LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH SERVICES ACT
ANNUAL UPDATE
FISCAL YEAR 2013-14

MARVIN J. SOUTHARD, D.S.W.
DIRECTOR

Los Angeles County Board of Supervisors
Adopted June 25, 2013

WELLNESS • RECOVERY • RESILIENCE

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MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Los Angeles

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

Local Mental Health Director	County Auditor-Controller/City Financial Officer
Name: Marvin J. Southard, D.S.W.	Name: Wendy L. Watanabe
Telephone Number: (213) 738-4601	Telephone Number: (213) 974-8302
E-mail: msouthard@dmh.lacounty.gov	E-mail: wwatanabe@auditor.controller.gov
Local Mental Health Mailing Address: County of Los Angeles - Department of Mental Health Program Support Bureau - MHSA Implementation & Outcomes Division 695 S. Vermont Avenue, 8th floor Los Angeles, CA 90005	

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

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

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

Signature Date

I hereby certify that for the fiscal year ended June 30, 2012, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892 (f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/14/12 for the fiscal year ended June 30, 2012. I further certify that for the fiscal year ended June 30, 2012 the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the county/City has complied with WIC section 5891 (a), in that local MSHA funds may not be loaned to a county general fund or any other county fund.

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

Wendy L. Watanabe
County Auditor Controller/City Financial Officer

Signature Date 5/2/13

[1]Welfare and Institutions Code Sections 5847 (b)(9) and 5899 (a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (2/14/2013)

Los Angeles County
Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

May 5, 2013

Marvin J. Southard, DSW
Director
Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Southard:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING
2013/14 ANNUAL UPDATE
NOTICE OF PLAN APPROVAL

On April 25, 2013 the Chairman and a quorum of the Los Angeles County Mental Health Commission (Commission) made the following motion at the Public Hearing of the Mental Health Services Act Annual Update (Plan) conducted at St. Annes in Los Angeles County:

MOTION: The Los Angeles County Mental Health Commission moves toApprove the Fiscal Year 2013/14 Annual Update.

It is, therefore, with pleasure that the Commission approve your Department's submission of the Fiscal Year 2013/2014 Annual Update, which was publically posted on March 1, 2013 and presented at the April 18, 2013 Public Hearing. We would also like to commend the Department for encouraging and fostering an environment where advocacy and input are valued.

The Commission looks forward to your continued progress in improving the lives of clients receiving services in the public mental health system and continuing our partnership.

Sincerely,

Larry Gasco

Larry Gasco, PhD, LCSW
Chairman
LG:DIG:TGL:tgl

550 South Vermont Avenue, 12th Floor, Los Angeles, California 90020 ~ Phone: 213.738 4772 ~ Fax: 213 738 2120
Email: mentalhealthcommission@dmh.lacounty.gov ~ Website: http://dmh.lacounty.info/mhc

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

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DEPARTMENT OF MENTAL HEALTH
http://dmh.lacounty.gov

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To: (213) 738-4601
Fax: (213) 386-1297

June 18, 2013

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES
27 June 25, 2013
SACHI A. HAMAI
EXECUTIVE OFFICER

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

Dear Supervisors:

ADOPT THE DEPARTMENT OF MENTAL HEALTH'S MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2013-14

(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Annual Update for Fiscal Year 2013-14.

IT IS RECOMMENDED THAT THE BOARD:

Adopt Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2013-14 (Attachment); the Annual Update has been certified by the County Mental Health Director and the County Auditor-Controller to meet specified MHSA requirements in accordance with Welfare and Institutions Code (WIC) Section 5847.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Adoption of the MHSA Annual Update for FY 2013-14 is necessary in order for DMH to submit the Annual Update to the Mental Health Services Oversight and Accountability Commission (Commission) and is required by WIC Section 5847. Recent amendments to the MHSA require that the three-year program and expenditure plans, and annual updates be adopted by the County Board of Supervisors and that the three-year plan and the updates be certified by the County Mental Health Director and the County Auditor-Controller attesting that the County has complied with any fiscal

accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the MHSA requirements. Under the MHSA, a draft three-year program and expenditure plans, and annual updates must be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans. Additionally, the MHSA requires that the Mental Health Commission conduct a public hearing on the draft three-year program and expenditure plans and the annual updates at the close of the 30-day comment period.

In order to fulfill the latter requirements, DMH posted the MHSA Annual Update for FY 2013-14 on its web site for 30 days for public comments on March 1, 2013. DMH also convened a Public Hearing on April 18, 2013, at which time DMH addressed public questions and concerns. The Mental Health Commission voted to approve the MHSA Annual Update for FY 2013-14 at its meeting on April 25, 2013.

Implementation of Strategic Plan Goals

The recommended actions support the County's Strategic Plan Goal 3, Integrated Services Delivery.

FISCAL IMPACT/FINANCING

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Assembly Bill (AB) 1467, chaptered into law on June 27, 2012, implemented changes to the MHSA law. AB 1467 requires each county mental health program to prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the County Board of Supervisors and submitted to the Commission. It also requires that the three-year plan and the annual updates be certified by the County Mental Health Director and the County Auditor-Controller. This includes the County Mental Health Director's certification as to the requisite stakeholder participation and compliance with MHSA non-supplantation provisions.

AB 1467 also requires the State Department of Health Care Services, in consultation with the Commission and the California Mental Health Directors Association, to develop and administer instructions for the Annual MHSA Revenue and Expenditure Report.

The Commission provided direction to the counties to complete the MHSA Annual Update for FY 2013-14 through a memo dated November 21, 2012, and distributed the final MHSA Fiscal Accountability Certification Form to be completed by the County Director of Mental Health and County Auditor-Controller.

The public hearing notice requirements referenced in WIC Section 5848, subdivisions (a) and (b) have been fulfilled and are recorded in the MHSA Annual Update. The County Auditor-Controller and County Mental Health Director have both signed the MHSA Fiscal Accountability Certification Form, included in the Annual Update.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Annual Update for FY 2013-14 will ensure compliance with AB 1467 requirements.

Respectfully submitted,

MARVIN J. SOUTHARD, D.S.W.
Director of Mental Health

MJS:DM:DIG:sk

Enclosures

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

ASD:	Anti-Stigma and Discrimination
ASIST:	Applied Suicide Intervention Skills Training
ASL:	American Sign Language
BSFT:	Brief Strategic Family Therapy
CBITS:	Cognitive Behavioral Intervention for Trauma in Schools
CBO:	Community-Based Organizations
CDOL:	Center for Distance and Online Learning
CEO:	Chief Executive Office
CFOF:	Caring for our Families
CORS:	Crisis Oriented Recovery Services
CPP:	Child Parent Psychotherapy
CSS:	Community Services & Supports
CW:	Countywide
DBT:	Dialectical Behavioral Therapy
DCFS:	DCFS Los Angeles County Department of Children and Family Services
DMH:	Department of Mental Health
DPH:	Department of Public Health
DTQI:	Depression Treatment Quality Improvement
EBP(s):	Evidence Based Practice(s)
ECC:	Education Coordinating Council
EESP:	Emergency Shelter Program
FCCS:	Field Capable Clinical Services
FFT:	Functional Family Therapy
FOCUS:	Families Overcoming Under Stress
FSP(s):	Full Service Partnership(s)
FSS:	Family Support Services
FY:	Fiscal Year
Group CBT:	Group Cognitive Behavioral Therapy
GROW:	General Relief Opportunities for Work
GVRI:	Gang Violence Reduction Initiative
HOME:	Homeless Outreach and Mobile Engagement Team
HWLA:	Healthy Way Los Angeles
ICM:	Integrated Clinic Model
IEP(s):	Individualized Education Program
IMD:	Institution for Mental Disease
IMHT:	Integrated Mobile Health Team
IMPACT:	Improving Mood-Promoting Access to Collaborative Treatment
Ind CBT:	Individual Cognitive Behavioral Therapy
IPT:	Interpersonal Psychotherapy for Depression
ISM:	Integrated Service Management Model
LIFE:	Loving Intervention Family Enrichment
LPP:	Licensure Preparation Program
MAP:	Managing and Adapting Practice
MDFT:	Multidimensional Family Therapy
MDT:	Multidisciplinary Team Meetings
MH:	Mental Health
MHCLP:	Mental Health Court Linkage Program
MHIP:	Mental Health Integration Program
MHSA:	Mental Health Services Act
MMSE:	Mini-Mental State Examination
MORS:	Milestones of Recovery Scale
MOU:	Memorandum of Understanding
MPAP:	Make Parenting a Pleasure
MPG:	Mindful Parenting Groups

NFP:	Nurse Family Partnerships
OA:	Older Adult
OBPP:	Olweus Bullying Prevention Program
OEF:	Operation Enduring Freedom
OMA:	Outcome Measures Application
OND:	Operation New Dawn
PATHS:	Providing Alternative Thinking Strategies
PCIT:	Parent-Child Interaction Therapy
PDAT:	Public Defender Advocacy Team
PE:	Prolonged Exposure
PEARLS:	Program to Encourage Active, Rewarding Lives for Seniors
PEI:	Prevention and Early Intervention
PEMR(s):	Probation Electronic Medical Records
PRISM:	Peer-Run Integrated Services Management
PRRCH:	Peer-Run Respite Care Homes
PSP:	Partners in Suicide Prevention
PTSD:	Post-Traumatic Stress Disorder
ROSTCP:	Recovery Oriented Supervision Training and Consultation Program
RPP:	Reflective Parenting Program
SA:	Service Area
SAPC:	Substance Prevention and Control
SED:	Severely Emotionally Disturbed
SF:	Strengthening Families Program
SPMI:	Sever and Persistently Mentally Ill
SS:	Seeking Safety
START:	School Threat Assessment And Response Team
TAY:	Transitional Age Youth
TF-CBT:	Trauma Focused-Cognitive Behavioral Therapy
Triple P:	Triple P Positive Parenting Program
UCC(s):	Urgent Care Center(s)
UCLA TTM:	UCLA Ties Transition Model
UCLA:	University of California, Los Angeles
UREP:	Under-Represented Ethnic Populations
VALOR:	Veterans' and Loved Ones Recovery
WCRSEC:	Women's Community Reintegration Service and Education Centers
WET:	Workforce Education and Training

THE DEPARTMENT'S PROCESS FOR DEVELOPING FY 2013-14 ANNUAL UPDATE INCLUDED:

- January 10, 2013: Presentation to Mental Health Commission Executive Committee, Service Area Advisory Committee (SAACs) Chairs and Service Area District Chiefs
- February 20, 2013: Systems Leadership Team* (SLT) Presentation
- February 27, 2013: Presentation of highlights to the Mental Health Commission
- March 1, 2013 – March 30, 2013: 30-Day Posting
- April 1-17, 2013: MH Commission to review public comments
- April 18, 2013: Public Hearing

Great efforts were made this year to involve the Service Area stakeholders in the providing of feedback to the Department, via the SAACs.

*The role of the SLT is to support the Department in system transformation and monitoring MHSA implementation. This includes the following responsibilities:

- Develop process and structural frameworks to support overall system transformation (e.g., performance measures; budget dilemmas).
- Monitor progress on implementation of MHSA Plans (e.g., track performance, identify design issues, initiate workgroups, etc.).
- Provide feedback to Department on proposed MHSA Plan extensions or revisions.
- Work with Department and consultant to develop agendas for Delegates meetings.
- Comment on workgroup recommendations before Department makes final decisions.

JANUARY 10, 2013*

Presentation to Mental Health Commission Executive Committee, SAAC Chairs and District Chiefs for Service Areas 2-8

Comments, suggestions and recommendations:

- Consider highlighting inter-departmental activities where relevant to MHSA
- Greater color differentiation on stacked graphs to discern colors when projected
- Documentation of stacked graphs in another format if material is reproduced in non-colored printers
- Present ethnicity and language by Service Area for CSS and PEI
- Acronym page
- Is it possible to report on client transitions from one type of service to another?
- Make cost/client calculations as relevant as possible. Consider the audience and explain what it is inclusive of and what it might mean
- Consider another term for FSP "disenrollments" (slide 51, 52, 53). *Would discontinuation of partnership be a better way to characterize?*
- Specify the "one time adjustment" for FY 12/13 for slide 78
- Add Fax # to email address in slide 80

Modified slides were sent to District Chiefs and SAAC Chairs for their use immediately after the presentation.

*See Appendix pages 111-112 for minutes, comments, questions and recommendations.

FEBRUARY 20, 2013
Briefing to the Systems Leadership Team. See Appendix pages 113-134 for minutes, comments, questions and recommendations.

FEBRUARY 26, 2013:
Summary presentation at DMH MHSA Implementation meeting, reviewing SLT comments and questions.

FEBRUARY 27, 2013:
Summary presentation to the Mental Health Commission.

MARCH 13, 2013:
Agenda Review Briefing.

MARCH 1 – 31, 2013:
Public posting of draft Annual Update on http://file.lacounty.gov/dmh/cms1_191091.pdf. See Appendix pages 134-142 for announcement and public review comments.

APRIL 18, 2013:
Public Hearing convened by Mental Health Commission. See Appendix pages 143-161 for minutes, comments, questions and recommendations.

APRIL 25, 2013:
Mental Health Commission approved Annual Update. See Appendix page 162 for signed Mental Health Commission approval letter.

1 **32,276 new clients received mental health services through the CSS plan**
44% were Hispanic, 25% were African American and 21% were white.

2 **96,710 unique clients received a direct mental health services through the CSS plan**
38% were Hispanic, 27% were African American 24% were white, 6% were Asian, 2% were other, 2% were unknown, 1% were Native American and less than 1% were Pacific Islander

3 **Of the 2,890 clients that disenrolled from the FSP program, 44% met their goals**

4 **Expansion of the Wellness Outreach Worker (WOW) Program**
This year, more than 100 volunteers attended trainings offered in English and Spanish. WOW volunteers provide services in Wellness, FCCS, and FSP Programs. Wellness Outreach Workers are consumers or community members with lived experience who volunteer for Wellness, FSP, and FCCS Programs. Wellness Outreach Workers provide supportive face-to-face services to clients by engaging them in the triage process, accompanying clients in the community for support, and running self-help groups.

5 **94% increase in the number of days Adult FSP clients lived independently**

6 **70% increase in the number of days Adult FSP clients were employed competitively**

7 **Reduction in the number of days Older Adult FSP clients spent homeless and in jail**
86% reduction in jail days and 80% reduction in homeless days

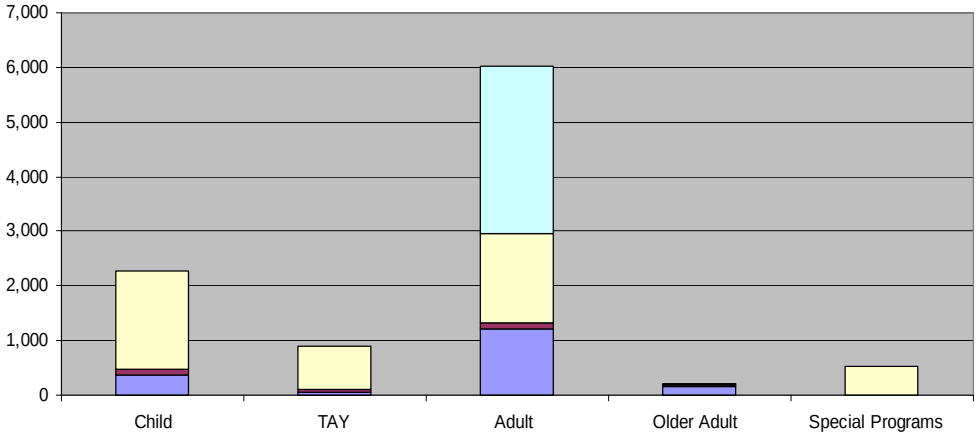
8 **Reduction in the number of days Adult FSP clients spent homeless and in jail**
67% reduction in jail days and 69% reduction in homeless days

9 **8 clinical Ambassadors were trained**
In FY 2011-12, as part of a pilot project, a total of eight volunteers from two clinics in Los Angeles County were trained and functioned as Clinic Ambassadors. Clinic Ambassadors are currently providing services in Wellness and FCCS programs. Clinic Ambassadors are Peer Volunteers who provide support in the welcoming and triage areas. They help to ensure new and existing clients have a safe and welcoming environment to come to and provide support and linkage for new clients.

10 **65% increase in the number of days Transitional Age Youth FSP clients lived independently**

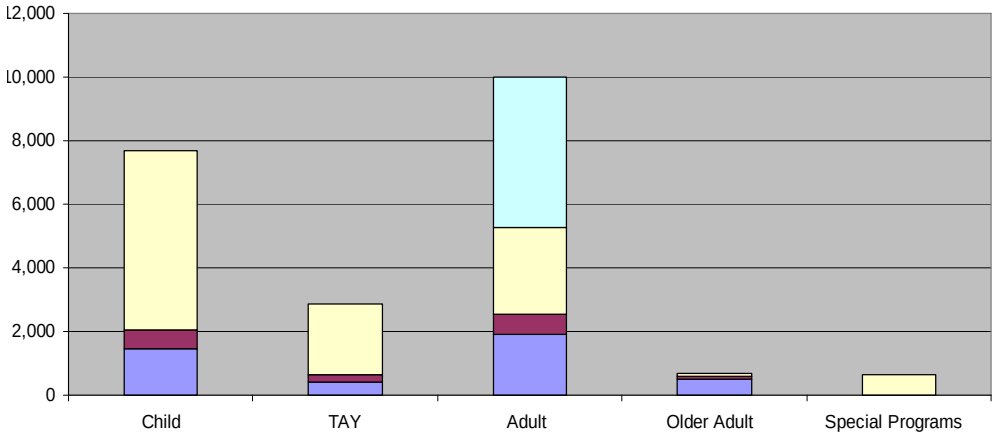
Service Area Client Counts* FY 2011-12

SERVICE AREA 1



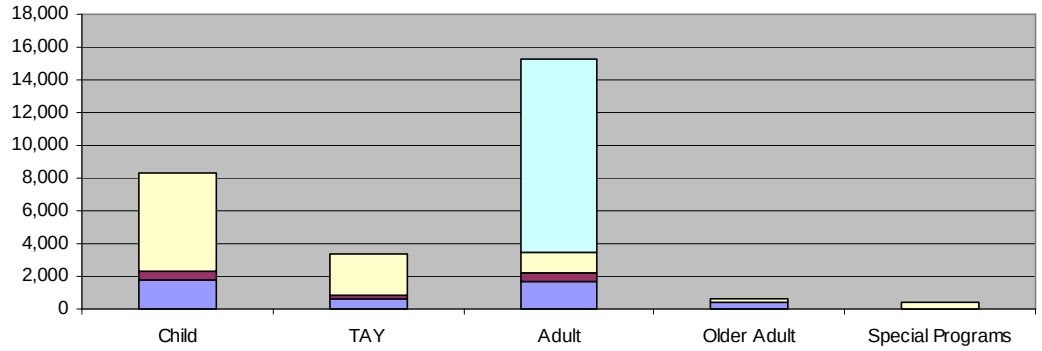
MHSA Program	Child	TAY	Adult	Older Adult	Special Programs
Field Capable Clinical Services	365	41	1,228	158	
Full Service Partnership	122	69	100	18	
Prevention and Early Intervention	1,797	788	1,622	36	516
Wellness/Client Run			3,073		

SERVICE AREA 2

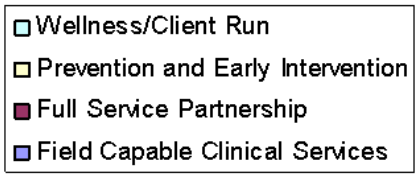


MHSA Program	Child	TAY	Adult	Older Adult	Special Programs
Field Capable Clinical Services	1,463	396	1,931	521	
Full Service Partnership	560	258	619	85	
Prevention and Early Intervention	5,666	2,197	2,705	70	657
Wellness/Client Run Centers			4,745		

SERVICE AREA 3



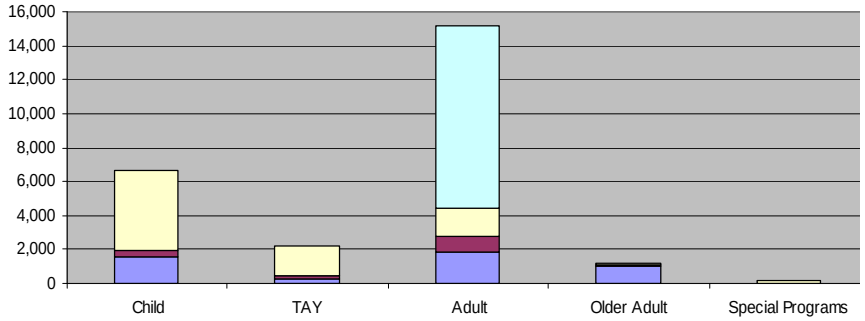
MHSA Program	Child	TAY	Adult	Older Adult	Special Programs
Field Capable Clinical Services	1,812	602	1,701	397	
Full Service Partnership	479	220	496	61	
Prevention and Early Intervention	6,049	2,560	1,239	142	378
Wellness/Client Run			11,834		



***Client counts based on only direct service claims**

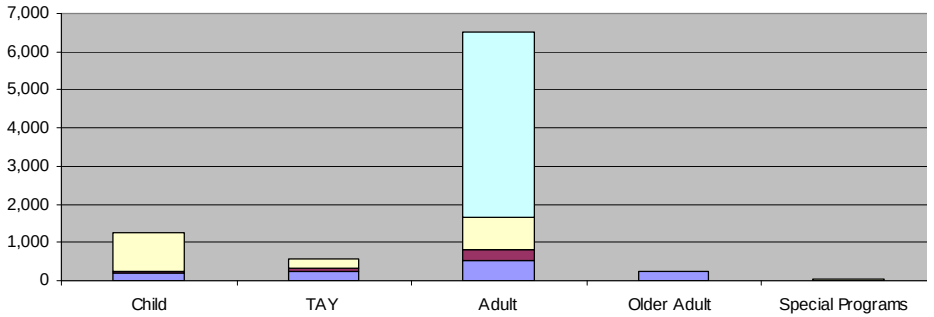
Service Area Client Counts* (continued)

SERVICE AREA 4



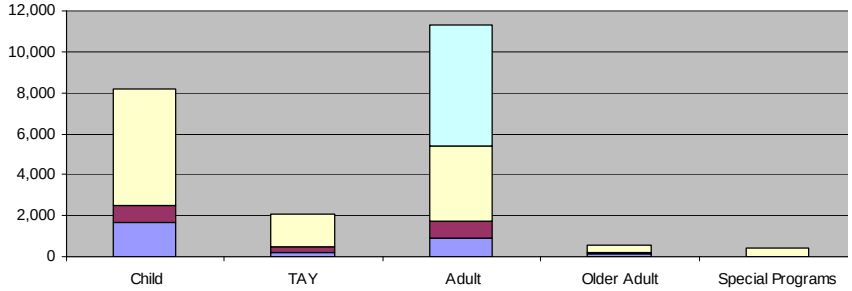
MHSA Program	Child	TAY	Adult	Older Adult	Special Programs
Field Capable Clinical Services	1,560	239	1,889	984	
Full Service Partnership	362	264	868	90	
Prevention and Early Intervention	4,771	1,688	1,674	88	202
Wellness/Client Run			10,750		

SERVICE AREA 5

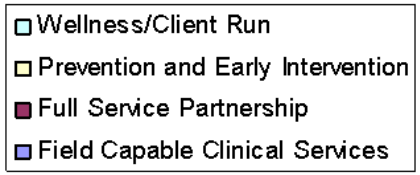


MHSA Program	Child	TAY	Adult	Older Adult	Special Programs
Field Capable Clinical Services	204	245	507	232	
Full Service Partnership	49	83	283	26	
Prevention and Early Intervention	999	227	860	3	33
Wellness/Client Run			4,372		

SERVICE AREA 6

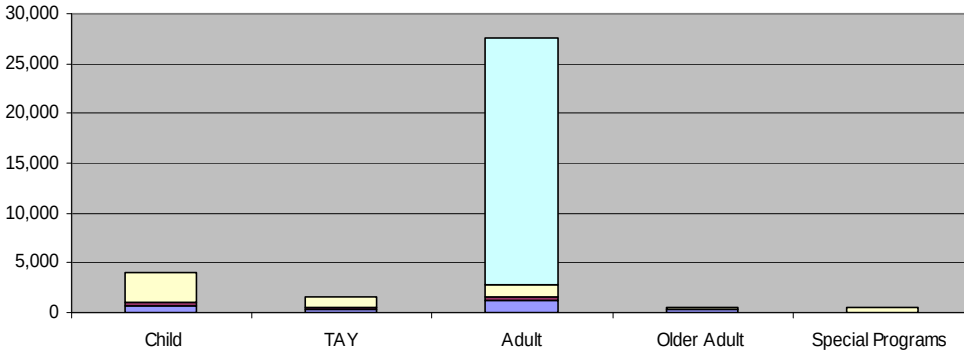


MHSA Program	Child	TAY	Adult	Older Adult	Special Programs
Field Capable Clinical Services	1,688	177	910	171	
Full Service Partnership	775	326	826	40	
Prevention and Early Intervention	5,706	1,590	3,678	339	437
Wellness/Client Run			5,862		



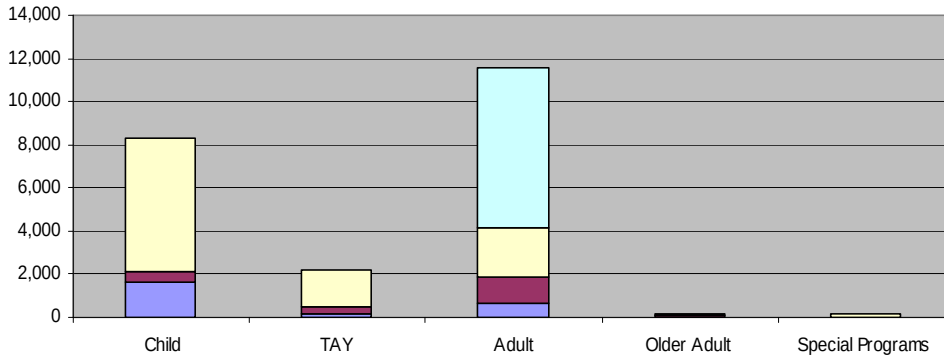
***Client counts based on only direct service claims**

SERVICE AREA 7

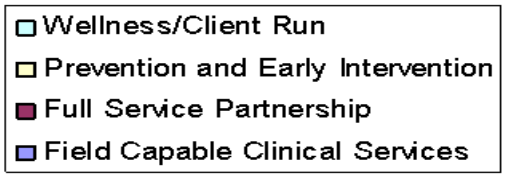


MHSA Program	Child	TAY	Adult	Older Adult	Special Programs
Field Capable Clinical Services	718	266	1,176	316	
Full Service Partnership	378	194	470	79	
Prevention and Early Intervention	2,905	1,053	1,207	53	608
Wellness/Client Run			24,716		

SERVICE AREA8



MHSA Program	Child	TAY	Adult	Older Adult	Special Programs
Field Capable Clinical Services	1,641	196	630	34	
Full Service Partnership	481	263	1,219	34	
Prevention and Early Intervention	6,152	1,763	2,341	91	196
Wellness/Client Run			7,402		



***Client counts based on only direct service claims**

New CSS Client Counts
Ethnicity/Primary Language Breakdown FY 2011-12

Number of New Clients* receiving CSS services Countywide:

All New CSS Clients								
New Clients, No Previous PEI			New Clients, Previous PEI			TOTAL NEW CSS CLIENTS		
Ethnicity	Count	Percent	Ethnicity	Count	Percent	Ethnicity	Count	Percent
Hispanic	12,706	43.27%	Pacific Islander	1,567	53.87%	Hispanic	14,273	44.22%
African American	7,197	24.51%	Native American	725	24.92%	African American	7,922	24.54%
White	6,490	22.10%	Unknown	444	15.26%	White	6,934	21.48%
Asian	1,194	4.07%	Other	83	2.85%	Asian	1,277	3.96%
Unknown	980	3.34%	Asian	24	0.83%	Unknown	1,004	3.11%
Other	599	2.04%	White	51	1.75%	Other	650	2.01%
Native American	139	0.47%	African American	12	0.41%	Native American	151	0.47%
Pacific Islander	62	0.21%	Hispanic	3	0.10%	Pacific Islander	65	0.20%
TOTAL	29,367	100.00%	TOTAL	2,909	100.00%	TOTAL	32,276	100.00%
PrimaryLanguage	Count	Percent	PrimaryLanguage	Count	Percent	PrimaryLanguage	Count	Percent
English	22,228	75.69%	English	2,167	74.49%	English	24,395	75.58%
Spanish	5,454	18.57%	Spanish	604	20.76%	Spanish	6,058	18.77%
Unknown/not reported	519	1.77%	Unknown/not reported	36	1.24%	Unknown/not reported	555	1.72%
Armenian	235	0.80%	Armenian	24	0.83%	Armenian	259	0.80%
Other	230	0.78%	Farsi	14	0.48%	Other	244	0.76%
Korean	143	0.49%	Other	9	0.31%	Korean	152	0.47%
Farsi	102	0.35%	Cambodian	19	0.65%	Farsi	121	0.37%
Vietnamese	93	0.32%	Korean	13	0.45%	Cambodian	106	0.33%
Cambodian	92	0.31%	Russian	4	0.14%	Vietnamese	96	0.30%
Pilipino, Tagalog	66	0.22%	Mandarin	3	0.10%	Pilipino, Tagalog	69	0.21%
Cantonese	61	0.21%	Vietnamese	5	0.17%	Mandarin	66	0.20%
Mandarin	61	0.21%	Pilipino, Tagalog	2	0.07%	Cantonese	63	0.20%
Russian	49	0.17%	Cantonese	7	0.24%	Russian	56	0.17%
Arabic	22	0.07%	Arabic	1	0.03%	Arabic	23	0.07%
American Sign	9	0.03%	American Sign	1	0.03%	American Sign	10	0.03%
Hmong	3	0.01%	Hmong	0	0.00%	Hmong	3	0.01%
TOTAL	29,367	100.00%	TOTAL	2,909	100.00%	TOTAL	32,276	100.00%

*Based on claims to CSS plans in the IS as of 12/17/2012

Los Angeles County
Service Areas
Unique clients served through CSS
Fiscal Year 2011-12

Ethnicity Breakdown

Service Area 1
Hispanic – 36%
African-American – 34%
White – 26%
Other – 1%
Asian – 1%
Unknown – 1%
Native American - <1%
Pacific Islander- <1%

Service Area 2
White –42%
Hispanic –38%
African-American –10%
Asian –5%
Other –3%
Unknown –2%
Native American - <1%
Pacific Islander- <1%

Service Area 3
Hispanic –51%
White –21%
Asian –12%
African-American –10%
Unknown –3%
Other –2%
Native American - <1%
Pacific Islander- <1%

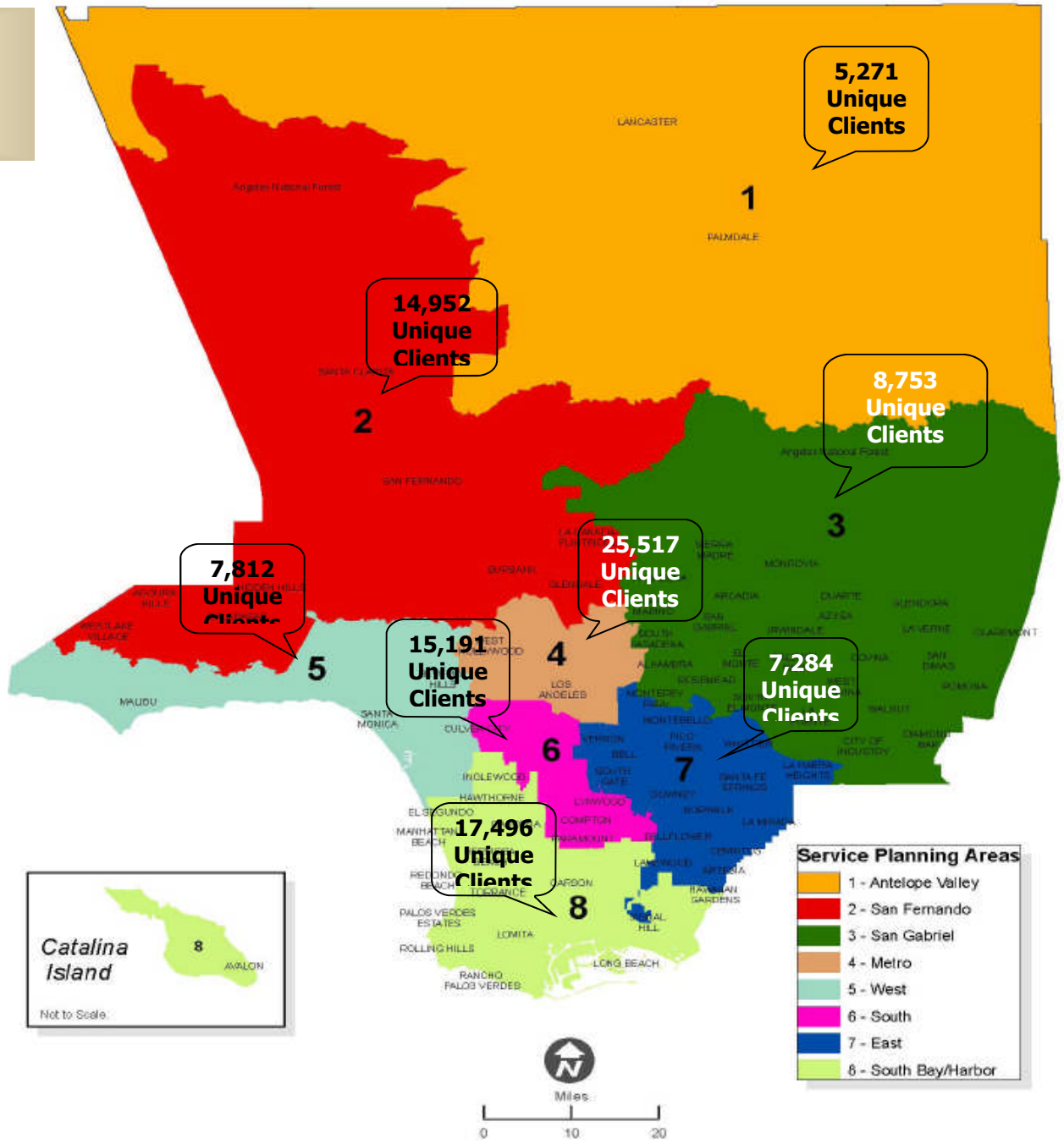
Service Area 4
Hispanic –40%
African-American –28%
White –21%
Asian –7%
Other –2%
Unknown –2%
Native American - 1%
Pacific Islander- <1%

Service Area 5
White – 41%
African-American – 30%
Hispanic –17%
Unknown –7 %
Other – 3%
Asian – 2%
Native American - <1%
Pacific Islander- <1%

Service Area 6
African-American – 59%
Hispanic –35%
White – 4%
Unknown – 1%
Other – 1%
Asian – 1%
Native American - <1%
Pacific Islander- <1%

Service Area 7
Hispanic –64%
White – 18%
African-American – 8%
Asian – 4%
Native American - 2%
Unknown – 2%
Other – 1%
Pacific Islander- <1%

Service Area 8
Hispanic –30%
African-American – 29%
White – 26%
Asian – 10%
Unknown –3 %
Other – 2%
Pacific Islander- 1%
Native American - <1%



COST PER CLIENT*

FULL SERVICE PARTNERSHIPS

PLAN NAME:	Child FSP
UNIQUE CLIENTS:	3,104
COST:	$43,314,737
AVERAGE COST:	$13,954

PLAN NAME:	TAY FSP
UNIQUE CLIENTS:	1,651
COST:	$ 21,821,443
AVERAGE COST:	$ 13,217

PLAN NAME:	Adult FSP
UNIQUE CLIENTS:	4,841
COST:	$54,941,303
AVERAGE COST:	$11,349

PLAN NAME:	Older Adult FSP
UNIQUE CLIENTS:	428
COST:	$4,057,542
AVERAGE COST:	$9,480

FIELD CAPABLE CLINICAL SERVICES

PLAN NAME:	Child FCCS
UNIQUE CLIENTS:	9,348
COST:	$45,030,728
AVERAGE COST:	$4,817

PLAN NAME:	TAY FCCS
UNIQUE CLIENTS:	2,156
COST:	$ 9,395,719
AVERAGE COST:	$ 4,357

PLAN NAME:	Adult FCCS
UNIQUE CLIENTS:	9,928
COST:	$39,868,381
AVERAGE COST:	$4,015

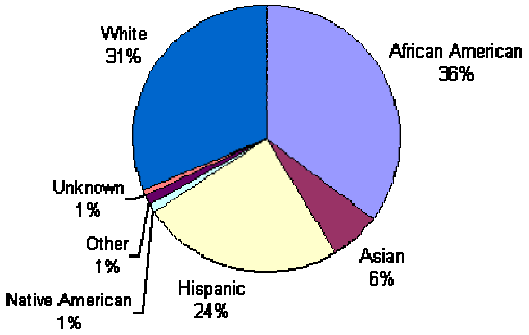
PLAN NAME:	Older Adult FCCS
UNIQUE CLIENTS:	2,991
COST:	$16,750,462
AVERAGE COST:	$5,600

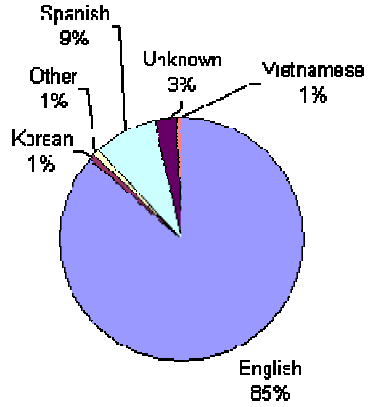
*Calculation based on Mode 15 services, inclusive of Federal Financial Participation (FFP) & Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Not inclusive of community outreach services or client supportive services expenditures. Data as of 12/17/2012.

PROGRAM DESCRIPTION

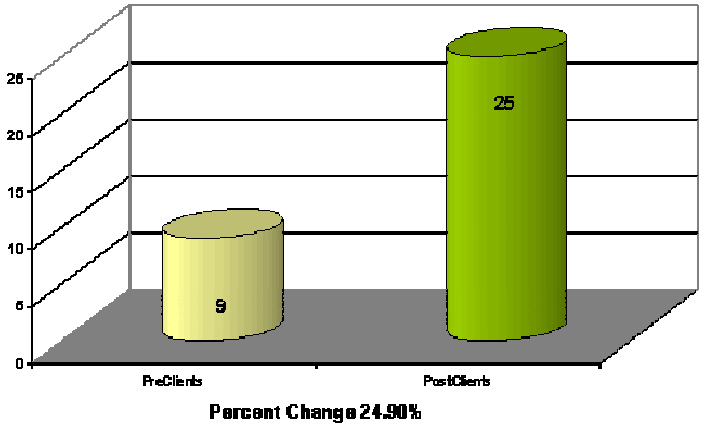
Adult FSP program is designed for adults, 26-59, who have been diagnosed with a severe mental illness and would benefit from an intensive service program, who are homeless, incarcerated, transitioning from institutional settings, or for whom care is provided solely through the family. Services include a wide array of mental health services, medication support, and linkage to community resources, housing, employment and money management services and assistance in obtained need medical care. Programs target clients from all ethnic communities, with a collaborative focusing specifically on the Asian Pacific Islander communities.

UNIQUE CLIENTS SERVED: 4,841*





More FSP Adult Were Participating in "Supportive Employment"



Supportive Employment is defined as competitive employment with ongoing on-site or off-site job related support services provided.

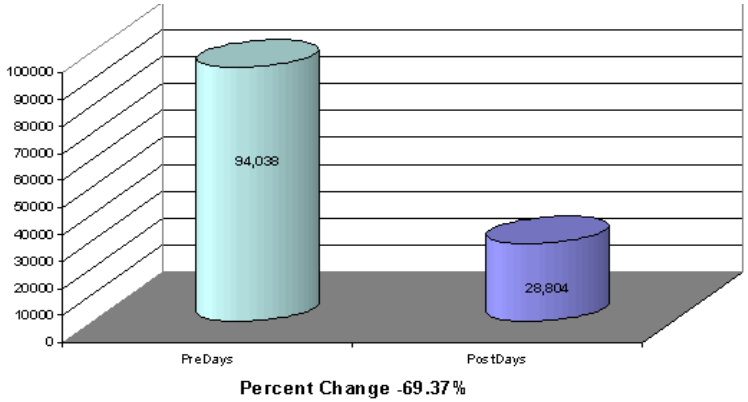
ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

During this year, outcomes data demonstrated an improvement in quality of life measures. Compared to one year prior to participation in the FSP program, outcomes show:

- Jail/ Incarceration days were decreased by 67%
- Prison days were decreased by 79%
- The number of days clients lived independently was increased by 94%
- Competitive Employment days increased 70%
- Unemployment days were decreased by 2%
- Of the 1,188 FSP-Adult clients that disenrolled, 36% disenrolled successfully.

FSP Adult Spent Fewer Days Homeless Post Partnership

FY 2011-12 Outcomes
Employment: N=3,428
Housing: N=931



SIGNIFICANT CHANGES FOR FY 2013-14

In FY 2013-14, Adult Systems of Care expects to focus on ensuring individuals participating in FSP programs meet their goals and are able to graduate to lower levels of care. This will be done by refining Field Capable Clinical Services as a Step-Down level of care and through case reviews in collaboration with the service area and provider. This fiscal year will also focus on integration with healthcare reform and ensuring the FSP program fits within the new system of care. Finally, FY 2013-14 will focus on increased training and support for serving the forensic population as forensic services are realigned to the county level and the outpatient population with a recent forensic history increases.

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

Unique Clients Served: 50,197*
Client contacts: 73,254 (Community Outreach Services)

Program Description

Wellness/Client Run Centers are self-directed, community-based services staffed by peer and professional support geared toward physical/emotional recovery and increased community integration. Clients at higher levels of recovery are the focal population.

Significant Changes for FY 2013-14

Wellness programs will remain the largest adult service program in FY 2013-14. The focus in this fiscal year will be collaboration and integration with healthcare and substance abuse programming. FY 2013-14 will see continued expansion of peer supports in both paid and volunteer roles to act as navigators, greeters, and work as part of treatment teams.

Achievements/Highlights in FY 2011-12

According to a survey distributed at 13 Wellness Centers, clients reported the following improvements:

- 71% clients reported usually or sometimes doing well in work/school/preferred activities.
- 83% clients reported usually or sometimes making progress in wellness/ recovery goals.
- 86% reported being usually or sometimes able to manage symptoms.
- 82% clients reported feeling usually or sometimes welcomed and respected by staff.
- 72% clients reported usually or sometimes having opportunities to join social, spiritual, and/ or recreational activities in their life.
- 79% of clients were usually or sometimes satisfied with their role in making decisions about their care.
- • 73% reported living in their own place (house, apartment, etc.), living with family, or living with roommates.

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

Number of Client Contacts: 639*

Program Description

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, health, substance abuse treatment and supportive services.

Significant Changes for FY 2013-14

Expansion of specialized IMD Step-Down beds to provide intensive integrated services for individuals being released from State and County hospitals and the criminal justice system.

Additional training will be available to all providers on managing individuals with criminal justice histories who are high risk.

Achievements/Highlights in FY 2011-12

- Provided integrated health and co-occurring mental health and substance abuse treatment, and housing with benefits establishment
- 639 individuals were served by IMD Step-Down programs in FY 2011-12
- Average length of stay was 421.04 days
- Peer Bridging/Advocates provide services at all IMD Step-Down Programs
- 60% of individuals discharged during FY 2011-12 were discharged to lower levels of care
- 45% of those discharged were enrolled in to Full Service Partnerships
- 17% of those enrolled and discharged to FSPs from IMD Step-Down Programs had a psychiatric hospitalization within the year
- Implemented a Medical/Psychiatric IMD Step-Down Program for 30 individuals from institutional settings who have complex medical and psychiatric needs
- 91% received benefits
- Peer Bridgers/Advocate services are provided to all programs

* As reported by program lead for FY 2011-12 Exhibit 6 Repo

PROGRAM DESCRIPTION

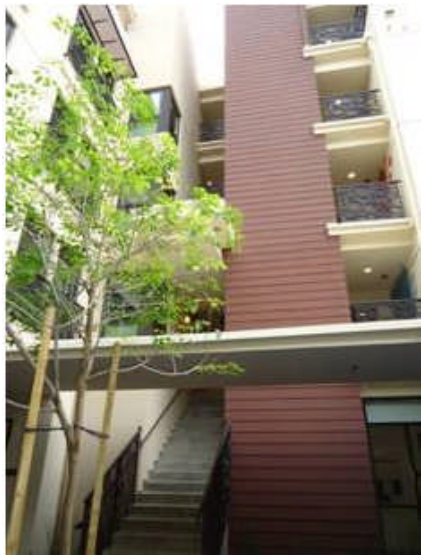
The Adult Housing Services include 14 Countywide Housing Specialists that provide housing placement services primarily to individuals and families that are homeless in their assigned Service Area.

SIGNIFICANT CHANGES FOR FY 2013-14

The funding that was once identified for the Safe Haven Program was eliminated from the CSS Plan in 2010 (MHSA Annual Update FY 2011-12). The $732,000 will be used for temporary shelter services for homeless individuals through the CSS Plan, Planning, Outreach and Engagement (POE). This will be in addition to the $92,000 already in the POE budget for this purpose. The current purpose of these funds is consistent with the initial purpose and target population for this funding.

ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

- Los Angeles Family Housing – Palo Verde is a 61-unit housing development project of which 45 are MHSA units. It was opened in December 2011 in Service Area 2, Supervisorial District 3.
- Montecito Terraces is a 98-unit housing development project of which 10 are MHSA units targeting adults over 55. It was opened in January 2012 in Service Area 2, Supervisorial District 3.



Marvin J. Southard, DSW (Director), Darrell Steinberg (CA State Senator) and Robin Kay, Ph.D. (Chief Deputy Director)

Author of the Mental Health Services Act (MHSA) and California State Senate President pro Tem Darrell Steinberg was on hand to see his work in action at the five-year celebration of the MHSA Housing Program at the Villas at Gower on Friday, November 9, 2012. Co-sponsored by the Supportive Housing, Alliance, the event recognized the collaborative partnerships that made the 33 current housing projects partially funded by the MHSA Housing Program, a reality.

Darrell Steinberg stated, "Nothing has been more important in my career than the passage of MHSA. It's time to treat people with dignity and provide support for them to live in the community."

BELOW IS A LIST OF PROJECTS THAT OPENED DURING FISCAL YEAR 2011-12 THROUGH THE MHSA HOUSING PROGRAM:

Project Name	Occupancy Date	Location		Target Population	Number of Units		MHSA Unit Size					MHSA Capital Loan	MHSA Operating Subsidy	TOTAL
		SA	SD		MHSA	Total Units	Studio	1 BR	2 BR	3 BR	4 BR			
28th Street YMCA Residences	6/1/2012	6	2	TAY (ages 16-25); Single Adults	30	48	30	0	0	0	0	$4,277,064	$3,120,000	$7,397,064
Epworth Apartments	5/1/2012	6	2	TAY (ages 16-25)	19	20	2	17	0	0	0	$1,991,770	$1,976,000	$3,967,770
Ford Apartments	8/1/2011	4	2	Single Adults; Older Adults (ages 60+)	90	151	90	0	0	0	0	$9,434,700	$9,360,000	$18,794,700
Montecito Terraces Apartments	7/1/2011	2	3	Older Adults (ages 60+)	10	98	0	8	2	0	0	$1,275,000	$0	$1,275,000
Palo Verde Apartments	11/1/2011	2	3	Single Adults	45	61	45	0	0	0	0	$4,500,000	$173,442	$4,673,442
Parkview on the Park Apartments	10/1/2011	4	1	Older Adults (ages 60+)	40	80	40	0	0	0	0	$1,099,760	$0	$1,099,760
Progress Place Apartments	8/1/2011	4	1	TAY (ages 16-25)	14	16	0	14	0	0	0	$1,400,000	$1,400,000	$2,800,000
Villas at Gower Apartments	11/1/2011	4	3	Families and Adults (ages 18+)	35	70	10	15	10	0	0	$3,500,000	$250,000	$3,750,000
Willis Avenue Apartments	5/1/2012	2	3	Older Adults (ages 60+)	34	42	0	34	0	0	0	$3,490,000	$0	$3,490,000
Young Burlington Apartments	9/1/2011	4	1	TAY (ages 16-25)	14	21	0	14	0	0	0	$1,400,000	$1,400,000	$2,800,000
				TOTAL	331	607	217	102	12	0	0	**$32,368,294**	**$17,679,442**	**$50,047,736**

JAIL TRANSITION & LINKAGE SERVICES
A-05

NUMBER OF CLIENT CONTACTS: 3,316*

PROGRAM DESCRIPTION

Jail Transition and Linkage Services are designed to perform outreach and engage individuals involved in the criminal justice system and receiving services from jail or jail related services (e.g. court workers, attorneys, etc.). The goal is to successfully link them to community-based services upon their release from jail. The program addresses the needs of individuals in collaboration with the judicial system by providing identification, outreach, support, advocacy, linkage, and interagency collaboration in the courtroom and in the jail. Jail Transition and Linkage staff work with the MHSA Service Area Navigators as well as service providers to assist incarcerated individuals with accessing appropriate levels of mental health services and support upon their release from jail, including housing, benefits and other services as indicated by individual needs and situations. The goal of these services is to prevent release to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services.

SIGNIFICANT CHANGES FOR FY 2013-14

Some of the courts are anticipated to close due to State budget cuts and MHCLP services will be adjusted as appropriate.

As the population within County jails continues to increase, it is anticipated that there will be a need for expanded resources, including increasing the number of staff.

* As reported by program lead for FY 2011-12 Exhibit 6 Report

ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

- Mental Health Court Linkage Program (MHCLP) services were provided in all Service Areas Countywide with the addition of co-located services in the Antelope Valley. Services are now provided in 24 courts.
- Increased the number of alternative sentencing beds at Olive Vista in order to serve more clients.
- Established MHCLP services at an AB 109 revocation court.
- Jail Linkage release planning has expanded to include community outreach, AB 109 clients, and all other incarcerated clients with release planning needs.
- The census in the jail has increased significantly in volume, therefore Jail Linkage duties and caseloads have also increased.
- Jail Linkage is now working closely with Countywide Resource Management in the referral and placement of AB 109 clients.
- The number of conservatorship applications initiated by the Jail Linkage team has increased due to a higher number of severely and persistently mentally ill clients being incarcerated.
- AB 109 staff at the women's jail has increased.
- Women's Community Reintegration Service and Education Center (WCRSEC) has expanded employment services to its consumers.
- WCRSEC continues to provide jail in-reach by providing daily groups on community reintegration in general population areas and many women come to the WCRSEC upon release from jail.

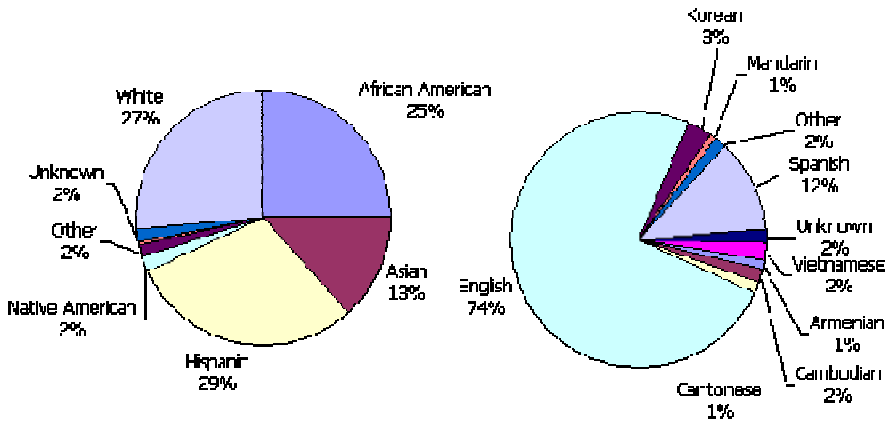
PROGRAM DESCRIPTION

The Adult Field Capable Clinical Services (FCCS) program provides an array of recovery-oriented, field-based and engagement -focused mental health services to adults. Providers will utilize field-based outreach and engagement strategies to serve the projected number of clients. The goal of Adult FCCS is to build the capacity of DMH to serve this significantly underserved population with specifically trained professional and paraprofessional staff working together as part of a multi-disciplinary team. Services provided include: outreach and engagement, bio-psychosocial assessment, individual and family treatment, evidence-based practices, medication support, linkage and case management support, treatment for co-occurring disorders, peer counseling, family education and support, and medication support.

SIGNIFICANT CHANGES FOR FY 2013-14

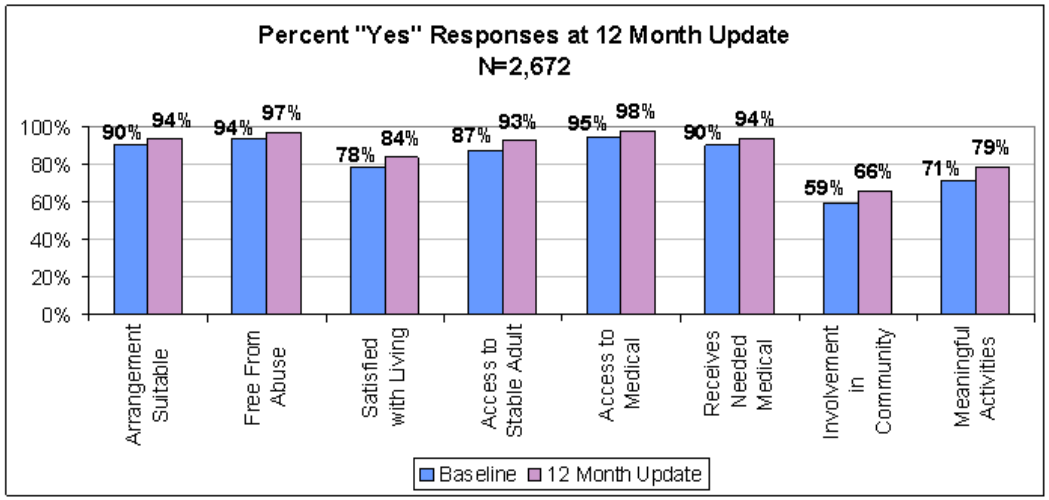
In the coming fiscal year, FCCS will be further refined as a Step-Down level of care for the FSP program and focus on serving clients in the AB109 programs who are not eligible for FSP. Finally, FY 2013-14 will focus on increased training and support for serving the forensic population as forensic services are realigned to the county level of responsibility, as the outpatient population with a recent forensic history increases.

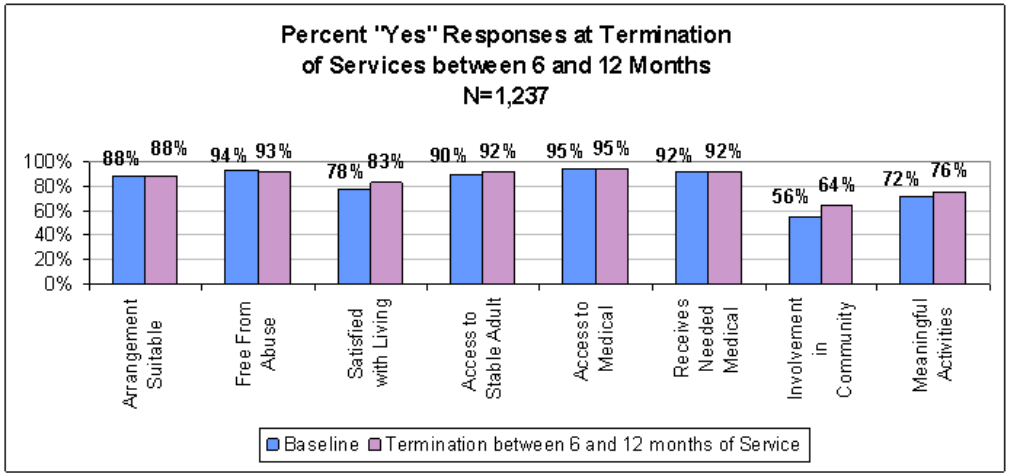
UNIQUE CLIENTS SERVED: 9,928*



ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

The Adult FCCS program served 9,928 clients countywide. Outcomes data demonstrate improvements in several key areas after 12 months of service in an FCCS program.





Outcome data as of 11/21/2012

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

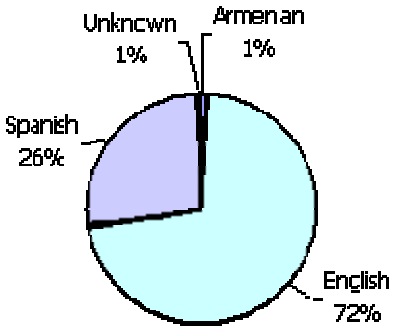
PROGRAM DESCRIPTION

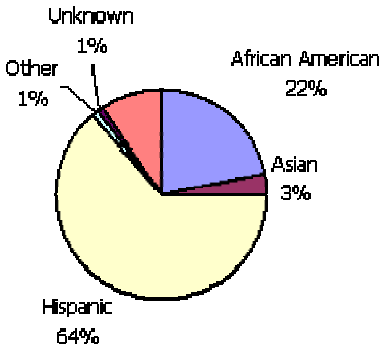
Children's FSP program is comprised of resiliency-focused services created in collaboration with family/caretakers and a multidisciplinary team that develops and implements an individualized plan. Child FSPs deliver intensive mental health services and supports to children ages 0-15 who are high need, high risk Seriously Emotionally Disturbed (SED) children and their families/caretakers. Focal populations include children 0-5 with a serious emotional disturbance, children with a mental illness involved with Department of Children and Family Services, schools or the probation system.

SIGNIFICANT CHANGES FOR FY 2013-14

No significant changes. However, Service Area Navigator meetings, Roundtable meetings, and Full Service Partnership (FSP) provider meetings will continue to be held for program monitoring. There will be changes to regularly communicate with providers as soon as possible to enhance outcomes and service improvement. The satisfaction survey will be expanded to follow up on successfully disenrolled clients.

UNIQUE CLIENTS SERVED: 3,104*





* Unique Clients are counted by claims in the Integrated System

ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

During FY 2011-12, Child FSP providers served 3,104 unique children and their families and achieved a 55% "goal met" success rate upon completion of the FSP program.

Child FSP is excited about the services provided to consumers and their families and published their first publication entitled, "Child Full Service Partnership: Strengthening Families", detailing five years of Child FSP Program's accomplishments.

In January 2011, Countywide (CW) Child FSP Program Administration teamed with Parent Partners and Service Area Navigators to begin conducting face-to-face interviews with families who had successfully reached their treatment goals while enrolled in FSP. The focus was to measure FSP family satisfaction, and more than 80% of the families visited indicated that their child was happier, better able to cope with daily life and had better relationships with their caregivers and siblings after meeting their treatment goals. Ninety-four percent got better grades and 100% participated in extra curricular activities.

Telephonic surveys were also conducted for those families who chose to disenroll from the FSP program prior to completing their treatment goals. CW contacted 103 families and 65% were satisfied with the FSP services received, while 78% stated that they would recommend services to other families.

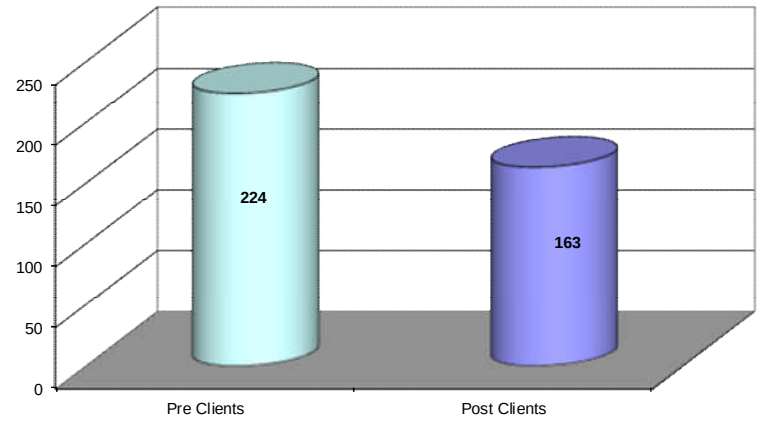
Wanting to hear about the families experiences with FSP, on June 4, 2012, Countywide held a Parent Focus Group to look at the families' overall satisfaction with the program. We learned that these families wanted FSP to be easily accessible to the community; to increase the number of Parent Partners; knowledge about the whole program; and less change among therapists. The information collected will be used to modify programs and provide more technical support to agencies.

Achievements/Highlights in FY 2011-12 (Continued)

Parent Partners serve as a bridge between treatment teams and families by providing clinical staff with the parent perspective and using their personal experience to give new families entering the system the empathy, support, and hope they need to get better. A training workshop was developed to create a pool of Parent Partners and 78 new Parent Partners were certified.

Reflective supervision was another important workforce development project because the nature of its design allowed it the capacity to not only train and educate, but provide technical support as well. The Reflective Supervision training project provided Child FSP treatment teams with monthly two-hour sessions designed to teach nine specific training objectives (Core Practice Model; Engaging to meet needs of Children and Families; Cultural Sensitivity; Family-Driven and Client-Centered Services; Enhancing Strengths/Needs-Based Practices; 24/7 In Person Crisis Intervention/Field-Safety; Trauma-Informed Child Welfare System; Parent Partners; and Providing Continuity of Care). Dr. Stroud's assessment included a rating scale that indicated that 100% of CW's training objectives had been met and that the project was well received and demonstrated a high level of overall success. Team cohesiveness and communication improved progressively with each session as individual members experienced increased self-awareness and professional development.

Fewer FSP Children Were Hospitalized Post Partnership



Percent Change -27.23%

FY 2011-12 Outcomes, Housing: N=1,163

Elvira's Story (from Child FSP: Strengthening Families)

The Department of Children and Family Services removed Elvira from her mother's care due to allegations of physical and emotional abuse. Elvira was returned to her mother five years later, but during her time in foster care, Elvira had become a different child, developing many behavioral and emotional issues. Due to her own mental health issues, Elvira's mother was having difficulties parenting Elvira and her daughter's extreme behavior was more than she could handle.

By the time she was enrolled in Hathaway-Sycamores' FSP program at age 12, Elvira's aggressive behaviors had escalated dramatically. She was paranoid, believing everyone was talking about her and began banging her head against walls and floors to stop the hallucinations she was experiencing. At school, Elvira's academic performance was declining and she became physically aggressive to the point of breaking the arm of a fellow classmate.

During the two years that Elvira was enrolled in Hathaway-Sycamores' FSP program, the treatment team had connected her to the local YMCA using Flex Funds to pay for membership fees and helped her join the dance group Belado Shoes, with who she now dances at a variety of venues. The parenting education Elvira's mother received helped her address her daughter's emotional needs and correct Elvira's negative behaviors in a positive way. "I am especially grateful for the support she received from Sonia, the treatment team's Parent Partner," she confided. In May 2011, Elvira was successfully stepped down to less intensive services and is doing well. "It is important to always support your kids in any circumstance. Fortunately, a Child FSP provides parents with the tools and support to do just that."

NUMBER OF CLIENT CONTACTS: 240*

PROGRAM DESCRIPTION

Family Support Services (FSS) provide access to mental health services such as individual psychotherapy, couples/group therapy, psychiatry/medication support, crisis intervention, case management linkage/brokerage, parenting education, domestic violence and Co-Occurring Disorder services to parents, caregivers, and/or other significant support persons of Full Service Partnership (FSP) enrolled children who need services, but who do not meet the criteria to receive their own mental health services.

ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

During FY 2011-12 FSP providers provided direct service to 240 family members utilizing the family support services component of FSP.

SIGNIFICANT CHANGES FOR FY 2013-14

In an effort to increase utilization of FSS funding and enhance services, Respite Care Services were revamped and re-introduced as a pilot program in FY 2012-2013. The pilot consists of 11 providers representing all eight Service Areas. Based on the data collected at the end of FY 12/13, Respite Care Services Pilot will be expanded to all agencies countywide.

Service Area Navigator meetings, Roundtable meetings, and FSP Provider meetings will continue to be held for the purpose of program monitoring. Changes will be regularly communicated to providers as soon as possible to enhance outcomes and service improvement. Countywide will continue to monitor the use of Family Support Services and encourage provider use to ensure clients and families are receiving the full scope of services offered in Child FSP, incorporating the "whatever it takes" MHSA philosophy.

* As reported by program lead for FY 2011-12 Exhibit 6 Report

PROGRAM DESCRIPTION

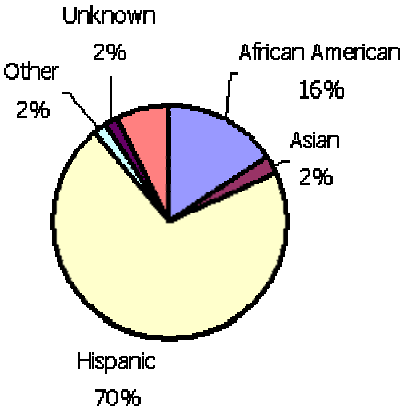
Children's Field Capable Clinical Services (FCCS) program provides an array of resiliency-oriented and field-based mental health services to children and families. Children's FCCS programs provide specialized mental health services delivered by a team of professional and para-professional staff. The focus of FCCS is working with community partners to provide a wide range of services that meet individual needs. The program is designed to provide services to individuals who are isolated, unwilling or unable to access traditional mental health outpatient services due to location/distance barriers, physical disabilities, or because of the stigma associated with receiving clinic-based services.

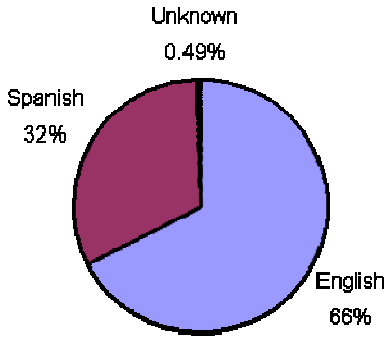
SIGNIFICANT CHANGES FOR FY 2013-14

Countywide Child MHSA Administration (CW) does not anticipate any significant changes for FY 2013-2014. In order to support FCCS providers, CW will continue to monitor and provide technical support.

- Continue quarterly roundtable meetings with providers.
- Ongoing consultation and monthly meetings with Service Area Child Navigators.
- Continue the programmatic and data monitoring of Child FCCS programs.
- Encourage and monitor the use of best practices and evidenced-based practices (EBPs) in FCCS; survey and compare those clients with no EBPs delivered.
- Continue to provide a training curriculum around issues relevant to providers (e.g. Engaging Families in Treatment, School-based Mental Health Services, Field Safety, EBPs and Cultural Competence).

UNIQUE CLIENTS SERVED: 9,348*

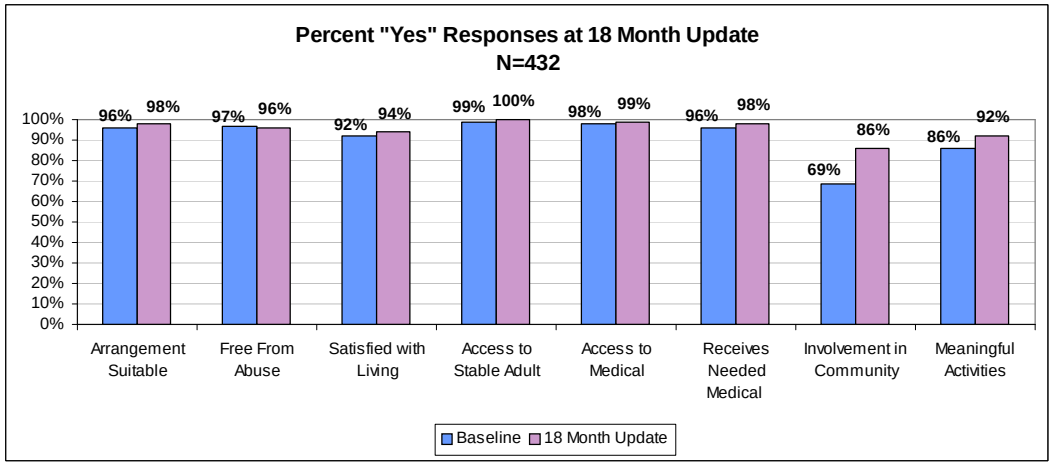


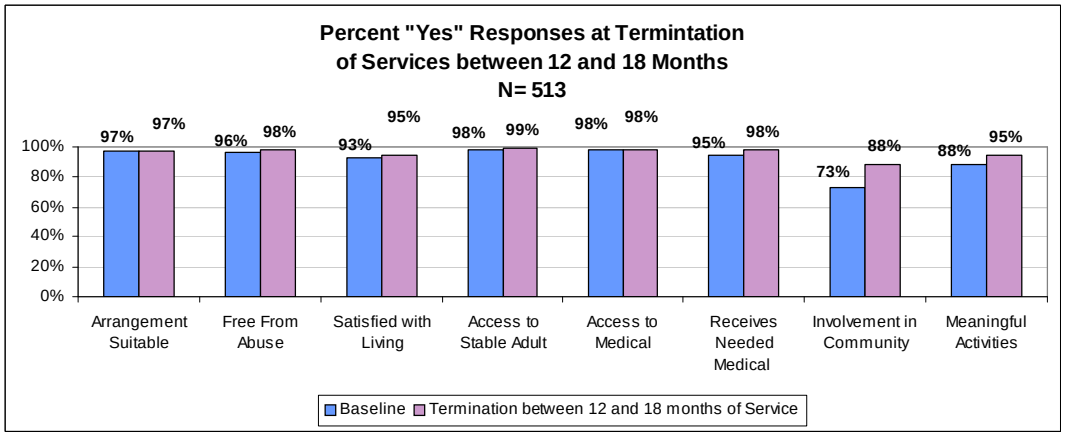


* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

Achievements/Highlights in FY 2011-12

In an effort to assist providers with successfully implementing FCCS, CW provided training curriculum on topics such as Cultural Competence, LGBTQ, Introduction to Motivational Interviewing, Non-Violent Education and Parenting, Emotional Intelligence, Sand Play and Art Therapy, Child Abuse Reporting Laws and DCFS, and various evidence based practices.





Outcome data as of 11/21/2012

PROGRAM DESCRIPTION

The Older Adult (OA) FSP program is provides services and support to clients ages 60 and older. The FSP assists individuals with mental health and substance abuse issues and ensures linkage to other needed services, such as benefits establishment, housing, transportation, healthcare and nutrition care. Older Adult FSP program works collaboratively with the OA client, family, caregivers, and other service providers and offers services in homes and the community. Older Adult FSPs place an emphasis on delivering services in ways that are culturally and linguistically appropriate.

SIGNIFICANT CHANGES FOR FY 2013-14

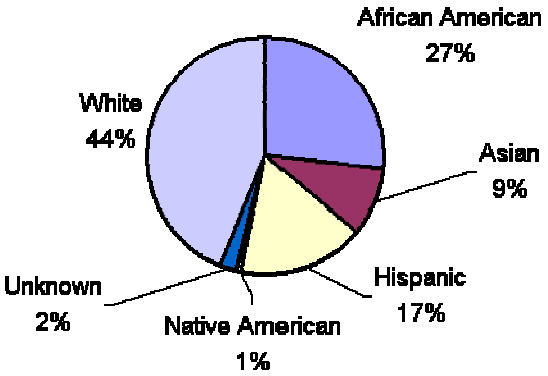
Expect 60 additional countywide OA FSP slots.

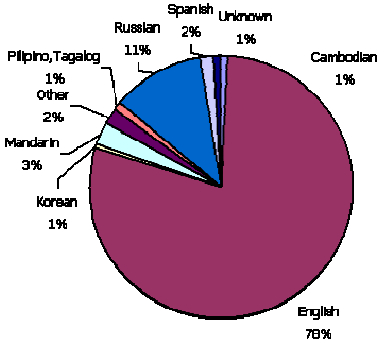
The FSP Integration Pilot Project will begin 3/1/2013 with Heritage Clinic. The pilot will integrate the FCCS program into an expanded FSP program. The hope is to create a seamless service continuum with the use of funds for services otherwise limited at an FCCS level. The use of Milestones of Recovery Scale (MORS) scores to determine the level of care with 10% of clients going into the pilot program need to fall within FSP criteria.

ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

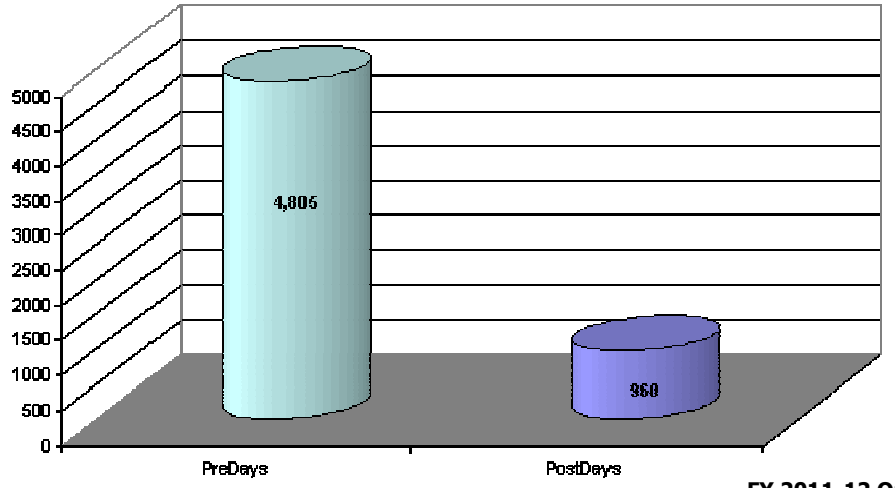
- 20 new OA slots in Service Area (SA) 1, 2, 3, 4, & 8.
- New site in Service Area 8, Didi Hirsch with 7 OA slots.
- Slot utilization for the end of FY 2011-112 was at 97%.
- Slot utilization increase of 10% for entire Fiscal Year.
- UREP had a slight increases: Latino + 6, API + 1%, African American + 8%

UNIQUE CLIENTS SERVED: 428*



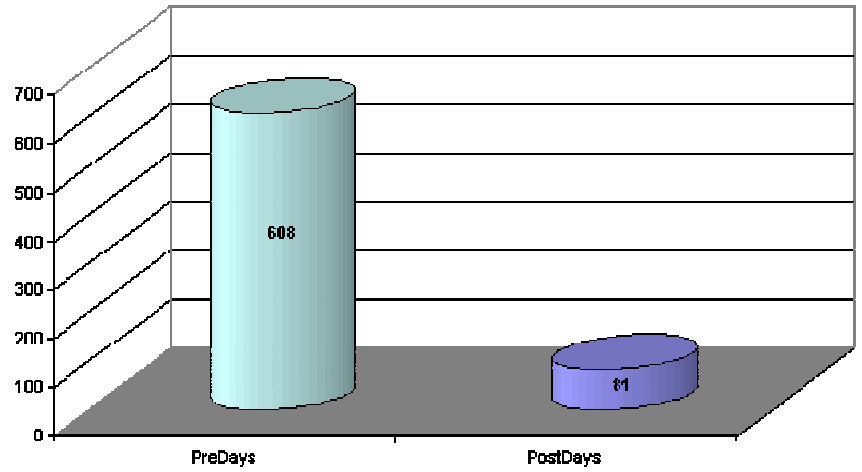


FSP Older Adults Spent Fewer Days Homeless Post Partnership



Percent Change -80.03%

FSP Older Adults Spent Fewer Days in Jail Post Partnership



Percent Change -86.63%

FY 2011-12 Outcomes, Housing: N=90

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012

PROGRAM DESCRIPTION

The Older Adult Transformation Team provides system support to develop the infrastructure of older adult services within MHSA. The team will:

- Monitor outcome measures utilized in the FSP & FCCS programs.
- Utilize performance-based contracting measures to promote program services.

SIGNIFICANT CHANGES FOR FY 2013-14

Starting in FY 2012-13, the Older Adult FCCS Administrative team is providing agencies with charts illustrating OMA data and responses, indicating domains where agency's outcomes could be improved based on client response. For FY 13/14 this data will be more accurate and provide a clearer understanding to staff and agencies of client progress and areas where improvement is needed. Additionally, the Team is expected to be involved in the introduction of a 2nd cognitive screening tool to be used by OA providers.

Field Capable Clinical Services
OA-03

MHSA Annual Update Fiscal Year 2013-14

Program Description

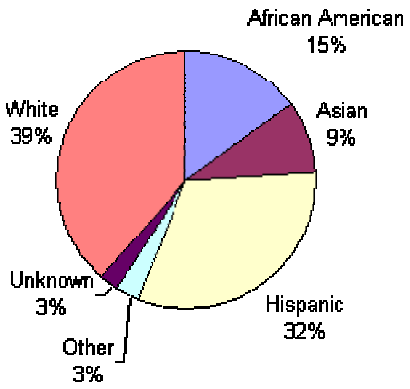
An individual must be either 60 years of age and above or be a "transitional age adult (55-59 years) and have a serious and persistent mental illness or have a less severe or persistent Axis I disorder that is resulting in a functional impairment or that places the Older Adult at risk of losing or not attaining a life goal, for example risk of losing safe and stable living arrangement, risk of losing or inability to access services, risk of losing independence.

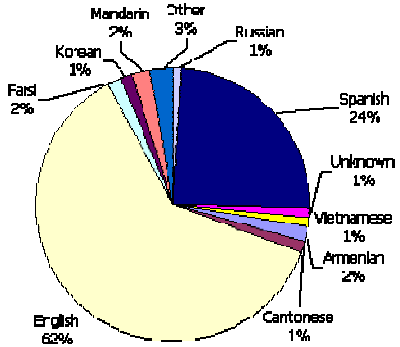
Services provided include: outreach and engagement, bio-psychosocial assessment, individual and family treatment, medication support, linkage and case management support, treatment for co-occurring disorders, peer counseling, family education and support. FCCS will directly respond to and address the needs of unserved/underserved older adults by providing screening, assessment, linkage, medication support, and geropsychiatric consultation.

Significant Changes for FY 2013-14

The result of the pilot program (referenced in OA-01) may have impact on other FCCS programs. We will also work to promote flow to lower levels of care by working with directly operated Wellness programs to ensure that they can offer meaningful services to older adult clients. This may include the introduction of psycho-educational training models developed for older adults to help them maintain their current level of recovery.

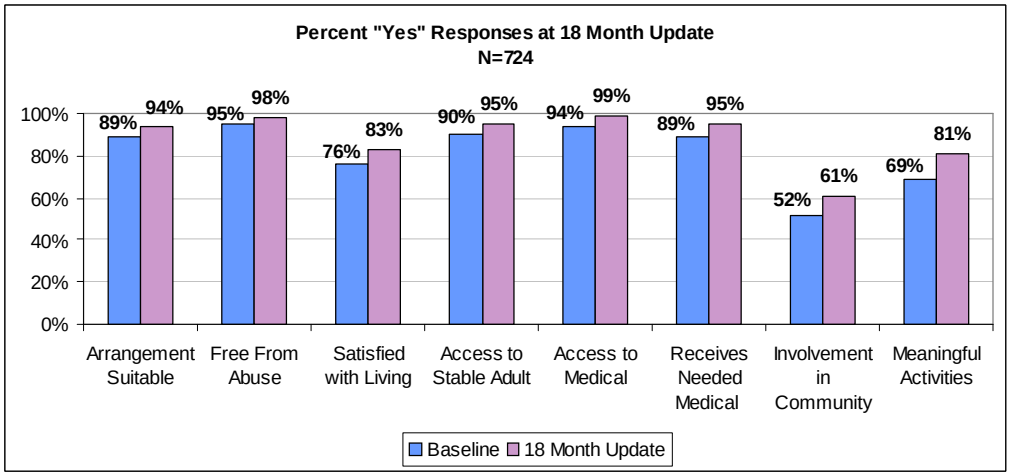
Unique clients served: 2,991*

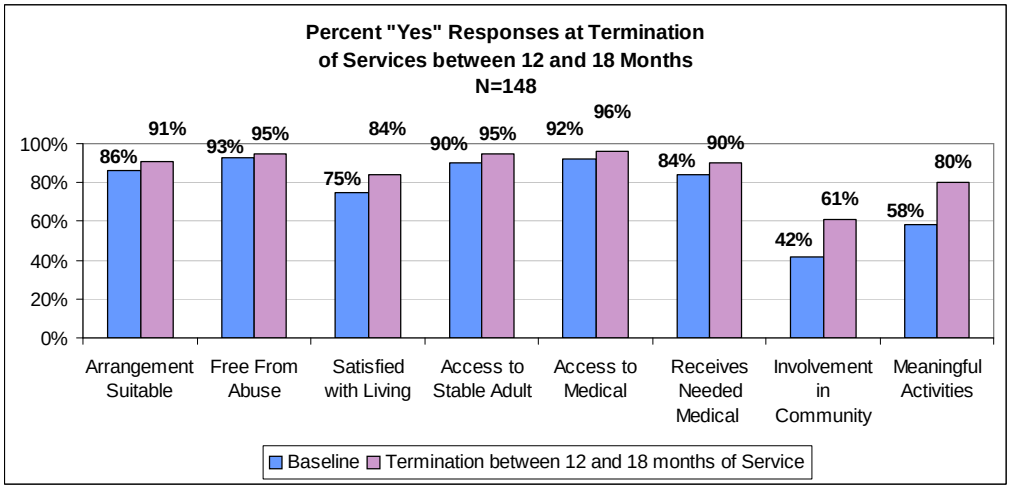




Achievements/Highlights in FY 2011-12

There are 28 directly-operated and contracted agencies providing Older Adult FCCS county-wide. Sixty-nine percent of those services are provided in the field e.g. home, board & care, health center, or other locations preferred by client such as parks or restaurants. There are over 30 languages spoken in these programs, including a variety of Asian Pacific Islander languages, some African, and Hebrew.





Outcome data as of 11/21/2012

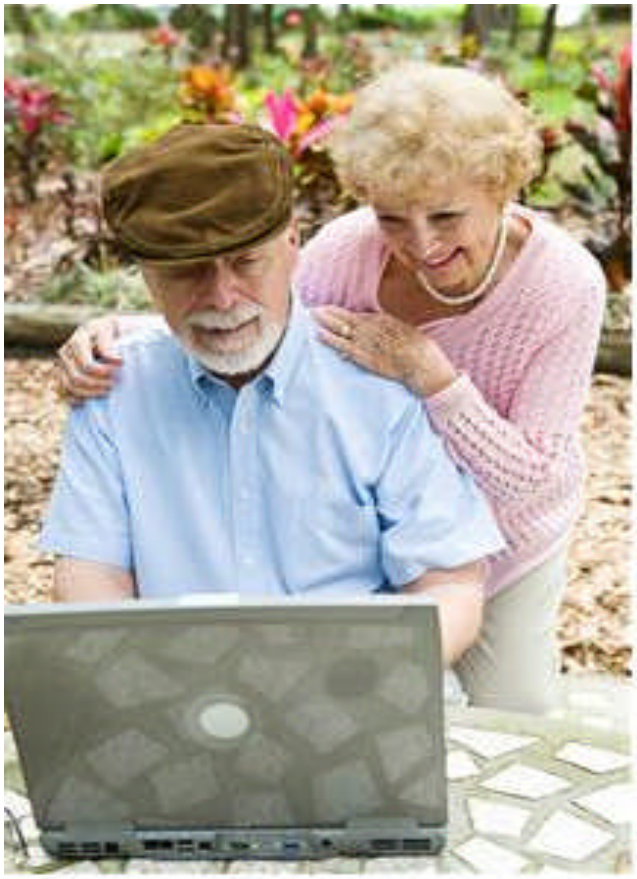
* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

Number of Client Contacts: 29*

Program Description
Service Extenders are peers in recovery, family members or other individuals interested in providing services to older adults as part of the multi-disciplinary FCCS teams. Forty individuals are targeted for providing these services.

Significant Changes for FY 2013-14
Explore the possibility of increasing the Service Extender allocation for FY 13/14 to allow for more Service Extenders in directly-operated programs providing additional training, e.g. running peer-run groups.

Achievements/Highlights in FY 2011-12
An "Academy" to train new Service Extenders was held in August 2011. Twenty-three prospective Service Extenders completed the 9-hour course, and nine were placed in FCCS programs during this fiscal year.



* As reported by program lead for FY 2011-12 Exhibit 6 Report

Program Description

The Older Adult Training Program will address the training needs of existing mental health professionals and community partners by providing the following training topics: field safety, elder abuse, documentation, co-occurring disorders, hoarding, geriatric psychiatry, geropsychiatry fellowship.

Significant Changes for FY 2013-14

Continue training in Evidence Based Practices and the Integration of Health, Mental Health and Substance Abuse Treatment models. Address workforce development by the creation of the Geriatric Mental Health 101 & 201 series.

Achievements/Highlights in FY 2011-12

- Treatment of Substance Abuse and Medical Co-Morbidity
- Implementation of the MMSE as a Cognitive Screening Tool
- Trainings in Suicide Prevention and Elder Abuse
- Hosted a Hoarding Forum
- Trainings in PEI Evidence Based Programs including PEARLS & CORS

PROGRAM DESCRIPTION

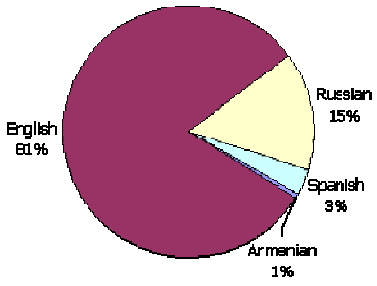
Transition Age Youth (TAY) FSP program delivers intensive mental health services and support to high need and high-risk Severely Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY ages 16 -25. TAY FSPs place an emphasis on recovery and wellness while providing an array of community and social integration services to assist individuals with developing skill-sets that support self-sufficiency. The foundation of the TAY FSP program is doing "whatever it takes" to assist individuals with accessing mental health services and supports (e.g. housing, employment, education and integrated treatment for those with co-occurring mental health and substance abuse disorders). Unique to FSP programs are a low staff to consumer ratio, a 24/7 crisis availability and a team approach that is a partnership between mental health staff and consumers.

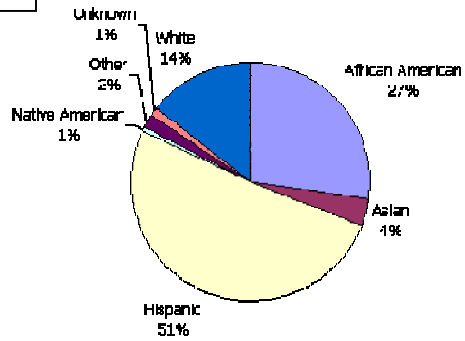
SIGNIFICANT CHANGES FOR FY 2013-14

Continue the use of OMA data as a tool for monitoring program effectiveness and providing the necessary technical support to improve client outcomes and program performance. Conduct annual TAY FSP Client Satisfaction Surveys in order to better identify the needs of TAY clients and to improve service delivery and client outcomes.

The Bi-monthly FSP Workshop Group was initiated and will continue to address the complex problems of serving this population group.
Within the TAY Division, there will be an identified TAY clinician to address the interagency problems.

UNIQUE CLIENTS SERVED: 1,651*



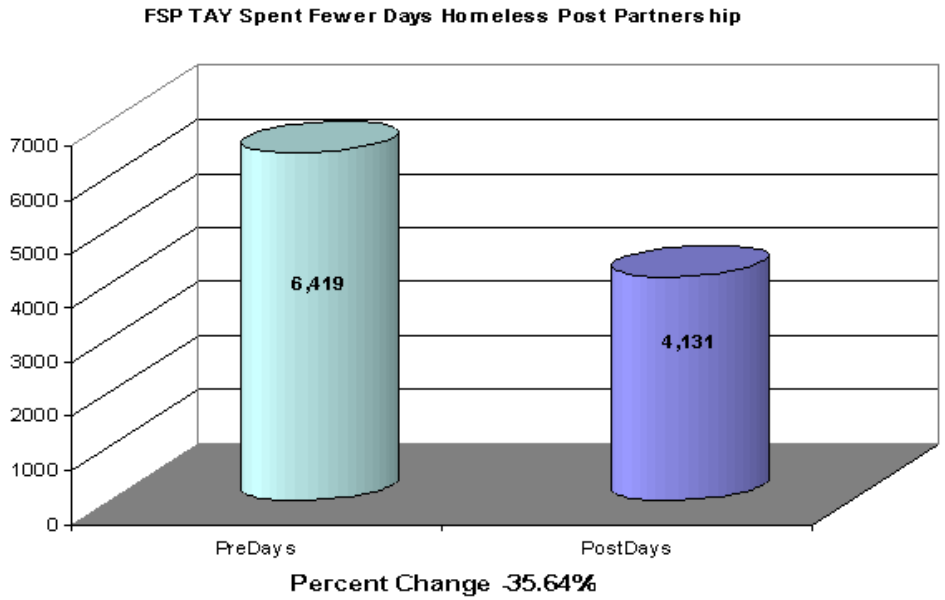


* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

The TAY Administration has provided technical support to providers in cleaning up much of the backlog of OMA errors. The first TAY Client Satisfaction Survey to assess clients' perceptions of services was completed.

During FY 2011-12, the TAY Division conducted a Telephonic Satisfaction Survey for the FSP program and included Enrolled and Disenrolled TAY. Of the 1,241 TAY, 153 were successfully interviewed. General results showed that most TAY were satisfied with their current FSP services. However, TAY providers continue to struggle with transitioning clients to less intensive services especially for the longer term FSP clients. In some service areas there were a lack of available slots for FSP services. This also has an impact on hospitals, IMD's and other residential placements needing to refer their TAY patients to FSP programs. There has been an expressed need by some service areas to have an arena to express their concerns. The TAY FSP workshop group was developed to address these concerns as well as other multi-systemic issues. This group is meeting bi-monthly and is facilitated by a TAY Program Manager.



FY 2011-12 Outcomes, Housing: N=368

NUMBER OF CLIENT CONTACTS: 876*

PROGRAM DESCRIPTION

TAY Drop-In Centers are intended as entry points to the mental health system for homeless youth or youth in unstable living situations. Drop-In Centers provide "low demand, high tolerance" environments in which youth can find temporary safety and begin to build trusting relationships with staff members who can, connect them to the services and supports that they need. Drop-In Centers also help to meet the youths' basic needs such as meals, hygiene facilities, clothing, mailing address, and a safe inside place to rest that is away from the elements. Generally, these centers are operated during regular business hours. MHSA funding allows for expanded hours of operation of Drop-In Centers during evenings and weekends when access to these centers is even more crucial.

ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

TAY Division has provided evidence-based treatment trainings in Motivational Interviewing and Seeking Safety. Several staff at the Drop-In Centers has been trained in Motivational Interviewing to assist with outreaching and engaging TAY, especially youth who are more reluctant to seek services. Drop-In Center staff has also been trained in Seeking Safety, treatment model focusing on trauma and substance abuse. Seeking Safety is a present-focused stabilization model providing youth with coping skills to increase involvement with services.

SIGNIFICANT CHANGES FOR FY 2013-14

Drop-In Center staff will be encouraged to send new staff to evidenced based trainings such as Motivational Interviewing and Seeking Safety. This will reduce potential barriers and risk factors for youth and increase engagement in services. DMH will develop one additional TAY Drop-In Center in FY 2013-14.

* As reported by program lead for FY 2011-12 Exhibit 6 Report

PROGRAM DESCRIPTION

There are three housing related systems development investments for the TAY population. These include:

- 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. The annual target for EESP is 300 clients.
- 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.

SIGNIFICANT CHANGES FOR FY 2013-14

- Continue to decrease homelessness by increasing number of TAY served countywide. Due to increased number of clients served since the inception of the program, EESP budget has been increased to $905,000. The "Good Seed" increased its availability to eight beds which will result in increased number of homeless clients served.
- Improvement in the process by which shelter clients become enrolled in FSP; with a focus on timely outreach, engagement, authorization and enrollment.
- Continue construction of MHSA Housing Projects to accommodate homeless TAY.
- Continuance of Housing Specialist and Clinical Mental Health staff in providing assistance and case management to the various MHSA Housing Projects.
- Continued involvement with problem-solving for the residents and providing community resources for TAY to ensure their successful stay.
- Identify additional permanent supportive housing projects that can benefit from this subsidy.
- Designate clinical staff to provide short-term intervention services and linkage to TAY.

NUMBER OF CLIENT CONTACTS: *1,238

ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

In Fiscal Year 11-12: Approximately 731 unique youth have been housed in the TAY EESP shelters. These youth were provided with successful linkages to mental health services, substance abuse and housing resources as a result of supportive services provided by clinically trained navigation staff. The "Good Seed" was added as a new EESP Shelter provider in Service Area 6. They house six male clients.

Other highlights include: A tool was developed to provide discharge outcome information on 100% of TAY entering emergency shelters and reduced client length of stay by setting limits on available shelter extensions days. This resulted in improved linkage for permanent housing.

MHSA Permanent Housing has been developed for several housing projects during this time period and TAY residents have been recruited county-wide. At least four Permanent Housing Programs were opened serving approximately 62 TAY residents. Those TAY not selected were placed on the waiting list. The TAY Housing Specialist continued to play a crucial and full-time role in coordinating access to MHSA Housing Programs. The Specialist was also involved in the implementation and maintenance of the Supportive Service Plans for each Housing project.

* As reported by program lead for FY 2011-12 Exhibit 6 Report

Transitional Age Youth Probation Camps
T-04

Program Description

TAY Probation Camp Services provide services to youth ages 16 to 20 who are residing in Los Angeles County Probation Camps; particularly youth with SED, SPMI, those with co-occurring substance disorders and/or those who have suffered trauma.

A multidisciplinary team of parent/peer advocates, clinicians, probation staff, and health staff provide an array of on-site treatment and support services that include the following: assessments, substance abuse treatment, gender-specific treatment, medication support, aftercare planning and transition services. TAY Probation services fund mental health staff at the following probation camps: Camp Rockey-Paige-Afflerbaugh, Camp Scott-Scudder, Camp Holton-Routh, Camp Gonzales, Challenger Complex and Camp Miller-Kilpatrick.

Number of Client Contacts: 3,725*

Achievements/Highlights in FY 2011-12

Operational and staffing challenges have been addressed to improve and increase services, including:

- Probation Electronic Medical Records (PEMRs) facilitated information exchange between the Juvenile Halls and the Camps. The PEMRS system was fully implemented and utilized throughout the juvenile justice programs. This provides for improved access to client information across the system. Multi-disciplinary team meetings were instituted at all Probation camps. These meeting include Mental Health, Probation, LACOE, health, the youth and their families. This has served to enhance coordinated case planning. Transition Aftercare staff focused on the youth's reentry funded through PEI began attending MDTs and facilitating aftercare planning.
- With the hiring of 88 additional clinical staff, 26 of which were MHSA-funded, services have been enriched, and mental health services are now available 7 days a week, including evening hours and there is an increase in the ability of clinical staff to respond to crises.
- Transportation vans are now available to transport families to attend Multidisciplinary Team meetings (MDT), IEPs, and to visit with their detained children.

Significant Changes for FY 2013-14

Continued improved linkage with the Transition Aftercare staff to facilitate successful reintegration into communities and families. Evidence-based practices, including groups co-facilitated by probation and mental health staff, include: Aggression Replacement Training, adapted Dialectical Behavioral Therapy (DBT), and Seeking Safety. Improved provision of services for youth with co-occurring disorders and specific incorporation of substance abuse goals have been incorporated into the treatment plan.

* As reported by program lead for FY 2011-12 Exhibit 6 Report

PROGRAM DESCRIPTION

The Transitional Age Youth Field Capable Clinical Services (FCCS) program provides an array of resiliency-oriented, field-based and engagement-focused mental health services to TAY and their families. The TAY FCCS program provides specialized mental health services delivered by a team of professional and paraprofessional staff. The focus of the FCCS program is to work with community partners to provide a wide range of services that meet individual needs. The TAY FCCS program is designed to provide services to individuals who are isolated, unwilling or unable to access traditional mental health outpatient services due to location/distance barriers, physical disabilities, or because of the stigma associated with receiving clinic-based services.

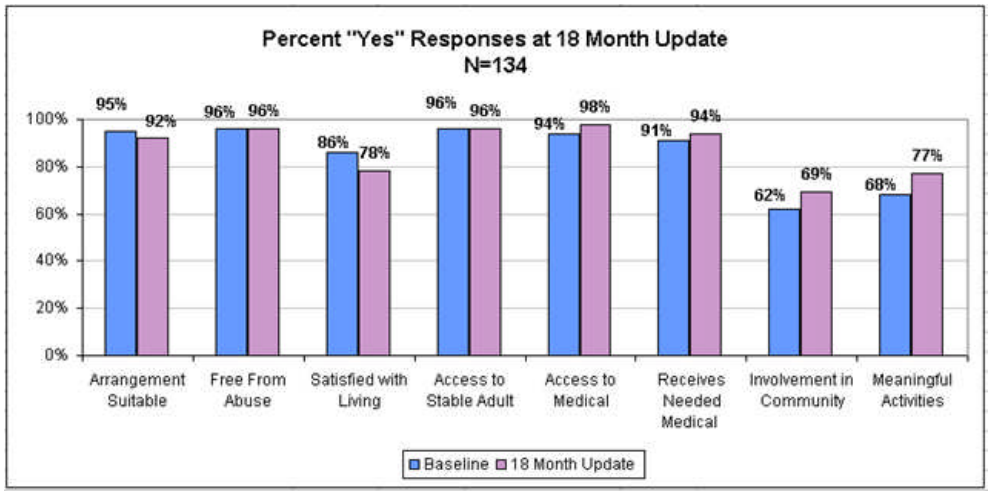
SIGNIFICANT CHANGES FOR FY 2013-14

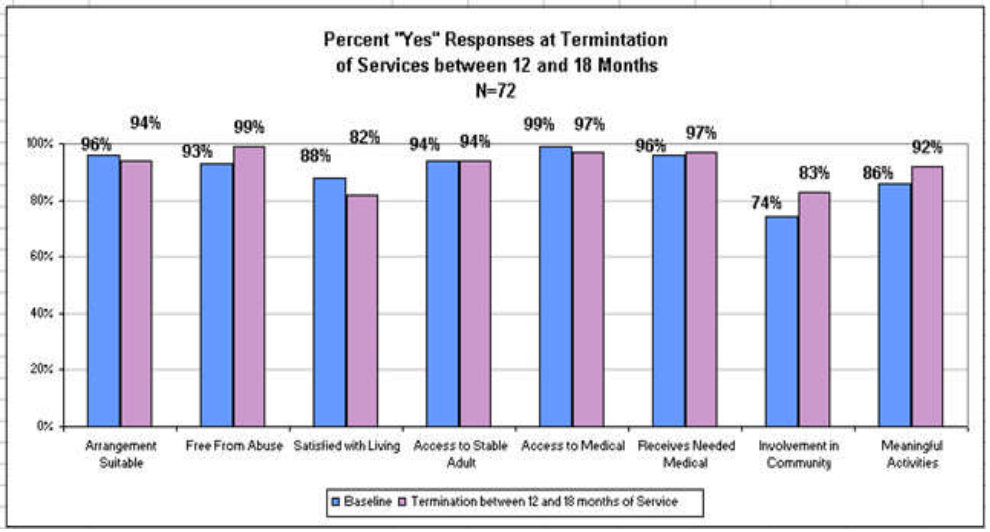
FCCS capacity will be expanded to assist FSP clients in transitioning to lower level of care while also increasing the availability of FSP slots. This will be achieved by shifting unused FSP flex funding to create or enhance direct service capacity.

UNIQUE CLIENTS SERVED: 2,156*

ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

The TAY Navigators continued to provide referrals and linkages to the countywide TAY FCCS programs.





Outcomes data as of 11/21/2012

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

Systems Navigator
SN-01

Program Description

Service Area Navigator Teams will assist individuals and families in accessing mental health and other supportive services and network with community-based organizations in order to strengthen the array of services available to clients of the mental health system. Such networking creates portals of entry in a variety of settings that would make the Department's long-standing goal of no wrong door achievable.

The Service Area Navigators increase knowledge of and access to mental health services through the following activities:

- Engaging in joint planning efforts with community partners, including 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 clients in the mental health system.
- Promoting awareness of mental health issues and the commitment to recovery, wellness and self-help.
- Engaging with people and families to quickly identify currently available services, including supports and services tailored to a client's particular cultural, ethnic, age and gender identity.
- Recruiting community-based organizations and professional service providers to become part of an active locally-based support network for people in the service area, including those most challenged by mental health issues.
- Following up with people with whom they have engaged to ensure that they have received the help they need.

Significant Changes for FY 2013-14

No significant changes are anticipated for Service Area Navigators. They will continue to develop and integrate local resources into their portfolio of referral options and will play an important role in referring clients to integrated service programs.

Number of client contacts: 22,189*

Achievements/Highlights in FY 2011-12

As services are added to a local continuum of care, Service Area Navigators have developed additional resources. New resources include referring clients into Healthy Way LA, AB 109 client navigation issues, clients formerly served by AB 3632 and Innovation services. They continue to be valued by their communities.

* As reported by Service Area Navigators for FY 2011-12 Exhibit 6

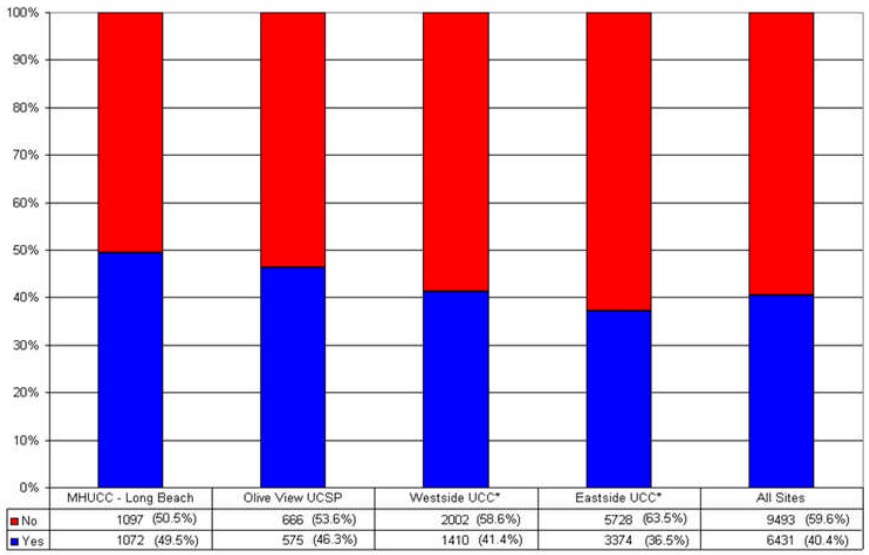
PROGRAM DESCRIPTION

Alternate Crisis Services (ACS) provides a comprehensive range of services and supports for mentally ill individuals that are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care, reduce homelessness, and prevent incarceration. These programs are essential to crisis intervention and stabilization, service integration and linkage to community-based programs, e.g. Full Service Partnerships (FSP) and Assertive Community Treatment Programs (ACT), housing alternatives and treatment for co-occurring substance abuse. ACS provides these services and supports to individuals 18 years of age and older of all genders, race/ethnicities, languages spoken.

SIGNIFICANT CHANGES FOR FY 2013-14

Implementation of Augustus F. Hawkins Urgent Care Center at Martin Luther King Medical Center when it reopens in March 2014.

Any Treatment at an Outpatient Clinic within 90 Days of Having Been Seen at a UCC January 1, 2012 through September 30, 2012



	MHUCC - Long Beach	Olive View UCSP	Westside UCC*	Eastside UCC*	All Sites
No	1097 (50.5%)	666 (53.6%)	2002 (58.6%)	5728 (63.5%)	9493 (59.6%)
Yes	1072 (49.5%)	575 (46.3%)	1410 (41.4%)	3374 (36.5%)	6431 (40.4%)

*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.

ACHIEVEMENTS/HIGHLIGHTS IN FY 2011-12

Urgent Care Centers

- Served 24,413* individuals during FY 2011-12
- 21% were homeless
- 21% had benefits
- 8.2% were admitted to acute inpatient units within 30 days of discharge from UCCs. This includes admissions from two LPS-designated UCCs that admit directly to inpatient units on WIC 5150s when necessary.
- 3.3% were admitted to emergency rooms within 30 days of discharge from UCCs.
- 46% of those discharged from UCCs received outpatient mental health services within 90 days

Countywide Resource Management

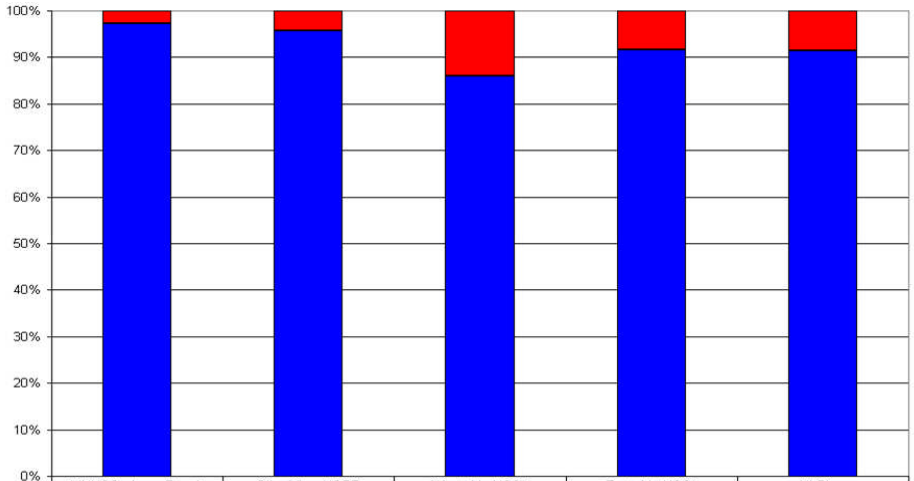
- 10,762* individuals were transitioned to all levels of care available under the program during FY 2011-12
- Planned, developed and implemented a comprehensive system of mental health services with other county departments and community agencies to serve individuals released under Assembly Bill 109
- Oversaw 6 Homeless Services Projects that provide health, mental health, and substance abuse treatment in permanent housing including one with the Greater Los Angeles Veterans Administration and LAC+USC Medical Center Street Medical Center
- Provided Residential and Bridging Services
- 7,429* individuals were served in FY 2011-12 to transition individuals from state and County hospitals, criminal justice system, and the community to appropriate levels and types of mental health services

Enriched Services

- Provides integrated health and co-occurring mental health and substance abuse treatment, and housing with benefits establishment
- 90 individuals were served by Enriched Services in FY 2011-12
- 90% have received benefits
- Peer Bridgers/Advocate services are provided to all residents

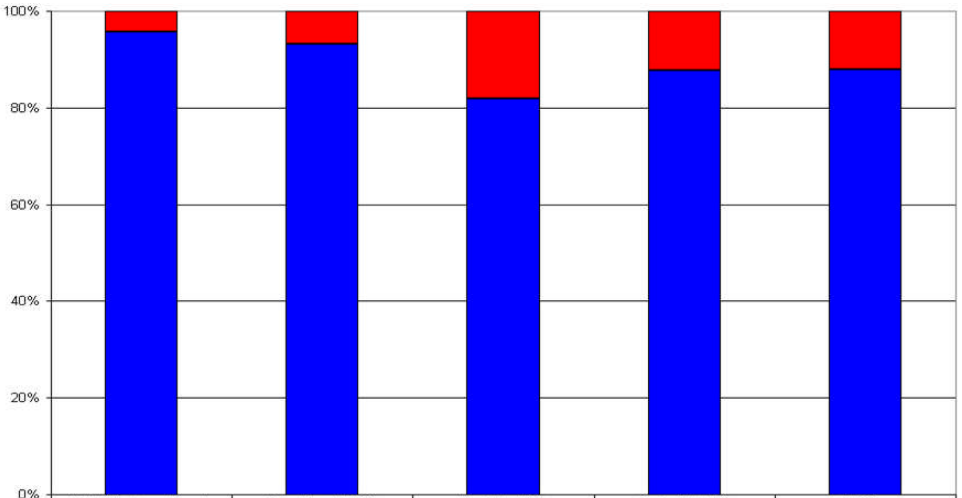
* As reported by program lead for FY 2011-12

New Admissions to Urgent Care Centers (UCC) with Acute Psychiatric Inpatient Hospitalization within 30 Days of Receiving Services
January 1, 2012 through September 30, 2012



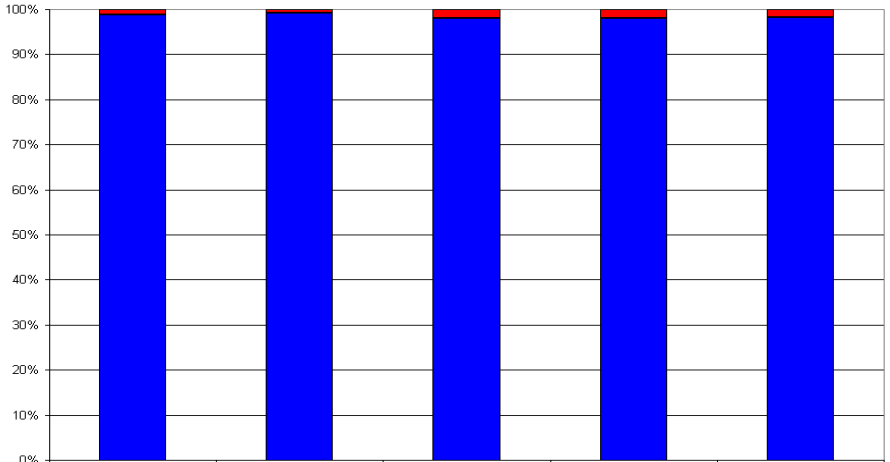
	MHUCC - Long Beach	Olive View UCSP	Westside UCC*	Eastside UCC*	All Sites
Yes	60 (2.8%)	52 (4.3%)	481 (16.4%)	768 (9.2%)	1361 (9.3%)
No	2109 (97.2%)	1189 (95.7%)	2931 (83.6%)	8334 (90.8%)	14563 (90.7%)

Any Inpatient, PMRT, Psych ER, Jail MH Contact within 30 Days of a UCC Assessment
January 1, 2012 through September 30, 2012



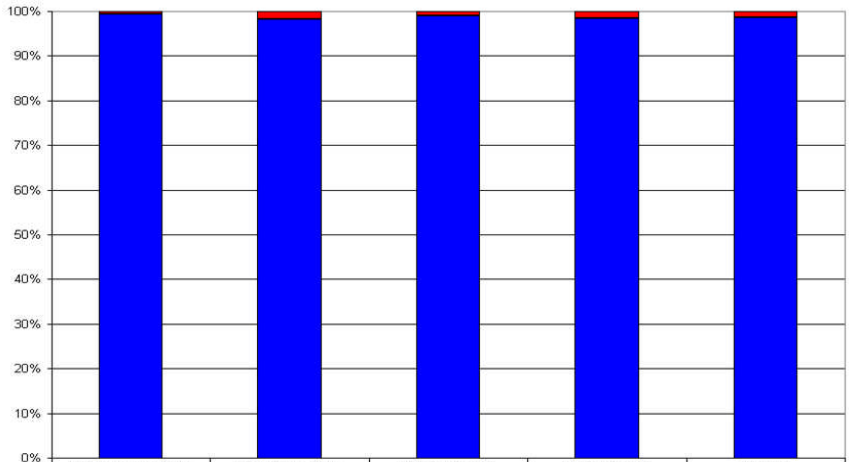
	MHUCC - Long Beach	Olive View UCSP	Westide UCC	Eastside UCC	All Sites
Yes	97 (4.5%)	88 (7.2%)	649 (22.1%)	1160 (13.8%)	1994 (13.6%)
No	2119 (95.5%)	1213 (92.8%)	2931 (77.9%)	8357 (86.2%)	14620 (86.4%)

Any Contact With Jail Mental Health Services within 30 Days of Being Seen at a UCC
January 1, 2012 through September 30, 2012



	MHUCC- Long Beach	Olive View UCSP	Westside UCC	Eastside UCC	All Sites
Yes	24 (1.0%)	10 (.77%)	72 (2.02%)	187 (2.0%)	293 (1.7%)
No	2192 (99.0%)	1291 (99.23%)	3508 (97.98%)	9320 (98.0%)	16311 (98.3%)

Any Visit to a Psychiatric Emergency Room within 30 Days of Being Seen at a UCC
January 1, 2012 through September 30, 2012



	MHUCC Long Beach	Olive View UCSP	Westside UCC*	Eastside UCC*	All Aites
Yes	11 (.49%)	23 (1.79%)	38 (1.07%)	144 (1.53%)	216 (1.31%)
No	2205 (99.51%)	1278 (98.21%)	3542 (98.93%)	9363 (98.47%)	16388(98.69%)

PROGRAM DESCRIPTION

Project 50 is a demonstration program to identify, engage, house and provide integrated supportive services to the 50 most vulnerable, long-term chronically homeless adults living on the streets of Skid Row. Project 50 involves 3 phases: 1) Registry of homeless individuals; 2) Outreach Team to assess needs, define services and develop plan for service delivery; and 3) Integrated Supportive Services Team to coordinate interagency collaboration for comprehensive care and services. Project 50 serves the most vulnerable, chronically homeless adults in the Skid Row area of downtown Los Angeles across gender and linguistic diversity.

Homeless Outreach and Mobile Engagement Team (HOME), formerly known as HOET, provides county-wide, field-based, and dedicated outreach and engagement services to the most un-served and under-served of the homeless mentally ill population. In this capacity its staff function as the 'first link in the chain' to ultimately connect the homeless mentally ill individual to recovery and mental health wellness services through a collaborative effort with other care giving agencies and county entities. HOME serves predominantly adults and TAY by providing intensive case management services, linkage to health services, substance abuse, mental health, benefits establishment services, transportation, assessment for inpatient psychiatric hospitalizations and any other services required in order to assist the chronically homeless and mentally ill across gender, cultural and linguistic diversity.

Under-Represented Ethnic Populations (UREP)

Through the use of one time funding, the Department has been able to fund projects aimed at serving unserved, underserved and inappropriately served populations with the goal of reducing racial/ethnic disparities. One such example is Training for and Services provided by Promotores de Salud. The purpose of the training is to support the development and increase the capacity of Promotores to perform specialized mental health work with the Latino community, including mental health outreach to the Latino indigent population and monolingual Spanish-speaking communities. Similarly, a mental health worker program has been designed to provide professional support for Latino students interested in entering the mental health field. This project will involve the enhancement of existing mental health paraprofessional training programs.

NUMBER OF CLIENT CONTACTS: 16,856*

PROGRAM DESCRIPTION (CONTINUED)

MHSA programs such as the ones mentioned above focus on reducing racial/ethnic disparities and providing services to unserved, underserved populations and inappropriately served.

SIGNIFICANT CHANGES FOR FY 2013-14

No significant changes are anticipated for Planning, Outreach & Engagement.

* As reported by Service Area Outreach & Engagement Staff for FY 2011-12

1 **61,422 unique clients received mental health services through the PEI plan**

58% were Hispanic, 22% were African American, 14% were White and 3% were Asian

2 **40,062 new clients received mental health services through the PEI plan**

57% were Hispanic, 21% were African American, 15% were White and 3% were Asian

3 **PEI clients served by Service Area**

4,502 clients served in SA1; 10,937 served in SA2; 10,002 served in SA 3; 8,242 served in SA 4; 2,090 served in SA 5; 11,375 served in SA 6; 5,599 served in SA 7; 10,261 served in SA8

4 **PEI Plan1: Six School Based Practices have been implemented**

To date, 6 Practices have been implemented by DMH directly operated and contracted agencies: ART, CBITS, MDFT, OPP, PATHS & SF

5 **PEI Plan 2: Seven Family Education & Support Practices have been implemented**

To date, 7 Practices have been implemented by DMH directly operated and contracted agencies: CFOF, IY, MAP, NFP, MP, PATHS & Triple P

6 **PEI Plan 3 : Twelve At-Risk Family Programs have been implemented**

To date, 12 Programs have been implemented by DMH directly operated and contracted agencies: BSFT, CPP, FOCUS, Group CBT, IY, MAP, MPAP, MP, PCIT, RPP, Triple P & UCLA TTM

7 **PEI Plan 4: Eleven Trauma Recovery Programs have been implemented**

To date, 11 Programs have been implemented by DMH directly operated and contracted agencies: CORS, CPP, DBT, DTQI, Group CBT, Ind CBT, PCIT, PE-PTSD, SS, System Navigators for Veterans & TF-CBT

8 **PEI Plan 5: Four Primary Care & Behavioral Health Practices have been implemented**

To date, 4 Practices have been implemented by DMH directly operated and contracted agencies: AF-CBT, IY, MHIP & Triple P

9 **PEI Plan 6: Four Early Care & Support for TAY Programs have been implemented**

To date, 4 Programs have been implemented by DMH directly operated and contracted agencies: ART, IPT, MDFT & SS

10 **PEI Plan 7: Eight Juvenile Justice Services Programs have been implemented**

To date, 8 Programs have been implemented by DMH directly operated and contracted agencies: ART, CBITS, FFT, Group CBT, LIFE, MDFT, MST & TF-CBT

11 **PEI Plan 8: Five Early Car & Support for Older Adults Programs have been implemented**

To date, 5 Programs have been implemented by DMH directly operated and contracted agencies: CORS, Group CBT, IPT, PEARLS & PST

12 **PEI Plan 9: Five Improving Access for Underserved Populations Programs have been implemented**

To date, 5 Programs have been implemented by DMH directly operated and contracted agencies: Group CBT, GLBT Champs, NFP, PE-PTSD & TF-CBT

COST PER CLIENT*

PEI SERVICES

PLAN NAME:	PEI-Child
UNIQUE CLIENTS:	33,080
COST:	$148,012,745
AVERAGE COST:	$4,474

PLAN NAME:	PEI-Older Adult
UNIQUE CLIENTS:	822
COST:	$ 1,204,727
AVERAGE COST:	$ 1,465

PLAN NAME:	PEI-TAY
UNIQUE CLIENTS:	11,497
COST:	$ 44,799,346
AVERAGE COST:	$ 3,896

PLAN NAME:	PEI-Special Programs
UNIQUE CLIENTS:	3,023
COST:	$ 3,668,940
AVERAGE COST:	$ 1,213

PLAN NAME:	PEI-Adult
UNIQUE CLIENTS:	15,243
COST:	$18,205,490
AVERAGE COST:	$ 1,194

*Calculation based on Mode 15 services, inclusive of Federal Financial Participation (FFP) & Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Not inclusive of community outreach services or client supportive services expenditures. Data as of 12/17/2012.

1 **Center for the Assessment & Prevention of Prodromal States**
30 Agencies/Clinics and 74 Staff

2 **Cognitive Behavioral Intervention for Trauma in Schools**
15 Agencies/Clinics and 64 Staff

3 **Crisis Oriented Recovery Services**
19 Agencies/Clinics and 88 Staff

4 **Families Overcoming Under Stress**
5 Agencies/Clinics and 83 Staff

5 **Group Cognitive Behavioral Therapy for Major Depression**
18 Agencies/Clinics and 55 Staff

6 **Interpersonal Psychotherapy for Depression**
45 Agencies/Clinics and 277 Staff

7 **Managing and Adapting Practice**
88 Agencies/Clinics and 915 Staff

8 **Mental Health First Aid Staff Training (Prevention)**
48 Agencies/Clinics and 81 Staff

9 **Mental Health First Aid Instructor Training (Prevention)**
9 Agencies/Clinics and 16 Staff

10 **Program to Encourage Active and Rewarding Lives for Seniors**
19 Agencies/Clinics and 200 Staff

11 **Prolonged Exposure Therapy for Post Traumatic Stress Disorder**
15 Agencies/Clinics and 45 Staff

12 **Seeking Safety**
73 Agencies/Clinics and 855 Staff

13 **Trauma Focused Cognitive Behavioral Therapy** 51 Agencies/Clinics and 245 Staff

14 **Triple P – Levels 2-3 (Prevention)**
12 Agencies/Clinics and 48 Staff

UNIQUE CLIENT COUNTS* BY AGE GROUP:

Service Area 1			Service Area 2			Service Area 3			Service Area 4		
Prevention and Early Intervention			Prevention and Early Intervention			Prevention and Early Intervention			Prevention and Early Intervention		
Plan Age Group	Count	Percent	Plan Age Group	Count	Percent	Plan Age Group	Count	Percent	Plan Age Group	Count	Percent
Child	1,797	37.76%	Child	5,666	50.16%	Child	6,049	58.34%	Child	4,771	56.64%
TAY	788	16.56%	TAY	2,197	19.45%	TAY	2,560	24.69%	TAY	1,688	20.04%
Adult	1,622	34.08%	Adult	2,705	23.95%	Adult	1,239	11.95%	Adult	1,674	19.87%
Older Adult	36	0.76%	Older Adult	70	0.62%	Older Adult	142	1.37%	Older Adult	88	1.04%
Special Programs	516	10.84%	Special Programs	657	5.82%	Special Programs	378	3.65%	Special Programs	202	2.40%
TOTAL	4,759	100.00%	TOTAL	11,295	100.00%	TOTAL	10,368	100.00%	TOTAL	8,423	100.00%

Service Area 5			Service Area 6			Service Area 7			Service Area 8		
Plan Age Group	Count	Percent	Plan Age Group	Count	Percent	Plan Age Group	Count	Percent	Plan Age Group	Count	Percent
Child	999	47.08%	Child	5,706	48.56%	Child	2,905	49.86%	Child	6,152	58.35%
TAY	227	10.70%	TAY	1,590	13.53%	TAY	1,053	18.07%	TAY	1,763	16.72%
Adult	860	40.53%	Adult	3,678	31.30%	Adult	1,207	20.72%	Adult	2,341	22.20%
Older Adult	3	0.14%	Older Adult	339	2.89%	Older Adult	53	0.91%	Older Adult	91	0.86%
Special Programs	33	1.56%	Special Programs	437	3.72%	Special Programs	608	10.44%	Special Programs	196	1.86%
TOTAL	2,122	100.00%	TOTAL	11,750	100.00%	TOTAL	5,826	100.00%	TOTAL	10,543	100.00%

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

New PEI Client Counts
Ethnicity/Primary Language Breakdown FY 2011-12

Number of New Clients* receiving PEI services Countywide:

New Clients, No Previous CSS			New Clients, Previous CSS			TOTAL NEW PEI CLIENTS		
Ethnicity	**Count**	**Percent**	**Ethnicity**	**Count**	**Percent**	**Ethnicity**	**Count**	**Percent**
Hispanic	20,570	60.22%	Pacific Islander	2,370	40.16%	Hispanic	22,940	57.26%
African American	6,383	18.69%	Native American	2,012	34.09%	African American	8,395	20.96%
White	4,794	14.03%	Unknown	1,108	18.77%	White	5,902	14.73%
Asian	862	2.52%	Other	225	3.81%	Asian	1,087	2.71%
Unknown	680	1.99%	White	60	1.02%	Other	740	1.85%
Other	646	1.89%	Asian	92	1.56%	Unknown	738	1.84%
Native American	156	0.46%	African American	24	0.41%	Native American	180	0.45%
Pacific Islander	69	0.20%	Hispanic	11	0.19%	Pacific Islander	80	0.20%
TOTAL	34,160	100.00%	TOTAL	5,902	100.00%	TOTAL	40,062	100.00%
Primary Language	**Count**	**Percent**	**Primary Language**	**Count**	**Percent**	**Primary Language**	**Count**	**Percent**
English	24,176	70.77%	English	4,632	78.48%	English	28,808	71.91%
Spanish	8,926	26.13%	Spanish	971	16.45%	Spanish	9,897	24.70%
Unknown/not reported	309	0.90%	Unknown/not reported	85	1.44%	Unknown/not reported	394	0.98%
Armenian	194	0.57%	Armenian	30	0.51%	Armenian	224	0.56%
Other	130	0.38%	Farsi	34	0.58%	Other	164	0.41%
Mandarin	68	0.20%	Other	24	0.41%	Mandarin	92	0.23%
Farsi	63	0.18%	Cambodian	19	0.32%	Farsi	82	0.20%
Korean	56	0.16%	Korean	26	0.44%	Cantonese	82	0.20%
Cambodian	56	0.16%	Russian	14	0.24%	Korean	70	0.17%
Cantonese	49	0.14%	Mandarin	18	0.30%	Vietnamese	67	0.17%
Pilipino, Tagalog	38	0.11%	Vietnamese	24	0.41%	Cambodian	62	0.15%
Vietnamese	32	0.09%	Pilipino, Tagalog	17	0.29%	Pilipino, Tagalog	49	0.12%
Arabic	23	0.07%	Cantonese	5	0.08%	Arabic	28	0.07%
Russian	21	0.06%	Arabic	3	0.05%	Russian	24	0.06%
American Sign	18	0.05%	American Sign	0	0.00%	American Sign	18	0.04%
Hmong	1	0.00%	Hmong	0	0.00%	Hmong	1	0.00%
TOTAL	34,160	100.00%	TOTAL	5,902	100.00%	TOTAL	40,062	100.00%

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

Client Counts by Evidence Based Practice
Service Area and Age Group Breakdown FY 2011-12

Service Area 1*:

Service Area 1					
Evidence Based Practice	Child	TAY	Adult	Older Adult	Total
11-EBP FFT	59	15	0	0	74
2A-Brf Strat FamTher	1	0	0	0	1
2B-CPP Chld-Prnt Ther	71	1	1	0	73
2F-DTQI-Dep Treat QI	3	1	0	0	4
2J-Group CBT Maj Dep	0	2	5	0	7
2K-IMPACT-MHIP	1	31	292	20	344
2L-Incredible Years	54	0	0	0	54
2M-IPT Depression	29	11	1	0	41
2R-PCIT	4	0	0	0	4
2T-Prolong Exps PTSD	0	0	1	0	1
2W-Trauma Foc CBT	572	90	0	0	662
2Y-Triple P	185	6	0	0	191
4A-ART-Aggress Replc	137	25	0	0	162
4D-CORS-Crisis Recov	38	113	449	16	616
4K-MAP-Mng Adap Prac	726	132	0	0	858
4N-Seeking Safety	146	273	96	6	521
7A-START	86	60	5	0	151
8A-Cog Beh Therapy	0	0	3	0	3
Multiple EBPs	1	0	0	1	2
No Or Unknown EBP	746	647	1,435	73	2,901
Service Strategy Only	5	5	23	0	33

Service Area 2*:

Service Area 2					
Evidence Based Practice	Child	TAY	Adult	Older Adult	Total
10-EBP MST	15	26	0	0	41
11-EBP FFT	31	31	0	0	62
2A-Brf Strat FamTher	0	2	1	0	3
2B-CPP Chld-Prnt Ther	153	1	0	0	154
2C-CBITS	3	1	0	0	4
2F-DTQI-Dep Treat QI	7	7	0	0	14
2J-Group CBT Maj Dep	1	2	10	3	16
2K-IMPACT-MHIP	4	40	394	98	536
2L-Incredible Years	7	0	0	0	7
2M-IPT Depression	8	11	3	2	24
2R-PCIT	152	1	0	0	153
2S-PEARLS	0	0	0	2	2
2V-Strengthen Famili	76	182	0	0	258
2W-Trauma Foc CBT	1,792	278	0	0	2,070
2Y-Triple P	776	29	0	0	805
2Z-PATHS	7	0	0	0	7
3B-Caring Our Famili	4	0	0	0	4
3D-GLBT Champs	0	1	0	0	1
4A-ART-Aggress Replc	467	651	2	0	1,120
4B-Altrnatv for Fmly	6	1	1	0	8
4D-CORS-Crisis Recov	37	112	524	67	740
4K-MAP-Mng Adap Prac	1,765	612	5	0	2,382
4N-Seeking Safety	774	1,145	150	18	2,087
7A-START	244	163	0	0	407
7B-Stigma-Discrim	0	1	0	0	1
8B-Dialec Beh Therapy	0	0	1	0	1
Multiple EBPs	2	16	12	1	31
No Or Unknown EBP	1,954	1,228	2,269	233	5,684
Service Strategy Only	170	85	29	3	287

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

Client Counts by Evidence Based Practice
Service Area and Age Group Breakdown FY 2011-12

Service Area 3*:

Service Area 3					
Evidence Based Practice	Child	TAY	Adult	Older Adult	Total
10-EBP MST	0	1	0	0	1
11-EBP FFT	2	0	0	0	2
2A-Brf Strat FamTher	74	11	0	0	85
2B-CPP Chld-Prnt Ther	113	2	0	0	115
2C-CBITS	10	2	0	0	12
2F-DTQI-Dep Treat QI	68	39	0	0	107
2J-Group CBT Maj Dep	0	5	44	1	50
2K-IMPACT-MHIP	5	29	244	52	330
2L-Incredible Years	64	0	0	0	64
2M-IPT Depression	275	324	5	1	605
2P-Multidim Fam Ther	11	25	0	0	36
2R-PCIT	95	1	0	0	96
2S-PEARLS	0	0	2	2	4
2T-Prolong Exps PTSD	0	0	1	0	1
2V-Strengthen Famili	3	0	0	0	3
2W-Trauma Foc CBT	1,437	371	0	0	1,808
2Y-Triple P	665	74	2	0	741
2Z-PATHS	628	3	0	0	631
4A-ART-Aggress Replc	535	241	0	0	776
4B-Altrnatv for Fmly	3	0	0	0	3
4D-CORS-Crisis Recov	21	39	141	40	241
4K-MAP-Mng Adap Prac	2,091	537	0	0	2,628
4N-Seeking Safety	840	1,191	318	119	2,468
4R-FOCUS	0	1	0	0	1
4S-PST	0	0	9	4	13
7A-START	306	182	5	0	493
7D-PC Latina Youth	0	2	4	0	6
8A-Cog Beh Therapy	0	6	21	0	27
Multiple EBPs	69	22	3	0	94
No Or Unknown EBP	3,491	1,532	821	101	5,945
Service Strategy Only	94	122	36	12	264

Service Area 4*:

Service Area 4					
Evidence Based Practice	Child	TAY	Adult	Older Adult	Total
11-EBP FFT	71	15	0	0	86
2A-Brf Strat FamTher	8	2	0	0	10
2B-CPP Chld-Prnt Ther	456	3	1	0	460
2C-CBITS	17	0	0	0	17
2F-DTQI-Dep Treat QI	14	2	0	0	16
2J-Group CBT Maj Dep	0	19	58	5	82
2K-IMPACT-MHIP	3	12	165	46	226
2L-Incredible Years	445	2	1	0	448
2M-IPT Depression	60	62	30	4	156
2R-PCIT	82	0	0	0	82
2S-PEARLS	0	0	2	1	3
2T-Prolong Exps PTSD	0	0	3	0	3
2V-Strengthen Famili	1	1	0	0	2
2W-Trauma Foc CBT	1,136	206	0	0	1,342
2Y-Triple P	443	41	0	0	484
3B-Caring Our Famili	33	1	0	0	34
3L-Reflect Parenting	19	4	0	0	23
4A-ART-Aggress Replc	58	84	0	0	142
4D-CORS-Crisis Recov	21	44	180	23	268
4K-MAP-Mng Adap Prac	1,340	291	0	0	1,631
4N-Seeking Safety	314	520	255	27	1,116
4R-FOCUS	1	1	0	0	2
7A-START	435	240	8	0	683
7B-Stigma-Discrim	1	0	0	0	1
7L-Prtnr Law Enforce	0	3	0	0	3
8A-Cog Beh Therapy	0	0	1	0	1
Multiple EBPs	6	0	0	0	6
No Or Unknown EBP	2,165	865	1,253	146	4,429
Service Strategy Only	178	227	7	0	412

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

Client Counts by Evidence Based Practice
Service Area and Age Group Breakdown FY 2011-12

Service Area 5*:

Service Area 5					
Evidence Based Practice	Child	TAY	Adult	Older Adult	Total
10-EBP MST	0	0	1	0	1
2A-Brf Strat FamTher	3	0	0	0	3
2B-CPP Chld-Prnt Ther	66	0	0	0	66
2F-DTQI-Dep Treat QI	1	1	0	0	2
2J-Group CBT Maj Dep	0	0	6	0	6
2K-IMPACT-MHIP	1	3	24	6	34
2M-IPT Depression	37	15	3	0	55
2P-Multidim Fam Ther	1	0	0	0	1
2S-PEARLS	0	0	1	0	1
2W-Trauma Foc CBT	182	34	0	0	216
2Y-Triple P	96	0	0	0	96
3B-Caring Our Famili	8	0	0	0	8
3L-Reflect Parenting	4	1	0	0	5
3M-UCLA Ties	31	0	0	0	31
4A-ART-Aggress Replc	2	0	0	1	3
4D-CORS-Crisis Recov	14	27	205	10	256
4K-MAP-Mng Adap Prac	432	104	0	0	536
4N-Seeking Safety	69	75	199	14	357
4R-FOCUS	1	1	0	0	2
4S-PST	0	1	0	0	1
7A-START	115	51	2	0	168
8A-Cog Beh Therapy	0	0	1	0	1
Multiple EBPs	11	0	0	0	11
No Or Unknown EBP	372	177	567	35	1,151
Service Strategy Only	17	4	3	0	24

Service Area 6*:

Service Area 6					
Evidence Based Practice	Child	TAY	Adult	Older Adult	Total
10-EBP MST	8	3	0	0	11
11-EBP FFT	162	87	1	0	250
2A-Brf Strat FamTher	2	0	2	0	4
2B-CPP Chld-Prnt Ther	171	3	0	0	174
2C-CBITS	26	0	0	0	26
2F-DTQI-Dep Treat QI	6	1	0	0	7
2J-Group CBT Maj Dep	0	1	26	5	32
2K-IMPACT-MHIP	5	13	212	26	256
2L-Incredible Years	47	0	0	0	47
2M-IPT Depression	62	35	7	1	105
2S-PEARLS	0	0	0	1	1
2W-Trauma Foc CBT	1,177	265	1	0	1,443
2Y-Triple P	1,071	70	0	0	1,141
2Z-PATHS	0	5	10	1	16
3B-Caring Our Famili	16	3	0	0	19
3D-GLBT Champs	3	12	1	0	16
4A-ART-Aggress Replc	38	23	1	0	62
4B-Altrnatv for Fmly	100	17	0	0	117
4D-CORS-Crisis Recov	1,800	612	1,389	109	3,910
4K-MAP-Mng Adap Prac	1,001	158	5	1	1,165
4N-Seeking Safety	102	146	138	5	391
4R-FOCUS	2	2	0	0	4
7A-START	237	80	9	2	328
8A-Cog Beh Therapy	0	3	9	1	13
Multiple EBPs	27	5	4	0	36
No Or Unknown EBP	2,479	991	2,116	198	5,784
Service Strategy Only	170	303	1,422	141	2,036

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

Client Counts by Evidence Based Practice
Service Area and Age Group Breakdown FY 2011-12

Service Area 7*:

Service Area 7					
Evidence Based Practice	Child	TAY	Adult	Older Adult	Total
10-EBP MST	5	0	0	0	5
11-EBP FFT	162	76	1	0	239
2A-Brf Strat FamTher	3	2	0	0	5
2B-CPP Chld-Prnt Ther	69	3	0	0	72
2C-CBITS	13	0	0	0	13
2F-DTQI-Dep Treat QI	0	0	1	0	1
2J-Group CBT Maj Dep	0	3	8	0	11
2K-IMPACT-MHIP	8	32	178	39	257
2L-Incredible Years	35	0	0	0	35
2M-IPT Depression	86	63	9	3	161
2P-Multidim Fam Ther	0	1	0	0	1
2R-PCIT	3	0	1	0	4
2S-PEARLS	1	1	0	1	3
2T-Prolong Exps PTSD	0	0	4	0	4
2V-Strengthen Famili	43	2	1	0	46
2W-Trauma Foc CBT	786	181	4	0	971
2Y-Triple P	268	10	0	0	278
2Z-PATHS	32	0	0	0	32
3B-Caring Our Famili	15	0	0	0	15
3E-LIFE Program	1	1	0	0	2
4A-ART-Aggress Replc	16	9	1	0	26
4B-Altrnatv for Fmly	103	20	0	0	123
4D-CORS-Crisis Recov	62	106	477	39	684
4K-MAP-Mng Adap Prac	999	201	4	1	1,205
4N-Seeking Safety	142	287	271	22	722
7A-START	267	106	1	0	374
7D-PC Latina Youth	261	105	1	0	367
8A-Cog Beh Therapy	0	9	27	0	36
8B-Dialec Beh Therapy	0	1	0	0	1
Multiple EBPs	10	7	23	3	43
No Or Unknown EBP	1,274	665	905	55	2,899
Service Strategy Only	65	18	60	19	162

Service Area 8*:

Service Area 8					
Evidence Based Practice	Child	TAY	Adult	Older Adult	Total
10-EBP MST	29	35	2	0	66
11-EBP FFT	241	171	0	0	412
2A-Brf Strat FamTher	9	3	1	0	13
2B-CPP Chld-Prnt Ther	416	5	1	0	422
2C-CBITS	19	0	0	0	19
2F-DTQI-Dep Treat QI	30	41	1	0	72
2J-Group CBT Maj Dep	3	30	217	11	261
2K-IMPACT-MHIP	4	7	152	31	194
2L-Incredible Years	66	0	1	0	67
2M-IPT Depression	13	8	12	1	34
2R-PCIT	368	2	0	0	370
2S-PEARLS	0	0	0	3	3
2T-Prolong Exps PTSD	1	2	33	0	36
2V-Strengthen Famili	5	0	0	0	5
2W-Trauma Foc CBT	1,760	353	1	0	2,114
2Y-Triple P	268	22	0	0	290
3B-Caring Our Famili	226	60	0	0	286
3E-LIFE Program	82	13	0	0	95
3L-Reflect Parenting	20	0	0	0	20
3M-UCLA Ties	35	1	2	0	38
3P-Mindful Parenting	10	0	0	0	10
4A-ART-Aggress Replc	72	80	4	0	156
4B-Altrnatv for Fmly	49	11	0	0	60
4D-CORS-Crisis Recov	56	157	624	42	879
4K-MAP-Mng Adap Prac	1,969	398	2	0	2,369
4N-Seeking Safety	434	516	712	46	1,708
4R-FOCUS	3	1	3	0	7
7A-START	245	108	4	0	357
7J-Surviv Supp Grp	0	0	1	0	1
8A-Cog Beh Therapy	0	8	45	2	55
8B-Dialec Beh Therapy	0	1	4	0	5
Multiple EBPs	52	66	2	0	120
No Or Unknown EBP	2,793	1,033	1,353	89	5,268
Service Strategy Only	330	145	23	5	503

Los Angeles County
Service Areas
Unique clients served through PEI
Fiscal Year 2011-12

Ethnicity Breakdown

Service Area 1
African-American – 35%
Hispanic – 32%
White – 26%
Unknown – 1%
Other – 1%
Asian – <1%
Native American - <1%
Pacific Islander- <1%

Service Area 2
Hispanic –60%
White –23%
African-American –10%
Other –3%
Asian –2%
Unknown –2%
Native American - <1%
Pacific Islander- <1%

Service Area 3
Hispanic –67%
White –12%
African-American –12%
Asian – 5%
Other – 2%
Unknown – 1%
Native American - <1%
Pacific Islander- <1%

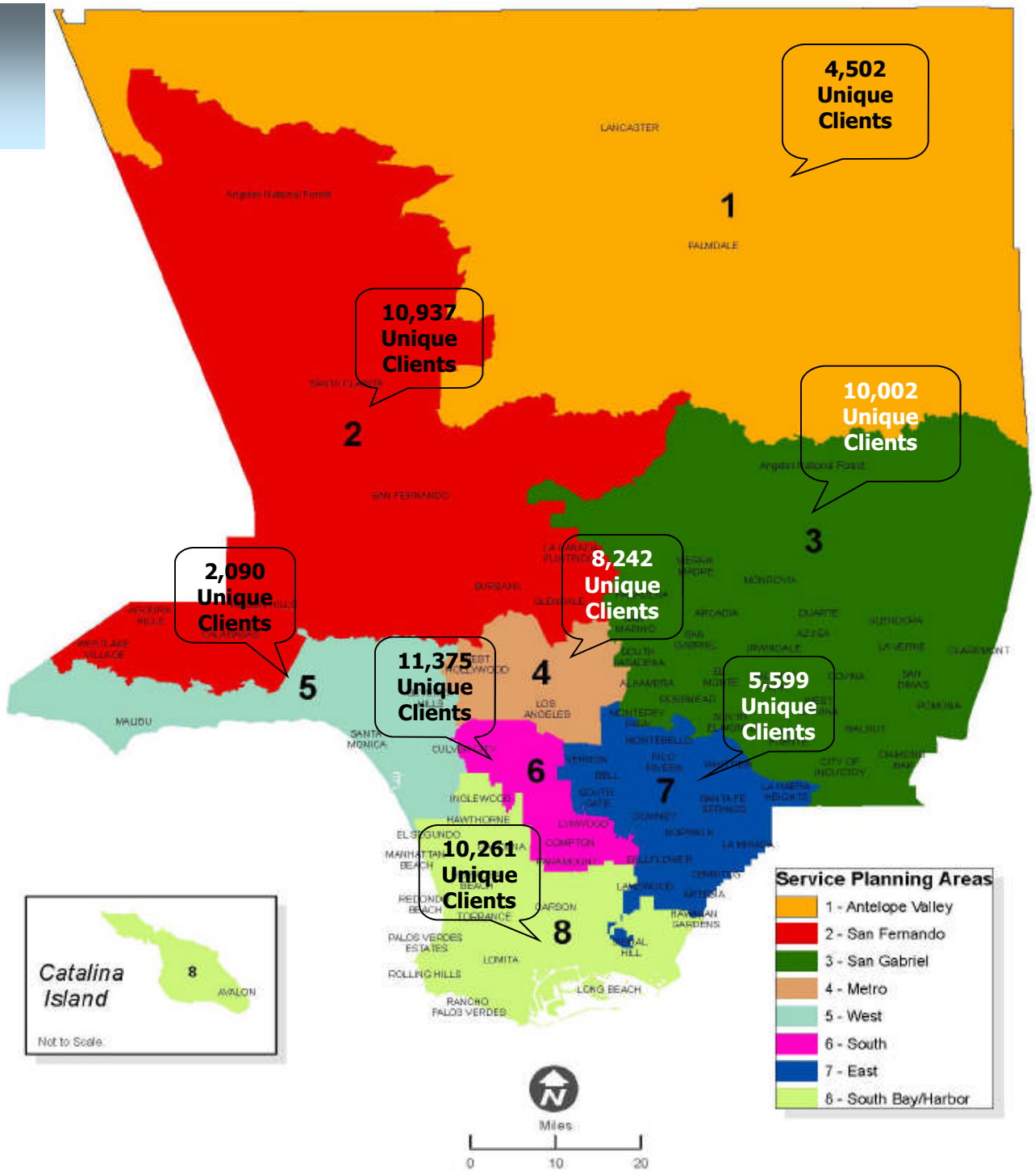
Service Area 4
Hispanic – 70%
African-American –13%
White –11%
Asian –3%
Other –2%
Unknown – 2%
Native American - <1%
Pacific Islander- <1%

Service Area 5
Hispanic –37%
White – 30%
African-American – 23%
Other – 5%
Unknown –3 %
Asian – 2%
Native American - <1%
Pacific Islander- <1%

Service Area 6
Hispanic –47%
African-American – 47%
White – 3%
Unknown – 2%
Other – <1%
Asian – <1%
Native American - <1%
Pacific Islander- <1%

Service Area 7
Hispanic – 81%
White – 10%
African-American – 5%
Asian – 1%
Native American - 1%
Unknown – 1%
Other – <1%
Pacific Islander- <1%

Service Area 8
Hispanic –52%
African-American – 28%
White – 13%
Asian – 3%
Unknown – 2 %
Other – 2%
Pacific Islander- <1%
Native American - <1%



PROGRAM DESCRIPTION

The Early Start Suicide Prevention Program provides suicide prevention services by strengthening the capacity of existing community resources; and creating new collaborative and comprehensive efforts at the individual, family, and community level. These services include community outreach and education in the identification of the suicide risks and protective factors; linking direct services and improving the quality of care to individuals contemplating, threatening, or attempting suicide; access to evidence based interventions trained suicide prevention hotlines; building the infrastructure to further develop and enhance suicide prevention programs throughout the county across all age groups and cultures.

IMPLEMENTATION AS OF JUNE 30, 2011

- **24/7 Crisis Hotline:** Didi Hirsch provides 24/7 Crisis Hotline services in English and Spanish; support services to attempters and/or those bereaved by a suicide; and assistance consultation to law enforcement and first responders. It is also building community capacity by offering evidence-based training in the Applied Suicide Intervention Skills Training (ASIST) and safe TALK models. In FY 2011-12 the Hotline responded to 23,223 calls. It also provided 524 Spanish-speaking crisis hotline services, 839 support services to attempters and/or those bereaved by a suicide, 63 assistance and consultation to law enforcement and first responders; and 255 trainings in ASIST and safe TALK to various staff to recognize and respond appropriate to suicide. In 2012 the agency began providing 8 hours of coverage in the Korean language seven days a week from 6:30pm to 2:30am. As well they are continuing trying to staff up their Vietnamese language.
- **Latina Youth Program**: Pacific Clinics provides 24/7 bilingual (Spanish) emergency and information telephone counseling, consultation and education to schools regarding suicide risk factors among teens. It also provides education and support services in the community about warning signs and risk factors for suicide among youth.

Latina Youth Program (continued):
The program has expanded to include male as well as female youth – ages 14 – 25, who were identified as being "at risk" for suicide. In FY 2011-12, a total of 1,928 contacts were made, with the majority of services for information referral only (635), school problems (635), stress (183), and parent training (121).

CHALLENGES

The Department continues to experience high turn over rates as the result of limited positions available for advancement. The Partners in Suicide Prevention (PSP) team faced dealt with loss of core team staff and adjunct trainers. Despite these losses, the team was able to focus on major efforts that coincided with the California Strategic Plan on reducing suicide among all age groups such as launching the first Los Angeles County Suicide Prevention Summit. This noteworthy event brought together well known experts from mental health, law enforcement, schools, providers, researchers and survivors to collaborate and develop a comprehensive strategy for suicide prevention over the next ten years.

The PSP team has a strong history of working closely and strategically together to provide the most effective interventions on suicide prevention, intervention and post-intervention to underserved high risk groups. As a result of the recent economic hardships and a rise in suicides within the middle age group (45-59) in the state of California, PSP's goal has been to focus on gatekeepers such as school personnel, clergy, parents, consumers, case workers, nurses and grassroots organizations where skills can be developed to quickly assist a suicidal person. Research indicates that a person suffering from suicidal thoughts will likely reach out to a gatekeeper first before seeing a mental health professional, hence the need to continue to increase training for gatekeepers.

In addition, the team narrowed its focus on targeting two high risk groups: the elderly and youth. These two populations often show trends in high suicide attempts and completions. Consequently, PSP team began a two year project with the Department of Children and Family Services (DCFS) to train all (3,000) DCFS staff; including the Emergency Command Post, MAT, Wrap Liaisons, TDM facilitators and supervisors. The team also targeted the elderly population by providing 23 trainings at senior apartments, eight trainings at the adult day health care centers and three trainings at senior housing centers. Trainings for QPR were available in five different languages: English, Spanish, Korean, Chinese and Farsi.

Implementation as of June 30, 2011 (continued)

- **Web-based Training for School Personnel on Suicide Prevention:** The Los Angeles County Office of Education (LACOE), Center for Distance and Online Learning (CDOL) was contracted to design, develop, and maintain a website dedicated to provide critical online information and materials on suicide prevention, intervention, and postvention for school personnel, parents, and students in all 80 K-12 school districts in Los Angeles County. Launched in January 2011, the website has been widely publicized throughout the County, State (through the Office of Suicide Prevention), and at national conferences and meetings of various suicide prevention networks/organizations (including a recent Webinar on "Responding After a Suicide: Best Practices for Schools," sponsored by the Suicide Prevention Resource Center). Targeted local outreach activities have included 20 presentations to approximately 1,500 Los Angeles Unified School District (LAUSD) school personnel as well as presentations to the LACOE Board and multiple LACOE divisions and programs to a combined total of over 1,000 participants. Nearly 3,000 website flyers and posters have been distributed throughout the County. During the second and third phases of the project, the staff will continue to analyze survey results and data obtained from other sources, and then continue to refine, update, and expand the website content/resources, while developing more focused implementation strategies for selected school districts.

- **Partners in Suicide Prevention (PSP) Team for Children, Transition Age Youth (TAY), Adults, and Older Adults** is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The Team offers education; identifies appropriate tools, such as evidence-based practices; and provides linkage and referrals to age appropriate services. PSP team members participated in a total of 197 suicide prevention events during FY 2011-12, outreaching to more than 4,300 Los Angeles County residents. These events included countywide educational trainings, participation in suicide prevention community events, and collaboration with various agencies and partners. Highlights included providing seven Applied Suicide Intervention Skills Training (ASIST); attaining three new provisional ASIST Trainers for a with a total of 13 trainers; coordinating the *Los Angeles County Suicide Prevention Network* which has recruited over 40 members from a wide variety of organizations and has conducted quarterly meetings to increase collaboration and coordination of suicide prevention activities; and providing over 100 Educational Presentations and Trainings to Directly Operated and Contracted Agencies.

PEI Success Stories

"I was feeling down, and there was no life for me. Now I'm not feeling down, not thinking of the past, and I'm able to stop and think before getting into arguments. I started going to Zumba, going out more often, socializing, and to the doctor for appointments. I don't have any depressive symptoms anymore, and if I do, I will go forward no back by not putting myself down." (PEI client who has completed IPT treatment, Telecare Corporation)

"I feel the PEI program is helping me, I am able to talk about my mental health now, which I was not able to do before. I wish I met the therapist early on before getting so depressed. I look forward to the session, it is a great help and I am hopeful now. The support and encouragement I get from the therapist helped me reconnect and continue to be active in the senior center. I carry around the quote my therapist gave me 'It's never too late to be what you might have been'. This helps me push forward." (PEI client who completed Seeking Safety program, Pacific Clinics)

PSP Program Testimonials: Comments offered by participants in the Applied Suicide Intervention Skills Training:

"Good information to have, flows wells, time goes by fast, good presenters. Hard topic, yet the training helped one feel comfortable and not scared about it."

"Excellent training and excellent facilitators."

"ASIST really addresses all of the barriers to helping/reaching out to those contemplating suicide."

"It helped me feel better prepared. I have a structure to follow to help me remain calm and focused."

"I believe every single staff from program head to clinical staff should take this workshop. Not only for clients, but for co-workers as well."

"I think EVERYONE needs to take this course; students, teachers, professionals and non-professionals alike."

PROGRAM DESCRIPTION

The Early Start School Mental Health Initiative Program focuses on school mental health needs to reduce and eliminate stigma and discrimination. Addresses the high need of students with developmental challenges, emotional stressors, and various mental health risks and reduces violence at all levels of educational institutions through collaborative efforts and partnerships with the community. This is a comprehensive prevention and early intervention program to prevent violence in schools to create a safe learning environment. The services include eliminating substance use and abuse; addressing any trauma experiences; development of school-based crisis management teams; training, early screening and assessment of students of concern; and to provide them with services at the earliest onset of symptoms.

IMPLEMENTATION AS OF JUNE 30, 2011

The School Threat Assessment and Response Team (START):
Started in 2009, START was the first program in the country to establish a law enforcement-education-mental health collaborative dedicated to the prevention of targeted school violence by identifying students at risk and providing an immediate comprehensive response. START has developed teams composed of a law enforcement officer and a DMH clinician who partners with all levels of educational institutions (K-12 through higher education); school based mental health programs, substance. The START program provides: 1) Training and Program Consultation; 2) Early Screening and Identification; 3) Assessment; 4) Intervention with educational institutions and law enforcement to provide a response appropriate to the situation at hand including arrest or detention, involuntary psychiatric hospitalization, voluntary outpatient psychiatric treatment, residential placement, monitoring, and case management services; and 5) case management & monitoring.

START addresses the national and local concern about school safety and campus violence by emphasizing and operationalizing a proactive versus reactive approach through training and consultation, early screening and identification, assessment and intervention, and Case Management and Monitoring. START has implemented a School Threat Assessment tool and has screened over 4,000 students. It has intervened in over 50 cases where there was an imminent threat of violence and prevented that violence from occurring. START continues to monitor over 75 students of concern. In FY 2011-12 DMH completed 2,100 School Threat Assessments and provided intervention and case management services to those who meet criteria for the START program.

IMPLEMENTATION AS OF JUNE 30, 2011 (CONTINUED)

A total of 2,085 trainings/presentations were made to professionals, students, and parents. Most recently START partnered with the local FBI office and trained Riverside and Orange County professionals on effective partnerships and strategies for the prevention of targeted school violence.

START recently established a Memorandum of Understanding (MOU) with the Los Angeles Unified School District and Los Angeles Police Department to collaborate on students of concern. Recognizing that the student may require mental health services, academic assistance, or criminal intervention, this partnership allows for a coordinated effort to assist school threat management teams and enhance intervention strategies. This partnership is the first of its kind in the country and was recognized in September 2012 by the Ash Center for Democratic Governance and Innovation, Harvard Kennedy School, John F. Kennedy School of Government, through their Bright Ideas in Government program.

CHALLENGES

The Department continues to experience a lack of staff resources to manage the increasing number of referrals concerning students who have made or who pose a threat. Highly resistant students and their parents complicate the referral and linkage process to mental health providers. The START provides the ongoing case management or monitoring until a comprehensive safety net, including therapy services, are established.

CHANGES IN FY 2013-14

The solicitation bid for the School Mental Health Prevention and Early Intervention Demonstration Pilot in Service Area 6 was released in fall 2012 and will be implemented in FY 2013-14. This program will serve Service Area 6, one of the most at-risk community areas with a sizable African/African American and Latino populations, and is scheduled for release in summer 2012. Two programs will be funded, one in the northern section of Service Area 6 and another in the southern section.

PROGRAM DESCRIPTION

The purpose of the Early Start Stigma and Discrimination Project is to reduce and eliminate barriers that prevent people from utilizing mental health services by prioritizing information and knowledge on early signs and symptoms of mental illness through client- focused, family support and education, and community advocacy strategies. There are three core strategies is to reduce stigma and discrimination, increase access to mental health services, and reduce the need for more intensive mental health services in the future. The services include anti-stigma education specifically targeting underrepresented communities through outreach utilizing culturally sensitive and effective tools; educating and supporting mental health providers; connecting and linking resources to schools, families, and community agencies; and client and family education and empowerment.

The following components of the Early Start Suicide Prevention Project have been implemented as of June 30, 2011:

- **Family-focused Strategies to Reduce Mental Health Stigma and Discrimination**: The Los Angeles County Alliance for the Mentally Ill is implementing the "Family-focused Strategies to Reduce Mental Health Stigma and Discrimination". Services include education about mental illness, treatment, medication, and rehabilitation as well as teach communication and coping skills. The program includes a family support bureau training program, parental support services, and consultative services.
- **Children's Stigma and Discrimination Reduction Project**: Education to parents and to the community is provided through two distinct curricula. The first is a 10-week course, developed specifically to reduce stigma, includes healing and communication tools to promote mental wellness and creating a world that is empathic to children. The second is a 12-week curriculum, developed by United Advocates for Children and Families, is an education course on childhood mental illnesses and it also includes grief and loss, and navigating the multiple systems, e.g. mental health, juvenile justice, and DCFS. The parents and community members have responded highly to the presentations that have taken place around the county.

CHANGES FOR FY 2013-14

Older Adult Anti-Stigma and Discrimination's goals for Fiscal Year 2012-13 include rolling out the new "Preserving Memory through Brain Exercise". There are two more presentations in development: Emotional Resiliency and Medication Management. For the next fiscal year, OA ASD will also increase outreach in Service Areas 1, 6 and 8.

PROGRAM DESCRIPTION (CONTINUED)

- **Older Adults Mental Wellness**: The Older Adult Anti-Stigma and Discrimination Team (OA ASD) participated in a total of 232 events during the fiscal year 2011-2012, outreaching to more than 3669 Los Angeles County residents. These events included countywide educational presentation, community events, and collaboration with various agencies. Highlights of OA ASD's accomplishments include providing over 224 workshops for seniors throughout the county, participating in eight Health Fairs throughout the county; and serving under-represented and under-served ethnic populations. OA ASD met its annual goal of increasing awareness on Mental Well-Being for older adults throughout Los Angeles County, particularly among underserved and underrepresented communities. Presentations were available in five different languages: English, Spanish, Korean, Chinese and Farsi.
- **Profiles of Hope Project**: The Profiles of Hope and accompanying Public Service Announcements (PSAs) aim to show that anyone could be subject to the stigma a mental illness has traditionally carried and change their mind about how they support and view others with a diagnosis of mental illness. Profiles of Hope, a 60-minute film, promote an anti-stigma message for those diagnosed with mental illness and have been broadcast on local television stations as well as the PSAs.
- **Videos:** Six high-profile personalities, experienced and passionate advocates in promoting hope, wellness and recovery, donated their time and talent to create 10-15 minute videos aired on various television stations, including: Latina boxing champion Mia St. John; CSI-Las Vegas actor and musician Robert David Hall; actress and author Mariette Hartley; psychiatrist in recovery Clayton Chau, M.D., Ph.D.; Veteran General Hospital actor Maurice Bernard; and US Vets CEO Steve Peck, M.S.W.

CHALLENGES

Continuing challenges include the need to increase culturally sensitive educational trainings and presentations on stigma and discrimination in Service Areas, as well as reducing barriers in outreaching to various organizations involved in providing mental health support to consumers, including law enforcement, veterans, and schools. Strategies to mitigate these challenges include increasing collaborative relationships with faith based organizations, grass root organizations providing education to various underrepresented ethnic populations, and community colleges to increase their awareness and understanding of mental health. Trainings and presentations to address ethnic specific stigma and discrimination issues also needs to be undertaken.

PROGRAM DESCRIPTION

The School Based Services Project is intended to build resiliency and increase protective factors among children, youth and their families; identify as early as possible children and youth who have risk factors for mental illness; and provide on-site services to address non-academic problems that impede successful school progress. These programs 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.

In FY 2011-12, DMH initiated Integrated School Health Centers (ISHCs) with the Department of Health Services, school districts, community organizations, and mental health providers in strategic areas with high percentages of medically underserved residents. These ISHCs will enable the integration of behavioral health services with County-funded primary care services for children and TAY, their families and members of the community. A majority of the services are provided on site at the schools as well as school-linked services provided at satellite sites or through community partners. DMH contract agencies provide outreach, education, and "warm hand-off" referrals; help promote mental wellness through prevention strategies; help foster a positive school climate; and offer early intervention mental services. A total of 16 ISHCs were established, with nine on high school campuses, and five at elementary and/or middle schools.

ISHC mental health providers are currently completing an implementation survey that will provide detailed client data and other relevant information that should be available by February 28, 2013.

Since June 30, 2011 DMH has provided training in the Olweus Bullying Prevention Program (OBPP), a universal prevention program, in 38 schools and trained 665 school staff. Program outcomes regarding the impact on bullying over the next three years will be gathered from the participating schools.

Through a 2012 MOU with the County of Los Angeles Chief Executive Office-Education Coordinating Council (CEO-ECC), the Department is supporting mental health prevention activities at three Schools Attendance Taskforce Workgroups that target high risk DCFS and Probation youth at risk for school/educational failure. The program targets Children and TAY targeted in PEI Projects 1, 2, 6, and 7. Services will continue through June 30, 2013.

CHALLENGES

Continuing challenges include the need to increase culturally sensitive educational trainings and presentations on stigma and discrimination in Service Areas, as well as reducing barriers in outreaching to various organizations involved in providing mental health support to consumers, including law enforcement, veterans, and schools. Strategies to mitigate these challenges include increasing collaborative relationships with faith based organizations, grass root organizations providing education to various underrepresented ethnic populations, and community colleges to increase their awareness and understanding of mental health. Trainings and presentations to address ethnic specific stigma and discrimination issues also needs to be undertaken.

The challenges relative to implementation of the ISHCs have included the following: personnel changes among some school site administrators and school liaisons for the mental providers have impacted school leadership and service coordination; the LAUSD Wellness Centers at selected school sites have been delayed in start-up and operation; there have been delays in securing adequate space and facilities at several school sites necessary for mental health providers to locate staff and deliver appropriate services. School administrators, designated school district coordinators and liaisons, DMH Service Area managers and School-based Mental Health Coordinators, and representatives from selected County Board of Supervisors offices have worked collaboratively to proactively address these challenges. An Implementation Workgroup (convened by the LA County Chief Executive Office) has also developed an MOU to guide and facilitate the establishment of integrated services at LAUSD school sites.

SIGNIFICANT CHANGES FOR FY 2013-14

A solicitation for prevention programs directed at school districts will be released in winter 2013, with implementation in FY 2013-14. School districts have the opportunity to implement the Make Parenting a Pleasure, Triple P – Levels 2 and 3, a pilot project for underserved populations, or a pilot project for TAY at risk for school failure, substance abuse, or juvenile justice involvement.

PROGRAM DESCRIPTION

The purpose of the Family Education and Support Project is to build competencies, capacity and resiliency in parents, family members and other caregivers in raising their children by teaching a variety of strategies. 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.

DMH has continued Nurse Family Partnerships (NFP) program with the Los Angeles County Department of Public Health (DPH) whereby services are provided to multiple services areas, with a special emphasis on pregnant teens. All 26 nurses have now been hired and trained in NFP, and all have completed Unit 2 training.

Through a 2012 DMH Memorandum of Understanding (MOU) with DMH, the Los County Public Library will hire librarians, and pages to expand the Family Place and Parent Cafes. Triple P Levels 2 and 3 parenting materials will be purchased for all 89 libraries. The goal is to have a bigger supply of resources in the libraries in which Triple P Stay Positive will be rolled out. The program targets all age groups targeted in PEI Projects 2, 3, 7 and 9. Services will continue through June 30, 2013.

PROGRAM DESCRIPTION

The At Risk Family Services Project provides 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; builds skills for families with difficult, out of control or substance abusing children who may face the juvenile justice involvement; and provides support to families whose environment and history renders them vulnerable to forces that lead to destructive behavior and the disintegration of the family.

In June 2011 DMH implemented Make Parenting a Pleasure (MPAP), a universal prevention program, through 11 community based agencies that serve preschools, elementary schools, community centers, and other services directed at at-risk families. Evaluation surveys from parents will be compiled and assessed at the end of the FY 2012-13 contracting period.

In June 2012 DMH funded 18 community-based organizations that had no current funded contracts with the Department to provide parenting programs. A total of 11 agencies are implementing Make Parenting a Pleasure (MPAP), a promising practice group-based parent training program designed for parent educators of parents and/or caregivers of children from birth to eight years of age. The program was designed to address the stress, isolation, and lack of adequate parenting information and social support that many parents experience. Another seven agencies are implement Triple P Level2 (brief parenting interventions and selected seminars) and Level 3 (primary care and discussion groups). MPAP and Triple P are provided in a wide variety of community settings. These services will continue through June 30, 2013.

CHALLENGES:

Challenges have included the addition of new staff and turnover in staff agencies, necessitating obtaining additional training from the practice developers and/or designated trainers due to contracting issues and/or scheduling training workshops.

CHANGES:

A solicitation for prevention-only providers targeted at community-based agencies and school districts will be released in winter 2013, and is expected to be implemented FY 2013-14. These will be new providers that do not have a current funded contract with the Department is intended to expand the community based for mental health prevention activities. Services to be provided include MPAP, other parenting programs, and programs targeting high risk families.

PROGRAM DESCRIPTION

The Trauma Recovery Services Project provides short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event. It also provides 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.

In 2010 DMH entered into an MOU with the Department of Military and Veterans Affairs (DMVA) for the implementation of the System Navigators for Veterans. This is a pilot project that employs 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. The staff follows up with the Veterans and their families to ensure that these individuals have successfully linked up and received the help they need. Since inception of the program through June 30, 2012, DMVA submitted 6618 claims for veterans, and their Veterans Outreach program had 1,985 contacts with homeless veterans.

CHALLENGES:

Frequent intradepartmental meetings have been beneficial to address implementation challenges, such as: consistent provision of demographic information to facilitate timely contact with referred person, reinforcing importance of primary care provider discussing intent to refer person for mental health services, and determining best method of contacting primary care providers to discuss mental health concerns that may have bearing on their health status.

PROGRAM DESCRIPTION

The Primary Care and Behavioral Health project develops 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. It also prevents patients at primary care clinics from developing severe behavioral health issues by addressing their mental health issues early on.

Many individuals who suffer from mental illness face challenges in accessing care. This is particularly problematic for individuals dealing with both physical illness (es) and mental illness. The co-location of mental health providers in primary care settings is intended to bring needed early intervention mental health services into settings that are non-stigmatizing to lessen the severity and duration of mental illness, while simultaneously improves health care outcomes. In collaboration with Los Angeles County Department of Health Services (DHS), DMH placed small teams of mental health providers on a full-time basis in DHS Comprehensive Health Centers and Multi-service Ambulatory Care Centers in order to provide early intervention mental health services. Beginning Dec. 30, 2010 through the close of FY 10-11, DMH implemented four DMH/DHS Collaboration Programs in DHS. Multiple pre- and post-implementation meetings occurred between the departments to ensure a shared understanding of the services and process related to referrals and mental health service delivery.

Initiated in 2011 the Primary Care and Behavioral Health Project develops 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. This has been accomplished by integrating behavioral health professionals skilled in a short-term evidence-based collaborative service delivery model within the primary care system. By offering assistance in identifying emotional and behavioral issues in a health clinic setting, the stigma associated with seeking mental health services is minimized. This helps prevent patients from developing more severe behavioral health issues through early intervention efforts that target psychiatric symptoms when they are first identified.

Since Fiscal Year (FY) 2010-11, DMH has expanded the Primary Care and Behavioral Health Project from four to six DMH-DHS Collaboration Programs in Los Angeles County Department of Health Services (DHS) Comprehensive Health Centers and Multi-service Ambulatory Care Centers.

PROGRAM DESCRIPTION (CONTINUED)

On July 1, 2011, an additional 24 primary health care agencies that previously contracted only with DHS entered into contracts with DMH to provide integrated primary care and behavioral health services in 57 sites across Los Angeles County. In addition to the integrated sites, 54 DHS directly-operated and contract providers without on-site behavioral health services established partnerships with DMH directly-operated or contract agencies, allowing for seamless referrals to mental health services.

In spring 2011, DMH began training mental health and health care staff in the Mental Health Integration Program, or MHIP (formerly known as Improving Mood – Promoting Access to Collaborative Treatment, or IMPACT). MHIP is an evidenced-based early intervention practice geared toward treating individuals with mild to moderate levels of depression, anxiety and some trauma who are referred by primary care clinicians and receive mental health services almost exclusively in primary care settings. A total of 247 staff has been trained in MHIP system-wide.

FY 2012-13 will bring additional integrated sites and a continued strengthening of the provider network through increased utilization of the partnerships cultivated in FY 2011-12 for sites where integration is not possible at this time.

CHALLENGES:

Frequent intradepartmental meetings have been beneficial in addressing implementation challenges, such as: consistent provision of demographic information to facilitate timely contact with referred persons; reinforcing the importance of the primary care provider discussing intent to refer a person for mental health services; determining best method of contacting primary care provider to discuss mental health concerns that may have bearing on person's health status, and; support from primary care physicians to prescribe anti-depressant and anti-anxiety medications as required by the MHIP model.

PROGRAM DESCRIPTION

The Early Support and Care for TAY Project builds resiliency, increase protective factors, and promote positive social behavior among TAY. It also addresses depressive disorders among the TAY, especially those from dysfunctional backgrounds and identifies, supports, treats, and minimizes the impact for youth who may be in the early stages of a serious mental illness. Emancipating, emancipated, and homeless TAY are a special focus of this project.

ACHIEVEMENTS/HIGHLIGHTS

DMH also implemented integrated treatment services of mental health PEI programs through the Co-Occurring Disorders (COD) project at the County's Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) Antelope Valley Rehabilitation Center in Action in Service Area 1. The program serves TAY females with co-occurring disorders who are mothers of children at high-risk of emotional or behavioral problems. The program utilizes Group Cognitive Behavioral Therapy and Seeking Safety.

In June 2012, DMH funded seven community-based organizations that had no current funded contracts with the Department to provide services to TAY at risk of substance abuse. Services include outreach and referral, assessment, anger management and conflict resolution workshops, case management, and education workshops for youth and their caregivers. These services will continue through June 30, 2013.

In 2012, DMH established six MOUs targeting at-risk TAY that include:

1. Department of Public Health – Substance Abuse Prevention and Control (DPH-SAPC). Persons to be provide PEI services include individuals affected by alcohol and/or drug related problems; families of youth who are at risk for out-of-home placement and at risk for or currently involved in the juvenile justice system; and youth at risk for serious mental illness and/or have a past history of trauma/trauma-related events. A wide range of prevention and early interventions services will be provided to children, youth, TAY and their families targeted in PEI Projects 3, 6, 7 and 9.
2. Department of Public Social Services: The Los Angeles County Office of Education (LACOE) will provide life skills curriculum (e.g., money management, problem solving) to GROW TAY.
3. Community Services and Supports - Systems Involved Youth Workforce: The intent of this program is to promote self-sufficiency by providing system involved youth with career and employment opportunities through the WorkSource Center network.
4. Los Angeles County Public Library: Structured activities will be offered that build confidence, stress personal safety skill, teach conflict resolution, and address bullying prevention.
5. CEO - Gang Violence Reduction Initiative (GVRI) – This supports the GVRI through 15 projects by providing a range of PEI services to high-risk, high-need youth and young adults in the four demonstration site areas.
6. L.A. County Commission on Human Relations – GRVI: This targets racialized gang violence in the Harbor-Gateway, implements some of the recommendations of the "2010 Offender Re-entry Blueprint", and assists in training on respect, equity, and peace in interpersonal and intergroup relations.

All MOUs will continue through June 30, 2013.

PROGRAM DESCRIPTION

The Juvenile Justice Services Project builds 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; promotes coping and life skills to youths in the juvenile justice system to minimize recidivism; and identifies mental health issues as early as possible and provide early intervention services to youth involved in the juvenile justice system. Services are to be provided at probation camps throughout the County, residential treatment facilities, health clinics, community settings, and other non-traditional mental health sites.

ACHIEVEMENTS

The Juvenile Justice Transition Aftercare Services (JJTAS) program is a comprehensive countywide program that addresses the mental health needs of youth at risk of or experiencing juvenile justice system involvement. Staffed by a multidisciplinary team of clinicians and case managers, the program enhances DMH service capacity and expands mental health services for juvenile justice involved children, youth, and their families. The JJTAS program seeks to (1) build resiliency and protective factors that leave this population at risk for continued involvement in the juvenile justice system; (2) promote coping and life skills in these youth to minimize recidivism; and (3) identify mental health issues as early as possible and provide early intervention services to assist the youth to successfully remain in the community.

Program staff engages individual youth before their release from the Los Angeles County Probation camp facilities and outreaches to their families to involve them in treatment planning. Services are primarily delivered in the field, client homes, and at "non-branded" mental health sites (such as Probation Department area offices, community agencies, schools, parks and recreation centers, faith-based organizations, and other County co-located sites). Program staff coordinates linkages to services in the community, provide case management, implement evidenced based practices, and collaborate with community and other County Department partners. The JJTAS program delivers Evidence Based Practices (EBP). The EBPs currently utilized are Seeking Safety, Trauma Focused Cognitive Behavioral Therapy, and Group Cognitive Behavioral Therapy for Depression. Aggression Replacement Training and Functional Family Therapy will be implemented in the near future. Outcome measures are collected and reviewed for all EBP services delivered to clients and families.

ACHIEVEMENTS (CONTINUED)

The JJTAS program began receiving referrals and opening cases in March of 2012. Over 900 individuals and families have been served since program inception.

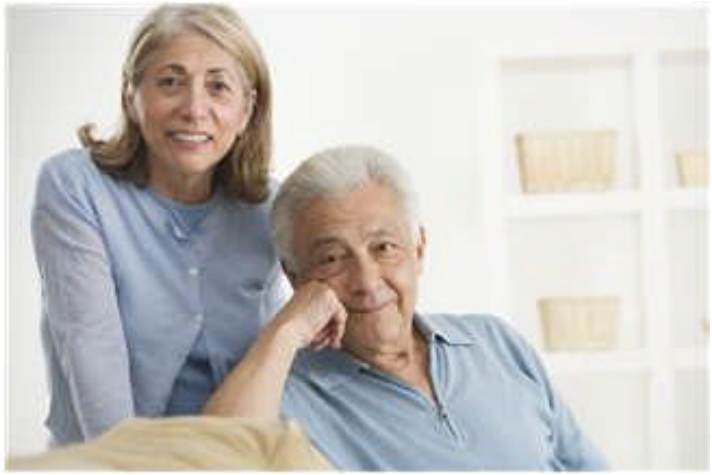
In June 2012 DMH funded 11 community-based organizations that had no current funded contracts with the Department. A total of eight agencies are focusing attention on youth on involved in or at risk of being involved in the juvenile justice system and at risk of school failure, while another three agencies are working with youth on probation. All services are provided in a wide variety of community settings and will continue through June 30, 2013.

In 2012 DMH entered into an MOU with the Los Angeles County Public Defender's Office to partner with their Gang Reduction Violence Initiative. Two programs are being initiated: 1) Public defender volunteer lawyers, paralegals, and social workers have participated with Parks and Recreation and CBOs to bring information to high-risk youth and their families related to Juvenile Justice involvement. 2) The PDAT program targets probationers who re-offend; this project will focus on these highest-risk youth offenders and their need for linkage and advocacy to a wide range of resources. Funding will continue through June 30, 2013.

PROGRAM DESCRIPTION

The purpose of the Early Care and Support Project for Older Adults is to 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. Its goal is to prevent and alleviate depressive disorders among the elderly; and provide brief mental health treatment for individuals. Services are directed at older adults, their family members, caregivers, and others who interact with and provide services to this senior citizen population.

DMH entered two Memorandums of Understanding (MOU) with the Los County Community Services and Supports (CSS) to support two programs for older adults. The Family Caregiver Support Program is designed to promote mental wellness among older adult caregiver who may be experiencing stress. Stress may be related to caregiving activities, loss of a loved one, loss of employment, loss of income, decline in health, and/or activities of daily living. The goal is to attend to the special needs of these caregivers by improving their coping skills and providing connectedness, as well as decrease the risk factors for abuse, neglect, and out-of-home placement. Outreach and engagement services will be offered to older adult caregivers to promote mental health awareness, and to refer and link the caregiver to a DMH older adult mental health provider for mental health services. The purpose of the Community Based PEI Project is to deliver outreach and engagement, referral and linkage services in the 15 senior community centers managed by CSS to identify older adults who are experiencing mild to moderate signs of anxiety and/or depression. Services in both programs will continue through June 30, 2013.



PROGRAM DESCRIPTION

The Improving Access for Underserved Populations Project is intended to 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. Its goal is to identify as early as possible individuals who are a risk for emotional and mental problems and 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.

ACHIEVEMENTS

In 2010 The Department implemented the Veterans' and Loved Ones Recovery (VALOR) program for adults. Approximately 30% of returning Operation Iraq Freedom (OIF), Operation Enduring Freedom (OEF) and Operation New Dawn (OND) veterans will meet full criteria for Post-Traumatic Stress (PTSD), Substance Use and Abuse, Depression, and/or will struggle with Anxiety-related challenges. This does not include our Veterans from wars and military actions long forgotten. VALOR provides the following services to the community: benefit establishment, employment and education; assistance, peer support, collaboration with other veteran service organizations, referral for children and family support, and housing for the homeless. Almost 40% of the homeless in the Los Angeles County are Veterans, which is the largest population of veterans in the United States. In order to reduce veteran homelessness in Los Angeles County, and prevent other consequences from untreated mental and physical challenges from our nation's existing and returning heroes, the VALOR program has been established to aid our nation's current and forgotten heroes.

In June 2012 DMH funded 16 community-based organizations that had no current funded contracts with the Department to provide services to underserved populations. Populations served under this program include African Americans, Armenians, Cambodians, Chinese, Ethiopians, Filipinos, Japanese, Iranians, Koreans, Hispanics/Latinos, Samoans, Tongans, and Vietnamese. Lesbian/Gay/Bisexual/Transgender youth, veterans, and recent immigrants are being served at these programs also. All services are provided in a wide variety of community settings and will continue through June 30, 2013.

CHANGES FOR FY 2013-14

Two solicitations will be released in 2013, one to serve the deaf/hearing impaired countywide through evidence-based programs, and the other through prevention programs implemented by faith-based organizations in high need areas and/or underserved populations.

CHALLENGES

One challenge for the NFP program is that nurses needed to be trained in American Sign Language in order to successfully work with the deaf and hard-of-hearing population. This fiscal year 2013-13, 25 nurses are currently receiving four workshops in American Sign Language (ASL). The ASL classes will focus on medical terminology, pregnancy including labor and delivery, childbirth and child development. The workshops are taking place at East Los Angeles City College (ELAC).

Program Description

The American Indian Project will build resiliency and increase protective factors among children, youth and their families. It will also address stressful forces in children/youth lives, teaching coping skills, and divert suicide attempts, as well as 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.

Achievements/Highlights in FY 2011-12

In FY 2011-12, DMH implemented Trauma-focused Cognitive Behavioral Therapy, with an adaption for the American Indian population.

Significant Changes for FY 2013-14

A solicitation will be released in spring 2013 for the American Indian Life Skills (AILS) program, a program aimed at preventing suicide among American Indian youth.

PROGRAM LEVEL:

- **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.

- **TRIPLE P PARENTING:** This practice aimed at reducing parenting and family difficulties has resulted in a **37%** positive change as endorsed by parents and a **23%** positive change as endorsed by children on the YOQ-SR.

- **TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY:** For the 64 agencies providing trauma focused services, **71%** 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 **37%** improvement in their overall functioning, representing 51% and 38% 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.

- **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:** Trends based on a small number of clients to date indicate reductions to depressive symptoms to just below the clinical cutoff, as reported on the Patient Health Questionnaire-9 (PHQ-9).

- **AGGRESSION REPLACEMENT TRAINING (ART):** Trends based on a small number of clients to date indicate symptom reduction to below the clinical cutoff, as measured by the YOQ-SR & YOQ.

- **SEEKING SAFETY:** Trends based on a small number of clients to date indicate reduction in reported symptoms and overall functioning after completion of this evidence-based practice, as measured by the PTSD-RI and the Outcome Questionnaire/YOQ-SR & YOQ (parent and self-report). Average symptom reduction after completion of practice ranges from **15% to 28%** depending upon the questionnaire.

SYSTEMS LEVEL:

- **LOW INCOME HEALTH PLAN - HEALTHY WAY L.A.:** To date **2,878** unique clients have been seen for short-term mental health care in integrated primary care settings.

- **SCHOOL MENTAL HEALTH - SCHOOL THREAT ASSESSMENT AND RESPONSE TEAM (START):** A partnership between local K-12 and University/Colleges, federal and local law enforcement agencies and mental health providers to prevent campus violence by providing training, program consultation, early screening and intervention, assessment and case management related to violence potential. In 2012 the START program was recognized by the John F. Kennedy School of Government at Harvard University for preventing school violence.

- **SUICIDE PREVENTION - PARTNERS IN SUICIDE PREVENTION TEAM:** During FY 2011-12 the team, comprised of staff representing the systems of care of Children, TAY, Adults, and Older Adults, participated in **197** suicide prevention events, outreaching to more than **4,300** LA County residents, including leading the following:
  - Provided **7** Applied Suicide Intervention Skills Training (ASIST).
  - Expanded the ASIST trainer network to enhance training capacity.
  - Coordination of the LA County Suicide Prevention Network, recruiting over **40** members from across the County.
  - Provided over **100** trainings to mental health providers on suicide prevention.
  - Participated in **9** community events to increase suicide prevention awareness.
  - Launched the first Suicide Prevention Summit in LA County.
  - Launched a two-year project to train Department of Children and Family Services staff in suicide prevention.
  - Launched Question, Persuade, Refer (QPR) training, providing **30** trainings countywide.
  - Enhanced the Youth Suicide Prevention Project web site with educational materials and videos.
  - Promoted suicide prevention in the Korean community.
  - Conducted **30** presentations to older adults, Adult Day Health Centers and Senior Centers.

The County of the Los Angeles MHSA - Workforce Education and Training Plan, approved April 8, 2009, seeks to address the fundamental concepts of creating and supporting a workforce (both present and future) that is culturally competent, consumer/family driven and promotes the transformation of mental health services to a strength based approach that is inclusive of recovery, resilience and wellness. Such tenets are cornerstones of MHSA. The Plan provides opportunities to recruit, train and re-train public mental health staff to meet those mandates.

For the County of Los Angeles, personnel shortages remain a constant concern; however, the needs far out weigh the positions available. In particular the need for personnel that is bilingual and bicultural to provide services to the underserved unserved populations is critical. In addition, there is a shortage of personnel with expertise relevant to working with the following populations: 0 to 5, Children/TAY, LGBTQ, Veterans, and Older Adults.

1 **145 staff trained through Transformation Academy Without Walls**
During FY 2011-12, 145 individual staff members of the public mental health workforce attended the Public Mental Health Workforce Immersion into MHSA

2 **Licensure Examination Preparation**
256 individuals have received Licensure Examination Preparation assistance since FY 2011-12 (on-going)

3 **37 individuals completed the Health Navigator Skill Development Program**
20 are working or have completed the necessary hours for full certification

4 **28 individuals completed Advance Peer Support Training Program**
These individuals are currently employed in the mental health system in a peer advocate capacity.

5 **17 mental health consumers completed the Core Peer Advocate Training**
These consumers are interested in becoming part of the public mental health workforce as mental health peer advocates.

6 **614 individuals attended the Community College Collaborative Symposiums**
The symposiums were held on 4 campuses across the County

7 **78 parents completed the Parent Partner/Parent Advocate training program**

8 **1,210 faculty and students attended MHSA presentations or MHSA mini-immersion**

9 **137 participants completed the Intensive MH Recovery Specialist Training Program**

10 **161 supervisors completed the Recovery Oriented Supervision**

1-Workforce Education and Training (WET) Coordination

This program provides the funding for the MHSA WET Administrative unit. WET Administration continued to be tasked with implementation and oversight off all WET-funded activities.

2 -WET County of Los Angeles Oversight Committee

The WET County of Los Angeles Oversight Committee was active throughout the development of the WET plans and may continue to provide recommendations to the LACDMH. The Committee is composed of various subject matter experts, representing many underserved ethnicities in our County.

3 -Transformation Academy without Walls

Public Mental Health Workforce Immersion into MHSA

Since 2007-2008, this program offers public mental health staff (i.e., clerical, clinical staff to program administrators) a three day immersion program on the tenets of MHSA. The training incorporates the MHSA experience including consumers sharing their recovery journey. Upon completion, staff is expected to acquire an understanding of the recovery oriented approach and to also incorporate such concepts into practice in their work.

During FY 2011/2012, 145 individual staff members of the public mental health workforce attended this training

Public Mental Health Workforce Immersion into MHSA – No changes are expected for the first 6 months of FY 2013/2014. During the second half of FY 2013/2014 a new contract is anticipated to be awarded and anticipated to address the integration of mental health, health and co-occurring disorders.

Licensure Preparation Program (LPP)

Implemented during FY 2011/2012, this program funds licensure preparation study materials and workshops for unlicensed social workers, marriage and family therapists, and psychologists. All accepted participants must be employed in the public mental health system and have completed their clinical hours to take the mandatory Part I, and thereafter Part II of the respective licensure board examinations. During FY 2011/2012, the following number of slots where secured thru various Purchase Orders: MSW Part I – 53; MSW Part II – 82; MFT Part I – 73; MFT Part II – 73, Psychology Part I – 22; and Psychology Part II – 60.

Licensure Preparation Program (LPP) – The Licensure Preparation Program will continue with no significant changes for FY 2013-2014.

Health Navigator Skill Development Program

In preparation for Health Care Reform, this program trains individuals (Peer Advocates, Community Workers and Medical Case Workers) on knowledge and skills needed to assist consumers navigate and likewise advocate for themselves in both the public health and mental health systems. This 52 hour course uniquely incorporates a seven hour orientation for participants' supervisors and is intended to support the participants' navigator role. Implemented during FY 2011/2012, 89% of participants represented un- or under- served populations.

While 37 individuals have completed the training, 20 are working or have completed the necessary hours required for full certification.

Health Navigator Skill Development Program – This program will continue with no significant changes during FY 2013/2014.

Outcomes

Public Mental Health Workforce Immersion into MHSA

During FY 2011/2012, 145 individual staff members of the public mental health workforce attended this training.

Licensure Preparation Program (LPP)

Licensure outcomes for this program are pending due to participants scheduling of their examinations and subsequent notification of testing results. Participant data reflects that 55% represent un- or under- served communities and 64% speak one of the thirteen threshold languages. As of December 2012, the number of participants for each specific exam is as follows:

Examination	Participants
MSW - Part I	62
MSW - Part II	49
MFT - Part I	72
MFT - Part II	42
Psychologist - Part I	12
Psychologist - Part II	19
TOTAL	**256**

Health Navigator Skill Development Program

While thirty-seven individuals have completed the training. Twenty are working or have completed the necessary hours required for full certification.

5 - Recovery Oriented Supervision Trainings

The goal of the Recovery Oriented Supervision Training and Consultation Program (ROSTCP) is to increase the capacity of the public mental health system to deliver best practice recovery-oriented mental health services. The ROSTCP is designed for front line supervisors and managers as they are the primary individuals who assume the important leadership roles to teach, support, and elevate the recovery and resilience philosophies among direct service staff in the public mental health system. The ROSTCP will train supervisors and managers across all age groups and includes all public mental health programs. Total supervisors and managers to be trained = 240 annually.

During FY 2011/2012, 161 participants completed the program. 56% participants represented individuals from un- or under- served populations and 30% spoke one of the thirteen threshold languages of the County of Los Angeles and seven individuals spoke a non-threshold language.

The ROSTCP program will not undergo any significant changes during FY 2013-2014.

6 - Interpreter Training Program

The Interpreter Training Program (ITP) offers trainings for bilingual staff that currently performs or interested in performing interpreter services and to monolingual English speaking mental health providers. The use of linguistically and culturally competent interpreters is important to bridging the language and cultural gap in the delivery of services in public mental health. This training opportunity consisted of the following: 3-Day Introduction to Interpreting Training; Advanced Interpreting Training; and monolingual English speaking Provider focused training entitled "How to Use Interpreters in a Mental Health Setting".

FY 2011/2012 Outcomes:

Training Title	Total
3-Day Training (Intro)	74
Advanced Training - Part I	19
Advanced Training - Part II	14
Provider Training	13
Total	**120**

7 - Training for Community Partners

Community College Collaboration

This training performs outreach and engages the college student, faculty and the community at large. It is held at their respective community colleges. These collaborative events provide information regarding recovery oriented mental health services in the community and how to access them.

During FY 2011/2012, 4 collaborative symposiums were held at community college campuses across the County. The following identify the school, the Service Area, and total attendance:

Campus (Service Area)	Total Participants
Cerritos College (SA 7)	145
College of the Canyons (SA 2)	135
El Camino Compton College (SA 6)	171
Torrance College (SA 8)	163
Total	**614**

Faith Based Roundtable Pilot Project

This project is designed for clergy and mental health staff to come together to address the mental health issues of the individuals and communities they mutually serve. It has provided an opportunity for faith-based clergy to understand the essence of mental health services focused on recovery as well as for mental health personnel to understand and integrate spirituality in the recovery process. Implementation began in FY 2010/2011 and continued through FY 2011/2012 in Service Areas 6 and 7.

During FY 2011/2012, the roundtables in Service Areas 6 and 7 were composed on the following:

Round Table Composition	SA 6	SA 7
DMH Staff	4	6
Clergy	5	6
Total	**9**	**12**

While there will be no change to the program model in FY 2013-14, the area to be targeted will shift from SAs 6 and 7 to two additional Service Areas.

8 - Intensive Mental Health Recovery Specialist Training Program

Mental Health Rehabilitation Specialist Training will prepare consumers and family members with a Bachelor's degree, advanced degree, equivalent certification, to work in the field of mental health as psycho-social rehabilitation specialists. This 12-16 weeks program is delivered in partnership with mental health contractors and the local community colleges. Successful completion of this program ensures that participants are qualified to apply for career opportunities in the public mental health system.

Two contractors delivered this training and completed by 137 individuals interested in employment in the public mental health system.

No changes are anticipated for the first 6 months of FY 2013/2014. A new contract is expected to be issued for the remainder of the year projecting workforce needs for the implementation of health care reform.

9 - Expanded Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System

Peer Advocate Training prepares individuals interested in work as mental health peer advocates in the public mental health system. During FY 2011/2012, certificated training included core peer advocate training, advanced peer advocate training, and Train-The-Trainer. This training was designed to train no less than 60 individuals. The targeted population for each training component was:

a. Core Peer Advocate Training: For mental health consumers interested in becoming part of the public mental health workforce as mental health peer advocates.

b. Advanced and Train-The-Trainer training: For individuals who are currently employed in the mental health system in a peer advocate capacity.

Program	Total Graduates
Basic Peer Advocate	17
Advanced Peer Advocate	28
Train-the-Trainer	13
TOTAL	**58**

10 - Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System

This training program is designed to provide knowledge and technical skills to Parent Advocates/Parent Partners who are committed to: the work of family support for mental health; supporting the employment of parents and caregivers of children and youth consumers in our public mental health system; and/or promoting resilience and sustained wellness through an emphasis on increasing the availability of a workforce oriented to self-help, personal wellness and resilience techniques that are grounded in parent advocate/parent partner empowerment. This program will provide four unique training: Basic (50 participants); Supervisory and Administrative (80 participants); Advanced and Specialty (80 participants); and Train-The-Trainer (10 participants).

During FY 2011/2012, the Department delivered a 3 day training to advance the skills of parent advocate/parent partners currently employed in the public mental health system. 78 individuals completed this training.

During FY 2011/2012 the program was partially implemented; it is anticipated that for FY 2013-2014 additional opportunities will be offered for parent advocate/parent partner training.

11 - Expanded Employment and Professional Advancement Opportunities for Family Members in the Public Mental Health System

The proposed trainings would prepare family members of consumers to develop or augment skills related to community outreach, advocacy and leadership and decrease barriers to employment. These trainings would include such topics as public speaking, navigating systems, and resource supports for consumers and families. Priority will be given to those family members coming from targeted communities particularly those culturally and linguistically underserved in the County of Los Angeles (i.e., Spanish speaking, Asian Pacific Islanders, etc.).

This program is expected to be implemented FY 2013/2014 with the intent to target/outreach families members about mental health services in the community meeting the objective of the program outline in the MHSA-WET Plan above.

12 - Mental Health Career Advisors

In the effort to meet the workforce needs of the public mental health system, this program is designed to fund career advisor services. Services will include: the provision of ongoing career advice, coordination of financial assistance, job training, mentoring, tutoring, information sharing and advocacy; the Mental Health Career Advisors will essentially function as a one-stop shop for upward career mobility.

A pilot program is intended to be implemented during FY 2013-14.

13- High School Through University Mental Health Pathway

The County of Los Angeles will focus on promoting mental health careers to high school, community college and university students, particularly in communities or areas of the County where ethnically diverse populations reside.

A pilot program is intended to be implemented during FY 2013-14.

14 - Market Research and Advertising Strategies for Recruitment of Professionals in the Public Mental Health System

Market research and advertising strategies can assist in defining ways of attracting and targeting new professionals into the public mental health field. The goal is to establish collaboration with an academic institution, research institute or think tank to conduct market research and then formulate advertising strategies based on that research. Studies would include designing research to target more bilingual staff, as well as staff to serve ethnic minority communities, addressing cultural variances and access factors. Indirectly, these efforts may also support the retention of current staff or encourage their further professional development.

To date, no formal market research has been completed to address these issues.

15 - Partnership with Educational Institutions to Increase the Number of Professionals in the Public Mental Health System (Immersion of Faculty-MFT, MSW, etc)

College Faculty Immersion Training Program – Immersion training services update college and graduate school faculty on the current best practices and requirements for the human services workforce in real-world jobs. This program delivers in class presentation to students on the core tenets of MHSA; consultative services with faculty on recovery oriented curriculum enhancement; and MHSA mini immersion training opportunities where students and faculty learn first about the benefits of MHSA and the recovery process.

During FY 2011/2012, a total of 1,210 faculty and students received curriculum consultation, attended the MHSA presentations or MHSA mini-immersion.

No changes are expected for the first 6 months of FY 2013/2014. During the second half of FY 2013/2014 a new contract is anticipated to be awarded. The new contract will target workforce needs which integrate mental health, health and co-occurring disorders services.

16 - Recovery Oriented Internship Development

A wide range of quality internships and placements must be available to students and interns for them to gain the maximum benefit from these experiences. Ideally, these placements include supervision that is both welcoming and supportive of recovery based services. Unfortunately, many potential quality placements cannot be utilized because they lack a supervisor with a degree that meets the standards of the academic institution and/or their accrediting body. At the same time, many of the supervisors who meet academic standards in qualified placements are not well versed in recovery and at times are wholly opposed to recovery centered service philosophies and practice. This latter problem leads to situations where students are receiving recovery oriented instruction in the classroom, only to have it not practiced in the field. The proposed Recovery Oriented Internship Development Program will address these problems by working with degree granting institutions providing recovery oriented classroom instruction to develop relationships with nontraditional providers, amend restrictive policies related to supervision of interns, employ a supervisor(s) who can provide supervision to interns across multiple agencies, and work with existing providers to increase the number of internships available through in-house supervisor recruitment and support.

19 - Public Mental Health Workforce Financial Incentive Program

The Public Mental Health Workforce Financial Incentive Program represents a consolidation of WET Plans #19 (Tuition Reimbursement Program) and #22 (Loan Forgiveness Program). This program is intended to deliver educational/financial incentives to individuals employed in the public mental health workforce, as well as serve as a potential recruitment tool.

Tuition Reimbursement Program

The County of Los Angeles' needs assessment revealed significant occupational shortages of licensed and unlicensed mental health professionals and paraprofessionals. This tuition reimbursement program will provide up to $5,000 dollars per year for tuition expenses for those individuals interested in enhancing skills relevant to mental health workforce needs. It will include peer advocates, consumers, family members, parent advocates and professionals employed in directly operated and contracted agencies. Tuition reimbursement students will be expected to make a commitment to continue working in the public mental health system. Additionally, those candidates who are bilingual/bicultural and/or willing to commit to working with unserved and underserved communities in the County will be given priority.

Loan Forgiveness Program

Striving to meet MHSA expectations of a linguistically and culturally competent workforce, Los Angeles County will explore loan forgiveness programs as a supplement to the loan forgiveness programs developed by the State. Based on specific geographic, cultural and linguistic needs unique to Los Angeles County, the Oversight Committee will review the need and efficacy for such a program, for which classifications of workers should be targeted, and how best to complement existing loan forgiveness strategies.

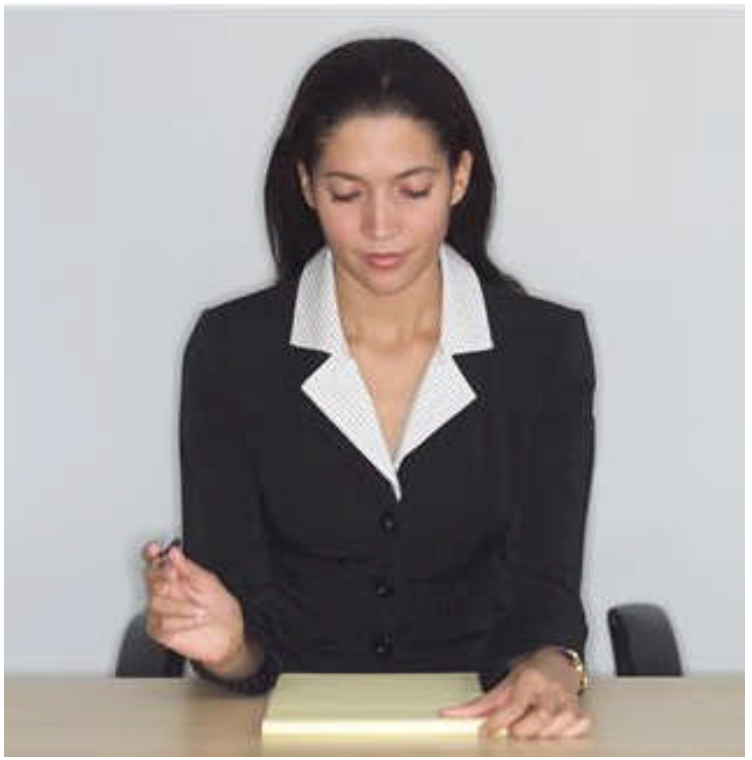
This program is expected to be up for solicitation for services and projected to be delivered during FY 2013-14.

21 - Stipend Program for Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners, and Psychiatric Technicians

LACDMH provides 2nd year students with education stipends in the amount of $18,500 in exchange for a contractual obligation to secure employment in a hard-to-fill area of the county for a minimum of 1 year. This program targets students who are linguistically and/or culturally able to service the traditionally unserved and underserved populations of the County.

During FY 2011/2012 this program was available to 20 MFT, 18 MSW, and 2 Nurse Practitioners students were funded. In addition to these stipends, PEI allocations funded an additional 2 Nurse Practitioner, 32 MSW, and 32 MFT stipends. However, no Nurse Practitioner stipends were awarded.

In addition to the stipends, 6 post-doctoral fellows were like wise funded.



PROGRAM DESCRIPTION

The Department of Mental Health (DMH)-UCLA Translational Research fellowship Program Projects is designed to improve access to and effectiveness of client-centered, culturally competent mental health services in Los Angeles County through investigation of the clinical, socio-cultural, and operational factors that shape policies and practices in public mental health. Through projects involving the application of rigorous, state-of-the-art research methodologies for examination of key Departmental service designs; this Program is designed to generate results that can be feasibly and effectively implemented to improve the quality of public mental health care in Los Angeles County. The program builds upon two decades of strong collaboration between DMH and UCLA to produce clinically relevant research projects that improve care in the Los Angeles County public mental health system.

- **Low Income Health Plan Implementation (LIHP) Evaluation**
  - Research Question: What facilitates or inhibits the integration of primary and mental health care in the community?
  - Immediate Objective: Evaluation of the implementation of the LIHP mental health component for adults served by Healthy Way Los Angeles (HWLA).
- **Peer Health Navigator Implementation**
  - Research Questions: What implementation strategies promote the most efficient and effective introduction of peer health navigators in public mental health systems? What are the impacts of peer health navigators on client wellness in public mental health?
  - Immediate Objective: Completion of training, intervention manuals and operational protocols for a workable peer health navigator intervention that can be widely generalized to the DMH system of care.
- **Qualitative Analysis of MHSA Transformation in DMH Clinics**
  - Research Questions: (a) What have been the impacts of Mental Health Services Act (MHSA)-generated transformational change on DMH clients and providers? (b) What positive steps might be taken to guide the process of transformational change in the future?
  - Immediate Objective: An evidence-based analysis of the impact of transformation on DMH clients and providers through the development of a coding and analytic procedure for efficient and replicable qualitative data mining.

STATUS

Low Income Health Plan (LIHP) Implementation Evaluation: The research protocol was finalized and submitted to UCLA's IRB. Pending IRB approval, it will be submitted to DMH's Human Subjects Research Committee (HSRC). A tentative list of study sites was created.

Peer Health Navigator Implementation: The intervention forms were translated into Spanish. Five interviews were conducted with current peer navigators; these were transcribed. A conceptual overview paper was submitted and accepted. A letter of intent for a 3 year grant was submitted to PCORI; the grant application itself is under final revision prior to submission. The assessment measures were finalized.

Qualitative Analysis of MHSA Transformation in DMH Clinics: A coding scheme was drafted, reviewed, and finalized. 100 interviews were entered into Dedoose; 50 interviews were coded. A protocol for testing inter-rater reliability was finalized and a test of inter-rater reliability carried out. An analysis and quantitative data integration plan was finalized.

FUNDING

- FY 2011-12 (prorated for four months): $66,666;
- FY 2012-13: $200,000;
- FY 2012-2014 (prorated for eight months): $133,333

Program Description
The Older Adult Research Project is designed to gather evidence establishing the psychometric properties of the MORS-OAV, using clients at three agencies within Los Angeles County which provide services to the homeless mentally ill and have substantial numbers of clients over age 60. The total sample size for the project will be approximately 450 clients (150 from each agency). The Milestones of Recovery Scale (MORS) is a data tool developed by Mental Health America – Los Angeles (MHA-LA) which was first used with adult clients to capture aspects of recovery and level of care from an agency perspective, based on key indicators of risk. It is an eight-point scale, and is used to generate a monthly client progress report. It has been shown to have good inter-rater and test-retest reliability, as well as construct validity when compared to the LOCUS in a sample of homeless mentally ill, however the psychometric properties of the Older Adult Version (MORS-OAV) are unknown.

FUNDING: FY 2011-12: $99,000

STATUS
The Older Adult Research Project (*Inter-rater Reliability of a Mental Health Recovery Assessment for Older Adults*) has been approved by the Department's HSRC. MHA-LA has conducted the research project with three participating Mental Health Services Act (MHSA)-funded older adult agencies (Heritage Clinics Center for Aging Resources, Pacific Clinics, and Special Services for Groups). California State University Long Beach (CSULB) will proceed with the analysis and validation process of the tool. Working closely with CMHDA-OASOC, and as an active participating county in the statewide Milestone of Recovery Scale – Older Adult Version (MORS-OAV) project, Los Angeles County completed its MORS-OAV Inter-Rater Reliability Study in May, 2012. Mental Health America – Los Angeles, author of the MORS-OAV tool, presented the findings at the CMHDA-OASOC statewide meeting during the September CMHDA Policy Forum held in Sonoma County. As a follow up, Los Angeles County was granted permission by MHA-LA to embed the tool for use in its upcoming electronic health record system that is currently under design and construction. In partnership with MHA-LA, training of LAC-DMH OASOC provider staff to use MORS-OAV is targeted for 2013.

WET REGIONAL PARTNERSHIP
OLIVE VIEW PSYCHIATRIC RESDIENCY PROGRAM

Program Description
The goal of this program is to enhance prevention and early intervention and, secondarily, to decrease non-emergent visits in the psychiatric emergency room at Olive View Community Mental Health Urgent Care Center, the Department leveraged psychiatric services through the partial funding of six psychiatry residents at the Center, thereby expanding available mental health services. This increased capacity will facilitate an optimal environment to teach psychiatric residents the various clinical modalities used to treat such clients, namely short-term, crisis-oriented psychopharmacology and psychotherapy.

FUNDING:
- FY 2012-13: $500,049
- FY 2013-14: $500,049
- FY 2014-15: $500,049

Status:
This program will be implemented in FY 2012-2013.

PROGRAM DESCRIPTION

Child STEPs is a series of projects designed to improve community mental health care for children and adolescents. Its long-term goal is to understand the best ways of designing, training, and supporting best practices for youth mental health. Child STEPs is an initiative of the Network on Youth Mental Health, whose work is sponsored by grants from the John D. and Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, and State and County funding sources. Phase I of Child STEPs was a comprehensive review of the evidence for the effectiveness of various mental health treatments for children and adolescents. Phase II was an innovative comparison of their performance in community mental health settings. Phase III, currently underway, is an extension of the findings from Phase II. As one of two components of Phase III, ChildSTEPs Los Angeles County includes a greater age range of youth, and treatment components modified to cover symptoms of traumatic stress as well as depression, anxiety, and disruptive behavior. Child STEPs Los Angeles County compares MATCH treatment with routine standards of care.

FUNDING:

- FY 2011-12: $216,000
- FY 2012-13: $177,000

STATUS

Three organizations were selected for participation in this project: Hathaway Sycamores, Pacific Clinics, and Hillsides. Over 70 therapists were subsequently enrolled in the project, of which 39 were randomly assigned to the MATCH training condition. Those therapists attended a five day clinical training in August 2010, followed by administrative meetings on enrollment logistics in the month of September. In October of 2010, families" enrollment began. A second MATCH training was held in August 2011 to add four more therapists to the project. A third training was held in July 2012, adding an additional four therapists to the MATCH condition and four therapists to the UC condition.

The overall number of families screened is similar to that of the number screened during the same quarter last year. Hathaway Sycamores has shown a particular increase in identifying possible participants. Because the project is entering its final quarter of enrollment, these data have once again been reviewed with agency directors to identify strategies to increase referral rates in the final months of 2012. Hillsides and Pacific Clinics added new therapists to the study in July as their main strategy to increase participation. This quarter 11 of the 12 families screened qualified, which is the best performance by agencies over the course of the project.

STATUS (CONTINUED)

More than 70% of the sessions in the MATCH condition involved Cognitive Behavioral Therapy (CBT) and parenting techniques. The most common procedures used from the MATCH program continue to be Problem Solving training for depression followed by "Practicing" (exposure for anxiety concerns). In 204 MATCH sessions (28% of the total delivered), material from outside the MATCH program was covered, which mainly involved stabilization of the family or addressing crisis. This level of "other" activity is higher than estimates from the previous study using MATCH, in which 19% of sessions were spent on "other" activities, for similar reasons; these differences appear to be due to the greater level of functional impairment encountered in this study and suggests that stabilization procedures might be an important target of future study, because they are so common. The most common participant in MATCH sessions is the child, but more than half of MATCH sessions do not include a child (52% are with a caregiver or significant adult in the child's ecology). This is to be expected, since the MATCH procedures for disruptive behavior are mostly caregiver-based, and disruptive behavior is the most common concern among participating families. Rate of change was calculated by examining all responses on a weekly phone interview using the Brief Problem Checklist. Improving cases were those whose scores trended downward over time. Across all indicators, a greater percentage of MATCH cases have improved so far. Results are more pronounced for internalizing problems, for which UC cases are less likely to respond well overall. Caregivers asked about their satisfaction with MATCH after treatment was completed scored slightly higher than caregivers whose children received services as usual. Seventeen cases were closed during the past quarter, and 100 have been closed so far overall. So far, more MATCH cases were closed overall (59 versus 41). This rate of routine termination for MATCH is lower than the 50% or so seen in other contexts, and is also quite low in the UC condition. Overall, usual care cases are taking a little longer on average, and this is obscured somewhat by the fact that MATCH cases are less likely to drop out early in treatment. The average number of sessions is about 22 for MATCH and about 28 for usual care. Combined with the data on treatment length, this means MATCH cases are meeting fairly regularly (a session every 8 days), as are usual care cases (a session every 9 days). Enrollment of new families will close on December 31, 2012.

PROGRAM DESCRIPTION

The California Social Work Education Center (CalSWEC) Aging Initiative (AI) project addresses one of the components of the Mental Health Services Act (MHSA), namely the development of a competent, diverse workforce to meet the needs of an increasingly diverse population of aging Californians and their families. This project assists County Directors in their efforts to recruit and train individuals who will serve as leaders of organizations developing and providing social work, health, mental health and other services to older adults. The project has four strategic priorities: 1) the creation of a statewide coalition to promote social work workforce development in aging; 2) the development of core competencies in geriatric social work; 3) the development of workforce development strategies; and 4) the development of capacity building and sustainability strategies.

FUNDING:

- FY 2011-12: $20,000
- FY 2012-13: $20,000

STATUS:

LACDMH continues to provide ongoing support to the AI project through CalSWEC. Through partnerships with statewide schools of social work, the AI Committee is continuing its mission of promoting older adult and workforce development issues through activities such as regional meetings, webinars, and work plans to address the needs of the underserved older adult population. Current activities are focused on such diverse areas as public relations and curriculum development and delivery. As a partner with CMHDA-OASOC and the CalSWEC AI, Los Angeles County DMH OASOC staff has supported and participated in the CalSWEC AI statewide meeting and special project to discuss and address workforce, training, and curriculum issues pertaining to geriatric social work and services.

An Aging Summit was hosted by CalSWEC AI on September 19, 2012 in Sacramento. Themed "The Road Ahead: Advocating for Social Work Service Delivery in Aging,", the Aging Summit established the following objectives: (1) To articulate a vision of the workforce of the future that is needed to respond to the changing landscape of service delivery for older adults in a health care- driven system; (2) To highlight collaborative environments where social workers are effective members of cross-disciplinary teams serving older adults. This one-day forum was well attended, including representation from LAC-DMH OASOC, which brought together a diverse group of leaders to brainstorm ideas and develop strategies on gerontological social work practice and education.

Program Description

This research project studies implementation of the Drumming for Your Life program, designed to enhance reading fluency, rapidity, and comprehension for detained juveniles utilizing basic rhythm and drumming techniques. Delivered by a Drumming for Your Life Institute Reading & Rhythm facilitator, this pilot program will supplement regular in-class reading instruction as a one-time, six-week, after-school or pull-out program for small groups (typically 8-10) of juveniles in need of reading remediation. Students will meet in their small groups for one hour twice weekly, and participate in two one-hour assessment sessions. Students will learn to use rhythm and drumming techniques to help move fluidly through syllables in multi-syllable words, and from word to word and sentence to sentence, working up to passages of increasing length at gradually faster speeds. To measure outcomes relevant to shifts in motivation, self-esteem, and emotions and attitude towards reading, the following evaluation instruments will be used: the Wigfield Guthrie: Motivation for Reading Questionnaire, and the Rosenberg Self-Esteem Measure. The aim of this program is to improve reading skills and increase self-esteem among juveniles in a juvenile justice setting.

FUNDING: FY 2012-13: $50,000

STATUS

This research project will likely be implemented in early 2013.

PROJECTS

Capital Facilities	Cost	Project Status
Downtown Mental Health Center	$14,000,000	CEO Director of Real Estate is starting the process to purchase the building. $3.5m to purchase building, and $10.5m for refurbish
Arcadia Mental Health Center	$12,000,000	In the process of Finalizing the Request for Proposal and Scoping Document to secure a Design/Build Firm. On schedule now to break ground in August 2013.
West Valley Mental Health Center		On hold pending verification of available funding. The first 2 projects have budget projections that went beyond the initial projection.
Long Beach Mental Health Center		
Training/Conference Center		
Renovate/Construct New Facilities to Support MHSA Programs and Administrative Services		
Renovate/Expand County Owned Facilities to Support MHSA Programs and Administrative Services		
Purchase of Land and Building to Support MHSA Programs and Administrative Services		

Remaining Balance: $13,300,000

Contract Provider Technology Project (CPTP)

Project Status: On Schedule
Budget Status: Within Approved Budget
Project Start Date: 3/19/2008
Project End Date: 6/30/2018

Status as of June 30, 2012

- 49 contract providers completed the project proposal review and approval process and prepared Technological Needs Funding Agreements (TNFA) for each contract provider that has at least one approved project
- 54 projects approved
- 48 TNFAs have been fully executed
- 2 TNFAs are pending full execution

Accomplishments

- Continued review of IT project proposal submissions from Legal Entity Contract Providers
- Held three TNFA orientation sessions for contract providers with project proposals that are at or near approval

Scheduled Activities for Next Period

- Monthly TNFA Orientations
- CPTT Workgroup Meeting October 16, January 15, and April 16

Personal Health Record Awareness & Education

Project Status: Not Started
Budget Status: N/A
Project Start Date: To be determined
Project End Date: To be determined

Status

The IBHIS vendor has been selected and the product acquisition has been completed. IBHIS client portal will be used to deliver the PHR. However this project has not started because the implementation planning and strategy in relation to the IBHIS implementation is still to be determined.

Integrated Behavioral Health Information System (IBHIS)

Project Status: On Schedule
Budget Status: Within Approved Budget
Project Start Date: 4/1/2009
Project End Date: 12/15/2015

Status

Continued with project plan execution and monitoring activities with selected contractor. Avatar Configuration Training for DMH Chief Information Office Bureau (CIOB) Business Analysts (Bas) and DMH Subject Matter Experts (SMEs) was completed. They were exposed and trained through lecture, hands on training and exercises, on Avatar and key areas where configuration decisions will be made. Began data conversion planning meetings with IBHIS data conversion workgroup to develop a comprehensive approach to the conversion. Conducted GAP analysis of DMH's original requirements against Avatar system software. Began collecting currently used reports to review and determine potential gaps and identify tools to be used to address and mitigate the respective gaps.

Accomplishments

- Executed Change Notice No. 3 to purchase Netsmart's Order Connect Software Application module
- Began First Risk Management meeting between Netsmart and DMH
- Netsmart conducted site visits with IBHIS business analysts to familiarize them on DMH's business processes
- IBHIS Management Plans were approved: Communication plan and Issue Plan
- Meetings continued to be held
- DMH staff attended Netsmart Connections 2012 Conference

Scheduled Activities for Next Period

- Obtain approval from IBHIS Project Directors of Project Charter and IBHIS Training Plan
- Continue integration tasks planning and requirements gathering meetings
- Continue DMHS Scanning Project Meetings to develop the DMH Scanning Action Plan with DMH Scanning workgroup
- Continue with ongoing meetings

*Signed IT Annual Project Status Report included in Appendix

Consumer/Family access to Computer Resources

Project Status: On Schedule
Budget Status: Within Approved Budget
Project Start Date: 1/19/2010
Project End Date: 06/30/2018

Status:

- DMH is planning to consolidate existing consumer-dedicated computer resources with new ones to provide a consistent platform and take advantage of economies of scale.
- DMH and Los Angeles County Public Library entered into an agreement through an MOU that was developed to enable the library to take the responsibility of installing and maintain the computers and printers for the consumers. Many project assumptions have been mutually confirmed.
- LA County Library and DMH are currently working together to install 83 computers, the printers and ergonomic carts to 17 DMH sites.

Accomplishments

- Successfully completed pilot testing at South Bay Mental Health Clinic
- Conducted monthly Steering Committee meetings
- Provided project status reports to stakeholders, monthly
- Identified library sites in proximity to DMH sites
- Ordered a total of 41 ergonomics stand-sit computer carts for ten sites
- Installed computers and printers at five sites
- Trained DMH staff to process and issue library cards to consumers at 22 sites
- Completed a Service Level Agreement between DMH and Los Angeles County Public Library that will identify the expectations for maintenance and support: LA County Library took over the installation and maintenance of the computers at sites

Scheduled Activities for Next Period

- Identify vendor for computer training classes and order licenses for 72 computers
- Visit more sites

*Signed IT Annual Project Status Report included in Appendix

Data Warehouse Re-Design

Project Status: Not Started
Budget Status: N/A
Project Start Date: To be determined
Project End Date: To be determined

Status

This project is closely tied to the IBHIS project and is on hold until DMH is well underway with IBHIS planning and implementation activities. The IBHIS project planning activities have been initiated. The redesign project is again experiencing resource constraints since the project manager and other allocated team members are participating in IBHIS planning and implementation activities. It is anticipated that the redesign project activities will resume in Fiscal Year 2012-13.

Telepsychiatry Implementation

Project Status: On Schedule
Budget Status: Within Approved Budget
Project Start Date: 7/1/2010
Project End Date: 12/31/2012

Status

- Change Notice for 24 additional remote locations approved. Phased procurement underway for first 12 units.
- County Internal Services Department is continuing bandwidth upgrades to all County facilities/sites.
- DMH Executive Management Team approved funding for permanent "Tele-Hub." DMH OMD, ASOC and ASB developing space request (pending final approval). Anticipated 1 year to complete acquisition, lease, and build out.
- OMD RFP for clinical telepsychiatry consultant cancelled, following second posting and no responses. Procurement of clinical consultant contract services is expected to be cancelled entirely.

Accomplishments

- Training materials in development
- Production began

Scheduled Activities for Next Period

Additional endpoint procurement and deployment.

IT Annual Project Status Report

For an MHSA-Funded IT Project

PROJECT INFORMATION		
Project Name: Consumer/Family Access to Computer Resources		**DMH Project ID #:** LA-05
Executive Sponsor: Dr. Robert Greenless **Title:** CIO		**County:** Los Angeles
Project Status ☐ Not Started ☒ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule	**Budget Status** ☒ Within Approved Budget ☐ Over Budget	**For Fiscal Year Ending:** 06/30/2012 **Project Start Date:** 01/19/10 **Project End Date:** 06/30/18
MHSA IT Project Contact Person's Name: JC DuVall **Telephone Number:** 213-251-6411 **E-mail Address:** jcduvall@dmh.lacounty.gov		
Project Objectives: ▪ Promote consumer/family growth and autonomy by increasing access to computer resources, relevant health information and trainings. ▪ Provide basic computer skills training to consumers allowing them to effectively utilize the computer resources made available to them. ▪ Provide appropriate access to technical assistance resources when needed		

MAJOR MILESTONE STATUS						
Project Phase	**Deliverables / Milestones**	**Planned Start**	**Actual Start**	**Planned Completion**	**Actual Completion**	**Status**
Initiation Phase	Conduct business analysis, research and site visits.	1/22/10	1/22/10	6/30/10	5/17/10	Completed

Initiation Phase	Create project planning documents: • Project Charter • Project Schedule • Project Resource Plan • Project Risk Management Plan • Quality Plan • Validate IT Project Budget Estimate and update Plan	 1/22/10 1/22/10 1/22/10 6/15/11 No plan 7/26/10	 1/22/10 1/22/10 1/22/10 6/15/11 7/26/10	 6/30/10 1/22/10 1/22/10 7/11/11 7/26/10	 9/2/10 1/22/10 1/22/10 7/5/11 7/26/10	 Completed Completed Completed Completed Not started Completed
Initiation Phase	Establish Project Team • Steering Committee • Identify Stakeholders	4/30/10	5/15/10	5/15/10	05/15/10	Completed
Initiation Phase	Conduct Kickoff Meeting with Stakeholders	4/15/10	4/29/10	5/15/10	5/15/10	Completed
Requirements Phase	Gather Requirements Memorandum of Understanding	6/24/10	6/24/10	4/30/12	1/15/12	Completed
Design Phase	Solution Design	7/1/10	7/1/10	4/30/12	2/15/12	Completed
Construction Phase (Software Deployment for COTS)	Configure Solution	9/1/10	9/1/10	4/30/12		In Progress
Testing Phase	User Acceptance Testing	4/18/11	4/18/11	9/30/11	9/30/11	Completed
Implementation Phase	General Rollout	4/1//11	4/1/11	9/30/12		In Progress
Post-Implementation Phase	Project Closeout	TBD		TBD		Not Started
PIER	PIER Document	TBD		TBD		Not Started

TOTAL PROJECT BUDGET INFORMATION (MHSA Only)		
Category	**Budgeted Costs**	**Actual Costs to Date**
Staff (Salaries & Benefits)	$398,945	$331,333
Hardware	$ 500,000	$134,301
Software	$ 150,000	$ 43,418.
Contract Services	$ 2,651,339	$0
Total Project Costs	**$ 3,700,284**	**$509,052**

STATUS / MAJOR ACCOMPLISHMENTS / SCHEDULED ACTIVITIES

STATUS

- Project initiated on 1/22/10.
- Project has a revised schedule and a goal to complete the first 83 computer installations by 9/30/12.
- DMH is planning to consolidate existing consumer-dedicated computer resources with new ones to provide a consistent platform and take advantage of economies of scale.
- DMH and LAC Public Library entered into an agreement through an MOU that was developed to enable the Library to take the responsibility of installing and maintaining the computers and printers for the consumers. Many project assumptions have already been mutually confirmed.
- LA County Library and DMH are currently working together to install all 83 computers, the printers and ergonomic carts to seventeen DMH sites.

ACCOMPLISHMENTS

- Conducted pilot testing with one computer at South Bay Mental Health Clinic which was successful
- Conducted Steering Committee meetings monthly.
- Provided Project Status reports to stakeholders, monthly.
- Obtained hardware specifications. LAC Public Library working on computer image for the first five sites
- Ordered hardware and software for twenty-two sites.
- Identified Mavis Beacon typing tutor software as the standard for all of the computers
- Received all hardware and software for twenty-two sites
- Set up WAN connections through ISD for twenty-two sites
- Completed the Memorandum of Understanding (MOU) between LAC DMH and LAC Public Libraries. LAC Public Libraries will maintain the computer resources, once they hire the technicians, using their proven consumer-dedicated model.
- Completed a Service Level Agreement (SLA) between LAC DMH and LAC Public Library that will identify the expectations for maintenance and support.
- LA County Library IT staff took over the installations and maintenance of the computers at sites
- LA County Library posted job openings for the hiring of the two technicians that will support the computers
- Discussed HIPAA Compliancy issues related to the library card form, again, with Veronica Jones, DMH Privacy Officer. Identified a form that must be filled out by Consumers and filed at the DMH sites to meet HIPAA compliance and learned that if a Consumer's family member requests a library card the clinician at the DMH site will have to create a chart for them. No Business Associates agreement is required according to Veronica.
- Trained DMH Staff to process and issue library cards to Consumers at twenty-two sites
- Installed computers and printers at first five sites
- Scheduled delivery and install of computers for seven more sites
- Ordered a total of 41 ergonomic stand-sit computer carts for ten sites
- Identified Library Sites in Proximity to DMH sites.

SCHEDULED ACTIVITIES FOR NEXT PERIOD

The following action items are assigned to appropriate steering committee participants and remain open:

1. Complete computer installations at the remaining seventeen sites that are ready by September 30, 2012
2. Receive, deliver and install 41 ergonomic sit-stand computer carts at ten sites
3. Identify vendor for computer training classes and order licenses for 72 computers
4. Complete cost estimate to train DMH staff on the software to be used.
5. Library to provide DMH with a template of their monthly reports.
6. Library will show DMH what their filters look like. Then, DMH can decide which filters are appropriate.
7. Visit More Sites.

CRITICAL ISSUES

Include any critical or high priority issues impacting the project.

No critical issues reported

RISKS

Include any critical or high risks that may impact the project – Note Probability (High, Medium, Low) and Response (Watch, Mitigate, Accept)

- If locations are not available with jacks and power these locations will not be able to have the computers – Probability is Medium. Response is Watch.

Post Implementation Evaluation Report

Please Include The Following Sections In Your Final Status Report

OBJECTIVES ACHIEVED
Describe the Achieved Objectives in Comparison to the Objectives Listed in the MHSA IT Funding Request form. Also describe the User and Management Acceptance of the Completed Project. •

LESSONS LEARNED
Describe Lessons Learned, Best Practices used for the project, any Notable Occurrences, or Factors that contributed to the project's success or problems, or other information, which could be helpful during future project efforts. Describe Problems that were Encountered and How they were Overcome. •

CORRECTIVE ACTIONS
Note: This section must be included when the project is deemed to be a Limited Success or Failure, or when there are Significant Differences between Project Expectations and Project Results. If this condition applies, summarize alternatives for improving the outcome. •

NEXT STEPS
Describe if the project has any Future Phases or Enhancements; or will it be in Maintenance Phase. •

County Approvals

Signature	Date	Phone
Mark J for JC DuVall	11/28/12	213-247-4508

Prepared By

Signature	Date	Phone
	11/28/12	(213) 251-6481

MH Chief Information Officer
Robert Greenless, Ph.D. CIO

IT Annual Project Status Report

For an MHSA-Funded IT Project

PROJECT INFORMATION		
Project Name: Contract Provider Technology Project (CPTP)		**DMH Project ID #:** LA-04
Executive Sponsor: Marvin Southard, DSW **Title:** Director – Los Angeles County Department of Mental Health		**County:** Los Angeles
Project Status ☐ Not Started ☒ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule	**Budget Status** ☒ Within Approved Budget ☐ Over Budget	**For Fiscal Year Ending:** 06/30/2012 **Project Start Date:** 03/19/08 **Project End Date:** 06/30/18
MHSA IT Project Contact Person's Name: Gordon Bunch **Telephone Number:** (213) 251-6413 **E-mail Address:** gbunch@dmh.lacounty.gov		
Project Objectives: The primary objective is to provide a means for Non-Governmental Agency Short-Doyle Contract Providers within the LAC-DMH provider network to obtain the funding necessary to fully participate in the County's Integrated Information Systems Infrastructure and address their technological needs consistent with the MHSA Capital Facilities and Technological Needs Guidelines.		

MAJOR MILESTONE STATUS

Project Phase	Deliverables / Milestones	Planned Start	Actual Start	Planned Completion	Actual Completion	Status
Initiation Phase	Write Project Plan and Receive Funding from State	03/19/2008	03/19/2008	07/01/2009	07/01/2009	Completed
Requirements Phase	Evaluate mechanisms for establishing contractual agreements and develop Technological Needs Funding Agreement (TNFA) to award funds to contractors	08/13/2008	08/13/2008	12/31/2008	02/23/2009	Completed
Requirements Phase	Evaluate CPTP data collection needs and software solutions for managing CPTP administrative operations	02/26/2009	02/26/2009	07/30/2009	07/30/2009	Completed

Requirements Phase	Evaluate Business Processes for the Contract Provider Technological Needs Projects Unit (CPTNP) and Draft administrative Policies and Procedures	05/01/2009	05/01/2009	06/30/2009	06/30/2009	Completed
Design Phase	Create database tables and data entry screen layouts for CPTNP Projects administration database	09/01/2009	09/01/2009	12/31/2010	01/15/2010	Completed
Construction Phase (Software Deployment for COTS)	CPTNP Projects administration database development – Phased Deployment	09/15/2009	09/15/2009	06/30/2010	04/29/2010	Completed
Testing Phase	CPTNP Projects administration database - Phased Testing	11/02/2009	11/02/2009	11/30/2010	11/17/2101	Completed
Implementation Phase	CPTNP Projects administration database – Phased Implementation	11/15/2009	11/15/2009	12/31/2010	12/9/2010	Completed
Implementation Phase	Review eligible Contract Provider Project Proposals	03/02/2009	03/24/2009	7/1/2013		In-Progress
Implementation Phase	Execute TNFA(s) with 121 eligible Contract Providers	04/03/2010	04/08/2010	09/29/2013		In-Progress
Implementation Phase	All eligible Contract Providers funded through TNFA are EDI Certified with DMH at a minimum for 837 P/I and receipt of 835 transactions from IBHIS	05/03/2010	4/7/2010	06/30/2014		In-Progress
Implementation Phase	Eligible Contract Providers complete all approved IT Projects	05/03/2010	04/08/2010	12/31/2017		In-Progress
Post-Implementation Phase	Archive CPTP Project Documents and Data – Disband CPTNP Unit	01/02/2018		06/30/2018		Not Started
PIER	Prepare final Project Status Report and submit report to CDMH	05/01/2018		05/31/2018		Not Started

TOTAL PROJECT BUDGET INFORMATION (MHSA Only)		
Category	**Budgeted Costs**	**Actual Costs to Date**
Staff (Salaries & Benefits)	$ 1,094,289	$1,474,637
Hardware	$ 0	$ 0
Software	$ 0	$ 0
Contract Services	$ 23,475,142	$ 3,871,659
Total Project Costs	**$ 24,569,431[1]**	**$5,296,098**

[1] **Total Project Costs is limited to MHSA IT Plan approved project costs and does not include direct and indirect administrative overhead costs.**

STATUS / MAJOR ACCOMPLISHMENTS / SCHEDULED ACTIVITIES

STATUS

- As of June 30, 2012
  - 49 Contract Providers completed the project proposal review and approval process and prepared Technological Needs Funding Agreements (TNFA) for each Contract Provider that has at least one approved project
  - 54 projects approved
    - 1 Clinical Data Management (CDM)
    - 2 Computerized Provider Order Entry (CPOE)
    - 1 Electronic Data Interchange (EDI)
    - 46 Electronic Health Record Systems (EHRS)
    - 4 Infrastructure Security and Privacy (ISP)
  - 48 TNFA(s) have been fully executed
  - 2 TNFA(s) are pending full execution

ACCOMPLISHMENTS

- Continued review of IT Project Proposal submissions from Legal Entity Contract Providers
- Held three TNFA Orientation Sessions for Contract Providers with project proposals that are at or near approval

SCHEDULED ACTIVITIES FOR NEXT PERIOD

- TNFA Orientations monthly
  CPTT Workgroup Meeting October 16, January 15, and April16

CRITICAL ISSUES

Include any critical or high priority issues impacting the project.

None reported.

RISKS

Include any critical or high risks that may impact the project – Note Probability (High, Medium, Low) and Response (Watch, Mitigate, Accept)

- Contract Providers delaying requests for project approval – Probability is High. Response is Mitigate. Mitigation strategy – Seek Executive Management Team approval to release a project proposal submission deadline of 3/1/2013 and a deadline to achieve project approval by 7/1/2013.

Post Implementation Evaluation Report

Please Include The Following Sections In Your Final Status Report

OBJECTIVES ACHIEVED
Describe the Achieved Objectives in Comparison to the Objectives Listed in the MHSA IT Funding Request form. Also describe the User and Management Acceptance of the Completed Project. •

LESSONS LEARNED
Describe Lessons Learned, Best Practices used for the project, any Notable Occurrences, or Factors that contributed to the project's success or problems, or other information, which could be helpful during future project efforts. Describe Problems that were Encountered and How they were Overcome. •

CORRECTIVE ACTIONS
Note: This section must be included when the project is deemed to be a Limited Success or Failure, or when there are Significant Differences between Project Expectations and Project Results. If this condition applies, summarize alternatives for improving the outcome. •

NEXT STEPS
Describe if the project has any Future Phases or Enhancements; or will it be in Maintenance Phase. •

County Approvals

Signature	Date	Phone
[signature]	11/27/12	(213)251-6413

Prepared By

Signature	Date	Phone
[signature]	11/28/12	(213) 251-6481

MH Chief Information Officer
Robert Greenless, Ph.D. CIO

IT Annual Project Status Report

For an MHSA-Funded IT Project

PROJECT INFORMATION			
Project Name:	**Data Warehouse Re-Design**	**DMH Project ID #: LA-07**	
Executive Sponsor: **Title:**	**Dr. Robert Greenless** **CIO**	**County: Los Angeles**	
Project Status [X] Not Started [ ] On Schedule [ ] Ahead of Schedule [ ] Behind Schedule	**Budget Status** [ ] Within Approved Budget [ ] Over Budget	**For Fiscal Year Ending:**	**06/30/12**
		Project Start Date: **Project End Date:**	**TBD** **TBD**
MHSA IT Project Contact Person's Name: John Ortega **Telephone Number: 213-251-6424** **E-mail Address: jortega@dmh.lacounty.gov**			
Project Objectives: Redesign the current data warehouse to support the data requirements of the Department of Mental Health's new Integrated Behavioral Health Information System (IBHIS) as well as new data collected from MHSA programs such as Prevention & Early Intervention (PEI), Workforce Education and Training and Innovation. The re-designed data warehouse will include the full scope of MHSA program and service data including clinical, administrative, and financial and outcomes data.			

MAJOR MILESTONE STATUS						
Project Phase	**Deliverables / Milestones**	**Planned Start**	**Actual Start**	**Planned Completion**	**Actual Completion**	**Status**
Initiation Phase		TBD		TBD		Not Started
Requirements Phase		TBD		TBD		Not Started
Design Phase		TBD		TBD		Not Started
Construction Phase (Software Deployment for COTS)		TBD		TBD		Not Started
Testing Phase		TBD		TBD		Not Started
Implementation Phase		TBD		TBD		Not Started
Post-Implementation Phase		TBD		TBD		N/A
PIER		TBD		TBD		N/A

TOTAL PROJECT BUDGET INFORMATION (MHSA Only)		
Category	**Budgeted Costs**	**Actual Costs to Date**
Staff (Salaries & Benefits)	$ 1,299,657	$ 0
Hardware	$ 320,000	$ 0
Software	$ 161,084	$ 0
Contract Services	$ 250,000	$ 0
Total Project Costs	**$ 2,030,741**	**$ 0**

STATUS / MAJOR ACCOMPLISHMENTS / SCHEDULED ACTIVITIES

STATUS

- This project is closely tied to the IBHIS project and is on hold until DMH is well underway with IBHIS planning and implementation activities. The IBHIS project planning activities have been initiated. The redesign project is again experiencing resource constraints since the project manager and other allocated team members are participating in IBHIS planning and implementation activities. It is anticipated that the redesign project activities will resume in Fiscal Year 2012-13.

ACCOMPLISHMENTS

- Not Applicable

SCHEDULED ACTIVITIES FOR NEXT PERIOD

- Not Applicable

CRITICAL ISSUES

Include any critical or high priority issues impacting the project.

None reported.

RISKS

Include any critical or high risks that may impact the project – Note Probability (High, Medium, Low) and Response (Watch, Mitigate, Accept)

None reported.

Post Implementation Evaluation Report

Please Include The Following Sections In Your Final Status Report

OBJECTIVES ACHIEVED

Describe the Achieved Objectives in Comparison to the Objectives Listed in the MHSA IT Funding Request form.
Also describe the User and Management Acceptance of the Completed Project.

•

LESSONS LEARNED

Describe Lessons Learned, Best Practices used for the project, any Notable Occurrences, or Factors that contributed to the project's success or problems, or other information, which could be helpful during future project efforts. Describe Problems that were Encountered and How they were Overcome.

•

CORRECTIVE ACTIONS

Note: This section must be included when the project is deemed to be a Limited Success or Failure, or when there are Significant Differences between Project Expectations and Project Results.
If this condition applies, summarize alternatives for improving the outcome.

•

NEXT STEPS

Describe if the project has any Future Phases or Enhancements; or will it be in Maintenance Phase.

•

MHSA IT Annual Project Status Report LACDMH

County Approvals

Signature	Date	Phone
[signature]	11/28/2012	(213)251-6609

Prepared By

Signature	Date	Phone
[signature]	11/28/12	(213)251-6481

MH Chief Information Officer
Robert Greenless, Ph.D. CIO

IT Annual Project Status Report

For an MHSA-Funded IT Project

PROJECT INFORMATION		
Project Name: Integrated Behavioral Health Information System		**DMH Project ID #:** LA-03 (IBHIS)
Executive Sponsor: Dr. Marvin Southard **Title:** Director, Department of Mental Health		**County:** Los Angeles
Project Status ☐ Not Started ☒ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule	**Budget Status** ☒ Within Approved Budget ☐ Over Budget	**For Fiscal Year Ending:** 06/30/2012 **Project Start Date:** 04/01/2009 **Project End Date:** 12/05/2015
MHSA IT Project Contact Person's Name: LA-03 (IBHIS) Adrina Moreno **Telephone Number:** 213 251-6420 **E-mail Address:** amoreno@dmh.lacounty.gov		
Project Objectives: To acquire commercial-off-the-shelf (COTS) and proven software with the necessary clinical functionality to support the delivery of quality mental health services consistent with the Mental Health Services Act and integrated with administrative and financial functionality.		

MAJOR MILESTONE STATUS						
Project Phase	**Deliverables / Milestones**	**Planned Start**	**Actual Start**	**Planned Completion**	**Actual Completion**	**Status**
Initiation Phase	IBHIS Kick Off held 6/22/06	6/2006	6/2006	6/2006	6/22/06	Completed
Requirements Phase/Develop Specifications	Create EHR technical and business requirements documents. Create and issue vendor RFP. Create EHR vendor proposal evaluation.	7/2006 Revised Require-ments 4/2009	7/2006 4/3/2009	2/2007 11/2009	9/2008 Issued 2nd RFP 11/18/09	1st RFP Canceled 4/2/09 2nd RFP Completed
Select Vendor	Host EHR bidder's conference. Evaluate proposals. Select vendor. Notify unsuccessful bidders. Begin contract negotiations with selected software vendor.	10/2008 2nd RFP 11/2009	10/2008 11/24/09	09/2009 10/2010	9/7/2010	Completed

Project Phase	Deliverables / Milestones	Planned Start	Actual Start	Planned Completion	Actual Completion	Status
Acquire Software	Complete contract negotiations with software vendor. Obtain vendor signed contract. Obtain legal and Board of Supervisors approval of EHR vendor contract.	9/2010	9/7/2010	7/2011	10/18/11	Completed
Design Phase/Construction Phase/Configure Software	Create EHR System Implementation Plan. Install software and configure. Develop conversion programs and interfaces. Initiate process redesign.	Revised 12/6/11	12/6/11	9/21/12		*In Progress
Testing Phase	Develop test plans, test scripts; execute system and user acceptance test, review test results.	05/12		5/13		Not Started
Pilot Tests/System Acceptance	Monitor production system reliability and monitor data for accuracy in compliance with the terms of the vendor agreement.	6/13		10/13		Not Started
Implementation Phase/Production Roll-Out	Review and execute production roll-out plans. Review risks and actions.	11/13		6/15		Not Started
Post-Implementation Phase	Initiate project closeout; document lessons learned; production metrics baselines/targets.	6/15		9/15		Not Started
PIER	Complete Post-Implementation Evaluation Report.	9/16		12/15		Not Started

TOTAL PROJECT BUDGET INFORMATION (MHSA Only)		
Category	**Budgeted Costs**	**Actual Costs to Date**
Staff (Salaries & Benefits)	$6,890,592	$6,590,101 *
Hardware	$ 3,640,000	$ 3,504,428
Software	$ 30,138,116	$ 6,625,286
Contract Services	$ 11,595,303	$ 160,939
Total Project Costs	**$ 52,264,011***	**$ 16,880,754**

**** Salary projections are based on the 5th step and are not adjusted to reflect actual costs. As a result, the figures may vary from the cost report figures."***

STATUS / MAJOR ACCOMPLISHMENTS / SCHEDULED ACTIVITIES

STATUS

- Continued with Project Plan Execution and Monitoring activities with selected Contractor. Avatar Configuration Training for DMH Chief Information Office Bureau (CIOB) Business Analysts (BA's) and DMH Subject Matter Experts (SME's) was completed. They were exposed and trained through lecture, hands on training and exercises, on Avatar and key areas where configuration decisions will be made. Began Data Conversion Planning meetings with IBHIS Data Conversion workgroup to develop a comprehensive approach to the conversion. Conducted GAP analysis of DMH's original requirements against Avatar system software. Began collecting currently used reports to review and determine potential gaps and identify tools to be used to address and mitigate the respective gaps.

ACCOMPLISHMENTS

- Executed Change Notice No. 3 to purchase Netsmart's OrderConnect Software Application module (e-Prescribing).
- Began first Risk Management meeting between Netsmart and LACDMH.
- Netsmart conducted Site Visits with IBHIS Business Analysts to familiarize them on LACDMH business processes.
- The following IBHIS Management Plans were approved:
  - Communication Plan
  - Issue Plan
- Netsmart provided a Gap Analysis results report of the Functional and Technical requirement based on the Discovery sessions.
- Continued ongoing meetings:
  - Avatar Configuration Tool (ACT) Meetings:
    - Clinical Acts
    - Fiscal/Operations ACTS
    - Managed Care ACTS
    - Appointment Discharge and Transfer (ADT) and Appointment Scheduling ACT
  - IBHIS Clinical Operations and Financial Leadership Committee meetings
  - Scanning Meetings
  - Technical Leadership Meetings
  - Project Directors/ Project Managers (PD/PM)Status Meetings
  - Data Conversion Plan Development Meetings
  - Credentialing Interface Development Meetings
  - eCaps Interface Development Meetings
  - Training Plan Development Meetings
  - Risk Management Meetings
  - Issue Review Meetings
- A group of DMH SMEs and CIOB BAs attended the Netsmart Connections 2012 Conference in April. Dr. Paul Arns IBHIS Clinical Project Director participated in the first ongoing clinical advisory group with Netsmart and Duane Nguyen participated in the new technical advisory group.
- Completed discovery sessions toward configuring the MSO module in Avatar so that Netsmart team could learn more about the management of contracts for Non-Governmental Agency (NGA). Also, reviewed Contract Providers' contract management and Fee-For-Service Two (FFS2) Providers processes.

SCHEDULED ACTIVITIES DURING THE NEXT REPORTING PERIOD:

- Obtain approval from IBHIS Project Directors of Project Charter and IBHIS Training Plan.
- Continue Integration tasks planning and requirements gathering meetings with DMH Subject Matter Experts and Netsmart (i.e., eCaps interface development (Task 6.1.1 – Develop Checkwrite File Interface), Credentialing Interface development (Task 6.1.3 – Develop Credentialing Interfaces) , Develop ADT interface for opening new Contractor Provider to create a client and episode (Task 6.1.2 – Develop Standard Interfaces)).
- Continue DMH Scanning Project Meetings to develop the DMH Scanning Action Plan with DMH Scanning workgroup.
- Ongoing Meetings:
  - Weekly PM/PD Status Meetings
  - Training Plan Development
  - Weekly Avatar Configuration Meetings
  - IBHIS Clinical Operations and Financial Leadership Committee meetings
  - Scanning Meetings
  - Technical Leadership Meetings
  - Project Directors/ Project Managers Status Meetings
  - Data Conversion Plan Development Meetings
  - Credentialing Interface Development Meetings
  - eCaps Interface Development Meetings
  - Training Plan Development Meetings
  - Risk Management Meetings
  - Issue Review Meetings
  - Credentialing Meetings

CRITICAL ISSUES

Include any critical or high priority issues impacting the project.

None reported.

RISKS

Include any critical or high risks that may impact the project – Note Probability (High, Medium, Low) and Response (Watch, Mitigate, Accept)

- Non-availability of adequate numbers of appropriately skilled non-IT resources, particularly clinicians, necessary to effectively implement IBHIS – Probability is Medium. Response is Mitigate.
- Adequate Training rooms are not available to train DMH staff throughout the implementation phase ending in February 2014 – Probability is High. Response is Watch.
- DMH must ensure IBHIS has the capability to interface with other County EHR/Client Management Systems – Probability is High. Response is Mitigate.
- Potential delays in defining Data Exchange Transactions for data exchange between Contract Services Providers and LACDMH – Probability is High. Response is Mitigate.
- LACDMH Need to find a way to manage the IS to IBHIS transition period without having to dump claims out of Avatar to an external database for CPE processing. Most likely we'll have to depend on a reporting process with MCA expenditures being reported in Avatar and merged with reports from IS to reconcile across the two systems – Probability is High. Response is Avoid.
- Potential delay in delivery of Key Conversion Deliverables 9.2 Develop Data Conversion Programs, 9.3 Data Conversion Test, and 9.4 Conduct Conversion - Probability is High. Response is Mitigate.
- Lack of centralized business process for CSI Data management – State reporting. Probability is High. Response is Mitigate.
- Potential slow down to the day to day business operations due to Network latency issues at some LACDMH Sites. Probability is Medium. Response is Mitigation.

Post Implementation Evaluation Report

Please Include The Following Sections In Your Final Status Report

OBJECTIVES ACHIEVED
Describe the Achieved Objectives in Comparison to the Objectives Listed in the MHSA IT Funding Request form. Also describe the User and Management Acceptance of the Completed Project. •

LESSONS LEARNED
Describe Lessons Learned, Best Practices used for the project, any Notable Occurrences, or Factors that contributed to the project's success or problems, or other information, which could be helpful during future project efforts. Describe Problems that were Encountered and How they were Overcome. •

CORRECTIVE ACTIONS
Note: This section must be included when the project is deemed to be a Limited Success or Failure, or when there are Significant Differences between Project Expectations and Project Results. If this condition applies, summarize alternatives for improving the outcome. •

NEXT STEPS
Describe if the project has any Future Phases or Enhancements; or will it be in Maintenance Phase. •

County Approvals

Signature	Date	Phone
Adrina T. Moreno	12/14/12	213 251-6420

Project Manager
Adrina Moreno

Signature	Date	Phone
	12/14/12	213 251 6481

Project Director
MH Chief Information Officer
Robert Greenless, Ph.D. CIO

Signature	Date	Phone
	01/29/13	213-738-4600

Project Sponsor
DMH Director
Dr. Marvin Southard

Signature	Date	Phone
	1/28/13	213.253.5222

Independent Verification & Validation
Associate CIO
Henry Balta

County Approvals

IT Annual Project Status Report

For an MHSA-Funded IT Project

PROJECT INFORMATION			
Project Name:	**Personal Health Record Awareness & Education**	**DMH Project ID #: LA-06**	
Executive Sponsor: **Title:**	**Dr. Robert Greenless** **CIO-LAC-DMH**	**County: Los Angeles**	
Project Status [X] Not Started [ ] On Schedule [ ] Ahead of Schedule [ ] Behind Schedule	**Budget Status** [ ] Within Approved Budget [ ] Over Budget	**For Fiscal Year Ending:**	**06/30/2012**
		Project Start Date: **Project End Date:**	**TBD** **TBD**
MHSA IT Project Contact Person's Name: Sudha Prakash **Telephone Number: 213-480-3652** **E-mail Address: suprakash@dmh.lacounty.gov**			
Project Objectives: Through the stakeholder process, LAC-DMH received considerable feedback suggesting that many mental health consumers have limited awareness of Personal Health Record (PHR) and how a PHR may be used as a recovery and wellness tool. The written and online PHR awareness and education materials developed through this project will be used to increase consumer/family understanding and awareness. In addition, Mental Health Services Providers are part of the targeted audience to promote a collaborative therapeutic relationship.			

MAJOR MILESTONE STATUS						
Project Phase	**Deliverables / Milestones**	**Planned Start**	**Actual Start**	**Planned Completion**	**Actual Completion**	**Status**
Initiation Phase		TBD		TBD		Not Started
Requirements Phase		TBD		TBD		Not Started
Design Phase		TBD		TBD		Not Started
Construction Phase (Software Deployment for COTS)		TBD		TBD		Not Started
Testing Phase		TBD		TBD		Not Started
Implementation Phase		TBD		TBD		Not Started

Post-Implementation Phase		TBD		TBD		Not Started
PIER		TBD		TBD		Not Started

TOTAL PROJECT BUDGET INFORMATION (MHSA Only)		
Category	**Budgeted Costs**	**Actual Costs to Date**
Staff (Salaries & Benefits)	$ 13,722	$ 0
Hardware	$ 0	$ 0
Software	$ 0	$ 0
Contract Services	$ 496,488	$ 0
Total Project Costs	**$ 510,210**	**$ 0**

STATUS / MAJOR ACCOMPLISHMENTS / SCHEDULED ACTIVITIES

STATUS

- No status changes.
- The IBHIS vendor has been selected and the product acquisition has been completed. IBHIS client portal will be used to deliver the PHR. However this project has not started because the implementation planning and strategy in relation to the IBHIS Implementation is still to be determined.

ACCOMPLISHMENTS

- Not Applicable

SCHEDULED ACTIVITIES FOR NEXT PERIOD

- Not Applicable

MHSA IT Annual Project Status Report LACDMH

CRITICAL ISSUES

Include any critical or high priority issues impacting the project.

None reported.

RISKS

Include any critical or high risks that may impact the project – Note Probability (High, Medium, Low) and Response (Watch, Mitigate, Accept)

None reported.

Post Implementation Evaluation Report

Please Include The Following Sections In Your Final Status Report

OBJECTIVES ACHIEVED
Describe the Achieved Objectives in Comparison to the Objectives Listed in the MHSA IT Funding Request form. Also describe the User and Management Acceptance of the Completed Project. •

LESSONS LEARNED
Describe Lessons Learned, Best Practices used for the project, any Notable Occurrences, or Factors that contributed to the project's success or problems, or other information, which could be helpful during future project efforts. Describe Problems that were Encountered and How they were Overcome. •

CORRECTIVE ACTIONS
Note: This section must be included when the project is deemed to be a Limited Success or Failure, or when there are Significant Differences between Project Expectations and Project Results. If this condition applies, summarize alternatives for improving the outcome. •

NEXT STEPS
Describe if the project has any Future Phases or Enhancements; or will it be in Maintenance Phase. •

County Approvals

Signature	Date	Phone
S. Prakash	11/28/12	213-480-3652

Prepared By

Signature	Date	Phone
	11/28/12	(213) 251-6481

MH Chief Information Officer
Robert Greenless, Ph.D. CIO

IT Annual Project Status Report

For an MHSA-Funded IT Project

PROJECT INFORMATION		
Project Name: Telepsychiatry Implementation		**DMH Project ID #:** LA-10
Executive Sponsor: Marvin Southard, DSW **Title:** Director Los Angeles County Department of Mental Health		**County:** Los Angeles
Project Status ☐ Not Started ☒ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule	**Budget Status** ☒ Within Approved Budget ☐ Over Budget	**For Fiscal Year Ending:** 06/30/12 **Project Start Date:** 07/01/10 **Project End Date:** 12/31/12
MHSA IT Project Contact Person's Name: Karen Van Sant, Project Director **Telephone Number:** (213) 251-6476 **E-mail Address:** kvansant@dmh.lacounty.gov		
Project Objectives: To address service disparities among remote and underserved populations by implementing networked videoconferencing at multiple service locations to allow provision of direct telepsychiatry treatment services to clients by psychiatrists and specialty tele-consultation between psychiatrists and primary care providers.		

MAJOR MILESTONE STATUS

Project Phase	Deliverables / Milestones	Planned Start	Actual Start	Planned Completion	Actual Completion	Status
Initiation Phase	Charter approved.	4/05/10	2/01/10	5/10/10	2/24/11	Completed
Initiation Phase	Project Plan, Funding Approval from State	2/01/10	2/01/10	7/01/10	8/13/10	Completed
Initiation Phase	Approved Adjusted Project Plan (Schedule) Baseline	10/01/10	10/01/10	1/15/11	3/31/11	Completed
Requirements Phase	BRD, T-Specs	5/11/10	8/13/10	6/07/10	4/23/11	Completed
Design Phase	Technical Design Document	9/20/10	8/13/10	6/14/11	4/23/11	Completed
Construction Phase	Procurement Planning and Procurement Completion	9/20/10	9/20/10	12/31/12		In Process
Testing Phase	Developed and Installed Solution; Testing Complete	11/01/10	10/13/10	6/30/11	6/30/11	Completed
Implementation Phase	Training Complete; Go-Live	3/01/11	3/01/11	12/31/12		In Process
Post-Implement. Phase	Final QPSR and Closeout	6/29/10		12/31/12		Not Started
PIER	PIER	6/29/10		12/31/12		Not Started

TOTAL PROJECT BUDGET INFORMATION (MHSA Only)		
Category	**Budgeted Costs**	**Actual Costs to Date**
Staff (Salaries & Benefits)	$ 26,075	$ 28,840
Hardware	$ 164,500	$ 75,021
Software	$ 114,960	$ 1,886
Contract Services	$ 214,651	$ 36,969
Total Project Costs	**$ 520,186**	**$ 142,716**

STATUS / MAJOR ACCOMPLISHMENTS / SCHEDULED ACTIVITIES

STATUS

- Project has been reduced in priority, and Project Manager reassigned. Project currently is under the direction of Karen Van Sant, Project Director.
- Change Notice for 24 additional remote locations approved. Phased procurement underway for first 12 units.
- County Internal Services Department is continuing bandwidth upgrades to all County facilities/sites.
- DMH EMT approved funding for permanent "Tele-Hub." DMH OMD, ASOC and ASB developing space request (pending final approval). Anticipated 1 year to complete acquisition, lease, and build out.
- OMD RFP for clinical telepsychiatry consultant cancelled, following second posting and no responses. Procurement of clinical consultant contract services is expected to be cancelled entirely.

ACCOMPLISHMENTS

- Training materials in development and production begun.

SCHEDULED ACTIVITIES FOR NEXT PERIOD

- Additional endpoint procurement and deployment.

CRITICAL ISSUES

Include any critical or high priority issues impacting the project.

None reported.

RISKS

Include any critical or high risks that may impact the project – Note Probability (High, Medium, Low) and Response (Watch, Mitigate, Accept)

- Limited MDs available to provide services – Probability is Medium. Response is Watch.
- User acceptance of technology slow – Probability is Medium. Response is Mitigate.
- ROI and breakeven delayed – Probability is High. Response is Accept.

Post Implementation Evaluation Report

Please Include The Following Sections In Your Final Status Report

OBJECTIVES ACHIEVED

Describe the Achieved Objectives in Comparison to the Objectives Listed in the MHSA IT Funding Request form.
Also describe the User and Management Acceptance of the Completed Project.

-

LESSONS LEARNED

Describe Lessons Learned, Best Practices used for the project, any Notable Occurrences, or Factors that contributed to the project's success or problems, or other information, which could be helpful during future project efforts. Describe Problems that were Encountered and How they were Overcome.

-

CORRECTIVE ACTIONS

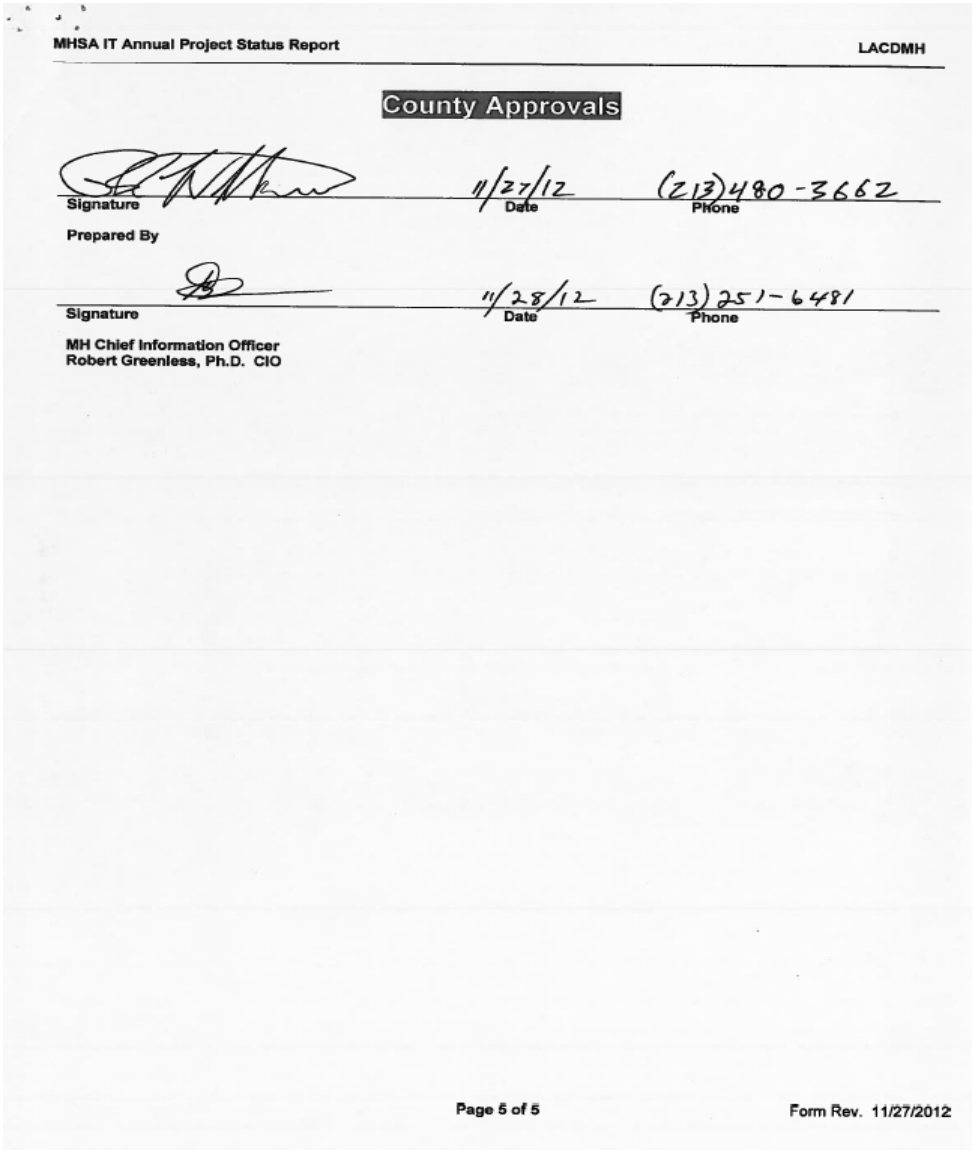
Note: This section must be included when the project is deemed to be a Limited Success or Failure, or when there are Significant Differences between Project Expectations and Project Results.
If this condition applies, summarize alternatives for improving the outcome.

-

NEXT STEPS

Describe if the project has any Future Phases or Enhancements; or will it be in Maintenance Phase.

-



MHSA IT Annual Project Status Report LACDMH

County Approvals

Signature 11/27/12 Date (213)480-3662 Phone

Prepared By

Signature 11/28/12 Date (213) 251-6481 Phone

MH Chief Information Officer
Robert Greenless, Ph.D. CIO

Page 5 of 5 Form Rev. 11/27/2012

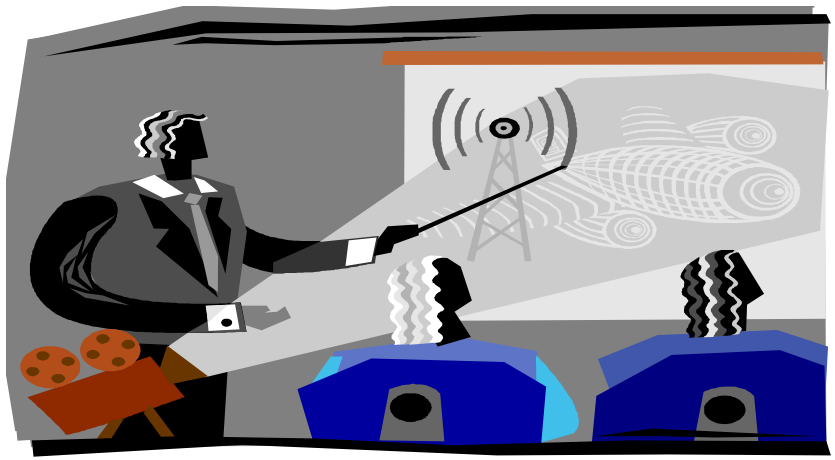
1. Youth Suicide Prevention Project Website

Project Description:

Expand, enhance and develop the resources and online tools in the Youth Suicide Prevention Project website in partnership with Dr. Laurel Bear. We propose to develop and enhance Alhambra Unified School District's "Gateway to Success" program by: Integrating "Gateway To Success" into our in partnership with Dr. Laurel Bear to support development of suicide prevention programs for other school districts; developing video and multimedia tools to enhance already existing "Gateway To Success" materials and resources for school personnel and district communities; & focus on inclusion of communities/families to engage in efforts to promote mental health, well-being, early identification of needs, accessing Mental Health resources/services, etc.: Development and dissemination of materials and effective approaches regarding working with diverse audiences, underserved and/or UREP populations.

Project Status:

Dr. Southard signed the amendment on March 12, 2012. LACOE/CDOL staff has completed videotaping of a "Gateways to Success" staff training workshop conducted by Laurel Baer as well as individual interview sessions with her. Relevant content and highlights are being edited for final production of segments to be uploaded to the Youth Suicide Prevention Project (YSPP) website and for subsequent dissemination of corresponding resource information/materials.



2. Proposal: Families of Children ages 0-5

Project Description:

This proposal focuses on families of children ages 0-5 who have developmental disabilities and behavioral issues that do or can lead to mental health service needs. People with disabilities are identified as a target population in the County's PEI Plan submitted to the State in August 2009 (cited 13 times). We propose to develop and implement a coaching curriculum to coach parents of very young children who are at risk of or have a dual developmental and mental health diagnosis, to empower them to navigate both systems in a DD-MH cross-walk. The curriculum would be available to other Dual Diagnosis/Mental Health collaborative statewide: Interactive and Practicum sessions, Peer Support and Development and dissemination of materials

Project Status:

A vendor was identified: Family Resource Library and Assistive Technology Center and trainings are scheduled to begin in June 2012.

3. Extended Training for Families Overcoming under Stress (FOCUS)

Project Description:

Extended training for FOCUS (Families Overcoming Under Stress) Service Extenders - ES 3 - Interactive and practicum sessions, development and dissemination of materials and related consulting services to enhance the sharing of information and resources for veterans and their families in need of services to overcome and reduce stress of deployment

Project Status:

No funding this fiscal year from PEI Technical Assistance. Funding to begin FY 2012-13. Amendment request has been submitted to Budget on March 1, 2012. It is pending Budget approval.

4. Wellness Outreach Workers (WOW)

Project Description:
Interactive and practicum sessions transforming recovering clients into credentialed DMH volunteers and peer advocate candidates.

Project Status:
During the current FY 2011-12, two WOW trainings were provided (12/8-9/2011 and 2/22-23/2012) for a total of 100 consumer and family member volunteers. A third training is scheduled for 4/24-25/2012 that will add another 50 potential WOW volunteers. WOW trainings have been provided in both English and Spanish.

In FY 2012-13, ASOC will offer at least two (2) WOW trainings that will add another 100 volunteers to the pool of potential WOW. We anticipate that the full allocation for FY 12/13 will be utilized and there may be a need for some additional funds.

5. Community Health Workers Training

Project Description:
Collaboration between the Department of Health Service, Mental Health, and the Worker Education and Resource Center to create a pilot curriculum for community health outreach workers on the development, implementation and evaluation of prevention.

Project Status:
The curriculum has been completed and training began for 30 Peer Staff in the WERC model for Community Health Care Workers on January 26, 2012. This 160 hour course covers health care education topics including: Communications, Leadership, Mental Health, Substance Abuse, Domestic Violence, Sexual Education, Nutrition, Cancer and Health Education.

6. Regional Data Workgroup

Project Description:
Multi-county regional collaborative funded through CalMHSA to strengthen the capacity and skill sets in evaluation and data-informed decision-making, with the goal of increasing quality data and service quality.

Project Status:
The board letter was heard by the Board of Supervisors on 5/29/12.

Project Status for items 7-11

7. P - ABC B - 5 Materials: Materials have been ordered.
8. Provide translation Department wide: Project has been deferred till FY 2012-13
9. Hope and Recovery Conference: Conferences were held in July, September and October, 2011.
10. REGENTS of CA - UCLA AFFILIATION AGREEMENT: On-going services are being delivered.
11. Offer computer training Department wide: Project has been deferred till FY 2012-13.
12. Provide training for Human Resources Bureau Staff: Trainings began 2/16/12.

13. Hire a Consultant

Project Description:
Hire a consultant to outreach, training and provide technical assistance services for the purpose of increasing the use of the arts and media for community development within and between mental health agencies, to increase social support for people with mental illness, and to break through the barriers of internal and external stigma.
Project Status:
Bidding was closed on 4/10/12.

14. Augustus F. Hawkins- Faith-Based PEI Outreach & Engagement Training

Project Status:
On April 4, 2012, the bid was awarded to Lidia Gamulin, LCSW. Ms. Gamulin provided her first training on Saturday, April 28, 2012. She is continuing her trainings and Technical Assistance activities.

15. West Central Family- Early Care and Support for Lesbian, Gay, Bisexual and Transgender (LGBT) TAY & Adults

Project Status:
On April 5, 2012, bid was awarded to Lisa Powell, Esq. Ms. Powell is in the implementation process and has scheduled her first training for May 16, 2012. She will continue her trainings and Technical Assistance activities.

16. LGBTQ Latino TAY

Project Description:
This project focuses on LGBTQ Latino TAY who could benefit from MH services but are unwilling or unable to because of fear/stigma related to being LGBTQ. Many of these youth/young adults are experience depression, trauma, bullying, and referrals to service providers who lack the cultural awareness and/or sensitivity to engage these high-risk TAY. We are proposing to identify 1-2 agencies that currently specialize in serving LGBTQ TAY (especially UREP primarily Latino) that will provide training and technical assistance to MH and Non-Branded Providers on successful O&E strategies for this population; including establishing "welcoming" and safe places for clinical engagement, etc. The agency(s) will prepare training materials and disseminate information via presentations, etc. They will work to establish a network of train-the-trainers that will continuously identify and build upon effective strategies for this population.

Project Status:
Bid closed week of 4/16/12. On April 25, 2012, a purchase order (PO) was issued to The Village Family Services for SA 2 and on April 25, 2012, a PO was issued to Whittier Rio Hondo AIDS Project for SA 7. Both programs are currently in the implementation process and will begin trainings and Technical Assistance activities immediately.

17. Education and Engagement for TAY

Project Description:
It will provide peer support, advocacy through education, and engagement to TAY. Young adults who have been trained as mental health workers and/or peer advocates will provide psycho educational and Outreach & Engagement to high risk youth/young adults in non-MH branded settings. The primary goal of this peer-driven project is to educate MH and reduce self-stigma and other self-imposed barriers that prevent TAY from seeking needed MH and COD services. Non-MH branded CB's and FBO's that serve TAY and families, and TAY navigators will be targeted as collaborative partners.

Project Status:
On April 16, 2012, the Amendment was signed and approved for Pacific Clinics to start providing services. As of April 16, 2012, Pacific Clinics immediately began implementing the project. One (1) bid closed week of April 16, 2012 to serve Service Area 5. On April 25, 2012, a PO was issued to Step Up on Second Street. This program is in the implementation process and will begin trainings and TA activities immediately.

18. TAY Mobile Library Project

Project Description:
PEI Early Start Anti-Stigma and Discrimination program seeks to increase awareness, understanding, and access to mental health services and supports. This project expands existing TAY library project by creating additional mobile display units.

Project Status:
Appropriate items are being ordered and some of these items have been received through the Special Requests (SR) process.

Project Status for items 19-22

19. Juvenile Justice Mental Health Competency-Judge Nash Project: The end of March 2012, a Department Services Order was sent to the Department of Probation for the Los Angeles County Juvenile Dependency and Delinquency Court System Project provided by Probation Department to DMH for FY 2011-2012.

20. Peer-to-Peer project for an existing provider with a Drop-In Center in Service Area 6: On April 16, 2012, the Amendment was signed and approved for Tessie Cleveland to start providing services. As of April 16, 2012, Tessie Cleveland immediately began implementing the project.

21. Shots Fired Series of training videos on targeted school violence is being translated into Spanish: Awaiting the approval of the sole source by the Los Angeles County Internal Services Department.

22. Hire a consultant to develop a curriculum and provide training on focusing on mental health, mental illness, suicide prevention and accessing mental health services that are tailored for people of Ethiopian descent: This project has been deferred until Fiscal Year 2012-13.

Program Goal

Four models to test out different approaches to the integration of mental health, primary care and substance abuse services for clients with serious mental illness and one or more co-occurring disorders. Services to continue through the end of FY 2013-14. The evaluation of Innovation is estimated to begin at the end of FY 2011-12. The programs will be evaluated by model and program according to:

- Health status of clients served
- Mental health status of clients served
- Substance use patterns of clients served
- Degree of integrated service attained
- Client satisfaction
- Community satisfaction
- Cost effectiveness
- Degree to which programs in certain models enhance client quality of life through the reduced use of psychiatric and medical emergency departments, reduced psychiatric hospitalizations, increases in employment and education and reductions in homelessness and increases in clients living independently.

1. Community-Designed Integrated Services Management Model (ISM)

The Community-Designed Integrated Service Management Model (ISM) envisions a holistic model of care whose components are defined by specific ethnic communities and also promotes collaboration and community based partnerships to integrate health, mental health, and substance abuse services together with other needed non-traditional care to support the recovery of consumers.

The five ethnic communities targeted are African Immigrant / African American, American Indian / Alaska Native, Asian Pacific Islander/ Eastern European / Middle Eastern and Latino.

The ISM model consists of discrete teams of specially-trained and culturally competent "service integrators" that help clients use the resources of both formal (i.e. mental health, health, substance abuse, child welfare, and other formal service providers) and nontraditional (i.e., community defined healers) networks of providers, who use culturally-effective principles and values. The ISM Model services are grounded in ethnic communities with a strong foundation of community based, non-traditional, and natural support systems such as faith-based organizations.

Unique Client Contacts for FY 2011-12

Integrated Services Management Model: 407*
Integrated Clinic Model: 538*
Integrated Mobile Health Team: 1,870*

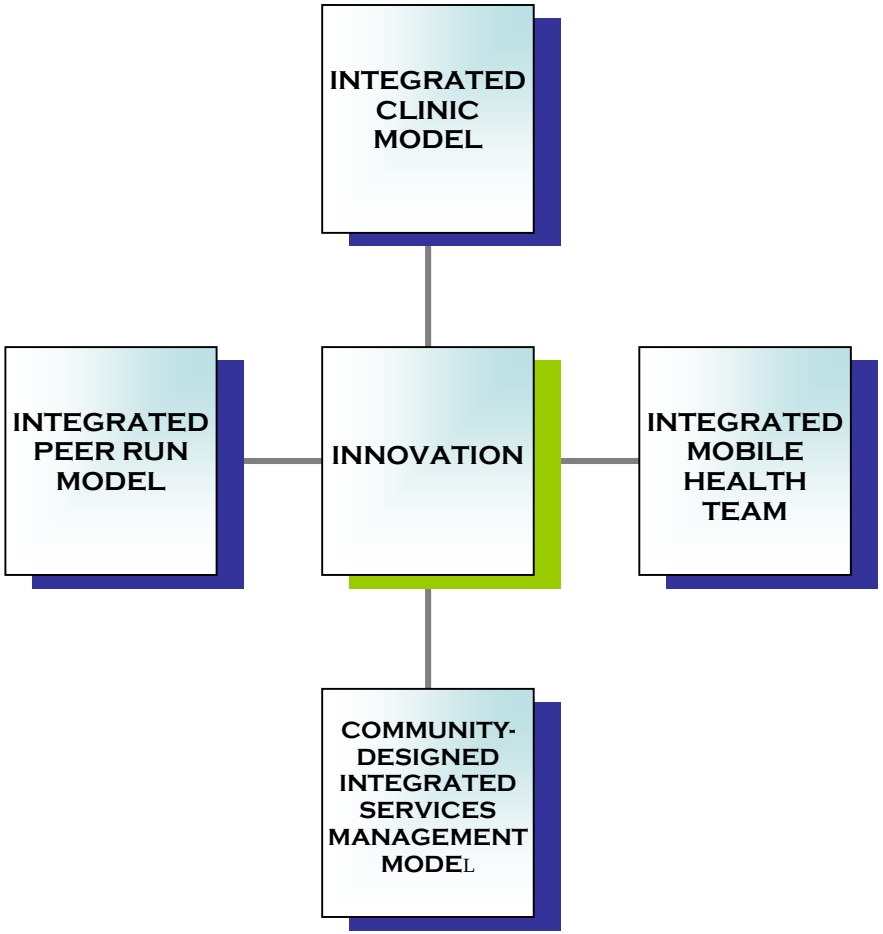
2. Integrated Clinic Model (ICM)

The Integrated Clinic Model (ICM) is designed to improve access to quality culturally competent services for individuals with physical health, mental health and co-occurring substance use diagnoses by integrating care within both mental health and primary care provider sites. ICM's are staffed with multidisciplinary professional teams and specially trained peer counselors and paraprofessionals.

ICMs provide: Recovery Oriented Assessments, Mental Health Treatment Services, Co-occurring Substance Use Services, Peer Counseling and Self Help, Primary Care Services, Homeless/Housing Services, Care Management, Wellness Activities

3. Integrated Mobile Health Team Model (IMHT)

The Integrated Mobile Health Team (IMHT) service model is designed to improve and better coordinate the quality of care for individuals with a mental illness and their families, if appropriate, who are homeless or have recently moved into Permanent Supportive Housing (PSH) and have other vulnerabilities. Vulnerabilities include but are not limited to age, years homeless, co-occurring substance abuse disorders and/or physical health conditions. Improving the quality of care will be accomplished by having multidisciplinary staff that provide mental health, physical health and substance abuse services work as one team, under one point of supervision, operate under one set of administrative and operational policies and procedures and use an integrated medical record/chart. The program is designed to provide the level of services necessary to support clients to successfully transition from homelessness into PSH and to improve their mental health and co-occurring disorders.



4. INTEGRATED PEER-RUN MODEL

The Innovative Integrated Peer Run Model: Peer-Run Integrated Services Management (PRISM) and Peer-Run Respite Care Homes (PRRCH) are peer-operated and member driven community based, recovery oriented, holistic alternatives to traditional mental health programs. PRISM offers linkage to health, mental health, substance abuse, and housing services as part of a program designed to empower individuals to sustain their own recovery. PRRCH offers guests a short-stay voluntary opportunity to grow through distress in a warm, safe, and healing environment while engaging in recovery focused supportive services as desired.

ACHIEVEMENTS/HIGHLIGHTS FOR FYS 2011-12 AND 2012-13

The Board approved contracts for the Integrated Clinic model, the Community-Designed Integrated Services Management model and the Integrated Mobile Health Team model in February and March, 2012. Services began soon after Board approval. In July, 2012 a contract was awarded to the University of California, San Diego for the evaluation of Innovation. After conducting focus groups on proposed outcome measures, in September measures were selected, providers were trained on the use of the measures and how to enter outcome data into the UCSD electronic data system. Quarterly learning sessions with all providers began in October, 2012, with a focus on service integration and use of outcome data for learning purposes and quality improvement.

The Integrated Peer-Run Model board letter is expected to be approved by the Board in February, 2013, with services beginning immediately after contracts are signed.

FY 2013-14
MHSA FUNDING SUMMARY

County: Los Angeles Date: 2/25/2013

DRAFT

	MHSA Funding					
	CSS	WET	CFTN	PEI	INN	Local Prudent Reserve
A. Estimated FY 2013/14 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years [a]	$ 50,882,242	$44,175,407	$90,438,526	$ 71,549,971	$32,789,190	
2. Estimated New FY 2013/14 Funding [b]	$250,533,363			$65,020,341	$16,594,529	
3. Transfer in FY 2013/14[a/]						$0
4. Access Local Prudent Reserve in FY 2013/14						$0
5. Estimated Available Funding for FY 2013/14	$301,415,605	$44,175,407	$90,438,526	$136,570,312	$49,383,719	
B. Estimated FY 2013/14 Expenditures [c]	$299,016,067	$13,102,677	$51,532,165	$103,296,809	$31,149,873	
C. Estimated FY 2013/14 Contingency Funding	$2,399,538	$31,072,730	$38,906,361	$33,273,503	$18,233,846	

[a/]Per Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2013	$150,725,402
2. Contributions to the Local Prudent Reserve in FY 2013/14	$0
3. Distributions from Local Prudent Reserve in FY 2013/14	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2014	$150,725,402

Notes: (a) Total unspent State Allocation based on fiscal year end closing estimates for FY 2010-11 and FY 2011-12 and FY 2012-13 estimate as of January 2013.
(b) Amount provided by CMHDA based on Innovative Financing Models as of September, 2012.

(c) Amount based on FY 2013-14 Budget Request.

FSP Employment Data – FY 2011-12
Data Extracted from Outcomes Measurement Application (OMA)

Employement Statistics				
Program Name	Number of Baselines	Total Tenure in Days	Average Tenure in Days	Program Factor
FSP-Child	1,245	648,095	520.56	0.70
FSP-Transitional Age Youth	1,024	753,785	736.12	0.49
FSP-Adult	3,428	3,099,321	904.12	0.40
FSP-OlderAdult	317	243,548	768.29	0.47
Wraparound FSP-Child	222	69,293	312.13	1.16
Wraparound FSP-TAY	55	20,927	380.49	0.95

Employment Pre and Post by Program								
Program Name	Employment Type	Number of Days Pre	Number of Clients Pre	Average Number of Days Pre	Annualized Days Post	Number of Clients Post	Average Number of Days Post	Percent Change
FSP-Child	Unemployed	448,290	1228	365	442586.5	1226	361.00	-1.10%
	Other Gainful Employment	294	1	294	42.7	1	42.70	-85.48%
	Competitive Employment	14	1	14	331.1	4	82.78	491.25%
FSP- TAY	Unemployed	352,986	993	355	336843.27	983	342.67	-3.47%
	Competitive Employment	15,196	84	180	19640.18	58	338.62	88.12%
	Non Paid Employment	2,145	14	153	3621.59	7	517.37	238.15%
	Other Gainful Employment	954	5	190	1648.85	5	329.77	73.56%
	Supportive Employment	680	4	170	1404.83	4	351.21	106.59%
	Paid In House Employment	427	5	85	2553.39	19	134.39	58.10%
	Transitional Employment	365	1	365	1116.22	9	124.02	-66.02%
FSP-Adult	Unemployed	1,205,161	3376	356	1178225.52	3381	348.48	-2.11%
	Transitional Employment	1,920	17	112	6666.8	28	238.10	112.59%
	Supportive Employment	2,062	9	229	4299.6	25	171.98	-24.90%
	Paid In House Employment	3,984	35	113	13159.5	60	219.33	94.09%
	Other Gainful Employment	4,578	25	183	8220.4	28	293.59	60.43%
	Non Paid Employment	4,659	26	179	6551.6	36	181.99	1.67%
	Competitive Employment	29,998	170	176	41841.97	140	298.87	69.81%
FSP-Older Adult	Unemployed	95,390	263	362	116190	320	363.09	0.30%
	Competitive Employment	1,388	6	231	63.92	1	63.92	-72.33%
	Non Paid Employment	730	2	365	515.12	1	515.12	41.13%
	Transitional Employment	365	1	365	167.32	1	167.32	-54.16%
	Other Gainful Employment	365	1	365	0	0	0.00	-100.00%

FSP Living Arrangement Data– FY 2011-12
Data Extracted from OMA (continued)

FSP Program	Number of Clients Included
Child	1,163
TAY	368
Adult	931
Older Adult	90

Number of Days Pre and Post in Residential Type, by Program

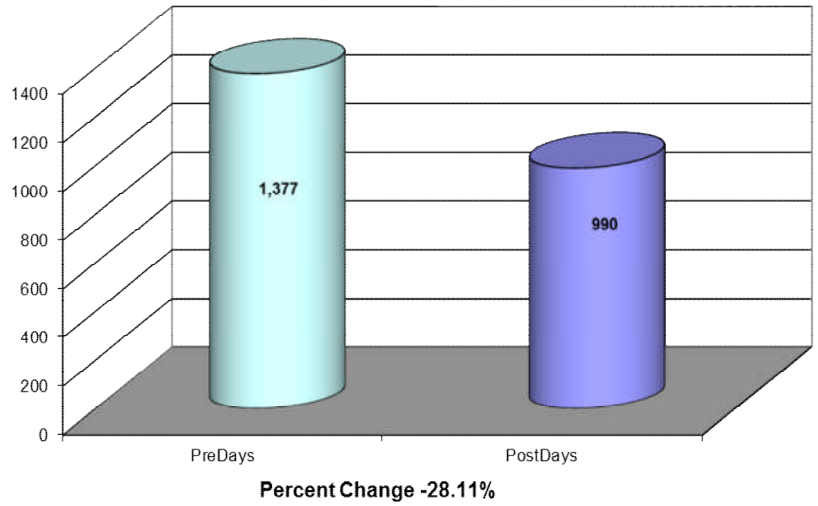
Program Name	Residential Type	Number of Days Pre	Number of Days Post	Percent Change
FSP-Child	Homeless	306	163.4	-46.60%
	Hospitalization	3620	3166.4	-12.53%
	Independent Living	5214	6020.1	15.46%
	Juvenile Hall	1377	990.0	-28.11%
FSP-TAY	Homeless	6419	4131.2	-35.64%
	Hospitalization	2564	5005.2	95.21%
	Independent Living	6360	13486.1	112.05%
	Jail	1729	2678.7	54.93%
	Juvenile Hall	638	656.6	2.91%
FSP-Adult	Homeless	94038	28803.8	-69.37%
	Hospitalization	13871	10075.6	-27.36%
	Independent Living	44580	86310.0	93.61%
	Jail	19894	6247.1	-68.60%
FSP-Older Adult	Homeless	4805	959.6	-80.03%
	Hospitalization	3168	2706.5	-14.57%
	Independent Living	8367	10145.9	21.26%
	Jail	608	81.3	-86.63%
Wraparound FSP-Child	Homeless	0	1.2	0.00%
	Hospitalization	180	238.9	32.70%
	Juvenile Hall	51	44.1	-13.53%
	Hospitalization	32	36.9	15.41%
	Juvenile Hall	24	0.0	-100.00%

Count of Pre and Post Clients by Residential Type

Residential Type	Program Name	Number of Clients Pre-Enrollment	Number of Clients Post-Enrollment	Percent Change
Homeless	FSP-Child	2	8	300.00%
	FSP-TAY	35	28	-20.00%
	FSP-Older Adult	20	12	-40.00%
	FSP-Adult	396	263	-33.59%
Hospitalization	FSP-Child	224	163	-27.23%
	FSP-TAY	87	68	-21.84%
	FSP-Adult	276	284	2.90%
	FSP-Older Adult	28	28	0.00%
Independent Living	FSP-Child	18	21	16.67%
	FSP-TAY	34	56	64.71%
	FSP-Adult	203	374	84.24%
	FSP-Older Adult	29	40	37.93%
Jail	FSP-TAY	18	27	50.00%
	FSP-Adult	189	183	-3.17%
	FSP-Older Adult	3	2	-33.33%
Juvenile Hall	FSP-Child	20	40	100.00%
	FSP-TAY	7	4	-42.86%

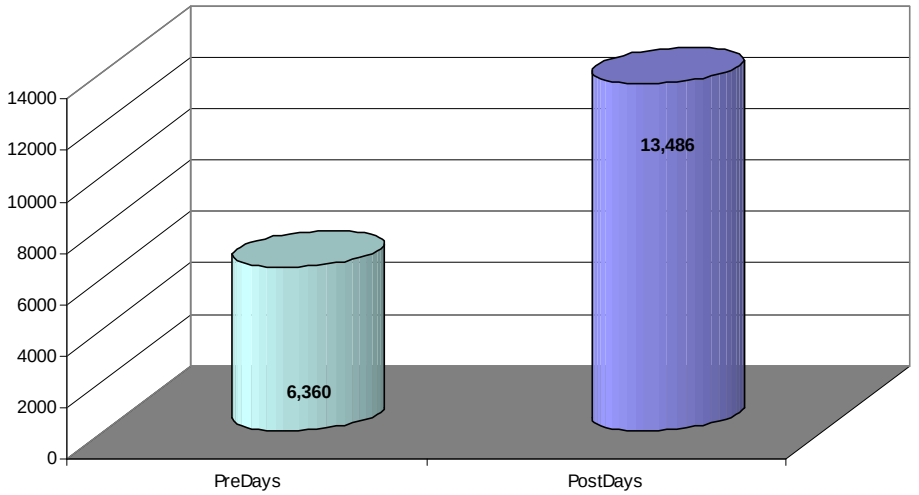
FSP LIVING ARRANGEMENT DATA– FY 2011-12
DATA EXTRACTED FROM OMA (CONTINUED)

FSP Children Spent Fewer Days in Juvenile Hall Post Partnership



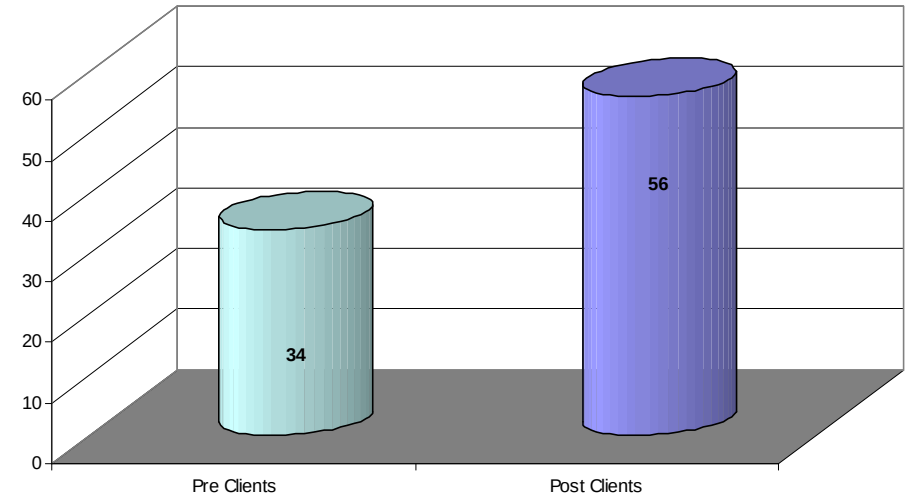
Percent Change -28.11%

FSP TAY Spent More Days Living Independently Post Partnership



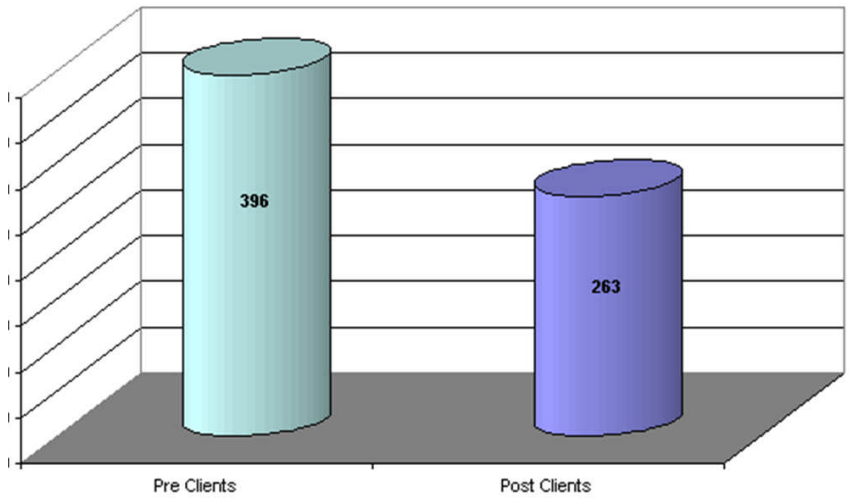
Percent Change 112.05%

More FSP TAY Clients Were Living Independently Post Partnership



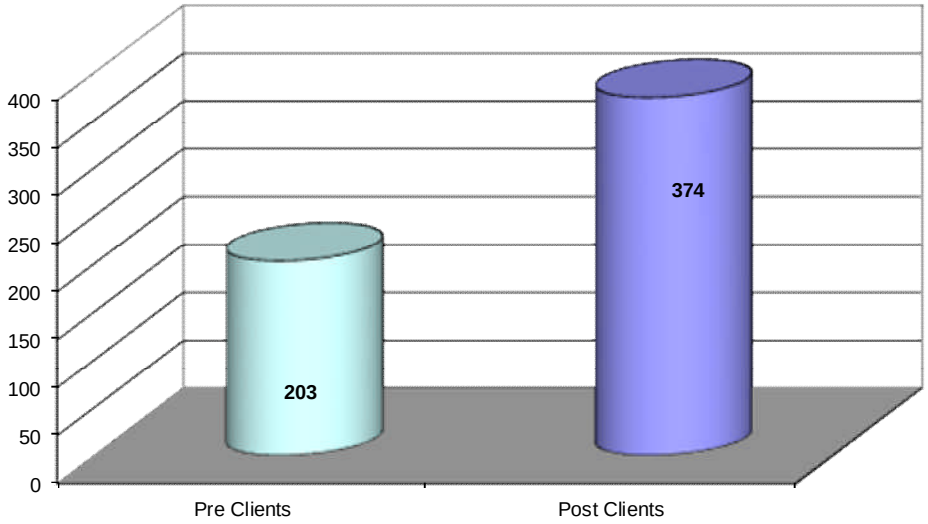
Percent Change 64.71%

Fewer FSP Adults Were Homeless Post Partnership



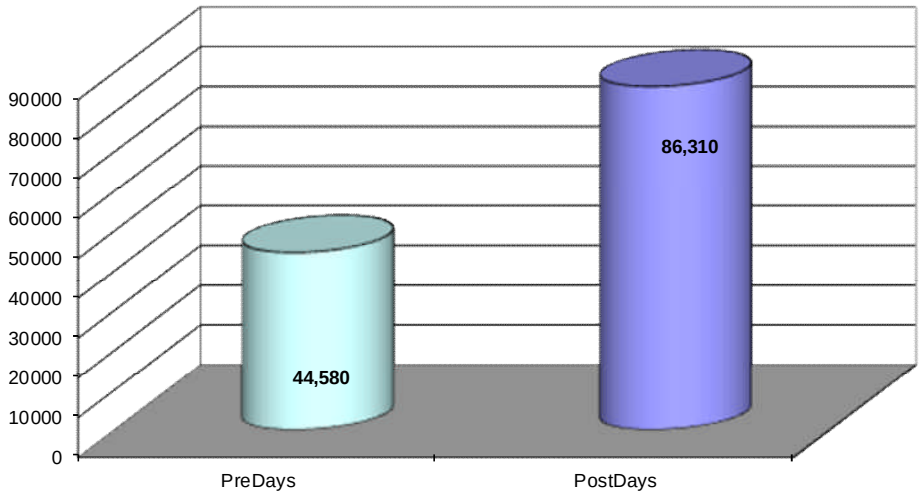
Percent Change -33.59%

More FSP Adults Were Living Independently Post Partnership



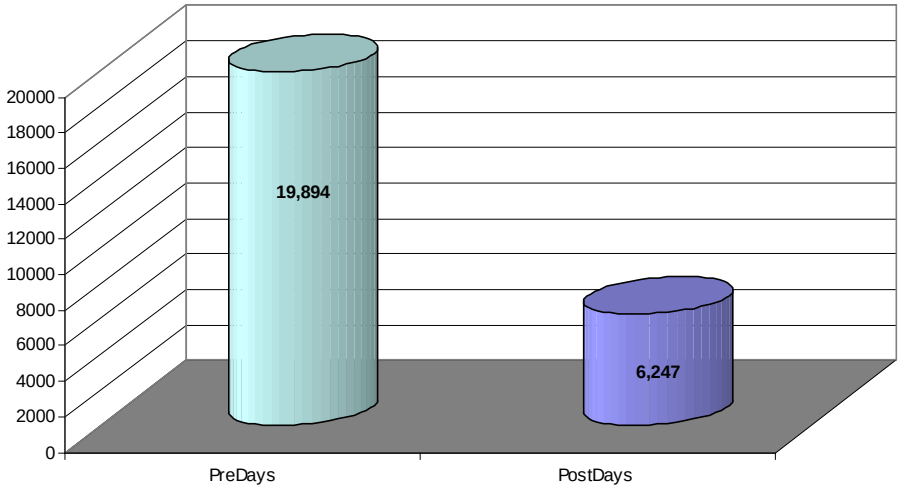
Percent Change 84.24%

FSP Adults Spent More Days Living Independently Post Partnership



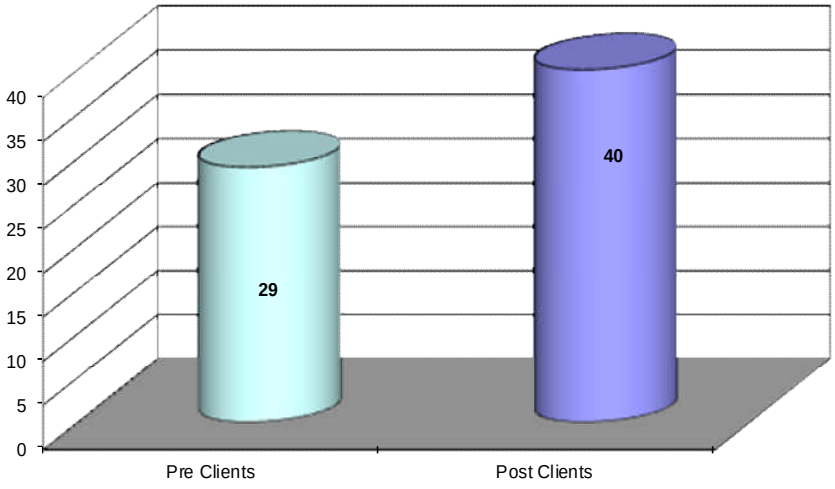
Percent Change 93.61%

FSP Adults Spent Fewer Days in Jail Post Partnership



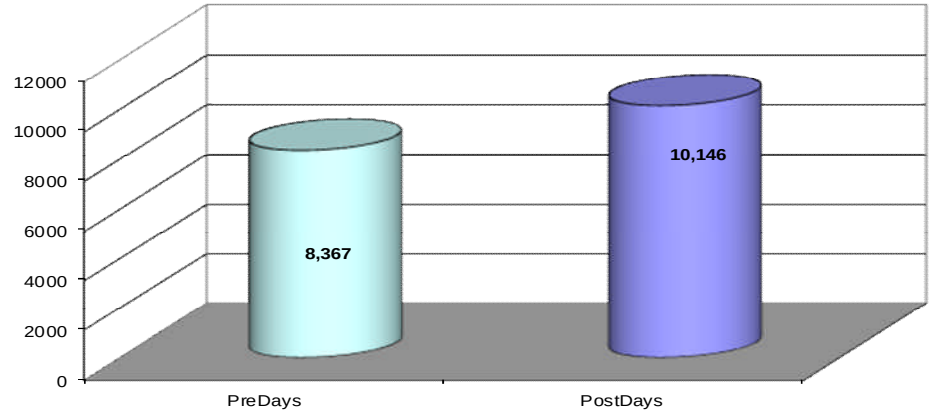
Percent Change -68.60%

More FSP Older Adults Were Living Independently Post Partnership



Percent Change 37.93%

FSP Older Adults Spent More Days Living Independently Post Partnership



Percent Change 21.26%

Unique Clients Served By FSP & FCCS Programs- FY 2011-12*
Primary Language and Ethnicity

	Full Service Partnership				Field Capable Clinical Services			
Age Group (Plan ID #)	Child (C-01)	TAY (T-01)	Adult (A-01)	Older Adult (OA-01)	Child (C-06)	TAY (T-06)	Adult (A-06)	Older Adult (OA-03)
Client Count								
Clients Served	3,104	1,651	4,841	428	9,348	2,156	9,928	2,991
Ethnicity								
African American	677	451	1,705	115	1,488	394	2,486	452
Asian	105	63	296	39	223	87	1,331	264
Hispanic	1,950	833	1,156	72	6,568	1,299	2,908	949
Native American	11	12	59	3	15	7	188	12
Other	41	31	69	2	188	57	165	76
Pacific Islander	6	5	11	1	11	4	43	4
Unknown*	23	20	62	9	172	20	159	78
White	291	236	1,483	187	683	288	2,648	1,156
TOTAL:	3,104	1,651	4,841	428	9,348	2,156	9,928	2,991

	Full Service Partnership				Field Capable Clinical Services			
Age Group (Plan ID #)	Child (C-01)	TAY (T-01)	Adult (A-01)	Older Adult (OA-01)	Child (C-06)	TAY (T-06)	Adult (A-06)	Older Adult (OA-03)
Primary Language								
American Sign	0	0	0	0	3	2	6	1
Arabic	0	2	2	1	6	0	11	7
Armenian	24	10	18	0	18	16	103	51
Cambodian	4	0	16	3	24	0	180	8
Cantonese	6	0	12	2	18	3	121	37
English	2,199	1,320	4,097	334	6,179	1,633	7,346	1,822
Farsi	0	7	10	2	8	1	44	50
Korean	15	0	39	3	15	7	288	39
Mandarin	4	6	16	11	5	4	72	64
Other	5	1	40	9	18	8	184	87
Pilipino,Tagalog	1	1	13	4	3	2	48	11
Russian	0	248	17	48	4	4	9	23
Spanish	818	54	409	8	2,985	443	1,144	723
Unknown*	21	2	125	3	45	28	163	39
Vietnamese	7		27		17	5	209	29
TOTAL:	3,104	1,651	4,841	428	9,348	2,156	9,928	2,991

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

UNIQUE CLIENTS SERVED BY PEI AGE GROUPS - FY 2011-12*
PRIMARY LANGUAGE AND ETHNICITY

Unique Client Count						
Age Group	Child	TAY	Adult	Older Adult	Cross Cutting	**Total**
Clients Served	33,080	11,497	15,243	822	3,023	**63,665**

Ethnicity						
Age Group	Child	TAY	Adult	Older Adult	Cross Cutting	**Total**
African American	5,939	2,555	4,746	296	524	14,060
Asian	498	276	601	81	83	1,539
Hispanic	22,778	6,948	5,248	217	1,621	36,812
Native American	128	40	103	3	14	288
Other	563	175	278	17	52	1,085
Pacific Islander	63	19	33	3	5	123
Unknown*	474	172	302	28	64	1,040
White	2,637	1,312	3,932	177	660	8,718
TOTAL:	**33,080**	**11,497**	**15,243**	**822**	**3,023**	**63,665**

Primary Language						
Age Group	Child	TAY	Adult	Older Adult	Cross Cutting	**Total**
American Sign	20	11	1	0	0	32
Arabic	16	3	14	2	5	40
Armenian	62	32	176	15	28	313
Cambodian	6	12	73	7	2	100
Cantonese	40	9	41	10	10	110
English	22,686	8,987	11,822	539	1,980	46,014
Farsi	17	8	99	3	16	143
Korean	27	15	42	13	3	100
Mandarin	42	13	42	10	8	115
Other	50	28	127	14	19	238
Pilipino, Tagalog	9	4	45	6	6	70
Russian	4	5	34	0	1	44
Spanish	9,929	2,240	2,410	166	896	15,641
Unknown*	166	114	284	11	46	621
Vietnamese	6	16	33	26	3	84
TOTAL:	**33,080**	**11,497**	**15,243**	**822**	**3,023**	**63,665**

* Unique Clients are counted by claims in the Integrated System claiming as of 12/17/2012.

STAKEHOLDER COMMENTS/RECOMMENDATIONS

Comments from SAAC 7 meeting held on January 11, 2013:

1. Slide 10 -- # of children in FSSP more than Slide 11 TAY
    a. There aren't enough slots for TAY population
    b. Schools are seeing more children at earlier age
    c. Numbers of clients – see slide 10 – are lower for FY 2011-12 than 2010-11 – does this mean less slots? But there is more money per slide 11 – why are the slots going down? Are the clients not successfully enrolled
    d. Children's programs are 0 to 16
2. Slide 11 demonstrates the enhancement of services—does this mean there are other ways to be successful with service delivery
3. Slide 17 – enhancement of funding demonstrated so that is a success, more than doubled from 2008-09 and 2010-11 for community services plan support. Encouraging to see trend going up
4. Slides that demonstrate accommodation of language/ethnicity are growing. But ethnicity and need for language are not sometimes correlating but need is there. But note: Pacific Islander population is not well served.
5. Slide 16 notes Native American served at just 1% -- but ABC's drop out rates note that within the over all drop out rate, 20% of the drop-outs are Native American
6. Slide 24 – is the 24,716 in Wellness – is that in error? Indicates the continuum of care isn't being well served. Question – is the drop-in client being counted but not really receiving services? We need to look at this.
7. All graphs indicate that child populations are not well served except for 2 and 6. In SAAC 7, the child served population is very small, not unlike the other SAACs. Service delivery needs to be representative of service for all age groups.
8. Slide 31 – Alternative Crisis Services – only 36% of clients going to urgent care are subsequently linked to longer term services for East Side. This is pretty low compared to the other SAACs, demonstrating a gap. Is this relating to issues of poverty, where parents or clients can't afford to follow up? County facilities are overwhelmed so it isn't surprising that long term services are not provided. IN school based setting with psychiatric hospitalizations, accessing discharge plan services is on the parents. And these are high risk clients. Question was: could it be that some follow up services are private? But all have county contracts. Also, Eastside UCC is larger than all other SAACs combined served. So that is another challenge. For school based settings, schools need to have discharge plans and guidance from the professionals about what the feedback needs to be to keep kids safe. But sometimes schools and private providers are not communicating. Parents are key to whether this is success. Need more parent advocates and parent engagement operating in the school districts. Parent engagement is critical in successful outcomes for entire families. The other side of that is that children are not supported by families – they are suffering on their own – the family is not there for them. In these cases, schools are great partners with the community based agencies. If schools can't show effectiveness in working with community based agencies to work with families, schools are missing an important link.
9. Slides 35 and 36 note that FSP service provides successful outcomes for children. So this is a good thing. Likewise, homeless rates in TAY reduced significantly with post-FSP service.
10. These leads to discussion: post-service termination or graduation needs to be described more accurately – it is not the case that clients just stop coming, for example.
11. Slide 53 demonstrates the % of clients that met goals – SAAC 7 has second lowest percent of clients that met their goals countywide. Discussion needs to happen as to why FSP in SAAC 7 are demonstrating this low success in clients meeting goals. It could be an artifact of the type of goals being set in SAAC 7 or whether an artifact of whether goals are set too high or whether providers are describing client successes in lower levels of expectations. Also, rate of hospitalizations for SAAC 7 seems high, given there are no residential facilities, especially for under age 12 group, any longer.
12. Is it possible to see how a factor was determined? For example, for urgent care services, are some of the facilities also included in the hospitalization numbers? Is there also a way to drill down and get more detailed information? The response was yes, the comprehensive report is extensive.
13. There was a question on persons who are incarcerated or homeless – questions should be sent to Robin.
14. The question was – does every SAAC get a different funding allocation because that would impact the comparisons of the SAACs? Relative to poverty level, Ana explained SAAC 7 is under-funded and under-resourced. It would be good to know what the funding allocation for SAAC 7 is. Another question is could we get an idea of availability of service slots for programs by SAACs – is it because resources are not available, or that resources are not being utilized.

Comments from SAAC 5 meeting held on January 22, 2013:
(Compiled by Celinda Jungheim, SAAC Co-Chair)

SAAC-5 met on Tuesday, January 22, 2013 and reviewed the MHSA Update power point presentation. Dr. Karen Williams, District Chief, was unable to attend. I'm sure she would have been able to answer many of the questions that came up. There was good discussion and feedback. The following are comments or questions that arose:

Slide 10: The group assumed that some of the clients from FY 2010-11 were also served in FY 2011-12. Do we know how many were served in both years? Also wanted to know why Family Support Services dropped so dramatically and why did all the numbers from in FY 2011-12 were lower?

Slide 14: There was discussion that Service Area Navigators might be cut but looking at the number of clients served it appears they should be retained. There were questions about Alternative Crisis Services as to who oversees these services and specifically what services are they?

Slide 16 and 63: People questioned the numbers for Asians and Hispanics feeling they were low when we know their percentage in our population is higher. They also wondered if these were only Medi-Medi clients.

Slide 22: Does this data reflect the transformation of MHSA if it only counts direct services? What are the services that happen in the Wellness Centers? Are COS services included? And there were questions about how this data is collected.

Slide 26: There were questions and discussion about why the Westside UCC reflected more subsequent hospitalizations than the other UCCs, although we realize the total number is much less than, say the Eastside UCC. There were questions about how this data is compiled. Is this just from self-reporting? Does it indicate the Westside has the greatest need?

Slide 27: There were questions about duplicated services. I.E. do these numbers reflect people who make repeat visits to the UCC?

Slide 28: A question about how this data was collected.

Slide 30: Again a question about how these numbers were generated. Is it self-reported?

Slide 31: Interest in knowing about people who have private insurance and may see someone out of the DMH system. Also interested to know about others not tracked in the IS system.

Slides 37-47: It was felt that looking at hospitalization data for FSP along with housing and employment would be useful.

Slide 44: Typo in "Older"

Slide 50: Why are these numbers so low – just 25 people. There was discussion that most FSP clients probably aren't capable of employment and therefore numbers would be low. If there is another reason it might be explained.

Slides 51-53: As I recall the term "Disenrollment" was going to be changed if a better term can be found. Our group didn't have a better suggestion.

Slide 54: There was some discussion about how these responses are obtained. Are children able to answer these questions or is this the judgment of the adults in their lives?

Slide 62: People wondered if these same forms are being collected from clients in other services such as FSP and clinical services.

Slides 64 – 71 – people questioned how valid it is to have an Evidence Based Practice where only one or a few clients have been served. Appears to be an area to review as to the effectiveness of some of these programs or why more people aren't being served.

Slide 77: Although it is pretty obvious it would be good to state that the numbers are in Millions.

We realize that the full report will include more detail that will probably answer these questions. If there are any questions please contact Celinda Jungheim, SAAC-5 Co-Chair (celinda@isp.com or 310-306-6766)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, February 20, 2013 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90010

REASONS FOR MEETING

1. To provide an update from the County of Los Angeles Department of Mental Health.
2. To inform the group about State budget, legislative, and related issues.
3. To report on action items from prior SLT meetings.
4. To present the FY 2013-2014 MHSA Annual update and to receive feedback.

AGENDA

I.	**Meeting Opening** A. Welcome and Introductions B. Review Meeting Agenda, Notes and Materials	9:30-9:40
II.	**Department of Mental Health—Update** A. *Marvin J. Southard, Director* County of Los Angeles, Department of Mental Health	9:40-10:00
III.	**State Budget, Legislation & Related Issues—Update** A. *Susan Rajlal, Legislative Analyst* County of Los Angeles, Department of Mental Health	10:00-10:15
IV.	**Follow Up Items: Prior SLT Meetings—Update** A. *Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division* County of Los Angeles, Department of Mental Health	10:15–10:25
V.	**FY 2013-2014 MHSA Annual Update** A. *Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division* County of Los Angeles, Department of Mental Health (40 min) B. 5 minute break C. Discussion and Feedback (60 min) D. Public Comments (5 min)	10:25–12:15
VI.	**Public Comments and Announcements**	12:15 – 12:30
VII.	**Adjourn**	12:30

The *INNOVA* Group, Inc. 714.504.7446 rigoberto@sbcglobal.net

Meeting notes from SLT held on February 20, 2013:

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MEETING NOTES

Department of Mental Health - Update	***Dr. Marvin J. Southard, Director*, County of Los Angeles, Department of Mental Health** Dr. Southard updated the SLT on two major developments for the Department of Mental Health. First, the preparation and implementation of health reform in Los Angeles County. He discussed the strength of the Los Angeles County model and how the model will assist in readiness and implementation, but also addressing potential obstacles DMH faces. Second, he discussed service integration with the partners for alcohol and drugs. He spoke about the creation of a new model for Alcohol and Drug Benefit for Medicaid that would be employed as soon as possible. In addition, Dr. Southard discussed the upcoming budget presentation to the CEO, highlighting the budget implications of the EPSDT match, realignment issues related to AB109 –specifically as it relates to covering costs for individuals who lose their funding after they leave AB109 programs, and finally how to characterize and plan on using MHSA funds going into the future. Finally, he noted that Antonia Jimenez from the CEO's office will conduct a focus group process with the SLT after the April 17th meeting. **FEEDBACK** A. **Question:** On the AB109 aftercare, will that problem be covered by the expanded opportunity to put people onto Medicaid and get 100% government funding? a. **Response:** Yes, only if they fit in the right category. If the individual is disabled then it is not 100% it is 50% federal funding. We are trying to make sure that everybody who is on AB109 gets enrolled in either Medicaid or the LIHP in preparation for that. The enrollment process is less robust than we hoped.

b. **Response:** We may need institutional help from mental health advocacy or organizations. I want to do an automatic signup program so that as people get discharged from jail, AB109 or not, get enrolled in programs they are eligible for. In the long run, this assists those eligible for Medicaid expansion and the kind of person that our health plan wants to enroll; young, healthy people who do not think they need medical care.

B. **Comment:** At the state level, we did something similar for juveniles because Medicaid benefits were cut off when they went into Juvenile Hall. It took 45 days to re-enroll them after they got out. The state terminated their benefits instead of suspending them. We worked on two things, automatic enrollment when exiting camp or the halls and a suspension mechanism instead of a termination mechanism. The model is there.

Response: There is a concomitant thing that happens with juveniles that we hope to extend to adults; if a kid is in a juvenile facility and they need to be hospitalized they had MediCal. That MediCal coverage applied in the hospital that they go to for the appendectomy or the mental health treatment. If they had MediCal before they get MediCal coverage. That does not yet apply on the adult side. We are seeing if the federal legislation can be changed to apply to the adult side. This would help our financial picture a lot.

C. **Question:** It's my understanding with MHSA that family members and consumers should be actively involved with all levels of planning. They advocated for a representative from NAAMI and United Advocates for Children to be a part of that work group.

a. **Response**: Health care reform is not MHSA. What we are doing within DMH is having our employees develop our process for implementation of health reform. The next phase is the community engagement. But first the department needs to know what it is doing.

b. **Response**: I thought with MHSA--the idea was to really push for family members and consumers to be active in all levels of planning. Why is it isolated only to MHSA? Health care reform is a massive change in the system. For clients and families to be shut out seems wrong.

c. **Response**: The advocates are not being shut out. We do not know what groups are going to be formed. The goal right now is merely to figure out what kind of structures we put in place to engage community for all of the decisions you are referring to.

d. **Response**: At this stage of the process its internal department of mental health managers that are structuring a process to then include community representatives.

e. **Response**: Different managers are responsible for different things. Since last Monday and Tuesday, my group is health neighborhoods. There are 4 or 5 people that I talk to that work for the Department of Mental Health. We are discussing how we will gather the stakeholders necessary to implement a health neighborhood approach. Some will be geographical. LA is so big; you cannot do everything at once. It has to be staged. So

	that staging process is what I am looking to develop. f. **Response**: Are you referring more to the broader policy discussions on how to implement the Affordable Care Act, statewide and county specific? g. **Response**: My understanding is that we are supposed to be involved with all levels of the process--even the very early stages. h. **Response**: DMH used stakeholder process to make important decisions before there was an MHSA. And it will continue to do so. So it's not related merely to MHSA. MHSA just became the latest manifestation of a commitment to community engagement with clients and families that started with CCC, which preceded MHSA. D. **Question:** With regards to health reform, is there going to be a concerted effort to work with younger people in developing programs with respect to alcohol and drug since the goal is to start programs prior to January 2014? a. **Response:** I am trying to expedite a benefit that is available widely because I think that is the best way of implementing a prevention strategy for MHSA. I do not run or start the programs for substance abuse, the Department of Public Health does. b. **Response**: I want to go on record that it's important for us to really consider programs for adolescence. c. **Response**: I agree completely. d. **Response**: The general literature for adolescence says it does not make sense to talk about co-occurring disorder. Addiction and mental illness are probably manifestations of a single disorder; and, among adolescents at least, probably indistinguishable. I would support the starting of those programs in exactly the way you are describing. E. **Comment:** That is a very strong concern of ours as well. We are intending to include adolescents and transition age youth in our service expansion. F. **Question:** I wanted to address a point you discussed in your budget hearing with the CEO about the EPSDT match and the possible dwindling local funds to cover that. I am most concerned about wrap around as part of the services that DCFS is heavily emphasizing to serve the Katie A class. How does the scenario that you presented impact the case rate on wrap around? How do you see that impacting the case rate? a. **Response**: I do not think it affects the case rate. We bill EPSDT to the maximum that we can bill EPSDT. What we cannot bill EPSDT for, in my understanding, is a part of the case rate, right? b. **Response**: Yes. If the EPSDT is up to 50% that would mean that the case rate would be 50%.

c. **Response**: No. So, the service has to be provided at 100% and paid for at 100%. How it is paid for is 50% federal, 50% local. So, DMH must find that 50% local from some place. MHSA, County general fund, wherever. There is no unspent amount or uncovered amount that drifts into the case rate.

G. **Comment:** What is case rate?

H. **Question:** Case rate is the non-EPSDT eligible portion of wrap around services. The 50% is really my question as to whether you believe wrap around services are only reimbursable at 50% EPSDT.

Response: No. Nothing has changed. The part that is EPSDT remains 100% paid for by Medicaid funds. Just the portion of that Medicaid payment that comes from local sources has moved from 10% to 50%. But the part that is covered by Medicaid is still covered in this exact same way. Our hope is that the Katie A. documentation manual will give us the ability to claim more things that were dumped into the case rate that will now be covered by EPSDT.

I. **Comment:** I want to talk about the stakeholders as part of the planning process. If we are talking about what a health neighborhood looks like without involving family and parents and consumers in it we are not going to end up with the same thing. I also wanted to ask Bruce Salser: have you been involved in any discussions about planning of health care with the Department?

J. **Comment:** Providers are already getting input in terms of health care reform. MHSA should not be the only place in the department that we include the various stakeholders. I ask that the department rethink its way of going forward and recognize that all stakeholders have an interest in helping design--if you are on your three "A's"--on your triple "A's"; the best experience of care--where are you going to get that from?

a. **Response**: I have had this conversation on what the department is doing with health reform with the Board of ACSA, the Client Coalition and the NAAMI execs at their monthly meeting.

b. **Comment:** In terms of a planning process, the first phase is design: what do you want to accomplish, who are the stakeholders, etc. This first phase typically does happen through informal conversations. It is through the design phase that you figure out the actual structure of the planning process. The second phase, you do the planning and make some decisions around the plan and then you do the implementation phase. The way I interpret Dr. Southard's comments is that, there is a design conversation going on right now and at a future point in time, stakeholders will be formally engaged in a planning process.

c. **Response**: I recognize that. I also recognize that we need to hit the ground running on January 1, 2014. We have less than a year. My experience is that if we take the design portion for months and months then the planning comes to us to complete in one or two months. I am pushing to get it happening earlier.

State Budget, Legislation & Related Issues - Update	***Susan Rajlal, Legislative Analyst,* County of Los Angeles, Department of Mental Health** 1. Mental health and increasing mental health in the schools seems to be a more palatable issue for many elected folks than stronger gun control. This is a time when we can take that opportunity to teach these officials what works. There are two bills that have been introduced. One is the Mental Health in Schools Act (HR62.) You will find a summary in your handouts. 2. Congresswoman Grace Napolitano introduced this legislation. She unsuccessfully introduced some form of the mental health in schools act approximately 4 times in previous years. This year there is more momentum. We have met with her and given her some input. 3. Dr. Tony Beliz runs a program called the 'School Threat Assessment and Response Team' program. Over time, we gained a lot of incite about what works with early intervention and prevention in the schools. Please consider giving your support through writing letters or contacting these offices to help the Schools and Mental Health Act be passed this year. 4. Senators Stabenow and Blunt introduced the Excellence in Mental Health Act (S264). It would establish a federally qualified community behavioral health center. This could be very important s because the FQHC have the option of obtaining funding that is not available to us because we do not have FQHCs. 5. If this passed potential available resources could fund the electronic health records. Another option would be funding capital facilities in communities. We want to support this bill and follow it. 6. Steinberg has gone to Washington and New York two weeks ago, as well as several other states talking about the successes we had with MHSA in California and how it could be a national model for delivery of mental health services and how early intervention and prevention works. He was received positively. He met with Vice-President Biden and has had a lot of inquiries. 7. At the state level, we are in the special session on Health Care Reform. The special session on reform has thus far dealt with bills that increase access to Medi-Cal eligibility by relaxing some of the rules. For instance, instead of monthly status reports there would be status reports twice a year. In addition, there would be presumptive eligibility. This would be a different way to compute eligibility and exclude the resource limits that existed in the past. 8. When thinking about health care reform we remember the larger goals that we have as mental health advocates. We can never lose sight of them. Truth of the matter is, right now, Sacramento is trying to set up basic structures before they even get to the part that includes us. We are following every day to see what has happened.

	9. There are 15 bills related to health care reform, right now. When you look at the summary you will see that most do not discuss mental health. We must review every line in every single bill because if we are not there then we should be. I they have put something in eligibility regulations or in some primary care regulation that would exclude us somehow; we need to be aware so that we can express our opinion of what should happen. 10. A lot of the health care reform will not occur in the special session on health care reform but as we churn out the changes and code, the bills, and as the budget is enacted. It's going to be a process where the county is watching all the time to see what the set-up of structure by the state so that we can respond. 11. We do have some principles: : inclusiveness, the rehab model, and cultural competence--that we are trying to make sure that everyone on the health care sub committees know about. We are watching all of these bills very intently. 12. The only bill that I wanted to call to your attention is SB22. This is a bill from Jim Bell, who has had a parity bill every year for the last 5 or 6 years. This year his parity bill focuses on enforcing compliance with mental health parity by setting up some standards to evaluate for. 13. The way that compliance was evaluated in the past is that if there were no complaints to the state agency that monitored then everything is okay. We know that everything is not okay. They are going to develop some new standards to see if people are served and to see if there are indicators that quality is delivered. 14. Approximately 3 weeks ago someone from CMHDA sent out a bulletin that said that the governor's home page showed a transfer of $37 million from mental health growth funds to cover CalWorks. We started looking into that and it seems that the Department of Finance worked with the governor to do that. The Department of Health Care Services was unaware and was not in favor of it and neither was Senator Steinberg. We want to make sure that that realignment deal that included the earlier realignment is not undone; that they do not recapitulate it in any way because we have an agreement regarding the funding. We want to see that it is enforced. 15. Daryl Steinberg is going to carry the LPS reform bill. Many are concerned about the proposal for LPS reform that came from the California Hospital Association because they felt it was one sided, only looking at the hospital's point of view. Daryl Steinberg indicated that he is going to carry this legislation, and that the wording will be released later this week or early next. He is very intent on hearing from everyone that is a stakeholder. 16. It is not going to be a bill that just reinforces those recommendations that came from the study group. There are many issues that he is concerned about that, in LA County, we could have solutions to. 17. There are lots of solutions to problems. Just because we are doing it one way does not mean that any of the counties are because every county is different. I encourage you to engage in the dialogue on this LPS reform law because many people willing to hear your input.

FEEDBACK

A. **Comment:** I want to call your attention of AB 252: it's the Yamada bill that is looking to reserve the payroll title of social workers to those that have a Degree in Social Work.

B. **Question:** You said to keep an eye out on some of these bills. Is it time to write letters? Or do we wait and see?

   a. **Response:** Right now we do not have the language on everything. We are getting it. We are looking at it. If it's time to write letters I will let you know. Usually I send out an email to stakeholders.

   b. **Response:** As the language progresses on these bills, can alerts go out to the SLT email list?

   c. **Response:** On the federal bills: now is the time to write letters.

C. **Question:** To get more information on the federal bills can they contact you directly? What is the best mechanism?

   Response: You can contact me if you want. But if you go on the internet and just type in the name of these bills you will get a lot of information.

D. **Question:** On HR628, can you give us a short synopsis of what it is asking for?

   Response: This is a bill that would give grants for mental health services funding to local school systems. If they get money for mental health services we want them to use evidence based best practices for prevention and early intervention for school violence. In addition that the money be used not only for students identified as being victims but also the bullies--that it be used to educate students and also family members. We want grants to be used to educate the school personnel in identifying who these kids are and when there should be an intervention and what the interventions are.

E. **Comment:** One clarification regarding the LPS reform meetings. Urgent cares are a great solution in terms of dealing with non-emergency mental health issues for people that need services. At times some individuals are released from a hold early in order to make more room. I think urgent care centers are great. I'd like to see those resources expanded.

   Response: Certainly. We know that in LA County. If there are solutions that you think of please do take the time to submit them.

F. **Question:** The LPS legislation seems to be against the current law. I work for patient rights and the multiple holds really goes against clients' rights and freedoms. If this does get passed and challenged in court, how do you foresee that? Or is the law going to change?

   a. **Response:** Many of the things that exist in law today were written in 1978; today, we are talking about a recovery, resiliency based model. We are not talking about restricting people's rights unless we have to. The language should reflect the current system of care that we have in improving that.

	b. **Dr. Southard's Response:** The law could be changed in ways that make it easier to hold people than is currently the case. There are two energy flows in regards to this. One is, 'just clarify the law to make it clear to everybody what the actual law really means ' The other stream of energy is, 'let's make the law clearer but also give greater ability to take action for cases in which we believe people ought to be treated involuntarily." In addition, there are a host of technical issues associated with both of these streams. You could go in stream A or stream B and have technical things that cause problems for hospitals, law enforcement, or mental health. In some ways, that is why some things have stayed the same because any change hurts somebody's viewpoint. We will watch to make sure that not clients, not hospitals, not law enforcement, not mental health, end up feeling an undue burden with whatever changes might take place. G. **Comment:** There is a third stream of energy and that is to adjust the law so that it is uniformly applied across the state rather than the very major differences in county to county, district to district, which is a mess. I also wanted to point out that there are now 45 cosponsors for 628. There are also cosponsors for S264. A major point of activity would be, on S264, to bombard our senators with letters urging co-sponsorship. H. **Question:** You said to "push for best practices." My concern is that a lot of the best practices do not serve some of our cultures. What about promising practices? **Response:** We include promising practices as well.
Follow Up Items: Prior SLT Meetings - Update	N/A
FY 2013-2014 MHSA Annual Update	Debbie Innes-Gomberg, Please see MHSA slides included in SLT Meeting Handouts. CSS PLAN A. **Question:** With the navigators, do we have data on how many clients are actually connected to services through the navigators? **Response:** We do not at this time. It is a resource issue but we want to address this question. B. **Question:** On slide 13 why are there so few services extenders for older adults? **Response:** Service extenders are a very small part of the budget. The numbers are fairly consistent year to year.

C. **Question:** When are we going to start breaking out the Middle Easterners and Russians from 'White'?

Response: That question comes up about once a year in this meeting. It's an IT issue that I will bring back to IT. [Subsequent to meeting – the "white" category will have greater definition once our Electronic Health Record is implemented]

D. **Question:** On slide 36 and 37, when we look at PEI and housing situation are we controlling for age? If we are just getting older PEI who are living independently that looks weird.

Response: No. The way we do housing outcomes is that you look at the client the year prior and compare any changes, positive or negative, so that may or may not be a function of age. It's a limiting factor in the sense that somebody may start at age 17 and then at 19 they are still in FSP but get housed. It's hard to know whether that was solely a function of age or, the fact that they were in FSP that helped. We cannot say that definitively.

E. **Question:** Have we looked at the FSP dropouts and what happened in terms of services used the year after the dropout?

Response: We have not, but that would be a great thing for a graduate to get involved in doing.

F. **Question:** Is there an explanation of why the amount of children served went down while the adults and older adults went up?

Response: When comparing clients served in Fiscal Year 10/11 with those served in Fiscal Year 11/12, the number of children served in Fiscal 11/12 decreased by 7%, TAY increased by 23%, adult increased by 6.5% and older adults had no change.

G. **Question:** If you just love this data and want to look at more of it is there a website or is there a way to look at past years' reports both within the county, and maybe this would be a question for Richard, statewide; can we compare one county to the other?

Response: The annual updates, to the degree that we presented the data in the same way, would be able to give you snapshots, fiscal year by fiscal year. Most of those on our website--one of them is probably archived--but I have them all. We could do a neat analysis.

H. **Question:** On slide 51, there is a notation on the right – "lost contact." Have you looked at whether the lost contact is due to the family, I am talking mainly about children and PEI, not feeling comfortable or not feeling that their needs are being met through the services provided. Under the full service partnership, slide 51, when we say 'discontinued' and 'lost contact' is there any way within the OMA, to differentiate some of the questions asked or any comment section.

Response: I am going to check in with children system of care because, on an annual basis, they do a customer

	service satisfaction survey with FSP families. They may look at that. I am not sure. But it's a good question. I think that could tie into the quality improvement effort that I think we might undergo. I. **Question:** In terms of the move, I read a DCFS case in which the child had been referred for services, and lived in Santa Clarita, and then the family moved to Palmdale. And there was no link. Do you look at the link being referred from one service area to another or one provider to another? **Response:** We do. It's actually part of the transfer process in FSP. J. **Question:** Regarding information on the urgent care centers: where did the clients come from? If they are referred from the hospitals or walk-ins, the police? Do you have that? **Response:** I know we do at least for some of them, for example Exodus Recovery reports on that. K. **Question:** Inevitably, these tables will be taken out of context from the report and show up elsewhere. Have you looked at listing sources and dates, even small, on these individual examples so that you can know where it really came from--with the date, etc.? **Response:** We draw the data at a certain point. We draw the outcomes from the outcome measure application. Or, in the case of the urgent care centers we get that from Mary Marx. So we have documented how we got the information. The annual update itself should sufficiently address how we do that. L. **Question:** I have a general question about the proportion--the number of older adults served, proportional to population. And I do think that is a question that should be on the table. **Response:** Claiming analyses demonstrated cross cost growth for each of the age groups from FY 08-09 through FY 11-12, despite decreasing MHSA allocations. Proportionally, older adult gross and net costs have decreased though from FY 08-09 through FY 11-12. M. **Comment:** A comment on 25% with older adults: given the limited number of older adults in full service partnerships, as some of the older adult providers have been transitioning to EHRS, including our own, there are clients that were kept on the record in FSP because of a transition process, billing process, things like that--so I think there may be a little of a data glitch in that 25%. N. **Question:** I am curious about putting these numbers in context. Any program the client actively participates in, I think, is going to be successful. What is our jail rate is for people with mental illness? What is our incarceration--arrest rates? And has that changed since MHSA has been implemented? That would be these numbers in a context of the system as a whole. **Response:** We did a lot of research when we did the CSS plan and of course when we did PEI. We may be able to go back to look at some of that data.

O. **Comment**: I liked Jim's question comparing data from years prior to this year. I hope I can get that information. When, I look at some of the API rates and it's always less than 1%--you know at least we have some absolute numbers so I appreciate that.

Response: It's a quality improvement issue. What I am hearing several of you say is, maybe I will bring this to the MHSA implementation meeting, because if we can have a couple of age groups agree to do some sampling, take a look at the clients that dis-enrolled for those particular reasons, and then go to providers and find out if there is more information, we can glean why this happened and how to prevent it in the future? It is a good idea.

P. **Question:** On slide 62, it talks about clients reported activities--social, spiritual, all that, recreation activities--do you have a question about actual participation; not just having the opportunities?

Response: After reviewing the instrument, the question does not ask about actual participation. ASOC has indicated they are reviewing this instrument.

Q. **Question:** On slide 61, access to stable adults: does that include living and not living with the client?

Response: Access to a stable adult is broad. It could be parent, a friend, or somebody you are living with or not living with. It is broad, intentionally.

R. **Question:** What are your written conclusions from your data analysis such as the outcomes or effectiveness of services or the impact on the clients, so forth and so on? If you talk to the general public, or a client, or someone that is concerned about outcomes this can be confusing. Can you tell us what you are getting out of that data that tells us if we are moving in the right or wrong direction? What is the department thinking around these numbers?

Response: I could give you an assessment, but I prefer that each of you take this data back and have a conversation with your constituents about what it means to you. My interpretation though is that we have to do a much better job as a system at improving. First of all, giving clients experience in the community, and integrating them into the community. In a way, that changes the role of the treatment team. I think FSPs excel in reducing some of these negative outcomes but then it's that transition to really getting a full life-where we need to go next.

PEI & INN PLAN

A. **Question:** We discussed including promising practices but I do not see it listed here.

Response: Sometimes we use the 'catch all' phrase evidence based practices. It includes every PEI practice that we do, including promising and community-defined evidence practices.

B. **Question:** When we were talking about housing for PEI and even for adults, you were saying that the number represented those who are receiving services. Is that for people who have applied for services in housing? Or is that

	the number of people who actually received housing? a. **Response:** Are you referring to FSP outcomes or are you referring to PEI housing? b. **Response:** PEI housing. c. **Response:** That is the number of clients served by housing. d. **Response:** They are actually in their own housing? Or is that including multiple patients live in situations? e. **Response:** It is anybody outreached and served to get housing. f. **Response:** That is the distinction I wanted to hear. They were served to get housing but are not necessarily in housing. C. **Comment:** I wanted to make a statement regarding EBPs —and promising practices.' It was stated that those are included. It is our experience that if it is not clearly stated in whatever you are trying to do then it will not be included. Make sure that promising practices is stated. D. **Question:** In terms of law enforcement, what is the interaction between CSS and law enforcement? **Response:** Many of our programs, particularly our FSP program and our Start program are funded through PEI and have strong contacts with law enforcement. If a consumer is detained by local law enforcement they will work with that jurisdiction to help that client not go to jail. Several FSP programs give their clients cards that say--and they can choose to keep them and put them in their wallets or purses--but it says, 'I am a member of 'this' FSP program. If you need to contact my case manager. Here is their number.' E. **Question:** I had a question about the crossover motion of allocation of funds. Would that have come from PEI? You said earlier that there was not any change in PEI funding and therefore you did not have to include that as a request for approval. But wasn't that a prevention? a. **Response:** No, the crossover proposal was funded by the Community Services and Supports Plan. That was a midyear adjustment to the FY 12/13 Annual Update. b. **Response:** And really the reason for that is the service being offered is for somebody who is already affected by mental illness. It is preventing crossing over but it is not preventing mental illness. So the prevention that PEI refers to is preventing mental illness, not preventing incarceration. That is why, for a programmatic reason, the funding came from CSS. F. **Comment:** The data system, state wide, is this old Legacy system--that it does not get this information and we really need to change that whole data system. The state should copy LA because LA has figured out how to do it in terms of the data issues. There needs to be a more serious push toward using some of the state money that is left, which is a

	hundred million plus, toward some consumer and family employment training. There has not been sufficient input from the consumer and family organizations to the new WET plan. It would behoove NAAMI folks and client coalition folks, etc. to get involved in this because it is out of mental health's hand. It's over at OSHPID, the state health planning department. **Response:** In response to Richard's observation, I just got an email today that Angelita Diaz Akahori from our Training Division was appointed to the OSHPD advisory group on this matter. So contact Angelita and she will have access to getting information about things we want in that plan. G. **Question:** How are you breaking out the Hispanic compared to how the census is now collecting that information? Are you not counting them in the sort of 'Whites' or 'African Americans' because you are counting them as 'Hispanic'? a. **Response:** Correct they are counted as Hispanic or Latino b. **Response:** The census data is counting them as separate but you are not. c. **Response:** That is our information system. I am not sure if that follows CSI or not. That is our information system. H. **Question:** With respect to slide 78, will the SLT have to wait until March 1 when the update is to find out which contracts will continue and which will not? For example, the $100,000 grants that were given out under PEI? Dr. Southard, at an earlier meeting, had indicated that some of them were up and running and others were not. There was an impression that some might not. But is there an idea as to who is in and who is not in, in terms of money, not only at the $100,000, but other monies? **Response:** First let me point out that for next fiscal year we are going to see a drop in overall funds related to this fiscal year due to that one time bump up. So as a result of that, we are not going to be making a lot of changes. We are going to be using carry over money to sustain us. In terms of the prevention funds you are talking about those programs are being evaluated now. I. **Question:** Does the SLT weigh in on recommending a continuance or not of these programs? Does the SLT get involved in the program level discussions or is it more at the provider level? **Response:** I think that at the provider level, if I understand you--we would not be--but I do think that it would be fair in an upcoming SLT meeting to bring the results of the evaluation of the programs. J. **Comment:** In regards to the FSP children decline, you mentioned it had to do with satisfaction or evaluations with the parents or something? **Response:** I did mention that children system of care does an annual satisfaction survey.

K. **Comment:** Right. There are a lot of declines and that it's something I do not think we can capture.

L. **Question:** What is a decline?

M. **Comment:** People getting out of FSP; disenrollment. It is not a question you can ask because no one will respond. We just know about it. There is a fear that parents have, that a provider will go on and get involved and before they know it their children will be removed. Truth or not truth. That is not that the agencies are doing something wrong or that the family is doing something wrong. It's just that they have that fear.

Response: I will tell you that the parent advocates are part of that process. That has helped that.

N. **Comment:** Because we continuously look at this data one of the things that we have to look at is what happens to the system as we sequentially roll out programs. What is of significance is the relationship between CSS and the PEI implementation for children. In the past, we have had certain kinds of very high intensity mental health services but not the advantage of short-term evidence based practices for children. Children got what was available. We now have a continuum of care for children. So we witnessed exponential increase in children being served by, first FCCS programs, when those rolled out and then with PEI programs, once we implemented the PEI services. It means we are delivering the right amount of service to children at the right time. What is also important--if you look at the numbers--although the numbers of children seen in CSS programs declined slightly the dollar amount of the services rendered continue to rise. That supports the hypothesis that children that really need high intensity services get high intensity services. I think we have to look not just at the individual programs but the system as a whole to try and understand some of the data. It may not be an explanation that is contained within a program.

O. **Question:** What is happening with the WET funding—for example, the action items we had, some of them have not come out. What happened to that funding? Has that already been taken and put somewhere else?

Response: No. You will see this in the annual update. We have a table that has the status of each of the WET projects; because WET had a, I think it's a 10 year reversion program, as opposed to a three year. Some of the WET projects were not implemented as quickly just because of resource issues.

P. **Question:** My concern is the use of the Evidence Based Practices (EBPs), the tables that you have for the EBPs. There are a lot of those--most of the cultural groups are included in those tables. They are not separated as we see. A lot of those EBPs are not translated or adapted to different cultures.

a. **Response:** Yes. In our outcome reports, there is an ethnicity break down. Once CIOB creates the XML process then you can look at your raw data and start to do the analyses that you are talking about. We are reporting on ethnicity. As you do see with PEI, there is a high percentage of clients that are Latino. As we drill down into that data, we will look at which practices are effective and for what populations. The biggest issue with PEI right now is the lack of post outcome data. We need to get enough matched comparisons so we can do the analysis that

you want us to do.

b. **Response:** How are you going to do it when you do not have the translations?

c. **Response:** We actually do.

d. **Response:** --Well there are no translations for Armenians for EBPs. We are having a problem with using it with the Armenian population. Others like the Arabic or the Russian populations. They may be having some problems with that too.

e. **Response:** I hear two questions. The one question is about which EBPs have already been translated to these target populations. The second question is for those that have, what are the outcomes and how can we find out what kinds of outcomes?

f. **Response:** No, my question is not about outcomes. My concern is if we do not have the data and the translation of those EBPs for the different cultural groups then we may drop some of the EBPs that can be very useful for the different cultural groups.

g. **Response:** This is something that perhaps when we meet with the UREP leadership. We need to do something about it. We have taken a look at a lot of these EBPs and promising practices as well as so called CDEs. Especially for the EBPs, some of these developers; the translation is just not available. They are proprietary. So we have to go through that whole dance with some of them. Some of them we can translate. We need to dedicate some time to figure out which ones--and money yes--but I think that is something that maybe we can talk about and have as part as something we commit to move things forward.

Q. **Comment:** American Sign Language is pretty much accepted as the fourth most common language here. Why is it not on your list? Why aren't you tracking that?

Response: ASL is included

R. **Question:** The intent of the Mental Health Services Act in Prop 63 was to expand mental health care. Is there data on the unique number of individuals served by the MHSA? Is there data that we could look at for the number of individuals served by the DMH across all funding sources and then compare the number of people served today compared to 5 years ago when the MHSA was implemented? Is there some measure of unmet need, to see in fact, if we've actually made a dent in unmet need or have we really expanded the mental health services in a way that the act was intended?

a. **Response:** That is a great analysis. It is one of those things that I think we will have to undergo in our next planning process for the integrated plan; whatever that might look like.

b. **Response:** You can look at the information sent to CMIH that showed that client counts. We saw over the past few years there are less folks served obviously in none MHSA funded--so that whole thing shifted over time--so

	if you want we can send that out with the minutes if you want to take a look at that. c. **Response:** Right and then the real careful nuance is the extent to which criminal justice data is included or not included because if you include the jail mental health programs and the probation programs the end goes up sharply in various compilations of data through the years. Sometimes it's been in and sometimes it's been out. That is one of the things that we would need to be careful; that we are getting a uniform data source for that. The point is well taken that it would be a valuable thing to look at. S. **Question:** I wanted to go back to field capable clinical services. It seems like the markers that were used at baseline, were all pretty favorable and then there was not much change at the point where they looked at the end of the year. I am wondering has there been any thought as to whether these are actually very good markers for judging if this program is actually effective or not? **Response:** It is a great question. We have not spent a lot of time addressing your question yet. At a certain point we realized that the first 4 or so 5 indicators do not tell us a lot then we probably need to re-evaluate our evaluation strategy. We selected these based on what we thought FCCS would yield and it has evolved over time. I would suspect that in the next year or so that we could re-evaluate how we evaluate FCCS, maybe as part of the integrated plan. T. **Question:** Why is there is such a large number of known or unknown EBP? **Response:** I think it is a function primarily of providers ramping up in terms of understanding--this is from 11/12, this is last fiscal year--but we have talked over and over again about importance of identifying--at the point at which you say this is a PEI client--the practice that you are going to provide that client and then indicating that in the EBP field. And clearly, as of last June, providers are still struggling with that. U. **Question:** Why is there is no uniformity between the different service areas in EBP? For example there is no grief counseling in one of them or parenting in another. Who decides which EBP is offered? a. **Response:** When we originally went through the PEI process, service areas selected their priorities in terms of evidence based promising and community defined practices. When you compare the planning process to the children's implementation of PEI it differed a little bit because of transformation. But, one of the things I think would be a really rich discussion at the service area level would be to go back to that plan and say, 'for your service area, is this the right mix of services? b. **Response:** As the service areas chose the menu but then the provider chose the entrees from the menu because some providers did not implement choices that they could have picked from the menu of services available. In the implementation some of the providers did not have the workforce to actually implement a particular practice. That is why it did not happen.

	V. **Comment:** I want to get on record that the WET training for parents, family, and peers did not involve evidence based practice training. I know the department is taking steps to change that. So I am just putting that out there; that we need to make sure that we are doing EBPs at every level. W. **Question:** With WET, does it include students that may be in school that may want to be in that program? **Response:** It does. We have sent a number of folks back to school, including participation in the mental health loan assumption program, which is now overseen by OSHPOD. X. **Question:** With Innovation, I know originally you said it was going to be like 3 years. Is it 3 years from the time they start? **Response:** For Innovation, at the moment, we got a pretty late start; so at the moment the services are still going through FY 13-14. But we realize that the learning may take longer than that so we are exploring options. Y. **Question:** As far as the service area advisory councils--how much time do we have to give input into your final update? **Response:** You have until the annual update is published to do that. So obviously the sooner you can get comments in the better. You have until April 18th. Each service area should go back and review all the service area data that is in the annual update. But, basically go back, in terms of PEI, take a look at the practices in your implementation. Does it meet the needs of your service area? Is it consistent with how you thought PEI would be implemented in your service area? Z. **Question:** How does this play out against health care reform because a major portion of that is about prevention. Health has some prevention programs that they have and use to try and prevent the onslaught of major issues as time goes by. But the question is we need to make sure that our effort around prevention is strong and clear in mental health portion of that as well because we have a lot to say about that. So, hopefully that is being taken up as a part of this redesign. **Response:** In the last couple of months the focus and the understanding of what prevention and early intervention are have really risen, in part, due to some very tragic incidents. The focus on how you prevent mental illness from occurring or how you prevent violence from occurring has really risen nationally.
Public Comments and Announcements	A. **Question:** On slide 10, the service to children declined--could it be related to the laws that give children to ability to choose whether or not they have services? Could that be tracked? Response: I do not know. Given the relative lack of change in terms of the number of clients served I really would think not. But I do not really know. 3180 versus 3104; a little bit of a drop in FCCS but I think not.

	B. **Announcement:** regarding free dental care (flyers available). C. **Announcement:** LA community college partnering project is having a mental wellness day: bridge the gap to empowerment. It's about education and employment. We are doing collaboration with DMH and LA trade tech college. It's going to be Wednesday February 27th from 8:30 AM - 4 PM. D. **Announcement:** There is the 14th annual [inaudible] hope and recovery conference: building wellness. Tuesday April 9, 8:30 AM - 4 PM at the Doubletree by Hilton in Culver City. (flyers available)

SLT MEMBERS
February 20, ,2013

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH SYSTEM LEADERSHIP TEAM - MEMBERS SIGN-IN SHEET 2013

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SLT MEMBERS
February 20, ,2013

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SLT MEMBERS
February 20, ,2013

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH SYSTEM LEADERSHIP TEAM - MEMBERS SIGN-IN SHEET 2013

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MARVIN J. SOUTHARD, D.S.W.
Director
ROBIN KAY, Ph.D.
Chief Deputy Director
RODERICK SHANER, M.D.
Medical Director

MHSA FY 2013/2014 ANNUAL UPDATE
AVAILABLE FOR PUBLIC REVIEW

March 1, 2013

The Los Angeles County Department of Mental Health (LACDMH), as required under the Mental Health Services Act (MHSA), is opening a Public Review and Comment period for the MHSA Fiscal Year (FY) 2013/2014 Annual Update. The Public Review and Comment period will begin March 1, 2013 and expires March 30, 2013. During the Public Review and Comment period, an open Public Hearing will be held at St. Anne's, 155 N. Occidental Blvd., Los Angeles, CA 90026. The Public Hearing will be hosted by the Los Angeles County Mental Health Commission on April 18, 2013 and the reception is scheduled to begin at 11:30 AM.

The document under review is posted on the LACDMH website (http://dmh.lacounty.gov/wps/portal/dmh/press_center/annoucments), and hard copies are available at the LACDMH MHSA Implementation & Outcomes Division, 695 South Vermont Avenue, 8th Floor, Los Angeles, CA 90020. Any member of the public may request a hard copy of the document by contacting Debbie Innes-Gomberg, Ph.D. at 213-251-6817.

To provide input, recommendations and comments, please email your comments to DIGomberg@dmh.lacounty.gov or submit written comments to:

Los Angeles County Department of Mental Health
MHSA Implementation & Outcomes Division
Attention: Annual Update 13/14
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

PUBLIC ANNOUNCEMENT

PUBLIC HEARING OF THE

LOS ANGELES COUNTY MENTAL HEALTH COMMISSION
Dr. Larry Gasco, Chairperson, Presiding

Thursday, April 18, 2013
11:30 AM – 3:00 PM
St. Anne's Auditorium
155 N. Occidental Blvd.
Los Angeles, CA 90026

Public Hearing Goals

- Mental Health Service Act (MHSA) Fiscal Year 2013-14 Annual Update
- Provide an open forum for Public Comments on current progress of work plans and implementation efforts and funding request for MHSA FY 2013-2014

Agenda

11:30 – 12:30 PM	Reception (Lunch provided)
12:30 – 1:00 PM	Opening Session (Welcome &Introductions) – Dr. Gasco
1:00 – 1:10 PM	Overview of Public Hearing Process – Susan Rajlal
1:10 – 1:45 PM	Annual MHSA Update – Dr. Innes-Gomberg
1:45 – 2:40 PM	Public Comments Period – Dr. Gasco
2:40 – 2:45 PM	Close Public Comments Period – Dr. Gasco
2:45 – 3:00 PM	***Next Steps** – April 25, 2013 Full Commission Meeting

- Spanish & Korean translation services will be available
- For American Sign Language and other translation services contact: Cheryl Peterson at (213) 251-6827 by Thursday, April 4, 2013
- MHSA documents and meetings are posted for public review and comments at: http://dmh.lacounty.gov/wps/portal/dmh/press_center/announcements
- Media inquiries: Kathleen Piche, PIO, (213) 738-4041

*The Commission will be conducting its regular full meeting on April 25, 2013. At that meeting, the Commission will have its final discussion on the process and propose a motion.

For more information, please contact the Office of the Mental Health Commission at (213) 738-4772 or email your questions to Mentalhealthcommission@dmh.lacounty.gov

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA Fiscal Year (FY) 13/14 Annual Update
30-day Public Review and Comment Period
March 1, 2013 – March 30, 2013

PUBLIC REVIEW

Name: Nella Hollingsworth
Agency/ Organization:
E-mail address:
Mailing Address:

I would like the support at Women Community Reintegration Services to continue because a lot of us need this need help and support and the services they have to offer. The of the main services is the supportive employment program

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County of Los Angeles - Department of Mental Health
MHSA Implementation and Outcomes Division
Attention: Debbie Innes-Gomberg
695 S. Vermont Ave, 8th Floor
Los Angeles, CA 90005
Fax # (213) 351-2762

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA Fiscal Year (FY) 13/14 Annual Update
30-day Public Review and Comment Period
March 1, 2013 – March 30, 2013

PUBLIC REVIEW

Personal Information (OPTIONAL)
Name: Adelina Sorkin, LCSW/ACSW
Agency/ Organization: SLT Member
E-mail address:

Comments

TAY Housing providers should use Housing First model to increase occupancy and address need.

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PUBLIC REVIEW

Name: Angela Cervantes
Agency/ Organization: Women's Community Reintegration Services & Education Services
E-mail address:
Mailing Address:

We would like to keep supportive employment services. It gave me a second chance, and changed my life for the greater.

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PUBLIC REVIEW

Name: Cynthia Wynder
Agency/ Organization:
E-mail address: NA
Mailing Address:

I would like To become A Peers in the Future I would like the Employment Support To carry on. At Womens Community Reintegration Services & Education Center

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PUBLIC REVIEW

Name: Sparkle Whalen
Agency/ Organization:
E-mail address:
Mailing Address:

I would like to become a peers in the futuers
I would like the Empolyment Support to and the Scruices. they have to offer.

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PUBLIC REVIEW

Name: Souville Martinez
Agency/ Organization:
E-mail address:
Mailing Address:

I would love to see this program push through for the simple fact that they are women out there who needs this kind of program. they need help to stay clean. We would love for it to stay at the Women's Community Reintergration Service Education Center. Because we learn that we are safe and loved. So I Beg could you please remain this programs open. Especially the Supportive Employment Programme.

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PUBLIC REVIEW

Name: Danielle Young
Agency/ Organization:
E-mail address:
Mailing Address:

I would like to see the Supportive empmloyment Program Continue at Women community Reintegration Sevices Education Center

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PUBLIC REVIEW

Name: Catherine Clay
Agency/ Organization:
E-mail address:
Mailing Address:

I Catherine Clay belive that it is imporant to keep supportive work going here at Womens Reintegration Center.

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PUBLIC REVIEW

Name: Sparkle Whalem

Agency/ Organization: Women Reintegration Center

E-mail address:

Mailing Address:

I Sparkle Whalem is asking the you're please leaving back ave peers program. and Supportive Work for the Womens Reintegration Center.

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PUBLIC REVIEW

Name: Cynthia Hill

Agency/ Organization:

E-mail address:

Mailing Address:

I want to keep supportive services going at Womenk Community Reintegration Services & Education Center.

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This email was received (sender redacted) by Dr. Debbie Innes-Gomberg on April 17, 2013. More information is needed to answer some of the questions. Some issues will not be able to be addressed until the Department begins its planning process for the MHSA Integrated 3 Year Plan. DMH responses are noted in red:

Hi Debbie,
As I went through the report, I noticed on page 154 that comments can be made until April 18th in terms of the Service Area Advisory Councils, so I'm hoping that you could accept a few belated comments from DCFS on the MHSA Annual Update. I hope you will be able to respond, if not publically than at least to me.

1. Can you please explain the rationale for the difference in the proportionate spending and numbers of clients served between the populations of children verses transitional age youth?
   DMH: Need more information to answer question. Average cost/client for CSS and PEI for child and TAY does not differ much.

2. It appears that the relative rate of funding will remain unchanged for children; is the assumption that their needs are being served adequately by this funding plan? Does DMH presume the same for TAY?
   DMH: The FY 13/14 budget does not allow for an increase in services to any age group.

3. Why is the number of unique TAY FSP clients only 34% of the number of unique adult clients served in FY 11/12?
   DMH: The percentage of unique FSP clients per age group has not changed in FY 11/12, compared to FY 10/11 and FY 09/10. Child increased from 24% in 09/10 to 31% in FY 11/12. TAY varied between 15 and 16%. Adult peaked at 56% in FY 09 and then remained constant at 48% for the next 2 FY's.

4. Why is the number of unique TAY FCCS clients on 22% of the number of unique adult clients served in FY 11/12?
   DMH: When age groups made the decision to expand FCCS, it was largely due to the loss of CGF and the transformation to an appropriate MHSA service. Because the TAY system of care was just developing itself, there was much less of a CGF reduction and a need to transform to MHSA.

5. How does the FY 13/14 attempt to bridge this gap in services, especially in light of the loss of AB3632 opportunities to serve the mental health needs of younger TAY youth?
   DMH: The Department is making all efforts to ensure that children and families who need services obtain those services within the existing array of services.

6. Page 34 of the report says that capacity will be expanded to assist TAY FSP clients to transition to a lower level of care while increasing the number of FSP slots using unused FSP flex funds, but how many more TAY youth will be served by this increase in FSP slots? Will it be a significant expansion of services?
   DMH: This shift will be allowed only to the extent that the 51% balance of CSS funds to FSP in maintained.

7. Prevention and Early intervention client counts are also significantly lower for TAY than for children (varying from 10.70% of the total population served in Service Area 5 to 24.69% in Service Area 3) in 11/12. Is there any plan to significantly increase that proportion of the population of TAY served by these programs?
DMH: The agreed upon 65% of the service recipients for PEI would be child and TAY aged. During FY 11/12, 70% of PEI services countywide were provided to child and TAY aged clients.

8. How are the 13/14 PEI funds to be distributed across the age groups? Within the Child and TAY populations, what are the budgeted allocations for each program?
DMH: No significant changes are being proposed for FY 13/14.

DISCLAIMER: This is NOT a certified or verbatim transcript, but rather represents only the context of the class or meeting, subject to the inherent limitations of real-time captioning. The primary focus of real-time captioning is general communication access and as such, this document is not suitable, acceptable, nor is it intended for use in any type of legal proceeding.

DMH – PUBLIC HEARING
APRIL 18, 2013
ST. ANNE'S, LOS ANGELES, CA
CAPTIONING PROVIED BY
TOTAL RECALL CAPTIONING - Transcript of public comments after Annual Update Presentation:

SO WE'LL START IN ABOUT TWO MINUTES. YOU CAN BRING UP YOUR COMMENT CARD UNTIL WE RUN OUT OF TIME. AT 2:45 WE'LL STOP. WE'LL END THE PUBLIC COMMENT PERIOD AND WE'LL HAND IT BACK TO LARRY GASCO AND WHAT WE AGREED TO, IF MEMBERS OF THE MENTAL HEALTH COMMISSION WANT TO ADD ADDITIONAL COMMENT, REFLECTION, ETCETERA, YOU HAVE THOSE 15 MINUTES. IS THAT OKAY? MAKE SURE YOU BRING YOUR COMMENTS UP. SO WE HAVE 5 ALREADY. YOU HAVE ONE MINUTE TO EXPRESS YOUR COMMENT. RIGHT AFTER YOUR COMMENT, DEBBIE WILL EITHER RESPOND TO IT OR FIELD IT AND WE'LL START WITH THIS AND WE'LL JUST ALTERNATE. LET'S GO AHEAD AND START THE PUBLIC COMMENT PERIOD.

AUDIENCE MEMBER: WELL, MOSTLY, I HAVE A CONCERN. WE WENT THROUGH AN EXTENSIVE PLAN FOR OUR PEI, AND WE PICKED OUR EVIDENCE-BASED PRACTICES. THE THREE TOP ONES WE PICKED, TWO OF THEM WAS NEVER IMPLEMENTED. AND I WANT TO KNOW WHY.

DEBBIE INNES-GOMBERG: YOU WANT TO KNOW WHY?

AUDIENCE MEMBER: YES.

DEBBIE INNES-GOMBERG: LILLIAN, ARE YOU HERE? SO THE QUESTION WAS WE HAD A COMMUNITY BASED PROCESS FOR EARLY INTERVENTION WHERE RECOMMENDATIONS WERE MADE FOR EVIDENCE BASED PRACTICES AND IN SOME CASES, THEY WERE NOT IMPLEMENTED. THERE WERE A NUMBER OF REASONS WHY PRACTICES WEREN'T IMPLEMENTED. SOME OF IT RELATED TO THE LACK OF CAPACITY FOR TRAINING. OTHERS RELATE IT TO AN INABILITY TO ADOPT THE PRACTICE. THINGS ALONG THOSE LINES. SO I WANT TO ADDRESS IT SPECIFICALLY.

AUDIENCE MEMBER: I WANT TO SAY ONE MORE THING ABOUT IT. I WANT TO ASK. DO WE HAVE OPPORTUNITY TO CHOOSE THE OTHER ONES WE WANT?

DR. GASCO: THE ANSWER IS NOT NOW, BECAUSE THIS IS A PUBLIC REVIEW OF THE PLAN THAT HAS BEEN, RATHER THAN THE NEXT PROCESS WHICH IS THE PLAN THAT WILL BE. THE NEW PLAN, THE NEW 3-YEAR PLAN, THAT'S WHEN YOU GET TO ADD THOSE NEW THINGS, AND THE ANSWERS TO AS DEBBIE SAID ARE SPECIFIC TO THE ONES, TO THE PARTICULAR PROPOSALS, ABOUT YOU THEY GENERALLY FELL INTO TWO CATEGORIES. ONE IS WE COULDN'T FIND A PROVIDER THAT WAS WILLING TO DO THE PARTICULAR PROJECT OR THAT THE COST OF TRAINING EXCEEDED THE AMOUNT THAT WOULD HAVE MADE IT PRACTICAL TO ACTUALLY IMPLEMENT BECAUSE SOMETIMES THE EBP'S ARE LIKE COPYRIGHTED. [SOMETIMES TRAINING IS PROHIBITIVELY EXPENSIVE] A TRAINING THING AND THEY WOULD CHARGE US AIRFARE FROM BOSTON TO DO THE TRAINING AND IT WOULD HAVE BEEN TOO EXPENSIVE. THOSE ARE THE TWO BIGGEST, BROADEST CATEGORIES.

AUDIENCE MEMBER: NEXT YEAR, ARE YOU GOING TO TELL US THAT SO WE'LL ALREADY KNOW?

DR. GASCO: WELL, WHEN WE KNOW MORE ABOUT IT, YOU'LL KNOW. SOME OF THIS WE DIDN'T REALLY KNOW OURSELVES. WE KNEW THESE WERE EVIDENCE-BASED PRACTICES. WE HAVE LEARNED A LOT. SOME OF THE PEOPLE WHO DO EBP'S ARE VERY FLEXIBLE, AND SOME ARE VERY RIGID.

MODERATOR: CAN SHE COME BACK TO YOU? PHYLLIS?

AUDIENCE MEMBER: I WANT TO FOCUS ON THREE ITEMS. MAINTAINING FUNDS FOR PUBLIC SPEAKING TRAINING. IT'S IMPORTANT AS IT IS FOR PEOPLE TO BE ABLE TO EAT AND DRINK EVERY DAY. IT'S IMPORTANT FOR PEOPLE TO LEARN YOU HOW TO SPEAK, TO ADVOCATE FOR THEMSELVES AND OTHERS AND TO LEARN TO COMMUNICATE IN GENERAL IS A PLUS. THE SECOND ONE IS MAINTAINING THE LINES FOR VARIOUS CULTURES AND ETHNICITIES THAT'S A WAY TO KEEP HOSPITAL COSTS DOWN AND IT'S PROVEN TO BE A VERY SUCCESSFUL PROGRAM. AND THE THIRD ITEM WOULD BE MAINTAINING THE SERVICE EXTENDER PROGRAMS TO ASSIST PEOPLE RETURNING THE WELLNESS COMMUNITY TO SHELTERS, FROM GOING TO NEW YOU HOUSING EDUCATION AWAYS, LEARNING INDEPENDENT LIVING SKILLS AND A MORE BUDDY-BUDDY FRIENDLY SYSTEM.

DEBBIE INNES-GOMBERG: THANK YOU. THOSE ARE GOOD INVESTMENTS.

AUDIENCE MEMBER: I'D LIKE TO SAY THAT I'M VERY SUPPORTIVE OF THIS PROCESS AND YOU PUT IN A LOT OF HARD WORK AND I DEFINITELY WANT TO SEE THIS BE PASSED TODAY AND BROUGHT FORWARD. SO I JUST WANT TO SAY THAT I DEFINITELY APPRECIATE ALL THE HARD WORK THAT DMH HAS PUT IN; HOWEVER, I ALSO NEED TO BE UP

FRONT AND THAT THERE ARE SOME CONSTRUCTIVE CRITICISMS THAT I WOULD LIKE TO MAKE BUT I'M NOT WANTING TO DO IT RIGHT NOW. IF I DO THAT, I FEEL THAT IT WILL SLOW DOWN THE PROCESS. SO WHAT I WOULD LIKE TO SAY TO YOU IS LET'S HAVE LUNCH. AND LET'S PASS THIS DOCUMENT AS IT'S BEING PRESENTED TODAY.

DEBBIE INNES-GOMBERG: THANK YOU, DENNIS, IF YOU THINK OF ANYTHING YOU'D LIKE TO WRITE DOWN, THAT WOULD BE GREAT, ALSO.

AUDIENCE MEMBER: GOOD AFTERNOON. MY NAME IS LUIS MONTEZ. I WORK AT MENTAL HEALTH AMERICA ANTELOPE VALLEY, AND I WANT TO TAKE A MINUTE TO THANK DR. SOUTHARD FOR HIS LEADERSHIP. I THINK FOLKS THAT HAVEN'T WORKED OUTSIDE L.A. COUNTY DON'T UNDERSTAND HOW PROGRESSIVE WE ARE WITH DELIVERING RECOVERY TO PEOPLE. SO THANK YOU AND THANK YOU TO YOUR EXECUTIVE TEAM AS WELL. I THINK THAT WE HAVE ACCOMPLISHED THIS THROUGH ADVOCACY SO TODAY; MY ROLE IS GOING TO BE AS AN ADVOCATE. I MOVED TO THE ANTELOPE VALLEY TWO AND A HALF YEARS AGO. I MOVED FROM LONG BEACH, AND I USED TO, WORKING ON IN ORANGE COUNTY AS WELL. I THINK IN ORDER FOR US TO CONTINUE TO GROW HEALTHY IS THROUGH ADVOCACY. ONE OF THE THINGS I WANTED TO ASK IS I WAS LOOKING AT THE ALLOCATIONS FOR PEACE SERVICES AND THE ANTELOPE VALLEY IS GETTING 1/3 OF THE LOWEST SERVICE AREA. SO I THINK SERVICE AREA 5 HAS GOT ABOUT 223 AND WE HAVE GOT ABOUT A HUNDRED. SO IT'S A BIG DIFFERENCE. SO I JUST WANT TO, I HOPE YOU GUYS LOOK INTO THAT AND FIGURE OUT A WAY TO HELP US OUT. I THINK WE DO HELP PEOPLE GET A LIFE OUTSIDE THE MENTAL HEALTH SYSTEM. SO IF YOU CAN LOOK INTO THAT AND ALSO WE DON'T HAVE AN URGENT THE CARE IN ANTELOPE VALLEY. IT TAKES 60 MILES JUST TO DRIVE TO SYLMAR FOR THE NEAREST URGENT CARE.

DEBBIE INNES-GOMBERG: THE FSP PILOT INTEGRATION PROJECT WILL CREATE A GREATER ARRAY OF FSP SERVICES. THAT I THINK WILL HAVE BENEFIT SERVICE AREA 1 GREATLY. BUT I UNDERSTAND YOUR CONCERNS. THANK YOU.

MODERATOR: NEXT.

AUDIENCE MEMBER: GOOD AFTERNOON. MY NAME IS JOSEPH DEGUERA. FIRST, I WANT TO SAY, IT'S YOU TRUE, I HAVE TO SAY I'M VERY HAPPY TO BE A PART OF, YOU KNOW, LOS ANGELES COUNTY MENTAL HEALTH. THERE ARE A LOT OF THINGS THEY ARE DOING AND IT'S YOU TRUE, THIS IS THE TEMPLATE OF THE NATION. AS FAR AS HOW YOU'VE DONE THINGS AND HOW MUCH SERVICES ARE BEING PROVIDED AND WHAT'S BEING DONE FOR THE CLIENTS AND WITH THE LEADERSHIP OF DR. SOUTHARD AND HIS CARE AND HIS TEAM THAT, YOU KNOW, PRETTY MUCH YOU CAN JUDGE AN INSTITUTION BY THE LEADERSHIP AND PRETTY MUCH IT'S BEEN, WE'VE BEEN IN VERY GOOD SHAPE AND WE HAVE SOMEONE WHO REALLY CARES FOR US. I THANK GOD WE DO HAVE THAT. GETTING BACK TO MY QUESTION NOW, I JUST WANTED TO SAY IT'S MORE OF A STATEMENT. I APPRECIATE THE WOW SERVICE INTERAGE

WHERE WE GET AN OPPORTUNITY TO TRAIN THE CLIENTS TO BE ABLE TO LEARN TO BE ABLE TO GO BACK AND GIVE BACK TO THEIR WELLNESS CENTERS AND HELP CLIENTS OUT. THIS GIVES AN OPPORTUNITY FOR THE CLIENTS TO NOT BE SIT BEING THERE AND THEY NEED TO GO OUT AND HELP AND BE A PART OF THE PROCESS OF HELP. THIS IS A WONDERFUL THING AND I WANT TO SEE MORE FUNDING IN THOSE THINGS. ALSO WITH THE OLDER ADULT PROGRAMS WITH PUBLIC SPEAKING PROGRAM WITH NORTON AND -- I FORGET NAMES. BUT YOU KNOW WHO THEY ARE. AND THE THING S I JUST THANK GOD THAT THERE ARE A LOT PROGRAMS OUT THERE, AND THIS IS A GREAT ENVIRONMENT TO ENCOURAGE CLIENTS TO BE A PART OF THE PROGRAM AND TO BE ABLE TO HELP ONE ANOTHER AND BE A PART OF THE SYSTEM AND RECOVERY. BECAUSE THERE'S RECOVERY. AND THE GOOD THING ABOUT IT IS, YOU KNOW, WE'RE LIVING PROOF IN HERE. THERE'S LIVING PROOF OF THAT AND THEY'RE PART OF IT, AND I JUST WANTED TO SHOW YOU THAT THE MONEY IS BEING USED PROPERLY.
[APPLAUSE].

DEBBIE INNES-GOMBERG: THANK YOU. SO HERE'S WHAT I'M NOTICING. ONE MINUTE IS NOT ENOUGH SO CAN WE SAY TWO MINUTES BUT WE'LL HOLD YOU TOUT TWO MINUTES? YEAH? OKAY.
[LAUGHTER]

SO LETS DO TWO MINUTES AND WE'LL GIST LET YOU KNOW WHEN YOU HAVE 30 SECONDS TO GO. YOU BUT WHEN YOU GET THE THREAD CARD, I WILL NOT FEEL GUILTY JUMPING IN. LET'S GO ON WITH THE NEXT PERSON.

AUDIENCE MEMBER: AZIZA SHEPHERD. I WORK FOR MENTAL HEALTH AMERICA IN THE ANTELOPE VALLEY. IN REGARDS TO WORK FORCE EDUCATION AND TRAINING PROGRAMS, ARE THOSE PROGRAMS GOING TO BE OFFERED DMH CONTRACTORS WHO PROVIDE A LARGE PERCENTAGE OF MANAGEMENT SERVICES? IF NOT, IS THERE A PLAN IN THE FUTURE TO DO SO?

DR. SOUTHARD: THEY ALREADY ARE. THE PROGRAMS FOR THE STIPEND REIMBURSEMENT PROGRAMS, THE STUDENTS, ALL THEY HAVE TO DO IS MAKE A COMMITMENT TO WORK IN THE PUBLIC COMMENT SYSTEM, WHICH COULD BE DIRECTLY OPERATED OR CONTRACTORS IN ORDER TO FULFILL THE OBLIGATION FOR THE STIPENDS.

MODERATOR: DID THAT RESPOND TO YOUR QUESTION? MAKE SURE WE GET THE RIGHT ONE HERE.

AUDIENCE MEMBER: ODD IT IS, BUT I DON'T THINK THOSE RESOURCES ARE BEING ALLOCATED TO THE ANTELOPE VALLEY OR THEY'RE NOT BEING COMMUNICATED PROPERLY TO STUDENTS.

DR. SOUTHARD: ACTUALLY,Y WE SET UP A PROGRAM IN THE ANTELOPE VALLEY WITH CAL STATE BAKERSFIELD WHERE THEY HAD A SATELLITE PROGRAM IN LANCASTER THAT WE FUNDED WITH STIPENDS FROM THIS PROGRAM,

SPECIFICALLY FOR THE SATELLITE PROGRAM. AS I UNDERSTAND IT, THAT DIDN'T WORK OUT IN THE -IN-THE- LONG RUN AS WELL AS WE HAD HOPED SO WE'RE TRYING TO ENCOURAGE A SIMILAR PROGRAM USING NORTHRIDGE NOW TO DO OUTREACH TO THE ANTELOPE VALLEY FOR IT. BUT WE HAVE SPECIFICALLY FOCUSED ON THE ANTELOPE VALLEY BECAUSE THE RECRUITMENT NEEDS FOR ANTELOPE VALLEY ARE GREAT. WE INSTITUTED A PROGRAM. LET'S GROW OUR OWN. LET'S GROW PROFESSIONALS IN THE ANTELOPE VALLEY, RATHER THAN HAVING PEOPLE BE TRANSFERRED TO THE ANTELOPE VALLEY AND THEY'RE COMMUTING BACK AND FORTH AND THEY TRANSFER OUT AS SOON AS THEY CAN. SO WE WERE HOPING TO HAVE A "LET'S GROW OUR OWN" PROGRAM AND NOT ALL THE PIECES HAVE, WORKED AS WELL AS WE WOULD HAVE LIKED BUT IT'S BEEN AN ONGOING COMMITMENT TO FIND A WAY TO MAKE IT WORK. EITHER THROUGH YOU CAL STATE BAKERSFIELD OR NORTHRIDGE SO WE HAVE A PROGRAM IN THE VALLEY SO IT'S THERE, SO PEOPLE DON'T HAVE TO GO LONG DISTANCES. THAT'S OUR INTENTION.

AUDIENCE MEMBER: GOOD AFTERNOON. I COME FROM LONG BEACH MENTAL HEALTH AS A VOLUNTEER. ONE OF THE THINGS I'VE NOTICED OVER THE COURSE OF BEING A PEER COUNSELOR AND LIFE COACH AND FORMERLY HAVING BEEN A WILD WORKER IS THAT THERE NEEDS TO BE A STANDARDIZATION OF -- OF -- WHAT'S REQUIRED OF US. WE ALSO NEED C.E.U.'S TO KEEP OUR SKILLS REFRESHED. I'M ALSO ASKING THAT WE HAVE A CENTRALIZED LOCATION TO START WITH THAT'S 4 OPERATED THAT WILL UPON HELP FACILITATE THIS SO WE'RE NOT ASKING, YOU KNOW, ANY PARTICULAR OFFICE OF DMH TO ADD ANOTHER THING TO THEIR LOAD BUT TO ALLOW US PEERS TO START STEPPING UP TO THE PLATE AND KEEP THE INNOVATION GOING IN LOS ANGELES.
[APPLAUSE]. THANK YOU

AUDIENCE MEMBER: PATRICIA RUSSELL. I'M A NAMI MEMBER, AND I APPRECIATE DR. SOUTHARD AND THE FAMILY MEMBERS AND BEING PART OF THE TEAM. I'M TALKING TODAY ABOUT TWIN TOWERS CORRECTIONAL FACILITY AND THE EDUCATION THAT WAS THERE FOR THE MENTALLY ILL SECTIONS OF THE JAIL THAT I'M TOLD ARE NOT THERE ANY THINK LOWER, EXCEPT FOR SUBSTANCE ABUSE, WHICH IS VERY VALUABLE. I'M TOLD THERE ARE NO OTHER CLASS THAT IS CAN HAVE THE INMATES TO HAVE THINGS DURING THE DAY TO ENRICH THEMSELVES SO THEY CAN MOVE ON WITH THEIR LIVES WHEN THEY MOVE OUT. MY SON IS BACK THERE. IT'S REALLY SAD. IT'S A REVOLVING DOOR, AND SOME DAY, I'D REALLY LIKE TO TALK ABOUT NA RESOLVING DOOR WITH WHO WILL EVER IS ENTERED. I KNOW WE ALL KNOW ABOUT IT, BUT YOU WE REALLY NEED TO ADDRESS IT TO STOP:
TARA . THANKS.

DEBBIE INNES-GOMBERG: THANK YOU, WE'LL TAKE THAT BACK TO ADMINISTRATION. I WORKED AT TWIN TOWERS AND I KNOW IT'S A CHALLENGING ENVIRONMENT. THE MENTAL HEALTH SERVICES ACT DOESN'T ACTUAL FUND SERVICES IN THE JAIL OR IN JUVENILE HALL, BUT WE WILL BRING THAT BACK.

AUDIENCE MEMBER: IN MASSACHUSETTS, THERE'S AN ORGANIZATION THERE CALLED RECOVERING LEARNING CENTERS, AND RECOVERING LEARNING COMMUNITIES. I THINK THERE'S A RECOVERING LEARNING CENTER IN RIVERSIDE. SOME OF THE THINGS THEY COME UNDER ARE CERTIFIED PEER SPECIALIST, CLIENT-RUN STUFF AND I'D LIKE TO SEE SOME OF THAT HERE IN LOS ANGELES.

DEBBIE INNES-GOMBERG: THANK YOU, MARK. IF YOU HAVE INFORMATION ON THAT, IF YOU COULD SEND IT TO ME, THAT WOULD BE NICE.

AUDIENCE MEMBER: OKAY. THERE'S -- I THINK I GAVE THAT TO YOU A COUPLE TIMES. OKAY. ALSO LOS ANGELES COUNTY COALITION MEETING FRIDAY AND IT'S BEING TO BE AT 550 SOUTH [INDISCERNIBLE]. INNOVATIONS CONFERENCE IS MAY 3 AT THE CALIFORNIA ENDOWMENT. REGISTRATION FORMS FOR THE CONFERENCE. I HAVE A FEW PEOPLE HERE IF PEOPLE WANT TO JOIN IN AND JOIN THE CLIENT COALITION. I HAVE REGISTRATION SHIPS WITHY ME. YOU WANT ME TO TAKE A LOOK FOR THOSE?

MODERATOR: SO WE'LL GO TO CHERYL. ANYONE ELSE ON YOUR LIST? NO? OKAY. BELINDA? MARIA? GO AHEAD.

AUDIENCE MEMBER: GOOD AFTERNOON. MY NAME IS MARIA AND I AM A SERVICE EXTENDER. I THANK THE DEPARTMENT MENTAL HEALTH WHO HELPED CONSUMERS LIKE ME, WHO WORK FROM THE VERY GROUND OF MENTAL HEALTH SERVICES UP. DR. SOUTHARD, I ALWAYS ADORE EVERYTHING YOU SAID FROM THE VERY BEGINNING OF HOPE AND RECOVERY, THAT MENTAL HEALTH IS CONSTANTLY SUPPORT GROUP AND MEDICATIONS. I WILL NEVER FORGET THAT.

BUT ANY WAY, MY QUESTION IS THIS. MR. BIDARY FROM SERVICE AREA 4 DID A DATA PRESENTATION LIKE, TWO MONTHS AGO. AND THIS DATA PRESENTATION THAT HE DID IS ABOUT 2010 TO 2011 AND 11 TO 12.

NOW, HE PRESENTED THERE, THAT THERE WAS A 46.1 MILLION FROM THE PRUDENT RESERVE THAT WE SERVE THAT WERE PUT FROM THE D-PROGRAMS AND PARTICIPANTS OF THE DIRECTLY OPERATED AND CONTRACTED AGENCY PARTICIPANTS OF THIS MONEY. MY QUESTION IS WHEN I VERIFIED IT, TO THE SERVICE AREA 5 DISTRICT CHIEF JACK WILCOX. HE SAID THAT THE MONEY THAT THEY GOT WAS ALLOCATED TO TAY HOUSING. I WOULD LIKE TO REQUEST AN EXPANSION OF EXPLANATION OF THIS 4-POINT SIXTY ONE MILLION MONEY. BECAUSE SOME OF OUR PROGRAMS IN THE OLDER ADULT, THE PILOT PROGRAM HAS BEEN DISCONTINUED AND ONE OF THE PROGRAMS IS BARELY MAKING IT FOR THE OLDER DOCUMENT ADULTS. I THANK YOU.

DEBBIE INNES-GOMBERG: THANK YOU. AND I THINK YOU ARE REFER TO THE PRUDENT RESERVE PLAN WE HAD A YEAR AGO. WE WILL INCLUDE A COPY OF THAT WITH THE PUBLIC COMMENTS FOR THE ANNUAL UPDATE.

DR. SOUTHARD: AND JUST THE GENERAL ANSWER, BECAUSE I DON'T KNOW THE SPECIFICS. THE PRUDENT RESERVE WAS MEANT TO FILL IN THE HOLES SO THAT WE WOULD NOT HAVE TO CUT ONGOING PROGRAMS IN YEARS WHEN FUNDING DIPPED. THAT'S WHAT PRUDENT RESERVE IS FOR AND THAT'S WHAT WE USED IT FOR. SO IT WAS USED TO PRESERVE SERVICES.

AUDIENCE MEMBER: I WANTED TO CONTINUE AND SAID LIKE I TELL YOU, THE REASON I BROUGHT UP THAT PROCESS WE WENT THROUGH, YOU KNOW NOT ONLY MENTAL HEALTH OR ANY OTHER GOVERNMENT AGENCY, PEOPLE DON'T TRUST THEM. WE GO THROUGH ALL OF THAT PROCESS AND I, IT WAS ALMOST THE END OF THE YEAR BEFORE I REALIZED THEY DIDN'T USE THE ONES WE PICKED. SO YOU'VE GOT TO BE MORE DILIGENT AND EXPLAIN WHY YOU CAN'T DO SOMETHING TO PEOPLE AND JUST LIKE THE LADY I JUST GOT THROUGH ASKING ABOUT A PROGRAM WE HAD, IT WAS OPEN TO EVERYBODY. SOMEBODY GOT TO DO A BETTER JOB OF COMMUNICATING SO THOSE PEOPLE CAN FIND OUT WHAT'S GOING ON. THIRDLY, I GUESS THIS IS SOLID TO HER. THE COMMISSION IS TRYING TO MAKE SURE THAT THEY GET SERVICE AREA ADVISORY COUNCIL OUT THERE BECAUSE WITH THE GROUP THAT WE HAVE, YOU KNOW, WE MEET WITH THE COMMISSION. SUPPOSEDLY ALL EIGHT AND IF YOU HAD YOUR SERVICE AREA OPERATING, I THINK YOU WOULD LEARN MORE ABOUT WHAT'S GOING ON IN THE COUNTY. AND I NEVER TAKE TIME TO GIVE PEOPLE THEIR ACCOLADES OR WHATEVER. BUT I'VE ALWAYS THOUGHT FROM THE DAY I MET DR. SOUTHARD, I LIKE HIS STYLE OF LEADERSHIP. SEE, THERE'S A LOT PEOPLE THAT WORK FOR HIM.

I'VE GOTTEN ALL KINDS OF COMMENTS EVER SINCE HE'S BEEN HERE. AND I GOT TO TELL DEBBIE, I'M FOREVER TELLING PEOPLE IF THEY'LL COMPLAIN ABOUT SOMETHING, I SAY GO TELL DEBBIE. DEBBIE LISTENS. [LAUGHTER] AND SHE'LL TRY TO IMPLEMENT WHATEVER YOU TELL HER.

MODERATOR: OUR TIME IS UP.

AUDIENCE MEMBER: AND I THANK YOU

MODERATOR: THIS IS THE WAY SHE'S ABLE TO GET MORE TIME BY THANKING.
[LAUGHTER]

AUDIENCE MEMBER: I KNOW THAT.

MODERATOR: BUT WE LOVE YOU.

DEBBIE INNES-GOMBERG: AND I WANT TO -- I AM LISTENING. I WANT TO RESPOND. I THINK IT WAS TWO DAYS AGO. I WAS PREPARING FOR A PRESENTATION AND PART OF IT HAD TO DO WITH PEI AND SO I DIDN'T WANT TO JUST CALL LILLIAN RIGHT AWAY.

I THOUGHT, I'M GOING TO BE SELF-SUFFICIENT AND PULL OUT OUR PEI PLAN, AND OF COURSE, THE PEI PLAN IS THAT BIG. SO I WAS GOING THROUGH IT TO TRY AND FIND THE INFORMATION AND I WAS AMAZED AT THE LEVEL OF INFORMATION AND THE PLANNING. YOU KNOW, YOU FORGET ABOUT THESE THINGS AS YOU GET DEEP INTO IMPLEMENTATION. ONE OF THE THINGS WE DISCOVERED IS THERE ARE A LOT OF THINGS WE THOUGHT WE COULD DO, WITH THE INFORMATION WE HAD OVER TIME, THAT OVER TIME, TURNED OUT NOT TO BE THE CASE. AND YOU'RE RIGHT, WE COULD ALWAYS BETTER COMMUNICATE THAT INFORMATION AND I'M GOING TO DO A LITTLE BIT OF ANALYSIS. WELL, WE ORIGINALLY PLANNED FOR SERVICE AREA 6 THAN WHAT WAS ON THIS SIDE.

AUDIENCE MEMBER: WENDY, AND I'M ALSO FROM SERVICE AREA 1, CONNECTED WITH A.V. WELLNESS CENTER. I WANT TO GIVE A KUDOS TO JUDY COOPERBERG, AND DR. SOUTHARD, AS WELL AS DR. GASCO. I'M SAYING JUDY'S NAME FIRST BECAUSE WE'RE FROM THE SAME SERVICE AREA. KEEP UP THE GOOD WORK. I LOOK FORWARD TO MAINTAINING A PARTNERSHIP IN ORDER TO BE EFFECTIVE IN OUR COMMUNITY. THANK YOU.
[APPLAUSE].

MODERATOR: ANYONE ELSE BEFORE CLOSE THE COMMENT PERIOD? GO AHEAD. SO YOU ARE RAISING YOUR HAND? OKAY. SO WE HAVE THREE MORE FOLKS. ONE, TWO AND THREE. CAN WE SAY WITH MARK WE'LL END? OKAY. WE'LL END WITH MARK. AND THEN WE'LL BRING IT BACK.

AUDIENCE MEMBER: I REALIZE THERE'S A STIPEND PROGRAM. WILL THERE BE ANY LOAN FORGIVENESS OR TUITION REIMBURSEMENT TYPE PROGRAMS FOR THOSE INDIVIDUALS, MASTER LEVEL INDIVIDUALS WORKING IN THESE ANTELOPE VALLEY CONTRACTED AGENCIES?

DR. SOUTHARD: CORRECT ME WHERE I'M WRONG, BUT MY UNDERSTANDING IS THE CURRENT LOAN FORGIVENESS PROGRAM INCLUDES CONTRACT AGENCIES, ANYONE WHO HAPPENS TO LIVE ANYWHERE IN L.A. COUNTY AND IT'S JUST THE APPLICATION PROCESS IS A LITTLE CUMBER. BUT ANGELITA MAY WANT TO SPEAK A LITTLE MORE ON THAT.

ANGELITA: RIGHT NOW, WE'RE WORKING ON THE RFS. IT'S PRETTY MUCH DRAFTED AND WE'RE WORKING ON THE CRITERIA AND ELIGIBILITY, AND IT WILL BE OPEN TO ALL INDIVIDUALS WORKING IN PUBLIC MENTAL HEALTH. AND BOTH CONTRACTORS AND DIRECTLY OPERATING. I'LL JUST SAY FUNDING IS NOT ONLY DMH, IT'S CONTRACTORS. WE HAVE INCLUDED A TUITION REIMBURSEMENT PROGRAM AND WE ALSO HAVE A LOAN ASSUMPTION PROGRAM, TOO. WE'RE FINALIZING THE CRITERIA.

MODERATOR: AND IT'S INCLUSIVE OF ANTELOPE VALLEY, BUT NOT FOCUSED ON IT.

AUDIENCE MEMBER: LICENSING PREPARATION.

ANGELITA: YES, WE DO HAVE PREPARATIONS. AND IF YOU HAVE GOT ANY INFORMATION, GIVE USA I CALL. RIGHT NOW, RANDY FABO IS THE ONE THAT'S OVERSEEING THAT AND IT'S GOING TO BE RUN THROUGH THIS CAREER AND WE'LL CONTINUE TO RENEW THE PURCHASE ORDERS. WE ESSENTIALLY BUY SLOTS AND WE BID IT OUT AND BUY SLOTS FOR THAT AND THAT IS AVAILABLE.

MODERATOR: IF YOU HAVE ANYMORE SPECIFIC QUESTIONS, CAN YOU APPROACH BEFORE THE TIME ENDS. LET'S CONTINUE ON WITH ADDITIONAL COMMENTS.

AUDIENCE MEMBER: I HAD TO CUT OFF MY ORIGINAL STATEMENT BECAUSE I KNOW WE HAD A TIME CONSTRAINT. THIS IS JUST A CONTINUATION OF IT. I JUST WANTED TO SAY WHEN SOMEONE FEELS LIKE ACTUALLY PEOPLE CARE ABOUT WHAT THEY THINK AND THEY'RE NOT STIGMATIZING THEM AND LOOKING AT THEM AS IF SOMETHING IS WRONG WITH THEM, THAT'S THE BEGINNING OF RECOVERY. ONE OF THE THINGS I LOVE AND LIKE I WAS SAYING BEFORE, ONE OF THE THINGS I LOVE ABOUT, YOU KNOW, BEING HERE IN THE L.A. MENTAL HEALTH CARE, I CONSIDER DR. SOUTHARD TO BE THE SHEPHERD, AND WE'RE THE SHEEP. HE DOESN'T TREAT US LIKE THAT. THOUGH HE MAY HAVE PEOPLE UNDER HIS STAFF THAT MAY LOOK AT US LIKE THAT, BUT HIM, HIMSELF, DOESN'T. AND THAT IS RESPECT. AND THAT GIVES ME AN INCEPTIVE THAT KNOWS US AND CARES FOR US, THAT REALLY, REALLY LOOKS FOR OUR WELL-BEING AND DOESN'T LOOK AT US LIKE, OH, YOU'RE A CLIENT. YOU KNOW, LET'S JUST GIVE YOU MEDICINE AND PUT YOU AWAY SOMEWHERE. I RESPECT THAT. I HAVE GREAT RESPECT FOR THAT.

I THINK THAT WE NEED TO, AND ALL OF US NEED TO HAVE THAT UNDERSTANDING. WHEN WE LOOK AT CLIENTS AND NOT JUST MINUTE CLIENTS BUT SOMEONE WHO HAS A PERSON THAT HAS REASON AND CAN UNDERSTAND AND COMMUNICATE, THAT WILL BE THE BEGINNING OF RECOVERY. THEY WILL FEEL THAT AND THEY WILL THEN HAVE THAT FULL RECOVERY.

AUDIENCE MEMBER: [SPEAKING SPANISH] HI, MY NAME IS GABRIEL A I WANT TO SAY THANK YOU FOR THE PROFESSIONAL TRANSLATING SERVICES NOT ONLY HERE BUT IN OTHER MEETINGS. THANK YOU.

MODERATOR: MARK. HERE COMES THE MIC.

MARK: THE PLACE I WAS SPEAKING ABOUT IS CALLED THE TRANSITIONAL CENTER. IT'S IN MASSACHUSETTS. YOU CAN TAKE A LOOK AT THAT. THEY'RE TRANSFORMING THEIR SYSTEM AS WELL. THANK YOU. AND THE ALTERNATIVES WORKSHOPS.

AUDIENCE MEMBER: I WOULD BE REMISS IF I DIDN'T SAY TWO THINGS TO AT LEAST CONCLUDE MY PORTION OF THIS DIE. THE FIRST THING I'D LIKE TO SAY IS DR. SOUTHARD COULD HAVE EASILY PUT THE DO NOT DISTURB SIGN OUTSIDE OF HIS OFFICE FOR THE WAY I TREATED HIM A COUPLE WEEKS AGO. I'M REALLY SORRY FOR TAKING THAT KIND OF ACTION, AND I WAS TRAUMATIZED SO WHEN I BOTTOM TRAUMATIZED, I DO SOME VERY FOOLISH THINGS SO I MADE MY SUGGESTION YESTERDAY, AND I HOPE THAT'S VERY MUCH TAKEN INTO CONSIDERING.

LAST THING I WOULD LIKE TO SAY IS I WOULD LIKE TO THANK THE COMMISSION FROM THE BOTTOM OF MY HEART. THERE'S NO REASON, THERE'S NO REASON WHY YOU HAD TO TAKE ME IN.

AUDIENCE MEMBER: WE LOVE YOU.

AUDIENCE MEMBER: FOR THAT, I'M HUMBLY GRATEFUL. DR. GASCO ADVISED ME, HEY, THERE'S AN EMPTY SEAT. PLEASE COME UP AND JOIN US WHEN IT'S POSSIBLE. AND THEN I THINK HEY, I GET TO ACT LIKE A LITTLE SEMI-COMMISSIONER, TOO.
[LAUGHTER]

I HOPE MY COMMENTS ARE VALUABLE TO THE COMMISSIONERS. THAT'S WHAT I'M ALL ABOUT. I'M HERE -- I'M HERE TO MAKE A BETTER SYSTEM. I'M HERE TO HELP EVERYBODY IN THE SYSTEM OUT. I TRY AS HARD AS I CAN. I WAS GIVEN A MESSAGE AT ONE TIME FROM MY FATHER "YOU'LL NEVER AMOUNT TO NOTHING. YOU'LL NEVER BE NOTHING. AND WHAT YOU HAVE TO SAY IS NOT GOING TO AMOUNT TO ANYTHING." I FEEL THAT WITH ALL MY HEART, WORK AND EDUCATION AND DIFFERENT PARTICIPATION, DR. SOUTHARD AND DR. GASCO HAS MADE A VERY, VERY SIGNIFICANT AND VERY IMPORTANT CONTRIBUTION TO MY LIFE. WITHOUT THEM I DON'T KNOW WHERE I WOULD BE BUT I MIGHT STILL BE BELIEVING WHAT MY DAD SAID THAT THERE'S NO REASON FOR YOU TO BE HERE ON THIS EARTH. AND I WANT TO BELIEVE SO MUCH THAT IS NOT THE CASE. THAT WHAT HE HAD TO SAY ABOUT ME WAS JUST A BUNCH OF FOOLISHNESS. BUT AT THE SAME TIME, IT WAS FIGHT OR DIE. I JUST WANT TO SAY TO THANK YOU FROM THE BOTTOM OF MY HEART.
[APPLAUSE].

MODERATOR: I THINK WE HAVE FOUR MORE MINUTES.

AUDIENCE MEMBER: DR. SOUTHARD, I HAVE A GREAT CONCERN FOR THIS. I DO KNOW WHEN THE TEST IS GIVEN FOR L.A. COUNTY AND PEOPLE PASS A TEST AND THEN THEY'RE PLACED IN DIFFERENT AREAS ON JOBS, WHEN THEY'RE PLACED IN MENTAL HEALTH FACILITIES, ARE THEY TRAINED? BECAUSE YOU GET A LOT OF PEOPLE THAT'S WORKING AT THE WINDOW, AND, WORKING WITH CLIENTS AND THEY DON'T SEEM TO HAVE SUFFICIENT TRAINING AND SOMETIMES CLIENTS FEEL THAT THEY'RE TALKED TO THE WRONG WAY. THERE'S BEEN COMMENTS THAT I EVEN HEAR AS A VOLUNTEER FROM SOME STAFF MEMBERS THAT SHOULD NOT BE SAID ABOUT CLIENTS. IF THEY ARE TRYING TO KNOW WHAT TYPE OF COMMUNITY YOU'RE WORKING WITH CAN HELP THEM, BECAUSE THE WAY I SEE MANY THAT NEED THE SERVICES THEMSELVES AND HAVEN'T IDENTIFIED.
[APPLAUSE].
[LAUGHTER]
AND THAT'S THE TRUTH. BECAUSE THE WAY I LOOK AT IT, WE ALL, WHO HAVE A BRAIN, HAVE MENTAL HEALTH. SO SOME WE HAVE -- I ALWAYS SAID MENTAL HEALTH STRUGGLES. BUT I HEARD YESTERDAY WHEN IT WAS MENTIONED IN THE S.L.T. MEETING WITH ONE OF THE PRESENTERS, SHE SAID MENTAL HEALTH CHALLENGES AND I LET HER KNOW THAT I EMBRACE THOSE WORDS BECAUSE SO MANY TIMES, THE LANGUAGE IS WHAT CAN PUSH A PERSON DOWN. MY THING IS LIFTING THEM UP. AND DENNIS, ALL I WANT TO SAY TO YOU IS WE LIFT YOU UP. AND THAT'S ALL UNDERSTANDABLE AND YOUR REACTIONS TO THAT MEETING BECAUSE WE ALL POUT SOMETIME. THANK YOU.
[APPLAUSE]

DR. SOUTHARD: IT'S A LEGITIMATE ISSUE WE NEED TO FOCUS ON AND ONE WAY WE'RE APPROACHING ON IS WE'RE WORKING WITH THE UNIONS TO PUT INTO PLACE, AN IMPROVEMENT IN THE WAY THAT ALL OF OUR STAFF AT ALL LEVELS PROVIDE CUSTOMER SERVICE BECAUSE WE SURVIVE IN THE FUTURE, INSOFAR AS WE TREAT PEOPLE WITH DIGNITY, RESPECT. THAT'S HOW WE WERE GOING TO SURVIVE IS IF IN THE FUTURE ACCIDENT PEOPLE RECOGNIZE AS ONE THAT'S BEING RESPECTED. SO WE'RE DOING THAT ABSOLUTELY FOR SURE IN AND THAT PROGRAM IS GETTING STARTED. ANOTHER THING WE'RE GOING TO BE DOING IS IT WE HAVE ARRANGED THROUGH CATHERINE BOND TO HAVE SOME OF OUR WORKERS GO TO SOME CLINICS AND JUST TAKE A SURVEY AMONG THE CLIENTS WHO ARE WAITING IN THE WAITING ROOMS ABOUT THE QUALITY OF THEIR EXPERIENCE IN THE SYSTEM. YOU KNOW, ARE YOU TREATED WITH RESPECT, ARE THE BATHROOMS CLEAN. JUST LIKE THE PEOPLE, I SEEM TO BE UCLA'S FAVORITE PERSON TO CALL TO INQUIRE ABOUT WHAT MY LAST DOCTOR'S APPOINTMENT IS ABOUT. THEY SAY IT'S RANDOM. BUT EVERY TIME I GO TO THE DOCTOR, I GET CALLED. ANY WAY, THEY ASK ALL OF THESE QUESTIONS ABOUT HOW DO THE RECEPTIONS TREAT YOU, HOW DID THE DOCTOR TREAT YOU. WERE THE WAITING ROOMS CLEAN? SO WE'RE GOING TO DO SOMETHING LIKE THAT AND WE'RE PILOTING IT RIGHT NOW. WE WANT TO DO IT THE RIGHT WAY. WEEP THE TO MAKE SURE IT'S RIGHT -- WE WANT TO MAKE SURE IT'S RIGHT FOR THE CLIENTS, AND DOESN'T STIGMATIZE THE STAFF.

MODERATOR: CAN I NOW BRING IT BACK TO THE COMMISSION. THEY ALSO MIGHT HAVE COMMENTS SO WE HAVE THE NEXT FEW MINUTES FOR YOU ALL TO MAKE COMMENTS AND INTERVENE. SO I'LL BRING IT BACK TO LARRY.

LARRY GASCO: THANK YOU FOR FACILITATING THE MEETING TODAY. I REALLY WANT TO THANK ALL OF YOU WHO HAVE STUCK THROUGH FOR THE WHOLE PROCESS. WE LOST A FEW PEOPLE. AGAIN, I REALLY THINK IT'S VERY IMPORTANT, IT'S CRITICAL TO HAVE INVOLVEMENT FOR MEMBERS OF THE PUBLIC. ANYONE, ACTUALLY, THAT USES THEIR TIME TO COME IN AND JOIN US AND GIVE US FEEDBACK. ONE OF THE THINGS THAT'S VERY IMPORTANT, I THINK IT'S IMPORTANT BOTH FOR THE DEPARTMENT OF MINUTE STAFF AND ALSO FOR THE MENTAL HEALTH COMMISSION TO HEAR, THOSE THINGS -- AT LEAST YOU KNOW YOU'RE GOING IN THE RIGHT DIRECTION. AND MAYBE MORE IMPORTANT IF NOT, EQUALLY IMPORTANT, AT LEAST, THOSE THINGS WHERE THE DEPARTMENT COULD IMPROVE. I THINK IT'S REALLY IMPORTANT. AND ONE OF THE GOOD THINGS EARLIER IT WAS MENTIONED THAT ONE OF THE THINGS ABOUT ARE YOU LISTENING. WELL, SOME OF US DON'T LISTEN REAL WELL. I THINK ONE OF THE TRUE EXCEPTIONS IS DR. DEBBIE INNES GOMBERG. IF SHE COMMITS -- SHE COMMITS TO DOING SOMETHING. I DO WANT TO COMPLIMENT THE DEPARTMENT FOR PROVIDING THE SUPPORT TO HER STAFF AND TO DEBBIE FOR REALLY IMPLEMENTING SOME OF THE MANY CHANGES THAT HAVE OCCURRED. THINGS FOR BETTER. I WANT TO THANK YOU, MARV, AND THE MANAGEMENT, I THINK WE'RE FORTUNATE TO HAVE THE TOP MANAGERS OF THE DEPARTMENT IN TERMS OF THE SERVICE TO THE RESIDENTS OF LOS ANGELES COUNTY.

DELORES HUFFMAN: I MUST SAY THAT MRS. LAMONT IS MY MENTOR. I WANT TO SHARE WITH THOSE THAT HAVE GONE THROUGH RECOVERY AND THEY HAVE MAINTAINED. NOW, WE CAN BE AN APPLICANT FOR AREAS WITHIN OUR COMMUNITIES. WHEN I SEE SOMETHING THAT IS NOT HAPPENING RIGHT SORE SOMEONE'S TALKING DOWN TO AN INDIVIDUAL, I HAVE A UNIQUE WAY IN GETTING TO THAT PERSON AND LETTING THEM KNOW, THERE'S NOTHING WRONG WITH THIS PERSON. HE'S JUST ISN'T NORMAL LIKE YOU ARE. SO WE HAVE TO KIND OF BE AN ADVOCATE WHEREVER WE GO. AND I THINK FOR CLIENT COALITION, THERE'S A SLOGAN "THERE'S NOTHING ABOUT US WITHOUT US." AND WE WANT TO THANK EACH AND EVERY CLIENT THAT GAVE THEIR INPUT BECAUSE WITHOUT THE INPUT, WE CANNOT JUDGE OUR MEASURE OF PRODUCTIVITY OR THE THINGS THAT WE HOPE TO ACCOMPLISH. SO MY HAT IS OFF TO DR. SOUTHWARD, TO THE COMMISSION WE HAVE TO CONTINUE THIS WORK AND WE CAN ONLY DO IT THROUGH GOD'S HELP. THANK YOU.

JERRY LUBIN: I WANT TO TELL YOU HOW MUCH I'VE LEARNED FROM EVERYONE. STAFF, CLIENTS, POTENTIALS OTHER COMMISSIONERS. OTHER DEPARTMENTS IN THE DEPARTMENT THAT REACT WITH THIS DEPARTMENT. AND THE OPENNESS OF THIS DEPARTMENT AND IT'S GOOD RELATIONS BETWEEN THE DEPARTMENT AND THE COMMISSION. THERE ARE OTHER DEPARTMENTS IN THE COUNTY WHERE YOU WONDER WHO'S THE FRIEND, BUT IT'S NOT ALWAYS THE COMMISSION AND THE POINT OF VIEWS OF THE DEPARTMENT AND VICE VERSA. BUT TO MEET

PEOPLE LIKE DR. SOUTHARD, ROBIN K. ROD SHANER, THE SECRETARIES, THE STAFFS THAT IN MANY CASES ARE REAL ADMINISTRATORS BEHIND THE NAME. THE FACT THAT IN MANY CASES, IF EDDIE AND I ARE SITTING TOGETHER OR ON OPPOSITE SIDES OF THE ROOM IN MOST CASES, WE END UP WITH THE SAME PRIORITIES AND I GOT TO TELL YOU, THIS IS A STAFF THAT AS I KNOW MORE AND MORE OF THE STAFF, I HAVE MORE AND MORE RESPECT FOR THEIR OPENNESS, FOR THEIR SUPPORT FOR THEIR GOING OUT OF THE WAY TO DO SOMETHING EXTRA. AND IT'S BEEN AN EXPERIENCE THAT'S BEEN LEARNING FROM MY POINT OF VIEW, ANY DAY. I USED TO MEET WEEKLY WITH MARV SOUTHARD. I COULD BRING UP ANYTHING, GET AN HONEST RESPONSE AND IT'S GREAT TO SEE PEOPLE LIKE DEBBIE WHO ARE SO EFFECTIVE. BUT IT'S AN ATMOSPHERE AND EDDIE, YOU MISSED MY TELLING HOW GOOD I FEEL WHEN YOU AND I END UP ON THE SAME SIDE OF JUST ABOUT EVERYTHING. SO MANY THANKS AND IF WE SUCCEED, IT'S BECAUSE OF A CULTURE, OF AN ATMOSPHERE AND OF PEOPLE LIKE EDDIE. THANK YOU.
[APPLAUSE].

HERMAN DEBOSE: I AM A COMMISSIONER ALSO; I WANT TO THANK DR. GASCO FOR HELPING FACILITATE THIS TODAY. I ALSO WANT TO GIVE BIG THANKS TO DEBBIE INNES-GOMBERG. I AGREE WITH DR. GASCO. I CALL HER ON THE PHONE. WHEN SHE'S NOT THERE SHE DOES CALL ME BACK. I SHARE THE COMMENTS THAT I HAVE. AND SHE GIVES THEM BACK TO ME. SO I WANTED TO PUBLICLY SAY I APPRECIATE THE WORK YOU HAVE DONE.

I ALSO WANT TO THANK THE FOLKS FROM ANTELOPE VALLEY, FOR TRAVELING, I THINK ABOUT A HUNDRED MILES TO GET HERE.
[APPLAUSE].

THE EVENT WE HAD THERE IN DECEMBER, I HOPE IT WAS SUPPORTIVE, AND I THINK BY THE MERE FACT OF SHOWING UP TODAY TO GIVE YOUR INPUT, HOPEFULLY, SOME THINGS CAN BE DONE. I ALSO HOPE AS A FACULTY MEMBER OF CAL STATE NORTHRIDGE, I WAS VERY GLAD TO HEAR DR. SOUTHARD SAY WE'RE GOING TO DO STUFF WITH THE MSW PROGRAM AT NORTHRIDGE, THAT'S THE ONE WHERE IT DIDN'T WORK AT BAKERSFIELD. I HAVE A GOOD RELATIONSHIP WITH MY DEAN AND WITH THE CHAIR OF SOCIAL WORK. SO IF I CAN HELP FACILITATE THAT, I WOULD REALLY BE GLAD TO SEE STUDENTS GET PIPE ENDS COMING OUT TO THE SAN FERNANDO VALLEY. I SHARED WITH OTHERS THAT I WORKED FOR LOS ANGELES COUNTY 19 YEARS, AND MENTAL HEALTH WAS ONE OF THE AREAS I WORKED IN. I THINK SOME PEOPLE DO SHOW SIGNS OF DISRESPECT FOR THOSE WHO HAPPEN TO HAVE A MENTAL ILLNESS. WHEN YOU SAID THAT, YOU SAID THERE WOULD BE A PILOT SATISFACTION SURVEY. WHEN I GO TO KAISER, I GET AN E-MAIL ASKING IF I'M SATISFIED. I THINK IF WE COULD DO SOMETHING LIKE THAT, IT WOULD BE REALLY REAL ESTATE GOOD. AND THE, THING IS TO GET BACK TO SOMETHING MS. LAMONT SAID. WHEN WE HAVE THE MEETINGS AND YOU ASK PEOPLE FOR THE SUGGESTIONS ON WHAT SHOULD BE DONE, AND THOSE THINGS, THE RESOURCES MAY NOT BE THERE TO DO THOSE, BUT I THINK WE OWE THEM AN EXPLANATION AS TO WHY THOSE THINGS CAN'T BE DONE OR WERE NOT DONE. OTHERWISE WHAT'S GOING TO HAPPEN, PEOPLE ARE GOING TO SAY WHY SHOULD I GIVE

MY INPUT WHEN NOTHING IS GOING TO BE DONE. SO I HOPE THAT WHEN YOU LOOK THROUGH ALL THAT INFORMATION THAT YOU'LL BE ABLE TO SEND HER AND SOME COMMENTS AS TO WHY THOSE THINGS WEREN'T DONE. THE LAST PIECE FOR ME IS WHAT WILL BE THE PROCESS FOR THE COMMISSION TO GET ACCESS TO THE COMMENTS THAT WERE MADE TODAY?

MODERATOR: SO MAYBE WE CAN BRING IT BACK TO DEBBIE.

DEBBIE INNES-GOMBERG: THE TRANSCRIPTION WILL BE READY IN ABOUT A WEEK OR SO. WE'LL SUMMARIZE ALL THE COMMENTS HERE, AND THE, PUBLIC COMMENTS, AND WE RECEIVED COMMENTS YESTERDAY THAT WILL BE RECEIVED, ALL OF THOSE WILL GO INTO THE TIME ANNUAL UPDATE. YOU WILL ALL RECEIVE AN ELECTRONIC, AS WELL AS A PAPER COPY, FOR THE ANNUAL UPDATE WITH THE SIGNIFICANCE OF DR. SOUTHARD AND THE LETTER, PRESUMABLY, OF ADOPTION BY MENTAL HEALTH COMMISSION NEXT THURSDAY.

MODERATOR: ANY OTHER COMMENTS FROM THE COMMISSIONERS? OKAY, BRINGING IT BACK TO LARRY TO CLOSE.

LARRY GASCO: IN CLOSING, WE'RE SUPPOSED TO GO ON TO THE NEXT STEPS. BEFORE DOING THAT, I WANTED TO BRIEFLY JUST DESCRIBE HOW DID WE GET HERE IN TERMS OF REVIEW BODIES. FOR THE FIRST TIME I MENTIONED THE SERVICE AREA ADVISORY COMMITTEES WERE PH WE'RE BRIEFED AND IN THE PROCESS OF BEING INVOLVED IN MAKING NEEDS, MAKING THE NEEDS OF THEIR VARIOUS AREAS KNOWN TO THE DEPARTMENT. I WANT TO THANK DEBBIE AND THE DEPARTMENT FOR THAT.

IT DOESN'T GET MENTIONED SUFFICIENTLY, SYSTEM LEADERSHIP TEAM IS THE, IN LOS ANGELES COUNTY, IS THE DIVERSE STAKEHOLDER GROUP THAT REVIEWS THIS PLAN PRIOR TO COMING HERE. WE DO BENEFIT A GREAT DEAL, AND THEY ARE ALSO WORKING AND HAVING A MORE MEANINGFUL ROLE IN PROVIDING ADVICE AND FEEDBACK TO THE DEPARTMENT, IN ADDITION TO SOME OF THE THINGS THEY DO ALREADY. NOW, I BELIEVE DR. O'BRIEN MENTIONED HE HAD SOME VERY SPECIFIC THINGS IN TERMS OF IMPROVING THE PROCESS, AND I WAS GLAD HE RAISED THAT BECAUSE THE WHOLE PROCESS OF IMPROVING THIS WHOLE PUBLIC HEARING AND EVERYTHING THAT LEADS TO IT, IS NOT JUST BECAUSE IT'S GOING TO HAPPEN TODAY. IT'S A CONTINUAL PROCESS. SO ANY THOUGHTS THAT YOU MIGHT HAVE, I WOULD REALLY ENCOURAGING YOU TO SHARE IT WITH THE DEPARTMENT AND WITH THE COMMISSION BECAUSE ALL THIS TOGETHER TO MAKE THIS WHOLE PROCESS MORE MEANINGFUL TO THE PEOPLE SERVED, WHICH ARE THE RESIDENTS OF LOS ANGELES COUNTY, I THINK WE ALL HAVE AN INVESTMENT. IF WE DON'T, WE SHOULD HAVE. BUT I BELIEVE WE DO. I KNOW YOU DO, BECAUSE YOU'RE HERE. SO AGAIN, I DO WANT TO ENCOURAGE YOU TO POINT OUT THE THINGS YOU THINK MIGHT BE HELPFUL.

I FEEL SAFE IN SAYING THAT THERE WILL BE -- THEY WILL BE ASSESSED. FOR REASON, THEY'RE JUST NOT FEASIBLE, AND I THINK THE BEST PRACTICES MARV RESPONDED TO, THESE ARE TOO EXPENSE OF. BUT AT LEAST IT'LL BE REVIEWED AND, SERVICED AND SOMEONE WILL LET YOU KNOW WHY IT WASN'T POSSIBLE. SOUNDS LIKE THAT'S AN AREA THAT REQUIRES IMPROVEMENT. SO AS WE GO ON AFTER TODAY, IN THE PAST, AS I MENTIONED, IN MY OPENING REMARKS, WE WILL ENTERTAIN A MOTION. WE'LL PUT THE MOTION OUT THERE AND THIS YEAR, IT'S DIFFER, WE'RE NOT GOING TO HAVE A MOTION APPROVING THE ANNUAL UPDATE. THAT WILL OCCUR NEXT WEEK. WE'RE GOING TO HAVE A REGULAR MENTAL HEALTH COMMISSION MEETING AND THIS WILL BE A WEEK FROM TODAY. TODAY'S THE 18. SO IT HAS TO BE THE 25 AT THE HALL OF ADMINISTRATION AND OUR MEETING WILL START AT 11:00 A.M.

AND OF COURSE THE MAJOR PEACE WILL BE TO REVIEW SOME OF COMMENTS, A LOT OF THE COMMENTS THAT WERE MADE TODAY, WHETHER IN WRITING OR VERBALLY, AND THE OTHER ONES SUBMITTED BETWEEN THE 30 DAY OF PUBLIC COMMENT PERIOD AND TODAY. SO AGAIN, THANK YOU, AND I REALLY DO APPRECIATE THE COMMISSIONERS. WE HAD TO DO DOUBLE DUTY IT MONTH IN TERMS OF ATTENDING MEETING AND ANOTHER. BUT AGAIN I THINK THE REAL THANKS IS TO ALL OF YOU WHO ARE HERE AND ARE WILLING TO SHARE. I KNOW SOME OF YOU HAVE WORKED FOR THE DEPARTMENT. SOME OF YOU DON'T.

THIS PUTS US BETTER EQUIPPED TO WORK TOWARDS EVEN BETTER AND APPROPRIATE SERVICES FOR THE RESIDENTS OF LOS ANGELES. THANK YOU VERY MUCH AND SEE YOU NEXT YEAR.
[APPLAUSE].

MODERATOR: THANK YOU VERY MUCH, EVERYWHERE. IT'S 3:00 EXACTLY. RIGHT ON TIME. HAVE A GREAT DRIVE BACK HOME. FOLKS FROM THE ANTELOPE VALLEY, HAVE A SAFE DRIVE. ENJOY THE SCENERY.

IF YOU HAVE A PUBLIC COMMENT CARD YOU HAVE NOT TURNED IN, TURN IT INTO CHERYL OVER THERE BY THE DOOR OR TO LINDA. IF YOU WANT YOUR THOUGHTS WRITTEN UP, TYPED UP, MAKE SURE YOU TURN IT IN. THANK YOU VERY MUCH.

MEETING ADJOURNED AT 3 P.M.

EXHIBIT F

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA ANNUAL UPDATE FISCAL YEAR 2012-13

Section I: Prudent Reserve

Utilization of the Prudent Reserve (PR) will make up for the Community Services and Supports (CSS) shortfall for Fiscal Year 2011-12. Funding will address urgent needs associated with CSS elements and initial commitments with 30 million dollars to be used over fiscal years 2012-13 and 2013-14. This will be the last year for several fiscal years counties will be able to withdraw funds from the PR. Funds will be taken out of the PR according to how they were put in, relative to age group allocation.

Section II: Use of the Prudent Reserve

Age Group	Program	Expansion Dollar Amount	Expansion Plan, including approximate additional clients to be served
Child	Field Capable Clinical Services (FCCS)	$2,039,954	627 new clients will be served
	N/A	$109,880	This money will support the infrastructure for Children's System of Care (social worker and clerical staff)
Transitional Age Youth (TAY)	FSP	$800,000	30 more FSP slots will be added and designated as directly operated probation camp slots; an additional 8 slots for contractor Step-Up on Second in Service Area 5
	Emergency Shelter Bed	$300,000	An additional 3,529 shelter bed nights per fiscal year
	Drop-In Center	$250,000	Funding will support an additional TAY Drop-In Center and will provide access to 250 TAY, year-round (including weekends and after hours)
	FCCS	$250,000	The dollars will be used primarily for probation camp youth returning to Service Area 6, 60 unique clients will be served.
	N/A	$410,000	This money will support the infrastructure for TAY System of Care
	TAY Navigator	$100,000	The funds will support a Department of Children & Family Service – Probation Navigator

Age Group	Program	Expansion Dollar Amount	Expansion Plan
Adult	FCCS	$189,000	94 new clients will be served
	Wellness Center	$1,861,000	1,255 new clients will be served
Older Adult	FSP	$587,000	Approximately 66 slots will be added
	FCCS	$549,075	Approximately 100 new clients will be served
	Wellness Center		Approximately 300 existing older adult clients being currently served in Wellness Centers will receive specialized assessment (MMSE), WRAP for older adults, psychosocial groups focused on older adult issues and case management to access specialized housing options, healthcare and Medicare benefits.
Cross Cutting	Alternative Crisis Services (Urgent Care Centers, IMD Step Down Services)	$6,000,000	Approximately 11,000 additional clients would be served in Urgent Care Centers and an additional 126 additional clients served in IMD Step-down programs per year.

MENTAL HEALTH COMMISSION – PUBLIC HEARING
Sign-In Sheet – April 18, 2013

Check (√) applicable category (↓)

Name	Interested Citizen	Family Member	Consumer	Other (Please Specify)
Jerry Lubin	✓	✓		MHC
Sonia Hurtado	✓			
Joseph [illegible]				
[illegible] PHD	✓			
[illegible]				CCP
Rose Hugh	✓			
Nancy Lombao				DMH [illegible]
America A. Gonzalez			✓	Rio Hondo MHC Cerritos
Haydee Cervantes	✓			Hollywood Mental Health
Kevin Tsay				DMH OAI
Angelita Diaz-Akahori				DMH
TERRI BOYKINS				DMH
Tom Bel				DMH
[illegible]				DMH/ARC
VILMA V [illegible]				DMH
Angel Baker				DMH

Name	Interested Citizen	Family Member	Consumer	Other (Please Specify)
Carlos Orellana			✓	~~SLT~~
Shaylale' Taylor				SLT
Maria Elena Juarez				
Sabrina Gutierrez				MHALA
Ozza Shepherd				MHALA
[illegible] Henry				MHALA
JOHN GLOVER			✓	MHALA
Phyllis [illegible]			✓	
[illegible] Boone			✓	MH Commission
[illegible]				
Myrna [illegible]				
BRUCE [illegible]				DMH
Reyne Brown				DMH
Gordon Burch				DMH
PAUL STANSBURY		✓		NAMI South [illegible]

MENTAL HEALTH COMMISSION – PUBLIC HEARING
Sign-In Sheet – April 18, 2013

Check (✓) applicable category (↓)

Name	Interested Citizen	Family Member	Consumer	Other (Please Specify)
Marissa Squirrel Celeste		✓	✓	Not consistent Life coach
Maria Tan			✓	
NICK ASHBAUGH			✓	
Judy Coopenberg				Commissioner
JOHN FAAS (LCSW)	✓			Provider
Luis Montes				MHACA
Martha Jones				DMH
GITA CUGLEY				DMH
ROBERT BYRD				DMH
Lucinda Mansfield	✓			DMH
[illegible]				DMH
Lillia Blue				DMH
HERMAN C. DEBOSE	✓			
Josh Cornell				DMH
Chandler Norton				DMH
IRMA CASTANEDA				EOB/DMH

Name	Interested Citizen	Family Member	Consumer	Other (Please Specify)
Sharon Lee	✓	✓	✓	Advocate
Mark Ramos	✓			
Eddie Lamon	✓	[redacted]		
Dorothy Banks			✓	
FELIX GARCIA	✓	✓	✓	
WENDY CARSIL			✓	
Debi Berzon Leitett			SHC	DMH/SA
[illegible]				
Miriam Brown				DMH
Victoria Soto				MHC
Elizabeth Fitzgerald				DMH
Arlene Gilbert				DMH
Kimberly Neill				DMH
Harold Turner	✓	✓		NAMI
Suma R Lee				DMH
Carolyn Winston	✓	✓		NAMI
Lisa Sorenson				DCFS
Karen Tavsalas				DMH

FOR ADDITIONAL INFORMATION CONTACT:

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