Los Angeles County - Department of Mental Health

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act

Three Year Program & Expenditure Plan
Fiscal Years 2014-15 through 2016-17

Los Angeles County Board of Supervisors
Adopted July 15, 2014

(Updated May 28, 2015 to reflect Mid-Year Adjustments)

Marvin J. Southard, D.S.W.
Director

Table of Contents

Introduction

Welfare and Institutions Code Section (WIC) 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Updates for Mental Health Services Act (MHSA) programs and expenditures. The MHSA 3 Year Program and Expenditure Plan provides an opportunity for the Los Angeles County Department of Mental Health (Department) to review its MHSA programs and services and obtain feedback from a broad array of stakeholders on those services. Any changes made to the Department's MHSA program would need to be in accordance with the MHSA, current regulations and relevant state guidance.

The Department engaged in individual community planning processes for each component of the MHSA, as guidelines were issued by the California Department of Mental Health. Implementation of each component began after plan approval by either the California Department of Mental Health or the Mental Health Services Oversight and Accountability Commission (MHSOAC):

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

**Date Approved by the State*

The programs funded within each component are described in this document, along with the number of clients served and relevant program outcomes.

Through the implementation of the MHSA, the Department has strived to create a service continuum for each age group that spans prevention, early intervention and a broad array of mental health community services and supports. Each component of the MHSA contributes to an array of services that will increase recovery, resiliency and create healthier communities.

Any questions or comments should be directed to:

Debbie Innes-Gomberg, Ph.D.
District Chief, MHSA Implementation and Outcomes Division
Los Angeles County Department of Mental Health
(213) 251-6817 or DIGomberg@dmh.lacounty.gov

Executive Summary

The MHSA stipulates that counties shall prepare and submit a MHSA Three-Year Program and Expenditure Plan, shall post it for 30 days for public comment, and the County Mental Health Commission should convene a Public Hearing on the Plan. The Plan was posted on the Department's website on April 7, 2014, and was approved by the Mental Health Commission at the conclusion of the Public Hearing on May 22, 2014.

The County Auditor-Controller and Mental Health Director have both signed the MHSA Fiscal Accountability Certification Form included in the Three-Year Program and Expenditure Plan as to compliance with all applicable laws and regulations.

The Mental Health Services Oversight and Accountability Commission provided direction to counties to complete the MHSA Three-Year Program and Expenditure Plan for Fiscal Years (FYs) 2014-15, 2015-16 and 2016-17 through a memo dated August 2, 2013, and distributed the final MHSA Fiscal Accountability Certification Form to be completed by the Director of Mental Health and Auditor-Controller.

Highlights of the Impact of MHSA-Funded Programs in FY 2012-13:

- 97,370 unique clients received a direct mental health service from a Community Services and Supports (CSS) program.
- 73,140 unique clients received a direct mental health service from a Prevention and Early Intervention (PEI) program.
- Full Service Partnership (FSP) programs continue to reduce homelessness, psychiatric hospitalization, and incarcerations:
    - Adults achieved a 68% increase in days living independently and a 57% increase in the number of clients living independently.
    - Adults achieved a 71% reduction in days homeless and a 31% decrease in the number of clients homeless.
    - Adults achieved a 50% reduction in the number of days incarcerated.
    - Transition Age Youth (TAY) achieved a 39% increase in the number of days and the number of clients living independently.
    - TAY achieved a 59% reduction in days spent in Juvenile Hall and a 60% reduction in the number of clients residing in Juvenile Hall.
    - Children achieved a 40% reduction in the number of days psychiatrically hospitalized and a 35% reduction in the number of clients psychiatrically hospitalized.

- The PEI practices have resulted in overall improvement in depression, anxiety, trauma, parenting and family difficulties, disruptive behavior disorders and short-term crisis symptoms, when comparing symptoms prior to treatment to those reported at the conclusion of treatment.

- Innovation integrated care models are reducing impairment associated with mental and physical illnesses, increasing level of recovery, and clients are experiencing less stigma related to mental illness.
- Workforce Education and Training projects are infusing new skills and competencies into the public mental health workforce as well as enhancing the breadth of the workforce.

Community Program Planning Process

A community planning process that involved input from each of the eight Service Area Advisory Committees and the Department's System Leadership Team (SLT) culminated in the MHSA Three-Year Program and Expenditure Plan. The Plan was built upon the learning and outcomes of the MHSA programs over the last eight years to address identified service gaps and key unserved and underserved focal populations. While the Plan contains recommendations for most components of MHSA, the Department asked specifically for recommendations for the CSS Plan due to the identification of additional unspent funding for this component. The SLT made the following recommendations to the Department to enhance the MHSA CSS Plan:

Services to be Expanded:

- Adult FSP slots expanded by 480, including 300 for the implementation of Assisted Outpatient Treatment.
- Institutes for Mental Disease (IMD) Step-Down Program capacity expanded by 82, including 60 dedicated to the implementation of Assisted Outpatient Treatment.
- Urgent Care Center capacity expanded to serve the South Bay, Southeast Los Angeles, the Antelope Valley and San Gabriel Valley.
- TAY and Older Adult FSP slot expansion, 18 and 122, respectively.
- Field Capable Clinical Service (FCCS) capacity expansion by approximately 330 for children, 36 for TAY, 200 for adults, and 407 for older adults.
- Housing investments will be continued through the Housing Trust Fund and expanded through the MHSA Housing Program.
- Wellness and Client Run Center service augmentations involving increased peer staffing, enhanced service array and supported employment services.

New services to be added to the CSS Plan:

- Family Wellness/Resource Centers for children and families that will serve as community informational hubs as well as a place to access self-help and other services.
- Respite Care services to address family crises in the moment.
- Self-help support groups for children and for TAY using evidence-based approaches.

- Mental health promoters to provide enhanced culturally relevant mental health outreach and engagement and education to individuals from under-represented ethnic populations.
- TAY employment services.
- Co-Occurring mental health and substance use training and technical assistance for providers.

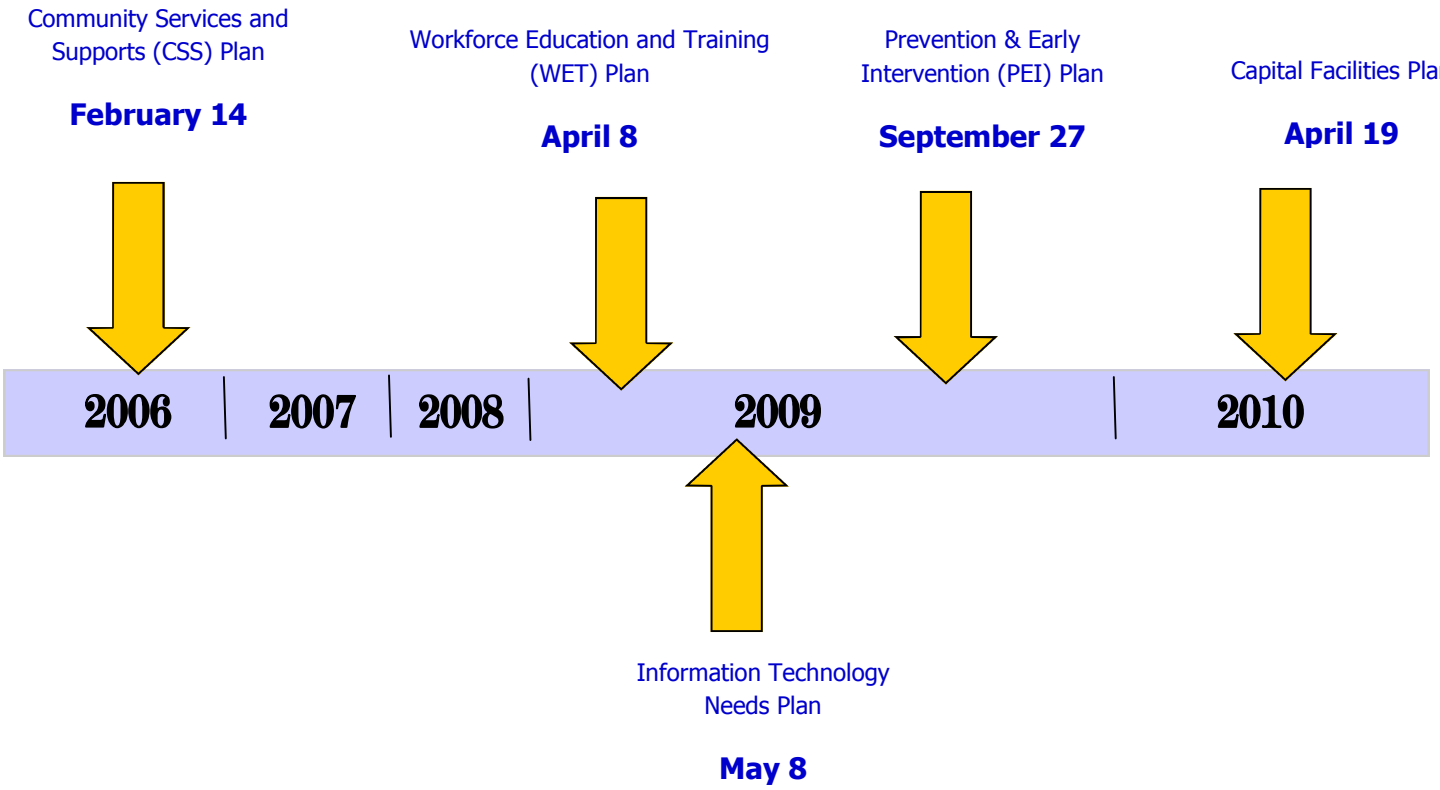
Programs to be Added or Expanded in FY 2014-15:

- Housing Trust Fund
- MHSA Housing Program
- Mental Health Promoters
- Expansion of TAY, Adult and Older Adult FSP slots
- Expansion of TAY Drop-In Centers
- Expansion of TAY, Adult and Older Adult FCCS capacity
- TAY Supported Employment Services
- Wellness Center Augmentation
- Assisted Outpatient Treatment (AB 1421- Laura's Law)
- Expansion of IMD Step-Down services
- CHFFA SB 82 alternative crisis service expansion

Programs to be Added or Expanded in FY 2015-16:

- Family Resource Center
- Children's Respite Care Services
- Self-help support groups for children and TAY
- Co-Occurring Disorders training and technical assistance

Mental Health Services Act
Plan Approval Dates by the State



MHSA County Compliance Certification

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Los Angeles

☑ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director	Program Lead
Name: Marvin J. Southard, D.S.W.	Name: Debbie Innes-Gomberg, Ph.D.
Telephone Number: (213) 738-4601	Telephone Number: (213) 251-6817
Email: msouthard@dmh.lacounty.gov	Email: digomberg@dmh.lacounty.gov
Local Mental Health Mailing Address: County of Los Angeles - Department of Mental Health MHSA Implementation and Outcomes Division 695 S. Vermont Avenue, 8th Floor Los Angeles, CA 90005	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on July 15, 2014.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant. All documents in the attached annual update are true and correct.

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

Robin Kay for Marvin J. Southard — 7-21-14
Signature — Date

MHSA County Fiscal Accountability Certification

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
Name: Marvin J. Southard, D.S.W.	Name: John Naimo
Telephone Number: (213) 738-4601	Telephone Number: (213) 974-8484
Email: msouthard@dmh.lacounty.gov	Email: jnaimo@auditor.controller.gov
Local Mental Health Mailing Address: County of Los Angeles – Department of Mental Health MHSA Implementation and Outcomes Division 695 S. Vermont Ave., 8th Floor Los Angeles, CA 90005	

I hereby certify that the **Three-Year Program and Expenditure Plan** 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 counties in future years.

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

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

Signature 05.21.14
Date

I hereby certify that for the fiscal year ended June 30, 2013, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/16/13 for the fiscal year ended June 30, 2013. I further certify that for the fiscal year ended June 30, 2013 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 MHS 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 if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

John Naimo
County Acting Auditor-Controller (PRINT)

John Naimo 5/28/14
Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Mental Health Commission Approval Letter

Los Angeles County
Mental Health Commission
"Advocacy, Accountability and Oversight in Action"

May 22, 2014

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
THREE YEAR PROGRAM & EXPENDITURE PLAN
FISCAL YEARS 2014-15 THROUGH 2016-17
NOTICE OF PLAN APPROVAL

On May 22, 2014 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 Three Year Program & Expenditure Plan for Fiscal Years 2014-15 through 2016-17 conducted at St. Anne's in Los Angeles County:

MOTION: The Los Angeles County Mental Health Commission moves to approve the Three Year Program & Expenditure Plan for Fiscal Years 2014-15 through 2016-17.

It is, therefore, with pleasure that the Commission approve your Department's submission of the Fiscal Years 2014-15 through 2016-17 Three Year Program & Expenditure Plan, which was publically posted on April 7, 2014 and presented at the May 22, 2014 Public Hearing. We would also like to commend the Department for engaging in such an inclusive Planning Process.

The Commission looks forward to your continued progress 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

Los Angeles County Board of Supervisors Adopted Letter

LAC DMH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

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

July 15, 2014

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

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

16 July 15, 2014
SACHI A. HAMAI
EXECUTIVE OFFICER

Dear Supervisors:

ADOPT THE DEPARTMENT OF MENTAL HEALTHS MENTAL HEALTH SERVICES ACT THREE-YEAR PROGRAM AND EXPENDITURE PLAN FOR FISCAL YEARS 2014-15, 2015-16, AND 2016-17

(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Three-Year Program and Expenditure Plan for Fiscal Years 2014-15, 2015-16, and 2016-17.

IT IS RECOMMENDED THAT THE BOARD:

Adopt Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years (FYs) 2014-15, 2015-16, and 2016-17 (Attachment). The MHSA Three-Year Program and Expenditure Plan 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 Three-Year Program and Expenditure Plan is necessary in order for DMH to submit the Plan 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 Plan and the Annual Updates be adopted by the County Board of Supervisors. Additionally, it is required that the Three-Year Program and the Annual 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 Plan and the 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 Plan and the Annual Updates at the close of the 30-day comment period.

In order to fulfill the latter requirements, DMH posted the MHSA Three-Year Program and Expenditure Plan on its web site for 30 days for public comments on April 7, 2014. DMH also convened a Public Hearing on May 22, 2014, where DMH addressed public questions and concerns. The Mental Health Commission voted to approve the MHSA Annual Update for FY 2014-15 at its meeting on May 22, 2014.

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 the Annual Updates, adopted by the County Board of Supervisors and submitted to the Commission. It also requires that the Three-Year Program 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.

The Commission provided direction to the counties to complete the MHSA Three-Year Program and Expenditure Plan for FYs 2014-15, 2015-16, and 2016-17 through a memo dated August 2, 2013, and distributed the final MHSA Fiscal Accountability Certification Form to be completed by the County Mental Health Director 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 Three-Year Program and Expenditure Plan. The County Auditor-Controller and County Mental Health Director have both signed the MHSA Fiscal Accountability Certification Form included in the Three-Year Program and Expenditure Plan.

The MHSA Three-Year Program and Expenditure Plan builds upon the initial State approved MHSA Three-Year Program and Expenditure Plan for each MHSA component. It contains a summary of MHSA programs for FY 2012-13, including clients served by MHSA program and Service Area and program outcomes. In addition, the plan also describes the planning process that resulted in

recommended service expansions, as well as new MHSA Community Services and Supports Plan programs recommended by the System Leadership Team to be implemented over the course of the next three fiscal years.

The following MHSA programs are being expanded:
* Adult Full Service Partnership slots expanded by 480, including 300 for the implementation of Assisted Outpatient Treatment.
* IMD Step-Down Program capacity expanded by 82, including 60 dedicated to the implementation of Assisted Outpatient Treatment.
* Urgent Care Center capacity expanded to serve the South Bay, Southeast Los Angeles, Antelope Valley, and San Gabriel Valley.
* Transition Age Youth and Older Adult Full Service Partnership slot expansion,18 and 122 respectively.
* Field Capable Clinical Service capacity expansion by approximately 330 for children, 36 for Transition Age Youth,200 for adults, and 407 for older adults.
* Housing investments will be continued through the Housing Trust Fund and expanded through the MHSA Housing Program.
* Wellness and Client Run Center service augmentations involving increased peer staffing, enhanced service array, and supported employment services.

New services to be added to the MHSA service array include:
* Family Wellness/Resource Centers for children and families that will serve as community informational hubs as well as a place to access self-help and other services.
* Respite Care services to address family crises in the moment.
* Self-help support groups for children and for Transition Age Youth using evidence-based approaches.
* Mental health promoters to provide enhanced culturally relevant mental health outreach and engagement and education to individuals from under-represented ethnic populations.
* Transition Age Youth employment services.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Three-Year Program and Expenditure Plan for FYs 2014-15, 2015-16, and 2016-17 will ensure compliance with AB 1467 requirements.

Respectfully submitted,

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

MJS:DM:DIG:rc

Enclosures

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

Acronyms

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
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
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:	Severe 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

Definitions

Unique clients means a single client claimed in the Integrated System. Data as of October 24, 2013.

New Community Services and Supports clients may have received a non-MHSA mental health service.

New Prevention and Early Intervention clients may have received a non-MHSA mental health service.

Total client cost calculation is based on Mode 15 services, inclusive of Federal Financial Participation (FFP) & Early Periodic Screening, Diagnosis, and Treatment (**EPSDT**) Program. Not inclusive of community outreach services or client supportive services expenditures. Data as of October 24, 2013.

Client contacts are based on Exhibit 6 reporting by program leads for FY 2012-13.

Client Run Center counts are based on client contacts using Community Outreach Services billing. Data as of October 24, 2013.

Community Planning Process

To create meaningful stakeholder involvement, the Department engaged 3 levels of stakeholder involvement in the development of this 3 Year Program and Expenditure Plan:

- The System Leadership Team (SLT), the Department's stakeholder workgroup to inform the implementation and monitoring of MHSA programs. In order to ensure adequate breadth and diversity in the planning process, the SLT was increased from its 50 members to 55 members. The composition of the expanded SLT is as follows:
  - *LA County Chief Executive Office*
  - *Representation from each Service Area Advisory Committee*
  - *Consumer and family member representation, including NAMI, self-help and the LA County Client Coalition*
  - *Department of Public Social Services*
  - *Health Care, including the Hospital Association and LA County Department of Public Health, LA County Department of Health Services*
  - *LA Police Department*
  - *Probation*
  - *Housing development*
  - *Older Adult service providers and LA County Community and Senior Services*
  - *Under-Represented Ethnic Populations, including Asian Pacific Islanders, American Indian, African American, Latino*
  - *Clergy*
  - *City of Long Beach*
  - *Veterans*
  - *LA County Mental Health Commission*
  - *Unions*
  - *Co-Occurring Joint Action Council*
  - *Education, including the LA Unified School District, universities and charter schools*
  - *Lesbian, Bisexual, Gay, Transgender and Questioning (LBGTQ)*
  - *LA Department of Children and Family Services*
  - *LA County Commission on Children and Families*
  - *Junior blind*
  - *Statewide perspective*

- The efforts of the SLT were guided by an ad hoc workgroup that was formed and comprised of volunteers from the SLT and Department managers with responsibility for planning, implementing and managing MHSA programs. The ad hoc workgroup represented diverse perspectives and was a microcosm of the larger SLT. The ad hoc workgroup served to make recommendations to the Department on the process for developing the 3 Year Program and Expenditure Plan. The ad hoc workgroup met on the following dates: August 8, 2013, September 6, 2013, September 16, 2013, October 3, 2013, October 21, 2013, November 14, 2013, December 3, 2013, January 7, 2014, January 23, 2014, February 3, 2014, February 13, 2014, March 3, 2014 and March 10, 2014.

- The Service Area Advisory Committees (SAAC) were given information on MHSA programs, including program descriptions, service information for Fiscal Year 2012-13 at the Countywide and Service Area levels, program outcome data at the Countywide and Service Area levels and a comprehensive set of slides to orient SAAC members and the general public on the MHSA and on MHSA programs (see Appendix). SAACs were offered orientation presentations conducted by Debbie Innes-Gomberg, Ph.D., District Chief of the MHSA Implementation and Outcomes Division and lead for the 3 Year Program and Expenditure Plan. Seven of the eight SAACs requested orientation presentations. Below is a list of SAAC presentation dates:
    - *SAAC 5 – November 26, 2013*
    - *SAAC 8 – December 6, 2013*
    - *SAAC 3 – December 12, 2013*
    - *SAAC 7 – December 13, 2013*
    - *SAAC 6 – December 19, 2013*
    - *SAAC 4 – December 19, 2013*
    - *SAAC 2 – February 13, 2014*

Key dates for the 3 Year Program and Expenditure Plan are:

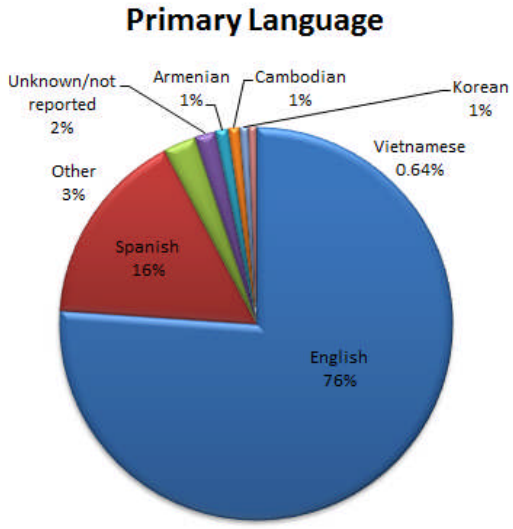
September 18, 2013:	*SLT: Overview of the Three Year Program and Expenditure Plan guidelines from the Mental Health Services Oversight and Accountability Commission (MHSOAC) and initial discussion on planning.*
October 30, 2013:	*Orientation to the MHSA to new SLT members. SLT expands to full day meeting through February, 2014. Service continuums for each age group reviewed with initial discussion of service gaps by age group.*
November 20, 2013:	*SLT: Review of LA County MHSA budget, further questions and comments related to the MHSA program orientation held in October, discussion related to the recruitment of additional SLT members for the planning process and information feedback from the SAACs to the SLT.*
December 18, 2013:	*SLT: Presentation on the Affordable Care Act and its impact on MHSA, presentation and discussion on unserved and under-served populations, including the interface between focal population and ethnicity. Initial discussion from SAAC representatives on their planning efforts.*
January 22, 2014	*SLT: SAACs presented on the status of their planning processes and SLT reviewed and initiated prioritization of the age group service continuums.*
February 5, 2014:	*SAAC recommendations due to the MHSA implementation and Outcomes Division*
February 11, 2014:	*Briefing of the SAAC co-chairs on the status of the planning process.*
February 19, 2014	*SLT review of SAAC recommendations, incorporating them into the age group service priorities.*
March 19, 2014	*SLT final plan development and vetting of spending plans.*

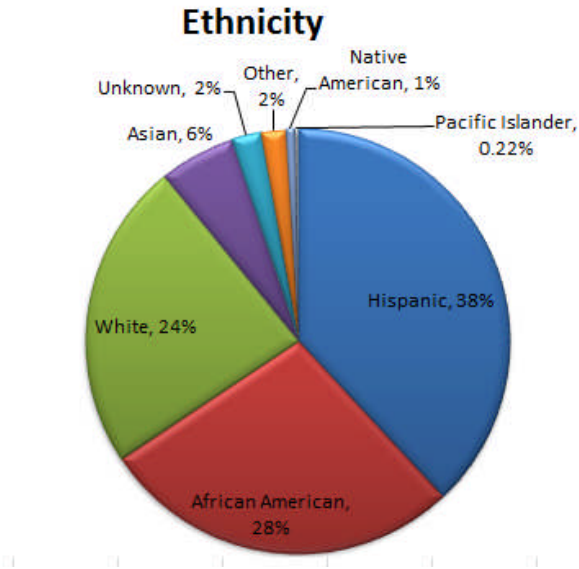
March 25, 2014:	*Presentation of Three Year Program and Expenditure Plan to the SLT, with final recommendations made to DMH Executive Management Team.*
March 27, 2014:	*Briefing on the Three Year Program and Expenditure Plan to the Mental Health Commission.*
April 7, 2014:	*Thirty day Public Posting of the Three Year Program and Expenditure Plan on the Department's website, with the link to the Plan emailed to all SLT members, SAAC chairs, all Department District Chiefs and Department staff with programmatic, administrative or fiscal implementation responsibility for MHSA programs, the Department's Public Information Officer and its Executive Management Team. In addition, the Mental Health Commission received the link to the Plan as well as a bound paper copy of the Plan.*
May 6, 2014:	*While the Plan will remain on the website and public comment will continue to be received, public comments received to date will be sent to the Mental Health Commission for their review and to relevant staff in the Department.*
May 22, 2014:	*Public Hearing convened by the Mental Health Commission.*
June, 2014:	*Development of Board Letter and presentation at Agenda Review*
July, 2014:	*Anticipated Board of Supervisor adoption of Three Year Program and Expenditure Plan and submission to the MHSOAC within 30 days of Board adoption.*

The Board of Supervisors, via their Health Deputies, and the Chief Executive's Office (CEO) will be briefed over the course of this planning process.

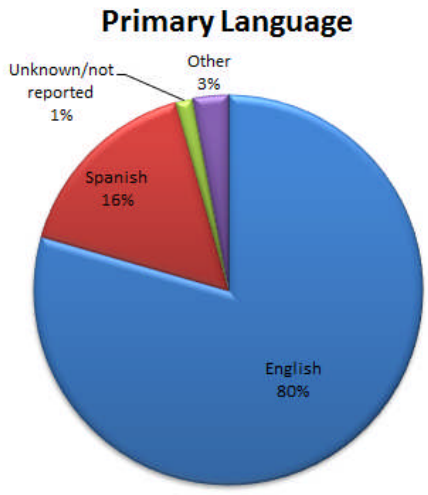
Fiscal Year 2012-13 MHSA Program Community Services and Supports

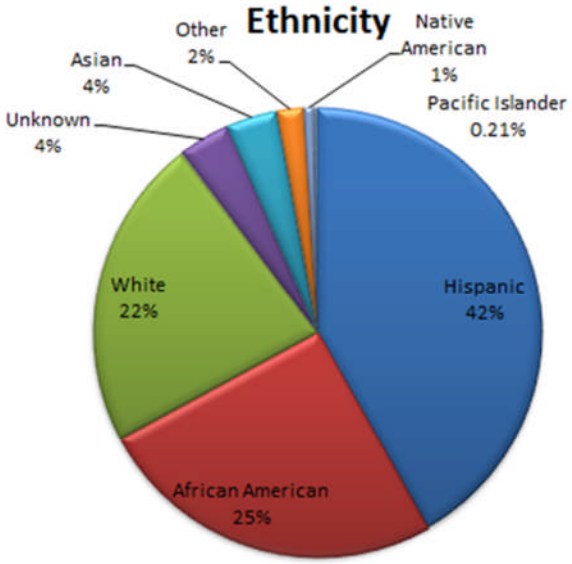
Unique clients receiving a direct Mental Health Service through the CSS Plan: **97,370**





New clients receiving CSS Services Countywide with no previous MHSA Service: **25,093**





Adult Full Service Partnership: A-01

Unique Clients Served: 4,534
Cost: $53,647,204
Average Cost per Client: $11,832
Slots Allocated: 4,866 (as of February 2014)

Serves adults, ages 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 and would be at risk of the above if it were not for the family's support. Services include a wide array of mental health services, medication support, linkage to community resources, housing, employment and money management services and assistance in obtaining needed medical care. Programs target clients from all ethnic communities, with a collaborative focusing specifically on the Asian Pacific Islander communities.

Focal Population Targeted: Homeless; Jail; Institutionalized (State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital); Lives with Family Members.

Wellness/Client Run Center: A-02

Unique Clients Served: 50,670
Client Contacts: 73,394 *(Services provided at Peer-Run Centers)*

Wellness Centers are programs staffed by at least 51% consumer staff, who provide an array of mental health and supportive services to clients at higher levels of recovery. Services include medication support, linkage to physical health and substance use services, self-help and a variety of peer-supported services, including crisis and self-management skill development.

IMD Step-Down Facilities: A-03

Client Contacts: 793

IMD Step-Down

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

Project 50

Project 50 is a specific 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 three 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.

Adult Housing Services: A-04

Client Contacts: 1,706

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

MHSA Housing Program

The MHSA Housing Program provides funding for permanent, supportive, affordable housing for individuals living with serious mental illness, who are homeless and their families. It is a statewide program that includes a partnership with California Housing Finance Agency. DMH provides supportive services including mental health services to tenants living in MHSA funded units.

Below is a list of projects that opened during fiscal year 2012-13 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			
Menlo Family Housing	3/1/2013	4	2	Older Adults (ages 60+)	20	60	0	5	10	5	0	$2,596,600	$0	$2,596,600
Mid-Celis Apartments	3/1/2013	2	3	Single Adults	7	20	0	3	2	2	0	$525,000	$0	$525,000
NoHo Senior Villas	11/1/2012	2	3	TAY (16-25 ages); Single Adults	30	49	0	30	0	0	0	$3,144,900	$3,120,000	$6,264,900
Osborne Place Apartments	11/1/2012	2	3	TAY (16-25 ages)	39	64	30	5	4	0	0	$6,499,460	$400,000	$6,899,460
Step Up on Vine	3/1/2013	4	3	Older Adults (ages 60+)	32	34	32	0	0	0	0	$3,328,000	$0	$3,328,000
				TOTAL	128	227	62	43	16	7	0	**$16,093,960**	**$3,520,000**	**$19,613,960**

Jail Transition & Linkage Services: A-05

Client Contacts: 5,629

Jail Transition and Linkage Services are designed to perform outreach and engage individuals involved in the criminal justice system who are 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.

Adult Field Capable Clinical Services: A-06

Unique Clients Served: 9,792
Cost: $41,193,182
Average Cost per Client: $4,207

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.

Children's Full Service Partnership: C-01

Unique Clients Served: 3,097
Cost: $41,959,360
Average Cost per Client: $13,548
Slots Allocated: 1,771 (as of March 2014)

Children's Full Service Partnership (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.

Focal Population Targeted: Children ages, 0-15 with serious emotional disturbance (SED) and one or more: Zero to five-year old: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder; DCFS or risk of involvement; In transition to a less restrictive placement; Experiencing in School: Suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation; Involved with Probation and is on psychotropic medication and transitioning back into a less structured home/community setting.

Family Support Services: C-02

Client Contacts: 219

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 FSP enrolled children who need services, but who do not meet the criteria to receive their own mental health services.

New Services Initiated during FY 2012-13: In an effort to expand FSS under Child FSP Programs, and in response to feedback gathered from parents/caregivers of Child FSP enrolled clients, Children's Systems of Care Administration (CSOCA) launched the FSS Enhanced Respite Care Pilot Program for Fiscal Years 2012-2014 to provide supportive services to parents and/or caregivers of children with SED. The purpose of the pilot is to provide short-term relief to caregivers that provide in-home care for a Child FSP-enrolled child or youth, between the ages of birth to 15 years. FSS Enhanced Respite Care Services are positive, supportive services intended to help relieve families from the stress and family strain that result from providing constant care for a child with SED, while at the same time addressing minor behavior issues, implementing existing behavioral support plans, and assisting with daily living needs. Eight (8) Child FSP providers participated in the pilot. Agencies agreed to shift up to 30% of their FSS allocation to manual invoicing, resulting in approximately $238,562 for respite services. The Respite pilot was launched in April, 2013; and as of August 2013 a total of 46 families have received respite services.

Children Field Capable Clinical Services: C-05

Unique Clients Served: 8,479
Cost: $44,934,426
Average Cost per Client: $ 5,300

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.

New Services Initiated during FY 2012-13: In response to the Katie A. class action lawsuit against Los Angeles County, and in accordance with the County settlement agreement, during fiscal year (FY) 2012-2013, DMH used $1,850,000 of the Prudent Reserve to enable eligible agencies providing FCCS to expand the services they provide to include Intensive Field Capable Clinical Services (IFCCS) and Intensive Targeted Case Management (ITCM). These services are specifically intended to address the more intensive mental health needs of Katie A. subclass members and ensure that these youth receive medically necessary mental health services. The Katie A. subclass members are defined as children with open DCFS cases**,** Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligibility, and:

1. Are in or being considered for: Wraparound, Therapeutic Foster Care or other intensive services, Therapeutic Behavioral Services, specialized care rate due to behavioral health needs or crisis stabilization/intervention; or
2. Are currently in or being considered for a group home (RCL 10 or above), a psychiatric hospital or 24 hour mental health treatment facility, or has experienced his/her 3rd or more placement within 24 months due to behavioral health needs.

The goal of IFCCS is to preserve the integrity of the family and minimize inpatient psychiatric hospitalizations, out-of-home placements in congregate care settings, and/or placement in juvenile detention centers. IFCCS are individualized, strength-based mental health treatment interventions designed to ameliorate mental health symptoms and behaviors that interfere with a child's functioning. While Child FCCS is typically for individuals birth to age 15 years, the IFCCS is providing services to

DCFS youth over age 16 to address the high need of this specialized population. Rehabilitative interventions are aimed at helping the subclass member and their identified support network build and support the child's social and community competencies by building or reinforcing those daily living skills that will assist the child/youth in living successfully at home and in the community. These specialized rehabilitative services include but are not limited to:

1. Educating the child's family about and training the family in managing the child's identified mental health disorder
2. Medically necessary, skill-based remediation of behaviors, including developing and implementing a behavioral plan, with positive behavioral supports and modeling for the child's family and others to assist them in implementing behavior change strategies
3. Improving self-care and self-regulation by addressing behaviors and social skills deficits that interfere with daily living tasks and the avoidance of exploitation by others
4. Improving self-management of symptoms, including assisting with increasing compliance with psychotropic medication
5. Improving social decorum, by addressing social skills deficits and anger management
6. Supporting the development and maintenance of social support networks and the use of community resources
7. Supporting educational objectives through identifying and addressing behaviors that interfere with succeeding in academic programs in the community

Older Adult Full Service Partnership: OA-01

Unique Clients Served: 464
Cost: $4,058,696
Average Cost per Client: $8,747
Slots Allocated: 585 (as of February 2014)

The Older Adult (OA) FSP program provides services and support to clients ages 60 and older. The OA 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. OA FSP program works collaboratively with the OA client, family, caregivers, and other service providers and offers services in homes and the community. OA FSPs place an emphasis on delivering services in ways that are culturally and linguistically appropriate.

Sixty additional countywide OA FSP slots were added. The FSP Integration Pilot Project began 7/1/2013 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 are used to determine the level of care. Ten percent of clients going into the pilot program need to fall within FSP criteria.

Focal Population Targeted: Serious mental illness and one or more: homeless or at imminent risk of homelessness; hospitalizations; jail or at risk of going to jail; imminent risk for placement in a skilled nursing facility (SNF) or nursing home or being released from SNF/nursing home; presence of a co-occurring disorder; serious risk of suicide or recurrent history or is at risk of abuse or self-neglect who are typically isolated.

Transformation Design Team: OA-02

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

- Monitors outcome measures utilized in the FSP & FCCS programs.

- Utilizes performance-based contracting measures to promote program services.

Field Capable Clinical Services: OA-03

Unique Clients Served: 2,891
Cost: $15,756,661
Average Cost per Client: $5,450

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.

Service Extenders: OA-04

Stipend Recipients: 34

Service Extenders include peers in recovery, family members and 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.

Older Adults Training: OA-05

The Older Adult Training Program addresses 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, service extenders and evidence based practices.

Transitional Age Youth Full Service Partnership: T-01

Unique Clients Served: 1,683
Cost: $20,671,381
Average Cost per Client: $12,282
Slots Allocated: 1,241 (as of December 15, 2013)

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.

Focal Population Targeted: serious emotional disturbance and or/severe and persistent mental illness and one or more: homeless or at risk of homelessness; aging out of child mental health system, child welfare system or juvenile justice system; leaving long term institutional care; experiencing 1st psychotic break.

Transitional Age Youth Drop - In Centers: T-02

Client Contacts: 1,061

TAY Drop-In Centers are intended as entry points to the mental health system for homeless youth or youth in unstable living situations. Drop-In Centers provide "low demand, high tolerance" environments in which youth can find temporary safety and begin to build trusting relationships with staff members who can, connect them to the services and supports they need. 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. 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.

The following are the TAY drop-in center locations:

Pacific Clinics
HOPE Youth Center
13001 Ramona Blvd., Suite I
Irwindale, CA 91706
(626) 337-3828

LA Gay and Lesbian Center
The Youth Center on Highland
1220 N. Highland Ave.
Los Angeles, CA 90038
(323) 860-2280; Toll Free (888) 255-2429

Transitional Age Youth Housing Services: T-03

Client Contacts: 1,247

There are 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. EESP has exceeded its annual target of 300. EESP served 606 clients in the fiscal year.
- A team of 8 Housing Specialists develop local resources and help TAY find and move into affordable housing.

Transitional Age Youth Probation Camps: T-04

Client Contacts: 2,558

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.

Transitional Age Youth Field Capable Clinical Services: T-05

Unique Clients Served: 2,055
Cost: $9,668,984
Average Cost per Client: $4,705

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.

Alternative Crisis Services: ACS-01

Client Contacts: 39,536

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.

Countywide Resource Management:

Responsible for overall administrative, clinical, integrative and fiscal aspects of the programs. Coordinates functions to maximize flow of clients between various levels of care and community-based mental health services and supports.

Residential and Bridging Program:

Involves psychiatric social workers and peer advocates assisting in the coordination of psychiatric services and supports for TAY, adults, and older adults with complicated psychiatric and medical needs. The program ensures linkages to appropriate levels and types of mental health and supportive services through collaboration with Service Area Navigators, Full Service Partnerships, residential providers, self-help groups, and other community providers. Peer advocates provide support to individuals in IMDs, IMD step-down facilities, and intensive residential programs to successfully transition to community living.

The County Hospital Adult Linkage Program is part of the Residential and Bridging program and has a mission to assist in the coordination of psychiatric services for Department of Mental Health (DMH) clients at Department of Health Services (DHS) County Hospitals in order to ensure linkage of clients being discharged with the appropriate level and type of mental health, residential, substance abuse, or other specialized programs. The County Hospital Adult Linkage Program promotes the expectation that clients must be successfully reintegrated into their communities upon discharge and that all care providers must participate in client transitions.

Service Area Navigator: SN-01

Client Contacts: 20,823j

Service Area Navigator Teams 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.

Planning Outreach & Engagement: POE-01

Client Contacts: 17,779

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 Community Mental Health Promoters. The purpose of the training is to support the development and increase the capacity of Promoters 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 enhances existing mental health paraprofessional training programs.

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

New Services Initiated during FY 2012-13:

For several years, DMH has participated in a program referred to as the Crossover Youth Multi-disciplinary Team Program (MDT) in cooperation with the Departments of Children and Family Services (DCFS) and Probation. The purpose of the program is to evaluate youth who are the subject of a WIC§ 241.1 hearing (created for those youth who are part of the dependency system and then allegedly commit crimes and become simultaneously part of the Delinquency system) and to make recommendations to the juvenile court regarding the legal status of the referred youth and the services and supports necessary to promote the best interests of the youth and the safety of the community. The program originated with one psychiatric social worker servicing the Pasadena Delinquency Court and has now expanded to allow DMH to participate in the program more fully and provide mental health staffing for the multi-disciplinary teams across the county (there currently are a total of ten Psychiatric Social Workers (PSWs) to cover the ten delinquency courtrooms across Los Angeles County that are participating in this crossover model). The youth are identified in the same manner as the 241.1 youth (who will now be treated as MDT cases). JCMHS PSWs will be required to do the following:

- Review available records of referred youth related to mental health, child welfare, and Probation history. Records will include, but will not be limited to: court files, police reports, current and past mental health reports, Individualized Education Plans (IEPs), psychiatric hospital discharge summaries, and DCFS court reports. Records will be reviewed for the purpose of providing information to the other MDT members during the meetings and for writing reports.

- Consult with case-carrying children's social worker and the assigned deputy probation officer, as well as attorneys, children's advocates, and others on the multi-disciplinary team.

- Conduct comprehensive mental health evaluations of referred youth (when permitted within the guidelines of the multi-disciplinary team) and prepare written reports of findings and recommendations that are then presented to the delinquency judicial officer to assist him/her with disposition.

- Participate in multi-disciplinary team meetings to discuss findings and recommendations and appear in juvenile delinquency court hearings as requested.

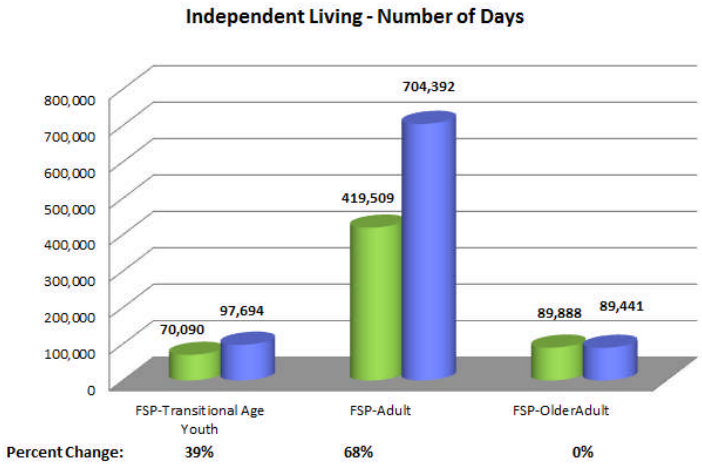
The first group was hired between February and July 2012. Between April and December 2012 the five PSWs attended a total of 368 meetings.

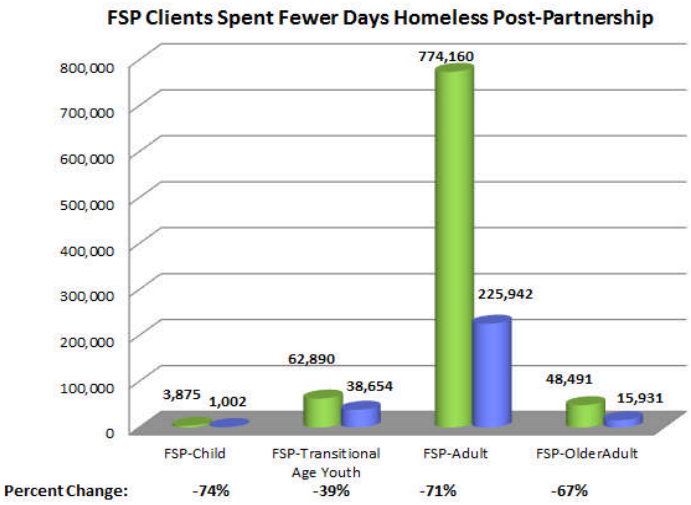
The second group of five PSWs came on between March and April 2013. From January through September, 2013, the ten PSWs have attended a total of 933 meetings.

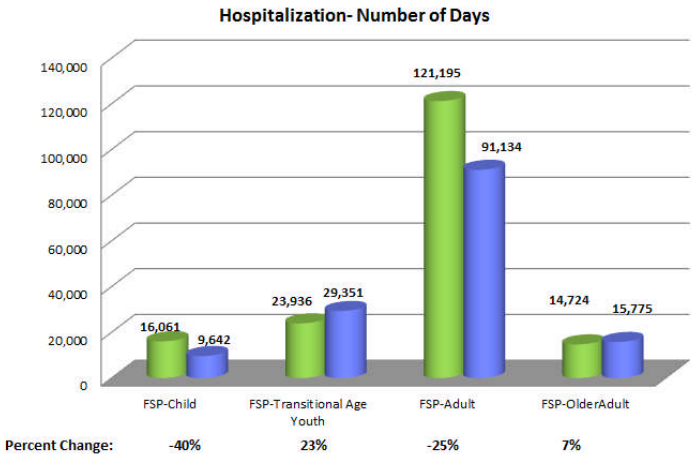
Full Service Partnership Outcomes

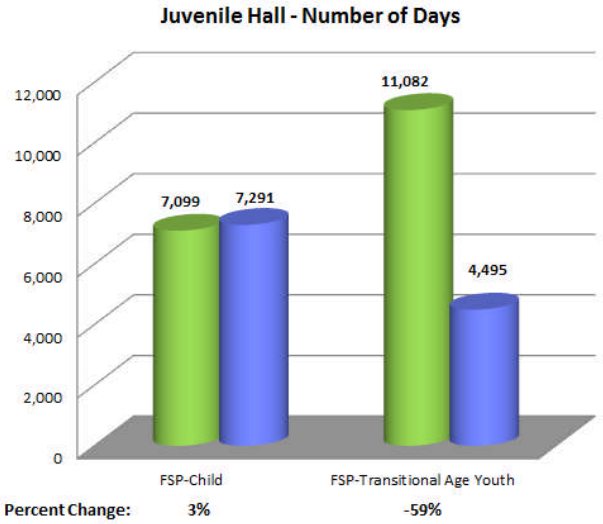
Residential

Number of Baselines Included (N) - Child: 6,135
Transitional Age Youth: 2,820
Adult: 7,812
Older Adult: 770





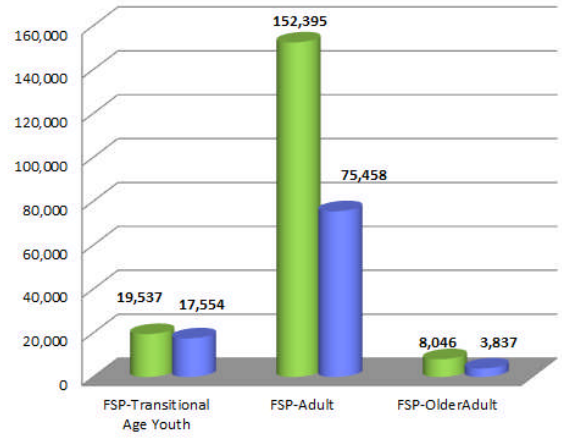




Pre Days

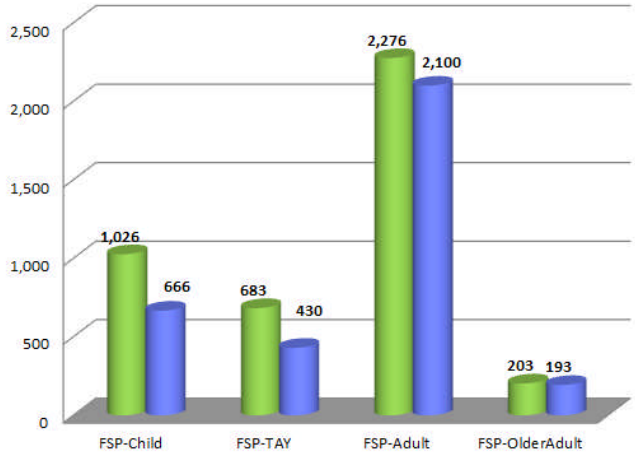
Post Days

FSP Clients Spent Fewer Days in Jail Post-Partnership



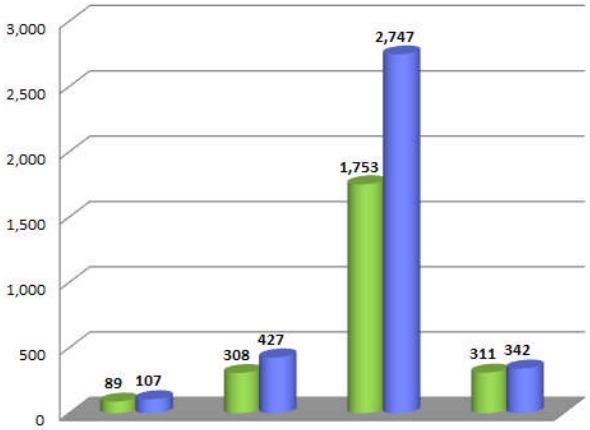
Percent Change:	-10%	-50%	-52%

FSP Clients had Fewer Hospitalizations Post Partnership



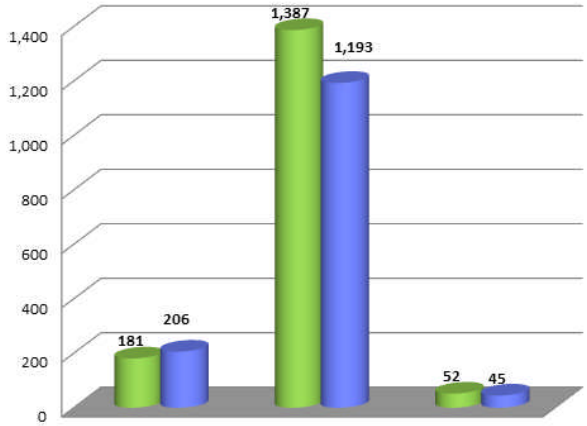
Percent Change:	-35%	- 37%	-8%	-5%

More FSP Clients Live Independently Post Partnership



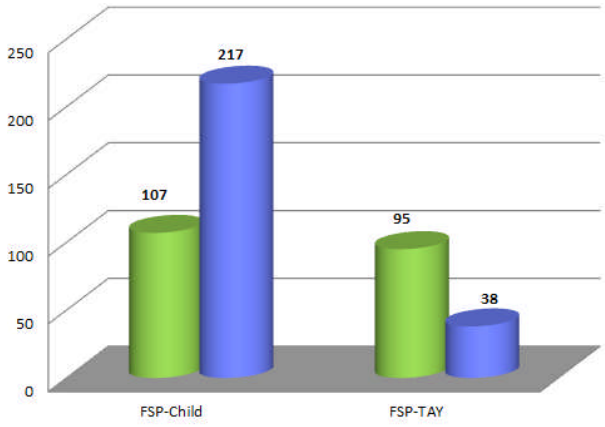
Percent Change:	20%	39%	57%	10%

Jail - Number of Clients



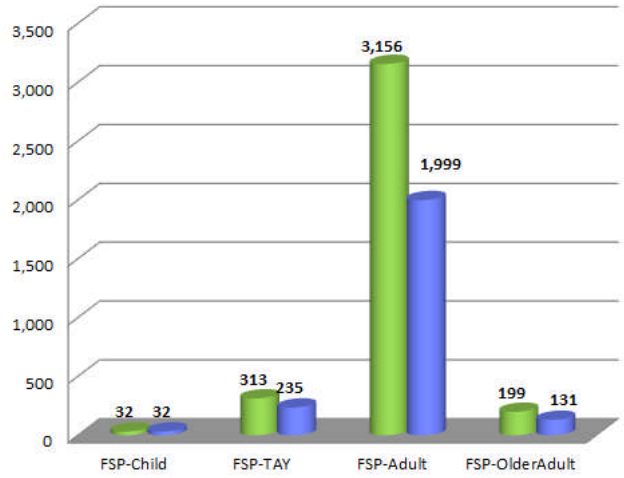
Percent Change:	14%	-14%	-13%

Juvenile Hall - Number of Clients



Percent Change:	103%	-60%

Homeless - Number of Clients



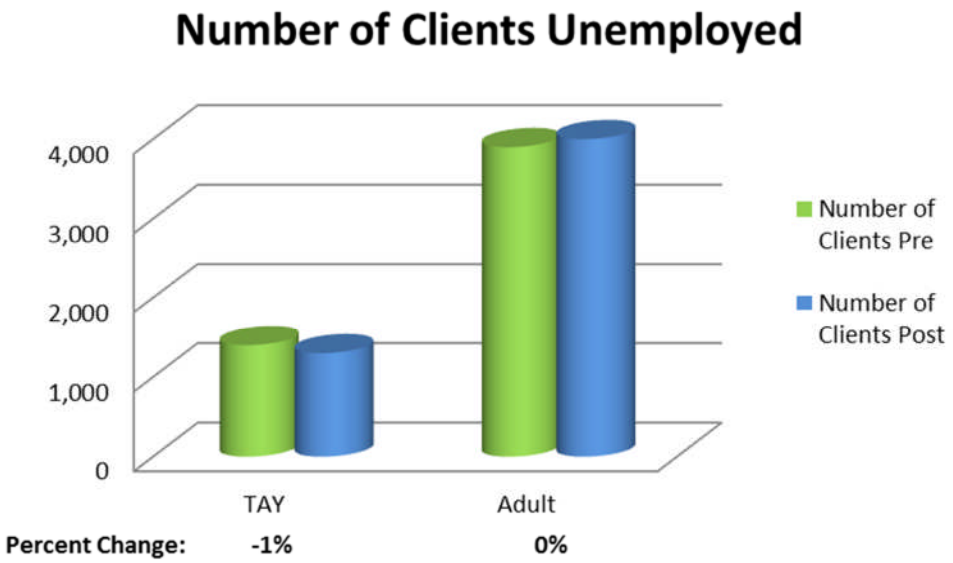
Percent Change:	0%	-25%	-37%	-34%

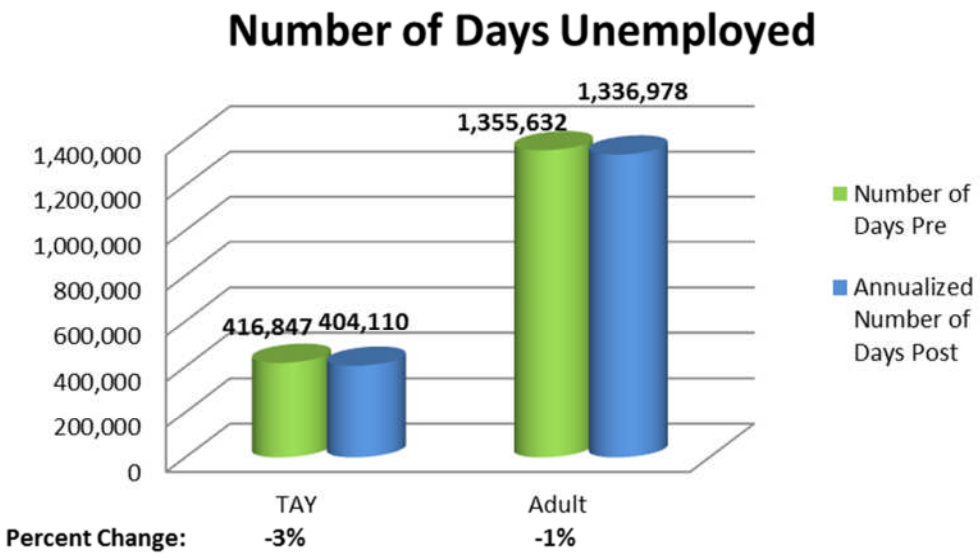
Pre Days

Post Days

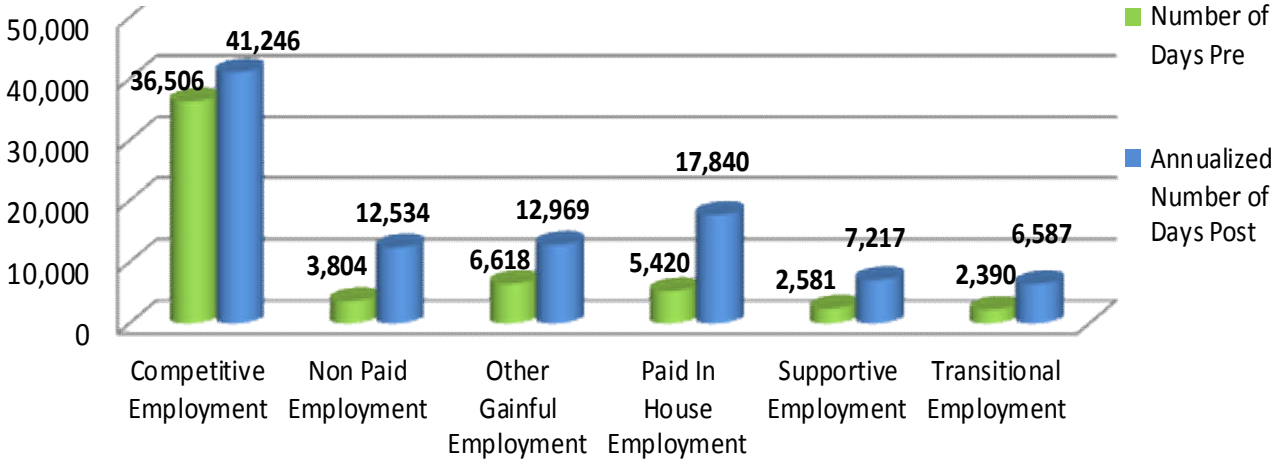
Employment

Number of Baselines Included (N) - Transitional Age Youth: 1,210
Adult: 3,866
Clients may have more than one employment type at any time.



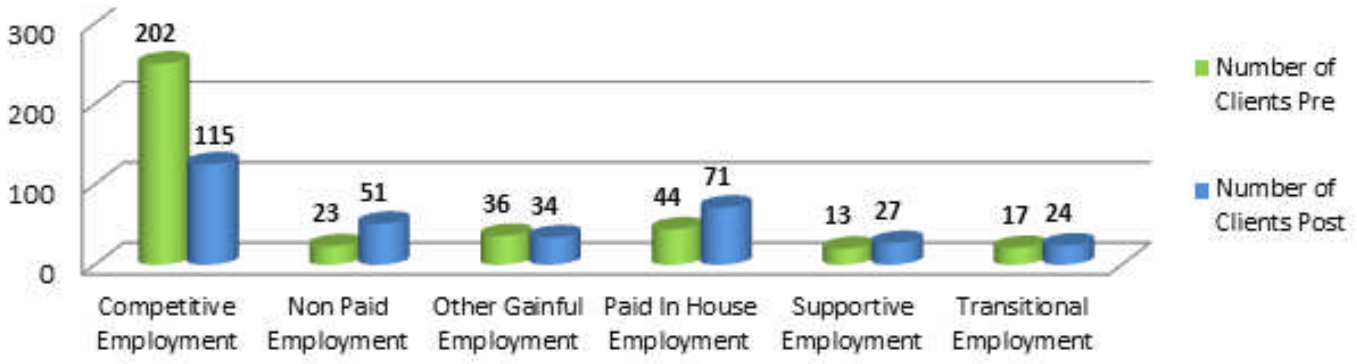


Adult Employment Outcomes- Number of Days



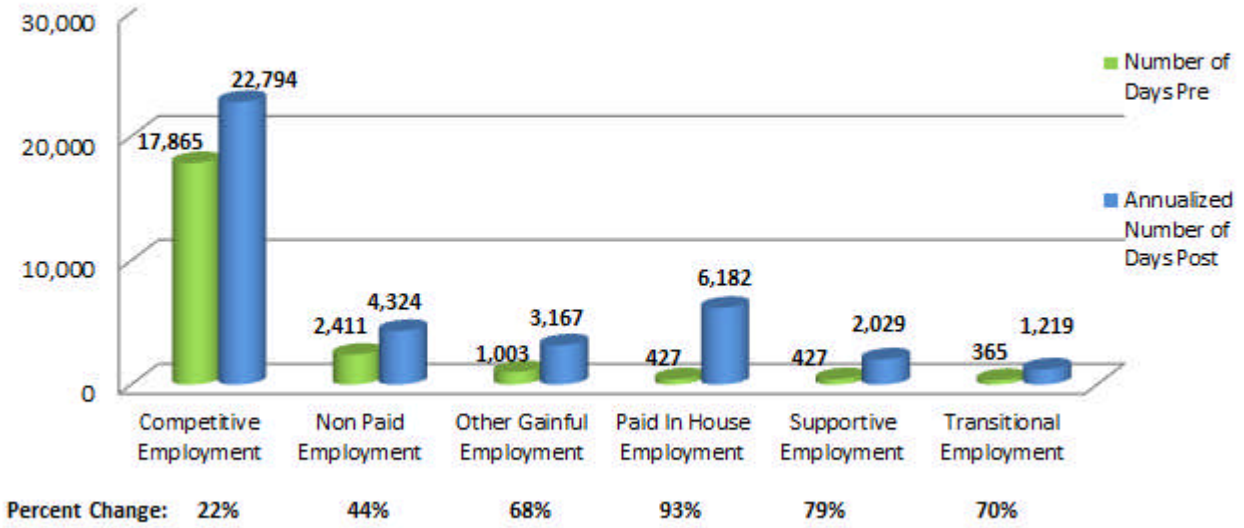
Percent Change:	**11%**	**70%**	**49%**	**70%**	**64%**	**64%**

Adult Employment Outcomes- Number of Clients



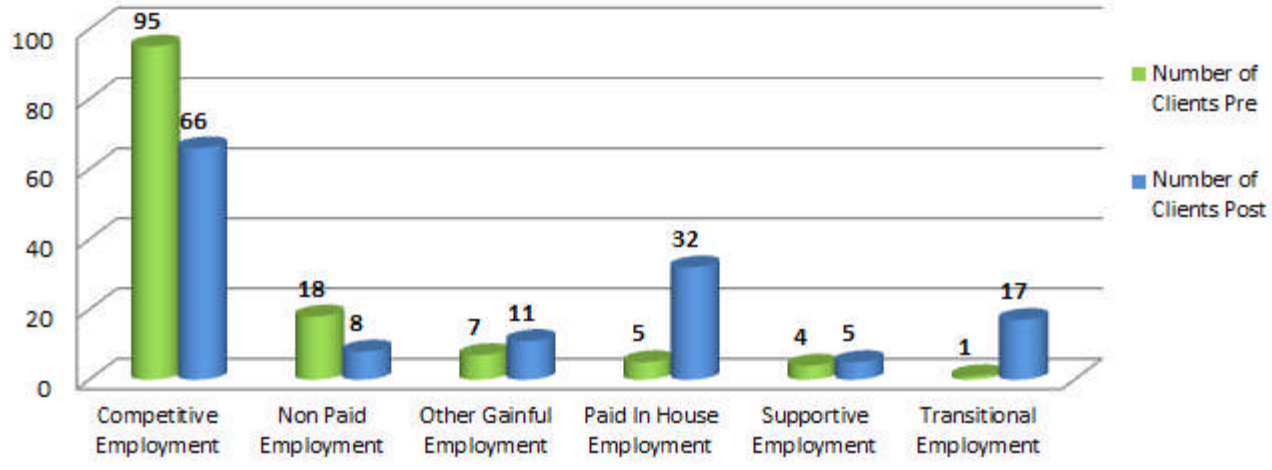
Percent Change:	**-76%**	**55%**	**-6%**	**38%**	**52%**	**29%**

TAY Employment Outcomes- Number of Days



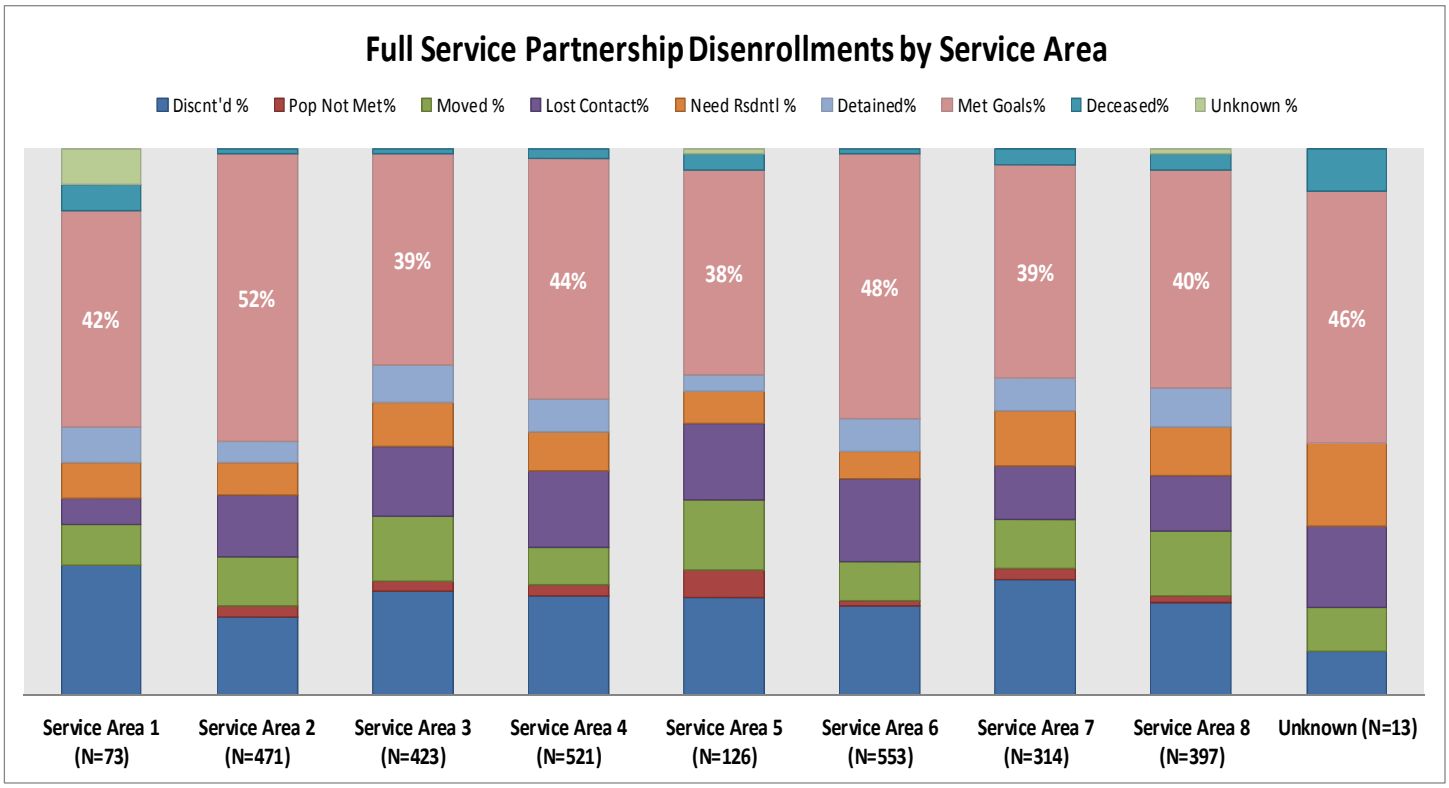
Percent Change:	22%	44%	68%	93%	79%	70%

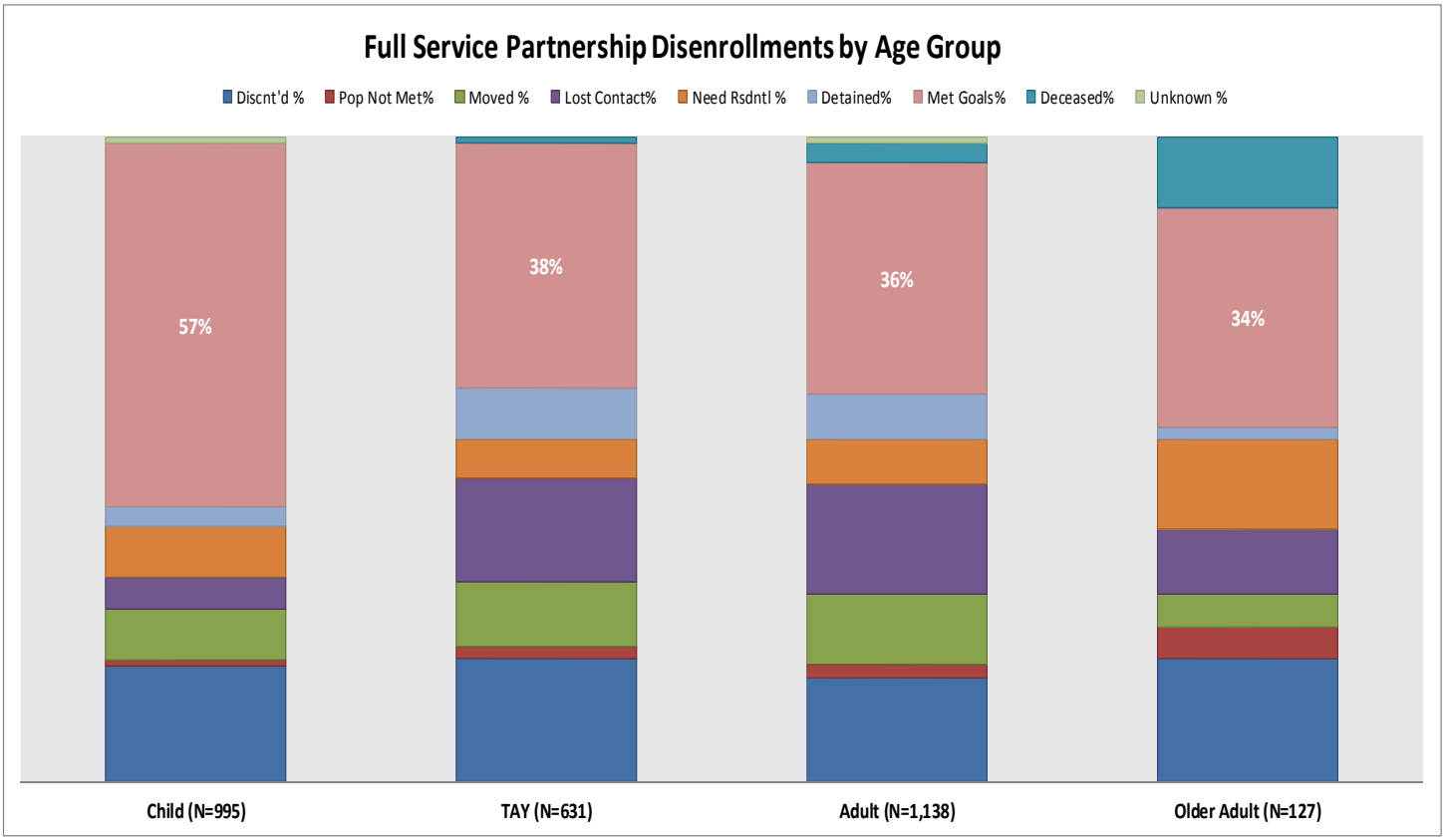
TAY Employment Outcomes- Number of Clients



Percent Change:	-44%	-125%	36%	84%	20%	94%

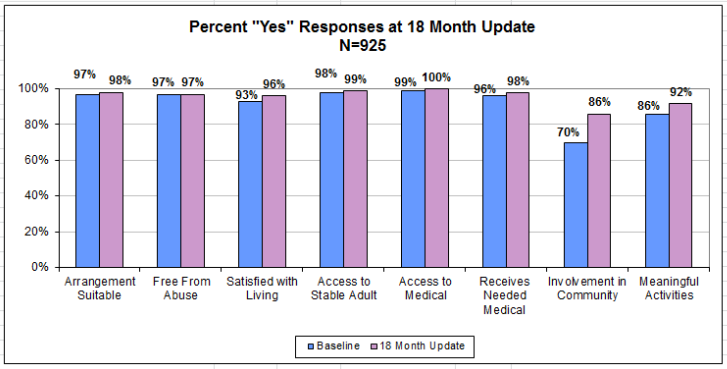
Full Service Partnership Disenrollments

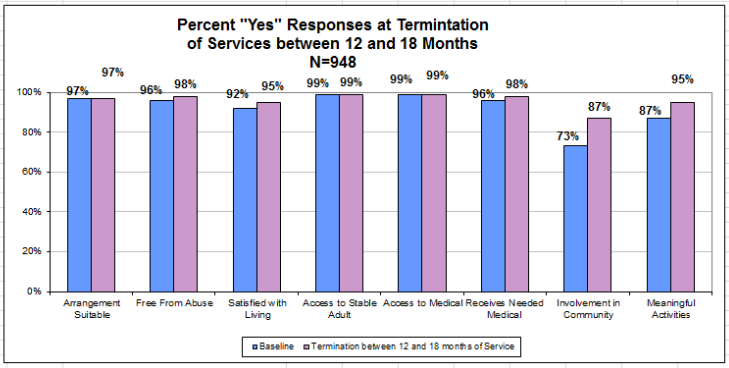




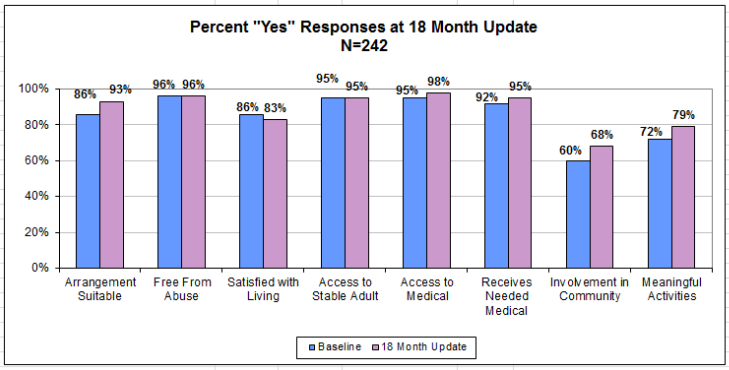
Field Capable Clinical Services Outcomes

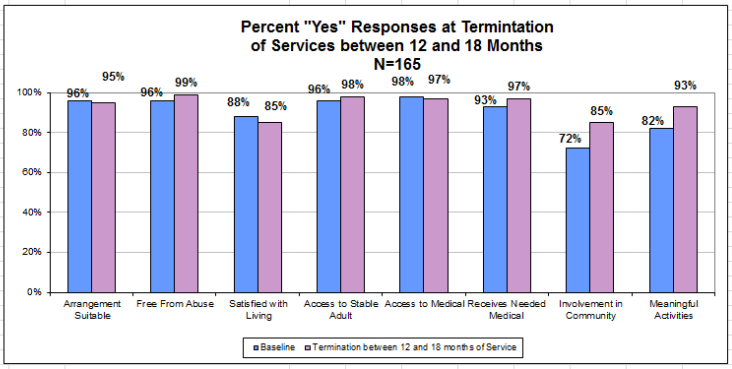
Child Program



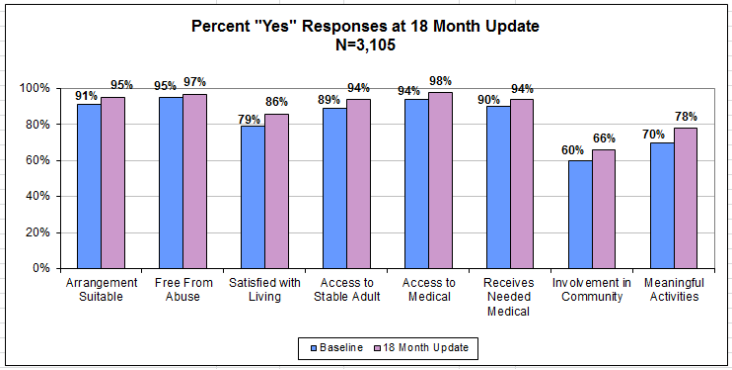


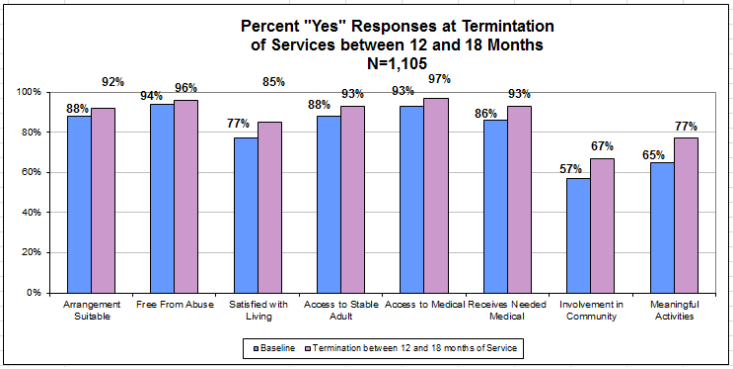
TAY Program



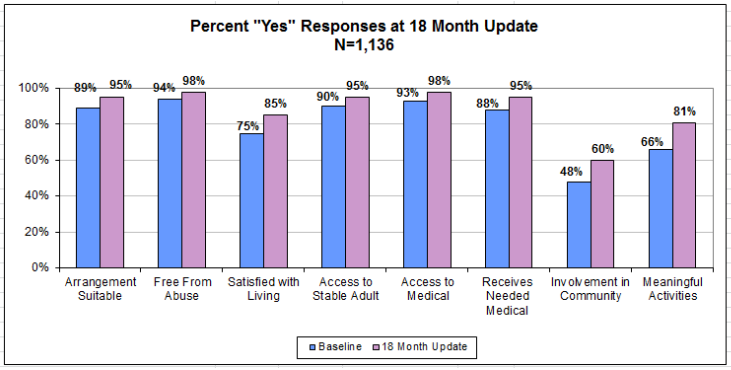


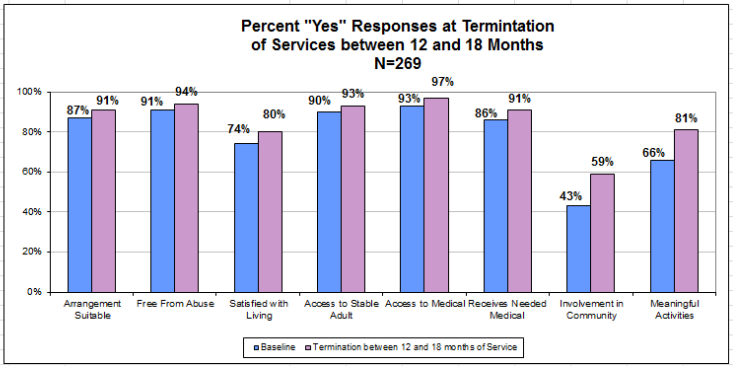
Adult Program





Older Adult Program

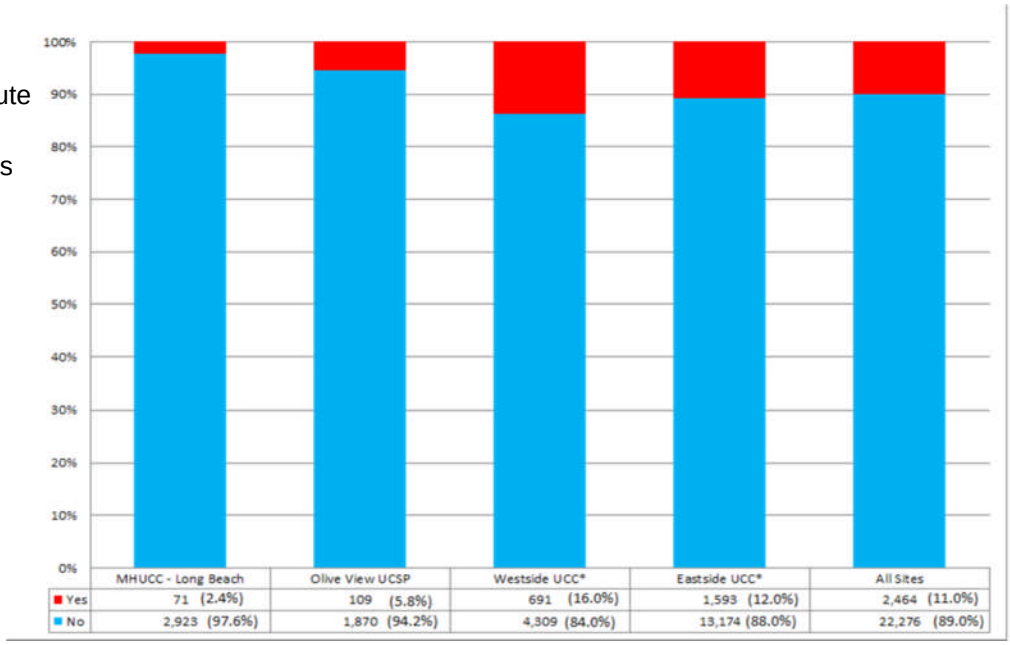




Alternative Crisis Services - Outcomes

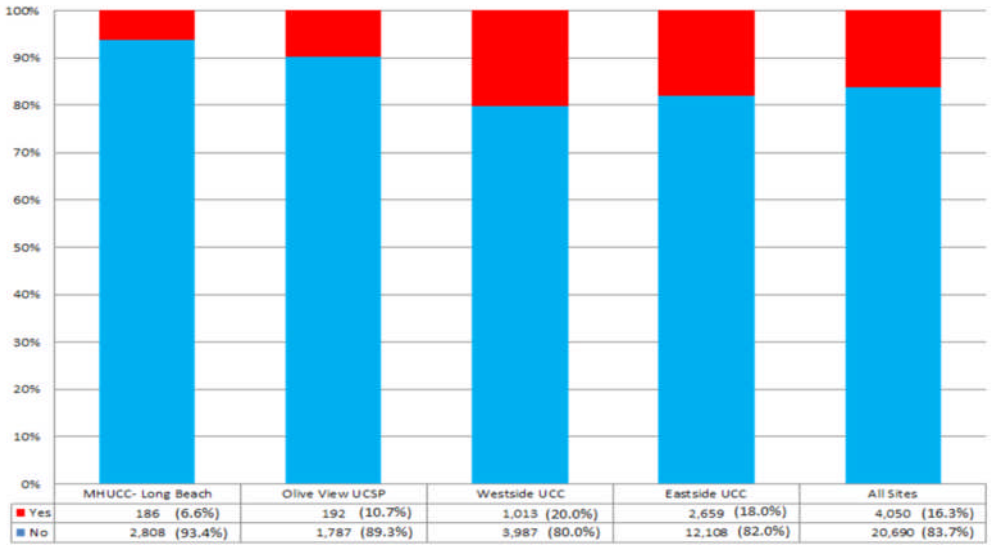
July 1, 2012 through June 30, 2013 (FY 2012-13)

New Admissions to Urgent Care Centers (UCC) with Acute Psychiatric Inpatient Hospitalization within 30 Days of UCC Services



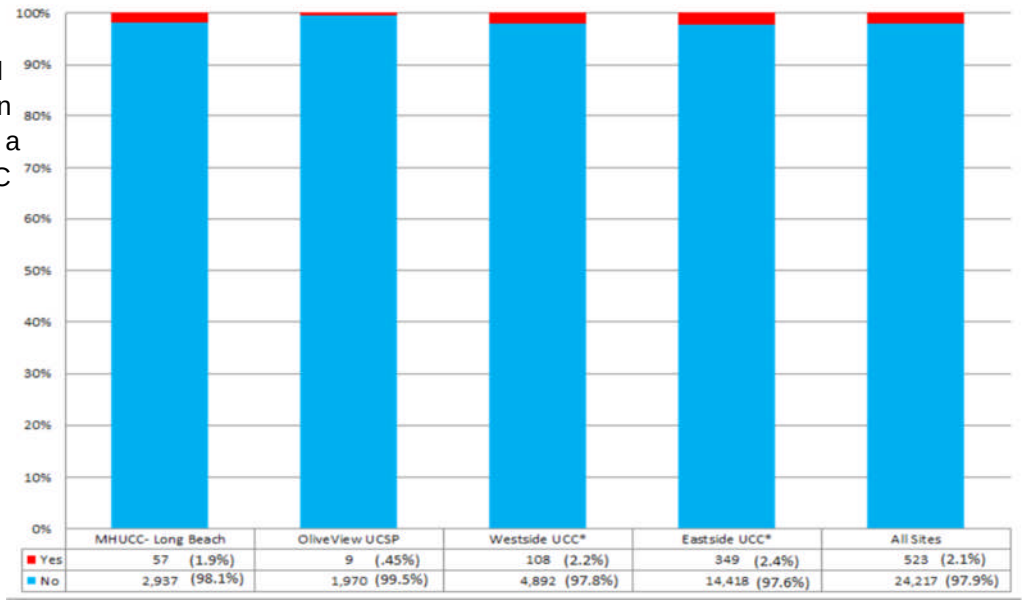
	MHUCC - Long Beach	Olive View UCSP	Westside UCC*	Eastside UCC*	All Sites
Yes	71 (2.4%)	109 (5.8%)	691 (16.0%)	1,593 (12.0%)	2,464 (11.0%)
No	2,923 (97.6%)	1,870 (94.2%)	4,309 (84.0%)	13,174 (88.0%)	22,276 (89.0%)

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



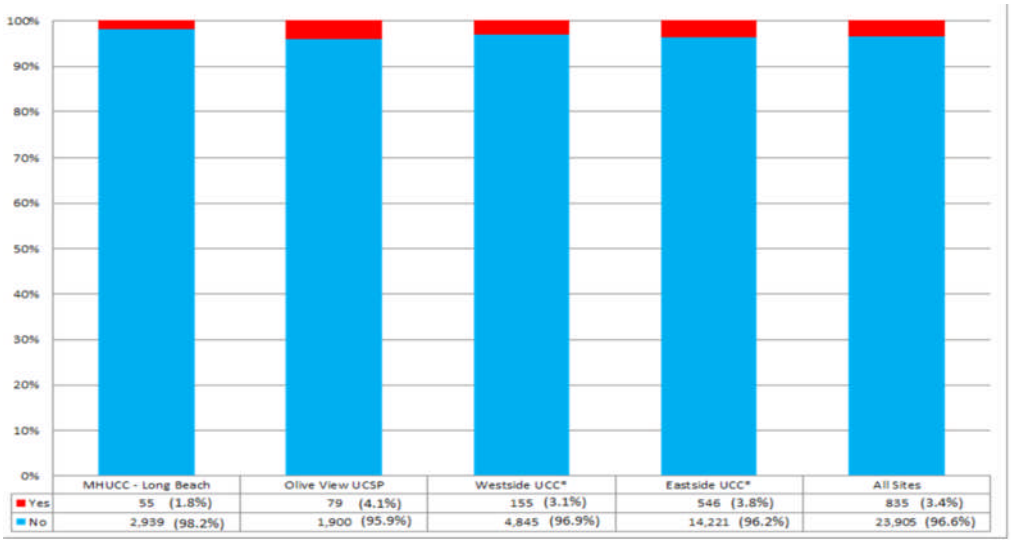
	MHUCC- Long Beach	Olive View UCSP	Westside UCC	Eastside UCC	All Sites
Yes	186 (6.6%)	192 (10.7%)	1,013 (20.0%)	2,659 (18.0%)	4,050 (16.3%)
No	2,808 (93.4%)	1,787 (89.3%)	3,987 (80.0%)	12,108 (82.0%)	20,690 (83.7%)

Any Contact with Jail Mental Health Services Within 30 Days of Being Seen at a UCC



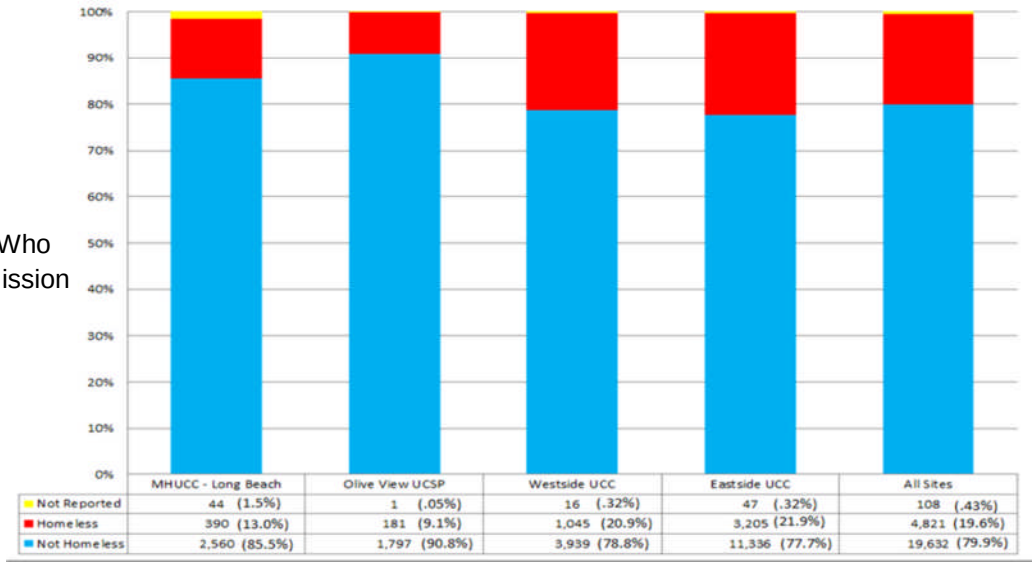
	MHUCC- Long Beach	OliveView UCSP	Westside UCC*	Eastside UCC*	All Sites
Yes	57 (1.9%)	9 (.45%)	108 (2.2%)	349 (2.4%)	523 (2.1%)
No	2,937 (98.1%)	1,970 (99.5%)	4,892 (97.8%)	14,418 (97.6%)	24,217 (97.9%)

Any Visit to a Psychiatric Emergency Room within 30 Days of Being Seen at a UCC



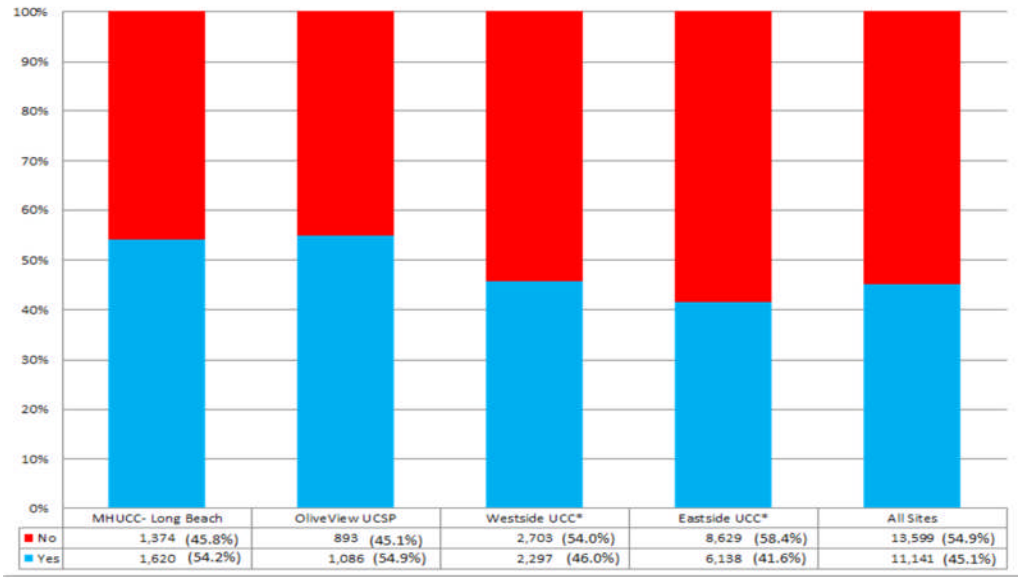
	MHUCC - Long Beach	Olive View UCSP	Westside UCC*	Eastside UCC*	All Sites
Yes	55 (1.8%)	79 (4.1%)	155 (3.1%)	546 (3.8%)	835 (3.4%)
No	2,939 (98.2%)	1,900 (95.9%)	4,845 (96.9%)	14,221 (96.2%)	23,905 (96.6%)

New Admissions at UCCs Who Were Homeless upon Admission



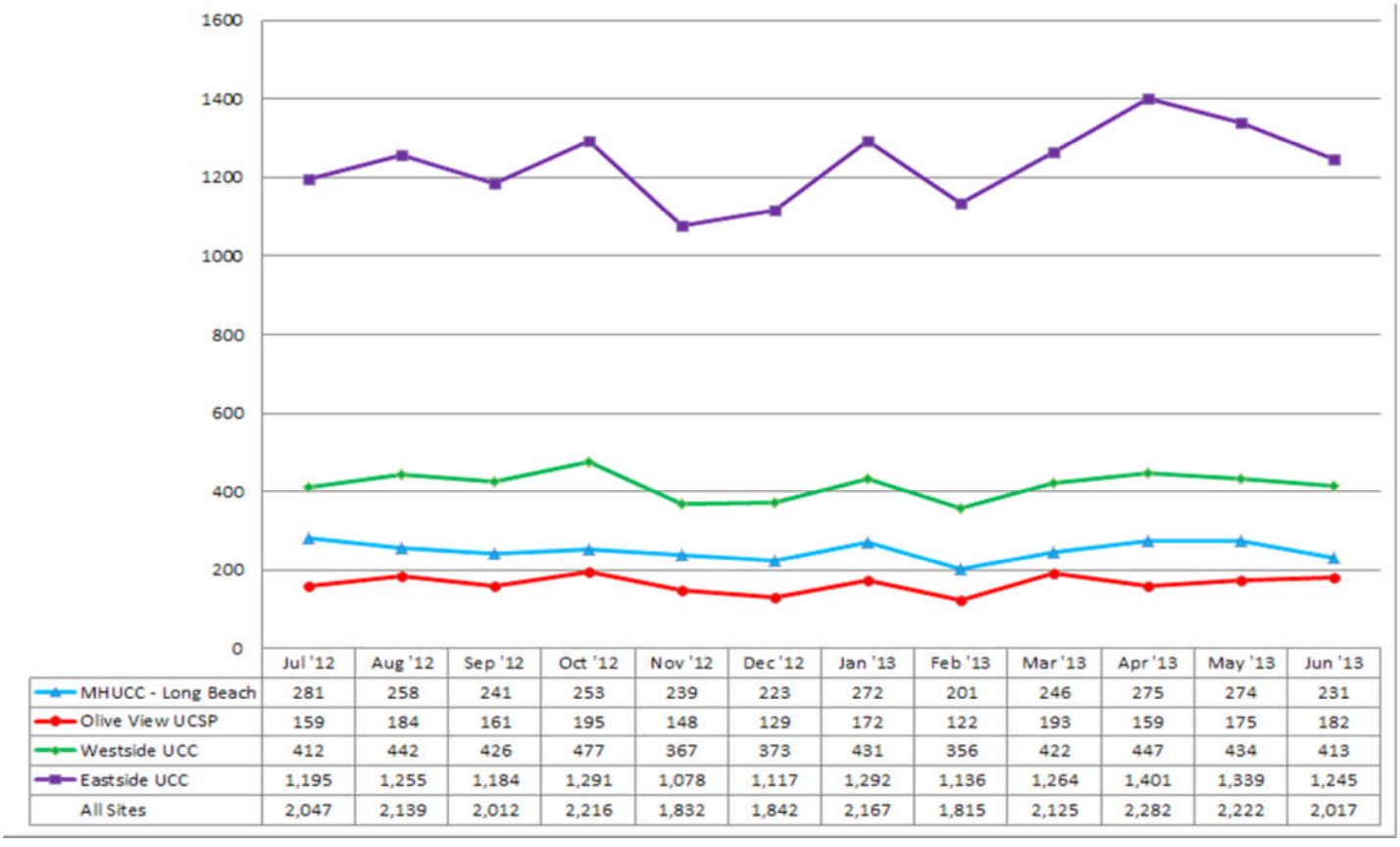
	MHUCC - Long Beach	Olive View UCSP	Westside UCC	Eastside UCC	All Sites
Not Reported	44 (1.5%)	1 (.05%)	16 (.32%)	47 (.32%)	108 (.43%)
Homeless	390 (13.0%)	181 (9.1%)	1,045 (20.9%)	3,205 (21.9%)	4,821 (19.6%)
Not Homeless	2,560 (85.5%)	1,797 (90.8%)	3,939 (78.8%)	11,336 (77.7%)	19,632 (79.9%)

Any Treatment at an Outpatient Clinic within 90 Days of Having Been Seen at a UCC



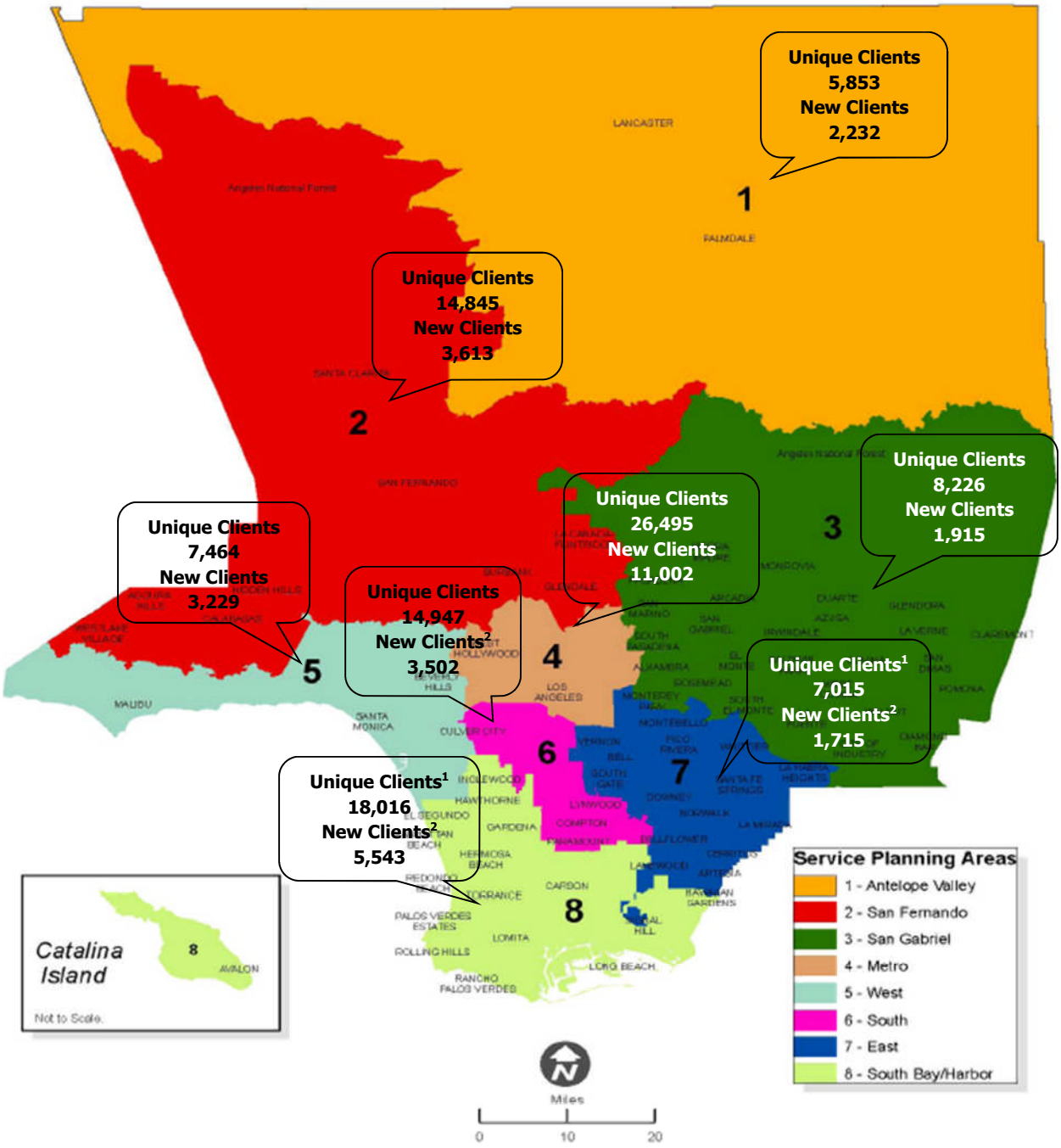
	MHUCC- Long Beach	OliveView UCSP	Westside UCC*	Eastside UCC*	All Sites
No	1,374 (45.8%)	893 (45.1%)	2,703 (54.0%)	8,629 (58.4%)	13,599 (54.9%)
Yes	1,620 (54.2%)	1,086 (54.9%)	2,297 (46.0%)	6,138 (41.6%)	11,141 (45.1%)

New Admissions to UCCs by Facility



	Jul '12	Aug '12	Sep '12	Oct '12	Nov '12	Dec '12	Jan '13	Feb '13	Mar '13	Apr '13	May '13	Jun '13
MHUCC - Long Beach	281	258	241	253	239	223	272	201	246	275	274	231
Olive View UCSP	159	184	161	195	148	129	172	122	193	159	175	182
Westside UCC	412	442	426	477	367	373	431	356	422	447	434	413
Eastside UCC	1,195	1,255	1,184	1,291	1,078	1,117	1,292	1,136	1,264	1,401	1,339	1,245
All Sites	2,047	2,139	2,012	2,216	1,832	1,842	2,167	1,815	2,125	2,282	2,222	2,017

Los Angeles County Clients Served through CSS by Service Areas Fiscal Year 2012-13



Number of Clients Served by CSS Program

Service Area 1
Alternative Crisis Services - 244
Client Run Centers- 3,074
Field Capable Clinical Services - 1,981
Full Service Partnership - 315
Probation Camp-MHSA - 1,159
Wellness Centers - 3,096

Service Area 2
Alternative Crisis Services - 2,484
Client Run Centers- 4,746
Family Support Services - 26
Field Capable Clinical Services - 3,772
Full Service Partnership - 1,511
Probation Camp-MHSA - 271
Wellness Centers - 8,396

Service Area 3
Alternative Crisis Services - 3
Client Run Centers- 11,840
Family Support Services - 45
Field Capable Clinical Services - 4,229
Full Service Partnership - 1,256
IMD Step Down Facilities - 57
Service Area Navigation - 82
Wellness Centers - 2,963

Service Area 4
Alternative Crisis Services - 11,553
Client Run Centers- 10,764
Family Support Services - 56
Field Capable Clinical Services - 4,411
Full Service Partnership - 1,638
IMD Step Down Facilities - 334
Planning- Outreach & Engagement - 57
Probation Camp-MHSA - 169
Service Area Navigation - 1,611
Wellness Centers - 9,485

Service Area 5
Alternative Crisis Services - 347
Client Run Centers- 4,876
Family Support Services - 6
Field Capable Clinical Services - 1,176
Full Service Partnership - 457
Wellness Centers - 2,934

Service Area 6
Alternative Crisis Services - 739
Client Run Centers- 5,894
Family Support Services -27
Field Capable Clinical Services - 2,020
Full Service Partnership - 1,961
Jail-Transition/Linkage - 635
Wellness Centers - 9,665

Service Area 7
Alternative Crisis Services - 588
Client Run Centers- 24,794
Family Support Services - 27
Field Capable Clinical Services - 2,445
Full Service Partnership - 1,118
Probation Camp-MHSA - 117
Wellness Centers - 3,229

Service Area 8
Alternative Crisis Services - 2,450
Client Run Centers- 7,406
Family Support Services - 27
Field Capable Clinical Services - 2,760
Full Service Partnership - 1,881
IMD Step Down Facilities - 1
Service Area Navigation - 671
Wellness Centers - 11,300

Ethnicity

Service Area 1
African-American – 36%
Hispanic – 32%
White – 27%
Other – 2%
Asian – 1%
Unknown – 1%
Native American - 1%
Pacific Islander - <1%

Service Area 2
White – 41%
Hispanic – 38%
African-American –10%
Asian – 5%
Other – 3%
Unknown – 2%
Native American - <1%
Pacific Islander - <1%

Service Area 3
Hispanic – 52%
White – 20%
Asian –13%
African-American –10%
Other –2%
Unknown –2%
Native American -1%
Pacific Islander -<1%

Service Area 4
Hispanic –40%
African-American –29%
White –20%
Asian –7%
Other –2%
Unknown – 1%
Native American -1%
Pacific Islander -<1%

Service Area 5
White – 40%
African-American – 28%
Hispanic – 18%
Unknown – 8 %
Other – 3%
Asian – 2%
Native American - <1%
Pacific Islander- <1%

Service Area 6
African-American – 59%
Hispanic –35%
White – 3%
Unknown – 1%
Other – 1%
Asian – 1%
Native American - <1%
Pacific Islander- <1%

Service Area 7
Hispanic – 65%
White – 19%
African-American – 8%
Asian – 3%
Native American - 3%
Unknown – 2%
Other – 1%
Pacific Islander- <1%

Service Area 8
African-American – 30%
Hispanic – 30%
White – 26%
Asian – 9%
Unknown – 3%
Other – 2%
Native American - <1%
Pacific Islander- <1%

Primary Language

Service Area 1
English - 88%
Spanish - 11%
Unknown/Not Reported - 1%
Other - <1%

Service Area 2
English - 69%
Spanish - 19%
Armenian - 5%
Farsi – 2%
Unknown/Not Reported - 1%
Other - 3%
Russian - 1%
Pilipino/Tagalog - 1%

Service Area 3
English - 70%
Spanish - 17%
Cantonese - 3%
Vietnamese - 2%
Unknown/Not Reported - 3%
Other - 3%
Mandarin - 2%

Service Area 4
English - 75%
Spanish - 17%
Unknown/Not Reported - 2%
Other - 4%
Korean - 2%
Armenian - 1%

Service Area 5
English - 89%
Spanish - 6%
Unknown/Not Reported - 2%
Other - 3%

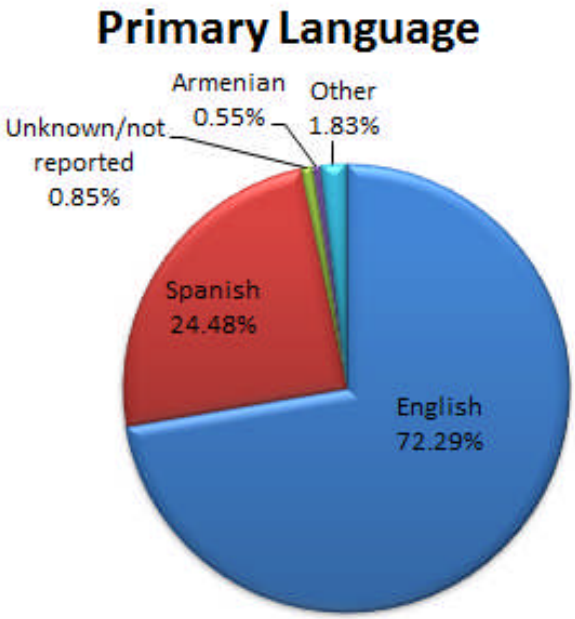
Service Area 6
English - 79%
Spanish - 19%
Unknown/Not Reported - 2%
Other - <1%

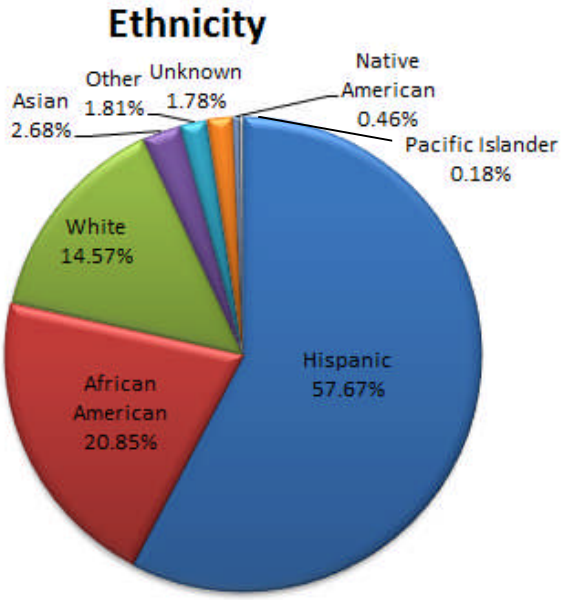
Service Area 7
English - 70%
Spanish - 25%
Unknown/Not Reported - 2%
Other - 2%
Cambodian - 1%

Service Area 8
English - 79%
Spanish - 12%
Cambodian - 4%
Vietnamese - 1%
Unknown/Not Reported - 1%
Other - 1%
Korean - 1%
Pilipino/Tagalog - 1%

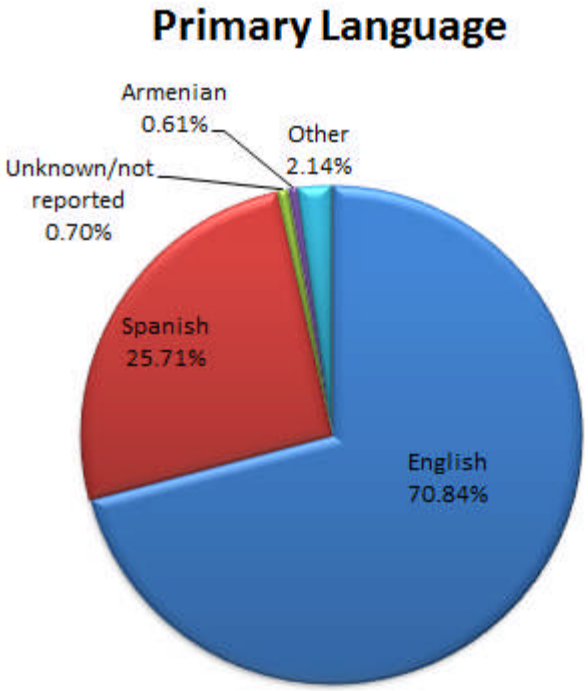
Prevention and Early Intervention

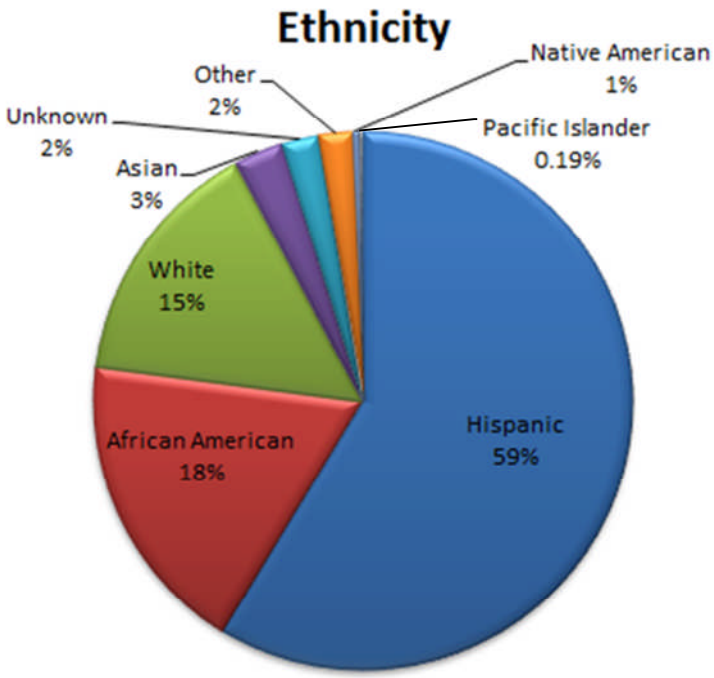
Unique Clients Receiving a Direct Mental Health Service through the PEI Plan: **73,140**





New Clients Receiving PEI Services Countywide with No Previous MHSA Service: **38,154**





Evidenced Based Practices (EBPs)

Number of Clients Served by EBP

Top 10 EBPs Delivered in the County

Managing and Adapting Practice
Unique Clients Served: 16,457
Average Cost per Client: $4,138

Seeking Safety
Unique Clients Served: 11,849
Average Cost per Client: $3,230

Trauma Focused CBT
Unique Clients Served: 11,404
Average Cost per Client: $3,868

Crisis Oriented Recovery Services
Unique Clients Served: 4,987
Average Cost per Client: $1,237

***Mental Health* Integration Program**
Unique Clients Served: 4,766
Average Cost per Client: $814

Triple P Positive Parenting Program
Unique Clients Served: 4,212
Average Cost per Client: $2,623

School Threat Assessment Response
Unique Clients Served: 3,607
Average Cost per Client: $2,415

Interpersonal Psychotherapy for Depression
Unique Clients Served: 2,593
Average Cost per Client: $2,517

Child Parent Psychotherapy
Unique Clients Served: 2,178
Average Cost per Client: $3,788

Aggression Replacement Training
Unique Clients Served: 2,081
Average Cost per Client: $2,458

Top 5 EBPs Delivered in the County by Age Group

Children

Managing and Adapting Practice - 13,308
Trauma Focused CBT - 9,490
Triple P Positive Parenting Program - 3,973
Seeking Safety - 2,726
School Threat Assessment Response Team - 2,387

TAY

Seeking Safety - 4,718
Managing and Adapting Practice - 3,124
Trauma Focused CBT - 1,846
School Threat Assessment Response Team - 1,164
Aggression Replacement Training - 885

Adult

Seeking Safety - 3,992
Mental Health Integration Program - 3,734
Crisis Oriented Recovery Services - 2,481
Individual Cognitive Behavioral Therapy - 1,380
Interpersonal Psychotherapy for Depression - 913

Older Adult

Mental Health Integration Program - 613
Interpersonal Psychotherapy for Depression - 415
Seeking Safety - 413
Crisis Oriented Recovery Services - 197
Problem Solving Therapy - 159

Early Intervention Projects and Implementation

(EBP-Evidence-Based Practice; PP = Promising Practice; CDE – Community Defined Evidence Practice)

PEI Early Start-Suicide Prevention: ES-1

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

EBP/PP/CDEs Implemented:

24/7 Crisis Hotline: Didi Hirsch provides 24/7 crisis hotline services in English as well as 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. The hotline has responded to 23,114 calls. It also provided 412 Spanish-speaking crisis hotline services; 701 support services to attempters and/or those bereaved by a suicide, 365 assistance and consultation to law enforcement and first responders; and 345 trainings in ASIST and safe TALK to various staff to recognize and respond appropriate to suicide. In 2012 the agency began providing eight hours of coverage in the Korean language seven days a week from 6:30pm to 2:30am. Efforts are being made to increase their Vietnamese speaking staff.

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 has expanded to include male as well as female youth ages 14-25 years of age, who were identified as being "at risk" for suicide. In FY 2012-2013, a total of 3,181 contacts were made, with the majority of services for information referral only (449), school problems (969), stress (95), and parent training (278).

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 post- intervention 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).

Partners in Suicide (PSP) Team for Children, Transition Age Youth (TAY), Adults, and Older Adults:
It is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The team includes one Korean-speaking and three Spanish-speaking members. The team offers education, identifies appropriate tools, such as evidence-based practices, and provides linkage and referrals to age appropriate services

Team members participated in a total of 220 suicide prevention events during, outreaching to more than 5,600 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 10 Applied Suicide Intervention Skills Training (ASIST); attaining 4 new provisional ASIST trainers for a total of 17 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, and conducted the 2nd Annual Suicide Prevention Summit which was attended by nearly 100 participants.

PEI Early Start - School Mental Health Initiative: ES-2

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

EBP/PP/CDEs Implemented:

1. School Threat Assessment and Response Team (START)
2. Service Area 6 School Mental Health Demonstration Pilot*

Process of being implemented in FY 2013-14

PEI Early Start-Anti-Stigma Discrimination: ES-3

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. Core strategies have been identified to reduce stigma and discrimination, increase access to mental health services, and reduce the need for more intensive mental health services in the future. The services include anti-stigma education specifically targeting underrepresented communities through outreach utilizing culturally sensitive and effective tools; educating and supporting mental health providers; connecting and linking resources to schools, families, and community agencies; and client and family education and empowerment.

EBP/PP/CDEs Implemented:

1. Family-focused Strategies to Reduce Mental Health Stigma and Discrimination
2. Children's Stigma and Discrimination Reduction Project
3. Older Adults Mental Wellness
4. Profiles of Hope Project
5. Videos

School Based Services: PEI-1

The School-Based Services Project is intended to (1) build resiliency and increase protective factors among children, youth and their families; (2) identify as early as possible children and youth who have risk factors for mental illness; and (3) provide on-site services to address non-academic problems that impede successful school progress. 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.

EBP/PP/CDEs Implemented:

1. Aggression Replacement Training
2. Cognitive Behavioral Intervention for Trauma in School
3. Multidimensional Family Therapy
4. Olweus Bullying Prevention Program
5. Promoting Alternative Thinking Strategies
6. Strengthening Families
7. Why Try? Program

Family Education & Support Services: PEI-2

The purpose of the Family Education and Support Project is to build competencies, capacity and resiliency in parents, family members and other caregivers 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.

EBP/PP/CDEs Implemented:

1. Caring for Our Families
2. Incredible Years
3. Managing and Adapting Practice*
4. Mindful Parenting*
5. Promoting Alternative Thinking Strategies*
6. Nurse-Family Partnership
7. Nurturing Parenting Program
8. Triple P Positive Parenting Program

Program was added to the PEI Plan after 2009

At Risk Family Services: PEI-3

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. It 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.

EBP/PP/CDEs Implemented:

1. Brief Strategic Family Therapy
2. Child-Parent Psychotherapy
3. Families OverComing Under Stress (FOCUS)*
4. Group Cognitive Behavioral Therapy for Major Depression
5. Incredible Years
6. Make Parenting a Pleasure
7. Mindful Parenting*
8. Parent-Child Interaction Therapy
9. Reflective Parenting Program
10. Triple P Positive Parenting Program
11. UCLA Ties Transition Model

Program was added to the PEI Plan after 2009

Trauma Recovery Services: PEI-4

The Trauma Recovery Services Project (1) provides short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event; and (2) 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.

EBP/PP/CDEs Implemented:

1. Child-Parent Psychotherapy
2. Crisis Oriented Recovery Services
3. Dialectal Behavioral Therapy*
4. Depression Treatment Quality Improvement*
5. Group Cognitive Behavioral Therapy for Major Depression
6. Individual Cognitive Behavioral Therapy*
7. Parent-Child Interaction Therapy

8. Prolonged Exposure Therapy for Posttraumatic Stress Disorder
9. Seeking Safety
10. System Navigators for Veterans
11. Trauma Focused Cognitive Behavioral Therapy

Program was added to the PEI Plan after 2009

Primary Care & Behavioral Health: PEI-5

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. The goal of the project is to prevent patients at primary care clinics from developing severe behavioral health issues by addressing their mental health issues early on. Behavioral health professionals skilled in consultation and primary care liaison will be integrated within the primary care system. By offering assistance in identifying emotional and behavioral issues at a clinic setting, the stigma associated with seeking out mental health services will be minimized.

EBP/PP/CDEs Implemented:

1. Alternatives for Families – Cognitive Behavioral Therapy
2. Incredible Years
3. Mental Health Integration Program (formerly IMPACT)
4. Triple P Positive Parenting Program

Early Care & Support for Transition Age Youth: PEI-6

The Early Support and Care for Transition-Age Youth Project (1) builds resiliency, increase protective factors, and promote positive social behavior among TAY; (2) addresses depressive disorders among the TAY, especially those from dysfunctional backgrounds; and (3) 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.

EBP/PP/CDEs Implemented:

1. Aggression Replacement Training
2. Center for the Assessment and Prevention of Prodromal States*
3. Group Cognitive Behavioral Therapy for Major Depression
4. Interpersonal Psychotherapy for Depression
5. Multidimensional

Process of being implemented in FY 2013-14

Juvenile Justice Services: PEI-7

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.

EBP/PP/CDEs Implemented:

1. Aggression Replacement Training
2. Cognitive Behavioral Intervention for Trauma in School
3. Functional Family Therapy
4. Group Cognitive Behavioral Therapy for Major Depression
5. Loving Intervention for Family Enrichment
6. Multidimensional Family Therapy
7. Multisystemic Therapy
8. Trauma Focused Cognitive Behavioral Therapy

Early Care & Support for Older Adults: PEI-8

The purpose of the Early Care and Support Project for Older Adults is to (1) establish the means to identify and link older adults who need mental health treatment but are reluctant, are hidden or unknown, and/or unaware of their situation; (2) prevent and alleviate depressive disorders among the elderly; and (3) provide brief mental health treatment for individuals. Services are directed at older adults, their family members, caregivers, and others who interact with and provide services to this senior citizen population.

EBP/PP/CDEs Implemented:

1. Cognitive Behavioral Therapy for Late Life Depression
2. Crisis Oriented Recovery Services
3. Interpersonal Psychotherapy for Depression
4. Program to Encourage Active Rewarding Lives for Seniors (PEARLS)
5. Problem Solving Therapy*

Program was added to the PEI Plan after 2009

Improving Access for Underserved Populations: PEI-9

The Improving Access for Underserved Populations Project is intended to (1) build resiliency and increase protective factors among monolingual and limited English-speaking immigrants and underserved cultural populations, lesbian/gay/bisexual/transgender/ questioning (LGBTQ) individuals, deaf/hard of hearing individuals, blind/visually impaired individuals and their families; (2) identify as early as possible individuals who are a risk for emotional and mental problems; and (3) provide culturally and linguistically appropriate early mental health intervention services. The programs will provide outreach and education as well as promote mental wellness through universal and selective prevention strategies.

EBP/PP/CDEs Implemented:

1. Group Cognitive Behavioral Therapy for Major Depression
2. Nurse-Family Partnership
3. Prolonged Exposure Therapy for Posttraumatic Stress Disorder
4. Trauma Focused Cognitive Behavioral Therapy

American Indian Project: PEI-10

The American Indian Project (1) builds resiliency and increase protective factors among children, youth and their families; (2) addresses stressful forces in children/youth lives, teaching coping skills, and diverting suicide attempts; and (3) identifies 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.

EBP/PP/CDEs Implemented:

1. American Indian Life Skills*
2. Trauma Focused Cognitive Behavioral Therapy: Honoring Children, Mending the Circle*

Process of being implemented in FY 2013-14

Cost per Client

For non-mental health services delivered to 4,497 individuals, the cost per individual was $204. The services included case management, assessment, and counseling. The clients received services through the following projects:

Project 4 – School-Based Services

Project 5 – Family Education and Support Services

Project 6 – Early Care and Support for TAY'

Project 10 – Juvenile Justice Services

Project 12 – Improving Access to Underserved Populations

PEI Practices Implemented

(As of October 1, 2013 and pending in 2014)

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
1	**Aggression Replacement Training (ART)**	ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control training, and training in moral reasoning. Skill-streaming teaches pro-social skills. In anger control training, youths are taught how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others.	Children (ages 5-12) – Skillstreaming Only Children (ages 12-15) TAY (ages16-17)	Prevention & Early Intervention	4, 9, 10
2	**Alternatives for Families – Cognitive Behavioral Therapy (AF-CBT)**	AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.	Children (ages 4-15) TAY (ages 16-17)	Early Intervention	8
3	**American Indian Life Skills Program (AILSP)**	AILSP is designed to build life skills and increase suicide prevention skills for American Indian high school students. It is designed to promote self-esteem, identify emotions and stress, increase communication and problem solving skills, and recognize and eliminate self-destructive behavior (including substance use). AILSP provides American Indian children and TAY information on suicide and suicide intervention training and helps them set personal and community goals. To be implemented early 2014.	Children (ages 14-15) TAY (ages 16-18)	Prevention	13
4	**Brief Strategic Family Therapy (BSFT)**	BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.	Children (ages 10-15) TAY (ages 16-18)	Prevention & Early Intervention	6
5	**Caring for Our Families (CFOF)**	Adapted from the "Family Connections" Model, CFOF includes community outreach, family assessment, and individually tailored treatment programs. The goal is to help families meet the basic needs of their children and reduce the risk of child neglect. The core components include emergency assistance/concrete services; home-based family intervention (e.g., outcome-driven service plans, individual and family counseling); service coordination with referrals targeted toward risk and protective factors; and multi-family supportive recreational activities.	Children (ages 5-11)	Prevention & Early Intervention	5, 6

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
6	**Center for the Assessment and Prevention of Prodromal States (CAPPS)**	The focus of this CAPPS PEI Demonstration Pilot will be to conduct outreach and engagement specifically to those youth who are experiencing their first-break psychosis and early onset of serious mental illnesses with psychotic features. In order to mitigate mental health challenges and reduce the progression of these challenges into mental health diagnoses, this project will also engage families and significant others of the youth as well as the youth themselves in PEI services. To be implemented in 2014.	TAY	Prevention & Early Intervention	9
7	**Child-Parent Psychotherapy (CPP)**	CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma.	Young Children (ages 0-6)	Early Intervention	6,7
8	**Cognitive Behavioral Intervention for Trauma in School (CBITS)**	CBITS is an early intervention for children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of Posttraumatic Stress Disorder (PTSD), depression, or anxiety. To improve access to mental health care, services are delivered within the school setting by clinical staff as part of multi-disciplinary treatment teams. CBITS intends to reduce the impact of trauma-related symptoms, build resilience, and increase peer and parental support for students at-risk of school failure.	Children (ages 10-15) TAY	Prevention & Early Intervention	4,10
9	**Crisis Oriented Recovery Services (CORS)**	DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed in the future. The psychotherapy component assists individuals who are currently depressed to gain understanding of factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disorder.	Children TAY Adults Older Adults	Prevention & Early Intervention	7
10	**Depression Treatment Quality Improvement (DTQI)**	DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, dialectical strategies, mindfulness, contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.	Children (ages 12-15) TAY (ages16-20)	Early Intervention	8,9

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
11	**Dialectical Behavior Therapy (DBT)**	Didi Hirsch provides 24/7 crisis hotline services in English, Spanish, and Korean. Support services are provided to attempters and/or those bereaved by a suicide, as well as consultation to law enforcement and first responders. This practice builds 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.	TAY (18-25) Adults Older Adults Directly Operated Clinics only	Prevention & Early Intervention	7
12	**Early Start Suicide Prevention - 24/7 Crisis Hotline**	Didi Hirsch provides 24/7 crisis Hotline services in English, Spanish, and Korean. Support services are provided to attempters and/or those bereaved by a suicide, as well as consultation to law enforcement and first responders. This practice builds 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.	Children TAY Adults Older Adults	Prevention	1
13	**Early Start Suicide Prevention – 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. The program has expanded to include male as well as female youth, 14 to 25 years of age, who are identified as being “at risk” for suicide.	Children TAY Adults Older Adults	Prevention	1
14	**Early Start Suicide Prevention – 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).	Children TAY Adults Older Adults	Prevention	1
15	**Early Start Suicide Prevention – Partners in Suicide (PSP) Team**	PSP 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 participate in suicide prevention events including Countywide educational trainings, suicide prevention community events, and collaboration with various agencies and partners.	Children TAY Adults Older Adults	Prevention	1

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
16	**Early Start School Mental Health – School Threat Assessment Response Team (START)**	The START program developed 21 teams composed of a law enforcement officer and a DMH clinician who partner with educational institutions (K-12 through higher education) school-based mental health programs, substance abuse programs, and other social service providers in the community to prevent school violence. Staff conducts school threat assessments and provides intervention and case management services to those who meet criteria for the START program.	Children TAY Adults Older Adults	Prevention	2
17	**Early Start School Mental Health – Service Area 6 School Mental Health Demonstration Program**	The School Mental Health PEI Demonstration Pilot (SMHPEI Demonstration Pilot) will provide school-based mental health outreach and education, on-site school crisis intervention, a peer support network, and early screening. Proposals to serve the northern and southern parts of SA 6 are currently being evaluated, and it is expected that programs will start in 2014.	Children TAY	Prevention	2
18	**Early Start Stigma and Discrimination – Family-Focused Strategies to Reduce Mental Health Stigma and Discrimination**	The Los Angeles County Alliance for the Mentally Ill is implementing "Family-focused Strategies to Reduce Mental Health Stigma and Discrimination" for consumers' families and parents/caregivers. Services include education about mental illness, treatment, medication, and rehabilitation, as well as teaching communication and coping skills. The program includes a family support bureau training program, parental support services, and consultative services.	Adults Older Adults	Prevention	3
19	**Early Start Stigma and Discrimination – Children's Stigma and Discrimination Reduction Project**	The project provides education to parents and the community through two distinct curricula. 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. A 12-week curriculum, developed by United Advocates for Children and Families on childhood mental illnesses which includes topics such as grief and loss, and navigating the multiple systems, e.g. mental health, juvenile justice, and DCFS.	Adults Older Adults	Prevention	3
20	**Early Start Stigma and Discrimination – Older Adults Mental Wellness**	The Older Adult Anti-Stigma and Discrimination Team (OA ASD) outreaches to residents through countywide educational presentations, community events, and collaboration with various agencies. OA ASD increases awareness on mental well-being for older adults throughout Los Angeles County, particularly among underserved and underrepresented communities. Presentations are available in 5 different languages: English, Spanish, Korean, Chinese and Farsi.	Older Adults	Prevention	3

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
21	**Early Start Stigma and Discrimination – Profiles of Hope Project**	The Profiles of Hope and accompanying Public Service Announcements (PSAs) aim to show that anyone can be subject to the stigma a mental illness has traditionally carried, and change their minds about how they support and view others with a diagnosis of mental illness. "Profiles of Hope," a 60-minute film, promotes an anti-stigma message for those diagnosed with mental illness and has been broadcast on local television stations along with the PSAs.	TAY Adults Older Adults	Prevention	3
22	**Early Start Stigma and Discrimination – 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 anti-stigma and discrimination videos that are 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.	TAY Adults Older Adults	Prevention	3
23	**Families Over Coming Under Stress (FOCUS)**	Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family as a whole by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.	Children TAY Adults	Prevention &Early Intervention	3
24	**Functional Family Therapy (FFT)**	FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.	Children (ages 11-15) TAY (ages16-18)	Early Intervention	7,12
25	**Group Cognitive Behavioral Therapy for Major Depression (Group CBT)**	Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is particularly helpful in challenging distorted perceptions and bringing thoughts more in-line with reality. Cultural tailoring of treatment and case management shows increased effectiveness for low-income Latino and African-American adults.	TAY (ages 18-25) Adults Older Adults	Prevention &Early Intervention	6,7,9,10,11

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
26	**Incredible Years (IY)**	IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/emotional competencies. Teacher training intervention focuses on teachers' classroom management strategies, promoting pro-social behaviors and school readiness.	Young Children (ages 2-5) Children (ages 6-12)	Prevention &Early Intervention	5,6,8
27	**Individual Cognitive Behavioral Therapy (Ind. CBT)**	CBT is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psychoeducation, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.	TAY (18-25) Adults Older Adults Directly Operated Clinics only	Prevention &Early Intervention	6,7,8,9,10
28	**Interpersonal Psychotherapy for Depression (IPT)**	IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.	Children (ages 9-15) TAY Adults Older Adults	Prevention &Early Intervention	9,11
29	**Loving Intervention Family Enrichment Program (LIFE)**	An adaptation of Parent Project, LIFE is a 22-week skills-based curriculum implemented with parenting classes/support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/or school failure.	Children (ages 10-18)	Early Intervention	10
30	**Make Parenting a Pleasure (MPAP)**	MPAP is a group-based parent training program designed for parents and caregivers of children from birth to eight years of age. The program addresses the stress, isolation, and lack of adequate parenting information and social support that many parents experience. MPAP begins by recognizing the importance of parents as individuals, and builds on family strengths and helps parents develop strong support networks. The curriculum focuses first on the need for self-care and personal empowerment, and then moves from an adult focus to a parent/child/family emphasis.	Children (ages 0-8) TAY Adults Older Adults	Prevention	5,6,9

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
31	**Managing and Adapting Practice (MAP)**	MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP as implemented in L.A County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.	Young Children Children TAY (ages 16-21)	Prevention &Early Intervention	4,5,6,7
32	**Mental Health First Aid (MHFA)**	MHFA is a public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. An interactive 8-hour course, MHFA presents an overview of mental illness and substance use disorders and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. Participants learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.	TAY Adults Older Adults	Prevention	5,12
33	**Mental Health Integration Program (MHIP) formerly known as IMPACT**	MHIP delivers specialty mental health services to Tier 2 PEI and Low-Income Health Plan (LIHP)/Healthy Way LA enrollees with less intense mental health needs who are appropriately served through focused, time-limited early intervention strategies. An integrated behavioral health intervention program is provided within a primary care facility or in collaboration with a medical provider. MHIP is used to treat depressive disorders, anxiety disorders or PTSD, and to prevent a relapse in symptoms.	Adults	Prevention &Early Intervention	8,11
34	**Mindful Parenting Groups (MP)**	MP is a 12-week parenting program for parents and caregivers of infant, toddler and preschool children at risk for mental health problems and disrupted adoptions. Parents/caregivers and children are grouped in tight developmental cohorts with no more than 4-6 months difference in age for the children.	Young Children (ages 0-3)	Early Intervention	6
35	**Multidimensional Family Therapy (MDFT)**	MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with pro-social influences such as schools, peer groups, and recreational and religious institutions.	Children (ages 12-15) TAY (ages 16-18)	Early Intervention	4,9,10

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
36	**Multisystemic Therapy (MST)**	MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family, friends) and removing barriers (e.g. parental substance abuse, high stress).	Children (ages 12-15)TAY (ages 16-17)	Early Intervention	10
37	**Nurse Family Partnership (NFP)**	Registered nurses conduct home visits to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits may continue until the baby is two years old. Provided in conjunction with the L.A. County Department of Public Health.	Young Children (ages 0-2)	Prevention &Early Intervention	5,12
38	**Olweus Bullying Prevention Program (OBPP)**	OBPP is designed to promote the reduction and prevention of bullying behavior and victimization problems for children. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers, and students with the classroom, the school as a whole, and the community. School staff has the primary responsibility for introducing and implementing the program.	Children (ages 6-15)	Prevention	4
39	**Parent-Child Interaction Therapy (PCIT)**	PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.	Young Children (ages 2-7)	Prevention &Early Intervention	6,7
40	**Problem Solving Therapy (PST)**	PST has been a primary strategy in IMPACT/MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.	Older Adults	Early Intervention	11
41	**Program to Encourage Active Rewarding Lives for Seniors (PEARLS)**	PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.	Older Adults	Prevention &Early Intervention	11,12

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
42	**Prolonged Exposure – Post Traumatic Stress Disorder (PE-PTSD)**	PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.	TAY (ages 18-25) Adults Older Adults Directly Operated Clinics Only	Early Intervention	7,10,12
43	**Promoting Alternative Thinking Strategies (PATHS)**	PATHS is a school-based preventive intervention for children in elementary school. The intervention is designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skills concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations.	Children (ages 5-12)	Prevention &Early Intervention	4
44	**Reflective Parenting Program (RPP)**	RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents /caregivers enhance their reflective functioning and build strong, healthy bonds with their children.	Young Children (ages 2-5) Children (ages 6-12)	Early Intervention	6
45	**Seeking Safety (SS)**	SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.	Children (ages 13-15) TAY Adults Older Adults	Early Intervention	7,9
46	**Strengthening Families (SF)**	SF is a family-skills training intervention designed to enhance school success and reduce substance use and aggression among youth. Sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines, and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences.	Children (ages 3-15) TAY (ages 16-18)	Prevention & Early Intervention	4
47	**Trauma Focused Cognitive Behavioral Therapy (TF-CBT)**	An early intervention for children who may be at risk for symptoms of depression and psychological trauma, subsequent to any number of traumatic experiences, particularly those individuals who are not currently receiving mental health services. Services are specialized mental health services delivered by clinical staff, as part of multi-disciplinary treatment teams. Program is intended to reduce symptoms of depression and psychological trauma, which may be the result of any number of traumatic experiences (e.g., child sexual abuse, domestic violence, traumatic loss, etc.), for children and TAY receiving these services.	Young Children Children TAY (ages16-18)	Early Intervention	7,9,10,12

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
48	**Trauma Focused CBT (TF-CBT):** **"Honoring Children, Mending the Circle"**	This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational well-being. Traditional aspects of healing with American Indians and Alaskan natives from their world view are included. Training to begin late 2013/2014.	Children	Early Intervention	13
49	**Triple P Positive Parenting Program (Triple P)**	Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through community-based organizations. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by DMH directly operated and contract agencies.	Young Children (ages 0-5) Children (ages 6-15) TAY (age 16)	Prevention& Early Intervention	5,6,8
50	**UCLA Ties Transition Model (UCLA TTM)**	UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho-educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation).	Young Children (0-5) Children (ages 6-12)	Early Intervention	6
51	**Veterans System Navigators**	Military veterans engage veterans and their families in order to identify and link them to support and services tailored to the particular cultural, ethnic, age and gender identity of those seeking assistance. Navigators also engage in joint planning efforts with community partners, including veterans groups, veterans administration, community-based organizations, other County Departments, schools, faith-based organizations, etc. with the goal of increasing access to mental health services and strengthening the network of services available to veterans. Provided in conjunction with the L.A. County Department of Military and Veterans Affairs.	TAY Adults Older Adults	Prevention	7

PEI Prevention Programs

IMPLEMENTED BY COMMUNITY BASED ORGANIZATIONS
Fiscal Years 2011-12, 2012-13 and 2013-14

Selection Of Prevention Agencies

In October 2011, a Request for Information (RFI) was sent to 103 qualified agencies on the MHSA Master Agreement List. These agencies did not have a current funded contract with DMH, were not government entities, school districts, community colleges or community partners. The funding was for FY 12-13 (one-year) at $100,000 per agency. Services could be provided countywide or in specific service areas. There were six prevention-only programs to be funded under the PEI plan. All age groups were to be served. Three programs were specifically for TAY and two were for children and their parents.

Sixty agencies submitted responses to the initial inquiry and 55 agencies submitted supporting documentation and descriptions of their proposed programs in the second phase. In May 2012, the Board approved funding for 54 Community Based Organizations (CBOs).The remaining agency was a for-profit agency and was disqualified. After being approved, two agencies did not follow through with implementation due to internal agency financial problems and closed their offices. The remaining 52 agencies could begin providing services as soon as the signed executed contracts were finalized. Many agencies were able to begin providing services in June 2012.

Programs Funded

Agencies responding to the RFI could select among six programs that were intended to prevent and minimize the impact of mental health issues for consumers and their families. These included:

- Making Parenting a Pleasure (MPAP) is 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 is designed to address the stress, isolation, and lack of adequate parenting information and social support that many parents experience. The curriculum focuses first on the need for self-care and personal empowerment, and moves from an adult focus to a parent/child/family emphasis. Its content is adaptable and flexible to fit a wide range of parent education programs and has broad appeal to families from a wide spectrum of socioeconomic, educational, cultural and geographic conditions.
- Outreach and Education Pilot (OEP) for Underserved Populations focuses on assisting racial/ethnic minorities and underserved communities in Los Angeles County. By providing community-based outreach, educational workshops, case management, individual counseling, group sessions delivered by and for targeted communities, services can occur in culturally appropriate settings, which can range from community events to faith-based organizations, as well as other community-based organizations, primary care settings, community centers, and schools. Such activities are intended to help identify situations in which educational programs may lessen the impact or prevent more serious mental health issues from occurring.
- Outreach and Education Pilot (OEP) for Transition Age Youth:
    - at-risk of or involved with juvenile justice system and at-risk for School Failure
    - at-risk or on Probation
    - at-risk of Substance Abuse

  Services to TAY at-risk populations include community-based outreach, educational workshops, case management, individual counseling, group sessions, to TAY and their caregivers. Service

delivery sites include juvenile probation settings, group homes, schools, community centers, community-based organizations, faith centers, and other non-traditional mental health settings.

- Positive Parenting Program (Triple P) is an evidence-based practice that is a multi-level parenting and family support strategy designed to prevent and treat behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills and confidence of parents. While acknowledging and respecting the diversity of family types and cultural backgrounds, the program builds on existing parenting strengths, and focuses on increasing parents' abilities to self-regulate and self-monitor their parenting skills. The Triple P system has interventions for individual families and small to large groups of parents. Interventions are available in a variety of delivery formats with varying levels of intensity including individual sessions, group sessions, seminars for large groups, self-help materials (self-help book and a self-directed online application), and mass media outreach and engagement materials.

Each prevention program provides one or more types of services including: case management and/or individual services; workshops or seminars (one-time-only services); and group sessions (multiple session services). Information on the 52 prevention programs funded, age groups served, and service areas are provided below:

Prevention Program	Age Group Served	No. Agencies Funded	Service Areas
Making Parenting a Pleasure (MPAP)	Parents of Children (ages 0-8 years)	11	1, 2, 3, 4, 6, 7, 8
OEP for TAY At-Risk of or Involved with the Juvenile Justice System and At-Risk for School Failure	TAY (ages 16-25)	8	2, 4, 6, 8
OEP for TAY At-Risk or on Probation	TAY (ages 16-25)	3	1, 2, 4, 6, 8
OEP for TAY At-Risk of Substance Abuse	TAY (ages 16-25)	7	2, 3, 4, 6, 7, 8
OEP for Underserved Populations	All Ages	16	2, 3, 4, 5, 6, 7, 8
Positive Parenting Program (Triple P) Levels 2 and 3	Parents of Children (ages 0 – 12 years)	7	2, 3, 4, 5, 6, 7, 8

Populations Served	
Racial/Ethnic Minority Groups	Special Populations
1. African/African American (including Ethiopian) 2. Asian (Cambodian, Chinese, Korean, Filipino, Japanese, Thai, Vietnamese) 3. Hispanic/Latino 4. Native American/American Indian 5. Pacific Islander (Hawaiian, Samoan, Tongan) 6. Middle Eastern (Persian)	1. Military families and veterans 2. LGBTQ individuals and their families/support groups 3. Widows, single parents 4. Bereaved spouses and their grieving children 5. Foster children

Outcome Surveys

Post-program outcome surveys were developed for each of the six prevention programs. Agencies administered the surveys after the participants completed the specific services at the agency (case management/individual service; workshop/seminar; group session/service). The surveys ask participants to 1) provide demographic characteristics about themselves; 2) indicate the types of services they received or participated in; 3) rate their levels of satisfaction with program services; and 4) respond to a set of outcome questions about the programs overall. Agencies were trained in administering the surveys and were advised that it was mandatory to hand out the surveys to their participants. The survey results accounted for a significant part of their program evaluations.

PREVENTION PROGRAM	POST-PROGRAM OUTCOME SURVEYS
Triple P	• Program I: Primary Care Intervention • Program I: Seminars • Program I: Discussion Group
MPAP	• Program II: Group Session
OEP: Juvenile Justice/School Failure	• Program III: Case Management/Individual Service • Program III: Workshop/Seminar • Program III: Group Sessions/Series
O & E: Probation	• Program IV: Case Management/Individual Service • Program IV: Workshop/Seminar • Program IV: Group Sessions/Series
O & E: Substance Abuse	• Program V: Case Management/Individual Service • Program V: Workshop/Seminar • Program V: Group Sessions/Series
O & E: Underserved Populations	• Program VI: Case Management/Individual Service • Program VI: Workshop/Seminar • Program VI: Group Sessions/Series

Evaluation of Prevention Programs

The contracts for PEI prevention services specified the criteria, method of data collection, and performance targets that each agency was expected to achieve.

Performance-Based Criteria		
Criteria	**Method Of Data Collection**	**Performance Targets**
1. Contractor maintains accurate records of participants (children, TAY, adults, and/or older adults; parents, family members, and/or caregivers) attending Contractor's PEI Prevention Program. Contractor will at minimum provide its PEI Prevention program to participants as detailed in the Fee Schedule in Los Angeles County Supervisorial District(s) during the contract term.	Contractor centralizes an accurate record that tracks children, TAY, adults, and/or older adult family members and/or caregiver participants by using sign-in sheets.	Contractor maintains an accurate and complete database, including sign-in sheets, and required reports are submitted to DMH on or before due date every month.
2. Contractor increases the number of underserved and/or underrepresented participants in the PEI Prevention Program.	Contractor establishes collaborative relationships with community-based organizations used by underrepresented and/or underserved constituents, and utilizes these relationships to provide PEI Prevention Program services to these populations.	Contractor maintains an accurate and complete database, including the number of PEI Prevention Program participants, and submits required reports to DMH on or before due date each month.
3. Contractor's protocols used are consistent with one or more missions of the PP, EBP, or DMH's OEP Pilot Prevention program.	Contractor's verification of staff training and utilization of training and/or course/class curriculum.	100% of Contractor's PEI Prevention Program participants receive services consistent with the PP, EBP, or OEP Pilot Prevention program.
4. Contractor participates in all of the training sessions mandated by the PEI Program.	Sign-in sheets from training sessions.	100% of all mandatory trainings are attended by required Contractor staff.
5. Contractor has completed Program outcome measures as detailed in the Statement of Work (SOW) and as determined by DMH.	Contractor completes appropriate outcome measures in a format and schedule designated by DMH. An evaluation tool (e.g. pre- and post-training screening survey) is to be administered by Contractor to each PEI Prevention Program participant.	Contractor uses a DMH-approved evaluation tool (pre- and post-training screening survey) at each PEI Prevention Program event. Contractor maintains an accurate and complete database, including copies of the evaluation tool, and ensures required reports are submitted to DMH on or before due date each month.

PERFORMANCE-BASED CRITERIA		
CRITERIA	METHOD OF DATA COLLECTION	PERFORMANCE TARGETS
6. Contractor participates in the mandatory PEI meetings.	Sign-in sheets from PEI meetings.	100% of all mandatory monitoring sessions are attended by Contractor.
7. Contractor participates in the mandatory PEI monitoring sessions and submits all required monitoring reports.	Sign-in sheets. Reports from the PEI Evaluation Consultants regarding the Contactor's participation and outcomes.	100% of all mandatory monitoring sessions are attended and required monitoring reports are submitted by Contractor.

PEI staff conducted site visits to each of the 52 prevention agencies and provided technical assistance on-site and/or at the DMH office as needed. For consideration of an additional year of funding for FY 13-14, agencies were evaluated based on the achievement of their deliverables, population served, program design/program implementation and participant satisfaction.

EVALUATION CATEGORY	OBJECTIVES / OUTCOMES	DATA SOURCES
Deliverables	• The agency will meet 100% of its deliverables as specified in the contract • As of December 31, 2013, the agency will meet 50% or greater of its contract	• Invoices submitted as of December 31, 2013 and as of March 31, 2013. • Agency monthly reports of services (information on financial claiming and the monthly report, compliance with contract Statement of Work, numbers of persons served, group size, program documents, persons delivering services) • Agency's completed timeline/budget form
Population Served	• Agency serves the number of persons specified in their contract • Agency serves the population indicated in their proposal and contract	• Pre-site visit questionnaire • Agency site visits • Post-Program Outcome Surveys • Agency monthly reports
Program Design and Implementation	• The agency is implementing the program approved by DMH or the agency is following the protocols of MPAP or Triple P • The agency has a well thought-out program that meets the needs of their target populations • Staff has been trained in MPAP, Triple P, or the agency has provided training regarding this program	• Agency site visits • Agency documentation regarding their PEI program, such as curriculum, reports, manuals, brochures, outreach materials, etc. • Participant sign-in sheets • MPAP, Triple P and Mental Health First Aid sign-in sheets • Attendance at prevention provider meetings
Participant Satisfaction	• Participants are satisfied to very satisfied with the services received	• Post-Program Outcome Surveys

A summary report of the first year of the PEI Prevention Programs is currently being written. It includes an analysis of the post-program outcome surveys as well as a program review including strengths and successes, challenges and concerns, lessons learned, and recommendations.

Cost

The average cost per client for community-based prevention programs for FY 2012-13 was $204 for 4,497 clients. Direct prevention services mapped to the following five projects: School-based Services, Family Education and Support Services, Early Care and Support for TAY, Juvenile Justice Services and Improving Access to Underserved Populations

PEI Outcomes

PEI metrics were chosen based on input from practice developers, a review of the outcome measure literature and input from providers and other stakeholders. In addition, cost, length of instrument and languages an instrument has been translated into were factors related to measures selection.

A general measure and focus of treatment specific measure is administered at the beginning of treatment and at the end of treatment, with pre- and post-treatment changes analyzed. If the treatment lasts greater than six months, both measures are given again at the six-month marker.

While DMH has focused most of its initial PEI evaluation efforts on outcome measures training, use of the PEI OMA (web-based application) and identifying successful strategies to increase the percentage of pre-post matched comparisons in order to evaluate the effectiveness of PEI, the following trends are emerging in terms of the effectiveness of evidence-based practices for a PEI population:

At the 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 **38%** positive change as endorsed by parents and a **22%** positive change as endorsed by children on the YOQ-SR. The practice has also demonstrated 58-60% positive reliable change in parent/caregiver ECBI scores.

Trauma Focused Cognitive Behavioral Therapy: For the 64 agencies providing trauma focused services, **74%** of the recipients of this practice self-identify as Latino. Both children and parent/caregivers have endorsed positive change on the YOQ. Parents endorsed a **38%** improvement in their children's overall functioning, while children reported a **35%** improvement in their overall functioning, representing **51%** and **47%** reliable change percentage, respectively. On average, parents report a **37%** improvement and children report a **42%** improvement in trauma symptoms on the Post Traumatic Stress Disorder Reaction Index (PTSD-RI) after completing Trauma Focused Cognitive Behavioral Therapy.

Incredible Years: This practice aimed at improving parenting skills and reducing family difficulties has an average client age of 8. Sixty-six percent of clients are male and **81%**are Latino. A comparison between pre and post-average scores for the ECBI and the YOQ shows a reduction in symptoms below the clinical cutoff. Reductions in average scores range from **17% to 33%.**

Group CBT for Depression: This practice aimed at reducing early course depression has demonstrated on average a **35%** reduction in symptoms as measured

by the PHQ-9 and a **21%** reduction in overall symptoms as measured by the Outcome Questionnaire (OQ-45.2), representing **38% to 43%** positive reliable change respectively.

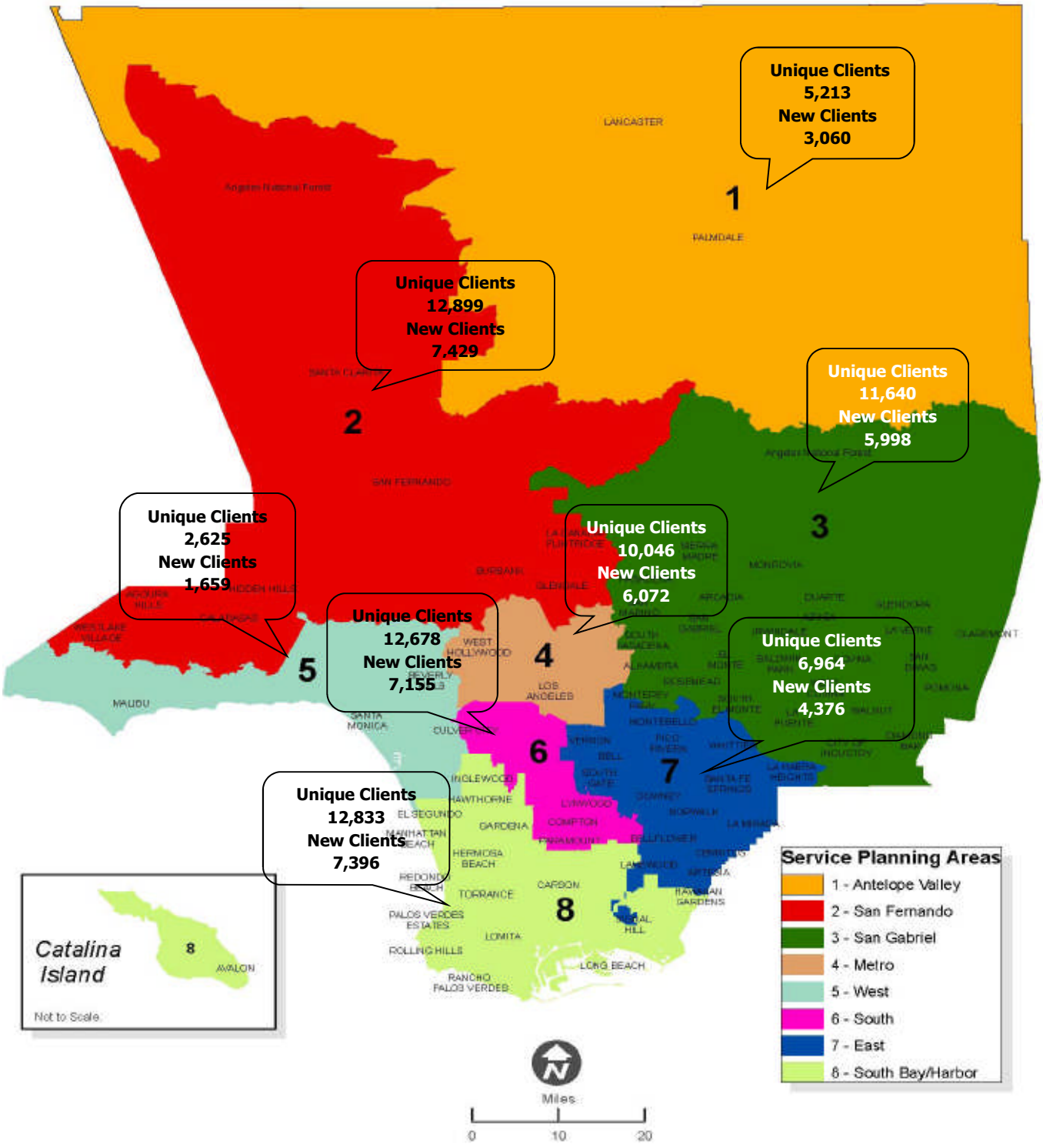
Aggression Replacement Training (ART): Sixteen agencies are providing this practice aimed at treating disruptive behavior disorders in 12-17 year olds. When comparing pre and post-treatment average scores for the ECBI, the practice has led to **14 to 25%** reductions in symptoms and **11 to 25%** reductions in average scores pre and post-treatment on the YOQ-Parent and YOQ-SR.

Seeking Safety: A robust implementation involving 73 contract agencies and county-operated programs has demonstrated, as measured by the PTSD-RI and the Outcome Questionnaire/YOQ-SR & YOQ (parent and self-report), significant reductions in trauma. Average symptom reduction after completion of the practice for children and their parent/caregiver ranges from **29% to 35%** depending upon the questionnaire. Average symptom reduction for adults aged 18 and above is **20%**, with reductions seen below the clinical cutoff for the PTSD-RI for adults.

Child Parent Psychotherapy: Thirty-one contract agencies and county operated programs are providing this practice geared to treat trauma in young children ages 0–6 and their parent/caregivers. This practice has yielded a **62%** improvement in trauma symptoms as measured by the YOQ-Parent.

Crisis Oriented Recovery Services (CORS): Thirty-two contract and county operated programs are providing this brief treatment model to address situational crises. Adults and children who completed the six session model experience a **21%** improvement as measured by the OQ 45.2 and YOQ-SR respectively. Parents reported a **33%** improvement in their child's symptoms.

Los Angeles County Number of Clients served Through PEI by Service Areas Fiscal Year 2012-13



Ethnicity

Service Area 1
African-American – 34%
Hispanic – 36%
White – 24%
Unknown – 2%
Other – 2%
Asian – 1%
Native American - 1%
Pacific Islander- <1%

Service Area 2
Hispanic –59%
White –24%
African-American –9%
Other –3%
Asian –3%
Unknown –2%
Native American - <1%
Pacific Islander- <1%

Service Area 3
Hispanic –67%
White –13%
African-American –11%
Asian – 5%
Other – 2%
Unknown – 1%
Native American - <1%
Pacific Islander- <1%

Service Area 4
Hispanic – 65%
African-American –13%
White –12%
Asian –4%
Other –2%
Unknown – 2%
Native American - 1%
Pacific Islander- <1%

Service Area 5
Hispanic –36%
White – 30%
African-American – 24%
Other – 4%
Unknown –3 %
Asian – 2%
Native American - <1%
Pacific Islander- <1%

Service Area 6
Hispanic –48%
African-American – 46%
White – 3%
Unknown – 1%
Other – 1%
Asian – 1%
Native American - <1%
Pacific Islander- <1%

Service Area 7
Hispanic – 82%
White – 9%
African-American – 4%
Asian – 1%
Native American - 1%
Unknown – 1%
Other – 1%
Pacific Islander- <1%

Service Area 8
Hispanic –52%
African-American – 26%
White – 15%
Asian – 3%
Unknown – 2%
Other – 2%
Pacific Islander- <1%
Native American - <1%

Primary Language

Service Area 1
English - 73%
Spanish - 26%
Unknown/
Not Reported - 1%
Other - <1%

Service Area 2
English - 88%
Spanish - 11%
Unknown/
Not Reported - <1%
Other - 2%

Service Area 3
English - 73%
Spanish - 22%
Unknown/
Not Reported - 1%
Other - 2%

Service Area 4
English - 65%
Spanish - 31%
Unknown/
Not Reported -1%
Other - 2%
Korean - 1%
Armenian - 1%

Service Area 5
English - 83%
Spanish - 13%
Unknown/
Not Reported -1%
Other - 2%
Farsi - 1%

Service Area 6
English - 73%
Spanish - 26%
Unknown/
Not Reported - 1%
Other - <1%

Service Area 7
English - 69%
Spanish - 31%
Unknown/
Not Reported - <1%
Other - <1%

Service Area 8
English - 75%
Spanish - 23%
Unknown/
Not Reported - 1%
Other - 1%
Cambodian - 1%

Top 5 EBPs Delivered

by Age Group Plan

Service Area 1
Child - 2,297
TAY - 624
Adult - 1,321
Older Adult - 37
Special Programs - 1,032

Service Area 2
Child - 5,999
TAY - 2,354
Adult - 3,486
Older Adult - 205
Special Programs - 1,330

Service Area 3
Child - 6,593
TAY - 2,477
Adult - 1,999
Older Adult - 214
Special Programs - 713

Service Area 4
Child - 5,099
TAY - 1,814
Adult - 2,571
Older Adult - 315
Special Programs - 457

Service Area 5
Child - 1,184
TAY - 225
Adult - 1,096
Older Adult - 48
Special Programs - 110

Service Area 6
Child - 6,009
TAY - 1,539
Adult - 4,214
Older Adult - 447
Special Programs - 825

Service Area 7
Child - 3,644
TAY - 1,262
Adult - 1,344
Older Adult -174
Special Programs - 741

Service Area 8
Child - 7,208
TAY - 2,126
Adult - 3,262
Older Adult - 195
Special Programs - 392

PEI Training, Technical Assistance and Capacity Building (PEI TTACB)

Per State Department of Mental Health Info Notice 08-37, PEI TTACB funds were earmarked for use in developing or enhancing partnerships between counties local non-mental health partners for purposes of enhancing the development, implementation and evaluation of PEI. These one-time funds are available through June 30, 2014. The final two projects funded by LA County are:

Regional Outcome Data Workgroups: $300,000. Funded through CalMHSA and approved by the Board of Supervisors on May 29, 2012, RAND Corporation has held quarterly regional trainings and technical assistance meetings to strength the capacity and skill sets of counties to evaluate MHSA programs and make outcome-informed decision-making, with the goal of increasing data and service quality. Specifically within Los Angeles County, Service Areas 4, 5 and 8 formed quarterly provider meetings where existing DMH outcome data reports were reviewed and analyzed, with the goals of improving data quality and using outcomes to inform practice.

UCLA Training and Technical Assistance: $357,427. UCLA, through the Harbor-UCLA Medical Center, shall provide for additional consultation, training, and academic supervision for the inpatient and outpatient programs at Harbor-UCLA Medical Center. These services shall include, but not be limited to, clinical psychological testing, evaluation, and therapy services provided by clinical psychology interns and fellows as part of their training programs, and teaching and training of psychiatry interns, residents and facility staff in the areas of psychiatric emergency, crisis, and general adult/child outpatient and inpatient services. In addition, faculty from Harbor-UCLA Medical Center will provide training and consultation in evidenced based practices (i.e. CBT and DBT) to mental health service providers.

Innovation

The following is an overview of the Innovation program, outcomes for the first year of program implementation, and highlights of the lessons learned and considerations for the second year of implementation.

Innovation Program Overview

The overall goal of the MHSA-funded Innovation (INN) Program is to identify new practices with the primary goal of learning and exploring creative and effective approaches that can be applied to the integration of mental health, physical health, and substance use services for uninsured, homeless, and underrepresented populations.

In order to achieve the goals of the INN program, four models of care have been developed, each focusing on innovative recruitment and care delivery services.

The Integrated Clinic Model (ICM) model is designed to improve access to high quality, culturally competent care 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.

The Integrated Mobile Health Team Model (IMHT) model is designed as a client-centered, housing-first approach that uses harm reduction strategies across all modalities of mental health, physical health, and substance abuse treatment. IMHT particularly focuses on individuals who are homeless or recently moved to Permanent Supportive Housing (PSH) and are considered to have vulnerabilities such as age, years homeless, co-occurring substance abuse disorders, and/or physical health conditions.

The Community-Designed Integrated Services Management Model (ISM) model provides a holistic model of care, the components of which are defined by specific ethnic communities and which promote collaboration and community based partnerships to integrate health, mental health, and substance abuse services together with other needed non-traditional care to support recovery. The ISM model is divided into five ethnic models: African Immigrant/African American, American Indian/Alaskan Native, Asian Pacific Islander, Eastern European/Middle Eastern, and Latino.

Lastly, the Integrated Peer-Run Model serves individuals with mental health needs who also have additional health and/or substance abuse treatment needs by providing programs that are designed and run by people with lived experience of mental health issues.

In order to evaluate the implementation and obtainment of program goals, LACDMH contracted an evaluation team comprising University of California, San Diego's Health Services Research Center (HSRC), Harder+Company Community Research, and the University of Southern California (USC).

On July 17, 2013 the System Leadership Team approved a motion to extend the Innovation Project so that each model will have 3 fiscal years to engage in the learning described above. As such, the Integrated Clinic Model, Community-designed Integrated Services Management Model, and Integrated Mobile Health Team Model will be extended through FY 2014-15 and the Integrated Peer Run Model will be extended through the end of Fiscal Year 2015-16.

Year One Learning Sessions

The evaluation team helped design and facilitate four learning sessions during year one. Learning sessions were designed to support the implementation of INN by creating opportunities for providers and LACDMH to identify common challenges and recognize potential best practices as they develop in real-time. The intent of Learning Sessions is to support INN program implementation in the short run and strengthen networks of relationships among providers throughout Los Angeles County.

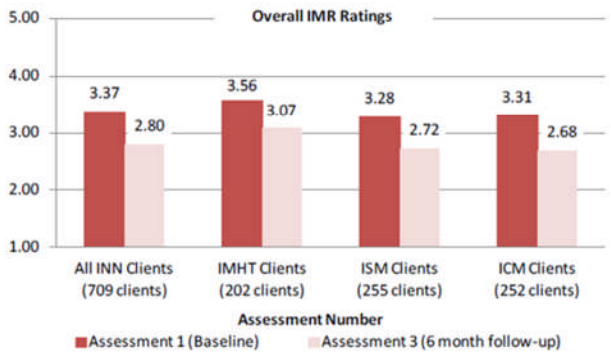
Initial Learning Sessions were primarily conceptualized and led by LACDMH and evaluation team members. Over time, there has been an intentional shift in the focus of Learning Sessions, so that at least half of each session involves provider-led panel discussions and small group activities designed to facilitate sharing and learning. Learning Session participants are encouraged to nominate topics for each Learning Session to ensure sessions are relevant and useful to providers. Following Learning Sessions II-IV, Learning Briefs were produced and shared with providers in order to document the activities, challenges, and innovations that emerged during each meeting. Learning Briefs consist of a summary of the session's activities, highlights of key findings, and extensive appendices capturing table notes and group ideas with the goal of extending learning opportunities beyond the session.

Year One Enrollment and Evaluation Outcomes

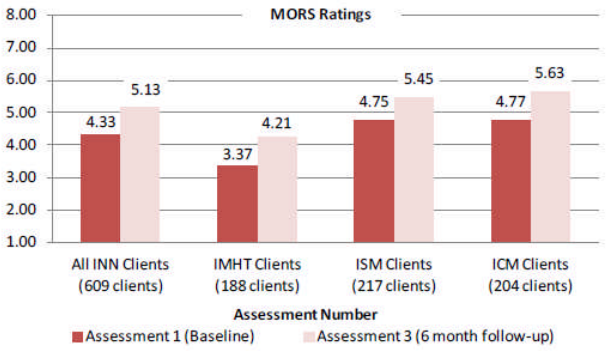
To date, a total of 2,649 clients (one in 2011, 1,419 in 2012, and 1,229 in 2013) have enrolled in INN programs. Current INN clients are most likely to be between the ages of 48 to 59 (34.6%), and Latino/a (35.0%) or African/African American (28.4%). Gender was almost evenly split between males and females.

Measures were selected based on goals across all models, and included validated measures and health indicators. Findings on some of the key outcomes at the six month time point are presented below.

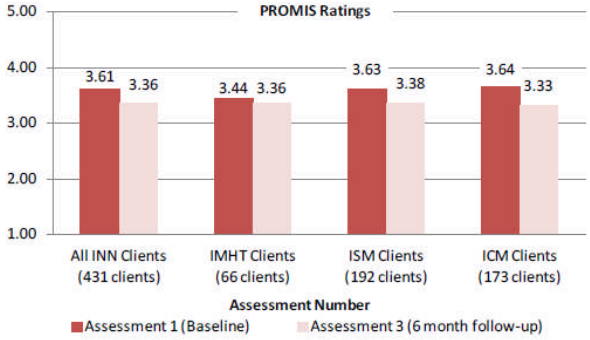
On the clinician-completed Illness Management and Recovery Scale (IMR), there were significant reductions in scores from the baseline assessment to the six month assessment for each of the INN models. This indicates that clients were better able to manage their mental health and made progress towards their recovery. There were also significant overall reductions on each of the three IMR subscales: Recovery, Management, and Substance Use.



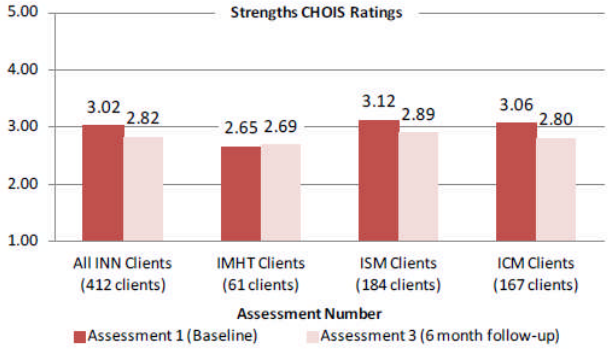
There were significant increases in scores on the clinician-completed Milestones of Recovery Scale (MORS) from the baseline assessment to the six month assessment for each of the INN models. This indicates that clients were in more advanced stages of recovery after participating in INN for six months.



Scores on the client-completed PROMIS Global Health Scale were significantly reduced for ISM and ICM clients from the baseline assessment to the six month assessment. This indicates that ISM and ICM model clients experienced less impairment due to their physical and mental health.



On the client-completed CHOIS supplement, there were significant reductions in the Strengths subscale from the baseline assessment to the six month assessment for clients in the ISM and ICM models. This indicates that ISM and ICM model clients had greater recovery-oriented personal strengths after receiving INN services for six months.



Clients also completed the Internalized Stigma of Mental Illness scale (ISMI) to assess mental health related stigma. There was a significant reduction in ISMI scores from baseline to six months for ISM clients. This indicates that clients in the ISM model were less likely to feel stigmatized based on their mental health at the six month assessment.

The tool was developed at Case Western Reserve University through support from a SAMHSA grant and incorporates the best available evidence – combining theoretical, empirical, and practice based knowledge.

Initial Lessons Learned

While ITT site visits focused on individual programs, there are lessons learned from this implementation evaluation that are applicable across individual programs and INN models. These lessons pertain to barriers and facilitators of integrated care that exist at the individual, program, and systems levels. A summary of these lessons learned is provided in the table below.

Initial Lessons Learned from ITT
#1: There are developmental stages of integration.
#2: Policies/procedures and CQI are in early stages of development.
#3: Peer specialist roles are still evolving.
#4 - Interdisciplinary team meetings work.
#5: Effective care coordination requires efficient and timely communication.
#6: Innovation programs continue to face numerous barriers to maximizing effective communication.
#7: Care manager role and duties are typically shared by more than one person or a full team.
#8: The CCCP is a perceived barrier to integrated care planning.
#9: There are opportunities for training.
#10: Programs are preparing to become data driven.

A full summary of each lesson learned is provided in the full report, but the following includes three of the major lessons learned.

There are developmental stages of integration. Most INN programs represent new organizational partnerships and have experienced "growing pains" to different degrees.

In some cases these growing pains have resulted in the termination of certain partnerships (e.g., dissolution of agreement between FQHC and mental health provider) and in other cases have resulted in additional plans to expand the scope of the relationship (e.g., plans to develop newly formed, co-located clinics). Although there has not been a single, clear trajectory among all programs, INN programs that are more fully integrated have gone through a process in which organizational boundaries get blurred and the INN program is embraced by and central to all partners' missions. This translates into a change from identifying problems that are separately faced by each organizational partner into addressing challenges as a shared responsibility between all partners.

Interdisciplinary team meetings work. This seemingly obvious statement is supported by programs that convene interdisciplinary meetings, those that do not, and those that take a hybrid approach. A hybrid approach refers to programs that may hold a series of meetings that involve different disciplines (e.g., meeting with mental health therapist and psychiatrist, mental health therapists and addiction specialists, care manager and primary care provider) but do not have a venue for all team members to meet together to discuss patient care. Treatment team meetings support integrated care in the following ways:

- *By facilitating interdisciplinary communication and care coordination.*
- *By providing a venue for group supervision and case review.*
- *By offering an opportunity for cross disciplinary training.*

INN programs continue to face numerous barriers to maximizing effective communication and coordination of care. Most notable were regulatory or perceived-regulatory barriers to interdisciplinary communication (e.g. HIPAA violations). Although most programs established protocols that would allow for communication between mental health, substance abuse, and primary care providers (e.g., joint release of information), there were still some programs that have not crossed that divide. There were also several barriers to improved communication that relate specifically to suggestions made within the ITT to utilize electronic health records (EHR), telemedicine, and patient-portals or websites.

Considerations for Year Two

During the first year of INN, providers continuously adapted their outreach efforts and service offerings to best meet the needs of their target populations. As best practices are established and implemented in year two, these changes will likely be reflected in the outcome measures. Additionally, as more clients are enrolled, the evaluation team will be better able to conduct more detailed statistical analyses.

Clients Served for FY 2012-13

Community-Designed Integrated Services Management Model

Unique Clients Served: 1,060

Cost: $4,829,335

Average Cost per Client: $4,556

Integrated Clinic Model

Unique Clients Served: 1,108

Cost: $3,120,826

Average Cost per Client: $2,817

Integrated Mobile Health Team

Unique Clients Served: 473

Cost: $6,020,797

Average Cost per Client: $12,729

Learning Sessions

Working in partnership with LACDMH staff, the evaluation team designed and facilitated four Learning Sessions during year one. Learning sessions were designed to support the implementation of INN by creating opportunities for providers and LACDMH to identify common challenges and recognize potential best practices as they develop in real-time. The intent of Learning Sessions is to support INN program implementation in the short run and strengthen networks of relationships among providers in Los Angeles County. The graphic timeline below illustrates the timing and topical focus of each of the year one learning sessions.

Initial Learning Sessions were primarily conceptualized and led by LACDMH and evaluation team members. Over time, the team has intentionally shifted the focus of Learning Sessions, so that at least half of each session involves provider-led panel discussions and small group activities designed to facilitate sharing and learning. Learning Session participants are encouraged to nominate topics for each Learning Session to ensure sessions are relevant and useful to providers. Continuing education (CEU) hours were offered at two of the first year sessions to increase the value to participants.

Typically organizations bring between two and five team members, and include a mix of administrative and clinical staff. While some organizations have opted to bring the same core set of staff members, others alternate attendance at each session, often with the program director attending consistently and other program staff attending based on interest in agenda topics and availability.

After providing detailed notes to LACDMH for Learning Session I, the team proposed to produce a more comprehensive summary of Learning Session activities that could be shared with participants, which have developed into four to six page "Learning Briefs." Learning Briefs were produced following Learning Sessions II-IV in order to document the activities, challenges, and innovations that emerged during each meeting. Learning Briefs consist of a summary of the session's activities, highlights of key findings and extensive appendices capturing table notes and group ideas with the goal of extending learning opportunities beyond the session.

Workforce Education and Training

The Los Angeles County 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 that 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. In particular, the need for bilingual and bicultural personnel 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: children/tay, lgbtq, veterans, and older adults.

1 *155 staff trained through the Recover Oriented Practice (formerly known as Public Mental Health Workforce Immersion)*

During FY 2012-13, 155 individual staff members of the public mental health workforce attended the Public Mental Health Workforce Immersion into MHSA

2 *Licensure Examination Preparation*

Previous Annual Update data reflected approved participants from multiple fiscal years. In order to accurately reflect the participant data, it is not being reported by Fiscal Year. During FY 11-12, 89 participants were approved, while 192 were for FY 12-13.

3 *42 individuals completed the Health Navigator Skill Development Program*

21 have received certification and 18 are working towards the necessary hours for full certification. Three participants are no longer working/volunteering in the public mental health system

4 *36 individuals completed Advance Peer Support Training*

These individuals are currently employed in the mental health system in a peer advocate capacity.

5 *27 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 *512 individuals attended the Community College Collaborative Symposiums*

The symposiums were held on three campuses across the County.

7 *678 faculty and students attended MHSA presentations or MHSA mini-immersion*

8 *145 participants completed the Intensive Mental Health Recovery Specialist Training Program*

9 *138 supervisors completed the Recovery Oriented Supervision Training*

10 *124 staff members participated in the Interpreter Training Program*

1-Workforce Education and Training (WET) Coordination

This program provides the funding for the MHSA WET Administrative unit. WET Administration is 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 will 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 (Recovery Oriented Practices)

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 incorporate these concepts into practice in their practice. The delivered curriculum also addresses the integration of mental health, physical health and co-occurring disorders.

During FY 2012/2013, 155 individual staff members of the public mental health workforce attended this training.

Public Mental Health Workforce Immersion into MHSA – No change is expected during FY 2013/2014.

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 the required clinical hours to take the mandatory Part I and Part II of the respective licensure board examinations.

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. During FY 2012/2013, 88% of participants represented un or underserved populations.

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

Public Mental Health Workforce Immersion into MHSA

During FY 2012/2013, 155 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. Thus far, 50% of participants who received assistance from the first two fiscal years have passed the respective licensure test. The number of participants for each specific exam is as follows:

Examination	FY 11-12	FY 12-13	Total
MSW - Part I	27	36	38
MSW - Part II	0	61	32
MFT - Part I	40	31	16
MFT - Part II	13	37	19
Psychologist - Part I	0	23	9
Psychologist - Part II	9	4	9
TOTAL	**89**	**192**	**281**

Health Navigator Skill Development Program

Forty-two individuals have completed the training and21 have received certification. Of those 18 are working towards the necessary hours for full certification. Three are no longer working/volunteering in the public mental health system.

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 individuals interested in becoming a supervisor, front line supervisor or managers. They will assume 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 public mental health programs. Two-hundred and forty individuals are trained annually.

During FY 2012/2013, 138 participants completed the program. Fifty-nine percent of the participants represented individuals from un- or under- served populations and 42% spoke one of the thirteen threshold languages of the County of Los Angeles.

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 is interested in performing interpreter services to 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 consists 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 2012/2013 Outcomes:

Training Title	Total
3-Day Training (Intro)	74
Advanced Training - Part I	15
Advanced Training - Part II	12
Provider Training	23
Total	**124**

7 - Training for Community Partners

Community College Collaboration

This training engages the college student, faculty and the community at large at their respective community colleges. Collaborative events provide information regarding recovery oriented mental health services in the community and ways to access them.

During FY 2012/2013, participants attended three collaborative symposiums were held at community college campuses across the County:

Campus (Service Area)	Total Participants
West Los Angeles College (SA 5)	119
Los Angeles Trade Technical College (SA 4)	286
Citrus College (SA 3)	107
Total	**512**

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 provides an opportunity for faith-based clergy to understand recovery focused mental health services and mental health personnel to understand and integrate spirituality in the recovery process. During FY 2012/2013, this program expanded to Service Areas 2 and 4. The participant breakdown for these 2 SAs was:

Round Table Composition	SA 2	SA 4
DMH Staff	4	6
Clergy	5	6
Total	**9**	**12**

There will be no significant change to the program model in FY 2013-14.

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 to 145 individuals interested in employment in the public mental health system. As of October 2013, 69 participants (47.5%) have secured employment.

No changes are anticipated during FY 2013/2014.

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 2012/2013, 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:

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

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	27
Advanced Peer Advocate	36
Train-the-Trainer	9
TOTAL	**73**

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 is anticipated to begin major implementation during the latter part of FY 2013/2014.

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 now funded with MHSA WET dollar effective FY 2013/2014

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12 - Mental Health Career Advisors

This program is designed to fund career advisor services in the effort to meet the workforce needs of the public mental health system, Services will include: the provision of ongoing career advice, coordination of financial assistance, job training, mentoring and tutoring and 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 promote 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. 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 2012/2013, a total of 678 faculty and students received curriculum consultation, attended the MHSA presentations or MHSA mini-immersion.

No changes are expected during FY 2013/2014.

16 - Recovery Oriented Internship Development (Recovery Oriented and Integrated Care Internship Training Program)

A component of this program includes establishing training that targets supervising field instructors employed in the public mental health system (PMHS) and their student interns. The purpose of this program is to 1) promote recovery oriented and integrated care principles and 2) establish standards for student training critical for the preparation of the future PMHS workforce. Field instructors will have an opportunity to increase their exposure, knowledge and expertise in recovery oriented and integrated care principles; as well as augment student interns' classroom instruction through training and supervised direct service experience.

Implementation is projected to begin during FY 2013/2014.

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

This tuition reimbursement program will provide 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.

This program is expected to be implemented during FY 2013/2014.

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 2012/2013 this program was available to 20 MFT, 20 MSW, and two 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 likewise funded. No significant change is expected for this program.

WET Regional Partnership

Translational Research Program Projects

Project Summary: The Department of Mental Health (DMH)-UCLA Translational Research 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 factors facilitate or inhibit 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 HWLA.

Peer Health Navigator Implementation

Research Questions: (a) What implementation strategies promote the most efficient and effective introduction of peer health navigators in public mental health systems? And (b) what are the impacts of a peer health navigator on client wellness in public mental health?

Immediate Objective: Completion of training and 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 Report:

Low Income Health Plan (LIHP) Implementation Evaluation: All participants have been enrolled, and their interviews transcribed and coded. The results of the second data analysis were presented to DMH. Progress Report 4 was completed.

Peer Health Navigator Implementation: Two interviews were completed with health navigators, and one with a supervisor. A summary of all cost and operational data was collected. The

preliminary assessment report of the study set-up for the PCORI-sponsored trial of the Bridge project was completed.

Qualitative Analysis of MHSA Transformation in DMH Clinics: Coding and analysis of interviews continues per the established and approved coding scheme.

Funding: FY 2011-12 (prorated for four months): $66,666
FY 2012-13: $200,000
FY 2013-14: $200,000

Older Adult Research Project (MORS-OAV)

Project Summary: 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. 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).

Status Report: The Older Adult Research Project (*Inter-rater Reliability of a Mental Health Recovery Assessment for Older Adults*) was approved by the Department's HSRC. MHA-LA 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) completed 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, currently under design and construction. Training of providers on the use of MORS-OAV is on hold as the Department is exploring other options, i.e. the Level of Care Utilization System (LOCUS).

Funding: FY 2011-12: $99,000

Child TEPs (System and Treatment Enhancement Projects) Los Angeles County

Project Summary: 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.

Status Report: 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, enrollment of families 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 was similar to that of the number screened during the same quarter of the previous year. Hathaway Sycamores showed a particular increase in identifying possible participants. Hillsides and Pacific Clinics added new therapists to the study in July as their main strategy to increase participation. That quarter 11 of the 12 families screened qualified, which was the best performance by agencies over the course of the project.

Most of the sessions in the MATCH condition (more than 70%) involved CBT and parenting techniques. The most common procedures used from the MATCH program were 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 was 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 suggest that stabilization procedures might be an important target of future study, because they are so common. The most common participant in MATCH sessions was the child, but more than half of MATCH sessions did not include a child (52% were with a caregiver or significant adult in the child's ecology). This was to be expected, as the MATCH procedures for disruptive behavior were mostly caregiver-based, and disruptive behavior was 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 improved. Results were more pronounced for internalizing problems, for which UC cases were 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. Overall, usual care cases took slightly longer on average; this was obscured somewhat by the fact that MATCH cases were less likely to drop out early in treatment. The average number of sessions was about 22 for MATCH and about 28 for usual care. Combined with the data on treatment length, this means MATCH cases were meeting fairly regularly (a session every 8 days), as were usual care cases (a session every 9 days). Enrollment of new families closed on December 31, 2012, and fiscal support of this project ended with the 2012-13 FY.

Funding: FY 2011-2012: $216,000
FY 2012-2013: $177,000

CMHDA – CA Social Work Education Center (CalSWEC) Aging Initiative (AI) project

Project Summary: The CalSWEC 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.

Status Report: LACDMH has continued to provide support to the AI project through CalSWEC. Through partnerships with statewide schools of social work, the AI Committee has continued 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. On January 23, 2014, CalSWEC AI completed the last of 3 webinar series on aging and its relationship to health care reform and workforce issues. Additionally, the 2014 Aging Summit, with a focus on geriatric workforce development and curriculum, has been planned and scheduled for February 5, 2014 in Sacramento. Note, the CMHDA agreement with DMH for the CalSWEC project ends this fiscal year.

Funding: FY 2011-12: $20,000; FY 2012-13: $20,000; FY 2013-14: $21,600.

Olive View Psychiatric Residency program

Project Summary: As part of the effort 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.

Status Report: Residents have been successfully integrated into the workforce at San Fernando Mental Health Clinic (MHC) and Olive View Urgent Care Clinic (UCC). Residents at San Fernando MHC provide psychotherapy services to child and adolescent clients; those at Olive View provide urgent psychiatric care. Residents at both locations have increased clinical access for clients, while the addition of the residency program has increased the number of DMH training sites and opportunities for workforce development. The integration of the residents into service delivery has additionally enhanced system-wide collaboration between the Department of Health Services (DHS) and DMH.

Funding: No Regional Partnership funds were allocated for FY 2011-2012. FY 2012-13: $500,049; FY 2013-14: $500,049, 2014-15: $500,049.

Geropsych Fellowship Services

Project Summary: UCLA Psychiatry fellows will be supervised concomitant with the provision of services as members of Older Adults System of Care (OASOC) multidisciplinary teams.

Status Report: The UCLA Geriatric Psychiatry Fellowship DMH rotation began in July 2011 consisting of two fellows each year for two days a week for 6 month each. They receive formal and informal trainings

in geriatric psychiatry the DMH community mental health program called GENESIS. They are integrated into a team approach requiring home visits in a designated geographic area. They have been exposed to the Los Angeles County Elder Abuse Forensic Center and all were enthusiastic about that exposure. They receive training in Field Safety, which they find beneficial. It would be helpful to broaden the constraints of the geographic area but we are working “special cases” out on a case by case basis. We are also discussing ways that perhaps the fellows could participate in the completion of Capacity Declaration forms when needed. The do assessments as well as ongoing therapy and treatment. They both attend and participate in OACT trainings (OACT-HQ, OACT-MD and OACT-MD Seminar with case presentation), formal CME-approved and informal trainings. They attend other OA training provided by DMH on their assigned days.

The fellows have each integrated into the GENESIS program extraordinarily well and the praise by our staff and the fellows have often reflected this. One previous fellow has started an OA community mental health program in Texas a la GENESIS and another is working to create a home-based palliative care program she describes as modeling the GENESIS program The fellowship rotation was presented at last year’s AAGP as a positive training model by the fellow, Dr. Espinoza, and program lead Dr. Sarah Gelberd, the Medical Director of DMH OA Services. Fellows receive supervision from Dr. Gelberd and the UCLA Geropsych training program director of the Geropsych fellowship. Dr. Gelberd provides a formal review at the end of each rotation and has participated in the UCLA annual retreat of the fellowship program, as well as meeting with Dr. Espinoza annually, plus contact as needed. Dr. Espinoza has recently stated in an email January 2014, “I do hope a funding source is identified as the program has been a resounding success for us and, I think, for you.”

Funding: FYs 09-10 through current: $122,375 annually.

Technological Needs Projects

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

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.

Integrated Behavioral Health Information System (IBHIS)

Project Status: On Schedule
Budget Status: Within Approved Budget
Project Start Date: 4/1/2009
Project End Date: 3/1/2015

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.

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

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.

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

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.

Data Warehouse Re-Design

Project Status: On Schedule
Budget Status: N/A
Project Start Date: July 2013
Project End Date: To be determined

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.

Telepsychiatry Implementation

Project Status: On Schedule
Budget Status: Within Approved Budget
Project Start Date: 7/1/2010
Project End Date: 6/30/2018

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.

Capital Facilities

Downtown Mental Health Center

Project Description: Purchasing 25,000 sq. ft. building for $3.5 Million and refurbish and retro fit entire building. Construction to start June 2014.
Supervisorial District: 2
Cost: *$ 14,000,000*

Arcadia Mental Health Center

Project Description: Building a new 12,000 sq. ft. clinic in existing parking lot of old clinic, then tear down old clinic to make way for parking lot. In the process of finalizing the Design/Build Firm. On schedule now to break ground in Sept 2014.
Supervisorial District: 5
Cost: *$ 12,000,000*

Rio Hondo Mental Health Center

Project Description: Purchase current site with adjacent lot for parking.
Supervisorial District: 4
Cost: *$ 4,500,000*

Huntington Park Wellness Center and Service Area 7 Administration

Project Description: Look to purchase space
Supervisorial District: 1
Cost: *$ 3,000,000*

Northeast Mental Health Center

Project Description: Look to purchase space
Supervisorial District: 1
Cost: *$ 4,500,000*

Fiscal Year 2014-15 MHSA Services by Component

Community Services and Supports Plan

Stakeholder Recommended Changes from Previously Approved Plan

The Department's Executive Management Team identified a trend of under-spending within the CSS Plan and asked the SLT for an age group allocation methodology for $30 million in each of the next 3 Fiscal Years. After reserving $10 million for Board of Supervisor expansion program priorities, the SLT approved the following age group percent distribution of net CSS dollars:

Child: 13% TAY: 13% Adult: 61% Older Adult: 13%

This would result in an additional $2.6 million allocation for child, TAY and Older Adults and $12.2 million for adults for each of the Fiscal Years 2014-15, 2015-16, 2016-17.

After reviewing 51 proposals, the SLT recommended to the Department and to the Mental Health Commission the following program expansions and new programs. A list of all proposals is in the Appendix.

Board Priorities with Stakeholder support from SLT

1. Implementation of Laura's Law/Assisted Outpatient Treatment via the expansion of adult FSP services, Service Area Navigation Teams and Alternative Crisis Services:

MHSA Component and Work Plan: Adult, Assisted Outpatient Treatment Program is an expansion of the following Adult CSS programs:

- Service Area Navigation Teams – 500 evaluations per year
- Full Service Partnership – Adult, 300 additional slots
- Alternative Crisis Services – capacity to serve 60 additional clients

What is being expanded? Assembly Bill 1421 established the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002, known as Laura's Law. Laura's Law addresses the needs of mentally ill adults by providing a process to allow court-ordered outpatient treatment. The legislation established an option for counties to provide a way for courts, probation, and the mental health systems to address the needs of individuals who are unable to benefit from mental health treatment programs in the community without supervision. The unique programmatic component of Laura's Law is the AOT Team. These teams screen requests, conduct extensive outreach and engagement, develop petitions and manage the court processes to connect AOT enrollees with service providers primarily those who are Full Service Partnership Providers (FSP). Extensive outreach and engagement must be completed by this team in order to adequately assess for the law's detailed criteria. Successful implementation is predicated upon extensive inter-agency collaboration and provision of significant resources from the courts, County Counsel, Public Defender, the District Attorney's office, and local law enforcement. Laura's Law enrollees

require higher levels of care, which may include on-site mental health and supportive services to transition to stable community placement and prepare for more independent community living. The Enriched Residential Services program will provide such services at selected Adult Residential Facilities.

Estimated MHSA Budget: Service Area Navigation, MHSA $726,658
FSP, MHSA $ 1,919,880
IMD Step-Down, MHSA $ 1,226,400

Estimated Medi-Cal Budget: Service Area Navigation, MHSA $1,089,988
FSP, MHSA $2,879,820
IMD Step-Down, MHSA $1,839,600

2. IMD Step Down Programs: This program expansion will help decompress LA County hospital psychiatric emergency services

MHSA Component and Work Plan: Adult, Alternative Crisis Services - Institutions for Mental Disease (IMD)

What is being expanded? The IMD Step-Down program will be expanded to increase by **22** additional beds. IMD Step-Down Facilities are designed to provide supportive on-site mental health services at selected Adult Residential Facilities, and, in some instances, assisted living, congregate housing, or other independent living situations. The program accommodates persons being discharged from acute psychiatric inpatient units or intensive residential facilities, or those who are at risk of being placed in these higher levels of care who are appropriate for this service. The program targets those individuals in higher levels of care who require on-site mental health and supportive services to transition to stable community placement and prepare for more independent living.

Estimated MHSA Budget: $1.2 Million

3. Service component of SB82 California Health Facilities Financing Authority (CHFFA) Grant

MHSA Component and Work Plan: Adult, Alternative Crisis Services - Urgent Care Centers and Crisis Residential Programs. Investment in Mental Health Wellness Act of 2013 (SB82) California Health Facilities Financing Authority (CHFFA) Grant.

What is being expanded? Alternate Crisis Services provide 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.

- Urgent Care Centers (UCC) provide intensive crisis services to individuals who otherwise would be brought to emergency rooms.
- Crisis Residential Programs stabilize symptoms through medication intervention and develop social rehabilitation skills to facilitate community reintegration.

DMH has requested funds from the SB82 CHFFA grant to develop four UCCs to be located on the campus of Harbor-UCLA Medical Center, South-East Los Angeles, the Antelope Valley and the San Gabriel area to serve 72 individuals at any given time and 35 new Crisis Residential Programs to increase capacity by 560 beds countywide.

The new UCCs are intended to decompress the County Hospital emergency rooms and acute inpatient services. Two of the four new UCCs are intended to serve as points of entry for the proposed Pre-Booking Diversion Pilot Programs and the Assisted Outpatient Treatment Programs for the AV and LB Police Departments. The new Crisis Residential Programs will increase capacity countywide.

Estimated MHSA Budget:	$3 Million	
Estimated Medi-Cal Budget:	Medicaid Expansion	$1,020,000
	Medi-cal (Gross)	$990,000
	Total	**$2,010,000**

Child

Existing Programs

Child Full Service Partnership (C-01)
No changes to existing plan.

Family Support Services (C-02)
No changes to existing plan.

Child Field Capable Clinical Services (C-05)
Expanded to serve an additional 330 clients per FY ($1.13 mil for each of FY's 14/15, 15/16, 16/17).

Housing Trust Fund (listed under Adult in the CSS Plan but multi-age group): Continue funding at $250,000 for FY's 15/16 and 16/17

MHSA Housing Program: $200,000 for FY's 15/16 and 16/17 to build permanent housing.

New Programs

1. Family Wellness/Resource Centers

Program Description: Family Wellness/Resource Centers (FWRC) are designed to act as a welcoming and family-friendly center within the community where families with children in need of mental health services can go to obtain information and resources to navigate the mental health, physical health and educational systems and participate in self-help meetings and workshops. FWRCs include a resource library and computer stations for families within the community and offers peer counseling, parent support groups and educational classes. FWRCs are located within established community organizations (e.g. Integrated School Health Centers, parks and recreational centers, children's mental health clinics, health clinics, etc.) and work in partnership with other community non-profit and government agencies. Parent Partners/Parent Advocates are integral to FWRCs.

Target Population: FWRC offers resources and self-help groups/workshops to families with children in need of mental health services.

Program Goals:

a) To provide resources, training and support to families within the community caring for children with mental health problems

b) To provide family-focused information, which empower families to make informed choices and decisions
c) To enhance collaboration between parents/caregivers and community partners (e.g. mental health agencies/clinics, schools, health clinics, etc.)

Intended Program Outcomes:

a) Increase timely access to services
b) Increase community awareness of mental health services

Estimated Budget by FY: MHSA: $750,000 for FY 2015/16 and 16/17
Medi-Cal: $0

2. Family Crisis Services: Respite Care Program

Program Description: Respite Care Services are positive, supportive services intended to help relieve families from the stress and family strain that result from providing constant care for a child with Severe Emotional Disturbance (SED), while at the same time addressing minor behavior issues, implementing existing behavioral support plans, and assisting with daily living needs. Approximately 166 clients will be served each FY.

Target Population: Respite Care will be available to parents/caregivers that are providing in-home care for a child or youth, aged 0-15, with SED and receiving mental health services (e.g. FCCS or FSP) and meet the following conditions:

a) Parents/caregivers are under significant stress as a result of the responsibility of providing constant care to the client enrolled in Child FSP.
b) Continued caretaking without respite care may result in out-of-home placement; and
c) All other available formal and informal sources of support have been exhausted.

Program Goals: Respite care is intended to provide short-term relief to caregivers that provide in-home care for a SED child to prevent out-of-home placements and preserve the family.

Intended Program Outcomes: Anticipated outcomes of the Family Crisis Services/Respite Care Program include:

a) Increase family stability and well-being
b) Reduce incidence of out-of-home placement

Estimated Budget by FY: MHSA: $500,000 for FY 2015/16 and 16/17
Medi-Cal: $0

3. Self-help Support Groups for Children

Program Description: This funding will be used to establish self-help support groups for four evidence-based self-help programs: 1) Rainbows for children (4-15) who have experienced trauma, death, divorce, violence, removal from home and other losses; 2) La Leche League for at risk children 0-5 to establish healthy parental attachment; 3) Alateen for children (13-15) who have parents with mental health, substance abuse or other dysfunction in their families; 4) Because I Love You for parents of Children(10-15) with ADD, mental health and other behavioral issues.

Target Population: Children and parents needing support for the issues described above.

Program Goals: Improved outcomes for 0-5 at risk children; Having children realize that they are not to blame and are not alone in facing issues in their lives; Teens who cannot be distinguished from teens coming from functional families when compared in their 20's; Parents engaged with the mental health system and better coordination of services, as well as better outcomes for children with mental health and other behavioral issues.

Intended Program Outcomes: Eighty percent of ages 0-5 at-risk children will have excellent attachment; 80 percent of participants in Rainbows will improve communication in their families and peer relationships. After a year Rainbow participants will improve school attendance and academic performance; 60 percent of Alateen attenders will experience less negative moods and significantly more positive moods and higher self-esteem; 70 percent of Because I Love You participants will express more competence in being parents of children with mental health issues.

Estimated Budget (MHSA only): FY 15/16, $75,000
FY 16/17, $75,000

4. Community Mental Health Promoters/Community Health Workers

Program Description: This proposal seeks to add Community Mental Health Promoters (Promoters) /Community Health Workers (CHWs) as a directly operated, cross-cutting program across age groups, within each Service Area. Community Mental Health Promoters/Community Health Workers are trained and stipend community members who are trusted members of and/or have an unusually close understanding of the community served. Community Mental Health Promoters/Community Health Workers generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve. These social attributes and trusting relationships enable CHWs to serve as educators, stigma busters, and as a liaison, link, or intermediary between health, mental health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competence of services. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino and Asian Pacific Islander communities.

Target Population: Minority ethnic and cultural underserved individuals and families who traditionally do not seek mental health services or do not understand the symptoms of mental health as a result of cultural beliefs and/or the stigma associated with seeking mental health services. A special emphasis is on linguistic capacity to serve linguistically isolated populations.

Program Goals:

General: Promoters/CHWs can enhance a community's understanding of mental health symptoms, syndromes, and available treatments. They can assist with provider-client communication; preventive care; follow-up, and referral; and navigation of the mental health/health and educational systems for all age groups. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino communities

Specifics: Roll Out is planned over a 3-year period.

a) Year 1

1. Roll out of Promoters/Health Navigator Teams in each Service Area, following an established and tested model, including initial training, coaching and presentations for a small core group of participants.
2. Translate all prepared and available presentations from Spanish to English.
3. Train in-house trainers with the help of Training Consultant to assure sustainability.

b) Year 2

1. Complete roll out and training of all selected Promoters. Increase participants as needed by SA.
2. Develop Strategies to adapt program to other languages and cultural groups.

c) Year 3: Roll out expanded program, including translated and culturally adapted trainings, to other cultural and linguistic groups within the SA, according to the needs of the different regions.

Intended Program Outcomes:

a) Decrease stigma and fear, associated with either being diagnosed with a mental illness or seeking mental health services.
b) Improve timely access to mental health services for underserved populations
c) Increase community awareness of mental health services, particularly for linguistically and culturally underserved groups.
d) Coordinate services between health/mental health service providers for community members seeking their assistance.

Estimated Budget by FY:

FY 14/15: $250,000
FY 15/16: $250,000
FY 16/17: $250,000

Transition Age Youth

Existing Programs

TAY Full Service Partnership (T-01)
Expand the number of slots by18. For fiscal years 14/15, 15/16 and 16/17 add $141,000.

TAY Drop-In Centers (T-02)
Three additional centers. FY 14/15, serve additional 400 clients with $250,000. FY 15/16 and 16/17, serve an additional 1,200 clients with $750,000.

TAY Housing Services (T-03)
No changes to program.

TAY Probation Camp services (T-04)
No changes to program.

TAY Field Capable Clinical Services (T-05)
Expand capacity to serve an additional 36 clients at $88,000 for FY's 14/15, 15/16 and 16/17.

Housing Trust Fund: FY 14/15: $46,950, FY 15/16: $610,000, FY 16/17: $610,000.

MHSA Housing Program: For fiscal years 14/15, 15/16 and 16/17 add $550,000

New Programs

1. Community Mental Health Promoters/Community Health Workers

Program Description: This proposal seeks to add Community Mental Health Promoters (Promoters) /Community Health Workers (CHWs) as a directly operated, cross-cutting program across age groups, within each Service Area. Mental Health Promoters/Community Health Workers are trained and stipend community members who are trusted members of and/or have an unusually close understanding of the community served. Community Mental Health Promoters/Community Health Workers generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve. These social attributes and trusting relationships enable CHWs to serve as educators, stigma busters, and as a liaison, link, or intermediary between health, mental health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competence of services. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino and Asian Pacific Islander communities.

Target Population: Minority ethnic and cultural underserved individuals and families who traditionally do not seek mental health services or do not understand the symptoms of mental health as a result of cultural beliefs and/or the stigma associated with seeking mental health services. A special emphasis is on linguistic capacity to serve linguistically isolated populations.

Program Goals:

General: Promoters/CHWs can enhance a community's understanding of mental health symptoms, syndromes, and available treatments. They can assist with provider-client communication; preventive care; follow-up, and referral; and navigation of the mental health/health and educational systems for all age groups. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino communities

Specifics: Roll Out is planned over a 3-year period.

a) Year 1
    1. Roll out of Promoters/Health Navigator Teams in each Service Area, following an established and tested model, including initial training, coaching and presentations for a small core group of participants.
    2. Translate all prepared and available presentations from Spanish to English.
    3. Train in-house trainers with the help of Training Consultant to assure sustainability.
b) Year 2
    1. Complete roll out and training of all selected Promoters. Increase participants as needed by SA.
    2. Develop Strategies to adapt program to other languages and cultural groups.
c) Year 3: Roll out expanded program, including translated and culturally adapted trainings, to other cultural and linguistic groups within the SA, according to the needs of the different regions.

Intended Program Outcomes:

a) Decrease stigma and fear, associated with either being diagnosed with a mental illness or seeking mental health services.
b) Improve timely access to mental health services for underserved populations.

c) Increase community awareness of mental health services, particularly for linguistically and culturally underserved groups.
d) Coordinate services between health/mental health service providers for community members seeking their assistance.

Estimated Budget by FY: FY 14/15: $228,000
FY 15/16: $228,000
FY 16/17: $228,697

2. Self-Help Support Groups for TAY

Program Description: Using four evidence-based self-help programs:1) Rainbows for TAY (15-18) who have experienced trauma, death, divorce, violence, removal from home and other losses; 2) La Leche League for pregnant TAY support for attachment parenting and breastfeeding; 3) Alateen for teens who have parents with mental health, substance abuse or other dysfunction in their families; 4) Because I Love You for parents of TAY (15-30) with ADD, mental health and other behavioral issues.

Estimated Budget by FY: FY 15/16: $45,000; FY 16/17: $45,000

3. TAY Supportive Employment

Program Description: Employment is an important aspect of an individual's recovery. It provides a sense of identity and structure Utilizing evidence based supportive employment services (such as the Individual Placement and Support model), TAY Supportive Employment will assist TAY, receiving mental health services and residing in permanent supportive housing (and other housing situations), to obtain and maintain gainful employment to achieve self-sufficiency. TAY Supportive Employment will incorporate effective strategies that are driven by the individual's choice and include principles that integrate with mental health treatment.

The proposed funding will be utilized to train current TAY mental health providers in implementing supportive employment services within their existing mental health delivery system.

Target Population: TAY (18-25 years old)

Program Goals: Provide supportive employment services to TAY to increase their self-sufficiency by: obtaining and maintaining gainful employment and maintaining stable housing.

Intended Program Outcomes: Seventy-five percent of the TAY enrolled in the program will achieve employment success, as defined by maintaining their employment for a period of 6 months. Ninety percent of the TAY enrolled in the program will maintain their housing situation.

Estimated Budget by FY: FY 14/15: $125,000 (30 clients to be served)
FY 15/16: $500,000 (125 clients to be served)
FY 16/17: $500,000 (125 clients to be served)

4. Integration of Co-Occurring Mental Health and Substance Abuse Disorders (COD) Treatment Practices Training and Technical Assistance

Program Description: Both the COD Integration Training Project and the Annual Integrated Care Conference provide essential support for the effective implementation of full service partnerships by

continuing to develop, expand, and support fully integrated age appropriate Co-Occurring Disorder models of integrated treatment to serve Children and their caregivers, Transitional Age Youth (TAY), Adult, and Older Adult consumers affected by Co-occurring disorders.

COD was included in the original CSS plan for children only and ended in 2008. This will add COD training back into the CSS Plan.

Target Population: Behavioral health service providers.

Program Goals: To build and improve a system of care utilizing age appropriate strategies that seamlessly and effectively addresses and integrates the treatment of co-occurring disorders that often significantly exacerbate the effects of mental illness.

Intended Program Outcomes:

a) Provide didactic training, consultation and education that enhances Knowledge, Skills and Ability in the provision of integrated services to clinical staff, physicians, nurse practitioners and paraprofessional staff from DMH, contract agencies, and community partners, that provide direct Full Service Partnership treatment services to Children, Transitional Age Youth (TAY), Adult, Jail Mental Health, AB 109 populations, and selected community partners in the context of the development of Health Neighborhoods.

b) Provide ongoing consultation in person and via DMH Tele-Mental Health System to trained staff to enhance screening, assessment, treatment, care coordination and care management practices in the provision of COD services.

c) Develop programs for on-line seminars, workshops and forums to educate and train on, issues faced by these diverse populations.

d) One and one-half day Annual Conference on Integrated Care for 1,000+ attendees.

Estimated Budget by FY: FY 15/16: $36,391
FY 16/17: $36,391

Adult

Existing Programs

Adult Full Service Partnership (A-01)

Slots will be expanded in the following ways:

a) Twenty-five slots will be added in FY 14/15.
b) One hundred slots will be added for FY 15/16. Seventy-five additional slots to be added to providers who demonstrated success with their Innovation program, which ends June 30, 2015. Psychiatric capacity expanded by four psychiatrists across the directly operated FSP system.
c) One hundred slots will be added for FY 16/17. Seventy-five additional slots to be added to providers who demonstrated success with their Innovation program, which ends June 30, 2015. Psychiatric capacity expanded by four psychiatrists across the directly operated FSP system.

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Assisted Outpatient Program described under Board priorities #1 above.

Wellness/Client Run Centers (A-02)

Services are being expanded in the following ways:

a) Adjunct services for clients in Wellness Centers who are not in need of intensive services as part of this model will include medication management, non-intensive case management, and peer support. Staffing for the Wellness adjunct program to minimally include a Psychiatric Nurse and Peer Case Manager. Estimated to serve an additional 29,000 clients in FY's 14/15, 15/16 and 16/17.
b) Expand staffing to implement Supported Employment, an Evidenced-based Practice, which assists clients to obtain and maintain employment. 150 clients to be served in FY 14/15 and 300 clients in FY's 15/16 and 16/17.
c) Adding one Housing Specialist per program to ensure field capable housing support for Wellness Services to support individuals in maintaining their housing and to create service capacity for clients with a Section 8 Voucher which requires a service match to maintain. The Wellness program definition will also need to be clarified to ensure field services are available "as needed" to support housing stability. 1,500 clients to be served in each of FY's 14/15, 15/16 and 16/17.
d) Adding a total of 35 peer staff to directly operated Wellness Centers and to contract Client Run Centers to serve an additional 1,750 clients
e) Expand Client Run Centers to ensure availability in every service area. Increase support to pilot "Life Coaches" in Peer Run Centers. Expand Peer Run Center staff to ensure services are available in multiple languages and meet cultural needs. In FY 14/15 an additional 500 clients would be served while in FY's 15/16 and 16/17 an additional 2,000 clients would be served.

IMD Step-Down Facilities (A-03)
Expansions listed under Board priorities above.

Adult Housing Services (A-04)

a) **MHSA Housing Program**
    1. An investment in capital development and operating subsidies to expand the number of affordable, permanent supportive housing units for DMH clients. Funding goes through CalFHA.
    2. FY 14/15, $2.5 mi.
b) **Housing Trust Fund**
    1. Extending the current 5 year contracts which are ending for some agencies. The funding will also allow us to expand supportive services to more permanent supportive housing programs.
    2. FY 14/15: $156,500
    3. FY 15/16: $980,000
    4. FY 16/17: $1.6 mi.

Jail Transition and Linkage (A-05)
No changes to previously approved work plan.

Adult Field Capable Clinical Services (A-06)
Additional capacity will be created in the following ways:

a) FY 14/15: Increase clients served by 50
b) FY 15/16: Increase clients served by 200. Providers who demonstrated success with their Innovation program, ending in June 30, 2015, will have their contracts amended to serve collectively an additional 132 clients.
c) FY 16/17: Increase clients served by 200. Providers who demonstrated success with their Innovation program, ending in June 30, 2015, will have their contracts amended to serve collectively an additional 132 clients.

New Programs

1. Community Mental Health Promoters/Community Health Workers

Program Description: This proposal seeks to add Community Mental Health Promoters/Community Health Workers as a directly operated, cross-cutting program across age groups, within each Service Area. *Mental Health* Promoters/Community Health Workers are trained and stipend community members who are trusted members of and/or have an unusually close understanding of the community served. Mental Health Promoters / Community Health Workers (CHWs) generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve. These social attributes and trusting relationships enable CHWs to serve as educators, stigma busters, and as a liaison, link, or intermediary between health, mental health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competence of services. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino and Asian Pacific Islander communities.

Target Population: Minority ethnic and cultural underserved individuals and families who traditionally do not seek mental health services or do not understand the symptoms of mental health as a result of cultural beliefs and/or the stigma associated with seeking mental health services. A special emphasis is on linguistic capacity to serve linguistically isolated populations.

Program Goals:

General: Promoters/CHWs can enhance a community's understanding of mental health symptoms, syndromes, and available treatments. They can assist with provider-client communication; preventive care; follow-up, and referral; and navigation of the mental health/health and educational systems for all age groups. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino communities

Specifics: Roll Out is planned over a 3-year period.

a) Year 1
    1. Roll out of Promoters/Health Navigator Teams in each Service Area, following an established and tested model, including initial training, coaching and presentations for a small core group of participants.
    2. Translate all prepared and available presentations from Spanish to English.
    3. Train in-house trainers with the help of Training Consultant to assure sustainability.
b) Year 2
    1. Complete roll out and training of all selected Promoters. Increase participants as needed by SA.
    2. Develop Strategies to adapt program to other languages and cultural groups.
c) Year 3: Roll out expanded program, including translated and culturally adapted trainings, to other cultural and linguistic groups within the SA, according to the needs of the different regions.

Intended Program Outcomes:

a) Decrease stigma and fear, associated with either being diagnosed with a mental illness or seeking mental health services.
b) Improve timely access to mental health services for underserved populations.

c) Increase community awareness of mental health services, particularly for linguistically and culturally underserved groups.
d) Coordinate services between health/mental health service providers for community members seeking their assistance.

Estimated Budget by FY:
FY 14/15: $350,000
FY 15/16: $350,000
FY 16/17: $350,000

2. Integration of Co-Occurring Mental Health and Substance Abuse Disorders (COD) Treatment Practices Training and Technical Assistance:

Estimated Budget by FY:
FY 15/16: $170,000
FY 16/17: $170,000

Issues Requiring Action or Further Discussion

During the planning process, a concern was expressed that adult MHSA programs where peer staffing was mandated as part of the program are not being staffed accordingly. The Department agreed to review peer staffing discrepancies and hold providers (contracted and directly operated) to the expectations documented in FSP guidelines, Wellness Center RFS requirements and contractual language.

Older Adult

Existing Programs

Older Adult Full Service Partnership (OA-01)
Expand slots by 122 over the three fiscal years.

Transformation Design Team (OA-02)
No changes to previously approved work plan.

Field Capable Clinical Services (OA-03)
Increase capacity by 456 clients over the three fiscal years.

Service Extenders (OA-04)
No changes to previously approved work plan.

Older Adults Training (OA-05)
No changes to previously approved work plan.

Housing Trust Fund (A-04)
$250,000 per Fiscal Year for older adult housing development.

Services Cutting Across Age Groups

Existing Programs

System Navigators (SN-01)
See Assisted Outpatient Treatment program under Board priorities above for service expansions.

Alternative Crisis Services (ACS-01)
See programs listed under Board priorities above for service expansions.

Planning, Outreach & Engagement (POE-01)
Strategies to enhance existing outreach and engagement services include:

a) Identifying specific outreach and engagement strategies to engage TAY into services, including the use of social media and technology.
b) Outreach and engage TAY who are victims of commercial/sexual exploitation.
c) Focus TAY outreach efforts in high schools, alternative schools, community colleges, universities and trade/vocational schools.
d) Focus outreach and engagement efforts at unserved and under-served ethnic communities, using the UREP recommendations.
e) Outreach and engage the TAY LBGTQ community with early signs of mental illness.
f) Incorporate learning from the Integrated Services Management Model Innovation programs to the outreach and engagement process, including the utilization of effective non-traditional approaches.

Prevention and Early Intervention

Stakeholder Recommended Changes from Previously Approved Plan

No changes will be made to the current PEI Plan.

Potential Changes Requiring Additional Stakeholder Discussion and Input:

a) An interest was expressed to categorize early intervention services at the level of the PEI Program rather than at the more granular level of the early intervention Evidence-Based Practice, Promising Practice or Community-Defined Evidence practice. Each program would still consist of one of more of these practices but would be augmented with other services, such as employment support or short-term targeted case management that would aid in the transition back to a pre-morbid or higher level of functioning.
b) The Department will examine its Prevention programs in the next planning cycle to prioritize those most at risk of developing a mental illness and the programs and services that align with early intervention and, to some degree, CSS programs.
c) The Department will review the results of the PEI Statewide Projects that have created local impact in Los Angeles County to determine whether those efforts should continue.
d) Focus and build capacity to target TAY and Older Adult for stigma and discrimination reduction and Suicide Prevention trainings, presentations, and services. Utilize Mental Health First Aid; Question, Persuade, Refer; Applied Suicide Intervention Skills Training.
e) Identify and integrate best practices related to stigma reduction in schools settings targeting TAY.
f) Provide training to reduce staff stigma. The proposal, entitled “From the inside out: Turning the Tide of Stigma and Discrimination” would train staff, consumers, family members and other

friendly community members to counter stigmatizing and discriminatory language and behavior in the community with direct, respectful and assertive messages.

g) A DHS psychiatrist is funded for the provision of psychiatric services, including consultation and directive services to clients receiving mental health services through the DMH/DHS Collaboration Program. Clients will receive integrated physical and mental health services provided through a primary care provider and treatment team.

Workforce Education and Training

Stakeholder Recommended Changes from Previously Approved Plan

No recommended changes from previously approved plan.

Potential Changes Requiring Additional Stakeholder Discussion and Input

Expand WET Project 9 to include a TAY-focused peer certification process to prepare TAY aged individuals to work as peer advocates within the mental health system. Individuals trained would be able to provide peer services in outreaching to TAY and for TAY accessing mental health services.

Capital Facilities and Technological Needs:

Stakeholder Recommended Changes from Previously Approved Plan

The allocated amount for Capital Facilities (CF) and Information Technology (IT) is $131,007,000. Stakeholders determined 70% ($91,704,900) of funds above would support IT Projects, with the remainder to support CF Projects.

Change: Move $3 million from CF Projects to IT to support the continued deployment of the Integrated Behavioral Health Information System (IBHIS), changing the initial ratio of TN to CF funds from 70%/30% to 72% TN, 28% CF. The recommended change was approved by the SLT.

Innovation

The Integrated Mobile Health Team, Integrated Clinic Model and Integrated Services Management Model all are scheduled to conclude on June 30, 2015. The Integrated Peer Run Model will conclude on June 30, 2016.

The Department is beginning the process of identifying potential new Innovation projects that would begin sometime during FY 2015-16.

Budget

FY 2014-15 through FY 2016-17 Three-Year MHSA Expenditure Plan

Funding Summary

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	74,249,630	64,375,234	24,966,643	37,706,313	68,749,428	
2. Estimated New FY2014/15 Funding	307,716,320	79,855,221	20,393,277			
3. Transfer in FY2014/15[a/]	0					
4. Access Local Prudent Reserve in FY2014/15						0
5. Estimated Available Funding for FY2014/15	381,965,950	144,230,455	45,359,920	37,706,313	68,749,428	
B. Estimated FY2014/15 MHSA Expenditures	336,625,486	99,015,347	31,183,047	13,102,677	32,875,395	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	45,340,464	45,215,108	14,176,873	24,603,636	35,874,033	
2. Estimated New FY2015/16 Funding	302,131,271	78,412,941	20,021,971			
3. Transfer in FY2015/16[a/]	0					
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	347,471,735	123,628,049	34,198,843	24,603,636	35,874,033	
D. Estimated FY2015/16 Expenditures	342,454,357	99,015,347	4,631,743	13,102,677	19,210,395	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,017,378	24,612,702	29,567,100	11,500,959	16,663,638	
2. Estimated New FY2016/17 Funding	339,553,930	88,126,256	22,506,866			
3. Transfer in FY2016/17[a/]	0					
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	344,571,308	112,738,958	52,073,966	11,500,959	16,663,638	
F. Estimated FY2016/17 Expenditures	343,289,708	99,015,347	1,207,796	11,427,779	7,391,519	
G. Estimated FY2016/17 Unspent Fund Balance	1,281,601	13,723,611	50,866,170	73,180	9,272,119	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	160,725,402
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	160,725,402
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	160,725,402
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	160,725,402

a/ Pursuant to 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.

Community Services and Supports (CSS) Component Worksheet

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's Full Service Partnerships	47,752,999	8,850,625	21,308,729		17,593,645	
2. Family Support Services	2,921,877	2,921,877				
3. Children-Field-Capable Clinical Services	3,239,411	517,345	1,581,024		1,141,043	
4. Child Promotores	75,000	75,000				
5. TAY Full Service Partnerships	29,189,122	15,843,382	9,097,374		4,248,366	
6. Drop-in Centers	350,000	350,000				
7. TAY Housing Services	1,584,748	1,584,748				
8. TAY Supportive Employment Services	37,500	37,500				
9. TAY Promotores	68,400	68,400				
10. Probation Camp Services	1,138,097	1,138,097				
11. TAY-Field-Capable Clinical Services	3,209,223	771,374	1,500,997		936,524	328
12. Adult Full Service Partnerships	78,747,567	52,295,820	26,391,281		60,466	
13. Wellness/Client Run Centers	32,704,596	24,774,975	7,373,867		273,320	282,434
14. IMD Step Down Facilities	10,802,120	6,992,700	3,809,420			
15. Adult Housing Services	1,278,268	1,278,268				
16. Adult Supportive Employment Model Pilot	154,771	82,355	72,416			
17. Adult Promotores	105,000	105,000				
18. Jail transition & Linkage Services	3,333,063	3,207,235	83,250		2,808	39,770
19. Adult-Field-Capable Clinical Services	15,138,691	8,377,769	6,757,222		1,098	2,602
20. Older Adult Full Service Partnerships	8,258,927	4,864,370	3,394,557			
21. Field-Capable Clinical Services	3,404,701	2,148,359	1,196,653			59,690
22. Older Adult Co-Occurring Disorders	9,704	9,704				
23. OA Training	39,772	39,772				
24. Service Area Navigator Teams	8,534,313	7,731,316	793,065		9,527	405
25. Alternative Crisis Services	31,919,316	24,431,543	7,277,533	0	201,688	8,552
26.	0					

Non-FSP Programs						
1. Children-Field-Capable Clinical Services	50,750,776	8,105,073	24,769,370		17,876,333	
2. Child Promotores	175,000	175,000				
3. Drop-in Centers	650,000	650,000				
4. TAY Supportive Employment Services	87,500	87,500				
5. TAY Housing Services	1,056,498	1,056,498				
6. TAY Promotores	159,600	159,600				
7. Probation Camp Services	3,414,292	3,414,292				
8. TAY-Field-Capable Clinical Services	7,488,188	1,799,873	3,502,327		2,185,223	765
9. Wellness/Client Run Centers	60,737,107	46,010,670	13,694,324		507,594	524,519
10. IMD Step Down Facilities	3,600,707	2,330,900	1,269,807			
11. Adult Housing Services	5,113,073	5,113,073				
12. Adult Supportive Employment Model Pilot	361,133	192,163	168,970			
13. Adult Promotores	245,000	245,000				
14. Jail transition & Linkage Services	3,333,063	3,207,235	83,250		2,808	39,770
15. Adult-Field-Capable Clinical Services	28,014,710	15,497,213	12,510,627		2,038	4,833
16. Transformation Design Team	481,208	481,208				
17. Field-Capable Clinical Services	19,293,307	12,174,035	6,781,031			338,241
18. Older Adult Co-Occurring Disorders	14,556	14,556				
19. OA Service Extenders	229,500	229,500				
20. OA Training	159,086	159,086				
21. Service Area Navigator Teams	3,657,563	3,313,422	339,884		4,083	174
22. Planning, Outreach, Engagement	13,222,437	13,102,437	120,000			
23. Alternative Crisis Services	24,485,195	18,623,074	5,683,028	0	171,808	7,285
24.	0					
CSS Administration	32,580,528	31,501,795				1,078,733
CSS MHSA Housing Program Assigned Funds	484,750	484,750				
Total CSS Program Estimated Expenditures	543,791,962	336,625,486	159,560,004	0	45,218,371	2,388,101
FSP Programs as Percent of Total	84.4%					

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's Full Service Partnerships	47,752,999	8,850,625	21,308,729		17,593,645	
2. Family Support Services	2,921,877	2,921,877				
3. Children-Field-Capable Clinical Services	3,239,411	517,345	1,581,024		1,141,043	
4. Family Wellness Center	37,500	37,500				
5. Child Self Help Group	3,750	3,750				
6. Respite Care	125,000	125,000				
7. Child Housing	100,000	100,000				
8. Child Promotores	75,000	75,000				
9. TAY Full Service Partnerships	29,424,854	16,079,114	9,097,374		4,248,366	
10. Drop-in Centers	525,000	525,000				
11. TAY Self Help Support Groups	2,250	2,250				
12. TAY Co-Occuring Disorders	14,556	14,556				
13. TAY Spportive Empolyment Services	150,000	150,000				
14. TAY Housing Services	1,584,748	1,584,748				
15. TAY Promotores	68,400	68,400				
16. Probation Camp Services	1,138,097	1,138,097				
17. TAY-Field-Capable Clinical Services	3,209,223	771,374	1,500,997		936,524	328
18. Adult Full Service Partnerships	80,647,567	53,791,570	26,795,531		60,466	
19. Wellness/Client Run Centers	32,894,924	24,965,303	7,373,867		273,320	282,434
20. IMD Step Down Facilities	10,802,120	6,992,700	3,809,420			
21. Adult Supportive Employment Model Pilot	227,187	82,355	144,832			
22. Adult Promotores	105,000	105,000				
23. Adult Co-Occuring Disorders	68,000	68,000				
24. Adult Housing Services	778,268	778,268				
25. Jail transition & Linkage Services	3,333,063	3,207,235	83,250		2,808	39,770
26. Adult-Field-Capable Clinical Services	15,836,190	8,893,356	6,939,134		1,098	2,602
27. Older Adult Full Service Partnerships	8,910,134	5,124,853	3,785,281			
28. Field-Capable Clinical Services	3,551,223	2,206,968	1,284,566			59,690
29. Older Adult Co-Occuring Disorders	9,704	9,704				
30. OA Training	39,772	39,772				
31. Service Area Navigator Teams	8,534,313	7,731,316	793,065		9,527	405
32. Alternative Crisis Services	31,919,316	24,431,543	7,277,533	0	201,688	8,552
33.	0					

Non-FSP Programs						
1. Children-Field-Capable Clinical Services	50,750,776	8,105,073	24,769,370		17,876,333	
2. Family Wellness Center	712,500	712,500				
3. Child Self Help Group	71,250	71,250				
4. Respite Care	375,000	375,000				
5. Child Housing	100,000	100,000				
6. Child Promotores	175,000	175,000				
7. Drop-in Centers	975,000	975,000				
8. TAY Self Help Support Groups	42,750	42,750				
9. TAY Co-Occuring Disorders	21,835	21,835				
10. TAY Spportive Empolyment Services	350,000	350,000				
11. TAY Housing Services	1,056,498	1,056,498				
12. TAY Promotores	159,600	159,600				
13. Probation Camp Services	3,414,292	3,414,292				
14. TAY-Field-Capable Clinical Services	7,488,188	1,799,873	3,502,327		2,185,223	765
15. Wellness/Client Run Centers	61,090,571	46,364,134	13,694,324		507,594	524,519
16. IMD Step Down Facilities	3,600,707	2,330,900	1,269,807			
17. Adult Supportive Employment Model Pilot	530,103	192,163	337,940			
18. Adult Promotores	245,000	245,000				
19. Adult Co-Occuring Disorders	102,000	102,000				
20. Adult Housing Services	3,113,073	3,113,073				
21. Jail transition & Linkage Services	3,333,063	3,207,235	83,250		2,808	39,770
22. Adult-Field-Capable Clinical Services	28,867,209	16,127,375	12,732,964		2,038	4,833
23. Transformation Design Team	481,208	481,208				
24. Field-Capable Clinical Services	20,123,595	12,506,150	7,279,204			338,241
25. Older Adult Co-Occuring Disorders	14,556	14,556				
26. OA Service Extenders	229,500	229,500				
27. OA Training	159,086	159,086				
28. Service Area Navigator Teams	3,657,563	3,313,422	339,884		4,083	174
29. Planning, Outreach, Engagement	13,222,437	13,102,437	120,000			
30. Alternative Crisis Services	24,485,195	18,623,074	5,683,028	0	171,808	7,285
31.	0					
CSS Administration	32,580,528	31,501,795				1,078,733
CSS MHSA Housing Program Assigned Funds	2,090,000	2,090,000				
Total CSS Program Estimated Expenditures	551,647,528	342,454,357	161,586,699	0	45,218,371	2,388,101
FSP Programs as Percent of Total	84.1%					

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's Full Service Partnerships	47,752,999	8,850,625	21,308,729		17,593,645	
2. Family Support Services	2,921,877	2,921,877				
3. Children-Field-Capable Clinical Services	3,239,411	517,345	1,581,024		1,141,043	
4. Family Wellness Center	37,500	37,500				
5. Child Self Help Group	3,750	3,750				
6. Respite Care	125,000	125,000				
7. Child Housing	100,000	100,000				
8. Child Promotores	75,000	75,000				
9. TAY Full Service Partnerships	29,424,854	16,079,114	9,097,374		4,248,366	
10. Drop-in Centers	525,000	525,000				
11. TAY Self Help Support Groups	6,750	6,750				
12. TAY Co-Occuring Disorders	14,556	14,556				
13. TAY Spportive Empolyment Services	150,000	150,000				
14. TAY Housing Services	1,584,748	1,584,748				
15. TAY Promotores	91,200	91,200				
16. Probation Camp Services	1,138,097	1,138,097				
17. TAY-Field-Capable Clinical Services	3,209,223	771,374	1,500,997		936,524	328
18. Adult Full Service Partnerships	80,647,567	53,865,066	26,722,035		60,466	
19. Wellness/Client Run Centers	32,894,924	24,965,303	7,373,867		273,320	282,434
20. IMD Step Down Facilities	10,802,120	7,015,695	3,786,425			
21. Adult Supportive Employment Model Pilot	227,187	82,355	144,832			
22. Adult Promotores	105,000	105,000				
23. Adult Co-Occuring Disorders	68,000	68,000				
24. Adult Housing Services	778,268	778,268				
25. Jail transition & Linkage Services	3,333,063	3,207,235	83,250		2,808	39,770
26. Adult-Field-Capable Clinical Services	15,836,190	8,893,356	6,939,134		1,098	2,602
27. Older Adult Full Service Partnerships	9,003,164	5,162,065	3,841,099			
28. Field-Capable Clinical Services	3,572,155	2,215,341	1,297,125			59,690
29. Older Adult Co-Occuring Disorders	9,704	9,704				
30. OA Training	39,772	39,772				
31. Service Area Navigator Teams	8,534,313	7,744,032	780,349		9,527	405
32. Alternative Crisis Services	31,919,316	24,431,543	7,277,533	0	201,688	8,552

Non-FSP Programs						
1. Children-Field-Capable Clinical Services	50,750,776	8,105,073	24,769,370		17,876,333	
2. Family Wellness Center	712,500	712,500				
3. Child Self Help Group	71,250	71,250				
4. Respite Care	375,000	375,000				
5. Child Housing	100,000	100,000				
6. Child Promotores	175,000	175,000				
7. Drop-in Centers	975,000	975,000				
8. TAY Self Help Support Groups	38,250	38,250				
9. TAY Co-Occuring Disorders	21,835	21,835				
10. TAY Spportive Empolyment Services	350,000	350,000				
11. TAY Housing Services	1,056,498	1,056,498				
12. TAY Promotores	136,800	136,800				
13. Probation Camp Services	3,414,292	3,414,292				
14. TAY-Field-Capable Clinical Services	7,488,188	1,799,873	3,502,327		2,185,223	765
15. Wellness/Client Run Centers	61,090,571	46,364,134	13,694,324		507,594	524,519
16. IMD Step Down Facilities	3,600,707	2,338,565	1,262,142			
17. Adult Supportive Employment Model Pilot	530,103	192,163	337,940			
18. Adult Promotores	245,000	245,000				
19. Adult Co-Occuring Disorders	102,000	102,000				
20. Adult Housing Services	3,113,073	3,113,073				
21. Jail transition & Linkage Services	3,333,063	3,207,235	83,250		2,808	39,770
22. Adult-Field-Capable Clinical Services	28,867,209	16,127,375	12,732,964		2,038	4,833
23. Transformation Design Team	481,208	481,208				
24. Field-Capable Clinical Services	20,242,208	12,553,595	7,350,372			338,241
25. Older Adult Co-Occuring Disorders	14,556	14,556				
26. OA Service Extenders	229,500	229,500				
27. OA Training	159,086	159,086				
28. Service Area Navigator Teams	3,657,563	3,318,871	334,435		4,083	174
29. Planning, Outreach, Engagement	13,222,437	13,102,437	120,000			
30. Alternative Crisis Services	24,485,195	18,623,074	5,683,028	0	171,808	7,285
31.	0					
CSS Administration	32,580,528	31,501,795				1,078,733
CSS MHSA Housing Program Assigned Funds	2,710,000	2,710,000				
Total CSS Program Estimated Expenditures	552,500,102	343,289,708	161,603,923	0	45,218,371	2,388,101
FSP Programs as Percent of Total	83.9%					

Prevention and Early Intervention Component Worksheet

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI Early Start-Suicide Prevention	1,548,480	1,548,480				
2. PEI Early Start-School Mental Health Initiative	2,903,982	2,903,982				
3. PEI Early Start-Stigma Discrimination	1,870,220	1,870,220				
4. School-based Services	2,375,225	2,375,225				
5. Family Education and Support Services	5,280,600	5,280,600				
6. At-risk Family Services	3,616,343	3,616,343				
7. Trauma Recovery Services	308,214	308,214				
8. Primary Care & Behavioral Health	1,411,514	1,411,514				
9. Early Care & Support for TAY	2,683,738	2,683,738				
10. Juvenile Justice Services	510,722	510,722				
11. Early Care & Support for Older Adults	2,441,105	2,441,105				
12. Improving Access for Underserved Populations	2,160,212	2,160,212				
13. American Indian Project	362,730	362,730				
PEI Programs - Early Intervention						
14. PEI Early Start-Suicide Prevention	1,548,480	1,548,480				
15. PEI Early Start-School Mental Health Initiative	1,190,784	967,993	181,430		41,361	
16. PEI Early Start-Stigma Discrimination	207,802	207,802				
17. School-based Services	21,346,066	3,931,725	10,052,825		7,361,517	
18. Family Education and Support Services	25,930,463	3,017,708	13,226,909		9,685,846	
19. At-risk Family Services	26,097,147	4,283,795	12,592,253		9,221,098	
20. Trauma Recovery Services	73,529,795	19,323,626	31,291,745		22,914,425	
21. Primary Care & Behavioral Health	13,680,929	2,601,222	6,396,013		4,683,694	
22. Early Care & Support for TAY	22,170,711	3,924,492	10,533,045		7,713,174	
23. Juvenile Justice Services	28,878,065	7,303,085	12,454,648		9,120,332	
24. Early Care & Support for Older Adults	22,437,409	4,173,523	10,543,244		7,720,642	
25. Improving Access for Underserved Populations	17,802,815	3,147,501	8,460,114		6,195,201	
26. American Indian Project	2,365,824	362,730	1,156,332		846,762	
PEI Administration	16,748,579	16,748,579				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	301,407,957	99,015,347	116,888,557	0	85,504,053	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI Early Start-Suicide Prevention	1,548,480	1,548,480				
2. PEI Early Start-School Mental Health Initiative	2,903,982	2,903,982				
3. PEI Early Start-Stigma Discrimination	1,870,220	1,870,220				
4. School-based Services	2,375,225	2,375,225				
5. Family Education and Support Services	5,280,600	5,280,600				
6. At-risk Family Services	3,616,343	3,616,343				
7. Trauma Recovery Services	308,214	308,214				
8. Primary Care & Behavioral Health	1,411,514	1,411,514				
9. Early Care & Support for TAY	2,683,738	2,683,738				
10. Juvenile Justice Services	510,722	510,722				
11. Early Care & Support for Older Adults	2,441,105	2,441,105				
12. Improving Access for Underserved Populations	2,160,212	2,160,212				
13. American Indian Project	362,730	362,730				
PEI Programs - Early Intervention						
14. PEI Early Start-Suicide Prevention	1,589,841	1,548,480			41,361	
15. PEI Early Start-School Mental Health Initiative	1,149,423	967,993	181,430			
16. PEI Early Start-Stigma Discrimination	7,569,319	207,802			7,361,517	
17. School-based Services	23,670,395	3,931,725	10,052,825		9,685,846	
18. Family Education and Support Services	25,465,716	3,017,708	13,226,909		9,221,098	
19. At-risk Family Services	39,790,474	4,283,795	12,592,253		22,914,425	
20. Trauma Recovery Services	55,299,064	19,323,626	31,291,745		4,683,694	
21. Primary Care & Behavioral Health	16,710,409	2,601,222	6,396,013		7,713,174	
22. Early Care & Support for TAY	23,577,869	3,924,492	10,533,045		9,120,332	
23. Juvenile Justice Services	27,478,376	7,303,085	12,454,648		7,720,642	
24. Early Care & Support for Older Adults	20,911,968	4,173,523	10,543,244		6,195,201	
25. Improving Access for Underserved Populations	12,454,376	3,147,501	8,460,114		846,762	
26. American Indian Project	1,519,062	362,730	1,156,332			
PEI Administration	16,748,579	16,748,579				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	301,407,957	99,015,347	116,888,557	0	85,504,053	0

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI Early Start-Suicide Prevention	1,548,480	1,548,480				
2. PEI Early Start-School Mental Health Initiative	2,903,982	2,903,982				
3. PEI Early Start-Stigma Discrimination	1,870,220	1,870,220				
4. School-based Services	2,375,225	2,375,225				
5. Family Education and Support Services	5,280,600	5,280,600				
6. At-risk Family Services	3,616,343	3,616,343				
7. Trauma Recovery Services	308,214	308,214				
8. Primary Care & Behavioral Health	1,411,514	1,411,514				
9. Early Care & Support for TAY	2,683,738	2,683,738				
10. Juvenile Justice Services	510,722	510,722				
11. Early Care & Support for Older Adults	2,441,105	2,441,105				
12. Improving Access for Underserved Populations	2,160,212	2,160,212				
13. American Indian Project	362,730	362,730				
PEI Programs - Early Intervention						
14. PEI Early Start-Suicide Prevention	1,589,841	1,548,480			41,361	
15. PEI Early Start-School Mental Health Initiative	1,149,423	967,993	181,430			
16. PEI Early Start-Stigma Discrimination	7,569,319	207,802			7,361,517	
17. School-based Services	23,670,395	3,931,725	10,052,825		9,685,846	
18. Family Education and Support Services	25,465,716	3,017,708	13,226,909		9,221,098	
19. At-risk Family Services	39,790,474	4,283,795	12,592,253		22,914,425	
20. Trauma Recovery Services	55,299,064	19,323,626	31,291,745		4,683,694	
21. Primary Care & Behavioral Health	16,710,409	2,601,222	6,396,013		7,713,174	
22. Early Care & Support for TAY	23,577,869	3,924,492	10,533,045		9,120,332	
23. Juvenile Justice Services	27,478,376	7,303,085	12,454,648		7,720,642	
24. Early Care & Support for Older Adults	20,911,968	4,173,523	10,543,244		6,195,201	
25. Improving Access for Underserved Populations	12,454,376	3,147,501	8,460,114		846,762	
26. American Indian Project	1,519,062	362,730	1,156,332			
PEI Administration	16,748,579	16,748,579				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	301,407,957	99,015,347	116,888,557	0	85,504,053	0

Innovations Component Worksheet

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Community Designed Integrated Management Model	18,222,523	13,110,718	4,405,544		706,261	
2. Integrated Clinic Model	10,034,019	6,035,764	3,998,255			
3. Integrated Mobil Health Team Model	12,413,070	6,651,965	5,697,311		63,794	
4. Integrated Peer-Run Model	3,033,947	3,033,947				
INN Administration	2,350,653	2,350,653				
Total INN Program Estimated Expenditures	46,054,212	31,183,047	14,101,110	0	770,055	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Community Designed Integrated Management Model	0					
2. Integrated Clinic Model	0					
3. Integrated Mobil Health Team Model	0					
4. Integrated Peer-Run Model	3,033,947	3,033,947				
INN Administration	1,597,796	1,597,796				
Total INN Program Estimated Expenditures	4,631,743	4,631,743	0	0	0	0

Pending approval of Inn Project

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Community Designed Integrated Management Model	0					
2. Integrated Clinic Model	0					
3. Integrated Mobil Health Team Model	0					
4. Integrated Peer-Run Model	0					
INN Administration	1,207,796	1,207,796				
Total INN Program Estimated Expenditures	1,207,796	1,207,796	0	0	0	0

Pending Approval of Inn Project

Workforce, Education and Training Component Worksheet

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	655,134	655,134				
2. Mental Health Career Pathway	4,245,267	4,245,267				
3. Residency and Internship	131,027	131,027				
4. Financial Incentive	6,629,955	6,629,955				
WET Administration	1,441,294	1,441,294				
Total WET Program Estimated Expenditures	13,102,677	13,102,677	0	0	0	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	655,134	655,134				
2. Mental Health Career Pathway	4,245,267	4,245,267				
3. Residency and Internship	131,027	131,027				
4. Financial Incentive	6,629,955	6,629,955				
WET Administration	1,441,294	1,441,294				
Total WET Program Estimated Expenditures	13,102,677	13,102,677	0	0	0	0

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	571,389	571,389				
2. Mental Health Career Pathway	3,702,600	3,702,600				
3. Residency and Internship	114,278	114,278				
4. Financial Incentive	5,782,457	5,782,457				
WET Administration	1,257,055	1,257,055				
Total WET Program Estimated Expenditures	11,427,779	11,427,779	0	0	0	0

Capital Facilities/Technological Needs (CFTN) Component Worksheet

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Downtown Mental Health Center	7,000,000	7,000,000				
2. Arcadia Mental Health Center	1,000,000	1,000,000				
3. Rio Hondo Mental Health Center	4,500,000	4,500,000				
4. Huntington Park Wellness and Service Area 7	3,000,000	3,000,000				
CFTN Programs - Technological Needs Projects						
5. Integrated Behavioral Health Information System	8,372,509	8,372,509				
6. Consumer Family Access to Computer Resources	1,533,606	1,533,606				
7. Telepsychiatry Implementation	0	0				
8. Data Warehouse Re-design	496,491	496,491				
9. Personal Health Record – Awareness and Education	250,903	250,903				
10. Contract Provider Technology Needs Project	5,000,000	5,000,000				
CFTN Administration	1,721,886	1,721,886				
Total CFTN Program Estimated Expenditures	32,875,395	32,875,395	0	0	0	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Downtown Mental Health Center	1,500,000	1,500,000				
2. Arcadia Mental Health Center	2,000,000	2,000,000				
CFTN Programs - Technological Needs Projects						
3. Integrated Behavioral Health Information System	8,372,509	8,372,509				
4. Consumer Family Access to Computer Resources	1,533,606	1,533,606				
5. Telepsychiatry Implementation	0	0				
6. Data Warehouse Re-design	496,491	496,491				
7. Personal Health Record – Awareness and Education	250,903	250,903				
8. Contract Provider Technology Needs Project	3,500,000	3,500,000				
CFTN Administration	1,556,886	1,556,886				
Total CFTN Program Estimated Expenditures	19,210,395	19,210,395	0	0	0	0

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Downtown Mental Health Center	1,466,010	1,466,010				
2. Arcadia Mental Health Center	1,466,010	1,466,010				
CFTN Programs - Technological Needs Projects						
3. Integrated Behavioral Health Information System	2,066,523	2,066,523				
4. Consumer Family Access to Computer Resources	378,528	378,528				
5. Telepsychiatry Implementation	0	0				
6. Data Warehouse Re-design	122,545	122,545				
7. Personal Health Record – Awareness and Education	61,929	61,929				
8. Contract Provider Technology Needs Project	1,500,000	1,500,000				
CFTN Administration	329,974	329,974				
Total CFTN Program Estimated Expenditures	7,391,519	7,391,519	0	0	0	0

Appendix

Visit http://dmhoma.pbworks.com for the most current version of the PEI-EBP Outcome Measures table.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division
Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

FOCUS OF TREATMENT	EBP, CDE, PP	AGE	GENERAL OUTCOME MEASURE	AGE	SPECIFIC OUTCOME MEASURE	Age	AVAILABLE THRESHOLD LANGUAGES
ANXIETY	Managing and Adapting Practice (MAP) - *Anxiety & Avoidance* **	3 - 19	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	Revised Child Anxiety and Depression Scales (RCADS) - Parent Revised Child Anxiety and Depression Scales (RCADS) - Child	6 - 18 6 - 18	Chinese, English, Spanish, Korean
	Individual Cognitive Behavioral Therapy - Anxiety (CBT-Anxiety)	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Generalized Anxiety Disorder - 7 (GAD-7)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog
	Mental Health Integration Program (MHIP) - Anxiety	18 - 60+	No general measure is required				
TRAUMA	Child Parent Psychotherapy (CPP)	0 - 6	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	Trauma Symptom Checklist for Young Children (TSCYC)	3 - 6	Chinese, English, Korean, Spanish, Armenian
	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	10 - 15	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	UCLA PTSD-Reaction Index for Children and Adolesoents (UCLA PTSD-RI) – Parent UCLA PTSD-Reaction Index for Children and Adolesoents (UCLA PTSD-RI) – Child/Adolesoents	3 - 18 6 - 20	**Adult** - English **Parent** - English, Chinese, Japanese, Russian, Spanish **Child/Adolesoent** - English **Child** - Chinese, Farsi, Japanese, Russian, Spanish **Adolesoent** - Chinese, Spanish
	Alternatives for Families-Cognitive Behavioral Therapy [formerly: Abuse Focused-Cognitive Behavioral Therapy] (AF-CBT)	6 - 15					
	Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) *	3 - 18					
	Managing and Adapting Practice (MAP) - *Traumatic Stress* **	2 - 18					
	Seeking Safety (SS)	13 - 60+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	UCLA PTSD-Reaction Index for Children and Adolesoents (UCLA PTSD-RI) – Parent UCLA PTSD-Reaction Index for Children and Adolesoents (UCLA PTSD-RI) – Child/Adolesoents UCLA PTSD-Reaction Index (UCLA PTSD-RI) – Adult Short Form	3 - 18 6 - 20 21+	
	Individual Cognitive Behavioral Therapy -Trauma (CBT-Trauma)	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	UCLA PTSD-Reaction Index for Children and Adolesoents (UCLA PTSD-RI) – Child/Adolesoents UCLA PTSD-Reaction Index (UCLA PTSD-RI) – Adult Short Form	18 - 20 21+	
	Prolonged Exposure for PTSD (PE)	18 - 70	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Posttraumatic Stress Diagnostic Scale (PDS)	18 - 65	English
	Mental Health Integration Program (MHIP)-Trauma	18 - 60+	No general measure is required		PTSD Checklist-Civilian (PCL-C)	18+	Chinese, English, Spanish

Service Area Handouts

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

Mental Health Services Act (MHSA)
Three Year Program & Expenditure Plan Information Sheet
Service Area I - Antelope Valley
Fiscal Year 2014-15 through 2016-17

Community Services and Supports (CSS) Data for Fiscal Year (FY) 2012-13:

Unique Clients[1] Served through CSS: 5,853

Ethnicity:

African American –36%	Asian –1%
Hispanic –32%	Unknown –1%
White –27%	Native American - 1%
Other –2%	Pacific Islander-<1%

Primary Language:

English – 88%
Spanish –11%
Unknown/not reported –1%
Other -<1%

The following table is a client count[1] by CSS program and age group:

Service Area I

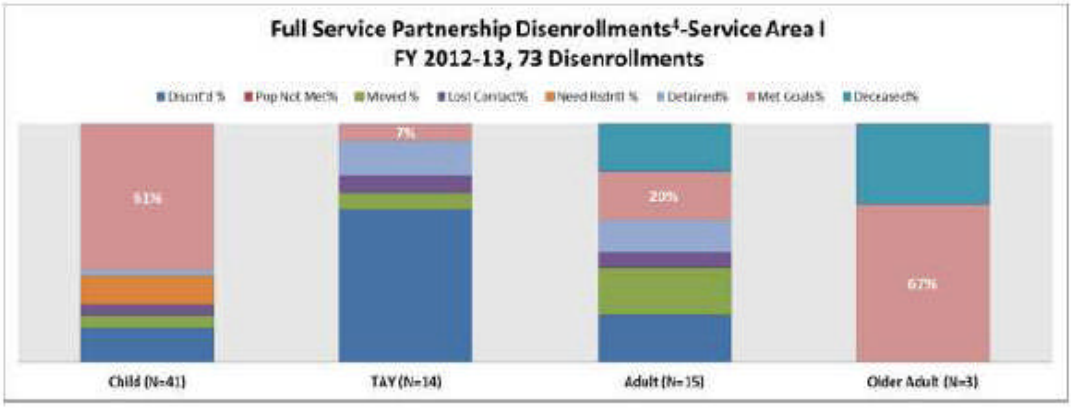
CSS Program	Child	TAY	Adult	Older Adult	Cross Cutting
Alternative Crisis Services	0	0	0	0	244
Client Run Centers	0	0	3,074	0	0
Field Capable Clinical Services	257	48	1,504	172	0
Full Service Partnership	127	64	102	22	0
Probation Camp - MHSA	0	1,159	0	0	0
Wellness Centers	0	0	3,096	0	0

New CSS Clients[1] to the Service Area[2]: 2,232

Full Service Partnership Program (FSP) Authorized Referrals and Slot Allocations[3]:

Age Group	Child	TAY	Adult	Older Adult
# of Slots	50	43	155	54
# of Authorized Slots	31	45	152	50
Focal Population	Serious Emotional Disturbance (SED) and one or more: • Zero to five-year old: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder • DCFS or risk of involvement • In transition to a less restrictive placement • Experiencing in School: Suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation • Involved with Probation and is on psychotropic medication and transitioning back into a less structured home/community setting	SED and or/Severe and Persistent Mental Illness and one or more: •Homeless or at risk of homelessness •Aging Out of child mental health system, child welfare system or juvenile justice system •Leaving Long Term Institutional Care •Experiencing 1st Psychotic Break	• Homeless • Jail • Institutionalized: State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital • Lives with Family Members	Serious Mental Illness and one or more: • Homeless or at imminent risk of homelessness • Hospitalizations • Jail or at risk of going to jail • Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home or being released from SNF/Nursing Home • Presence of a co-occurring disorder • Serious risk of suicide • Recurrent history or is at risk of abuse or self-neglect who are typically isolated

Three Year Program & Expenditure Plan Information Sheet
Service Area I - Antelope Valley



Prevention and Early Intervention (PEI) FY 2012-13 Data

Unique Clients[1] Served through PEI: 5,213

Ethnicity:

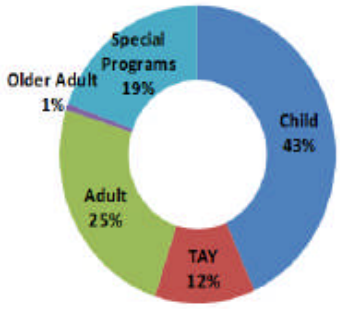
Hispanic –36%	Asian –1%
African American –34%	Unknown –2%
White –24%	Native American -1%
Other –2%	Pacific Islander-<1%

Primary Language:

English –88%
Spanish –11%
Unknown/not reported –1%
Other -<1%

Unique Clients[1] Served by Age Group Plan[5]:

PEI Plan Age Group	Count
Child	2,297
TAY	624
Adult	1,321
Older Adult	37
Special Programs (Cross-cutting)	1,032



New PEI Clients[1] to the Service Area[2]: 3,060

Top 5 Evidence Based Practices Delivered in Service Area I:

EBP	# of Clients
Managing and Adapting Practice (MAP)	1,086
Trauma Focused CBT (TF-CBT)	934
Mental Health Integration Program (MHIP)	505
Seeking Safety (SS)	387
Crisis Oriented Recovery Services (CORS)	251

[1]Clients are counted by claims entered into the Integrated System with the exception of Client Run Centers for FY 2012-13. Client Run Centers are based on client contacts using Community Outreach Services billing. Data pulled October 24, 2013.
[2]Clients may have received MHSA services in another Service Area.
[3]Data provided by reports distributed through Countywide Administration. Child data as of 10/2/13, TAY data as of 9/15/13, Adult data as of 10/28/13 and Older Adult data as of 10/31/13.
[4]As reported by providers in the Outcomes Measurement Application.
[5]Clients may have received services in more than one age group.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

Mental Health Services Act (MHSA)
Three Year Program & Expenditure Plan Information Sheet
Service Area II - San Fernando Valley
Fiscal Year 2014-15 through 2016-17

Community Services and Supports (CSS) Data for Fiscal Year (FY) 2012-13:

Unique Clients[1] Served through CSS: 14,845

Ethnicity:

African American –10%	Asian –5%
Hispanic –38%	Unknown –2%
White –41%	Native American -<1%
Other –3%	Pacific Islander -<1%

Primary Language:

English –69%	Unknown/not reported –1%
Spanish –19%	Other -3%
Armenian –5%	Russian –1%
Farsi –2%	Pilipino, Tagalog –1%

The following table is a client count[1] by CSS program and age group:

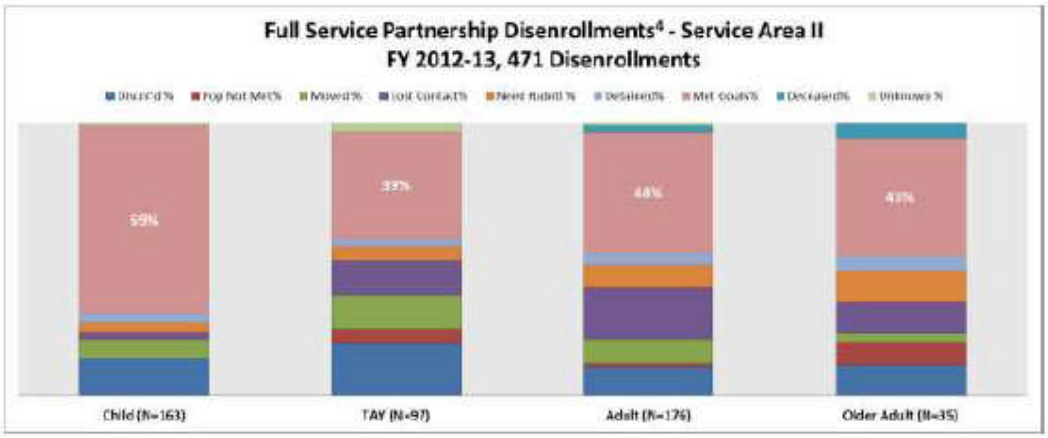
Service Area II

CSS Program	Child	TAY	Adult	Older Adult	Cross Cutting
Alternative Crisis Services	0	0	0	0	2,484
Client Run Center	0	0	4,746	0	0
Family Support Services	26	0	0	0	0
Field Capable Clinical Services	1,178	321	1,778	495	0
Full Service Partnership	543	251	618	99	0
Probation Camp - MHSA	0	271	0	0	0
Wellness Centers	0	0	8,396	0	0

New CSS Clients[1] to the Service Area[2]: 3,613

Full Service Partnership Program (FSP) Authorized Referrals and Slot Allocations[3]:

Age Group	Child	TAY	Adult	Older Adult
# of Slots	265	156	840	96
# of Authorized Slots	222	414	694	79
Focal Population	Serious Emotional Disturbance (SED) and one or more: • Zero to five-year old: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder • DCFS or risk of involvement • In transition to a less restrictive placement • Experiencing in School: Suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation • Involved with Probation and is on psychotropic medication and transitioning back into a less structured home/community setting	SED and or/Severe and Persistent Mental Illness and one or more: • Homeless or at risk of homelessness • Aging Out of child mental health system, child welfare system or juvenile justice system • Leaving Long Term Institutional Care • Experiencing 1st Psychotic Break	• Homeless • Jail • Institutionalized: State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital • Lives with Family Members	Serious Mental Illness and one or more: • Homeless or at imminent risk of homelessness • Hospitalizations • Jail or at risk of going to jail • Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home or being released from SNF/Nursing Home • Presence of a co-occurring disorder • Serious risk of suicide • Recurrent history or is at risk of abuse or self-neglect who are typically isolated



Prevention and Early Intervention (PEI) FY 2012-13 Data

Unique Clients[1] Served through PEI: 12,899

Ethnicity:

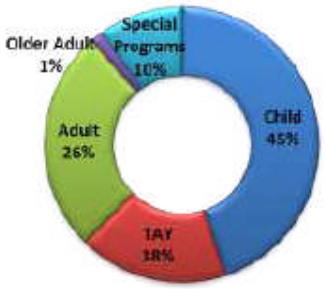
Hispanic –59%	Asian –3%
African American –9%	Unknown –2%
White –24%	Native American -<1%
Other –3%	Pacific Islander-<1%

Primary Language:

English –88%
Spanish –11%
Unknown/not reported –<1%
Other -2%

Unique Clients[1] Served by Age Group Plan[5]:

PEI Plan Age Group	Count
Child	5,999
TAY	2,354
Adult	3,486
Older Adult	205
Special Programs (Cross-cutting)	1,330



New PEI Clients[1] to the Service Area[2]: 7,429

Top 5 Evidence Based Practices Delivered in Service Area II:

EBP	# of Clients
Managing and Adapting Practice (MAP)	2,850
Seeking Safety (SS)	2,796
Trauma Focused CBT (TF-CBT)	2,117
Mental Health Integration Program (MHIP)	1,189
Aggression Replacement Training (ART)	881

[1]Clients are counted by claims entered into the Integrated System with the exception of Client Run Centers for FY 2012-13. Client Run Centers are based on client contacts using Community Outreach Services billing. Data pulled October 24, 2013.
[2]Clients may have received MHSA services in another Service Area.
[3]Data provided by reports distributed through Countywide Administration. Child data as of 10/2/13, TAY data as of 8/15/13, Adult data as of 10/28/13 and Older Adult data as of 10/31/13.
[4]As reported by providers in the Outcomes Measurement Application.
[5]Clients may have received services in more than one age group.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

Mental Health Services Act (MHSA)
Three Year Program & Expenditure Plan Information Sheet
Service Area III - San Gabriel Valley
Fiscal Year 2014-15 through 2016-17

Community Services and Supports (CSS) Data for Fiscal Year (FY) 2012-13:

Unique Clients[1] Served through CSS: 8,226

Ethnicity:

African American –10%	Asian –13%
Hispanic –52%	Unknown –2%
White –20%	Native American -1%
Other –2%	Pacific Islander -<1%

Primary Language:

English –70%	Cantonese –3%
Spanish –17%	Vietnamese –2%
Unknown/not reported –3%	Mandarin –2%
Other -3%	

The following table is a client count[1] by CSS program and age group:

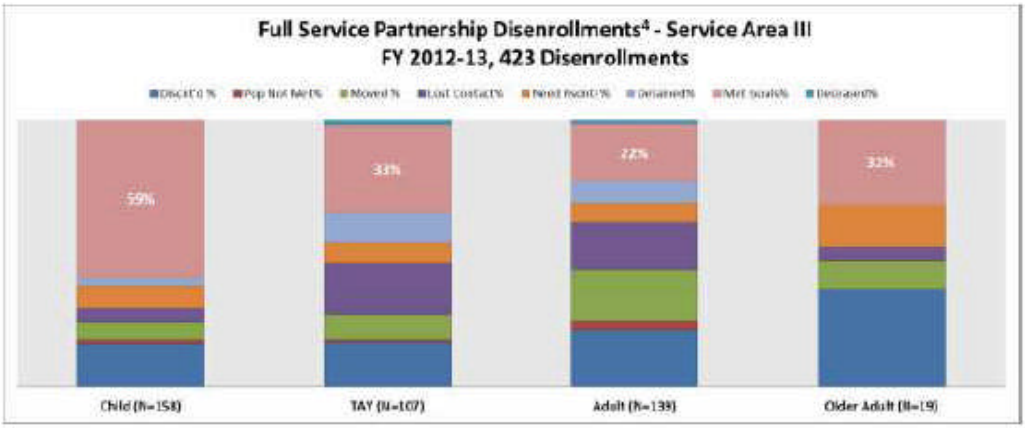
Service Area III

CSS Program	Child	TAY	Adult	Older Adult	Cross Cutting
Alternative Crisis Services	0	0	0	0	3
Client Run Centers	0	0	11,840	0	0
Family Support Services	45	0	0	0	0
Field Capable Clinical Services	1,748	542	1,600	339	0
Full Service Partnership	489	217	481	69	0
IMD Step Down Facilities	0	0	57	0	0
Service Area Navigation	0	0	0	0	82
Wellness Centers	0	0	2,963	0	0

New CSS Clients[1] to the Service Area[2]: 1,915

Full Service Partnership Program (FSP) Authorized Referrals and Slot Allocations[3]

Age Group	Child	TAY	Adult	Older Adult
# of Slots	252	165	533	137
# of Authorized Slots	211	116	445	136
Focal Population	Serious Emotional Disturbance (SED) and one or more: • Zero to five-year old: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder • DCFS or risk of involvement • In transition to a less restrictive placement • Experiencing in School: Suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation • Involved with Probation and is on psychotropic medication and transitioning back into a less structured home/community setting	SED and or/Severe and Persistent Mental Illness and one or more: • Homeless or at risk of homelessness • Aging Out of child mental health system, child welfare system or juvenile justice system • Leaving Long Term Institutional Care • Experiencing 1st Psychotic Break	• Homeless • Jail • Institutionalized: State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital • Lives with Family Members	Serious Mental Illness and one or more: • Homeless or at imminent risk of homelessness • Hospitalizations • Jail or at risk of going to jail • Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home or being released from SNF/Nursing Home • Presence of a co-occurring disorder • Serious risk of suicide • Recurrent history or is at risk of abuse or self-neglect who are typically isolated



Prevention and Early Intervention (PEI) FY 2012-13 Data

Unique Clients[1] Served through PEI: 11,640

Ethnicity:

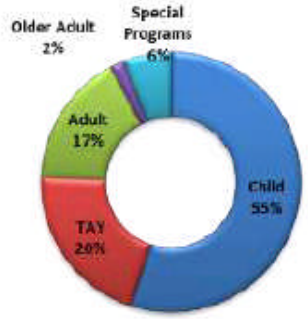
Hispanic –67%	Asian –5%
African American –11%	Unknown –1%
White –13%	Native American -<1%
Other –2%	Pacific Islander- <1%

Primary Language:

English –73%
Spanish –22%
Unknown/not reported –1%
Other -2%

Unique Clients[1] Served by Age Group Plan[5]:

PEI Plan Age Group	Count
Child	6,593
TAY	2,477
Adult	1,999
Older Adult	214
Special Programs (Cross-cutting)	713



New PEI Clients[1] to the Service Area[2]: 5,998

Top 5 Evidence Based Practices Delivered in Service Area III:

EBP	# of Clients
Managing and Adapting Practice (MAP)	3,064
Seeking Safety (SS)	2,478
Trauma Focused CBT (TF-CBT)	1,770
Triple P Positive Parenting Program	858
Interpersonal Psychotherapy for Depression (IPT)	755

[1]Clients are counted by claims entered into the Integrated System with the exception of Client Run Centers for FY 2012-13. Client Run Centers are based on client contacts using Community Outreach Services billing. Data pulled October 24, 2013.
[2]Clients may have received MHSA services in another Service Area.
[3]Data provided by reports distributed through Countywide Administration. Child data as of 10/2/13, TAY data as of 8/15/13, Adult data as of 10/28/13 and Older Adult data as of 10/31/13.
[4]As reported by providers in the Outcomes Measurement Application.
[5]Clients may have received services in more than one age group.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

Mental Health Services Act (MHSA)
Three Year Program & Expenditure Plan Information Sheet
Service Area IV - Metro Los Angeles
Fiscal Year 2014-15 through 2016-17

Community Services and Supports (CSS) Data for Fiscal Year (FY) 2012-13:

Unique Clients[1] Served through CSS: 26,495

Ethnicity:

African American –29%	Asian –7%
Hispanic –40%	Unknown –1%
White –20%	Native American -1%
Other –2%	Pacific Islander -<1%

Primary Language:

English –75%	Other -4%
Spanish –17%	Korean –2%
Unknown/not reported –2%	Armenian –1%

The following table is a client count[1] by CSS program and age group:

Service Area IV

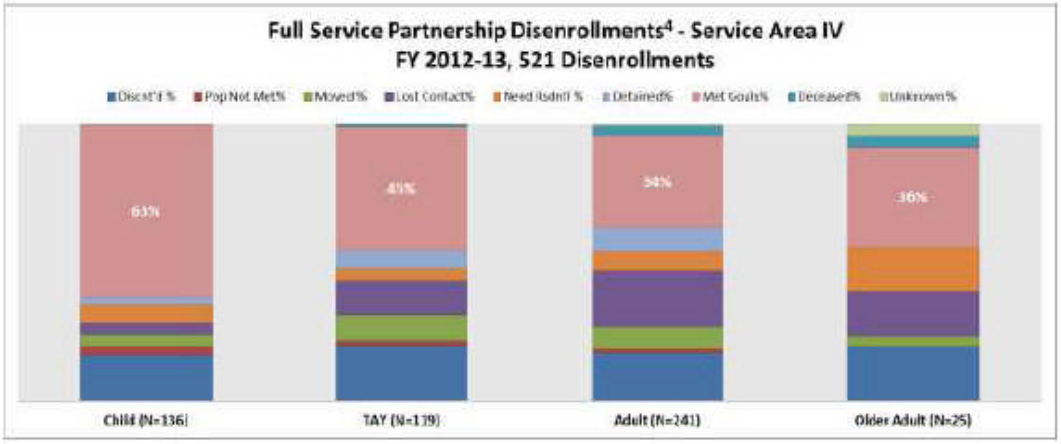
CSS Program	Child	TAY	Adult	Older Adult	Cross Cutting
Alternative Crisis Services	0	0	0	0	11,553
Client Run Centers	0	0	10,764	0	0
Family Support Services	56	0	0	0	0
Field Capable Clinical Services	1,309	257	1,900	945	0
Full Service Partnership	405	281	851	101	0
IMD Step Down Facilities	0	0	334	0	0
Planning-Outreach&Engagement	0	0	0	0	57
Probation Camp - MHSA	0	169	0	0	0
Service Area Navigation	0	0	0	0	1611
Wellness Centers	0	0	9,485	0	0

New CSS Clients[1] to the Service Area[2]: 11,002

Full Service Partnership Program (FSP) Authorized Referrals and Slot Allocations[3]

Age Group	Child	TAY	Adult	Older Adult
# of Slots	248	209	608	94
# of Authorized Slots	189	175	533	85
Focal Population	Serious Emotional Disturbance (SED) and one or more: • Zero to five-year old: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder • DCFS or risk of involvement • In transition to a less restrictive placement • Experiencing in School: Suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation • Involved with Probation and is on psychotropic medication and transitioning back into a less structured home/community setting	SED and or/Severe and Persistent Mental Illness and one or more: • Homeless or at risk of homelessness • Aging Out of child mental health system, child welfare system or juvenile justice system • Leaving Long Term Institutional Care • Experiencing 1st Psychotic Break	• Homeless • Jail • Institutionalized: State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital • Lives with Family Members	Serious Mental Illness and one or more: • Homeless or at imminent risk of homelessness • Hospitalizations • Jail or at risk of going to jail • Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home or being released from SNF/Nursing Home • Presence of a co-occurring disorder • Serious risk of suicide • Recurrent history or is at risk of abuse or self-neglect who are typically isolated

Three Year Program & Expenditure Plan Information Sheet
Service Area IV - Metro Los Angeles



Prevention and Early Intervention (PEI) FY 2012-13 Data

Unique Clients[1] Served through PEI: 10,046

Ethnicity:

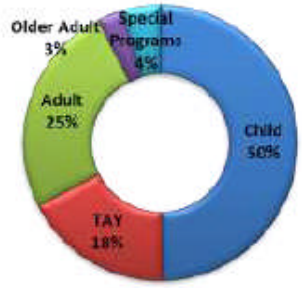
Hispanic –65%	Asian –4%
African American –13%	Unknown –2%
White –12%	Native American -1%
Other –2%	Pacific Islander-<1%

Primary Language:

English – 65%	Korean -1%
Spanish –31%	Armenian –1%
Unknown/not reported –1%	
Other -2%	

Unique Clients[1] Served by Age Group Plan[5]:

PEI Plan Age Group	Count
Child	5,099
TAY	1,814
Adult	2,571
Older Adult	315
Special Programs (Cross-cutting)	457



New PEI Clients[1] to the Service Area[2]: 6,072

Top 5 Evidence Based Practices Delivered in Service Area IV:

EBP	# of Clients
Managing and Adapting Practice (MAP)	2,125
Seeking Safety (SS)	1,370
Trauma Focused CBT (TF-CBT)	1,337
School Threat Assessment Response Team (START)	917
Child Parent Psychotherapy (CPP)	596

[1]Clients are counted by claims entered into the Integrated System with the exception of Client Run Centers for FY 2012-13. Client Run Centers are based on client contacts using Community Outreach Services billing. Data pulled October 24, 2013.
[2]Clients may have received MHSA services in another Service Area.
[3]Data provided by reports distributed through Countywide Administration. Child data as of 10/2/13, TAY data as of 8/15/13, Adult data as of 10/28/13 and Older Adult data as of 10/31/13.
[4]As reported by providers in the Outcomes Measurement Application.
[5]Clients may have received services in more than one age group.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

Mental Health Services Act (MHSA)
Three Year Program & Expenditure Plan Information Sheet
Service Area V - West Los Angeles
Fiscal Year 2014-15 through 2016-17

Community Services and Supports (CSS) Data for Fiscal Year (FY) 2012-13:

Unique Clients[1] Served through CSS: 7,464

Ethnicity:

African American –28%	Asian –2%
Hispanic –18%	Unknown –1%
White –40%	Native American - <1%
Other –3%	Pacific Islander- <1%

Primary Language:

English –89%
Spanish –6%
Unknown/not reported –2%
Other -3%

The following table is a client count[1] by CSS program and age group:

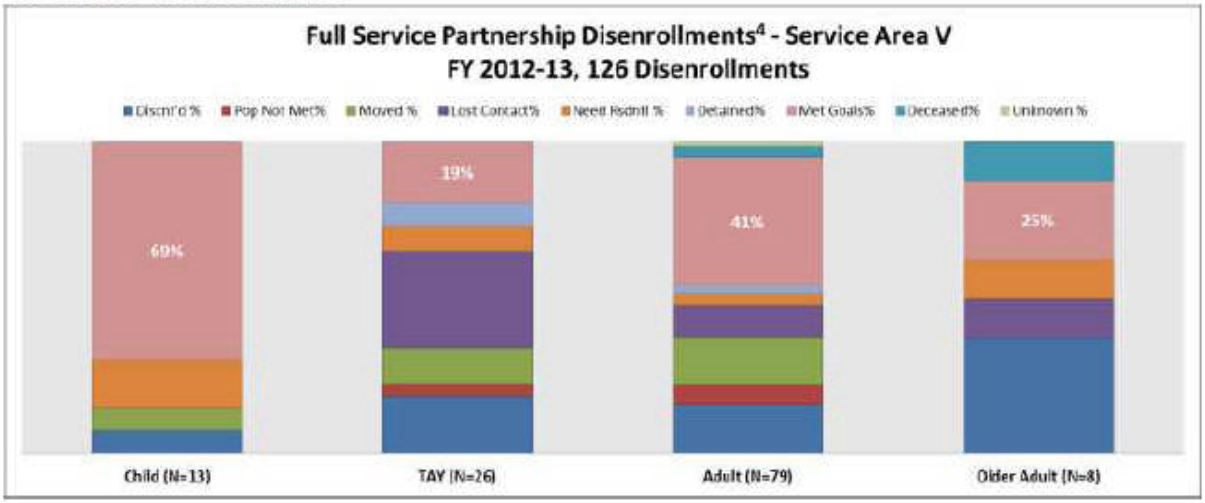
Service Area V

CSS Program	Child	TAY	Adult	Older Adult	Cross Cutting
Alternative Crisis Services	0	0	0	0	347
Client Run Centers	0	0	4,876	0	0
Family Support Services	6	0	0	0	0
Field Capable Clinical Services	202	241	532	201	0
Full Service Partnership	52	87	288	30	0
Wellness Centers	0	0	2,934	0	0

New CSS Clients[1] to the Service Area[2]: 3,229

Full Service Partnership Program (FSP) Authorized Referrals and Slot Allocations[3]:

Age Group	Child	TAY	Adult	Older Adult
# of Slots	27	59	278	22
# of Authorized Slots	24	55	237	23
Focal Population	Serious Emotional Disturbance (SED) and one or more: • Zero to five-year old: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder • DCFS or risk of involvement • In transition to a less restrictive placement • Experiencing in School: Suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation • Involved with Probation and is on psychotropic medication and transitioning back into a less structured home/community setting	SED and or/Severe and Persistent Mental Illness and one or more: • Homeless or at risk of homelessness • Aging Out of child mental health system, child welfare system or juvenile justice system • Leaving Long Term Institutional Care • Experiencing 1st Psychotic Break	• Homeless • Jail • Institutionalized: State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital • Lives with Family Members	Serious Mental Illness and one or more: • Homeless or at imminent risk of homelessness • Hospitalizations • Jail or at risk of going to jail • Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home or being released from SNF/Nursing Home • Presence of a co-occurring disorder • Serious risk of suicide • Recurrent history or is at risk of abuse or self-neglect who are typically isolated



Prevention and Early Intervention (PEI) FY 2012-13 Data

Unique Clients[1] Served through PEI: 2,625

Ethnicity:

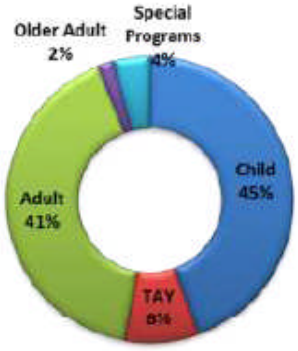
Hispanic –36%	Asian –2%
African American –24%	Unknown –3%
White –30%	Native American -<1%
Other –4%	Pacific Islander-<1%

Primary Language:

English –83%	Other -2%
Spanish –13%	Farsi –1%
Unknown/not reported –1%	

Unique Clients[1] Served by Age Group Plan[5]:

PEI Plan Age Group	Count
Child	1,184
TAY	225
Adult	1,096
Older Adult	48
Special Programs (Cross-cutting)	110



New PEI Clients[1] to the Service Area[2]: 1,659

Top 5 Evidence Based Practices Delivered in Service Area V:

EBP	# of Clients
Managing and Adapting Practice (MAP)	720
Seeking Safety (SS)	269
School Threat Assessment Response Team (START)	196
Trauma Focused CBT (TF-CBT)	190
Triple P Positive Parenting Program	120

[1]Clients are counted by claims entered into the Integrated System with the exception of Client Run Centers for FY 2012-13. Client Run Centers are based on client contacts using Community Outreach Services billing. Data pulled October 24, 2013.
[2]Clients may have received MHSA services in another Service Area.
[3]Data provided by reports distributed through Countywide Administration. Child data as of 10/2/13, TAY data as of 8/15/13, Adult data as of 10/28/13 and Older Adult data as of 10/31/13.
[4]As reported by providers in the Outcomes Measurement Application.
[5]Clients may have received services in more than one age group.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

Mental Health Services Act (MHSA)
Three Year Program & Expenditure Plan Information Sheet
Service Area VI - South Central/Compton/Lynwood
Fiscal Year 2014-15 through 2016-17

Community Services and Supports (CSS) Data for Fiscal Year (FY) 2012-13:

Unique Clients[1] Served through CSS: 14,947

Ethnicity:

African American –59%	Asian –1%
Hispanic –35%	Unknown –1%
White –3%	Native American -<1%
Other –1%	Pacific Islander-<1%

Primary Language:

English –79%
Spanish –19%
Unknown/not reported –2%
Other -<1%

The following table is a client count[1] by CSS program and age group:

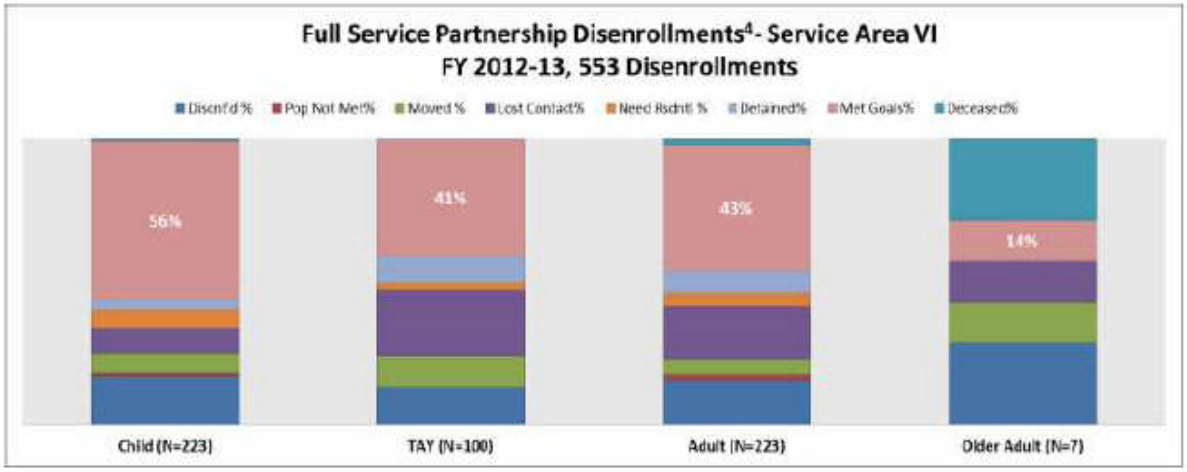
Service Area VI

CSS Program	Child	TAY	Adult	Older Adult	Cross Cutting
Alternative Crisis Services	0	0	0	0	739
Client Run Centers	0	0	5,894	0	0
Family Support Services	27	0	0	0	0
Field Capable Clinical Services	1,589	220	15	196	0
Full Service Partnership	763	318	843	37	0
Jail-Transition/Linkage	0	0	0	0	635
Wellness Centers	0	0	9665	0	0

New CSS Clients[1] to the Service Area[2]: 3,502

Full Service Partnership Program (FSP) Authorized Referrals and Slot Allocations[3]:

Age Group	Child	TAY	Adult	Older Adult
# of Slots	350	208	735	30
# of Authorized Slots	254	172	578	27
Focal Population	Serious Emotional Disturbance (SED) and one or more: • Zero to five-year old: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder • DCFS or risk of involvement • In transition to a less restrictive placement • Experiencing in School: Suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation • Involved with Probation and is on psychotropic medication and transitioning back into a less structured home/community setting	SED and or/Severe and Persistent Mental Illness and one or more: • Homeless or at risk of homelessness • Aging Out of child mental health system, child welfare system or juvenile justice system • Leaving Long Term Institutional Care • Experiencing 1st Psychotic Break	• Homeless • Jail • Institutionalized: State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital • Lives with Family Members	Serious Mental Illness and one or more: • Homeless or at imminent risk of homelessness • Hospitalizations • Jail or at risk of going to jail • Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home or being released from SNF/Nursing Home • Presence of a co-occurring disorder • Serious risk of suicide • Recurrent history or is at risk of abuse or self-neglect who are typically isolated



Prevention and Early Intervention (PEI) FY 2012-13 Data

Unique Clients[1] Served through PEI: 12,678

Ethnicity:

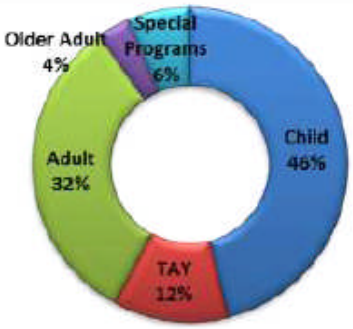
Hispanic –48%	Asian –1%
African American –46%	Unknown –1%
White –3%	Native American -<1%
Other –1%	Pacific Islander-<1%

Primary Language:

English –73%
Spanish –26%
Unknown/not reported –1%
Other -<1%

Unique Clients[1] Served by Age Group Plan[5]:

PEI Plan Age Group	Count
Child	6,009
TAY	1,539
Adult	4,214
Older Adult	447
Special Programs (Cross-cutting)	825



New PEI Clients[1] to the Service Area[2]: 7,155

Top 5 Evidence Based Practices Delivered in Service Area VI:

EBP	# of Clients
Crisis Oriented Recovery Services (CORS)	2,925
Seeking Safety (SS)	2,073
Managing and Adapting Practice (MAP)	1,736
Trauma Focused CBT (TF-CBT)	1,714
Triple P Positive Parenting Program	1,134

[1]Clients are counted by claims entered into the Integrated System with the exception of Client Run Centers for FY 2012-13. Client Run Centers are based on client contacts using Community Outreach Services billing. Data pulled October 24, 2013.
[2]Clients may have received MHSA services in another Service Area.
[3]Data provided by reports distributed through Countywide Administration. Child data as of 10/2/13, TAY data as of 8/15/13, Adult data as of 10/28/13 and Older Adult data as of 10/31/13.
[4]As reported by providers in the Outcomes Measurement Application.
[5]Clients may have received services in more than one age group.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

Mental Health Services Act (MHSA)
Three Year Program & Expenditure Plan Information Sheet
Service Area VII - Southeast Los Angeles
Fiscal Year 2014-15 through 2016-17

Community Services and Supports (CSS) Data for Fiscal Year (FY) 2012-13:

Unique Clients[1] Served through CSS: 7,015

Ethnicity:

African American –8%	Asian –3%
Hispanic –65%	Unknown –2%
White –19%	Native American -3%
Other –1%	Pacific Islander -<1%

Primary Language:

English –70%	Other -2%
Spanish –25%	Cambodian –1%
Unknown/not reported –2%	

The following table is a client count[1] by CSS program and age group:

Service Area VII

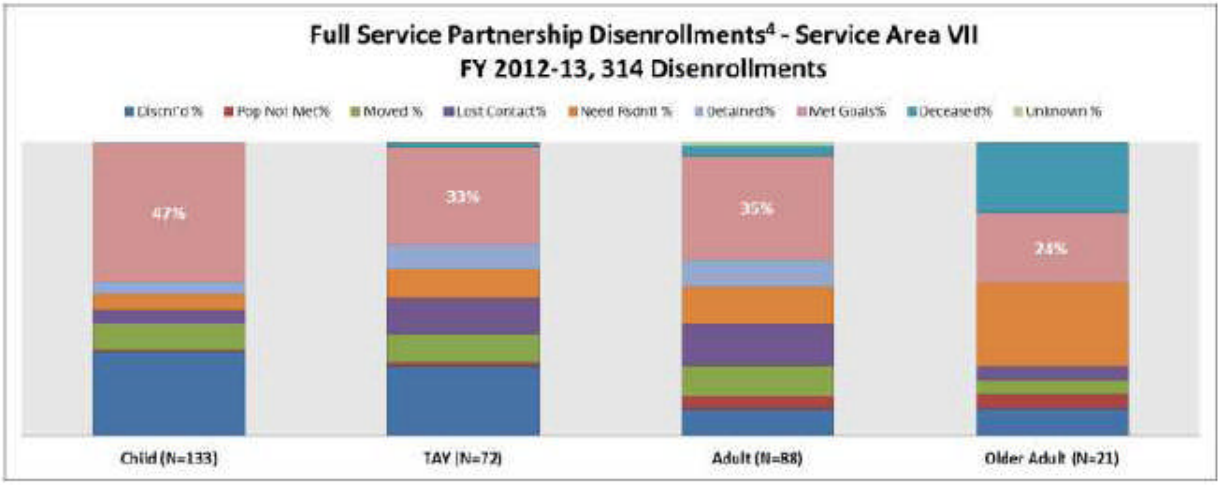
CSS Program	Child	TAY	Adult	Older Adult	Cross Cutting
Alternative Crisis Services	0	0	0	0	588
Client Run Centers	0	0	24,794	0	0
Family Support Services	27	0	0	0	0
Field Capable Clinical Services	687	239	1,181	338	0
Full Service Partnership	372	197	464	85	0
IMD Step Down Facilities	0	0	169	0	0
Probation Camp - MHSA	0	117	0	0	0
Wellness Centers	0	0	3,229	0	0

New CSS Clients[1] to the Service Area[2]: 1,715

Full Service Partnership Program (FSP) Authorized Referrals and Slot Allocations[3]:

Age Group	Child	TAY	Adult	Older Adult
# of Slots	240	154	390	56
# of Authorized Slots	200	135	359	50
Focal Population	Serious Emotional Disturbance (SED) and one or more: • Zero to five-year old: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder • DCFS or risk of involvement • In transition to a less restrictive placement • Experiencing in School: Suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation • Involved with Probation and is on psychotropic medication and transitioning back into a less structured home/community setting	SED and or/Severe and Persistent Mental Illness and one or more: • Homeless or at risk of homelessness • Aging Out of child mental health system, child welfare system or juvenile justice system • Leaving Long Term Institutional Care • Experiencing 1st Psychotic Break	• Homeless • Jail • Institutionalized: State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital • Lives with Family Members	Serious Mental Illness and one or more: • Homeless or at imminent risk of homelessness • Hospitalizations • Jail or at risk of going to jail • Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home or being released from SNF/Nursing Home • Presence of a co-occurring disorder • Serious risk of suicide • Recurrent history or is at risk of abuse or self-neglect who are typically isolated

Three Year Program & Expenditure Plan Information Sheet
Service Area VII - Southeast Los Angeles



Prevention and Early Intervention (PEI) FY 2012-13 Data

Unique Clients[1] Served through PEI: 6,964

Ethnicity:

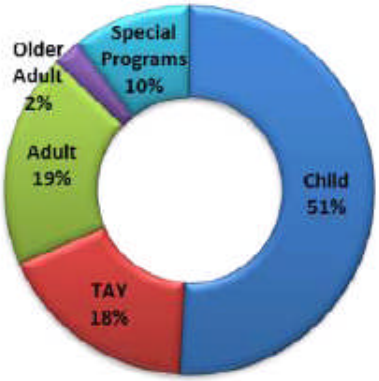
Hispanic –82%	Asian –1%
African American –4%	Unknown –1%
White –9%	Native American -1%
Other –1%	Pacific Islander-<1%

Primary Language:

English –69%
Spanish –31%
Unknown/not reported –<1%
Other -<1%

Unique Clients[1] Served by Age Group Plan[5]:

PEI Plan Age Group	Count
Child	3,644
TAY	1,262
Adult	1,344
Older Adult	174
Special Programs (Cross-cutting)	741



New PEI Clients[1] to the Service Area[2]: 4,376

Top 5 Evidence Based Practices Delivered in Service Area VII:

EBP	# of Clients
Managing and Adapting Practice (MAP)	1,887
Trauma Focused CBT (TF-CBT)	1,117
Seeking Safety (SS)	803
Mental Health Integration Program (MHIP)	624
Individual Cognitive Behavioral Therapy	531

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[3]Data provided by reports distributed through Countywide Administration. Child data as of 10/2/13, TAY data as of 8/15/13, Adult data as of 10/28/13 and Older Adult data as of 10/31/13.
[4]As reported by providers in the Outcomes Measurement Application.
[5]Clients may have received services in more than one age group.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

Mental Health Services Act (MHSA)
Three Year Program & Expenditure Plan Information Sheet
Service Area VIII - Long Beach/South Bay
Fiscal Year 2014-15 through 2016-17

Community Services and Supports (CSS) Data for Fiscal Year (FY) 2012-13:

Unique Clients[1] Served through CSS: 18,016

Ethnicity:

African American –30%	Asian –9%
Hispanic –30%	Unknown –3%
White –26%	Native American -<1%
Other –2%	Pacific Islander -<1%

Primary Language:

English –79%	Cambodian – 4%
Spanish –12%	Vietnamese –1%
Unknown/not reported –1%	Korean –1%
Other - 1%	Pilipino, Tagalog –1%

The following table is a client count[1] by CSS program and age group:

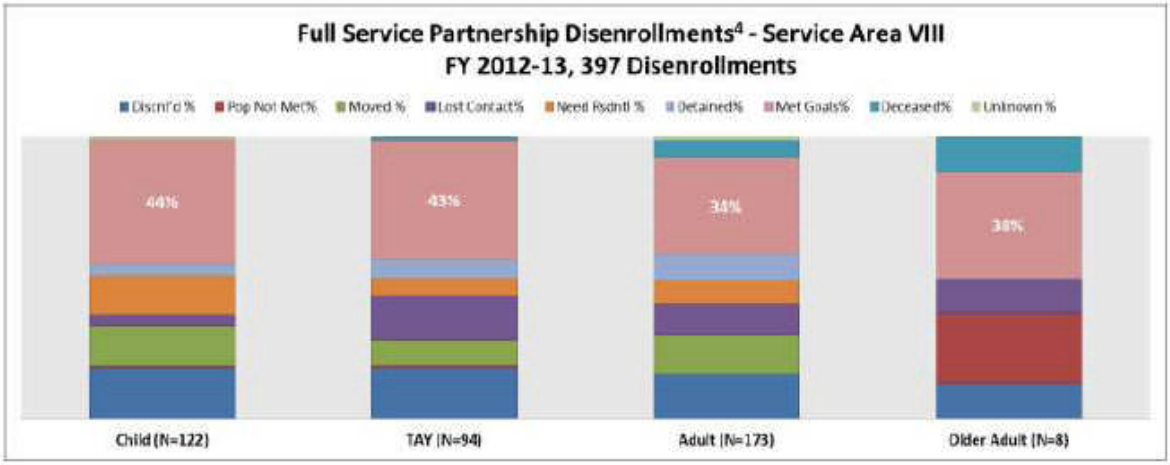
Service Area VIII

CSS Program	Child	TAY	Adult	Older Adult	Cross Cutting
Alternative Crisis Services	0	0	0	0	2,450
Client Run Centers	0	0	7,406	0	0
Family Support Services	27	0	0	0	0
Field Capable Clinical Services	1,568	206	729	257	0
Full Service Partnership	555	346	945	35	0
IMD Step Down Facilities	0	0	1	0	0
Service Area Navigation	0	0	0	0	671
Wellness Centers	0	0	11,300	0	0

New CSS Clients[1] to the Service Area[2]: 5,543

Full Service Partnership Program (FSP) Authorized Referrals and Slot Allocations[3]:

Age Group	Child	TAY	Adult	Older Adult
# of Slots	301	239	1,120	87
# of Authorized Slots	214	218	932	92
Focal Population	Serious Emotional Disturbance (SED) and one or more: • Zero to five-year old: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder • DCFS or risk of involvement • In transition to a less restrictive placement • Experiencing in School: Suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation • Involved with Probation and is on psychotropic medication and transitioning back into a less structured home/community setting	SED and or/Severe and Persistent Mental Illness and one or more: • Homeless or at risk of homelessness • Aging Out of child mental health system, child welfare system or juvenile justice system • Leaving Long Term Institutional Care • Experiencing 1st Psychotic Break	• Homeless • Jail • Institutionalized: State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital • Lives with Family Members	Serious Mental Illness and one or more: • Homeless or at imminent risk of homelessness • Hospitalizations • Jail or at risk of going to jail • Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home or being released from SNF/Nursing Home • Presence of a co-occurring disorder • Serious risk of suicide • Recurrent history or is at risk of abuse or self-neglect who are typically isolated



Prevention and Early Intervention (PEI) FY 2012-13 Data

Unique Clients[1] Served through PEI: 12,833

Ethnicity:

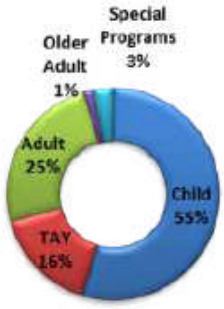
Hispanic –52%	Asian –3%
African American –26%	Unknown –2%
White –15%	Native American -<1%
Other –2%	Pacific Islander -<1%

Primary Language:

English –75%	Other -1%
Spanish –23%	Cambodian –1%
Unknown/not reported –1%	

Unique Clients[1] Served by Age Group Plan[5]:

PEI Plan Age Group	Count
Child	7,208
TAY	2,126
Adult	3,262
Older Adult	195
Special Programs (Cross-cutting)	392



New PEI Clients[1] to the Service Area[2]: 7,396

Top 5 Evidence Based Practices Delivered in Service Area VIII:

EBP	# of Clients
Managing and Adapting Practice (MAP)	2,989
Trauma Focused CBT (TF-CBT)	2,225
Seeking Safety (SS)	1,673
Individual Cognitive Behavioral Therapy	688
Child Parent Psychotherapy (CPP)	553

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[3]Data provided by reports distributed through Countywide Administration. Child data as of 10/2/13, TAY data as of 8/15/13, Adult data as of 10/28/13 and Older Adult data as of 10/31/13.
[4]As reported by providers in the Outcomes Measurement Application.
[5]Clients may have received services in more than one age group.

Service Area Advisory Committee (SAAC) Review and Feedback of MHSA Programs

SAAC 1

PREVENTION - CHILD

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PROGRAM A Partners in Suicide	Limited information about this program	No information about if or whether program was offered in service area 1	Increased communication amongst and between DMH programs – especially between centralized and service area staff and managers; much interest in having this as a resource, especially in the schools
PROGRAM B A Reason to Care and Connect (ARCC)		Unknown in Service Area 1	
PROGRAM C Project Rise		Penny Lane sponsors LBGTQ conference – With RISE participants – seems to be a Good/worthwhile program, however no Specific details available about this Prevention EBP	Much interest from the community – will follow up and invite to SAAC
PROGRAM D Project Spin		No information about this service	
PROGRAM E			

EARLY INTERVENTION - CHILD

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PROGRAM A First 5 LA – Parent Child Interaction Therapy (PCIT)	Good model, however difficulty engaging families – large number of foster caregivers who have not been interested or responsive	*No ability to provide in outlying areas due to hardware requirements *Difficulty obtaining commitment from caregivers *Difficult with foster kids	Identify strategies to encourage participation, incentives for foster caregivers
PROGRAM B PEI funded EBPs	Varying results – TF-CBT works well with foster kids as they can work through their own narrative regardless of having parents participate MAP works well in schools	*TRIPLE P – hard to get parent participation *Limited resources for parents who may have their own mental health problems *movement of foster kids through the system and lack of continuity	*Expand Seeking Safety *Identify others – such as Breakthrough parenting and The Parenting Project - that seem to get good results, but are not DMH Approved/funded EBPs *Identify additional training dollars and train-the-trainer programs *Identify models that work with pregnant teens
PROGRAM C Integrated School-Based Mental Health	Adapted for the Antelope Valley – since there no health offices in any of the schools – project has been very effective in under-resourced school district located in underserved community		Increase ability to use COS funding to replicate the school site collaboration
PROGRAM D Nurse Family Partnership	Public Health collaborates with existing collaboratives (Best Babies, AV Partners for Health, etc)		Expand visibility and capacity

PREVENTION - TAY

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PROGRAM A Partners in Suicide	Aware of service, but limited participation in SA	Could be helpful in high school settings	Increase and maintain communication between centralized staff and service areas to improve awareness of this as a valuable resource
PROGRAM B TAY Mobile Response Library		No information in Service Area 1	
PROGRAM C			
PROGRAM D			

EARLY INTERVENTION - TAY

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PROGRAM A PEI Funded EBPs	Some effectiveness – although age group break-out is odd/difficult for providers	*Younger TAY participate with children's providers *Limited resources for TAY over age 18 – who are typically seen in adult outpatient programs	*Increase use of TAY specific EBPs, especially Seeking Safety – *More kids with Developmental Disabilities coming into system – identify EBP for that group if available
PROGRAM B Juvenile Justice Transition Aftercare Services	Some of the providers have heard about this service, but have no detailed information	No collaboration re linkage to existing resources	*Increase awareness in community *Increase collaboration between centralized staff and service area navigators
PROGRAM C AB 129 – Dual Status	No information	Does not impact service area	None
PROGRAM D Project Spin			
PROGRAM E			

PREVENTION - ADULT

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PROGRAM A EBPs	Effective when consumers participate	*Not everyone able to make the commitment to participate *no-shows for appointments *No services in outlying areas	*Ensure that FCCS staff are trained in EBPs *Increase train-the-trainer models to address staff turnover *Add additional EBPs (DBT, Prolonged Exposure for PTSD) *add additional
PROGRAM B Veterans and Loved Ones Recovery (VALOR)	Limited capacity in SA 1 – staff from Los Angeles travel when there are appointments at the Adult Outpatient clinics	*Limited capacity – especially for large number of veterans in the community	*Develop specific day/time that staff will be in the Service Area *Expand to include staff at Palmdale Mental Health
PROGRAM C Co-Located Mental Health Services with Health	Currently DMH staff are located at DHS at the High Desert MAC		*Include field services in this model
PROGRAM D **		NON-MHSA PROGRAM!!	*Develop co-located services at Mental Health Court for adults

EARLY INTERVENTION - ADULTS

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PROGRAM A Partners in Suicide (PSP)	Unaware that there was a separate partners in suicide training targeting adults available in the service area		*Connect with adult centralized staff responsible for managing/facilitating this service
PROGRAM B Anti-Stigma and Discrimination Team			Similar comments
PROGRAM C Office of Family Engagement	Centrally located Provides support to service area		Provide dedicated staff for each Service Area
PROGRAM D Promotores	Not currently available in Service Area		Implement in Service Area 1 – in underserved/monolingual communities to reduce stigma
PROGRAM E Wellness Outreach Workers (WOW)	Limited WOW workers currently	Limited to primarily wellness programs and in Directly Operated programs	*Expand to contract providers *Increase stipends available

PREVENTION - OLDER ADULT

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PROGRAM A Partners in Suicide	*Good collaboration between centralized and service area staff *Lots of trainings to support staff at professional and paraprofessional levels	SA needs to identify additional opportunities for central staff	*Bring resource to attention of SAAC
PROGRAM B Anti-Stigma/Discrimination	Same comments		Same Comments
PROGRAM C			
PROGRAM D **			

EARLY INTERVENTION – OLDER ADULTS

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PROGRAM A EBPs	Compliment of EBPs available in community	Availability of service in underserved communities	Ensure that FCCS staff are trained in EBPs
PROGRAM B Partners in Suicide		Unclear whether this is available in SA 1	Invite participation to SA 1 for staff delivering this service
PROGRAM C			
PROGRAM D			
PROGRAM E			

COMMUNITY SERVICES AND SUPPORTS PROGRAMS

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
FSP-ADULT	Consumers remain in program longer than intended (more than 2 years) due to insufficient resources in community and links to housing	*Less than 100 slots which are always filled *Insufficient resources in community to allow flow between levels of care	*Increase slots to 300 *Expand providers offering FSP services
FSP- CHILD	*Programs able to engage families and flow through within 12-18 months *Even with minimal slots, there has been flow and 3 times as many kids were served as there were slots	Only 50 slots available in the Service Area between 2 programs – one of whom is chronically understaffed	*Restore FSP slots that were abandoned when provider went out of business (additional 25 slots) *Recruit additional providers for this service to allow for more program diversity
FSP- TAY	Some flow, however limited outpatient resources if TAY needs ongoing services, including medication support	*Limited TAY resources, once completed FSP, must wait for FCCS if they need ongoing services, or be referred to an adult outpatient program for medication support *Insufficient resources for younger TAY (16-17)	*Increase TAY slots, especially for 16-17 year olds *Expand providers offering FSP services
FSP- OLDER ADULT			Increase slots
FCCS-CHILD	Limited information – as very few programs have the service – used in school based settings due to flexibility	*Need to increase as only limited flow from higher level service (FSP) *Insufficient slots when child does not need intensity of FSP, but needs more intensity than outpatient.	Increase capacity and increase providers who have it in their contracts

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
FCCS- TAY		Limited resources and typically filled with TAY flowing from FSP program	Increase FCCS slot/capacity to be available as a more intensive prevention program as well as a step-down service
FCCS- ADULT		Limited resources in SA 1	Increase FCCS capacity to 300 slots
FCCS-OLDER ADULT		Limited resources in SA 1 – especially to address seniors in outlying areas	Increase FCCS capacity
WELLNESS CENTERS	Limited space and infrastructure to support increasing number of consumers	*Appropriate staffing for the needs of the consumers – including rehab specialists, substance abuse, vocational/educational specialists *No supervisors/managers in standalone program *Problem with flowing from higher levels of care – especially when consumer coming from large and well stocked programs into the small county space.	*Increase space and resources
CLIENT-RUN CENTERS		Currently program services one portion of the SA – and with transportation problems results in many consumers unable to participate	Develop client run center in Lancaster to compliment the program in Palmdale

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PROGRAM Housing/housing specialists	Approved MHSA Housing project was never implemented	*Limited community housing resources *Many FSP consumers get housing assistance which tends to keep them in the higher level service longer	*Develop additional housing resources for all age groups *Establish coalition of housing providers (landlords, B & C operators, etc.) to discuss problems/solutions *Develop housing continuum (B & C, Step-Down, Adult/TAY Residential *Develop Shelter program with mental health contract
PROGRAM			

PROGRAM NAMI – Peer-to-Peer Recovery Paretns as Teachers and Allies Provider Education			Increase availability of educational opportunities through NAMI in SA 1.

INNOVATION

MHSA Innovation programs are time-limited opportunities to engage in learning. Innovative projects focus on one of the following:

a. Introduces a mental health practice or approach that is new to the overall mental health system.
b. Makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.
c. Introduces a new application to the mental health system of a promising community-driven practice that has been successful in non-mental health contexts.

MHSA Innovation programs have one or more of the following criteria as their primary focus:

a. Increasing access to mental health services, including to underserved populations.
b. Increasing the quality of mental health services, including better outcomes.
c. Promoting interagency collaboration related to mental health services and supports.

If you Service Area Advisory Committee has a recommendation for a future Innovation Project that meets the above criteria, please complete the table below:

INNOVATION PROJECT	DESCRIPTION	INNOVATION CRITERIA FULFILLED
Project 1 Aging Caregiver Support Services	Designed to provide support and mental health services for aging caregivers who are parents of adults with a mental illness – who may/may not be in treatment	A, B, C to underserved population
Project 2 Mobile Integrated Service Delivery	Designed to bring treatment services to outlying communities and underserved populations	Underserved populations in remote and rural areas
Project 3		
Project 4		

SAAC 3

PREVENTION

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
OLDER ADULTS	PEI dollars not being spent by providers	Seniors are not enrolling, may be due to stigma. Shortage of funding allocated to outreach and engagement. Eligibility for the program has been an obstacle.	More public education; peer education used at PC-O/A. Because outreach and engagement is critical for the PEI population and community partners, there needs to be more flexibility regarding percentage of use; integrate older adult services to adult wellness centers. Create self-help senior phone tree to provide more support.
ADULTS	Insufficent assessment of substance use / abuse.	Adult clients not disclosing due to stigma	Integrate health and substance abuse screenings.
TAY	Service Area 3 piloted a Peer Engagement Project for TAY to educate them about mental illness and reduce stigma. This project had highly successful outcomes and needs to be implemented county wide.	There are no prevention programs for TAY. CAPPS is very delayed. There needs to be more integration with substance abuse.	Consider Peer Engagment project. Start up funds needed for CAPPS. Integration with substance abuse providers.
CHILDREN	Deficient parenting skills and intervention skills.	Mental health services not consistently available during after hours	Psychoeducation about signs and symptoms of mental illness.

EARLY INTERVENTION

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
CHILDREN	Various ethnic groups are still not being engaged; especially the parents/ caregivers of children.	Triage Teams-Culturally Competent Outreach & Engagement needed at the Provider level. Be able to bill and enagage for family interventions.	Add parent advocates of different ethnic groups in triage teams to serve UREP pops.
OLDER ADULT PEI	Improve outcome measures to better engage	Lack of engagement. Not enough funding allocated to Outreach and Engagement efforts. Require EBPs and lacked of training dollars create service barriers.	Look at new ways to engage- partnering up with churches, senior centers, parks and rec. Allocate more funding for outreach and engagement. Use PEI funds to integrate into wellness or expand current MHSA program
TAY	High levels of suicide among TAY. High substance use among TAY reflecting in early psychotic symptoms.	Lack of engagement. Not enough early intervention programs. Delay in launch of CAPPS program to address these issues.	Increase suicide prevention in all schools; better training for school staff. Substance abuse and mental health education related to psychotic symptoms necessary.
ADULT	UREP populations not responding to EBPs	EBPs not appropriate for UREP populations	Require providers to provide EBPs that are appropriate to the ethnic populations they serve. Encourage use of CDRP plans & incorporate more promising practices vs EBP's
OLDER ADULT	Older adults are not seeking mental health services.	EBP's pose barreirs to client care and need to be more adaptable. More MHSA funds need to be allocated and there needs to be more flexibility with its use.	Restore Adult System of Care funding

COMMUNITY SERVICES AND SUPPORT PROGRAMS

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
FSP - ADULT	Employment; level of care more demanding than what FSP can provide. Difference in staff/clt. Ratio	Level of care is not being met. Lack of inpateint hospital beds for client needs	AB109/Homeless intensity. Integrate substance use disorder treatment and health care services.
FSP - CHILD	# in juvenile halls (post). How can this # be prevented. What's this a reflection of?	# of youth going to juvenile hall after getting services	Study why so many children go to juvenile hall after receiving services.
FSP - TAY	Demographics. Staff / clt. Ratio. Housing & employment. API TAY lack of use of drop-in ctr.	Housing and employment gap. Not enough EBP's to meet the needs of the TAY population.	More engagement with API pop. & focus on housing and employment skills. Increase amount of slots and the cost of each slot per client. Need to develop more housing resources for TAY in SA3.
FSP - OLDER ADULT	Aging population may create need for more O/A slots.	Aging population which does not seek help, struggles with transportation and medicaid issues	Nurse practitioner in each program. Intergenerational peer programs (youth & seniors interacting for support at client run centers and wellness centers). Increase FCCS services to support the Older Adult Continuum. Allow providers flexibility in serving older adults with adult slots. Add In-Home psych services.
FCCS - CHILD	Emotional problems may not be improving due to lack of parental involvement.	Parents need their own mental health treatment.	Child providers should also treat parents.
FCCS - TAY	Flex funds needed for housing	Housing shortage in SA 3; definition of "homelessness" is a barrier.	Redefine definition of "homelessness"; make funds available / sec 8 vouchers available. Increased housing through shared housing which does not involve federal support
FCCS - ADULT	Flex funds needed for housing	Housing shortage in SA 3; definition of "homelessness" is a barrier.	Redefine definition of "homelessness"; make funds available / sec 8 vouchers available.Increased housing through shared housing which does not involve federal support
FCCS - OLDER ADULT	Flex funds needed for housing	Housing shortage in SA 3; definition of "homelessness" is a barrier.	Redefine definition of "homelessness"; make funds available / sec 8 vouchers available. Increased housing through shared housing which does not involve federal support
WELLNESS CENTERS	Flex funds needed for housing	Housing shortage in SA 3; definition of "homelessness" is a barrier.	Redefine definition of "homelessness"; make funds available / sec 8 vouchers available. Increased housing through shared housing which does not involve federal support
CLIENT-RUN CENTERS	Self-help groups better utilized	Housing shortage in SA 3; definition of "homelessness" is a barrier.	Redefine definition of "homelessness"; make funds available / sec 8 vouchers available. Increased housing through shared housing which does not involve federal support
HOUSING	Shortage in SA3, families very vulnerable; definition of homelessnes is a barrier; flex funds more accessible; DMH using coord. Entry system track housing/physical & mental health	Shortage of housing in SA 3 More affordable housing needed.	Redefine definition of "homelessness" and make funds more available for hoiusing.

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
EMPLOYMENT	Concern for all programs, not only FSP; support to maintain employment; employment support groups	Less than 2% of clients are employed. Need more employment services; lack of understanding of available benefits to clients. Lack of understanding of employment resources available.	Implement employment self-help groups and development of partnerships with local business that may hire consumers. Provide trainings to mental health staff on the importance of employment in recovery and local employment resources that their consumers can benefit from such as DOR case service contracts. Employment goals should also be established for each type of program
API POPULATION	Innovation programs in place, yet asian population growing and needs intensity	Only 23% of those who need services received them in SA 3. API are the least likely of any ethnic group to receive services	Create DMH Profiles of Hope videos in API languages. Outreach to API tv, radio. Create one-stop web site for API pop. To include m.h. info. & resources. Foster API self-help grps. (i.e. NAMI in mandarin) Use CDRP reports to gather data on cultural needs. Serve 5% more API by 2016. Create systemwide list of services for API.
SUBSTANCE ABUSE	Substance use among clients is not decreasing	Mental health providers not addressing substance abuse issues and clients do not disclose easily, especially among API population.	Need more integration of substance abuse & Mental healthcare. More training to clinicians on how to interview and address substance abuse, especially API population.
INNOVATION PROJECT	DESCRIPTION	INNOVATION CRITERIA FULFILLED	
COLLABORATIVE PARKS & REC	All ages to address health issues	Physical exercise associated w/ improvement of overall health (i.e. decreases depression, improves sleep cycle, decrease weight.)	
FOCUS GROUP	Community Organizations that specialize in OA population - due to contract providers not spending PEI allocations.	Build collaboratives with non-traditional organiations that cater to older adult population to reduce the stigma of mental health issues.	
CONFERENCE FOR BETTER PRACTICE W/ OLDER ADULTS	Due to contract providers not spending PEI allocations	Invite well established organizations that specialize working with OA ethnic populations (senior centers; red hat club, faith-based organizations)	
API ISM	O & E to Vietnamese & Korean speakers which are two groups which do not seek help	Extend ISM model to serve Vietnemese and Koreans.	
TAY	Innovative Emotion Regulation- stress management skills	Extend emotion regulation to LAUSD students	

SAAC 4

PROGRAM	GAPS	RECOMMENDATIONS
Client Run Centers	There is not enough community involvement by consumers, and too much "hanging out" in facility and not getting out to explore community and "outside world"; need more Consumer involvement as center staff There are not enough Consumer Run Centers which need to be located close to where consumers live More information on locations & on how someone can qualify for services, and more outreach to Peers	Expand Life Skills program, develop more education and promotion and Life coaching available in all centers to move people to community engagement Develop more Consumer Run Centers and more Consumer involvement
Depression	Lack of warm line numbers and funding Seasonal depression – not addressed, and there is not enough socialization to combat depression Adults in various ethnic communities need access to treatment for depression New medication have too many side effects	More training for warm line staff and more funding Increase consumer training and coping skills to deal with depression More outreach during holidays and anniversaries of traumatic events and more focus on stigma reduction; More outreach before depression turns into a crisis New medications need more research- with less side effects and more use of natural medication
FSP Adult	Employment: not enough training re job success; Consumers do not know how to manage problems that happen due to work-related issues Lack of information on Public Transit Need more Substance Abuse treatment centers Need more Spanish speaking clinicians; Need lower staff to client ratio; GAP in weekend on-call workers; Need a Peer Advocate FSP Counselors/Case Managers and Psychiatrists not showing up for treatment appointments Huge gap in outreach and engagement; better plan to serve people being release from prison Lack of housing - increase**s** danger in clients' lives; Long Term Housing: Not enough slots and dollars per slot for chronic M.I.; need Improved Housing and Help for consumers with up-keep; Inspect housing before placing clients	Train on getting and maintaining work; More training on how to identify volunteering as first step; More on-site job sites; Help consumers get jobs; DMH should hire more people; hire Employment specialist More weekend workers; Use mobile van on weekends and after hours More information on Public Transits system Need more Funding Needs more administration to help to connect clients to housing; Give FCCS programs flex funds; Help clients obtain Housing benefits more quickly Hire well trained, more experience Case managers; More training for peer advocates
Innovation	Reach out to more colleges Need to create an artistic and creative environment for consumers for them to express feelings through creativity Consumers could benefit from Acting/Coaching (get to practice life experience) Consumers need more access to help them navigate multiple systems - Navigate all situations, not just mental health Training on consumers rights Advocate for consumers Trainings on self-esteem for consumers, on mental illness in general and on public speaking	Develop Drumming circles for consumers Develop more Arts – drama, theater, comedy, improvisation, music Provide trainings free of cost Develop an One stop shop Housing Center / Wellness Center (Full Service Center) Implement Infant Developmental Screening & linkage

PROGRAM	GAPS	RECOMMENDATIONS
Parental and Family Difficulties	Families are not informed or educated about MH issues; Parents themselves may have MH issues; Need to address Stigma early, when people are young, about developmental problems	More education for Parents
PEI	Programs focused on very young children Lack of understanding about mental health issues and consequences especially in depression Lack of feedback on program fidelity/service delivery PEI services not known by many people; Need more Outreach-Linkage Children EBPs can't be used for TAY population that's aging out of children's' programs leading to barriers to care Too many clients rushed out of treatment insensitively DMH clinician do not understand language barrier: do not understanding culture, lack of empathy	Equally divide funding among age groups Increase training for administrators and teachers on MH More training for kids on stigma Need more discharge planning Use SAAC and other means to spread more information on PEI Relax boundaries between child & TAY for PEI EBP service continuum. Develop PSA on PEI services. To reduce stigma, increase awareness of services starting as young as Elementary and Junior HS up to Senior High School Need more Spanish speaking and culturally sensitive staff
Trauma: Adult Older Adult Child & Parent TAY	Not enough treatment modalities for adults and older adults Need more Child care, parenting, education classes, transportation, Parenting skills; Need more emphasis on 0-5 Diagnostic criteria – to help identify trauma issues before symptom mimic Axis I disorders Not enough counseling for TAY Stigma about adult trauma; need education regarding trauma; Gap of knowledge regarding trauma focused EBPs Lack of ability for disabled population to get treatment	More treatment modalities and training More PSA announcements on these topics and Develop Teenage focused PSAs Provide more Education regarding trauma On-going informative training by DMH to improve service delivery
Wellness Centers	Rules too strict on assignment to psychiatrist. No choice in your doctors. Program rules can be inflexible Clients miss a sense of ownership and control over program Lack of community resources and information Lack of pet therapy Need more outreach and engagement No Wellness Centers for Older Adults: many are homebound and isolated and unable to get to centers Not a 24 hour service	Let clients maintain the doctor of their choice More Peer training for family and others Increase food, nutrition groups, substance abuse counseling Train primary care physicians to work with medication management Resources for volunteer and regular jobs; Job coaches; More occupational therapists needed DMH provide funding for therapy pets Funding for OA Wellness Centers and creation of "wellness without walls" program to alleviate isolation of frail OA Need more client run centers Need access to services after 5:00 p.m.

Group 1

Linda

PROGRAM	GAPS	RECOMMENDATIONS
Innovations		Automatic filing of names for names for available housing
		Life coaching available in all clinics to move people from diagnosis to community engagement
		Recovery Learning Centers based Boston Mode.
		Life Skills expanded program for ongoing out of care
Clinic Run Center	Center has moved 3x - inconsistency of servies.	More education and promotion More PSA's for
	Poor communication removes available services.	Find out why there aren't CRC's
	Not enough CRC in SA 4!!!	
	More Consumers involves to Staff - Consumers Split between obligations	More Consumer involvement
FSP Adult	Counselors/Case Management Psychiatrists not showiing up for treatment	
	Centers moved without warning	
	Lower staff: client ration	More Funding
	Lack of housing - increase danger in clients' lives	Needs more admin. Help to connect clients to housing
FSP Older Adults	OA not eligible for funding specifically Portals	Know where to send them
FSP Children & TAY	More need than funding	More Funding
Trauma	Share is closeknit - no job - funding concentrated on homeless	Education about PEI appropriate for trauma
	Stigma about adult trauma	Education regarding trauma
	Education lacking regarding trauma	Ongoing informative training by DMH/to improve service delivery
	Gap of knonledge regarding trauma focused EBPs	
	Lack of ability for disable population to get treatment	
	Lack of feedback on program fidelity/service deliver	
PEI All Ages	Some don't know about it	Handout info. Sheet at SAAC
	Childern EBPs can"t be used for TAY population that's aging out of childrens' their care plan stops	Make info. Available in general
	Funding for EBPs center - (CPPP) had to stop training. OA affects services delivery	PSA info. Reducing stigma - increase awareness of services - as low as Elementry and Junior HS up S.H.
		Relax boundaries between child & TAY for service cotinuum
		More funding

Group 2 Facilitator: Phyllis Coto Page 1 of 3

PROGRAM	GAPS	RECOMMENDATIONS
Full Service Partnership: Adult Older Adult	Housing – Need more Substance Abuse treatment centers Testing to increase for Sober Living Homes, e.g. use the Grade scale (A-, A, A+) standards More Spanish speaking clinicians Plan to serve people being release from prison Huge gap in outreach and engagement Lack of medical case workers Get OA to receive mental health services.	Outreach and Engagement through Bill Boards
Trauma: Adult Older Adult Child & Parent TAY	Treating modalities for adults and older adults Child care, parenting, education classes, transportation, Parenting sills More emphasis from 0-5 Better nutrition Diagnostic criteria – to help identify trauma issues before symptom mimic Axis I disorders Not enough counseling for TAY Getting more Ads	More treatment modalities and training PSA announcements Individualized treatment e.g. Short terming Community setting Services Extenders PSA Nutrition Socialization fun activities support groups, NAMI Getting counseling Teenager PSAs
Depression:	Gap in getting information form the Suicide Hotline to DMH Lack of warm line numbers and funding	More warm lines training More funding
FSP: Adult	Delayed referral process Lack of FSP referrals	Shorten time for referral/approval

Group 2 Facilitator: Phyllis Coto Page 2 of 3

Children	GAP in weekend/on-call workers Lack of safe environment Lack of information on Public Transit Lack of Educational goals Employment not addressed Educational supplies not paid for Lack of specialist staff	Drop-in Centers More weekend workers Use mobile van or weekends and after hours More police partners Drop-in centers More information on Public Transits system Educational goal Help get job Speakers training "Whatever it Takes" Hire more people Decrease caseload Agencies work together regarding Parent/Child FSP cases Employment specialist Save money
Wellness Centers: Adults Older Adults	Lack of community resources and information Decrease dependency No agencies to transition clients from the Wellness Centers Lack of pet therapy Lack of self-motivation Therapies More outreach and engagement needed	Training primary care physicians to work with medication management Resources for volunteer and regular jobs. Job coaches More occupational therapists needed DMH provide funding for therapy

	Lack of trainings	pets Public speaking classes Outreach and engagement in pairs More training.

GROUP 3

Christina

PROGRAM	GAPS	RECOMENDATIONS
CSS Client-Run Centers	Outreach for Peers in groups Create more centers close by More information on locations & you can qualify Lack of information on centers	Case management funding
Innovation	Training on consumers rights, advocating for consumers Trainings on self-steam for consumers & mental illness in general & public speaking	Provide trainings free of cost
FSP Adult	No information Lack of information Peer advocate FSP Improve Housing Help with homes uptake Inspect housing before placing..	Well trained more experience Case management More training for peer advocates
Prevention Adults PEI	Outreach-Linkage Intp. Psycho. Therapy Psychology/Therapist Waiting too long. Too many clients rushed out Non Sensitive Medication side effects DMH clinician do not understand language barrier. Not just understanding culture, lack of empathy	Communication Speak Spanish Longer sessions Fully understand More frequently
Depression Adults	Emergencies with depression therapist & hospital Get information Get DMH to allow therapist to go to hospital. New medication-too many side effects.	Allow therapist in hospitals More natural medication New medication New research-with less side effects More understanding Inform consumers on where to go for emergencies

PROGRAM	GAPS	RECOMMENDATIONS
Depression: Serious depression	Seasonal depression – not planned More flexible monies Not enough socialization and/or rigid funding Hard to find consumers are hiding from _____	Increase training and coping skills to learn about depression More outreach during holidays and anniversaries (of traumatic event) Increase basic socialization More outreach before depression turns into a crisis
EBPs	How do you locate people that have experience? More services – hoe do we reach out to people? Need more outreach Do not understand how consumers are matched with EBPs. Broaden definition of "trauma"	Training LEs, teachers Increase understanding of how homelessness is traumatic
Parental and Family Difficulties	Families are not informed or educated about MH issues Parents themselves may have MH issues Sigma – address early and young about developmental problems Family must be on board and support the treatment	More education for Parents
PEI	Programs focused on very young children, some skipping ages Disconnect with schools Lack of training _____ about mental health to children missing in young grades – reduce stigma Lack of understanding about mental health issues and consequences especially in depression – cope, predict Housing increase area in order to prevent in and out	Equally and/or approximately divide money among age groups Increase training for administrators and teachers More training to kids about stigma

	hospitalizations Discharge planning (holidays, housing, socialization) Hard to connect the money required for housing, beds Disconnect from BOS and Providers and DMH.	
Wellness Centers	Strict rules about your psychiatrist. No choice in your doctors Program rules can be inflexible Missing a sense of ownership and control over program	Maintain their own doctor More Peer training for family and others Increase food, nutrition groups, substance abuse counseling
Client-Run Wellness Centers	Not enough community involvement Too much "hanging out"; not explore community and "outside world" Focus on merging both worlds	
TAY	Housing expensive; many want to live at home Hard to connect to them COD Substance Abuse	Drop-In Centers More team/integrated Peers to support each other Programs to address drug and alcohol use
FSP Adults	Employment • Not enough training re job success Hard to work if HOMELESS Hard to work if Hospitalized Consumers do not know how to manage persons that happens due to work-related issues How do we access Department of Rehab? Unemployment High	Train on getting and maintaining work If you not housed then you cannot get and keep a job More training on how to identify volunteering as first step More on-site job sites

Innovation	Reach out to colleges then high schools Create an artistic and creative environment Express feelings through creativity Acting/Coaching (get to practice life experience) More access to help them navigate multiple systems - help them thought it. Navigate all situations, not just mental health	Drumming circles More Arts – drama, theater, comedy, improvisation, music

GROUP 5

GREG

PROGRAM	GAPS	RECOMENDATIONS
Innovation		One stop shop Housing center Wellness Center (Full Service Center) Infant Developmental Screening & linkage
Wellness Program	Lack of Funding Not 24 hour service	A place to go more client run centers Access to services after 5:00 p.m. Linkage External supports
FSP Adult	Housing Long Term Not enough slots and $per slot for chronic M.I.	Housing Options benefits more quickly Graduation More FCCS programs FCCS program having flex funds
Depression	Various Adults ethic communities getting Tx-for depression	Better coordination between M.H. & Criminal Justice system Overcoming distrust of the system Meeting medical necessity Stigma reduction Recovery model Training
PEI **Gateways OP**	Attendance	Transportation accessibility
Didi Hirsch	O.A. Transportation	Childcare for Attendance
I.R.N.	Funding or programs for Service the need (Homeless)	
Portals	Re: staff training and turnover	Additional training

GROUP 5

GREG

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Portals	Re: staff training and turnover	Additional training

SAAC 5

County of Los Angeles Department of Mental Health

Prioritizing Initial Proposal: Ranking Sheet

Most Important	Next Most Important	Next Most Important	Next Most Important	Next Most Important	Next Most Important
6	5	4	3	2	1

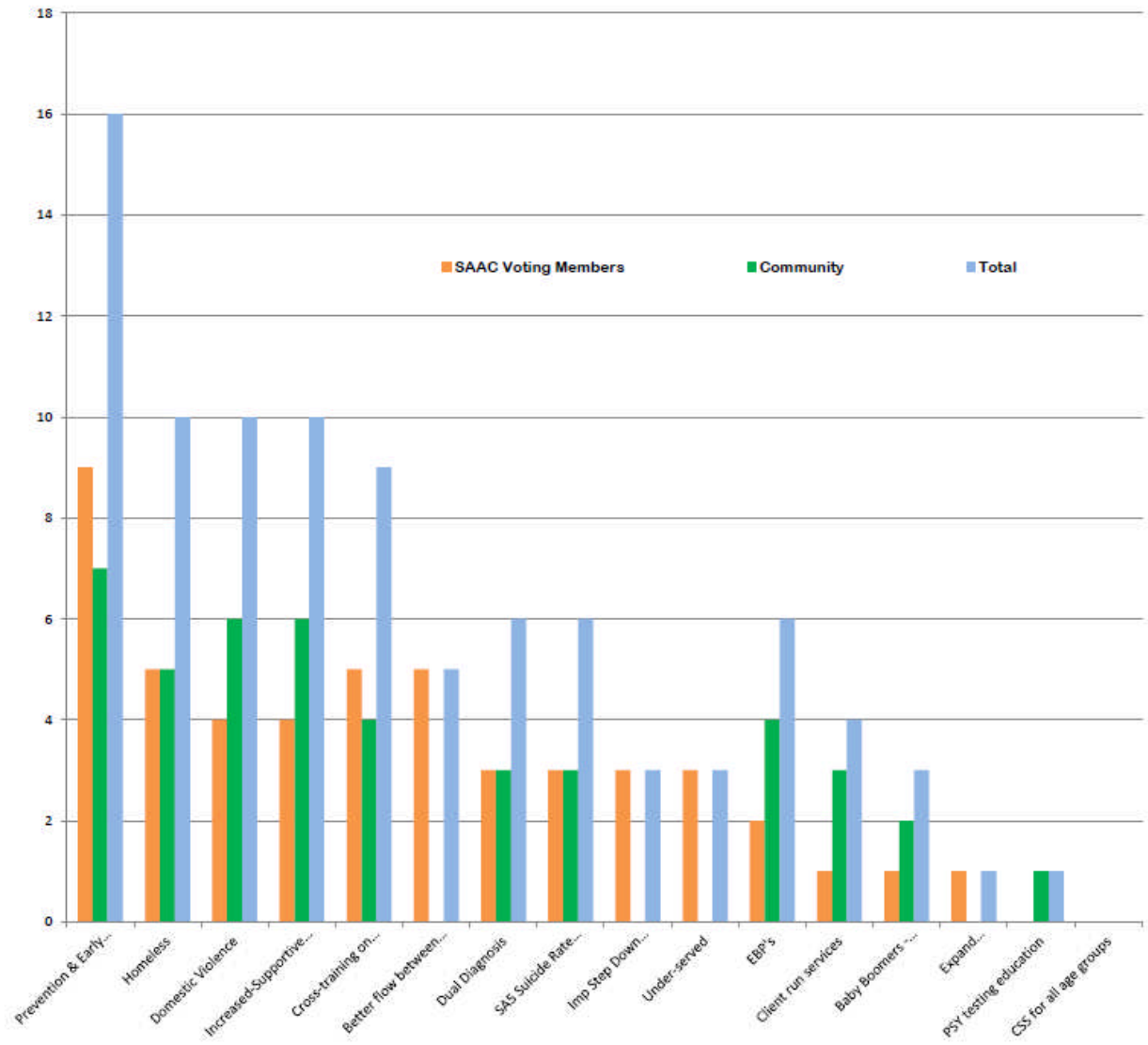
Ranking	Proposal	Why is This Most Important?
6	Early Prevention & Very Early Intervention (PEI) - Pre-School MH 0-5 - Family Evaluations - Couple's Therapy - Parenting.	Help kids, parents, and families early enough to prevent everyday problems from becoming severe. This would prevent future expenditures of more intensive mental health services, and support resiliency.
5	Homeless (CSS) - Better linkage of incarcerated individuals - Development of effective strategies for service resistant homeless people	People with mental health problems are released from jail out to the streets with little to no resources. More street level interventions are needed for service resistant homeless individuals.
4	Domestic Violence (PEI) - All age groups Better Collaboration between Mental Health, Domestic Violence and Substance Abuse Providers Attention to children from families experiencing DV	There is a high incidence of Domestic Violence (DV) in SPA 5. DV causes trauma, which creates increased vulnerability to mental health as well as substance abuse problems. Many individuals with a mental illness have underlying trauma and need services that integrate all the aspects of DV. DV impacts every member of the family: Adults and children.
3	Supportive Housing (CSS) - More MHSA Permanent Supportive housing in SPA 5 - Not just for Homeless or Inappropriately Housed	Many who are recovered and ready to live in permanent independent housing must move out of SPA 5 in order to find suitable units. More permanent supportive housing Units in SPA 5 are needed to keep people in their home communities.
2	Staff Cross-training (CSS, PEI, INN) -Strengthen workforce's ability to integrate physical, mental & spiritual health as well as substance abuse in order to address the recovery needs of the "whole" person.	The workforce needs more training in addressing complex conditions that involve physical health and substance abuse, such as severe eating disorders, complicated substance abuse, diabetes, or people stuck in skilled nursing facilities with health or mobility issues.
1	Better flow between levels of Service (FSP, FCCS, etc.).	Smoother transitions between levels of care, to ensure people don't fall between the cracks, and their process of Recovery continues smoothly.

Reflections

What principles or values did you hear that could be used to prioritize services as a whole system?
1. Doing an overall better job at promoting hope, wellness and recovery. 2. Better integration of the whole System so the parts work smoothly together. 3. Better integration of people with lived experience at all levels of care. 4. Integrating services to treat the whole person: Mind, body and soul.
Any other reflections or comments?
Strengths of the System identified by the community: 1. Ability to meet immediate medication needs (UCC) 2. SPA 5 DMH Leadership 3. Increased & improved communication between DMH & clients 4. Training clients in self-help advocacy 5. Many positive pre-existing partnerships among our agencies (e.g. Healthcare) 6. Community collaboration (e.g. Clergy Advisory, Westside MH Network Meeting)

	Gap	SAAC Voting Members
1	Prevention & Early Intervention	9
2	Homeless	5
3	Cross-training on symptoms physical, mental & Spiritual health	5
4	Better flow between services levels: FSP to FCCS, etc.	5
5	Domestic Violence	4
6	Increased- Supportive Housing	4
7	Dual Diagnosis	3
8	SA5 Suicide Rate (older white males)	3
9	Imp Step Down Intensive residential	3
10	Under-served	3
11	EBP's	2
12	Client run services	1
13	Baby Boomers - Older Adults	1
14	Expand Wellness Centers	1
15	PSY testing education	0
16	CSS for all age groups	0

	Gap	SAAC Voting Members	Community	Total	Phase
1	Prevention & Early Intervention	9	7	16	1
2	Homeless	5	5	10	2
3	Domestic Violence	4	6	10	
4	Increased-Supportive Housing	4	6	10	
5	Cross-training on symptoms physical, mental & Spiritual health	5	4	9	
6	Better flow between services levels: FSP to FCCS, etc.	5	0	5	3
7	Dual Diagnosis	3	3	6	
8	SA5 Suicide Rate (older white males)	3	3	6	
9	Imp Step Down Intensive residential	3	0	3	
10	Under-served	3	0	3	
11	EBP's	2	4	6	
12	Client run services	1	3	4	
13	Baby Boomers - Older adults	1	2	3	
14	Expand Wellness Centers	1	0	1	4
15	PSY testing education	0	1	1	
16	CSS for all age groups	0	0	0	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SAAC Voting Members
Community
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Prevention & Early...
Homeless
Domestic Violence
Increased-Supportive...
Cross-training on...
Better flow between...
Dual Diagnosis
SAS Suicide Rate...
Imp Step Down...
Under-served
EBP's
Client run services
Baby Boomers -...
Expand...
PSY testing education
CSS for all age groups

Service Area 6

SERVICE AREA ADVISORY COMMITTEE 6:

MHSA Three-Year Program and Expenditure Plan Feedback

Over the last year Service Area Advisory Committee (SAAC) 6 has spent much time reviewing its goals and focus as well as looking at services and needs in this largely minority community. Therefore the following feedback, chart below, is a constellation of the input from several meetings throughout the year 2013 and 2014 and represents the most important service issues for the Service Area.

In addition to the input about specific programs for the various age groups the SAAC also identified the following issues for all service delivery:

- The term "resiliency" used as a part of the Department of Mental Health's core values should be defined by consumers from their point of view.
- The term "wellness" used as a part of the core values of services in DMH needs to be defined more accurately and by consumers.
- Consumers should participate in all levels of service, including SAAC meetings, and meeting information should be posted in all the mental health clinics so consumers and family members can know when meeting occur and have information about the meetings.
- Field based staff/workers should be asked about service gaps; they often see what the community needs because they are out in the field.
- Mental Health stigma needs to be addressed with the professional staff both in mental health and physical health.
- Overall, mental health stigma should be addressed continuously in all communities.
- Cultural competence should be an outcome in all service delivery.
- Waiting times for receiving mental health services should be eliminated; this is especially a problem for the Latino and monolingual consumers and families, both continues to be a problem in this community.

Service Area 7

Children:

- Need Family Resource Centers to support families
- Need indigent funding for foreign born and undocumented kids and parents
- ✓ Consider funding a well-researched California program often used in schools, the Primary Intervention Program (PIP) as a PEI Prevention program.
- Allow schools to supply the match and bill EPSDT directly in order to expand services.
- Need Housing for homeless families with a mentally ill adult or child.
- Close the "gap" between PEI and FSP for children
- Serve the Community Kids (non-DCFS or Probation kids) on an equitable level.
- Use Promotores to outreach to monolingual Spanish speaking families

TAYS:

- Create Drop In Centers or TAY Wellness Centers with specific needs of TAYS in mind
- Provide more TAY housing with less restrictions so more TAYS who are "couch surfing" or living in cars or garages are eligible.
- Consider and Emergency TAY shelter or Crisis Residential Home for TAYS ages 16-24
- Provide re-integration resources to TAYS and families, for TAYS being released from Juvenile Hall
- Use Promotores to outreach to monolingual Spanish speaking TAYS

Adult:

- Expand treatment services for Adults in SA 7, particularly the Huntington Park and surrounding areas
- Housing – expand options for housing, including using Housing Navigators in client run centers, creating a one-stop housing referral site in the SA,
    - Use supportive services to maintain housing, develop housing options for the undocumented.
- Use the Latino media to get out the word about services to Latinos, to fight stigma and improve access. Do Profiles of Hope videos in Spanish.
- Extend funding for Bilingual Promotores
- Dedicate "saved" CGF dollars for people who now have MediCal (such as Healthy Way L.A.) to the undocumented population, and give it to providers who show a dedication to serving this population
- Find more sustainable EBP's
- Fund outreach efforts to the API community.
- Give Providers more flexibility on "buckets" so they can more easily create "flow" between programs (FSP-FCCS-Wellness).

<u>Older Adults</u>

- Increase "field based" services to seniors, including Psychiatry services
- Use Telepsychiatry when possible to avoid long commutes for disabled seniors
- Find indigent funding for undocumented or "foreign born" seniors
- Co-locate services at Senior Centers.

Service Area 8

SAAC 8 identified the below underserved and underrepresented populations: PEI, CSS, INNOVATION, WET- Samoan, Deaf/hearing impaired, and Multi-ethnic college students with unidentified, unmet and/or underserved mental health needs

Substance Abuse services and outcome data: There appears to be a lack of data regarding the integration of mental health and substance abuse services to underrepresented populations

MHSA funding allocation: Allow contract providers to permanently shift funds between their MHSA programs and age groups in order to better meet the needs of the service area.

PREVENTION

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PEI Early Start - School Mental Health		-There is a lack of stigma/discrimination reducing efforts, outreach, and early screening/assessment to high school and college students from underrepresented populations (e.g., API, LGBTQ) that may have emerging concerns.	-Wellness centers are needed at High Schools and colleges to reduce stigma and discrimination, provide outreach, early screening and assessment of students with emerging concerns.
PEI Early Start – Anti-Stigma Discrimination		-There is a lack of stigma/discrimination reducing efforts, outreach, and early screening/assessment to high school and college students from underrepresented populations (e.g., API, LGBTQ) that may have emerging concerns.	-Active Minds program at high schools and colleges -Peer mentoring/CORE training -- Integration of NAMI on-campus
PEI Family Education & Support Services	Prevention only outcome data pertaining to family education and increasing mental health advocacy is not yet available to evaluate effectiveness of PEI prevention only programs.	-There needs to be more parent education about mental health advocacy for their children in order to reduce risk factors and increase protective factors that promote mental health.	-Increase funding to expand the prevention only EBP/PP/CDEs that promotes parent/family education on mental health advocacy for their children.
PEI Mental Health Outreach & Education to Teen Domestic Violence population		Teenage domestic violence is a huge concern and is not sufficiently addressed through mental health education and treatment. -There is no PEI prevention only practice being implemented to provide mental health education in order to prevent mental illness for this population.	-Increase funding for mental health outreach and education to victims of teen domestic violence to prevent mental illness. -Increase funding for mental health outreach and education to the promote protective factors in the population of youth who are at risk of becoming involved in teen domestic violence and developing mental health issues as a result of domestic violence.

EARLY INTERVENTION

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PEI Child, TAY, Adult, Older Adult (EBPs).	-Outcome measures are not available in Spanish or Khmer for most EBPs used with this population in SA 8. -Data is indicating that the API is underserved by PEI for all age groups. -Data is indicating that there is tremendous unmet mental health need within the college student population	-Programs are not culturally competent for certain populations in LA county. LA county is so unique and diverse that even though an EBP may have been normed or used with other large cities, these areas do not reflect LA county. -EBPs used with the Cambodian population require clinicians that speak Khmer and are culturally fluent and bicultural in understanding the culture and trauma of the population yet the materials and outcome forms for clients are not in Khmer and require translation. -The API may be underserved by PEI due to inadequate outreach and engagement efforts that are culturally appropriate. -Multi-ethnic college students with unidentified, unmet and/or underserved mental health needs.	EBPs need to allow for Train-the-Trainer model for sustainability and applicability to a diverse population. -DMH needs to accept the use of Promising Practices and CDEs as EBPs for certain populations that the current EBPs do not meet the need. -Select EBPs or CDEs that have materials and outcomes available in the SA 8 threshold languages (e.g., Khmer and Spanish) -EBPs need to be delivered by bicultural and culturally competent staff in the language preferred by the client in a culturally competent manner. -Culturally and linguistically appropriate outreach to API families and parents who are monolingual but may be the primary person to refer their English-speaking family member who needs PEI services, is critical.
PEI Child & TAY	Outcome measures do not capture the mental health needs of the collateral parent or caregiver who is involved in the treatment for their child who is receiving the PEI services.	-When the child/youth who is receiving the EBP services reaches his/her treatment goals, services are terminated, including both core and ancillary services such as collateral and family therapy. These services may have also benefited the parent/caregiver who may themselves be experiencing mental health symptoms but have not been able to access their own treatment.	-Provide continued funding to allow parents/caregivers to receive appropriate PEI EBP services to treat their underlying mental health conditions in order to maintain the progress of their child/youth long after the child reaches his or her treatment goals under PEI. -Provide continued funding to allow case management services to caregivers who may need their own targeted case management services (e.g., return to school for credentialing or degree to obtain employment) related to their mental health condition in order to maintain their child's progress.
PEI Child & TAY		-Children/Youth who are uninsured and/or indigent due to their legal status need more indigent funding to receive PEI services that children/youth without legal status issues receive.	-Provide increased indigent funding for children/youth with legal status issues that prevent them from accessing the needed PEI services.
PEI Child & TAY		-There is an increased need for services to be provided in schools to target the PEI Child & TAY population.	-Provide increased training funds to obtain further consultation or training in order to adapt and implement EBPs in schools. -Provide ongoing funding each fiscal year to prevention only providers who provide services in the schools.

EARLY INTERVENTION (continued)

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PEI OA		-There are many OA, especially in Cambodian and API communities that have mental health and health issues but are not being outreached to. -Family members of OA are often relied on to assist with navigation/linkage of both mental health and health services and benefits	-OA PEI outreach and education needs to occur in the field in various settings in the community to reach Cambodians, API, and other OA with health and mental health concerns. -Field-based OA outreach teams need training to better discern or screen clients for mental health and health concerns. -Mental health staff that are providing outreach and education need training to learn how to screen and intervene early in order to reduce worsening of health conditions that may trigger mental health problems. -The API community needs training on how to screen and identify health conditions that may worsen and trigger mental health issues if not addressed. -Increase funding for OA Health Navigators that can assist and collaborate with the family members of an OA with navigation/linkage to health benefits, health and mental health services.
PEI OA	Lack of unique API clients served in SA 8.	-Traditional outreach, education, and engagement strategies are not effective for certain cultural populations (e.g., API). -Traditional MH providers, especially those that are not connected to a faith or cultural organization, are not trusted by OA API and their families which often results in ineffective outreach and engagement.	-Provide funding so that OA PEI providers can utilize non-traditional and culturally appropriate outreach, education, and engagement strategies to reduce stigma and reach API and other underserved populations. -Provide funding for new faith or community based PEI and Prevention only providers that can better link OA to services.- -Provide continuation of funding for current Prevention only providers to expand their services by collaborating with faith organizations in order to improve outreach and education to the OA population and their families.

EARLY INTERVENTION (continued)

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
PEI Improving Access for Underserved Populations: LGBTQ POPULATION	No specific data regarding outcomes for LGBTQ Child & TAY	-Prevention and/or early intervention programs specifically to target LGBTQ Child and TAY are not currently being implemented and current EBPs are not adapted well for this population. -There are not enough train-the-trainers with LGBTQ expertise for EBPs currently being implemented who can adapt EBP models for this population- -There are not enough clinicians with LGBTQ expertise that can implement and adapt EBPs with this population.	- Increase PEI training funds to contract providers so that they can work with existing EBP developers and trainers to provide more specific LGBTQ train-the-trainer trainings in order to better address the needs and appropriately treat the specific needs of this population.
PEI Improving Access for Underserved Populations		FOR SA 8: -Although 30% of the unique clients served through CSS and 26% served through PEI were African American in FY 2012-2013, it is unknown whether these services appropriately addressed the mental health needs and were delivered in a culturally appropriate and competent manner to benefit this population. -Only 3% of the unique clients served through PEI, and 9% served through CSS were identified as API, yet most of the EBPs and outcome measures are not available in Asian languages.	-Increase training funds to provide culturally and linguistically appropriate early mental health intervention with the PEI population utilizing current existing EBPs. -Increase mental health outreach and education to African American, API (especially Cambodian and Samoan) and other underserved or inappropriately served populations to ensure services are culturally and linguistically appropriate and can benefit these populations.
PEI Prevention Only			Increase funding to Prevention Only providers who provide substance abuse treatment for children at risk of substance abuse.
PEI: ASD, FAMILY EDUCATION, & IMPROVING ACCESS FOR UNDERSERVED POPULATIONS	Outcome data on the # of families, parents, and underserved populations outreached to by PEI prevention only providers was not available.	-Mental health education and outreach events are not accessible to certain populations or due to stigma; certain populations may not attend events that are not located at trusted venues.	-Provide one-time costs to cover vehicles to transport parents/family members and targeted populations to community mental health outreach and education events. -Provide one-time costs to lease space at faith or community-based facilities that are trusted by the community for mental health outreach and education to underserved populations. -Allow these one-time costs per PEI prevention only provider as well as PEI mental health contract provider. -Study whether these one-time costs for vehicles or leasing facility space resulted in increased positive outcomes and effectiveness of these programs.
PEI Anti-Stigma Discrimination			-Provide ASD trainings to probation staff.

COMMUNITY SERVICES AND SUPPORTS

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
FSP-ADULT	The rate of actual graduation from FSP into a lower level of care, such as FCCS, is low.	-The average cost per client, number of clients served, may not be cost-effective when considering that a high proportion of clients are exiting FSP due to dropouts, jail, hospitalization, or other unknown reason and not due to meeting recovery-oriented treatment goals. -We need to improve outcomes and the cost-effectiveness of the FSP program by improving the following outcome variables, such as fewer days homeless, decreased hospitalization or jail, and increasing paid or gainful employment.	-Reduce funding limitations so that unused FSP Adult flex funds can be used for Adult FCCS clients who also having housing, employment/education, and life skills needs. This may allow for better flow of FSP clients to FCCS as they meet their recovery-oriented treatment goals so that clients who may still have housing, transportation, or other needs but are more stable for FCCS can graduate from FSP. -Allowing flexible use of flex funds will reduce the number of clients who are referred and admitted to FSP due to needing flex funds and could actually be served by FCCS instead.
FSP- TAY	The rate of actual graduation from FSP into a lower level of care, such as FCCS, is low.	-There are not enough FSP TAY slots in SA 8. -The cost of care for FSP TAY clients is high due to the supports needed. -Not enough TAY EESP and permanent supportive housing, drop-in centers, employment and education resources, life skills supports and services, and peer mentoring programs in SA 8. -The average cost per client, number of clients served, may not be cost-effective when considering that a high proportion of clients are exiting FSP due to dropouts, jail, hospitalization, or other unknown reason and not due to meeting recovery-oriented treatment goals. -We need to improve outcomes and the cost-effectiveness of the FSP program by improving the following outcome variables, such as fewer days homeless, decreased hospitalization or jail, and increasing paid or gainful employment.	-Increase funding for more FSP TAY slots in SA 8. -Review cost allocation per slot and increase to appropriately serve the needs of FSP TAY clients. -Reduce funding limitations so that unused FSP TAY flex funds can be used for TAY FCCS clients who also having housing, employment/education, and life skills needs. This may allow for better flow of FSP clients to FCCS as they meet their recovery-oriented treatment goals so that clients who may still have housing, transportation, or other needs but are more stable for FCCS can graduate from FSP. -Allowing flexible use of flex funds will reduce the number of clients who are referred and admitted to FSP due to needing flex funds and could actually be served by FCCS instead.

COMMUNITY SERVICES AND SUPPORTS (continued)

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
FSP- OLDER ADULT	The rate of actual graduation from FSP into a lower level of care, such as FCCS, is low.	-In SA 8, there are many OA who do not quite meet FSP criteria but can benefit from FCCS; however, there are no flex funds to assist with their housing, transportation, or health needs. -The average cost per client, number of clients served, may not be cost-effective when considering that a high proportion of clients are exiting FSP due to dropouts, jail, hospitalization, or other unknown reason and not due to meeting recovery-oriented treatment goals. -We need to improve outcomes and the cost-effectiveness of the FSP program by improving the following outcome variables, such as fewer days homeless, decreased hospitalization or jail, and increasing paid or gainful employment.	-Reduce funding limitations so that unused FSP OA flex funds can be used for OA FCCS clients who also having housing, employment/education, and life skills needs. This may allow for better flow of FSP clients to FCCS as they meet their recovery-oriented treatment goals so that clients who may still have housing, transportation, or other needs but are more stable for FCCS can graduate from FSP. -Allowing flexible use of flex funds will reduce the number of clients who are referred and admitted to FSP due to needing flex funds and could actually be served by FCCS instead.
FCCS- TAY		-Not enough TAY EESP and permanent supportive housing, drop-in centers, employment and education resources, life skills supports and services, and peer mentoring programs in SA 8.	- Reduce funding limitations so that flex funds can be used for TAY FCCS clients who also having housing, employment/education, and life skills needs.
FCCS- ADULT		-There are no flex funds to assist with housing, transportation, or health needs for clients who meet FCCS criteria but are not yet in need of FSP.	-Reduce funding limitations so that flex funds can be used for ADULT FCCS clients who have similar needs (e.g., housing, transportation, health) as FSP Adult clients.
FCCS-OLDER ADULT		-In SA 8, there are many OA who can benefit from FCCS; however, there are no flex funds to assist with their housing, transportation, or health needs.	-Reduce funding limitations so that flex funds can be used for OA FCCS clients who have similar needs (e.g., housing, transportation, health) as FSP OA clients.
FCCS-OLDER ADULT		-OA have multiple health conditions that impact their mental health yet there are not enough services that integrate both mental health and health services. -OA FCCS providers need more training to help their clients navigate and access health services.	-Increase funding for OA health navigators on each FCCS team. -Provide health navigator training to OA FCCS staff.

COMMUNITY SERVICES AND SUPPORTS (continued)

SERVICES BY PROGRAM	PROGRAM EFFECTIVENESS: DATA & OUTCOMES	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
OA FSP and FCCS		-Providers are not serving clients where clients reside (e.g., nursing facilities, senior centers).	-Increase funding for co-located OA FCCS staff to be placed at senior centers, nursing facilities, and health settings to provide access to services.
OA		-OA population is underserved as it is difficult to identify OA with mental health and health needs due to being under the care of families instead of professional care and stigma.	-Continue providing funding for anti-stigma outreach and education efforts to OA communities to target their families that are caring for an OA. -Provide funding for service extenders that are culturally appropriate and bicultural to provide health and mental health navigation to the OA population and especially the underserved ethnic populations.
OA HEALTH NAVIGATORS		-OA experience health conditions that impact their mental health but often do not have access to care and appropriate screening so they can get the needed services. -OA often times have difficulty understanding their benefits and insurance coverage which limits their access to needed healthcare.	-OA need assistance to navigate and link to the appropriate health services to prevent worsening of conditions that may impact their mental health condition. -OA health navigators need training on benefits and insurance eligibility/coverage for OA in order to assist them in linkage and navigation.
CHILD WELLNESS CENTERS		-There are a large number of Child clients with SPMI who are well enough to only need medication support services once they have reached their treatment goals and no longer need therapy or case management. -Clinic psychiatrists are saturated with “meds only” clients making it difficult to schedule new clients who are in treatment but not psychiatric services as well. -Child services need to better incorporate family support services and NAMI linkage in order to graduate clients from outpatient programs. There are currently no child Wellness Centers that are for children and their families. Some parents/families do not want to terminate outpatient MHS as they have become reliant on the MH system for support to address non-mental health issues even after their child reaches their treatment goals.	- Develop a Wellness Center or network of providers for children who only need medication support services until they can locate/identify a physician or psychiatrist in the community that can continue psychotropic medications. Clinic psychiatrists are saturated with “meds only” clients making it difficult to schedule new clients who are in treatment but not psychiatric services as well. -NAMI and parent/family support services located at Child Wellness Centers can help families to locate services in the community and transition their child from outpatient programs into services located in the community.
TAY DROP-IN CENTERS		-There is only 1 TAY drop-in center in SA 8 which does not adequately address the needs for this service area.	-Increase funding to add one more drop-in center or expand services of the existing ones. -Expand services available at drop-in centers to include assisting with after-school jobs, job training programs, and peer support.

COMMUNITY SERVICES AND SUPPORTS (continued)

SERVICES BY PROGRAM	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
TAY WELLNESS CENTERS	-There are no wellness centers or wellness center like services in Juvenile Halls for TAY to help them to prepare and transition to the community upon discharge. -TAY coming out of juvenile halls, especially those who age out 18 and over, may need linkage to community resources, support groups that focus on employment, education, or substance abuse support groups to prepare for their discharge and more successfully transition and link to the outpatient MHS. It is difficult to accomplish all this in the short time frame between discharge and opening a new episode at a clinic and some of this work can be done during their juvenile hall stay in order to reduce recidivism.	-Develop Wellness Centers or wellness center like services within Juvenile Halls that go beyond traditional mental health services that may not address the needs of the youth in juvenile hall. -Expand the definition and criteria of Wellness Center to allow the Juvenile Hall population to benefit from any Wellness Center groups or services (e.g., employment, education, housing, living skills, dual diagnosis substance abuse support groups, linkage and navigation to community resources) so they can be better prepared upon discharge from juvenile hall.
TAY HOUSING SERVICES	-lack of housing and employment for TAY 18-25, high school dropout rates, are still a problem for TAY. There are still not enough services to address the complicated needs of TAY.	-Increase Countywide Housing, Employment, Education and Resource Division services and funding to TAY to promote scholarships, college bound programs, attainment of certifications, degrees, or diplomas needed for employment) -Provide more CSS dollars to pay for financial aid, college applications and registration fees, SAT prep courses so that TAY can pursue higher education in order to improve mental health outcomes.
TAY ALTERNATIVE CRISIS SERVICES	-there needs to be more TAY appropriate (18-25 yrs) alternative crisis services to prevent IMD placement, inpatient hospitalizations, emergency room care, and incarceration.	-Develop and increase funding for TAY appropriate ACS.
TAY	-There is a special population of TAY single fathers who experience mental illness (e.g., depression, bipolar disorder, schizophrenia) that impacts their parenting skills yet there are not enough agencies or clinicians that specialize in providing this specialized mental health services.	-Provide funding for community defined practices that deliver culturally appropriate mental health interventions that also promote fatherhood and effective parenting.
ADULT HOUSING SERVICES	-Lack of housing for mental health clients whose sole source of income is GR only. -there needs to be more self-pay DMH shelter options for those that no longer or do not meet the criteria for the DMH temporary shelter program TSP) -DMH TSP shelters that accept self-pay clients charge any where from $600-$1003/month per person.	-Leverage MHSA housing funding to permanently house more low-income/GR only income adults with mental illness. -Provide funding to develop Shared Housing collaborations for individuals with mental illness and only GR income. -Provide subsidies to pay for client's shelter stay for those that do not meet Temporary Shelter Program (TSP) eligibility criteria that way the client pays a portion of their GR income to the shelter and DMH pays the remainder to help pay for a client's shelter stay for up to 6 months. This costs less that the full TSP rate of $1003 but would give some clients more time to transition to permanent housing in a DMH setting rather than a general population shelter or back to homelessness on the streets.

INNOVATION

INNOVATION PROJECT	DESCRIPTION	INNOVATION CRITERIA FULFILLED
PACS ISM Model	SAAC 8 recommends funding to continue this project.	-Targeted culturally and linguistically appropriate services to underserved API populations in SA 8. -Promoted interagency collaboration to provide culturally effective integrated substance abuse and mental health services. -Expand this model to other underrepresented, underserved populations and communities in SA 8
DMH/DDS Psychiatric Fellowship program	-In SA 8, dually diagnosed individuals who are clients of both DMH and regional centers need ongoing integrated psychiatric services to appropriately treat their comorbid conditions. -There is a lack of psychiatrists in the community that are specialized in treating this dually diagnosed population. -Psychiatrists within the DMH system have not received specialized training to treat dually diagnosed clients. -Primary Care Physicians that treat regional center clients in the community do not have the training or specialized training to prescribe medications for dually diagnosed clients. -Replicate the San Gabriel Pomona Regional Center's MHSA project that funded a local fellowship practicum project for DMH clinics and/or private psychiatrists to receive education, training, and supervision for treating dually diagnosed clients. Trainings should include best practices in medication management, side effects, and monitoring.	- Increase the community and service area capacity to appropriately serve dually diagnosed individuals. -Improve service integration between DMH and DDS to appropriately serve the dually diagnosed population.
DMH/DDS Collaboration Pilot Project	-Develop and expand interagency collaboration related to mental health services and supports for intellectually disabled individuals who also receive Regional Center services. -Strengthen and expand already existing collaborative network to provide support, consultation, and training to develop the mental health providers' expertise in the area of Dual Diagnosis (a developmental or intellectual disability combined with a mental health disorder).	- Increasing the quality of mental health services, including better outcomes for mental health clients who are also dually served by the regional centers. - Promoting interagency collaboration related to mental health services and supports.
Integrated education/health/mental health collaboration	-Develop innovative collaborative projects with education/schools and mental health to support the mental health needs of students with mental illness and former beneficiaries of AB3632. -Employ and educate teachers in the Teacher Child Interaction Therapy (TCIT) EBP.	-Increasing access to mental health services, including to underserved populations. -Increasing the quality of mental health services, including better outcomes. -Promoting interagency collaboration related to mental health services and supports. - Increasing the quality of mental health services, including better outcomes. - Promoting interagency collaboration related to mental health services and supports.
Integrated Peer-Run Model: PRISM (Hope Well) and PRRCH programs (Hacienda of Hope).	SAAC 8 recommends funding to continue the PRISM and PRRCH programs. -Expand the PRISM and PRRCH programs to provide services to those that are homeless and experiencing mental illness as a way to outreach and engage them for mental health services and reduce homelessness. -Employ peers with lived experience (mental illness and homelessness) to deliver services.	-Increasing access to mental health services, including to underserved populations. -Increasing the quality of mental health services, including better outcomes. -Promoting interagency collaboration related to mental health services and supports.

INNOVATION (continued)

INNOVATION PROJECT	DESCRIPTION	INNOVATION CRITERIA FULFILLED
Integrate L.A. College Building Healthy Communities Initiative (BHCI) Program	During 2012-13 the CalMHSA L.A. College Consortium (BCHI) hosted 3 Regional Strategizing Forums between the Los Angeles Colleges and LACDMH with the goal of optimizing the networking potential of both entities in support of meeting the mental health needs of unidentified, unserved or underserved college students and LACDMH college bound consumers. On 12/12/13 consensus was reached on several planning items which would assist those in need of mental health support. The consensus building occurred as a result of the data exchange between the two entities over the course of one year.	-Continue the funding for the BCHI in support of continued progress on the CalMHSA Programs goals and objectives after the cessation of CalMHSA funding in 2014. Program should be expanded to include all college in the Los Angeles County area. -Recommended planning items: LACDMH to designate one spot on SAAC Advisory Committees for higher ed reps.; offer streamlined referral process with med evals, hospitalization, and therapy as appropriate; Explore possibility of having a DMH staff member on college campuses once a week as the Department of Rehabilitation does; support recovery oriented doctoral and Masters level college internship mental health service sites because of its cost-effectiveness and usefulness for workforce development; establish supported education and supported employment programs which include the colleges; authorize one DMH staff member to serve on college Behavioral Intervention Teams (BIT Teams); establish a tracking system of college referrals to optimize communication access on consumers who have provided signed releases; establish treatment protocols for mid-range students/consumers; develop mental health resources in support of homeless students/consumers, undocumented students, student VETS and LGTBQ students; collaboration on research projects which target the consumer experience in higher ed; provide disability verification to college Disabled Student Programs to ensure student access to state and federally mandated services.

WORKFORCE EDUCATION AND TRAINING

SERVICES BY PROGRAM	SERVICE GAPS BY PROGRAMS	RECOMMENDATIONS
WET Community College Collaboration	-Although there were collaborative relationships existing between DMH SA 8 and 3 local colleges, there were no collaborative symposiums held under WET at these campuses to train college students, faculty, and the community at large.	-Provide funding to hold a training symposium at LA Harbor College and Cal State Dominguez Hills to train their faculty and staff, students, and the community at large.
Employment And Professional Advancement Opportunities For Parent Advocates, Child Advocates, And Caregivers Mental Health Career Advisors	-There are not enough advancement opportunities for peer advocates. -There are not enough peer-run, peer-mentoring for professional and career advancement opportunities.	-To develop a culturally competent workforce, fund a peer-run career development ladder and train peers from different underrepresented populations.
Mental Health Career Advisors	-There are no mental health career advisors for TAY. -OA peer advocates need mental health career advisement, especially for underrepresented populations in SA 8 (e.g., API)	To develop a culturally competent workforce: -Provide funding (e.g., stipends) and training for TAY Peers to be trained as career advisors to other TAY peer advocates. -Provide funding (e.g., stipends) and training for OA peers to be trained as career advisors for other OA peer advocates.
WET HEALTH NAVIGATOR SKILL DEVELOPMENT PROGRAM	-We need more certified Health Navigators to help mental health clients access needed health services that impact their mental health.	

System Leadership Team Meeting Agenda and Notes - March 19, 2014

COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, March 19, 2014 from 9:30 AM to 4:00 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. To deliberate and approve the allocation realignment within the MHSA Capital Facilities and Technological Needs Plan (CF/TN Plan).
2. To deliberate and approve the recommended goals and strategies for the MHSA Three-Year Program and Expenditure Plan.
3. To deliberate and approve the recommended budget and associated programs and services for the MHSA Three-Year Program and Expenditure Plan.
4. To formalize agreements that made consensus possible and/or key unresolved divergences.
5. To be clear about next steps.

AGENDA

I.	**Meeting Opening** A. Welcome, Meeting Overview, Notes and Materials B. Recommendation-Making Method and Conflict of Interest	9:30-9:40
II.	**Realigning Allocation within the MHSA CF/TN Plan** A. Presentation (5 min) B. Deliberation and Approval (15 min)	9:40-10:00
III.	**Proposed Goals and Strategies** A. Background (5 min) B. Presentations (25 min) 1. Older Adults 2. Adults 3. Children 4. TAY 5. Cross-Cutting C. Deliberation and Approval (40 min) D. Public Comments before Approval (5 min)	10:00-11:15
IV.	**Proposed Budget** A. Presentation (15 min) 1. Amount Available 2. Recommended Method 3. Proposed Allocation by Age Group B. Discussion and Agreement (25 min) C. Clarifying Afternoon Work (5 min)	11:15-12:00
V.	Lunch	12:00-1:00

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VI.	**Proposed Budget** (Continued) A. If Relevant, Continue with Morning Items B. Cross-Cutting Proposals 1. Deliberation and Approval	1:00-2:00
VII.	**Age-Group Budgets and Associated Programs** A. Clarify Task and Amounts (5 min) B. Small Group Work (35 minutes)	2:00-2:40
VIII.	**Proposed Budgets** and Program Recommendations (Continued) A. Presentations (20 min) 1. TAY 2. Adults 3. Children 4. Older Adults B. Deliberation and Approval (45 min)	2:40-3:45
IX.	**Documenting Agreements and Divergences** A. Agreements that Made Consensus Possible B. Unresolved Divergences	3:45-3:55
X.	**Public Comments**	3:55-4:00
XI.	**Next Steps and Adjourn**	4:00

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5. To be clear about next steps.

MEETING NOTES

Meeting Opening	***Debbie Innes-Gomberg, Ph.D., District Chief,* Los Angeles County Department of Mental Health** A. Today is not the end of a planning process it is the beginning. This is an opportunity to use the information that we gathered, all the budget data, the plans we talked about, gaps and services, the desire to strengthen prevention and early intervention, community services and supports plan, and workforce education training. I can almost guarantee you that the plan you recommend to the Executive Management Team, to the Mental Health Commission and ultimately to the Board of Supervisors will not be a perfect plan, but it will meet our needs at this moment. This is the beginning of a process that we will continue to refine based on an analysis of program outcomes, budget, and claiming data, as well as your own experiences. B. The next item is a request that the Department is making related to our Capital Facilities and Technological Needs (CFTN) plan. While the CFTN plan is one plan, we bifurcated the two planning and approval processes in Los Angeles. The Technological Needs plan was approved by the state in May 2009. Our Capital Facilities plan was approved by the state in April 2010; however, the allocation is a joint one. Locally we decided that 70% would be dedicated to information technology or Technological Needs and 30% to capital facilities, which pays for county-owned buildings. C. In implementing our electronic health record we realized two things: we needed a little bit more money and we are not able to use all of our capital facilities money. Dr. Bob Greenless will discuss the proposal that you will vote on.
Proposal	***Robert Greenless, Ph.D., Chief Information Officer,* County of Los Angeles, Department of Mental Health** ***A copy of Bob Greenless' presentation was included in the SLT meeting packet.* **FEEDBACK** 1. **Question**: The $3 million is that all you will need or do you need more? **Response:** We will probably need more than that ultimately. 2. **Question**: Will the funding allocated for the peers to have computer access be spent before the reversion date?

	Response: That is a separate from the IBIS project. There are over a hundred computers right now. Because of the IBHIS project we have not had time to see if there is an opportunity to expand. 3. **Question**: Is there any consideration to the agencies that are experiencing the same problem with funding and trying to get this done by the May deadline? **Response**: I do not see an option there. We allocated, approximately $27 million to the agencies. That is something no other county has done. At this point we need to get IBHIS in or the rest will not matter very much. 4. **Question**: Will the reduction of the $3 million affect the providers in any way? a. **Response**: This is not a reduction. b. **Response**: Not that I am aware of. It cannot because the rules for construction are that construction money be used for county owned facilities not for providers therefore the switch is from county construction to information technology. In our initial discussions, we explored every avenue for using these efforts to support the contractors. This is why 70% of the money goes toward IT/TN because that was the part we could share with community agencies. 5. **Question**: Your slide shows that we have $57 of $100+ million we need. Where is the other $40 million you need to complete the IBHIS project going to come from? **Response**: From the regular IT budget. 6. **Question:** Will we have the funds to integrate into the new healthcare models that we are working on in Health Neighborhood? Is this fund going to be enough to do what we need to do to integrate that? **Response**: Basically we cannot do that unless we get IBHIS implemented. This helps us get the base in place to do that. ***Proposal: Support shifting $3 million from Capital Facilities to Technological Needs.*** ***VOTE:*** ***31 SLT Members Voted*** ***20 Strongly Agreed*** ***11 Agreed*** ***Proposal Approved***
Age Group Q&A and Deliberation	Rigoberto Rodriguez, Facilitator A. At the last meeting the SLT approved the goals that were presented with the exception of goal 8 for children. That was presented at the very end. Today you will be asked to approve goal 8. B. At the last meeting we identified the top three strategies that you felt would have the most impact in achieving those goals by age group and cross cutting age groups. Each age group discussed the strategies and reported their recommendations. The document titled "Proposed Priority Categories, Goals and Strategies"; resulted from that recommendation that you issued last time. These goals, strategies, and categories all came from the multiple forums and deliberations that included not just the SLT but members of the public and SAACs. C. What we are asking you to approve today is Children's goal #8 and the

top 3 strategies per goal.

FEEDBACK

1. **Question**: (Older Adults) On goal 1, #2, goal 4, #1 and goal 5, #2—are those cost neutral?
    a. **Response**: The common denominator for older adults is that with the growing population older adults could use funding in every area. We looked at where we have existing initiatives where we could do something without funding. For instance, on goal 5, #2, provide training to service extenders and community volunteers, we have a service extender academy. We do not use any additional funding. We use our staff and then volunteers from some contract agencies that currently have service extenders. It could be done that way. Or it could be done where you pay another agency to come in and provide training. So I am just suggesting that, "Would funding be great? Yes". In the absence of funding there are avenues to make some of these things happen.

2. **Question**: On children's, it is not clear what is meant by goal 2, strategy #3, “implementation of the California reducing disparities project--recommendations to use EBP's.” Does that mean making the EBP's more culturally sensitive? Does it mean that whatever CRDP has come up with they will implement in the EBP's?
    a. **Response**: Some of the strategies were broad. The proposals have more detail in some of those.

    b. **Response**: This recommendation came out of the SAAC. In terms of further clarification I apologize. I do not have more than that.
3. **Question**: TAY did not include anything about making EBP's more culturally sensitive for the TAY group in all the goals and strategies (Goal 3, #2)
    a. **Response**: This is a synthesis of past meetings. The stigmatization includes all of those different cultural and ethnic disparities that would be addressed with EBP's.

    b. **Response**: Some can be addressed in the ways that you are implying. But some of it is really inherent in the EBP's. To do fidelity to the EBP you have to do what the developers say. So changing it is not in our power. What we can accomplish is to prepare the context in which the EBP's are provided so that they are as culturally relevant as possible.

4. **Question**: In the arena of aging, I look at goal 5, and my concern is the more fundamental issue of whether there is any process for supporting basic nutritional sufficiency for the aging population. How is that dealt with in terms of the programs listed here?
    Response: We thought about the Older Americans Act, which is separate from MHSA funding, as a way of mitigating that issue. I think a good point is being made that the mental health piece can prevent access, that you need the case management sometimes to help access the other resources. So the dollars are not necessary but the access is.
5. **Question**: Is there a way that the strategies that you do have can address

	that issue? **Response**: 'Increase number of FSP slots' because that is where it is and that will include the case management that helps somebody access that. That is a normal part of the FSP and the FSP pilot program. 6. **Question**: In the children, adult, and older adult the strategy is consistent. But I am seeing an inconsistency in the TAY. To give you an example, under goal 2, #1, consistency. They talk about education, to identify early symptoms indicative of mental health issues and to address stigma. The outreach and engagement efforts to parents and caregivers of ethnic and cultural groups ensuring linguistic capacity through expansion of the Promatores program and create the cultural equivalence of the Promoters model. a. **Response**: So if we added "cultural equivalent" that would address the concern. b. **Response**: Yes. c. **Response**: I think it was addressed for the outreach. We left the 'expand and adapt the Promoters model' as an outreach and cultural groups. So we referenced the cross cutting strategy and proposal that deals specifically with expanding and adapting Promatores not only to the Latino community but inclusive of all ethnic and cultural considerations. d. **Response**: We could be more explicit with the wording. 7. **Comment**: LGBT needs to be infused into these various levels. **Response**: If you look at page 1 under Children, at the very bottom, the footnote, this was one of the explicit recommendations that was made last time. Whenever we referred to cultural groups that we explicitly mention LGBT. We listed that at the beginning of the document, so it applies across the board from what the group agreed to last time. 8. **Question**: Under Children, goal 3, strategy 2, would that include an EBP like expanding PCIT? I see it here for children 0-5 specifically. **Response**: We did not specifically say PCIT but in the proposals for the PEI we collapsed PEI expansion and expanding integrated school health centers. We want to look at all of the EBP's that are currently utilized including PCIT. What we put in there is really to analyze and really to review the current EBP's to see and look at the outcomes. After that analysis we will look at which ones to expand. 9. **Question**: This is regarding Workforce Education and Training as a suggestion/clarification that goes with all of the age groups. Dr. Southard explained almost all of the EBP's that we use with Older Adults--the majority are not culturally sensitive to the population served in East LA. My suggestion is that we put language in that encourages partnership with local universities with providers that are having community defined promising practices which could turn community defined promising

practices into EBP's.

a. **Response**: I think there is a rich opportunity here. On the one hand when we look at outcomes pre and post for EBP's for PEI we are seeing a huge reduction in symptoms particularly for the Latino population. I think the opportunity exists for possible WET regional partnership projects. That might be one avenue in which to think about doing this. Our next Innovations project may be another.

b. **Response**: One final clarification is that Promatores/Community Workers is an EBP of prevention but not considered an EBP of early intervention. That makes things a little difficult.

10. **Question**: I found one group that we used to talk about--you did not put the blind in there.
    a. **Response**: That we have under "Persons with physical disabilities." Do you want me to make it explicit? Blind?

    b. **Response**: Yes.

11. **Question**: On page 24, on TAY drop in centers, this is excellent, but we need to address the impact for the street kids out there specifically in each SAAC. I know budget is limited but I suggest that we expand our horizons and make sure we have a drop in center at each SAAC area minimum.

12. **Comment**: Should some of these be in the PEI category as opposed to CSS? As an example, under TAY, goal 2, #1 about outreach and engagement; the reason we bring it up is because there is a heavy burden on CSS.

13. **Comment**: Where you see a check mark around the MHSA component sometimes we registered not so much where the money is going to come from but rather who brought it up and they thought it was PEI or CSS.
    a. **Response**: The staff should look to make sure that if we do get to the funding part that it might, especially on the CSS part, be fundable in other areas.

    b. **Response**: I think the intent is there and the desire is there.

14. **Comment**: I want to make sure that the Promatores model is not implemented to all of the ethnic groups and that characteristics of the outreach and engagement are taken into consideration the different characteristics of the different ethnic groups.
    Response: The Promatores model is actually a defined model which in its basic components the community people are educated in mental health or health if they are doing Promatores or health navigator work in health because it is and has been done with the health community and with the domestic violence community and the with AIDS community. The main issue is that we train people to be educators of the community. So that can be translated to any ethnic community. The key is bringing in cultural and linguistic components of that community in doing the presentations.

15. **Comment**: Models have consistencies in certain areas and communities however the adaptation is culturally relevant to the community you are serving. That community must define and adapt it so that it meets its cultural relevant. I want to be clear about that.
    Response: In January we gave you the definition of cultural competency. It is not an "if we do it" it is already required in terms of how we do the work.

16. **Question**: Is there a catalogue of all of the existing work plans that we can have reference to?
    Response : Yes.

17. **Question**: Is there a one for one correspondence between this document and the detailed document that we are going to have this afternoon?
    Response: Yes. We are asking you to approve the overarching skeleton, the bones, and then the meat is what we are going to get into in terms of resources and how to actually implement some of those strategies that you are prioritizing.

18. **Comment**: We never specified. We did not want to specify 0-5 because we want this program for 0-16 or 18 or whatever children are. Once you specify something you omit or exclude somebody else.

19. The SLT discussed adding a goal related to the client congress proposal to allocate 7.5% of the budget be spent on peer services. After discussion, emphasizing the importance of peer services and holding the Department accountable for supporting them, the group created a goal that focused on accountability to the development of peer services that was subsequently voted on.

20. **Question**: Regarding co-occurring disorders the strategy reads, "Provide ongoing workforce development to increase knowledge, skills, and abilities, in the provision of co-occurring disorder services." Maybe in an innovation kind of way say, not just training people but thinking out of the box and saying, "Create new groups that are ongoing at the various mental health clinics."
    Response: We have a couple of EBP's that incorporate substance abuse and co-occurring. Our challenge is one of training. Our social workers, psychologists and psychiatrists come to us with a very minimal amount of training to provide this. The primary thing that we are focused on is awareness with our staff and ensuring that they raise these questions and the training is what we use to support that.

21. **Comment**: Here is the first proposal. We will test for agreement. If there is an "E"--someone that blocks the second alternative--then we will vote on both of those. 60% or more is what carries forward the recommendation. The voting is now open. This proposal has two parts: one is adopt the children's goal #8 and the priority strategies, up to three strategies, that you heard from the each of the goals across the age groups. What we are asking you to adopt is the document.

22. Question: You are asking me to vote on this document that has goal 8 added that we did not have last time and with a missing page that we do not have?
    Response: That we have up here, yes.

23. Comment: If you want to change and add the revenue neutral peer services at this point you vote E.

24. Question: We suggested some inconsistencies and changes that need to be made. Are you saying that is included or not?
    Response: That is included in the strategies and what the people intended. It is a friendly amendment.
25. Question: Everyone knows that we are just voting on this document, goal #8, as the one that was expanded on and we want to make sure to get that included, but the caveat is that after this vote we will have openings, to discuss any amendments.
    Response: If someone blocks it.

26. Question: If somebody wants to make an amendment and the body agrees we can amend or add.
    Response: Correct. When we go into the second round of discussion.

27. Comment: We now open a second round. You can present an alternative proposal.

    Proposal: Adopt the proposed goals and key strategies for all Age Groups.

    VOTE: (42 voters)
    15=A - 'Strongly Agree'
    16=B - 'Agree'
    2=C - 'Neutral'
    3=D - 'Disagree'
    6=E - 'Block'

28. Question: I want to get make to your interpretation on what 'A' means. You said it is "without changes." Definitely, before we made this vote you said that the things that the doctor and other people have brought up is included in the change, not in the document as written, right?
    a. Response: Right.

    b. Response: That's what my interpretation was when I voted. But you said there were no changes.

    c. Response: If you are an 'A' you strongly agree without any changes. If you have minor divergences you are a 'B'. 'C' you are neutral. 'D' you disagree. You disagree strongly but are still willing to not block the group from going forward. If you are a 'D' one thing that we ask is that what those key reservations are for the record. If you are an 'E' you are blocking because you have a major concern and then you want to propose something different from the group.

29. **Comment:** Before voting on the adult, to see handouts.
    a. **Response**: Can we have a chance to look at them and then exclude that from the vote right now so that we can look at them and vote on them later?

    b. **Response**: So you propose voting on all except adults.

    c. **Response**: Yes.

30. **Comment**: My problem was with the procedure mostly. I was thinking that we are voting on 3 things at the same time. They required 3 different votes. Like the 'adopt children's goal #8' is one vote. We need to vote on that separately. The age groups, that's another thing that we need to vote separately on. I think also the suggestions--the questions that we raised are also separate.

You propose voting on the 3 items separately.

31. **Comment**: Mark Parra pointed this out and I really missed this. Page 8 on the adults, goal 4 and the two strategies beautifully explain and puts on paper our whole discussion about cultural competence and EBP's and all of that. So my only suggestion is to perhaps scratch #2--is that if we could say that the adults go forward with 3 strategies would it be valid for all ages.

32. A member of the SLT initially proposed that the group add a goal that said, "The MHSA integrated plan include a benchmark of 7.5% of the overall funds for the peer services". Some members expressed the importance of including a benchmark for peer services, citing that it is important to hold the Department accountable. In addition, some noted that current budget allocations already exceeded the 7.5% benchmark. Others felt that the benchmark of 7.5% was problematic because of potential impact on services, the lack of clarity on how much 7.5% was, and setting a precedent for creating percentages for all services. The Executive Management team felt that this might be more of a compliance issue related to existing service and staffing expectations. A commitment was made to ensuring existing standards for peer services are adhered to.

33. After discussion, the SLT revised the proposal and voted on adopting that following statement, "The LA County MHSA three year program and expenditure plan include a clear commitment and accountability system for peer services."

Proposal: "The LA County MHSA three year program and expenditure plan include a clear commitment and accountability system for peer services."
VOTE: (34 Voters)
A=17
B=7
C=7
D=3
E=0

	The Proposal passes 34. <u>Comment</u>: Before voting, the group reviewed the key points for inclusion in the age group strategies. Key points included emphasizing the importance of culturally competent EBP's. including the blind as part of the cultural groups, that we are clear that Promoters must have a cultural equivalent defined by the community, explicitly name or bring cultural competency in TAY in alignment with the rest of the document, be clear about LGBT across all levels, co-occurring disorders: making sure that as you look at that strategy that you look at Innovations or innovative ways that this could be embedded in groups, and a commitment to the importance of drop in centers for youth across all of the SAAC's. 35. <u>Comment</u>: On page 8, besides EBP can we add community defined practices and promising practices. 36. <u>Question</u>: What are Community-Defined Evidence (CDEs) and Promising Practices (PPs)? <u>Response</u>: There is Evidence Based Practice, Community Defined Evidence and then Promising Practice. Typically it is the EBP's that we end up using because of all of these studies, experimental and quasi-experimental designs behind the evidence. In our community there is history, community wisdom and other forms of evidence that we can use. Promising Practices have some degree of studies behind them but not necessarily the most "scientifically" rigorous, quasi-experimental, etc.? ***Proposal 3: To adopt the proposed goals and key strategies for all age groups.*** *Vote :(34 voters)* *A=17* *B=10* *C=4* *D=0* *E=0* ***We have adopted this framework for the 3 year integrated plan***.
Budget Plan, Q & A, and Deliberations	***Dennis Murata, Deputy Director,*** **Program Support Bureau** A. The most important recommendation today is the one that we just made. If we are not clear about the goals and strategies then it is difficult to allocate resources. Some strategies may or may not have money to be implemented the first year, second year, or third year. We are committed to achieving those goals and implementing those strategies. B. We are asking you to make 2 more recommendations. The first recommendation is around the broad budget. When we started this process in September and October we were informed that there was no new money. However, about a month ago the department put forward a proposal around the unspent dollars for CSS to the Ad Hoc Group. We want to focus specifically on the amount of funds that are available through CSS for the next three years. Having consulted with members of the EMT and being an EMT member himself Dennis will present three

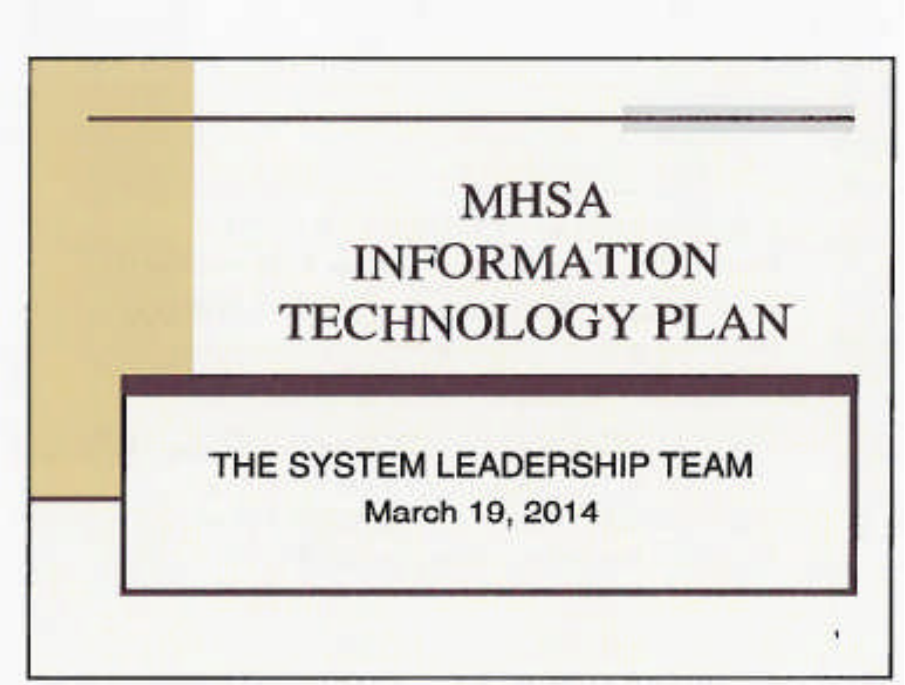
	options on how to distribute the money from the unspent dollars from CSS for each of the age groups. Then we will deliberate and agree to one of those options. C. There are no additional unspent dollars for PEI or WET. The budgets have to conform to CSS fundable strategies. The final point as we move into the budget is conflict of interest. The Conflict of interest rule states that a person cannot be involved directly in making a decision around public funds that benefit them or an organization that they work for or with directly. D. How Conflict of Interest is applied to a multi stakeholder body is yet another question. First, one is not in conflict of interest when, for example, through ad hoc planning processes through small work groups, or if you give recommendations around general priorities or even a general breakdown of a budget. For this next part we are in the clear. No one has conflict of interest. E. What we do have is a commitment to a whole system. We do have interests in terms of specific constituencies and age groups. We want that to be part of this conversation. However, after we reach an agreement around the distribution of resources by age group we will go back into small groups and at the small group level you can continue to give your opinion around the relative allocation of resources for your age group. When we bring those proposals back to the large group we are then going to be very strict about the conflict of interest policy. F. At our SLT Ad Hoc group the Department and the EMT put forward a proposal. Basically there is $90 million available for the next 3 years of unspent CSS dollars. The task was then to think of that $90 million and allocate it by about $30 million per year for the next three years. G. Whatever strategies we identify to be funded through these dollars should be services and programs that become funded through ongoing dollars in year 4, instead of onetime dollars. There are a couple of interests we have to balance. We do not want to fund something with one-time dollars that we then have to dismantle in year three. H. That $90 million is an accumulation of dollars over many years. The bulk of those unspent dollars came to us either last year or the year before. We had a big boost of CSS dollars. There were some dollars held up in the state reserve. Those dollars were one-time. They are not sustainable. It is not something we are going to get every year. I. Rather than having a free for all and saying, "Okay, which strategies do we fund or not?" we thought it more effective to first ask, "What percent of those dollars can be allocated by age group?" We will then ask you to go back to your groups and to deliberate on the proposals and bring your strategies and amounts in conformity with the amount. J. This one it is titled comparison of CSS and PEI. This was based on last fiscal year. You will see the first few row shows number of clients served, their percentage, as well as the net dollars for CSS. In this case net

	dollars are 100% MHSA dollars. Gross dollars include those net dollars and any revenue that would draw down from Medi-Cal. So that's for CSS and PEI. K. The key thing we wanted to highlight is that depending on the age group and type of program some of these dollars are heavily leveraged. For example, if you take a look at kids under CSS, $1 net buys an additional $5.30 approximately. The $30 million are net dollars. Those are not gross dollars. L. One recommendation was to distribute it by age group. What we are proposing in this chart here, if you a take a look there are three options. We could do the allocation, and this is the yellow piece, of what that actual net dollar percentage is by age group for CSS. That's the yellow option there. That will show you how much of, let's say, $20 million will be distributed by age group. M. When you take a look at kids, it may only represent 6.2% for kids for CSS but the bulk of PEI are for children in terms of the net and gross dollars. It is hard to separate that. Even though they are different plan components when folks come into service these are services that are available to them period. That's why we thought maybe another option would be to combine those two amounts and then take a look at what that percentage distribution would be. That's the green section there. That would show you what that allocation would be based on $20 million. N. The third option is looking at the client or consumer distribution by age group. We are willing to hear other options as well. We are talking about $30 million. So why am I talking about $20 million? The Board priorities are roughly $10 million. We took that money off the top. That is why the balance would be $20 million to distribute.
	FEEDBACK 1. The SLT asked questions of clarification that included discussion of Board Priorities (Laura's Law, IMD Step Down, and Staffing and service for SB82), which groups benefitted the most from the priorities, and the use of CSS dollars only. Dennis also provided context for why the proposals used actual claiming numbers from both CSS and PEI. The group asked about the impact of the Affordable Care Act, and the impact of the leveraging of dollars by age group. 2. The group voted on 5 different funding models a. Net CSS dollars b. Combined PEI and CSS models c. CSS Clients d. 14.18%. 12% for TAY, 60% for adult, and 13.92% for older adult. e. 10% Children, 14% TAY, 63% for Adult, 13% for Older Adult *Round One:* *Proposal: Vote on the top two budget frameworks* *A=7 (Net CSS Dollars)* *B=8 (Combined PEI and CSS models)*

	C=9 (CSS Clients) *D=18 (14.18%. 12% for TAY, 60% for adult, and 13.92% for older adult)* *E=14 (10% Children, 14% TAY, 63% for Adult, 13% for Older Adult* *Our top 2 are D and E.* *Round Two:* *Proposal: Vote for either proposal D or E* *Option D=19* *Option E=11* 3. The SLT discussed the merits of Option D and Option E. Some members felt that Option D gave too much to children and not enough to TAY, some felt that the Adult System of Care needed more resources given the cuts it had taken over the years. Some felt that TAY were covered by both child and adult funding. Others chose E because they felt children have EPSDT and have more help. 4. The SLT voted for consensus on both proposals D and E, and neither passed. *VOTE:* *Option D: A: 62 percent, B: 0 percent, C: 7 percent, D: 17 percent, E: 14 percent* *Option E: A: 45 percent, B: 7 percent, C: 14 percent, D: 10 percent, E: 24 percent* 5. The SLT then went to a vote on the two proposals: *VOTE:* *D=16 (57%), E=12 (43%)* 6. In order for one proposal to be selected, it must garner 60% of the vote. Neither proposal garnered 60%. The SLT was then asked to provide an alternative proposal. 7. The SLT proposed 13% Children, 13% TAY, 61% Adults, 13% Older Adults. *VOTE:* *Proposal: 13% Children, 13%, TAY 13%, 61% Adults, 13% Older Adults.* *A: Strongly Agree = 9 (35%)* *B: Agree = 7 (27%)* *C: Agree with Reservations = 6 (23%)* *D: Disagree but will not block = 4 (15%)* *E: Block = 0 (0%)* *We have consensus on this.* 8. Based on consensus reached by SLT, the CSS dollars per fiscal year, broken down by age group is: $2.6 million for Children, $2.6 million for TAY, 12.2 million for Adults, $2.6 million for Older Adults. 9. The group was provided with a packet that included all proposals that were submitted by age group, a one page document that provided budget information for CSS proposals including the Board Priorities, cross-cutting strategies, and age group strategies.

	10. The SLT divided into smaller working groups by age group. Each age group was asked to allocate resources to the strategies they wanted to prioritize. The group was asked to provide a breakdown by Fiscal Years 1, 2 and 3. Each age group was required to align their budget with the allocation of CSS money that they were given. 11. The group was unable to finish their deliberations and continued their work in a special session of the SLT on Tuesday, March 25, 2014.

System Leadership Team Meeting Handouts - March 19, 2014



FUNDING

- L.A. allocated $131,007,000 for Capital Facilities (CF) and Information Technology (IT)
- Stakeholders determined 70% ($91,704,900) of funds above would support IT Projects
- Remainder would support CF Projects
- PROPOSED CHANGE: Move $3M from CF Projects to IT to support the continued deployment of the Integrated Behavioral Health Information System (IBHIS)

RATIONAL FOR CHANGE

- CF Projects have long lead times in the County
- CF/IT funds not spent by June 30, 2018, revert to State
- Based on current status of CF projects, not all funds will be successfully applied to CF projects by the funding reversion date
- IBHIS implementation is very resource intensive
- MHSA IT Plan currently supports $57.6 million of a projected $100+ million project budget
- IBHIS can effectively use the additional $3M well before 6/30/18 to provide needed roll-out support

System Leadership Team Meeting Agenda - March 25, 2014

COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Tuesday, March 25, 2014 from 1:00 to 3:00 PM
550 Vermont, 9th Floor Conference Room, Los Angeles, CA 90020

REASONS FOR MEETING

1. To deliberate and approve the recommended budget and associated programs and services for the MHSA Three-Year Program and Expenditure Plan.
2. To formalize agreements that made consensus possible and/or any unresolved divergences.
3. To be clear about next steps.

ACTION NOTES

I. Conflict of Interest (COI) Policy

A. Definition:
   1. COI policy promotes transparency in decision-making processes, particularly decisions involving public funds.
   2. In general, COI occurs when individuals and/or organizations stand to gain materially from their participation in decisions involving public funds.
   3. The COI policy extends to individuals who sit on the Board of Directors of organizations that might benefit from public funds.

B. Applying COI Policy:
   1. Consistent with prior MHSA planning processes, COI policy did not apply to the following:
      a. To ad hoc committee participation, where ideas are being developed but not finalized;
      b. To new programs for which a solicitation process will occur.

   2. The COI policy was applied to the following situations:
      a. For existing programs slated for expansion through a contract amendment: individuals and organizations were not allowed to vote or participate in the discussion influencing that program budget.
      b. For existing programs slated for expansion through a new solicitation: individuals and organizations that might be applying for funds were not allowed to vote or participate in the discussion influencing that program budget.

C. Method:
   1. Each SLT member filled out a form where they checked off program budgets where they had a COI and turned these in before final discussions and voting occurred.
   2. Before a vote on a program budget, the facilitator asked if anyone had a COI and SLT members identified themselves. If a member had a COI, they did not vote on the item.

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

3. The names of people with COI were noted for each vote.

II. Age-Group Proposed Budgets and Associated Programs

A. Each age group broke into small groups to prioritize and budget their key strategies.
B. Age group leads will submit budget allocations to Debbie Innes-Gomberg.

III. Consensus on Age Group Recommendations

A. Used a consent calendar approach. By age group, pulled out items individuals needed further discussion on and voted on the uncontested items.
B. The group pulled out the following items:
   1. TAY Housing Proposal
   2. Older Adult Budget–group wanted to consider adding items to budget.
   3. Psychiatrist item
C. Proposal 1: Do you endorse the adult proposed budgets and priorities?
   1. Conflict of Interest: Jim Preis, Ruth Holman, Mariko Kahn.
   2. Vote: 10 Yes, 3 abstain.
   3. Result: Adult budget passes.
D. Proposal 2: Do you endorse the TAY proposed budgets and priorities with the exception of Item 2: TAY Housing Proposal?
   1. Conflict of Interest: Jim Preis, Ruth Holman, Mariko Kahn
   2. Vote: 11 yes, 2 abstain
   3. Result: TAY Budget passes with the exception of the TAY Housing Proposal.
E. Proposal 3: Do you endorse the Children's budget with the exception of item 9, the housing proposal?
   1. Conflict of Interest: Jim Preis, Ruth Holman, Mariko Kahn
   2. Vote: 10 people yes, 2 abstain
   3. Result: Children's budget with the exception of the housing proposal passes.
F. Proposal 4: Include the housing proposals with each of the age group.
   1. Conflict of Interest Jim Preis
   2. Vote: 11 agree to include, 1 block
G. Since the housing proposal was blocked the following amendment was proposed: To move the money that was designated for housing programs be moved to FSP for TAY and FCCS for Children.
   1. Conflict of Interest: Jim Preis
   2. Vote: 1 agree, 6 disagree, 3 block
H. The group agreed to a majority vote on each of the following items:
I. Proposal: How many people would support the housing proposal
   1. Conflict of Interest: Jim Preis
   2. Vote: 9 support, 1 against

J. Proposal: How many people would support moving TAY housing money to FSP?
   1. Conflict of Interest: Jim Preis, Mariko Kahn
   2. Vote: 1 support, 8 against, 1 abstention

K. Proposal: How many would support the Child housing program allocation?
   1. Conflict of Interest: Jim Preis, Mariko Kahn
   2. Vote: 8 support, 1 against, 1 abstention

L. Proposal: How many would support moving the Child housing program allocation into FCCS?
   1. Conflict of Interest: Jim Preis, Mariko Kahn
   2. Vote: 1 Support, 8 against, 1 abstention

M. Proposal: Does the group endorse the 4 items already listed in the Older Adult budget?
   1. Conflict of Interest: Jim Preis, Ruth Holman
   2. Vote: 10 support, 0 against

N. The group discussed the importance of building the capacity of older adults. The work group specifically wanted to address the core needs for the older adults given the limited resources. As such, they focused on increasing their capacity in FSP and FCCS.

O. The OA workgroup felt Promotores was an outreach and engagement strategy. Other SLT members agreed and noted that it did not make sense to outreach if OA did not have services they could offer potential new clients. They group felt the needs could be addressed via service extenders or by training the Adult Promotores workers to do outreach for OA.

P. THE OA group also discussed the fact that it did not make sense to support the Psychiatrist line item since there were no older adults to be served.

Q. SLT members proposed moving wellness onto the OA budget list.

R. Proposal: How many people would block wellness from being added to the Older Adult budget
   1. Conflict of Interest: Ruth Holman and Jim Preis
   2. Vote: 7 block, 3 for adding.
   3. Result: Wellness was not added to the list.

S. Proposal: How many people would block Promotores from being added to the OA budget list?
   1. Conflict of Interest: None
   2. Vote: 5 block, 4 for adding, 1 abstention.

T. Alternative Proposal: The Adult Promotores would be trained to outreach to Older Adults.
   1. Conflict of Interest: None
   2. Vote: 7 support, 3 abstentions.

U. Proposal: To add 78k in Year 1, 229k, in Year 2, and 420k in year 3 to maintain current levels of OA housing. The OA work group would be charged with bringing the budgets into alignment.
   1. Conflict of Interest: Jim Preis, Ruth Holman
   2. Vote: 9 support, 0 against

V. Final agreed upon proposals are reflected in the age group summary documents.

Expansion Budget Proposals

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

MHSA Three-Year Program and Expenditure Plan (CSS) for Children

		FY 14-15				FY 15-16				FY 16-17	
Table	Program Name	MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served	MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served	MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served
	Cross-Age Group Proposals:									
6	Promotoras	250,000			250,000			250,000		
8	Housing Trust Fund	31,300			250,000		2.5	250,000		2.5
9	MHSA Housing Program				200,000			200,000		
	Child-Specific Proposals:									
10	Family Wellness Centers				750,000			750,000		
11	Respite Care Program				500,000		166	500,000		166
12	FCCS Expansion	1,131,000	1,017,900	330	1,131,000	1,017,900	330	1,131,000	1,017,900	330
15	Self-Help Groups				75,000			75,000		
	TOTAL	**1,412,300**	**1,017,900**	**330**	**3,156,000**	**1,017,900**	**498.5**	**3,156,000**	**1,017,900**	**498.5**
	ALLOCATION	**2,600,000**								
	ROLLOVER TO FY15-16 & FY16-17	**1,187,700.0000**								

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH 3/26/2014

MHSA Three-Year Program and Expenditure Plan (CSS) for TAY **Revised Budget Proposals**

		FY 14-15				FY 15-16				FY 16-17	
		MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served	MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served	MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served
Table #	Program									
4	Integration of Co-Occurring Mental Health and Substance Abuse Disorders	$0	$0	0	$36,391	$0		$36,391	$0	
5	Staff for FSP/FCC/Wellness (Psychiatrists)	$0	$0	0	$235,732	$0		$235,732	$0	
6	Promotores de Salud/Community Wellness Workers	$228,000	$0		$228,000	$0		$228,000	$0	
8	Housing Trust Fund	$46,950	$0		$610,000	$0		$610,000	$0	
9	MHSA Housing Program	$550,000	$0		$550,000	$0		$550,000	$0	
15	Self Help Support Groups for Children/TAY	$0	$0	0	$45,000	$0		$45,000	$0	
17	TAY Supportive Employment Service	$125,000	$0	30	$500,000	$0	125	$500,000	$0	125
27	TAY FSP (18 slots)	$141,000	$147,000	18	$141,000	$147,000	18	$141,000	$147,000	18
27	TAY FCCS (36 slots)	$88,000	$110,000	36	$88,000	$110,000	36	$88,000	$110,000	36
28	TAY Drop-In Center (3 Drop-In Centers)	$250,000	$0	400	$750,000	$0	1200	$750,000	$0	1200

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MHSA Three-Year Program and Expenditure Plan (CSS) for Adults **Revised Budget Proposals**

		FY 14-15			FY 15-16				FY 16-17	
		MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served	MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served	MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served
Table #	Adult Proposed Programs									
31	Wellness Adjunct Services	$3,830,525	$4,206,683	29,000	$3,536,317	$4,206,683	29,000	$3,536,317	$4,206,683	29,000
32	FSP and FCCS	FCCS - $184,500 FSP - $246,000	FCCS - $94,500 FSP - $126,000	25 FSP 50 FCCS	FCCS - $738,000 FSP - $984,000	FCCS - $378,000 FSP - $504,000	100 FSP, 200 FCCS	FCCS - $738,000 FSP - $984,000	FCCS - $378,000 FSP - $504,000	100 FSP, 200 FCCS
38	FSP and FCCS INN	$0.00	$0.00	0	$1,000,000	unknown	unknown	$1,000,000	unknown	unknown
33	Peer Staff in CSS Programs	$1,237,338	$518,731	35 Peer staff to serve 1750	$1,237,338	$518,731	35 Peer staff to serve 1750	$1,237,338	$518,731	35 Peer staff to serve 1750
34	Peer Run Centers	250,000	$0.00	500	$1,000,000	$0.00	2,000	$1,000,000	$0.00	2,000
36	Supportive Employment Model Pilot	$274,518	$241,386	150	$274,518	$482,772	300	$274,518	$482,772	300
37	Housing Specialists for Wellness Programs	$1,844,758	$1,099,311	1,500	$1,932,758	$1,099,311	1,500	$1,932,757	$1,099,311	1,500
	Cross-Cutting Stategies for ASOC									
6	Community Health Workers (Promotores)	$350,000	$0.00	unknown	$350,000	$0.00	unknown	$350,000	$0.00	unknown
9	Housing Proposal	$2,500,000	$0.00	25 x 50 years	$0.00	$0.00	25 x 50 years	$0.00	$0.00	25 x 50 years
8	Housing Trust Fund	$156,500	unknown	unknown	$980,000	unknown	unknown	$1,600,000	unknown	unknown
4	COD	$0.00	$0.00	unknown	$170,000	$0.00	unknown	$170,000	$0.00	unknown
5	FSP/FCCS/Wellness - CSS Psychiatrists (4)	$0.00	$0.00	0	$350,000	unknown	unknown	$350,000	unknown	unknown
		$10,874,139		32,575	$12,552,931		34,850	$13,172,930		34,850
		$1,325,861 (use yr 1 & 2)			($352,931)			($972,930)		

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

MHSA Three-Year Program and Expenditure Plan (CSS) for Older Adults **Revised Budget Proposals**

		FY 14-15			FY 15-16				FY 16-17	
		MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served	MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served	MHSA Dollars	Approximate MediCaid Dollars	Approximate Number of Clients Served
Table #	Program									
	OA FCCS	$ 1,116,355	$ 1,674,533	326	$ 1,507,079	$ 2,260,619	440	$ 1,562,897	$ 2,344,346	456
	OA FSP	744,237	1,116,355	87	1,004,720	1,507,079	117	1,041,932	1,562,897	122
	Housing Trust Fund	250,000			250,000			250,000		
	COD	24,260			24,260			24,260		
	Total	$ 2,134,852		413	$ 2,786,059		557	$ 2,879,089		578

County of Los Angeles – Department of Mental Health
Options for Distributing One-Time CSS Dollars

CSS IS Plan	Child (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60 & +)	COS Unknown Age Catalog	Total
Net CSS dollars	6.20%	12.60%	66.00%	11.00%	4.20%	100.00%
Net PEI dollars	32.00%	21.00%	40.50%	5.10%	1.40%	100.00%
Net Combined dollars	12.10%	14.50%	60.20%	9.60%	3.50%	100.00%
CSS Clients	11.92%	14.16%	62.75%	11.17%	0.00%	100.00%

Unspent CSS Balance minus the BOS Priorities $ 20,000,000	Child (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60 & +)	COS Unknown Age Catalog	Total
Distribute by NET CSS	$ 1,239,099	$ 2,517,615	$ 13,208,427	$ 2,198,316	$ 836,544	$ 20,000,000
Distribute by Net CSS & PEI Combined	$ 2,417,020	$ 2,903,355	$ 12,042,069	$ 1,929,972	$ 707,584	$ 20,000,000
Distribute by CSS Clients	$ 2,383,072	$ 2,832,397	$ 12,549,760	$ 2,234,770	$0	$ 20,000,000

PSB:DWM 03/19/2013

County of Los Angeles - Department of Mental Health
Comparison of CSS and PEI Net and Gross Dollars
Fiscal Year 2012-13

CSS IS Plan	Child (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60 & +)	COS Unknown Age Catalog	Total
Clients	11.9%	14.2%	62.7%	11.2%	0.0%	100.0%
Net CSS	6.2%	12.6%	66.0%	11.0%	4.2%	100.0%
Gross	21.7%	13.7%	52.5%	9.7%	2.3%	100.0%
PEI IS Plan	**Child (0-15)**	**TAY (16-25)**	**Adult (26-59)**	**Older Adult (60 & +)**	**COS Unknown Age Catalog**	**Total**
Clients	50.0%	20.7%	26.0%	3.3%	0.0%	100.0%
Net PEI	32.0%	21.0%	40.5%	5.1%	1.4%	100.0%
Gross PEI	63.9%	22.1%	11.9%	1.7%	0.3%	100.0%

Combined	Child (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60 & +)	COS Unknown Age Catalog	Total
CSS Net	$ 14,060,826	$ 28,568,938	$ 149,884,233	$ 24,945,654	$ 9,492,789	$ 226,952,440
PEI Net	$ 21,498,253	$ 14,145,092	$ 27,278,122	$ 3,448,006	$ 917,156	$ 67,286,629
Total Net	$ 35,559,079	$ 42,714,030	$ 177,162,355	$ 28,393,660	$ 10,409,945	$ 294,239,069
Net %	12.1%	14.5%	60.2%	9.6%	3.5%	100.0%
CSS Gross	$ 88,704,189	$ 56,126,339	$ 214,251,409	$ 39,658,252	$ 9,492,789	$ 408,232,978
PEI Gross	$ 169,580,693	$ 58,696,337	$ 31,627,962	$ 4,589,814	$ 917,156	$ 265,411,962
Total Gross (Includes Net)	$ 258,284,882	$ 114,822,676	$ 245,879,371	$ 44,248,066	$ 10,409,945	$ 673,644,940
Gross %	38.3%	17.0%	36.5%	6.6%	1.5%	100.0%
One Net Dollar buys an additional…						
CSS	$ 5.3	$ 1.0	$ 0.4	$ 0.6	$ -	$ 0.8
PEI	$ 6.9	$ 3.1	$ 0.2	$ 0.3	$ -	$ 2.9
Combined	$ 6.3	$ 1.7	$ 0.4	$ 0.6	$ -	$ 1.3

Notes: (1) Based on approved IS claims submitted for FY 2012-13. (2) Costs do not include invoiced billing e.g., CSS/Flex Funds; 3) All MHSA modes of service included. 4) Costs are for DMH and contracted legal entities; 4) $ Buys (gross-net)/net

County of Los Angeles - Department of Mental Health
Community Services and Support (CSS)
CSS Unduplicated Client Counts by Age Group

FY 12-13 UNDUPLICATED CLIENT COUNT

CSS IS Plan	Child (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60 & +)	Total
ACS	352	4,077	15,348	861	20,551
FCCS - Adult	1	581	8,418	992	9,796
FCCS - Child	8,236	385	1	.	8,489
FCCS - Older Adult	.	6	360	2,588	2,887
FCCS - TAY	56	2,000	47	.	2,055
FSP - Adult	.	85	4,325	215	4,540
FSP - Child	2,222	229	2	.	2,309
FSP - Older Adult	.	.	6	461	465
FSP - TAY	12	1,499	70	.	1,532
IMD Step Down MHSA	.	54	479	31	556
Jail Transition	.	118	518	16	636
MHSA Fam Supp Svc	26	20	170	1	216
MHSA Prob Camp	321	1,282	.	.	1,538
MHSA Svcs Navi	11	847	1,326	170	2,352
MHSA TAY HOUSING	.	.	.	.	.
MHSA WRAP FSP Child	765	84	.	.	827
MHSA WRAP FSP TAY	6	152	.	.	154
Wellness	347	4,849	39,969	6,685	50,765
TOTAL ---	11,859	14,095	62,452	11,121	97,412
	11.9%	14.2%	62.7%	11.2%	100.0%

COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU-MHSA IMPLEMENTATION AND OUTCOMES DIVISION

MHSA Three-Year Program and Expenditure Plan Proposals

Prepared for 3/17/14 SLT Ad Hoc Meeting

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*Note: An * indicates that the proposals is 'no cost'.*

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23. MHSA Program Expansion Proposal: TAY Goal 3: Strategy 2 – Incorporate EBP's that address and reduce stigmatization for TAY (16-25 years old) in all school settings.*
24. MHSA Program Expansion Proposal: TAY Goal 4: Strategy 1 – Provide school based mental health and supportive services to TAY*
25. MHSA Program Expansion Proposal: TAY Goal 5: Strategy 1 – Ensure that TAY (16-25 years old) involved in and exiting from the Probation system receive appropriate services and supports to successfully achieve goals*
26. MHSA Program Expansion Proposal: TAY Goal 5: Strategy 2 – Increase opportunities to leverage resources for services and supports to crossover TAY (16-25 years old), including parenting TAY (16-25 years old)*
27. MHSA Program Expansion Proposal: TAY Goal 6: Strategy 1 – Increase TAY (16-25 years old) FSP and FCCS capacity.
28. MHSA Program Expansion Proposal: TAY Goal 6: Strategy 2 – Expand TAY (16-25 years old) Drop-In Centers for Service Areas where none currently exist.
29. MHSA Program Expansion Proposal: TAY Goal 6: Strategy 3 – Incorporate training and services (crisis oriented/trauma/co-occurring mental health and substance abuse/anxiety/depression) for TAY (16-25 years old) victims of commercial and sexual exploitation.
30. MHSA New Program Proposal: Self Help Support Groups for TAY

Adult

31. MHSA Program Expansion Proposal: Wellness Adjunct Services Goal 3: Strategy 2
32. MHSA Program Expansion Proposal: Expansion of Adult Full Service Partnership and Field Capable Clinical Services --Goal 1: Strategy 1
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35. MHSA Program Expansion Proposal: Expansion of Suicide Prevention Programs to Meet Community and Cultural Needs --Goal 11: Strategy 2
36. MHSA Program Expansion Proposal: Supported Employment Model Pilot --Goal 6: Strategy 1
37. MHSA Program Expansion Proposal: Housing Support for Wellness Programs--Goal 8: Strategy 1
38. MHSA Program Expansion Proposal: Adult FSP and FCCS –Service capacity for INN Models and Providers who demonstrate success.

Older Adult

39. MHSA Program Expansion Proposal: Older Adult FCCS
40. MHSA Program Expansion Proposal: Older Adult FSP
41. MHSA New Program Proposal: CSS OA Wellness Programs –PSW!!
42. Expansion Proposal: CSS FSP Integration Program (2-2)*
43. Expansion Proposal: Integration Mental Health First Aid Training (MHFA 3-2)*
44. Expansion Proposal: CSS Community Integration of Veterans Programs 3-3*
45. Expansion Proposal: WET OA Specialty Training Foundation and Integration of Health Care, Mental Health and Substance Abuse*
46. Expansion Proposal: WET Service Extender Training Program 5-2*

Older Adult (cont.)

47. Expansion Proposal: WET Hoarding Intervention Training*
48. Expansion Proposal: CSS Service Extender

Cross Cutting

49. MHSA New Program Proposal: Turning Tide of Stigma
50. MHSA New Program Proposal: Psychiatric Consultation Services

1. MHSA Program Expansion Proposal: Service Area Navigation Teams

MHSA Component and Work Plan	MHSA – Adult Service Area Navigation Teams Assisted Outpatient Treatment Program
What is being expanded?	Assembly Bill 1421 established the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002, known as Laura's Law. Laura's Law addresses the needs of mentally ill adults by providing a process to allow court-ordered outpatient treatment. The legislation established an option for counties to provide a way for courts, probation, and the mental health systems to address the needs of individuals who are unable to benefit from mental health treatment programs in the community without supervision. The unique programmatic component of Laura's Law is the AOT Team. These teams screen requests, conduct extensive outreach and engagement, develop petitions and manage the court processes to connect AOT enrollees with service providers primarily those who are Full Service Partnership Providers (FSP). Extensive outreach and engagement must be completed by this team in order to adequately assess for the law's detailed criteria. Successful implementation is predicated upon extensive inter-agency collaboration and provision of significant resources from the courts, County Counsel, Public Defender, the District Attorney's office, and local law enforcement. Laura's Law enrollees require higher levels of care, which may include on-site mental health and supportive services to transition to stable community placement and prepare for more independent community living. The Enriched Residential Services program will provide such services at selected Adult Residential Facilities.
Will expansion impact D.O. and C.P.?	Yes. DMH staff will be responsible for assessment and linkage, as well as, the legal, clinical, administrative, and fiscal monitoring. The treatment component of Laura's Law will be delivered primarily through FSP providers.
Estimated MHSA Budget	$ 3,800,000
Estimated Medi-Cal budget	
Other pertinent information	DMH has developed model policies, procedures and budget estimates necessary to support full implementation of Laura's Law in LA County. The scale of the program is approximately 500 evaluations per year, 300 enrollees, including about 60 crisis residential beds.

2. MHSA Program Expansion Proposal: IMD Step-Down Facilities

MHSA Component and Work Plan	MHSA – Adult Institutions for Mental Disease (IMD) Step-Down Facilities
What is being expanded?	The IMD Step-Down program will be expanded to increase by 22 additional beds. IMD Step-Down Facilities are designed to provide supportive on-site mental health services at selected Adult Residential Facilities, and, in some instances, assisted living, congregate housing, or other independent living situations. The program accommodates persons being discharged from acute psychiatric inpatient units or intensive residential facilities, or those who are at risk of being placed in these higher levels of care who are appropriate for this service. The program targets those individuals in higher levels of care who require on-site mental health and supportive services to transition to stable community placement and prepare for more independent living.
Will expansion impact D.O. and C.P.?	Yes. DMH staff at Countywide Resource Management oversees the placement activities of the program and are responsible for administrative, clinical and fiscal monitoring. Contract agencies will have the capacity to expand services to an additional 22 individuals.
Estimated MHSA Budget	$1.2 Million
Estimated Medi-Cal budget	
Other pertinent information	This program expansion will help decompress LA County Hospitals psychiatric emergency services.

3. MHSA Program Expansion Proposal: CHFFA

MHSA Component and Work Plan	MHSA – Adults Alternate Crisis Services – Urgent Care Centers and Crisis Residential Programs Investment in Mental Health Wellness Act of 2013 (SB82) California Health Facilities Financing Authority (CHFFA) Grant
What is being expanded?	Alternate Crisis Services provide 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. • Urgent Care Centers (UCC) provide intensive crisis services to individuals who otherwise would be brought to emergency rooms. • Crisis Residential Programs stabilize symptoms through medication intervention and develop social rehabilitation skills to facilitate community reintegration. DMH has requested funds from the SB82 CHFFA grant to develop four UCCs to be located on the campus of Harbor-UCLA Medical Center, South-East Los Angeles, the Antelope Valley and the San Gabriel area to serve 72 individuals at any given time and 35 new Crisis Residential Programs to increase capacity by 560 beds countywide.

Will expansion impact D.O. and C.P.?	Yes. The CHFFA grant is for capital development and does not provide ongoing service dollars for day-to-day operations of UCCs and Crisis Residential Programs. DMH staff at Countywide Resource Management oversees the placement activities of the program and are responsible for administrative, clinical and fiscal monitoring. Implementation of the additional UCCs and Crisis Residential Program will expand capacity for intensive crisis services across the County.
Estimated MHSA Budget	$3 Million
Estimated Medi-Cal budget	MCE = $1,020,000 M/C (Gross) = $990,000 Total = $2,010,000
Other pertinent information	The new UCCs are intended to decompress the County Hospital emergency rooms and acute inpatient services. Two of the four new UCCs are intended to serve as points of entry for the proposed Pre-Booking Diversion Pilot Programs and the Assisted Outpatient Treatment Programs for the AV and LB Police Departments. The new Crisis Residential Programs will increase capacity countywide.

4. MHSA New Program Proposal: Integration of Co-Occurring Mental Health & Substance Abuse Disorders

Program Name	**Integration of Co-Occurring Mental Health and Substance Abuse Disorders (COD) Treatment Practices to all Age Groups.** (COD was included in the original CSS plan for children only. This proposal is to add COD training into the 3 year plan for all age groups)
Program Description	Both the COD Integration Training Project and the Annual Integrated Care Conference provide essential support for the effective implementation of full service partnerships by continuing to develop, expand, and support fully integrated age appropriate Co-Occurring Disorder models of integrated treatment to serve Children and their caregivers, Transitional Age Youth (TAY), Adult, and Older Adult consumers affected by Co-occurring disorders.
Target Population	Children 0-15, Transitional Age Youth 16-25, Adults 26-59, and Older Adults 60 and over.
Program Goals	To build and improve a system of care utilizing age appropriate strategies that seamlessly and effectively addresses and integrates the treatment of co-occurring disorders that often significantly exacerbate the effects of mental illness.
MHSA Component (CSS, PEI)	CSS- (This program expands current MHSA fiscal commitment to Children's System of Care to include all 4 Age groups as outlined in the LAC MHSA CSS Plan.)

Intended Program Outcomes	1. Provide didactic training, consultation and education that enhances Knowledge ,Skills and Ability in the provision of integrated services to clinical staff, physicians, nurse practitioners and paraprofessional staff from DMH, contract agencies, and community partners, that provide direct Full Service Partnership treatment services to Children, Transitional Age Youth (TAY), Adult, Jail Mental Health, AB 109 populations, and selected community partners in the context of the development of Health Neighborhoods. 2. Provide ongoing consultation in person and via DMH Tele-Mental Health System to trained staff to enhance screening, assessment, treatment, care coordination and care management practices in the provision of COD services. 3. Develop programs for on-line seminars, workshops and forums to educate and train on, issues faced by these diverse populations. 4. One and one-half day Annual Conference on Integrated Care for 1,000+ attendees.
Estimated Budget (MHSA Only)	COD Training Project $144,000 per FY Integrated Care Conference $135,293 per FY **Per FY Age Group Breakdown:** Adult $179,154.56 Child $34,151.34 TAY $40,589.70 Older Adult $31,911.90 **Subtotal: $279,929 for FYs 2015-16 &2016-17** **Total $ 559,858**

5. MHSA Program Expansion Proposal: Staff for FSP/FCCS/Wellness

MHSA Component and Work Plan	CSS – FSP/FCCS/Wellness
What is being expanded?	During the last year and a half, DMH has utilized Locum Tenens (LT) psychiatrists to augment the capacity for psychiatric services in MHSA programs in order to meet the needs of the community. These additional psychiatrists will be placed at Adult outpatient clinics and Telemental Health and Psychiatric Consultation to provide psychiatric care to clients who receive services in the following existing MHSA programs: Field Capable Clinical Services, Full Service Partnerships, and Wellness Centers.
Will expansion impact D.O. and C.P.?	Yes-Directly Operated Programs

Estimated MHSA Budget	Salary and Employee Benefits (S&EB) for one (1) Mental Health Psychiatrist for FY 2014-15 is estimated at $331,091. Services and Supplies for one (1) MHP $20,750. **Total: $351,841 per MHP and $2,814,728 per FY.** Age Group Breakdown: • Child: $128,773 • TAY: $389,463 • Adult: $1,721,697 • Older Adult: $306,199
Estimated Medi-Cal budget	N/A
Other pertinent information	

6. MHSA New Program Proposal: *Promotores de Salud*/Community Wellness Workers

Program Name	Promotores de Salud/Community Health Workers
Program Description	This proposal seeks to add *Promotores de Salud* /Community Health Workers as a directly operated, cross-cutting program across age groups, within each Service Area. *Promotores de Salud*/Community Health Workers are trained and stipended community members who are trusted members of and/or have an unusually close understanding of the community served. Promotores de Salud / Community Health Workers (CHWs) generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve. These social attributes and trusting relationships enable CHWs to serve as educators, stigma busters, and as a liaison, link, or intermediary between health, mental health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competence of services. *Promotores*/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino and Asian Pacific Islander communities.
Target Population	Minority ethnic and cultural underserved individuals and families who traditionally do not seek mental health services or do not understand the symptoms of mental health as a result of cultural beliefs and/or the stigma associated with seeking mental health services. A special emphasis is on linguistic capacity to serve linguistically isolated populations.
Program Goals	General: Promotores/CHWs can enhance a community's understanding of mental health symptoms, syndromes, and available treatments. They can assist with provider-client communication; preventive care; follow-up, and referral; and navigation of the mental health/health and educational systems for all age groups. Promotores/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino communities Specifics:

	Roll Out is planned over a 3-year period. **Year 1** - Roll out of Promotores /Health Navigator Teams in each Service Area, following an established and tested model, including initial training, coaching and presentations for a small core group of participants. - Translate all prepared and available presentations from Spanish to English. - Train in-house trainers with the help of Training Consultant to assure sustainability. **Year 2** - Complete roll out and training of all selected Promotores. Increase participants as needed by SA. - Develop Strategies to adapt program to other languages and cultural groups. **Year 3** - Roll out expanded program, including translated and culturally adapted trainings, to other cultural and linguistic groups within the SA, according to the needs of the different regions.
MHSA Component (CSS, PEI)	PEI
Intended Program Outcomes	1. Decrease stigma and fear, associated with either being diagnosed with a mental illness or seeking mental health services. 2. Improve timely access to mental health services for underserved populations 3. Increase community awareness of mental health services, particularly for linguistically and culturally underserved groups. 4. Coordinate services between health/mental health service providers for community members seeking their assistance.
Estimated Budget (MHSA Only)	$912,000 - Promotores for All Service Areas $100,000 - Training Consultant $936,756 - MH Services Coordinators II (9) $121,287 - Mental Health Training Coordinator $310,506 - Administrative Costs (15%) $19,451 - Training and Presentation Supplies **$2,400,000** - Total Cost for Countywide Program

7. MHSA Program Expansion Proposal: Targeted Community Outreach and Engagement Services

MHSA Component and Work Plan	**PEI – Prevention. Multiple PEI Projects: Family Education and Support Services; At-Risk Family Services; Early care and Support for TAY & Older Adults and Improving Access to Underserved Populations.**
What is being expanded?	Outreach and Engagement. Specialized and targeted community outreach/engagement activities to increase community capacity to support individuals/families prior to, during or after receiving mental health services and reduction of mental health stigma and service disparity.

Will expansion impact D.O. and contract C.P.?	Yes, the system of care would be impacted in several ways: increased access to services for underserved populations; prevention and community education to reduce stigma and address mental health needs at an early stage or assist consumers in their recovery to be supported in the communities in which they reside; available of culturally relevant peer support and self- help services; and involvement in the development of a health neighborhood through collaboration with other community resources including place-based initiatives, faith-based, social services, etc.
Estimated MHSA Budget	$2.5 million each year for three years. Award 10 sites – one in each service area and two countywide at $250k each.
Estimated Medi-Cal budget	Activities are not Medi-Cal Reimbursable.
Other pertinent information	Services to be contracted out via a solicitation process to community-based organizations with demonstrated history of community involvement with the selected targeted communities or cultural groups.

8. MHSA Program Expansion Proposal: Housing Trust Fund

MHSA Component and Work Plan	**Adult Housing: Housing Trust Fund** Even though the MHSA plan is Adult Housing, all age groups are served including TAY, older adults and families.
What is being expanded?	Extending the current 5 year contracts which are ending for some agencies. The funding will also allow us to expand supportive services to more permanent supportive housing programs.
Will expansion impact D.O. and C.P.?	The funding goes to contracted programs but clients of both DMH and contracted agencies benefit from the housing resource.
Estimated MHSA Budget	Year 1- $313,000 Year 2 - On-going $5.4 million or $20.3 million of one-time funds to be used over 5 years.
Estimated Medi-Cal budget	N/A - These are consultant contracts and reimbursement is based on the actual costs. Services are not claimable through Medi-Cal.
Other pertinent information	Currently we have 16 agencies that provide this service to tenants in 483 units.

9. MHSA Program Expansion Proposal: MHSA Housing Program

MHSA Component and Work Plan	**Adult Housing: MHSA Housing Program** Even though the MHSA plan is Adult Housing, all age groups are served including TAY, older adults and families countywide.
What is being expanded?	An investment in capital development and operating subsidies to expand the number of affordable, permanent supportive housing units for DMH clients.
Will expansion impact D.O. and contract C.P.?	The funding is sent to California Housing Finance Agency who administers the program on behalf of the Counties. CalHFA enters into contracts with housing developers as directed by DMH. Clients of both DMH and contracted agencies benefit from the housing resource. The number of units depends on the amount allocated.

Estimated MHSA Budget	Year 1 and on-going $5 million per year (51 units/year), or $10 million of one-time funds (102 units) Average is $98,000 invested per unit for capital
Estimated Medi-Cal budget	N/A
Other pertinent information	Currently we have 41 housing developments countywide that fund a total of 912 units of permanent supportive housing dedicated for DMH clients.

10. MHSA New Program Proposal: Family Wellness/ Resource Centers

Program Name	Family Wellness/Resource Centers
Program Description	Family Wellness/Resource Centers (FWRC) are designed to act as a welcoming and family-friendly center within the community where families with children in need of mental health services can go to obtain information and resources to navigate the mental health, physical health and educational systems and participate in self-help meetings and workshops. FWRCs include a resource library and computer stations for families within the community and offers peer counseling, parent support groups and educational classes. FWRCs are located within established community organizations (e.g. Integrated School Health Centers, parks and recreational centers, children's mental health clinics, health clinics, etc.) and work in partnership with other community non-profit and government agencies. Parent Partners/Parent Advocates are integral to FWRCs.
Target Population	FWRC offers resources and self-help groups/workshops to families with children in need of mental health services.
Program Goals	1. To provide resources, training and support to families within the community caring for children with mental health problems 2. To provide family-focused information, which empower families to make informed choices and decisions 3. To enhance collaboration between parents/caregivers and community partners (e.g. mental health agencies/clinics, schools, health clinics, etc.)
MHSA Component (CSS, PEI)	CSS and PEI
Intended Program Outcomes	1. Increase timely access to services 2. Increase community awareness of mental health services
Estimated Budget (MHSA Only)	$1.5 million (proposal for two FWRCs-north and south county)

11. MHSA New Program Proposal: Respite Care Program

Program Name	Family Crisis Services: Respite Care Program
Program Description	Respite Care Services are positive, supportive services intended to help relieve families from the stress and family strain that result from providing constant care for a child with Severe Emotional Disturbance (SED), while at the same time addressing minor behavior issues, implementing existing behavioral support plans, and assisting with daily living needs.
Target Population	Respite Care will be available to parents/caregivers that are providing in-home care for a child or youth, aged 0-15, with SED and receiving mental health services (e.g. FCCS or FSP) and meets the following conditions: 1. Parents/caregivers are under significant stress as a result of the responsibility of providing constant care to the client enrolled in Child FSP. 2. Continued caretaking without respite care may result in out-of-home placement; and 3. All other available formal and informal sources of support have been exhausted.
Program Goals	Respite care is intended to provide short-term relief to caregivers that provide in-home care for a SED child to prevent out-of-home placements and preserve the family.
MHSA Component (CSS, PEI)	CSS
Intended Program Outcomes	Anticipated outcomes of the Family Crisis Services/Respite Care Program include: 1. Increase family stability and well-being 2. Reduce incidence of out-of-home placement
Estimated Budget (MHSA Only)	$1.2 million (would be able to serve about 400 families: $30/hr X 16hrs/month X 6mths)

12. MHSA Program Expansion Proposal: Children's FCCS (C-05)

MHSA Component and Work Plan	**FCCS (C-05)**
What is being expanded?	Would like to increase capacity of FCCS programs through additional funding and expansion of focal populations to include: birth to five children involved with or at risk of involvement with the Child Welfare System and children at risk of or are victims of human/sex trafficking.
Will expansion impact directly operated and contract programs?	Yes, the children's continuum of care would be able to increase capacity to serve children with mental health needs that are in the "middle": higher levels of need beyond PEI services and do not meet criteria for intensive services (e.g. Full Service Partnership) while at the same time expanding the focal populations to include children ages birth to five and victims of human/sex trafficking.

Estimated MHSA Budget	230,000 (Indigent) 2,070,000 (Match) 2,300,000 Total MHSA
Estimated Medi-Cal budget	2,070,000 (MHSA) 2,070,000 (FFP) 4,140,000 Total Medi-Cal
Other pertinent information	This expansion is anticipated to serve approximately 637 additional clients.

13. MHSA Program Expansion Proposal: Children's FSP (C-01)

MHSA Component and Work Plan	FSP (C-01)
What is being expanded?	Would like to increase capacity of Child FSP programs through expansion of focal/target population. Would like to change current focal population from: "child/youth who is involved with Probation, is on psychotropic medication and is transitioning back into a less structured home/community setting" to "child/youth who is involved with probation and is transitioning back into a less structured home/community setting or at risk of entering a restricted setting (such as Juvenile Hall, Residential Treatment Center and/or Probation Camp)."
Will expansion impact directly operated and contract programs?	Yes, with the expansion of focal population to include probation involved youth at risk of entering a restricted setting, capacity will be increased for youth involved in the Juvenile Justice System.
Estimated MHSA Budget	NA
Estimated Medi-Cal budget	NA
Other pertinent information	NA

14. MHSA Program Expansion Proposal: Children's PEI Integrated School Health Centers

MHSA Component and Work Plan	Child PEI (Integrated School Health Centers-ISHC and PEI Services)
What is being expanded?	Year 1: Conduct an evaluation of current Child PEI services including Integrated School Health Centers: review outcomes and sustainability of current EBP/PP/CDEs and data analysis of PEI service utilization trends. Years 2&3: Based on findings from above, expand PEI services through expansion of specific EBP/PP/CDEs and increase number of ISHC across all service areas (currently not offered in SA 3, 5 and 8).
Will expansion impact D.O. and CP?	Yes, the children's continuum of care would be able to increase capacity to serve children with mental health needs at an early stage and their families within the communities they reside.

Estimated MHSA Budget	200,000 (Indigent) 1,800,000 (Match) 2,000,000 Total MHSA
Estimated Medi-Cal budget	1,800,000 (MHSA) 1,800,000 (FFP) 3,600,000 Total Medi-Cal
Other pertinent information	This expansion is anticipated to serve approximately 584 additional clients.

15. MHSA New Program Proposal: Self Help Support Groups for Children

Program Name	Self-Help Support Groups for Children
Program Description	This funding will be used to establish self-help support groups for four evidence-based self-help programs: 1) Rainbows for children (4-15) who have experienced trauma, death, divorce, violence, removal from home and other losses; 2) La Leche League for at risk children 0-5 to establish healthy parental attachment; 3) Alateen for children (13-15) who have parents with mental health, substance abuse or other dysfunction in their families; 4) Because I Love You for parents of Children(10-15) with ADD, mental health and other behavioral issues.
Target Population	Children and parents needing support for the issues described above.
Program Goals	Improved outcomes for 0-5 at risk children; Having children realize that they are not to blame and are not alone in facing issues in their lives; Teens who cannot be distinguished from teens coming from functional families when compared in their 20's; Parents engaged with the mental health system and better coordination of services, as well as better outcomes for children with mental health and other behavioral issues.
MHSA Component (CSS, PEI)	CSS
Intended Program Outcomes	80 percent of 0-5 at-risk children will have excellent attachment; 80 percent of participants in Rainbows will improve communication in their families and peer relationships. After a year Rainbow participants will improve school attendance and academic performance; 60 percent of Alateen attenders will experience less negative moods and significantly more positive moods and higher self-esteem;70 percent of Because I Love You participants will express more competence in being parents of children with mental health issues;
Estimated Budget (MHSA Only)	$150,000 for all four programs. Rainbows charges $200 for each facilitator trained and $36 for materials for each child served.

16. MHSA Program Expansion Proposal: TAY System Navigators TAY Goal 2: Strategy 3 & Goal 3: Strategy 1

MHSA Component and Work Plan	CSS: SN-01 Systems Navigators
What is being expanded?	Outreach and engagement. This strategy seeks to include all school settings for TAY students as a focus of for current outreach and engagement efforts. Expand upon current: planning efforts; promotion of awareness of mental health issues; anti-stigma activities; and linking TAY students to community-based services and supports, to include various school settings.
Will expansion impact D.O. and CP?	This strategy will impact Service Area Navigation Teams and contract program providers in the Service Areas by assisting TAY students in accessing mental health and other supportive services. Collaborations between the system of care and different school settings to provide outreach and engagement (including anti-stigma activities) to school settings for TAY students.
Estimated MHSA Budget	NA – This is a focusing of a population and networking with school settings within existing outreach and engagement activities.
Estimated Medi-Cal budget	NA
Other pertinent information	Tay Goal 2, Strategy 3 and Goal 3, Strategy 1: Outreach and engage TAY (16-25 years old) in services in all school settings (i.e., high schools, alternative schools, continuation schools, community colleges, trade/vocational schools, universities, etc.).

17. MHSA New Program Proposal: Supportive Employment TAY Goal 5: Strategy 3

Program Name	TAY Supportive Employment
Program Description	Employment is an important aspect of an individual's recovery. It provides a sense of identity and structure Utilizing evidence based supportive employment services (such as the Individual Placement and Support model), TAY Supportive Employment will assist TAY, receiving mental health services and residing in permanent supportive housing (and other housing situations), to obtain and maintain gainful employment to achieve self-sufficiency. TAY Supportive Employment will incorporate effective strategies that are driven by the individual's choice and include principles that integrate with mental health treatment. The proposed funding will be utilized to train current TAY mental health providers in implementing supportive employment services within their existing mental health delivery system.
Target Population	TAY (18-25 years old)
Program Goals	Provide supportive employment services to TAY to increase their self-sufficiency by: • Obtaining and maintaining gainful employment • Maintaining stable housing

MHSA Component (CSS, PEI)	CSS
Intended Program Outcomes	75% of the TAY enrolled in the program will achieve employment success, as defined by maintaining their employment for a period of 6 months. 90% of the TAY enrolled in the program will maintain their housing situation.
Estimated Budget (MHSA Only)	$500,000 per year

18. MHSA Program Expansion Proposal: TAY Goal 1: Strategy 1 – Expand Employment and Professional Advancement Opportunities

MHSA Component and Work Plan	WET 9 Expand Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System
What is being expanded?	Not an expansion, but rather an inclusion of a TAY-focused peer certification process to prepare TAY aged individuals to work as peer advocates within the mental health system. Individuals trained would be able to provide peer services in outreaching to TAY and for TAY accessing mental health services.
Will expansion impact D.O. and C.P.?	This strategy may impact both directly-operated and contract programs in a couple of ways: 1) programs could identify TAY-aged individuals who may be interested and 2) programs may be able to incorporate TAY peer advocates within their service delivery system.
Estimated MHSA Budget	NA
Estimated Medi-Cal budget	NA
Other pertinent information	TAY Goal 1, Strategy 1: Initiate a peer certification process specifically for TAY (16-25 years old) and incorporate peer support services into existing TAY (16-25 years old) services to reduce stigma.

19. MHSA Program Expansion Proposal: Systems Navigators--TAY Goal 1: Strategy 2

MHSA Component and Work Plan	**CSS: SN-01** **Systems Navigators**
What is being expanded?	Outreach and engagement. Focused and targeted strategies (such as utilizing social media and technology) to increase engagement, access to services, and awareness of resources for TAY. Build upon existing outreach and engagement activities by utilizing different communication strategies (including, but not limited to utilization of social media and other forms of communication such as messaging/email).
Will expansion impact D.O. and C.P.?	This strategy will impact Service Area Navigation Teams and contract program providers in the Service Areas by outreaching and engaging TAY to access needed mental health and other supportive services.
Estimated MHSA Budget	NA

Estimated Medi-Cal budget	NA
Other pertinent information	TAY Goal 1: Strategy 2 – Identify specific community outreach and engagement strategies to engage TAY (16-25 years old) in services and supports (i.e. utilizing social media and technology).

20. MHSA Program Expansion Proposal: TAY Goal 1: Strategy 3 – Increase anti-stigma, anti-discrimination and suicide prevention trainings and services

MHSA Component and Work Plan	**PEI: ES-1 PEI Early Start-Suicide Prevention PEI: ES-3 PEI Early Start-Anti-Stigma Discrimination**
What is being expanded?	Anti-Stigma and Discrimination and Suicide Prevention trainings, presentations, and services. Increase the capacity for and the number of trainings, presentations, and services that address reducing stigma and discrimination and suicide prevention for TAY and to individuals/groups who work with TAY. The funding would allow for: • Capacity building: training/recertifying current staff in trainings (such as Mental Health First Aid; Question, Persuade, Refer; Applied Suicide Intervention Skills Training) to be able to provide these services to TAY and to individuals/groups who work with TAY • Presentation/training material: cover the cost of manuals and handouts associated with the increased number of trainings that are being proposed
Will expansion impact directly operated and contract programs?	This expansion will impact current directly-operated staff who are part of the Countywide Anti-Stigma and Discrimination and Partners in Suicide Prevention teams.
Estimated MHSA Budget	$75,000 (training of staff; required recertification of staff; and training materials)
Estimated Medi-Cal budget	NA
Other pertinent information	

21. MHSA Program Expansion Proposal: TAY Goal 2: Strategy 1 – Outreach and engage TAY (16-25 years old) who are victims of CSEC and educate the community (e.g., service providers; law enforcement; justice system; community-based organizations) regarding this issue.

MHSA Component and Work Plan	**CSS: SN-01 Systems Navigators**
What is being expanded?	Outreach and engagement. This strategy seeks to include victims of commercial and sexual exploitation as a priority/focus for current outreach and engagement efforts. Expand upon current: planning efforts; promotion of awareness of mental health issues; anti-stigma activities; and linking victims

	of commercial and sexual exploitation to community-based services and supports.
Will expansion impact directly operated and contract programs?	This strategy will impact Service Area Navigation Teams and contract program providers in the Service Areas by assisting victims of commercial and sexual exploitation in accessing mental health and other supportive services. Collaborations between the system of care, other County departments, and community-based organizations to provide outreach and engagement.
Estimated MHSA Budget	NA – This is a focusing of a population within existing outreach and engagement activities.
Estimated Medi-Cal budget	NA
Other pertinent information	

22. MHSA Program Expansion Proposal: TAY Goal 2: Strategy 2 – Identify and implement effective outreach models for LGBTQ TAY (16-25 years old).

MHSA Component and Work Plan	CSS: POE-01 Planning Outreach & Engagement
What is being expanded?	Planning Outreach and Engagement (POE) programs. Expand POE to include strategies to effectively outreach to the LGBTQ TAY community (inclusive of all other cultural considerations). Strategies that include outreach, engagement, and addresses reducing stigma (for this population, this may include "dual stigma" – stigma associated with mental illness and being part of the LGBTQ community) will be identified and implemented to effectively engage LGBTQ TAY into appropriate and culturally competent mental health services and supports.
Will expansion impact D.O. and C.P.?	This strategy will impact directly-operated and contract programs by how outreach and engagement is provided to the LGBTQ community. An analysis of how mental health services are currently delivered to this community would be conducted to support best practices to effectively outreach, engage, and deliver services.
Estimated MHSA Budget	NA
Estimated Medi-Cal budget	NA
Other pertinent information	Leverage TAY Goal 1: Strategy 3 (Increase anti-stigma, anti-discrimination and suicide prevention trainings and services to TAY and to individuals working with TAY), to provide these trainings and presentations for the LGBTQ community.

23. MHSA Program Expansion Proposal. TAY Goal 3: Strategy 2 – Incorporate EBP's that address and reduce stigmatization for TAY (16-25 years old) in all school settings.

MHSA Component and Work Plan	PEI-1 School Based Services
What is being expanded?	Research and integrate Evidence-Based Practices (EBPs), promising practices (PPs), and community-defined evidence (CDEs) practices that address reducing stigmatization for TAY (16-25 years old) in all school settings. These strategies that address reducing stigma would then be integrated to existing school based services.
Will expansion impact directly operated and contract programs?	This strategy will impact directly-operated and contract programs currently delivering school based mental health services.
Estimated MHSA Budget	NA – This strategy seeks to identify and implement specific EBPs, PPs, and/or CDEs that address reducing stigma in school settings.
Estimated Medi-Cal budget	NA
Other pertinent information	In conjunction with TAY Goal 1: Strategy 3 – Increase anti-stigma and discrimination and suicide prevention trainings and services to TAY, outreach will occur at school settings to provide these trainings and presentations.

24. MHSA Program Expansion Proposal: TAY Goal 4: Strategy 1 – Provide school based mental health and supportive services to TAY

MHSA Component and Work Plan	WET: WET-7 Training for Community Partners
What is being expanded?	Increase and build upon existing collaborations (such as the Community College Collaboration) to provide services and supports to TAY in different educational systems. Strategize with educational systems on ways to promote mental health services for TAY students. Through these collaborations, TAY students will be provided with information regarding mental health services, anti-stigma and discrimination presentations and supports and referrals/linkages to community-based resources.
Will expansion impact directly operated and contract programs?	This strategy will impact directly-operated and contract programs currently involved with collaborations with different educational systems. Directly-operated and contract programs in the system of care would also be impacted through the provision of outreach and engagement activities and in the delivery of needed mental health services and supports for TAY students.
Estimated MHSA Budget	NA
Estimated Medi-Cal budget	NA
Other pertinent information	

25. MHSA Program Expansion Proposal: TAY Goal 5: Strategy 1 – Ensure that TAY (16-25 years old) involved in and exiting from the Probation system receive appropriate services and supports to successfully achieve goals.

MHSA Component and Work Plan	PEI-7 Juvenile Justice Services
What is being expanded?	Juvenile Justice Services for TAY involved in and exiting from the Probation system. Ensure timely coordination with Probation Department for the delivery of mental health services and supports. Juvenile Justice Services programs and Probation Department will collaborate to provide needed mental health services for all TAY, involved in the juvenile justice system. Through this coordination, TAY who are exiting the probation system will be provided with the appropriate mental health services and supports to ensure their continuity of care as they transition back into the community.
Will expansion impact D.O. and C.P.?	This strategy would impact directly-operated and contract programs providing Juvenile Justice Services for TAY involved with and exiting from the Probation system to ensure continuity of care.
Estimated MHSA Budget	NA
Estimated Medi-Cal budget	NA
Other pertinent information	

26. MHSA Program Expansion Proposal: TAY Goal 5: Strategy 2 – Increase opportunities to leverage resources for services and supports to crossover TAY (16-25 years old), including parenting TAY (16-25 years old).

MHSA Component and Work Plan	CSS: POE-01 Planning Outreach and Engagement
What is being expanded?	With Medi-Cal and Drug Medi-Cal expansion, maximize opportunities to leverage resources to provide services and supports to crossover TAY (16-25 years old), including parenting TAY. DMH participates in Multidisciplinary Team (MDT) meetings to assess and prepare reports regarding the treatment recommendations. DMH staff also provides linkages to mental health services and supports to community-based organizations to ensure continuity of care.
Will expansion impact directly operated and contract programs?	This strategy will impact directly-operated programs currently providing services to crossover TAY as part of the MDT process. Contract programs are also impacted with the provision of mental health services and supports provided in the community.

Estimated MHSA Budget	NA
Estimated Medi-Cal budget	NA
Other pertinent information	

27. MHSA Program Expansion Proposal: TAY Goal 6: Strategy 1 – Increase TAY (16-25 years old) FSP and FCCS capacity.

MHSA Component and Work Plan	**CSS: T-01 TAY Full Service Partnership CSS: T-05 TAY Field Capable Clinical Services**
What is being expanded?	The proposal is to increase TAY FSP and TAY FCCS capacity countywide. The increase will focus on high need, low-resourced areas of the County, such as in the Antelope Valley. Additional: 20 TAY FSP slots; and 40 TAY FCSS slots
Will expansion impact directly operated and contract programs?	This proposed expansion would impact both directly operated and contract programs currently providing TAY FSP and TAY FCCS services, with the focus on high need areas of the County.
Estimated MHSA Budget	20 TAY FSP Slots: $152,000 40 TAY FCCS Slots: $100,000 = $252,000
Estimated Medi-Cal budget	20 TAY FSP Slots: $168,000 40 TAY FCCS Slots: $120,000 = $288,000
Other pertinent information	Total Budget = $540,000 per year Budget was calculated utilizing the following approximation: 50% EPSDT/Non-EPSDT 35% MCE 15% Indigent* **Non-MCE eligible*

28. MHSA Program Expansion Proposal: TAY Goal 6: Strategy 2 – Expand TAY (16-25 years old) Drop-In Centers for Service Areas where none currently exist.

MHSA Component and Work Plan	CSS: T-02 TAY Drop-In Centers
What is being expanded?	DMH contracted TAY Drop-In Centers currently exist in Service Areas 3 and 4. Two more TAY Drop-In Centers are pending. The plan is to implement TAY Drop-In Centers in all other Service Areas. 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, as the youth is ready and willing, 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.
Will expansion impact D.O. and C.P.?	This proposed expansion would impact existing (and possibly) new contract programs. A solicitation process will be utilized to award contracts for the new TAY Drop-In Centers.
Estimated MHSA Budget	$250,000 per TAY Drop-In Center x 4 (Number of Service Areas without TAY Drop-In Center = $1,000,000
Estimated Medi-Cal budget	NA
Other pertinent information	Services provided at TAY Drop-In Centers are invoiced. TAY Drop-In Centers also provide services during after-hours (weekdays and weekends). TAY Drop-In Centers submit invoices (inclusive of administrative costs) for reimbursement.

29. MHSA Program Expansion Proposal: TAY Goal 6: Strategy 3 – Incorporate training and services (crisis oriented/trauma/co-occurring mental health and substance abuse/anxiety/depression) for TAY (16-25 years old) victims of commercial and sexual exploitation.

MHSA Component and Work Plan	PEI-6 Early Care and Support for TAY
What is being expanded?	Develop 'centers of excellence' in each Service Area focusing on providing mental health services and supports to victims of commercial and sexual exploitation within this existing plan. Services and supports would include those that target crisis situations, trauma, co-occurring mental health and substance abuse, anxiety, depression and access to housing.
Will expansion impact directly operated and contract	This strategy would impact contract programs currently providing Early Care and Support for TAY under PEI and new entities (would need to complete the process to become a MHSA provider) with experience providing services to this population. These 'centers of excellence' will collaborate with other

programs?	County departments and community-based organizations to form health neighborhoods targeted at providing services and supports for this population. Targeted outreach and engagement will be conducted to the victims and the centers would provide education, training, and technical assistance regarding commercially and sexual exploitation to their Service Areas.
Estimated MHSA Budget	Approximately $500,000 (MHSA) Gross: $1,000,000 per year. Award 10 sites – two in Service Areas 2 and 6 and one in each other Service Area at $100,000 each.
Estimated Medi-Cal budget	Approximately $500,000
Other pertinent information	Services would be contracted out through a solicitation process to agencies that are able to demonstrate the ability to provide the array of services and supports for in a culturally appropriate manner for this population.

30. MHSA New Program Proposal: Self Help Support Groups for TAY

Program Name	Self-Help Support Groups for TAY
Program Description	This funding will be used to establish self-help support groups for four evidence-based self-help programs:1) Rainbows for TAY (15-18) who have experienced trauma, death, divorce, violence, removal from home and other losses; 2) La Leche League for pregnant TAY support for attachment parenting and breastfeeding; 3) Alateen for teens who have parents with mental health, substance abuse or other dysfunction in their families; 4) Because I Love You for parents of TAY (15-30) with ADD, mental health and other behavioral issues.
Target Population	TAY needing support for the issues described above.
Program Goals	Improved outcomes parents of 0-5 children; Having children realize that they are not to blame and are not alone in facing issues in their lives; Teens who cannot be distinguished from teens coming from functional families when compared in their 20's; Parents engaged with the mental health system and better coordination of services, as well as better outcomes for children and TAY with mental health and other behavioral issues
MHSA Component (CSS, PEI)	PEI
Intended Program Outcomes	80 percent parents in La Leche League will have excellent attachment with their babies; 80 percent of participants in Rainbows will improve communication in their families and peer relationships. After a year Rainbow participants will improve school attendance and academic performance. 60 percent of Alateen attenders will experience less negative moods and significantly more positive moods and higher self-esteem; 70 percent of Because I Love You participants will express more competence in being parents of TAY with mental health issues;
Estimated Budget (MHSA Only)	$150,000 for all four programs for TAY. Rainbows charges $200 for each facilitator trained and $36 for materials for each child served.

31. MHSA Program Expansion Proposal: Wellness Adjunct Services Goal 3: Strategy 2

MHSA Component and Work Plan	CSS
What is being expanded?	Expand Wellness to include adjunct services for clients in Wellness Centers who are not in need of intensive services as part of this model will include medication management, non-intensive case management, and peer support.
Will expansion impact D.O. and C.P.?	The recommendation is for implementation at 29 contract provider sites and will serve 1,000 clients per site.
Estimated MHSA Budget	Net: $250,000 per program site to enhance Wellness services. Staffing for the Wellness adjunct program to minimally include a Psychiatric Nurse and Peer Case Manager. Total: $7,250,000
Estimated Medi-Cal budget	Services are expected to be provided to a population that consists of 25% indigent and 75% Medi-Cal covered. Of the 75% Medi-Cal covered, it is expected 75% will consist of the Medicaid Expansion population, and 25% will consist of the traditional Medi-cal population, including SSI, with services matched at 50%.
Other pertinent information	This proposal suggests the implementation of the Department's "Care Clinic" model into the Legal Entity Wellness Centers. To assist in bridging Wellness clients back to the community when possible and to ensure linkage to healthcare providers.

32. MHSA Program Expansion Proposal: Expansion of Adult Full Service Partnership and Field Capable Clinical Services --Goal 1: Strategy 1

MHSA Component and Work Plan	CSS
What is being expanded?	Expand Adult Full Service Partnership (FSP) and Adult Field Capable Clinical Services (FCCS) as needed to fill identified gaps in Service Areas and ensure access to all levels of care for clients in need of services. A Wellness expansion is detailed in a separate proposal.
Will expansion impact D.O. and C.P.?	Expansion will occur in both Directly Operated and Contracted service sites.
Estimated MHSA Budget	FSP Cost per Person Served: $16,000 Total FSP Expansion – $1.6 million to serve 100 FCCS Cost per Person Served: $6,000 Total FCCS Expansion - $1.2 million to serve 200 Total Expansion: $2.8 million

Estimated Medi-Cal budget	Services are expected to be provided to a population that consists of 30% indigent and 70% Medi-Cal covered. Of the 70% Medi-Cal covered, it is expected 10% will consist of the Medicaid Expansion population, and 90% will consist of the traditional Medi-cal population, including SSI, with services matched at 50%.
Other pertinent information	Allocations will be dependent on assessment of regional needs.

33. MHSA Program Expansion Proposal: Expansion of Peer Services in CSS Programs Goal 5: Strategy 1

MHSA Component and Work Plan	CSS
What is being expanded?	Expand Peer Employment in all levels of care to increase employment opportunities within the Mental Health System for persons with lived experience and to ensure representation of lived experience on treatment teams.
Will expansion impact D.O. and C.P.?	Expansion of Peer Services is expected in both directly operated and contracted sites to work within Full Service Partnership, Field Capable Clinical Services, and Wellness Programs.
Estimated MHSA Budget	<table><tr><td>Item</td><td>Cost Per Item</td><td>Number</td><td>Total Cost</td></tr><tr><td>Community Worker</td><td>$54,289</td><td>40</td><td>$2,171,560</td></tr><tr><td>Sr. Community Worker</td><td>$62,379</td><td>10</td><td>$623,790</td></tr><tr><td>Total</td><td></td><td>130</td><td>$2,795,350</td></tr></table>
Estimated Medi-Cal budget	Mental health rehabilitation services are claimable to Medi-Cal. Services are expected to be provided to a population that consists of 30% indigent and 70% Medi-Cal covered. Of the 70% Medi-Cal covered, it is expected 30% will consist of the Medicaid Expansion population, and 70% will consist of the traditional Medi-cal population, including SSI, with services matched at 50%.
Other pertinent information	Allocation will depend on regionally identified needs.

34. MHSA Program Expansion Proposal: Increase Peer Run Services In Los Angeles County -- Goal 9, Strategy 1

MHSA Component and Work Plan	CSS
What is being expanded?	Expand Peer Run Centers to ensure availability in every service area to 14 total by implanting services in Service Areas 3 and 6. Increase support to pilot "Life Coaches" in Peer Run Centers. Expand Peer Run Center staff to ensure services are available in multiple languages and meet cultural needs. Expand PRRCH model currently to two more sites to ensure regional availability.

Will expansion impact D.O. and C.P.?	All Peer Run Centers are contracted and available to clients of contracted and directly operated programs.
Estimated MHSA Budget	

Item	Cost Per Item	Number	Total Cost
Expand Peer Run Centers to Service Areas 3 and 6	$500,000	2	$1,000,000
Life Coaches	$55,000	14	$770,000
PRRCH	$750,000	2	$1,500,000
Bilingual Peer Group Leaders	$40,000	14	$560,000
Total			$3,830,000

Estimated Medi-Cal budget	Peer Run Centers do not claim to Medi-cal.
Other pertinent information	Allocation will depend on regionally identified needs.

35. MHSA Program Expansion Proposal: Expansion of Suicide Prevention Programs to Meet Community and Cultural Needs --Goal 11: Strategy 2

MHSA Component and Work Plan	PEI
What is being expanded?	Expand the Suicide Prevention Program to address the needs of diverse cultural populations in Los Angeles County. The Suicide Prevention team provides education and intervention training for community members (schools, churches, etc.) and treatment teams. Trainings are needed in additional threshold languages identified for Los Angeles County.
Will expansion impact D.O. and C.P.?	Suicide prevention training and services will be available to contract and directly operated clinics as well as community groups. Team expansion will be centralized with the Department of Mental Health.
Estimated MHSA Budget	

Item	Cost	Number	Total
Mental Health Clinician	$104,084	8	$832,672
Training Coordinator	$121,287	1	$121,287
Total		9	$953,959

Estimated Medi-Cal budget	Services consist of community outreach and education and not claimable to Medi-cal
Other pertinent information	Need to identify culturally specific models for training.

36. MHSA Program Expansion Proposal: Supported Employment Model Pilot--Goal 6: Strategy 1

MHSA Component and Work Plan	CSS
What is being expanded?	Expand Wellness program staffing to pilot the implementation of the Supported Employment Model, an evidenced based practice, which assists clients to obtain and maintain employment.
Will expansion impact D.O. and C.P.?	Yes, expansion will benefit both Directly Operated and Contracted Programs.
Estimated MHSA Budget	Item: Medical Case Worker; Cost: $75,729; Number: 20; Total: $1,514,580
Estimated Medi-Cal budget	Mental health rehabilitation services are Medi-Cal Reimbursable. Services are expected to be provided to a population that consists of 15% indigent and 85% Medi-Cal covered. Of the 85% Medi-Cal covered, it is expected 50% will consist of the Medicaid Expansion population, and 50% will consist of the traditional Medi-cal population, including SSI, with services matched at 50%.
Other pertinent information	

37. MHSA Program Expansion Proposal: Housing Support for Wellness Programs--Goal 8: Strategy 1

MHSA Component and Work Plan	CSS
What is being expanded?	Expand Wellness programs by adding one Housing Specialist per program to ensure field capable housing support for Wellness Services to support individuals in maintaining their housing and to create service capacity for clients with a Section 8 Voucher which requires a service match to maintain. The Wellness program definition will also need to be clarified to ensure field services are available "as needed" to support housing stability.
Will expansion impact D.O. and C.P.?	Yes, expanded funds will benefit both Directly Operated and Contract Providers.
Estimated MHSA Budget	Item: Community Worker; Cost: $54,289; Number: 50; Total: $2,714,450
Estimated Medi-Cal budget	Field based mental health rehabilitation services are claimable to Medi-Cal. Services are expected to be provided to a population that consists of 25% indigent and 75% Medi-Cal covered. Of the 75% Medi-Cal covered, it is expected 30% will consist of the Medicaid Expansion population, and 70% will consist of the traditional Medi-cal population, including SSI, with services matched at 50%.

Other pertinent information	

38. MHSA Program Expansion Proposal: Adult FSP and FCCS –Service capacity for INN Models and Providers who demonstrate success.

MHSA Component and Work Plan	FSP Adult FCCS - Adult
What is being expanded?	Service capacity for INN models and INN providers who demonstrate success- IMHT (FSP), ICM (FCCS), ISM (FCCS)
Will expansion impact D.O. and C.P.?	Contracted
Estimated MHSA Budget	$5 million annually, beginning in FY 15/16
Estimated Medi-Cal budget	$3.5 million estimated
Other pertinent information	

39. MHSA Program Expansion Proposal: Older Adult FCCS

MHSA Component and Work Plan	Community Services and Supports (CSS)
What is Being Expanded?	Older Adult Field Capable Clinical Services (OA FCCS).
Will expansion impact D.O. and C.P.?	All current contract providers with OA FCCS programs.
Estimated MHSA Budget	$3,793,500 (includes Indigent & match)
Estimated Medi-Cal Budget	$2,276,100 (FFP Only)
Other Pertinent Information	The 2010 Census Report showed approximately 1.5 million adults age 60 and older, residing in Los Angeles County. This number is estimated to nearly double by 2030, in particular among the population of Hispanics, Asian-Pacific Islanders, and African-Americans who are projected to represent two third (2/3) of the County's older adult population in 2030. Access to preventative and comprehensive care that is also culturally competent is critical to addressing the physical and mental health needs of this growing population. Notably, due to the lack of funding, a high number of clients who are 60 and older are treated in the Adult FCCS programs. These client numbers are shown below per fiscal year:

	• FY 10-11= 861 • FY 11-12= 951 • FY 12-13= 993 • FY 13-14=843 The additional funding will allow us to serve 843 more OA FCCS clients. As a result, we will be able expand our capacity to treat older adults in programs designed to meet their unique needs by staff who have received specialized training to work with older adults. This plan addresses the 843 current short fall in OA FCCS and builds in an additional 20% to accommodate needed growth and program expansion. Input from the Systems Leadership Team, Older Adult System of Care Bureau (OASOCB), Service Area Advisory Committees (SAACS) and community partners support the need for more OA FCCS services throughout Los Angeles County.

40. MHSA Program Expansion Proposal: Older Adult FSP

MHSA Component and Work Plan	Community Services and Supports (CSS)
What is being expanded?	Older Adult Full Service Partnership (OA FSP).
Will expansion impact D.O. and C.P.?	Expansion will impact OA FSP contract providers.
Estimated MHSA Budget	$2,551,500 (Includes Indigent & match)
Estimated Medi-Cal Budget	$1,530,900 (FFP Only)
Other Pertinent Information	The 2010 Census Report showed approximately 1.5 million adults age 60 and older, residing in Los Angeles County. This number is estimated to nearly double by 2030, in particular among the population of Hispanics, Asian-Pacific Islanders, and African-Americans who are projected to represent two third of the County's Older Adult population in 2030. Access to preventative and comprehensive care that is also culturally competent is critical to addressing the physical and mental health needs of this growing population. The OA FSP slot and utilization data below illustrates the increasing service need for older adults. While each fiscal year shows an increase in capacity via slots, the utilization rate continues to climb: • FY 11/12 - 344 slots, with 91% utilization countywide; • FY 12/13 - 365 slots, with 92% utilization countywide; • FY 13/14, 3rd quarter - 579 slots (due to FSP/FCCS Integration Pilot), with 94% utilization countywide.

	Additionally, due to the shortage of overall slots for older adults, a high number of clients who are age 60 and older are treated in the Adult FSP program. These client numbers are shown below per fiscal year: • FY 10/11 – 213 • FY 11/12 – 240 • FY 12/13 – 215 • **FY 13/14 - 243** Additional funding to enhance the OA FSP program by 243 new slots will expand our capacity to treat older adults in programs designed to meet their unique needs by staff who have received specialized training to work with older adults. **This plan addresses the 243 current short fall in OA FSP slots and builds in an additional 20% to accommodate needed growth and program expansion.** Input from the Systems Leadership Team, Older Adult System of Care Bureau (OASOCB), Service Area Advisory Committee (SAACS) and community partners support the need for more OA FSP services throughout Los Angeles County.

41. MHSA New Program Proposal: CSS Older Adult Wellness Programs--PSWII's

Program Name	Community Services and Support Older Adult Wellness Programs
Program Description	Improve transition to appropriate levels of care with the addition of an Older Adult Specialist within Wellness Programs.
Target Population	Program would serve older adults stepping down from FSP or FCCS programs to Wellness Centers.
Program Goals	Develop older-adult specific programs and services for clients who can be seen in Wellness Centers.
MHSA Component (CSS, PEI)	Community Services and Support
Intended Program Outcomes	Improve transitions to appropriate levels of care for older adult clients. OA Specialists would be assigned to each Adult Wellness program serving 200 older adult clients.
Estimated Budget (MHSA Only)	Hiring approximately 12 PSW II's for selected Adult Wellness Programs and 1 MH Clinical Supervisor to provide administrative oversight of OA Wellness Programs. Proposed budget $1,600,000.

42. MHSA Program Expansion Proposal: CSS FSP Integration Program (2-2)

MHSA Component and Work Plan	Community Services & Support FSP Integration Program (2 – 2)
What is being expanded?	Expansion of FSP/FCCS Integration Project To include additional Older Adult Providers
Will expansion impact directly operated and contract programs?	Expansion of FSP/FCCS Integration Project will impact contract providers.
Estimated MHSA Budget	No impact to MHSA Budget
Estimated Medi-Cal budget	No impact to Medi-Cal budget
Other pertinent information	

43. MHSA Program Expansion Proposal: WET Community Integration Mental Health First Aid Training (MHFA) 3 - 2

MHSA Component and Work Plan	Workforce Education and Training Community Integration Mental Health First Aid Training (MHFA) 3 - 2
What is being expanded?	Expansion of MHFA training to community partners to sensitize them to work with older adult clients with mental illness.
Will expansion impact directly operated and contract programs?	Neither directly operated or contract programs will be impacted by this training program.
Estimated MHSA Budget	Costs limited to purchase of MHFA participant workbooks.
Estimated Medi-Cal budget	No impact on Medi-Cal budget
Other pertinent information	Only two OASOC staff members currently qualified as MFHA trainers.

44. MHSA Program Expansion Proposal: CSS Community Integration of OA Veterans Programs 3-3

MHSA Component and Work Plan	Community Services and Support Community Integration of Older Adult Veterans Programs 3 – 3
What is being expanded?	Consultation and Collaboration with veterans-specific service programs, e.g. VALOR
Will expansion impact directly operated and contract programs?	Potential impact on both directly operated and contract programs serving veterans
Estimated MHSA Budget	No additional costs identified at this time.
Estimated Medi-Cal budget	No direct impact on Medi-Cal budget.
Other pertinent information	None available at this time.

45. MHSA Program Expansion Proposal: WET Older adult specialty training – Foundation & Integration of Care for Health, Mental Health and Substance Abuse. 5 – 1

MHSA Component and Work Plan	Workforce Education and Training Older adult specialty training – Foundation & Integration of Care for Health, Mental Health and Substance Abuse 5 - 1
What is being expanded?	Training program to provide for ongoing workforce development
Will expansion impact directly operated and contract programs?	Training program would impact both directly operated and contract agencies
Estimated MHSA Budget	No estimate at this time available.
Estimated Medi-Cal budget	No impact on Medi-Cal budget
Other pertinent information	

46. MHSA Program Expansion Proposal: WET Service Extender Training Program

MHSA Component and Work Plan	Workforce Education and Training Service Extender Training Program 5 – 2
What is being expanded?	Expansion of Service Extender Program will require the training of other cohorts of community volunteers to provide support to older adult clients.
Will expansion impact directly operated and contract programs?	Service Extender Training Program will benefit both directly operated and contract agencies.
Estimated MHSA Budget	No budget available at this time.
Estimated Medi-Cal budget	No impact on Medi-Cal budget
Other pertinent information	

47. MHSA Program Expansion Proposal: WET Hoarding Intervention Training 5-3

MHSA Component and Work Plan	Workforce Education and Training Hoarding Intervention Training 5 - 3
What is being expanded?	Training of Older Adult workforce on hoarding intervention.
Will expansion impact directly operated and contract programs?	Both directly operated and contract agencies can benefit from this training.
Estimated MHSA Budget	No budget available at this time.
Estimated Medi-Cal budget	No impact on Medi-Cal budget
Other pertinent information	

48. MHSA Program Expansion Proposal: Older Adult CSS Service Extender

MHSA Component and Work Plan	Community Services and Support Service Extender
What is being expanded?	Services extender play an important role as members of multi-disciplinary treatment teams by providing peer support to older adult clients.
Will expansion impact directly operated and contract programs?	Services extenders are volunteers paid a stipend in DMH directly-operated programs, and paid staff in contract agencies.
Estimated MHSA Budget	$535,000
Estimated Medi-Cal budget	No impact
Other pertinent information	Service extenders often provide language capacity and cultural diversity that might not otherwise be achieved. OASOCB has a long history of recruiting, providing training and support of peer and community advocates.

49. MHSA New Program Proposal: The Turning Tide of Stigma

Program Name	From the Inside-Out: Turning the Tide of Stigma and Discrimination
Program Description	This funding will be used to train staff, consumers, family members and other friendly community members to counter stigmatizing and discriminatory language and behavior in the community with direct, respectful and assertive messages.
Target Population	Residents of Los Angeles County, many of whom have direct or indirect contact with mental health consumers receiving or not receiving services, including our partners in Health Neighborhoods, Behavior Centers of Excellence and faith-based communities.
Program Goals	The overarching goal is to reduce stigmatization of mental illness in Los Angeles County. By giving people the tools to respectfully educate and convey positive understandings of mental health issues, the ever growing group of sensitized people will begin the dialogues needed to dismantle prejudicial and discriminatory attitudes towards mental health. People will be equipped with behavioral tools and mechanisms to produce a positive, people first, stigma-free environment.
MHSA Component (CSS, PEI)	PEI One-time

Intended Program Outcomes	75% of participants will report actively working to replace stigmatizing behaviors with behaviors of encouragement and dignity. Additionally, this level of positive change creates the potential for a "snowball effect," resulting in sustainable, systemic change within institutions as well as individuals. Mental health service team members will report having better personal and professional skills to intervene persuasively to counteract stigma when encountered.
Estimated Budget (MHSA Only)	$250,000 to train DMH staff, contractor staff, consumers, family members, volunteers and community members.

50. MHSA New Program Proposal: Psychiatric Consultation Services

Program Name	**Psychiatric Consultation Services to DMH/DHS Collaboration Program**
Program Description	A DHS psychiatrist is funded for the provision of psychiatric services, including consultation and directive services to clients receiving mental health services through the DMH/DHS Collaboration Program. Clients will receive integrated physical and mental health services provided through a primary care provider and treatment team.
Target Population	Adults 19-59, and Older Adults 60 and older.
Program Goals	Clients will have improved access to mental health services to mental health services within a primary health setting, including prevention and early intervention efforts, as well as ongoing specialty services meet their recovery and rehabilitative goals. Decrease costs as clients are linked to health and mental health systems of care.
MHSA Component (CSS, PEI)	PEI
Intended Program Outcomes	• Consumer access to psychiatric consultation and guidance in a primary care setting regarding mental health assessment, differential diagnosis, treatment planning, psychotropic medication options and dosage, and other non-pharmacologic interventions. • Decreased symptomology of anxiety, depression, and trauma • Improve medication adherence as prescribed • Increase levels of functioning
Estimated Budget (MHSA Only)	One full-time licensed psychiatrist at $342,315 (salary and employee benefits) **Total: $342,315**

Public Review and Comment Period

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

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

MHSA THREE YEAR PROGRAM & EXPENDITURE PLAN
FISCAL YEAR (FY) 2014-15 THRU 2016-17
AVAILABLE FOR PUBLIC REVIEW

April 7, 2014

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 Three Year Program & Expenditure Plan Fiscal Year (FY) 2014-15 thru 2016-17. The Public Review and Comment period will begin April 7, 2014 and expires May 6, 2014. 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 May 22, 2014 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/announcements) and hard copies are available at the LACDMH MHSA Implementation and 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 and Outcomes Division
Attention: MHSA Three Year Program & Expenditure Plan
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA THREE YEAR PROGRAM & EXPENDITURE PLAN
Fiscal Year (FY) 2014-15 thru 2016-17
30-day Public Review and Comment Period
April 7, 2014 – May 6, 2014

PUBLIC REVIEW

Personal Information (OPTIONAL)	
Name:	
Agency/ Organization:	E-mail address:
Mailing Address:	

Comments

Any member of the public may submit written comments on or before May 6, 2014. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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

Public Hearing

PUBLIC ANNOUNCEMENT

PUBLIC HEARING OF THE

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

Thursday, May 22, 2014
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) Three Year Program & Expenditure Plan
- Provide an open forum for Public Comments on current progress of work plans and proposed MHSA Three Year Program and Expenditure Plan.

Agenda

11:30 – 12:30 PM	Reception (Lunch provided)
12:30 – 12:45 PM	Opening Session (Welcome & Introductions) - Dr. Gasco
12:45 – 12:50 PM	Overview of Public Hearing Process - Susan Rajlal
12:50 – 1:45 PM	MHSA Three Year Program & Expenditure Plan – Dr. Innes-Gomberg
1:45 – 2:50 PM	Public Comments Period - Dr. Gasco
2:50 – 2:55 PM	Close Public Comments Period - Dr. Gasco
2:55 – 3:00 PM	Motion to approve plan

- Spanish & Korean translation services will be available
- For American Sign Language and other translation services contact: Cheryl Peterson at (213) 251-6827 by Thursday, May 8, 2014
- 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 June 26, 2014.

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

Mental Health Services Act (MHSA)
Three Year Program and Expenditure Plan Overview
Fiscal Years 2014-15 Through 2016-17
Public Hearing – May 22, 2014

Purpose and Facts

- The Mental Health Services Act stipulates that counties shall prepare and submit a MHSA Three-Year Program and Expenditure Plan
- The Plan requires a 30 day public comment period and a Public Hearing
- Mental Health Director and County Auditor Controller certification as to compliance with laws and regulations
- The plan must be approved by the Mental Health Commission and adopted by the Board of Supervisors

Content of the MHSA 3 Year Plan

- Description of meaningful stakeholder involvement
- Documentation of public posting, public comments and public hearing, including any substantive changes made to the proposed plan
- Number of clients served and description of services
- Budget, including prudent reserve
- Cost per client for direct service programs
- Programmatic outcomes

Content of the MHSA 3 Year Plan

- Introduction
- Executive Summary
- MHSA Plan Approval Dates
- MHSA County Fiscal Accountability Certification
- Acronyms
- Definitions
- Community Planning Process
- Community Services and Supports (CSS) pages 15-38
  - *CSS Client Counts*
  - *CSS Programs*
  - *Full Service Partnership Outcomes*
  - *Alternative Crisis Services Outcomes*
  - *CSS Client Counts by Service Area*

Content of the MHSA 3 Year Plan

- Prevention and Early Intervention (PEI) pages 39-68
  - *PEI Client Counts*
  - *Evidence Based Practices Delivered*
  - *Early Intervention Projects and Implementation*
  - *PEI Practices Implemented*
  - *PEI Prevention Programs*
  - *PEI Outcomes*
  - *PEI Client Counts by Service Area*
  - *Training, Technical Assistance & Capacity Building*

Content of the MHSA 3 Year Plan

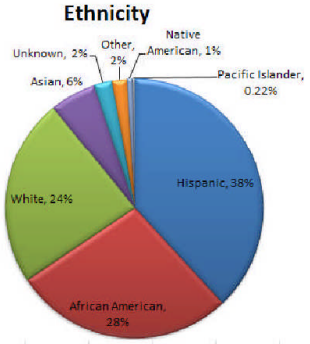
- Innovation
- Workforce Education and Training (WET)
- WET Regional Partnership
- Technological Needs
- Capital Facilities
- Fiscal Year 2014-15 through 2016-17 MHSA Services by Component
- Budget
- Appendix

Key Dates

November 2013 – January 2014	Service Area Advisory Committee Orientation, Plan Review and Recommendations
November 2013 – February 2014	System Leadership Team synthesis of information and recommendations presented to the Department of Mental Health
March 19, 2014	Presentation of the plan to the System Leadership Team
March 27, 2014	Briefing to the Mental Health Commission
April 7, 2014	Public Posting of Plan for 30 days
May 22, 2014	Public Hearing convened by the Mental Health Commission
May 30, 2014	Attestations completed by the Auditor Controller and Director of Mental Health
June 2014	Board Letter presented at Agenda Review
July 2014	Board adoption and submission to Mental Health Services Oversight and Accountability Commission

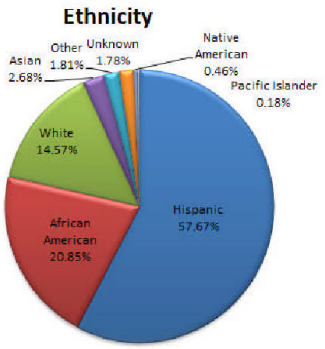
Service Summary from FY 2012-13

Unique clients receiving a direct mental health service through the CSS Plan: **97,370**



Service Summary from FY 2012-13

Unique clients receiving a direct mental health service through the PEI Plan: **73,140**



Process for Obtaining Feedback

- System Leadership Team Ad Hoc Workgroup
- System Leadership Team Expanded Membership
- Service Area Advisory Committees
  - Training, orientation and support
  - Assessment of service continuums
- Development of categories, goals and strategies by age group
- Recommendations for $30 million of unspent funds per fiscal year of CSS funding

Allocation Plan for Unspent Community Services and Supports Plan Funds

- $30 million/year for Fiscal Years 2014-15 through 2016-17
- Age group allocation agreed upon by the SLT:
  - Child: 13%
  - TAY: 13%
  - Adult: 61%
  - Older Adult: 13%

Program Expansion by Fiscal Year – Board Priorities

Assisted Outpatient Treatment (AB 1421):

- Outreach and Engagement (Service Area Navigation); These teams screen requests, conduct extensive outreach and engagement, develop petitions and manage the court processes to connect AOT enrollees with service providers primarily those who are Full Service Partnership Providers.
- FSP (primarily adult) expansion
- Residential Services program will provide such services at selected Adult Residential Facilities.
- 500 evaluations per year, serve 300 clients, including about 60 crisis residential beds.
- FYs 14/15, 15/16 and 16/17

Program Expansion by Fiscal Year - Board Priorities

IMD Step Down Program:

- Increase by 22 additional beds.
- IMD Step-Down Facilities are designed to provide supportive on-site mental health services at selected Adult Residential Facilities, and, in some instances, assisted living, congregate housing, or other independent living situations.
- The program accommodates persons being discharged from acute psychiatric inpatient units or intensive residential facilities, or those who are at risk of being placed in these higher levels of care who are appropriate for this service.
- The program targets those individuals in higher levels of care who require on-site mental health and supportive services to transition to stable community placement and prepare for more independent living.
- FYs 14/15, 15/16 and 16/17

Program Expansion by Fiscal Year - Board Priorities

Alternative Crisis Services: To accompany the SB 82 CHFFA grant (providing infrastructure), the following services will be expanded:

- Alternate Crisis Services provide 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.
- Urgent Care Centers (UCC) expansion to provide intensive crisis services to individuals who otherwise would be brought to emergency rooms. Harbor-UCLA Medical Center, South-East Los Angeles, the Antelope Valley and the San Gabriel area.
- Crisis Residential Programs (IMD Step-down) to stabilize symptoms through medication intervention and develop social rehabilitation skills to facilitate community reintegration.
- Serve 72 individuals at any given time and 35 new Crisis Residential Programs to increase capacity by 560 beds countywide.
- FYs 14/15, 15/16 and 16/17

New Programs by Fiscal Year - Child

Family Wellness Centers:

- Family Wellness/Resource Centers (FWRC) are designed to act as a welcoming and family-friendly center within the community where families with children in need of mental health services can go to obtain information and resources to navigate the mental health, physical health and educational systems and participate in self-help meetings and workshops.
- FWRCs include a resource library and computer stations for families within the community and offers peer counseling, parent support groups and educational classes.
- FWRCs are located within established community organizations.
- FYs 15/16 and 16/17

New Programs by Fiscal Year - Child

Respite Care Services:

- Positive, supportive services intended to help relieve families from the stress and family strain that result from providing constant care for a child with Severe Emotional Disturbance (SED), while at the same time addressing minor behavior issues, implementing existing behavioral support plans, and assisting with daily living needs.
- Estimated clients to be served/fiscal year: 166
- FYs 15/16 and 16/17

New Programs by Fiscal Year - Child

Self-Help Support Groups for Children:

- Establish self-help support groups using four evidence-based self-help programs:

  1) Rainbows for Children (4-15) who have experienced trauma, death, divorce, violence, removal from home and other losses;

  2) La Leche League for at risk children 0-5 to establish healthy parental attachment;

  3) Alateen for Children (13-15) who have parents with mental health, substance abuse or other dysfunction in their families;

  4) Because I Love You for parents of Children (10-15) with ADD, mental health and other behavioral issues.

- FYs 15/16 and 16/17

New Programs by Fiscal Year - Child

Mental Health Promoters:

- Trusted members of the community who generally share the ethnicity, language, socioeconomic status and life experiences of the community members they serve.
- Promoters will be paid a stipend to outreach and engage community members who could benefit from mental health services.
- FYs 14/15, 15/16 and 16/17

Program Expansion by Fiscal Year - Child

Field Capable Clinical Services:

To serve an additional 330 clients per FYs 14/15, 15/16 and 16/17

- Birth to Five children at risk or involved with DCFS
- Children at risk or victims of human/sex trafficking

Housing Trust Fund:

$250,000 for FYs 15/16 and 16/17

MHSA Housing Program:

$200,000 for FYs 15/16 and 16/17 to build permanent housing

New Programs by Fiscal Year - TAY

Mental Health Promoters:

- Trusted members of the community who generally share the ethnicity, language, socioeconomic status and life experiences of the community members they serve.
- Promoters will be paid a stipend to outreach and engage community members who could benefit from mental health services.
- FYs 2014/15, 15/16 and 16/17

New Programs by Fiscal Year - TAY

Self-Help Support Groups for TAY:

- Establish self-help support groups using four evidence-based self-help programs:
  - 1) Rainbows for TAY (15-18) who have experienced trauma, death, divorce, violence, removal from home and other losses
  - 2) La Leche League for pregnant TAY provide and support for attachment parenting and breastfeeding
  - 3) Alateen for teens who have parents with mental health, substance abuse or other dysfunction in their families
  - 4) Because I Love You for parents of TAY (15-30) with ADD, mental health and other behavioral issues
- FYs 15/16 and 16/17

New Programs By Fiscal Year - TAY

TAY Supportive Employment Services:

- TAY supportive employment will assist TAY receiving mental health services and residing in permanent supportive housing and other housing situations to obtain and maintain gainfully employment to achieve self-sufficiency.
- 75% of the TAY enrolled in the program will achieve employment success, as defined by maintaining their employment for a period of 6 months.
- 90% of the TAY enrolled in the program will maintain their housing situation.
- FYs 14/15, 15/16 and 16/17

Co-Occurring Disorders Service Training and Technical Assistance

- Provided through the UCLA Integrated Substance Abuse Program
- FY 15/16: $36,391
- FY 16/17: $36,391

Program Expansion By Fiscal Year - TAY

Housing Trust Fund:

- An investment in capital development and operating subsidies to expand the number of affordable, permanent supportive housing units for DMH clients
- Funding goes through CalHFA
- FY 14/15: $46,950
- FY 15/16: $610,000
- FY 16/17: $610,000

MHSA Housing Program:

- Extending the current 5 year contracts which are ending for some agencies
- The funding will also allow us to expand supportive services to more permanent supportive housing programs
- $550,000 for FY's 14/15, 15/16 and 16/17

Program Expansion By Fiscal Year - TAY

FSP:

Increase TAY FSP countywide capacity. This increase will focus on high need, low resourced areas of the county.

- 18 additional slots

FCCS:

Increase TAY FCCS countywide capacity. This increase will focus on high need, low resourced areas of the county.

- 36 additional clients served

TAY Drop In Centers:

- 3 additional centers
- FY 14/15, serve an additional 400 clients
- FYs 15/16 and 16/17, serve an additional 1,200 clients

New Programs by Fiscal Year - Adult

Mental Health Promoters:

- Trusted members of the community who generally share the ethnicity, language, socioeconomic status and life experiences of the community members they serve.
- Promoters will be paid a stipend to outreach and engage community members who could benefit from mental health services.
- FYs 2014/15, 15/16 and 16/17

Co-Occurring Disorders Services Training and Technical Assistance:

- Provided through the UCLA Integrated Substance Abuse Program
- FYs 15/16 and 16/17

Program Expansion by Fiscal Year - Adult

Wellness Centers:

- Service expansion to include adjunct services for clients in Wellness Centers who are not in need of intensive services, including medication management, non-intensive case management and peer support.
- Staffing for the Wellness adjunct program to minimally include a Psychiatric Nurse and Peer Case Manager
- Estimated to serve an additional 29,000 clients
- FYs 14/15, 15/16 and 16/17
- Expand staffing to implement the Supported Employment Model, an evidenced based practice to assist clients to obtain and maintain employment
  - 150 clients to be served in FY 14/15
  - 300 in FY 15/16
  - 300 in FY 16/17

Program Expansion by Fiscal Year - Adult

Wellness Centers (continued):

- Adding one Housing Specialist per program to support individuals in maintaining their housing and to create service capacity for clients with a Section 8 Voucher which requires a service match to maintain.
- The Wellness program definition will also be clarified to ensure field services are available "as needed" to support housing stability.
- Serving an additional 1,500 clients in each of FYs 14/15, 15/16 and 16/17.

Wellness/Client-Run Centers:

- Adding a total of 35 peer staff to directly operated Wellness Centers and to Client Run Centers.
- Serving an additional 1,750 clients in FYs 14/15, 15/16 and 16/17.

Program Expansion by Fiscal Year - Adult

Client-Run Centers:

- Expand Peer Run Centers to ensure availability in every service area
- Increase support to pilot "Life Coaches" in Peer Run Centers
- Expand Peer Run Center staff to ensure services are available in multiple languages and meet cultural needs
- Serving an additional 500 clients in FY 14/15, 2,000 clients in FY 15/16 and 2,000 clients in FY 16/17

FSP:

- FY 14/15 – increase slots by 25, FYs 15/16 and 16/17, increase slots by 100
- Additional slots to be added for successful Innovation models/agencies providing integrated care at the conclusion of INN Projects ($750,000)
- Expand psychiatric capacity (4) $350,000 for each of FY's 15/16 and 16/17

FCCS:

- FY 14/15 increase clients by 50, FYs 15/16 and 16/17 increase clients by 200
- Additional capacity to fund successful Innovation models/agencies providing integrated care at the conclusion of INN Projects ($250,000)

Program Expansion by Fiscal Year- Adult

MHSA Housing Program:

- An investment in capital development and operating subsidies to expand the number of affordable, permanent supportive housing units for DMH clients
- Funding goes through CalHFA
- FY 14/15: $2.5 million

Housing Trust Fund:

- Extending the current 5 year contracts which are ending for some agencies
- The funding will also allow us to expand supportive services to more permanent supportive housing programs
- FY 14/15: $156,500
- FY 15/16: $980,000
- FY 16/17: $1.6 million

Program Expansion by Fiscal Year - Older Adult

FSP:

- Increase by 109 clients for FYs 14/15, 15/16 and 16/17

FCCS:

- Increase by 407 clients for FYs 14/15, 15/16 and 16/17

Housing Trust Fund:

- Extending the current 5 year contract which are ending for some agencies
- The funding will also allow us to expand supportive services to more permanent supportive housing programs
- $250,000 per fiscal year
- **Co-Occurring Disorders Services Training and Technical Assistance:**
- Provided through the UCLA Integrated Substance Abuse Program
- FY 15/16: $24,260
- FY 16/17: $24,260

Programs to be Added or Expanded in Fiscal Year 2014/15

- Housing Trust Fund
- MHSA Housing Program
- Mental Health Promoters
- Expansion of TAY, Adult and Older Adult FSP slots
- Expansion of TAY Drop In Centers
- Expansion of TAY, Adult and Older Adult FCCS capacity
- TAY Supported Employment Services
- Wellness Center Augmentation
- Assisted Outpatient Treatment (AB 1421- Laura's Law)
- Expansion of IMD Step-Down services
- CHFFA SB 82 alternative crisis service expansion

Programs to be Added or Expanded in Fiscal Year 2015/16

- Family Resource Center
- Children's Respite Care Services
- Self-help support groups for children and TAY
- Co-Occurring Disorders training and technical assistance

Public Comment Themes Received

- Promotores Model
  - The name implies a singular focus, grounded in the Latino community
  - Name changed to Mental Health Promoters with a recognition that services will be geared toward the ethnic and cultural populations served in the Service Areas where this is implemented
- Outreach and engagement focus to engage boys and men of color, incorporating learning from the Innovation ISM model and community-informed social marketing approach
- Support for continued funding of the student mental health mini grants issued by CalMHSA, funded through PEI Statewide Project funding
- Request for clarification and recommendations on implementation (program budgets, etc.)

Action Steps

After Mental Health Commission approval and Board adoption:

- SLT Standing Workgroup re-convened to review implementation, ensuring consistency with approved and adopted plan, make recommendations to the SLT on aspects of implementation
- DMH to develop principles to guide program expansion for reviewed by SLT Standing Workgroup and SLT
- DMH to draft Board Letters to request authority to amend contracts and add positions to directly operated programs with regular reports to the SLT
- DMH to brief the Mental Health Commission and seek Commission input at agreed upon monthly meetings
- Mental Health Commission to participate on SLT Standing Workgroup
- SLT Standing Workgroup to review and make recommendations to the SLT on the 3 Year Plan "parking lot" issues

Action Steps

- SLT Standing Workgroup to work with DMH to review the next Innovation Project proposals
- SLT Standing Workgroup to review and synthesize all recommendations related to outreach and engagement strategies and make recommendations to the SLT
- SLT to make recommendations to DMH on incorporating UREP Leadership Committee recommendations
- Select outcome measures and approach to collection of outcomes for new programs
- DMH to inform DHCS of new CSS programs for reporting purposes

Estimated LA County MHSA Budget

FY	CSS*	PEI*	INN*	Total*
2012-13	$345	$86.2	$22.7	$453.9
2013-14	$271.2	$67.8	$17.8	$356.8
2014-15	$352.6	$88.1	$23.2	$467.5
2015-16	$304.3	$76.1	$20	$400.4
2016-17	$311.1	$77.8	$20.5	$409.4

*Reported in millions of dollars

- Total does not reflect current WET, CFTN or WET Regional Partnership funds
- Not inclusive of EPSDT, FFP or unspent funds from prior fiscal years
- Fiscal year budgets 2013-14 through 2016-17 are estimates based on projections by Mike Geiss, fiscal consultant for CMHDA

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MHSA. PLAN THREE-YEAR PROGRAM AND EXPENDITURE PLAN
LOS ANGELES, CA
5/22/14
CAPTIONED BY TOTAL RECALL, www.yourcaptioner.com

DR. INNES-GOMBERG REVIEWED SLIDES THAT SUMMARIZED THE NUMBER OF CLIENTS DIRECTLY SERVED AND THEIR ETHNIC BREAKDOWN FOR CSS AND PEI PROGRAMS FOR FY 2012-13. DR. INNES-GOMBERG THEN SUMMARIZED A PLAN TO SPEND $30 MILLION OF UNSPENT CSS FUNDS FOR EACH OF THE NEXT FISCAL YEARS, INVOLVING PROGRAM EXPANSIONS AND NEW CSS PROGRAMS.

PUBLIC COMMENTS PERIOD COMMENCES AT 1:26 P.M.

RIGO RODRIGUEZ: YOU BROKE A RECORD.
(APPLAUSE)

SHE BROKE A RECORD BY FOUR MINUTES, YAY. SO WHY DON'T WE DO THIS. IT IS 1:26. TAKE FOUR MINUTES TO PREPARE PUBLIC COMMENTS.

SO WE'RE GOING TO HAVE ABOUT 60 MINUTES AGO OR SO FOR PUBLIC COMMENTS. TAKE A LITTLE BIT OF TIME TO JUST FILL OUT THE COMMENT CARD, WHAT THINGS THAT YOU LIKE ABOUT WHAT YOU HEARD.
WHAT QUESTIONS DO YOU HAVE OR ANY SUGGESTIONS THAT YOU HAVE.
SO TAKE THE TIME TO WRITE DOWN THOSE COMMENTS.
AT 1:00.

DR. HERMAN DEBOSE: I JUST HAVE A QUICK QUESTION FOR DEBBIE.
IS THERE A REASON THAT THE COMMISSION WAS LEFT OUT OF THE ACTION STEPS? THAT YOU IMPLEMENT THAT YOU WANT TO IMPLEMENT? I KNOW YOU SAID AFTER THE APPROVAL.

RIGO RODRIGUEZ: SO, I THINK ABOUT TWO MORE MINUTES AS THEY CLARIFY SOMETHING. SO THERE'S TWO MICS ONE ON EACH SIDE AND THERE'S A LONELY MIC DOWN HERE IN CASE YOU WANTED TO BE FIRST IN LINE AS WELL. LET ME SEE A SHOW OF HANDS, HOW MANY OF YOU WOULD LIKE TO GIVE OR OFFER A PUBLIC COMMENT TODAY? JUST RAISE YOUR HAND. LET ME JUST EYE BALL IT, ONE, TWO (COUNTING).SO IT SOUNDS LIKE ABOUT 20 OF YOU WANT TO MAKE A PUBLIC COMMENT. SO LET'S DO THIS.
INSTEAD OF ONE MINUTE, YOU'LL HAVE TWO MINUTES, IF THAT'S OKAY.
THAT WILL GIVE YOU MORE TIME TO EXPRESS YOUR VIEWS BUT THEN WE'LL BE REALLY RIGID TO THE TIME-LIMIT. TWO MINUTES.

SO, IT LOOKS LIKE ABOUT 20-25 OF YOU. SO, OKAY ON SO WITH THAT, LET'S GO AHEAD AND BEGIN OUR PUBLIC COMMENTS.

CAN I ASK FOLKS THAT ARE TALKING IF YOU COULD START WINDING DOWN YOUR COMMENTS, IN OTHER WORDS, AS WE SAY, VERY HUMBLY, SHHHH. THANK YOU.

AND SO, ONE LAST INTRODUCTION SO YOU GET TWO MINUTES, BELINDA OVER HERE WILL LET YOU KNOW WHEN YOU HAVE 30 SECONDS TO GO AND WHEN YOUR TIME IS UP; OKAY? AND THEN, SHHHH. THANK YOU.

AND THEN FINALLY, SOMETIMES YOUR COMMENTS OR QUESTIONS WILL INVOLVE MAYBE A DEPARTMENT REPRESENTATIVE RESPONDING TO YOUR QUESTION SO I WILL DEFER TO DEBBIE OR TO DENNIS IF THEY HAVE A RESPONSE JUST LET ME KNOW, OKAY?

SO WITH THAT, LET ME START ON THIS SIDE.

AUDIENCE MEMBER: SO GOOD AFTERNOON COMMISSIONERS MY NAME IS MARIKO KAHN AND I AM WITH PACIFIC ASIAN COUNSELING SERVICES AND ALSO ON BOARD WITH OF THE ASIAN PACIFIC PLANNING COUNSEL. WE APPROVE OF THE BROAD DETAILS OF THE PLAN AND ONCE APPROVED, THE WORK OF IMPLEMENTING ADHERENCE TO THE SPIRIT OF THE PLAN WILL CONTINUE AND WILL NEED YOUR OVERSIGHT. OUR CHIEF CONCERNS DURING IMPLEMENTATION ARE, FIRST, WITH THE ADDITION OF FSP SLOTS API'S ARE VERY CONCERNED WITH HOW THEY WILL BE ALLOCATED.

THE INITIAL ALLOCATIONS OF SERVICE AREAS DID NOT SUFFICIENTLY ALLOCATE THE SLOTS TO THE AGENCIES THAT CAN BEST SERVE API'S AND I MIGHT THINK IT APPLIES TO OTHER ETHNIC GROUPS.

TWO, WE STRONGLY SUPPORT FUNDING FOR THE CONTINUATION OF IDENTIFIED SUCCESSFUL PROJECTS UNDER THE INNOVATION PLAN.
API'S HAVE LEARNED THE STRONG NEED FOR ONGOING COMMUNITY BASED OUTREACH AND ENGAGEMENT. WE HOPE THAT THESE EVIDENCE SUPPORTED LEARNINGS WILL CONTINUE TO BE SUPPORTED.

THREE, AS AN AGENCY AND THREE SERVICE AREAS, I HOPE THE SPECIFIC NEEDS IDENTIFIED BY EACH SERVICE AREA WILL BE CONSIDERED AND IMPLEMENTED AS MUCH AS POSSIBLE. IT IS IMPORTANT THAT THIS TYPE OF INDIVIDUALIZATION BE RESPECTED BECAUSE EACH SERVICE AREA IS UNIQUE WITH DIFFERENT NEEDS. FLEXIBILITY IS NEEDED.

FOURTH, OVER AND OVER AGAIN DURING THE PLANNING PROCESS, THERE WERE MANY REQUESTS TO REMOVE THE SILOS BETWEEN FUNDING SUCH AS FSP AND FCCS AND TO SIGNIFICANTLY REDUCE THE PAPERWORK WHICH BURNS OUT OUR STAFF AND INCREASES COSTS NEEDLESSLY AND I HOPE THE COMMISSION WILL CONTINUE TO PROVIDE OVERSIGHT FOR THOSE THINGS. THANK YOU.

RIGO RODRIGUEZ: THANK YOU.LET'S GO OVER TO THIS SIDE.

AUDIENCE MEMBER: GOOD AFTERNOON MY NAME IS PATRICIA DAWSON. I'M FROM WICKER STATE (sic), # 500 SOUTH VERMONT BOULEVARD I'M AN ADVOCATE, VOLUNTEER AND A CONSUMER. AND, MY FIRST QUESTION WAS TO DR. DEBBIE I WANT TOP EXACTLY WHAT SUPPORT EMPLOYMENT MODEL WHAT EXACTLY IS THAT MODEL?

RIGO RODRIGUEZ: DO YOU NEED A RESPONSE RIGHT NOW?

AUDIENCE MEMBER: I CAN WAIT.

RIGO RODRIGUEZ: SHE'LL RESPOND TO THAT QUESTION. GO AHEAD WITH YOUR OTHER COMMENTS.

AUDIENCE MEMBER: THANK YOU. AS A PART OF THE WOMEN'S INTEGRATION PROGRAM IT'S A PART OF RESTORATION BACK INTO THE COMMUNITY WE WORK WITH WOMEN THAT MAY OR MAY NOT HAVE CRIMINAL HISTORIES. WOMEN WITH OR WITHOUT CHILDREN. THE PROGRAM MY PEERS IS SUCH A UNIQUE AND EXCEPTIONAL PROGRAM AND WHAT WE DO IS REINTEGRATE BACK INTO THE COMMUNITY AND ONE OF OUR PROBLEMS IS AS WE ALL KNOW UNEMPLOYMENT IS VERY HIGH AND EXTENSIVE BUT ALSO WITH A MENTAL HEALTH SITUATION GOING ON, IT'S EVEN HIGHER. SO, WHAT I WAS WONDERING IS IS IT POSSIBLE AND HOW AND WHOM DO I TALK TO REGARDING SOME TYPE OF ON-THE-JOB TRAINING, REGARDING THE FUNDING THAT HAS BEEN GIVEN AND THAT WE ARE IN SERVICE AREA 6 IF ANY OPINION NEEDS TO KNOW? BUT I NEED SOME HELP IN ADVOCATING FOR US TO BECOME SELF-SUFFICIENT IN OUR LIFESTYLES AND CONTINUE TO THRIVE.

RIGO RODRIGUEZ: THANK YOU SO MUCH. SO THEN THERE'S TWO QUESTIONS ONE IS WHAT IS THAT EMPLOYMENT PROGRAM THAT'S REFERENCED HERE, RIGHT? AND THEN, THE ON THE JOB TRAININGS RESOURCE DOES THAT COVER IT OR --

AUDIENCE MEMBER: NO. IT DIDN'T COVER. IT DID ANSWER SOME QUESTIONS REGARDING EMPLOYMENT FOR MY PEERS BUT, HOWEVER, I'M LOOKING AT THE WHOLE ENTIRE COMMUNITY IS AND THE WOMEN IN OUR COMMUNITY AND THE WOMEN THAT WE SERVICE.

DR. INNES-GOMBERG: SO, THE ANSWER TO SUPPORTED EMPLOYMENT IT'S A EVIDENCE BASED MODEL THAT -- THAT SAMHSA HAS ENDORSED AND BASICALLY IT STARTS OFF IF I AM A CLIENT THAT WANTS TO WORK YOU'RE GOING TO HELP THEM FIND A JOB AND YOU'RE GOING TO SUPPORT THEM ON THE JOB. SO IT'S A WONDERFUL EVIDENCE BASED PRACTICE THAT AGENCIES THAT HAVE ADOPTED IT HAVE ACTUALLY HAD THE OPPOSITE STATISTICS OF EMPLOYMENT THAT WE DO. AND USUALLY IT'S ABOUT 95 PERCENT OF

PEOPLE ARE EMPLOYED AS OPPOSED TO SAY FIVE TO TEN PERCENT. SO IT'S A VERY EFFECTIVE EVIDENCE BASED PRACTICE.

RIGO RODRIGUEZ: SO IN THIS PLAN, THERE ARE RESOURCES SO THAT ORGANIZATIONS CAN IMPLEMENT THAT MODEL THAT HAS BEEN REALLY SUCCESSFUL IN TARGETING THE COMMUNITIES THAT WE'RE REFERRING TO THAT WE'RE TALKING ABOUT IN GETTING EMPLOYMENT SO THAT'S WHAT THAT PARTICULAR PROGRAM REFERS TO.

AUDIENCE MEMBER: WELL WE ONCE HAD A PEER PROGRAM BUT THEY TOOK THE FUNDING SO -- THE IS THE FUNDING BACK? I MEAN DO WE HAVE THE FUNDING STILL? IS IT GOING TO COME BACK THIS FISCAL YEAR?

RIGO RODRIGUEZ: LET ME POSE THAT QUESTION AND COME BACK TO YOU ON THAT. LET ME COME BACK -- THE WAY I'M UNDERSTANDING IS IF THERE ARE PROGRAMS THAT HAVE BEEN RECEIVING RESOURCES AND THEY DON'T HAVE RESOURCES THEN WHAT HAPPENS TO THOSE PROGRAMS, RIGHT?

AUDIENCE MEMBER: THAT AND HOW CAN WE BRING THEM BACK OR WHATEVER TYPE OF PROGRAM BECAUSE THE NAME AND TITLES ALWAYS SEEM TO CHANGE BUT WE WANTED THAT TYPE OF PROGRAM TO INSTILL --

RIGO RODRIGUEZ: SO WE GOT THAT QUESTION UP THERE AND IT WILL BE PART OF THE RESPONSE GIVEN TO YOU. LET'S GO.

AUDIENCE MEMBER: HELLO MY NAME IS SUSAN FRIEDMAN, I CHAIR THE COMMITTEE ON CSEC, COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN -- WHICH IS KNOWN AS SEX TRAFFICKING. DEBBIE WAS TALKING ABOUT THE PRIORITIES OF THE BOARD OF SUPERVISORS.PROBABLY ONE OF THE MOST SIGNIFICANT PRIORITIES OF THE BOARD OF SUPERVISORS RIGHT NOW --

RIGO RODRIGUEZ: FOLKS THERE ARE DIFFERENT CONVERSATIONS HAPPENING IN THE BACKGROUND AND I WANT TO KNOW WE ALSO TRANSCRIBE ALL OF THIS INFORMATION. SO SOMETIMES IF FOLKS ARE SPEAKING IN THE BACKGROUND OUR TRANSCRIBER CAN'T HEAR SO WE REALLY APPRECIATE IT AND IF YOU DO HAVE SOMETHING URGENT THAT YOU NEED TO TALK TO, YOU CAN STEP OUTSIDE AND HAVE THAT CONVERSATION OUTSIDE. THIS WAY WE CAN MAKE SURE EVERYTHING IS RECORDED, MY APOLOGIES FOR INTERRUPTING YOU. WE'LL GIVE YOU THE TIME AGAIN. START OVER AGAIN.

AUDIENCE MEMBER: I'M SUSAN FRIEDMAN I'M A COMMISSIONER ON THE COUNTY COMMISSION FOR CHILDREN AND FAMILIES I CHAIR THE COMMITTEE ON CSEC WHICH IS COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN WHICH IS ACTUALLY SEX TRAFFICKING OF CHILDREN -- CHILDREN FROM THE AGES OF 12 TO 17, 80 PERCENT OF WHOM ARE FOSTER CHILDREN.

THIS IS A -- DEBBIE WAS MENTIONING A PRIORITY OF THE BOARD OF SUPERVISORS, THIS IS A PRIORITY -- AND IT IS NOT ONLY A PRIORITY OF THE BOARD OF SUPERVISORS IT IS A PRIORITY OF THE CONGRESS THERE'S DOZENS OF BILLS ADDRESSING THIS. I WENT TO A MEETING LAST WEEK OF ALL THE GROUP HOMES WHO REALLY WANT TO CARE FOR THESE GIRLS WHO WANT TO TRAIN THEIR PEOPLE TO CARE FOR THESE GIRLS. WHO WILL SET ASIDE BEDS TO CARE FOR THESE GIRLS AND UNANIMOUSLY THEY ALL SAID YOUR PAPERWORK WAS MORE TRAUMATIC THAN DEALING WITH THESE GIRLS.SO, ONE, I NEED TO SEE SOMETHING IN HERE THAT SETS ASIDE MONEY FOR TRAINING, FOR THERAPY FOR THESE GIRLS.
I SEE HERE CHILDREN HAT RISK OF HUMAN SEX TRAFFICKING BUT IT'S JUST LIKE LUMPED INTO SOMETHING. IT REALLY NEEDS TO BE SET ASIDE AND I KNOW THAT THIS WEEK YOU CAME UP WITH $20 MILLION OF EXTRA P.E.I. MONEY, SOME OF THAT MUST GO TO CSEC WE MUST ADDRESS THIS PROBLEM NOW BEFORE IT GETS SO OUT OF HAND THAT WE HAVE LOST THE BATTLE.

DR. INNES-GOMBERG: SUSAN, IF YOU COULD –(APPLAUSE) YOU MENTIONED TRAINING ON YOUR PUBLIC COMMENT IF YOU COULD WRITE DOWN WHAT TRAINING THAT MIGHT BE --

AUDIENCE MEMBER: I DON'T KNOW THE TRAINING YOU GUYS KNOW THE TRAINING. I DON'T KNOW THE TRAINING. I DON'T KNOW THE TRAINING BUT I ASSUME YOU KNOW HOW TO DO THE TRAINING AND IT IS VERY COMPLICATED. I KNOW.

DR. MARVIN SOUTHARD: MAYBE I CAN BE HELPFUL. THE SECOND DISTRICT AND THE DEPARTMENT SCHEDULED THE TRAINING. BROUGHT IN A CONSULTANT THAT'S BEEN WORKING WITH THE PROBATION DEPARTMENT FOR THE LAST SEVERAL YEARS TO DO TRAINING FOR THE MENTAL HEALTH STAFF ON THE BEST APPROACHES FOR THE TREATMENT AND ENGAGEMENT OF THE VICTIMS OF CHILD SEX -- THIS TRAFFICKING ISSUE. THAT IS CONTINUING AS A PART OF A COUNTY STRATEGIC PLAN FOR MULTIPLE DEPARTMENTS WORKING TOGETHER. EMBODIED IN THIS PLAN IS PART OF DMH'S RESPONSE IT THAT OVERALL APPROACH. THIS DEPARTMENT AS WELL AS OTHER DEPARTMENTS DO A REGULAR REPORT BACK TO THE BOARD OF SUPERVISORS FOR PRECISELY THE REASONS THAT YOU HAVE ARTICULATED ON THIS MATTER. SO YOU'RE ABSOLUTELY RIGHT, TRAINING IS AN IMPORTANT COMPONENT AND WE'RE ALREADY BEGUN TO BE ENGAGED IN THIS PROCESS. SO THAT'S PART 1.

PART 2 IS IF YOU'RE GOING TO BILL FOR MEDI-CAL SERVICES YOU GOT TO DO THE PAPERWORK OR YOU'LL GET AN AUDIT EXCEPTION AND THE STATE WILL TAKE BACK YOUR MONEY. SO THAT PART WE HAVE DONE TRAINING BEFORE AND THE GROUP HOME PROVIDERS I THINK ARE FAMILIAR WITH THAT IF THEY HAVE A CONTRACT WITH US FOR MEDI-CAL SERVICES BUT, YOU KNOW, IT'S

LIKE THAT'S PAYING THE PIPER, IT'S LIKE IF -- WE HAVE TO FOLLOW THOSE RULES, THE PAPERWORK IS WHAT IT IS. UNTIL THOSE ISSUES ARE CHANGED AT THE FEDERAL LEVEL THAT'S JUST REALLY WHAT WE GOT TO DO. IT'S MEANT TO CONTROL FRAUD AND ABUSE IS THAT'S WHY THE PAPERWORK IS LIKE IT IS.

RIGO RODRIGUEZ: WE APPRECIATE YOUR COMMENTS I DO HAVE TO GO ONTO THE NEXT PERSON SO WE GIVE EVERYBODY AN OPPORTUNITY TO SPEAK. I REALLY APPRECIATE YOUR COMMENTS. I'M SORRY TO JUMP IN HERE BUT THANK YOU SO MUCH. LET'S GO OVER GIVE -- AGAIN EVERYBODY HAS IMPORTANT ISSUES SO SOMETIMES I'M THE BAD GUY HERE. SO GO AHEAD.

AUDIENCE MEMBER: MY NAME IS CATHERINE CLAY I'M THE AMBASSADOR OF WOMEN'S INTEGRATION AND I'M ALSO A PEER SPECIALIST I WOULD LIKE TO SAY I'M VERY HAPPY OF THE MHSA. HOUSING BUT I WOULD LIKE TO ELABORATE TO THE TRAINING THAT WE NEED TO IMPLEMENT WHEN -- INSIDE THAT OF PARTICULAR ENTITY.I THINK SOME OF THE THINGS THAT MUST THOSE PEERS NEED TO HAVE IS HEALTH NAVIGATIONAL TRAINING AND MENTAL HEALTH FIRST AIDERS AND ECPR TRAINING JUST BECAUSE I CURRENTLY LIVE IN M.H.S.A. HOUSING AND SOME OF THE ISSUES THAT I INCURRED HAVE BEEN DEALING WITH THOSE PARTICULAR TOPICS.
SO IF WE'RE GOING TO PUT PEER SPECIALIST IN THOSE POSITIONS I BELIEVE THAT THOSE ARE THE THREE CERTIFICATIONS THAT NEEDS TO COME WITH THOSE POSITIONS BECAUSE YOU'RE DEALING WITH ONSITE AND IT ALSO FREES UP THE CLINICAL STAFF SO A HEALTH NAVIGATOR CAN COMMUNICATE WITH THREE DIFFERENT CLINICS INSTEAD OF HAVING THREE DIFFERENT CLINICS INSIDE OF THAT ONE M.H.S.A. HOUSING. SO I THINK THAT'S ONE OF THE IMPORTANT THINGS THAT WE NEED TO IMPLEMENT AND IT ALSO HELPS OUT FOR SUPPORT OF EMPLOYMENT.

RIGO RODRIGUEZ: THANK YOU FOR THE COMMENT.LET'S GO OVER TO OUR NEXT PERSON.

AUDIENCE MEMBER: GOOD AFTERNOON I'M AUJANAY FROM MENTAL HEALTH AMERICA IN ANTELOPE VALLEY AND I'D LIKE TO KNOW HOW THIS PLAN ADDRESSES THE UNMET NEEDS IN THE ANTELOPE VALLEY IN TERMS OF PSYCHIATRY AND ALSO FSPS SLIGHT INCREASE.

RIGO RODRIGUEZ: THANK YOU FOR THAT QUESTION LET ME REITERATE THAT QUESTION TO DEBBIE, HOW DOES THIS PLAN ADDRESS THE PSYCHIATRIC NEEDS IN SERVICE AREA ONE ANTELOPE VALLEY AND --

AUDIENCE MEMBER: AND ALSO FSP FUNDRAISING.

DR. INNES-GOMBERG: ONE OF THE URGENT CARE CENTERS IS SLATED TO BE IN ANTELOPE VALLEY. WE WILL MAKE SURE THAT ANTELOPE VALLEY IN TERMS OF THE SLOTS FOR FULL SERVICE PARTNERSHIP PROGRAMS ACROSS AGE GROUPS THAT ADDED THEM, THAT ANTELOPE VALLEY WILL BE ADDRESSED IN THAT WAY.I THINK AT THIS POINT, WE DON'T HAVE DETAILS BEYOND THAT UNLESS THERE'S SOMEBODY IN DMH THAT CAN SAY MORE ABOUT THIS. I'M LOOKING AROUND.ANY OF THE AGE GROUPS? NO.OKAY, BUT YOUR COMMENT IS WELL-NOTED. THANK YOU.

RIGO RODRIGUEZ: AND JUST KNOW, THE SYSTEM LEADERSHIP TEAM THAT DEBBIE REFERENCED IS GOING TO BE ONE OF THE GROUPS THAT'S GOING TO FOLLOW UP ON ALL THESE THINGS THAT THERE WOULD BE A SERVICE AREA ADVISORY COUNCIL FOR SERVICE AREA ONE IN THESE GROUP -- IN THIS GROUP TO MAKE SURE THERE'S FOLLOW-THROUGH ON THIS. SO THANK YOU. LET'S GO OVER TO THIS OTHER SIDE AND IT WOULD BE REALLY GREAT IS IF AFTER YOU GIVE US YOUR COMMENT YOU COULD EITHER GIVE US YOUR COMMENT CARD OR TURN IT IN OVER AT THE CORNER SO WE HAVE A DOCUMENTATION OF YOUR COMMENT. SO NEXT PERSON OVER ON THIS SIDE.

AUDIENCE MEMBER: HELLO I'M WILLIAM LAJAIRE I'M FROM THE BLACK COALITION GANG COALITION, AND I'M EXCITED ABOUT THE NEW MHSA. PROGRAM FOR ALL AGE GROUPS FROM SOUTH TO OLDER ADULTS. THE ONE THING YOU GIVE ALL THIS MONEY FOR THESE NEW PROGRAMS, BUT WHAT ABOUT THE COALITION? YOU KNOW THE LACCC, AND THE BLACCC AND THE ASIAN AND LATINO, WE GET -- EVERY YEAR WE GET $15,000 A YEAR.
AND I KNOW DR. SOUTHARD HAS SAID THAT DHM DOES NOT HAVE THE MONEY TO PAY US MORE.BUT (INAUDIBLE) HAVE BEEN TRYING TO BRING IN MORE MONEY TO HELP BLACKS WITH SUPPORT EMPLOYMENT, FOR HOUSING AND OTHER ISSUES. I WANT DEBBIE TO COMMENT ON THAT. THANK YOU.

DR. INNES-GOMBERG: THANK YOU.WE'LL TAKE THAT BACK. THE UREP LEADERSHIP GROUP ADDRESSES THE NEEDS OF THE DIFFERENT UNDERREPRESENTED ETHNIC POPULATIONS AND THE ASSOCIATIONS WITH THEM. SO I'M GOING ON TO HAVE TO TAKE THAT BACK TO UREP.

AUDIENCE MEMBER: IT IS MY UNDERSTANDING THAT THOSE PEOPLE WHO ARE EMPLOYED AS CERTIFIED PEER SPECIALISTS ARE ONCE THEY GET THE TRAINING WHEN THEY GO TO THEIR CENTERS, AND START DOING THE WORK THEY'RE NOT DORKS ASSIGNED TO DUTIES THAT ARE RELATED TO THEIR TRAINING AND THAT THEY -- AND THAT NEEDS TO HAPPEN. ONE OF THE SUGGESTIONS THAT CAME UP AS A RESULT OF THAT -- ON THE NATIONAL MENTAL HEALTH CONSUMERS SELF-HELP CLEARING HOUSE WAS THAT THERE WAS -- WAS THAT THEY LOOK AT WHAT OTHER STATES HAVE DONE AND IF YOU GUYS LOOK AT WHAT OTHER STATES HAVE DONE READ THOSE -- AND UNDER THE MENTAL HEALTH SERVICES ACT AS FAR AS I'M CONCERNED, AND I DON'T CARE WHERE BUT BRING IT IN, AND MAKE SURE THAT THERE'S A

MONITORING TYPE PROCESS SO THAT THE -- SO THAT THE PEOPLE WHO ARE CERTIFIED AS PEER SPECIALISTS ARE DOING WHAT THEY'RE TRAINED TO DO.

RIGO RODRIGUEZ: SO THE CONCERN IS THAT -- I'M SORRY DID YOU FINISH YOUR COMMENT?

AUDIENCE MEMBER: YES I THINK I DID.

RIGO RODRIGUEZ: ARE YOU DONE?

AUDIENCE MEMBER: I CAN GIVE YOU SOME MORE. LOOK AT OTHER STATES AND WHAT THEY'VE DONE.

RIGO RODRIGUEZ: ALL RIGHT THANK YOU MARK FOR THAT COMMENT. LET'S GO OVER TO THE OTHER SIDE.

AUDIENCE MEMBER: MY NAME IS BARBARA WILSON I'M A MENTAL HEALTH ADVOCATE FOR SERVICE AREA 2 AND I DO APPRECIATE ALL OF THE HARD WORK THAT EVERYONE HAS DONE. I JUST WANTED TO ASK A QUESTION AND I'M NOT SURE WHETHER OR NOT THIS IS AN APPROPRIATE QUESTION FOR THIS VENUE. BUT I CONTINUE TO BE CONCERNED ABOUT THE DWINDLING OF LICENSED BOARD AND CARE HOMES. IN PARTICULARLY ALL I KNOW ABOUT IS SERVICE AREA 2 WE HAVE NO NEW HOMES WE HAVE A LOT OF FACILITIES THAT ARE LICENSED BUT THEY WILL NOT ACCEPT PEOPLE THAT HAVE A PRIMARY MENTAL ILLNESS DIAGNOSIS. THERE'S ABSOLUTELY NO INCENTIVE TO HAVE A NEW LICENSE. ON THE OTHER HAND WE SEE A HUGE NUMBER OF FACILITIES THAT ARE GROWING THAT ARE UNLICENSED AND THEY'RE MAKING IT VERY DIFFICULT FOR ACCEPT AMBIGUOUS OF ANY FACILITIES IN OUR R1 AND R2 ZONES SO I'M JUST WAND WANTING TO CALL THAT OUT. THANK YOU.

RIGO RODRIGUEZ: ANY COMMENTS ON THAT?

DR.INNES-GOMBERG: I THINK WE'LL NOTE THAT. COMMUNITY CARE LICENSING IS THE ONE THAT OVERSEES BOARD AND CARES AND ADULT RESIDENTIAL FACILITIES BUT I THINK I HEARD YOU TALK ABOUT THAT WHEN I WAS AT THE SAAC 2 MEETING

RIGO RODRIGUEZ: LET'S GO OVER TO THE OTHER SIDE.

AUDIENCE MEMBER: HI MY NAME IS JOHN CERNAK. I'M ADVOCATING FOR LONG BEACH SERVICE AREA 8 BUT I THINK ALL SERVICE AREAS HAVE THE SAME NEED. LONG BEACH SERVICE AREA 8 NEEDS A FREE-STANDING WELLNESS CENTER TO COVER THE NEEDS OF DIRECTLY OPERATED CLINICS, LONG BEACH ADULT CLINIC, LONG BEACH PACIFIC ISLANDERS, AND LONG BEACH CHILD AND ADOLESCENT PROGRAMS THEY ALSO NEED TO INCLUDE SUPPORTIVE EDUCATION SYSTEMS AND LIFE SKILLS TRAINING.

THIS WOULD GIVE CONSUMERS A PLACE TO GO BEYOND THE CLINIC SERVICES AND CREATE FLOW OUT OF DIRECTLY OPERATED CENTERS AND CONTRACTED AGENCIES.

RIGO RODRIGUEZ: THANK YOU FOR YOUR COMMENT.

DR. INNES-GOMBERG: THANK YOU JOHN.

AUDIENCE MEMBER: BRUCE WHEATLEY CO-CHAIR OF THE CULTURAL COMPETENCY COMMITTEE. I'D LIKE TO SAY THANK YOU TO THE DHM FOR HEARING THE VOICES OF THE CULTURAL COMPETENCY COMMITTEE AND UNDERREPRESENTED CULTURAL POPULATIONS AS WE'VE HAD SOME EXTENSIVE AND HEARTFELT CONVERSATIONS ABOUT EQUALITY AND DIVERSITY AS WE MOVE TOWARDS A INTEGRATED SYSTEM. IT'S IMPERATIVE THAT WE'RE WORKING TOGETHER TO ACHIEVE THE END GOAL OF MENTAL HEALTH PARITY IN OF THE AFFORDABLE HEALTH ACT YOU LAW.
MY RECOMMENDATION IS I SEE THAT SOME OF THEM WERE ACTUALLY INCLUDED IN THE SLIDE PRESENTATION, HOWEVER JUST A QUICK NOTE THERE'S 147,000 CHILDREN AND YOUTH WHO HAVE DROPPED OUT AND ARE UNEMPLOYED IN THE LOS ANGELES COUNTY, RANKING THE CITY NO. 99 OUT OF 100. I THINK WHEN WE LOOK AT THE SMORGASBORD, THERE SHOULD CERTAINLY BE SOME DOLLAR ALLOCATION BECAUSE AS DEBBIE SAID JOKINGLY, THINGS COME UP TO KEEP THE STAFF BUSY AND WE MUST BE ABLE TO HOLD OUR LEADERSHIP ACCOUNTABLE TO MAKE CERTAIN THAT THOSE DOLLARS AND THESE PROGRAMS ARE ACTUALLY FACILITATED.
SO WITH THAT REGARDING THE BOYS AND MEN OF COLOR INITIATIVE OF WHICH PRESIDENT OBAMA HAS LAUNCHED, I WE LIKE TO SEE A MILLION DOLLARS ALLOCATED TO SERVE THAT POPULATION BECAUSE, IN FACT, THIS ISSUE WITH THE SEX TRAFFICKING -- IT IS IN PART THESE YOUNG MEN WHO ARE THE FACILITATORS OF THAT ATROCITY. SO WE HAVE TO BE ABLE TO PAY CLOSE ATTENTION THERE AND ALSO ON THE SOCIAL MARKETING GIVEN THAT WE'RE MOVING TOWARD AN INTEGRATED SYSTEM IT'S IMPERATIVE THAT WE ENGAGE OTHER COUNTY DEPARTMENTS AND THE COMMUNITIES AT LARGE TO INSURE THAT THERE ARE -- THAT THEY'RE REPRESENTED IN THE TRANSFORMATION OF SERVICES BECAUSE THAT'S WHEN DISPARITY BEGINS TO ELIMINATE AND I'D LIKE TOESHOE A MILLION DOLLAR ALLOCATION THERE, TIME'S UP. THANK YOU.

RIGO RODRIGUEZ: THANK YOU FOR YOUR COMMENT. I'M GOING OVER HERE.

AUDIENCE MEMBER: I'M DR. JIMENEZ AND I'M ONE OF THE CO-CHAIRS FOR THE CULTURAL COMPETENCE COMMITTEE. WE REVIEW THE MHSA. PLAN AND WE'D LIKE TO FIRST OF ALL CONGRATULATE THE DEPARTMENT FOR SUCH A WONDERFUL JOB. WE APPROVED THE PLAN OVERALL AND WE THINK THAT -- ESPECIALLY THE FOCUS ON CULTURAL COMPETENCY, AND, THE FACT THAT WE AS CULTURAL COMPETENCY COMMITTEE AND THE UNDERREPRESENTED

ETHNIC POPULATION SUBCOMMITTEES WERE INVOLVED IN THE -- IN SOME OF THE THESE COMMENTS AND SO FORTH, SO WE REALLY APPRECIATE YOU HEARING OUR VOICE ON THAT. WE REALLY SUPPORT THE MHSA PROGRAM EXPANSION PROPOSAL WHICH HAS BEEN THE CCC UREP COMMUNITY TARGETING OUTREACH AND ENGAGEMENT SERVICES AND WE'D LIKE TO SEE THAT WE'RE LOOKING FORWARD TO SEEING THAT IMPLEMENTED.

ONE OF THE THINGS THAT WE WOULD LIKE TO BE CHANGED IN THE PLAN ITSELF IS THAT IT THE VERY END THE FOOTNOTE UNDER THE PROPOSED PRIORITY CATEGORIES GOALS AND STRATEGIES WHICH IS THE FINAL SECTION OF THE PLAN, UNDER THE FOOTNOTE TO INDICATE THE CULTURAL GROUPS THROUGHOUT THIS DOCUMENTATION REFERS SUPPLEMENTALLY SO GROUPS INCLUDED IN THE DEFINITION OF CULTURAL FROM THE NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATED SENSE FOR HEALTH AND HEALTH CARE. THAT'S REALLY IMPORTANT BECAUSE IT MAKES IT A LOT MORE -- IT'S MUCH MORE INCLUSIVE, NOT JUST ETHNICITY AND LANGUAGE.

ALSO YOU'VE ALREADY CHANGED THE PROMOTORES NAME BUT WE'D LIKE TO RECOMMEND THAT DHM USE THE MODEL AS IT IS IMPLEMENTED AND ADAPTED TO OTHER CULTURALLY DIVERSE GROUPS AND FINALLY, WE ALSO WOULD LIKE TO RECOMMEND THAT THE CCC THE CULTURAL COMPETENCY COMMITTEE THE EUROPE SUBCOMMITTEES AND OTHER CULTURALLY BASED COMMUNITIES AS WELL AS THE CALIFORNIA REDUCING DISPARITY'S PROJECT REPORTS BE UTILIZED AS SPRING BOARDS DURING THE PROGRAM PLANNING AS THIS MHSA PLAN IS IMPLEMENTED AND WE SUBMITTED SOME OTHER RECOMMENDATIONS FOR THE FUTURE IMPLEMENTATION SO THANK YOU.

RIGO RODRIGUEZ: THANK YOU SO MUCH. LET'S GO OVER TO THIS NEXT SIDE. AND, SO WE'LL GIVE AGAIN HER TWO MINUTES IN SPANISH AND THEN -- WILL YOU DO SIMULTANEOUS OR AFTERWARDS? IT HAS TO BE CONSECUTIVE SO SHE'S GIVEN US TWO DOUBLE TIME.

AUDIENCE MEMBER: (SPEAKING SPANISH) GOOD AFTERNOON MY NAME IS MARTHA, I'VE GO TO TALK ABOUT PROP 63. I THANK DHM FOR ADOPTING THIS VISIONARY PROJECT. THAT HAS TO DO WITH MENTAL HEALTH PROMOTORES OF HEALTH. AND ALSO TO THE TEAM THAT FORMS PART OF THIS VERY IMPORTANT PILOT PROGRAM AND FOR PREPARING ME TEACHING AND MAKING ME PART OF THAT VERY SAME PROGRAM. WITH THE KNOWLEDGE THAT WE'VE ACQUIRED NOT THAT WE CAN NOW WE CAN BE PART OF THIS LATINO COMMUNITY ... INFILTRATED BY BREAKING STIGMA AND BARRIERS ... THAT IMPEDE US RECOGNIZING ... OTHERS FROM RECOGNIZING AND TALKING ABOUT THESE THINGS OPENLY THAT ARE RECOGNIZED AND THESE ARE CONDITIONS AND HEALTH ISSUES WITH MENTAL HEALTH. I AM TRULY PROUD AND HAPPY ... THAT THIS PROJECT HAS BEEN SUCCESSFUL. AND I'M ALSO PROUD TO BE PART OF IT. BECAUSE WE'RE GOING TO HAVE MORE

ASSOCIATES IN OTHER AREAS AND OTHER ETHNICITIES AS WELL IT SEEMS AS THOUGH IT'S GOING TO BE WIDENED IN ORDER TO GIVE A VAST REACH ... TO ALL THE NEEDS THAT WE HAVE WITHIN MENTAL HEALTH. THANK YOU SO VERY MUCH.

RIGO RODRIGUEZ: THANK YOU.GO AHEAD.

AUDIENCE MEMBER: THANK YOU AGAIN FOR ALLOWING US TO BE HERE. MY NAME IS CRYSTAL DAVIS WILSON, I'M PART OF THE [WOMENS' REINTEGRATION PROGRAM] THE CENTER THERE ON 8300 SOUTH VERMONT I ALSO REPRESENT MY OWN ORGANIZATION WHICH I FOUNDED BACK IN 1997 FAMILY LOVE OUTREACH. NOW MY THOUGHT AND IDEA IS WHAT IS THE PLAN FOR ASTHETICS IN THE COMMUNITY WHERE MENTAL HEALTH YOU KNOW IS BEING PUT FORTH? SEE THE NEEDS FOR MURALS AND BILLBOARDS AND YOU KNOW HOW THE BUS BENCH SHELTERS PEOPLE SIT THERE A LOT OF TIMES DRINK BEER SLEEP AND EVERYTHING.

I THOUGHT THAT COULD BE A SEAT WHERE YOU COULD SIT VOLUNTEERS, VOLUNTEERS COULD SIT SPEAK AND HOLD CONVERSATIONS ON MENTAL HEALTH AND WELLNESS ISSUES YOU KNOW I'M JUST SITTING THERE FOR ANOTHER THREE HOURS OR SO PEOPLE COME UP, HI HOW ARE YOU TODAY? HOW IS YOUR MENTAL HEALTH HAVE YOU HAD IT CHECKED? SO YOU HAVE THOSE STATIONS ALL AROUND ALL THE SPOT AREAS YOU UNDERSTAND AND SO PEOPLE ARE REALLY GETTING IT FIRST-HAND THEY MAY NOT EVEN KNOW THEY'RE COMING TO GET THIS HELP BUT IT'S THERE WAITING. I SEE THAT AS A NEED.

AND I ALSO HAVE A QUESTION AS TO CAN CHURCH AND COMMUNITY OUTREACH PROGRAMS BE TRAINED ON SOME OF THE SAME SERVICES THAT DMH OFFERS EVER OFFERS SO THE CHURCH THAT HAS A BIG PLACE LIKE THIS CAN BE FILLED WITH PEOPLE WHO HAVE NEEDS AND THEY CAN -- INTERACT INTERACTED WITH THEM AND THEY HAVE THE SAME CREDENTIALS AND TRAININGS THAT YOUR PEOPLE IN DHM HAS? BECAUSE I THINK THAT WOULD BE VERY HELPFUL AND IT WILL HELP DOUBLE AND TRIPLE YOUR NUMBERS THAT YOU'RE PUTTING UP THERE FOR 15, 16, I'M LIKE WOW 2,000 PEOPLE, WE NEED TO HELP 10,000 SO I'M ASKING CAN CHURCHES AND COMMUNITY ORGANIZATIONS BE TRAINED LIKE THAT? AND THEN ALSO TO BE ABLE TO RAISE THE FUNDS BECAUSE IF I'M WAITING FOR SOMEBODY TO GIVE ME $20 OR I CAN SELL MY CD'S AND MAKE $200 IN THE INTERIM WAITING I WILL HAVE MY WHOLE SITUATION HANDLED SO I'M SEEING THESE THINGS AS NOT A REAL BIG DEAL BUT HOW CAN THAT HAPPEN BECAUSE OF THE RED TAPE AND ALL THAT KIND OF STUFF. HOW CAN THAT ACTUALLY HAPPEN?

DR. MARVIN SOUTHARD: SO HAVE I QUICK ANSWER TO THE FIRST TWO PARTS OF IT. AND YOUR VISION IS OUR VISION.

AUDIENCE MEMBER: OH THANK YOU.

DR. MARVIN SOUTHARD: BECAUSE BASICALLY WE'RE TRYING TO USE THE HEALTH NEIGHBORHOOD CONCEPT WHICH IS REALLY BASED ON A PROGRAM IN SOUTH LOS ANGELES CALLED "COMMUNITY PARTNERS IN CARE" IN WHICH THE COMMUNITY WAS TRAINED TO DELIVER MENTAL HEALTH SERVICE, NOT PROFESSIONALS BUT THE COMMUNITY WAS TRAINED TO DELIVER MENTAL HEALTH SERVICES IN CHURCHES, IN BARBER SHOPS -- PLACES WHERE PEOPLE GATHER. THEY TESTED, IT NOT ONLY PRODUCED POSITIVE MENTAL HEALTH OUTCOMES BUT IT ALSO SAVED MONEY. SO, IT GOT SEVERAL ARTICLES PUBLISHED ABOUT IT, IT RECEIVED A NATIONAL AWARD IN WASHINGTON DC FOR TEAM SCIENCE, FIRST NON-HARD SCIENCE AWARD EVER GIVEN AND SO WE'RE USING THAT MODEL AS THE MODEL FOR IMPLEMENTING THE HELP NEIGHBORHOODS ACROSS ALL OF LA COUNTY FOR INTEGRATING HEALTH, MENTAL HEALTH AND INTUITION SERVICES. SO THAT OUGHT TO BE THE WAY IN WHICH WE ADDRESS THOSE THINGS THAT YOU ARE ADDRESSING BECAUSE, YOU'RE SAYING ABSOLUTELY TRUE, MENTAL HEALTH SERVICES WILL NEVER DO ALONE. WE REALLY NEED THE COMMUNITY TO HEAL ITSELF AND THE COMMUNITIES COMMUNITY'S RESOURCES ESPECIALLY THE FAITH COMMUNITY ARE A STRONG PARTNER IN THAT.

AUDIENCE MEMBER: SO HOW CAN WE GET THAT INFORMATION? IS THAT AVAILABLE?

DR. MARVIN SOUTHARD: WELL LAST TWO WEEKS AGO WE GOT A FEDERAL GRANT TO START IMPLEMENTING THAT IT'S GOING TO START IN 13 COMMUNITIES IN LA AS THE STARTING POINT FOR AFRICAN-AMERICAN COMMUNITIES, FOUR LATINO, TWO CHINESE, ONE NATIVE-AMERICAN AND TWO RURAL SO THAT -- WE'RE TRYING TO FIGURE OUT HOW TO DID THAT BUT THAT WILL BE ROLLING OUT OVER THE NEXT SEVERAL MONTHS.

RIGO RODRIGUEZ: WE HAVE 30 MINUTES LEFT AND THIS WILL BE A TRANSLATED ONE AS WELL.

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AUDIENCE MEMBER: HI MY NAME IS YOMAN I'M A PARENT -- FIRST OF ALL, REALLY THANK YOU VERY MUCH, VERY FEW -- FIRST OF ALL I'D LIKE TO REALLY APPRECIATE -- SHOW MY APPRECIATION BECAUSE OF YOUR INTERVENTION MY SON WAS ABLE TO GET AN APPOINTMENT AND BECOME INDEPENDENT PERSON AND SO YOU HAVE DONE A HUGE, HUGE FAVOR FOR US. I APPRECIATED HEARING ABOUT SUPPORTED EMPLOYMENT IN THE PRESENTATION TODAY. I TOLD THE INTERPRETER WHAT TO SAY TO SAVE TIME SO THE INTERPRETER WILL GO AHEAD. I AM MORE, MOSTLY CONCERNED ABOUT THE BORDERLINE YOUNG PATIENTS.
SOME OF THE PATIENTS WHO HAVE SEVERE SYMPTOMS THEY NEED SUPERVISION AND THEY'RE NOT INDEPENDENT. THEN THERE ARE THOSE

WHO RESPONDED VERY WELL TO TREATMENTS AND SOME OF THEM HAVE EVEN GONE TO COLLEGE BUT THEN THERE IS A LARGE POPULATION OF BORDERLINE YOUTH, SUCH AS MY SON, AND THEY HAVE ACTUALLY LOT OF TIME WHOLE LOT OF TIME ON THEIR HANDS, IN THE MORNING THESE YOUTH MAY NOT GET OUT OF BED BECAUSE THEY DON'T HAVE ANYTHING TO DO. THE DAY STRETCHES ON THEY ROAM THE STREETS AIMLESSLY AND -- BUT THEY'RE HEALTHY AND THEY ARE CAPABLE OF DOING SOMETHING. IT IS JUST THAT IT'S HARD TO FIND AN EMPLOYMENT OR EMPLOYER WHO WILL BE -- WOULD BE WELCOMING THEM AND WOULD KNOW WHAT TO DO WITH THEM. SO. I DON'T KNOW IF THERE ARE ALREADY IS A LIST OF EMPLOYERS WHO WOULD HIRE THESE BORDERLINE PATIENTS BUT IF WE -- IF THE MENTAL HEALTH DEPARTMENT COULD COME UP WITH A LIST OF WILLING EMPLOYERS WHO WOULD BE ABLE TO TRY THEM OUT AND MAYBE IF THERE IS SOME KIND OF A FINANCIAL SUBSIDY OR BENEFITS FOR THESE EMPLOYERS TO HIRE AND TRAIN OUR YOUTH I THINK THAT WILL BE -- THAT WILL MAKE SUCH A VISIBLE DIFFERENCE AND A HUGE DIFFERENCE IN THE LIVES OF THESE YOUTH.

RIGO RODRIGUEZ: THANK YOU. (APPLAUSE)

AUDIENCE MEMBER: AND SO THE MOST IMPORTANT THING IS I'M LOOKING FOR THE LIST, LIST OF EMPLOYERS AND CONTACT INFORMATION.

DR.INNES-GOMBERG: CAN I ASK A QUESTION OF CLARIFICATION. WHEN YOU SAY BORDERLINE YOUTH, CAN YOU DESCRIBE A LITTLE BIT MORE -- DOES THAT MEAN YOUR SON HAS SOME SYMPTOMS OR HE'S BEEN TREATED?

AUDIENCE MEMBER: YOU CAN ASK ME, THANK YOU VERY MUCH. YOU KNOW THE BORDERLINE MY BORDERLINE, I DON'T KNOW THE -- MANY A FEW SIMPLE -- THEY CAN REACH GRADE 8 THEY CAN REACH YOU KNOW SOME CERTIFICATE AND THEN NOT VERY LOW CONSUMER BUT VERY STILL IN THE HOSPITAL, SOMETHING LIKE THAT. BUT MEDIUM IS MY SONS AND FRIENDS, VERY MANY, AND THEN THEY JUST SLEEP LATE AND THEN JUST WALKING AROUND -- ALL AROUND MAYBE --

DR. INNES-GOMBERG: HOW OLD IS YOUR SON?

AUDIENCE MEMBER: THIRTY-ONE YEARS OLD. AND THEN JUST TO, NOT ONLY MY SON, JUST FRIENDS, MAYBE, YOU KNOW, SOMEBODY TELL ME TOO MUCH IS TAKING THE MEDICATION THAT'S WHY THEY SLEEP. THAT'S RIGHT BUT SOMETHING -- THEY DON'T HAVE NOTHING, YOU KNOW, WHAT CAN DO IT, BUT MAYBE THEY HAVE SOME, YOU KNOW, THEY CANNOT FULL-TIME THEY CANNOT WORK FULL-TIME JUST SOME PART-TIME, MAYBE THEY HAVE TWO TIME IN A WEEK SOMETHING LIKE THAT, MAYBE THEY HAVE MUCH, MUCH BETTER AND PROUD AND REALLY -- BUT WE CANNOT VERY HARD YOU KNOW SO I JUST, PLEASE, JUST LOOKS LIKE SECTION 8 APARTMENT, GOVERNMENT DHM, YOU KNOW, SOMETHING?

DR. INNES-GOMBERG: CAN I MAKE A RECOMMENDATION YOUR SON IS AN ADULT. KALEEN GILBERT IN THE GREEN OVER THERE WE'RE GOING TO INTRODUCE THE TWO OF YOU AND THAT'S GOING IT TALK A LITTLE BIT MORE TO YOU AND SEE WHAT SHE CAN DO ABOUT YOUR REQUEST, OKAY?

AUDIENCE MEMBER: OKAY, THANK YOU VERY MUCH.

RIGO RODRIGUEZ: THANK YOU FOR YOUR INDULGENCE AS WE TRY TO MAKE SURE EVERYBODY HAZARD A OPPORTUNITY TO COMMUNICATE ACROSS DIFFERENT LANGUAGES.

AUDIENCE MEMBER: MY NAME IS MATTIE COAL COLEMAN AND I'M FROM THE LA COUNTY BLACK COALITION, AND I WANT TO THANK ALL OF YOU WHO ARE INVOLVED FOR PRESENTING THIS PRESENTATION TODAY OF THE THREE-YEAR PLAN. I'M VERY GLAD I CAME IT'S VERY TIMELY AND IT DIDN'T TAKE TOO LONG SO I WAS KIND OF EXCITED ABOUT THAT. HOW DO WE FIND OUT MORE ABOUT THE SB82 PROGRAMS FOR STIPENDS? THE LADY BEFORE ME HER SON IF HE HAD MORE EMPLOYMENT, HE WOULD PROBABLY, YOU KNOW, IF HE HAD SOMETHING TO DO AS FAR AS DOING SOMETHING TO MAKE MONEY, HE WOULD FEEL MORE PROUDER OF HIMSELF IS WHAT I HEARD HER SAY.
MY CONCERN IS THAT -- OH BY THE WAY, THE SB82 PROGRAMS FOR STIPENDS AND JOB OPPORTUNITIES SUCH AS THE OPPORTUNITIES AND THE MENTAL HEALTH PROMOTER PROGRAM WHICH I WANT TO THANK THE LATINO COMMUNITY FOR BRINGING US, EL PROMOTORES IS THAT HOW IT'S PRONOUNCED? AND I THINK THAT I WOULD BE VERY INTERESTED IN BEING A PART OF THIS. NOW, MY COALITION AND DR. SOUTHARD HAVE MET ON SEVERAL OCCASIONS AND WE KNOW PRETTY MUCH ABOUT THE TRIAGE POSITIONS THAT ARE IN THE SB82.MY CONCERN IS THAT SOME OF THESE POSITIONS ARE CONTRACTED. SO, IF -- YOU KNOW, I DON'T WANT TO ASK THE HARD QUESTIONS RIGHT NOW.BUT I WANT TO KNOW IS THE PROGRAM JUST BEGINNING TO GET STARTED? WHEN WILL WE FIND OUT INFORMATION BECAUSE I AM LOOKING FOR AN INTERN POSITION. I RECENTLY GRADUATED WITH MY AS DEGREE, I'LL BE 60 THIS JULY, AND I HAVE MY AS DEGREE IN PSYCHOLOGY, FINALLY. I HAVE AN AS THAT -- I HAVE AN AA DEGREE IN THE SUBSTANCES, THE PSYCHOLOGY OF SUBSTANCE ABUSE AND I FINISHED A COUPLE OF -- A PROGRAM AT THE LOS ANGELES SOUTHWEST COLLEGE FOR, YOU KNOW, CHEMICAL DEPENDENCY AND SUBSTANCE ABUSE COUNSELING. SO I WORK PRETTY HARD AND I'M WORKING WITH THE DOR AND EVERYTHING BUT I WANTED TO INVOLVE MYSELF IN ONE OF THESE PROGRAMS THAT ARE UPCOMING IN THE SB82.

RIGO RODRIGUEZ: THIRTY SECONDS MORE.

AUDIENCE MEMBER: THE BLACK LOS ANGELES COUNTY COALITION IS A COALITION HAS IDEAS THAT THEY HAVE ALREADY PROMOTED AND NO ONE HAS LISTENED TO US AND WE HAD NO IDEA THAT UREP WAS AN INTEGRAL

PART OF HOW WE ARE TO BE MORE, YOU KNOW, PUT FORWARD INTO THE FRONT ARENA TO BE ABLE TO SUGGEST IDEAS SUCH AS LA PROMOTORES AND WE THINK WE HAVE IN GREAT IDEAS TOO. SO WE BASICALLY WANT TO JUST PUT OUR COALITION OUT THERE AND LET YOU KNOW THAT WE'RE INSIDE THE DEPARTMENT OF MENTAL HEALTH AND WE'RE CHURNING OUT IDEAS AND WE'RE HOPING ONE OF OUR IDEAS WILL BE NOTICED ONE OF THESE DAYS. THANK YOU.

RIGO RODRIGUEZ: THANK YOU SO MUCH. LET'S MAKE THE CONNECTIONS.

AUDIENCE MEMBER: I'M DEBBIE IRWIN I'M A SOCIAL SECURITY RECIPIENT MY 59-YEAR-OLD TWIN SISTER REFUSES TREATMENT AS WELL AS GOVERNMENT MONEY. SHE REFUSES MEDICATIONS AND OFTEN CHOOSES TO BE HOMELESS SHE'S LIVING WITH ME AND I AM SUPPORTING HER. I RECEIVE SOCIAL SECURITY AROUND $800 A MONTH, WHERE, LOTS OF TIMES NOTHING MONTHLY FOR MY SISTER'S CARE. SHE REFUSES TO HAVE HER MOTHER TO RECITE EVEN IN THE SAME TOWN OF GRANADA HILLS. I HAVE SUPPORTED THIS TO SOCIAL SECURITY AND BUT MY NIECE IS A CPA AND IT'S VERY CLEVER AND SOCIAL SECURITY HAS NOT GIVEN ME OR OTHERS A HEARING. AND ACCORDING TO MY NIECE SOCIAL SECURITY --

RIGO RODRIGUEZ: SO, YOU JUST SHARED A CASE, A SITUATION WE'VE DOCUMENTED IT I'M NOT SURE IF THERE'S A COMMENT. OKAY SO THEN TERRY WILL FOLLOW UP WITH YOU. THANK YOU. LET'S GO OVER TO OUR NEXT SPEAKER.

AUDIENCE MEMBER: HI MY NAME IS JANKTO I'M A MEMBER OF ABCIC, LISTEN LACCC I ONLY CONDUCT A ONE YEAR PROGRAM. WE RAISE OUR VOICE ABOUT STIGMA AND DISCRIMINATIONS FROM MY COMMUNITY. THAT'S A -- FUNDING TO -- OUR ACTIVITIES.

RIGO RODRIGUEZ: THANK YOU FOR YOUR COMMENT. LET'S GO OVER TO THIS OTHER SIDE.

AUDIENCE MEMBER: MY NAME IS PATRICIA RUSSELL AND I'M FROM SERVICE AREA 2 AND IMUS ALSO A MEMBER OF -- ON PAGE 18 OF THE LARGE BOOK, THAT WE HAVE, IT'S HAS FAMILY SUPPORT FSS AND C-02 AND I'M JUST WONDERING FOR MORE CLARIFICATION IT SAID THAT CLIENTS SERVE 219 -- COULD YOU TELL US A LITTLE BIT MORE ABOUT WHAT THAT IS AND WHETHER THAT'S 219 IS REALLY ALL THAT ARE SERVED IN FAMILY SUPPORT SERVICES.

DR. INNES-GOMBERG: I'M GOING TO ASK SOMEBODY FROM CHILD TO TALK ABOUT THAT. FAMILY SUPPORT SERVICES IS PART OF THE COMMUNITY SERVICES AND SYSTEMS DEVELOPMENT PROGRAM. DR. BIRD.

DR. BYRD: FAMILY SUPPORT SERVICES IS UNIQUE TO CHILD FSP. IT'S A FUNDING SOURCE THAT WE HAVE ALLOCATED TO PARENTS AND CAREGIVERS AND CHILDREN WHO ARE INVOLVED IN FSP, CHILD FSP. SO THE NUMBERS ARE PRETTY SMALL BECAUSE THEY'RE FOR SERVICES TO PARENTS OR CAREGIVERS OR A SIBLING WHO HAS A NEED AND THEY MAY NOT HAVE OTHER INSURANCE OR MEET MEDICAL NECESSITY FOR SERVICES. THOSE WHO ACTUALLY MEET MEDICAL NECESSITY FOR ADULT SERVICES WOULD BE REFERRED FOR THEIR OWN ADULT SERVICES. SO THE 219 IS SOLELY FOR THIS FUNDING, THIS SMALL FUNDING SOURCE.

AUDIENCE MEMBER: IS THERE HAVE A FUNDING FOR ADULT SERVICE PEOPLE WHO ARE HELPING YOU KNOW FAMILY MEMBERS THAT HAVE ADULT CHILDREN OR BROTHERS AND SISTERS AND THAT THEY NEED SUPPORT? I WAS JUST WONDERING AS PART OF THE -- I MEAN THIS PROGRAM DEALING WITH THAT OR IS IT ALREADY IS THERE ALREADY SERVICES FOR THAT.

DR. BYRD: WELL FAMILY SUPPORT SERVICES IS UNIQUE TO CHILD FSP'S SO THE RECIPIENT WOULD NEED TO BE A PARENT, CAREGIVER --

AUDIENCE MEMBER: I KNOW FOR YEARS I'M JUST WONDERING IN TERMS OF ANY OF THE PROGRAMS IS THERE ANYTHING FOR -- I'M GLAD THAT THERE IS THAT FOR THE CHILD THAT'S AWESOME. IS THERE ANY FOR PEOPLE WHO HAVE ADULT --

DR. INNES-GOMBERG: IN NOT IN THE EXACT SAME WAY BUT AS ANY MENTAL HEALTH SERVICES YOU CAN BRING COLLATERAL IN AND BE ABLE TO PROVIDE THAT SORT OF SUPPORT RELATED TO THE PRIMARY CLIENT WHICH IN THIS CASE WOULD BE THE ADULT.

AUDIENCE MEMBER: MAYBE THAT'S SOMETHING THAT COULD TAKE PLACE FOR INNOVATIONS THAT WE'RE DEALING WITH ON THE STANDING COMMITTEE. WE'LL NOTE THAT.

RIGO RODRIGUEZ: THANK YOU FOR THE QUESTION PATRICIA. RUTH YOU WANT TO COME -- NO YOU DON'T HAVE TO WALK. AND THEN RUTH I JUST WANT TO MAKE SURE.

AUDIENCE MEMBER: MY NAME IS SHARON AND I'M GOING ENACT THE ADA TRANSLATION I NEED EXTENDED TIME I WANT TO ASK FOR THAT.
I'M A MEMBER OF THE CULTURAL COMPETENCY THE UREP THE COMBINED MEETINGS ALSO A MEMBER OF, EXCUSE ME, NMI ALSO A MEMBER OF THE STATE OF CALIFORNIA REDUCED DISPARITIES FOR AFRICAN-AMERICANS AND ALSO THE FIRST IMPLEMENTATION ON THE FIRST IMPLEMENTATION FOR THE C.R.D. REPORTS AND I'M CURRENTLY WAITING TO BE IMPLEMENTED FOR THE FOURTH -- UTILIZING INFORMATION FROM THE CULTURAL COMPETENCE COMMITTEE GUIDED PRINCIPLE OF LAW THE NATIONAL STANDARDS FOR

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES OF HEALTH AND HEALTH CARE.A BLUEPRINT FOR ADVANCING SUSTAINED CLASS POLICIES AND PRACTICE, OFFICE OF MINORITY HEALTH, US DEPARTMENT OF HEALTH AND HUMAN SERVICES, APRIL 20TH, EXCUSE ME, APRIL 2013 REGULAR 2100.100 THOSE REGS READING THOSE THEY'RE TOO SMALL FOR ME TO READ. I'M GOING TO ASK DR. BELINDA TO ASSIST ME.READ THE OVERVIEW PLEASE.

CULTURE THE INTEGRATED PATTERN OF THOUGHTS, COMMUNICATIONS, ACTIONS, CUSTOMS, BELIEFS, VALUES AND INSTITUTIONS ASSOCIATED FULLY OR PARTIALLY WITH RACIAL ETHNIC OR LINGUISTIC GROUPS.THANK YOU. AS WELL AS WITH RELIGIOUS, SPIRITUAL, BIOLOGICAL, GEOGRAPHICAL OR -- CULTURAL CULTURE IS NICK IN NATURE AND INDIVIDUALS MIGHT IDENTIFY WITH MULTIPLE CULTURES OVER THE COURSE OF THEIR LIFETIME.

AUDIENCE MEMBER: AND THERE'S A LIST OF ABJECT TIFFS BEHIND IT, STARTING WITH AGE, COGNITIVE ABILITY OR LIMITATIONS, COUNTRY OF ORIGIN, DEGREE OF ACCULTURATION, ENVIRONMENTAL SURROUNDINGS, FAMILY AND HOUSEHOLD COMPOSITION -- GENDER IDENTITY, GENERATION, HEALTH PRACTICES INCLUDING USE OF TRADITIONAL HEALER TECHNIQUES, LINGUISTIC CHARACTERISTICS INCLUDING LANGUAGES SPOKEN WRITTEN OR SIGNED, DIALECTS -- AND OTHER LITERARY NEEDS.

AUDIENCE MEMBER: AND THEN THANK YOU AND GOING BY THE CULTURAL COMPETENCY WORK GROUP HANDOUT AGENDA FOR MAY 14TH, 2014 IT STATES CAN UTILIZE REP SUBCOMMITTEE, CCC, CULTURAL COMPETENCY COMMITTEE AND PLANNING DEVELOPMENT TO GATHER FEEDBACK ON THE CULTURAL RELEVANCE OF NEW PROJECTIONS, PROGRAMS, ESPECIALLY THOSE BEING DESIGNED TO REDUCE DISPARITIES AND UNDERSERVED ETHNIC POPULATIONS AND OTHER CULTURAL POPULATIONS. THAT'S WHY IT CAME UP AND DRAFTED FOR THE CULTURALLY RELEVANT COMMUNITY HEALTH/WELLNESS WORKER WHICH I WILL REFER TO AS CRC, HEALTH AND/WELLNESS WORKER I DID MY OWN SURVEY IN THE COMMUNITY HAVING INDIVIDUALS TO AFRICAN-AMERICAN AND ALSO FROM THE LATINO POPULATION. TO SEE DID THEY CHOOSE PROMOTORES AND -- I HAVE AND THE MOST RESPECT BECAUSE IT WAS A PROGRAM THAT I HAVE BEEN ADVISED THAT WAS CREATED IN MEXICO WITHIN THE RURAL REGIONS TO MAKE SURE ALL NEEDS WERE PERFECTED BUT CURING THAT DURING THAT SAME TIME THE AFRICAN-AMERICAN COMMUNITY WAS BEING TRICKED INTO RECEIVING SYPHILIS AS A CARREFOUR THE TUSKEGEE INSTITUTE. BUT UTILIZING LAW IT'S A VARIANCE FOR MOURN ONE OR MORE PROGRAMS, THERE ARE PROGRAMS THAT ARE REFERENCING EXACTLY FROM AFRICAN-AMERICANS FOR AFRICAN-AMERICANS WITHIN THE CRDP. ON PAGE 108 IT SHOWS THAT WE FEEL WE WERE IGNORED FACINGS DEHUMANIZING SOCIAL ENCOUNTERS. WITH WHAT WE NEED IS RESPECT TO BUILD OUR COMMUNITY AND REBUILD OFF OF TRAUMAS THAT HAVE ALREADY BEEN SET IN OUR

COMMUNITY. SO I'M VERY THANKFUL FOR THE DMH BUT THERE'S ALSO A TIME TO HIGHLIGHT EACH GROUP BECAUSE I DO KNOW THE NATIVE-AMERICANS HAVE A SPIRIT WALKERS, THE API IS WORKING ON ONE, LGBT IS FORMULATING SO I WOULD LIKE TO MAKE SURE THAT THAT'S PROTECTING BECAUSE UTILIZING A RURAL ENVIRONMENT VERSUS AN URBAN WAR ZONE ATMOSPHERE, AND, AGAIN, AS A MEMBER OF THE CULTURAL COMPETENCY I AM THE ONLY COMMUNITY MEMBER, I RIDE THE BUS, I RIDE THE TRAINS. THE WHOLE DEMEANOR WITHIN ON THE TRAINS AND BUSES IS ONE OF LACK OF HOPE. THANK YOU.

RIGO RODRIGUEZ: THANK YOU SHARON.

AUDIENCE MEMBER: HELLO EVERYBODY GOOD AFTERNOON. MY NAME IS RUTHY I'M A PARENT ADVOCATE. I WANT TO SHARE A SHORT STORY, VERY BRIEF THAT WAS THERE WAS A COUPLE OF PARENTS THAT WERE GOING TO COME TODAY AND THEY WERE GRADUATES OF FSP PROGRAM AND THEY WANTED TO THANK EVERYBODY IN THE DEPARTMENT FOR LETTING THEM PARTICIPATE IN SUCH A PROGRAM WHICH HELPS SUCCEED AND THEY WERE BEING HELPED. THERE ARE SOME AGENCIES THAT ARE SUPPORTING THE GROWTH AND THE SPIRIT OF THE M.H.S.A. AND WHAT THEY WANTED TO SAY IS HAVING A PARENT PARTNER ON THEIR TEAM REALLY HELPED THEM AND EMPOWER THEM AND NOW SINCE THEY'VE BEEN WITH THAT PROGRAM THEY'VE GRADUATED, THEY'VE DOWN-ESCALATED THEIR -- THEY'RE DOING REGULAR TREATMENTS SO I WANTED TO SHARE A SUCCESS STORY. AS FAR AS ALSO TOO SOME OF THESE PARENTS WERE ALSO EMPOWERED BY THE AGENCIES THAT THEY WORKED WITH TO GO TO CONFERENCES AND OTHER THINGS THAT THEY WERE ABLE TO DO SO THAT'S -- YAY, FSP FUNDS THAT ARE REALLY WORKING AND BENEFITING THE PROGRAMS AND THAT IS HOW THE ARE DOING WHATEVER IT TAKES WHICH I WANTED TO SAY. BUT ON THAT HALF, THERE'S ALWAYS PEOPLE THAT MANE ME AS A PARENT ADVOCATE, HOW CAN WE BETTER HAVE PARENT ADVOCATES IN ALL THE CHILDREN PROGRAMS BECAUSE SOME AGENCIES HAVE THEM, SOME DON'T AND WE KNOW THAT IT'S BEEN PROVEN THAT PARENT ADVOCATES AS PEERS HAVE WORKED WITH THAT.

RIGO RODRIGUEZ: WE'LL DOCUMENT THAT COMMENT.

AUDIENCE MEMBER: REAL QUICK TOO I HAVE ANOTHER QUICK COMMENT TOO. AS FAR AS THE HEALTH CARE REFORM AND EVERYTHING WE'VE CHANGED, I KNOW THAT HAS GONE AND GO AHEAD AND ADAPTED BUT I SEE A LOT OF FAMILIES THROUGHOUT THE COUNTY AND THROUGHOUT CALIFORNIA THAT ARE NOT GETTING THE SERIOUS EMOTIONALLY DISTURBED GETTING INTO FSP AND GETTING INTO PEI BECAUSE THEY HAVE PRIVATE INSURANCE I WANTED TO BE ABLE TO KNOW HOW WE'RE GOING TO BENEFIT THAT BECAUSE THEY'RE STILL BEING UNDERSERVED.

WE HAVE TEN MINUTES LEFT IN THE PUBLIC COMMENTS SECTION.

RIGO RODRIGUEZ: WE HAVE TEN MINUTES LEFT IN THE PUBLIC COMMENTS SECTION. LAST SPEAKER AND WE'LL BRING IT BACK TO DEBBIE FOR SOME FINAL REFLECTIONS.

AUDIENCE MEMBER: GOOD AFTERNOON. TWO THINGS, FIRST, YOU KNOW, AS A CONSUMER, IN DEPARTMENTAL HEALTH I LOOK AROUND THIS HEALTH AND I'M ASKING MYSELF WHERE ARE WE? ARE WE AWARE OF THE FACT THAT HOW IMPORTANT THIS MEETING IS TODAY? THAT WE HAVE A VOICE TO BE HEARD? AND THEN IT MAKES ME WONDER WHAT IS IT THAT WE CAN DO SO THAT MORE OF US WILL BE INVOLVED IN MEETINGS OF SUCH BECAUSE THIS IS ALL ABOUT US. THIS IS ABOUT ME, I TAKE THIS VERY PERSONALLY. IT JUST REALLY MAKES ME WONDER SO I'M HOPING THAT THERE'S SOMETHING THAT WE CAN DO NARROWED TO INFORM MY PEERS OF THE IMPORTANCE OF MEETINGS OF SUCH OR EVEN JUST THE FACT THAT THEY EXIST.

SECOND THING IS THAT ON PAGE 13 IN OUR SLIDES, IT TALKS ABOUT WELLNESS CENTERS/PEER CASE MANAGERS. I'M CURIOUS TO KNOW WHAT IS A PEER CASE MANAGER AND WHAT IS IT QUALIFIED TO BE A PEER CASE MANAGER AS WELL AS WHAT COLOR IS THAT BADGE?

RIGO RODRIGUEZ: SO ARE YOU DONE WITH YOUR -- YEAH? THANK YOU FOR THOSE COMMENTS. (APPLAUSE)

KALENE GILBERT: THERE'S A RECOGNITION AMONG OUR WELLNESS CENTERS THAT PEERS PLAY A VARIETY OF ROLES AND WE WANT THEM TO CONTINUE TO PLAY THE ROLE OF A PEER. BUT A LOT OF THEM IN THAT ROLE WILL DO CASE MANAGEMENT WORK SO THE CONTRACTORS AS PART OF THIS DISCUSSION ABOUT WELLNESS ADJUNCT, RECOGNIZE THAT SOME OF THAT WORK REALLY IS BEST DONE BY A PEER. SO, IT COULD BE A PARAPROFESSIONAL ROLE IT COULD BE A BACHELOR LEVEL ROLE WITH SOMEBODY WHO HAS LIVED EXPERIENCE WE REALLY WANT TO MAKE SURE THAT'S OPEN FOR THE PROGRAMS TO BRING IN FOLKS WHO CAN BEST SERVE IN THE ROLE. AND HELP CLIENTS WITH WHAT THEY NEED.

AUDIENCE MEMBER: WHAT COLOR IS THE BADGE?

KALENE GILBERT: THAT BADGE? OH THAT IS A PAID POSITION. IF THIS ISN'T THE DEPARTMENT THOSE PARTICULAR POSITIONS ACTUALLY ARE ALL WITH CONTRACT AGENCIES NOT WITH THE DEPARTMENT. BUT THE PAID PEER POSITIONS IN THE COUNTY ARE YELLOW BADGES THOSE ARE ALL PAID POSITIONS, THE HOUSING AND THOSE PEER POSITIONS, THOSE ARE ALL PAID POSITIONS IN THE DEPARTMENT.

RIGO RODRIGUEZ: THANK YOU. THANK YOU EVERYONE FOR YOUR INSIGHTFUL COMMENTS. LET ME BRING IT BACK TO DR. DEBBIE INNES-GOMBERG WHO WE'LL COME BACK TO DR. DEBOSE IN THE MENTAL HEALTH COMMISSION.

DR. INNES-GOMBERG: I THINK I'VE BEEN DOING ANNUAL UPDATES AND PUBLIC HEARINGS I THINK THIS MIGHT BE THE FOURTH YEAR AND IT IS BY FAR THE MOST MEANINGFUL IN TERMS OF THE FEEDBACK AND THE PARTICIPATION IN MY TIME, SO THANK YOU.

THE SECOND THING I WANTED TO SAY WAS OR ACKNOWLEDGE WAS AN OMISSION THAT WAS SIGNIFICANT IN THE THREE-YEAR PLAN AND THAT OMISSION AS I WAS TALKING ABOUT NEXT STEPS I TALKED A LOT ABOUT THE SYSTEMS LEADERSHIP TEAM AND THE STANDING WORK GROUP. WHAT I DID NOT ACKNOWLEDGE WAS THE ROLE AND THE IMPORTANCE OF THE MENTAL HEALTH COMMISSION IN THAT PROCESS. WHILE THE MENTAL HEALTH COMMISSION HAS A REPRESENTATIVE, JERRY LUBIN, ON THE COMMISSION I NEGLECTED TO TALK ABOUT THE ROLE THAT THE COMMISSION PLAYS IN OVERSEEING OUR MENTAL HEALTH SERVICES ACT PROGRAM SO MY APOLOGIES. WE WILL ADD THAT TO THE NEXT STEPS RELATED TO THE IMPLEMENTATION OF THE THREE YEAR PLAN.

JERRY LUBIN: IT'S MORE THAN JUST PARTICIPATING AS AN INDIVIDUAL. WHAT HAS TO BE CLARIFIED, I DO BELIEVE, IS THE ROLE ON AN ONGOING BASIS BETWEEN THE SLT, THE COMMISSION, AND THE DEPARTMENT. THE DEPARTMENT, OF COURSE, HAS DIRECT LINK TO THE BOARD AS DOES THE COMMISSION. SO THE THING THAT SEEMS TO BE MISSING AND THAT I THINK WE ALL HAVE TO AGREE TO, AND I DID TRY TO RAISE THIS NUMEROUS TIMES DURING THE DISCUSSIONS WHEN I WAS THERE, WHAT'S THE FLOW PRIOR TO THE FINAL THING BETWEEN SLT AND THE COMMISSION ON MORE THAN JUST YOUR PRESENTATION? BECAUSE THERE'S A LOT OF MATERIAL THAT REALLY HAS TO BE LOOKED AT CLOSELY AND -- SO I CAN SEE AT LEAST THREE CIRCLES ARE -- SLT, COMMISSION, DEPARTMENT, AND I GUESS I JUST KIND OF PUT IT THAT WAY.

RIGO RODRIGUEZ: AND ALSO ADD SAACS BUT KEEP GOING.

AUDIENCE MEMBER: SAACS COMES FIRST AND THEN THERE'S SLT AND THEN THE COMMISSION, THE COMMISSION SHOULD GET THE SAME THING THAT WE GET, THE SAACS.

RIGO RODRIGUEZ: SO THERE IS SOME WORK TO MAKE SURE NOW THAT AS SUSAN RAJLAL MENTIONED WE DO HAVE MORE LOCAL SORT OF POWER AROUND THIS PLAN TO MAKE SURE THERE IS AN EFFECTIVE RELATIONSHIP BETWEEN THE SERVICE AREA ADVISORY COMMITTEES, THE SYSTEM LEADERSHIP TEAM, THE MENTAL HEALTH COMMISSION, IN RELATIONSHIP TO

THE DEPARTMENT SO THAT WE ARE IN SYNC EVEN MORE SO. THAT'S A POINT REALLY WELL-TAKEN BUT PARTICULARLY WITH THE MENTAL HEALTH COMMISSION, AND YOUR ROLE IN OVERSIGHT IT INCREASES EVEN MORE THE SIGNIFICANCE OF MAKING THIS VERY, VERY CLEAR. SO I JUST INTERVENED BECAUSE THAT WAY, WE CAN MOVE OVER TO THIS NEXT PART. THANK YOU DEBBIE. ANYTHING ELSE DEBBIE BEFORE WE CLOSE?

DR. INNES-GOMBERG: I DON'T HAVE ANYTHING THANK YOU VERY MUCH.

RIGO RODRIGUEZ: SO LET ME BRING IT BACK TO DR. DEBOSE TO CLOSE THE PUBLIC COMMENT PERIOD. AND MOVE FORWARD.

DR. HERMAN DEBOSE: THANK YOU I JUST WANT TO REITERATE WHAT JERRY JUST SAID IN REGARDS TO THE ROLE OF THE COMMISSION. I JUST WENT ONLINE AND PULLED UP THE DUTIES AND RESPONSIBILITIES OF THE COMMISSION. THE FOURTH DUTY IS TO REVIEW AND APPROVE THE PROCEDURES USED TO INSURE CITIZEN AND PROFESSIONAL INVOLVEMENT ALL AT ALL STAGES OF THE PLANNING PROCESS. SO I THINK THAT WE HAVE TO REVIEW WHAT IS OUR ROLE, WHAT IS OUR FUNCTION? ONE OF THE THINGS THAT I THINK I'M CLEAR AND I WOULD THROW IT BACK OUT TO THE PUBLIC, FROM WHAT I HEARD I GATHERED THAT MOST OF YOU WERE COMFORTABLE WITH THE PLAN BUT YOUR CONCERN WAS MOST OVER IMPLEMENTATION? WOULD THAT ABLE FAIR ASSESSMENT? IF THAT'S A FAIR ASSESSMENT THEN I'M GOING TO GO BACK TO THE ACTION STEPS THAT'S LAID OUT IN THIS PACKAGE THAT DEBBIE GAVE US BECAUSE IN THE ACTION STEPS THE COMMISSION IS NOT INCLUDED IN ANY FORM OR FASHION, WHICH I THINK IS AN OVERSIGHT AS TO THE RESPONSIBILITIES AND THE DUTIES THAT THE COMMISSION HAS BEEN GRANTED BY OUR APPOINTMENT BY THE MEMBERS OF THE BOARD AND ALSO BY THE STATE LEGISLATION. I'M GOING IT ASK DEBBIE AND OTHERS IN THE DEPARTMENT TO REWORK THESE ACTION STEPS THAT THE COMMISSION ASSUMES THE DESIGNATED ROLE THAT IT HAS BEEN GIVEN IN STEP 4 OF WHAT'S OUTLINED IN THE DUTIES AND THE RESPONSIBILITIES.

NOW WITH THAT BEING SAID I WILL SIT WITH MY FELLOW COMMISSIONERS AND FOR THE MOST PART THAT THEY ARE IN AGREEMENT WITH THAT THEN I WOULD ASSUME THAT WE PROBABLY CAN MOVE FORWARD WITH THE VOTE. BUT I WOULD JUST LIKE TO KNOW FROM MY FELLOW COMMISSIONERS THAT IF WE GET SOME GUARANTEE THAT WHEN THIS DOCUMENT IS REWRITTEN THAT IN MY OPINION THE APPROPRIATE PLACE AND THE ROLE AND THE RESPONSIBILITY OF THE COMMISSION IS OUTLINED IN THIS IN REGARDS TO RECOMMENDATIONS, FOLLOWING HOW PLANS ARE PUT TOGETHER, THAT THE COMMISSION IS SOUGHT OUT FOR ITS COLLECTIVE OPINION REGARDING THIS PROCESS AND NOT THAT THINGS ARE JUST BROUGHT TO THE COMMISSION AND SAY HERE VOTE. BECAUSE I THINK THAT'S A DISRESPECT TO THE LEGISLATION, TO THE MEMBERS OF THE BOARD AND TO THOSE OF US

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April 7, 2014 – May 6, 2014

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Cindy Czernek

Agency/ Organization: Long Beach AIA Fam. Mental Health Center

E-mail address: [redacted]

Mailing Address: [redacted]

Comments

Why would Peer Specialist be paid employees to do case management? Are we getting paid as Case management? Shouldn't we? Aren't are roles as Peer Specialist be working with other peers?! I agree we do our own case work with who we engage with.

Any member of the public may submit written comments on or before May 6, 2014. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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

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Personal Information (OPTIONAL)

Name: Debbie Irwin

Agency/ Organization:

E-mail address: [redacted]

Mailing Address: [redacted]

Comments

I am concerned that there is a gap in the system re: financial abuse by substitute payees.

My 59 yr old twin sister refuses treatment as well as "government money." She refuses medications & often chooses to be homeless.

She is living with me & I am supporting her. I receive $850/mo Social Sec. My Niece randomly pays $40-$500, refuses to have her Mother reside here in the same town - Granada Hills.

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I have reported this to Social Security but my niece is a CPA & is very clever.

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Mark Kerametz

Agency/ Organization: Project Return / LASCC | E-mail address:

Mailing Address:

Comments

IT IS MY UNDERSTANDING THAT people who have been ~~HIRED~~ trained as Peer certified Peer Specialist when they get hired are not assigned duties ~~Related~~ unrelated to their training. There needs to be monitoring so that services for which the person has been ~~HIRED~~ trained are provided

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Barbara B Wilson

Agency/ Organization: | E-mail address: [redacted]

Mailing Address: [redacted]

Comments

I am concerned about the dewindling number of licensed Board & Care homes and the burgeoning growth of unlicensed facilities & Sober living facilities also unlicensed.

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name:

Agency/ Organization: Parent | E-mail address:

Mailing Address:

Comments

How is FSP PEI FCCS

We are the working POOR. Many families who had Ins. (Kaiser, ~~Blue~~ Health Care Partners etc...) Are being put on the back burner because of this. How, when & what kind of Accountability can be done so ~~All~~ Families are served ~~THE~~ MHSA-SAYS

0-100 ⇒ For All individuals who are participating or TRYING to get connected to these programs are being put on HOLD/or not being taken, or ~~SOC~~ (Too High) By Providers/Programs

Because of the Health Care changes/Private Ins. is NOT being taken by (Providers) ~~some~~ many families are still falling in between the cracks being unserved & underserved.

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of identified successful projects/programs from the Innovation plan. APs have learned the strong need for ongoing, community based outreach & engagement. We hope that these evidence supported learnings will continue to be supported.

3) As an agency in 3 service areas, I hope the specific needs identified by each SA will be considered and implemented as much as possible. It is important that this type of individualization be requested because each SA is unique with different needs. Flexibility is needed.

4) Over again and again in the planning process, there were many requests to remove silos between funding such as FSP & FCCS and to significantly reduce the paperwork which burns out our staff and increases costs needlessly.

[signature]
5/22/14

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*

5/22/14

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Crystal DAVIS-Wells / Volunteer for Women's Center

Agency/ Organization: FAmily Love Outreach. ORG

E-mail address: [redacted]

Mailing Address: [redacted]

Comments

What is the plan for aesthetics in the Community of MH.? I see the need of murals & Billboards and Stations like the Bus' Benches/letters that speak "a language of "Love" "Healing," "Health," "Peace and Beauty," where Volunteers Sit along the streets and welcome Conversation and information to the Community on MH & Wellness. (Sit, speak and Be healed)

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Can Church & Community Outreach Programs Be Trained to give the same services DMH offers? Or Raise funds

[redacted]

3) The Service Navigation Prog. / interagency or
- there was a recommendation to create agency to get enough clients for each navigator. Some navigators has to do it already but it has to be spelled out in (plan.
- the reason for create angency is to find agency supportive that will support the idea of Health Navigation. With that there is a shared for them to work for that is agency.
4) - Sue been a trainer chair for LACCC + 3rd funding for 8 yrs. I teach people c phy + mental disab. about MH + provide new information to both LACCC general coalition, how can I get more support.
5) in stretching (dollars, I would like to recommend to outsource young people to bring their talents + education to other, state, adult communities + countries where money can be use effectively until they become sustainable. This can be done with supervision so that they can be guided.

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

CULTURAL COMPETENCY COMMITTEE

Comments on the MHSA 3-Year Program and Expenditure Plan Fiscal Year (FY) 2014-15 thru 2016-17

For the Los Angeles County Department of Mental Health Commission Public Hearing May 22, 2014

Support

- MHSA Program Expansion Proposal: CCC/UREP Targeted Community Outreach and Engagement Services: Specialized and targeted community outreach/engagement activities to increase community capacity to support individuals/families prior to, during, or after receiving mental health services and reduction of mental health stigma and service disparity.
- The focus of cultural competency, specifically on the "Proposed Priority Categories, Goals and Strategies" (final section of the plan).

Recommendations

- Future MHSA 3-Year Program and Expenditure Plan and Reports [and other future LACDMH reports – MHSA and non-MHSA reports] to clearly state their intent in and the specific strategies being addressed by MHSA programs/ projects in reducing mental health disparities. Reports need to address system wide impact of implemented MHSA programs in terms of reducing disparities within the County of Los Angeles and creating a more culturally responsive system of care.
- Utilize the CCC, UREP subcommittees, and other culture-based committees, as well as the California Reducing Disparities Project (CRDP) Reports, as spring boards during program planning/development to gather feedback on the cultural relevance of new projects/programs –especially

those being designed to reduce disparities in underserved ethnic and other cultural populations.

- Expand on the criteria used for definitions and mathematical calculations of disparities beyond prevalence rates to account for factors such as poverty level and high rates of incarceration.
- Incorporate the lessons learned from the INN models' integration of physical health, mental health and substance abuse as a guide for culturally competent service delivery.
- Program effectiveness evaluations to include cultural competency-based outcome measures or community-specific outcome measures from the very start of the process.
- Treatment effectiveness evaluations to include cultural competency-based outcome measures or community-specific outcome measures from the very start of the assessment process, making sure to include thorough cultural formulations.
- Inspire the LACDMH workforce, including its contractors, by reporting both quantitative and qualitative outcomes collected. Everyone loves to hear how we are making a difference in the words of the communities we serve.
- Data that is being collected throughout DMH should be used to provide a deeper data analysis within the major 5 ethnic groups. For example, primary language could be used to identify subgroups and conduct data analysis, for example how different subgroups perform on outcome measures of EBP's – data collection and data analysis for ethnicity and language need to drill down to reflect profiles of ethnic [including bi-racial and multi-racial] as well as language subpopulations, including country of origin and ancestry/ heritage.
- Change the name of the "Promotores de Salud" program to a name English (for example, Promoters of Health, Promoters of Mental Health, Community Health Workers, Community Mental Health Workers, etc.) so that different ethnic groups will be able to identify with the program, without

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CULTURAL COMPETENCY COMMITTEE

assuming it is only for Hispanic populations. However, maintain the commitment to use and ensure the fidelity to the Promotoras de Salud Model as it is implemented and adapted to other culturally diverse groups.

- In the program description of the "Promotores de Salud/ Community Health Workers" delete any reference to specific ethnic groups. For example, at the end of paragraphs 1 and 3: "...among communities such as..." These sentences may be changed to read, "...among underrepresented and underserved culturally diverse communities." This is more inclusive of all culturally diverse communities.
- Either develop, adapt, and/or implement EBP's, Promising Practices, and Community Defined Evidence Practices to be culturally appropriate and culturally relevant.
- Set funding aside for capacity building, to adequately train and supervise staff to be able to work effectively with diverse cultural populations.
- Change the footnote on the "Proposed Priority Categories, Goals and Strategies" (final section of the plan) to indicate that "Cultural Groups" throughout this document refers explicitly to groups included in the "Definition of Culture" from the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice from the office of Minority Health U.S. Department of Health and Human Services, April 2013. This definition goes beyond ethnicity and language. It is more inclusive of culturally diverse populations, for example people with diverse spiritual beliefs, diverse family and household compositions, physical and developmental disabilities, gender identity, sexual orientations, socioeconomic status, age, country of origin, acculturation levels, etc.

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care:

A Blueprint for Advancing and Sustaining CLAS Policy and Practice

Office of Minority Health

U.S. Department of Health and Human Services

April 2013

OMH

THINK CULTURAL HEALTH

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LAC DMH

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: CHANH TO

Agency/ Organization: API MH Speakers Bureau Asian Coalition

E-mail address: [redacted]

Mailing Address: [redacted]

Comments

Hi, I'm member of API CLC, API Mental Health Speakers' Bureau, Asian Coalition, LACCC We only conduct one year program we raise our voices about stigma and discrimination from a minor community. That's helpful. Please help us by funding to continue our activities

Any member of the public may submit written comments on or before May 6, 2014. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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

1 of 2

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA THREE YEAR PROGRAM & EXPENDITURE PLAN
Fiscal Year (FY) 2014-15 thru 2016-17
30-day Public Review and Comment Period
April 7, 2014 – May 6, 2014

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: BRUCE WHEATLEY LACDMH CULTURAL COMPETENCY CO-CHAIR

Agency/ Organization: INNER CITY INDUSTRY

E-mail address: [redacted]

Mailing Address: [redacted]

Comments

NAME CHANGE UNDER NEW PROGRAMS TO:
*CULTURALLY RELEVANT OR RESPONSIVE COMMUNITY HEALTH WORKERS
—ENSURE INNOVATION OF UNIQUE STRATEGIES OUTREACH & ENGAGE CHILDREN & YOUTH POPULATIONS.

* ALLOCATE $1 million UNDER PLANNING, OUTREACH $ENGAGEMENT/POE TO DEVELOP AND IMPLEMENT PROGRAM TARGETING BOY & MEN OF COLOR.

* ALLOCATE $2million ANNUALLY UNDER "POE" FOR COMMUNITY INTEGRATION & COLLABORATION WITH OTHER COUNTY DEPARTMENT COLLABORATORS.

Any member of the public may submit written comments on or before May 6, 2014. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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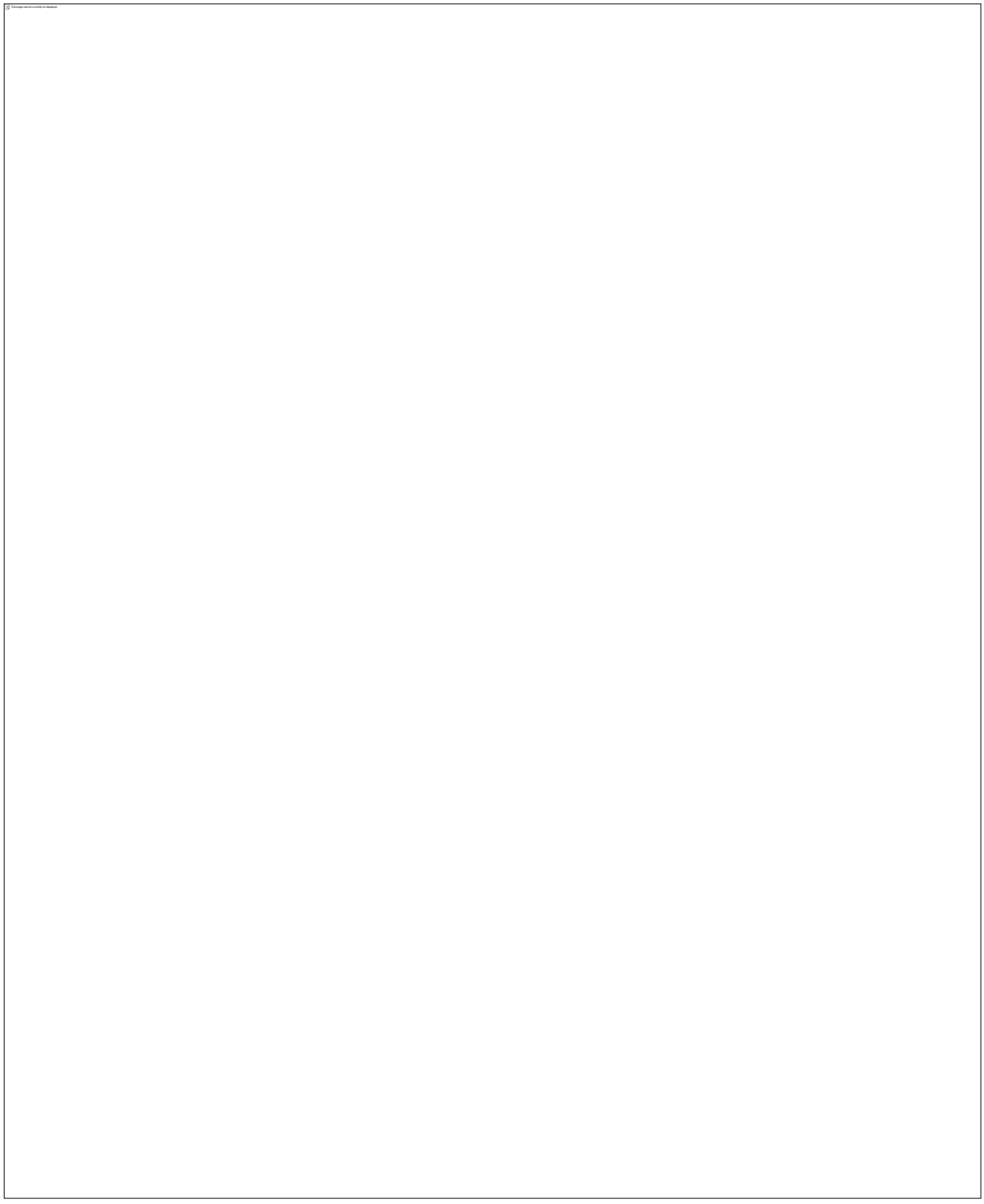
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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Sandra Eberhardt

Agency/ Organization: Los Angeles Harbor College

E-mail address: drseberhardt@gmail.com

Mailing Address:

Comments

I am pleased to see LACDMH take a positive stand toward funding programs for community student mental health. These services are vital to the success of the students they serve. Mental health services have helped many young adults get the psychological assistance they needed to complete their educational goals and thrive in careers — Thank you for focusing attention on college student mental health.

Any member of the public may submit written comments on or before May 6, 2014. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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April 7, 2014 – May 6, 2014

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Tejal Shah

Agency/ Organization:

E-mail address: tshah@pepperdine.edu

Mailing Address:

Comments

I am so pleased to see that DMH is giving attention to the huge (and growing) concerns related to college mental health. Thank you, DMH!

Any member of the public may submit written comments on or before May 6, 2014. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Jessica Flitter

Agency/ Organization: Student

E-mail address: jessie.flitter@gmail.com

Mailing Address:

Comments

I am so grateful for DMH's efforts to increase mental health resources for college students — a deserving and in-need population. Please continue to do your wonderful work and contribution to this vital college community. Thank you so much!

Any member of the public may submit written comments on or before May 6, 2014. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: SUSAN FRIEDMAN

Agency/ Organization: LA COUNTY COMM. ON CHILDREN + FAMILIES

E-mail address: SUENEVE222@YAHOO.COM

Mailing Address:

Comments

Where is the CSEC $? — We need MHSA money now for training? social workers and therapists in this vital area affecting our community — primarily from children (girls ages 12-17).

Any member of the public may submit written comments on or before May 6, 2014. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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Attention: Debbie Innes-Gomberg
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Pacific Clinics
ADVANCING BEHAVIORAL HEALTHCARE

ESTABLISHED IN 1926

800 S. Santa Anita Ave.
Arcadia, California91006-3555

Tel: 626.254.3000
Fax: 626.294.1077

May 5, 2014

Dr. Marvin Southard, DSW
Director of Mental Health
550 S. Vermont Ave., 12th Floor
Los Angeles, California 90020

Dear Dr. Southard:

Pacific Clinics' management team reviewed the County of Los Angeles Department of Mental Health's "Mental Health Services Act Three Year Program and Expenditure Plan: Fiscal Year 2014-2015 through 2016-2017" and gathered comments regarding aspects of the plan in the attached enclosure. In general, we have the following feedback about the plan:

We are pleased to see the plan includes an:

- Increase to Adult Programs, especially in Wellness and Client Run Centers.
- Integration of Supportive Employment and Housing into the Wellness programs.
- Increase in Older Adult Field Capable Clinical capacity throughout the County.

We would like to see reconsiderations in the following parts of the plan:

- Full Service Partnership Slot Allocations and Amounts
  - The number of new FSP slots is not enough, especially in regards to the TAY population, who are only receiving an additional 6 slots per year countywide.
  - The cost per slot is too low based on ours and other providers' experiences. The cost to provide FSP TAY services averages about $18,000 and up. Also, why were the new FSP slots only allocated at $7,833?
  - The TAY population is trending on the older side of TAY (21-25). More dollars need to be allocated to serve older TAY to meet this need.
  - TAY System of Care should consider a FSP-FCCS integration pilot.

- Data Reporting and Usage
  - The plan lacked consistency in how data was reported and what was reported.
  - No methodology was presented on how data was compiled, leading to question certain data, such as the average cost per client in the FSP and FCCS programs.
  - Outcomes that are expected for new and existing programs have not been substantiated by trend data. In some cases, outcomes are either stated without supportive data or the outcomes do not match the data that was reported for FY 12-13 in the beginning of the plan.

Pacific Clinics appreciates the opportunity LACDMH has provided for public comment of the plan and hope that the Department takes in consideration our comments and thoughts for finalizing the MHSA plan. Thank you.

Sincerely,

Sue Shearer, LCSW
Senior Vice President

Enclosures (1)

cc: Susan Mandel, Ph.D, CEO

Los Angeles County- Department of Mental Health
MHSA Three Year Program and Expenditure Plan
Fiscal Year 2014-2015 through 2016-2017

PACIFIC CLINICS COMMENTS

FISCAL YEAR 2012-2013 MHSA PROGRAM COMMUNITY SERVICES AND SUPPORTS

Community Services and Supports Programs

Transitional Age Youth Drop-In Centers (Page 22)
- What are "client contacts" defined as?
- How many unduplicated TAY were served?

Prevention and Early Intervention

PEI Early Start Anti-Stigma Discrimination (Page 43)
- No mention of the Peer Engagement Program Pilot.

Innovation (page 69)

- According to DMH, INN was developed to help us learn about the different cultural groups included in the project. The section does not do a complete analysis of how the programs have met this objective. Also, the budget for the program is extended by one year and that is not stated anywhere in this section.
- Confusing reporting of ISM data. On page 69, it is stated that ISM model includes five specific ethnic models, but the data reported seems to be only on the results two of the ethnic models, i.e. African/African American and Latino/a (page 70, second paragraph).
- It is not clear whether the data reported in the tables reflect the outcomes on all racial/ethnic communities included in INN or if it is data from the same ethnic populations mentioned above.
- The section needs to include a breakdown of data on the specific racial/ethnic populations included in INN.
- Are those ten points the only "lessons learned"? How do they relate to each racial/ethnic group?

Workforce Education and Training (Page 75)

Mental Health Worker Course not listed in WET section.

WET, 3- Transformation Academy without Walls: Licensure Preparation Program (Page 76)
Recommendation: Include unlicensed professional clinical counselors for funding of licensure preparatory materials and study guides. Objective: Increase diversity of licensed professionals within behavioral health, to include Licensed Professional Clinical Counselors (LPCCs)

WET, 15- Partnership with Educational Institutions to Increase the Number of Professionals in the Public Mental Health System (Page 81)

Recommendation: Enhance program to include immersion training of high school teachers. Develop a Teacher Externship Program for high school teachers to educate them about the public MH system. Objective: Inspire teachers to imbed wellness & recovery/resiliency principles and develop mental/behavioral health topics within the high school curricula to introduce, educate, and expose students earlier in their academic life towards a career in the public mental health system.

WET, 21 - Stipend Program for Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners, and Psychiatric Technicians (Page 82)
Recommendation: Include Licensed Professional Clinical Counselors (LPCCs) and state-certified Substance Abuse Counselors in the Stipend Program.
Objective: Increase workforce diversity and capacity to better meet the communities' diverse service needs within an integrated behavioral healthcare system.

FISCAL YEAR 2014-2015 MHSA SERVICES BY COMPONENT

CHILD

1. Implementation of Laura's Law/Assisted Outpatient Treatment (Page 91)
- Data showing effectiveness of SA navigators needed.
- The role of SA navigators in description: is it within their scope of work?
- Give the money allocated to SA navigators to legal entities to provide the level of outreach and engagement the program demands.

Child- New Programs (Page 93)
1. Family Wellness/Resource Centers
- How many FWRCs will be funded? What are the budget assumptions?

2. Family Crisis Services: Respite Care Program
- How is the program going to be funded?
- The program is expected to serve clients in both the FCCS and FSP program (over 11,000 clients). Why has the program only been allocated enough funding for 166 clients?
- How many agencies will have the Respite Care Program available to their clients?

3. Self Help Support Groups for Children
- What is the definition of "self help" with the children population?
- Is the model replicable or cost-effective?

TAY

Existing programs (Page 96)

TAY Full Service Partnership
- Based on the funding and slot allocation on page 96, the cost per slot is calculated at $7,833. This is very low considering the average cost per client in FY 12-13 was $12,282.
- Not enough slots are being added to TAY FSP to meet the needs of the population.

- How many of the 18 slots will be EPSDT vs. Medi-Cal? The program is seeing an increasing amount of older TAY and there needs to be more allocation of slots and funds to meet this need.
- In the appendix under the 26. MHSA Program Expansion Proposal: TAY Goal 6: Strategy 1 – Increase TAY (16-25 years old) FSP and FCCS capacity, it was mentioned that the Antelope Valley could be receiving these additional slots. We would like to reiterate the need for more slots in the existing TAY programs and also ask where the money to fund a TAY program in the Antelope Valley would come from.

TAY Drop-In Center

- Where is the data supporting the client served expectation?
- The existing Centers are barely sustainable serving 400 clients with only $250,000. The expectation that these new Centers initially serve 400 and grow their client base with the same level of funding over the course of two years is not realistic.
- No funding has been allocated to outreach and engagement, yet the Centers are expected to grow over two years.
- No increase has been made to fund the existing Drop-In Centers since its inception 5 years ago.

Housing

- More supportive housing is needed to the meet the needs of the TAY population.

FCCS

- The cost per slot is extremely low. At $88,000 for 36 clients, cost per client is only $2,444. In FY 12-13, the average cost per client was $4,705 (page 23).

Suggestion: Incorporate an FSP-FCCS Integration pilot for the TAY population.

New Programs (page 97)

2. Self-Help Support Groups for TAY (page 98)

- What program will these self-help groups be implemented into?

3. TAY Supportive Employment

- Data is needed to substantiate the established outcomes of the program.
- Intended program outcomes are not realistic. Should consult with TAY providers to development more realistic outcomes.

ADULTS

Existing Programs (page 99)

Adult Full Service Partnership (page 99)

- Object to funding additional four psychiatrists across the directly operated FSP system. Why is the funding only limited to the directly operated programs?
- What is the definition of "success" for the Innovation program?
- How many agencies will the 75 slots be distributed to? How did LACDMH decide on 75 slots? Why not more?

Wellness Centers (page 100)

- We are happy to see that Peer Run Centers will expand to Service Areas 3 and 6.
- The addition of a Housing Specialist and Supportive Employment to Wellness programs is much needed to meet the recovery goals of clients. Great to see the additions.

Adult Field Capable Clinical Services (page 100)

- More money should be allocated to FCCS given the budget cuts from previous years to the Adult System of Care.

OLDER ADULTS

Existing Programs (page 102)

Older Adult Full Service Partnership (page 102)

- How much money will be allocated to expand slots over three fiscal years? If it is based on the FY 12-13 data reported on page 20, which reports that the average cost per client is $11,832, then we would like LACDMH to reevaluate the true cost of serving an Older Adult in FSP. The cost to serve clients in this program is much higher.

Older Adult Field Capable Clinical Services (page 102)

- We are happy to see that LACDMH will increase the capacity of this program by 456 clients. How much money will be allocated to expand the capacity of the program over three fiscal years?

From: Cristine Bruzzone [redacted]
Sent: Tue 5/6/2014 6:48 PM
To: Debbie Innes-Gomberg
Subject: LACDMH SAAC8 MHSA 3-Year Program and Expenditure plan PUBLIC COMMENT

PUBLIC REVIEW

Dear Dr. Lee:

Thank you for focusing attention on college student mental health!

As a current graduate student, as well as the mother of two college students, and having worked as a psychological intern counselor on multiple campuses, I have witnessed the benefits to college students who have access to a counseling center for support, therapy and finding additional resources to help with their individual needs. As the college student population continues to diversify both in age and ethnicity, and as environmental stressors increase, it is essential to their success--and that of communities across the nation--that the stigma of mental illness is reduced (eliminated would be better!) so that more college students can access the care they deserve and desire.

Therefore, please support continued funding for college student mental health.

Sincerely,

Cristine E. Bruzzone, M.A., Doctoral Candidate
Psychology Intern
Student Health & Psychological Services, B112
[redacted]
http://www.csudh.edu/shps

From: Bruce Wheatley
Sent: Monday, May 05, 2014 4:09 PM
To: Debbie Innes-Gomberg
Subject: 3 YR Public Review & Comment Form

Appreciate consideration of the attached recommendations.

Regards,

Bruce M. Wheatley

For all that you do you are the chosen one...chose wisely

"There is nothing more powerful than an idea whose time has come" -Victor Hugo

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA) – PUBLIC REVIEW COMMENTS

MHSA THREE YEAR PROGRAM & EXPENDITURE PLAN
Fiscal Year (FY) 2014-15 thru 2016-17
30-day Public Review and Comment Period
April 7, 2014 – May 6, 2014

Personal Information (OPTIONAL)
Name: Dellis Frank
Agency/ Organization: LAUSD E-mail address: def5363@lausd.net Mailing Address: 333 South Beaudry LA. CA. 90017

Comments: SUMMARY SUPPORTING THREE (3) RECOMMENDATIONS.

The Department of Mental Health 3 Year Program and Expenditure Plan introduction of new program *Promotores de Salud*/Community Wellness Workers does not take into account MHSA Regulations Section 3200.100 toward increasing understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among the African/African American population. In fact, reinforces historical bias, racism, and other forms of discrimination by eliminating African/African Americans from mention in the program description, goals and budget details across age group (i.e. children, transition-aged youth and adults.)

According to the 3 year program and expenditure information sheet Community Services and Supports (CSS) and Prevention Early Intervention (PEI) Data for Fiscal Years (FY) 2012-13:

Among Unique CSS Clients served across eight service areas, African American received near equal services to the Hispanic population per service area percentages. However, among Unique PEI Clients served across the eight service areas, Hispanics benefitted by percent in seven of eight service areas. Therefore;

RECCOMENDATION 1: Under New Program(s) for Children, Transition-aged Youth and Adults

To ensure the equitable distribution of Mental Health Service Act funding for a fair, impartial and diverse group of competitive innovative proposals, this recommendation suggest the following changes and editions:

New Program Name Change: Culturally Relevant Community Health/Wellness Workers eliminating mention of Promotores de Salud as the new program. Correspondingly, eliminate use of such name in each program component. (i.e. program description, program goals, budget estimate)

Within each Child, TAY and Adult program description and goals: Include African/African American with the identified Hispanic/Latino and Asian Pacific Islander communities.

Continued...

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA) – PUBLIC REVIEW COMMENTS

RECCOMENDATION 2: Under Services Cutting Across Age Groups: Planning, Outreach and Engagement (POE-1):

Given the annual $13 million dollar budget allocation for Planning, Outreach, Engagement (POE-1) and the overrepresentation of children, youth and transition-aged youth (TAY) in out of home placement in service area six as the targeted community; it is recommended $3 million dollars over 3 years ($1 million each year) be allocated to plan, develop and implement proactive prevention, early intervention outreach and education strategies exclusively engaging boys and men of color in alignment with President Obama's My Brother's Keeper Initiative.

RECCOMENDATION 3: Develops specific intent and allocation of budget funds:

Under Services Cutting Across Age Groups: Planning, Outreach and Engagement (POE-1): Specifically related to item f); *"incorporate learning from the Integrated Services Management Model Innovation programs to the outreach and engagement process, including the utilization of effective non-traditional approaches"*. **It is recommended;**

Given the POE-1 $13 million annual budget allocation, $6 million dollars over 3 years ($2 million each year) be allocated to plan and fund community-informed social marketing outreach and engagement strategies advancing an integrated system of care to ensure mental health parity per Affordable Care Act law.

The collaboration with county departments (i.e. DCFS, DHS, DPS, Probation, LACOE, Sheriffs etc.), non-traditional service providers (Community Based Organizations) and Community Stakeholder leadership shall plan and design innovative services and supports that utilize and strengthen forms of healing from the individuals perspective. Outcomes advance effective community integration and equal access to comprehensive integrated services of equal quality in diverse communities. The competitive award will be provided to a Department of Mental Health contracted provider that effectively communicate its strategy and processes as means to eliminate mental health stigma.

Therefore, learning from the Integrated Services Management Models Innovation programs will appropriately be utilized to inform non-traditional approaches to service delivery.

Any member of the public may submit written comments on or before May 6, 2014. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to: 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

STATE OF CALIFORNIA — BRICE W. HARRIS, CHANCELLOR

CALIFORNIA COMMUNITY COLLEGES
CHANCELLOR'S OFFICE
1102 Q STREET, SUITE 4554
SACRAMENTO, CA 95811-6549
(916) 445-8752
http://www.cccco.edu

April 28, 2014

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

RE: Public Comment in Support of the "Integrate L.A. College Building Healthy Communities Initiative (BHCI) Program, for Fiscal Year (FY) 2014-15 thru 2016-17

Dear Ms. Innes-Gomberg:

On behalf of the Chancellor's Office for California Community Colleges, I am submitting this letter as part of your public comment process in support of the inclusion of the above project into LA County's MHSA Three Year Program and Expenditure Plan for Fiscal Year (FY) 2014-14-2016-17.

As you are aware, we have been working with the LA College Consortium for the past 3 years as part of our California Community Colleges Student Mental Health Program (CCC SMHP) that was funded through CalMHSA funds with the support of county mental health. We have greatly appreciated the opportunity that was provided to us to support statewide efforts such as those that have been implemented in LA County through the LA College Consortium. LA Harbor College has served as lead for the consortium, and includes LA Southwest College, LA City College, LA Mission College, LA Pierce College, and LA Trade Tech College.

The activities that were implemented as part of this grant have been numerous and incredibly successful. Highlights include: the 3 regional strategizing forums to forge networking and partnerships with LACDMH to support the needs of unserved/underserved/unidentified consumers that attend colleges; collaboration with other district partners as well as CSU Dominguez Hills, Cal State Long Beach, UCLA, Pepperdine, El Camino College/Compton Center, and Rio Hondo College; the initiation of Active Minds and NAMI (National Alliance on Mental Illness) student chapters/clubs at campuses within the Consortia and the establishment of campus-based peer mentor programs for both veteran and LGTBQ students. In addition, each campus in the consortia has developed and strengthened their resource and referral systems to serve students in need of mental health resources.

Again, these are just brief highlights and I am attaching a summary of their achievements which I hope help illustrate the valuable contributions this project has, and our support for consideration of the Integrate L.A. College Building Healthy Communities Initiative (BHCA) Program in your MHSA PEI expenditure plan efforts as they progress.

Please don't hesitate to contact me if you have questions or need more information. Thank you.

Betsy Sheldon

Betsy Sheldon, Specialist
Student Support and Special Programs
bsheldon@cccco.edu

Attachment

BACKGROUND
As part of the California Community College Student Mental Health Program, the Los Angeles College Consortium was awarded $250,000 in support of their "Building Healthy Communities Initiative". Los Angeles Harbor College is the lead campus on the grant with five additional colleges participating as consortia members. The five consortia colleges include LA Southwest College, LA City College, LA Mission College, LA Pierce College, and LA Trade Tech College.

Listed below is detailed information regarding how the consortium is implementing Prevention and Early Intervention services on their campuses and within the local community.

OBJECTIVES & IMPACT – Los Angeles College Consortium

Develop and implement targeted training to sensitize college community members within consortium on how to identify and refer students who may be experiencing mental health problems.

- The Consortia administered a campus mental health needs survey to all colleges within the consortia, and presented the survey data to participants attending a campus/county/community forum referred to as Regional Strategizing Forum # 1(RSF). The survey data was also used to customize the Prevention and Early Intervention training on all of the campuses. Adjustments in the Strategic planning also occurred as a result of this data.
- The Consortia completed 88 trainings, presentations, and workshops that focused on Prevention and Early Intervention and mental health wellness in Year 1, reaching over **1,414 Faculty, Staff and Students. Examples of training include:** Crisis Intervention Team Training, Student Mental Health Wellness Symposium, Student Success Committee Task Force Training – Incorporating Mental Health Awareness into Student Success, Coping with Depression, and the offering of a film and discussion series "Coping with the Stigma of Mental Health Illnesses".
- In addition to in-person training activities, the Consortia provided Kognito Interactive Suicide Prevention training to approximately 600 faculty, staff and students. Kognito is a web based training that helps to build gatekeeper skills to encourage and make referrals for students in need. Kognito offers 6 training modules, having just launched new modules to support LGTBQ and veteran student populations. The training effort has been customized for each college with up to date community resources to assist the campuses with the referral processes. The Kognito Program is also being offered in Year 2 with District-wide support being given by the college Administration, Academic Senate, Unions, and faculty, staff and students.
- Additionally, The Consortia collaborated with the Associated Student Organization (ASO) to provide mental health screenings for the students and provide programming on domestic violence/stalking prevention.

- During the current academic year, the Consortia will administer the ***American College Health Association -National College Health Assessment*** *which is a* nationally recognized research survey to assist in collecting precise data about students' health habits, behaviors, and perception. This data will help to formulate strategies to support faculty, staff, and students.

Develop and implement targeted violence prevention training on how to develop safe and secure learning environments.

- The Los Angeles Community College District (LACCD) is working to establish Behavior Intervention Teams (BIT) within each college. The district initiative is being supported by the LACCD Vice Chancellor and college presidents. It will support the development of formalized policies and procedures to address wellness oriented behavior intervention on all 9 campuses within the District. District-wide training for BIT TEAM Members is scheduled for October 2013.
- The Consortia hosted a two-day Violence Prevention Training during year 1 with 9 colleges analyzing and discussing the root causes of violence and practical ways to address the problems of violence on campus. The workshops included: College Student Mental Health Overview, Student Panel, Non-Violence Communication and a speaker on Threat Assessment. The Consortia will be hosting a second Violence Prevention training in the Fall 2013.
- The Consortia also hosted a focused Non-Violent Communication Workshop for faculty/staff in the Fall 2012 semester.
- The Consortia also hosted a focused Threat Assessment Workshop, presenting the basic statistics on the prevalence of different types of campus crime and worked on identifying strategies to address the problem.

Develop Training Manual for Consortia Colleges on How to Start Intern-Based Mental Health Sites with website posting.

- In order to support the massive mental health and wellness needs of students on campus, LA Harbor College established a model mental health services intern program which has been designated as a best-practice by the California Community College Chancellor's Office. The Program is called the Life Skills Center. A non-stigmatizing name was given to The Center to attract a broader spectrum of students wishing to participate in mental health services. The Center utilizes Masters Level and Doctoral level psychology interns who contribute 10-20 hours per week of counseling services and training/workshop for students. The Center is highly cost effective and student efficient because it allows the campus to provide between 120-150 hours per week of direct mental health services for the students. The Intern support is FREE so it doesn't pose a negative cost factor for the colleges. The Life Skills Center offers: crisis intervention and referral, liaison services with faculty/staff and law enforcement, information and community referrals, individual and group counseling, career guidance, psycho-educational support groups, student success workshops, and learning disability assessment, referral and support. The Program has been so successful that it is now being replicated at other colleges in the L.A. District and on other campuses in the State. The Administrative Director and Clinical Director are frequent speakers at workshops to teach others how to develop this programming.

- Currently the Consortia is developing a Manual which will serve as a guide to help others replicate this program within the district and other campuses in the state. The preliminary program model design will allow for cost-effective and efficient ways to meet the mental health needs of students by utilizing "smart classrooms" for weekly trainings. Additionally, LA Harbor will provide technical assistance to other colleges interested in initiating a similar project.

Regional Strategizing Forums and Collaboration:

- The Consortia hosted two Regional Strategizing Forums (RSF) during Year 1. There were 120 attendees at the first RSF and 78 attendees at the second RSF. Attendees included faculty, staff, students, higher education partners, county mental health and local community organizations. The focus of the first forum was to present research findings from the Mental Health Needs Survey conducted at each of the consortium campuses, provide an overview of the CalMHSA grant objectives, discuss college student mental health needs, and a presentation on evidence-based practices for MH referrals and building off-campus partnerships. The purpose of the second forum was to allow the colleges to understand the dynamics of the LACDMH system. Top notch speakers from LACDMH presented a wealth of information about resources and expressed a strong commitment to team with the colleges in support of consumer/student success. The result was the identification of specific themes for the action planning which would occur during Year 2 of the Project.
- As a result of the first RSF the Consortia created action teams to support the development of referral and resource lists for each of the 6 consortium campuses. The action teams which are comprised of both campus and county representatives will convene at the next Regional Strategizing Forums and will to continue planning and resource-building. The final Regional Strategizing Forum will focus on evaluating the effectiveness of the plans.
- In addition to creating cross District partnerships, the Consortia has also developed a strong working relationship with local colleges and Universities including CSU Dominguez Hills, Cal State Long Beach, UCLA, Pepperdine, El Camino College/Compton Center, and Rio Hondo College.
- There is a long history of collaboration with the leadership of the L.A. Consortia with LACDMH, and Community Mental Health Agencies. The Project Director has served as the Stakeholder Delegate representing Higher Education in the LACDMH MHSA Planning Process. She also has a long history of serving on the LACDMH Workforce, Education and Training Advisory Committee with full participation in LACDMH activities which are an outgrowth of this committee. She also teams with the LACDMH Emergency Outreach Bureau in support of college violence prevention activities. The Project Training Director served on the LACDMH MHSA PEI Advisory Committee during the MHSA Planning process. Both Directors are now integral members of local SAACs.
- The leadership of the consortia also participates routinely as conference presenters and resource individuals to the larger community.

Develop pathways for the potential integration of Active Minds Chapters on college campuses and strengthen the role that NAMI Chapters can play within the consortium colleges.

- Active Minds and NAMI (National Alliance on Mental Illness) student chapters/clubs have been initiated at campuses within the Consortia. With doctoral interns facilitating chapter presence and activities on each of the campuses.
- The consortia is currently establishing campus-based peer mentor programs for both veteran and LGTBQ students.

Develop appropriate on-campus and off-campus referral resources for each college and collaborate with Kognito to customize the training with local resources.

- Through the Regional Strategizing Forums and mental health intern program (Life Skills Center) each campus in the consortium is equipped with an updated referral process and resource listing for each campus.

WEBSITE Development for cost-effect user=friendly dissemination of Project Deliverables

- The Consortia is developing a website in Year 2 to post all deliverables from the Project in support of sustainability and wide dissemination.

CAMPUS-BASED GRANTS

In addition to LA College Consortium, several other colleges in Los Angeles county were awarded campus-based grants through the California Community Colleges Student Mental Health Program, including:

College of the Canyons, Pasadena Community College, Rio Hondo Community College, Santa Monica College, and West Los Angeles College.

Reports for all campuses in Los Angeles County are available, for reports please contact:

STUDENT MENTAL HEALTH PROGRAM

Betsy Sheldon, Specialist
Mental Health Services
California Community College Chancellor's Office
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LA COLLEGE CONSORTIUM
Dr. Deborah Tull
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310-233-4621

Dr. Bonnie Burstein
bursteb@lahc.edu
310-233-4586

From: Nicola Merry
Sent: Monday, April 14, 2014 11:38 PM

County of Los Angeles - Department of Mental Health Mental Health Services Act (MHSA)
MHSA THREE YEAR PROGRAM & EXPENDITURE PLAN
Fiscal Year (FY) 2014-15 thru 2016-17
30-day Public Review and Comment Period
April 7, 2014 – May 6, 2014
PUBLIC REVIEW

Comments: Re: TEMPORARY HOUSING FOR LA HOMELESS, BUILT FROM SHIPPING CONTAINERS.

28 donated shipping containers were used to create New Jerusalem Orphanage, a Vibrant Shipping Container Home for South African children. Designed by 4D and A Architects

2013 Greater Los Angeles Homeless Count
Executive Summary – Los Angeles County
(LAHSA)

At least 190,000 men, women and children experienced homelessness in Los Angeles over the course of a year, an increase of more than 65,000 from 2011 estimates (based on the two continua that do annualized estimates - Los Angeles and Pasadena)
(The annualized number estimates the number of persons who experience homelessness during a twelve month period around the count. The count represents a single point in time)
*Excludes Continua of Long Beach and Glendale
Continuum of Care (CoC) Annualized Estimates of Homelessness

Annualized Estimates

	2011	2013
Los Angeles CoC	120,070	187,119
Pasadena CoC	4,864	3,088
Los Angeles County Total*	124,934	190,207

Builders of affordable and low income housing will complete about 3000 units in 2014. At this rate it will take many many years to house the numbers of homeless on our streets, and many will never get a roof over their heads. I find it appalling that we have that many people on our streets. There are not enough adequate places to wash, or use restrooms and stand for hours in line on skid row, to get to the bathroom in one of the missions. The lines stretch for miles just for this basic human need. The stench of urine, filth and trash is everywhere. Not only is this a public health problem but also costs the state huge amounts of money in medical bills. It just is'nt acceptable that in a city with this wealth, people have to live like this, no bathrooms, living in tents or boxes, there are even families with small babies.

2013 Greater Los Angeles Homeless Count
Executive Summary – Los Angeles County
(LAHSA)

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Los Angeles County Total*	124,934	190,207

When 250,000 homes were destroyed during Hurricane Katrina, FEMA provided trailer homes. 4 years later a lot of those people are still living in them. That was a national disaster, but so is the homeless situation in Los Angeles. Why have'nt we provided temporary housing like this to our homeless.

FEMA trailer park alongside the road. **FEMA trailer that is still occupied**

Shipping containers containers, when rehabilitated for human use would include flooring, dry wall, electrical outlets, windows and man sized doorway. The cost would be 2500.00 per 40' shipping container.

These homes could be placed on any open unused city or county land, mobiles bathrooms, showers, and a cooking area, meeting, case management mobile unit would be necessary. A community kitchen, and a meeting room/dining area/church/training area would also be necessary, and all could be mobile units. Pockets of empty land could be donated from each city in Los Angeles County to house these people. Social services etc would need to be offered on site. Excess land could be used to grow food etc.

By providing temporary housing for our homeless population we will not only be improving our business districts where they frequent, we will be improving the view our tourists have of our city, we will also be saving the tax payer huge savings on emergency medical bills and will also be providing the public with healthier cleaner streets.

On the websites below you will see beautiful homes and apt buildings made from shipping containers.

http://www.bing.com/images/search?q=house+in+toronto+made+from+shipping+containers&qpvt=house+in+toronto+made+from+shipping+containers&FORM=IGRE#a

1. 8 eye-catching **shipping container homes**: The Ecopod | MNN ...
   www.mnn.com/...**home**/...**shipping-container**-...

Below is a group of Container Homes from China:

40ft Shipping Container House (CH-32)
Contact Now

Flat Packed Container House (CH-16)

Contact Now

ISO Shipping Container House (CH-01)
Contact Now

2*40ft Modified Container House&40ft Flat Packed Container Home (CH-110)

Contact Now

Thank you.

Nicola Merry

Debbie Innes-Gomberg

From: Tull, Deborah <tulld@lahc.edu>
Sent: Wednesday, March 05, 2014 12:47 PM
To: Debbie Innes-Gomberg
Subject: CalMHSA Campus Based Grant Planning
Attachments: Campus Based Grant Strategic Plan 2014 MHSA LACDMH Tulll 3 2 14.doc

Importance: High

Hi Dr. Debbie!

I hope you are doing well during this challenging time. My guess is that you have more deadlines than time to accomplish everything! My guess is that we also know that times will always be challenging when the needs always exceed the budgetary resources – a decades long dilemma! It heightens our critical need to make mental health planning efforts cost efficient and consumer efficient.

The Los Angeles County MHSA Campus Based Grant leadership is hopeful that LACDMH will integrate portions of the best practice programs into the LACDMH system because the state MHSA grant funds end this year and the programs are highly successful. CalMHSA has always had sustainability and interagency collaboration as top goals for these programs. The services provided are both cost efficient, consumer efficient and address critical gaps in mental health services to unserved and underserved high-risk student populations.

The purpose of this e-mail is to share a copy of the Mental Health Services Act (MHSA) 2014 Community College Strategic Action Plan that I have developed as a result of three MHSA Campus based grant Strategic Action Plan Forums that were held in 2013. These forums were our version of the Stakeholder Delegate Forums that LACDMH had when shaping the initial MHSA Plans. Attendees of the three forums included MHSA campus based grant leaders from the L.A. College Consortium: Building Healthy Communities Initiative, the campus based grant project leaders from Rio Hondo College and West Los Angeles College and service area LACDMH professionals. At the final forum on December 13, 2013 the group reached consensus on some specific planning items that should be included in the development of a Strategic Action Plan which would support the mental health wellness and academic success of consumers and unserved or underserved high-risk student populations.

We will be holding our final Regional Strategizing Forum on March 27, 2014 at Los Angeles Trade Tech College. I will forward an invitation to you with hopes that you may be able to attend. The attached Strategic Action Plan is a draft document. Attendees of the forum will review the document and provide feedback for any needed changes. I am going to circulate the document to the attendees prior to our event so they can give it thoughtful consideration.

I would love to have an opportunity to meet with you to discuss the Campus Based Grant planning effort and to even discuss any potential leadership role that I may be able to play if LACDMH moves forward with adoption of the Strategic Action Plan in a more formalized way. There is much to discuss. Without knowing what budgetary resources may be available and what the operational plan may look like (integration within LACDMH as a formal program or the use of new community vendors to develop and maintain the program or ?). Perhaps you can give me some guidance. I look forward to hearing back from you and perhaps even getting to see you.

All the best, Deb

Dr. Deborah Tull, Director

CalMHSA L.A. College Consortium: Building Healthy Communities Initiative.

tulld@lahc.edu

(310) 233-4621

DRAFT Developer: Dr. Deborah Tull, tulld@lahc.edu ,(310) 233-4621

Los Angeles County
Mental Health Services Act (MHSA) 2014 Community College Strategic Action Plan
Memorandum of Understanding

Partners:

- CalMHSA Los Angeles 6 College Consortium: Building Healthy Communities Initiative and Los Angeles CalMHSA Campus Based Grant Allies
- Los Angeles County Department of Mental Health (LACDMH)

Introduction:

CalMHSA approved funding for the development of 23 MHSA Community College Campus Based Grants throughout California in 2012. Most of the Projects are funded through May 2014. The local grant projects include the Los Angeles College Consortium (the largest community college mental health consortium in the State of California), and campus based grants at West Los Angeles College, Rio Hondo College, College of the Canyons, Pasadena City College and Santa Monica College.

An important element of the campus based grants has always been to ensure sustainability after the grant ends so the programmatic efforts of the MHSA Projects will continue to meet college student mental health needs (including suicide prevention and stigma reduction) well into the future. LACDMH MHSA funding is necessary for full sustainability of the campus based grant effort and for the implementation and attainment of the goals contained within the 2014 Community College Strategic Action Plan.

This planning document is the result of a one year effort by several of the Los Angeles Campus Based MHSA Grant Projects to optimize the networking capacity between LACDMH and the colleges to better support the mental health needs and life success rates of the populations we serve.

Over the past year, the CalMHSA Los Angeles 6 College Consortium, West Los Angeles College Project and Rio Hondo College Project invited key Los Angeles County Department of Mental Health professionals from LACDMH service areas to participate in a series of Strategizing Forums to discuss mental health needs, service offerings of both entities, identify gaps in services, and reach consensus on planning items which would improve mental health service delivery and support college student mental health for consumers and those who are unserved or underserved. The Forums were held on May 30, 2013, June 14, 2013, and December 13, 2013.

The final Forum will be held on March 27, 2014 for preliminary approval of this planning document (Strategic Action Plan) with integration of changes as appropriate, presentation of recognition awards and press coverage on the Campus Based Grant effort. Consensus on the planning items was obtained by DMH partners and college partners at the December 13, 2013 Strategizing Forum. The planning items provide the framework for the recommended strategies in this Strategic Action Plan which is being developed by the Los Angeles College Consortium for the benefit of LACDMH partners

For more information please contact: Dr. Bonnie Burstein, bursteb@lahc.edu , (310) 233-4586 or Dr. Deborah Tull, tulld@lahc.edu , (310) 233-4621

and Los Angeles College partners. Refined implementation plans will be developed in each of the respective college/DMH Service Area Advisory Committees to meet needs specific to the local areas.

Vision:

- ☐ To dedicate resources and collaborative effort in support of the development of state-of-the-art, culturally competent mental health services and college programs and services that promote recovery/wellness for transitional age youth, adults and older adults with mental health challenges.
- ☐ To adhere to the California Community College Student Mental Health Program Goals: (1) To implement and sustain Prevention and Intervention strategies that will allow campuses to address the mental health needs of the overall student population in general and student veterans in particular and (2) Promote sustainable collaborative infrastructure between campuses and local mental health services systems.
- ☐ To support the DMH MHSA Guiding Principle: "To implement specific strategies to achieve more meaningful collaboration with local resources such as education in order to promote creative and innovative ways to provide integrated services with the goals of adequate health care, independent living and self sufficiency" and ensure that "Care must be collaborative and integrated, not fragmented."
- ☐ To embrace the MHSA DMH pledge "to look beyond 'business as usual' to help build a system where access will be easier, services are more effective ... and stigma toward mental illness and emotional disturbance no longer exists."

Need:

- ☐ The mental health needs of college populations (Multi-ethnic Transition Aged Youth, Adults and Older Adults) are not being addressed sufficiently and research is identifying many areas of concern. The majority of colleges do not have mental health service sites which meet these needs. There has been a lack of formalized inclusion in the LACDMH offerings to assist this population.
- ☐ Alarming and growing trend that began in the mid-1990s: University and college counseling centers report a shift in the needs of students seeking counseling services from more developmental and informational needs to students needing help with serious mental health challenges (National Counseling Center Directors Survey, 2010).
- ☐ Survey respondents reported that 44% of their students had serious psychological problems, a sharp increase from 16% in 2000. The most common disorders were depression, anxiety, suicidal ideation, alcohol abuse, eating disorders and self-injury. (National Counseling Center Directors Survey, 2010).
- ☐ 24.3% of college counseling center directors reported an increase in students with eating disorders, 39.4% reported increases in students with self-injury issues, 45.7% reported

increases in students struggling with alcohol abuse (National Counseling Center Directors Survey, 2010).

- ☐ College student mental health issues are more prevalent than in past years with increases in the following (ACHA-NCHA,2012): Feeling Overwhelmed, Alcohol and Substance Abuse, Family Dysfunction, Impact of Violence, Depression, Bipolar Disorder, Anxiety, Fear, Worry.
- ☐ 4% of students who dropped out of college left for mental health reasons. The primary diagnoses of respondents were depression, bipolar disorder and posttraumatic stress disorder (NAMI College Student Survey, 2012).
- ☐ 72% of students experienced a mental health crisis on campus but 34% said their campus didn't know about their crisis. 36% of the students said stigma was a barrier to accessing their college's mental health services and supports. (NAMI College Student Survey, 2012).
- ☐ Problems affecting academic performance (ACHA-NCHA 2012 Survey):
  - Alcohol Use: 5.0%
  - Anxiety: 21.0%
  - Assault (physical): 0.6%
  - Assault (sexual): 0.8%
  - ADHD: 5.3%
  - Concern over a friend/family member: 11.7%
  - Death of a friend/family member: 6.1%
  - Depression: 12.8%
  - Drug Use: 1.9%
  - Eating Disorder/problem: 1.1%
  - Finances: 6.9%
  - Relationship difficulties: 10.9%
  - Sleep Difficulties: 22.0%
  - Stress: 30.5%
  - Work: 14.3%

Goals:

- ☐ 1. To promote interagency collaboration related to mental health services and support within the Los Angeles County Department of Mental Health and Los Angeles County Community Colleges to enhance individual recovery/wellness goals, reduce stigma and encourage higher education goal attainment.
- ☐ 2. To introduce a mental health approach that is new to the overall mental health system with service applications to the college population.
- ☐ 3. To increase access to mental health services, including unserved and underserved college populations.
- ☐ 4. To promote integration of Peer to Peer Support network, NAMI, and Active Minds within the college setting.
- ☐ 5. To increase the quality of mental health services and educational support services to improve outcomes for consumers and college students.

Strategies to Achieve Strategic Plan Goals

Goal 1:
To promote interagency collaboration related to mental health services and support within the Los Angeles County Department of Mental Health and Los Angeles County Community Colleges to enhance individual recovery/wellness goals, reduce stigma and support higher education goal attainment.

Partner	Strategy	Implementation Suggestions
College	C1.1 College participation in each LACDMH Service Area Advisory Committee (SAAC) C1.2 College participation in research efforts designed to optimize the higher education experience for consumers and students with mental health challenges.	
LACDMH	DMH 1.1 Fund and Integrate the College Building Healthy Communities Initiative Program into LACDMH offerings after cessation of CALMHA funding in 2014 with an expansion to possibly include all Los Angeles colleges. Adopt best practices already developed by CalMHSA Projects as per grant project goals, objectives and work plans. DMH 1.2 Designate one spot on SAAC Advisory Committee for higher education representative. DMH 1.3 Place a DMH staff member on college campuses once a week as the Department of Rehabilitation does. DMH 1.4 Participate in LACDMH research efforts designed to optimize the higher education experience for consumers.	

Goal 2:
To introduce a mental health approach that is new to the overall mental health system and community college system with service applications to the college population.

Partner	Strategy	Implementation Suggestions
College	C2.1 College participation in each LACDMH Service Area Advisory Committee (SAAC) C2.2 College participation in LACDMH research efforts designed to optimize the higher education experience for consumers and students with mental health challenges.	
LACDMH	DMH 2.1 Offer streamlined referral process to colleges with medication evaluation, hospitalization, and therapy as appropriate. DMH 2.2 Place a DMH staff member on college campuses once a week as the Department of Rehabilitation does. DMH 2.3 Support recovery oriented Doctoral and Masters level college internship mental health service sites. DMH 2.4 Authorize one DMH staff member to serve on college Behavioral Intervention Teams (BIT). DMH 2.5 Participate in LACDMH research efforts designed to optimize the higher education experience for consumers.	

Goal 3:
To increase access to mental health services, including unserved and underserved college populations.

Partner	Strategy	Implementation Suggestions
College	C 3.1 Establish population specific services for Veterans, LGBTQ and others as appropriate. C 3.2 Develop Language for faculty to use in course syllabi regarding availability of student success oriented mental health services. C 3.3 Develop college policies and procedures which make access to mental health services easily obtainable. C 3.4 Provide confidential office space with secure record's area to support the mental health service process. C 3-.5 Develop a streamlined referral process with LACDMH to provide services to students who are unserved or underserved.	
LACDMH	DMH 3.1 Offer streamlined referral process to colleges with the offering of medication evaluation, hospitalization, and therapy as appropriate to unserved and underserved populations. DMH 3.2 Place a DMH staff member on college campuses once a week as the Department of Rehabilitation does. DMH 3.3 Support recovery oriented doctoral and Masters Level college internship mental health service sites. DMH 3.4 Authorize one DMH staff member to serve on college Behavioral Intervention Teams (BIT). DMH 3.5 Establish a tracking system from college referrals with easy communication access for college professionals about consumers who have provided signed releases. DMH 3.6 Establish treatment protocols for mid-range students/consumers. DMH 3.7 Develop resources in support of homeless students/consumers, undocumented students, student VETS, LGBTQ and Foster Care students.	

Goal 4:
To promote integration of Peer to Peer Support Network, NAMI, and Active Minds within college settings.

Partner	Strategy	Implementation Suggestions
College	C 4.1 Establish a pilot program for inclusion of NAMI/Active Mind Chapters/LACDMH Peer-to-Peer Network support on college campuses in alignment with Wellness Center Concept. C 4.2 Provide confidential office space with secure record's area to support the mental health service process.	
LACDMH	DMH 4.1 Support college Peer-to-Peer integration efforts.	

Goal 5:
To increase the quality of mental health services and educational support services to improve outcomes for consumers and college students.

Partner	Strategy	Implementation Suggestions
College	C 5.1 With continued MHSA funding, continue the mental health training of faculty, staff, students to reduce suicide, fight stigma, and alert faculty about identification and referral protocols for students in need and support inclusion of NAMI and Active Minds. C 5.2 Develop pilot program with curriculum development to support satellite Personal Development Classes at local DMH Wellness Centers. C 5.3 Develop efficient stop-out and start-up process for consumers/students. C 5.4 Cultivate nurturing climates in which help seeking behavior is rewarded for consumers/students. C 5.5 Offer college class/service learning credit to support college student participation in local SAACs. C 5.6 Endorse College Health Center Parity between mental health and physical health through use of existing Health Center Budgets with increases in the health fees/Health Center Budgets when colleges lack resources for service provision. C 5.7 Develop Language for faculty to use in course syllabi regarding availability of student success oriented mental health services. C 5.8 Develop college policies and procedures which make access to mental health services easily obtainable. C 5.9 Provide confidential office space with secure record's area to support the mental health service process.	
LACDMH	DMH 5.1 Fund and Integrate the College Building Healthy Communities Initiative Program into LACDMH offerings after cessation of CALMHA funding in 2014 with an expansion to possibly include all Los Angeles colleges. Adopt best practices already developed by CalMHSA Projects as per grant project goals, objectives and work plans.	

	DMH 5.2 Place a DMH staff member on college campuses once a week as the Department of Rehabilitation does. DMH 5.3 Support recovery oriented Doctoral and Masters level college internship mental health service sites. DMH 5.4 Establish supported education and supported employment programs on the college campuses as necessary. DMH 5.5 Authorize one DMH staff member to serve on college Behavioral Intervention Teams (BIT). DMH 5.6 Establish a college referral tracking system to optimize communication access for college mental health professionals about consumers who have provided signed releases. DMH 5.7 Establish treatment protocols for mid-range students/consumers. DMH 5.8 Develop resources in support of homeless students/consumers, undocumented students, student VETS, LGTBQ and Foster Care students. DMH 5.9 Provide timely disability verification to college Disabled Student Programs to ensure student access to state and federally mandated services.	

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA THREE YEAR PROGRAM & EXPENDITURE PLAN
Fiscal Year (FY) 2014-15 thru 2016-17
30-day Public Review and Comment Period
April 7, 2014 – May 6, 2014

5/22/14

PUBLIC REVIEW

Personal Information (OPTIONAL)	
Name: Lisa Schoyer, Countywide Regional Centers Liaison for children (Birth through School-age)	
Agency/ Organization: LAC DMH CSOC FCP & Child PEI	E-mail address: lschoyer@dmh.lacounty.gov
Mailing Address:	

Comments

In terms of CAPTA (Federal Child Abuse Prevention & Treatment Act), I would think such vulnerable children should be linked to appropriate services; Among the most vulnerable are children screened to have both mental health and developmental concerns.

I see and commend the Family Resource Center recommendation, and suggest that the (IDEA Part C-funded) (Early Start) Family Resource Centers would be a great opportunity to make/strengthen that linkage since they're already set up with resource libraries & trained parent peers.

[To that effect also...]
- I received a 1x PEI grant in 2012 to promote the development of a Pilot training program

Any member of the public may submit written comments on or before May 6, 2014. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

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

to train parents of dually diagnosed MH/DD children ages 0-5, with good result, & would like to see how to increase partnerships to support this doubly-vulnerable population. Supporting parents as staff so trained would be valuable in building & sustaining this important, needed and too-often neglected-due-to-not-understanding-their-needs population (MORE ...)

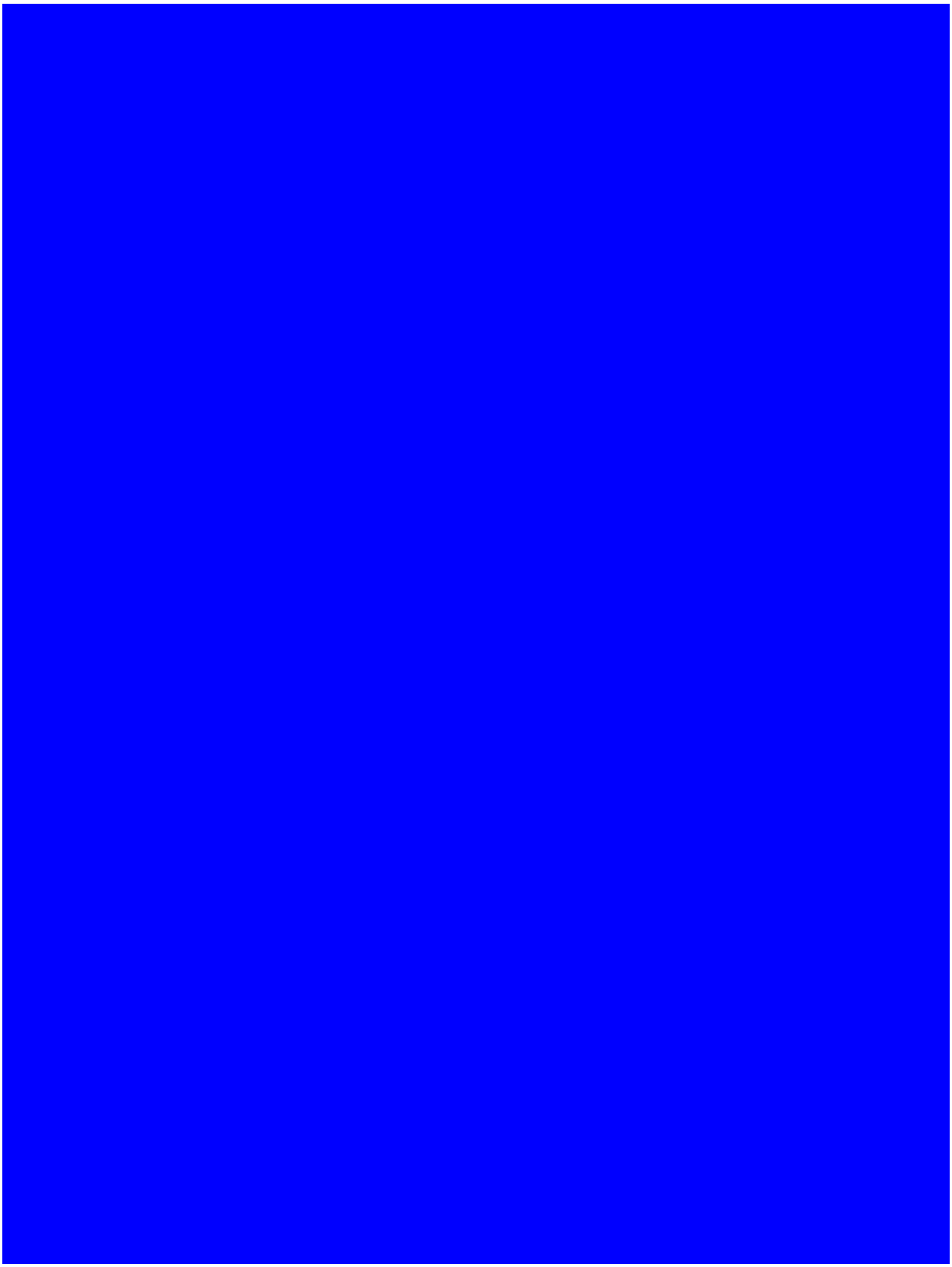
As they mature the DD population is particularly struck by anxiety & depression due to frustrations & dawning recognition of their differences, on top of being bullied. Short-term mental health services Can help them!

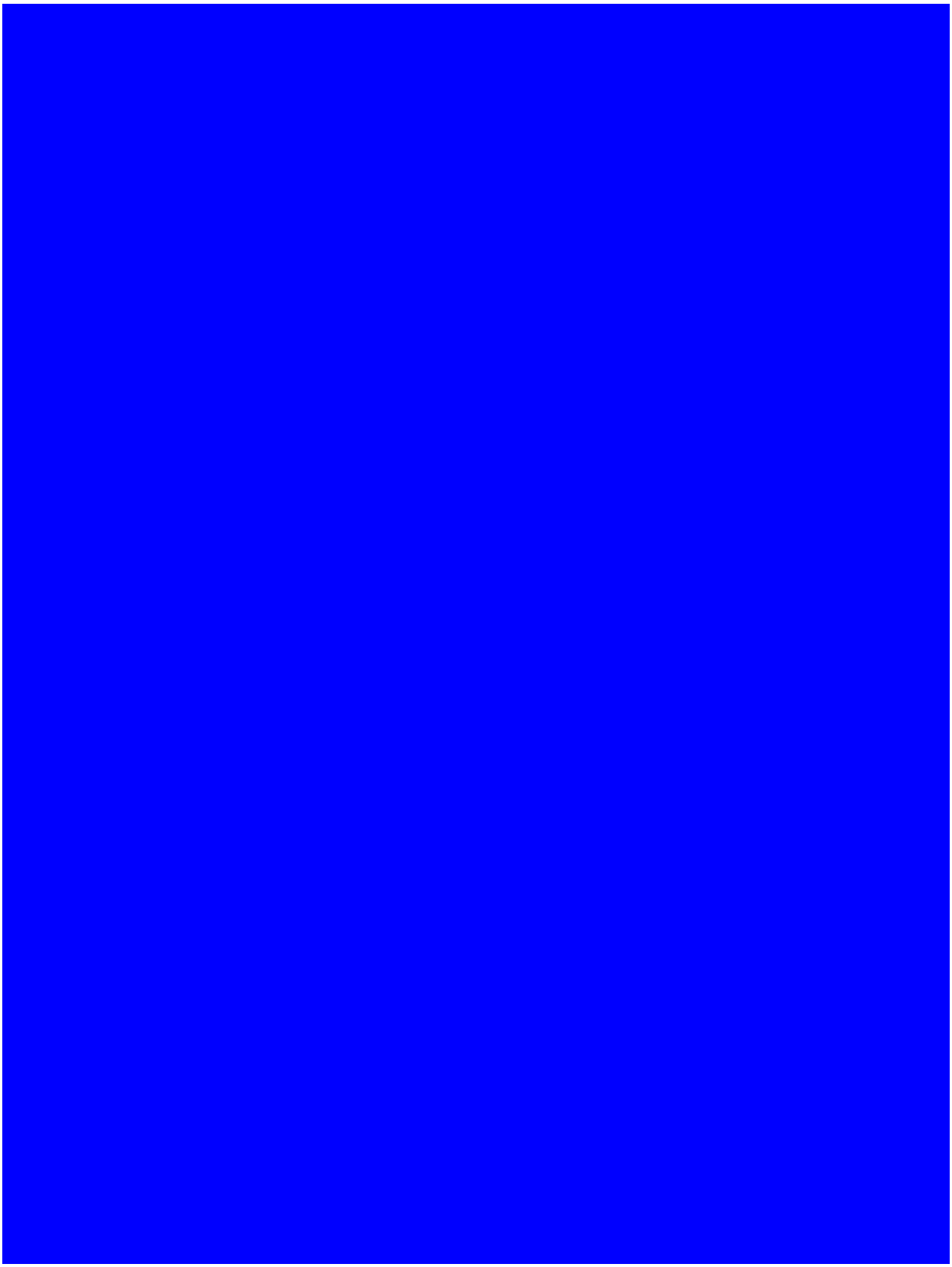
& behavioral issues

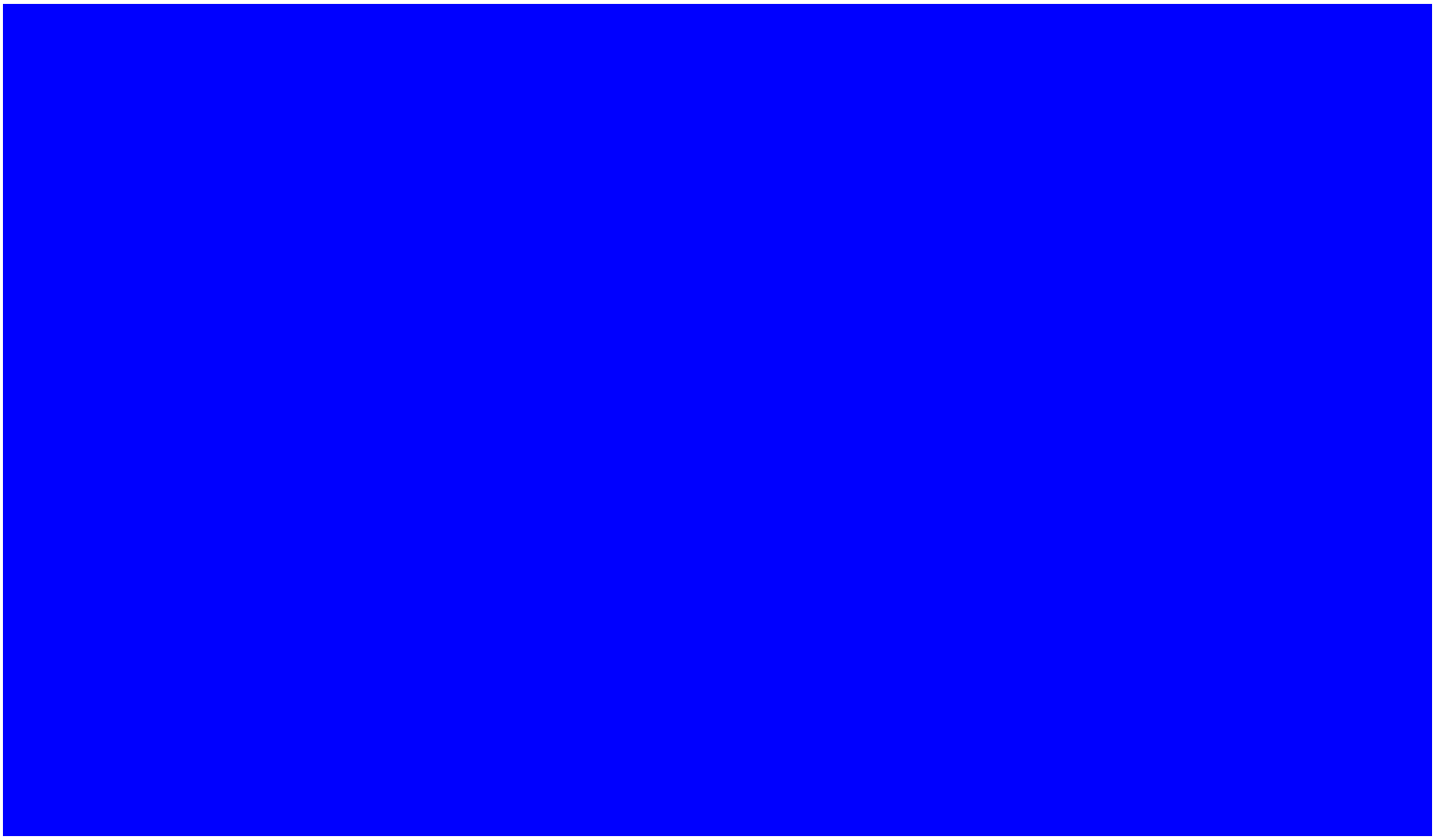
I withheld from speaking at the mike because of the stigma I know DMH has against individuals with developmental disabilities in terms of providing mental health services (despite Irma Castaneda's capable efforts... which I see focusing on strengthening relations with the RC colleagues than transforming MH staff & providers' perceptions...

Note: The CCC (cultural competency committee) recommends that the definition of Culture include...
→ cognitive ability or disability

P.S. There IS SAMHSA funding for children... so it's not just Substance Abuse.







COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH SERVICES ACT (MHSA)
THREE YEAR PROGRAM AND EXPENDITURE (3YPE) PLAN
FISCAL YEARS 2014-15 THROUGH 2016-17
MID-YEAR ADJUSTMENT

Community Services and Supports (CSS) Plan Expansion, Including Proposal to Add General Systems Development Work Plan Integrated Care Program (ICP)

BACKGROUND

The first round of MHSA Innovation (INN) projects on three (3) integrated service models, the Integrated Mobile Health Team (IMHT), the Integrated Clinic Model (ICM) and the Community-Designed Integrated Services Management model (ISM), all yielded significant improvement in client mental health and physical health status, substance use status, high client satisfaction, reduced client self-stigma. Due to the time-limited nature of MHSA INN, these models are scheduled to end on June 30, 2015.

Specifically, the following outcomes were achieved by model:

Integrated Clinic Model

- There were significant improvements on the Illness Management Recovery Scale (IMR), a clinician-rated mental health measure, 6, 12 and 18 months after enrollment in INN services, compared to ratings at baseline.
- The majority of ICM clients had clinically meaningful improvement in Overall IMR scores 6 months (71.0%), 12 months (79.4%) and 18 months (81.8%) after enrolling in services.
- There were significant improvements in client-rated physical health outcomes 6, 12 and 18 months after enrollment in INN services, compared to ratings at baseline.
- Close to half of ICM clients had clinically meaningful improvement in PROMIS Physical Health scores 6 months (40.7%) and one year (39.9%) after enrolling in services, compared to baseline.
- 73.8% of ICM clients had a clinically meaningful improvement in MORS ratings 18 months after enrolling in services, compared to baseline.
- 10.3% of ICM clients had a clinically meaningful reduction in drug use 12 months after enrolling in ICM.
- There was a significant decrease in use of emergency services 6, 12 and 18 months after enrollment in INN services, compared to baseline.

Integrated Mobile Health Team

- IMHT clients had significant improvements on the IMR, a clinician-rated mental health measure, 6 and 12 months after enrollment in INN services, compared to ratings at baseline. Clients continued to significantly improve between 12 and 24 months after first receiving INN services.
- The majority of IMHT clients had clinically meaningful improvement in Overall IMR scores 6 months (65.4%) and 12 months (74.9%) after enrollment.
- The majority of IMHT clients had clinically meaningful improvement in MORS ratings 6 months (60.1%) and one (1) year (72.9%) after enrolling in services, compared to baseline.
- 52.7% of IMHT clients had clinically meaningful improvement in PROMIS Physical Health scores 6 months after enrolling in services, and over half of clients (52.7%) had clinically meaningful improvements 12 months after enrollment when compared to baseline.
- 32.5% of IMHT clients had a clinically meaningful reduction in alcohol consumption 12 months after enrolling in services.
- 28.2% of IMHT clients had a clinically meaningful reduction in drug use 12 months after enrolling in services.
- There was a significant decrease in use of emergency services 6 and12 months after enrollment in INN services, compared to baseline.
- More IMHT clients (69.9%) experienced a clinically meaningful reduction one year after enrollment in IMHT.

Community-Designed Integrated Services Management Model

- The majority of ISM clients had clinically meaningful improvement in Overall IMR scores 6 months (73.1%) and one (1) year (76.2%) after enrolling in services.
- 62.1% of ISM clients had a clinically meaningful improvement in MORS ratings 12 months after enrolling in services, compared to baseline.
- Many ISM clients had clinically meaningful improvement in PROMIS Physical Health scores 6 months (33.8%) and 12 months (38.3%) after enrolling in services, compared to baseline.
- ISM clients reported a significant increase in paid employment 6 and 12 months after enrollment in INN services. 23.7% of ISM clients reported that they maintained paid employment for the first year of services; 10.7% of ISM clients gained employment within the first year of services.

Due to the success of these integrated care programs, the System Leadership Team (SLT) at their November 19, 2014 meeting recommended to the Department of Mental Health (DMH) to provide ongoing funding through the MHSA CSS plan, should DMH have unallocated funds.

An evaluation rubric was developed with DMH and provider input for each model, based on program expectations and the degree of achievement of positive outcomes. An analysis of the evaluation rubric for each model yielded a decision by DMH to continue providers within each of the three (3) models that achieved a threshold level of success on the evaluation rubric. Specifically, three (3) IMHT provider partnerships across three (3) Service Areas, four (4) ICM provider partnerships across two (2) Service Areas and 10 ISM provider partnerships across seven (7) Service Areas and countywide for one particular underrepresented ethnic population (UREP) community. The proposed plan allows for integrated services in each Supervisorial District and in all Service Areas that initially had MHSA Innovation-funded integrated services.

INNOVATION EVALUATION RUBRIC ACROSS MODELS

Client Level (60%)	**IMHT**	**ICM**	**ISM**
▪ Quality of Care	59%	59%	40%
▪ Quality of Life	34%	34%	40%
▪ Client Satisfaction	7%	7%	20%
Program Level (40%)			
▪ Data Compliance	15%	10%	11%
▪ Access to Care	30%	25%	26%
▪ Staffing	16%	12%	6%
▪ Cost	0%	24%	0%
▪ Integration	22%	17%	26%
▪ Outreach and Engagement	17%	12%	31%

PROPOSED ACTIONS FOR CONTINUED FUNDING:

Integrated Mobile Health Team:
MHSA CSS Plan, Adult FSP, specialized homeless vulnerable population
$3,584,791 (Net MHSA only, not inclusive of Medi-Cal)

Integrated Clinic Model and the Community-Designed Integrated Services Management Model:
New MHSA CSS Plan Work Plan entitled “Integrated Care Program” **(Requesting SLT Approval)**
ICM: $3,280,000 (Net MHSA only, not inclusive of Medi-Cal)
ISM: $9,052,509 (Net MHSA only, not inclusive of Medi-Cal)

Total MHSA CSS Funding: $15,917,300

Integrated Care Program

Program Description: Integrated Care Programs (ICP) are designed to integrate mental health, physical health, substance abuse, and other needed care such as non-traditional services to more fully address the spectrum of needs of individuals. The ICP service array will support the recovery of individuals with particular attention to those who are homeless, uninsured, and/or members of UREP. ICPs promote collaboration and partnerships by and between service providers and community-based organizations utilizing an array of services that may include traditional and non-traditional services.

Target Population: The target population for the ICP is individuals with Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED) that meet the Medi-Cal medical necessity criteria for receiving specialty mental health services, including those with co-occurring substance abuse and/or physical health issues, who are economically disadvantaged or uninsured, and/or members of a UREP.

Program Goals:

General: Integrating care in a large, diverse urban environment with complex systems of care. Differentiating specific needs and approaches for distinct populations including under-represented ethnic communities. Incorporating culturally relevant outreach and engagement strategies, peers into the staff and service array of providers and/or incorporating non-traditional approaches in improving outreach and engagement for the under-represented ethnic communities.

Intended Program Outcomes:

a) Improve physical and mental health and reduce substance use/abuse through an integrated service approach.
b) Improve timely access to services for underserved populations.
c) Decrease stigma and fear, associated with either being diagnosed with a mental illness or seeking mental health services.