth and parent support groups, case management, and training for staff that are likely to work with trauma victims.
5. Primary Care and Behavioral Health Services $5,475,984	The Primary Care and Behavioral Health Project will develop mental health services within primary care clinics in order to increase primary care providers' capacity to offer effective mental health guidance and early intervention through the implementation of screening, assessment, education, consultation, and referral. Another purpose is to prevent patients at primary care clinics from developing severe behavioral health issues by addressing their mental health issues early on. Behavioral health professionals skilled in consultation and primary care liaison will be integrated within the primary care system. It is the intent of the Project to build resiliency and increase protective factors among children, youth, adults and older adults and their families and other caregivers through the PEI programs. By offering assistance in identifying emotional and behavioral issues at a clinic setting, the stigma associated with seeking out mental health services will be minimized.

PEI PROJECT ALLOCATION	PROJECT SUMMARIES
6. Early Care and Support for Transition-Age Youth $9,017,928	The Early Support and Care for Transition-Age Youth Project will (1) to build resiliency, increase protective factors, and promote positive social behavior among TAY; (2) address depressive disorders among the TAY, especially those from dysfunctional backgrounds; and (3) identify, support, treat, and minimize the impact for youth who may be in the early stages of a serious mental illness. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; offer early mental health intervention services on school sites, youth centers and other youth-friendly sites; and provide training in mental health evidence-based programs to school personnel and providers working with TAY. Emancipating, emancipated, and homeless TAY are a special focus of this project.
7. Juvenile Justice Services $10,663,120	The Juvenile Justice Services Project will (1) build resiliency and protective factors among children and youth who are exposed to risk factors that leave them vulnerable to becoming involved in the juvenile justice system; (2) promote coping and life skills to youths in the juvenile justice system to minimize recidivism; and (3) identify mental health issues as early as possible and provide early intervention services to youth involved in the juvenile justice system. Services will be provided at probation camps throughout the County, residential treatment facilities, health clinics, community settings, and other non-traditional mental health sites.
8. Early Care and Support for Older Adults $9,026,660	The Early Care and Support Project for Older Adults will (1) establish the means to identify and link older adults who need mental health treatment but are reluctant, are hidden or unknown, and/or unaware of their situation; (2) prevent and alleviate depressive disorders among the elderly; and (3) provide brief mental health treatment for individuals. The stigma of mental illness is a significant barrier for the older generation who often do not seek treatment until the illness has progressed significantly. Services are directed at older adults, their family members, caregivers, and others who interact with and provide services to this senior citizen population.
9. Improving Access for Underserved Populations $7,243,176	The Improving Access for Underserved Populations Project will (1) build resiliency and increase protective factors among monolingual and limited English-speaking immigrants and underserved cultural populations, lesbian/gay/bisexual/transgender/questioning (LGBTQ) individuals, deaf/hard of hearing individuals and their families; and blind/visually impaired individuals and their families; (2) identify as early as possible individuals who are a risk for emotional and mental problems; and (3) provide culturally and linguistically appropriate early mental health intervention services. The programs will provide outreach and education as well as promote mental wellness through universal and selective prevention strategies.
10. American Indian Project $990,000	The American Indian Project will (1) build resiliency and increase protective factors among children, youth and their families; (2) address stressful forces in children/youth lives, teaching coping skills, and divert suicide attempts; and (3) identify as early as possible children and youth who have risk factors for mental illness. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; offer early mental health intervention services at comfortable, non-stigmatizing localities; and involve multi-generations in the American Indian children and youth's lives. An important emphasis is on preventing suicide among American Indian youth, given the high rate among this population.

(2) Project Programs

PEI = Program combines both prevention and early intervention strategies.
CW = Countywide

	Program Title	Age Groups	Strategy	Service Areas	No. of Individuals and Families to be Served	
					Prevention	Early Interven.
1. SCHOOL-BASED SERVICES PROJECT						
1	Aggression Replacement Training	Children	PEI	2	300 Individ. 100 Families	600 Individ. 200 Families
2	Cognitive Behavioral Intervention for Trauma in Schools (CBTS)	Children, TAY	Early Intervention	4, 5, 6, CW		650 Individ. 650 Families
3	Early Risers for Success	Children	Early Intervention	3, 7		480 Individuals 480 Families
4	Families and Schools Together	Children	Prevention	1, 2, 5, 6	1,800 Individ. 1,800 Families	
5	Multidimensional Family Therapy	Children	PEI	4	40 Individ. 40 Families	80 Individ. 80 Families
6	Olweus Bullying Prevention Program	Children	Prevention	1	2,800 Individ. 2,800 Families	
7	Psychological First Aid	Young Children, Children, TAY	PEI	1, 6, 7	24,000 Individ.	40,000 Individ.
8	Strengthening Families	TAY	PEI	6	125 Individ. 125 Families	100 Individ. 100 Families
9	Why Try? Program	Children	PEI	6, 7	900 Individ. 900 Families	360 Individ. 360 Families
2. FAMILY EDUCATION AND SUPPORT PROJECT						
1	Caring for Our Families	Children	Early Intervention	4, 8		180 Individ. 180 Families
2	Incredible Years	Young Children, Children	PEI	2, 3, 4, 5, 7, 8,	140,400 Individ. 140,400 Fam.	1,560 Individ. 1,560 Families
3	The Mothers and Babies Course "Mamas y Bebes"	TAY	PEI	7	240 Individ. 240 Families	240 Individ. 240 Families
4	Nurse-Family Partnership	Young Children, TAY	PEI	1, 4, 6, 8	250 Individ. 250 Families	250 Individ. 250 Families
5	Nurturing Parenting Program	Children	PEI	7	100 Individ. 100 Families	200 Individ. 200 Families
6	Triple P Positive Parenting Program	Young Children, Children	PEI	1, 4	460 Individ. 460 Families	114 Individ. 114 Families
3. AT-RISK FAMILY SERVICES PROJECT						
1	Brief Strategic Family Therapy	Children	PEI	2	200 Individ. 200 Families	320 Individ. 320 Families
2	Child-Parent Psychotherapy	Young Children	Early Intervention	7		120 Individ. 120 Families
3	Group CBT for Major Depression	Adults	PEI	3, 5, 6	1,800 Individ.	3,600 Individ.
4	Incredible Years	Young Children, Children	PEI	3, 4, 8	54,000 Individ. 54,000 Families	600 Individ. 600 Families

Program Title		Age Groups	Strategy	Service Areas	No. of Individuals and Families to be Served	
					Prevention	Early Interven.
5	Making Parenting a Pleasure	Young Children	Prevention	2	240 Individ. 240 Families	
6	Parent-Child Interaction Therapy	Children	Early Intervention	2		320 Individ. 320 Families
7	Reflective Parenting Program	Young Children	Early Intervention	5, 6, 7, 8		4,200 Individ. 4,200 Families
8	Triple P Positive Parenting Program	Young Children, Children	PEI	3, 6, 8	2,760 Individ. 2,760 Families	684 Individ. 684 Families
9	UCLA Ties Transition Model (TTM)	Young Children	PEI	2	100 Individ. 100 Families	200 Individ. 200 Families
4. TRAUMA RECOVERY SERVICES						
1	Child-Parent Psychotherapy	Young Children	Early Intervention	2, 4, 5, 6, 8		525 Individ. 525 Families
2	Crisis Oriented Recovery Services	Adults, Older Adults	Early Intervention	All		10,440 Individ.
3	Group Cognitive Behavioral Therapy for Major Depression	Adults	PEI	1	150 Individ.	300 Individ.
4	Parent-Child Interaction Therapy	Young Children	Early Intervention	2, 4, 8		800 Individ. 800 Families
5	Prolonged Exposure Therapy for PTSD	TAY, Adults, Older Adults	Early Intervention	1, 3, 4. CW		2,360 Individ. 516 Families
6	Seeking Safety	TAY, Adults	Early Intervention	4		864 Individ. 144 Families
7	System Navigators for Veterans	TAY, Adults, Older Adults	Prevention	CW	600 Individ.	
8	Trauma Focused Cognitive Behavioral Therapy	Young Children, Children, TAY	Early Intervention	2, 3, 6, 8		1,600 Individ. 1,600 Families
5. PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES						
1	Advice Line	TAY, Adults, Older Adults	PEI	CW	4,000 Individ.	4,000 Individ.
2	Alternatives for Families	Children	Early Intervention	CW		310 Individ. 310 Families
3	IMPACT	Adults, Older Adults	Early Intervention	1, 7, 8		2,100 Individ. 450 Families
4	Incredible Years	Young Children, Children	PEI	CW	10,800 Individ. 10,800 Families	120 Individ. 120 Families
5	Maternal Wellness Center	Adults	PEI	3, 4	420 Individ. 420 Families	300 Individ. 300 Families
6	Prevention & Early Treatment of Depression in Primary Care	TAY, Adults, Older Adults	PEI	6, 7, CW	315 Individ.	350 Individ.
7	Triple P Positive Parenting Program	Young Children, Children	PEI	CW	230 Individ. 230 Families	57 Individ. 57 Families
6. EARLY CARE AND SUPPORT FOR TAY						
1	Aggression Replacement Training	TAY	PEI	2	300 Individ.	600 Individ.

	Program Title	Age Groups	Strategy	Service Areas	No. of Individuals and Families to be Served	
					Prevention	Early Interven.
					100 Families	200 Families
2	Asian American Family Enrichment Network (AAFEN) Program	TAY	PEI	3	200 Individ. 200 Families	260 Individ. 260 Families
3	Center for the Assessment & Prevention of Prodromal States (CAPPS)	TAY	PEI	2, 5, 6, 7, 8	180 Individ. 180 Families	288 Individ. 288 Families
4	Early Detection and Intervention for the Prevention of Psychosis (EDIPP)	TAY	PEI	4, 8	400 Individ. 400 Families	44 Individ. 44 Families
5	Group Cognitive Behavioral Therapy for Major Depression	TAY	PEI	1, 8	900 Individ. 300 Families	1,800 Individ. 600 Families
6	Interpersonal Psychotherapy for Depression	TAY	PEI	3, 5, 7	780 Individ. 260 Families	1,170 Individ. 390 Families
7	Multidimensional Family Therapy	TAY	PEI	6	20 Individ. 20 Families	40 Individ. 40 Families
8	Seeking Safety	TAY	Early Intervention	6		576 Individ. 192 Families
7. JUVENILE JUSTICE PROJECT						
1	Aggression Replacement Training	Children, TAY	PEI	CW	150 Individ. 50 Families	300 Individ. 100 Families
2	Cognitive Behavioral Intervention for Trauma in School (CBITS)	Children, TAY	Early Intervention	CW		100 Individ. 100 Families
3	Functional Family Therapy	Children, TAY	Early Intervention	7, CW		768 Individuals 768 Families
4	Group Cognitive Behavioral Therapy for Major Depression	TAY	PEI	CW	450 Individ. 150 Families	900 Individ. 300 Families
5	LIFE (Loving Intervention for Family Enrichment) Program	Children, TAY	Early Intervention	4, 6, 7, 8		280 Individ. 280 Families
6	Multidimensional Family Therapy (MDFT)	TAY	PEI	2	80 Individ. 80 Families	160 Individ. 160 Families
7	Multisystemic Therapy	Children, TAY	Early Intervention	8		96 Individ. 96 Families
8	Positive Directions	Children, TAY	Early Intervention	6		220 Individ. 220 Families
9	Prolonged Exposure Therapy for Post Traumatic Stress Disorder	TAY	Early Intervention	CW		240 Individ. 80 Families
10	Trauma Focused Cognitive Behavioral Therapy	Children, TAY	Early Intervention	CW		200 Individ. 200 Families
8. EARLY CARE AND SUPPORT FOR OLDER ADULTS						
1	Cognitive Behavioral Therapy for Late Life Depression	Older Adults	Early Intervention	2, 3, 7		975 Individ. 321 Families
2	Gatekeeper Case-finding Model	Older Adults	Early Intervention	4, 5		3,750 Individ. 1,250 Families
3	Live Well, Live Long, Steps to Mental Wellness	Older Adults	PEI	2, 4, 5	15,500 Individ. 5,166 Families	7,750 Individ. 2,583 Families

	Program Title	Age Groups	Strategy	Service Areas	No. of Individuals and Families to be Served	
					Prevention	Early Interven.
4	PATCH	Older Adults	Early Intervention	6		100 Individ. 33 Families
5	PEARLS	Older Adults	PEI	3, 6, 8	1,080 Individ. 360 Families	540 Individ. 180 Families
6	Promotores de Salud	Older Adults	Prevention	7	400 Individ. 133 Families	
9. IMPROVING SERVICES TO UNDERSERVED POPULATIONS						
1	Cognitive Behavioral Therapy for Depression with Antidepressant Medication	Adults	PEI	2	450 Individ.	900 Individ.
2	Family Coping Skills Program	Adults	Prevention	6	900 Individ. 900 Families	
3	GLBT CHAMPS: Comprehensive HIV & At-Risk Mental Health Services	TAY	PEI	CW	80 Individ. 80 Families	20 Individ. 20 Families
4	Group Cognitive Behavioral Therapy for Major Depression	TAY, Adults, Older Adults	PEI	2, 4, 7, 8, CW	3,375 Individ. 50 Families	6,750 Individ. 100 Families
5	Nurse-Family Partnership	Young Children	PEI	CW	50 Individ. 50 Families	50 Individ. 50 Families
6	Nurturing Parenting Programs	Young Children, Children	PEI	CW	100 Individ. 100 Families	200 Individ. 200 Families
7	Prolonged Exposure Therapy for PTSD	Adults, Older Adults	Early Intervention	CW		80 Individ.
8	Trauma Focused Cognitive Behavioral Therapy	TAY	Early Intervention	CW		200 Individ. 200 Families
10. AMERICAN INDIAN PROJECT						
1	American Indian Life Skills	Children, TAY	Prevention	CW	216 Individ. 216 Families	
2	Trauma Focused Cognitive Behavioral Therapy: Honoring Children, Mending the Circle	Children, TAY	Early Intervention	CW		200 Individ. 200 Families

C. PEI EARLY START PROJECTS

In fall 2008 LACDMH submitted its plan for three PEI Early Start Projects. The MHSOAC approved the plan on March 26, 2009. The Early Start Projects include (1) Suicide Prevention, (2) School Mental Health-Violence Prevention, and (3) Stigma and Discrimination. Although the Early Start Projects were developed through a planning process separate from the MHSA PEI stakeholder process, these projects are intended to be part of the County array of MHSA prevention and early intervention services.

6. SERVICE AREA AND COUNTYWIDE PROGRAMS

PEI services will be delivered at various sites throughout Los Angeles County at the Service Area and countywide level. Service Areas are the County's method of organizing cities and services within specific geographic boundaries. While the previous section described the projects according to purpose and programs, this section identifies the specific services proposed for these geographic regions. A total of 137 new programs will be implemented in FY 09-10.

Service Area	Allocation	No. of Programs
SA 1 - Antelope Valley	$ 3,296,534	9
SA 2 - San Fernando Valley	$17,682,711	16
SA 3 - San Gabriel Valley	$12,790,312	12
SA 4 - Downtown	$13,389,534	17
SA 5 - West	$ 4,376,783	11
SA 6 - South	$12,800,129	21
SA 7 - East	$12,048,099	18
SA 8 - South Bay/Long Beach	$13,543,441	16
Countywide	$ 9,991,949	17
Total Programs	$99,919,492	137 New Programs

SERVICE AREAS

Service Area 1 – Antelope Valley

Service Area 2 – San Fernando Valley

Service Area 3 – San Gabriel Valley

Service Area 4 – Downtown

Service Area 5 – West

Service Area 6 – South

Service Area 7 – East

Service Area 8 – South Bay/Long Beach

A. SERVICE AREA 1 – ANTELOPE VALLEY

While SA1 is the largest service area geographically, it has the smallest population. Overall, the service area has an almost equal number of people who identified themselves as Latinos and Whites. Examining the two urban areas reveals a somewhat different ethnic distribution. In the Lancaster area, no ethnic group has a majority, but in the Palmdale area, Latinos are the majority ethnic group, followed by Western European Whites and African-Americans who constitute 10% of the local area population. Spanish is the second most common language and is reportedly spoken in 28% of homes. SA1 has a younger population than other service areas, as 31.6% of the populations are children aged 0-15 years; the county average for this age group is 25%. This Service Area 1 had the highest Child Abuse and Neglect Rate (1.98) found across the county and had an Adult Protective Services (APS) Rate of 3.2 for elder and dependent abuse, which was the second highest rate seen in the county across all service areas. It also had the highest rates for school suspension (8.9%) and expulsion (0.6%) throughout the county. The overall poverty rate in SA1 of 41.2% was higher than the county average of 38.7%. Over 50% of African-Americans were living beneath the 200% Federal Poverty Level (FPL), and similarly the Hispanic population had over 50% of its population in the urban areas living beneath the 200% FPL.

Consistent with the PEI planning process, SA1 communities participated in the planning process by voicing their interest with five key individual interviews, six focus groups and hosting one Community Forum with 115 registered participants. After this information-gathering, a 28-member PEI Ad Hoc Steering Committee met over three months. The Steering Committee was comprised of representatives of all the mandated sectors as per SDMH guidelines, plus age group representatives, a SAAC co-chair, and District Chief. This same membership structure was followed for all Service Areas. Considering the wide geographic area there was some concern about the participation of the various stakeholders from health, education, mental health, law enforcement, social services, families, clients, and cultural and ethnic populations, yet participation remained high and intense resulting in selections of Priority Populations, sub-populations and interventions that truly represent the needs of this service area.

Service Area 1 – Antelope Valley						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
1	Crisis Oriented Recovery Services	Adults, Older Adults	Underserved Cultural Populations Trauma-Exposed	4.	720	
2	Families and Schools Together	Children	Children/Youth in Stressed Families	1.	360	360
3	Group Cognitive Behavioral Therapy for Major Depression	TAY Adults	Children/Youth in Stressed Families Underserved Cultural Populations	6. 4.	1,350	300

Service Area 1 – Antelope Valley						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
4	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)	Older Adults	Trauma-Exposed	5.	150	50
5	Nurse-Family Partnership	Young Children	Children/Youth in Stressed Families	2.	100	100
6	Olweus Bullying Prevention Program	Children	Children/Youth at Risk for School Failure	1.	2,800	2,800
7	Prolonged Exposure Therapy for PTSD	TAY Adults Older Adults	Children/Youth at Risk for School Failure Underserved Cultural Populations Trauma-Exposed	4.	240	52
8	Psychological First Aid (CDE)	TAY	Children/Youth in Stressed Families	1.	16,000	
9	Triple P Positive Parenting Program	Young Children	Children/Youth in Stressed Families	2.	287	287

B. SERVICE AREA 2 – SAN FERNANDO VALLEY

SA2 is the most populous service area in Los Angeles County. Latinos account for 38.4% of the population. Western European Whites have the highest proportion of its population in the San Fernando Valley as do Armenians, Russians, South Asians, and American Indians/Alaskan Natives. Nearly 30% of American Indians/Alaskan Natives live within the San Fernando Valley. English and Spanish are the predominant languages spoken at home in 42.8% and 31.4% of households, respectively; this means that a full quarter of the remaining population speaks other languages. The percentage of children ages 0-15 living in SA2 (23.9%) is about county average (25%), but because of the population size, SA2 has more children in this age category than the other service areas. African-Americans and Hispanic students had the lowest graduation rates, with both under 70%. The overall Penetration Rate for SA 2 was 0.18, well below the countywide rate of 0.34. Such a figure suggests that the local mental health resources may have a smaller reach into the SMI population than other parts of the county, so that the PEI approach to employing more non-traditional mental health resources may help minimize barriers and de-stigmatize seeking help.

In addition to the five key individual interviews and six focus groups, two community forums were hosted in two distinct areas of the service area, one on a Wednesday evening in Van Nuys, and the other on a Saturday morning in Mission Hills. Over 180 persons attended these community forums. The dedicated 30-member Steering Committee met weekly to review information from all relevant sources including the community forums, focus groups, individual interviews and from the represented constituencies to determine the priority populations, sub-populations, and identify

interventions and strategies. Given these parameters the service area selections of sub-populations and interventions proved vital in supporting and directing the countywide prevention and early interventions projects.

Service Area 2 –San Fernando Valley						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
1	Aggression Replacement Training	Children TAY	Children/Youth at Risk for School Failure Children/Youth in Stressed Families	1. 6.	1,800	600
2	Brief Strategic Family Therapy	Children	Children/Youth in Stressed Families	2.	520	520
3	Center for the Assessment and Prevention of Prodromal States – CAPPS (CDE)	TAY	Individuals Experiencing Onset of Serious Psychiatric Illness	6.	273	273
4	Cognitive Behavioral Therapy for Depression with Antidepressant Medication	Adults	Underserved Cultural Populations	9.	1,350	
5	Cognitive Behavioral Therapy for Late Life Depression	Older Adults	Individuals Experiencing Onset of Serious Psychiatric Illness	8.	450	150
6	Child-Parent Psychotherapy	Young Children	Children/Youth in Stressed Families Underserved Cultural Populations	4.	180	180
7	Crisis Oriented Recovery Services	Adults Older Adults	Underserved Cultural Populations Individuals Experiencing Onset of Serious Psychiatric Illness	4.	2,160	
8	Families and Schools Together	Children	Children/Youth at Risk for School Failure	1.	720	720
9	Group CBT for Major Depression	Adults	Underserved Cultural Populations	9.	2,925	
10	Incredible Years	Young Children	Children/Youth in Stressed Families Underserved Cultural Populations	2.	21,840	21,840
11	Live Well, Live Long, Steps to Mental Wellness	Older Adults	Individuals Experiencing Onset of Serious Psychiatric Illness	8.	12,000	3,999
12	Making Parenting a Pleasure	Young Children	Children/Youth in Stressed Families	2.	320	320
13	Multidimensional Family Therapy	TAY	Children/Youth in Stressed Families	7.	240	240
14	Parent-Child Interaction Therapy (PCIT)	Young Children Children	Children/Youth in Stressed Families	4. 3.	640	640
15	Trauma Focused Cognitive Behavioral Therapy	TAY	Individuals Experiencing Onset of Serious Psychiatric Illness	4.	200	200
16	UCLA Ties Transition Model (CDE)	Young Children	Children/Youth in Stressed Families	3.	300	300

C. SERVICE AREA 3 – SAN GABRIEL VALLEY

The total population of SA3 is 1.6 million, with Latinos the largest ethnic group in the area (45%), followed by Asians (23.7%). The San Gabriel Valley is home to the largest proportion of Asians in the county with 33.6% of their entire population residing within its boundaries. Four of the largest Asian communities are found within SA3. About 39% of all households speak English and 32% speak Spanish. For the most part, the remaining non-English/non-Spanish-speaking households have an Asian language as their language spoken. Age-wise, the service area closely resembles the countywide distribution of age groups, though there are, perhaps, slightly more older adults in this area than the county average.

The weekday forum in Pasadena and the Saturday forum in Glendora were well attended by over 275 persons with richly diverse voices. The forum recommendations, together with the five key individual interviews and six focus groups, served as the foundation for the 32-member Ad Hoc Steering Committee meetings to incorporate data sets. The investment of time and energy from this committed group forged a lasting bond for the Service Area in supporting each other's ideas and needs. This was highlighted as the Steering Committee moved into its decision-making when one member represented another stakeholder's interest in nominations of a sub-population having no prior knowledge of those needs before being a part of the committee. Collectively, the needs of the underserved communities were seen as predominant.

Service Area 3 –San Gabriel Valley						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
1	Asian American Family Enrichment Network Program (CDE)	TAY	Underserved Cultural Populations	6.	460	460
2	Cognitive Behavioral Therapy for Late Life Depression	Older Adults	Undeserved Cultural Populations	8.	275	91
3	Crisis Oriented Recovery Services	Adults Older Adults	Underserved Cultural Populations	4.	1,440	
4	Early Risers Skills for Success	Children	Children/Youth in Stressed Families	1.	270	270
5	Group Cognitive Behavioral Therapy for Major Depression	Adults		3.	2,700	
6	Incredible Years	Young Children Children	Children/Youth in Stressed Families Underserved Cultural Populations	2. 3.	65,520	65,520
7	Interpersonal Psychotherapy for Depression	TAY	Underserved Cultural Populations	6.	1,200	400
8	Maternal Wellness Center (CDE)	Adults	Underserved Cultural Populations	5.	240	240
9	PEARLS	Older Adults	Underserved Cultural Populations	8.	450	150

Service Area 3 –San Gabriel Valley						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
10	Prolonged Exposure Therapy for PTSD	TAY Adults	Trauma-Exposed Underserved Cultural Populations	4.	680	160
11	Trauma Focused Cognitive Behavioral Therapy	Young Children Children TAY	Underserved Cultural Populations Children/Youth in Stressed Families Trauma-Exposed	4.	600	600
12	Triple P Positive Parenting Program	Young Children	Children/Youth in Stressed Families	3.	1,435	1,435

D. SERVICE AREA 4 – DOWNTOWN

The majority of the population in SA4 is Latino (54.1%), followed by Western European Whites (17.3%), Asians (16.8%), and African-Americans (5.1%). The Downtown area has the highest Spanish-speaking rate in the service area (68.7%). Two language groups, Korean and Tagalog, have their largest proportions of speakers in the county contained within the service area. SA4 had the lowest graduation rates across all ethnic groups within the county without exception. It also accounted for 18.5% of the county's PTSD cases, the largest proportion between service areas. The Metro area had the second-highest poverty rate in the county with a majority (51.3%) of its residents living beneath the 200% FPL, a figure considerably higher than the county–wide rate of 38.7%. This area has the highest number of homeless persons in its boundaries.

The rich cultural diversity of this Service Area coupled with the overwhelming needs in pockets of SA4 supported the community process of five key individual interviews, six focus groups, and two well-attended community forums in Los Angeles with nearly 250 participants. This insightful 30-member Ad Hoc Steering Committee made a great effort to find the best way to support the prevention and early intervention needs of this divergent community. The foundational meetings where data and experience enhanced the understanding of these various stakeholders assisted the group in arriving at optimal decisions for the Service Area.

Service Area 4 –Downtown						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
1	Caring for Our Families (CDE)	Children	Children/Youth in Stressed Families Underserved Cultural Populations	2.	90	90
2	Cognitive Behavioral Intervention Therapy for Schools (CBITS)	Children	Children/Youth in Stressed Families	1.	300	300

Service Area 4 –Downtown						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
3	Child-Parent Psychotherapy	Young Children	Trauma-Exposed	4.	120	120
4	Crisis Oriented Recovery Services	Adults Older Adults	Underserved Cultural Populations	4.	1,440	
5	Early Detection and Intervention for the Prevention of Psychosis	TAY	Children/Youth in Stressed Families	6.	222	222
6	Gatekeeper Case-Finding Model	Older Adults	Underserved Cultural Populations	8.	3,000	1,000
7	Group Cognitive Behavioral Therapy for Major Depression	Adults	Underserved Cultural Populations	9.	1,350	
8	Incredible Years	Young Children Children	Children/Youth in Stressed Families Underserved Cultural Populations	3. 2.	21,840	21,840
9	Loving Intervention for Family Enrichment (LIFE) Program (CDE)	Children TAY	Children/Youth in Stressed Families Underserved Cultural Populations	7.	80	80
10	Live Well, Live Long, Steps to Mental Wellness	Older Adults	Underserved Cultural Populations	8.	9,000	3,000
11	Maternal Wellness Center (CDE)	Adults	Underserved Cultural Populations	5.	480	480
12	Multidimensional Family Therapy	Children	Children/Youth in Stressed Families	1.	120	120
13	Nurse-Family Partnership	Young Children TAY	Children/Youth in Stressed Families	2.	100	100
14	Parent-Child Interaction Therapy	Young Children	Trauma-Exposed	4.	320	320
15	Prolonged Exposure Therapy for PTSD	TAY	Trauma-Exposed	4.	320	104
16	Seeking Safety	TAY Adults	Trauma-Exposed Underserved Cultural Populations	4.	864	144
17	Triple P Positive Parenting Program	Children	Children/Youth in Stressed Families	2.	287	287

E. SERVICE AREA 5 – WEST

A majority of the population in SA5 are Western European Whites (55%), followed by Latinos (12%), Asians (10%), and African-Americans (7%). West Los Angeles has a sizeable Asian population (20%). In terms of primary language, SA5 has the highest proportion of individuals across the county who report English as the language they speak at home (64.6%). This is also true for Farsi speakers (3.0%) and Russian speakers (1.4%). SA5 has the lowest proportion of individuals across the county whose primary language is Spanish (11.4%). The age distribution in the service area is very different from the county. The proportion of children through young adulthood, (i.e., ages 0-5 years) at 27.6% is substantially lower in number than the countywide proportion of 39.8%. This trend is seen on the other end of the lifespan with older adults

accounting for 18% of the service area population while, countywide, this age group accounts for 13.5% of the population. The median household income in the service area of $61,151 was much higher than the county median of $48,282.

Armed with the information from the over 110 participants at the community forums held in Los Angeles and Culver City, five key individual interviews and six focus groups, the 29-member Ad Hoc Steering Committee easily formed to make recommendations regarding the PEI plan. While the geography is small for this service area, nevertheless, the recommendations had to include the unique requirements of the people within the area for prevention and early intervention services.

Service Area 5 – West						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
1	Center for the Assessment and Prevention of Prodromal States – CAPPS (CDE)	TAY	Individuals Experiencing Onset of Serious Psychiatric Illness	6.	78	78
2	Child-Parent Psychotherapy	Young Children	Children/Youth in Stressed Families Trauma-Exposed	4.	60	60
3	Cognitive Behavioral Intervention Therapy for Schools (CBITS)	Children	Children/Youth at Risk for School Failure	1.	100	100
4	Crisis Oriented Recovery Services	Adults Older Adults	Individuals Experiencing Onset of Serious Psychiatric Illness Trauma-Exposed	4.	720	
5	Families and Schools Together	Children	Children/Youth at Risk for School Failure	1.	360	360
6	Gatekeeper Case-Finding Model	Older Adults	Individuals Experiencing Onset of Serious Psychiatric Illness	8.	750	250
7	Group Cognitive Behavioral Therapy for Major Depression	Adults	Individuals Experiencing Onset of Serious Psychiatric Illness	3.	1,350	
8	Incredible Years	Children	Children/Youth in Stressed Families	2.	10,920	10,920
9	Interpersonal Psychotherapy for Depression	TAY	Individuals Experiencing Onset of Serious Psychiatric Illness	6.	450	150
10	Live Well, Live Long, Steps to Mental Wellness	Older Adults	Individuals Experiencing Onset of Serious Psychiatric Illness	8.	2,250	750
11	Reflective Parenting Program	Young Children	Children/Youth in Stressed Families Trauma-Exposed	3.	1,200	1,200

F. SERVICE AREA 6 – SOUTH

SA6 has the most at-risk factors in the entire county. A greater percentage of the population is 25 years of age or less (47.9%) than any other service area in the county. With 30% of its population 0-15 years of age, it is second only to SA1 in the relative

numbers of young children in the area. It has the highest poverty rate within the county with 60.6% of its residents living beneath the 200% FPL, substantially above the countywide percentage of 38.7%. The second-highest child abuse and neglect rate is in this area, with the Watts area (2.15) having the highest rate in the county. The highest APS Rate (3.9) among all county service areas is here. It was the only service area where adults accounted for a greater proportion of cases than children. Across the county, SA6 had the lowest graduation rate, 55.7%, or slightly more than half of all students. Its students had the lowest English Fluency (52.7%) rate in the county. Also, SA 6 had the largest numbers of youth sent to probation camps. Two groups account for 94.1% of the SA6 population: Hispanics (65.9%), followed by African-Americans (28.2%). Primary Spanish speakers are the majority in SA6 (56.7), followed by primary English speakers (30.9%).

With the recognized high needs of this community, this Service Area was instrumental in having two well-attended community forums on a Wednesday morning and Saturday morning in Los Angeles, with over 300 attendees representing all aspects of the community. In addition to the community forums, input from five key individual interviews and six focus groups, helped inform the 30-member Ad Hoc Steering Committee. Because the needs of the area are so great, this group processed much information, debated, and worked hard to make the best choices for services in prevention and early intervention that will make the most impact. Reflected in these choices for priority populations, sub-populations, and intervention are some hard-pressed decisions.

Service Area 6 - South						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
1	Center for the Assessment and Prevention of Prodromal States – CAPPS (CDE)	TAY	Children/Youth at Risk for School Failure	6.	39	39
2	Cognitive Behavioral Intervention Therapy for Schools (CBITS)	Children	Trauma-Exposed	1.	150	150
3	Child-Parent Psychotherapy	Young Children	Trauma-Exposed	4.	60	60
4	Crisis Oriented Recovery Services	Adults Older Adults	Underserved Cultural Populations	4.	1,080	
5	Families and Schools Together	Children	Children/Youth in Stressed Families	1.	360	360
6	Family Coping Skills Program	Adults	Underserved Cultural Populations	9.	900	900
7	Group Cognitive Behavioral Therapy for Major Depression	Adults	Underserved Cultural Populations	3.	1,350	
8	Loving Intervention for Family Enrichment (LIFE) Program (CDE)	TAY	Children/Youth in Stressed Families	7.	40	40
9	Multidimensional Family Therapy	TAY	Children/Youth in Stressed Families	6.	60	60

Service Area 6 - South						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
10	Nurse-Family Partnership	Young Children	Children/Youth in Stressed Families	2.	100	100
11	Prevention and Early Treatment of Depression in Primary Care (CDE)	Adults	Underserved Cultural Populations	5.	190	
12	Positive Directions (CDE)	Children TAY	Children/Youth in Stressed Families	7.	220	220
13	Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	Older Adults	Underserved Cultural Populations	8.	540	180
14	Psychogeriatric Assessment and Treatment in City Housing (PATCH)	Older Adults	Underserved Cultural Populations	8.	100	33
15	Psychological First Aid (CDE)	Children	Children/Youth in Stressed Families	1.	16,000	
16	Reflective Parenting Program (CDE)	Young Children	Children/Youth in Stressed Families	3.	1,200	1,200
17	Seeking Safety	TAY	Children/Youth in Stressed Families	6.	576	192
18	Strengthening Families	TAY	Children/Youth at Risk for School Failure	1.	225	225
19	Trauma Focused Cognitive Behavioral Therapy	Young Children Children	Trauma-Exposed	4.	400	400
20	Triple P Positive Parenting Program	Young Children Children	Children/Youth in Stressed Families	3.	861	861
21	Why Try? Program (CDE)	Children	Children/Youth in Stressed Families	1.	420	420

G. SERVICE AREA 7 – EAST

A significant majority of the population in SA7 is Latino (70.9%), followed by Western European Whites (14.8%), Asians (9.1%), and African-Americans (2.9%). Across the Service Area, Spanish is the primary language in 54% of households. Not surprisingly, SA7 had a linguistic isolation score of 8.8%, above the county figure of 7.8%. This Service Area has a young population with 43.1% under the age of 26. The median household income of $48,717 was equal to the county median of $48,282, though the mean income was a bit lower than the county mean. Educationally, SA 7 had a college graduation rate of 15.9% (in adults 25+), much lower than the countywide average. The overall Penetration Rate for SA 7 was 0.16, the lowest rate in the county (overall rate was 0.34). Language, culture, race/ethnicity, immigration status, and poverty are among the risk factors that raise barriers to seeking mental health assistance in SA 7.

With the needs of the Latino community as paramount, this Service Area was instrumental in creating a strong community response to enable the voices of the monolingual Spanish speaking community to come forward. Both community forums, a

weekday event and a Saturday event, had an enormous turnout of Spanish-speaking individuals, families, and teens, with over 315 attendees. This was carried through in the five key individual interviews and six focus groups conducted in the Service Area. It was with this background that the 30-member Steering Committee representing various sectors of the community met to deliberate the needs of this community. From the beginning this Steering Committee, gracious and poised with each other, participated in a re-learning of the Service Area in the interest of making the best choices for the PEI plan. Their interest in solidifying the needs of this community continued past deadlines to insure and enable the community to have the best programs to meet their needs.

Service Area 7 – East						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
1	Center for the Assessment and Prevention of Prodromal States – CAPPS (CDE)	TAY	Underserved Cultural Populations	6.	39	39
2	Child-Parent Psychotherapy	Young Children	Children/Youth in Stressed Families	3.	120	120
3	Cognitive Behavioral Therapy for Late Life Depression	Older Adults	Underserved Cultural Populations	8.	250	80
4	Crisis Oriented Recovery Services	Adults Older Adults	Underserved Cultural Populations	4.	1,440	
5	Early Risers Skills for Success	Children	Children/Youth at Risk for School Failure	1.	210	210
6	Functional Family Therapy	TAY	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	7.	384	384
7	Group Cognitive Behavioral Therapy for Major Depression	Adults	Underserved Cultural Populations	9.	1,800	
8	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)	Older Adults	Underserved Cultural Populations	5.	600	200
9	Incredible Years	Young Children Children	Children/Youth in Stressed Families Underserved Cultural Populations Children/Youth at Risk for School Failure	2.	54,600	54,600
10	Interpersonal Psychotherapy for Depression	TAY	Underserved Cultural Populations	6.	300	100
11	Loving Intervention for Family Enrichment (LIFE) Program (CDE)	Children TAY	Children/Youth in Stressed Families	7.	80	80
12	Mamas y Bebes	TAY	Underserved Cultural Populations	2.	480	480
13	Nurturing Parenting Program	Children	Children/Youth in Stressed Families	2.	300	300
14	Prevention and Early Treatment of Depression in Primary Care (CDE)	Adults	Underserved Cultural Populations	5.	285	
15	Promotores de Salud (CDE)	Older Adults	Underserved Cultural Populations	8.	400	133

Service Area 7 – East						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
16	Psychological First Aid (CDE)	Young Children	Underserved Cultural Populations	1.	32,000	
17	Reflective Parenting Program (CDE)	Young Children	Underserved Cultural Populations	3.	1,200	1,200
18	Why Try? Program (CDE)	Children	Children/Youth at Risk for School Failure	1.	840	840

H. SERVICE AREA 8 – SOUTH BAY / LONG BEACH

There is no overall ethnic majority group in SA8. The largest group is Latino (36%), followed by Western European White (29%), African-American (15%), and Asian (14%). English and Spanish are the two main languages spoken at home throughout the service area. Other language groups are in evidence throughout the service area in small numbers, including Cambodian, Korean, and Tagalog speakers. Age groups are similar to the countywide average statistics. The median household income for the service area, $50,960, was a bit higher than the county median of $48,282. Similarly, the service area communities' mean incomes were also elevated over the county mean. Educationally, SA8 had a college graduation rate of 30% (in adults 25+), exceeding the countywide average of 27.8%.

SA8 forged ahead early in the planning process by hosting the first community forum in the county, developing an early start Steering Committee and supporting other voices to come forward with five key individual interviews and six focus groups. A weekday forum was held in Carson and a Saturday forum in Long Beach, with a total of over 180 attendees. With the broadness and diversity of needs in the Service Area, the 29-member Ad Hoc Steering Committee educated others about the interface necessary to enable prevention and early intervention services to benefit the most in need.

Service Area 8 – South Bay/Long Beach						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
1	Center for the Assessment and Prevention of Prodromal States – CAPPS (CDE)	TAY	Individuals Experiencing Onset of Serious Psychiatric Illness	6.	39	39
2	Caring for Our Families (CDE)	Children	Children/Youth in Stressed Families	2.	90	90
3	Child-Parent Psychotherapy	Young Children	Children/Youth in Stressed Families	4.	90	90
4	Crisis Oriented Recovery Services	Adults Older Adults	Underserved Cultural Populations	4.	1,440	

Service Area 8 – South Bay/Long Beach						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
5	Early Detection and Intervention for the Prevention of Psychosis (EDIPP)	TAY	Individuals Experiencing Onset of Serious Psychiatric Illness	6.	222	222
6	Group CBT for Major Depression	TAY Adults	Underserved Cultural Populations	6. 9.	4,950	600
7	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)	Adults Older Adults	Underserved Cultural Populations	5.	1,350	200
8	Incredible Years	Young Children Children	Underserved Cultural Populations Children/Youth in Stressed Families	2. 3.	21,840	21,840
9	Loving Intervention for Family Enrichment (LIFE) Program (CDE)	Children TAY	Underserved Cultural Populations	7.	80	80
10	Multisystemic Therapy	Children TAY	Underserved Cultural Populations	7.	96	96
11	Nurse-Family Partnership	Young Children	Children/Youth in Stressed Families Underserved Cultural Populations	2.	100	100
12	Parent-Child Interaction Therapy	Young Children	Children/Youth in Stressed Families Underserved Cultural Populations	4.	160	160
13	Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	Older Adults	Underserved Cultural Populations	8.	630	210
14	Reflective Parenting Program	Young Children	Children/Youth in Stressed Families Underserved Cultural Populations	3.	600	600
15	Trauma Focused Cognitive Behavioral Therapy	Children TAY	Underserved Cultural Populations Individuals Experiencing Onset of Serious Psychiatric Illness	4.	400	400
16	Triple P Positive Parenting Program	Young Children Children	Children/Youth in Stressed Families	3.	1,148	1,148

I. COUNTYWIDE

A total of 14 key individual interviews and 159 individuals from 17 countywide agencies/ organizations were asked to participate in focus group discussions. Nearly 300 persons attended the countywide community forum. There was one breakout session for American Indians, one for veterans, one for deaf/hard of hearing, two for gay/lesbian/bisexual/transgender/questioning, two for countywide health plans, and four sessions for juvenile justice. The 15-member Countywide Ad Hoc Steering Committee recommended priority populations, subpopulations, and EBPs/PPs that should be included in the PEI plan.

Countywide						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
	AMERICAN INDIAN					
1	American Indian Life Skills	Children TAY	Children/Youth in Stressed Families	10.	216	216
2	Trauma Focused CBT: Honoring Children, Mending the Circle	Children TAY	Trauma-Exposed	10.	200	200
	BLIND/VISUALLY IMPAIRED					
3	Group CBT for Major Depression	TAY Adults Older Adults	Underserved Cultural Populations	9.	450	
	DEAF/HARD OF HEARING					
4	Nurse-Family Partnership	Young Children	Children/Youth in Stressed Families	9.	100	100
5	Nurturing Parenting Program	Young Children Children	Children/Youth in Stressed Families	9.	300	300
6	Prolonged Exposure Therapy for PTSD	Adults Older Adults	Trauma-Exposed	9.	80	
	COUNTYWIDE HEALTH PLANS					
7	Advice Line	TAY Adults Older Adults	Children/Youth in Stressed Families Individuals Experiencing Onset of Serious Psychiatric Illness	5.	4,000	
8	Alternatives for Families	Children	Children/Youth in Stressed Families	5.	310	310
9	Cognitive Behavioral Intervention Therapy for Schools (CBITS)	Children TAY	Underserved Cultural Populations	1.	100	100
10	Incredible Years	Young Children Children	Underserved Cultural Populations	5.	10,920	10,920
11	Prevention and Early Treatment of Depression in Primary Care (CDE)	TAY Adults Older Adults	Children/Youth in Stressed Families	5.	190	
12	Triple-P Positive Parenting Program	Young Children Children	Children/Youth in Stressed Families	5.	287	287
	JUVENILE JUSTICE					
13	Aggression Replacement Training	Children TAY	Children/Youth in Stressed Families	7.	450	150
14	Cognitive Behavioral Intervention Therapy for Schools (CBITS)	Children TAY	Children/Youth art Risk for School Failure	7.	100	100
15	Functional Family Therapy	Children TAY	Children/Youth in Stressed Families	7.	384	384
16	Group CBT for Major Depression	TAY	Children/Youth in Stressed Families	7.	1,350	450
17	Prolonged Exposure Therapy for PTSD	TAY	Children/Youth in Stressed Families Trauma-Exposed	7.	240	80

Countywide						
Program		Age Group	Priority Populations to be Served	Project No.	Approx. Annual Unduplicated Clients	
					Individ.	Fam.
18	Trauma Focused CBT	Children TAY	Children/Youth in Stressed Families Trauma-Exposed	7.	200	200
	LGBTQ					
19	GLBT Champs (CDE)	TAY	Underserved Cultural Populations	9.	100	100
20	Group CBT for Major Depression	TAY Older Adults	Underserved Cultural Populations	9.	450	150
21	Trauma Focused CBT	TAY	Underserved Cultural Populations	9.	200	200
	VETERANS					
22	Prolonged Exposure Therapy for PTSD	TAY Adults Older Adults	Individuals Experiencing Onset of Serious Psychiatric Illness Trauma-Exposed	4.	1,120	200
23	System Navigators	TAY Adults Older Adults	Individuals Experiencing Onset of Serious Psychiatric Illness Trauma-Exposed	4.	600	

It is important to note that although certain programs were specifically targeted for the special countywide populations due to needing a broader service approach, several of the projects and programs also target the special populations for service delivery. All of the LACDMH PEI projects and programs address disparities in access to services, whether related to cultural, language, race/ethnicity, physical disability, poverty, stigma, or other barriers that need to be dismantled.

Instructions: Please provide a narrative response and any necessary attachments to address the following questions. (Suggested page limit including attachments, 6-10 pages)

County: Los Angeles Date: June 30, 2009

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process

Marvin J. Southard, DSW	Director, Los Angeles County Dept. of Mental Health (LACDMH)
William Arroyo, MD	Children's Medical Director, LACDMH
Dennis Murata, MSW	Deputy Director, Program Support Bureau (PSB)
Lisa Wicker, LCSW	District Chief, PSB PEI Administration Unit
Lillian Bando, JD, MSW	Division Chief, PSB PEI Administration Unit

b. Coordination and management of the Community Program Planning Process

The County developed a team comprised of DMH staff and consultants to coordinate and manage the Community Program Planning Process.

LACDMH Prevention and Early Intervention Administration Unit

William Arroyo, MD	Children's Medical Director
Dennis Murata, MSW	Deputy Director, Program Support Bureau (PSB)
Lisa Wicker, LCSW	District Chief, PSB PEI Administration Unit
Lillian Bando, JD, MSW	Division Chief, PSB PEI Administration Unit
Mary Silvestrini, LCSW	Program Head, PSB PEI Administration Unit
Randall Ahn, PhD, MLIS	Sr. Community Psychologist, PSB PEI Admin. Unit
Lea Bush, MSW, MPA	Mental Health Analyst I, PSB PEI Administration Unit
Kristen Laws, MSW	Mental Health Analyst I, PSB PEI Administration Unit

PEI Consultants

Yvette Townsend, LCSW	Consultant
Cora Fullmore, LCSW	Consultant
Walter R. McDonald & Associates (WRMA)	Consultant
EvalCorp Research & Consulting	Consultant
Laura Valles & Associates	Consultant
California Institute of Mental Health (CiMH)	Consultant

In addition to the PEI Administration Unit staff listed above, the following DMH units and advisory groups also had responsibility for outreach and ensuring stakeholder participation in the Community Program Planning Process

Underrepresented Ethnic Groups (UREP)	
Gladys Lee, LCSW	District Chief, PSB Planning Division
Age Group Leads	
Olivia Celis-Karim, MPL, LCSW	Deputy Director – Children
Sam Chan, PhD	District Chief – Children
Sandra Thomas, LCSW	Deputy Director – Transition-age Youth
Terri Boykins, LCSW	District Chief, Transition-age Youth
Debbie Innes-Gomberg, PhD	District Chief – Adults
Carl McKnight, PhD	Psychologist – Adults
Carlotta Childs-Seagle, LCSW	Acting Deputy Director – Older Adults
James Cunningham, PhD	Psychologist – Older Adults
Service Areas	
JoEllen Perkins	District Chief – Service Area 1
Ron Klein	District Chief – Service Area 2
Eva Carrera	District Chief – Service Area 2
Alfredo Larios	Division Chief – Service Area 3
Edward Vidaurri	District Chief – Service Area 4
Karen Williams	District Chief – Service Area 5
Yolanda Whittington	District Chief – Service Area 6
Ana Suarez	District Chief – Service Area 7
Cathy Warner	District Chief – Service Area 8

c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

The LACDMH PEI Administration Unit worked with the Mental Health Commission and the MHSA Stakeholder Delegates to ensure that community stakeholders were involved in all stages of the planning process. Toward this end, several Advisory Groups were specifically established to provide input into the initial planning steps, development of guidelines, the plan development, and service area recommendations. In order to minimize barriers to participation, the County provided interpretation services as well as translated materials in the various threshold languages, American Sign Language interpretation for deaf and hard of hearing participants, transportation, and child care services at the advisory meetings, community meetings, and other needs assessment activities, such as the key individual interviews, focus groups, and community forums. The PEI advisory groups included the following:

MHSA Stakeholder Delegates. The Los Angeles County MHSA Stakeholder Delegates group was originally formed in 2005 to obtain community input to the MHSA Community Services and Supports (CSS) Plan. In 2007 membership was revised and expanded to include broader representation from non-traditional mental health providers as well as the required PEI sectors (individuals with serious mental health illness and/or their families, underserved cultural populations, providers of mental health services, social services, education, health, and law enforcement) and the recommended sectors (community family resource centers, employment, and media). Currently, the Stakeholder Delegates group is comprised of over 100 community representatives from the PEI sectors, various L.A. County departments, community organizations, racial/ethnic groups, and special needs populations groups. (See Appendix 1-A for the MHSA Stakeholder Delegates Roster.)

Ad Hoc Plan-to-Plan Advisory Group. The Plan-to-Plan Advisory Group was formed in August 2007 and met over a period of three months. The purpose of the Plan-to-Plan Advisory Group was to advise the Department regarding the strategies and planning process for the County's MHSA PEI Plan. The role of the members was to provide the guidance and necessary expertise to represent the required and recommended sectors for PEI planning. The members also reviewed related documents and provided feedback to LACDMH and its PEI staff to help ensure a successful stakeholder planning process. Membership was drawn from the System Leadership Team (SLT), MHSA Stakeholder Delegates, and other PEI sector representatives. (See Appendix 1-B for the Ad Hoc Plan-to-Plan Advisory Group.)

Ad Hoc Guidelines Advisory Group. The Guidelines Advisory Group, convened from March to April 2008, developed a set of guidelines on how to develop service area PEI plans in an inclusive, consistent, and effective manner. The System Leadership Team (SLT) determined that membership should consist of MHSA Stakeholder Delegates and Alternates, with additional participants as necessary to cover required sectors for PEI planning, as well as representation from the Service Area Advisory Committee (SAAC) Chairs and District Chiefs. Members developed a mission statement and guiding principles, common expectations for the SAAC's role in the PEI planning process, and community forum models. (See Appendix 1-C for the Ad Hoc Guidelines Advisory Group.)

Ad Hoc PEI Plan Development Advisory Group. The purpose of the Plan Development Advisory Group was to provide guidance for the countywide community forum targeted at special populations and to review the Department's PEI resource manual, which included EBPs and PPs. Members from the Ad Hoc Guidelines Advisory Group were invited as members, and other individuals were sought to ensure inclusion of the special countywide populations. The Advisory Group met from October 2008 to May 2009. (See Appendix 1-D for the Ad Hoc PEI Plan Development Advisory Group.)

Service Area Advisory Committees (SAACs). Due to the large geography and large population density in Los Angeles county, Service Planning Areas were established to

ensure local planning could occur. Therefore, PEI planning built upon this existing structure. The SAACs are comprised of dedicated and experienced community leaders and have a membership ranging from 50-150 volunteers. These committees have been in existence for over 20 years and have historically played an important role in providing valuable feedback to LACDMH on programs, service delivery priorities, and budget allocation issues impacting their regions. Given their importance to LACDMH, SAAC participation in the community-based planning process has been essential to the development of locally-driven recommendations regarding which community mental health needs and populations are of the highest priority for PEI programs within a given service area. SDMH as well as the MHSOAC have emphasized the importance of building upon the CSS planning process, and using existing organizations, rather than creating new and temporary groups that will be involved in long-term MHSA planning. (See Appendix 2-A for the SAAC Co-Chairs Roster.)

Service Area PEI Ad Hoc Steering Committee. Each of the SAACs was asked to establish a PEI Ad Hoc Steering Committee (AHSC) and convene regular meetings of the AHSC. The intent of establishing the Steering Committees was to provide the regional leadership and guidance necessary for a successful PEI planning process within the service area. Eight Steering Committees were formed, comprised of 28-30 members representing the four age groups, underserved communities, required PEI sectors, a SAAC Chair, and Service Area District Chief. The dedicated members worked intensively over several months to (1) rank the importance of each priority population for a service area utilizing an evaluation tool based on findings from the service area data profiles, key individual interviews, focus groups, and community forums; (2) determine the appropriateness of Evidence-Based Practices and Promising Practices for each service area's needs, priority populations and subpopulations; and (3) develop recommendations identifying the priority populations to be served, specific subpopulations, and PEI programs to be implemented in the service areas and countywide. A by-product of the development of the Ad Hoc Steering Committees was they enabled the SAACs to engage a more diverse representation from community partners not previously involved in mental health planning. (See Appendix 2-B for the Service Area AHSC Rosters.)

2. Explain how the county ensured that the stakeholder participation process accomplished the following objectives (please provide examples):

In 2007 LACDMH initiated an intensive, inclusive, and multi-faceted approach to developing the County's MHSA PEI Plan. Community input from a broad and diverse group of stakeholders has been built into the planning process in multiple stages, both formally and informally. Active involvement by community stakeholders – consumers, parents, caregivers, family members, sector members, and other concerned individuals – in the PEI planning process was critical to developing effective, representative and culturally-appropriate PEI services. At all stages the County made a concerted decision to include all of the above-identified stakeholders in the planning process. In

order to capture the concerns of local communities, the focus for developing the PEI Plan occurred predominantly at the Service Area (SA) level, which encompasses eight geographic areas within Los Angeles County.

Phase 1: Outreach and Education

The community planning process was undertaken in three phases: (1) Outreach and Education, (2) Needs Assessment, and (3) Plan Development. The first phase started in the summer of 2007 with pre-planning activities and continued through winter 2008. Active involvement by community stakeholders – consumers, parents, caregivers, family members, sector members, and other concerned individuals – in the PEI planning process was critical to developing effective, representative and culturally-appropriate PEI services. The County's road map provides an overview of the planning stages. (See Appendix 3 for a detailed copy of the PEI Road Map.)

Initial Planning. In spring 2007 the Department began initial planning in anticipation of SDMH's release of the PEI guidelines. A core part of the planning involved strategizing to ensure meaningful involvement and engagement of diverse communities and potential individual participants, their families, and other community stakeholders. This initial planning stage resulted in the submission of LACDMH's community program planning request to SDMH.

Information Campaign. LACDMH developed a multi-media information campaign at the beginning of the PEI planning process to provide information about the PEI guidelines and to solicit community participation in the various planning activities. The information campaign included live presentations by the LACDMH PEI unit as well as outreach workers, printed materials in English and the 12 threshold languages, and PowerPoints. The information campaign resulted in the following:

- Conducted a successful countywide PEI information campaign, which included 133 presentations that reached over 5,300 community members.
- Conducted informational presentations in all eight service areas as well as many sector-related meetings (e.g., education, health, law enforcement, probation, etc.).
- Held mental health community forums sponsored with the Board of Supervisors in each of the five Supervisorial districts.
- Developed a PowerPoint slideshow in both English and Spanish for orienting individuals and organizations about PEI. (See Appendix 4 for a copy of the PowerPoint: "Prevention and Early Intervention: The Mental Health Services Act in Los Angeles County.")
- Developed and distributed a tri-fold PEI informational brochure translated in all the threshold languages (Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Simplified Chinese, Spanish, Tagalog, and Vietnamese) that provided individuals the opportunity to be added to the LACDMH information

distribution list and receive future information on the PEI plan. (See Appendix 5 for copies of the information brochures.)

- Developed and distributed a PEI orientation booklet with detailed information on the PEI planning process. (See Appendix 6 for a copy of the PEI Orientation to Planning Process booklet.)
- Developed and distributed a graphic "road map" of the PEI planning process with a narrative explanation.
- Developed the DMH PEI website, which includes an overview of the Plan, six PEI resource documents, links to PEI information on the State DMH and CiMH websites, and the PEI brochure in all of the threshold languages for L.A. County. The website can be accessed at *http://dmh.lacounty.gov/ AboutDMH/MHSA/MHSA_Plans/pei.html)*.
- Developed and distributed a PEI newsletter.
- Developed a PEI distribution database with a current membership of over 6,800 individuals to catalog outreach and engagement activities by sector, agency/organization, priority population, Service Area, and Supervisorial District, which will provide data to demonstrate the county's planning process in the PEI Plan submitted to the state.
- Developed a resource database to facilitate the identification and selection of subject matter experts, key individuals, and focus groups.

Position Papers. The Department received a number of papers from organizations stating their positions on the PEI Plan, including details on the selection of the priority populations, top community mental health needs, allocation of funding, age group emphasis, and preferred programs and/or strategies. In the interest of disseminating this information to stakeholders, LACDMH posted the position papers on its website. The presence of a paper on the website did not indicate LACDMH endorsement in any way, but it allowed for the exchange of views. LACDMH reviewed nine position papers on the PEI plan and approved and posted four PEI position papers on its website.

Phase 2: Needs Assessment

In order to create the best possible MHSA PEI Plan, it was essential that LACDMH compile and generate accurate information from a wide range of sources. To gather this information, the Department employed six different needs assessment strategies: recommendations from CSS planning, community surveys, service area data profiles, key individual interviews, focus groups, and community countywide forums. Each of these six strategies built on the knowledge gained through earlier strategies. Through each strategy, the questions being asked and answered became more specific and the depth of knowledge increased. Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical

and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI. Decision-making bodies (such as the SAACs, the MHSA Stakeholder Delegates, and LACDMH staff) were asked to examine the gathered information collectively so that there emerged a clearer picture of the county's PEI needs. As each needs assessment strategy was completed, the information was summarized and made available to the public though the MHSA PEI website.

Community Services and Supports Plan Identifying PEI Needs. The Department reviewed the reports from the CSS community planning process to identify recommendations specifically related to prevention and early intervention. This involved a review of the 29 MHSA-CSS countywide work groups and the eight Service Area Advisory Committees (SAACs) final reports. These reports, and the pertinent PEI recommendations, provided a starting point for a critical analysis and discussion relating to prevention and early intervention needs, strategies, implementation, and outcomes. Although the assessments were conducted in 2004 and the reports generated in 2004-2005, the needs that were identified then still exist, as funding for prevention and early intervention services was not yet available. The development of the MHSA PEI Plan and availability of SDMH funding for Los Angeles County offer opportunities to acknowledge and incorporate the recommendations from these earlier planning processes. The Department developed and distributed the 12-page report, *Recommendations Related to Prevention and Early Intervention from the 2005 Los Angeles County Mental Health Services Act Community Services and Supports Needs Assessment.* (See Appendix 7 for a copy of the CSS Needs Assessment report.)

Community Surveys. Beginning in October 2007, the Department distributed a community survey requesting input into planning for PEI programs in the local communities. The survey was used to gather initial feedback regarding planning priorities on PEI age groups, key community mental health needs, and priority populations. The PEI community survey was administered in English and Spanish at over 133 meetings between October 2007 and April 2008, resulting in 1500 surveys being submitted. Nearly 20% of the surveys were completed by self-identified consumers, family members, and parents. The results indicated that across Los Angeles County children are a clear priority for many individuals; however, more information needs to be gathered to determine which specific PEI priority populations should be targeted. (See Appendix 8 for a copy of the Summary of Community Survey Results.)

Data Profiles. A key tenet of the MHSA PEI planning process is that decisions should be based on objective available data. The purpose of the data profiles was to provide objective information to planners and stakeholders on the characteristics of Los Angeles County and each of the County's eight services areas. Profiles for each of the eight service areas as well as a countywide report were published. The service area data profiles consolidated demographic data relevant to PEI from a wide variety of sources. Socio-economic demographic data and mental health statistics were included. Key

indicators of risk were selected for each of the six PEI priority populations: underserved cultural populations, individuals experiencing onset of serious psychiatric illness, children/youth in stressed families, trauma-exposed, children/youth at risk for school failure, and children/youth at risk of or experiencing juvenile justice involvement. Key indicators included ethnicity, primary language, linguistic isolation, serious mental illness penetration rate, depression, co-occurring disorders, poverty, unemployment rate, disrupted families, safe place to play, child abuse statistics, elder abuse statistics, post traumatic stress disorder (PTSD), homelessness, high school graduation rates, English fluency, 3rd grade reading level, school discipline, juvenile felony arrests, youths on probation, language capacity of mental health providers, deaths by suicide, and mental health emergency statistics.

In addition, specific data profiles were developed for the special populations discussed at the countywide community forum, including the deaf/hard of hearing, veterans, gay/lesbian/bisexual/transgender/questioning individuals, and countywide health plans. The Department collaborated with the County of Los Angeles Departments of Children and Family Services, Community and Senior Services, Internal Services, Probation, Public Health, and Urban Research/GIS in the compilation of data. A special report for the PEI Roundtable in October 2008, *Vulnerable Communities in Los Angeles County: Special Edition for PEI Roundtable*, was distributed. A countywide report, *Vulnerable Communities in Los Angeles County: Key Indicators of Mental Health Fall 2008* was widely distributed. (See Appendix 9 for a copy of the *Vulnerable Communities data r*eport.) Eight reports specific to each service area, *Vulnerable Communities in Los Angeles County: Key Indicators of Mental Health Fall 2008 – Service Area*, were distributed at the community forums. Staff also compiled special reports for the Countywide Community forum. Copies of all these reports are available on the LACDMH website.

Key Individual Interviews. The purpose of the key individual interviews was to conduct in-depth discussions with individuals whose position, education, or experience indicated that they were knowledgeable about a specific community, issue, or problem which can inform mental health prevention and early intervention. Key individuals included, but were not limited to, community leaders, community members, gatekeepers, service providers, consumers, and other individuals who possess noteworthy insight and understanding about an issue, can articulate specific needs, and can assist in program planning. These individuals were also selected based on service area, priority population experience, knowledge of community mental health needs, and age group focus. The information gathered from the key individual interviews and focus groups was used to identify potential strategies for PEI program development and to guide the discussions made at the community forums. A total of 54 key individual interviews were conducted, including five in each of the eight service areas and 14 countywide from February to September 2008. The interviews represented all the PEI required sectors, as well as transition-age youth, adults, and older adults. The interviewees represented racial/ethnic diversity, including African American, Latino, Chinese, Japanese, Armenian, Vietnamese, Cambodian, and Caucasian. All of the

participants spoke English, one-quarter spoke Spanish, and about one-fourth spoke Tagalog. Additional languages spoken by smaller percentages of participants included Farsi, Armenian, Cambodian, and Chinese. The report, *Findings from the Key Individual Interviews,* was distributed to over 2500 individuals and posted on the LACDMH website. (See Appendix 10 for a copy of the Key Individual Interviews report.)

Focus Groups. The purpose of the focus groups was to determine the gaps, barriers and challenges to mental health services with community members, especially those that are currently unserved or underserved, in order to identify their concerns, issues, and recommendations for developing PEI strategies. Focus groups were composed of 6-10 individuals who explored through a structured discussion a specific priority population or key community mental health need. Focus groups drew individuals from existing groups in the required and recommended sectors. A total of 65 focus groups were held, including six in each of the eight service areas and 17 at the countywide level from April to September 2008. The 572 individuals representing all six PEI required sectors as well as TAY, adults, and older adults. The focus groups were diverse, including and included African American, Ethiopian, Hispanic, Chinese, Japanese, Armenian, Vietnamese, Cambodian, and Caucasian. Focus groups were conducted in the languages of English, Spanish, Cambodian, Korean, Mandarin, Tagalog, and Vietnamese. The findings were compiled into ten reports, including *Findings from the Focus Groups* (eight separate reports for each service area as well as one for the countywide focus groups and a summation, *Overall Summary Report of the Focus Groups*. Copies of all these reports are available on the LACDMH website. Copies of the reports were distributed to over 2500 individuals and posted the *Findings* reports on the LACDMH MHSA PEI website. (See Appendix 11 for a copy of the *Overall Focus Groups Summary Report.)*

Community Forums. The purpose of the community forums was to identify the priority populations in each service area and the key components that must exist in a PEI program. Broad and diverse community input was sought from consumers, parents, family members, mental health providers, and required and recommended PEI sector partners. The community forums were open to the general public, but were especially targeted to individuals that have an interest in mental health strategies related to prevention and early intervention. LACDMH staff collaborated with the SAAC Chairs as well as the SAACs themselves to plan for the community forums and ensure extensive outreach to ensure broad and diverse participation. SAAC community forum planning committees were established in each of the eight service areas. As co-conveners, the SAACs assisted LACDMH in selecting locations, days, times, and outreach strategies that were appropriate for their service area. There were 15 service area community forums held from October to December 2008, including two community forums in each service area, with the exception of Service Area 1, which held only one community forum. More than 1800 individuals attended the service area community forums. In addition, the January 2009 countywide community forum focusing on special populations was attended by nearly 300 individuals. Interpretation services at all community forums, and included Spanish, Cambodian, Cantonese, Korean, Mandarin,

and Vietnamese languages as well as American Sign Language interpreters. On-site childcare services and transportation services were provided at all service area and county wide community forums.

The community forums resulted in Service Area-specific recommendations for the priority populations that need to be served in the local areas and the types of program strategies required to serve these populations. The findings were compiled into ten reports, including *Findings from Community Forums* (eight separate reports for each service area and one for countywide) and a summation, *Overall Summary Report of the Community Forums.* Printed copies of the *Findings* were distributed to over 2500 individuals and posted on the LACDMH MHSA PEI website. (See Appendix 12 for a copy of the *Overall Community Forums Summary Report.)*

Phase 3: PEI Plan Development

PEI Roundtable. On October 2, 2008 the Department held the Los Angeles County PEI Roundtable. The purpose of the Roundtable was to provide an introduction to the MHSA PEI Plan; to summarize "What We've Learned So Far" through results from the needs assessments activities to date; and to enable the different sector groups to break out into nine discussion sessions to exchange information about PEI and their priority populations. The Roundtable was attended by over 350 individuals who engaged in an initial discussion on PEI priority populations. Copies of the report, *Vulnerable Communities in Los Angeles County – Special Edition for PEI Roundtable* and *Selected Findings from the Key individual Interviews*, were distributed. Afterwards, a video of the Roundtable was posted on the LACDMH website, together with the handouts, and questions and answers, was made available on the LACDMH website.

Teach-Ins. From November to December 2008, the Department co-sponsored, together with the SAACs, a "PEI teach-in" in each service area to provide an introductory training for interested stakeholders regarding EBPs, PPs, emerging practices (EPs), and CDEs. The teach-ins were intended to be an introduction to the types of programs that LACDMH would be including in its PEI Plan and that the Steering Committees would be considering in its deliberations. Over 190 individuals attended the eight Service Area teach-ins. The PowerPoint, "Understanding Evidence-Based Practices" and a webcast of the teach-in was posted on the LACDMH website for those unable to attend a live presentation. (See Appendix 13 for a copy of the PowerPoint: Understanding Evidence-Based Practices.)

Ad Hoc Steering Committee Deliberations. The Service Area PEI Ad Hoc Steering Committees were formed in fall 2008 and began meeting as early as November 2008 through the end of March 2009. A countywide steering committee for the special populations was also formed in early 2009. In order to proceed with project building, all of the community assessment information was made available to a group of ad hoc steering committees who further refined population, age, and program selections. The Steering Committees developed a set of service area recommendations identifying (1)

the top two priority populations for the children and youth age groups and the top one priority population for adults and older adults that would be served; (2) 3-5 subpopulations for each of the top priority populations selected; and (3) the PEI EBPs and PPs that should be implemented to serve these populations. The final sets of recommendations were summarized in a planning document that was utilized for developing the PEI projects at the service area and countywide levels. (See Appendix 14 for a copy of the Summary of the Service Area PEI Ad Hoc Steering Committee Recommendations.)

a. Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations.

As indicated in the above description of the County's PEI planning process, representatives and family members of unserved and underserved populations were included at all stages of the community planning. This included representation on the MHSA Stakeholder Delegates, Ad Hoc Advisory Groups, and eight Service Area and one Countywide Ad Hoc Steering Committees. In addition, representatives and family members were interviewed during the key individual and focus group sessions. Extensive participation from these groups was seen in the Roundtable, teach-ins, and community forums. Representatives and family members included individuals from the African-American; American Indian; Asian/Pacific Islander (including Cambodian, Chinese, Japanese, Korean, Pilipino, Samoan, Tongan, and Vietnamese); Hispanic (Mexican, El Salvadoran, and other Central and South Americans); Middle Eastern (Armenian and Iranian); and Eastern European (Polish). Consumer and family groups included NAMI, the Mental Health Association, the Client Coalition, and other consumer groups.

b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, race/ethnicity and language.

Geographic Location. The PEI community planning process has been focused at the Service Area (SA) level, which encompasses eight geographic areas within Los Angeles County. Each of the SAs has distinct and varying demography, geography, resources, and other factors that make it critical for PEI services to be specific to regional and community-based needs. Encompassing 4,084 square miles, Los Angeles County is one of the nation's largest counties in geographic area. Approximately 27% of California's residents live in this County. There are 88 cities within the county, each with its own city council. More than 65% of the county is unincorporated. To ensure geographic diversity, LACDMH undertook the following activities:

- From the outset of the PEI planning, LACDMH conducted outreach and information activities at the service area meetings and local community meetings.
- Staff held two meetings with the Service Area Advisory Committee (SAAC) chairs to orient them to the PEI planning process, obtain their input into the planning

strategies, and develop local planning committees to co-sponsor the community forums.

- In each service area, five key individual interviews were conducted with community leaders from the local area, and 14 interviews were held with individuals representing interests that were countywide and not specifically tied to a service area.
- In each service area, six focus groups reflecting the special concerns of the particular local community were conducted. In addition, 17 focus groups representing countywide concerns and drawing from participants throughout the entire county were conducted.
- The community forums were held in Bell Gardens, Carson, Culver City, Glendora, Lancaster, Long Beach, Los Angeles (6 different sites), Mission Hills, Norwalk, Pasadena, and Van Nuys.
- Free transportation was made available at each of the community forums, including taxi vouchers, and van pickup. Childcare was provided at all of the community forums and at focus groups as needed.
- Ad Hoc PEI Steering Committees were established in each of the service areas as well as a countywide Steering Committee.

Age. In 2005 the median age in the County was 33.7 years, which made it one of the most youthful areas in the country. Twenty-eight percent (28%) of the population was under 18 years and 10% was 65 years and older.

- Three-quarters of the key individual interviewees were adults, just under one-quarter were older adults, and one participant was a transition-age youth.
- Two focus groups were conducted with TAY and seven groups with older adults (included organizations that served senior citizens).
- The community forum breakout groups were structured by age groups, and TAY participated at all of the community forums, and at least 1-2 breakout sessions focusing on this age group were held. Likewise, older adult attendance was present at all the community forums, and older adult breakout groups were formed.

Gender. The population in Los Angeles County in 2005 was comprised of 4.9 million females (51%) and 4.8 million (49%) males. The trend in participation at all stages of the needs assessment and advisory groups has been two-thirds female and one-third male, reflecting the predominance of women in the human services and caregiving field.

Sexual Orientation. West Hollywood ranks as the fourth largest city in the U.S. with a gay/lesbian population. The Los Angeles-Long Beach metropolitan area is also ranked number 2 across the nation in the numbers of gay/lesbian households with children.

- The Stakeholder Delegates, Ad Hoc PEI Advisory Groups, and Steering Committees were structured to ensure representation by the LGBTQ population.

- The key individual interviews included a representative of the LGBTQ community and a focus group was held with LGBTQ individuals.
- The LGBTQ community was one of the specifically-identified countywide populations and two breakout sessions were conducted at the countywide forum in January.
- Specific LGBTQ recommendations were generated by the LGBTQ subcommittee of the Ad Hoc PEI Countywide Steering Committee.

Race/Ethnicity. Minorities constitute the majority in Los Angeles. The ethnic breakdown is comprised of 47% Hispanic, 30% White non-Hispanic, 13% Asian, 9% African-American, 1% American Indian/Alaskan Native, and 0.5% Native Hawaiian/Pacific Islander. In terms of heritage, 36% of the people living in the County in 2005 were foreign-born, 64% were native-born. While members of the public who attended the community forums were not asked to indicate their ethnicity, at all the community forums, the participants represented a very racially diverse group. Concerted outreach efforts were made in local communities, especially those with greater concentrations of a specific race/ethnicity, to promote participation in the PEI planning.

- The Stakeholder Delegates, Ad Hoc PEI Advisory Groups, and Steering Committees were structured to ensure participation by a broad diverse race and ethnic groups, specifically representatives from the African-American, American Indian, Asian/Pacific, Hispanic, and Eastern European/Middle Eastern groups.
- Approximately half of the key individual interviewees were Caucasian, 15% were Latino/Hispanic, 10% were Asian/Pacific Islanders, 8% were Eastern European/Middle Eastern, 7% were African-American, 6% were American Indian, and 4% were other ethnicities.
- Fourteen (14) focus groups were specifically targeted for racial/ethnic groups.

Language. In terms of heritage, 36% of the people living in the County in 2005 were foreign-born. Among people at least five years old, 60.1% spoke a language other than English at home. Of these, 61.8% spoke Spanish.

- The informational brochures were written in English and the 12 threshold languages.
- The PEI informational PowerPoint was in both English and Spanish.
- The community survey was available in both Spanish and English.
- Focus groups were conducted in Spanish, Cambodian, Korean, Mandarin, Tagalog and Vietnamese.
- Spanish language interpreters and facilitators were available at all 16 community forums. Two of the forums had Korean language interpreters and facilitators; one had both Cantonese and Mandarin interpreters. Spanish language materials were available at the community forums, including the evaluation forms.
- Spanish, Korean and ASL language interpreters were available at the Ad Hoc Steering Committee meetings as required.

- Although the key individual interviewees spoke English, one-quarter also spoke Spanish, and about one-fourth spoke Tagalog. Additional languages spoken by smaller percentages of participants included Farsi, Armenian, Cambodian, and Chinese.

Deaf/Hard of Hearing. About two to four of every 1,000 people in the United State are "functionally deaf," though more than half became deaf relatively late in life, and one out of 1,000 people became deaf before 18 years of age. The County is committed to addressing the mental health issues that arise due to the difficulty with dealing with mental health illness among deaf and non-deaf children and/or their deaf and non-deaf parents. LACDMH ensured that persons who are deaf or hearing impaired had meaningful opportunities to participate in the PEI activities.

- Deaf/hard of hearing representatives serve on the MHSA Stakeholder Delegates, Ad Hoc Advisory Groups, and Steering Committees.
- A key individual interview was held with a deaf/hard of hearing representative, and another focus group was held with deaf participants.
- American Sign Language interpreters provided services for the deaf/hard of hearing at all of the community forums, including tactile signing.

b. Included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate.

The County is dedicated to promoting the participation of clients with serious mental illness and/or serious emotional disturbance and their family members (parents, relatives, and other caregivers) at all stages of the PEI planning process. These included:

- Membership on the MHSA Stakeholder Delegates, all three Ad Hoc PEI Advisory Groups, and Service Area and Countywide Ad Hoc Steering Committees.
- Inclusion as participants in the key individual interviews, focus groups, and community forums.
- Outreach to consumer/client groups including the Mental Health Association, National Association of Mentally Ill, Client Coalition, Underrepresented Ethnic Groups, and other groups.

3. Explain how the county ensured that the Community Program Planning Process included the following required stakeholders and training:

a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:

- **Individuals with serious mental illness and/or serious emotional disturbance and/or their families**

- **Providers of mental health and/or related services such as physical health care and/or social services**
- **Educators and/or representatives of education**
- **Representatives of law enforcement**
- **Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families**

LACDMH ensured there was participation by all essential stakeholders in all stages of the PEI Community Program Planning Process, from the pre-planning stages to the final public review, including the MHSA Stakeholder Delegates, three Ad Hoc PEI Advisory Groups, and Ad Hoc Steering Committees. Community members participated in the countywide PEI sector informational meetings, community surveys, key informant interviews, focus groups, community forums, SAAC meetings, SAAC Ad Hoc Work Groups, Board of Supervisors mental health forums, as well as other informational meetings. DMH conducted extensive outreach to encourage participation by all the PEI sectors.

Almost half of the key individual interviewees were mental health advocates, 41% were mental health service providers, 37% were health/human services/social services providers, 28% were interested community members, 22% were county employees, 20% were family members of consumers of mental health services and/or other. Additionally, 15% were other government employees and 9% were consumers of mental health services.

The chart on the next page lists the number of participants by sector at each our LACDMH's planning activities. In many instances the Department did not have the specific information as the membership or affiliation of participants was not identified, and these activities are not listed on the chart. Also, self-identification as an individual with SED or SMI, or a family member dealing with these issues, was understandably low.

PARTICIPANTS IN PEI PLANNING BY SECTOR								
PEI PLANNING GROUPS / ACTIVITIES	REQUIRED PEI STAKEHOLDER / SECTOR GROUPS							
	Individuals. w/SMI and/or SED and/or Their Families	Underserved	Mental Health	Health	Education	Social Services	Law Enforcement	Other Organizations/Info Not Available
ADVISORY GROUPS								
MHSA Stakeholder Delegates	6	10	10	5	4	3	5	48
Ad Hoc PEI Plan-to-Plan Advisory Group	4	5	19	6	2	5	6	7
Ad Hoc PEI Guidelines Advisory Group	4	4	5	3	3	3	2	2
Ad Hoc PEI Plan Development Advisory Group	4	3	5	2	2	2	2	2
SERVICE AREA A AD HOC PEI STEERING COMMITTEES								
Countywide Steering Committee	3	8	0	2	0	0	2	0
SA 1 - Antelope Valley	3	6	2	2	2	2	2	9
Sa 2 – San Fernando Valley	3	9	2	2	2	2	2	7
SA 3 – San Gabriel Valley	3	8	2	2	2	2	2	7
SA 4 – Central Los Angeles	3	7	2	2	2	2	2	9
SA 5 – West LA/Santa Monica	3	7	2	2	2	2	2	9
SA 6 – South Los Angeles	3	7	2	2	2	2	2	9
SA 7 – East	3	9	2	2	2	2	2	8
SA 8 – South Bay/Long Beach	3	8	2	2	2	2	2	8
ROUNDTABLE AND COMMUNITY FORUMS (this information was not always available for all participants)								
PEI Roundtable	15	66	76	22	37	27	4	53
Countywide	48	47	88	35	28	49	10	55
SA 1 Lancaster	19	10	29	17	17	25	5	20
SA 2 Van Nuys	17	21	33	7	22	12	3	16
SA 3 Mission Hills	26	7	22	8	10	10	5	13
SA 3 Pasadena	36	28	65	10	23	18	2	19
SA 3 Glendora	37	15	20	7	9	8	1	6
SA 4 Los Angeles Downtown	31	29	64	13	13	24	3	27
SA 4 Los Angeles Mid-Wilshire	12	15	20	13	5	11	0	21
SA 5 West LA/Santa Monica	15	9	25	9	14	15	5	10
SA 5 Culver City	8	6	5	5	0	5	1	5
SA 6 Los Angeles Midtown	59	33	59	16	15	32	5	33
SA 6 Southwest College	19	26	15	4	6	8	1	28
SA 7 Norwalk	55	26	50	9	36	24	5	40
SA 7 Bell Gardens	25	13	14	6	12	21	3	27
SA 8 Carson	44	10	43	22	14	11	4	60
SA 8 Long Beach	26	9	18	13	10	7	0	25
TOTALS	492	370	646	216	271	307	57	458

b. Training for county staff and stakeholders participating in the Community Program Planning Process.

The County provided training for county staff and stakeholders at all stages of the community planning process. The following training activities were undertaken:

- Information about the PEI plan was disseminated at community and LACDMH staff meetings, including meetings in each service area and supervisorial district.
- Special information meetings were held focusing on the law enforcement and health sectors that addressed specific issues relating to these particular sectors, and special presentations were made to the Probation Department and the Los Angeles County Office of Education.
- Staff gave presentations at each Service Area Advisory Committee not only to provide information about the PEI planning process, but to encourage participation at all stages and on multi-levels of the process.
- Staff conducted orientation and training for the Steering Committee members to ensure their fullest participation in the selection and recommendations for the PEI programs.
- Teach-ins conducted by CiMH were held in each service area to provide community members with a general overview on EBPs, PPs, and CDEs.
- Training was specifically given to the SAAC Chairs, as the SAACs played a key role in organizing the Ad Hoc Steering Committees.
- Training was conducted by CiMH to advise the Steering Committees about the PEI EBPs and PPs in the Resource Manual to assist the members in selecting programs appropriate for their service area.
- Extensive information about the County's PEI planning process was posted on the LACDMH website and sent to over 6800 persons on the PEI database.

4. Provide a summary of the effectiveness of the process by addressing the following aspects:

a. The lessons learned from the CSS process and how these were applied in the PEI process.

Below is a brief description of lessons learned and the major implications for LACDMH's PEI planning process. The lessons focus on the CSS successes, failures, implementation barriers, innovations, and creative solutions to problems encountered during the CSS planning and implementation process. These improved approaches build upon the CSS process and addressed anticipated challenges to the PEI planning process.

Lessons Learned from the CSS Planning Process		
Lessons Learned	Challenges	Improved PEI Approach
Preliminary planning needs to begin as early as possible	*Planning needs to start far in advance of the release of final guidelines. Staff need to be aware of the SDMH and MHSOAC's preliminary plans*	Staff began developing initial planning strategies as State guidelines were being developed
Sufficient resources must be allocated early on to achieve goals and objectives	*At the onset of the CSS process, insufficient staff and resources were assigned to manage this extensive community outreach and planning effort. County bureaucracy made it difficult to purchase supplies and cover non-traditional expenses*	In advance of the notice for SDMH community planning funds, LACDMH identified the number of staff, type of positions needed, consultants, and other resources that would be required in the PEI planning process. A consultant agency was hired to assist LACDMH with the facilitation and event coordination for the key individual interviews, focus groups, and community forums.
Develop a plan with clearly defined stages and targeted deadline dates to guide the process within an achievable, realistic framework to have a clear and organized process.	*Participants were not clear what the steps were in the CSS planning process and where they were going. Stakeholders felt some activities took too long, while others left them feeling too rushed to make a decision.*	Finding the right balance between speed and efficiency versus comprehensiveness and inclusion will be important for future planning efforts. A mission statement and guidelines and documentation (roadmap, process diagrams, meeting minutes) were developed.
Identify as early as possible to stakeholders the limitations imposed in the PEI guidelines and planning process to manage expectations	*In contrast to CSS where the guidelines changed during the initial course of planning, the final PEI guidelines were determined before LACDMH began its formal planning process. The need to balance the constraints of the MHSA and PEI requirements with the call for broad community and sector input can appear contradictory.*	The County conducted an extensive outreach and education campaign to explain the PEI guidelines.
Build on existing frameworks as much as possible and utilize the community structures built during the CSS process	*The SAACs had been actively involved in the CSS process. However, the CSS plan was presented as a county-wide plan and did not adequately reflect the specific service area concerns. This resulted in distrust in participating in another MHSA planning process.*	Rather than creating a duplicative system, DMH involved and relied on the existing stakeholder groups to provide input into the planning process and generate recommendations for the PEI plan. These groups were expanded to include representatives from the required and recommended sectors.

Lessons Learned from the CSS Planning Process		
Lessons Learned	Challenges	Improved PEI Approach
Focus the planning at the service area level and ensure that the PEI plan clearly reflects the specific service area recommendations.	*The CSS process started as a broad-based community organizing effort that solicited a wide range of viewpoints, and then gradually narrowed as the final State guidelines were determined for the CSS plan. This very broad effort taxed LACDMH capacity and disillusioned some participants who viewed the narrowed focus at the end as disregarding their input.*	At the outset LACDMH decided that the focus of the PEI planning efforts would be at the Service Area level so that services were based on service area data, expressed needs, and local input. The SAAC involvement, Service Area community forums, and Service Area Ad Hoc Steering Committees were expressly intended to fulfill this commitment.
Establish effective communications	*There had been no formal CSS kickoff campaign and some people were not aware of the progress of the planning.*	A five-month information campaign was carried out and a Roundtable was held to share the results of the needs assessments, kick off the community forums, and start the plan development.
Ensure that culturally diverse input from all groups, including underserved populations is maintained and recognized	*Diverse voices were included in the CSS Plan, but another level of input, PEI required and recommended sectors, was a new facet. CSS participants wanted formal incorporation and recognition in the planning process of diverse voices.*	Participants at all stages in the planning process (informational meetings, key individual interviews, focus groups, roundtable, community forums, and database inclusion) were asked to identify their sector representation. Membership on the Steering Committees included specific race/ethnic representation in addition to the age and sectors groups.
Have a transparent, inclusive process	*Because people get involved in the process at different points in time, it was not always clear what LACDMH was planning*	Outreach efforts laid out the timelines, steps and activities for the planning process. The MHSA Stakeholders made key decisions impacting the PEI plan at their meetings, as did the Steering Committees. These were reported to the SAACs and community at large.

b. Measures of success that outreach efforts produced an inclusive and effective community program planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth.

The County's success in outreach efforts culminating in an inclusive and effective community program planning process includes both quantitative and qualitative measures. From the outset of its planning process, LACDMH monitored the breadth of stakeholder involvement as well as the satisfaction of the participants.

Quantitative Measures. These included tracking the number of stakeholders involved in the community program planning process, as well as the engagement of diverse participants.

- Over 5,300 persons were outreached to in the 133 PEI informational presentations.
- A 6,800 member PEI distribution database was compiled based on individuals who had indicated an interest in participating in the PEI planning process.
- A total of 54 persons participated in the key individual interviews, including a racially/ethnically diverse group of African Americans, Asian/Pacific Islanders, Middle Eastern/Eastern European, Latino/Hispanic, Native American, LGBTQ, deaf/hard of hearing, and immigrant and refugees groups.
- A total of 572 persons participated in the 65 focus groups that included representatives from all of the priority populations, required and recommended PEI sectors, individuals from the underserved cultural populations identified above, TAY, adults, and older adults. In addition to English, the focus groups were conducted in Cambodian, Korean, Mandarin, and Vietnamese.
- Over 1800 individuals participated in the Roundtable, 15 service area community forums, and one countywide community forum, including individuals from the underserved cultural populations identified above, TAY, adults, and older adults.
- Over 260 individuals participated in the service area and countywide Ad Hoc Steering Committees, including individuals from the underserved cultural populations identified above and the required and recommended sectors. In addition, community members attended the AHSC meetings which were open to the public.

Qualitative Measures. At the conclusion of the each needs assessment effort, participants were asked to rank their satisfaction with the planning process and their ability to give meaningful input to the process. The participants evaluated the PEI activity on a scale of 0-5 (with 5 being the highest and very satisfied). The return rate for the evaluations ranged from 60% to 93%. Overall, participants rated their satisfaction with the process and ability to give meaningful input as extremely high.

- Key Individual Interviews: Evaluation respondents scored their satisfaction with the interview process at 4.94. Respondents commented, *"The interview process was very helpful and gave me an opportunity to see aspects of our community in a new light" and "Thank you for allowing me to be part of this process."*
- Focus Groups – Evaluation respondents scored their overall satisfaction with the focus group process at 4.87. Respondents frequently commented that what they liked best about the process was "*The opportunity for everyone to speak to the questions," "Diversity of participants but similarities in focus," and "Opportunity to provide input at initial step."*
- Roundtable – Evaluation respondents scored their satisfaction with various aspects of the roundtable at 4.43. Respondent comments about what they liked best about the process included, "*It was a great opportunity to obtain a more*

comprehensive overview of PEI," "Great to meet other sector members and good questions posed," and "Great idea! Would have liked more time for the breakout groups to respond to all the questions because a lot of ideas were being generated"

- Community Forums – Evaluation respondents scored their overall satisfaction with the community forum process at 4.69. Representative frequent comments were, "*Well organized. I hope our ideas and input will be used and/or will help to enhance mental health services in our community.*" "*It was a great experience, great facilitators, there should be more forums like this.*" "*Excellent facilitation & engagement of all participants.*" "*It was very to the point! I liked it a lot! Made some good contacts and am optimistic about the future possibilities," "We needed more time in the breakout groups because we had so many ideas and this was a great way to tell what we thought."*

5. Provide the following information about the required county public hearing:

a. The date of the public hearing:

The Public hearing for the County's PEI plan was held on Thursday, June 25, 2009.

b. A description of how the PEI Component of the Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any other interested parties who requested it.

Copies of the proposed PEI Plan and Summary Plan Highlights were circulated to stakeholders and other interested parties via the methods in the charts below.

Distribution of Draft PEI Plan		
Method	**Target Audience**	**Number**
Electronic Notice	Notice was sent via the LACDMH PEI e-mail distribution list that the PEI Plan had been posted on the LACDMH website, including a link to the website, contact person, and instructions on how to provide public comments. A separate notice about the public hearing was also sent.	Over 3000
Mailing of Notice	Notification of the plan's posting was sent via U.S. Postal Service to individuals on the PEI distribution list who did not have e-mail. Print copies were mailed upon request. Postcards announcing the public hearing data and agenda were also mailed to individuals on the LACDMH PEI database who did not have an e-mail address.	Over 900 notifications

Distribution of Draft PEI Plan		
Method	**Target Audience**	**Number**
Mailing or Pick-up of Printed Copies	Printed copies of the PEI Plan were mailed to individuals who requested hard copies. Copies were also given to individuals who came to DMH to pick up print copies. A total of 30 hard copies were distributed.	30
Website	The PEI Plan was posted on the LACDMH website, together with notice about the public hearing and a public comment form.	Not available
Meetings	A 12-page Summary of PEI Plan Highlights was distributed to the Stakeholder Delegates, Mental Health Commission, Service Area Advisory Committee members, Ad Hoc PEI Steering Committee members, provider meetings, community meetings, and other LACDMH meetings.	Over 700

c. A summary and analysis of any substantive recommendations for revisions.

After the draft PEI Plan was developed, there were three opportunities for public comment and recommendations. The first was the MHSA Stakeholder Delegates meeting held on May 22, 2009. The second opportunity was during the public comment period from May 26 to June 24. The third opportunity was at the public hearing held on June 25, 2009.

Changes to Service Area Plans. The Department presented the Draft PEI Plan at the MHSA Stakeholder Delegates meeting on May 22, 2009. The Delegates achieved full consensus affirming that the PEI planning process and the proposed PEI Plan satisfied the key process and structural thresholds established by the Delegates. However, the Delegates' affirmation was based on reconciling the Service Area program selections with those appearing in the proposed PEI Plan. There was concern that some of the Service Areas' program recommendations were not the same as the ones that appeared in the proposed PEI Plan for their Service Area. It was explained that these program changes occurred because the program costs had to be reconciled with the available funds for the Service Area. Due to time constraints, however, these program changes were not communicated to the Service Areas before the Delegates meeting on May 22, 2009. Several Delegates stressed that it would be important to consult and communicate directly with the Service Areas and Countywide group to explain these changes.

Thereafter, during the public comment period, LACDMH staff contacted the Co-Chairs for the Service Area Ad Hoc Steering Committees, and also in some instances the

SAAC Chairs, to determine whether the Committees wished to reconvene to review the Plan and reconsider their recommendations. Similarly, with regard to the Countywide Steering Committees for the six special population groups, the Department contacted the subject matter representatives of each Countywide Steering Committee. In some instances, the Committees chose to reconvene and made some changes to their original recommendations as well as to the DMH recommended programs. Five of the eight Service Area Steering Committees decided to make some program changes. Four of the Countywide Steering Committees decided to reconsider the DMH recommended programs, but only one group ultimately decided to make a change. The decisions to reconsider and revise the service area programs were made following the Ad Hoc Steering Committee guidelines. The changes primarily centered around the CDEs, as the CDE Guide was not yet available for review by the Committees when they deliberated in March 2009. The changes resulted in substantive changes to the Plan.

Addition of Program Serving the Blind/Visually Impaired. At the MHSA Stakeholder Delegates meeting on May 22, 2009 the Delegates recommended that services be provided to the blind/visually impaired. The Department identified a program to serve this population at the countywide level. Recognizing that services would need to be adapted to serve this population, staff is working with representatives from the blind/visually impaired community at the implementation stage to ensure the program is appropriate to this population. Scheduled actions include a key individual interview and a focus group with blind/visually impaired individuals.

Circulation of Substantive Changes to Proposed PEI Plan. The changes to the draft PEI Plan were circulated at SAAC meetings, provider meetings, the June 24th MHSA Stakeholder Delegates meeting, and the public hearing on June 25th. Thereafter, the changes were posted on the LACDMH website and notification was sent to the PEI stakeholders about the revised plan sent to the State. In response to these changes, public comments received about the changes primarily focused on three aspects: first, how the changes were made (process); second, who made the changes (stakeholder input); and third, why the changes were made (rationale).

With regard to the process, there was concern expressed about who made the decision to make the changes. It was explained that after presentation of the draft plan at the May 22nd Stakeholder meeting, the Delegates requested and the Department concurred that LACDMH staff would offer the opportunity for the Steering Committees to reconsider and revise the programs during the 30-day public comment period. LACDMH staff attended the Steering Committee meetings to provide information about the PEI plan and the Evidence-Based Practices, Promising Practices, Community-Defined Evidence programs, and pilot programs that comprised the PEI Plan.

With regard to input on the revisions, there was concern expressed that the stakeholders who had been principally involved in developing the plan were not consulted about the changes. LACDMH indicated that to the contrary, all the same bodies that had formulated the initial PEI recommendations, namely the Service Area

Steering Committees and Countywide Steering Committee, were consulted about the draft Plan proposed by the Department. In the reconsideration and review stage, these groups followed the same rules and procedures that had guided their initial deliberations, including quorum requirements, consensus, and voting.

With regard to the reasons for changes, there were comments about why certain programs were added or deleted. It was explained that the original plan had been for the Steering Committees to consider CDEs in their deliberations, but that the CDE review process had been delayed and could not be completed until more than a month after the deliberations had concluded. In general, the comments were positive about switching some EBPs for CDEs and especially adding more CDEs reflecting the needs of their communities. In the one instance (American Indian Project) where a CDE recommended by the Department had been switched to an EBP, it was explained that the Steering Committee had originally recommended the EBP and wished to have that program implemented.

The following chart summarizes the changes that were made to the draft PEI Plan in response to stakeholder input during the 30-day comment period.

Summary of Programmatic Changes to the PEI Plan
During the 30-Day Public Comment Period

Age Group	Draft Plan Programs	Final Plan Programs	Comments re Changes
Service Area 1 – Antelope Valley			
Young Children 0-5	Nurse-Family Partnership	Nurse-Family Partnership	*No Changes.*
	Triple P	Triple P	
Children 6-15	Families and Schools Together	Families and Schools Together	
	Olweus Bullying Prevention	Olweus Bullying Prevention	
Transition-age Youth 16-25	Psychological First-Aid	Psychological First-Aid	
	Group CBT for Major Depression	Group CBT for Major Depression	
	Prolonged Exposure for PTSD	Prolonged Exposure for PTSD	
Adults 26-59	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	Prolonged Exposure for PTSD	Prolonged Exposure for PTSD	
	Group CBT for Major Depression	Group CBT for Major Depression	
Older Adults 60+	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	Prolonged Exposure for PTSD	Prolonged Exposure for PTSD	
	IMPACT	IMPACT	
Service Area 2			
Young Children 0-5	Incredible Years	Incredible Years	*EDIPP Program eliminated. Funding shifted to expand the CAPPS program.*
	Making Parenting a Pleasure	Making Parenting a Pleasure	
	UCLA Ties Transition Model	UCLA Ties Transition Model	
	Child-Parent Psychotherapy	Child-Parent Psychotherapy	

Age Group	Draft Plan Programs	Final Plan Programs	Comments re Changes
	Parent-Child Interaction Therapy	Parent-Child Interaction Therapy	*CAPPS is a CDE that the Ad Hoc Steering Committee did not have the opportunity to consider in their initial deliberations in March 2009.*
Children 6-15	Families and School Together	Families and School Together	
	Aggression Replacement Training	Aggression Replacement Training	
	Brief Strategic Family Therapy	Brief Strategic Family Therapy	
	Parent-Child Interaction Therapy	Parent-Child Interaction Therapy	
Transition-age Youth 16-25	Trauma Focused CBT	Trauma Focused CBT	
	CAPPS	CAPPS	
	EDIPP	CAPPS*	
	Aggression Replacement Training	Aggression Replacement Training	
	Multidimensional Family Therapy	Multidimensional Family Therapy	
Adults 26-59	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	CBT for Depression with Antidepressant Medication	CBT for Depression with Antidepressant Medication	
	Group CBT for Major Depression	Group CBT for Major Depression	
Older Adults 60+	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	CBT for Late Life Depression	CBT for Late Life Depression	
	Live Well, Live Long, Steps to Mental Wellness	Live Well, Live Long, Steps to Mental Wellness	
Service Area 3 – San Gabriel Valley			
Young Children 0-5	Incredible Years	Incredible Years	*No changes.*
	Triple P	Triple P	
	Trauma Focused CBT	Trauma Focused CBT	
Children 6-15	Early Risers Skills for Success	Early Risers Skills for Success	
	Incredible Years	Incredible Years	
	Trauma Focused CBT	Trauma Focused CBT	
Transition-age Youth 16-25	Trauma Focused CBT	Trauma Focused CBT	
	Prolonged Exposure for PTSD	Prolonged Exposure for PTSD	
	Interpersonal Psychotherapy for Depression	Interpersonal Psychotherapy for Depression	
	Asian American Family Enrichment Network	Asian American Family Enrichment Network	
Adults 26-59	Group CBT for Major Depression	Group CBT for Major Depression	
	Crisis Resolution Services	Crisis Resolution Services	
	Prolonged Exposure for PTSD	Prolonged Exposure for PTSD	
	Maternal Wellness	Maternal Wellness	
Older Adults 60+	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	CBT for Late Life Depression	CBT for Late Life Depression	
	PEARLS	PEARLS	
Service Area 4 - Downtown			
Young Children 0-5	Nurse-Family Partnership	Nurse-Family Partnership	*No changes.*
	Incredible Years	Incredible Years	

Age Group	Draft Plan Programs	Final Plan Programs	Comments re Changes
	Child-Parent Psychotherapy	Child-Parent Psychotherapy	
	Parent-Child Interaction Therapy	Parent-Child Interaction Therapy	
Children 6-15	CBITS	CBITS	
	Multidimensional Family Therapy	Multidimensional Family Therapy	
	Incredible Years	Incredible Years	
	Triple P	Triple P	
	Caring for Our Families	Caring for Our Families	
	LIFE Program	LIFE Program	
Transition-age Youth 16-25	Nurse-Family Partnership	Nurse-Family Partnership	
	Prolonged Exposure for PTSD	Prolonged Exposure for PTSD	
	Seeking Safety	Seeking Safety	
	EDIPP	EDIPP	
	LIFE Program	LIFE Program	
Adults 26-59	Seeking Safety	Seeking Safety	
	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	Maternal Wellness	Maternal Wellness	
	Group CBT for Major Depression	Group CBT for Major Depression	
Older Adults 60+	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	Gatekeeper Case-finding Model	Gatekeeper Case-finding Model	
	Live Well, Live Long, Steps to Mental Wellness	Live Well, Live Long, Steps to Mental Wellness	
Service Area 5 - West			
Young Children 0-5	Child-Parent Psychotherapy	Child-Parent Psychotherapy	*Replaced Parent-Child Interaction Therapy with Reflective Parenting Program. Replaced Second Step with CBITS. Replaced Prevention & Early Treatment of Depression in Primary Care with CAPPS.* *Reflective Parenting Program and CAPPS are CDEs that the Ad Hoc Steering Committee did not have the opportunity to consider in their initial deliberations in March 2009. CBITS was originally recommended by the Ad Hoc Steering Committee.*
	Parent-Child Interaction Therapy	Reflective Parenting Program*	
Children 6-15	Families and Schools Together	Families and Schools Together	
	Second Step	CBITS#	
	Incredible Years	Incredible Years	
Transition-age Youth 16-25	Interpersonal Psychotherapy for Depression	Interpersonal Psychotherapy for Depression	
	Prevention & Early Treatment of Depression in Primary Care	CAPPS*	
Adults 26-59	Group CBT for Major Depression	Group CBT for Major Depression	
	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
Older Adults 60+	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	Gatekeeper Case-finding Model	Gatekeeper Case-finding Model	
	Live Well, Live Long, Steps to Mental Wellness	Live Well, Live Long, Steps to Mental Wellness	

Age Group	Draft Plan Programs	Final Plan Programs	Comments re Changes
Service Area 6 - South			
Young Children 0-5	Nurse-Family Partnership	Nurse-Family Partnership	*Replaced UCLA Ties Transition Model with Reflective Parenting Program. Replaced LIFE Program (for Children 6-15) with Positive Directions. Added Positive Directions for TAY 16-25. Replaced Maternal Wellness Center with Prevention & Early Treatment of Depression in Primary Care.* *Reflective Parenting Program, Positive Directions, and Prevention & Early Treatment of Depression In Primary Care are all CDEs that the Ad Hoc Steering Committee did not have the opportunity to consider in their initial deliberations in March 2009.*
	Triple P	Triple P	
	UCLA Ties Transition Model	Reflective Parenting Program*	
	Trauma Focused CBT	Trauma Focused CBT	
	Child-Parent Psychotherapy	Child-Parent Psychotherapy	
Children 6-15	CBITS	CBITS	
	Families and Schools Together	Families and Schools Together	
	Psychological First-Aid	Psychological First-Aid	
	Why Try? Program	Why Try? Program	
	Triple P	Triple P	
	Trauma Focused CBT	Trauma Focused CBT	
	LIFE Program	Positive Directions*	
Transition-age Youth 16-25	Strengthening Families	Strengthening Families	
	Seeking Safety	Seeking Safety	
	Multidimensional Family Therapy	Multidimensional Family Therapy	
	CAPPS	CAPPS	
	-	Positive Directions*	
	LIFE Program	LIFE Program	
Adults 26-59	Group CBT for Major Depression	Group CBT for Major Depression	
	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	Maternal Wellness Center	Prevention & Early Treatment of Depression in Primary Care*	
	Family Coping Skills Program	Family Coping Skills Program	
Older Adults 60+	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	PATCH	PATCH	
	PEARLS	PEARLS	
Service Area 7 - East			
Young Children 0-5	Incredible Years	Incredible Years	*Replaced Trauma Focused CBT with Reflective Parenting. Replaced Family Coping Skills Program with Prevention & Early Treatment of Depression in Primary Care. Added Psychological First-Aid, Why Try?, and CAPPS.* *All of the programs*
	Child-Parent Psychotherapy	Child-Parent Psychotherapy	
	-	Psychological First-Aid*	
	Trauma Focused CBT	Reflective Parenting Program*	
Children 6-15	Early Risers Skills for Success	Early Risers Skills for Success	
	Nurturing Parenting Program	Nurturing Parenting Program	
	Incredible Years	Incredible Years	
	LIFE Program	LIFE Program	
	-	Why Try?*	
Transition-age	Mamas y Bebes	Mamas y Bebes	

Age Group	Draft Plan Programs	Final Plan Programs	Comments re Changes
Youth 16-25	Interpersonal Psychotherapy for Depression	Interpersonal Psychotherapy for Depression	*added are CDEs that the Ad Hoc Steering Committee did not have the opportunity to consider in their initial deliberations in March 2009.*
	LIFE Program	LIFE Program	
	-	CAPPS*	
	Functional Family Therapy	Functional Family Therapy	
Adults 26-59	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	Family Coping Skills Program	Prevention & Early Treatment for Depression in Primary Care*	
	Group CBT for Major Depression	Group CBT for Major Depression	
Older Adults 60+	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	IMPACT	IMPACT	
	Promotores de Salud	Promotores de Salud	
	CBT for Late Life Depression	CBT for Late Life Depression	
Service Area 8 – South Bay/Long Beach			
Young Children 0-5	Incredible Years	Incredible Years	*Added Reflective Parenting Program. Eliminated Psychological First Aid.* *Reflective Parenting Program is a CDE that the Ad Hoc Steering Committee did not have the opportunity to consider in their initial deliberations in March 2009.*
	Nurse-Family Partnership	Nurse-Family Partnership	
	-	Reflective Parenting Program*	
	Triple P	Triple P	
	Parent-Child Interaction Therapy	Parent-Child Interaction Therapy	
	Child-Parent Psychotherapy	Child-Parent Psychotherapy	
Children 6-15	Caring for Our Families	Caring for Our Families	
	Incredible Years	Incredible Years	
	Triple P	Triple P	
	Trauma Focused CBT	Trauma Focused CBT	
	Multisystemic Therapy	Multisystemic Therapy	
	LIFE Program	LIFE Program	
	Psychological First Aid	-	
Transition-age Youth 16-25	Trauma Focused CBT	Trauma Focused CBT	
	EDIPP	EDIPP	
	Group CBT for Major Depression	Group CBT for Major Depression	
	CAPPS	CAPPS	
	LIFE Program	LIFE Program	
	Multisystemic Therapy	Multisystemic Therapy	
Adults	Crisis Oriented Recovery	Crisis Oriented Recovery Services	

Age Group	Draft Plan Programs	Final Plan Programs	Comments re Changes
26-59	Services		
	IMPACT	IMPACT	
	Group CBT for Major Depression	Group CBT for Major Depression	
Older Adults 60+	Crisis Oriented Recovery Services	Crisis Oriented Recovery Services	
	IMPACT	IMPACT	
	PEARLS	PEARLS	
Countywide Populations			
American Indian	Trauma Focused CBT: Honoring Children, Mending the Circle	Trauma Focused CBT: Honoring Children, Mending the Circle	*Replaced Red Hawk Project with American Indian Life Skills. American Indian Life Skills was originally recommended by the Ad Hoc Steering Committee.* *Added a program for Blind/Visually Impaired populations following input from the MHSA Stakeholder Delegates, comments during the 30-day public comment period, and comments at the public hearing. A focus group with blind/visually impaired individuals and a key individual interview with a blind/visually impaired provider are currently scheduled to be conducted in early August to gather additional stakeholder input from this population to assist in implementation.*
	Red Hawk Project	American Indian Life Skills	
Deaf/HH	Prolonged Exposure for PTSD	Prolonged Exposure for PTSD	
	Nurse-Family Partnership	Nurse-Family Partnership	
	Nurturing Parenting Program	Nurturing Parenting Program	
LGBTQ	Trauma Focused CBT	Trauma Focused CBT	
	GLBT CHAMPS	GLBT CHAMPS	
	Group CBT for Major Depression	Group CBT for Major Depression	
Veterans	System Navigators	System Navigators	
	Prolonged Exposure for PTSD	Prolonged Exposure for PTSD	
Blind/VI	-	Group CBT for Major Depression	
Countywide Health Plans	Triple P	Triple P	
	Advice Line Project	Advice Line Project	
	Prevention & Early Treatment of Depression in Primary Care	Prevention & Early Treatment of Depression in Primary Care	
	CBITS	CBITS	
	Alternatives for Families	Alternatives for Families	
	Incredible Years	Incredible Years	
Juvenile Justice	Group CBT for Major Depression	Group CBT for Major Depression	
	Prolonged Exposure for PTSD	Prolonged Exposure for PTSD	
	Aggression Replacement Training	Aggression Replacement Training	
	CBITS	CBITS	
	Functional Family Therapy	Functional Family Therapy	
	Trauma-Focused CBT	Trauma-Focused CBT	

* Program is a Community Defined Evidence (CDE) program and therefore was not originally considered by the Ad Hoc Steering Committees in March 2009 because the CDE Guide had not yet been completed.

\# Program was originally recommended by the Ad Hoc Steering Committee, but was not included in the Draft Plan.

Summary of Substantive Public Comments. The table in Appendix 17 summarizes the substantive comments about the PEI Plan received during the public comment period and public hearing, together with LACDMH's response to each substantive theme or topic of interest. Substantive comments are defined as suggestions or recommendations that would result in specific significant changes in the PEI Plan projects, programs or funding allocations. The comments in the table represent written statements submitted on the public comment form as well as oral comments made during the 30-day comment period, at the June 25th MHSA Stakeholder Delegates meeting, and the June 25th public hearing. In a number of instances, the comments are summarized because several of the comments were similar and duplicative. A total of 89 written comments were received. Additionally, LACDMH corrected typos and clarified statements in the Plan as pointed out by respondents.

d. The estimated number of participants:

During the review of the draft PEI Plan and the public comment period, the Department received input from a multitude of sources as described above. More than 230 individuals attended the public hearing on June 25th. Many other individuals could not or did not attend the hearing, but provided written or verbal comments to the Department. It is estimated that over 750 individuals participated in the draft PEI Plan review process.

Note: County mental health programs will report actual PEI Community Program Planning expenditures separately on the annual MHSA Revenue and Expenditure Report.

OVERVIEW OF PEI PROJECTS

NAME OF PROJECT & AMOUNT REQUESTED	PROJECT SUMMARIES	PEI PROGRAMS
1. School-based Services Project $8,606,785	The School-Based Services Project will (1) build resiliency and increase protective factors among children, youth and their families; (2) identify as early as possible children and youth who have risk factors for mental illness; and (3) provide on-site services to address non-academic problems that impede successful school progress. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; foster a positive school climate; offer early mental health intervention services on school sites; and provide training in mental health evidence-based programs to school personnel and providers working with youth and children.	1. Aggression Replacement Training 2. Cognitive Behavioral Intervention for Trauma in School 3. Early Risers for Success 4. Families and Schools Together 5. Multidimensional Family Therapy 6. Olweus Bullying Prevention Program 7. Psychological First Aid 8. Strengthening Families 9. Why Try? Program
2. Family Education and Support Project $11,324,296	The Family Education and Support Project will build competencies, capacity and resiliency in parents, family members and other caregivers in raising their children by teaching a variety of strategies. Services will be offered to a diverse population throughout the county. The project utilizes universal and selective intervention as well as early intervention approaches for children/youth in stressed families. The programs will address the risk factors and protective factors that promote positive mental health, concentrating on parental skill-building through a variety of training, education, individual, group parent, and family interaction methods.	1. Caring for Our Families 2. Incredible Years 3. The Mothers and Babies Course "Mamas y Bebes" 4. Nurse-Family Partnership 5. Nurturing Parenting Program 6. Triple P Positive Parenting Program
3. At-risk Family Services $10,780,932	The At-Risk Family Services Project will (1) provide training and assistance to families whose children are at risk for placement in foster care, group homes, psychiatric hospitals, and other out of home placements; (2) build skills for families with difficult, out of control or substance abusing children who may face the juvenile justice involvement; and (3) provide support to families whose environment and history renders them vulnerable to forces that lead to destructive behavior and the disintegration of the family.	1. Brief Strategic Family Therapy 2. Child-Parent Psychotherapy 3. Group Cognitive Behavioral Therapy for Major Depression 4. Incredible Years 5. Making Parenting a Pleasure 6. Parent-Child Interaction Therapy 7. Reflective Parenting Program 8. Triple P Positive Parenting Program 9. UCLA Ties Transition Model

OVERVIEW OF PEI PROJECTS

NAME OF PROJECT & AMOUNT REQUESTED	PROJECT SUMMARIES	PEI PROGRAMS
4. Trauma Recovery Services $26,790,611	The Trauma Recovery Services Project will (1) provide short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event; and (2) provide more intensive services to trauma-exposed youth, adults, and older adults to decrease the negative impact and behaviors resulting from the traumatic events. The programs include outreach and education, psychosocial assessment, individual short-term crisis counseling, family counseling, youth and parent support groups, case management, and training for staff that are likely to work with trauma victims.	1. Child-Parent Psychotherapy 2. Crisis Resolution Services 3. Group Cognitive Behavioral Therapy for Major Depression 4. Parent-Child Interaction Therapy 5. Prolonged Exposure Therapy for Posttraumatic Stress Disorder 6. Seeking Safety 7. System Navigators for Veterans 8. Trauma Focused Cognitive Behavioral Therapy
5. Primary Care and Behavioral Health Services $5,475,984	The Primary Care and Behavioral Health Project will develop mental health services within primary care clinics in order to increase primary care providers' capacity to offer effective mental health guidance and early intervention through the implementation of screening, assessment, education, consultation, and referral. Another purpose is to prevent patients at primary care clinics from developing severe behavioral health issues by addressing their mental health issues early on. Behavioral health professionals skilled in consultation and primary care liaison will be integrated within the primary care system. It is the intent of the Project to build resiliency and increase protective factors among children, youth, adults and older adults and their families and other caregivers through the PEI programs. By offering assistance in identifying emotional and behavioral issues at a clinic setting, the stigma associated with seeking out mental health services will be minimized.	1. Advice Line 2. Alternatives for Families 3. IMPACT 4. Incredible Years 5. Maternal Wellness Center 6. Prevention & Early Treatment of Depression in Primary Care 7. Triple P Positive Parenting Program
6. Early Care and Support for Transition-Age Youth $9,017,928	The Early Support and Care for Transition-Age Youth Project will (1) to build resiliency, increase protective factors, and promote positive social behavior among TAY; (2) address depressive disorders among the TAY, especially those from dysfunctional backgrounds; and (3) identify, support, treat, and minimize the impact for youth who may be in the early stages of a serious mental illness. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; offer early mental health intervention services on school sites, youth centers and other youth-friendly sites; and provide training in mental health evidence-based programs to school personnel and providers working with TAY. Emancipating, emancipated, and homeless	1. Aggression Replacement Training 2. Asian American Family Enrichment Network Program 3. Center for the Assessment and Prevention of Prodromal States 4. Early Detection and Intervention for the Prevention of Psychosis 5. Group Cognitive Behavioral Therapy for Major Depression 6. Interpersonal Psychotherapy for Depression 7. Multidimensional Family Therapy 8. Seeking Safety

OVERVIEW OF PEI PROJECTS

NAME OF PROJECT & AMOUNT REQUESTED	PROJECT SUMMARIES	PEI PROGRAMS
	TAY are a special focus of this project.	
7. Juvenile Justice Services $10,663,120	The Juvenile Justice Services Project will (1) build resiliency and protective factors among children and youth who are exposed to risk factors that leave them vulnerable to becoming involved in the juvenile justice system; (2) promote coping and life skills to youths in the juvenile justice system to minimize recidivism; and (3) identify mental health issues as early as possible and provide early intervention services to youth involved in the juvenile justice system. Services will be provided at probation camps throughout the County, residential treatment facilities, health clinics, community settings, and other non-traditional mental health sites.	1. Aggression Replacement Training 2. Cognitive Behavioral Intervention for Trauma in School 3. Functional Family Therapy 4. Group Cognitive Behavioral Therapy for Major Depression 5. Loving Intervention for Family Enrichment (LIFE) Program 6. Multidimensional Family Therapy 7. Multisystemic Therapy 8. Positive Directions 9. Prolonged Exposure Therapy for Posttraumatic Stress Disorder 10. Trauma Focused Cognitive Behavioral Therapy
8. Early Care and Support for Older Adults $9,026,660	The Early Care and Support Project for Older Adults will (1) establish the means to identify and link older adults who need mental health treatment but are reluctant, are hidden or unknown, and/or unaware of their situation; (2) prevent and alleviate depressive disorders among the elderly; and (3) provide brief mental health treatment for individuals. The stigma of mental illness is a significant barrier for the older generation who often do not seek treatment until the illness has progressed significantly. Services are directed at older adults, their family members, caregivers, and others who interact with and provide services to this senior citizen population.	1. Cognitive Behavioral Therapy for Late Life Depression 2. Gatekeeper Case-finding Model 3. Live Well, Live Long, Steps to Mental Wellness 4. Program to Encourage Active Rewarding Lives for Seniors (PEARLS) 5. Promotores de Salud Para Nuestra Tercera Edud (Health Promotores for Our Third Age or Community Health Workers for Latino Older Adults) 6. Psychogeriatric Assessment and Treatment in City Housing (PATCH)

OVERVIEW OF PEI PROJECTS

NAME OF PROJECT & AMOUNT REQUESTED	PROJECT SUMMARIES	PEI PROGRAMS
9. Improving Access for Underserved Populations $7,243,176	The Improving Access for Underserved Populations Project will (1) build resiliency and increase protective factors among monolingual and limited English-speaking immigrants and underserved cultural populations, lesbian/gay/bisexual/transgender/questioning (LGBTQ) individuals, deaf/hard of hearing individuals, blind/visually impaired individuals and their families; (2) identify as early as possible individuals who are a risk for emotional and mental problems; and (3) provide culturally and linguistically appropriate early mental health intervention services. The programs will provide outreach and education as well as promote mental wellness through universal and selective prevention strategies.	1. Cognitive Behavioral Therapy for Depression with Antidepressant Medication 2. Family Coping Skills Program 3. GLBT CHAMPS: Comprehensive HIV & At-Risk Mental Health Services 4. Group Cognitive Behavioral Therapy for Major Depression 5. Nurse-Family Partnership 6. Nurturing Parenting Programs 7. Prolonged Exposure Therapy for Posttraumatic Stress Disorder 8. Trauma Focused Cognitive Behavioral Therapy
10. American Indian Project $990,000	The American Indian Project will (1) build resiliency and increase protective factors among children, youth and their families; (2) address stressful forces in children/youth lives, teaching coping skills, and divert suicide attempts; and (3) identify as early as possible children and youth who have risk factors for mental illness. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; offer early mental health intervention services at comfortable, non-stigmatizing localities; and involve multi-generations in the American Indian children and youth's lives. An important emphasis is on preventing suicide among American Indian youth, given the high rate among this population.	1. American Indian Life Skills 2. Trauma Focused Cognitive Behavioral Therapy: Honoring Children, Mending the Circle

County: Los Angeles

PEI Project 1: SCHOOL-BASED SERVICES

Date:

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☒	☐	☐
4. Stigma and Discrimination	☒	☒	☐	☐
5. Suicide Risk	☒	☒	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☒	☐	☐
4. Children and Youth at Risk for School Failure	☒	☒	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒	☐	☐
6. Underserved Cultural Populations	☒	☒	☒	☒

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

In order to create the best possible MHSA PEI Plan, it was essential that LACDMH compile and generate accurate information from a wide range of sources. To gather this information, the Department employed six different needs assessment strategies: recommendations from CSS planning, community surveys, service area data profiles, key individual interviews, focus groups, and community/countywide forums. (See Appendix 18 for the Summary Data Report.) Through each strategy, the questions being asked and answered became more specific and the depth of knowledge increased.

Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project. As part of a multi-modal assessment, data was gathered formally through a stakeholder poll, a series of key individual interviews, a series of focus groups, and several community forums. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI. All of the community assessment information was made available to the Ad Hoc Steering Committees who further refined population, age, and program selections. The current list of PEI projects emerged from these final sets of recommendations and reflects not only the localized needs of county service areas but also the specialized needs of countywide populations as well. The main components of the needs assessment are discussed below as they relate to these specific patterns of responses which led to the creation of the School-based Services Project.

(1) Stakeholder Input

(a) Key Individual Interviews

► Input Regarding Priority Population. When all interviews were qualitatively analyzed, it became clear that collectively, the experts believed that all PEI priority populations deserved full attention. But because not all priority populations could be served by one project alone, the individuals interviewed were able to advise planners on a reasonable course of action to guide project differentiation. In particular, key individuals with knowledge and experience of the Children/Youth at Risk for School Failure and Children/Youth in Stressed Families populations suggested that a school-based mental health project be developed in order to address issues of academic achievement and the inter-relationship between ethnicity, family stressors, and behavior and mental health problems in the school setting. Below are paraphrased examples of the Key individual responses:

- *Children at-risk of school failure addresses the academic needs of the students I serve, while a focus on children in stressed families addresses the needs of the families of the students I teach.*
- *We need to reach them in schools where they are a "captive" audience, and use this access to bridge into family problems…into issues affecting the whole family.*
- *We are seeing problems because we haven't had a chance to do early intervention in the schools. We need to catch them early and devote funds and priority to at-risk populations. For Children at-risk of school failure, there is a need for greater parent education and support so that parents can be more effective and help eliminate problems.*
- *A large proportion of community youth are at risk of becoming involved with the Juvenile Justice system. Similarly, two-thirds of the youth in this community do not graduate, so those students who are at at-risk for school failure also need attention.*
- *The reasons children are at risk of school failure are in many cases due to mental health issues that have not yet been identified or addressed. LAUSD will have failed its educational mission if it does not reach these students.*

► Input Regarding Age Groups. In general, most respondents indicated that children from pre-K through middle school were a priority. Other voices indicated that the children through TAY populations were appropriate for this type of project. Below are paraphrased examples of the Key individual responses:

- *Children ages 6-15 "are more open to structured classroom approaches, to taking on information, being part of school." Elementary school is a natural place for prevention because it is the largest referral base for children with school problems that have not yet become mental health issues.*
- *Parents are not in despair yet, if we involve parents "behind us" then we can turn kids around. Interventions introduced in high school may be too late (as seen by failing grades, kids dropping out, teen pregnancy, gangs, drugs, and addiction)*
- *Children's disabilities and related social-emotional issues may arise that can be attended to immediately and resolved before the issues became more difficult to address. The needs of elementary school children are easier to catch early because they spend a significant time with one teacher, compared to middle school*
- *Prevention can occur first in ages 0-5 to create safe home environments for children to thrive; then it can occur in ages 6-15 to create safe schools for children to grow, avoiding trauma and future need for mental health services. By focusing on the earliest ages, children's needs and issues can be dealt with and prevention can have the biggest impact. Schools are extremely important for prevention.*

- *"If they don't succeed in education, it has dire consequences for their adult life." Early intervention is important, especially with so many children exhibiting symptoms of PTSD within this age group. CBITS, as an early intervention program has been found to improve attendance and raise functional capacity of the students.*
- *It is Important to catch children before they drop out of the school system. Second Step, as a violence prevention program, is crucial for elementary school students.*

(b) Focus Group Interviews

► Input Regarding Priority Population. Similar to the Key Individual Interviews mentioned above, Focus Groups with knowledge and experience of the Children/Youth at Risk for School Failure and Children/Youth in Stressed Families populations pointed to the creation of a school-based mental health project. Below are paraphrased examples of the focus group responses:

- *The group emphasized the need for increased funding and expansion of school-based prevention and early intervention programs, including expanded medical and mental health screenings, individual counseling, parent education and support, student education and development of pro-social and resiliency skills, and teacher/school administrator education and training. Additionally, they discussed the need for expansion of community based programs to supplement what the schools were able to offer and to provide access to uninsured and non-English speaking populations.*
- *The group prioritized the need for the expansion of school-based services that were on-site, curriculum-based, and fit with families' schedules. They recommended services in schools could include individual and family counseling, anger management, anti-bullying, grief, coping, parenting, dealing with divorce and trauma, gang prevention, and suicide prevention.*
- *The group suggested working together with PTA/PTOs and community organizations to provide services to meet families' needs in a non-threatening way, providing food and/or therapeutic child care as needed.*
- *When asked what early intervention services are needed, the group listed the following services: … School-based services that prevent young people from dropping out of high school; and, Support services for young people with special needs, especially learning disabilities.*
- *Overall, the group emphasized "more home- and school-based" services were needed. In particular, they stated that the services needed to be more accessible within their community, either within walking distance or a short bus ride. In addition, the following prevention services/resources were specifically recommended: Parenting programs, providing free education and resources to families; Programs to address after school care and tutoring (particularly needed*

due to number of latch key children); Walk-in counseling and expanded mental health services at school sites, from Kindergarten through college levels; mentoring programs to assist single parents, and for boys and girls; Support groups for parents; Anger management programs and character education classes at school;

- *The participants suggested that more support groups and resources at schools, especially high schools were needed. They asked for greater support from school administrators and teachers of LGBT students.*

► Input Regarding Age Groups. In general, respondents indicated that children from pre-K through middle school were a priority but there were also groups which indicated that PEI services were needed in higher education systems. Below are some paraphrased examples of these responses:

- *One group recommended the following: School-based health centers in every school (elementary, middle, and high school) that address both medical and mental health. They advocated for increased collaboration between education and mental health sectors.*
- *Another group recommended that additional funding for existing programs be increased. Increased mental health professionals (such as LCSWs, psychiatrists, prevention and early intervention experts) on community college campuses are needed in order to increase timeliness of services. Universal and primary prevention campaigns that reach the entire campus population could decrease stigma, increase mental health awareness, and create a culture change among the student body to normalize positive mental health. Prevention-focused program staff who are trusted in the community can perform effective student outreach. Alternate counseling delivery mechanisms could include telephone and online supports and services.*

(c) Community Forum Recommendations

Benefiting from the needs assessment that had been completed, Community Forum attendees were asked to prioritize PEI populations and age groups. These were then used by Ad Hoc Steering Committee members in making program selection recommendations. PEI projects were subsequently built by organizing programs into clusters of related interventions. The following represent the strategies relating to the School-Based Project. Note: Stakeholders asked that PEI planning separate 0-5 years from the PEI Child age group and this is reflected in the age groups reported throughout the Projects.

► Input Regarding Priority Strategies. In general, respondents emphasized the need for comprehensive approaches and involved the school, the family and the community. Below are some paraphrased examples of these responses:

- *Integrated and coordinated services such as mental health supports, school readiness, community and parental supports, stigma reduction, and children who do not qualify for special education programs and services provided by DMH and others in child care facilities, schools, day care centers for, and safe community centers.*
- *Provide education for therapists, professionals, families, schools, and health providers that is integrated into professional programs or community based, with particular attention to working with ages zero to five.*
- *Comprehensive school-based services delivered by community agencies and organizations that integrate primary care and mental health services.*
- *Provide accessible, user-friendly, mental health services, including comprehensive assessments and social supports, for parents and children delivered in partnership with trusted community agencies.*
- *Create stronger partnerships with schools where both parents and teachers receive increased training on how to recognize/identify mental health issues and address them through a multi-disciplinarian approach under non-stressed conditions.*
- *School-based health clinics and PEI programs.*
- *Strategies to improve the way schools work with children and their families, including implementing school-wide positive behavior support programs, incentives to engage parents as part of that education, and train teachers in cultural competence to reduce misdiagnoses of children.*
- *School and community based education/programs regarding substance abuse, mental health and life skills.*
- *Parenting classes that focus on self-esteem and the developmental stages and challenges of an adolescent. Classes to be facilitated at schools, parks, and community centers. Classes to be culturally and linguistically sensitive with no access criteria.*

(d) Ad Hoc Steering Committee Recommendations

The Ad Hoc Steering Committees were instrumental in developing PEI projects. Specifically, they identified key sub-populations and recommended programs to address the needs of those sub-populations.

► Input Regarding Sub-populations. Committee members prioritized groups that were in need of a comprehensive approach involving the school, the family and the community. Below are some examples of these responses:

- *Youth who are suspended, truant, or drop-out.*
- *Children with school phobias, children who are self-injurious, children with anger management and peer pressure issues; or children who lack social skills, and*

friendship, children who are ineligible to access mental health services due to diagnosis.

- *Children who are fearful of attending school due to the lack of safety in certain schools, children who are victims of bullying or those who bully and mistreat other children, and children targeted by gangs.*
- *Homeless, neglected children, and/or children removed from their homes.*
- *Children in families and/or communities with domestic violence, child abuse, police brutality and/or gang, racial or community violence.*
- *Parents, teachers, and or caregivers of trauma-exposed children.*
- *Children dealing with grief and loss as result of death or incarceration of family member or loved one.*
- *Children experiencing prodromal symptoms of psychosis; children experiencing social/emotional maladjustment that results in poor academic achievement.*
- *Children at risk of school failure due to parental acculturation.*
- *Children who lack parental involvement; or, children lacking role models and positive support systems/gang involvement kids/substance use.*
- *Children at risk of school failure due to suspension, transfers, and/or frequent changes in schools.*
- *Children from underserved cultural populations including English learners.*

(2) Data Analysis

(a) Statistical and Demographic Indicators

The LACDMH *Vulnerable Communities in Los Angeles County: Key Indicators of Mental Health* report detailed demographic variables and key risk factors. Each indicator in the report was selected on the basis of its empirical link with a PEI priority population and community mental health need. Together with the Key Individual Interviews and Focus Groups responses presented above, the following indicators were found to be confirm the need for the creation of a project focused on the needs of Children/Youth at Risk for School Failure and Children/Youth in Stressed Families populations. The following selected demographic variables and risk factors demonstrate the need for services: High School Graduation Rates, High School Dropout Rates, English Fluency Rates of students, and 3rd Grade Reading Levels, and Poverty.

(b) High School Dropout Rates

State figures indicated that over a quarter of all students in Los Angeles County drop out of high school over a four-year period. Examining ethnic categories indicated that African-American students were most at risk for not finishing high school, followed by Pacific Islander, American Indian/Alaska Native, and Hispanic or Latino Students.

15.5% of White students drop out of high school. Two ethnic groups had dropout rates below this: Asian, 7.4% and Filipino, 12.8%.

(c) High School Graduation Rates

Across the county, African-Americans had the lowest high school graduation rates reported: 65.4%. This was followed by American Indians or Alaskan Natives at 70.8%; Hispanics, 70.9%; Pacific Islanders, 75.9%; Whites, 89.6%; Filipinos, 70.9%; and Asians, 93.9%. When comparing service areas, one can see that Service Areas 4 and 6 had graduation rates below 60% - about 4 out of every 10 children in those areas do not graduate. Looking within the services areas yielded two American Indian or Alaskan Native populations in Service Areas 4 and 5 whose high school graduation rates were below 50% - less than one out of every two children.

(d) English Fluency

English fluency is a predictor of school failure. Children who are from non-English language backgrounds may be more than 1.5 times likely to leave school than those with an English language background. Across the county, the overall fluency rate for all students was 68.3% and suggested that a large number of children are at risk for school failure as a result of a language barrier. Service Area 6 had the lowest fluency rate in the county at 52.7% and Service Area 4 was close to this figure at 54.3%. In fact, these two service areas held the lowest high school graduation rates in the county as mentioned above. -

3. PEI PROJECT DESCRIPTION

A. Why the proposed PEI project – including key community need(s), priority population(s), desired outcomes and selected programs – addresses needs identified during the community program planning process

By reviewing the available information generated from the LACDMH's needs assessment, stakeholder groups were able to recommend PEI programs for their respective communities and constituencies. As indicated above, the data sources on which these recommendations were based ranged from the expert interviews to population demographic and behavioral statistics. As the Ad Hoc Steering Committees generated their program recommendations and targeted sub-populations, clusters of related programs began to coalesce around a core service which was then reified as the School-based Services Project.

The extent of the county's needs in terms of the school-age population and its risk for school failure can be seen by reviewing the data sources presented. Enrollment statistics provided by the California Department of Education clearly indicated that large

groups of underserved cultural populations were dropping out of school. These data were corroborated by additional high school graduation statistics compiled by the US Census Bureau. The County also assessed the level of suspensions and expulsions across school districts as well as other educational and social indicators related to school problems. What emerged was a complex pattern of risk factors that varied across geographic areas.

By listening to the stated needs and desires of community stakeholders through key interviews, focus groups, and forums spread throughout the county, across planning sectors, age groups, and decision-making groups, prioritizing solutions to attenuate these risks factors became possible. Some of the comments the County received with regard to the school-age population are extracted above and show the intensity of stakeholder convictions that a school-based project was needed.

Project Purpose. The School-based Services Project will (1) build resiliency and increase protective factors among children, youth and their families; (2) identify as early as possible children and youth who have risk factors for mental illness; and (3) provide on-site services to address non-academic problems that impede successful school progress. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; foster a positive school climate; offer early mental health intervention services on school sites; and provide training in mental health evidence-based programs to school personnel and providers working with youth and children.

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Poverty • Ethnicity • Geographic region • English fluency • Low academic achievement • Insecure attachment • Drug use • Family dysfunction and violence • Gang affiliation • Life stress • Mental health disorders • Victimization • Peer rejection and aggression • Truancy • Poor organizational skills • Early onset of aggressive behavior • Learning problems	• Coping skills • Family support • Social support • Goal persistence • Achievement motivation • Effective parenting • Self-efficacy • Sociability • Religious beliefs, • Teacher expectations • Rewards system

Project Components. Each project is comprised of the following components:

1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.
2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.
3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures so that accurate data is captured on a systematic and ongoing basis that the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.
4. PEI Programs – There are a total of nine EBP and CDE programs that will be implemented in eight service areas for the School-based Services Project.

Outreach and Engagement to Unserved and Underserved Communities. Because one of the overarching goals of the MHSA is the reduction of mental health disparities experienced by specific racial/ethnic and other cultural groups, all projects have been built with service components to achieve this end. The outreach and engagement component for each PEI project is a critical element in reducing disparities because it is primarily concerned with increasing access to programs, a first step in dismantling barriers to services. The County strategy for outreach and engagement involves the utilization of existing County outreach workers, activating existing community resources and organizations, and the development of culturally and linguistically sensitive materials. All of these tools will be combined into a coordinated effort to seek out difficult to reach populations, educate groups regarding PEI programs, and facilitate entry into an appropriate program.

Outreach and engagement activities for the School-based Services Project will include, but are not limited, to the following:

Community Leaders, Parents, and Organizations

- Working with school administrative staff and teachers to inform them of PEI programs and how they may be of service to the children and families with whom they work.
- Working with neighborhood parents to leverage their networking ability across school sites.
- Working with cultural brokers or community representatives to develop outreach strategies for specific populations. In particular, LACDMH will seek input from the key individuals, focus group participants, and community organizations from the

planning process to identify and implement culturally and linguistically appropriate methods for their communities.
- Engaging local ethnic community leaders and gatekeepers, while recognizing that many people in these communities lack knowledge of, distrust, and/or are reluctant to use mental health services. Personal contact with these individuals is a key method to increase community knowledge about PEI programs and to facilitate access to these programs.
- Providing information and training in small group settings (e.g. church, temple or other place of worship that has a primarily minority congregation) in local neighborhoods or ethnic community. These sites would be asked to host training and educational forums, bulletins for educational information, and people to serve as volunteers.

Educational Materials
- Developing educational materials about the School-based Services Project. The materials will be translated, culturally relevant, at the appropriate literacy level, and visually accessible (large print and Braille). Community input will be sought in the approach and design of materials to ensure the materials are culturally sensitive.
- Distributing an information sheet about the outreach and engagement efforts, including outreach staff contact information as well as programs' contact information. These flyers will be distributed at meetings and posted in places where the target population is expected to congregate, such as schools, day care/childcare centers, pre-schools, teen clubs, afterschool activities, PTA meetings, health centers, ESL classes, and so forth.
- Distributing press releases, informational articles, and paid advertising (both in English and the appropriate threshold language) in local ethnic newspapers, radio, television, and websites.

Community Outreach Workers
- Collaborating with LACDMH's CSS outreach and engagement staff. Since the inception of the CSS programs, these individuals have developed relationships with numerous community providers. LACDMH will seek the assistance of these staff to provide community linkages for the PEI programs and distribution of information.
- Hiring and training outreach workers, especially those with non-English language ability, from the local communities and the unserved/underserved communities.
- Recruiting and training volunteers from the community who are familiar with the unserved/underserved communities.

Partner Organizations
- Working though existing organizations, such as schools, clubs, churches, and other organizations.
- Collaborating with partner organizations to promote joint outreach efforts.

- Providing training or informational sessions to local organizations such as schools, neighborhood groups, PTAs, human service agencies, about the PEI programs.

School-based Programs. An emphasis was made on selecting the most effective, efficacious and safe programs that could be offered to the school-age population and their families. These programs were chosen to specifically address the problems of children/youth who are at-risk for truancy, suspensions, expulsions, and dropping out: Aggression Replacement Training, Early Risers Skills for Success, and Families and Schools Together (FAST), Olweus Bullying Prevention Program, and Strengthening Families. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) was chosen to address the problems of underserved cultural populations in becoming successful in the school environment due to living in high crime/community violence/impoverished areas. Overlapping these needs and programs were those chosen to address the problems facing at-risk children/youth in stressed families: Early Risers Skills for Success for children exposed to violence or having a familial mental health problems; and FAST for children living in impoverished communities with few resources and familial mental health and substance abuse problems.

Prevention	Prevention & Early Intervention	Early Intervention
Families and Schools Together	Aggression Replacement Therapy	Cognitive Behavioral Intervention for Trauma in School (CBITS)
Olweus Bullying Prevention Program	Multidimensional Family Therapy	Early Risers Skills for Success
	Psychological First Aid	
	Strengthening Families	
	Why Try? Program	

(1) Prevention Services

❖ **Families and Schools Together (FAST) – Children.** This is a multi-family group selective prevention program designed to build protective factors for children, to empower parents to be the primary prevention agents for their own children, and to build supportive parent-to-parent groups. The overall goal of the FAST program is to intervene early to help at-risk youth succeed in the community, at home, and in school and thus avoid problems such as adolescent delinquency, violence, addiction, and dropping out of school. The program begins when a teacher or other school professional identifies a child with problem behaviors who is at risk for serious future academic and social problems. A trained team consisting of a parent, a school professional, a clinical social worker, and a substance abuse counselor facilitates the meetings. The team is also required to represent the culture of the families participating in the program. This EBP is targeted to school-aged children at risk for academic failure.

❖ **Olweus Bullying Prevention Program – Children.** This is a universal prevention program developed to promote the reduction and prevention of bullying behavior and

victimization problems for children. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers and students with the classroom, the school as a whole, and the community. The main arena for the program is the school, and school staff that have the primary responsibility for introducing and implementing the program. The Olweus Bullying Prevention program is an EBP directed at elementary and junior high school students.

(2) Prevention and Early Intervention Services

- **Aggression Replacement Training (ART) – Children.** Aggression Replacement Training is a multimodal psychoeducational universal and selective prevention and early intervention program designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. ART has been implemented in school, delinquency, and mental health settings. ART is an EBP that will be implemented in Service Area 2.

- **Multidimensional Family Therapy (MDFT) – Children.** Multidimensional Family Therapy is a selective prevention and early intervention family-based treatment and substance-abuse prevention program developed for adolescents with drug and behavior problems. Treatment seeks to significantly reduce or eliminate an adolescent's substance abuse and other problem behavior and to improve overall family functioning. The objectives for the adolescent include transformation of a drug-using lifestyle into a developmentally normative lifestyle and improved functioning in several developmental domains. The objectives for the parent include blocking parental abdication by facilitating parental commitment and investment, improving the overall relationship and day-to-day communication between parent and adolescent, and increasing knowledge about and changes in parenting practices. MDFT is an EBP of intervention for 11-18 year-olds with conduct and substance abuse problems.

- **Psychological First Aid – Young Children, Children and Transition-age Youth.** Training and nationally-published educational materials for teachers whose students have experienced a disaster, school crisis, or emergency. Psychological First Aid is a CDE that addresses the needs of children who have experienced trauma.

- **Strengthening Families – Transition-age Youth.** This is a universal and selective prevention and early intervention family skills training program designed to enhance school success and reduce youth substance use and aggression among 10- to 14-year-olds. The 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. The Strengthening Families EBP will be implemented in Service Area 6.

❖ **Why Try? Program – Children.** This is a 10-week group curriculum (45 minutes each) designed to prevent delinquency and school failure. Why Try? Program is a Community-Defined Evidence Practice that builds resiliency in youth.

(3) Early Intervention Services

❖ **Cognitive Behavioral Intervention for Trauma in School (CBITS) – Children and Transition-age Youth.** The CBITS program is an early intervention for reducing children's symptoms of posttraumatic stress disorder (PTSD) and depression caused by exposure to violence that has been used successfully in inner city schools with multicultural populations. CBITS has three main goals: to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support. CBITS was designed for use in schools for children who have had substantial exposure to violence and who have symptoms of PTSD in the clinical range. The EBP will be implemented in Service Areas 4, 5, 6 and countywide.

❖ **Early Risers Skills for Success – Children.** Early Risers is based on the premise that early, comprehensive, and sustained intervention is necessary to target multiple risk and protective factors. The program uses integrated child-, school-, and family-focused interventions to move high-risk children onto a more adaptive developmental pathway. The family-focused component has family nights with parent education and family support. The program is intended for elementary school students who are at high risk for substance abuse and behavior problems leading to early school failure. The EBP will be implemented in Service areas 3 and 7.

(4) Targeted Populations

The table below describes the targeted populations for each of the School-based Programs.

Program	SA	Age Group	Target Populations
Aggression Replacement Training	2	Children	➢ Children exposed to domestic violence, trauma, abuse, neglect and substance abuse, children who bully and mistreat other children, children targeted by gangs, and children with anger management and peer pressure issues; or children who lack social skills, and friendship, children who are ineligible to access mental health services due to diagnosis. ➢ The primary cultural groups anticipated to be served are Hispanics/Latinos, Western European Whites, and Asians as they make up 38.4%, 35.4%, and 8.6% of the Service Area population respectively. Additionally, there are also significant Armenian (5.6%), African American (3.9%), Iranian (1.8%), Other Middle Eastern (1.6%), and South Asian (1.4%) populations in

Program	SA	Age Group	Target Populations
			Service Area 2 that this program intends to serve as well.
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	4	Children	➢ Children who are trauma exposed and those who live in high crime neighborhoods. ➢ The primary cultural groups served will include Hispanics/Latinos, Asians (particularly Korean and Chinese), and Western European Whites. There are also significant African American (5.1%), Russian (1.6%), Armenian (1.2%), and South Asian (1.1%) populations who will be served through this program.
	5	Children	➢ Children who experience domestic violence, community violence, or economic crises, children who experience emotional distress at school or who act out at school, and children with poor school performance. ➢ Primary cultural groups of the area including Western European Whites, Hispanics/Latinos, and Asians. There are also significant numbers of African Americans (8.1% of the population), Russians (5.3%), Iranians (1.3%), Other Middle Easterners (2.3%), and South Asians (1.5%) residing in Service Area 5 who will be served by this program.
	6	Children	➢ Homeless, neglected children, and/or children removed from their homes, as well as children in families and/or communities with domestic violence, child abuse, police brutality and/or gang, racial, or community violence. Also, parents, teachers, or caregivers of trauma-exposed children, and children dealing with grief and loss as a result of death or incarceration of a family member or loved one. ➢ African Americans and Latinos who make up 28.2% and 65.9% of the population respectively.
	Health	Children TAY	➢ Students experiencing language/cultural competence limitations. ➢ Primary cultural groups served will vary by community, but will include Hispanics/Latinos, African Americans, and Asians/Pacific Islanders.
Early Risers Skills for Success	3	Children	➢ Children who are abused or exposed to violence, domestic violence, and/or trauma within their family or community. Staff will reach out to children and families facing multi-generational mental illness, substance abuse, and/or whose parentis have poor parenting and coping skills. ➢ Hispanics/Latinos and Asians (particularly Chinese) will be the primary cultural groups served by this program as they make up 45.0% and 23.7% of the Service Area population.
	7	Children	➢ Children experiencing prodromal symptoms of psychosis; children experiencing social/emotional maladjustment that results in poor academic achievements; children at risk of school failure, especially those who do not speak English; and children of single mothers; or pregnant teens; or children with lack of parental involvement or supervision; or children with parents who are separated/divorced. ➢ Hispanics/Latinos will be primary cultural group receiving these services as

Program	SA	Age Group	Target Populations
			they make up 70.9% of the Service Area 7 population. Other significant groups such as Asians and Western European White will also be recipients of these services.
Families and Schools Together	1	Children	➢ Children who lack parental involvement, children lacking positive support systems, children who lack academic readiness skills, children with disruptive behavior including truancy, attention deficit disorder, chronic absenteeism and children who are defiant. ➢ Primary cultural groups include Hispanics/Latinos and Western European Whites, and African Americans, as they make up 41.1%, 39.0% and 12.8% of the Service Area 1 population, respectively.
	2	Children	➢ Children who have been exposed to domestic violence, trauma, abuse, neglect and substance abuse, children with school phobias, children who are self-injurious, children with anger management and peer pressure issues, children who lack social skills, and friendship, children who are ineligible to access mental health services due to diagnosis, children who are fearful of attending school due to the lack of safety in certain schools, children who are victims of bullying or those who bully and mistreat other children, and children targeted by gangs. ➢ Primary cultural groups include Hispanics/Latinos (38.4% of the Service Area population), Western European Whites (35.4%), Asians (8.6%), and Armenians (5.6%). There are also significant African American (3.9%), Russian (2.6%), and Iranian (1.8%) populations who will be served.
	5	Children	➢ Children with undiagnosed mental health issues, learning disabilities, speech disabilities, and/or inappropriate school placements, children without adequate support services from the school system, children who express or experience emotional distress at school or children who act out at school, and children with poor school performance or who have been expelled. ➢ Western European Whites, Hispanics/Latinos, and Asians will be the primary cultural groups served by this program, though there are also significant African American, Russian, Iranian, and other Middle Eastern communities that will be served.
	6	Children	➢ Children in homes with economic hardships, lack of access to medical services, limited parental education and/or lack of knowledge of and access to educational resources, children in homes with alcohol/substance abuse, mental illness, chronic medical illness and/or physical disability and children at risk of school failure due to suspension, transfers, and/or frequent changes in schools. ➢ Primarily Hispanics/Latinos and African Americans who make up 65.9% and 28.2% respectively.
Multidimensional Family Therapy	4	Children	➢ Children at risk for school failure, children who have been exposed to family trauma and children who have a sibling or parent absent due to incarceration or deportation.

Program	SA	Age Group	Target Populations
			➢ Primary cultural groups include Hispanics/Latinos, Asians, and Western European Whites, as well as African Americans, Russians, Armenians, and South Asians.
Olweus Bullying Prevention Program	1	Children	➢ Children who lack parental involvement, children lacking role models and positive support systems, and children gang involvement/substance abuse issues. ➢ Hispanics/Latinos (who comprise 41.1% of the SA population), Western European Whites (39.0%), and African Americans (12.8%) therefore they will be the primary beneficiaries of these services. Additionally, there is also a significant Asian community, who will receive these services.
Psychological First Aid	1	Children	➢ Children who have experienced child abuse, domestic violence, divorce, or any kind of neglect where the child's needs are not met. The program will also serve children who have parents with substance abuse/addiction issues or gang involvement. ➢ Primarily, Hispanics/Latinos, African Americans, Western European Whites, and Asians.
	6	TAY	➢ Youth in out of home placement or kinship care, children in homes with alcohol/substance abuse, mental illness, chronic medical illness and/or physical disability, and children who experience child abuse, domestic violence, gang violence, and/or community violence. ➢ Primarily, Hispanic/Latino and African American cultural groups, as well as services to Asians, Western European Whites and other groups.
	7	Young Children	➢ Children in families where parents are suffering from mental health issues, suffering form substance abuse, have a family history of domestic violence, child abuse and/or lack parenting skills. ➢ Primarily Latinos, but also Asians, Western European Whites, and African Americans.
Strengthening Families	6	TAY	➢ Youth who have been suspended, truant, or drop-out, high school students funneled into alternative education (i.e. special ed., continuation, probation schools) due to behavioral issues, youth in schools with poor conditions, and TAY with mental health challenges in secondary/post-secondary schools. ➢ Primary cultural groups of Hispanic/Latinos and African Americans who make up the majority of service recipients, as well as Asians and Western European Whites.
Why Try? Program	6	Children	➢ Youth at risk of school failure due to suspension, transfers, and/or frequent changes in schools, children experiencing behavior and/or academic challenges attending underperforming schools, and children who are homeless, neglected or removed from their homes. ➢ Primary cultural groups include African American and Hispanics/Latinos.
	7	Children	➢ Children at risk for school failure, especially those who do not speak English, children who are truant or absent from school, children at risk of delinquency, children of single mothers, pregnant teens, children who lack parental involvement or supervision and children with parents who are separated or divorced.

Program	SA	Age Group	Target Populations
			➢ Primary cultural groups will be Hispanics/Latinos, but also Asians and Western European Whites.

B. Implementation Partners and Type of Organization/Setting That Will Deliver the PEI Program and Interventions

The programs in the School-based Service Project may be operated by schools, community-based organizations, mental health providers, social service agencies, and other organizations selected through the County's competitive bidding process. The majority of services will be delivered at school sites, including pre-school, elementary, middle school, and high school. Alternative sites may include the home, recreation site, health clinics, and other sites as determined to be necessary. Implementation partners include the Los Angeles County Office of Education (LACOE), Los Angeles Unified School District (LAUSD), other local schools districts, and the participating schools where the services will be based. Other key partners include the Los Angeles County Departments of Health and Public Health and the Community Clinic Association of Los Angeles County (CCALAC), child care and development programs serving children from birth to five, and other health, mental health, and other social services that may already be co-located and/or delivering services on-site at the selected schools. It is expected that agencies selected to run the PEI programs will be experienced or have the capacity to provide school-based services as well as collaborate with other agencies to provide integrated school-based services.

Should it be determined that additional mental health or other services not available at the school site are needed or that more intensive mental health services are needed than the program offers, the PEI agency will be expected to confer with and refer the student and his/her family to appropriate resources. Each PEI agency will build collaborative relationships with a range of health, social service, mental health, educational, and other resources.

C. Target Community Demographics

This project will target the pre-K-12 student population of all ethnicities and their families throughout the entire county. Please see Appendix 9, for a full description of the demographic profile of the county and its service areas. This is a sizeable number of individuals. Roughly one quarter of the 10 million county residents fall within the PEI Child age group (0-15) and an additional 14% of individuals fall within the TAY age group (16-25). There were 1.93 million students enrolled in pre-K through high school (2005) and roughly 2.3 million family households.

Through the *Vulnerable Communities* report LACDMH was able to identify regions where underserved cultural populations reside and also identify areas which had particularly high dropout rates. For example, as indicated in the demographic and statistical data section above, problems in school disproportionally affected underserved cultural groups especially non-White and non-Asian students. African-American and American Indian/Alaskan Native students had the lowest high school graduation rates seen across racial groups and Service Areas 4 and 6 had the lowest graduation rates across county service areas.

D. Highlights of New and Expanded Programs

The nine PEI programs in the School-based Project are new programs that are being offered at school sites that do not currently provide these services. The County will work with local school districts, County Departments of Health, Alcohol and Drug Abuse Program, and Public Health to select sites where these programs may be located. The approach to these services is meant to be an integrated service model, with preventive and early intervention services acting as a partner with other health services, preventive public health services, and child care and development programs. Where possible, the PEI programs will be offered at a school health center located at the site to encourage family to participate in the programs and to minimize any stigma or discrimination barriers to accessing these services.

E. Action Plan

The School-based Services Project will require the following start-up activities for contract agencies:

1. Solicit proposals through County bidding process
2. Establish partnerships with schools, agencies, health centers, and other partnerships
3. Establish MOUs or other contracts confirming partnerships and scope of activities as needed
4. Recruit and hire staff
5. Train staff in EBP/CDE model protocols
6. Conduct outreach and education

Specific activities for each PEI program are listed below.

Programs	Objectives: Frequency And Duration
Aggression Replacement Training	• Conduct three 1-hour sessions per week for 10 weeks or each round of services
Cognitive Behavioral Intervention for Trauma in School (CBITS)	• Hold 10 child group sessions for each client as needed • Conduct 1-3 individual child sessions for each client • Conduct at least two parent educational sessions • Hold at least one teacher informational meeting
Early Risers for Success	• Provide 4-day/week summer day camp for 6 weeks • Conduct school year friendship groups (number to be determined) • Hold five family nights with parent education per year • Provide case management and mentoring as needed
Families and Schools Together (FAST)	• Conduct eight weekly meetings (2.5 hours) in groups of 8-12 families • Conduct monthly follow-up meetings for 2 years
Multidimensional Family Therapy (MDFT)	• Conduct two sessions per week for a period of 3-6 months for each round of services
Olweus Bullying Prevention Program	• Conduct weekly 20-40 minute classroom meetings over a period of 25-52 weeks
Psychological First Aid	• Identify school and teachers to be trained • Conduct teacher training
Strengthening Families	• Conduct seven 2-hour sessions with parents and children for each
Why Try? Program	• Conduct a 10 week curriculum, with lessons 45-minutes each, for each training session

F. Key Milestones and Timeline

1.	Develop Requests for Proposals/Requests for Services	Months 1-3
2.	Obtain County Counsel approval for RFPs/RFSs	Months 1-3
3.	Solicit proposals & evaluate proposals	Months 3-9
4.	Award proposals	Months 6-12
5.	Develop LACDMH PEI program and infrastructure	Months 1-3
6.	Recruitment, hiring and training of staff (LACDMH)	Months 1-6
7.	Implement programs	Months 6-12
8.	Conduct training on LACDMH requirements for agencies	Months 7-12
9.	Conduct training in EBP and CDE model protocols	Months 7-12
10.	Conduct outreach and education	Months 3-12
11.	Set up data collection procedures and requirements	Months 1-6
12.	Conduct quarterly PEI provider meetings	Month 12 and on

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Aggression Replacement Training (ART)	Individuals: 300 Families: 100	Individuals: 600 Families: 200	4
Cognitive Behavioral Intervention for Trauma in School (CBITS)	Individuals: Families:	Individuals: 650 Families: 650	4
Early Risers Skills for Success	Individuals: Families:	Individuals: 480 Families: 480	4
Families and Schools Together	Individuals: 1,800 Families: 1,800	Individuals: Families:	4
Multidimensional Family Therapy	Individuals: 40 Families: 40	Individuals: 80 Families: 80	4
Olweus Bullying Prevention Program	Individuals: 2,800 Families: 2,800	Individuals: Families:	4
Psychological First Aid	Individuals: 24,000 Families:	Individuals: 40,000 Families:	4
Strengthening Families	Individuals: 125 Families: 125	Individuals: 100 Families: 100	4
Why Try? Program	Individuals: 900 Families: 900	Individuals: 360 Families: 360	4
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 29,965 Families: 5,765**	**Individuals:42,270 Families: 1,870**	4

5. LINKAGES TO COUNTY MENTAL HEALTH AND PROVIDERS OF OTHER NEEDED SERVICES

A. Linking PEI Participants to Services

This project will provide information about mental health, other supportive services and community resources to the children, youth, and family members who participate in the programs at the school sites. In instances where students and/or their parents or caregivers are perceived to need mental health assessment or extended treatment for mental illness or emotional disturbance, the provider is responsible for identifying appropriate agencies where these services can be provided. The provider will ensure that there is a direct referral and actual linkage with the referred agency so as to avoid creating additional barriers to services. These referrals will include mental health and primary care agencies as well as community-based organizations. Staff will help children, youth, parents, and other caregivers to articulate their needs and enhance their capacity to identify and connect with other appropriate services.

B. Linking PEI Participants to Non-Traditional Services

The School-based programs will enable students and their parents and other caregivers to access prevention and early intervention community resources including educational, substance abuse, domestic violence, community support, housing, employment, and high quality child care and development programs, and other resources. Programs are expected to conduct an assessment at the onset and conclusion of services to identify needs in order to ensure that referrals are made to appropriate services. Staff will help children, youth, parents, and other caregivers to link to these services and follow up to ensure a connection has been made.

C. Sufficiency to Achieve Outcomes

LACDMH conducted research on each of the EBP and CDE models to determine the costs for each program and ensure that the budget and program designs were adequate to achieve the required outcomes. The analysis also determined that program outcomes were in line with the project, State, SDMH, LACDMH, and community expectations. In the bidding process, agencies must demonstrate financial viability, organizational experience, management capability, and cultural competency to provide the services. All agencies selected to run the PEI programs will be required to participate in LACDMH training, including cultural competence, EBPs, PEI policies, and LACDMH policies. Further, they will be required to collect needs assessment data and participate in the evaluation protocols and activities in order to ensure the program is properly developed, clients adequately served and outcomes achieved.

6. COLLABORATION AND SYSTEM ENHANCEMENTS

A. Relationships, Collaborations and Arrangements

The School-based Services Project requires extensive collaboration with both government and private agencies. LACDMH already has a long-standing collaborative relationship with many of the elementary, middle and high schools located in the targeted regions in the Service Areas. Educational agencies include the Los Angeles County of Education, the school district in which the selected school sites are located, including the largest, the Los Angeles Unified School District. It is important that relationships be maintained or developed with key school personnel, including administration, teachers, nurses, social workers, and other educational professionals. To encourage collaboration and promote new partnerships, community-based organizations (CBOs) and non-mental health providers will have an opportunity to provide input to educational agencies through monthly Service Area Advisory Committee meetings and Service Area Provider meetings. Because this project requires defined parameters in working with schools each service area will be advised to implement school based planning meetings integrating PEI with other school based services to create a more holistic host of services for children and their families.

PEI will also provide regularly held PEI Provider meetings that will be open to the community at large. PEI Provider meetings will encourage and facilitate sharing resources and promoting partnerships and will offer technical assistance on PEI program sustainability to the group and to individual providers as needed. The Departments of Health, Public Health, Children and Family Services, and Public Social Services as well as the Regional Centers and law enforcement agencies are key implementation partners. Private agencies include health organizations, the Community Clinical Association of Los Angeles County, mental health providers, child care and development programs, and other social service, health, and family organizations. The project will build upon existing relationships in the community-based mental health and primary care system to provide school-based prevention and early intervention services.

(1) Outreach Strategies

PEI will outreach to CBOs and non-mental health providers through SAAC meetings, Service Area Provider meetings, PEI Provider meetings, the DMH PEI website, the PEI newsletter and the PEI distribution database that has a current membership of over 6,800 individuals. Outreach efforts will serve to bring CBOs and non-mental health providers to the implementation phase.

(2) Improving Collaboration with CBOs and Non-Mental Health Providers

LACDMH has included community based organizations (CBOs) and non-mental health providers from the very inception of the PEI planning process. To bring these organizations into the implementation phase, LACDMH has four different approaches:

(a) Incubation Academy

This program was designed to assist community and local mental health service providers in obtaining contracts with the Department of Mental Health to build capacity within the mental health system. Comprehensive information, resource references, technical assistance, mentorship, and/or sponsorship opportunities are included in this program, as well as guidance regarding County contracting procedures, documentation, and day-to-day business operations requirements.

(b) Master Agreement List Workshops

PEI Administration will hold a series of workshops to train prospective agencies, including CBOs, on how to qualify for inclusion on the Master Agreement list. The intention of this detailed workshop is to help agencies unfamiliar with county business practices clear the initial and sometimes confusing hurdles in becoming a contractor. As such, this training will include information on how to submit a Statement of Qualifications (SOQ) in response to a Request for Statement of Qualifications (RFSQ), and the ins and outs of the Requests for Services (RFS) process, the pathway by which they could ultimately provide PEI services.

(c) CDE Technical Assistance Workshops

PEI Administration will provide workshops to developers, including CBOs, whose programs were denied in the initial round of qualification. The workshops will focus on clarifying requirements for the CDE application, identification of outcome approaches, cultural practices, and procedures for resubmission. The intent of the CDE TA Workshops is to provide a hands-on step by step support for helping agencies develop and qualify their program as a CDE practice. In conjunction with this process, PEI Administration will work with developers on becoming an approved provider (i.e. qualifying for the Master Agreement List) as outlined above.

(d) Subcontracting

PEI administration recognizes that County minimum requirements to qualify for the Master Agreement List may not be met by many potential worthy MHSA/PEI service providers. In order to address those situations and for those CBOs who are not interested in obtaining a direct contract with LACDMH, another way for them to provide PEI services is to subcontract through an existing LACDMH provider. Additionally, this is an opportunity for small organizations to partner with and receive mentoring from experienced providers which in turn, may eventually lead to a direct contract with LACDMH.

B. Building Upon the Mental Health and Primary Care System

Expanded and new partnerships with mental health and primary care providers will be established through the School-based Services Project. It is anticipated that several of the PEI programs will be situated at school health centers already established at schools throughout the County, as well as at new school health centers currently in development. The stigma associated with seeking mental health services can be minimized by providing these services at the school health sites. Students, parents and caregivers will be referred to primary care providers as medical needs are identified. LACDMH provides mental health services to almost all of the 88 school districts in the County, and referrals from the PEI programs to existing traditional mental health providers should be a smoother process.

C. Leveraging Resources

The School-based Services Project will work with school districts and other educational and health agencies to leverage resources for the PEI programs. Leveraged resources include space, equipment, and staff time as needed. In the solicitation process, potential providers will be notified that agencies are expected to generate support and leveraged resources, such as space, equipment, staff, and volunteer time. LACDMH will seek those agencies that can demonstrate existing capacity and/or a systematic plan for generating resources through the bidding process. Where appropriate, Medi-Cal billing will be allowed.

D. Sustaining the PEI Project

Through the solicitation process, the County will determine the organizational and fiscal capacity of each agency to fiscally manage and sustain the PEI program. Continued funding of the program will be through MHSA PEI funds, as well as continuation of any leveraged funds, including in-kind resources and services. LACDMH will monitor the programs to ensure that outcomes are being met in a timely manner and that fiscal, program, and contract standards are adhered to as required.

7. INTENDED OUTCOMES

A. Specific Cultural Outcomes

Through its community mental health needs assessment, the county obtained a comprehensive understanding of the racial/ethnic and linguistic distribution of the population across fairly small geographic regions. The cultural diversity in the population required that the county carefully consider programs that could be implemented successfully for different ethnic and language groups. For this reason, when building each PEI project, programs were first identified on the basis of whether they had been

developed with specific cultural populations included in their validated studies. Inclusion of cultural populations during development is crucial in order to demonstrate and later realize the community effectiveness (i.e. generalizability) of a particular program for a specific population.

From there, program selections were made for each service area in accordance with the demographic profile of the area and the inputs received from the collection of local planning bodies mentioned earlier. As a result of this process, most individual outcomes directly involve underserved cultural populations as had been planned. In many cases due to the ethnic distribution across the county, these underserved cultural populations constitute, in fact, a majority in actual population estimates for a given region. So, programs residing in these areas will obviously impact these groups. Due to the inter-relationships between ethnicity, poverty, and other key indicators, locating programs within these areas is paramount and will be an important detail to note during the RFS process. To make this explicit, the following represents a sample of possible outcomes that can be expected for these specific populations based upon the programs selected in Los Angeles County:

- Reduction of high school drop-out rates for African-American, American Indian, Latino, and White students across the county.
- Reduction of the level of stigma attached to mental health problems for African-American, American Indian, Latino, and Asian/Pacific Islander populations.
- Reduction of symptoms of trauma in school aged children and TAY for African-American, American Indian, Latino, and Asian/Pacific Islander populations.
- Reduction of school violence (i.e. bullying and gang activity) for African-American, American Indian, Latino, and Asian/Pacific Islanders.
- Inclusion of two community-defined evidence programs.

B. General Project Outcomes

The tables below depict a more general summary of the project and program level outcomes and methods for measuring them.

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
INDIVIDUAL	• Decrease high school dropout rates • Decrease school behavior problems • Improve academic performance • Improve parental involvement • Improve coping skills	• California Dept. of Education Dropout Rates • School suspensions/expulsions • Student GPA • SPED Referrals for SED • Truancies • School violence reports
PROGRAM/SYSTEM	• Increased integration of mental	• Number of MHS offered within a school setting

	health/educational services • Increase number of children receiving mental health services • Increased involvement of parents in school-related matters	• Number of children receiving mental health screening • Number of children receiving mental health services • Improved attendance rates, standardized academic scores, API

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Aggression Replacement Training	• Reduced impulsiveness • Improved interpersonal skills • Decreased recidivism	• School Discipline reports • School violence reports • Student self report
Cognitive Behavioral Intervention for Trauma in School (CBITS)	• Decreased symptoms of depression • Decreased trauma symptoms • Improved parental psychosocial functioning	• Student self report on measures of anxiety/depression • Parent report
Early Risers for Success	• Improved academic achievement • Improvements in self-regulation for severely aggressive children • Improvement in parental distress for parents of severely aggressive children • Improvement in the use of effective parental discipline	• GPA • Parent, Teacher, Student report • School behavior reports • Measures of Achievement motivation
Families and Schools Together	• Improved social skills • Decreased aggression • Improved academic performance • Increased parent involvement in school	• Parent report • Teacher report • Standardized behavior scales
Multidimensional Family Therapy	• Increased school readiness for preschoolers • Decreased parental stress • Decreased parental drug use • Increased resource utilization	• Parent report • Therapist assessment
Olweus Bullying Prevention Program	• Reduction in reports of bullying and victimization • Reduction in student reports of general antisocial behavior – fighting, truancy and vandalism • Significant improvement in social climate of the class – less disruption, more order and discipline	• School violence reports • Student self report • Teacher report • School discipline reports
Psychological First Aid	• Stabilized emotions and behaviors of students • Students returned to an improved mental and emotional state after a crisis or disaster, ready to attend school and reengage in classroom learning	• Student self report measures of anxiety/depression • Mental health referrals post crisis • School attendance records
Strengthening Families	• Decreases in child behavior problems and depressive symptoms • Improvement in positive parenting • Improvement in family cohesion and communication	• Family assessment • Parent report

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Why Try? Program	• Increased social skills • Increased conflict resolution skills • Increased coping skills	• Student, Parent, Teacher reports • School discipline report • Attendance reports • GPA • Student self report survey • Measures of Achievement Motivation

C. Long Term Project Outcomes

The School-based Services Project will result in an improvement in the targeted student population which over time will increase the overall psychological adjustment of the student body. Long term outcomes include the reduction of school discipline problems in the classroom and acts of violence committed by students on campus. Additionally, the project will lead to an increase in the number of underserved students who graduate from high school and a decrease in the number children who develop a mental health disorder.

8. COORDINATION WITH OTHER MHSA COMPONENTS

A. Coordination with CSS

As part of their orientation, providers will be trained in the range of mental health services available in the County, including MHSA programs. As student needs are identified, providers will refer the students, parents, and other caregivers to appropriate MHSA CSS programs, such as the Full Service Partnerships for children, TAY, adults and older adults, juvenile justice linkages/collaboration, and alternative crisis services.

B. Intended Use of WET Funds

Students, parents, and other caregivers will be given information about relevant programs in the Workforce, Education and Training Plan, as appropriate given their expressed desire to enhance their education and/or vocational goals and meet the criteria to qualify.

C. Intended Use of Capital Facilities and Technology Funds

The County does not intend to use Capital Facilities and Technology Funds for this PEI Project at this time.

9. ADDITIONAL COMMENTS (OPTIONAL)

County: Los Angeles

PEI Project 2: FAMILY EDUCATION AND SUPPORT

Date:

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☒	☐	☐
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition -Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☒	☐	☐
4. Children and Youth at Risk for School Failure	☒	☒	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒	☐	☐
6. Underserved Cultural Populations	☒	☒	☒	☒

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Input gathered at various stages in the planning process from the six different needs assessment strategies was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project. As part of a multi-modal assessment, data was gathered formally through a stakeholder poll, a series of key individual interviews, a series of focus groups, and several community forums. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI. In order to proceed with project-building, all of the community assessment information was made available to the Ad Hoc Steering Committees who further refined population, age, and program selections. The current list of PEI projects emerged from these final sets of recommendations and reflects the localized needs of county service areas but also the specialized needs of countywide populations.

Given the population of Los Angeles County, the community needs assessment was correspondingly large and resulted in a diversity of findings which was not unanticipated. The main components of the needs assessment are discussed below as they relate to these specific patterns of responses which led to the creation of the Family Education and Support Project.

(1) Stakeholder Input

(a) Key Individual Interviews

► Input Regarding Priority Population. Key individuals with knowledge and experience of the Children/Youth in Stressed Families and Underserved Cultural Populations suggested that a primarily preventative project be developed in order to address issues of young parents and children and the difficulties involved with raising young families. Below are paraphrased examples of the Key individual responses:

- *Addressing the mental health needs of children is not sufficient. If the children return to stressed/dysfunctional families, the interventions with the child are often counteracted by the presenting problems of the family.*
- *Children in stressed families are considered a priority because they are "a precursor to all the other populations listed."*
- *Instead of treating populations separately, it makes more sense to develop PEI programs to be used across all of the priority populations. Services should be home- and school-based, designed to create strong, supportive environments in homes and schools where children can thrive. In homes, prevention could include parenting classes or other support services needed by families.*

- *It also would be important to include the children's family members. Early intervention is best done early, but there is a need to include family members as they are often not aware of how to identify mental illness and address co-occurring health and mental health issues.*
- *Children in stressed families are also often at-risk of school failure and involved with the juvenile justice system. This population lends itself more to true prevention and early intervention services where individuals with problems are caught early and families are addressed also.*
- *"These are the kids who come to our attention." If stressed children and their families can get help early on, it would prevent them from staying in the system, reduce their risk factors, and build the families' capacity.*
- *Children/youth in stressed families should be a priority as it is inclusive of all of the other priority populations.*
- *"I see a huge potential to help these children and their families—" the children and youth in stressed families.*

► Input Regarding Age Groups. In general, most respondents indicated that children were a priority, especially very young children, aged 0–5. Below are paraphrased examples of the Key individual responses:

- *"At every step of that age range you can intervene. Also, children are a sponge all the way up to 15 and there is not that stigma. And if you do early intervention, children are really smart and they can learn how to integrate that into their life. They are a lot more open and receptive to what any type of early intervention would mean for them."*
- *Most issues occur at a young age—anywhere between the ages of 0 and 15. The earlier services are provided to children, the better the outcomes.*
- *The first five years are key to the social, emotional, and physical development of children. "If those early years are health, children have more resiliency long-term."*
- *"Children are the barometer for the health in the household." When children start to show symptoms, it presents an entrée into the lives of families and an opportunity to engage parents in a conversation.*
- *Pre-natal to K is a top priority because the category includes the care of pregnant mothers. "If we address the needs of this priority population we can instill changes in behavior and improve outcomes."*
- *The behaviors in which the mother is engaged during and after pregnancy have an effect on the child. Therefore, we should reach mothers early and engage them in education and/or services that deter them from putting their in-utero child at-risk; as well as educating mothers once the child is born about positive child-rearing such as infant stimulation, attachment, and other parenting skills.*

- *Research exists supporting prevention among prenatal to five year old children. Research also indicates the long-term cost savings of prevention services. "It's an efficacious way to make a big but longer term impact."*

(b) Focus Group Interviews

► Input Regarding Priority Population. Focus Groups with knowledge and experience of the Children/Youth in Stressed Families and Underserved Cultural Populations suggested that a prevention project be developed to address the needs of young families. Below are paraphrased examples of the focus group responses:

- *The group prioritized the following needed early intervention services: More resources that would make it easier for families to obtain services; and, increased funding for high-need areas. One participant noted, "I believe we can be more effective if we had regular contact with DMH and were aware of other programs and services for the families that we're both committed to serving. If we know more we can do more and right now we feel this is a good start."*
- *Child abuse prevention training for mandated reporters and parents (i.e., parents need to know signs of child abuse and supervise their children when they are with friends and family); Funding for programs that can treat the parents as well as the children (i.e., a comprehensive family support system is needed); and All trainings need to be culturally relevant.*
- *Poverty was described by all respondents as another factor in the mental health needs noted above. Two respondents spoke about the poor state of the current economy which forces both parents to work in order to provide for their families. One participant added that the consequence of both parents working is that it leads to the disintegration of the nuclear family unit and reduces the amount of "quality time" families can spend together.*
- *The social-emotional well-being of families and communities is impeded "People are falling through the cracks."*
- *Young children in child care and child development programs are being expelled because they exhibit atypical behavior that the adults, care givers, and teachers are unable to address and handle. Parents and caregivers do not understand that family stressors can affect the child's development, exacerbate existing atypical behavior, and place additional stress on the child and the parents. There are higher rates of depression and suicide among mothers, especially during critical periods, such as during the postpartum and bonding/attachment stages.*

► Input Regarding Age Groups. Focus groups responses appeared to target the entire age spectrum with specific services envisioned for the very young (0 – 5) to older adults. This appeared to be due to the recognition that many environmental and social risk factors affect the entire family and not a single age grouping. Below are paraphrased examples of the focus group responses:

- *One group saw the need for early intervention services across the entire age spectrum to reduce all the risks mentioned earlier. Families are at risk because of high parental stress levels due to pressures such as poverty, work pressures, home/family conflicts, etc. There is a need for parents and their children to spend more time together which would increase their emotional well-being.*
- *Another group reported that a cadre of well-trained mental health consultants with expertise in the developmental needs of children 0 to 5 was needed; individuals who can work at sites to build a high quality nurturing environment that is able to address the social-emotional needs of the children without referring them out for services. One member saw the need for parent leadership training. "Once you get the parents leaders in there, and those budget cuts start coming they will come in and say, Oh, no! You can't take that away."*

(c) Community Forum Recommendations

Community Forum attendees were asked to prioritize PEI populations and age groups. These selections were then used by Ad Hoc Steering Committee members in making program selection recommendations.

► Input Regarding Priority Strategies. Below are some of the priority strategies selected by forum participants relating to the Family Education and Support Project:

- *Early assessments and referrals for parents during pregnancy and for children 0-5 at childcare centers, hospitals, Women Infant and Children (WIC) offices and other community based organizations.*
- *Provide comprehensive mental health and support services for children and their families through childcare development programs.*
- *Provide awareness raising trainings to children, youth, parents and teachers*
- *Education and training for parents and youth to identify and address mental health settings.*
- *No-cost, open eligibility, linguistically appropriate prevention education services for parents such as parenting classes on how to raise children, early identification on mental problems, and legal information about child abuse and service access advocacy.*
- *Provide low-cost or no-cost early intervention counseling services in non-traditional settings (e.g., in-home) for DCFS birth parents, couples, families, and individuals who may not have a diagnosis – participants emphasized that counseling services should be linguistically and culturally sensitive*
- *Education and outreach for families, community members, and providers on detecting early warning signs, reducing stigma, etc.*
- *Early education and mandatory pre-kindergarten for all income levels that include mental health and early intervention*

- *Prevention education for parents and teens on mental illness, stigma, and tolerance towards the gay, lesbian, bisexual and transgender community and holistic psycho-education support groups, and teen mentoring programs.*
- *Parenting classes that focus on self-esteem and the developmental stages and challenges of an adolescent. Classes to be facilitated at schools, parks, and community centers. Classes to be culturally and linguistically sensitive with no access criteria*
- *Provide culturally and linguistically sensitive education/support groups on leadership, advocacy, and child development. Groups to be facilitated by parents at trusted locations such as: schools, parks, and community centers. Groups to be open to everyone regardless of their legal status.*
- *Increase availability and access to no-cost, community-friendly services, including family therapy for undocumented families, which promote building healthy parent child relationships.*

(d) Ad Hoc Steering Committee Recommendations

The Ad Hoc Steering Committees were instrumental in developing PEI projects. Specifically, they identified key sub-populations and recommended programs to address the needs of those sub-populations.

► Input Regarding Sub-populations. Committee members prioritized groups that were need of a comprehensive approach involving the school, the family and the community. Below are some examples of these responses:

- *Children whose parents are in need of a culturally competent parenting class(es).*
- *Children whose parents need support & guidance to establish healthy and trusting relationships with their children including a need for supports for healthy attachment.*
- *Children/families dealing with special needs (i.e. developmental or physical abilities, including siblings affected by special needs.)*
- *Children of single mothers; or, pregnant teens; or, children with a lack of parental involvement or supervision.*
- *Children experiencing prodromal symptoms of psychosis; children experiencing social/emotional maladjustment that results in poor academic achievement.*
- *Children of single mothers; or, pregnant teens; or, children with lack of parental involvement or supervision; or, children with parents who are separated/divorced.*
- *Children with physical and developmental disabilities.*
- *Teen parents.*
- *Families and children where care is being provided by a grandparent or other relative caregiver; children of parents who have mental health issues and developmental disabilities; or children of adolescent mothers and fathers.*

- *Families and children with multiple needs of children and where daily needs are not met, including families with low socioeconomic status and/or support, families with special needs children, and families experiencing food scarcity, children in families without transportation, or children in families on cash aid/family separation due to military service, incarceration or other life trauma.*
- *Children of single mothers; or, pregnant teens; or, children with a lack of parental involvement or supervision.*
- *Families and children where care is being provided by a grandparent or other relative caregiver; children of parents who have mental health issues and developmental disabilities; or children of adolescent mothers and fathers.*
- *Families and children with multiple needs of children and where daily needs are not met, including families with low socioeconomic status and/or support, families with special needs children, and families experiencing food scarcity, children in families without transportation, or children in families on cash aid/family separation due to military service, incarceration or other life trauma.*

(2) Data Analysis

(a) Statistical and Demographic Indicators

The LACDMH *Vulnerable Communities* report detailed demographic variables and key risk factors. Each indicator in the report was selected on the basis of its empirical link with a PEI priority population and community mental health need. Together with the Key Individual Interviews and Focus Groups responses, the following indicators were found to confirm the need for the creation of a project focused on the needs of Children/Youth at Risk for School Failure and Children/Youth in Stressed Families populations. The following selected demographic variables and risk factors demonstrate the need for services: Poverty, Unemployment Rate, Disrupted Families, Ethnicity, Primary Language, and Linguistic Isolation.

(b) Poverty

Research on neighborhood effects demonstrates that socioeconomic status is an important predictor of behavioral, mental health and academic outcomes for children (Leventhal & Brooks-Gunn, 2000; Wadsworth & Achenbach, 2005). Children and adolescents residing in impoverished areas are more likely to developmental disorders, commit crimes, and have problems in school. Adults in disadvantaged neighborhoods have been found to be more likely to develop major depression and substance abuse disorders (Silver, Mulvey, Swanson, 2002).

County summary figures indicated that poverty is widespread and disproportionately affects ethnic minority populations. In the *Vulnerable Communities* report, three percentages were reported for each ethnic group. The first of these figures indicated the percent of individuals within an ethnic group who fell under 200% FPL. In 2005, 40.2%

of African-Americans in Los Angeles County were living below the 200% FPL, 30.3% of Asians, 53.5% of Hispanics and 18.5% of Whites. The second poverty figure reported, the percentage of individuals living under 200% FPL by ethnicity, indicated that Whites made up 14.1% of the poverty population, African-Americans, 9.3%, and Hispanics 65.2%. These figures also told us that Hispanics were overrepresented within the poverty population, as they make up 47% of the county's total population. The final poverty figure reported was an ethnic group's population living in poverty as a percentage of the total population. In Los Angeles County, 5.5% of the population were Whites living in poverty and 3.6% of the county's population were African-Americans living in poverty. The most striking figure in this set showed that 25.2%, or one in four individuals in the county, were Hispanic and living in poverty.

(c) Unemployment Rate

Though correlated with the poverty indicator, unemployment rate is another way to understand the economic stress that families face. Additionally, unemployment itself contributes to mental illness, especially when it occurs at critical points in a family's life cycle (McKee-Ryan, Song, Wanberg, & Kinicki, 2005). Specifically, unemployment has been linked with increased rates of somatic complaints, anxiety, depression, marital problems, suicide, and child abuse in families (Dew, M. A., Penkower, L., & Bromet, E. J., 1991). Californian Labor Market Information (State of California, Employment Development Division) indicated that unemployment rates over 2005-07 have risen in Los Angeles County, the State of California, and the United States. Despite the different methods and sources employed in gathering these data, there is a clear rising trend in the unemployment across the county, state, and nation.

(d) Disrupted Families

Research indicates that, in general, single-parent families encounter more stress and have more difficulty coping with stressful life events than families headed by a married couple. This indicator shows areas where high concentrations of disrupted families reside with lower ratios indicating more social disruption (Goodman & Haugland, 1994). Countywide, the Disrupted Families (DF) ratio was 2.2, which means that there were over twice as many intact families, (i.e., families with two parents), as single-parent families across the county. Across service areas, the DF ratio ranged from 2.7 in Service Area 3 to 1.6 in Service Areas 4 and 5. The smaller ratio in the West and Metro areas may indicate more widespread family stress typically associated with single parenting.

(e) Ethnicity

Ethnicity is the single most important indicator in terms of mental health disparities in the research literature. Numerous studies have shown that ethnic minorities and, in particular, African-Americans, Latinos, Asian/Pacific Islanders, and American Indians,

encounter more barriers in accessing mental health services than Whites. Los Angeles County has a diverse ethnic population representing nationalities and ethnic groups from all over the world. The Hispanic population is the largest ethnic group residing in the county and makes up 47.0% of residents, or almost one-half of the population. Following this, Western European Whites are the second most populous ethnic group and account for 25.2 percent of the population. Asians are the third most populous group at 12.5%, and African-Americans make up 8.9% of the county population. No other ethnic group accounts for more than 3% of the population. Even so, there are sizeable numbers of Armenians, Russians, South Asians, Iranians, multiethnic individuals, and other Middle Easterners throughout the county.

Since the US Census 2000, when individuals gained the opportunity to be counted as having "two or more major races," the nation has seen a rising trend in the numbers of individuals within this category. Multi-ethnic individuals now are more numerous in the county than Armenians, Russians, South Asians, Iranians, and American Indians/ Alaskan Natives. Research on the mental health problems of multi-ethnic individuals within clinic populations indicates that the severity of their behavior problems may exceed those with a mono-ethnic identity (Choi, Harachi, Gillmore, Catalano, 2006; Shih & Sanchez, 2005).

(f) Primary Language

An individual's Primary Language, if something other than English, can function as a barrier to accessing mental health services. Results from the ACS 2003-2006 consistently rank California as the state with the highest numbers of individuals (about 20%) reporting limited English proficiency, (i.e., they report speaking English "less than very well", ACS American Factfinder, 2008). Studies conducted with Spanish-speaking and Asian language-speaking populations have reported large disparities in accessing mental health services; individuals proficient in English have a clear advantage in getting mental health help over those who are not proficient (Snowden, Masland, & Guerrero, 2007). Across the county, the most common Primary Language, English, was only identified by 40.0% of the population and this was only a few percentage points higher than Spanish (37.1%). This also indicates that 60% of the county's population identifies a language other than English as the language they speak at home. Following English and Spanish, and at far fewer numbers, the most frequently spoken languages across the county were Tagalog (2.2%), Korean (1.9%), Chinese (1.7%), and Armenian (1.4%).

(g) Linguistic Isolation

Limited English proficiency represents a strong barrier to mental health treatment, learning, and school success. Besides ethnicity, limited English contributes to mental health disparities involving access to services (Snowden, Masland, & Guerrero, 2007). Linguistically isolated families represent some of the most disadvantaged individuals in

society. In terms of mental health, linguistically isolated families may not be receiving information on where or how to get help when a family member needs it. Overall, approximately 247,418, or 7.8% percent, of households in Los Angeles County reported that they were linguistically isolated. Across the county, this percentage ranged from the low of 0.4% in the Long Beach E. area, 0.5% in the Redondo-Manhattan-Hermosa-El Segundo Beach areas to 22.7% in the East LA area, and 25.5% in the Pico Heights area.

3. PEI PROJECT DESCRIPTION

A. Why the proposed PEI project – including key community need(s), priority population(s), desired outcomes and selected programs – addresses needs identified during the community program planning process

By reviewing the available information generated from the county needs assessment, stakeholder groups were able to recommend PEI programs for their respective communities and constituencies. As the Ad Hoc Steering Committees generated their program recommendations and targeted sub-populations, clusters of related programs began to coalesce around a core service which was then named the Family Education and Support Services Project.

The extent of the need for services to families is seen by a review of the data sources presented. Poverty statistics provided by the US Census Bureau indicated that large groups of underserved cultural populations were living with family incomes below 200% of the Federal Poverty Level. A correlational analysis of key indicators found that poverty was highly related to virtually all other risk factors relevant to PEI. Poverty appeared to function as a higher order risk factor that generally placed afflicted families at-risk for many (if not all) of the social problems which the MHSA was meant to address. Besides clear racial differences, poverty was seen to be tied to geographic regions and individuals in these areas, regardless of race, were similarly affected. Another measure, disrupted families, was used to assess family stress related to single parent families. The data for this indicator highlighted communities where there were a significant number of single parents compared to intact families.

Demographic indicators were also considered by stakeholders because they are highly related to issues pertaining to mental health disparities. Ethnic and primary language distribution indicated where potential barriers to services might exist. Since individuals who cannot speak English are often the most isolated in Los Angeles, LACDMH assessed where these individuals lived and reported it to stakeholder groups.

Prioritizing solutions to attenuate these family-related risks factors became possible by listening to the stated needs and desires of community stakeholders through the needs assessment activities. Some of the comments the Department received with regard are

extracted above and show the intensity of stakeholder convictions that a family-focused project was needed, one that was largely related to addressing parenting and the prevention needs for the very young and another targeted at the older children, TAY, and adults as more of an early intervention.

Project Purpose. The Family Education and Support Project will build competencies, capacity and resiliency in parents, family members and other caregivers in raising their children by teaching a variety of strategies. Services will be offered to a diverse population throughout the county. The project utilizes universal and selective intervention as well as early intervention approaches for children/youth in stressed families. The programs will address the risk factors and protective factors that promote positive mental health, concentrating on parental skill-building through a variety of training, education, individual, group parent, and family interaction methods.

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Poverty • Ethnicity • Geographic region • Family dysfunction • Insecure attachment • Authoritarian parenting • Parental mental health disorder • Early sexual behavior • Early onset of aggression • Mental health disorders • Victimization • Family violence • Teen pregnancy • Marital conflict	• Effective parenting • Family support • Sociability • Problem solving skills • Parental sense of competence • Social support • Self-efficacy • Marital satisfaction

Project Components. Each project is comprised of the following components:

1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.
2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.
3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures that accurate data is captured on a systematic and ongoing basis so that the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure

that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.

4. PEI Programs – There are a total of six EBP and CDE programs that will be implemented in eight service areas for the Family Education and Support Services Project.

Outreach and Engagement to Unserved and Underserved Communities. Because one of the overarching goals of the MHSA is the reduction of mental health disparities experienced by specific racial/ethnic and other cultural groups, all projects have been built with service components to achieve this end. The outreach and engagement component for each PEI project is a critical element in reducing disparities because it is primarily concerned with increasing access to programs, a first step in dismantling barriers to services. The County strategy for outreach and engagement involves the utilization of existing County outreach workers, activating existing community resources and organizations, and the development of culturally and linguistically sensitive materials. All of these tools will be combined into a coordinated effort to seek out difficult to reach populations, educate groups regarding PEI programs, and facilitate entry into an appropriate program.

Outreach and engagement activities for the Family Education and Support Project will include, but are not limited, to the following:

Community Leaders and Organizations

- Working with cultural brokers or community representatives to develop outreach strategies. LACDMH will seek input from the key individuals, focus group participants, and community organizations that participated in the planning process to identify and implement culturally and linguistically appropriate methods for reaching the targeted individuals in these unserved/underserved communities.
- Engaging local ethnic community leaders and gatekeepers, while recognizing that many people in these communities lack knowledge of, distrust, and/or are reluctant to use mental health services. Personal contact with these individuals is a key method to increase community knowledge about PEI programs and to facilitate access to these programs.
- Providing information and training in small group settings (e.g. church, temple or other place of worship that has a primarily minority congregation) in local neighborhoods or ethnic community. These sites would be asked to host training and educational forums, bulletins for educational information, and people to serve as volunteers.

Educational Materials

- Developing educational materials about the Family Education and Support Project. The materials will be translated, culturally relevant, at the appropriate literacy level, and visually accessible (large print and Braille). Community input will be sought in

the approach and design of materials to ensure the materials are culturally sensitive.
- Distributing an information sheet about the outreach and engagement efforts, including outreach staff contact information as well as programs' contact information. These flyers will be distributed at meetings and posted in places where the target population is expected to congregate, such as health centers, schools, day care/childcare centers, pre-schools, PTA meetings, health centers, ESL classes, and so forth.
- Distributing press releases, informational articles, and paid advertising (both in English and the appropriate threshold language) in local ethnic newspapers, radio, television, and websites.

Community Outreach Workers
- Collaborating with LACDMH's CSS outreach and engagement staff. Since the inception of the CSS programs, these individuals have developed relationships with numerous community providers. LACDMH will seek the assistance of these staff to provide community linkages for the PEI programs and distribution of information.
- Hiring and training outreach workers, especially those with non-English language ability, from the local communities and the unserved/underserved communities.
- Recruiting and training volunteers from the community who are familiar with the unserved/underserved communities.

Partner Organizations
- Working though existing organizations, such as schools, clubs, churches, and other organizations.
- Collaborating with partner organizations to promote joint outreach efforts.
- Providing training or informational sessions to local organizations such as schools, neighborhood groups, PTAs, human service agencies, about the PEI programs.

Family Education and Support Programs. Incredible Years, Triple P Positive Parenting Program, and Nurturing Parenting Program were selected to address a host of family risk factors such as living in poverty, being uninsured, being recent immigrants, living in high crime areas, having a family member with a mental illness, witnessing or suffering from violence, living in a single parent household, and living with a disability, having an out of home placement to name a few. Mamás y Bebés was chosen to address the problem of teen parenting and special problems of Latino immigrants. And the Nurse-Family Partnership program was selected to address the needs of overwhelmed families, very young families, families where maternal depression is evidenced, and families with children at-risk for out of home placement.

Prevention & Early Intervention	Early Intervention
Incredible Years	Caring for Our Families
The Mothers and Babies Course "Mamás y Bebés"	
Nurse-Family Partnership	
Nurturing Parenting Program	
Triple P Positive Parenting Program	

(1) Prevention and Early Intervention Services

- **Incredible Years – Young Children and Children.** Incredible Years is a set of comprehensive, multifaceted, and developmentally based curricula targeting 2-12 year-old children and their parents and teachers. The parent, child, and teacher Incredible Years training interventions are guided by developmental theory on the role of multiple interacting risk and protective factors in the development of conduct problems. The parent, child, and teacher training components are designed to work jointly to promote emotional and social competence and to prevent, reduce, and treat behavioral and emotional problems in young children. Incredible Years is an EBP geared toward young children and school age children at risk for school failure or juvenile justice involvement. This program will be implemented in Service Areas 2, 3, 4, 5, 7, and 8.

- **The Mothers and Babies Course "Mamás y Bebés" – Transition-age Youth.** Mamás y Bebés is a prenatal intervention designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. Developed in Spanish and English, this EBP uses a cognitive-behavioral mood management framework, and incorporates social learning concepts, attachment theory, and socio-cultural issues. Methods have been adapted from existing psychological treatment approaches, such as interpersonal psychotherapy and cognitive-behavioral therapy. The goal of the intervention is to help participants create a healthy physical, social, and psychological environment for themselves and their infants. The program is specifically designed to be culturally sensitive and linguistically appropriate for immigrant, low-income Latinas. The Mothers and Babies Course “Mamás y Bebés” has been implemented with Latina mothers at risk for depression during pregnancy and postpartum. It will be implemented in Service Area 7.

- **Nurse-Family Partnership – Young Children and Transition-age Youth.** The Nurse-Family Partnership (NFP) program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child’s second birthday. Ideally, nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits may continue until the baby is two years old. Nurses use their professional nursing

judgment and increase or decrease the frequency and length of visits based on the client's needs. The Nurse-Family Partnership program is an EBP intended for first-time low-income mothers. This program will be implemented in Service Areas 1, 4, 6, and 8.

- **Nurturing Parenting Program – Children.** The Nurturing Parenting Programs are family-based programs utilized for the treatment and prevention of child abuse and neglect. Developed from the known behaviors that contribute to the maltreatment of children, the goals are to teach age-appropriate expectations and neurological development of children; develop empathy and self worth in parents and children; utilize nurturing, non-violent strategies and techniques in establishing family discipline; empower parents and children to utilize their personal power to make healthy choices, and increase awareness of self and others in developing positive patterns of communication while establishing healthy, caring relationships. The Nurturing Parenting Program is an EBP for school age children and their parents or caregivers. This program will be implemented in Service Area 7.

- **Triple P Positive Parenting Program – Young Children and Children.** The Triple P—Positive Parenting Program is a multilevel system or suite of parenting and family support strategies for families with children from birth to age 12, with extensions to families with teenagers ages 13-16. Developed for use with families from many cultural groups, Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program, which also can be used for early intervention and treatment, has five intervention levels of increasing intensity to meet each family's specific needs. This is an EBP that will be implemented in Services Areas 1 and 4.

(2) Early Intervention Services

- **Caring for Our Families – Children.** Caring for Our Families is a culturally appropriate adaptation of national "Family Connections" model that includes community outreach, family assessment, and individually tailored program of counseling, referrals and linkages. The goal of Caring for Our Families/Family Connections is to help families meet the basic needs of their children and reduce the risk of child neglect. Nine practice principles guide FC interventions: community outreach; individualized family assessment; tailored interventions; helping alliance; empowerment approaches; strengths perspective; cultural competence; developmental appropriateness; and outcome-driven service plans. The core components of FC include (a) emergency assistance/concrete services; (b) home-based family intervention (e.g., family assessment, outcome-driven service plans, individual and family counseling); (c) service coordination with referrals targeted toward risk (e.g., substance abuse treatment) and protective factors (e.g., mentoring program); and (d) multi-family supportive recreational activities (e.g., theme-based gatherings such as Black History month, trips to museums, etc.). This is a CDE early intervention practice that will be implemented in Services Areas 4 and 8.

(3) Targeted Populations

The table below describes the targeted populations for each of the Family Education and Support Programs.

Program	SA	Age Group	Target Populations
Caring For Our Families	4	Children	➢ Children at risk of neglect. Children in immigrant families. Children exposed to family trauma such as domestic violence, incarceration, or substance abuse. ➢ Primary cultural groups are Korean and Cambodian immigrant families, though the program may also serve other Asian/Pacific Islander communities.
	8	Children	➢ Children at risk of neglect. Children in families with mental health/social issues such as mental health problems, drug abuse, poor parenting, teen parents, incarceration, domestic violence. Groups who are linguistically, culturally, or socially isolated and may be inappropriately served. ➢ Primary cultural groups are Korean and Cambodian immigrant families, though the program may also serve other Asian/Pacific Islander communities.
Incredible Years	2	Young Children	➢ Children at risk of school failure. Children in families with insufficient income and resources to meet their children's needs. Children whose parents are in need to culturally competent parenting classes. ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, and Asians. There are also significant populations of Armenians, African Americans, and Russians who will be served.
	3	Young Children	➢ Children of immigrant families and families who cannot access mental health care due to stigma, educational, financial, or isolation issues. Historically underserved populations. Children whose parents are experiencing mental and/or physical disabilities, substance abuse, domestic violence, incarceration, lack of parenting skills, or a death or divorce in the family. ➢ Primary cultural groups are Hispanics/Latinos, who make up 45.0% of the Service Area 3 population, Asian groups (particularly Chinese) who make up 23.7%, and Western European Whites (23.3%).
	4	Children	➢ Children of uninsured immigrant families. Children who live in high crime neighborhoods. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
	5	Children	➢ Children in non-traditional families such as LGBTQ couple, grandparents in a parenting role, single parent families, and foster families. Children in families without support systems and who have not accesses needed services. ➢ Primary cultural groups include Western European Whites (53.1% of the population), Hispanics/Latinos (14.4%), Asians (11.4%), African Americans (8.1%) and Russians (5.3%).
	7	Young Children, Children	➢ Children experiencing emotional and/or behaviorally difficulties in school. Children with a prior unsubstantiated child abuse report. Children at risk for school failure, especially those who do not speak English. ➢ The primary cultural group in Service Area 7 is Hispanics/Latinos, making up

Program	SA	Age Group	Target Populations
			70.9% of the population. There are also significant Asian (9.1%) and Western European White (14.8%) populations who will be served.
	8	Young Children	➢ Children with physical or developmental disabilities. Children in out-of-home care. Children in families with socio-economic issues such as poverty, single parents, immigrant status, or a lack of insurance. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians, and African Americans.
The Mothers and Babies Course "Mamás y Bebés"	7	TAY	➢ Immigrant, low-income Latinas. Latina mothers at risk for depression during pregnancy and postpartum. ➢ The primary cultural group to be served by this program is Hispanic/Latina women.
Nurse-Family Partnership	1	Young Children	➢ First-time low-income mothers. Children of parents who have mental health issues. Children of adolescent mothers or fathers. Families and children with multiple needs where the daily needs are not met. ➢ The primary cultural groups are Hispanics/Latinos (41.0% of the Service Area 1 population), Western European Whites (39.0%) and African Americans (12.8%).
	4	Young Children TAY	➢ First-time low-income mothers. Children of parents who have mental health issues such as postpartum/maternal depression. Children in or at risk for involvement in the foster care system. Pregnant or parenting youth. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
	6	Young Children	➢ First-time low-income mothers. Children in families with substance abuse, domestic violence, and/or gang involvement. Children living in high crime/poverty neighborhoods. Children involved in the child welfare system. ➢ African Americans and Hispanics/Latinos will be the primary cultural groups served by this program.
	8	Young Children	➢ First-time low-income mothers. Children who need assistance outside traditional systems such as the homeless or the uninsured. Families with mental health/social issues include drug abuse, poor parenting, teen parents, incarceration or domestic violence. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
Nurturing Parenting Program	7	Children	➢ School age children and their parents or caregivers. Single parents, teen parents, and children who have experienced family violence. ➢ The primary cultural group in Service Area 7 is Hispanics/Latinos, making up 70.9% of the population. There are also significant Asian (9.1%) and Western European White (14.8%) populations who will be served.
Triple P Positive Parenting Program	1	Young Children	➢ Children in the care of a relative caregiver. Children of parents with a mental health issue or development disability. Children of adolescent parents. ➢ The primary cultural groups are Hispanics/Latinos (41.0% of the Service Area 1 population), Western European Whites (39.0%) and African Americans (12.8%).

Program	SA	Age Group	Target Populations
	4	Children	➢ Children in out of home placement, children exposed to family trauma, and children with a parent/sibling absent due to incarceration or deportation. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.

B. Implementation Partners and Type of Organization/Setting That Will Deliver the PEI Program and Interventions

Implementation partners include preschools and Headstart programs, family resource centers, community centers, hospitals, health clinics, and participating schools where the services may be offered. Other key partners include the Los Angeles County Departments of Health and Public Health and the Community Clinic Association of Los Angeles County (CCALAC), child care and development programs serving children from birth to five, and other health, mental health, and other social services that may already be co-located and/or delivering services on-site at schools and health centers. The Family Education and Support Project components will be offered at community sites where families are more prone to visit, such as community centers, churches, local parks and community-based agencies, school site, and health clinics. Community-based organizations as well as agencies with mental health and/or other human service experience will be solicited to provide these services through the County's bidding process. Implementation partners include health, education, social services, family resource centers, as well as mental health providers. Should it be determined that additional mental health or other services not available at the school site are needed or that more intensive mental health services are needed than the program offers, the PEI agency will be expected to confer with and refer the child and his/her family to appropriate resources. Each PEI agency will build collaborative relationships with a range of health, social service, mental health, educational, and other resources.

C. Target Community Demographics

This project will serve children and families throughout the entire county. In 2005, there were roughly 2.1 million households with an average of 2.6 individuals per family or approximately 5.5 million people. Through the *Vulnerable Communities* report the Department was able to identify regions where underserved cultural populations reside and also identify geographic areas which had particularly high risk factors. For example, as indicated in the demographic and statistical data section above, poverty disproportionally affected underserved cultural groups who were found to reside in different parts of the county. Because of the size of the county, no service area goes untouched in terms of its social problems; each has neighborhoods where poverty,

crime, and mental health and behavior problems intersect. But because the Department does have this information, programs for this project can be localized to reflect the cultural needs of the surrounding neighborhoods within a planning area.

D. Highlights of New and Expanded Programs

The six programs in the Family Education and Support Project are new programs that will be offered at sites that do not currently provide these services. The programs will be in culturally and linguistically appropriate for the target populations. The PEI programs will be offered at non-mental health sites, such as child care and development programs to encourage families to participate in the programs and to minimize any stigma or discrimination barriers to accessing these services.

E. Action Plan

The Family Education and Support Project will require the following start-up activities for contract agencies:

1. Solicit proposals through County bidding process
2. Establish partnerships with schools, agencies, health centers, and other partnerships
3. Establish MOUs or other contracts confirming partnerships and scope of activities as needed
4. Recruit and hire staff
5. Train staff in EBP model protocols
6. Conduct outreach and education

Specific activities for each PEI program are listed below.

Programs	Objectives: Frequency And Duration
Caring for Our Families	• Provide Emergency Assistance/Concrete Services • Provide Home-based Family Intervention • Provide Service Coordination with Referrals • Provide Multi-family Supportive Recreational Activities
Incredible Years	• Provide Child Intervention • Conduct Parent Intervention • Conduct Teacher Training
The Mothers and Babies Course "Mamás y Bebés"	• Provide Mood management course with booster sessions
Nurse-Family Partnership	• Conduct 60-90 minute hospital/home visits with mother and child
Nurturing Parenting Program	• Conduct 12-48 group or home based sessions for parents and their children

Programs	Objectives: Frequency And Duration
Triple P Positive Parenting Program	• Conduct Level 1: media campaign • Conduct Level 2: 1-2 20 minute consultations with clients • Conduct Level 3: 4 20-minute sessions with clients • Conduct Level 4: 10 individual or 8 group sessions (10 hours total) with clients • Conduct Level 5: Additional 3-5 individual sessions added to level 4

F. Key Milestones and Timeline

1.	Develop Requests for Proposals/Requests for Services	Months 1-3
2.	Obtain County Counsel approval for RFPs/RFSs	Months 1-3
3.	Solicit proposals & evaluate proposals	Months 3-9
4.	Award proposals	Months 6-12
5.	Develop LACDMH PEI program and infrastructure	Months 1-3
6.	Recruitment, hiring and training of staff (LACDMH)	Months 1-6
7.	Implement programs	Months 6-12
8.	Conduct training on LACDMH requirements for agencies	Months 7-12
9.	Conduct training in EBP and CDE model protocols	Months 7-12
10.	Conduct outreach and education	Months 3-12
11.	Set up data collection procedures and requirements	Months 1-6
12.	Conduct quarterly PEI provider meetings	Month 12 and on

4. PROGRAMS

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Caring for Our Families	Individuals: Families:	Individuals: 180 Families: 180	4
Incredible Years	Individuals: 140,400 Families: 140,400	Individuals: 1,560 Families: 1,560	4
The Mothers and Babies Course "Mamás y Bebés"	Individuals: 240 Families: 240	Individuals: 240 Families: 240	4
Nurse-Family Partnership	Individuals: 250 Families: 250	Individuals: 250 Families: 250	4
Nurturing Parenting Program	Individuals: 100	Individuals: 200	4

	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		
	Families: 100	Families: 200	
Triple P Positive Parenting Program	Individuals: 460 Families: 460	Individuals: 114 Families: 114	4
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 141,450** **Families: 141,450**	**Individuals: 2,544** **Families: 2,544**	4

5. LINKAGES TO COUNTY MENTAL HEALTH AND PROVIDERS OF OTHER NEEDED SERVICES

A. Linking PEI Participants to Services

This project will provide information about mental health, other supportive services and community resources to the children, youth, and family members who participate in the programs. In instances where children, youth and/or their parents or caregivers are perceived to need mental health assessment or extended treatment for mental illness or emotional disturbance, the provider is responsible for identifying appropriate agencies where these services can be providers. In addition to linkages to MHSA programs, agencies will consider mental health, primary care agencies, substance abuse programs, domestic violence programs, employment centers, educational institutions, as well as community-based organizations. The provider will ensure that there is a direct referral and actual linkage with the referred agency so as to avoid creating additional barriers to services. Staff will help children, youth, parents, and other caregivers to articulate their needs and enhance their capacity to identify and connect with other appropriate services.

B. Linking PEI Participants to Non-Traditional Services

The Family Education and Support Project will enable children, youth, their parents and other caregivers to access prevention and early intervention community resources including educational, substance abuse, domestic violence, community support, housing, employment, high quality child care and development program, and other resources. Programs are expected to conduct a needs assessment at the onset and conclusion of services to identify needs in order to ensure that referrals are made to needed services. Staff will help children, youth, parents, and other caregivers to link to these services and follow up to ensure a connection has been made.

C. Sufficiency to Achieve Outcomes

DMH and CiMH conducted research on each of the EBP and CDE models to determine the costs for each program and ensure that the budget and program designs were adequate to achieve the required outcomes. The analysis also determined that program outcomes were in line with the project, State, SDMH, LACDMH, and community expectations. In the bidding process, agencies must demonstrate financial viability, organizational experience, management capability, and cultural competency to provide the services. All agencies selected to run the PEI programs will be required to participate in DMH training, including cultural competence, EBPs, PEI policies, and LACDMH policies. Further, they will be required to collect needs assessment data and participate in the DMH evaluation protocols and activities in order to ensure the program is properly developed, clients adequately serviced, and outcomes achieved.

6. COLLABORATION AND SYSTEM ENHANCEMENTS

A. Relationships, Collaborations and Arrangements

The Family Education and Support Project requires extensive collaboration with both government and private agencies and organizations. LACDMH already has a long-standing collaborative relationship with many of the elementary, middle and high schools located in the targeted regions in the Service Areas. To encourage collaboration and promote new partnerships, CBOs and non-mental health providers will have an opportunity to provide input to family education and support agencies through monthly Service Area Advisory Committee meetings and Service Area Provider meetings. PEI will also provide regularly held PEI Provider meetings that will be open to the community at large. PEI Provider meetings will encourage and facilitate sharing resources and promoting partnerships and will offer technical assistance on PEI program sustainability to the group and to individual providers as needed. The Departments of Health, Public Health, Children and Family Services, and Public Social Services as well as educational institutions, family resource centers, Regional Centers and law enforcement agencies are key implementation partners. Private agencies include health organizations, community centers, mental health providers, child care and development programs, and other social service, health, and family organizations. The project will building upon existing relationships in the community-based mental health and primary care system to provide school-based prevention and early intervention services.

(1) Outreach Strategies

PEI will outreach to CBOs and non-mental health providers through SAAC meetings, Service Area Provider meetings, PEI Provider meetings, the DMH PEI website, the PEI newsletter and the PEI distribution database that has a current membership of over

6,800 individuals. Outreach efforts will serve to bring CBOs and non-mental health providers to the implementation phase.

(2) Improving Collaboration with CBOs and Non-Mental Health Providers

LACDMH has included community based organizations (CBOs) and non-mental health providers from the very inception of the PEI planning process. To bring these organizations into the implementation phase, LACDMH has four different approaches:

(a) Incubation Academy

This program was designed to assist community and local mental health service providers in obtaining contracts with the Department of Mental Health to build capacity within the mental health system. Comprehensive information, resource references, technical assistance, mentorship, and/or sponsorship opportunities are included in this program, as well as guidance regarding County contracting procedures, documentation, and day-to-day business operations requirements.

(b) Master Agreement List Workshops

PEI Administration will hold a series of workshops to train prospective agencies, including CBOs, on how to qualify for inclusion on the Master Agreement list. The intention of this detailed workshop is to help agencies unfamiliar with county business practices clear the initial and sometimes confusing hurdles in becoming a contractor. As such, this training will include information on how to submit a Statement of Qualifications (SOQ) in response to a Request for Statement of Qualifications (RFSQ), and the ins and outs of the Requests for Services (RFS) process, the pathway by which they could ultimately provide PEI services.

(c) CDE Technical Assistance Workshops

PEI Administration will provide workshops to developers, including CBOs, whose programs were denied in the initial round of qualification. The workshops will focus on clarifying requirements for the CDE application, identification of outcome approaches, cultural practices, and procedures for resubmission. The intent of the CDE TA Workshops is to provide a hands-on step by step method for helping agencies develop and qualify their program as a CDE practice. In conjunction with this process, PEI Administration will work with developers on becoming an approved provider (i.e. qualifying for the Master Agreement List) as outlined above.

(d) Subcontracting

PEI administration recognizes that County minimum requirements to qualify for the Master Agreement List may not be met by many potential worthy MHSA/PEI service providers. In order to address those situations and for those CBOs who are not interested in obtaining a direct contract with LACDMH, another way for them to provide PEI services is to subcontract through an existing LACDMH

provider. Additionally, this is an opportunity for small organizations to partner with and receive mentoring from experienced providers which in turn, may eventually lead to a direct contract with LACDMH.

B. Building Upon the Mental Health and Primary Care System

Expanded and new partnerships with mental health and primary care providers will be established through the Family Education and Support Project. It is anticipated that some of the PEI programs will have classes based at school health centers already established at schools throughout the County, as well as at new school health centers currently in development. Students, parents and caregivers will be given culturally appropriate information as well as referred to primary care and other behavioral health providers as medical needs are identified.

C. Leveraging Resources

The Family Education and Support Project will work with health, educational, and other social service agencies to leverage resources for the PEI programs. Leveraged resources include space, equipment, and staff time as needed. In the solicitation process, potential providers will be notified that agencies are expected to generate support and leveraged resources, such as space, equipment, staff, and volunteer time. LACDMH will seek or prioritize those agencies that can demonstrate existing capacity and/or a systematic plan for generating resources during the bidding process. Where appropriate, Medi-Cal billing will be another resource.

D. Sustaining the PEI Project

Through the solicitation process, the Department will determine the organizational and fiscal capacity of each agency to fiscally manage and sustain the PEI program. Continued funding of the program will be through MHSA PEI funds, as well as continuation of any leveraged funds, including in-kind resources and services. LACDMH will monitor the programs to ensure that outcomes are being met in a timely manner and that fiscal, program, and contract standards are adhered to as required.

7. INTENDED OUTCOMES

A. Specific Cultural Outcomes

Through its community mental health needs assessment, the county obtained a comprehensive understanding of the racial/ethnic and linguistic distribution of the population across fairly small geographic regions. The cultural diversity in the population

required that the county carefully consider programs that could be implemented successfully for different ethnic and language groups. For this reason, when building each PEI project, programs were first identified on the basis of whether they had been developed with specific cultural populations included in their validated studies. Inclusion of cultural populations during development is crucial in order to demonstrate and later realize the community effectiveness (i.e. generalizability) of a particular program for a specific population.

From there, program selections were made for each service area in accordance with the demographic profile of the area and the inputs received from the collection of local planning bodies mentioned earlier. As a result of this process, most individual outcomes directly involve underserved cultural populations as had been planned. In many cases due to the ethnic distribution across the county, these underserved cultural populations constitute, in fact, a majority in actual population estimates for a given region. So, programs residing in these areas will obviously impact these groups. Due to the inter-relationships between ethnicity, poverty, and other key indicators, locating programs within these areas is paramount and will be an important detail to note during the RFS process. To make this explicit, the following represents a sample of possible outcomes that can be expected for these specific populations based upon the programs selected in Los Angeles County:

- Prevention of child abuse and neglect for African-American, American Indian, Asian/Pacific Islander, and Latino populations.
- Prevention of domestic violence in African-American, American Indian, Asian/Pacific Islander, and Latino populations across the county.
- Promotion of positive parenting practices in African-American, American Indian, Latino, and Asian/Pacific Islanders.
- Inclusion of two community-defined evidence programs aimed at the Cambodian and Korean refugee population and the immigrant, low-income, Latina population

B. General Project Outcomes

The tables below depict a more general summary of the project and program level outcomes and methods for measuring them.

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
INDIVIDUAL	Decrease oppositional/defiant behavior in children Improved parenting skills Decrease in corporal punishment Improved parent stress management skills and other coping skills	Parent report Child report Therapist report

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
PROGRAM/SYSTEM	Decrease in SCAN reports Increase in number of parenting programs available Increase in the number of parents trained Improved interaction between DCFS/DMH More inclusive eligibility criteria for services	SCAN reports Number of Parenting programs offered Number of parents trained

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Caring for Our Families	• Improved child well-being • Decreased parental stress • Decreased child behavior problems	• Parent self report on measures of stress/depression • Child, parent, teacher ratings
Incredible Years	• Increase in positive and nurturing parenting • Decrease in harsh discipline • Reduction in child behavior problems at home and in school • Improvements in children's social competence and school readiness skills • Improved parent-child bonding • Improved parent-teacher and school involvement	• Parent report • Therapist assessment and report • Child behavior ratings • Teacher report and ratings
The Mothers and Babies Course "Mamás y Bebés"	• Fewer major depressive episodes for intervention in pilot trial • Improved stress management	• Mother self report of anxiety/ depression • Mother's health status • Prevalence of postpartum depression • Neonatal outcomes
Nurse-Family Partnership	• Improved maternal prenatal health • Fewer injuries to children • Reduced child abuse and neglect • Reduced arrests among mothers • Reducing arrests among adolescents of mothers participating in NFP	• Nurse ratings • SCAN reports • Maternal health status • Child health status • Maternal self report on depression scale
Nurturing Parenting Program	• Positive changes in parenting and childrearing attitudes • Clear differentiation of parent-child roles • Decrease in the use of corporal punishment	• Child/Parent ratings • SCAN reports
Triple P Positive Parenting Program	• Decreased child behavior problems • Increased parental competence • Decreased parental stress • Higher levels of parental self-efficacy in handling home and work responsibilities	• Parent ratings • Parent self report • Decreased SCAN reports • Therapist assessments

C. Long Term Project Outcomes

Long-term project outcomes include an increase in parenting skills, stress management and other coping behaviors with a related decline in child behavior problems. Parents should come to feel more in control and effective and for those participants one would expect to see a greatly diminished involvement of child protective services or an overall decline in the numbers of SCAN reports generated for participants. With multiple avenues for parenting support and training, one of the project goals would be to increase the awareness of community members regarding the resources that are available to assist stressed families. Finally as a system-wide change, one would expect to see greater coordination of services and follow-up between DCFS and DMH.

8. COORDINATION WITH OTHER MHSA COMPONENTS

A. Coordination with CSS

As part of their orientation, providers will be trained in the range of mental health services available in the County, including MHSA programs. As child/youth, parents and caregivers' needs are identified, providers will refer them to appropriate MHSA Community Services and Supports programs, such as the Full Service Partnerships for children, TAY, adults and older adults, juvenile justice linkages/collaboration, and alternative crisis services.

B. Intended Use of WET Funds

Students, parents, and other caregivers will be given information about relevant programs in the Workforce, Education and Training Plan, as appropriate given their expressed desire to enhance their education and/or vocational goals and meet the criteria to qualify.

C. Intended Use of Capital Facilities and Technology Funds

The Department does not intend to use Capital Facilities and Technology Funds for this PEI Project at this time.

9. ADDITIONAL COMMENTS (OPTIONAL)

County: Los Angeles

PEI Project 3: AT-RISK FAMILY SERVICES

Date:

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒	☒	☒
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition -Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☐	☐
3. Children and Youth in Stressed Families	☒	☒	☐	☐
4. Children and Youth at Risk for School Failure	☒	☒	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒	☐	☐
6. Underserved Cultural Populations	☒	☒	☒	☒

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s)

To create the best possible MHSA PEI Plan, it was essential that LACDMH compile and generate accurate information from a wide range of sources. The Department employed six different needs assessment strategies: recommendations from CSS planning, community surveys, service area population data profiles, key individual interviews, focus groups, and community/countywide forums to gather this information. Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups should be targeted in a given project. Input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI.

All of the community assessment information was made available to the Ad Hoc Steering Committees who further refined population, age, and program selections. The current list of PEI projects emerged from these final sets of recommendations and reflects not only the localized needs of county service areas but also the specialized needs of countywide populations. The main components of the needs assessment are discussed below as they relate to these specific patterns of responses which led to the creation of the At-Risk Family Services Project.

(1) Stakeholder Input

(a) Key Individual Interviews

► Input Regarding Priority Population. Key individuals with knowledge and experience of the Children/Youth in Stressed Families and Underserved Cultural Populations suggested that a primarily early intervention project be developed in order to address issues faced by families throughout the family life cycle. Below are paraphrased examples of the key individual responses:

- *Many kids don't have enough family support because the parents need to work a lot. There may not be enough empathy for the struggling people by the elected officials. People who are poor have migrated to this community and have brought their problems with them.*
- *Early interventions for children exposed to violence or extreme familial or community stressors are a priority because they tend to be sort of interlocking. It's hard to be in this community and not have one of the family stressors not be community violence. But it can also be domestic violence.*
- *Effective parenting should be a higher priority … we need to invest in breaking the cycle of generational mental health problems in families. We have a pretty good idea of the kids who are at risk… if we invested in really good prevention*

and early intervention, we might be able to break the cycles with some of these families.

- *Involving the parents in the process and using parenting education not only as a prevention measure, but as an intervention measure is crucial. "If parents are able to detect early symptoms it will be a lot easier to help them."*
- *Two priorities were unanimously endorsed by all of the participants: youth employment programs, and increased funding to create more services/programs for young people and parents since, "Parents are their child's first teachers" are vitally needed services.*
- *When asked to prioritize needed prevention services, participants ranked the top need services in the following order: 1) Education about mental health illnesses and abuse/domestic violence; 2) Provision of support services such as childcare and transportation; and, 3) Mentoring and peer support programs (for fathers in particular). One participant explained, "The typical participant in an anger management class is a male, usually a father, who's been involved in some typically more minor type domestic violence or issues with child abuse.*

► Input Regarding Age Groups. In general, most respondents indicated that children were a priority, especially very young children, aged 0-5. Below are paraphrased examples of the key individual responses:

- *Pre-natal to Pre-K age group for developmental reasons as issues of trust and stability are developed during the first years. "If we start with these small children, that is a preventive service."*
- *For the Prenatal to Pre-K age, "there's research showing that if you address it early, there's a lot of good outcomes for parents." The Nurse Family Partnership program providing home-based services to young mothers has been very effective with good, long-term outcomes. Children aged 6-15 could also benefit from services as they are more aware of and impacted by their environment; they are "trying to figure out how to cope with it." Children are old enough to be taught coping skills to help them deal with the stressors in their environment.*
- *"You start from one [age group] and you build it up; you work with the groups as they grow older."*
- *The Prenatal to Pre-K age range is considered the most important because "Biology is on our side with neuro-plasticity" (the brain's capacity for modification and reorganization). Parents with young children have a desire to "be good parents." They also have not yet become discouraged by the system, and are open to new experiences and ways of responding to their child. As a result children learn new patterns and ways of responding (which are registered by the brain). Even patterns that have already been established have an opportunity to be modified with new and different experiences. The impact is long-term.*

- *Teen parent population is key as intervention is possible with two populations simultaneously-- helping the adolescent with her issues and "helping her to be able to bond and develop the capacity to nurture that child."*

(b) Focus Group Interviews

► Input Regarding Priority Population. Focus groups with knowledge and experience of the Children/Youth in Stressed Families and Underserved Cultural Populations suggested that an early intervention project devoted to families at risk was needed. Below are paraphrased examples of the focus group responses:

- *One group saw the need to include comprehensive training across sectors, family-centered services, and integrated service provision. Comprehensive knowledge- and theory-based training about mental health for the 0-5 population could include: core training across sectors (physicians, teachers, family specialists, mental health professionals) on normal childhood development. Training for nurses on how to talk about mental health, especially those who provide home visitation services. Training that focuses on how to view the family system across multiple domains. Training on how to diagnose mental health issues in infants and young children.*
- *When asked what early intervention services are needed, the group listed the following services: Increased low-cost and no-cost inpatient and outpatient services for low-income people who lack insurance.*
- *Participants generally emphasized how drug addiction and the lack of treatment of individuals in poverty have exacerbated mental health problems to levels of crisis. This was particularly evident among their HIV clients. They also discussed the following problems related to the top mental health needs: An increase in homelessness, an increase in unemployment, an increase in criminal activity, and more incidents of domestic violence. The experience of multiple and intersecting stressors, such as HIV, drug addiction, and poverty lead to limited options and hopelessness and Intergenerational mental health and substance abuse problems.*
- *"Everyday I see kids having kids and they are the kids of the folk who have struggled with mental health and substance abuse for decades. It breaks my heart to see these kids repeat the same maladaptive behaviors of their parents."*

► Input Regarding Age Groups. Focus groups commented on providing services to age groups ranging form the very young through adulthood. Below is a paraphrased example of the focus group responses:

- *One group saw the need to include comprehensive training across sectors, family-centered services, and integrated service provision. Comprehensive knowledge- and theory-based training about mental health for the 0 to 5 population could include: Core training across sectors (physicians, teachers, family specialists, mental health professionals) on normal childhood*

development. Training for nurses on how to talk about mental health, especially those who provide home visitation services. Training that focuses on how to view the family system across multiple domains. Training on how to diagnose mental health issues in infants and young children.

(c) Community Forum Recommendations

Benefiting from the needs assessment that had been completed, Community Forum attendees were asked to prioritize PEI populations and age groups. These recommendations were then used by Ad Hoc Steering Committee members in making program selection recommendations.

► Input Regarding Priority Strategies. The following examples are some of the recommendations regarding priority strategies.

- *Embed service providers such as mental health specialists, family therapists, parent educators, "Mommy/daddy and Me" class facilitators, family literacy coaches and other mental health 'team' members at sites that at-risk families frequent such as preschools, early education centers, faith based organizations, and medical centers.*
- *Work with whole families-of-origin, particularly with youth in foster care, residential treatment facilities, and incarcerated youth. This would include crisis intervention for witnesses of violence (i.e. sibling and caregivers).*
- *Greater access to mental health services for youth prior to being released via Mental Health Courts (AB 2034 services). Services to include counseling and parenting classes for incarcerated youth with visits (family) based on successful program attendance.*
- *Provide low-cost or no-cost early intervention counseling services in non-traditional settings (e.g., in-home) for DCFS birth parents, couples, families, and individuals who may not have a diagnosis – participants emphasized that counseling services should be linguistically and culturally sensitive.*
- *Education and outreach for families, community members, and providers on detecting early warning signs, reducing stigma, etc. Free counseling services to prevent major mental health issues from developing*
- *Integrated services that are provided by government and/or with community- and faith-based organizations that link mental health with social services, substance abuse services, primary care, HIV testing, and short-term supportive housing.*
- *Stigma reduction by engaging faith-based organizations, using media, and programs in academic institutions.*
- *A collaborative cross-system network of mental health, community, and faith-based providers and organizations.*
- *Develop culturally and linguistically appropriate community outreach and PEI services, which includes the training of providers to be more culturally and linguistically appropriate.*

- *Collaborate with non-mental health agencies and trusted community agencies to identify early signs, refer to services, or provide PEI services.*
- *Mandated or incentivized parenting classes focused on child development, dealing with difficult teens, and mental health education.*

(d) Ad Hoc Steering Committee Recommendations

PEI projects were subsequently built by organizing programs into clusters of related interventions. The Ad Hoc Steering Committees were asked to further identify sub-populations that should be served in their service areas.

► Input Regarding Sub-populations. Below are examples of the target populations that the Steering Committees recommended for At-Risk Family Services Project.

- *Children in homes where domestic violence is present; children of abused parents, inter-generational violence; children living with emotional or verbal abuse; or, children who have experienced physical or sexual abuse.*
- *Families experiencing poverty, racism psychiatric and/or oppression; families with substance abuse and/or domestic violence; or families with individuals experiencing the onset of serious illness.*
- *Mothers who do not receive prenatal care; children of teen mothers who may be in foster homes or have a long history of being in foster care, who often experience insecure attachment; or, children who did not obtain secure child-parent/caregiver attachment.*
- *Children with caregivers who have a mental illness or substance abuse problem including postpartum depression.*
- *Children/families dealing with special needs (i.e.. developmental or physical abilities, including siblings affected by special needs).*
- *Foster children and youth or homeless children.*
- *Children whose parents, including teen parents, are experiencing mental and/or physical disability, substance abuse, domestic violence, incarceration, lack of parenting skills and a death or divorce in the family.*
- *Children in or at risk for involvement in the foster care system or children in the reunification process.*
- *Children at risk for gang involvement*
- *Children in families experiencing chronic homelessness.*
- *Children/families involved in the child welfare system whose mental health issues have not been diagnosed or addressed, or have not been accurately diagnosed or adequately treated.*
- *Children involved with DCFS and/or in out-of-home care*

(2) Data Analysis

(a) Statistical and Demographic Indicators

Demographic variables and key risk factors were compiled in the Department's report, *Vulnerable Communities in Los Angeles County: Key Indicators of Mental Health*. Each indicator was selected on the basis of its empirical link with a PEI priority population and community mental health need. Together with the Key Individual Interviews and Focus Groups responses presented above, the following indicators were found to be confirm the need for the creation of a project focused on the needs of Children/Youth in Stressed Families and Underserved Cultural Populations. The *Vulnerable Communities*, Key Individuals, and Focus Group data were excerpted for Community Forum attendees and Ad Hoc Steering Committee Members to assist in their deliberations. The following selected demographic variables and risk factors demonstrate the need for services: Poverty, Unemployment Rate, Disrupted Families, Ethnicity, Primary Language, and Linguistic Isolation.

(b) Poverty

Research on neighborhood effects demonstrates that socio-economic status is an important predictor of behavioral, mental health and academic outcomes for children. Children and adolescents residing in impoverished areas are more likely to developmental disorders, commit crimes, and have problems in school. Adults in disadvantaged neighborhoods have been found to be more likely to develop major depression and substance abuse disorders (Silver, Mulvey, Swanson, 2002). County summary figures indicated that poverty is widespread and disproportionately affects ethnic minority populations. In the *Vulnerable Communities* report, three percentages were reported for each ethnic group. The first of these figures indicated the percent of individuals within an ethnic group who fell under 200% FPL. In 2005, 40.2% of African-Americans in Los Angeles County were living below the 200% FPL, 30.3% of Asians, 53.5% of Hispanics and 18.5% of Whites. The second poverty figure, the percentage of individuals living under 200% FPL by ethnicity, indicated that Whites made up 14.1% of the poverty population, African-Americans, 9.3%, and Hispanics 65.2%. Hispanics were overrepresented within the poverty population, as they make up 47% of the county's total population. The final poverty figure, an ethnic group's population living in poverty as a percentage of the total population, show that 5.5% of the population were Whites living in poverty and 3.6% of the county's population were African-Americans living in poverty. The most striking figure in this set showed that 25.2%, or one in four individuals in the county, were Hispanic and living in poverty.

(c) Unemployment Rate

Though correlated with the poverty indicator, unemployment rate is another way to understand the economic stress that families face across the county. Additionally, unemployment itself contributes to mental illness, especially when it occurs at critical

points in a family's life cycle (McKee-Ryan, Song, Wanberg, & Kinicki, 2005). Specifically, unemployment has been linked with increased rates of somatic complaints, anxiety, depression, marital problems, suicide, and child abuse in families (Dew, M. A., Penkower, L., & Bromet, E.J., 1991). The tables generated from Californian Labor Market Information (State of California, Employment Development Division) indicated that unemployment rates over 05 - 07 have risen in Los Angeles County, the State of California, and the United States. Despite of the different methods and sources employed in gathering these data, one can see there is a clear rising trend in the unemployment across the county, state, and nation.

(d) Disrupted Families

Research indicates that, in general, single-parent families encounter more stress and have more difficulty coping with stressful life events than families headed by a married couple. This indicator shows areas where high concentrations of disrupted families reside with lower ratios indicating more social disruption (Goodman & Haugland, 1994). Countywide, the Disrupted Families (DF) ratio was 2.2, meaning there were over twice as many intact families, (i.e., families with two parents), as single-parent families across the county. Across service areas, the DF ratio ranged from 2.7 in Service Area 3 to 1.6 in Service Areas 4 and 5. The smaller ratio in the West and Metro areas may indicate more widespread family stress typically associated with single parenting.

(e) Ethnicity

Ethnicity is the single most important indicator in terms of mental health disparities in the research literature. Numerous studies have shown that ethnic minorities and, in particular, African-Americans, Latinos, Asian/Pacific Islanders, and American Indians, encounter more barriers in accessing mental health services than Whites. Los Angeles County has a diverse ethnic population representing nationalities and ethnic groups from all over the world. The Hispanic population is the largest ethnic group residing in the county and makes up 47.0% of residents, or almost one-half of the population. Following this, Western European Whites are the second most populous ethnic group and account for 25.2 percent of the population. Asians are the third most populous group at 12.5%, and African- Americans make up 8.9% of the county population. No other ethnic group accounts for more than 3% of the population. Even so, there are sizeable numbers of Armenians, Russians, South Asians, Iranians, multiethnic individuals, and other Middle Easterners throughout the county.

Since the US Census 2000, when individuals gained the opportunity to be counted as having "Two or more major races," the nation has seen a rising trend in the numbers of individuals within this category. Multi-ethnic individuals now are more numerous in the county than Armenians, Russians, South Asians, Iranians, and American Indians/ Alaskan Natives. Research on the mental health problems of multi-ethnic individuals within clinic populations indicates that the severity of their behavior problems may

exceed those with a mono-ethnic identity (Choi, Harachi, Gillmore, Catalano, 2006; Shih & Sanchez, 2005).

(f) Primary Language

An individual's Primary Language, if something other than English, can function as a barrier to accessing mental health services. Results from the ACS 2003-2006 consistently rank California as the state with the highest numbers of individuals (about 20%) reporting limited English proficiency, (i.e., they report speaking English "less than very well", ACS American Factfinder, 2008). Studies conducted with Spanish-speaking and Asian language-speaking populations have reported large disparities in accessing mental health services; individuals proficient in English have a clear advantage in getting mental health help over those who are not proficient (Snowden, Masland, & Guerrero, 2007). Across the county, the most common Primary Language, English, was only identified by 40.0% of the population and this was only a few percentage points higher than Spanish (37.1%). This also indicates that 60% of the county's population identifies a language other than English as the language they speak at home. Following English and Spanish, and at far fewer numbers, the most frequently spoken languages across the county were Tagalog (2.2%), Korean (1.9%), Chinese (1.7%), and Armenian (1.4%).

(g) Linguistic Isolation

Limited English proficiency represents a strong barrier to mental health treatment, learning, and school success. Besides ethnicity, limited English contributes to mental health disparities involving access to services (Snowden, Masland, & Guerrero, 2007). Linguistically isolated families represent some of the most disadvantaged individuals in society. In terms of mental health, linguistically isolated families may not be receiving information on where or how to get help when a family member needs it. Overall, approximately 247,418, or 7.8% percent, of households in Los Angeles County reported that they were linguistically isolated. Across the county, this percentage ranged from the low of 0.4% in the Long Beach E. area and 0.5% in the Redondo-Manhattan-Hermosa-El Segundo Beach areas to 22.7% in the East LA area and 25.5% in the Pico Heights area

3. PEI PROJECT DESCRIPTION

A. Why the proposed PEI project – including key community need(s), priority population(s), desired outcomes and selected programs – addresses needs identified during the community program planning process

After their review of the information generated from the county needs assessment, stakeholder groups were able to recommend PEI programs for their respective

communities and constituencies. As the Ad Hoc Steering Committees generated their program recommendations and targeted sub-populations, clusters of related programs began to coalesce around a core service which was then reified as the At-risk Family Services Project. The extent of needs among at-risk families is clearly elucidated by the aforementioned data sources. Poverty statistics provided by the US Census Bureau indicated that large groups of underserved cultural populations were living with family incomes below 200% of the Federal Poverty Level. A correlational analysis of key indicators found that poverty was highly related to virtually all other risk factors relevant to PEI. Poverty appeared to function as a higher order risk factor that generally placed afflicted families at-risk for many (if not all) of the social problems which the MHSA was meant to address. Besides clear racial differences, poverty was seen to be tied to geographic regions and individuals in these areas, regardless of race, were similarly affected. Another measure, disrupted families, was used to assess family stress related to single parent families. The data for this indicator highlighted communities where there were a significant number of single parents compared to intact families. Demographic indicators were also considered by stakeholders because they are highly related to issues pertaining to mental health disparities. Ethnic and primary language distribution indicated where potential barriers to services might exist. Since individuals who cannot speak English are often the most isolated in Los Angeles, the county assessed where these individuals lived and reported it to stakeholder groups.

By listening to the stated needs and desires of community stakeholders through key interviews, focus groups, and forums spread throughout the county, prioritizing solutions to attenuate these family-related risks factors became possible. Tackling problems as pervasive as poverty are beyond the scope of PEI, but putting programs in place to at least mitigate its harmful effects was not. The comments above regarding at-risk families indicate the intensity of stakeholder convictions that family-focused programs for at-risk children, youth, parents and other caregivers were needed.

Project Purpose. The At-Risk Family Services Project will (1) provide training and assistance to families whose children are at risk for placement in foster care, group homes, psychiatric hospitals, and other out of home placements; (2) build skills for families with difficult, out of control or substance abusing children who may face the juvenile justice involvement; and (3) provide support to families whose environment and history renders them vulnerable to forces that lead to destructive behavior and the disintegration of the family.

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Poverty • Ethnicity • Geographic region • Family dysfunction • Insecure attachment	• Effective parenting • Family support • Sociability • Problem solving skills • Parental sense of competence

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Authoritarian parenting • Parental mental health disorder • Early sexual behavior • Early onset of aggression • Mental health disorders • Victimization • Family violence • Teen pregnancy • Marital conflict	• Social support • Self-efficacy • Marital satisfaction • Extended family

Project Components. Each project is comprised of the following components:

1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.
2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.
3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures that accurate data is captured on a systematic and ongoing basis so that the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.
4. PEI Programs – There are a total of nine EBP and CDE programs that will be implemented in eight service areas for the At-Risk Family Service Project.

Outreach and Engagement to Unserved and Underserved Communities. Because one of the overarching goals of the MHSA is the reduction of mental health disparities experienced by specific racial/ethnic and other cultural groups, all projects have been built with service components to achieve this end. The outreach and engagement component for each PEI project is a critical element in reducing disparities because it is primarily concerned with increasing access to programs, a first step in dismantling barriers to services. The County strategy for outreach and engagement involves the utilization of existing County outreach workers, activating existing community resources and organizations, and the development of culturally and linguistically sensitive materials. All of these tools will be combined into a coordinated effort to seek out difficult to reach populations, educate groups regarding PEI programs, and facilitate entry into an appropriate program.

Outreach and engagement activities for the At-risk Family Services Project will include, but are not limited, to the following:

Community Leaders, Parents, and Organizations

- Parent to parent networks provide ideal cultural brokers in ethnic communities to share information and services, these networks will be used to increase the communities knowledge of available services.
- Working with cultural brokers or community representatives to develop outreach strategies. LACDMH will seek input from the key individuals, focus group participants, and community organizations that participated in the planning process to identify and implement culturally and linguistically appropriate methods for reaching the targeted individuals in these unserved/underserved communities.
- Engaging local ethnic community leaders and gatekeepers, while recognizing that many people in these communities lack knowledge of, distrust, and/or are reluctant to use mental health services. Personal contact with these individuals is a key method to increase community knowledge about PEI programs and to facilitate access to these programs.
- Providing information and training in small group settings (e.g. church, temple or other place of worship that has a primarily minority congregation) in local neighborhoods or ethnic community. These sites would be asked to host training and educational forums, bulletins for educational information, and people to serve as volunteers.

Educational Materials

- Developing educational materials about the At-risk Family Services Project. The materials will be translated, culturally relevant, at the appropriate literacy level, and visually accessible (large print and Braille). Community input will be sought in the approach and design of materials to ensure the materials are culturally sensitive.
- Distributing an information sheet about the outreach and engagement efforts, including outreach staff contact information as well as programs' contact information. These flyers will be distributed at meetings and posted in places where the target population is expected to congregate, such as health centers, schools, day care/childcare centers, pre-schools, PTA meetings, health centers, ESL classes, and so forth.
- Distributing press releases, informational articles, and paid advertising (both in English and the appropriate threshold language) in local ethnic newspapers, radio, television, and websites.

Community Outreach Workers

- Collaborating with LACDMH's CSS outreach and engagement staff. Since the inception of the CSS programs, these individuals have developed relationships with numerous community providers. LACDMH will seek the assistance of these staff to provide community linkages for the PEI programs and distribution of information.

- Hiring and training outreach workers, especially those with non-English language ability, from the local communities and the unserved/underserved communities.
- Recruiting and training volunteers from the community who are familiar with the unserved/underserved communities.

Partner Organizations

- Working though existing organizations, such as schools, clubs, churches, and other organizations.
- Collaborating with partner organizations to promote joint outreach efforts.
- Providing training or informational sessions to local organizations such as schools, neighborhood groups, foster care agencies, and human service agencies, about the PEI programs.

At-Risk Family Programs. Because the county was committed to providing its residents with the best mental health interventions possible, an emphasis was made on selecting the most effective, efficacious, and safe programs that could be offered to the at-risk families. A variety of parenting programs such as Incredible Years, Triple P Positive Parenting Program, Making Parenting a Pleasure, and Reflective Parenting Program were selected in order to address at-risk family problems such as poverty, language barriers, familial mental and physical disabilities, child abuse, domestic violence, failure to thrive, teen parenting, and recent immigration. Early intervention programs such as Child-Parent Psychotherapy, Brief Strategic Family Therapy, and Parent-Child Interaction Therapy were selected to address problems such as exposure to domestic violence, familial mental health, physical health, or substance abuse disorders, families with special needs (disabilities), children at-risk for out of home placement, and child abuse. Adult programs under this project will target individuals experiencing the onset of depression with Group Cognitive Behavioral Therapy for Major Depression. UCLA Ties Transition Model was selected to assist parents with high risk kids, whereas Making Parenting a Pleasure was selected to as a comprehensive preventive program.

Prevention	Prevention & Early Intervention	Early Intervention
Making Parenting a Pleasure	Brief Strategic Family Therapy	Child-Parent Psychotherapy
	Group CBT for Major Depression	Parent-Child Interaction Therapy (PCIT)
	Incredible Years	Reflective Parenting Program
	Triple P Positive Parenting Program	
	UCLA Ties Transition Model (TTM)	

(1) Prevention Services

❖ **Making Parenting a Pleasure – Young Children.** Make Parenting a Pleasure is a comprehensive group-based positive parenting curriculum for stressed parents of children birth to eight. This curriculum is designed for professional parent educators

and does not require additional training, although training is recommended. Parents learn the importance of taking care of themselves so they can better care for their children, practical stress management and communication skills, and effective parenting skills and positive approaches to discipline. This EBP program will be implemented in Service Area 2.

(2) Prevention and Early Intervention Services

- **Brief Strategic Family Therapy (BFST) – Children.** Brief Strategic Family Therapy (BSFT) is a family-based intervention designed to prevent and treat child and adolescent behavior problems. BSFT targets 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. Therapy is tailored to target the particular problem interactions and behaviors in each client family. BSFT is a short-term, problem oriented EBP intervention targeted for youth with substance abuse and conduct problems. The program will be implemented in Service Area 2.

- **Group Cognitive Behavioral Therapy (CBT) for Major Depression – Adults.** Cognitive-behavioral therapy is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Cultural tailoring and case management show increased effectiveness for low-income Latino and African-American adults. Group CBT is an EBP that will be implemented in Service Areas 3, 5, and 6.

- **Incredible Years – Young Children and Children.** Incredible Years is a set of comprehensive, multifaceted, and developmentally based curricula targeting 2-12 year-old children and their parents and teachers. The child, parent, and teacher components are designed to work jointly to promote emotional and social competence and to prevent, reduce, and treat behavioral and emotional problems in young children. This EBP will be implemented in Service Areas 3, 4, and 8.

- **Reflective Parenting Program – Young Children.** Reflective Parenting Program is a CDE that focuses on enhancing the bonds between parents and children to improve parenting outcomes, and support emotionally healthy children. Parents and caregivers participate in a ten week workshop series designed to increase parental reflective functioning. This program will be implemented in Service Areas 5, 6, 7, and 8.

- **Triple P Positive Parenting Program – Young Children and Children.** The Triple P—Positive Parenting Program is a multilevel system or suite of parenting and family support strategies for families with children from birth to age 12, with extensions to families with teenagers ages 13-16. Developed for use with families from many cultural groups, Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program, which also can be used for early intervention and treatment, is founded on social learning theory and draws on cognitive, developmental, and public health theories. This EBP program will be implemented in Service Areas 3, 6, and 8.

- **UCLA Ties Transition Model (TTM) – Young Children.** UCLA Ties Transition Model 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 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). UCLA Ties Transition Model is a CDE that will be implemented in Service Area 2 with families in the process of adopting.

(3) Early Intervention Services

- **Child-Parent Psychotherapy – Young Children.** This is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach 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. Child-parent interactions are the focus of intervention modalities aimed at restoring a sense of mastery, security, and growth and promoting congruence between bodily sensations, feelings, and thinking on the part of both child and parent and in their relationship with one another. Child-Parent Psychotherapy is an EBP that will be implemented with young children in Service Area 7.

- **Parent-Child Interaction Therapy (PCIT) – Children.** PCIT has highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions, and, 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. PCIT was initially targeted for families with children ages 2-7 with oppositional defiant and other externalizing behavior problems. It has been adapted successfully to serve physically abusive parents with children 4-12. PCIT may be conducted with parents, foster parents, or others in a parental/caretaker role. PCIT is an EBP that will be implemented in Service Area 2.

(4) Targeted Populations

The table below describes the targeted populations for each of the At-Risk Family Programs.

Program	SA	Age Group	Target Populations
Brief Strategic Family Therapy	2	Children	➢ Children experiencing domestic violence, trauma, neglect, substance abuse, poverty. Children/youth at risk of involvement with the juvenile justice system. ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, and Asians. There are also significant populations of Armenians, African Americans, and Russians who will be served.
Child-Parent Psychotherapy	7	Young Children	➢ Children not thriving socially or emotionally. Children with an absent parent. Children in families experiencing domestic violence, substance abuse, mental illness or special needs. ➢ The primary cultural group in Service Area 7 is Hispanics/Latinos, making up 70.9% of the population. There are also significant Asian (9.1%) and Western European White (14.8%) populations who will be served.
Group CBT for Major Depression	3	Adults	➢ Immigrants and/or non-English speaking adults. Individuals who are deaf or hard-of-hearing. Families who are dealing with a family member with psychiatric illness, complex trauma, and cultural barriers regardless of ability to pay. ➢ Primary cultural groups are Hispanics/Latinos, who make up 45.0% of the Service Area 3 population, Asian groups (particularly Chinese) who make up 23.7%, and Western European Whites (23.3%).
	5	Adults	➢ Adults experiencing anxiety/depression related to an economic crisis (i.e. homelessness, job loss, change in living situation, etc.) ➢ Primary cultural groups include Western European Whites (53.1% of the population), Hispanics/Latinos (14.4%), Asians (11.4%), African Americans (8.1%) and Russians (5.3%).
	6	Adults	➢ Adults with undiagnosed mental illnesses. Latinos, African-Americans, Asians, and new immigrants not aware of mental illnesses and/or not seeking services due to stigma. Adults returning to the community after incarceration, rehabilitation, and other institutions (i.e. military) who are in need of mental health services. ➢ African Americans, Hispanics/Latinos, and Asians will be the primary cultural groups served by this program.
Incredible Years	3	Children	➢ Children from immigrant families and from ethnic communities who lack resources, experience social stigma and/or are isolated and may be experiencing social and emotional distress. Single, teenage mothers, fathers and pregnant minors. Children who are abused or exposed to violence, domestic violence and/or trauma within their family or community. ➢ Primary cultural groups are Hispanics/Latinos, who make up 45.0% of the Service Area 3 population, Asian groups (particularly Chinese) who make up 23.7%, and Western European Whites (23.3%).

Program	SA	Age Group	Target Populations
	4	Young Children	➢ Children whose parents have mental health issues such as postpartum/maternal depression. Children in or at risk for involvement in the foster care system or children in the reunification process. Children experiencing domestic violence or living in families with marital problems. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
	8	Children	➢ Children in families with mental health/social issues such as drug abuse, teen parents, poor parenting, incarceration, domestic violence. Children at risk for gang involvement. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
Making Parenting a Pleasure	2	Young Children	➢ Families impacted by poverty, oppression, linguistic challenges, substance abuse, and trauma. Children of parents who lack parenting skills and/or a support system. Children being raised by "parents" other than their biological parents. ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, and Asians. There are also significant populations of Armenians, African Americans, and Russians who will be served.
Parent-Child Interaction Therapy	2	Children	➢ Children exposed to domestic violence, trauma, abuse, neglect and substance abuse. Children from underserved cultural populations who parents are in need of parenting skills. ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, and Asians. There are also significant populations of Armenians, African Americans, and Russians who will be served.
Reflective Parenting Program	5	Young Children	➢ Children whose parents need support and guidance to establish healthy and trusting relationships with their children. Children with caregivers who have a mental illness or substance abuse problem. Children in families dealing with special needs. ➢ Primary cultural groups include Western European Whites (53.1% of the population), Hispanics/Latinos (14.4%), Asians (11.4%), African Americans (8.1%) and Russians (5.3%).
	6	Young Children	➢ Children in families experiencing chronic homelessness. Children in families with substance abuse, domestic violence, and/or gang involvement issues. African American and Hispanic children who are disproportionally represented in the child welfare system. ➢ African Americans and Hispanics/Latinos will be the primary cultural groups served by this program.
	7	Young Children	➢ Children in isolated families including immigrant families that are socially isolated form their country of origin and other family members. Children in single-parent families. Children of teen parents. Children being raised by grandparents or siblings. ➢ The primary cultural group in Service Area 7 is Hispanics/Latinos, making up 70.9% of the population. There are also significant Asian (9.1%) and Western European White (14.8%) populations who will be served.
	8	Young	➢ Children physical or development disabilities. Children not participating in pre-

Program	SA	Age Group	Target Populations
		Children	school programs. Children exposed to trauma. Children involved with the child welfare system. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
Triple P Positive Parenting Program	3	Young Children	➢ Children who experience failure to thrive, physical/emotional disabilities, or health issues. Children whose parents are experiencing a mental/physical disability, substance abuse, domestic violence, incarceration, lack of parenting skills or a death or divorce in the families. ➢ Primary cultural groups are Hispanics/Latinos, who make up 45.0% of the Service Area 3 population, Asian groups (particularly Chinese) who make up 23.7%, and Western European Whites (23.3%).
	6	Young Children, Children	➢ Children experiencing chronic homelessness. Children in out of home placement or foster care. Children at risk of school failure due to suspension, transfers, and/or frequent changes in schools. African American and Hispanic children/families that are disproportionately represented in the child welfare system ➢ African Americans and Hispanics/Latinos will be the primary cultural groups served by this program.
	8	Young Children, Children	➢ Children in families with mental health issues, drug abuse, poor parenting or incarceration. Children involved with DCFS. Children exposed to trauma. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
UCLA Ties Transition Model	2	Young Children	➢ Families in the process of adopting. Children raised by "parents" other than their biological parents. Trauma exposed children and their families. ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, and Asians. There are also significant populations of Armenians, African Americans, and Russians who will be served.

B. Implementation Partners and Type of Organization/Setting That Will Deliver the PEI Program and Interventions

The programs in the At-Risk Family Services Project may be operated by social service agencies, schools, community-based organizations, mental health providers, and other organizations selected through the County's competitive bidding process. Implementation partners include the Los Angeles County Departments of Child and Family Services, Health, Alcohol and Drug Abuse Programs, Public Health, Probation, law enforcement agencies, child care and development programs serving children from birth to five, family resource centers, family advocates, and other health, mental health, and other social services. Community-based organizations as well as agencies with mental health and/or other human service experience will be solicited to provide these services through the County's bidding process. Services will be provided in community settings, homes, primary care clinics, churches, service clubs, schools, and other non-traditional mental health settings. Should it be determined that additional mental health or other services not available at the school site are needed or that more intensive

mental health services are needed than the program offers, the PEI agency will be expected to confer with and refer the child and his/her family to appropriate resources. Each PEI agency will build collaborative relationships with a range of health, social service, mental health, educational, and other resources.

C. Target Community Demographics

Through the *Vulnerable Communities* report LACDMH was able to identify regions where underserved cultural populations reside and also identify geographic areas which had particularly high risk factors. For example, as indicated in the demographic and statistical data section above, poverty disproportionally affected underserved cultural groups who were found to reside in different parts of the county. Because of the size of the county, no service area goes untouched in terms of its social problems; each has neighborhoods where poverty, crime, and mental health and behavior problems intersect. But because the county does have this information, programs for this project can be localized to reflect the cultural needs of the surrounding neighborhoods within a planning area.

D. Highlights of New and Expanded Programs

The nine PEI programs in the At-Risk Families Project are new programs that are being offered at school sites that do not currently provide these services. The programs will be in culturally and linguistically appropriate for the target populations. The PEI programs will be offered at non-mental health sites, child care and child development programs to encourage families to participate in the programs and to minimize any stigma or discrimination barriers to accessing these services. The Project will work closely with DCFS and law enforcement agencies to prevent these families from losing their children to out of home placements and prevent their children from become entangled with the juvenile justice court system.

E. Action Plan

The At-Risk Family Services Project will require the following start-up activities for contract agencies:

1. Solicit proposals through County bidding process
2. Establish partnerships with schools, agencies, health centers, and other partnerships
3. Establish MOUs or other contracts confirming partnerships and scope of activities as needed
4. Recruit and hire staff
5. Train staff in EBP model protocols
6. Conduct outreach and education

Specific activities for each PEI program are listed below.

Programs	Objectives: Frequency And Duration
Brief Strategic Family Therapy	• Conduct 12-15 sessions (60-90 minutes each) over the course of 3 months.
Child-Parent Psychotherapy	• Conduct session per week lasting 1-1.5 hours. • Provide sessions for clients occur over 50 weeks
Group CBT for Major Depression	• Conduct group sessions for clients
Incredible Years	• Provide child intervention strategies • Conduct parent intervention activities • Conduct teacher training
Making Parenting a Pleasure	• Provide13 1.5-2 hour parent education sessions
Parent-Child Interaction Therapy (PCIT)	• Conduct 12-20 sessions with parent and child
Reflective Parenting Program	• Conduct 10 90 minute workshops for parents
Triple P Positive Parenting Program	• Conduct level 1: media campaign • Provide level 2: 1-2 20 minute consultations • Conduct level 3: 4 20-minute sessions • Provide level 4: 10 individual or 8 group sessions (10 hours total) • Provide level 5: Additional 3-5 individual sessions added to level 4
UCLA Ties Transition Model (TTM)	• Conduct psycho-educational groups • Provide monthly support sessions • Provide adoption-specific counseling • Carry out home visit • Provide interdisciplinary educational and pediatric consultation

F. Key Milestones and Timeline

1.	Develop Requests for Proposals/Requests for Services	Months 1-3
2.	Obtain County Counsel approval for RFPs/RFSs	Months 1-3
3.	Solicit proposals & evaluate proposals	Months 3-9
4.	Award proposals	Months 6-12
5.	Develop LACDMH PEI program and infrastructure	Months 1-3
6.	Recruitment, hiring and training of staff (LACDMH)	Months 1-6
7.	Implement programs	Months 6-12
8.	Conduct training on LACDMH requirements for agencies	Months 7-12
9.	Conduct training in EBP and CDE model protocols	Months 7-12
10.	Conduct outreach and education	Months 3-12
11.	Set up data collection procedures and requirements	Months 1-6
12.	Conduct quarterly PEI provider meetings	Month 12 and on

4. PROGRAMS

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Brief Strategic Family Therapy	Individuals: 200 Families: 200	Individuals: 320 Families: 320	4
Child-Parent Psychotherapy	Individuals: Families:	Individuals: 120 Families: 120	4
Group CBT for Major Depression	Individuals: 1800 Families:	Individuals: 3,600 Families:	4
Incredible Years	Individuals: 54,000 Families: 54,000	Individuals: 600 Families: 600	4
Making Parenting a Pleasure	Individuals: 240 Families: 240	Individuals: Families:	4
Parent-Child Interaction Therapy (PCIT)	Individuals: Families:	Individuals: 320 Families: 320	4
Reflective Parenting Program	Individuals: Families:	Individuals: 4,200 Families: 4,200	4
Triple P Positive Parenting Program	Individuals: 2,760 Families: 2,760	Individuals: 684 Families: 684	4
UCLA Ties Transition Model (TTM)	Individuals: 100 Families: 100	Individuals: 200 Families: 200	4
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 59,100 Families: 57,300**	**Individuals:10,044 Families: 6,444**	**4**

5. LINKAGES TO COUNTY MENTAL HEALTH AND PROVIDERS OF OTHER NEEDED SERVICES

A. Linking PEI Participants to Services

This project will provide information about mental health, other supportive services and community resources to the children, youth, and family members who participate in the programs. In instances where children, youth, and/or their parents or caregivers are perceived to need mental health assessment or extended treatment for mental illness or emotional disturbance, the provider is responsible for identifying appropriate agencies

where these services can be providers. In addition to linkages to MHSA programs, agencies will consider mental health, primary care agencies, substance abuse programs, domestic violence programs, employment centers, educational institutions, as well as community-based organizations. The provider will ensure that there is a direct referral and actual linkage with the referred agency so as to avoid creating additional barriers to services. Staff will help children, youth, parents, and other caregivers to articulate their needs and enhance their capacity to identify and connect with other appropriate services.

B. Linking PEI Participants to Non-Traditional Services

The At-Risk Family Services Project will enable children, youth, their parents and other caregivers to access prevention and early intervention community resources including educational, substance abuse, domestic violence, community support, housing, employment, high quality child care and development programs, and other resources. Programs are expected to conduct a needs assessment at the onset as well as conclusion of services to identify needs in order to ensure that referrals are made to needed services. Staff will help children, youth, parents, and other caregivers to link to these services and follow up to ensure a connection has been made.

C. Sufficiency to Achieve Outcomes

LACDMH conducted research on each of the EBP and CDE models to determine the costs for each program and ensure that the budget and program designs were adequate to achieve the required outcomes. The analysis also determined that program outcomes were in line with the project, State, SDMH, LACDMH, and community expectations. In the bidding process, agencies must demonstrate financial viability, organizational experience, management capability, and cultural competency to provide the services. All agencies selected to run the PEI programs will be required to participate in LACDMH training, including cultural competence, EBPs, PEI policies, and LACDMH policies. Further, they will be required to collect needs assessment data and participate in the Department's evaluation protocols and activities in order to ensure the program is properly developed, clients adequately serviced, and outcomes achieved.

6. COLLABORATION AND SYSTEM ENHANCEMENTS

A. Relationships, Collaborations and Arrangements

The At-Risk Family Services Project requires extensive collaboration with both government and private agencies and organizations. Collaborative efforts will be expanded and initiated with the Departments of Children and Family Services, Public Social Services, Health, Alcohol and Drug Administration Programs, Public Health, as well as educational institutions, family resource centers, churches, and law enforcement

agencies. To encourage collaboration and promote new partnerships, CBOs and non-mental health providers will have an opportunity to provide input to agencies involved in providing services to at-risk families through monthly Service Area Advisory Committee meetings and Service Area Provider meetings.

PEI will also provide regularly held PEI Provider meetings that will be open to the community at large. PEI Provider meetings will encourage and facilitate sharing resources and promoting partnerships and will offer technical assistance on PEI program sustainability to the group and to individual providers as needed. Private agencies include health organizations, community centers, mental health providers, child care and development programs, and other social service, health, and family organizations. The project will building upon existing relationships in the community-based mental health and primary care system to provide school-based prevention and early intervention services.

(1) Outreach Strategies

PEI will outreach to CBOs and non-mental health providers through SAAC meetings, Service Area Provider meetings, PEI Provider meetings, the DMH PEI website, the PEI newsletter and the PEI distribution database that has a current membership of over 6,800 individuals. Outreach efforts will serve to bring CBOs and non-mental health providers to the implementation phase.

(2) Improving Collaboration with CBOs and Non-Mental Health Providers

LACDMH has included community based organizations (CBOs) and non-mental health providers from the very inception of the PEI planning process. To bring these organizations into the implementation phase, LACDMH has four different approaches:

(a) Incubation Academy

This program was designed to assist community and local mental health service providers in obtaining contracts with the Department of Mental Health to build capacity within the mental health system. Comprehensive information, resource references, technical assistance, mentorship, and/or sponsorship opportunities are included in this program, as well as guidance regarding County contracting procedures, documentation, and day-to-day business operations requirements.

(b) Master Agreement List Workshops

PEI Administration will hold a series of workshops to train prospective agencies, including CBOs, on how to qualify for inclusion on the Master Agreement list. The intention of this detailed workshop is to help agencies unfamiliar with county business practices clear the initial and sometimes confusing hurdles in becoming a contractor. As such, this training will include information on how to submit a Statement of Qualifications (SOQ) in response to a Request for Statement of

Qualifications (RFSQ), and the ins and outs of the Requests for Services (RFS) process, the pathway by which they could ultimately provide PEI services.

(c) CDE Technical Assistance Workshops

PEI Administration will provide workshops to developers, including CBOs, whose programs were denied in the initial round of qualification. The workshops will focus on clarifying requirements for the CDE application, identification of outcome approaches, cultural practices, and procedures for resubmission. The intent of the CDE TA Workshops is to provide a hands-on step by step method for helping agencies develop and qualify their programs as a CDE practice. In conjunction with this process, PEI Administration will work with developers on becoming an approved provider (i.e. qualifying for the Master Agreement List) as outlined above.

(d) Subcontracting

PEI administration recognizes that County minimum requirements to qualify for the Master Agreement List may not be met by many potential worthy MHSA/PEI service providers. In order to address those situations and for those CBOs who are not interested in obtaining a direct contract with LACDMH, another way for them to provide PEI services is to subcontract through an existing LACDMH provider. Additionally, this is an opportunity for small organizations to partner with and receive mentoring from experienced providers which in turn, may eventually lead to a direct contract with LACDMH.

B. Building Upon the Mental Health and Primary Care System

Expanded and new partnerships with mental health and primary care providers will be established through the At-Risk Family Services Project. The stigma associated with seeking mental health services can be minimized by providing these services at primary health clinics, school health sites or other non-traditional mental clinics. Students, parents and caregivers will be referred to primary care providers as medical needs are identified. Children, youth, parents and caregivers will be given culturally appropriate information as well as referred to primary care and other behavioral health providers as medical needs are identified.

C. Leveraging Resources

The At-Risk Family Services Project will work with the Department of Children and Family Services, law enforcement agencies, school districts, and health agencies to leverage resources for the PEI programs. Leveraged resources include space, equipment, and staff time as needed. In the solicitation process, potential providers will be notified that agencies are expected to generate support and leveraged resources, such as space, equipment, staff, and volunteer time. LACDMH will give priority to

those agencies that can demonstrate existing capacity and/or a systematic plan for generating resources during the bidding process.

D. Sustaining the PEI Project

Through the solicitation process, the Department will determine the organizational and fiscal capacity of each agency to fiscally manage and sustain the PEI program. Continued funding of the program will be through MHSA PEI funds, as well as continuation of any leveraged funds, including in-kind resources and services. LACDMH will monitor the programs to ensure that outcomes are being met in a timely manner and that fiscal, program, and contract standards are adhered to as required.

7. INTENDED OUTCOMES

A. Specific Cultural Outcomes

Through its community mental health needs assessment, the county obtained a comprehensive understanding of the racial/ethnic and linguistic distribution of the population across fairly small geographic regions. The cultural diversity in the population required that the county carefully consider programs that could be implemented successfully for different ethnic and language groups. For this reason, when building each PEI project, programs were first identified on the basis of whether they had been developed with specific cultural populations included in their validated studies. Inclusion of cultural populations during development is crucial in order to demonstrate and later realize the community effectiveness (i.e. generalizability) of a particular program for a specific population.

From there, program selections were made for each service area in accordance with the demographic profile of the area and the inputs received from the collection of local planning bodies mentioned earlier. As a result of this process, most individual outcomes directly involve underserved cultural populations as had been planned. In many cases due to the ethnic distribution across the county, these underserved cultural populations constitute, in fact, a majority in actual population estimates for a given region. So, programs residing in these areas will obviously impact these groups. Due to the inter-relationships between ethnicity, poverty, and other key indicators, locating programs within these areas is paramount and will be an important detail to note during the RFS process. To make this explicit, the following represents a sample of possible outcomes that can be expected for these specific populations based upon the programs selected in Los Angeles County:

- Improved family functioning to decrease symptoms of mental illness in African-American, American Indian, Asian/Pacific Islander, and Latino populations.

- Increased family preservation by decreasing the likelihood of out of home placements or family dissolution for African-American, American Indian, Asian/Pacific Islander, Latino, and White populations.
- Reduction of the harmful effects of family violence in African-American, American Indian, Asian/Pacific Islander, and Latino populations across the county.
- Provision of family supports in fragmented or newly constituted African-American, American Indian, Latino, and Asian/Pacific Islanders families.
- Inclusion of two community-defined evidence programs for parents and families.

B. General Project Outcomes

The tables below depict a more general summary of the project and program level outcomes and methods for measuring them.

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
INDIVIDUAL	• Decrease child behavior problems • Decrease SCAN Reports • Improve parenting skills • Improve parent coping skills • Improve attachment style	• Child, parent, teacher ratings • SCAN reports • Parent self report • Therapist assessment and other treatment outcome measures
PROGRAM/SYSTEM	• Decrease overall prevalence of child abuse and neglect • Increase the number of earl y intervention treatment programs available to families	• Overall number of SCAN reports • Number of clients served • Pooled treatment effects for like programs

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Brief Strategic Family Therapy	• Decrease in drug use • Decrease in conduct problems • Improvement in family functioning	• Child, parent behavior ratings • Therapist family assessment measures • Child substance abuse
Child-Parent Psychotherapy	• Significant improvement in maternal distress • Significant reductions in child behavior problems • Reductions in child trauma symptoms	• Parent behavior ratings • Parent self report on stress and coping • Therapist family assessment
Group CBT for Major Depression	• Decreased depressive symptoms; increased functioning	• Client self report on measures of depression and stress • Therapist GAF and other assessments

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Incredible Years	• Increase in positive and nurturing parenting • Decrease in harsh discipline • Reduction in child behavior problems at home and in school • Improvements in children's social competence and school readiness skills • Improved parent-child bonding • Improved parent-teacher and school involvement	• Parent, teacher behavior ratings • Parent self report of depression, family functioning • Teacher ratings • SCAN reports
Making Parenting a Pleasure	• Decrease in inappropriate discipline • Increase in parental self-esteem • Decrease in parental stress • Decrease in child abuse potential	• Parent behavior ratings • Parent self report of stress and coping • SCAN reports
Parent-Child Interaction Therapy (PCIT)	• Decreased child behavior problems • Decreases in re-reports of child abuse • Parents report using higher levels of praise and lower levels of criticism	• Parent behavior rating • Therapist assessment • SCAN reports
Reflective Parenting Program	• Increases in parent reflective functioning	• Parent self report of stress and depression • Child behavior ratings • Therapist assessment by clinical interview
Triple P Positive Parenting Program	• Decreased child behavior problems • Increased parental competence • Decreased parental stress • Higher levels of parental self-efficacy in handling home and work responsibilities	• Parent ratings • Parent self report • Decreased SCAN reports • Therapist assessments
UCLA Ties Transition Model (TTM)	• Fewer placement disruptions than national average and comparison groups receiving standard community of care • Fewer child mental health problems after 1 year of intervention in comparison to children receiving standard community care	• Number of placement disruptions • Parent, teacher behavior ratings • Parent self report measures on stress • IQ test scores

C. Long Term Project Outcomes

The project targets high risk families which are characterized by high rates of parent anti-social behaviors, domestic violence, and child abuse. The long-term outcomes for this project include a reduction of domestic violence, and child abuse, and diagnosed psychopathology within the family. In terms of positive effects, one would expect to see greater stability of family systems with fewer out of home placements and other disruptions.

8. COORDINATION WITH OTHER MHSA COMPONENTS

A. Coordination with CSS

As part of their orientation, providers will be trained in the range of mental health services available in the County, including MHSA programs. As client needs are identified, providers will refer the children, youth, parents, and other caregivers as well as adults and older adults to appropriate MHSA Community Services and Supports programs, such as the Full Service Partnerships for children, TAY, adults and older adults, juvenile justice linkages/collaboration, and alternative crisis services.

B. Intended Use of WET Funds

Students, parents, and other caregivers will be given information about relevant programs in the Workforce, Education and Training Plan, as appropriate given their expressed desire to enhance their education and/or vocational goals and meet the criteria to qualify.

C. Intended Use of Capital Facilities and Technology Funds

The County does not intend to use Capital Facilities and Technology Funds for this PEI Project at this time.

9. Additional Comments (optional)

County: Los Angeles

PEI Project 4: TRAUMA RECOVERY SERVICES

Date:

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒	☐	☐
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☒	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition -Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒	☐	☐
4. Children and Youth at Risk for School Failure	☐	☐	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒	☐	☐
6. Underserved Cultural Populations	☒	☒	☒	☒

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s)

Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project. As part of a multi-modal assessment, data was gathered formally through a stakeholder poll, a series of key individual interviews, a series of focus groups, and several community forums. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI.

In order to proceed with project-building, all of the community assessment information was made available to the Ad Hoc Steering Committees who further refined population, age, and program selections. The current list of PEI projects emerged from these final sets of recommendations and reflects not only the localized needs of county service areas but also the specialized needs of countywide populations as well. The main components of the needs assessment are discussed below as they relate to these specific patterns of responses which led to the creation of the Trauma Recovery Services.

(1) Stakeholder Input

(a) Key Individual Interviews

► Input Regarding Priority Population. Key individuals with knowledge and experience of the Trauma-Exposed and Underserved populations suggested that a primarily early intervention project be developed in order to address issues faced by individuals who have been victims of maltreatment or neglect. Below are paraphrased examples of the key individual responses:

- *Trauma-exposed individuals are generally children and youth in stressed families. Furthermore, treatment of trauma-exposed children and youth is one mental health area in which it is possible to make a difference in a short period of time without significant expense. "We have such compelling research that shows that if we just do a few things, you know in 20 sessions, we can really turn disorders around."*
- *Domestic violence, emotional abuse, mental issues in families have tremendous impact on families (parents and children) emotionally, physically, and spiritually. This has a ripple effect which often leads to catastrophic emotional experiences – affecting parents and teens, disrupting coping mechanisms, leading to improper behavior and "shipwrecked lives." Trauma puts people on the verge of mental illness, leads to negative replacement behaviors, or becoming truly mentally ill.*

- *Research conducted together with LAUSD by the Trauma Services and Adaptation Center revealed that 88 to 93 percent of children are at-risk of PTSD due to exposure to traumatic or violent situations. Twenty-seven to 34 percent of those children experienced full-onset of PTSD within a year of their exposure to the traumatic event.*
- *If we are able to reach the trauma-exposed population early on, there is a good chance of being able to stave off depression. Of all the populations listed, the trauma-exposed population makes the most sense to prioritize because crime is not committed on underserved cultural populations alone.*
- *A participant cried when she talked about her son getting shot. Her son is now disabled. She cannot forget the incident. Whenever she hears or witnesses a gunshot, it reminds her of her child getting shot.*

► Input Regarding Age Groups. Program selections for this project included a range of services for all ages. Below are paraphrased examples of the key individual responses:

- *The "vast majority of people that need help are in the adult age group." Even though the symptoms and issues may have been present and/or identified at a younger age, the need for services may not be recognized and acknowledged until adulthood.*
- *Adults are a good starting point. "I would like to start from there because everything trickles down to the children-they have an effect on the children."*
- *Children not receiving needed services for their victimization often end up homeless, jobless, dropping out, pregnant, or in the juvenile justice system.*
- *"When I look at early trauma, I'm very concerned about cognitively how well kids are going to do. I look at trauma-exposed and again I know cognitively, the outcomes may not be good."*
- *The levels of violence to which youth are exposed require youth to develop coping mechanisms, such as self-medicating/substance abuse, which lead to more crime and violence.*

(b) Focus Group Interviews

► Input Regarding Priority Population. Focus groups with knowledge and experience of the Trauma-exposed and Underserved populations suggested that a trauma recovery project was needed to address the widespread victimization and exposure to violence in the county. Below are paraphrased examples of the focus group responses:

- *Participants identified no prevention and few early intervention services available in their community, and advocated for more services available in their language. In addition, the group surfaced a strong need for greater economic security and*

access to transportation. Participants felt that it was common among Cambodian women to feel isolated and not know where to seek help during crises.

- *"…because there are no interpreters, there are no services, and there's no counseling for them and so you can't get them placed….So they're stuck in their relationship or whatever or they're killed or they're hurt because they have no access to services."*
- *"I want to say there's like zero communication between DCFS and the Department of Mental Health. I mean there's just--there's no sharing of information. It's not a partnership. They're separate entities, and it [causes] serious problems 'cause the goals are the same but we're banging heads."*
- *Seven of the respondents in a group spoke at length about the need for: a) improvements to the foster care system such as counseling for children and better follow-up by social workers, b) training and supervision of foster parents, c) hotline numbers to report inappropriate foster parents, and d) orientations to help children learn how to protect themselves while in the custody of the foster care system.*
- *"People don't have access to mental health care. The services like anger management, domestic violence type services aren't out there in the communities as they need to be. Parenting-type programs need to be out there…if you had access to these kinds of services, you would definitely start seeing a decrease in some of the violence that we're having in our communities."*

► Input Regarding Age Groups. Focus groups mentioned needed services that spanned age groups from childhood through adulthood. Implicit within these responses were a focus on treating children who had been victimized in some way or were in out of home placements, adult women who were victims of domestic violence, and parents of children at risk for abuse.

(c) Community Forum Recommendations

Benefiting from the needs assessment that had been completed, Community Forum attendees were asked to prioritize PEI populations and age groups. These selections were then used by Ad Hoc Steering Committee members in making program selection recommendations.

► Input Regarding. The following represent the community forum recommendations regarding strategies.

- *Increase specific services and programs, such as domestic violence, rape, trauma, and victim assistance programs, and after school programs that have open eligibility requirements and allow for more sessions.*
- *Training, education, and outreach for veterans and their family members addressing life skills, job training, and system navigation; as well as training, education, and outreach for providers on treatment approaches.*

- *Training on post-traumatic stress disorder (PTSD), brain trauma, and other forms of trauma.*
- *Increase outreach to homebound/shut-ins.*
- *Education on mental health to media, professionals, patients and their families, and school personnel about signs, symptoms, and treatments for trauma exposure.*
- *Education on linguistic and cultural competence for public, gatekeepers, community, faith-based, doctors, mental health providers, and law enforcement.*
- *Establish one stop, 24 hour family resource centers in high-need neighborhoods.*
- *Development of support services for trauma exposed older adults that include in home services, support groups and immediate intervention when there is a critical incident in the community.*

(d) Ad Hoc Steering Committee Recommendations

► Input Regarding Sub-populations. The Steering Committee identified targeted sub-populations for trauma recovery services.

- *Victims of domestic violence, trauma, abuse, neglect and substance.*
- *Children in families experiencing chronic homelessness.*
- *Children in families with substance abuse, domestic violence, and/or gang involvement, or who are living in areas with high rates of substance abuse, crime, and/or poverty.*
- *Children who are homeless or in families that are economically distressed or lack basic resources.*
- *Veterans, particularly those who are trauma-exposed and experiencing post-traumatic stress disorder; and, families of veteran families, including children.*
- *TAY who have experienced severe trauma such as natural disaster, child abuse, sexual abuse, domestic violence, combat in war, victim of violent crime, or have a loved one who died as result of homicide/suicide or witnessed a violent crime.*
- *Survivors of non-combat-related traumatic events (including plane/car/train crashes, physical/mental abuse, gang/community violence, bullying, substance abuse, and domestic violence).*
- *Witnesses/victims of family violence (domestic violence, sexual abuse, etc.)*
- *Witnesses/victims of community violence (gangs, sexual assault, bullying, etc.)*
- *TAY who have made suicide attempts or at risk for suicide.*
- *Children dealing with grief and loss as result of death or incarceration of family member or loved one. Adults experiencing complex trauma including war veterans. Individuals with combat-related post-traumatic stress disorder (PTSD*).

(2) Data Analysis

(a) Statistical and Demographic Indicators

The Department developed the report, *Vulnerable Communities in Los Angeles County: Key Indicators of Mental Health*, which detailed demographic variables and key risk factors. Each indicator was selected on the basis of its empirical link with a PEI priority population and community mental health need. Together with the Key Individual Interviews and Focus Groups responses presented above, the following indicators were found to confirm the need for the creation of a project focused on the needs of Trauma-exposed and Underserved Cultural Populations. The following selected demographic variables and risk factors demonstrate the need for services: Child Abuse Statistics, Elder and Dependent Adult Abuse Statistics, Posttraumatic Stress Disorder Statistics, Homelessness Statistics, Ethnicity, Primary Language, and Linguistic Isolation, and Mental Health Emergency Statistics.

(b) Child Abuse

Four indicators were used to detail child abuse and neglect cases throughout the county. One indicator, substantiated child abuse and neglect cases, made it possible to report on the child abuse/neglect base rates for a given community. A second indicator, the Department of Children and Family Services (DCFS) triage response following a suspected child abuse/neglect report, led to the creation of a triage response acuity score. This acuity score is a weighted sum adjusted to child populations within a given community that indicates the severity of victimization for a given area. The third and fourth indicators, ethnicity and age, indicate the scope of victimization across the county. All raw data come from the DCFS for the 2006 calendar year.

Data indicated that across the county, 148,343 suspected child abuse reports were filed, with 20.6% of these, or 30,533 allegations, substantiated. On the average, a child is abused every 17 minutes in the county. There was wide variation in whether abuse was substantiated by DCFS across service areas. Service Area 5, for instance, had the lowest rate of substantiated abuse reports at 14.3%, while Service Area 1 had the highest rate of confirmed child abuse, 23.9%. Overall, the Triage Response Acuity score for the county was 0.15. Service Area 1 had the highest Acuity score (0.25), followed closely by Service Area 6 (0.23) and Service Area 4 (0.18). Service Area 5 had the lowest Acuity score (0.08). Service Area 1 has the most emergent child abuse and neglect problems across the county.

Countywide, four groups exceed 2000 CAN reports: African-Americans, Whites, Mexican nationals, and Hispanics. As a group, Hispanics are the majority of SCAN Report victims, followed by African-Americans, Whites, and Mexican nationals.

(c) Elder and Dependent Adult Abuse

Elder abuse is related to mental health issues in two ways. First, older adults who have a mental disorder, cognitive impairment, or alcohol problem are at increased risk for being abused. Second, once experiencing abuse, the elderly are at increased risk for a variety of mental health, (e.g., Posttraumatic Stress Disorder; Depression) disorders, physical disorders and injury, and death (including suicide) (Baker, 2007). Service Area 1 had an APS Rate1 of 3.2, which was the second highest rate seen in the county across all service areas. Service Area 4 had an APS Rate1 of 3.1, which was above the countywide rate. Within the service area, the Downtown area had the highest APS Rate1 score (4.6). Service Area 6 (3.9) had the highest APS Rate1 among all county service areas. Three of the six most at-risk communities across the county were contained within this service area in terms of their respective APS Rate1 scores. The Baldwin Hills S. area (5.8) had the highest rate found within the county, followed by the Hancock N. area (4.7) and the Watts area (4.4). Service Area 8 had an overall APS Rate1 score of 2.7, which was slightly above the countywide rate of 2.6. Service Areas 2, 3, 5 and 7 had APS Rates that were below the countywide rate.

(d) Posttraumatic Stress Disorder

During the 2006-07 reporting period, 5,912 individuals were seen within the county mental health system. Children under the age of 16 accounted for a majority of PTSD cases, 51.8% or 3,062 individuals. In all service areas, child cases outnumbered adult cases with the exception of Service Area 6, where adult PTSD cases were more numerous. Across the county adults accounted for 28.2% of PTSD cases, TAY, 17.7%, and older adults, 2.3%. Across service areas the largest proportion of total PTSD cases were found in Service Area 4, which also had the largest proportion of child cases, 21.2%. Service Area 2 had the largest proportion of TAY cases (21.1%), though Service Area 4 (20.6%) was very close to this figure. Service Area 8 had the largest proportion of PTSD in the adult and older adult populations, 22.6% and 32.9%, respectively. Service Area 6 had nearly the same proportion of Adult cases, 21.2%. Across the county, Service Area 5 had the smallest proportion of PTSD cases. Across seven tracked ethnic groups in the above table, Latinos accounted for 47.9. % of clients diagnosed with PTSD, followed by African-Americans (25.9%), Whites (11.6%), Asians (6.2%), and Other Ethnicities (2.7%). Native Americans (0.6%) and Pacific Islanders (0.1%) each accounted for less than 1% of the PTSD client population.

(e) Homelessness

Homeless individuals, especially homeless youth, represent one of the most vulnerable populations in the county. Research indicates that most homeless youth have experienced a trauma in their lives and most have endured multiple traumas (Gwadz, Nish, Leonard & Strauss, 2007; Stewart, Steiman, Cauce, Cochran, Whitbeck, & Hoyt, 2004). A great many of these children suffer from PTSD. The Greater Los Angeles

Homeless Count estimated 156,380 individuals were homeless in Los Angeles County in 2007. Homelessness occurs in virtually all geographic locations and ethnic groups across the county. In four service areas, 2, 3, 4 and 6, estimates were well over 20,000 individuals in each area; the majority of these individuals were unsheltered. In terms of age groupings, the most populous category was individuals between the ages of 25-55 years, who accounted for 65.5% of the entire estimated homeless population.

Children under the age of 18 accounted for 14.9% of the estimated homeless population. With respect to gender, adult males accounted for 69% of the estimated homeless population, adult females, 28.5%, and adult transgender individuals, 2.5%. In terms of ethnicity, Black/African-Americans accounted for 43.9% of the estimated homeless population, Hispanic or Latino, 27.2%, White, 22.4%, and Multi-racial and Other individuals, 6.5%. Homeless Black/African-Americans were estimated in large numbers, (i.e., greater than 20,000 individuals), in Service Areas 4 and 6. Estimates indicated, for example, that 20,454 children were homeless across the county -- and of these, 8,853 children were under the age of 5. 57,473 individuals with mental illness were homeless across the county; 18,075 of the homeless were veterans and 16,540 individuals were victims of domestic violence.

3. PEI PROJECT DESCRIPTION

A. Why the proposed PEI project – including key community need(s), priority population(s), desired outcomes and selected programs – addresses needs identified during the community program planning process

By reviewing the available information generated from the county needs assessment, stakeholder groups were able to recommend PEI programs for their respective communities and constituencies. As the ad hoc steering committees generated their program recommendations and targeted sub-populations, clusters of related programs began to coalesce around a core service which was then reified as the Trauma Recovery Services Project. By reviewing the data sources presented, one can see the extent of the county needs in terms of the trauma-exposed population. The Department examined child abuse and neglect statistics, elder and dependent adult abuse statistics, the extent of homelessness across regions, and the prevalence of posttraumatic stress disorder as indicators for the trauma-exposed population. The findings of this assessment identified underserved populations especially Hispanic, African-American, American Indian, and Asians spanning all PEI age groups. Additionally, the assessment was able to pinpoint sub-service area communities where abuse levels were the greatest. Such an assessment enabled planners to see for the first time where these communities were located in the county. The PTSD data was useful in detailing the extent of the disorder in a similar manner by indicating which ethnic groups, age groups, and service areas consumed the most services.

By listening to the stated needs and desires of community stakeholders through key interviews, focus groups, and forums spread throughout the county, prioritizing solutions to attenuate problems experienced by the trauma-exposed and underserved populations became possible. Some of the comments the Department received with regard to the trauma-exposed population are extracted above and show the intensity of stakeholder convictions that a trauma recovery services project was needed.

Project Purpose. The Trauma Recovery Services Project will (1) provide short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event; and (2) provide more intensive services to trauma-exposed youth, adults, and older adults to decrease the negative impact and behaviors resulting from the traumatic events. The programs include outreach and education, psychosocial assessment, individual short-term crisis counseling, family counseling, youth and parent support groups, case management, and training for staff that are likely to work with trauma victims.

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Poverty • Ethnicity • Geographic region • Victimization • Exposure to violence • Mental health disorders • Peer rejection • Family dysfunction and violence • Ineffective parenting • Life stressors • Parental mental health disorder • Family transitions	• Effective parenting • Sociability • Problem solving skills • Family and peer support • Self-efficacy

Project Components. Each project is comprised of the following components:

1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.
2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.
3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures that accurate data is captured on a systematic and ongoing basis so that

the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.

4. PEI Programs – There are a total of eight EBPs, Promising Practices, CDE, and pilot project programs that will be implemented in eight service areas for the Trauma Recovery Project.

Outreach and Engagement to Unserved and Underserved Communities. Because one of the overarching goals of the MHSA is the reduction of mental health disparities experienced by specific racial/ethnic and other cultural groups, all projects have been built with service components to achieve this end. The outreach and engagement component for each PEI project is a critical element in reducing disparities because it is primarily concerned with increasing access to programs, a first step in dismantling barriers to services. The County strategy for outreach and engagement involves the utilization of existing County outreach workers, activating existing community resources and organizations, and the development of culturally and linguistically sensitive materials. All of these tools will be combined into a coordinated effort to seek out difficult to reach populations, educate groups regarding PEI programs, and facilitate entry into an appropriate program.

Outreach and engagement activities for the Trauma Recovery Services Project will include, but are not limited, to the following:

<u>Community Leaders, First Responders, and Organizations</u>

- Working with cultural brokers or community representatives to develop outreach strategies. LACDMH will seek input from the key individuals, focus group participants, and community organizations that participated in the planning process to identify and implement culturally and linguistically appropriate methods for reaching the targeted individuals in these unserved/underserved communities.
- Engaging with first responders such as the fire departments, local police, County child welfare and County senior services departments, and others who can identify neighborhoods where PEI trauma recovery services are needed.
- Engaging local ethnic community leaders and gatekeepers, while recognizing that many people in these communities lack knowledge of, distrust, and/or are reluctant to use mental health services. Personal contact with these individuals is a key method to increase community knowledge about PEI programs and to facilitate access to these programs.
- Providing information and training in small group settings (e.g. church, temple or other place of worship that has a primarily minority congregation) in local neighborhoods or ethnic community. These sites would be asked to host training and educational forums, bulletins for educational information, and people to serve as volunteers.

Educational Materials

- Developing educational materials about the Trauma Recovery Services Project. The materials will be translated, culturally relevant, at the appropriate literacy level, and visually accessible (large print and Braille). Community input will be sought in the approach and design of materials to ensure the materials are culturally sensitive.
- Distributing an information sheet about the outreach and engagement efforts, including outreach staff contact information as well as programs' contact information. These flyers will be distributed at meetings and posted in places where the target population is expected to congregate, such as the Veterans Hospital, health centers, women's shelters, refugee centers, employment centers, victim's rights meetings, and so forth.
- Distributing press releases, informational articles, and paid advertising (both in English and the appropriate threshold language) in local ethnic newspapers, radio, television, and websites.

Community Outreach Workers

- Collaborating with LACDMH's CSS outreach and engagement staff. Since the inception of the CSS programs, these individuals have developed relationships with numerous community providers. LACDMH will seek the assistance of these staff to provide community linkages for the PEI programs and distribution of information.
- Hiring and training outreach workers, especially those with non-English language ability, and those with experience in working with traumatized individuals, from the local communities and the unserved/underserved communities.
- Recruiting and training volunteers from the community who are familiar with the unserved/underserved communities.

Partner Organizations

- Working though existing organizations, such as health clinics, schools, clubs, churches, and other organizations.
- Collaborating with partner organizations to promote joint outreach efforts.
- Providing training or informational sessions to local organizations such as victim's rights groups, refugee and immigrant organizations, neighborhood groups, foster care agencies, and human service agencies, about the PEI programs.

Trauma Recovery Programs. Trauma-focused CBT, Child-Parent Psychotherapy, and Parent-Child Interaction Therapy (PCIT) were selected for the trauma-exposed population of young children and children with the following problems: child abuse victims, exposure to domestic violence, homelessness, familial mental health or substance abuse problems, and exposure to community violence. Prolonged Exposure Therapy, Seeking Safety, and Trauma-focused CBT were selected for the trauma-exposed TAY population with problems such as familial mental health or substance abuse, homelessness, risky behaviors, exposure to natural disasters, community

violence, domestic violence, being a victim of crime, and experiencing suicidal ideation and at-risk for serious mental illness.

Adult programs selected for this population include Prolonged Exposure Therapy for PTSD, Seeking Safety, and Group CBT for Major Depression in order to address individuals including veterans who have experienced trauma, individuals who have a dual diagnosis, non-English speakers and deaf and hard of hearing clients, survivors of domestic violence, sexual abuse, war, and natural disasters. Crisis Oriented Recovery Services was developed for brief crisis counseling to mitigate additional stress and psychological harm. Lastly, the System Navigators for Veterans will assist veterans and their families in navigating the public and private resources that are available to assist the military veterans.

Prevention	Prevention & Early Intervention	Early Intervention
System Navigators for Veterans	Group CBT for Major Depression	Child-Parent Psychotherapy
		Crisis Oriented Recovery Services
		Parent-Child Interaction Therapy (PCIT)
		Prolonged Exposure Therapy for PTSD
		Seeking Safety
		Trauma Focused Cognitive Behavioral Therapy

(1) Prevention Services

- **System Navigators for Veterans – Transition-age Youth, Adults and Older Adults.** This is a pilot project that will utilize military veterans to engage veterans and their families in order to identify currently available services, including supports and services tailored to the particular cultural, ethnic, age and gender identity of those seeking assistance. They will follow-up with the veterans and their families to ensure that these individuals have successfully linked up and received the help they need. Training about available public and private resources will be provided to assist the system navigators. The System Navigators will engage in joint planning efforts with community partners, including veterans groups, veterans administration, community-based organizations, other County Departments, intradepartmental staff, schools, health service programs, faith based organizations, self-help and advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services available to veterans within and outside the mental health system. Further, System Navigators will assist the veterans and their families by promoting awareness of mental health issues and work towards de-stigmatizing seeking help. It is expected that System Navigators will develop effective working relationships with a number of community-based agencies that

serve veterans as well as other programs that can address the unique needs of veterans who may be undergoing mental health problems including community colleges, housing programs, social service agencies).

(2) Prevention and Early Intervention Services

- **Group Cognitive Behavioral Therapy (CBT) for Major Depression – Adults.** Cognitive-behavioral therapy is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Cultural tailoring and case management show increased effectiveness for low-income Latino and African-American adults. This EBP will be implemented in Service Area 1.

(3) Early Intervention Services

- **Child-Parent Psychotherapy – Young Children.** Child-Parent Psychotherapy is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach 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. Child-parent interactions are the focus of six intervention modalities aimed at restoring a sense of mastery, security, and growth and promoting congruence between bodily sensations, feelings, and thinking on the part of both child and parent and in their relationship with one another. This EBP for young children who have experienced trauma and their caregivers will be implemented in Service Areas 2, 4, 5, 6, and 8.

- **Crisis Oriented Recovery Services (CORS) – Adults and Older Adults.** 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 of the CORS program is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress or psychological harm. CORS 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. Services are designed to provide alternatives to emergency room care, acute inpatient hospitalizations or other institutional care. Immediate access to short-term crisis intervention, mental health and case management services is at the core of the program. This is a Promising Practice that will be implemented in all eight service areas.

- **Parent-Child Interaction Therapy (PCIT) – Young Children.** PCIT is an evidence-based treatment model with highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions, and, 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. PCIT may be conducted with parents, foster parents, or others in a parental/caretaker role. This EBP for young children will be implemented in Service Areas 2, 4, and 8.

- **Prolonged Exposure Therapy for PTSD – Transition-age Youth, Adults and Older Adults.** This is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have PTSD. The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. This EBP will be implemented in Service Areas 1, 3, and 4 as well as with the countywide veterans' population.

- **Seeking Safety – Transition-age Youth and Adults.** Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psychoeducation and has five key principles: safety; integrated treatment; focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; four content areas: cognitive, behavioral, interpersonal, and case management; attention to clinician processes. This EBP will be implemented in Service Area 4.

- **Trauma Focused Cognitive Behavioral Therapy – Young Children, Children, and Transition Age Youth.** Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Sessions are conducted once a week. This EBP program will be implemented in Service Areas 2, 3, 6, and 8.

(4) Targeted Populations

The table below describes the targeted populations for each of the Trauma Recovery Programs.

Program	SA	Age Group	Target Populations
Child-Parent Psychotherapy	2	Young Children	➢ Children who are victims of domestic violence, trauma, abuse, neglect, and substance abuse. Children whose parents/caregivers lack parenting skills. Children whose parents/caregivers lack a support system. ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, and Asians. There are also significant populations of

Program	SA	Age Group	Target Populations
			Armenians, African Americans, and Russians who will be served.
	4	Young Children	➢ Children experiencing, exposed to, or at risk for exposure to family or community violence. Children exposed to sexual abuse. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
	5	Young Children	➢ Children experiencing violence, abuse, or neglect in the home or community. Children with parents with unresolved trauma. ➢ Primary cultural groups include Western European Whites (53.1% of the population), Hispanics/Latinos (14.4%), Asians (11.4%), African Americans (8.1%) and Russians (5.3%).
	6	Young Children	➢ Children in families experiencing chronic homelessness. Children in families with substance abuse, domestic violence, and/or gang involvement or who are living in areas with high rates of these issues. ➢ African Americans and Hispanics/Latinos will be the primary cultural groups served by this program.
	8	Young Children	➢ Children who need assistance outside traditional systems as a result of issues like homelessness, lack of insurance, or immigration status. Children in families with mental health/social issues such as mental illness, drug abuse, poor parenting, teen parents, incarceration, or domestic violence. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
Crisis Oriented Recovery Services (previously referred to as Crisis Resolution Services)	1	Adults, Older Adults	➢ Adults and older adults impacted by traumatic events. Veterans, particularly those that are trauma exposed and experiencing post-traumatic stress disorder, and their families. Latino, Asian, American Indian, and African American communities. Multicultural families. Mono-lingual (non-English) individuals. ➢ The primary cultural groups are Hispanics/Latinos (41.0% of the Service Area 1 population), Western European Whites (39.0%) and African Americans (12.8%). However, Asian and American Indian population will also be served.
	2	Adults, Older Adults	➢ Adults and older adults impacted by traumatic events. All ethnic and racial groups experiencing a lack of access due to available, geography, limited finances, limited transportation, or language issues. Homeless, LGBTQ, and HIV positive populations, especially those of minority status. ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, Asians, and African Americans. There are also significant populations of Armenians, Russians, Iranians, and South Asians who will be served.

Program	SA	Age Group	Target Populations
	3	Adults, Older Adults	➢ Adults and older adults impacted by traumatic events. Immigrant and/or non-English speaking adults. Deaf/hard-of-hearing individuals and their families. Adults experiencing complex trauma including war veterans. ➢ Primary cultural groups are Hispanics/Latinos, who make up 45.0% of the Service Area 3 population, Asian groups (particularly Chinese) who make up 23.7%, and Western European Whites (23.3%).
	4	Adults, Older Adults	➢ Adults and older adults impacted by traumatic events or violence. Linguistically isolated individuals. Individuals who are homeless or at risk for homelessness. Individuals who do not identify as having a mental illness. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
	5	Adults, Older Adults	➢ Adults and older adults impacted by traumatic events. Adults experiencing anxiety/depression related to an economic crisis such as homelessness, hob loss, or a change in living situation. Adults with recently diagnosed serious medical conditions. Adults caring for children and/or disabled/infirm family members. ➢ Primary cultural groups include Western European Whites (53.1% of the population), Hispanics/Latinos (14.4%), Asians (11.4%), African Americans (8.1%) and Russians (5.3%).
	6	Adults, Older Adults	➢ Adults and older adults impacted by traumatic events. Latinos, African Americans, Asians, and new-immigrants not aware of mental illnesses or not seeking services due to stigma. Adults at risk of or exposed to HIV/AIDS or hepatitis-C. ➢ African Americans, Asians, and Hispanics/Latinos will be the primary cultural groups served by this program.
	7	Adults, Older Adults	➢ Adults and older adults impacted by traumatic events. Individuals in crisis due to loss. Victims of violence and/or experiencing post-traumatic stress disorder. Caregivers in crisis due to living with a severely mentally ill family member. Mono-lingual Spanish-speaking male Latinos without insurance. ➢ The primary cultural group in Service Area 7 is Hispanics/Latinos, making up 70.9% of the population. There are also significant Asian (9.1%) and Western European White (14.8%) populations who will be served.
	8	Adults, Older Adults	➢ Adults and older adults impacted by traumatic events. Veterans and LGBTQI individuals. Ethnic minorities and non-English speaking adults. Individuals with disabilities, medical/physical issues, and their caregivers. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
Group CBT for Major Depression	1	Adults	➢ Adults from the Latino, African-American, Asian, American Indian/Alaskan Native and other minority communities, as well as veterans and their families. ➢ The primary cultural groups are Hispanics/Latinos (41.0% of the Service Area 1 population), Western European Whites (39.0%) and African Americans (12.8%). However, Asian and American Indian population will also be served.
Parent-Child	2	Young Children	➢ Children with emotional or behavioral problems. Young children exposed to domestic violence, trauma abuse, neglect, and substance abuse. Children

Program	SA	Age Group	Target Populations
Interaction Therapy			from underserved cultural populations whose parents are in need of parenting skills. ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, Asians, and African Americans. There are also significant populations of Armenians, Russians, Iranians, and South Asians who will be served.
	4	Young Children	➢ Children experiencing, exposed to, or at risk for exposure to family or community violence. Children exposed to sexual abuse. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
	8	Young Children	➢ Children in families with mental health/social issues (mental health, drug abuse, poor parenting, teen parents, incarceration, domestic violence, etc.). Children exposed to trauma. Children involved with DCFS and/or in out-of-home care ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
Prolonged Exposure Therapy for PTSD	1	TAY, Adults, Older Adults	➢ Individuals with a history of trauma and post-traumatic stress disorder. Individuals who are engaging in risky behavior (e.g., sexual promiscuity, substance abuse, truancy, and/or street racing). Dually-diagnosed population with developmental disability and/or mental illness and dual-diagnosis/substance abuse population and mental illness. Veterans and families of veterans. ➢ The primary cultural groups are Hispanics/Latinos (41.0% of the Service Area 1 population), Western European Whites (39.0%) and African Americans (12.8%). However, Asian and American Indian population will also be served.
	3	TAY, Adults	➢ TAY and adults impacted by traumatic events. Immigrant and/or non-English speaking adults. Deaf/hard-of-hearing individuals and their families. Adults experiencing complex trauma including war veterans. TAY who have experiencing severe trauma such as natural disaster, child abuse, sexual abuse, domestic violence, combat in war, violent crime, or the death of a loved one. ➢ Primary cultural groups are Hispanics/Latinos, who make up 45.0% of the Service Area 3 population, Asian groups (particularly Chinese) who make up 23.7%, and Western European Whites (23.3%).
	4	TAY	➢ Individuals with a history of trauma and post-traumatic stress disorder. Witnesses and victims of family or community violence. Foster youth and former foster youth. Homeless or runaway youth. Youth who have experienced the criminal justice system. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
	Veterans	TAY, Adults, Older	➢ Individuals with combat-related post-traumatic stress disorder. Survivors of non-combat-related traumatic events including automobile accidents, abuse, gang/community violence, bullying, substance abuse, or domestic violence.

Program	SA	Age Group	Target Populations
		Adults	➢ Primary cultural populations include African Americans, Hispanics/Latinos, and Western European Whites.
Seeking Safety	4	TAY, Adults	➢ Witnesses and victims of family or community violence. Foster youth and former foster youth. Individuals who are homeless. Youth who have experienced the criminal justice system. Linguistically isolated individuals. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
System Navigators for Veterans	Veterans	TAY, Adults, Older Adults	➢ Individuals with combat-related post-traumatic stress disorder or other mental health issues. Survivors of non-combat-related traumatic events including automobile accidents, abuse, gang/community violence, bullying, substance abuse, or domestic violence. ➢ Primary cultural populations include African Americans, Hispanics/Latinos, and Western European Whites.
Trauma Focused Cognitive Behavioral Therapy	2	TAY	➢ Individuals with a history of trauma. Youth with a combination of prodromal symptoms such as hallucinations, withdrawal, and decreased self-care. Youth lacking support systems ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, Asians, and African Americans. There are also significant populations of Armenians, Russians, Iranians, and South Asians who will be served.
	3	Young Children, Children, TAY	➢ Children of immigrant families and/or undocumented children and families who cannot access mental health services are experiencing stigma, educational, financial and isolation issues. Children/youth who are in multi-generational gang affiliated families or who are at risk of gang recruitment. Children/youth who have experienced severe trauma such as natural disaster, child abuse, sexual abuse, domestic violence, combat in war, victim of violent crime, or have a loved one who died as result of homicide or suicide or was witness to violent crime. ➢ Primary cultural groups are Hispanics/Latinos, who make up 45.0% of the Service Area 3 population, Asian groups (particularly Chinese) who make up 23.7%, and Western European Whites (23.3%).
	6	Young Children, Children	➢ Children and families exposed to child abuse and neglect, domestic violence, incest and gang violence. Children dealing with grief and loss as result of death or incarceration of family member or loved one. Children in foster care traumatized by multiple placements and/or removal experience. Homeless, neglected children, and/or children removed from their homes. ➢ African Americans (28.2% of the population) and Hispanics/Latinos (65.9%) will be the primary cultural groups served by this program.
	8	Children TAY	➢ Children in families with mental health/social issues such as mental illness, drug abuse, poor parenting, teen parents, incarceration, or domestic violence. Children/youth involved with DCFS and/or in out-of-home care. Youth in juvenile justice system. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites,

Program	SA	Age Group	Target Populations
			Asians/Pacific Islanders, and African Americans.

B. Implementation Partners and Type of Organization/Setting That Will Deliver the PEI Program and Interventions

The programs in the Trauma Recovery Services Project may be operated by primary care clinics, schools, community-based organizations, social service agencies, veteran's organizations, mental health agencies, and other organizations selected through the County's competitive bidding process. Services will be delivered at primary care clinics, schools, homes, mental health settings, residential treatment centers, community settings, veterans' centers, and other community settings. Implementation partners include the Veterans Administration, Los Angeles County Departments of Health and Public Health, Alcohol and Drug Abuse Programs, the Community Clinic Association of Los Angeles County (CCALAC), child care and development programs serving children from birth to five, and other health, mental health, and social services agencies. It is expected that agencies selected to run the PEI programs will be experienced in or have the capacity to provide short-term crisis counseling and trauma-focus services as well as collaborate with other agencies to provide these much-needed services.

Should it be determined that additional mental health or other services not available at the agency are needed or that more intensive mental health services are needed than the program offers, the PEI agency will be expected to refer the youth, adult, older adult, his/her parents and/or caregiver to appropriate resources. Each PEI agency will build collaborative relationships with a range of health, social service, mental health, educational, and other resources.

C. Target Community Demographics

This project will focus on individuals who have been victimized or trauma-exposed. Although SDMH has defined "trauma-exposed" rather loosely, LACDMH has adopted a more traditional interpretation of the term to address individuals who have been abused or neglected or exposed to a traumatic event (as defined by the DSM IV-TR). In the figures reported above, the County found there were over 148,000 suspected child abuse reports in 2006 filed with over 30,000 of them substantiated. At the other end of the life spectrum, the County reported that in FY 06-07 there were over 19,000 open cases for elder and dependent adult abuse throughout the county. Finally, in 2007 there were an estimated 150,000 homeless individuals living in the county.

Through the *Vulnerable Communities* report LACDMH was able to identify regions where underserved cultural populations reside and also identify geographic areas which had particularly high risk factors. For example, child abuse disproportionally affected underserved cultural groups especially Hispanic and African-American children and children who were residing in service areas 1, 4 and 6. Elder and dependent adult abuse was found to be relatively high in those areas as well. County figures detailing PTSD diagnoses found that the majority of cases involve the PEI age group of children (0–15) and this corresponds to the high number of abuse cases investigated by the county as mentioned above.

D. Highlights of New and Expanded Programs

The eight PEI programs in the Trauma Recovery Services are new programs that will serve the targeted populations at different sites throughout the county. The approach to these services is prevention (outreach and education) and early identification of potential problems, and early intervention (crisis debriefing, crisis counseling, therapy for trauma-exposure), together with case management for supportive services. Throughout all of these programs, the emphasis is on ensuring the programs are delivered in a culturally appropriate manner by individuals from the target populations themselves and/or sensitive to the cultural and other issues confronting the individuals to be served. Veterans are a particularly vulnerable group that the programs are specially designed to serve. Wherever possible, the PEI programs will be offered at non-traditional mental health settings to encourage individuals and families to participate in the programs and to minimize any stigma or discrimination barriers to accessing these services.

E. Action Plan

The Trauma Recovery Services Project will require the following start-up activities for contract agencies:

1. Solicit proposals through County bidding process
2. Establish partnerships with veterans' organizations, schools, agencies, health centers, and other key partners
3. Establish MOUs or other contracts confirming partnerships and scope of activities as needed
4. Recruit and hire staff
5. Train staff in EBP/Promising Practices/CDE/ and project model protocols
6. Conduct outreach and education

Specific activities for each PEI program are listed below.

Programs	Objectives: Frequency And Duration
Child-Parent Psychotherapy	• Conduct one session per week lasting 1-1.5 hours for families

Programs	Objectives: Frequency And Duration
	• Providers sessions over the space of 50 weeks
Crisis Oriented Recovery Services	• Establish protocols for CORS • Conduct brief crisis counseling sessions
Group CBT for Major Depression	• Conduct group sessions for clients
Parent-Child Interaction Therapy (PCIT)	• Conduct 12-20 sessions for clients
Prolonged Exposure Therapy for PTSD	• Conduct 9-12 90-minute individual sessions 1-2 times per week
Seeking Safety	• Provide flexible number of individual or group sessions as determined needed
System Navigators for Veterans	• Recruit, hire and train veterans • Conduct outreach and awareness • Participate in interagency planning efforts
Trauma Focused Cognitive Behavioral Therapy	• Conduct 12-15 weekly one hour sessions for child and parent

F. Key Milestones and Timeline

1.	Develop Requests for Proposals/Requests for Services	Months 1-3
2.	Obtain County Counsel approval for RFPs/RFSs	Months 1-3
3.	Solicit proposals & evaluate proposals	Months 3-9
4.	Award proposals	Months 6-12
5.	Develop LACDMH PEI program and infrastructure	Months 1-3
6.	Recruitment, hiring and training of staff (LACDMH)	Months 1-6
7.	Implement programs	Months 6-12
8.	Conduct training on LACDMH requirements for agencies	Months 7-12
9.	Conduct training in EBP and CDE model protocols	Months 7-12
10.	Conduct outreach and education	Months 3-12
11.	Set up data collection procedures and requirements	Months 1-6
12.	Conduct quarterly PEI provider meetings	Month 12 and on

G. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Child-Parent Psychotherapy	Individuals: Families:	Individuals: 525 Families: 525	4

	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		
Crisis Oriented Recovery Services	Individuals: Families:	Individuals: 10,440 Families:	4
Group CBT for Major Depression	Individuals: 150 Families:	Individuals: 300 Families:	4
Parent-Child Interaction Therapy (PCIT)	Individuals: Families:	Individuals: 800 Families: 800	4
Prolonged Exposure Therapy for PTSD	Individuals: Families:	Individuals: 2,360 Families: 516	4
Seeking Safety	Individuals: Families:	Individuals: 864 Families: 144	4
System Navigators for Veterans	Individuals: 600 Families:	Individuals: Families:	4
Trauma Focused Cognitive Behavioral Therapy	Individuals: Families:	Individuals: 1,600 Families: 1,600	4
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 750 Families: 0**	**Individuals: 16,889 Families: 3,585**	**4**

5. LINKAGES TO COUNTY MENTAL HEALTH AND PROVIDERS OF OTHER NEEDED SERVICES

A. Linking PEI Participants to Services

This project will provide information about mental health, other supportive services and community resources to the children, youth, adults, older adults, and family members who participate in the programs. In instances where clients and/or their parents or caregivers are perceived to need mental health assessment or extended treatment for mental illness or emotional disturbance, the provider is responsible for identifying appropriate agencies where these services can be providers. The provider will ensure that there is a direct referral and actual linkage with the referred agency so as to avoid creating additional barriers to services. These referrals will include mental health and primary care agencies as well as community-based organizations. Staff will help children, TAY, Adults, and older adults, parents, and other caregivers to articulate their needs and enhance their capacity to identify and connect with other appropriate services.

B. Linking PEI Participants to Non-Traditional Services

The Trauma Recovery Services Project will enable children, youth, adults, and older adults. their parents and other caregivers to access prevention and early intervention community resources including educational, substance abuse, domestic violence, community support, housing, employment, high quality child care and development programs, and other resources. Programs are expected to conduct a needs assessment at the onset and conclusion of services to identify needs in order to ensure that referrals are made to needed services. Staff will help children, youth, parents, and other caregivers to link to these services and follow up to ensure a connection has been made.

C. Sufficiency to Achieve Outcomes

LACDMH conducted research on each of the EBP and CDE models to determine the costs for each program and ensure that the budget and program designs were adequate to achieve the required outcomes. The analysis also determined that program outcomes were in line with the project, State, SDMH, LACDMH, and community expectations. In the bidding process, agencies must demonstrate financial viability, organizational experience, management capability, and cultural competency to provide the services. All agencies selected to run the PEI programs will be required to participate in LACDMH training, including cultural competence, EBPs, PEI policies, and LACDMH policies. Further, they will be required to collect needs assessment data and participate in the Department's evaluation protocols and activities in order to ensure the program is properly developed, clients adequately serviced, and outcomes achieved.

6. COLLABORATION AND SYSTEM ENHANCEMENTS

A. Relationships, Collaborations and Arrangements

The Trauma Recovery Services Project requires extensive collaboration with both government and private agencies and organizations. Because crisis and trauma services are often sought at medical centers, it is important that relationships be maintained or developed with primary care personnel, including administration, physicians, nurses, and other medical care professionals. LACDMH already has a long-standing collaborative relationship with the countywide health plans and many of the community care clinics located in the targeted regions in the Service Areas. Also, the County Departments of Health, Public Health, Children and Family Services, Public Social Services, Law Enforcement, and Fire Departments are key collaborative partners. To encourage collaboration and promote new partnerships, CBOs and non-mental health providers will have an opportunity to provide input to primary care and other agencies that provide trauma recovery services through monthly Service Area Advisory Committee meetings and Service Area Provider meetings.

PEI will also provide regularly held PEI Provider meetings that will be open to the community at large. PEI Provider meetings will encourage and facilitate sharing resources and promoting partnerships and will offer technical assistance on PEI program sustainability to the group and to individual providers as needed. Private agencies include health organizations, the Community Clinic Association of Los Angeles County, mental health providers, childcare and development programs, and other social service, health, and family organizations.

(1) Outreach Strategies

PEI will outreach to CBOs and non-mental health providers through SAAC meetings, Service Area Provider meetings, PEI Provider meetings, the DMH PEI website, the PEI newsletter and the PEI distribution database that has a current membership of over 6,800 individuals. Outreach efforts will serve to bring CBOs and non-mental health providers to the implementation phase.

(2) Improving Collaboration with CBOs and Non-Mental Health Providers

LACDMH has included community based organizations (CBOs) and non-mental health providers from the very inception of the PEI planning process. To bring these organizations into the implementation phase, LACDMH has four different approaches:

(a) Incubation Academy

This program was designed to assist community and local mental health service providers in obtaining contracts with the Department of Mental Health to build capacity within the mental health system. Comprehensive information, resource references, technical assistance, mentorship, and/or sponsorship opportunities are included in this program, as well as guidance regarding County contracting procedures, documentation, and day-to-day business operations requirements.

(b) Master Agreement List Workshops

PEI Administration will hold a series of workshops to train prospective agencies, including CBOs, on how to qualify for inclusion on the Master Agreement list. The intention of this detailed workshop is to help agencies unfamiliar with county business practices clear the initial and sometimes confusing hurdles in becoming a contractor. As such, this training will include information on how to submit a Statement of Qualifications (SOQ) in response to a Request for Statement of Qualifications (RFSQ), and the ins and outs of the Requests for Services (RFS) process, the pathway by which they could ultimately provide PEI services.

(c) CDE Technical Assistance Workshops

PEI Administration will provide workshops to developers, including CBOs, whose programs were denied in the initial round of qualification. The workshops will

focus on clarifying requirements for the CDE application, identification of outcome approaches, cultural practices, and procedures for resubmission. The intent of the CDE TA Workshops is to provide a hands-on step by step method for helping agencies develop and qualify their programs as a CDE practice. In conjunction with this process, PEI Administration will work with developers on becoming an approved provider (i.e. qualifying for the Master Agreement List) as outlined above. Presently, the majority of qualified CDE developer agencies appear on the current Master Agreement List.

(d) Subcontracting

PEI administration recognizes that County minimum requirements to qualify for the Master Agreement List may not be met by many potential worthy MHSA/PEI service providers. In order to address those situations and for those CBOs who are not interested in obtaining a direct contract with LACDMH, another way for them to provide PEI services is to subcontract through an existing LACDMH provider. Additionally, this is an opportunity for small organizations to partner with and receive mentoring from experienced providers which in turn, may eventually lead to a direct contract with LACDMH.

B. Building Upon the Mental Health and Primary Care System

Expanded and new partnerships with mental health and primary care providers will be established through the Trauma Recovery Services Project. The stigma associated with seeking mental health services can be minimized by providing these services at the primary care, school, and community-based sites. Children, youth adults, older adults, and their parents and/or caregivers will be referred to primary care providers as medical needs are identified.

C. Leveraging Resources

The Trauma Recovery Services Project will work with school districts and other educational and health agencies to leverage resources for the PEI programs. Leveraged resources include space, equipment, and staff time as needed. In the solicitation process, potential providers will be notified that agencies are expected to generate support and leveraged resources, such as space, equipment, staff, and volunteer time. LACDMH will give priority to those agencies that can demonstrate existing capacity and/or a systematic plan for generating resources in the bidding process.

D. Sustaining the PEI Project

Through the solicitation process, the County will determine the organizational and fiscal capacity of each agency to fiscally manage and sustain the PEI program. Continued funding of the program will be through MHSA PEI funds, as well as continuation of any leveraged funds, including in-kind resources and services. LACDMH will monitor the

programs to ensure that outcomes are being met in a timely manner and that fiscal, program, and contract standards are adhered to as required.

7. INTENDED OUTCOMES

A. Specific Cultural Outcomes

Through its community mental health needs assessment, the county obtained a comprehensive understanding of the racial/ethnic and linguistic distribution of the population across fairly small geographic regions. The cultural diversity in the population required that the county carefully consider programs that could be implemented successfully for different ethnic and language groups. For this reason, when building each PEI project, programs were first identified on the basis of whether they had been developed with specific cultural populations included in their validated studies. Inclusion of cultural populations during development is crucial in order to demonstrate and later realize the community effectiveness (i.e. generalizability) of a particular program for a specific population.

From there, program selections were made for each service area in accordance with the demographic profile of the area and the inputs received from the collection of local planning bodies mentioned earlier. As a result of this process, most individual outcomes directly involve underserved cultural populations as had been planned. In many cases due to the ethnic distribution across the county, these underserved cultural populations constitute, in fact, a majority in actual population estimates for a given region. So, programs residing in these areas will obviously impact these groups. Due to the inter-relationships between ethnicity, poverty, and other key indicators, locating programs within these areas is paramount and will be an important detail to note during the RFS process. To make this explicit, the following represents a sample of possible outcomes that can be expected for these specific populations based upon the programs selected in Los Angeles County:

- Reduction of suicidal ideation/behaviors in high risk populations such as adults, older adults, African-American, American Indian, Latino, and White populations.
- Reduction of symptoms associated with trauma and posttraumatic stress disorder in African-American, American Indian, Asian/Pacific Islander, and Latino populations.
- Reduction of the harmful effects of exposure to community violence in African-American, American Indian, Asian/Pacific Islander, and Latino populations across the county.
- Reduction of symptoms of depression in African-American, American Indian, Latino, and Asian/Pacific Islanders families.

- Inclusion of two locally developed pilot programs to assist all age groups and Veterans.

B. General Project Outcomes

The tables below depict a more general summary of the project and program level outcomes and methods for measuring them.

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
INDIVIDUAL	• Reduction of symptoms of anxiety and depression • Improved coping skills • Improved social support • Improved global functioning	• Child, parent, teacher, therapist ratings on depression, anxiety, and family functioning, and social functioning
PROGRAM/SYSTEM	• Creation of a system of care for trauma-exposed individuals • Increased number of trauma focused programs	• Number of programs offered to treat trauma • Number of clients served by trauma focused services

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Child-Parent Psychotherapy	• Significant improvement in maternal distress • Significant reductions in child behavior problems • Reductions in child trauma symptoms	• Parent behavior ratings • Parent self report on stress and coping • Therapist family assessment
Crisis Oriented Recovery Services	• Decreased depressive symptoms; increased functioning • Decreased utilization of ERs • Decreased trauma symptoms	• Physician/medical personnel ratings
Group CBT for Major Depression	• Decreased depressive symptoms; increased functioning	• Client self report on measures of depression and stress • Therapist GAF and other assessments
Parent-Child Interaction Therapy (PCIT)	• Decreased child behavior problems • Decreases in re-reports of child abuse • Parents report using higher levels of praise and lower levels of criticism	• Parent behavior rating • Therapist assessment • SCAN reports
Prolonged Exposure Therapy for PTSD	• Reduced severity of trauma symptoms • Significantly reduced symptoms of depression • Improved social adjustment • Reduced anxiety symptoms	• Client self report of anxiety and depression • Therapist ratings
Seeking Safety	• Reductions in substance use • Improvement in trauma symptoms • Improved psychosocial functioning	• Client self report of anxiety and risky behaviors • Therapist behavior ratings • Child alcohol/substance use
System Navigators for Veterans	• Improved utilization of resources serving veterans	• Client self report on measures of depression and stress • Completed linkages to resources

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Trauma Focused Cognitive Behavioral Therapy	• Decreased child behavior problems • Decreased trauma symptoms • Decreased depression • Improved social competence	• Child, parent, teacher ratings • Therapist assessment • SCAN reports

C. Long Term Project Outcomes

Long-term outcomes for the current project include filling a county need to specialize trauma focused services. Presently services are fragmented and service coverage is uneven so the new project would standardize treatment for trauma-exposed individuals. With its depth of evidence-based practices, the project is meant to transform treatment in the area into a cutting edge service. Other expected long term outcomes include a reduction of co-morbid disorders and a decreased need for more extended treatment.

8. COORDINATION WITH OTHER MHSA COMPONENTS

A. Coordination with CSS

As part of their orientation, providers will be trained in the range of mental health services available in the County, including MHSA programs. As child/youth, parents and caregivers' needs are identified, providers will refer them to appropriate MHSA Community Services and Supports programs, such as the Full Service Partnerships for children, TAY, adults and older adults, juvenile justice linkages/collaboration, and alternative crisis services.

B. Intended Use of WET Funds

Students, parents, and other caregivers will be given information about relevant programs in the Workforce, Education and Training Plan, as appropriate given their expressed desire to enhance their education and/or vocational goals and meet the criteria to qualify.

C. Intended Use of Capital Facilities and Technology Funds

The County does not intend to use Capital Facilities and Technology Funds for this PEI Project at this time.

9. ADDITIONAL COMMENTS (OPTIONAL)

County: Los Angeles

PEI Project 5: PRIMARY CARE AND BEHAVIORAL HEALTH

Date:

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒	☐	☐
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒	☐	☐
4. Children and Youth at Risk for School Failure	☐	☐	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐	☐	☐
6. Underserved Cultural Populations	☒	☒	☒	☒

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s)

As part of a multi-modal assessment, data was gathered formally six different needs assessment strategies: recommendations from CSS planning, community surveys, service area data profiles, key individual interviews, focus groups, and community/ countywide forums. Aadditional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI. Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project.

In order to proceed with project-building, all of the community assessment information was made available to the Ad Hoc Steering Committees who further refined population, age, and program selections. The current list of PEI projects emerged from these final sets of recommendations and reflect not only the localized needs of county service areas but, also, the specialized needs of countywide populations. The main components of the needs assessment are discussed below as they relate to these specific patterns of responses which led to the creation of the Primary Care and Behavioral Health Project.

(1) Stakeholder Input

(a) Key Individual Interviews

► Input Regarding Priority Population. Key individuals with knowledge and experience of the Underserved Cultural Populations suggested that a primarily early intervention project be developed in order to address individuals and family holistically through integrated behavioral health services. Below are paraphrased examples of the key individual responses:

- *This community also needs more localized mental health screening and services. There is some limited screening at this clinic, but there needs to be more available to a wider breadth of the population. The primary care doctors here provide some limited mental health screening help. Our doctors and medical staff can only provide limited counseling, and some medication assistance. We need more training in mental health for medical providers, and psychiatric services co-located at this center.*
- *Coordination of primary care and mental health services as a means of accessing mental health through health care should be a priority. For example, our agency is conducting a study to measure the effectiveness of outsourcing a mental health professional to work at a primary care site. We need to take a*

holistic approach to PEI utilizing primary care, mental health and related services.

- *It would be beneficial to have mental health screenings and services integrated with health screenings and services.*
- *"It is really a matter of a connection between behavior, mental health, and physical health."*
- *Things to Improve Access to Mental Health Services: Foster an integrated system of medical and mental health services.*

(b) Focus Group Interviews

► Input Regarding Priority Population. Focus groups with knowledge and experience of Underserved Cultural Populations called for the creation of a primary care/integrated behavioral health project. Below are paraphrased examples of the focus group responses:

- *A model of comprehensive, integrated health care is needed in which health care clinics approach mental health as part of the health care continuum with mental health professionals as part of the health care team.*
- *One group suggested that an early mental health consultation system is needed that is connected to early care and education sites and integrates medical needs, educational needs, and developmental/disability needs, etc. - in other words, family-centered holistic services. PEI should use strategies that engage pediatricians in PEI efforts (e.g., reimbursing physicians for conducting screenings) and enhance effective existing services rather than create new ones.*
- *Participants ranked the top needed prevention services in the following order: 1) cross training for developmental disability and mental health professionals; 2) As a long-term priority, non-discriminatory, equal access to services for the developmentally disabled. As a short-term priority, housing a mental health professional on-site at the Harbor Regional Center.*
- *Specific prevention service needs identified by a group included: 12-step programs for substance abuse-involved youth, early teen pregnancy resources, and reporting hotlines for teen youth.*
- *A group suggested grounding services in a holistic approach that is culturally and linguistically appropriate. Recommendations included parent education on emotional health to learn to manage emotions and help children learn how to manage their emotions; education on preventing alcohol and drug abuse; education services on domestic violence; education on sexuality, STDs, and chronic illness. There is a high rate of young teen girls who are sexually active and become pregnant or are exposed to STDs. Health promotion programs should connect physical, mental, and spiritual health – especially for the Latino*

community. An example of this kind of approach is diabetes care, which has both a physical and emotional dimension.

► Input Regarding Age Groups. From the responses excerpted above, focus groups suggested that integrated behavioral health services should target the entire family or the entire age range. Certain of the programs in this project are concerned with specific age groups. Teen pregnancy education and outreach programs obviously target older children and the TAY population. Health and mental health promotion activities can involve individuals across the life span and can include individuals with disabilities and non-English speaking backgrounds.

(c) Community Forum Recommendations

Utilizing the needs assessment results, Community Forum attendees were asked to prioritize PEI populations and age groups. These recommendations were then used by Ad Hoc Steering Committee members in making program selection recommendations.

► Input Regarding Priority Strategies. The following examples are some of the recommendations regarding strategies for primary care and behavioral health.

- *Interdisciplinary, holistic approaches to services, including cross-training amongst professionals.*
- *Co-locate/provide services in community based organizations and develop comprehensive community outreach plans*
- *School-based health clinics and PEI programs. Countywide Health Plans*
- *Promotion of healthy youth development, including cultural, spiritual, physical, and emotional health.*
- *Universal health insurance or medical for the undocumented population that includes mental health treatment and medication*
- *Collaboration and partnership to provide mental health education and services through community based locations such as a "wellness club", to non-English speaking, monolingual, undocumented and uninsured individuals that is culturally and linguistically appropriate.*
- *Integrated services that are provided by government and/or with community- and faith-based organizations that link mental health with social services, substance abuse services, primary care, HIV testing, and short-term supportive housing.*
- *Increased screening at senior centers, doctor's offices, gay and lesbian centers, rehabilitation centers, and other non-traditional settings*

(d) Steering Committee Recommendations

The Ad Hoc Steering Committees were asked to further identify sub-populations that should be served in their service areas.

► Input Regarding Sub-populations. Below are examples of the target populations that the Steering Committees recommended for primary care services.

- *Trauma-exposed, including gang activity and exposure to domestic and/or community violence, etc.*
- *Persons on fixed income; or, seniors experiencing financial difficulties, poverty, loss of income, death of spouse, or other types of loss/grief.*
- *Older adults who are geographically isolated; or, older adults who lack access to services, with barriers such as transportation.*
- *Seniors dealing with major health issues; or, seniors dealing with a loss of medical services and/or benefits/depression/substance use.*
- *Individuals who are at risk for depression/suicide.*
- *Veterans*
- *Individuals with disabilities, medical/physical issues, and their caregivers*
- *Frail, chronically ill, and those living with chronic pain; disabled, especially those who have mobility issues and/or are vision-impaired*
- *Latino or non-English-speakers, including elders from the Cambodian community.*
- *Uninsured Individuals experiencing language/cultural competence limitations.*
- *Trauma-exposed, including gang activity and exposure to domestic and/or community violence, etc.*

(2) Data Analysis

(a) Statistical and Demographic Indicators

Information from the Key Individual Interviews and Focus Groups responses presented above and the *Vulnerable Communities* Report, were found to be confirm the need for the creation of a project focused on the needs of Underserved Cultural Populations. The following selected demographic variables and risk factors demonstrates the need for services: Ethnicity, Primary Language, and Linguistic Isolation.

(b) Ethnicity

Ethnicity is the single most important indicator in terms of mental health disparities in the research literature. Numerous studies have shown that ethnic minorities and, in particular, African-Americans, Latinos, Asian/Pacific Islanders, and American Indians, encounter more barriers in accessing mental health services than Whites. Los Angeles County has a diverse ethnic population representing nationalities and ethnic groups from all over the world. The Hispanic population is the largest ethnic group residing in the county and makes up 47.0% of residents, or almost one-half of the population. Following this, Western European Whites are the second most populous ethnic group and account for 25.2 percent of the population. Asians are the third most populous

group at 12.5%, and African- Americans make up 8.9% of the county population. No other ethnic group accounts for more than 3% of the population. Even so, there are sizeable numbers of Armenians, Russians, South Asians, Iranians, multiethnic individuals, and other Middle Easterners throughout the county.

Since the US Census 2000, when individuals gained the opportunity to be counted as having "Two or more major races," the nation has seen a rising trend in the numbers of individuals within this category. Multi-ethnic individuals now are more numerous in the county than Armenians, Russians, South Asians, Iranians, and American Indians/Alaskan Natives. Research on the mental health problems of multi-ethnic individuals within clinic populations indicates that the severity of their behavior problems may exceed those with a mono-ethnic identity (Choi, Harachi, Gillmore, Catalano, 2006; Shih & Sanchez, 2005).

(c) Primary Language

An individual's Primary Language, if other than English, can function as a barrier to accessing mental health services. Results from the ACS 2003-2006 consistently rank California as the state with the highest numbers of individuals (about 20%) reporting limited English proficiency, (i.e., they report speaking English "less than very well", ACS American Factfinder, 2008). Studies conducted with Spanish-speaking and Asian language-speaking populations have reported large disparities in accessing mental health services; individuals proficient in English have a clear advantage in getting mental health help over those who are not proficient (Snowden, Masland, & Guerrero, 2007). Across the county, the most common Primary Language, English, was only identified by 40.0% of the population and this was only a few percentage points higher than Spanish (37.1%). This also indicates that 60% of the county's population identifies a language other than English as the language they speak at home. Following English and Spanish, and at far fewer numbers, the most frequently spoken languages across the county were Tagalog (2.2%), Korean (1.9%), Chinese (1.7%), and Armenian (1.4%).

(d) Linguistic Isolation

Limited English proficiency represents a strong barrier to mental health treatment, learning, and school success. Besides ethnicity, limited English contributes to mental health disparities involving access to services (Snowden, Masland, & Guerrero, 2007). Linguistically isolated families represent some of the most disadvantaged individuals in society. In terms of mental health, linguistically isolated families may not be receiving information on where or how to get help when a family member needs it. Overall, approximately 247,418, or 7.8% percent, of households in Los Angeles County reported that they were linguistically isolated. Across the county, this ranged from the low of 0.4% in the Long Beach E. area and 0.5% in the Redondo-Manhattan-Hermosa-El Segundo Beach areas to 22.7% in the East LA area and 25.5% in the Pico Heights area.

(e) Healthcare Plans

In the interests of promoting systems transformation, the American Psychological Association has launched an Integrated Healthcare Initiative which is in line with the PEI mission, to provide innovative preventative care and early interventions within a natural community setting. At the forefront of the initiative is California's Primary Care Association and the Community Clinic Association of Los Angeles County, key stakeholders from the PEI health sector at the state and county level.

The beneficial effects on health, mental health, and the economic system have become well documented. For several years, research has demonstrated the bi-directional effects of mind and body disorders. This has been especially apparent in the context of chronic disease where psychological traits and behaviors can compound physical problems leading to poorer outcomes, more costly procedures, and death. Other areas where embedded mental health clinicians have shown promise is in the early intervention of mental health disorders which come to light during a visit to a primary care provider. Mental health clinicians on site can provide preventative care and early interventions so that sub-threshold disorders either are avoided or delayed in onset.

Los Angeles County has several documented health behavior problems which are known to be treatable with a lifestyle/behavioral health interventions. The Public Health Department, for example, reported that across the county, 12.9% of adults were clinically depressed. Depression leads to poorer health outcomes due to its effect on decreasing medical regimen adherence and increasing unhealthy behaviors. Other findings include that 23% of children are overweight, 35.5% of adults are overweight, and 20% of adults are obese. It was found that half of adults don't get enough exercise, and the majority of kids don't get enough either. Other unhealthy behaviors include a high degree of teen drinking and smoking. 14% of adults smoke. All of these unhealthy behaviors, poor diet, lack of exercise, and drinking and smoking can be treated with psychosocial and psycho-educational interventions to alter lifestyles and the motivation to change.

There is a great opportunity to provide mental health services within a primary care setting because the sheer numbers of clinical encounters is quite large. For example, the 2002 National Ambulatory Study indicated that counseling and/or education and/or therapeutic services were ordered or provided at 44.7 percent of visits to primary care providers. In the county the size of Los Angeles, using this figure, rough estimates suggest that as many as 8-9 million visits to a primary care provider occur in a given year where mental health is provided. Obviously, this scope of clinical encounters warrants that primary care providers receive assistance and training from mental health providers who are best able to address the mental health component of physical illness, lifestyle changes, and behavioral health promotion.

3. PEI Project Description

A. Why the proposed PEI project – including key community need(s), priority population(s), desired outcomes and selected programs – addresses needs identified during the community program planning process

By reviewing the available information generated from the county needs assessment, stakeholder groups were able to recommend PEI programs for their respective communities and constituencies. As the Ad Hoc Steering Committees generated their program recommendations and targeted sub-populations, clusters of related programs began to coalesce around a core service which was then reified as the Primary Care and Behavioral Health Project.

By reviewing the data sources presented, one can see the extent of the county needs in terms of the most at-risk populations with regard to their economic and linguistic isolation. Data provided by the US Census Bureau illustrated the pervasiveness of poverty across the county and stakeholders were able to learn which ethnic groups and which geographic regions were most affected. Related to this, the county stakeholders were provided with reports documenting the uninsured population in the county – individuals who cannot afford to see a health or mental health professional. Beside poverty, language barriers have been identified as being especially difficult to surmount; county stakeholders were provide with information on where the most isolated families were in the county. Finally, a system-wide need was identified at the national, state, and local level regarding the current economic recession and the growing costs of non-integrated health/mental health systems.

By listening to the stated needs and desires of community stakeholders through key individual interviews, focus groups, and forums spread throughout the county, prioritizing solutions to address the problems encountered by the most economically and linguistically marginalized individuals in the county became possible. Some of the comments the county received with regard to this population are extracted above and show the interest stakeholders had in creating a primary care/behavioral health project. As a check on the soundness of these statements, a semantic analysis was performed on all stakeholder inputs and the results appeared to confirm the project's identification. That is, a circumscribed set of key descriptors defining stakeholder comments formed a pattern of semantic units around an abstract core service which was labeled, Primary Care And Behavioral Health.

Project Purpose. The Primary Care and Behavioral Health Project will develop mental health services within primary care clinics in order to increase primary care providers' capacity to offer effective mental health guidance and early intervention through the implementation of screening, assessment, education, consultation, and referral. Another purpose is to prevent patients at primary care clinics from developing severe behavioral health issues by addressing their mental health issues early on. Behavioral

health professionals skilled in consultation and primary care liaison will be integrated within the primary care system. It is the intent of the Project to build resiliency and increase protective factors among children, youth, adults and older adults and their families and other caregivers through the PEI programs. By offering assistance in identifying emotional and behavioral issues at a clinic setting, the stigma associated with seeking out mental health services will be minimized.

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Poverty • Ethnicity • Geographic region • Family dysfunction and violence • Victimization • Mental health and physical health status • Maternal depression • Suicidal ideation • Physical disability • Co-morbidity of mental and physical disorders • Linguistic and social isolation • Lack of social support • Pessimism • Type A personality • Life stressors • Inactivity • Smoking • Drug use • High risk sexual behavior • Obesity	• Coping skills • Family support • Social support • Effective parenting • Sociability • Activity level • Community support • Treatment adherence • Physical and mental health status • Optimism • Health lifestyle and diet

Project Components. Each project is comprised of the following components:

1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.
2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.
3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures that accurate data is captured on a systematic and ongoing basis so that the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure

that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.

4. PEI Programs – There are a total of seven EBP, CDE and pilot project programs that will be implemented in eight service areas for the Primary Care and Behavioral Health Project.

Outreach and Engagement to Unserved and Underserved Communities. Because one of the overarching goals of the MHSA is the reduction of mental health disparities experienced by specific racial/ethnic and other cultural groups, all projects have been built with service components to achieve this end. The outreach and engagement component for each PEI project is a critical element in reducing disparities because it is primarily concerned with increasing access to programs, a first step in dismantling barriers to services. The County strategy for outreach and engagement involves the utilization of existing County outreach workers, activating existing community resources and organizations, and the development of culturally and linguistically sensitive materials. All of these tools will be combined into a coordinated effort to seek out difficult to reach populations, educate groups regarding PEI programs, and facilitate entry into an appropriate program.

Outreach and engagement activities for the Primary Care and Behavioral Health Project will include, but are not limited, to the following:

Community Leaders, Community Health Clinics, and Organizations

- Working with cultural brokers or community representatives to develop outreach strategies. LACDMH will seek input from the key individuals, focus group participants, and community organizations that participated in the planning process to identify and implement culturally and linguistically appropriate methods for reaching the targeted individuals in these unserved/underserved communities
- Engaging local ethnic community leaders and gatekeepers, while recognizing that many people in these communities lack knowledge of, distrust, and/or are reluctant to use mental health services. Personal contact with these individuals is a key method to increase community knowledge about PEI programs and to facilitate access to these programs.
- Engaging indigenous health leaders, such as native healers, acupuncturists, and other ethnic health providers or practitioners of alternate therapies.
- Engaging our community health clinics where the indigent and uninsured consumers use services.
- Providing information and training in small group settings (e.g. community clinic, church, temple or other place of worship that has a primarily minority congregation) in local neighborhoods or ethnic community. These sites would be asked to host training and educational forums, bulletins for educational information, and people to serve as volunteers.
- Contacting disease specific support groups that focus on health factors which have a large impact on minority communities (e.g., diabetes, high blood pressure, etc.)

Educational Materials

- Developing educational materials about the Primary Care and Behavioral Health Project. The materials will be translated, culturally relevant, at the appropriate literacy level, and visually accessible (large print and Braille). Community input will be sought in the approach and design of materials to ensure the materials are culturally sensitive.
- Distributing an information sheet about the outreach and engagement efforts, including outreach staff contact information as well as programs' contact information. These flyers will be distributed at meetings and posted in places where the target population is expected to congregate, such as the ethnic specific health centers, women's shelters, refugee centers, and so forth.
- Distributing press releases, informational articles, and paid advertising (both in English and the appropriate threshold language) in local ethnic newspapers, radio, television, and websites.

Community Outreach Workers

- Collaborating with LACDMH's CSS outreach and engagement staff. Since the inception of the CSS programs, these individuals have developed relationships with numerous community providers. LACDMH will seek the assistance of these staff to provide community linkages for the PEI programs and distribution of information.
- Hiring and training outreach workers, especially those with non-English language ability, from the local communities and the unserved/underserved communities.
- Recruiting and training volunteers from the community who are familiar with the unserved/underserved communities.

Partner Organizations

- Working though existing organizations, such as health clinics (including FQHC's), medical associations, and other organizations.
- Collaborating with partner organizations to promote joint outreach efforts.
- Providing training or informational sessions to local organizations such as victim's rights groups, refugee and immigrant organizations, neighborhood groups, health care agencies, and human service agencies, about the PEI programs.
- Distribute educational pamphlets and brochures through frequently utilized vendors or providers, such as home-delivered meal programs, pharmacies, and Medicare carriers.
- Participating in local health fairs and health-screening events, particularly those directed at racial groups and the unserved/underserved.

Primary Care and Behavioral Health Programs. For the Primary Care and Behavioral Health Project, programs were selected in order to reach the entire age spectrum with thought given to where these could be offered and how they could be integrated in to community clinics. The Incredible Years and Triple P Positive Parenting Programs were

selected to address the needs of children and their parents. Abuse Focused CBT for Child Physical Abuse (recently renamed Alternatives for Families) was selected to address the health sector's concern for those victimized or exposed to domestic or community violence. The IMPACT program was chosen to address problems seen within the older adult age group such as depression, social isolation, poverty, suicidal ideation, and living with a chronic disease or disability. Lastly, a pilot project was developed with LA Care to assist their primary care staff to identify and treat mental health problems with their patients as early as possible.

Prevention & Early Intervention	Early Intervention
Advice Line	Alternatives for Families
Incredible Years	IMPACT
Maternal Wellness Center	
Prevention & Early Treatment of Depression in Primary Care	
Triple P Positive Parenting Program	

(1) Prevention and Early Intervention Services

- **Advice Line – Transition-age Youth, Adults and Older Adults.** Advice Line is a LACDMH-LA Care Pilot Project. LA Care Health Plan (Local Initiative Health Authority for Los Angeles County) is the Nation's largest public health plan, serving over 800,000 members in Los Angeles County. LA Care is one of the Plans in the "two plan model" designed by the State of California to serve its Medi-Cal population within counties in California. Specialty Mental Health Services for the Medi-Cal population within the two plan model counties is a "carve out" and in Los Angeles, is the purview of LACDMH. LA Care is responsible for the basic mental health benefit for its beneficiaries, while LACDMH is responsible for the specialty mental health benefit. These two organizations are mandated to collaborate on providing care to Medi-Cal beneficiaries. SDMH, which oversees the activities of the Medi-Cal Plans, mandates a functional interface between the two entities for improved patient care and coordination. The goal of this pilot project is to assist LA Care primary care physician's staff with providing psychiatric treatment more effectively to their Medi-Cal beneficiaries who have mild mental health problems. The need for specialty mental health consultation in the form of case discussions among other types of education has been raised in primary provider focus groups initiated by LA Care administration. The pilot project will allow the two entities to provide support and measure the effectiveness of this simple, informal, yet reliable potential solution to the expressed need. In addition, when the program is successful, LA Care primary care physicians will be more capable of providing basic mental health treatment to beneficiaries who have mental disorders.

- **Incredible Years – Young Children and Children.** Incredible Years is a set of comprehensive, multifaceted, and developmentally based curricula targeting 2-12 year-old children and their parents and teachers. The parent, child, and teacher training interventions that compose Incredible Years are guided by developmental theory on the role of multiple interacting risk and protective factors in the development of conduct problems. The three program components are designed to work jointly to promote emotional and social competence and to prevent, reduce, and treat behavioral and emotional problems in young children. This EBP for parents of young children and school age children will be provided by countywide health organizations in order to enhance treatment capacity on a countywide basis.

- **Maternal Wellness Center – Adults.** The Maternal Wellness Center is a culturally appropriate, evidence-based prevention and early intervention for perinatal depression with on-site psychiatric services and perinatal care. It includes screening, assessment, individual and/or group therapy, and medication management and support through six months postpartum (employs validated measures and cognitive-behavioral therapy). The program is a CDE for high-risk women and their infants that will be implemented in Service Areas 3 and 4.

- **Prevention & Early Treatment of Depression in Primary Care – Transition-age Youth, Adults, and Older Adults.** Prevention & Early Treatment of Depression in Primary Care is a culturally appropriate evidence-based collaborative care model that includes screening, prevention, and early intervention for depressive symptoms and disorders (employs validated measures and cognitive behavioral therapy). This CDE for low-income TAY, adults, and older adults will be implemented in Service Areas 6 and 7 and on a countywide basis. Additionally, relevant technical assistance will be provided to countywide health organizations.

- **Triple P Positive Parenting Program – Young Children and Children.** The Triple P—Positive Parenting Program is a multilevel system or suite of parenting and family support strategies for families with children from birth to age 12, with extensions to families with teenagers ages 13-16. Developed for use with families from many cultural groups, Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. This EBP is intended to provide a multi-level system of parenting and social support to families with children ages 3-16. Technical assistance will be provided to countywide health organization so implementation can occur on a countywide basis.

(2) Early Intervention Services

- **Alternatives for Families - Children.** Alternatives for Families (also know as Abuse Focused CBT for Child Physical Abuse) is based on principles derived from learning and behavioral theory, family systems, cognitive therapy, and developmental

victimology. It integrates specific techniques to target school-aged abused children, their offending caregivers, and the larger family system. Through training in specific intrapersonal and interpersonal skills, Alternatives for Families seeks to promote the expression of appropriate/pro-social behavior and discourage the use of coercive, aggressive, or violent behavior. Essential components include: education about CBT model and physical abuse, establish agreement with family to refrain from using physical force, review child's exposure to emotional abuse, identify and address cognitive contributors to abusive behavior in caregivers, teach affect management skills, teach parents behavioral strategies to reinforce and punish behavior as alternatives to physical discipline, and teach pro-social communication and problem-solving skills to the family and help them to establish them as everyday routines. This is an EBP that will be implemented with families through countywide health organizations.

- **Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) – Adults and Older Adults.** IMPACT is an intervention for patients who have major depression or dysthymic disorder. The intervention is a one-year, stepped collaborative care approach in which a nurse, social worker, or psychologist works with the patient's regular primary care provider to develop a course of treatment. During the first visit, a depression care manager (DCM) completes an initial assessment, provides education about treatment, and discusses the patient's preference for depression treatment. The DCM works with the patient and his/her primary care provider to establish a treatment plan according to the recommended treatment algorithm; the patient and provider make the actual treatment choices. An EBP which reduces depression in individuals, IMPACT will be implemented in Service Areas 1, 7, and 8.

(3) Targeted Populations

The table below describes the targeted populations for each of the Primary Care and Behavioral Health Programs.

Program	SA	Age Group	Target Populations
Advice Line	Health	TAY, Adults, Older Adults	➢ Individuals enrolled in Med-cal with mental illness. Individuals experiencing language/cultural competence limitations. ➢ Primary cultural groups served will vary by community, but will include Hispanics/Latinos, African Americans, and Asians/Pacific Islanders.
Alternatives for Families	Health	Children	➢ Children who have been trauma-exposed as a result of gang activity, domestic violence, or community violence. Individuals who face linguistic or cultural barriers when attempting to access services. ➢ All cultural populations throughout Los Angeles County.

Program	SA	Age Group	Target Populations
IMPACT	1	Older Adults	➢ Older adults experiencing or at risk for depression. Persons on infixed income or experiencing financial difficulties. Older adults who are geographically isolated or lack transportation. Seniors dealing with major health issues, a loss of medical services, or substance abuse. ➢ The primary cultural groups are Hispanics/Latinos (41.0% of the Service Area 1 population), Western European Whites (39.0%) and African Americans (12.8%). However, Asian and American Indian population will also be served.
	7	Older Adults	➢ Individuals who are at risk for depression. Monolingual Spanish-speaking Latinos who are isolated with physical/mental health issues. First-generation immigrants. ➢ The primary cultural group in Service Area 7 is Hispanics/Latinos, making up 70.9% of the population. There are also significant Asian (9.1%) and Western European White (14.8%) populations who will be served.
	8	Adults, Older Adults	➢ Individuals experiencing or at risk for depression Veterans, ethnic minorities, and members of the LGBTQI community. Individuals with disabilities and their caregivers. Frail, chronically ill, or vision impaired older adults. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
Incredible Years	Health	Young Children, Children	➢ Parents of young children and school age children experiencing language/cultural competence limitations. Children exposed to trauma. The program will be provided by countywide health organizations in order to enhance treatment capacity on a countywide basis. ➢ All cultural populations throughout Los Angeles County.
Maternal Wellness Center	3	Adults	➢ High-risk, low-income women and their infants. Immigrants and/or non-English speaking adults. Deaf and hard-of-hearing populations. Adults who are homeless, low-income, or uninsured. ➢ Primary cultural groups are Hispanics/Latinos, who make up 45.0% of the Service Area 3 population, Asian groups (particularly Chinese) who make up 23.7%, and Western European Whites (23.3%).
	4	Adults	➢ High-risk, low-income women and their infants. Linguistically isolated families. Immigrants. People with physical/mental health symptoms but not seeking services or individuals who do not identify as having a mental illness. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
Prevention & Early Treatment of Depression in Primary Care	6	Adults	➢ Low-income adults at-risk for or experiencing depression. Latinos, African Americans, Asians and new immigrants not aware of mental illness and/or not seeking services due to stigma. Adults at risk of or exposed to HIV/AIDS or hepatitis C. ➢ African Americans, Hispanics/Latinos, and Asians will be the primary cultural groups served by this program.
	7	Adults	➢ Low-income adults at-risk for or experiencing depression. Individuals in crisis due to loss. Uninsured Latino immigrants, particularly monolingual Spanish-speaking males. ➢ The primary cultural group in Service Area 7 is Hispanics/Latinos, making up 70.9% of the population. There are also significant Asian (9.1%) and Western

Program	SA	Age Group	Target Populations
			European White (14.8%) populations who will be served.
	Health	TAY, Adults, Older Adults	➢ Low-income TAY, adults, and older adults at-risk for or experiencing depression. The focus will be on populations experiencing linguistic isolations, a lack of access to services, or poverty. The program will be provided by countywide health organizations in order to enhance treatment capacity on a countywide basis. ➢ All cultural populations throughout Los Angeles County.
Triple P Positive Parenting Program	Health	Young Children, Children	➢ Parents of young children and school age children experiencing language/cultural competence limitations. Children exposed to trauma. The program will be provided by countywide health organizations in order to enhance treatment capacity on a countywide basis. ➢ All cultural populations throughout Los Angeles County.

B. Implementation Partners and Type of Organization/Setting That Will Deliver the PEI Program and Interventions

The programs in the Primary care and Behavioral Health Project will be operated by primary care clinics and other medical clinics associated with the countywide health organizations. Providers will be selected through the County's competitive bidding process. The majority of services will be delivered at community clinics, hospitals, community centers, and in home. Implementation partners include the Los Angeles County Departments of Health and Public Health, LA Care, HealthNet, the Community Clinic Association of Los Angeles County (CCALAC), child care and development programs serving children from birth to five, and other health, mental health, social services, and educational agencies that may be delivering primary care services in the target areas to the target populations. It is expected that agencies selected to run the PEI programs will be experienced or have the capacity to provide the mental health services as well as collaborate with other agencies to provide integrated services. If it is determined that additional mental health or other services not available at the health clinic are needed or that more intensive mental health services are needed than the program offers, the PEI agency will be expected to confer with and refer the child and his/her family to appropriate resources. Each PEI agency will build collaborative relationships with a range of health, social service, mental health, educational, and other resources.

C. Target Community Demographics

This project will focus on the poverty population of all ages in Los Angeles County. County summary figures indicated that poverty is widespread and disproportionately

affects ethnic minority populations. Through the *Vulnerable Communities* report the LACDMH was able to identify regions where underserved cultural populations reside and also identify geographic areas which had particularly high risk factors. For example, poverty disproportionally affected underserved cultural groups especially Hispanic and African-American children and children who were residing in service areas 4 and 6. Also, 40.2% of African-Americans in Los Angeles County were living below the 200% FPL, 30.3% of Asians, 53.5% of Hispanics and 18.5% of Whites. One in four individuals in the county were Hispanic and living in poverty.

D. Highlights of New and Expanded Programs

The seven PEI programs in the Primary Care/Behavioral Health Project are new programs that are being offered at sites that do not currently provide these services. Primary care patients with risk factors associated with mental illness will benefit from a psycho-educational intervention to manage emotional stress and unhealthy behavioral patterns, including those associated with medical conditions. The approach to these services is meant to be integrated service model, with preventive and early intervention services acting as a partner with the primary care clinics and preventive public health services. Where possible, the PEI programs will be offered at a primary care clinic to encourage individuals to participate in the programs and to minimize any stigma or discrimination barriers to accessing these services.

E. Action Plan

The Primary Care and Behavioral Health Project will require the following start-up activities for contract agencies:

1. Solicit proposals through County bidding process
2. Establish partnerships with clinics, hospitals, medical centers, mental health agencies, and other key partners
3. Establish MOUs or other contracts confirming partnerships and scope of activities as needed
4. Recruit and hire staff
5. Train staff in EBP model protocols
6. Conduct outreach and education

Specific activities for each PEI program are listed below.

Programs	Objectives: Frequency And Duration
Advice Line	• Identify patients who exhibit emotional/mental health issues • Provide consultation to physicians regarding patients with more serious mental health problems • Provide training to medical personnel

Programs	Objectives: Frequency And Duration
Alternatives for Families	• Conduct 12-18 hours of direct service • Provide one-hour contacts 1-2 times per week to clients
IMPACT	• Conduct 6-8 sessions of brief structured psychotherapy. • Provide course of antidepressant medication as needed
Incredible Years Parenting Program	• Provide child Intervention • Conduct parent Intervention activities • Provide teacher training
Maternal Wellness Center	• Conduct group or individual therapy • Provide medication management and support for six months
Prevention & Early Treatment of Depression in Primary Care	• Conduct Depression Prevention Program through 8 weekly 2-hour sessions with case management as needed • Conduct Early Depression Treatment Program through 16 individual CBT sessions and/or anti-depressant medication
Triple P Positive Parenting Program	• Conduct level 1: media campaign • Provide level 2: 1-2 20 minute consultations • Level 3: 4 20-minute sessions • Level 4: 10 individual or 8 group sessions (10 hours total) • Level 5: Additional 3-5 individual sessions added to level 4

F. Key Milestones and Timeline

1.	Develop Requests for Proposals/Requests for Services	Months 1-3
2.	Obtain County Counsel approval for RFPs/RFSs	Months 1-3
3.	Solicit proposals & evaluate proposals	Months 3-9
4.	Award proposals	Months 6-12
5.	Develop LACDMH PEI program and infrastructure	Months 1-3
6.	Recruitment, hiring and training of staff (LACDMH)	Months 1-6
7.	Implement programs	Months 6-12
8.	Conduct training on LACDMH requirements for agencies	Months 7-12
9.	Conduct training in EBP/CDE model protocols	Months 7-12
10.	Conduct outreach and education	Months 3-12
11.	Set up data collection procedures and requirements	Months 1-6
12.	Conduct quarterly PEI provider meetings	Month 12 and on

4. PROGRAMS

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type	Number of months in operation through

			June 2010
Advice Line	Individuals: 4,000 Families:	Individuals: 4,000 Families:	June 2010 4
Alternatives for Families	Individuals: Families:	Individuals: 310 Families: 310	4
IMPACT	Individuals: Families:	Individuals: 2,100 Families: 450	4
Incredible Years	Individuals: 10,800 Families: 10,800	Individuals: 120 Families: 120	4
Maternal Wellness Center	Individuals: 420 Families: 420	Individuals: 300 Families: 300	4
Prevention & Early Treatment of Depression in Primary Care	Individuals: 315 Families:	Individuals: 350 Families:	4
Triple P Positive Parenting Program	Individuals: 230 Families: 230	Individuals: 57 Families: 57	4
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 15,765 Families: 11,450**	**Individuals: 7,237 Families: 1,237**	**4**

5. LINKAGES TO COUNTY MENTAL HEALTH AND PROVIDERS OF OTHER NEEDED SERVICES

A. Linking PEI Participants to Services

This project will provide information about mental health, other supportive services and community resources to the children, youth, and family members who participate in the programs at the primary care clinics. In instances where children, youth, adults, and older adults and/or their parents or caregivers are perceived to need greater mental health assessment or extended treatment for mental illness or emotional disturbance, the provider is responsible for identifying appropriate agencies where these services can be providers. The provider will ensure that there is a direct referral and actual linkage with the referred agency so as to avoid creating additional barriers to services. These referrals will include mental health, other primary care agencies as well as community-based organizations. Staff will help children, youth, adults and older adults as well as parents and other caregivers to articulate their needs and enhance their capacity to identify and connect with other appropriate services.

B. Linking PEI Participants to Non-Traditional Services

The Primary Care/Behavioral Health Services Project will enable individuals and their families to access prevention and early intervention community resources including

educational, substance abuse, domestic violence, community support, housing, high quality child care and development programs, and
employment resources in a medical setting. Programs are expected to conduct a needs assessment at the onset and conclusion of services to identify needs in order to ensure that referrals are made to needed services. Staff will help children, youth, parents, and other caregivers to link to these services and follow up to ensure a connection has been made.

C. Sufficiency to Achieve Outcomes

LACDMH conducted research on each of the EBP and CDE models to determine the costs for each program and ensure that the budget and program designs were adequate to achieve the required outcomes. The analysis also determined that program outcomes were in line with the project, State, SDMH, LACDMH, and community expectations. In the bidding process, agencies must demonstrate financial viability, organizational experience, management capability, and cultural competency to provide the services. All agencies selected to run the PEI programs will be required to participate in LACDMH training, including cultural competence, EBPs, PEI policies, and Department policies. Further, they will be required to collect needs assessment data and participate in the Department's evaluation protocols and activities in order to ensure the program is properly developed, clients adequately serviced, and outcomes achieved.

6. COLLABORATION AND SYSTEM ENHANCEMENTS

A. Relationships, Collaborations and Arrangements

The Primary Care/Behavioral Health Project requires extensive collaboration with both government and private agencies and organizations. It is important that relationships be maintained or developed with primary care personnel, including administration, physicians, nurses, and other medical care professionals. The Advice Line Pilot Project is a cooperative and collaborative arrangement between LACDMH and LA Care that demonstrates their ongoing commitment to the integration and interface of physical and mental health care. In addition to the long-standing collaborative relationship with the countywide health plans, LACDMH has relationships with many of the community care clinics located in the targeted regions in the Service Areas. Also, the County Departments of Health, Public Health, Children and Family Services, and Public Social Services are key collaborative partners. To encourage collaboration and promote new partnerships, CBOs and non-mental health providers will have an opportunity to provide input to primary care and countywide health plan agencies through monthly Service Area Advisory Committee meetings and Service Area Provider meetings.

PEI will also provide regularly held PEI Provider meetings that will be open to the community at large. PEI Provider meetings will encourage and facilitate sharing

resources and promoting partnerships and will offer technical assistance on PEI program sustainability to the group and to individual providers as needed. Private agencies include health organizations, the Community Clinic Association of Los Angeles County, mental health providers, child care and development programs, and other social service, health, and family organizations.

(1) Outreach Strategies

PEI will outreach to CBOs and non-mental health providers through SAAC meetings, Service Area Provider meetings, PEI Provider meetings, the DMH PEI website, the PEI newsletter and the PEI distribution database that has a current membership of over 6,800 individuals. Outreach efforts will serve to bring CBOs and non-mental health providers to the implementation phase.

(2) Improving Collaboration with CBOs and Non-Mental Health Providers

LACDMH has included community based organizations (CBOs) and non-mental health providers from the very inception of the PEI planning process. To bring these organizations into the implementation phase, LACDMH has four different approaches:

(a) Incubation Academy

This program was designed to assist community and local mental health service providers in obtaining contracts with the Department of Mental Health to build capacity within the mental health system. Comprehensive information, resource references, technical assistance, mentorship, and/or sponsorship opportunities are included in this program, as well as guidance regarding County contracting procedures, documentation, and day-to-day business operations requirements.

(b) Master Agreement List Workshops

PEI Administration will hold a series of workshops to train prospective agencies, including CBOs, on how to qualify for inclusion on the Master Agreement list. The intention of this detailed workshop is to help agencies unfamiliar with county business practices clear the initial and sometimes confusing hurdles in becoming a contractor. As such, this training will include information on how to submit a Statement of Qualifications (SOQ) in response to a Request for Statement of Qualifications (RFSQ), and the ins and outs of the Requests for Services (RFS) process, the pathway by which they could ultimately provide PEI services.

(c) CDE Technical Assistance Workshops

PEI Administration will provide workshops to developers, including CBOs, whose programs were denied in the initial round of qualification. The workshops will focus on clarifying requirements for the CDE application, identification of outcome approaches, cultural practices, and procedures for resubmission. The intent of the CDE TA Workshops is to provide a hands-on step by step method

for helping agencies develop and qualify their program as a CDE practice. In conjunction with this process, PEI Administration will work with developers on becoming an approved provider (i.e. qualifying for the Master Agreement List) as outlined above. Presently, the majority of qualified CDE developer agencies appear on the current Master Agreement List.

(d) Subcontracting

PEI administration recognizes that County minimum requirements to qualify for the Master Agreement List may not be met by many potential worthy MHSA/PEI service providers. In order to address those situations and for those CBOs who are not interested in obtaining a direct contract with LACDMH, another way for them to provide PEI services is to subcontract through an existing LACDMH provider. Additionally, this is an opportunity for small organizations to partner with and receive mentoring from experienced providers which in turn, may eventually lead to a direct contract with LACDMH.

B. Building Upon the Mental Health and Primary Care System

Expanded and new partnerships with mental health and primary care providers will be established through the Primary Care/Behavioral Health Project. It is anticipated that the majority of the PEI programs will be situated at community clinics already established where the priority subpopulations have been identified. The Project offers the opportunity to build a seamless integration of primary care and behavioral services to a clientele reluctant to seek services at traditional mental health agencies.

C. Leveraging Resources

The Primary Care/Behavioral Health Project will work with LA Care, HealthNet, and health agencies to leverage resources for the PEI programs. Leveraged resources include space, equipment, and staff time as needed. In the solicitation process, potential providers will be notified that agencies are expected to generate support and leveraged resources, such as space, equipment, staff, and volunteer time. LACDMH will give priority to those agencies that can demonstrate existing capacity and/or a systematic plan for generating resources in the bidding process.

D. Sustaining the PEI Project

Through the solicitation process, the County will determine the organizational and fiscal capacity of each agency to fiscally manage and sustain the PEI program. Continued funding of the program will be through MHSA PEI funds, as well as continuation of any leveraged funds, including in-kind resources and services. LACDMH will monitor the programs to ensure that outcomes are being met in a timely manner and that fiscal, program, and contract standards are adhered to as required.

7. INTENDED OUTCOMES

A. Specific Cultural Outcomes

Through its community mental health needs assessment, the county obtained a comprehensive understanding of the racial/ethnic and linguistic distribution of the population across fairly small geographic regions. The cultural diversity in the population required that the county carefully consider programs that could be implemented successfully for different ethnic and language groups. For this reason, when building each PEI project, programs were first identified on the basis of whether they had been developed with specific cultural populations included in their validated studies. Inclusion of cultural populations during development is crucial in order to demonstrate and later realize the community effectiveness (i.e. generalizability) of a particular program for a specific population.

From there, program selections were made for each service area in accordance with the demographic profile of the area and the inputs received from the collection of local planning bodies mentioned earlier. As a result of this process, most individual outcomes directly involve underserved cultural populations as had been planned. In many cases due to the ethnic distribution across the county, these underserved cultural populations constitute, in fact, a majority in actual population estimates for a given region. So, programs residing in these areas will obviously impact these groups. Due to the inter-relationships between ethnicity, poverty, and other key indicators, locating programs within these areas is paramount and will be an important detail to note during the RFS process. To make this explicit, the following represents a sample of possible outcomes that can be expected for these specific populations based upon the programs selected in Los Angeles County:

- Expansion of the use of integrated behavioral health services for African-American, American Indian, Asian/Pacific Islander, and Latino populations in community clinics.
- Improvement of the mental health knowledge base of primary care providers who work with African-American, American Indian, Asian/Pacific Islander, and Latino populations.
- Reduction of co-morbid depression within African-American, American Indian, Asian/Pacific Islander, and Latino community clinic populations.

- Improvement of adherence to medical regimens and depression management protocols for African-American, American Indian, Asian/Pacific Islander, and Latino populations across the county.
- Promotion of wellness and resilience in high risk, immigrant and linguistically isolated minority populations.
- Inclusion of two community-defined evidence programs for low income minority women, adults, and older adults.

B. General Project Outcomes

The tables below depict a more general summary of the project and program level outcomes and methods for measuring them.

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
INDIVIDUAL	• Decrease depressive symptoms • Improve coping skills • Improve parenting skills • Decrease child abuse and neglect • Improves medical treatment adherence	• Child, parent, teacher, therapist ratings of depression • SCAN reports • Therapist, care giver assessments of functioning • Medical treatment adherence rates
PROGRAM/SYSTEM	• Increases the integrated services across medical and mental health settings • Increases the knowledge and resource base of primary care providers with regard to mental health issues • Decreases prevalence of depression	• Number of integrated behavioral health sites • Number of client referrals made by primary care providers to mental health providers • Medical treatment adherence measures • Medical cost offsets

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Advice Line	• Increased access to care • Increased identification of mental health disorders • Increased competence of primary care staff to provide mental health treatment	• Client ratings • Physician ratings
Alternatives for Families	• Improved parental anger management • Decreases in physical discipline	• Child, parent, teacher behavior ratings
IMPACT	• Reduced severity of depressive symptoms • Improved functioning	• Client, care manager depression ratings
Incredible Years	• Increase in positive and nurturing parenting • Decrease in harsh discipline • Reduction in child behavior problems at home and in school • Improvements in children's social competence and school readiness skills • Improved parent-child bonding	• Parent, teacher behavior ratings • Parent self report of depression, family functioning • Teacher ratings

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
	• Improved parent-teacher and school involvement	• SCAN reports
Maternal Wellness Center	• Increased identification of perinatal depressive symptoms and disorders • Increased access to care • Increased engagement in care	• Client self report of depression • Nurse ratings • Neonatal indicators
Prevention & Early Treatment of Depression in Primary Care	• Improved access to care for depressive symptoms and depressive disorders • Improved engagement in care for depressive symptoms and disorders • Decreased depressive symptoms	• Client self report of depression • Medical cost offsets
Triple P Positive Parenting Program	• Decreased child behavior problems • Increased parental competence • Decreased parental stress • Higher levels of parental self-efficacy in handling home and work responsibilities	• Parent ratings • Parent self report • Decreased SCAN reports • Therapist assessments

C. Long Term Project Outcomes

The primary outcome for the project is to improve upon the integrated services model reuniting physical health services with behavioral health services. Long-term outcomes include a better trained primary care practitioner base which is able to access mental health services for their patients. Other outcomes include increased physical health of the population due to better medical regimen adherence and also prevention or delay in onset of a serious mental health disorders. Overall system outcomes include demonstrating medical cost offsets and the promotion of system transformation to facilitate further integration.

8. COORDINATION WITH OTHER MHSA COMPONENTS

A. Coordination with CSS

As part of their orientation, providers will be trained in the range of mental health services available in the County, including MHSA programs. As client/consumer needs are identified, providers will refer them to appropriate MHSA Community Services and Supports programs, such as the Full Service Partnerships for children, TAY, adults and older adults, juvenile justice linkages/collaboration, and alternative crisis services.

B. Intended Use of WET Funds

Students, parents, and other caregivers will be given information about relevant programs in the Workforce, Education and Training Plan, as appropriate given their

expressed desire to enhance their education and/or vocational goals and meet the criteria to qualify.

C. Intended Use of Capital Facilities and Technology Funds

The County does not intend to use Capital Facilities and Technology Funds for this PEI Project at this time.

9. ADDITIONAL COMMENTS (OPTIONAL)

County: Los Angeles

PEI Project 6: EARLY CARE AND SUPPORT FOR TAY

Date:

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☒	☒	☒
2. Psycho-Social Impact of Trauma	☐	☒	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☐	☒	☐	☐
4. Stigma and Discrimination	☐	☒	☐	☐
5. Suicide Risk	☐	☒	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☐	☒	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☒	☐	☐
3. Children and Youth in Stressed Families	☐	☒	☐	☐
4. Children and Youth at Risk for School Failure	☐	☒	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☒	☐	☐
6. Underserved Cultural Populations	☐	☒	☒	☒

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

The Department employed six different needs assessment strategies: recommendations from CSS planning, community surveys, service area data profiles, key individual interviews, focus groups, and community/countywide forums to obtain information to develop the PEI projects. Each of these six strategies built on the knowledge gained through earlier strategies. Through each strategy, the questions being asked and answered became more specific and the depth of knowledge increased. Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI.

In order to proceed with project-building, all of the community assessment information was made available to a group of Ad Hoc Steering Committees who further refined population, age, and program selections. The current list of PEI projects emerged from these final sets of recommendations and reflect not only the localized needs of county service areas but also the specialized needs of countywide populations as well. The main components of the needs assessment are discussed below as they relate to these specific patterns of responses which led to the creation of the Early Care and Support for TAY Project.

(1) Stakeholder Input

(a) Key Individual Interviews

► Input Regarding Priority Population. Key individuals with knowledge and experience of the Children/Youth in Stressed Families and Individuals Experiencing Early Onset of Serious Psychiatric illness populations suggested that a primarily early intervention project be developed in order to address the TAY population's mental health needs. Below are paraphrased examples of the key individual responses:

- *The onset of serious mental illness occurs during this age (TAY). Mental health needs to bridge the lag time between identification and service provision (many people go from one service to another before receiving proper treatment).*
- *The early onset of mental illness among this age group in the community. Interviewee stressed that the 16 to 25 year olds are "not adults yet who have been in and out of treatment, so that is the best time to prepare them…" to understand the signs of mental health and what to do about it.*

- *The first symptoms of mental illness usually occur in early 20's or between ages 18-26. If information and support are provided pre-break, it can make a significant difference in the severity of impact and management of mental illness.*
- *"Those are the kids most influenced by peer pressure, media, trends, fads, phases, and make decisions that impact their adult life."*
- *DCFS serves a large TAY population, many of whom have been in foster care for a long time, have lost their connections with family, and don't have anybody. At this age, they are not ready to be on their own. There is a need for transitional housing and wrap-around support services for TAY with mental health issues. When children leave the system, they are often homeless, with no job or place to go. "We can do so much for this group. If we did it right, we could find some of their families."*
- *There is a high rate of first psychotic breaks among TAY, and services and medication were needed for this population to "get them on the right track."*

► Input Regarding Age Groups. Key individuals had much to say regarding the focus of a TAY project. Below are paraphrased examples of the Key individual responses:

- *The TAY population is important because they represent the community's last chance to intervene before the issues become too serious and or difficult to affect.*
- *It seems like mental health issues will be more noted, and it is a good place to intervene. With the younger group, there are developmental issues which might mask real mental health issues. Also members of the TAY population may have independent families (through marriage) where interventions could be useful.*
- *"They are overlooked more often." Early identification prevents later violence, drugs, incarceration, and severe mental illness. Early service provision prevents homelessness and all that comes with it such as "living on the streets," and "eating out of cans."*
- *16 to 25 is a transitional time in people's lives; and, thus, the appropriate time to address mental health issues before they manifest themselves. "You can minimize the length of treatment if you really deal with the issues early."*
- *Based on statewide statistics, 18 to 29 year old individuals with a developmental disability and mental illness represented twice as many psychiatric hospitalizations as other age groups in 2006 and 2007. In addition, while developmentally disabled youth are living at home they generally have a support system through the school, their parents or other family members, and through the services provided by the system. Once the TAY leave the school system and move on to live independently, they often do not develop*

the proper coping and or support systems (i.e.,. financial and system services) to sustain their well-being. Without support they move toward risky behaviors, substance abuse, and involvement with the law, and eventually wind up being hospitalized. "

- *From an economic perspective, there are definitive treatment and resource issues with this population. "Truly from a preventative approach, if you're providing early intervention, then you are reducing the likelihood of providing life-long treatment."*

(b) Focus Group Interviews

► Input Regarding Priority Population. Focus groups with knowledge and experience of the Children/Youth in Stressed Families and Individuals Experiencing Early Onset of Serious Psychiatric illness populations suggested that the creation of a TAY-oriented project was needed. Below are paraphrased examples of the focus group responses:

- *The system is insensitive to the real needs of youth – the system is set up to get kids fixed and out the door.*
- *More and more youth are left unsupported without people they can trust and resources to help them with the issues they struggle over. As a result, they turn to drugs, alcohol, and gang involvement as a means of coping with their un-addressed issues.*
- *Focus group members indicated that there is a definite need for services addressing the issues of Transition-age Youth, including housing, education, and employment services. "Employment", it was offered, "could be the number one barrier to lessen or even prevent homelessness for this population." Members of this group also feel that "positive recreation and safe community space is critical in these communities*."

► Input Regarding Age Groups. As focus groups above indicated, a TAY-focused project would a fill a gap in needed services across the county.

(c) Community Forum Recommendations

Benefiting from the needs assessment that had been completed, Community Forum attendees were asked to prioritize PEI populations and age groups. These selections were then used by Ad Hoc Steering Committee members in making program selection recommendations. PEI projects were subsequently built by organizing programs into clusters of related interventions.

► Input Regarding Strategies. The following represents the community forum recommendations relating strategies to serve the TAY.

- *Provide more mental health services where TAY are (community centers, faith based organizations, shopping malls, etc.).*
- *Supports in schools that use peer-to-peer approach, including mentoring and issue-specific clubs.*
- *Provide traditional and non-traditional campus based mental health services with case management that include fun, culturally-specific activities for youth.*
- *Peer advocacy training for youth. Youth to be trained on mental health issues, patient's rights, and advocacy. Trainers to be paid for their work in the community.*
- *DMH can use its influence to create safer spaces for marginalized groups and youth within the community, schools, and by mental health service providers.*
- *School-based strategies which include more school, after school, and extra-curricular activities that are culturally relevant and support linguistic, nutritional, and other individual needs.*
- *Provide mental health education to parents, teachers, judges, TAY, etc., on the following topics: Prodromal symptoms, physiology, the impact of substance abuse on the brain, and PEI resources in the community.*
- *Change the way agencies and systems work with youth, including empowering youth in decision-making that impacts their lives, using a rehabilitative versus punitive approach, and creating trusting and safe spaces for youth.*
- *Prevention education for parents and teens on mental illness, stigma, and tolerance towards the gay, lesbian, bisexual and transgender community and holistic psycho-education support groups, and teen mentoring programs.*
- *Serve the undocumented TAY population in order to build their capacity via programs and strategies such as community involvement and engagement, community and cultural activities.*

(d) Ad Hoc Steering Committee Recommendations

The Ad Hoc Steering Committees were instrumental in developing PEI projects. Specifically, they identified key sub-populations and recommended programs to address the needs of those sub-populations.

► Input Regarding Sub-populations. Committee members targeted specific groups of TAY to receive services. Below are some examples of these responses:

- *Youth with mental health issues who may not be appropriately served (e.g., undiagnosed bipolar disorder; youth with learning disabilities whose parents are unable or unwilling to advocate on behalf of their children; or, youth with low self-esteem issues that can lead to suicide).*

- *Emancipated youth (DCFS) or youth/young adults who are newly independent.*
- *TAY who feel they cannot involve their families when accessing services. Drug-addicted youth, school drop-outs, pregnant teens, and LGBTQ youth.*
- *People with a combination of Prodromal symptoms such as hallucinations, withdrawal, and decreased self-care.*
- *Youth in families with mental health/social issues (mental health, drug abuse, poor parenting, teen parents, incarceration, domestic violence, etc.)*
- *Youth living "out of home" including TAY who are homeless, runaways, or who are living with friends/relatives.*
- *Youth at risk for depression/suicide.*
- *Youth in impoverished families, or independent, who are homeless or with unstable housing and/or lack access/eligibility to health care (primary, mental).*
- *Youth lacking parental involvement and/or positive reinforcement due to mental illness, incarceration, and/or substance abuse.*
- *Asian American youth who are at risk but not identified due to, but not limited to, role expectations such as, model minority perception and generational challenges, etc.*

(2) Data Analysis

(a) Statistical and Demographic Indicators

LACDMH's report, *Vulnerable Communities in Los Angeles County: Key Indicators of Mental Health,* details demographic variables and key risk factors in Los Angeles County. Each indicator was selected on the basis of its empirical link with a PEI priority population and community mental health need. Together with the Key Individual Interviews and Focus Groups responses presented above, the following indicators were found to be confirm the need for the creation of a project focused on the needs of Children/Youth in Stressed Families and Individuals Experiencing Early Onset of Serious Psychiatric illness populations. The following selected demographic variables and risk factors demonstrates the need for services: Poverty, Disrupted Families, Mental Health Treatment Penetration Rate, Depressive Disorders Statistics, Co-occurring Disorders Statistics, and Deaths by Suicide Statistics.

(b) Poverty

Research on neighborhood effects demonstrates that socio-economic status is an important predictor of behavioral, mental health and academic outcomes for children (Leventhal & Brooks-Gunn, 2000; Wadsworth & Achenbach, 2005). Children and adolescents residing in impoverished areas are more likely to developmental disorders, commit crimes, and have problems in school. Adults in disadvantaged neighborhoods have been found to be more likely to develop major depression and substance abuse

disorders (Silver, Mulvey, Swanson, 2002). County summary figures indicated that poverty is widespread and disproportionately affects ethnic minority populations.

In the *Vulnerable Communities* report, three percentages were reported for each ethnic group. The first of these figures indicated the percent of individuals within an ethnic group who fell under 200% FPL. In 2005, 40.2% of African-Americans in Los Angeles County were living below the 200% FPL, 30.3% of Asians, 53.5% of Hispanics and 18.5% of Whites. The second poverty figure reported, the percentage of individuals living under 200% FPL by ethnicity, indicated that Whites made up 14.1% of the poverty population, African-Americans, 9.3%, and Hispanics 65.2%. These figures also told us that Hispanics were overrepresented within the poverty population, as they make up 47% of the county's total population. The final poverty figure reported was an ethnic group's population living in poverty as a percentage of the total population. In Los Angeles county, 5.5% of the population were Whites living in poverty and 3.6% of the county's population were African-Americans living in poverty. The most striking figure in this set showed that 25.2%, or one in four individuals in the county, were Hispanic and living in poverty.

(c) Unemployment Rate

Though correlated with the poverty indicator, unemployment rate is another way that one can understand the economic stress that families face across the county. Additionally, unemployment itself contributes to mental illness, especially when it occurs at critical points in a family's life cycle. Specifically, unemployment has been linked with increased rates of somatic complaints, anxiety, depression, marital problems, suicide, and child abuse in families. Information from the Californian Labor Market Information (State of California, Employment Development Division) indicated that unemployment rates over 2005-07 have risen in Los Angeles County, the State of California, and the United States. Despite of the different methods and sources employed in gathering these data, one can see there is a clear rising trend in the unemployment across the county, state, and nation.

(d) Disrupted Families

Research indicates that, in general, single-parent families encounter more stress and have more difficulty coping with stressful life events than families headed by a married couple. This indicator shows areas where high concentrations of disrupted families reside with lower ratios indicating more social disruption (Goodman & Haugland, 1994). Countywide, the Disrupted Families (DF) ratio was 2.2, which means that there were over twice as many intact families, (i.e., families with two parents), as single-parent families across the county. Across service areas, the DF ratio ranged from 2.7 in Service Area 3 to 1.6 in Service Areas 4 and 5. The smaller ratio in the West and Metro areas may indicate more widespread family stress typically associated with single parenting.

(e) Mental Health Treatment Penetration Rates

"A penetration rate provides an indicator of whether persons with mental illness are receiving services and whether the system is responsive to various consumer populations." (McGee, 2002). The countywide penetration rate was 0.34, which may be read as a measure of how well a mental health system of care can serve the local SMI population. In general, larger numbers reflect greater penetration into the SMI population. But, it is important to understand that even at a penetration rate at or above 100%, one cannot be certain that all individuals with SMI are necessarily being served. Still the penetration rate figures are important to consider since they can point to disparities across county regions and across ethnic groups. Countywide, there was wide variation in penetration rates seen across ethnic groups. The Asian population (0.07) had the lowest overall penetration rate, followed by the Latino population (0.18), the White population (0.18), the Native American population (0.47), and the African-American population (0.69). Undoubtedly, there is a complex social process driving these results.

(f) Depressive Disorders

Depressive disorders rank as the most debilitating mental health disorders worldwide in terms of disease burden. The World Health Organization reported that, "Depression is the leading cause of disability as measured by Years Lived with a Disability (YLD) and the 4th leading contributor to the global burden of disease in 2000. By the year 2020, depression is projected to reach 2nd place of the ranking of Disability Adjusted Life Years (DALYs, the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability) calculated for all ages, both sexes. Today, depression is already the 2nd cause of DALYs in the age category 15-44 years for both sexes combined." Depressive disorders are associated with poorer outcomes in terms of physical health, economic well-being, school achievement, co-occurring disorders, and criminal behavior. All of these outcomes are important for the PEI planner to consider. Additionally, research has indicated that ethnic disparities exist in terms of depression treatment with African-American and Hispanic clients receiving treatment at a lower rate than for Whites (Simpson, S. M., Krishnan, L. L., Kunik, M. E., & Ruiz, P. (2007). The TAY group accounted for 21.0% of depressed clients while making up 13.8% of the population.

(g) Ethnicity

Across seven tracked ethnic groups, Latinos accounted for 42.0% of depressed clients. This was followed by African-Americans (21.9%), Whites (19.6%), Asians (4.4%), and Other Ethnicities (2.9%). Native Americans (0.6%) and Pacific Islanders (0.1%) accounted for less than 1% of the client population. In Service Area 6, 27.9% of depressed African-American clients, 45.8% of depressed Native American clients were

served in Service Area 7, 32.3% of depressed Asian clients were served in Service Area 8, and 22.0% of depressed Latino clients were served in Service Area 4.

(h) Co-occurring Disorders (COD)

CODs are difficult to treat and are associated with unfavorable outcomes in economic status, health status, mental health disorders, and family relations. Individuals with COD have a greater likelihood of dropping out of school or becoming involved in criminal behavior. Treatment-resistant COD can lead to heavy and repeated service utilization for inpatient and outpatient episodes. Across the county, 30,439 DMH clients were diagnosed with a co-occurring disorder, of whom 25.6% were TAY. In general, the TAY population accounted for a quarter of all COD clients but, in some areas, it was higher. In Service Area 7, for example, 36.5% of the COD clients treated were from the TAY group.

(i) Deaths by Suicide

Reducing suicide risk is a key PEI mental health initiative. The number of completed suicides is important to consider since it may reveal neighborhood effects contributing to an individual's environmental stress. Completed suicides represent failures in the mental health system to identify and adequately treat individuals at risk. Suicide rates were calculated and standardized to the number of suicides/100,000 residents. Across the county, the suicide rate was 7.0. Data indicated that Service Area 5 had the highest suicide rate (10.6), followed by Service Area 1 (9.9) and Service Area 4 (8.4). By inspection, a few trends were apparent: males were at higher risk than females, Whites and Native Americans were at higher risk than other ethnicities, and older adults were at higher risk than other age groups.

3. PEI PROJECT DESCRIPTION

A. Why the proposed PEI project – including key community need(s), priority population(s), desired outcomes and selected programs – addresses needs identified during the community program planning process

By reviewing the available information generated from the county needs assessment, stakeholder groups were able to recommend PEI programs for their respective communities and constituencies. As the ad hoc steering committees generated their program recommendations and targeted sub-populations, clusters of related programs began to coalesce around a core service which was then reified as the Early Care and Support for TAY Project. By reviewing the data sources presented, one can see the extent of the county needs in terms of the TAY population and its risk for mental illness, school problems, and juvenile justice involvement. The related data sources covering

school problems and juvenile justice issues appear in the discussion of those projects and may be reviewed by the diligent for purposes of completeness.

For the TAY project, though, aside from the general problems influenced by pervasive poverty in underserved populations, mental health needs were apparent after examining the depressive disorders and co-occurring disorders prevalence data for the county. In terms of depressive disorders, stakeholders learned that the TAY population accounted for over 20% of all cases treated in the county mental health system (over 12,000 individuals/year). Additionally, stakeholders were able to see which ethnic groups and which communities were most at-risk for developing a depressive disorder. Similarly, with regard to co-occurring disorders, stakeholders learned that over a quarter of all COD cases involved the TAY population in a given year. As with the depressive disorders data, stakeholders could pinpoint ethnic groups and geographic regions which served the largest numbers of the TAY population for COD. Additionally, general population statistics were useful to locate where large numbers of the TAY population resided in the county, especially when stakeholders reviewed suicide rates for the TAY population (6.5/100k). Some of the comments the Department received with regard to the TAY population are extracted above and show the intensity of stakeholder convictions that a TAY-related project was needed.

Project Purpose. The Early Support and Care for Transition-age Youth Project will (1) to build resiliency, increase protective factors, and promote positive social behavior among TAY; (2) address depressive disorders among the TAY, especially those from dysfunctional backgrounds; and (3) identify, support, treat, and minimize the impact for youth who may be in the early stages of a serious mental illness. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; offer early mental health intervention services on school sites, youth centers and other youth-friendly sites; and provide training in mental health evidence-based programs to school personnel and providers working with TAY. Emancipating, emancipated, and homeless TAY are a special focus of this project.

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Poverty • Ethnicity • Geographic region • Insecure attachment • Family dysfunction • Discord and violence • Authoritarian parenting • Life stress • Legal problems • Antisocial behavior • Alcohol/drug use	• Coping skills • Family support • Social support • Effective parenting • Problem solving skills • Optimism • Self-efficacy • Secure attachments • Positive peer groups • Pro-social behaviors • Sociability

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Early sexual behavior • Gang involvement • Exposure to violence • Victimization • Mental health disorders • Early onset of aggression	• Employment • Academic Achievement

Project Components. Each project is comprised of the following components:

1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.
2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.
3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures that accurate data is captured on a systematic and ongoing basis so that the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.
4. PEI Programs – There are a total of eight EBP and CDE programs that will be implemented in eight service areas for the School-Based Services Project.

Outreach and Engagement to Unserved and Underserved Communities. Because one of the overarching goals of the MHSA is the reduction of mental health disparities experienced by specific racial/ethnic and other cultural groups, all projects have been built with service components to achieve this end. The outreach and engagement component for each PEI project is a critical element in reducing disparities because it is primarily concerned with increasing access to programs, a first step in dismantling barriers to services. The County strategy for outreach and engagement involves the utilization of existing County outreach workers, activating existing community resources and organizations, and the development of culturally and linguistically sensitive materials. All of these tools will be combined into a coordinated effort to seek out difficult to reach populations, educate groups regarding PEI programs, and facilitate entry into an appropriate program.

Outreach and engagement activities for the Early Care and Support for Transition-age Youth Project will include, but are not limited, to the following:

Community Leaders and Organizations

- Working with cultural brokers or community representatives to develop outreach strategies. LACDMH will seek input from the key individuals, focus group participants, and community organizations that participated in the planning process to identify and implement culturally and linguistically appropriate methods for reaching the targeted individuals in these unserved/underserved communities.
- Engaging local ethnic community leaders and gatekeepers, while recognizing that many people in these communities lack knowledge of, distrust, and/or are reluctant to use mental health services. Personal contact with these individuals is a key method to increase community knowledge about PEI programs and to facilitate access to these programs.
- Providing information and training in small group settings (e.g. church, temple or other place of worship that has a primarily minority congregation, community recreation centers, after school settings) in local neighborhoods or ethnic community. These sites would be asked to host training and educational forums, bulletins for educational information, and people to serve as volunteers.

Educational Materials

- Developing educational materials about the Early Care and Support for Transition-age Youth Project. The materials will be translated, culturally relevant, at the appropriate literacy level, and visually accessible (large print and Braille) and designed especially for the TAY age group. Community input will be sought in the approach and design of materials to ensure the materials are culturally sensitive.
- Distributing an information sheet about the outreach and engagement efforts, including outreach staff contact information as well as programs' contact information. These flyers will be distributed at meetings and posted in places where the target population is expected to congregate, such as malls, recreation centers, schools, ethnic specific health centers, foster care agencies, shelters, and so forth.
- Distributing press releases, informational articles, and paid advertising (both in English and the appropriate threshold language) in local ethnic newspapers, radio, television, and websites.

Community Outreach Workers

- Collaborating with LACDMH's CSS outreach and engagement staff. Since the inception of the CSS programs, these individuals have developed relationships with numerous community providers. LACDMH will seek the assistance of these staff to provide community linkages for the PEI programs and distribution of information.
- Hiring and training outreach workers, especially those with non-English language ability, from the local communities and the unserved/underserved communities.
- Recruiting and training volunteers from the community who are familiar with the unserved/underserved communities.

Partner Organizations

- Working though existing organizations, such as schools, clubs, churches, and other organizations.
- Collaborating with partner organizations to promote joint outreach efforts.
- Providing training or informational sessions to local organizations such as foster care agencies, youth centers, job training/employment centers, neighborhood groups, health care agencies, and human service agencies, about the PEI programs.

TAY Programs. Four types of programs were selected to address the needs of the TAY population. One group involved the Aggression Replacement Training in order to reach the early TAY population and to prevent them from developing anti-social behaviors. Stakeholders selected this program for youths who are at-risk for developing substance abuse problems or becoming involved with a gang. They were particularly concerned that children within dysfunctional families (with domestic violence, substance abuse, or serious mental illness) be targeted. A second group of programs were selected by stakeholders to address depressive disorders within the population. Group CBT for Major Depression, Interpersonal Psychotherapy for Depression, and Multidimensional Family Therapy was selected to address risk factors such as familial alcohol/drug use, families living in poverty, victimization, sexual orientation, and peer rejection, out of home placements, emancipation, and exposure to violence. A third main focus of the project involved the EDIPP and CAPPS programs in order to provide supports for the TAY population with regard to the early identification of a psychotic disorder. Finally, Asian American Family Enrichment Network Program was selected to provide support to immigrant TAY and their parents coping with acculturation and other stressors.

Prevention & Early Intervention	Early Intervention
Aggression Replacement Training	Seeking Safety
Asian American Family Enrichment Network (AAFEN) Program	
Center for the Assessment and Prevention of Prodromal States (CAPPS)	
Early Detection and Intervention for the Prevention of Psychosis (EDIPP)	
Group Cognitive Behavioral Therapy for Major Depression	
Interpersonal Psychotherapy for Depression	
Multidimensional Family Therapy	

(1) Prevention and Early Intervention Services

- **Aggression Replacement Training (ART) – Transition-age Youth.** ART is a multimodal psychoeducational universal and selective prevention and early intervention program designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. ART is an EBP for youth who are aggressive and at risk of juvenile justice involvement or an in the juvenile justice system. This program will be implemented in Service Area 2.

- **Asian American Family Enrichment Network Program – Transition-age Youth.** Asian American Family Enrichment Network Program is a bicultural 12-week skill-based parenting program for Asian immigrants. Outreach, engagement, and support activities are also part of curriculum. The Asian American Family Enrichment Network Program is a CDE for Asian immigrant parents and/or caregivers of teenage youth. This program will be implemented in Service Area 3.

- **Center for the Assessment and Prevention of Prodromal States (CAPPS) – Transition-age Youth.** CAPPS provides universal prevention through public education and community outreach efforts as well as selective prevention of and early intervention for youth at-risk of or experiencing their first episode of psychotic illness through multi-modal, comprehensive psychiatric and psychosocial interventions for one year, with booster sessions as needed for a second year. CAPPS is a CDE that provides services to individuals in the prodromal stage of psychosis. The program will be implemented in Service Areas 2, 5, 6, 7, and 8.

- **Early Detection and Intervention for the Prevention of Psychosis (EDIPP) – Transition-age Youth.** The EDIPP programs consists of targeted and universal community education and outreach aimed at increasing early identification; universal community education aimed at reducing stigma and removing barriers to treatment; and clinical service activities aimed at engagement and treatment. EDIPP is an EBP for youth experiencing the onset of prodromal symptoms of psychosis or who are at high risk for developing a mental health issue. The goals are to improve outcomes and prevent the onset of the psychotic phase of illnesses like Bipolar Disorder, Major Depression, and Schizophrenia. EDIPP will be implemented in Service Areas 4 and 8.

- **Group Cognitive Behavioral Therapy (CBT) for Major Depression – Transition-age Youth.** Group Cognitive-Behavioral Therapy (CBT) is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. The treatment focuses on

changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Cultural tailoring and case management show increased effectiveness for low-income Latino and African-American adults. This EBP will be implemented in Service Areas 1 and 8.

- **Interpersonal Psychotherapy for Depression (IPT) – Transition-age Youth.** IPT was developed for the treatment of ambulatory depressed, nonpsychotic, nonbipolar patients. It has been demonstrated to successfully treat patients with depression, and has been modified to treat other psychiatric disorders (substance abuse, dysthymia, bulimia) and patient populations (adolescents, late-life, primary medical care). It has primarily been utilized as a short term (approximately 12-16 week) therapy, but has also been modified for use as a maintenance therapy for patients with recurrent depression. This EBP will be implemented with TAY in Service Areas3, 5, and 7.

- **Multidimensional Family Therapy (MDFT) – Transition-age Youth.** MDFT is a selective prevention and early intervention family-based treatment and substance abuse prevention program developed for adolescents with drug and behavior problems. Treatment seeks to significantly reduce or eliminate an adolescent's substance abuse and other problem behavior and to improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. Objectives for the adolescent include transformation of a drug-using lifestyle into a developmentally normative lifestyle and improved functioning in several developmental domains. This EBP for families with youth who have conduct and substance abuse problems will be implemented in Service Area 6.

(2) Early Intervention Services

- **Seeking Safety – Transition-age Youth.** Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psychoeducation and has five key principles: safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); integrated treatment (working on both PTSD and substance abuse at the same time); a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; four content areas: cognitive, behavioral, interpersonal, and case management; and attention to clinician processes (helping clinicians work on counter-transference, self-care, and other issues). Seeking Safety is an EBP that will be implemented in Service Area 6.

(3) Targeted Populations

The table below describes the targeted populations for each of the TAY programs.

Program	SA	Age Group	Target Populations
Aggression Replacement Training	2	TAY	➢ Youth who have experienced violence in the home or in the community. Youth who are living in high crime or gang infested areas. Homeless youth and youth with substance abuse issues. Additionally this program will serve vulnerable groups such as pregnant teens, LGBTQ youth, and youth experiencing depression. ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, Asians, and African Americans. There are also significant populations of Armenians, Russians, Iranians, and South Asians who will be served.
Asian American Family Enrichment Network	3	TAY	➢ Asian/Pacific Islander youth and their parents dealing with intergenerational acculturation issues. ➢ The primary cultural group for this program is Asian/Pacific Islanders, particularly Chinese youth.
CAPPS	2	TAY	➢ Youth with a combination of prodromal symptoms such as hallucinations, withdrawal, and decreased self-care. Depressed youth. ➢ The primary cultural groups to be served by this program are Latinos, Western European Whites, Asians, and African Americans. There are also significant populations of Armenians, Russians, Iranians, and South Asians who will be served.
	5	TAY	➢ TAY with a family history or mental illness and/or substance abuse. TAY who might reject traditional mental health services. TAY who are struggling academically and/or at work. ➢ Primary cultural groups include Western European Whites (53.1% of the population), Hispanics/Latinos (14.4%), Asians (11.4%), African Americans (8.1%) and Russians (5.3%).
	6	TAY	➢ TAY with mental health challenges in secondary/post-secondary schools. ➢ African Americans (28.2% of the population) and Hispanics/Latinos (65.9%) will be the primary cultural groups served by this program.
	7	TAY	➢ Youth at risk for depression or suicide. Youth with co-occurring substance abuse and mental health disorders. Youth who are failing academically and socially. ➢ The primary cultural group in Service Area 7 is Hispanics/Latinos, making up 70.9% of the population. There are also significant Asian (9.1%) and Western European White (14.8%) populations who will be served.
	8	TAY	➢ Youth who are experiencing the onset of serious psychiatric illness including youth with substance abuse problems, youth in the juvenile justice system, and youth who have families with mental health or substance abuse issues. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.

Program	SA	Age Group	Target Populations
EDIPP	4	TAY	➢ Youth who are at risk for developing serious psychiatric illness including individuals who are trauma-exposed. Homeless or runway youth. Foster youth and former foster youth. ➢ Hispanics/Latinos are the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
	8	TAY	➢ Youth who are experiencing the onset of serious psychiatric illness including youth with substance abuse problems, youth in the juvenile justice system, and youth who have families with mental health or substance abuse issues. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
Group CBT for Major Depression	1	TAY	➢ Foster youth and emancipated foster youth. LGBTQ youth. Youth with low self-esteem that can lead to suicide. Gang involved youth. Children of substance abusing parentis. ➢ The primary cultural groups are Hispanics/Latinos (41.0% of the Service Area 1 population), Western European Whites (39.0%) and African Americans (12.8%). However, Asian and American Indian population will also be served.
	8	TAY	➢ Youth in families with mental health/social issues such as mental illness, drug abuse, incarceration, or domestic violence. Groups who are linguistically/culturally/socially isolated and may be inappropriately served (ethnic minorities, deaf & hard of hearing, immigrants, affected by stigma). Youth who are LGBTQI ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
Interpersonal Psychotherapy for Major Depression	3	TAY	➢ Unaccompanied minors who may be experiencing the onset of mental illness or substance abuse issues. Traditionally underserved TAY such as a LGBTQ, immigrants, uninsured, or homeless individuals. ➢ Primary cultural groups are Hispanics/Latinos, who make up 45.0% of the Service Area 3 population, Asian groups (particularly Chinese) who make up 23.7%, and Western European Whites (23.3%).
	5	TAY	➢ TAY experiencing rejection or lack of support due to sexual orientation, pregnancy, or cultural beliefs. Youth living "out-of-home" including TAY who are homeless, runaways, or who are living with friends/relatives. Youth in immigrant families, single parent families, low-income communities, or families experiencing mental illness. ➢ Primary cultural groups include Western European Whites (53.1% of the population), Hispanics/Latinos (14.4%), Asians (11.4%), African Americans (8.1%) and Russians (5.3%).
	7	TAY	➢ Youth at risk for depression or suicide. Latino immigrants and their families needing mental health services. ➢ The primary cultural group in Service Area 7 is Hispanics/Latinos, making up 70.9% of the population. There are also significant Asian (9.1%) and Western European White (14.8%) populations who will be served.

Program	SA	Age Group	Target Populations
Multidimensional Family Therapy	6	TAY	➢ Youth exposed to or at risk of exposure to violence, abuse, or hate crimes due to race or sexual orientation, youth in impoverished areas, homeless youth, and youth lacking parental involvement. ➢ African Americans (28.2% of the population) and Hispanics/Latinos (65.9%) will be the primary cultural groups served by this program.
Seeking Safety	6	TAY	➢ TAY who are in the process of emancipating from the foster care system or have already done so. ➢ African Americans (28.2% of the population) and Hispanics/Latinos (65.9%) will be the primary cultural groups served by this program.

B. Implementation Partners and Type of Organization/Setting That Will Deliver the PEI Program and Interventions

The programs in the TAY may be operated by youth-focused organizations, schools, community-based organizations, primary care and mental health providers, social service providers, and other organizations selected through the County's competitive bidding process. Services will be delivered at home, recreation sites, health clinics, schools, and other sites as determined to be necessary. In addition to partnering with TAY organizations working with youth at risk for substance abuse, domestic violence, trauma, emotional problems. Implementation partners will include the Los Angeles County Office of Education (LACOE), Los Angeles Unified School District (LAUSD), other local schools districts, County Departments of Health and Public Health, and the Community Clinic Association of Los Angeles County (CCALAC). If additional mental health or other services not available at the provider site are needed or that more intensive mental health services are needed than the program offers, the PEI agency will be expected to confer with and refer the child and his/her family to appropriate resources. Each PEI agency will build collaborative relationships with a range of health, social service, mental health, educational, and other resources.

C. Target Community Demographics

This project will focus on the TAY group throughout Los Angeles County. The county TAY population of approximately 1.3 million youth accounted for 13.8% of the total population. Because the service areas differ greatly in overall population, TAY programs may be located in areas with a higher density of the TAY population. Service Area 2 contained 20% of the entire TAY population followed by Service Area 3 (17.1%), Service Area 8 (16.0%), Service Area 7 (15.2%), Service Area 6 (12.4%), Service Area 1 (4.7%) and Service Area 5 (3.8%).

D. Highlights of New and Expanded Programs

The eight PEI programs are new initiatives that will serve TAY throughout the county. The focus is on seeking out and identifying as early as possible TAY who are at risk of developing emotional and other problems due to childhood environments, parental issues, or genetics. A number of the programs target specific ethnic groups, youths emancipating or having emancipated from foster homes, youths exhibiting behavior that has not been examined or diagnosed. The TAY Project offers an opportunity to put in place social, financial, medical, and emotional supports for youths heading into adulthood who without such early care may see their conditions deteriorate.

E. Action Plan

The Early Care and Support for TAY Project will require the following start-up activities for contract agencies:

1. Solicit proposals through County bidding process
2. Establish partnerships with youth organizations, DCFS, social service agencies, health centers, and key partners
3. Establish MOUs or other contracts confirming partnerships and scope of activities as needed
4. Recruit and hire staff
5. Train staff in EBP model protocols
6. Conduct outreach and education

Specific activities for each PEI program are listed below.

Programs	Objectives: Frequency And Duration
Aggression Replacement Training	• Conduct three 1-hour sessions per week for 10 weeks with clients
Asian American Family Enrichment Network (AAFEN) Program	• Conduct 12 week parent curriculum per cycle
Center for the Assessment and Prevention of Prodromal States (CAPPS)	• Conduct biweekly/weekly peer and parent groups (1.5 hours each) • Provide medication support • Provide case management
Early Detection and Intervention for the Prevention of Psychosis (EDIPP)	• Conduct outreach and education at community sites • Conduct screening and assessment • Provide initial services as determined
Group Cognitive Behavioral Therapy for Major Depression	• Conduct weekly group sessions for clients
Interpersonal Psychotherapy for Depression	• Conduct 12-16 weeks of individual 1-hour sessions for clients
Multidimensional Family Therapy (MDFT)	• Conduct two sessions per week for 3-6 months (average 4 months for each client)
Seeking Safety	• Provide individual and/or group sessions as determined

F. Key Milestones and Timeline

1.	Develop Requests for Proposals/Requests for Services	Months 1-3
2.	Obtain County Counsel approval for RFPs/RFSs	Months 1-3
3.	Solicit proposals & evaluate proposals	Months 3-9
4.	Award proposals	Months 6-12
5.	Develop LACDMH PEI program and infrastructure	Months 1-3
6.	Recruitment, hiring and training of staff (LACDMH)	Months 1-6
7.	Implement programs	Months 6-12
8.	Conduct training on LACDMH requirements for agencies	Months 7-12
9.	Conduct training in EBP/CDE model protocols	Months 7-12
10.	Conduct outreach and education	Months 3-12
11.	Set up data collection procedures and requirements	Months 1-6
12.	Conduct quarterly PEI provider meetings	Month 12 and on

4. PROGRAMS

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Aggression Replacement Training	Individuals: 300 Families: 100	Individuals: 600 Families: 200	4
Asian American Family Enrichment Network (AAFEN) Program	Individuals: 200 Families: 200	Individuals: 260 Families: 260	4
Center for the Assessment and Prevention of Prodromal States (CAPPS)	Individuals: 180 Families: 180	Individuals: 288 Families: 288	4
Early Detection and Intervention for the Prevention of Psychosis (EDIPP)	Individuals: 400 Families: 400	Individuals: 44 Families: 44	4
Group Cognitive Behavioral Therapy for Major Depression	Individuals: 900 Families: 300	Individuals: 1,800 Families: 600	4
Interpersonal Psychotherapy for Depression	Individuals: 780 Families: 260	Individuals: 1,170 Families: 390	4
Multidimensional Family Therapy (MDFT)	Individuals: 20 Families: 20	Individuals: 40 Families: 40	4
Seeking Safety	Individuals: Families:	Individuals: 576 Families: 192	4

	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 2,780** **Families: 1,460**	**Individuals: 4,778** **Families: 2,014**	**4**

5. LINKAGES TO COUNTY MENTAL HEALTH AND PROVIDERS OF OTHER NEEDED SERVICES

A. Linking PEI Participants to Services

This project will provide information about mental health, other supportive services and community resources to the TAY and family members who participate in the programs. In instances where students and/or their parents or caregivers are perceived to need mental health assessment or extended treatment for mental illness or emotional disturbance, the provider is responsible for identifying appropriate agencies where these services can be providers. The provider will ensure that there is a direct referral and actual linkage with the referred agency so as to avoid creating additional barriers to services. These referrals will include mental health and primary care agencies as well as community-based organizations. Staff will help youth, parents, and other caregivers to articulate their needs and enhance their capacity to identify and connect with other appropriate services.

B. Linking PEI Participants to Non-Traditional Services

The TAY project will enable youths and their parents and other caregivers to access prevention and early intervention community resources including educational, substance abuse, domestic violence, community support, housing, employment, resources. Programs are expected to conduct a needs assessment at the onset and conclusion of services to identify needs in order to ensure that referrals are made to needed services. Staff will help youth, parents, and other caregivers to link to these services and follow up to ensure a connection has been made.

C. Sufficiency to Achieve Outcomes

LACDMH researched each of the EBP and CDE models to determine the costs for each program and ensure that the budget and program designs were adequate to achieve the required outcomes. The analysis also determined that program outcomes were in line with the project, State, SDMH, LACDMH, and community expectations. In the

bidding process, agencies must demonstrate financial viability, organizational experience, management capability, and cultural competency to provide the services. All agencies selected to run the PEI programs will be required to participate in LACDMH training, including cultural competence, EBPs, PEI policies, and LACDMH policies. Further, they will be required to collect needs assessment data and participate in the Department's evaluation protocols and activities in order to ensure the program is properly developed, clients adequately serviced, and outcomes achieved.

6. COLLABORATION AND SYSTEM ENHANCEMENTS

A. Relationships, Collaborations and Arrangements

The Early Care and Support for TAY Project targets health, educational, mental health, and other professionals who work most closely with youth. The Project requires extensive collaboration with the provider community, the school professional work force, and other key professionals who might encounter young persons evidencing emotional disturbances such as depression and substance abuse and/or may be in the early stages of deterioration toward psychosis. Educational agencies include the Los Angeles County Office of Education, LAUSD, and other school districts in which services may be offered. It is important that relationships be maintained or developed with key school personnel, including administration, teachers, nurses, social workers, and other educational professionals. The Departments of Health, Public Health, Children and Family Services, and Public Social Services, and law enforcement agencies are key partners. To encourage collaboration and promote new partnerships, CBOs and non-mental health providers will have an opportunity to provide input to professionals and agencies that work closely with youth through monthly Service Area Advisory Committee meetings and Service Area Provider meetings.

PEI will also provide regularly held PEI Provider meetings that will be open to the community at large. PEI Provider meetings will encourage and facilitate sharing resources and promoting partnerships and will offer technical assistance on PEI program sustainability to the group and to individual providers as needed, private agencies include health organizations, the Community Clinic Association of Los Angeles County, mental health providers, and other social service, health, and family organizations.

(1) Outreach Strategies

PEI will outreach to CBOs and non-mental health providers through SAAC meetings, Service Area Provider meetings, PEI Provider meetings, the DMH PEI website, the PEI newsletter and the PEI distribution database that has a current membership of over 6,800 individuals. Outreach efforts will serve to bring CBOs and non-mental health providers to the implementation phase.

(2) Improving Collaboration with CBOs and Non-Mental Health Providers

LACDMH has included community based organizations (CBOs) and non-mental health providers from the very inception of the PEI planning process. To bring these organizations into the implementation phase, LACDMH has four different approaches:

(a) Incubation Academy

This program was designed to assist community and local mental health service providers in obtaining contracts with the Department of Mental Health to build capacity within the mental health system. Comprehensive information, resource references, technical assistance, mentorship, and/or sponsorship opportunities are included in this program, as well as guidance regarding County contracting procedures, documentation, and day-to-day business operations requirements.

(b) Master Agreement List Workshops

PEI Administration will hold a series of workshops to train prospective agencies, including CBOs, on how to qualify for inclusion on the Master Agreement list. The intention of this detailed workshop is to help agencies unfamiliar with county business practices clear the initial and sometimes confusing hurdles in becoming a contractor. As such, this training will include information on how to submit a Statement of Qualifications (SOQ) in response to a Request for Statement of Qualifications (RFSQ), and the ins and outs of the Requests for Services (RFS) process, the pathway by which they could ultimately provide PEI services.

(c) CDE Technical Assistance Workshops

PEI Administration will provide workshops to developers, including CBOs, whose programs were denied in the initial round of qualification. The workshops will focus on clarifying requirements for the CDE application, identification of outcome approaches, cultural practices, and procedures for resubmission. The intent of the CDE TA Workshops is to provide a hands-on step by step method for helping agencies develop and qualify their program as a CDE practice. In conjunction with this process, PEI Administration will work with developers on becoming an approved provider (i.e. qualifying for the Master Agreement List) as outlined above. Presently, the majority of qualified CDE developer agencies appear on the current Master Agreement List.

(d) Subcontracting

PEI administration recognizes that County minimum requirements to qualify for the Master Agreement List may not be met by many potential worthy MHSA/PEI service providers. In order to address those situations and for those CBOs who are not interested in obtaining a direct contract with LACDMH, another way for them to provide PEI services is to subcontract through an existing LACDMH provider. Additionally, this is an opportunity for small organizations to partner with and receive mentoring from experienced providers which in turn, may eventually lead to a direct contract with LACDMH.

B. Building Upon the Mental Health and Primary Care System

Expanded and new partnerships with mental health and primary care providers will be established through the Early Support and Care for TAY Project. It is anticipated that several of the PEI programs will be situated at youth centers, community centers, or health and behavioral sites so that the stigma associated with seeking mental health services will be minimized. TAY, parents and caregivers will be referred to primary care providers as medical needs are identified.

C. Leveraging Resources

The TAY Project will work with the County Department of Children and Family Services, school districts, other educational agencies, and health agencies to leverage resources for the PEI programs. Leveraged resources include space, equipment, and staff time as needed. In the solicitation process, potential providers will be notified that agencies are expected to generate support and leveraged resources, such as space, equipment, staff, and volunteer time. In the bidding process, LACDMH will give priority to those agencies that can demonstrate existing capacity and/or a systematic plan for generating resources. Where appropriate, Medi-Cal billing will be another resource.

D. Sustaining the PEI Project

Through the solicitation process, the County will determine the organizational and fiscal capacity of each agency to fiscally manage and sustain the PEI program. Continued funding of the program will be through MHSA PEI funds, as well as continuation of any leveraged funds, including in-kind resources and services. LACDMH will monitor the programs to ensure that outcomes are being met in a timely manner and that fiscal, program, and contract standards are adhered to as required.

7. INTENDED OUTCOMES

A. Specific Cultural Outcomes

Through its community mental health needs assessment, the county obtained a comprehensive understanding of the racial/ethnic and linguistic distribution of the population across fairly small geographic regions. The cultural diversity in the population required that the county carefully consider programs that could be implemented successfully for different ethnic and language groups. For this reason, when building each PEI project, programs were first identified on the basis of whether they had been developed with specific cultural populations included in their validated studies. Inclusion of cultural populations during development is crucial in order to demonstrate and later

realize the community effectiveness (i.e. generalizability) of a particular program for a specific population.

From there, program selections were made for each service area in accordance with the demographic profile of the area and the inputs received from the collection of local planning bodies mentioned earlier. As a result of this process, most individual outcomes directly involve underserved cultural populations as had been planned. In many cases due to the ethnic distribution across the county, these underserved cultural populations constitute, in fact, a majority in actual population estimates for a given region. So, programs residing in these areas will obviously impact these groups. Due to the inter-relationships between ethnicity, poverty, and other key indicators, locating programs within these areas is paramount and will be an important detail to note during the RFS process. To make this explicit, the following represents a sample of possible outcomes that can be expected for these specific populations based upon the programs selected in Los Angeles County:

- Reduction of the incidence of psychotic disorders within the African-American, American Indian, Asian/Pacific Islander, and Latino TAY populations.
- Reduction of depressive symptoms (including suicidal ideation and behaviors) within African-American, American Indian, Asian/Pacific Islander, and Latino TAY populations.
- Improvement of early identification of at-risk pre-psychotic TAY populations for African-American, American Indian, Asian/Pacific Islander, and Latino populations.
- Reduction of substance abuse and other antisocial behaviors for African-American, American Indian, Asian/Pacific Islander, and Latino TAY populations exposed to community and domestic violence.
- Inclusion of two community-defined evidence programs for Asian youth and youth at-risk for psychotic disorders.

B. General Project Outcomes

The tables below depict a more general summary of the project and program level outcomes and methods for measuring them.

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
INDIVIDUAL	• Improve coping skills • Improve stress management • Improve family environment • Decrease psychotic symptoms and prevalence of psychotic disorders • Decrease depressive disorders	• Adolescent, parent, teacher, and therapist ratings • School achievement, behavior reports • Prevalence of depressive and psychotic disorders • Therapist assessment of GAF • Therapist assessment of family functioning

PROGRAM/SYSTEM	• Improve workforce knowledge base of prodromal symptoms • Improve number of referrals for Early Intervention of psychotic disorders • Expand system of care for TAY youth experiencing the onset of SMI	• Number of programs able to work with prodromal TAY population • Prevalence of depressive and psychotic disorders within treatment population • Extant of community outreach and training efforts

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Aggression Replacement Training	• Reduced impulsiveness • Improved interpersonal skills • Decreased recidivism	• School discipline reports • School violence reports • Student self report
Asian American Family Enrichment Network (AAFEN) Program	• Improved family functioning • Improved family relationships and attitudes	• Adolescent, parent, teacher, therapist ratings • Therapist assessment of family functioning
Center for the Assessment and Prevention of Prodromal States (CAPPS)	• Increased early identification • Increased knowledge about symptoms • Improved functioning (clinical symptoms, family relationships, social, school/work)	• Adolescent, parent, teacher, therapist rating scales • Prevalence of psychotic disorders • Academic performance indicators • Number of community referrals
Early Detection and Intervention for the Prevention of Psychosis (EDIPP)	• Delayed onset of a psychotic disorder • Reduced symptoms • Improved functioning	• Adolescent, parent, therapist ratings • Prevalence of psychotic disorders • Number of community referrals
Group Cognitive Behavioral Therapy for Major Depression	• Decreased depressive symptoms; increased functioning	• Adolescent self report on measures of depression and stress • Therapist GAF and other assessments
Interpersonal Psychotherapy for Depression	• Decrease in depressive symptoms • Improvements in family outcomes	• Adolescent, therapist ratings
Multidimensional Family Therapy (MDFT)	• Decreased drug use • Improved family functioning • Decreased conduct problems	• Parent report • Therapist assessment
Seeking Safety	• Reductions in substance use • Improvement in trauma symptoms • Improved psychosocial functioning	• Adolescent self report of anxiety and risky behaviors • Therapist behavior ratings • Child alcohol/substance use

C. Long Term Project Outcomes

One of the overriding long-term project outcomes is to improve the community's ability to accurately identify and refer at-risk TAY populations to specialized treatment programs aimed at reducing the prevalence of SMI. This project targets the depression and a psychotic disorders and one would expect to see a rise in specialty referrals from the community to TAY providers. Within the TAY population, one would expect to see a decline in prevalence or a delay in onset of a serious psychiatric illness as a result of undergoing early intervention. System-wide changes include the expansion of programs

able to effectively intervene with at-risk TAY populations and the decline in stigma related barriers to treatment for the population.

8. COORDINATION WITH OTHER MHSA COMPONENTS

A. Coordination with CSS

As part of their orientation, providers will be trained in the range of mental health services available in the County, including MHSA programs. As youth needs are identified, providers will refer the students, parents, and other caregivers to appropriate MHSA Community Services and Supports programs, such as the Full Service Partnerships for children, TAY, adults and older adults, juvenile justice linkages/collaboration, and alternative crisis services.

B. Intended Use of WET Funds

Transition-Age Youth, parents, and other caregivers will be given information about relevant programs in the Workforce, Education and Training Plan, as appropriate given their expressed desire to enhance their education and/or vocational goals and meet the criteria to qualify.

C. Intended Use of Capital Facilities and Technology Funds

The County does not intend to use Capital Facilities and Technology Funds for this PEI Project at this time.

9. ADDITIONAL COMMENTS (OPTIONAL)

County: Los Angeles

PEI Project 7: JUVENILE JUSTICE SERVICES

Date:

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☐	☐
2. Psycho-Social Impact of Trauma	☒	☒	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☒	☐	☐
4. Stigma and Discrimination	☒	☒	☐	☐
5. Suicide Risk	☒	☒	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☐	☐
3. Children and Youth in Stressed Families	☒	☒	☐	☐
4. Children and Youth at Risk for School Failure	☒	☒	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒	☐	☐
6. Underserved Cultural Populations	☒	☒	☐	☐

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s)

LACDMH compiled and generated accurate information from a wide range of sources in order to develop the Juvenile Justice Project. The Department employed six different needs assessment strategies: recommendations from CSS planning, community surveys, service area data profiles, key individual interviews, focus groups, and community/countywide forums. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI.

The Countywide Community Forum focused on Juvenile Justice as one of its special populations, and the Countywide Ad Hoc Steering Committee developed recommendations for Children/Youth at Risk of or Experiencing Juvenile Justice Involvement. The main components of the needs assessment are discussed below as they relate to these specific patterns of responses leading to the creation of the Juvenile Justice Services Project.

(1) Stakeholder Input

(a) Key Individual Interviews

► Input Regarding Priority Population. Individuals with knowledge and experience of Children/Youth at Risk of or Experiencing Juvenile Justice Involvement population suggested that a balanced prevention and early intervention project be developed in order to address the juvenile justice population's mental health needs. Below are paraphrased examples of the Key Individual Interviewee responses:

- *Foster care and probation systems need to be held accountable for getting children into mental health services. "Systems must be in place to get kids into mental health services."*
- *Current programs are not sophisticated enough to reduce the rate of recidivism among those already involved in the Juvenile Justice System. What is needed are mental health coverage for youth on probation who are returning to the community and, re-entry services for mentally ill offenders returning to the community.*
- *There are misconceptions about available services to youth parolees, lack of insurance, and lack of funds. A surprisingly large number of youth who are on parole have not yet been identified despite having spent significant time in institutions and on probation.*

- *A large number of the youth who access services are on probation or are at-risk of becoming involved with the Juvenile Justice System. Services for this priority population are needed to prevent at-risk children and youth from embarking on the wrong trajectory and ending up in prison as adults. "We really have to work with children and try to change their thinking and their behavior, and show them that there is another way, a better way, to be able to do these things, that they don't have to get in trouble, that they can live good normal lives without having to end up in prison."*
- *All of the populations intercede with each other, but this population is who law enforcement works with the most.*
- *Youth are at-risk of developing mental health issues or exacerbating existing issues when they become involved with gangs or the Juvenile Justice System. There is a significant gang problem in Los Angeles with a high concentration in SPA 6. A lack of family infrastructure (young single parents, lack of parent involvement, absent fathers) as well as parents' lack of parenting skills and knowledge of child development puts children, youth, and young adults at-risk for joining gangs. Gangs catch these fragile and unattended youth and indoctrinate them into an "extended family that [before then] has not been present or was dysfunctional and unable to manage the youth adequately." These youth are at-risk of developing mental health problems. In addition, many of these youth are at-risk of entering into the juvenile justice system, and frequently require mental health services upon release.*
- *"I'm excited about it because it gives me hope." We need to "tear down the walls of separation" between agencies such as the Probation Department, the Mental Health Department, the Sheriff's Department, and the District Attorney's Office in order to create a more streamlined approach to service provision so that the complex needs of the youth and families in the community will be met.*

► Input Regarding Age Groups. Juvenile justice advocates offered the following as reasons for building a juvenile justice project:

- *Early intervention creates opportunity for correction – avoid the MH system, giving children coping skills and the power to choose.*
- *"From 16 to 25 is where you get the bulk of the violence that's being contributed against our society and the welfare of our citizens….There is a need there."*
- *As children get older, they harden. So we have less of an impact. At earlier ages children can change a bit, later they may have personality disorders and it is a little too late. So much of children's development occurs early on. We need to be able to identify problems early and respond appropriately. If nothing is done, problems escalate over time. Once they are in the justice system, if not treated, they will stay in the system forever.*

- *TAY years are a critical developmental period for preventing youth from developing risky behaviors. "It's a formation time for them….everything around is like your eyes are opening, and you just want to absorb everything, everything is so new and you are going to become aware of what is happening."*
- *The TAY group exhibits a high use of drugs and street wandering is a striking issue. The TAY group seems to be headed for disaster…prison/crime.*

(b) Focus Group Interviews

► Input Regarding Priority Population. Focus groups with knowledge and experience of the Children/Youth at Risk of or Experiencing Juvenile Justice Involvement population suggested that a prevention and early intervention project be developed. Below are paraphrased examples of the focus group responses:

- *One group suggested that once someone is released from jail, we should provide them with proper supports so that they are less likely to recommit crimes. These supports include shelters, community centers, and mentorship. The group reported that it seemed as if systems (or older adults) were against them, or at the very least, not in support of them. The group conveyed a sense that systems attempted to solve problems by incarceration or medication, instead of dealing with what one participant called the "roots" of the problem. "They're setting you up just to see if they could get rid of you again, instead of like really wanting to deal with the problem."*
- *One group mentioned the problem with the lack of prevention services: "We wait until someone becomes so ill and acute in symptoms before providing treatment…we wait until they do a crime and go to jail…"*
- *One group suggested that the following prevention services/resources were needed: More recreational, artistic, and after-school programs that provide safe places with sensitive counselors with whom teens can talk (with special attention paid to summer activities such as camp).*
- *"Thank you for listening to our voice and stories before you decided what was wrong with us and what was best for us."*
- *In particular, participants identified poverty, dominant perceptions of who is classified as a "gang member," the lack of opportunities for those involved with the criminal justice system to re-integrate into the community, and poor guidance and support by parents in their early years.*
- *Some group members stated that "zero tolerance school policies" tended to send kids to jail instead of treatment. Others were concerned by instances of "mistreatment by professionals". Additionally, some group members reported that "top down" political barriers make advocating for certain populations difficult. One member stated, "… even if everyone wished to go into treatment, there is not*

nearly enough to go around". Other members of the group reported that the police presence in some neighborhoods is very debilitating and controversial.

- *One group suggested that acute situations are also a drain on law enforcement and jail resources. Lack of prevention services for at-risk children leads to gang involvement, violence, crime, drug abuse, and school drop-outs.*

► Input Regarding Age Groups. Focus group input seemed fall in into two different categories. One of these involved the direct services that targeted older children and adolescents in order to prevent their behavior from deteriorating into a juvenile justice concern. Another age group involved adults and older, or parents, care-givers, administrators, police officers, and other who directly impact children and youth at risk for juvenile justice involvement.

(c) Community Forum Recommendations

Community Forum attendees were asked to prioritize PEI populations and age groups. These selections were then used by Ad Hoc Steering Committee members in making program selection recommendations. PEI projects were subsequently built by organizing programs into clusters of related interventions.

► Input Regarding Strategies. The following represents the community forum recommendations relating strategies for juvenile justice services.

- *Education on the early signs of mental illness for law enforcement (probation and parole officers), school officials, DCFS and caregivers.*
- *Multiple prevention and early intervention services including, but not limited to, gang prevention, counseling, mentoring, skill-building classes, sports, etc., offered in friendly environments, such as, schools, after-school programs, community centers, community/faith-based organizations, parks and recreational centers, probation camps, and family resource centers with free transportation available.*
- *Work with whole families-of-origin, particularly with youth in foster care, residential treatment facilities, and incarcerated youth. This would include crisis intervention for witnesses of violence (i.e., siblings and caregivers).*
- *Greater support for community-based intervention programs and lower-level diversion programs within the court system instead of camps or jail.*
- *Greater access to mental health services for youth prior to being released via Mental Health Courts (AB 2034 services). Services to include counseling and parenting classes for incarcerated youth with visits (family) based on successful program attendance.*
- *One-stop-shop-based resource centers located in the community, schools, and courts, which would include diversionary approaches to working with youth as an alternative to incarceration and detention.*

- *Change the way agencies and systems work with youth, including empowering youth in decision-making that impacts their lives, using a rehabilitative versus punitive approach, and creating trusting and safe spaces for youth*

(d) Ad Hoc Steering Committee Recommendations

The Service Area and Countywide Ad Hoc Steering Committees were instrumental in developing PEI projects. The table below summarizes these selections for a Juvenile Justice Project.

► Input Regarding Sub-populations. Committee members targeted specific groups of TAY to receive services. Below are some examples of these responses:

- *Probation camps.*
- *Youth/families with co-occurring substance abuse and mental health issues.*
- *Youth who are failing academically and socially.*
- *Youth surrounded by negative environmental factors, such as, high rates of crime, drugs, graffiti and truancy.*
- *Children in stressed families – to include parents/caregivers that are struggling to get assistance for their child who may suspect the youth is using drugs, alcohol or may be committing crimes or seeking participation in a gang. Parents/caregivers who are experiencing any of the other items identified herein that is creating stress or dysfunction in the family unit. Parents/caregivers who feel powerless to improve family functioning or to navigate the justice/school/service systems to get help for their children/family and who believe that the youth are at risk drugs/alcohol, school failure, gang involvement, behavioral deterioration.*
- *Poverty/deprivation issues – lack of health care or insurance, food, clothing, housing, medication and medical/mental health treatment.*
- *Children involved with DCFS and/or in out-of-home care*
- *Youth in families with mental health/social issues (mental health, drug abuse, poor parenting, teen parents, incarceration, domestic violence, etc.)*

(2) Data Analysis

(a) Statistical and Demographic Indicators

Each indicator in the LACDMH *Vulnerable Communities* report was selected on the basis of its empirical link with a PEI priority population and community mental health need. Together with the Key Individual Interviews and Focus Groups responses presented above, the following indicators were found to be confirm the need for the creation of a project focused on the needs of the Children/Youth at Risk of or

Experiencing Juvenile Justice Involvement population. The following selected demographic variables and risk factors demonstrate the need for services: School Discipline Statistics, Juvenile Felony Arrests Statistics, and Probation Department Statistics.

(b) School Discipline

There is a strong link between disruptive classroom behaviors, school suspensions and expulsions with later criminal behaviors (Skiba & Peterson, 2000) and researchers suggest that early intervention of low-level disruptive behavior may prevent later delinquency. Identifying where disciplinary actions occur may shed light on the neighborhood effect contributing to criminal behavior, though other factors likely influence these figures. Local educational practices and philosophies, for example, undoubtedly shape disciplinary standards. Minorities and, in particular, African-Americans, are overrepresented in these disciplinary actions when other factors have been controlled. Youths entering the juvenile justice system are more likely to have mental health and behavior problems than youths who have never been arrested (Hirschfield, Maschi, White, Traub, & Loeber, 2006). Overall, 3.7% of students were suspended throughout the county and 0.1% were expelled from their school. Service Area 1 had the highest suspension and expulsion rate.

(c) Juvenile Felony Arrests

This indicator shows in actual numbers the population of youth that have been arrested under the suspicion of committing a serious crime, but does not capture the entire population who may enter the justice system for lesser offenses. Of the 23,787 youths arrested on felony charges during the reporting period, 84.2% were males, 15.8%, females. Ethnically, Hispanic youths were involved in the majority of felony arrests (57.2%), followed by Black/African-American youths (30.3%) and Whites (9.1%). All other ethnicities combined accounted for less than 4% of the juvenile felony arrests.

(d) Probation Statistics

It is important to track the number of youth currently on various forms of probation because they reflect roughly two-thirds of all youth initially referred to the Probation Department for disposition (McCrosky, 2006). The overwhelming majority of youths arrested in Los Angeles County are referred to the Probation Department (99.2% in 2003; McCrosky, 2006), so the probation numbers are good indicators of juvenile justice involvement. The countywide camp population was similar in composition to the Juvenile Felony Arrest data. Hispanic youths were a majority of the camp population (58.6%), followed by Black/African-American youths (33.7%) and Whites (5.8%). All other ethnicities accounted for less than 2% of the entire camp population of 2,082 youths. Service Areas 6 (27.2% or about one in four) and 8 (16.3%) had the most youths consigned to camps. The relative percentages of youths under supervision by

the Probation Department again revealed a similar pattern: Hispanic youths were a majority under supervision (55.2%), followed by African-American (23.2%) and Whites (8.4%). Ethnicity was unknown for 9.5% of the population and the remaining ethnicities accounted for less than 4% of the population. Service Areas 6 and 8 had the highest numbers of youths under supervision.

3. PEI PROJECT DESCRIPTION

A. Why the proposed PEI project – including key community need(s), priority population(s), desired outcomes and selected programs – addresses needs identified during the community program planning process

By reviewing the available information generated from the county needs assessment, stakeholder groups were able to recommend PEI programs for their respective communities and constituencies. As the Ad Hoc Steering Committees generated their program recommendations and targeted sub-populations, clusters of related programs began to coalesce around a core service which was then reified as the Juvenile Justice Project. In a review of the data sources presented, the extent of the county needs in terms of the children/youth population and its risk for juvenile justice involvement became clearly evident.

Probation Department statistics indicated that large groups of underserved cultural populations were entering into the juvenile justice system. With these figures alone, stakeholders were able to understand the scope of the problem facing Los Angeles County. In 2008, over 19,000 youths were under supervision and another 2,000 were consigned to a probation camp involving primarily three ethnic groups: Hispanics, African-Americans, and Whites. Additionally, stakeholders learned that different regions of the county tended to have a disproportionate number of youths either under supervision or in camp. Law enforcement statistics indicated that over 47,000 juvenile felony arrests occurred in 2005, again involving the three primary ethnic groups mentioned above. Stakeholders also learned that early signs of anti-social behavior could be traced to school behavior problems. By examining school suspensions and expulsions, they were able to identify communities that were experiencing high rates of adolescent misbehavior in the classroom. As was true for other projects, the overlay of poverty was a key risk factor in areas exhibiting high rates of crimes committed by juveniles and their subsequent detention.

By listening to the stated needs and desires of community stakeholders through key individual interviews, focus groups, and community forums spread throughout the county, across planning sectors, age groups, and decision-making groups, prioritizing solutions to address the juvenile justice population became possible. Some of the comments the county received with regard to the population are extracted above and

show the intensity of stakeholder convictions that a Juvenile Justice Services Project was needed.

Project Purpose. The Juvenile Justice Services Project will (1) build resiliency and protective factors among children and youth who are exposed to risk factors that leave them vulnerable to becoming involved in the juvenile justice system; (2) promote coping and life skills to youths in the juvenile justice system to minimize recidivism; and (3) identify mental health issues as early as possible and provide early intervention services to youth involved in the juvenile justice system. Services will be provided at probation camps throughout the County, residential treatment facilities, health clinics, community settings, and other non-traditional mental health sites; all services will be offered on a voluntary basis.

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Poverty • Ethnicity • Geographic region • Family dysfunction and violence • Insecure attachment • Gang involvement • Antisocial behavior • Mental health disorders • Life stressors • Early onset of aggression • School behavior problems • Alcohol/drug/tobacco use • Parental educational status • Low academic achievement • Absent parents • Antisocial siblings	• Coping skills • Family support • Social support • Effective parenting • Problem solving skills • Sociability • Peer support • Self-efficacy • Optimism • Goal persistence • High achievement motivation • Community supports

Project Components. Each project is comprised of the following components:

1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.
2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.
3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures that accurate data is captured on a systematic and ongoing basis so that

the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.

4. PEI Programs – There are a total of 10 EBP and CDE programs that will be implemented in eight service areas and in many of the juvenile facilities throughout the county.

Outreach and Engagement to Unserved and Underserved Communities. Because one of the overarching goals of the MHSA is the reduction of mental health disparities experienced by specific racial/ethnic and other cultural groups, all projects have been built with service components to achieve this end. The outreach and engagement component for each PEI project is a critical element in reducing disparities because it is primarily concerned with increasing access to programs, a first step in dismantling barriers to services. The County strategy for outreach and engagement involves the utilization of existing County outreach workers, activating existing community resources and organizations, and the development of culturally and linguistically sensitive materials. All of these tools will be combined into a coordinated effort to seek out difficult to reach populations, educate groups regarding PEI programs, and facilitate entry into an appropriate program.

Outreach and engagement activities for the Juvenile Justice Services Project will include, but are not limited, to the following:

Community Leaders and Organizations

- Working with cultural brokers or community representatives to develop outreach strategies. LACDMH will seek input from the key individuals, focus group participants, and community organizations that participated in the planning process to identify and implement culturally and linguistically appropriate methods for reaching the targeted individuals in these unserved/underserved communities.
- Engaging with local law enforcement, probation officers, teen centers, boys and girls clubs will provide access to youth and their parents.
- Engaging local ethnic community leaders and gatekeepers, while recognizing that many people in these communities lack knowledge of, distrust, and/or are reluctant to use mental health services. Personal contact with these individuals is a key method to increase community knowledge about PEI programs and to facilitate access to these programs.
- Providing information and training in small group settings (e.g. church, temple or other place of worship that has a primarily minority congregation, recreation centers) in local neighborhoods or ethnic community. These sites would be asked to host training and educational forums, bulletins for educational information, and people to serve as volunteers.

Educational Materials

- Developing educational materials about the Juvenile Justice Services Project. The materials will be translated, culturally relevant, at the appropriate literacy level, and visually accessible (large print and Braille) and designed for a youthful population. Community input will be sought in the approach and design of materials to ensure the materials are culturally sensitive.
- Distributing an information sheet about the outreach and engagement efforts, including outreach staff contact information as well as programs' contact information. These flyers will be distributed at meetings and posted in places where the target population is expected to congregate, such as malls, recreation centers, the courts, probation camps, juvenile halls, alternative schools, foster care agencies, and so forth.
- Distributing press releases, informational articles, and paid advertising (both in English and the appropriate threshold language) in local ethnic newspapers, radio, television, and websites.

Community Outreach Workers

- Collaborating with LACDMH's CSS outreach and engagement staff. Since the inception of the CSS programs, these individuals have developed relationships with numerous community providers. LACDMH will seek the assistance of these staff to provide community linkages for the PEI programs and distribution of information.
- Hiring and training outreach workers, especially those with non-English language ability, from the local communities and the unserved/underserved communities.
- Recruiting and training volunteers from the community who are familiar with the unserved/underserved communities.

Partner Organizations

- Working though existing organizations, such as the courts, probation camps, gang programs, and other organizations.
- Collaborating with partner organizations to promote joint outreach efforts.
- Providing training or informational sessions to local organizations such as court personnel, probation staff, youth centers, shelters, employment centers, neighborhood groups, health care agencies, and human service agencies, about the PEI programs.

Juvenile Justice Programs. Programs selected to address the juvenile justice population were varied and reflected attempts to attenuate the multi-faceted risk factors facing county youth. Programs selected to build resilience and coping skills included Aggression Replacement Training. Stakeholders identified that abuse, victimization, and witnessing traumatic events was often at the heart of youth problems and so they recommended Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Prolonged Exposure Therapy for PTSD, and Trauma Focused CBT. One anti-gang/anti-substance abuse intervention was selected by stakeholders, Positive

Directions, as gang resistance is an issue in many communities. Additionally, stakeholders recommended that programs address the family component in adolescent misbehavior using Multisystemic Therapy, Multidimensional Family Therapy (MDFT), Loving Intervention for Family Enrichment Program (LIFE), and Functional Family Therapy.

Prevention & Early Intervention	Early Intervention
Aggression Replacement Training	Cognitive Behavioral Intervention for Trauma in School (CBITS)
Group Cognitive Behavioral Therapy for Major Depression	Functional Family Therapy
Multidimensional Family Therapy (MDFT)	Loving Intervention for Family Enrichment) Program (LIFE)
	Multisystemic Therapy
	Positive Directions
	Prolonged Exposure Therapy for Post Traumatic Stress Disorder
	Trauma Focused Cognitive Behavioral Therapy

(1) Prevention and Early Intervention Services

- **Aggression Replacement Training (ART) – Children and Transition-age Youth.** ART is designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. The program relies on repetitive learning techniques to teach participants to control impulsiveness and anger and use more appropriate behaviors. In addition, guided group discussion is used to correct antisocial thinking. ART has been implemented in school, delinquency, and mental health settings. This EBP will be implemented with the juvenile probation camp population.

- **Group Cognitive Behavioral Therapy (CBT) for Major Depression – Transition-age Youth.** Group CBT for Major Depression is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Cultural tailoring and case management show increased effectiveness for low-income Latino and African-American adults. This EBP for individual experiencing depression will be implemented in a juvenile probation camp.

- **Multidimensional Family Therapy (MDFT) – Transition-age Youth.** MDFT is a family-based treatment and substance-abuse prevention program developed for adolescents with drug and behavior problems. Treatment seeks to significantly reduce or eliminate an adolescent's substance abuse and other problem behavior and to improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. This EBP will be implemented in Service Area 2.

(2) Early Intervention Services

- **Cognitive Behavioral Intervention for Trauma in School (CBITS) – Children and Transition-age Youth.** CBITS is a cognitive and behavioral therapy group intervention for reducing children's symptoms of PTSD and depression caused by exposure to violence that has been used successfully in inner city schools with multicultural populations. CBITS has three main goals: to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support. CBITS is an EBP for youth who have been exposed to violence and will be implemented in the juvenile probation camp system serving youth from across the county.

- **Functional Family Therapy (FFT) – Children and Transition-age Youth.** FFT is a family-based prevention and intervention program for dysfunctional youths that has been applied successfully in a variety of multi-ethnic, multicultural contexts to treat a range of high-risk youths and their families. The model includes specific phases: engagement/ motivation, behavior change, and generalization. This is an EBP for you with substance abuse and conduct problems. It will be implemented in Service Area 7 and countywide with youth in the probation camp system.

- **LIFE Program (Loving Intervention for Family Enrichment) Program – Children and Transition-age Youth.** LIFE is an adaptation of Parent Project, a national model which is a 22-week skills-based curriculum for parents of children at risk of or involved with the juvenile justice system and multi-family group therapy. The program was designed for low income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/or school failure. LIFE is a CDE and will be implemented in Service Areas 4, 6, 7, and 8.

- **Multisystemic Therapy (MST) – Children and Transition-age Youth.** MST uses a home-based model of service delivery to reduce barriers that keep families from accessing services. MST therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g., extended family, neighbors, friends, church members) and removing barriers (e.g., parental substance abuse, high stress, poor relationships between partners). The family–therapist collaboration allows the family to take the lead in

setting treatment goals as the therapist helps them to accomplish their goals. MST is an EBP and will be implemented in Service Area 8.

- **Positive Directions – Children and Transition-age Youth.** Positive Directions is a comprehensive package of three national evidence-based interventions for the prevention and early intervention of substance use/abuse and delinquency. Youth participate for 9-12 months and receive individual case management in addition to the three 12-week, group-based, consecutively delivered interventions. This CDE will be implemented in Service Area 6.

- **Prolonged Exposure Therapy for PTSD – Transition-age Youth.** This is a cognitive-behavioral treatment program for TAY(ages 18-65+) who have experienced single or multiple/continuous traumas and have PTSD. The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. The program has three components: post-trauma difficulties, imaginal exposure, repeated recounting of the trauma memory, and in vivo exposure, gradually approaching trauma reminders that are feared and avoided despite being safe.

- **Trauma Focused Cognitive Behavioral Therapy (CBT) – Children and Transition-age Youth** Trauma Focused Cognitive Behavioral Therapy (CBT) is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. The program also includes conjoint child-parent sessions will be implemented in the juvenile probation camps serving youth from across the county.

(3) Targeted Populations

The table below describes the targeted populations for each of the Juvenile Justice Programs.

Program	SA	Age Group	Target Populations
Aggression Replacement Training	Juvenile Justice	Children, TAY	➢ Juvenile program camp population including youth who have experienced family and community violence, youth with substance abuse issues, youth from families facing poverty and other stressful situations. ➢ Primary cultural populations are Latinos, African Americans, and Western European Whites.
CBITS	Juvenile Justice	Children, TAY	➢ Juvenile program camp youth from across the county. Youth participants will include youth who have experienced family and community violence, neglect and parental substance abuse or mental illness. ➢ Primary cultural populations are Latinos, African Americans, and Western

Program	SA	Age Group	Target Populations
			European Whites.
Functional Family Therapy	7	TAY	➢ Youth/families with co-occurring substance abuse and mental health issues. Youth surrounded by negative environmental factors, such as, high rates of crime, drugs, graffiti and truancy. ➢ Hispanics/Latinos will be primary cultural group receiving these services as they make up 70.9% of the Service Area 7 population. Other significant groups such as Asians and Western European White will also be recipients of these services.
	Juvenile Justice	Children TAY	➢ TAY at risk for juvenile justice involvement and countywide with youth in the probation camp system. ➢ Primary cultural populations are Latinos, African Americans, and Western European Whites.
Group CBT for Major Depression	Juvenile Justice	TAY	➢ Individuals experiencing depression will be implemented in a juvenile probation camp. ➢ Primary cultural populations are Latinos, African Americans, and Western European Whites.
LIFE Program	4	Children TAY	➢ Immigrant families, children with a parent/sibling absent due to incarceration or deportation, children at risk for school failure due to truancy, suspension, transfers, or frequent school changes, children exposed to community or family violence, and single parent or teen parent families. ➢ The primary cultural groups served will include Hispanics/Latinos, Asians (particularly Korean and Chinese), and Western European Whites. There are also significant African American (5.1%), Russian (1.6%), Armenian (1.2%), and South Asian (1.1%) populations who will be served through this program.
	6	TAY	➢ Immigrant families, children with a parent/sibling absent due to incarceration or deportation, children at risk for school failure due to truancy, suspension, transfers, or frequent school changes, children exposed to community or family violence, and single parent or teen parent families. ➢ African Americans and Latinos who make up 28.2% and 65.9% of the population respectively.
	7	Children TAY	➢ Immigrant families, children with a parent/sibling absent due to incarceration or deportation, children at risk for school failure due to truancy, suspension, transfers, or frequent school changes, children exposed to community or family violence, and single parent or teen parent families. ➢ Hispanics/Latinos will be primary cultural group receiving these services as they make up 70.9% of the Service Area 7 population. Other significant groups such as Asians and Western European White will also be recipients of these services.

Program	SA	Age Group	Target Populations
	8	Children TAY	➢ Immigrant families, children with a parent/sibling absent due to incarceration or deportation, children at risk for school failure due to truancy, suspension, transfers, or frequent school changes, children exposed to community or family violence, and single parent or teen parent families. ➢ Primary cultural groups include Hispanics/Latinos, Western European Whites, Asians/Pacific Islanders, and African Americans.
Multidimensional Family Therapy	2	TAY	➢ TAY who have experienced violence in the home, youth living in high crime neighborhoods, homeless or runaway youth. Additionally, this program will service depressed youth, youth with drug addiction issues, LGBTQ youth, and youth who have dropped out of school. ➢ LGBTQ cultural populations. Expected cultural populations are Hispanics/Latinos, Western European Whites, and Asians as they make up 38.4%, 35.4%, and 8.6% of the Service Area population respectively. Additionally, there are also significant Armenian (5.6%), African American (3.9%), Iranian (1.8%), Other Middle Eastern (1.6%), and South Asian (1.4%) populations in Service Area 2 that this program intends to serve as well.
Multisystemic Therapy	8	Children, TAY	➢ Youth from families with mental health or social issues, children involved with the child welfare system, and youth experiencing school issues. ➢ Primary cultural groups include Hispanics/Latinos, Asians (Cambodians, Pacific islanders), and African Americans.
Positive Directions	6	Children TAY	➢ Youth in homes with alcohol/substance abuse, youth emancipating form foster care, youth lacking parental involvement, and youth at risk for school failure. ➢ African Americans and Latinos who make up 28.2% and 65.9% of the population respectively.
Prolonged Exposure for PTSD	Juvenile Justice	TAY	➢ Individuals who have experienced family and community violence, parental neglect or substance abuse, as well as other types of trauma. ➢ Primary cultural populations are Latinos, African Americans, and Western European Whites.
Trauma Focused CBT	Juvenile Justice	Children TAY	➢ Individuals who have experienced family and community violence, parental neglect or substance abuse, as well as other types of trauma. ➢ Primary cultural populations are Latinos, African Americans, and Western European Whites.

B. Implementation Partners and Type of Organization/Setting That Will Deliver the PEI Program and Interventions

The programs in the Juvenile Justice Services Project may be operated by and services delivered at schools, community-based organizations, juvenile halls, probation camps, detention centers, substance abuse facilities, residential treatment centers, mental health providers, social service agencies, and other organizations selected through the County's competitive bidding process. A significant number of services will be delivered

at juvenile halls and probation camps. Alternative sites may include the home, recreation site, health clinics, and other sites as determined to be necessary. Implementation partners include the Los Angeles County Probation Department, County Sheriff's Department, and other local law enforcement agencies. Other key partners include the Los Angeles County Departments of Health and Public Health, Alcohol and Drug Program Administration, and other mental health and social services that may already be co-located and/or delivering services on-site at the selected sites. It is expected that agencies selected to run the PEI programs will be experienced or have the capacity to provide juvenile justice as well as collaborate with other agencies to provide juvenile justice-focused services.

Should it be determined that additional mental health or other services not available at the sites are needed or that more intensive mental health services are needed than the program offers, the PEI agency will be expected to confer with and refer the child or youth and his/her family to appropriate resources. Each PEI agency will build collaborative relationships with a range of law enforcement, health, social service, mental health, educational, and other resources.

C. Target Community Demographics

This project will focus on individuals who are at risk of juvenile justice involvement and juveniles, including those currently consigned to a probation camp. Through the *Vulnerable Communities* report the Department was able to identify regions where underserved cultural populations reside and also identify geographic areas which had particularly high risk factors. For example, county probation statistics indicated that three racial groups (Whites, Hispanics, and African-Americans) accounted for most of the youths in the system. Two underserved cultural groups, Hispanic and African-American youths (over 15,000 youths), accounted for 78% of all youths under probation supervision (over 19,000). These youth were found to be disproportionately distributed throughout the County with large numbers from service areas 3, 6, 7, and 8. Additionally, the youth camp population in 2006 exceeded 2000 juveniles; again, the three racial groups mentioned above accounted for most of the youths in camp.

D. Highlights of New and Expanded Programs

The ten PEI programs in the Juvenile Justice Services Project are new programs that will be offered at sites that do not currently provide these services. The County will work with County Probation Department, Department of Public Health, including the Office of Alcohol and Drug Program Administration, and other law enforcement agencies, as well as community based agencies to select sites where these programs may be located. Where possible, the PEI Juvenile Justice programs will encourage family members to participate in the programs and to minimize any stigma or discrimination barriers to accessing these services.

E. Action Plan

The Juvenile Justice Services Project will require the following start-up activities for contract agencies:

1. Solicit proposals through County bidding process
2. Establish partnerships with County Department of Probation, law enforcement agencies, residential treatment sites, and other community agencies
3. Establish MOUs or other contracts confirming partnerships and scope of activities as needed
4. Recruit and hire staff
5. Train staff in EBP model protocols
6. Conduct outreach and education

Specific activities for each PEI program are listed below.

Programs	Objectives: Frequency And Duration
Aggression Replacement Training	• Conduct three 1-hour sessions per week for 10 weeks for each client
Cognitive Behavioral Intervention for Trauma in School (CBITS)	• Conduct ten child group sessions for each round of service • Provide 1-3 individual child sessions per client • Provide two parent educational sessions for each client • Conduct one teacher informational meeting at each school
Functional Family Therapy	• Conduct 8-20 family sessions over 3-6 months per client
Group Cognitive Behavioral Therapy for Major Depression	• Conduct group sessions once a week for clients
LIFE (Loving Intervention for Family Enrichment) Program	• Conduct 22-week skills-based curriculum for parents
Multidimensional Family Therapy (MDFT)	• Conduct two sessions per week for 3-6 months for each client
Multisystemic Therapy	• Provide 60 hours of contact over a 4-month period for each client
Positive Directions	• 3 12-week group-based interventions
Prolonged Exposure Therapy for Post Traumatic Stress Disorder	• Conduct 9-12 90-minute individual sessions 1-2 times per week per client
Trauma Focused Cognitive Behavioral Therapy	• Conduct 12-15 weekly one hour sessions for child and parent

F. Key Milestones and Timeline

1.	Develop Requests for Proposals/Requests for Services	Months 1-3
2.	Obtain County Counsel approval for RFPs/RFSs	Months 1-3
3.	Solicit proposals & evaluate proposals	Months 3-9
4.	Award proposals	Months 6-12

5.	Develop LACDMH PEI program and infrastructure	Months 1-3
6.	Recruitment, hiring and training of staff (LACDMH)	Months 1-6
7.	Implement programs	Months 6-12
8.	Conduct training on LACDMH requirements for agencies	Months 7-12
9.	Conduct training in EBP/CDE model protocols	Months 7-12
10.	Conduct outreach and education	Months 3-12
11.	Set up data collection procedures and requirements	Months 1-6
12.	Conduct quarterly PEI provider meetings	Month 12 and on

4. PROGRAMS

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Aggression Replacement Therapy	Individuals: 150 Families: 50	Individuals: 300 Families: 100	4
Cognitive Behavioral Intervention for Trauma in School (CBITS)	Individuals: Families:	Individuals: 100 Families: 100	4
Functional Family Therapy	Individuals: Families:	Individuals: 768 Families: 768	4
Group Cognitive Behavioral Therapy for Major Depression	Individuals: 450 Families: 150	Individuals: 900 Families: 300	4
LIFE (Loving Intervention for Family Enrichment) Program	Individuals: Families:	Individuals: 280 Families: 280	4
Multidimensional Family Therapy (MDFT)	Individuals: 80 Families: 80	Individuals: 160 Families: 160	4
Multisystemic Therapy	Individuals: Families:	Individuals: 96 Families: 96	4
Positive Directions	Individuals: Families:	Individuals: 220 Families: 220	4
Prolonged Exposure Therapy for Post Traumatic Stress Disorder	Individuals: Families:	Individuals: 240 Families: 80	4
Trauma Focused Cognitive Behavioral Therapy	Individuals: Families:	Individuals: 200 Families: 200	4
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED*	**Individuals: 680** **Families: 280**	**Individuals: 3,264** **Families: 2,304**	**4**

	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		
COUNT OF INDIVIDUALS TO BE SERVED			

5. LINKAGES TO COUNTY MENTAL HEALTH AND PROVIDERS OF OTHER NEEDED SERVICES

A. Linking PEI Participants to Services

This project will provide information about mental health, other supportive services and community resources to TAY and family members who participate in the juvenile justice programs. In instances where youth, adult, older adults, and/or their parents or caregivers are perceived to need mental health assessment or extended treatment for mental illness or emotional disturbance, the provider is responsible for identifying appropriate agencies where these services can be providers. The provider will ensure that there is a direct referral and actual linkage with the referred agency so as to avoid creating additional barriers to services. These referrals will include mental health and primary care agencies as well as community-based organizations. Staff will help the TAY, parents, and other caregivers to articulate their needs and enhance their capacity to identify and connect with other appropriate services.

B. Linking PEI Participants to Non-Traditional Services

The Juvenile Justice Services Project will enable students and their parents and other caregivers to access prevention and early intervention community resources including educational, substance abuse, domestic violence, community support, housing, employment, and other resources. Programs are expected to conduct an s assessment at the onset and conclusion of services to identify needs in order to ensure that referrals are made to needed services. Staff will help children, youth, parents, and other caregivers to link to these services and follow up to ensure the connection was made.

C. Sufficiency to Achieve Outcomes

LACDMH conducted research on each of the EBP and CDE models to determine the costs for each program and ensure that the budget and program designs were adequate to achieve the required outcomes. The analysis also determined that program outcomes were in line with the project, State, SDMH, LACDMH, and community expectations. In the bidding process, agencies must demonstrate financial viability, organizational experience, management capability, and cultural competency to provide the services. All agencies selected to run the PEI programs will be required to

participate in LACDMH training, including cultural competence, EBPs, PEI policies, and LACDMH policies. Further, they will be required to collect needs assessment data and participate in the Department's evaluation protocols and activities in order to ensure the program is properly developed, clients adequately serviced, and outcomes achieved.

6. COLLABORATION AND SYSTEM ENHANCEMENTS

A. Relationships, Collaborations and Arrangements

The Juvenile Justice Services Project requires extensive collaboration with both government and private agencies and organizations. LACDMH already has a long-standing collaborative relationship with many of the juvenile justice system partners, including the Probation Department, courts, and other law enforcement agencies. It is important that relationships be maintained or developed with key juvenile justice personnel, including probation staff, law enforcement officers, administration, mental health providers, social workers, and other staff involved with working with the youth both within the camp and at risk of becoming involved in the juvenile justice system. The Departments of Probation, Public Health, Children and Family Services, and Public Social Services as well as law enforcement agencies are key implementation partners. To encourage collaboration and promote new partnerships, CBOs and non-mental health providers will have an opportunity to provide input to juvenile justice agencies and organizations through monthly Service Area Advisory Committee meetings and Service Area Provider meetings.

PEI will also provide regularly held PEI Provider meetings that will be open to the community at large. PEI Provider meetings will encourage and facilitate sharing resources and promoting partnerships and will offer technical assistance on PEI program sustainability to the group and to individual providers as needed. Private agencies include health organizations mental health providers, social services, health, and family organizations. The project will building upon existing relationships in the community-based mental health and primary care system to provide prevention and early intervention services.

(1) Outreach Strategies

PEI will outreach to CBOs and non-mental health providers through SAAC meetings, Service Area Provider meetings, PEI Provider meetings, the DMH PEI website, the PEI newsletter and the PEI distribution database that has a current membership of over 6,800 individuals. Outreach efforts will serve to bring CBOs and non-mental health providers to the implementation phase.

(2) Improving Collaboration with CBOs and Non-Mental Health Providers

LACDMH has included community based organizations (CBOs) and non-mental health providers from the very inception of the PEI planning process. To bring these organizations into the implementation phase, LACDMH has four different approaches:

(a) Incubation Academy

This program was designed to assist community and local mental health service providers in obtaining contracts with the Department of Mental Health to build capacity within the mental health system. Comprehensive information, resource references, technical assistance, mentorship, and/or sponsorship opportunities are included in this program, as well as guidance regarding County contracting procedures, documentation, and day-to-day business operations requirements.

(b) Master Agreement List Workshops

PEI Administration will hold a series of workshops to train prospective agencies, including CBOs, on how to qualify for inclusion on the Master Agreement list. The intention of this detailed workshop is to help agencies unfamiliar with county business practices clear the initial and sometimes confusing hurdles in becoming a contractor. As such, this training will include information on how to submit a Statement of Qualifications (SOQ) in response to a Request for Statement of Qualifications (RFSQ), and the ins and outs of the Requests for Services (RFS) process, the pathway by which they could ultimately provide PEI services.

(c) CDE Technical Assistance Workshops

PEI Administration will provide workshops to developers, including CBOs, whose programs were denied in the initial round of qualification. The workshops will focus on clarifying requirements for the CDE application, identification of outcome approaches, cultural practices, and procedures for resubmission. The intent of the CDE TA Workshops is to provide a hands-on step by step method for helping agencies develop and qualify their program as a CDE practice. In conjunction with this process, PEI Administration will work with developers on becoming an approved provider (i.e. qualifying for the Master Agreement List) as outlined above. Presently, the majority of qualified CDE developer agencies appear on the current Master Agreement List.

(d) Subcontracting

PEI administration recognizes that County minimum requirements to qualify for the Master Agreement List may not be met by many potential worthy MHSA/PEI service providers. In order to address those situations and for those CBOs who are not interested in obtaining a direct contract with LACDMH, another way for them to provide PEI services is to subcontract through an existing LACDMH provider. Additionally, this is an opportunity for small organizations to partner with and receive mentoring from experienced providers which in turn, may eventually lead to a direct contract with LACDMH.

B. Building Upon the Mental Health and Primary Care System

Expanded and new partnerships with mental health and primary care providers will be established through the Juvenile Justice Services Project. It is anticipated that several of the PEI programs will be situated at probation camps, juveniles halls, residential treatment centers, and community-based organizations already established throughout the County. Children, youth, parents and caregivers will be referred to primary care providers as medical needs are identified.

C. Leveraging Resources

The Juvenile Justice Project will work with the County Department of Probation, Department of Public Health, Alcohol and Drug Program Administration, law enforcement agencies, educational, community-based organizations and other social services agencies to leverage resources for the PEI programs. Leveraged resources include space, equipment, and staff time as needed. In the solicitation process, potential providers will be notified that agencies are expected to generate support and leveraged resources, such as space, equipment, staff, and volunteer time. LACDMH will give priority to those agencies that can demonstrate existing capacity and/or a systematic plan for generating resources in the bidding process. Medi-Cal billing will be another resource where appropriate.

D. Sustaining the PEI Project

Through the solicitation process, the County will determine the organizational and fiscal capacity of each agency to fiscally manage and sustain the PEI program. Continued funding of the program will be through MHSA PEI funds, as well as continuation of any leveraged funds, including in-kind resources and services. LACDMH will monitor the programs to ensure that outcomes are being met in a timely manner and that fiscal, program, and contract standards are adhered to as required.

7. INTENDED OUTCOMES

A. Specific Cultural Outcomes

Through its community mental health needs assessment, the county obtained a comprehensive understanding of the racial/ethnic and linguistic distribution of the population across fairly small geographic regions. The cultural diversity in the population required that the county carefully consider programs that could be implemented successfully for different ethnic and language groups. For this reason, when building each PEI project, programs were first identified on the basis of whether they had been developed with specific cultural populations included in their validated studies. Inclusion of cultural populations during development is crucial in order to demonstrate and later

realize the community effectiveness (i.e. generalizability) of a particular program for a specific population.
From there, program selections were made for each service area in accordance with the demographic profile of the area and the inputs received from the collection of local planning bodies mentioned earlier. As a result of this process, most individual outcomes directly involve underserved cultural populations as had been planned. In many cases due to the ethnic distribution across the county, these underserved cultural populations constitute, in fact, a majority in actual population estimates for a given region. So, programs residing in these areas will obviously impact these groups. Due to the inter-relationships between ethnicity, poverty, and other key indicators, locating programs within these areas is paramount and will be an important detail to note during the RFS process. To make this explicit, the following represents a sample of possible outcomes that can be expected for these specific populations based upon the programs selected in Los Angeles County:

- Reduction of juvenile felony arrests for the African-American, Latino, and White populations across the county.
- Reduction of probation camp population and youth under supervision at home for the African-American, Latino, and White populations across the county.
- Reduction of symptoms of trauma within African-American, Latino, and White populations within county probation camps.
- Improvement of family functioning in fragmented or single parent families for African-American, Latino, and White youth under probation supervision at home.
- Reduction of substance abuse and other antisocial/gang behaviors for African-American, Latino, and White populations across the county.
- Inclusion of a community-defined evidence program for English and Spanish speaking youth

B. General Project Outcomes

The tables below depict a more general summary of the project and program level outcomes and methods for measuring them.

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
INDIVIDUAL	• Decrease alcohol/drug use • Decrease arrests • Increase school attendance • Decrease behavior problems • Improve family functioning	• Adolescent, parent, teacher, therapist behavior ratings • Drug testing • School attendance and achievement records • Arrests/Probation violations
PROGRAM/SYSTEM	• Increase opportunities for treatment within the juvenile justice system • Increase integrated services between DCFS,	• Number of mental health treatment programs available to probation youth • Number of prevention programs targeting at

	DMH, and the probation department • Decrease number of juveniles in detention	risk probation youth • Overall juvenile arrests • Overall probation department census

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Aggression Replacement Training	• Reduced impulsiveness • Improved interpersonal skills • Decreased recidivism	• School discipline reports • School violence reports • Student self report
Cognitive Behavioral Intervention for Trauma in School (CBITS)	• Decreased symptoms of depression • Decreased trauma symptoms • 3. Improved parental psychosocial functioning	• Student self report on measures of anxiety/depression • Parent report
Functional Family Therapy	• Reduced re-arrests • Improved family functioning	• Parent behavior report • Child self report • Therapist family assessment • Child alcohol/drug use
Group Cognitive Behavioral Therapy for Major Depression	• Decreased depressive symptoms; increased functioning	• Client self report on measures of depression and stress • Therapist GAF and other assessments
LIFE (Loving Intervention for Family Enrichment) Program	• Decreases in youth aggressive behaviors and social problems • Improved youth self-efficacy • Improved parenting skills and parenting competence	• Child, parent, therapist behavior ratings • Therapist assessment of family functioning
Multidimensional Family Therapy (MDFT)	• Decreased drug use • Improved family functioning • Decreased conduct problems	• Parent report • Therapist assessment • Juvenile arrests
Multisystemic Therapy	• Decreased re-arrest rates • Significantly fewer criminal arrests as an adult • Decreased alcohol and drug use • Decreased peer aggression	• Juvenile arrests • Alcohol/drug use • School attendance records • Adolescent, parent, therapist behavior ratings
Positive Directions	• Decreased substance abuse • Increased pro-social behavior • Increased knowledge of and skill use in anger management and conflict resolution • Increased knowledge of and skill use in problem solving, goal setting, and communications skills • Increased utilization of community support system, particularly around relapse prevention	• Client self report on measures
Prolonged Exposure Therapy for Post Traumatic Stress Disorder	• Reduced severity of trauma symptoms • Significantly reduced symptoms of depression • Improved social adjustment • Reduced anxiety symptoms	• Client self report of anxiety and depression • Therapist ratings

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Trauma Focused Cognitive Behavioral Therapy	• Decreased child behavior problems • Decreased trauma symptoms • Decreased depression • Improved social competence	• Child, parent, teacher ratings • Therapist assessment • SCAN reports

C. Long Term Project Outcomes

The long-term project goals include a prevention component and an early intervention component. With regard to prevention, the intent of the project is to engage at-risk youth prior to joining a gang or engaging in unlawful behavior. One would expect to see a decline in the numbers of targeted youth who join a gang or engage in behaviors leading to arrest. An overall decline in arrests would demonstrate the prevention aspect of the project. With regard to early intervention, one would expect to see more programs in place that serve youth currently in detention or at home under probation supervision. With these youths, one would expect to see a decline in the prevalence of mental health and alcohol/substance abuse disorders and improved school performance. One would also expect to see a decline in re-arrests.

8. COORDINATION WITH OTHER MHSA COMPONENTS

A. Coordination with CSS

As part of their orientation, providers will be trained in the range of mental health services available in the County, including MHSA programs. As the participant's needs are identified, providers will refer children, youth, parents, and other caregivers to appropriate MHSA Community Services and Supports programs, such as the Full Service Partnerships for children, TAY, adults and older adults, juvenile justice linkages/collaboration, and alternative crisis services.

B. Intended Use of WET Funds

Youth will be given information about relevant programs in the Workforce, Education and Training Plan, as appropriate given their expressed desire to enhance their education and/or vocational goals and meet the criteria to qualify.

C. Intended Use of Capital Facilities and Technology Funds

The County does not intend to use Capital Facilities and Technology Funds for this PEI Project at this time.

9. ADDITIONAL COMMENTS (OPTIONAL)

County: Los Angeles

PEI Project 8: EARLY CARE AND SUPPORT FOR OLDER ADULTS

Date:

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☐	☐	☒
2. Psycho-Social Impact of Trauma	☐	☐	☐	☒
3. At-Risk Children, Youth and Young Adult Populations	☐	☐	☐	☒
4. Stigma and Discrimination	☐	☐	☐	☒
5. Suicide Risk	☐	☐	☐	☒

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☐	☐	☐	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☒
3. Children and Youth in Stressed Families	☐	☐	☐	☒
4. Children and Youth at Risk for School Failure	☐	☐	☐	☒
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐	☐	☒
6. Underserved Cultural Populations	☐	☐	☐	☒

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s)

Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project. As part of a multi-modal assessment, data was gathered formally through a stakeholder poll, a series of key individual interviews, a series of focus groups, and several community forums. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI.

In order to proceed with project-building, all of the community assessment information was made available to a group of ad hoc steering committees who further refined population, age, and program selections. The Early Care and Support for Older Adults emerged from these final sets of recommendations and reflect not only the localized needs of county service areas but also the specialized needs of countywide populations as well. The main components of the needs assessment are discussed below as they relate to these specific patterns of responses which led to the creation of the Early Care and Support for Older Adults Project.

(1) Stakeholder Input

(a) Key Individual Interviews

► Input Regarding Priority Population. Key individuals with knowledge and experience of the Underserved Cultural Populations and the Individuals Experiencing the Early Onset of Serious Psychiatric Illness suggested that a balanced prevention and early intervention project be developed in order to address the older adult population's mental health needs with regard to serious psychiatric illness. Below are paraphrased examples of the Key Individual Interview responses:

- *"The earlier we can intervene and address [the onset of serious psychiatric illness] and create, not only a safe environment, but if medications are appropriate, we can stop the deterioration and the downslide, and the risk of suicide and the risk of homelessness."*
- *Due to the stigma it is often difficult to identify individuals experiencing the onset of serious psychiatric illness but that it becomes more apparent with the other services provided.*
- *Individuals experiencing the onset of serious psychiatric illness represent a large percentage of patients who are referred to mental health staff.*

- *The other five priority populations leave out the majority of people who need help. "It seems that Individuals Experiencing the Onset of a Psychiatric Illness is getting to the bulk of people who are in most need of the services, that is those over 21 (26-59, if based on priority age groups)"*
- *"The earlier we educate, the earlier we treat, the more possibilities for this person to become functional, and the more possibilities for long- term stabilization, independent living, surviving in the community, and not using the services as much."*
- *The biggest challenge is understanding serious psychiatric illness and accepting it. "Accepting that there is no cure, but with treatment and taking your medication, you become functioning."*

► Input Regarding Age Groups, Key individuals stated the following reasons for an older adult/early onset project:

- *For older adults, "early intervention and quick intervention…can be quite effective at reducing the onset of serious mental illness among a significant number of mental health needs.*
- *Seniors really need prevention services. This population is often overlooked, but in a community which is dramatically aging, the problem of depression and prescription drug misuse is very high and serious.*
- *All ages can benefit from prevention services, however older people may benefit the most if their problems are identified early because they have more life experiences and coping skills to draw from; thereby increasing the likelihood of successful outcomes. Most research shows that interventions with older adults have an 80% success rate.*

(b) Focus Group Interviews

► Input Regarding Priority Population. Focus groups with knowledge and experience of the Underserved Cultural Populations and the Individuals Experiencing the Early Onset of Serious Psychiatric Illness suggested the creation of a prevention and early intervention program aimed at addressing the needs of the older adult population in the county. Below are paraphrased examples of the focus group responses:

- *One group prioritized the following needed early intervention services: Increase in funding for programs designed for older adults; and, greater access to services through expansion of Dial-a-Ride programs.*
- *Focus group participants noted they worried there would not be concrete support from DMH in their time of need and that the majority of older adults in the area lack financial security to cover day-to-day expenses such as food and medications. Creating more opportunities for transportation for older adults in Service Area 1 is key to improving their access to existing prevention and early intervention services. Older adults often face unique limitations such as restricted*

mobility and frailty that may keep them from seeking care in a traditional clinic setting. To overcome this, assistance should be made available in a variety of settings, including senior centers and at clients' homes.

- *One group mentioned their needs: Free or affordable services for older adults lacking medical insurance or the ability to pay; Services that will help older adults navigate the system;*
- *When asked to find the top three needed prevention services from this list, one group identified the following three needs: Field-based Services; Education and training for seniors as well as for professionals who work with seniors; and, funding disparities.*
- *One group recommended increasing the number of health educators serving older adults and perhaps waging a media campaign with the message, "It's not normal to feel sad if you're an older adult." The group felt that mental health education and awareness should be messaged wherever seniors receive services, including primary care physician offices, faith-based centers, senior centers, and through support groups.*

► Input Regarding Age Groups. Clearly focus groups responses indicated a desire for the county to devise an older adult focused project. Groups were able specify the needs of the older adult population throughout services areas and in response, stakeholders advocated for the creation of the older adult project.

(c) Community Forum Recommendations

Utilizing the needs assessment results, Community Forum attendees were asked to prioritize PEI populations and age groups. These recommendations were then used by Ad Hoc Steering Committee members in making program selection recommendations.

► Input Regarding Priority Strategies. The following represent the recommendations of the Community Forum participants regarding the older adult population and related interventions.

- *Culturally and linguistically appropriate services and education/training on an array of mental health issues.*
- *Develop culturally and linguistically appropriate community outreach and PEI services, which includes the training of providers to be more culturally and linguistically appropriate.*
- *Provide peer or Promotoras models for PEI service provision and/or to assist in accessing services (models would bring services out into the community and help educate older adults, as well as the community at large, about mental health utilizing linguistically and culturally relevant and appropriate strategies/materials).*
- *Training for professionals that included sensitivity to the sixty and over age group, listening and communication skills, and foreign language trainings.*

- *Increase outreach to homebound/shut-ins.*
- *Reducing the stigma associated with the loss of independence by providing services and outreach through a peer Train the Trainer model that assures high quality and culturally and linguistically sensitive care.*
- *Increase funding for community programs such as Promotoras type models and peer counselor programs; staff such as psychologists, clinicians, and administrative staff, and for programs targeting seniors at-risk of becoming homeless.*
- *Development of support services for trauma exposed older adults that include in home services, support groups and immediate intervention when there is a critical incident in the community.*
- *Increased screening at senior centers, doctor's offices, gay and lesbian centers, rehabilitation centers, and other non-traditional settings.*
- *Increase professional clinical staff permanently on-site in community based organizations and senior centers and available after hours and weekends that would provide field based services; psycho-educational counseling groups for bereavement, victims, medical issues, and addictions; and mobile response teams.*

(d) Ad Hoc Steering Committee Recommendations

The Ad Hoc Steering Committees were asked to further identify sub-populations that should be served in their service areas.

► Input Regarding Sub-populations. Below are examples of the target populations for the Older Adults Project.

- *Older Adults residing in nursing facilities, residential placements, homebound or have transportation limitation, co-occurring disorders, suffering from dementia, end of life and/or suicidal issues, loss of loved ones, cultural/linguistic challenges including the deaf.*
- *Older Adults reluctant to seek support outside family and lacking knowledge about mental health needs due to cultural norms and/or economic barriers including immigrants, refuges and undocumented who fear seeking services.*
- *Homeless and/or impoverished older adults who are uninsured or underinsured.*
- *Older Adults who are isolated or homebound by virtue of living situation, disconnect from family, or neglect.*
- *Older Adults lacking access to culturally/linguistically appropriate services.*
- *Older Adults with a recently diagnosed serious medical condition or a chronic medical condition.*

- *Persons on fixed income; or, seniors experiencing financial difficulties, poverty, loss of income, death of spouse, or other types of loss/grief.*
- *Older adults isolated in their homes without transportation.*
- *"Seniors", including ethnic and immigrant adults, who do not access mental health system due to stigma and/or lack of knowledge.*
- *Latino; or non-English-speakers, including elders from the Cambodian community*
- *Elderly living alone and isolated; under the care of adult protective services.*

(2) Data Analysis

(a) Statistical and Demographic Indicators

Together with the Key Individual Interviews and Focus Groups responses presented above, the following indicators were found to confirm the need for the creation of a project focused on the needs of Underserved Cultural Populations and Individuals Experiencing the Early Onset of Serious Psychiatric Illness. The following selected demographic variables and risk factors demonstrate the need for services: Ethnicity, Primary Language, Linguistic Isolation, Mental Health Penetration Rate, Depressive Disorders Statistics, Co-occurring Disorders Statistics, Elder Abuse Statistics, and Deaths by Suicide Statistics.

(b) Ethnicity

Ethnicity is the single most important indicator in terms of mental health disparities in the research literature. Numerous studies have shown that ethnic minorities and, in particular, African-Americans, Latinos, Asian/Pacific Islanders, and American Indians, encounter more barriers in accessing mental health services than Whites. Los Angeles County has a diverse ethnic population representing nationalities and ethnic groups from all over the world. The Hispanic population is the largest ethnic group residing in the county and makes up 47.0% of residents. Western European Whites are the second most populous ethnic group and account for 25.2 percent of the population. Asians are the third most populous group at 12.5%, and African-Americans make up 8.9% of the county population. Since the US Census 2000, when individuals gained the opportunity to be counted as having "Two or more major races," the nation has seen a rising trend in the numbers of individuals within this category. Multi-ethnic individuals now are more numerous in the county than Armenians, Russians, South Asians, Iranians, and American Indians/Alaskan Natives. Research on the mental health problems of multi-ethnic individuals within clinic populations indicates that the severity of their behavior problems may exceed those with a mono-ethnic identity (Choi, Harachi, Gillmore, Catalano, 2006; Shih & Sanchez, 2005).

(c) Primary Language

An individual's Primary Language, if something other than English, can function as a barrier to accessing mental health services. Results from the ACS 2003-2006 consistently rank California as the state with the highest numbers of individuals (about 20%) reporting limited English proficiency, (i.e., they report speaking English "less than very well", ACS American Factfinder, 2008). Studies conducted with Spanish-speaking and Asian language-speaking populations reported large disparities in accessing mental health services; individuals proficient in English have a clear advantage in getting mental health help over those who are not proficient (Snowden, Masland, & Guerrero, 2007). Across the county, the most common Primary Language, English, was only identified by 40.0% of the population and this was only a few percentage points higher than Spanish (37.1%). This indicates that 60% of the county's population identifies a language other than English as the language they speak at home.

(d) Linguistic Isolation

Limited English proficiency represents a strong barrier to mental health treatment, learning, and school success. Besides ethnicity, limited English contributes to mental health disparities involving access to services (Snowden, Masland, & Guerrero, 2007). Linguistically isolated families represent some of the most disadvantaged individuals in society. In terms of mental health, linguistically isolated families may not be receiving information on where or how to get help when a family member needs it. Overall, approximately 247,418, or 7.8% percent, of households in Los Angeles County reported that they were linguistically isolated. This percentage was high in the East LA area at 22.7% and in the Pico Heights area at 25.5%.

(e) Mental Health Treatment Penetration Rates

"A penetration rate provides an indicator of whether persons with mental illness are receiving services and whether the system is responsive to various consumer populations." (McGee, 2002). Overall, the countywide penetration rate was 0.34, which may be read as a measure of how well a mental health system of care can serve the local SMI population. In general, larger numbers reflect greater penetration into the SMI population. Countywide, there was wide variation in penetration rates seen across ethnic groups. The Asian population (0.07) had the lowest overall penetration rate, followed by the Latino population (0.18), the White population (0.18), the Native American population (0.47), and the African-American population (0.69). Undoubtedly, there is a complex social process driving these results. Without conducting more involved statistical analyses, we can only speculate about the degree to which factors such as mental health stigma, language barriers, and therapists' language capacities may be responsible for these numbers.

(f) Depressive Disorders

Depressive disorders rank as the most debilitating mental health disorders worldwide in terms of disease burden. Depressive disorders are associated with poorer outcomes in terms of physical health, economic well-being, school achievement, co-occurring disorders, and criminal behavior. All of these outcomes are important for the PEI planner to consider. Additionally, research has indicated that ethnic disparities exist in terms of depression treatment with African-American and Hispanic clients receiving treatment at a lower rate than for Whites (Simpson, S. M., Krishnan, L. L., Kunik, M. E., & Ruiz, P. (2007). Across the county, 60,203 DMH clients were diagnosed with a Depressive Disorder. The older adult group accounted for 7.5% of depressed clients while making up 13.5% of the county population.

(g) Co-occurring Disorders (COD)

CODs are difficult to treat and are associated with unfavorable outcomes in economic status, health status, mental health disorders, and family relations. Individuals with COD have a greater likelihood of dropping out of school or becoming involved in criminal behavior. Treatment-resistant COD can lead to heavy and repeated service utilization for inpatient and outpatient episodes. Across the county, 30,439 DMH clients were diagnosed with a co-occurring disorder, with older adults accounting for 2.3%.

(h) Deaths by Suicide

Reducing suicide risk is a key PEI mental health initiative. The number of completed suicides is important to consider since it may reveal neighborhood effects contributing to an individual's environmental stress. Completed suicides represent failures in the mental health system to identify and adequately treat individuals at risk. Suicide rates were calculated and standardized to the number of suicides/100,000 residents. Across the county, the suicide rate was 7.0. Data indicated that Service Area 5 had the highest suicide rate (10.6), followed by Service Area 1 (9.9) and Service Area 4 (8.4). By inspection, a few trends were apparent: males were at higher risk than females, Whites and Native Americans were at higher risk than other ethnicities, and older adults were at higher risk than other age groups.

(i) Elder and Dependent Adult Abuse

Elder abuse is related to mental health issues in two ways: first, older adults who have a mental disorder, cognitive impairment, or alcohol problem are at increased risk for being abused, and second, once experiencing abuse, the elderly are at increased risk for a variety of mental health, (e.g., PTSD, depression) disorders, physical disorders and injury, and death (including suicide) (Baker, 2007). Service Area 6 (3.9) had the highest APS Rate1 among all county service areas; the countywide rate is 2.6. Three of the six most at-risk communities across the county were contained within Service Area 6 in

terms of their respective APS Rate1 scores. Service Area 1 had an APS Rate1 of 3.2, which was the second highest rate seen in the county across all service areas. Within the service area, the Lancaster community had the highest rate of APS cases using two different base rates calculations. Likewise, Service Area 4 had an APS Rate1 of 3.1, which was above the countywide rate, and the Downtown area had the highest APS Rate1 score (4.6).

3. PEI PROJECT DESCRIPTION

A. Why the proposed PEI project – including key community need(s), priority population(s), desired outcomes and selected programs – addresses needs identified during the community program planning process

By reviewing the available information from the PEI needs assessment, stakeholder groups could see the needs in terms of mental health risk factors for the older adult population. As the Ad Hoc Steering Committees generated their program recommendations and targeted sub-populations, clusters of related programs began to coalesce around a core service which was then defined as the Early Care and Support for Older Adults Project. Data provided by the US Census Bureau assisted stakeholders in learning where ethnic and age groups were distributed throughout the county. Because the age distribution varied across service areas, it was important for stakeholders to examine where the largest, most needy groups resided. Prevalence data for Depressive Disorders and Co-occurring Disorders were presented to stakeholders and indicated that the distribution of cases followed population estimates for older adults across county service areas. Other data such as county suicide rates indicated that older adults had the highest rates seen across PEI age groups. Additional ethnic group, gender, and geographic location risk factors emerged. Finally, stakeholders were able to review county elder and dependent adult abuse statistics which indicated where high risk areas were located in the county.

By listening to the stated needs and desires of community stakeholders through key interviews, focus groups, and forums spread throughout the county, prioritizing solutions to address the problems encountered by the older adult population became possible. Some of the comments the county received with regard to this population are extracted above and show the interest stakeholders had in creating an older adult project.

Project Purpose. The Early Care and Support Project for Older Adults will (1) establish the means to identify and link older adults who need mental health treatment but are reluctant, are hidden or unknown, and/or unaware of their situation; (2) prevent and alleviate depressive disorders among the elderly; and (3) provide brief mental health treatment for individuals. The stigma of mental illness is a significant barrier for the older generation who often do not seek treatment until the illness has progressed

significantly. Services are directed at older adults, their family members, caregivers, and others who interact with and provide services to this senior citizen population.

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Poverty • Ethnicity • Geographic region • Mental and physical health status • Death of spouse • Pessimism • Chronic pain • Social and linguistic isolation • Inactivity • Life stressors • Unhealthy lifestyle and diet • Suicidal ideation	• Coping skills • Family support • Social support • Optimism • Activity level • Health lifestyle and diet • Treatment/medication adherence

Project Components. Each project is comprised of the following components:

1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.
2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.
3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures that accurate data is captured on a systematic and ongoing basis so that the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.
4. PEI Programs – There are a total of six EBP and CDE program that will be implemented in for the Early Care and Support for Older Adults Project.

Outreach and Engagement to Unserved and Underserved Communities. Because one of the overarching goals of the MHSA is the reduction of mental health disparities experienced by specific racial/ethnic and other cultural groups, all projects have been built with service components to achieve this end. The outreach and engagement component for each PEI project is a critical element in reducing disparities because it is primarily concerned with increasing access to programs, a first step in dismantling

barriers to services. The County strategy for outreach and engagement involves the utilization of existing County outreach workers, activating existing community resources and organizations, and the development of culturally and linguistically sensitive materials. All of these tools will be combined into a coordinated effort to seek out difficult to reach populations, educate groups regarding PEI programs, and facilitate entry into an appropriate program.

Outreach and engagement activities for the Early Care and Support for Older Adults Project will include, but are not limited, to the following:

Community Leaders, Senior Programs, and Organizations

- Working with cultural brokers or community representatives to develop outreach strategies. LACDMH will seek input from the key individuals, focus group participants, and community organizations that participated in the planning process to identify and implement culturally and linguistically appropriate methods for reaching the targeted individuals in these unserved/underserved communities.
- Engaging with local senior centers, Area Agency on Aging sites, and Adult Day Care programs and their staff will provide access to this targeted population.
- Engaging local ethnic community leaders and gatekeepers, while recognizing that many people in these communities lack knowledge of, distrust, and/or are reluctant to use mental health services. Personal contact with these individuals is a key method to increase community knowledge about PEI programs and to facilitate access to these programs.
- Providing information and training in small group settings (e.g. church, temple or other place of worship that has a primarily minority congregation) in local neighborhoods or ethnic community. These sites would be asked to host training and educational forums, bulletins for educational information, and people to serve as volunteers.

Educational Materials

- Developing educational materials about the Early Care and Support for Older Adults Project. The materials will be translated, culturally relevant, at the appropriate literacy level, and visually accessible (large print and Braille). Community input will be sought in the approach and design of materials to ensure the materials are culturally sensitive.
- Distributing an information sheet about the outreach and engagement efforts, including outreach staff contact information as well as programs' contact information. These flyers will be distributed at meetings and posted in places where the target population is expected to congregate, such as senior citizen centers, health clinics, and so forth.
- Distributing press releases, informational articles, and paid advertising (both in English and the appropriate threshold language) in local ethnic newspapers, radio, television, and websites.

Community Outreach Workers

- Collaborating with LACDMH's CSS outreach and engagement staff. Since the inception of the CSS programs, these individuals have developed relationships with numerous community providers. LACDMH will seek the assistance of these staff to provide community linkages for the PEI programs and distribution of information.
- Hiring and training outreach workers, especially those with non-English language ability, and those with experience in working with older adults from the local communities and the unserved/underserved communities.
- Recruiting and training volunteers from the community who are familiar with the unserved/underserved communities.

Partner Organizations

- Working though existing organizations, such as senior citizen groups, visiting nurses associations, health clinics, clubs, churches, and other organizations.
- Collaborating with partner organizations to promote joint outreach efforts.
- Providing training or informational sessions to local organizations such as senor centers, health care agencies, and human service agencies, about the PEI programs.

Older Adult Programs. Programs selected by stakeholders addressed the full range of prevention of mental health disorders through early intervention of a depressive disorder. The Live Well, Live Long, Steps to Mental Wellness was selected to address health promotion for seniors with issues such as living on fixed incomes, being home-bound, having a chronic illness, living alone after the death of a spouse, living in isolation, or without culturally responsive services. The PATCH program and Gatekeeper Case-finding Models were selected to identify older adults who may be at-risk for developing a mental illness. Both programs were selected for their ability to work with underserved cultural populations who may be isolated, home-bound, or living with a chronic disease. For older adults who have entered the early stages of depression, stakeholders recommended the PEARLS program and Cognitive Behavioral Therapy for Late Life Depression.

Prevention	Prevention & Early Intervention	Early Intervention
Promotores de Salud Para Nuestra Tercera Edad (Health Promotores for Our Third Age or Community Health Workers for Latino Older Adults	Live Well, Live Long, Steps to Mental Wellness	Cognitive Behavioral Therapy for Late Life Depression
	Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	Gatekeeper Case-finding Model
		Psychogeriatric Assessment and Treatment in City Housing (PATCH)

(1) Prevention Services

- **Promotores de Salud Para Nuestra Tercera Edad (Health Promoters for Our Third Age or Community Health Workers for Latino Older Adults) – Older Adults.** Promotores de Salud Para Nuestra Tercera Edad is a program where volunteer community members are trained in outreach and education activities specific to common physical health conditions in older Latino adults and their associated mental health conditions (e.g., diabetes and depression). Volunteers are trained to conduct basic physical health status assessments and to follow-up with participants who have evidence of chronic health conditions (including knowledge of local referrals). This CDE will be implemented in Service Area 7.

(2) Prevention and Early Intervention Services

- **Live Well, Live Long, Steps to Mental Wellness – Older Adults.** Live Well, Live Long, Steps to Mental Wellness is an EBP for older adults with symptoms of depression and/or anxiety. It includes health promotion strategies and materials developed by the American Society on Aging through a cooperative agreement with the Centers for Disease Control and Prevention. The materials are in the public domain and can be used by staff in senior citizen centers, health education or public health settings or other community-based organizations serving older adults at risk to depression and anxiety. This program will be implemented in Service Areas 2, 4, and 5.

- **Program to Encourage Active Rewarding Lives for Seniors (PEARLS) – Older Adults.** PEARLS is an intervention for people 60 years and older who have minor depression or dysthymia and are receiving home-based social services from community services agencies. The program is designed to reduce symptoms of depression and improve health-related quality of life. Counselors use three depression management techniques: problem-solving treatment; social and physical activity planning; and planning to participate in pleasant events. Counselors encourage participants to use existing community services and attend local events. This EBP will be implemented in Service Areas 3, 6, and 8.

(3) Early Intervention Services

- **Cognitive Behavioral Therapy (CBT) for Late Life Depression – Older Adults.** This EBP is an active, directive, time-limited, and structured problem-solving approach program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. CBT for Late-Life Depression includes specific modifications for elderly depressed individuals who are being treated as outpatients. Patients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and develop more adaptive and flexible thoughts. This program will be implemented in Service Areas 2, 3, and 7.

❖ **Gatekeeper Case-finding Model – Older Adults.** The Gatekeeper Case-finding Model is designed to identify at-risk older adults who do not typically come to the attention of the mental health and aging service delivery systems. Non-traditional community referral sources are organized and trained to identify high-risk elders who may be experiencing problems that threaten their ability to live independently and safely in the community. Gatekeepers refer the older person to a designated agency for a comprehensive assessment and evaluation with subsequent linkage to needed mental health, aging, medical, or other social services. This EBP will be implemented in Service Areas 4 and 5.

❖ **Psychogeriatric Assessment and Treatment in City Housing (PATCH) – Older Adults.** Psychogeriatric Assessment and Treatment in City Housing, also known as PATCH, is a program intended to meet the mental health needs of the elderly who live in public housing or other social living settings. In an effort to maintain the elderly in their existing environment, PATCH attempts to improve and coordinate community services to the elderly and to educate caregivers about their special needs. With two part-time psychiatrists and a nurse, it provides mental health assessments and referrals of the elderly for whom traditional treatment settings have been ineffective. PATCH is an Evidence-Based Practice for older adults who are unlikely to access traditional mental health services. It will be implemented in Service Area 6.

(4) Targeted Populations

The table below describes the targeted populations for each of the Older Adult Programs.

Program	SA	Age Group	Target Populations
CBT for Late Life Depression	2	Older Adults	➢ Oder adults who may be experiencing a wide range of stressors including loss of social support and independence, death of a spouse, poverty, or homelessness. Additionally, this program will serve older adults who have not been screened for mental illness by a primary care provider, are linguistically/culturally/socially isolated and older adults living in nursing facilities or other types of residential care. ➢ Primarily Hispanics/Latinos, Western European Whites, and Asians as they make up 38.4%, 35.4%, and 8.6% of the Service Area population respectively. Additionally, there are also significant Armenian (5.6%), African American (3.9%), Iranian (1.8%), Other Middle Eastern (1.6%), and South Asian (1.4%) populations in Service Area 2 that this program intends to serve as well.
	3	Older Adults	➢ Immigrants and those with limited English proficiency including deaf and hard of hearing who may lack knowledge about mental illness or who face stigma, linguistic, cultural or other barriers to accessing services. Older Adults reluctant to seek support outside family and lacking knowledge about mental health needs due to cultural norms and/or economic barriers including immigrants, refuges and undocumented who fear seeking services.

Program	SA	Age Group	Target Populations
			➢ Hispanics/Latinos and Asians (particularly Chinese) will be the primary cultural groups served by this program as they make up 45.0% and 23.7% of the Service Area population.
	7	Older Adults	➢ Monolingual Spanish-speaking Latinos who are isolated with physical/mental health issues. Individuals who are at risk for depression/suicide. ➢ Hispanics/Latinos will be primary cultural group receiving these services as they make up 70.9% of the Service Area 7 population. Other significant groups such as Asians and Western European White will also be recipients of these services.
Gatekeeper Case-finding Model	4	Older Adults	➢ Home--bound or socially isolated individuals who may or may not have medical or mental health issues, older adults lacking access to linguistically/culturally appropriate services, older adults who are caring for infirm family members, and individuals who may have a limited awareness/understanding of mental illness or may experience stigma. ➢ Hispanics/Latinos are expected to be the primary cultural group to be served, followed by Western European Whites, Asians (particularly Koreans and Chinese), African Americans, and Russians.
	5	Older Adults	➢ Older Adults lacking access to culturally/linguistically appropriate services, who are isolated or homebound by virtue of living situation, disconnect from family, or neglect. Also, Older Adults caring for children and/or disabled/infirm family members (i.e. spouse, adult children, etc.) and Older Adults with a recently diagnosed serious medical condition or a chronic medical condition. ➢ Primary cultural groups of the area including Western European Whites, Hispanics/Latinos, and Asians. There are also significant numbers of African Americans (8.1% of the population), Russians (5.3%), Iranians (1.3%), Other Middle Easterners (2.3%), and South Asians (1.5%) residing in Service Area 5 who will be served by this program.
Live Well, Live Long, Steps to Mental Wellness	2	Older Adults	➢ p. 237 – "Participants in this program will include older adults experiencing financial difficulties, the death of a spouse, loss of independence, homebound individuals or individuals who are socially isolated, caregivers, linguistically isolated, and individuals recently diagnosed with a serious medical condition."
	4	Older Adults	➢ Linguistically-isolated; Non-English speaking persons; individuals. Home-bound individuals who may or may not have medical or mental health issues; or, socially isolated. Caregivers. Homeless, including those at-risk for homelessness; or, living in residential care; or, multiple families in crowded living conditions; or impoverished persons. ➢ Hispanics/Latinos are expected to be the primary cultural group to be served, followed by Western European.
	5	Older Adults	➢ Older Adults who are isolated or homebound by virtue of living situation, disconnect from family, or neglect. Older Adults lacking access to culturally/linguistically appropriate services. Older Adults caring for children and/or disabled/infirm family members (i.e. spouse, adult children, etc.). Older Adults with a recently diagnosed serious medical condition or a chronic medical condition.. ➢ In addition to Western European Whites, the cultural groups include Hispanics/Latinos, and Asians as well as African Americans (8.1% of the

Program	SA	Age Group	Target Populations
			population), Russians (5.3%), Iranians (1.3%), Other Middle Easterners (2.3%), and South Asians (1.5%).
Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	3	Older Adults	➢ Older caregivers who are taking care of older parents and raising and supporting adult children and other family members. Older Adults reluctant to seek support outside family and lacking knowledge about mental health needs due to cultural norms and/or economic barriers including immigrants, refuges and undocumented who fear seeking services. Homeless and/or impoverished older adults who are uninsured or underinsured. Older Adults residing in nursing facilities, residential placements, homebound or have transportation limitation, co-occurring disorder, suffering from dementia, end of life and/or suicidal issues, loss of loved ones, cultural/linguistic challenges including the deaf. ➢ Hispanics/Latinos and Asians (particularly Chinese) will be the primary cultural groups served by this program as they make up 45.0% and 23.7% of the Service Area population.
	6	Older Adults	➢ Population in the Lynnwood, Watts, Baldwin Hills, Baldwin Hills South, Crenshaw, and Compton areas. Older adults isolated in their homes without transportation. Older ethnic and immigrant adults, who do not access mental health system due to stigma and/or lack of knowledge. Grandparents who are parenting ➢ African Americans and Latinos who make up 28.2% and 65.9% of the population respectively.
	8	Older Adults	➢ Latino and non-English-speakers, including elders from the Cambodian community. LGBTQI older adults. Elderly living alone and isolated; under the care of adult protective services Frail, chronically ill, and those living with chronic pain; disabled, especially those who have mobility issues and/or are vision-impaired. ➢ Primary cultural groups include Hispanics/Latinos, Asians (Cambodians, Pacific islanders), and African Americans.
Promotores de Salud Para Nuestra Tercera Edad	7	Older Adults	➢ Monolingual Spanish-speaking Latinos who are isolated and have physical/mental health issues. Additionally, this program will serve individuals who are at risk for depression/suicide, homebound individuals, and individuals with co-occurring substance abuse and mental health disorders. ➢ Hispanic/Latino cultural populations.
Psychogeriatric Assessment and Treatment in City Housing (PATCH)	6	Older Adults	➢ Individuals living the Lynwood, Watts, Baldwin Hills, Crenshaw, and Compton areas, immigrants, and other underserved ethnic populations. ➢ African Americans and Latinos who make up 28.2% and 65.9% of the population respectively.

B. Implementation Partners and Type of Organization/Setting That Will Deliver the PEI Program and Interventions

The programs in the Older Adults Project may be operated by senior centers, community health centers and primary care clinics, community-based organizations, mental health providers, social service agencies, and other organizations selected through the County's competitive bidding process. It is anticipated that a majority of services will be delivered at in the home, at senior centers, churches, or other places where older adults comfortably congregate. Services sites should be flexible and may include a mobile team offering services where the seniors choose. Implementation partners will include the County Department of Community and Senior Services, Health, and Public, the Public Guardian, Area Agencies on Aging, and other senior organizations. It is expected that agencies selected to run the PEI programs will be experienced or have the capacity to provide the services to the older adult populations as well as collaborate with other agencies that interact with this population.

Should it be determined that additional mental health or other services not available at the school site are needed or that more intensive mental health services are needed than the program offers, the PEI agency will be expected to confer with and refer the child and his/her family to appropriate resources. Each PEI agency will build collaborative relationships with a range of health, social service, mental health, educational, and other resources.

C. Target Community Demographics

This project will focus the older adult population in Los Angeles County. In 2005 the 1.3 million older adults in the county accounted for 13.5% of the entire population. Through the *Vulnerable Communities* report the county was able to identify regions where older adults resided. Service Area 2 which had the largest proportion of the county's population also had the largest proportion of older adults there, 22.2%. This was followed by Service Area 3 (20.4%), Service Area 8 (16.2%), Service Area 7 (12.3%), Service Area 4 (10.5%), Service Area 5 (8.1%), Service Area 6 (7.6%), and Service Area 1 (2.9%). Although Service Area 5 had a relatively small number of older adults in comparison to other parts of the county, within the service area, older adults accounted for 18% of the population. This was the largest proportion of older adults seen within the county's services areas.

D. Highlights of New and Expanded Programs

The six PEI programs in the Older Adults Project are new programs that will be offered in the community in non-traditional mental health sites. The focus is on educating older adults, their family members, and caregivers about mental health to promote and maintain well-being as well as how to access services. A range of services delivered in a culturally and linguistically appropriate manner, from community education, screening and assessment, brief interventions, referral and linkage, and follow-up are the hallmarks of this Project.

E. Action Plan

The Older Adults Project will require the following start-up activities for contract agencies:

1. Solicit proposals through County bidding process
2. Establish partnerships with older adult organizations, health centers, and other key partners
3. Establish MOUs or other contracts confirming partnerships and scope of activities as needed
4. Recruit and hire staff
5. Train staff in EBP model protocols
6. Conduct outreach and education

Specific activities for each PEI program are listed below.

Programs	Objectives: Frequency And Duration
Cognitive Behavioral Therapy for Late Life Depression	• Conduct 20 50-60 minute sessions following a structured manual
Gatekeeper Case-finding Model	• Recruit and train gatekeepers in identifying at-risk seniors • Develop and train providers on resources
Live Well, Live Long, Steps to Mental Wellness	• Distribute health promotion materials at senior sites
Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	• Conduct eight 1-hour sessions over 19 weeks for clients
Promotores de Salud Para Nuestra Tercera Edad (Health Promotores for Our Third Age or Community Health Workers for Latino Older Adults	• Conduct home visits to seniors • Conduct basic health assessment • Provide resource referrals and follow-up on linkages
PATCH Psychogeriatric Assessment and Treatment in City Housing (PATCH)	• Conduct weekly or biweekly visits for up to 6 months

F. Key Milestones and Timeline

1.	Develop Requests for Proposals/Requests for Services	Months 1-3
2.	Obtain County Counsel approval for RFPs/RFSs	Months 1-3
3.	Solicit proposals & evaluate proposals	Months 3-9
4.	Award proposals	Months 6-12
5.	Develop LACDMH PEI program and infrastructure	Months 1-3
6.	Recruitment, hiring and training of staff (LACDMH)	Months 1-6
7.	Implement programs	Months 6-12
8.	Conduct training on LACDMH requirements for agencies	Months 7-12
9.	Conduct training in EBP/CDE model protocols	Months 7-12
10.	Conduct outreach and education	Months 3-12
11.	Set up data collection procedures and requirements	Months 1-6

12. Conduct quarterly PEI provider meetings	Month 12 and on

4. PROGRAMS

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Cognitive Behavioral Therapy for Late Life Depression	Individuals: Families:	Individuals: 975 Families: 321	4
Gatekeeper Case-finding Model	Individuals: Families:	Individuals: 3,750 Families: 1,250	4
Live Well, Live Long, Steps to Mental Wellness	Individuals: 15,500 Families: 5,166	Individuals: 7,750 Families: 2,583	4
Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	Individuals: 1,080 Families: 360	Individuals: 540 Families: 180	4
Promotores de Salud Para Nuestra Tercera Edad (Health Promotores for Our Third Age or Community Health Workers for Latino Older Adults	Individuals: 400 Families: 133	Individuals: Families:	4
Psychogeriatric Assessment and Treatment in City Housing (PATCH)	Individuals: Families:	Individuals: 100 Families: 33	4
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 16,980 Families: 5,659**	**Individuals:13,115 Families: 4,367**	**4**

5. LINKAGES TO COUNTY MENTAL HEALTH AND PROVIDERS OF OTHER NEEDED SERVICES

A. Linking PEI Participants to Services

This project will provide information about mental health, other supportive services and community resources to the older adults, family members, and caregivers who participate in the programs. In instances where the older adult and/or caregivers are perceived to need mental health assessment or extended treatment for mental illness or emotional disturbance, the provider is responsible for identifying appropriate agencies where these services can be providers. The provider will ensure that there is a direct referral and actual linkage with the referred agency so as to avoid creating additional barriers to services. These referrals will include mental health and primary care agencies as well as community-based organizations. Staff will help the seniors, family

members, and other caregivers to articulate their needs and enhance their capacity to identify and connect with other appropriate services.

B. Linking PEI Participants to Non-Traditional Services

The Older Adult Project will enable senior citizens, family members, and other caregivers to access prevention and early intervention community resources including mental health, health, substance abuse, domestic violence, elder abuse, community support, housing, and financial resources. Programs are expected to conduct a needs assessment at the onset and conclusion of services to identify needs in order to ensure that referrals are made to needed services. Staff will help the clients and other caregivers to link to these services and follow up to ensure a connection was made.

C. Sufficiency to Achieve Outcomes

LACDMH conducted research on each of the EBP and CDE models to determine the costs for each program and ensure that the budget and program designs were adequate to achieve the required outcomes. The analysis also determined that program outcomes were in line with the project, State, SDMH, LACDMH, and community expectations. In the bidding process, agencies must demonstrate financial viability, organizational experience, management capability, and cultural competency to provide the services. All agencies selected to run the PEI programs will be required to participate in LACDMH training, including cultural competence, EBPs, PEI policies, and LACDMH policies. Further, they will be required to collect needs assessment data and participate in the Department's evaluation protocols and activities in order to ensure the program is properly developed, clients adequately serviced, and outcomes achieved.

6. COLLABORATION AND SYSTEM ENHANCEMENTS

A. Relationships, Collaborations and Arrangements

The Older Adult Project requires extensive collaboration with both government and private agencies and organizations. Collaborative efforts and relationships will have to be expanded or forged with the aging network, consumer and family advocates, family resource centers, faith-based institutions, primary care providers, first responders, and healthcare organizations. To encourage collaboration and promote new partnerships, CBOs and non-mental health providers will have an opportunity to provide input to agencies and organizations that provide services to the older adult population through monthly Service Area Advisory Committee meetings and Service Area Provider meetings.

PEI will also provide regularly held PEI Provider meetings that will be open to the community at large. PEI Provider meetings will encourage and facilitate sharing resources and promoting partnerships and will offer technical assistance on PEI

program sustainability to the group and to individual providers as needed. Relationships with public organizations will also facilitate the implementation of this Project, including the Commission on Aging and Area Agency on Aging, as well as other agencies focused on serving the elderly.

(1) Outreach Strategies

PEI will outreach to CBOs and non-mental health providers through SAAC meetings, Service Area Provider meetings, PEI Provider meetings, the DMH PEI website, the PEI newsletter and the PEI distribution database that has a current membership of over 6,800 individuals. Outreach efforts will serve to bring CBOs and non-mental health providers to the implementation phase.

(2) Improving Collaboration with CBOs and Non-Mental Health Providers

LACDMH has included community based organizations (CBOs) and non-mental health providers from the very inception of the PEI planning process. To bring these organizations into the implementation phase, LACDMH has four different approaches:

(a) Incubation Academy

This program was designed to assist community and local mental health service providers in obtaining contracts with the Department of Mental Health to build capacity within the mental health system. Comprehensive information, resource references, technical assistance, mentorship, and/or sponsorship opportunities are included in this program, as well as guidance regarding County contracting procedures, documentation, and day-to-day business operations requirements.

(b) Master Agreement List Workshops

PEI Administration will hold a series of workshops to train prospective agencies, including CBOs, on how to qualify for inclusion on the Master Agreement list. The intention of this detailed workshop is to help agencies unfamiliar with county business practices clear the initial and sometimes confusing hurdles in becoming a contractor. As such, this training will include information on how to submit a Statement of Qualifications (SOQ) in response to a Request for Statement of Qualifications (RFSQ), and the ins and outs of the Requests for Services (RFS) process, the pathway by which they could ultimately provide PEI services.

(c) CDE Technical Assistance Workshops

PEI Administration will provide workshops to developers, including CBOs, whose programs were denied in the initial round of qualification. The workshops will focus on clarifying requirements for the CDE application, identification of outcome approaches, cultural practices, and procedures for resubmission. The intent of the CDE TA Workshops is to provide a hands-on step by step method for helping agencies develop and qualify their program as a CDE practice. In conjunction with this process, PEI Administration will work with developers on

becoming an approved provider (i.e. qualifying for the Master Agreement List) as outlined above. Presently, the majority of qualified CDE developer agencies appear on the current Master Agreement List.

(d) Subcontracting

PEI administration recognizes that County minimum requirements to qualify for the Master Agreement List may not be met by many potential worthy MHSA/PEI service providers. In order to address those situations and for those CBOs who are not interested in obtaining a direct contract with LACDMH, another way for them to provide PEI services is to subcontract through an existing LACDMH provider. Additionally, this is an opportunity for small organizations to partner with and receive mentoring from experienced providers which in turn, may eventually lead to a direct contract with LACDMH.

B. Building upon the Mental Health and Primary Care System

Expanded and new partnerships with mental health and primary care providers will be established through the Older Adults Project. It is anticipated that several of the PEI programs will be situated at senior centers or community-based organizations. The stigma associated with seeking mental health services can be minimized by providing these services in-home or in familiar surroundings. Older adults and their caregivers will be referred to primary care providers as medical needs are identified. The project will building upon existing relationships in the community-based mental health and primary care system to provide school-based prevention and early intervention services.

C. Leveraging Resources

The Older Adults Project will work with public and private senior service, health, and other organizations to leverage resources for the PEI programs. Leveraged resources include space, equipment, and staff time as needed. In the solicitation process, potential providers will be notified that agencies are expected to generate support and leveraged resources, such as space, equipment, staff, and volunteer time. LACDMH will seek those agencies that can demonstrate existing capacity and/or a systematic plan for generating resources in the bidding process. Medi-Cal billing is another resource where applicable.

D. Sustaining the PEI Project

Through the solicitation process, the County will determine the organizational and fiscal capacity of each agency to fiscally manage and sustain the PEI program. Continued funding of the program will be through MHSA PEI funds, as well as continuation of any leveraged funds, including in-kind resources and services. LACDMH will monitor the programs to ensure that outcomes are being met in a timely manner and that fiscal, program, and contract standards are adhered to as required.

7. INTENDED OUTCOMES

A. Specific Cultural Outcomes

Through its community mental health needs assessment, the county obtained a comprehensive understanding of the racial/ethnic and linguistic distribution of the population across fairly small geographic regions. The cultural diversity in the population required that the county carefully consider programs that could be implemented successfully for different ethnic and language groups. For this reason, when building each PEI project, programs were first identified on the basis of whether they had been developed with specific cultural populations included in their validated studies. Inclusion of cultural populations during development is crucial in order to demonstrate and later realize the community effectiveness (i.e. generalizability) of a particular program for a specific population.

From there, program selections were made for each service area in accordance with the demographic profile of the area and the inputs received from the collection of local planning bodies mentioned earlier. As a result of this process, most individual outcomes directly involve underserved cultural populations as had been planned. In many cases due to the ethnic distribution across the county, these underserved cultural populations constitute, in fact, a majority in actual population estimates for a given region. So, programs residing in these areas will obviously impact these groups. Due to the inter-relationships between ethnicity, poverty, and other key indicators, locating programs within these areas is paramount and will be an important detail to note during the RFS process. To make this explicit, the following represents a sample of possible outcomes that can be expected for these specific populations based upon the programs selected in Los Angeles County:

- Improvement of community awareness of the problems facing older adults, particularly ethnic minorities, and activating communities to solve these problems by removing the dual stigmas of mental illness and age.
- Reduction of the incidence of depression in older adult populations across the county for African-American, Asian/Pacific Islander, Latino, and White populations.
- Reduction of suicidal ideation/behaviors for in African-American, American Indian, Latino, and White populations.
- Improvement of the breadth of community supports for African-American, Latino, and Asian populations who are living in impoverished environments.
- Inclusion of a community-defined evidence program for monolingual Spanish speakers.

B. General Project Outcomes

The tables below depict a more general summary of the project and program level outcomes and methods for measuring them.

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
INDIVIDUAL	• Improved health status • Improved mental health status especially depression • Increased activity level • Increased social support	• Physical health status • Medical regimen adherence • Client, therapist mood ratings
PROGRAM/SYSTEM	• Improved outreach and detection of depression in older adults • Increased number of programs providing intervention services to older adults • Increased community involvement in identifying at-risk seniors Removal of stigma of mental health disorders • Decrease suicide rate	• Number of programs offering screening and prevention services to older adults • Number of referrals generated by community support staff • Suicide rate for older adult population

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Cognitive Behavioral Therapy for Late Life Depression	• Reduced depressive symptoms • Reduced depression and re-occurrence of depression • Improved life satisfaction • Improved overall adjustment and coping strategies • Decreased psychiatric symptoms	• Client, therapist ratings of depression • Activity level • Social support
Gatekeeper Case-finding Model	• Increased identification of older adults in need of mental health, health, and/or social services • Increased enrollment and retention in case management services	• Number of community referrals made • Diversity of gatekeeper population • Number of clients referred who receive treatment
Live Well, Live Long, Steps to Mental Wellness	• Increased knowledge about depressive disorders	• Number of inquiries from older adults about mental health disorders • Number of community referrals
Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	• Reduced symptoms of depression • Improved health-related quality of life in functional and emotional well-being	• Client, therapist rating of depression • Health status • Activity level • Social support
Promotores de Salud Para Nuestra Tercera Edad (Health Promotores for Our Third Age or Community Health Workers for Latino Older Adults	• Increased engagement in positive health behaviors, specifically those related to diabetes and hypertension • Improved communication with health providers	• Client health status including diet and weight • Client mental health status including depression and healthy behaviors

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Psychogeriatric Assessment and Treatment in City Housing (PATCH)	• Reduced symptoms of depression and other psychiatric symptoms	• Client, mental health worker ratings • Number of referrals to social services

C. Long Term Project Outcomes

This project aims to increase the general level of wellness in the older adult population and over time one would expect to see a physically healthier population with fewer symptoms of mental illness. One of the long-term outcomes involves changing the system so that it is better able to detect at-risk older adults and provide them with the necessary early intervention in order to stave off a more debilitating mental disorder. Over time one would expect to see a decline in the overall prevalence of mental health disorders for the population and a decline in the high suicide rate for the age group. Additionally, as a hallmark of the project, one would expect to see a general increase in awareness in the community of the problems faced by older adults, especially those who are home-bound, living with a chronic disease, or socially or linguistically isolated.

8. COORDINATION WITH OTHER MHSA COMPONENTS

A. Coordination with CSS

As part of their orientation, providers will be trained in the range of mental health services available in the County, including MHSA programs. As client needs are identified, providers will refer the older adult and/or their caregivers to appropriate MHSA Community Services and Supports programs, such as the Full Service Partnerships for older adults, field capable clinical services, alternative crisis services, and wellness centers.

B. Intended Use of WET Funds

Family members and other caregivers will be given information about relevant programs in the Workforce, Education and Training Plan, as appropriate given their expressed desire to enhance their education and/or vocational goals and meet the criteria to qualify. Individuals interested in working with the older population will be encouraged to apply for WET programs that apply to serving this elderly group.

C. Intended Use of Capital Facilities and Technology Funds

The County does not intend to use Capital Facilities and Technology Funds for this PEI Project at this time.

9. ADDITIONAL COMMENTS (OPTIONAL)

County: Los Angeles

PEI Project 9: IMPROVING ACCESS FOR UNDERSERVED POPULATIONS

Date:

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☐	☐	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☒	☒	☐
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒	☒	☒
4. Children and Youth at Risk for School Failure	☐	☐	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐	☐	☐
6. Underserved Cultural Populations	☒	☒	☒	☒

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s)

The Department's needs assessment strategy employed six different methods: recommendations from CSS planning, community surveys, service area data profiles, key individual interviews, focus groups, and community/countywide forums. Each of these six strategies built on the knowledge gained through earlier strategies. Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI.

In order to proceed with project-building, all of the community assessment information was made available to the Ad Hoc Steering Committees who further refined population, age, and program selections. The main components of the needs assessment are discussed below as they relate to these specific patterns of responses which led to the creation of the Improving Access to Underserved Populations Project, which focuses on monolingual non-English speaking) and immigrant populations, the LGBTQ groups, and deaf/hard of hearing individuals and their families.

(1) Stakeholder Input

(a) Key Individual Interviews

► Input Regarding Priority Population. Key Individuals with knowledge and experience of the Underserved Cultural Populations suggested that a prevention and early intervention project be developed in order to address the access issues related to an underserved population's mental health needs. Below are paraphrased examples of the key individual responses:

- *Raising the level of familiarity with community services reduces stigma and increases likelihood that individuals in need will seek out services earlier.*
- *"In Cambodian culture, when you are talking about mental health, people would equate that term with insanity or crazy. People don't want to associate themselves with craziness or insanity because it is very shameful."*
- *Services need to be much more in-tune with the reality of this community. Whether some neighborhoods are 80 percent African American (or the other way around), there is a disproportionate numbers of African American children in general in any system you look at in this community: schools, death rates, …."*
- *Ensure that programs are appropriate for the population being served and do not assume that "one size fits all" when it concerns treatment programs.*

- *There are not enough culturally-competent and bilingual services. Additionally, services need to be more accessible to uninsured populations.*
- *With every new population, it is necessary to modify and adjust the program to meet the needs of each specific community.*
- *It is more expensive to run multi-lingual programs. Contracts usually are "one size fits all" and do not cover the extra staffing and costs involved. Due to insufficient funding, programs are often cut. "When these programs are not being provided in those areas of need, then the families go un-served."*

► Input Regarding Age Groups. Key individuals generally stated that services to underserved populations should target all age groups:

- *Transition-age youth is the age at which young people begin to identify themselves as LGBT and are vulnerable to the psycho-social trauma associated with this stage of development. "If services could be available, supportive resources available for people who are at that early stage of their development as gay people, that would probably go a long way toward prevention of significant mental illness."*
- *All age subgroups could best benefit or should benefit because the goal of MHSA is to create programs. They help mentally ill persons to experience the quality of life that enables them to live, work, learn and participate fully in their community. Transformation and change; this is the approach. Consumer-guided approaches to wellness.*
- *"Most conflict happens in any family when a child enters adolescence… I think especially for immigrant families, it becomes particularly more challenging because of the need for independence. it doesn't necessarily jive with the Asian cultural where the family name and the family sake is more important than the individual. For TAY, the time when Asians enter college is a key time for intervention for alcohol use, substance abuse, and risky behaviors because "they go from a very protective, restricted environment…. There's a huge environmental shift as far as what they weren't able to do.*

(b) Focus Group Interviews

► Input Regarding Priority Population. Focus groups with knowledge and experience of the Underserved Cultural Populations suggested that a prevention and early intervention project be developed in order to address the access issues related to an underserved population's mental health needs. Below are paraphrased examples of the focus group responses:

- *One focus group reported that revised and flexible eligibility criteria were needed. Also important was the development of language about mental health that is "acceptable, culturally competent, non-judgmental, non-stigmatizing, and person-first."*

- *One group saw the need for licensed, certified, degreed, and qualified professionals to meet the mental health needs of the deaf and deaf-blind community. They called for mandated training for physicians, hospital and emergency room staff, and clinicians about the deaf population. Additionally, they reported that systems needed to be expanded to include supports and services for deaf clients and non-English speakers at hospitals, medical offices, and other service provider locations such as the use of paid interpreters.*
- *Participants expressed a great need for prevention services that promote tolerance, take a more personalized approach, are geared to the LGBT community, and have mental health professionals who are trained in and can relate to the LGBT experience and respect client's confidentiality.*
- *One group advocated for more peer to peer services.*
- *One group called for mental health organizations to specifically gear services toward the gay, lesbian, bisexual, and transgender (LGBT) community, with therapists and other staff who can relate to the LGBT community's needs.*
- *"Because of the homelessness there is more crime, increased prostitution, increased substance abuse, and increased victimization among families that are over-stressed." Focus group participants stated that the impacts noted above are due to the disparities in access to services, lack of available services, state of the economy, and the stigma associated with mental health illness.*
- *"Parents, coming from a place with a different cultural and educational background, force what they have learned on their children. But when the children attend American schools, they assume most of this treatment as abuse or degradation and this results in children feeling different, incapable, or oppressed."*
- *"I think if people drop their prejudices -- and I think there's a lot of prejudice about developmental disabilities, and a lot of prejudice about people with mental illness. If they can drop those prejudices about each other's systems, we'd work beautifully together."*
- *The reality of culture shock for recently arrived immigrants can impact their ability to adapt to a new environment effectively. One participant explained, "I know lots of people that wait or don't know how and where to get help. They end up either in jail or in the emergency room with less chances of full recovery. This doesn't have to be our reality."*

► Input Regarding Age Groups. Focus groups reported that all age groups were important and services should target access issues for underserved populations. Respondents were concerned that the services rendered be done so in an age-appropriate manner.Below are paraphrased examples of the focus group responses:

- *When asked to prioritize needed prevention services, participants stated that the following were all important for prevention: Education for youth, parents, extended families, and church leaders to overcome stigma and bring community*

members into services; Training of mental health advocates, counselors, and social workers to provide high quality, linguistically appropriate services; and, Funding is needed to provide culturally competent services that the community trusts.

(c) Community Forum Recommendations

Community Forum attendees were asked to prioritize PEI populations and age groups. These recommendations were then used by Ad Hoc Steering Committee members in making program selection recommendations.

► Input Regarding Priority Strategies. The following examples represent the recommendations of the Community Forum participants regarding underserved populations and related interventions.

- *Free counseling services to prevent major mental health issues from developing. (Vietnamese-speaking group).*
- *Utilize the Promotoras Comunitarias model to inform/educate community on mental health.*
- *Increase the availability and accessibility of culturally and linguistically appropriate mental health treatment, support services, and materials.*
- *Prevention service funding for particular populations (e.g., deaf, developmentally disabled, substance abusers).*
- *Linguistic/cultural appropriateness through tailor-made strategies based on needs assessments for Asian Pacific Islanders, Armenians, LGBTQ, American Indians, and Latino communities.*
- *Educate mental health/medical professionals, patients and their families, as well as society in general, on cultural sensitivity when providing treatments/assistance to minority groups such as the Chinese population.*
- *Prevention education for parents and teens on mental illness, stigma, and tolerance towards the gay, lesbian, bisexual and transgender community and holistic psycho-education support groups, and teen mentoring programs.*
- *One-stop Center with well-trained staff, who are culturally and linguistically competent, who can provide culturally sensitive and relevant age-appropriate services to deaf and/or hard-of-hearing kids and their families, as well as to deaf and deaf-blind kids and their families, and/or deaf and developmentally disabled kids and their families.*
- *Training and technical assistance regarding LGBTQ issues for school personnel, teachers, providers, community- and faith-based organizations, DPSS, DCFS, DMH and peer mentors using a strength-based approach, incentives, and culturally and linguistically appropriate materials.*

(d) Ad Hoc Steering Committee Recommendations

The Ad Hoc Steering Committees were asked to identify sub-populations that should be served in their service areas.

► Input Regarding Sub-populations. Below are examples of the target populations for the Underserved Populations Project.

- *All ethnic and racial groups experiencing a lack of access due to availability, geography, limited finances, limited transportation, and language issues; and those who are often under-reported due to family stigma about mental health and immigration status; or individuals from a mixed race/culture.*
- *Latinos, African-Americans, Asians, and new immigrants not aware of mental illnesses and/or not seeking services due to stigma.*
- *Latino immigrants and their families needing mental health services.*
- *Linguistically isolated families; people experiencing a language barrier due to limited English skills; people who are foreign born/immigrants; or undocumented immigrants.*
- *Latino immigrants and their families needing mental health services.*
- *LGBTQ.*
- *Ethnic minorities/monolingual (non-English-speaking).*
- *Hard-of-hearing and/or non-signing.*
- *Deaf and deaf-blind.*

(2) Data Analysis

(a) Statistical and Demographic Indicators

The Key Individual Interviews, Focus Groups, and *Vulnerable Communities* data were excerpted for Community Forum attendees and Ad Hoc Steering Committee members to assist in their deliberations. The following selected demographic variables and risk factors report demonstrates the need for services: Ethnicity, Primary Language, Linguistic Isolation, and Language Capacity of Mental Health Services Providers.

(b) Ethnicity

Across seven tracked ethnic groups in the above table, Latinos accounted for 33.2% of clients diagnosed with a co-occurring disorder. This was followed by African-Americans (26.3%), Whites (27.3%), Asians (1.9%), and Other Ethnicities (2.2%). Native Americans (0.9%) and Pacific Islanders (0.1%) each accounted for less than 1% of the COD client population. In Service Area 4, 33.3% of African-American clients with a COD were served; 41.3% of Native American clients with a COD were served in Service Area

7; 28.5% of Asian clients with a COD were served in Service Area 4; and 22.0% of Latino clients with a COD were served in Service Area 4.

(c) Primary Language

An individual's Primary Language, if something other than English, can function as a barrier to accessing mental health services. Results from the ACS 2003-2006 consistently rank California as the state with the highest numbers of individuals (about 20%) reporting limited English proficiency, (i.e., they report speaking English "less than very well", ACS American Factfinder, 2008). Studies conducted with Spanish-speaking and Asian language-speaking populations have reported large disparities in accessing mental health services; individuals proficient in English have a clear advantage in getting mental health help over those who are not proficient (Snowden, Masland, & Guerrero, 2007). In LA County, English was only identified by 40.0% of the population as their primary language, and this was only a few percentage points higher than Spanish (37.1%). This also indicates that 60% of the county's population identifies a language other than English as the language they speak at home.

(d) Linguistic Isolation

Limited English proficiency represents a strong barrier to mental health treatment, learning, and school success. Besides ethnicity, limited English contributes to mental health disparities involving access to services (Snowden, Masland, & Guerrero, 2007). Linguistically isolated families represent some of the most disadvantaged individuals in society. In terms of mental health, linguistically isolated families may not be receiving information on where or how to get help when a family member needs it. Overall, approximately 247,418, or 7.8% percent, of households in Los Angeles County reported that they were linguistically isolated.

(e) Language Capacity of Mental Health Providers

It is difficult to find a single measure of mental health stigma or discrimination for Los Angeles County and like other forms of discrimination, it is difficult to identify, quantify, and track. Research in the field tells us that mental health stigma (including self-stigma) is a barrier to accessing mental health treatment. We do not have any firm numbers detailing how much stigma prevents individuals in Los Angeles County from accessing treatment, though we do know it contributes, in part, to this problem. One way that we can look at this is to examine the language capacity of clinics to treat individuals most vulnerable to mental health stigma and discrimination: ethnic minorities. Statistics also indicate that deaf/hard of hearing and deaf-blind individuals are at also vulnerable to stigma and discrimination.

Because the burden of mental health stigma is the most extreme for populations already experiencing discrimination, it is important to have in place clinicians who can

communicate with clients in their primary language and who are versed in their client's cultural milieu. Client-based staffing ratios depict county mental health therapist language abilities across identified primary languages. On average, for each English-speaking rendering provider, (i.e., a mental health therapist), there were 7.7 clients who have identified themselves as English-speaking. Ethnicities with higher ratios indicated that there were fewer therapists with a particular language capability. Among the highest of these appeared to be the Cambodian population (23.4), the Armenian population (13.2), and the Vietnamese population (9.5).

(f) Lesbian/Gay/Bisexual/Transgender/Questioning Individuals

As with other non-ethnic underserved populations, it is challenging to determine the precise extent of gaps in needed mental health services. Part of this is due to negligence in population monitoring practices which are largely limited to tracking ethnic and age groups. Research based upon sampling the LGBTQ populations indicates that there is a great need for mental health services across the life span. For example, gay and bisexual men are 3 times more likely to meet criteria for major depression and close to 5 times more likely to meet criteria for a panic disorder than are heterosexual men. Further, nearly 20% of gay–bisexual men overall are co-morbid for two or more disorders. In general, co-morbidity rates for the LGBTQ populations are much greater than that observed among heterosexuals; this also predicts severity of illness and higher rates of treatment use.

It is believed that key risk factors for developing mental illness for LGBTQ populations include stigma and discrimination against sexual minorities (institutional and personal). This particular finding has particular relevance for children and youth within the LGBTQ population. Gay teens in U.S. schools are often subjected to such intense bullying that they're unable to receive an adequate education. One study found that 28% of gay students will drop out of school. This is more than three times the national average for heterosexual students and is even higher than the Los Angeles County rate. Gay, lesbian and bisexual youth are also up to six times more likely to have serious substance use or mental health problems depression and anxiety; additionally, these are known risk factors for both attempted and completed suicide.

Aside from the research literature, the County needs assessment yielded both Key Individuals and Focus Groups who mentioned the need for services for the LGBTQ populations. For example, one individual remarked, "If services could be available, supportive resources available for people who are at that early stage of their development as gay people, that that would probably go a long way toward prevention of significant mental illness." Using these recommendations as well as the data on LGBTQ populations, Ad Hoc Steering Committees suggested that more integrated services were needed for the populations and that there was a great need for training the workforce to deal with the stigma and discrimination issues surrounding mental illness and sexual orientation. The overwhelming research evidence combined with

stakeholder inputs determined that the LGBTQ needed specialized PEI programming to meet their needs.

(g) Deaf and Hard of Hearing

The Deaf and Hard of Hearing (DHH) population appears to be underserved for several reasons. First, it is a difficult-to-reach population and a difficult one to ascertain the extent of its mental health needs. Because the population is not tracked in a similar fashion to underserved ethnic populations, statistical data in the form of population counts is unobtainable. The US Census Bureau, for example, groups deaf individuals along with the blind and this makes it difficult to generate an accurate estimate of the deaf population alone. If a population goes uncounted, then the chances of it going unnoticed and therefore, underserved is greatly enhanced. Research based on sampling the DHH population has indicated that the prevalence of mental health disorders is likely greater than in the general population.

Additionally, it is estimated that less than 2% of the DHH population needing mental health services actually receive them. And this results in an exacerbation of problems so that only the most severe cases of mental illness receive treatment attention. It is estimated that nationwide, fewer than 3% of mental health services providers have the ability to work with DHH clients. In county focus groups, this finding was echoed by participants who noted there were very few treatment sites located in the mental health system that could treat DHH clients. Ad Hoc Steering Committee members noted the lack of evidence-based programs tailored for the DHH which also contributed to the large gap in needs versus existing services. One particular provider of DHH services reported that their program was inundated with potential clients whom they could neither serve nor refer to another DHH rendering provider. On the basis of the research literature and stakeholder inputs, there was a clear need for additional DHH programs throughout Los Angeles County.

3. PEI PROJECT DESCRIPTION

A. Why the proposed PEI project – including key community need(s), priority population(s), desired outcomes and selected programs – addresses needs identified during the community program planning process

By reviewing the data sources presented, one can see the extent of the county needs in terms of mental health risk factors for the underserved population. Data provided by the US Census Bureau assisted stakeholders in learning where ethnic groups were distributed throughout the county. This was crucial to the planning process because ethnicity is inter-twined with poverty and both are related to mental health disparities in the United States. Related to ethnicity were the indicators of primary languages spoken in homes and the most severe form of language barriers, linguistic isolation. All of these

indicators, ethnicity, primary language, and linguistic isolation have been shown to decrease the likelihood of an individual successfully seeking, accessing, and benefiting from mental health services. Data provided by LACDMH corroborated this information by documenting disparities in mental health service utilization across ethnic groups. Additionally, through the calculation of population and client-based staffing ratios, stakeholders learned where shortages in linguistically qualified therapists existed and which ethnic groups experienced the greatest of these barriers to access.

By listening to the stated needs and desires of community stakeholders through key interviews, focus groups, and forums spread throughout the county, prioritizing solutions to address the problems encountered by underserved populations became possible. Some of the comments the county received with regard to the many underserved populations are extracted above and show the interest stakeholders had in creating a specialized project to counteract existing disparities.

Project Purpose. The Improving Access for Underserved Populations Project will (1) build resiliency and increase protective factors among monolingual and limited English-speaking immigrants and underserved cultural populations, lesbian/gay/bisexual/ transgender/questioning (LGBTQ) individuals, deaf/hard of hearing individuals and their families, and blind/visually impaired individuals and their families; (2) identify as early as possible individuals who are a risk for emotional and mental problems; and (3) provide culturally and linguistically appropriate early mental health intervention services. The programs will provide outreach and education as well as promote mental wellness through universal and selective prevention strategies.

It should be noted that this Project is not inclusive of all services for racial and ethnic minority populations, although these groups are included in the Improving Access for Underserved Project. In addition, several services for African-Americans, American Indians, Asian/Pacific Islanders, Hispanic/Latino, and Middle Eastern/Eastern Europeans have been placed in other Projects throughout the Plan as those focused services address specific needs and strategies as well as access.

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Poverty • Ethnicity • Geographic region • Linguistic and social isolation • Mental health disorders • Family dysfunction, discord and violence • Alcohol/drug/tobacco use • Insecure attachments • Antisocial behavior	• Coping skills • Family support • Social supports • Secure attachments • Effective parenting • Self-efficacy • Community supports

Project Components. Each project is comprised of the following components:

1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.
2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.
3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures that accurate data is captured on a systematic and ongoing basis so that the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.
4. PEI Programs – There are a total of eight EBP and CDE programs that will be implemented in eight service areas and countywide for the Improving Access to the Underserved Populations Project.

Outreach and Engagement to Unserved and Underserved Communities. Because one of the overarching goals of the MHSA is the reduction of mental health disparities experienced by specific racial/ethnic and other cultural groups, all projects have been built with service components to achieve this end. The outreach and engagement component for each PEI project is a critical element in reducing disparities because it is primarily concerned with increasing access to programs, a first step in dismantling barriers to services. The County strategy for outreach and engagement involves the utilization of existing County outreach workers, activating existing community resources and organizations, and the development of culturally and linguistically sensitive materials. All of these tools will be combined into a coordinated effort to seek out difficult to reach populations, educate groups regarding PEI programs, and facilitate entry into an appropriate program.

Outreach and engagement activities for the Improving Access for Underserved Populations Project will include, but are not limited, to the following:

Community Leaders and Organizations

- Working with cultural brokers or community representatives to develop outreach strategies. LACDMH will seek input from the key individuals, focus group participants, and community organizations that participated in the planning process to identify and implement culturally and linguistically appropriate methods for reaching the targeted individuals in these unserved/underserved communities.
- Engaging local ethnic community leaders and gatekeepers, while recognizing that many people in these communities lack knowledge of, distrust, and/or are reluctant to use mental health services. Personal contact with these individuals is a key

method to increase community knowledge about PEI programs and to facilitate access to these programs.
- Providing information and training in small group settings (e.g. church, temple or other place of worship that has a primarily minority congregation) in local neighborhoods or ethnic community. These sites would be asked to host training and educational forums, bulletins for educational information, and people to serve as volunteers.

Educational Materials
- Developing educational materials about the Improving Access for Underserved Populations Project. The materials will be translated, culturally relevant, at the appropriate literacy level, and visually accessible (large print and Braille). Community input will be sought in the approach and design of materials to ensure the materials are culturally sensitive.
- Distributing an information sheet about the outreach and engagement efforts, including outreach staff contact information as well as programs' contact information. These flyers will be distributed at meetings and posted in places where the target population is expected to congregate, such as community centers, youth clubs, health clinics, and so forth.
- Distributing press releases, informational articles, and paid advertising (both in English and the appropriate threshold language) in local ethnic newspapers, radio, television, and websites.

Community Outreach Workers
- Collaborating with LACDMH's CSS outreach and engagement staff. Since the inception of the CSS programs, these individuals have developed relationships with numerous community providers. LACDMH will seek the assistance of these staff to provide community linkages for the PEI programs and distribution of information.
- Hiring and training outreach workers, especially those with non-English language ability, from the local communities and the unserved/underserved communities.
- Recruiting and training volunteers from the community who are familiar with the unserved/underserved communities.

Partner Organizations
- Working though existing organizations, such as deaf/hard of hearing, blind/visually impaired, LGBTQ, health clinics, clubs, churches, and other organizations.
- Collaborating with partner organizations to promote joint outreach efforts.
- Providing training or informational sessions to local organizations such as youth groups, social service organizations, and human service agencies, about the PEI programs.

Improving Access for Underserved Populations Programs. Stakeholders selected a broad range of programs to address the many concerns they had for the underserved.

The programs intended to be delivered include GLBT Champs, Group CBT for Major Depression, and Trauma Focused CBT for the LGBTQ populations; for the deaf and hard of hearing communities, Nurse-Family Partnership and Nurturing Parenting Program, and Prolonged Exposure Therapy for PTSD. For monolingual and/or immigrant families, the programs selected were Family Coping Skills, CBT for Depression with Antidepressant Medication, and Group CBT for Major Depression.

Prevention	Prevention & Early Intervention	Early Intervention
Family Coping Skills Program	Cognitive Behavioral Therapy for Depression with Antidepressant Medication	Prolonged Exposure Therapy for PTSD
	GLBT CHAMPS: Comprehensive HIV & At-Risk Mental Health Services	Trauma Focused Cognitive Behavioral Therapy
	Group Cognitive Behavioral Therapy for Major Depression	
	Nurse-Family Partnership	
	Nurturing Parenting Programs	

(1) Prevention Services

- **Family Coping Skills Program – Adults.** Family Coping Skills Program is a depression prevention program developed specifically for low-income Latina mothers. The culturally-tailored approach enhances recruitment and retention of participants. Family Coping Skills Program is an EBP designed to decrease depressive symptoms though group and family sessions. This program will be implemented in Service Area 6.

(2) Prevention and Early Intervention Services

- **Cognitive Behavioral Therapy (CBT) for Depression with Antidepressant Medication – Adults.** Cognitive Behavioral Therapy (CBT) for Depression with Antidepressant medication was designed for low-income women (African-American, White and Latina) diagnosed with Major Depressive Disorder. The intervention includes antidepressant medication for six months; cognitive behavioral therapy for eight weeks (weekly group or individual sessions); followed by eight additional sessions for non-improvers; participant and therapist manuals adapted from a program specifically for low-income English and Spanish speakers, or referral to a community provider. This EBP is designed to reduce depressive symptoms and will be implemented in Service Area 2.

- **Gay/Lesbian/Bisexual/Transgender Comprehensive HIV & At-Risk Mental Health Services (GLBT CHAMPS) – Transition-age Youth.** GLBT CHAMPS is a comprehensive package of interventions with enhanced case management and outreach intervention, mobile van HIV testing, and a CDC evidence-based social skills intervention for enhancing risk reduction education and decreasing stigma among HIV+ African American females (SISTA). Some of the elements of this program are consistent with PEI, while others are consistent it CSS. GLBT CHAMPS is a CDE targeting African-American HIV+ individuals and will be implemented countywide to serve LGBTQ populations.

- **Group Cognitive Behavioral Therapy (CBT) for Major Depression – Transition-age Youth, Adults and Older Adults.** Group CBT for Major Depression is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. Treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Cultural tailoring and case management show increased effectiveness for low-income Latino and African-American adults. This EBP will be implemented in Service Areas 2, 4, 7, and 8 as well as with the LGBTQ and blind/visually impaired populations countywide.

- **Nurse-Family Partnership – Young Children.** The Nurse-Family Partnership (NFP) program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Nurses use their professional nursing judgment and increase or decrease the frequency and length of visits based on the client's needs. Clients are able to participate in the program for two-and-a-half years and the program is voluntary. This EBP will be implemented countywide with the deaf/hard-of-hearing community.

- **Nurturing Parenting Programs – Young Children and Children.** Nurturing Parenting Programs 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 12-48 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. In addition, programs for children 5-11 years old and teens 12-18 years old are also offered. Parents and their children meet in separate groups that meet concurrently. The program was developed from the known behaviors that contribute to the maltreatment of children. This EBP will be implemented countywide with the deaf/hard-of-hearing community.

(3) Early Intervention Services

- **Prolonged Exposure Therapy for Posttraumatic Stress Disorder (PTSD) – Adults and Older Adults.** Prolonged Exposure Therapy for PTSD is a cognitive-

behavioral treatment program for individuals who have experienced single or multiple/ continuous traumas and have PTSD. The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. PE has three components: post-trauma difficulties, revisiting the trauma memory in imagination; and in vivo exposure, gradually approaching trauma reminders that are feared and avoided despite being safe. An EBP for the survivors of trauma, this program will be implemented with the deaf/hard-of-hearing community countywide.

❖ **Trauma Focused Cognitive Behavioral Therapy (CBT) – Transition-age Youth**
Trauma Focused Cognitive Behavioral Therapy (CBT) is a conjoint child and parent psychotherapy model for youth who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Sessions are conducted once a week. This EBP will be implemented with the LGBTQ population countywide.

(4) Targeted Populations

The table below describes the targeted populations for each of the Improving Access for Underserved Populations Programs.

Program	SA	Age Group	Target Populations
CBT for Depression with Antidepressant Medication	2	Adults	➢ Trauma-exposed individuals and individuals experiencing a lack of access due to availability, geography, limited resources, stigma, and language issues. ➢ All cultural populations.
Family Coping Skills Program	6	Adults	➢ Latino immigrants and their families who may not be aware of services or who may not seek them due to stigma. This program will also help individuals returning to the community after incarceration, rehabilitation, or time spent in other institutions ➢ Hispanic/Latino immigrants.
GLBT CHAMPS	LGBTQ	TAY	➢ LGBTQ populations, particularly TAY, with substance abuse issues and individuals who have been exposed to trauma. ➢ All LGBTQ cultural populations throughout Los Angeles County.
Group CBT for Major Depression	2	Adults	➢ Trauma exposed individuals. Persons experiencing a lack of access due to availability, geography, limited finances, limited transportation, and language issues; and those who are often under-reported due to family stigma about mental health and immigration status; or individuals from a mixed race/culture. ➢ The primary cultural groups anticipated to be served are Hispanics/Latinos, Western European Whites, and Asians as they make up 38.4%, 35.4%, and 8.6% of the Service Area population respectively. Additionally, there are also significant Armenian (5.6%), African American (3.9%), Iranian (1.8%), Other

Program	SA	Age Group	Target Populations
			Middle Eastern (1.6%), and South Asian (1.4%) populations in Service Area 2 that this program intends to serve as well.
	4	Adults	➢ Individuals with exposure to trauma or violence (domestic violence, community violence, etc.) Individuals living in poverty; individuals who are at risk of being homeless; or homeless individuals who do not have access to resources for mental health services. Linguistically isolated families; people experiencing a language barrier due to limited English skills; people who are foreign born/immigrants; or undocumented immigrants. ➢ With an emphasis on limited English language ability, the primary cultural groups served will include Hispanics/Latinos, Asians (particularly Korean and Chinese), and Western European Whites. There are also significant African American (5.1%), Russian (1.6%), Armenian (1.2%), and South Asian (1.1%) populations who will be served through this program.
	7	Adults	➢ Latino immigrants and their families needing mental health services. ➢ Hispanic/Latino cultural population.
	8	Adults	➢ Ethnic minorities/monolingual (non-English-speaking), LGBTQ individuals, and persons living in poverty or homeless. ➢ LGBTQ cultural populations and non-English speaking individuals.
	Blind/VI	TAY Adults, Older Adults	➢ Transition-age youth, adults and older adults who are blind or visually impaired. ➢ All cultural populations throughout Los Angeles County.
	LGBTQ	TAY, Adults, Older Adults	➢ Transition-age youth and individuals who are 50 years and older. ➢ All LGBTQ cultural populations throughout Los Angeles County.
Nurse-Family Partnership	Deaf/HH	Young Childre n	➢ Deaf/hard-of-hearing community, including deaf-blind, and non-signing populations. ➢ All racial/ethnic populations throughout Los Angeles County.
Nurturing Parenting Program	Deaf/HH	Young Childre n, Childre n	➢ Deaf/hard-of-hearing community, including signing and non-signing individuals as well as individuals who are deaf-blind. ➢ All cultural populations throughout Los Angeles County.
Prolonged Exposure Therapy for PTSD	Deaf/HH	TAY Adults, Older Adults	➢ Deaf/hard-of-hearing survivors of trauma, including individuals who sign, those who don't sign, and individuals who are deaf-blind. ➢ All cultural populations throughout Los Angeles County.
Trauma Focused CBT	LGBTQ	TAY	➢ LGBTQ youth who have experienced trauma and their parents. Youth in this program will include individuals who have experienced family and community violence, parental neglect or substance abuse, as well as other types of trauma.

Program	SA	Age Group	Target Populations
			➢ All LGBTQ cultural populations throughout Los Angeles County.

B. Implementation Partners and Type of Organization/Setting That Will Deliver the PEI Program and Interventions

The programs in the Improving Access for Underserved Populations will be operated by community-based organizations, mental health services providers, social service agencies, and other organizations with demonstrated cultural and other relevant capacity to serve the targeted underserved populations. Providers will be as selected through the County's competitive bidding process. It is anticipated that services will be delivered at community-based organizations, community centers, family resource centers, public health clinics, homes, primary care clinics, schools, social service agencies, and other non-traditional mental health settings. Key implementation partners include refugee and immigrants groups, LGBTQ advocates and providers, deaf/hard of hearing advocates and providers, and ethnic specific organizations.

Should it be determined that additional mental health or other services not available at the primary provider site are needed or that more intensive mental health services are needed than the program offers, the PEI agency will be expected to confer with and refer the client and his/her family to appropriate resources. Each PEI agency will build collaborative relationships with a range of health, social services, mental health, educational, and other resources.

C. Target Community Demographics

This project will focus on underserved populations across Los Angeles County. Through the *Vulnerable Communities* report LACDMH was able to identify regions where underserved cultural populations reside. As shown in the table below, each ethnic group has been highlighted to show where the largest populations are throughout the county's service areas. For example, the sizeable Hispanic population is dispersed throughout the county with the largest proportion of the population residing in Service Area 7. Over 70% of the residents in Service Area 7 are of Hispanic origin. The largest African-American population resided in Service Area 6; the largest Asian population resided in Service Area 3.

Particular attention should be paid to populations experiencing a language barrier. The Linguistic Isolation indicator mentioned above showed that 7.8% of households in Los

Angeles County reported that they were linguistically isolated. Service Area 4 had the highest isolation scores obtained in the county, 14%. Primary languages reported by residents there included Spanish, Tagalog, and Korean.

D. Highlights of New and Expanded Programs

The eight PEI programs in the Underserved Populations Project are new programs that will be offered at different sites throughout the county. The approach to these services is prevention (outreach, education, training) and early intervention (early identification of potential problems, activities to resolve the issues, and brief treatment for early onset of more serious illnesses). Throughout all of these programs, the emphasis is on ensuring the programs are delivered in a culturally appropriate manner by individuals from the target populations themselves and/or sensitive to the cultural and other issues confronting the individuals to be served. Especially given the language and cultural barriers, together with the special issues confronting the LGBTQ and deaf/hard of hearing populations, wherever possible, the PEI programs will be offered at non-traditional mental health settings to encourage individuals and families to participate in the programs and to minimize any stigma or discrimination barriers to accessing these services.

E. Action Plan

The Improving Access for Underserved Cultural Populations Project will require the following start-up activities for contract agencies:

1. Solicit proposals through County bidding process
2. Establish partnerships with culturally specific community organizations, LGBTQ groups, deaf/hard of hearing organizations, schools, agencies, health centers, and other key partners
3. Establish MOUs or other contracts confirming partnerships and scope of activities as needed
4. Recruit and hire staff
5. Train staff in EBP model protocols
6. Conduct outreach and education

Specific activities for each PEI program are listed below.

Programs	Objectives: Frequency And Duration
Cognitive Behavioral Therapy for Depression with Antidepressant Medication	• Provide CBT for 8 weekly sessions (group or individual) with antidepressant medication for 6 months for clients
Family Coping Skills Program	• Conduct six groups sessions and two family sessions for each family client
GLBT CHAMPS: Comprehensive HIV	• Provide enhanced case management and outreach intervention

Programs	Objectives: Frequency And Duration
& At-Risk Mental Health Services	(MOHOP) • Conduct mobile van HIV testing • Provide a CDC evidence-based social skills intervention for enhancing risk reduction education and decreasing stigma
Group Cognitive Behavioral Therapy for Major Depression	• Conduct weekly group sessions for clients
Nurse-Family Partnership	• 60-90 minute visits beginning in early pregnancy and continuing until child is 2 years old (weekly, then biweekly, then monthly)
Nurturing Parenting Programs	• 12-48 group or home-based sessions
Prolonged Exposure Therapy for PTSD	• Conduct 9-12 90-minute individual sessions 1-2 times per week for clients
Trauma Focused Cognitive Behavioral Therapy	• Conduct 12-15 weekly one hour sessions for child and parent.

F. Key Milestones and Timeline

1.	Develop Requests for Proposals/Requests for Services	Months 1-3
2.	Obtain County Counsel approval for RFPs/RFSs	Months 1-3
3.	Solicit proposals & evaluate proposals	Months 3-9
4.	Award proposals	Months 6-12
5.	Develop LACDMH PEI program and infrastructure	Months 1-3
6.	Recruitment, hiring and training of staff (LACDMH)	Months 1-6
7.	Implement programs	Months 6-12
8.	Conduct training on LACDMH requirements for agencies	Months 7-12
9.	Conduct training in EBP/CDE model protocols	Months 7-12
10.	Conduct outreach and education	Months 3-12
11.	Set up data collection procedures and requirements	Months 1-6
12.	Conduct quarterly PEI provider meetings	Month 12 and on

4. PROGRAMS

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Cognitive Behavioral Therapy for Depression with Antidepressant Medication	Individuals: 450 Families:	Individuals: 900 Families:	4
Family Coping Skills Program	Individuals: 900	Individuals:	4

	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		
	Families: 900	Families:	
GLBT CHAMPS: Comprehensive HIV & At-Risk Mental Health Services	Individuals: 80 Families: 80	Individuals: 20 Families: 20	4
Group Cognitive Behavioral Therapy for Major Depression	Individuals: 3,375 Families: 50	Individuals: 6,750 Families: 100	4
Nurse-Family Partnership	Individuals: 50 Families: 50	Individuals: 50 Families: 50	4
Nurturing Parenting Programs	Individuals: 100 Families: 100	Individuals: 200 Families: 200	4
Prolonged Exposure Therapy for PTSD	Individuals: Families:	Individuals: 80 Families:	4
Trauma Focused Cognitive Behavioral Therapy	Individuals: Families:	Individuals: 200 Families: 200	4
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 4,955** **Families: 1,180**	**Individuals: 8,200** **Families: 570**	**4**

5. LINKAGES TO COUNTY MENTAL HEALTH AND PROVIDERS OF OTHER NEEDED SERVICES

A. Linking PEI Participants to Services

This project will provide information about mental health, other supportive services and community resources to the children, youth, adults, older adults, and family members who participate in the programs. In instances where the children, youth, and/or their parents or caregivers are perceived to need mental health assessment or extended treatment for mental illness or emotional disturbance, the provider is responsible for identifying appropriate agencies where these services can be provided. The provider will ensure that there is a direct referral and actual linkage with the referred agency so as to avoid creating additional barriers to services. These referrals will include mental health and primary care agencies as well as community-based organizations. Staff will help children, youth, parents, and other caregivers to articulate their needs and enhance their capacity to identify and connect with other appropriate services.

B. Linking PEI Participants to Non-Traditional Services

The Underserved Populations parenting projects will enable children, youth, and their parents and other caregivers to access prevention and early intervention community resources including educational, substance abuse, domestic violence, community support, housing, employment, resources. PEI agencies are expected to conduct a needs assessment at the onset and conclusion of services to identify needs in order to ensure that referrals are made to needed services. Staff will help children, youth, parents, and other caregivers to link to these services and follow up to ensure a connection has been made.

C. Sufficiency to Achieve Outcomes

LACDMH conducted research on each of the EBP and CDE models to determine the costs for each program and ensure that the budget and program designs were adequate to achieve the required outcomes. The analysis also determined that program outcomes were in line with the project, State, SDMH, LACDMH, and community expectations. In the bidding process, agencies must demonstrate financial viability, organizational experience, management capability, and cultural competency to provide the services. All agencies selected to run the PEI programs will be required to participate in LACDMH training, including cultural competence, EBPs, PEI policies, and Department policies. Further, they will be required to collect needs assessment data and participate in the Department's evaluation protocols and activities in order to ensure the program is properly developed, clients adequately serviced, and outcomes achieved.

6. COLLABORATION AND SYSTEM ENHANCEMENTS

A. Relationships, Collaborations and Arrangements

The Improving Access for Underserved Populations Project requires extensive collaboration with both government and private agencies and community-based organizations. It is important that relationships be maintained or developed with local advocates, key school personnel, community leaders, and other educational professionals. The Departments of Health, Public Health, Children and Family Services, and Public Social Services as well as the Regional Centers and law enforcement agencies are key implementation partners. To encourage collaboration and promote new partnerships, CBOs and non-mental health providers will have an opportunity to provide input to agencies and organizations that work to improve access to underserved populations through monthly Service Area Advisory Committee meetings and Service Area Provider meetings.

Additionally, LACDMH currently has a countywide task force for underrepresented groups with five sub-groups. PEI will engage this group in a collaborative effort to ensure full participation. PEI will also provide regularly held PEI Provider meetings that will be open to the community at large. PEI Provider meetings will encourage and

facilitate sharing resources and promoting partnerships and will offer technical assistance on PEI program sustainability to the group and to individual providers as needed. Private agencies include health organizations, the Community Clinic Association of Los Angeles County, mental health providers, and other social service, health, and family organizations. The project will building upon existing relationships in the community-based mental health and primary care system to provide these prevention and early intervention services.

(1) Outreach Strategies

PEI will outreach to CBOs and non-mental health providers through SAAC meetings, Service Area Provider meetings, PEI Provider meetings, the DMH PEI website, the PEI newsletter and the PEI distribution database that has a current membership of over 6,800 individuals. Outreach efforts will serve to bring CBOs and non-mental health providers to the implementation phase.

(2) Improving Collaboration with CBOs and Non-Mental Health Providers

LACDMH has included community-based organizations (CBOs) and non-mental health providers from the very inception of the PEI planning process. To bring these organizations into the implementation phase, LACDMH has four different approaches:

(a) Incubation Academy

This program was designed to assist community and local mental health service providers in obtaining contracts with the Department of Mental Health to build capacity within the mental health system. Comprehensive information, resource references, technical assistance, mentorship, and/or sponsorship opportunities are included in this program, as well as guidance regarding County contracting procedures, documentation, and day-to-day business operations requirements.

(b) Master Agreement List Workshops

PEI Administration will hold a series of workshops to train prospective agencies, including CBOs, on how to qualify for inclusion on the Master Agreement list. The intention of this detailed workshop is to help agencies unfamiliar with county business practices clear the initial and sometimes confusing hurdles in becoming a contractor. As such, this training will include information on how to submit a Statement of Qualifications (SOQ) in response to a Request for Statement of Qualifications (RFSQ), and the ins and outs of the Requests for Services (RFS) process, the pathway by which they could ultimately provide PEI services.

(c) CDE Technical Assistance Workshops

PEI Administration will provide workshops to developers, including CBOs, whose programs were denied in the initial round of qualification. The workshops will focus on clarifying requirements for the CDE application, identification of

outcome approaches, cultural practices, and procedures for resubmission. The intent of the CDE TA Workshops is to provide a hands-on step by step method for helping agencies develop and qualify their program as a CDE practice. In conjunction with this process, PEI Administration will work with developers on becoming an approved provider (i.e. qualifying for the Master Agreement List) as outlined above. Presently, the majority of qualified CDE developer agencies appear on the current Master Agreement List.

(d) Subcontracting

PEI administration recognizes that County minimum requirements to qualify for the Master Agreement List may not be met by many potential worthy MHSA/PEI service providers. In order to address those situations and for those CBOs who are not interested in obtaining a direct contract with LACDMH, another way for them to provide PEI services is to subcontract through an existing LACDMH provider. Additionally, this is an opportunity for small organizations to partner with and receive mentoring from experienced providers which in turn, may eventually lead to a direct contract with LACDMH.

B. Building Upon the Mental Health and Primary Care System

Expanded and new partnerships with mental health and primary care providers will be established through the Underserved Populations Project. The stigma associated with seeking mental health services can be minimized by providing these services at community sites where the underserved populations are more likely to visit. Students, parents and caregivers will be referred to primary care providers as medical needs are identified. LACDMH provides mental health services to almost all of the 88 school districts in the County, and referrals from the PEI programs to existing traditional mental health providers should be a smoother process.

C. Leveraging Resources

The Underserved Populations Project will work with health agencies, community organizations, school districts, and other educational agencies to leverage resources for the PEI programs. Leveraged resources include space, equipment, and staff time as needed. In the solicitation process, potential providers will be notified that agencies are expected to generate support and leveraged resources, such as space, equipment, staff, and volunteer time. LACDMH will seek agencies that can demonstrate existing capacity and/or a systematic plan for generating resources in the bidding process.

D. Sustaining the PEI Project

Through the solicitation process, the County will determine the organizational and fiscal capacity of each agency to fiscally manage and sustain the PEI program. Continued funding of the program will be through MHSA PEI funds, as well as continuation of any

leveraged funds, including in-kind resources and services. LACDMH will monitor the programs to ensure that outcomes are being met in a timely manner and that fiscal, program, and contract standards are adhered to as required

7. INTENDED OUTCOMES

A. Specific Cultural Outcomes

Through its community mental health needs assessment, the county obtained a comprehensive understanding of the racial/ethnic and linguistic distribution of the population across fairly small geographic regions. The cultural diversity in the population required that the county carefully consider programs that could be implemented successfully for different ethnic and language groups. For this reason, when building each PEI project, programs were first identified on the basis of whether they had been developed with specific cultural populations included in their validated studies. Inclusion of cultural populations during development is crucial in order to demonstrate and later realize the community effectiveness (i.e. generalizability) of a particular program for a specific population.

From there, program selections were made for each service area in accordance with the demographic profile of the area and the inputs received from the collection of local planning bodies mentioned earlier. As a result of this process, most individual outcomes directly involve underserved cultural populations as had been planned. In many cases due to the ethnic distribution across the county, these underserved cultural populations constitute, in fact, a majority in actual population estimates for a given region. So, programs residing in these areas will obviously impact these groups. Due to the inter-relationships between ethnicity, poverty, and other key indicators, locating programs within these areas is paramount and will be an important detail to note during the RFS process. To make this explicit, the following represents a sample of possible outcomes that can be expected for these specific populations based upon the programs selected in Los Angeles County:

- Augmentation of the collection of services (and associated culturally competent workforce) for ethnic minorities as well as other underserved populations.
- Removal of the stigma of mental illness for African-American, Asian/Pacific Islander, Latino populations by improving the specificity of outreach, messaging, and community education efforts.
- Recognition of the mental health needs of traditionally difficult to count sub-populations within the county such as the Deaf and Hard of Hearing, Blind, Visually-impaired, Homeless, Uninsured, and Lesbian, Gay, Bisexual, and Transgender populations.

- Adoption of a wellness approach across the lifespan for all ethnic minorities and underserved populations in order to prevent depressive disorders and to facilitate recovery from traumatic life events.
- Inclusion of a community-defined evidence program for sexual-orientation minority youth.

B. General Project Outcomes

The tables below depict a more general summary of the project and program level outcomes and methods for measuring them.

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	• OUTCOMES	• METHOD/MEASURES OF SUCCESS
INDIVIDUAL	• Increase level of wellness • Improve medical regimen adherence • Decrease symptoms of mental illness • Decrease child abuse and neglect	• Client, therapist behavior and mood ratings • Physical health status • SCAN Reports
PROGRAM/SYSTEM	• Improve system-wide focus on wellness • Improve number of services to the underserved populations • Improve the integration of services across age groups and health/mental health sectors • Decrease level of stigma attached to mental illness	• Number of language specific programs available • Staffing ratios for primary languages • Measure of outreach and mental health promotion activities • Increase in the number of programs designed for special populations

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Cognitive Behavioral Therapy for Depression with Antidepressant Medication	• Decreased depressive symptoms and improved functioning	• Client, therapist depression ratings • Medication adherence
Family Coping Skills Program	• Decreased depressive symptoms	• Client, therapist depression ratings
GLBT CHAMPS: Comprehensive HIV & At-Risk Mental Health Services	• Improved medication management • Improved engagement in medical and mental health care • Improved mental health status • Improved housing and employment stability	• Client, therapist behavior ratings • Medical regimen adherence • Client, therapist depression and anxiety ratings
Group Cognitive Behavioral Therapy for Major Depression	• Decreased depressive symptoms; increased functioning	• Client self report on measures of depression and stress • Therapist GAF and other assessments

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
Nurse-Family Partnership	• Improved maternal prenatal health • Fewer injuries to children • Reduced child abuse and neglect • Reduced arrests among mothers • Reducing arrests among adolescents of mothers participating in NFP	• Nurse ratings • SCAN reports • Maternal health status • Child health status • Maternal self report on depression scale
Nurturing Parenting Programs	• Positive changes in parenting and childrearing attitudes • Clear differentiation of parent-child roles • Decrease in the use of corporal punishment	• Child/Parent ratings • SCAN reports
Prolonged Exposure Therapy for PTSD	• Reduced severity of trauma symptoms • Significantly reduced symptoms of depression • Improved social adjustment • Reduced anxiety symptoms	• Client self report of anxiety and depression • Therapist ratings
Trauma Focused Cognitive Behavioral Therapy	• Decreased child behavior problems • Decreased trauma symptoms • Decreased depression • Improved social competence	• Child, parent, teacher ratings • Therapist assessment • SCAN reports

C. Long Term Project Outcomes

The long-term goal of the Underserved Populations Project is to address mental health disparities seen across underserved populations. Over time, a main expected outcome includes the expansion of services for these populations in terms of number and the ability to provide services in a culturally and linguistically capable manner. Because the issue of mental health stigma is a difficult barrier for various culturally populations, one would expect to see individually tailored outreach strategies to these populations in a variety of natural settings. Overall, the project aims at increasing the number, awareness, and the acceptance of mental health programs for underserved communities.

8. COORDINATION WITH OTHER MHSA COMPONENTS

A. Coordination with CSS

As part of their orientation, providers will be trained in the range of mental health services available in the County, including MHSA programs. As consumer/client needs are identified, providers will refer the children, youth, adults, older adults parents, and other caregivers to appropriate MHSA Community Services and Supports programs,

such as Full Service Partnerships, field-capable clinical services, juvenile justice linkages/collaboration, and alternative crisis services.

B. Intended Use of WET Funds

TAY, adults, parents, and other caregivers will be given information about relevant programs in the Workforce, Education and Training Plan, as appropriate given their expressed desire to enhance their education and/or vocational goals and meet the criteria to qualify.

C. Intended Use of Capital Facilities and Technology Funds

The County does not intend to use Capital Facilities and Technology Funds for this PEI Project at this time.

9. ADDITIONAL COMMENTS (OPTIONAL)

County: Los Angeles

PEI Project 10: AMERICAN INDIAN PROJECT

Date:

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☒	☐	☐
4. Stigma and Discrimination	☒	☒	☐	☐
5. Suicide Risk	☒	☒	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition -age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☒	☐	☐
4. Children and Youth at Risk for School Failure	☒	☒	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒	☐	☐
6. Underserved Cultural Populations	☒	☒	☒	☒

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s)

Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project. As part of a multi-modal assessment, data was gathered formally through a stakeholder poll, a series of key individual interviews, a series of focus groups, and several community forums. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI.

In order to proceed with project-building, the community assessment information was made available to the participants at the Countywide Community Forum, in particular the American Indian breakout group and the Countywide Ad Hoc Steering Committee that further refined population, age, and program selections. The American Indian Project emerged from these final sets of recommendations and reflects the needs of the American Indian populations throughout the county. The main components of the needs assessment are discussed below as they relate to these specific patterns of responses that led to the creation of the American Indian Project.

(1) Stakeholder Input

(a) Key Individual Interviews

► Input Regarding Priority Population. Key individuals with knowledge and experience of the underserved American Indian population recommended that a prevention and early intervention project be developed in order to address the access issues related to this underserved population's mental health needs. Below are paraphrased examples of the Key Individual responses:

- *LA has the largest American Indian population in the United States, estimated to number approximately 200k. The data is very skewed and may not be completely reliable. The largest part of the community is low income, terribly needy, has a short life span, and is largely disenfranchised. All of the people I raised my children with are dead. Older adult for this community is 55. One in 6 people from this community are on Skid Row—many homeless American Indians also live in the Long Beach area. There is a significant lack of cultural competence historically, in the way services have been provided to this population. There are still significant levels of distrust among this population due (in part) to historical events and systemic exploitation.*

► Input Regarding Age Groups. Key Individuals generally stated that services to the American Indian population should target all age groups, though perhaps the most

pressing needs were found in the children's age group. Below are paraphrased examples of this:

- *When you talk about prenatal to five, you are really teaching their parents to parent.*
- *Perhaps prenatal to 15 or so - I think this population is in real trouble long before then, but perhaps this is our last best chance to pull them back…give them some real help that will strengthen their core values.*

(b) Focus Group Interviews

► Input Regarding Priority Population. Similar to the Key Individual Interviews mentioned above, Focus Groups with knowledge and experience of the underserved American Indian population pointed to the creation of a prevention and early intervention project. Below are paraphrased examples of the focus group responses:

- *One respondent explained that help is needed in transferring Indian values into jobs. Often Indian values get lost or as one participant explained, it is hard for Native Americans to adjust to mainstream American values.*
- *Increased comprehensive mental health services for the Indian/Native American throughout the county is needed. "We can't take referrals from Lancaster! There needs to be training to assist clinicians to recognize specific needs with a self-identified American Indian on what to do or how to treat them…people don't know what it's like to be American Indian…they need someone they can talk to, to connect with someone who understands what it means to be Indian."*
- *Some of what is needed includes more substance abuse assistance and programs for youth and families; a physical space or center for the Native American community that includes an outdoor space for ceremonies and sports programs for youth. The group reported that increased parent involvement and sharing of culture and history were important and specific programs for constructive social activities for youth and anger management were needed. The need for a central meeting space where everyone can come together was greatly emphasized.*
- *Some participants talked about how Native American girls are becoming more involved with gangs, sex, and drugs. They reported watching these girls turn into young women who have children and expose them to gang life, causing a multi-generational impact.*

► Input Regarding Age Groups. Focus group input suggested that programs which targeted the entire family were needed. As the above excerpts indicate, there was particular emphasis on programs to assist youth through older adulthood. The importance of all age groups and their place in American Indian culture is implicit throughout group responses.

(c) Community Forum Recommendations

► Input Regarding Sub-populations. Countywide Community Forum attendees in the American Indian breakout group were asked to prioritize PEI populations, age groups, and strategies. These selections were then used by the Countywide Ad Hoc Steering Committee members in making program selection recommendations. Below are the priority strategies for American Indians.

- *Promotion of healthy youth development, including cultural, spiritual, physical, and emotional health.*
- *Utilization of the American Indian Center as a cross-training center; and, increased use of American Indian paraprofessionals and volunteers to reach geographically isolated community members, and to spearhead a movement towards greater awareness of wellness.*

(d) Ad Hoc Steering Committee Recommendations

► Input Regarding Sub-populations. The Steering Committee identified targeted American Indian sub-populations that should be served:

- *Children/families that lack information and access to resources, including culturally-relevant healthcare.*
- *Children suffering from child abuse, families with domestic violence, and families impacted by substance use.*
- *Persons experiencing domestic violence and/or substance use.*
- *Acculturating populations and/or populations experiencing a transitory living situation, including the homeless.*
- *Persons experiencing domestic violence and/or substance use.*
- *Acculturating populations and/or populations experiencing a transitory living situation, including the homeless.*

(2) Data Analysis

(a) Statistical and Demographic Indicators

Together with the Key Individual Interviews and Focus Groups responses presented above, the following indicators were found to be confirm the need for the creation of a project focused on the needs of the underserved American Indian population. The *Vulnerable Communities*, Key Individuals, and Focus Group data were excerpted for Community Forum attendees and Ad Hoc Steering Committee members to assist in their deliberations. The following selected demographic variables and risk factors demonstrate the need for services: Ethnicity, Poverty, Depressive Disorders Statistics, Co-occurring Disorders Statistics, Posttraumatic Stress Disorder Statistics, High School Dropout Rates, and Deaths by Suicide Statistics.

(b) Ethnic Distribution

Historically, US Government agencies have had difficulty in accurately counting the American Indian population. One estimate yielded a count of 150,000 American Indians/Alaskan Natives for Los Angeles County as of July 1, 2006, making it the most populous county in the nation with regard to this population. Throughout the county, the American Indian/Alaskan Native-Non-Hispanic (AIANNH) population accounted for 0.2% of the total population (2005). In Service Areas 5, 6, 7, the AIANNH population accounted for 0.1% of each area's respective population. In Service Area 8, the AIANNH population accounted for 0.2% of the area's population. In Service Areas 1, 2, 4, the AIANNH population accounted for 0.3% of each area's respective population. Across the county, 29.4% of the AIANNH population resided in Service Area 2. This was followed by Service Area 4, 17.9%; Service Area 8, 17.3%; Service Area 3, 12.9%; Service Area 7, 8.3%; Service Area 6, 5.7%; Service Area 1, 5.3%; and Service Area 5, 3.2%.

(c) Mental Health Penetration Rate

"A penetration rate provides an indicator of whether persons with mental illness are receiving services and whether the system is responsive to various consumer populations." (McGee, 2002). Overall, the countywide penetration rate was 0.34, which may be read it as a measure of how well a mental health system of care can serve the local SMI population. In general, larger numbers reflect greater penetration into the SMI population. But, it is important to understand that even at a penetration rate at or above 100%, one cannot be certain that all individuals with SMI are necessarily being served. To be sure, one would need to analyze individual client records to ascertain diagnoses, assess levels of functional impairment, and levels of treatment. Still the penetration rate figures are important to consider since they can point to disparities across county regions and across ethnic groups. Countywide, there was wide variation in penetration rates seen across ethnic groups. The overall Penetration Rate for the county was 0.34. Across ethnicities, the Native American population penetration rate was 0.47.

(d) Depressive Disorders

Depressive disorders rank as the most debilitating mental health disorders worldwide in terms of disease burden. The World Health Organization reported that, "Depression is the leading cause of disability as measured by Years Lived with a Disability (YLD) and the 4th leading contributor to the global burden of disease in 2000. By the year 2020, depression is projected to reach 2nd place of the ranking of Disability Adjusted Life Years (DALYs, the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability) calculated for all ages, both sexes. Today, depression is already the 2nd cause of DALYs in the age category 15-44 years for both sexes combined." Depressive disorders are associated with poorer outcomes in terms of physical health, economic well-being, school achievement, co-occurring disorders,

and criminal behavior. Additionally, research has indicated that ethnic disparities exist in terms of depression treatment with African-American and Hispanic clients receiving treatment at a lower rate than for Whites (Simpson, S. M., Krishnan, L. L., Kunik, M. E., & Ruiz, P. (2007). Across the county, the Native American population accounted for 0.6% of all individuals treated for a depressive disorder (2006-07). A total of 45.8% of all Native Americans treated for a depressive disorder received services in Service Area 7. Service Area 6 (3.6%) treated the fewest Native Americans in the county.

(e) Co-Occurring Disorders (COD)

CODs are difficult to treat and are associated with unfavorable outcomes in economic status, health status, mental health disorders, and family relations. Individuals with COD have a greater likelihood of dropping out of school or becoming involved in criminal behavior. Treatment-resistant COD can lead to heavy and repeated service utilization for inpatient and outpatient episodes. Across the county, the Native American population accounted for 0.6% of all individuals treated for a COD. Native Americans treated for COD accounted for over 1% of clients served in Service Areas 4 and 7. Across the county, Service Area 4 saw the largest proportion (36.1%) of Native Americans with a COD. This was followed by Service Area 7 (21.4%). Service Area 5 saw the fewest numbers of Native Americans with a COD (0.5%).

(f) Poverty

Research on neighborhood effects demonstrates that socio-economic status is an important predictor of behavioral, mental health and academic outcomes for children (Leventhal & Brooks-Gunn, 2000; Wadsworth & Achenbach, 2005).Children and adolescents residing in impoverished areas are more likely to developmental disorders, commit crimes, and have problems in school. Adults in disadvantaged neighborhoods have been found to be more likely to develop major depression and substance abuse disorders (Silver, Mulvey, Swanson, 2002). County summary figures indicated that poverty is widespread and disproportionately affects ethnic minority populations. Across the county, 28.4% of the American Indian population was living below the 200% FPL. In particular, Service Area 6 saw 66.8% of the American Indian population living below the 200% FPL. Across the county, American Indians living below the 200% FPL accounted for 0.3% of the total poverty population.

(g) Posttraumatic Stress Disorder

Across the county, Native Americans accounted for 0.6% of all clients treated for PTSD. Service Area 4 treated the largest proportion of Native Americans with PTSD (36.1%) followed by Service Area 7 (21.4%). Service Area 5 treated the fewest numbers of Native Americans (0.5%) across the county.

(h) Homelessness

Homeless individuals, especially homeless youth, represent one of the most vulnerable populations in the county. Research indicates that most homeless youth have experienced a trauma in their lives and most have endured multiple traumas (Gwadz, Nish, Leonard & Strauss, 2007; Stewart, Steiman, Cauce, Cochran, Whitbeck, & Hoyt, 2004). A great many of these children suffer from Posttraumatic Stress Disorder. The Greater Los Angeles Homeless Count estimated 156,380 individuals were homeless in Los Angeles County in 2007. Homelessness occurs in virtually all geographic locations and ethnic groups across the county. In four service areas (2, 3, 4 and 6) estimates were well over 20,000 individuals in each area; the majority of these individuals were unsheltered. In terms of age groupings, the most populous age category was individuals between the ages of 25-55 years, who accounted for 65.5% of the entire estimated homeless population. Children under the age of 18 accounted for 14.9% of the estimated homeless population. With respect to gender, adult males accounted for 69% of the estimated homeless population, adult females, 28.5%, and adult transgender individuals, 2.5%. 2% of the homeless population across the county are from the AIAN population.

(i) High School Dropout Rates

State figures indicated that over a quarter of all students in Los Angeles County drop out of high school over a four-year period. AIAN students had a 2006-07 drop-out rate of 36.1%, much higher than the countywide rate of about 25%.

(j) High School Graduation Rates

Across the county, 29.2% of AIAN students failed to graduate in 2004-05. Service Area 4 (60.9%) and Service Area 5 (51.9%) had the highest drop-out rates seen in the county. Additionally, several communities across the county saw graduation rates for AIAN students below 50%: the Burbank and La Tuna Canyon areas in Service Area 2, the Pasadena and Baldwin Park-Azusa-Duarte areas in Service Area 3, the Downtown area in Service Area 4, the Playa Vista area in Service Area 5, the Hancock N. area in Service Area 6, and the Long Beach N. area in Service Area 8.

(k) Deaths by Suicide

Reducing suicide risk is a key PEI mental health initiative. The number of completed suicides is important to consider since it may reveal neighborhood effects contributing to an individual's environmental stress. Completed suicides represent failures in the mental health system to identify and adequately treat individuals at risk. Suicide rates were calculated and standardized to the number of suicides/100,000 residents. Across the county, the suicide rate was 7.0. Data indicated that Service Area 5 had the highest suicide rate (10.6), followed by Service Area 1 (9.9) and Service Area 4 (8.4). By

inspection, a few trends were apparent: males were at higher risk than females, Whites and American Indians (10.2) were at higher risk than other ethnicities, and older adults were at higher risk than other age groups.

3. PEI PROJECT DESCRIPTION

A. Why the proposed PEI project – including key community need(s), priority population(s), desired outcomes and selected programs – addresses needs identified during the community program planning process

Stakeholders reviewed information generated from the county needs assessment, ranging from the well-informed key individual interviews to population demographic and behavioral statistics. The depth of needs among the American Indian population is clearly evident based on the reviewed data. Data sources consistently highlight the need for services for the American Indian population and its risk for social and mental disorders. In the county's needs assessment, many indicators demonstrated that the American Indian population suffered from a disproportionate amount of problems of relevance for PEI. For instance, stakeholders learned that in terms of Depressive Disorders, Co-occurring Disorders, and Posttraumatic Stress Disorder, the American Indian population experienced at least 5-6 times the number of cases that population estimates accord them. The suicide rate for the American Indian population was well above the countywide rate. In terms of poverty, American Indians had about three times as many individuals living in poverty as population estimates would predict and 20 times as many homeless individuals as population estimates would predict.

In terms of youth populations, stakeholders learned that American Indian students were found to drop out of high school at a rate much higher than the countywide average. In two out of the eight county service areas, more American Indians dropped out of school rather than completed school. By listening to the stated needs and desires of community stakeholders through key individual interviews, focus groups, and forums spread throughout the county, across planning sectors, age groups, and decision-making groups, prioritizing solutions to address the American Indian population became possible. Some of the comments LACDMH received with regard to the population are extracted above and show the intensity of stakeholder convictions that an American Indian project was needed.

Project Purpose. The American Indian Project will (1) build resiliency and increase protective factors among children, youth and their families; (2) address stressful forces in children/youth lives, teaching coping skills, and divert suicide attempts; and (3) identify as early as possible children and youth who have risk factors for mental illness. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; offer early mental health intervention services at comfortable, non-stigmatizing localities; and involve multi-generations in the

American Indian children and youth's lives. An important emphasis is on preventing suicide among American Indian youth, given the high rate among this population.

PROJECT FOCUS	
Risk: Factors	Protective: Factors
• Poverty • Ethnicity • Geographic region • Family dysfunction, discord & violence • Peer rejection • Lack of social network • Mental health disorders • Alcohol/drug use • Familial history of suicide • Insecure attachment • Inter-generational acculturation differences • Victimization	• Coping skills • Family support • Social support • High achievement motivation • Sociability • Secure attachment • Family cohesion • Effective parenting • Self-efficacy

Project Components. Each project is comprised of the following components:

1. Outreach and Education – Providers will be required to conduct outreach and education activities about their program, especially in the critical start-up and early implementation stages.
2. Training and Technical Assistance – LACDMH training activities include information on County procedures, PEI information, and specific EBP/PP/CDE training as needed. Technical assistance in the area of program start-up, program requirements, referrals, collaboration and coordination will be initiated.
3. Data Collection, Outcomes, Monitoring and Evaluation – This component ensures that accurate data is captured on a systematic and ongoing basis so that the programs can be properly evaluated and their effectiveness measured against the identified outcomes. Program monitoring will be carried out to ensure that fidelity to the PEI program model is maintained and that proper procedures and policies are being followed.
4. PEI Programs – There are two American Indian programs that will be implemented throughout Los Angeles County.

Outreach and Engagement to Unserved and Underserved Communities. Because one of the overarching goals of the MHSA is the reduction of mental health disparities experienced by specific racial/ethnic and other cultural groups, all projects have been built with service components to achieve this end. The outreach and engagement component for each PEI project is a critical element in reducing disparities because it is primarily concerned with increasing access to programs, a first step in dismantling

barriers to services. The County strategy for outreach and engagement involves the utilization of existing County outreach workers, activating existing community resources and organizations, and the development of culturally and linguistically sensitive materials. All of these tools will be combined into a coordinated effort to seek out difficult to reach populations, educate groups regarding PEI programs, and facilitate entry into an appropriate program.

Outreach and engagement activities for the American Indian Project will include, but are not limited, to the following:

Community Leaders and Organizations

- Working with American Indian cultural brokers or community representatives to develop outreach strategies. LACDMH will seek input from the key individuals, focus group participants, and community organizations that participated in the planning process to identify and implement culturally and linguistically appropriate methods for reaching the targeted individuals in these unserved/underserved communities.
- Engaging local American Indian community leaders and gatekeepers, recognizing that many people in these communities lack knowledge of, distrust, and/or are reluctant to use mental health services. Personal contact with these individuals is a key method to increase community knowledge about PEI programs and to facilitate access to these programs.
- Providing information and training in small group settings (e.g. church, temple or other place of worship that has a primarily minority congregation) in local neighborhoods or ethnic community. These sites would be asked to host training and educational forums, bulletins for educational information, and people to serve as volunteers.

Educational Materials

- Developing educational materials about the Improving Access for the American Indian Project. The materials will be culturally relevant, at the appropriate literacy level, and visually accessible (large print and Braille). Community input will be sought in the approach and design of materials to ensure the materials are culturally sensitive.
- Distributing an information sheet about the outreach and engagement efforts, including outreach staff contact information as well as programs' contact information. These flyers will be distributed at meetings and posted in places where the target population is expected to congregate, such as American Indian community centers, youth clubs, health clinics, and so forth.
- Distributing press releases, informational articles, and paid advertising in local newspapers, radio, television, and websites.

Community Outreach Workers

- Collaborating with LACDMH's CSS outreach and engagement staff. Since the inception of the CSS programs, these individuals have developed relationships with numerous community providers. LACDMH will seek the assistance of these staff to provide community linkages for the PEI programs and distribution of information.
- Hiring and training American Indian outreach workers from the local communities.
- Recruiting and training volunteers from the community who are familiar with the unserved/underserved communities.

Partner Organizations

- Working though existing organizations, such as the American Indian Commission, American Indian Health Center, clubs, and other organizations.
- Collaborating with partner organizations to promote joint outreach efforts.
- Providing training or informational sessions to local organizations such as youth groups, social service organizations, and human service agencies, about the PEI programs.

American Indian Programs. The programs selected to address the American Indian population reflected attempts to attenuate the multi-faceted risk factors facing the youth population. American Indian Life Skills program was selected to decrease risk of suicide and improve school outcomes. Trauma Focused Cognitive Behavioral Therapy was selected for children less than 18 years who may live in families where domestic violence and/or alcohol/substance abuse is occurring or in families that are isolated from resources or homeless.

Prevention	Early Intervention
American Indian Life Skills	Trauma Focused Cognitive Behavioral Therapy: Honoring Children, Mending the Circle

❖ **American Indian Life Skills – Children and Transition-age Youth.** American Indian Life Skills is a prevention program serving American Indian children and youth in an urban environment. This EBP incorporates a school-based, culturally tailored curriculum for suicide prevention among American Indian youth. The intended outcomes are a reduction in feelings of hopelessness and improvement in suicide prevention skills for American Indian youth at risk of depression or suicide countywide.

❖ **Trauma Focused Cognitive Behavioral Therapy (TF-CBT): Honoring Children, Mending the Circle – Children and Transition-age Youth.** TF-CBT is a selective prevention and early intervention program with traditional aspects of healing with American Indians and Alaskan Natives from their world view included. This is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive

interventions with cognitive behavioral, family, and humanistic principles. Trauma Focused CBT is an EBP and will be implemented countywide.

❖ **Targeted Populations.** The table below describes the targeted populations for each of the American Indian Programs.

Program	SA	Age Group	Target Populations
American Indian Life Skills	Countywide	Children TAY	➢ American Indian Children and families that lack information and access to resources, including culturally-relevant healthcare. Another vulnerable group includes youth and TAY suffering from child abuse, families with domestic violence, and families impacted by substance abuse. ➢ American Indians throughout Los Angeles County.
Trauma Focused CBT: Honoring Children, Mending the Circle	Countywide	Children TAY	➢ American Indian trauma-exposed children, including children and families experiencing domestic violence and/or substance use. Another emphasis will be on acculturating populations and/or populations experiencing a transitory living situation, including the homeless. ➢ American Indians throughout Los Angeles County.

B. Implementation Partners and Type of Organization/Setting That Will Deliver the PEI Program and Interventions

The programs in the American Indian Project may be operated by schools, community-based organizations, mental health services providers, social service agencies, and other organizations selected through the County's competitive bidding process. Providers are expected to have strong connections, experience, and credibility in the American Indian community. It is anticipated that services will be delivered at school sites, community settings, tribal organization meeting places, and other places where American Indians are likely to congregate. Key implementation partners include local American Indian agencies, including the County American Indian Commission, United American Indian Involvement, American Indian Counseling Center (DMH), and the American Indian Health Center, among other American Indian organizations. Public agency implementation partners include the Los Angeles County Office of Education (LACOE), Los Angeles Unified School District (LAUSD), other local schools districts, and the participating schools where the services will be based. Other key partners may include the Los Angeles County Departments of Health and Public Health, and other health, mental health, and social services agencies. The selected agencies will be experienced or have the capacity to collaborate with other agencies to provide the PEI services. Should it be determined that additional mental health or other services not available at the site are needed or that more intensive mental health services are needed than the program offers, the PEI agency will be expected to confer with and refer the child/youth and his/her family to appropriate resources. Each PEI agency will

build collaborative relationships with a range of health, social service, mental health, educational, and other resources.

C. Target Community Demographics

This project will focus on the American Indian population in Los Angeles County. Through the *Vulnerable Communities* report the LACDMH was able to identify regions where American Indians reside. As mentioned earlier, government estimates placed the American Indian population in Los Angeles County at 150,000 individuals. Almost 30% of the entire American Indian population resides in Service Area 2. This is followed by Service Area 4 (17.9%), 8 (17.3%), 3 (12.9%), 7 (8.3%), 6 (5.7%), 1 (5.3%), 5 (3.2%).

D. Highlights of New and Expanded Programs

The American Indian Project programs are new programs that will be offered throughout the county at expanded or new sites that offer services to the target American Indian population. The Project offers an exciting opportunity to expand services to a community in much need, utilizing two culturally adapted EBPs and one specific local American Indian CDE programs that have expected and measurable outcomes. Although stakeholders have identified children and youth as the primary recipients of these PEI services, the services require the participation of other generations in the child and youth's family.

E. Action Plan

The American Indian Project will require the following start-up activities for contract agencies:

1. Solicit proposals through County bidding process
2. Establish partnerships with American Indian organizations, schools, agencies, health centers, and other partnerships
3. Establish MOUs or other contracts confirming partnerships and scope of activities as needed
4. Recruit and hire staff
5. Train staff in EBP/CDE model protocols
6. Conduct outreach and education

Specific activities for each PEI program are listed below.

Programs	Objectives: Frequency And Duration
American Indian Life Skills	• Conduct sessions with youth 3 times per week over 30 weeks.

Programs	Objectives: Frequency And Duration
Trauma Focused Cognitive Behavioral Therapy: Honoring Children, Mending the Circle	• Conduct 12-15 weekly one hour sessions for child and parent

F. Key Milestones and Timeline

1.	Develop Requests for Proposals/Requests for Services	Months 1-3
2.	Obtain County Counsel approval for RFPs/RFSs	Months 1-3
3.	Solicit proposals & evaluate proposals	Months 3-9
4.	Award proposals	Months 6-12
5.	Develop LACDMH PEI program and infrastructure	Months 1-3
6.	Recruitment, hiring and training of staff (LACDMH)	Months 1-6
7.	Implement programs	Months 6-12
8.	Conduct training on LACDMH requirements for agencies	Months 7-12
9.	Conduct training in EBP and CDE model protocols	Months 7-12
10.	Conduct outreach and education	Months 3-12
11.	Set up data collection procedures and requirements	Months 1-6
12.	Conduct quarterly PEI provider meetings	Month 12 and on

4. PROGRAMS

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
American Indian Life Skills	Individuals: 216 Families: 216	Individuals: Families:	4
Trauma Focused Cognitive Behavioral Therapy: Honoring Children, Mending the Circle	Individuals: Families:	Individuals: 200 Families: 200	4
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 216** **Families: 216**	**Individuals: 200** **Families: 200**	**4**

5. LINKAGES TO COUNTY MENTAL HEALTH AND PROVIDERS OF OTHER NEEDED SERVICES

A. Linking PEI Participants to Services

This project will provide information about mental health, other supportive services and community resources to the children, youth, and family members who participate in the PEI programs. In instances where children, youth, and/or their parents or caregivers are perceived to need mental health assessment or extended treatment for mental illness or emotional disturbance, the provider is responsible for identifying appropriate agencies, and where available, culturally appropriate organizations where these services can be provided. The provider will ensure that there is a direct referral and actual linkage with the referred agency so as to avoid creating additional barriers to services. These referrals will include mental health and primary care agencies as well as community-based organizations. Staff will help children, youth, parents, and other caregivers to articulate their needs and enhance their capacity to identify and connect with other appropriate services.

B. Linking PEI Participants to Non-Traditional Services

The American Indian Project will enable students and their parents and other caregivers to access prevention and early intervention community resources including educational, substance abuse, domestic violence, community support, housing, employment and other resources, particularly those provided by and for American Indians. Programs are expected to conduct a needs assessment at the onset and conclusion of services to identify needs in order to ensure that referrals are made to needed services. Staff will help children, youth, parents, and other caregivers to link to these services and follow up to ensure a connection has been made.

C. Sufficiency to Achieve Outcomes

DMH and CiMH conducted research on each of the EBP and CDE models to determine the costs for each program and ensure that the budget and program designs were adequate to achieve the required outcomes. The analysis also determined that program outcomes were in line with the project, State, SDMH, LACDMH, and community expectations. In the bidding process, agencies must demonstrate financial viability, organizational experience, management capability, and cultural competency to provide the services. All agencies selected to run the PEI programs will be required to

participate in LACDMH training, including cultural competence, EBPs, PEI policies, and LACDMH policies. Further, they will be required to collect needs assessment data and participate in the LACDMH evaluation protocols and activities in order to ensure the program is properly developed, clients are adequately serviced, and outcomes are achieved.

6. COLLABORATION AND SYSTEM ENHANCEMENTS

A. Relationships, Collaborations and Arrangements

The American Indian Project requires extensive collaboration with both government and private agencies and organizations, particularly those organizations involved in the American Indian communities. Collaborative relationships are expected to be sustained and/or developed with key local American Indian agencies, the County American Indian Commission, United American Indian Involvement, American Indian Counseling Center (DMH), American Indian Health Center, among other American Indian organizations. As needed, it is important that relationships be maintained or developed with staff who work within the American Indian groups including, teachers, nurses, social workers, and other educational processionals. The Departments of Health, Public Health, Children and Family Services, and Public Social Services as well as the Regional Centers and law enforcement agencies are key implementation partners. To encourage collaboration and promote new partnerships, CBOs and non-mental health providers will have an opportunity to provide input to government and private agencies, as well as to other American Indian organizations through monthly Service Area Advisory Committee meetings and Service Area Provider meetings. LACDMH currently has a special American Indian task force which meets monthly, ensuring that PEI services will have a place to seek guidance and collaboration.

PEI will also provide regularly held PEI Provider meetings that will be open to the community at large. PEI Provider meetings will encourage and facilitate sharing resources and promoting partnerships and will offer technical assistance on PEI program sustainability to the group and to individual providers as needed. Private agencies include health organizations, the Community Clinic Association of Los Angeles County, mental health providers, and other social service, health, and family organizations.

(1) Outreach Strategies

PEI will outreach to CBOs and non-mental health providers through SAAC meetings, Service Area Provider meetings, PEI Provider meetings, the DMH PEI website, the PEI newsletter and the PEI distribution database that has a current membership of over 6,800 individuals. Outreach efforts will serve to bring CBOs and non-mental health providers to the implementation phase.

(2) Improving Collaboration with CBOs and Non-Mental Health Providers

LACDMH has included community based organizations (CBOs) and non-mental health providers from the very inception of the PEI planning process. To bring these organizations into the implementation phase, LACDMH has four different approaches:

(a) Incubation Academy

This program was designed to assist community and local mental health service providers in obtaining contracts with the Department of Mental Health to build capacity within the mental health system. Comprehensive information, resource references, technical assistance, mentorship, and/or sponsorship opportunities are included in this program, as well as guidance regarding County contracting procedures, documentation, and day-to-day business operations requirements. .

(b) Master Agreement List Workshops

PEI Administration will hold a series of workshops to train prospective agencies, including CBOs, on how to qualify for inclusion on the Master Agreement list. The intention of this detailed workshop is to help agencies unfamiliar with county business practices clear the initial and sometimes confusing hurdles in becoming a contractor. As such, this training will include information on how to submit a Statement of Qualifications (SOQ) in response to a Request for Statement of Qualifications (RFSQ), and the ins and outs of the Requests for Services (RFS) process, the pathway by which they could ultimately provide PEI services.

(c) CDE Technical Assistance Workshops

PEI Administration will provide workshops to developers, including CBOs, whose programs were denied in the initial round of qualification. The workshops will focus on clarifying requirements for the CDE application, identification of outcome approaches, cultural practices, and procedures for resubmission. The intent of the CDE TA Workshops is to provide a hands-on step by step method for helping agencies develop and qualify their program as a CDE practice. In conjunction with this process, PEI Administration will work with developers on becoming an approved provider (i.e. qualifying for the Master Agreement List) as outlined above. Presently, the majority of qualified CDE developer agencies appear on the current Master Agreement List.

(d) Subcontracting

PEI administration recognizes that County minimum requirements to qualify for the Master Agreement List may not be met by many potential worthy MHSA/PEI service providers. In order to address those situations and for those CBOs who are not interested in obtaining a direct contract with LACDMH, another way for them to provide PEI services is to subcontract through an existing LACDMH provider. Additionally, this is an opportunity for small organizations to partner with and receive mentoring from experienced providers which in turn, may eventually lead to a direct contract with LACDMH.

B. Building Upon the Mental Health and Primary Care System

Expanded and new partnerships with mental health and primary care providers will be promoted through the American Indian Project. It is anticipated that the PEI programs will be situated at American Indian community centers or other locations already established in the County, as well as at new sites to be developed. The stigma associated with seeking mental health services can be minimized by providing these services at the American Indian community agencies. Children, youth, parents and caregivers will be given culturally appropriate information sources and referred to primary care providers as medical needs are identified.

C. Leveraging Resources

The American Indian Project will work with educational, health, and mental health agencies as well as with government funding agencies and private foundations to leverage resources for the American Indian programs. In the solicitation process, potential providers will be notified that agencies are expected to generate support and leveraged resources, such as space, equipment, staff, and volunteer time. LACDMH will give priority to those agencies that can demonstrate existing capacity and/or a systematic plan for generating resources in the bidding process.

D. Sustaining the PEI Project

Through the solicitation process, the County will determine the organizational and fiscal capacity of each agency to fiscally manage and sustain the PEI program. Continued funding of the program will be through MHSA PEI funds, as well as continuation of any leveraged funds, including in-kind resources and services. LACDMH will monitor the programs to ensure that outcomes are being met in a timely manner and that fiscal, program, and contract standards are adhered to as required.

7. INTENDED OUTCOMES

A. Specific Cultural Outcomes

Through its community mental health needs assessment, the county obtained a comprehensive understanding of the racial/ethnic and linguistic distribution of the population across fairly small geographic regions. The cultural diversity in the population required that the county carefully consider programs that could be implemented successfully for different ethnic and language groups. For this reason, when building each PEI project, programs were first identified on the basis of whether they had been developed with specific cultural populations included in their validated studies. Inclusion of cultural populations during development is crucial in order to demonstrate and later

realize the community effectiveness (i.e. generalizability) of a particular program for a specific population.

From there, program selections were made for each service area in accordance with the demographic profile of the area and the inputs received from the collection of local planning bodies mentioned earlier. As a result of this process, most individual outcomes directly involve underserved cultural populations as had been planned. In many cases due to the ethnic distribution across the county, these underserved cultural populations constitute, in fact, a majority in actual population estimates for a given region. So, programs residing in these areas will obviously impact these groups. Due to the inter-relationships between ethnicity, poverty, and other key indicators, locating programs within these areas is paramount and will be an important detail to note during the RFS process. To make this explicit, the following represents a sample of possible outcomes that can be expected for these specific populations based upon the programs selected in Los Angeles County:

- Augmentation of the collection of culturally sensitive programs for the American Indian population across the county to remove the stigma of mental illness.
- Reduction of suicidal ideation/behaviors in American Indian youth across the county.
- Improvement of high school graduation rates for American Indian youth across the county.
- Reduction of depressive symptoms and adverse effects of trauma exposure for American Indian children across the county.

B. General Project Outcomes

The tables below depict a more general summary of the project and program level outcomes and methods for measuring them.

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
INDIVIDUAL	• Decreased levels of depression • Decreased alcohol/substance abuse • Decreased child abuse and neglect • Decrease in the prevalence of mental health disorders • Improved school attendance and performance	• Child, parent, therapist behavior and mood ratings • Alcohol/substance use assessments • SCAN reports • School attendance and achievement reports
PROGRAM/SYSTEM	• Improve the number of services targeting the American Indian population • Provision of culturally relevant services for the American Indian population • Increased awareness in the community on the	• Number of mental health services available to the American Indian population • Client satisfaction ratings of the cultural appropriateness of services • Prevalence rates of mental health and

PROJECT OUTCOMES: Individual / Program / System		
PROJECT PRIORITIIES	OUTCOMES	METHOD/MEASURES OF SUCCESS
	importance of the cultural component for the American Indian population • Reduction in the prevalence of mental health disorders, especially depression and COD • Reduction of the American Indian suicide rate	substance abuse disorders • School dropout rates • Suicide rates

PROGRAM OUTCOMES		
PROGRAM	OUTCOMES	METHOD/MEASURES OF SUCCESS
American Indian Life Skills	• Decrease in hopelessness • Improvement in suicide prevention skills	• Adolescent, therapist depression ratings • Assessment of suicidal ideation • Assessment of alcohol/substance abuse use
Trauma Focused Cognitive Behavioral Therapy: Honoring Children, Mending the Circle	• Treatment goals to improve spiritual, mental, physical, emotional, and relational well-being	• Child, parent, teacher ratings • Therapist assessment • SCAN reports

C. Long Term Project Outcomes

One of the long-term project outcomes which the Department hopes to achieve as a result of the American Indian Project is feedback from the American Indian community that the provided services have been beneficial and culturally appropriate. It is important to expand services for this population, and one would expect to see an increase in the number of providers who can appropriately serve the population. Through these efforts, one would expect to see a decline in the prevalence of mental health and alcohol abuse disorders for the population. Related to this, one would also expect to see a decline in child abuse rates, domestic violence, and suicide rates. System-wide, one would expect to see a general rise in the cultural acceptance of mental health disorders and treatment within the American Indian population as stigma against mental illness declines.

8. COORDINATION WITH OTHER MHSA COMPONENTS

A. Coordination with CSS

As part of their orientation, providers will be trained in the range of mental health services available in the County, including MHSA programs. As children, youth and their family/caregiver needs are identified, providers will refer them to appropriate MHSA Community Services and Supports programs, such as the Full Service

Partnerships for children, TAY, adults and older adults, juvenile justice linkages/collaboration, and alternative crisis services.

B. Intended Use of WET Funds

Students, parents, and other caregivers will be given information about relevant programs in the Workforce, Education and Training Plan, as appropriate given their expressed desire to enhance their education and/or vocational goals and meet the criteria to qualify.

C. Intended Use of Capital Facilities and Technology Funds

The County does not intend to use Capital Facilities and Technology Funds for this PEI Project at this time.

9. ADDITIONAL COMMENTS (OPTIONAL)

FY 2009/10 Mental Health Services Act
Summary Funding Request

County: **Los Angeles County** Date: 6/30/2009

	MHSA Component				
	CSS	**CFTN**	**WET**	**PEI**	**Inn**
A. FY 2009/10 Planning Estimates					
1. Published Planning Estimate[a/]					
2. Transfers[b/]					
3. Adjusted Planning Estimates	$0	$0	$0	$0	$0
B. FY 2009/10 Funding Request					
1. Required Funding in FY 2009/10[c/]				$121,661,559	
2. Net Available Unspent Funds					
a. Unspent FY 2007/08 Funds[d/]				$19,034,052	
b. Adjustment for FY 2008/09[e/]				$19,034,052	
c. Total Net Available Unspent Funds	$0	$0	$0	$0	$0
3. Total FY 2009/10 Funding Request	**$0**	**$0**	**$0**	**$121,661,559**	**$0**
C. Funding					
1. Unapproved FY 06/07 Planning Estimates					
2. Unapproved FY 07/08 Planning Estimates				**$0**	
3. Unapproved FY 08/09 Planning Estimates (a)				**$65,335,400**	
4. Unapproved FY 09/10 Planning Estimates				**$56,326,159**	
5. Total Funding[f/]	**$0**	**$0**	**$0**	**$121,661,559**	**$0**

Note (a): PEI Early Start, $17,617,600 has been included in FY 2009/10 Annual State Update; $17,617,600 is excluded in Unapproved Planning Estimates for FY 07/08 & FY 08/09.

a/ Published in DMH Information Notices
b/ CSS funds may be transferred to CFTN, WET and Prudent Reserve up to the limits specified in WIC 5892b.
c/ From Total Required Funding line of Exhibit E for each component
d/ From FY 2007/08 MHSA Revenue and Expenditure Report
e/ Adjustments for FY 2008/09 additional expenditures and/or lower revenues than budgeted
f/ Must equal line B.3., Total FY 2009/10 Funding Request, for each component

FY 2009/10 Mental Health Services Act
Prevention and Early Intervention Funding Request

County: Los Angeles Date: 6/30/2009

	PEI Work Plans		FY 09/10 Required MHSA Funding	Estimated MHSA Funds by Type of Intervention			Estimated MHSA Funds by Age Group			
	No.	Name		Universal Prevention	Selected/ Indicated Prevention	Early Intervention	Children, Youth, and Their Families	Transition Age Youth	Adult	Older Adult
1.	PEI-1	School-based Services	$ 8,606,785	$ 645,962	$ 2,595,391	$ 5,365,432	$ 7,924,392	$ 682,393	$ -	$ -
2.	PEI-2	Family Education and Support Services	$ 11,324,296	$ 143,451	$ 7,062,726	$ 4,118,119	$ 10,006,763	$ 1,317,533	$ -	$ -
3.	PEI-3	At-risk Family Services	$ 10,780,932	$ 1,268,828	$ 3,666,218	$ 5,845,886	$ 9,003,198	$ -	$ 1,777,734	$ -
4.	PEI-4	Trauma Recovery Services	$ 26,790,611	$ -	$ 420,605	$ 26,370,006	$ 8,416,031	$ 4,034,407	$ 7,458,465	$ 6,881,708
5.	PEI-5	Primary Care & Behavioral Health	$ 5,475,984	$ 193,023	$ 1,733,201	$ 3,549,760	$ 510,418	$ 53,474	$ 3,515,085	$ 1,397,007
6.	PEI-6	Early Care & Support for TAY	$ 9,017,928	$ 945,357	$ 2,717,009	$ 5,355,562	$ -	$ 9,017,928	$ -	$ -
7.	PEI-7	Juvenile Justice Services	$ 10,663,120	$ 72,000	$ 624,957	$ 9,966,163	$ 3,093,355	$ 7,569,765	$ -	$ -
8.	PEI-8	Early Care & Support for Older Adults	$ 9,026,660	$ -	$ 3,331,257	$ 5,695,403	$ -	$ -	$ -	$ 9,026,660
9.	PEI-9	Improving Access for Underserved Populations	$ 7,243,176	$ -	$ 2,947,936	$ 4,295,240	$ 1,185,719	$ 1,141,026	$ 4,734,302	$ 182,129
10.	PEI-10	American Indian Project	$ 990,000	$ 495,000	$ -	$ 495,000	$ 495,000	$ 495,000	$ -	$ -
11.										
12.										
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20.										
21.										
22.										
23.										
24.										
25.										
26.	**Subtotal: Work Plans[a/]**		**$ 99,919,492**	$ 3,763,621	$ 25,099,300	$ 71,056,571	$ 40,634,876	$ 24,311,526	$ 17,485,586	$ 17,487,504
27.	**Plus County Administration**		**$ 10,681,925**							
28.	**Plus Optional 10% Operating Reserve**		**$ 11,060,142**							
31.	**Total MHSA Funds Required for PEI**		**$ 121,661,559**							

a/ Majority of funds must be directed towards individuals under age 25--children, youth and their families and transition age youth. Percent of Funds directed towards those under 25 years= 65.00%

Note: PEI Early Start, $17,617,600 has been included in FY 2009/10 Annual State Update ($17,617,600 is excluded from this PEI Funding Request).

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Los Angeles** Date: 6/30/2009

PEI Project Name: **School-based Services**

Provider Name (if known): **County of Los Angeles Department of Mental Health**

Intended Provider Category: **County agency**

Proposed Total Number of Individuals and Families to be served:	FY 09-10	87,505
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	0
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget	
Proposed Expenses and Revenues	FY 09-10	Total
A. Expenditure		
1. Personnel (list classifications and FTEs)		
a. Salaries, Wages		
10 FTE Psychiatric Social Worker II (9035)	$ 758,608	$ 758,608
2 FTE Senior Community Worker II (8105)	$ 90,702	$ 90,702
0.65 FTE Mental Health Services Coordinator II (8149)	$ 49,187	$ 49,187
0.325 Secretary III (2096)	$ 15,361	$ 15,361
b. Benefits and Taxes @ 19.27%	$ 176,100	$ 176,100
c. Total Personnel Expenditures	$ 1,089,958	$ 1,089,958
2. Operating Expenditures		
a. Facility Cost	$ 259,493	$ 259,493
b. Other Operating Expenses	$ 90,147	$ 90,147
c. Total Operating Expenses	$ 349,640	$ 349,640
3. Subcontracts/Professional Services (list/itemize all subcontracts)		
Families and Schools Together	$ 839,364	$ 839,364
Olweus Bullying Prevention Program	$ 286,042	$ 286,042
Psychological First-Aid	$ 474,292	$ 474,292
Aggression Replacement Training	$ 1,057,321	$ 1,057,321
Early Risers Skills for Success	$ 1,864,929	$ 1,864,929
Multidimensional Family Therapy	$ 643,368	$ 643,368
Cognitive Behavioral Intervention for Trauma in Schools	$ 879,741	$ 879,741
Why Try? Program	$ 664,707	$ 664,707
Strengthening Families	$ 457,423	$ 457,423
a. Total Subcontracts	$ 7,167,187	$ 7,167,187
4. Total Proposed PEI Project Budget	$ 8,606,785	$ 8,606,785
B. Revenues (list/itemize by fund source)		
* To be determined (see comment on following page)		
1. Total Revenue	$ -	$ -
5. Total Funding Requested for PEI Project	$ 8,606,785	$ 8,606,785
6. Total In-Kind Contributions	$ -	$ -

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

B. Revenues (list/itemize by fund source)
* Exact sources, types, and amounts of leveraging for this project will be determined during implementation. Potential sources of leveraging include: School districts' health/counseling and other discretionary funding; California Endowment; Los Angeles Trust funds; Healthy Kids; SAMHSA Safe Schools; Los Angeles County Department of Health Services; Headstart; Early Start; Federally Qualified Health Centers; CBO's discretionary funding and assets (maximum leveraging of 25% of PEI funding)

1. SCHOOL-BASED SERVICES

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.1.a	10 FTE - Psychiatric Social Worker II ($758,608) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes. 2 FTE - Senior Community Worker II ($90,702) Provides support to individuals and their families in engaging in mental health early intervention and preventive evidence based practices, promising practices, and community defined practices. 0.65 FTE - Mental Health Service Coordinator II ($49,187) Provides coordination, linkage, engagement, and outreach between individuals, families, agencies community organizations, and county programs who provide evidence based practices, promising practices, and community defines practices ensuring access to these services. 0.325 FTE - Secretary III ($15,361) Provides full-time secretarial assistance to staff by scheduling meetings, taking minutes, following up on assignments, preparing correspondence, etc.
A.1.b	Benefits and Taxes at 19.27% - $176,100
A.1.c	Total Personnel Expenditures - These dollars ($1,089,958) will be used to fund new infrastructure for program development and administration.
A.2.c	Total Operating Expenses - These dollars ($349,640) will be used to fund the services and supplies for the new infrastructure/administration positions. This includes space, computers, local printers, training, office supplies, estimated

	mileage, travel, mobile communications, county telephone, telecom system, etc.
A.3.a	Total Subcontracts - These dollars ($7,167,187) will be used to support School-based Services.
A.4	Total Proposed PEI Project Budget - $8,606,785
B.5	Total Funding Requested for PEI Project - $8,606,785

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Los Angeles** Date: 6/30/2009

PEI Project Name: **Family Education, Training and Support Services**

Provider Name (if known): **County of Los Angeles Department of Mental Health**

Intended Provider Category: **County agency**

Proposed Total Number of Individuals and Families to be served:	FY 09-10	431,982
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	0
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget	
Proposed Expenses and Revenues	FY 09-10	Total
A. Expenditure		
1. Personnel (list classifications and FTEs)		
a. Salaries, Wages		
9 FTE Psychiatric Social Worker II (9035)	$ 682,747	$ 682,747
4 FTE Senior Community Worker II (8105)	$ 181,405	$ 181,405
1 FTE Mental Health Services Coordinator II (8149)	$ 75,672	$ 75,672
0.5 Secretary III (2096)	$ 23,633	$ 23,633
b. Benefits and Taxes @ 19.27%	$ 185,658	$ 185,658
c. Total Personnel Expenditures	$ 1,149,115	$ 1,149,115
2. Operating Expenditures		
a. Facility Cost	$ 288,350	$ 288,350
b. Other Operating Expenses	$ 201,094	$ 201,094
c. Total Operating Expenses	$ 489,444	$ 489,444
3. Subcontracts/Professional Services (list/itemize all subcontracts)		
Caring for Our Families	$ 1,378,552	$ 1,378,552
Incredible Years	$ 3,729,835	$ 3,729,835
Nurse-Family Partnership	$ 4,167,490	$ 4,167,490
Triple P Positive Parenting Program	$ 409,860	$ 409,860
a. Total Subcontracts	$ 9,685,737	$ 9,685,737
4. Total Proposed PEI Project Budget	$ 11,324,296	$ 11,324,296
B. Revenues (list/itemize by fund source)		
* To be determined (see comment on following page)		
	$ -	$ -
	$ -	$ -
1. Total Revenue	$ -	$ -
5. Total Funding Requested for PEI Project	$ 11,324,296	$ 11,324,296
6. Total In-Kind Contributions	$ -	$ -

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

B. Revenues (list/itemize by fund source)
* Exact sources, types, and amounts of leveraging for this project will be determined during implementation. Potential sources of leveraging include: First 5 L.A.; Los Angeles County Department of Public Health; Head Start; Early Start; childcare centers; Los Angeles County Department of Parks and Recreation; CBO's discretionary funding and assets (maximum leveraging of 25% of PEI funding).

2. FAMILY EDUCATION, TRAINING & SUPPORT SERVICES

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.1.a	9 FTE - Psychiatric Social Worker II ($682,747) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes. 4 FTE - Senior Community Worker II ($181,405) Provides support to individuals and their families in engaging in mental health early intervention and preventive evidence based practices, promising practices, and community defined practices. 1 FTE - Mental Health Service Coordinator II ($75,672) Provides coordination, linkage, engagement, and outreach between individuals, families, agencies community organizations, and county programs who provide evidence based practices, promising practices, and community defines practices ensuring access to these services. 0.5 FTE - Secretary III ($23,633) Provides full-time secretarial assistance to staff by scheduling meetings, taking minutes, following up on assignments, preparing correspondence, etc.
A.1.b	Benefits and Taxes at 19.27% - $185,658
A.1.c	Total Personnel Expenditures - These dollars ($1,149,115) will be used to fund new infrastructure for program development and administration.
A.2.c	Total Operating Expenses - These dollars ($489,444) will be used to fund the services and supplies for the new infrastructure/administration positions. This includes space, computers, local printers, training, office supplies, estimated

	mileage, travel, mobile communications, county telephone, telecom system, etc.
A.3.a	Total Subcontracts - These dollars ($9,685,737) will be used to support Family Education and Support Services.
A.4	Total Proposed PEI Project Budget - $11,324,296
B.5	Total Funding Requested for PEI Project - $11,324,296

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Los Angeles** Date: 6/30/2009

PEI Project Name: **At-risk Family Services**

Provider Name (if known): **County of Los Angeles Department of Mental Health**

Intended Provider Category: **County agency**

Proposed Total Number of Individuals and Families to be served:	FY 09-10	192,632
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	0
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget	
Proposed Expenses and Revenues	FY 09-10	Total
A. Expenditure		
1. Personnel (list classifications and FTEs)		
a. Salaries, Wages		
18 FTE Psychiatric Social Worker II (9035)	$ 1,365,494	$ 1,365,494
1.05 FTE Mental Health Services Coordinator II (8149)	$ 79,456	$ 79,456
0.525 Secretary III (2096)	$ 24,815	$ 24,815
		$ -
b. Benefits and Taxes @ 19.27%	$ 283,223	$ 283,223
c. Total Personnel Expenditures	$ 1,752,987	$ 1,752,987
2. Operating Expenditures		
a. Facility Cost	$ 391,073	$ 391,073
b. Other Operating Expenses	$ 483,891	$ 483,891
c. Total Operating Expenses	$ 874,964	$ 874,964
3. Subcontracts/Professional Services (list/itemize all subcontracts)		
Group Cognitive Behavioral Therapy for Major Depression	$ 427,867	$ 427,867
Incredible Years	$ 1,589,575	$ 1,589,575
Making Parenting a Pleasure	$ 442,451	$ 442,451
Parent-Child Interaction Therapy	$ 989,521	$ 989,521
Reflective Parenting Program	$ 1,780,694	$ 1,780,694
Triple P Positive Parenting Program	$ 2,361,076	$ 2,361,076
UCLA Ties Transition Model	$ 561,797	$ 561,797
a. Total Subcontracts	$ 8,152,981	$ 8,152,981
4. Total Proposed PEI Project Budget	$ 10,780,932	$ 10,780,932
B. Revenues (list/itemize by fund source)		
* To be determined (see comment on following page)		
	$ -	$ -
	$ -	$ -
1. Total Revenue	$ -	$ -
5. Total Funding Requested for PEI Project	$ 10,780,932	$ 10,780,932
6. Total In-Kind Contributions	$ -	$ -

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

B. Revenues (list/itemize by fund source)
* Exact sources, types, and amounts of leveraging for this project will be determined during implementation. Potential sources of leveraging include: Title IV E funding; Los Angeles County Department of Children and Family Services (Child Welfare); School Districts' health/counseling funding and other discretionary funding; Early and Periodic Screening, Diagnosis and Treatment (EPSDT); Los Angeles County Department of Parks and Recreation; CBO's discretionary funding and assets (maximum leveraging of 25% funding).

3. AT-RISK FAMILY SERVICES

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.1.a	18 FTE - Psychiatric Social Worker II ($1,365,494) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes. 1.05 FTE - Mental Health Service Coordinator II ($79,456) Provides coordination, linkage, engagement, and outreach between individuals, families, agencies community organizations, and county programs who provide evidence based practices, promising practices, and community defines practices ensuring access to these services. 0.525 FTE - Secretary III ($24,815) Provides full-time secretarial assistance to staff by scheduling meetings, taking minutes, following up on assignments, preparing correspondence, etc.
A.1.b	Benefits and Taxes at 19.27% - $283,223
A.1.c	Total Personnel Expenditures - These dollars ($1,752,987) will be used to fund new infrastructure for program development and administration.
A.2.c	Total Operating Expenses - These dollars ($874,964) will be used to fund the services and supplies for the new infrastructure/administration positions. This includes space, computers, local printers, training, office supplies, estimated mileage, travel, mobile communications, county telephone, telecom system, etc.
A.3.a	Total Subcontracts – These dollars ($8,152,981) will be used to support At-Risk Family Services.

A.4	Total Proposed PEI Project Budget – $10,780,932
B.5	Total Funding Requested for PEI Project - $10,780,932

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Los Angeles** Date: 6/30/2009

PEI Project Name: **Trauma Recovery Services**

Provider Name (if known): **County of Los Angeles Department of Mental Health**

Intended Provider Category: **County agency**

Proposed Total Number of Individuals and Families to be served:	FY 09-10	24,809
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	0
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget	
Proposed Expenses and Revenues	FY 09-10	Total
A. Expenditure		
1. Personnel (list classifications and FTEs)		
a. Salaries, Wages		
41.5 FTE Supervising Psychiatric Social Worker II (9038)	$ 3,517,419	$ 3,517,419
109 FTE Psychiatric Social Worker II (9035)	$ 8,268,823	$ 8,268,823
12.15 FTE Mental Health Services Coordinator II (8149)	$ 919,415	$ 919,415
5.075 Secretary III (2096)	$ 239,874	$ 239,874
b. Benefits and Taxes @ 19.27%	$ 2,494,604	$ 2,494,604
c. Total Personnel Expenditures	$ 15,440,135	$ 15,440,135
2. Operating Expenditures		
a. Facility Cost	$ 3,335,918	$ 3,335,918
b. Other Operating Expenses	$ 741,586	$ 741,586
c. Total Operating Expenses	$ 4,077,504	$ 4,077,504
3. Subcontracts/Professional Services (list/itemize all subcontracts)		
Child-Parent Psychotherapy	$ 1,704,489	$ 1,704,489
Group Cognitive Behavioral Therapy for Major Depression	$ 139,627	$ 139,627
Parent-Child Interaction Therapy	$ 1,965,336	$ 1,965,336
Prolonged Exposure Therapy for PTSD	$ 2,480,008	$ 2,480,008
System Navigators	$ 374,528	$ 374,528
Trauma Focused Cognitive Behavioral Therapy	$ 608,984	$ 608,984
a. Total Subcontracts	$ 7,272,972	$ 7,272,972
4. Total Proposed PEI Project Budget	$ 26,790,611	$ 26,790,611
B. Revenues (list/itemize by fund source)		
* To be determined (see comment on following page)		
	$ -	$ -
	$ -	$ -
1. Total Revenue	$ -	$ -
5. Total Funding Requested for PEI Project	$ 26,790,611	$ 26,790,611
6. Total In-Kind Contributions	$ -	$ -

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

B. Revenues (list/itemize by fund source)
* Exact sources, types, and amounts of leveraging for this project will be determined during implementation. Potential sources of leveraging include: Veterans Administration funding; Early and Periodic Screening, Diagnosis and Treatment (EPSDT); Medi-Cal; SAMHSA Safe Schools; Healthy Families; Los Angeles County Department of Health Service; Federally Qualified Health Centers; Los Angeles County Department of Children and Family Services; California Endowment; First 5 L.A.; CBO's discretionary funding and assets (maximum leveraging of 25% funding)

4. TRAUMA RECOVERY SERVICES

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.1.a	41.5 FTE – Supervising Psychiatric Social Worker ($3,517,419) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes. 109 FTE - Psychiatric Social Worker II ($8,268,823) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes. 12.15 FTE - Mental Health Service Coordinator II ($919,415) Provides coordination, linkage, engagement, and outreach between individuals, families, agencies community organizations, and county programs who provide evidence based practices, promising practices, and community defines practices ensuring access to these services. 5.075 FTE - Secretary III ($239,874) Provides full-time secretarial assistance to staff by scheduling meetings, taking minutes, following up on assignments, preparing correspondence, etc.
A.1.b	Benefits and Taxes at 19.27% - $2,494,604
A.1.c	Total Personnel Expenditures - These dollars ($15,440,135) will be used to fund new infrastructure for program development and administration.

A.2.c	Total Operating Expenses - These dollars ($4,077,504) will be used to fund the services and supplies for the new infrastructure/administration positions. This includes space, computers, local printers, training, office supplies, estimated mileage, travel, mobile communications, county telephone, telecom system, etc.
A.3.a	Total Subcontracts - These dollars ($7,272,972) will be used to support Trauma Recovery Services.
A.4	Total Proposed PEI Project Budget - $26,790,611
B.5	Total Funding Requested for PEI Project - $26,790,611

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Los Angeles** Date: 6/30/2009

PEI Project Name: **Primary Care & Behavioral Health**

Provider Name (if known): **County of Los Angeles Department of Mental Health**

Intended Provider Category: **County agency**

Proposed Total Number of Individuals and Families to be served:	FY 09-10	48,376
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	0
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget	
Proposed Expenses and Revenues	FY 09-10	Total
A. Expenditure		
1. Personnel (list classifications and FTEs)		
a. Salaries, Wages		
1 FTE Psychiatrist (4735)	$ 187,488	$ 187,488
0.5 FTE Intermediate Typist Clerk (2214)	$ 18,661	$ 18,661
b. Benefits and Taxes @ 19.27%	$ 39,725	$ 39,725
c. Total Personnel Expenditures	$ 245,874	$ 245,874
2. Operating Expenditures		
a. Facility Cost	$ 28,450	$ 28,450
b. Other Operating Expenses	$ 228,261	$ 228,261
c. Total Operating Expenses	$ 256,711	$ 256,711
3. Subcontracts/Professional Services (list/itemize all subcontracts)		
IMPACT	$ 1,695,168	$ 1,695,168
Incredible Years	$ 117,915	$ 117,915
Maternal Wellness Center	$ 939,279	$ 939,279
Alternatives for Families	$ 200,000	$ 200,000
Prevention & Early Treatment of Depression in Primary Care	$ 1,828,534	$ 1,828,534
Triple P Positive Parenting Program	$ 192,503	$ 192,503
a. Total Subcontracts	$ 4,973,399	$ 4,973,399
4. Total Proposed PEI Project Budget	$ 5,475,984	$ 5,475,984
B. Revenues (list/itemize by fund source)		
* To be determined (see comment on following page)		
	$ -	$ -
	$ -	$ -
1. Total Revenue	$ -	$ -
5. Total Funding Requested for PEI Project	$ 5,475,984	$ 5,475,984
6. Total In-Kind Contributions	$ -	$ -

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

B. Revenues (list/itemize by fund source)
* Exact sources, types, and amounts of leveraging for this project will be determined during implementation. Potential sources of leveraging include: Los Angeles County Department of Health Services; School districts' health/counseling funding; First 5 L.A.; California Endowment; Los Angeles Trust funds; Healthy Families; Federally Qualified Health Centers; CBO's discretionary funding and assets (maximum leveraging of 25% funding)

5. PRIMARY CARE & BEHAVIORAL HEALTH

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.1.a	1 FTE – Psychiatrist ($187,488) Provides clinical and psychiatric assessment and treatment for individuals enrolled in the early intervention Evidence Based Practices, Promising Practices or Community Defined Services. 0.5 FTE – Intermediate Typist Clerk ($18,661) Provides clerical and administrative support to clinical and professional staff.
A.1.b	Benefits and Taxes at 19.27% - $39,725
A.1.c	Total Personnel Expenditures - These dollars ($245,874) will be used to fund new infrastructure for program development and administration.
A.2.c	Total Operating Expenses - These dollars ($256,711) will be used to fund the services and supplies for the new infrastructure/administration positions. This includes space, computers, local printers, training, office supplies, estimated mileage, travel, mobile communications, county telephone, telecom system, etc.
A.3.a	Total Subcontracts - These dollars ($4,973,399) will be used to support Primary Care and Behavioral Health Services.
A.4	Total Proposed PEI Project Budget - $5,475,984
B.5	Total Funding Requested for PEI Project - $5,475,984

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Los Angeles** Date: 6/30/2009

PEI Project Name: **Early Care & Support for Transition-age Youth**

Provider Name (if known): **County of Los Angeles Department of Mental Health**

Intended Provider Category: **County agency**

Proposed Total Number of Individuals and Families to be served:	FY 09-10	14,506
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	0
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget	
Proposed Expenses and Revenues	FY 09-10	Total
A. Expenditure		
1. Personnel (list classifications and FTEs)		
a. Salaries, Wages		
1.1 FTE Supervising Psychiatric Social Worker II (9038)	$ 93,233	$ 93,233
8 FTE Psychiatric Social Worker II (9035)	$ 606,886	$ 606,886
1 FTE Mental Health Clinician II (9030)	$ 71,855	$ 71,855
0.2 FTE Psychiatrist (4735)	$ 37,498	$ 37,498
0.4 FTE Clinical Psychologist II (8697)	$ 39,117	$ 39,117
0.4 FTE Intermediate Typist Clerk (2214)	$ 14,928	$ 14,928
1.15 FTE Mental Health Services Coordinator II (8149)	$ 87,023	$ 87,023
0.575 Secretary III (2096)	$ 27,178	$ 27,178
b. Benefits and Taxes @ 19.27%	$ 188,406	$ 188,406
c. Total Personnel Expenditures	$ 1,166,124	$ 1,166,124
2. Operating Expenditures		
a. Facility Cost	$ 251,848	$ 251,848
b. Other Operating Expenses	$ 122,915	$ 122,915
c. Total Operating Expenses	$ 374,763	$ 374,763
3. Subcontracts/Professional Services (list/itemize all subcontracts)		
Aggression Replacement Training	$ 1,050,468	$ 1,050,468
Asian American Family Enrichment Network Program	$ 280,925	$ 280,925
CAPPS	$ 2,019,618	$ 2,019,618
EDIPP	$ 1,075,258	$ 1,075,258
Group Cognitive Behavioral Therapy for Major Depression	$ 831,179	$ 831,179
Interpersonal Psychotherapy for Depression	$ 1,897,909	$ 1,897,909
Multidimensional Family Therapy	$ 321,684	$ 321,684
a. Total Subcontracts	$ 7,477,041	$ 7,477,041
4. Total Proposed PEI Project Budget	$ 9,017,928	$ 9,017,928
B. Revenues (list/itemize by fund source)		
* To be determined (see comment on following page)		
	$ -	$ -
1. Total Revenue	$ -	$ -
5. Total Funding Requested for PEI Project	$ 9,017,928	$ 9,017,928
6. Total In-Kind Contributions	$ -	$ -

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

B. Revenues (list/itemize by fund source)
* Exact sources, types, and amounts of leveraging for this project will be determined during implementation. Potential sources of leveraging include: Los Angeles County Probation Department; Early and Periodic Screening, Diagnosis and Treatment (EPSDT); School districts' health/counseling funding; California Endowment; Los Angeles Trust funds; Healthy Families; Federally Qualified Health Centers; CBO's discretionary funding and assets (maximum leveraging of 25% funding)

6. EARLY CARE & SUPPORT FOR TRANSITION-AGE YOUTH

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.1.a	1.1 FTE - Supervising Psychiatric Social Worker ($93,233) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes. 8 FTE - Psychiatric Social Worker II ($606,886) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes. 1 FTE – Mental Health Clinician II ($71,855) Provides a wide variety of clinical services for persons and their families who are in need of early intervention and preventive mental health services using Evidence Based Practices, Promising Practices, or Community Defined Services. 0.2 FTE – Psychiatrist ($37,498) Provides clinical and psychiatric assessment and treatment for individuals enrolled in the early intervention Evidence Based Practices, Promising Practices or Community Defined Services. 0.4 FTE – Clinical Psychologist II ($39,117) Provides clinical and psychological assessment and treatment for individuals enrolled in the early intervention Evidence Based Practices, Promising Practices or Community Defined Services. 0.4 FTE – Intermediate Typist Clerk ($14,928)

Provides clerical and administrative support to clinical and professional staff.

1.15 FTE - Mental Health Service Coordinator II ($87,023)
Provides coordination, linkage, engagement, and outreach between individuals, families, agencies community organizations, and county programs who provide evidence based practices, promising practices, and community defines practices ensuring access to these services.

0.575 FTE - Secretary III ($27,178)
Provides full-time secretarial assistance to staff by scheduling meetings, taking minutes, following up on assignments, preparing correspondence, etc.

A.1.b Benefits and Taxes at 19.27% - $188,406

A.1.c Total Personnel Expenditures - These dollars ($1,166,124) will be used to fund new infrastructure for program development and administration.

A.2.c Total Operating Expenses - These dollars ($374,763) will be used to fund the services and supplies for the new infrastructure/administration positions. This includes space, computers, local printers, training, office supplies, estimated mileage, travel, mobile communications, county telephone, telecom system, etc.

A.3.a Total Subcontracts - These dollars ($7,477,041) will be used to support Early Care and Support for Transition-Age Youth services.

A.4 Total Proposed PEI Project Budget - $9,017,928

B.5 Total Funding Requested for PEI Project - $9,017,928

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Los Angeles** Date: 6/30/2009

PEI Project Name: **Juvenile Justice**

Provider Name (if known): **County of Los Angeles Department of Mental Health**

Intended Provider Category: **County agency**

Proposed Total Number of Individuals and Families to be served:	FY 09-10	9,112
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	0
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget	
Proposed Expenses and Revenues	FY 09-10	Total
A. Expenditure		
1. Personnel (list classifications and FTEs)		
a. Salaries, Wages		
1 FTE Supervising Psychiatric Social Worker II (9038)	$ 84,757	$ 84,757
10 FTE Psychiatric Social Worker II (9035)	$ 758,608	$ 758,608
5 FTE Mental Health Clinician II (9030)	$ 359,275	$ 359,275
b. Benefits and Taxes @ 19.27%	$ 231,749	$ 231,749
c. Total Personnel Expenditures	$ 1,434,388	$ 1,434,388
2. Operating Expenditures		
a. Facility Cost	$ 324,800	$ 324,800
b. Other Operating Expenses	$ 240,812	$ 240,812
c. Total Operating Expenses	$ 565,612	$ 565,612
3. Subcontracts/Professional Services (list/itemize all subcontracts)		
Functional Family Therapy	$ 912,889	$ 912,889
Group Cognitive Behavioral Therapy for Major Depression	$ 275,256	$ 275,256
Loving Intervention Family Enrichment (LIFE) Program	$ 3,057,495	$ 3,057,495
Multidimensional Family Therapy	$ 1,286,736	$ 1,286,736
Multisystemic Therapy	$ 1,187,964	$ 1,187,964
Positive Directions	$ 1,618,036	$ 1,618,036
Prolonged Exposure Therapy for PTSD	$ 324,744	$ 324,744
a. Total Subcontracts	$ 8,663,120	$ 8,663,120
4. Total Proposed PEI Project Budget	$ 10,663,120	$ 10,663,120
B. Revenues (list/itemize by fund source)		
* To be determined (see comment on following page)		
	$ -	$ -
	$ -	$ -
1. Total Revenue	$ -	$ -
5. Total Funding Requested for PEI Project	$ 10,663,120	$ 10,663,120
6. Total In-Kind Contributions	$ -	$ -

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

B. Revenues (list/itemize by fund source)
* Exact sources, types, and amounts of leveraging for this project will be determined during implementation. Potential sources of leveraging include: Los Angeles County Probation Department; Medi-Cal; Early and Periodic Screening, Diagnosis and Treatment (EPSDT); SAMHSA Safe Schools; School District health/counseling funding; CBO's discretionary funding and assets (maximum leveraging of 25% funding)

7. JUVENILE JUSTICE SERVICES

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.1.a	1 FTE – Supervising Psychiatric Social Worker ($84,757) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes. 10 FTE - Psychiatric Social Worker II ($758,608) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes. 5 FTE – Mental Health Clinician II ($359,275) Provides a wide variety of clinical services for persons and their families who are in need of early intervention and preventive mental health services using Evidence Based Practices, Promising Practices, or Community Defined Services.
A.1.b	Benefits and Taxes at 19.27% - $231,748
A.1.c	Total Personnel Expenditures - These dollars ($1,434,388) will be used to fund new infrastructure for program development and administration.
A.2.c	Total Operating Expenses - These dollars ($565,612) will be used to fund the services and supplies for the new infrastructure/administration positions. This includes space, computers, local printers, training, office supplies, estimated mileage, travel, mobile communications, county telephone, telecom system, etc.

A.3.a	Total Subcontracts - These dollars ($8,663,120) will be used to support Juvenile Justice Services.
A.4	Total Proposed PEI Project Budget - $10,663,120
B.5	Total Funding Requested for PEI Project - $10,663,120

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Los Angeles** Date: 6/30/2009

PEI Project Name: **Early Care & Support for Older Adults**

Provider Name (if known): **County of Los Angeles Department of Mental Health**

Intended Provider Category: **County agency**

Proposed Total Number of Individuals and Families to be served:	FY 09-10	50,147
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	0
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget	
Proposed Expenses and Revenues	FY 09-10	Total
A. Expenditure		
1. Personnel (list classifications and FTEs)		
a. Salaries, Wages		
1.2 FTE Psychiatric Social Worker II (9035)	$ 91,033	$ 91,033
0.5 Intermediate Typist Clerk (2214)	$ 18,661	$ 18,661
b. Benefits and Taxes @ 19.27%	$ 21,138	$ 21,138
c. Total Personnel Expenditures	$ 130,832	$ 130,832
2. Operating Expenditures		
a. Facility Cost	$ 32,510	$ 32,510
b. Other Operating Expenses	$ 50,288	$ 50,288
c. Total Operating Expenses	$ 82,798	$ 82,798
3. Subcontracts/Professional Services (list/itemize all subcontracts)		
Cognitive Behavioral Therapy for Late Life Depression	$ 2,292,505	$ 2,292,505
Gatekeeper Case-finding Model	$ 1,079,311	$ 1,079,311
Live Well, Live Long, Steps to Mental Wellness	$ 1,939,324	$ 1,939,324
PATCH	$ 788,039	$ 788,039
PEARLS	$ 2,713,851	$ 2,713,851
a. Total Subcontracts	$ 8,813,030	$ 8,813,030
4. Total Proposed PEI Project Budget	$ 9,026,660	$ 9,026,660
B. Revenues (list/itemize by fund source)		
* To be determined (see comment on following page)		
	$ -	$ -
	$ -	$ -
1. Total Revenue	$ -	$ -
5. Total Funding Requested for PEI Project	$ 9,026,660	$ 9,026,660
6. Total In-Kind Contributions	$ -	$ -

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

B. Revenues (list/itemize by fund source)
* Exact sources, types, and amounts of leveraging for this project will be determined during implementation. Potential sources of leveraging include: Los Angeles County Department of Health Services; Federally Qualified Health Centers: L.A. Care; L.A. HealthNet; Medicare; Los Angeles County Department of Community and Senior Services; City and County of Los Angeles Area Agency on Aging (AAA) funds; CBO's discretionary funding and assets (maximum leveraging of 25% funding).

8. EARLY CARE & SUPPORT FOR OLDER ADULTS

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.1.a	1.2 FTE - Psychiatric Social Worker II ($91,033) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes. 0.5 FTE – Intermediate Typist Clerk ($18,661) Provides clerical and administrative support to clinical and professional staff.
A.1.b	Benefits and Taxes at 19.27% - $21,138
A.1.c	Total Personnel Expenditures - These dollars ($130,832) will be used to fund new infrastructure for program development and administration.
A.2.c	Total Operating Expenses - These dollars ($82,798) will be used to fund the services and supplies for the new infrastructure/administration positions. This includes space, computers, local printers, training, office supplies, estimated mileage, travel, mobile communications, county telephone, telecom system, etc.
A.3.a	Total Subcontracts - These dollars ($8,813,030) will be used to support Early Care and Support for Older Adult services.
A.4	Total Proposed PEI Project Budget - $9,026,660
B.5	Total Funding Requested for PEI Project - $9,026,660

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Los Angeles** Date: 6/30/2009

PEI Project Name: **Improving Access for Underserved Populations**

Provider Name (if known): **County of Los Angeles Department of Mental Health**

Intended Provider Category: **County agency**

Proposed Total Number of Individuals and Families to be served:	FY 09-10	16,655
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	0
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget	
Proposed Expenses and Revenues	FY 09-10	Total
A. Expenditure		
1. Personnel (list classifications and FTEs)		
a. Salaries, Wages		
b. Benefits and Taxes @ 19.27%	$ -	$ -
c. Total Personnel Expenditures	$ -	$ -
2. Operating Expenditures		
a. Facility Cost		$ -
b. Other Operating Expenses		$ -
c. Total Operating Expenses	$ -	$ -
3. Subcontracts/Professional Services (list/itemize all subcontracts)		
Cognitive Behavioral Therapy with Antidepressant Med.	$ 1,156,425	$ 1,156,425
Family Coping Skills Program	$ 637,166	$ 637,166
GLBT Champs	$ 512,700	$ 512,700
Group Cognitive Behavioral Therapy for Major Depression	$ 2,987,901	$ 2,987,901
Nurse-Family Partnership	$ 833,498	$ 833,498
Nurturing Parenting Program	$ 352,221	$ 352,221
Prolonged Exposure Therapy for PTSD	$ 154,281	$ 154,281
Trauma Focused Cognitive Behavioral Therapy	$ 608,984	$ 608,984
a. Total Subcontracts	$ 7,243,176	$ 7,243,176
4. Total Proposed PEI Project Budget	$ 7,243,176	$ 7,243,176
B. Revenues (list/itemize by fund source)		
* To be determined (see comment on following page)		
	$ -	$ -
	$ -	$ -
1. Total Revenue	$ -	$ -
5. Total Funding Requested for PEI Project	$ 7,243,176	$ 7,243,176
6. Total In-Kind Contributions	$ -	$ -

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

B. Revenues (list/itemize by fund source)
* Exact sources, types, and amounts of leveraging for this project will be determined during implementation. Potential sources of leveraging include: First 5 L.A.; Los Angeles County Department of Public Health; Early and Periodic Screening, Diagnosis and Treatment (EPSDT); Medi Cal; California Endowment; Ryan White HIV/AIDS Program (federal); CBO's discretionary funding and assets (maximum leveraging of 25% funding)

9. MPROVING ACCESS FOR UNDERSERVED POPULATIONS

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.3.a	Total Subcontracts - These dollars ($7,243,176) will be used to support Improving Access for Underserved Populations.
A.4	Total Proposed PEI Project Budget - $7,243,176
B.5	Total Funding Requested for PEI Project - $7,243,176

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Los Angeles** Date: 6/30/2009

PEI Project Name: **American Indian Project**

Provider Name (if known): **County of Los Angeles Department of Mental Health**

Intended Provider Category: **County agency**

Proposed Total Number of Individuals and Families to be served:	FY 09-10	1,248
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	0
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget	
Proposed Expenses and Revenues	FY 09-10	Total
A. Expenditure		
1. Personnel (list classifications and FTEs)		
a. Salaries, Wages		
4 FTE Psychiatric Social Worker II (9035)	$ 303,443	$ 303,443
		$ -
b. Benefits and Taxes @ 19.27%	$ 58,473	$ 58,473
c. Total Personnel Expenditures	$ 361,916	$ 361,916
2. Operating Expenditures		
a. Facility Cost	$ 81,200	$ 81,200
b. Other Operating Expenses	$ 51,884	$ 51,884
c. Total Operating Expenses	$ 133,084	$ 133,084
3. Subcontracts/Professional Services (list/itemize all subcontracts)		
American Indian Life Skills	$ 495,000	$ 495,000
		$ -
a. Total Subcontracts	$ 495,000	$ 495,000
4. Total Proposed PEI Project Budget	$ 990,000	$ 990,000
B. Revenues (list/itemize by fund source)		
* To be determined (see comment on following page)		
	$ -	$ -
	$ -	$ -
1. Total Revenue	$ -	$ -
5. Total Funding Requested for PEI Project	$ 990,000	$ 990,000
6. Total In-Kind Contributions	$ -	$ -

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

B. Revenues (list/itemize by fund source)
* Exact sources, types, and amounts of leveraging for this project will be determined during implementation. Potential sources of leveraging include: federal American Indian health funding; Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (maximum leveraging of 15% funding).

10. AMERICAN INDIAN PROJECT

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.1.a	4 FTE - Psychiatric Social Worker II ($303,443) Performs a wide variety of professional social work services including supervision of clinical and community staff in providing Evidence Based Practices, Promising Practices, and Community Defined Practices as defined in the Plan, ensuring fidelity to these practices to support quality client outcomes.
A.1.b	Benefits and Taxes at 19.27% - $58,473
A.1.c	Total Personnel Expenditures - These dollars ($361,916) will be used to fund new infrastructure for program development and administration.
A.2.c	Total Operating Expenses - These dollars ($133,084) will be used to fund the services and supplies for the new infrastructure/administration positions. This includes space, computers, local printers, training, office supplies, estimated mileage, travel, mobile communications, county telephone, telecom system, etc.
A.3.a	Total Subcontracts - These dollars ($495,000) will be used to support the American Indian Project.
A.4	Total Proposed PEI Project Budget - $990,000
B.5	Total Funding Requested for PEI Project - $990,000

PEI Administration Budget Worksheet

Form No. 5

County: Los Angeles Date: 6/30/2009

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2009-10		Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator					$0
b. PEI Support Staff					$0
c. Other Personnel (list all classifications)		95	$7,240,618		$7,240,618
MH Clinical District Chief, Program Head,					$0
MH Analyst, MH Services Coordinator,					$0
Clinical Psychologist, Behavioral Science					$0
Consultant, Support Staff					$0
d. Employee Benefits			$1,395,494		$1,395,494
e. Total Personnel Expenditures			$8,636,112		$8,636,112
2. Operating Expenditures					
a. Facility Costs			$1,034,000		$1,034,000
b. Other Operating Expenditures			$1,011,813		$1,011,813
c. Total Operating Expenditures			$2,045,813		$2,045,813
3.County Allocated Administration					
a. Total County Administration Cost			$0		$0
4. Total PEI Funding Request for County Administration Budget			$10,681,925		$10,681,925
B. Revenue					
1 Total Revenue			$0		$0
C. Total Funding Requirements			$10,681,925		$10,681,925
D. Total In-Kind Contributions			$0		$0

PEI ADMINISTRATION

BUDGET NARRATIVE – FY 2009-10

Line Item	Description/Justification
A.1.a	*Prevention & Early Intervention Team* 20 FTE – Mental Health Clinical District Chief, Mental Health Clinical Program Head, Senior Community Mental Health Psychologist, Clinical Psychologist II (4), Mental Health Analyst II (3), Mental Health Analyst I (2), Senior Secretary III, Secretary III (2), Guest Instructor, Mental Health Services Coordinator II (2), Psychiatric Social Worker II, and Senior Typist Clerk ($1,615,597) These positions will provide countywide leadership for the planning, design and implementation of the PEI Plan, including outreach and engagement to stakeholders, coordination of the community planning processes, programming, fiscal, contracts, and budget. This team will ensure projects are implemented as planned in each service area, structure the countywide trainings for the Evidence Based Practices, and Community Defined Practices ensuring uniformity and fidelity to the models. *Eight Service Areas* 32 FTE – Mental Health Education Consultant (8), Mental Health Services Coordinator I (8), Mental Health Analyst II (8), and Senior Typist Clerk (8) ($2,404,111) These positions will direct the implementation and monitoring of the programmatic and service delivery aspects of the MHSA PEI Plan in each of the eight Service Areas. Oversees the development and implementation of prevention and early intervention programs to help ensure that the Key Community Mental Health Needs of identified priority populations, sub-populations and underrepresented communities are engaged and addressed. Ensures appropriate utilization and coordination of PEI programs countywide, including collaboration and resource leveraging with state-required sectors/partner organizations. Ensures

local level training of models, manages service area integration, collaboration, and planning.

Age Group Leads

20 FTE – Mental Health Clinical Program Head (4), Clinical Psychologist II (3), Mental Health Analyst II, Mental Health Services Coordinator II (4), Secretary III (4), and Intermediate Typist Clerk (4) ($1,508,871)

These positions will provide lead responsibility countywide for the identification, development and implementation of appropriate Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) service strategies and programs for the 4 age population in each of the eight Service Areas (Child, TAY, Adult and Older Adults). Ensures project lead with age and specialty focus.

Empowerment and Advocacy Division

3 FTE – Mental Health Clinical Program Head, Mental Health Analyst I, and Mental Health Service Coordinator II ($275,791)

These positions will be assigned to the MHSA Empowerment and Advocacy Division that was created to effect new programs, policy directions and projects to empower clients, family members and community advocates within the mental health system and to serve as the essential infrastructure to support Los Angeles community-based wellness and peer support services.

Office of the Medical Director

3 FTE – Division Chief, Program Development, Mental Health Analyst II, and Mental Health Analyst I ($296,448)

These positions will direct the program planning, development, oversight and administration activities of the Integrated Treatment Services Division within the Office of the Medical Director. The Division ensures that strategic DMH programs provide early intervention and prevention based services and supports in collaboration with other community agencies (behavioral and primary health, social

service, and other programs interfacing with underserved populations) and the provision of integrated and evidence-based services to consumers who would not otherwise be served or served comprehensively by the Department. This integrated service encompasses trauma related concerns as well as co-occurring mental and physical health issues and conditions. The Integrated Treatment Service Division is responsible for developing and implementing crosscutting programs throughout the Department.

Office of the Administrative Deputy

8 FTE – Mental Health Analyst III, Mental Health Analyst I (2), Administrative Services Manager I, Administrative Assistant III, Senior Departmental Personnel Technician, Departmental Personnel Technician, and Intermediate Typist Clerk ($591,134)

These positions will be responsible for coordinating all the activities of the various administrative bureaus to ensure successful implementation of the PEI Plan, including recommending and implementing internal controls and other policies and procedures to ensure compliance with program requirements and County and fiscal policies. The positions will be assigned to Budget Division, Contracts Division, Administrative Services Bureau, Human Resources Bureau and the Administrative Deputy's Office.

Training Division

8 FTE – Staff Assistant II ($466,176)

These positions will be assigned to the Training Division and provide administrative support to cover mandatory continuing education requirements, curriculum development for the eight service area training needs and successful completion of processes and tasks for conference events.

Adult Systems of Care

1 FTE – Administrative Services Manager I ($82,490)

This position will provide administrative oversight to all directly operated clinics with Prevention Early Intervention programs within the Adult Systems of Care Bureau. The

position will ensure all programs remain in compliance with MHSA policies, procedures and state regulations and guidelines.

A.1.d Benefits and Taxes at 19.27% - $1,395,494

A.1.e Total Personnel Expenditures - These dollars ($8,636,112) will be used to fund new infrastructure for program development and administration.

A.2.c Total Operating Expenses - These dollars ($2,045,813) will be used to fund the services and supplies for the new infrastructure/administration positions. This includes space, computers, local printers, training, office supplies, estimated mileage, travel, mobile communications, county telephone, telecom system, etc.

A.4 Total PEI Funding Request for County Administration Budget – $10,681,925

C. Total Funding Requirements - $10,681,925

County: Los Angeles **Date: 6/30/2009**

☐ Check this box if this is a "very small county" (see glossary for definition) and the county is electing the option to waive the requirement to conduct a local evaluation of a PEI project. Very small counties electing this option do not need to complete the remainder of this form.

PEI Project Name: Juvenile Justice Services

1. a. Identify the programs (from Form No. 3 PEI Project Summary) the county will evaluate and report on to the State.

All of the Juvenile Justice Services programs, which are comprised of Evidence-based Practices (EBPs) and Community-defined Evidence (CDE) Practices, will be included in the local evaluation. They are as follows:

1. **Aggression Replacement Training (ART)** - EBP
   A psycho-educational curriculum designed to improve anger management skills, moral reasoning, and social competences in youth.

2. **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** – EBP
   A group cognitive-behavioral treatment for youth who have Posttraumatic Stress Disorder, depressive disorders, or other negative effects of trauma exposure.

3. **Functional Family Therapy (FFT)** – EBP
   A family-based prevention and early intervention program for behavior problems and substance abuse.

4. **Group Cognitive Behavioral Therapy (GCBT) for Major Depression** – EBP
   A manualized cognitive-behavioral treatment program for group treatment of depression.

5. **Loving Intervention for Family Enrichment (LIFE) Program –** CDE
   Utilizes the Parent Project curriculum to build psychosocial skills, personal responsibility, and coping skills for youth experiencing behavior problems who are at-risk for juvenile justice involvement.

6. **Multidimensional Family Therapy (MDFT)** – EBP
   A family-based treatment and substance abuse prevention program for adolescents with drug and behavior problems.

7. **Multisystemic Therapy (MST)** – EBP
   A home-based family-focused treatment to decrease anti-social behaviors,

substance abuse, and mental illness in youth who are at-risk for out of home placement or juvenile justice involvement.

8. **Positive Directions (PD)** – CDE
   A combination of three treatment packages for anger management, substance abuse, and psychosocial skills designed for underserved youth.

9. **Prolonged Exposure for Posttraumatic Stress Disorder (PE)** – EBP
   A cognitive-behavioral treatment program for individuals who have experienced single/multiple traumas and have posttraumatic stress disorder.

10. **Trauma Focused Cognitive Behavioral Therapy (TFCBT)** - EBP
    A conjoint child/parent cognitive-behavioral therapy for youth with Posttraumatic Stress Disorder or who are experiencing the negative effects of trauma.

1.b. Explain how this PEI project and its programs were selected for local evaluation.

The Juvenile Justice Services Project was selected for the following reasons:

- **Stakeholder Input Regarding the Importance of the Project**
  After reviewing the county needs assessment data, stakeholders indicated that there was a great need for additional services to address gang problems, alcohol and substance abuse, the effects of child abuse and neglect, and school problems related to entering into the juvenile justice system.

- **Commission Recommended**
  The County Commission on Children, Youth, and Families has prioritized a review of services, programs, and funding available for youth in probation camps with mental health and substance abuse needs. The Commission has asked that the Departments of Mental Health, Children and Family Services, and Probation identify systematic failures in coordinating services for high-risk youth.

- **Interdepartmental Coordination**
  Because the Juvenile Justice Services Project intersects with the missions of the Probation Department, the Department of Children and Family Services (DCFS), and the Los Angeles County Office of Education (LACOE), it provides LACDMH with an opportunity to work more closely with its partner county agencies.

- **Strong Alignment with a PEI Priority Population**
  The current project is meant to address the defining features of the priority population: Children/Youth at Risk of or Experiencing Juvenile Justice Involvement.

- **Social Burden of Youth Crime**
  Recent research has been conducted regarding the cost of crimes committed by juveniles in large urban areas. Extrapolating these figures for the County of Los Angeles yields a cost estimate of $356-400 million dollars/year (Welsh, B. C., Loeber, R., Stevens, B. R., Stouthamer-Loeber, M., Cohen, M. A., & Farrington, D. P. (2008). Costs of juvenile crime in urban areas: A longitudinal perspective. Youth Violence and Juvenile Justice.
  Vol 6(1), (2008), 3-27.).

- **Availability of Data Sources**
  Ability to gather and share data from partner County departments was demonstrated during our needs assessment. Agencies such as the Probation Department, local school districts, local law enforcement agencies, LACOE, as well as LACDMH's internal information system were seen as viable data sources for an evaluation.

- **Evaluation across Service Settings**
  Because the Juvenile Justice Services Project spans outpatient settings and probation camps, it provides the county with a unique opportunity to examine the relative differences seen in at-risk youth at home and those incarcerated.

- **Treatment Effects**
  Because the composite programs of the project are either evidence-based practices or community-defined evidence practices (which have undergone a review of their research base), they have the best chances for demonstrating statistically and clinically significant effect sizes.

2. What are the expected person/family-level and program/system-level outcomes for each program?

The intent of the Juvenile Justice Services Project is to address the major risk factors which contribute to the likelihood that a youth might become involved in antisocial behaviors and subsequently come to the attention of law enforcement. Because most youth participating in this project's programs will have entered the juvenile justice system, most of the programs are geared toward early intervention. So, a main focus will be to treat mental health symptoms and disorders such as depression, posttraumatic stress disorder, substance abuse, and other behavioral and family-related problems as soon as possible and especially for youth new to the system. Related to these problem areas, one would expect to see improvements in overall school functioning, peer relations, self-efficacy, other aspects of psychological resilience, and of course, a reduction in recidivism.

Consistent with the MHSA tenet that services be innovative and transformational, the great majority of programs contained in the Juvenile Justice Services Project are evidence-based treatments. At present, there are only five known EBPs offered by LACDMH, so the addition of these programs as well as numerous others in the other

County PEI projects, represents an extraordinary transformation of the current system of care. In short, it is the intent of the project to promote evidence-based treatment approaches as the de facto standard of care for the juvenile justice population and to demonstrate that such an approach is a viable and cost effective one which can be replicated by counties of all sizes. Additionally, another of the project's primary goals is to improve upon the workforce's clinical skills by orienting those unfamiliar to the practices to the technical aspects involved with implementation, fidelity adherence, and on-going client assessment. Below is a table depicting these project-level outcomes.

PROJECT INTENDED OUTCOMES		
LEVEL	**OUTCOMES**	**METHOD/MEASURES OF SUCCESS**
INDIVIDUAL/ FAMILY	• Decrease alcohol/drug use • Decrease recidivism rates, arrests/days incarcerated • Increase school attendance and achievement • Decrease depressive disorders, PTSD, and other mental health problems • Improve positive peer relations and dissuade gang activity/affiliation • Decrease externalizing behavior problems • Improve family functioning, parenting skills, and cohesion	• Adolescent, parent, teacher, therapist behavior ratings • Drug testing • School attendance and achievement records • Arrests/Probation records
PROGRAM/ SYSTEM	• Increase opportunities for treatment within the juvenile justice system • Increase integrated services between DCFS, LACDMH, and the Probation department • Improve clinical screening of juveniles in detention • Determine relative benefits of treatment programs • Determine effects of treatment site on outcome • Improve data gathering methods • Institute a community development team to facilitate treatment delivery, monitoring, and evaluation • Promote the use of EBPs as the de facto standard of care for juvenile justice populations	• Number of mental health treatment programs available to probation youth • Number of PEI programs targeting at risk probation youth • Overall project treatment effects • Relative program treatment effects • Overall juvenile arrests • Overall probation department census • System-wide and interdepartmental feedback

The following table details individual program outcomes for clients and families and for the system of care. All of these programmatic outcomes may be seen as extensions of the basic outcomes mentioned above.

PROGRAM OUTCOMES AND MEASURES OF SUCCESS

PROGRAM	OUTCOMES	
	INDIVIDUAL/FAMILY	PROGRAM/SYSTEM
Aggression Replacement Training	• Reduced impulsiveness • Improved interpersonal skills • Decreased recidivism	• Increase number of MHS offered in county probation camps • Decrease level of violence with camp population • Expand use of EBP and train community providers on evidence-based practices
LIFE (Loving Intervention for Family Enrichment) Program	• Decrease youth aggression and social problems • Improve youth self-efficacy • Improve parenting skills and parenting competence	• Promote a locally developed community-defined evidence program for underserved cultural populations • Create system infrastructure to develop community-defined evidence programs
Positive Directions	• Decrease substance abuse • Increase pro-social behavior • Increase knowledge of and skill use in anger management and conflict resolution • Increase knowledge of and skill use in problem solving, goal setting and communication skills • Increase utilization of community support system, particularly around relapse prevention	• Promote a locally developed community-defined evidence program for underserved cultural populations • Create system infrastructure to develop community-defined evidence programs
Group Cognitive Behavioral Therapy for Major Depression	• Decrease depressive symptoms • Improve social functioning • Improve coping skills and problem solving skills	• Increase number of MHS offered in county probation camps • Improved coordinated services with county ADPA • Expand use of EBP and train community providers on evidence-based practices
Multidimensional Family Therapy (MDFT)	• Decrease drug use • Improve family functioning • Decrease conduct problems	• Increase programs for underserved populations • Increase programs for youth with co-occurring disorders • Expand use of EBP and train community providers on evidence-based practices
Multisystemic Therapy	• Decrease recidivism • Decrease alcohol and drug use • Decrease peer aggression • Improve parenting • Improve prosocial behaviors • Improve school performance	• Reduce juvenile crime rate • Reduce number of out of home placements • Reduce long term rates of criminal behavior • Expand use of EBP and train community providers on evidence-based practices

PROGRAM OUTCOMES AND MEASURES OF SUCCESS		
PROGRAM	OUTCOMES	
	INDIVIDUAL/FAMILY	PROGRAM/SYSTEM
Cognitive Behavioral Intervention for Trauma in School (CBITS)	• Decrease symptoms of depression • Decrease trauma symptoms	• Increase number of MHS offered in county probation camps • Expand use of EBP and train community providers on evidence-based practices
Functional Family Therapy	• Reduced recidivism • Improved family functioning • Decrease substance use • Decrease violent behavior	• Increase number of MHS offered in county probation camps • Provide treatment which can include parents/care-givers for incarcerated youth as well as youth at home • Provide an EBP within multiple natural settings • Expand use of EBP and train community providers on evidence-based practices
Prolonged Exposure Therapy for Post Traumatic Stress Disorder	• Reduced severity of trauma symptoms • Significantly reduced symptoms of depression • Improved social adjustment • Reduced anxiety symptoms	• Improved coordinated services with county Alcohol and Drug Program Administration (ADPA) • Expand use of EBP and train community providers on evidence-based practices
Trauma Focused Cognitive Behavioral Therapy	• Decrease child behavior problems • Decrease trauma symptoms • Decrease depression • Improved social competence	• Increase number of MHS offered in county probation camps • Provide treatment which can include parents/care-givers for incarcerated youth • Provide treatment context for discharge planning from camp • Expand use of EBP and train community providers on evidence-based practices

3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For "other", provide numbers of individuals served for whom a category is not provided (i.e., underserved cultural populations; e.g., gay, lesbian, bisexual, transgender, questioning; hearing impaired, etc.). Please indicate at the bottom of the form an estimate of the total *unduplicated* count of individuals to be served. If the focus of the intervention is families, count each person in the family.

A. Calculating Client Estimates

In order to calculate the project's overall unduplicated client count (i.e. the base Juvenile Justice population), each program was analyzed in order to determine staffing patterns, budgets, and maximum clients who could be served given the first two parameters. This base population was then adjusted by applying different factors using published research and the county's community needs assessment as a guide in these estimates.

The Trauma-exposed calculations were based upon research detailing the co-morbidity of trauma and posttraumatic stress disorder within the Juvenile Justice population. First Onset estimates were based upon SDMH Serious Mental Illness (SMI) estimated rates for ethnicity and age groupings. Stressed Families estimates were based upon the poverty population estimates derived from the county's community needs assessment. School Failure figures were derived from the California Department of Education's study of 4-year drop outs. The Suicide Prevention numbers were derived from research indicating co-morbidity rates between incarcerated youth and suicidal ideation. And Stigma and Discrimination numbers were thought to include all members of the base Juvenile Justice population.

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVEN-TION	STIGMA/ DISCRI-MINATION
ETHNICITY/ CULTURE							
African American	1955	167	850	894	2114	1459	2114
Asian Pacific Islander	84	7	28	34	91	63	91
Latino	4653	412	2691	1615	5030	3471	5030
Native American	4	0	2	1	5	3	5
Caucasian	708	52	142	119	765	528	765
Other (Indicate if possible)	55	5	26	22	59	0	59
AGE GROUPS							
Children & Youth (0-17)	2164	187	1085	779	2339	1602	2339
Transition Age Youth (16-25)	5295	457	2654	1906	5725	3921	5725
Adult (18-59)	0	0	0	0	0	0	0
Older Adult (>60)	0	0	0	0	0	0	0
TOTAL	7459	644	3739	2685	8064	5523	8064
Total PEI project estimated ***unduplicated*** count of individuals to be served: 9112							

4. How will achievement of the outcomes and objectives be measured? What outcome measurements will be used and when will they be measured?

As the details of project implementation become apparent, refinements to the proposed procedures and materials may occur, and LACDMH will further refine the current design to maximize statistical power. The basic intent of the current evaluation is to proceed with a quasi-experimental approach in order to determine how well the project met its goals. This section covers the important research questions driving the evaluation, the

longitudinal design of the study, and dependent measures.

B. Measurement Points in Time

The present evaluation will employ a repeated measures design with measurement occurring at five crucial points in time. Because of the complexity of the population involved, different cohorts, depending upon their path through the juvenile justice system, will likely be assessed at different times. The following five points in time delineate the general timeline when the study's main measures will be obtained:

Time 0 (T0): Pre-implementation baseline data gathering

Time 1 (T1): Initial assessment at Juvenile Hall

Time 2 (T2): Post-adjudication/pre-treatment

Time 3 (T3): Post-treatment

Time 4 (T4): Follow-up

C. Outcome Measures

All outcomes and objectives will be measured using a variety of clinical instruments, rating scales, behavioral indicators, and existing information from several sources including clients, family members, teachers, therapists, county departments, and other interested parties. The following matrix illustrates where each projected measure will be useful in answering a particular evaluation question. Implementation details will determine which particular measures will be included in the final study. For the purposes of this proposal, general classes of instruments with potential tools are listed below which will comprise an evaluation packet to be completed in part by adolescents, parents, and therapists:

OUTCOME MEASURES	
Measure	**Instruments**
Individual/Family Measures	
Behavioral Measures (Beh)	• Arrest/probation records Source: Probation Department/Local law enforcement records • Recidivism Source: Probation Department/Local law enforcement records • Days incarcerated Source: Probation Department/Local law enforcement records • School discipline reports (SchD) Source: Parent, teacher, student report, LACOE records, Local school district records

OUTCOME MEASURES	
Measure	**Instruments**
Academic Measures (ACAD)	• School attendance and achievement (SAA) Source: Parent, teacher, student report, LACOE records, Local school district records • Truancies (TRU) Source: Parent, teacher, student report, LACOE records, Local school district records • Child Behavior Checklist (CBCL) Source: Teachers
Family Measures (FAM)	• Family Adaptability and Cohesion Evaluation Scales IV (FACES-IV) Source: Adolescents, parents • Family Environment Scale (FES) Source: Adolescents, parents
Psychosocial Measures (Psy)	• Self Report Delinquency (SRD) Scale Source: Adolescents • Self-efficacy Scale (S-eS) Source: Adolescents • Peer Relations Inventory (PRI) Source: Adolescents • Prosocial Moral Objective Reasoning (PROM) Source: Adolescents • Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) Source: Adolescents • Youth Outcome Questionnaire – 2 (YOQ®-2.0 SR, YOQ®-2.01) Source: Adolescents, Parents • Outcome Questionnaire (OQ®-45.2) Source: Adults, Parents • University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA-PTSD RI) Source: Adolescents • Child Depression Index (CDI) Source: Adolescents
Alcohol/substance abuse measures (Alc-SA)	• Drug tests Source: Adolescents • Personal Experience Inventory (PEI) Source: Adolescents
Therapeutic Alliance (TA)	• Adolescent Working Alliance Inventory (AWAI) Source: Adolescents • California Psychotherapy Alliance Scales (CALPAS) Source: Adolescents • Helping Alliance Questionnaire (HAq-II) Source: Adolescents
Program and System Measures	

OUTCOME MEASURES	
Measure	**Instruments**
System Capacity (SysC)	• Non-EBP, Programs offered for targeted youth populations (treatment as usual, TAU) Source: DMH IS • EBP Programs offered for targeted youth populations Source: DMH IS • CDE Programs offered for targeted youth populations Source: DMH IS • Joint Interdepartmental Programs for targeted youth populations Source: DMH IS • Adolescent clients served Source: DMH IS • Workforce Demographics Source: DMH IS • Workforce Training Indicators Source: DMH IS
Juvenile Justice Population (JJP)	• Probation population and camp census Source: Department of Probation • Adjudication data Source: Department of Probation • Out of home placements Source: Probation, DCFS reports

E. Summary of Evaluation Questions, Objectives, Outcomes, and Measures

SUMMARY	
Evaluation Questions	Objectives, Dependent Measures, Measurement Time
1. Program: Aggression Replacement Training	
Are individual and family outcomes being met?	Objective 1: Decrease Impulsivity. Dependent Measures: MAYSI-2, YOQ-SR, SchD, CBCL Measurement Points: T1 – T4
	Objective 2: Improve interpersonal skills Dependent Measures: MAYSI-2, YOQ-SR Measurement Points: T1 – T4
	Objective 3: Decrease recidivism Dependent Measures: All Beh Measurement Points: T1 - T4
Are program and system-wide outcomes being met?	Objective 1: Increase system capacity Dependent Measures: SysC, JJP Measurement Points: T0, T3
	Objective 2: Decrease level of violence with camp population Dependent Measures: Probation reports Measurement Points: T0, T3
	Objective 3: Expand and train workforce using EBPs Dependent Measures: SysC Measurement Points: T0, T3
2. Program: Cognitive Behavioral Intervention for Trauma in School (CBITS)	
Are individual and family outcomes being met?	Objective 1: Decrease symptoms of depression Dependent Measures: MAYSI-2, YOQ 2.0 SR, CDI Measurement Points: T1 – T4
	Objective 2: Decrease trauma symptoms Dependent Measures: MAYSI-2, YOQ 2.0 SR, UCLA-PTSD RI Measurement Points: T1 – T4
Are program and system-wide outcomes being met?	Objective 1: Increase system capacity Dependent Measures: SysC Measurement Points: T0, T3
	Objective 2: Expand use of EBP and train community providers on EBPs Dependent Measures: SysC Measurement Points: T0, T3
3. Program: Functional Family Therapy	
Are individual and family outcomes being met?	Objective 1: Decrease recidivism Dependent Measures: MAYSI-2, YOQ 2.0 SR, Beh Measurement Points: T1 – T4

SUMMARY	
Evaluation Questions	Objectives, Dependent Measures, Measurement Time
	Objective 2: Improve family functioning Dependent Measures: FAM Measurement Points: T1 – T4
	Objective 3: Decrease substance use Dependent Measures: Alc-SA Measurement Points: T1 – T4
Are program and system-wide outcomes being met?	Objective 1: Increase system capacity Dependent Measures: SysC Measurement Points: T0, T3
	Objective 2: Increase treatment opportunities for parents with incarcerated youth Dependent Measures: JJP, FAM Measurement Points: T0, T3
	Objective 3 Expand use of EBP and train community providers on EBPS Dependent Measures: SysC Measurement Points: T0, T3
4. Program: Group Cognitive Behavioral Therapy for Major Depression	
Are individual and family outcomes being met?	Objective 1: Decrease depressive symptoms Dependent Measures: MAYSI-2, YOQ 2.0 SR, OQ®-45.2, CDI Measurement Points: T1 – T4
	Objective 2: Improve social functioning Dependent Measures: MAYSI-2, YOQ 2.0 SR, OQ®-45.2, PRI Measurement Points: T1 – T4
	Objective 3: Improve coping skills Dependent Measures: MAYSI-2, YOQ 2.0 SR, OQ®-45.2, S-eS Measurement Points: T1 – T4
Are program and system-wide outcomes being met?	Objective 1: Increase system capacity Dependent Measures: SysC Measurement Points: T0, T3
	Objective 2: Improve coordination of services between DMH and ADPA Dependent Measures: SysC Measurement Points: T0, T3
	Objective 3: Expand use of EBP and train community providers on EBPs Dependent Measures: SysC Measurement Points: T0, T3
5. Program: Loving Intervention for Family Enrichment (LIFE)	
Are individual and family outcomes being met?	Objective 1: Decrease youth aggression and social problems. Dependent Measures: MAYSI-2, YOQ-SR, PRI Measurement Points: T1 – T4

SUMMARY	
Evaluation Questions	Objectives, Dependent Measures, Measurement Time
	Objective 2: Improve youth self-efficacy Dependent Measures: S-eS Measurement Points: T1 – T4
Are program and system-wide outcomes being met?	Objective 1: Create system infrastructure to develop CDE practices Dependent Measures: SysC Measurement Points: T0, T3
	Objective 2: Promote a locally developed community-defined evidence practice Dependent Measures: SysC Measurement Points: T0, T3
6. Program: Multidimensional Family Therapy (MDFT)	
Are individual and family outcomes being met?	Objective 1: Decrease drug use Dependent Measures: MAYSI-2, YOQ 2.0 SR, Alc-SA Measurement Points: T1 – T4
	Objective 2: Improve family functioning Dependent Measures: FAM Measurement Points: T1 – T4
	Objective 3: Decrease conduct problems Dependent Measures: MAYSI-2, YOQ 2.0 SR, CBCL, School discipline reports Measurement Points: T1 – T4
Are program and system-wide outcomes being met?	Objective 1: Increase programs for underserved populations Dependent Measures: SysC Measurement Points: T0, T3
	Objective 2: Increase number of programs for youth with co-occurring disorders Dependent Measures: SysC Measurement Points: T0, T3
	Objective 3: Expand use of EBP and train community providers on EBP Dependent Measures: SysC Measurement Points: T0, T3
7. Program: Multisystemic Therapy	
Are individual and family outcomes being met?	Objective 1: Decrease recidivism. Dependent Measures: MAYSI-2, YOQ 2.0 SR, Beh Measurement Points: T1 – T4
	Objective 2: Decrease alcohol and drug use Dependent Measures: MAYSI-2, YOQ 2.0 SR, Alc-SA, SRD Measurement Points: T1 – T4
	Objective 3: Decrease peer aggression Dependent Measures: MAYSI-2, YOQ 2.0 SR, PRI Measurement Points: T1 – T4

SUMMARY	
Evaluation Questions	Objectives, Dependent Measures, Measurement Time
Are program and system-wide outcomes being met?	Objective 1: Reduce juvenile crime rate Dependent Measures: JJP Measurement Points: T0, T3
	Objective 2: Reduce out of home placements Dependent Measures: JJP Measurement Points: T0, T3
	Objective 3: Expand use of EBP and train community providers on EBPs Dependent Measures: SysC Measurement Points: T0, T3
8. Program: Positive Directions	
Are individual and family outcomes being met?	Objective 1: Decrease substance abuse Dependent Measures: Alc-SA Measurement Points: T1 – T4
	Objective 2: Increase anger management and conflict resolution skills Dependent Measures: MAYSI-2, YOQ-2.0 SR Measurement Points: T1 – T4
	Objective 3: Increase utilization of community support system for relapse prevention Dependent Measures: Therapist reports Measurement Points: T1 – T4
Are program and system-wide outcomes being met?	Objective 1: Promote a locally developed community-defined evidence program Dependent Measures: SysC Measurement Points: T0, T3
	Objective 2: Create system infrastructure to develop community-defined evidence programs Dependent Measures: SysC Measurement Points: T0, T3
9. Program: Prolonged Exposure Therapy for Post Traumatic Stress Disorder	
Are individual and family outcomes being met?	Objective 1: Reduce severity of trauma symptoms Dependent Measures: OQ®-45.2 Measurement Points: T2 – T4
	Objective 2: Decrease depression Dependent Measures: OQ®-45.2 Measurement Points: T2 – T4
	Objective 3: Improve social adjustment Dependent Measures: OQ®-45.2 Measurement Points: T2 – T4
Are program and system-wide outcomes being met?	Objective 1: Improve coordination of services between DMH and ADPA Dependent Measures: SysC Measurement Points: T0, T3

SUMMARY	
Evaluation Questions	Objectives, Dependent Measures, Measurement Time
	Objective 2: Expand use of EBP and train community providers on EBPs Dependent Measures: SysC Measurement Points: T0, T3
10. Program: Trauma Focused Cognitive Behavioral Therapy	
Are individual and family outcomes being met?	Objective 1: Decrease externalizing behavior problems. Dependent Measures: MAYSI-2, YOQ 2.0 SR, CBCL Measurement Points: T1 – T4
	Objective 2: Decrease symptoms due to trauma-exposure Dependent Measures: MAYSI-2, YOQ 2.0 SR, UCLA-PTSD RI Measurement Points: T1 – T4
	Objective 3: Decrease depression Dependent Measures: MAYSI-2, YOQ 2.0 SR, CDI Measurement Points: T1 – T4
Are program and system-wide outcomes being met?	Objective 1: Increase system capacity Dependent Measures: SysC Measurement Points: T0, T3
	Objective 2: Increase number of clients treated with an EBP Dependent Measures: SysC Measurement Points: T0, T3
	Objective 3: Increase satisfaction with discharge planning (for incarcerated youth) Dependent Measures: JJP, Therapist report Measurement Points: T3, T4

5. How will data be collected and analyzed?

A. DMH Central Data Evaluation Unit

Data collection and analyses will be managed by a centralized data evaluation unit that the department intends to create as PEI moves into its implementation phase. Data gathering, on-going clinical assessment, and feedback to clinicians are requirements that differ from what county clinicians normally experience. To facilitate this transformation, the department will expand EBP usage throughout the mental health system. The extent to which LACDMH can readily transform its current data evaluation practices will dictate the depth of the data management.

B. Data Collection Procedures

Data collection procedures will be managed centrally by the unit mentioned above in the interests of standardization and streamlining work flows, but will be implemented on a site by site basis according to staffing and program requirements. As a means of

insuring data gathering compliance, LACDMH intends to specify this requirement as part of its bidding process. Data collection procedures have been planned based upon the general measurement timeline mentioned below:

T0: Pre-implementation baseline data gathering. Data generated as a result of the community needs assessment conducted during the PEI planning phase can be used to establish baselines for the juvenile justice population. Additional sources of information will be collected by the centralized data unit for use later in the statistical analyses as they become completely determined.

T1: Initial Assessment at Juvenile Hall. All youth currently in detention at County Juvenile Hall must undergo a screening by the County Departments of Mental Health, Probation, and the Office of Education. County mental health workers administer a collection of screening instruments, and this will be augmented by the PEI outcome measures. These instruments will be scored and stored by the centralized data unit in order to document a baseline level of functioning. Additional demographic information and records (e.g. probation records, educational status) provided by partnering departments will be available at that time and will be collected and stored by the centralized data unit.

T2: Post-adjudication/pre-treatment. A cohort of youth is routinely referred to the mental health system for treatment and others may be self-referred or referred by different systems pathways. T2 PEI outcome instruments will be administered by county mental health staff in order to document a pre-treatment level of functioning upon entering a PEI juvenile justice program. Statistical analyses will be able to compare differences in functioning between different cohorts (i.e. comparison groups) at the start of treatment and also differences in functioning within the Juvenile Hall cohort attributable to the passage of time (i.e. time to treat). These instruments will be scored either by the clinician for their immediate use and/or stored by the centralized data unit for later statistical analyses.

T3: Post-treatment. As clients and their families terminate from their PEI intervention, it will be possible to assess their level of functioning similar to traditional treatment outcome research. County mental health staff will administer a packet of measures which will be scored and stored for later analyses by the centralized data unit. Additionally, for programmatic and systemic outcomes, the centralized data unit will be responsible for gathering data on these indicators.

T4: Follow-up. Due to the differences in the project's composite programs, follow-up will proceed at different points in time beyond T3. The centralized data unit will be primarily responsible for following clients, administering the outcome measures, scoring, and storing, and analyzing data.

C. Data Analyses

All data will be submitted for statistical analyses using traditional methods examining differences between and within groups pertinent to the evaluation questions posed above. It should be noted that besides the individual main effects attributable to a specific program, the current evaluation design makes it possible to examine project-wide effects. Below is a sample of possible statistical comparisons that could be made and their implications for answering both program and project-level evaluative questions.

Q. Does a particular program work in decreasing symptoms of depression?
Statistical test: *Compare pre-test, post-test, and follow-up scores on outcome measures such as the MAYSI-2 and the CDI*

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Q. Does a particular program work in decreasing recidivism?
Statistical test: *Compare recidivism rate and treatment utilization at each measurement point in time.*

Q. Does a particular program work in increasing school indicators?
Statistical test: *Compare school attendance records, and grades with treatment utilization at each measurement point in time.*

Q. Which family therapy program can best treat prevent substance abuse?
Statistical test: *Compare group substance abuse scores across treatment modalities.*

D. Extending Basic Theory

The current design lends itself to examining important questions pertaining to the theories of intervention for the juvenile justice population. Questions using the study data set could be answered in the following ways:

Q. How does therapeutic alliance and client motivation influence treatment success in the juvenile justice population?
Statistical test: *Compare indicators of treatment progress (i.e. recidivism rate) with level of therapeutic alliance strength reported by adolescents.*

Q. How important are therapist characteristics, such as ethnicity, in achieving positive outcomes?
Statistical test: *Calculate congruence in therapist-child dyads and compare to outcome indicators. Additionally, determine if congruence and alliance levels interact to determine outcomes.*

Q. Can any of the programs effect lasting changes in the moral reasoning of adolescents?

Statistical test: *Compare group PROM scores, recidivism, and PRI scores across treatment programs and over the measurement timeline.*

6. How will cultural competency be incorporated into the programs and the evaluation?

Central to the notion of providing culturally competent mental health services is the extent to which ethnic and language differences function as barriers to accessing services. These differences have had at least two effects in Los Angeles County. One is that the number of youth from underserved populations is disproportionately represented within the juvenile justice/probation system and mental health system. Additionally, the county's needs assessment indicated that this great need was compounded by discrepancies in mental health staffing ratios across primary language groups. Each program within the Juvenile Justice Services Project can be documented according to variables such as staffing ratios or the congruence between client and therapist demographic profiles, and treatment population demographics.

One of the reasons for the inclusion of the Juvenile Justice Services Project is the obvious problem with the ethnic distribution of incarcerated youth and youth under probation supervision. The programs selected for the project came from analyzing the needs assessment data and the subjective inputs provided by individual and group stakeholders. In short, they will all target at-risk youth from underserved populations. To further increase services for underserved youth, two community-defined evidence practices which were specifically developed for underserved populations are included in the present project.

Cultural competence variables can be assessed in a similar fashion to the clinical and system-wide outcomes mentioned above. In fact, one should really think of cultural competence outcomes as being a specialized system outcome that should be examined at the individual program level, but also at the project level and beyond. Similar to the comparison mentioned previously, the central data unit will manage data gathering and analyses for the culturally related variables to demonstrate how the system has evolved during the course of the reporting period (e.g. T0 – T3, T4).

7. What procedure will be used to ensure fidelity in implementing the model and any adaptation(s)?

A. Establishing Fidelity Controls

Since all programs are either EBPs or CDEs which have been extensively reviewed to insure replicability, all of the selected programs have a standardized treatment protocol or accompanying manual which makes assessing adherence to the treatment model straightforward. Additionally, in some cases, programs have a fairly comprehensive

training component embedded into their protocol that practitioners must complete in order to become a certified provider. LACDMH recently implemented a Community Development Team (CDT) whose goals are the promotion, monitoring, and fidelity control of evidence-based practices. The team's approach to fidelity control will be applied to all PEI projects including the Juvenile Justice Services Project.

Fidelity controls may be thought of as a set of tools used to standardize service delivery in order to maximize a particular practice's proven treatment effects. Without such controls in place, over time, therapeutic systems may lose focus or begin introducing new elements or neglecting others that, in turn, influence treatment effects in unforeseen ways. The following represents the fidelity controls which are envisioned and it is believed that these will be augmented when consultation with experts in EBP implementation occurs.

- **Data Evaluation Unit**
  The data evaluation unit will oversee on-going clinical assessment and service utilization statistics for PEI programs, gather relevant outcomes data, and publish timely reports concerning individual, program, and system-wide outcomes. The experience of the Department's CDT has shown that regular reporting helps to keep clinicians on course and within the treatment parameters of a given practice.

- **Standardized and Manualized Treatments**
  A hallmark of Los Angeles County's PEI Projects is the use of Evidence-Based Practices. Again, one of the features that makes a program successful in the lab is the adherence to a treatment protocol. Having a manual and the infrastructure to promote its use makes insuring fidelity largely a training issue for clinicians new to the practice and a monitoring issue for those with more experience.

- **Supervision/Consultation Model**
  A key component will be the extensive level of supervision and support provided to individual clinicians and provider agencies. The CDTs have developed a model that includes the following features:

  i. Hierarchical consultation for line staff by local implementation experts, county experts, and the developer themselves. The information pathways lead to the developer of the practice who maintains authority control of the practice features.

  ii. On-going consultation – CDTs maintain on-going group consultations between provider sites in order to ensure standardization across agencies.

  iii. Video and audio taping sessions – Line staff are required to submit video and audio taped sessions for review by the CDTs in order to provide technical assistance and determine where drift in standardization is occurring. The CDTs have found that it is easier to implement a corrective action at the line

staff level before a potentially viral and non-standard feature propagates throughout an agency.

iv. Clinical feedback – The importance of a feedback loop within the treatment system is essential in maintaining the integrity of the treatment approach. Because all social systems are characterized by variation at the individual level and because small variations can lead to larger ones later, a system must have in place a mechanism to correct for and to adjust to drift. While some errors in protocol may be self-correcting, others may require additional supports. Utilization reports, coded video and audio recorded sessions, and supervision/consultation function as feedback to clinicians who will then be able to make adjustments to their practice.

8. How will the report on the evaluation be disseminated to interested local constituencies?

Dissemination of all evaluation reports will be conducted in two ways: first, traditional methods for publishing public information will be used to reach as broad an audience as possible, and second, more focused methods of outreaching to interested stakeholder groups will occur to insure that special populations are adequately informed. Descriptions of these approaches appear below.

A. Versions

The evaluation findings will be provided in a variety of formats and languages. All reports will be available in electronic and print formats.

- Full report (English and Spanish) – A detailed write up of the evaluation procedures, methods, materials, and statistical analyses.
- Executive Summary (English and Spanish) – A condensed write up of the main effects and important conclusions of the evaluation.
- Fact Sheet (threshold languages) - A highly condensed and extracted list of important findings.
- PowerPoint – PowerPoint presentations highlighting the evaluation phase of the PEI project and also highlights of the evaluation findings.

B. Local Dissemination Mirrors Planning Phase

Targeted Presentations. Because of the size of the county, the planning process proceeded regionally across the county's eight Service Areas. Additional planning was conducted for special countywide populations who were not tied to a particular Service Area. Informational meetings to present the evaluation findings will be held so that results can be distributed to interested stakeholders in each Service Area. Because of

the structure of the planning process and the implementation phase of PEI, it was thought that providing feedback at the Service Area level would be a natural and expected feature of the entire endeavor.

Besides the Service Areas, the planning phase involved several important stakeholder groups who would also benefit from learning about the evaluation findings. Management staff within LACDMH, the MHSA delegates group, and various county commissions all have a vested interest in outcome findings. Presentations will be arranged to provide them with an overview of the findings. Because the PEI stakeholder contact database developed during the planning phase includes several thousand individuals, it will be possible to contact stakeholders based upon their stated interests and constituencies. Additional meetings to distribute findings will be possible based upon planning sector representation, age group interests, underserved populations, and supervisorial districts. For example, it will be possible to target the PEI Law Enforcement sector in order to arrange an informational meeting to discuss study results.

Widespread Dissemination - Electronic Versions. As mentioned above, the PEI stakeholder database contains several thousand interested individuals and email correspondence to them will alert them of the evaluation finding documents available to them. The full report, executive summary, and all the language specific fact sheets will be posted in pdf format on the LACDMH website: http://dmh.lacounty.gov/.

Widespread Dissemination - Professional Publication. It is believed that the proposed evaluation has the possibility of extending theoretical understanding of the community mental health services in a variety of ways. Given time and approval from the Department of Mental Health's Human Subjects Committee, aspects of the program evaluation may be separately prepared and submitted for publication in a peer-reviewed journal. Contributing to the professional literature insures that lessons learned from the current project can be replicated in other urban areas within the United States.