

Mental Health Services Act Overview



WELLNESS • RECOVERY • RESILIENCE



Debbie Innes-Gomberg, Ph.D.
October 30, 2013

“Nurturing Hope, Promoting Wellness and Supporting Recovery”

Overview

- ❑ **Proposition 63 – Mental Health Services Act (MHSA)**
 - California ballot proposition
 - Passed November 2004
 - Funding began January 1, 2005
- ❑ **How it is funded** – 1% state tax on incomes of \$1 million or more
- ❑ **What it funds** – Expansion of mental health services and programs
- ❑ **Who it serves** – All ages (ages defined in CSS Guidelines)
 - Children (0-15)
 - Transitional Age Youth (16-25)
 - Adults (26-59)
 - Older Adults (60 and older)

MHSA Core Principles

- Client/family driven
- Cultural competence
- Community collaboration
- Service integration
- Focus on recovery, wellness, and resilience

MHSA Plan Components

- **Community Services and Support (CSS) Plan:**
*Feb. 14, 2006**
- **Workforce Education and Training (WET) Plan:**
*April 8, 2009**
- **Information Technology Needs Plan:**
*May 8, 2009**
- **Prevention and Early Intervention (PEI) Plan:**
*Sept. 27, 2009**
- **Innovation (INN) Plan:**
*Feb. 2, 2010**
- **Capital Facilities Plan:**
*April 19, 2010**

* Date Approved by the State

MHSA Funding Information

MHSA funding is allocated as follows:

Component	Annual Percentage of MHSA	Reversion Period
CSS	75 – 80%	3 years
PEI	15-20%	3 years
INN	5%	3 years*
WET	One time funding	10 years
CF	One time funding	10 years
TN	One time funding	10 years
Housing	One time funding	10 years

*The county is required to utilize 5% of the total funding for CSS and PEI for Innovation Programs

Counties can allocate up to 20% for CF/TN, WET and the Prudent Reserve for any year after 07-08

Relevant MHSA Guidance

- The Mental Health Services Act
http://www.dmh.ca.gov/prop_63/mhsa/
- Mental Health Services Act regulations
California Code of Regulations Title 9, Div.
1, Chapter 14, Section 3200.010- 3650
- AB 100
- AB 1467

The Mental Health Services Act: Key Elements of the Legislation

- ❑ Specifies a Prevention and Early Intervention program that prevents mental illnesses from becoming severe and disabling and services should reduce the duration of untreated severe mental illnesses and assist people in quickly regaining productive lives.
- ❑ Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons.

The Mental Health Services Act: Key Elements of the Legislation

- ❑ Funds dedicated to remedy the shortage of qualified individuals to provide services to address severe mental illnesses (WET).
- ❑ Mental health services for each age group.
- ❑ Innovation programs to be funded to increase access to underserved to services and to increase access to services for underserved groups, to increase the quality of services and/or to promote interagency collaboration.
- ❑ Establishes a Mental Health Services Oversight and Accountability Commission at the State level.

The Mental Health Services Act: Key Elements of the Legislation

- ❑ Each county shall prepare a 3 Year Program and Expenditure Plan that is updated annually.
- ❑ Each plan and update shall be developed with local stakeholder input.
- ❑ A draft plan shall be prepared and circulated for review and comment for at least 30 days to representative stakeholders.

The Mental Health Services Act: Key Elements of the Legislation

A county mental health program shall include an allocation of funds from a reserve to be used in years in which the allocation of funds are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year (Prudent Reserve).

Mental Health Services Act Regulations: Key Elements

- ❑ Definitions
- ❑ Defines systems of care as the Community Services and Supports plan.
- ❑ No person shall be denied access based solely on his/her voluntary or involuntary legal status.
- ❑ The county is not obligated to use MHSA funding to fund court mandates.
- ❑ The county shall not supplant funds.

Mental Health Services Act Regulations: Key Elements

- Quarterly progress reports for CSS programs (Exhibit 6)
- FSP performance outcome data defined
- Key services defined for CSS components
- FSP focal populations identified

AB 100

- Effective March 24, 2011
- Supported MHSA cash flow to counties and local accountability for MHSA funds
- MHSA plans no longer approved by the State Department of Mental Health
- Mental Health Commission approves MHSA Annual Update

AB 1467

- ❑ Enacted on June 27, 2012 as part of a trailer bill to the FY 2012/13 State budget.
- ❑ Amends language from State DMH Innovation Guidelines into statute.
- ❑ County MHSA Annual Updates and 3 Year Program and Expenditure Plans must be adopted by the local Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission within 30 days of Board adoption.

AB 1467

- Augments the stakeholder engagement requirements to require counties to “demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning and implementation, monitoring, quality improvement, evaluation and budget allocations.”
- Providers of alcohol and drug services and health care organizations were added to the list of stakeholders to be engaged in the development of the 3 Year Plan and Annual Update processes.

County of Los Angeles
MHSA Stakeholder Delegates

CSS
Ad Hoc
Work Groups

INN
Ad Hoc
Work Groups

WET
Ad Hoc
Work Groups

IT/CF
Ad Hoc
Work Groups

PEI
Service Area Level
Planning Process

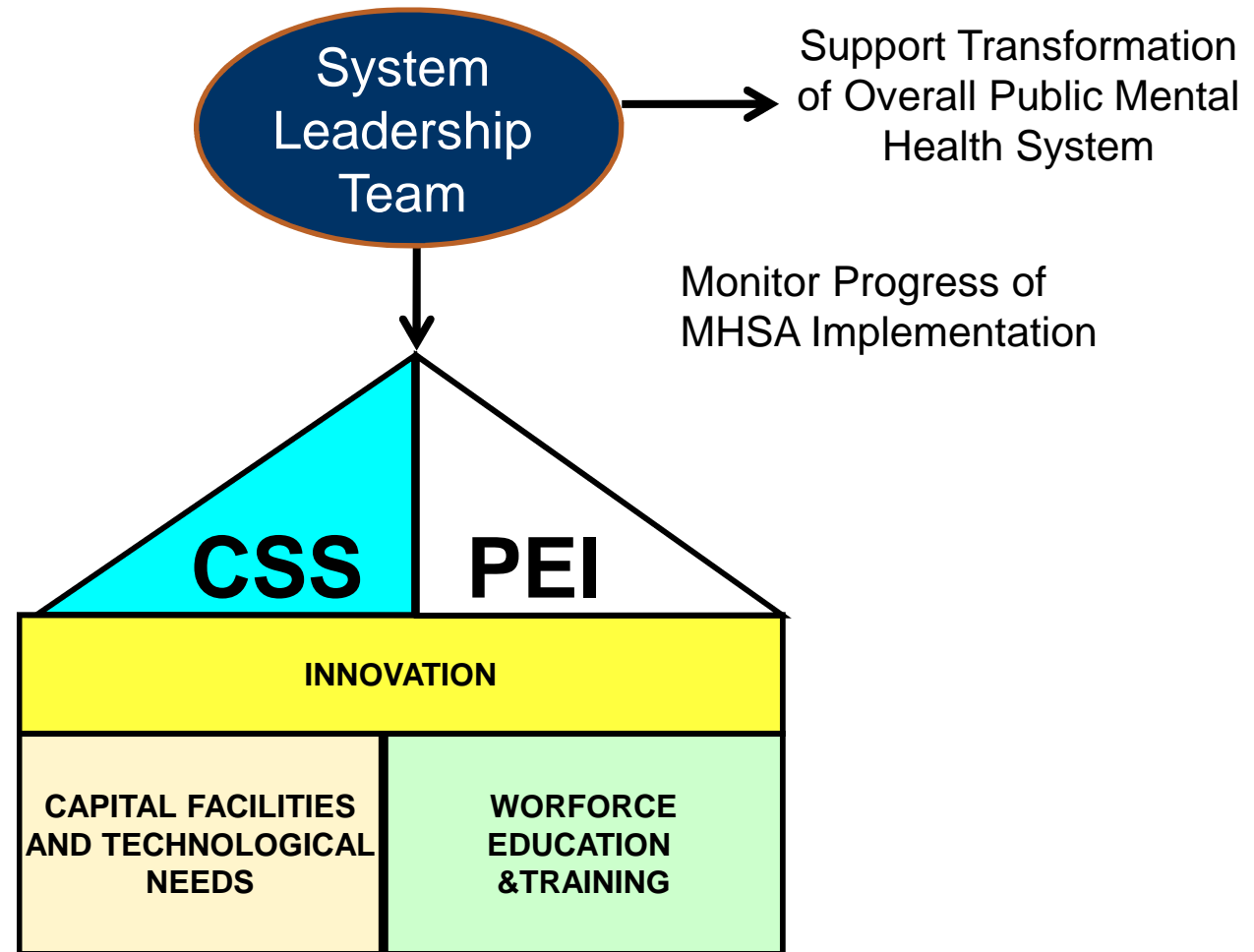
Underrepresented Ethnic
Populations

Service Area Advisory Committees (SAAC)

- SAAC 1
- SAAC 2
- SAAC 3
- SAAC 4
- SAAC 5
- SAAC 6
- SAAC 7
- SAAC 8



MHSA Stakeholder Process



From the Mental Health Services Act

Focal Populations

- **Underserved:** A client diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided with the necessary or appropriate opportunities to support their recovery, wellness and/or resilience.
 - Includes clients who are so poorly served that they are at risk for homelessness, institutionalization, incarceration, out of home placement or other serious consequences.
 - Includes members of ethnic/racial, cultural and linguistic populations.

From the Mental Health Services Act

Focal Populations

- **Unserved:** Those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with the county are also considered unserved.

Full Service Partnership Focal Population

Section 3620.05. Must meet eligibility under WIC 5600.3 *and* be unserved or underserved and:

Child: Have a serious emotional disturbance *and*:

1. Aged 0-5 who is either at risk of expulsion from pre-school, is involved with or at risk of being detained by DCFS or has a parent/caregiver with SED or SMI, has a substance abuse disorder or co-occurring disorder.
2. Child/youth who has been removed or is at risk of being removed from their home by DCFS or is in transition to a less restrictive placement.
3. Child/youth who is experiencing suspension or expulsion, violent behaviors, drug possession or use or suicidal and/or homicidal ideation at school.
4. Child/youth who is involved with probation, is on psychotropic medication and is transitioning back into a less structured home/community setting.

Transition Age Youth: Have a serious emotional disturbance or serious mental illness *and*:

1. Aging out of child mental health, child welfare system or juvenile justice system.
2. Youth leaving long-term institutional care (CTF, IMD, level 12-14 group homes, jail, State Hospital or probation camps).
3. Youth experiencing first psychotic break.
4. Co-occurring substance use disorder in addition to meeting any of 1-3.
5. Homeless or currently at risk of homelessness.

Full Service Partnership Focal Population

Section 3620.05. Must meet eligibility under WIC 5600.3 *and* be unserved or underserved and:

Adult: Has a serious mental illness *and*:

1. Homeless
2. Recent history of incarcerations.
3. Transitioning out of an IMD or State Hospital.
4. Frequent user of hospitals or emergency services.
5. Living with family members without whose support the individual would be at imminent risk of homelessness, incarceration or hospitalization.

Older Adult: Has a serious mental illness *and*:

1. Homeless or at imminent risk.
2. Recent history of incarcerations or at imminent risk.
3. Recent history of psychiatric hospitalizations.
4. At imminent risk for placement in a Skilled Nursing Facility or nursing home.
5. Presence of a co-occurring substance abuse, developmental, medical or cognitive disorder.
6. Has a recurrent history or is at risk of abuse or self-neglect
7. Serious risk of suicide.

Field Capable Clinical Services

Focal Populations

Child: Individuals, ages 0-15, who have a Serious Emotional Disturbance (SED) and are unserved, underserved or inappropriately served, including:

- Individuals who are in the foster care system or at risk of foster care placement; and/or
- Individuals who have co-occurring substance abuse, developmental or medical disorders; and/or
- Individuals who are at serious risk of school failure; and/or
- Individuals who are at serious risk of involvement in the juvenile justice system; and/or
- Individuals who have experienced trauma; and/or
- Individuals for whom intensive FSP services are not appropriate or available; and/or
- Individuals who have a history of recent psychiatric hospitalizations or are at high risk for psychiatric hospitalization; and/or
- Individuals who are at serious risk for suicide.

Transition Age Youth: Individuals, ages 16-25, who have SED and/or Severe and Persistent Mental Illness (SPMI), and persons with Co-Occurring Substance Abuse Disorders (COD).

- Individuals who are in need of mental health services and supports, but who are unable or unwilling to avail themselves of these services in traditional mental health clinic settings.
- Clients at "transition points" e.g. transitioning from Child to TAY-focused mental health services and supports, and clients transitioning from congregate care to community-based or home-based settings.
- Individuals with COD who are more likely to access services and supports through non-mental health community based organizations than through community mental health clinics.
- Individuals authorized for intensive services programs (e.g. FSP) who have been in Outreach and Engagement for an extended period of time and who are ambivalent or chose not to participate in an enrollment-based intensive services program.
- Individuals enrolled or participating in intensive services programs or settings
- Individuals from existing caseloads with open episodes whose mental health needs could be better served in an FCCS program; and/or
- Individuals whose mental health services and support needs can be met in community settings; and/or
- Individuals who can otherwise live independently and/or with minimum supervision in the community while receiving mental health services and supports.

Field Capable Clinical Services

Focal Populations

Adults: Individuals, ages 26-59, who have a serious mental illness and have difficulty accessing traditional adult outpatient clinic-based services including:

- ❑ Persons who are isolated or homebound; and/or
- ❑ Persons who are difficult to engage through traditional clinic-based service approaches; and/or
- ❑ Persons who are otherwise at high risk, but either do not qualify for FSP or ACT or are transitioning out of those services and are not ready for Wellness Center services; and/or
- ❑ Persons transitioning out of IMDs or other institutions who either do not qualify or are not best served by FSP programs; and/or
- ❑ Persons receiving a service from a community agency who would benefit from co-located, on-site mental health services provided in conjunction with the community agency.

Older Adult: Individuals, age 60 and above who have a SPMI or who have a serious mental illness that is impairing their ability to function and are unable or unwilling to access mental health services in a traditional mental health clinic may receive FCCS.

- ❑ Transitional age adults, ages 55-59, whose needs are more consistent with individuals age 60 and above, who have a SPMI or who have a serious mental illness that is impairing their ability to function and are unable or unwilling to access mental health services in a traditional mental health clinic may receive FCCS. Older adult focal populations to be served through FCCS include:
 - ❑ Isolated and/or homebound older adults unable to care for self, with limited or no support system; and/or
 - ❑ Older adults with a history of or who are at serious risk of neglect or abuse; and/or
 - ❑ Older adults with co-occurring mental illness and substance abuse, developmental, cognitive and/or medical disorders; and/or
 - ❑ Older adults transitioning from one level of care to another (e.g. home to residential or skilled nursing facility); and/or
 - ❑ Older adults released from jail or with a history of or who are at risk of incarceration; and/or
 - ❑ Older adults with multiple psychiatric hospitalizations in the recent past.

Focal Populations Across the Spectrum

IMD Step-Down Services:

- Clients transitioning out of IMD programs.

Prevention and Early Intervention:

- **Prevention:** Services geared toward preventing those with a risk of developing a serious mental illness or serious emotional disturbance from developing it.
- **Early Intervention:** Services geared toward clients early in the course of a serious mental illness or serious emotional disturbance.

Innovation:

- Individuals with a serious mental illness and one or more co-occurring physical health or substance abuse disorders.
- Unserved and underserved populations include:
 - Focus on engaging and serving clients without a payor source (all models).
 - Focus of engaging and serving clients from the African-American, Latino, Asian Pacific Islander, Middle Eastern-Eastern European and Native American communities (Integrated Services Management Model)
 - Focus on engagement and services for homeless and vulnerable populations (Integrated Mobile Health Team).

The Community Services and Supports (CSS) Plan

- ❑ Mental health service delivery systems for all age groups, similar to WIC sections 5800 (adult and older adult systems of care) and 5850 (for children's system of care) MHPA regulations-3200.080.
- ❑ Regulations define 3 categories:
 - Full Service Partnerships (FSP)
 - General Systems Development
 - Outreach and Engagement
- ❑ FSP programs must comprise over half of CSS funding.

Community Services and Supports (CSS) Plan

- ❑ Full Service Partnership (FSP) Programs
- ❑ Field Capable Clinical Services (FCCS)
- ❑ Family Support Services (FSS)
- ❑ Linkage Programs
- ❑ Drop-In Centers for Transition Age Youth (TAY)
- ❑ TAY Housing
- ❑ Wellness/Client Run Centers
- ❑ MHSA Housing Trust Fund (HTF)
- ❑ Alternative Crisis Services

Community Services and Supports Plan- Fiscal Year 2011-12 Clients Served

- ❑ 96,710 unique clients received a direct mental health service in a CSS program.
- ❑ Of those unique clients served, 32,276 were new clients to the system. 44% were Latino.
- ❑ Of the new clients in CSS programs with no previous MH service of any kind, 43% were Latino.
- ❑ Of the new clients in CSS programs who had previously been served in PEI programs, 54% were Pacific Islander.

Community Services and Supports (CSS) Plan

Full Service Partnership (FSP) Programs

- In Los Angeles County, focal populations have been limited primarily to those with recent histories of hospitalization, homelessness, institutionalization, incarceration, and for children and TAY, in or risk of out of home placement or school failure.
- Serve clients with intensive needs doing “whatever it takes”.
- Comprehensive (full service) mental health and supportive services, including housing support.
- Low staff to client ratio, not to exceed 1:15.
- 24/7 availability by a person known to the client.

FSP Program Outcomes

- Children in Full Service Partnership (FSP) programs spent 28% fewer days residing in juvenile hall settings after enrolling in FSP programs.
- 27% fewer children were psychiatrically hospitalized after enrolling in FSP programs.
- 64% more TAY clients were living independently after enrolling in FSP programs, with a 112% increase in the number of days living independently.

FSP Program Outcomes

- 35% fewer adults were homeless after enrolling in FSP programs, with a 69% decrease in the number of days homeless.
- 84% more adults were living independently after enrolling in FSP programs, with a 93% increase in the number of days living independently.
- Adults in FSP programs spent 69% fewer days in jail after enrolling in FSP programs.
- 25% more adult clients were participating in supported employment services after enrolling in an FSP program.

FSP Program Outcomes

- Older adults in FSP programs experienced an 80% reduction in the number of days homeless and an 86% reduction in the number of days in jail after enrolling in an FSP.
- 38% more older adults were living independently after enrolling in an FSP program.

FSP Cost Offsets

An analysis done through the Mental Health Services Act Oversight and Accountability Commission for FSP clients served in LA during FY 09/10 yielded:

- 208% offset of FSP costs for Transition Age Youth
- 262% offset of FSP costs for adults
- 184% offset of FSP costs for older adults

Field Capable Clinical Services (FCCS)

- ❑ Specialized clinical services delivered by professional and paraprofessional staff as part of a multi-disciplinary treatment team.
- ❑ An essential element of FCCS is the formation of partnerships with community agencies to better serve children and their families.
- ❑ 35-70% of all FCCS are to be provided in field-based settings.
- ❑ Services are intended to improve access to mental health services for those individuals who are unwilling or unable to utilize mental health services offered in traditional mental health settings.
- ❑ Field-based services are new and unduplicated services that seek to reach individuals with a mental illness or serious emotional disturbance who are at-risk of needing higher level services.

FCCS Program Outcomes

Clients across the age spectrum continue to experience increases in involvement in their communities and in meaningful activities as a result of Field Capable Clinical Services (FCCS) programs.

Linkage Programs

- ***Service Area Navigators:***

- A team in each Service Area who provide education and linkage to mental health services.

- ***Jail Linkage Team:***

- Outreaches and engages individuals involved in the criminal justice system and receiving services from jail or jail-related services and successfully link them to community-based services upon their release from jail.

- ***Housing Specialists:***

- Assist clients with obtaining permanent housing through identifying available housing and assisting clients with the paperwork associated with renting and leasing.

Drop-In Centers for Transition Age Youth (TAY)

Drop-In Centers are intended as entry points into the mental health system for Serious Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY who are living on the street or in unstable living situations.

Drop-In Centers provide:

- “Low-demand, high tolerance” environments in which youth can find temporary safety and basic supports.
- Increase access to basic support and services for TAY. Basic support and services include, but are not limited to;
 - Showers, meals, housing, and linkage to mental health treatment and substance abuse resources.

The funding for this program also assists with Outreach and Engagement efforts to TAY during the extended evening and weekend hours.

TAY Housing

- ❑ **Enhanced Emergency Shelter Program (EESP)** (Previously, Motel Voucher Program) for TAY that are homeless, living on the streets and in dire need of immediate short-term shelter while more permanent housing options are being explored.
- ❑ **Project-Based Operating Subsidies for Permanent Housing** to address the long-term housing needs of SED/SPMI TAY who, with sufficient support, could live independently in community settings. The targeted number of youth to secure units with TAY Project-Based Operating Subsidies is 72.
- ❑ A team of 8 **Housing Specialists** develop local resources and help TAY find and move into affordable housing.

Wellness/Client Run Centers

- ❑ Self-directed, community-based services staffed by peer and professional.
- ❑ Support geared toward physical and emotional recovery and increased community integration.
- ❑ Focal population is clients at higher levels of recovery.

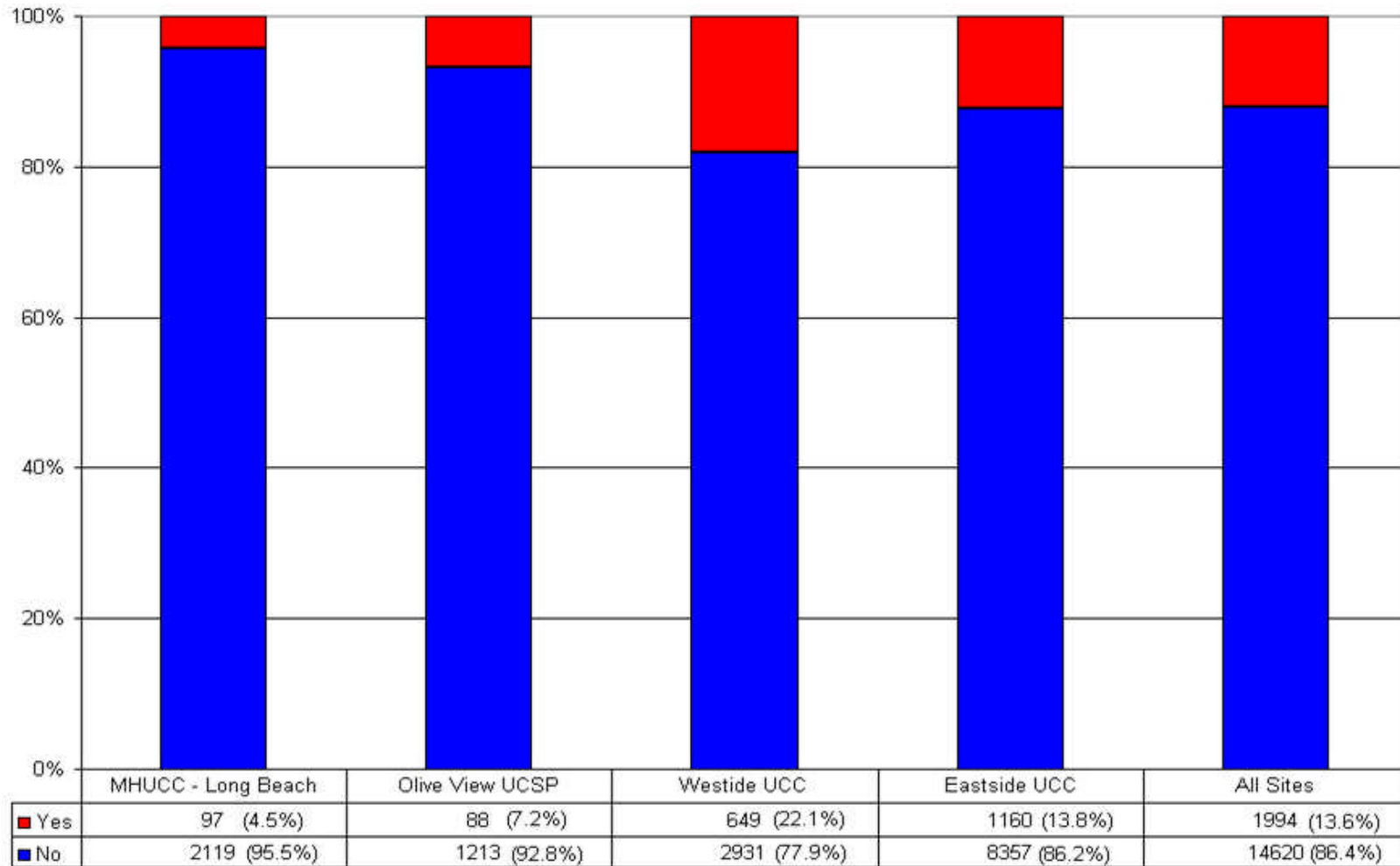
Alternative Crisis Services: Urgent Care Centers (UCC)

- ❑ Provide intensive crisis services to individuals who otherwise would be brought to emergency rooms.
- ❑ Provide up to 23 hours of immediate care and linkage to community-based solutions.
- ❑ Provide crisis intervention services, including integrated services for co-occurring substance abuse disorders.
- ❑ Geographically located throughout the County.
- ❑ Focus on recovery and linkage to ongoing community services and supports that are designed to impact unnecessary and lengthy involuntary inpatient treatment.

Alternative Crisis Services (ACS-01)

Any Inpatient, PMRT, Psych ER, Jail MH Contact Within 30 Days of a UCC Assessment

January 1, 2012 through September 30, 2012



41

***Westside and Eastside UCCs are the only LPS-designated UCCs; many persons are on a 5150 upon admission and transferred to acute inpatient setting therefore their hospitalization rates are higher.**

Alternative Crisis Services: Institute for Mental Disease (IMD) Step-Down

- ❑ IMD Step-down Facility programs are designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities (ARF), and in some instances, assisted living, congregate housing or other independent living situations.
- ❑ The program also assists clients transitioning from acute inpatient and institutional settings to the community by providing intensive mental health and supportive services.

Alternative Crisis Services: Residential and Bridging

- ❑ DMH program liaisons and peer advocates to assist in the coordination of psychiatric services and supports for individuals being discharged from County Hospital Psychiatric Emergency Services, Urgent Care Centers, IMDs, and crisis residential, supportive residential, substance abuse, and other specialized programs.
- ❑ Promotes the expectation that individuals must be successfully reintegrated in their communities upon discharge and that all care providers must participate in the individual's transition to the community.
- ❑ Mental Health Peer Advocates facilitate self-help and substance abuse groups in IMD and IMD Step-Down Programs. In addition, Advocates provide education and information about recovery and wellness to clients, families, and providers.

Alternative Crisis Services: Countywide Resource Management (CRM)

- ❑ Provide overall administrative, clinical, integrative, and fiscal management functions for the Department's indigent acute inpatient, long-term institutional, and crisis, intensive, and supportive residential resources, with a daily capacity for approximately 1,400 persons.
- ❑ Provide coordination, linkage, and integration of inpatient and residential services throughout the system to reduce rates of re-hospitalization, incarceration, and the need for long-term institutional care, while increasing the potential for community living and recovery.

Capital Facilities and Technological Needs (CFTN)

The MHPA-IT Plan includes six technological needs projects.

The largest and most expensive of these projects, the ***Integrated Behavioral Health Information System*** (IBHIS) project, involves selecting an electronic health record (EHR) vendor and implementing an EHR system for use within LAC-DMH directly operated clinics.

The remaining five projects are:

- Contract Provider Technological Needs Project
- Consumer/Family Access To Computer Resources Project
- Personal Health Record Awareness and Education Project
- Telepsychiatry Implementation Project
- Data Warehouse Re-design Project

Workforce Education & Training

- ❑ Expanded Employment/Professional Advancement for Family Members in the Public MH System
- ❑ MH Career Advisors
- ❑ High School through University MH Pathways
- ❑ Market Research and Advertising Strategies for Recruitment of Professionals in the Public MH System
- ❑ Partnerships with Educational Institutions
- ❑ Recovery Oriented Internship Development
- ❑ Public MH Workforce Financial Incentives
- ❑ Stipend Program-Psychology, MSWs, MFTs, Psychiatric Nurse Practitioners & Psych Technicians

Workforce, Education & Training

FY 11/12

- ❑ 145 staff trained in Public Mental Health Immersion to MHSA
- ❑ 256 individuals have received Licensure Examination Preparation assistance since FY 11-12 (on-going)
- ❑ 37 individuals completed the Health Navigator Skill Development Program, 20 are working or have completed the necessary hours for full certification
- ❑ 161 supervisors completed the Recovery Oriented Supervision
- ❑ 107 interpreters trained
- ❑ 13 monolingual providers trained in using interpreters
- ❑ 614 individuals the Community College collaborative symposiums held on 4 campuses across the County
- ❑ 21 clergy and DMH staff where trained in implementation of roundtables in SA 6 and 7 as part of the Faith Based Pilot Project

Workforce, Education & Training

FY 11/12

- ❑ 137 participants completed the Intensive MH Recovery Specialist Training Program
- ❑ 78 parents completed the Parent Partner/Parent Advocate training program
- ❑ A total of 1,210 faculty and students attended the MHSA presentations or MHSA mini-immersion
- ❑ Stipends were provided to 20 Marriage Family Therapist (MFT) students and 18 Masters of Social Work (MSW) students. Additionally, 32 MFT and 32 MSW stipends were funded by MHSA PEI
- ❑ Six Postdoctoral Fellows were funded to receive additional educational opportunities that support evidence-based model and the under- and un-served communities

Workforce, Education & Training

FY 11/12

- ❑ 17 mental health consumers interested in becoming part of the public mental health workforce as mental health peer advocates completed the Core Peer Advocate Training
- ❑ 28 individuals who are currently employed in the mental health system in a peer advocate capacity completed the Advance Peer Support training program
- ❑ 13 individuals who are currently employed in the mental health system in a peer advocate capacity completed the Train-the-Trainer training program

Prevention & Early Intervention (PEI)

- Reduction of the 7 negative outcomes
 - Suicide
 - Incarcerations
 - School failure or dropout
 - Unemployment
 - Prolonged suffering
 - Homelessness
 - Removal of children from families

Prevention & Early Intervention

Stakeholders approved:

- 45 Evidence-Based Practices and Community Defined Evidence Practices
- 65% of services for children and transition age youth
- 30% for new Community-Based Organizations
- 30% for Directly Operated
- 60% for existing legal entity contractors

Prevention & Early Intervention – Clients served in FY 2011-12

- 61,422 unique clients served
 - 58% Latino
- 40,062 new clients received PEI services. Of those:
 - 60% of the clients who had never received a prior PEI or CSS service were Latino
 - 40% of the clients who were new to PEI but had previously received a CSS service were Pacific Islander

Prevention & Early Intervention

PEI Programs and Projects:

- School-based services
- Family Education, Training and Support Services
- At-Risk Family Services
- Trauma Recovery Services, including Veterans
- Primary Care and Behavioral Health
- Early Care and Support for Transition Age Youth
- Juvenile Justice
- Early Care and Support for Older Adults
- Improving Access to Underserved Populations
- Services for Native Americans

The Initial Impact of PEI Services

- **Managing and Adapting Practice (MAP):** This practice encompasses several foci of treatment, including anxiety, trauma, depression and disruptive behavior disorders. While the matched pairs are relatively low at this point, both children and parent/caregivers have endorsed the strongest positive change related to the treatment of disruptive behavior disorders, with **67%** of parents endorsing positive change on the Youth Outcome Questionnaire (YOQ) and **57%** endorsing positive change on the Eyberg Child Behavior Inventory (ECBI), **40%** of children endorsing positive change on the YOQ-SR, and **55%** endorsing positive change on the ECBI. Overall, matched pair results to date indicate that parent/caregivers are endorsing positive change related to MAP **64%** of the time, with a **45%** improvement in functioning achieved and children are endorsing positive change **55%** of the time, with a **41%** improvement in functioning achieved. All comparisons are made at the beginning and at the end of treatment.

The Initial Impact of PEI Services

- **Triple P Parenting:** This practice aimed at reducing parenting and family difficulties has resulted in a **38%** positive change as endorsed by parents and a **22%** positive change as endorsed by children on the YOQ-SR. The practice has also demonstrated 58-60% positive reliable change in parent/caregiver ECBI scores.
- **Trauma Focused Cognitive Behavioral Therapy:** For the 64 agencies providing trauma focused services, **74%** of the recipients of this practice self-identify as Latino. Both children and parent/caregivers have endorsed positive change on the YOQ. Parents endorsed a **38%** improvement in their children's overall functioning, while children reported a **35%** improvement in their overall functioning, representing 51% and 47% reliable change percentage, respectively. On average, parents report a **37%** improvement and children report a **42%** improvement in trauma symptoms on the Post Traumatic Stress Disorder Reaction Index (PTSD-RI) after completing Trauma Focused Cognitive Behavioral Therapy.

The Initial Impact of PEI Services

- **Incredible Years:** This practice aimed at improving parenting skills and reducing family difficulties has an average client age of 8, with **66%** of clients being male and **81%** of Latino background. When comparing pre- and post-average scores for the ECBI and the YOQ, the practice has led to reductions in symptoms below the clinical cutoff. Reductions in average scores range from **17% to 33%**.
- **Group CBT for Depression:** This practice aimed at reducing early course depression has demonstrated on average a **35%** reduction in symptoms as measured by the PHQ-9 and a **21%** reduction in overall symptoms as measured by the Outcome Questionnaire (OQ- 45.2), representing **38% to 43%** positive reliable change respectively.

The Initial Impact of PEI Services

- ❑ **Aggression Replacement Training (ART):** 16 agencies are providing this practice aimed at treating disruptive behavior disorders in 12- 17 year olds. When comparing pre- and post-treatment average scores for the ECBI, the practice has led to **14-25%** reductions in symptoms and **11 to 25%** reductions in average scores pre- and post-treatment on the YOQ-Parent and YOQ-SR, to below the clinical cutoff.
- ❑ **Seeking Safety:** A robust implementation involving 73 contract agencies and county-operated programs has demonstrated, as measured by the PTSD-RI and the Outcome Questionnaire/YOQ-SR & YOQ (parent and self-report), significant reductions in trauma. Average symptom reduction after completion of the practice for children and their parent/caregiver ranges from **29% to 35%** depending upon the questionnaire. Average symptom reduction for adults aged 18 and above is **20%**, with reductions seen below the clinical cutoff for the PTSD-RI for adults.

The Initial Impact of PEI Services

- ❑ **Child Parent Psychotherapy:** 31 contract agencies and county operated programs are providing this practice geared to treat trauma in young children ages 0 – 6 and their parent/caregivers. This practice has yielded a **62%** improvement in trauma symptoms as measured by the YOQ-Parent.
- ❑ **Crisis Oriented Recovery Services (CORS):** 32 contract and county operated programs are providing this brief treatment model to address situational crises. Adults and children who completed the 6 session model experience a **21%** improvement as measured by the OQ 45.2 and YOQ-SR respectively while the parents of children report a **33%** improvement in their child's symptoms.

Innovation (INN)

- ❑ An innovative project is one that primarily contributes to learning by:
 - Introducing new mental health practices or approaches that have never been done before.
 - Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community.
 - Introduces a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings.
- ❑ Time-limited
- ❑ If successful and the county wishes to continue it, ongoing funding must be secured through a source other than Innovation.

Innovation

- L.A. County focus is on adopting 4 distinct practices for the integration of health, mental health and substance abuse care:
 - Integrated Clinic Model*
 - Integrated Mobile Health Team Model*
 - Community-Designed Integrated Service Management Model*
 - Latino
 - Asian and Pacific Islander
 - Middle Eastern/Eastern European
 - African/African American
 - American Indian/Native American
 - Integrated Peer-Run Services Model**

* Services end June 30, 2015

** Services end June 30, 2016

Innovation – Clients Served in Fiscal Year 2011-12

Model	Clients Served FY 2011-12
Integrated Services Management Model	407
Integrated Clinic Model	535
Integrated Mobile Health Team	1,870
Total Unique Clients	2,815

Estimated LA County MHSA Budget

<u>FY</u>	<u>CSS*</u>	<u>PEI*</u>	<u>INN*</u>	<u>Total*</u>
2012-13	\$343.1	\$88.8	\$22.7	\$454.6
2013-14	\$303	\$78.4	\$20.1	\$401.5
2014-15	\$332.8	\$86.1	\$22.1	\$441.0
2015-16	\$314.2	\$81.3	\$20.8	\$416.3

*Reported in millions of dollars

Total does not reflect current WET, CFTN or WET Regional Partnership funds.

Not inclusive of EPSDT, FFP or unspent funds from prior Fiscal Years
Fiscal Year budgets 2013-14 through 2015-16 are estimates based on projections by Mike Geiss, fiscal consultant for CMHDA